MUSC
MEDICAL UNIVERSITY of SOUTH CAROLINA
Changing What's Possible

High Reliability

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Agenda

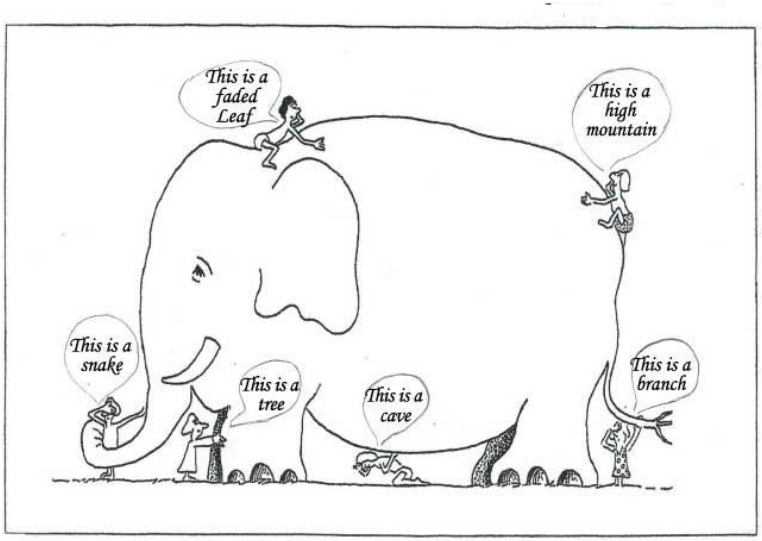
- Tactics for achieving High Reliability
  - Mental models
  - Transparency
  - Culture of Safety
  - Leadership Engagement
  - Process Improvement
- Successes and Challenges
- How do you know it is working?
  - Culture of Safety survey
  - Employee & Physician engagement survey
  - Serious Safety Event Rate

Shared mental models

‘mental model’ is an important contributor to what actually happens; concepts of reality – imaginary, often blurred, and shifting; humans use them to reduce mental load and free up capacity in the conscious mind to focus on deliberate activities.

Examples of shared mental models:

- Roger Bannister
- Wrong site surgeries
- CLABSI, CAUTI, VAP



6 blind men describe an elephant (old indian fable)

Shifting Mental models

Zero Harm

This is not a project; it is a way of life

What do we mean by harm?

- Patient harm (physical, psychological)
- Employee harm (physical, psychological)
- MUSC harm (finance, reputation)

Reliability is a shared mental model

The extent to which an experiment, test, or measuring procedure yields the same results on repeated trials….

It is the extent to which an intended process results in the desired outcome…

High Reliability Organization (HRO) Public Commitment

MUSC leaders attended Inaugural meeting in February 2013; signed our commitment

SCHA South Carolina Hospital Association *every patient counts*

South Carolina SafeCare creating highly reliable healthcare – every patient, every time!

The Joint Commission

South Carolina Safe Care
High Reliability Commitment
Inaugural Meeting

February 15-16, 2013

Transparency

Transparency purpose

- Stimulate public trust and rapid improvements

Policy passed by CLC and Board

Task Force with 3 subgroup

- Quality
- Operations
- Finance
- Medical record

Guiding Principle

- Internal before external
- Not based on current performance alone

Key components of a highly reliable organization

SCHA South Carolina Hospital Association

South Carolina SafeCare creating highly reliable healthcare – every patient, every time!

The Joint Commission

Progress – Process Improvement

>2500 employees have received some level of training.

>100 projects completed in 2 years.

Innumerable offerings on Lean, Six sigma, Change management (both “a la carte” and certification training)

Heavy emphasis on process literacy

“What is your process for….”

“How reliable is your process for...”

Progress – Culture of Safety

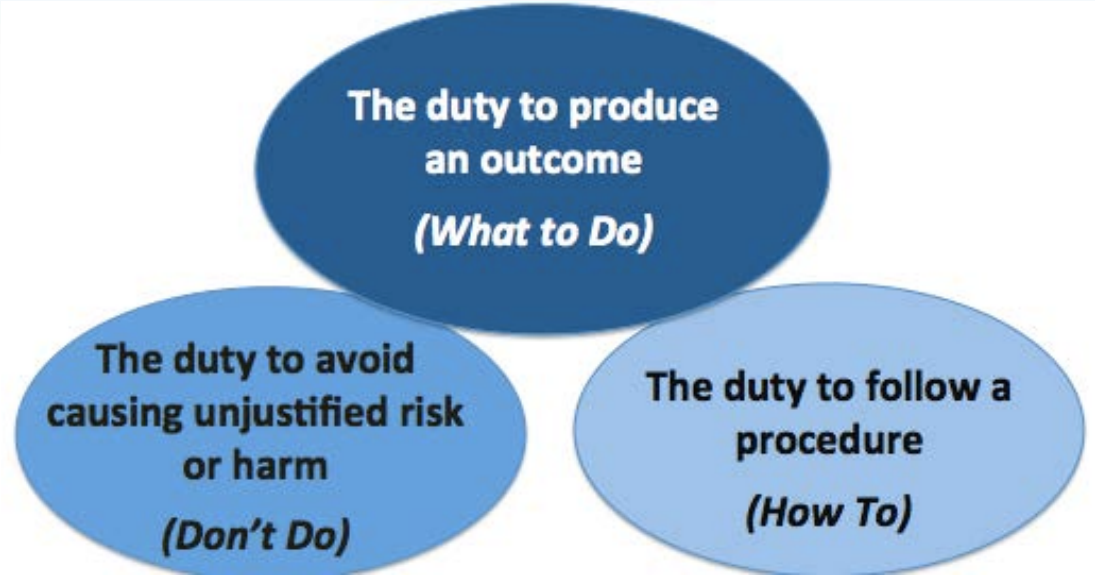
Evidence based approach to improve COS

- Daily “safely speaking”
- 3-5 hours patient safety rounds a week
- Unit safety huddles
- “Exception Based Reporting” for lowest 25th% with coaching
- “Daily Check In” leadership call 7 days a week

Fully embraced Just Culture at all organizational levels

- 20 certified trainers from variety of areas
- Human Resources
- Physician and nursing peer review
- Compliance

Progress – Culture of Safety



Weaved into HR; "fillable" algorithm (documentation & teaching)

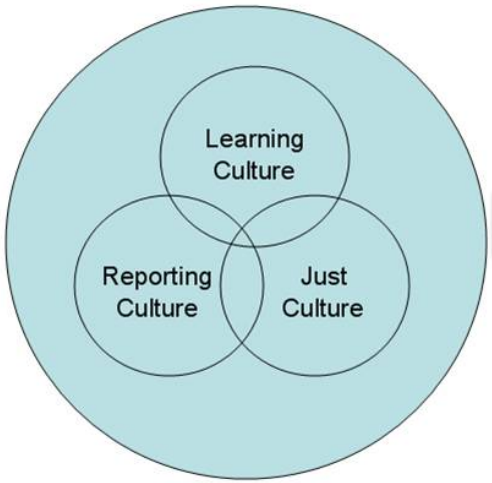
Progress – Culture of Safety

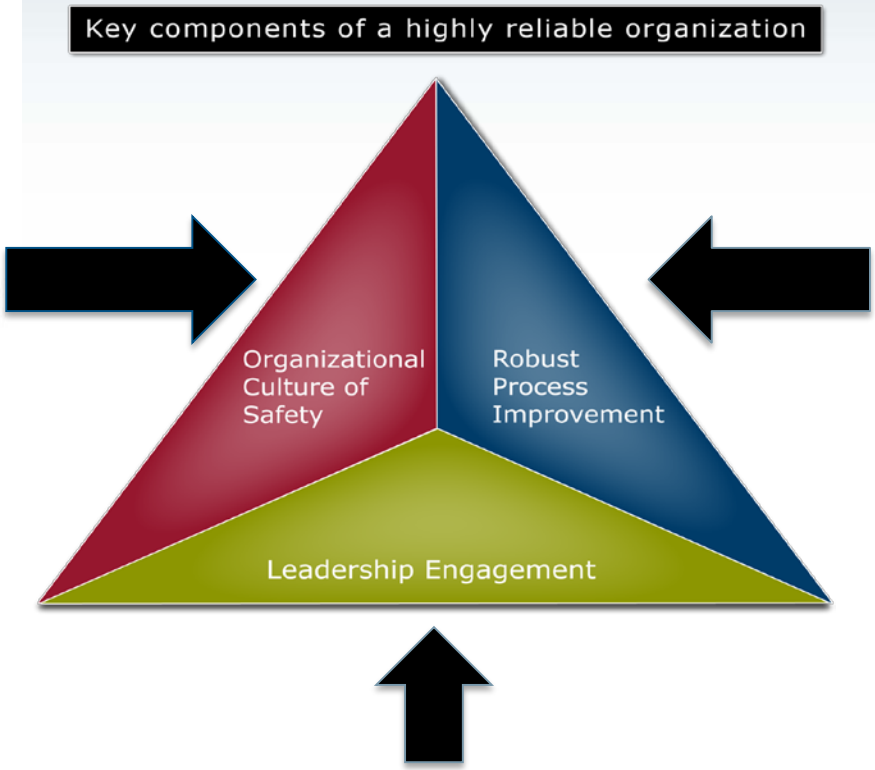
Human Error	At-Risk Behavior	Intolerable Behavior
Product of Our Current System Design and Behavioral Choices Manage through changes in: • Choices • Processes • Procedures • Training • Design • Environment	*A Choice: Risk Believed Insignificant or Justified* Manage through: • Removing incentives for at-risk behaviors • Creating incentives for healthy behaviors • Increasing situational awareness	*Conscious Disregard of Substantial and Unjustifiable Risk* Manage through: • Remedial action • Disciplinary action
Console	**Coach**	**Discipline**

Progress - Leadership

- Public commitment to zero harm – defects
- Commitment to Transparency
- 8 hour training devoted to HRO April 2015
  - 500 physicians and medical center staff
- “High Reliability Institute” 20 subject matter experts leading
- Certified in Just Culture and trained in HRO concepts
- Physician leadership development courses in College of Medicine

Putting it all together





Successes

- Dart board analogy is extremely easy to understand
  - Each leader is give a dart to envision where it lands
- HRO Story telling at every leader meeting, non-medical examples
  - Bathroom design and risk of interruptions
  - Alter serving and risk of fire
  - Summer beach vacation and risk of shark attacks
  - Stage safety and risk of falls
- Just Culture story telling at every leader meeting
  - Speeding on the interstate
  - Elf on the shelf
- “Forcing” discomfort with harm (moment of silence)
- Reward and recognition

Challenges

Just Culture and physicians

Zero harm concept (“but my patients really are sicker”)

Engaging non-clinicians (facilities, environment of care, schedulers, revenue cycle, security, IT)

How do you know it is working?

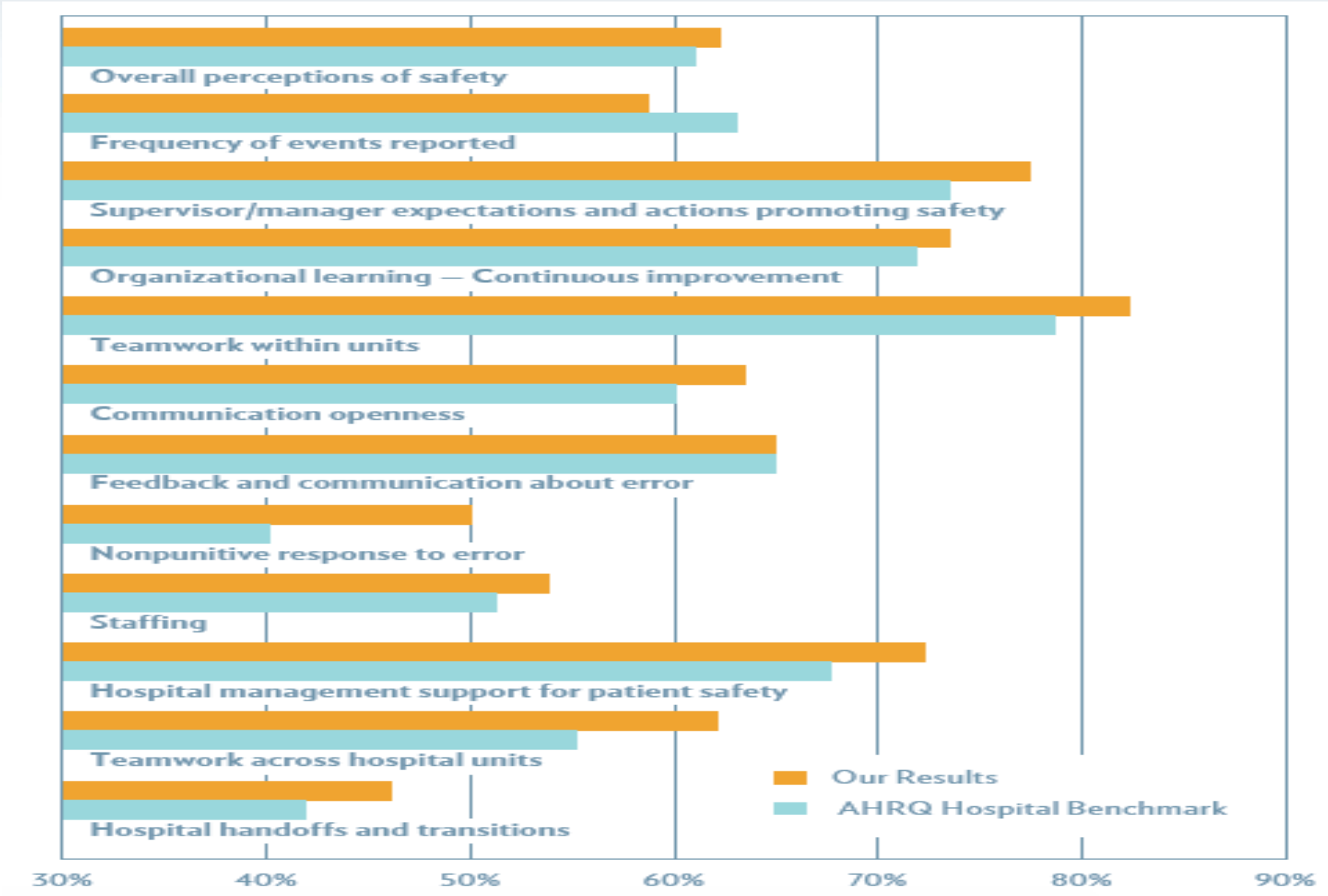
Culture of Safety surveys

Employee and Physician engagement surveys

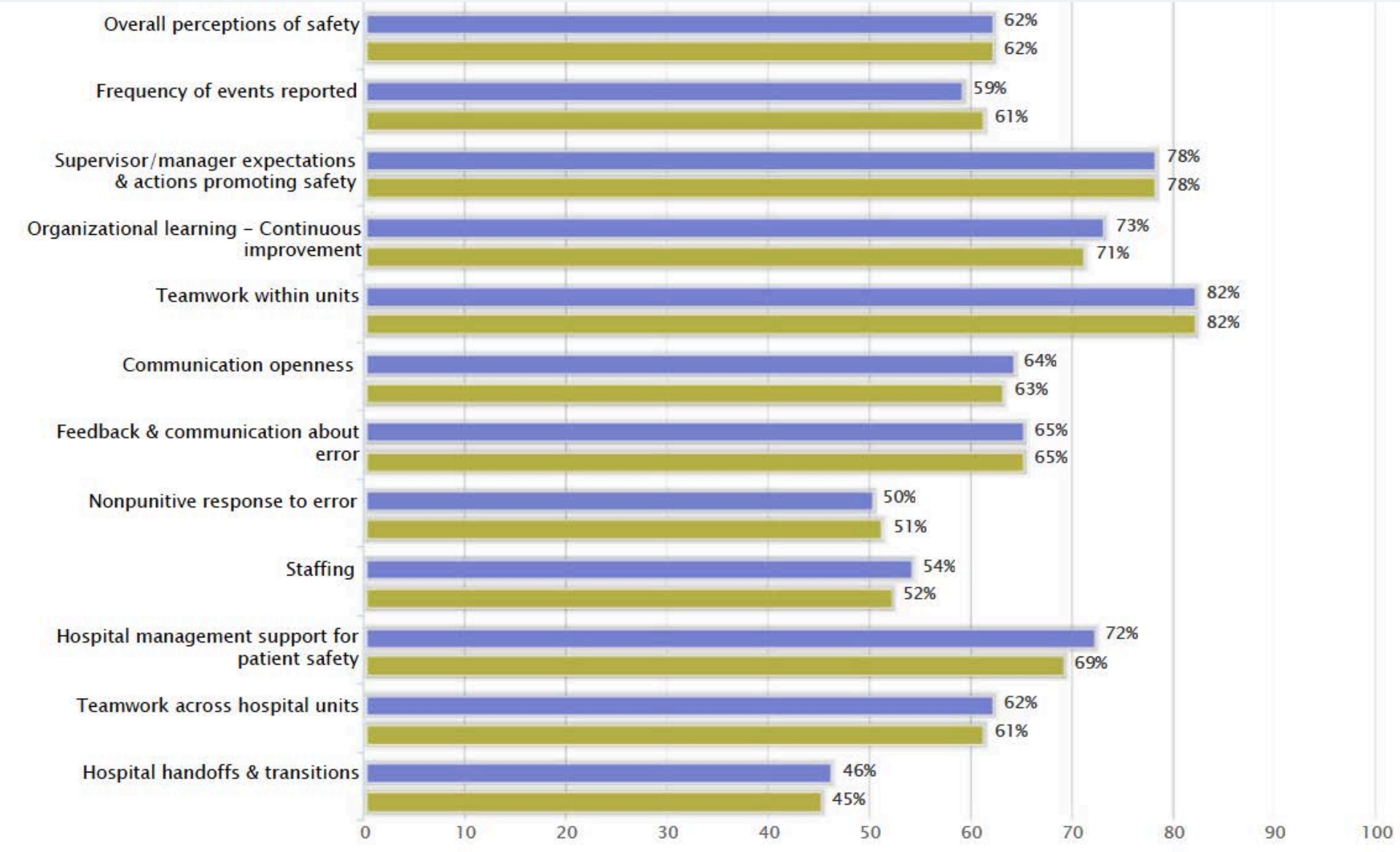
Serious Safety Event Rates

Joint Commission HRO tool

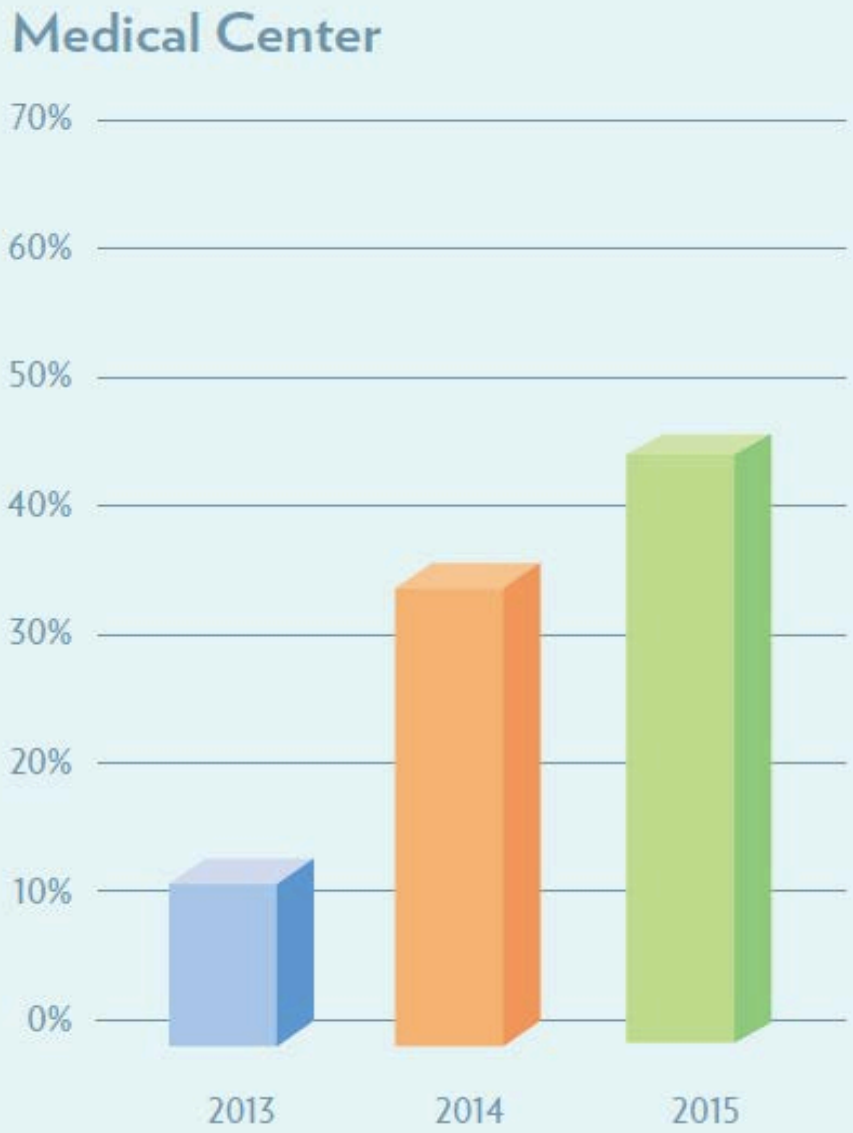
Culture of Safety 2015 Versus benchmark

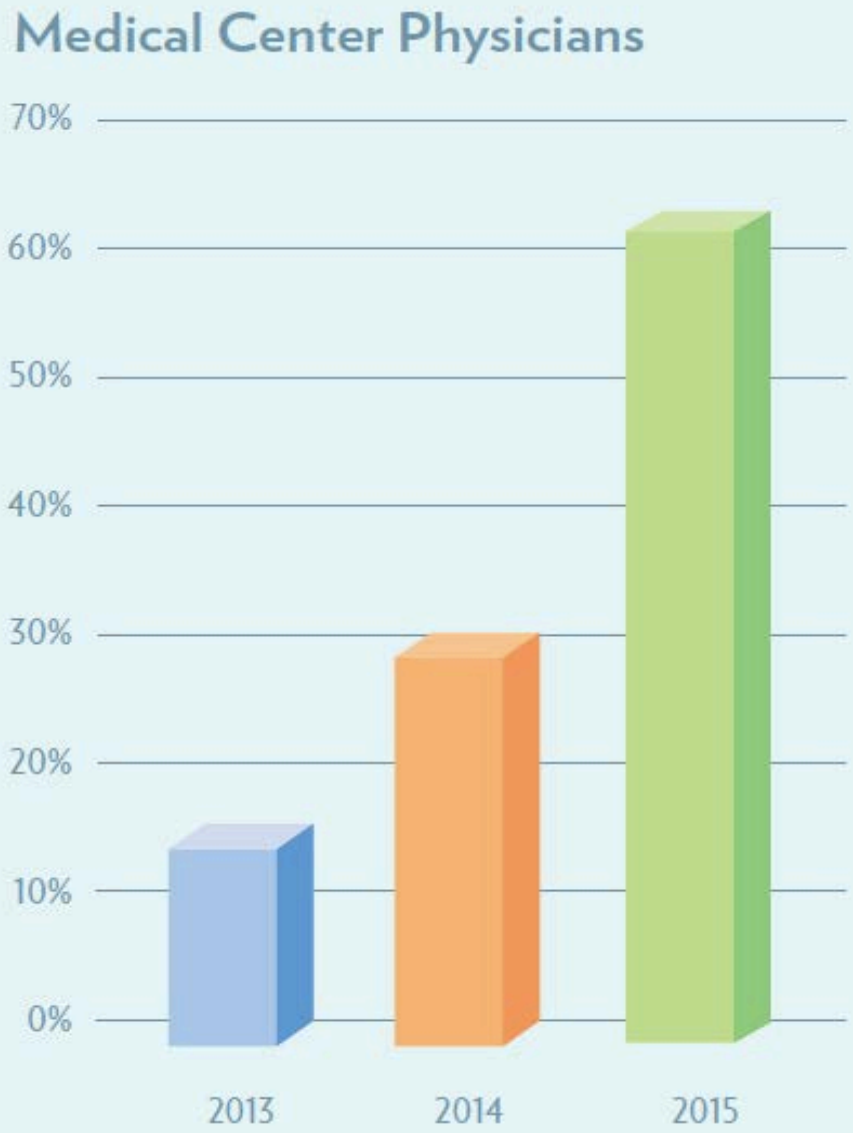


Culture of Safety 2014-2015



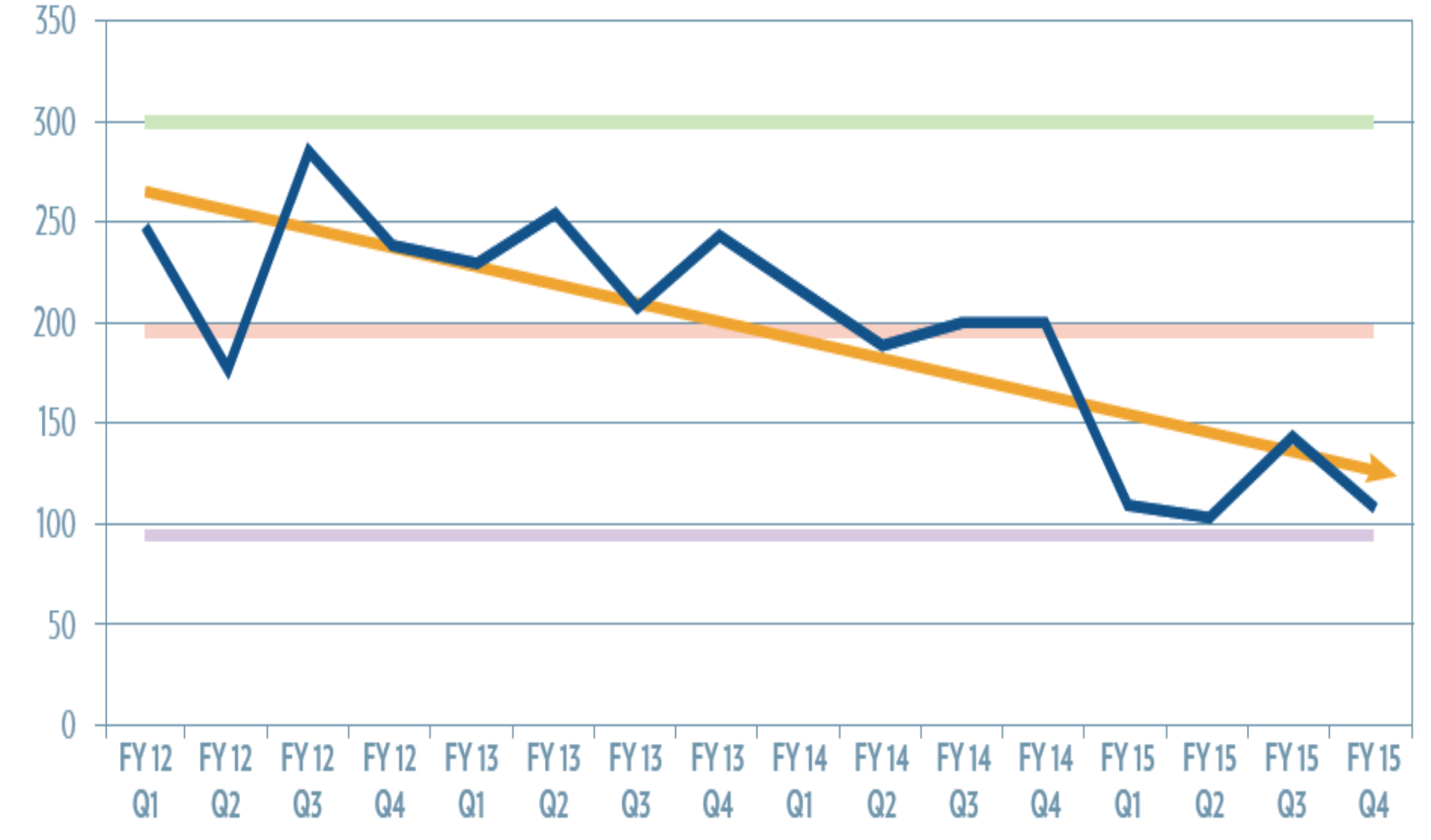
Employee-Physician Engagement %





Serious Safety Event Rate

Total harm events



Oro™ 2.0 Assessment Results: Results Over Time

Medical University of South Carolina Medical Center
HCO ID: 6584

Beginning | Developing | Advancing | Approaching

Domain	Component	2013 Draft Consensus	2013 HRST Consensus Survey	2014 HRST Concensus Survey	2015 HRST Consensus Survey
Leadership	Board	Developing	Developing	Developing	Developing
	CEO/management	Approaching	Approaching	Approaching	Approaching
	Physicians	Advancing	Advancing	Advancing	Advancing
	Quality strategy	Advancing	Advancing	Advancing	Advancing
	Quality measures	Advancing	Approaching	Advancing	Approaching
	Information technology	Developing	Developing	Developing	Advancing
Safety Culture	Trust	Approaching	Approaching	Approaching	Approaching
	Accountability	Advancing	Advancing	Approaching	Approaching
	Identifying unsafe conditions	Advancing	Advancing	Advancing	Advancing
	Strengthening systems	Developing	Developing	Developing	Approaching
	Assessment	Advancing	Advancing	Approaching	Approaching
Performance Improvement	Methods	Advancing	Approaching	Approaching	Approaching
	Training	Advancing	Advancing	Advancing	Advancing
	Spread	Developing	Advancing	Advancing	Advancing

Summary

- Foundations of High Reliability
  - Mental model of zero harm
  - Transparency
- Pillars on the foundation
  - Culture of Safety
  - Leadership
  - Process improvement
- Monitor progress
  - Culture of Safety
  - Engagement
  - Harm
  - Oro 2.0