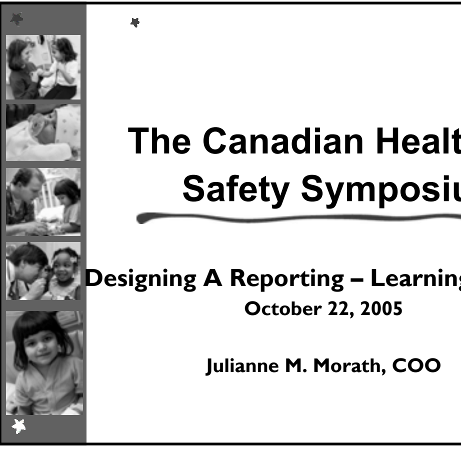


The Canadian Healthcare Safety Symposium

Designing A Reporting – Learning System

October 22, 2005

Julianne M. Morath, COO

Children's Hospitals and Clinics of Minnesota

First, do no harm….
Developing and Implementing a Culture of Safety

“The single greatest impediment to prevent harm is that we judge and punish people for making mistakes.”

Lucian Leape

Commit to Becoming A Learning Organization

How Different Organizational Cultures Handle Safety Information

Pathological Culture	Bureaucratic Culture	Generative Culture
Don't want to know	May not find out	Actively seek it
Messengers (Whistle blowers) are "shot"	Messengers are listened to if they arrive	Messengers are trained and rewarded
Failure is punished or concealed	Failure leads to local repairs	Failures lead to far-reaching reforms
New ideas are actively discouraged	New ideas often present problems	New ideas are welcomed

Safety culture is generative, constantly "uneasy", seeking, learning, changing.

Learning Culture

- Transparency of errors
- Ask and tell
- Blameless reporting
- Debriefs, simulations and rehearsals
- Stories
- Complex conversations
- Safe Spaces

Create A Reporting System

Preparatory Work

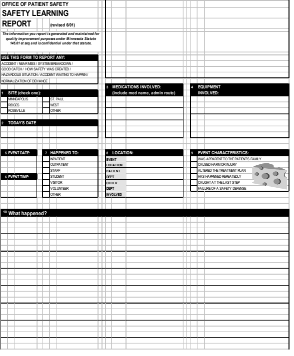
- C-Suite, Board, Managers, Physicians, Employees
- Patient Safety Vision
- Context of over-all plan
- Mini-course and dialogues
- Mentoring groups
- Study and design

Reporting Learning System (ASRS – Based)

Blameless reporting of hazards, "near-misses" and accidents

- **text-based**
- **reading groups**
- **keep the stories alive**
- **learning stacks**
- **analysis to action**
- **OOPS**

On-Line Safety Learning Report



CHILDREN'S HOSPITALS AND CLINICS
OFFICE OF PATIENT SAFETY
SAFETY LEARNING REPORT (revised 6/01)

The information you report is generated and maintained for quality improvement purposes under Minnesota Statute 145.61 et seq and is confidential under that statute.

ADDRESSOGRAPH OR NAME / MEDICAL RECORD # / DOB / ACCOUNT NUMBER

USE THIS FORM TO REPORT ANY:
ACCIDENT / NEAR MISS / SYSTEM BREAKDOWN / GOOD CATCH / HOW SAFETY WAS CREATED / HAZARDOUS SITUATION / ACCIDENT WAITING TO HAPPEN / NORMALIZATION OF DEVIANCE

1 SITE (check one):
- MINNEAPOLIS
- ST. PAUL
- RIDGES
- WEST
- ROSEVILLE
- OTHER

2 TODAY'S DATE

3 MEDICATIONS INVOLVED: (include med name, admin route)

4 EQUIPMENT INVOLVED:

5 EVENT DATE:

6 EVENT TIME:

7 HAPPENED TO:
- INPATIENT
- OUTPATIENT
- STAFF
- STUDENT
- VISITOR
- VOLUNTEER
- OTHER

8 LOCATION:
EVENT LOCATION
PATIENT DEPT
OTHER DEPT INVOLVED

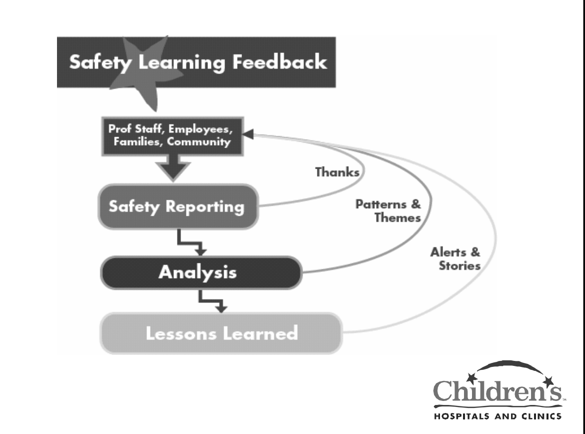
9 EVENT CHARACTERISTICS:
- WAS APPARENT TO THE PATIENT'S FAMILY
- CAUSED HARM OR INJURY
- ALTERED THE TREATMENT PLAN
- HAS HAPPENED REPEATEDLY
- CAUGHT AT THE LAST STEP
- FAILURE OF A SAFETY DEFENSE

10 What happened?

Reciprocal Accountability

Reciprocal Accountability
Mutual Trust

- ***THE SYSTEM MUST TRUST THAT YOU WILL CALL OUT***
- ***YOU MUST TRUST THAT THE SYSTEM WILL LISTEN***



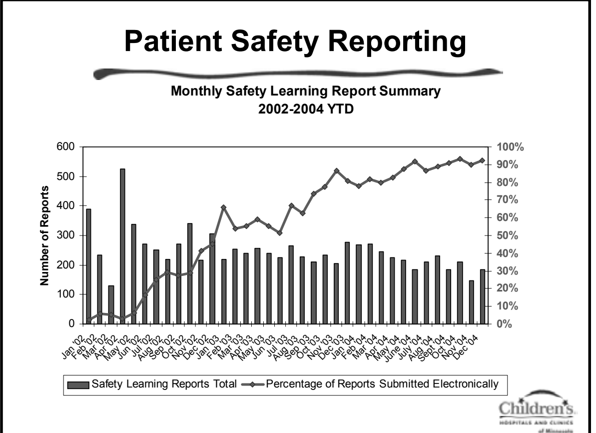
Office of Patient Safety
OOPS

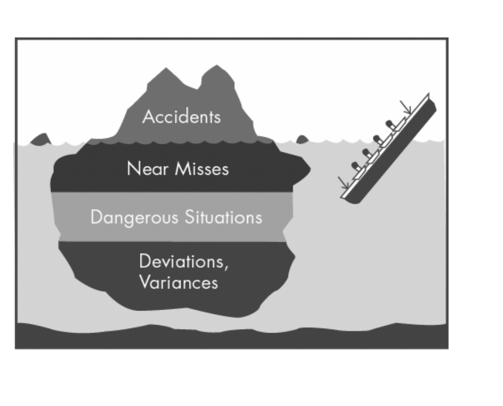
- **Virtual entity, protected by legislative language for quality improvement data**
- **24-hour reading for all reports**
- **Provide content analysis**
- **Detect pattern/themes to inform goals**
- **Act as catalyst for learning – action model**
- **Conduct inquiries and studies**

Office of Patient Safety
OOPS

- Convene reading groups/safety action teams
- Create learning stacks
- Provide recognition and public celebration of risk and hazard identification
- Manage http://createsafety.net/
  - Alerts
  - Lessons Learned
  - De-identified case studies
- Build predictive modeling

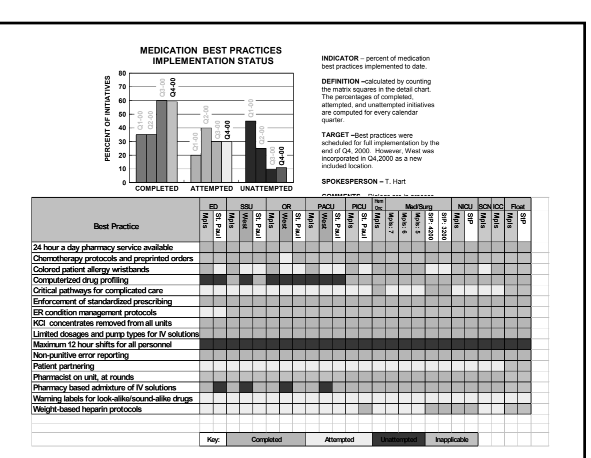
Patient Safety Reporting





Explicit Safety Goals

Accountability Through Structure and Process Measures



Safety Action Teams

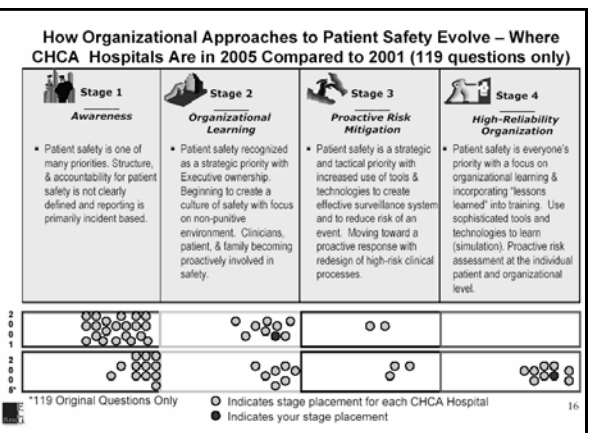
- **Interdisciplinary, frontline staff**
- **Tools**
  - **Learning stacks**
  - **Good catch logs**
  - **Simple rules**
  - **Local problem-solving**
  - **Simple rules**

Simple Rules

- ***Fix what you can***
- ***Tell what you fixed***
- ***Find someone who can fix what you cannot***

Frontline Management Dilemmas

- **Blameless reporting versus individual accountability**
- **Perception of Loss of knowledge/control**
- **Use of information for performance evaluation**
- **New paradigm for management competencies**
- **Incentives**



Questions/Comments/ Discussion

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