Patient Experience & Patient Safety Culture
April 19 - 21, 2010
Baltimore, MD

12th CAHPS & 2nd SOPS
USER GROUP MEETING

Using Hospital SOPS To Improve Patient Care Through Collaboration

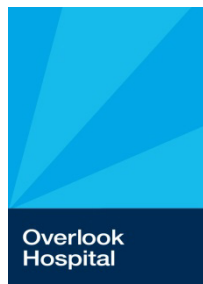## Donald Casey
Nancy Vardaro
Atlantic Health

Track: SOPS Patient Safety Improvement Initiatives
Session: Initiatives to Improve Reporting and Nonpunitive Response to Error
Date & Time: April 20, 2010, 11:00 am
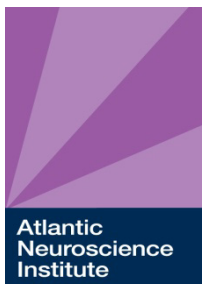**Track Number**: SOPS T2 – S2

Tuesday, April 20th, 2010

THE PASSION TO LEAD

ATLANTIC
HEALTH

Morristown Memorial Hospital — ATLANTIC HEALTH
Overlook Hospital — ATLANTIC HEALTH
Goryeb Children's Hospital — ATLANTIC HEALTH
Carol G. Simon Cancer Center — ATLANTIC HEALTH
Gagnon Cardiovascular Institute — ATLANTIC HEALTH
Atlantic Neuroscience Institute — ATLANTIC HEALTH
Atlantic Rehabilitation Institute — ATLANTIC HEALTH

2009 Vital Statistics
Morristown Memorial

5,850+ Employees
1,200+ Physicians
178 Medical residents
650 Licensed beds *
38,082 Admissions
4,016 Births
12,065 Inpatient surgeries
14,596 Same Day Surgeries
79,883 Emergency visits
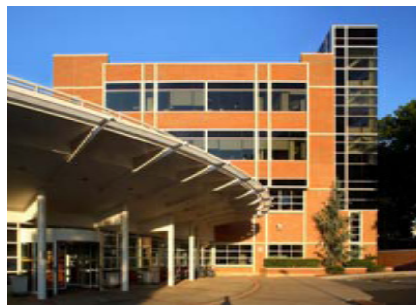282,481 Outpatient visits

2009 Vital Statistics
Atlantic Health

10,200+ Employees [1]
2,500+ Physicians
248 Medical residents
1,154 Licensed beds *
63,225 Admissions
6,510 Births
18,222 Inpatient surgeries
24,187 Same Day Surgeries
161,780 Emergency visits
625,266 Outpatient visits [2]

2009 Vital Statistics
Overlook Hospital

3,400+ Employees
1,300+ Physicians
70 Medical residents
504 Licensed beds *
25,143 Admissions
2,494 Births
6,157 Inpatient surgeries
9,591 Same Day Surgeries
81,897 Emergency visits[3]
189,367 Outpatient visits

[1] – includes corporate employees
[2] – includes Homecare certified and non Medicare visits
[3] – includes Union E.D.

* Normal newborn bassinets are not licensed by the State and are not included

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ATLANTIC HEALTH

Atlantic Health: Culture of Safety Potential Areas for Action—2008

- **Managers' Expectations and Actions Promoting Safety (refers to supervisor)**

- **Handoffs and Transitions**

- **Non-Punitive Response to Error**

- **Number of Events Reported in Past 12 mos.**

Overlook

- **Overall Perceptions of Safety**

- **Staffing**

Morristown Memorial

- **Communication Openness (staff comfort)**

- **Teamwork across Units**

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Culture of Patient Safety Pilots
First Group meeting April, 2008

- Two patient care areas from each hospital
  - Both Operating Room Staffs
  - New Gagnon A Cardiac Care unit at Morristown
  - New 6th Floor Med-Surg unit at Overlook
- First group meeting to discuss:
  - Identification of risks to patients – Close Calls & No Harm
  - Develop multidisciplinary team approaches to solving potential impediments & barriers in reporting occurrences
  - Creating an organizational culture of Patient Safety

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Participants in the Atlantic Health Culture of Safety Pilots

- **Roberta Prisco, Nurse Manager J3/CCU/Electrophysiology/Pacemaker (MMH)**
- **Kelly Giammanco, Clinical Coordinator J3 (MMH)**
- **Angie Grippo, Clinical Coordinator J3 (MMH)**
- **Samantha Venet, Clinical Coordinator CCU (MMH)**
- **Ann Wanderling, Clinical Coordinator CCU (MMH)**
- **Nancy Vardaro- Nurse Manager OR Manager (MMH)**
- **Suzanne St. Germaine, RN, Nursing Coordinator, Surgical Access Unit (MMH)**
- **Dale Fleischer, RN, Nursing Coordinator OR, (MMH)**
- **Nancy Logan, RN, Nursing Coordinator,   (111 Madison)**
- **Lucy Duffy – Manager of Perioperative Services (OVL)**
- **Carol Smith – Manager 6C (OVL)**
- **Cara Yaccarino – RN 6C (OVL)**
- **Mary Ellen Daly – RN Ambulatory Surgery (OVL)**
- **Laura Trajer – RN O.R. (OVL)**
- **Sue Bien – RN PACU (OVL)**

Reasons why I don't report Patient Safety Events (as we've heard from you)

1. It's more time (and work) for me: I'm already too busy!
2. I don't want to get anyone in trouble (especially me)
3. No one would do anything about my report, anyway (i.e. They never did before, so why should I believe they'll do it now)
4. Nothing bad happened so it's not really that important.
5. Personal responsibility versus Systems improvements (not my job…..)

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Figure 1: Conceptual Model of Accidents and Errors

Misadventure
Death\severe harm

Actual Harm

Actually
Occurred

No Harm Event
Potential for harm is present

Near Miss
Unwanted consequences were
prevented because of recovery

Recovery
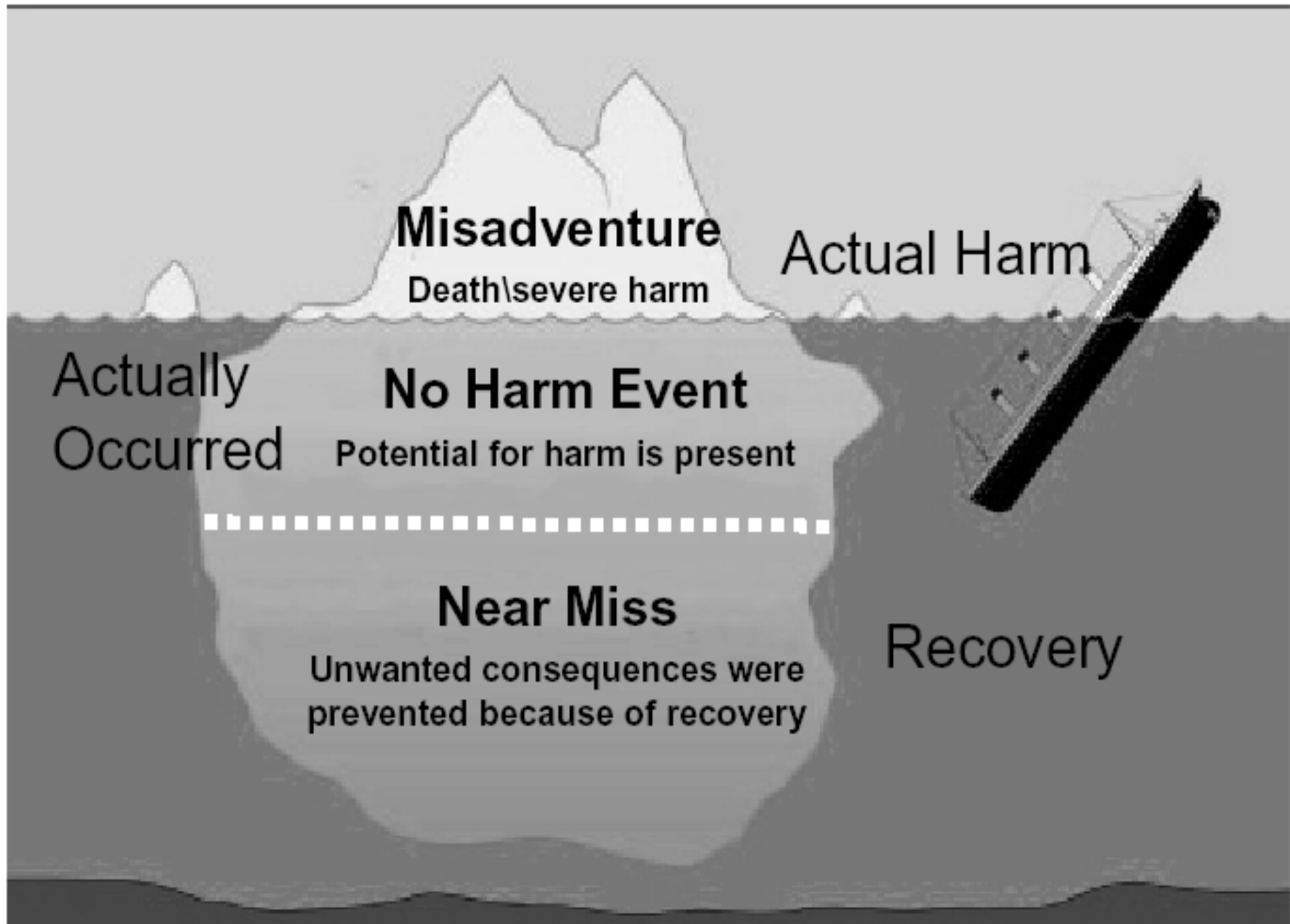
What we want you to accomplish today

- Learn more about near-miss and no-harm events
- Think about what gets directly or indirectly in your staff's way relative to identifying and reporting risks to patients
- Learn more from you about how we can more effectively engage our staff members to think differently about their individual and team role in reducing medical errors as part of their daily patient care duties
- Design and implement a pilot project within your patient care unit or area that would dramatically improve your staff's involvement in identifying, reporting and fixing patient safety problems
- Have fun!

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Action Step Recommendations for Pilot Units

- Create and/or locate education module on near misses for local inservice

- Ask local staffs to design process for reporting near misses and improving utilization of Quantros

- Make "Technical Support" available 24/7 either on site or remotely to help trouble shoot and clarify

- Collect reporting data, ask end-users for insights and provide timely feedback

- Use onsite near miss stories in real time fashion to brainstorm solutions to problems, followed by reporting

- Consider simplifying near miss reporting, perhaps using a method other than Quantros

- Set milestones and benchmarks for each pilot

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Key Success Factors for Culture of Safety Pilot Groups

- Each team was empowered to develop their own initiatives to address the barriers identified.

- Support and encouragement was provided by Senior Management, Risk Management and the Quality staff of Atlantic Health.

- Units were also encouraged to evaluate their efforts in the context of HCAHPS measures.

- Teams were monitored on a periodic basis and reconvened regularly to share improvement successes, including innovative breakthrough strategies for promoting patient safety reporting, which has increased significantly since the onset of the project.

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Culture of Safety
Carol Smith BSN, RNC
Nurse Manager 6C and 9CD

Initiated 10/08 for both units which are post-operative care.

Goal was to establish a culture of safety through hourly rounding, walking rounds, and increased quantros reporting.

Challenge: changing nursing process

Key Interventions

- Establishing process of hourly rounding (hospital protocol written and being implemented hospital-wide)
- Establishing process of walking rounds
- Encouraging quantros reporting through reeducation on procedure
- Encouraging application of all aspects of fall risk protocol (reteaching all care givers on how to set bed alarms)

Critical Measures of Success

- Falls 6C (new unit) maintained a rate of 1.5 falls per 1000 patient days in 2009

- Falls 9CD maintained a rate of 1.6 falls per 1000 patient days in both 2008 and 2009

- Quantros reporting up 5% in 2009 over 2008 on 9CD

- Patient satisfaction scores increased close to 30% on 9CD in 2009 (see graph on next slide)

- Employee engagement scores combined average of 94% for both units

CAHPS DATA 6C

- 2008
- Tell you what medicine is for 75%
- Call button 38%
- Toileting   55%
- Pain control 62%
- Discharge   82%

- 2009
- Tell you what medicine is for 75%
- Call button   71%
- Toileting   73%
- Pain control   62%
- Discharge   80%

Patient Safety Initiative

Roberta Prisco RN, BSN, CCRN-Manager of CCU and Gagnon A

A Cardiac Critical Care Unit- 10 bed and Gagnon A- a cardiac telemetry unit- 25 bed

The Move To the Gagnon Cardiovascular Institute

Challenges/Barriers:

acclimation to new areas- inclusive of new layout/configuration of patient rooms and support space-all private rooms- (lack of direct patient observation)- staff assignments-   new equipment- new processes and patient flow-poor utilization of Quantros reporting with near misses/ or close calls

Key Interventions

- Safety rounds to new areas prior to move-floor plan map/ with punch lock combos-oxygen turn off –extinguishers- fire exits- crash carts-etc
- Staff re-educated to Quantros reporting and near misses/close calls
- Above process simplified as per staff input and request
- Ensure use and functionality of bed alarms on GA
- Patient Safety Rounding- collaborative approach with oncoming and departing nurses- and enforcing this practice
- Hourly Patient Safety Rounds by the nurse and or nursing assistant during their shift- and enforcing this practice
- Staffing of 2 nursing assistants during peak times on GA
- Consistent use of Vocera(a hands free communication device)
- Completion of a post fall report(with a fall) assessment of the pts environment, medications, age, and any comments can be made by the assigned nurse and the action plan to be initiated
- A mirror strategically placed in an awkwardly configured CCU room and installation of video cameras in rooms that lack pt. visualization
- Realization that bed alarms are different in CCU and the trialing of an alternative devise (Tabs)

Critical Measure of Success

Gagnon A	CCU

Gagnon A

- Falls approximately 2 per month (posting of the day/time/room info with each occurrence)

- Volumes/occupancy rate = 92%

- Press Ganey= 99 percentile

- Engagement Score=96%

- Quantros reporting up 5%
  1st quarter 2009= 20 ; 4th quarter 2009 = 21

CCU

- Falls- none in last 9 months

- Volumes/occupancy rate= 80%

- Press Ganey=99 percentile

- Engagement Score=88%

- Quantros reporting up 3 fold
  1st quarter 2009 = 5 and 4th quarter = 16

Major Revelations/Transformations

- Achieve staff buy-in/Solicit input from all staff

- Allow staff to identify concerns/ issues while recommending potential solutions

- Quantros reporting made easier- and completed as though second nature- no questions asked

- Communication is key

Overlook Surgical Services

- **It was noted by the staff that the Quantros reporting system was cumbersome to use and time consuming.**

- **Staff requested increased education on differences between actual and near miss events.**

Overlook Surgical Services
Key Interventions

▶ **Staff in all the Surgical Services Units were re-educated on the use of Quantros reporting by Risk Management.**

▶ **4 Key staff members developed poster presentations for actual and near miss education for their peers.**

▶ **Each unit has a Resource Nurse for the Culture of Safety.**

Overlook Surgical Services
Key Interventions

▶ **We are tracking and trending increased reporting on all units which demonstrates success.**

▶ **In 2010 our Resource Nurses are extending themselves to the Endoscopy unit to increase awareness and education.**

The OR and in house cardiac units were moving to newly constructed patient care areas. The areas selected were Cardiac Critical Care (CCU), Cardiac telemetry (J3) General, Endovascular and Cardiac Surgery OR's. (or 8 new OR's)

The relocation to the new areas required a significant change in patient care processes including both obvious and hidden patient safety issues.

The opportunity for staff to use close call or near miss reporting to identify potential patient safety issues was determined to be appropriate and necessary.

These units were identified based on prioritization of issues as defined by our SOP survey.

The outcomes of the project have been shared house wide and best practices have been adopted or adapted to all patient care areas.

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The OR team members were selected to participate in a failure mode effect analysis, (FMEA), to identify all the safety issues and changes that would affect patient care outcomes. Interventions were devised and implemented for each issue with the OR teams input as well as the key personnel in the OR.

The following is how the FMEA issues were addressed:

•*Housekeeping* is very much a part of the OR team, coverage was rearranged

•*Nursing assistants* were permanently assigned to the new OR wing with additional responsibility due to the location of other support services such as clean case carts.

•*Computerized documentation* printers were located in a place where editing could also be made as needed by the nurses

•*Room turnover* and disposition of dirty case cart responsibilities are shared with the nursing assistants now

The following is how the FMEA issues were addressed:

•*Equipment* issues again addressed by the assignment of two nursing assistants willing to take on the additional needs and rose to the level of commitment necessary as well as several dry run case set ups were performed to assure all needs for all cases were anticipated prior to any patient entering the new OR's

•*Patient identification* and correct patient, correct room were managed with dry runs of patient transport, clear understandable signage for rooms outside of the OR's and on the OR schedule. Clear communication of room numbers and identification at multiple staff meetings and physician meetings. Also upon opening of the new OR's physician case assignment was tracked so all physicians could be escorted by staff to the new OR's to assure proper orientation to the new wing.

•Active monitoring of *time out* regardless of OR suite being utilized.

Communication of the CAHPS report card takes place monthly with the physician, nursing staff, and allied health.

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Summary:

Now that the patient care unit moves are complete and the new OR wing has opened, an uneventful transition has come to fruition. Patients are cared for in what the staff and physicians have expressed was a well planned and safe manner with quality care as the outcome. Our planning, intervention and implementation has had a positive impact on our patients and their care givers as evidenced by their willingness to cooperate and embracing the close call forms.

Process improvement is seen as an opportunity.
By utilizing the data from HCAHPS and SOP,
listening to the concerns of our staff,
Patients and physician; we have been given an opportunity
to develop a safe, positive and quality approach to change.

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Patient Safety initiatives that evolved from the institution of the close call form

- Standardization of OR room supplies/storage location
- Medications moved in OR Pyxis due to look alike vials
- Medications moved in anesthesia medication carts due to look alike vials
- Look alike safety process developed with Pharmacy to identify vendor/vial change of medications
- Process implemented for improved immediate communication
- The staff embraced the close call form for all process issues
- Raised the bar on our practice and care delivery
- All "stories" shared at monthly staff meetings with a very positive affect

Quantros : Reporting Volume (2008-2009)

	MMH	OH	AH
2008	3,172	1,908	5,080
2009	4,516	2,356	6,872
Relative Change	42.4% Increase	23.5% Increase	35.5% Increase

AH Quantros : Reporting Volume
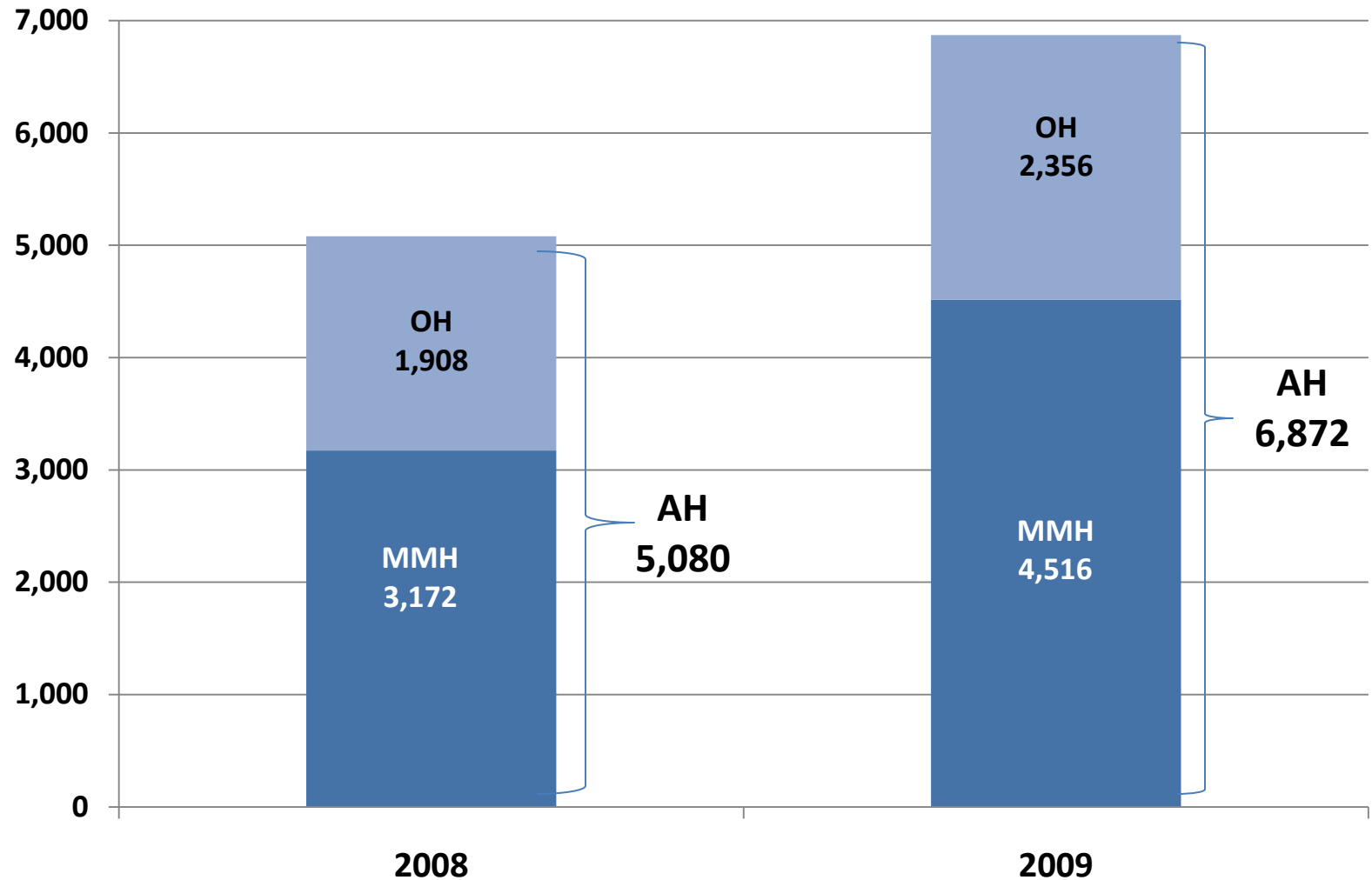
MMH (42.4% Increase) ; OH (23.5% Increase); AH (35.5% Increase)

Atlantic Health Culture of Safety Survey (AHRQ) Comparison Results 2008 & 2010

Scale	MMH			OH		
	2008	2010	Change	2008	2010	Change
1. Teamwork Within Units	77%	78%	No Change	74%	78%	Better
2. Supervisor/Manager Expectations & Actions Promoting Patient Safety	68%	65%	Worse	68%	71%	Better
3. Management Support for Patient Safety	64%	66%	Better	66%	71%	Better
4. Organizational Learning—Continuous Improvement	70%	69%	No Change	67%	71%	Better
5. Overall Perceptions of Patient Safety	59%	44%	Worse	50%	44%	Worse
6. Feedback and Communication About Error	63%	61%	Worse	63%	64%	No Change
7. Communication Openness	58%	58%	No Change	60%	60%	No Change
8. Frequency of Events Reported	62%	55%	Worse	62%	60%	Worse
9. Teamwork Across Units	47%	52%	Better	53%	59%	Better
10. Staffing	48%	49%	No Change	39%	45%	Better
11. Handoffs & Transitions	34%	40%	Better	36%	42%	Better
12. Nonpunitive Response to Error	30%	45%	Better	32%	45%	Better

Overall Perceptions of Patient Safety

Chart legend: All Staff, Frontline Staff, Mid- Managers, Senior Exec, MD's, Bench Min, Bench Max

Categories:
1. It is not by chance that more serious mistakes don't happen around here.
2. Patient safety is never sacrificed to get more work done.
3. We do not have patient safety problems in this unit.
4. Our procedures and systems are good at preventing errors from happening.

Joint Commission Resources

AHRQ Hospital Survey on Patient Safety Culture
Date: April 14, 2010
Results At A Glance:
Safety Culture Scale Scores with High/Low Benchmarks

Percent Positive

Safety Culture Scale	All Staff	Low Benchmark	High Benchmark
1. Teamwork Within Units	78%	52%	97%
2. Supervisor /Manager Expectations & Actions Promoting Patient Safety	65%	47%	95%
3. Management Support for Patient Safety	66%	39%	94%
4. Organizational Learning — Continuous Improvement	69%	37%	97%
5. Overall Perceptions of Patient Safety	44%	27%	89%
6. Feedback and Communication About Error	61%	32%	90%
7. Communication Openness	58%	40%	98%
8. Frequency of Events Reported	55%	33%	84%
9. Teamwork Across Units	52%	14%	91%
10. Staffing	49%	25%	87%
11. Handoffs & Transitions	40%	19%	93%
12. Nonpunitive Response to Error	45%	14%	82%

Safety Culture Scales

Joint Commission Resources

■ All Staff   ■ Low Benchmark   ⊠ High Benchmark

Atlantic Health achievements in quality and patient safety for 2009 (to name a few)

- 23% decline in inpatient mortality and improvement in rankings within the University Healthsystem Consortium (UHC) since 2006

- 30% decline in Venous Thromboembolism (VTE) mortality since 2006

- 20% decline in Sepsis mortality (Thank you for washing your hands!)

- Overlook #1, Morristown #7 General Surgery Mortality in UHC

- Morristown #1, Overlook #12 in Patient Safety Indicators in UHC

- US News and World Report and American Heart Association recognition for Stroke Quality Improvement at both Overlook and Morristown in July, 2009

- National presentations on Atlantic Health's Palliative Care Programs

- Magnet re-certification in October for MMH, OL applying now for 2011

- 32% decline in Overall (General and Vascular Surgery) Surgical Site Infections in NSQIP for MMH

- Several Joint Commission Disease-specific "Center of Excellence" Certifications (Accreditation site visits possible in 2010!)

Conclusions

- The AHRQ Culture of Safety Survey is a very useful tool to help health systems identify their strengths and weaknesses with respect to making improvements in Patient Safety.

- Empowering Patient Care units within hospitals to identify and act on opportunities to improve the "Culture of Safety" can be an effective method of employee engagement.

- Improving the Culture of Safety is necessary but not sufficient to improve Patient Experience through HCAHPS measurements.

- Further research is needed to better define methods of engaging microsystems to achieve success with improving the "Culture of Safety". This research should include cross-correlation with Patient Safety Indicators and other relevant clinical outcomes, including mortality.

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Thank you.

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