Excellence Algorithm

St. Louis Psychiatric Rehabilitation Center

January , 2017

Key Question

- In any negative outcome involving clients or staff:
  - Is it the system's fault? OR
  - Is it the person's (persons') fault? OR
  - Is it some of both?

Factors Impacting System Performance

- Barriers to prevent failure
- Redundancy to limit the effects of failure
- Recovery to capture failures before they become critical
- Human factors' design to reduce the rate of error

…..knowing that systems will NEVER be perfect

Factors Affecting Human Performance

- Information/Training
- Equipment/Tools
- Qualifications/Skills
- Environmental context
- Organizational Environment
- Supervision
- Communications

….. Knowing that humans will never be perfect

Leadership/Management Obligation

Leadership's and Management's Responsibility -

- To design the best systems possible
- Knowing that they will not be perfect
- Knowing that the persons who operate within them are not perfect

So what do we agree with?

- "There are activities in which the degree of professional skill which must be required is so high, and the potential consequences of the smallest departure from that high standard are so serious, that one failure to perform in accordance with those standards is enough to justify dismissal" (Lord Denning, English Judge)
- "We are serious about our safety action plan which stresses improved safety through stronger enforcement and tougher penalties. Those who disregard truck safety regulation will feel the full force of federal response." (Kenneth R. Wykle, Administrator Federal Highway Administration)
- "People make errors, which lead to accidents. Accidents lead to deaths. The standard solution is to blame the people involved. If we find out who made the errors and punish them, we solve the problem, right? Wrong. The problem is seldom the fault of the individual. It is the fault of the system. Change the people without changing the system and the problems will continue." (Don Norman, Apple Fellow)
- "No matter how well equipment is designed, no matter how sensible regulations are, no matter how much humans can excel in their performance, they can never be better than the system that bounds them" (Captain Daniel Maurino, Human Factors Coordinator, International Civil Aviation Organization)
- "The single greatest impediment to error prevention in the medical industry is 'that we punish people for making mistakes'. We report only what we can not hide." (Dr. Lucian Leape, Professor, Harvard School of Public Health, Testimony before Congress on Health Care Quality Improvement)

Problem Statement

Need for a balance between a Blame-Free and a Punitive Culture, to ensure the highest support of System Efficiency and Client Safety

Culture Matters

- Don't start with the "investigational assumption"
  - That any failure is the product of human error
  - That all we need to do is find the culprit and punish him or her
- Instead start with the "performance improvement" assumption
  - That most errors are systemic in nature
  - That people want to perform well, care about their work, and care about their customers
  - That we don't spend ALL our time investigating past incidents to figure out who best to blame
  - Focus instead on what we can do from this point forward to make the system safer
- Make a Commitment to Excellence

Elements of Commitment to an Excellent Culture

- Design Better Systems and Improve them When they Fail
- Helpful Management of Human Choice
  - Recognize that humans will make mistakes
  - Enable them to learn from those mistakes…
  - … In order to make better choices for the future
- Creation of a Learning Environment
  - People are hungry for knowledge about …
  - … how to reduce risk at the individual and organizational level

Elements of Commitment to an Excellent Culture (con.)

- Emphasis on Transparency, Engagement, Equity, and Justice
  - Acknowledges fallibility at all levels
  - Makes data and information available to all
  - Invites involvement and input in decision-making at all levels
  - Minimizes differences that otherwise divides us – professional and para-professional, nursing and non-nursing, support and clinical, direct care and management, client and staff
  - Celebrates the richness of diversity
  - Seeks justice rather than punishment
- Insistence on Shared Vision, Shared Values, and above all, a Shared Desire for Excellence
  - In the quality of our interactions with one another as staff
  - In how we accomplish our mission, and achieve outcomes for our clients

So How Do We Manage Error in an Excellent Culture?

Profess and Sustain these Core Beliefs

- To err is human
- To become **inattentive** is human
- Risk of error is ever-present.
- Risk = Severity of Error x Likelihood of Error
- We reduce risk by improving performance in our processes and our systems, but no system can ever be Risk Free
- Moreover, a Risk Free System is antithetical to our Mission because it would rob our clients of the potential for growth and choice and independence of movement
- Real and Desired Safety = Reasonableness of Risk
- We are all accountable – to the taxpayers, to one another, to our clients and their families
- Progress can be measured and excellence can be shown

So How Do We Manage Error in an Excellent Culture? (con.)

Design Strategies

- Commitment to skill and knowledge through training
- Involvement of our clients in the design of systems and processes that involve them
- Barriers/engineering against error – personal protective equipment, technology
- Redundancy through engagement – everyone's a member of the treatment team and we all back each other up
- Recovery from error
  - We can learn from our mistakes and do it differently in the future
  - if one way doesn't work, we can always try another

So How Do We Manage Error in an Excellent Culture? (con.)

Management of Human Behavior

- We manage through **consolation** when errors are the product of systems or processes rather than individual culpability
- We manage through **coaching**
  - **Simple/Blameless Errors -** involving: (a) Either Lack of practiced skill in the application of complex tasks; (b) Misremembering or Misapplication of procedures from new policies or complex procedures from little used policies
  - **Inattention** – the human tendency when we think things are safe to not be on guard and demonstrate unconscious infidelity to policies and practices which keep our staff, our clients, or the public safe
  - **Careless behavior** - a choice that increases risk where risk is not recognized or is mistakenly believe to be justified
- We manage through **discipline**
  - **Willful/Blameworthy behavior** – a choice to consciously and recklessly disregard policy, our facility values, or the safety of our staff, clients, or the public
  - **Heedlessness** – a choice to ignore prior efforts at coaching
  - **Abuse, Neglect, or Misuse of Client Funds**

How to Manage Behavior

System Error	Simple/Blameless Errors, Inattention, or Careless Behavior/	Willful/Blameworthy Behavior
Product of our current system design (often the primary responsibility of the employee – systemic in nature)	Unintentional Risk-Taking (often a shared breach between employer and employee due to the interaction between a system that could be improved and the employee)	Intentional Risk-Taking (owned entirely by employee)
Manage through: • Processes • Procedures • Training • **Design (build in redundancy)** • Environment	Manage through: • Removing incentives for At-Risk behaviors • Creating incentives for healthy behaviors • Increasing situational awareness	Manage through: • Remedial action • Disciplinary Action
CONSOLE	COACH[1]	PUNISH[2]

1. Why is Coaching in the organization's interest, rather than Termination? – Because the employee who replaces that individual will not have had the benefit of the experience and will not learned because of it
2. Remember Psychology 101 - while punishment can be effective in managing willful behavior, it does not guide day to day behavior and is never an effective deterrent against at risk behavior (not even for managers, who will often tacitly reward employees for "cutting corners" to get the job done)

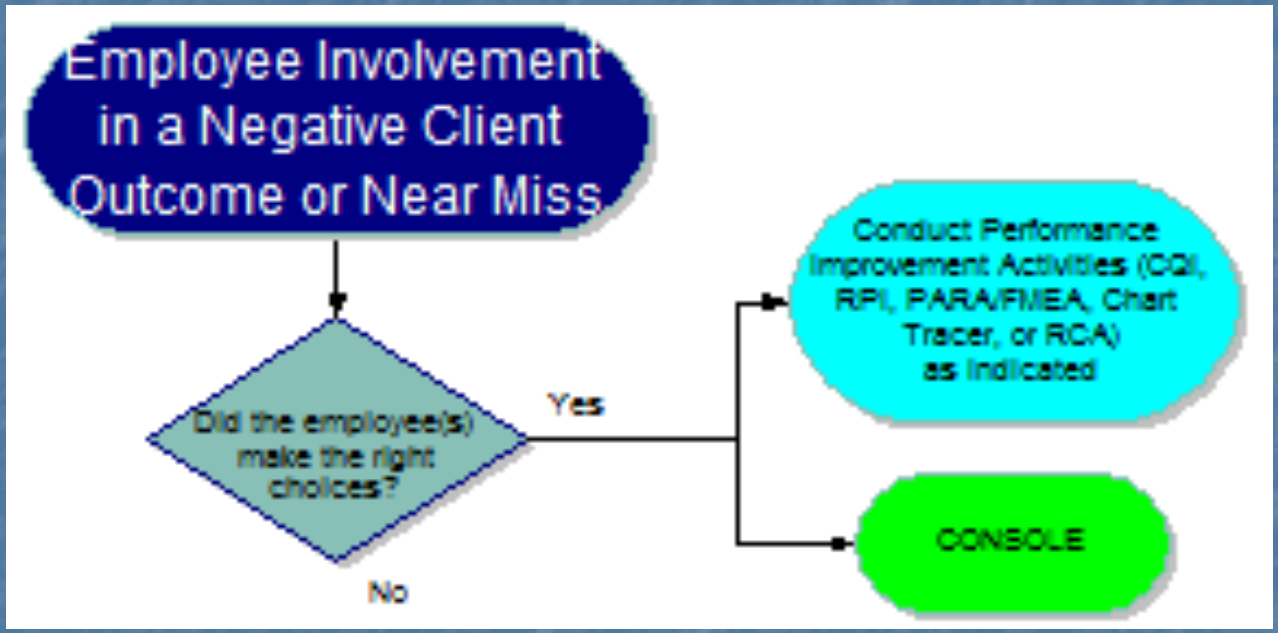
So What do We Mean by Coaching and Consoling?

- **Consoling**
  - "We realize that this must have been very difficult, if not traumatic, for you to experience this event."
  - "We want you to know that we don't consider this a reflection on you, your values, your performance, your commitment to this organization or your clients."
  - "If you need any additional assistance in coping with this, please let us know." [EAP?]
- **Coaching**
  - **Validating**: "You are an enormously important part of our SLPRC family, and we are so fortunate to have you with us. We hope that you make this facility your career."
  - **Recognizing System Errors** [if appropriate]: "We know that what contributed to this situation was a set of infirmities and imperfections in our systems and processes. We're committee to addressing these and have started to do that through [CQI, RCA, Chart Tracer, or Other Performance Improvement process]"
  - **Consoling**: This is always an aspect of coaching, so do not forget it. Should always be offered BEFORE Guiding.
  - **Guiding**: "[While we do that, and recognizing that this may take some time for us to achieve and perfect], We want to ensure that we give you whatever guidance and coaching we can for the best possible outcome for yourself and your clients, and we welcome whatever ideas or suggestions you have for fixing this for everyone else. We will reflect that dialogue in a Log Note, and will use a de-identified version of that note to help inform our efforts to fix the flawed systems and processes."

The Flowcharts

- Employee Related Negative Outcome
- **The Excellence Algorithm**
- The Discipline Decision
- The Discipline Process

Employee Involvement in a Negative Outcome – What to Consider?

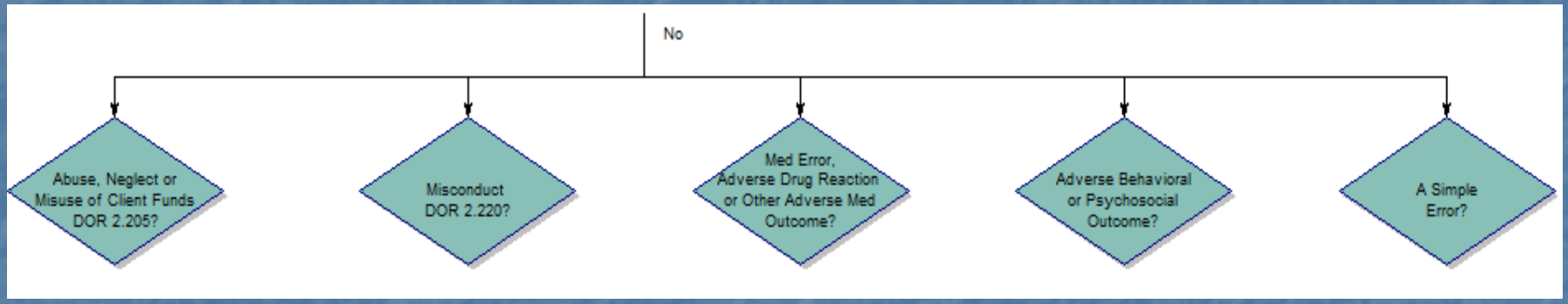


Employee Involvement in a Negative Outcome – What to Consider? (con.)

- Did the employee(s) make the right choices?
  - If YES
    - Console – the error happened to them, regardless of who else was involved
    - Look at opportunities for system improvement

Employee Involvement in a Negative Outcome – What to Consider? (con.)

- If NO, what was the nature of the error made?

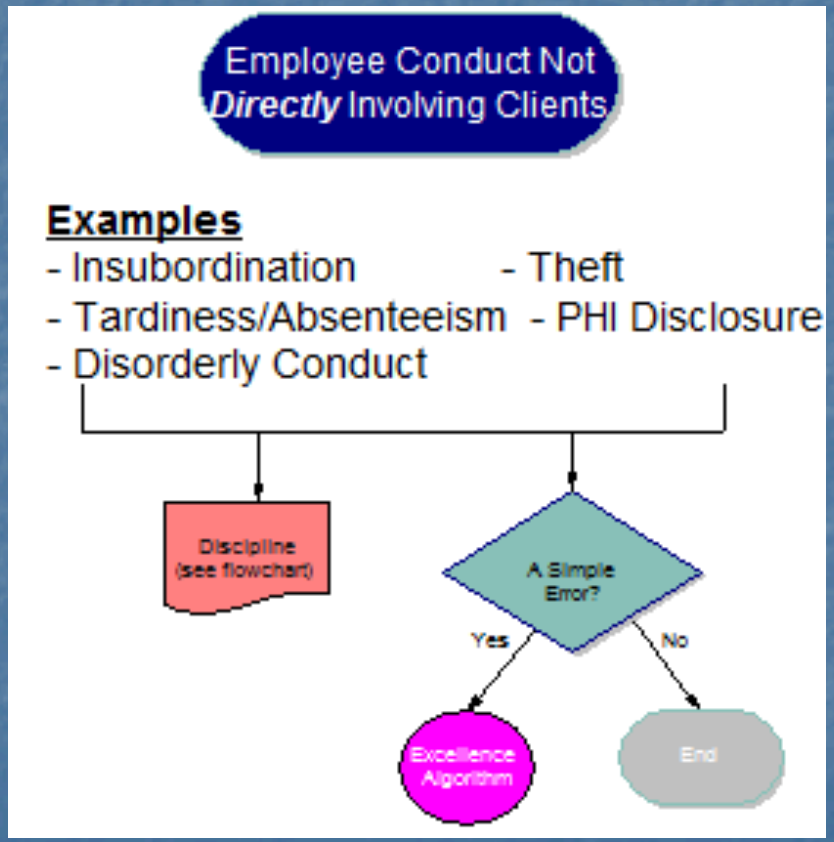


Employee Involvement in a Negative Outcome – What to Consider? (con.)

- Abuse/Neglect, Misuse of Client Funds?
- Misconduct
- Med Error, Adverse Drug Reaction, Other Adverse Medical Outcome
- Adverse Behavioral/Psychological Outcome
- Simple Error

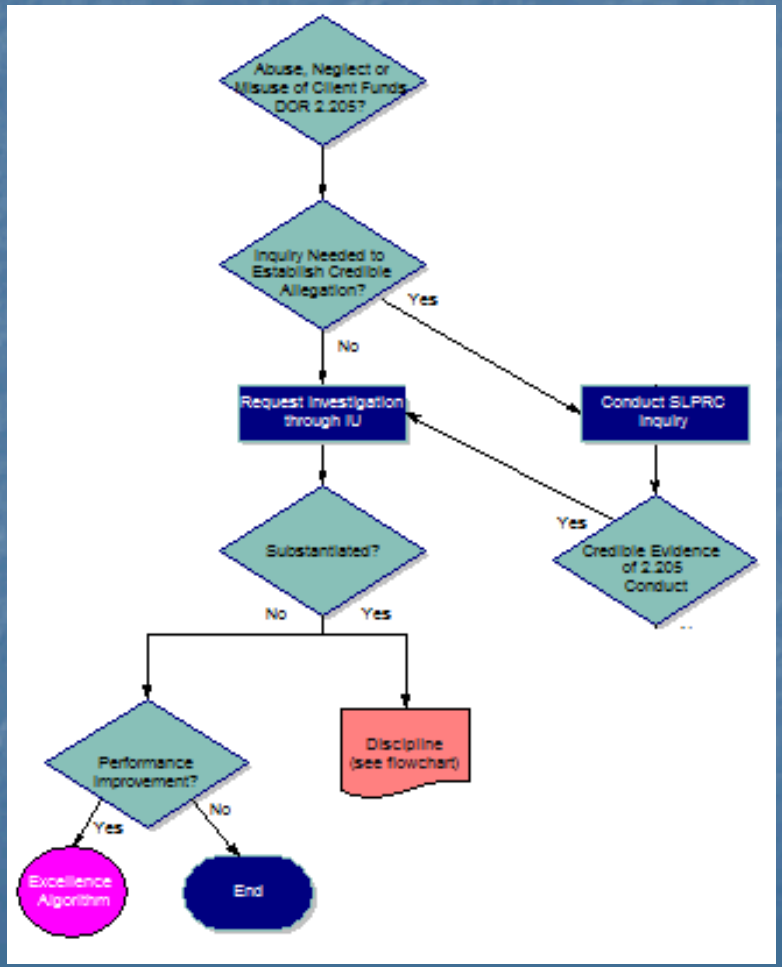
Employee Involvement in a Negative Outcome – What to Consider? (con.)

- Or did the error not involve any client in a direct manner whatsoever?



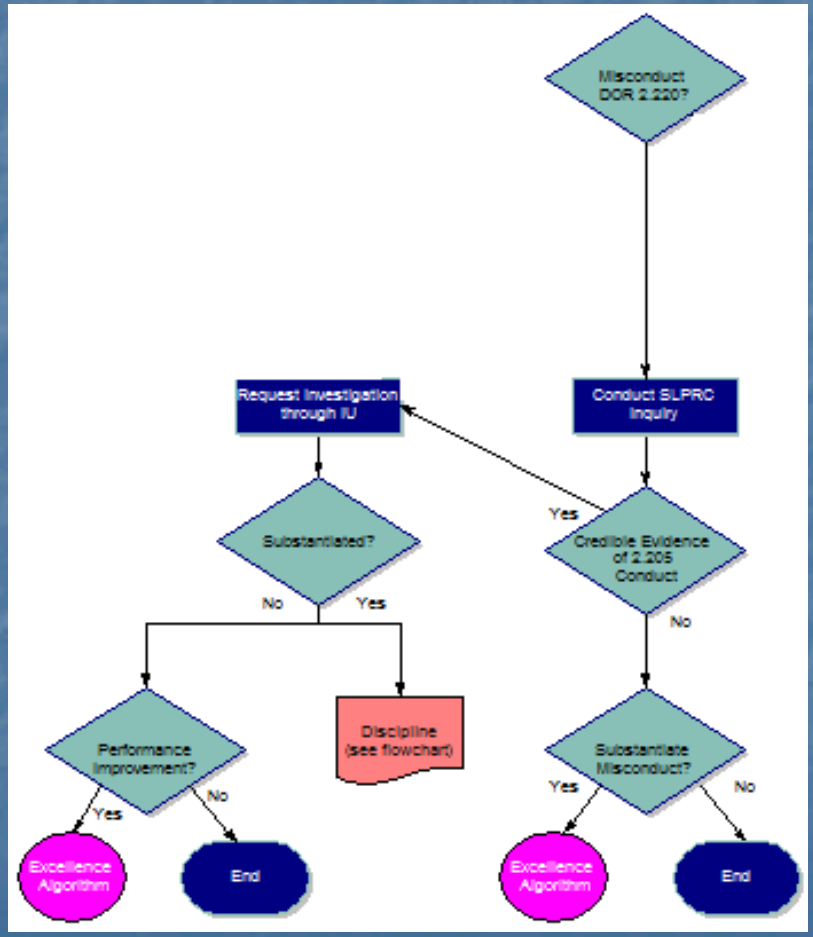
Employee Involvement in a Negative Outcome – What to Consider? (con.)

- Abuse/Neglect, or Misuse of Client Funds?



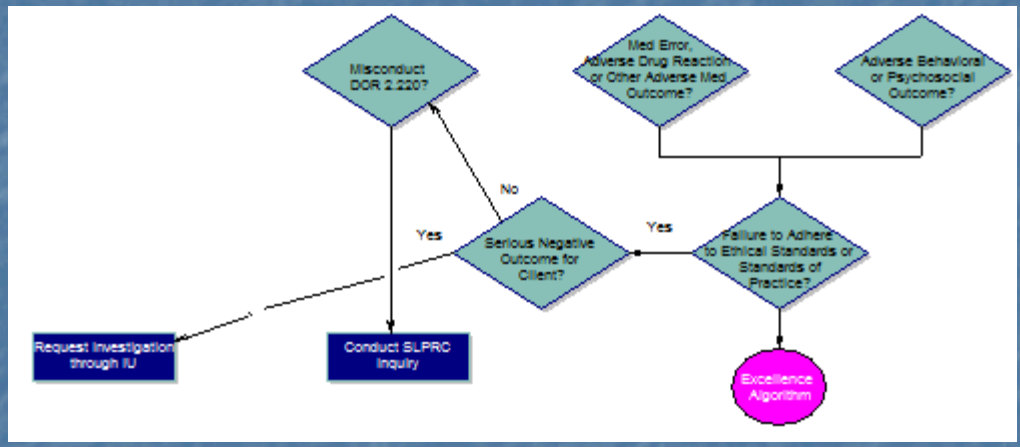
Employee Involvement in a Negative Outcome – What to Consider? (con.)

- Employee Misconduct?



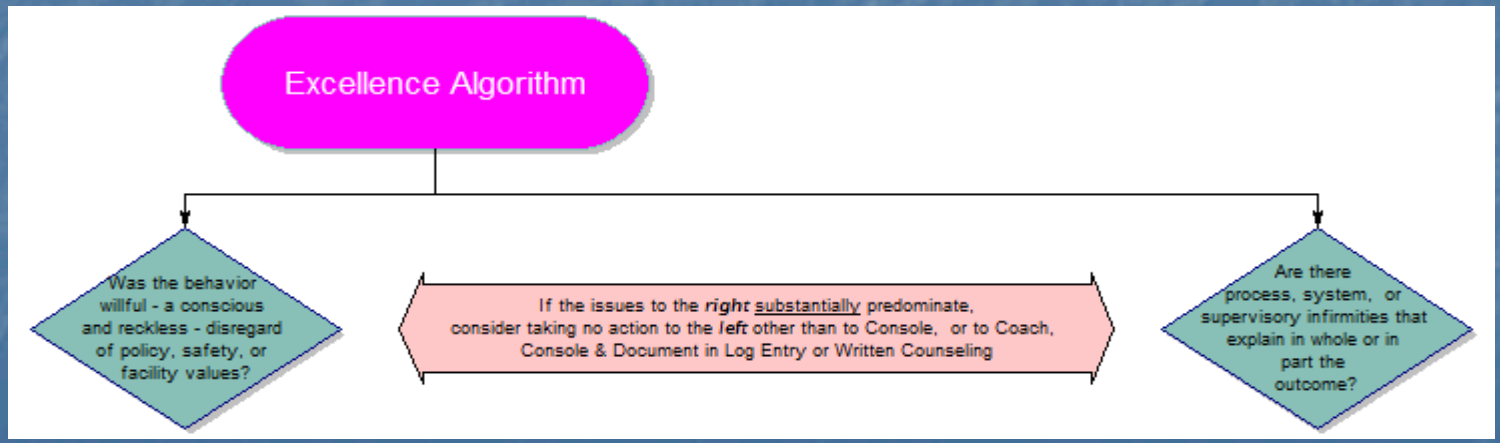
Employee Involvement in a Negative Outcome – What to Consider? (con.)

- Adverse Drug or Adverse Behavioral or Psychosocial Reaction?



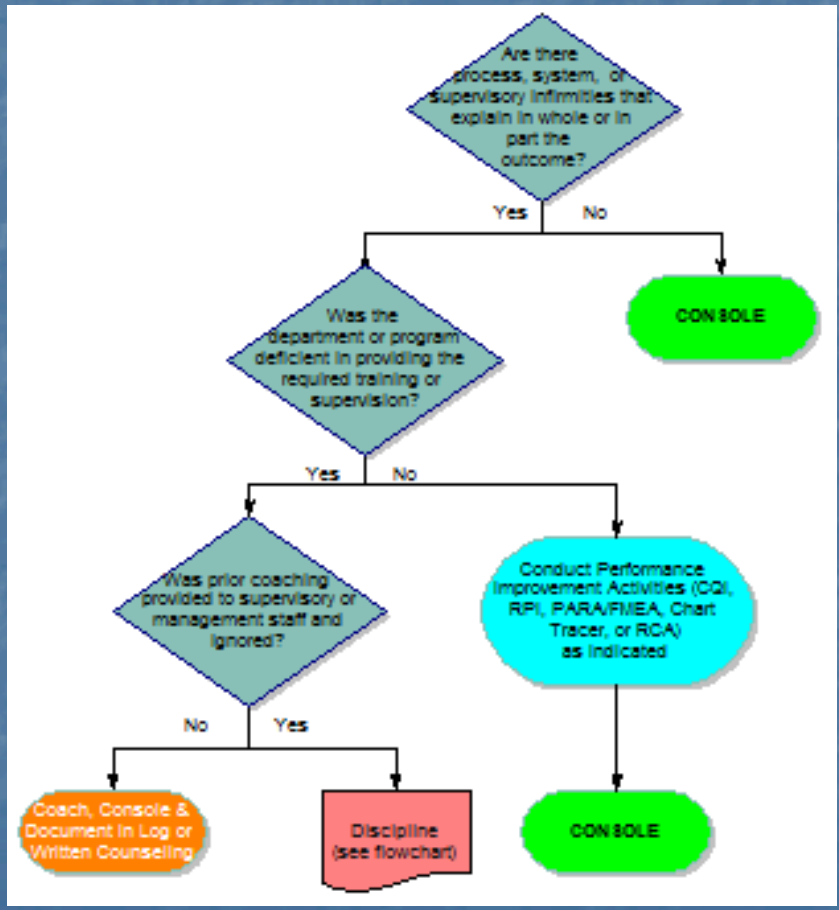
Excellence Algorithm

- First Decision: Is what we observed primarily secondary to systems, process or supervisory infirmities?
  - If so, avoid discipline!



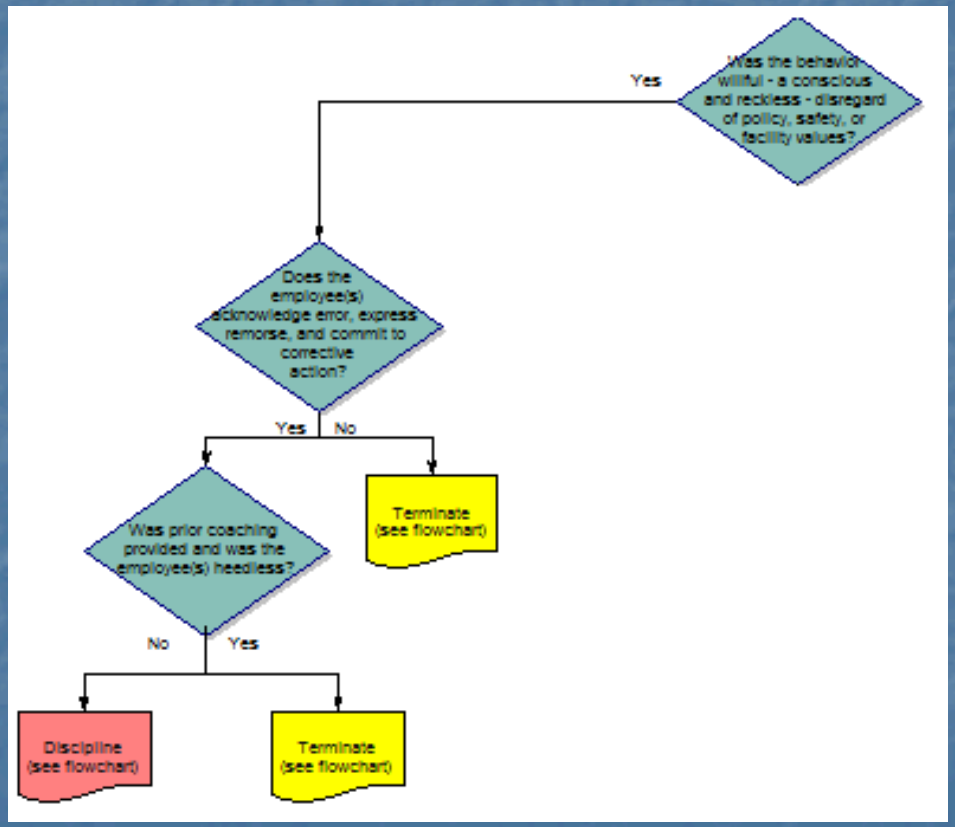
Excellence Algorithm (con.)

- If it's a system problem, performance improvement is our best bet, as are consoling and coaching



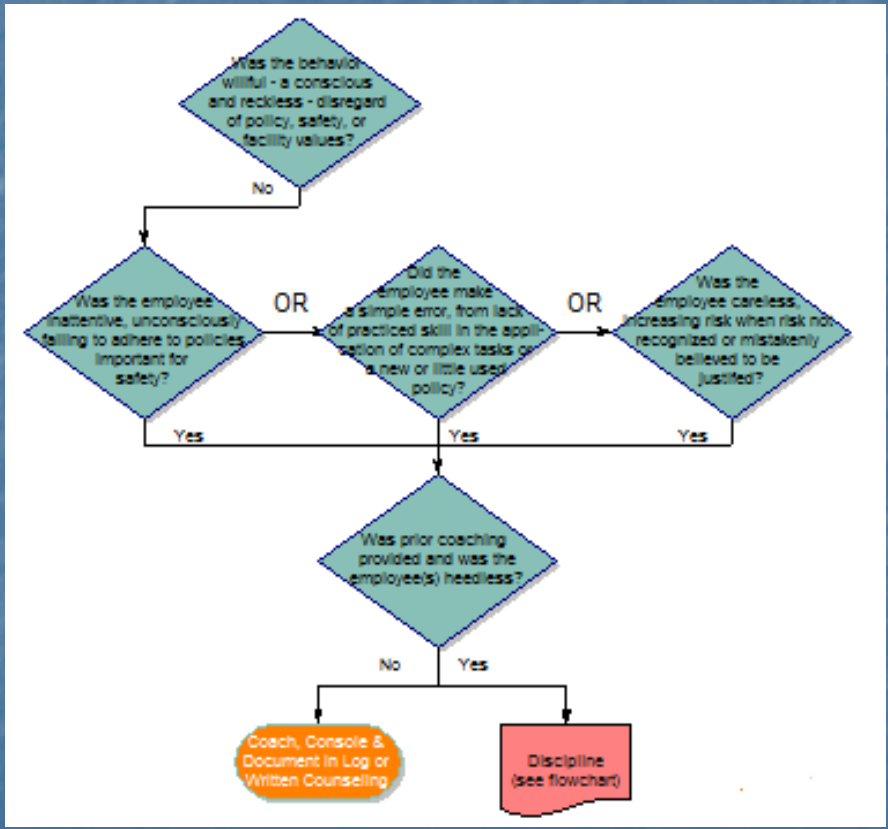
Excellence Algorithm (con.)

- If we conclude that the behavior was in fact willful or blameworthy



Excellence Algorithm (con.)

- If we conclude that the behavior was NOT willful or blameworthy
  - Inattention
  - Simple or blameless error
  - Careless error



Factors to Consider in Assessing Inattention and Carelessness

- Stress
- Fatigue
- Lighting
- Communication
- Noise
- Distraction
- Procedure design

CQI, Root Cause Analyses, PARA/FMEA, and Robust Performance Improvement

- All about systems and processes rather than "finding a culprit to punish"
- "Systems Investigations"
  - Different from an HR inquiry/investigation – In those, we stop our investigation after establishing who made the error
  - In systems investigations, we ask ***why*** persons made those mistakes, assuming that no one wanted to make them, and look at the system and processes in the environment of care that allowed those mistakes to occur

Basics to System Investigation

- In increasing order of value
  - What happened?
  - Why did it happen?
  - How were we managing it?
- Explain human error in terms of performance shaping factors
  - Information / communication
  - Equipment/Tools
  - Qualifications/Skills/Training
  - Supervision

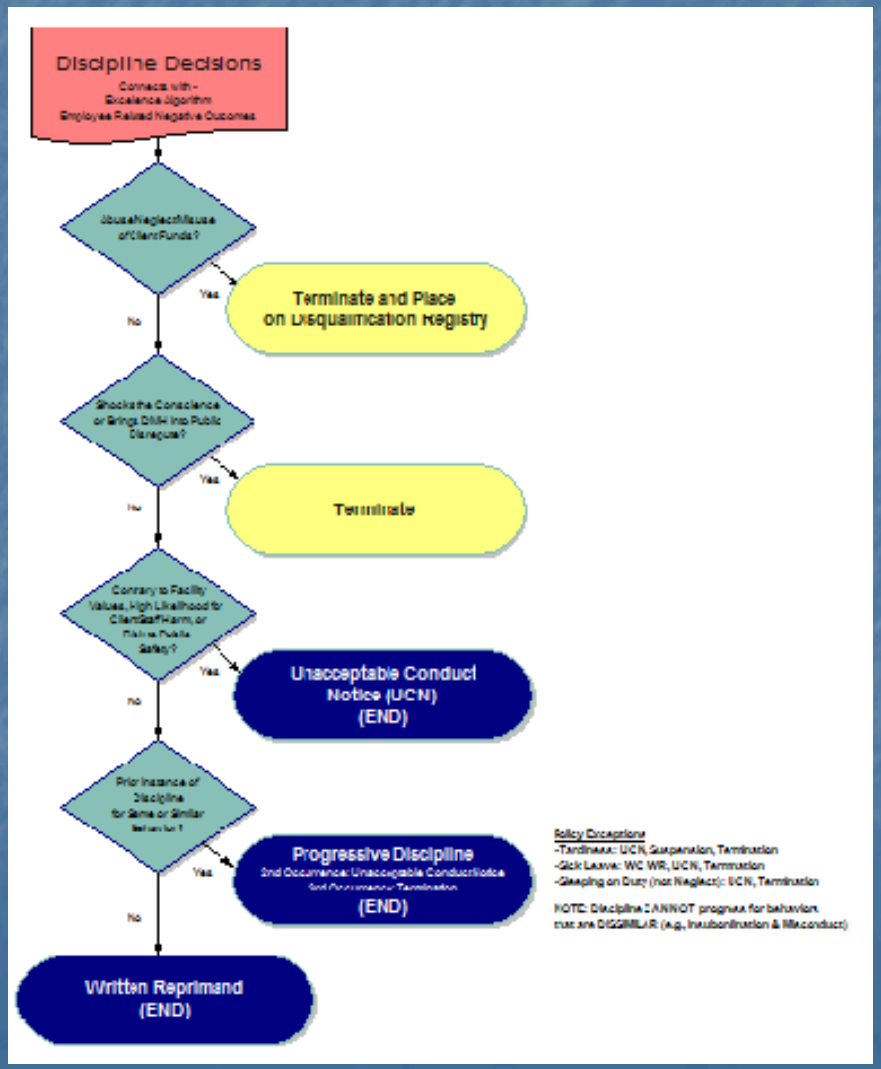
Basics to System Investigation (con.)

- If Careless Behavior identified
  - Why was that behavior exhibited?
    - Incentives to cut corners from management?
    - Inaccurate perceptions of risk?
  - How prevalent is the behavior?
    - Unique to that individual?
    - Or common in the group (a group norm or de facto practice)?

Basics to System Investigation (con.)

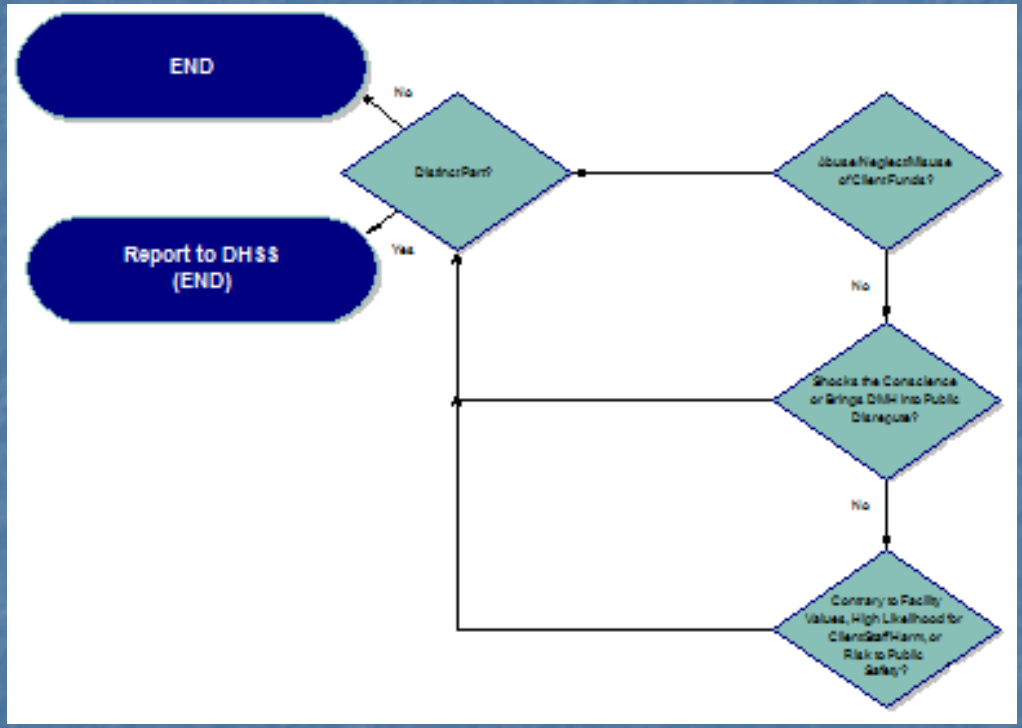
- How Did Leadership Manage Risk Ahead of the Event?
  - Policy?
  - Training?
  - Barriers to error?
  - Redundancy?
  - Recovery?

Discipline


Discipline Decisions
Connects with -
Excellence Algorithm
Employee Related Negative Outcomes
Abuse/Neglect/Misuse of Client Funds?
Yes
Terminate and Place on Disqualification Registry
No
Shocks the Conscience or Brings DMH Into Public Disrepute?
Yes
Terminate
No
Contrary to Facility Values, High Likelihood for Client/Staff Harm, or Risk to Public Safety?
Yes
Unacceptable Conduct Notice (UCN) (END)
No
Prior Instance of Discipline for Same or Similar Behavior?
Yes
Progressive Discipline
2nd Occurrence: Unacceptable Conduct/Notice
(END)
No
Written Reprimand (END)
Policy Exceptions
-Tardiness: UCN, Suspension, Termination
-Sick Leave: WC WR, UCN, Termination
-Sleeping on Duty (not Neglect): UCN, Termination
NOTE: Discipline CANNOT progress for behaviors that are DISSIMILAR (e.g., Insubordination & Misconduct)

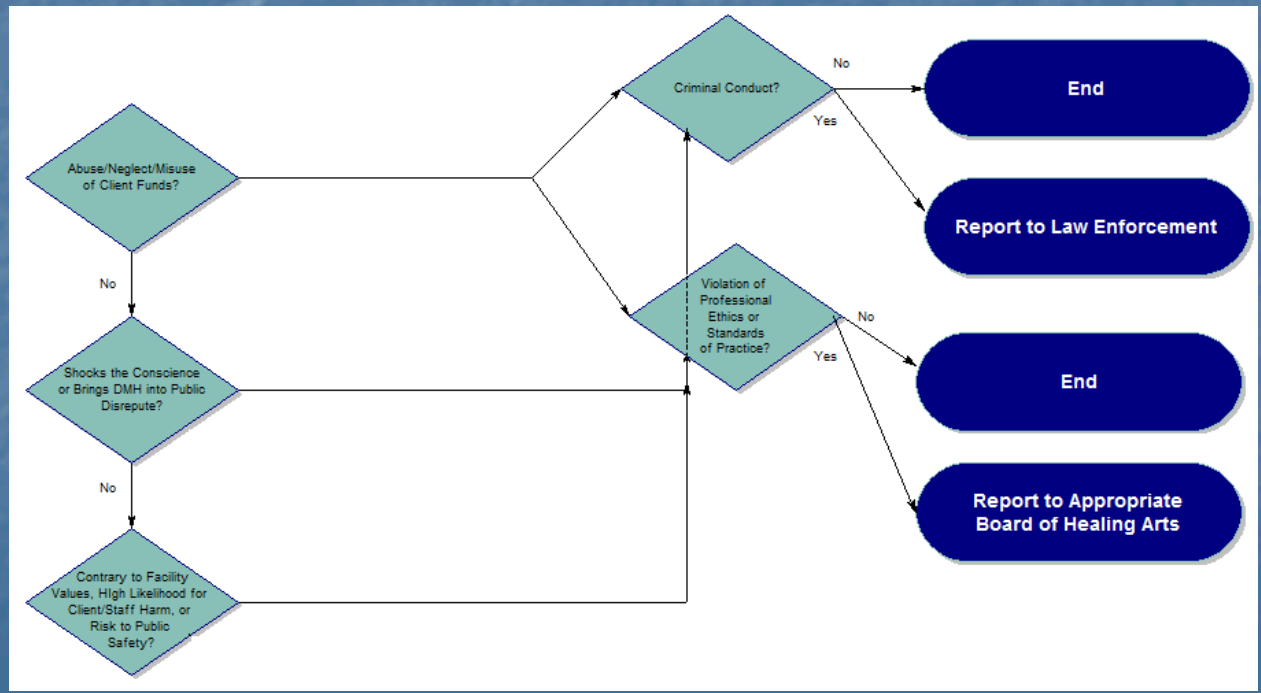
Discipline (con.)

- If we conclude Abuse/Neglect, Misuse of Client Funds, or a Major Misconduct, AND it happened on the distinct part, we need to let DHSS know

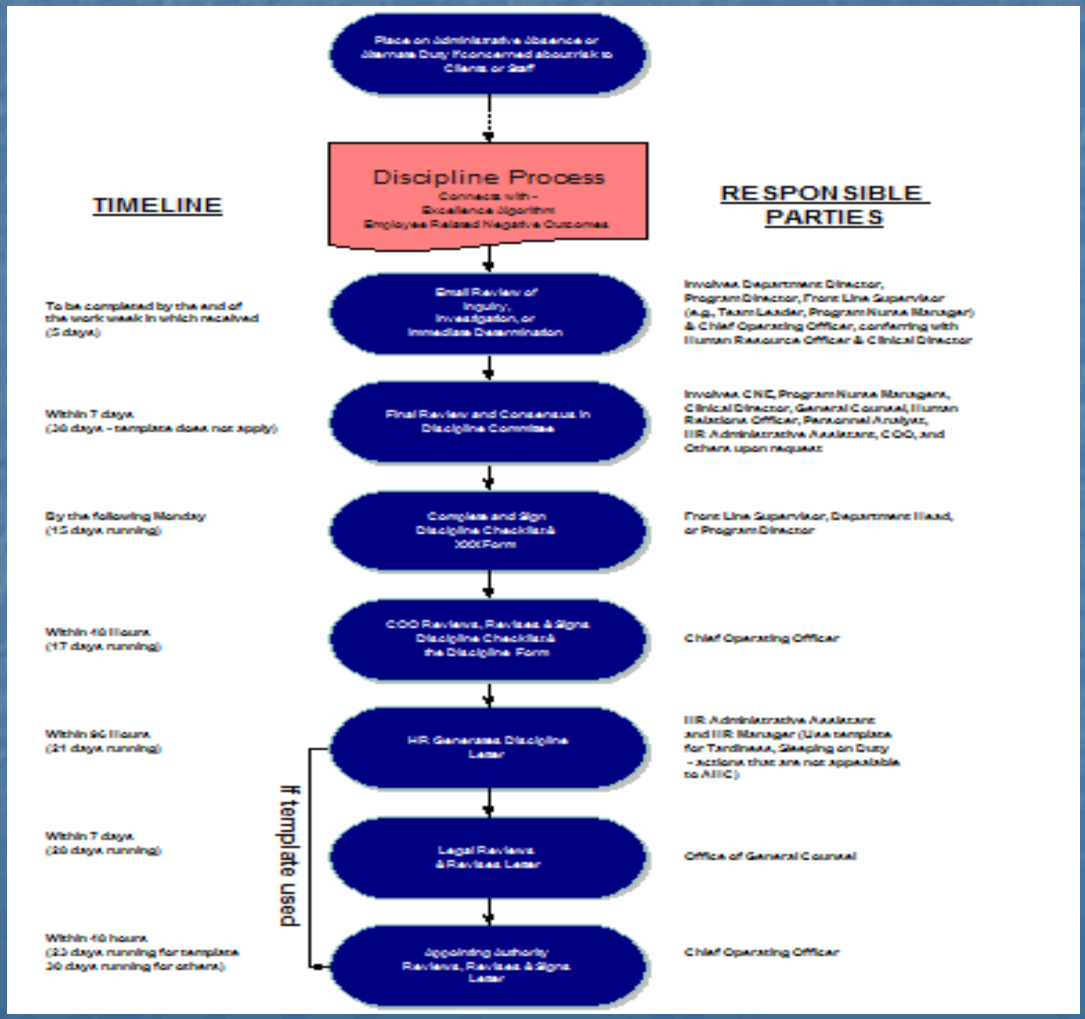


Discipline (con.)

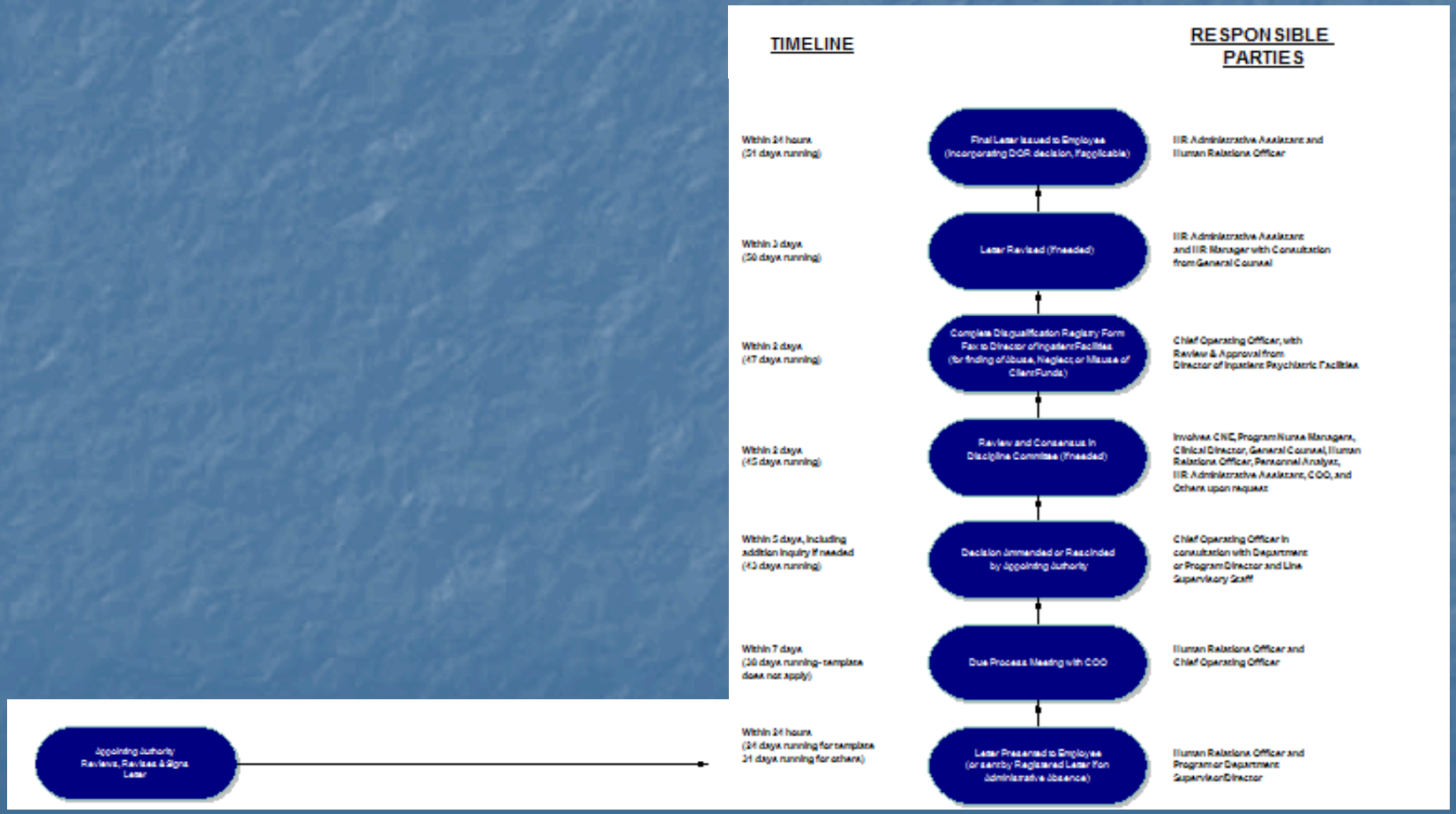
- Also need to consider whether this is criminal conduct or an ethics violation



Discipline Process



Discipline Process (con.)



Exercise 1

- Narrative: A client on standard precautions slams his head into the wall, resulting in loss of consciousness and semi-paralysis
  - Action?
    - Systemic?
    - Employee Specific?

Exercise 2

- Narrative: PT staff escort a group of 8 clients with escorted privileges to the gym. There are two other groups present, and escorted staff converse with one other staff and lose track of one client who goes into the courtyard
  - Systemic?
  - Employee Specific?
  - If the latter, Neglect or excellence algorithm?

Exercise 3

- Narrative: A PT staff member falls asleep while 1:1 with a client in restraints
  - Systemic?
  - Employee Specific?
  - If the latter, Neglect or excellence algorithm?

Exercise 4

- Narrative: An RT on an out-trip with a group of 5 clients, a PT, and a driver goes to the movie theater, and has a client escape once the movie starts and the theater darkens?
  - Systemic?
  - Employee Specific?
  - If the latter, Neglect or excellence algorithm?

Exercise 5

- Narrative: An RN is struck by a patient and per the instruction of the attending psychiatrist administers a PRN during a Manual hold, injecting the patient through his jeans
  - Systemic?
  - Employee Specific?
  - If the latter, Neglect or excellence algorithm?

Exercise 6

- Narrative: A social worker withdraws $100 for a pre-approved out-trip for a client scheduled for the following week, and uses $25 to pay for sodas for the ward picnic today, replacing the money the following day
  - Systemic?
    - Employee Specific?
    - If the latter, Neglect or excellence algorithm?

Exercise 7

- Scenarios from the Audience

Core Leadership Perspective

- Effective Risk Management involves
  - Being a Hawk before the event, aggressively intervening to mitigate risk and prevent error; and
  - Being a Dove after the event, by attempting to calm everyone down and looking for systemic improvements rather than blame
- It's all about our Values
  - Partnership – among each of our employees at all levels to improve the situation for both our clients and our staff
  - Responsiveness – to our collective need for safety and for the reduction of avoidable errors
  - Integrity – in looking beyond the easy opportunity to affix blame
  - Dignity – by respecting out staff's desire to serve our clients in an excellent fashion and to learn from any failures
  - Empowerment – of our staff to improve our processes, systems, and our performance as an organization

Core Leadership Perspective (con.)

- Cultural Change
  - Takes time and energy
  - Isn't easy
  - Takes the commitment of leadership, HR, and supervisory staff
  - Requires alignment of both policy and leadership
    - Good leadership cannot overcome bad policy….
    - …but good policy cannot overcome mediocre leadership
- How do we know we have "arrived?"
  - A commitment to identifying opportunities for improvement and mitigation of risk
  - We live the "80/20" Rule
    - 80% of our effort is around system redesign
    - 20% of our effort is on investigation and discipline
  - We review Recovery as a possibility for our staff and our organization, with the same level as certainly as for our clients
  - Pervasive Growth of CQI and RPI
  - Use of performance improvement for near miss events
  - Our policies are aligned with our values, and our algorithm
  - Recognition of our excellence and pride in our organization and in ourselves