Maintaining Your Patient Safety Culture in Challenging Times

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Milestones in Rural Health
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IHA 100 Years of Service
Illinois Health and Hospital Association

For Today's Presentation….

Disclosures:

No one involved in the planning or presentation of this activity has disclosed any relevant conflict of interest with any commercial entity.

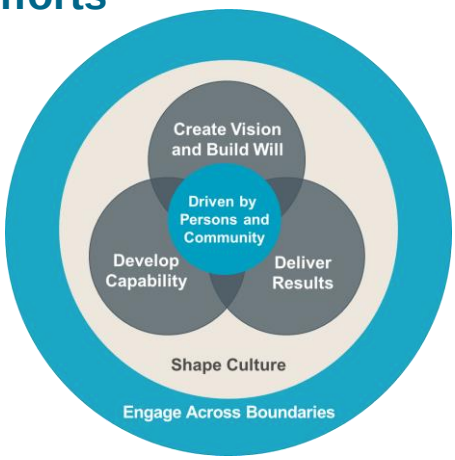
IHA's Institute for Innovations in Care and Quality

- Addressing Health Disparities
- Clinical Leader Engagement
- Illinois Poison Center
- Midwest Alliance for Patient Safety
- Quality Improvement Initiatives
- Advocacy & Health Policy

Things to Consider

- Shaping safety culture – Identify safety issues or problems within organizational systems – not employees – to drive change.
- Creating psychological safety – Encourage staff to identify and report errors in real time.
- Reporting systems are critical – Robust software helps identify systemic issues.
- Engaging leadership – Recognizing team members that report events encourages more reporting.
- Starting positive conversations – Near misses can be positive "near miss events" for staff.
- Closing the loop on events – Update staff on resolutions, continue with processes and engage staff in patient safety improvement.
- Minimizing risk – Not reporting events increases the hospital's risk for financial loss.

Shaping Safety Culture: Where Leaders Focus Efforts



- Culture reflects the attitudes and behaviors of the organization.
- Make culture and operations visible, at all levels. Use measurements, feedback surveys, etc.
- Act on specific insights in ways that are visible, meaningful and sustainable.
- Requires a clear, fair set of rules that apply to everyone.

Swensen S, Pugh M, McMullan C, Kabcenell A. *High-Impact Leadership: Improve Care, Improve the Health of Populations, and Reduce Costs*. Cambridge, MA: Institute for Healthcare Improvement; 2013. Available on www.ihi.org.

Creating Psychological Safety

What is it?

A shared belief that the team is safe for interpersonal risk taking. It can be defined as "being able to show and employ one's self without fear of negative consequences of self-image, status or career" (Kahn 1990, p. 708).

- It feels safe to speak up – people have a voice.
- Reporting events will not result in retaliation.
- Team members can ask questions, ask for feedback, make innovative suggestions and be appropriately critical.
- Leaders play a critical role – how long does it take when you walk in for your brain to say “This is a good day” vs. a bad day?
- It is about setting the tone and environment of the organization.

Two Practices You Can Implement

Promote your organization's safety culture using the following:

1. Leadership WalkRounds
2. Error Reporting

Leadership WalkRounds

Leadership WalkRounds?

- **Who**: Executives and leaders
- **What**: Walk around and engage in candid discussions with frontline staff about patient safety incidents or near-misses
- **Where**: Everywhere! If this is a new process start where safety events might occur or where you have the most patients and staff.
- **When**: At least once per week for a year
- **Why**: Increase awareness and reinforce the importance of safety

Getting Started!

1) Identify leaders to participate
2) Determine your cadence for WalkRounds
   - Will leaders round together?
   - Will leaders rotate who leads rounds each day or each week?
3) Identify frequency
   - Once a week and in multiple care areas?
   - Or multiple days a week with specific care areas for each day
4) Outline questions for rounds
   - Examples are on the next slide
5) Provide feedback

Examples of Questions to Ask

- Has anything happened in the past few days that led to an increased length of stay for a patient?
- Have there been any near-miss events that almost caused a patient harm but didn't?
- When an error occurs does it get reported?
- Is there anything we can change to prevent the next near-miss or adverse event?
- What intervention can leadership direct to make your work safer?
- What would make the Leadership WalkRounds more effective?

Keys to Success

- Keep discussions focused on safety – this is hard but it keeps the safety message at the forefront.
- Communicate plans with managers so they know why senior leaders are visiting their departments
- Take pictures! They can be integrated into your staff presentations and patient safety meetings.
- Before leaving each department – summarize the themes and concerns that have been identified and ask for staff to prioritize two or three items to address first.
- Provide feedback to your front-line staff.

Robust Error Reporting

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Event Reporting

- *Patient Safety 101*: "safety" is defined as "*avoiding harm to patients from care that is intended to help them. It involves the prevention and mitigation of harm caused by errors of omission or commission in healthcare, and the establishment of operational systems and processes that minimize the likelihood of errors and maximize the likelihood of intercepting them when they occur*."

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Reporting Systems and Error/Event Reporting

- Provide a consistent format of event submission.
- Capture basic but critical event information.
- Choose electronic software for standardized record-keeping, easy retrieval and analytics.
- Develop a supportive environment for event reporting.
- Protect the privacy of staff who report events.
- Review reports from a broad range of personnel both clinical and non-clinical.
- Distribute report summaries in a timely fashion to determine action plans and next steps.

Engaging Leadership

The Office of Inspector General in the U.S. Department of Health and Human Services - June 2022

- In just one month, 25% of Medicare patients experienced what the OIG terms “adverse events and temporary harm events” during their hospital stays.
- 43% of these events could have been prevented.
- **Other data shows that avoidable medical errors are now the third leading cause of death in the United States**.

Starting Positive Conversations

Recognizing near misses

- *A study released by the US Department of Health and Human Services (HHS) indicated roughly **86% of patient safety incidents** in healthcare organizations go unreported.*
- Near Miss events generally result in no harm or severity score.

Examples of near misses

- A nurse notices the wrong dose for a patient before administering medications.
- A pair of non-skid socks is left behind in a patient's room who is at high-risk for a fall. The CNA notices this and retrieves the socks so the patient can walk around the unit safely.

Starting Positive Conversations

Closing the loop on events

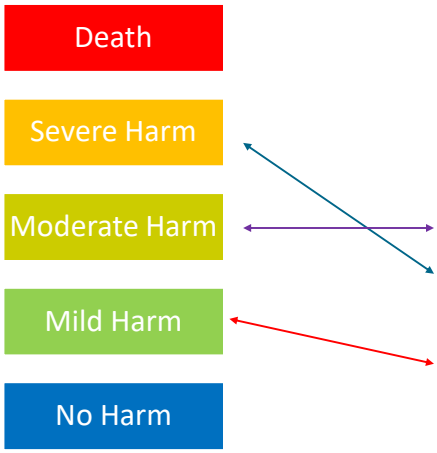
- What should be reported?
- Staff needs to understand what events should be reported at all harm levels.
- Determine a severity scale for evaluating events: no harm, mild harm, moderate harm, severe harm and death

Examples of patient incidents

- Falls: assisted, unassisted, poor balance
- Medication events: wrong route, wrong medication, adverse drug interaction, allergic reaction
- Pressure Injury: partial skin loss, deep red/purple discoloration, exposed muscle or tissue damage

Starting Positive Conversations

Harm Severity Scale



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Minimizing Risk

Improves Quality and Patient Safety

- Incident and event reporting help identify areas of quality improvement. Focus on improving patient care, consistently evaluating clinical processes and reviewing operations.

Facilitates a Safety and Learning Culture

- Most clinicians and healthcare staff want to learn from healthcare errors and work on improving processes. Promote learning in a non-punitive environment.

Reduces Risk of Reoccurrence

- Incident reporting in healthcare is reducing the risk of reoccurrence. Healthcare providers can easily capture, analyze and share data.

Key Take Aways

- Implementing a positive patient safety culture will increase your staff's engagement and ultimately improve your patient's outcomes
- Leadership WalkRounds are an effective tool for encouraging positive patient safety culture.
- Incident and near miss reporting is critical to your patient safety strategy; use the reports to identify gaps in processes.
- Establish a safe environment where staff are encouraged and rewarded for sharing issues and reporting events.

Resources

- Leadership WalkRound:
  - IHI Leadership WalkRound Tool: https://www.ihi.org/resources/Pages/Tools/PatientSafetyLeadershipWalkRounds.aspx
  - IHI Providing Feedback to Staff: https://www.ihi.org/resources/Pages/Changes/ProvideFeedbacktoFrontLineStaff.aspx
  - Perm J. 2006 Summer; 10(2): 29–36. Published online Summer 2006. doi: 10.7812/tpp/05-137 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3076966/
- Event Reporting:
  - Agency for Healthcare Research and Quality – PSNet https://psnet.ahrq.gov/primer/reporting-patient-safety-events
  - The Joint Commission – Release of Sentinel Event Data for 2022 https://www.jointcommission.org/resources/news-and-multimedia/news/2023/04/the-joint-commission-releases-sentinel-event-data/
  - Office of Inspector General (OIG) https://oig.hhs.gov/reports-and-publications/featured-topics/adverse-events/

Thank you!

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