Medical Mindfulness

A customer (patient) is the most important visitor on our premises.
He is not dependent on us. We are dependent on him.
He is not an interruption in our work. He is the purpose of it.
He is not an outsider in our business. He is part of it.
We are not doing him a favor by serving him. He is doing us a favor by giving us an opportunity to do so.

… Mahatma Gandhi

What is the Burning Platform for Becoming a High Reliability Healthcare System?

- It is the right thing to do ... “First Do No Harm”
- Higher public accountability
- Transparency of quality data
- Our current healthcare system is harming and killing patients at an unacceptable rate
- Reimbursement is now tied to quality
Hospital Safety 1966


Findings:
• 44,000-98,000 accidental deaths/yr in US hospitals
• Many due to drug errors
• Most errors were preventable

2008 - Still a Problem

“One in 200 patients who spends a night or more in the hospital will die from a medical error. One in 16 will pick up an infection. Deaths from preventable hospital infections exceed 100,000, more than those from AIDS, breast cancer and auto accidents combined.”
Medical Mistakes

• One in seven Medicare patients (13.5%) experienced at least one serious instance of harm from medical care that prolonged their hospital stay, caused permanent harm, required life-sustaining intervention, or contributed to their death.

• An estimated 134,000 hospitalized Medicare beneficiaries experienced harm from medical care in one month, with the event contributing to death for 1.5% or approximately 15,000 patients.

If healthcare was an airline…

“If healthcare was an airline, only dedicated risk takers, thrill seekers and those tired of living would fly on it.”

Patient Safety (2005) by Charles Vincent

What is Required to Become a High Reliability Organization?

• Commitment from Governance
  – More time discussing quality at board meetings and board quality committee meeting
  – Hold leadership and physicians accountable for practicing high quality evidence-based medicine
  – Make quality a high priority in credentialing and re-credentialing
“When Progress is measured, Progress improves …

When Progress is measured and REPORTED, Progress accelerates …”
Move the organization from Safety as a priority to Safety is a Core Value

What is the leadership behavioral expectation when safety is a core value?

“No Excuses Accountability” from Leadership

How Do We Improve Quality and Patient Safety?

• Senior leadership rounding
• Hourly nurse rounding
• “Just culture”
• Patient safety is everyone’s responsibility

Five Principles of HROs

Three Principles of Anticipation
Preoccupation with Failure
Regarding small, inconsequential errors as a symptom that something’s wrong

Sensitivity to Operations
Paying attention to what’s happening on the front-line

Reluctance to Simplify Interpretations
Encouraging diversity in experience, perspective, and opinion

Two Principles of Containment
Commitment to Resilience
Developing capabilities to detect, contain, and bounce-back from events that do occur
Deference to Expertise
Pushing decision making down and around to the person with the most related knowledge and expertise
Essential Success Factors

• Precise Execution
• Organizational Hardwiring
• Sustainability of Results
• No Excuses Accountability

High Reliability Organizations

Commercial Aviation
Air Traffic Control
Nuclear Aircraft Carriers

MHHS Safety Culture Training

Hospital Training Complete
>20,000 Employees Trained
>3,000 Physicians Trained
>540 Safety Coaches Trained
>$18M Expense
Breakthroughs in Patient Safety Training

Self-Checking With STAR* (Stop, Think, Act, & Review)

"It sort of makes you stop & think, doesn't it?"

Red Rules
Absolute Compliance

1. Patient Identification
2. Time Out
3. Two Provider Check
**Hospital Acquired Conditions**

"Never Events"

**Acute Hemolytic Transfusion Reactions**

Transfusion Events Jan 2007 - June 2014

- 1,845,000 Adjusted Admissions
- 9,991,000 Adjusted Pt Days
- 954,500 Transfusions

**Joint Commission Hand Hygiene**

Center for Transforming Healthcare

Baseline Compliance - 44%
Adult ICU Central Line Associated Blood Stream Infections (CLABSI)

- Hand Hygiene
- TJC CTH

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Adult Ventilator Associated Pneumonias (VAP)

- Hand Hygiene
- TJC CTH

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Hospital Acquired Infections, Conditions and Patient Safety Indicators

- Central Line Associated Bloodstream Infections
- Ventilator Associated Pneumonias
- Surgical Site Infections
- Retained Foreign Bodies
- Iatrogenic Pneumothorax
- Accidental Punctures and Lacerations
- Pressure Ulcers Stages III & IV
- Hospital Associated Injuries
- Deep Vein Thrombosis and/or Pulmonary Embolism
- Deaths Among Surgical Inpatients with Serious Treatable Complications
- Birth Traumas
- Serious Safety Events
Central Line Associated Bloodstream Infections
Ventilator Associated Pneumonias
Surgical Site Infections
Retained Foreign Bodies
Accidental Punctures and Lacerations
Pressure Ulcers Stages III & IV
Deep Vein Thrombosis and/or Pulmonary Embolism
Deaths Among Surgical Inpatients with Serious Treatable Complications
Birth Traumas
Serious Safety Events

MH Southeast Hospital
Iatrogenic Pneumothorax

22 Months
Zero Iatrogenic Pneumothorax
High Reliability Certified Zero Award

1. Zero Events
2. 12 Consecutive Months
3. Certified Zero Category

MH Northwest: Zero Retained Foreign Bodies

MH Katy: Zero Central Line Blood Stream Infections Hospital-Wide
MH Woodlands: Zero Ventilator Associated Pneumonias

MH Katy: Zero Pressure Ulcers Stages 3 & 4

High Reliability 2011-14 Certified Zero Awards

- ICU Central Line Associated Bloodstream Infections (12)
- Hospital-Wide Central Line Associated Bloodstream Infections (3)
- Ventilator Associated Pneumonias (23)
- Surgical Site Infections
- Retained Foreign Bodies (29)
- Iatrogenic Pneumothorax (15)
- Accidental Punctures and Lacerations (3)
- Pressure Ulcers Stages III & IV (21)
- Hospital Associated Injuries (5)
- Deep Vein Thrombosis and/or Pulmonary Embolism
- Deaths Among Surgical Inpatients with Serious Treatable Complications
- Birth Traumas (11)
- Serious Safety Events 1&2 (8)
- All Serious Safety Events (1)
- Early Elective Deliveries (1)
John M. Eisenberg Patient Safety and Quality Award

March 8, 2013 | Washington, DC

Healthcare as a High Reliability Organization

High Reliability Organizations

Commercial Aviation

Nuclear Aircraft Carriers

Air Traffic Control
High Reliability Organizations

Commercial Aviation

Air Traffic Control

Nuclear Aircraft Carriers

Memorial Hermann Health System

Air Traffic Control

Nuclear Aircraft Carriers

Commercial Aviation

Thank you!

“You must be the change you want to see in the world”

Mahatma Gandhi (1869-1948)