

# Building a Culture of Safety

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## Background

The concept of safety culture originated outside health care, in studies of high reliability organizations (HROs)

HRO Definition :

Organizations that consistently minimize adverse events despite carrying out intrinsically complex and hazardous work.

## Examples of HROs

- Commonly discussed examples include:
  - Air traffic control systems
  - Nuclear power plants
  - Naval aircraft carriers
- Applicability: Healthcare/Surgery/ASCs
  - Physiological
  - Psychological
  - Sociological

# HRO Characteristics Defined

- Preoccupation with failure—the acknowledgment of the high-risk, error-prone nature of an organization's activities and the determination to achieve consistently safe operations
- Commitment to resilience—the development of capacities to detect unexpected threats and contain them before they cause harm, or bounce back when they do

# HRO Characteristics Defined

- Sensitivity to operations—an attentiveness to the issues facing workers at the frontline. This feature comes into play when conducting analyses of specific events (e.g., frontline workers play a crucial role in root cause analyses by bringing up unrecognized latent threats in current operating procedures), but also in connection with organizational decision-making, which is somewhat decentralized. Management units at the frontline are given some autonomy in identifying and responding to threats, rather than adopting a rigid top-down approach
- A **culture of safety**— an environment in which individuals feel comfortable drawing attention to potential hazards or actual failures without fear of censure from management

# Key Definitions

- **Patient safety** is defined as the avoidance and prevention of patient injuries or adverse events resulting from the processes of health care delivery.
- An **event** is defined as any type of error, mistake, incident, accident, or deviation, regardless of whether or not it results in patient harm

# Implications

- Improving the culture of safety within health care is an essential component of preventing or reducing errors and improving overall health care quality
- Safety culture has been defined and can be measured, generally by surveys of providers at all levels

# Safety Culture and Measurement by Surveys

- Increasingly, actions by federal and state governments and the private sector are underscoring the need for a safety culture. The federal Centers for Medicare and Medicaid Services and private insurers have established lists of preventable medical errors for which reimbursement is now denied.
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# Questionnaire Structure

Questions usually grouped according to a general category and rated on a five point scale

Strongly Disagree	Disagree	Neither	Agree	Strongly Agree
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# General Categories

<http://www.ahrq.gov/professionals/quality-patient-safety/patientsafetyculture/hospital/resources/facilscanform.pdf>

- Background Information
- Work area /Unit
- Supervisor/Manager
- Communications
- Frequency of Events Reported
- Your Facility
- Number of Events Reported
- Comments (Open Ended)

# Survey: Sample Questions

## Work Area

- We are actively doing things to improve patient safety
- Staff feel like their mistakes are held against them
- Mistakes have led to positive change here
- Patient Safety is never sacrificed to get more work done
- We have patient safety problems in this Facility

# Survey: Sample Questions

## Supervisor

- My supervisor says a good word when he/she sees a job done according to established patient safety procedures
- My supervisor/manager seriously considers staff suggestions for improving patient safety
- My supervisor/manager overlooks patient safety problems that happen over and over

## Survey: Sample Questions Communications

- We are given feedback about changes put into place based on event reports
- Staff will speak up if they see something that may negatively affect patient care
- We are informed about errors that happen in this Facility
- Staff feel free to question the decisions or actions of those with more authority

## Survey: Sample Questions Facility

- Management provides a work climate that promotes patient safety
- Units in this facility do not coordinate well with each other
- Things “fall between the cracks” when transferring patients from one unit to another
- There is good cooperation among units that need to work together

# Culture of Safety Survey Results

- Differences among
  - Different job titles
  - Different work areas
  - Differing areas of training
  - Differing levels of authority
- Do results correlate with actual Culture?
- Does Culture correlate with actual practice?
- Does Culture of Safety correlate with actual Safety?

## Survey Results

- Studies have documented considerable variation in perceptions of safety culture across organizations and job descriptions. In prior surveys, nurses have consistently complained of the lack of a blame-free environment, and providers at all levels have noted problems with organizational commitment to establishing a culture of safety.
- The underlying reasons for the underdeveloped health care safety culture are complex, with poor teamwork, poor communications, and “authority gradients” all playing a role.

# Local v. Global Issue

- Safety culture is fundamentally a local issue, and wide variations in the perception of safety culture can exist within a single organization.
- The perception of safety culture might be high in one unit within a hospital and low in another unit, or high among management and low among frontline workers.
- Research also shows that individual provider burnout negatively affects safety culture perception. These variations likely contribute to the mixed record of interventions intended to improve safety climate and reduce errors.
- Therefore, organizational leadership must be deeply involved with and attentive to the issues frontline workers face, and they must understand the established norms and "hidden culture" that often guide behavior. Many determinants of safety culture are dependent on interprofessional relationships and other local circumstances, and thus changing safety culture occurs at a **microsystem level**.
- As a result, safety culture improvement often needs to emphasize incremental changes to providers' everyday behaviors.

# Building a Culture of Safety

- Close alignment with Risk Management
- Acknowledgment of the potential for error while proactively seeking to avoid (or minimize) potential threats
  - Reliance on collaboration across all areas and individuals to identify solutions to potential vulnerabilities

# Building a Culture of Safety

## Leadership Techniques

- Leaders visit every area with established frequency
- Employees see leadership is easily accessible
- Ensure staffing is adequate and that they have tools and resources to be successful
- Ask employees about safety concerns they may have
- Assess how the employees are working together as a team
- Holds employees accountable for doing the right thing every time

# Building a Culture of Safety

Communicate efforts facility wide

- Review Culture of Safety with Quality Committee
  - Involvement of Risk Manager and Medical Director
  - Incorporate Culture of Safety reporting to Board on ongoing basis to encourage physician involvement
  - Develop Staff & Physician Champions

# Building a Culture of Safety

## Stop the Line Policy

- Every employee is responsible for patient safety and can speak up at anytime to “Stop the Line”
- Ensure every employee knows they are supported through all of management to “Stop the Line” whenever they question patient safety
- Establish direct phrase that all employees and physicians are educated about

# Building a Culture of Safety

## Stop the Line Policy: Phrase Examples

Stop the Line: “I need clarification that this is the correct dosage.”

Repeat Stop the Line: “I need clarification...”

If the process is not immediately discontinued, then:

- Call manager and state, “I have a Stop the Line event”
- Manager drops everything to support employee

# Building a Culture of Safety

## Staff Education

- Include all employees, physicians, contract and part time personnel
- Education upon orientation and annual competency training
  - What adverse events are reported
  - How to report these events
  - The importance of reporting “Good Catches”
- Obtain employee and physician attestation regarding understanding of and adherence to patient safety policies

# Reflections on a Recent Tragedy



# Reflections-What We Know

- August 28, 2014
- Yorkville Endoscopy
- New York City, New York
- 81 Year Old Female Patient
- Scheduled for Upper GI Endoscopy

# Reflections-What We Know

Ms. Rivers stopped breathing during an endoscopic procedure at New York City-based Yorkville Endoscopy, after which she was immediately transferred to Mount Sinai Hospital in New York City. There, she was in critical condition and was placed on life support. After her daughter, Melissa Rivers, requested she be taken off life support, Joan Rivers died Sept. 4 at the age of 81.

Lawrence Cohen, MD, co-owner and former medical director of Yorkville Endoscopy, performed Ms. Rivers' scheduled procedure. Dr. Cohen also has admitting privileges at The Mount Sinai Hospital. Dr. Cohen has since been placed on administrative leave from the surgery center. He was subsequently released from the center, according to one report.

During the procedure, Dr. Cohen allowed the ear, nose and throat physician Ms. Rivers brought along with her — now identified as Gwen Korovin, MD,— to enter the procedure room in which Ms. Rivers was undergoing care. This was the offense for which Dr. Cohen was fired by the Yorkville Endoscopy board, according to the report. Dr. Korovin is a well-known, Manhattan-based ENT with several celebrity patients. She does not have privileges to practice at Yorkville Endoscopy.

What happened in the procedure room is a matter of speculation, with multiple unnamed sources providing conflicting reports. Allegedly, according to anonymous staff sources at Yorkville Endoscopy, Dr. Korovin performed an unauthorized biopsy on Ms. Rivers' vocal cords after Dr. Cohen completed his authorized procedure.

# Reflections- What We Don't Know

- About the Procedure: Endoscopy/Laryngoscopy
  - What was scheduled v. performed (consent v. OR)
    - What was done (biopsy)
    - By what physicians (GI/ENT)
    - Using what equipment
    - Anesthesia (in OR/in Facility)
    - Privileging/Approved Procedure
  - What occurred
    - Airway Issue/Laryngospasm
    - Cardiac/Vascular Issue
    - Bleeding/Perforation
    - Pulmonary Issue
    - Drug Reaction
    - Location

# The Blame Game

Dr. Lawrence Cohen not currently performing procedures at Yorkville Endoscopy; nor is he currently serving as medical director

Dr. Gwen Korovin is reportedly in hiding and not practicing medicine

Investigation by N.Y. State Health Department and the Medical Examiner

An autopsy performed by the city medical examiner was inconclusive. More tests are reportedly being done to determine the cause of death

## The Blame Game

### The New York City Medical Examiner's Report (after autopsy and/or "other tests")

According to the press release, the official cause of death was "anoxic encephalopathy due to hypoxic arrest during laryngoscopy and upper gastrointestinal endoscopy with propofol sedation for evaluation of voice changes and gastroesophageal reflux disease."

# ASCs Under Indictment

- Are they safe?
- Are they regulated?
- Significance of Accreditation?
- Impacted by governance issues?
- Do they have the appropriate staff?
- Do they have the appropriate equipment?
- Are the physicians qualified and competent?
- Do they have the capacity to address medical emergencies?

# Culture of Safety

## Quality Outcomes

- Patients receive high level of care
- Teamwork across the facility improves
- Communication flows between employees and physicians
- Minimizes frustrations and improves workflow
- Improved physician and patient satisfaction

# Culture of Safety

Employee Satisfaction

Physician Satisfaction

Patient Satisfaction

Patient Safety

Quality of Care

Improved Outcomes

# Final Exam

A Culture of Safety in my ASC can be created, sustained and enhanced by:

- A) Federal Governmental Agencies
- B) The Texas State Legislature
- C) Dr. David Shapiro, M.D.
- D) Me

# Final Thoughts

“To err is human;  
to forgive, divine”

Alexander Pope,  
“Essay on Criticism”

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