

**ASHRM 09** Taking You Higher  
**Annual Conference & Exhibition**  
Denver • Oct. 22-25, 2009 • Colorado Convention Center

**Session Title** How do you rate your safety?  
**Presenter** Jane McCaffrey and Leisa Butler  
**Company** Self Regional Healthcare  
**City, ST** Greenwood, SC

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**OBJECTIVES**

- Introduce a safety measuring process that tracks both worker and patient safety
- Discuss safety related objectives that correlate with an overall goal of rate reduction
- Demonstrate integration of safety measuring into organizational goals

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**What are We Trying to Impact?**  
(Why a safety "rate?")

- The number of events affecting patients and staff!
- At Self we want to be one of the safest healthcare organizations in our region
- This would:
  - Increase patient & staff satisfaction
  - Decrease expenses
  - Be the right thing to do

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### History

- Introduction of measuring strategy for a safety rate
- Agreement on definitions of what events would be measured
- Measurement system / data collection
- Establish a baseline
- Setting goals
- Introducing strategies for impacting the outcomes (data)



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### How is a patient safety rate determined?

- Patient safety rate
  - All events involving or impacting patients?
  - Significant ones are “scored” as Level I or II events (see handout for expanded definitions of Level I & II)
  - Monthly rate calculated per 10,000 adjusted patient days (this includes inpatient and outpatient)
- Example (for September, 2009)
  - 6 Level I / 7 Level II = 13
  - 9,570 adjusted patient days
  - Patient safety rate = **13.6** ( $13/9570 \times 10,000$ )



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### Level I & II Patient Events

- Level I events reach the patient
- Level II are “near misses” or caught events
- Listing is serious events or potential for their happening (TJC list/ never events)
- Patient Identification events no matter when caught are in one of these two categories
- See full definitions- “What are Safety Events?” document



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### Worker Safety Rate Example (1<sup>st</sup> quarter, FY 2009)

- Employee reports and follow up with staff reporting injuries results in identification of "OSHA recordable events"
- A rate is determined using hours worked
- This rate can be calculated by department or organization-wide
- 1<sup>st</sup> Q 09
  - 20 recordable events total x 200,000
  - Divided by hours worked (1,047,120)
  - Rate 3.82




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### Total Organizational Rate

- Patient Safety Rate + Worker Safety Rate equals Organizational Safety Rate
- Annual goal is set to measure a change in the year's previous measure (with safety rate the goal is to reduce)
- Self has placed goal at a 10% reduction for each of the last three years




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### Self Regional Healthcare Organizational Goals FY 2009

People	Service	Quality & Safety	Growth	Finance
<p>Self will be the most preferred place to work.</p> <ul style="list-style-type: none"> <li>• Increase the number of work units whose annual employee survey Grand Mean is greater than or equal to 4.11 by 5%.</li> <li>• Decrease voluntary turnover by 5%.</li> </ul>	<p>Patients, families and physicians recommend Self for care.</p> <ul style="list-style-type: none"> <li>• Self patient satisfaction score will be ranked in the top 10% in the nation.</li> <li>• Self outpatient scores will be consistently ranked in the top 25% in the nation.</li> </ul>	<p>Self will provide patients with exceptional quality of care in a safe environment.</p> <ul style="list-style-type: none"> <li>• The Overall, Cumulative, Appropriate Care Measure Score will increase by 2 percentage points from FY08.</li> <li>• Our commitment to providing a safe environment for our patients and their caregivers will result in a 10% reduction in the Safety Rate.</li> <li>• Increase the number of certified ISO 9001:2009 departments by 20%.</li> </ul>	<p>Self will have the facilities and services to be the provider of choice for residents of the communities we serve.</p> <ul style="list-style-type: none"> <li>• Increase outpatient volume targeting an increase of 5% for the following services:                             <ul style="list-style-type: none"> <li>primary care physicians</li> <li>wound healing</li> <li>bone health</li> <li>cardiovascular</li> <li>imaging</li> <li>oncology</li> </ul> </li> </ul>	<p>Self will continue to generate resources to bring advanced care close to home.</p> <ul style="list-style-type: none"> <li>• Meet or exceed an operating margin of 4.0%.</li> </ul>




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### Organizational "Banding" or Measure

- Reduce rate by 10%
- PSR + WSR = Rate
  - 5%- 20% or more reduction
  - 4%- 11% to 19% reduction
  - 3%- 10% reduction
  - 2%- 1% to 9% reduction
  - 1%- no reduction
- This measure used for Administration and tracked by Board Quality Committee



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### What Goals Do Departments Have?

- Medical Units- fall focus
- Procedural areas- Universal Protocol
- Registration- Patient ID
- Emergency Room-Specimen ID
- Lab-ID
- Outpatient areas-Falls / ID
- Pharmacy- medication dosages



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### Causes must be the focus

- Events can be tracked using measures such as significant occurrence rates or worker injury rates
- Goal is to first reduce the event rates for patient & staff
- Creating a "culture of safety" starts with LEADERSHIP!
  - Must build accountabilities
  - Remove barriers for successful behaviors
  - Expect the best- patients do



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### How Can these Events (Rates) be Impacted?

- Evaluate events as they occur for causes- short term effects
- Trend and process map ALL areas involved in similar processes
  - Teams exist for patient ID, patient handling, and Medication Safety
  - Teams have worked on registration, IV site, ID of isolation patients, dealing with combative patients, sharps injuries
  - Safe lift program initiated including equipment
- Initiate preventive strategies over the long term
  - Cue staff into the situations and behaviors (sometimes unconscious actions) that cause / prevent error
  - Job hazard analysis and PPE usage accountability



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### Specific Activities Performed to Date at Self

- Organizational identification of:
  - Red Rules
  - Behaviors at all levels that could best prevent error (“behavior based expectations”)
- Increase accountability for all staff but particularly upper management
  - Establish a measurable goal
  - Objectively collect data



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### Specific Activities /Strategies to Enhance Safety

- Accountability with Red Rules
  - Hand Hygiene
  - Use of two unique identifiers for patient care
- SELF PRIDE- Behaviors
  - Expected behaviors support safety
- SELF Standards on Safety
  - Correlate with SELF PRIDE and other recognized safe behaviors



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### Type of Patient Safety Events Experienced

- Patient ID
  - No ID band / wrong ID band / 2 different ID bands
  - Med given to wrong patient or labeled with wrong name
  - Specimen mislabel or no label
  - Results entered on wrong patient
- Patient Falls
- IV site extravasation
- Miscellaneous
  - Utility / mechanical system failure



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### A Focus Example

- Patient Identification- In FY 2006 73% of all Level I & II Events
- In 1<sup>st</sup> Q 2007, over 80% of all events
  - Most are caught before reaching the patient
  - Though a basic process, error often happens because of staff assumptions and “work arounds”
  - Simple to do correctly
  - Mistakes can be disastrous to a patient
  - Misidentification comes in many ways and at many points



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### Multi-Disciplinary Team Formed to Assess and Address

- Gathered metrics on all ID events
- Conducted Common Cause Analysis of all ID events and categorized by type and area
- Put focus on high volume areas and did observations, interviews and reviews for “best practice”



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- Looked for system/process aspects that “set” staff up for error
  - Limitations of technology (Accucheck)
  - Lack of technology (bar coded armbands)
  - Understanding of designed process
  - Workarounds
  - Lack of feedback




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Common Cause Analysis- Self's Safety Profile

- ✓ **Non-Compliance With Policies, Procedures, Expectations**
  - *taking shortcuts, being overconfident*
  - *failure to perform some of the “basics”*
  - *likely due to poor compliance culture/less than adequate accountability*
- ✓ **Inattention to Detail**
  - *failure to “self-check” (distractions, multitasking to a fault)*
- ✓ **Lack of Questioning Attitude or Critical Thinking**
  - *Wrong assumptions or poor validation/verification (lazy mode)*
  - *Unable to discern need to validate/verify (inexperienced mode)*




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Findings & Initial Actions

- Staff alert and accountability on verification of patient info on Acucheck
- “Stop the Line” for Lab and transporters when patient / specimen / paperwork did not match
- Rate reduction made part of every Director / VP's annual evaluation
- Process mapping & FMEA's




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### Other Activities & Initiatives

- “Ticket to Ride” mandated for all transports
- Barcoded armbands led to bedside labeling
- Admin Rx- Scan system for bedside medication administration
- Acucheck w/ added confirmatory system
- EKG upgrade with ID scan capability



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### So Where Are We Now?

- Patient Level I & Level II Rate
  - 18.89 (2005)
  - 8.65 (YTD 2009)
  - 54% reduction in 4 yrs
- 2009 Goal for Patient Safety Rate (10% reduction from FY 08) was 14.44
  - 46.1% reduction so far for the FY



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### History on Worker Safety Rate

- First measure in 2006- TCIR was 5.56
- FY 07- 3.88
- FY 08- 3.48
- FY 09- 3.65 (as of 3<sup>rd</sup> quarter of FY) goal was 3.13
- Identified need to have worker safety focus in FY10



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## Barriers

- Putting a metric to safety
- Definitions
- Accepting ownership of the processes
- Dedicating resources
- Understanding “rate”
- Consistency in actions



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## What for the Future?

- In FY 10 similar goal adopted
- Emphasis will be on worker safety
- More systems will be evaluated in the patient safety arena
  - Communication – risk issues and culture / employee satisfaction survey results will be addressed
  - More metrics reported



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## Questions?

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## What are Safety Events?

Level	Description	Potential Response(s)
I	<p><b>PATIENT</b></p> <ul style="list-style-type: none"> <li>▪ Death or permanent loss of major function –unanticipated or unrelated to diagnosis or progression of disease <sup>1</sup></li> <li>▪ Significant injury or complication - unanticipated or unrelated to diagnosis or progression of disease <sup>1</sup></li> <li>▪ Suicide or suicide attempt</li> <li>▪ Rape or assault</li> <li>▪ Fire</li> <li>▪ Abduction (adult or child)</li> <li>▪ Infant or child discharged to wrong family</li> <li>▪ Elopement by a person that lacks competence or capacity in the decision to leave. “Elopement” is the unauthorized departure from the necessary care area.</li> <li>▪ Surgery on the wrong individual or wrong body part</li> <li>▪ Unintended retention of a foreign object in an individual after surgery or other procedure</li> <li>▪ Severe neonatal hyperbilirubinemia (bilirubin &gt;30 milligrams/deciliter)</li> <li>▪ Prolonged fluoroscopy with cumulative dose &gt;1500 rads to a single field, or any delivery of radiotherapy to the wrong body region or &gt;25% above the planned radiotherapy dose</li> <li>▪ Others...</li> </ul> <p><sup>1</sup> Includes (but not limited to) death, loss of function, or injury attributable to:</p> <ul style="list-style-type: none"> <li>▪ transfusion reactions</li> <li>▪ medication errors</li> <li>▪ missed diagnoses</li> <li>▪ missed treatments or procedures</li> <li>▪ treatment or procedure errors or delays</li> <li>▪ wrong site/side surgeries and procedures</li> <li>▪ nosocomial infections</li> <li>▪ unanticipated death of a full-term infant</li> <li>▪ misidentification that reaches the patient even in absence of harm</li> </ul> <p><b>EMPLOYEE</b></p> <ul style="list-style-type: none"> <li>• Fatality</li> <li>• Spinal injury resulting in quadriplegia or paraplegia</li> <li>• Brain injuries</li> <li>• Loss of limb</li> <li>• Blood or body fluid exposure resulting in seroconversion</li> <li>• Burns covering 10% or more of the body</li> <li>• Single accidents involving multiple workers (Employees must have a resulting injury; observations and assessments of workers do not constitute a Sentinel Event.)</li> <li>• Injuries due to violence (requiring law enforcement intervention)</li> <li>• Occupational exposure to airborne infection and inhalation particulate, including but not limited to, meningitis, tuberculosis, silicosis, etc. (resulting in a conversion)</li> </ul>	<ul style="list-style-type: none"> <li>▪ Root Cause Analysis (REQUIRED)</li> </ul>

## What are Safety Events?

Level	Description	Potential Response(s)
II	<p><b>PATIENT</b></p> <ul style="list-style-type: none"> <li>▪ Significant near miss that may have resulted in a Level I event</li> <li>▪ Undesirable pattern or trend of minor events</li> <li>▪ Misidentification (medication administration, procedure, specimen, registration) even if caught before reaching the patient or causing no harm</li> <li>▪ Administrator's discretion</li> <li>▪ Others...</li> </ul> <p><b>EMPLOYEE</b></p> <ul style="list-style-type: none"> <li>▪ Significant near miss that may have resulted in a Level I event</li> <li>▪ Undesirable pattern or trend of minor events</li> <li>▪ All Lost Time Claims</li> <li>▪ Administrator's discretion</li> <li>▪ All Injuries that result in a Claim</li> <li>▪ All Injuries that are required to go on OSHA 300 Log as a recordable case</li> </ul>	<ul style="list-style-type: none"> <li>▪ Root Cause Analysis (OPTIONAL)</li> <li>▪ Common Cause Analysis</li> <li>▪ Quality Improvement Team</li> <li>▪ FMEA</li> </ul>
III	<p><b>PATIENT</b></p> <ul style="list-style-type: none"> <li>▪ General Safety Issues: A General Safety Issue is a concern or issue that a staff member believes has the potential to create a risk to safety, or cause an error, but has not yet resulted in a safety event or a near miss. The issue may involve a process, system, or procedure.</li> <li>▪ Health Care Events: A Health Care Event is any event that is not consistent with the usual processes for providing health care services or operation of the facility. It may be an event, which has reached a patient or employee, a near-miss, or an issue, or a situation that may result in an error or adverse event.</li> </ul> <p><b>EMPLOYEE</b></p> <ul style="list-style-type: none"> <li>▪ General Safety Issues: A General Safety Issue is a concern or issue that a staff member believes has the potential to create a risk to safety, or cause an error, but has not yet resulted in a safety event or a near miss. The issue may involve a process, system, or procedure.</li> <li>▪ Health Care Events: A Health Care Event is any event that is not consistent with the usual processes for providing health care services or operation of the facility. It may be an event, which has reached a patient or employee, a near-miss, or an issue, or a situation that may result in an error or adverse event.</li> </ul> <p>All events where a SREO has been filled out</p>	<ul style="list-style-type: none"> <li>▪ Event Reporting</li> <li>▪ Tracking and Trending</li> <li>▪ FMEA</li> <li>▪ Common Cause Analysis</li> </ul>

Use of the ISMP Occurrence Reporting Scale to provide guidance on other events (such as IV infiltrates, medication errors, falls, etc.) to determine if they are a Level I or II safety event per our definition. In using the scale from ISMP - Levels G, H, and I are Level I in the nomenclature and ISMP Levels D, E, and F are Level II in the nomenclature. ISMP Levels A, B, and C correspond to Level III event.

## What are Safety Events?

### Occurrence Reporting Scale

- Level A        Circumstances or events that have the capacity to cause an occurrence.
- Level B        An occurrence was detected but did not reach the patient. (An “omission” occurrence does reach the patient).
- Level C        An occurrence that reached the patient but did not cause patient harm.
- Level D        An occurrence that reached the patient and required monitoring to confirm that it resulted in no harm to the patient and/or required intervention to preclude harm.
- Level E        An occurrence that may have contributed to or resulted in temporary harm to the patient and required intervention.
- Level F        An occurrence that may have contributed to or resulted in temporary harm to the patient and required initial or prolonged hospitalization.
- Level G        An occurrence that may have contributed to or resulted in permanent patient harm.
- Level H        An occurrence that required intervention necessary to sustain life.
- Level I        An occurrence that may have contributed to or resulted in the patient’s death.