Our Journey to Zero Harm:

Medical errors should not be the third leading cause of death in this country

OBJECTIVE:

1. Improving health outcomes and patient safety facility wide by having all staff in each department commit to consistently deliver safe and reliable service, even in high risk, complex environments that are common in a hospital
2. Show how we sustain the principles of high reliability organizations (HRO's) by having them ingrained into the organization's culture though monthly trainings and education on risk reducing behaviors.
3. Show how we have involved patients and their families in our initiative of toward zero harm.

BACKGROUND:

In 2018, we started working on driving down patient harm with the use of the SafetyFirst Program. Using the behaviors and tools in that program, we were able to demonstrate an increased awareness of what harm is (even having an extra needle stick or lab repeated is harm).

According to the Joint Commission, 70-80% of serious medical issues are a result of communication failures. Poor handoffs between care providers are an area of highest concern. By implementing tools like SBAR, Stop and Resolve, Document Legibly and Accurately, 5P's, and ARC (stop the line), we can decrease these errors.

ACTIONS TAKEN:

- Safety Culture Assessment 2023= increase in favorable ratings by collogues that our culture in non-punitive for incident reporting
- Safety Coaches provide peer to peer support to frontline staff. They encourage staff to report any concerns that could lead to near-misses, and to use the safety behaviors. The Safety Coaches turn in a monthly report of how they have seen staff overcome potential errors in their own departments. We have seven of our original Safety Coaches continuing to work on the committee, which shows their dedication to the safety culture after five years.
- Coaches bring in articles about harm that happened in other facilities so we can look at what we could do differently in the same situation using our safety tools. These articles then go out to the whole hospital for their huddle boards, so multidisciplinary groups get to education themselves on harm that is happening and how to avoid it.
- Great Catch slides are made for those situations when someone sees a colleague catch a potential safety concern before it can reach a patient. This is one of the ways that we celebrate these

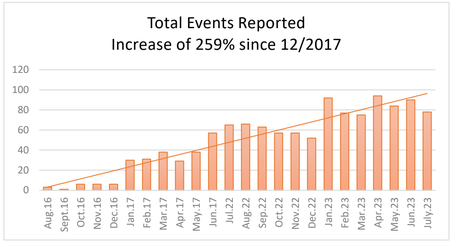
Patient Safety Event: **Lesson Learned**

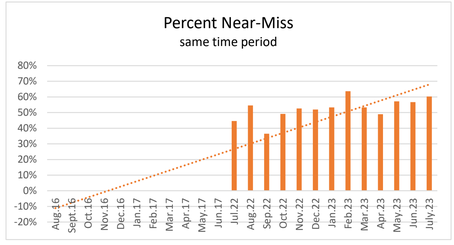
S **SITUATION** – Dietary is occasionally finding non-nutrition items being left on patient trays (such as used bandages).

B **BACKGROUND** – Only washable patient items should be sent back down to dietary after a meal.

A **ASSESSMENT** – Used items such as bandages can spread infectious disease and should not be transported to other areas of the facility.

R **RECOMMENDATION** – To prevent unnecessary cross-contamination, all disposable items should be thrown away in proper waste bins prior to sending trays back down to dietary. This should include (but is not limited to) used bandages, napkins, milk cartons, and disposable plastic (such as fruit cups, silverware, etc).





Washington County man sues Iowa City hospital for causing opioid overdose

https://www.thegazette.com/crime-courts/washington-county-man-sues-iowa-city-hospital-for-causing-opioid-overdose/

What happened?

60 y/o male is suing Mercy Hospital in Iowa City for giving him 10 times the dose of an opioid drug (Dilaudid) in 2021 while in the ED after a fall where he sustained broken ribs. After getting the initial ordered dose of 1 mg, the staff (the hospital refused to identify "who") later repeated the medication by giving 10 mg. He became blue, unresponsive and made "noises that were alarming" to his wife & daughter who were at the bedside. They yelled for help. The staff gave naloxone to counteract the effects of an opioid overdose, which meant he had to be admitted to the hospital and kept on a naloxone IV for the next day. The hospital staff told the family what had gone wrong and said they would not be billed for the mistake. When the patient recovered and requested to see his bill, the hospital allegedly would not give him access to the complete record. The billing that he was able to find showed $19,000 in charges submitted to his insurance company. He said that the hospital's actions of not providing his billing records shows evidence of fraudulent misrepresentation by making it appear that nothing was being billed to him.

Then What:

His wife suffered emotional distress and daughter suffered "bystander emotional distress" resulting from the emotional impact of seeing and hearing the "negligence committed" by the hospital when the staff member gave Fisher the wrong drug dosage, the suit contends. A "reasonable person" in either woman's position would believe their loved one could have a "serious injury or be killed."

According to the lawsuit, the $250,000 damages cap placed on Iowa medical malpractice cases is insufficient compensation in this case.

Select a Tool(s) used to prevent:

Check & Coach; Read back & Repeat Back; Stop & Resolve; Star; 5Ps; ARCC, SBAR; Document legibly & accurately; Safe Patient Handling & mobility

ACTIONS TAKEN (cont.):

incidents and reward those on the frontline. When an incident report reaches the leadership team, a "thank you" for reporting note goes out. This decreases fear of punitive consequences of putting in an incident report.

- Severity Event Classification Team (SEC) meets twice a month to do a root cause analysis using LEAN to classify all incidents that reach the patient with a systems focus.
- All new leadership is trained within 90 days of hire in Just Culture and Rounding to Influence. During these rounds, they reinforce the safety behaviors and tools with their staff. Leaders are accountable to the administrative team for turning in their rounding tool each month.
- Every week day, there is a Safety Call lead by Senior Leadership and attended by all department leads. There is complete transparency during this zoom meeting about all incidents that have been reported in the prior 24 hours, and each day is rated as green (no safety concerns) yellow (safety concerns that were caught before reaching the patient) and red (serious safety events reported). This maintains accountability and transparency between departments, eliminating silos.
- Patient and family engagement is an important part of this transparent culture. They are encouraged to report any safety concerns immediately. We instruct them to report lack of handwashing to Infection Prevention. The Patient and Family engagement counsel receive updates on hospital safety concerns that would impact the community.

ANALYSIS:

Our safety culture is strong and employees do not fear reporting incidents that could impact safety.

NEXT STEPS:

- Ongoing training for new hires and new leadership
- Ongoing recognition for those who find incidents and close the gaps in the "Swiss Cheese "before a patient is harmed
- Continue with the "Behavior of the Month" from Together Safe and Safety First Tools
- Continue to reinforce the need for communication to prevent safety errors, especially during hand-offs.
- Continue to make it hard to do the wrong thing and easier to do the right thing!

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