



A featured project from the Essential Hospitals Engagement Network (EHEN)



San Francisco General Hospital and Trauma Center (SFGH)

Becoming Transparent: Using Patient Safety Dashboards

Problem Identified

During rounds as part of SFGH's first site visit with America's Essential Hospitals in 2012, most staff were unable to identify what patient harm conditions they were working to address. Prior to the site visit, hospital management had developed dashboards for Sepsis, central line-associated blood stream infections (CLABSI), falls, and hospital-associated pressure ulcers (HAPU) that were sent electronically. However, the site visit revealed the dashboard was not being used to reduce the targeted hospital conditions on the units.

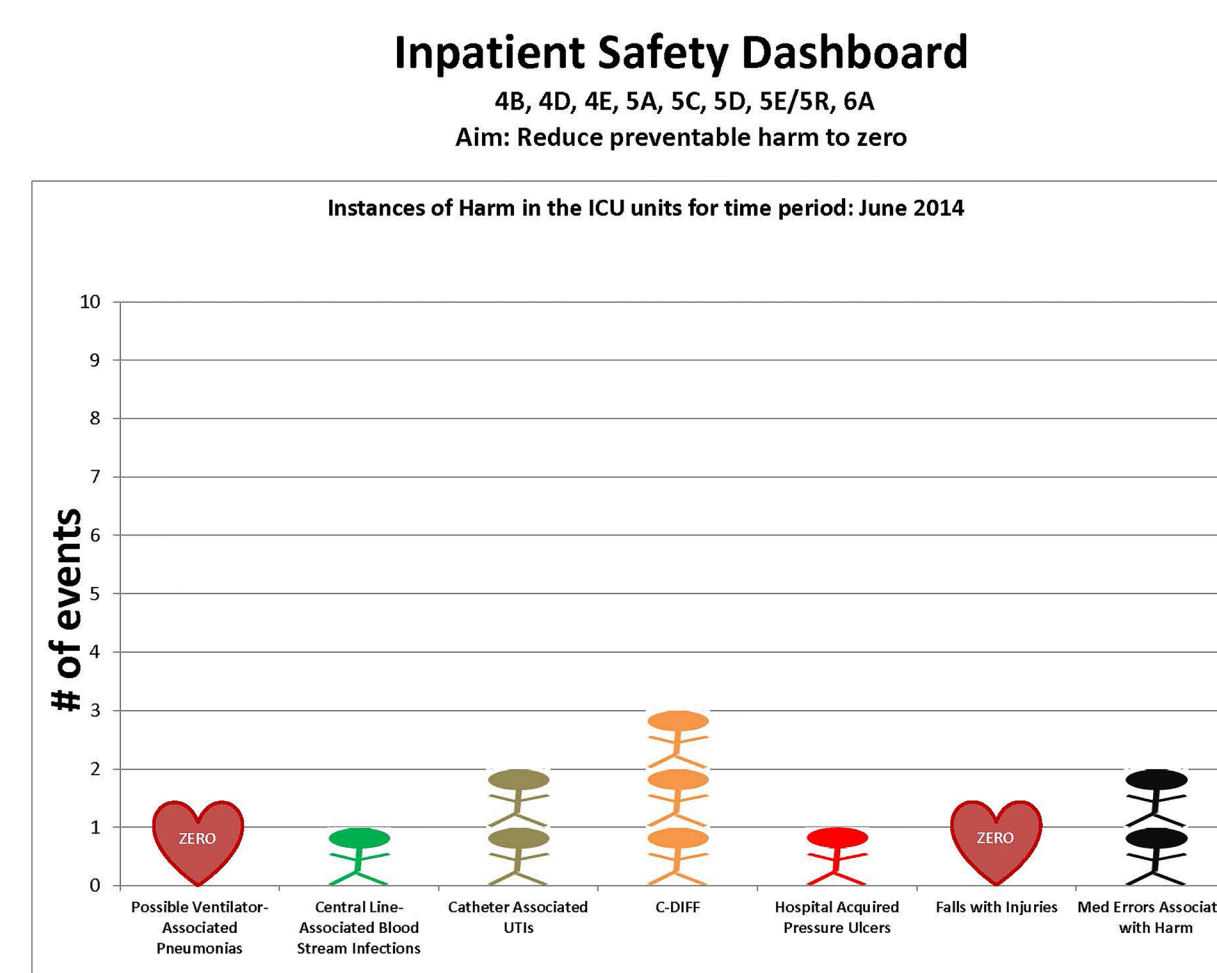
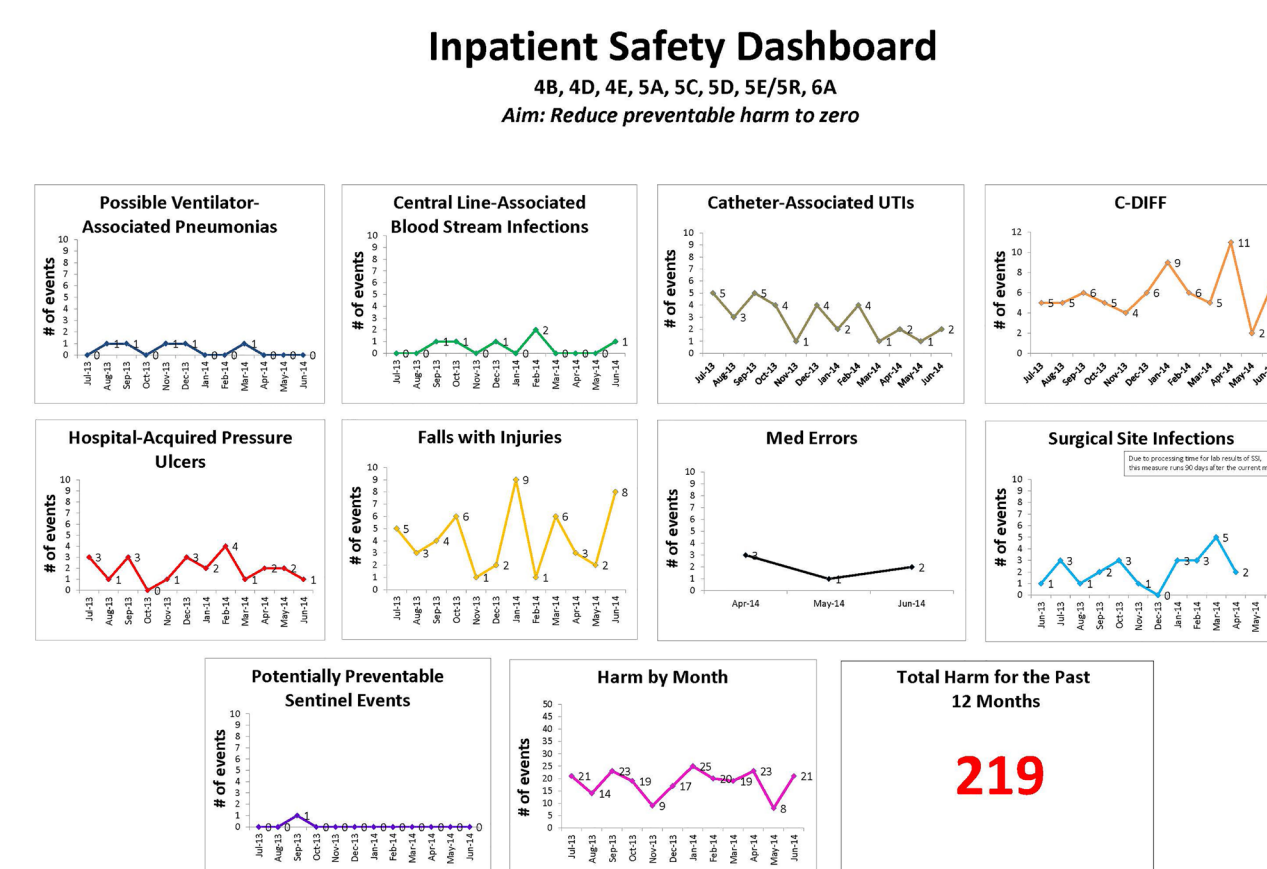
Interventions

The patient safety team decided to take this on to improve the knowledge of staff on four conditions: CLABSI, HAPU, falls, and sepsis. The team developed a schedule of weekly patient safety huddles, visiting every inpatient medical/surgical unit and intensive care unit to post the four dashboards. The team gathered as many multidisciplinary team members that were available and explained the conditions, presented the data, and strategies to improve. The huddles took five minutes.



Outcomes

The outcome was significant. During a visit by The Centers for Medicare & Medicaid Services in June 2013, SFGH tested a new patient safety survey and rounding on units. Asking about quality improvement was a large component of the survey, with 100 percent of the units using the dashboards and engaging in a patient safety huddle. An additional survey of the nursing staff revealed a 50 percent improvement in perceptions of knowledge.



Leadership and Patient Engagement

SFGH was fortunate to have the support of CEO Sue Currin. She guided the initiative from the beginning and assisted the safety team in small tests of change along the way. The effort has been fully supported by the hospital's quality management department and data center. These departments assisted the team with each test of change and improved the dashboard based on end users' feedback.

Lessons Learned

Performance dashboards will bring some staff resistance to posting sensitive data in public view, but eventually will be well received. The team learned it was best to start with dashboards that may already exist, then take initiative to get them posted. During SFGH's six-week implementation, there were frequent delays in receiving data updates. As a result, the team plans to explore ways to regularly refresh dashboard data about hospital-associated conditions.

Strategies for Successful Replication

Strategies for successfully implementing a program to reduce patient harm from hospital-associated conditions should include the following:

- Identify the conditions that are the largest contributors to your harm score.
- Complete Plan-Do-Study-Act cycles or small tests of change using each month of data.
- Ask for suggestions from staff and make the changes the following month, not quarterly.