The American Hospital
Quest for Quality Prize

AHA
Advancing Health in America
Dear Health Care Leader:

As health care providers and members of the community, hospitals and the men and women who work there every day—nurses, physicians, lab technicians, housekeeping staff—have made a commitment to provide the safest, most appropriate care to their family, friends and neighbors. While each hospital, clinic and health center across the country strives for perfection in delivering this care, some lead the way with innovations in patient safety and quality.

These innovators and leaders are the winners of the “2002 American Hospital Quest for Quality Prize: Honoring Leadership and Innovation in Patient Care Quality, Safety and Commitment.”

The American Hospital Association is pleased to honor these hospitals, and encourage others to excel in quality and safety by rewarding excellence and sharing their ideas with the entire health care field. This special supplement highlights the tremendous contributions these folks have made and shines the spotlight on these exciting programs.

These hospitals have demonstrated a commitment to improve care delivery by creating a culture of safety in which all employees feel free to report potential and real adverse events without fear of blame. Their quality and patient safety programs provide the essential supportive systems that help caregivers provide the best possible care.

But this award would not be possible without the assistance of others. The AHA is grateful to McKesson Corp. and the McKesson Foundation for supporting the award’s program, and for their commitment and leadership in this critical area.

I encourage you to participate in the 2003 American Hospital Quest for Quality Prize. For details, visit wwwaha.org/questforquality. In the end, the winners are always the patients and communities that we serve—and that’s what it’s all about.

Sincerely,

Dick Davidson  
President  
American Hospital Association
Inside

WINNER

4

Trust Thrives in Open Environment
Missouri Baptist Medical Center, Town and Country

FINALIST

7

Patient Safety Takes Flight
Children's Hospitals and Clinics, Minneapolis/St. Paul

FINALIST

9

Safety is Everybody's Business
Fairview Hospital, Great Barrington, Mass.

CITATION OF MERIT

11

The Trailblazer
Brigham & Women's Hospital, Boston.
PATIENTS FIRST: Nancy Kimmel, patient safety specialist; Kathy Banage, director of performance improvement; and Max Cohen, M.D., vice president and chief medical officer at Missouri Baptist Medical Center, meet on a patient floor to review staff recommendations for the patient safety program.
Trust Thrives in Open Environment

Missouri Baptist Medical Center, Town and Country

Many health care workers shy away from reporting errors for fear of retribution. Not at Missouri Baptist Medical Center.

The hospital's long-term patient safety program, in place prior to the Institute of Medicine's 1999 report on medical errors, has created a culture of safety in which employees feel free to discuss actual and potential errors. The open environment, based on trust and understanding, is supported by a system that readily implements procedures to improve the safety and quality of care provided.

"Initially, it was difficult for some people to acknowledge that the system was broken," says Kathy Benage, director of performance improvement. "Now, all employees know our patient safety and quality improvement efforts are the right thing to do. They are not comfortable with the status quo."

Building a blame-free environment is crucial if patient safety programs are to succeed, says Max Cohen, M.D., vice president and chief medical officer. That allows staff to focus on safety, help identify and report events and near-misses, and promote and implement improvement processes throughout the organization. But getting there was not easy. A survey of staff and managers revealed significant confusion about what a non-punitive environment entailed. Managers had to be taught how to respond to staffers who raise safety concerns, and specific criteria were added to the non-punitive policy detailing when employees would be disciplined. "If the policy had been implemented without this understanding, it would have failed," Cohen says.

All employees receive a brochure addressing Missouri Baptist's commitment to improving patient safety and its non-punitive approach to reporting events.

"We believe we are at the beginning of the journey," Cohen says. "It's not been easy. It started out as a small group of people working in isolation and has taken several years to spread across the organization."

To oversee the process, Missouri Baptist hired a full-time patient safety specialist. The position, held by Nancy Kimmel, a clinical pharmacist, provides staff a single contact for all safety issues. Kimmel is responsible for, among other things, ensuring that the hospital incorporates and uses methods to improve all aspects of patient safety and promotes a culture that recognizes patient safety as a priority. "Employees are starting to see their efforts pay off and it provides the impetus for them to keep it up," she says. "They see they are not only creating a safer environment for patients, but also a safer work environment for themselves."

Patient safety initiatives are developed through a variety...
of means. Senior leaders participate in weekly walkarounds to discuss safety and quality issues with staff. In addition, employees are encouraged to speak with their managers or the patient safety specialist any time concerns arise.

Cohen says a goal is to make the reporting system easy. An employee can submit an anonymous, one-page, check-box report developed for medication-related events. A safety hotline provides another opportunity to anonymously report safety incidents, and accounts for more than 60 percent of all reports filed.

Efforts to encourage reporting appear to be working. Since the hotline was created almost two years ago, reporting has increased by more than 200 percent. Incident reports alone doubled to about 150 reports per month. The organization’s goal is to double reporting again in 2002.

Leaders know that the information is valuable only if meaningful data can be extracted from the reports of errors and near-misses. All reports are put into a risk master database to help identify trends and ultimately prevent their recurrence. The database, maintained by the director of risk management and shared with the patient safety specialist, is used to produce process control charts and severity indexes of errors and near-errors every month. When a trend is identified, an improvement team is assembled and its recommendations are given top priority from the performance improvement department. Copies of the information from the hotline calls and incident reports, however, are given to managers immediately so action can be taken and shared with employees.

Missouri Baptist uses assessment tools to improve processes throughout the organization; for instance, it performs the failure mode evaluation analysis on its medication dispensing system. The Root Cause Analysis is used to review sentinel events, as mandated by the Joint Commission on Accreditation of Healthcare Organizations. Missouri Baptist also uses RCA for all potentially serious adverse events, conducting 18 over the past year. “The RCA process has produced a great number of major changes throughout our medical center,” Benahe says. “By conducting a thorough assessment of an event, we can ensure the changes we are making are helpful and not creating problems down the line. It helps eliminate the Band-Aid approach to safety issues.”

The chief medical officer and the director of risk management determine when the RCA will be conducted by the performance improvement and risk management departments. A 12-month follow-up ensures the process changes have been implemented and sustained. Other assessment tools used by Missouri Baptist include the Institute for Safe Medication Practices’ assessment for medication safety and the Focus-PDCA Model.

EXECUTIVE ATTENTION

Leadership visibility and follow-through are a central element of Missouri Baptist’s patient safety program. “Executive walkarounds have made a difference in staff awareness of our patient safety program and the culture we are trying to initiate in our facility,” Kimmel says. During the walkarounds, executives take notes and identify actions to be taken. Feedback is shared with hospital staff through a twice-monthly newsletter, We Heard You, We Acted, from the chief medical officer.

On one walkaround, Cohen says, an employee expressed concern that patients were not receiving intravenous piggybacks because the administration times were not printed on the medication administration record. A review of the process and the data determined such failures accounted for 30 percent of MAR-related events. So, a team created to improve the IVPB process set standardized administration times similar to those already in place for oral and injectable medications. It asked the vendor for the pharmacy management system to make the changes, and followed with an extensive education campaign that included pocket cards.

Prior to the changes, Cohen says, about 10 to 15 missed medication reports were filed per month. Since the program was implemented last November, no reports have been filed.

AWARDING SAFETY EFFORTS

To recognize such innovative solutions, Missouri Baptist began a Patient Safety Award program. Winners receive $100 to $5,000 toward their efforts, based on whether the proposed change’s impact is unit-specific or organizationwide.

Despite the successes, Cohen acknowledges that more improvements are needed, and staff members have already provided so many recommendations that they would take several years to implement. A priority, he says, is improving feedback to employees. “We need to reinforce to our staff that their input is helping us achieve our patient safety goals,” he says.

“If you don’t fundamentally change culture, you won’t succeed,” Cohen says. “Every person knows they are responsible for quality and safety and they are now comfortable with those responsibilities. Only when you reach that kind of accountability will you succeed.”
Patient Safety Takes Flight

Children's Hospitals and Clinics, Minneapolis/St. Paul

When Children's Hospitals and Clinics set its patient safety agenda in 1999, it confronted several challenges. Officials from the 105-bed hospital believed, among other things, that improving patient safety is only possible when organizational culture supports all employees as they improve care delivery. Secondly, administrators knew they had to inspire a team approach to identifying actual and potential problems.

Children's agenda calls for the organization to shape culture through knowledge and trust, develop infrastructure to support information and build efficient systems, and design a world-class, error-free medication administration system. Its goal: to create an environment of high-reliability that produces zero defects in care and treatment. Since the agenda was adopted, leaders say that Children's has created a pervasive patient safety culture led by the board, CEO, executive managers and other staff. To get

SAY CHEESE: Children's COO Juliana Morath joins patients holding up cheese slices, symbolizing the Swiss cheese model of patient safety—finding and stopping holes in care.
there, they used a free-flow of story-based patient safety information and modified proven team-building techniques.

Children's officials implemented an anonymous reporting and learning system based on a principle of "reciprocal accountability." All employees are expected to share vulnerabilities and gaps in safety, while managers are to follow up on reports in a timely, non-punitive manner. Safety reports may not be used for disciplinary purposes unless the violation was intentional. "Building a team-approach to patient safety was deemed as important as the creation of a non-punitive environment," says Eric Knox, M.D., director of patient safety.

Children's looked to the airlines for examples: "Hospitals are in virtually the same place as the airline industry was 25 years ago in terms of teamwork," Knox says. "We've adapted their proven policies and practices in regards to team building and error acknowledgement."

Northwest Airlines' Crew Resource Training Manual serves as a main resource for establishing a teamwork discipline. The hospital even sent a couple of employees to train with Northwest's pilots to learn how the airline instilled the principles of risk management and high reliability into team building. Knox said the training has been incorporated into Children's unit-based team training.

Children's adapted other safety and information models from the airlines. Nurses use a huddle system modeled after a Federal Aviation Administration program in which all airlines get together every few hours to see how the system is working. At Children's, nurses meet at shift-change to discuss whether work has gone as expected, and assess how assignments are coming along and whether adjustments are needed.

Safety Action Teams, which consist of multidisciplinary front-line staff, meet monthly to discuss safety issues, review good-catch logs, and work on improving practices and developing standards. Knox says the real value of the Safety Action Teams is to empower staff members to develop their own methods of working together to improve safety.

Employees are further empowered by the hospital's "Stop the Line" policy, which allows all staff members, physicians, parents or patients to stop a procedure if a safety concern is raised. Stop the Line also gives nurses and pharmacists the right to refuse an order that contains unsafe order-writing habits. Verbal orders have been banned, with limited exceptions, Knox says.

In another method adapted from the airline industry, multidisciplinary reading and improvement groups review safety reports to identify themes and learn systems. The reading groups are modeled after the Airline Safety Reporting System, Knox says. ASRS provides a confidential way for anyone, including passengers, to share their thoughts and ideas about actual and potential safety problems. The reports are reviewed by an outside consultant.

The multidisciplinary reading teams at Children's deal with issues within their units and report to the office of patient safety. The information is reviewed and shared with the unit or across the organization.

"Leadership commitment to patient safety is essential," Knox says. Children's even bases a portion of management's incentives on progress with patient safety goals selected from the organization's long-term strategic plan. Past goals have focused on event reporting, creating safety action teams and electronic reporting.

Other employees are motivated by seeing their suggestions turn into action, Knox says. One of the biggest challenges is how to disseminate the information that is collected, including best practices, near-misses and policy changes. Children's will not have a universal e-mail system until mid-2003, so the organization relies heavily on newsletters, education sessions and dialogues. In the interim, Children's has developed a safety Web site, www.createsafty.net, where employees can submit safety-learning reports and access various patient safety resources, including Children's policy and procedural manual.
PHARMACY THE KEY: Fairview Hospital's Vice President Doreen Hutchinson visited the hospital's pharmacy, which keeps staff up to date on safety issues with its "For Your Information" reports.

Safety is Everybody's Business
Fairview Hospital, Great Barrington, Mass.

At Fairview Hospital, patient safety begins before an employee walks in the door the first time. "Patient safety is not a defined program, but how we do our work every day," says Doreen Hutchinson, vice president of operations and acute care. "As such, it determines what kind of people we hire."

Operating under the principle that safety is everyone's responsibility, Fairview uses every opportunity to partner with staff on patient safety, Hutchinson says. For example, Fairview surveyed staff members and physicians before revising its reporting system, and allowed staff to name the new process. A follow-up survey of the Quality Tracking System found that most employees supported the new process and believed it to be non-punitive.

Fairview executives say the non-punitive environment is the key to success. The organization uses open communication and education to convince employees that speaking up is the right thing to do. Hutchinson maintains that an open environment not only helps reduce the stigma of making mistakes; it provides learning opportunities and instills trust across the organization.

The 24-bed hospital also stresses teamwork among staff, management, physicians and patients to provide a safety net for employees and improve processes throughout the facility.

Physician involvement in the safety program remains a challenge. "Historically, it's been too easy for physicians to complain about a lab test not being delivered fast enough or a nurse not being able to participate in rounds," says Brian Burke, M.D., director of medicine. "But it's becoming difficult for physicians to ignore the patient safety efforts since staff involvement is so apparent." As encouragement for doctors, Fairview is working to install a computerized physician order entry system by the end of summer. And Burke plans to meet one-on-one with the 35 to 40 active physicians at Fairview to seek suggestions.

Those who work at Fairview are one piece of its safety ini-
tiative; customers are the other. "Patients and their families can help identify safety issues," says Bobbi Krzlewski, a pharmacy technician. The hospital provides patients and families with information on medical errors and encourages them to speak up. Patient advocates discuss safety concerns with them and talk about satisfaction with care in general.

A campaign is under way throughout the hospital to help collect real-time feedback from patients and families. Patient safety volunteers visit all units and waiting rooms to discuss concerns. If a patient safety issue is raised, the volunteer reports it to the charge nurse or the director of volunteers. All responses from patients and families are stored and referred to the unit manager for follow-up.

Fairview is striving to create a proactive approach to reducing risk. It began its safety initiative by reviewing programs in place, a process that led to the formation of a patient safety team, the umbrella group for safety programs throughout the hospital. The risk manager also serves as the director of quality, and is a liaison with other directors and departments on safety issues.

Education is another essential element of Fairview's patient safety program. "One of our biggest challenges is convincing staff that the potential for errors exists," says Lauren Smith, director of community relations and development. "It's hard for well-meaning professionals to believe they can make mistakes. There is a strong need for education to constantly address patient safety throughout the organization."

The hospital uses a variety of tools to keep staff up to date. It requires staff to attend safety fairs twice a year. The pharmacy department issues "For-Your-Information" reports and distributes posters on issues identified through the Quality Tracking System. Other tools include self-learning packets, newsletters, one-on-one dialogue and lectures. Since Fairview revised its reporting system and launched its aggressive education campaign, error reports have increased 120 percent. But, education and training would be useless if leaders were not committed to the patient safety program and didn't demonstrate that staff views and suggestions are valued and acted upon, Hutchinson says.

Fairview's location in a small community also presents challenges. "Being a community hospital, the importance of our patient safety program is a bit different," Hutchinson says. "We aren't treating patients. We are treating friends and family. In that sense, it's bigger than a program. It's a basic value and what we do every day."

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**The Trailblazer**

*Brigham & Women's Hospital, Boston*

Brigham and Women's Hospital is a leader in the use of information technology to support patient safety efforts. "We restructured our medication safety committee to include a member of the IT staff," says Tejai Gandhi, M.D., director of medicine. A computerized physician order entry system, equipped with an adverse drug event monitor, has been in place since 1993. Handwritten prescribing has been virtually eliminated. The CPOE system "provides a proactive approach to reducing medication errors," Gandhi says. Since CPOE was installed, medication errors have dropped 55 percent.

In addition, a computer system in the pharmacy department provides real-time test results to detect adverse reactions to medications. Another system lets pharmacists access medication-related facts about patients to avert mistakes in ordering. The hospital is also working to install bar coding technology throughout the facility.

A computerized alerting system pages physicians when critical lab reports are available. And, all primary care physicians are alerted by e-mail when a patient is discharged from the emergency department or hospital and provided a list of discharge medications and instructions.

Brigham and Women's safety program emphasizes more than technology, particularly education of staff and executive involvement. Hospital executives participate in walkarounds twice a week to meet with staff about safety issues. Staff members who raise safety concerns are sent a thank-you and confirmation note after the visit to ensure that their message was heard—and heard correctly.

Technology, however, remains a cornerstone. A Web-based reporting system will make staff feedback more efficient and timely. Ideally, Gandhi says, technology will serve as backup to efficient processes that signal potential events before they occur.
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