Community Health Network

ESKENAZI HEALTH

Indiana University Health

Franciscan HEALTH

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VA HEALTH CARE Defining EXCELLENCE in the 21st Century

AN ORIENTATION TO

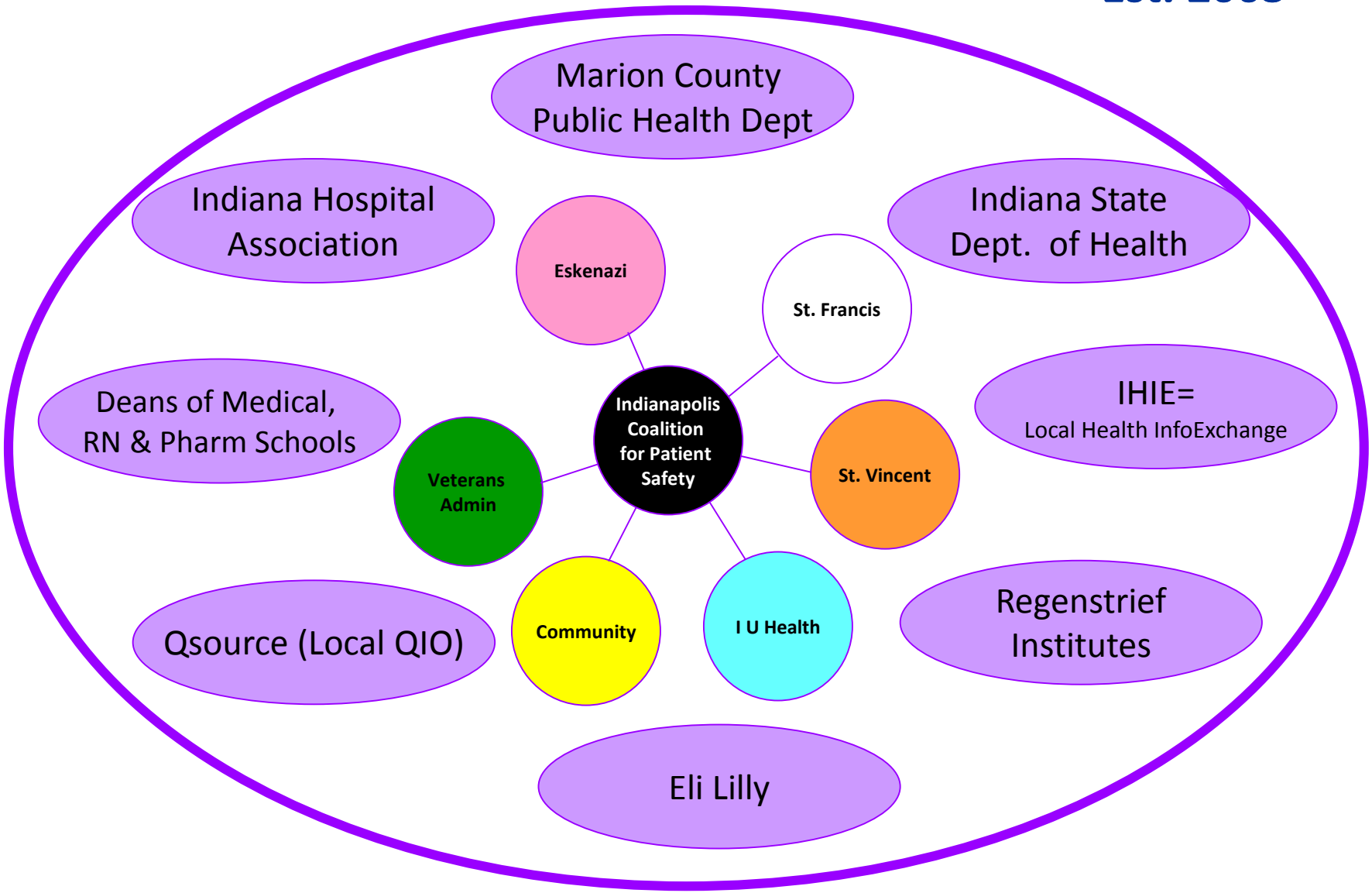
Indianapolis Coalition for Patient Safety

Committed to Excellence

www.indypatientsafety.org

Members and State-wide Collaborators:

Indianapolis Coalition for Patient Safety
Committed to Excellence
Est. 2003



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

SHARED VISION & CHALLENGE

>>Make Indianapolis & surrounding counties safest for health care

WORKING TOGETHER

>> Shared Resources

>> Shared Performance Targets

>> Shared Accountability

>> Shared Funding

>> Shared Learning

COLLECTIVE ACHIEVEMENT

>> Outcomes: Accelerated Improvement

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)

Franciscan Health / ICPS Nursing Leadership Forum

Culture of Safety

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)

Indiana Patient Safety Center
of the Indiana Hospital Association

Culture of Safety
Planning, Implementing, Performance Improving

August 29, 2017

IHAconnect.org/Quality-Patient-Safety

Indiana Hospital Association

Indiana Patient Safety Center
of the Indiana Hospital Association

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

Indiana Patient Safety Center
of the Indiana Hospital Association

- 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

Indiana Patient Safety Center
of the Indiana Hospital Association

- 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

Indiana Patient Safety Center
of the Indiana Hospital Association

To make Indiana the safest place to receive health care in the United States…
if not the world

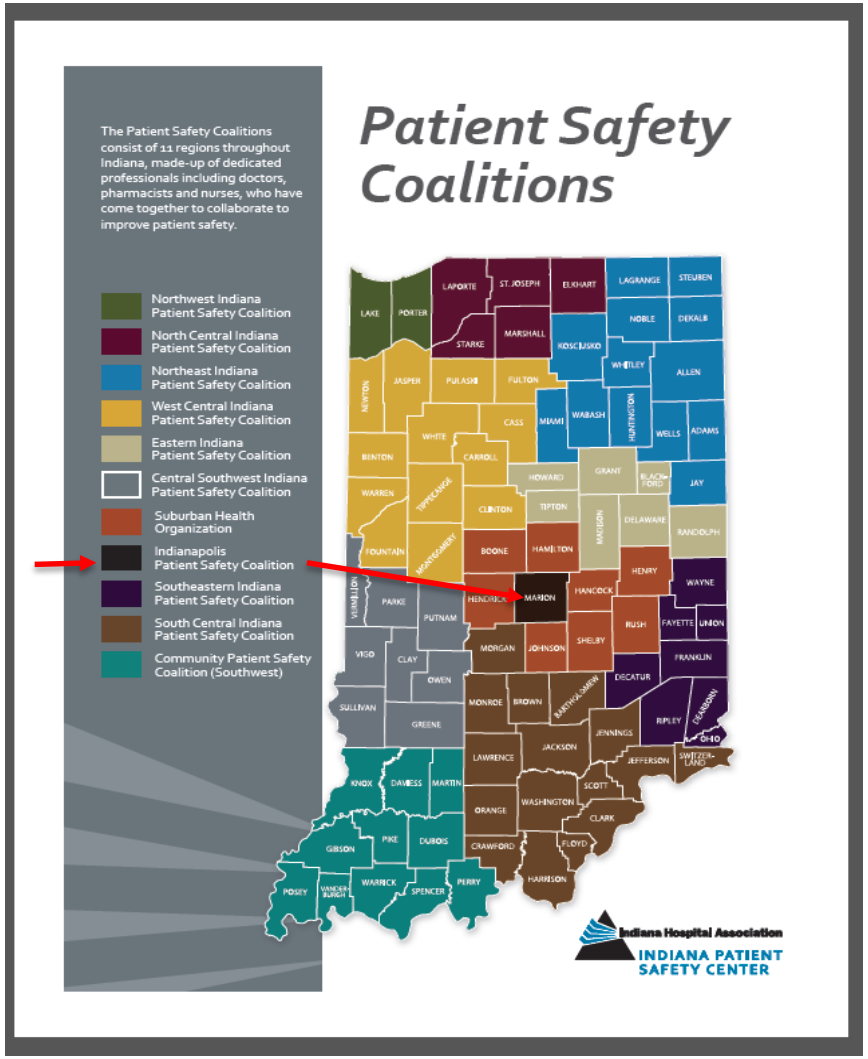
Culture of Safety Priority

Indiana Patient Safety Center
of the Indiana Hospital Association

- Partner with American Hospital Association's (AHA) Health Research & Educational Trust (HRET) in advancing Indiana in the CMS national harm reduction initiative; current program, **H**ospital **I**mprovement **I**nnovation **N**etwork (**HIIN**) formerly known as **HEN** or **H**ospital **E**ngagement **N**etwork
- **STRIVE** – CDC's **S**tates **T**argeting **R**eduction in **I**nfections via **E**ngagement 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

Indiana Patient Safety Center
of the Indiana Hospital Association



Key Contacts for the Indianapolis Coalition for Patient Safety

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AHRQ Culture of Patient Safety Survey

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Safety Culture Definition

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Safety culture

World Health Organization | Patient Safety
A World Alliance for Safer Health Care

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

Indiana Patient Safety Center
of the Indiana Hospital Association

- 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.).

AHRQ Agency for Healthcare Research and Quality
Advancing Excellence in Health Care

Composites and Definitions

Indiana Patient Safety Center
of the Indiana Hospital Association

Patient Safety Culture Composite	Definition: *The extent to which…*
Communication Openness	Staff freely speak up if they see something that may negatively affect a patient and feel free to question those with more authority.
Feedback and Communication About Error	Staff are informed about errors that happen, are given feedback about changes implemented, and discuss ways to prevent errors.
Frequency of Events Reported	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.
Handoffs and Transitions	Important patient care information is transferred across hospital units and during shift changes.
Management Support for Patient Safety	Hospital management provides a work climate that promotes patient safety and shows that patient safety is a top priority.
Nonpunitive Response to Error	Staff feel that their mistakes and event reports are not held against them and that mistakes are not kept in their personnel file.
Organizational Learning—Continuous Improvement	Mistakes have led to positive changes and changes are evaluated for effectiveness.
Overall Perceptions of Patient Safety	Procedures and systems are good at preventing errors and there is a lack of patient safety problems.

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

Surveys on Patient Safety Culture™

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Modifications or Changes to Questions

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- 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?

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- 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

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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?

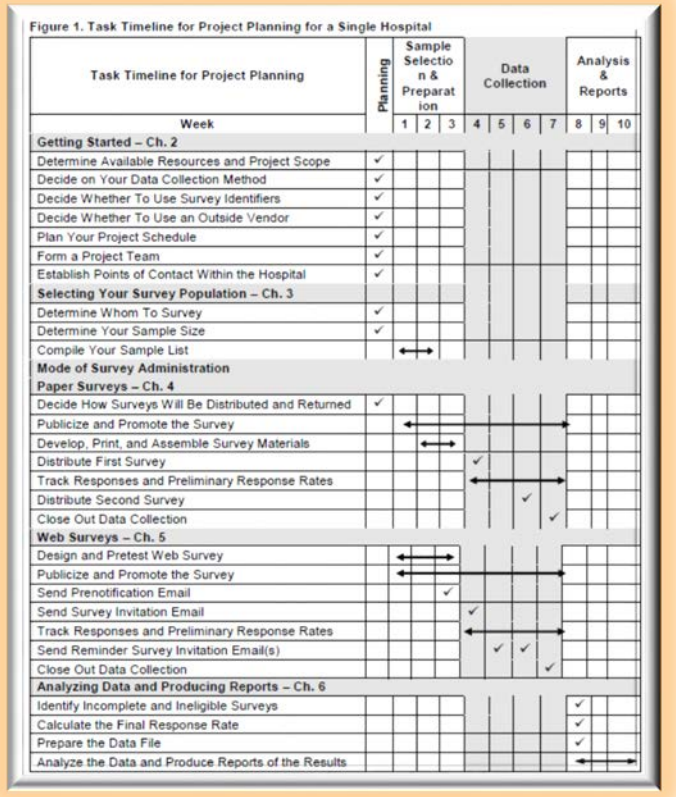

Figure 1. Task Timeline for Project Planning for a Single Hospital

Task Timeline for Project Planning	Planning	Sample Selection & Preparation			Data Collection				Analysis & Reports		
Week		1	2	3	4	5	6	7	8	9	10
Getting Started – Ch. 2											
Determine Available Resources and Project Scope	✓										
Decide on Your Data Collection Method	✓										
Decide Whether To Use Survey Identifiers	✓										
Decide Whether To Use an Outside Vendor	✓										
Plan Your Project Schedule	✓										
Form a Project Team	✓										
Establish Points of Contact Within the Hospital	✓										
Selecting Your Survey Population – Ch. 3											
Determine Whom To Survey	✓										
Determine Your Sample Size	✓										
Compile Your Sample List		↔									
Mode of Survey Administration											
Paper Surveys – Ch. 4											
Decide How Surveys Will Be Distributed and Returned	✓										
Publicize and Promote the Survey		←							→		
Develop, Print, and Assemble Survey Materials			↔								
Distribute First Survey					✓						
Track Responses and Preliminary Response Rates					↔				→		
Distribute Second Survey							✓				
Close Out Data Collection								✓			
Web Surveys – Ch. 5											
Design and Pretest Web Survey		↔									
Publicize and Promote the Survey		←							→		
Send Prenotification Email			✓								
Send Survey Invitation Email					✓						
Track Responses and Preliminary Response Rates					↔				→		
Send Reminder Survey Invitation Email(s)						✓	✓				
Close Out Data Collection								✓			
Analyzing Data and Producing Reports – Ch. 6											
Identify Incomplete and Ineligible Surveys									✓		
Calculate the Final Response Rate									✓		
Prepare the Data File									✓		
Analyze the Data and Produce Reports of the Results									↔		

Form a Project Team and Facility Lead

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- 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.

Maximizing Your Response Rates

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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

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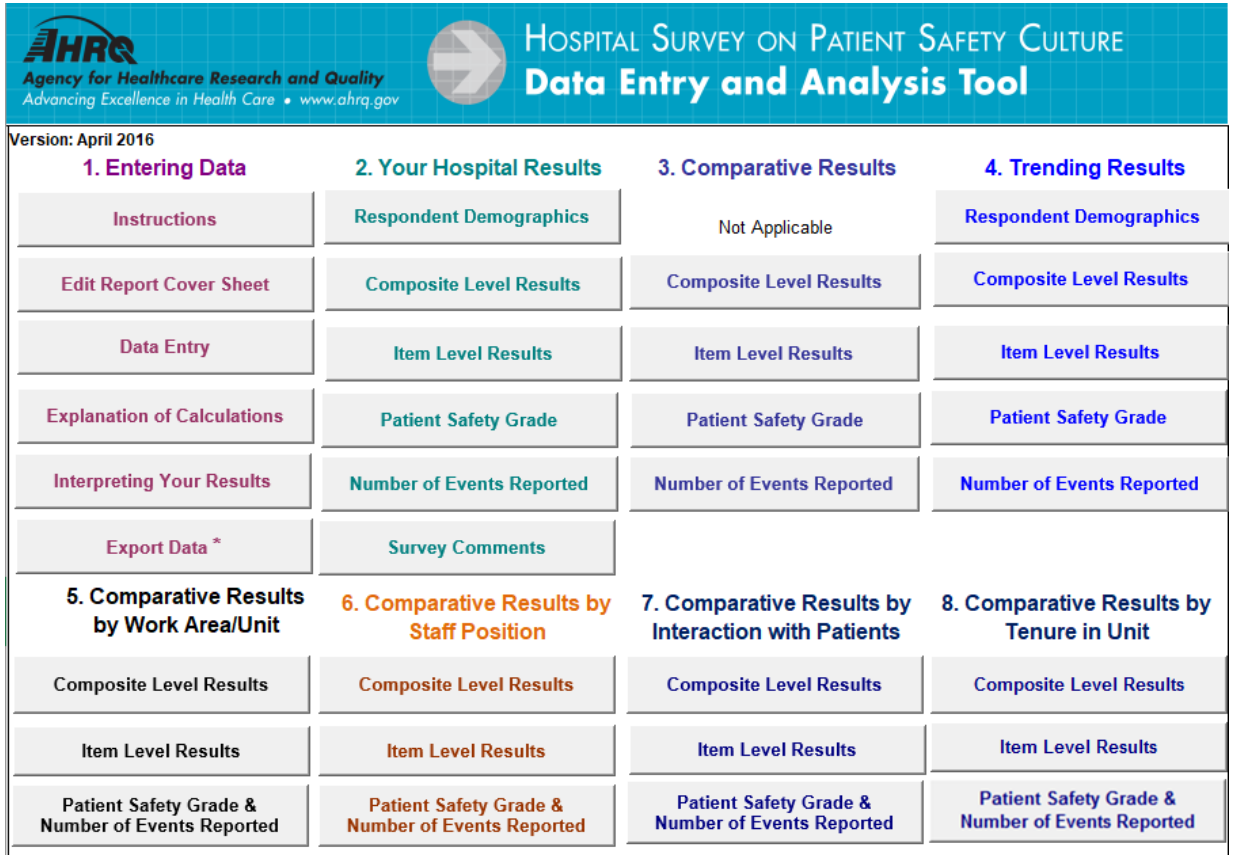
- Outside vendor, like IHA
- AHRQ Survey Tool – only for non-modified surveys
- Manual data analysis or internal tool



Analyzing Your Results

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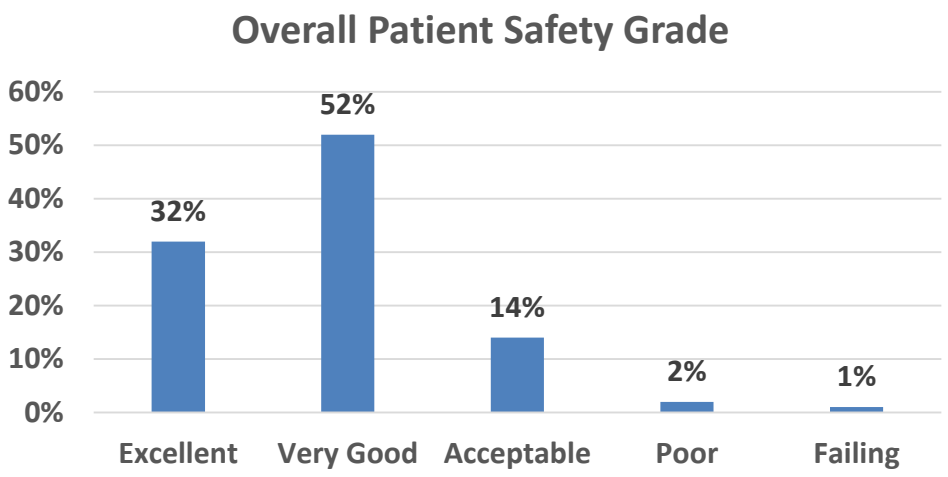
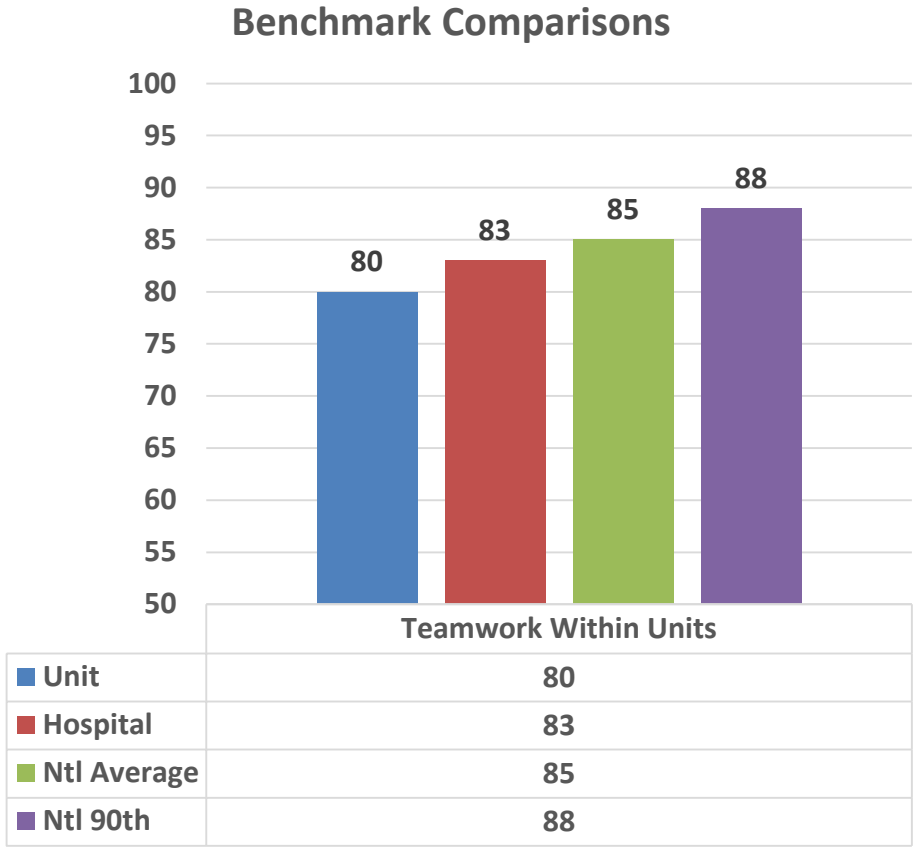
Time Worked in the Hospital (Years) (Survey Item: H1)	N	%
Less than 1 year	117	15%
1 to 5 years	234	30%
6 to 10 years	134	17%
11 to 15 years	116	15%
16 to 20 years	82	10%
21 years or more	104	13%
Total	787	100%





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How Are The Responses Scored?

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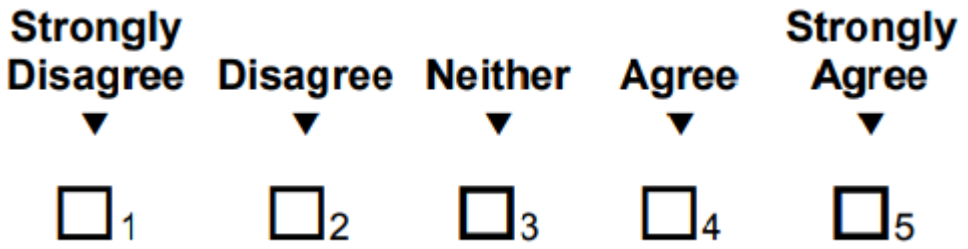
- Responses are converted to “positive, neutral and negative” responses
- About half of the survey questions are **reverse worded** – meaning you want the respondent to disagree with the statement
- That is factored in to the analysis

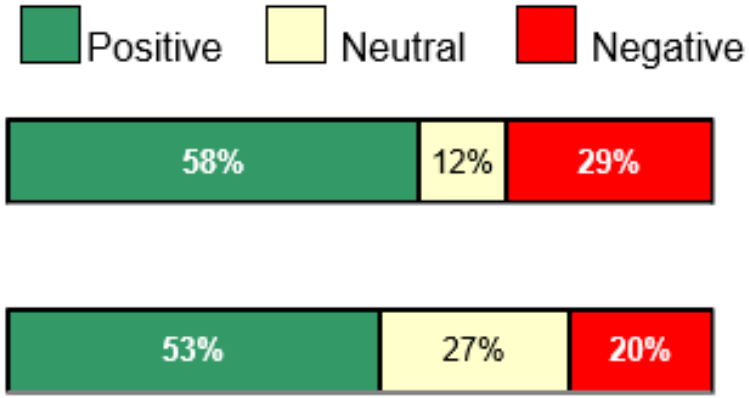


10. Staffing

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

Reverse Worded Question

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



Comments

- 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

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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

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- 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).

AHRQ 2016 User Comparative Database Report

Indiana Patient Safety Center
of the Indiana Hospital Association

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 transistions-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

Indiana Patient Safety Center
of the Indiana Hospital Association

Survey Participant Description:	Indiana Statewide Comparative										
Year Survey Taken:	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	
# Hospitals Participated in Survey	49	34	62	52	60	48	43	66	52	64	
AHRQ Comparative Year*	2007	2008	2009	2010	2011	2012	2012	2014	2014	2016	Change from
Dimension Description	% Positive	% Positive	% Positive	% Positive	% Positive	% Positive	% Positive	% Positive	% Positive	% Positive	2007 to 2016
1. Teamwork Within Units	78.6	78.7	79.9	80.7	80.7	81.4	83.6	80.8	82.0	81.9	3.3
2. Supervisor/Manager Expectations & Actions Promoting Patient Safety	73.3	74.2	73.5	73.4	73.1	74.1	77.5	73.5	74.9	77.4	4.1
3. Organizational Learning--Continuous Improvement	70.0	70.6	70.9	72.4	70.6	70.7	72.7	67.9	69.1	72.4	2.4
4. Management Support for Patient Safety	70.2	69.4	70.1	72.5	70.6	69.8	74.7	65.9	68.0	69.7	-0.5
5. Overall Perceptions of Patient Safety	62.6	62.2	64.3	65.6	64.8	64.7	70.0	63.5	64.4	66.4	3.8
6. Feedback & Communication About Error	59.6	59.7	59.9	64.5	63.3	65.5	68.9	65.1	67.4	64.1	4.5
7. Communication Openness	60.0	60.7	60.8	60.0	60.0	60.6	63.7	60.0	62.2	61.2	1.2
8. Frequency of Events Reported	56.5	56.3	57.1	61.8	61.5	62.4	66.4	62.3	64.7	61.6	5.1
9. Teamwork Across Units	53.2	51.5	53.4	55.3	55.0	55.8	60.0	55.2	56.3	57.7	4.5
10. Staffing	57.4	55.9	59.4	57.7	54.9	54.5	59.1	51.7	51.0	52.9	-4.5
11. Handoffs & Transitions	39.1	39.5	39.7	39.8	39.7	41.6	44.1	40.6	41.3	42.5	3.4
12. Nonpunitive Response to Errors	43.1	43.0	43.4	42.5	42.4	43.7	46.9	42.8	45.1	47.3	4.2

R: < 25th percentile | O: 25-49th percentile | Y: 50-74th percentile | G: 75-89th percentile | B: 90th percentile

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

ICPS Results

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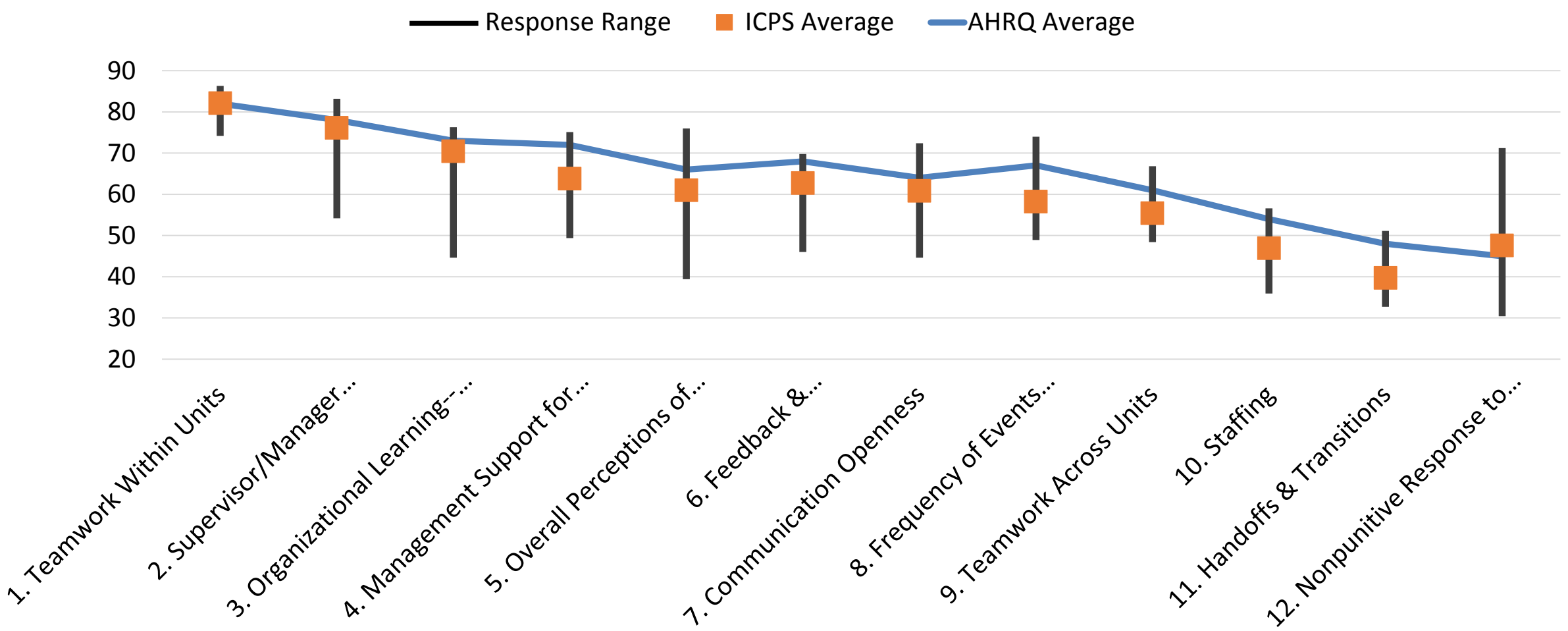

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ICPS Results

Indiana Patient Safety Center
of the Indiana Hospital Association

	ICPS Average	AHRQ Average	Difference	Highest Score
1. Teamwork Within Units	82	82	0	86
2. Supervisor/Manager - Promoting Patient Safety	76	78	-2	83
3. Org. Learning/Continuous Improvement	70	73	-3	76
4. Management Support for Patient Safety	64	72	-8	75
5. Overall Perceptions of Patient Safety	61	66	-5	76
6. Feedback & Communication about Error	63	68	-5	70
7. Communication Openness	61	64	-3	72
8. Frequency of Events Reported	58	67	-9	74
9. Teamwork Across Units	55	61	-6	67
10. Staffing	47	54	-7	57
11. Handoffs & Transitions	40	48	-8	51
12. Nonpunitive Response to Errors	48	45	3	71

HRET-HIIN Resources

Indiana Patient Safety Center
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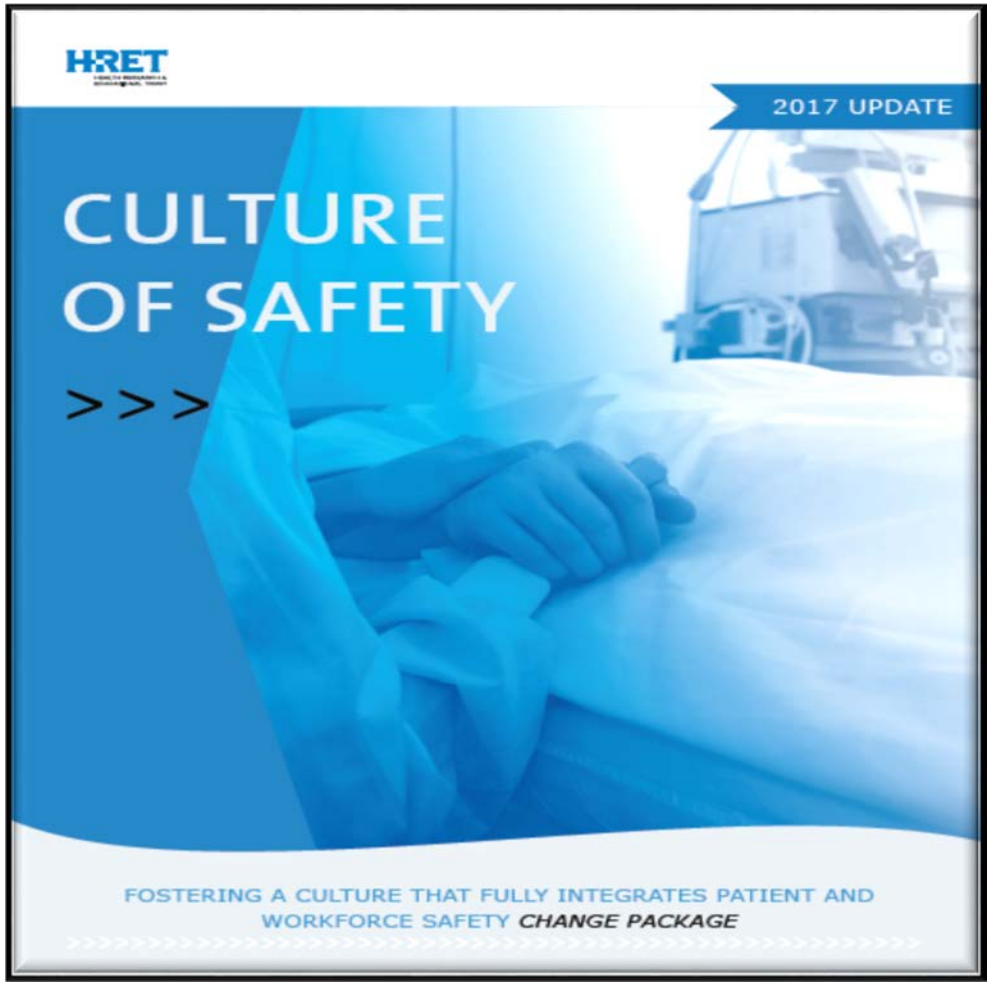

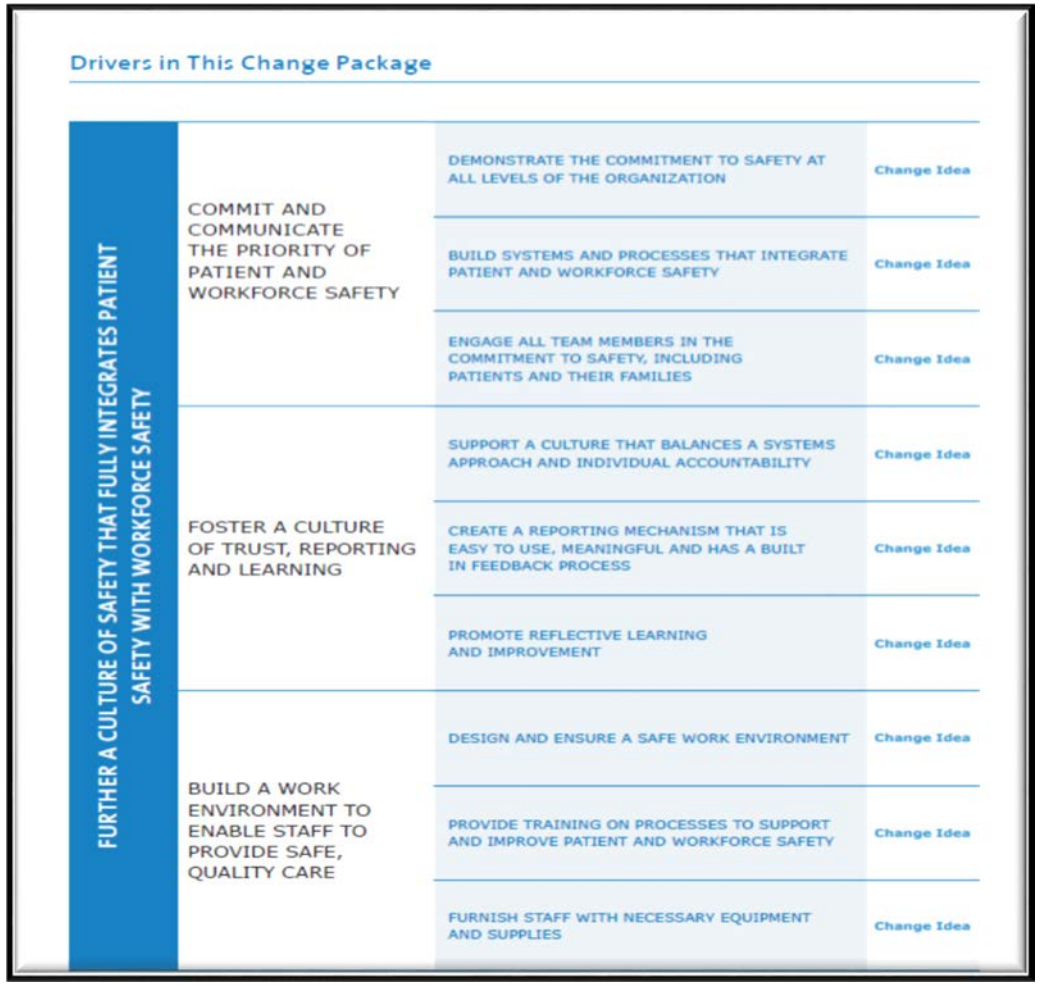

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Culture of Safety Top Ten Checklist

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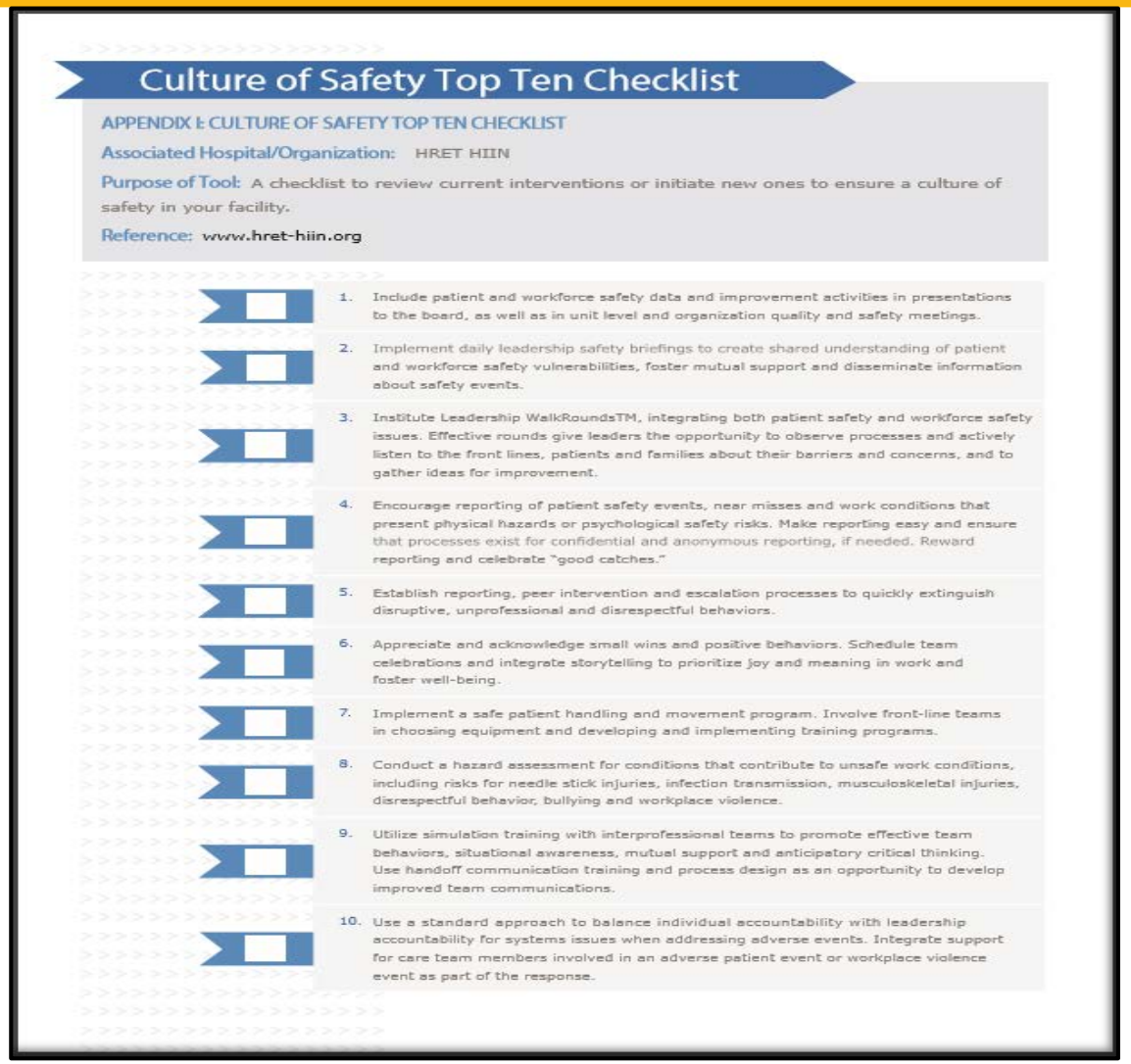


Culture of Safety Top Ten Checklist

APPENDIX I: CULTURE OF SAFETY TOP TEN CHECKLIST

Associated Hospital/Organization: HRET HIIN

Purpose of Tool: A checklist to review current interventions or initiate new ones to ensure a culture of safety in your facility.

Reference: www.hret-hiin.org

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 briefings to create shared understanding of patient and workforce safety vulnerabilities, foster mutual support and disseminate information about safety events.
3. Institute Leadership WalkRoundsTM, integrating both patient safety and workforce safety issues. Effective rounds give leaders the opportunity to observe processes and actively listen to the front lines, patients and families about their barriers and concerns, and to gather ideas for improvement.
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 intervention and escalation processes to quickly extinguish 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 front-line 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 needle stick injuries, infection transmission, musculoskeletal injuries, disrespectful behavior, bullying and workplace violence.
9. Utilize simulation training with interprofessional teams to promote effective team behaviors, situational awareness, mutual support and anticipatory critical thinking. Use handoff 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 care team members involved in an adverse patient event or workplace violence event as part of the response.

CEO Resource From IHI/NPSF

Indiana Patient Safety Center
of the Indiana Hospital Association

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.

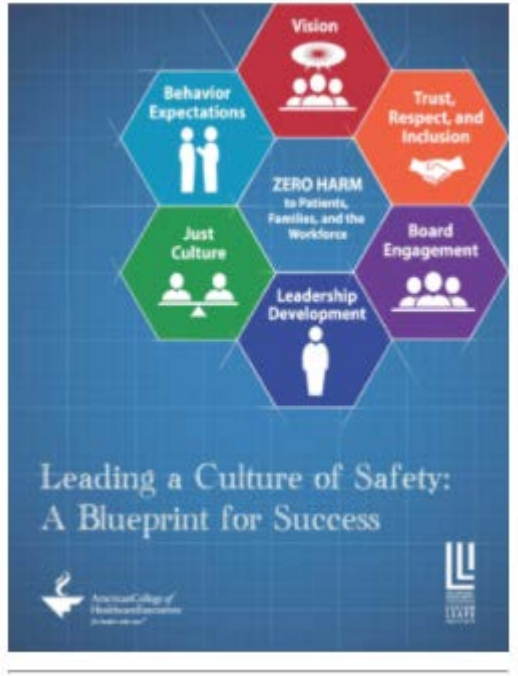
2.) Build trust, respect, and inclusion.

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/cultureofsafety

IHAconnect.org/Quality-Patient-Safety

Resources

Indiana Patient Safety Center
of the Indiana Hospital Association

AHRQ Agency for Healthcare Research and Quality
Advancing Excellence in Health Care

https://www.ahrq.gov/professionals/quality-patient-safety/patientsafetyculture/planningtool.html

https://www.ahrq.gov/professionals/quality-patient-safety/patientsafetyculture/planningtool4.html#items1-3

https://www.ahrq.gov/teamstepps/about-teamstepps/index.html

https://www.ahrq.gov/professionals/quality-patient-safety/patientsafetyculture/hospital/hosp-reports.html

Institute for Healthcare Improvement
NPSF
TOGETHER FOR SAFER CARE

http://www.npsf.org/page/cultureofsafety

World Health Organization

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

HRET
HEALTH RESEARCH & EDUCATIONAL TRUST

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

The Joint Commission

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

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

Questions

Our IPSC Team

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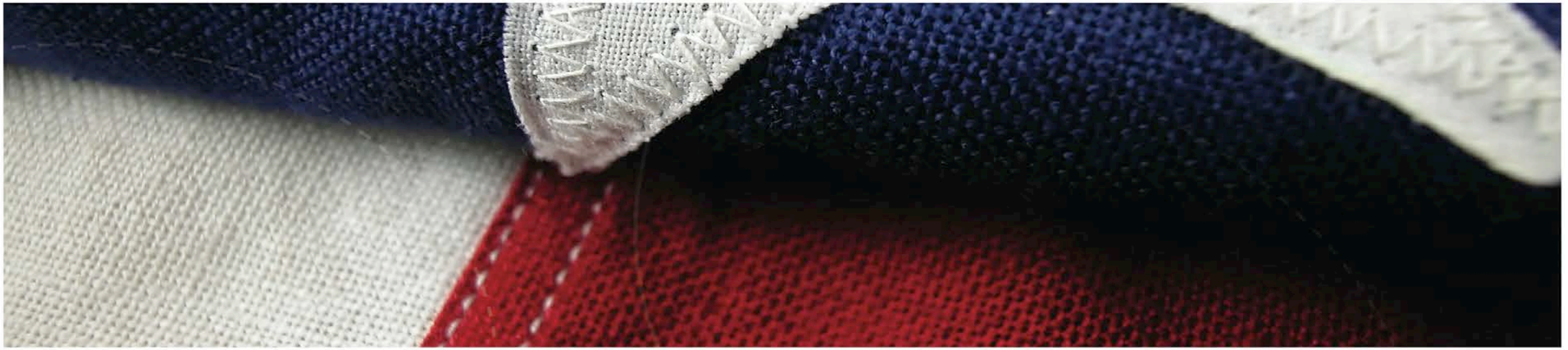

Root Cause Analysis Process

Karen J. Arthur, PharmD, BCPS
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Medication Safety Program Manager
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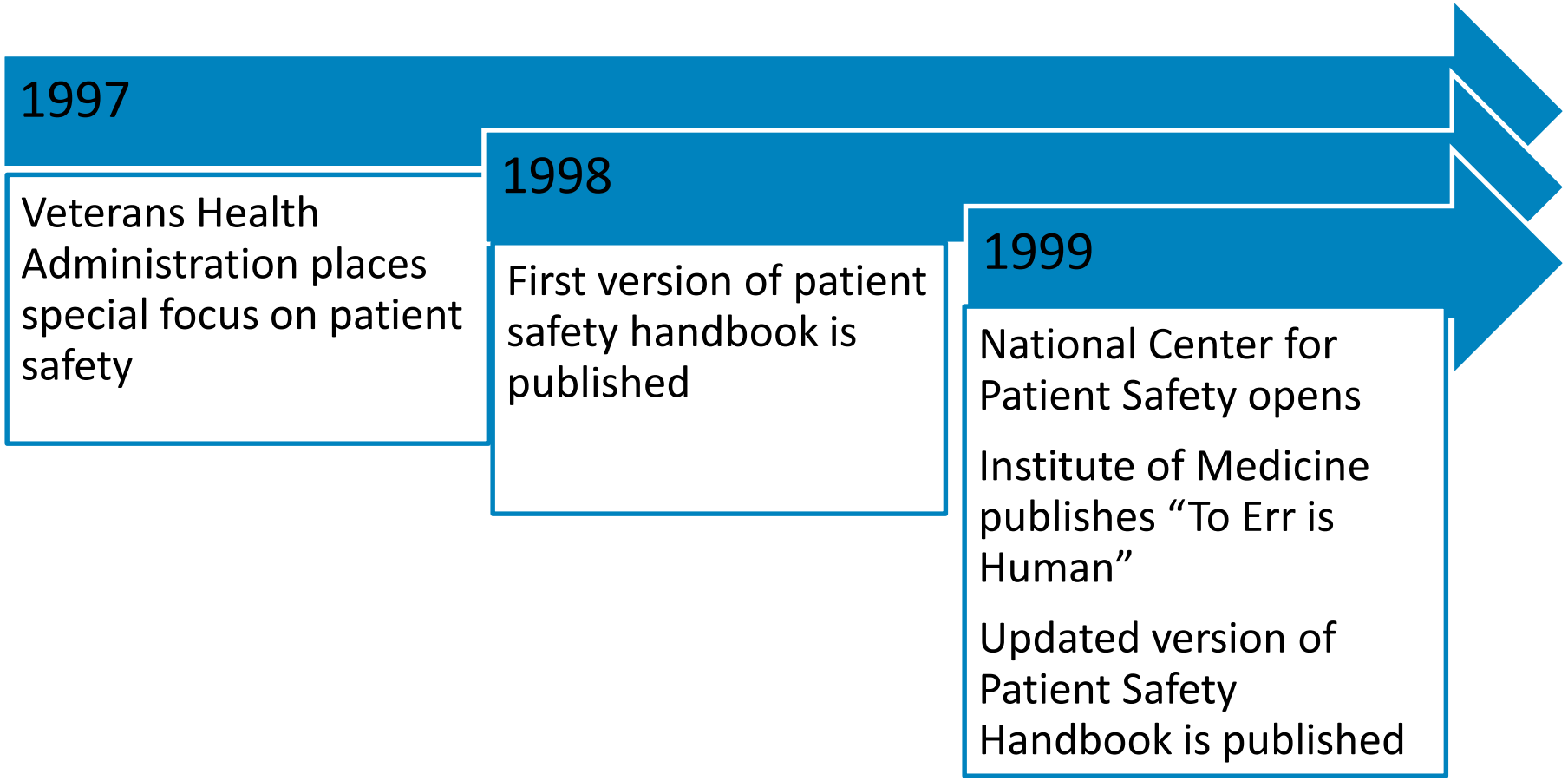
VA HEALTH CARE | Defining EXCELLENCE in the 21st Century

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



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

Probability & Severity	Catastrophic	Major	Moderate	Minor
Frequent	3	3	2	1
Occasional	3	2	1	1
Uncommon	3	2	1	1
Remote	3	2	1	1

Safety Assessment Code

Catastrophic	Major
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

Catastrophic	Major
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

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

Probability & Severity	Catastrophic	Major	Moderate	Minor
Frequent	3	3	2	1
Occasional	3	2	1	1
Uncommon	3	2	1	1
Remote	3	2	1	1

What is the SAC Score

	Actual	Potential
Severity		
Probability		

Is an RCA Required?

Aggregate?

What is the SAC Score

	Actual (2)	Potential (3)
Severity	Moderate	Major
Probability	Frequent	Frequent

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 PaO_2. 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

Probability & Severity	Catastrophic	Major	Moderate	Minor
Frequent	3	3	2	1
Occasional	3	2	1	1
Uncommon	3	2	1	1
Remote	3	2	1	1

What is the SAC Score

	Actual	Potential
Severity		
Probability		

Is an RCA Required?

Aggregate?

What is the SAC Score

	Actual (1)	Potential (3)
Severity	Moderate	Catastrophic
Probability	Occasional	Occasional

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

Probability & Severity	Catastrophic	Major	Moderate	Minor
Frequent	3	3	2	1
Occasional	3	2	1	1
Uncommon	3	2	1	1
Remote	3	2	1	1

What is the SAC Score

	Actual	Potential
Severity		
Probability		

Is an RCA Required?

Aggregate?

What is the SAC Score

	Actual (1)	Potential (3)
Severity	Moderate	Catastrophic
Probability	Occasional	Occasional

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

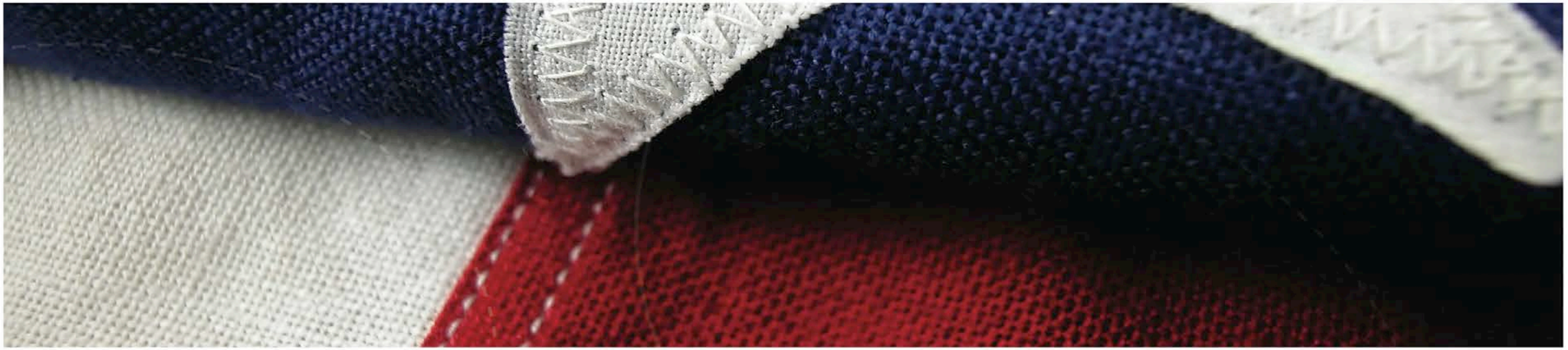
- Weaker Actions
  - Double Checks
  - Warnings and labels
  - New procedure/memorandum/policy
  - Training
  - Additional study/analysis

Resources

- https://www.patientsafety.va.gov/professionals/onthejob/rca.asp
- Included RCA tools
- RCA Step by Step by step guide
- Root Cause Analysis flow Charts
- Patient Safety Handbook

References

- VHA Handbook 1050.01, VHA National Patient Safety Improvement Handbook, March 4, 2011.



Questions/Comments

VA HEALTH CARE Defining EXCELLENCE in the 21st Century

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

The Problem

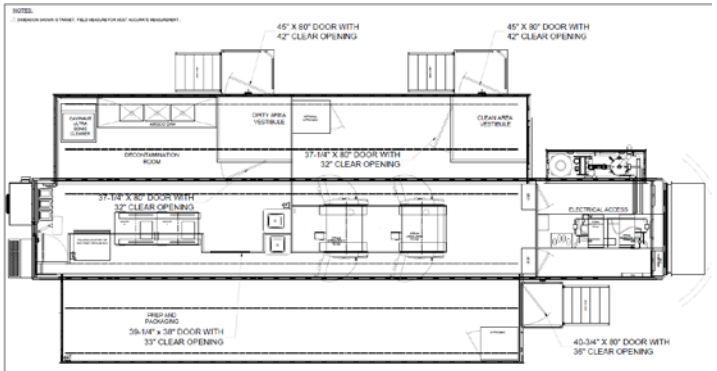
Renovating Sterile Processing Decontamination Area

- 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

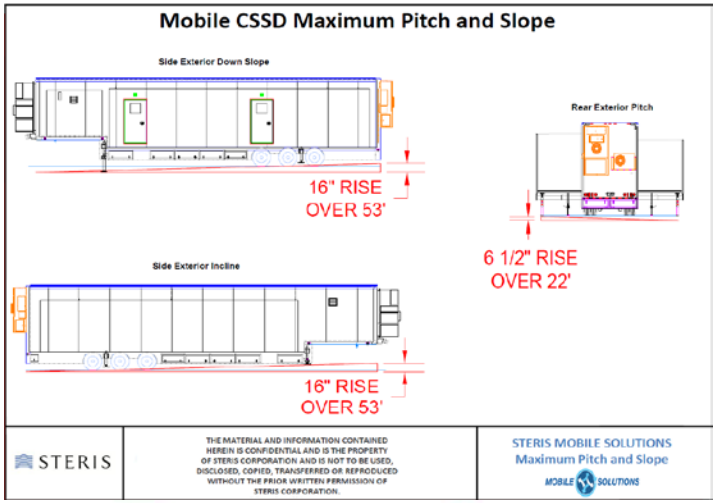
The Opportunity

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



STERIS Mobile CSSD 106 and 107 Entrance and Egress Door Dimensions



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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.

Starting the Journey

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.

FMEA in Healthcare

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

FMEA in Healthcare

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

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FAILURE MODE EFFECTS ANALYSIS

PROCESS STEP	FAILURE MODE	EFFECT OF FAILURE	SEV	POTENTIAL CAUSE OF FAILURE	OCR	CURRENT CONTROLS FOR PREVENTION/DETECTION	DET	RPN	RECOMMENDED ACTION	IMP	EFF	PRIO	RESPONSIBLE	ACTION TAKEN	SEV	OCR	DET	RPN
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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

AN HFMEA FORM

St. Vincent Indianapolis
HEALTHCARE FAILURE MODE EFFECTS ANALYSIS

				SCORING			DECISION																
PROCESS STEP	FAILURE MODE	EFFECT OF FAILURE	POTENTIAL CAUSE OF FAILURE	SEV	PROB	HZRD	SPW?	ECM?	DETECT?	PROCEED?	ACTION TYPE *(Control, Accept, Eliminate)*	RECOMMENDED ACTION/RATIONALE FOR STOPPING	OUTCOME MEASURE	RESPONSIBLE	IMP	EFF	PRIO	ACTION TAKEN	COMPLETION DATE	SEV	OCR	DET	RPN
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Identify Failure Modes and Their Effects

Evaluate Risk and Prioritize

Determine, Access And Take Actions

Measure Impact

Hazard Score
Severity x Probability

Priority of Action (PRIOR)
Effort x Impact x RPN

The FMEA Journey

STEP 1: Define The Scope

- Target high risk processes

High Risk Process	Healthcare
• Variable inputs	• Humans
• Complex	• Many processes
• Non-standardized	• Many lacks standard
• Heavily dependent on human interaction	• High degree of human interaction
• Hierarchical (not team) based	• Very hierarchical

Source: Ting Ching Ching, Using FMEA for Process Improvement in Patient Safety

- Set the boundaries and focus; understand start and end point

Our Journey:

To develop processes and policies around the implementation and operation of the mobile decontamination units

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The FMEA Journey

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*

The FMEA Journey

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 need.
- 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

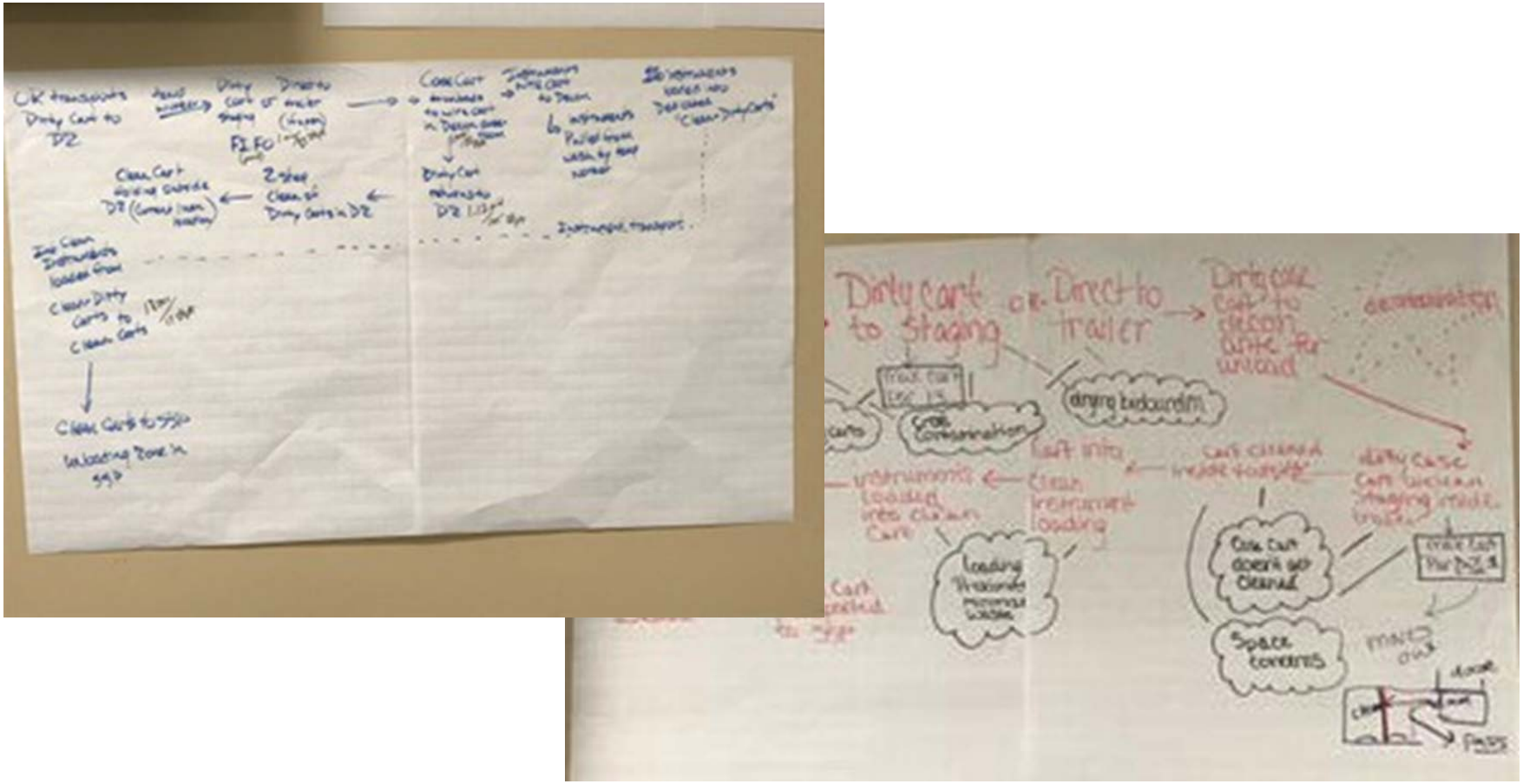
Our Journey:

- 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 in to 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.*

The FMEA Journey

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

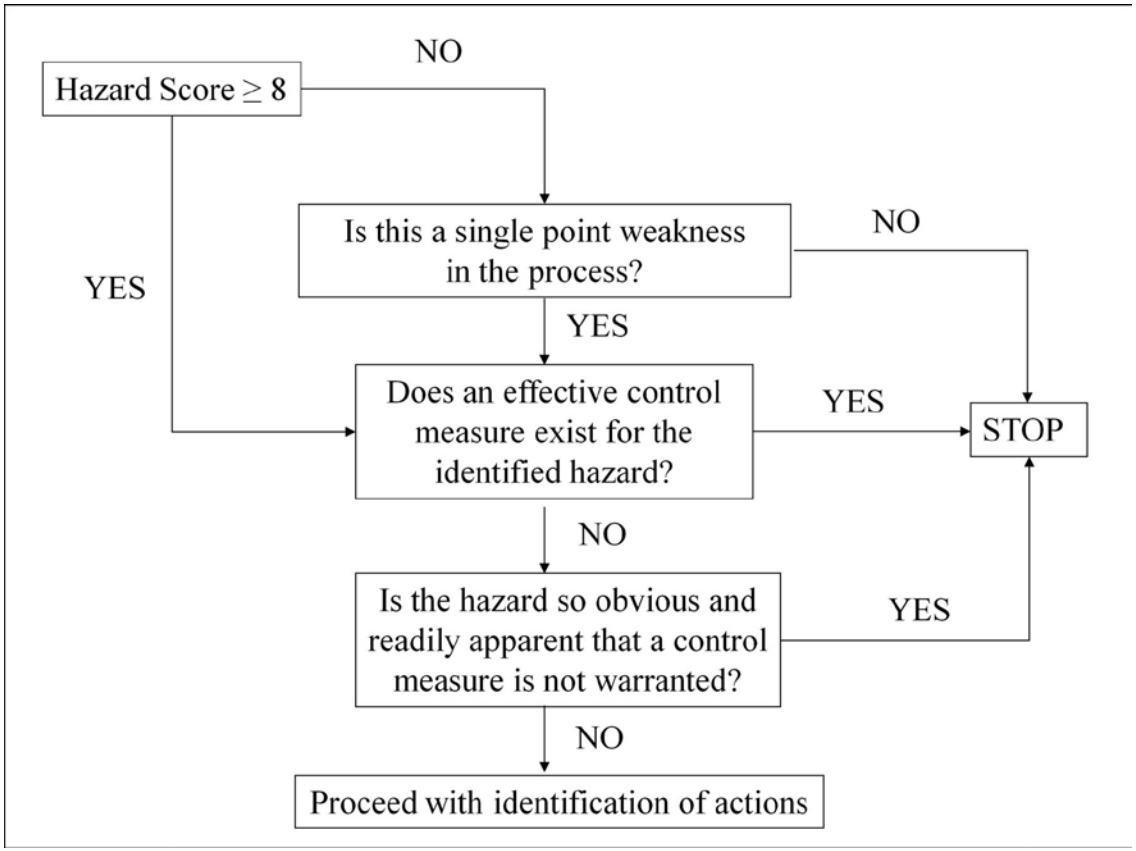
SEVERITY	Frequent (4)	Occasional (3)	Uncommon (2)	Remote (1)
Catastrophic (4)	16	12	8	4
Major (3)	12	9	6	3
Moderate (2)	8	6	4	2
Minor (1)	4	3	2	1
	PROBABILITY			

KEY

- Must Take Action
- Should Take Action
- May Need to Take Action

STEP 4: Conduct Failure Mode/Hazard Analysis

- Evaluate Hazard Using Decision Tree



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

PROCESS STEP		FAILURE MODE	EFFECT OF FAILURE	POTENTIAL CAUSE OF FAILURE	SCORING SEV	PROB	HZRD
5A	Decontamination	Mandatory Evacuation	Delayed Processing, Backup of Cases Carts, IUSS Increase	Severe Weather	4	3	12
				Equipment Failure	4	2	8
		Medical Emergency of Associate in Trailer/Walkway	Delay of Response, Impact to Associate	Education/ Training related to location of trailers	4	2	8
		Security Breech	Vandalism, Delay in Processing	Surgeon Exiting	2	3	6
				Active Shooter	4	1	4

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

The FMEA Journey

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

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The FMEA Journey

STEP 5: Develop and Implement Actions and Countermeasures

Our Journey:

St. Vincent Indianapolis
FAILURE MODE EFFECTS ANALYSIS

PROJECT NAME:
Mobile Sterilization Process

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

ACTION TYPE *(Control, Accept, Eliminate)*	RECOMMENDED ACTION/RATIONALE FOR STOPPING	OUTCOME MEASURE	RESPONSIBLE
Control	Evacuation for associate safety; explore options for utilizing CVOR decon if weather persists	Continued safe operation	OR/SSP Leadership

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:

STATUS	ACTION TAKEN	COMPLETION DATE
Complete	Existing policy governing severe weather and evacuation plan will apply; drills (fire drill) executed with team.	5/30/2017

St. Vincent Indianapolis
FAILURE MODE EFFECTS ANALYSIS

PROJECT NAME:
Mobile Sterilization Process

PROCESS STEP		FAILURE MODE	EFFECT OF FAILURE	POTENTIAL CAUSE OF FAILURE	SCORING SEV	PROB	HZRD	ACTION TYPE (Control, Accept, Eliminate)	RECOMMENDED ACTION/RATIONALE FOR STOPPING	OUTCOME MEASURE	RESPONSIBLE	STATUS	ACTION TAKEN	COMPLETION DATE
5A	Decontamination	Mandatory Evacuation	Delayed Processing, Backup of Cases Carts, IUSS Increase	Severe Weather	4	3	12	Control	Evacuation for associate safety; explore options for utilizing CVOR decon if weather persists	Continued safe operation	OR/SSP Leadership	Complete	Existing policy governing severe weather and evacuation plan will apply; drills (fire drill) executed with team.	5/30/2017
				Equipment Failure	4	2	8	Control	Evacuation for associate safety; explore options for utilizing CVOR decon for long term failure; Trimedex to be consulted for trailer malfunctions	Continued safe operation	OR/SSP Leadership	Complete	Maximum cart capacity plan formed and communicated; visiual cue (light system) in place to indicate capacity plan activiation required; Trimedex contact info posted in both trailers for maintenance needs.	5/4/2017
		Medical Emergency of Associate in Trailer/Walkway	Delay of Response, Impact to Associate	Education/ Training related to location of trailers	4	2	8	Control	Education/Maps provided for emergency responders provided; Emergency Drills to be executed	Responders act in acceptable amount of time	PI/ED	Complete	Education/maps provided to ED and staff educated on location of trailers; Emergency Drills executed with SSP and facility.	5/4/2017
		Security Breech	Vandalism, Delay in Processing	Surgeon Exiting	2	3	6	Control	Medical staff to be educated on new regulations related to temporary structure	Medical staff exit the building properly	OR Leadership	Complete	Secondary location provided for Medical staff entry and exit from the building	5/1/2017
				Active Shooter	4	1	4	Stop	Existing policy and training provided; no additional action required					

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

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Safety Event Review

Riley Hospital for Children
Indiana University Health

Kristin Cummins, DNP, RN, NE-BC

Amy Birchfield, BSN, RN

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

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North Shore LIJ
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HOSPITAL
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Children's
Hospital of Pittsburgh
of UPMC
KAPI'OLANI
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& Health Center
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Helen DeVos
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University of Vermont
Children's Hospital
Children's
HOSPITAL & MEDICAL CENTER
Children's National
Medical Center
WINTHROP
University Hospital
Children's Medical Center
Kids' Your Health Means Everything
HEALTH
University of Minnesota
Masonic Children's Hospital
The Children's Hospital of Philadelphia
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PROMEDICA
TOLEDO CHILDREN'S HOSPITAL
children's hospital
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CovenantChildren's
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MEDICAL CENTER
Cleveland Clinic Children's
Hasbro Children's Hospital
The Pediatric Division of Rhode Island Hospital
A Lifespan Partner
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Children's Hospital of Chicago
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Children's Hospital
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Children's Hospital
at Vanderbilt
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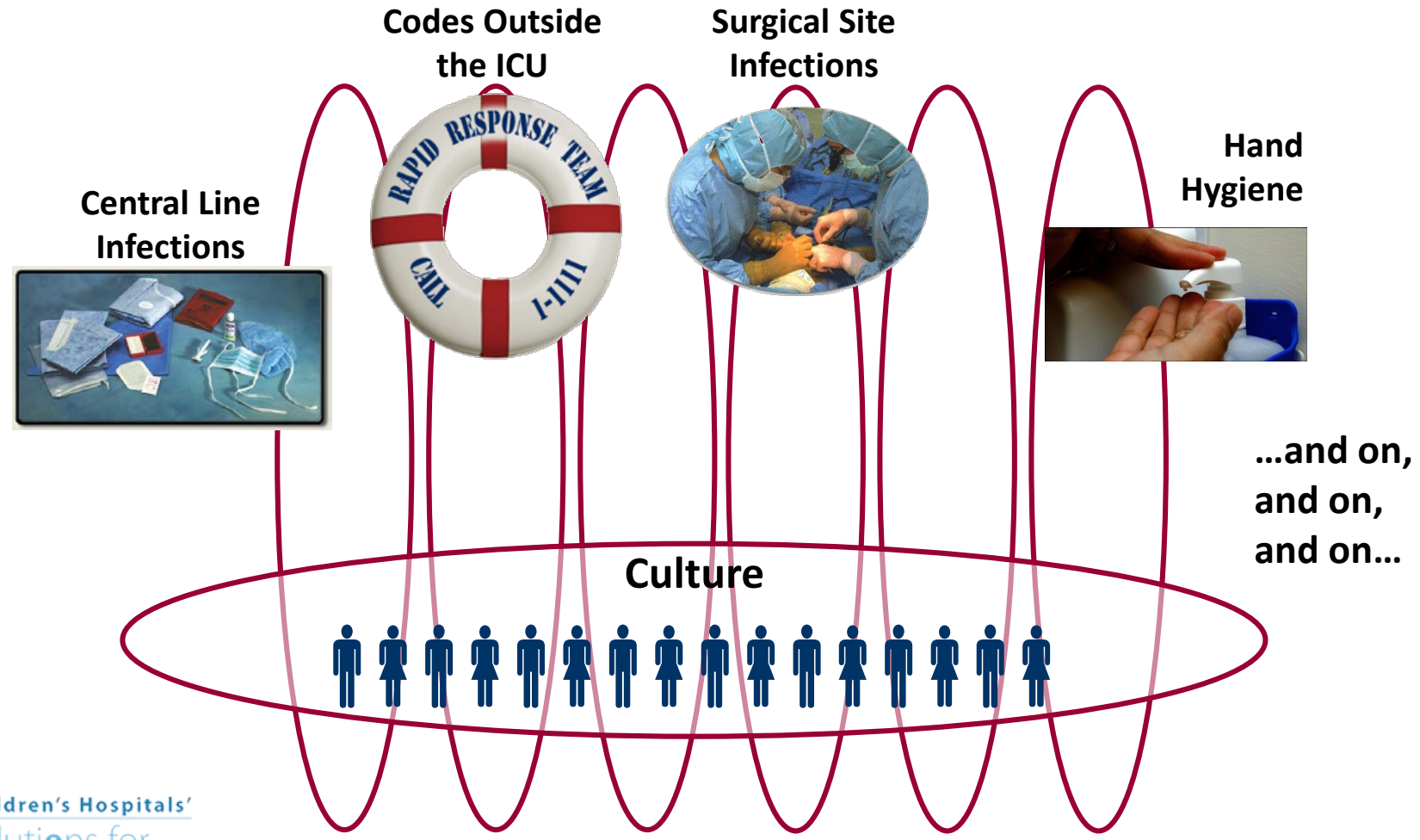
Complementary Strategies



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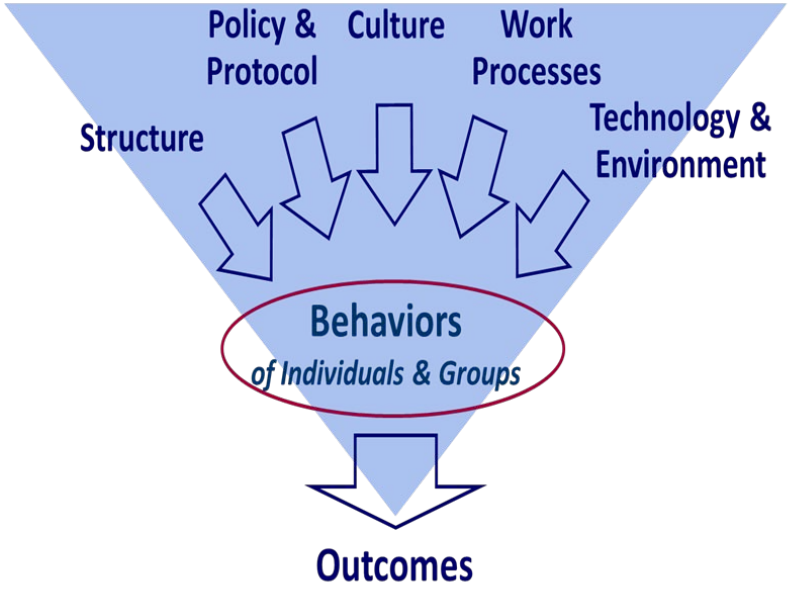
Safety Event Reporting

- 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)



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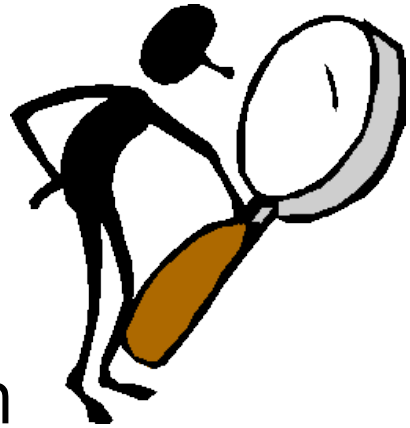
Eyes on Incident Reports

- 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)



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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

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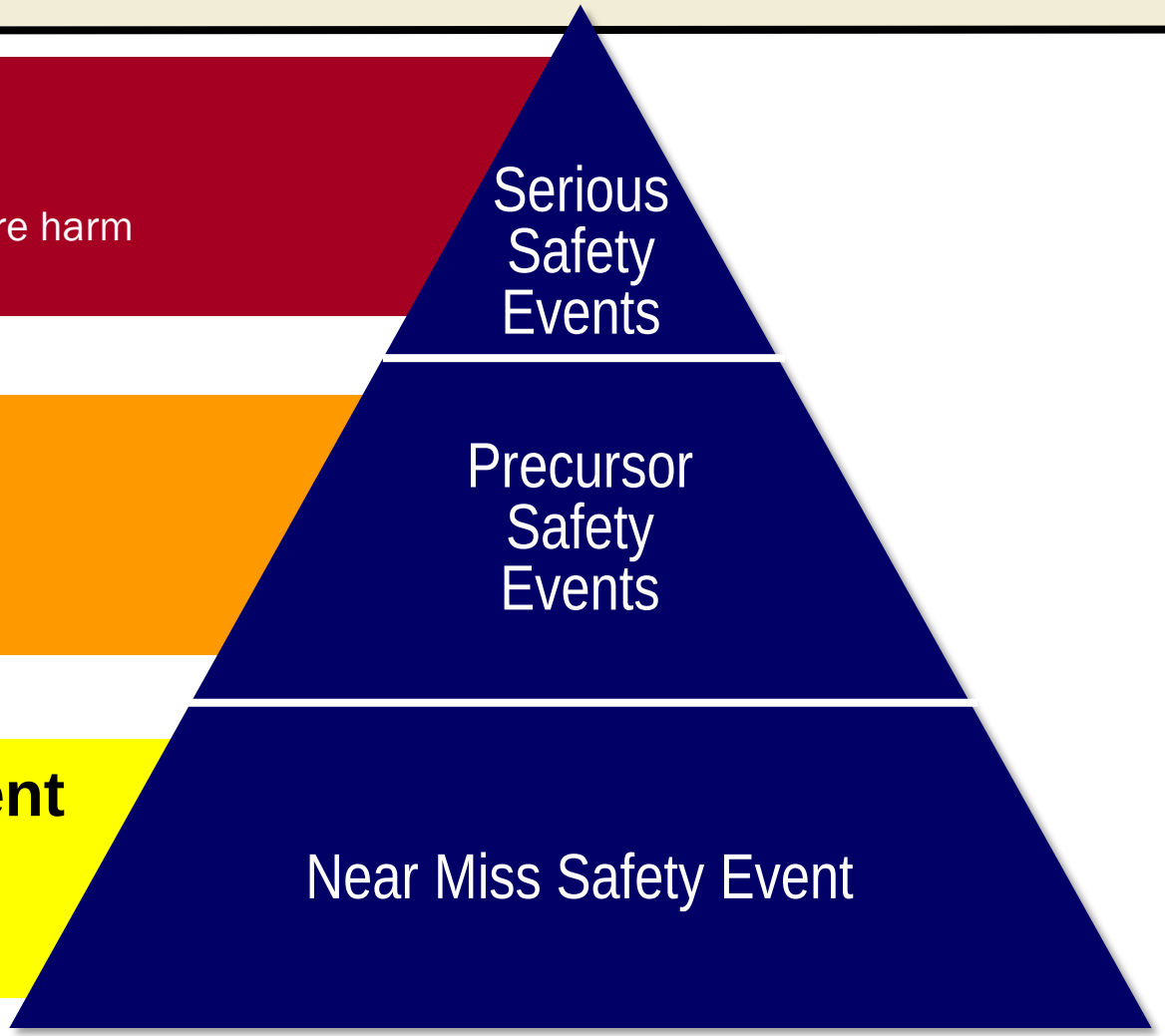
A deviation from generally accepted performance standards (GAPS) that…

SEC Safety Event Classification SM HPI

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



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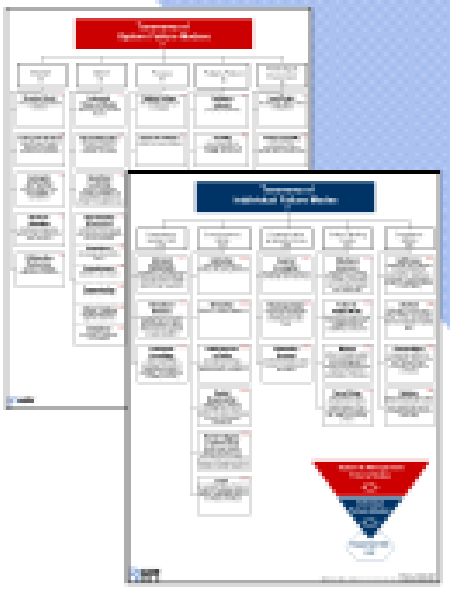
Failure Modes

Causal Factors of Inappropriate Acts



System & Management Failure Modes (26)

- Structure (4 modes)
- Culture (8 modes)
- Process (6 modes)
- Policy & Protocol (4 modes)
- Technology & Environment (4 modes)

Individual Failure Modes (20)

- Competency (3 modes)
- Consciousness (6 modes)
- Communication (3 modes)
- Critical Thinking (4 modes)
- Compliance (4 modes)

Inappropriate Act

HPI

Slide 47

Children

WHY the individual experienced the error (System-related)

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

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HOW the individual experienced the error

Competency	The person does not have the knowledge of how to perform the task or a well-developed skill in performing the task.
Consciousness	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.
Communication	The person receives information and hears it incorrectly or ascribes incorrect meaning to the information.
Critical Thinking	The person fails in the cognitive processing of information or in decision making based on information.
Compliance	The person knows the performance expectation, thinks about it at the time, and makes a choice to act differently.

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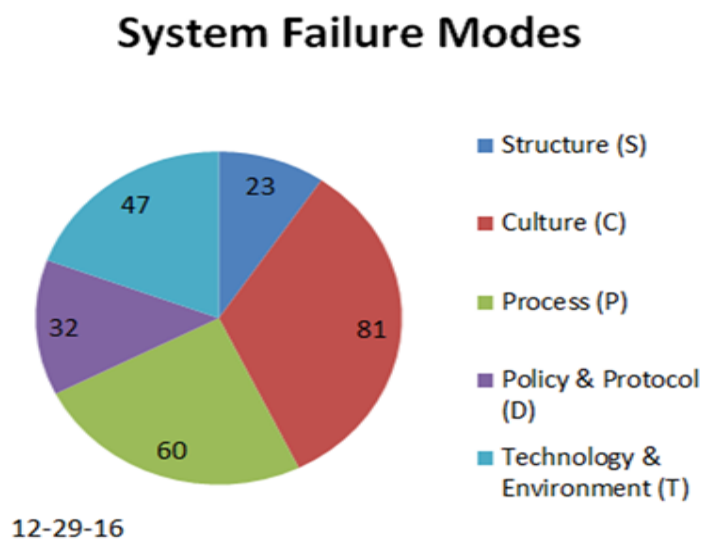
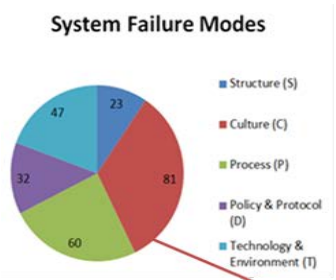
FAILURE MODE DATA

System Failure Modes



12-29-16



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

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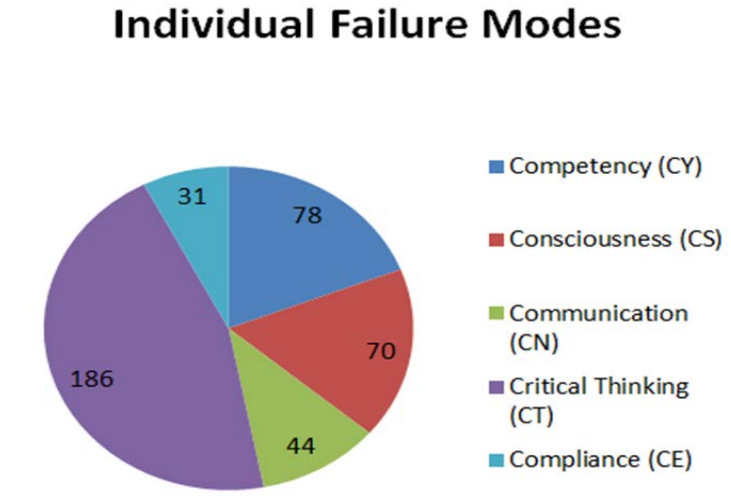
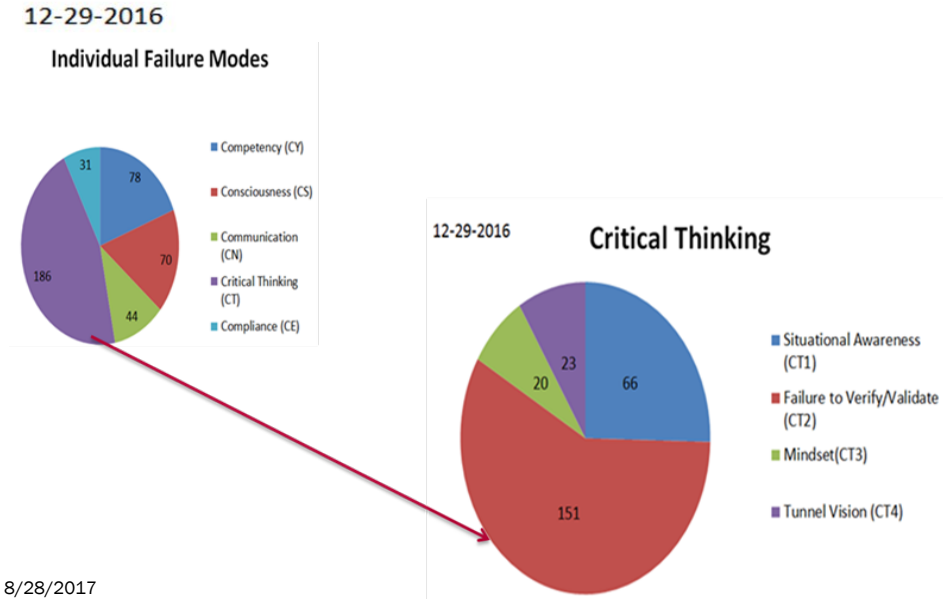
Individual Failure Modes





- Drives selection of effective prevention strategies
- Assists in the evaluation of education, communication, and accountability among team members

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LEADER FAILURE MODE TRAINING

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Purpose

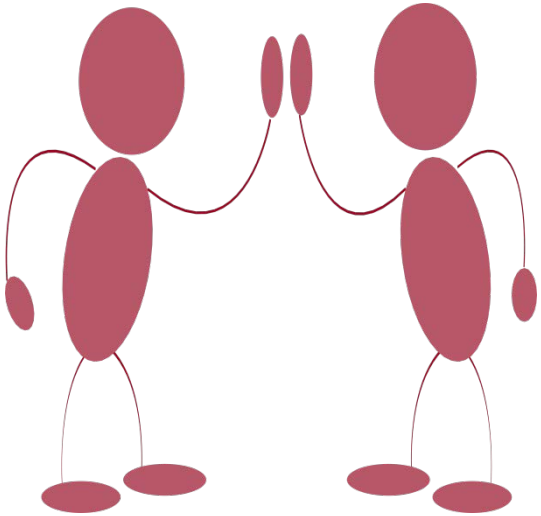
Effective responses to incidents

Identify error modes

Trend error modes

Intentional focus on trended data

ZERO PRVENTABLE HARM



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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

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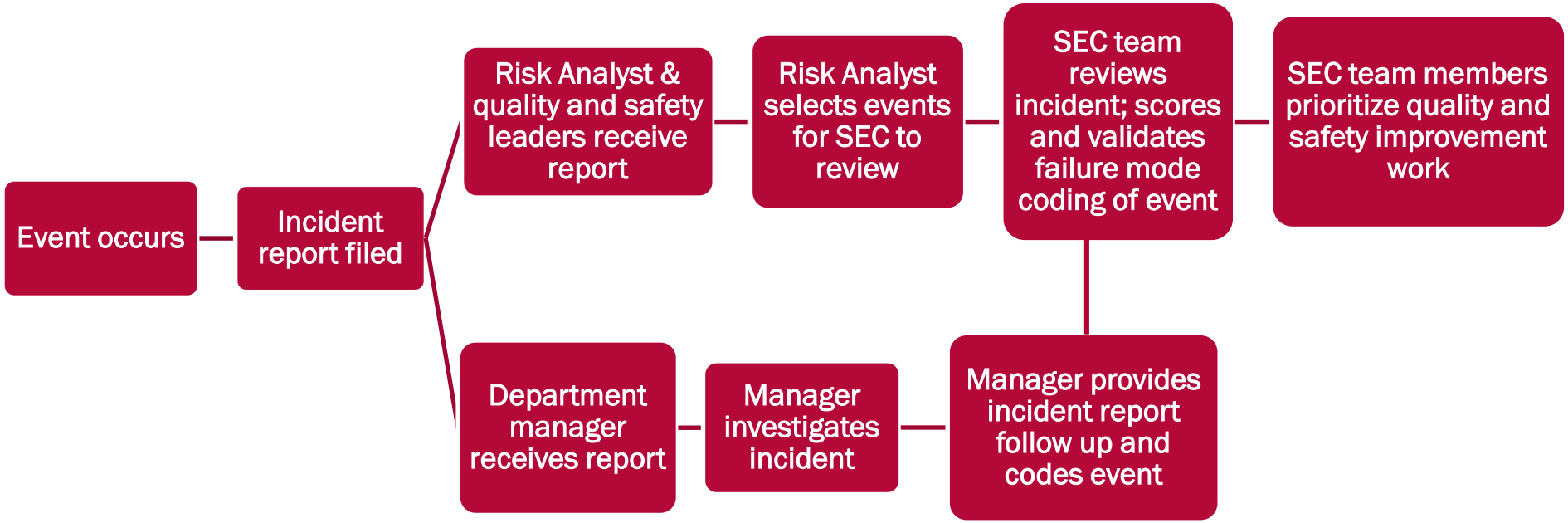
Safety Event Review Process



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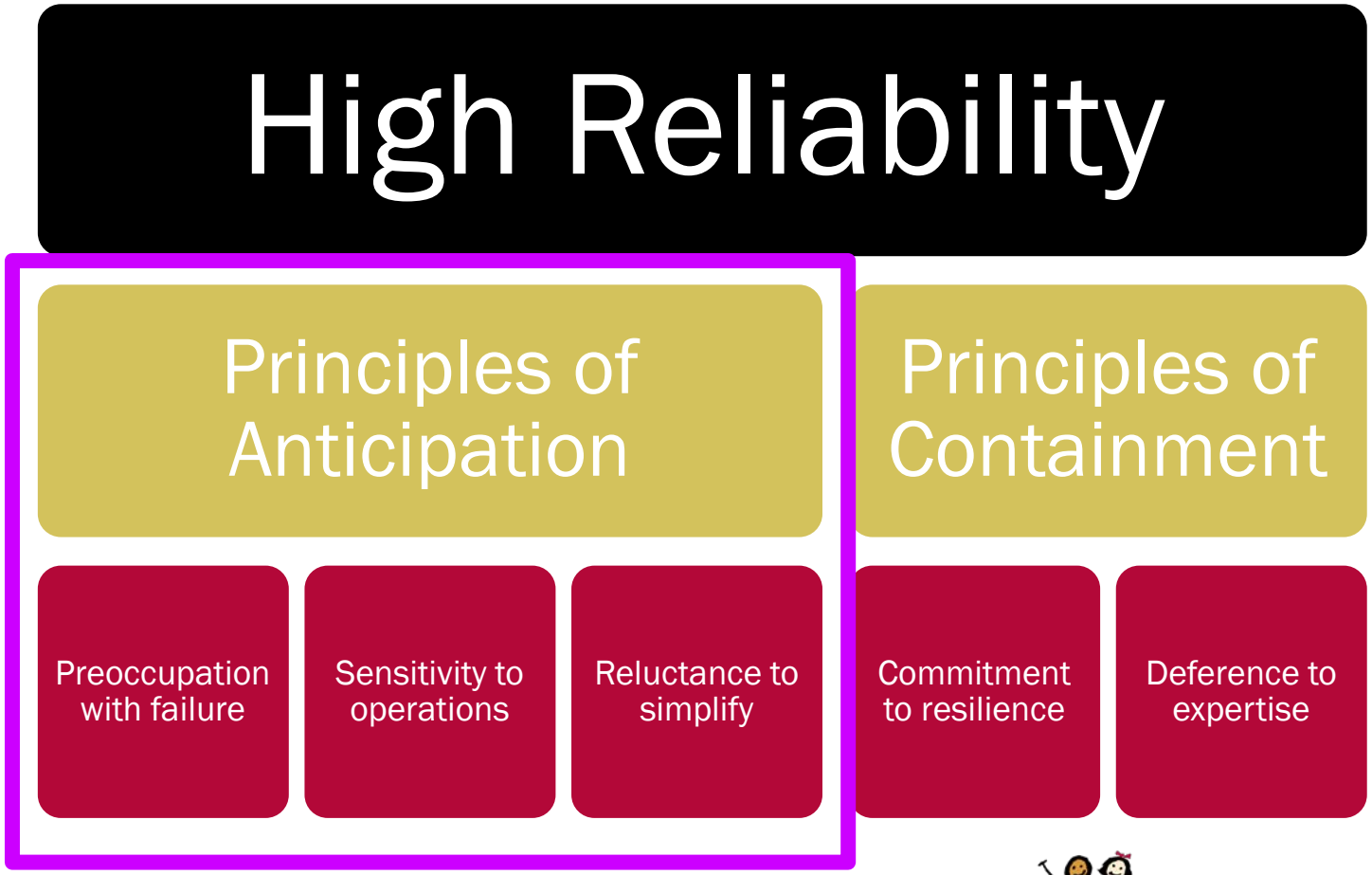
High Reliability Organizing



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Risk Mitigation Strategies

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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

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Example:

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.*

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Example:

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.*

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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

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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

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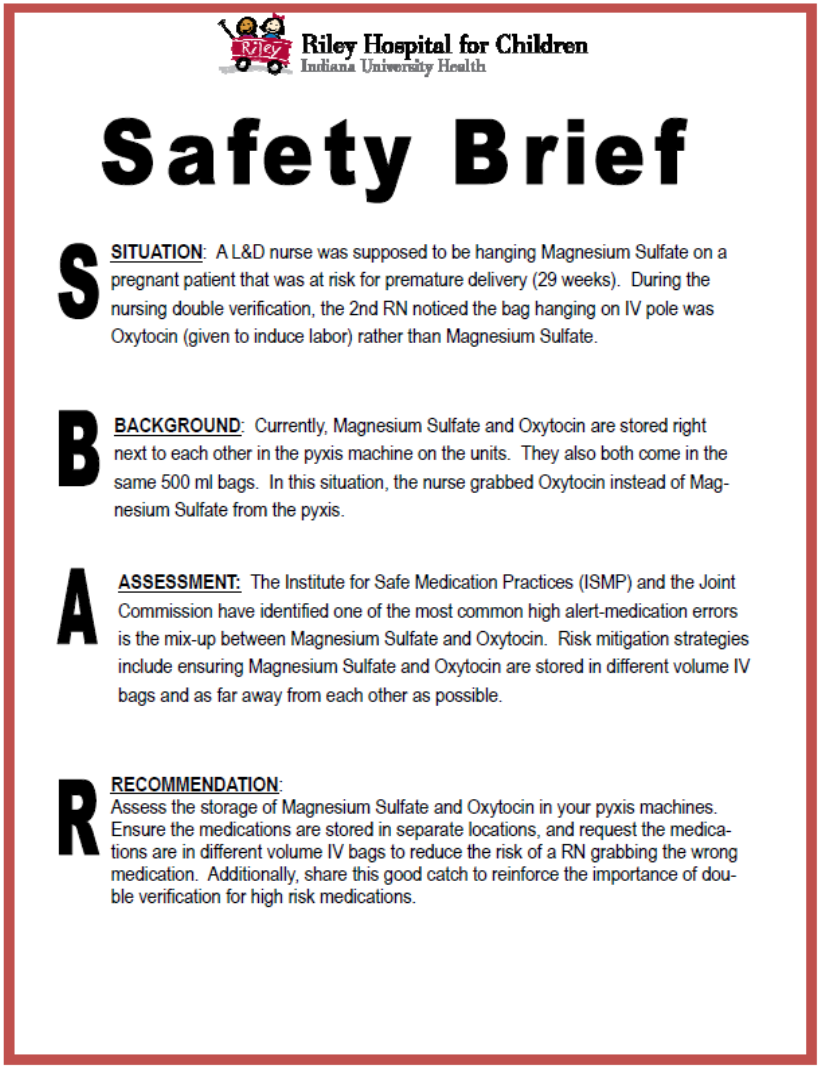
SBAR example



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Safety Brief

S **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.

B **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.

A **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.

R **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

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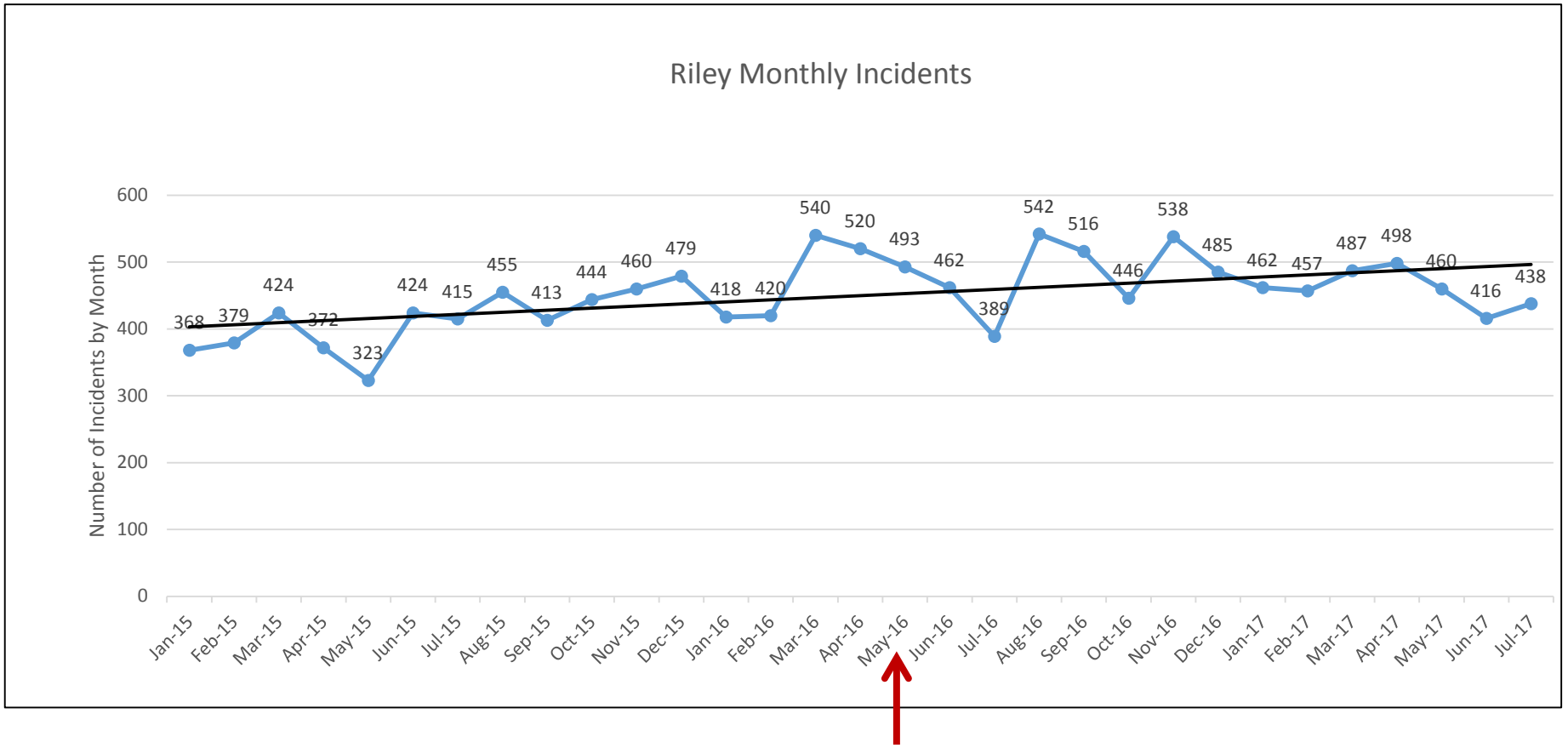
OUTCOMES

Incident Reporting



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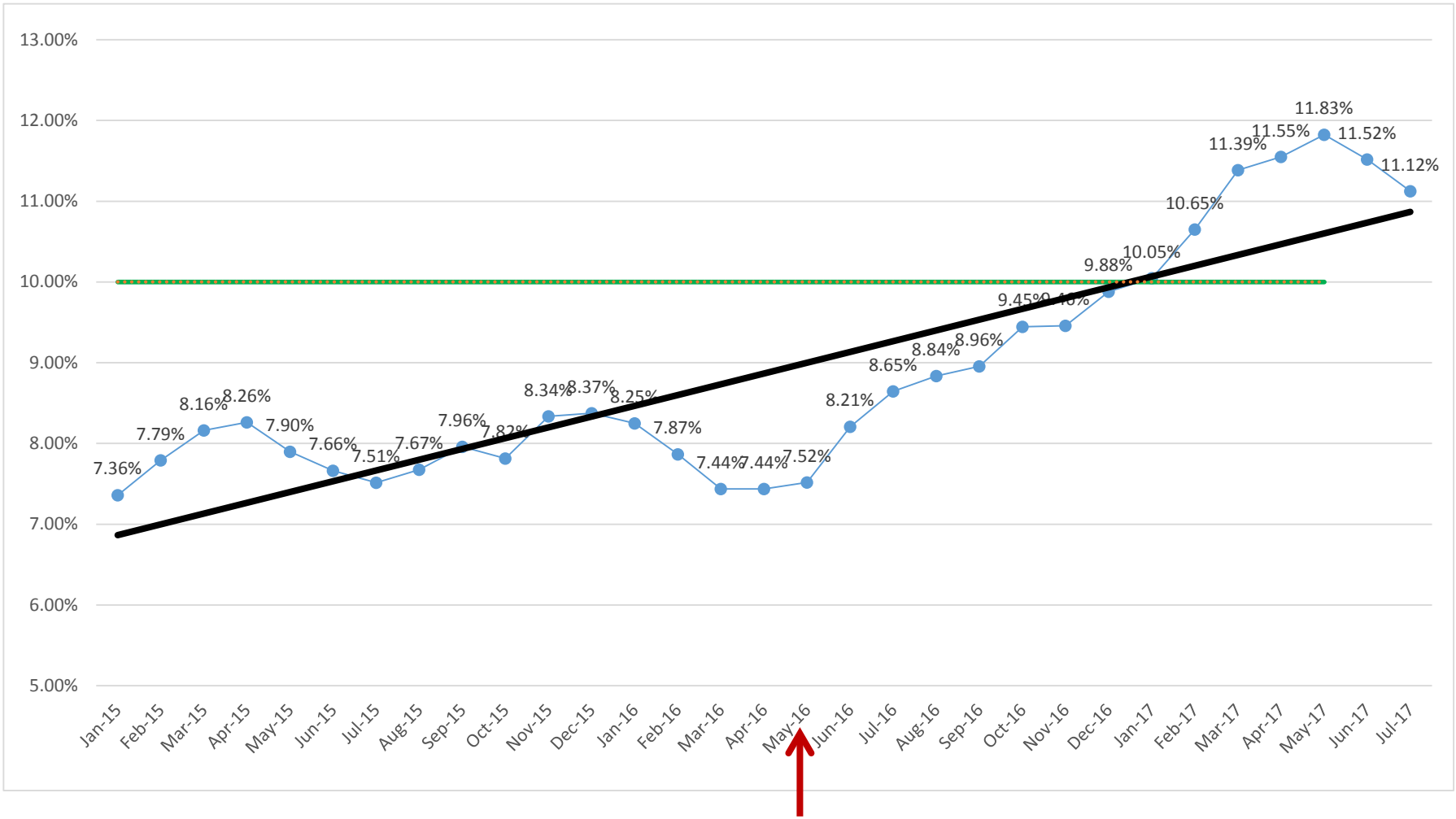
Incident Reporting – Good Catches



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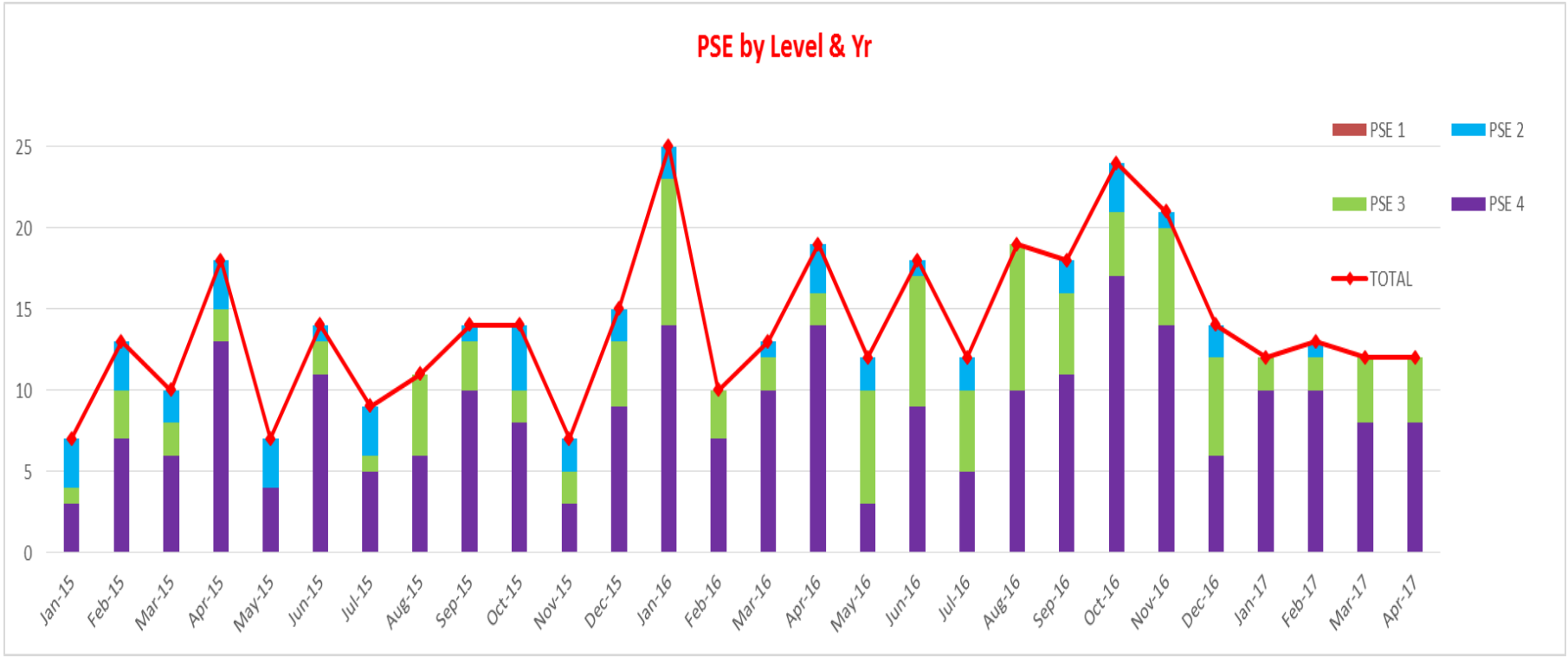
Precursor Safety Events



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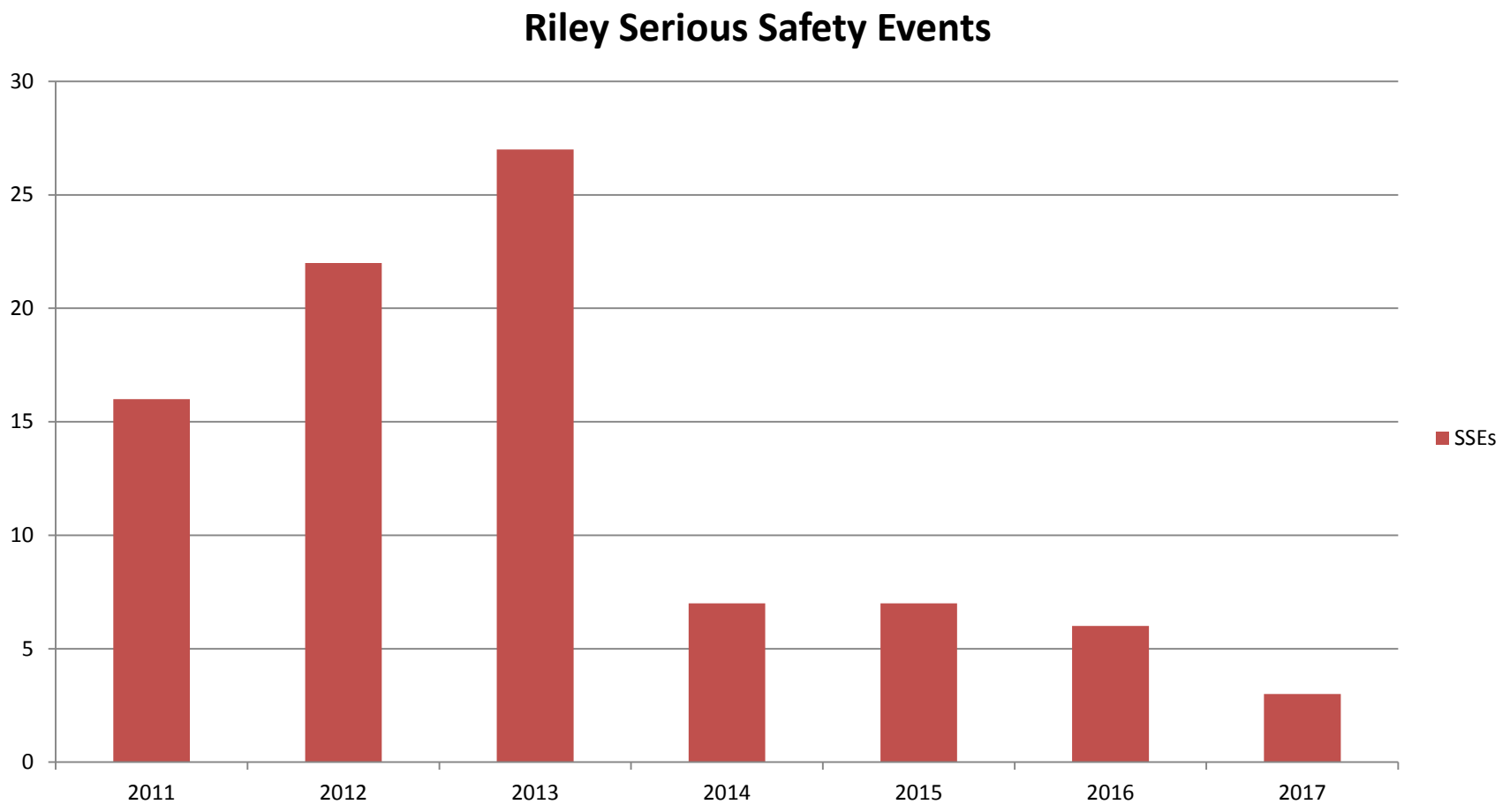
Serious Safety Events



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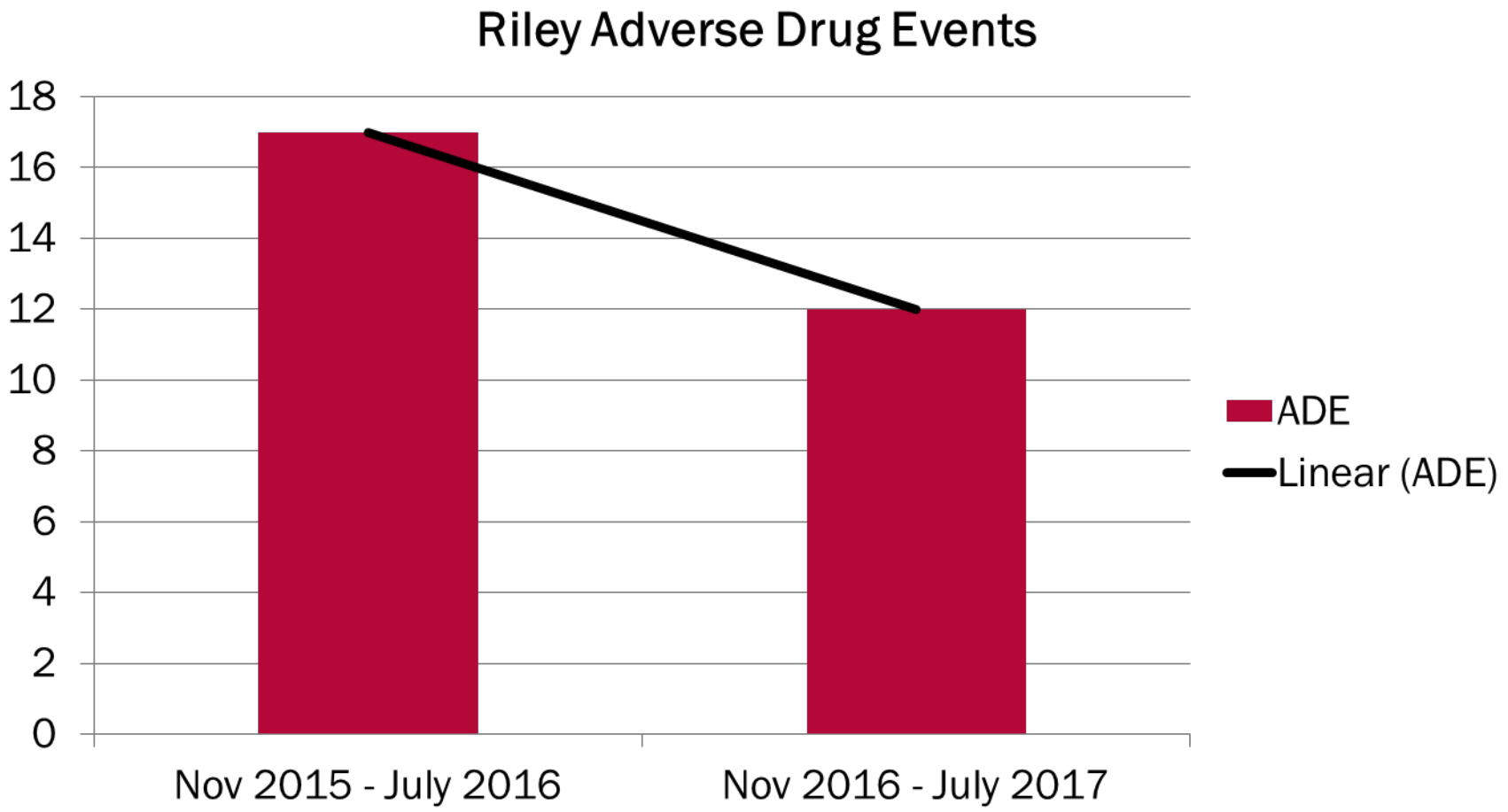
Adverse Drug Events



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Team Member Engagement

Quality and Safety	2015	2016	2017
"This organization provides high-quality care and service" **key driver	3.81	4.23	4.22
"This organization makes every effort to deliver safe, error free care to patients" **key driver	3.74	4.21	4.24

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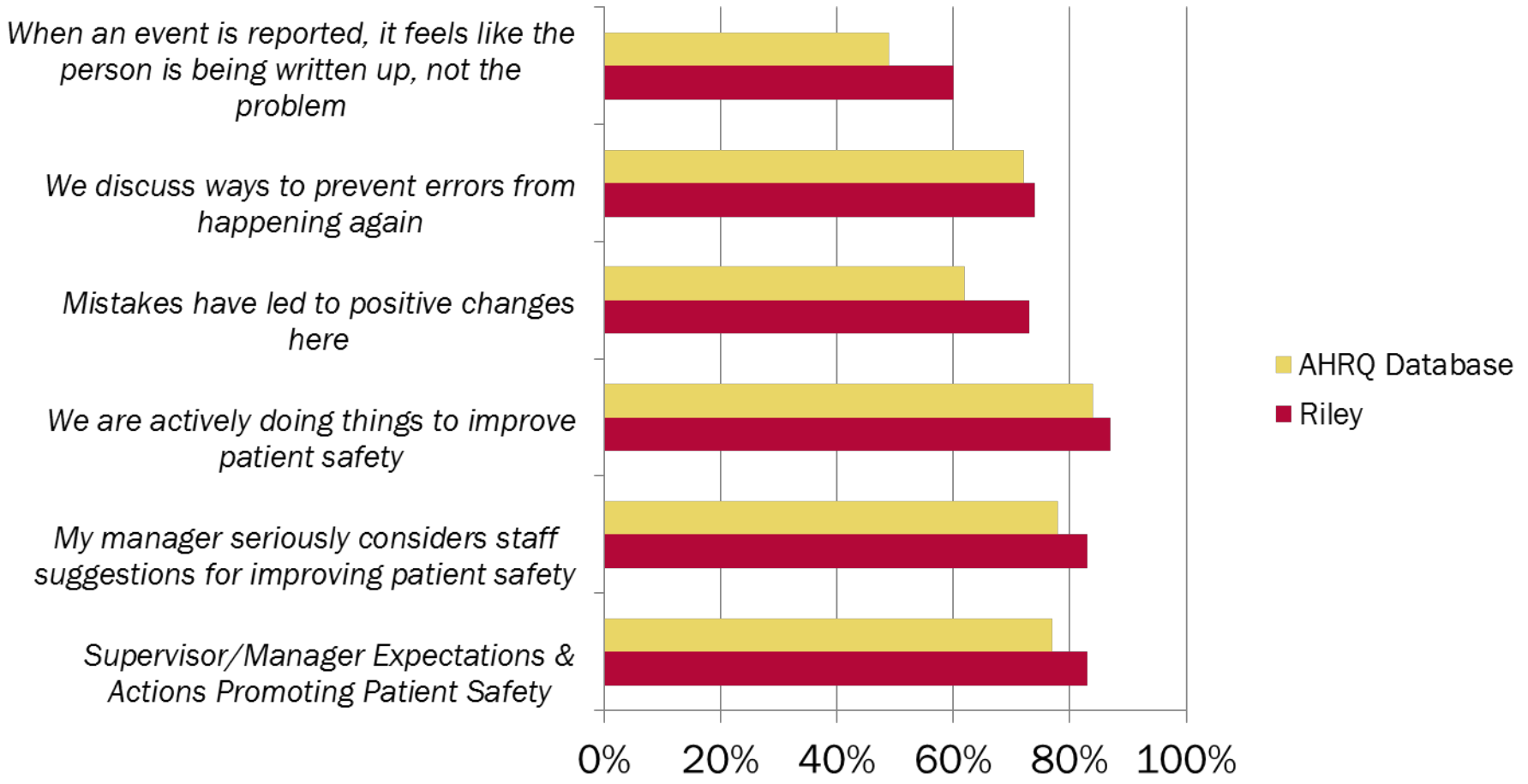
Culture of Safety Results



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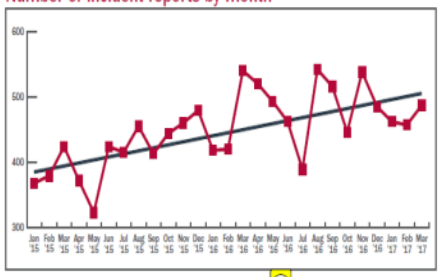
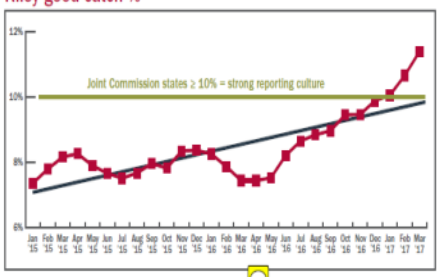
Dashboards

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

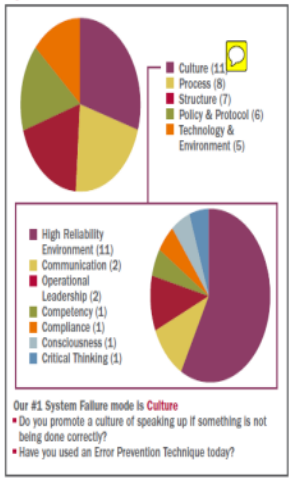
Number of incident reports by month



Riley good catch %



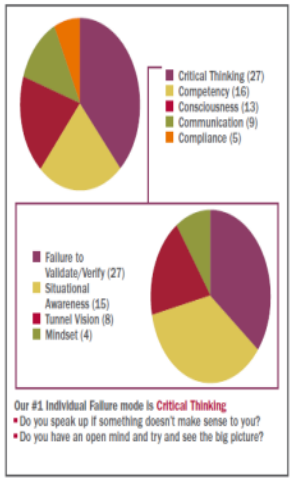
System failure modes (after 36 events classified)



Our #1 System Failure mode is **Culture**

- Do you promote a culture of speaking up if something is not being done correctly?
- Have you used an Error Prevention Technique today?

Individual failure modes (after 36 events classified)



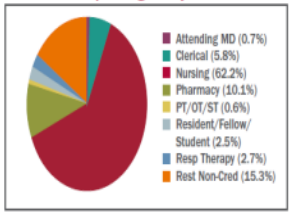
Our #1 Individual Failure mode is **Critical Thinking**

- Do you speak up if something doesn't make sense to you?
- Do you have an open mind and try and see the big picture?

Good catch %

12 Month Rolling Good Catch %	March Good Catch %
9.7%	20%

Credential reporting analysis



Riley Hospital for Children
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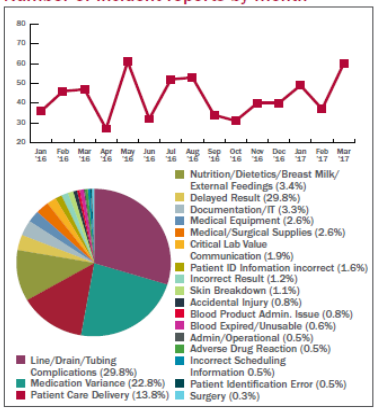
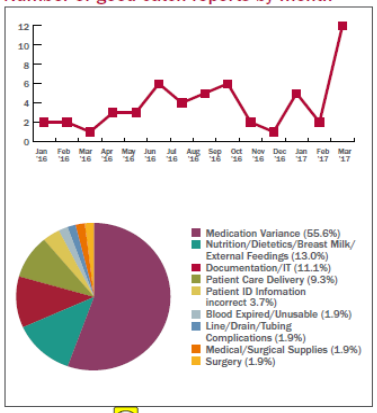
Riley NICU incident reporting summary – April 2017

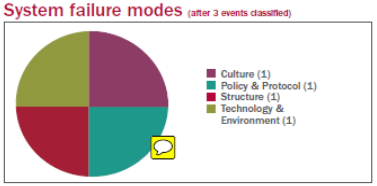
Number of incident reports by month



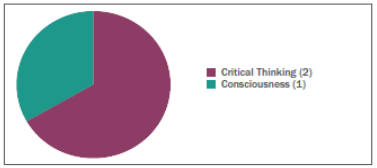
Number of good catch reports by month



System failure modes (after 3 events classified)



Individual failure modes (after 3 events classified)



Good catch %

Joint Commission states ≥ 10% – strong reporting culture

12 Month Rolling Good Catch %	March Good Catch %
9.7%	20%

Q1 Good Catch Reporters

Lindsay Gale, Lori Hanshaw, Nicole Wilson, William Hayes, Stephanie Shook, Nathan Walleser, Emily Werner, Sophia Kim, Meredith Marschand, Katie Malloy, Anita Shelley, Tammy Losh, Austin Combs, Lisa Rossetter, Jordan Conley, Jody Hause, Jessica Vleck, Caryn Sundling, Paula Miller, Sara Acker, Emily Smith, Caryn Sundling, Sara Krusenoski

Riley Hospital for Children
Indiana University Health

Riley Hospital for Children
Indiana University Health

Lessons Learned

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

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Indiana University Health

References

- DiCuccio, M. H. (2015). The relationship between patient safety culture and patient outcomes: a systematic review. *Journal of patient safety*, *11*(3), 135-142.
- Roehr, B. (2012). US hospital incident reporting systems do not capture most adverse events. *BMJ, 344*. doi: https://doi.org/10.1136/bmj.e386

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Questions?

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Indiana University Health

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

Posner, K.; Brent, D.; Lucas, C.; Gould, M.; Stanley, B.; Brown, G.; Zelazny, J.; Fisher, P.; Burke, A.; Oquendo, M.; Mann, J.

- 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)

Columbia:
Children – Pediatric, and Cognitive Impairment is available

- **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 sever 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

	Past month	
Ask questions that are bolded and underlined.	YES	NO
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?		
2) Suicidal Thoughts: 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.		
3) Suicidal Thoughts with Method (without Specific Plan or Intent to Act): Person endorses thoughts of suicide and has thought of a 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." Have you been thinking about how you might kill yourself?		
4) Suicidal Intent (without Specific Plan): 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." Have you had these thoughts and had some intention of acting on them?		
5) Suicide Intent with Specific Plan: Thoughts of killing oneself with details of plan fully or partially worked out and person 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?		
6) **Suicide Behavior Question:** Have you ever done anything, started to do anything, or prepared to do anything to end your life? 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. 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?		

Lifetime/Recent & Since Last Visit

Typical Administration Time=Few Minutes

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.

	Lifetime: Time He/She Felt Most Suicidal		Past 1 month	
	Yes	No	Yes	No
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?*** If yes, describe:	☐	☐	☐	☐
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?*** If yes, describe:	☐	☐	☐	☐
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?*** If yes, describe:	☐	☐	☐	☐
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?*** If yes, describe:	☐	☐	☐	☐
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?*** If yes, describe:	☐	☐	☐	☐

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.

Lifetime - ***Most Severe Ideation:*** _____ (*Type # (1-5)*) _____ (*Description of Ideation*)

Recent - ***Most Severe Ideation:*** _____ (*Type # (1-5)*) _____ (*Description of Ideation*)

	Most Severe	Most Severe
Frequency ***How many times have you had these thoughts?*** (1) Less than once a week (2) Once a week (3) 2-5 times in week (4) Daily or almost daily (5) Many times each day	____	____
Duration ***When you have the thoughts how long do they last?*** (1) Fleeting - few seconds or minutes (2) Less than 1 hour/some of the time (3) 1-4 hours/a lot of time (4) 4-8 hours/most of day (5) More than 8 hours/persistent or continuous	____	____
Controllability ***Could/can you stop thinking about killing yourself or wanting to die if you want to?*** (1) Easily able to control thoughts (2) Can control thoughts with little difficulty (3) Can control thoughts with some difficulty (4) Can control thoughts with a lot of difficulty (5) Unable to control thoughts (0) Does not attempt to control thoughts	____	____
Deterrents ***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?*** (1) Deterrents definitely stopped you from attempting suicide (2) Deterrents probably stopped you (3) Uncertain that deterrents stopped you (4) Deterrents most likely did not stop you (5) Deterrents definitely did not stop you (0) Does not apply	____	____
Reasons for Ideation ***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 (in 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?*** (1) Completely to get attention, revenge or a reaction from others (2) Mostly to get attention, revenge or a reaction from others (3) Equally to get attention, revenge or a reaction from others and to end/stop the pain (4) Mostly to end or stop the pain (you couldn't go on living with the pain or how you were feeling) (5) Completely to end or stop the pain (you couldn't go on living with the pain or how you were feeling) (0) Does not apply	____	____

Lifetime/Recent – Helps Determine Intensity of Ideation

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)

Lifetime/Recent – Helps Give Clinical Guidance

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 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 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:	**Past month**	
Ask questions that are in bolded and underlined	**Yes**	**NO**
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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Community Health Network

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:

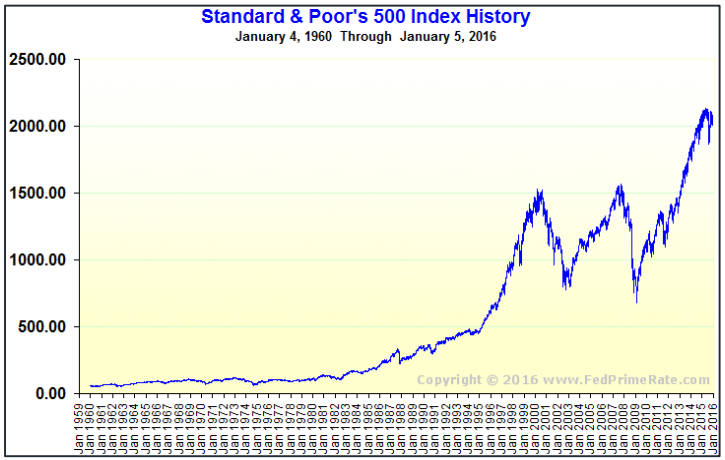
Dow Jones Industrial Average – The Dow Jones Industrial Average (DJIA) is a price-weighted average of 30 significant stocks traded on the New York Stock Exchange (NYSE) and the NASDAQ.

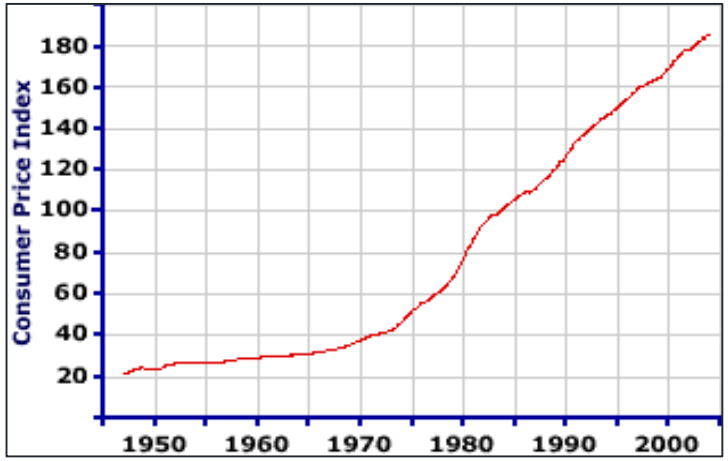
S&P 500 – The Standard & Poor's 500, is an American stock market index based on the market capitalizations of 500 large companies having common stock listed on the NYSE or NASDAQ.

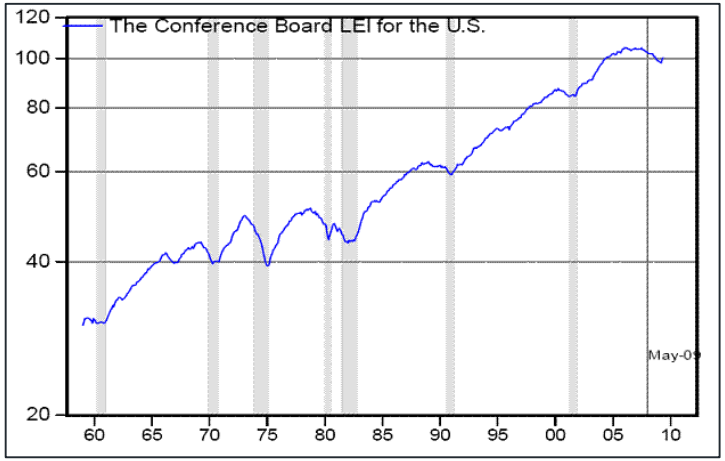
Consumer Price Index - The Consumer Price Index (CPI) is a measure that examines the weighted average of prices of a basket of consumer goods and services, such as transportation, food and medical care. It is calculated by taking price changes for each item in the predetermined basket of goods and averaging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

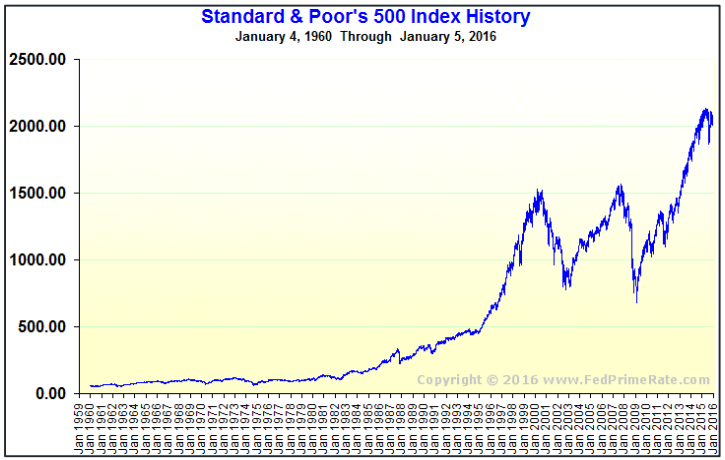
Well known indices

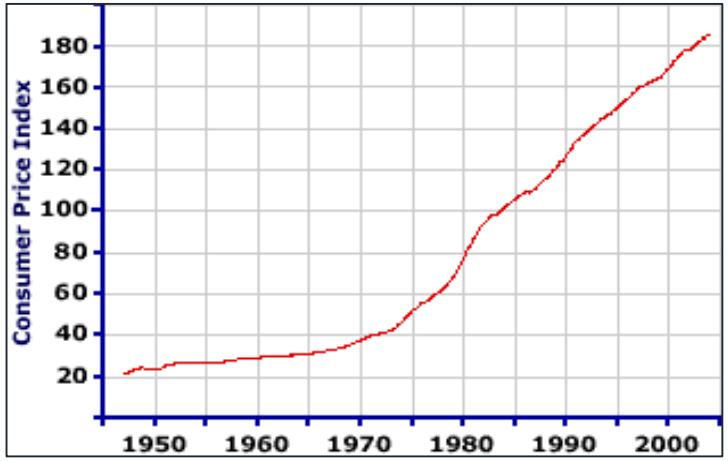






Well known indices





Harm Score

It’s an Index

Harm Score 1.0 (2014) and 1.1 (2015)

Index Calculation

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

Harms
CLABSI (Central Line associated Blood Stream Infections)
CAUTI (Catheter Associated Urinary Tract Infections)
SSI (Surgical Site Infections – in specified procedures)
Falls with Injury
Pressure Ulcers – Stage II and above
VTE (Venous Thrombo-embolism – potentially preventable)
VAP (Ventilator Associated Pneumonia)
ADEs
Adverse Drug Event – Warfarin (INR > 6)
Adverse Drug Event – Hypoglycemia (Blood Glucose ≤ 50)
Adverse Drug Event – Naloxone (Given for Opioid Reversal)

Harm Score 1.0 (2014) and 1.1 (2015)

Index Calculation

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

Why these?

Harms
CLABSI (Central Line associated Blood Stream Infections)
CAUTI (Catheter Associated Urinary Tract Infections)
SSI (Surgical Site Infections – in specified procedures)
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Why these?

Harms
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Adverse Drug Event – Hypoglycemia (Blood Glucose ≤ 50)
Adverse Drug Event – Naloxone (Given for Opioid Reversal)

- These were data that we were already tracking.
- Actively working on projects in these areas.

Dashboard View - Harm Score

Community Health Network

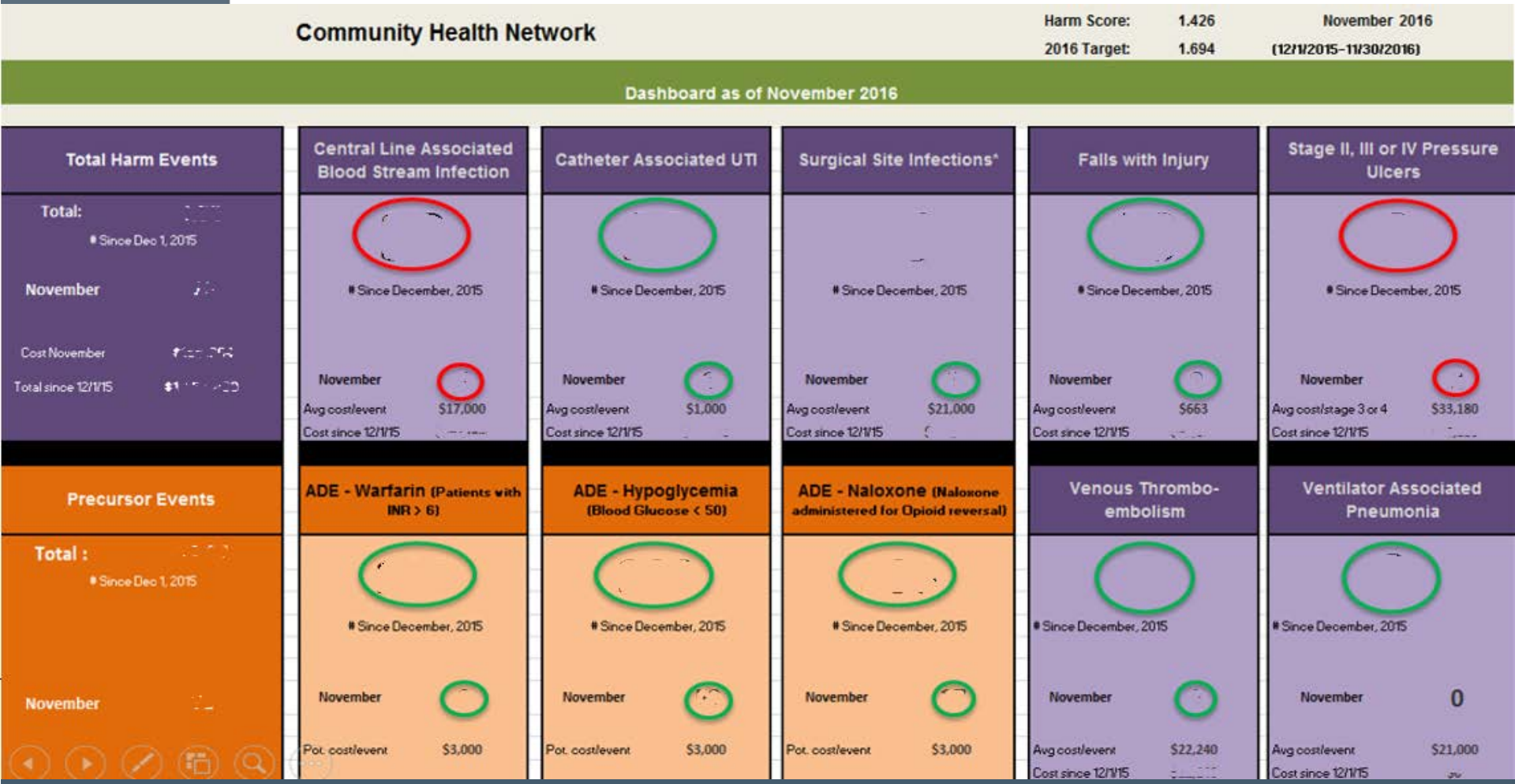
Harm Score: 0 October 1, 2014
2015 Target: < 1.40 (10/1/14-9/31/15)

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

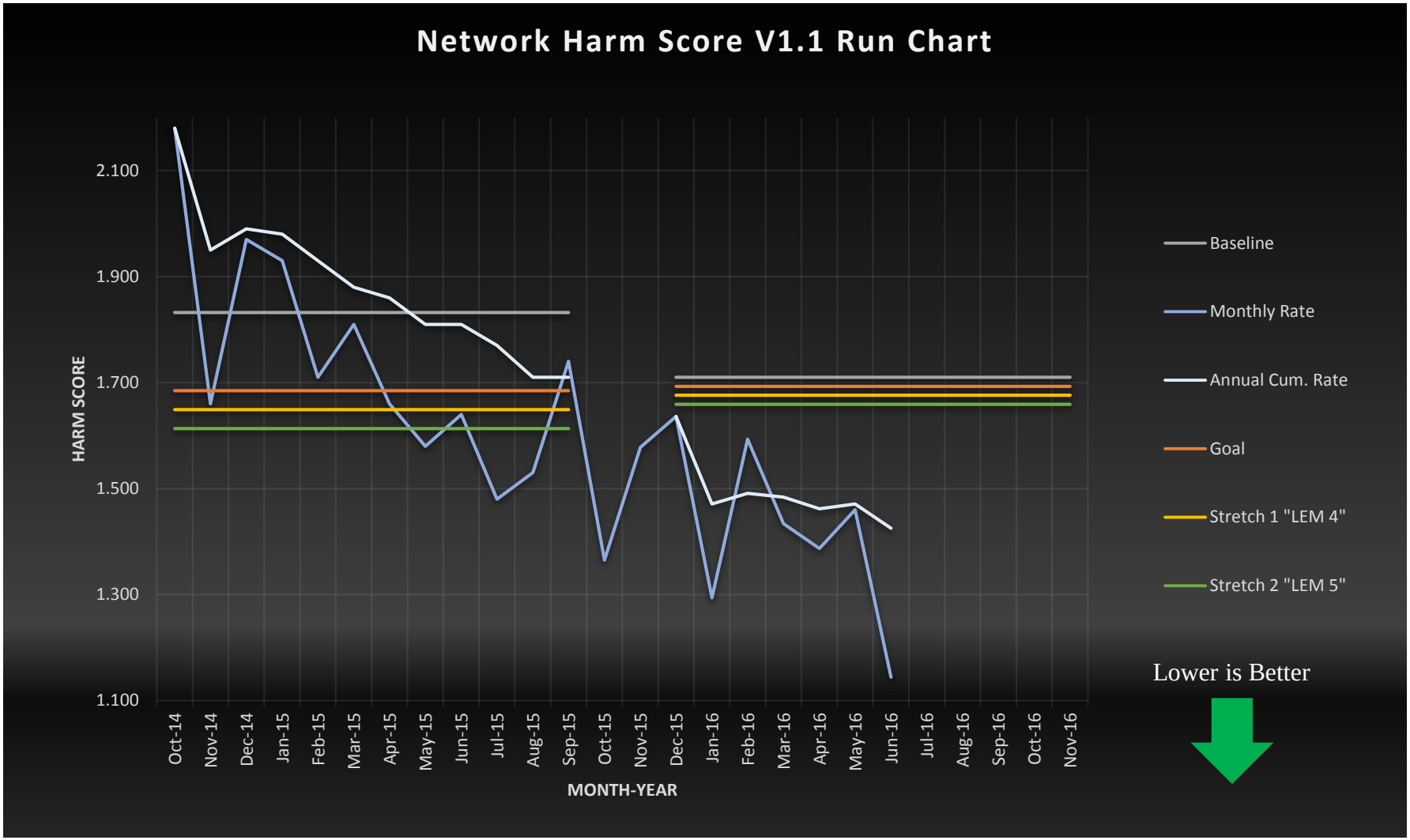
Tracked Harm Events		Central Line Associated Blood Stream Infection		Catheter Associated UTI		Surgical Site Infections		Falls with Injury		Pressure Ulcers	
Days Since	0	Days Since	0	Days Since	0	Days Since	0	Days Since	0	Days Since	0
#Since Oct 1, 2014	0	#Since Oct 1, 2014	0	#Since Oct 1, 2014	0	#Since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

Tracked Precursor Events		ADE - Warfarin (Patients with INR > 6)		ADE - Hypoglycemia (Blood Glucose < 50)		ADE - Naloxone (Naloxone administered for Opioid reversal)		Venous Thrombo-embolism		Ventilator Associated Pneumonia	
Number per Day	0	Number per Day	0	Number per Day	0	Number per Day	0	Days Since	0	Days Since	0
#Since Oct 1, 2014	0	#Since Oct 1, 2014	0	#Since Oct 1, 2014	0	#Since Oct 1, 2014	0	#Since Oct 1, 2014	0	#Since Oct 1, 2014	0
Daily Target	0	Daily Target	0	Daily Target	0	Daily Target	0		0		0
Annual Target	0	Annual Target	0	Annual Target	0	Annual Target	0	Annual Target	0	Annual Target	0
Annual Baseline	0	Annual Baseline	0	Annual Baseline	0	Annual Baseline	0	Annual Baseline	0	Annual Baseline	0
Monthly Target	0	Monthly Target	0	Monthly Target	0	Monthly Target	0	Monthly Target	0	Monthly Target	0
Monthly Baseline	0	Monthly Baseline	0	Monthly Baseline	0	Monthly Baseline	0	Monthly Baseline	0	Monthly Baseline	0
		Last Event	1/1/2014	Last Event	1/1/2014	Last Event	1/1/2014	Last Event	1/1/2014	Last Event	1/1/2014
		Avg cost/event	$3,000	Avg cost/event	$3,000	Avg cost/event	$3,000	Avg cost/event	$10,000	Avg cost/event	$43,000
		Cost since 10/1/14	$0	Cost since 10/1/14	$0	Cost since 10/1/14	$0	Cost since 10/1/14	$0	Cost since 10/1/14	$0

Dashboard View - Harm Score 1.1 (Developed - 2016)



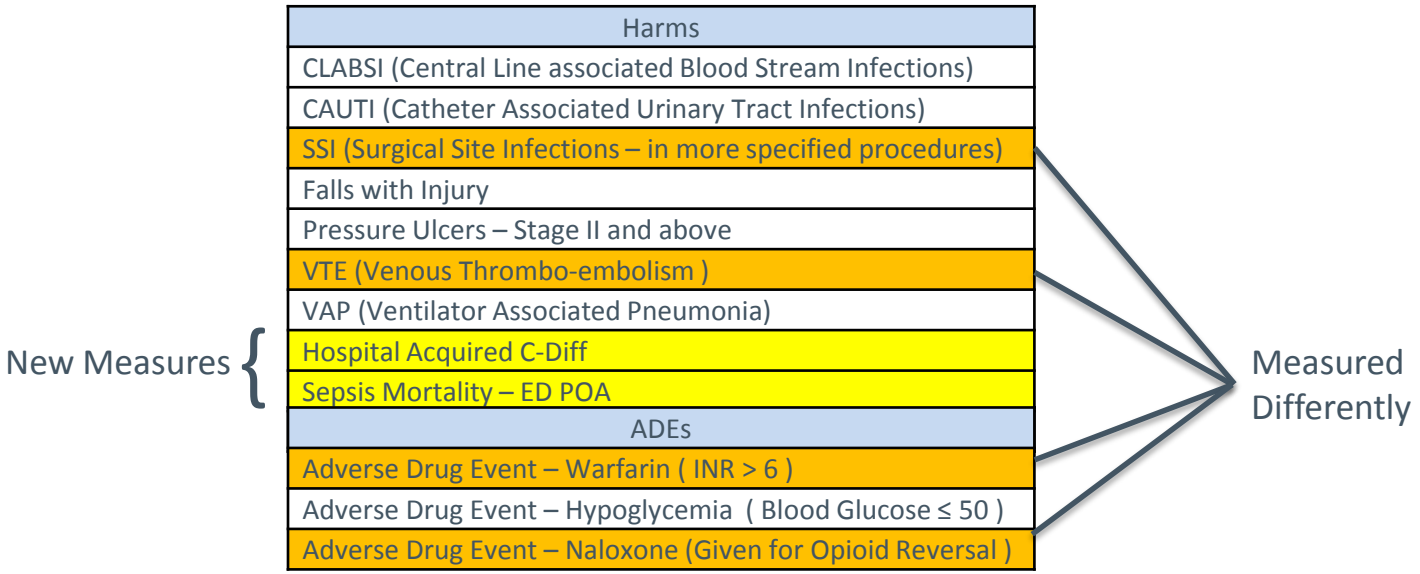
Harm Score 1.1



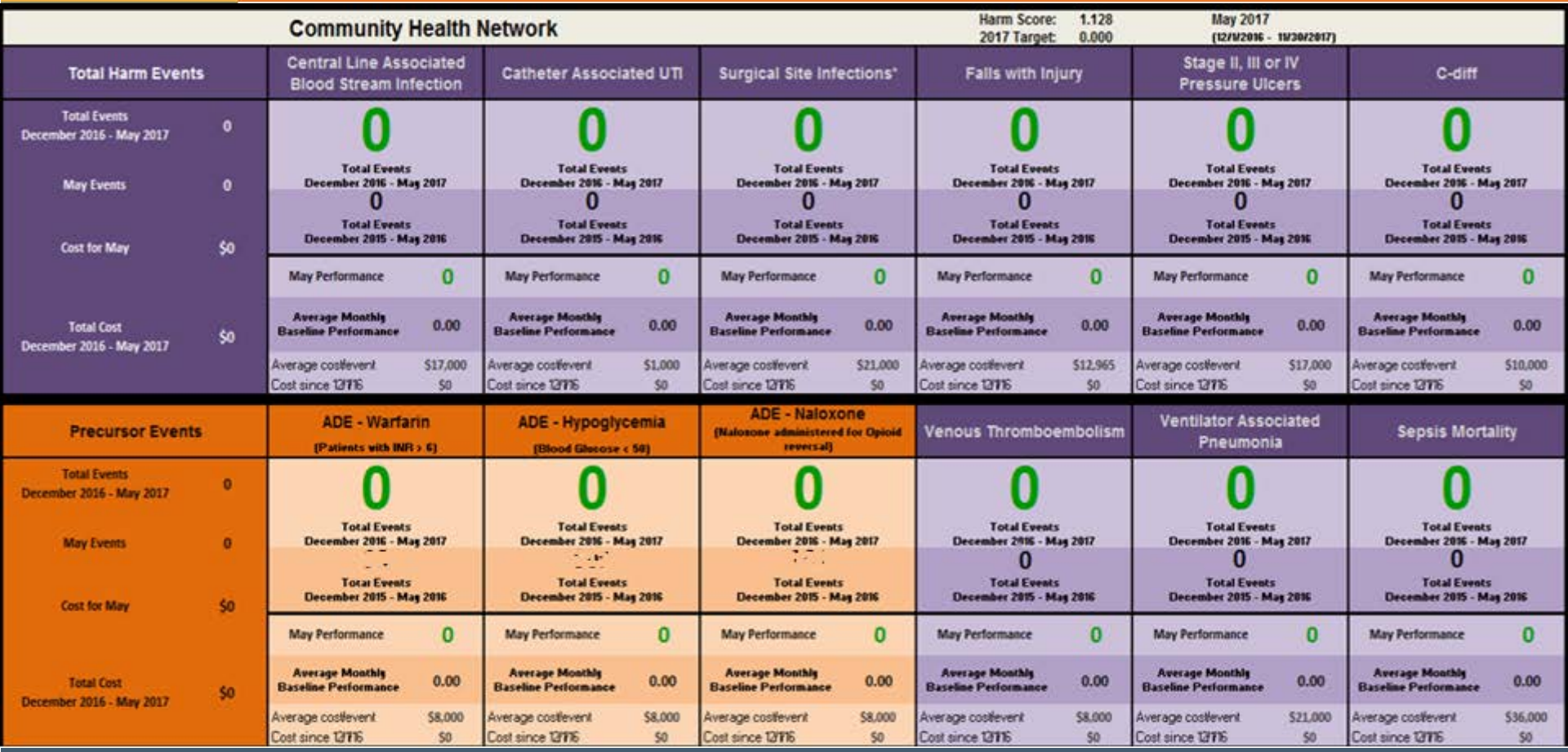
Harm Score v2.x

Index Calculation

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



Dashboard View - Harm Score 2.1 (Developed April 2017)



Community Health Network

Harm Score: 1.128
2017 Target: 0.000
May 2017
(12/1/2016 - 11/30/2017)

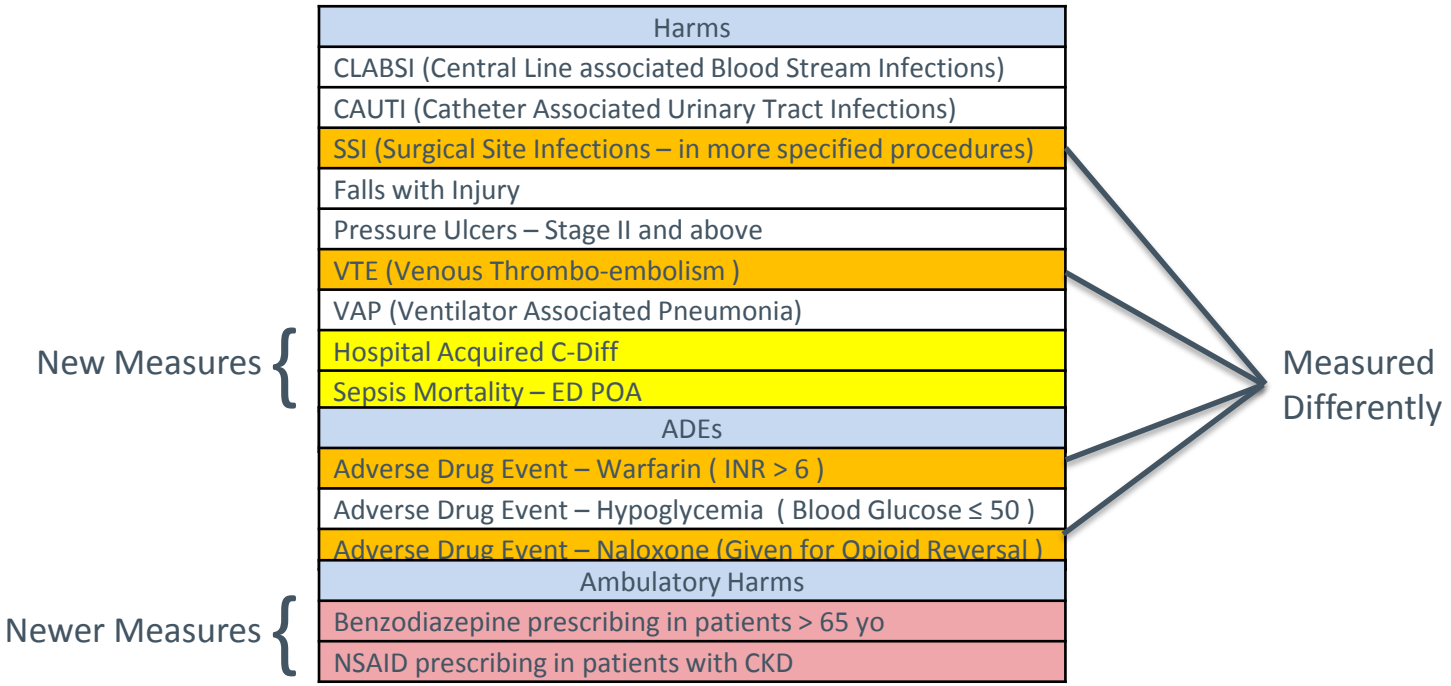
Total Harm Events	Central Line Associated Blood Stream Infection	Catheter Associated UTI	Surgical Site Infections*	Falls with Injury	Stage II, III or IV Pressure Ulcers	C-diff
Total Events December 2016 - May 2017: 0	0	0	0	0	0	0
May Events: 0	Total Events December 2016 - May 2017	Total Events December 2016 - May 2017	Total Events December 2016 - May 2017	Total Events December 2016 - May 2017	Total Events December 2016 - May 2017	Total Events December 2016 - May 2017
Cost for May: $0	0 Total Events December 2015 - May 2016	0 Total Events December 2015 - May 2016	0 Total Events December 2015 - May 2016	0 Total Events December 2015 - May 2016	0 Total Events December 2015 - May 2016	0 Total Events December 2015 - May 2016
Total Cost December 2016 - May 2017: $0	May Performance 0	May Performance 0	May Performance 0	May Performance 0	May Performance 0	May Performance 0
	Average Monthly Baseline Performance 0.00	Average Monthly Baseline Performance 0.00	Average Monthly Baseline Performance 0.00	Average Monthly Baseline Performance 0.00	Average Monthly Baseline Performance 0.00	Average Monthly Baseline Performance 0.00
	Average costlevent $17,000 Cost since 12/16 $0	Average costlevent $1,000 Cost since 12/16 $0	Average costlevent $21,000 Cost since 12/16 $0	Average costlevent $12,965 Cost since 12/16 $0	Average costlevent $17,000 Cost since 12/16 $0	Average costlevent $10,000 Cost since 12/16 $0

Precursor Events	ADE - Warfarin (Patients with INR > 6)	ADE - Hypoglycemia (Blood Glucose < 50)	ADE - Naloxone (Naloxone administered for Opioid reversal)	Venous Thromboembolism	Ventilator Associated Pneumonia	Sepsis Mortality
Total Events December 2016 - May 2017: 0	0	0	0	0	0	0
May Events: 0	Total Events December 2016 - May 2017	Total Events December 2016 - May 2017	Total Events December 2016 - May 2017	Total Events December 2016 - May 2017	Total Events December 2016 - May 2017	Total Events December 2016 - May 2017
Cost for May: $0	Total Events December 2015 - May 2016	Total Events December 2015 - May 2016	Total Events December 2015 - May 2016	0 Total Events December 2015 - May 2016	0 Total Events December 2015 - May 2016	0 Total Events December 2015 - May 2016
Total Cost December 2016 - May 2017: $0	May Performance 0	May Performance 0	May Performance 0	May Performance 0	May Performance 0	May Performance 0
	Average Monthly Baseline Performance 0.00	Average Monthly Baseline Performance 0.00	Average Monthly Baseline Performance 0.00	Average Monthly Baseline Performance 0.00	Average Monthly Baseline Performance 0.00	Average Monthly Baseline Performance 0.00
	Average costlevent $8,000 Cost since 12/16 $0	Average costlevent $8,000 Cost since 12/16 $0	Average costlevent $8,000 Cost since 12/16 $0	Average costlevent $8,000 Cost since 12/16 $0	Average costlevent $21,000 Cost since 12/16 $0	Average costlevent $36,000 Cost since 12/16 $0

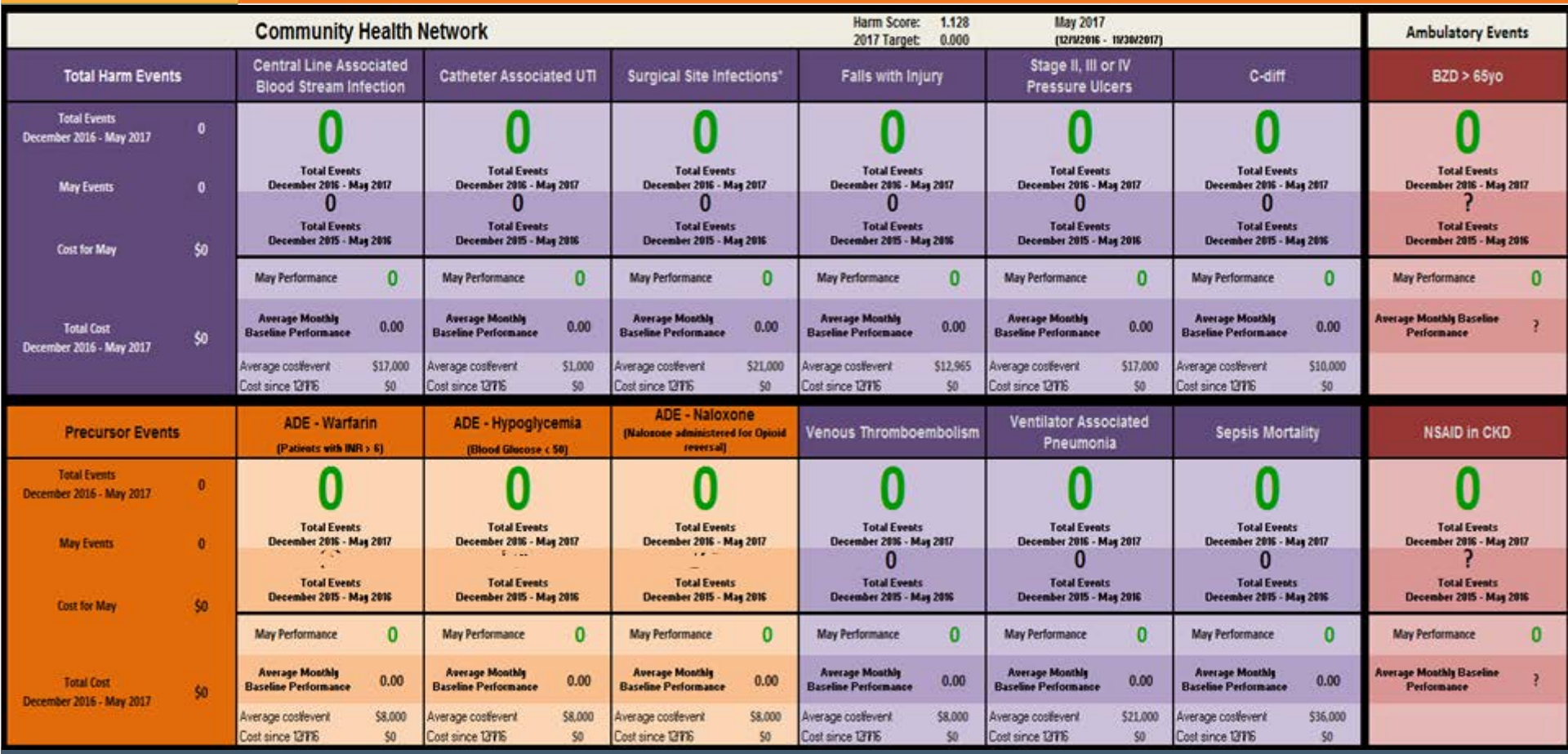
Harm Score v3.x

Index Calculation

(Amb. Harm Score) x (100 x ((Harms x 10) + ADEs) / Patient Days)/ **HarmScore Divisor** = **Harm Score**



Dashboard View - Harm Score 3.0 (Developed August 2017)

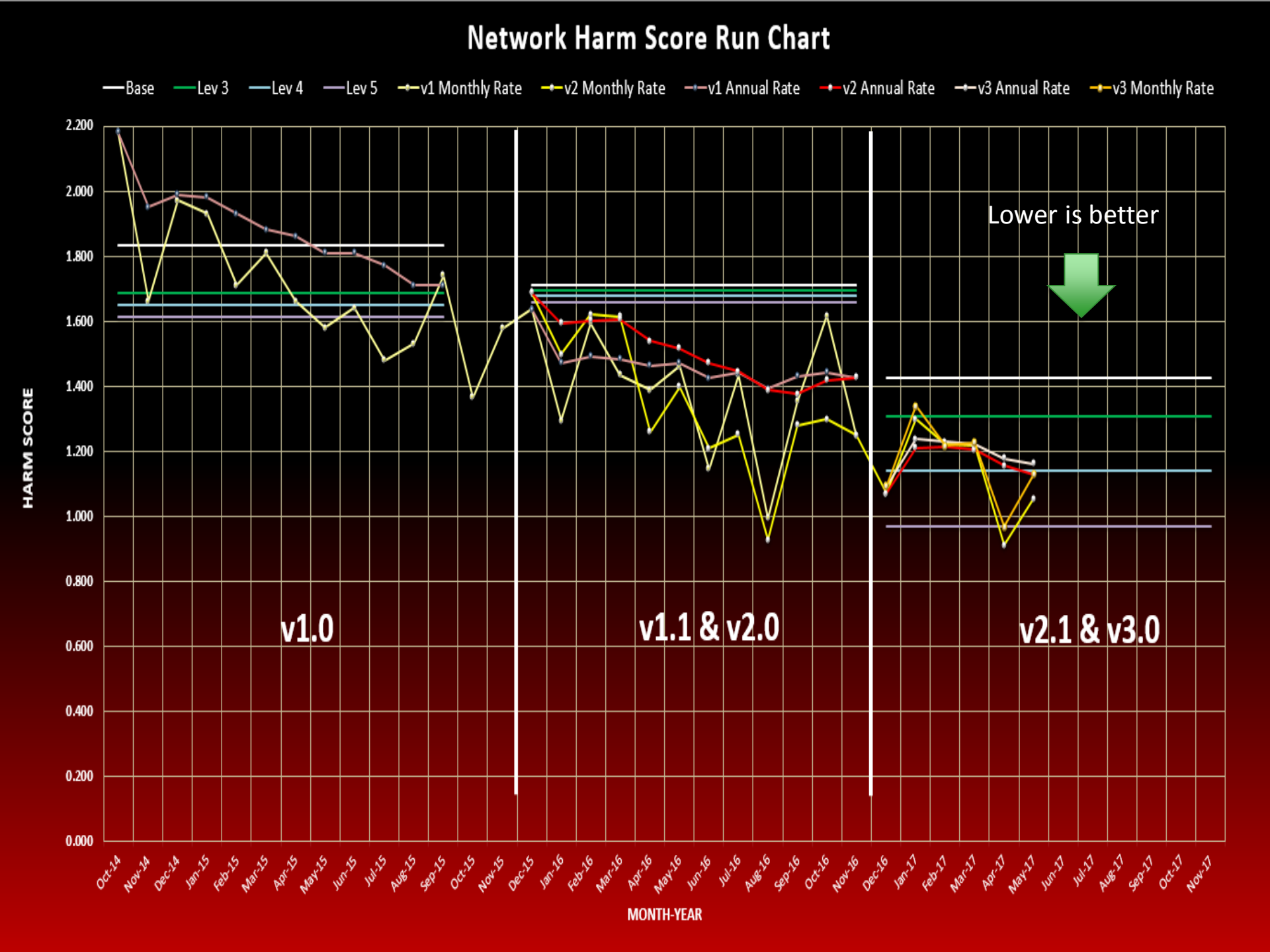


Community Health Network								Harm Score: 1.128	2017 Target: 0.000	May 2017 (12/1/2016 - 11/30/2017)				Ambulatory Events
Total Harm Events		**Central Line Associated Blood Stream Infection**		**Catheter Associated UTI**		**Surgical Site Infections***		**Falls with Injury**		**Stage II, III or IV Pressure Ulcers**		**C-diff**		**BZD > 65yo**
Total Events December 2016 - May 2017	0	0		0		0		0		0		0		0
		Total Events December 2016 - May 2017		Total Events December 2016 - May 2017		Total Events December 2016 - May 2017		Total Events December 2016 - May 2017		Total Events December 2016 - May 2017		Total Events December 2016 - May 2017		Total Events December 2016 - May 2017
May Events	0	0		0		0		0		0		0		?
		Total Events December 2015 - May 2016		Total Events December 2015 - May 2016		Total Events December 2015 - May 2016		Total Events December 2015 - May 2016		Total Events December 2015 - May 2016		Total Events December 2015 - May 2016		Total Events December 2015 - May 2016
Cost for May	$0	May Performance	0	May Performance	0	May Performance	0	May Performance	0	May Performance	0	May Performance	0	May Performance 0
Total Cost December 2016 - May 2017	$0	Average Monthly Baseline Performance	0.00	Average Monthly Baseline Performance	0.00	Average Monthly Baseline Performance	0.00	Average Monthly Baseline Performance	0.00	Average Monthly Baseline Performance	0.00	Average Monthly Baseline Performance	0.00	Average Monthly Baseline Performance ?
		Average cost/event	$17,000	Average cost/event	$1,000	Average cost/event	$21,000	Average cost/event	$12,965	Average cost/event	$17,000	Average cost/event	$10,000	
		Cost since 12/16	$0	Cost since 12/16	$0	Cost since 12/16	$0	Cost since 12/16	$0	Cost since 12/16	$0	Cost since 12/16	$0	
Precursor Events		**ADE - Warfarin** (Patients with INR > 6)		**ADE - Hypoglycemia** (Blood Glucose < 50)		**ADE - Naloxone** (Naloxone administered for Opioid reversal)		**Venous Thromboembolism**		**Ventilator Associated Pneumonia**		**Sepsis Mortality**		**NSAID in CKD**
Total Events December 2016 - May 2017	0	0		0		0		0		0		0		0
		Total Events December 2016 - May 2017		Total Events December 2016 - May 2017		Total Events December 2016 - May 2017		Total Events December 2016 - May 2017		Total Events December 2016 - May 2017		Total Events December 2016 - May 2017		Total Events December 2016 - May 2017
May Events	0							0		0		0		?
		Total Events December 2015 - May 2016		Total Events December 2015 - May 2016		Total Events December 2015 - May 2016		Total Events December 2015 - May 2016		Total Events December 2015 - May 2016		Total Events December 2015 - May 2016		Total Events December 2015 - May 2016
Cost for May	$0	May Performance	0	May Performance	0	May Performance	0	May Performance	0	May Performance	0	May Performance	0	May Performance 0
Total Cost December 2016 - May 2017	$0	Average Monthly Baseline Performance	0.00	Average Monthly Baseline Performance	0.00	Average Monthly Baseline Performance	0.00	Average Monthly Baseline Performance	0.00	Average Monthly Baseline Performance	0.00	Average Monthly Baseline Performance	0.00	Average Monthly Baseline Performance ?
		Average cost/event	$8,000	Average cost/event	$8,000	Average cost/event	$8,000	Average cost/event	$8,000	Average cost/event	$21,000	Average cost/event	$36,000	
		Cost since 12/16	$0	Cost since 12/16	$0	Cost since 12/16	$0	Cost since 12/16	$0	Cost since 12/16	$0	Cost since 12/16	$0	

Community Health Network

Harm Score Versions

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


Network Harm Score Run Chart
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
HARM SCORE
2.200
2.000
1.800
1.600
1.400
1.200
1.000
0.800
0.600
0.400
0.200
0.000
Lower is better
v1.0
v1.1 & v2.0
v2.1 & v3.0
Oct-14
Nov-14
Dec-14
Jan-15
Feb-15
Mar-15
Apr-15
May-15
Jun-15
Jul-15
Aug-15
Sep-15
Oct-15
Nov-15
Dec-15
Jan-16
Feb-16
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Dec-16
Jan-17
Feb-17
Mar-17
Apr-17
May-17
Jun-17
Jul-17
Aug-17
Sep-17
Oct-17
Nov-17
MONTH-YEAR

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?