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Shifting Patient Safety into High Gear

Boston, MA, November 16, 2012

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Lessons from Surgery

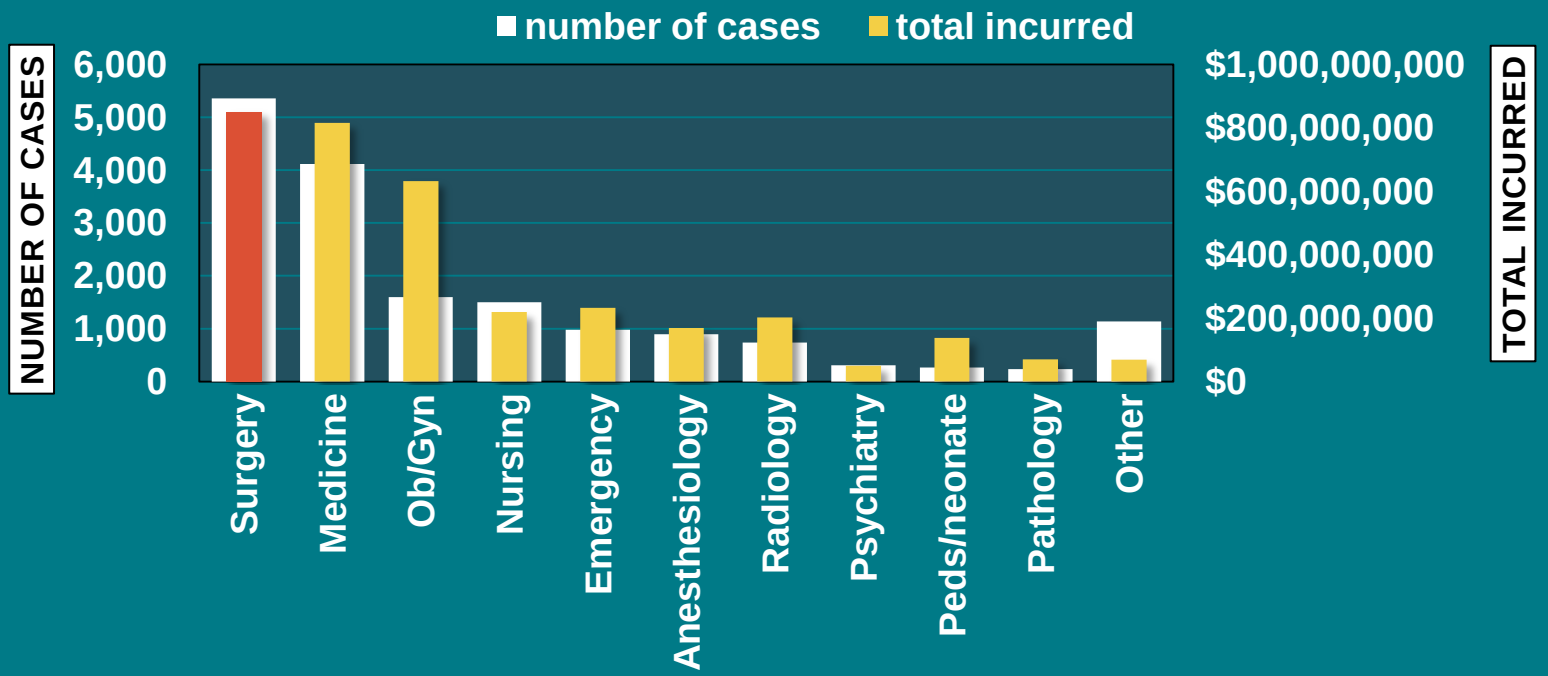
Bill Berry, MD | CRICO

Steve Schwaitzberg, MD | Cambridge Health Alliance

Larry Harmon, PhD | PULSE

Surgical services top malp. cases, losses

National Landscape: Primary Responsible Services



CBS N=17,124 coded professional liability cases asserted 1/1/07–12/31/11.

Total incurred includes reserves on open cases and payments on closed cases.

Surgery includes: General Surgery, Neurosurgery, Orthopedics, and Surgery Subspecialties (Bariatric Surgery, Colorectal Surgery, Cardiac Surgery, Otorhinolaryngology (with Plastic), Hand Surgery, Ophthalmology, Otolaryngology (No plastic), Plastic (NOC), Pediatric Surgery, Oncology (Surgical), Thoracic Surgery, Urology Surgery, Vascular Surgery, Transplant, Podiatry).

Medicine includes: General Medicine and Medicine Subspecialties (Cardiology, Dermatology, Endocrinology, Gastroenterology, Genetics, Geriatrics, Hematology, Hospitalist, Immunology and Allergy, Infectious Disease, Oncology (Medical), Nephrology, Neurology, Physical Medicine/Rehabilitation, Pulmonary Disease, Rheumatology).

Other includes: Dentistry/Oral Surgery, Allied Health, Non-clinical, and Pharmacy.

Surgery Malpractice Profile

5,361 cases | $851M total incurred

2007–2011

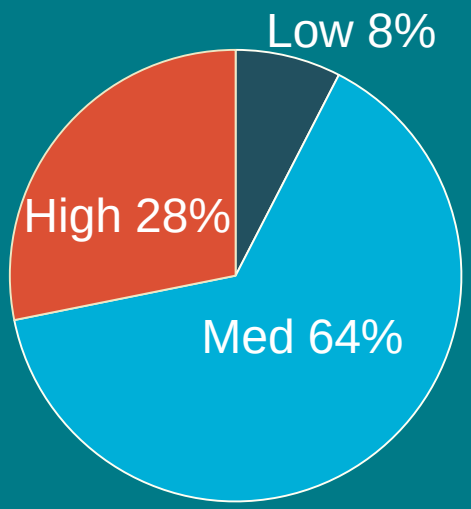
(cases with surgery as primary responsible service)

5,361 cases | $851M total incurred

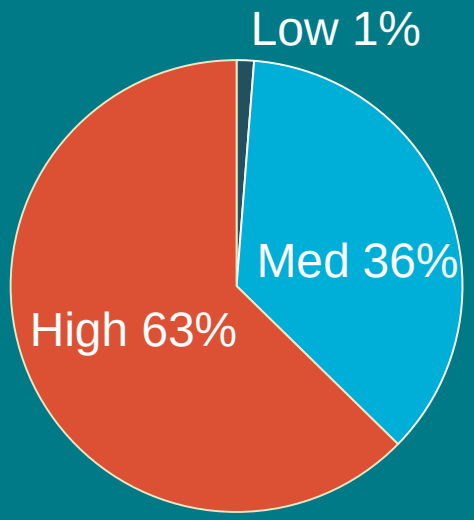
28% involved a high-severity injury

Injury Severity in Surgery Cases

PERCENT OF CASES



PERCENT OF TOTAL INCURRED



CBS N=5,361 coded professional liability cases asserted 1/1/07–12/31/11 with Surgery as the primary responsible service.

Surgery includes: General Surgery, Neurosurgery, Orthopedics, and Surgery subspecialties (Bariatric Surgery, Colorectal Surgery, Cardiac Surgery, Otorhinolaryngology (with Plastic), Hand Surgery, Ophthalmology, Otolaryngology (No plastic), Plastic (NOC), Pediatric Surgery, Oncology (Surgical), Thoracic Surgery, Urology Surgery, Vascular Surgery, Transplant, Podiatry).

Total incurred: Reserves on open cases and payments on closed cases.

Severity scale: High= death, permanent grave, permanent major, or permanent significant
Medium= permanent minor, temporary major, or temporary minor
Low= temporary insignificant, emotional only, or legal issue only

Common procedures involved

Top Procedures in Surgery Case

PROCEDURES	# CASES
Operations on musculoskeletal system	1,230
Operations on digestive system	675
Operations on integumentary system	649
Operations on nervous system	416
Operations on cardiovascular system	272
Operations on eye	231
Misc. diagnostic & therapeutic procedures	183
Operations on nose; mouth; and pharynx	160
Operations on urinary system	116

MUSCULOSKELETAL PROCEDURES	# CASES*
Arthroplasty	424
Treatment of fracture or dislocation	216
Spinal fusion	175
Therapeutic procedures on muscles and tendons	93

DIGESTIVE SYSTEM PROCEDURES	# CASES*
Cholecystectomy and common duct exploration	119
Upper GI therapeutic procedures	103
Hernia repair	98
Colorectal resection	85

INTEGUMENTARY PROCEDURES	# CASES*
OR therapeutic procedures on skin and breast	501
Procedures on breast	49
Excision of skin lesion	30

CBS N=5,361 coded professional liability cases asserted 1/1/07 - 12/31/11 with Surgery as the primary responsible service.

5,361 cases | $851M total incurred

Technical Skill, n

Top Contributing Fac

FACTOR	% CASES*
Technical skill	51%
Clinical judgment	44%
Communication	25%
Behavior-related	25%
Documentation	14%
Administrative	12%
Clinical systems	11%

TOP TECHNICAL SKILL FACTORS	# CASES*
Possible technical problem	1,748
Poor technique, other	355
Retained foreign body	260
Misidentification of anatomical structure	208

TOP CLINICAL JUDGMENT FACTORS	# CASES*
Selection/management therapy: surgical/invasive procedures	687
Pt assessment: failure/delay in ordering diagnostic test	473
Pt assessment: narrow dx focus-failure to establish differential dx	311
Lack of/inadequate pt assessment: failure to note clinical info	258

TOP COMMUNICATION FACTORS	# CASES*
Communication among providers regarding patient's condition	310
Inadequate informed consent for surgical/invasive procedures	290
Communication between patient/family & provider: other	235
Poor rapport (includes unsympathetic response to patient)	156

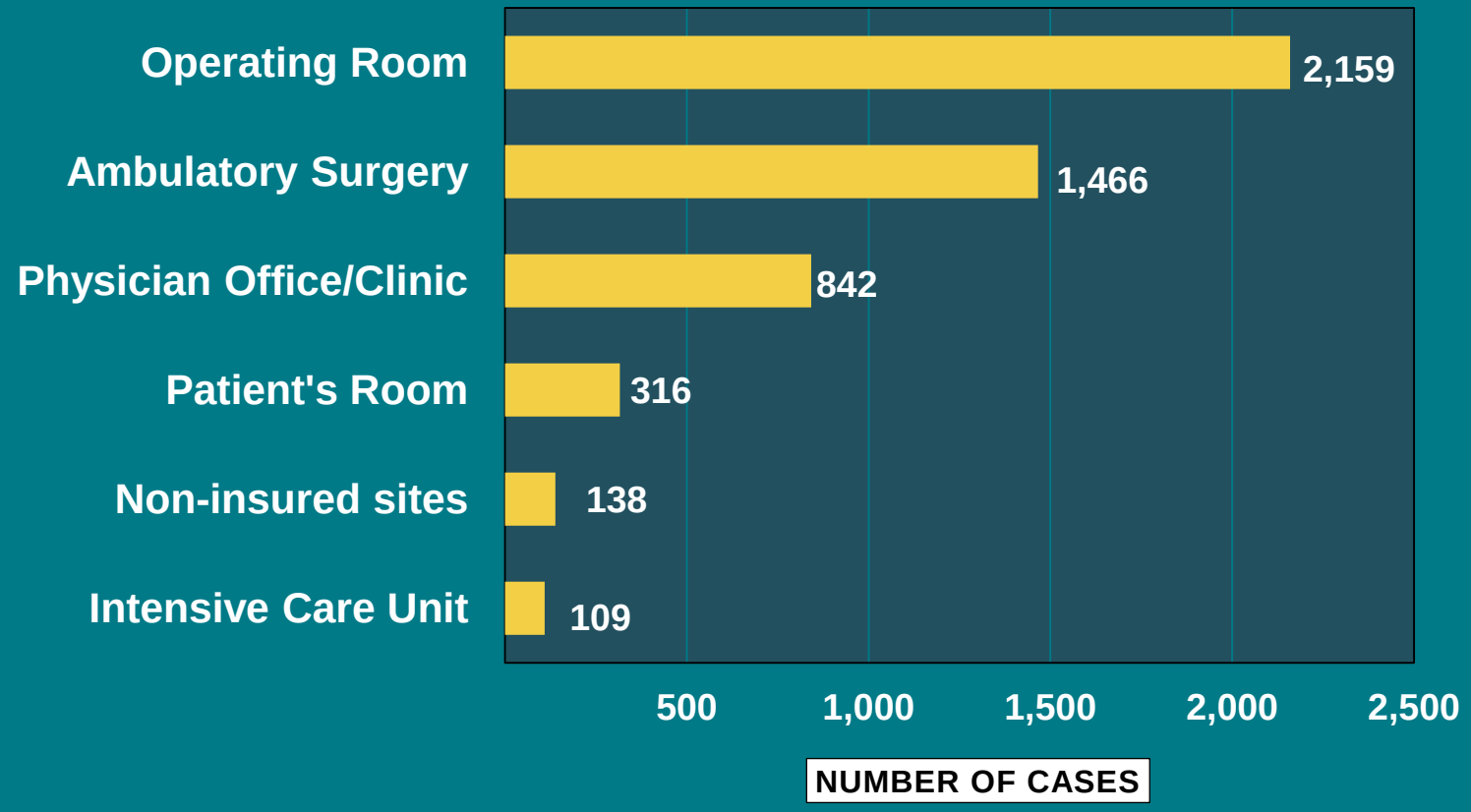
*A case will often have multiple fact

CBS N=5,361 coded professional lia
primary responsible service.

5,361 cases | $851M total incurred

Risks in Inpatient and Outpatient Settings

Top Locations in Surgery Cases



CBS N=5,361 coded professional liability cases asserted 1/1/07–12/31/11 with Surgery as the primary responsible service.

Case Discussion

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Hypoxia/Arrest

- Saturday: 50-year-old male presented with small bowel obstruction secondary to adhesions
- Taken to OR; necrotic bowel was found and 50cms removed
- Saturday night: patient transferred from the PACU to the floor
- Uneventful evening

Hypoxia/Arrest

- Sunday morning (7 a.m.) patient began to have increasing problems with oxygenation and breathing
- Seen by surgical residents
- Oxygen increased and (finally) placed on CPAP
- Not moved to the ICU
- Attending not called
- Sunday afternoon (12:30 p.m.) patient arrests
- Brain injury
- Case settled in the high range

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Lessons from Surgery

What can we learn from attending the PSO Experience?

Steve Schwaitzberg, MD

Chief of Surgery, Cambridge Health Alliance
Associate Professor, Harvard Medical School

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Hypothetical Problem: A Fire in the OR

700+/year

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If this were to happen….

PSO format provide peer protected environment to :

- Present to multidisciplinary audience
- Learn from institutions who made have had a similar experience

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If this were to happen….

PSO format provide peer protected environment to:

Share solutions locally applied from the event

Learn about solutions from institutions who have had a similar experience

Generate generic recommendations for PSO wide improvement

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Lessons from Surgery

Surgery Code of Excellence and Quality PULSE 360 / Coaching Pilot

Larry Harmon, PhD | PULSE 360

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Surgery Code of Excellence and Quality PULSE 360 / Coaching Pilot

FOR CONSIDERATION:

- As a Measurement
- As a Motivator
- The power of 360 Feedback + Coaching

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Brief History of the 360° Feedback in Business

- 1970s: Began in leadership programs
- 1980s: Improved management skills in: Accounting, Banking, Manufacturing, Police, Navy, Utility, University, etc.
- 1990s: 360 Feedback + Coaching improved managers' performance ratings, employee satisfaction, intentions to turnover, and commitment

Surgery Code of Excellence and Quality PULSE 360/ Coaching Pilot

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Harvard Surgery Code of Excellence

ADOPTED BY THE MEMBERS OF THE CRICO/HARVARD SURGICAL CHIEFS SAFETY COLLABORATIVE

1. **SERVICE:** Our surgeons are expected always to place patients' needs first.
2. **RESPECT:** Our surgeons are expected to treat patients, their families, visitors, students, trainees, other caregivers, and one another with respect and professional dignity.
3. **TEAMWORK:** Our surgeons are expected to work collaboratively in service of patient care, both as effective leaders of teams and as members of teams led by others.
4. **EXCELLENCE:** Harvard aims to provide patient care and service equivalent to the best in the world. Our surgeons are therefore expected:
   - to become board certified and maintain certification;*
   - to monitor their outcomes and record them;
   - to make their results available for evaluation;
   - to follow prudent safety practices and guidelines for optimal patient care;
   - to achieve and maintain proficiency in the procedures they perform and in the basic set of procedures they may be called upon to perform in their specialty;
   - to limit their practice, except in an emergency, to those areas in which they have maintained proficiency; and
   - to adopt beneficial new technologies and techniques.
5. **ETHICAL DISCIPLINE:** Our surgeons will not adopt/attempt experimental techniques and technologies outside of research ethics review and assessment, unless in an emergency.
6. **PERSONAL RESPONSIBILITY TO PATIENTS:** Our surgeons are expected to take full responsibility for ensuring the safe care of their patients. When unable to do so themselves, they will arrange appropriate handover or consultation with another colleague or institution. Our surgeons will take responsibility for covered patients as if they were their own.
7. **OPENNESS:** Our surgeons are expected to communicate openly and honestly with patients and in the medical record about all aspects of their care—including the nature of any procedures to be performed, rates of complications, potential difficulties for recovery, involvement of other team members, and occurrence of mistakes and adverse events.
8. **EDUCATION:** Our surgeons are expected to devote time, effort, and skill to educating caregivers and our next generation of clinicians.
9. **HUMILITY:** All surgeons have finite abilities. Our surgeons are therefore expected to assess when a case is beyond their or their institution's capabilities and to seek assistance and consultation accordingly.
10. **HEALTH:** Our surgeons are expected to value and maintain their health and wellness, as well as assist colleagues with their health.
11. **CONFLICT OF INTEREST:** Our surgeons are expected to maintain the knowledge, insight, and discipline required to keep the patient's interest above financial or any other conflict of interest.**

*Per institution protocol surrounding board certification requirements.

**Based on the American College of Surgeons Statement on Principles. Available at: http://www.facs.org/fellows_info/statements/stonprin.html. Accessed May 5, 2011.

11/22/11

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Quality PULSE 360: Questions and/or Scales

COLLEAGUES & HEALTHCARE STAFF

- Motivating behaviors
- Motivating impact
- Discouraging behaviors
- Discouraging impact
- Insight impact
- Burnout screening
- Cognitive screening

PATIENTS & FAMILY MEMBERS

- Patient care
- Medical knowledge
- Practice-based learning and improvement
- Professionalism
- Interpersonal and communication skills
- Patient satisfaction
- Systems-based practice
- Surgical competencies

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Crosswalk between Code and PULSE Survey

- Tailored carefully to match the spirit of the Code
- Measures whether surgeon actions are perceived by those around them to be consistent with the Code
- Also has potential to drive improvements in surgeon performance as they receive meaningful feedback about the way they interact with others and with medical system

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CRICO-Funded Pilot Program
Up to 3 hours of Debriefing/Coaching

- Debriefing: about 30-60 minutes (typically by phone)
  - Review Feedback: look for themes
  - Set at least 3 “Excellence Goals”
    - START Goals
    - STOP Goals
    - KEEP Goals

"Excellence Goals"

Date: _____

Your Name: Chris Surgeon, MD MD

Dept: Surgery Division: Ortho

PULSE Review with (Chief/Chair): Pat PULSE Coach, PhD MD

Instructions: Please complete the "6 Circles" learning activity by writing down on the form below your 6 major rater comment themes/goals.

1. *Some respondents would like me to* ***START***
   (My goal is to start...):
   a. Treat OR nursing staff with respect.
   b. Bringing my complaints first to the Nurse-Manager.

2. *Some respondents would like me to* ***STOP***
   (My goal is to stop...):
   a. Overreacting to small mistakes.
   b. Demeaning & intimidating nurses when frustrated.

3. *Some respondents APPRECIATE and would like me to* ***KEEP***
   (My goal is to keep...):
   a. Practicing quality surgery.
   b. Being an inspirational teacher.

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CRICO-funded Pilot Program
Up to 3 hours of Debriefing/Coaching

- Coaching Contacts: frequent 15-45 minutes
  - Identify strategies to reach goals
  - Learn/practice new skills
  - Reinforce improvement
- Follow-up PULSE Survey: 3-4 months later