Learning From the Death of Joan Rivers: The Physician's Role in Patient Safety

November 17, 2015

NCQC Patient Safety Organization

Patient Safety Listed PSO Organization

Our Speaker

Ken Rothfield, MD, MBA, CPE, CPPS
System Vice President
Chief Medical Officer
Saint Vincent's HealthCare
Ascension Health

What Happened?

WHAT HAPPENED?

- Joan Rivers was 81 years old
- History of chronic reflux disease and hoarseness
- Scheduled for upper endoscopy
- Presented to Yorkville Endoscopy on August 14, 2014

Yorkville Endoscopy

Dr. Lawrence Cohen, gastroenterologist

– Yorkville's Endoscopy's medical director

Dr. Gwen Korovin, otolaryngologist

– ENT physician to the stars

– Not credentialed at Yorkville Endoscopy

Dr. Renuka Bankulla, anesthesiologist

Vocal hero: Gwen Korovin is Broadway's throat doctor who has Patti LuPone, Hugh Jackman and more singing her praises

BY JOE DZIEMIANOWICZ Follow

She's also been the voice of reason for pop singers Celine Dion, Lady Gaga

NEW YORK DAILY NEWS / Updated: Wednesday, April 24, 2013, 12:33 PM

A A A

139 9

Dr. Gwen Korovin has been called Broadway's throat doc and the keeper of high-profile pipes.

Just ask Nathan Lane, who credits Korovin for guiding him past a rough patch during previews of "The Nance."

"I was fighting a bronchial infection," says Lane, who earned enthusiastic reviews for the burlesque-era drama a week ago. "I don't think I would have made it through opening night without her."

Besides antibiotics and anti-inflammatories and an accommodating schedule to fit busy actors, Korovin provided something that mattered just as much — compassion.

Korovin smiles at Lane's rave notice.

"I've always been fascinated by the human voice and music,"

The Planned Procedure

- Consented for "an upper endoscopy (EGD), with possible biopsy/possible polypectomy, possible dilatation of the esophagus”

Allegations by Melissa Rivers

- Dr. Cohen asked Dr. Korovin to examine vocal cords after Ms. Rivers was sedated
- Dr. Korovin announced “I’ll go first”
- Anesthesiologist “raised questions” but was ignored

CMS FINDINGS

- Procedure started at 0900. Dr. Bankulla met Dr. Korovin for the first time just before the procedure
- No consent for nasal laryngoscopy
- A Time Out was performed at 0904, but was incomplete. Not all of the planned procedures were verified.
- Dr. Korovin was noted as a referring physician, not as a member of the procedural team in the procedure note
- The nasal laryngoscopy was documented only in the anesthesia record

The Procedures

- Nasal laryngoscopy attempted, but aborted because of poor visualization

- Upper endoscopy performed and completed at 0928

- Nasal endoscopy repeated and completed at 0930

What About the Anesthesia?

Anesthetic Management

Gastroenterology

AGAJ

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December 2009 Volume 137, Issue 6, Pages 2161–2167

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Position Statement: Nonanesthesiologist Administration of Propofol for GI Endoscopy

John J. Vargo, MD, MPH (Member of the Committee), Lawrence B. Cohen, MD (Member of the Committee), Douglas K. Rex, MD (Member of the Committee), Paul Y. Kwo, MD (Member of the Committee)

Received: July 10, 2009; Accepted: July 10, 2009; Published Online: March 05, 2014

Monitored Anesthesia Care with Propofol by an Anesthesiologist

The Anesthesiologist (Allegedly) Speaks Up

- Ms. Rivers required a chin lift and increasing oxygen to maintain adequate saturation (CMS)
- Dr. Bankulla was concerned about airway edema, and wanted Dr. Cohen to examine the airway with the gastroscope prior to the repeat nasolarnygoscopy (MR)
- Dr. Cohen called her "a curious cat" and said “You always want to know what's going on” (MR)
- Dr. Cohen used his cell phone to take a picture of Dr. Korovin and the anesthetized Joan Rivers (CMS)

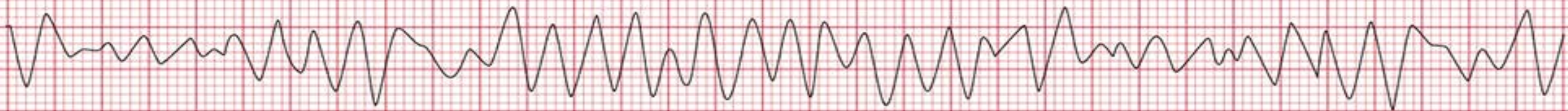
Vital Signs

TIME	BP	Pulse	RR	SpO2	ETCO2
9:12.49 AM	117/60	71	?	92%	?
9:16.13 AM	92/54	56	16	94%	26
9:21:42 AM	89/44	54	17	97%	19
9:26.36 AM	84/40	47	?	92%	?
9:30:04	**85/49**	**?**	**?**	**92%**	**?**

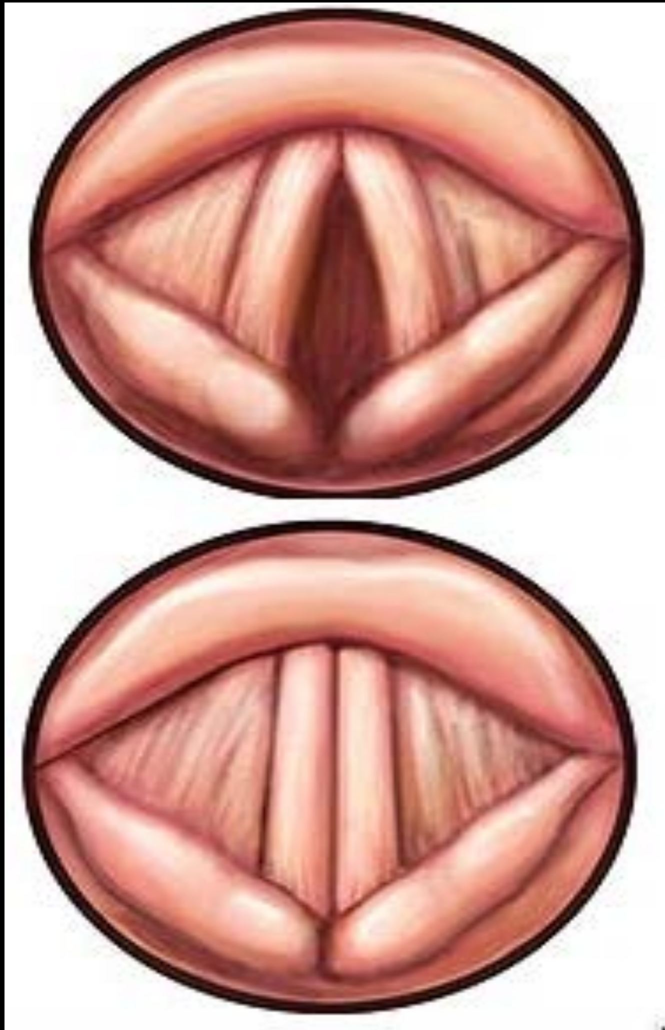
The Code: Conflicting Accounts

- **Cardiac Arrest Record**
  - Cardiac arrest at 0928
  - CPR started at 0930
  - Epinephrine and Atropine administered at 0938

- **Endoscopy Code Blue Record**
  - Ventricular Tachycardia *with a pulse* at 0928
  - CPR and assisted ventilation at 0928
  - Epinephrine and Atropine administered at 0928



Why Did Joan Rivers Arrest?



- Declining blood pressure and pulse during procedure
- Alleged that she developed laryngospasm after the second nasal laryngoscopy
- Succinylcholine was not administered
- Bankulla stated in court documents "The laryngospasm had already broken, and Joan Rivers was being adequately oxygenated with mask ventilation."

JOAN RIVERS

1933 - 2014

Legendary comedian Joan Rivers dies at 81 in 2014

Stars say goodbye at Joan Rivers' funeral

THE FBI'S TOP RECRUIT
IS NOW THEIR MOST WANTED

Joan Rivers had surprise throat biopsy that cut off her air supply, source claims

EXCLUSIVE: The late comedian went to Yorkville Endoscopy for a routine endoscopy on Aug. 28, but a doctor — who arrived with Rivers' entourage — offered to perform a biopsy after another doctor noticed 'something' on the entertainer's vocal chords, a medical source told the Daily News.

BY DON KAPLAN Follow / NEW YORK DAILY NEWS / Tuesday, September 9, 2014, 9:27 PM

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The Code: Allegations

- Cohen performed chest compressions
- Bankulla attempted intubation and failed
- Anesthesiologists Robert Koniuta and Suzanne Scarola assisted
- Scarola attempted intubation but failed
- Approximately 17 minutes later, Bankulla requested that Dr. Korovin perform a cricothyroidotomy
- Dr. Korovin left the scene during the code
- *911 is not called until 0940*

- Joan Rivers taken by ambulance to Mount Sinai Hospital
- She died 7 days later
- Autopsy report stated that the cause of death was anoxic encephalopathy due to hypoxic cardiac arrest

DISMISSED

‘I did everything to save her’

N.Y. / REGION

Joan Rivers's Doctor Denies Allegation That She Fled Procedure Room, Lawyer Says

By ANEMONA HARTOCOLLIS JAN. 28, 2015

Accreditation

- Accreditation by the American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF) revoked

- Withdrawal of federal accreditation by CMS *threatened*

Accreditation Association for Ambulatory Health Care (AAAHC)

Our facility adheres to the highest standards in quality, safety and compliance and we were awarded full accreditation by Medicare (CMS) and the Accreditation Association for Ambulatory Health Care (AAAHC).

Accreditation Association for Ambulatory Health Care (AAAHC), the nationwide leader in ambulatory health care accreditation. Accreditation from AAAHC ensures that Yorkville Endoscopy has adopted the best practices in health care, has complied with nationally-recognized standards and is recognized by third party payers and medical societies, as well as state and national government agencies.

NYC Medical Examiner's Office

"The manner of death is therapeutic complication….The classification of a death as a therapeutic complication means that the death resulted from a predictable complication of medical therapy."

Y YORKVILLE ENDOSCOPY

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New York, NY 10128
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Billing Inquiries

FAQ Yorkville Endoscopy Center (YEC)

Comprehensive
and compassionate care

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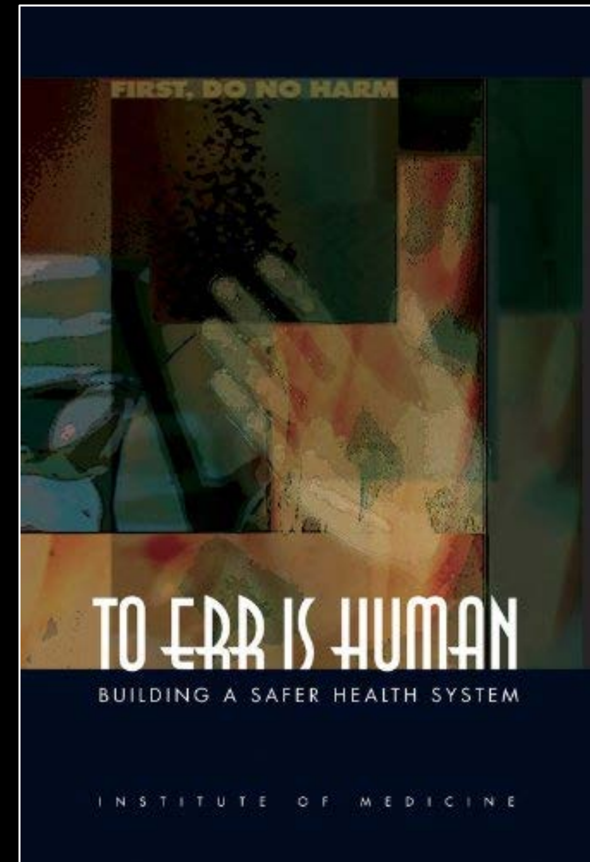
What Killed Joan Rivers?

Culture

How Safe is Healthcare?

440,000 Americans die every year because of preventable medical mistakes



Why Can’t Healthcare be as Safe as Commercial Aviation?

KLM. From the people who made punctuality possible.

Building an airline of KLM's standing requires a special kind of dedication. Like making a point of being punctual. A quality that's very much part of the Dutch.

It was Christiaan Huygens after all, who gave it real significance – when he invented the spring balance that made timepieces transportable. A creation without which life is inconceivable. Or air travel, for that matter. And one that illustrates that singular Dutch ability for doing things well. As you'll discover when you fly KLM. You'll find your trust sincerely reciprocated. With efficiency, punctualness and friendly understanding.

For that is the way the people of Holland are. People whose involvement make KLM a big, reliable, international airline. As your travel agent will confirm.

Visit any of Holland's clogmakers and watch Dutch craftmanship and precision in the old tradition. In this time-honoured process, logs are split, hollowed, shaped, smoothed and ultimately transformed into the article still worn in many parts of the country.

A right royal time is what you have in KLM's Royal Class. Service is punctual and princely. Dinner for instance, is always rounded off with a choice of seven different coffees. But then, it's only in keeping with that stylish class far too good to be called just first.

KLM

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Speak UP™

The Joint Commission

Psychological Safety

- Psychological safety is a shared belief that the team is safe for interpersonal risk taking
- In psychologically safe teams, team members feel accepted and respected

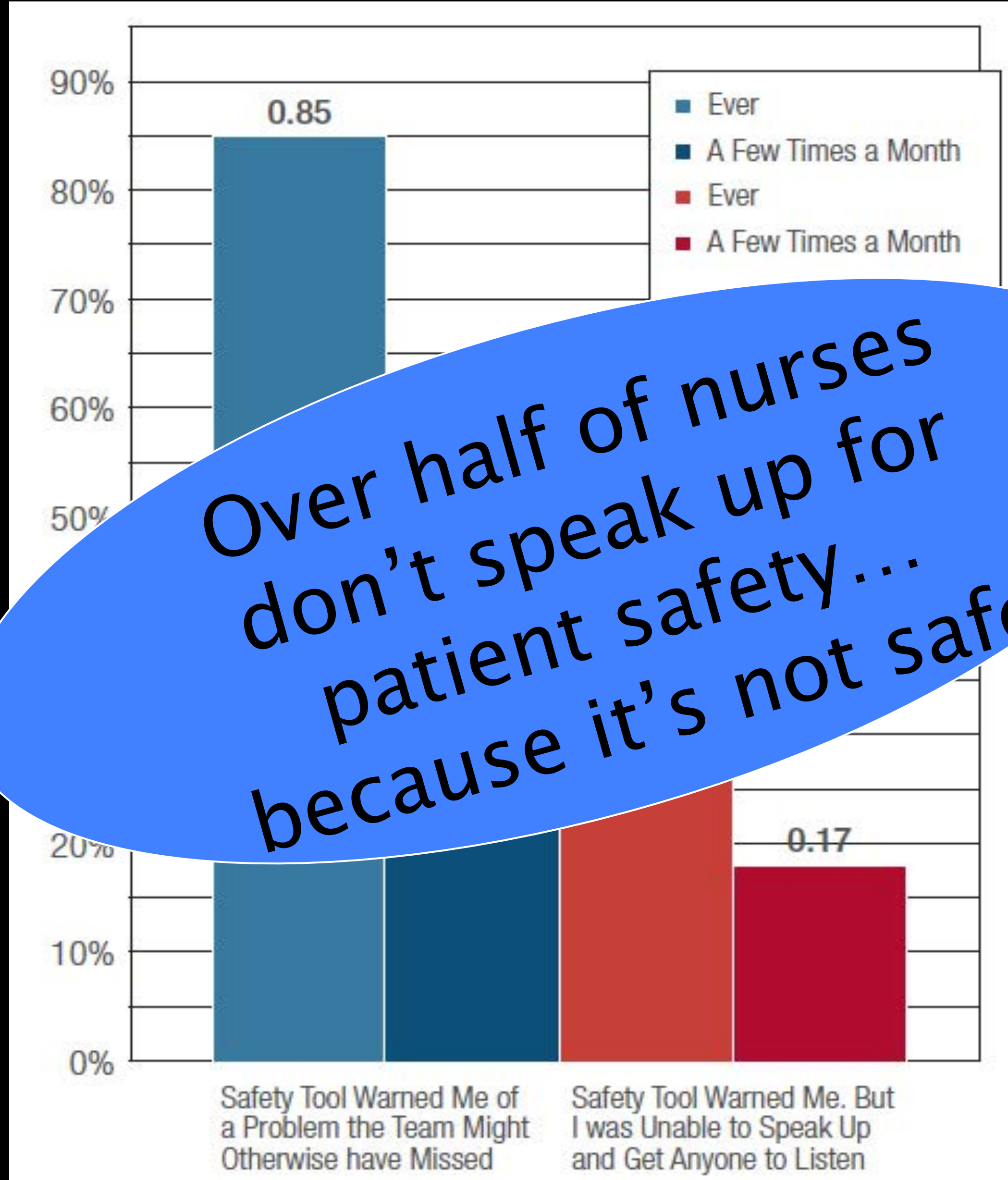
VitalSmarts, AORN, & AACN present:

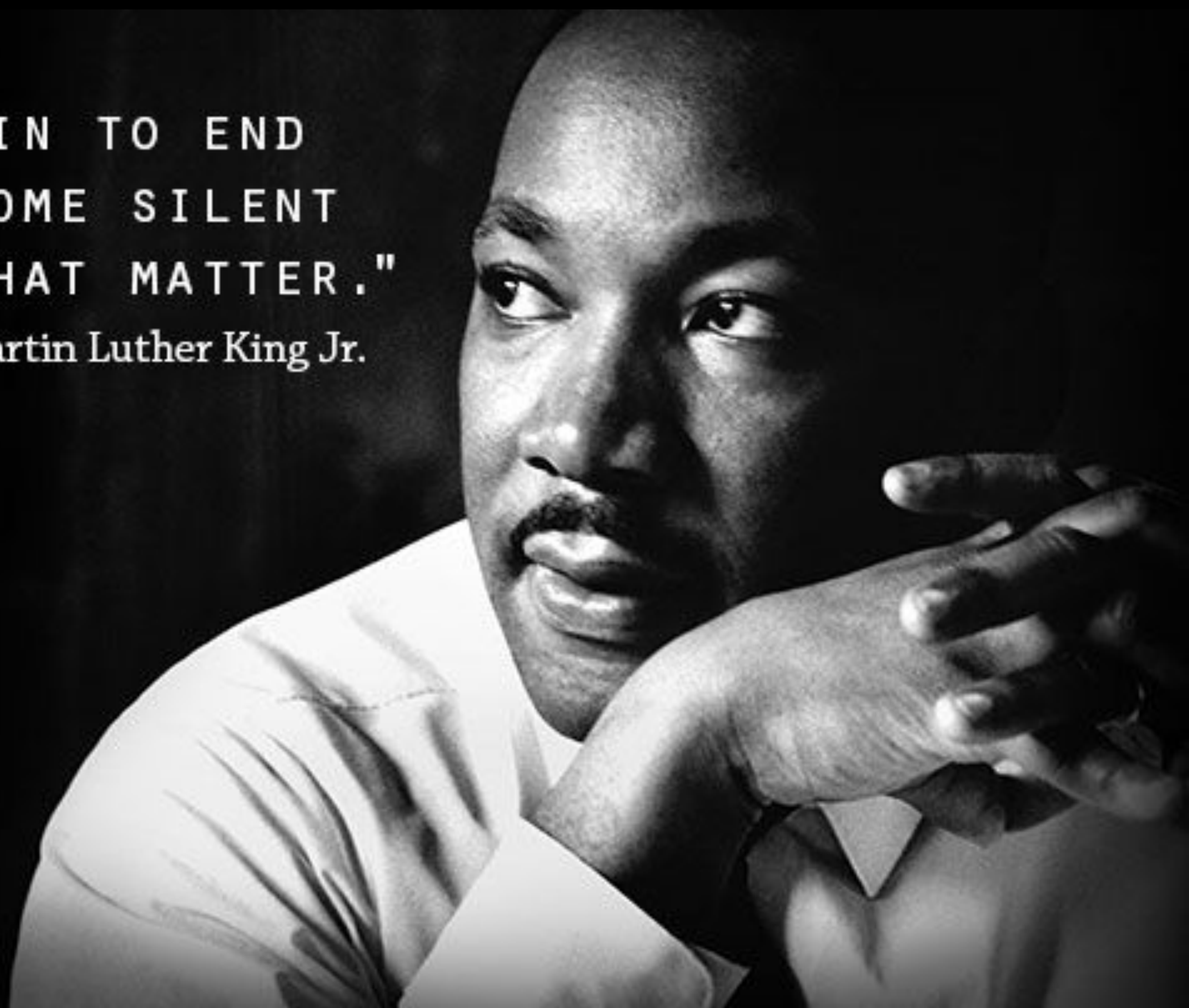
The Silent Treatment

Why Safety Tools and Checklists Aren't Enough to Save Lives

David Maxfield, Joseph Grenny, Ramón Lavandero, and Linda Groah

Imagine you are a nurse who has been given a set of new safety tools that warns you whenever your patients are in danger. That would be powerful, life-saving information, right? But what if nobody listened to you or heeded your warnings? This kind of breakdown is happening in hospitals every day. The quote below is one of 681 collected in the course of this research.


90%
80%
70%
60%
50%
20%
10%
0%
0.85
0.17
Ever
A Few Times a Month
Ever
A Few Times a Month
Safety Tool Warned Me of a Problem the Team Might Otherwise have Missed
Safety Tool Warned Me. But I was Unable to Speak Up and Get Anyone to Listen
Over half of nurses don't speak up for patient safety… because it's not safe

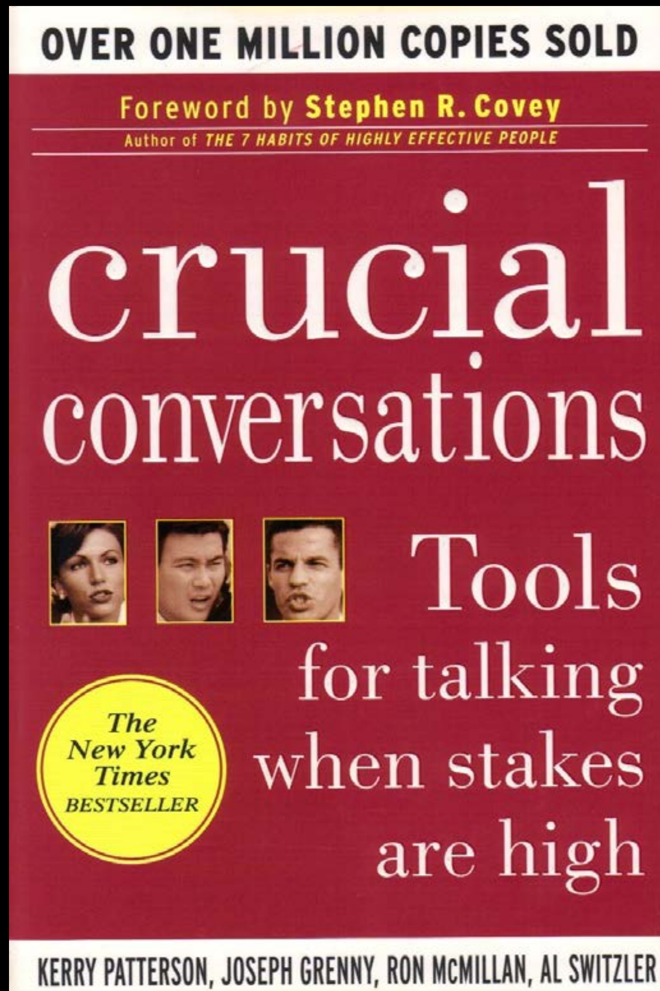


"OUR LIVES BEGIN TO END THE DAY WE BECOME SILENT ABOUT THINGS THAT MATTER."

~ Martin Luther King Jr.

@JamiePelaez

Crucial Conversation



- Stakes are high
- Opinions vary
- Emotions run strong

Crucial Conversation Tool
ARCC

Starts with a question and progressively increases in assertiveness until the condition prompting the question is resolved to the satisfaction of all.

- A – **Ask** a question
- R – Make a **Request**
- C – Express a **Concern**
- C – Follow your **Chain of Command**

Team Training Solution

TeamSTEPPS

Strategies and Tools to Enhance Performance and Patient Safety

Checklists

Culture and Leadership

The NEW ENGLAND JOURNAL of MEDICINE

SPECIAL ARTICLE

A Surgical Safety Checklist to Reduce Morbidity and Mortality in a Global Population

Alex B. Haynes, M.D., M.P.H., Thomas G. Weiser, M.D., M.P.H., William R. Berry, M.D., M.P.H., Stuart R. Lipsitz, Sc.D., Abdel-Hadi S. Breizat, M.D., Ph.D., E. Patchen Dellinger, M.D., Teodoro Herbosa, M.D., Sudhir Joseph, M.S., Pascience L. Kibatala, M.D., Marie Carmela M. Lapitan, M.D., Alan F. Merry, M.B., Ch.B., F.A.N.Z.C.A., F.R.C.A., Krishna Moorthy, M.D., F.R.C.S., Richard K. Reznick, M.D., M.Ed., Bryce Taylor, M.D., and Atul A. Gawande, M.D., M.P.H., for the Safe Surgery Saves Lives Study Group*

ABSTRACT

BACKGROUND

Surgery has become an integral part of global health care, with an estimated 234 million operations performed yearly. Surgical complications are common and often preventable. We hypothesized that a program to implement a 19-item surgical safety checklist designed to improve team communication and consistency of care

the operation.

RESULTS

The rate of death was 1.5% before the checklist was introduced and declined to 0.8% afterward (P=0.003). Inpatient complications occurred in 11.0% of patients at baseline and in 7.0% after introduction of the checklist (P<0.001).

CONCLUSIONS

Implementation of the checklist was associated with concomitant reductions in the rates of death and complications among patients at least 16 years of age who were undergoing noncardiac surgery in a diverse group of hospitals.

From the Harvard School of Public Health (A.B.H., T.G.W., W.R.B., A.A.G.), Massachusetts General Hospital (A.B.H.), and Brigham and Women's Hospital (S.R.L., A.A.G.) — all in Boston; University of

quests to Dr. Gawande at the Department of Surgery, Brigham and Women's Hospital, 75 Francis St., Boston, MA 02115, or at safesurgery@hsph.harvard.edu.

*Members of the Safe Surgery Saves Lives Study Group are listed in the Appendix.

This article (10.1056/NEJMsa0810119) was published at NEJM.org on January 14, 2009.

N Engl J Med 2009;360:491-9.

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2009

Death rate: DECREASED
Complications: DECREASED

The NEW ENGLAND JOURNAL of MEDICINE

SPECIAL ARTICLE

Introduction of Surgical Safety Checklists in Ontario, Canada

David R. Urbach, M.D., Anand Govindarajan, M.D., Refik Saskin, M.Sc., Andrew S. Wilton, M.Sc., and Nancy N. Baxter, M.D., Ph.D.

ABSTRACT

BACKGROUND

Evidence from observational studies that the use of surgical safety checklists results in striking improvements in surgical outcomes led to the rapid adoption of such checklists worldwide. However, the effect of mandatory adoption of surgical safety checklists is unclear. A policy encouraging the universal adoption of checklists by hospitals in Ontario, Canada, provided a natural experiment to assess the effectiveness of checklists in typical practice settings.

3.76 to 3.96) before implementation and 3.82% (95% CI, 3.71 to 3.92) afterward (odds ratio, 0.97; 95% CI, 0.90 to 1.03; P=0.29).

CONCLUSIONS

Implementation of surgical safety checklists in Ontario, Canada, was not associated with significant reductions in operative mortality or complications. (Funded by the Canadian Institutes of Health Research.)

From the Institute for Clinical Evaluative Sciences (D.R.U., A.G., R.S., A.S.W., N.N.B.), the Department of Surgery (D.R.U., A.G., N.N.B.) and Institute of Health Policy, Management and Evaluation (D.R.U., N.N.B.), University of Toronto, the University Health Network (D.R.U.), Mount Sinai Hospital

2014

NO IMPACT

The trouble with CHECKLISTS

An easy method that promised to save lives in hospitals worldwide may not be so simple after all.

WHY CHECKLISTS FAIL

Operating-theatre staff at ten UK hospitals were interviewed about the barriers to implementing the World Health Organization surgical checklist. The biggest problems were:

Staff resisted or failed to complete the checklist.

"When the surgeons weren't on board you were told to 'Oh shut up and let's get on with it.'"

The checklist was inappropriate or illogical.

"It's a bit bizarre and there's a sense of, I'm not actually progressing the patient care with this question."

The checklist was thought to waste time.

"Yet more delay! Oh gosh, we're going to get less work done for the patients."

Operating Room Crisis Checklists

BRIGHAM AND WOMEN'S HOSPITAL

HARVARD SCHOOL OF PUBLIC HEALTH

A JOINT CENTER FOR HEALTH SYSTEMS INNOVATION

>> Do not remove book from this room <<

Revised July 2013 (072413.1)

Based on the OR Crisis Checklists at www.projectcheck.org/crisis.
All reasonable precautions have been taken to verify the information contained in this publication.
The responsibility for the interpretation and use of the materials lies with the reader.

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6 Failed Airway

2 unsuccessful intubation attempts by an airway expert

START

1. **Call for expert anesthesiology help and a code cart**
   - **Ask**: *"Who will be the crisis manager?"*
2. **Get Difficult Airway Cart and a video laryngoscope**
3. **Bag-mask ventilate** with **100% oxygen**
4. **Is ventilation adequate?**

Ventilation **NOT ADEQUATE**

NOT ADEQUATE

- **Optimize ventilation**
  - Reposition patient
  - Oral airway/nasal airway
  - Two-handed mask
- **Check equipment**
  - Using 100% O_2
  - Capnography
  - Circuit integrity
- **Check ventilation**

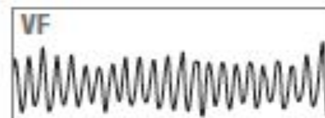
Remains **NOT ADEQUATE**

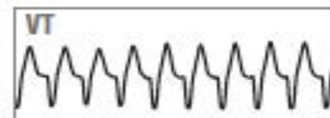
- **Place laryngeal mask airway (LMA) or other supraglottic (SG) device**
- **If unsuccessful, attempt intubation using video laryngoscope**
- **Prepare for surgical airway** (prep neck, get tracheostomy kit, call for surgeon)
- **Re-check ventilation**

Still **NOT ADEQUATE**

- **Implement surgical airway**

5 Cardiac Arrest – VF/VT





Shockable pulseless cardiac arrest

START

1. **Call for help and a code cart**
   - **Ask**: *"Who will be the crisis manager?"*
   - **Say**: "*Shock patient as soon defibrillator arrives*"
2. **Put backboard under patient, supine position**
3. **Turn FiO_2 to 100%, turn off volatile anesthetics**
4. **Start CPR — defibrillation — assessment cycle**
   - **Perform CPR**
     - "Hard and fast" about 100 compressions/min
     - Ensure full chest recoil with minimal interruptions
     - 8 breaths/minute, do not overventilate
   - **Defibrillate**
     - Shock at highest setting
     - Resume CPR immediately after shock
   - **Give epinephrine**
     - Repeat epinephrine every 3 – 5 minutes
     - Can give vasopressin to replace 1st or 2nd dose of epinephrine
   - **Consider giving antiarrhythmics for refractory VF/VT** (amiodarone preferred, if available)
   - **Assess every 2 minutes**
     - Change CPR compression provider
     - Check $ETCO_2$
       If: < 10 mm Hg, evaluate CPR technique
       If: Sudden increase to > 40 mm Hg, may indicate return of spontaneous circulation
     - Treat reversible causes, consider reading aloud Hs & Ts (see list in right column)
     - Check rhythm; if rhythm organized check pulse
       If: VF/VT continues: Resume CPR – defibrillation – assessment cycle (restart Step 4)
       If: Asystole/PEA: *go to* ▷ CHKLST 4

DRUG DOSES and treatments

Epinephrine:	1 mg IV, repeat every 3 – 5 mins.
Vasopressin:	40 U IV can replace 1st or 2nd dose of epinephrine

ANTIARRHYTHMICS

Amiodarone:	• 1st dose: 300 mg/IV/IO • 2nd dose: 150 mg/IV/IO
Magnesium:	1 to 2 g IV/IO for Torsades de Pointes

DEFIBRILLATOR instructions

1. Place electrodes on chest.
2. Turn defibrillator ON, set to DEFIB mode, and increase ENERGY LEVEL...
   - Biphasic: Follow manufacturer recommendation; if unknown use highest setting
   - Monophasic: 360J
3. Deliver shock: press CHARGE then press SHOCK.

Hs & Ts

- Hydrogen ion (acidosis)
- Hyperkalemia
- Hypothermia
- Hypovolemia
- Hypoxia
- Tamponade (cardiac)
- Tension pneumothorax
- Thrombosis (coronary/pulmonary)
- Toxin (local anesthetic, beta blocker, calcium channel blocker)

During CPR

Airway:	Bag-mask sufficient (if ventilation adequate)
Circulation:	• Confirm adequate IV or IO access • Consider IV fluids wide open
Assign roles:	Chest compressions, Airway, Vascular access, Documentation, Code cart, Time keeping

11 Malignant Hyperthermia

In presence of triggering agent: unexpected, unexplained increase in end-tidal CO_2, unexplained tachycardia/tachypnea, prolonged masseter muscle spasm after succinylcholine. Hyperthermia is a late sign.

START

1. **Call for help and a code cart**
   - ▶ **Ask**: ***"Who will be the crisis manager?"***
2. **Get Malignant Hyperthermia Kit**
3. **Call MH Hotline 1.800.644.9737**
4. **Assign dedicated person to start mixing dantrolene**
5. **Request chilled IV saline**
6. **Turn off volatile anesthetics** and **transition to non-triggering** anesthetics
   - **DO NOT** delay treatment to change circuit or CO_2 absorber
7. **Turn FiO_2 to 100%**
8. **Hyperventilate patient** at flows of 10 L/min or more
9. **Terminate procedure**, if possible
10. **Give dantrolene**
11. **Give bicarbonate** for suspected metabolic acidosis (maintain pH >7.2)
12. **Treat hyperkalemia**, if suspected
13. **Treat dysrhythmias**, if present
    - Standard antiarrhythmics are acceptable; **DO NOT use** calcium channel blockers
14. **Send labs**
    - Arterial blood gas
    - Electrolytes
    - Serum creatine kinase (CK)
    - Serum/urine myoglobin
    - Coagulation profile
15. **Initiate supportive care**
    - ▶ Consider cooling patient if temperature > 38.5°C:
      - **STOP** cooling if temperature < 38°C
      - Lavage open body cavities
      - Nasogastric lavage with cold water
      - Apply ice externally
      - Infuse cold saline intravenously
    - ▶ Place Foley catheter, monitor urine output
    - ▶ Call ICU

DRUG DOSES and treatments

Drug	Dose
Dantrolene	• Mix each ampule with 60 cc sterile water • 2.5 mg/kg IV every 5 minutes until symptoms subside • May require up to 30 mg/kg
Bicarbonate (for suspected metabolic acidosis)	• 1 – 2 mEq/kg, slow IV push

HYPERKALEMIA treatment

Drug	Dose
Calcium gluconate *- or -*	• 30 mg/kg
Calcium chloride	• 10 mg/kg IV
Insulin	• 10 units regular IV • 1 – 2 amps D50W

TRIGGERING AGENTS

- Inhalational (volatile) anesthetics
- Succinylcholine

DIFFERENTIAL diagnosis

Cardiorespiratory
- Hypoventilation
- Sepsis

Endocrine
- Thyrotoxicosis
- Pheochromocytoma

Iatrogenic
- Exogenous CO_2 source (e.g., laparoscopy)
- Overwarming
- Neuroleptic Malignant Syndrome

Neurologic
- Meningitis
- Intracranial bleed
- Hypoxic encephalopathy
- Traumatic brain injury

Toxicology
- Radiologic contrast neurotoxicity
- Anticholinergic syndrome
- Cocaine, amphetamine, salicylate toxicity
- Alcohol withdrawal

All reasonable precautions have been taken to verify the information contained in this publication. The responsibility for the interpretation and use of the materials lies with the reader. Revised July 2013 (072413.1)

Human Error

"The single greatest impediment to error prevention in healthcare 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

Demanding Perfection
vs.
No Harm No Foul

Just Culture

Balancing “no blame”
with individual accountability

“At-Risk Behavior” Defined

- “Behavioral choice that increases risk where risk is not recognized or is mistakenly believed to be justified”
- Conscious choice to do something other what is defined in policy, protocol, law, or accepted safety norms

At Risk Behavior

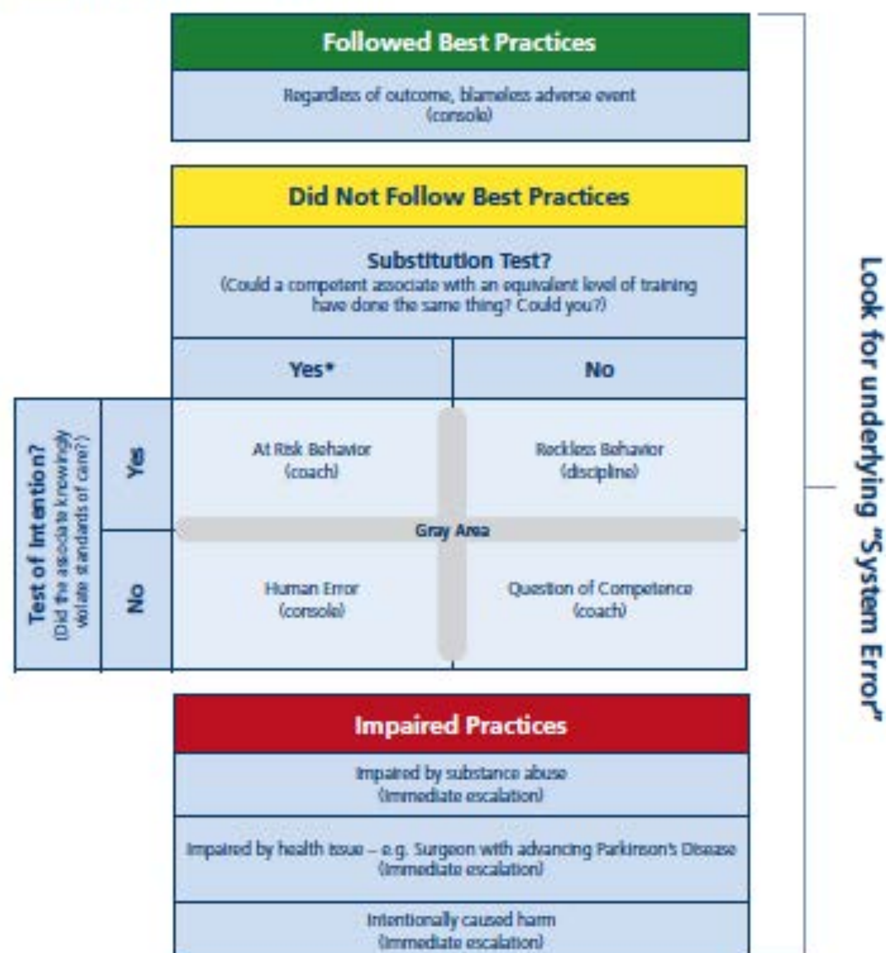
- Normalized deviance
- Workaround
- Drift

“Reckless Behavior” Defined

- Conscious behavioral choice to disregard a substantial and unjustifiable risk
- No intention to cause harm

JUST CULTURE TOOL

Influenced by the works of James Reason[1] and David Marx[2,3]



*** When a associate passes the substitution test, question the effectiveness of current practice and evaluate for "Normalization of Deviance".[4] Normalization of Deviance is defined as the gradual drift away from best practices until a deviant behavior is commonplace among associates (e.g. ignoring an alarm, bypassing a safety check, etc.).**

1. Reason J. Managing the risks of organizational accidents. Aldershot: Ashgate Publishing Group; 1997
2. Marx D. Whack-a-Mole: The Price We Pay for Expecting Perfection. By Your Side Studios; 2009
3. Marx D. Patient safety and the "just culture": a primer for health care executives. New York: Trustees of Columbia University; 2001
4. Vaughan D. The Challenger launch decision: risky technology, culture and deviance at NASA. Chicago, IL: University of Chicago Press; 1996

Created by Montefiore's Patient Safety Program.
Questions? Jason Adelman, MD, MS, Patient Safety Officer 718-920-6699, jadelman@montefiore.org

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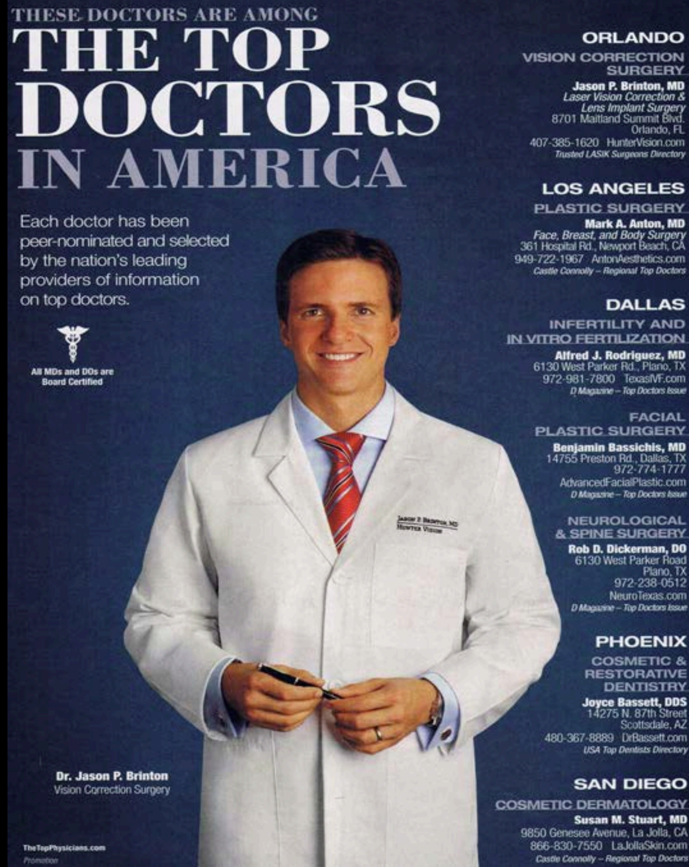
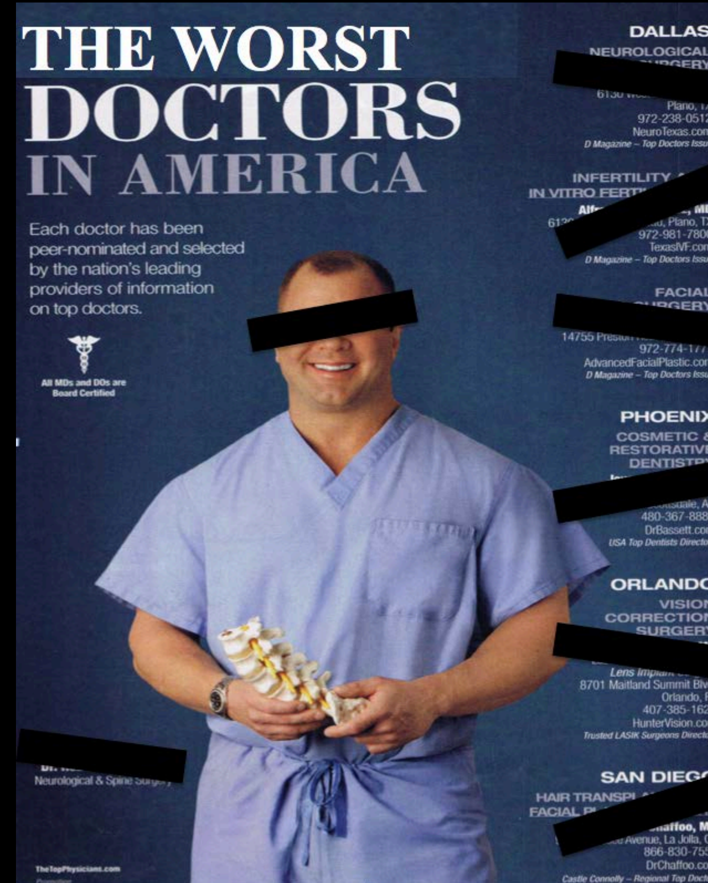
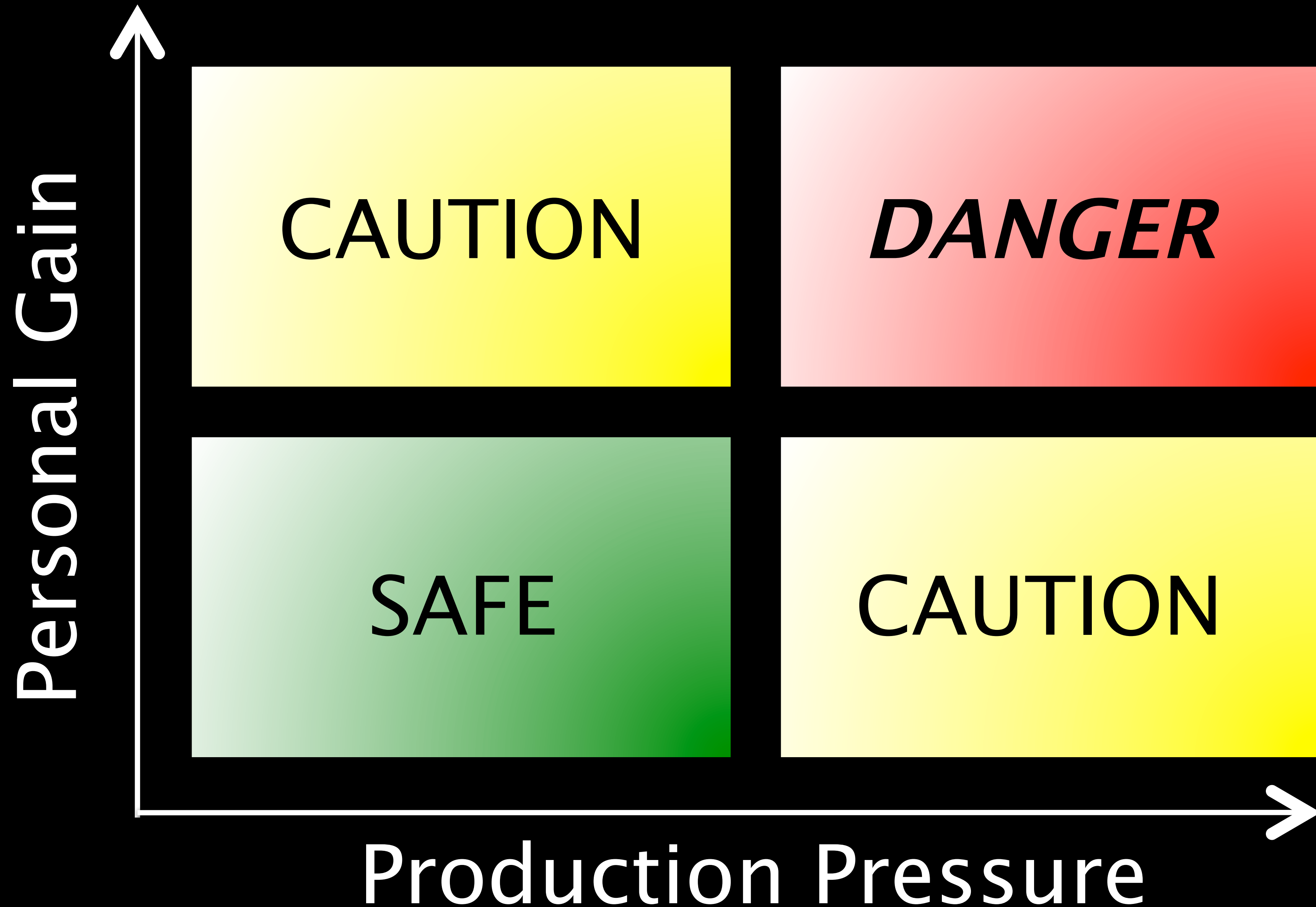
Inspired Medicine

Doctor's Aren't Perfect





Two Dimensions of Ethical Behavior



The Third Dimension

- Likelihood of being caught
- Integrity

Unnecessary Heart Procedures

UNNECESSARY HEART PROCEDURES

STENT FRAUD LAWYERS

REPRESENTING PATIENTS HURT BY
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& HEART CATHETERIZATION

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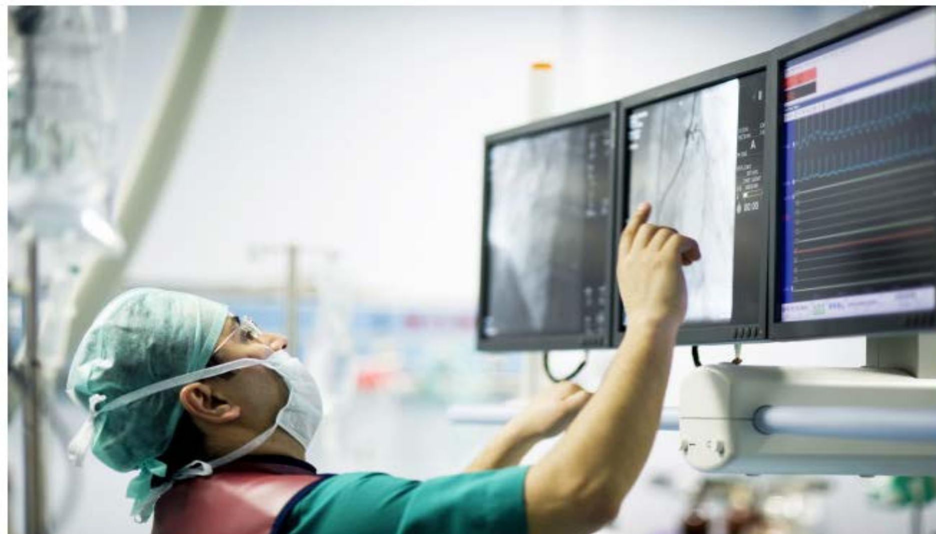
Are Doctors Exposing Heart Patients to Unnecessary Cardiac Procedures?

A U.S. News analysis finds some doctors may be putting patients at risk - and reaping the benefits in Medicare payments.



Dozens of cardiologists outside major metro areas are performing a far greater number of catherization procedures than those working at big city hospitals

The Role of Physician Leaders

Leaders vs. Managers

"Managers do things right,
but leaders do the right things"

» ***Warren Bennis***

Competition

Hierarchy

Autonomy

1.7k
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492
Tweet
195
Share
1
Submit
53
+1
0
reddit

PHARMA & HEALTHCARE | 11/02/2012 @ 11:20AM | 25,624 views

Do Starbucks Employees Have More Emotional Intelligence than Your Physician?

21 comments, 2 called-out + Comment Now + Follow Comments

A cranky customer snaps at his barista, lodging an unjustifiable complaint about the service, the temperature of the drink… about anything and everything. He came into the store angry (and in pain from a chronic illness) and he needed something–or someone!–to take it out on. He is met by a well-trained smile, the barista doling out a few words of sympathy while bending over backwards to make sure he knows she has taken his complaint seriously.

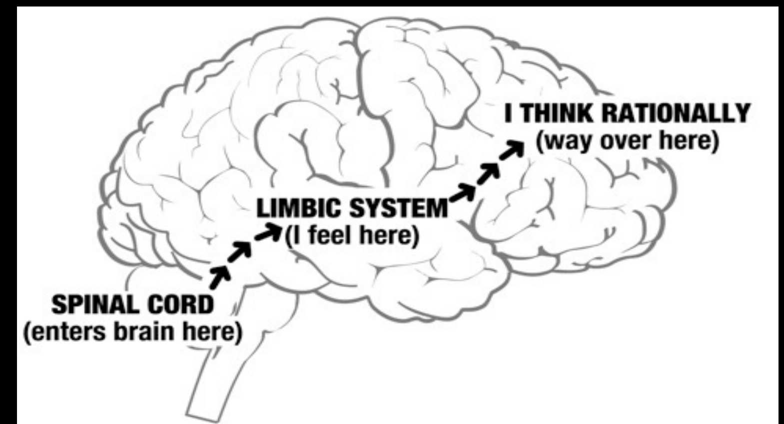
A Starbucks barista. (Photo credit: Wikipedia)

LATTE

- Listen
- Acknowledge
- Take action
- Thank
- Encourage to visit again

Emotional Intelligence

- The ability to identify, assess, and control the emotions of oneself, of others, and of groups
- A balance of personal and social awareness and competence



Teamwork Defined

A joint action by a group of people, in which each person subordinates his or her individual interests and opinions to the unity and efficiency of the group

A Team of Experts

An Expert Team

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Improving Safety Culture

Executive Leadership Support

- ***Culture is the foundation for vision and strategy*.** A culture characterized by fear and self-protection will not lend itself to openness, learning, and improvement.

- ***Transparency is the key to change the culture*.** An unwillingness to face and share the hard facts is an indicator of denial, and denial is not compatible with a safe environment.

- ***Safety must be the overarching strategy*.**

- ***Leaders must take ownership for setting the climate and focusing the work*.**

Sentinel Event Alert

August 27, 2009

Issue 43, August 27, 2009

Revised September 8, 2009*

Leadership committed to safety

Leadership is a critical function in promoting high quality, safe health care. In health care organizations, leadership is provided by the governing body, the chief executive and senior managers, and the leaders of the clinical staff. When a sentinel event occurs in a health care organization, inadequate or ineffective leadership is often one of the contributing factors. In fact, inadequate leadership was a contributing factor in 50 percent of the sentinel events reported to The Joint Commission in 2006. (1) Research shows that leadership makes a major difference in the quality and safety of patient care. (2,3,4,5,6,7,8) "Leaders must recognize that all sentinel events involve a failure in the systems and processes which led to the event," says Jeff Selberg, CEO of Exempla Healthcare. "As leaders, we are accountable for those systems and processes which provide the framework for the clinical environment our staff works within. My first priority is to understand how we improve our clinical environment to reduce the possibility of doing harm."

Health care organizations have not developed the "zero-defect" safety interventions seen in other high-risk industries such as aviation, energy and manufacturing. (8,9) But health care is moving in that direction. Progressive health care leaders have begun to apply lessons learned in other industries to reduce risk and strengthen the defenses against preventable patient harm in health care environments. (2,3,8)

The Joint Commission

The Role of Hospital Leaders in Patient Safety

Hospital leaders provide the foundation for an effective patient safety system by doing the following: [9]

- Promoting learning
- Motivating staff to uphold a fair and just safety culture
- Providing a transparent environment in which quality measures and patient harms are freely shared with staff
- Modeling professional behavior
- Removing intimidating behavior that might prevent safe behaviors
- Providing the resources and training necessary to take on improvement initiatives

The Joint Commission Journal on Quality and Patient Safety

5 Million Lives Campaign

Getting Boards on Board: Engaging Governing Boards in Quality and Safety

James Conway, M.S.

This article is the sixth and final in the series on the 5 Million Lives Campaign, the Institute for Healthcare Improvement's national initiative that aims to protect patients from five million incidents of medical harm in United States hospitals between December 2006 and December 2008.

HealthAffairs

At the Intersection of Health, Health Care and Policy

By Ashish Jha and Arnold Epstein

Hospital Governance And The Quality Of Care

ABSTRACT Hospitals' boards may influence the quality of care that hospitals provide, but their engagement in quality-related issues is largely unknown. We surveyed a nationally representative sample of board chairs of 1,000 U.S. hospitals to understand their expertise, perspectives, and activities in clinical quality. We found that fewer than half of the boards rated quality of care as one of their two top priorities, and only a minority reported receiving training in quality. The large differences in board activities between high-performing and low-performing hospitals we found suggest that governing boards may be an important target for intervention for policymakers hoping to improve care in U.S. hospitals.

What Killed Joan Rivers?

"When I die...
I want my funeral to be a huge showbiz affair with **lights, cameras, action.** I want Craft services, I want paparazzi and I want publicists making a scene! I want it to be Hollywood all the way. I don't want some rabbi rambling on; **I want Meryl Streep crying**, in five different accents. I don't want a eulogy; I want Bobby Vinton to pick up my head and sing "Mr. Lonely." **I want to look gorgeous, better dead than I do alive.** I want to be buried in a Valentino gown and I want Harry Winston to make me a toe tag. And I want a wind machine so that **even in the casket my hair is blowing just like Beyonce's."**

-Joan Rivers, "I Hate Everyone...Starting With Me"

CBS EVENING NEWS

We Can Do Better

Takeaways

- Assess and confront your culture
- Ensure psychological safety
- Enable frontline staff to speak up
- Implement Just Culture with intention
- Embrace checklists
- Get your Board on board

Ken Rothfield, MD, MBA

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