Safety Across the Board (SAB)

From Concept to Practice

Hospital Improvement Innovation Networks (HIINs)

Over 4,000 of our nation's hospitals have joined the Centers for Medicare & Medicaid Services (CMS) through a Hospital Improvement Innovation Network (HIIN) to create <u>safer hospitals and health systems.</u>

<u>Conceptual Definition of Safety Across the Board</u>:
*Building the Capacity for Safe, Reliable Care.
Keeping Patients, Family/Caregivers, and the
Workforce–Free From Harm.*

"Harm" as Defined by CMS:
"An injury, either temporary or permanent, that is the result of the patient's care, not their disease"

The Safety Across the Board approach has evolved since its inception, and this resource will provide conceptual context in understanding and organizing your organization's approach to implementing tactics and processes toward achieving *Safety Across the Board*.

Contents within this SAB Resource:

- Safety Across the Board (SAB) Overview
- Safety Across the Board (SAB) Framework, Key Imperatives, & Processes
- Safety Across the Board (SAB) Hospital/Health System Case Studies (From Concept to Process)
- Safety Across the Board (SAB) Related Resources, Models, & Approaches

To learn more about the Hospital Improvement Innovation Networks (HIINs), click here.

Resource maintained and updated by the HIIN SAB Affinity Group (see version control noted in the footer).

Evolution of Hospital Improvement Innovation Networks (HIINs) & Safety Across the Board:
- ❖ 2011 – 2014: Over 3,700 Hospitals involved with Hospital Engagement Networks (HENs)
- ❖ 2016 – 2019: Over 4,000 Hospitals involved with Hospital Improvement Innovation Networks (HIINs)

HIIN Areas of Focus:

Making Care Safer (Decrease Harm):

- Adverse Drug Events (ADE) Opioid Safety, Anticoagulation Safety, and Glycemic Management
- Central Line-Associated Blood Stream Infections (CLABSI)
- Catheter-Associated Urinary Tract Infections (CAUTI)
- *Clostridium difficile (C. diff)* including Antibiotic Stewardship
- Injuries from Falls and Immobility
- Pressure Ulcers/Injuries
- Sepsis and Septic Shock
- Surgical Site Infections (SSI)
- Venous Thromboembolism (VTE)
- Ventilator-Associated Events (VAE), to include Infection-Related Ventilator-Associated Complication (IVAC) and Ventilator-Associated Condition (VAC), and Possible VAP (PVAP)

> **HIIN Goals:**
> - Reduce Harm
> - Reduce Readmissions

> *Achieving __Safety Across the Board__ is the ability to use a broad and systematic approach to __reduce and prevent ALL patient harm__ --- which is the cornerstone of every hospital and health system.*

Improving Care Transitions:

- Reduce Avoidable Readmissions (Decrease Readmissions)

Additional Harm Areas to Consider:

- ➢ Multi-Drug Resistant Organisms (e.g. VRE, CRE, MRSA, etc.)
- ➢ Diagnostic Errors
- ➢ Addressing Malnutrition in the Inpatient Setting
- ➢ Airway Safety
- ➢ Iatrogenic Delirium
- ➢ Undue Exposure to Radiation
- ➢ Hospital Culture of Safety
- ➢ Pediatric Safety
- ➢ Surgical Safety
- ➢ Iatrogenic Pneumothorax
- ➢ Worker/Hospital Safety (Falls, violence, back injuries, worker compensation)
- ➢ Peripheral IV Infiltration or Extravasation
- ➢ Unplanned Extubations
- ➢ Obstetrical Harm
- ➢ Hand Hygiene
- ➢ Workforce Immunizations
- ➢ Behavioral Health
- ➢ Opioids
- ➢ Worker Safety
- ➢ Resilience

The framework for SAB involves three key imperatives: Culture, Strong Safety Processes and Engagement. Simultaneous execution of these three imperatives assists with keeping patients, family/caregivers and the workforce, free from harm.

Measuring Safety Across the Board (SAB):

As noted in the hospital case studies within this resource, measuring Safety Across the Board (SAB) is not prescriptive.

Regardless of what and how an organization measures SAB, the intent is to make safety (zero harm to patients, family/caregivers, and the workforce) --- a core value and mission of everyone in the organization.

Safety Across the Board:

- Moral responsibility for safety in hospitals and health systems
- Vital to organizational sustainability
- Enhances accountability & transparency for value based transformation

Three Imperatives to Operationalizing Safety Across the Board
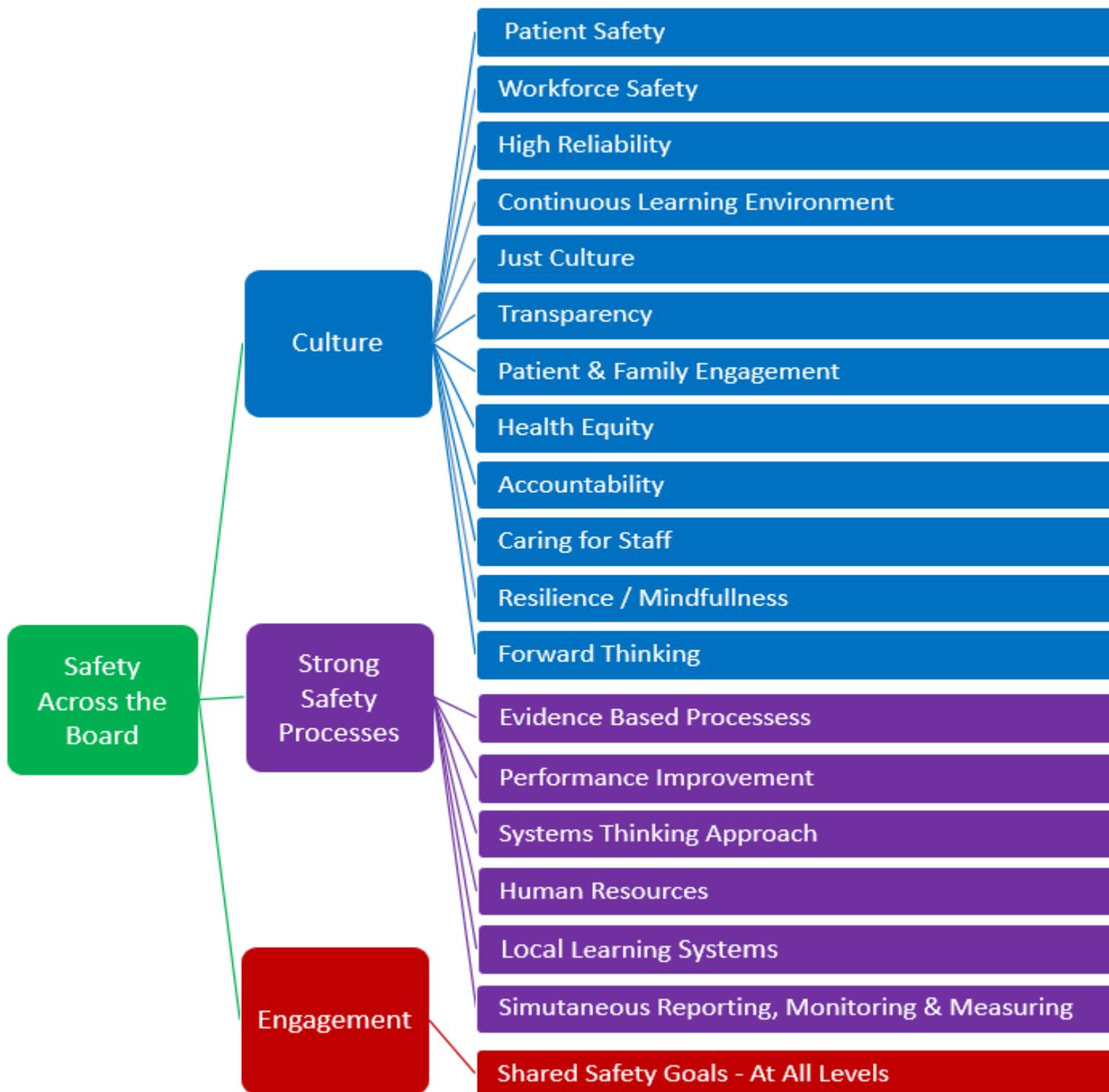
Culture

Strong Safety Processes

Engagement

Safety Across the Board: Building the Capacity for Safe, Reliable Care. Keeping Patients, Family & Caregivers, and the Workforce–Free From Harm.

Safety Across the Board (SAB) – Driver Diagram

Aim/Goal

Primary Drivers
High Level Factors Needed to Achieve the Aim

Secondary Drivers
Interventions/Process Changes Necessary to Achieve the Primary Drivers

Safety Across the Board

Culture
- Patient Safety
- Workforce Safety
- High Reliability
- Continuous Learning Environment
- Just Culture
- Transparency
- Patient & Family Engagement
- Health Equity
- Accountability
- Caring for Staff
- Resilience / Mindfullness
- Forward Thinking

Strong Safety Processes
- Evidence Based Processess
- Performance Improvement
- Systems Thinking Approach
- Human Resources
- Local Learning Systems
- Simutaneous Reporting, Monitoring & Measuring

Engagement
- Shared Safety Goals - At All Levels

Successful achievement of SAB results from operationalizing the three imperatives. Each imperative has several key components, as well as associated tactics to consider for implementation in order to move from concept to process.

Imperative	Components	Tactics to Consider (From Concept to Process)
Culture	Patient Safety	- Routine purposeful leadership rounding on units - Daily Leadership safety huddles/calls - Multi-disciplinary team hand-offs/bedside report (to include patient and family engagement) - Identification of harm (communicate and educate what harms are, streamlined process to report harms or near misses) - Increase the capacity to identify, address, monitor and evaluate multiple/all harms (create dashboards) - Relentless/constant messaging of safety (weekly or monthly harm newsletters, unit-based harm dashboards, transparent websites or hallway posters)
Culture	Workforce Safety	- Prioritize, measure, and take action toward workforce-related harms (message that the workforce must always feel/be safe) - Accountability and leadership/executive support of a safety culture (leadership models safety behavior and "walks the talk", enforces civility and accountability to openly and safely report and address concerns)
Culture	High Reliability	- Preoccupation with Failure (entire organization has a persistent heightened sense of potential failures, near misses, harms) - Reluctance to Simplify (reducing variation and understanding the complexity of the environment) - Sensitivity to Operations (situational awareness of the current state that may threaten patient safety) - Deference to Expertise (deferring expertise and feedback from workforce who are closest to the work and local—removing hierarchy to increase learning and promote safety) - Commitment to Resilience (continuously performing rapid assessments to identify and mitigate current and future safety threats)
Culture	Continuous Learning Environment	- Spread harm/safety learnings from one unit to another—throughout the organization - Learnings can be from near misses and shouldn't rely only on serious safety events - Learnings can be done through Root Cause Analysis (RCA), Failure Modes Effective Analysis (FMEA), Plan Do Study Act (PDSA) cycles, etc.
Culture	Just Culture (non-punitive)	- Increase reporting of patient harms/near misses/mistakes (make reporting transparent and non-punitive, good catch celebrations), move from secrecy to transparency - Support a proactive learning environment/culture with the understanding that humans make errors - Events are seen as opportunities to learn how to strengthen the system
Culture	Transparency	- Public display of harms (websites, community forums, hallway posters) - Frontline/provider communication of harms (i.e.: monthly feedback loops of harms to Nursing Units, Medical Executive Committee, Patient Safety Committee, Nursing Practice Committee, etc.) - Transparency of harm reports to C-Suite and Board

Imperative	Components	Tactics to Consider (From Concept to Process)
Culture	Patient and Family Engagement (PFE)	• Engaging patients and families at the bedside to ensure consistency in clinical practices (e.g. shift change huddles, bedside rounding, etc.), in organizational policy and protocol design and in organizational governance • PfP Strategic Vision Roadmap for Person and Family Engagement (PFE) https://www.healthcarecommunities.org/ResourceCenter/PartnershipforPatientsLibrary.aspx?CategoryID=836894&EntryID=107862 • Roadmap for PFE in Healthcare: https://patientfamilyengagement.org/
Culture	Health Equity	• Including health equity to inform quality efforts: Stratify/analyze harms by Race, Ethnicity, and Language (REAL) and/or other social/demographic factors (age, education, migrant status, income, etc.) to understand and be able to act on potential disparities in harm (i.e.: are more harms happening to limited-English Proficiency patients?) • Address rural health inequities (i.e.: lack of transportation, lack of providers, etc.) • Address access to care (insurance access) and affordability of needed medications within vulnerable populations served
Culture	Accountability	• Monitoring harm (composite/dashboards) • Link department harms to performance evaluations • Patient safety is everyone's responsibility (leadership to the frontline) • Hold providers accountable for organizational safety
Culture	Caring for Staff (Creating Joy)	• Address issues that lead to burnout, reduce burden, remove barriers, ask what can be done better • Engage staff to share ideas so they are part of the solutions • Support your workforce and create environments that increase fellowship and team building • Acknowledge and celebrate workforce success • Eliminate negative influences • Create a fun atmosphere; use humor (when appropriate) to create laughter and joy • Lead by example, be human and approachable as a leader; when staff are engaged and joyful, they are more motivated and productive
Culture	Resilience/ Mindfulness	• Increase the ability of your workforce to be self-aware and cope with adversity on the job by increasing the availability of organizational resources related to health and well-being—promoting the capacity to successfully endure stressors of the work environment and bounce back (team building, work life balance, relaxation, exercise, sleep, etc.) • [Resource: National Academy of Medicine Action Collaborative on Clinician Well-Being and Resilience https://nam.edu/initiatives/clinician-resilience-and-well-being/] • Promote compassion, relationships, caring for others, positive language, good listening, social support and cohesion, praise and appreciation
Culture	Forward Thinking	• Keep a pulse on future potential harm areas by mining data and mining literature

Imperative	Components	Tactics to Consider (From Concept to Process)
Strong Safety Processes	Evidence Based Processes	▪ Ensure inclusion of evidence-based practices (bundles, etc.)
Strong Safety Processes	Performance Improvement	▪ Performance improvement training for leadership, staff and providers (Model for Improvement, Plan Do Study Act, LEAN, Six Sigma, etc.)
Strong Safety Processes	Systems Thinking Approach	▪ Utilization of technology electronic triggers (alerts/triggers to identify/monitor all cause harms) ▪ Formal organizational performance improvement strategy (a formal way the organization will approach identified harm trends; project charter, etc.) from the frontline to the Board
Strong Safety Processes	Human Resources (HR)	▪ Ensure Human Resources (HR) has a prime role/process in quality/safety/behavioral standards/expectations (annual evaluations, competency, reward systems, hiring and firing) ▪ HR communicates that patient safety is an expectation of employment and everyone's responsibility
Strong Safety Processes	Local Learning Systems	▪ Systemically spread learnings from huddles, etc. ▪ Timely/appropriate safety training on an ongoing basis ▪ Utilization of unit-based safety tools/resources ▪ Support the frontline manager's development in safety/quality (day-to-day culture responses) ▪ How to be a coach (training) ▪ How to be a mentor (training) ▪ Team building training (frontline, to management, to C-Suite)
Strong Safety Processes	Simultaneous Reporting, Monitoring & Measuring	▪ To keep patients, family/caregivers and workforce free from harm ▪ To make safety (zero harm to patients, family/caregivers and workforce) a core value and mission of everyone in the organization
Engagement	Shared Safety Goals/Vision— at all levels	▪ Make patient safety a shared vision/goal by everyone in the organization ▪ Engage Leadership (C-Suite, Directors, Managers, and Providers); ensure they are championing harm reduction efforts ▪ Engage the Board in Safety/Quality Discussions (teach the board what harms are, teach the board performance improvement, use the numerator of harms to portray the number of persons harmed, in addition to the rates of harm) ▪ Engage Physician/Provider Champions (hold providers accountable to champion organizational safety and motivate laggards) ▪ Engage Nursing and Frontline Champions (hold nurses accountable to champion their unit safety) ▪ Engage and Develop Patient and Family Engagement Advisory Councils (PFACs); use PFACs to address organizational harm or ensure that the organization is aware of the importance of patient and family engagement ▪ Ensure there are patient representatives on the Board and PFACs are doing report-outs and the Board Meetings ▪ Ensure Board members attend PFAC meetings ▪ Ensure Board members are participating in organizational safety rounding

Imperative	Components	Tactics to Consider (From Concept to Process)
Engagement		▪ Creatively heighten the attention of harm in your organization by reframing the <u>rate of harms</u> to the <u>number (#)</u> of people harmed (i.e.: A rate of 0.2 can be displayed as 2 people of the last 10 people you cared for resulted in an adverse event--see page 9, White Plains Case Study as an example)

Continue to View Hospital/Health System Safety Across the Board (SAB) Case Studies

White Plains Hospital
Westchester County, NY
Montefiore Health Care System

New York State Partnership for Patients

Hospital Attributes:
- Non-Teaching Hospital
- Regional Stroke Center
- Cancer Care
- Orthopedic Program
- Level 3 Neonatal and Maternity Center
- Magnet Recognition
- Critical Care Beacon Award for Excellence
- Caregiver Support Program
- Numerous Cancer Recognition and Patient Experience Awards

Whole Harm Score Number is Composed of:
- NHSN
- CLABSI
- CAUTI
- VAP
- SSI (colon, hysterectomy, hips, knees)
- DVT
- PE – NPOA
- Hospital Acquired Injuries
- PSI
- PU Stage III and IV
- Iatrogenic Pneumo
- In Hospital Fall with Hip Fx (via Midas event reporting)
- Post op Sepsis
- Post op Wound Dehiscence
- Unrecognized Abdominopelvic Accidental Puncture or Laceration

Safety Across the Board---The Need:
- During the 2014 – 2015 period, the incidence of hospital acquired harm was increasing, despite multiple performance improvement teams and projects. The organization was going through a period of rapid change such as; a new partner in the Montefiore Health System, a new CEO, multiple construction projects, new physician partnerships and increased nursing turnover.
- During harm event investigations, it was apparent that leaders and staff did not understand or relate to the traditional rate method of reporting outcomes.
- Challenges included:
  - Rate methodology is not relatable to patients harmed
  - Benchmarks confusing and vary
  - Reporting multiple types of events is often overwhelming
- Transparency of events was limited to clinical staff, yet often prevention takes the entire organization.
- Needed a method to communicate harm that is relatable, easy, and involves Board to front-line staff.

Safety Across the Board—The Bold Aim:
- A goal was set to decrease hospital acquired harm by 50% in 2016.
- Read an article in a journal from Philadelphia Children's Hospital about decreasing harm with a whole harm score that was transferable and that was understood by staff, at all levels, so we decided to try it.

Safety Across the Board—The How:
- ☐ Culture:
  Harm Calculation Methodology:
  - Based on a Harm Reduction Program at Philadelphia Children's Hospital, a whole harm score was established.
  - The Whole Harm Score:
    - Identified highest number of harm events from 2015
    - The rate is calculated per 1000 inpatient discharges (number of harm events divided by number of inpatient discharges, times 1000)
    - This produces a whole number

  - Visual pie chart is presented monthly with the whole harm score and percent (%) of each event
  - Number of patients affected is represented by stick figures
  - White Plains Hospital has a culture of exceptional to which we added harm prevention
  - Embraced high reliability concepts of preoccupation with failure
  - Communicate monthly in easy to understand methods
  - Transparency from Board of Directors to front-line staff
  - Celebrate wins along the way
- ☐ Strong Safety Processes:
  - Harm Event Task Force (CAUTI, CLABSI, SSI, VTE, etc.) that includes a Root Cause Analysis on every harm event
  - Daily Multidisciplinary Rounds (MDRs) with harm concerns and prevention discussion
  - Harm score and events included as indicators on Nursing Unit Based Scorecards
  - Harm Score is an organizational goal and is included on Board of Directors and Senior Leader scorecards
  - Daily safety huddles at 8am & 8pm include; who are we concerned about, what is in place to keep them safe?
  - Monthly Good Catch Award to recognize staff members or physicians who prevented a harm event
- ☐ Engagement:
  - Nurse Leader rounding to assess for potential harm
  - Physician engagement with unit-based hospitalists
  - Quality RN liaisons for every inpatient unit
  - All hospital staff have the Harm Score as an annual goal on their evaluation
  - Harm Score is discussed at all monthly Magnet Clinical Councils

Safety Across the Board—The Results:
- We set an aggressive bold aim goal to cut the whole harm number by 50% the first year (which our colleagues told us we would never do) and we did it! Then we reduced it by 20% the second year!

Parrish Medical Center
Titusville, Florida
Mayo Clinic Network

Hospital Attributes:
- 210 beds
- 12 bed ICU
- 14 bed ED (40,000 annual visits)
- Consumer Reports: Florida's Safest Hospital
- Earns Top 100 SafeCare Hospitals Distinction and LeapFrog Group Hospital Safety Grade: evidence-based metrics of the CMS hospital value-based program (HVBP), readmissions reduction program (HRRP), and acquired complications reduction program (HACRP).
- Becker's Hospital Review "Top 150 Great Places to Work in 2017"
- Nation's first certified Integrated Care Network

This isn't just an initiative.... but how we lead.

Organization's GAME PLAN (strategic plan) guides everything that we do; the foundation of safety is the golden thread that is woven throughout our Game Plan.

Safety Across the Board---The Need:
- Safety journey began in 2002. Leadership had a vision to create an organization of healing, using scientific principles, which included a safety culture. We began looking at comparisons within our county, then our state, then nationally. When our community chooses us, it is a return on investment.

Safety Across the Board—The Bold Aim:
- To be and remain one of the safest places to obtain healthcare. We do not set median goals; we set goals at the top 90th percentile. We believe that zero harm is attainable and we are striving for it. This journey has to be intentional and personal; this does not happen by accident.

Safety Across the Board—The How:
- ☐ Culture:
  - We call our workforce Care Partners, not staff. We relentlessly message safety and use the message Use the mother test**.....*"if what you are doing for the person in the bed is not what you would do for your own mother, stop what you are doing."***
  - We are transparent with metrics across the organization and review on a monthly basis.
  - Weekly huddles: Safety briefings at the unit level; required weekly story telling time. We tell a story around our values. We ask our Care Partners to verbalize......*how in the various areas in the organization are we living our values?* We have a care circle discussion and ask guided questions around our values: *"What have you done today or seen today that shows us living our values?"* This creates conversations within team environments and how to apply it in one's own work. Since safety is the first one of our core values, this is weaved into the weekly huddles. Core Values: SLICES—(S) Safety, (L) Loyalty, (I) Integrity, (C) Compassion, (E) Excellence, (S) Stewardship. These huddles serve as a gut check to ask ourselves**....*"what are we doing today that will improve patient safety and result in a healing experience?"***
  - Weekly check-ins (with CNO): Discuss department and unit concerns, review retrospectively what happened in an incident (falls, infection, restraints). We ask, *"how did it happen and how can we make sure it doesn't happen again or how can we make our process more safe?"*
  - We keep ourselves fresh by relentlessly reviewing and searching for evidence-based practices.
  - Worker Safety: We track and trend injuries in the work place and we care for the caregiver.
- ☐ Strong Safety Processes:
  - We are a Lean Six Sigma organization and have trained every department head to be Green Belt Six Sigma Certified. Every director and manager needs to know how to lead process improvement and achieve quality and safety.
  - If we have 3 months in the red (not meeting our targets on a measure), this buys you a process improvement project and this requires a formal process improvement project:
    - Charter is developed
    - DMAIC rapid cycle tests
    - Test until we see improvement
    - Process improvement continues until we are back in the green
- ☐ Engagement:
  - We do safety and quality presentations (DMAIC format) to our Board of Directors monthly. Our board is Six Sigma certified and engaged in how quality improvement works. (We all speak the same language, from the unit level to the boardroom).
  - Patient and Family (PFE) Advisory Group is made up of 6 former patients or family of patients. Example: We involve PFE advisory group in multi-disciplinary care team rounds. We ask them…"Are we talking as a team when we meet with patient and are we talking in a way the patient and family understands?" Then they critique and tell us what to do better (i.e.: less medical jargon, what we were saying was not understood by the patients.)

Safety Across the Board—The Results:
- One of the nation's safest hospitals
- Sustained zero rate in CAUTI, VAP, CLABSI and Early Elective Deliveries (EED)

Chandler Regional & Mercy Gilbert Medical Centers
Dignity Health System, Arizona

Chandler Regional Medical Center:
- 338 beds
- Level 1 Trauma Center
- America's 50 Best Hospitals Award (Healthgrades)
- Best in Sepsis Award for 2016

Mercy Gilbert Medical Center:
- 198 beds
- Designated an Award Winning Healing Hospital
- Received the Best in Sepsis Award for 2016
- Joint Commission Top Performer Award on Key Quality Measures 2015

Critical SAB Tactics:
- ❖ Full engagement, support, and enthusiasm of executive leadership
- ❖ Engaging key physician leaders. *"These were not always the official medical directors but were often key influencers in the medical staff."*
- ❖ Establish and plan your infrastructure properly (unit safety tools, content, internal safety communication channels, etc.) ahead of the starting safety training program

Safety Across the Board---The Need:
- CEO's desire to be <u>excellent</u> at preventing serious safety events.
- Difficult discussions with the Board. We were having to explain serious safety events.

Safety Across the Board—The Bold Aim:
- 60-80% reduction in moderate to severe harm (including death) events in two to three years.
- Then, we will approach the less severe harm areas.

Safety Across the Board—The How:
- ☐ <u>Culture:</u>
  - The organization kicked off a Safety & Just Culture Program in 2015 using the Healthcare Performance Improvement (HPI) Serious Safety Event (SSE) Classification Model.
    - ➢ Train-the-trainer with clinical supervisors, managers, directors, and the executive leadership team (ELT) first, then we trained staff in September of 2016.
    - ➢ Trained physician champions to be teachers for physician classes and then trained providers in January 2017.
  - Culture of open reporting to reduce the anxiety around reporting from the front-line.
  - Human Resources Goal: Hire the right people (at the front-line and leadership positions) who truly care about safety (hire people who <u>live</u> safety and just culture).
- ☐ <u>Strong Safety Processes:</u>
  - Infrastructure:
    - o Aligned marketing and communication to ensure safety messaging is consistent and constant.
    - o Made it easy for staff to access materials and resources regarding safety (tools, etc.). Ensured safety tools and content availability and infrastructure was in place.
    - o Focused on a <u>safety tool of the month</u> to sustain safety momentum and communicate this organization wide.
  - Intentionally separated out the daily <u>Patient Experience Huddles</u> and the <u>Patient Safety Huddles</u> so the patient safety conversation was deliberately honored with a direct focus and not diluted in the patient experience conversation.
  - Daily safety huddles (talk about how many days since serious safety events and about when the last employee/workforce safety event was).
  - Ensure safety information (data) gets out to staff on regular basis with a monthly newsletter which includes (the serious safety event rate, good catches to celebrate, and number of days between events).
- ☐ <u>Engagement:</u>
  - Involved and engaged three different governance structures:
    1. Physician team of 15-20 champions (not necessarily the medical directors).
    2. Operations team (CNO, VPs of Operations, Patient Safety Officer, VP Med Affairs, Safety Culture Program Manager, and Education).
    3. Executive team (CEO, COO, CNO, CMO, VP Ops, VPMA, HR, Communications).
  - Dealing with medical staff pushback: We don't employ our physicians so we recommend that organizations start the safety journey conversation with medical staff very early to get traction and get them on board (it can take some time). Keep reminding medical staff that every safety event only further establishes an opportunity to develop a culture of safety and, if this safety culture was already established, this current safety event may not have happened (keep the pressure on).

Safety Across the Board—The Results:
- June 2015 baseline was 13 days between serious safety events. The record days between serious safety events in Year 1 is 91 at Chandler and 167 at Mercy.

Samaritan Healthcare
Moses Lake, Washington

- 50 Bed Hospital
- 9 bed Advanced Care (critical care unit)
- 4 Surgical Suites
- Cardiac Rehab Clinic
- Mother Baby Center
- Various Clinics and Urgent Care

Our Values:

Safety and quality:
- To produce the best possible results, consistent with current professional knowledge, within a safe environment.

We write thank you notes to our staff every month for reporting good catches. We thank people for submitting reports.

Safety Across the Board---**The Need:**
- The organization recruited a CNO/Chief Quality Officer who was familiar with the SAB concept and capitalized on this expertise.
- The desire to know how the organization compared to others in patient safety.

Safety Across the Board—**The Bold Aim:**
- Goal of zero harm. Heighten Board awareness and transparency of patient harm.

Safety Across the Board—**The How:**
- ☐ Culture:
  - Implemented SAB work in January 2015. Chose to use PfP harm areas and our comparison, as a rate. Chose adjusted patient dates to capture observation patients, ED patients and outpatient, not just inpatient because we have a high volume of ER visits, outpatients, and observation patients.
  - Worked with our Board to become more transparent by getting the safety information to them with the use of a SAB tool and graph (**see graph image**, below).
  - Once we had the measures chosen (see graph), we looked to see if there was more than one measure for the harm area (state and national) and we chose the measure with the most sensitivity to the state measure, instead of the national measure, so we could capture as many harms as possible.
- ☐ Strong Safety Processes:
  - Safety committee meets monthly and reports to the Board. First 15 minutes of the Board meeting is dedicated to a patient safety topic, with a story.
  - Daily leadership huddles to discuss any safety events that were reported and harm score, as well as days since last harm. **Even housekeeping and plant operations know about huddles and post fall assessments.**
  - General orientation presentation on safety, quality, near misses, serious safety events, etc. CNO presents SAB risk scoreboard at every medical staff committee meeting. The SAB rate is also on balanced scorecards quarterly as part of bonuses.

- ☐ Engagement:
  - SAB is reported to leadership and the front-line.
  - 3 foot poster representation of the data is developed for the front lobby of the hospital so patients can see harms along with an article (written by the patient safety nurse) every month which speaks to harm prevention. We engaged friends and family, who were not clinical, to ask them if the poster made sense to them (balance of technical and 8th grade level understanding).

Safety Across the Board—**The Results:**
- 32 days since last patient safety event.
- Started out with a harm rate of 14 harms per 10,000 adjusted patient days for the month and in a couple of years, the new rate is 6.17.
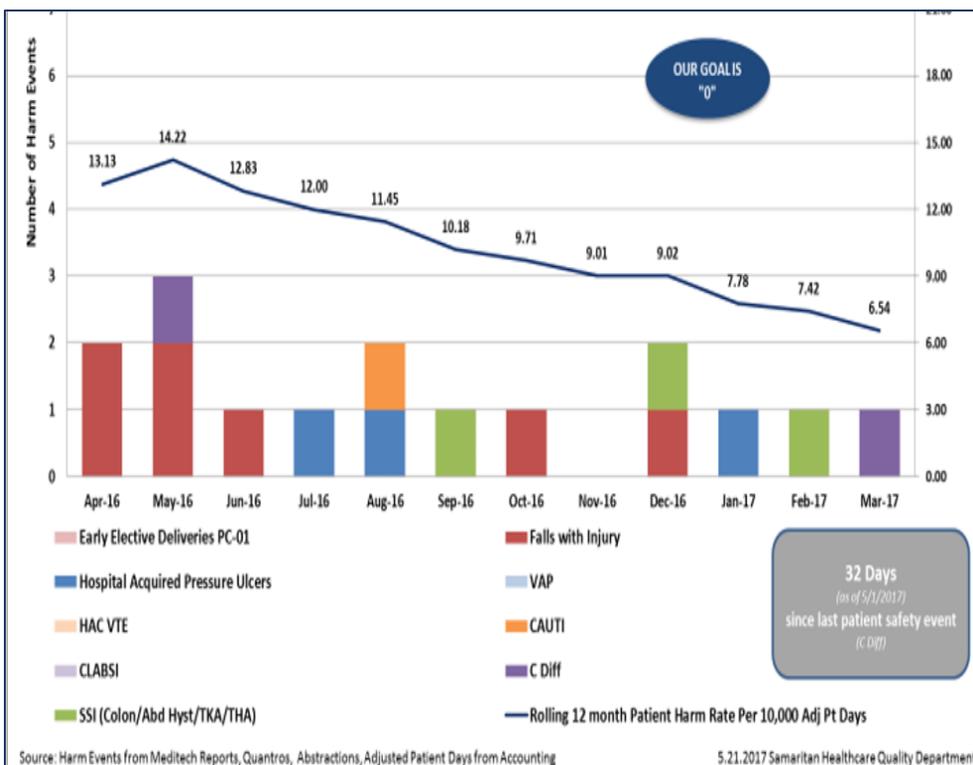
SWEDISH	Swedish Health Services (5 Hospital System) Greater Seattle, Washington	**Washington State Hospital Association**

- 5 Hospital System
- Greater Seattle area's largest, most comprehensive medical system
- Best hospital to work for in the Pacific Northwest

Lesson Learned:
Dispelling Myths
We had a high acuity oncology unit with elevated CLABSI rates. The attitude of the oncology staff was *"of course we have higher CLABSI rates, our patients are immunocompromised and at higher risk than other patients."*

We then provided the unit data of compared like units across the country, which showed other similar units had lower rates and were causing less harm than our unit.

This simple exercise influenced unit staff engagement in safety efforts which gleaned a dramatic reduction in CLABSI rates. We dispelled their myths.

Mess Up, Fess Up
Just Culture, Near Miss Reporting Encouragement Program

Safety Across the Board---The Need:
- In 2016, we realized that each one of the five campuses had been doing individual and separate pockets of work on these harm areas (CLABSI, CAUTI, *C.difficile*, Falls, and SSI).

Safety Across the Board—The Bold Aim:
- Leveraged the health system to create systemic pathways and better manage harms.

Safety Across the Board—The How:

☐ Culture:
- The CMO, CNO and COO from all five campuses met monthly and discussed the results of how the organization was doing on all of these measures (CLABSI, CAUTI, *C.diff*, Falls, SSI) at each campus.
- We assigned executive sponsors to take the lead for each initiative. The sponsor was responsible for developing a multi-disciplinary team to address each topic and develop a pathway for management, to include EPIC (the electronic medical record). Each team also developed a packet for each implemented pathway at each campus.
- We developed quality councils at each campus lead by CMO, CNO and the COO. These councils addressed the implementation of the packets and modified the PDSA. They looked at workflows, audit tools, etc.
- We have a just culture in the organization and we call this Mess Up Fess Up (to promote reporting of near misses). We want to make sure staff know that if they have a near miss and they report it in the electronic reporting system, they won't be in trouble. This helps our organization trend what is happening to see what we can do differently and reduce the chance of an error reaching a patient.
- Measuring culture: Switched from the AHRQ Safety Survey to the Press Ganey Safety Culture and on opposite years, we do an employee engagement survey from Towers Watson.

☐ Strong Safety Processes:
- Hand Hygiene: Staff were suffering from audit fatigue. We developed an iSurvey (the ability to audit with an iPad or iPhone). Everyone has access to allow more staff to participate in hand hygiene audits. Audits need to be local, and quick and easy; similar to existing apps that people already use.
- We record and disseminate monthly safety videos of front-line staff and champions performing safe practices. We encourage managers to show these videos at the beginning of staff meetings and have discussions about them. When leadership rounds, they ask the staff if they have seen the safety video of the month.

☐ Engagement:
- Physician engagement: We were mindful of when and how to engage physicians. Make sure you understand what you need the physician change to be before you engage them. They need to understand how the process change applies to them. Be very clear of what you are asking physicians to support and be super focused.
- Board engagement: We learned that we need to get our board to trust the process and help them understand that, just because we may not have yet met our goal, they need to trust the process. It is a journey and we shouldn't always switch horses.
- Workforce engagement: We learned that with change management, you have to show staff the process measures, they needed to see their improvement on process metrics before they will see the outcomes. Display this on a routine basis to keep them motivated and engaged and then they will see the outcomes follow. The process metrics shows how the workflow change actually worked.

Safety Across the Board—The Results:
- Recently received a 5 Star CMS rating. Only 337 hospitals out of 6,300 earned this and this is the highest overall safety/quality rating from CMS.

MemorialCare Health System
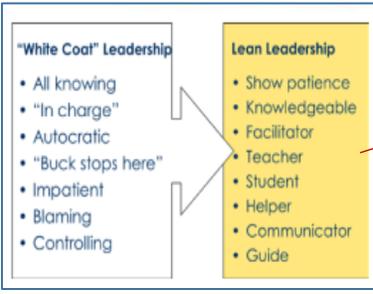Orange County and Los Angeles County
California

System Attributes:

- 5 Medical Centers
- 1 Medical Foundation Medical Group & IPA
- Participating in 5 ACOs
- 214,000 visits to 3 EDs
- 12 Urgent Care Sites
- 317,000 Patient Days
- 9 Free-standing Surgical Centers
- 13 Dialysis Centers
- 34 Imaging Locations
- 11,000 Employees

*The link to **Engagement** of the workforce is connecting it all back to a **Purpose.***

*Fostering to be part of something, **connecting** to the **bigger picture.***

- Go See
- Ask What, then Why
- Show Respect

"White Coat" Leadership
- All knowing
- "In charge"
- Autocratic
- "Buck stops here"
- Impatient
- Blaming
- Controlling

Lean Leadership
- Show patience
- Knowledgeable
- Facilitator
- Teacher
- Student
- Helper
- Communicator
- Guide

Safety Across the Board---The Need:
- Executive leadership established its bold goals for safety in 2006 with the use of Lean principles, since 2007.
- They adopted a focus on the "Harm Across the Board" (HAB) measure as a result of the initial HEN focus in 2012. HAB includes specific types of hospital-based harms (infections, pressure injuries, falls, bleeding from Warfarin and early elective delivery). The System has a number of bold goals they select each year including HAB.
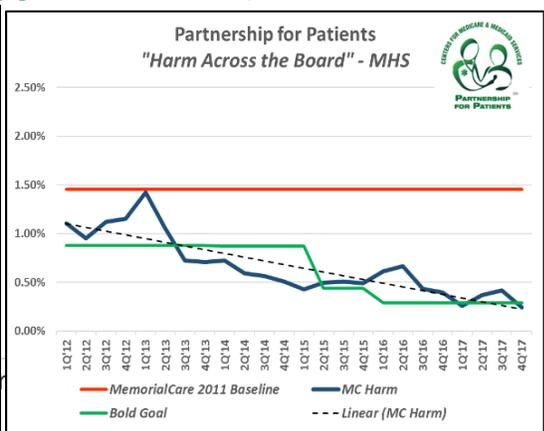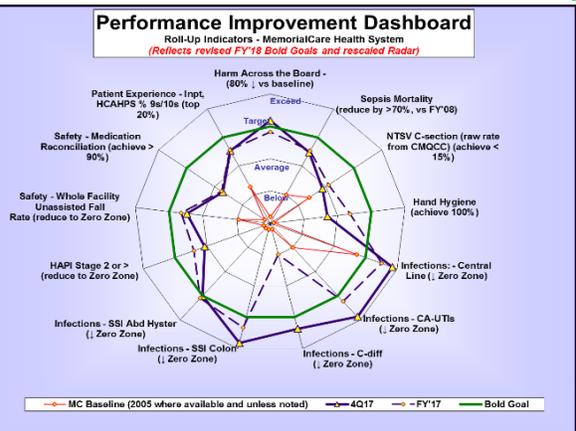
Safety Across the Board—The Bold Goal:
- Reducing Harm Across the Board target has been sequentially dropped from by 40% to now by 80% by 2018.

Safety Across the Board—The How:
☐ **Culture:**
- Patient safety is a priority in strategic planning, employee performance evaluations, organizational culture, and resource allocation.
- Lean has been part of the strategic plan's improvement model since 2007.
- Performance Improvement Radar Dashboard (image below) shows where we started, where we have been and where we are now. Performance is monitored by the system's Quality Committee.
- Participation in HIIN Network and IHI Leadership Alliance fosters shared learning.
- Starting every meeting with a story and lesson learned harnesses the power of storytelling.
- Relentless pursuit of non-value-added waste (Lean); helping staff redesign & co-create processes so they own it.

☐ **Strong Safety Processes:**
- **Education:** Ongoing patient safety education included in physician and employee development programs. Patient safety awareness campaigns, written articles, continuing education programs, seminars, pocket cards, and clinical tools built into system-wide electronic health records (EHR: inpatient, ED, and ambulatory).
- **Lean:** Leverage Lean mindset, methods and management systems to put the joy back in work and improve performance. Empowered teams including patients and families use Lean tools for problem-solving: A3 (PDSA), 5S (sort, simplify, sweep, standardize, sustain), and rapid process improvement and process design workshops for the gnarlier issues.
- **Measurement:** Metrics that matter are chosen at the unit level by staff and physicians to ensure they are meaningful to them. Unit team huddles held to review progress to metrics, per unit need (e.g. shift, daily, weekly). Huddles celebrate success, capture ideas, ensure follow-up. Huddles moved from manager-led to staff-led over time.
- **Leadership Walk-Rounds:** Day starts with joint Leadership Safety Huddle. Leadership coaching rounds made by executives and key leaders who talk with patients, huddle with staff at Visibility Boards and provide coaching.
- **Coaching Kata:** Do inquiry before advocacy (ask why first then go and see and show respect). Ask *"what obstacles are preventing you from reaching your goals?", "what will you test next?" and "when can I come back and see?"*
- **Technology as an Enabler:** Examples: Build of MEWS (adult), PEWS (peds), and OB (MEWTS) Early Warning EHR Trigger Systems; use of UV light (robots) to complement efforts to reduce infections.

☐ **Engagement:**
- **Leadership:** Leadership engaged in linking Lean with performance improvement and safety. All managers and many physicians engaged and trained in both Lean Leader and Facilitative Leadership.
- **Front-line:** Buy-in, linking Lean and Joy, with staff-led report outs from workshops (every Friday). Teams make decisions for processes they need to start by Tuesday and how to implement and measure success.

Safety Across the Board—The Results to Patients … AND to Staff:
- Reduced HAB rate by 73%, infections by 54%, sepsis mortality by 57% with updated HAB goal for 2019 to get to by 90% reduction. Health system measures Lives Touched by the bold goals, now totaling 137,166 since 2006.
- Increased engagement: Mission & Purpose of Team Clear 3.97→4.45, My Opinions Count 3.43→4.30 (0-5 scale).

Performance Improvement Dashboard — Roll-Up Indicators - MemorialCare Health System

Partnership for Patients "Harm Across the Board" - MHS

Survey Question (0-5)	2007 Baseline	2017
FOUNDATION		
Mission & purpose of my team is clear to me	3.97	4.45
I spend majority of time doing what I do best every day	4.12	4.38
VALIDATION		
My contributions and opinions count	3.43	4.30
I feel I am a valued member of the team	N/A	4.26
SUPPORT		
Supervisor committed to me personally & professionally	3.91	4.12
GRAND MEAN	3.78	4.27

VIDANT HEALTH

Vidant Health
Serves 29 Counties in Eastern North Carolina

PREMIER

System Attributes:
- Non-profit 1,439 bed hospital system
- Annually serves more than 1.4 million people in 29 Eastern North Carolina counties
- 8 Hospitals
- Multispecialty group Practices
- SurgiCenter
- Home Health & Hospice

Staff Safety Coach Program

We intentionally include **Patient Advisors** everywhere……
from the bedside to the Board room.

Their insights help us improve!

We use safety habits and error prevention tools to build reliability of our clinical care processes.

Safety Across the Board---The Need:
- Zero Harm: Healing without Harm
- Our commitment to the community to fulfill our Values: ICEAST -Integrity, Compassion, Education, Accountability, Safety, and Teamwork

Safety Across the Board—The Bold Aim:
- Zero events of preventable harm and 100 percent exceptional experiences for every person we serve. We set improvement goals and we measure our performance against those goals.

Safety Across the Board—The How:
☐ Culture:
- Board, leaders, physicians, and front line clinical teams partner with Patient Family Advisors (PFACs) to identify opportunities to improve care. This collaboration ensures we provide care that is safe, timely, efficient, effective, equitable, and patient and family centered.
- Leaders are trained in high reliability leadership principles. Methods such as a daily safety huddle to plan and prepare for a safe day are implemented system wide.
- Focused efforts to enhance a culture of reporting events and near misses to identify opportunities to improve and also to celebrate (Good Catches) when we are using our safety habits to prevent patient harm.
- Embracing a collaborative culture of safety by partnering with human resources, managers, and risk management to support, coach and console staff, using an algorithm for guidance.

☐ Strong Safety Processes:
- We track and trend patient safety issues and conduct event analyses on harm events in order to improve and determine system changes. We have specially trained patient advisors to participate in event analysis.
- Safety Coach Program: Each of our entities have established Safety Coach Programs. Coaches are clinical and non-clinical team members who role model, peer coach and reinforce expectations around our safety habits, also known as CHATS. Our safety habits and associated error prevention tools help us, as humans, prevent errors.
- We have an internal intranet dashboard that is transparent to all staff, providers, and leaders. It shows our 3 operational imperatives; 1) Quality/Safety, 2) Finance, 3) Experience and progress toward meeting our goals. In addition we are transparent through use of Quality Scorecards, weekly event review meetings, and sharing lessons learned from events. This elevates the attentiveness to quality and safety and holds us all accountable.

☐ Engagement:
- Board leadership: Vidant Health focused on quality and safety literacy for the Board so committee members are armed with the skills necessary to lead at the governance level.
- Quality experts partner with front line staff, leaders, and physicians to teach them how to use rigorous improvement methods to collect, measure and analyze safety and quality data. This process helps us understand the best ways to improve.
- Patient family advisors are an integral part of our quality and safety teams across all eight hospitals. They are active members on our Quality and Safety Committees as well as our Vidant Health Board. Five of our advisors are trained in FEMAs and RCAs. They continue to be involved in FEMAs and RCAs to ensure that the patient and family perspective is represented so that we may see things through the patients' and families' eyes to continue reducing harmful events.
- We have 79 patient advisors across the system and 28 of them are at our flagship tertiary care center.

Safety Across the Board—The Results:
- 55% increase in safety event reporting
- 7% improvement in punitive culture dimension of Patient Safety Culture Survey
- 62% serious safety event rate reduction
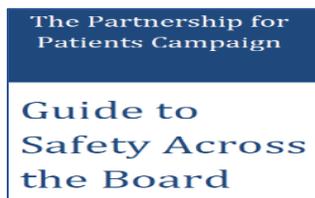
Guide to Safety Across the Board, Partnership for Patients 1.0 (2011-2014)
http://www.patientsafety.org/assets/sab_guide_12032014.pdf

Leading a Culture of Safety: A Blueprint for Success (NPSF/IHI/ACHE)
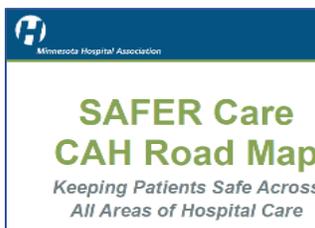http://www.npsf.org/page/cultureofsafety

We Lead for Safety (ACHE/NPSF/IHI)
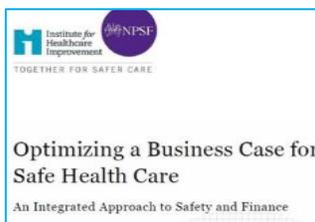Leadership pledge to commit to a culture of safety and assessing current safety measures.
http://safety.ache.org/

Tracking Safety Across the Board HIIN Improvement Calculator (AHA/HRET)
http://www.hret-hiin.org/resources/display/hiin-improvement-calculator

Eliminating Harm, Improving Patient Care: A Trustee Guide (AHA/HRET)
http://www.hret-hiin.org/Resources/Governance/17/Trustee_Guide_Workbook.pdf

SAFER Care CAH Road Map (Minnesota Hospital Association)
https://www.mnhospitals.org/Portals/0/Documents/ptsafety/SAFE%20CARE/SAFER%20Care%20CAH%20Roadmap.pdf

Optimizing a Business Case for Safety Health Care: An Integrated Approach to Safety and Finance (IHI/NPSF)
http://www.ihi.org/resources/Pages/Tools/Business-Case-for-Safe-Health-Care.aspx

Free from Harm: Accelerating Patient Safety Improvement Fifteen Years after "To Err is Human" (NPSF)
http://www.npsf.org/?page=freefromharm

Patient Safety Discussion Toolkit for System Expansion
Set of tools to guide health system leaders through a communication process that uncovers important patient safety considerations during system expansions (Ariadne Labs and CRICO/Risk Management Foundation)
https://www.ariadnelabs.org/safe-expansion/

Measuring and Monitoring of Safety Framework (The Health Foundation)
A practical guide to using a new framework for measuring and monitoring safety in the NHS (UK).
http://www.health.org.uk/sites/health/files/AFrameworkForMeasuringAndMonitoringSafetyPracticalGuide.pdf