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THE MAYO CLINIC SAFETY SYSTEM

SAFETY BY DESIGN

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LEARNING OBJECTIVES

- Discuss challenges in measuring patient safety
- Describe how safety culture influences safe behaviors and the ability of an organization to identify safety of current operations.
- Identify the key components of a healthcare organization’s safety system
- Describe key leadership behaviors that will influence the safety of care in an organization
- Identify ways to enhance an organizations learning and execution function to improve patient safety

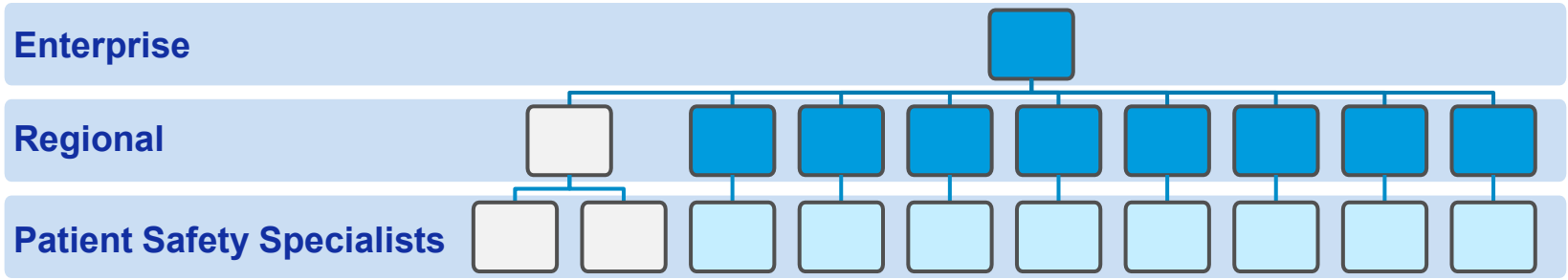
1

Organizational Structure & Alignment

PATIENT SAFETY

- Organizational Framework

- Quality – Matrix
- Patient Safety Officer (Physician) & Administrative Partner
- Patient Safety Specialists
- Risk Management[1]
- Enterprise Service Line
- Program Manager
- System Manger



[1]Risk Management – added functional role of safety in 2 regions

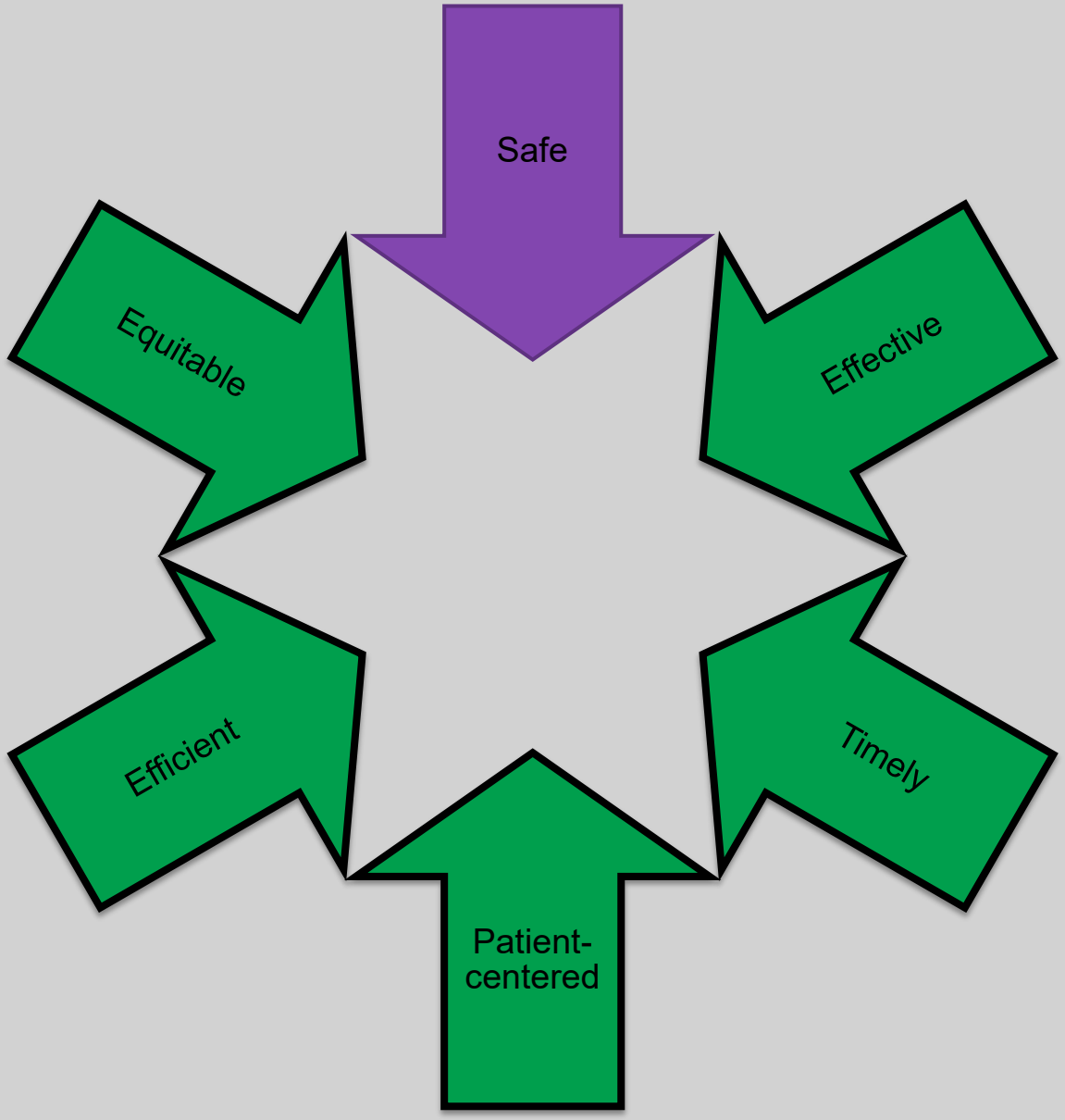
Partners

Identify. Prioritize. Respond. Innovate.

- Practice
- Quality Academy
- Electronic Health Record & Informatics
- Health Technology Management – Biomedical Engineering
- Legal
- Supply Chain Management
- Health Systems Engineering
- Enterprise Risk Management
- Quality & KERN

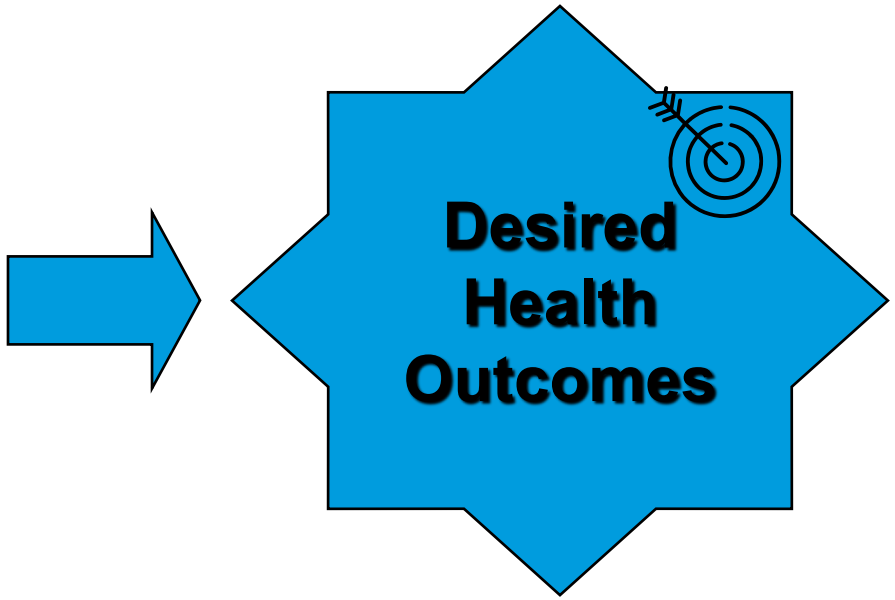
QUALITY IN HEALTHCARE

“THE DEGREE TO WHICH HEALTH SERVICES FOR INDIVIDUALS AND POPULATIONS INCREASE THE LIKELIHOOD OF DESIRED HEALTH OUTCOMES AND ARE CONSISTENT WITH CURRENT PROFESSIONAL KNOWLEDGE.”



A SYSTEM THAT PRODUCES OUTCOMES

Healthcare:
What we do, and how we do it
"The Practice"



- Influenced by CULTURE
- Influenced by INFRASTRUCTURE
- Modified by LEARNING
- Influenced by STANDARD WORK.
- "The Practice" needs support from the organization

CHALLENGES IN THE MEASUREMENT OF PATIENT SAFETY

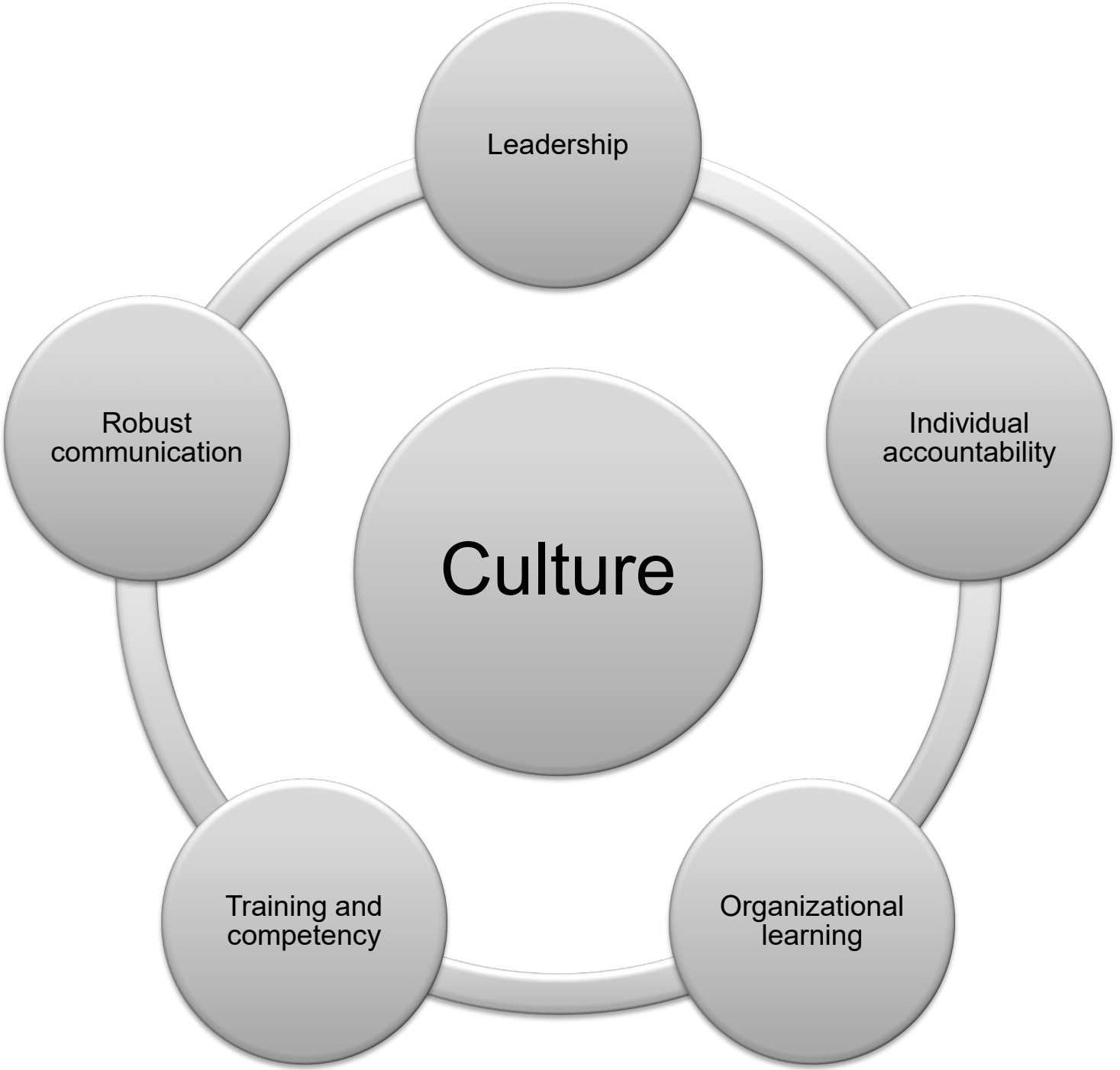
- Medical Record Audits
  - Retrospective
  - Depends upon documentation
- Voluntary reports
  - What is better—less, or more?
- Artificial intelligence
  - Unsafe conditions
  - False positives
  - False negatives
- Shared vs individual responsibility?
- Outpatient safety
  - How to find events?
  - How to report?
- Virtual care and safety?
- How do we measure how often ”it goes right”?

2

CULTURE OF SAFETY AND RELIABLE EXCELLENCE

Culture

Driver of high reliability



CANTU, J, TOLK, J, FRITTS, S, GHAREHYAKHEH, A. HIGH RELIABILITY ORGANIZATION (HRO) SYSTEMATIC LITERATURE REVIEW: DISCOVERY OF CULTURE AS A FOUNDATIONAL HALLMARK. J CONTINGENCIES AND CRISIS MANAGEMENT. 2020; 28: 399– 410. HTTPS://DOI.ORG/10.1111/1468-5973.12293

MAYO CLINIC QUALITY SYSTEM FRAMEWORK

The best care for EVERY patient EVERY day at EVERY location…

Outcomes + Safety + Experience / Cost

CULTURE

- Primary Values
- Behavioral Expectations
- Fair and Just Culture
- Psychological Safety
- Transparency of Data
- Physical Environment
- Leadership

DATA

- Extraction & Integrity
- Submissions / Sharing
- Reporting & Visualization
- Regulatory Requirements
- Data Governance & Standards

INSIGHTS

- Performance Review
- Ad Hoc Analysis
- Operational Monitoring
- Forecasting Scenarios
- Prescriptive Analysis
- Research

ENGINEERING

- Improvement Methods / Tools
- Systems Thinking Mindset
- Project Management
- Change Management

EXECUTION

- Governance & Oversight
- Accreditation
- Accountability
- Program Management
- Staff Empowerment
- Stewardship

TALENT

- Mayo Clinic Values
- Quality Academy
- Knowledge
- Skills
- Abilities

TECHNOLOGY

- Data Management Systems
- Electronic Health Record
- Learning - Education
- Simulation
- Unified Data Platform / Cloud
- Visualization

FUNDING

- Budget
- Development
- Grants
- Growth

Adapted from:
Bisognano, Pisek. 10 More Powerful Ideas for Improving Patient Care. Chicago: Health Administration Press & Institute for healthcare Improvement, 2006.
Kaplan, Robert S., Norton, David P.. The Execution Premium: Linking Strategy to Operations for Competitive Advantage. Harvard Business Press, 2008.

BEHAVIORAL EXPECTATIONS

The Needs of the Patient Come First—no room for conflict of interest

Physicians and everyone else are Salaried employees

Safety First: 5 Safe Behaviors

Respect and teamwork valued above brilliance and bravado

Work towards consensus, then follow the agreed upon standard care

Allow safe innovation

Everyone has two jobs: their work, and improving their work

Work towards perfection

5 SAFE BEHAVIORS

1. **PAY ATTENTION TO DETAIL.**
   Intentional focus on the specific task at hand to avoid errors.

2. **COMMUNICATE CLEARLY.**
   Accurate verbal or written exchange of information to help ensure comprehension.

3. **SPEAK UP AND RESPOND RESPECTFULLY.**
   Ask questions and seek clarity. Listen and respond in a respectful manner without judgment or defensiveness.

4. **HAND OFF EFFECTIVELY.**
   An interactive process of passing specific information from one person to another when responsibility is transferred.

5. **SUPPORT EACH OTHER.**
   Maintain a spirit of teamwork, collaboration, and mutual respect across all levels of staff.

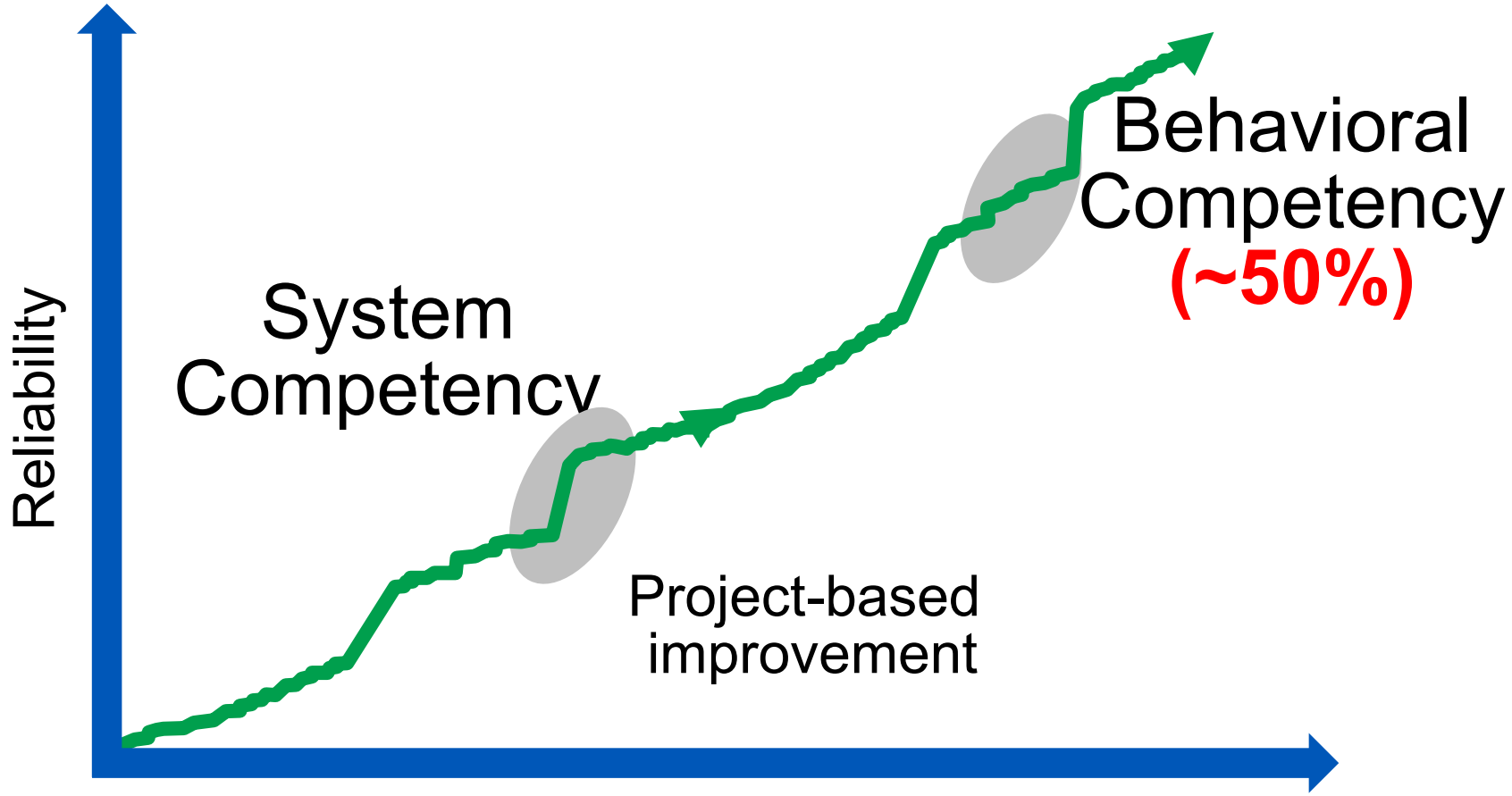
Standardization & Diffusion of Best Practices

- Technology to Reduce errors
- Standardization of Evidence Based Care
- Careful engineering of care pathways
- Safe Equipment
- Change Management
- Training

Commitment to Safety in a Fair & Just Culture

- Clearly defined behaviors
  - Pay attention to detail
  - Communicate clearly
  - Have a questioning and receptive attitude
  - Hand-off effectively
  - Support each other
- Accountability for behavior

TOWARD ZERO PREVENTABLE HARM



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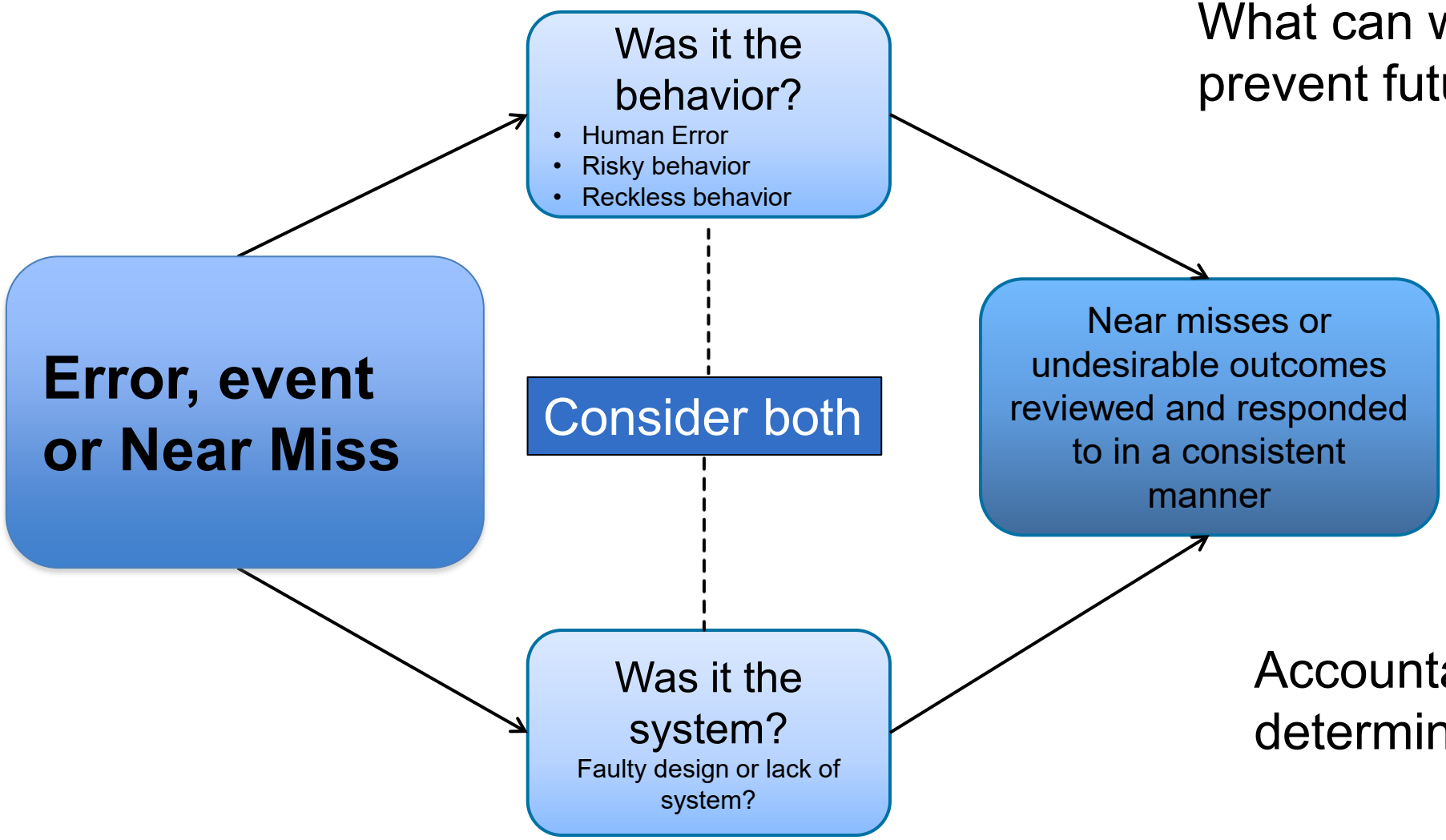
"THE SINGLE GREATEST IMPEDIMENT TO ERROR PREVENTION IN THE MEDICAL INDUSTRY IS THAT WE PUNISH PEOPLE FOR MAKING MISTAKES."

Dr. Lucian Leape, Father of Modern Patient Safety Movement

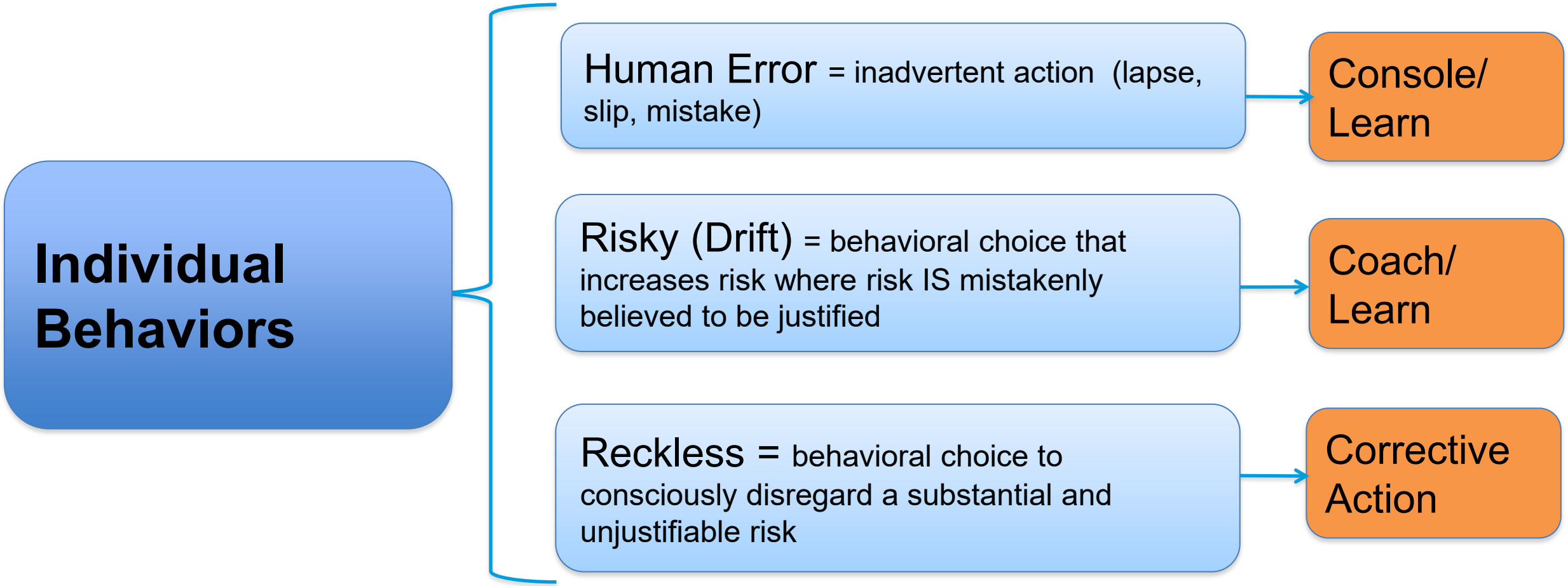
FAIR AND JUST CULTURE



What can we learn from this to prevent future harm?

Accountability is not determined by the outcome

BEHAVIORAL REVIEW & RESPONSE



PSYCHOLOGICAL SAFETY

- “Climate where people feel safe enough to take interpersonal risks by speaking up and sharing questions, ideas, and concerns.”
- “Psychological safety is a belief that one will not be punished or humiliated for speaking up with ideas, questions, concerns or mistakes.”

Amy C. Edmonson “The Fearless Organization” ©2019

LEARNING SYSTEM

- Psychological safety
- Consider both systems and behaviors
- Learn from daily work
- Appreciative inquiry
- Agility
- Engagement & Accountability
- Transparency & Storytelling

TRANSPARENCY: WHO KNOWS WHAT YOU KNOW?

Process awareness

- Unsafe situations
  - “Everyone”
- Behavioral competency issues
  - Person(s) responsible
  - Their supervisors, or those they are accountable to
  - The patient
- System competency issues
  - Senior leadership
  - Practice leadership
  - Project team
  - Everyone who uses that system

Safety outcomes

- Patients
- Providers

Safety depends on everyone, every day

Patient Safety Event Reporting as a system for engaging and learning

https://mcmedia.mayo.edu/asset-management/241HRGM5J1KS3?WS=SearchResults

Report

Initiate report from anywhere in workflow

https://mcmedia.mayo.edu/asset-management/241HRGMUDJSDW

Voluntary reported events

Report — *Everyone* can report. Launch from within workflow.

Review — Concurrent review by practice and patient safety. Multidisciplinary review group determines actions needed.

Analyze — Frequency, probability, severity, scope → Methodology

Respond — Align actions to causes & contributing factors. Solutions vary from “Just do it” to projects and programs.

Learn — Implementation and outcome measurement. Scope of solution – impact. Strategies to monitor effectiveness of solutions.

Platform Power

Capabilities

System design

Collaboration

New frontiers of teamwork - uniting unique data sets for novel insights better enabling ability to predict, prescribe, prevent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The goal on the horizon is perfection.
The goal for today is to do better than yesterday.

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