Creating a Culture of Safety: Leading to High Reliability
How Senior Leaders Lead
2016 Quest Conference

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Advocate Good Samaritan Hospital

Advocate Good Samaritan Hospital

- Part of Advocate Health Care
  - One of the top 15 health systems
  - Largest integrated health system in Illinois and largest ACO in America
- 300-bed Community Hospital
- 1,600 associates, 900 physicians & 500 volunteers
- Level I Trauma Center
- Advanced Perinatal Services

National Recognition For Excellence

Advocate Good Samaritan Hospital
Imagine A Hospital Culture…

- Where we stop killing the equivalent of the city of Miami (440,000) every year from medical errors
- Where the mindset transforms from “the unexpected just happens” to “we manage the unexpected”
- Where safety transforms from a program to a core value

High Reliability Attributes

- Preoccupation with failure
  - Chronic wariness of the possibility of unexpected events
- Sensitivity of operations
  - Actively looking for the “Swiss Cheese”
- Reluctance to simplify
  - Question assumptions and perceived wisdom
- Commitment to resilience
  - Detect, contain, and bounce back from errors
- Deference to expertise
  - Expertise over rank

An Organization That Is Successful NOW And In The Future

1.1a How do SENIOR LEADERS′ create and promote a culture of PATIENT safety?
Who We Are

Who We Serve

Winning Values

Our Beliefs

Physicians

Volunteers

Assistants

Families

Core Leader Traits

Who Is on Our Team

Mission Values Philosophy

Integrity

Passion

Caring

Who We Serve

What Leaders Must Accomplish

Set Direction

Establish Goals

Learn, Improve & Innovate

Patient

Physicians

Volunteers

Assistants

Families

Organize, Plan & Align

Organize, Plan & Align

Community

Suppliers

Partners

Develop, Reward & Recognize

Perform to Plan

Accountability for Results

Learn, Improve & Innovate

GSAM Leadership System

Set Direction

Establish Goals

Understand Stakeholder Requirements

Patient

Physicians

Volunteers

Assistants

Families

Set Direction

Establish Goals

Organize, Plan & Align

Develop, Reward & Recognize

Perform to Plan

accountability for results

Learn, Improve & Innovate

GSAM Leadership System
Understand Stakeholder Requirements

- Daily safety huddle (preparation, discussion, action plans)
- Safety events shared
- Safety aspects of peer review shared
- ACA/RCA analysis and sharing
- Culture of Safety survey analysis

Daily Safety Huddle

How Leaders Set Direction and Goals

- Advocate Experience
- Annual safety goals
- Behaviors of excellence for safety

Be Safe
- nearest/first/always highest priority when making decisions
- When performing an important task, I will give my full attention
- Asking clarifying questions to seek full expertise when I am unsure about how to proceed
- Communicate clearly
- Proactively report and correct hazards
- Report safety events, near misses, and unsafe conditions
**Role Model/Build Commitment**

- Set a powerful context for every safety action plan and goal
- Start every meeting with safety
- **Lead the daily safety huddle**
- Any performance improvement effort that deals with safety has a goal of ‘0’
- Executive sponsor for all RCAs

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**Organize, Plan and Align**

- Structures: Director of Patient Safety, physician Safety Champions and associate Safety Coaches
- Safety goals cascaded to every executive, leader and associate
- **Just Culture Decision Guide**
- **Be Safe behaviors and tools**
- High reliability units (HRUs)
Be Safe
Hang Tag

High Reliability Units (HRUs)

• Teaching, using and peer coaching Be Safe behaviors and tools
• Safety coaches influencing behaviors
• Deploying our Lean PI approach for safety

Communicate, Engage and Empower

• We make harm visible
• Online safety calendar
• Engage and empower
  – Associates in causal analysis
  – Physicians in complication review
  – High reliability units identify and solve problems
  – Just Culture Decision Guide
Perform to Plan Report Card

HRU Perform to Plan

Change of shift handovers removed nurses and PCAs from direct care 40 minutes/shift change; it’s now down to 16 minutes/shift change.

Accountability for Results

- ISO audits for processes
- Validation surveys for Be Safe behaviors & tools
Validation of Be Safe Tools

Develop, Reward and Recognize

- 18 month safety curriculum for leaders
- Safety goal achievement and safety behaviors tied to merit increases
- Quarterly Lifesaver and Annual Patient Safety Award programs

Safety Curriculum
Safety Curriculum

Motivate and Acknowledge
- Senior leader rounding on HRUs
- Thank you notes for 'good catches'
- Thank you lunch for safety award nominees

Learn, Improve and Innovate
- Lean approach to performance improvement: Visual management, standard work, A3-PDSA thinking
Inspire and Raise the Bar

- Relentless drive to zero events
- Stories use names
- Celebrate milestones around days between serious safety events
- “What If…” stories

“"A story is a fact, wrapped in an emotion that compels us to take an action that transforms our world.”

— Richard Maxwell and Robert Dickman

Pay Attention To Detail:
STAR – Stop, Think, Act & Review

Roger had a central line for administration of critical blood pressure meds. While moving him for toileting, the central line went unnoticed and was pulled out. Luckily, the nurse was able to start an emergency IV despite becoming hypotension. Roger underwent another procedure to reinsert his central line.

What if Roger’s RN and PCA had used STAR to pay attention to detail and note the location of the central line tubing and protect it while moving him?

We Manage The Unexpected

- Preoccupation with failure
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THANK YOU!

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