NAVIGATING AN APPROVAL FOR REMOVAL

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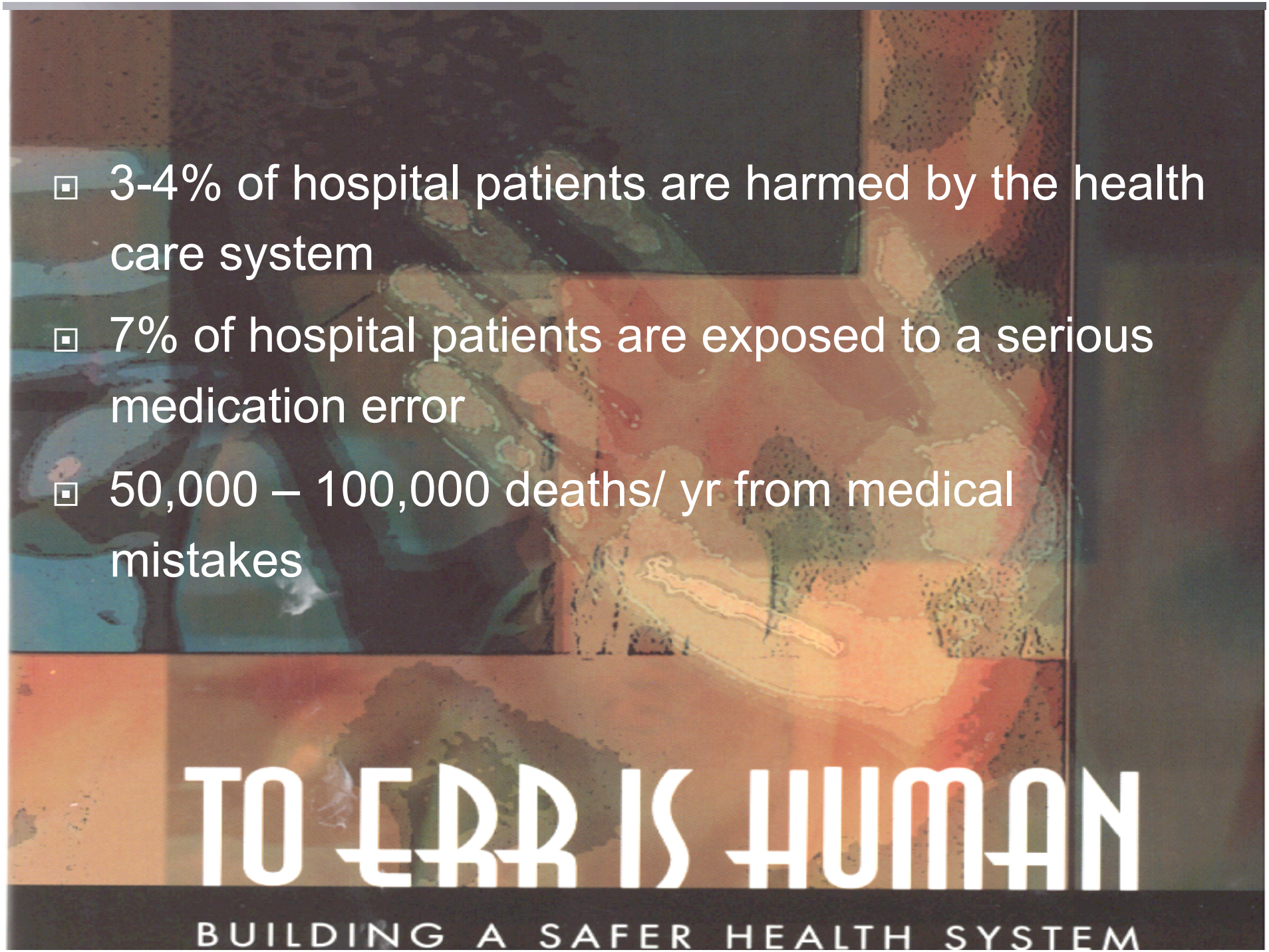
Objectives

- Describe the ubiquitous nature of errors
- Overview of a Performance Improvement Program and what it fixes and what it doesn't
- Describe importance of a decision matrix to address shades of grey
- Describe the need for objective reasons for loss of credential
- Define peer engagement and it's importance

"To make no mistakes is not in the power of man; but from their errors and mistakes the wise and the good learn wisdom for the future."

-Plutarch



- 3-4% of hospital patients are harmed by the health care system
- 7% of hospital patients are exposed to a serious medication error
- 50,000 – 100,000 deaths/ yr from medical mistakes

The measure of your system is not in the mistakes you make…

It is in the action taken to address those mistakes.

PI Programs of Old

- Outcomes based and provider focused
- Bad outcomes are caused by bad providers
- Mistakes are the fault of a bad provider

Doesn't seek out errors to fix
Catches errors to BLAME

Ignores

- **Cognitive**
  - Errors of omission/commission
  - Knowledge deficits
  - Skill retention/Training
- **Process/procedure**
  - Unclear or no procedure/protocol
  - Structured communication
- **System**
  - Equipment
  - System design/fatigue

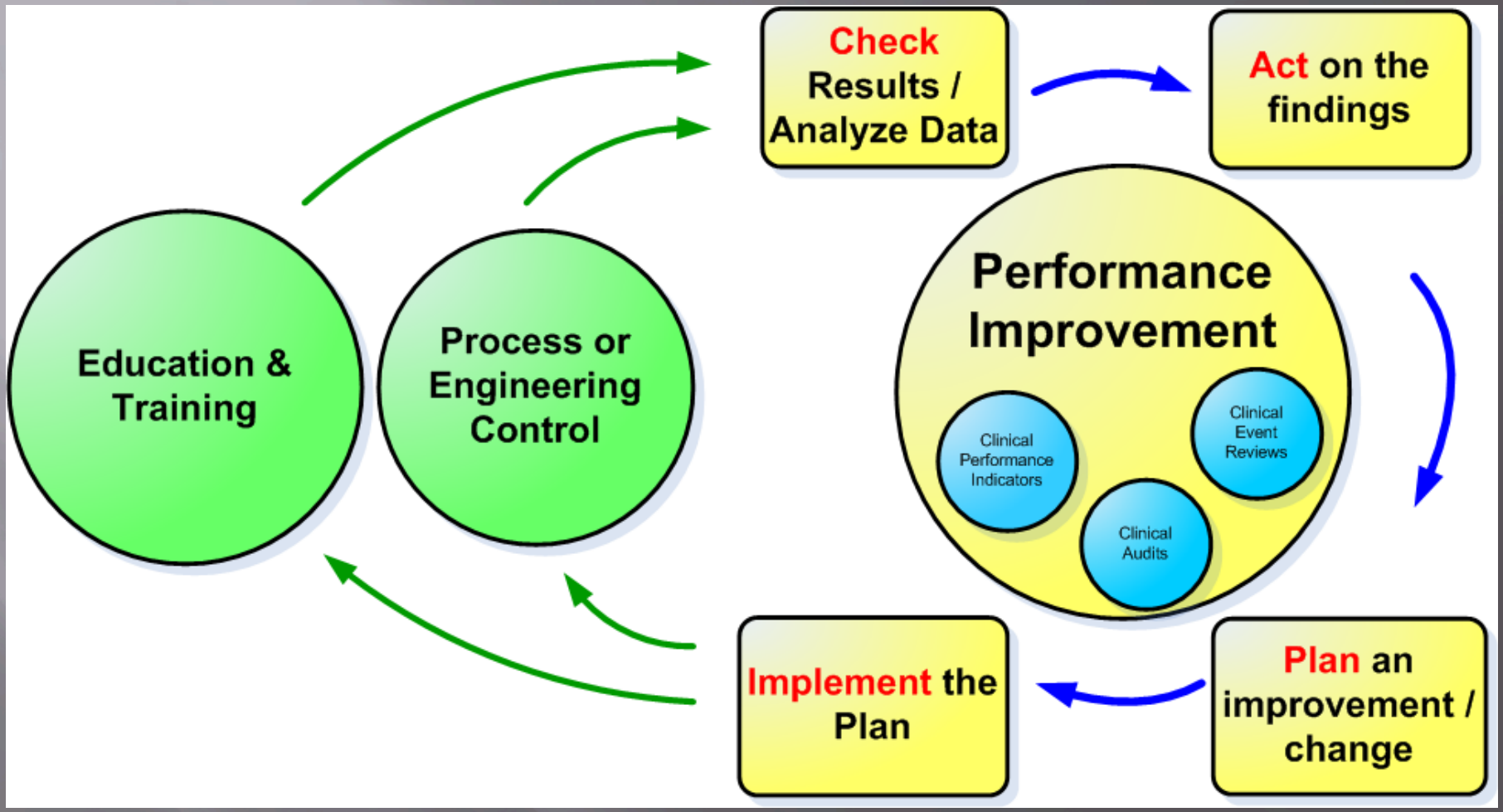
The healthcare professions have gotten better about this…

…to the exclusion of the contribution of the behavior of the individual?

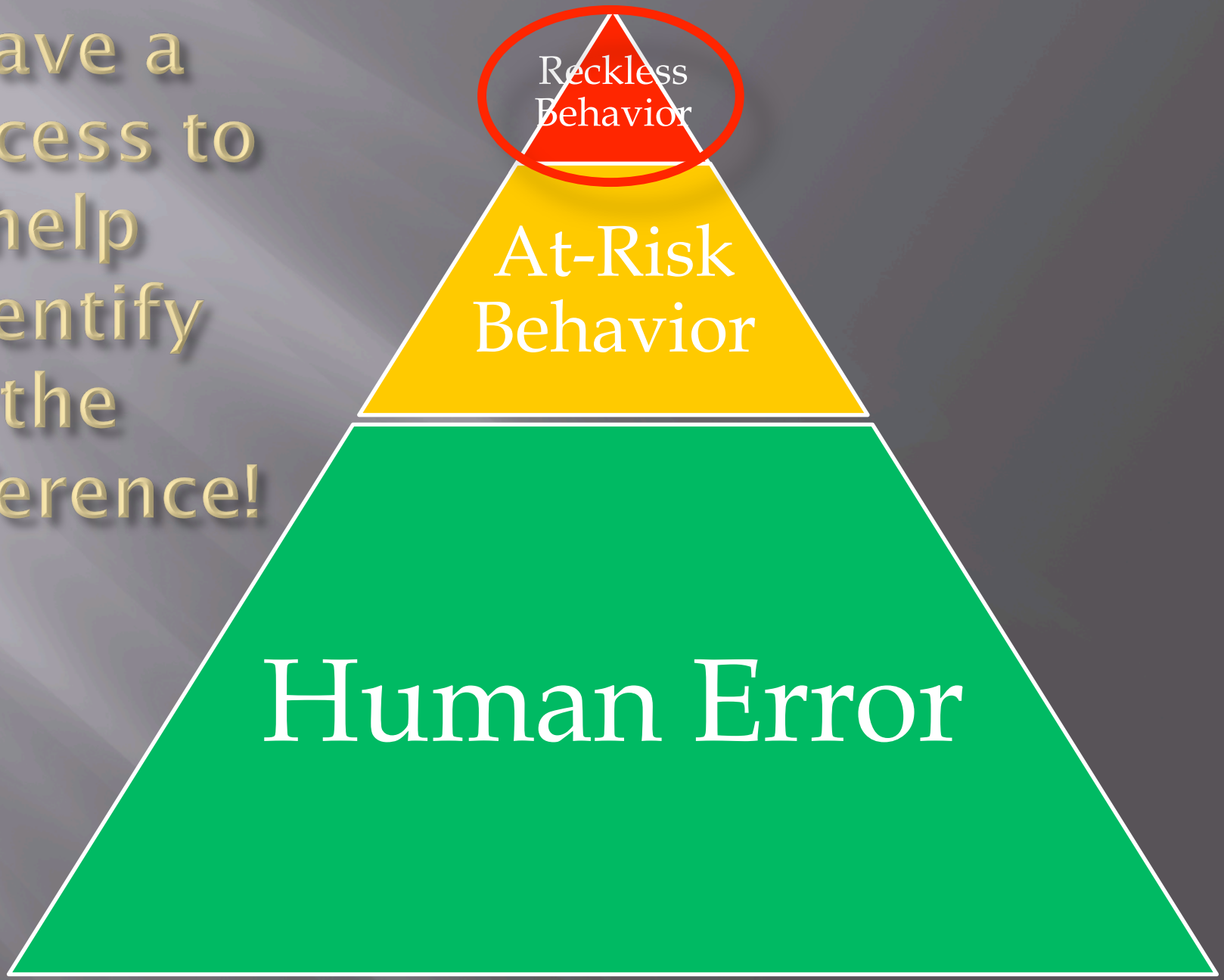
Performance Improvement Principles

Creating an program that seeks out errors in a non-punitive blame free environment does NOT mean that all behaviors can be tolerated.

Performance Improvement



Have a process to help identify the difference!



As professional caregivers you should WANT accountability for unacceptable behaviors to preserve:

Trust
Respect
Value
PRIDE

in what you do.

World of grey…much at stake

PROVIDERS

- Are in short supply
- Good ones want to work with like minded others
- Want validation of their contribution
- Define the quality of the care you provide and the System

STAKEHOLDERS

- Patients
  - IF they have a choice it is based on trust
- Hospitals/Physicians
  - Facilitate or hinder your clinical initiatives
- Community
  - Safety of your providers
  - Advocates for the service
- Politicians
  - Control your funding

Process and Structure

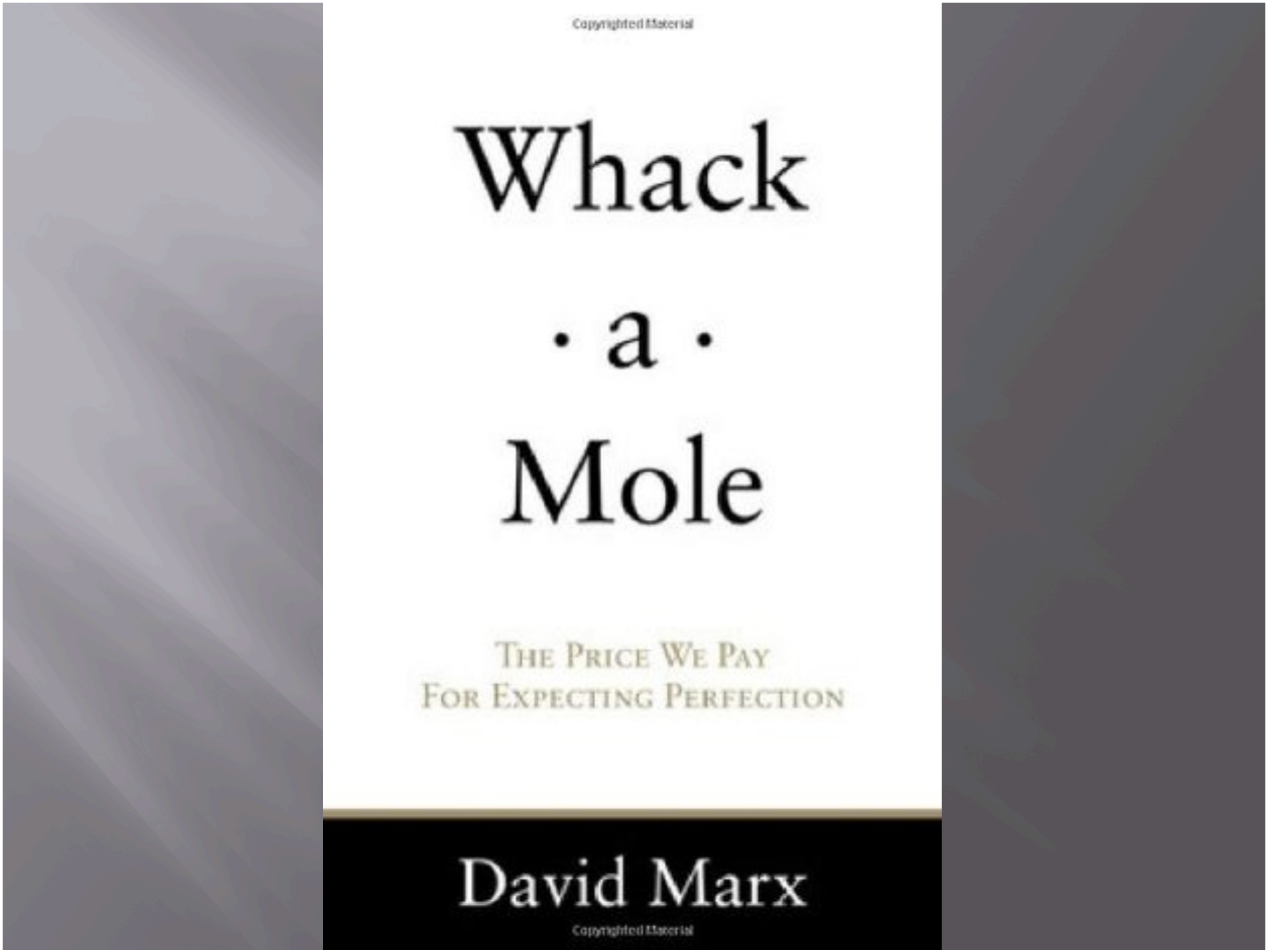
- Process to create reproducible decisions
  - Provides consistency
  - Defensible
- Structure of PI and review must be functional
  - Limited impact on System
  - Expedient for most event types
  - Increasing complexity and deliberation for more difficult cases

Process to Address Behaviors INDEPENDENT of Outcome

- Creates accountability for behaviors within the control of the clinician
- Ill intent doesn't always result in bad outcomes
- Bad outcomes do not indicate ill intent
- Clearly defines unacceptable behaviors

Unacceptable "Deadly Sins"

- Impaired
- Intentionally harming a patient
- Intentionally withholding care
- Integrity violation
- Failure to remediate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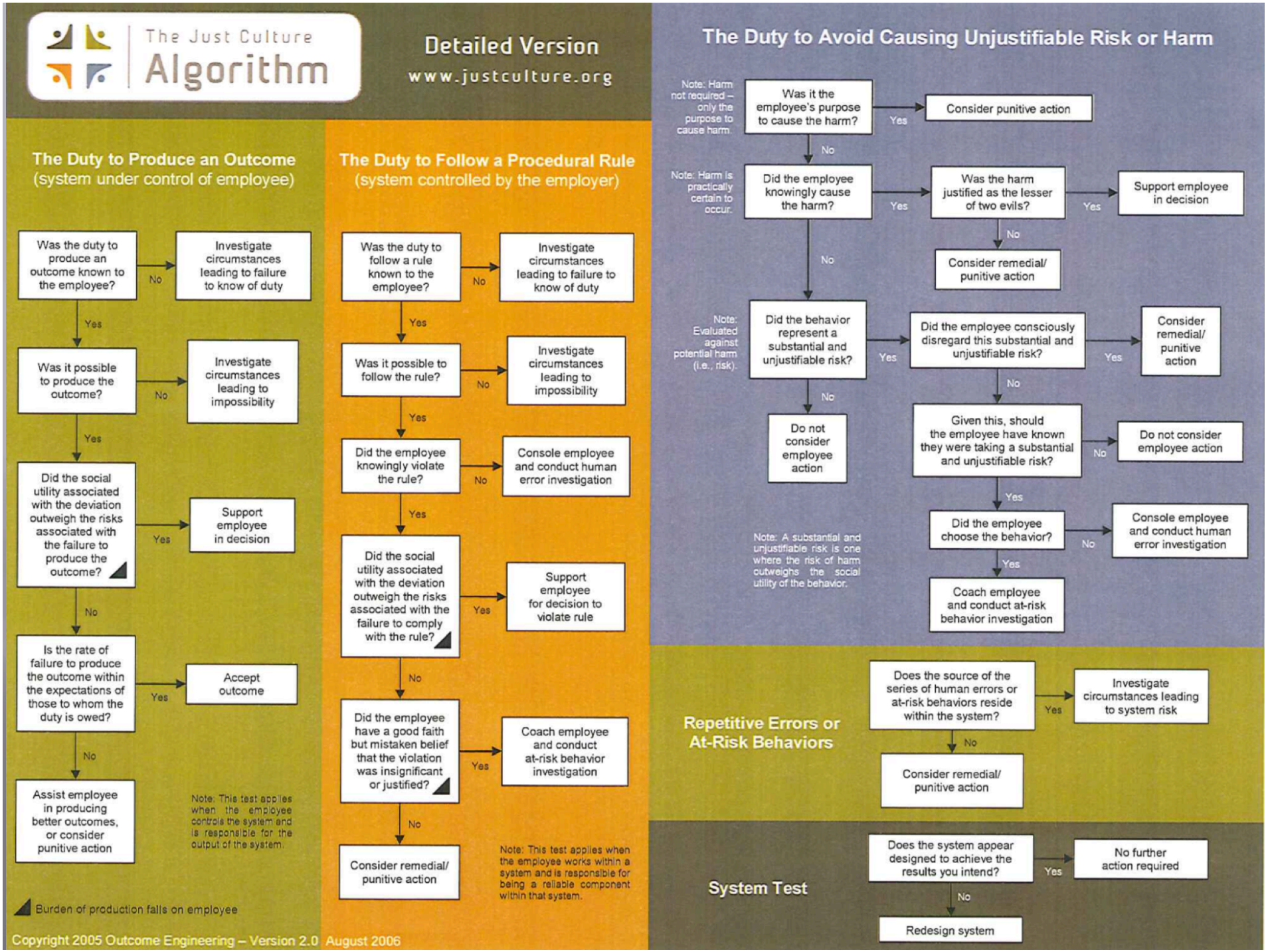
Tenets of a Just Culture

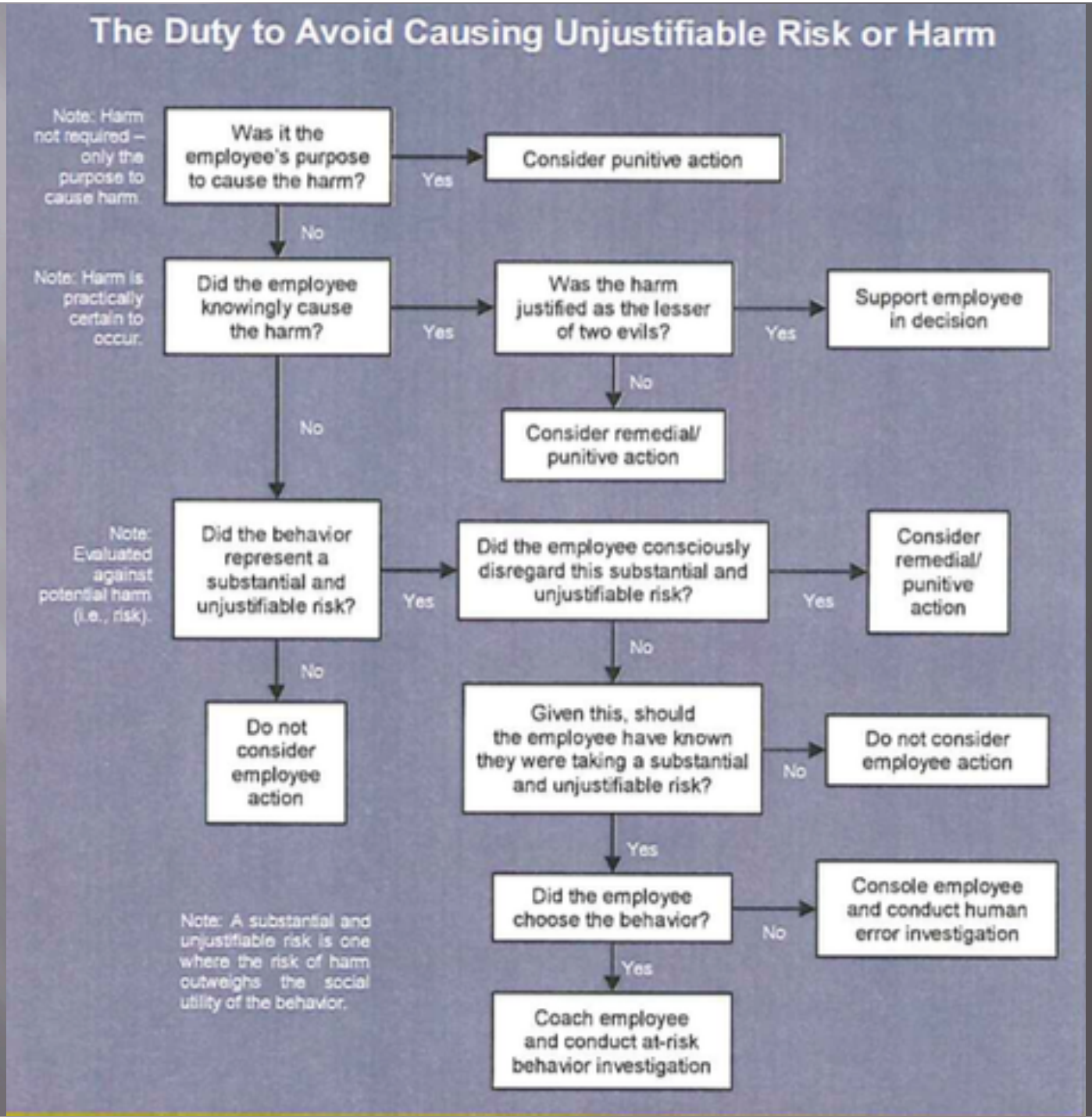
- Errors will occur
- System failures contribute to many errors
- Self reporting and error acknowledgement is essential to improvement in the system
- PUNISHMENT does not deter normal errors
- WILLFUL reckless behaviors cannot be tolerated in Safety/Just culture

Just Culture

- Human error, lapse, slip or mistake
  - Manage through process, procedure, training
  - **Console**
- At risk behavior(choice) where risk not recognized or believed justified
  - Incentivize healthy choices and increased situational awareness
  - **Coach**
- Reckless behavior is conscious disregard of unreasonable risk
  - Remedial action or removal
  - **Punish**



The Duty to Avoid Causing Unjustifiable Risk or Harm



Peer Review or Peer Torture

- Often used as the sole means of determining providers fate
- Uses "reasonable" peer as standard for behavior
- Often without education for participants

- If unstructured can do more harm than good

More harm than good?

- Peers are far more critical
- Can result in harsher action than intended
- Challenge to maintain error friendly environment
- Belief that the outcome is predetermined

Patient Safety Committee

- 3 peers and 2 physicians from medical society
- Blinded review of fact pattern that led to decredentialing recommendation
- If not unanimous a majority and dissenting opinion are submitted

Physicians work with peers and see acoutability

Assures no personality issues or influence on process or return to practice

Assures final decision is as informed as possible

Take Away

- Be proud of what you do, where you do it, and who you do it with
- PI focus should be on contributing factors but not to the exclusion of bad behaviors
- Create a non-punitive environment for errors but define and maintain accountability for unacceptable willful acts
- Use peer review assure process transparency and engagement for inside and outside stakeholders

“Personal responsibility is not only recognizing the errors of our ways. Personal responsibility lies in our willingness and ability to correct those errors individually and collectively.”

–Yehuda Berg