CHPSO Member Call

February 11, 2013
10-11 am

Rhonda Filipp RN, MPA
Director, Quality & Patient Safety

*For audio dial 712-432-3100
Passcode: 589557
Have you established your Patient Safety Evaluation System (PSES)?

<table>
<thead>
<tr>
<th>Answer Options</th>
<th>Response Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>29.4%</td>
</tr>
<tr>
<td>No</td>
<td>58.8%</td>
</tr>
<tr>
<td>I don't know.</td>
<td>11.8%</td>
</tr>
<tr>
<td>I do not know what defines a PSES.</td>
<td>0.0%</td>
</tr>
</tbody>
</table>
### Member Survey Results

#### If you answered "No" to the question above, what has prevented you from establishing your PSES?

Choose all answers that apply.

<table>
<thead>
<tr>
<th>Answer Options</th>
<th>Response Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>I do not know what steps to take to establish a PSES.</td>
<td>28.6%</td>
</tr>
<tr>
<td>I do not have the personnel or resources available to work on establishing a PSES.</td>
<td>14.3%</td>
</tr>
<tr>
<td>I do not have administrative or legal/risk management support for establishing a PSES.</td>
<td>0.0%</td>
</tr>
<tr>
<td>Other (please specify)</td>
<td>57.1%</td>
</tr>
</tbody>
</table>

- Not seen as a priority
- In progress
- Unsure whose responsibility it is to set-up the PSES
If you have established a PSES, are you currently submitting incident data to CHPSO/ECRI?

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<th>Response Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>14.3%</td>
</tr>
<tr>
<td>No</td>
<td>71.4%</td>
</tr>
<tr>
<td>I don't know</td>
<td>14.3%</td>
</tr>
</tbody>
</table>
If you answered "No" to the question above, what has prevented you from submitting incident data to CHPSO/ECRI? Choose all that apply

<table>
<thead>
<tr>
<th>Answer Options</th>
<th>Response Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>I do not know the process for sending data to CHPSO/ECRI.</td>
<td>69.2%</td>
</tr>
<tr>
<td>I do not have the personnel or resources available to submit data to CHPSO/ECRI.</td>
<td>38.5%</td>
</tr>
<tr>
<td>Other (please specify)</td>
<td></td>
</tr>
<tr>
<td>Responses to Other:</td>
<td></td>
</tr>
<tr>
<td>1) In progress</td>
<td></td>
</tr>
<tr>
<td>2) We have not established the PSES</td>
<td></td>
</tr>
</tbody>
</table>
CHPSO/ECRI Webinar: Patient Safety Evaluation System (PSES)

Wednesday, February 13, 2013
10 am-11:30 am

*PSO Basics* presentation is posted on CHPSO/ECRI portal
Crucial Conversations in Health Care

February 11, 2013
Member Call
A discussion between 2 or more people where
1) stakes are high
2) opinions vary
3) emotions run high
Why are they so difficult?

• We often learn from an early age to avoid confronting people.
• We feel uncomfortable.
• We lack skill & confidence.
The Joint Commission identifies communication as a root cause in 60% of sentinel events in their 2012 report.
• In the RCAs submitted for analysis by CHPSO members, communication issues were identified as a root cause or contributing factor in 66% of events.
• Low job satisfaction
  ➢ Decreased productivity
  ➢ Increased turnover
  ➢ Increased sick calls

• Low customer satisfaction
  ➢ patients
  ➢ families
  ➢ visitors
Study results

• 1700 respondents from 13 hospitals
  – Doctors, nurses, other clinicians, administrators
  – Teaching, general, and specialty hospitals
• Identified conversation categories that are especially difficult, and at the same time, essential in health care
  – Teamwork
  – Performance/competence
  – Behavior
Study results

- 84% physicians & 62% nurses & other clinical-care providers witnessed co-workers taking shortcuts that could be dangerous to patients.
- 1 in 5 physicians say they have seen harm come to patients as a result of poor communication, teamwork, or performance.
- 23% of nurses indicated that they are considering leaving their jobs because of these concerns.
How often do we speak up?

- Only 1 in 10 respondents fully discussed concerns with co-workers.
- Most indicated it was between difficult & impossible to confront people in crucial situations.
- Much tougher to confront a physician, even by other physicians.
Why don’t we speak up?

- We weigh the risk to benefit of having this conversation
  - Fear of retaliation
  - Low confidence that it will make a difference or improvement
- Belief that “it’s not my job”
- Lack of opportunity
Talking to others

• We may not bring it to the attention of the person involved, but we often will speak to others
  – 25% to 50% said they mentioned their concerns or frustrations to other co-workers or the person’s supervisor, not because they thought it would fix the problem but to
    • Create workarounds
    • Warn others
    • Blow off steam
Difficult Topics of Conversation

• Co-workers not following policies, guidelines, or accepted practice
• Concerns over co-worker competence
  – poor clinical judgment
  – missing basic skills
  – making mistakes*
• Poor teamwork
  – lack of support for co-workers
  – divisive behavior
  – disrespect
  – bullying
Too often we think we only have 2 options:

• **Option 1**: Speak up and turn this person into a sworn enemy

  **OR**

• **Option 2**: Suffer in silence and make a bad decision that may put patients at risk

Add an **Option 3**: I can speak up **AND** maintain my relationship with this person & protect my patients.
Starting the Conversation

• The environment must feel safe
• Conversation must be respectful
  – Ask yourself, “How can I be 100% honest & 100% respectful at the same time?”
• Stick to the facts
  – Reduces an emotional response
• Give the other person the opportunity to share their view of the issues
When you disagree

• **Listen**
  – you probably agree more than you think

• Ground the conversation with the *central issue*, not the specifics

• Point out where you agree

• Don’t tell the other person they are wrong; rather, point out where you differ
Benefits of speaking up

The 10% who address these crucial conversations report the following benefits

• more satisfied with their jobs
• better patient outcomes
• stronger relationships
• respected by peers & seen as top performers

❖ Improved communication, teamwork, and better outcomes = increased patient satisfaction
Culture of Safety

Huge return on investment

- Decreased errors
- Decreased turnover
- Increased productivity
- Increased satisfaction—patients, families, and staff
Silence Kills: The Seven Crucial Conversations for Healthcare
• Practice
• Develop a book club to review sections of this or others books and practice with each other.
  – Sutter Health used *Crucial Conversations* for leadership training
“The strategies and tools offered in Crucial Conversations were instrumental within our team. It broadened our ability to clarify important conversations, check our own thoughts and responses in preparation of those important and most times difficult conversations, and gave us tools to produce deliverables in a way that leaves both parties closer to a win-win outcome. It is an important read for healthcare leadership who have tough decisions to make, and deliver, in the months and years to come.”

Teresa L. Wallace, MSW, CPHRM, CPHQ
Sutter Health - Office of the General Counsel
Director, Healthcare Risk
Positive feedback is important, too

Don’t forget the importance of expressing gratitude and appreciation.

“Silent gratitude isn’t much use to anyone.”

-Gladys Bronwyn Stern
CHPSO/ECRI Webinar:

Top 10 Health Technology Hazards for 2013

Wednesday, February 25, 2013
11:30 am-12:30 pm
EHR documentation safety

• Promote reporting of EHR associated events
  – Examples:
    • Addendum charting that resulted in error
    • Results posted on the wrong patient’s chart
    • Errors associated with PACS screen display
Next Member Call:  
*Creating a Safe Journey for Patients:*
*Maximizing Results of Your AHRQ Culture of Safety Survey*

Steven Savage, EdD, Quality Improvement Network Facilitator, California Hospital Engagement Network (CalHEN), California Hospital Association

Kassie Waters, Director, Quality Improvement Marshall Medical Center in Placerville, CA

March 11, 2013  
10-11 am