Safety and Professional Accountability: It Takes a Plan

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Assistant Vice Chancellor for Health Affairs
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Vanderbilt University School of Medicine
Pursuing Reliability

**Definition:** “Failure free operation over time... effective, efficient, timely, pt-centered, equitable”

**Requires:**
- Vision/goals/core values
- Leadership/authority (modeled)
- A *safety* culture = willingness to report and address
  - Psychological safety
  - Trust

Professionalism and Self-Regulation

- Professionals commit to:
  - *Technical and cognitive competence*

- Professionals also commit to:
  - *Clear and effective communication*
  - *Being available*
  - *Modeling respect*
  - *Self-awareness*

- Professionalism promotes *teamwork*

- Professionalism demands *self- and group regulation*

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Case: “Time Out”

• The following event was reported to you (an authority figure: Anesthesia Clinical Director, Section Chief or Department Chair) through your electronic event reporting system. Policy defines that you review and follow up. Report:

  – Nurse X (Surgical Circulator) attempted to call a time out prior to start of a [procedure] on patient, Jane Doe, age 57.

  – Team members did not acknowledge... participated in side conversations and continued prepping...
Case: “Time Out”

– Nurse X tried again

– Dr. Surgeon interrupted, “I think we are all on the same page here...could we please begin,” and continued a conversation.

Threat to safety?
Represents a threat to safety?

1. Strongly Agree
2. Agree
3. Uncertain
4. Disagree
5. Strongly Disagree
In your microsystem, what % of the time would someone report the event to a responsible party or through an established event reporting system?

1. 0%-20%
2. 20%-40%
3. 40%-60%
4. 60%-80%
5. 80%-100%
If reported, what % of the time would a medical leader have a conversation with Dr. Surgeon?

1. 0%-20%
2. 20%-40%
3. 40%-60%
4. 60%-80%
5. 80%-100%
What are behaviors that undermine a culture of safety?
1981 NEW WUSE
OB- Dr. X
PASSIVE

AGGRESSIVE
Definition of Behaviors That Undermine a Culture of Safety

- Prevent or interfere with an individual’s or group’s work, or ability to achieve intended outcomes
- Create, or have potential to create intimidating, hostile, offensive, or unsafe work environment
- Threaten safety: aggressive or violent physical actions
- Violate policies, including conflicts of interest and compliance

It’s About Safety

Excerpts from Vanderbilt University and Medical Center Policy #HR-027, 2010
Common Failures:

- Practice hand hygiene
- Complete handoffs/documentation
- Observe protocols (e.g., time outs)
- Answer pages
- Practice EBM (CAUTI, CLABSI, VAP, C-DIFF, Sepsis, etc.)
- Rescue (prevent deterioration from complication of underlying illness or surgical procedure)
- Refrain from jousting
- Adhere to safety/quality guidelines
Why are we so hesitant to act?

What barriers exist?
Barrier
Consequences of Unsafe Behavior: Patient Perspective

- Lawsuits
- Infections/Errors
- Non adherence/noncompliance
- Surgical Complication
- Drop out
- Costs

(tip of the iceberg)

Bad-mouthing the hospital/practice to others

Consequences of Unsafe Behavior: Healthcare Professional Perspective

Harassment suits
Lack of retention
Burnout
Costs
Jousting
Bad-mouthing the organization in the community

(tip of the iceberg)
Infections/Errors

The Balance Beam

<table>
<thead>
<tr>
<th>Competing priorities</th>
<th>Do nothing</th>
<th>Do something</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not sure how lack tools, training</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Leaders “blink”</td>
<td></td>
<td></td>
</tr>
<tr>
<td>“Can’t change…”</td>
<td></td>
<td></td>
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<tr>
<td>Fear of antagonizing</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Staff satisfaction and retention</th>
<th>Reputation</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient safety, clinical outcomes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Liability, risk mgmt costs</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Why might a medical professional behave in ways that undermine a culture of safety?

1. 
2. 
3. 
4. 
5. 
6. 
7. 
8.
To “do something” requires more than a commitment to professionalism and personal courage. We need a plan.
(a function of preparation)
Infrastructure for Promoting Reliability & Professional Accountability (PA)

1. Leadership commitment (will not blink)
2. Goals, a credo, and supportive policies
3. Surveillance tools to capture observations/data
4. Processes for reviewing observations/data
5. Model to guide graduated interventions
6. Multi-level professional/leader training
7. Resources to address unnecessary variation
8. Resources to help affected staff and patients

Leadership commitment

- Hold all team members accountable for modeling...
- Enforce code of conduct consistently and equitably
- Recognize professionalism in action
- Employ appropriate measures designed to reduce unprofessional behaviors.
- Focus on behavior and performance.
Policies will not work if behaviors that undermine a culture of safety go unobserved, unreported and unaddressed
What Are “Surveillance Tools”? 

• **Risk Event Reporting System**
  - “Resuscitation run incorrectly...team afraid to speak up...dismisses those who say something...threatens culture of safety.”

• **Patient Relations Department**
  - Record patient/family concerns: “…didn’t listen...nor was Dr. __ forthcoming when asked for pros & cons of [one treatment plan]...just said, “no cons.”

1.6% of Physicians (n=31) were associated with 42% of behavior/conduct reports.

Audit Period: March 1, 2011 – February 28, 2014

This material is confidential and privileged information under the provisions set forth in T.C.A. §§ 63-1-150 and 68-11-272 and shall not be disclosed to unauthorized persons.
Pichert et al, 2011.  
Hickson et al, 2012.
Case: “Time Out”

• The following event was reported to you (an authority figure: Anesthesia Clinical Director, Section Chief or Department Chair) through your electronic event reporting system. Policy defines that you review and follow up. Report:
  
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  – Team members did not acknowledge... participated in side conversations and continued prepping...
Case: “Time Out”

– Nurse X tried again

– Dr. Surgeon interrupted, “I think we are all on the same page here...could we please begin,” and continued a conversation.
What might an “informal” intervention sound/look like?

What would you want if you were on the receiving end?
For leaders, there are two kinds of “Coffee” Conversations:

Regular and Espresso
Principles for “Informal” Conversations

• Your role (even as “the chief”):
  – To report an event
  – To let the colleague know that the behavior/action was noticed (surveillance)

• It’s not a control contest. (“I am coming as a colleague...”)

• Don’t expect thanks (acknowledgement)

• Know message and “stay on message”

• Know your natural default (your communication style; your “buttons”)

• Offer appreciation (if you can): “You’re important, if you weren't, I wouldn't be here.”

• Use “I” statements: “I heard...,” “I saw...,” “I received...”

• Avoid “you” statements...

• Review incident, provide appropriate specifics

• Ask for colleague’s view...pause...

• Respond to questions, concerns...
But what if it happens again?
Case: “Whistling a Tune”

• The following event was reported thru your org’s event reporting system. Report reads:
  – “Dr. Surgeon was scheduled to perform a ____ (choose any procedure) on a 72 y.o. pt.
  – Once in the OR, the team attempted to perform a ‘time out’ (verification of patient identity, correct side and site, and agreement on procedure to be done).
Case: “Whistling a Tune”

• It seems Dr. Surgeon asked everyone to ‘listen carefully,’ then as the process started Dr. Surgeon began whistling a tune...

• ‘We believe it was the Mickey Mouse Club theme song.’”

• You had a Cup of Coffee Conversation previously about a similar report. You decide to have an Espresso conversation with Dr. Surgeon.
• Same as the cup of coffee EXCEPT:
  – As your leader...let you know that the behavior/action was noticed
  – “Is the report factually true?”
  – Documentation – but declare, “I will drop a note...”
But wait, does any of this really work?
Med Mal Research Background Summary

- 1-6%+ hosp. pts injured due to negligence
- ~2% of all pts injured by negligence sue
- ~2-7 x more pts sue w/o valid claims
- Non-$$ factors motivate pts to sue
- Some physicians attract more suits
- High risk today = high risk tomorrow

While asking Dr. ___ about my surgery, he responded that my questions were annoying...wouldn’t listen and kept speaking over me...

We were so rushed that Dr. ___ couldn't even explain why they were recommending this medication for my mom over other types of anesthetics...unacceptable...

After my surgery I talked to Dr. ___ about how I reacted to the meds...Dr. ___ said, “Well, you got yourself into this situation...”
Academic vs. Community Medical Center Physicians

5% of physicians associated with 35% of concerns

35-50% of physicians are associated with NO concerns

<table>
<thead>
<tr>
<th>Predicted Risk Category*</th>
<th># (%) Physicians</th>
<th>Relative Expense*</th>
<th>% of Total Expense</th>
<th>Score (range)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 (low)</td>
<td>318 (49)</td>
<td>1</td>
<td>4%</td>
<td>0</td>
</tr>
<tr>
<td>2</td>
<td>147 (23)</td>
<td>6</td>
<td>13%</td>
<td>1 - 20</td>
</tr>
<tr>
<td>3</td>
<td>76 (12)</td>
<td>4</td>
<td>4%</td>
<td>21 - 40</td>
</tr>
<tr>
<td>4</td>
<td>52 (8)</td>
<td>42</td>
<td>29%</td>
<td>41 - 50</td>
</tr>
<tr>
<td>5 (high)</td>
<td>51 (8)</td>
<td>73</td>
<td>50%</td>
<td>&gt;50</td>
</tr>
<tr>
<td>Total</td>
<td>644 (100)</td>
<td></td>
<td>100%</td>
<td></td>
</tr>
</tbody>
</table>

* In multiples of lowest risk group

National comparison with peers


Since FY 2000, PARS® has identified >1020 U.S. physicians as high risk

Total # of high-risk physicians to date: 1021
First follow-up will be in 2014 or 2015: (131)
Departed before 12 month follow up: (78)
812 with follow-up data

Departed organization unimproved: 59 Physicians
Unimproved/worse: 119 Physicians
78% Successfully completed intervention process or are improving: 634 Physicians
15%
7%
Confidential and privileged information under the provisions set forth in T.C.A. § § 63-1-150 and 68-11-272; not be disclosed to unauthorized persons.

Medical Malpractice Suits Per 100 Physicians

--- SVMIC --- VUMC

Tort Reform in TN

2008 – Cert. of Merit w/ Notice
2011 – $750K Cap

VUMC Risk Prevention Initiatives

ID & intervene on high-risk VUMC physicians (PARS®)
2003 – Claims reviews w/ leaders
2005 – Standardized MM&Is; Faculty Disclosure Training
2007 – Allocation rebate program
2012 – Address unprofessional or unsafe behavior

*Data sources: With permission of State Vol Mutual Insurance Company, mutual insurer of 10,500 non-VUMC TN physicians, all specialties, 29% to 33% who practiced in Middle TN during the target date; ASHRM/Aon Hospital and Physician Professional Liability. October 2012, 2013.

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What else do patient complaints predict?
Patient Complaints

Clear and Effective Communication

Dr. __ did a very poor job of communicating. He raced through an explanation of what we should expect, then left without giving us a chance to get clarification.

Respectful

I said I had questions. Dr. __ looked up and asked, “Are you illiterate?” I said No. Dr. __ responded, “Oh, I just gave you a pamphlet that explains it. Since you didn’t get it, I thought maybe you could not read.”
**NSQIP and Pt Complaints**

**Question:** Do Periop Risk Factors moderate the relationship between Patient Complaints and Surgical Outcomes?

<table>
<thead>
<tr>
<th>Risks</th>
<th>Patient Complaints</th>
<th>PARS® Categories</th>
<th>Surgical Occurrences</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preop Risk Factors</td>
<td>ASA Class</td>
<td>Care &amp; Treatment</td>
<td>Intraoperative</td>
</tr>
<tr>
<td></td>
<td>Priority Status</td>
<td>Communication</td>
<td>Wound</td>
</tr>
<tr>
<td></td>
<td>Wound Class</td>
<td>Concern for Pt/Family</td>
<td>Urinary</td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td>Accessibility</td>
<td>CNS</td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td>Billing w/C&amp;T concern</td>
<td>Respiratory</td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td>Other</td>
</tr>
</tbody>
</table>
Results: Significant relationships between Occurrences & Complaints

- 66 surgeons; 10,536 procedures
- Correlations between pt complaints and occurrences:

<table>
<thead>
<tr>
<th>Occurrences</th>
<th>Correlation with Patient Complaints</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intraoperative</td>
<td>0.58, p&lt;.001</td>
</tr>
<tr>
<td>Wound</td>
<td>0.60, p&lt;.001</td>
</tr>
<tr>
<td>Urinary</td>
<td>0.61, p&lt;.001</td>
</tr>
<tr>
<td>Respiratory</td>
<td>0.59, p&lt;.001</td>
</tr>
<tr>
<td>Other</td>
<td>0.55, p&lt;.001</td>
</tr>
</tbody>
</table>

The relationship is moderated by perioperative risk
Regression Analysis: Perioperative Risk, Patient Complaints, and Surgical Occurrences*

*Lower perioperative risk patients:
Few adverse outcomes regardless of surgeons’ complaints

β = -.04, p = .77

*Wound depicted, same pattern for Urinary, Intraoperative, and Respiratory Occurrences
Analysis controls for # cases sampled. Catron, Guillamondegui et al. Submitted, 2014
Patient Complaints Moderate the Relationship Between Risk Factors and Surgical Outcomes *

--- Higher perioperative risk patients:
Few adverse outcomes for surgeons with few pt complaints; More adverse outcomes for surgeons with more complaints

\[ \beta = .42, \quad *p < .05 \]

--- Lower perioperative risk patients:
Few adverse outcomes regardless of surgeons’ complaints

\[ \beta = -.04, \quad p = .77 \]

*Interaction \( p < 0.01 \)

Wound Occurrences (in Standard Deviations)

Fewer # Pt Complaints  \( \rightarrow \) Greater # Pt Complaints

*Wound depicted, same pattern for Urinary, Intraoperative, and Respiratory Occurrences Analysis controls for # cases sampled. Catron, Guillamondeguit et al. Submitted, 2014
Case: “A Third Time Out Report”

The following event was reported to you (an authority figure: Anesthesia Clinical Director, Section Chief or Dept Chair) thru your electronic event reporting system. Report reads:

– Nurse reported the following occurred twice during consecutive surgeries:

  – “Dr. Surgeon arrived and announced a need to answer calls during the time out process, saying ‘Come get me when the time out has been completed.’”

– You are disappointed Dr. Surgeon has not self-corrected (2 previous cups of coffee and this is a new event). You prepare a letter...
Promoting Professionalism Pyramid

- Level 3 "Disciplinary" Intervention
- Level 2 "Guided" Intervention by Authority
- Level 1 "Awareness" Intervention
- "Informal" Cup of Coffee Intervention
- Egregious
- Mandated
- Vast majority of professionals - no issues - provide feedback on progress

Pichert et al, 2011.
Hickson et al, 2012.

Adapted from Hickson, Pichert, Webb, Gabbe. Acad Med. 2007. ©2012 VUMC
BUT,

none of this is possible
without a PLAN,
an INFRASTRUCTURE,
and LEADERSHIP.
Professionals commit to:
- *Technical and cognitive competence*

Professionals also commit to:
- *Clear and effective communication*
- *Being available*
- *Modeling respect*
- *Self-awareness*

Professionalism promotes teamwork
Professionalism demands self- and group regulation

Upcoming CPPA Conferences

Disclosure: How to Communicate about Unexpected Outcomes and Errors
• April 18, 2014

Promoting Professionalism: Addressing Behaviors that Undermine a Culture of Safety, Reliability and Accountability
• June 20-21, 2014
• October 24-25, 2014

http://www.mc.vanderbilt.edu/centers/cppa/education
The Center for Patient & Professional Advocacy

www.mc.vanderbilt.edu/cppa
But it is not just about individual performance...

Consider the following challenge...
Who is this man?

He had a good idea...
Professional Accountability
A Poor State of Affairs

• ~2MM pts suffer with healthcare-associated infections (HAIs) in US annually¹
• Direct annual cost of HAIs to hospitals: $28 – $45B²
• HH is the leading measure for reducing HAIs³

• Why can’t we get this right?

• 57 y/o, bilateral arthritis of knees, bone on bone

• Bilateral knee replacement in your system

• Surgery without difficulty

• To post-op room with good pain control

• Potential Risks?
VUMC Hand Hygiene Adherence (%) July 2008 – February 2009
A Call for Clean Hands: Vanderbilt Hand Hygiene

Tom Talbot, MD, MPH
Nancye Feistritzer, RN, MSN
Titus Daniels, MD, MPH
Claudette Fergus, RN, BA
Gerald Hickson, MD, the Hand Hygiene Committee and the Leadership Review Task Force

Confidential and privileged information under the provisions set forth in T.C.A. §63-1-150 and §68-11-272; not to be disclosed to unauthorized persons.
Level 2 "Guided" Intervention by Authority

Level 1 "Awareness" Intervention

Level 3 "Disciplinary" Intervention

Pattern persists

No Δ

Apparent pattern

Single "unprofessional" incidents (merit?)

Vast majority of professionals - no issues - provide feedback on progress

"Informal" Cup of Coffee Intervention

Egregious

Mandated

Mandated Reviews

Pichert et al, 2011.
Hickson & Pichert, 2012.
Hickson et al, 2012.
Pichert et al, 2013.
Talbot et al, 2013.
Hickson & Moore, in press.

We are all committed to minimizing the risk of healthcare-associated infections. Performing hand hygiene is the most important action we can take to reduce the spread of these infections to our patients and ourselves. For FY11, VUMC’s reach goal for hand hygiene is 95% compliance.

For November 2010, your area’s compliance rate was 35%, and for FY11-to-date, 47%.

A member of our Pillar Goal Committee team will contact you to schedule a time to meet so we may partner in achieving increased hand hygiene in your area.
The CPPA Process: Other Applications
Sharing Hand Hygiene Data

The CPPA Process. Share comparative feedback with tiered interventions using the Pyramid; Provide follow-up; Promote accountability
Anticipate Various Reactions

- No dispensers...
- Dispensers in the wrong/inconvenient location...
- This special area has dispenser outside closed door but none inside...
- It’s not our team, it’s the
  - Consult physicians
  - Residents
  - Traveling nurses
  - Dietary staff, transporters...
- Many others
Hand Hygiene Improvement Strongly Correlates with Low Infection Rates

Monthly Standardized Infection Ratio, All Inpatient Units Combined (CLABSI, CAUTI, VAP combined)

HIGH Infection Rates Correlate with LOW Hand Hygiene Adherence

Each data point indicates the VUMC-wide monthly HH adherence (x-axis) and infection rates (y-axis) between Jan 2007-Aug 2012

As adherence goes up, infection rates go down

LOW Infection Rates Correlate with HIGH Hand Hygiene Adherence

LOW Monthly Hand Hygiene Adherence Rate  HIGH

So everyone responded in a professional way?

Well, not exactly...
A Follow-Up “Cup of Coffee”
The following event was reported to you (responsible party) thru an event reporting system. Policy defines that you review and follow up.

A nurse observes:

– “Dr. ___ entered the room without foaming in...proceeded to touch area with purulent drainage...I offered a pair of gloves...he took them and dropped them into the trash can.”
So everyone responded in a professional way?

Well, not exactly...

But we were ready with a plan
Infrastructure for Promoting Reliability & Professional Accountability (PA)

1. Leadership commitment (will not blink)
2. Goals, a credo, and supportive policies
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4. Processes for reviewing observations/data
5. Model to guide graduated interventions
6. Multi-level professional/leader training
7. Resources to address unnecessary variation
8. Resources to help affected staff and patients

### A Project Bundle Rating Form

<table>
<thead>
<tr>
<th>Category</th>
<th>Low (1)</th>
<th>Medium (3)</th>
<th>High (5)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PEOPLE</strong></td>
<td></td>
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<tr>
<td>Leadership Commitment</td>
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<tr>
<td>Dedicated Team</td>
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<tr>
<td>Champion</td>
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<tr>
<td><strong>ORGANIZATION</strong></td>
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<tr>
<td>Alignment with Goals</td>
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<tr>
<td>Policies</td>
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<tr>
<td>Model for Interventions and Planning</td>
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<tr>
<td>Resources for Teams</td>
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<tr>
<td><strong>LEARNING SYSTEM</strong></td>
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<tr>
<td>Measurement and Surveillance Tools</td>
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<td></td>
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<tr>
<td>Process to Review Data</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Multi-Level Professional Training</td>
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