Indiana Hospital Association Patient Safety Summit

HURON

Reimagining (and Revitalizing) Quality, Safety, and High Reliability in the Post-Pandemic Era

Vikki Choate, DNP, MSN, RN, NEA-BC, CPHQ, CPPS

September 20, 2022

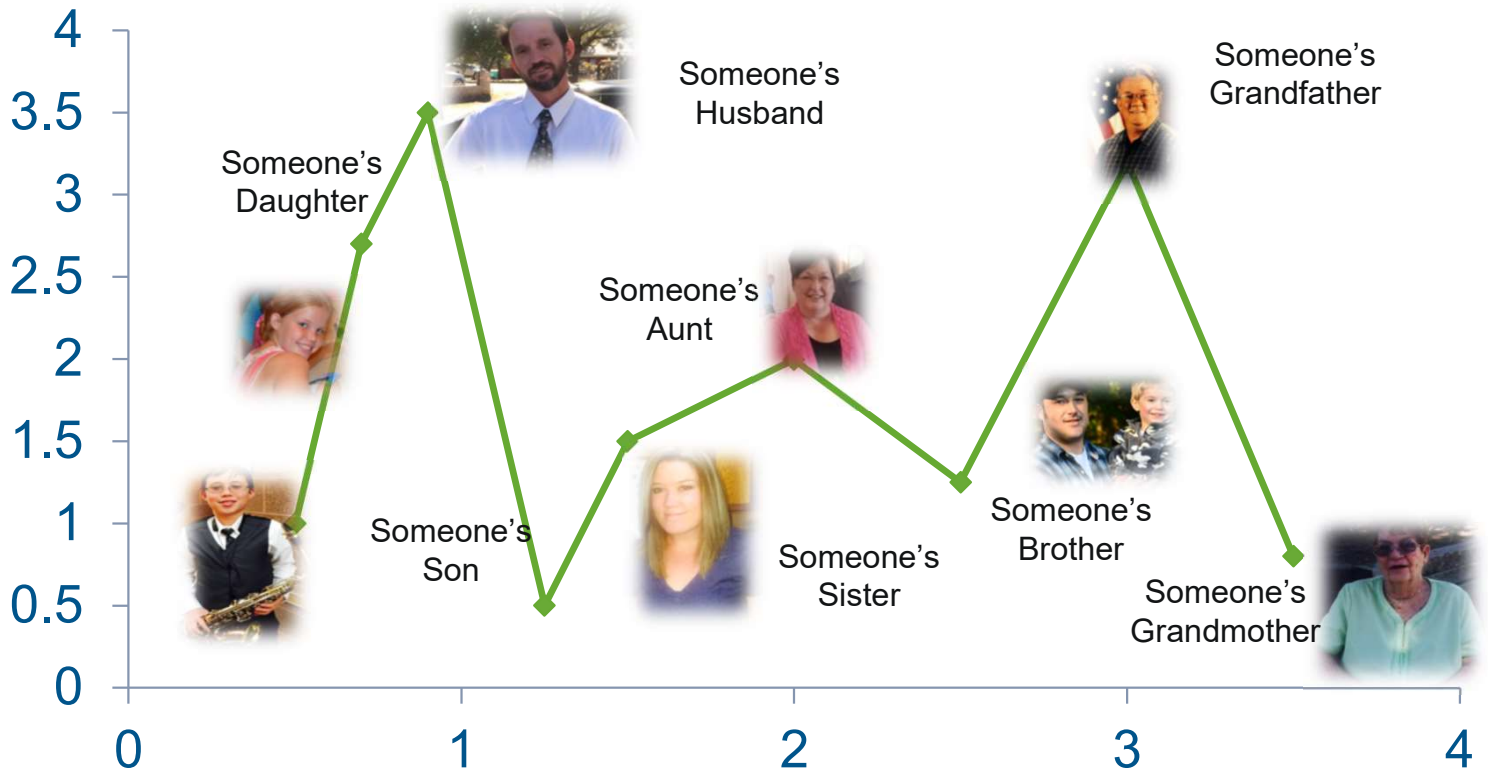
Learning Objectives

At the end of this session, patient safety leaders will be able to:

1. Use the impact of the pandemic on the healthcare industry and on your own organization's outcomes to create urgency for change
2. Describe the role of patient safety leaders in influencing the restoration of safety practices impacted by the pandemic through application of the key tenets of high reliability
3. Implement one innovative strategy to deepen patient engagement in your organization's post-pandemic patient safety agenda

Every ‘n’ Has a Name, Every Name Has a Story…..

And every story matters…..



Patient Safety is ***Very*** Personal for Me

John had a stroke as a result of mis-diagnosis

Mom died as a result of hospital error

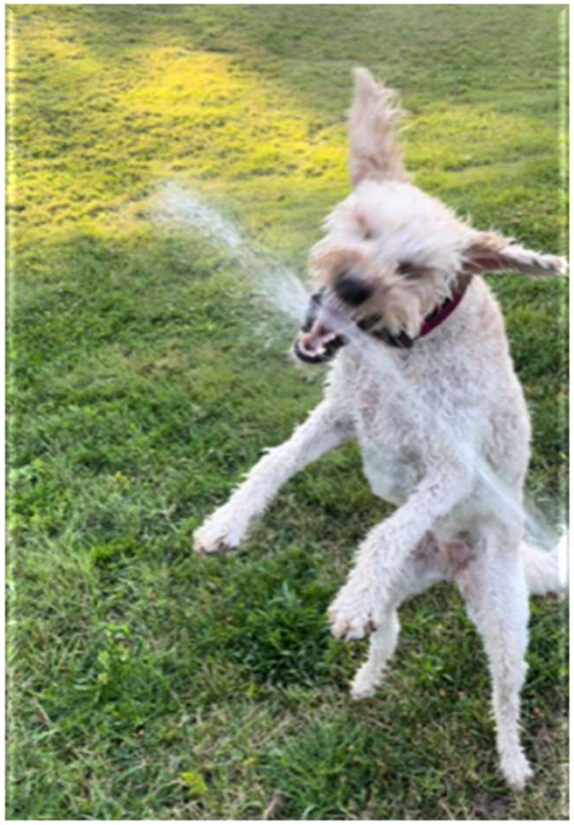
As a CQO once intimidated by TJC, I had the privilege of coaching them to sustained service excellence

1

Reflect and Connect

It’s Been a Doozie of a Past Few Years!

- Pandemic
- Weather events
- Economic Hardship
- Extensive media coverage
- Recognition of systemic racism
- Unstable political climate



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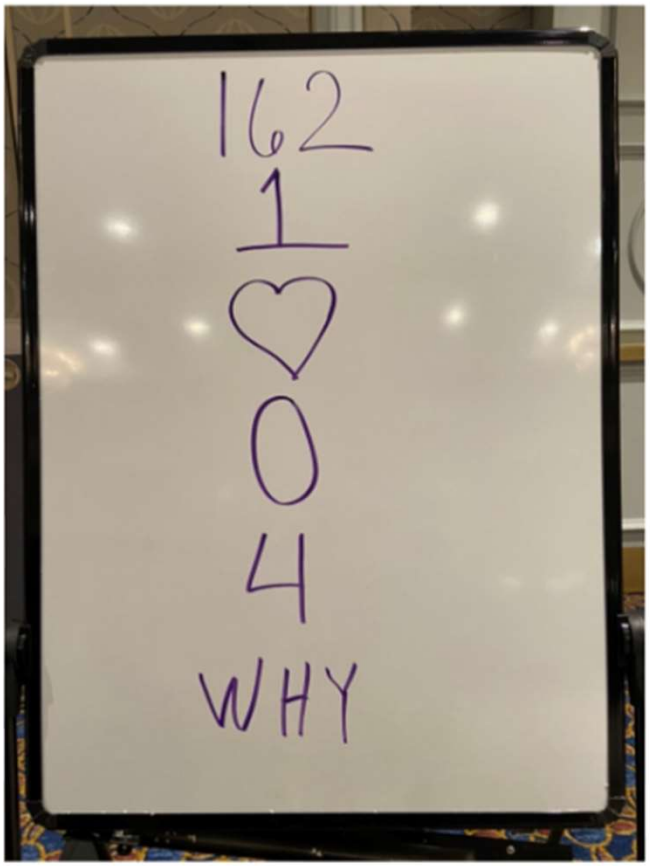
Using one word, describe how you're feeling today as an advocate and leader of quality, safety, and high reliability in healthcare today.

ⓘ Start presenting to display the poll results on this slide.

2

A Virus, a Teacher

High Reliability Conference | March 2020



Be a “Zip’per”!

(“Zero is Possible”)

And Yet…We've Known for Some Time

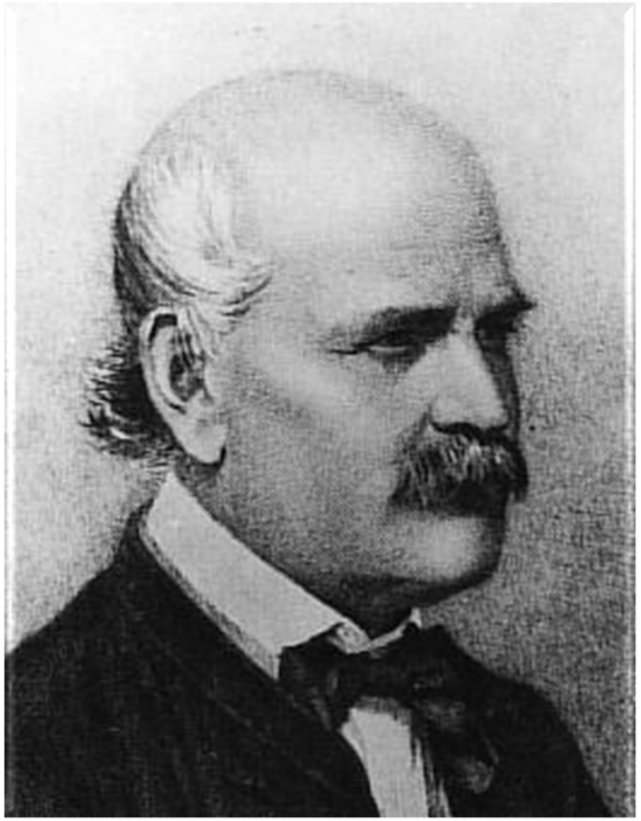
In 2020 (pre-pandemic), CDC reported:

- Healthcare workers wash hands **50% of the time we should**
- **1 in 3 patients** acquire an infection in the hospital

Currently, healthcare leaders report:

- They have **'slacked off'** evidence-based practices as a result of the pandemic
- Staffing shortages, role changes, and unclear priorities listed as top reasons

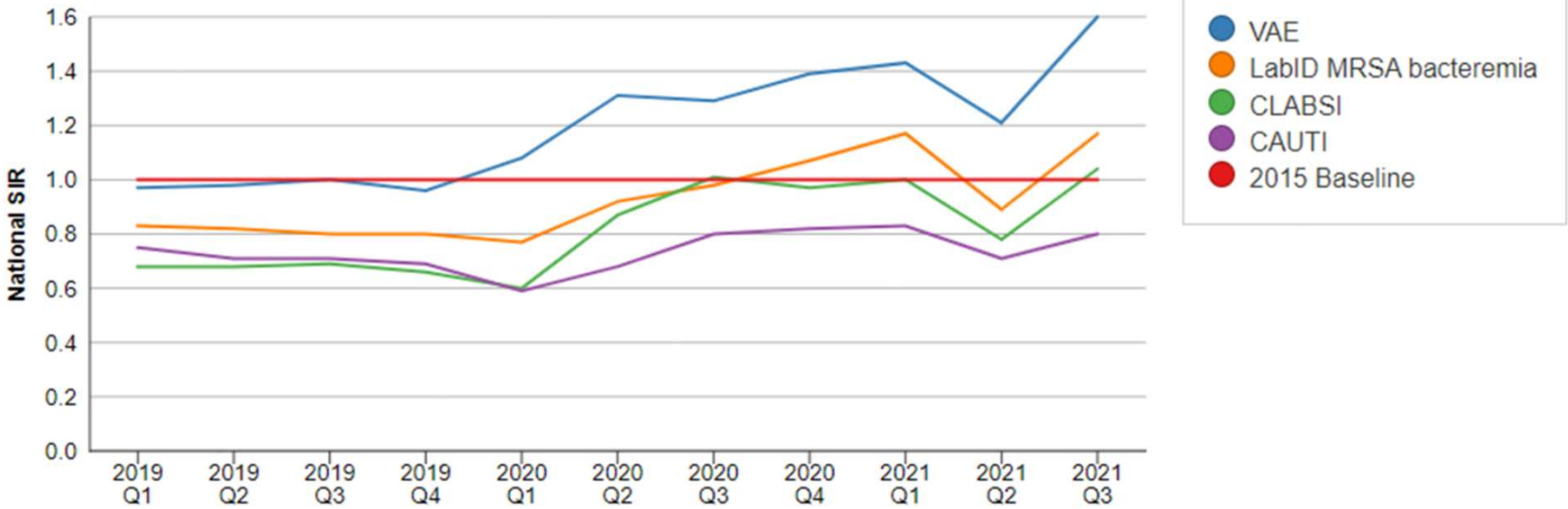
Despite pre-pandemic improvements in hospital-acquired infections, hospital-acquired injuries such as falls, and pressure wounds remain "resistant to treatment"



Hungarian Physician Ignaz Semmelweis | July 1818 – August 1865

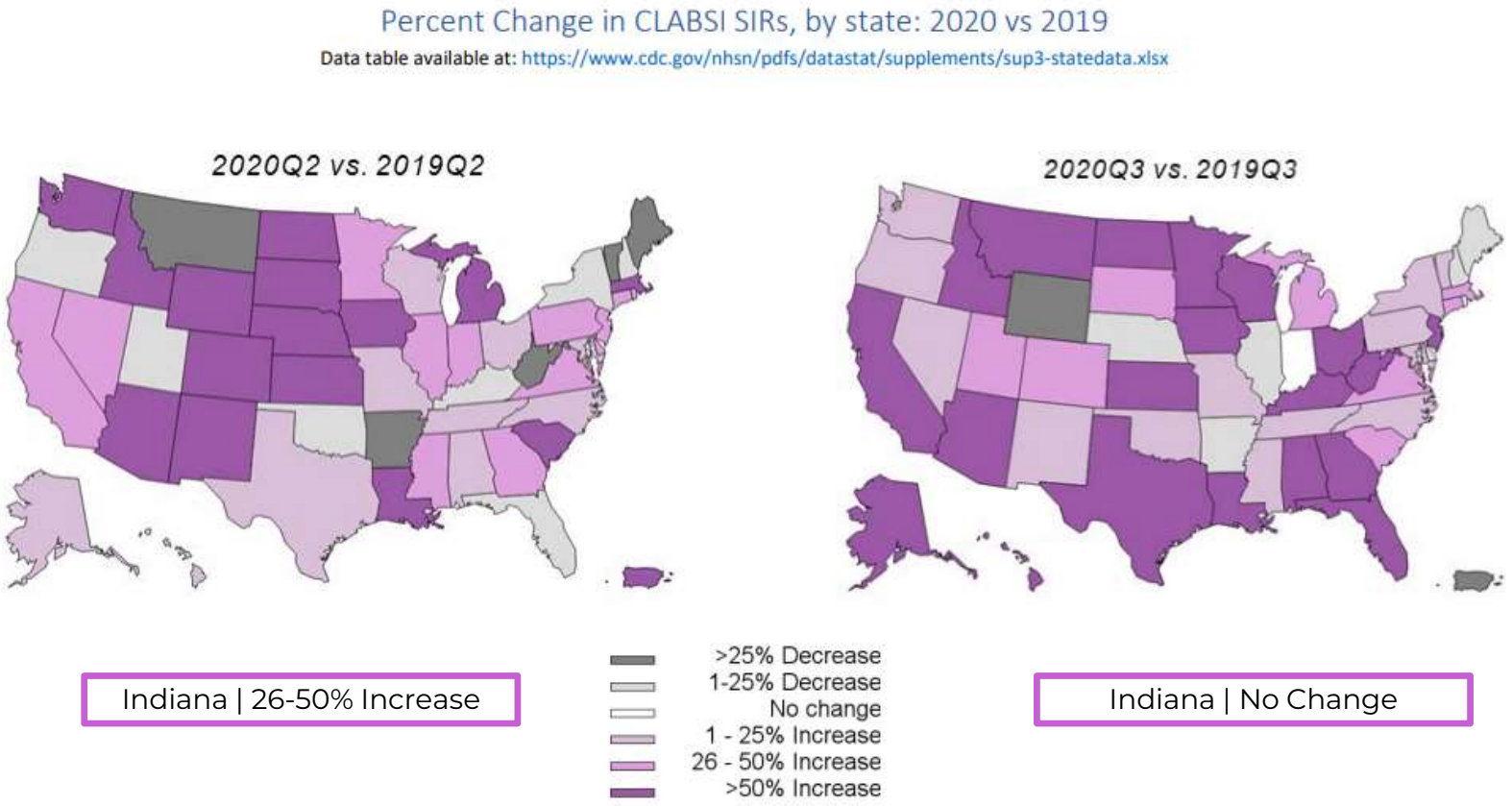
COVID Impact on HAIs | National SIRs

Figure 1. Quarterly National SIRs for Select HAI Types, 2019-Q1 - 2021-Q3



https://www.cdc.gov/hai/data/portal/covid-impact-hai.html#anchor_1654807396312; Retrieved 09.08.22

And Closer to Home | **CLABSI**

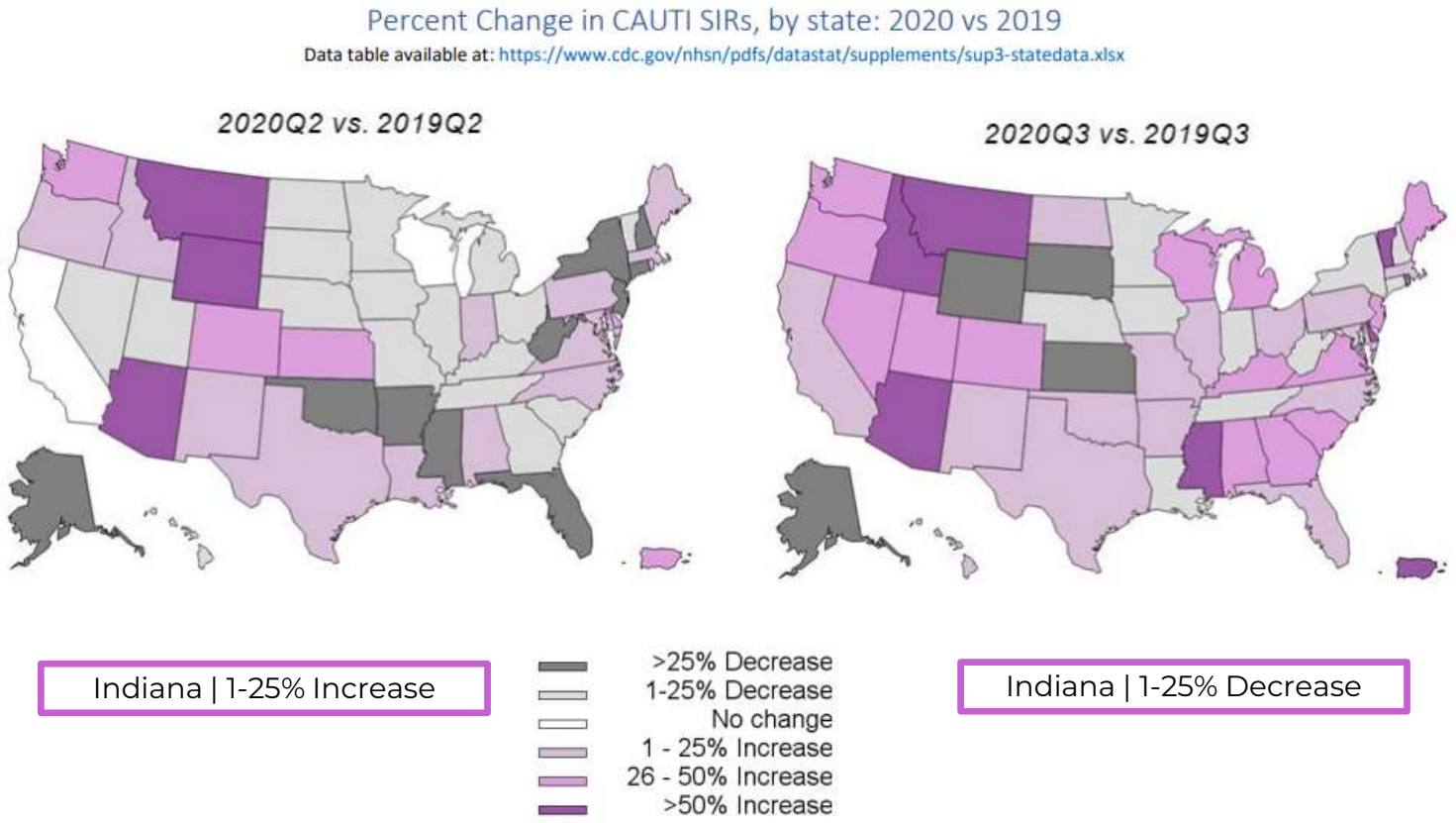


Indiana | 26-50% Increase

Indiana | No Change

Source: https://www.cdc.gov/nhsn/pdfs/datastat/supplements/USMaps-SIRchange-508.pdf; retrieved 09.08.22

And Closer to Home | **CAUTI**

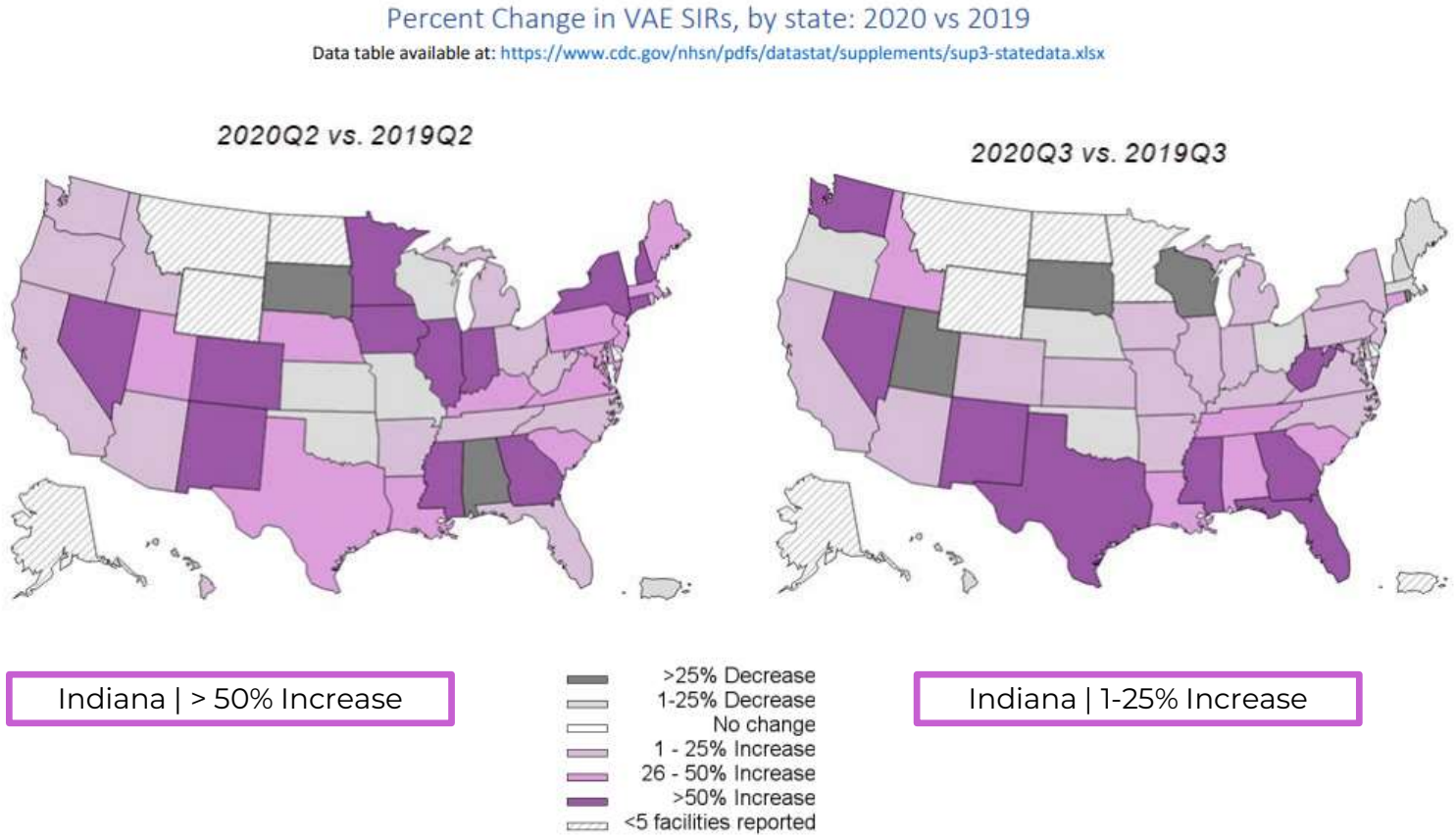


Indiana | 1-25% Increase

Indiana | 1-25% Decrease

Source: https://www.cdc.gov/nhsn/pdfs/datastat/supplements/USMaps-SIRchange-508.pdf; retrieved 09.08.22

And Closer to Home | **VAE**

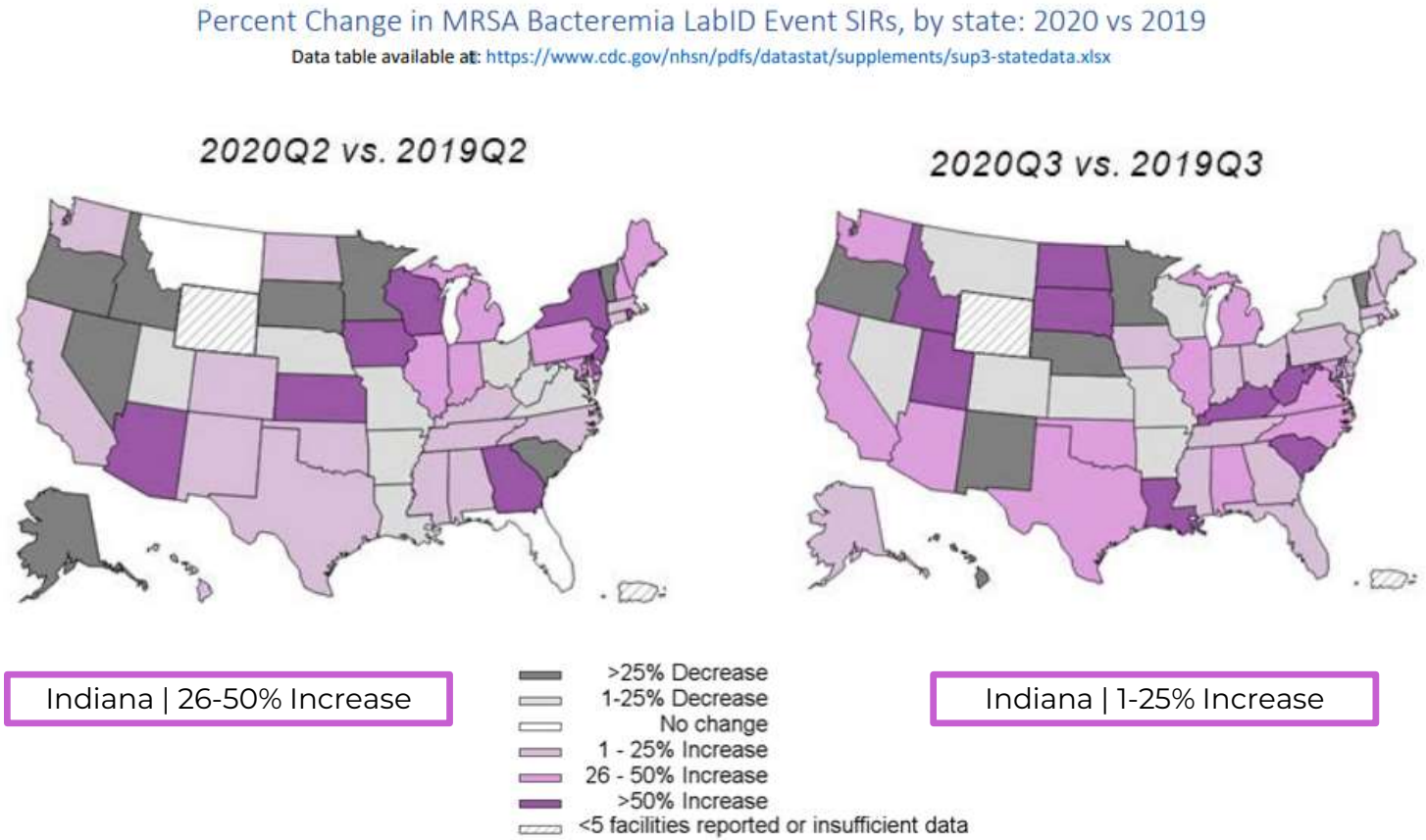


Indiana | > 50% Increase

Indiana | 1-25% Increase

Source: https://www.cdc.gov/nhsn/pdfs/datastat/supplements/USMaps-SIRchange-508.pdf; retrieved 09.08.22

And Closer to Home | **MRSA**



Indiana | 26-50% Increase

Indiana | 1-25% Increase

Source: https://www.cdc.gov/nhsn/pdfs/datastat/supplements/USMaps-SIRchange-508.pdf; retrieved 09.08.22

Adding to the Landscape of Hospital-Acquired Infections

Journal List › Int J Environ Res Public Health › v.18(2); 2021 Jan › PMC7827479

International Journal of Environmental Research and Public Health

MDPI

Int J Environ Res P

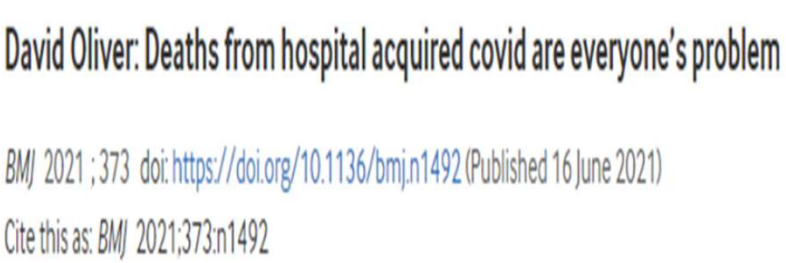
Int J Environ Res Public Health. 2021 Jan; 18(2): 489.
Published online 2021 Jan 9. doi: 10.3390/ijerph18020489

PMCID: PMC
PMID: 3

Hospital-Acquired SARS-Cov-2 Infections in Patients: Inevitable Conditions or Medical Malpractice?

Rosario Barranco,* Luca Vallega Bernucci Du Tremoul, and Francesco Ventura

▸ Author information ▸ Article notes ▸ Copyright and License information Disclaimer



David Oliver: Deaths from hospital acquired covid are everyone's problem

BMJ 2021 ; 373 doi: https://doi.org/10.1136/bmj.n1492 (Published 16 June 2021)

Cite this as: *BMJ* 2021;373:n1492

Infection Control Patient Safety & Outcomes Public Health Nursing

Physician viewpoint: Hospital-acquired COVID-19 is rampant, but facilities aren't sounding the alarm

Mackenzie Bean - Thursday, January 21st, 2021 Print | Email

Share Tweet Share 10 Listen

And Yet, COVID Taught Us That.....

- ICU beds can be created in an hour
- Care delivery methods can transform almost overnight
- Auto manufacturers can make high-tech medical equipment
- Communities can come together to support the frontline
- Government can adjust regulations quickly, can fast-track medication approvals
- Adoption of infection prevention practices can occur quickly and globally
- Acute level hospital care can be safely provided in patient homes
- Common public health strategies can become highly politicized
- Our colleagues would leave their professions to avoid being vaccinated
- And...**COVID-driven workarounds would threaten to become lasting practice**

“Never waste a good crisis”

- Winston Churchill

2

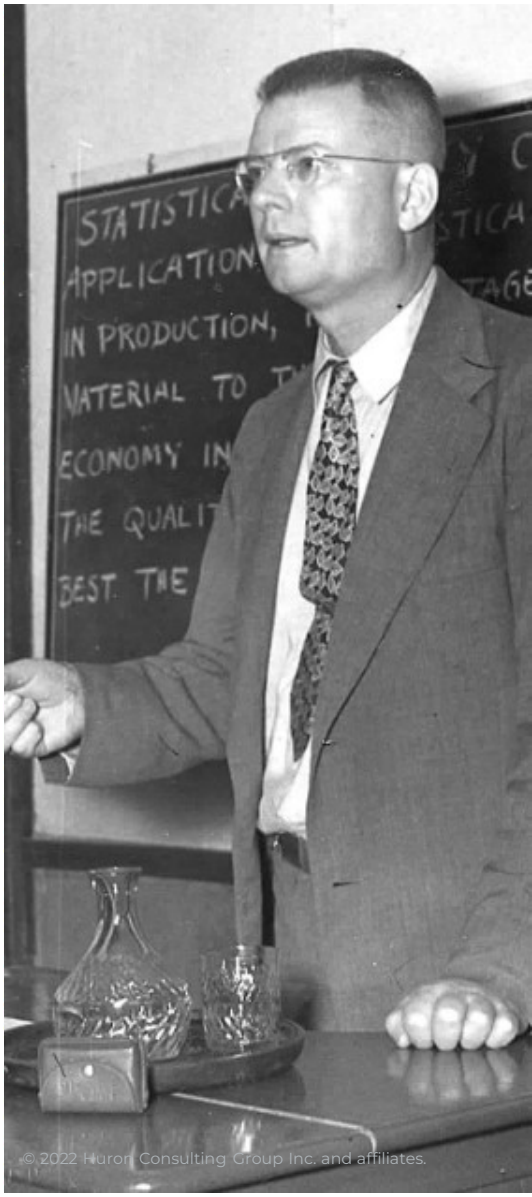
High Reliability:

Its Role in Patient Safety and What's in the Way of Zero Harm

“Every system is perfectly designed to get the results it gets.”

W. EDWARDS DEMING

NYU STATISTICS PROFESSOR, CONSIDERED THE FOUNDING FATHER OF QUALITY IMPROVEMENT



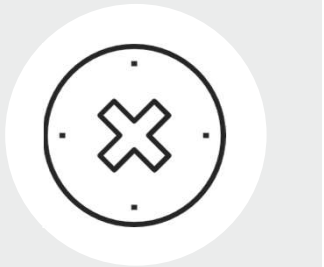
High Reliability Organizations (HROs)

HROs are organizations that operate in complex, high-hazard domains for extended periods without serious accidents or catastrophic failures.

HROs cultivate resilience by relentlessly prioritizing safety over other performance measures.

Source: https://psnet.ahrq.gov

Five Traits of High Reliability Organizations



1. PREOCCUPATION WITH FAILURE

- Constant focus on what could happen/go wrong
- Relentless commitment to prevent mistakes
- Recognizing signs that a threat may be developing
- Constant mindfulness of the situation at hand

2. COMMITMENT TO RESILIANCE

- Recognition that despite best efforts, errors will occur in this very complex environment
- Identifying & containing issues to prevent additional disruption
- Recovering quickly to avoid derailment

3. SENSITIVITY TO OPERATIONS

- Recognizing challenges of running a complex health system
- Evaluating how processes & systems affect the organization
- Supporting staff to pay attention to operations and to be aware of what is working and not working
- Driving organizational awareness through improved communication

4. DEFERENCE TO EXPERTISE

- Valuing experience
- Avoiding making decisions based on power
- Giving decision making authority to the person(s) identified to have the greatest expertise to manage the situation

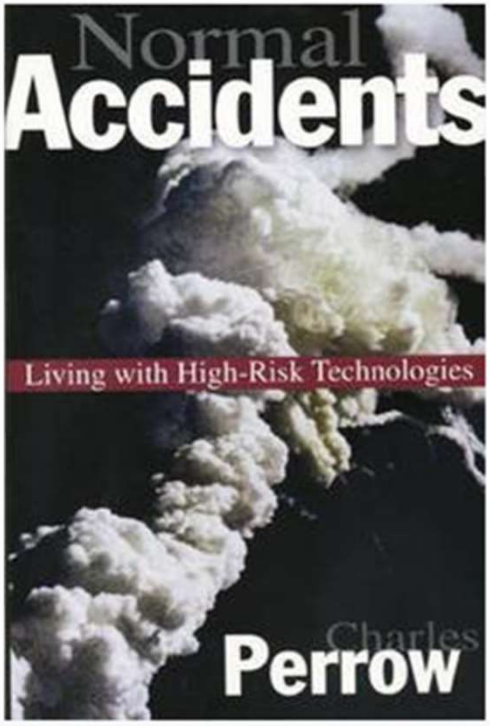
5. RELUNTANCE TO SIMPLIFY

- Understanding that threats to safety can be complex
- Accepting additional steps/work to ensure safety
- Refusing to simply reasons for errors or solutions to problems

Source: Weick, K., Sutcliffe, K. (2007). *Managing the Unexpected: Resilient Performance in the Age of Uncertainty*. Jossey-Bass.

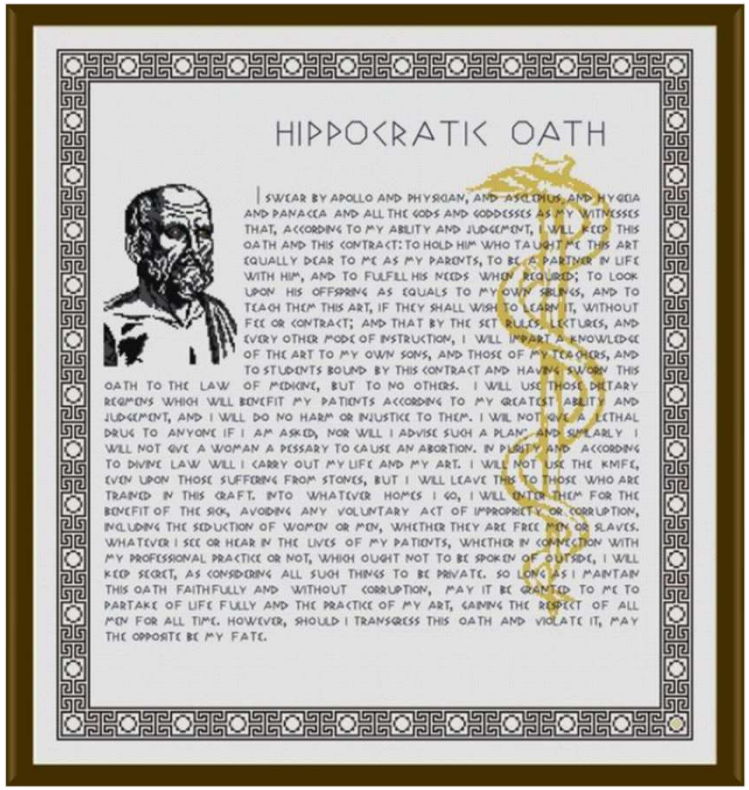
The History of High Reliability

Normal Accident Theory | “Big accidents almost always have very small beginnings” *Charles Perrow*



Source: Perrow, C. (1984). *Normal Accidents: Living with high-risk technologies*. Basic Books.

The *REAL* Beginnings of High Reliability in Healthcare



Hippocrates, 5th to 3rd centuries BC

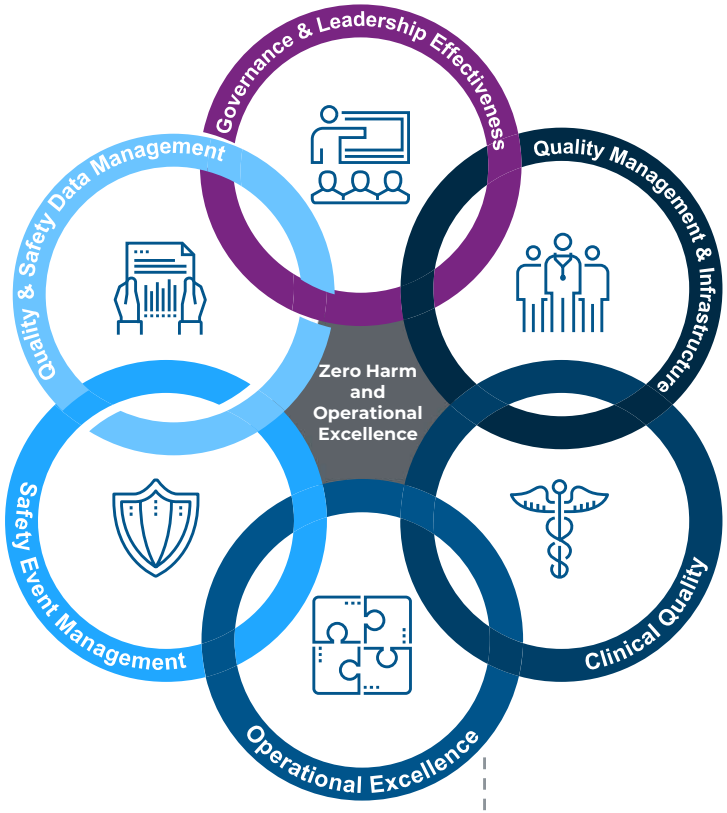
Lystra Gretter & Farrand Training School Grace for Nurses,1893

Patient Safety Areas of Focus

Quality, Safety, and High Reliability **Executive Committees**, Board Quality Sub-committee, **Culture of Safety, Accountability and Transparency**, Standards of Behavior/Code of Conduct

Dashboard Optimization, Utilization, and **Reporting, Data** Monitoring and Analyses, Data Integrity and Accuracy, Publicly Reported Quality/Safety Metrics

Safety Event Reporting, Event Escalation Management, Identification and Prioritization of Process Improvement Initiatives, Event Reporting Loop Closure, Root and Apparent Cause Analyses, Learning Culture



Leader/Provider/Staff Engagement and Education, Formal **Process Improvement** Methodology, Continuous Improvement/Sustainability Environment, Process Integrity, Audits and Validations, System and Site Quality Reporting Structure, Daily Leadership Safety Huddles

Patient and Workforce Safety, Service Line Specific Quality and Safety, Medication Errors, Unplanned Hospital Readmissions, Specimen Management, Hand Hygiene, Health Equity, Evidence-based Protocol and Bundle Adherence, Antibiotic Stewardship, Patient Experience, Infections, Falls, Pressure Injuries, Post-surgical Complications, Sentinel and Never Events

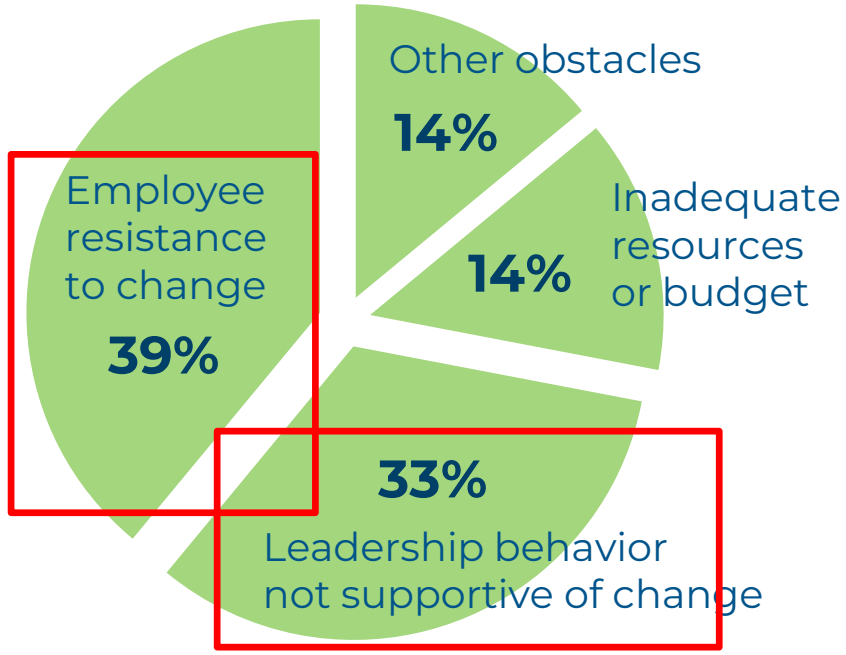
Environment of Care, Building Safety, Talent Management, Patient Flow and Throughput, Community Partnerships, Patient Family Advisory, Financial Performance, Supply Chain

Truth is, High Reliability is Hard!

And sustainability is elusive

Across healthcare, over 70% of change and transformation initiatives fail.

Understanding why strategies fail is important to avoiding pitfalls on the road to high reliability.



39 + 33 = **72%**

Source: McKinsey. (2015). *Changing change management*.

In the Way of Highly Reliable Patient Safety…

1. Reluctant to hold staff accountable out of fear
2. Uncomfortable ‘having the conversation’
3. Culture doesn’t fully promote speaking up
4. Leaders are pulled into frontline care/service delivery
5. Tolerant of variance

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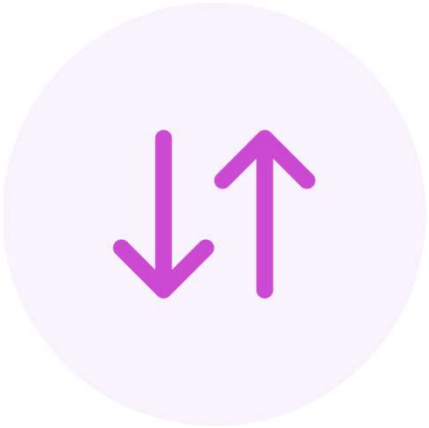


Rank the barriers to highly reliable outcomes at your organization

1 = largest, 5 = smallest

ⓘ Start presenting to display the poll results on this slide.

So……What do you think?

Let’s get some convo going on this one!

At your tables, take 10 minutes to:

- Discuss your thoughts about accountability as a tool to foster high reliability
  - Agree? Disagree? Still on the fence?
- Share feedback on the stories we just head from ‘Dear Accountability’
- Openly share the barriers to improving highly reliable outcomes at your organization
  - Where are the barriers? Why did you rank them the way you did?

Be ready to share with the rest of us!

4

Normalization of Deviance

Pandemic-Related Risk to Patient Safety

Normalization of Deviance Defined

The impact of undesired variation

- The **gradual process of deviating from standard operating procedures** for various reasons and the deviation, over time, becomes normal practice as no immediate adverse outcomes occur
- Concept and **term coined by Diane Vaughn** in her analysis of the **1986 Challenger disaster**
- Vaughn considered the **concept social in nature** as people within an organization become so accustomed to a deviation, they no longer consider it deviant or unsafe

Source: American Society for Health Care Risk Management. (2022). *ASHRM Patient safety tip sheet: Normalization of deviance in healthcare*

Normalization of Deviance | Safety in Space

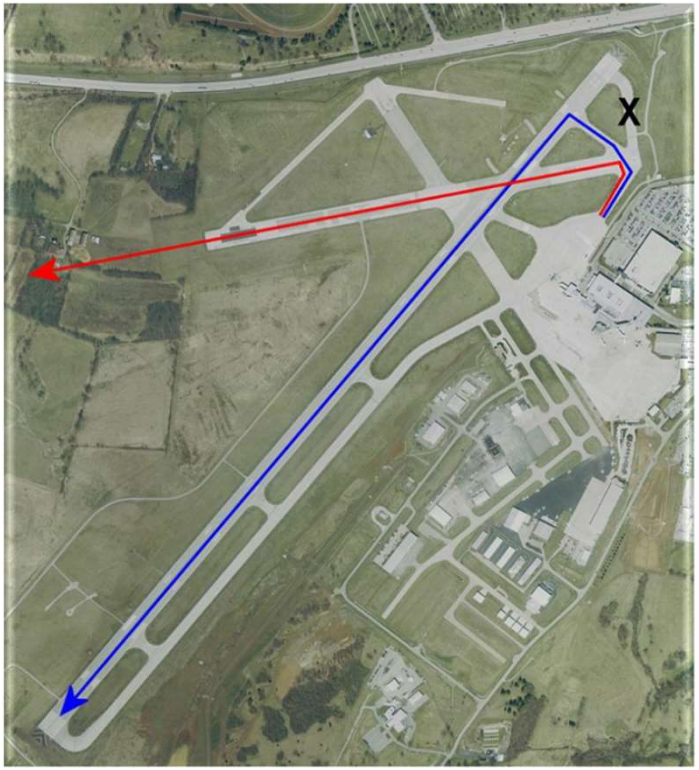
A slow drift away from the norm toward catastrophic failure.....

Space Shuttle Challenger | January 28,1986

The gradual process through which unacceptable practice or standards become acceptable.

Normalization of Deviance | Safety in the Air

A slow drift away from the norm toward catastrophic failure.....



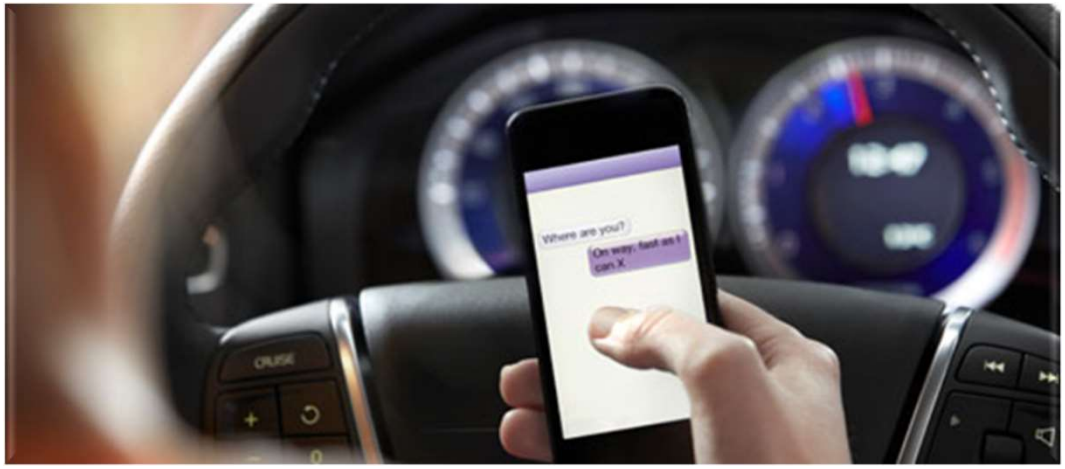
Comair Flight 5191 | August 27, 2006

The gradual process through which unacceptable practice or standards become acceptable.

Normalization of Deviance | Safety on the Road

A slow drift away from the norm toward catastrophic failure.....

The gradual process through which unacceptable practice or standards become acceptable.



Over 3,100 killed in distracted driver car accidents in 2019[1]

Distracted driving accident rates felt to be seriously under-reported[2]

Source 1: National Safety Council 2021
Source 2: CDC 2022

Normalization of Deviance | Safety at Home

A slow drift away from the norm toward catastrophic failure.....

The gradual process through which unacceptable practice or standards become acceptable.

500,00 treated for falls from ladders each year; 97% occur at home

Source: Industrial Safety & Hygiene News. (2017).

Normalization of Deviance | Healthcare

COVID demanded this of us…..but what about *before* COVID? And what do we do *moving forward*?

- Bypassing barcode alarms
- Not cleansing hands
- Skipping surgical checklist activities
- Hoarding/hiding scarce supplies
- Failure to address gaps in expected behavior
- Short-cutting care when staffing resources are limited

3

Leading through Influence

Rounding for Safety

“Trust is the foundation of a safety culture. Trust leads concerned employees to report unsafe situations and events and to identify opportunities for improvement.”

THE JOINT COMMISSION CENTER FOR TRANSFORMING HEALTHCARE

Anti-variance Strategy: Rounding for Safety

Rounding with others to identify workarounds and increase safety

- Highly reliable leaders build a positive, engaging work environment where they create strong relationships
- Rounding improves engagement in leaders and staff alike which results in improved safety and quality outcomes
- Rounding helps leaders gather actionable information efficiently
- Rounding provides a formal path for staff to share their wins, concerns, and ideas for safety and operational improvement

Source: Gallup, Inc. 2015. *The state of the American manager.*

Leading Through Influence: Rounding for Safety

Questions	Promotes
Personal connection*	Trust
What's going well* in terms of keeping our patients and team safe?	Commitment to Resilience, Zero Harm, Operational Excellence
Who can I recognize* for helping you or others keep our patients and work environment safe?	Psychological Safety, Collective Mindfulness, Trust
Do you have what you need* to keep yourself and our patients safe? (tools and equipment)	Preoccupation with Failure, Situational Awareness, Trust
What COVID-related workarounds are still happening today?	Sensitivity to Operations, Human Factors
What things changed during COVID that you think we should continue?	Deference to Expertise, Systems Thinking
What tough questions* about patient safety can I answer for you?	Psychological Safety, Trust

Note: *Bolded portion of question should remain the same when customizing focus for rounding

“Without a standard, there is no logical basis for decision making or taking action.”

JOSEPH DURAN

WIDELY CREDITED FOR ADDING THE HUMAN DIMENSION TO QUALITY MANAGEMENT

Leading Through Influence: Rounding for Safety

Considerations for Leader Standard Work

- **Coordinate rounding efforts** to ensure alignment, avoid duplicity
- **Identify key stakeholders** in accordance with your role
- Seek immediate **leader green** light to round with those you've identified
- Schedule time, introduce the safety rounding practice; **lean in heavily on the 'why'**
- **Create psychological safety** to foster transparency
- **Document findings** to track and trend
- **Thank** those you round with
- **Follow-up** on items as identified during rounds
- **Share findings broadly** to collaborate on prioritization of unit, department, and organizational process and practice restoration efforts

5

Deepening Patient Engagement in Safety Strategy

Health Equity

Health Equity as a Patient Safety Imperative

Viewpoint | Published: 14 May 2020

COVID-19 and Health Disparities: the Reality of "the Great Equalizer"

Stephen A Mein MD

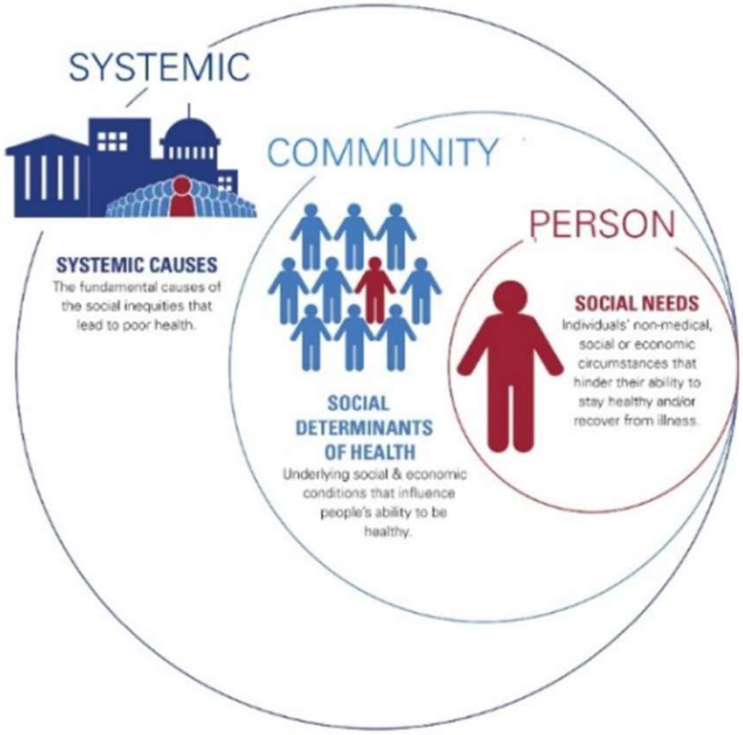
Journal of General Internal Medicine **35**, 2439–2440 (2020) | Cite this article

4570 Accesses | **68** Citations | **349** Altmetric | Metrics

Advancing health equity in patient safety: a reckoning, challenge and opportunity.

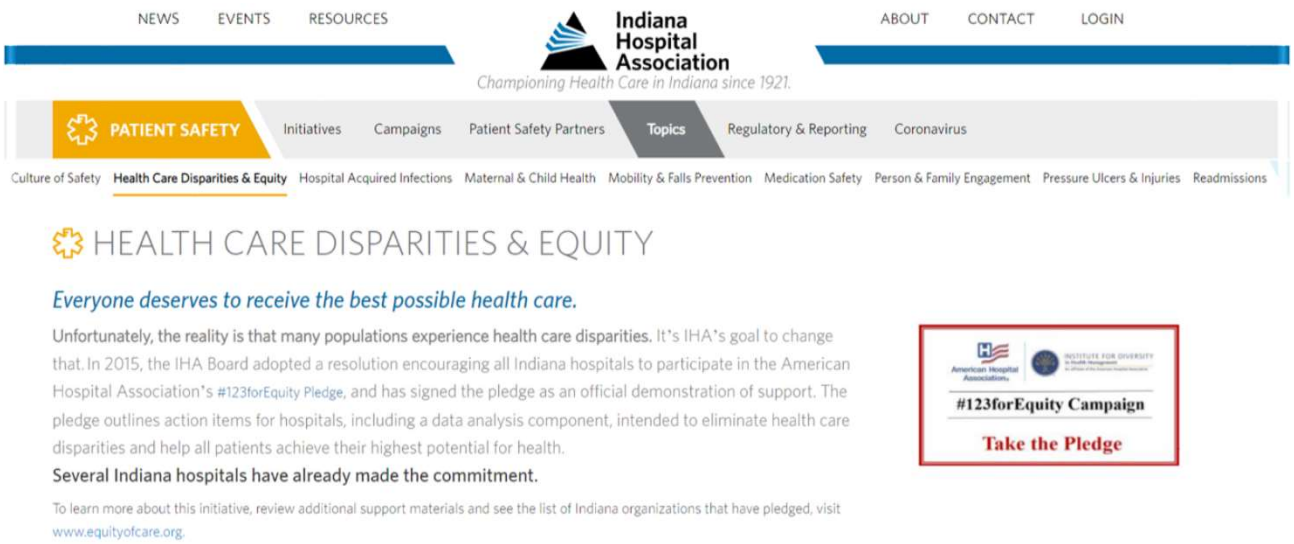
January 13, 2021

Chin MH. *BMJ Qual Saf.* 2021;30(5):356-361.



Graphic Source: https://www.aha.org/news/blog/2020-12-07-addressing-societal-factors-improve-health-equity

Health Equity in Indiana Hospitals



Health Equity Online Dashboard
- IU Health
- Franciscan Health
- Community Health Network
- Eskenazi
- Ascension St. Vincent

CMS Framework for Health Equity 2022 - 2023

Source: https://www.cms.gov/files/document/cms-framework-health-equity.pdf

New CMS Health Equity Quality Measures

Engaging patients in safety agenda

Measure Name	Finalized Start of Data Collection
Hospital Commitment to Health Equity	Calendar Year (CY) 23 reporting period
Screening for Social Drivers of Health	Voluntary reporting CY23; Mandatory CY24
Screen Positive Rate for Social Drivers of Health	Voluntary reporting CY23; Mandatory CY24

New CMS Health Equity Measures

Measure #1: Hospital Commitment to Health Equity Measure

- Measures **organizational competency aimed at achieving health equity** for racial and ethnic minority groups, people with disabilities, members of the LGBTQ+ community, individuals with limited English proficiency, rural populations, religious minorizes, and people facing socioeconomic challenges
- Includes 5 attestation domains and the elements within each of those domains the hospital must attest to in order to receive credit for that domain
- Domains include:
  - **Strategic planning**
  - **Data collection**
  - **Data analysis**
  - **Quality improvement**
  - **Leadership engagement**

New CMS Health Equity Measures

Measure #2: Screening for Social Drivers of Health

- Assesses whether a hospital **implements screening of all patients 18 years and older** for health-related social needs at the time of admission
- Health-related social needs include:
  - **Food insecurity**
  - **Housing instability**
  - **Transportation needs**
  - **Utilities difficulties**
  - **Interpersonal safety**
- Reported as a percent of qualifying admissions who were screened for all five of the health-related social needs
- CMS provided flexibility in selection of tools to screen patients

New CMS Health Equity Measures

Measure #3: Screen Positive Rate for Social Drivers of Health

- Identifies **percent of patients over 18 years of age who were screened positive** for one or more of the five health-related social needs
  - Numerator is number of qualifying admitted patients who screened positive for one or more of health-related social needs
  - Denominator is number of total qualifying admitted patients who were screened

New CMS Health Equity Measures

Engaging patients in the safety agenda

Plan

- Appoint an executive champion to oversee implementation
- Identify project management support resources
- Determine internal organizational stakeholders (departments and individuals)
- Establish project plan to include voluntary and mandatory reporting windows

Do

- Conduct current state gap analysis
- Update internal workflows, provide education

Check

- Validate consistent adoption of all new required processes and behaviors

Act

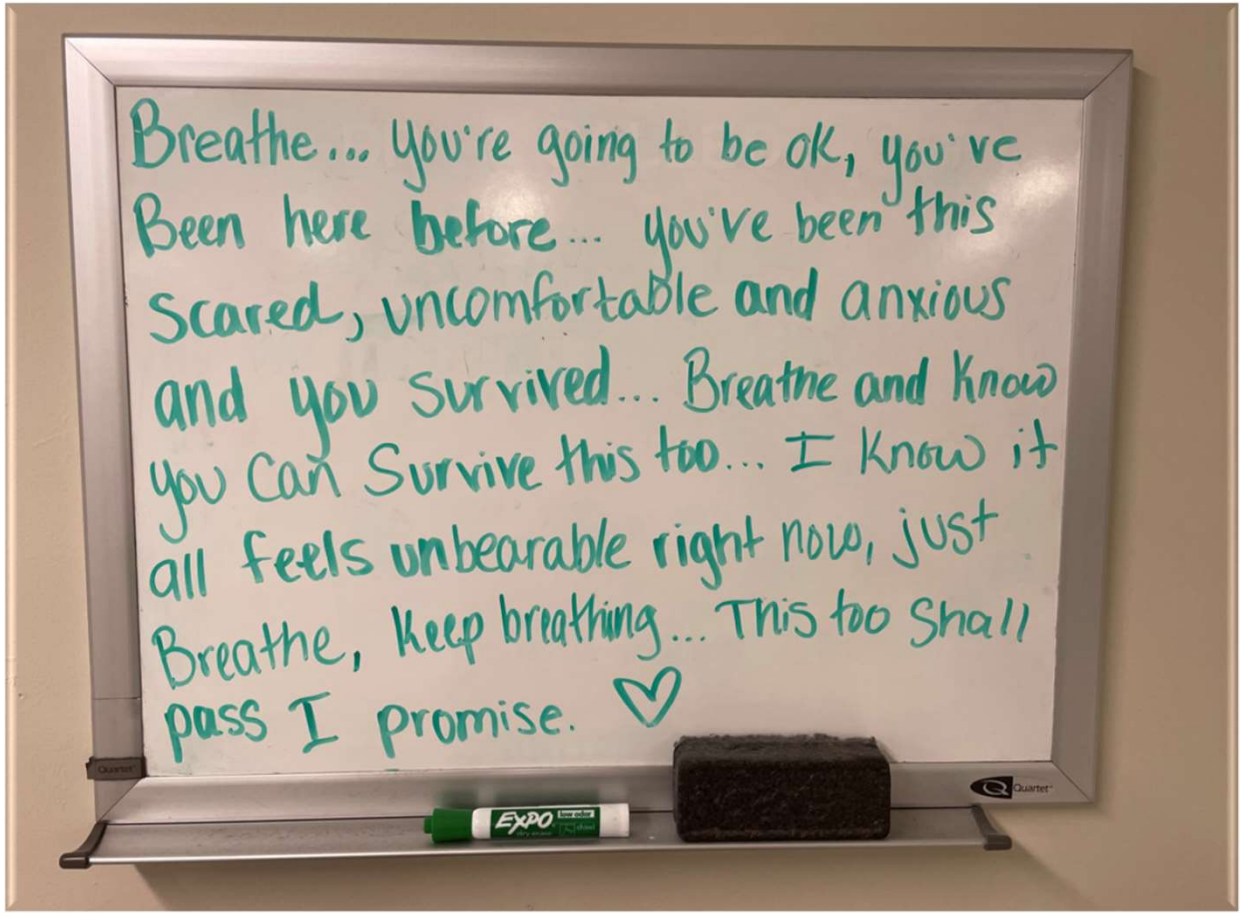
- Address gaps through process redesign, training, and/or coaching

Let’s Review our Learning Objectives

Are you now able to?

1. Use the impact of the pandemic on the healthcare industry and on your own organization’s outcomes to create urgency for change
2. Describe the role of patient safety leaders in influencing the restoration of safety practices impacted by the pandemic through application of the key tenets of high reliability
3. Implement one innovative strategy to deepen patient engagement in your organization’s post-pandemic patient safety agenda

No One Promised us Easy.....



But together, we've got this!

Thank You!

Vikki Choate, DNP, MSN, RN, NEA-BC, CPHQ, CPPS

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207.607.2218