Out from Under the Rug: Creating a Culture of Transparency

Warren Browner, MD, MPH
CEO, California Pacific Medical Center, Sutter Health
Out from Under the Rug: Creating a Culture of Transparency
What Do I Mean by “Culture”?

• A small (but I hope, memorable) illustration
This is What I Mean by Culture!
What Do I Mean by “Under the Rug”? 

• Non-disclosure of errors 
  – Whenever possible, even if adverse outcomes 
• Non-awareness of errors 
  – Staff, physicians, leadership 
• One “dust ball” at a time 
• Risk management perspective 
  – Settle or not 
• Reputation management 
  – “We don’t make mistakes”
What Do I Mean by Transparency?

• Disclosure of errors

• Awareness of errors

• Systematic approach

• Safety and quality perspective

• Reputation management (“We Try Harder”)

We Set Out to Change our Culture

• Fix what’s broken

• Can’t fix if we don’t know something’s broken

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

- Quality Delivery (QD) System
- Lean (Toyota) management
- Extensive involvement of staff, MD’s
Part of a Much Larger Effort

• No one wants a dust ball 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 metrics, 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 anything
- Tell some things to a few people sometimes
- Tell everyone everything every time
Everyone Everything Every Time?

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

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

• Every time = no exceptions
We Do Not Disclose Every Error

• Simply too many

• We disclose “Red Events”
  – Never events
  – Patient harm (death or substantial morbidity)
  – 51 Red Events in 2011 and 2012 combined
Overall Process

• Learn of a possible “Red Event”
• Involve CEO or EVP immediately
• 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
  – Still encountering delays
    • I didn’t think it was “Red”
    • I thought someone else told you

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

• CAO 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 on evenings, nights, 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, never even heard of...
Process: Details

• Action plan and follow-up
  – Directed to the problem
  – Monitored by QD 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
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 was made”
  – “A patient was injured”

• 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.

- **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 it is not a “Get Out of Jail Free” card

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

Roy Lichtenstein. *Portrait*. 
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 the power of ten
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
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
Serious Safety Events: 2011

JAN  MAR  MAY  JUL  SEP  NOV
Serious Safety Events: 2012

0  1  2  3  4  5  6
JAN  MAR  MAY  JUL  SEP  NOV