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Improving Patient Safety and Protecting the Process

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ERNST & YOUNG LLP

Agenda

- Patient Safety – A Mission Critical Issue Gone Awry
  - Culture of Silence
  - Culture of Shame
  - Culture of Silos
  - Culture of Delegation
- Patient Safety – A Mission Critical STRATEGY
  - Culture of Communication
  - Culture of Objective Scrutiny – Critique without Malice
  - Culture of Integration
  - Culture of Accountability
- Patient Safety - Protecting the Process

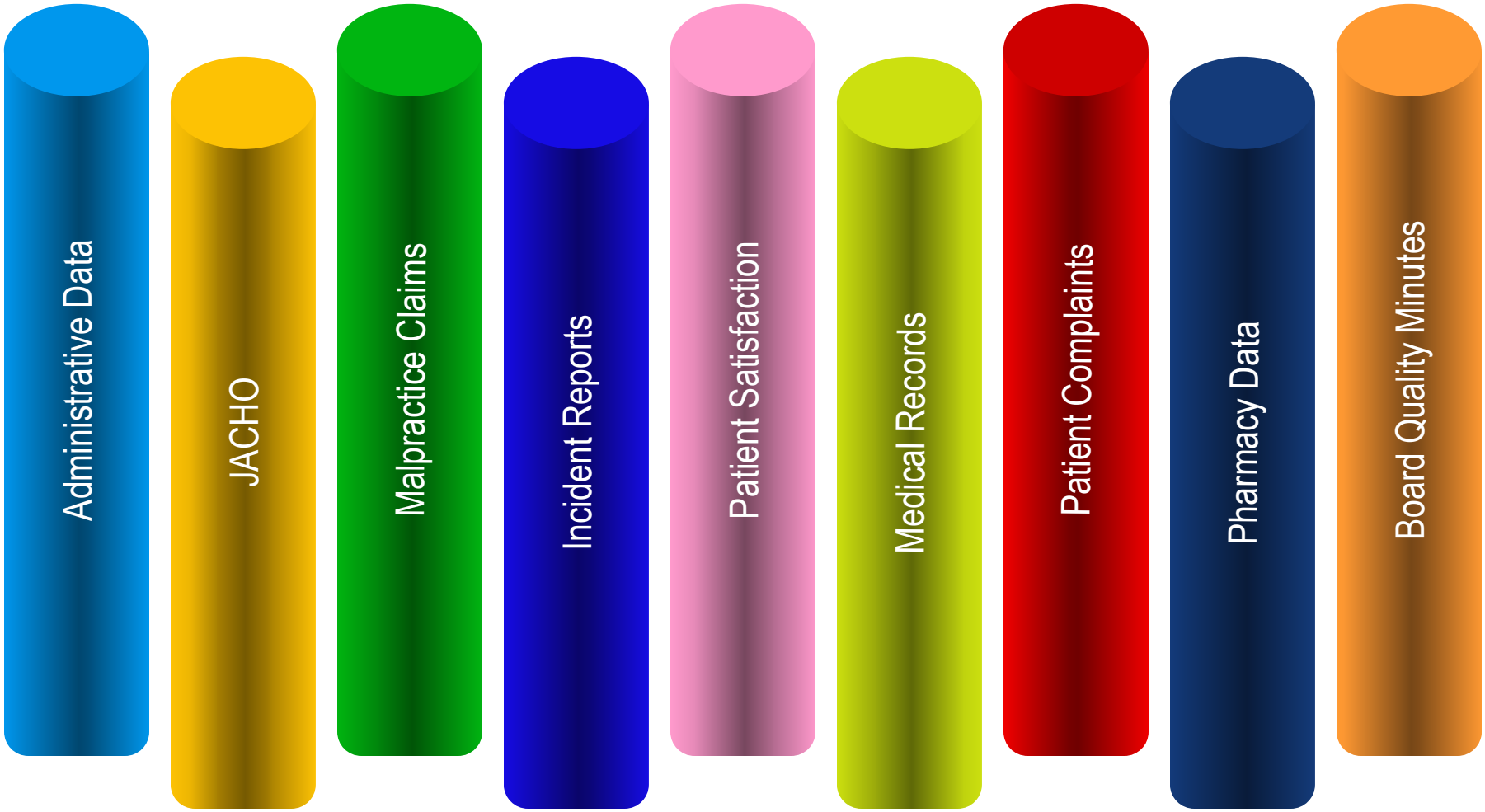
What is the Root of the Problem?

Systems, systems, systems …

"The majority of medical errors do not result from individual recklessness or the actions of a particular individual…more commonly errors are caused by faulty systems, processes and conditions that lead people to make mistakes or fail to prevent them."

Institute of Medicine – "Shaping the Future for Health, November 1999

Traditional Silos of Data and Information



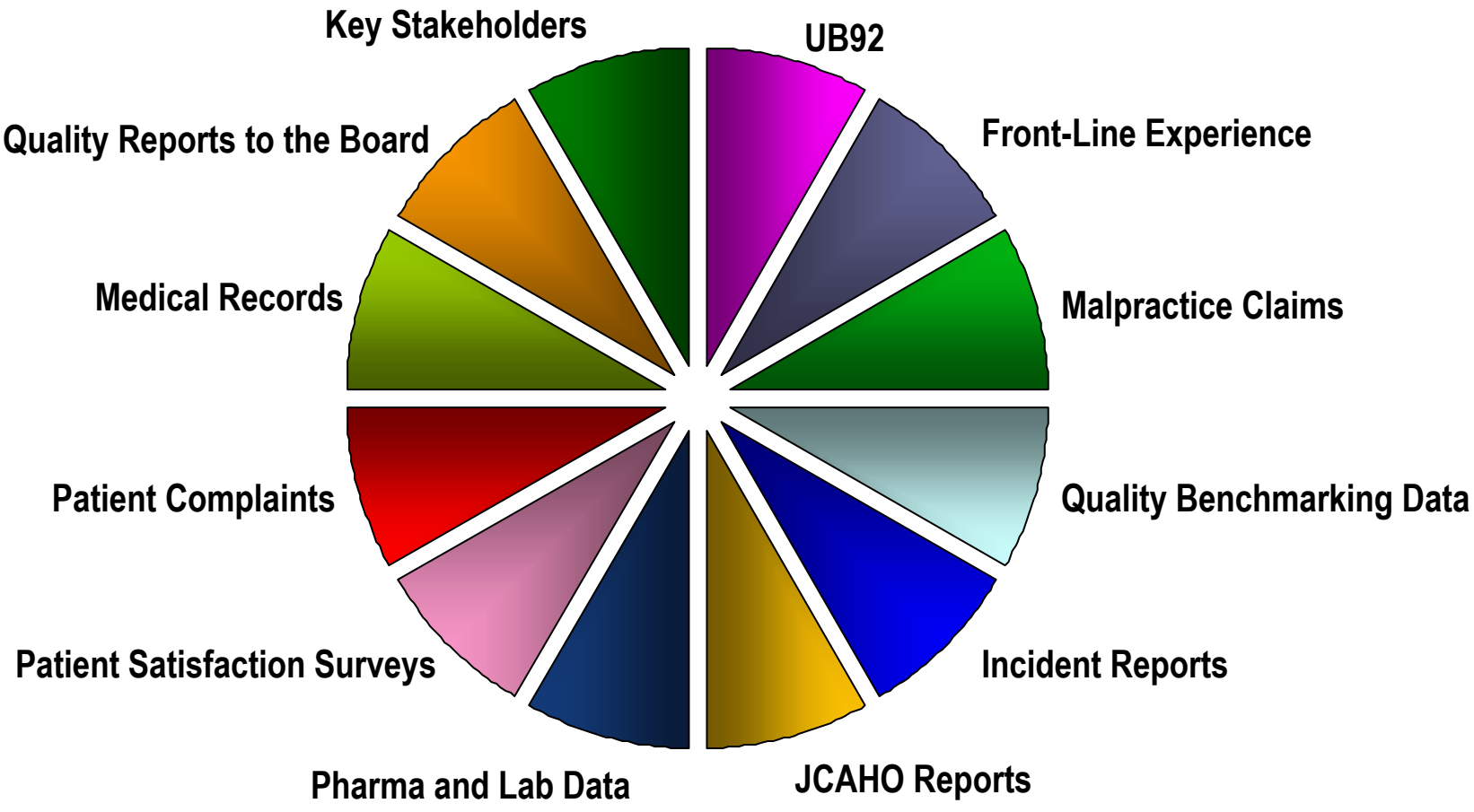
Traditional Culture

- Reactive
- Separate departments – “silos”
- Lower level responsibility
- “Don’t tell”
- Subjective
- Punitive

The Problems with Silos …

- No way to objectively assess data that might intersect with other data
- Subjectivity abounds within silos
- Shame makes professionals reluctant to expose errors or even weaknesses
- Information “hides” within silos
- Failure to recognize system issues is a byproduct of silos

Organizing the Data Differently

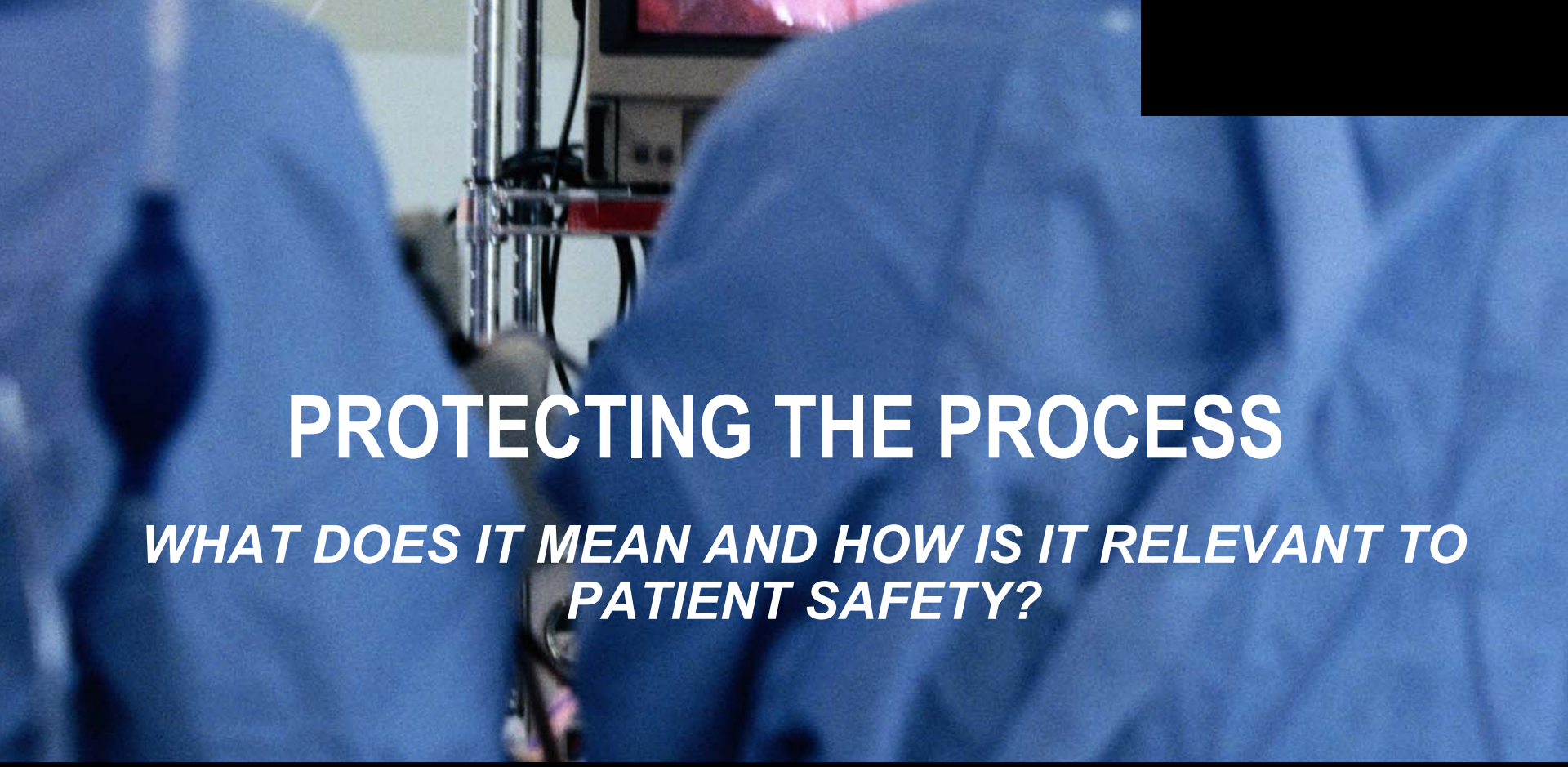


Open
The New ^ Culture

- Ethical
- Strategic
- System focus
- Data-driven (not crisis-driven)
- In touch with reality
- Open “floor-plan”
- Transparent
- Invite scrutiny – internal and external

How Am I Doing Now?

- Does everybody in the organization understand what is right and wrong in your business?
- Do you have silos – does the right hand know what the left hand is doing?
  - Is there in-fighting between departments/people?
  - Does your organizational structure promote integration?
  - Do your quality/risk/compliance/standards departments work hand-in-hand?
- Do you understand the benefits AND the risks involved in broader data analysis?
  - Peer Review protection violations
  - More people know about the “warts”
  - If you know, then what?



PROTECTING THE PROCESS

WHAT DOES IT MEAN AND HOW IS IT RELEVANT TO PATIENT SAFETY?

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What is the “Process”?

- Identification of Errors
- Investigation of Errors
- Root Cause Analyses
- Corrective Action Plans
- Committee Meetings and Discussion
- Systems Design

What does Protecting the Process Mean?

- Building a legal framework or structure that will ensure the confidentiality and nondiscoverability of the Process and its component parts

Why Protect the Process?

- Create maximum decision-making flexibility
- Encourage free and honest discussion of issues to improve patient safety
- Assist in addressing issues of system or enterprise liability

System or Enterprise Liability

- Plaintiff's attorneys are focusing less on the actions of individual providers and more on the breakdown in the system of care by institutional providers.
- Why?
  - Greater insurance coverage generally available at the system level than for individual providers
  - Easier to prove the breakdown of the system of care than the breach by an individual provider
  - Less sympathy for holding a system accountable than an individual provider
  - Creation of litigation tensions between systems and individual providers

How to Protect the Process

- It's **still** about systems, systems, systems…
- Need a systemic solution to this problem – do not rely on remembering to take action on each occasion
- The parts of the Process need to be identified in advance and research done to determine how they can be protected
- State statutory schemes for the protection of "peer review" materials exist in virtually every state
- They typically require a construct that identifies the forum(s) within which the various parts of the Process are conducted

What Can You Do Now?

- Determine what parts of the Process are operational in your system
- Determine what, if any, protections are **currently** being used in your system to protect the Process
- Determine what protections of the Process are available in your jurisdiction and how they need to be implemented
- Make the protection of the Process a part of your patient safety plans
- Educate the Board of Directors and Administration of the importance of protecting the Process

What Can You Do Now? (continued)

- Sources of information
  - Organizational documents for the system (e.g., medical staff bylaws, bylaws for the organization)
  - Legal counsel for the system
  - Insurer for the system
  - CEO or other administrative leadership for the system
  - State hospital or healthcare system association
  - State Medical Society
  - State Attorney General Office