Patient SAFETY
DEVELOPMENT OF THE FRONTLINE

...Patient Safety Deltas ..... 

Maureen Disbot MS, RN, CCRN
Daniel M. Feinberg, MD, FAAN
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“Although we have examples of really meaningful progress, real improvements in patient safety, we continue to have a major problem:

How do we diffuse knowledge out to all caregivers?

That’s the challenge for the next 5 years”

Lucien Leape, MD
When we started, we evaluated...

- PENN Occurrence Reporting & Tracking System (PORTS)
- 33 Failure Mode Effects Analyses (FMEA) chartered across the Health System (2003)
- 17 Root cause analysis (2003)
- Patient Satisfaction data
- Employee Satisfaction data

External professional development programs for organizational Effectiveness
- Staying in Role
- Honoring Scope of Practice
- Competency assessment and ongoing monitoring/mentoring
- Knowing when to ask
- Knowing when to escalate an issue
- Exquisite handoff procedures and communications

When we started, we had...

- Commitment from leadership on non-punitive strategy, but not a behavioral understanding
- Corporate Patient Safety Officers
  - Patient Safety Directors
  - Clinical Nurse Specialist Safety Director
- Common policies, but different operations
- UPHS reporting structure for patient safety
When we started, we didn’t have...

- Role Clarity and Expectations
- Clear Accountabilities 24x7
- Competencies Identified and approved
- Effective communication strategies
- A Culture of Safety

Highest ranked limiting factor: TIME
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Highest ranked limiting factor: TIME
1. Select the right person to get results with front line staff, leaders and providers and support multi-disciplinary teams

2. Market, and less importantly, “educate” regarding the program

OK to be exclusive
We knew the critical drivers of high reliability patient care:

- **Leadership**
- **Non-Punitive Culture**
- **Alignment of Systems**
- **Patient centered care** – Inviting patients and staff to speak up
- **Multi-disciplinary**
  - Everyone’s role matters
  - Not just one discipline's mission
  - Important to pay attention to clinical and non-clinical
  - Continuous Feedback – Close the Loop
Our Challenges...

- Demand for increased volume, expansion, improved financials, combined with rising acuity
- Continued challenge to achieve clinical excellence
- Consumer expectations – External reporting
- Quality of entry-level workforce
Providing clinicians/process owners with easy access to their own performance data.

Training in process improvement tools that can be easily executed at the unit level.

Teaching staff to implement interventions through several small cycles of trial and error.

Providing active guidance from QI experts throughout the problem solving process are associated with positive clinical outcomes.

Boonyasai, Romsai; Windish, Donna; Chakraborti, Chayan et al. JAMA. 2007; (298(9):1023-1037
Manager Involvement

- Manage team and individual performance
- Communicate roles, accountabilities and performance measures to all staff.
  - Partner with Delta for optimal outcomes
  - Identify unit quality metrics, review and track monthly; communicate to staff, and develop/implement action plans to improve performance.
  - Train staff in PORTS and encourage use as intended to capture patient safety trends.
-At no time in the history of healthcare delivery has the growth in knowledge and technology been more profound. Since the first randomized trial more than 50 years ago, the number of trials conducted has grown to more than 10,000 annually (Chassin, 1998).

-In one ICU study, failures of communication between team members accounted for 37% of all errors reported during a 4 month period. (Provonost, 2002)

-The most commonly reported failure in root cause analysis is communication among caregivers. (TJC, 2008)
Curriculum Design

- Link to organizational strategy and regulatory requirements
  - National Patient Safety Goals
  - IHI 100,000 Lives Campaign
  - Patient Satisfaction Goals
  - Simulation
  - Tracer Methodology
  - Magnet Nursing Application
  - Professionalism
- IOM Six Aims of Healthcare
- Concentration on Communication
- Attention to Human Factors
- Plan-Do-Check-Act
- Root cause analysis
- Failure Mode and Effects Analysis
- Courageous Conversations
- Crucial Conversations
- Service Excellence – Ritz Carlton
- “Just Culture”- David Marx, JD
- Tracer Methodology
- UPHS Quality and Safety Awards Program
Expectations

- Productivity and bottom line mentality may create disparate goals and poor outcomes for frontline staff and patient safety.
- Healthcare complexity and immature development of information systems create added burdens for already stressed staff.
- Organization does not promote true problem solving skills but approaches failures one at a time.
  - “The system is perfectly designed for the results we get.”
Expectations

- EveryONE is responsible for patient safety
- We are all part of a team with the patient at the center
  - Know the members of your team
  - Ask for help
  - Accept questions and suggestions about your area of responsibility
  - Appreciate your colleagues
  - Focus time and energy on important issues
  - Offer and accept apologies
  - Look for opportunities to work in groups
  - Embrace system level thinking
How much is too much?

LACK OF VISION
Human Factors

Knowing When to Ask

Consider:
- Environment
- End User
- Device Design
- Intended Use
- Safety Reports
- Voice of the Patient
Focus Going Forward
Feedback from Retreat 2009

- On-boarding process
  - IHI Open School

- Qualities of Deltas
  - Effective communicators
  - Front line patient caregivers
  - Innovators
  - Accountable and committed
Feedback from Retreat 2009

Communication/dissemination of ideas to co-workers

- Create “blogs” for Deltas
- Annual report of projects
- Regular newsletters to Deltas
- Integration into the Patient Safety Fairs during NPS Week
- Journal Clubs
Feedback from Retreat 2009

- Alignment with Penn’s Blueprint for Quality
  - Better coordination with the Unit Based Clinical Leadership Teams

- Alignment with AHRQ Patient Safety Culture Survey Results
  - Three main areas of opportunity:
    - Non punitive culture
    - Handoffs
    - Transitions of care from one hospital unit to another
Feedback from Retreat 2009

- Support from Deltas’ Managers
  - Ability to participate in unit “huddles”
  - Include Delta in orientation of new staff

- Ideas for successful projects
  - Unit based tracers
  - Patient safety video for patients/families
  - Department-specific projects
Delta Program of the Future

- Curriculum aligned with the Penn Medicine Quality and Safety goals
  - Preventing the preventable, including morbidity and mortality
  - Transitions in care
    - Reducing readmissions
    - Hand off communication
  - Pay for Performance
    - Anticoagulation Management
    - Ventilator Associated Pneumonia
    - UTIs
    - Central Line Infections
    - Surgical Care Improvement
Delta Program of the Future

- **Quarterly retreats**
  - Utilization of internal “talent”
  - Terrific opportunities to share successes/setbacks
  - Story telling, role playing
  - Crucial Conversations Program**

- **Application/reappointment process**
  - Clinical ladder/Professional development
  - Referrals/recommendations from colleagues and managers
OUR ULTIMATE GOAL:

...create a culture of safety