Out from Under the Rug: Creating a Culture of Transparency

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What Do I Mean by “Culture”?  

• A small (but I hope, memorable) illustration
This is What I Mean by Culture!
Thought Questions

• In the *entire history of humankind*, how people have died or suffered irreparable harm because they wore mismatched socks?

• When is the last time you wore mismatched socks? Accessories? Etc.?

• That’s the power of culture.
What Do I Mean by “Under the Rug”? 

• Non-disclosure of errors 

• Non-awareness of errors 

• This starts one “dustball” at a time 

• And then takes on institutional attributes 
  – Risk management perspective 
  – Reputation management
What Do I Mean by Transparency?

• Disclosure of errors

• Awareness of errors

• Systematic approach

• Which affects institutional attributes
  – Safety and quality perspective
  – Reputation management ("We Try Harder")
We Set Out to Change our Culture

• Fix what’s broken

• Can’t fix what we don’t know about

• Won’t find out if our interest level is unclear
Part of a Much Larger Effort

• Quality Delivery System (QDS)

• Lean (Toyota) management

• Extensive involvement of staff, MD’s
Part of a Much Larger Effort

• No one wants dustballs on their mantelpiece

• So if you’re going to get dust out from under your rug, you better have a vacuum cleaner

• Can’t just be transparent, must also be active
Part of a Much Larger Effort

• Not going to talk today about those efforts, quality metrics, etc.

• Not just numbers and process: stories are also needed
Conveying our Interest

• Created a Patient Safety Alert System

• Identify, report, and fix serious errors

• Mostly going to talk today about *reporting*
  – Straightforward way to say “This matters to us”
Decisions, Decisions

- Never tell anyone anytime
- Tell a few people sometimes
- Tell everyone every time
Decisions, Decisions

• Never tell anyone anytime

• Tell a few people sometimes

• Tell everyone every time
Everyone Every Time?

• Everyone = staff, MD’s, Board, Trustees

• Every time = no exceptions

• “Everything” = relevant details
  – No names (staff, MD’s, patients)
  – Units, not shifts
  – Medications, procedures if important
We Do Not Disclose Every Error

• Simply too many

• We started with “Red Events” (never events)
  – Patient harm (death or substantial morbidity)

• We’ve added near misses
Overall Process

- Learn of a possible Red Event
- Involve CEO or EVP immediately
- Root cause analysis (RCA) ASAP
- Action plan
- Communication
- Follow-up
Process: Details

• Learn of a possible Red Event
  – Many sources
    • Risk, managers, house supervisors, line staff, MD’s
  – Sometimes encounter delays
    • “I didn’t think it was ‘Red’”
    • “I thought someone else told you”
    • Didn’t become manifest until months later

• Notify Administrator on call (AOC)
  – All have been trained in the process
Process: Details

• AOC informs CEO or EVP immediately
  – CEO/EVP determines if event is Red and appoints a lead senior executive
  – Stops the line, if appropriate
  – Keeps the scene and personnel intact

• Who really runs your hospital evenings, nights, holidays, and weekends?
Process: Details

• Root cause analysis, as soon as possible
  – Led by Senior Executive
  – Assisted by risk management, “local” manager
  – Follow a standard protocol
  – Report (preliminary) within 48 hours

• CHPSO resources
Time is of the Essence

*Forgetfulness*

Billy Collins

The name of the author is the first to go
Followed obediently by the title, the plot,
The heartbreaking conclusion, the entire novel
Which suddenly becomes one you have never read,
ever even heard of...
Process: Details

• Action plan and follow-up
  – Directed to the problem
  – Monitored by QDS personnel
  – Weekly reports of concerns, if any
Process: Details

• Communication
  – Friction = When rubber meets road

• No one will object to involving the CEO 24/7/365, or having an RCA, or developing an action plan

• But telling everybody may be another story
Issues to Consider

• Culture change is never easy
• Potential resistance (fear of unknown) from
  – Physicians
  – Legal team
  – Board of Directors
  – Donors
  – Management and staff
Most Resistance was Predictable

- General concern about airing dirty laundry
  - “Are you sure this is a good idea?”
  - “What if someone sends it to the newspaper?”

- Specific concern about own department, unit

- Legal ramifications
Unanticipated MD Resistance

Warrior vs. Worrier
Recommendations

• Find and enlist a warrior who worries

• Prepare a “just in case” media plan

• Discuss the plan before you start disclosing

• Tell the “local team” first, at least initially
  – We still inform Chief of Staff if an MD is involved
Disclosure Format

• The **Red Event**
  – Description of what happened

• Plan of correction

• What we can all learn

• “Batched” monthly, all-hospital email from me
Disclosure Language

• Avoid vagueness
  – “A mistake occurred, and the process was corrected.”
  – “This may have resulted in an injured patient.”

• Say what happened

• We also include the patient’s outcome
Introduction to First Disclosure

• Each year, there are millions of medical errors in the U.S. resulting in more than 100,000 accidental deaths. While CPMC consistently receives high marks for patient safety, we must continually look for ways to improve. Beginning this year, we are taking bold steps to openly communicate any medical errors that may occur. We hope to create a culture of safety that fosters rigorous study of errors, learning from past experience, learning from evidence-based practices and sharing of knowledge.
Introduction to First Disclosure

• As part of our Quality Delivery System, we will now communicate all **Red Events**, or serious medical mistakes, in a timely manner. We will share relevant facts of any incident (taking HIPAA regulations into account), we will detail the steps taken to remedy the problem and we will share the lessons we have learned.
Introduction to First Disclosure

• Health care today is very complex. Errors are often caused by underlying system failures, not personal failures. The primary goal of this initiative is to facilitate change in the system, not to single out an individual or department for blame.

• Following are details about a Red Event that occurred near the end of 2010. By sharing this story, we hope you will consider opportunities in your own work for improvement.
Example Disclosure

• **The Red Event:** A medical error occurred in Radiation Oncology where a patient had received a wrong-site radiation treatment due to a transcription error. Fortunately the patient was not harmed. Once the error was discovered, the patient was notified and a team of senior leaders immediately assembled to get to the root cause of the problem and create a plan of correction.
Example Disclosure

- **Plan of Correction:** An enhanced pre-procedure checklist was developed within 48 hours of the Red Event. This checklist is now being used before all radiation therapy procedures.
Example Disclosure

• **What We All Can Learn:** In this instance, a dedicated focus on the “Time-Out” before the procedure could have prevented the problem. Just about every procedure we conduct at CPMC—from Foley placement to neurosurgery—has some sort of Time-Out process. The Time-Out is a planned period of interdisciplinary discussion focused on ensuring that key details on a pre-procedure checklist have been addressed, including patient identification, consent, and site of procedure.
Example Disclosure (2)

- **The Red Event**: A patient received the wrong-sized lens implant during eye surgery. Earlier that day, lens orders for three patients were placed on a shelf in the OR. The wrong lens was inadvertently selected, and was not verified by the team during the Time Out. The surgeon recognized the error before the patient left the OR suite. The patient was informed, and the incorrect lens was replaced with the correct one.
Example Disclosure (2)

- **Plan of Correction**: We implemented a standard work checklist for lens implants which must be verified during the Time Out. This includes reading the order sheet aloud, confirming that it is the correct lens and the right patient.
Example Disclosure (2)

• **What We Can All Learn**: This was a case of human error, but the underlying problem was in not having a mistake-proof process. We are working to do everything we can to reduce the likelihood of human error, such as creating checklists and adhering to standard work.
A Few Observations

• Very tempting to assume a motive

• “Never ascribe to malice that which can adequately be explained by incompetence.”
  Attributed to Napoleon

• Equally tempting to have blanket amnesty
Fair and Just Response

• Committing an error is not cause for discipline

• But neither is it a “Get Out of Jail Free” card

• Disclosing an error is admirable; concealing one is not
What We’ve Learned

What We’ve Learned

The best laid schemes of mice and men
Go often awry...

Robert Burns
What We’ve Learned

The holes line up all too frequently.
What We’ve Learned

• “Five rights” can go wrong
  – Faulty assumptions
• People (patients) do the darndest things
• The unfamiliar is not your friend
  – Equipment, procedures, medications
• Neither is gravity
• Or the power of ten (pre-EHR!)
What We’ve Learned

• No negative comments from anyone
• No adverse publicity
• Many “Thank you for doing this” comments
• System adopted much of what we do

• Good stories are also needed
  – e.g., near misses that were “saved”
Is It Working?

• Too soon to tell, really
  – Culture changes at a glacial pace
  – Evolutionary improvement requires selection pressure

• No clear metrics to follow
  – Each type of Red Event is rare
  – Perception of safety may worsen initially

• Many more disclosures
  – Risk: “Even we would not have known.”
  – MD’s: Ordered tests on wrong patients
Red Events: 2011

January  February  March  April  May  June  July  August  September  October  November  December

0  1  2  3  4  5  6

Death  Severe Permanent Harm  Moderate Permanent Harm  Severe Temporary Harm  Moderate Temporary Harm  No Harm
Red Events: 2012

- Death
- Severe Permanent Harm
- Moderate Permanent Harm
- Severe Temporary Harm
- Moderate Temporary Harm
- No Harm

JAN FEB MAR APR MAY JUN JUL AUG SEP OCT NOV DEC
Serious Safety Events: 2013

JAN  FEB  MAR  APR  MAY  JUN  JUL  AUG  SEP  OCT  NOV  DEC

1  2  3  4  5  6

Death  Severe Permanent Harm  Moderate Permanent Harm  Severe Temporary Harm  Moderate Temporary Harm  No Harm
Serious Safety Events: 2014

- **Death**
- **Severe Permanent Harm**
- **Moderate Permanent Harm**
- **Severe Temporary Harm**
- **Moderate Temporary Harm**
- **No Harm**
Thanks for your interest