Crucial Keys to a Culture of Quality

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- 8 hospitals
- 60 outpatient facilities
- 10,000 employees
- 980 volunteers
- 237,000 ED visits
- 800,000 patients served
- 1,738 physicians
- 1,700 licensed beds
What does a quality culture look like?
GOAL
Maintain TRUVEN TOP 100 Hospital designation & reach Top Decile in all metrics by end of 2014
What does a quality culture look like?

Everyone knows and aims for the goal: perfect care --- every patient, every time, everywhere
What does a quality culture look like?

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- We communicate, communicate, communicate
What does a quality culture look like?

❖ Everyone knows and aims for the goal: **perfect care: every patient, every time, everywhere**

❖ We communicate, communicate, communicate

❖ We are a team focused on the patient.
  ✤ People jump in when a nurse, PT, CT, doc needs help
  ✤ Newer employees are not afraid to ask for help from more experienced ones.
Engaged caring nurse will treat the patient like her grandma
What does a quality culture look like?

- Everyone knows and aims for the goal: perfect care: every patient, every time, everywhere

- We communicate, communicate, communicate

- We are a team focused on the patient.
  - People jump in when a nurse, PT, CT, doc needs help
  - Newer employees are not afraid to ask for help from more experienced ones.

- Each person knows how she/he contributes to perfect care.
5 Crucial Keys to A Culture of Quality

- Getting the right people on the bus & engaging them
- Valuing & appreciating employees who live the mission
- Making it easy to do the right thing
- Creating a Just Culture so people feel safe to report errors
- Sharing data so all teach, all learn thru unit/dept PDCA
Getting the right people on the bus
“Hire for attitude and train for skill.”

Spirit Magazine, Nov 2013
Characteristics of Engaged Employees…

- Make suggestions for improving work flow
- Find ways to save money and time
- Get along with their colleagues
- Generate infectious enthusiasm
Valuing & Appreciating Employees

- Best way to recognize them is MBWA so you can catch them doing something good!

- Directors, VPs, Presidents are tracked monthly for thank you notes written to employees.

- Great Catch Award
**NEW YEAR’S RESOLUTIONS**

**PROMISES, PROMISES**

Top 5 New Year’s resolutions in 2012:
1. Lose weight
2. Exercise
3. Spend less and save more
4. Quit smoking
5. Become a better person

Each January, nearly half of Americans vow to make at least one change:
- Make at least one resolution each year: 45%
- Make a resolution some years: 38%
- Never make a resolution: 17%

But the vast majority give up sooner or later:
- People who maintain their resolutions through...
  - 1 week: 75%
  - 2 weeks: 71%
  - 1 month: 64%
  - 6 months: 46%
  - 88% eventually fail

**BIGGEST LOSERS**

Losing weight and/or getting fit are the most common resolutions:
- 30% Spike in gym membership purchases around New Year’s
- 46 million Turkeys eaten on Thanksgiving
- 22 million Turkeys eaten on Christmas
- Average weight per turkey: 15 lb
Wow! Did you see that?
What is a “Great Catch”? 

- Any time an employee recognizes a problem and reports it before it becomes a larger problem.

- Early intervention and prevention of downstream negative consequences.

- Saving of money, time, and lives!
Why The Great Catch Recognition Program?

- Recognizes employees that care about quality and safety
- Promotes ownership and early intervention
Making it easy to do the right thing
HOW TO PICK THE CORRECT HOSPITAL CPT ADMISSION CODE

http://thehappyhospitalist.blogspot.com

BILL CPT 99291

Am I being honest?

Did I spend 30 minutes or more in evaluation?

Does your encounter meet criteria for critical care?

STOP
That's just ridiculous

Did I spend more than 134 minutes?

Screw my morals

Did I buy a big fancy home I couldn't afford?

Am I the attending physician?

Did I write an order for inpatient status?

Did I write an order for observation or ASC status?

Was the

How am I supposed to know? I was never trained to know this stuff

Sure

Did my utilization review folks agree with me?

I got it wrong anyway

Was the

Yes, I have no
CONTACT PRECAUTIONS
(In addition to Standard Precautions)

VISITORS: For safety reasons, we strongly recommend that you wear gown & gloves in the room. If you need assistance, please check with a patient care provider before entering the room.

- Use dedicated or disposable equipment when possible.
- Clean and disinfect shared equipment.
CAUTION: ALL STAFF
HIGH FALL RISK
PATIENT

WATCH ME CLOSELY
JUST CULTURE
Medical Error

Failure of a planned action to be completed as intended or the use of a wrong plan to achieve the aim. Errors can include problems in practice, products, procedures and systems.

Centers for Medicare & Medicaid (CMS):
Why Report adverse events?

- Right thing to do.
- To identify safety issue/concern on unit
- To look at trends-take action
- Risk mitigation
- Legal protection
- Promotes a Safety Culture
# S.A.F.E  
**Safety Awareness for Excellence**

## Online Incident Reporting

Improving the quality of care and services at Kettering Health Network

- Event Reporting is used to improve patient care. NOT to assign blame to any person.
- All events must be reported without delay.
- State the facts - who, what, when, where, why and how, no opinions.
- All MEDICAL FACTS concerning the event must be fully documented in the medical record.
- Copies of the event report should not be made, nor placed in the medical record or referenced to in the patient's medical record. Click on the appropriate Event tool to access the online form.
- Click here for PowerPoint Demo or print instructions.
- To report an Employee Event use the Employee Incident Report.

The Facility Name is connected to the Epic Department, Unit, Location. If the Facility is not in the list, select Other Facility. If Other Facility is selected, the event will be entered as a Non-Patient.

### Medication/IV Error

Use this form to report medication events such as wrong Dose, Inadequate Dose/Quantity, DoseIv, Administration Technique, Wrong Drug, Wrong Preparation, Wrong Patient, Wrong Route, Wrong Time, Unauthorized/Wrong Drug, IV infiltration, IV extravasation and IV Reta.

### Adverse Drug Reaction

Use this form to report adverse drug reaction. An ADR is any untoward medical event which follows the administration of a medicinal drug, and which does not necessarily have a causal relationship with the drug. Examples include allergic reactions, rash, fever, dizziness, and nausea.

### Surgery/Procedure Event

Use this form to report Anesthesia Related Events, Burn Anesthesia during Surgery, Cough, Inadequate Instrument Tray, Inadequate Instrumentation, Inadequate Surgical Equipment, Inadequate Instrumentation, Postoperative Laceration, Device Related Infection, Return to Surgery Site not Marked, Surgery Cancellation, Transfusion Issues, Time Out Issues, Unexpected Hemorrhage, Unplanned Organ Repair, Wrong Patient Site/Time, Wrong Site.

### Fall Event

Patient/Visitor - Use this form to report a slip, trip or fall. To report an Employee Fall use the Employee Incurred Injury Report provided by Employee Health.

### Tests/Treatment Event

Use this form to report events that may include Dye Cancellation, Policy Not Followed, Consent Issues, Limited Treatment, Documentation Issues, Lab Issues, or Specimen Issues.

### General Event

Use this form when none of the above forms match your event such as Patient Care equipment issues, AIA, patient property problems (stolen/mishandled), lost belongings, lost glasses, lost hearing aids, patient identification/embroidered missing or incorrect.

### Blood Transfusion Event

Use this form to report Blood Transfusion Reactions.

### Disruptive Behavior Event

Use this form to report Disruptive behavior either minor or major. This includes, but is not limited to, threats, assaults, batteries, harassment, stalking, vandalism, and other forms of intimidation. Any act that is manifested as threatening or intimidating may also be considered a disruptive behavior. Patient Disruptive Behavior is to be entered into a General Event Form.

### Moderate Sedation Event

Only use this form to report an adverse outcome on a patient who received moderate sedation.

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### Need Help?

Please contact your department manager.

If you are having computer issues, contact the Support Center at Extension 4450.
Just Culture

a KEY ELEMENT IN A Safe culture
Just Culture

Threshold Investigation

- WHAT HAPPENED?
- WHAT NORMALLY HAPPENS?
- WHAT DOES PROCEDURE REQUIRE? (if applicable)
- WHY DID IT HAPPEN?
- HOW WAS THE ORGANIZATION MANAGING THE RISK?
Organizational culture that promotes a “Culture of Safety”

- Recognizes that competent professionals are human and make mistakes (Human error)

- Some professionals will develop shortcuts, rule violations (At Risk Behavior)

- Zero tolerance for willful risky individual behavior (Reckless)

- Not held responsible for systems breakdowns

- Events reported, mistakes acknowledged, learning occurs. Balanced action depending on findings.
Just Culture

Did an employee put an organizational interest or value in harm’s way?

- Potential or actual harm to persons
- Potential or actual harm to property

Did the employee breach a duty to follow a procedural rule in a system designed by the employer?

Rule specifies *how* to perform the job
System largely controlled by employer

Did the employee breach a duty to produce an outcome?

Rule specifies the outcome to be achieved
System largely controlled by employee

If unsure, default to duty to follow a procedural rule
Relentless sharing of transparent data in a PDCA cycle
January 2014 Falls by Unit

- SH UN1, 1
- SH UN2, 2
- SH ICU, 1
- KH Xray, 1
- KH 2W Neur, 1
- KH EEG, 1
- KH ASC, 1
- KH MedReh, 2
- KH 2South, 2
- KBMC Adult, 3
- KH 3South, 3
- KH SDM, 1
- KH 2North, 1
- KH 3W CDU, 2
- KH 3East, 6
- KH 5North, 2
- KH 5South, 3
### Patient Safety Indicators

#### PSI90 Network Opportunities

<table>
<thead>
<tr>
<th>Patient Safety Indicator</th>
<th>Numerator</th>
<th>Denominator</th>
<th>Rate/1,000</th>
<th>Premier Cases</th>
<th>Premier Mean</th>
<th>Premier Median</th>
<th>Premier 25th Pctl</th>
<th>Premier 10th Pctl</th>
</tr>
</thead>
<tbody>
<tr>
<td>PSI-03 Pressure Ulcer</td>
<td>0</td>
<td>2,337</td>
<td>0.00</td>
<td>N/A</td>
<td>0.57</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
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<tr>
<td>PSI-04 Death in Surgical Pts w Treatable Complications</td>
<td>9</td>
<td>73</td>
<td>123.29</td>
<td>N/A</td>
<td>117.23</td>
<td>117.65</td>
<td>80.00</td>
<td>43.86</td>
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<tr>
<td>PSI-06 Iatrogenic Pneumothorax</td>
<td>1</td>
<td>7,489</td>
<td>0.13</td>
<td>N/A</td>
<td>0.33</td>
<td>0.24</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>PSI-07 Central Venous Catheter-Related Blood Stream Infection</td>
<td>0</td>
<td>4,539</td>
<td>0.00</td>
<td>N/A</td>
<td>0.51</td>
<td>0.25</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>PSI-09 Postop Hemorrhage or Hematoma</td>
<td>5</td>
<td>1,841</td>
<td>2.72</td>
<td>N/A</td>
<td>2.19</td>
<td>1.71</td>
<td>0.44</td>
<td>0.00</td>
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<tr>
<td>PSI-10 Postop Physiologic and Metabolic Derangement</td>
<td>2</td>
<td>1,005</td>
<td>1.99</td>
<td>N/A</td>
<td>0.56</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>PSI-11 Postop Respiratory Failure</td>
<td>7</td>
<td>833</td>
<td>8.40</td>
<td>N/A</td>
<td>9.85</td>
<td>7.90</td>
<td>3.77</td>
<td>0.00</td>
</tr>
<tr>
<td>PSI-12 Postop PE or DVT</td>
<td>13</td>
<td>1,833</td>
<td>7.09</td>
<td>N/A</td>
<td>4.52</td>
<td>3.82</td>
<td>1.84</td>
<td>0.00</td>
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<tr>
<td>PSI-13 Postop Sepsis</td>
<td>1</td>
<td>193</td>
<td>5.18</td>
<td>N/A</td>
<td>12.75</td>
<td>8.09</td>
<td>0.00</td>
<td>0.00</td>
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<tr>
<td>PSI-14 Postop Wound Dehiscence</td>
<td>0</td>
<td>212</td>
<td>0.00</td>
<td>N/A</td>
<td>1.97</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
</tbody>
</table>
Admit Date: 2/4/14  Discharge Date (if applicable):

Through review of **Account No #** 202576710  **MR #:** E165341 the following opportunity for improvement for best practice has been identified below.

**Coding Manager: Please review the chart for coding validation of OFI.**

Place an “X” by the HAC listed below. If the secondary diagnosis is not listed, place an “X” by “Other” and explain type.

<table>
<thead>
<tr>
<th>Urinary Catheter-Associated UTI (CAUTI)</th>
<th>Iatrogenic Pneumothorax</th>
<th>DVT and PE Following Ortho Procedures (Hips, Total Knees excluding revisions)</th>
<th>Vascular Catheter Assoc. Infections (includes localized infections)</th>
</tr>
</thead>
<tbody>
<tr>
<td>C Diff Infection</td>
<td>Pressure Ulcer Stage 3/4</td>
<td>Object Retained After Surgery</td>
<td>Manifestations of Poor Glycemic Control</td>
</tr>
<tr>
<td>Central Line Blood Stream Infection (CLABSI)</td>
<td>Falls with Trauma (fracture, dislocation, intracranial injury, crushing injur, burn, other injuries)</td>
<td>Surgical Site Infections following: CABG, Ortho procedures, Bariatric surgery</td>
<td>Surgical Site Infections following Cardiac Implantable Electronic Device (CIED)</td>
</tr>
<tr>
<td>Staph Aureus Sepsis Postop Sepsis</td>
<td>Air Embolism x</td>
<td>Postop Respiratory Failure</td>
<td>Accidental Laceration or Puncture</td>
</tr>
<tr>
<td>Ventilator-Associated Pneumonia</td>
<td>Blood Incompatibility</td>
<td>Postop Wound Dehiscence</td>
<td>Postop Hemorrhage or Hematoma</td>
</tr>
</tbody>
</table>
Summary:
5 Keys to A Culture Quality

- Getting the right people on the bus & engaging them
- Valuing & appreciating employees who live the mission
- Making it easy to do the right thing
- Creating a Just Culture so people feel safe to report errors
- Sharing data so all teach, all learn thru unit/dept PDCA
QUESTIONS?