How Three CAHs are Improving Safety

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Objectives

- Identify the importance of patient safety culture in a hospital setting
- Describe challenges in improving safety culture in a critical access hospital (CAH) and how to overcome them
- Use lessons learned and best practices from CAHs that have successfully applied culture change strategies in their organizations

What is patient safety culture?

An atmosphere of mutual trust in which all staff members can talk freely about safety problems and how to solve them, without fear of blame or punishment—essential to improving patient safety in any organization.

Institute for Healthcare Improvement

Institute of Medicine: To Err is Human

"The problem is not bad people; the problem is that the system needs to be made safer."

Institute of Medicine. (2000). *To Err is Human: Building a Safer Health System*.

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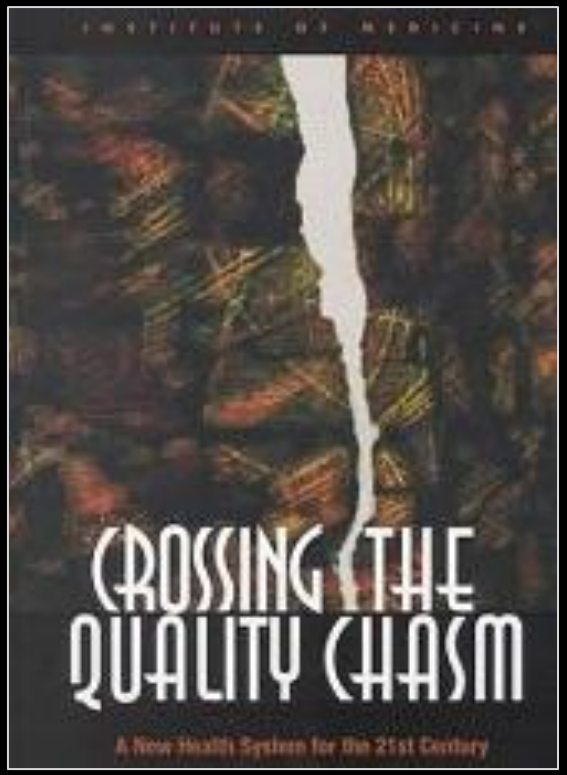
Institute of Medicine: Crossing the Quality Chasm

"The biggest challenge to moving toward a safer health system is changing the culture from one of blaming individuals for errors to one in which errors are treated not as personal failures, but as opportunities to improve the system and prevent harm."

Institute of Medicine. (2001). *Crossing the Quality Chasm: A New Health System for the 21st Century*



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Culture of Safety

Four beliefs present in a safe, informed culture

- Our processes are designed to prevent failure
- We are committed to detect and learn from error
- We have a just culture that responds based on behavioral choices, not outcomes
- People who work in teams make fewer errors

*In a culture of safety, people are not merely encouraged to work toward change; **they take action** when it is needed.*

Institute of Medicine (2004). *Patient Safety: A New Standard for Care*

Why is patient safety culture important?

- Improved clinical outcomes
- Higher staff retention
- National Quality Forum “Safe Practices” recommendation
- Joint Commission leadership standards

Pipestone County Medical Center and Family Clinic/Avera

Improving Safety Culture

Nancy Johnson, RN, BA

Pipestone County Medical Center, Southwest Minnesota

- Critical access hospital
- Clinic (including 2 satellites)
- Home care
- Hospice
- 10 providers
  - 6 family practice physicians
  - 1 general surgeon
  - 2 nurse practitioners
  - 1 physician assistant
- Average activity per year
  - 800 surgical cases (inpatient and outpatient)
  - 600 acute care inpatients
  - 2,250 ER visits
  - 60 babies delivered

Our Team

- Safety committee
- Safety director
- Quality director
- Human resources staff
- Administration

Problem: Safety program needed improvement in goals and direction (2009)

- Higher than average Workman's Compensation experience
- Incident reporting system outdated
- Safety program needed better organization and support
- Lack of staff education on the how and why of safety issues
- Lack of accountability

Goal

- Build culture of safety based on individual accountability with facility endorsement and support

Success Strategy 1

- **What:** Establish baseline for measurement
- **Why:** Determine where we are and where we want to be
- **How implemented:** Conducted AHRQ Safety Survey in 2009 and 2010
- **How motivated staff:**
  - Provided definition
  - Developed a general safety theory
  - Educated staff in what is involved in “culture of safety”
- **Barriers:**
  - Not knowing what we didn’t know
  - Educating leaders
  - Coordinating results and developing report
- **Solutions:**
  - Completed first survey in coordination with Stratis Health
  - Assisted through interpretation
  - Provided education for follow-up in 2009-2010

Success Strategy 2

- **What:** Leadership training
- **Why:** Challenge leaders to rethink safety approach—from “what to why”
- **How implemented:**
  - Leadership educational development meetings
  - Stratis Health in-service on tools to improve safety following first survey
- **How motivated staff:** Challenged to think about safety in a different way
- **Barriers:**
  - Managers have limited time
  - Presentations are too long for staff meetings
  - Managers are at the same educational level as most staff; we all need to improve together
- **Solutions:**
  - Conduct all culture of safety programs twice during first survey cycle
  - Focus on easy- to-apply principles
  - Use examples from staff work day
  - Make staff accountable and give staff permission to use safety tools

Success Strategy 3

- **What:** Improve safety incident and near-miss reporting
- **Why:**
  - Improve awareness and communication of safety issues
  - Facilitate communication and follow-up incidents/near misses
  - Include all staff in identification and prevention of incidents
- **How implemented:** Purchased on-line safety/risk management tool to report, document, follow-up, and track incidents
- **How motivated staff:**
  - Training increased awareness of high-risk situations and behaviors
  - Gave staff direct input to event reporting and ability to track progress of report follow-up
  - Increased accountability of managers to follow through promptly
- **Barriers:**
  - Cost
  - Training
  - System upkeep
- **Solutions:** System management duties shared by safety, quality, and HR staff

Tools

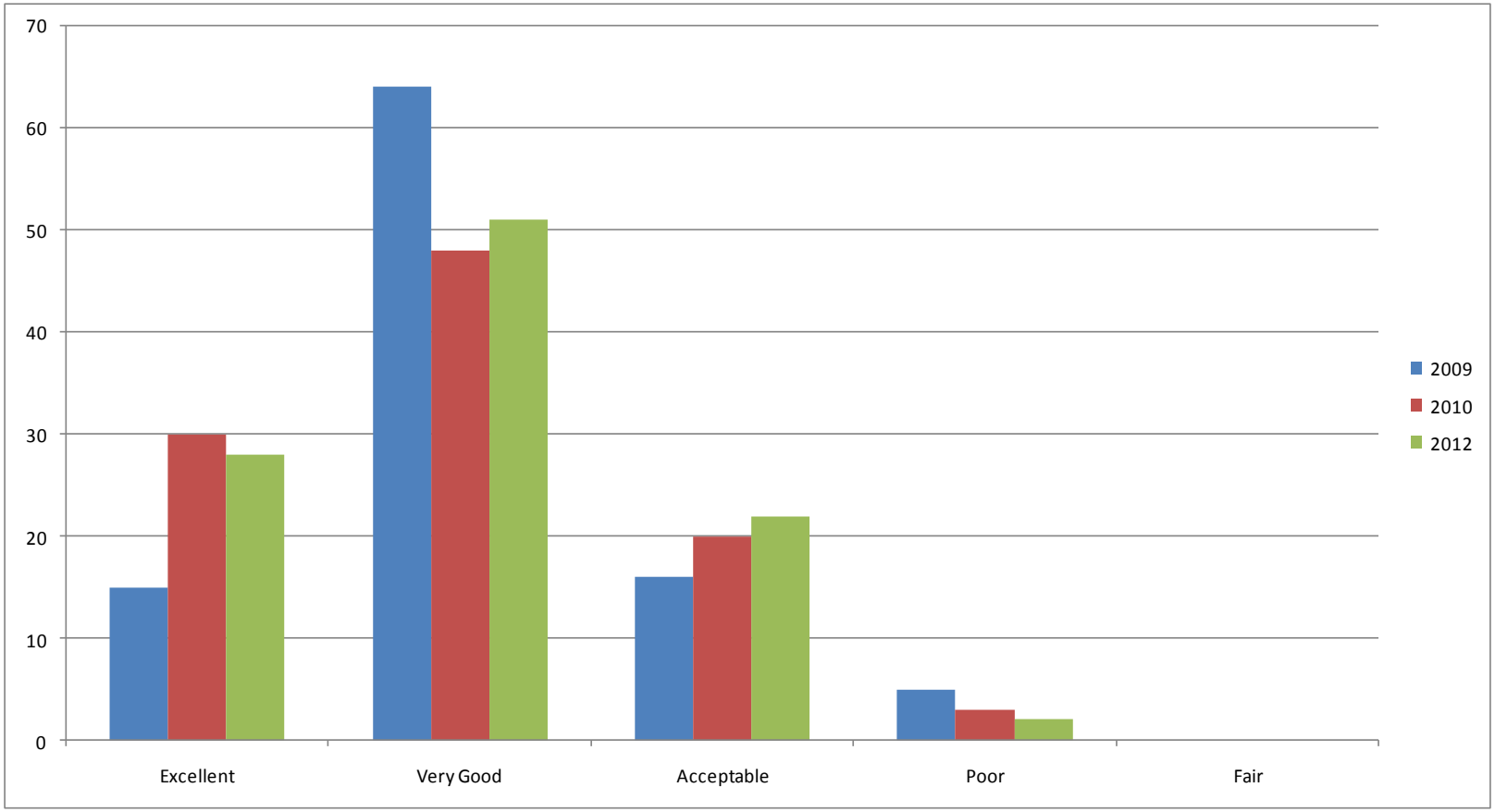
- Worked safety into Standards for Service Excellence
- Examples:
  - Respond promptly to any form of communication
  - When needed, offer to assist co-workers
  - Report incidents within 24 hours
  - Complete safety training
  - Use PPE as required
  - Maintain safe working environment

Tools: AHRQ toolkit

- Mutual support
- 2-challenge rule
- CUS
- STAR
- SBAR
- 3-part feedback
- Manage the message
- 3 Ws

PCMC Overall Grade on Safety Culture Survey 2009, 2010, and 2012

	Excellent	Very Good	Acceptable	Poor	Fair
2009	15	64	16	5	0
2010	30	48	20	3	0
2012	28	51	22	2	0



Increased excellent rating from 15 to 30% on AHRQ Patient Safety Survey

Barriers

- Time:
  - Use approaches and meetings that already exist
  - Work safety thinking into day-to-day approach to work
  - Report results back to staff
    - Used e-mail to report basic AHRQ results
    - Sent out a series of 13 short e-mails to report results

What would you recommend to others?

- Start with survey
- Take small training steps directly focused on survey results
- Use training based on staff members' actual work practices and experiences
- Reinforce "How does this apply to me?"

How will you sustain your improvements?

- Continue to take the AHRQ Safety Culture Survey
- Work on areas identified in survey

Questions?

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MA, APRN, ACNSBC

Chippewa County Montevideo Hospital

Melissa McGinty-Thompson, MA, APRN, ACNS-BC

Chippewa County Montevideo Hospital

- 25-bed critical access hospital
- Southwest Minnesota
- Onsite clinic and 3 satellite clinics
- Provide services across the lifespan
- ED, OB, Med/Surg, ICU, Oncology, Cardiac Rehab, OR, Home Care, Diabetes Care, Dialysis, Mental Health

Our Team

Left to right:

Peg Schumacher, Clinic Administrator; Wendy Augeson, RN; Anita Zelenka, RN; Carol Lietzau, MD; Vari Nelson, RN; Cathy Brouwer, RN; Melissa McGinty-Thompson, RN

Not pictured:

Amy Rongstad, NP; Mark Paulson, Hospital Administrator.; Linda Nelson, Director of Nursing; Sue Jerve, RN; Bruce Arvold, MD

Issue/Problem

The survey results drove our projects. Based on these results, we chose to work on:

- Communication
- Team Support

Goal or Aim

Enhance our communication to provide better handoff information that will ensure the patient's safety continues throughout the facility.

Success Strategy 1

- Interdepartment transfer form
- To provide consistent handoff communication between departments
- Provided education and introduction to form facility-wide; delivered forms to every department
- Motivation: to explain the impact from lack of communication on the patient's safety
- Verbal resistance
- Continued encouragement and shared success of utilization

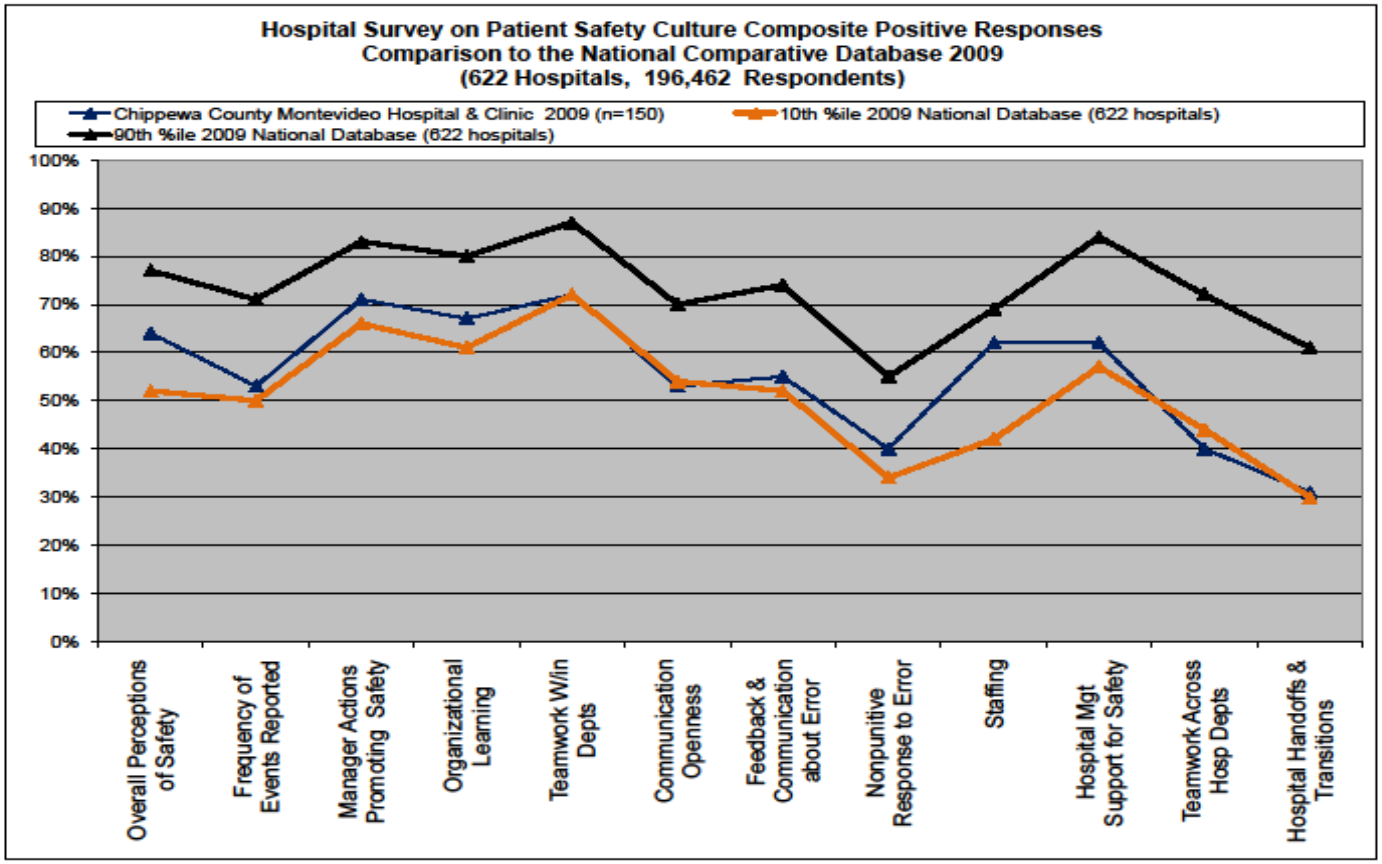
Success Strategy 2

- SBAR communication
  - Name badges, forms, telephone notepads
- To improve communication among individuals across the facility
- Education and introduction to all facility employees
- Provided examples of improved communication and its impact on patient and staff satisfaction
- Verbal resistance
- Survey and shared results

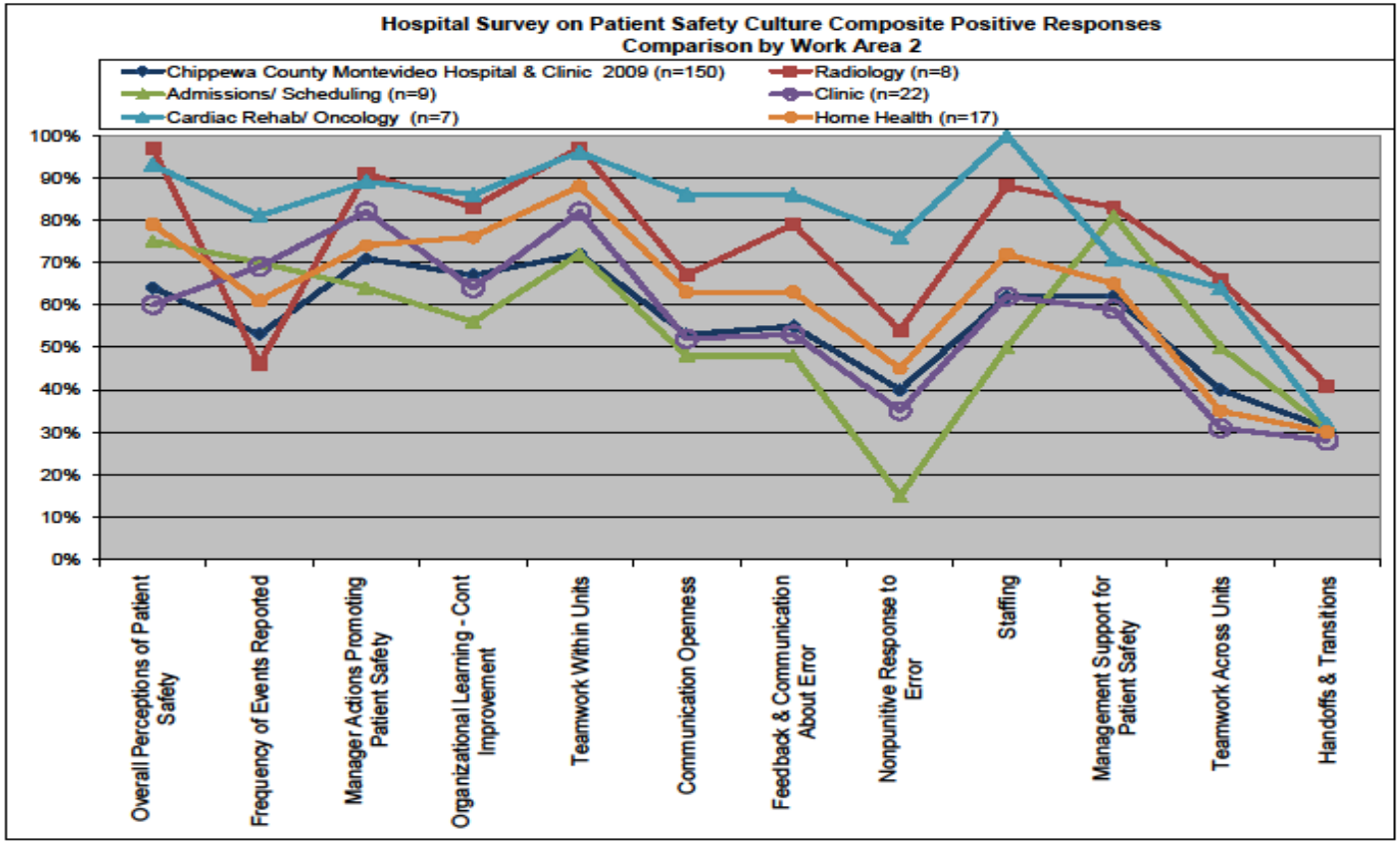
Success Path

Where we were…

Success Path



Success Path



Success Path

- Received survey results
- Shared results facility-wide at lunch and learn session
- Asked for participation on workgroups from all departments
- Developed tools
- Implemented tools

Success Path

Results!

Where we are going…

Success Path

- Continue to work on communication
- Second survey results
  - 10% increase in positive results for areas related to SBAR and patient handoff
  - 19% to 25% - excellent rating
  - Increase in number of incident reports

What Surprised You?

- The volunteers!
- Commitment and continued follow-through

Tools

- Interdepartment transfer form
- SBAR forms
  - Clinical
  - Nonclinical

Barriers

- Another form
- Extra work
- Verbal resistance

What Would You Change?

- Try and get more front-line staff involvement from the beginning
- Physician involvement

What Would You Recommend to Others?

- Get as many different disciplines involved from the beginning and seek input
- Have leadership support
- Communicate, communicate, communicate!

How Will You Sustain Your Improvements?

- Continue to meet monthly
- Develop other processes
- Communication team
- Leadership support
- Participating in MHA TCAB initiative

Thank you!

Contact Information:

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LifeCare
MEDICAL CENTER
caring for generations

Near Miss/Error Reporting

Non-punitive Response to Errors

Marilyn Grafstrom, RN, BSN, CPHRM

LifeCare
MEDICAL CENTER
caring for generations

- Roseau
- 25-bed critical access hospital
- Any further north, you'll be in Canada
- Known for hockey and Polaris snowmobiles

Services

- Medical Services

  Ambulance
  Behavioral Health
  Birthing Center
  Cancer Care
  Convenience Care
  Diabetes Center
  Emergency Department
  Endoscopy
  Imaging Services
  Laboratory

- Medical Surgical Nursing

  Outpatient Cardiac Services
  Outpatient Procedures
  Rehabilitation Services
  Respiratory Care Services
  Sleep Studies
  Social Services
  Surgery

Overview of Project

Hospital Survey on Patient Safety Culture, August 2008 (Rural Patient Safety Culture Project – Stratis Health)

Our targeted areas based on the survey findings:

- Increase reporting on incidents and near misses
- Improve communication of changes made based on incidents and near misses

Overview of Project, continued

- Make reporting as easy as possible (hot line)
- Reward the reporters
- Provide monthly feedback on incidents and near misses reported, and what has been done to prevent errors (Prove it)
- Reward the readers
- Just Culture education for leaders

Results

Significant improvement in targeted areas of the Hospital Survey on Patient Safety Culture, October 2009

Barriers

- Departmental silos
- Just Culture is not just education… and educating once is not enough

If we did it again, we would …

- Do more work on Just Culture
- Do more team building between leaders of critical departments

Advice

- Look for opportunities to recognize and reward staff members who make safety suggestions—you can't celebrate too much!
- Prove it—every chance you get
- Make sure all involved leaders are on the same page
- Be patient…culture work takes a long time
- Never, never give up!

Contact Information

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Project questions

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StratisHealth

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