Hospital or Healthcare System name and address, city, state, URL.

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Title of the application.

-Increasing Transparency of Harm: Zero Hero Huddle

Identify topical area(s) of focus in this application:
patient safety
quality improvement
patient experience

-Patient Safety, Quality Improvement Project, and Patient Experience

Brief Statement by an executive leader in support of the application:

Transparency is key to understanding and learning from system issues that contribute to preventable harm. I am proud to be associated with an organization and a team that believes in this work and made this process a reality.

Executive Summary (200 Words)

Patient safety is a serious public health issue countless healthcare systems are facing around the world. Despite technological advances and proven effective interventions, patients are still experiencing harm or even dying within hospitals due to preventable harm. Healthcare systems must drive and continue to seek improvement opportunities within the complexity of healthcare.

In 2015, the National Patient Safety Foundation published a paper, 'Free from Harm: Accelerating Patient Safety Improvements Fifteen years after to Err is Human.' The paper highlighted recommendations to accelerate process and approach total system improvement. The culture in which care is delivered is essential to patient safety.

At Valley Children's Hospital, safety culture is essential to how we conduct business. We are committed to excellence, innovation and collaboration. The question 'How can we improve?' is critical to how the

quality and patient safety department functions. Within that belief, the concept of *Zero Hero Huddle* was born. Built on the concept of transparency, *Zero Hero Huddle* was formed to identify and communicate possibilities encompassing a harm event. The goal of the huddle is to increase awareness, seek real-time information, and shape the culture of safety by engaging staff at all levels within the organization.

Background and Relevance

Transparency and knowledge of harm among staff, patients, and families vary within an organization. Healthcare systems are challenged with gathering and disseminating meaningful data to effect change. Searching for the root cause of an event is complex and limited information can extracted from the medical record.

Valley Children's Hospital recognized the need to elevate the urgency of harm by creating a system that supported transparency and effective communication to prevent and mitigate harm events.

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

A *Zero Hero Huddle* is a multidisciplinary action to gather key stakeholders to the site of a harm event. The goal is to gather crucial information closest to the occurrence as possible while increasing organizational awareness simultaneously. The information gained from the huddle is used to prevention reoccurring harm by identifying and mitigating risk within the system.

The *Zero Hero Huddle* process was developed using the PDSA cycles. The process was piloted on all identified Catheter-associated Bloodstream Infections (CLABSIs) within the organization. As the frequency of events occurred, more clarity and robustness was established. Key stakeholders were added and the communication tree was adjusted. Once reliability was established, the process was spread to other harm events.

Hospital-acquired Condition (HAC) Leads were established within the organization. The Leads were responsible for conducting surveillance and identifying harm events. Qualifying harm events for the huddle process include Catheter-associated Bloodstream Infections (CLABSIs), Catheter-associated Urinary Tract Infections (CAUTIs), Ventilator-associated Pneumonia (VAPs), Hospital-acquired Pressure ulcers (HAPU) Stage 3, 4 and unstageable, a fall classified a moderate or severe Injury, Adverse Drug events E-I and select surgical site infections (SSI) or any other serious harm event identified by patient safety. Once the HAC lead identifies a harm event, the huddle process is initiated.

Upon initiation of the huddle by the lead, communication is sent out according to Valley Children's Hospital Zero Hero Huddle Process Standard Operating Procedure. The huddle should occur within 24 hours of the event. The unit leadership selects a location to host the huddle. Once selected, the hospital operator is notified and 30 minutes prior and announces the huddle over the hospital loudspeaker. The announcement is an invitation for hospital leadership and staff to debrief on the event that has occurred. Senior leadership, physicians, nurses, ancillary care providers, quality and patient safety

representatives, specialty care staff, environmental services, regulatory and affected patients/families are encouraged to participant.

The Zero Hero Huddle begins with brief introduction of the patient with a description of the course of care by the nurse caring for the patient. Next, the HAC lead presents the definition of harm and how it is classified. The HAC lead also presents findings from the chart and potential gaps in care. The care team from the unit will present any chart findings and other clinical factors that may have contributed to the harm event. Three questions are asked as part of the huddle. They include:

1. Was there any harm to the patient?
2. What were the potential factors that may have contributed to this harm?
3. What can we do to improve care?

Patients and/or families are encouraged to share insight into the care given and any additional information surrounding the event. Staff is encouraged to listen to the patient experience and how harm impacted the patient and family. At the end of the huddle before closure, action items and next steps are discussed.

After completion of the huddle, the unit director and the physician partner will craft and finalize a letter with information gained from the huddle debrief. The finalized letter is sent electronically to unit staff, senior leadership, physician network executive, quality and patient safety leadership upon completion. Quality and patient safety leadership redacts patient identifiers and publishes the letter on the hospital intranet page. Also, the redacted letter is emailed to an expanded distribution list including all VPs, Manager Accreditation and Regulatory, Clinical Practice Specialist for HAPU, Home Care Director and supervisor, all medical directors.

Describe the results of the effort.

The impact of the *zero hero huddles* on the safety culture within the organization has been instrumental in key improvements for patient safety. Multiple opportunities have been identified including patient care gaps, product and medical device issues, education needs, and staffing issues. Each factor identified is reviewed and an action plan is developed. Furthermore, staff and employees express increased awareness and deeper understanding of harm in various committees and meetings.

Measurable outcomes

Implementing an intervention targeting safety culture has its challenges with outcome data. It is difficult to associate outcome data a comprehensive intervention that integration of several improvement approaches. However, important observations in outcome data have been noticed. Hand hygiene compliance rates are above 90% compliance house-wide for the current fiscal year. During each huddle, hand hygiene unit rates are shared and the importance of clean hands is reinforced. CAUTI infection rates and device utilization has decreased almost 20%, resulting in over 400 days between infections. Ventilator-associated Pneumonia infections rates are on target for a 50% reduction. The huddle has

identified key areas for improvement in our CLABSI efforts. Two taskforces have been created to support target prevention activities regarding HEM/ONC patients and central line maintenance.

Discuss the significance of the results. How do the results demonstrate outstanding achievement?

The vision of reaching zero preventable harm to patients is embedded in the hearts of all those in working in healthcare. There is a constant presents of learning and growing. With each event of harm prevented or mitigated, all involved win. Staff avoids becoming second victims, employees are fulfilled, and most importantly the patient can return to a full life. *The Zero Hero Huddle* affiliates and drives to achieve that vision of zero harm through transparency. It's a model of collaboration that is not exclusive, but inclusive about a topic deemed taboo for far too long; the topic of harm. 'Do no harm' or nonmaleficence is widely cited in healthcare and for good reason. Hospitals are inspired by those words. Beneficence is an action that is done for the benefit of others, the very essences of *the Zero Hero Huddle.*

Describe sustainability and scaling of the achievements.

There has been a lot of effort in hospitals in improved clinical quality and improved patient satisfaction. If we can create a safe culture through high reliability principles we will improve safety and also accelerate our improvements in quality and satisfaction.

Three means to achieve higher reliability:

1 Process Design – minimize variation (e.g. deployment of bundles or specifying best practice. Look to your policy manuals for details).

2 Reliability Culture – strong human performance reliability that minimizes human error

3 Human Factors Integration – designing the system to remove the human variability from the activity – i.e. make it virtually impossible to do the wrong thing and easy to do the right thing.

The Zero Hero Huddle is instrumental in helping with sustainability.

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

The *Zero Hero Huddle* has changed how opportunities for improvement are communicated and addressed within the organization. One of the greatest lessons learned during the journey to transparency of harm is the value of gaining real-time information from the bedside, where the care is delivered to the patient. The story that is portrayed within the medical record is limited. When the conversation happens at the bedside, it paints a vibrant picture of the systems in which direct care staff function. Healthcare systems must have a communication plan for addressing the opportunities identified and an infrastructure in place to address and prioritize the findings. Also, having roles and responsibilities clearly defined makes execution of the huddle smooth and efficient.