Strategies of a High-Reliability Organization

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Catholic Health – Overview

Catholic Health

Founded in Faith

Catholic Health has a unique perspective on health care.
We support patients in their totality: body, mind and spirit.

- Each of our hospitals was founded by an order of religious sisters, going back more than a century.
- We're guided by a deep sense of mission.
- We are strengthened and inspired by our core values.
- We provide medical excellence with comforting compassion.
- Our culture cherishes your humanity.

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Catholic Health: Our Integrated Health Care System

Ongoing commitment to being a truly integrated health care system

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Fast Facts

Annual volume demonstrates patient trust in Catholic Health

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CH Quality Risk Performance

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Quality Performance System-Wide

Catholic Health is recognized by numerous agencies as a health care leader

Quality Recognition

The Joint Commission – National Quality Approval

HomeCare Elite

CMS – Centers for Medicare & Medicaid Services

Patient Safety

Nationally Recognized – Leapfrog Hospital Safety Grade – A – Fall 2020

Nursing Excellence

Pathway Designated – American Nurses Credentialing Center

Magnet Recognized – American Nurses Credentialing Center

Orthopedics

High Performing Hospitals – U.S. News & World Report – 2020-21 – Orthopedics

Cardiology

Best Hospitals – U.S. News & World Report – National Cardiology & Heart Surgery – 2020-21

World's Best Hospitals 2020 – Newsweek – powered by statista

Neuroscience

High Performing Hospitals – U.S. News & World Report – 2020-21 – Neurology & Neurosurgery

The Joint Commission – American Heart Association – American Stroke Association – Certification – Meets standards for Primary Stroke Center

2020 Get With The Guidelines – Gold Plus – Target: Stroke Honor Roll – Stroke

Oncology

Commission on Cancer Accredited Program

A Quality Program of the American College of Surgeons

Short–Term Rehab

Best Nursing Homes – U.S. News & World Report – Short-Term Rehabilitation – 2020-21

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Five Principles of HROs

Preoccupation with Failure

Operating with a chronic wariness of the possibility of unexpected events that may jeopardize safety by engaging in proactive and preemptive analysis and discussion.

Sensitivity to Operations

Paying attention to what's happening on the front-line – Ongoing interaction and information-sharing about the human and organizational factors that determine the safety of a system as a whole.

Reluctance to Simplify *interpretations*

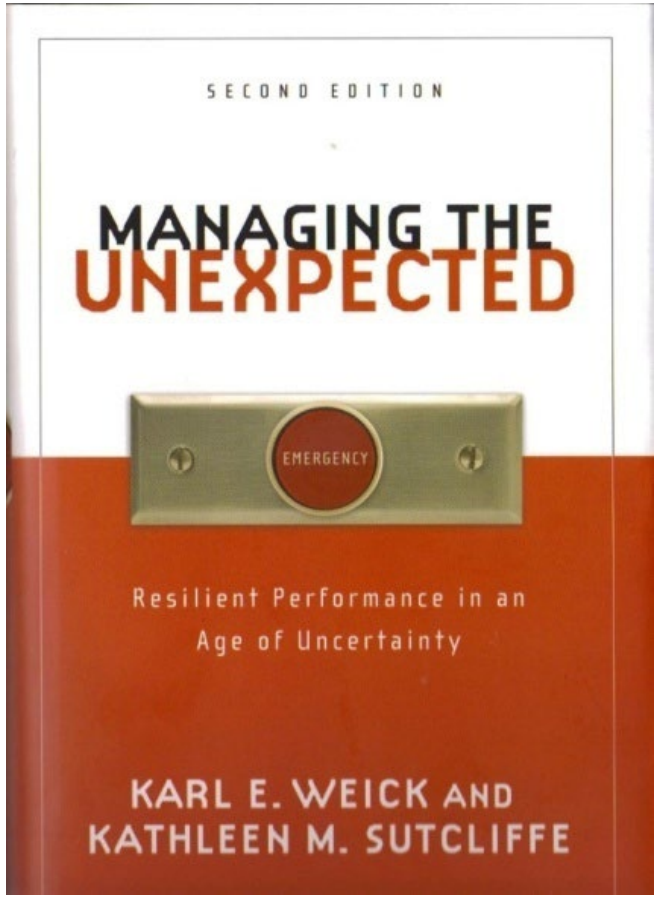
Taking deliberate steps to question assumptions and received wisdom to create a more complete and nuanced picture of ongoing operations.

Commitment to Resilience

Developing capabilities to detect, contain and bounce back from errors that have already occurred, before they worsen and cause more serious harm.

Deference to Expertise

During high-tempo operations, decision-making authority migrates to the person or people with the most expertise with the problem at hand, regardless of rank.



From Vogus & Sutcliffe, The Safety Organizing Scale, *Medical Care, 45/1*, Jan 2007, p. 46-54.

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Common Attributes of High-Reliability Organizations

1. Aggressively seek to know what they don't know

2. Design their reward and incentive systems to recognize costs of failures as well as benefits of reliability

3. Consistently communicate the big picture of what the organization seeks to do

Elements of Our Program

1. Common Cause Analysis
2. HRO Leader Training
3. Error Prevention Training for staff and medical staff; “train the trainer”
4. Serious Safety Event (SSE) team meetings
5. Rounding to Influence (RTI)
6. RCA, ACA and Density Analysis Process
7. Daily safety huddle, unit huddles and visual management systems
8. Physician Champions, Safety Champions, and Safety Coaches
9. Great Catch Program

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Safety Starts with Me!

Daily Patient Safety Principles

1. SUPPORT A CULTURE OF SAFETY

Why? Supporting a culture of safety encourages all care team members to share best practices, as well as providing opportunities for improvements to reduce harm.

How? Speak Up and use CUS or "Stop the Line" if there is a an Urgent Safety Concern:

C "I am Concerned"
U " I am Uncomfortable"
S "Stop – This is a Safety Issue"

Be a Safety Partner

- Look out for each other (cross check)
- Politely reinforce safe and productive behaviors
- Correct unsafe behaviors in a professional, helpful manner (coach)

Use "Tones" with Fellow Staff and Patients to Eliminate Barriers and Strengthen the Care Team

- Smile and greet others by saying hello
- Introduce yourself and explain your role
- Listen with empathy and intent to understand
- Communicate the positive intent of your actions
- Provide opportunities for others to ask questions

2. COMMUNICATE CLEARLY

Why? Miscommunication is a leading causes of error and patient harm.

How? Three-Way Repeat Back and Read Back:

- Sender initiates communication
- Receiver repeats back or writes down and reads back
- Sender acknowledges accuracy by stating back: "That's correct" or "That's not correct" (state error corrections)

Phonetic and Numeric Clarification

Say the letters and say the numbers

Ask Clarifying Questions

Ask one or two clarifying questions in high-risk situations or when information is unclear or ambiguous

Use SBAR for All Handoffs

Situation (What is the problem, patient or project?)
Background (What is important to know?)
Assessment (What is your thought?)
Recommendation/Request (What action do you recommend?)

3. PAY ATTENTION TO DETAIL AND HAVE A QUESTIONING ATTITUDE

Why? Health care is complex and details matter to ensure the best outcomes...if unsure, ask!

How? Self-Check with STAR:

Stop (Pause for 1-2 seconds before the act)
Think (Focus on the act)
Act (Perform the act)
Review (Check for desired results)

Questioning Attitude:

Qualify (Is the source reliable?)
Validate (Consistent with my knowledge? Is this typical and expected or outside of the norm? How do I know this is correct?)
Verify (Check with an expert source if necessary)

4. SUPPORT BEST PRACTICES AND GUIDELINES TO REDUCE HARM

Why? The best outcomes are achieved by following evidence-based protocols and bundles.

How?

- Follow CHS policies, procedures & protocols
- Use checklists and flow sheets
- Follow evidence-based EMR best practice advisories and soft and hard provider stops

5. FOLLOW CHS RED RULES FOR ABSOLUTE COMPLIANCE

- **Verify with two patient identifiers before acting**
- **Conduct a "time out" before invasive and high-risk procedures**
- **Two-provider check *before* administration of blood, blood products and high-risk medications**

Following Daily Patient Safety Principles Makes Every Day Safer for Our Patients

Patient Safety is our CORE VALUE

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Use “CUS” to Escalate Concerns

- ***We all*** have a responsibility to protect our patients and coworkers from harm.
- If you see or hear something that you think is a safety issue, escalate your concern in a *mutually respectful manner*.
- **Assert** yourself, but <u>don’t be</u> aggressive or rude.
- Escalate using the following tips:

First, just state your **C**oncern – in other words, offer a cross check

If that doesn’t work, state you are **U**ncomfortable

Still no response? Voice a concern using the following safety phrase:

“Stop, This is a **S**afety Issue…”

If still no resolution, notify your Chain of Command

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Cross Checking: Two Heads are Better than One

Individual reliability is limited:
1 defect per 1000 opportunities

1/1000 (**my** error probability)
x 1/1000 (**your** error probability)
= 1/1,000,000 (our combined **reliability**!!)

We are ***better together…***

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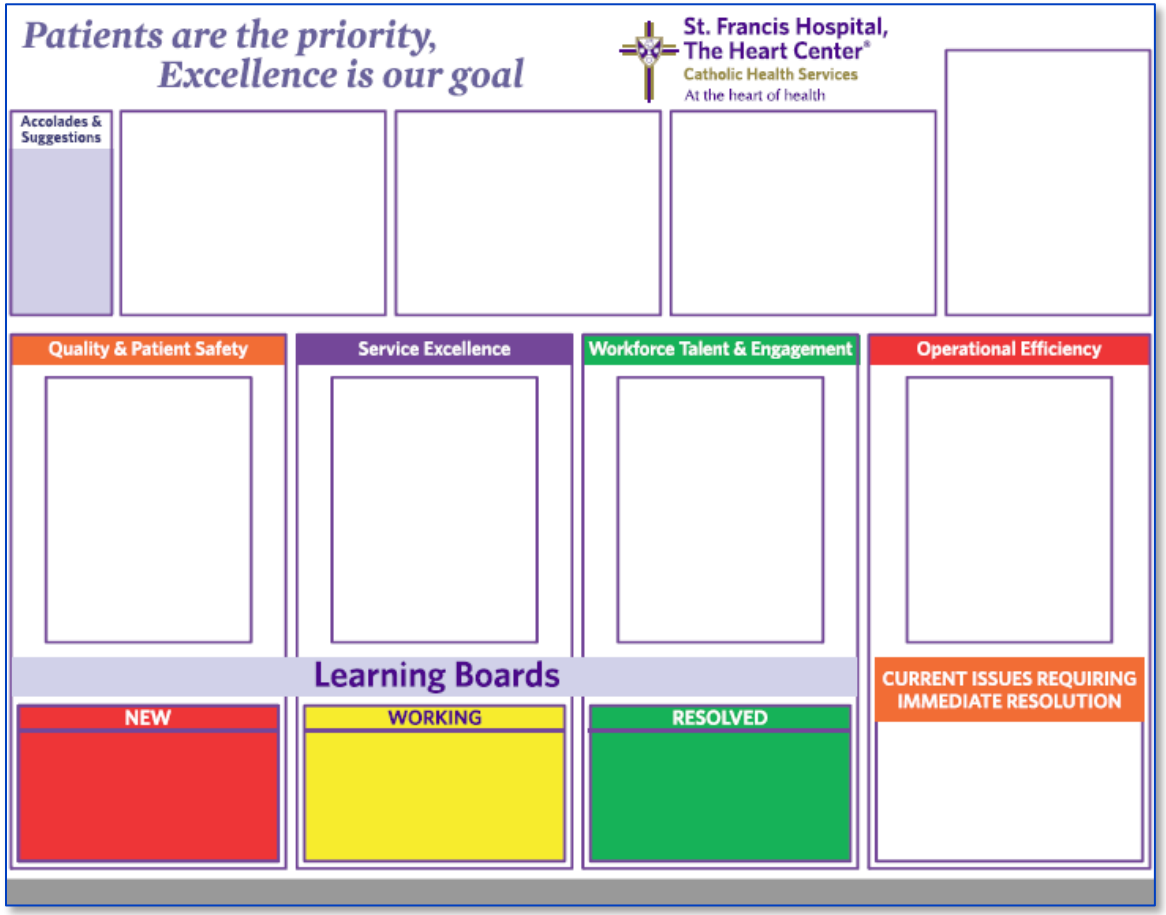
Learning Boards
Local Focus for Local Results

What Is It?

- A method for identifying local system issues that impact safe, effective and patient-centered care.
- Unit leaders – and shared governance - identify and implement solutions.

Why It Works?

- Focuses efforts of staff at unit level.
- Gives a shared understanding of problems, causes, and solutions.
- Creates momentum for more solving of local system issues.



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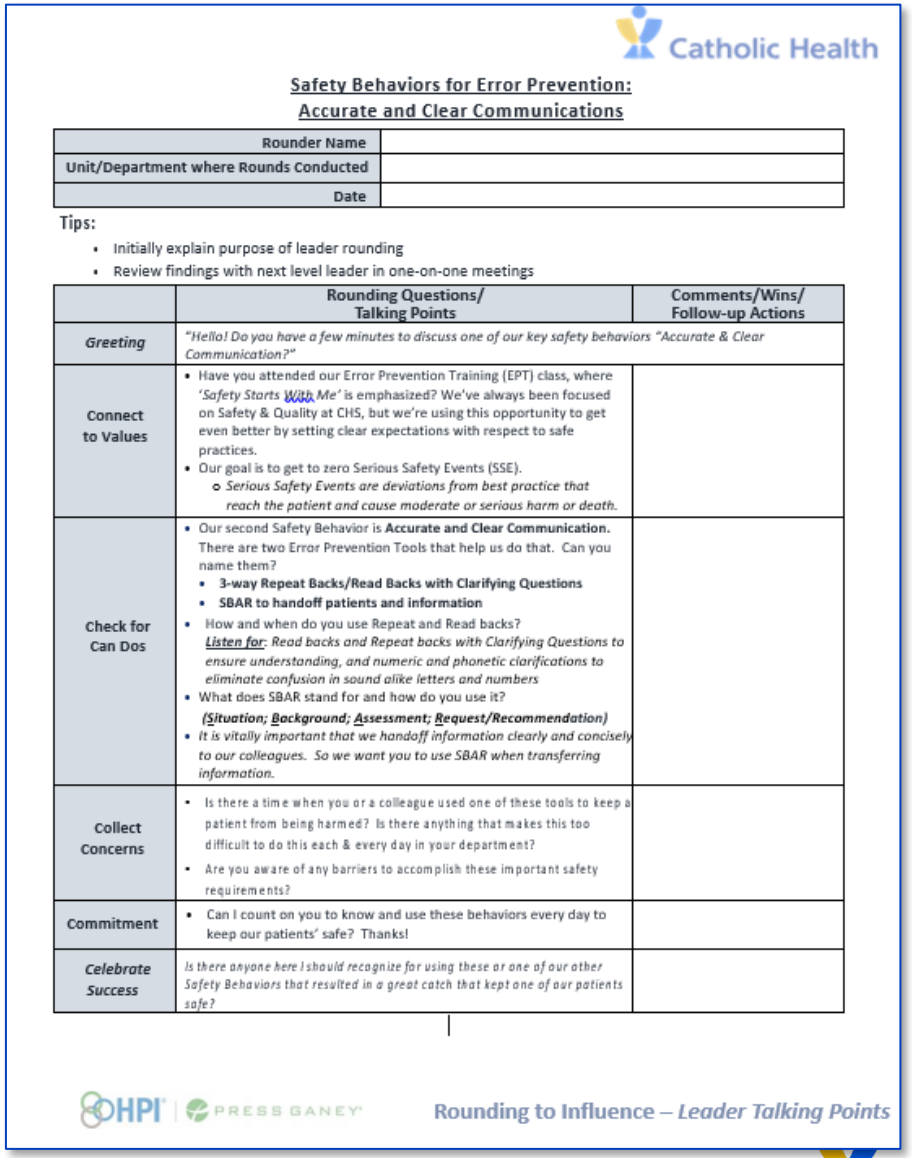
Leadership Rounding Scripts

Weekly Rounding by Leaders

- Connect to Values
- Check for Can Dos
- Collect Concerns
- Commitment
- Celebrate Success



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Safety Behaviors for Error Prevention:
Accurate and Clear Communications

Rounder Name	
Unit/Department where Rounds Conducted	
Date	

Tips:

- Initially explain purpose of leader rounding
- Review findings with next level leader in one-on-one meetings

	Rounding Questions/ Talking Points	Comments/Wins/ Follow-up Actions
Greeting	*"Hello! Do you have a few minutes to discuss one of our key safety behaviors "Accurate & Clear Communication?"*	
Connect to Values	• Have you attended our Error Prevention Training (EPT) class, where '*Safety Starts With Me*' is emphasized? We've always been focused on Safety & Quality at CHS, but we're using this opportunity to get even better by setting clear expectations with respect to safe practices. • Our goal is to get to zero Serious Safety Events (SSE). o *Serious Safety Events are deviations from best practice that reach the patient and cause moderate or serious harm or death.*	
Check for Can Dos	• Our second Safety Behavior is **Accurate and Clear Communication.** There are two Error Prevention Tools that help us do that. Can you name them? • **3-way Repeat Backs/Read Backs with Clarifying Questions** • **SBAR to handoff patients and information** • How and when do you use Repeat and Read backs? ***Listen for**: Read backs and Repeat backs with Clarifying Questions to ensure understanding, and numeric and phonetic clarifications to eliminate confusion in sound alike letters and numbers* • What does SBAR stand for and how do you use it? ***(Situation; Background; Assessment; Request/Recommendation)*** • *It is vitally important that we handoff information clearly and concisely to our colleagues. So we want you to use SBAR when transferring information.*	
Collect Concerns	• Is there a time when you or a colleague used one of these tools to keep a patient from being harmed? Is there anything that makes this too difficult to do this each & every day in your department? • Are you aware of any barriers to accomplish these important safety requirements?	
Commitment	• Can I count on you to know and use these behaviors every day to keep our patients' safe? Thanks!	
Celebrate Success	*Is there anyone here I should recognize for using these or one of our other Safety Behaviors that resulted in a great catch that kept one of our patients safe?*	

HPI | PRESS GANEY Rounding to Influence – *Leader Talking Points*

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What is a Daily Safety Huddle?

- A brief meeting made up of hospital leaders and key team members at the beginning of the day or shift
- Takes place daily 7 days a week at the same time each day
- Builds teamwork through communication and problem solving
- Ensures a common understanding of focus and priorities for the day

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Effective Daily Safety Huddle

Communicates the urgency of resolving safety issues and critical situations

Allows the team to plan for the unexpected

Allows team members' needs and expectations to be met

Uses concise and relevant information to promote effective communication across departments (breaks the silos!)

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Daily Safety Huddles

- LOOK BACK:

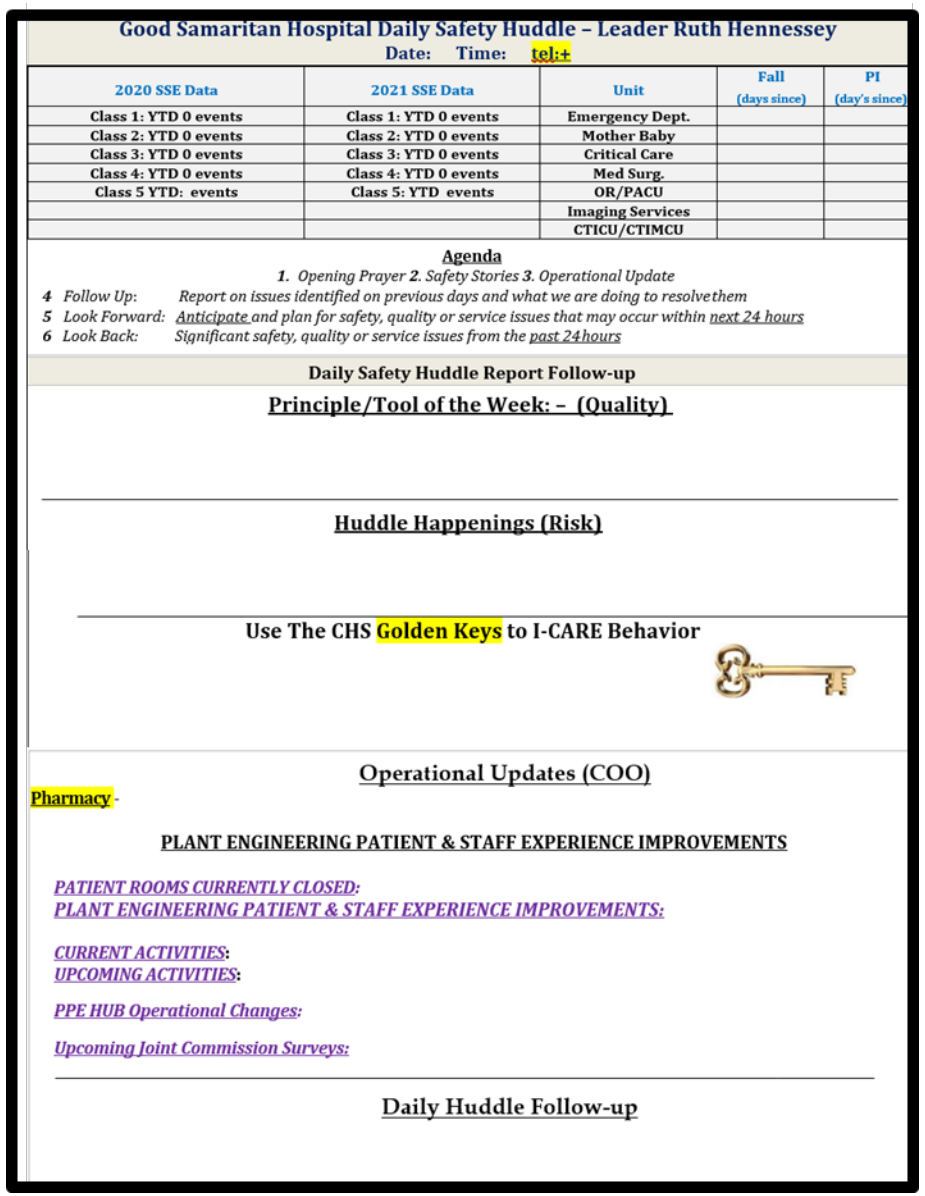
•Significant safety or quality issues from the last 24 hours/last shift

•LOOK AHEAD:

•Anticipate safety or quality issues in the next 24 hours/next shift

•FOLLOW UP:

•On Critical Issues



Good Samaritan Hospital Daily Safety Huddle – Leader Ruth Hennessey

Date: Time: tel:+

2020 SSE Data	2021 SSE Data	Unit	Fall (days since)	PI (day's since)
Class 1: YTD 0 events	Class 1: YTD 0 events	Emergency Dept.		
Class 2: YTD 0 events	Class 2: YTD 0 events	Mother Baby		
Class 3: YTD 0 events	Class 3: YTD 0 events	Critical Care		
Class 4: YTD 0 events	Class 4: YTD 0 events	Med Surg.		
Class 5 YTD: events	Class 5: YTD events	OR/PACU		
		Imaging Services		
		CTICU/CTIMCU		

Agenda

1. Opening Prayer 2. Safety Stories 3. Operational Update

4 Follow Up: Report on issues identified on previous days and what we are doing to resolve them

5 Look Forward: Anticipate and plan for safety, quality or service issues that may occur within next 24 hours

6 Look Back: Significant safety, quality or service issues from the past 24 hours

Daily Safety Huddle Report Follow-up

Principle/Tool of the Week: – (Quality)

Huddle Happenings (Risk)

Use The CHS Golden Keys to I-CARE Behavior

Operational Updates (COO)

Pharmacy -

PLANT ENGINEERING PATIENT & STAFF EXPERIENCE IMPROVEMENTS

PATIENT ROOMS CURRENTLY CLOSED:
PLANT ENGINEERING PATIENT & STAFF EXPERIENCE IMPROVEMENTS:

CURRENT ACTIVITIES:
UPCOMING ACTIVITIES:

PPE HUB Operational Changes:

Upcoming Joint Commission Surveys:

Daily Huddle Follow-up

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Safety Coaches

Safety coaches are team members who provide real-time feedback about practice and compliance with our safety behaviors and error prevention tools and who help to prevent events of harm.

Coaches are not the judge, the police or substitutes for manager engagement in safety

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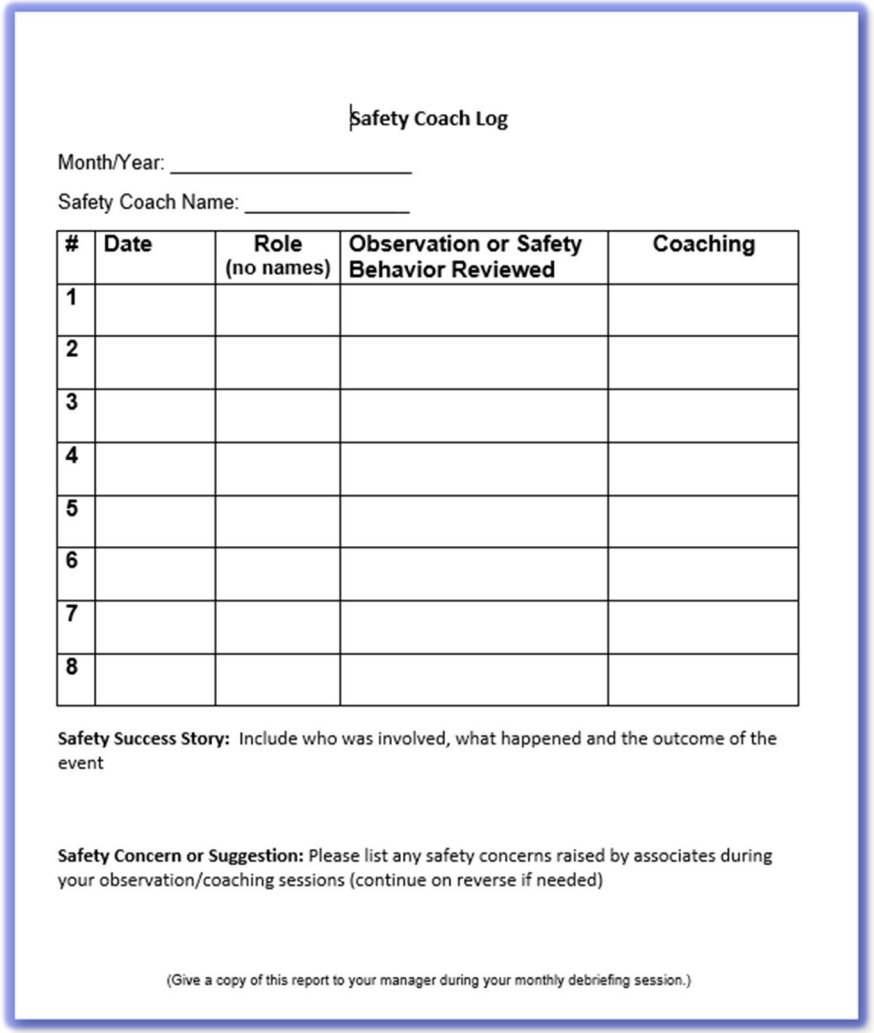

Safety Coach Log

Month/Year: _____

Safety Coach Name: _____

#	Date	Role (no names)	Observation or Safety Behavior Reviewed	Coaching
1				
2				
3				
4				
5				
6				
7				
8				

Safety Success Story: Include who was involved, what happened and the outcome of the event

Safety Concern or Suggestion: Please list any safety concerns raised by associates during your observation/coaching sessions (continue on reverse if needed)

(Give a copy of this report to your manager during your monthly debriefing session.)

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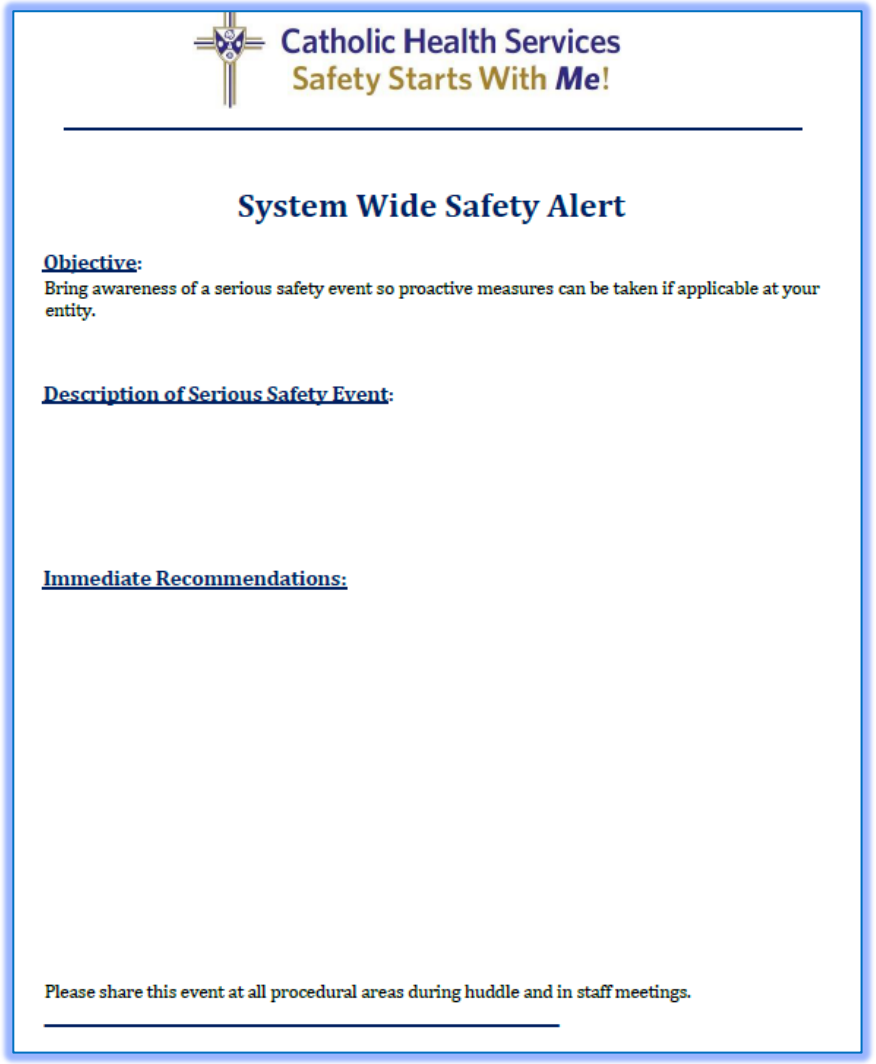
System-Wide Safety Alert



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Safety Starts With *Me*!

System Wide Safety Alert

Objective:
Bring awareness of a serious safety event so proactive measures can be taken if applicable at your entity.

Description of Serious Safety Event:

Immediate Recommendations:

Please share this event at all procedural areas during huddle and in staff meetings.

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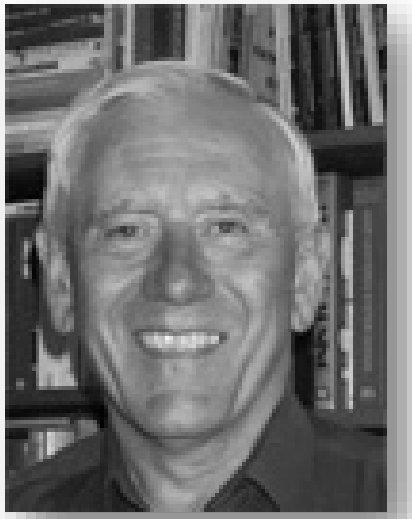
Fair and Just Culture

"Just Culture creates an atmosphere of trust in which people are encouraged to provide, and even rewarded for providing, essential safety-related information but in which they are clear about where the line must be drawn between acceptable and unacceptable behavior." **James Reason**



Managing the Risks of Organizational Accidents (1997)

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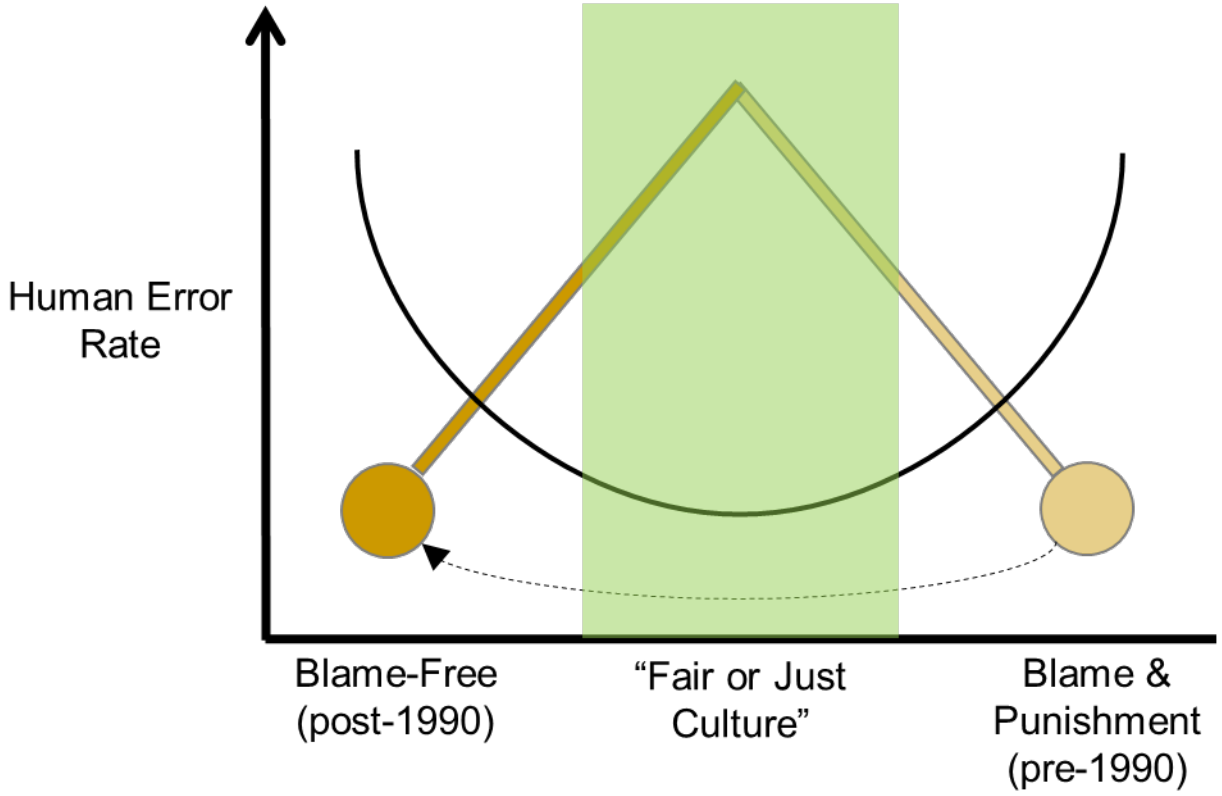
Striking the Right Balance



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How Leaders Respond

Employees need to know that a leader will respond and treat an employee fairly when performance does not meet expectations.

This is your management "moment of truth"

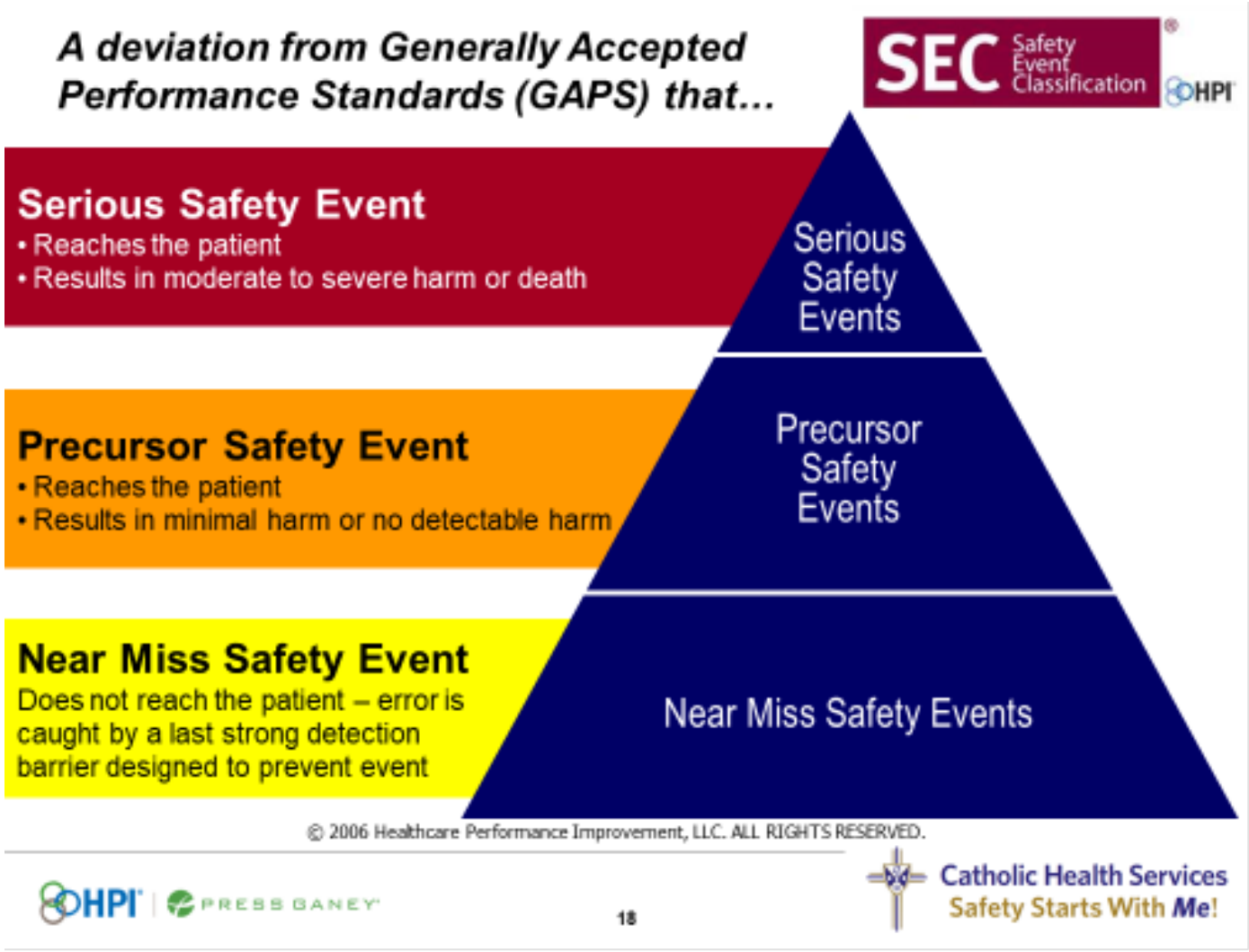
If employees perceive that individuals are unfairly punished:

- Reduced likelihood to report events, errors and mistakes
- Missed opportunities to find and fix problems, impacting performance and outcomes

If employees see management tolerance when there is an intentional disregard for work rules:

- The performance of other individuals and of the team as a whole will decline over time

Our Safety Program Strategy



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2023 HRO Journey:
Serious Safety Events 1 and 2

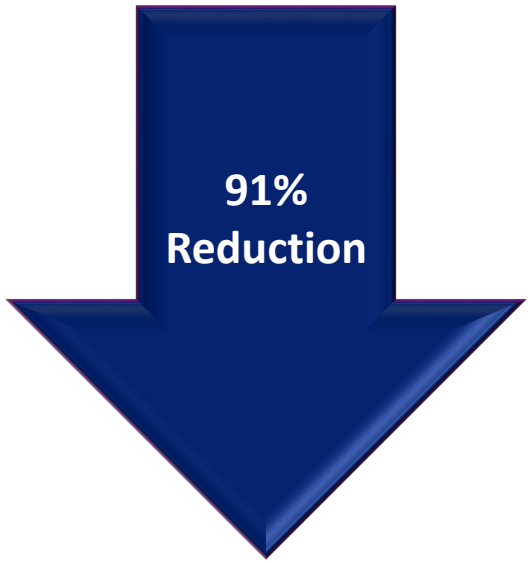
Death (Level 1) and Severe Permanent Harm (Level 2)

ACUTE CARE

2018 Baseline

0.28
12-Month Rolling
Rate per 10,000
Adjusted Patient
Days

21 Patients



2023 Q2

0.03
Current Rolling
Rate per 10,000
Adjusted Patient
Days

1 Patient

CONTINUING CARE

2022

0

Level 1 & 2 Events

2023 HRO Journey:
Serious Safety Events 3, 4, and 5

Moderate Permanent Harm (Level 3), Severe Temporary Harm (Level 4), and Moderate Temporary Harm (Level 5)

ACUTE CARE

2021 Baseline

12-Month Rolling Rate per 10,000 Adjusted Patient Days

8.1

2023 Q1

Current Rolling Rate per 10,000 Adjusted Patient Days

2.3

Next Leap…

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Next Leap…

+ Patient Experience

+ Employee Engagement

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Our Strategy

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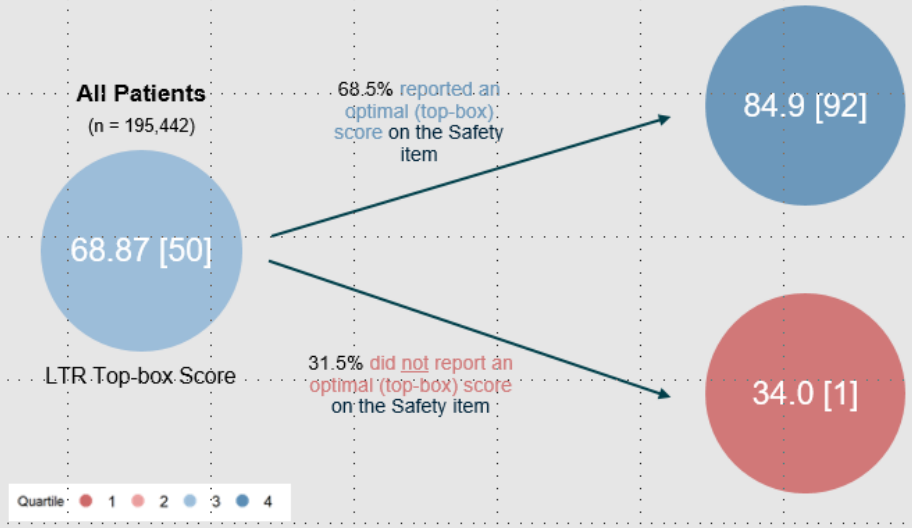
Linking Patient Experience to Safety

Patient Experience of Safety Directly Relates to Likelihood to Recommend the Hospital



- When patients report **optimal experiences of safety**, their LTR top-box score is **84.9**
- However, when patients **do not report optimal experiences of safety**, their LTR top-box score **decreases to 34.0**

- Inpatient HCAHPS & Integrated surveys received from June 2022 – May 2023.
- n = 195,442
- Respondents must have answered both safety and LTR items.

PressGaney

 14

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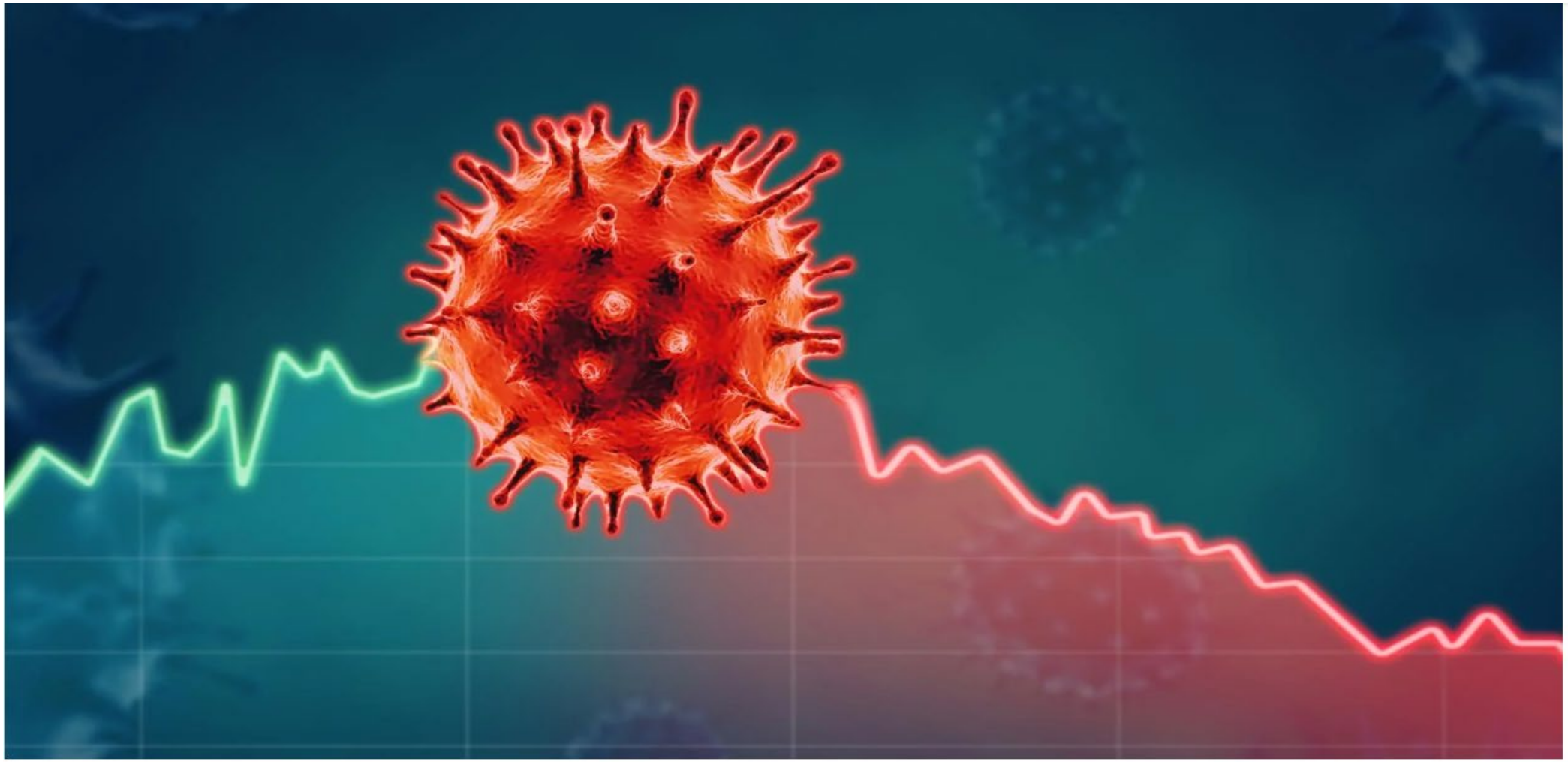
DISRUPTION!



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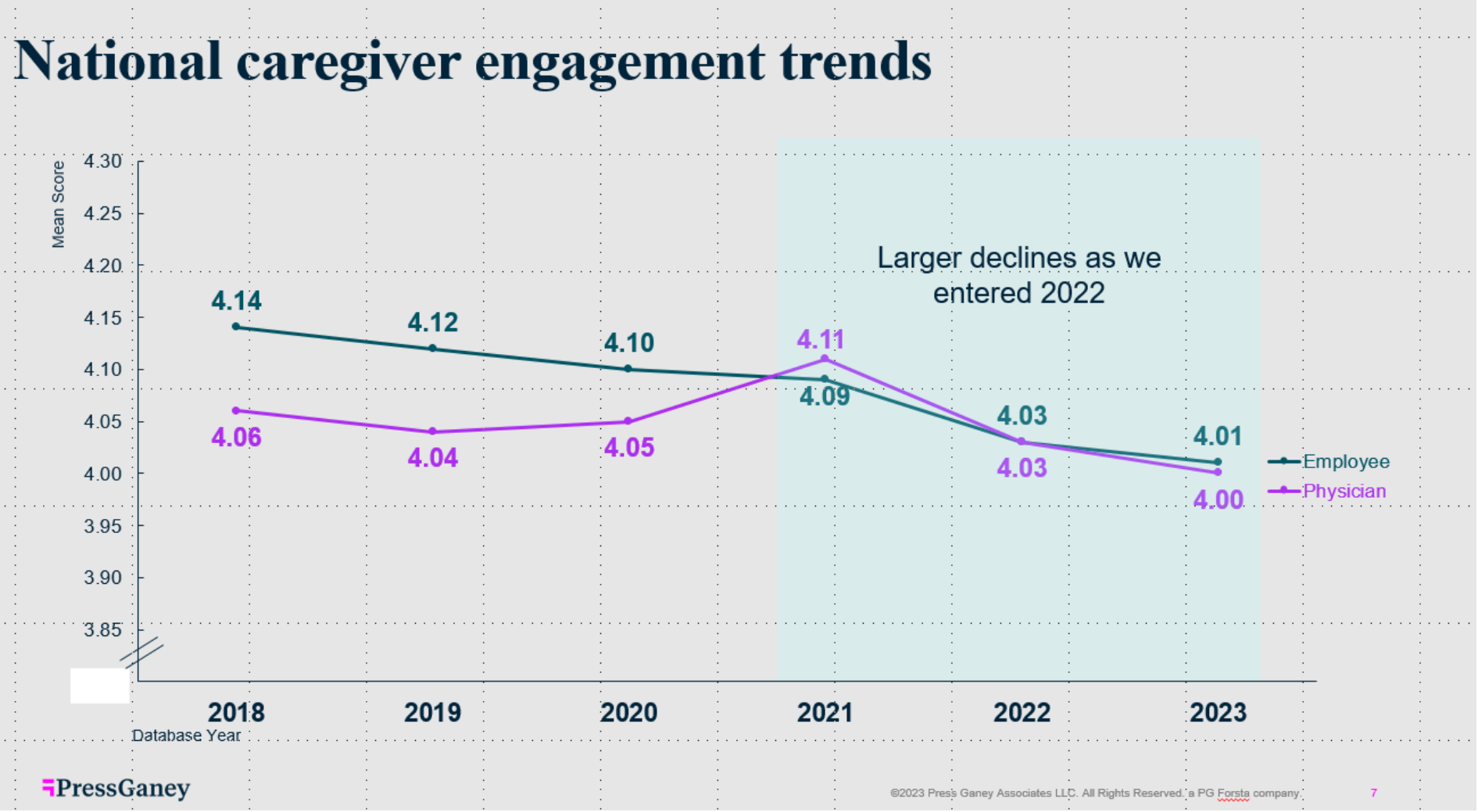
Workforce Engagement and its impact on Quality, Safety and Experience



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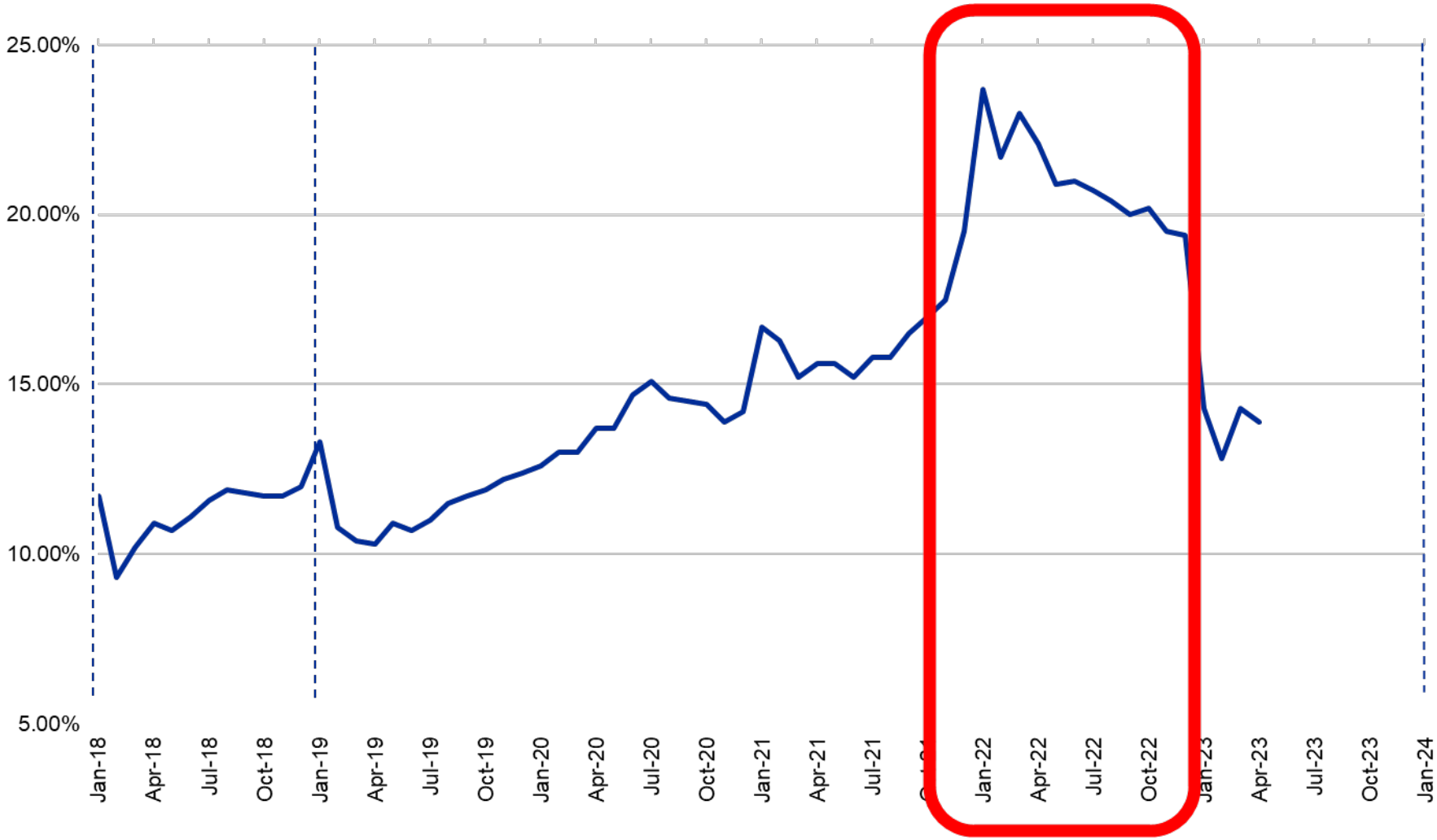
Workforce Talent and Engagement: Acute Care RN Turnover



Revive and Reset

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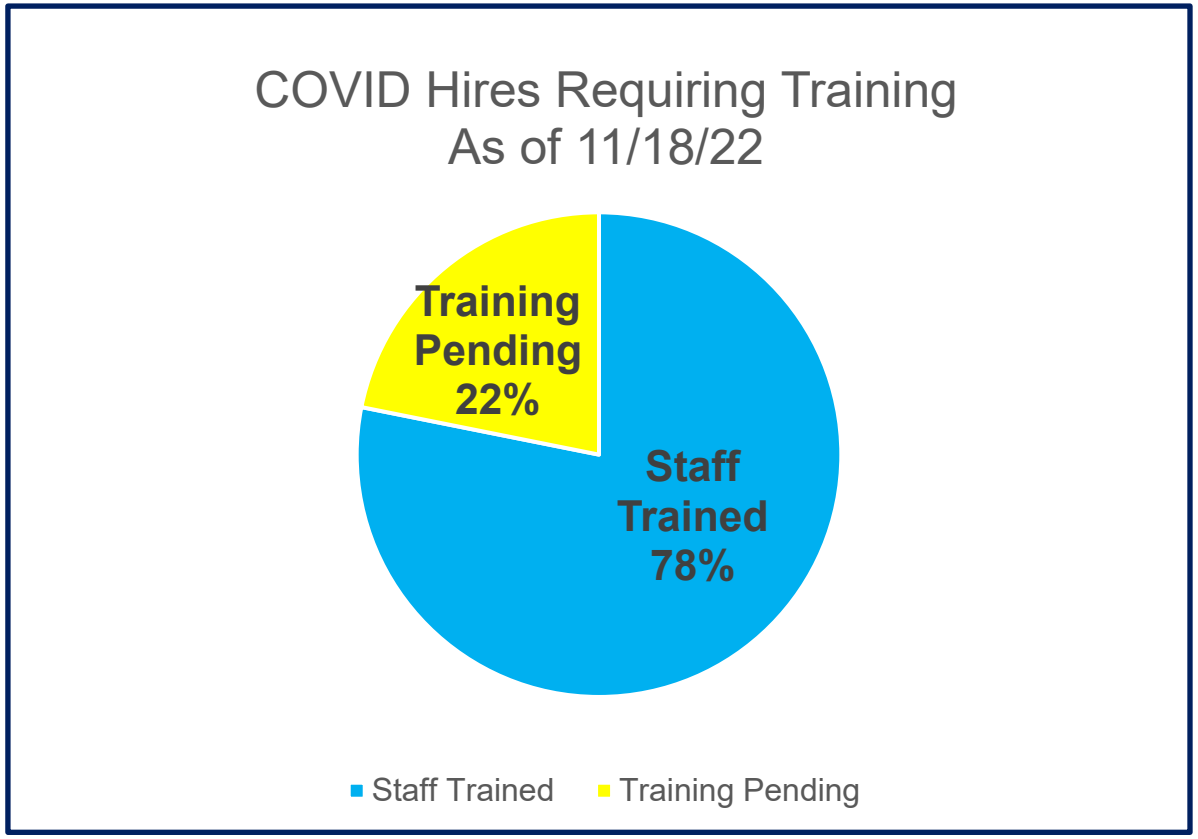
PX Reboot 2022
COVID Hire Re-Training: From Virtual to In-Person

2,617 Employees Hired from

January 2020 – June 2022

As of December 6, 2022:

Our PX Directors have retrained 2,045 employees



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Passable to Powerful Training

- Two hour in-person training for Mangers/Leaders to reinforce the techniques to identify passable to powerful behaviors

- October – December 2022

Passable-

Making eye contact

Not smiling

Body language is a tense

Powerful- Actively Present

Focused on the patient

Eye contact

Positive body language

Engaging with the patient while completing tasks

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Impact of COVID on HAI's

Infection Control & Hospital Epidemiology (2023), **44**, 997–1001
doi:10.1017/ice.2022.116

SHEA

Concise Communication

Continued increases in the incidence of healthcare-associated infection (HAI) during the second year of the coronavirus disease 2019 (COVID-19) pandemic

Lindsey M. Lastinger MPH[1], Carlos R. Alvarez MPH, CPH[1,2], Aaron Kofman MD[1], Rebecca Y. Konnor MPH[1,3], David T. Kuhar MD[1], Allan Nkwata PhD[1,2], Prachi R. Patel MPH[1,3], Vaishnavi Pattabiraman MSc, MS, MPH[1,2], Sunny Y. Xu MPH[1,3] and Margaret A. Dudeck MPH[1]

[1]Division of Healthcare Quality Promotion, Centers for Disease Control and Prevention, Atlanta, Georgia, [2]Leidos, Atlanta, Georgia and [3]CACI, Atlanta, Georgia

Abstract

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Daily Clinical Excellence Huddle

- **GOAL**- Situational awareness and ownership on the campuses
- Daily Zoom with All 6 CMOs and CNOs
- Leapfrog Metrics
  - Hospital Acquired Conditions (HAC)
  - Patient safety Indicators (PSI)
  - Heightened awareness monitoring
- ACA for every HAC and PSI

SYSTEM CLINICAL EXCELLENCE HUDDLE

12:00pm - 12:15pm | MONDAY - FRIDAY | 3/15/2023

WITHIN THE PAST 24 HOURS, HOW MANY_ (72 HOUR TRACKING MONDAY

EVENTS: (All Payers, All Units- excluding inpatient rehab and psych)	Suspected Cases	Confirmed #of Cases	Preliminary Root Cause of Service Failure	Days Since Last	Total Confirmed # of Cases since 1/1/2023	Total Confirmed # of Cases for HAC Program since	Expected # allowed per CMS
Infections	**TOTAL**	**TOTAL**	**All Units**				**FY 2023**
# of CLABSI	0	0		110	0	0	14
# of CAUTI	0	0		183	0	0	17
# of CDIF	0	0		20	4	4	71
# of MRSA	0	0		151	1	1	7
# of Colon SSI	0	0		205	0	0	8
Safety Events	**TOTAL**	**TOTAL**	**All Units**				**FY 2022**
Falls with Injury- All Stages	0	0		30	2	0	
Pressure Injury Stage 1 (NPOA, New or Worsened)	0	0		54	1	0	
Pressure Injury Stage 2 (NPOA, New or Worsened)	0	0		22	3	0	
Pressure Injury Stage 3 (NPOA, New or Worsened)	0	0			0	3	
Pressure Injury Stage 4 (NPOA, New or Worsened)	0	0			0	0	
Pressure Injury Unstageable (NPOA, New or Worsened)	0	0		13	2	1	7
Pressure Injury DTI (NPOA, New or Worsened)	0	0		30	2	0	
Iatrogenic PTX	0	0		86	0	0	7
Periop Hemorrhage	1	0	watchman procedure, will work with CDI to see if procedure will code out		0	0	17
Post-Op Kidney Inj Requiring Dialysis	0	0			1	1	6
Post-Op Respi Failure	0	0		65	1	1	17
Periop PE/DVT	0	0			0	0	17
Post-Op Sepsis	0	0		25	1	1	12
Post-Op Wound Dehiscence	0	0			0	0	1
Abd Puncture/Laceration	0	0			1	1	3

EVENTS: (All Payers, All Units- excluding inpatient rehab and psych)			Total # Per Unit								
Hightened Awareness Monitoring	**TOTAL**	**TOTAL**	**ED**	**Med/Sur**	**Telemetry**	**Intermedia**	**Critical Car**	**% of census**	**% of Census**		
# of Acute Foleys & CBI	52			24			20				
# of Chronic Indwelling Foleys											
# of Central Lines (double/triple lumen)	12						12				
# of PICCs	5		1		4						
# of Mediports	10				7	2	1				
# of Temporary HD Catheters	12				7		5				
# of Tunneled Hemodialysis Catheters											
# AV Fistulas											
# of Preventative Skin Rounds Conducted *to begin q1 2023*											

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System Clinical Excellence Council

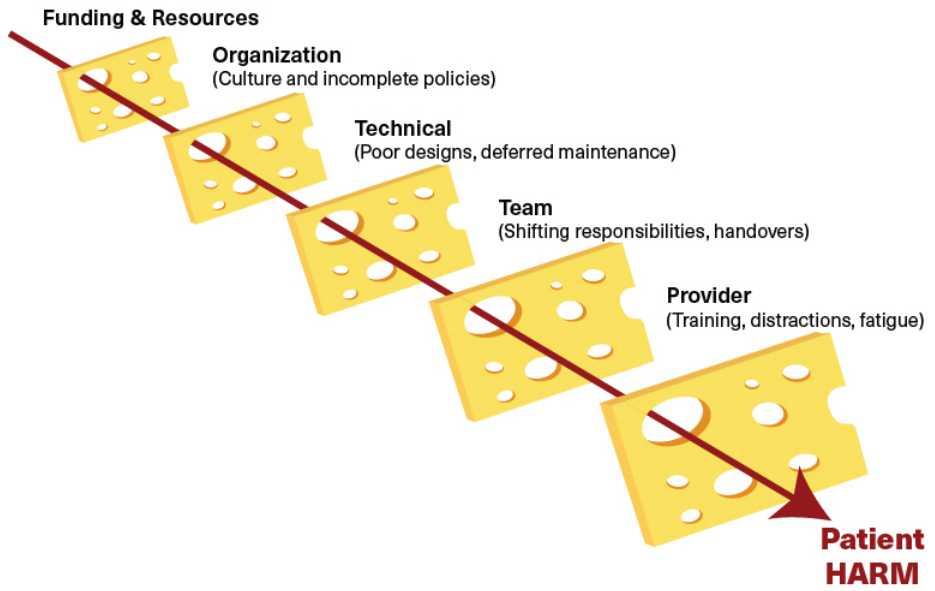
6 CMO's + 6 CNO's

Risk, Infection prevention, IT, Laboratory

- Monthly Meetings to work on system-wide clinical policies and processes.
- HAI's and PSI

Sample Agenda

Current Data on *C. diff*
Current Best Practices for *C. diff*
Gap analysis to see what is missing
Recommended changes to Practice
Plan for Diagnostic surveillance
Testing workflow
Accountability to Policy by using "Just Culture"



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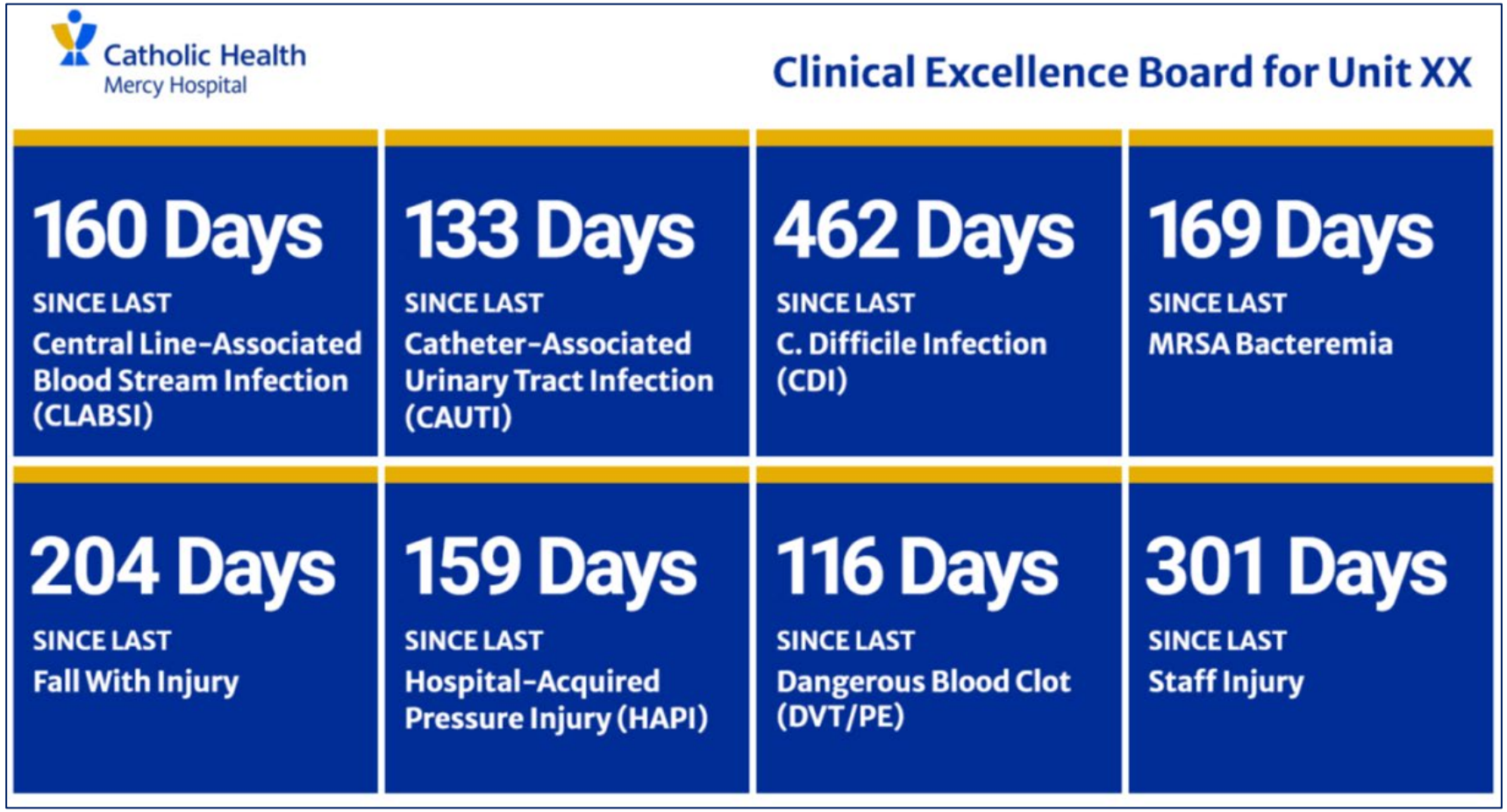
Clinical Excellence Boards



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