

# Changing the Culture: An Essential Part of Improving Error and Occurrence Reporting

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# Problem – Limited Baseline Data

- Pre-IOM report
  - JCAHO-interest items routinely reported to command (sentinel events, near-misses)
  - Claims settlements similarly reported
- Only the tip of the iceberg was tracked
- Limited ability to analyze “no-harm” occurrences in order to redesign systems

# Pilot Study

- Collected and aggregated data from 10 Department of Defense healthcare facilities across the country
- Initiative announced in January 2000
- Central data collection began April 2000
- Enthusiasm not overwhelming at outset

# Old Habits Die Hard

- IOM report itself did little to change medical and nursing staff practices
- Traditional mindset - circle the wagons, shut up, point fingers if necessary
- Blame “punishes” an individual, but leaves a flawed system intact to fail again

# Communication of goals

- Presentations and briefings during first quarter of 2000
- Letter from the CEO
  - Speak up
  - Proceed up the chain if necessary
  - Goal is prevention, not punishment

# Unrealistic Expectations

- Medicine and nursing share professional expectations of personal inerrancy
- Mitigates against systems thinking

# So How Do You Change a Culture?

- Appeal to reason
  - Education and awareness-building
  - Provide tools through training
  - Need for data collection, aggregation, analysis
  - Lucid description of reporting requirements
  - Epidemiology of errors
    - Parallel to reportable diseases

# So How Do You Change a Culture?

- Clear visibility of support from top management is essential

# Team Management Training

- Half-day program developed by a team of doctors, nurses, and others at Department of Defense hospital in Florida
- Focuses on the medical errors issue
- Provides tools for dealing with situations with error potential
- Reinforces content with small-group exercises and breakouts

# Team Management Training

- The name of the program itself underscores the concept of approaching patient care as a team, not as autonomous “Lone Rangers”

# Some Factors Leading to Errors...

- Excessive professional courtesy
- Halo effect
- Passenger syndrome
- Hidden agenda
- Accommodation

# More Examples. . .

- High-Risk Zones
- Strength of an idea
- Sudden Loss of Judgment
- Hazardous Attitudes
- Error Chain

# Recognizing “The Pinch”

- A situation that is potentially unsafe
- Butterflies in the stomach
- Hair stands on end
- “Uh-oh”
- Having a “gut” feeling that something has going wrong

# So What Do You Do?

- The assertive statement
- Two-challenge rule
- “Emergency Fever”
- Conservative response rule
- Sterile Medical Environment
- Aggressive Skepticism
- “I’m Safe” Checklist

# What Else Is Taught?

- Communication/listening skills
- Leadership skills
- Workload management
- Recognizing/dealing with distractions
- Recognizing/dealing with stress
- Situational awareness

# Pilot Project Results

- Error reporting increased during the past year
- Errors involving harm remained constant
- Medication errors most common type

# Conclusions

- Error reporting increased over the collection period
- Medication errors most common type
- Most medication errors related to labeling and dispensing
  - Robotic systems in pharmacies decreased this type of error

## Conclusions (cont)

- Overall error rate is consistent with data cited in November 1999 IOM report
- Other opportunities for improvement await further data collection, aggregation, and analysis
- Aggregation and analysis of data from multiple facilities is paying off