New Frontier - Patient Safety in Ambulatory and Outpatient Settings

Eastern Regional PS&Q Symposium

10 September 2014

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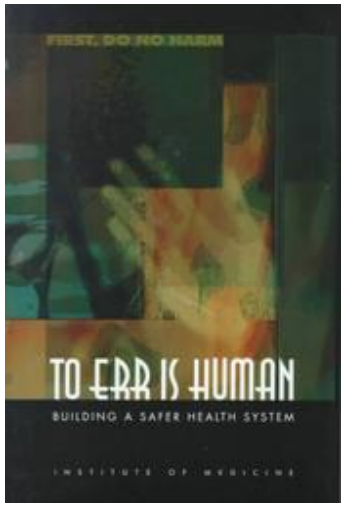


Death By Numbers

44,000 to 98,000 patient deaths per year from medical errors

To Err is Human, Institute of Medicine (1999)

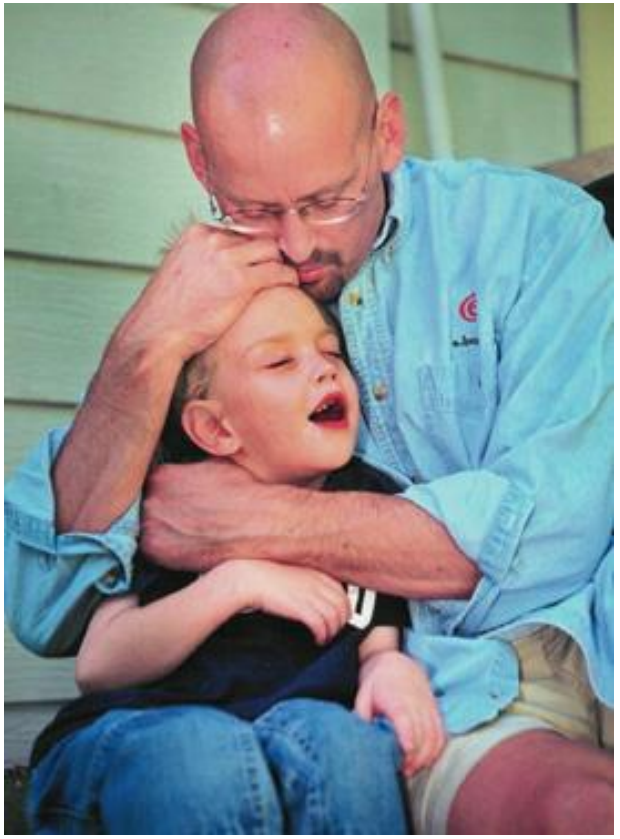
James Estimate

210,000 to 440,000 patients, each year, suffer from preventable harm that contributes to their death.

James, John, *A New Evidence-based Estimate of Patient Harms…*
Journal of Patient Safety, September **2013**, Volume 9, Issue 3

Darrie Eason – Misdiagnosis

Sebastian Ferrero – Medication Error



Patrick Sheridan – Misdiagnosis
Cal Sheridan - Misdiagnosis

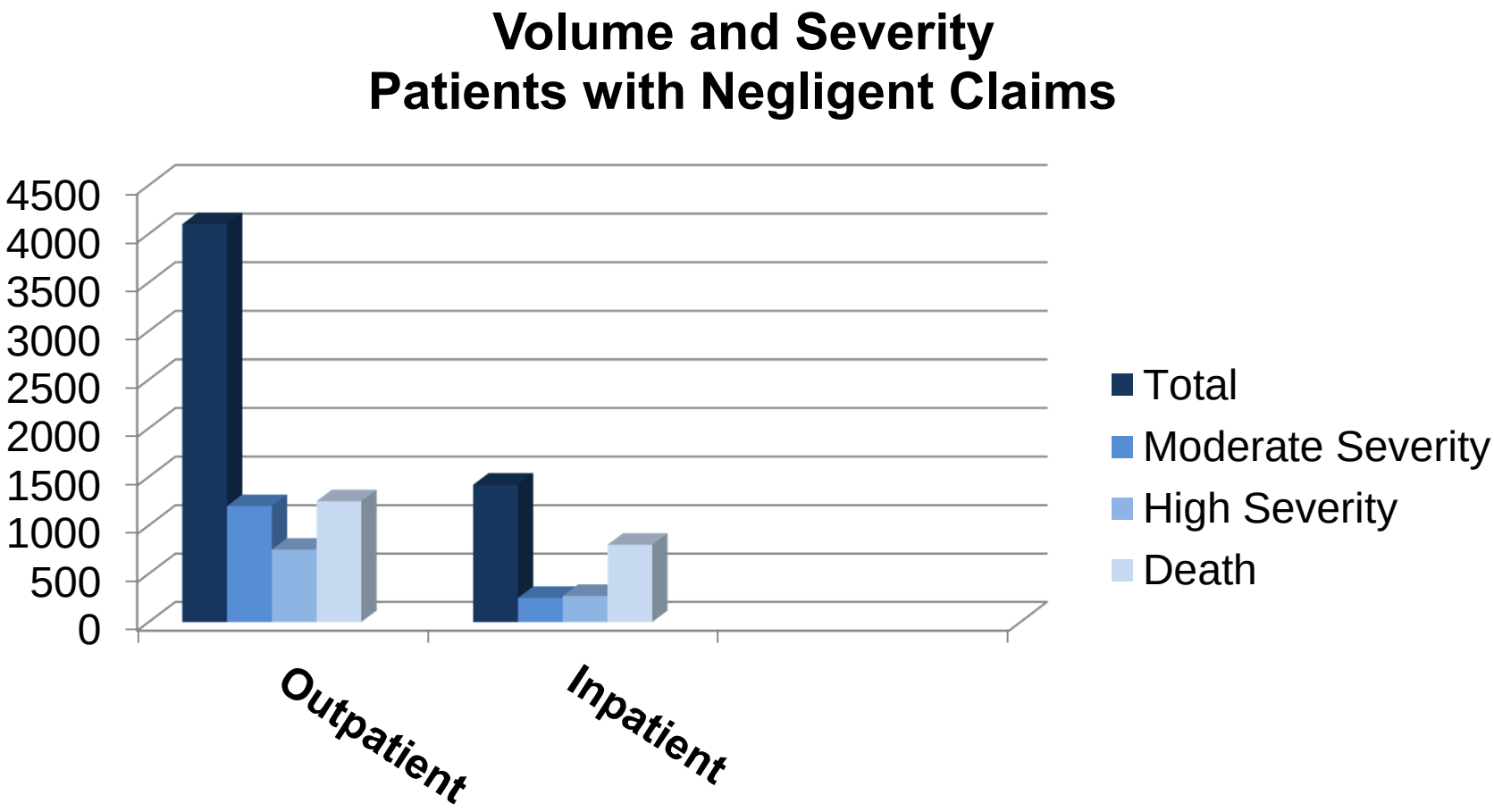
Patient Exposure

35 million hospital discharges annually

900 million clinic visits annually

Outpatient visits occur 25 times more frequently than hospital admissions

Outpatient vs. Inpatient Injuries



Source: Phillips RL Qual Saf Health Care 2004;13:121-126

What Will It Take?

Patient Safety WalkRounds

+

Address Patient Safety Alerts

+

Non-Punitive Approach to Reporting

+

TeamSTEPPS

+

Strategies in Targeted Outcomes

***BUT…* Will This Produce Significant Sustained Reduction in Serious Safety Events & Culture Change Across the Organization?**

Reliability Culture - Genius of the AND

Safety Focus	+	*performed as intended consistently over time*	=	No Harm zero EVENTS OF HARM
Evidence-Based Process Bundles	+	*performed as intended consistently over time*	=	Clinical Excellence Distinguished Hospital HEALTHGRADES 2010 Clinical Excellence
Patient Centered	+	*performed as intended consistently over time*	=	ñSatisfactionò CG-CAHPS
		HIGH RELIABILITY		
Financial Focus	+	*performed as intended consistently over time*	=	Margin STANDARD &POOR'S

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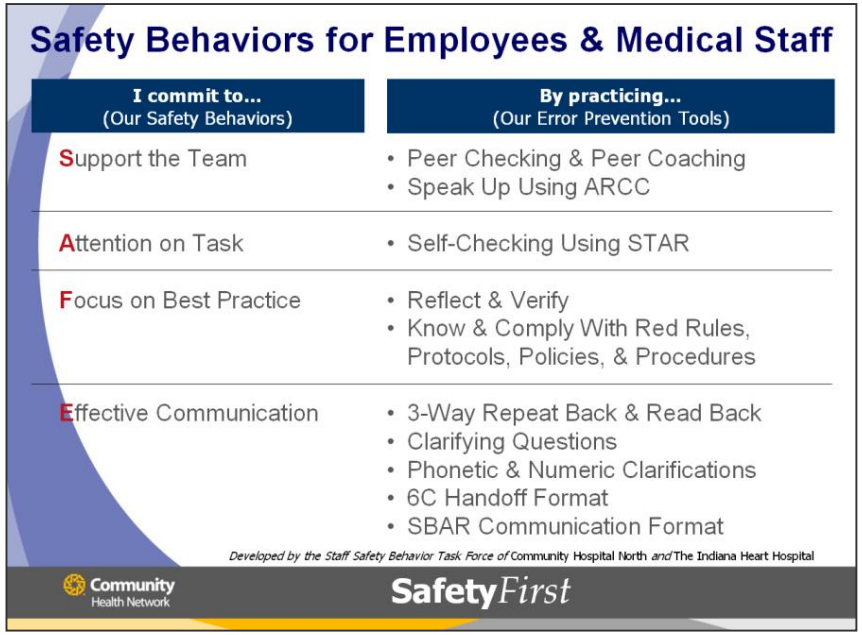
Published Cases

1. **Memorial Health University Health System** ï 89% serious harm reduction, Clinical Advisory Board, 2005
2. **Sentara Healthcare** ï 80% serious harm reduction overall (50% harm reduction in 18 months) - AHA Quest for Quality Award 2004, Eisenberg Quality Award 2005
3. **Advocate HealthCare** - ñCan Your Nurses Stop a Surgeon?ò *Hospitals & Health Networks*, September 2007
4. **Children's National Medical Center** ï 70% serious harm reduction, Journal of Healthcare Risk Management, 2012
5. **Nationwide Children's Hospital** ï 83% serious harm reduction, Journal of Pediatrics, 2013
6. **Memorial Hermann Health System** ï certified zero awards for harm on units, Eisenberg Quality Award, 2012
7. **Vidant Health** ï 83% serious harm reduction overall, 62% HAI reduction, and 98% optimal care (core measures). TJC Eisenberg Quality Award, 2013
8. **WellStar Health System** ï 90% serious patient harm reduction and 84% worker injury reduction, NPSF Annual Patient Safety Conference, 2014
9. **VCU Medical Center** ï 50% serious harm reduction, AHA Quest for Quality Award 2014

Process Bundle + People Bundle

4 for VAP Prevention

1. Elevation of the head of the bed to between 30 and 45 degrees
2. Daily ñsedation vacationò and daily assessment of readiness to extubate
3. Peptic ulcer disease (PUD) prophylaxis
4. Deep venous thrombosis (DVT) prophylaxis (unless contraindicated)



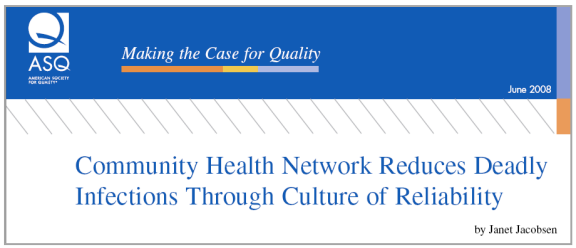
Safety Behaviors for Employees & Medical Staff

I commit to... (Our Safety Behaviors)	By practicing... (Our Error Prevention Tools)
Support the Team	• Peer Checking & Peer Coaching • Speak Up Using ARCC
Attention on Task	• Self-Checking Using STAR
Focus on Best Practice	• Reflect & Verify • Know & Comply With Red Rules, Protocols, Policies, & Procedures
Effective Communication	• 3-Way Repeat Back & Read Back • Clarifying Questions • Phonetic & Numeric Clarifications • 6C Handoff Format • SBAR Communication Format

Developed by the Staff Safety Behavior Task Force of Community Hospital North *and* The Indiana Heart Hospital

Community Health Network — SafetyFirst

Read More: *Community Health Network Reduces Deadly Infections Through Culture of Reliability*, American Society for Quality (June 2008)



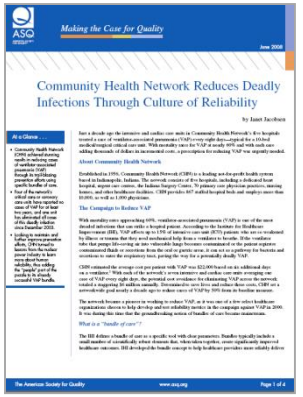
ASQ

Making the Case for Quality

June 2008

Community Health Network Reduces Deadly Infections Through Culture of Reliability

by Janet Jacobsen

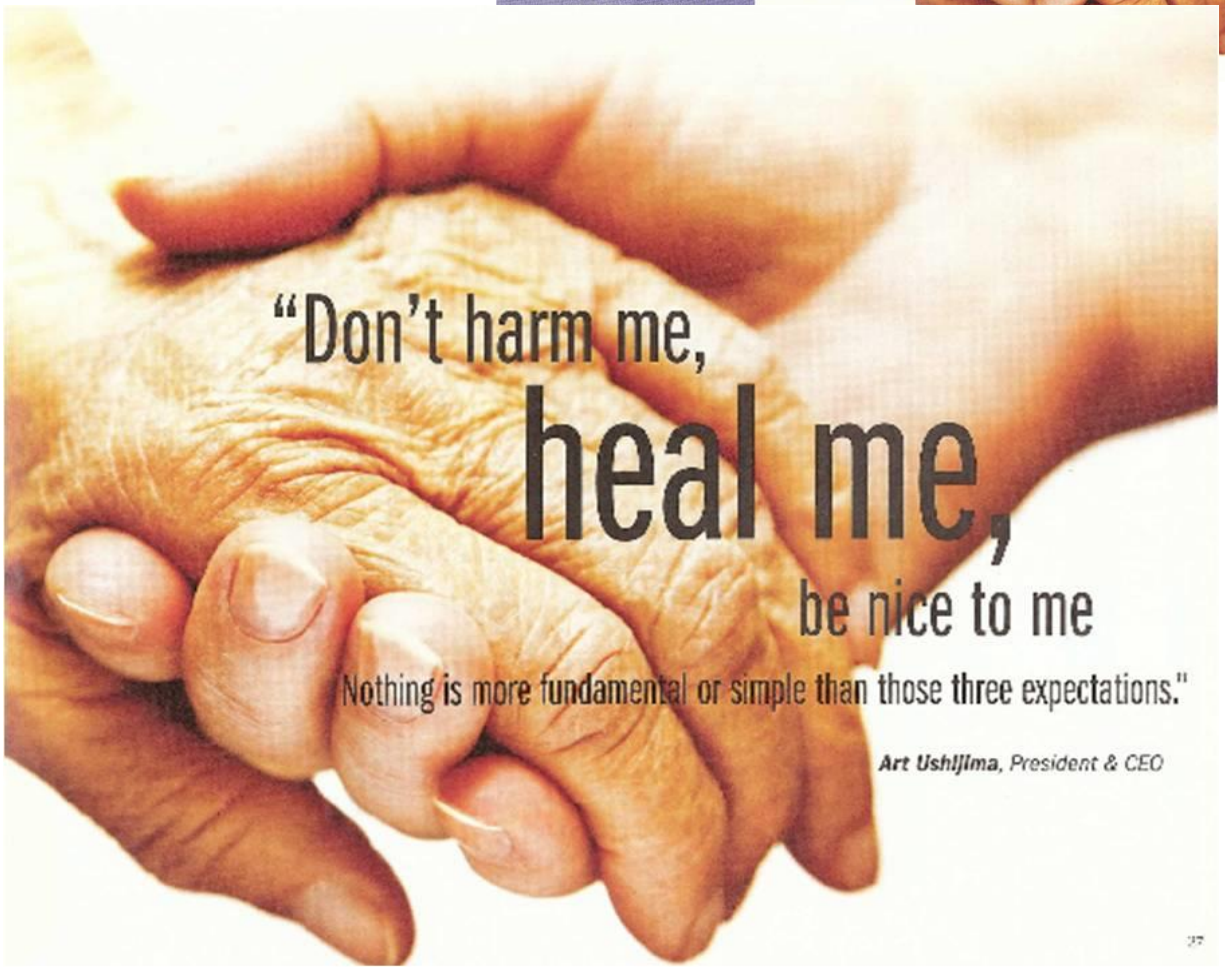


ASQ

Making the Case for Quality

Community Health Network Reduces Deadly Infections Through Culture of Reliability

HPI®



Kina' ole (flawlessness)

Doing the right thing in the right way, at the right time, in the right place, to the right person, for the right reason, with the right feeling, the first time.

Fiscal Year 2012 Playbook, *Queen's Medical Center, Honolulu, HI*

Changing Behaviors

Set Expectations

Educate & Build Skill

Reinforce & Build Accountability

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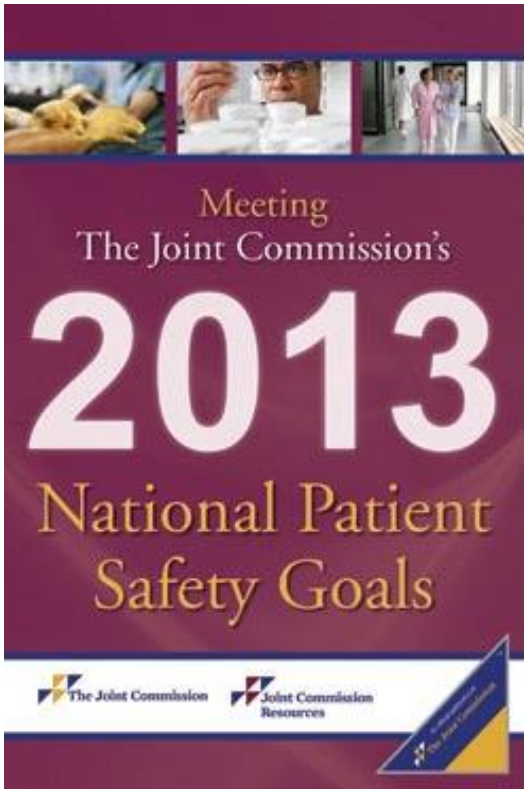
More Rules or More Tools?



Focused on several known harm events
Synergy with policy & protocol

Coverage on broad range of harm events
Synergy with people, process, and technology

HPI Compare

Medical Office Practice
Common Cause Analysis Data
2010-2011

Top 10 Patient Safety Event Types

Based on 1,613 events from 72 hospitals in HPI*Compare* CCA database

Office	All	
44.4%	21.3%	Medication Error (CM1)
17.8%	23.6%	Delay in Diagnosis or Treatment (CM8)
13.3%	2.2%	Wrong Patient Procedure (PR2)
8.9%	10.2%	Fall (EE3)
6.7%	15.2%	Other Care Management (CM10)
4.4%	7.4%	Other Procedural (PR6)
0	4.2%	Retained Foreign Object (PR4)
0	2.2%	Wrong Site Surgery (PR1)
0	1.2%	Suicide or Attempt (PP3)
0	1.1%	Grade 3 or 4 Pressure Ulcer (CM7)

Medical Offices N = 45

HPI Compare

Medical Office Practice
Common Cause Analysis Data
2010-2011

Professional Groups Experiencing Acts in Healthcare Safety Events *Comparison based on 3,112 inappropriate acts from 72 hospitals in HPI CCA Database*		
Office	All	
33.3%	39.0%	Nurse
28.9%	30.6%	Physician
14.0%	2.6%	Nurse Extender / Medical Assistant
7.9%	1.9%	Unit Clerk / Clerical Office Staff
6.1%	2.2%	Management
6.1%	1.6%	Physician Extender
3.5%	7.7%	Technician/Technologist

HPI Compare

Medical Office Practice
Common Cause Analysis Data
2010-2011

Top 10 Acts Leading to Patient Harm *Comparison based on 3,112 acts from72 hospitals in HPI CCA Database*		
Office	All	
28.2%	18.0%	Checking and verifying
13.7%	6.4%	Physician ordering
12.8%	15.6%	Coordinating care
6.8%	6.7%	Administering
5.1%	3.1%	Data Entering and Documenting
4.3%	10.0%	Assessing
4.3%	1.7%	Compensatory Actions
3.4%	3.1%	Preparing/Processing
2.6%	0.5%	Scheduling
2.6%	3.1%	Labeling

HPI

Medical Offices N = 117

HPI *Compare*

Medical Office Practice Common Cause Analysis Data 2010-2011

"How" Data		"Why" Data	
People Causes	HPI*Compare*	**Systems Causes**	HPI*Compare*
Knowledge & Skill	**3.9%** (12.8%)	Structure (job design)	**8.9%** (10.5%)
Attention on task	**19.5%** (15.0%)	Culture (people & people interaction)	**57.4%** (57.3%)
Information processing	**16.9%** (8.7%)	Process	**15.8%** (19.3%)
Critical Thinking	**29.9%** (36.0%)	Policy & Protocol	**5.9%** (8.2%)
Non-Compliance	**15.6%** (21.4%)	Technology & Environment	**11.9%** (4.7%)
Normalized Deviance	**14.3%** (6.0%)	*Culture Preventable* =	**72.7%** (76.3%)
Acts coded for human error	1,820 of 2,845 (64%)	Acts coded for system cause	2,444 of 3,102 (80%)
Based on 1,613 events from 72 hospitals in HPI*Compare* CCA database			

Medical Offices IFM N = 77
SFM N = 101

Questions for Reflection

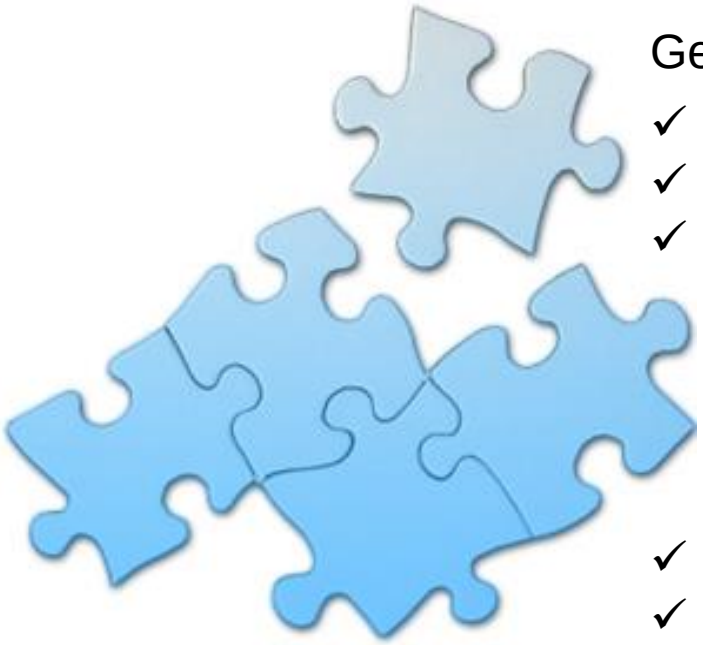
- Do people get well before being discharged from our hospitals?
- Have I prescribed life-saving meds?
- Has EMS transported a patient to my office from long-term care? And back?
- Has my team ever transferred a patient onto an exam table?
- Have I done procedures in the office that would require a time-out in a hospital? Or require the WHO checklist?

Getting Started

1. Authentic ñsafety firstòleadership
2. Safety Culture or Safety Climate assessment (to confirm a firm foundation)
3. Common Cause Analysis:
    a. Rule-out broken process(es) and knowledge & skill deficiencies as majority causes
    b. Select behaviors/skills indicated by study
4. Culture design leaders, staff, and medical staff
5. Educate leaders, staff, and medical staff

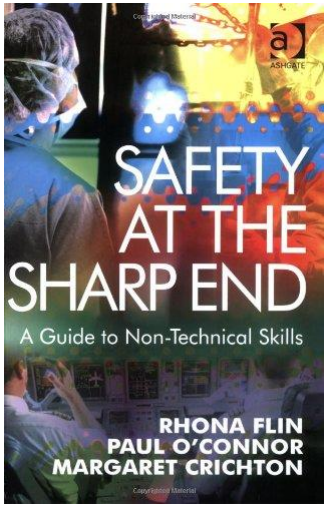
Non-Technical Skills

Non-technical skills describe how people interact with technology, environment, and other people. These skills are similar across a wide range of job functions. These skills include attention, information processing, and cognition.



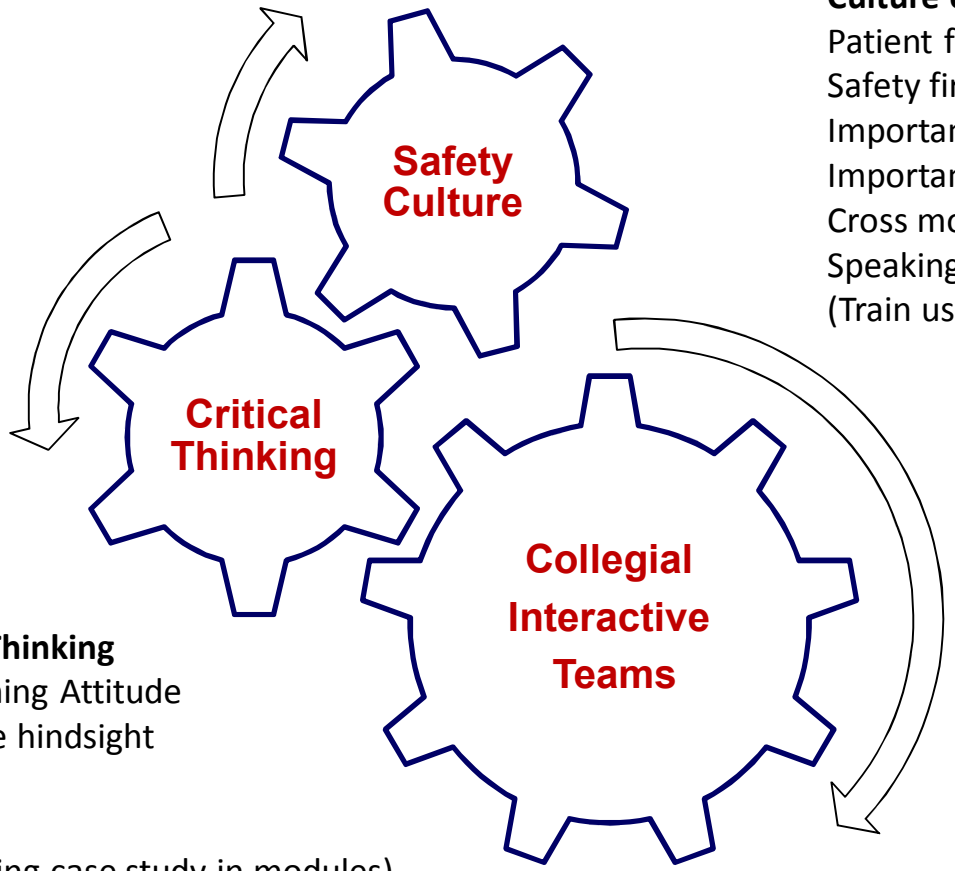
Generic **non-technical skills**:

- ✓ Situational awareness
- ✓ Attention
- ✓ Communication
  - ✓ repeat backs
  - ✓ call outs
  - ✓ phonetic & numeric clarification
  - ✓ clarifying questions
  - ✓ inquiry, advocacy, assertion
- ✓ Critical thinking
- ✓ Protocol use
- ✓ Decision-making



Flin, O'Connor, and Crichton
Safety at the Sharp End

Make Reliability a Reality



Culture of Safety
Patient first, every time
Safety first
Importance of attention (self-check)
Importance of compliance (Red Rules)
Cross monitoring
Speaking-up for safety *as a concept*
(Train using leader modules)

Critical Thinking
Questioning Attitude
Proactive hindsight
STEP
SORT
(Train using case study in modules)

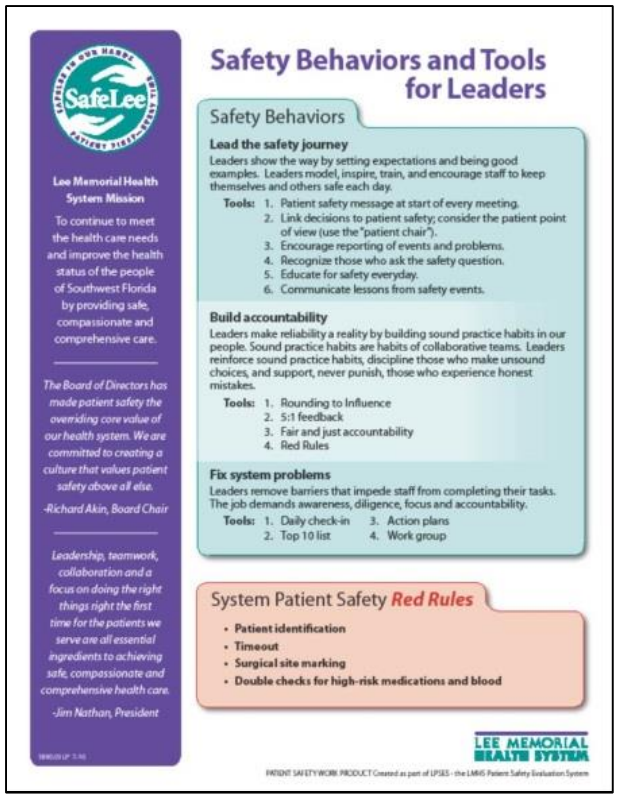
Collegial Interactive Teams
Situational awareness
Communication bundle:
ÅRepeat-back
ÅCall out
ÅPhonetic & numeric clarification
ÅClarifying questions
Speak-up (inquiry-advocacy-assertion)
Brief-Execute-Debrief
(Train in teams using simulation)

STEP = Story, Test story, Eliminate gaps in story, Plan to proceed
SORT = Statement of problem, Options, Rule-out options, Test and take action

Culture Embedding Mechanisms

From *Organizational Culture & Leadership*, by Edgar Schein

Primary Embedding Mechanisms	Secondary Articulation & Reinforcement Mechanisms
ÅWhat **leaders pay attention to**, measure, and control on a regular basis ÅHow **leaders react to critical incidents** and organizational crises ÅObserved criteria by which leaders **allocate scarce resources** ÅDeliberate **role modeling**, teaching, and coaching ÅObserved criteria by which leaders **allocate rewards and status** ÅObserved criteria by which leaders **recruit, select, promote, retire, and excommunicate** organizational members	ÅOrganizational design and structure ÅOrganizational systems and procedures ÅOrganizational rites and rituals ÅDesign of physical space, facades, and buildings ÅStories, legends, and myths about people and events ÅFormal statements of organizational philosophy, values, and creed



Lee Memorial Health System Mission

To continue to meet the health care needs and improve the health status of the people of Southwest Florida by providing safe, compassionate and comprehensive care.

The Board of Directors has made patient safety the overriding core value of our health system. We are committed to creating a culture that values patient safety above all else.

-Richard Akin, Board Chair

Leadership, teamwork, collaboration and a focus on doing the right things right the first time for the patients we serve are all essential ingredients to achieving safe, compassionate and comprehensive health care.

-Jim Nathan, President

Safety Behaviors and Tools for Leaders

Safety Behaviors

Lead the safety journey

Leaders show the way by setting expectations and being good examples. Leaders model, inspire, train, and encourage staff to keep themselves and others safe each day.

Tools:
1. Patient safety message at start of every meeting.
2. Link decisions to patient safety; consider the patient point of view (use the "patient chair").
3. Encourage reporting of events and problems.
4. Recognize those who ask the safety question.
5. Educate for safety everyday.
6. Communicate lessons from safety events.

Build accountability

Leaders make reliability a reality by building sound practice habits in our people. Sound practice habits are habits of collaborative teams. Leaders reinforce sound practice habits, discipline those who make unsound choices, and support, never punish, those who experience honest mistakes.

Tools:
1. Rounding to Influence
2. 5:1 feedback
3. Fair and just accountability
4. Red Rules

Fix system problems

Leaders remove barriers that impede staff from completing their tasks. The job demands awareness, diligence, focus and accountability.

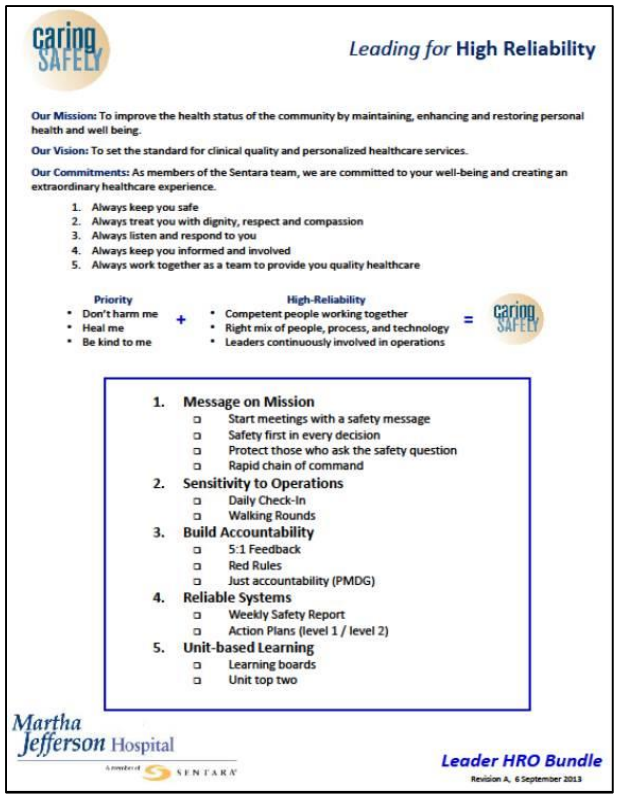
Tools:
1. Daily check-in
2. Top 10 list
3. Action plans
4. Work group

System Patient Safety *Red Rules*

- **Patient identification**
- **Timeout**
- **Surgical site marking**
- **Double checks for high-risk medications and blood**

LEE MEMORIAL HEALTH SYSTEM

PATIENT SAFETY WORK PRODUCT Created as part of LPSES - the LMHS Patient Safety Evaluation System



Leading for **High Reliability**

Our Mission: To improve the health status of the community by maintaining, enhancing and restoring personal health and well being.

Our Vision: To set the standard for clinical quality and personalized healthcare services.

Our Commitments: As members of the Sentara team, we are committed to your well-being and creating an extraordinary healthcare experience.

1. Always keep you safe
2. Always treat you with dignity, respect and compassion
3. Always listen and respond to you
4. Always keep you informed and involved
5. Always work together as a team to provide you quality healthcare

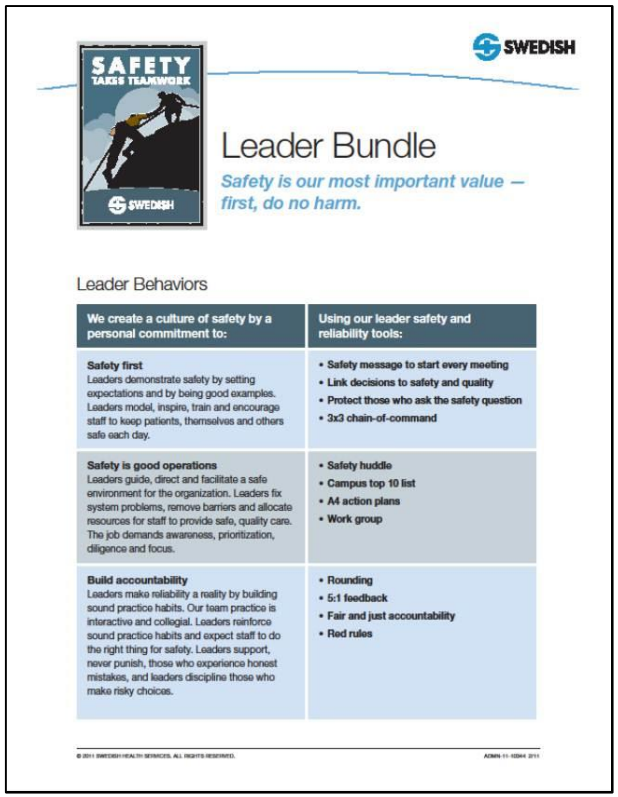
Priority		High-Reliability		
• Don't harm me • Heal me • Be kind to me	+	• Competent people working together • Right mix of people, process, and technology • Leaders continuously involved in operations	=	caring SAFELY

1. **Message on Mission**
   - ☐ Start meetings with a safety message
   - ☐ Safety first in every decision
   - ☐ Protect those who ask the safety question
   - ☐ Rapid chain of command
2. **Sensitivity to Operations**
   - ☐ Daily Check-In
   - ☐ Walking Rounds
3. **Build Accountability**
   - ☐ 5:1 Feedback
   - ☐ Red Rules
   - ☐ Just accountability (PMDG)
4. **Reliable Systems**
   - ☐ Weekly Safety Report
   - ☐ Action Plans (level 1 / level 2)
5. **Unit-based Learning**
   - ☐ Learning boards
   - ☐ Unit top two

Martha Jefferson Hospital
A member of SENTARA

Leader HRO Bundle

Revision A, 6 September 2013



SWEDISH

SAFETY TAKES TEAMWORK

SWEDISH

Leader Bundle

Safety is our most important value — first, do no harm.

Leader Behaviors

We create a culture of safety by a personal commitment to:	Using our leader safety and reliability tools:
Safety first Leaders demonstrate safety by setting expectations and by being good examples. Leaders model, inspire, train and encourage staff to keep patients, themselves and others safe each day.	• **Safety message to start every meeting** • **Link decisions to safety and quality** • **Protect those who ask the safety question** • **3x3 chain-of-command**
Safety is good operations Leaders guide, direct and facilitate a safe environment for the organization. Leaders fix system problems, remove barriers and allocate resources for staff to provide safe, quality care. The job demands awareness, prioritization, diligence and focus.	• **Safety huddle** • **Campus top 10 list** • **A4 action plans** • **Work group**
Build accountability Leaders make reliability a reality by building sound practice habits. Our team practice is interactive and collegial. Leaders reinforce sound practice habits and expect staff to do the right thing for safety. Leaders support, never punish, those who experience honest mistakes, and leaders discipline those who make risky choices.	• **Rounding** • **5:1 feedback** • **Fair and just accountability** • **Red rules**

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ADMN-11-10044 2011

Safety Message

A safety message is a two-minute communication about safety:

1. Share your convictions relative to patient safety or personal safety
2. Explain how safety contributes to our mission
3. Explain how our policy & practice contribute to safety
4. Tell a story about something good that we did
5. Tell a story about something bad that happened to us
6. Tell a story about harm in another healthcare system
7. Tell a story about another system preventing harm
8. Read a Safety Success Story from your people
9. Read a Safety Success Story from Providence
10. Review our safety behaviors
11. Teach applications of our safety behaviors to our jobs
12. Discuss the importance of reporting problems
13. Discuss the importance of speaking-up for safety
14. Ask staff to be safe, and explain how
15. Thank staff for practicing / working safely

7 Elements of Story

Story cuts through the clutter to connect mission to meaning

1. Who is the **protagonist**?
2. What is the hook?
3. What keeps it interesting?
4. Where is the **conflict**?
5. Have you included telling details?
6. What is the ***emotional*** hook?
7. Is the **meaning** clear?

Seven Questions to Sharpen Your Stories, Andy Goodman, 2003.

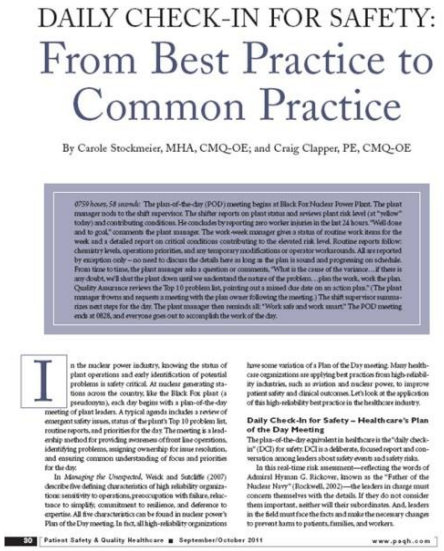
“Talking about safety should not be an event.”

Barbara Summers, President of Community Hospital North

- 9:00-9:15 AM, Monday thru Friday
- Held via conference call
- All departments, all directors
- 100% attendance expectation
- ñstep out of meeting to attendò
- Facilitated by senior leader

Daily Check-In Agenda

1. LOOK BACK ï Significant safety or quality issues from the last 24 hours/last shift
2. LOOK AHEAD ï Anticipated safety or quality issues in next 24 hours/next shift
3. Follow up on Start-the-Clock Safety Critical Issues



DAILY CHECK-IN FOR SAFETY:

From Best Practice to Common Practice

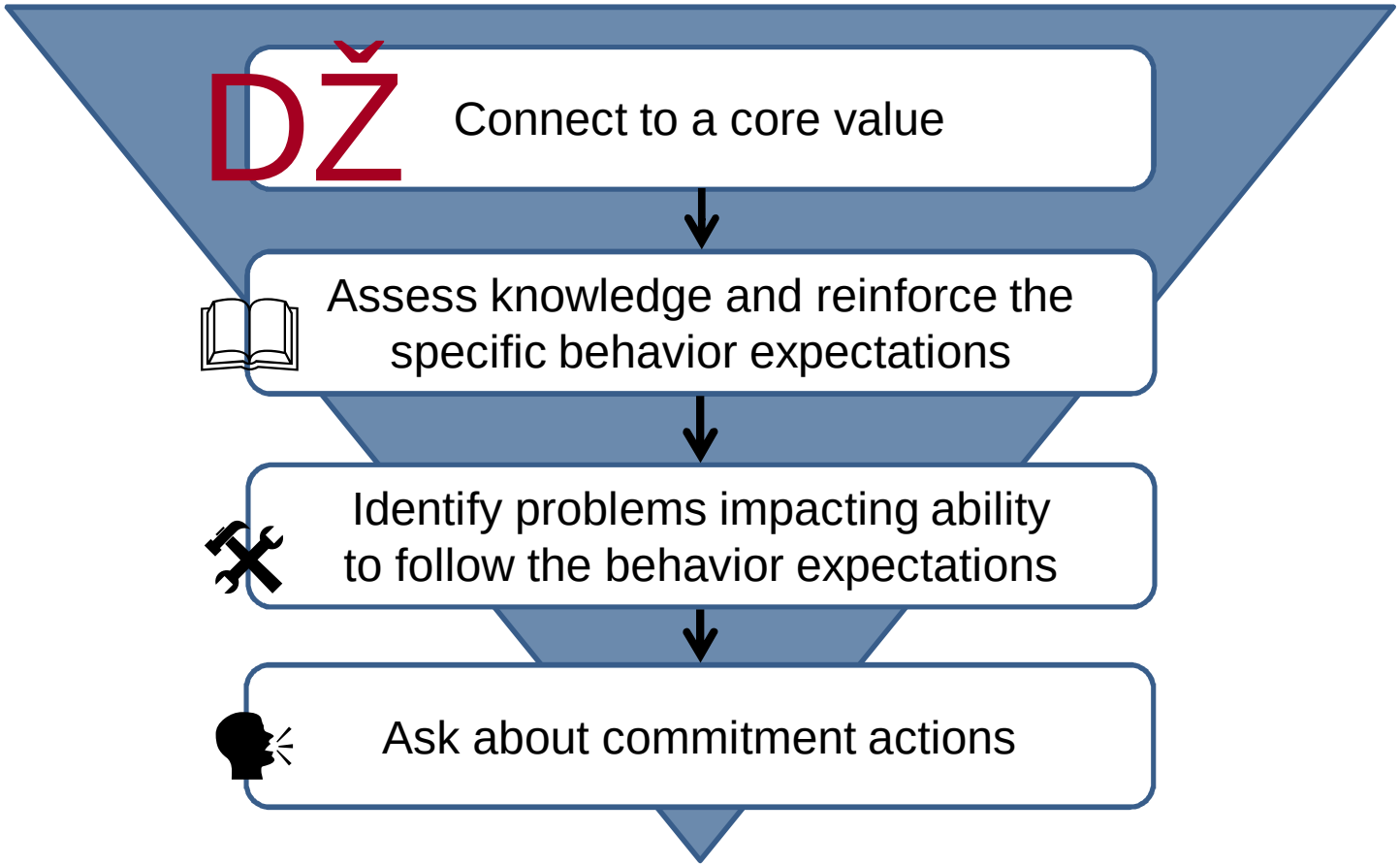
By Carole Stockmeier, MHA, CMQ-OE; and Craig Clapper, PE, CMQ-OE

Daily Check-In for Safety, PS&QH September/October 2011

Rounding to Influence (RTI)

a High Impact/Low Investment Leadership Method

A technique for reinforcing a vital behavior or performance expectation linked to a core value



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RTI ï What@s the Difference?

	Walking Rounds	Rounding To Influence	Genchi Genbutsu *"Go and see for yourself"*	Adopt-a-Unit
Sensitivity to Operations Threshold	Low - Moderate *How do your shoes feel?*	Low - Moderate *Shine your shoes*	Moderate *Take a few steps in their shoes*	High *Walk a mile in their shoes*
Time	30 minutes	5 to10 minutes	> 30 minutes	Recurring visit boluses
Theme	General awareness	Specific focus	Blunt end to sharp end translation of performance expectations	Practical knowledge and experience of unit work
Purpose	Å Identify problems that need to be fixed Å Build relationships	Å Influence a specific behavior expectation Å Identify problems impacting a *specific* performance expectation	Å *Empathy* for sharp end realities Å Identify performance deviations and conditions impacting performance that need remediation	Å *Sympathy* for sharp end realities Å Identify performance deviations and conditions impacting performance that need remediation
Implementing Detail	Global questions	Targeted questions	Observation of behaviors and environment	Participation in work and work life
Location	Work environment or other	Work environment or other	Work environment	Work environment

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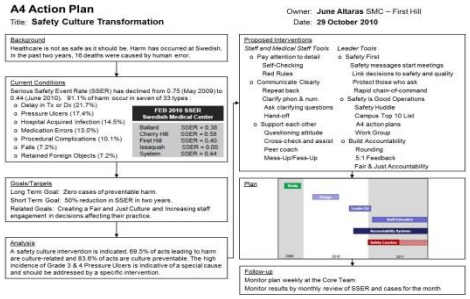
Unit-Based Learning System *Tools*

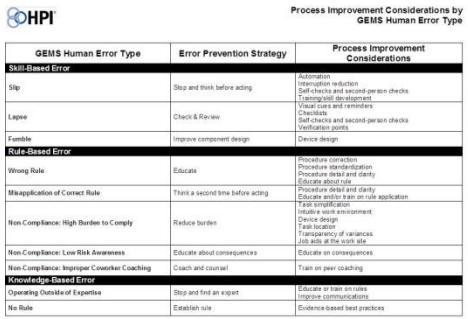
Cause Solving

Process mapping, task analysis, ask why five times, A3 Acton Plan



Process Improvement Guide

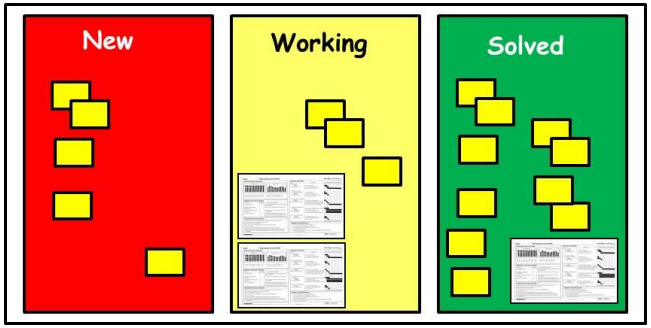
Solutions for human error in the Generic Error Modeling System (GEMS), human factors, protocol, and process



GEMS Human Error Type	Error Prevention Strategy	Process Improvement Considerations
Skill-Based Error		
Slip	Stop and think before acting	Automation Interruption reduction Self-checks and second-person checks Training/skill development
Lapse	Check & Review	Visual cues and reminders Checklists Self-checks and second-person checks Verification points
Fumble	Improve component design	Device design
Rule-Based Error		
Wrong Rule	Educate	Procedure correction Procedure standardization Procedure detail and clarity Educate about rule
Misapplication of Correct Rule	Think a second time before acting	Procedure detail and clarity Educate and/or train on rule application
Non-Compliance: High Burden to Comply	Reduce burden	Task simplification Intuitive work environment Device design Task location Transparency of variances Job aids at the work site
Non-Compliance: Low Risk Awareness	Educate about consequences	Educate on consequences
Non-Compliance: Improper Coworker Coaching	Coach and counsel	Train on peer coaching
Knowledge-Based Error		
Operating Outside of Expertise	Stop and find an expert	Educate or train on rules Improve communications
No Rule	Establish rule	Evidence-based best practices

Learning Boards

Visual management of new, working, and solved problems



What
Senior Leaders
Can Do To Promote
Safety Culture

Set the tone:

- Establish expectations for tones and tools (non-technical skills)
- Say, ñThank youò when someone reports an event or error. Then say, ñLetôs understand how that happenedé ò
- Ask your direct reports to let you know when one of their employees reports and event or error ï go thank that person.
- Ask about events and errors during Daily Check-In.
- Round-To-Influence on the non-technical skills
- Observe and coach operational leaders in their response(s)

What
Operational Leaders
Can Do To Promote
Safety Culture

Reinforce safe practice:

- Share great catches ï a.k.a. Safety Success Stories
- 5:1 feedback for safe practice ï especially non-technical skills
- Diagnoses the cause of human erroré and respond in a fair and just way:
  - ✓ Fix system and management problems causing error
  - ✓ Console and coach for unintended human error
  - ✓ Apply fair consequence for non-compliance
- Lead the local learning system

What
Staff & Physicians
Can Do To Promote
Safety Culture

Personal commitment to safety:

- Put safety first
- Practice non-technical skills
- Report events, errors, and mistakes
- Offer suggestions for improving the systems and processes
- Be eager to learn and apply lessons from events and the experience of others

HPI Client Community count as of December 2013

Craig Clapper, PE, CMQ/OE
Partner & Chief Knowledge Officer

Healthcare Performance Improvement
5041 Corporate Woods Drive, Suite 180
Virginia Beach, VA 23462
Phone: (757) 226-7479 Åwww.hpiresults.com