CHPSO
California Hospital Patient Safety Organization

Patient Safety News
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FMEA Trial Opportunity

CHPSO seeks to offer its member hospitals a complete range of tools, expertise and services to accelerate and strengthen their efforts to improve patient safety. In February of this year, we began discussions with QI Path. QI Path offers a web-based FMEA service to streamline and simplify the FMEA process.

The service is 100% web-based and requires no software installation; QI Path can have hospitals up and running with private, secure accounts very rapidly — often in minutes. QI Path offers use of the current version of the system, with up to six users per private account, free of charge to hospitals and researchers. CHPSO is exploring opportunities to offer use of QI Path's FMEA system to CHPSO members in an arrangement that could ultimately allow hospitals to conduct FMEA projects under Patient Safety Work Product protection and facilitate the broader use of this FMEA to prospectively identify and mitigate potential risks.

As our next step in exploring a possible relationship, CHPSO and QI Path are recruiting CHPSO member hospitals to participate in a free pilot program with the FMEA system. Hospitals willing to try the FMEA system can provide feedback on its potential value in advancing patient safety efforts and serve as beta sites for new features and functionality planned for the next major release. We encourage any interested hospitals to contact CHPSO at info@chpso.org. For a description of the FMEA system, see QI Path's website at www.qipath.com.

— Rory Jaffe, MD MBA, rjaffe@chpso.org

Interpersonal Conflict

Part 1: Case

Interpersonal conflict, resulting from the absence of psychological safety, positive relationships and good clear communication is a major cause of breaches of patient safety. To support our view, we are going to tell you about an accident in a hospital that resulted in a million-dollar-plus settlement, firings, resignations and terrible publicity.

The names and places have been changed to protect the innocent. In fact, we won't even use names. We are betting that you can fill in the spaces with names very close to home with a similar story about a colleague or friend.

The tragedy takes place at a children's hospital in the Southeast, in its Surgical Suite, where the atmosphere is one of intimidation and fear.

The Chief of Cardiovascular Surgery (let's call him the Chief) is constantly irritable and upset about everything and often takes it out on the Operating Room (OR) staff. Turnover is very high; no one wants to join the team; employment agency use is high; OR volume is down; and the Chief Nursing Officer (CNO) is very concerned.

The Chief continually voices complaints to the CEO about the OR. The CEO listens with great concern. He attempts to assuage the Chief by apologizing to him. The CEO worked hard to recruit the Chief and is afraid the Chief will leave and go to another institution if he isn't handled with kid gloves. The CEO can't find a tactful way to tell the Chief that he is a major part of the problem and is making it worse. The CEO assures the Chief he will talk to the CNO and work with her to fix the problem.

Meanwhile, the OR staff have filed complaints with the Director of Surgery, the CNO and Human Resources. The CNO reports to the CEO and the medical staff leadership that she believes the situation is getting worse. She's really frustrated because the Chief refuses to meet with her to even discuss the issues and just runs to the CEO.

The Chairman of the Department of Surgery, the Chief of Surgery and the Dean for the School of Medicine have also been ineffective in managing the Chief's behavior. They have backed away from the problem and told the CNO, "It's the CEO's problem. He's the holder of the Chief's contract. Just remember, the hospital can't afford to have the Chief leave." The situation in the OR is not addressed and keeps getting worse.

The problem turns into a disaster on a Monday morning when the Chief arrives to find his first case cancelled and his second case delayed because of a mix-up in the required prep. He is in a hurry, ticked off and hollers at the staff to get things moving. His next patient is a little girl of seven who suffers from a heart valve problem.

Before starting the prepping procedure, the circulating nurse and anesthesiologist attempt to initiate the required time out. But the Chief has had enough delays. "Screw the time out" he shouts and orders them to immediately start prepping the patient. He wants to get on with the surgery and back on schedule. The OR

staff, which is thoroughly intimidated and demoralized by the Chief, complies without a word. No one is willing to question the Chief's order to dispense with the time out.

The patient is anesthetized, prepped, draped and so forth. Her heart is exposed and opened. At this point, the Chief asks the scrub nurse to prepare the heart valve. The room falls silent. You can hear a pin drop. The scrub nurse tells him there is no valve in the room. The case had been scheduled as a "repair of the valve" and not as a "valve replacement." She also has to tell him that the valve he is requesting isn't a standard valve and isn't even in stock in the hospital.

The Chief is furious. He rants and raves and accuses everyone in the room of being totally incompetent. He tells them they are going to be held responsible if the child dies, and he is going to tell the parents just what happened and help them find an attorney. He is over the edge.

After a 30-minute delay, the correct valve is finally obtained from another hospital. The Chief proceeds to install it, shouting at the OR staff the whole time.

That night, the child's blood pressure drops ominously. The ICU nurse tries to bring it back up but is unable to. Naturally, she is afraid to involve the Chief. So she contacts the resident on call. But they have no success. Finally they call the Chief. But before they can tell him about the child's condition, the Chief launches into a five-minute tirade about the incompetence of the nursing staff. When the Chief finally comes in to see the little girl, it is too late. She has been hypotensive for too long, and a week or so later she dies, never having regained consciousness.

Subsequent review reveals that the Chief's own assistant mistakenly scheduled the surgery as a valve repair. However, because there was no time out, the error went unnoticed. The review also notes that there was a great deal of fear and intimidation in the OR and the Critical Care Unit. Because of that atmosphere, no one present was willing to oppose the Chief's order to dispense with the time out. The review also indicates the time lost when the nurse and resident delayed notifying the Chief contributed significantly to the child's death.

The hospital's Risk Manager reviews the case and finds that the hospital faces a million-dollar-plus lawsuit and settlement. The Board of Trustees for the hospital and the university are notified, and money is set aside to cover the potential losses.

The Chairman of the Board and the Chair of the Personnel Committee express dissatisfaction with the CEO's inability to rein in the Chief and ask for the CEO's resignation.

As for the Chief, the child's parents sue him. His insurance company pays out a large settlement, and his insurance rates are substantially increased.

Upon the recommendation of the hospital's counsel, the new CEO arranges for the Chief to receive training in anger management. However, the new CEO follows in the previous CEO's footsteps by choosing to avoid engaging the Chief in a forthright discussion about his behavior.

— Lewis Newman, Ph.D, lewis@lewisnewmanconsulting.com, and Sharon Tourville, RN MSN CNAA BC

Interpersonal Conflict

Part 2: Discussion

The dynamics of this situation are similar to those many health care CEOs have faced. They have a difficult, high-profile physician they are afraid to confront because of his or her status and power. They fear the physician will become disgruntled and leave the organization, significantly affecting their hospital's bottom line. They also fear the possibility of antagonizing an individual who can make their life miserable and put their careers at risk. These consequences help explain why the CEO in this incident failed to take the action that was required.

In this high-risk difficult situation, the CEO would have benefited greatly from the help of an internal or external consultant with expertise in preventing and managing conflicts, as well as in mediation and negotiation. Had the CEO sought such assistance, the disaster might have been avoided.

Monday morning quarterbacking is a great sport. However, we will describe some of the things a qualified professional could have done to help the CEO.

After gathering the facts, the consultant would begin by helping the CEO identify his hidden assumptions and errors in thinking about the Chief's attitude, needs and motivation. The CEO treats these negative, self-fulfilling assumptions as facts and never thinks of testing them.

His reasoning is closed, limiting the options available to him for dealing with the Chief. The CEO never considers the

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possibility that the Chief might be open to a discussion of the risks he is subjecting himself to with the OR staff and others. A year ago, the Chief was involved in a malpractice lawsuit. Another malpractice lawsuit could result in the Chief incurring either a substantial increase in the cost of his insurance or its cancellation. The possibility of these things happening could concern the Chief, which could motivate him to engage in an open and forthright conversation with the CEO.

After helping the CEO to critically examine and modify his assumptions and conclusions about the Chief, the consultant could provide the CEO with tools to successfully mediate the conflict. These include suggestions for securing a commitment to meet face-to-face from both the Chief and the CNO, as well as communication strategies and techniques to effectively mediate the conflict.

One tool is the ground rule of no power plays or walk-always. It prevents one-sided agreements based on one party having more power than the other, as well as various avoidance behaviors.

These tools will enable the Chief and the CNO to come to a mutually acceptable, behaviorally specific agreement. The nursing staff can also be taught to use these tools.

The consultant would then help the CEO, the Chief and the CNO plan what they will say to the OR staff and identify the steps they will take to create an environment in the OR that is conducive to improved communication.

The consultant would next encourage the CEO to publicly acknowledge that risk, fear and embarrassment within the hospital have produced an environment where important communication and feedback are circumvented and avoided.

The next step would be to announce and implement the organizational goal of improving the competencies of all hospital personnel and medical staff leadership in collaborative communication and conflict prevention and resolution. A comprehensive program of training, coaching and facilitation could produce these competencies.

Four benefits would follow from the CEO's actions:

First is elimination of time bombs like the one just described. Unresolved, dysfunctional conflicts are accidents ready to happen.

The second benefit is a significant reduction of the hidden dollar costs of wasted time, decreased motivation, degraded decision-making and replacement of employees, not to mention the more obvious legal costs.

The third benefit is improved morale and productivity of staff. Absent good communication and skills in conflict management and prevention, productivity and morale suffer greatly.

The fourth benefit is improved patient care. When conflict is managed effectively, staff morale goes up and patient care improves.

Since the type and quality of the consulting assistance you receive are extremely important, we will touch upon some important criteria to use when selecting a consultant.

First, if feasible, select an internal consultant from your organization's HR or Organization Development departments. All things being equal, it is more cost-effective to do so. This individual should not be involved in the conflict and should neither be intimidated by the parties who are in conflict nor biased. The individual also needs to be viewed as credible and elicit respect from the parties involved.

One advantage of selecting an internal consultant is you have first-hand knowledge of the individual's capabilities and ability to provide a quality program and services, given the particular circumstances.

A second criterion pertains to the type of services offered. A cookie-cutter, one-size-fits-all approach to problems of conflict prevention and management should not be employed. The consultant should be capable of tailoring the programs and services considering your organization's unique needs.

A third criterion pertains to the consultant's knowledge base and experience. In the 21st century, a common sense approach will not produce the results you need. The consultant should be trained and experienced in cutting edge practices that have been scientifically validated.

The fourth and perhaps most important criterion consists of three questions:

1. Can you work with the consultant?

2. Will you be open to the consultant's recommendations?

3. Are you willing to invest the time and energy required to skillfully use the communication tools that the consultant will teach you?

Your answer needs to be yes to all three questions if you hope to be effective in dealing with interpersonal conflict that can compromise patient safety.

Patient safety is one of the most important, defining issues of health care. The case we have shared with you illustrates

some of the costs and risks that result from dysfunctional interpersonal conflict and provides a viable remedy for this problem.

— Lewis Newman, Ph.D, lewis@lewisnewmanconsulting.com, and Sharon Tourville, RN MSN CNAA BC

Hidden Potential for Improvement

From QA to QI

Sometimes you have to test your assumptions to find the real opportunity for improving quality and safety. Let me share my own story.

Once upon a time, I was called to help a community hospital with a quality turn-around. Two years prior, the Joint Commission hammered it with 51 Type 1 citations (remember those?). The quality-minded medical staff then called for the CEO to resign, but the Board continued to support him in gratitude for having recently saved the facility from bankruptcy. When the CEO committed to invest energy in quality of care and revenue growth rather than expense reduction, the parties were able to reconcile. Even so, much work remained to be done.

Early on, I helped them map out a path to re-invigorate quality improvement activity. In one whiteboard chat with physician leaders, I illustrated how the various committees could be optimally realigned to support the effort. When I got to the point of describing my recommendations for the medical staff organization, I said, "And we'll put a firewall here to isolate medical staff peer review activity from our quality improvement (QI) work. We don't want that old-fashioned finger-pointing quality assurance (QA) stuff to contaminate our efforts to drive out fear on the QI side."

I wish you had been in the room with us. It was like the famous Uncle Remus story where Br'er Rabbit when caught by the fox says, "Do what you will with me Br'er Fox but whatever you do … *please don't throw me in that briar patch.*" Whence forth, the fox throws the rabbit in the briar batch only to find that he just let the rabbit escape. Almost as reflexively, the docs responded, "So, Marc.… What would it look like if peer review was done like QI instead of QA?" For me, it was a pure "Aha!" moment. Maybe we did not have to do it the way that physicians had been doing it for 30 years — the way that I assumed we would always do it.

With that, we took out a blank sheet of paper and started to design an alternative. When piloted in the department of medicine, it was so overwhelmingly successful in engaging physicians in clinical improvement and eliminating defensiveness to educational feedback that the physician leadership pushed it on all the other departments.

That was the beginning of my obsession with the challenge. In my subsequent work with this and other clients, it turned out that there was still much to learn about how to go from QA to QI.

— Marc T. Edwards, MD MBA, QA to QI Consulting, marc@QAtoQI.com

Editor's Note

Marc Edwards is a physician and health care consultant. The activity of his PSO complements ours. He has done two national studies of clinical peer review practices and published multiple related articles. Beginning this issue, we will regularly feature his column: *From QA to QI*. We hope that it will bring you fresh insights for improving quality and patient safety in your facility.

Pooling Experience: Retained Surgical Items

CHPSO members are now able to participate in an evaluation of retained surgical item (RSI) incidents. The purpose of this initiative is to assist hospitals in their root cause analysis process and help CHPSO identify common underlying causes of RSIs, particularly broken devices and fragments.

The information collection tool has been revised to incorporate member suggestions and will be distributed soon for use, along with a brief set of instructions. Watch your email for release of the revised tool.

The July member call (July 11 at 10 AM) will include time to discuss this initiative.

— Rory Jaffe, MD MBA, rjaffe@chpso.org

Secure Discussions

Members have asked for the capability to have secure discussions for sensitive topics. These discussions will be protected by the Patient Safety Work Product Privilege.

For example, a hospital may be having a problem with a device that posed a risk to patients and are wondering whether others are having the same difficulty. CHPSO is setting up a secure discussion group that will allow members to exchange information. By default, participants will not be identified in the messages. Please contact Rory Jaffe (rjaffe@chpso.org) if you have interest in this. CHPSO will verify the identity and authority of participants prior to their entry into the group.

— Rory Jaffe, MD MBA, rjaffe@chpso.org

Serious Reportable Events Update

The National Quality Forum (NQF) board recently approved an update to the Serious Reportable Events list. The public appeals period ends July 12. Barring NQF acceptance of an appeal, these will then go into effect.

Notable is clarification of the time surgery begins and ends, as this affects reporting of retained surgical items by removing the confusion about discovery and removal of an item after incision closure — if the discovery and removal occur before the patient leaves the operating room, it is not a serious reportable event (though still useful to analyze for lessons learned).

Please note that the California requirements for reporting adverse events deviate from the NQF definitions. For example, section 1279.1 of the Health and Safety Code states that reportable retention of a foreign object after surgery or other procedure excludes "objects intentionally implanted as part of a planned intervention and objects present prior to surgery that are intentionally retained." The NQF definition excludes those *and* "objects not present prior to surgery/procedure that are intentionally left in when the risk of removal exceeds the risk of retention (such as microneedles, broken screws)."

Definitions Relevant to Retained Surgical Items

Surgery is an invasive operative procedure in which skin or mucous membranes and connective tissue is incised or the procedure is carried out using an instrument that is introduced through a natural body orifice. It includes minimally invasive procedures involving biopsies or placement of probes or catheters requiring the entry into a body cavity through a needle or trocar. Surgeries include a range of procedures from minimally invasive dermatological procedures (biopsy, excision and deep cryotherapy for malignant lesions) to vaginal birth or Caesarian delivery to extensive multiorgan transplantation. It does not include use of such things as otoscopes and drawing blood.

Surgery begins, regardless of setting, at point of surgical incision, tissue puncture, or insertion of instrument into tissues, cavities or organs.

Surgery ends after all incisions or procedural access routes have been closed in their entirety, device(s) such as probes or instruments have been removed and, if relevant, final surgical counts confirming accuracy of counts and resolving any discrepancies have concluded and the patient has been taken from the operating/procedure room.

Unintended retention of a foreign object in a patient after surgery or other invasive procedure:

- **Includes** medical or surgical items intentionally placed by provider(s) that are unintentionally left in place.

- **Excludes** a) objects present prior to surgery or other invasive procedure that are intentionally left in place; b) objects intentionally implanted as part of a planned intervention; and c) objects not present prior to surgery/procedure that are intentionally left in when the risk of removal exceeds the risk of retention (such as microneedles, broken screws).

— Rory Jaffe, MD MBA, rjaffe@chpso.org

NQF webinar

On Tuesday, July 19 from 10 AM to 11 AM, CHPSO will offer members the webinar: "NQF Update of the Serious Reportable Events." Melinda Murphy, NQF Consultant, and Lindsey Tighe, NQF Project Manager, will discuss NQF's process and efforts in revising this list, what events were considered and which ones made it to the final list for public comment.

We thank our colleagues at the North Carolina Quality Center PSO for arranging this conference. Contact Colleen Meacham (cmeacham@chpso.org) for enrollment instructions.

Just Culture Roadmap to Adoption

Integral to a safer organization is a culture that acknowledges human error, the complexity of our work and the risks that ensue. A foundational part of this safety culture is a "Just Culture" that handles events fairly — fixing the system and not blaming the person when a human slip, lapse or mistake occurs, but assigning blame when a person acts willfully or recklessly.

Culture change, particularly one like this that moves us from the reflexive urge to assign blame when bad events occur to a disciplined review of the mechanism of error, takes time and resources. To assist California hospitals in achieving the goal of a just culture, CHPSO is developing a roadmap to success and will be developing a just culture toolkit and other support services.

During July's CHPSO Member call (July 11 10 AM) we will be discussing our latest draft of the roadmap and will ask for advice on refining the roadmap and developing a toolkit that meets members' needs.

— Rory Jaffe, MD MBA, rjaffe@chpso.org

Calendar

The following upcoming events are still open for enrollment. For more information or to enroll, use the contacts listed below.

July

11: *CHPSO*: Members Call. Just Culture Road Map; Retained Surgical Items. 10–11 AM

13: *PSCSD&IC* (Patient Safety Council of San Diego & Imperial Counties): Preventing Rehospitalizations Network (PRN). San Diego.

13: *SCPSC* (Southern California Patient Safety Collaborative): Track III — Perinatal Care. Industry Hills.

19: *PSCSD&IC*: Standardizing Dosing Limits. San Diego.

19: *CHPSO*: NQF Update of the Serious Reportable Events. 10–11 AM

21: *PSCSD&IC*: OBGYN Networking Breakfast. San Diego.

August

8: *CHPSO*: Members Call. 10–11 AM

9: *SCPSC*: Track I — Hospital Acquired Infections in the ICU Setting, Sepsis and Surgical Care Improvement Project. Industry Hills.

23: *SCPSC*: Perinatal Monthly Webinar. 12:15 PM

24: *PSCSD&IC*: Ending Elective Deliveries Before 39 Weeks Gestation. San Diego.

30: *PSCSD&IC*: Standardizing Dosing Limits. San Diego.

September

9: *CAPSAC*: California Patient Safety Action Coalition meeting. Sacramento.

12: *CHPSO*: Members Call. 10–11 AM

13: *SCPSC*: Track II — Pressure Ulcers, Readmissions and Transitions of Care. Industry Hills.

13: *PSCSD&IC*: Preventing Rehospitalizations Network (PRN). San Diego.

14: *PSCSD&IC*: Preventing Rehospitalizations Network (PRN). San Diego.

27: *SCPSC*: Perinatal Monthly Webinar. 12:15 PM

27: *PSCSD&IC*: HAI Elimination. San Diego.

October

10: *CHPSO*: Members Call. 10–11 AM

20: *PSCSD&IC*: Standardizing Dosing Limits. San Diego.

25: *SCPSC*: Perinatal Monthly Webinar. 12:15 PM

November

2: *PSCSD&IC*: Preventing Rehospitalizations Network (PRN). San Diego.

8: *SCPSC*: Track I — Hospital Acquired Infections in the ICU Setting, Sepsis and Surgical Care Improvement Project. Industry Hills.

14: *CHPSO*: Members Call. 10–11 AM

15: *SCPSC*: Track III — Perinatal Care. Industry Hills.

15: *PSCSD&IC*: Ending Elective Deliveries Before 39 Weeks Gestation. San Diego.

December

2: *CAPSAC*: California Patient Safety Action Coalition meeting. Torrance.

12: *CHPSO*: Members Call. 10–11 AM

13: *SCPSC*: Track II — Pressure Ulcers, Readmissions and Transitions of Care. Industry Hills.

13: *PSCSD&IC*: HAI Elimination. San Diego.

15: *PSCSD&IC*: Standardizing Dosing Limits. San Diego

For further information on these events:

CAPSAC: John Keats John.Keats@CHW.edu or www.capsac.org

CHPSO: Rory Jaffe rjaffe@chpso.org

PSCSD&IC: Lindsey Wade lwade@hasdic.org

SCPSC: Julia Slininger jslininger@hasc.org

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