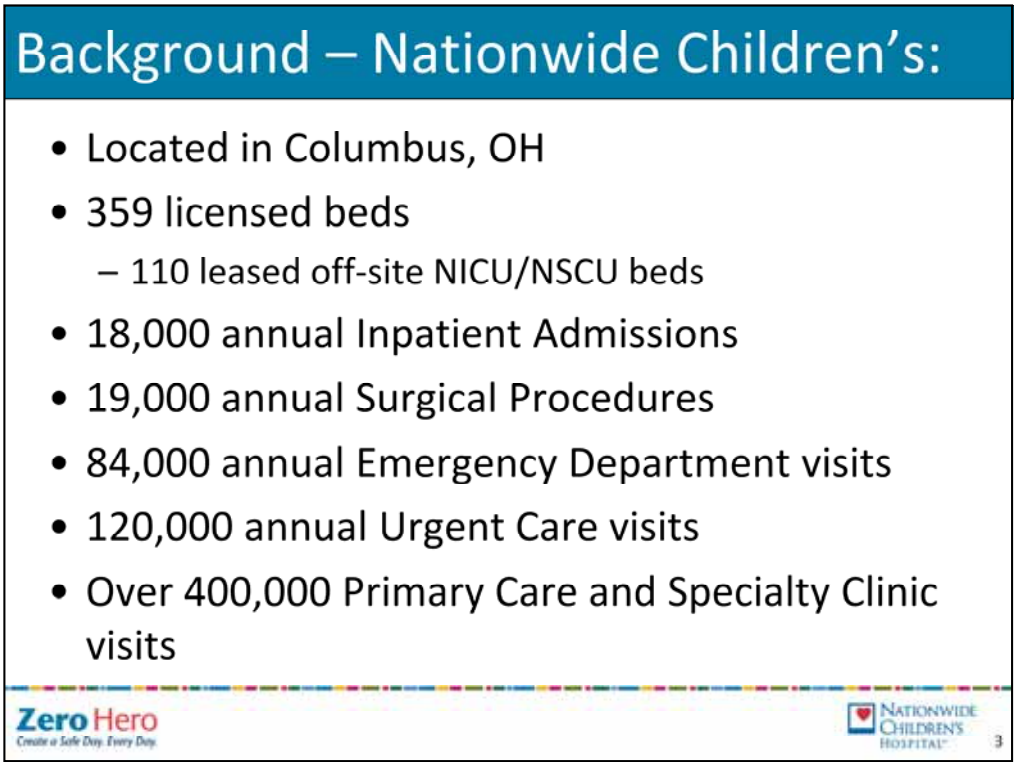
The Journey to Eliminating Preventable Harm

February 18, 2011

Cindy Hafer

Learning Objectives:

- Introduction to NCH's Preventable Harm Index
- Patient Safety Program
  - Low risk behaviors in a high risk environment
- The organizational benefit of 'branding' your patient safety program
- Describe several methods to create awareness and build momentum for a patient safety program

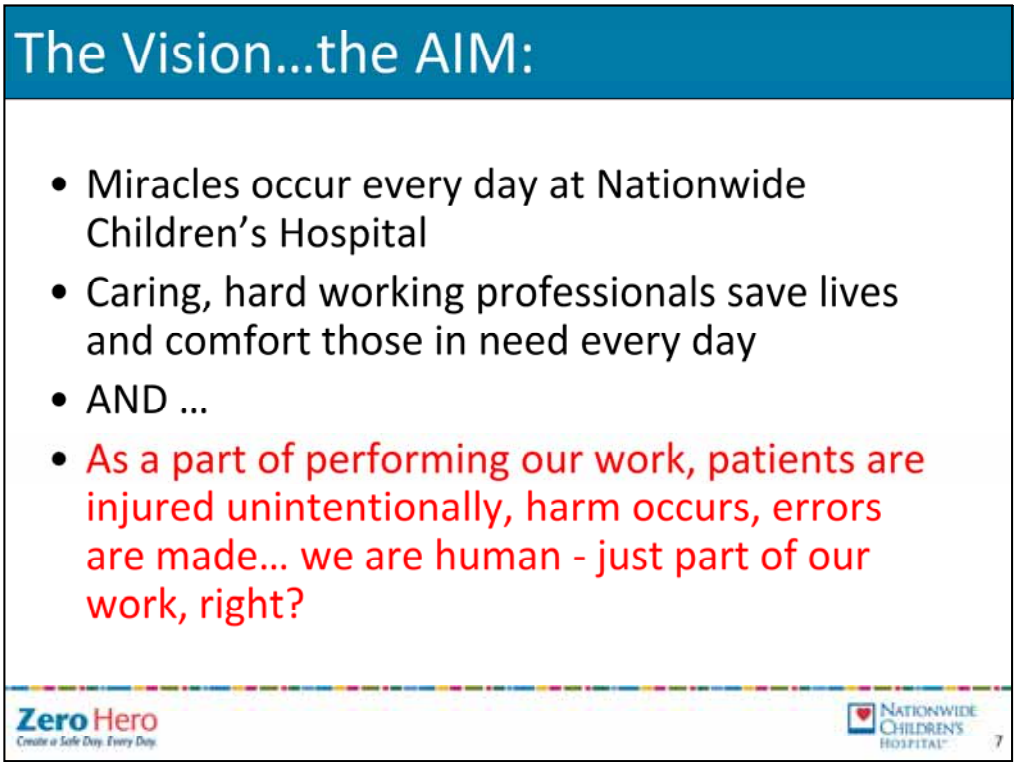


Background on NCH.

Picture of where NCH sits in relation to the city of Columbus.

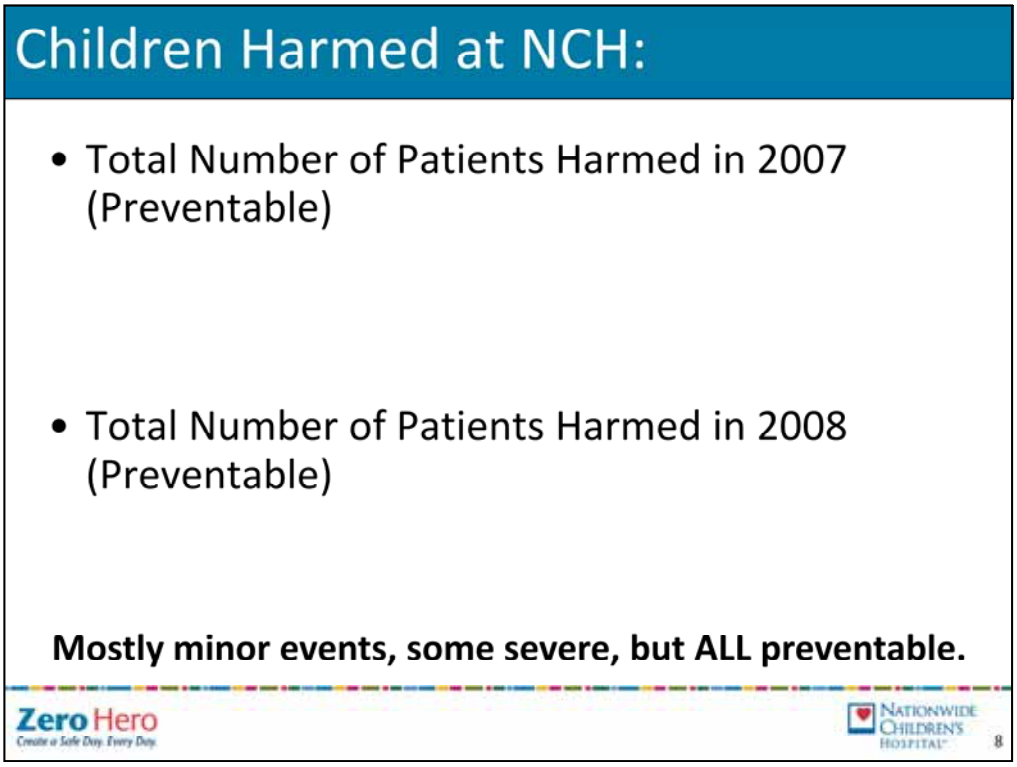
New replacement hospital being built with two floors opening in 2011 and the entire hospital opening in 2012.

NCH has many things to be proud of and as an organization, we strive on improving ourselves.

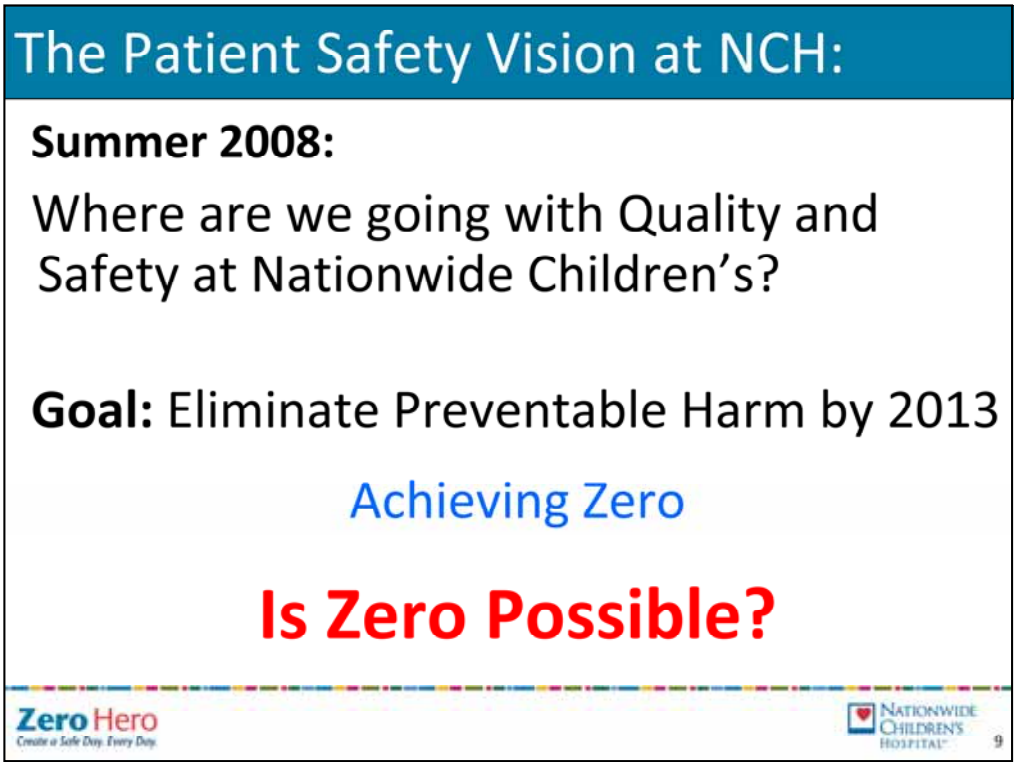


The Vision and Aim came from our Chief Medical Officer, Dr. Rich Brilli.

We care for almost 700,000 patients each year and during that time miracles occur and lives are saved by our caring and hard working staff members, but in the mix of things, patients are unintentionally harmed- does it come with the territory of being human, working in a high risk environment with high risk situations- just part of our job, right?



This slide represents how we were doing keeping our patients free from harm.



New CMO joined Nationwide Children's Hospital and the focus was not only on quality, but included patient safety. A goal was made; by 2013, there will be Zero Preventable Harm at NCH. Is Zero Possible? Do families and patients want to hear reduce harm or eliminate harm?

Zero is IMPOSSIBLE?

- Maybe ….Probably… no one has ever tried
- Is REDUCE what our families expect ?
- Is it OK to say to our families that a few preventable harm events or a few preventable deaths are acceptable, especially because it is hard to do
- By the very definition we are using, these events are preventable

What is "Preventable Harm"?

- Practical Definition:
  - Harm or Injury to a patient that could have been prevented by properly administering evidence based practices

- NCH Legal Definition

Nationwide Children's Hospital's Preventable Harm Index is a classification system designed to track similar occurrences with the goal to eliminate each class of occurrence. We have chosen to classify these occurrences as "harm" and "preventable" as a call to action for Children's healthcare community. It is designed to change the thinking that these occurrences are expected complications and, to instead, see them as a challenge that we need to work to reduce and to ultimately eliminate. Designation of "Preventable Harm" does not mean the occurrence in question was necessarily preventable at the time, which is often impossible to determine. We, instead, focus on the opportunity to improve patient care and, therefore, define harm as "preventable" in order to create the opportunity to eliminate classes of "harm" and get to ZERO.

Preventable Harm (PHI):

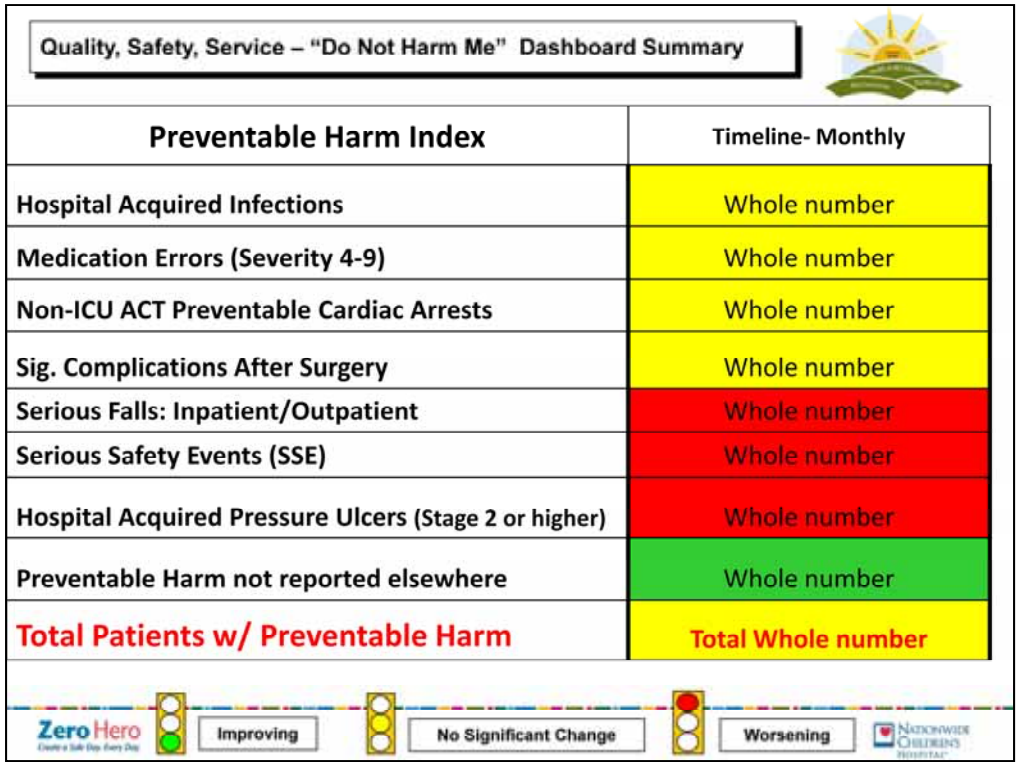
- Why the need for the legal definition?
  - The word PREVENTABLE!!
  - Potentially public information
  - Need to protect institution from inadvertent "admission of causation" that could be used in a litigation
  - Reference to a "class of occurrences" which can *potentially* be eliminated
  - **We** still struggle with these barriers to full transparency

Preventable Harm Index (PHI):

- PHI is designed to aggregate the total number of harm events
- Unlike rates, the PHI solely focuses on the numerator
- The PHI can be added up to a total number- unlike a rate
  - A number gives more meaning and makes it more personable- a child (daughter, son, grandson, niece, etc.)
  - Great motivator

Preventable Harm Index	2007	2008	2009	Q1 2010	Q2 2010	Q3 2010	Q4 2010	Jan 2011
Hospital Acquired Infections								
Medication Errors (Severity 4-9)								
Non-ICU ACT Preventable Cardiac Arrests								
Sig. Complications After Surgery								
Serious Falls: Inpatient/Outpatient								
Serious Safety Events (SSE)								
Hospital Acquired Pressure Ulcers (Stage 2 or higher)								
Preventable Harm not reported elsewhere								
Total Patients w/ Preventable Harm	sum	sum	sum	sum	sum	sum	sum	sum

This is NCH's Preventable Harm Index (PHI) that was developed by Dr. Richard Brilli.



At each board meeting, we update the board on how we are doing on reaching our goal of Zero by 2013.

The colors indicate how we are doing from quarter to quarter in that particular category:

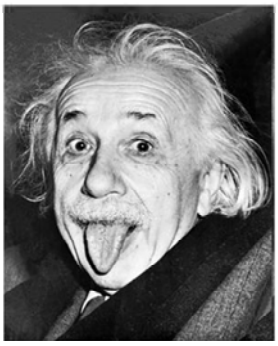
Red= worsening;

Yellow= No Significant Change;

Green= Improving

Unless you fundamentally change the system; you can expect the same results

Paraphrase - Don Berwick



"The definition of insanity is continuing to do the same thing over and over again & expecting a different result"

Albert Einstein (1879-1955)

Zero Hero
Create a Safe Day. Every Day.

Nationwide Children's Hospital

If we keep doing the same thing over and over then we can expect the same results over and over.

NCH's Journey to Creating a Patient Safety Culture:

- Partnered with a consulting Firm- HPI
- Conducted a diagnostic review on our data
- Determined the Individual and System failure modes associated with the events
  - Collectively selected low risk behavior tools- Zero Hero Essentials
- Created our Patient Safety Program- Zero Hero

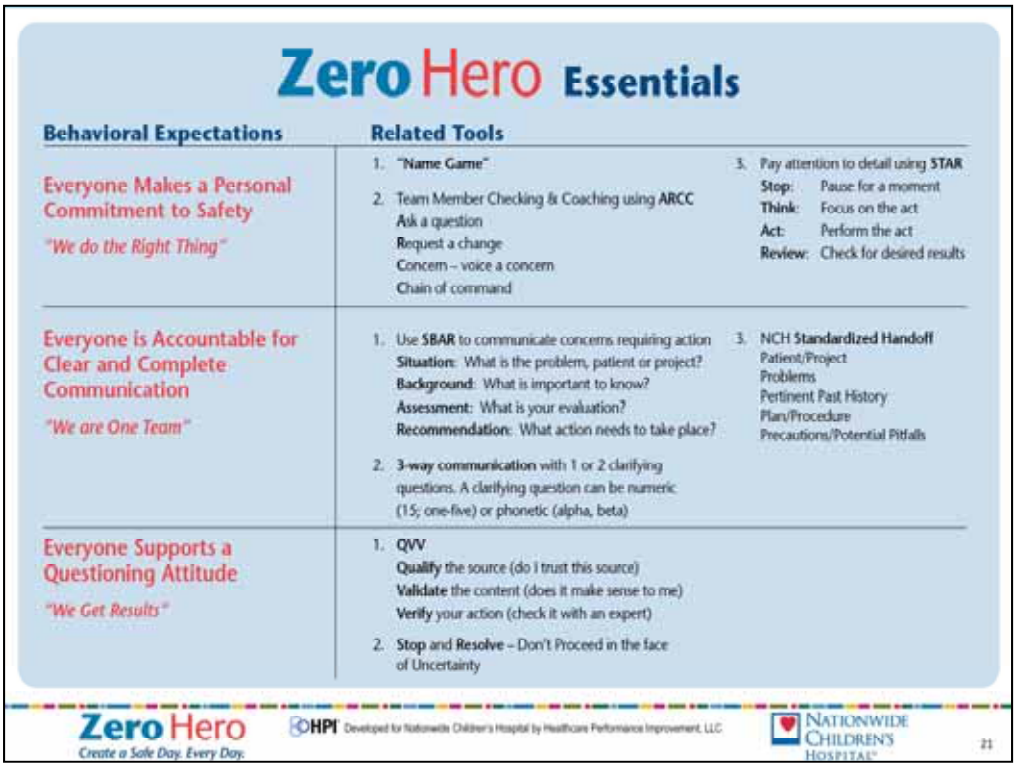
Zero Hero is our Patient Safety brand. Zero= Zero Preventable Harm by 2013. Hero= It will take an heroic effort by everyone, not just one person.

Achieving "Zero" Preventable Harm:

- Will be a heroic effort
- Is going to take EVERYONE
- Each of us must do our part to make EVERY DAY a SAFE DAY in our hospital
- We need to personalize this effort to Nationwide Children's Hospital

Zero Hero Training:

- All NCH employees attend training
  - Clinical and Non-Clinical
  - To date: 7,028 out of 7,200 have been trained
- Leaders in the organization attended 2 sets of training:
  - 1) Zero Hero: Basic Training
    - Made the case and taught the low risk behaviors and tools (Zero Hero Essentials)
  - 2) Zero Hero: Leadership Methods Training
    - Introduced ways to keep reinforcing the use of the Zero Hero Essentials- Rounding to Influence and 5:1 feedback



Safety Expectations and Error Prevention

This is the toolkit of patient safety behaviors adopted for the staff by a group of our peers. Recall that this toolkit was developed as the result of a study of human errors experienced by care providers, including physicians, at Nationwide Children's Hospital. Each expected safety behavior has one or more simple error prevention techniques that can be used to meet the expectation and reduce the likelihood of human errors. The behaviors are aligned with the organization's Mission: We Do the Right Thing – We Are One Team – We Get Results.

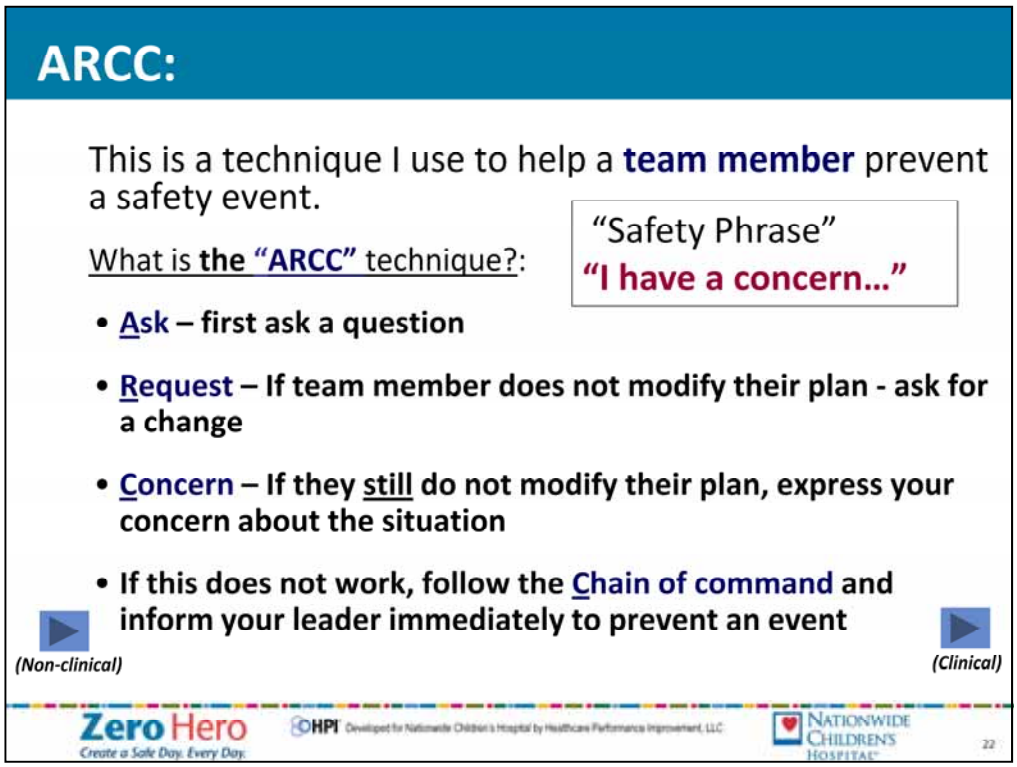
EXPECTATIONS → **TECHNIQUES**

What are Behavior-Based Expectations (BBEs)?

Behavior-based or behavioral expectations are the manner of conducting oneself that are considered to be reasonable, necessary, bound in duty or obligated. We are expected to meet certain defined standards and conduct our work in a specific manner. For example, a nurse and physician should be expected to communicate clearly and maintain a cooperative culture in the care of a patient.

What are Error Prevention Techniques?

An error prevention technique is a specific action or method an individual completes or uses to accomplish or satisfy a desired behavior-based expectation. For example, if an organization establishes a behavioral expectation regarding "clear communication", techniques such as "repeat-back communications", "asking clarifying questions, or using "phonetic alphabet" there is a higher probability that individuals will meet an expectation of "clear communication."



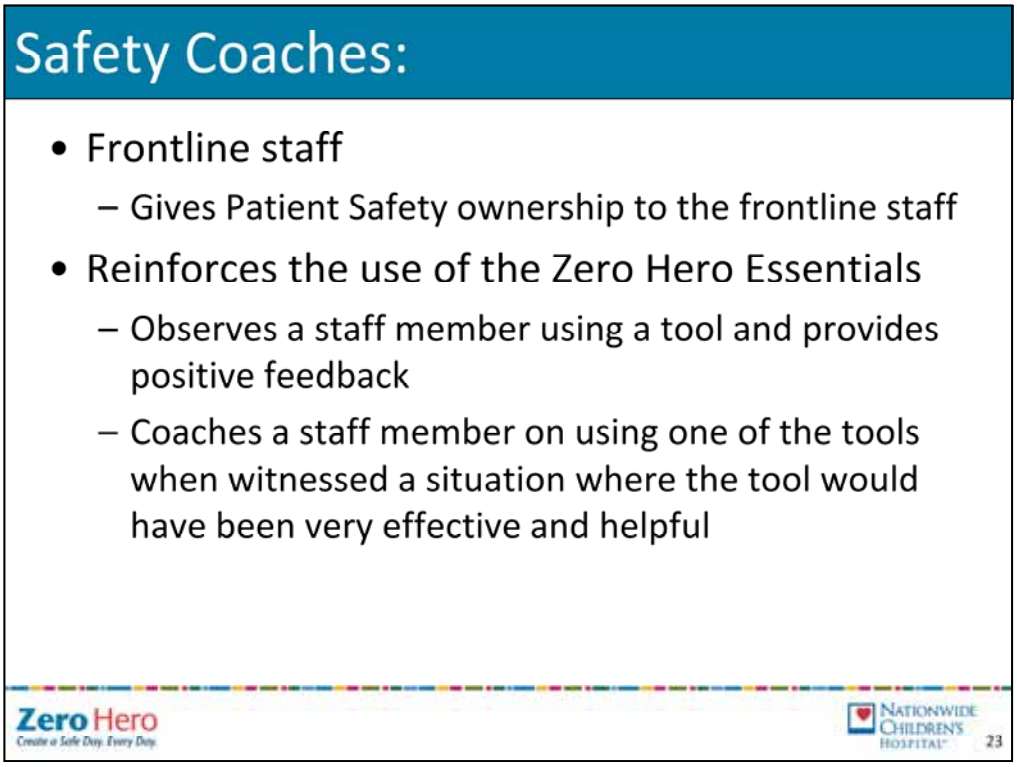
ARCC:
The technique is intended to start with an earnest question and progressively increase in assertiveness until the condition prompting the question is resolved to the satisfaction of all. The idea behind the technique is to avoid coming on too strong when a simple question would have sufficed.

Whenever any team member thinks that the apparent plan of action is not the best for the situation, **anyone present** should ask the question. This is called hint and hope. If we hint, then maybe others will recognize the problem and resolve the problem without any further effort on our part.

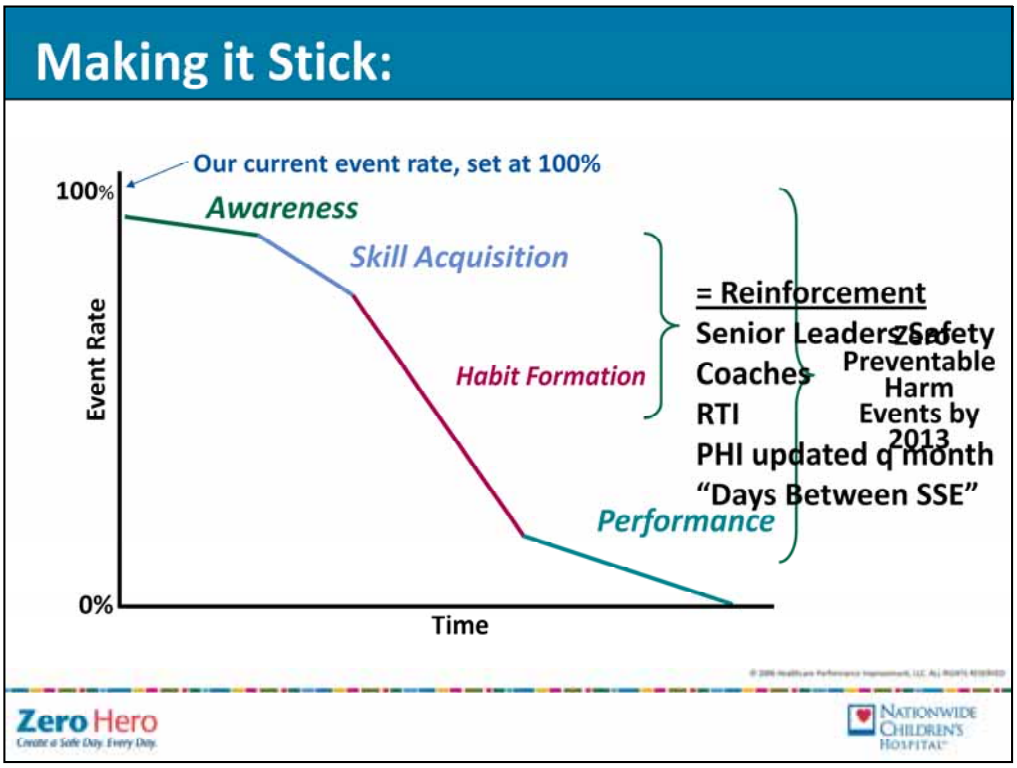
If you hint and they do not recognize the problem or continue on the present plan, then be more direct by advocating for a change to the plan and quickly explaining why.

If they still do not recognize the problem or continue on the present plan, then become even more direct by asserting the safe plan of action. When voicing a concern, use the official "safe word" for Nationwide Children's is "**concern**." State "**I have a concern**" or "**I am concerned with**…"

Hearing the safe word, we should all stop and resolve the concern, unless an emergency situation requires us to order them to proceed. If we do not resolve the concern by changing our plan of action or educating the others on the efficacy of our plan, the person voicing the concern will likely contact medical and/or administrative chain of command.



Safety Coaches were introduced for a couple of reasons: 1) to give ownership of the Patient Safety Program to our frontline staff and 2) To help reinforce the use of the Zero Hero Essentials.



One of the most important things for you to take away from this presentation is that our safety initiative does not end with this training session! Remember that our initiative is all about practicing new behaviors that will help prevent us from making errors – AND making those behaviors become our habits. Errors and harmful events will continue to happen if we do not make this initiative stick.

This graph shows the stages of an effective error prevention program:

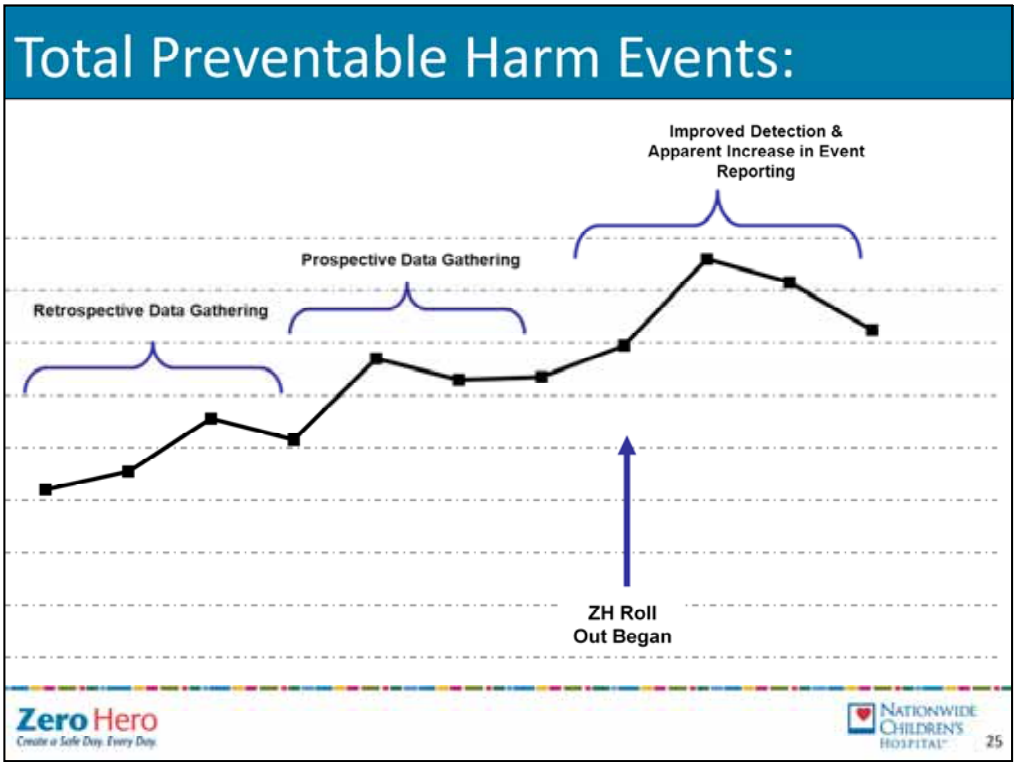
•**Awareness** – That's what our training session is all about; we're educating you on our behavior expectations and tools for error prevention. But as you can see on the graph, awareness will drop our event rate only a small amount.

•**Skill Acquisition** – When we leave this training session, we'll begin to practice our behaviors and use our error prevention tools. We won't have it down perfectly – sometimes we'll forget, and we may apply a technique incorrectly every once in a while. During this phase we'll be counting on leaders and team members to reinforce our behavior expectations and help build our accountability for practicing them.

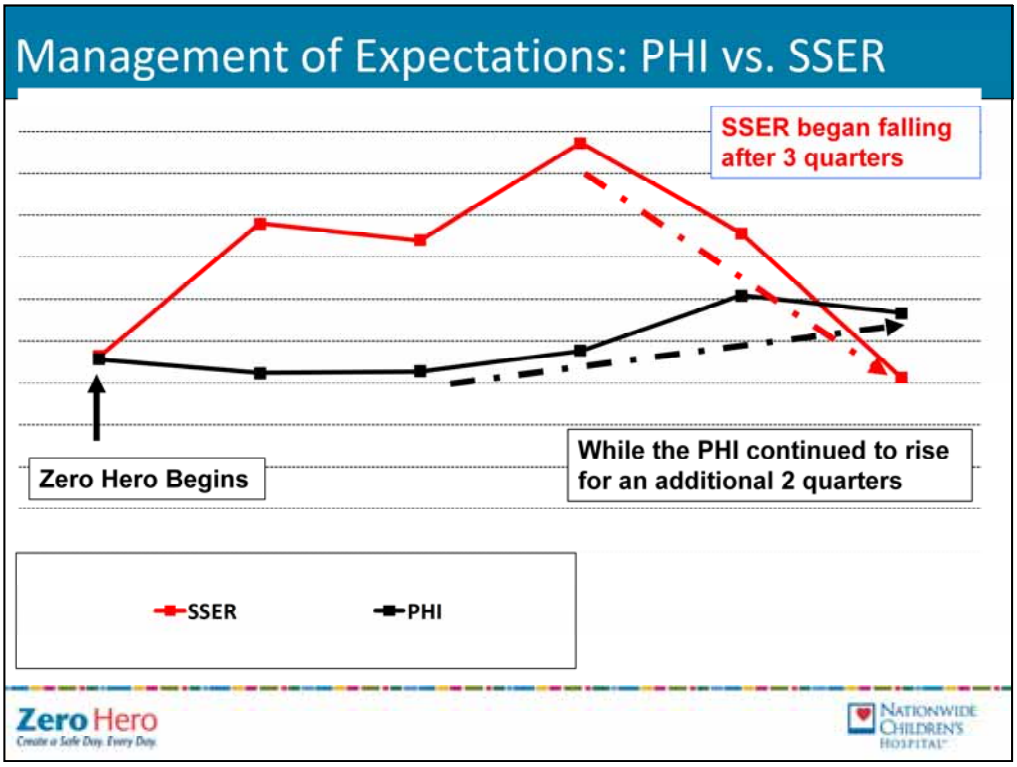
•**Habit Formation** – "Practice makes…habits!" At first, we'll have to consciously remember to practice our expected safety behaviors and error prevention techniques. But over time, they will indeed become our work habits. Most likely, you'll find yourself practicing them at home, too, and you'll see a reduction in the errors that you make outside of work. Our goal is to make these best practices become our common practices.

•**Performance** – As our expected safety behaviors become our common practice, we will begin to see a reduction in the number of errors we make as individuals and in the number of events that occur at our hospital.

EVERYONE CAN BE A ZERO HERO!



In 2008 monitoring was taking place, but it was more retrospectively. Moving into 2009, monitoring and data increased with new methods put in place. However, in the 4th quarter of 2009 Zero Hero began and improved detections were put in place along with awareness. Employee reporting increased once Zero Hero training began, employees realized the importance of reporting near misses (errors that were made, but didn't reach the patient). Before Zero Hero, the Employee Reporting System received, on average, 300 reports month by employees, it reached its all time high in 2010 with an average of 600 each month.



The Serious Safety Event Rate is the number of events classified as “serious” calculated as a rolling 12-month average expressed per 10,000 adjusted patient days (see red trend line).

This trend line has had dips and increases – factors that may have influenced this include:

•Increased transparency and reporting (increases)

•Targeted performance improvement activities (e.g,. Insulin Taskforce, others)

However, the PHI was rising while he SSER was falling. This is due to increased reporting and better data collection by staff members.

Zero Hero
Create a Safe Day. Every Day.

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Zero Hero
Create a Safe Day. Every Day.

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What is a Zero Hero – It is you and me !!

Zero Hero
Create a Safe Day. Every Day.

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Benefits of a Galvanizing Brand:

- Creates positive energy around the program
- Supports consistency in messages and appearance
- Enhances staff awareness and recognition of safety information
- Gets' the staff's attention!

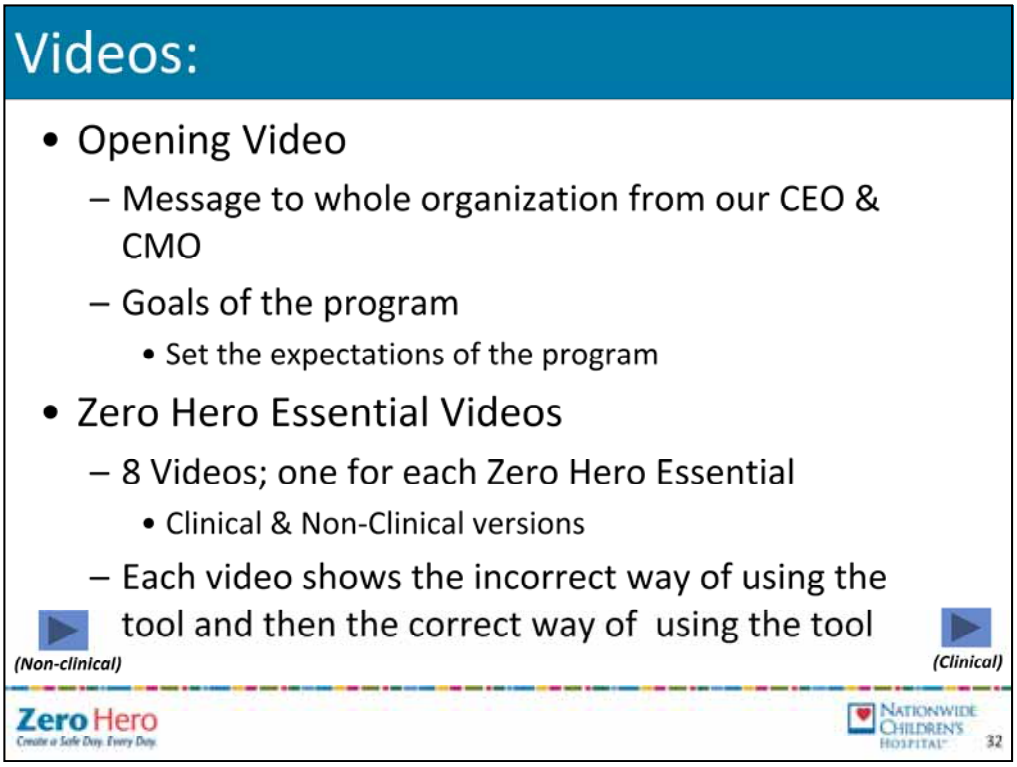
The 'Buzz' of the Brand:

- "It's a heroic effort"
- "be a zero hero"
- "that's a zero hero moment!"
- "It takes all of us to be a zero hero to get to zero!"
- "I get it…zero hero talking"

Communication- Images:

- Training Material
  - Zero Hero- Trainers
  - Basic Zero Hero Training- Leaders & Staff
  - Zero Hero Training- Leadership Methods
  - Safety Coach Training
  - Zero Hero Essentials- Reference Cards
- Messaging
  - Communication Templates
- Memorabilia
  - Buttons
  - T-shirts
  - Lapel pins
- Distraction Free Zone

This is a list of reinforcements we put into place at NCH.



To help drive home the message to the staff members, we created several videos. The first one that we show during training is a message from our CEO and CMO illustrating the importance of this training. The other videos are of the tools we ask our employees to practice to reduce the chance of making an error in a high risk environment. Each tool has a clinical and non-clinical version.

Electronic Support:

- Internal Patient Safety Website- Zero Hero
  - Preventable Harm Index
  - Unit Specific Quality and Safety Data
  - Tools and Resources

NATIONWIDE CHILDREN'S HOSPITAL
INTRANET
Search Intranet
SEARCH
Hospital Websites
Departments
Education
Patient Care
Employee Interests
Forms
Home
Contact Information
Contact us
Good Catch Stories
Recent Stories
Lessons Learned
Recent Lessons Learned
Quality & Safety at NCH
Complications of Surgery
Hospital Acquired Infections
Hospital Acquired Pressure Ulcers
Medication Errors
Non-ICU Cardiac Arrests
Preventable Harm not Reported Elsewhere
Serious Falls
Serious Safety Events
Safety Focus Guide
Recent Safety Focus Guide
Zero Hero Support
Leadership
Safety Coaches
Zero Hero Training
Completed List
Leadership Training
Staff Training
Training Material
Documents
Good Catch Story
High Risk Situation
Lessons Learned
Safety Focus
Training Material
Zero Hero Support
All Documents
Bulletin Board
Give Feedback
Search this site:
Go
Zero Hero
Days since last Serious Safety Event
Zero Hero training for Staff started 1 year ago today! Take a look at what we have accomplished in the past year!
6,500 staff members have been trained and as an organization, there are roughly 7,600 employees.
When training started, on average Nationwide Children's Hospital was experiencing a Serious Safety Event every days we are now at an average of every days!
The Employee Reporting System (ERS) increased from 400 incidents reported each month to over 600 each month!
Distraction Free Zones have been implemented
There are over 250 Safety Coaches!
It has been a busy year! Thank you for doing your part in Creating a Safe Day, Every Day.
Three Specific High Risk Situations at NCH for Medication Errors
As part of NCH quality processes and with some of our more complex medication errors, a team of our experts very rapidly huddle with the involved staff and unit leadership to review the event in detail while it is fresh in everyone's mind. While the numbers of analyses are still small, some themes may be emerging, suggesting that there are three situations where staff should be EXTRA CAUTIOUS-
click here to keep reading.
Safety Lessons
A patient in a busy patient care area needed fresh frozen plasma urgently and
Safety Focus Guides
The SFs is Nationwide Children's Hospital's standardized handoff. Click the link below to see additional information about the
Good Catch Story!
Stories from our Safety Coaches!
Coached a physician on

Electronic Support (cont'd):

- Electronic Documentation Site
  - Safety Coaches
    - Safety Coach Engagements
    - Good Catch Stories
  - Managers
    - Rounding To Influence
  - Activity Reports- all employees can pull

Zero Hero Documentation Site
HOME
SEARCH
REPORTS
FAQS
MANAGER
ADMIN
LOG OUT
Welcome to the Zero Hero Documentation Site
Select the Department from the drop down list and then click on the Data Entry button to start the documentation of your engagement. To pull an engagement Report, select the department and then click on the Report button.
Safety Coach Engagements
Safety Coach Engagements
--Select--
--Select--
Inpatient
3AE
3TN
3TS
4AE
4AW
4TN
4TS
5AE
5AW
6AE
6AW
C4
C5
CTICU
J5
NICU
NICU A2
NICU Riverside RMH
NSCU Doctors DHW
NSCU Dublin
NSCU Grant GMC
OR
Other
PACU
Zero Hero
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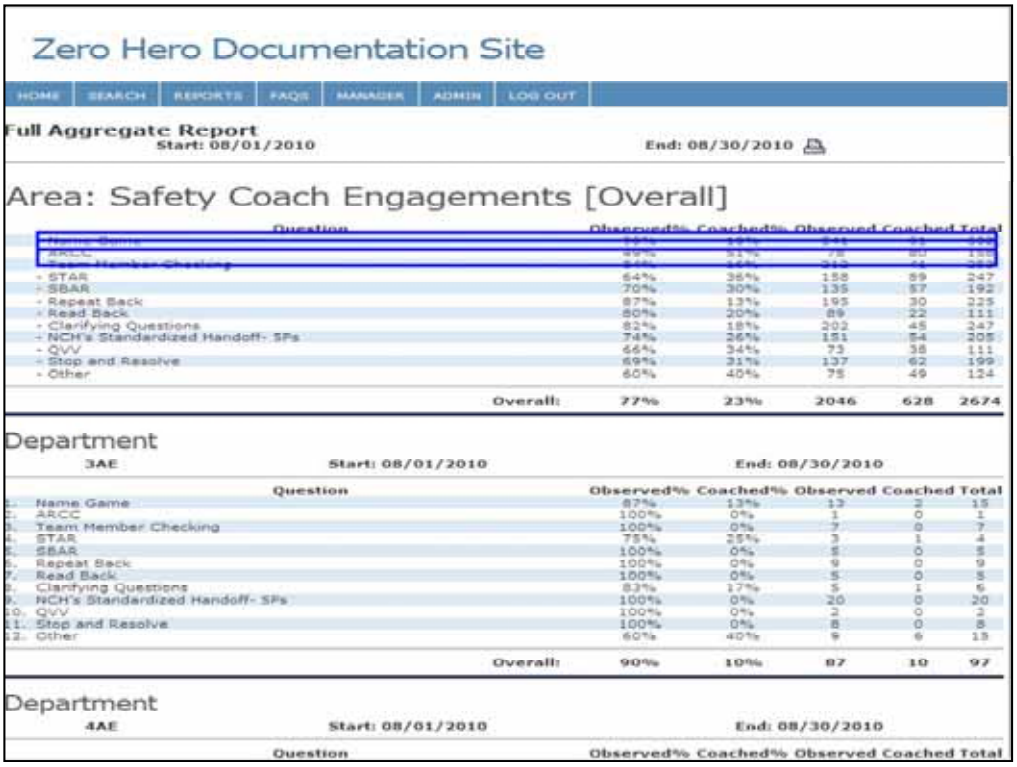
2010 Nationwide Children's Hospital



Zero Hero Documentation Site

HOME | SEARCH | REPORTS | FAQS | MANAGER | ADMIN | LOG OUT

Full Aggregate Report
Start: 08/01/2010 End: 08/30/2010

Area: Safety Coach Engagements [Overall]

Question	Observed%	Coached%	Observed	Coached	Total
- Name Game	82%	18%	543	61	604
- ARCC	69%	31%	73	60	133
- Team Member Checking	84%	16%	213	41	254
- STAR	64%	36%	158	89	247
- SBAR	70%	30%	135	57	192
- Repeat Back	87%	13%	195	30	225
- Read Back	80%	20%	89	22	111
- Clarifying Questions	82%	18%	202	45	247
- NCH's Standardized Handoff- SPs	74%	26%	151	54	205
- QVV	66%	34%	73	38	111
- Stop and Resolve	69%	31%	137	62	199
- Other	60%	40%	75	49	124
Overall:	77%	23%	2046	628	2674

Department

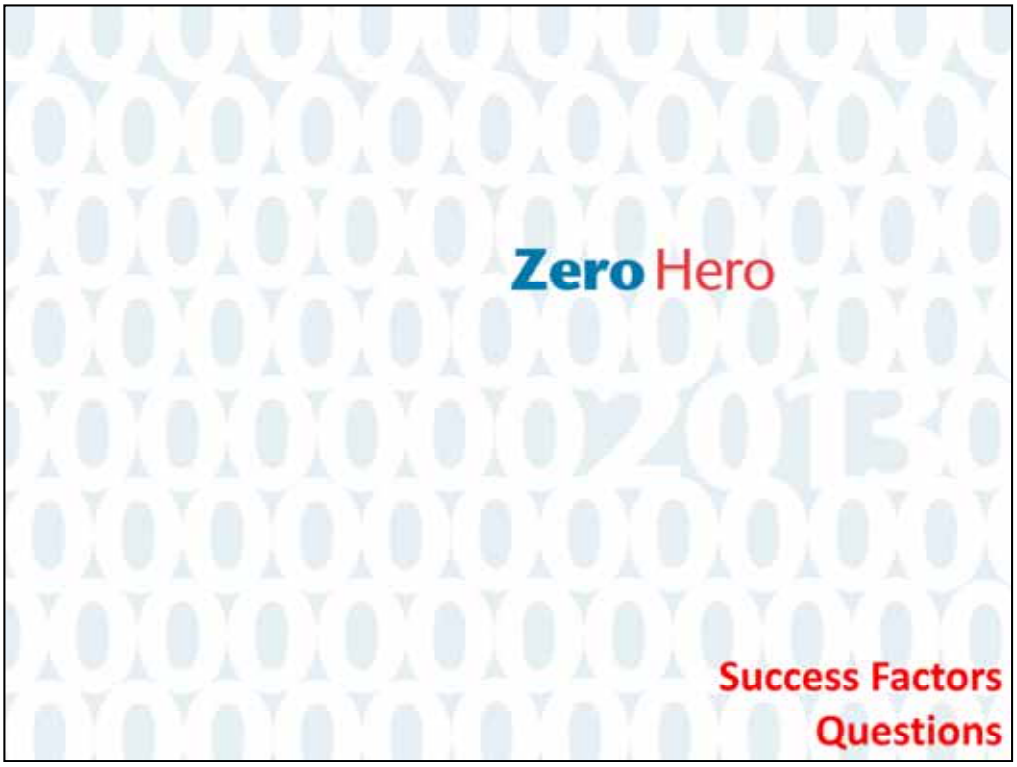
3AE Start: 08/01/2010 End: 08/30/2010

Question	Observed%	Coached%	Observed	Coached	Total
1. Name Game	87%	13%	13	2	15
2. ARCC	100%	0%	1	0	1
3. Team Member Checking	100%	0%	7	0	7
4. STAR	75%	25%	3	1	4
5. SBAR	100%	0%	5	0	5
6. Repeat Back	100%	0%	9	0	9
7. Read Back	100%	0%	5	0	5
8. Clarifying Questions	83%	17%	5	1	6
9. NCH's Standardized Handoff- SPs	100%	0%	20	0	20
10. QVV	100%	0%	2	0	2
11. Stop and Resolve	100%	0%	8	0	8
12. Other	60%	40%	9	6	15
Overall:	90%	10%	87	10	97

Department

4AE Start: 08/01/2010 End: 08/30/2010

Question	Observed%	Coached%	Observed	Coached	Total


Zero Hero
Success Factors
Questions

Critical Success Factors:

- Can add PHI numbers of various hospitals together to create a regional PHI
- No need for common definitions if:
  - Definitions are internally consistent over time
  - Target is zero
- Create a Patient Safety Program and have Leadership Support
- Select a logo and by-line that support your organization's vision, is simple to remember, and energizes staff
  - Consistently apply the logo and by-line to all information on the safety program
- Use humor and heart-string stories/videos where you can!

Thank You!

Preventable Harm Definition

Nationwide Children's Hospital's Preventable Harm Index is a classification system designed to track similar occurrences with the goal to eliminate each class of occurrence. We have chosen to classify these occurrences as "harm" and "preventable" as a call to action for Children's healthcare community. It is designed to change the thinking that these occurrences are expected complications and, to instead, see them as a challenge that we need to work to reduce and to ultimately eliminate. Designation of "Preventable Harm" does not mean the occurrence in question was necessarily preventable at the time, which is often impossible to determine. We, instead, focus on the opportunity to improve patient care and, therefore, define harm as "preventable" in order to create the opportunity to eliminate classes of "harm" and get to ZERO.

Serious Safety Event

The designation of a Serious Safety Event (SSE) is not an analysis, a determination, an admission, or even a suggestion, that any healthcare provider was negligent or deviated from the applicable "standard of care" as that term is defined under Ohio law governing medical claims, or that the healthcare provider's conduct in any way caused or contributed to legally cognizable damages. Rather, designation of a particular event/condition as an SSE means that the Hospital has determined that the event/condition is one that may be amenable to reduction and/or elimination through the implementation of additional interventions, actions, and/or related quality improvement initiatives. The qualification of an event as a "serious safety event" is based upon a retrospective review of the event and its potential to be instructive in improving the quality of healthcare services provided at the Hospital with the aspiration that steps may be taken to prevent the same or similar events in the future.