Hospital Quality Institute
2016 Vanguard Award Application

Providence Little Company of Mary Medical Center San Pedro

1300 W 7th Street
San Pedro, CA 90732
http://california.providence.org/san-pedro

Primary Contact Person:
Steven Brass, M.D., MPH, MBA
Director of Medical Affairs
Providence Little Company of Mary Medical Center San Pedro
310/514-5494
Steven.Brass@providence.org

Alternative Hospital Representative Contact:
Jeremy F. Baker
Administrative Director, Quality & Patient Safety
South Bay Community Services
Providence Little Company of Mary Medical Centers San Pedro & Torrance
310/303-6107
Jeremy.Baker@providence.org

Application Title: **The Patient Safety Huddle: One Step on Our Journey to Becoming a High Reliability Organization**

Topical Area(s):
☒ Patient Safety
☒ Quality Improvement
☒ Patient Experience

PROVIDENCE
Little Company of Mary
Medical Center
San Pedro

1300 W. 7th Street
San Pedro, California 90732
http://providence.org/sanpedro

PROVIDENCE
Little Company of Mary
Medical Center
San Pedro

Thursday, August 11, 2016

Hospital Quality Institute
1215 K Street, Ste 930
Sacramento, CA 95814

RE: 2016 Vanguard Award

To Whom It May Concern:

We began our journey to becoming a High Reliability Organization (HRO) at Providence Little Company of Mary Medical Center San Pedro in 2015. As part of our work, we have revamped the daily safety huddle to reflect HRO principles. This had a major impact on both the culture of safety and our quality and safety metrics. It is with full support and encouragement that we at Providence Little Company of Mary Medical Center San Pedro submit to you this application for the Hospital Quality Institute Vanguard Award 2016.

Sincerely,

Richard Glimp, M.D.
Chief Medical Officer
South Bay Community Services

Date: August 12, 2016

Hospital Quality Institute
1215 K Street
Suite 930
Sacramento, CA 95814

To Whom It May Concern,

We are pleased to submit our application for the Hospital Quality Institute Vanguard Award 2016.

The application is titled:

"The Patient Safety Huddle: One Step on Our Journey to Becoming a High Reliability Organization"

The application will be apply to all 3 categories of the award including patient safety, quality improvement and patient experience.

Thank You,

Steven Brass, MD MPH MBA

Director of Medical Affairs
Providence Little Company of Mary Medical Center San Pedro
Phone: 310-514-5494|
Address: 1300 West 7th Street, San Pedro, CA 90732
Email: Steven.Brass@providence.org

2. Executive Summary

A huddle is defined as a gathering where people "come together to talk about something privately." Our decision to develop a new daily patient safety huddle was one of the first steps taken on our journey to becoming a high reliability organization. The major goals were to break down silos and improve communication in the hospital across different departments; to help trouble shoot operational problems; to help focus the organization on the True North including including safety and quality clinical metrics, critical incident reporting and patient experience scores. Some of the major learning opportunities from the development phase of the patient safety huddle were that directors and managers need to get engaged and take ownership in designing the patient safety huddle; respect the employees time by starting and ending on time and take controversial or non –pertinent issues off line; ensure accountability for issues brought up at the huddle by taking minutes and by delegating a leader to take ownership of the problem and report back with a plan with an expected deadline. The patient safety huddle had a major impact on helping our hospital by increasing transparency regarding safety events, improving situational awareness in general and improving clinical quality metric deemed priorities. We have reduced central line infections, reduce catheter associated urinary tract infections, and developed new safety processes resulting from the safety huddle and improved overall patient experience scores.

3. Background and relevance of the problem being addressed and effort undertaken

In 2015, we committed at Providence Little Company of Mary Medical Center San Pedro to becoming a high reliability organization. High reliability organizations are organizations with "systems in place that make them exceptionally consistent in accomplishing their goals and avoiding potentially catastrophic errors." Safety huddle is one of the tools used in high reliability organizations to help improve communication and problems solving.

Prior to our establishment of our new daily patient safety huddle, a meeting took place daily where the nurse supervisor would meet briefly with nurse managers in the morning to review whether there were any incident reports. These meetings were brief and most of the time there were no safety issues reported and the group would have disbanded quickly. In these brief meetings the meetings focused on more census. Leadership noted several opportunities for improvement: there was no clear structure to the meeting, there were no ancillary support staff present, no anticipation of future safety problems, no review of quality metrics nor emphasis on front-line operational improvement.

Our decision to develop a new patient safety huddle was one of the first steps we took on our journey to becoming a high reliability organization. We decided we would hold the safety huddle 7 days a week in our main conference room. All clinical unit leaders and non-clinical

department leaders, executives, physicians and select front line employees were invited to attend the patient safety huddle from 9:30am to 10:00 am in the conference room. The patient safety huddle was led by members of the executive team on a rotational basis. A large monitor was present in the conference room allowing us to project data to the group as needed using a power point projection.

There were several goals the team wanted to accomplish by setting up this patient safety huddle including:

i) The Joint Commission reported that communication failures are responsible for 70 percent of sentinel events. Our goal was to break down silos and improve communication in the hospital across different departments.
ii) To improve the culture of safety by increasing the transparency regarding safety events in a timely fashion in a non-punitive environment;
iii) To help trouble shoot operational problems as a team as often problems involve multiple areas of the hospital and having everyone present in the room at the same time provided this opportunity to happen;
iv) To help improve critical thinking among leaders and front line caregivers and encouraging anticipation of future safety problems in the organization;
v) To help focus the organization on the True North including: zero harm, safety and quality clinical metrics, critical incident reporting and patient experience scores. The True North is a term used in the Lean lexicon to describe the ideal or state of perfection that a hospital should be continually striving towards.

4. Describe the effort, including the scope, process, strategies and tactics utilized, challenges encountered and how they were addressed.

There were several strategies used in order to roll out the patient safety huddle. Many of these involve basic organizational change management. First, we socialized with all employees the importance of becoming a high reliability organization. The executives and core leaders assembled and discussed that a daily patients safety huddle was one of the first steps we can take together to improve communication and transparency about safety. There was recognition need by both nursing, ancillary staff and leadership that there were many opportunities to improve the transparency regarding safety events and ensure there is follow up to resolve the safety issues. We assemble a subgroup of key stakeholders including the chief nursing officer, the director of medical affairs, the quality team and nurse managers and went through several iterations of patient safety huddle agenda taking into account some of the key safety issues and metrics that we wanted to drive. We then went back to the larger group of hospital leaders at our regularly scheduled weekly meeting (called “Flash”) where the topic and agenda were both presented in order to get the large group buy in on this concept. We encouraged constructive criticism including naysayers in the discussions to ensure that all had a voice at the table. After we agreed to move forward, we asked to secure their commitment for the patient safety huddle.

We then used PDSA (Plan, Do, Study, Act) is an iterative process based on the scientific method in which it is assumed that not all information or factors are available at the outset; thus, repeated

cycles of change will be needed to achieve the goal, each cycle closer than the previous one. With the improved knowledge, we may choose to refine or alter the goal (ideal state).We chose a go live date in April 2015 and then on a weekly basis for the first two months we asked for feedback and reviewed the positive and negative issues of the patient safety huddle and made appropriate changes. Our patient safety huddle agenda changed over time and now have a more permanent version. In addition, what initially took 45 minutes to complete has reduced down to 20 minutes on average.

Attachment A: Patient Safety Huddle Agenda.

We follow this agenda daily but on specific days we have themes where additional topics are reviewed.

I. Tuesday: Review recruitment and open positions
II. Wednesday: Close the loop on safety issues raised over the week
III. Thursday: Review of Hand Hygiene, MDRO, CAUTI, CLABSI, SSI, HAPU, Falls, Hand Hygiene by Unit
IV. Friday: HCAHPS and Patient Experience

Different from other patient safety huddles is that we use what is called a "patient safety huddle documentation tool." The "patient safety huddle documentation tools" are checklist completed by the frontline caregivers that are brought down by the clinical director to the patient safety huddle in order to dive down on certain clinical priorities. The clinical directors must come to the patient safety huddle with the patient safety documentation tool completed and report out on the findings on their unit based on the input of their front line employees.

Attachment B-E: Patient Safety Huddle Documentation Tools

The "patient safety documentation tools" include checklists with several important questions such as:

I. How long has the Foley catheter been in place?
II. What is the clinical indication for the Foley catheter?
III. What is your plan to remove the Foley catheter?
IV. Can we use a condom catheter as an alternative to a Foley catheter in this patient?
V. How long has the central line been in place?
VI. What is the clinical indication for the central line?
VII. What is the status of the dressing?
VIII. What is your plan to remove the central line?
IX. Which of your patients have any hospital acquired pressure ulcers?
X. How many of your patients are at risk for hospital acquired pressure ulcers?
XI. What is the risk factor identified?
XII. What plan of action have you implemented to reduce new or worsening pressure ulcers?
XIII. Do any of your patients have unformed stools? Has a sample been sent for C Dfif testing? Is the patient in isolation?

XIV. Do you have any patients in restraints? Can a sitter be used as an alternative? Is there a doctor order and proper documentation in the chart?

The case managers have their own "documentation tools" that are brought to the patient safety huddle. All patient whose length of stay is beyond 4 days is reviewed for whether or not there is a medical, social or operational reason for the prolonged stay. In addition, on a weekly basis case managers review all readmissions using a predefined checklist that drills down on whether there were opportunities to avoid readmissions by focusing whether proper education was documented, follow up appointment booked and whether medications upon discharge were filled by our hospital pharmacy. We believe this has been instrumental in emphasizing the importance of readmissions as a safety issue and placing greater emphasis on transitions of care.

Attachment F-G: Case Manager Documentation Tools

There have been many challenges as we rolled our patient safety huddle including:

I. Attendance. We encourage each clinical and nonclinical leader director or manager to attend the patient safety huddle and bring along one frontline employees when possible. We do take attendance and request the documentation tools to be submitted to our scribe. We have been able to improve attendance by implementing a hospital wide "no meeting zone" from 9:30am to 10:00 am every day where no meetings are allowed to be booked. If a leader cannot attend the patient safety huddle we ask for a substitute from the unit to be present.

II. Derailment. At times the controversial topics will arise at the patient safety huddle and usually one person will provide prolonged explanations or go off on a tangent. We usually are able to deal with this problem by acknowledging their concerns and encouraging a smaller focus group after the patient safety huddle to address this issue. We emphasize that we want to stick to our agenda for the patient safety huddle and agree to follow up on this issue "offline."

III. Accountability. Ensuring that safety concerns are properly addressed and that accountability is maintained minutes are taken by a scribe. We assign a person responsible to close the loop on the patient safety issue and ask them to report back on the issue at hand when the problem is addressed. On a weekly basis we go through this tracker and review it out loud and ask the person responsible for the follow up on the issue. This has not only improved accountability but has allowed the employees to think strategically on solving the safety issues.

Attachment H: Patient Safety Huddle Tracker

IV. Time management. One must respect the employee's time given the multitude of competing interests. The leaders provided input that the optimal duration of the patient safety huddle was less than 30 minutes. In order to keep to this request, the patient safety huddle starts exactly on time and ends on time.

5. Describe the results of the effort and discuss the significance of the results. How do the results demonstrate outstanding achievement?

In order to understand the result of the effort and its significance one should review a pertinent quotation from Dr. Mitchell H. Katz, Director, Los Angeles County Department of Health Services California who stated the following as it related to hospital associated conditions:

"The reason to prevent health care–associated infections is to save lives, not costs. ….Not paying for hospital-acquired infections or errors is an important part of the movement toward paying for quality, not quantity, of care."

The patient safety huddle has allowed us to prioritize patient safety allowing the hospital to pursue the triple aim: save lives, improved quality, raise patient experience and reduced costly errors and mistakes thus improving value.

Attachment I: Quality and Safety metrics

I. Number of reported safety events by category per month for April May June 2016. Note that we have collected data by categories including: patient safety, physician safety, employee safety, delays of service, EMR safety issues and plant/equipment problems.
II. 2016 Regional metrics: A spider chart is a graphical method of displaying multivariate data in the form of a two-dimensional chart in this case of 6 quantitative variables represented on axes starting from the same point. The 6 variables are CAUTI rate, CLABSI rate, C Diff rate, fall rate, surgical site infection rate for hysterectomy and surgical site infection rate for colon surgery. The target are based on CMS data. In 4/6 metrics we are at the 99 percentile.
III. CLABSI: From March 2015 to December 2015 there were 0 (zero) CLABSI present in the ICU.
IV. 30 Days Readmission Rate: Readmissions are reviewed weekly at the patient safety huddle. Notice our dropping readmission observed to expected ratio. We pay attention at the patient safety huddle to causes of readmissions via the readmission documentation tool.
V. Patient Experience Scores: Inpatient and Emergency Department: Patient experience data is reviewed weekly at the patient safety huddle. The data demonstrates the percent of patients ranking their overall care a "9 or 10" on a scale of 0-10 for the past 17 months. Notice the upward trend for inpatient and emergency department exceeding goals set by Providence health and Services. Data is from 1/2016 to 7/2016.
VI. Hand Hygiene Compliance: We review hand hygiene by unit on a weekly basis and have thrown pizza parties for unit scoring 100% at hand hygiene compliance. The overall hand hygiene has increased significantly from 81% to 93% in 2015.

To understand the economic impact of avoiding hospital acquired conditions one needs to review a large JAMA study quantifying the cost of these hospital associated infections. Central line-associated bloodstream infections are most costly to the organization and average about $45,814

per case. The most common infection is surgical site infections which cost around $20, 785 to treat. *C. difficile* infections is the second most common frequent hospital acquired infection which cost about $11,285 each to treat. Catheter associated urinary tract infections cost about $896 each per case.

The goal of the hospital was to become a highly reliable organization. By looking at the five traits of a high reliability organization we believe we were able to demonstrate several areas of achievement as it pertains to the implementation of the patient safety huddle.

I. Sensitivity to operations. In reviewing daily audits of central line, Foley catheters, skin ulcers and restraints and weekly quality metrics, readmissions as well as patient experience scores at the patient safety huddle we are not only becoming more transparent but we demonstrate what the priorities are and how we need to drive organizational change.
II. Reluctance to simplify. Safety incidents are discussed from an educational angle using the Socratic approach with deep dive questioning. We ask the employee to investigate and report back to the patient safety huddle their findings.
III. Defer to the expertise in the organization. We accomplish that is by allowing frontline workers and leaders in the department to solve the operational or safety issue that occur at the patient safety huddle with support from the executive team. The best way to make change happen is by allowing the frontline workers to identify the problem and come up with the solution themselves.
IV. Sensitivity to failure. We encourage daily at the patient safety huddle open discussion of near-misses and even celebrate "good catches." We recognize that a near-miss is an opportunity for improvement to avoid future harm.
V. Resilience. The patient safety huddle has allowed leaders to think outside the box on how to solve problems. After a wrong-patient event in Radiology that was reported at the patient safety huddle transpired the next day the Radiology director brought in a new checklist that she implemented to avoid this event from repeating.

6. Describe sustainability and scaling of the achievements.

We have been able to sustain the safety huddle daily seven days a week for over a year and half and even have scaled it up across the organization.

Due to its overwhelming success and from positive employee feedback we have created a patient safety huddle at our 120 bed sub-acute care nursing facility which is on the hospital property but in a separate building.

We are blessed at Providence Little Company of Mary Medical Center San Pedro to have a behavioral health campus. We have both a chemical dependency unit and a 24 bed inpatient psychiatry unit where we care for high-risk violent and suicidal patients. We have implemented recently a behavioral health safety huddle which occurs immediately after the main patient safety hospital huddle. The behavioral health patient safety huddle has 3 main themes: we ask the

employees to report back on safety events from the past 24 hours, we ask them to anticipate safety issues in the following 24 hours and we track outstanding action items for further discussion. In attendance include security, nursing, psychiatry, emergency medicine and mental health social workers. We actively go onto the behavioral health unit to for the purpose of creating situational awareness and engaging front line employees and leaders in this daily patient safety huddle.

Attachment J: Behavioral Health Patient Safety Huddle Agenda

The patient safety huddle has also become a forum for many topics. The patient safety huddle is where education about regulations take place as part of the daily safety message. Topics may include information regarding pain, restraint use or even egress. We have used the patient safety huddle as a means to prepare for the California Department of Public Health site survey showing photographs from environmental care round that were taken on the unit showing opportunities or deficiencies. Every Friday, our Patient Experience Manager reviews our patient experience metrics along with tips and action plans on how to improve. Patient comments both positive and negative about the different units are shared house wide. The patient safety awards are derived out of the patient safety huddle. We always end the patient safety huddle with recognition for outstanding achievement or recognition of "good catches." We award many of the employees with Patient Safety Certificates to recognize their efforts and to help elevate the culture of safety. Twice a year we have safety celebration lunches to recognize employees whose name came up at the safety huddle as it pertains to "good catches" or leading safety initiatives.

We have also recently implemented on each clinical unit "patient safety huddle boards." The clinical quality and safety metrics that are presented at the patient safety huddle are cascaded down to the front line caregivers and are displayed on the patient safety huddle boards. This has allowed both daily feedback and visual metrics to allow front line caregivers to not only understand what the True North is for the organization but understand how they are performing as a unit.

7. Describe key lessons learned and any advice to colleagues who might try to undertake a similar effort.

There are several key lessons learned that could be shared in order to help other hospitals move forward on implementing a patient safety huddle.

Get buy in from senior leadership. It is utmost important that senior leadership not only supports the concept but also provides input, attends the huddle but also encourages accountability for others to attend and to ensure the different services help to close the loop on safety issues raised. At our patient safety huddle the executive team takes turns leading the patient safety huddle. Mandatory Attendance is a must. It is crucial to have in person attendance and participate at the patient safety huddle by every director and preferably a front line employee from each department. Attendance should be documented via a roster.

Ensure a highly reliable consistent organized but focused agenda. The agenda for the patient safety huddle should be focused and limited in scope and take into account the metrics that your

organization wants to drive. The agenda should be reliable from one day to the next in terms of the topics covered.

Interdisciplinary involvement and participation is needed. Every unit and department manager attends or sends a substitute including but not limited to emergency medicine, infection prevention, risk management, quality improvement, medicine, intensive care unit, pharmacy, radiology, environmental services, case management, food services, patient registration, surgical department, human resources, central supply, chaplains, CNO, CMO, COO and CEO. We do include and invite physicians to attend as well. It is important for everyone to come prepared to participate in the patient safety huddle. The mandatory patient safety documentation tools have greatly improved both the front line employees and leader's participation in the patient safety huddle and increased accountability for our quality metrics.

Be open to receiving feedback and changing the format. Since we first adopted the patient safety huddle in March 2015 we have not only changed the format but the location taking into the feedback of our employees. Taking into their feedback was very helpful to not only improve the workflow but allowed them to have a voice and ownership over the patient safety huddle.

Have Mission and Spiritual Care involved. We are part of Providence Health & Services, a Catholic based health care system. The cornerstone of our mission is to "provide compassionate care that is accessible for all – especially those who are poor and vulnerable." Mission is of utmost important to us and thus we start each day with a short 1 minute reflection led by our team of chaplains. The reflection allows us to focus and center ourselves on the patient safety huddle. The chaplains are present at each patient safety huddle and we are honored by their daily presence and find their presence in the huddle a source of support for all.

Start with a safety story. Every day we start our patient safety huddle with a safety story or safety message. We encourage our employees to share a near miss or lesson learned from their department. If there are no specific safety stories we review a safety story from the news or review an important policy procedure or regulation.

Encourage recognition. We end our patient safety huddle on a high note by asking for our employees to recognize other employees who have gone the extra mile or for those who have been champions for patient safety such as being involved in a good catch that may have led to patient harm.

Be open and transparent regarding patient safety events. The tone should never be that of blame or punitive in nature. Reinforce the educational aspect of a safety event through Socratic approach of asking questions "What have we learnt from this?" What can we do different next time?" or "What was the educational opportunity in this case."

References:

1. Institute For Healthcare Improvement. 2004. Huddles. Retrieved from http://www.ihi.org/knowledge/Pages/Tools/Huddles.aspx accessed on 20 November, 2012.

2. Dingley, C., Daugherty, R., Derieg M.K., Persing, R. 2008 Improving Patient Safety Through Communication Strategy Enhancements. In K. Henriksne, J.B. Battles, M.A. Keyes, M. L. Grady (Eds.), Advances in patient safety: New directions and alternative approaches, Vol. 3: Performance and Tools. Rockville, MD: Agency for Healthcare Research and Quality. Retrieved from http://www.ncbi.nlm.nih.gov/books/NBK43663/#advances-dingley_14.r22 on 20 November

3. Katz MH. Pay for Preventing (Not Causing) Health Care–Associated Infections. JAMA
    a. Intern Med. 2013;173(22):2046. doi:10.1001/jamainternmed.2013.9754.

4. http://www.beckershospitalreview.com/hospital-management-administration/5-traits-of-high-reliability-organizations-how-to-hardwire-each-in-your-organization.html

5. Zimlichman E, Henderson D, Tamir O, et al. Health Care–Associated Infections: A Meta-analysis of Costs and Financial Impact on the US Health Care System. JAMA Intern Med. 2013;173(22):2039-2046. doi:10.1001/jamainternmed. 2013.9763.