Office of Patient Experience 2021

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Safety, Quality, Experience & Clinical Risk

Function together to stop harm and improve patient and caregiver experience by influencing a highly reliable “always safe” culture.

Office of Patient Experience 2021

Executive Team

- Chief Patient Experience Officer
- Executive Director
- Senior Nurse Executive

System Functions • Caring and Learning Together

- Safety
- Quality
- Experience
- Infection Prevention
- Patient Advocacy
- Regulatory Affairs
- Clinical Data
- External Reporting
- Physician Advisory Services

Caregivers are Deployed According to Geography and Care Continuum Demands

Patient & Family Advisors

OPE Teams

Align and support the work

- Hospitals
- Clinics
- Homecare

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OPE Work Groups

Geography

Care Continuum

Initiative

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Workgroup Structure

Directory Detail

Geographies

- Facilities in near proximity to facilitate resource flex as needed, e.g.,
  - Event or complaint management
  - Surveys
  - System or work deployment

Care Continuums

- Behavioral Health
- Children's Health, Primary Care
- Critical Care, Med Surg
- ED, Trauma
- Homecare, Hospice, Rehab
- Oncology
- Shared Services
- Surgical Services
- Women's Health

Initiatives

- Education
- Event Management
- Survey Readiness
- Provider Support
- Communication

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I **respect** you

Actively listen

Learn what matters to you

Use language you understand

I **care** about you

Support you with empathy

Answer your questions

Treat you with kindness

I keep you **safe**

Work collaboratively as a team

Speak up if there is a concern

Resolve problems when they come up

High Reliability = We do what we intend to do EVERYTIME

ARCC

- *Be approachable -- **LISTEN***
- *Encourage others' voices*
- *Listen for **'I have a concern'***

SBAR

- *Be clear and concise*
- *Respect others' time*
- *Request action*

STOP AND RESOLVE

- *Acknowledge uncertainty*
- *Address anything abnormal or unclear*
- *Listen for **'I have a concern'***

STANDARDIZED HAND OFF

- *Hand off situational awareness*
- *Model attention to detail*
- *What could go wrong?*

REPEAT-BACKS AND READ-BACKS

- *Take time and focus*
- *Confirm understanding of plan*
- *Listen for **'I have a clarifying question'***

STAR

- *Beware multitasking: stop and focus*
- *Take a diagnostic timeout*
- *Watch yourself for bias*

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Apology and Connection

Life of a Safety Event

Life of a Safety Event

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Life of a Safety Event

Reporting → Rapid Assessment → Analysis and Classification → Action Planning → Closing the loop

You cannot fix what you do not know is broken.

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Caring

What do our patients, their loved ones, and our caregivers need?

Learning

Did our process break down?

Do we need to make any changes to promote safety and experience?

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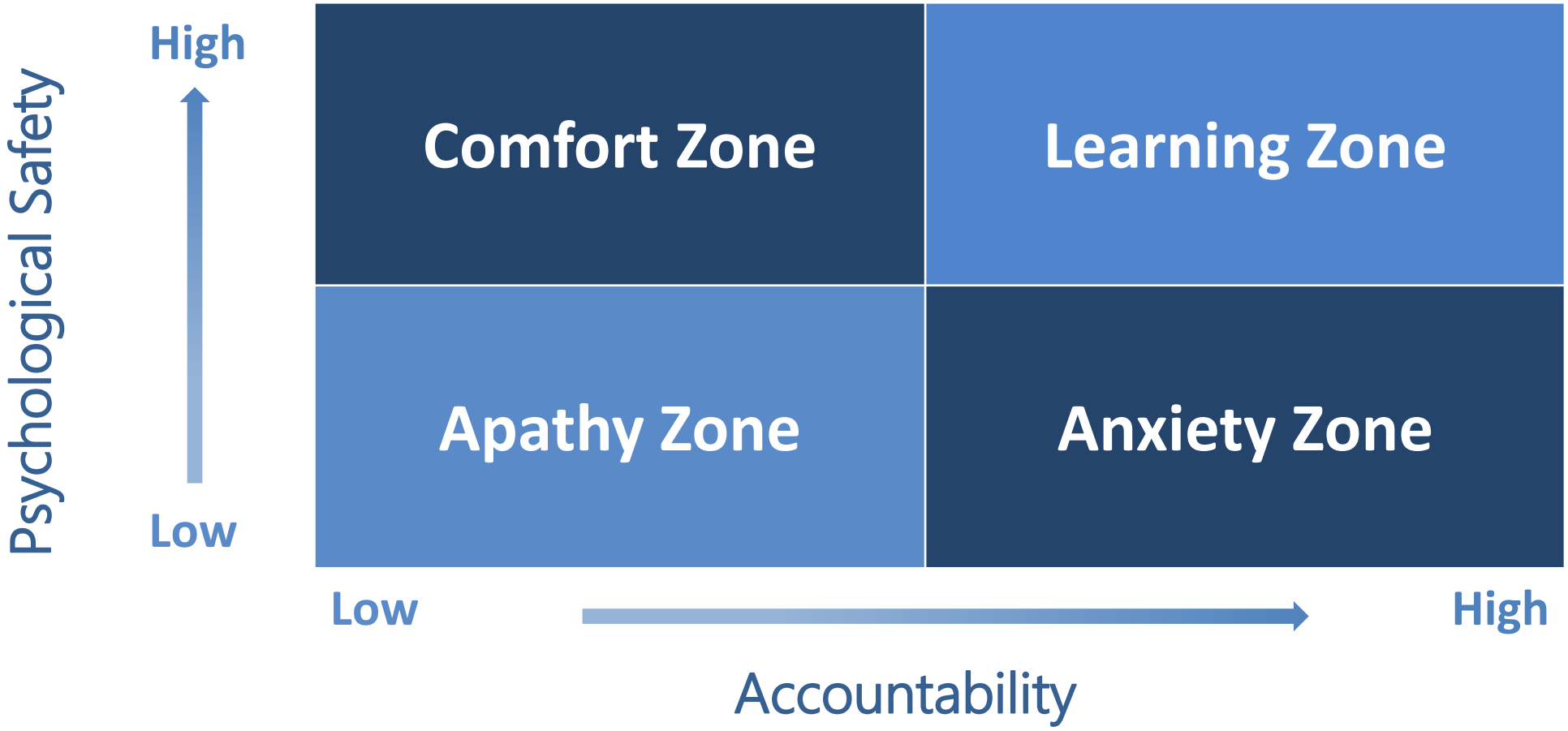
Psychological Safety and Accountability



Edmondson, Amy C. *Teaming: How Organizations Learn, Innovate, and Compete in the Knowledge Economy*. Jossey-Bass, 2012.

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Life of a Safety Event

Initial response to errors is key to ongoing transparency, and transparency is key to a highly reliable culture.

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Safety Pause

Caring

What do our patients, their loved ones, and our caregivers need?

Learning

Did our process break down?

Do we need to make any changes to promote safety?

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Safety Pause: Caring & Learning

A Brief Guide and Summary

The Safety Pause is an effective way for teams to respond when things don't go the way we intend or hope. A pause can be helpful after any difficult event: for example, the passing of a patient, a caregiver injury, a medical error, or an emotional encounter with an upset family member. Here's what you can expect:

Guiding Principles

1. **Caring:** What do our patients, their loved ones, and our caregivers need?
2. **Learning:** Did our process break down? Are any changes needed to promote safety?

Caring

Supporting caregivers after a difficult event

We want to help our patients live the healthiest lives possible, and our caregivers to be safe and fulfilled at work. Sometimes, despite our best efforts, the complexities of health and disease lead to unwanted outcomes – when this happens, we feel a great burden. Sharing this burden openly and intentionally, supporting one another, can help reduce the emotional toll on our caregivers.

Step 1. Notify your local leaders of the situation, who will engage the appropriate, small group, including the clinical risk team for support.

Step 2. This group will ask: How is the patient and family doing? What immediate communication or help do they need?

Step 3. A leader or peer will be assigned to reach out to affected caregivers to listen and offer emotional support. What do they need? Do they need time away from work? Offer employee assistance (EAP) contact.

Step 4. Huddling as a team and sharing emotions (EAP may be present for this) may be effective after difficult events. Ongoing support is often needed after difficult events. Contact your HR representative or the team lead for further guidance.

Learning

Learning quickly to improve our care

As an organization committed to keeping our patients and caregivers Always Safe, we strive to learn and continuously improve our processes.

Step 5. *Conversations to Learn:* The team will gather pertinent facts while memories are fresh to understand any potential risks that should be addressed immediately. Ask: Did our process break down?

Step 6. *Safety Pause Debrief:* The team lead will bring together involved caregivers to discuss what we learned. What immediate changes are needed to promote safety? How and when can the team safely return to work?

Is this a rigid process?

There may be variations in how this is done – and that's okay. Your teams and their leaders will provide some of the most effective support for each other. Remember that the guiding principles are **Caring** and **Learning** – aligning well with our values of Integrity, Trust, Excellence, Accountability, and Mutual Respect.

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Rapid Assessment (ad hoc meeting)

The Team:

1. Executive Leadership Team (Sentinel/Never Events)
2. Specialty Based and Community Based Leaders
3. Office of Patient Experience Leader
4. System Clinical Program and/or Shared Clinical Service Leaders
5. Local Administration, department leads and department managers
6. Clinical Risk and Safety

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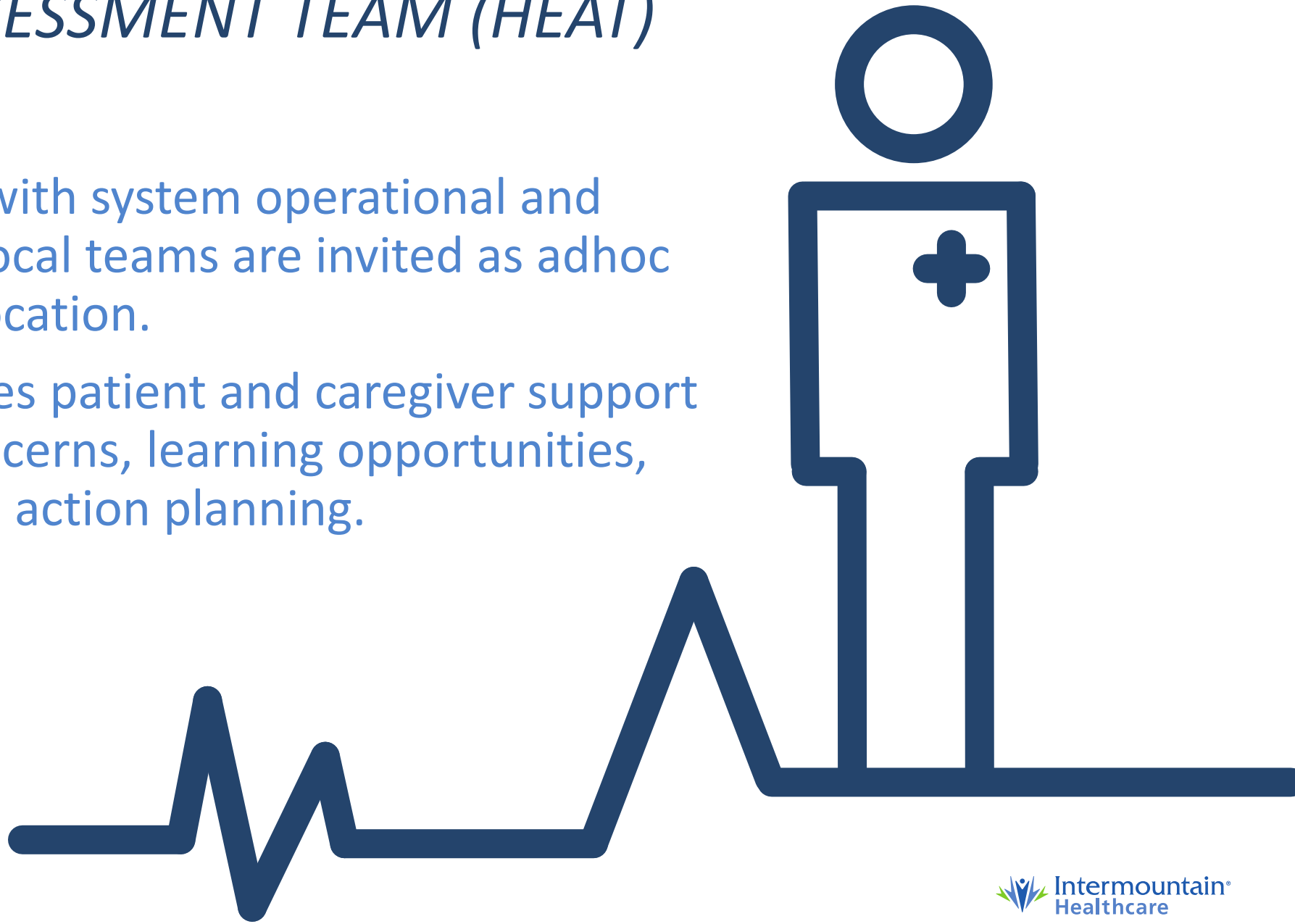
HARM EVENT ASSESSMENT TEAM (HEAT)

- Weekly meeting with system operational and clinical leaders. Local teams are invited as adhoc based on event location.
- Discussion includes patient and caregiver support needs, equity concerns, learning opportunities, classification, and action planning.



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Life of a Safety Event

Finding the holes in the cheese…

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PATIENT-CONTROLLED MORPHINE OVERDOSE

Cause Map

1 Problem

Pump was programmed for lower morphine concentration, which was not available

What	Problem(s)	Morphine overdose, patient death
When	Date	Unknown
	Different, unusual, unique	1 mg/mL cassette not available
Where	Facility, site	Post-anesthesia care unit & ward
	Unit, area, equipment	Infusion pump
	Task being performed	Pain management/recovering from C-section

Impact to the Goals

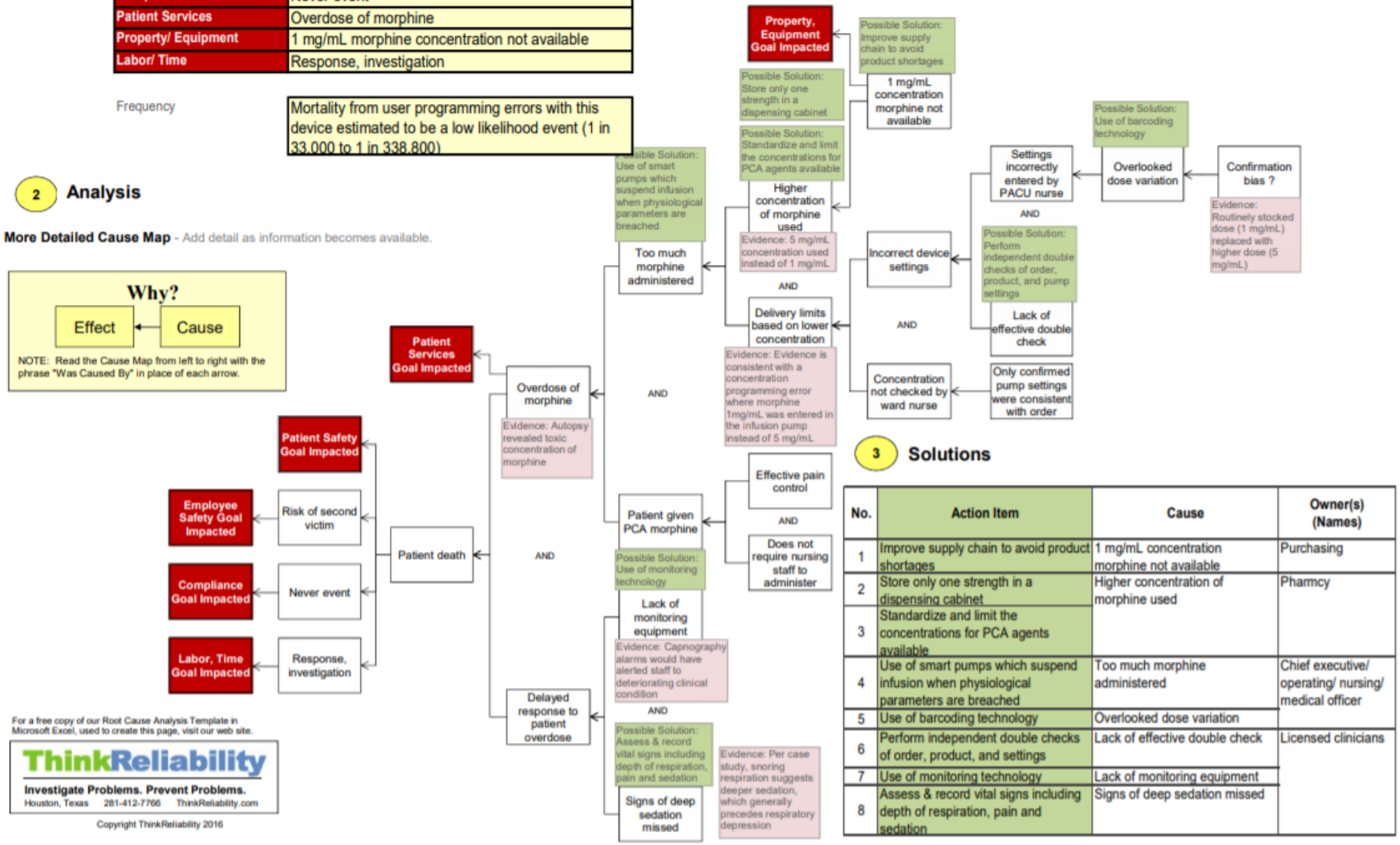
Patient Safety	Patient death
Employee Safety	Risk of second victim
Compliance	Never event
Patient Services	Overdose of morphine
Property/ Equipment	1 mg/mL morphine concentration not available
Labor/ Time	Response, investigation

Frequency: Mortality from user programming errors with this device estimated to be a low likelihood event (1 in 33,000 to 1 in 338,800)

Take-Home Points from "Death by PCA" Commentary by Rodney W. Hicks, PhD, RN, FNP
- PCA is widely used and is generally an effective method of postoperative pain management.
- While deaths from PCA are rare, they can occur and this heightens the importance of developing safe processes surrounding PCA use.
- Safe PCA use is highly dependent on a team comprised of clinicians, administrators, biomedical engineers, and quality improvement personnel.
- Organizations that employ PCAs must adopt and integrate technology - such as bedside barcoding and monitoring with capnography and oximetry - in order to facilitate safe medication use.

2 Analysis

More Detailed Cause Map - Add detail as information becomes available.



3 Solutions

No.	Action Item	Cause	Owner(s) (Names)
1	Improve supply chain to avoid product shortages	1 mg/mL concentration morphine not available	Purchasing
2	Store only one strength in a dispensing cabinet	Higher concentration of morphine used	Pharmcy
3	Standardize and limit the concentrations for PCA agents available		
4	Use of smart pumps which suspend infusion when physiological parameters are breached	Too much morphine administered	Chief executive/ operating/ nursing/ medical officer
5	Use of barcoding technology	Overlooked dose variation	
6	Perform independent double checks of order, product, and settings	Lack of effective double check	Licensed clinicians
7	Use of monitoring technology	Lack of monitoring equipment	
8	Assess & record vital signs including depth of respiration, pain and sedation	Signs of deep sedation missed	

For a free copy of our Root Cause Analysis Template in Microsoft Excel, used to create this page, visit our web site.

ThinkReliability
Investigate Problems. Prevent Problems.
Houston, Texas 281-412-7766 ThinkReliability.com

Example of Cause Map Tool

ThinkReliability

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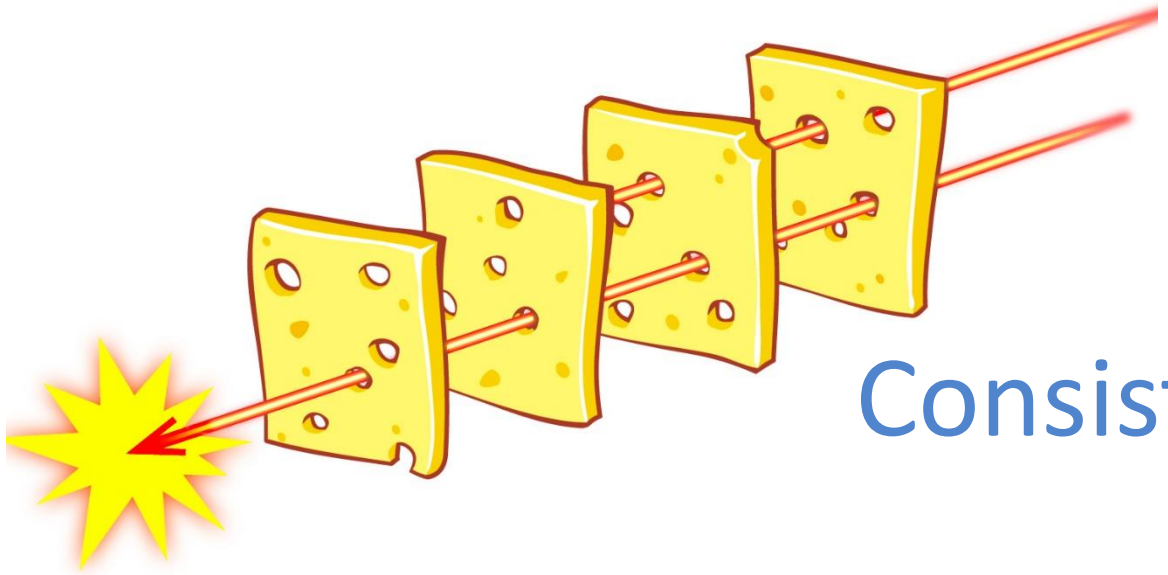
Reporting → Rapid Assessment → Analysis and **Classification** → Action Planning → Closing the loop



Consistently measuring harm

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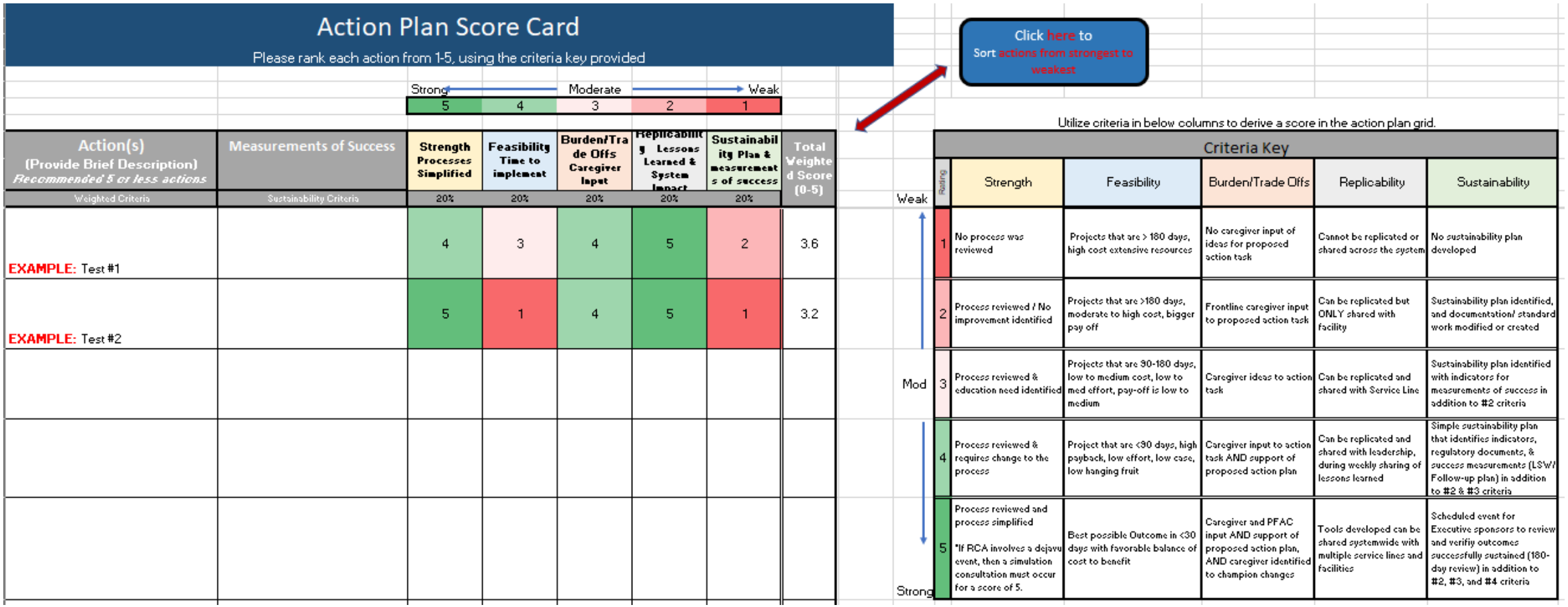
Life of a Safety Event

Reporting → Rapid Assessment → Analysis and Classification → **Action Planning** → Closing the loop

Strength of Action Planning Guide



Action Plan Score Card

Please rank each action from 1-5, using the criteria key provided

Strong ← Moderate → Weak

5	4	3	2	1

Action(s) (Provide Brief Description) *Recommended 5 or less actions*	Measurements of Success	Strength Processes Simplified	Feasibility Time to implement	Burden/Trade Offs Caregiver Input	Replicability Lessons Learned & System Impact	Sustainability Plan & measurements of success	Total Weighted Score (0-5)
Weighted Criteria	Sustainability Criteria	20%	20%	20%	20%	20%	
EXAMPLE: Test #1		4	3	4	5	2	3.6
EXAMPLE: Test #2		5	1	4	5	1	3.2

Click here to Sort actions from strongest to weakest

Utilize criteria in below columns to derive a score in the action plan grid.

Criteria Key

Rating	Strength	Feasibility	Burden/Trade Offs	Replicability	Sustainability
Weak					
1	No process was reviewed	Projects that are > 180 days, high cost extensive resources	No caregiver input of ideas for proposed action task	Cannot be replicated or shared across the system	No sustainability plan developed
2	Process reviewed / No improvement identified	Projects that are >180 days, moderate to high cost, bigger pay off	Frontline caregiver input to proposed action task	Can be replicated but ONLY shared with facility	Sustainability plan identified, and documentation/ standard work modified or created
Mod 3	Process reviewed & education need identified	Projects that are 90-180 days, low to medium cost, low to med effort, pay-off is low to medium	Caregiver ideas to action task	Can be replicated and shared with Service Line	Sustainability plan identified with indicators for measurements of success in addition to #2 criteria
4	Process reviewed & requires change to the process	Project that are <90 days, high payback, low effort, low case, low hanging fruit	Caregiver input to action task AND support of proposed action plan	Can be replicated and shared with leadership, during weekly sharing of lessons learned	Simple sustainability plan that identifies indicators, regulatory documents, & success measurements (LSW/ Follow-up plan) in addition to #2 & #3 criteria
Strong 5	Process reviewed and process simplified *If RCA involves a dejavu event, then a simulation consultation must occur for a score of 5.	Best possible Outcome in <30 days with favorable balance of cost to benefit	Caregiver and PFAC input AND support of proposed action plan, AND caregiver identified to champion changes	Tools developed can be shared systemwide with multiple service lines and facilities	Scheduled event for Executive sponsors to review and verify outcomes successfully sustained (180-day review) in addition to #2, #3, and #4 criteria

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Action Plan Tracking

Moving to the CI Portal

Problem Solving

Value Improvement

- Project Tracker
- Project Board
- Project Chart

Best Practice Integration

#	PROJECT NAME	PEOPLE	DEPARTMENT	KEY IDENTIFIERS	★	!	TEAM	START	FINISH	SAVINGS	📎	STATUS
1	Un...	Ryan Christensen, Daniel Nystrom	PC-Laboratory Transfusion	PSE, Physician/APP	Easy	!	PCH Safety Events	07/27/2020			1	10%
2	Gri...	Jeffrey Schunk, Stephanie Cruz	PC-Peds Infant Medical and Surg	NAS, Physician/APP	Easy	!	PCH Safety Events	07/08/2020			1	50%
3	Ri...	Angie Scartezina, Stephanie Cruz	PC-Peds Infant Medical and Surg	PSE	Med	!!	PCH Safety Events	07/01/2020			1	30%
4	Wr...	Ryan Christensen, Stephanie Cruz	PC-Imaging Administration	NAS	Easy	!	PCH Safety Events	05/06/2020			3	60%
5	Wr...	Lisa Vitkus, Stephanie Cruz	PC-Child Procedure Center	PSE	Hard	!!!	PCH Safety Events	06/17/2020			1	30%
6	VP...	Angie Scartezina, Daniel Nystrom	PC-Quality Management	Reportable, Physician/APP	Easy	!	PCH Safety Events	06/11/2020			2	0%
7	Mi...	Angie Scartezina, Daniel Nystrom	PC-Quality Management	PSE	Easy	!!	PCH Safety Events	05/28/2020			2	90%
8	De...	Lisa Vitkus, Stephanie Cruz	PC-Cardiology Administration	NAS	Easy	!	PCH Safety Events	05/27/2020	07/16/2020		1	100%
9	De...	Angie Scartezina, Stephanie Cruz	PC-Emergency Department	Physician/APP, PSE	Med	!!	PCH Safety Events	05/20/2020			1	40%
10	ED...	Angie Scartezina, Stephanie Cruz	PC-Emergency Department	SSE, Physician/APP	Easy	!!!	PCH Safety Events	05/20/2020			1	40%
11	St...	Lisa Vitkus, Stephanie Cruz	PC-Pediatrics Neuroscience-Trau...		Easy	!	PCH Safety Events	03/11/2020			1	50%
12	Bu...	Angie Scartezina, Stephanie Cruz	PC-Operating Rooms	Reportable, NAS	Easy	!	PCH Safety Events	03/10/2020	06/03/2020		1	100%
13	De...	Angie Scartezina, Stephanie Cruz	PC-Pediatrics Childrens Surgical	PSE	Hard	!!!	PCH Safety Events	04/15/2020			1	50%
14	De...	Angie Scar...										
15	Ur...	Angie Scar...										

Showing 1 to 15 of 20

Delay in Diagnosis of Abdominal Mass

CT PEOPLE DEPARTMENTS MEASUREMENTS A3 TASKS

edecessor Finish Date

LIST GANTT CALENDAR TEMPLATES

Name	Days	Start Date	Due Date	Assigned To	Flag	% Compl.	Notes
Action Plan Completed (within 30 days from HEAT)	30	05/27/2020	06/25/2020	Lisa Vitkus			
45 Day Check-in							
90 Day Check-in							
180 Day Check-in							
1 Year Check-in							

No Protected Health Information (PHI) or Personally Identifiable Information (PII) should be entered into this application

Sustainability

Life of a Safety Event

"The single biggest problem in communication is the illusion that it has taken place."

George Bernard Shaw

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Closing the Loop

- Reporting Caregiver
- Involved Caregivers
- Formal Lessons Learned
- Action Plan Evaluation Team
- Leadership Teams and Boards
- CI Portal Tracking

Questions?