AN ORIENTATION TO

www.indypatientsafety.org
Members and State-wide Collaborators:

We will **not compete** on safety and will share openly best practice
“The Indianapolis Coalition for Patient Safety is a prime example of how collaboration is accelerating change...among very competitive organizations (and) is a national model for community-based process improvement...”

--Don Berwick, IHI President and CEO

Do not compete on safety!
# Indianapolis Coalition for Patient Safety, Inc.  
## Table of Organization

| Board of Directors | • Health System Chief Executive Officers, One Chief Medical Officer, One representative from Pharmacy, from Nursing, and from Quality/Safety  
|                    | • Governance: approves strategic + annual operations plans, annual budget, Bylaws  
|                    | • Monitors progress and provides oversight for Coalition and Coalition staff  
|                    | • Meets twice annually  

| Executive Work Group | • Chief Medical Officers, Chief Nursing Officers, Patient Safety/Quality Officers, Pharmacy Officers from the Coalition hospitals  
|                     | • Appoints Work Group members  
|                     | • Approves Work Group recommendations  
|                     | • Endorses plans for hospital-level implementation of Coalition priorities  
|                     | • Develops strategic and operations plans  
|                     | • Meets every other month  

| Initiative Specific Work Groups | • Subject Matter Expert representative(s) from Coalition hospitals  
|                               | • Develops strategy, tactics, supporting documents, implementation plans for improvement  
|                               | • Meets at intervals as needed  

| **Individual hospital committees implement initiatives, track/monitor data with guidance from health system’s Coalition representatives** |
Indianapolis Coalition for Patient Safety, Inc.
Peer Review Protection

The Corporation has affiliate hospitals as indicated in IC 34-6-2-117(14)

As a result the Corporation shall be considered as a “Professional Health Care Provider” as defined by IC 34-6-2-117 but only for purposes of the Indiana Peer Review Law, IC 34-30-15
STANDARDIZATION AND IMPLEMENTATION OF BEST PRACTICE

CURRENT WORK GROUPS:
COMMON CAUSE -
HEART FAILURE READMISSION -
MEDICATION SAFETY —
  USP 800
  ASOP
  Standard IV Concentrations
  Medication Safety Symposium

BLOOD SAFETY-
CONTRAST MEDIA USAGE and EXPOSURE -
SMART PUMP Safety
MDRO’s
PERI-OP
PEDIATRICS
SUBSTANCE USE DISORDER
ADVANCE CARE PLANNING
IT/ INFORMATICS
  EPIC User Group (just forming)
RT Group (just forming)
At the conclusion of this symposium the participants will have a better understanding of the elements and strategies necessary to implement and maintain a Culture of Safety at their respective workplaces. They will also have a list of resources available to assist in improvement efforts.
Disclosure Slide

• This program is being jointly provided by Indianapolis Coalition for Patient Safety. Inc. and Franciscan Health.

• The planning committee members and presenters have declared no conflict of interest in providing this program.

• There has been no commercial support for the program

• The criteria for successful completion of the program
  – time in attendance at the event
  – submission of a completed evaluation form

• Franciscan Health is an approved provider of continuing nursing education by the Ohio Nurses Association, an accredited approver by the American Nurses Credentialing Center’s Commission on Accreditation. (OBN-001-91)(OH-407, 6/1/2020)
We are here to serve Indiana hospitals, patients and communities

To advance a health care delivery system that improves health and health care, we are working to:

• Improve quality and patient safety
• Defend and improve reimbursement
• Increase the capacity of the health care workforce
• Strengthen physician supply and physician-hospital relationships
• Influence health care policy and regulations—and in turn, the health status of Indiana citizens
• Assist hospitals in reacting to health reform and situational issues
Indiana Patient Safety Center

• Founded 2006

• Mission to engage and inspire health care providers to create safe cultures and reliable systems of care to prevent patient harm in Indiana
IPSC Strategic Priorities

- AHRQ Safety Culture Surveys
- #123 for Equity
- Person and Family Engagement
- Improvement Science and Change Management
- Patient Safety Organization (PSO) – partnership with the Michigan Health & Hospital Association’s Keystone Center
- Reducing Infant Mortality
- Antimicrobial Stewardship
- Workplace Violence
- Global health care-related harm reduction

To review the 2016 IPSC Annual Report, visit https://www.ihaconnect.org/Quality-Patient-Safety/Pages/Quality-and-Patient-Safety.aspx
Bold Aim

To make Indiana the safest place to receive health care in the United States... 

*if not the world*
Culture of Safety Priority

• Partner with American Hospital Association’s (AHA) Health Research & Educational Trust (HRET) in advancing Indiana in the CMS national harm reduction initiative; current program, Hospital Improvement Innovation Network (HIIN) formerly known as HEN or Hospital Engagement Network

• STRIVE – CDC’s States Targeting Reduction in Infections via Engagement program; CLABSI among targeted infections along with CAUTI, CDI and MRSA

• Partner with other state stakeholders; e.g. Indiana State Department of Health (ISDH) and Association for Professional in Infection Control (APIC) to share best practices and strategies
Regional Patient Safety Coalitions

Key Contacts for the Indianapolis Coalition for Patient Safety

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Madeline Wilson
Patient Safety & Quality Advisor
mwilson@IHAconnect.org

IHAconnect.org/Quality-Patient-Safety
AHRQ Culture of Patient Safety Survey
Safety culture

A culture that exhibits the following five high-level attributes that health care professionals strive to operationalize through the implementation of strong safety management systems.

1. A culture where all workers (including front-line staff, physicians, and administrators) accept responsibility or the safety of themselves, their coworkers, patients, and visitors.
2. [A culture that] prioritizes safety above financial and operational goals.
3. [A culture that] encourages and rewards the identification, communication, and resolution of safety issues.
4. [A culture that] provides for organizational learning from accidents.
5. [A culture that] provides appropriate resources, structure, and accountability to maintain effective safety systems.
AHRQ Patient Safety Culture Composites

- Survey offered to acute care hospitals, behavioral health facilities, surgery centers, physician offices, and extended care facilities
- 42 questions grouped into 12 composite measures, or composites
- 2 questions asking respondents to 1) provide an overall grade on patient safety for their work area/unit and 2) to indicate the number of events they reported over the past 12 months
- Provide limited background demographic information about themselves (work area/unit, staff position, whether they have direct interaction with patients, tenure in their work area/unit, etc.).
### Composites and Definitions

<table>
<thead>
<tr>
<th>Patient Safety Culture Composite</th>
<th>Definition: The extent to which...</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communication Openness</td>
<td>Staff freely speak up if they see something that may negatively affect a patient and feel free to question those with more authority.</td>
</tr>
<tr>
<td>Feedback and Communication About Error</td>
<td>Staff are informed about errors that happen, are given feedback about changes implemented, and discuss ways to prevent errors.</td>
</tr>
<tr>
<td>Frequency of Events Reported</td>
<td>Mistakes of the following types are reported: (1) mistakes caught and corrected before affecting the patient, (2) mistakes with no potential to harm the patient, and (3) mistakes that could harm the patient but do not.</td>
</tr>
<tr>
<td>Handoffs and Transitions</td>
<td>Important patient care information is transferred across hospital units and during shift changes.</td>
</tr>
<tr>
<td>Management Support for Patient Safety</td>
<td>Hospital management provides a work climate that promotes patient safety and shows that patient safety is a top priority.</td>
</tr>
<tr>
<td>Nonpunitive Response to Error</td>
<td>Staff feel that their mistakes and event reports are not held against them and that mistakes are not kept in their personnel file.</td>
</tr>
<tr>
<td>Organizational Learning—Continuous Improvement</td>
<td>Mistakes have led to positive changes and changes are evaluated for effectiveness.</td>
</tr>
<tr>
<td>Overall Perceptions of Patient Safety</td>
<td>Procedures and systems are good at preventing errors and there is a lack of patient safety problems.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Patient Safety Culture Composite</th>
<th>Definition: The extent to which...</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staffing</td>
<td>There are enough staff to handle the workload and work hours are appropriate to provide the best care for patients.</td>
</tr>
<tr>
<td>Supervisor/Manager Expectations and Actions Promoting Patient Safety</td>
<td>Supervisors/managers consider staff suggestions for improving patient safety, praise staff for following patient safety procedures, and do not overlook patient safety problems.</td>
</tr>
<tr>
<td>Teamwork Across Units</td>
<td>Hospital units cooperate and coordinate with one another to provide the best care for patients.</td>
</tr>
<tr>
<td>Teamwork Within Units</td>
<td>Staff support each other, treat each other with respect, and work together as a team.</td>
</tr>
</tbody>
</table>

[Surveys on Patient Safety Culture](http://IHAconnect.org/Quality-Patient-Safety)
Modifications or Changes to Questions

- AHRQ does not recommend making changes to the questions as it may affect reliability and validity of the survey and make comparisons with other hospitals difficult.
- You CAN modify the work areas and staff position names, but are requested to make a crosswalk between the AHRQ defined sites/positions, and your facilities positions.
- You CAN add items to the survey, but should add them to the end of the survey.
- If you should want to make a shorter survey with fewer items, you must delete ALL the items in the specific composite that you do not want to measure.
Who Should Be Surveyed?

- Include staff who have direct contact or interaction with patients.
- Those who do not have direct contact or interaction, but whose work directly affects patient care.
- Hospital employed or contract physicians who spend most of their work hours in the hospital.
- Hospital supervisors, managers, and administrators
Planning

Two of the most important elements of an effective project are a clear budget to determine the scope of your data collection effort and a realistic schedule. Think about your available resources:

- How much money and/or resources are available to conduct this project?
- Who within the hospital is available to work on this project?
- When do we need to have the survey results completed and available?
- Do we have the technical capabilities to conduct this project in the hospital, or do we need to consider using an outside company or vendor for some of the tasks?
Form a Project Team and Facility Lead

• This team will be responsible for defining the scope of your work, the available resources needed, a necessary budget to promote the survey, and deciding on materials needed for promotion. This is a big project, and having a team in place will ensure a smoother culture of safety survey experience. Consider pulling in your marketing and communications team!

• Assign a lead for each site if you are a multiple system network. This person will be responsible for answering questions about the process for responding to the survey, discuss any concerns, and sending an update each week to promote participation.
Offering incentives can be a good way to increase responses to a survey because respondents often ask, “What’s in it for me?”. You may want to offer individual incentives, such as catered lunches for hospital work areas/units with a least a 75% response rate. Be creative and think about what would motivate your physicians and staff to complete the survey.
What happens after the survey is completed?
Analyzing Your Results

- Outside vendor, like IHA
- AHRQ Survey Tool – only for non-modified surveys
- Manual data analysis or internal tool
Analyzing Your Results

<table>
<thead>
<tr>
<th>Time Worked in the Hospital (Years)</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 1 year</td>
<td>117</td>
<td>15%</td>
</tr>
<tr>
<td>1 to 5 years</td>
<td>234</td>
<td>30%</td>
</tr>
<tr>
<td>6 to 10 years</td>
<td>134</td>
<td>17%</td>
</tr>
<tr>
<td>11 to 15 years</td>
<td>116</td>
<td>15%</td>
</tr>
<tr>
<td>16 to 20 years</td>
<td>82</td>
<td>10%</td>
</tr>
<tr>
<td>21 years or more</td>
<td>104</td>
<td>13%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>787</td>
<td>100%</td>
</tr>
</tbody>
</table>

**Overall Patient Safety Grade**
- Excellent: 32%
- Very Good: 52%
- Acceptable: 14%
- Poor: 2%
- Failing: 1%

**Benchmark Comparisons**
- Teamwork Within Units
  - Unit: 80
  - Hospital: 83
  - Ntl Average: 85
  - Ntl 90th: 88

IHAconnect.org/Quality-Patient-Safety
How Are The Responses Scored?

- Responses are converted to “positive, neutral and negative” responses
- About half of the survey questions are reverse worded – meaning you want the respondent to disagree with the statement
- That is factored in to the analysis

10. Staffing

1. We have enough staff to handle the workload. (A2)

   - Strongly Disagree: 1
   - Disagree: 2
   - Neither: 3
   - Agree: 4
   - Strongly Agree: 5

   - Positive: 58%
   - Neutral: 12%
   - Negative: 29%

Reverse Worded Question

2. Staff in this unit work longer hours than is best for patient care. (A5R)

   - Positive: 53%
   - Neutral: 27%
   - Negative: 20%
• Respondents are given the option to provide written comments at the end of the survey. Carefully review these to ensure that they do not contain any information that could be used to identify who wrote the comment or individuals referred to in the comment.

• Much information can be abstracted from these comments to help you in your improvement efforts. Categorize the comments to see if there is a common theme identified.
Tips

Oftentimes leaders are discouraged after seeing their culture of safety survey results, because the data does not reflect a change from the previous survey. Here are some tips to working on your action plan for improvement:

- **Identify one or two areas for improvement.** Choose areas that will have the greatest positive impact on patient safety. Example: Was your Hand off and Communication score low? Did you have comments that reflected why staff responded the way that they did? If you need more information, consider doing a short 2 or 3 question survey monkey or even anonymous paper survey. Have drop boxes by timeclocks or exits so that staff can drop the paper into a box on their way out the door.

- **Do you have a low score that does not reflect your facility’s mission statement or meet regulatory requirements?** Example: Was your Nonpunitive Response to Error score low? Does your staff feel safe and not have a fear of retribution if they self report an error? Do you use near misses to encourage learning and future error prevention? Do you have a staff led safety team in place? Do you use the TeamSTEPPS approach or other culture of safety initiative?
Consider Changing Your Format

• Consider shortening your survey to just the top three areas of opportunity every other year.
• The Joint Commission Requirements state:

  Repeat organizational assessment of safety culture every 18 to 24 months to review progress and sustain improvement. Ensure that the assessment drills down to unit levels, and make these assessments part of strategic measures reported to the board.

  (LD.03.01.01-leaders create and maintain a culture of safety and quality throughout the organization).
The latest edition of the AHRQ Hospital Survey on Patient Safety Culture User Comparative Database Report presents data from 680 U.S. hospitals, providing initial results that hospitals can use to compare their patient safety culture to other U.S. hospitals. The 2016 report also includes a chapter on trending that presents results showing change over time for 326 hospitals that administered the survey and submitted data more than once. The report consists of a narrative description of the findings and four appendixes, presenting data by hospital characteristics and respondent characteristics for the database hospitals overall and separately for the 326 trending hospitals.

**National Top Three Dimensions with the greatest need for improvement efforts:**

1. Staff reporting smooth informational handoffs & care transitions-48% (52% do NOT feel it is a smooth process)
2. Nonpunitive Response to Error-average score 45% (55% feel they DO receive a punitive response to an error)
3. Adequate unit staffing to provide quality care-54% (45% believe staffing is NOT adequate)
## Indiana Statewide Comparative

### Survey Participant Description:

<table>
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<tr>
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<tbody>
<tr>
<td># hospitals Participated in Survey</td>
<td>49</td>
<td>34</td>
<td>62</td>
<td>52</td>
<td>60</td>
<td>48</td>
<td>43</td>
<td>66</td>
<td>52</td>
<td>64</td>
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### AHRQ Comparative Year

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</tr>
</thead>
<tbody>
<tr>
<td>1. Teamwork Within Units</td>
<td>78.6</td>
<td>78.7</td>
<td>79.9</td>
<td>80.7</td>
<td>80.7</td>
<td>81.4</td>
<td>83.6</td>
<td>80.8</td>
<td>82.0</td>
<td>81.9</td>
<td>3.3</td>
</tr>
<tr>
<td>2. Supervisor/Manager Expectations &amp; Actions Promoting Patient Safety</td>
<td>73.3</td>
<td>74.2</td>
<td>73.5</td>
<td>73.4</td>
<td>73.1</td>
<td>74.1</td>
<td>77.5</td>
<td>73.5</td>
<td>74.9</td>
<td>77.4</td>
<td>4.1</td>
</tr>
<tr>
<td>3. Organizational Learning—Continuous Improvement</td>
<td>70.0</td>
<td>70.6</td>
<td>70.9</td>
<td>72.4</td>
<td>70.6</td>
<td>70.7</td>
<td>72.7</td>
<td>67.9</td>
<td>69.1</td>
<td>72.4</td>
<td>2.4</td>
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<td>4. Management Support for Patient Safety</td>
<td>70.2</td>
<td>69.4</td>
<td>70.1</td>
<td>72.5</td>
<td>70.6</td>
<td>69.8</td>
<td>74.7</td>
<td>65.9</td>
<td>68.0</td>
<td>69.7</td>
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<td>5. Overall Perceptions of Patient Safety</td>
<td>62.6</td>
<td>62.2</td>
<td>64.3</td>
<td>65.8</td>
<td>64.8</td>
<td>64.7</td>
<td>70.0</td>
<td>63.5</td>
<td>64.4</td>
<td>66.4</td>
<td>3.8</td>
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<tr>
<td>6. Feedback &amp; Communication About Error</td>
<td>59.6</td>
<td>59.7</td>
<td>59.9</td>
<td>64.5</td>
<td>63.3</td>
<td>65.5</td>
<td>68.9</td>
<td>65.1</td>
<td>67.4</td>
<td>64.1</td>
<td>4.5</td>
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<td>7. Communication Openness</td>
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<td>60.8</td>
<td>60.0</td>
<td>60.0</td>
<td>60.6</td>
<td>63.7</td>
<td>60.0</td>
<td>62.2</td>
<td>61.2</td>
<td>1.2</td>
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<tr>
<td>8. Frequency of Events Reported</td>
<td>56.5</td>
<td>56.3</td>
<td>57.1</td>
<td>61.8</td>
<td>61.5</td>
<td>62.4</td>
<td>66.4</td>
<td>62.3</td>
<td>64.7</td>
<td>61.6</td>
<td>5.1</td>
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<td>9. Teamwork Across Units</td>
<td>53.2</td>
<td>53.5</td>
<td>53.4</td>
<td>55.3</td>
<td>55.0</td>
<td>55.8</td>
<td>60.0</td>
<td>55.2</td>
<td>56.3</td>
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<tr>
<td>10. Staffing</td>
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<td>54.9</td>
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<td>51.7</td>
<td>51.0</td>
<td>52.9</td>
<td>-4.5</td>
</tr>
<tr>
<td>11. Handoffs &amp; Transitions</td>
<td>39.1</td>
<td>39.5</td>
<td>39.7</td>
<td>39.8</td>
<td>39.7</td>
<td>41.6</td>
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<td>40.6</td>
<td>41.3</td>
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<td>3.4</td>
</tr>
<tr>
<td>12. Nonpunitive Response to Errors</td>
<td>43.1</td>
<td>43.0</td>
<td>43.4</td>
<td>42.5</td>
<td>42.4</td>
<td>43.7</td>
<td>46.9</td>
<td>42.8</td>
<td>45.1</td>
<td>47.3</td>
<td>4.2</td>
</tr>
</tbody>
</table>

**AHRQ Comparative Year - AHRQ starting releasing national comparative data every other year starting in 2012**

_IHAconnect.org/Quality-Patient-Safety_
ICPS Results

Response Range  ICPS Average  AHRQ Average
### ICPS Results

<table>
<thead>
<tr>
<th>Category</th>
<th>ICPS Average</th>
<th>AHRQ Average</th>
<th>Difference</th>
<th>Highest Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Teamwork Within Units</td>
<td>82</td>
<td>82</td>
<td>0</td>
<td>86</td>
</tr>
<tr>
<td>2. Supervisor/Manager - Promoting Patient Safety</td>
<td>76</td>
<td>78</td>
<td>-2</td>
<td>83</td>
</tr>
<tr>
<td>3. Org. Learning/Continuous Improvement</td>
<td>70</td>
<td>73</td>
<td>-3</td>
<td>76</td>
</tr>
<tr>
<td>4. Management Support for Patient Safety</td>
<td>64</td>
<td>72</td>
<td>-8</td>
<td>75</td>
</tr>
<tr>
<td>5. Overall Perceptions of Patient Safety</td>
<td>61</td>
<td>66</td>
<td>-5</td>
<td>76</td>
</tr>
<tr>
<td>6. Feedback &amp; Communication about Error</td>
<td>63</td>
<td>68</td>
<td>-5</td>
<td>70</td>
</tr>
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<td>61</td>
<td>64</td>
<td>-3</td>
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<td>8. Frequency of Events Reported</td>
<td>58</td>
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<td>-7</td>
<td>57</td>
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<td>48</td>
<td>45</td>
<td>3</td>
<td>71</td>
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</tbody>
</table>
## HRET-HIIN Resources

**CULTURE OF SAFETY**

### 2017 UPDATE

**Fostering a Culture that Fully Integrates Patient and Workforce Safety**

**Drivers in This Change Package**

<table>
<thead>
<tr>
<th>Change Idea</th>
</tr>
</thead>
<tbody>
<tr>
<td>Demonstrate the commitment to safety at all levels of the organization</td>
</tr>
<tr>
<td>Commit and communicate the priority of patient and workforce safety</td>
</tr>
<tr>
<td>Build systems and processes that integrate patient and workforce safety</td>
</tr>
<tr>
<td>Engage all team members in the commitment to safety, including patients and their families</td>
</tr>
<tr>
<td>Support a culture that balances a systems approach and individual accountability</td>
</tr>
<tr>
<td>Foster a culture of trust, reporting and learning</td>
</tr>
<tr>
<td>Create a reporting mechanism that is easy to use, meaningful, and has a built-in feedback process</td>
</tr>
<tr>
<td>Promote reflective learning and improvement</td>
</tr>
<tr>
<td>Design and ensure a safe work environment</td>
</tr>
<tr>
<td>Provide training on processes to support and improve patient and workforce safety</td>
</tr>
<tr>
<td>Furnish staff with necessary equipment and supplies</td>
</tr>
</tbody>
</table>

IHAAconnect.org/Quality-Patient-Safety
Culture of Safety Top Ten Checklist

1. Include patient- and workforce safety data and improvement activities in presentations to the board, as well as in unit level and organization quality and safety meetings.

2. Implement daily leadership safety huddles to create shared understanding of patient and workforce safety vulnerabilities, foster mutual support and disseminate information about safety events.

3. Institute Leadership Walkrounds/Patient Safety Rounds, integrating both patient-safety and workforce safety issues.散步 rounding gives leaders the opportunity to observe processes and activities first-hand, patient/patients and families about their barriers and concerns, and gather ideas for improvements.

4. Encourage reporting of patient safety events, near misses and work conditions that present physical hazards or psychological safety risks. Make reporting easy and ensure that processes exist for confidential and anonymous reporting, if needed. Reward reporting and celebrate “good catches.”

5. Establish reporting, peer-observation and escalation processes to quickly address disruptive, unprofessional, and disrespectful behaviors.

6. Appreciate and acknowledge small wins and positive behaviors. Schedule team celebrations and integrate storytelling to prioritize joy and meaning in work and foster well-being.

7. Implement a safe patient handling and movement program. Involve frontline teams in choosing equipment and developing and implementing training programs.

8. Conduct a hazard assessment for conditions that contribute to unsafe work conditions, including risks for needlestick and injuries, infection transmission, musculoskeletal injuries, disruptive behavior, bullying, and workplace violence.

9. Utilize simulation training with interprofessional teams to promote effective team behaviors, situational awareness, mutual trust, and anticipatory critical thinking. Use ReadBack® communication training and process design as an opportunity to develop improved team communications.

10. Use a standard approach to balance individual accountability with leadership accountability for systems issues when addressing adverse events. Integrate support for team members involved in an adverse patient event or workplace violence event as part of the response.
CEO Resource From IHI/NPSF

This resource is organized into six leadership domains that require CEO focus and dedication to develop and sustain a culture of safety.

1.) Establish a compelling vision for safety.
2.) Build trust, respect, and inclusion.
3.) Select, develop, and engage your Board.
4.) Prioritized safety in the selection and development of leaders.
5.) Lead and reward a just culture.
6.) Establish organizational behavior and expectations.

http://www.npsf.org/page/cultureofsafty
Resources


http://www.who.int/patientsafety/research/ps_online_course_session1_intro_1in1_english_2010_en.pdf

http://www.hret-hiin.org/topics/culture-of-safety.shtml

https://www.jointcommission.org/topics/patient_safety.aspx

https://www.jointcommission.org/assets/1/18/SEA_57_Safety_Culture_Leadership_0317.pdf

http://www.npsf.org/page/cultureofsafety
Questions
Our IPSC Team

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IHAnnect.org/Quality-Patient-Safety
Root Cause Analysis Process

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Medication Safety Program Manager
Roudebush VA Medical Center

Amy L. Sprague, DNP, RN, ACNS-BC, CCRN
Patient Safety Manger
Roudebush VA Medical Center
Objectives

• Review the history of the Patient Safety Program within the VA.

• Examine Safety Assessment Code Scoring aka SAC scoring.

• Apply SAC scoring to adverse events.

• Discuss the National Center for Patient Safety’s RCA process.
History of Patient Safety within the VA

1997
Veterans Health Administration places special focus on patient safety

1998
First version of patient safety handbook is published

1999
National Center for Patient Safety opens
Institute of Medicine publishes “To Err is Human”
Updated version of Patient Safety Handbook is published
VA Patient Safety Program

• Health Care is a system

• Reporting Adverse events and close calls

• Emphasis on prevention and not punishment

• Foundation is the RCA process
Adverse Events and Close Calls

• Adverse Events
  – Untoward incidents,
  – Therapeutic misadventures
  – Iatrogenic injuries
  – Other adverse occurrences directly associated with care

• Close Calls/near miss

• All adverse events and close calls are entered into Patient Safety Information System “WebSPOT”
Safety Assessment Code

- Developed by the VHA National Center for Patient Safety
- Two dimensional matrix
- Provides consistent categorization
- Prioritizes a particular event
Safety Assessment Code

- Two categories combined in a matrix
  - **Severity** - Catastrophic, Severe, Moderate, Minor
  - **Probability** - frequent, occasional, uncommon, remote (in the context of your facility)
- Matrix Score:
  - 3 = highest risk
  - 2 = intermediate risk
  - 1 = lowest risk
## Safety Assessment Matrix

<table>
<thead>
<tr>
<th>Probability &amp; Severity</th>
<th>Catastrophic</th>
<th>Major</th>
<th>Moderate</th>
<th>Minor</th>
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</thead>
<tbody>
<tr>
<td>Frequent</td>
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</tbody>
</table>
# Safety Assessment Code

<table>
<thead>
<tr>
<th>Catastrophic</th>
<th>Major</th>
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</thead>
</table>
| **Patients with Actual or Potential:** Death or major permanent loss of function (sensory, motor, physiologic, or intellectual) **not related to the natural course of the patient’s illness or underlying condition** (i.e., acts of commission or omission). This includes outcomes that are a direct result of injuries sustained in a fall; or associated with an unauthorized departure from an around-the-clock treatment setting; or the result of an assault or other crime. Any of the adverse events defined by the Joint Commission as reviewable “Sentinel Events” should also be considered in this category (see App. A, subpar. 1b). | **Patients with Actual or Potential:** Permanent lessening of bodily functioning (sensory, motor, physiologic, or intellectual) **not related to the natural course of the patient’s illness or underlying conditions** (i.e., acts of commission or omission) or any of the following:  
  a. Disfigurement  
  b. Surgical intervention required  
  c. Increased length of stay for three or more patients  
  d. Increased level of care for three or more patients |
| Moderate | Minor |
| **Patients with Actual or Potential:** Increased length of stay or increased level of care for one or two patients | **Patients with Actual or Potential:** No injury, nor increased length of stay nor increased level of care |
Sentinel Events

• Unanticipated death or major or permanent loss of function, not related to natural course of illness or conditions
• Suicide of any patient receiving care or within 72 hours of discharge
• Unanticipated death of a full-term infant
• Abduction of any patient receiving care, treatment and services
• Discharge of an infant to the wrong family
• Rape
• Hemolytic transfusion reaction
• Surgery on the wrong patient or wrong body part
• Severe neonatal hyperbilirubinemia
• Prolonged Fluoroscopy
# Safety Assessment Code

<table>
<thead>
<tr>
<th><strong>Catastrophic</strong></th>
<th><strong>Major</strong></th>
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</thead>
<tbody>
<tr>
<td><strong>Patients with Actual or Potential:</strong></td>
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</tr>
</tbody>
</table>
Probability Categories

- Frequent: Likely to occur immediately or within a short period (may happen several times in a year)
- Occasional: Probably will occur (may happen several times in 1 to 2 years)
- Uncommon: Possible to occur (may happen sometime in 2 to 5 years)
- Remote: Unlikely to occur (may happen sometime in 5 to 30 years)
Actual vs Potential Score

- Actual Score: What Really Happened

- Potential Score: What may have happened, or could with a future event

- Any SAC score **Potential or Actual** of 3 = RCA

- Aggregate Events: Medication Errors, Falls or Missing Patients
Example Case #1

- Nursing staff was providing care for a patient. The patient was seated in a shower chair being washed when he slide off the chair and hit his face, hip and shoulder. The patient was examined by the doctor and transferred to our Acute Evaluation Unit for further evaluation where X-rays were ordered. No fractures were noted the patient returned to his ward bed, and neuro checks were initiated per policy.
### Safety Assessment Matrix

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<th>Probability &amp; Severity</th>
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## What is the SAC Score

<table>
<thead>
<tr>
<th></th>
<th>Actual</th>
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<tbody>
<tr>
<td>Severity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Probability</td>
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</table>

Is an RCA Required?

Aggregate?
What is the SAC Score

<table>
<thead>
<tr>
<th></th>
<th>Actual (2)</th>
<th>Potential (3)</th>
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<tbody>
<tr>
<td>Severity</td>
<td>Moderate</td>
<td>Major</td>
</tr>
<tr>
<td>Probability</td>
<td>Frequent</td>
<td>Frequent</td>
</tr>
</tbody>
</table>

Is an RCA Required?  Yes

Aggregate?  Yes
Example Case #2

• Patient ordered 100% oxygen via facemask by the Primary Care Physician to correct a low PaO2. Patient Condition did not improve despite being on 100% oxygen during a 17 hour period. When the PCP returned and moved the bed to begin intubation, it was discovered the patient was not on oxygen. The tubing had been attached to the medical air flow meter. The patient did not require intubation, no further action was required. What is the SAC Score?
# Safety Assessment Matrix

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Is an RCA Required?

Aggregate?
What is the SAC Score

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Is an RCA Required? Yes

Aggregate? No
Example Case #3

• Two patients with the last name of Jones were on the same unit. Nurse gave morning medications for Mr. J. Jones to Mr. L Jones but there was no harm to the patient. Mr. J Jones was receiving Digoxin 0.25 mg daily, Verapamil 80 mg every 6 hours, Furosemide 120 mg twice daily, captopril 12.5 mg twice daily and Potassium Chloride 10 mEq twice daily. Mr. L Jones was prescribed digoxin 0.125 mg daily, and captopril 12.5 mg three times daily.

• What is the SAC Score?
## Safety Assessment Matrix

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| Probability | Actual | Potential |

Is an RCA Required?

Aggregate?
### What is the SAC Score

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Is an RCA Required?  Yes

Aggregate?  Yes
Root Cause Analysis

- Analysis focuses on SYSTEMS and PROCESSES rather than individual performance
- Focus is on finding vulnerabilities in the system & developing countermeasures
- Measure effectiveness of those countermeasures (i.e., fixes)
- Interdisciplinary team
- Team members are chartered that are most familiar with the process
- 5 - 7 people, with Team Leader
RCA process

• Chartered when the event is known to the facility
• Must be completed within 45 days of charter
  – Includes concurrence signature of facility director
  – Team members
• Process mapping, triage questions, cause and effect diagraming
• Includes at least one root cause statement and action plan
• Scored by NCPS
NCPS Scoring

• Root Cause Statements
  – Cause: Something
  – Effect: leads to something
  – Event: which increases the likelihood that something will occur

• Incorrect: The nurse was fatigued
• Correct: Nurses are scheduled 16 hours per day, which led to increase levels of fatigue, increasing the likelihood of medication administration errors
NCPS Scoring

• Stronger Actions
  – Architectural/physical Plant changes
  – New device with usability testing before purchasing
  – Engineering control or interlock
  – Simplify the process and remove unnecessary steps
  – Standardize on Equipment or process care maps
  – Tangible involvement and action by leadership in support of patient safety
  – High Reliability training
NCPS Scoring

• Intermediate Actions
  – Increase in staffing/decrease workload
  – Software enhancements/modifications
  – Eliminate/reduce distractions
  – Checklists/cognitive aids
  – Eliminate Look Alike Sound Alike
  – Read back
  – Enhanced documentation/communication
  – Redundancy
  – Training Using Simulation
NCPS Scoring

• Weaker Actions
  – Double Checks
  – Warnings and labels
  – New procedure/memorandum/policy
  – Training
  – Additional study/analysis
Resources

- Included RCA tools
- RCA Step by Step by step guide
- Root Cause Analysis flow Charts
- Patient Safety Handbook
References

Questions/Comments
Managing Risk in the Development of New Processes

Utilizing a FMEA to Evaluate Risk in the Development and Implementation of a Temporary Instrument Decontamination Facility

Indianapolis Coalition for Patient Safety (ICPS) Nursing Leadership Forum
August, 29 2017
Renovating Sterile Processing Decontamination Area

• Renovation process presented many unknowns
  ▪ Area was part of original structure of the hospital
  ▪ Contained original floor with piping underneath

• Initial renovation plan was to be completed in four (4) stages or a period of 24 months

• High surgery volumes throughout the renovation period, placing associates in potentially poor work conditions

• Increased risk to patient safety
The Opportunity

Utilize Mobile Decontamination Trailers During Renovation

• **Benefits**
  - Shorten renovation period from 24 months to 6 months
  - Reduced disruption to daily operations
  - Improved overall associate working conditions during construction
  - Increase capability over existing facility

• **Challenges**
  - Permitting: Approach new to State of Indiana
  - Location: Available real estate requires substantial “outside” transportation to access mobile units.
  - Process: Utilization of mobile units for decontamination forced new processes to be developed.
  - High likelihood of mobile unit operation during Joint Commission Survey
The Opportunity

Definition of Success

To develop processes and policies around the implementation and operation of the mobile decontamination units to support a reduced renovation schedule without increase risk to patient and associate safety, while maintaining compliance with standards and regulations.

Secondary Measures of Success

Utilize the opportunity to challenge historical process and practices to develop more efficient and effective management of decontamination flow that could be translated into the new area once renovation was complete.
Establishing the Plan

- Established baseline process and site plans with focused team with members from the OR, sterile processing, facilities, construction, and mobile unit support team.

- Due to the complexity of the implementation and operation required to support the mobile units, team quickly recognized the need to assess and mitigate potential risk.

- Agreement reached to utilize a Failure Modes and Effect Analysis (FMEA) to access and identify risk for further planning and development.
What is an FMEA?

FMEA = Failure Mode Effects Analysis

An FMEA is a tool and methodology that can help:

• Proactively ask “What if?” to identify the ways a process may fail and why it might fail
• Determine effects and impact of that failure
• Access and prioritize potential failures for further action
  • Eliminate the possibility of intolerable failures/errors
  • Control/minimize the consequences of unavoidable failures/errors
• Develop countermeasure to prevent, control, or to detect failures.
• Support and facilitate process improvement
History of FMEA

• First used in the 1960’s in the Aerospace industry during the Apollo missions

• In 1974, the Navy developed MIL-STD-1629 regarding the use of FMEA

• In the late 1970’s, the automotive industry was driven by liability costs to use FMEA

• Entered Healthcare in 1990’s when Six Sigma and Lean Principles were seen as viable process improvement methodologies.
Historically…

- Accident prevention has been a primary focus of hospital medicine
- Misguided reliance on “faultless” performance by healthcare professionals
- Hospital systems were not designed to prevent error; they just reactively made changes and were not typically proactive.

Source: NCPS VA National Center for Patient Safety
Today…

A Proactive Approach to Preventing Harm

“Proactive risk reduction prevents harm before it reaches the patient. By engaging in proactive risk reduction, a hospital can correct process problems in order to reduce the likelihood of experiencing adverse events.

In a proactive risk assessment the hospital evaluates a process to see how it could potentially fail, to understand the consequences of such a failure, and to identify parts of the process that need improvement.“

A Proactive Approach to Preventing Harm

“A number of tools are available to help organizations conduct a proactive risk assessment. One of the best known of these tools is the Failure Modes and Effects Analysis (FMEA). An FMEA is used to prospectively examine how failures could occur during high-risk processes and, ultimately, how to prevent them. “

Joint Commission Patient Safety Systems (PS), July 1, 2017
Why Do An FMEA

✓ • When new systems, products, and processes are being designed.
✓ • When existing processes are being changed.
✓ • When carry-over processes are used in new applications or new environments.
✓ • Early in the process improvement investigation

GOAL

TO ENHANCE THE OVERALL CULTURE OF SAFETY BY AVOIDING ADVERSE EVENTS THAT COULD POTENTIALLY CAUSE HARM TO PATIENTS, FAMILIES, ASSOCIATES, OR VISITORS.
FMEA Vs. HMFEA

- FMEA is the traditional approach of evaluating failure modes and risk by evaluating Severity, Occurrence and Detection to assign a Risk Profile Number for prioritization.

- HFMEA is a streamlined approach in evaluating risk by evaluating Severity and Probability to determine a Hazard Score then determine approach (proceed or stop) using a Decision tree looking at impact and detectability.
## A Traditional FMEA Form

### St. Vincent Indianapolis

### Failure Mode Effects Analysis

<table>
<thead>
<tr>
<th>Process Step</th>
<th>Failure Mode</th>
<th>Effect of Failure</th>
<th>Severity</th>
<th>Potential Cause of Failure</th>
<th>Current Controls for Prevention/Detection</th>
<th>Detection</th>
<th>RPN</th>
<th>Recommended Action</th>
<th>Responsible</th>
<th>Action Taken</th>
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**Identify Failure Modes and Their Effects**

**Identify Causes of the Failure Modes and Controls**

**Prioritize**

**Determine, Access And Take Actions**

**Measure Impact**

**Risk Profile Number (RPN)**

**Severity x Occurrence x Detection**

**Priority of Action (PRIOR)**

**Effort x Impact x RPN**
### Identifying Failure Modes and Their Effects

- Hazard Score: Severity x Probability
- Evaluate Risk and Prioritize
- Priority of Action (PRIOR): Effort x Impact x RPN
- Determine, Access And Take Actions
- Measure Impact
STEP 1: Define The Scope

- Target high risk processes

<table>
<thead>
<tr>
<th>High Risk Process</th>
<th>Healthcare</th>
</tr>
</thead>
<tbody>
<tr>
<td>Variable inputs</td>
<td>Humans</td>
</tr>
<tr>
<td>Complex</td>
<td>Many processes</td>
</tr>
<tr>
<td>Non-standardized</td>
<td>Many lacks standard</td>
</tr>
<tr>
<td>Heavily dependent on human interaction</td>
<td>High degree of human interaction</td>
</tr>
<tr>
<td>Hierarchical (not team) based</td>
<td>Very hierarchical</td>
</tr>
</tbody>
</table>

Our Journey:

To develop processes and policies around the implementation and operation of the mobile decontamination units
STEP 2: Assemble The Team

- A team approach is necessary
- Team should be multi-disciplinary and include:
  - Team Leader
  - FMEA Facilitator
  - Subject Matter Experts
  - Members Representing Impact Areas
  - Process Owner/Leaders
  - Outside Perspectives
- Six (6) to Ten (10) participants

Our Journey:

- Assigned a Project Manager, Surgical Services Performance Improvement Consultant
- Expanded team to include: OR, Sterile Processing, Life Safety, Construction, Facilities, IT, Mobile Unit Implementation Team, Risk, Accreditation, Infection Prevention, Environmental Services, Quality, and Performance Improvement
STEP 3: Map The Process

- Define the start and end point
- List all the steps in the process, include sub-process if additional detail is needed.
- If new process, use continuous improvement techniques to define and optimize.
- If existing process, chart the process as it is normally done.
- Recommended to number process and sub-process steps.

Our Journey:

- Significant work put into understanding and defining process, included:
  - Site visit to facility in Toronto operating with mobile units
  - Coordination with State officials to identify key process and facility requirements
  - Process mapping incorporated into Kaizen event to utilize multi-disciplinary team to not only define process, and understand potential risk, but also to optimize.
  - Process mapping event conducted with mobile units in place so team could “walk the process” and pilot/test process changes/concepts.
STEP 3: Map The Process

Our Journey: Process Mapping
STEP 4: Conduct Failure Mode/Hazard Analysis

- Brainstorm and list failure modes, effects and potential cause
  - May be multiple effects/causes for each process step/failure mode
- Determine Severity & Probability (HFMEA)

### HAZARD SCORE GENERAL GUIDELINE

<table>
<thead>
<tr>
<th>SEVERITY</th>
<th>Catastrophic (4)</th>
<th>Major (3)</th>
<th>Moderate (2)</th>
<th>Minor (1)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>16</td>
<td>12</td>
<td>8</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>12</td>
<td>9</td>
<td>6</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>8</td>
<td>6</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>

**KEY**
- Red: Must Take Action
- Orange: Should Take Action
- Yellow: May Need to Take Action

**PROBABILITY**
- Frequent (4)
- Occasional (3)
- Uncommon (2)
- Remote (1)
STEP 4: Conduct Failure Mode/Hazard Analysis

- Evaluate Hazard Using Decision Tree

1. **Hazard Score ≥ 8**
   - **NO**
   - **YES**

2. **Is this a single point weakness in the process?**
   - **YES**
   - **NO**

3. **Does an effective control measure exist for the identified hazard?**
   - **YES**
   - **NO**

4. **Is the hazard so obvious and readily apparent that a control measure is not warranted?**
   - **YES**
   - **NO**

5. **Proceed with identification of actions**

Source: NCPS VA National Center for Patient Safety
The FMEA Journey

STEP 4: Conduct Failure Mode/Hazard Analysis

Our Journey:

St. Vincent Indianapolis
FAILURE MODE EFFECTS ANALYSIS

PROJECT NAME:
Mobile Sterilization Process

<table>
<thead>
<tr>
<th>PROCESS STEP</th>
<th>FAILURE MODE</th>
<th>EFFECT OF FAILURE</th>
<th>POTENTIAL CAUSE OF FAILURE</th>
<th>SEV</th>
<th>PROB</th>
<th>HZRD</th>
</tr>
</thead>
<tbody>
<tr>
<td>5A Decontamination</td>
<td>Mandatory Evacuation</td>
<td>Delayed Processing, Backup of Cases</td>
<td>Severe Weather</td>
<td>4</td>
<td>3</td>
<td>12</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Carts, IUSS Increase</td>
<td>Equipment Failure</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Medical Emergency of Associate in Trailer/Walkway</td>
<td>Delay of Response, Impact to Associate</td>
<td>Education/Training related to location of trailers</td>
<td>4</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>Security Breach</td>
<td>Vandalism, Delay in Processing</td>
<td>Surgeon Exiting</td>
<td>2</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Active Shooter</td>
<td></td>
<td></td>
<td>4</td>
</tr>
</tbody>
</table>

Review Each Process Step for Failure Modes
Determine Risk/Failure Modes to Process Step
Determine Effects and Potential Causes for Failure Modes Related to Specific Process
Develop HZ Score
STEP 5: Develop and Implement Actions and Countermeasures

- Determine whether to Accept, Control or Eliminate Risk/Failure
- Brainstorm actions or countermeasures to address failure mode and or rationale for accepting or stopping
- Determine outcome measure “what right looks like”
- Determine ownership and timeline
STEP 5: Develop and Implement Actions and Countermeasures

Our Journey:

St. Vincent Indianapolis
FAILURE MODE EFFECTS ANALYSIS

PROJECT NAME: Mobile Sterilization Process

<table>
<thead>
<tr>
<th>PROCESS STEP</th>
<th>FAILURE MODE</th>
<th>EFFECT OF FAILURE</th>
<th>POTENTIAL CAUSE OF FAILURE</th>
<th>SEV</th>
<th>PROB</th>
<th>HZRD</th>
<th>ACTION TYPE</th>
<th>RECOMMENDED ACTION/RATIONALE FOR STOPPING</th>
<th>OUTCOME MEASURE</th>
<th>RESPONSIBLE</th>
</tr>
</thead>
<tbody>
<tr>
<td>5A</td>
<td>Decontamination</td>
<td>Delayed Processing, Backup of Cases Carts, USS Increase</td>
<td>Severe Weather</td>
<td>4</td>
<td>3</td>
<td>12</td>
<td>Control</td>
<td>Evacuation for associate safety; explore options for utilizing CVOR decon if weather persists</td>
<td>Continued safe operation</td>
<td>OR/SSP Leadership</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Equipment Failure</td>
<td>4</td>
<td>2</td>
<td>8</td>
<td>Control</td>
<td>Evacuation for associate safety; explore options for utilizing CVOR decon for long-term failure; Trinmedex to be consulted for trailer malfunctions</td>
<td>Continued safe operation</td>
<td>OR/SSP Leadership</td>
</tr>
<tr>
<td></td>
<td>Medical Emergency of Associate in Trailer/Walkway</td>
<td>Delay of Response, Impact to Associate</td>
<td>Education/Training related to location of trailers</td>
<td>4</td>
<td>2</td>
<td>8</td>
<td>Control</td>
<td>Education/Maps provided for emergency responders provided; Emergency Drills to be executed</td>
<td>Responders act in acceptable amount of time</td>
<td>PVED</td>
</tr>
<tr>
<td></td>
<td>Security Breach</td>
<td>Vandalism, Delay in Processing</td>
<td>Sergeant Exiting</td>
<td>2</td>
<td>3</td>
<td>6</td>
<td>Control</td>
<td>Medical staff to be educated on new regulations related to temporary structure</td>
<td>Medical staff exit the building quickly</td>
<td>OR Leadership</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Active Shooter</td>
<td>Stop</td>
<td>4</td>
<td>1</td>
<td>4</td>
<td>Stop</td>
<td>Existing policy and training provided; no additional action required</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ACTION TYPE (Control, Accept, Eliminate)</th>
<th>RECOMMENDED ACTION/RATIONALE FOR STOPPING</th>
<th>OUTCOME MEASURE</th>
<th>RESPONSIBLE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Control</td>
<td>Evacuation for associate safety; explore options for utilizing CVOR decon if weather persists</td>
<td>Continued safe operation</td>
<td>OR/SSP Leadership</td>
</tr>
</tbody>
</table>
The FMEA Journey

STEP 6: Use FMEA to Monitor and Track Improvement

- Track and report out on implementation of each action item
- Verify actions take have intended results
- Reevaluate new process for new risk or failure modes with new FMEA

Our Journey:

<table>
<thead>
<tr>
<th>PROCESS STEP</th>
<th>FAILURE MODE</th>
<th>EFFECT OF FAILURE</th>
<th>POTENTIAL CAUSE OF FAILURE</th>
<th>SCORING</th>
<th>ACTION TYPE</th>
<th>RECOMMENDED ACTION/RATIONALE FOR STOPPING</th>
<th>OUTCOME MEASURES</th>
<th>RESPONSIBLE</th>
<th>STATUS</th>
<th>ACTION TAKEN</th>
<th>COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>5A</td>
<td>Decontamination</td>
<td>Delayed Processing, Backup of Case, Cuts</td>
<td>Severe Weather</td>
<td>4</td>
<td>Control</td>
<td>Evacuation for associate safety; explore options for utilizing CVOR decon if weather persists</td>
<td>Continued safe operation</td>
<td>OR/SSP Leadership</td>
<td>Complete</td>
<td>Existing policy governing severe weather and evacuation plan will apply; drills (fire drill) executed with team.</td>
<td>5/30/2017</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Equipment Failure</td>
<td>4</td>
<td>Control</td>
<td>Evacuation for associate safety; explore options for utilizing CVOR decon for long term failure; Timescale to be consulted for failure functions</td>
<td>Continued safe operation</td>
<td>OR/SSP Leadership</td>
<td>Complete</td>
<td>Maximum cart capacity plan formed and communicated; visual cue (light system) in place to indicate capacity plan activation required; Timelines contact info posted in both trailers for maintenance needs.</td>
<td>5/4/2017</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Medical Emergency of Associate in Trailer/Walkway</td>
<td>4</td>
<td>Control</td>
<td>Education/Maps provided for emergency responders provided; Emergency Drills to be executed</td>
<td>Responders act in acceptable amount of time</td>
<td>PI/ED</td>
<td>Complete</td>
<td>Education/maps provided to ED and staff educated on location of trailers; Emergency Drills executed with ISP and facility.</td>
<td>5/4/2017</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Surgeon Exiting</td>
<td>3</td>
<td>Control</td>
<td>Medical staff to be educated on new regulations related to temporary structure</td>
<td>Medical staff exit the building properly</td>
<td>OR Leadership</td>
<td>Complete</td>
<td>Medical staff exit the building properly and exit from the building.</td>
<td>5/1/2017</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Active Shooter</td>
<td>4</td>
<td>Stop</td>
<td>Existing policy and training provided; no additional action required</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
The FMEA Journey

Our Journey:

• **Observed Impact**
  
  • Patient and associate safety remains intact throughout process
  
  • Able to maintain daily operations without Decontamination contributing to delays
  
  • Collaborative nature of project strengthened relationships between departments and disciplines
  
  • Mock survey of established processes yielded no significant findings
The FMEA Journey

Our Journey:

• **Observed Impact**
  
  • A project of this magnitude takes a village
    
    • Highly collaborative multidisciplinary team pivotal to success
  
  • Risks initially thought minimal prioritized higher through FMEA process
    
    • Extra measures taken to prevent drying of bioburden e.g. Extra Air Conditioners acquired, First in First out (FIFO) cart flow
    
    • Rigid container removal prior to case essential to daily operations
  
  • Full understanding of the project not grasped until Gemba
    
    • Walking the preconceived process with all disciplines identified gaps
    
    • Provided insight toward solutions
  
  • Location change led to missing instrumentation
Summary

- **Done right an FMEA:**
  - Ask “What If?” to help organizations identify ways a process or a service may fail and why the failure may occur.
  - Helps analyze and prioritize potential failures to help teams focus on highest risk failures

- FMEA should and can support process improvement efforts and is not just restricted to evaluating new processes

- An FMEA is a team sport, to find the true value in the process the team must represent the process and stakeholders.
Reference

History of FMEA


Smith, D.L (n.d.). FMEA: Preventing a Failure Before Any Harm Is Done . iSixSigma

Other Sources


Safety Event Review
Objectives

• To demonstrate the importance of safety event reporting and investigation
• To share how nursing leaders can be trained to investigate safety events systematically
• To demonstrate how failure mode coding of safety events results in the reduction of patient harm
• To share how focusing on improving safety culture increases team member engagement
Complementary Strategies

Central Line Infections

Codes Outside the ICU

Surgical Site Infections

Hand Hygiene

...and on, and on, and on...

Culture

Children's Hospitals’ Solutions for Patient Safety
Every patient. Every day.
Safety Event Reporting

- Medical errors are the 3rd leading cause of death in the US (BMJ, 2016)
- Incident reporting systems capture <10-14% of adverse events and errors (Roehr, 2012)
- Culture of safety impacts patient outcomes (DiCuccio, 2015)
Eyes on Incident Reports

- Risk Analyst
- Manager of area
- Executive Team
- Quality and Safety leadership team
- Safety Improvement Consultant

Safety Event Classification Team (Risk Analyst, CMO, CNO, Chief Resident, Pharmacy Director, Q&S Director, Q&S Medical Director, Medical Director of Infection Prevention, Safety Improvement Consultant, Quality Improvement Consultant)
Safety Event Classification (SEC) Process

- SEC team meets weekly for an hour
- Facilitated by risk analyst
- Review events concerning for deviation in practice
- Events reviewed methodically
- Respectful conflict is encouraged
A deviation from generally accepted performance standards (GAPS) that...

Serious Safety Event
• Reaches the patient and
• Results in moderate harm to severe harm or death

Precursor Safety Event
• Reaches the patient and
• Results in minimal harm or no detectable harm

Near Miss Safety Event
• Does not reach the patient
• Error is caught by a detection barrier or by chance
WHY the individual experienced the error (System-related)

<table>
<thead>
<tr>
<th>Structure</th>
<th>The organization did not provide the people, resources, or oversight to support the process or activity being performed.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Culture</td>
<td>The organization’s values and behavior expectations for leaders, physicians, and staff serve as a counter-influence to safe, reliable individual and team performance.</td>
</tr>
<tr>
<td>Process</td>
<td>There are deficiencies in the design of the expectations or flow of the work process expectations</td>
</tr>
<tr>
<td>Policy &amp; Protocol</td>
<td>There are deficiencies in the documents – policies, procedures, and job aids – that are intended to support the work process and guide individual decision making.</td>
</tr>
<tr>
<td>Technology &amp; Environment</td>
<td>The design of the workplace, equipment, and information systems makes it difficult for the person to carry out the task at hand.</td>
</tr>
</tbody>
</table>
## HOW the individual experienced the error

<table>
<thead>
<tr>
<th>Component</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Competency</td>
<td>The person does not have the knowledge of how to perform the task or a well-developed skill in performing the task.</td>
</tr>
<tr>
<td>Consciousness</td>
<td>The person knows exactly what to do and how to do it, yet they fail to carry out the task or they do it incorrectly because their thoughts are not on – or fully on – the task at hand.</td>
</tr>
<tr>
<td>Communication</td>
<td>The person receives information and hears it incorrectly or ascribes incorrect meaning to the information.</td>
</tr>
<tr>
<td>Critical Thinking</td>
<td>The person fails in the cognitive processing of information or in decision making based on information.</td>
</tr>
<tr>
<td>Compliance</td>
<td>The person knows the performance expectation, thinks about it at the time, and makes a choice to act differently.</td>
</tr>
</tbody>
</table>
FAILURE MODE DATA
System Failure Modes

- Provides real-time feedback allowing for proactive mitigation of process gaps
- Directs focus of safety work
Individual Failure Modes

- Drives selection of effective prevention strategies
- Assists in the evaluation of education, communication, and accountability among team members
LEADER FAILURE MODE TRAINING
Purpose

- Effective responses to incidents
- Identify error modes
- Trend error modes
- Intentional focus on trended data
- ZERO PREVENTABLE HARM
Key Objectives

• Orient team members to the safety event classification process

• Connect the task of processing incident report to high reliability organizing

• Help frontline leaders understand how to leverage the incident reporting system and failure mode trending to improve safety culture and drive patient harm reductions
Safety Event Review Process

Event occurs → Incident report filed → Risk Analyst & quality and safety leaders receive report → Risk Analyst selects events for SEC to review → SEC team reviews incident; scores and validates failure mode coding of event → SEC team members prioritize quality and safety improvement work

Department manager receives report → Manager investigates incident → Manager provides incident report follow up and codes event
High Reliability Organizing

High Reliability

Principles of Anticipation
- Preoccupation with failure
- Sensitivity to operations
- Reluctance to simplify

Principles of Containment
- Commitment to resilience
- Deference to expertise
Risk Mitigation Strategies

1. Design process for minimum error “mistake proof”
   • Ex: forcing functions

2. Control errors with active safety devices
   • Ex: checklists

3. Provide warning devices for manual action
   • Ex: electronic alert, visual aid

4. Use procedures for reduction of error and control
   • Ex: write a policy

5. Use administrative controls for reduction of error
   • Ex: performance management, compliance monitoring

6. Rely on knowledge and skill of staff
   • Ex: awareness – put in lessons learned or newsletter
Safety Event Follow-Up Post Training

• Incident report content more robust and focused on the process rather than the individual

• Changed perception of blame/punishment and incident reports disappearing into a “black hole”

• Collaboration among departments evident in the responses

• Mitigation strategies more readily identified
**Incident report:** Zofran ordered by MD and entered by pharmacy. Prior to giving medication to patient, RN asked patient if he needed the medication. Mom explained patient couldn’t take Zofran due to a heart issue. Medication was on allergy list. No Zofran was given.
**Manager comment:** This continues to be an issue with **overriding allergies** (this was the first of two incident with the same patient and medication). **We are working on a process for properly defining allergies vs. side effects.** Many times the allergies are not true allergies, but unwanted side effects so the pharmacist will override. This was a **great catch** on behalf of the nurse (RN with 8 years of experience). The provider should not be writing for medications the patient is allergic to and the pharmacist should not be overriding them. **Manager is sharing this with providers as well.** **The unit safety team met to discuss this issue.** This could be classified as a **technology failure** as there is no alert for the RN administering the medication as well as a situation of alert fatigue for the pharmacists. It can also be classified as **habit intrusion** for the provider writing the medication and for the pharmacist who is used to seeing alerts for allergies that are not true allergies. Fortunately, there was **no harm to the patient as the error was caught prior to administering.** **Manager has taken this to medication safety to be discussed at the next meeting.**
System Spread

12/13/16: Bloomington Hospital
2/6/17: Tipton Hospital
2/15/17: Blackford Hospital
2/27/17: Paoli Hospital
4/14/17: West Hospital
4/24/17: Adult AHC/Riley Hospital
6/7/17: Ball Hospital
System Adverse Event Huddle

- Occurs every Thursday at noon
- All IU Health hospitals report an adverse event
- Events reported in SBAR format
- Huddle summary sent out via e-mail to all IU Health hospitals following the call
- Discuss follow up items at Monday morning executive operations meeting
SBAR example

Safety Brief

**SITUATION:** A L&D nurse was supposed to be hanging Magnesium Sulfate on a pregnant patient that was at risk for premature delivery (29 weeks). During the nursing double verification, the 2nd RN noticed the bag hanging on IV pole was Oxytocin (given to induce labor) rather than Magnesium Sulfate.

**BACKGROUND:** Currently, Magnesium Sulfate and Oxytocin are stored right next to each other in the Pyxis machine on the units. They also both come in the same 500 ml bags. In this situation, the nurse grabbed Oxytocin instead of Magnesium Sulfate from the Pyxis.

**ASSESSMENT:** The Institute for Safe Medication Practices (ISMP) and the Joint Commission have identified one of the most common high alert medication errors is the mix-up between Magnesium Sulfate and Oxytocin. Risk mitigation strategies include ensuring Magnesium Sulfate and Oxytocin are stored in different volume IV bags and as far away from each other as possible.

**RECOMMENDATION:** Assess the storage of Magnesium Sulfate and Oxytocin in your Pyxis machines. Ensure the medications are stored in separate locations, and request the medications are in different volume IV bags to reduce the risk of a RN grabbing the wrong medication. Additionally, share this good catch to reinforce the importance of double verification for high risk medications.

Document Created: 4/1/17 by Emily Roberts, Maternity Clinical Nurse Specialist
OUTCOMES
Incident Reporting

Riley Monthly Incidents

Number of Incidents by Month
Precursor Safety Events
Serious Safety Events

Riley Serious Safety Events


Riley Hospital for Children
Indiana University Health
Adverse Drug Events

Riley Adverse Drug Events

- ADE
- Linear (ADE)

Nov 2015 - July 2016
Nov 2016 - July 2017
## Team Member Engagement

### Quality and Safety

<table>
<thead>
<tr>
<th>Question</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>“This organization provides high-quality care and service” <strong>key driver</strong></td>
<td>3.81</td>
<td>4.23</td>
<td>4.22</td>
</tr>
<tr>
<td>“This organization makes every effort to deliver safe, error free care to patients” <strong>key driver</strong></td>
<td>3.74</td>
<td>4.21</td>
<td>4.24</td>
</tr>
</tbody>
</table>
Culture of Safety Results

- When an event is reported, it feels like the person is being written up, not the problem
- We discuss ways to prevent errors from happening again
- Mistakes have led to positive changes here
- We are actively doing things to improve patient safety
- My manager seriously considers staff suggestions for improving patient safety
- Supervisor/Manager Expectations & Actions Promoting Patient Safety

[Bar chart showing comparison between AHRQ Database and Riley]
Dashboards

Riley Hospital for Children at IU Health incident reporting summary – April 2017

Number of incident reports by month

Riley good catch %

Joint Commission states ≥ 10% = strong reporting culture

System failure modes (after 30 events classified)

Individual failure modes (after 30 events classified)

Good catch %

12 Month Rolling Good Catch %

9.7%

March Good Catch %

20%

Credential reporting analysis

Riley NICU incident reporting summary – April 2017

Number of incident reports by month

Number of good catch reports by month

Joint Commission states ≥ 10% = strong reporting culture

System failure modes (after 3 events classified)

Individual failure modes (after 3 events classified)

Good catch %

12 Month Rolling Good Catch %

9.7%

March Good Catch %

20%

Q1 Good Catch Reporters

Lindsay Gale, Lori Hanshaw, Nicole Wilson, William Hayes, Stephanie Shook, Nathan Walliser, Emily Werner, Sophia Kim, Meredith Marseland, Katie Malley, Anita Shelley, Tammy Losh, Austin Cohns, Lisa Rossetter, Jordan Conley, Jody Hause, Jessica Vieck, Caryn Sundling, Paula Miller, Sara Acker, Emily Smith, Caryn Sundling, Sara Krueneski
Lessons Learned

• Continuous improvement...the journey never ends
• Bridge gap between frontline leaders and senior leaders
• The power of event transparency
• Safety is foundational
References


• Roehr, B. (2012). US hospital incident reporting systems do not capture most adverse events. *BMJ, 344*. doi: https://doi.org/10.1136/bmj.e386
Questions?

Kristin Cummins, Quality & Safety Director
kcummin1@iuhealth.org  @QualityKristin

Amy Birchfield, Quality Improvement Consultant
abirchfield@iuhealth.org
On the Road to Prevention: Identification & Triage Using the Columbia-Suicide Severity Rating Scale (C-SSRS)

Increasing Precision, Improving Care Delivery and Redirecting Scarce Resources

Adam Lesser, LCSW
Center for Suicide Risk Assessment
Columbia University
Background on Columbia -Suicide Severity Rating Scale


- 1st scale to assess full range of ideation, behavior, severity, density, and track change
- Input from leading experts
- Used by many leading experts
- 10s of millions administrations
- Available in 116 languages
- Very brief administration time
- Deemed “most” evidenced supported
- Age: suitable across the lifespan for use with adults, adolescents, and young children.
  Special Populations: indicated for cognitively impaired (e.g. Alzheimer's, Autism)
1. Wish to die
   - Have you thought about being dead or what it would be like to be dead?
   - Have you wished you were dead or wished you could go to sleep and never wake up?
   - Do you ever wish you weren’t alive anymore?

2. Active Thoughts of Killing Oneself
   - Have you thought about doing something to make yourself not alive anymore?
   - Have you had any thoughts about killing yourself?

3. Associated Thoughts of Methods
   - Have you thought about how you would do that or how you would make yourself not alive anymore (kill yourself)?

4. Some Intent
   - When you thought about making yourself not alive anymore (or killing yourself), did you think that this was something you might actually do?

5. Plan and Intent
   - Have you ever decided how or when you would make yourself not alive anymore/kill yourself?
   - Have you ever planned out (worked out the details of) how you would do it?
   - What was your plan?
   - When you made this plan (or worked out these details), was any part of you thinking about actually doing it?
Why the Columbia

- It is designed to assess both ideation and behaviors that are critical for risk assessment and suicide prevention.

- Helps to clarify a common language to use when staffing about suicide risk and determining needed interventions.

- It identifies risk not only if someone has previously attempted, considered suicide, prepared or aborted plans for suicide because of a last-minute change of heart or someone's intervention.
The Columbia is

**Simple**
Ask all the questions in a few moments or minutes — with no mental health training required to ask them.

**Efficient**
Use of the scale redirects resources to where they’re needed most. It reduces unnecessary referrals and interventions by more accurately identifying who needs help — and it makes it easier to correctly identify the level of support a person needs, such as patient safety monitoring procedures, counseling, or emergency room care.

**Effective**
Real-world experience and data show the scale has helped prevent suicide.

**Evidence-supported**
An unprecedented amount of research has validated the relevance and effectiveness of the questions used in the C-SSRS to assess suicide risk, making it the most evidence-based tool of its kind.
Suicide is a Major Public Health Crisis

- More deaths than war, homicide and natural disasters combined
- Leading cause of death across the world and across ages
- Every 40 sec. worldwide and every 13 minutes in the US a person dies by suicide
- 117 Americans die by suicide everyday
- Firearms are used in 50% of all suicides – > 469,096 number of emergency room visits due to self-inflected injury in one year
- LGBT youth who have experienced severe family rejection, are 8x more likely to report attempting suicide
- Number one cause of injury mortality in U.S.; more people die by suicide than motor vehicle crashes

Suicide is preventable cause of death
Indiana Statistics

National average 12.93 *per 100,000

- **Indiana Rate –14.25**

- Suicide is the 11th leading cause of death overall in Indiana

- 2nd leading cause of death among 15-24 year olds (Homicide is the 3rd leading cause of death for this age group)

- Third leading cause of death among 35-45 year old

- 4th leading cause of death 45-54 year olds
Myths About Suicide
True or False

“If someone is really suicidal, they are probably going to kill themselves at some point no matter what you do”

FALSE

- Multiple studies have found that >90% of the most serious attempters do not go on to die by suicide
- Most people are suicidal only for a short amount of time
- So, helping someone through a suicidal crisis can be life-saving
True or False

“There’s no point in asking about suicidal thoughts…if someone is going to do it they won’t tell you”

FALSE

- Many will tell clinician when asked, though might not have volunteered it –often a relief
- Ambivalence is characteristic in 95%
- Contradictory statements/behavior common
- Many give some hints/warnings to friends or family, even if don’t tell clinician
True or False

“ Asking a depressed person about suicide may put the idea in their heads”

FALSE

- Does not suggest suicide, or make it more likely
- Open discussion is more likely to be experienced as relief than intrusion
- Risk is in not asking when appropriate
**TRUE OR FALSE**

“If you stop someone from killing themselves one way, they’ll probably find another”

**FALSE**

- “Means restriction” has strong evidence as suicide prevention strategy

Examples:

- England 1998 – blister packaging for Tylenol = 44% reduction in Tylenol overdose over next 11 years
- Israeli military 2006 - restricted gun access on passes, suicide rate dropped 40% in military
Quick Review

- Asking does not suggest suicide, or make it more likely
- There is more Risk in not asking then asking
- Multiple studies have found that >90% of the most serious attempters do not go on to die by suicide
- Most people are suicidal only for a short amount of time so, helping someone through a suicidal crisis can be life-saving
- Many will tell when asked, though might not have volunteered it – asking often is a relief. Open discussion is more likely to be experienced as relief than intrusion
- Ambivalence is characteristic in 95%
- Contradictory statements/behavior common
- 2/3 of the people have a safety plan but at times unable it use it
Suicide is A Preventable Cause of Death
Our efforts depend first upon accurate identification

- The field of medicine is challenged by lack of conceptual clarity about suicidal behavior and absence of well-defined terminology (research and clinical)

- Variability of terms referring to same behaviors, i.e., threat, gesture (16 different terms for the same behavior)
Using Clear Terminology

- Method
- Plan
- Suicide Attempt
- Interrupted Attempt
- Aborted Attempt
- Preparatory Behavior
- Suicidal Behavior
Types of Columbia Tools

Screener
• a quick screen: wish to be dead, thoughts, and behavior

Lifetime
• For Ideation: Assess the most suicidal time – this is the most clinically meaningful – even if 20 years ago, much more predictive than current

• For Behavior: Lifetime behavior highly predictive (e.g. history of suicide attempt is #1 risk factor for suicide)

Lifetime Recent
• For Ideation: During the past month
• For Behavior: During the past 3 months
### Screener

Ask questions that are bolded and underlined.

Ask Questions 1 and 2

<table>
<thead>
<tr>
<th><strong>1) Wish to be Dead:</strong></th>
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<tbody>
<tr>
<td>Person endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up.</td>
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<table>
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<tr>
<th><strong>2) Suicidal Thoughts:</strong></th>
<th></th>
</tr>
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<tbody>
<tr>
<td>General non-specific thoughts of wanting to end one’s life/commit suicide, “I’ve thought about killing myself” without general thoughts of ways to kill oneself/associated methods, intent, or plan.</td>
<td></td>
</tr>
<tr>
<td>Have you actually had any thoughts of killing yourself?</td>
<td></td>
</tr>
</tbody>
</table>

*If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.*

<table>
<thead>
<tr>
<th><strong>3) Suicidal Thoughts with Method (without Specific Plan or Intent to Act):</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Person endorses thoughts of suicide and has thought of at least one method during the assessment period. This is different than a specific plan with time, place or method details worked out. “I thought about taking an overdose but I never made a specific plan as to when where or how I would actually do it....and I would never go through with it.”</td>
<td></td>
</tr>
<tr>
<td>Have you been thinking about how you might kill yourself?</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>4) Suicidal Intent (without Specific Plan):</strong></th>
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</tr>
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<td>Active suicidal thoughts of killing oneself and patient reports having some intent to act on such thoughts, as opposed to “I have the thoughts but I definitely will not do anything about them.”</td>
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<td>Have you had these thoughts and had some intention of acting on them?</td>
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<table>
<thead>
<tr>
<th><strong>5) Suicide Intent with Specific Plan:</strong></th>
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<tbody>
<tr>
<td>Thoughts of killing oneself with details of plan fully or partially worked out and person has some intent to carry it out.</td>
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</tr>
<tr>
<td>Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?</td>
<td></td>
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<tr>
<th><strong>6) Suicide Behavior Question:</strong></th>
<th></th>
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<tr>
<td>Have you ever done anything, started to do anything, or prepared to do anything to end your life?</td>
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<tr>
<td>Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn’t swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn’t jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc.</td>
<td></td>
</tr>
<tr>
<td><em>If YES, ask: How long ago did you do any of these?</em></td>
<td></td>
</tr>
<tr>
<td>☐ Over a year ago? ☐ Between three months and a year ago? ☐ Within the last three months?</td>
<td></td>
</tr>
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</table>
### SUICIDAL IDEATION

Ask questions 1 and 2. If both are negative, proceed to “Suicidal Behavior” section. If the answer to question 2 is “yes”, ask questions 3, 4 and 5. If the answer to question 1 and/or 2 is “yes”, complete “Intensity of Ideation” section below.

1. **Wish to be Dead**
   Subject endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up.
   *Have you wished you were dead or wished you could go to sleep and not wake up?*
   
<table>
<thead>
<tr>
<th>Yes</th>
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<td></td>
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2. **Non-Specific Active Suicidal Thoughts**
   General non-specific thoughts of wanting to end one’s life/commit suicide (e.g., “I’ve thought about killing myself”) without thoughts of ways to kill oneself/associated methods, intent, or plan during the assessment period.
   *Have you actually had any thoughts of killing yourself?*
   
<table>
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<th>Yes</th>
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3. **Active Suicidal Ideation with Any Methods (Not Plan) without Intent to Act**
   Subject endorses thoughts of suicide and has thought of at least one method during the assessment period. This is different than a specific plan with time, place or method details worked out (e.g., thought of method to kill self but not a specific plan). Includes person who would say, “I thought about taking an overdose but I never made a specific plan as to when, where or how I would actually do it...and I would never go through with it.”
   *Have you been thinking about how you might do this?*
   
<table>
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<tr>
<th>Yes</th>
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<td></td>
<td></td>
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</tbody>
</table>

4. **Active Suicidal Ideation with Some Intent to Act, without Specific Plan**
   Active suicidal thoughts of killing oneself and subject reports having some intent to act on such thoughts, as opposed to “I have the thoughts but I definitely will not do anything about them.”
   *Have you had these thoughts and had some intention of acting on them?*
   
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5. **Active Suicidal Ideation with Specific Plan and Intent**
   Thoughts of killing oneself with details of plan fully or partially worked out and subject has some intent to carry it out.
   *Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?*
   
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</table>

### INTENSITY OF IDEATION

The following features should be rated with respect to the most severe type of ideation (i.e., 1-5 from above, with 1 being the least severe and 5 being the most severe). Ask about time he/she was feeling the most suicidal.

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Most Severe</th>
</tr>
</thead>
<tbody>
<tr>
<td>How many times have you had these thoughts?</td>
<td></td>
</tr>
<tr>
<td>(1) Less than once a week</td>
<td>(4) Daily or almost daily</td>
</tr>
<tr>
<td>(2) Once a week</td>
<td>(5) Many times each day</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Duration</th>
<th>Most Severe</th>
</tr>
</thead>
<tbody>
<tr>
<td>When you have the thoughts how long do they last?</td>
<td></td>
</tr>
<tr>
<td>(1) Fleeting - few seconds or minutes</td>
<td>(4) 4-8 hours/most of day</td>
</tr>
<tr>
<td>(2) Less than 1 hour/some of the time</td>
<td>(5) More than 8 hours/continuous</td>
</tr>
<tr>
<td>(3) 1-4 hours/lot of time</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Controllability</th>
<th>Most Severe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Could/can you stop thinking about killing yourself or wanting to die if you want to?</td>
<td></td>
</tr>
<tr>
<td>(1) Easily able to control thoughts</td>
<td>(4) Can control thoughts with a lot of difficulty</td>
</tr>
<tr>
<td>(2) Can control thoughts with little difficulty</td>
<td>(5) Unable to control thoughts</td>
</tr>
<tr>
<td>(3) Can control thoughts with some difficulty</td>
<td>(6) Does not attempt to control thoughts</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Deterrents</th>
<th>Most Severe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are there things - anyone or anything (e.g., family, religion, pain of death) - that stopped you from wanting to die or acting on thoughts of committing suicide?</td>
<td></td>
</tr>
<tr>
<td>(1) Deterrents definitely stopped you from attempting suicide</td>
<td>(4) Deterrents most likely did not stop you</td>
</tr>
<tr>
<td>(2) Deterrents probably stopped you</td>
<td>(5) Deterrents definitely did not stop you</td>
</tr>
<tr>
<td>(3) Uncertain that deterrents stopped you</td>
<td>(6) Does not apply</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Reasons for Ideation</th>
<th>Most Severe</th>
</tr>
</thead>
<tbody>
<tr>
<td>What sort of reasons did you have for thinking about wanting to die or killing yourself? Was it to end the pain or stop the way you were feeling (no other words you couldn’t go on living with this pain or how you were feeling) or was it to get attention, revenge or a reaction from others? Or both?</td>
<td></td>
</tr>
<tr>
<td>(1) Completely to get attention, revenge or a reaction from others</td>
<td>(4) Mostly to end or stop the pain (you couldn’t go on living with the pain or how you were feeling)</td>
</tr>
<tr>
<td>(2) Mostly to get attention, revenge or a reaction from others</td>
<td>(5) Completely to end or stop the pain (you couldn’t go on living with the pain or how you were feeling)</td>
</tr>
<tr>
<td>(3) Equally to get attention, revenge or a reaction from others and to end/stop the pain</td>
<td>(6) Does not apply</td>
</tr>
</tbody>
</table>

**Lifetime/Recent & Since Last Visit**

**Typical Administration**

Time=Few Minutes
Once severity of ideation is determined, a few follow-up questions are asked:

- Frequency
- Duration
- Controllability
- Deterrents
- Reasons for ideation (stop the pain or make something else happen)
For Intensity of Ideation, risk is greater when:

- Thoughts are more frequent
- Thoughts are of longer duration
- Thoughts are less controllable
- Fewer deterrents to acting on thoughts
- Stopping the pain is the reason
Common Language

Using clear terminology - suicidal behavior

- Interrupted attempt
- Aborted attempt /self interrupted
- Preparatory behavior
Suicide Attempt Definition

A self-injurious act undertaken with at least some intent to die, as a result of the act

- There does not have to be any injury or harm, just the potential for injury or harm (e.g., gun failing to fire)

- Includes any "non-zero" intent to die –does not have to be 100%

- Intent and behavior must be linked
Suicide Attempt

A suicide attempt begins with the first pill swallowed or scratch with a knife

Questions:
The old way of asking-
¬ Have you made a suicide attempt?
¬ Have you done anything to harm yourself?

C-SSRS way of asking
¬ Have you done anything dangerous where you could have died?
Other Suicidal Behavior - Interrupted Attempt

When person starts to take steps to end their life but someone or something stops them

Question:
Our old way of asking-
Have you had thoughts of killing your self or wish to be dead

C-SSRS way of asking-
Has there been a time when you started to do something to end your life but someone or something stopped you before you actually did anything?
Aborted/Self-Interrupted Attempt

When person begins to take steps towards making a suicide attempt, but stops themselves before they actually have engaged in any self-destructive behavior.

Examples:
- Man walks up to the roof to jump, but changes his mind and turns around.
- She has gun in her hand, but then puts it down.

Question:
Our old way of asking –
Have you had thoughts of killing yourself or wish to be dead.

C-SSRS way of asking-
Has there been a time when you started to do something to end your life but you stopped yourself before you actually did anything?
Prevention begins with EVERYONE

Everyone,
Everywhere Can Ask

Everyone,
Everywhere can Help
The Lighthouse Project The Columbia Project

website
http://cssrs.columbia.edu/

Training Video
https://www.youtube.com/watch?v=Xfddz_Yfnc4
One Life Matters

Holly Hartman

Holly.stanbrough@Eskenazihealth.edu

317-880-4163
## C-SSRS SCREENER WITH TRIAGE POINTS

### I. SUICIDE IDEATION DEFINITIONS AND PROMPTS:

<table>
<thead>
<tr>
<th>Ask questions that are in bolded and underlined</th>
<th>Past month</th>
</tr>
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#### Ask Questions 1 and 2

1) **Wish to be Dead:**
   - Person endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up?
   - *Have you wished you were dead or wished you could go to sleep and not wake up?*

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   - General non-specific thoughts of wanting to end one’s life/commit suicide, “I’ve thought about killing myself” without general thoughts of ways to kill oneself/associated methods, intent, or plan.”
   - *Have you actually had any thoughts of killing yourself?*

If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6

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   If YES, ask: *How long ago did you do any of these?*
   - [ ] Over a year ago?  [ ] Between three months and a year ago?  [ ] Within the last three months?
Harm Score at CHNw

Robert Lindeman, MD, FAAP
Chief Quality Officer, CHNw

Jean Putnam, RN, MS, CPHQ
Chief Nursing Officer, CHNw
Why have a Harm Score?

Creation of shared interest and focus on quality/safety in a large organization
  Many people...
  Doing many things...
  For many reasons...
  Captured in one measure
Statistical Indices – what are they?

Several definitions, but for our purposes...

An index is a statistical measure of changes in a representative group of individual data points.

Examples:

**Dow Jones Industrial Average** – The Dow Jones Industrial Average (DJIA) is a price-weighted average of 30 significant stocks traded on the New York Stock Exchange (NYSE) and the NASDAQ.

**S&P 500** – The Standard & Poor's 500, is an American stock market index based on the market capitalizations of 500 large companies having common stock listed on the NYSE or NASDAQ.

**Consumer Price Index** - The Consumer Price Index (CPI) is a measure that examines the weighted average of prices of a basket of consumer goods and services, such as transportation, food and medical care. It is calculated by taking price changes for each item in the predetermined basket of goods and averaging them.

**Leading Economic Index** - An index published monthly by the Conference Board used to predict the direction of global economic movements in the months to come. It is made up of 10 economic components, whose changes tend to precede changes in the overall economy.
Well known indices

DJIA

Standard & Poor's 500 Index History

Consumer Price Index

The Conference Board LEI for the U.S.
Well known indices

- DJIA

Okay...

Some are more well known than others
Harm Score
It’s an Index
Harm Score 1.0 (2014) and 1.1 (2015)

Index Calculation

$$100 \times \frac{(\text{Harms} \times 10) + \text{ADEs}}{\text{Patient Days}} = \text{Harm Score}$$

<table>
<thead>
<tr>
<th>Harms</th>
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<tbody>
<tr>
<td>CLABSI (Central Line associated Blood Stream Infections)</td>
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<tr>
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</tr>
<tr>
<td>SSI (Surgical Site Infections – in specified procedures)</td>
</tr>
<tr>
<td>Falls with Injury</td>
</tr>
<tr>
<td>Pressure Ulcers – Stage II and above</td>
</tr>
<tr>
<td>VTE (Venous Thrombo-embolism – potentially preventable)</td>
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<td>VAP (Ventilator Associated Pneumonia)</td>
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<th>ADEs</th>
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<td>Adverse Drug Event – Warfarin (INR &gt; 6)</td>
</tr>
<tr>
<td>Adverse Drug Event – Hypoglycemia (Blood Glucose ≤ 50)</td>
</tr>
<tr>
<td>Adverse Drug Event – Naloxone (Given for Opioid Reversal)</td>
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Harm Score 1.0 (2014) and 1.1 (2015)

Index Calculation

\[ 100 \times \left( \frac{\text{Harms} \times 10 + \text{ADEs}}{\text{Patient Days}} \right) = \text{Harm Score} \]

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Why these?
Harm Score 1.0 (2014) and 1.1 (2015)

Index Calculation
100 x ((Harms x 10) + ADEs) / Patient Days = Harm Score

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Why these?
- These were data that we were already tracking.
- Actively working on projects in these areas.
Dashboard View - Harm Score

Community Health Network

<table>
<thead>
<tr>
<th>Tracked Harm Events</th>
<th>Central Line Associated Blood Stream Infection</th>
<th>Catheter Associated UTI</th>
<th>Surgical Site Infections</th>
<th>Falls with Injury</th>
<th>Pressure Ulcers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Days Since 0</td>
<td>Days Since 0</td>
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<td>Days Since 0</td>
<td>Days Since 0</td>
</tr>
<tr>
<td>Annual Target</td>
<td>Annual Target</td>
<td>Annual Target</td>
<td>Annual Target</td>
<td>Annual Target</td>
<td>Annual Target</td>
</tr>
<tr>
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<td>Annual Baseline</td>
<td>Annual Baseline</td>
<td>Annual Baseline</td>
<td>Annual Baseline</td>
<td>Annual Baseline</td>
</tr>
<tr>
<td>Monthly Target</td>
<td>Monthly Target</td>
<td>Monthly Target</td>
<td>Monthly Target</td>
<td>Monthly Target</td>
<td>Monthly Target</td>
</tr>
<tr>
<td>Monthly Baseline</td>
<td>Monthly Baseline</td>
<td>Monthly Baseline</td>
<td>Monthly Baseline</td>
<td>Monthly Baseline</td>
<td>Monthly Baseline</td>
</tr>
<tr>
<td>Last Event 1/1/2014</td>
<td>1/1/2014</td>
<td>1/1/2014</td>
<td>1/1/2014</td>
<td>1/1/2014</td>
<td>1/1/2014</td>
</tr>
<tr>
<td>Avg cost/event</td>
<td>Avg cost/event $19,000</td>
<td>Avg cost/event $750</td>
<td>Avg cost/event $20,000</td>
<td>Avg cost/event $11,250</td>
<td>Avg cost/event $33,180</td>
</tr>
<tr>
<td>Cost since 10/1/14</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Tracked Precursor Events</th>
<th>ADE - Warfarin (Patients with INR &gt; 6)</th>
<th>ADE - Hypoglycemia (Blood Glucose &lt; 50)</th>
<th>ADE - Naloxone (Naloxone administered for Opioid reversal)</th>
<th>Venous Thromboembolism</th>
<th>Ventilator Associated Pneumonia</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number per Day 0</td>
<td>Number per Day 0</td>
<td>Number per Day 0</td>
<td>Number per Day 0</td>
<td>Number per Day 0</td>
<td>Number per Day 0</td>
</tr>
<tr>
<td>Daily Target 0</td>
<td>Daily Target 0</td>
<td>Daily Target 0</td>
<td>Daily Target 0</td>
<td>Daily Target 0</td>
<td>Daily Target 0</td>
</tr>
<tr>
<td>Annual Target 0</td>
<td>Annual Target 0</td>
<td>Annual Target 0</td>
<td>Annual Target 0</td>
<td>Annual Target 0</td>
<td>Annual Target 0</td>
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<td>Annual Baseline 0</td>
<td>Annual Baseline 0</td>
<td>Annual Baseline 0</td>
<td>Annual Baseline 0</td>
<td>Annual Baseline 0</td>
<td>Annual Baseline 0</td>
</tr>
<tr>
<td>Monthly Target 0</td>
<td>Monthly Target 0</td>
<td>Monthly Target 0</td>
<td>Monthly Target 0</td>
<td>Monthly Target 0</td>
<td>Monthly Target 0</td>
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<tr>
<td>Monthly Baseline 0</td>
<td>Monthly Baseline 0</td>
<td>Monthly Baseline 0</td>
<td>Monthly Baseline 0</td>
<td>Monthly Baseline 0</td>
<td>Monthly Baseline 0</td>
</tr>
<tr>
<td>Last Event 1/1/2014</td>
<td>1/1/2014</td>
<td>1/1/2014</td>
<td>1/1/2014</td>
<td>1/1/2014</td>
<td>1/1/2014</td>
</tr>
<tr>
<td>Avg cost/event $3,000</td>
<td>Avg cost/event $3,000</td>
<td>Avg cost/event $3,000</td>
<td>Avg cost/event $3,000</td>
<td>Avg cost/event $10,000</td>
<td>Avg cost/event $43,000</td>
</tr>
<tr>
<td>Cost since 10/1/14</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
</tbody>
</table>

It has been XX days since we have harmed a patient at CHNw.

Harm Score: 0
2015 Target: < 1.40
(10/1/14-9/31/15)
### Dashboard View - Harm Score 1.1
(Developed - 2016)

#### Community Health Network

<table>
<thead>
<tr>
<th>Dataset</th>
<th>Harm Score</th>
<th>2016 Target</th>
<th>Period</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1.425</td>
<td>1.594</td>
<td>(12/1/2015-11/30/2016)</td>
</tr>
</tbody>
</table>

#### Dashboard as of November 2016

**Total Harm Events**

- **Central Line Associated Blood Stream Infection**
  - Since December, 2015
  - November
  - Average cost/event: $17,000
  - Total since 12/1/15

- **Catheter Associated UTI**
  - Since December, 2015
  - November
  - Average cost/event: $1,000
  - Total since 12/1/15

- **Surgical Site Infections**
  - Since December, 2015
  - November
  - Average cost/event: $21,000
  - Total since 12/1/15

- **Falls with Injury**
  - Since December, 2015
  - November
  - Average cost/event: $663
  - Total since 12/1/15

- **Stage II, III or IV Pressure Ulcers**
  - Since December, 2015
  - November
  - Average cost/event: $33,180
  - Total since 12/1/15

**Precursor Events**

- **ADE - Warfarin (Patients with INR > 6)**
  - Since December, 2015
  - November
  - Pot. cost/event: $3,000
  - Total since 12/1/15

- **ADE - Hypoglycemia (Blood Glucose < 50)**
  - Since December, 2015
  - November
  - Pot. cost/event: $3,000
  - Total since 12/1/15

- **ADE - Naloxone (Naloxone administered for Opioid reversal)**
  - Since December, 2015
  - November
  - Pot. cost/event: $1,000
  - Total since 12/1/15

- **Venous Thromboembolism**
  - Since December, 2015
  - November
  - Average cost/event: $22,240
  - Total since 12/1/15

- **Ventilator Associated Pneumonia**
  - November
  - 0

*Note: All costs are in USD.*
Network Harm Score V1.1 Run Chart

- **Baseline**
- **Monthly Rate**
- **Annual Cum. Rate**
- **Goal**
- **Stretch 1 "LEM 4"**
- **Stretch 2 "LEM 5"**

**Lower is Better**
Harms

CLABSI (Central Line associated Blood Stream Infections)
CAUTI (Catheter Associated Urinary Tract Infections)
SSI (Surgical Site Infections – in more specified procedures)
Falls with Injury
Pressure Ulcers – Stage II and above
VTE (Venous Thrombo-embolism)
VAP (Ventilator Associated Pneumonia)
Hospital Acquired C-Diff
Sepsis Mortality – ED POA

Index Calculation
(100 x ((Harms x 10) + ADEs) / Patient Days)/ HarmScore Divisor = Harm Score

New Measures

- Hospital Acquired C-Diff
- Sepsis Mortality – ED POA
- Adverse Drug Event – Warfarin (INR > 6)
- Adverse Drug Event – Hypoglycemia (Blood Glucose ≤ 50)
- Adverse Drug Event – Naloxone (Given for Opioid Reversal)

Measured Differently
Dashboard View - Harm Score 2.1
(Developed April 2017)

<table>
<thead>
<tr>
<th>Community Health Network</th>
<th>Harm Score: 1.128</th>
<th>May 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2017 Target: 0.000</td>
<td>(12/31/2016 - 5/31/2017)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Total Harm Events</th>
<th>Central Line Associated Blood Stream Infection</th>
<th>Catheter Associated UTI</th>
<th>Surgical Site Infections*</th>
<th>Falls with Injury</th>
<th>Stage II, III or IV Pressure Ulcers</th>
<th>C-diff</th>
</tr>
</thead>
<tbody>
<tr>
<td>December 2016 - May 2017</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>May Events</td>
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<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Cost for May</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>December 2016 - May 2017</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Precursor Events</th>
<th>ADE - Warfarin (Patients with INR &gt; 6)</th>
<th>ADE - Hypoglycemia (Blood Glucose &lt; 50)</th>
<th>ADE - Naloxone (Naloxone administered for Opioid reversal)</th>
<th>Venous Thromboembolism</th>
<th>Ventilator Associated Pneumonia</th>
<th>Sepsis Mortality</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Events</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>December 2016 - May 2017</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
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<tr>
<td>May Events</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Cost for May</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>December 2016 - May 2017</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
</tbody>
</table>
Harm Score v3.x

Index Calculation

\[(\text{Amb. Harm Score}) \times (100 \times ((\text{Harms} \times 10) + \text{ADEs}) / \text{Patient Days}) / \text{Harm Score Divisor} = \text{Harm Score}\]

<table>
<thead>
<tr>
<th>Harms</th>
</tr>
</thead>
<tbody>
<tr>
<td>CLABSI (Central Line associated Blood Stream Infections)</td>
</tr>
<tr>
<td>CAUTI (Catheter Associated Urinary Tract Infections)</td>
</tr>
<tr>
<td>SSI (Surgical Site Infections – in more specified procedures)</td>
</tr>
<tr>
<td>Falls with Injury</td>
</tr>
<tr>
<td>Pressure Ulcers – Stage II and above</td>
</tr>
<tr>
<td>VTE (Venous Thrombo-embolism)</td>
</tr>
<tr>
<td>VAP (Ventilator Associated Pneumonia)</td>
</tr>
<tr>
<td>Hospital Acquired C-Diff</td>
</tr>
<tr>
<td>Sepsis Mortality – ED POA</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ADEs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adverse Drug Event – Warfarin (INR &gt; 6)</td>
</tr>
<tr>
<td>Adverse Drug Event – Hypoglycemia (Blood Glucose ≤ 50)</td>
</tr>
<tr>
<td>Adverse Drug Event – Naloxone (Given for Opioid Reversal)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Ambulatory Harms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benzodiazepine prescribing in patients &gt; 65 yo</td>
</tr>
<tr>
<td>NSAID prescribing in patients with CKD</td>
</tr>
</tbody>
</table>

New Measures

New Measures

Measured Differently
## Harm Score Dashboard - May 2017

<table>
<thead>
<tr>
<th>Community Health Network</th>
<th>Harm Score 2017 Target: 1.128</th>
<th>May 2017 (12/1/2016 - 10/31/2017)</th>
<th>Ambulatory Events</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total Harm Events</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Central Line Associated Blood Stream Infection</strong></td>
<td>0</td>
<td>Total Events: December 2016 - May 2017</td>
<td>BZD &gt; 65yo</td>
</tr>
<tr>
<td><strong>Catheter Associated UTI</strong></td>
<td>0</td>
<td>Total Events: December 2016 - May 2017</td>
<td></td>
</tr>
<tr>
<td><strong>Surgical Site Infections</strong></td>
<td>0</td>
<td>Total Events: December 2016 - May 2017</td>
<td></td>
</tr>
<tr>
<td><strong>Falls with Injury</strong></td>
<td>0</td>
<td>Total Events: December 2016 - May 2017</td>
<td></td>
</tr>
<tr>
<td><strong>Stage II, III or IV Pressure Ulcers</strong></td>
<td>0</td>
<td>Total Events: December 2016 - May 2017</td>
<td></td>
</tr>
<tr>
<td><strong>C-diff</strong></td>
<td>0</td>
<td>Total Events: December 2016 - May 2017</td>
<td></td>
</tr>
<tr>
<td><strong>Total Events</strong></td>
<td>0</td>
<td>Total Events: December 2016 - May 2017</td>
<td></td>
</tr>
<tr>
<td><strong>Total Cost</strong></td>
<td>$0</td>
<td>Total Events: December 2016 - May 2017</td>
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</table>

### Precursor Events

<table>
<thead>
<tr>
<th>ADE - Warfarin (Patients with INR &gt; 5)</th>
<th>ADE - Hypoglycemia (Blood Glucose &lt; 50)</th>
<th>ADE - Naloxone (Naloxone administered for Opioid reversal)</th>
<th>Venous Thromboembolism</th>
<th>Ventilator Associated Pneumonia</th>
<th>Sepsis Mortality</th>
<th>NEAID in CKD</th>
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<tbody>
<tr>
<td><strong>Total Events</strong></td>
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<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total Cost</strong></td>
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<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
</tbody>
</table>

### Costs

- **Average cost/event**: $0
- **Cost since 12/1/16**: $0

**Other Notes**: The Harm Score Dashboard reflects the performance of the Community Health Network in May 2017, indicating improvements in various areas. The dashboard is developed in August 2017.
# Harm Score Versions

<table>
<thead>
<tr>
<th>Harm Score Version</th>
<th>Characteristics</th>
<th>Performance Year</th>
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</thead>
<tbody>
<tr>
<td>1.0</td>
<td>- As presented</td>
<td>2015</td>
</tr>
<tr>
<td></td>
<td>- Testing</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Goal for a select few leaders</td>
<td></td>
</tr>
<tr>
<td>1.1</td>
<td>- No change in measurement</td>
<td>2016</td>
</tr>
<tr>
<td></td>
<td>- Network wide goal</td>
<td></td>
</tr>
<tr>
<td>2.0</td>
<td>- More metrics (Sepsis, C. Diff)</td>
<td>2016</td>
</tr>
<tr>
<td></td>
<td>- Testing</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- More sensitive measurement (SSI, HAPU, VTE)</td>
<td></td>
</tr>
<tr>
<td>2.1</td>
<td>- Same construction as 2.0</td>
<td>2017</td>
</tr>
<tr>
<td></td>
<td>- Network wide goal</td>
<td></td>
</tr>
<tr>
<td>3.0</td>
<td>- Add ambulatory measurements</td>
<td>2017</td>
</tr>
<tr>
<td></td>
<td>- In development</td>
<td></td>
</tr>
<tr>
<td>3.1</td>
<td>- Same construction as 3.0</td>
<td>2018</td>
</tr>
<tr>
<td></td>
<td>- Role in goal setting not yet established for 2018</td>
<td></td>
</tr>
</tbody>
</table>
Network Harm Score Run Chart

Lower is better

HARM SCORE

v1.0  v1.1 & v2.0  v2.1 & v3.0

MONTH-YEAR

Base  Lev 3  Lev 4  Lev 5  v1 Monthly Rate  v2 Monthly Rate  v1 Annual Rate  v2 Annual Rate  v3 Annual Rate  v3 Monthly Rate
Why not have a Harm Score?

Things to consider...

How do you translate this through the organization’s hierarchy?

Incentivizing a decrease in harm might obfuscate learning for the sake of accountability... at least for a little while... at least in some areas.

How does the organization connect resource and efforts to the measure to ensure scalable and sustainable results?

- are the efforts identified?
- are the resources available?
That’s All... Questions?