UW Health Patient Safety and Quality Committee

September 27, 2023, 10:30 AM - 12:00 PM

https://uwhealth.webex.com/uwhealth/j.php?MTID=ma7e8b7d40d74fde15faab221d5bf84bd
Meeting Number: 2621 282 7620 // Password: 092723
Join by phone +1-415-655-0003 US TOLL Access code: 2621 282 7620

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# UW Health Patient Safety and Quality Committee - September 27, 2023 - Public Meeting Notice

## Agenda

<table>
<thead>
<tr>
<th>Time</th>
<th>Item</th>
<th>Presenter/Reader</th>
<th>Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>10:30 AM</td>
<td>I. Call to Order</td>
<td>Dr. Sandra Kamnetz</td>
<td>Introduction</td>
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<tr>
<td>10:30 AM</td>
<td>II. Welcome New Members - Dr. Beth Drolet and Ms. Karen Carl</td>
<td>Dr. Sandra Kamnetz</td>
<td>Introduction</td>
</tr>
<tr>
<td>10:35 AM</td>
<td>III. Open Session Minutes - July 20, 2023</td>
<td>Dr. Sandra Kamnetz</td>
<td>Approval</td>
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<tr>
<td>10:35 AM</td>
<td>IV. Patient Safety SuperHERO - Good Catches</td>
<td>Dr. Jeffrey Pothof</td>
<td>Informational</td>
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<td></td>
<td>Attachment - Patient Safety SuperHERO - Good Catches</td>
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<tr>
<td>10:40 AM</td>
<td>V. Just Culture</td>
<td>Ms. Lori Haack</td>
<td>Informational/Discussion</td>
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<td>Presentation - Just Culture</td>
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<td>11:05 AM</td>
<td>VI. Closed Session</td>
<td>Dr. Sandra Kamnetz</td>
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<td>Motion to enter into closed session pursuant to Wisconsin Statutes sections 146.38 and 19.85(1)(e) for the review and evaluation of health care services: and discussion of the following confidential, strategic matters, which for competitive reasons require a closed session: review and approval of closed session minutes; discussions of Patient Safety and Quality Committee Patient Metrics and Patient Relations Department Update; Health Care Associated Conditions – Pressure Injuries; and pursuant to Wisconsin Statutes section 19.85(1)(g), to confer with legal counsel regarding these and other matters.</td>
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<td>12:00 PM</td>
<td>VII. Adjourn</td>
<td>Dr. Sandra Kamnetz</td>
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Attachment

Patient Safety SuperHERO – Good Catches

September 27, 2023
Congratulations to this week’s Safety SuperHEROs, the Transitional Care Team

- Recently, the Transitional Care Team identified and found solutions to several potential patient safety events
- One example was a discharge order placed for trauma follow-up when the patient needed additional treatment in a different specialty
- A Transitional Care nurse noticed, notified the patient, immediately canceled the trauma appointment and scheduled with the correct provider
- Their catch ensured no delay in treatment and no unnecessary appointments for the patient
- The team’s other catches included unclear discharge instructions, unscheduled appointments and inaccurate patient medication lists at discharge
- After uncovering these events, the team ensured their patients received the care they needed in a safe and timely manner
Just Culture at UW Health
Let’s start with a story
The single greatest impediment to error prevention in the medical industry is “that we punish people for making mistakes.”

Dr. Lucian Leape  
Professor, Harvard School of Public Health  
Testimony before Congress on Health Care Quality Improvement
<table>
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<tr>
<th>Statement</th>
<th>Green</th>
<th>Red</th>
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<tbody>
<tr>
<td>I would recommend UW Health as a place to receive safe care.</td>
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<td>Patient safety is a high priority in my department.</td>
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<td>When an error is made, our team focuses on learning from it versus blaming someone.</td>
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<td>It is safe to speak up regarding safety concerns no matter who is involved,</td>
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<td>If I make a mistake in this team, I know it will not be held against me.</td>
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**Green**=Agreement (positive response)

**Red**=Disagreement (negative response)
Let’s Talk About Just Culture
Safety Culture

INFORMED CULTURE
Those who manage and operate the system have current knowledge about the human, technical, organisational and environmental factors that determine the safety of the system as a whole.

REPORTING CULTURE
An organizational climate in which people are prepared to report their errors and near-misses.

JUST CULTURE
An atmosphere of trust in which people are encouraged (even rewarded) for providing essential safety-related information, but in which they are also clear about where the line must be drawn between acceptable and unacceptable behaviour.

FLEXIBLE CULTURE
A culture in which an organisation is able to reconfigure themselves in the face of high tempo operations or certain kinds of danger - often shifting from the conventional hierarchical mode to a flatter mode.

LEARNING CULTURE
An organisation must possess the willingness and the competence to draw the right conclusions from its safety information system and the will to implement major reforms.
The Spectrum of Human Behavior

- **Human Error**
  - Not By Choice

- **At-Risk Behavior**
  - By Choice

- **Reckless**
  - By Choice

- **Knowledge**
  - By Choice

- **Purpose**
  - By Choice

Visuals include:
- An exit sign with a car driving on a highway.
- A speed limit sign with a speed of 65 mph.
- A sports car driving at 130 mph.
- A person parking a car in a designated spot.
The Spectrum of Human Behavior

- **Human Error**: Not By Choice
- **At-Risk Behavior**: By Choice
- **Reckless**: By Choice
- **Knowledge**: By Choice
- **Purpose**: By Choice
It’s the...

Quality of the Choice

..that matters more than the outcome.
THRESHOLD INVESTIGATION

- What happened?
- What normally happens?
- What does procedure require? (if applicable)
- Why did it happen?
- How was the organization managing the risk?
• National best practice
• Better outcomes
• Will help us meet TJC requirements
• Connects with UW Health Way and Respect for People
• Demonstrated need at UW Health
Let’s end with a story… with a Just Culture