# Improving the Culture of Safety in a High Reliability Organization

## Wednesday, May 1, 2024

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# How to Use the Chat Box Feature

## To send a Chat Message:

- **Open** the **Chat** Panel

- ***Scroll** All the Way **Down***
- ***Select "Everyone"***
  - ***Do not** select "All Attendees"*
- **Type message** in Chat Text Box, press **Enter** on your keyboard


**Enter in Chat:**

- **Name**
- **Role**
- **Organization**
- **State**

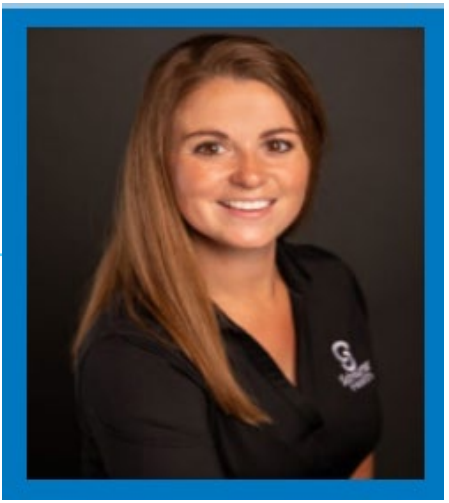
# Speaker

**Priscilla Ebone, MSN, RN, CPPS**
Patient Safety Subject Matter Expert
IPRO HQIC

Priscilla Ebone provides patient safety expertise to healthcare systems and organizations to advance the culture of patient safety and innovations at the point of care.

- With 15 years of RN bedside nursing care, Priscilla has practiced in the areas of home healthcare, acute care hospitals, hospice care, rehabilitation, and post-acute care settings. She recognizes that across the continuum of care, quality care is the necessary basic step to improve patient satisfaction, decrease length of stay, and better outcomes. In her patient safety role, she has conducted pressure ulcer event investigations, is very familiar with various root cause analysis outcomes, and has provided suggestions for best practices.
- Her passion to improve patient safety has motivated her to facilitate quarterly *HQIC Lunch and Learns.* She has chosen the topic of culture of safety this quarter.

# Speaker



Julia Harbuck-Valley, RN, BSN
Quality Manager Scheurer Health
Michigan Regional Healthcare

As a Quality Leader at Scheurer Health, Julia Harbuck-Valley thrives on evidence-based practice, data driven process improvement plans, and system-level team engagement to drive a culture of safety across our healthcare organization. With 10 years of nursing experience, Julia uses her expertise to understand clinical processes and foster engagement from frontline clinicians to further advance Scheurer's Culture of Safety.

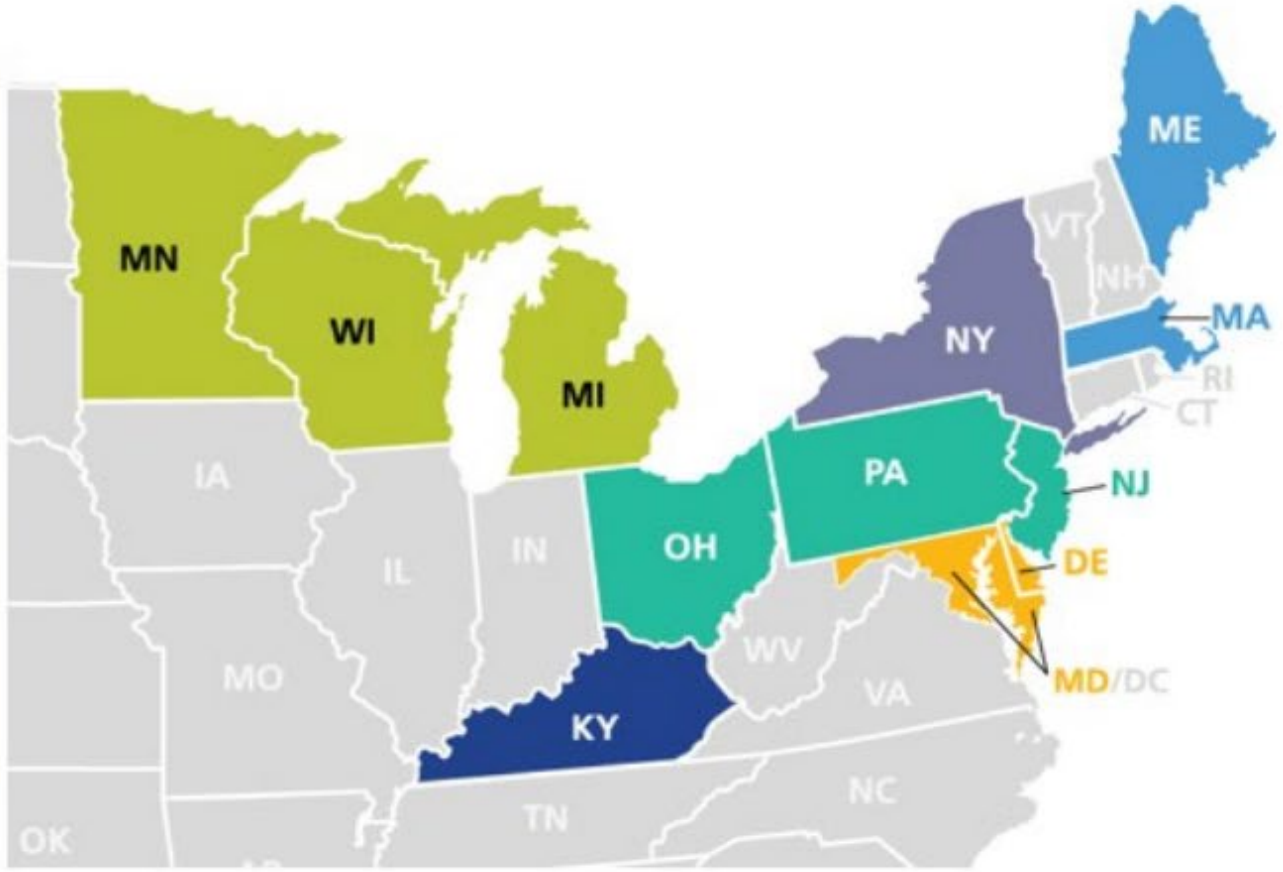
# Speaker

Jennifer Anderson, CPHQ
Lead Quality Performance Improvement Specialist
University of Michigan Health – Sparrow Michigan

- She stepped into the world of Healthcare Quality/Performance Improvement in 2014. She was then promoted to Community Hospital – Lead Quality/Performance Improvement Specialist in 2023 to begin standardizing work and reporting across the critical access and rural hospitals of the Sparrow Health System.
- Jennifer has been actively involved in the Michigan Critical Access Quality Network for over nine years. She led a Strategy Group – driven to ensure compliance with all data reporting to regulatory agencies. In 2017, Jennifer was elected by her peers to serve as Vice President, a position that she still holds. Recognized for demonstrating strong leadership in ensuring quality and safety across care settings, Jennifer was invited to serve on the HQIC Quality Advisory Council in 2022.

# IPRO Hospital Quality Improvement Contractor (HQIC)

- IPRO supports hospitals in improving care delivery systems affecting vulnerable populations
- IPRO works with 272 hospitals across 12 states
- Focus areas include:
  - All-cause harm
  - Patient and family engagement
  - Health equity
  - Immunizations and vaccines
  - Healthcare-acquired infections

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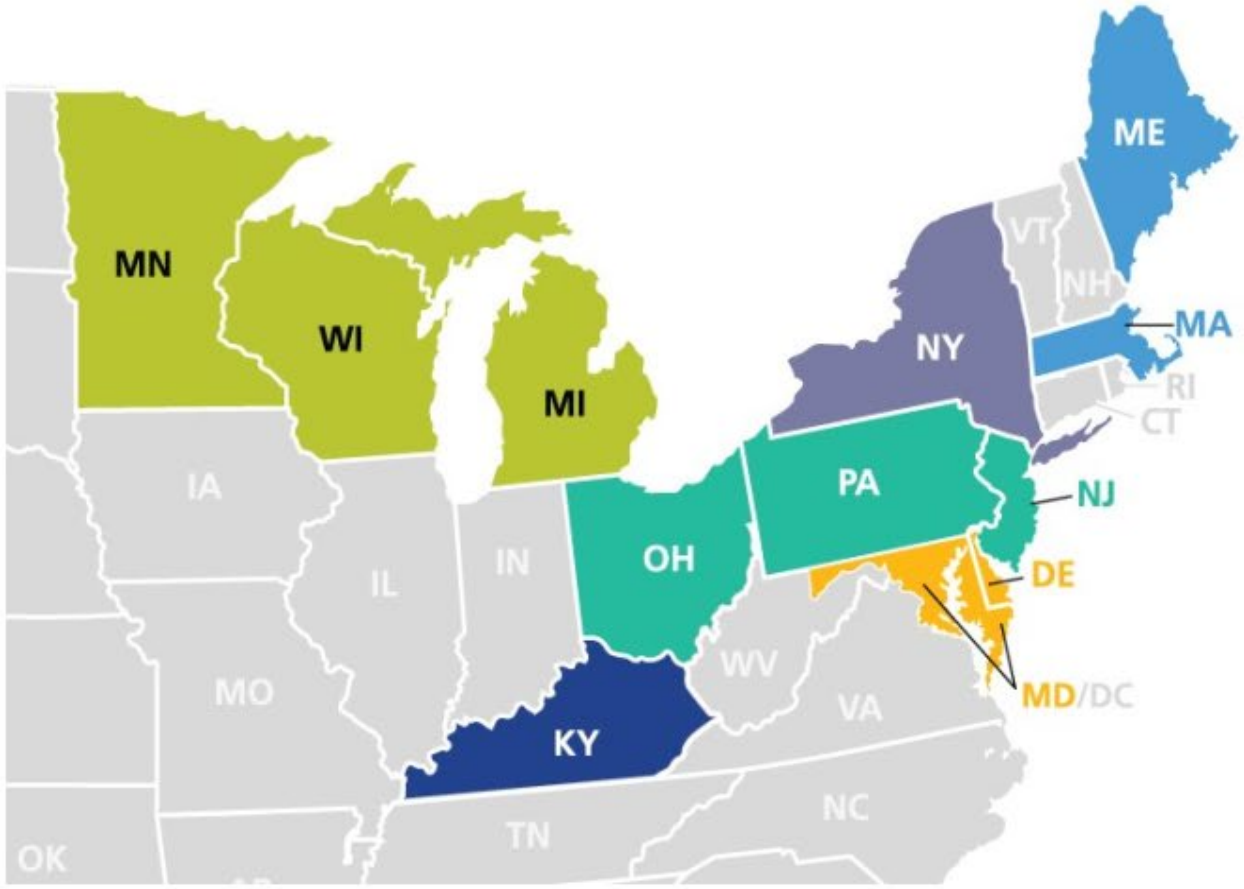
# IPRO Hospital Quality Improvement Contractor (HQIC)

| ENROLLMENT | | |
|---|---|---|
| | Enrolled at 6 months post contract award | Enrolled at 36 months post contract award |
| Total # of hospitals the HQIC has enrolled | 270 | 272 |
| Total # of rural hospitals | 97 | 94 |
| Total # of Critical Access Hospitals (CAHs) | 137 | 142 |
| Total # of tribal hospitals | 0 | 0 |
| Total # of Targeted IPPS (not included in the categories above) | 36 | 35 |
| Total # of REH | N/A | 1 |

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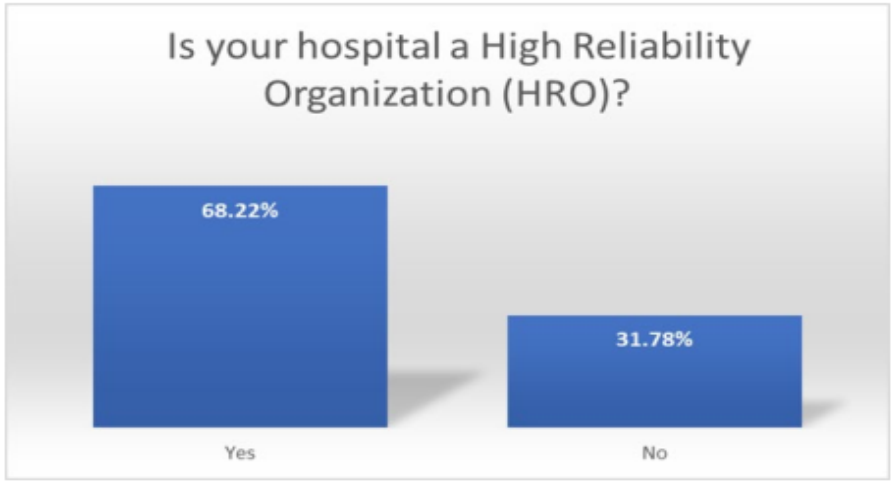
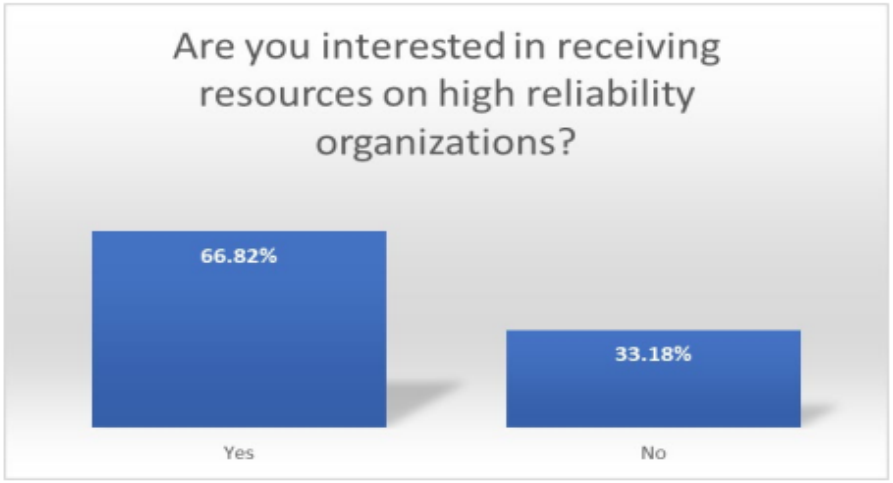
# IPRO Environmental Scan on HROs - Results

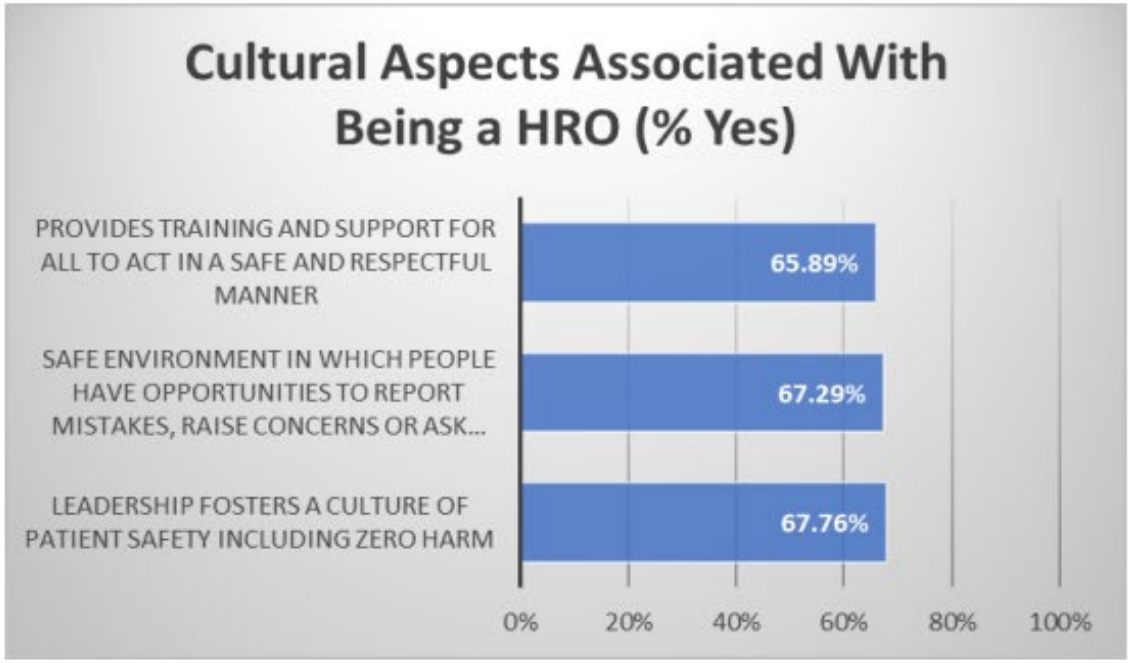
- Multi-topic scan – workplace violence, PFE, infection prevention training, HRO
- Received 214 completed assessments (78.7%)
- 8 questions focused solely on HROs

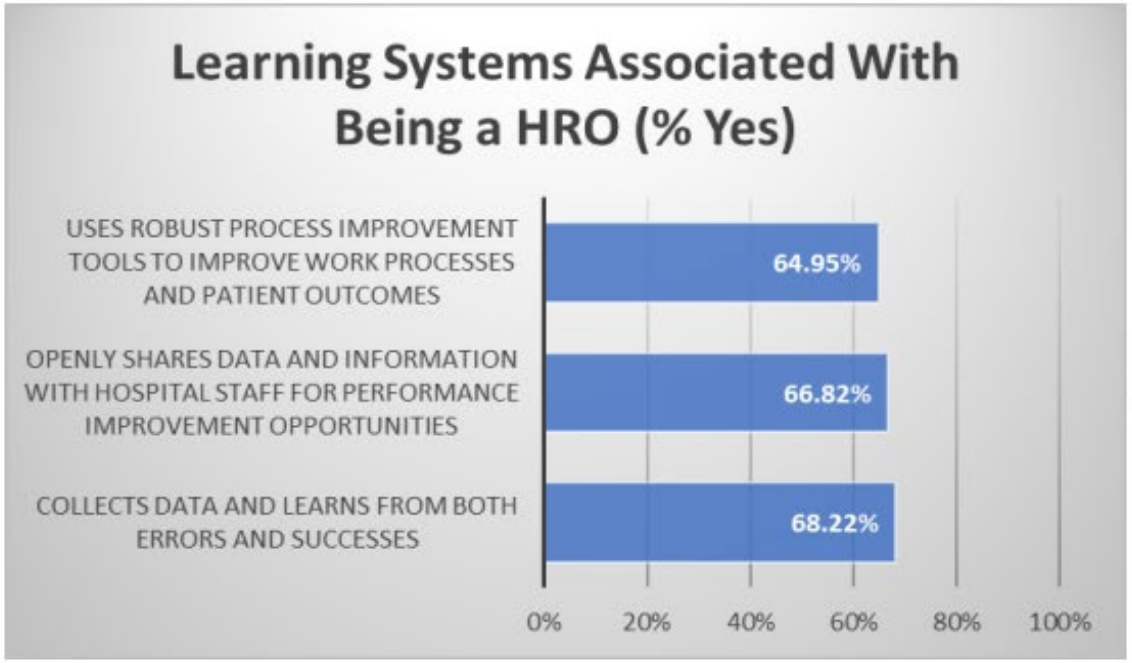



58% of HROs wanted additional resources (85/146)

# IPRO Environmental Scan on HROs - Results



# Objectives of Today's Presentation

In this Lunch and Learn webinar, you will learn about:

- The characteristics of the Culture of Safety
- Using successful tools to achieve the Culture of Safety
- How an organization adopted a safety culture in their High Reliability Organization (HRO) journey
- How leadership can support the Culture of Safety by using the proposed Patient Safety Structural Measure (AHRQ, 2023)

# Culture of Safety

Julia Harbuck-Valley RN, BSN
Manager of Quality

Scheurer Health

# Reaching to be an HRO

Purpose

Leadership & Education

Data & Transparency

Improvement Activities

Reassessment

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# Leadership

- Board & C-suite Executives prioritize safety as core value
- Provides resources
  - Education
  - Equipment
  - Personnel
  - Technology
- Data & transparency
- Assessment of culture
  - Employee engagement survey
  - SCORE survey

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# Culture of Safety

- Policies and protocols
- Education
  - Leadership
  - All employee
  - Orientation
- Promoting reporting
  - Ease of use
  - Confidential
  - Closed-loop communication
  - No blame environment
- Reducing burn out
- Data & transparency

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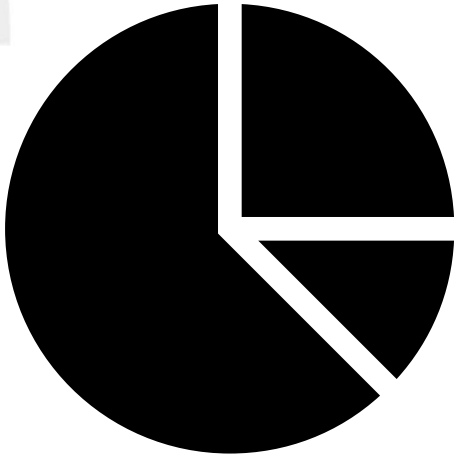
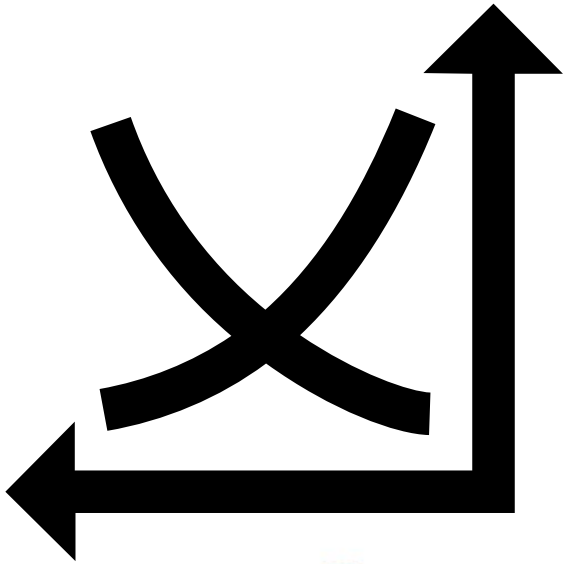
# Transparency

- Free flow of information
- Great catch – goal
- Safety dashboard
- Quality report cards
- Close-loop communication
- Rounding
  - Safety check-in
  - Clinical huddle
  - Department huddle
  - Senior leader rounding





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# Transparency
# = Trust in Leadership

- Accountability
- Empowerment
- Communication
- Collaboration
- Innovation
- Job Satisfaction

**Safe Environment**

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# An Occurrence

- Transparency and support
  - Patient and caregivers
  - Healthcare professionals
  - Leadership
  - Organization
- Action
  - Financial and nonfinancial reconciliation for patient
  - Event investigation
    - Root cause analysis
    - Event timeline
    - Process improvement

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# Questions?

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# High Reliability Journey


Jennifer Anderson, CPHQ

Community Hospital Lead Quality - Performance Improvement Specialist

University of Michigan Health – Sparrow Ionia




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# High Reliability Model


***Stages of maturity***

***Beginning ➡ Developing ➡ Advancing ➡ Approaching***

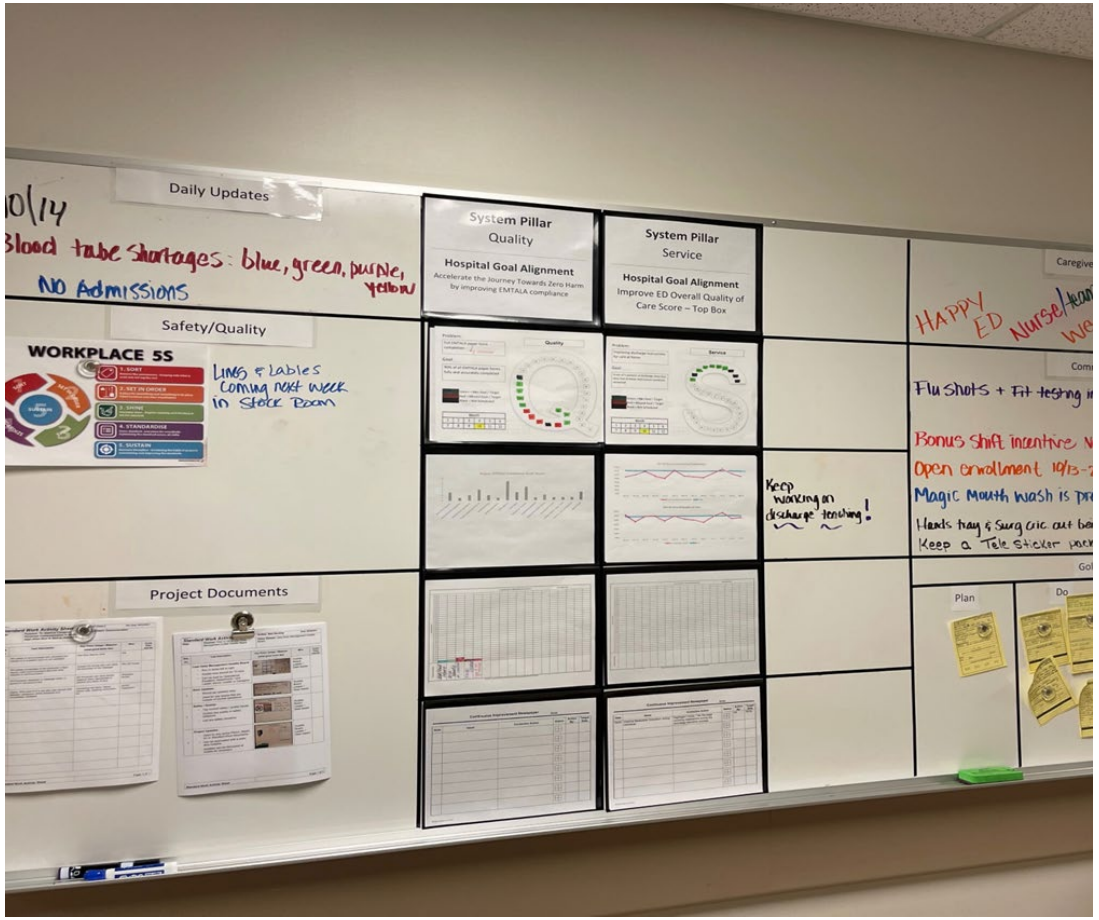
Joint Commission Center for Transforming Healthcare

# Leadership Commitment

- Board of Directors prioritized quality, safety culture, and zero patient harm
- Action plans are developed
  - Leadership domain: board
  - Safety culture domain: trust/just culture
- Strategic goals include quality, safety, and patient experience
- Complete the ORO HRO Assessment every 2 years

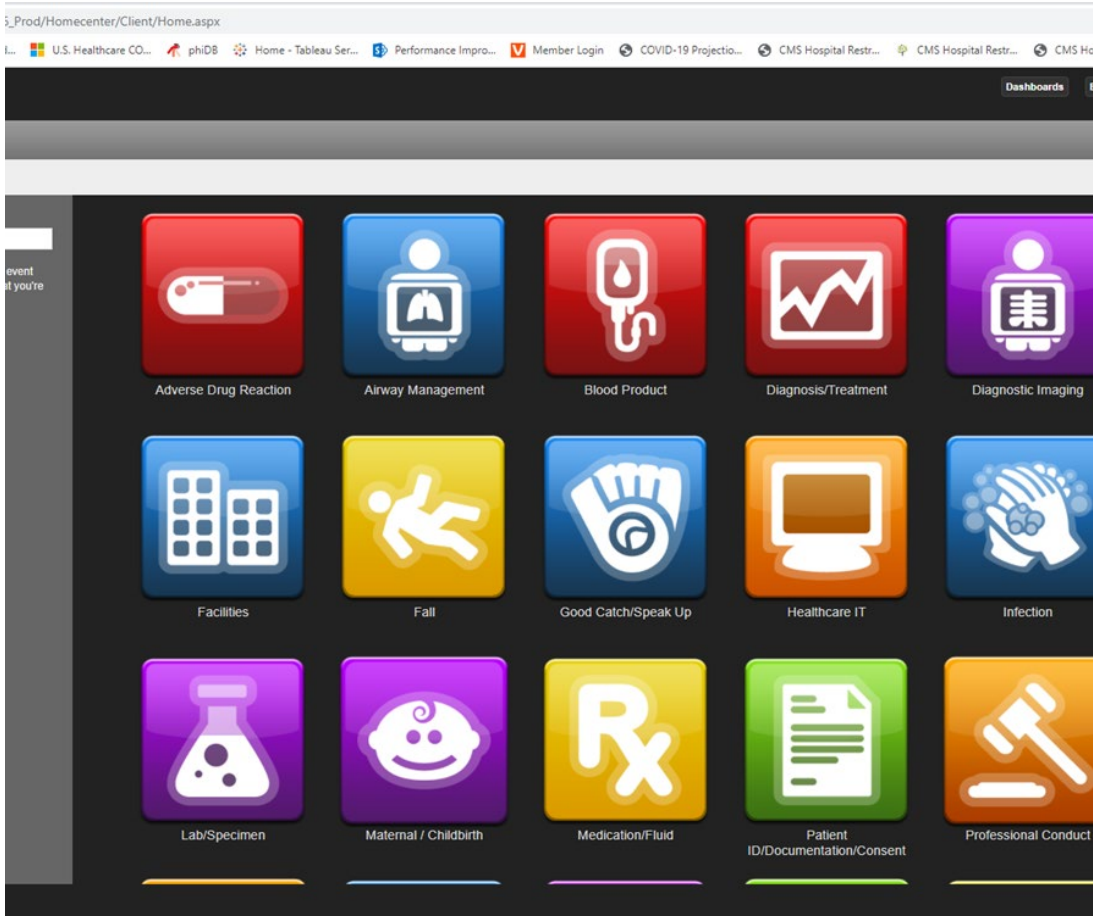
| | Beginning | Developing | Advancing | Approaching |
|---|---|---|---|---|
| **Leadership** | | | | |
| Board | ✓ | | | |
| CEO/management | | | | ✓ |
| Physicians | | ✓ | | |
| Quality strategy | | | ✓ | |
| Quality measures | | ✓ | | |
| Information technology | | ✓ | | |
| **Safety Culture** | | | | |
| Trust | | ✓ | | |
| Accountability | | | ✓ | |
| Identifying unsafe conditions | | ✓ | | |
| Strengthening systems | | ✓ | | |
| Assessment | | | | ✓ |
| **Robust Process Improvement** | | | | |
| Methods | | ✓ | | |
| Training | | ✓ | | |
| Spread | | ✓ | | |

# Strategic Planning and Organizational Policy




- Strategic goals for the system – results are reported to system board quality
- Hospital strategic goals – hospital board quality
- Department goals – scorecards/managing daily huddle boards
- Daily safety calls

# Adoption of a Safety Culture

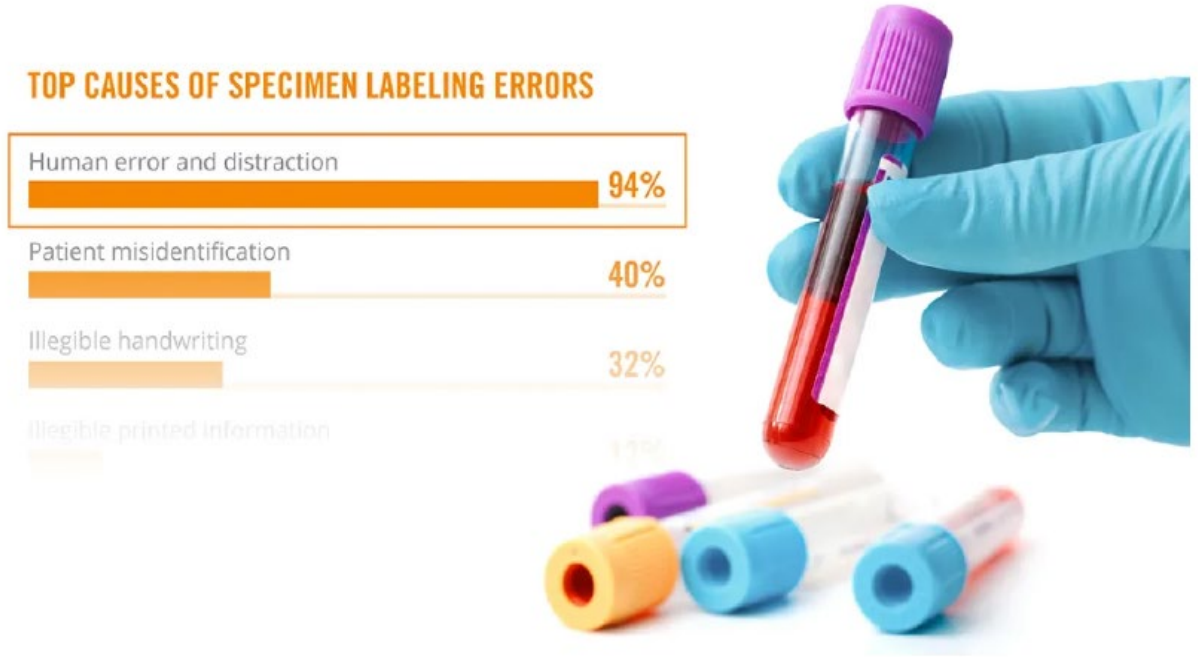



- Just culture training
- Electronic incident reporting
- Serious safety event committee
- Culture of Safety survey completed every 2 years
- Speak Up! campaign
- Engagement Survey completed every year

# Adoption of a Safety Culture

COVID pandemic impacting patient care:

- Isolation precautions
- Increase in the number of patients
- Decrease in staff
- Supply chain issues with products



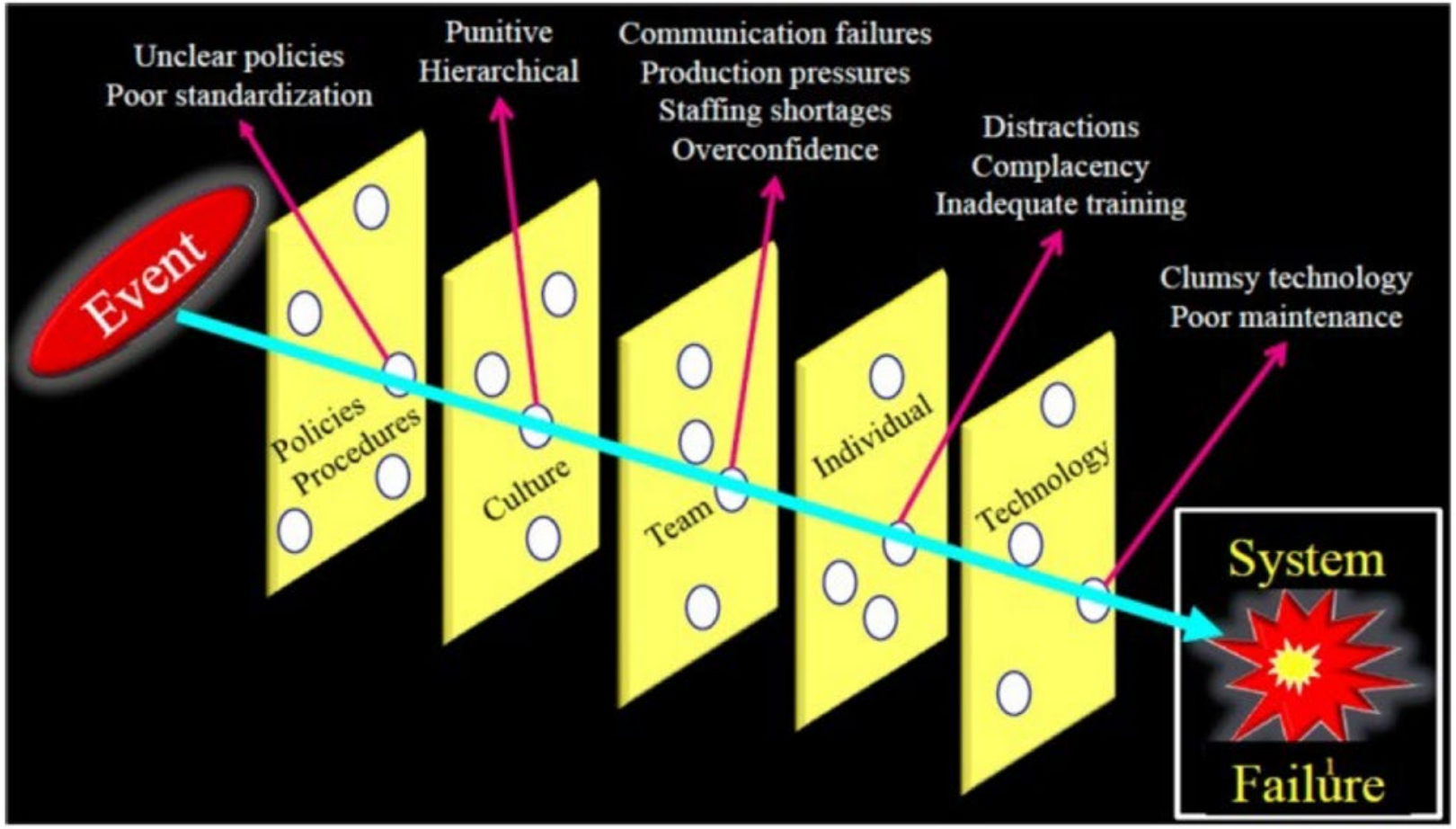

Incident Reporting

- In 2021, a noticeable increase in identification/specimen labeling errors occurred
- What really is the root cause of the errors?

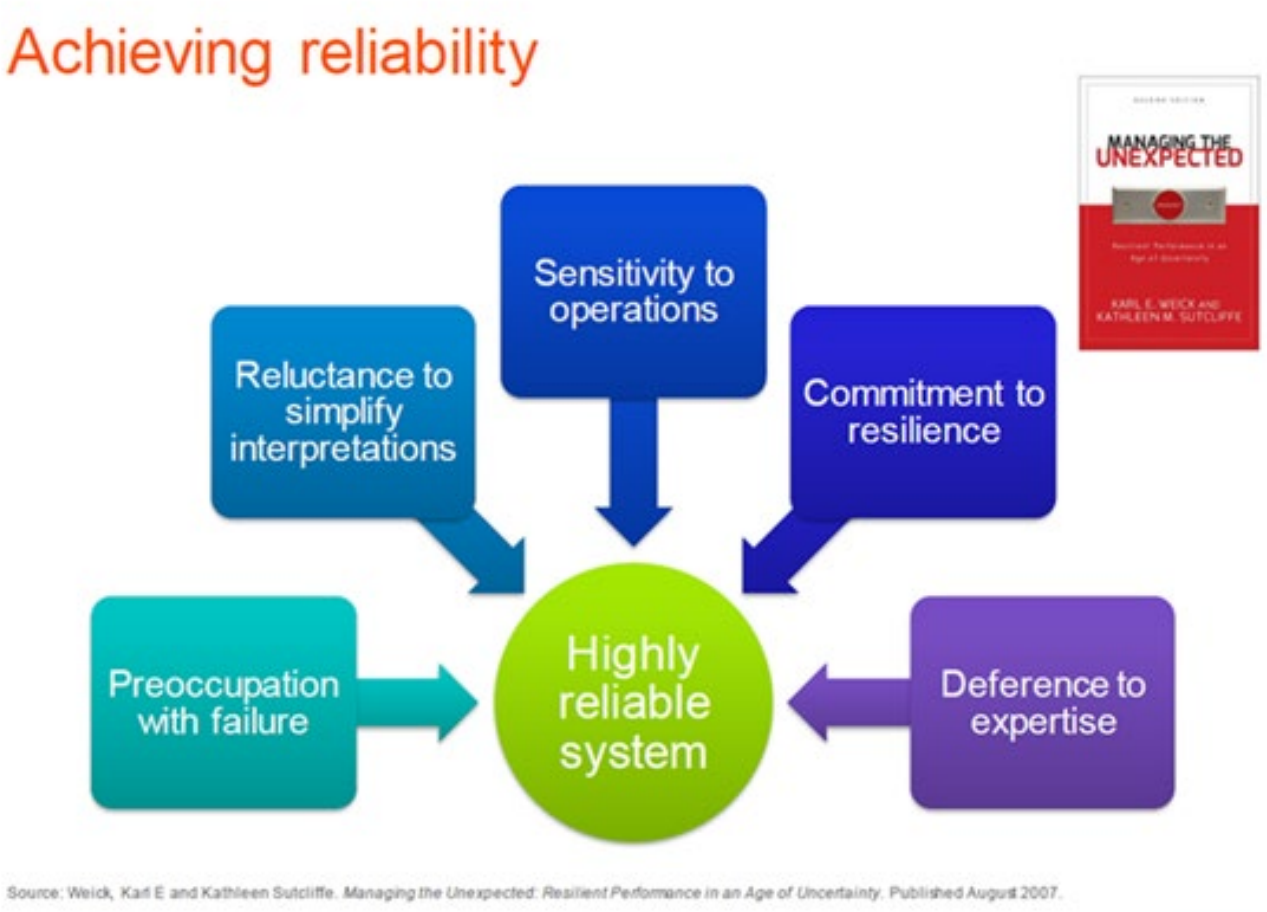
**Dr. W. Edwards Deming**

**94 percent** of variations observed in workers' performance levels have nothing to do with the workers. Instead, most of the performance variations are caused by the system, of which those people are but a part.

# Getting to the Root Cause

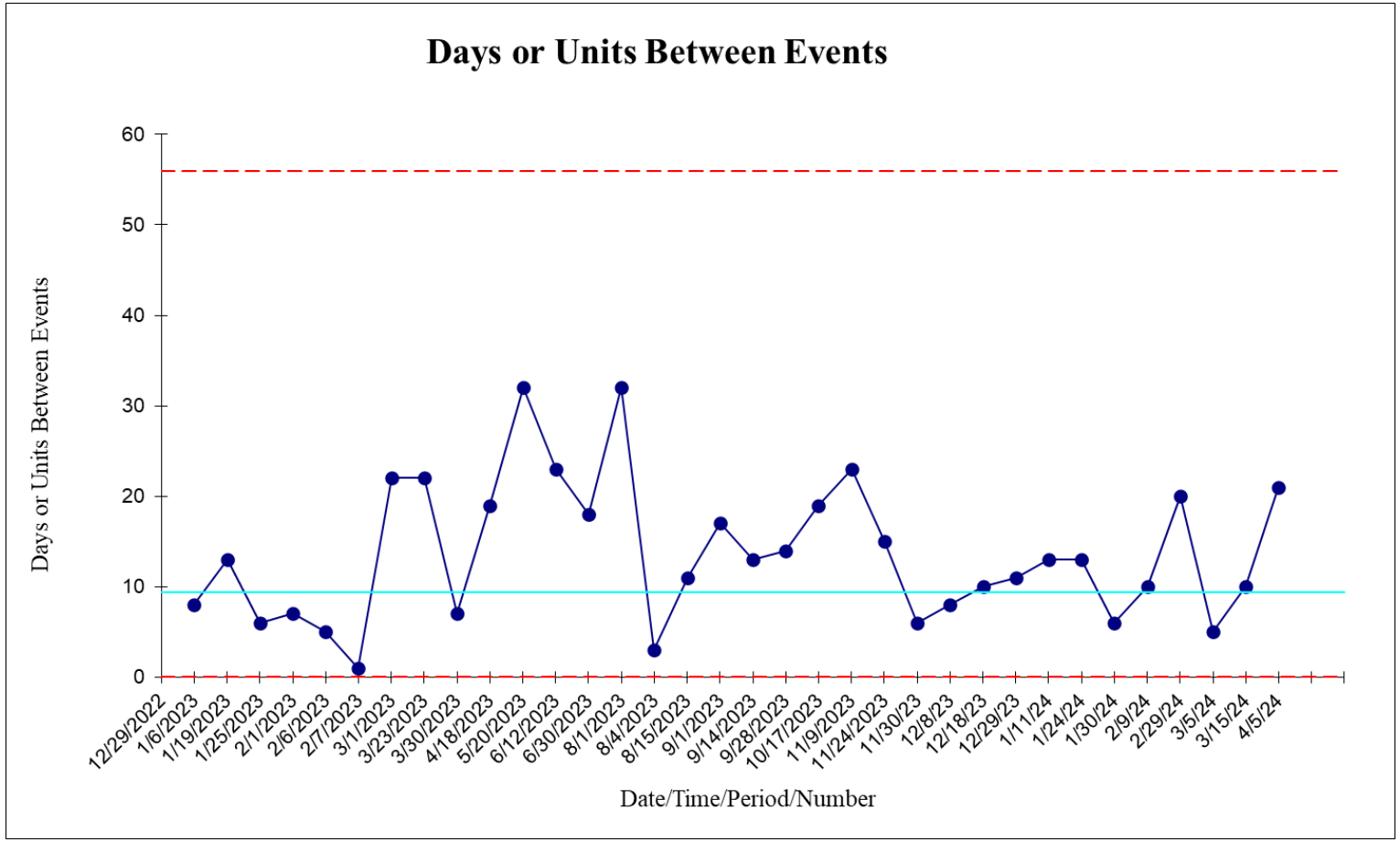


# Robust Process Improvement




- **Preoccupation with Failure**: any near miss/failure was to be reported in our incident reporting system
- **Deference to Expertise**: reviewed current process with frontline caregivers; identified process issues to supply gathering and patient labels
- **Sensitive to Operations**: staffing challenges have nurses, phlebotomists, medical assistants, and sometimes med techs collecting specimens; improved hand-off communication of specimens
- **Commitment to Resilience**: lab was empowered to stop the line when there were questions about specimens received for processing; leadership was notified in real-time to determine next steps; Just Culture was reinforced
- **Reluctance to Simplify:** double checks were put in place to ensure accuracy of specimen labeling
- **Daily Safety Call**: any near misses/failures are reported daily, monitoring last error

# Results


Days or Units Between Events
Days or Units Between Events
60
50
40
30
20
10
0
12/29/2022
1/6/2023
1/19/2023
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2/1/2023
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Date/Time/Period/Number

# Presenters' Contact Information

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