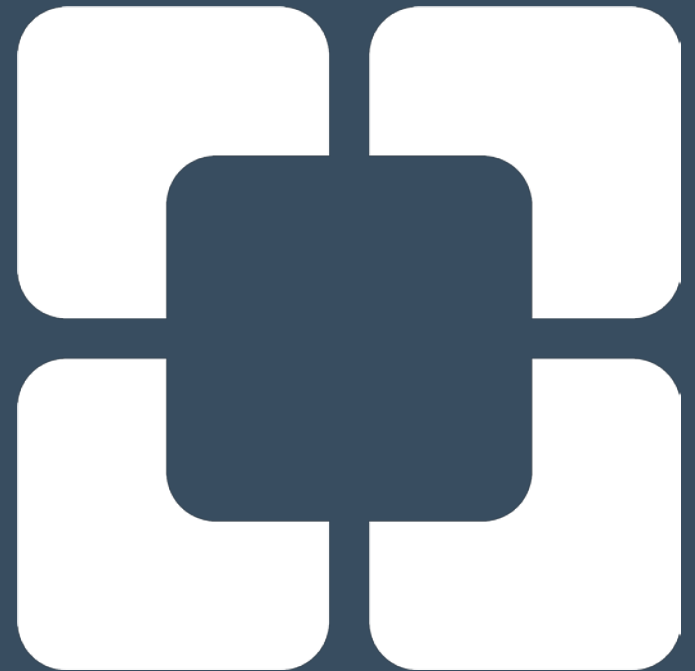# How far would you go to prevent harm to your patient and caregivers?

October 3rd, 2018

Aaron Hamilton, MD MBA

Medical Director Patient Safety and Clinical Risk
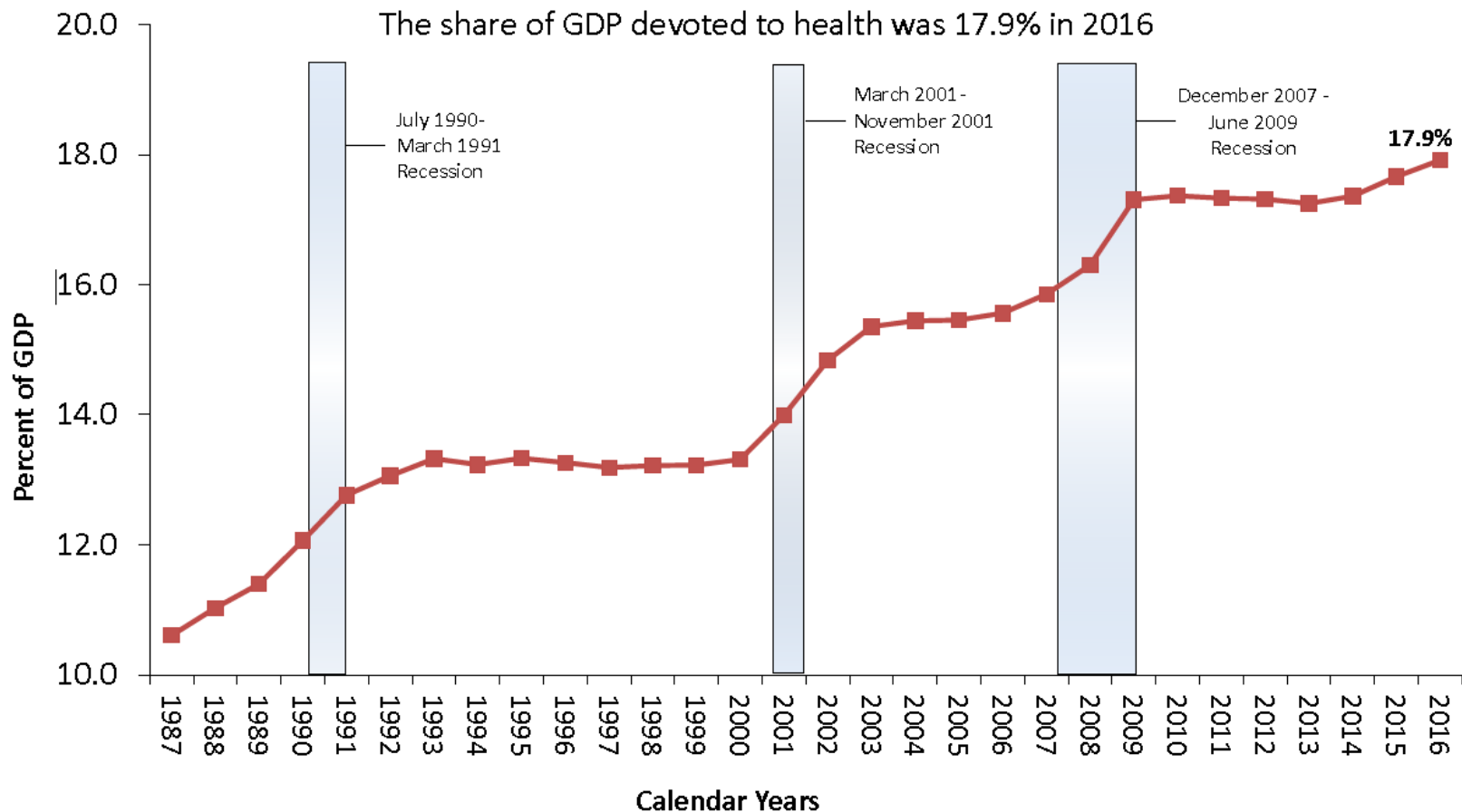
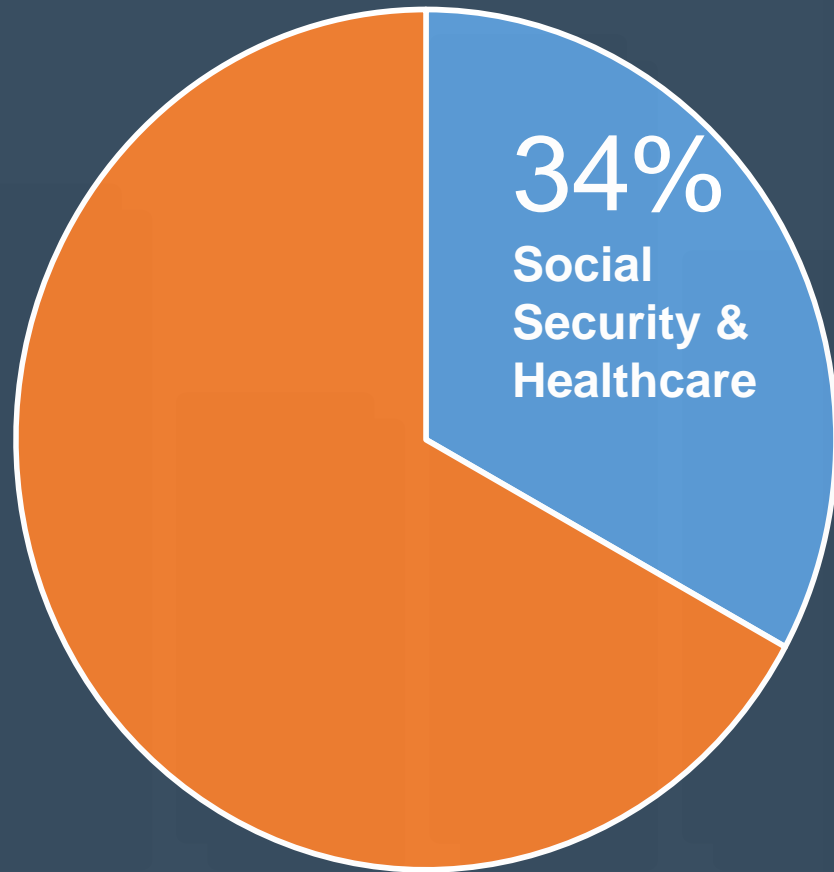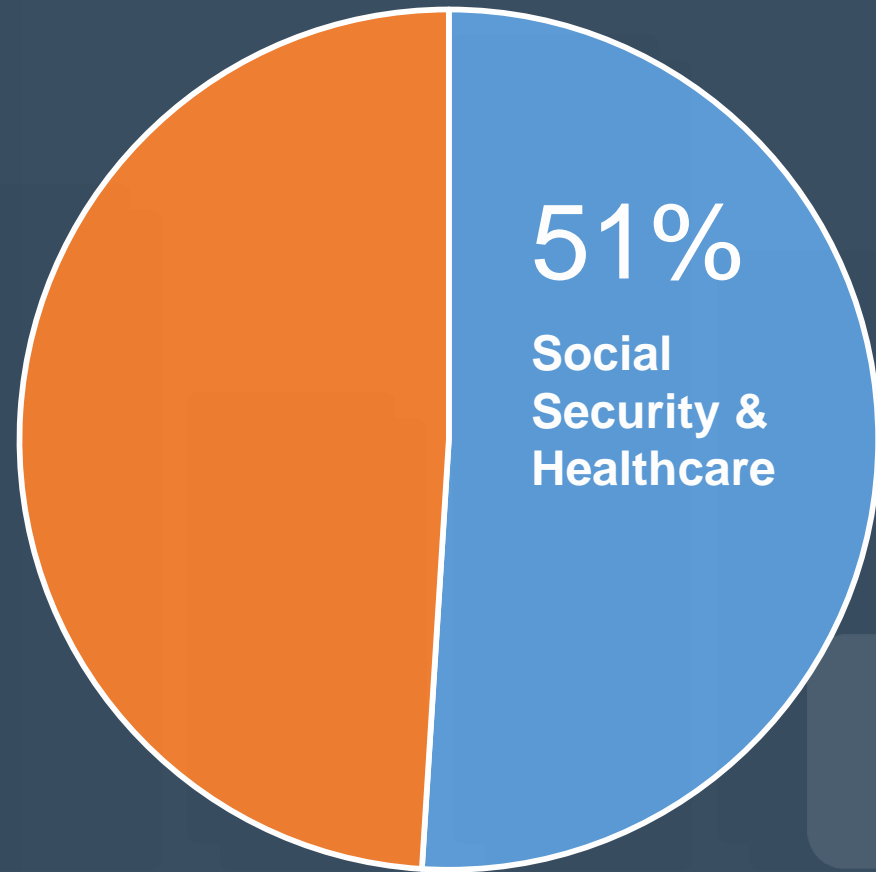**Cleveland Clinic**

Really far…

$3.3 Trillion or $10,348 per person

National Health Expenditures as a Share of Gross Domestic Product, 1987-2016

The share of GDP devoted to health was 17.9% in 2016

17.9%

July 1990-
March 1991
Recession

March 2001 -
November 2001
Recession

December 2007 -
June 2009
Recession

Percent of GDP

Calendar Years

US Federal Budget

34%
Social Security & Healthcare
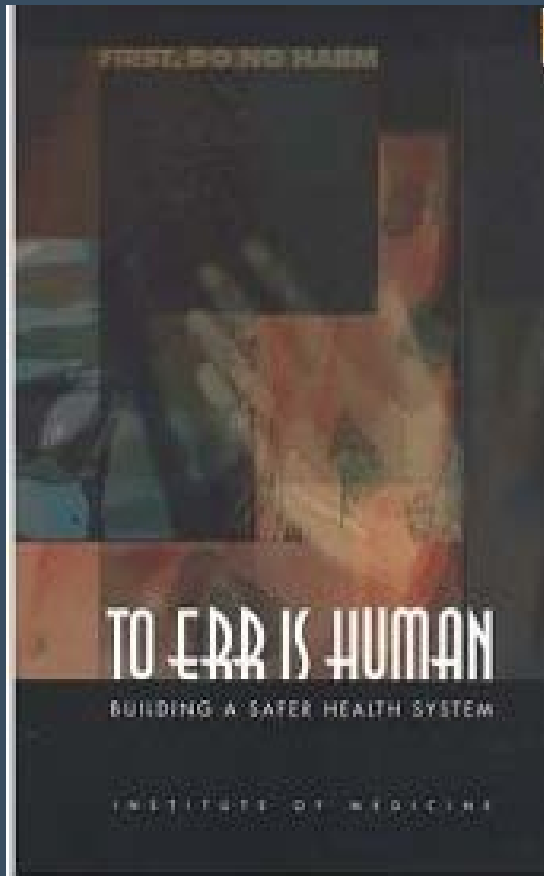
51%
Social Security & Healthcare

1975

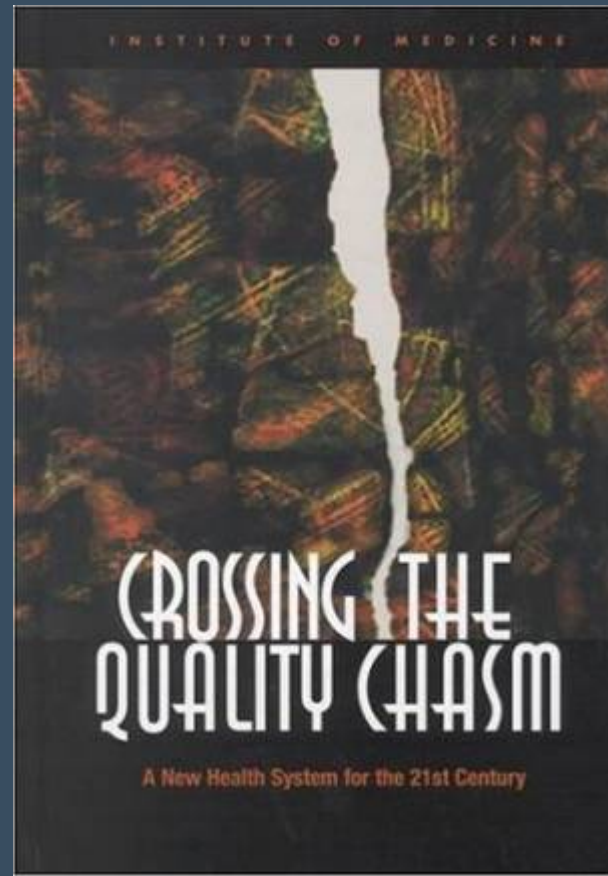**2017**

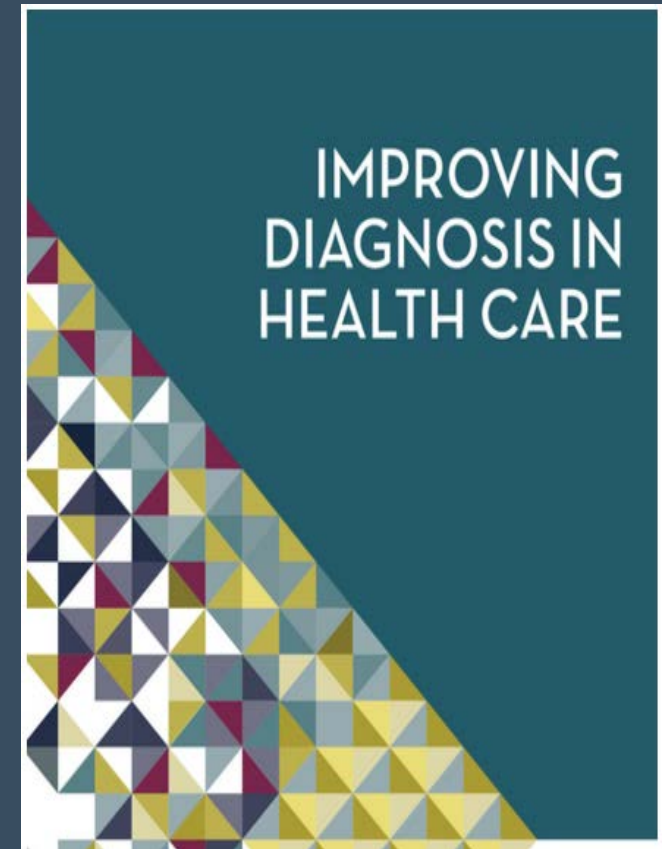# A Call to Action…

1999

2001

2015

IOM Dimensions

- Safe – avoiding injury
- Timely – reduce waits and delays
- Effective – evidence based
- Efficient – avoiding waste
- Equitable – consistent care
- Patient-Centered – patient values

Three of these crashing, every day

The $17.1 Billion Problem: The Annual Cost Of Measurable Medical Errors

Jill Van Den Bos[1], Karan Rustagi[2], Travis Gray[3], Michael Halford[4], Eva Ziemkiewicz[5], and Jonathan Shreve[6]

AFFILIATIONS ⌄

Healthcare Value
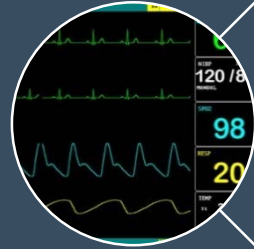
Safety

Outcomes

Service/Satisfaction

Cost / Affordability

The Triple Aim

The 4th aim?

Joy of Practice for caregivers

Better Population Health

Better Care for Individuals

Lower Cost through Improvement
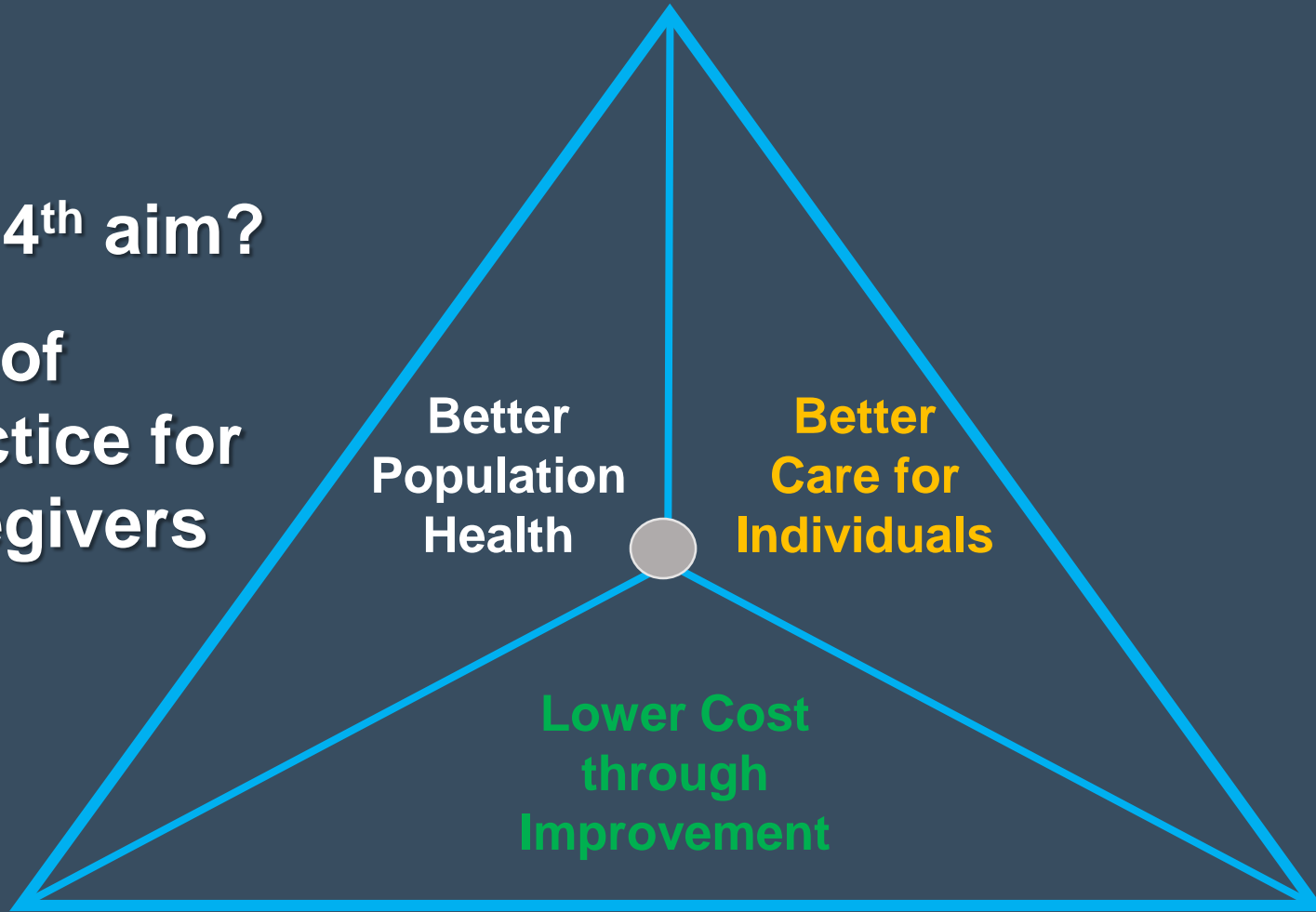
2018 Goals and Priorities

MISSION
To provide better care of the sick, investigation into their problems, and further education of those who serve.

GOALS

Patients First	Caregivers	Affordability	Growth	Impact

ENTERPRISE PRIORITIES

Access Solutions	Digitalization	Engagement	High Reliability	Population Management	System Development

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"Treat the patient and fellow caregivers as family, and the organization as your home"

Tomislav Mihaljevic, MD
CEO & President

Undisputed *Champions* of Safety

Traditional framing

Safety:	Complications, Infections, Safety Events, Caregiver Safety
Quality:	Sepsis, Readmissions, Clinical Outcomes
Patient Experience:	Patient satisfaction in all care settings

What patients think…

Safety:	Keep me safe.
Quality:	Heal me.
Patient Experience:	Know and Engage me.

A Safe Organization

What IS High Reliability in Healthcare?

"A Collective Mindfulness"

- Preoccupation with failure
- Reluctance to simplify observations
- Sensitivity to operations
- Resilience
- Deference to expertise

Weick, K.E., and K.M. Sutcliffe. 2007. *Managing the Unexpected.* 2nd ed. San Francisco: Jossey-Bass.

High Reliability Model

Leadership

Commitment to zero patient harm

Safety Culture

Empowering staff to speak up

Robust Process Improvement

Systematic, data-driven approach to complex problem solving

Chassin MR, Loeb JM. High-Reliability Health Care: Getting There from Here. *Milb Q* 2013;91(3):459-90

"The hallmark of an High Reliability Organization is <u>not</u> that it is error-free, but that errors don't disable it"

Updated: 30 April 2018

Safety Checklist Worksheet: All Surgeries and Procedures

Checklist to be used for all procedures performed inclusive of: surgery, procedure rooms, clinics, and bedside procedures

Sign In
Interactive Team Discussion prior to Procedure

☐ All team members introduce themselves to the patient by name and role

Patient and Procedure Verification

Correct Patient:
☐ Name
☐ Date of Birth

☐ **Correct Procedure verified:**
1. Informed Consent (2 person verification)
   1a.) Verified by: _____
   1b.) Verified by: _____
☐ 2. Scheduled procedure matches Informed Consent
☐ 3. H & P
☐ 4. As stated by patient

🛑 STOP and collaborate if 1-4 do not agree

☐ Site marked reflecting verified procedure site and side

Plan of Care
Anesthesia:
☐ Antibiotic
☐ Blood Products
☐ Pre-anesthesia assessment

Surgeon/Proceduralist:
☐ Implants to be inserted → *For each implant to be inserted, conduct Implant Verification*
☐ Existing Implants/Devices
☐ Imaging, diagnostic tests available
☐ Special equipment needed

Nursing:
☐ Allergies
☐ Compression stockings applied

🛑 Team resolves all questions before proceeding

Time Out
Interactive verbal communication immediately prior to incision/procedure start

Entire **team stops and agrees:**
☐ Correct Patient
☐ Correct Site
☐ Correct Side (if applicable)
☐ Correct Procedure
☐ Correct Position (if applicable)

Nursing:
☐ Discuss Fire Risk Assessment score and review interventions
☐ Check members at the field in close proximity to the patient for eyewear

Surgeon/Proceduralist states:
☐ All elements/issues resolved?
☐ Are we ready to start?

🛑 STOP entire team agrees before proceeding

Time Out Affirmation
Conducted if surgeon/proceduralist not present for initial time out

☐ All elements of time out included in affirmation

Note: The Sign-in and Time-out may be done at the same time if they are done immediately before the incision or start of the operation/procedure, when the physician/proceduralist remains with the patient.

Pause to ensure completion of all counts prior to closure of incision/conducting Sign Out

Sign Out
Verbal confirmation prior to team leaving the room

Team agrees:
☐ Correct procedure recorded
☐ Wound classification (as applicable)
☐ Disposition of blood products
☐ Counts completed and reconciled
☐ Specimen(s) placed into container, labeled prior to closing, and sent correctly

Team reviews appropriate documentation of the following:
☐ Key concerns for recovery and management of the patient
☐ Does the team have any outstanding issues in regards to this case?

Implant Verification
Two person verbal and visual verification of implant. Completed prior to opening item to field

☐ Expiration date: _____
☐ Manufacturer
☐ System / Type
☐ Size
☐ Intended location and/or laterality
☐ Serial and lot number

Please give completed worksheets to Unit / Department Nurse Manager or designee
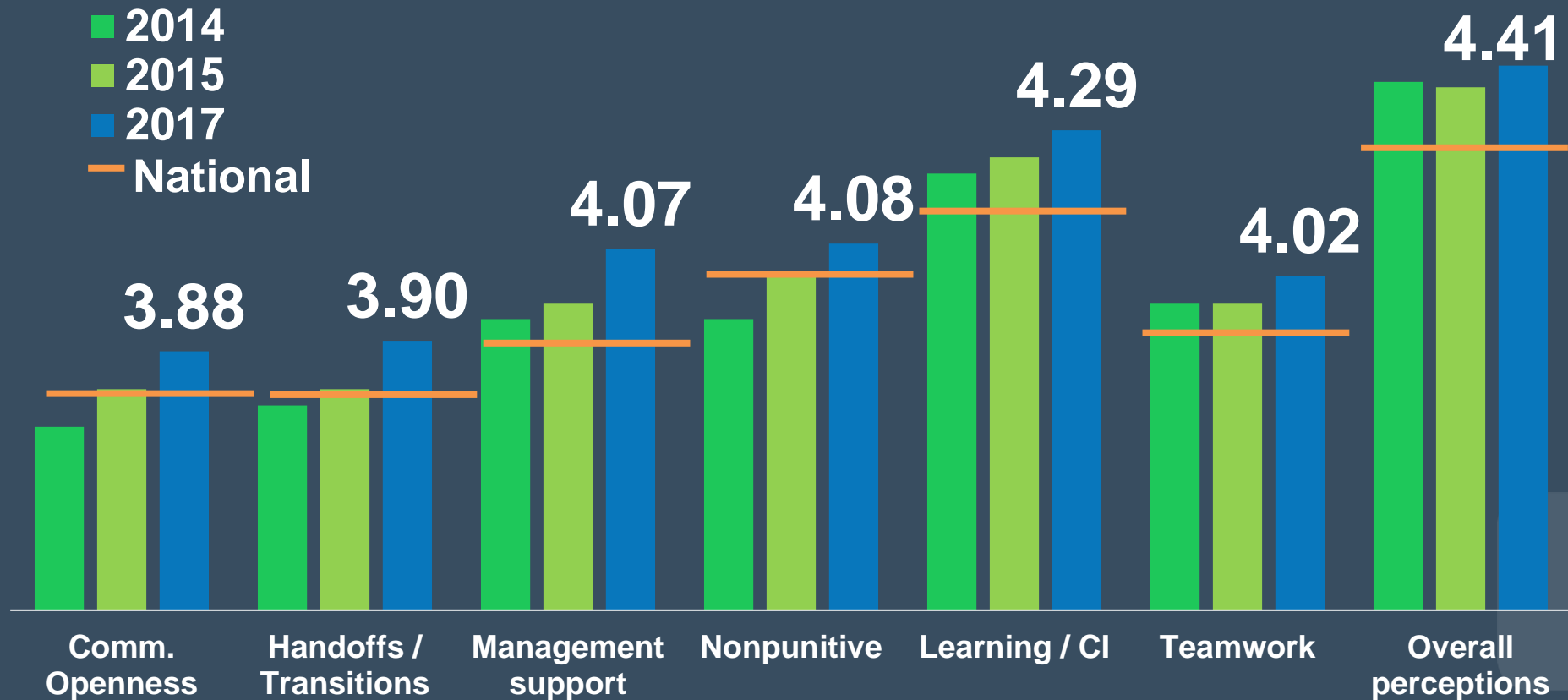
PWO 12510 Rev. 5/18

Highly Reliable Teams

START STRONG
and
FINISH STRONG

Together!

Incident Command Center Activation

Metrics that matter: Measuring Culture

Legend:
- 2014
- 2015
- 2017
- National

Values shown: 3.88, 3.90, 4.07, 4.08, 4.29, 4.02, 4.41

Categories: Comm. Openness, Handoffs / Transitions, Management support, Nonpunitive, Learning / CI, Teamwork, Overall perceptions

Safety Reporting Theory

- Safest units = highest reporting
- ANY member can "stop the line"

- Non-punitive response
- Loop will be closed – "My voice was heard"

Daily Safety Huddles

Psychological Safety

Opportunities

Curious

Fallible

What "zone" are you in?

"Quality" is integral to our goals.

Not something extra.

You get what you measure…

2018 Goals Summary

Device-related infections (CLABSI and CAUTI)	≤ 21/mo
C. difficile	≤ 50/mo
MRSA	0
Patient Safety Indicators (Complications)	≤ 44/mo
Serious Safety Events	0
Hand Hygiene	100%
Hospital Wide Readmissions	≤ 12.0%
Sepsis Mortality	≤ 14.9%
Hypertension Control	≥ 90%
Diabetes Control HbA1c > 9	≤ 10%
Diabetes Eye Exam	≥ 80%

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Transparency in healthcare…

Transparency

Daily Safety Huddles

Celebrate NICE CATCHES!

"Nothing about us, without us"

- Transformative progress
- Insight on patient perceptions
  - What are our blind spots?
- Focus on patient centered care
- Opportunity for proactive solutions
- Input on goals
- Test concepts prior to roll-out

Patient Involvement

Best Practices
- Patients on standing committees
- Pediatric family on Error Prevention Leadership Team
- Executive Rounding
- Patients involved in goal-setting
- Healthcare Partners

Healthcare Partners

Partnering with patients to promote safety and service

Focusing on patient centered care

Bringing patients and healthcare providers together

Empowering patients to take a active role in improving the patient experience

Healthcare Partners Structure

- Institute / Hospital Based
- 10-12 Patient Members
- Representing diversity of patient community
- One or Two year term (staggered)
- Volunteer Orientation
- Up to 4 employee members
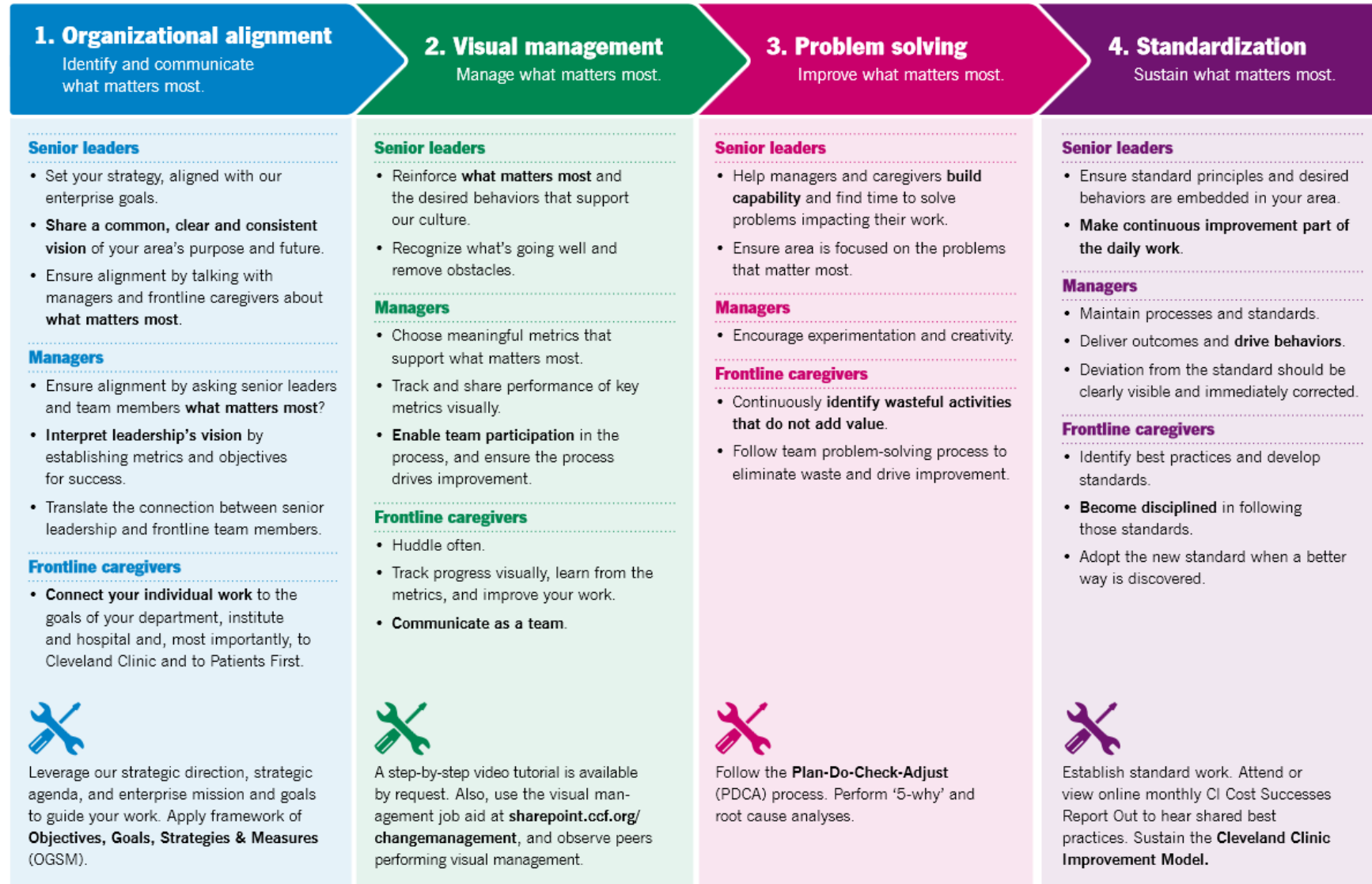- Meetings Monthly / Quarterly

Successes

- Creation of new caregiver welcome letter
- Standardized volunteer role on inpatient units
- Hospitality Rounds
- Leadership Rounds

Cleveland Clinic Improvement Model (CCIM)

Cleveland Clinic

Your team can start building a Culture of Improvement by answering the question, **What matters most?**

1. Organizational alignment
Identify and communicate what matters most.

Senior leaders
- Set your strategy, aligned with our enterprise goals.
- **Share a common, clear and consistent vision** of your area's purpose and future.
- Ensure alignment by talking with managers and frontline caregivers about **what matters most**.

Managers
- Ensure alignment by asking senior leaders and team members **what matters most?**
- **Interpret leadership's vision** by establishing metrics and objectives for success.
- Translate the connection between senior leadership and frontline team members.

Frontline caregivers
- **Connect your individual work** to the goals of your department, institute and hospital and, most importantly, to Cleveland Clinic and to Patients First.

Leverage our strategic direction, strategic agenda, and enterprise mission and goals to guide your work. Apply framework of **Objectives, Goals, Strategies & Measures (OGSM)**.

2. Visual management
Manage what matters most.

Senior leaders
- Reinforce **what matters most** and the desired behaviors that support our culture.
- Recognize what's going well and remove obstacles.

Managers
- Choose meaningful metrics that support what matters most.
- Track and share performance of key metrics visually.
- **Enable team participation** in the process, and ensure the process drives improvement.

Frontline caregivers
- Huddle often.
- Track progress visually, learn from the metrics, and improve your work.
- **Communicate as a team.**

A step-by-step video tutorial is available by request. Also, use the visual management job aid at **sharepoint.ccf.org/ changemanagement**, and observe peers performing visual management.

3. Problem solving
Improve what matters most.

Senior leaders
- Help managers and caregivers **build capability** and find time to solve problems impacting their work.
- Ensure area is focused on the problems that matter most.

Managers
- Encourage experimentation and creativity.

Frontline caregivers
- Continuously **identify wasteful activities that do not add value**.
- Follow team problem-solving process to eliminate waste and drive improvement.

Follow the **Plan-Do-Check-Adjust (PDCA)** process. Perform '5-why' and root cause analyses.

4. Standardization
Sustain what matters most.

Senior leaders
- Ensure standard principles and desired behaviors are embedded in your area.
- **Make continuous improvement part of the daily work.**

Managers
- Maintain processes and standards.
- Deliver outcomes and **drive behaviors.**
- Deviation from the standard should be clearly visible and immediately corrected.

Frontline caregivers
- Identify best practices and develop standards.
- **Become disciplined** in following those standards.
- Adopt the new standard when a better way is discovered.

Establish standard work. Attend or view online monthly CI Cost Successes Report Out to hear shared best practices. Sustain the **Cleveland Clinic Improvement Model.**

Right systems. Right behaviors. Right results.

For questions, improvement tools or assistance, contact Continuous Improvement at improve@ccf.org.

Culture of Improvement

Professional Practice Model Huddles

Solutions for Value Enhancement (SolVE)

Falls in healthcare

- Extraordinarily complex

- Lot of risk assessment tools

- How do we engage patients and families?

- Learning from "in-house" expertise?

An unanticipated synergy…

Can iPhones solve all our problems?

Believe it – you are high risk!
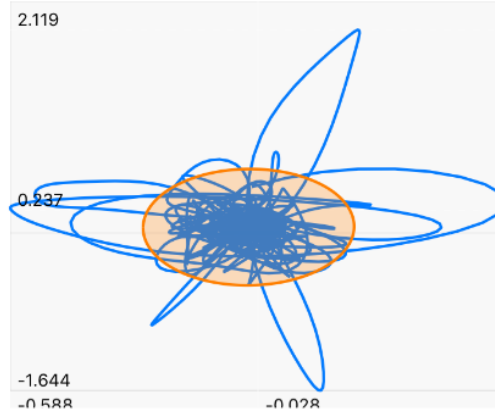
Top 10 Safety Issues Campaign

- Clinical alarms
- EMR and results
- High risk medications
- Caregiver safety
- Transitions of care
- Universal protocol
- Diagnostic reasoning
- Decision support
- Scaling safety solutions
- Safety event reporting

TACKLING THE
TOP 10 SAFETY ISSUES
FOR 2018

Thirty percent of U.S. hospitalized patients suffer preventable injury or death every year. Increasing awareness and standardizing best practices can protect our patients from preventable harm.

Together, by reporting safety events and near misses, and identifying trends, we can develop sustainable solutions.

1 — Identify critical clinical alarms to reduce alarm fatigue.

2 — Leverage technology to better manage the electronic health record and test results.

3 — Apply safeguards to **high-risk medications** like insulin and anticoagulants.

4 — Reduce workplace hazards to ensure caregiver safety.

5 — Practice seamless handoffs and transitions to maintain continuity of care.

6 — Follow the **universal protocol** with your team before any procedure. Confirm that the correct person is having the correct procedure on the correct site. All team members must participate to maximize patient safety.

7 — Seek input from the care team to reduce diagnostic errors.

8 — Encourage all physicians and caregivers to use the Safety Event Reporting System (SERS) to report safety events and near misses.

9 — Standardize processes and share safety solutions to deliver highly reliable care.

10 — Use clinical decision support to guide safe, high-quality care.

Providing safe care is not just being careful. It's providing highly reliable care across the enterprise to every patient, every time.

It means looking for what could go wrong, having the courage to speak up, reporting any safety concern in SERS and driving improvement — together.

Look for tips and resources each month to strengthen our commitment to safety — our patients are counting on us!

Cleveland Clinic

17-CCC-018

Key Takeaways

- We must all get better together
- Committed leadership essential
- Patient and caregiver voice is key
- Transparency drives engagement
- High Reliability mindset is engine

Cleveland Clinic Way
Quality and Patient Safety Intensive

October 24-26, 2018 | *Cleveland, Ohio*

Contact Global Executive Education to learn more

ExecutiveEducation@ccf.org   or   *www.CCFcme.org/QualityIntensive*

Cleveland Clinic

Every life deserves world class care.