Children's
HOSPITAL & MEDICAL CENTER

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Quality & Patient Safety

Resident Orientation

NO HARM
Our Patient Safety Journey

Purpose

To increase awareness that quality and patient safety are top priorities at Children's Hospital & Medical Center



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High reliability organizations (HROs)

"operate under very trying conditions all the time ***and yet manage*** to have fewer than their fair share of accidents."

Managing the Unexpected (Weick & Sutcliffe)

Risk is a function of ***probability*** and ***consequence***. By decreasing the probability of an accident, HRO's recast a high-risk enterprise as merely a high-consequence enterprise. HROs operate as to make systems ultra-safe.

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HPI

High Risk Categories for Errors

- Medication errors
- Laboratory
- Admission Discharge Transfer
- Vascular Access & Infusion

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What if an Error Happens?

1. Care for patient
2. Disclosure of event to patient and family
3. File Variance Report
4. Care for staff involved in error
5. Complete an analysis of the error
6. Implement improvement actions

Disclosure of Event

- The patient's attending physician will be notified promptly of the event
- As soon as feasible, the patient/family will be informed of the adverse event
- Children's utilizes a "disclosure team" model that may be utilized for disclosing adverse events to patients and families
- The disclosure team consists of the physician(s) in charge of the patient's care at the time of the event and other healthcare providers or non-clinical staff as appropriate
- See Disclosure to/Care of Patient and Family Experiencing an Adverse Event Policy (ADM019)

Serious Safety Event Reporting Process

- Immediately notify your supervisor
- Complete a variance report
- Supervisor will notify patient's attending physician and on-call administrator; decision will be made regarding disclosure
- Administrator will review event with the Safety Event Review Team and contact Performance Improvement for a **Root Cause Analysis** if deemed necessary

File Variance Report

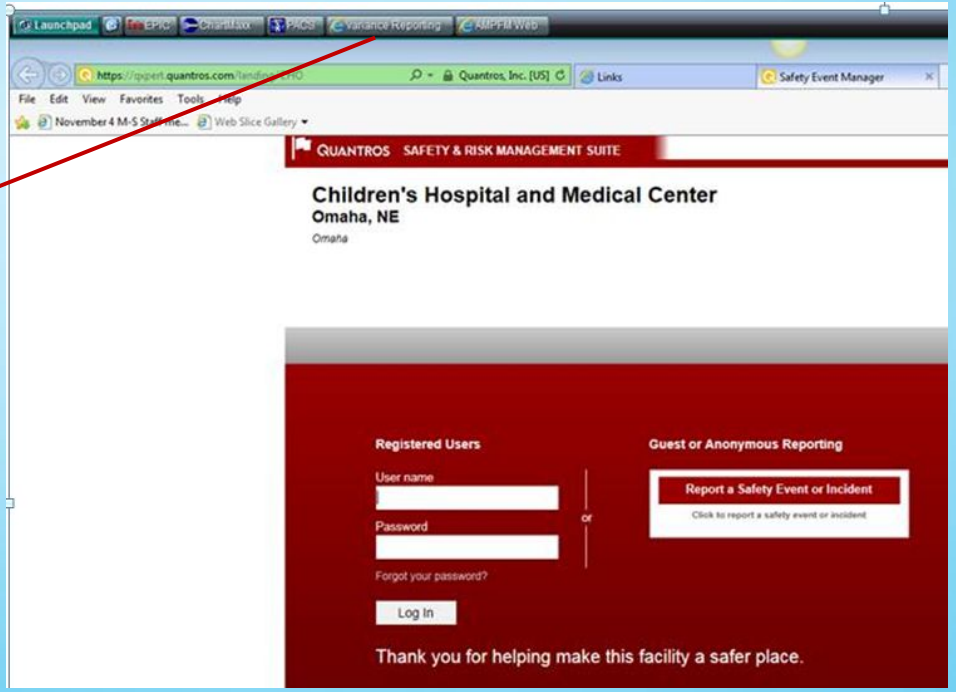
Two types of web-based reports on the intranet:

1. Quantros Variance Reporting for variances involving patients, visitors, physicians, or students
    - Actual and near miss events
2. Quantros Feedback Manager for patient/parent complaints

How to Enter a Variance into Quantros

- Click on the Quantros link on the intranet
- Login to Quantros Safety Event Manager with your Children's email and password

Link on clinical computers



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Variance Report Routing Process

- Automated, on-line routing to involved departments and Performance Improvement
- **DO NOT** copy a variance report
- **DO NOT** document in the patient record that a variance report was completed
- If the variance report itself is referenced in the medical record or if it is copied, legal discoverability protection is lost

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Patient Care or Safety Concerns

- Patients/families have the right to voice concerns or complaints without compromising patient care
- Utilize Chain of Command for concerns/complaints that are not resolved promptly
- Document complaint variances in Quantros Feedback Manager
- Information on how to report a concern is given to patients/families on admission
- Written or verbal concerns not promptly resolved may meet grievance criteria and should be forwarded to the Compliance Officer

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Care for Staff Involved in Error

- Caregivers are significantly affected by adverse events (“second victim”)
  - Caused the error
  - Dealing with after effects
  - Trust of co-workers
- Debriefing sessions are conducted after events as needed
- Support is available from managers, administration, and Employee Assistance Program (contact Employee Health)

Safety Event Definitions

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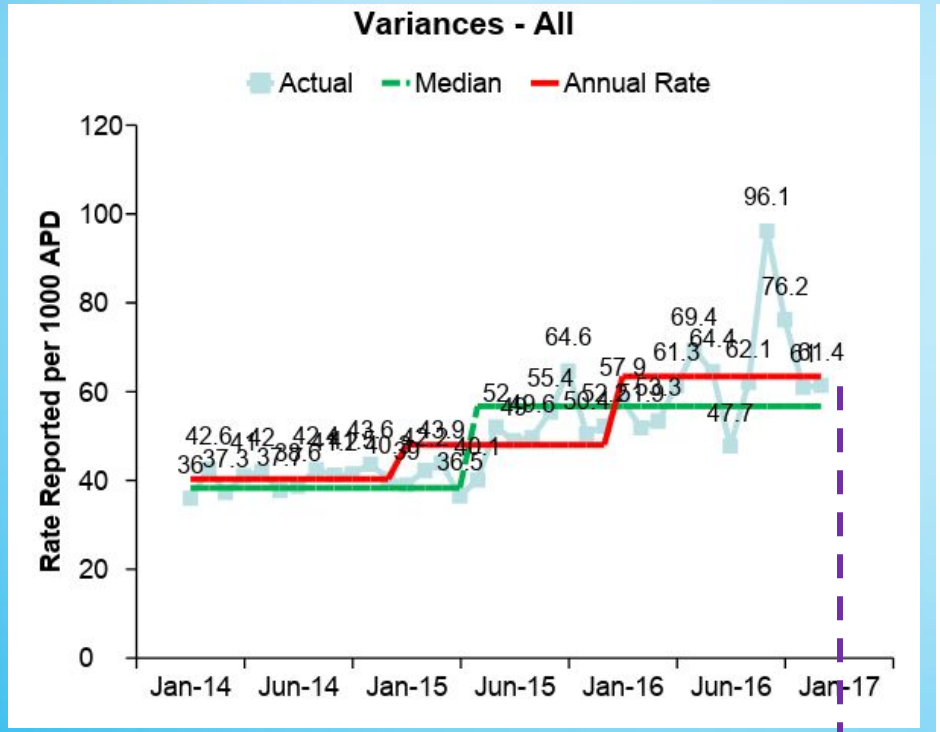
Complete an Analysis of the Error

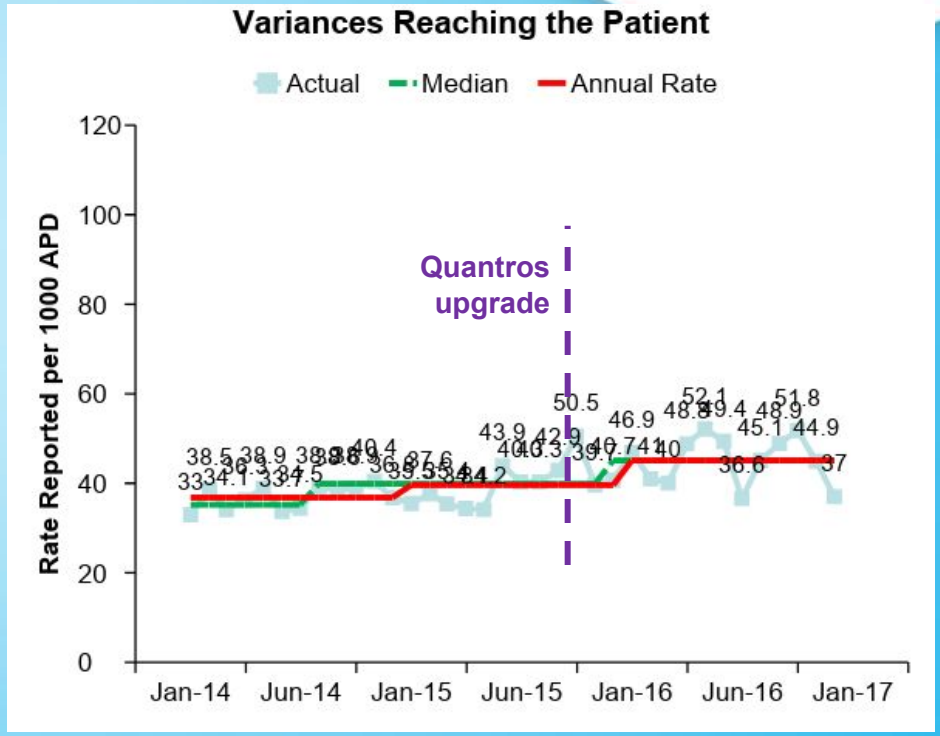
- Root Cause Analysis (RCA): Completed for serious safety events that reach the patient resulting in moderate to severe harm or death
- Apparent Cause Analysis (ACA): Completed for precursor events that reach the patient and cause minimal or no detectable harm or near miss events
- Common Cause Analysis (CCA): Completed on events with common characteristics and causes, including serious safety events, precursor safety events, and near miss events

Implement Improvement Actions

You can't manage what you can't measure.

Quantros Report Examples





Quality Scorecard

- Common (Q) drive, Scorecards, Quality Scorecard

	KEY INDICATORS	2016 Total	2016 Target	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	2017 YTD	2017 Target
Ongoing Monitors	Hospital-acquired Condition Harm Index (subtotal events per 1000 pt days) * 2015 events adjusted to include PIV infiltration	55 events* (1.6 rate)	65 events (1.8 rate)	9 events (2.6 rate)	9 events (3.0 rate)	5 events (1.5 rate)	14 events (4.7 rate)	9 events (3.2 rate)	5 events (1.7 rate)	2 events (0.6 rate)	12 events (4.2 rate)	3 events (1.0 rate)	9 events (2.8 rate)	8 events (2.7 rate)		85 events (2.5 rate)	64 events* (1.8 rate)
	Serious Safety Event (non-HAC) rate per 1000 apd	0	0.09	0	0	0	0	0	0	0	0.7	0	0	0.3		0.09 rate (3 events)	0.09 rate
	Employee Safety - Lost/restricted worktime injury/illness case rate (DART)	1.1	2.9 (US rate)	1.3	0.7	0	0.6	0	0	0.5	1.1	0	0	0		0.4	1.6 (US rate)
	Hand Hygiene Compliance (Biovigil)	98.2%	> 95%	97.6%	97.7%	97.6%	97.6%	97.7%	97.6%	97.7%	97.9%	98%	98%	98%		97.9%	> 95%
	Mortality rate per 100 discharges	0.58	0.6		0.53			1.1			0.67					0.77	0.6
	CLA-BSI Number for all inpatient areas	23 (44% reduction)	25 (39% reduction)	2	1	1	1	2	2	0	2	1	2	2		16 (33% decrease)	18 (20% reduction)
	Ambulatory CLABSI number	22		1	4	2	3	4	1	4	4	4	1	3		31 (55% increase)	18 (20% reduction)
	Surgical site infection (CT surg, VP shunt, spinal fusion, colon surg, abd hyster, total joint)	9 (44% reduction)	10 events (38% reduction)	0	1	0	1	0	0	1	0	0	1	0		4 (52% reduction)	7 events (20% reduction)
	Unplanned readmission to Inpt or observ within 7 days	3.6% (9% increase)	3.15% (10% reduction)	4.7%	3.7%	3.7%	3.3%	3.8%	2.8%	4.8%	4.2%	4.8%	4.4%		avail Feb	4.1%	3.15% (10% reduction)
	Admission within 3 days of ED visit (inpatient only, excludes observ pts)	0.53%	0.76% (CHA PHIS benchmark)	0.81%	0.66%	0.63%	0.62%	0.72%	0.65%	0.66%	0.73%	0.69%	0.71%	0.67%		0.69%	0.76% (CHA PHIS benchmark)
	EBP: Use of clinical pathways (Jan- ED asthma, Inpt asthma)	52%	60% compliance with MOS	79% (ED 83%; Inpt 75%)	80% (ED 74%; Inpt 100%)	79% (ED 78%; Inpt 88%)	82% (ED 83%; Inpt 76%)	95% (ED 94%; Inpt 100%)	88% (ED 86%; Inpt 100%)	80% (ED 81%; Inpt 71%)	90% (ED 89%; Inpt- 91%)	90% (ED 87%; Inpt- 100%)	83% (ED-80%; inpt- 100%)	83% (ED-80%; inpt- 100%)		85% (ED 84%; Inpt 90%)	60% compliance with MOS

Children's Hospital & Medical Center Error Prevention Techniques

Behavioral Expectations	Related Error Prevention Tools	
Everyone Makes a Personal Commitment to Safety **"We do the right thing"**	**1. Name Game** – introduce yourself to the team **2. Pay attention to detail using STAR** **S**top: Pause for a moment **T**hink: Focus on the act **A**ct: Perform the act **R**eview: Check your results	**3. Team member checking & ARCC** **A**sk a question **R**equest a Change **C**oncern – state "I have a concern" **C**hain of command
Everyone is Accountable for Clear and Complete Communication **"We are one team"**	**1. Use SBAR to communicate concerns requiring action** **S**ituation: What is the problem, patient or project? **B**ackground: What is important to know? **A**ssessment: What is your evaluation? **R**ecommendation: What action needs to take place? 2. **Three-way communication** Repeat back/Read back with 1 or 2 clarifying questions	**3. Standardized handoffs:** **I**ntroduction **S**tory **H**istory **A**ssessment **P**lan **E**rror Prevention **D**ialogue
Everyone Supports a Questioning Attitude **"We get results"**	**1. Stop and Resolve** – Don't proceed in the face of uncertainty	**2. QVV – Question the answers** **Q**ualify the source **V**alidate the content **V**erify with an expert source

Question…..

Do you act on your instincts or not?

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Be Mindful: Pay Close Attention

Vials similar to those confused during heparin events.

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Advocate For Your Patient

Reasons we don't speak up when we are uncomfortable about a situation

- Assumptions
- Fear
- Hierarchy
- Experience
- Culture
- Personality

Your Role

You **have a RESPONSIBILITY** to notify your Chief Resident or a staff member when you identify unsafe patient situations.

We Value Your Input

If you have an idea for a performance improvement project……

- Talk to your Chief Resident or;
- Call Performance Improvement ext. 3811

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Thank you for providing the safest and highest quality care for our patients!

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