Ready, Set, Go...

The Distance

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In 1999 a landmark publication captured the attention of all healthcare professionals. The Institute of Medicine Report "To Err Is Human" identified patient safety as an issue that could not be ignored. Increasingly, hospitals have implemented The Joint Commission National Patient Safety Goals and have focused various activities on patient safety. To show commitment to patient safety many organizations have included measures on their scorecard tied to financial incentives. However, to take patient safety to the next level, hospitals must engage the culture so that safety becomes a core value, not just a priority, or a program. In runner's terms, patient safety is not a sprint, it is a marathon. All distance runners know that to be successful they must develop a rigorous training program and stay the course!

READY

Early in 2009, a group of system leaders assembled to identify and develop key areas for success in patient safety. The first strategy articulated was to create a highly reliable environment that would lead to superior safety and quality outcomes. The resultant formula was Safety + Quality + Service = Exceptional Care. This became the key equation that must be followed to achieve patient safety as our core organizational value. To create the environment to incorporate patient safety into the culture, decision making of executives, managers, physicians and front-line staff needed to be aligned with this formula. To achieve this, responsibility was assigned at the highest level to the system CMO, to make certain a safety culture was developed throughout the organization.

In order to implement patient safety throughout the breadth of the system, it was necessary to add an expert in patient safety in the regional office that would assist the corporate CMO, in leading a team at the regional level. The addition of a Regional Director of Patient Safety emphasizes the strategic vision of patient safety as a core value.

Immediately, the region leaders found it necessary to obtain baseline performance information about patient safety in the five regional hospitals. An assessment tool, The Agency for Healthcare Research and Quality (AHRQ) Survey of Patient Safety Culture was offered to all employees. The regional CEOs encouraged participation resulting in 81.5 percent of staff in all departments participating in the online survey. This tremendous participation rate provided the system with valid and useful baseline data.

In support of transforming our culture, the system began a consulting relationship with Healthcare Performance Improvement (HPI). Late in 2009, HPI performed several diagnostic assessments of each hospital which provided additional insight for the leaders regarding event detection and readiness for culture change. Also, at each hospital, every Root Cause Analysis
(RCA) conducted during the previous 2 years was examined. From this data, a Serious Safety Event (SSE) rate was calculated, which serves as a baseline from which to measure improvement.

To enable effective change to be embraced and articulated as a shared vision, leaders must be educated about the basic concepts in patient safety and understand how their organizations compare with other healthcare systems. Areas of strength and weakness were identified for each regional hospital, and were presented by the consultant to our regional leaders. The CEO’s knew a culture change was necessary and this information helped prepare them to provide the vision and leadership necessary to successfully move forward.

**SET**

Given the mandate for change, funds were provided to improve technology, support, and training, to establish the structure for this organizational paradigm shift. The system found it necessary to charter a **High Reliability Steering Committee** to provide oversight for all actions. This committee is chaired by the Chief Medical Officer (CMO) of the system and is composed of system, regional and hospital leaders. There are also functional representatives from IT and communication to assure consistent information is disseminated.

During the first six months of 2010, the **High Reliability Steering Committee** formed sub teams to quickly address important work. The initial sub teams are:

- **Leadership Daily Check In** — Best practices show hospitals that begin each day with a patient safety story of a good catch or near miss effectively use this technique and information to help change the culture. This is a daily meeting with key leaders from each operational discipline. The participants (Directors) continue this practice by huddling on hospital units. Stories are daily shared from the leaders to the front-line, and the front line tells stories and brings safety concerns back to the attention of their leader.

- **Event Detection and Management** — This committee is charged with the identification of a consistent process that all regional hospitals will use for event detection and management. The system uses MIDAS remote data entry, but it was determined that several modifications were needed. Team recommendations included:
  - Improve reporting by all staff, not just the nursing staff
  - Provide a non-punitive atmosphere with reporting
  - Encourage only MIDAS for reporting, not verbal or telephone calls to Risk Management (RM)
  - Promote good catches to be reported in MIDAS
  - Have the staff select the level of severity when submitting the report
    - 1 = no injury;
    - 2 = minor, temporary injury;
    - 3 = moderate injury;
    - 4 = serious injury; and
    - 5 = severe permanent harm or death.
  - Incidents reported by staff will be submitted simultaneously to directors/managers and have these leaders close the loop in 72 hours
  - When the events are severe (defined as levels 3, 4 and 5), an e-mail will simultaneously inform Risk Management, the director, the hospital administrators, regional and system leaders.
  - With a severe event, a safety team would be assembled as soon as possible (but definitely within 24-48 hours of an event) to rapidly determine the extent of harm, mitigate risk and plan next steps
  - When Root Cause Analyses (RCA) are conducted, identify an executive owner, and use a standardized three meeting model
  - Have the RCA process and taxonomy embedded into MIDAS
• Safety Communication — This team works to identify a consistent approach to communicate safety events through the enterprise. Events includes such things as rewarding and publicizing good catches, sharing lessons learned from RCAs system wide, and using a standardized approach for safety alerts, i.e., product recalls. A gap analysis tool was also developed for hospitals to use following a safety alert.

• Error Prevention Tool Box Design — HPI client experience has demonstrated a 50–80 percent one time serious safety event reduction from the use of carefully designed error prevention tools. The region brought together 20 leaders and front line staff from each regional hospital, to determine what behaviors and techniques to teach and reinforce with all physicians, leaders and employees to help prevent errors. Behavior based expectations focused on patient, personal and team safety, communication that is clear and concise, having a questioning attitude and paying attention to detail. Individual tools will be selected and taught regarding each behavior. Use of the tools will be reinforced by using peer coaching.

• Performance Management Guide — The work of this committee will incorporate the principles of a just culture into a personnel management guide to align with the performance expectations of a high reliability organization. The guide will incorporate an algorithm that can be used to address and manage behavior. Patient safety professionals know that when a region or system believes a just culture exists, cultural transformation truly has occurred.

At the regional level, leadership understood that all leaders must own patient safety, but the underlying question existed: Who should be the Patient Safety Officer (PSO) in each hospital? Should this be someone who works in Quality Management? Should it be a well respected clinician? Should the PSO be a pharmacist since so much harm occurs with medications? Should the CNO be the PSO? In the end, each hospital CMO was asked to take on the role of the PSO.

Why? This position has the legitimate power and authority to deal with all levels of harm with staff, leaders and physicians. In addition, the CMO regularly interacts with the CEO, COO and CNO, and attends medical staff and board meetings.

One final aspect of planning to become a highly reliable culture involves organizational structure (see the table below). It was determined that the content from the system steering committee needed to be distributed to each regional steering committee and then be disseminated to each individual hospital with the least amount of variation. To assure uniformity in the tool box contents and teaching of techniques, we will utilize a train the trainer approach with certification for each trainer.

The Arizona market has leaders who understand the importance of walking the talk. Daily huddles have been established in the regional hospitals which begin with good catches. The hospitals formally recognize and reward one outstanding good catch each month. This is celebrated and published in hospital communications.

The Risk Managers and Quality Directors have been working on process changes to make the MIDAS remote data entry the only repository of reporting adverse events. The updates will be completed this fall. In addition, RM has come to consensus and uses a three (3) meeting model for RCAs with standardized analyses for root causes and action plans.

Standardized training in error prevention behaviors and techniques will also be implemented this fall. The goal is to have 19,000 employees trained just one year after beginning our patient safety journey.

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A common Sharp HealthCare adage is, “It’s a marathon, not a sprint.” Now in our sixth year of our team training journey we look back on the great progress that has been made, but we also look forward to the work still to be done. This critical initiative is about continual learning and steady progress toward our goal to be a safer organization to care for our patients.

SOURCES:

Internet Citation for Kotter’s Change steps:

AHRQ TEAMSTEPPS home page
http://teamstepps.ahrq.gov/

Professional Conduct Toolkit, 2010
http://health.mil/dodpatientsafety/ProductsandServices/Toolkits/ProfessionalConduct.aspx

Hospitalist: A clinical specialty, an administrative or management specialty, a venue to practice a specialty, or a new hospital employee?
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advanced training in hospital procedures and clinical management of complicated cases, there must be a recognition that the business and administrative aspect of being a hospitalist must be incorporated into educational programs for hospitalists. Furthermore, it must be accepted that this knowledge and skill can generally not be effectively learned without some formal education and mentoring. Residencies generally do not enjoy the expertise or the inclination to provide this type of education. Hopefully Sister Irene has opened the door to the possibility that being a care-giver and an effective administrator and businessman are not mutually exclusive career goals in today’s healthcare market.

SUMMARY

Over the past decade the hospitalist movement has taken on a new force within the structure of healthcare. It is seen by many to have an integral role in the future of hospital medicine. Nevertheless, its role and its definition within medical education and the healthcare community are still debated. What are the missing links necessary to formalize the hospitalist movement in the future of healthcare reform? This article explores some of the topics that need further discussion in this new “specialty.”