# The Role of Leadership in Implementing a Quality Improvement and Patient Safety Program

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## Embrace Change:

### Building today's leaders

Friday, October 19, 2018

# Disclosure of Conflict of Interest

I do not have any relevant financial relationships with any commercial interests.

# Learning Objectives

1. Describe leadership's responsibility for quality improvement and patient safety programs.

2. Describe the importance of regular quality reports to the governing board and to staff.

3. Describe how to develop a hospital culture that encourages reporting and discussing sentinel events or near misses without fear of repercussion.

# Paradox of Plenty

~Most advanced healthcare system in the world

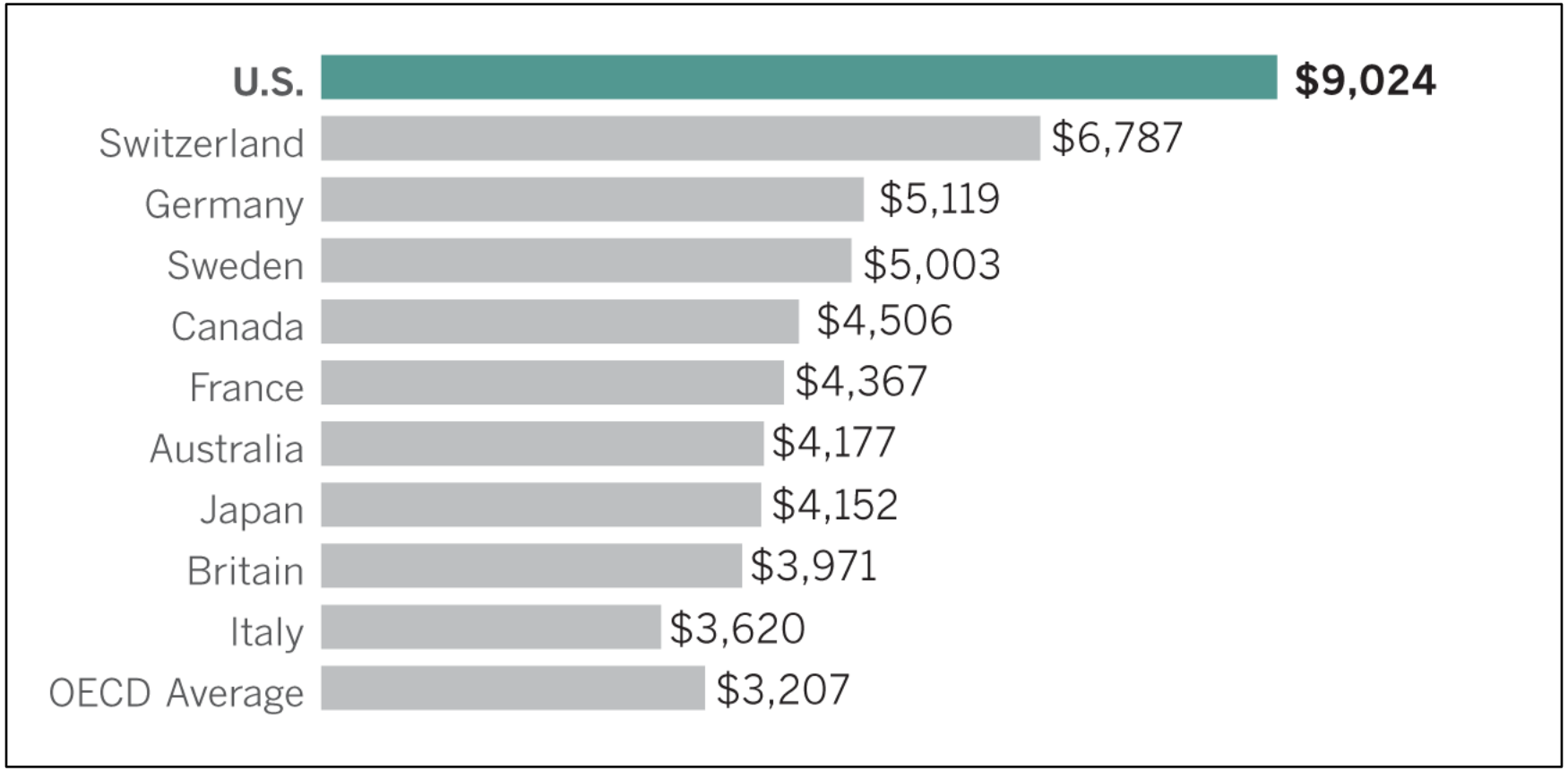
~High Cost, Low Quality

~For the money the United States spends on healthcare, about $3.2 trillion a year (2015)– the quality of care is unacceptably low

~Each year as many as 15 million patients harmed in some manner by America's healthcare system

# Health Care Spending per Capita

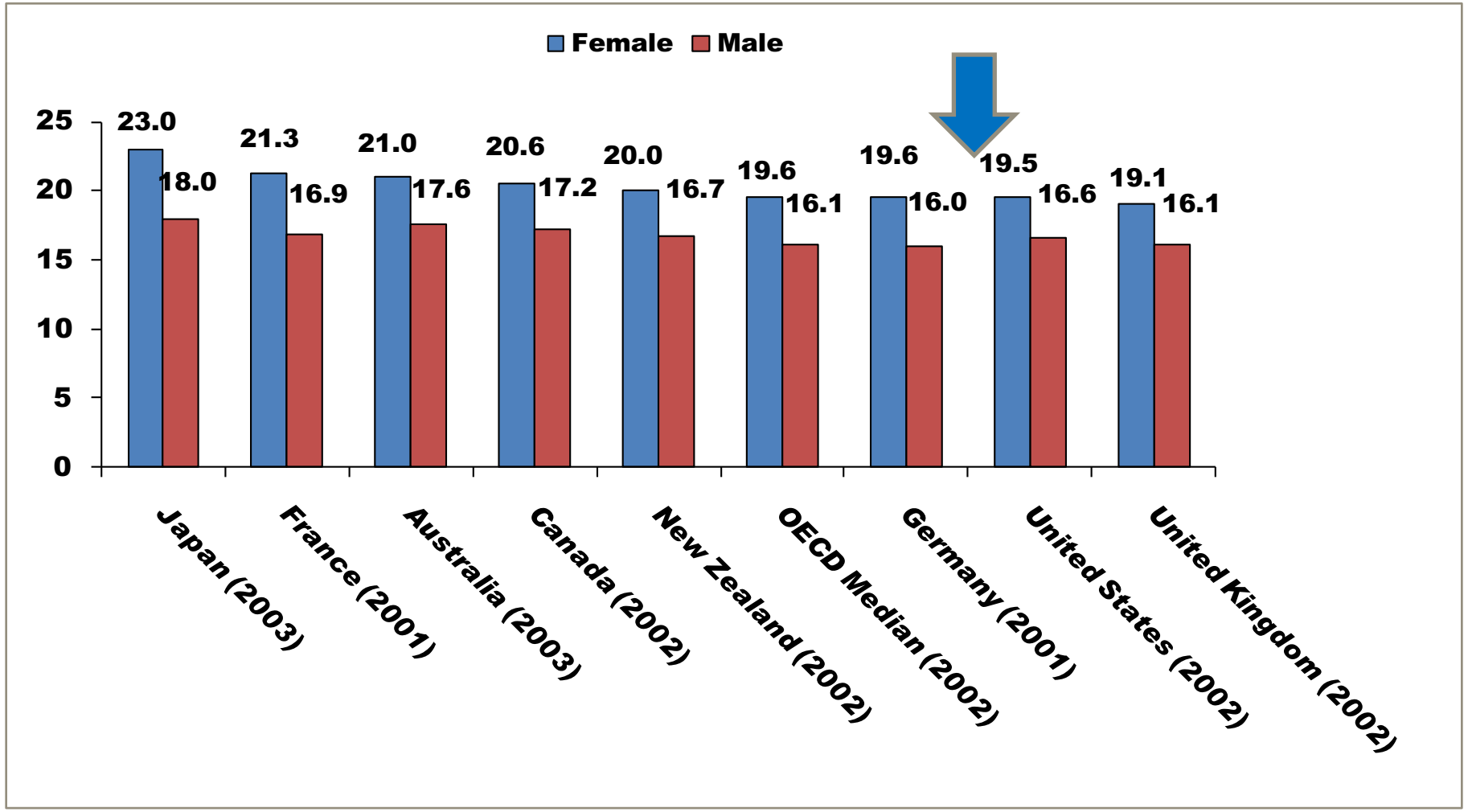
**Adjusted for Differences in Cost of Living**






Source: The Commonwealth Fund, data calculated from OECD Health Data 2015.

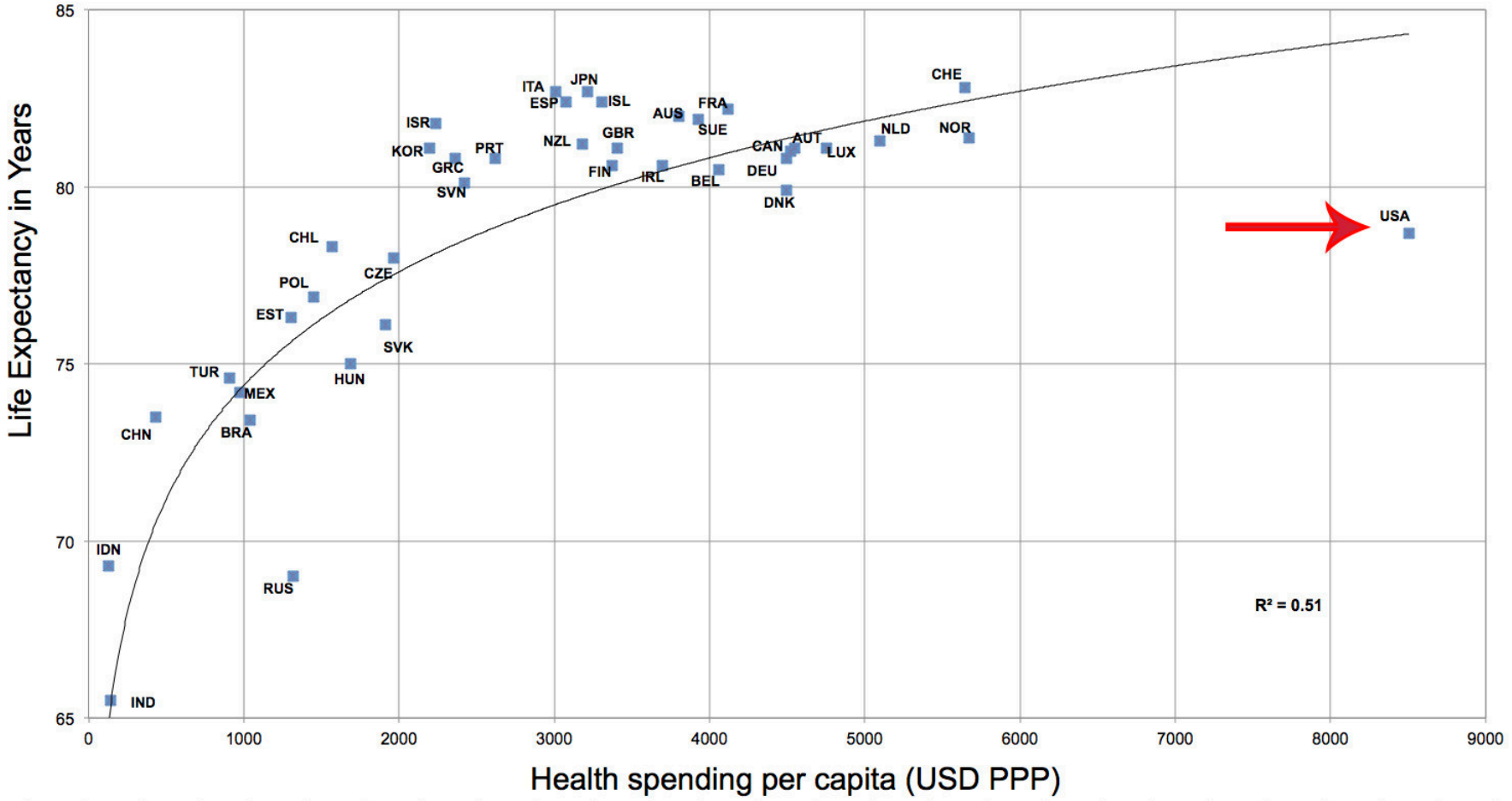
# Life Expectancy at Age 65



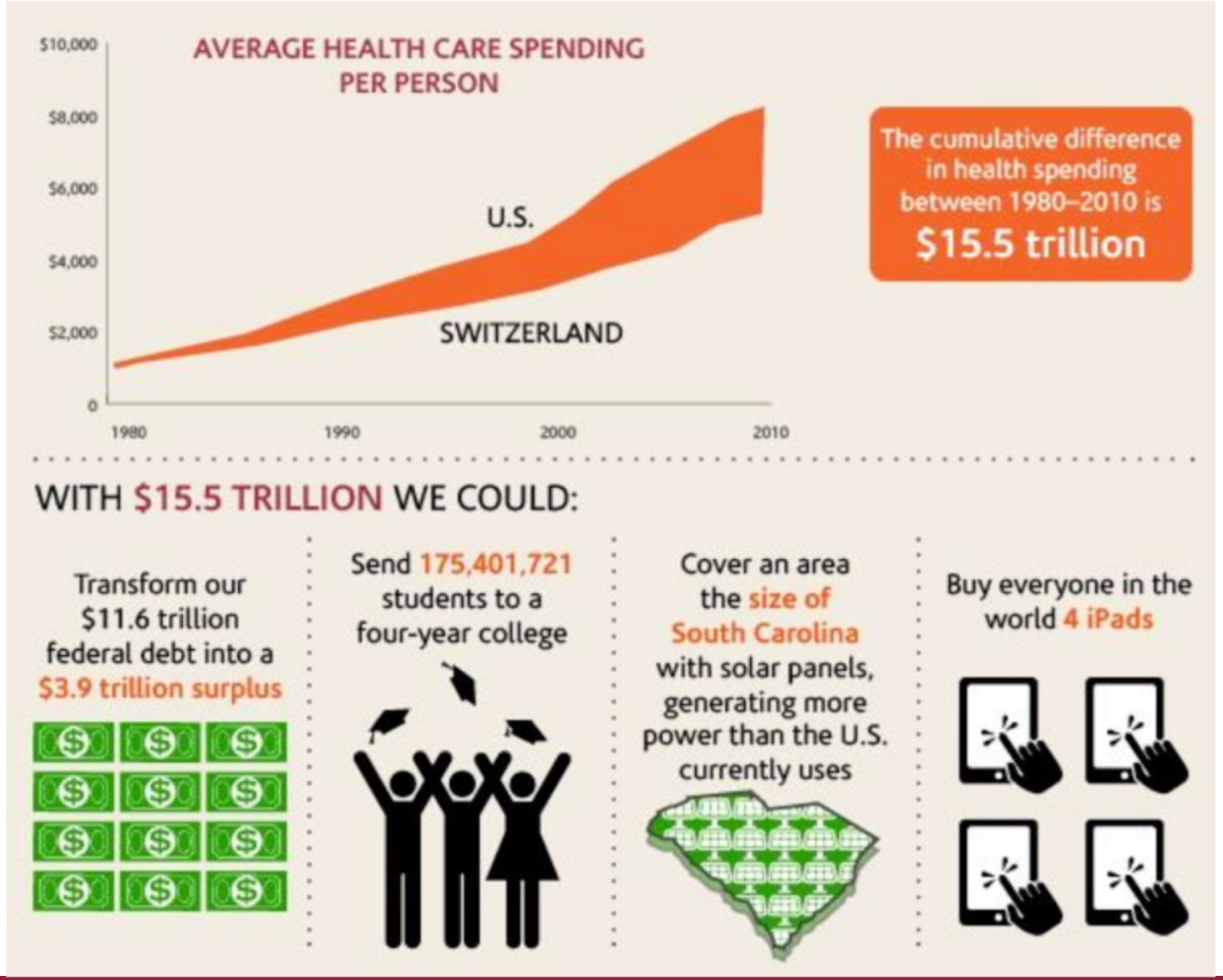



Source: The Commonwealth Fund, calculated from OECD Health Data, 2005.

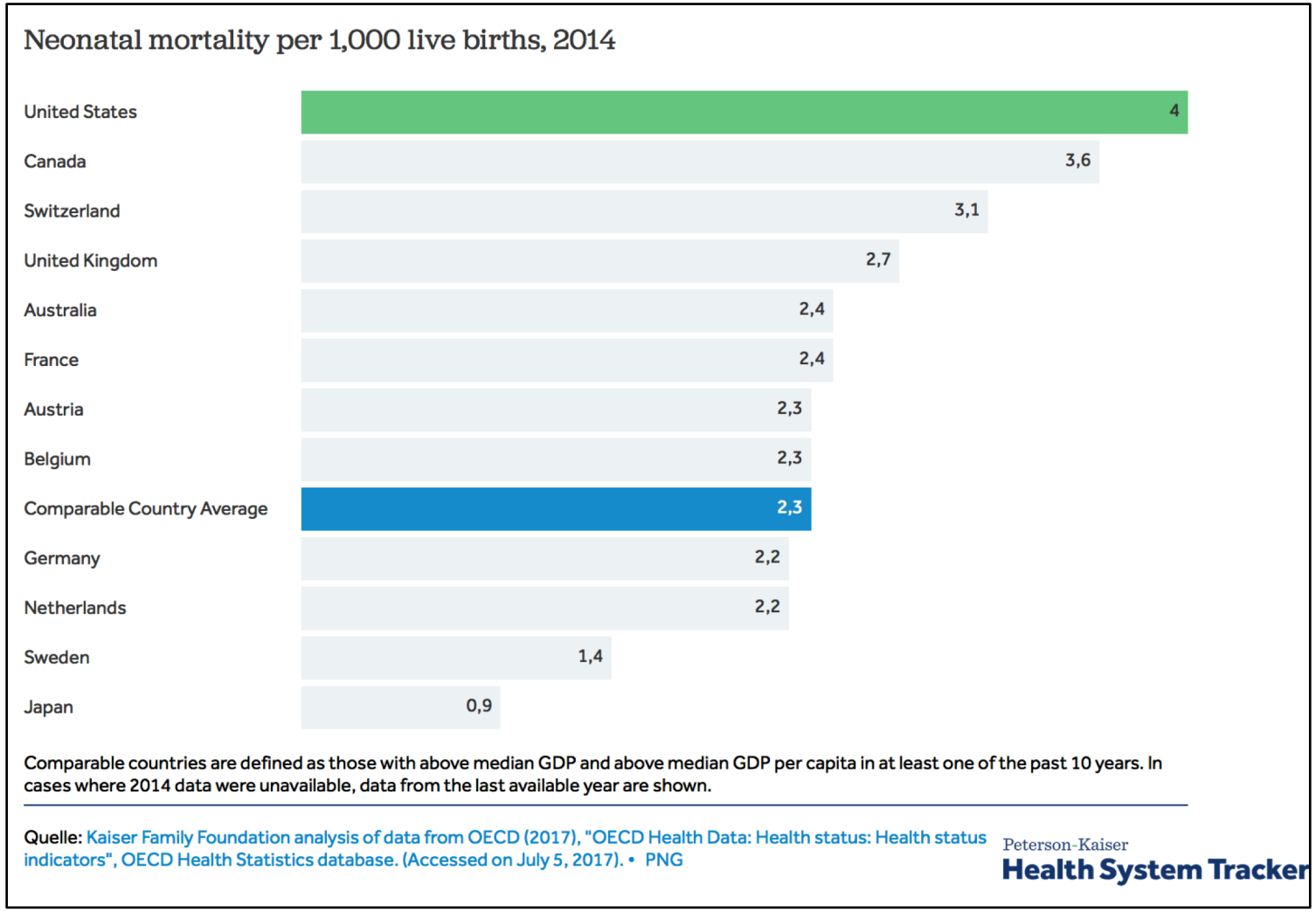
# Healthcare expenditure and life expectancy



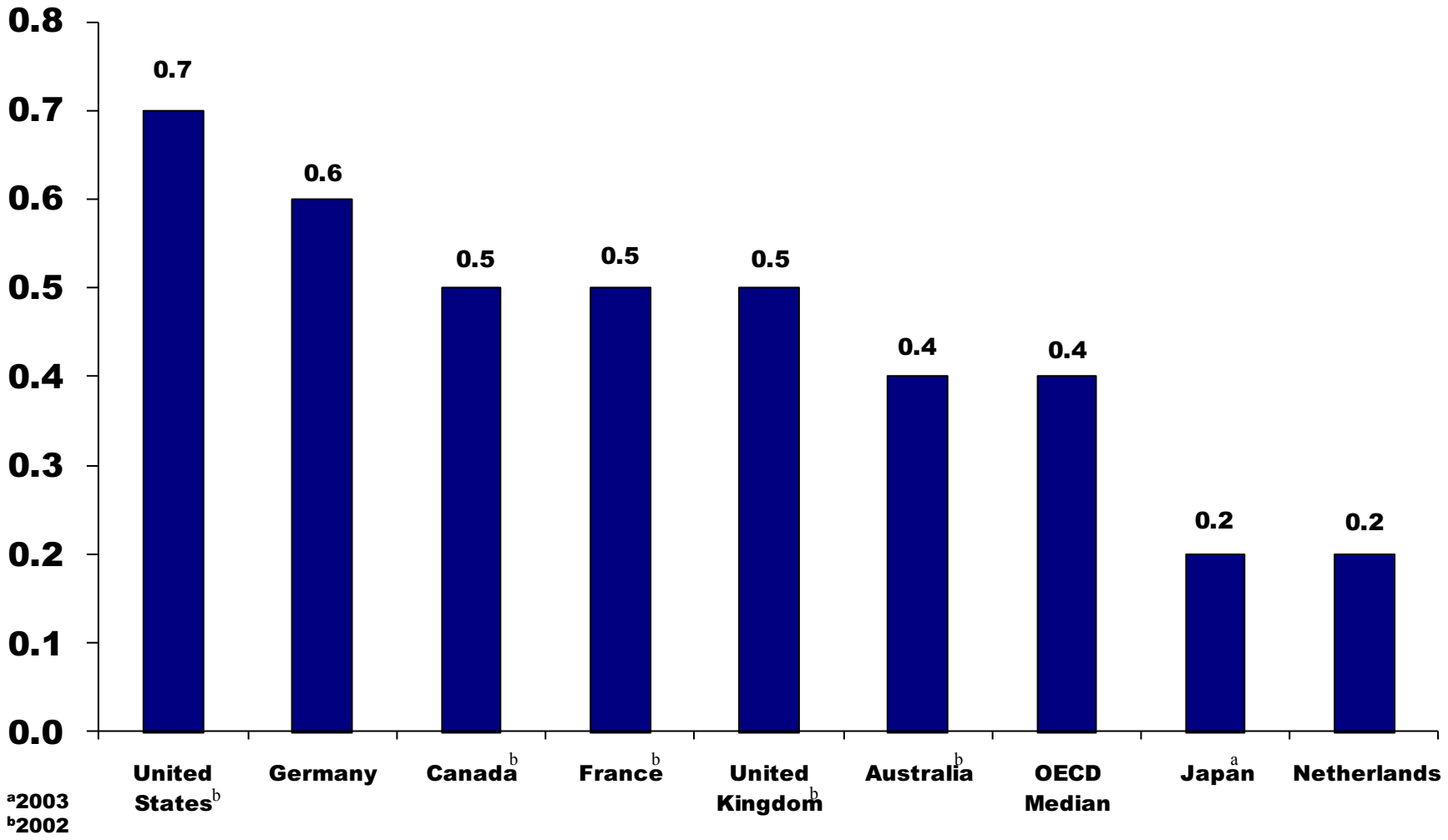
# Looking Back: What We Could Have Saved If We Had Matched the Next Highest Country (Switzerland)



# Infant Mortality Rate



# Deaths Due to Surgical or Medical Mishaps per 100,000 Population



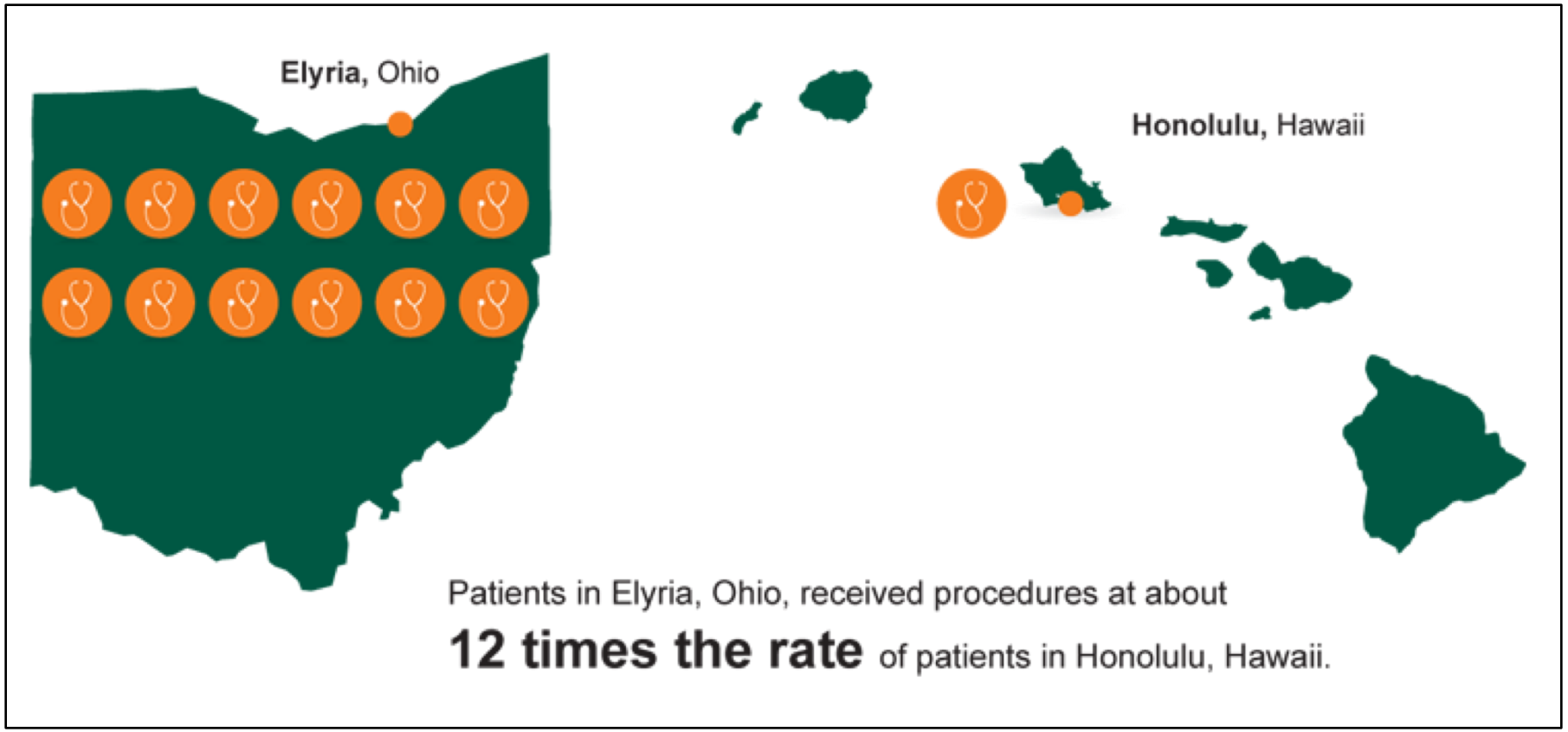



Source: The Commonwealth Fund, 2004 data calculated from OECD Health Data 2006.

# Waste Category Annual estimates

| Category | Cost to US Healthcare (2011 $B) |
|---|---|
| Overtreatment | $158 to $226 |
| Failures to coordinate care | $25 to $45 |
| Failures in care Delivery | $102 to $154 |
| Excess administrative costs | $107 to $389 |
| Excessive Health care prices | $84 to $178 |
| Fraud and Abuse | $82 to $272 |
| **2011 Total waste** | **$558 to $1263** |
| **% of Total Spending** | **21% to 47% (MED =34%)** |

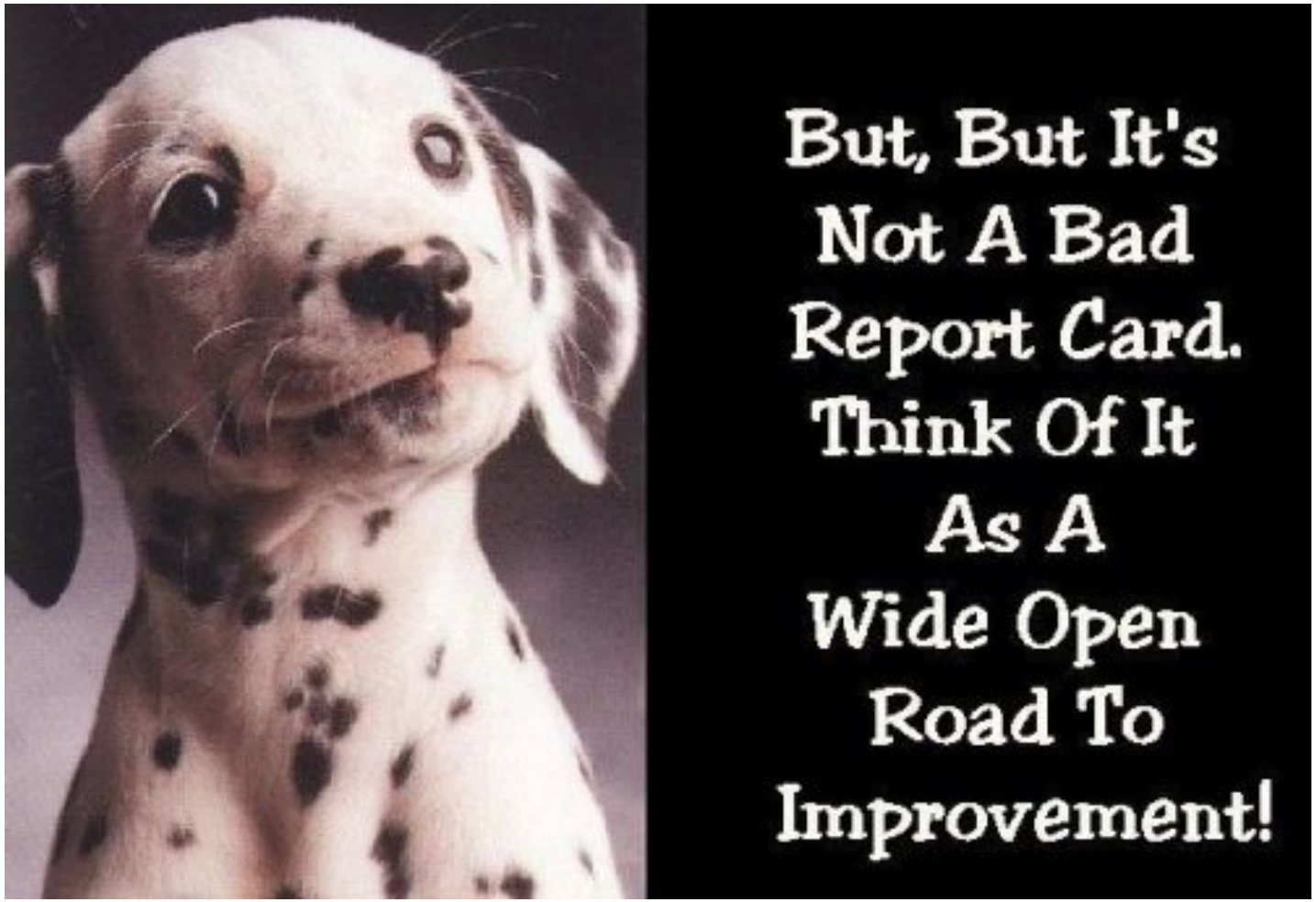
# Variation in Cardiac Care from State to State






*Cardiac Surgery Report*. Lebanon, NH: The Dartmouth Institute for Health Policy and Clinical Practice, 2005.

# Quality Efforts in Healthcare



# Quality Efforts in Healthcare

Quality in healthcare…

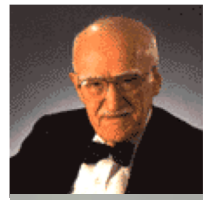
…what is it?

It depends

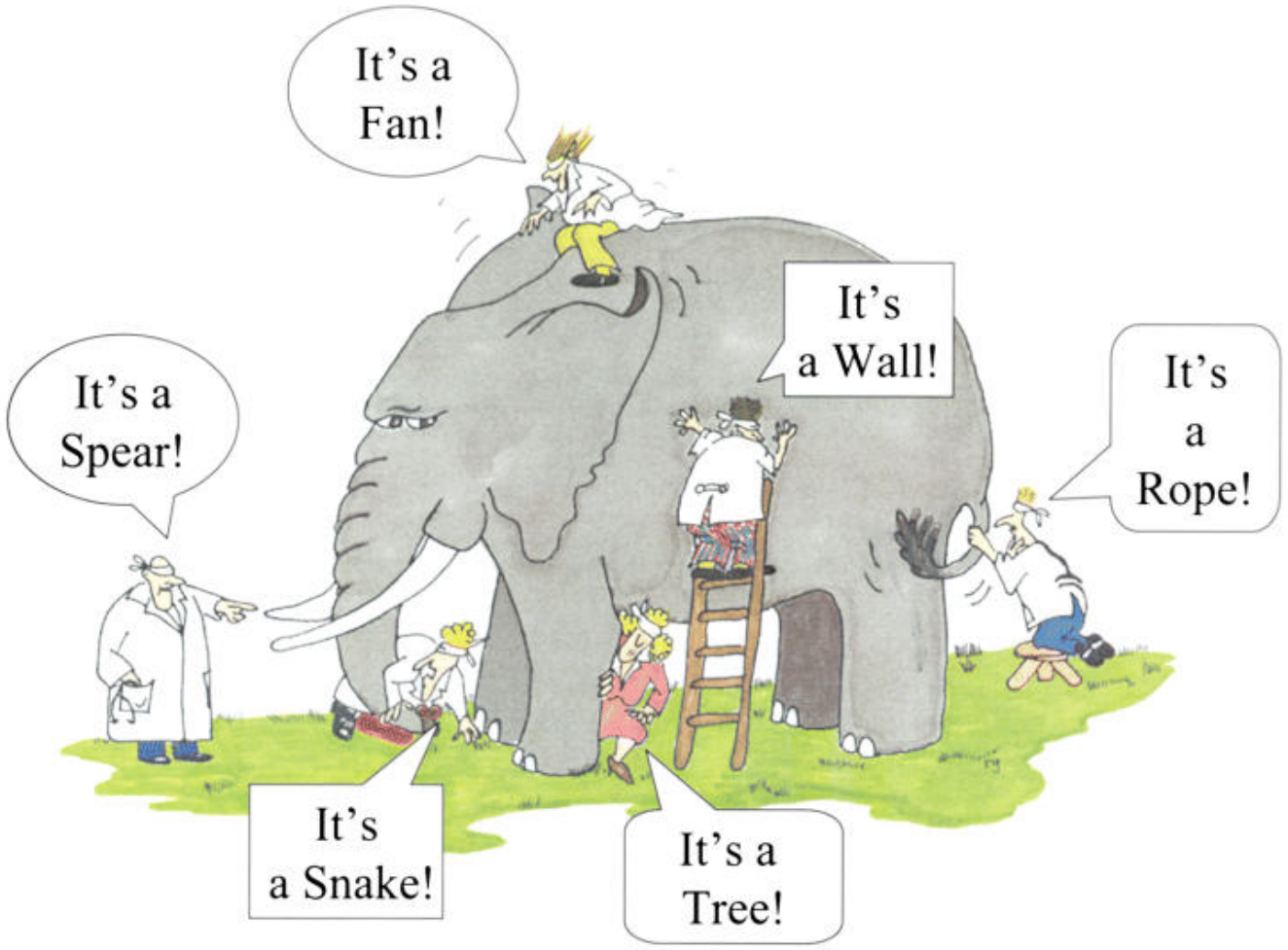
# Quality Efforts in Healthcare

Quality pioneers have different opinions:

- Dr. Joseph Juran – "fitness for use"
- Philip Crosby – "zero defects"
- Dr. Edwards Deming – "never-ending cycle of continuous improvement"

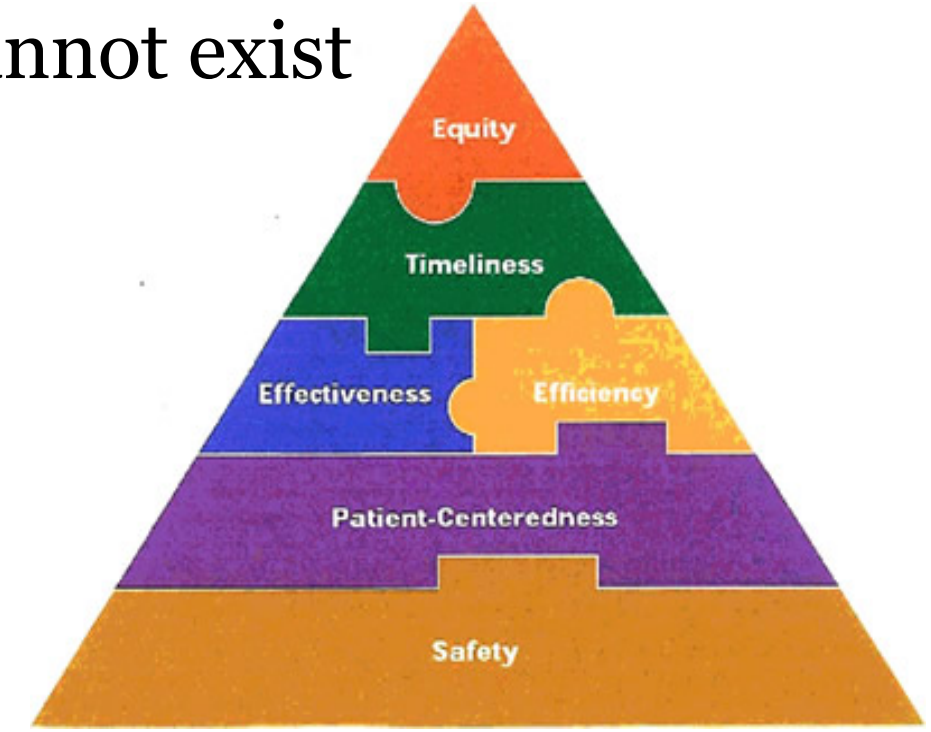


# Quality Efforts in Healthcare



# Quality and Patient Safety

If the patient is not safe from accidental harm, then high-quality healthcare cannot exist



# What do we mean by Patient Safety?

A culture that embraces the reduction of medical errors, complications, and other unanticipated adverse events which contributes to improved clinical outcomes through the adoption and management of evidence-based **practices, processes, and systems**

# What do we mean by Patient Safety?

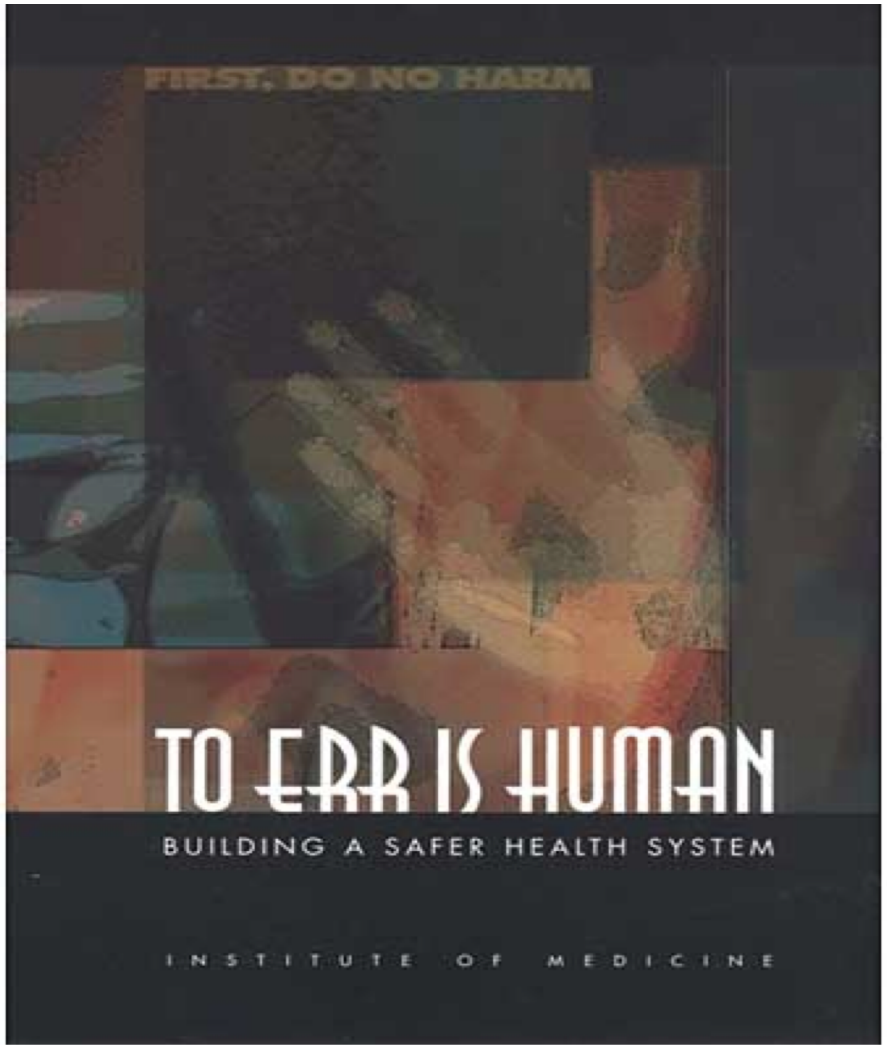
Distinction between patient safety issues (errors) and quality concerns

~ ***Operating on the wrong knee (error)*** ***vs. not using the proper surgical approach (quality)***

~ ***Overdosing a diabetic patient on insulin (error)*** ***vs. failing to properly control  a patient's diabetes (quality)***

~ ***Illegible prescription order (error)*** ***vs. not prescribing the most effective antibiotic (quality)***

# To Err is Human




- Financial Cost of Medical Errors: $29 **billion** each year in the United States alone

- Doctors, patients, insurers and hospital systems play a role in eradicating errors

# Institute of Medicine (IOM) Roundtable

*“ Serious and widespread quality problems exist throughout American medicine. These problems occur in small and large communities alike, in all parts of the country, and with approximately equal frequency in managed care and fee-for-service systems of care. Very large numbers of Americans are harmed as a result .”*

# What IOM Said:

- The patient safety problem is large.
- It (usually) isn't the fault of health care workers.
- Most patient injuries are due to system failures.

# Roundtable Categories

- Overuse (of procedures that cannot help)
- Underuse (of procedures that can help)
- Misuse (errors of execution)

# Health Care Examples of Overuse

- 30% of children receive excessive antibiotics for ear infections
- 20% to 50% of many surgical operations are unnecessary
- 50% of X-rays in back pain patients are unnecessary

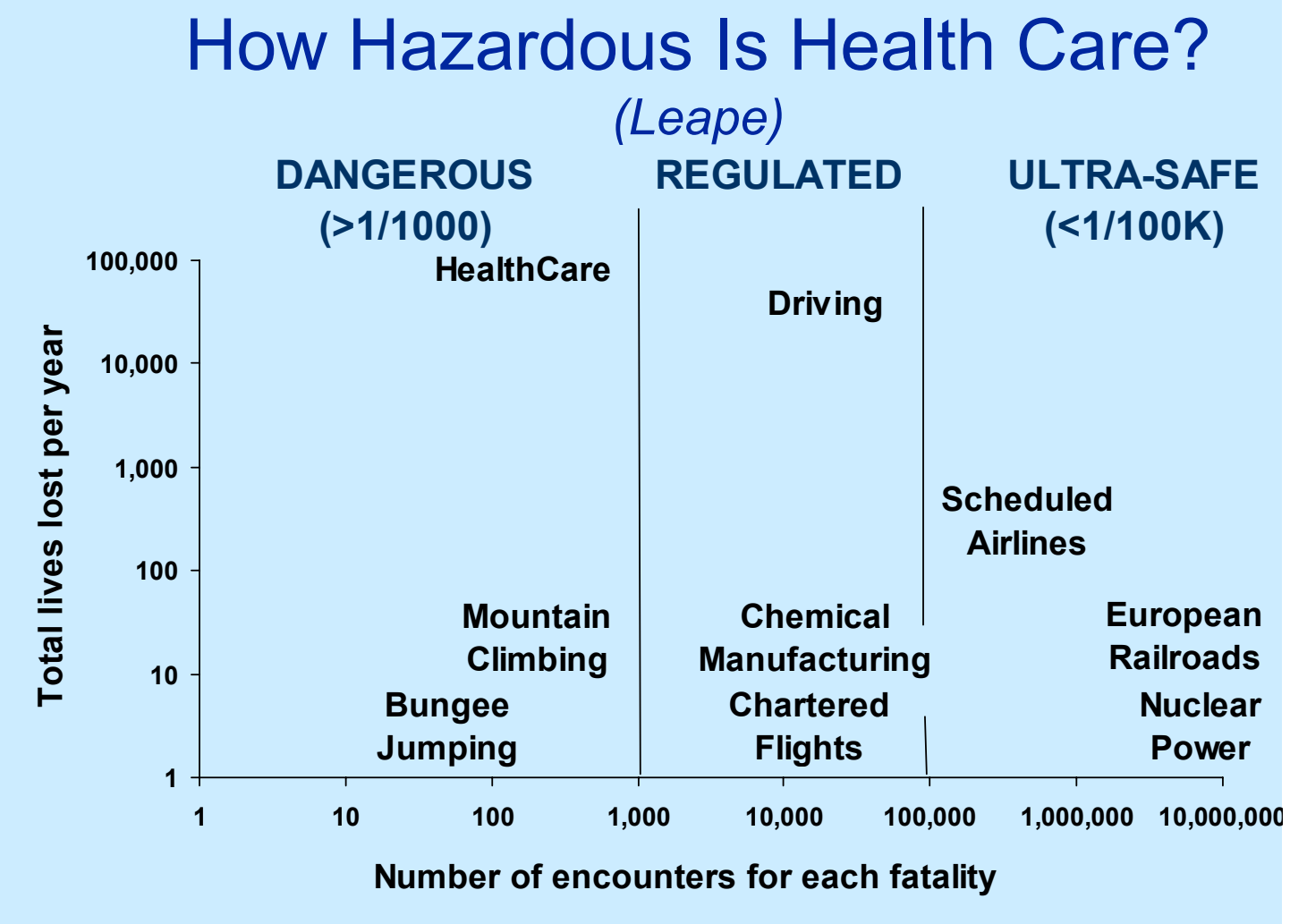
# Health Care Examples of Underuse

- 50% of elderly fail to receive pneumococcal vaccine
- 50% of heart attack victims fail to receive beta-blockers

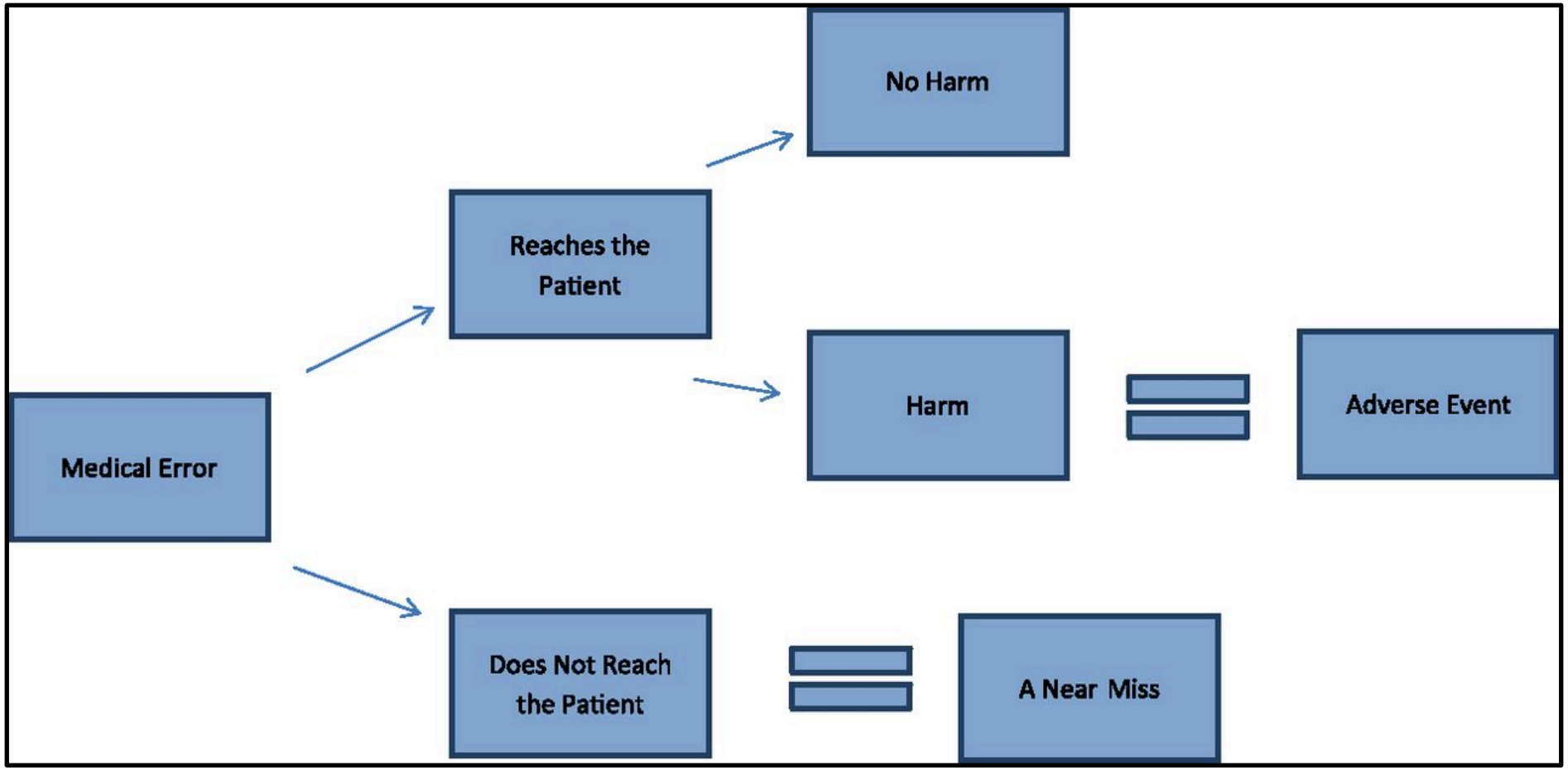
# Misuse of Healthcare Safety

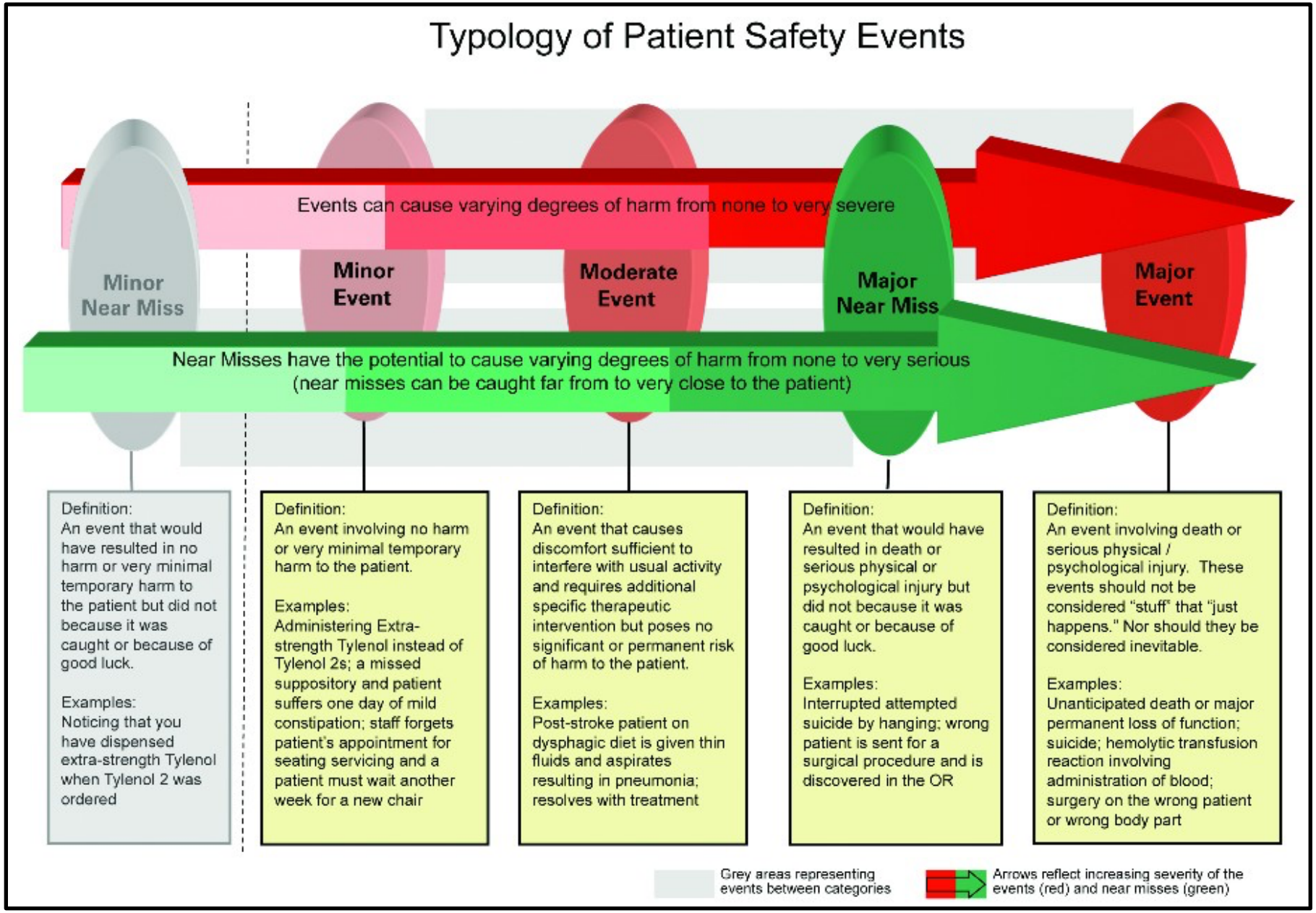
- 7% of hospital patients experience a serious medication error
- 1 out of every 5 people says that they or a family member experienced a medical mistake
- 51% reported the error as serious
- 28-35% of admissions experience an event that causes **HARM**

# Health Care Safety



# Types of Patient Safety Events




Typology of Patient Safety Events
Events can cause varying degrees of harm from none to very severe
Minor Near Miss
Minor Event
Moderate Event
Major Near Miss
Major Event
Near Misses have the potential to cause varying degrees of harm from none to very serious
(near misses can be caught far from to very close to the patient)
Definition:
An event that would have resulted in no harm or very minimal temporary harm to the patient but did not because it was caught or because of good luck.
Examples:
Noticing that you have dispensed extra-strength Tylenol when Tylenol 2 was ordered
Definition:
An event involving no harm or very minimal temporary harm to the patient.
Examples:
Administering Extra-strength Tylenol instead of Tylenol 2s; a missed suppository and patient suffers one day of mild constipation; staff forgets patient's appointment for seating servicing and a patient must wait another week for a new chair
Definition:
An event that causes discomfort sufficient to interfere with usual activity and requires additional specific therapeutic intervention but poses no significant or permanent risk of harm to the patient.
Examples:
Post-stroke patient on dysphagic diet is given thin fluids and aspirates resulting in pneumonia; resolves with treatment
Definition:
An event that would have resulted in death or serious physical or psychological injury but did not because it was caught or because of good luck.
Examples:
Interrupted attempted suicide by hanging; wrong patient is sent for a surgical procedure and is discovered in the OR
Definition:
An event involving death or serious physical / psychological injury. These events should not be considered "stuff" that "just happens." Nor should they be considered inevitable.
Examples:
Unanticipated death or major permanent loss of function; suicide; hemolytic transfusion reaction involving administration of blood; surgery on the wrong patient or wrong body part
Grey areas representing events between categories
Arrows reflect increasing severity of the events (red) and near misses (green)

# Patient safety incident reporting: a qualitative study of thoughts and perceptions of experts 15 years after *'To Err is Human'*

Imogen Mitchell,[1] Anne Schuster,[2] Katherine Smith,[3] Peter Pronovost,[4] Albert Wu[2]

*Inadequate report processes*

The overwhelming sentiment from all the participants was the unexpected large volume of reports generated in all incident reporting systems. There were often insufficient resources to deal with this volume of reports, leaving reports inadequately triaged, clustered, analysed or acted upon.

*Lack of adequate medical engagement*

A consistent theme was the lack of engaging doctors to report, own or lead the incident reporting process. This lack of engagement resulted in reporting bias frequently from the nurses and skewing the data. The key incidents, which would reflect medical decision-making, included diagnostic errors and hand offs.

*Insufficient action*

A key message from many participants that reporting could not be considered without linking it to action. In the years following the Institute of Medicine's (IOM) report, much attention had focused on reporting, but not the action or feedback loop to the reporter. Many participants believed that the lack of visible action led to under-reporting of meaningful incidents.

*Inadequate funding and institutional support*

It was acknowledged by many participants that there had been an under-resourcing of incident reporting systems whether nationally, state or at the local level. The lack of fiscal support had unintended consequences such as not being able to deal with the volume of reports, which inevitably led to a delay in analysing the reports and distilling recommendations for dissemination. There were also concerns raised over accountability of the incident reporting systems and their ensuing actions.

*Failure to capture evolving health information technology developments*

A repeated theme for the future of incident reporting systems was the use of technology to improve the reporting of incidents, to analyse the incidents and disseminate the results. In the USA, concern was raised that there had been inadequate resourcing or thought of linking the electronic health record to incident reporting.

*Illustrative quotes are embedded in the text.

*Inadequate report processes*

*Lack of adequate medical engagement*

*Insufficient action*

*Inadequate funding and institutional support*

*Failure to capture evolving health information technology developments*

# How to Create a Safety Culture


**A complimentary publication of The Joint Commission**
**Issue 57, March 1, 2017**

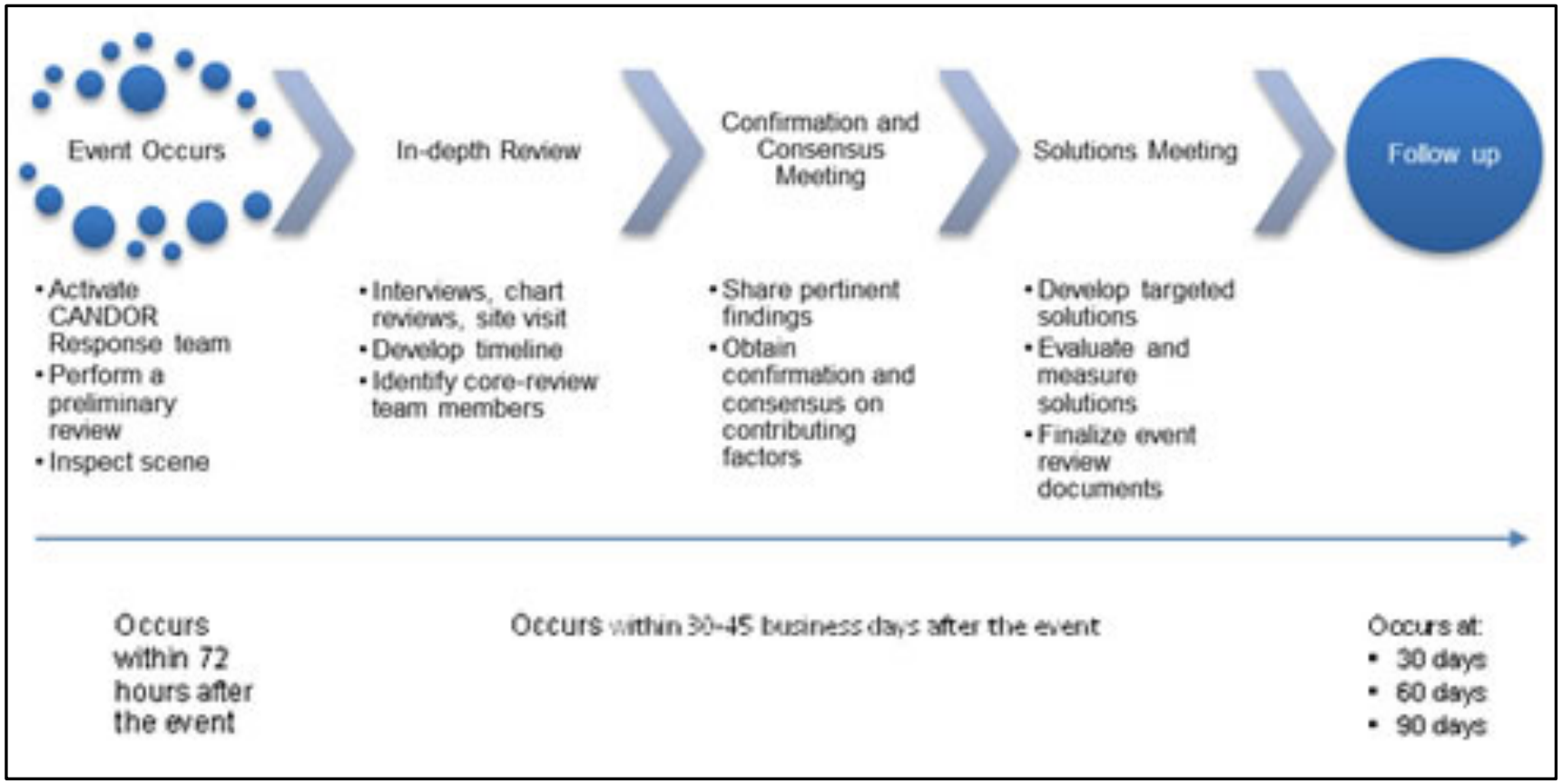
**The essential role of leadership in developing a safety culture**

# Inadequate Leadership

- Insufficient support of patient safety event reporting
- Lack of feedback or response to staff and others who report safety vulnerabilities
- Allowing intimidation of staff who report events
- Refusing to consistently prioritize and implement safety recommendations
- Not addressing staff burnout

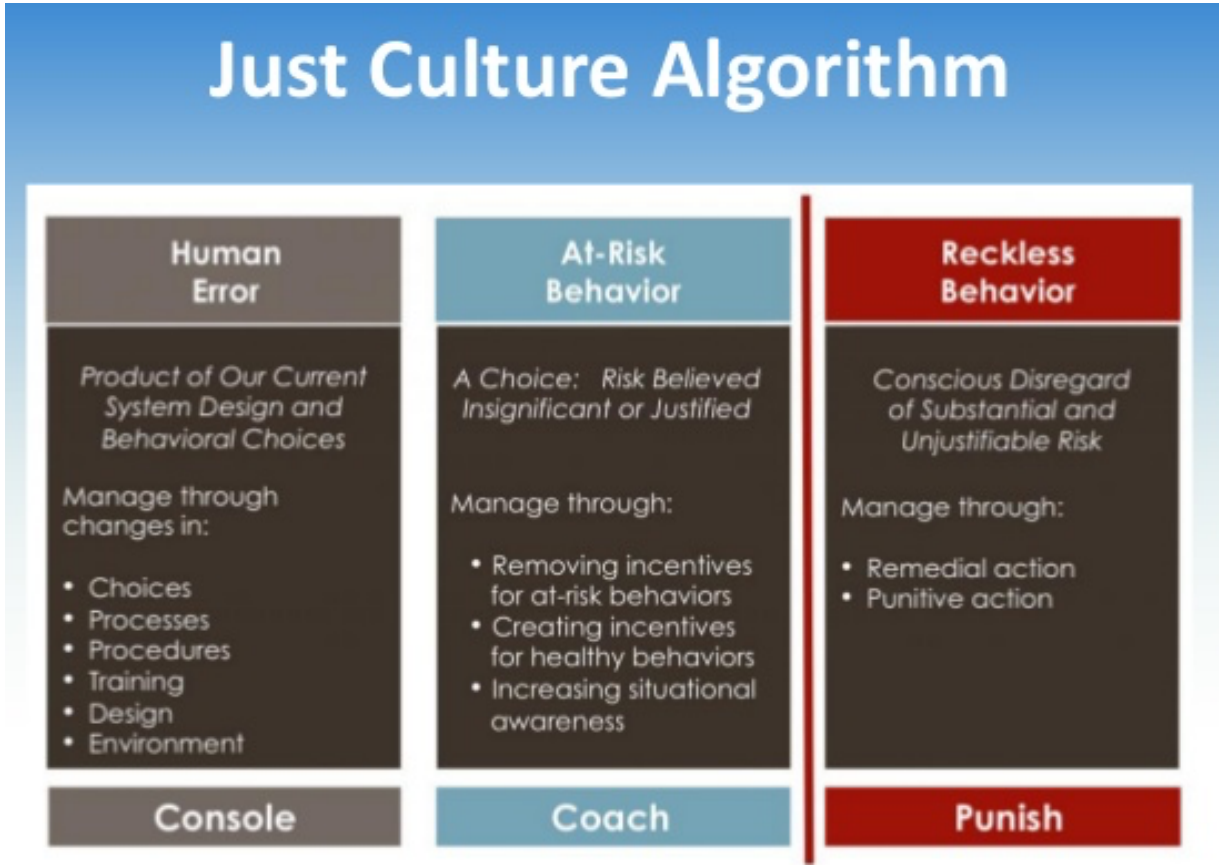
# JC Recommendations

Absolutely crucial is a transparent, non- punitive approach to reporting and learning from adverse events, close calls and unsafe conditions.



# JC Recommendations

Establish clear, just, and transparent risk- based processes for recognizing and separating human error and error arising from poorly designed systems from unsafe or reckless actions that are blameworthy.

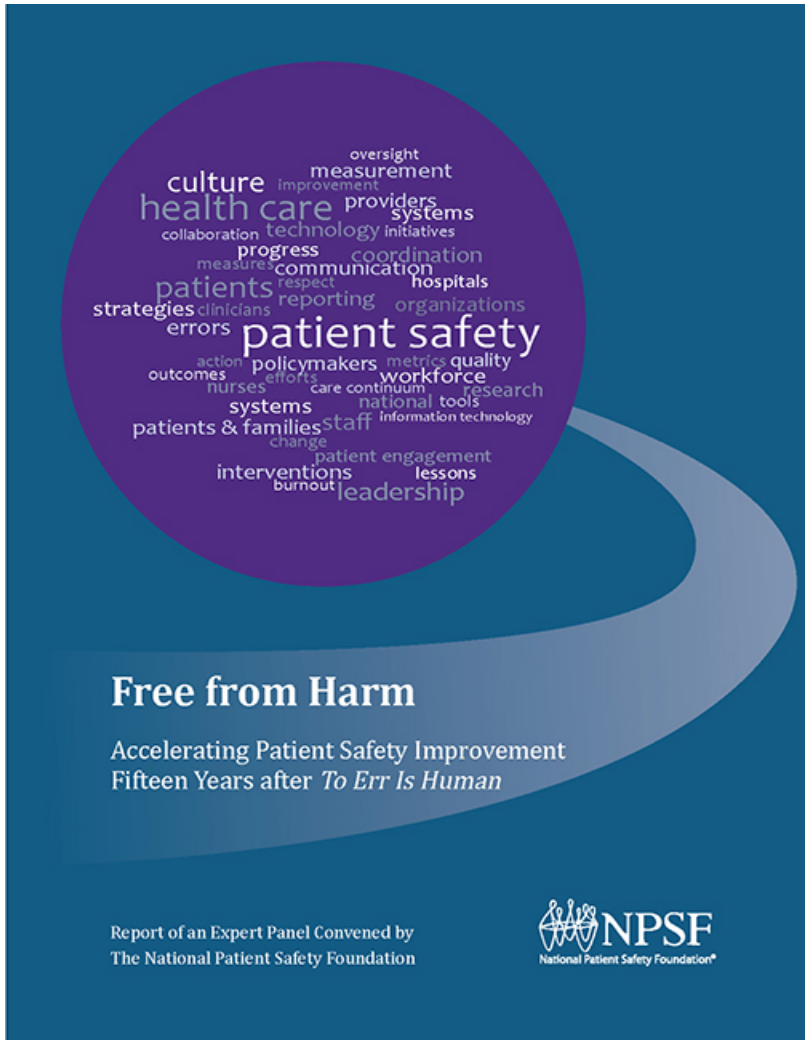


# JC Recommendations

Recognize care team members who report adverse events and close calls, who identify unsafe conditions, or who have good suggestions for safety improvements.

**The key to improving safety lies not in changing the human condition, but in changing the conditions under which humans work.**

# *Free from Harm* – December 2015




Download the full PDF report for free at:

**www.npsf.org/free-from-harm**

# Current State of Patient Safety

- Evidence mixed but panel overall felt that health care is safer but there is more work to be done

- While limited, progress notable
  - Young field
  - Still developing scientific foundations
  - Received limited investment

- Improving patient safety is a complex problem
  - Requires work by diverse disciplines to solve

# Total Systems Approach Needed

- Advancing patient safety requires an overarching shift from reactive, piecemeal interventions to a total systems approach

- Need to embrace wider approach beyond specific, circumscribed initiatives to generate change

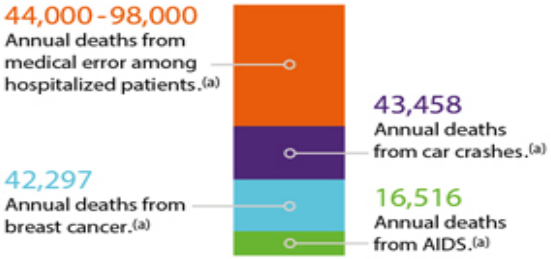
- Fundamental finding: Initiatives can advance only with a key focus on teamwork, culture and patient engagement

# FREE FROM HARM:

## ACCELERATING PATIENT SAFETY IMPROVEMENT FIFTEEN YEARS AFTER *TO ERR IS HUMAN*

Report of an expert panel convened by the National Patient Safety Foundation argues for looking at morbidity as well as mortality caused by medical errors and going beyond hospitals to improve safety across the continuum of care.

### TO ERR IS HUMAN FRAMED PATIENT SAFETY AS A SERIOUS PUBLIC HEALTH ISSUE (1999 ESTIMATES)




### BY SOME MEASURES, HEALTH CARE HAS GOTTEN SAFER SINCE TO ERR IS HUMAN

**1.3 Million**

Estimated reduction in hospital-acquired conditions (2011-2013) as a result of the federal Partnership for Patients initiative.(b)

### TO UNDERSTAND THE FULL IMPACT OF PATIENT SAFETY PROBLEMS, WE MUST LOOK AT BOTH MORTALITY AND MORBIDITY

**1in10**

patients develops a health care acquired condition (such as infection, pressure ulcer, fall, adverse drug event) during hospitalization.(b)

### BUT WE MUST LOOK BEYOND HOSPITALS TO THE FULL CARE CONTINUUM


Roughly 1 billion ambulatory visits occur in the US each year.(c)

About 35 million hospital admissions occur annually.(c)

### ADVANCEMENT IN PATIENT SAFETY REQUIRES AN OVERARCHING SHIFT FROM REACTIVE, PIECEMEAL INTERVENTIONS TO A TOTAL SYSTEMS APPROACH TO SAFETY(d)

1. Ensure that leaders establish and sustain a safety culture.
2. Create centralized and coordinated oversight of patient safety.
3. Create a common set of safety metrics that reflect meaningful outcomes.
4. Increase funding for research in patient safety and implementation science.
5. Address safety across the entire care continuum.
6. Support the health care workforce.
7. Partner with patients and families for the safest care.
8. Ensure that technology is safe and optimized to improve patient safety.

NPSF National Patient Safety Foundation®

To read the full report and detailed set of recommendations, visit **www.npsf.org/free-from-harm**

AIG

This project was made possible in part through a generous grant from AIG in support of the advancement of the patient safety mission. AIG had no influence whatsoever on report direction or its content. The views and opinions expressed herein are those of the author(s) and do not necessarily reflect those of American International Group, Inc. (AIG) or its subsidiaries, business units or affiliates. Sources: (a) Institute of Medicine. To Err Is Human: Building a Safer Health System. Washington, DC: The National Academies Press, 2000. (b) 2013 Annual Hospital-Acquired Condition Rate and Estimates of Cost Savings and Deaths Averted From 2010 to 2013. Rockville, MD: Agency for Healthcare Research and Quality; October 2015. AHRQ Publication No. 16-0006-EF. http://www.ahrq.gov/professionals/quality-patient-safety/pfp/index.html. (c) National Center for Health Statistics. Faststats A-Z. Ambulatory Care and Hospital Utilization. Available at: http://www.cdc.gov/nchs/fastats/ (d) National Patient Safety Foundation. Free from Harm: Accelerating Patient Safety Improvement Fifteen Years after To Err Is Human. Boston, MA: National Patient Safety Foundation; 2015. Available at: http://www.npsf.org/free-from-harm.

# Eight Recommendations for Achieving Total Systems Safety

### 1. ENSURE THAT LEADERS ESTABLISH AND SUSTAIN A SAFETY CULTURE

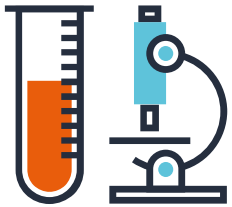
Improving safety requires an organizational culture that enables and prioritizes safety. The importance of culture change needs to be brought to the forefront, rather than taking a backseat to other safety activities.

### 2. CREATE CENTRALIZED AND COORDINATED OVERSIGHT OF PATIENT SAFETY

Optimization of patient safety efforts requires the involvement, coordination, and oversight of national governing bodies and other safety organizations.

### 3. CREATE A COMMON SET OF SAFETY METRICS THAT REFLECT MEANINGFUL OUTCOMES

Measurement is foundational to advancing improvement. To advance safety, we need to establish standard metrics across the care continuum and create ways to identify and measure risks and hazards proactively.



### 4. INCREASE FUNDING FOR RESEARCH IN PATIENT SAFETY AND IMPLEMENTATION SCIENCE

To make substantial advances in patient safety, both safety science and implementation science should be advanced, to more completely understand safety hazards and the best ways to prevent them.

# Eight Recommendations for Achieving Total Systems Safety

### 5. ADDRESS SAFETY ACROSS THE ENTIRE CARE CONTINUUM

Patients deserve safe care in and across every setting. Health care organizations need better tools, processes, and structures to deliver care safely and to evaluate the safety of care in various settings.

### 6. SUPPORT THE HEALTH CARE WORKFORCE

Workforce safety, morale, and wellness are absolutely necessary to providing safe care. Nurses, physicians, medical assistants, pharmacists, technicians, and others need support to fulfill their highest potential as healers.

### 7. PARTNER WITH PATIENTS AND FAMILIES FOR THE SAFEST CARE

Patients and families need to be actively engaged at all levels of health care. At its core, patient engagement is about the free flow of information to and from the patient.

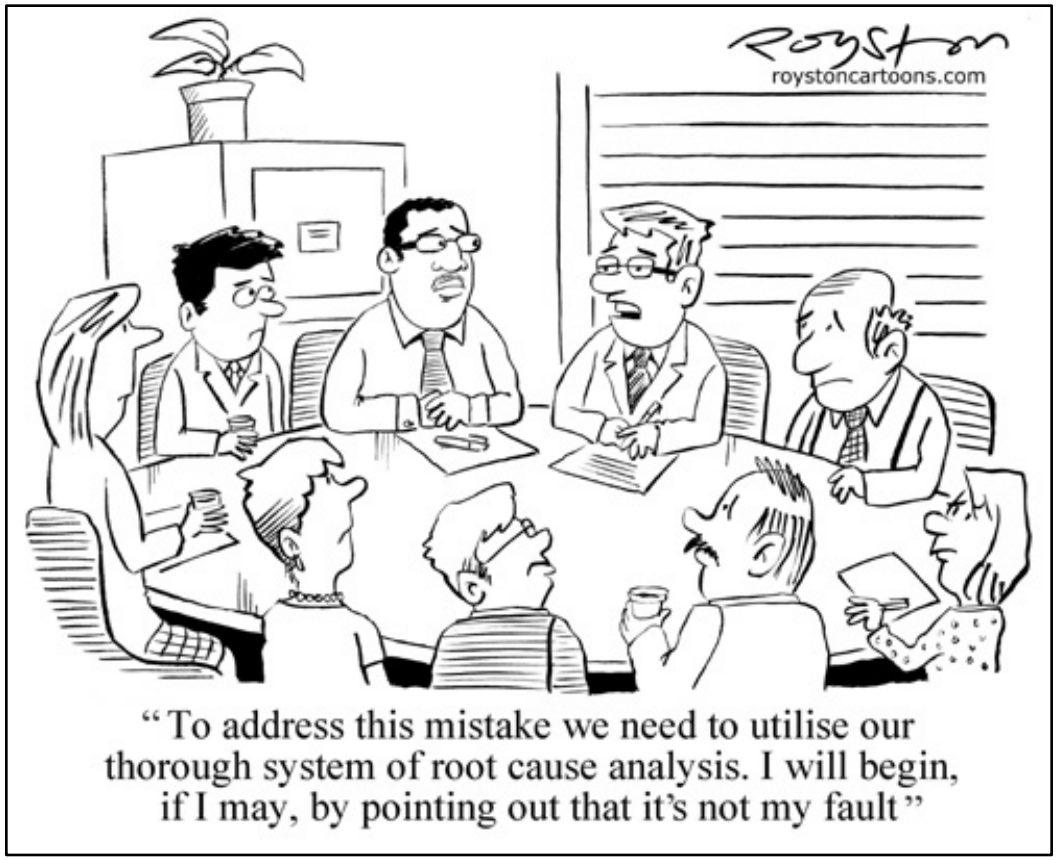
### 8. ENSURE THAT TECHNOLOGY IS SAFE AND OPTIMIZED TO IMPROVE PATIENT SAFETY

Optimizing the safety benefits and minimizing the unintended consequences of health IT is critical.

# 1- ENSURE THAT LEADERS ESTABLISH AND SUSTAIN A SAFETY CULTURE

Refocus the boards of organizations to guide and be accountable for patient safety through governance, goal setting, and ensuring that executives and all levels of management value and prioritize safety (e.g., ensure that safety data and stories are presented at every board meeting).

Ensure that leadership and governance bodies develop and implement robust processes to initiate and sustain transformation to a culture of safety and respect, specifically one that encourages honesty, fosters learning, and balances individual and organizational accountability.



# 1- ENSURE THAT LEADERS ESTABLISH AND SUSTAIN A SAFETY CULTURE

## Recommendations

- ~ PS/Q plan developed and shared with Leadership
- ~ Board has an agenda item and discussion related to PS at ALL board meetings
- ~ PS & Q dashboard at every board meeting
- ~ PS events that result in harm are discussed at all board meetings
- ~ Workforce safety dashboard at every board meeting

# 2- CREATE CENTRALIZED AND COORDINATED OVERSIGHT OF PATIENT SAFETY

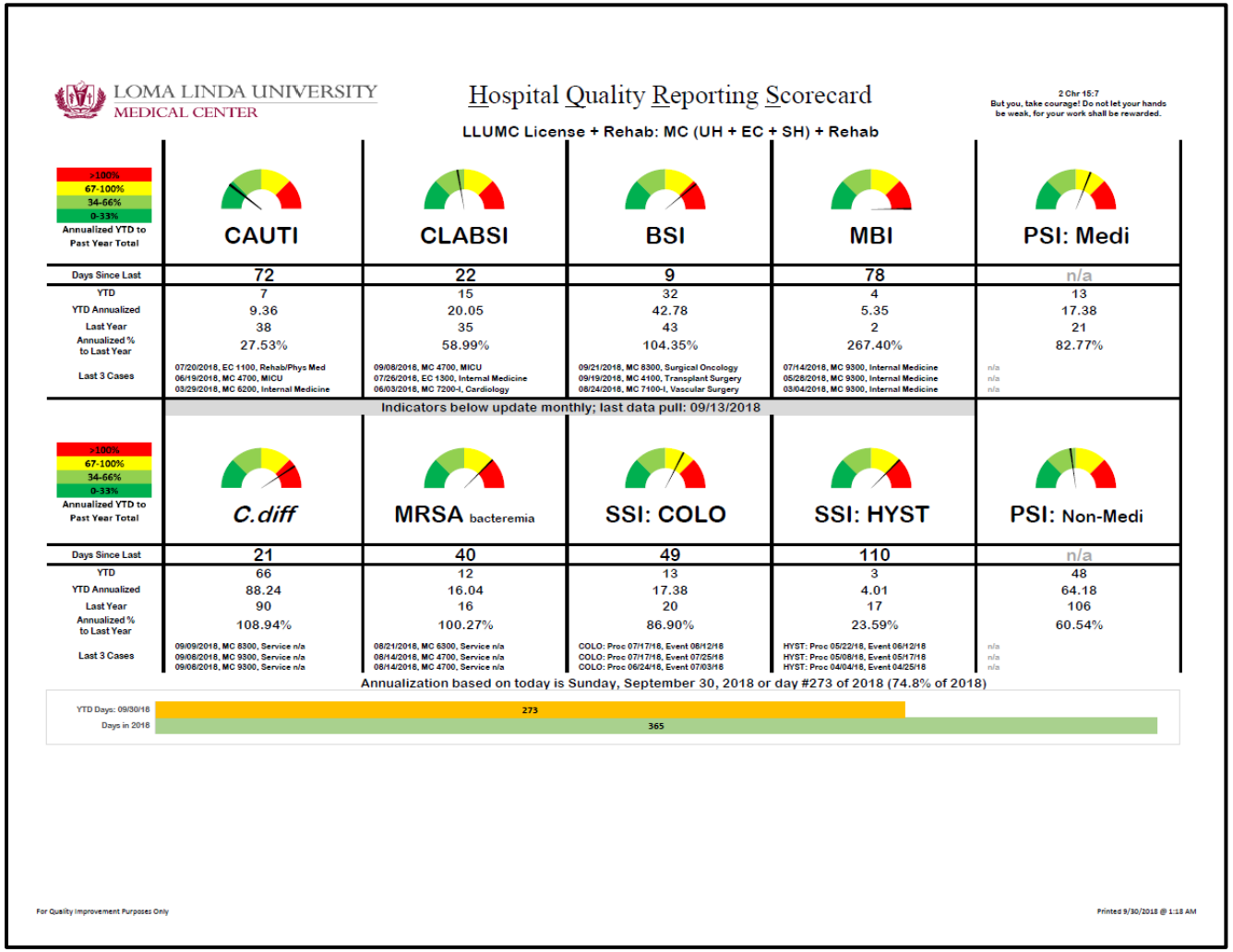
Align and harmonize national safety activities by designating or creating a central coordinating body.

Expand and accelerate collaborative improvement efforts (e.g., regional or specialty-specific coalitions) in patient safety across the care continuum.

- Federal Government
  - QIOs
  - Medicare Compare
  - Joint Commission “deemed status”
- State Governments
  - Increased licensing requirements
  - State review boards
  - Public report cards
- Corporations
  - Leapfrog
  - Business health coalitions
- Private Insurers
  - Pay for performance
  - Patient Centered Medical Homes
- Consumer Groups
  - Rankings and advisory groups
  - HealthGrades.com
  - Angie’s List

# 3- CREATE A COMMON SET OF SAFETY METRICS THAT REFLECT MEANINGFUL OUTCOMES

Create a portfolio of national standard patient safety process and outcome metrics across the care continuum and retire invalid measures.



LOMA LINDA UNIVERSITY MEDICAL CENTER

Hospital Quality Reporting Scorecard

2 Chr 15:7
But you, take courage! Do not let your hands be weak, for your work shall be rewarded.

LLUMC License + Rehab: MC (UH + EC + SH) + Rehab

| >100%<br>67-100%<br>34-66%<br>0-33%<br>Annualized YTD to Past Year Total | CAUTI | CLABSI | BSI | MBI | PSI: Medi |
|---|---|---|---|---|---|
| Days Since Last | 72 | 22 | 9 | 78 | n/a |
| YTD | 7 | 15 | 32 | 4 | 13 |
| YTD Annualized | 9.36 | 20.05 | 42.78 | 5.35 | 17.38 |
| Last Year | 38 | 35 | 43 | 2 | 21 |
| Annualized % to Last Year | 27.53% | 58.99% | 104.35% | 267.40% | 82.77% |
| Last 3 Cases | 07/20/2018, EC 1100, Rehab/Phys Med<br>06/19/2018, MC 4700, MICU<br>05/29/2018, MC 6200, Internal Medicine | 09/08/2018, MC 4700, MICU<br>07/26/2018, EC 1300, Internal Medicine<br>06/03/2018, MC 7200-I, Cardiology | 09/21/2018, MC 8300, Surgical Oncology<br>09/19/2018, MC 4100, Transplant Surgery<br>08/24/2018, MC 7100-I, Vascular Surgery | 07/14/2018, MC 9300, Internal Medicine<br>05/28/2018, MC 9300, Internal Medicine<br>03/04/2018, MC 9300, Internal Medicine | n/a<br>n/a<br>n/a |

Indicators below update monthly; last data pull: 09/13/2018

| >100%<br>67-100%<br>34-66%<br>0-33%<br>Annualized YTD to Past Year Total | *C.diff* | MRSA bacteremia | SSI: COLO | SSI: HYST | PSI: Non-Medi |
|---|---|---|---|---|---|
| Days Since Last | 21 | 40 | 49 | 110 | n/a |
| YTD | 66 | 12 | 13 | 3 | 48 |
| YTD Annualized | 88.24 | 16.04 | 17.38 | 4.01 | 64.18 |
| Last Year | 90 | 16 | 20 | 17 | 106 |
| Annualized % to Last Year | 108.94% | 100.27% | 86.90% | 23.59% | 60.54% |
| Last 3 Cases | 09/09/2018, MC 8300, Service n/a<br>09/08/2018, MC 9300, Service n/a<br>09/08/2018, MC 9300, Service n/a | 08/21/2018, MC 6300, Service n/a<br>08/14/2018, MC 4700, Service n/a<br>08/14/2018, MC 4700, Service n/a | COLO: Proc 07/17/18, Event 08/12/18<br>COLO: Proc 07/17/18, Event 07/25/18<br>COLO: Proc 06/24/18, Event 07/03/18 | HYST: Proc 05/22/18, Event 06/12/18<br>HYST: Proc 05/08/18, Event 05/17/18<br>HYST: Proc 04/04/18, Event 04/25/18 | n/a<br>n/a<br>n/a |

Annualization based on today is Sunday, September 30, 2018 or day #273 of 2018 (74.8% of 2018)

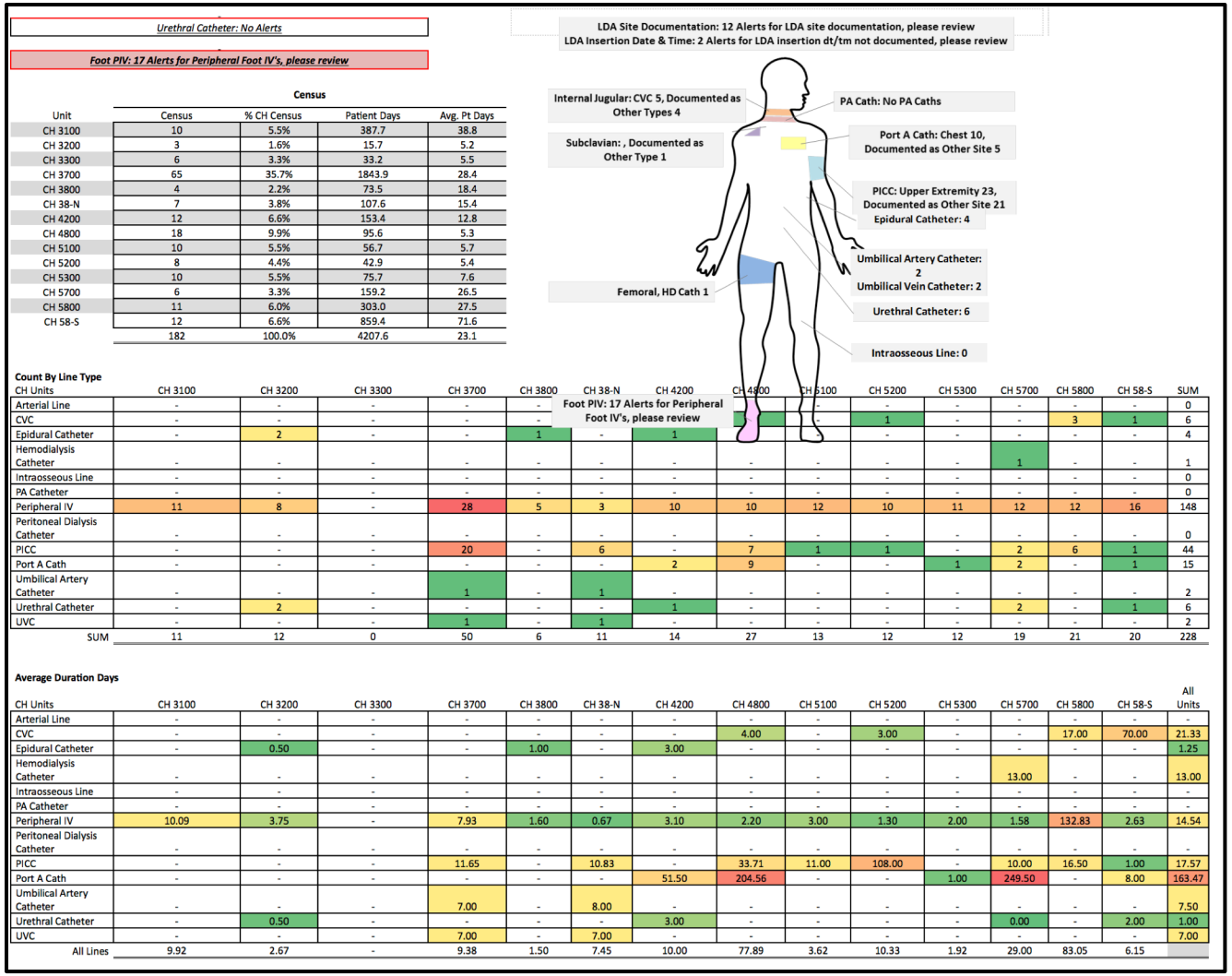


For Quality Improvement Purposes Only

Printed 9/30/2018 @ 1:18 AM

# 3- CREATE A COMMON SET OF SAFETY METRICS THAT REFLECT MEANINGFUL OUTCOMES

Develop processes and tools to identify and measure risks in real time to proactively manage hazards (e.g., identify the early signs of clinical deterioration).



*Urethral Catheter: No Alerts*

***Foot PIV: 17 Alerts for Peripheral Foot IV's, please review***

**LDA Site Documentation: 12 Alerts for LDA site documentation, please review**
**LDA Insertion Date & Time: 2 Alerts for LDA insertion dt/tm not documented, please review**

**Census**

| Unit | Census | % CH Census | Patient Days | Avg. Pt Days |
|---|---|---|---|---|
| CH 3100 | 10 | 5.5% | 387.7 | 38.8 |
| CH 3200 | 3 | 1.6% | 15.7 | 5.2 |
| CH 3300 | 6 | 3.3% | 33.2 | 5.5 |
| CH 3700 | 65 | 35.7% | 1843.9 | 28.4 |
| CH 3800 | 4 | 2.2% | 73.5 | 18.4 |
| CH 38-N | 7 | 3.8% | 107.6 | 15.4 |
| CH 4200 | 12 | 6.6% | 153.4 | 12.8 |
| CH 4800 | 18 | 9.9% | 95.6 | 5.3 |
| CH 5100 | 10 | 5.5% | 56.7 | 5.7 |
| CH 5200 | 8 | 4.4% | 42.9 | 5.4 |
| CH 5300 | 10 | 5.5% | 75.7 | 7.6 |
| CH 5700 | 6 | 3.3% | 159.2 | 26.5 |
| CH 5800 | 11 | 6.0% | 303.0 | 27.5 |
| CH 58-S | 12 | 6.6% | 859.4 | 71.6 |
| | 182 | 100.0% | 4207.6 | 23.1 |

Internal Jugular: CVC 5, Documented as Other Types 4
Subclavian: , Documented as Other Type 1
PA Cath: No PA Caths
Port A Cath: Chest 10, Documented as Other Site 5
PICC: Upper Extremity 23, Documented as Other Site 21
Epidural Catheter: 4
Umbilical Artery Catheter: 2
Umbilical Vein Catheter: 2
Femoral, HD Cath 1
Urethral Catheter: 6
Intraosseous Line: 0

**Count By Line Type**

| CH Units | CH 3100 | CH 3200 | CH 3300 | CH 3700 | CH 3800 | CH 38-N | CH 4200 | CH 4800 | CH 5100 | CH 5200 | CH 5300 | CH 5700 | CH 5800 | CH 58-S | SUM |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Arterial Line | - | - | - | - | - | - | - | - | - | - | - | - | - | - | 0 |
| CVC | - | - | - | - | - | - | - | - | - | 1 | - | - | 3 | 1 | 6 |
| Epidural Catheter | - | 2 | - | - | 1 | - | 1 | - | - | - | - | - | - | - | 4 |
| Hemodialysis Catheter | - | - | - | - | - | - | - | - | - | - | - | 1 | - | - | 1 |
| Intraosseous Line | - | - | - | - | - | - | - | - | - | - | - | - | - | - | 0 |
| PA Catheter | - | - | - | - | - | - | - | - | - | - | - | - | - | - | 0 |
| Peripheral IV | 11 | 8 | - | 28 | 5 | 3 | 10 | 10 | 12 | 10 | 11 | 12 | 12 | 16 | 148 |
| Peritoneal Dialysis Catheter | - | - | - | - | - | - | - | - | - | - | - | - | - | - | 0 |
| PICC | - | - | - | 20 | - | 6 | - | 7 | 1 | 1 | - | 2 | 6 | 1 | 44 |
| Port A Cath | - | - | - | - | - | - | 2 | 9 | - | - | 1 | 2 | - | 1 | 15 |
| Umbilical Artery Catheter | - | - | - | 1 | - | 1 | - | - | - | - | - | - | - | - | 2 |
| Urethral Catheter | - | 2 | - | - | - | - | 1 | - | - | - | - | 2 | - | 1 | 6 |
| UVC | - | - | - | 1 | - | 1 | - | - | - | - | - | - | - | - | 2 |
| SUM | 11 | 12 | 0 | 50 | 6 | 11 | 14 | 27 | 13 | 12 | 12 | 19 | 21 | 20 | 228 |

Foot PIV: 17 Alerts for Peripheral Foot IV's, please review

**Average Duration Days**

| CH Units | CH 3100 | CH 3200 | CH 3300 | CH 3700 | CH 3800 | CH 38-N | CH 4200 | CH 4800 | CH 5100 | CH 5200 | CH 5300 | CH 5700 | CH 5800 | CH 58-S | All Units |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Arterial Line | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - |
| CVC | - | - | - | - | - | - | - | 4.00 | - | 3.00 | - | - | 17.00 | 70.00 | 21.33 |
| Epidural Catheter | - | 0.50 | - | - | 1.00 | - | 3.00 | - | - | - | - | - | - | - | 1.25 |
| Hemodialysis Catheter | - | - | - | - | - | - | - | - | - | - | - | 13.00 | - | - | 13.00 |
| Intraosseous Line | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - |
| PA Catheter | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - |
| Peripheral IV | 10.09 | 3.75 | - | 7.93 | 1.60 | 0.67 | 3.10 | 2.20 | 3.00 | 1.30 | 2.00 | 1.58 | 132.83 | 2.63 | 14.54 |
| Peritoneal Dialysis Catheter | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - |
| PICC | - | - | - | 11.65 | - | 10.83 | - | 33.71 | 11.00 | 108.00 | - | 10.00 | 16.50 | 1.00 | 17.57 |
| Port A Cath | - | - | - | - | - | - | 51.50 | 204.56 | - | - | 1.00 | 249.50 | - | 8.00 | 163.47 |
| Umbilical Artery Catheter | - | - | - | 7.00 | - | 8.00 | - | - | - | - | - | - | - | - | 7.50 |
| Urethral Catheter | - | 0.50 | - | - | - | - | 3.00 | - | - | - | - | 0.00 | - | 2.00 | 1.00 |
| UVC | - | - | - | 7.00 | - | 7.00 | - | - | - | - | - | - | - | - | 7.00 |
| All Lines | 9.92 | 2.67 | - | 9.38 | 1.50 | 7.45 | 10.00 | 77.89 | 3.62 | 10.33 | 1.92 | 29.00 | 83.05 | 6.15 | |

# 4- INCREASE FUNDING FOR RESEARCH IN PATIENT SAFETY AND IMPLEMENTATION SCIENCE

Support collaboration between researchers in patient safety and researchers in safety sciences within other industries and sectors.

Identify and make available sustainable funding sources for safety and implementation research, including federal funding and public-private partnerships.

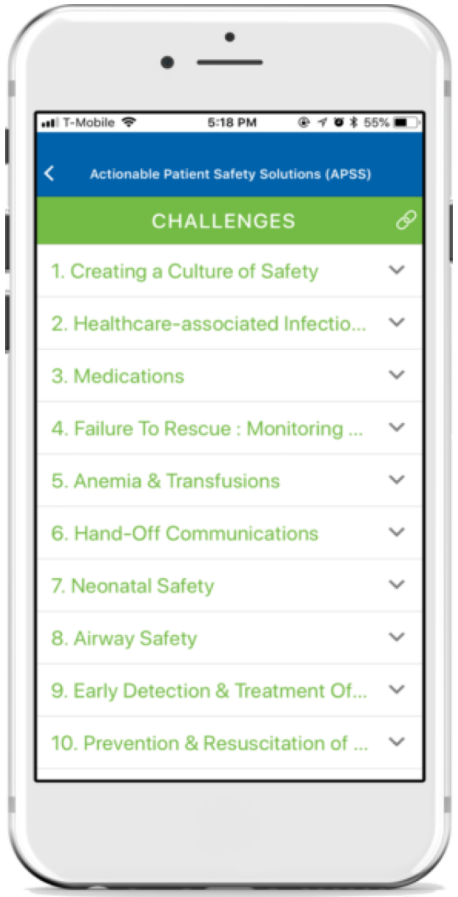
Expand health care safety scholar programs to train researchers with safety science expertise and to train operational and implementation leaders.

Encourage organizations that have successfully implemented safety innovations to establish learning labs and collaboratives to spread them to other organizations.

Patient Safety MOVEMENT
zero preventable deaths by 2020

TeamSTEPPS®
Team Strategies & Tools to Enhance Performance & Patient Safety

LEAN 6σ SIGMA



# 5- ADDRESS SAFETY ACROSS THE ENTIRE CARE CONTINUUM

## Recommendations

~ **Understand** the role of board in overseeing events of harm

~ Disclosure and apology

~ The process for/evaluation of RCAs for errors/harm

~ Just culture

- Transparency/communication of errors and harm with patients/families

~ High Reliability Organizations (HRO)

- Transparency/communication of errors and harm with public

# 6- SUPPORT THE HEALTH CARE WORKFORCE

## Recommendations

- ~ Employee satisfaction surveys
- ~ Culture of safety surveys
- ~ Workforce safety challenges (physical and emotional)
- ~ Employee turnover
- ~ Employee injury rates and safety reports (physical/emotional)
- ~ Workforce safety dashboards
- ~ Workmen's compensation rates

# 7- PARTNER WITH PATIENTS AND FAMILIES FOR THE SAFEST CARE

Recommendations

~Regularly evaluates/discusses Pt/Fam satisfaction surveys

~Regularly uses Pt/Fam stories

~Regularly evaluates and discusses Pt/Fam engagement surveys

~Engages with PFAC

~Has representation by Pt/Fam on committees

~Has at least 1 Pt/Fam member on its Board

# 8- ENSURE THAT TECHNOLOGY IS SAFE AND OPTIMIZED TO IMPROVE PATIENT SAFETY

| | |
|---|---|
| Establish mechanisms for vendors and users to be transparent about health IT safety hazards and best practices. | Transparency about safety issues is the key to improvement. |
| Identify and measure the adverse effects and unintended consequences of health IT and implement best practices for risk mitigation. | Health IT has the potential to improve patient safety, but to date poor design and implementation limit that potential. |
| Establish expectations for health IT safety performance, such as routine testing for unsafe orders. | Much work remains to optimize existing systems. |
| Design health IT to facilitate communication and coordination with the patient and family. | Health IT can facilitate patient engagement. |

# The Importance of Regular Quality Reports

- Quality improvement is the use of a deliberate and defined improvement process & the continuous and ongoing effort to achieve measurable improvements.
- What gets measured gets done
- Good plans lead to implementation
- Schedule for implementing QI efforts
- Schedule for reporting QI efforts to all stakeholders

# Why Report to the Board?

- Screen for potential quality and safety problems using easily accessible data.
- Compare themselves with other hospitals using national standardized measures to assess quality of hospital care

# Examples

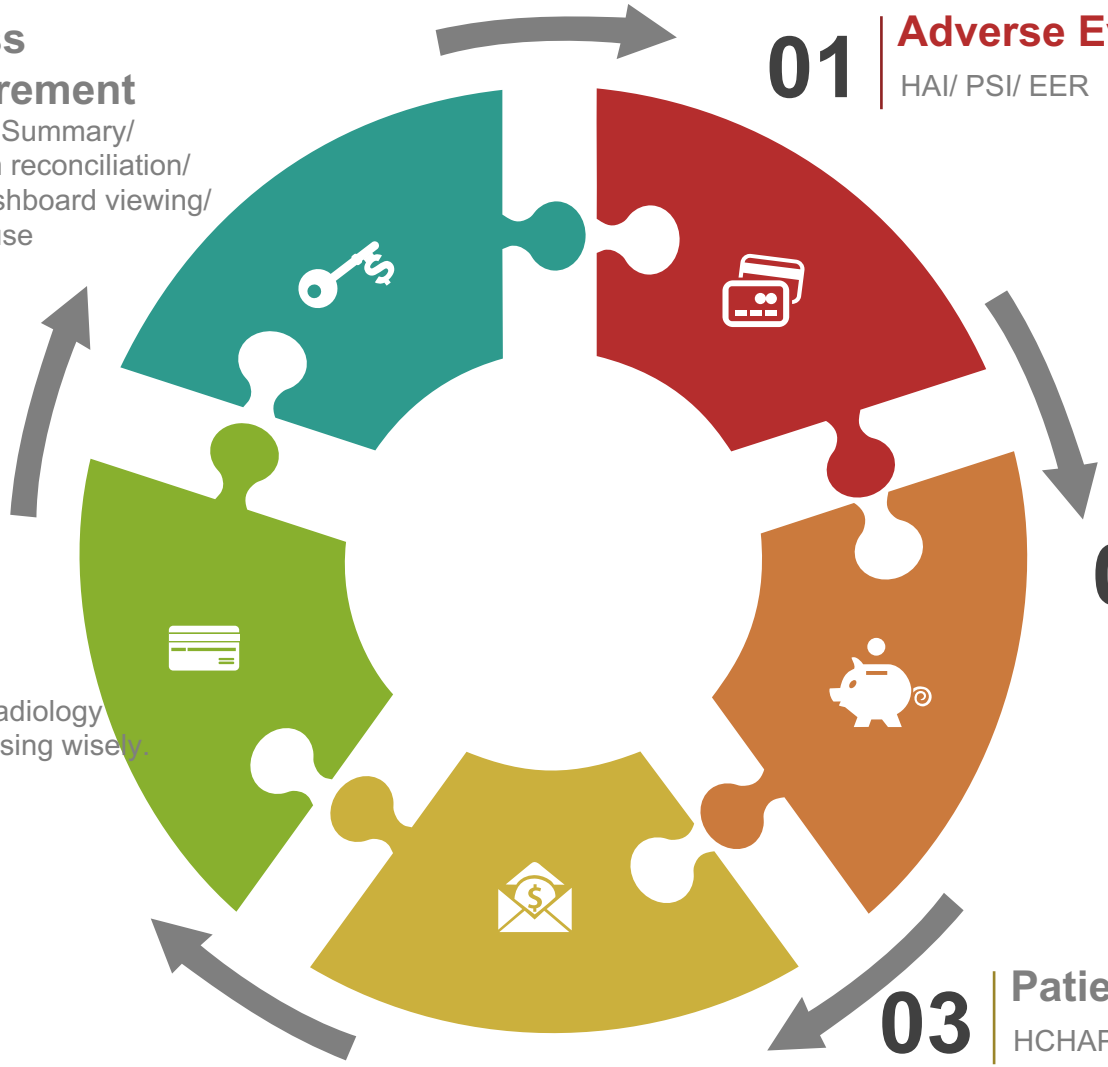
## External sources

- Pros:
  - ~ Allow benchmarking
  - ~ Publicly available
- Cons:
  - ~ Often reflect older data
  - ~ Not representative of all your patients
  - ~ Susceptible to changes in definitions

## Internal sources

- Pros:
  - ~ Real time data
  - ~ Your own definition
- Cons:
  - ~ Inability to benchmark or compare to other hospitals in real time

# Dashboards



**01 Adverse Event**
HAI/ PSI/ EER

**02 Operational**
Census/ CMI/ LOS/ Occurrence and time statistical analysis

**03 Patient Central Outcome**
HCHAPS/ Readmission/ Mortality

**04 Utilization**
Blood/ antibiotic/ medication/ lab/ radiology costs, SPB, Choosing wisely.

**05 Process Measurement**
Discharge Summary/ Medication reconciliation/ Notes/ Dashboard viewing/ % CPOE use

# Dashboards

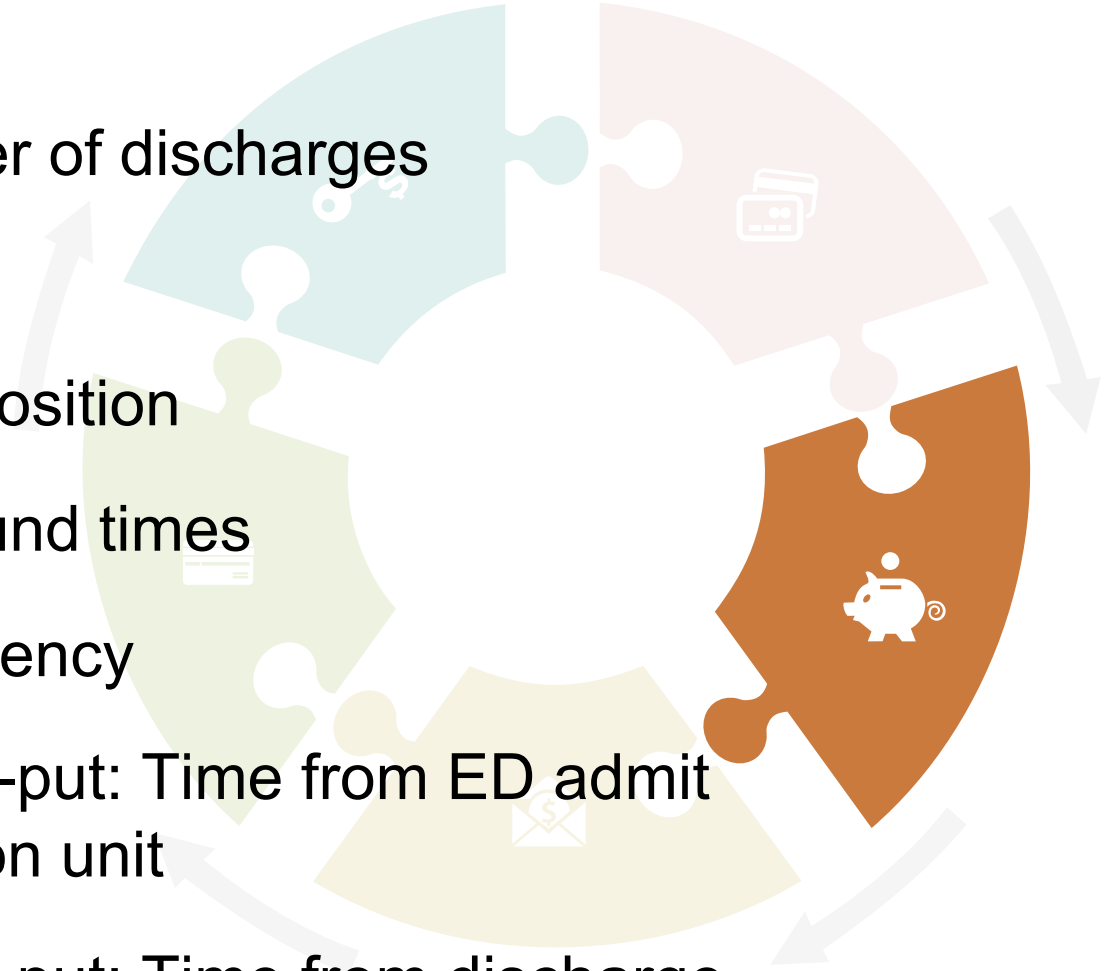
## 01 Adverse Event

- HAI
  - CLABSI
  - CAUTI
  - SSI
  - CDI
  - MRSA
- PSI
- EER

# Dashboards

## 02 Operational

- Census/ number of discharges
- CMI /LOS
- Discharge Disposition
- Room turn-around times
- Discharge efficiency
- Patient through-put: Time from ED admit order to arrival on unit
- Patient through-put: Time from discharge order to actual departure

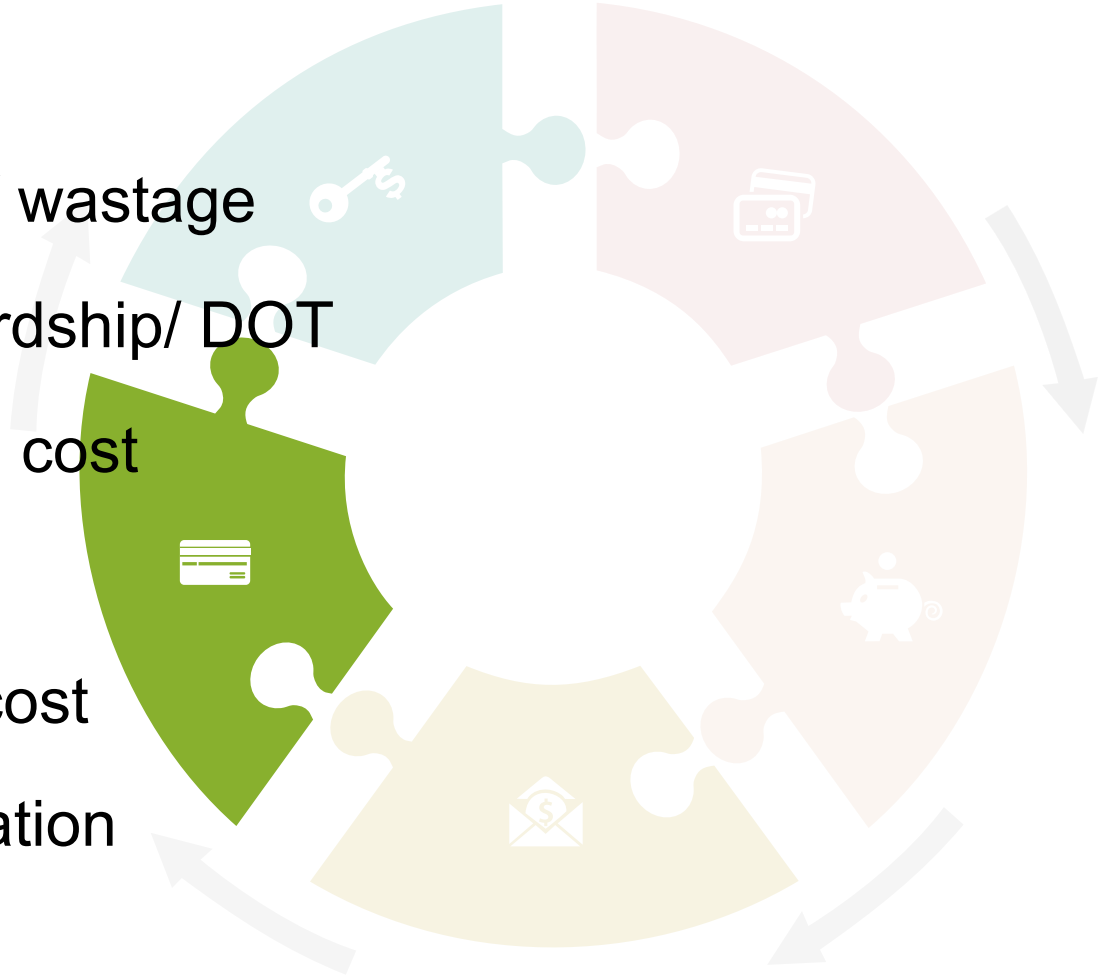


## 03 Patient Central Outcome

- HCHAPS
- Readmission
- Mortality
- Length of stay

## 04 Utilization

- Blood utilization/ wastage
- Antibiotic Stewardship/ DOT
- Total medication cost
- Total lab cost
- Total radiology cost
- Order sets utilization



## 05 Process Measures

- Discharge summary within 24 hours
- Medication reconciliation on admission
- Medication reconciliation upon discharge
- % copied notes
- % problem list updated upon discharge
- % patients with a post discharge clinic appointment within 7 days
- % CPOE use

# References


1. www.npsf.org/free-from-harm 2015
2. *Sentinel event alert.* A complimentary publication of The Joint Commission Issue 57, March 1, 2017
3. To Err is human November 1999


# Questions