# Safety STOP: Stopping the Line to Prevent Patient Harm

**Presenters:**
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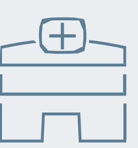
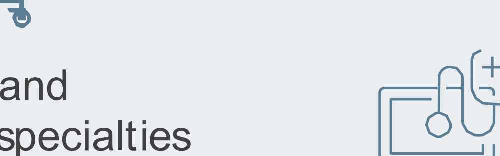
# Objectives

- Demonstrate an approach to decreasing serious safety events that is effective in large hospitals, critical access communities, and outpatient clinics.
- Identify strategies that can work to support a culture of safety.
- Discuss barriers to implementing effective action plans resulting from a Root Cause Analysis and strategies to overcoming them.

3 states



medical group with 139 clinics



51 medical and surgical specialties

3 Level II trauma centers

16,000 caregivers

10 medical centers

1,100+ physicians and providers

523,000 unique patients annually

# One PeaceHealth | Serving Many Communities

## A Lasting Commitment to the Pacific Northwest

FY18: JULY 2017–JUNE 2018

# **What Guides Us:** Our Guiding Principles

## Safety is #1

Safety is everyone's job. 100% Perfect Care, Zero Harm is everyone's primary motivator, above all else. The singular focus on safe patient care brings real change that's sustainable.

## Redefining Possible

To better serve our patients and communities, we are redefining possible for PeaceHealth with the vision to develop and implement systems that achieve 100% Perfect Care, Zero Harm.

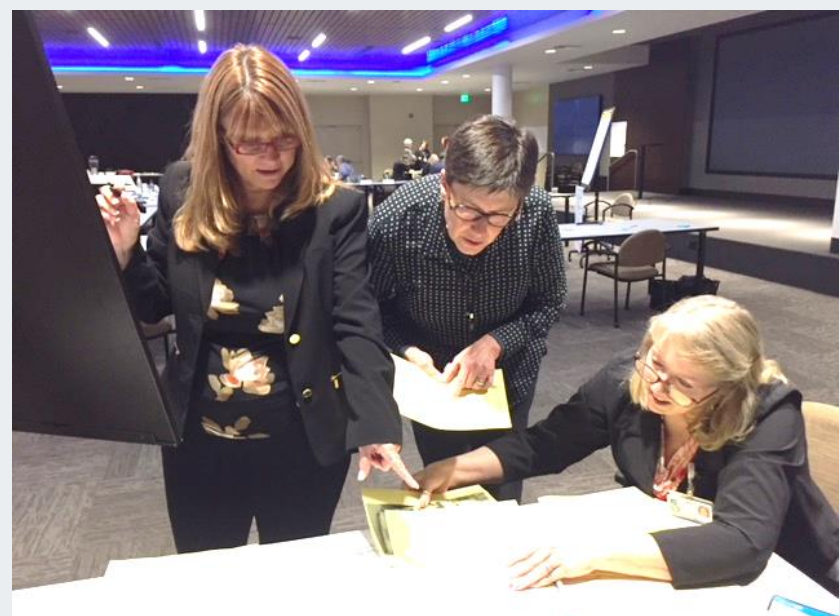
## A Just Culture

As a just culture we understand that to err is human. We are committed to designing systems that prevent human error from causing patient harm and enable all of us to succeed.

# Our first step: understanding our current state

# Our approach: Go and See to understand

- Started by **"going and seeing"**
- **34 patient harm** RCA cases reviewed
  - Evenly distributed across large hospitals, critical access hospitals and the medical group
  - "Go-see" teams in the different facilities



| Cycle | Wait | VA | NVA |
|---|---|---|---|
| 30 mins | 2 days | 20mins | 10mins |
| 10 hrs | 1 day | 2 hrs | 8hrs 480 |
| 20 mins | 4.5 days | 10 mins | 10mins |
| 45mins | 1 day | 10mins | 35mins |
| 15hrs. | 0 day | 8 hrs. | 7 hrs |
| 2hrs. | 23.5 days | 1.5hrs. | .5hrs. 30 min |
| 8hrs. | 20 days | 2hrs. | 6hrs. 360 min |
| 2 hrs. | 30 days | 10 min. | 1hr. 50min |
| 3 days | 1 day | 1 day | 2 day 2880 |
| 30 mins | 126 days | 5 mins | 25 mins |
| 6,665 111.08hrs 4.63days | 209 days | 2305mins 38.4hrs. 1.6 days | 4360mins 72.7hrs 3.03days |

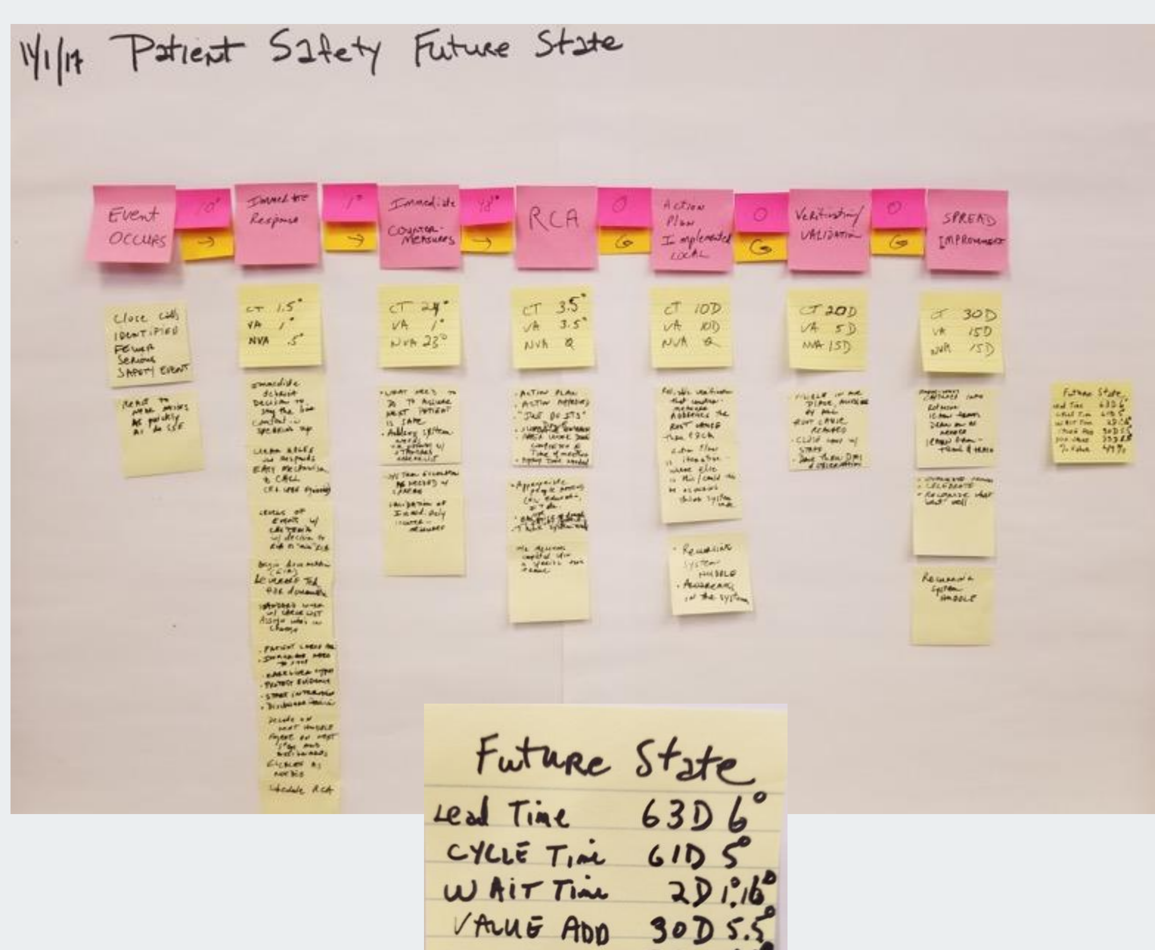
# Current state value stream map

October 2017

# Future state targets (outcome measures)

- Achieve lead time of **1 month** (local action plan implementation) by April 2019
- **Zero repeat SSEs** across the system by April 2019
- Improve our **culture of safety** staff engagement survey measure from 3.79 to 3.84 by July 2018

# Future state key features – process measures




- Safety STOP called **on discovery**
- Immediate response (**10 minutes**)
  - Immediate countermeasures
- RCA within **72 hrs**
- Implementation (**10 days** of RCA)
- Verification and validation (**20 days** of implementation)
- Closure Huddle (**33 days** of event)
- Spread (**63 days** of event)

# Future state – reduction in waste

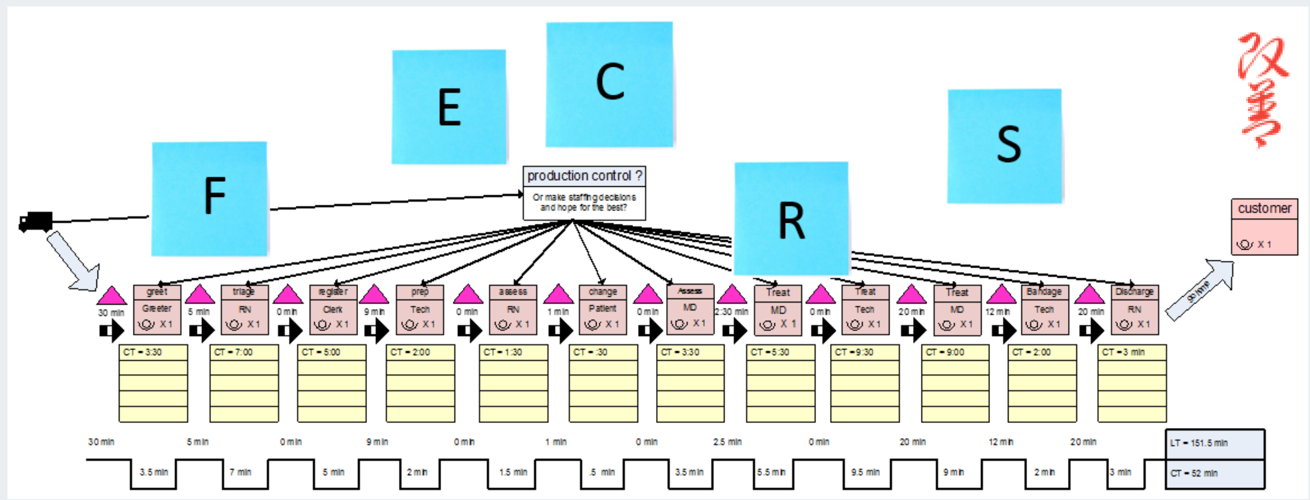
- **Improve response and management of safety concerns**
  - Reduced lead time
  - Eliminates waste of waiting
- **100% perfect care, zero harm**
  - Reduction in defects
  - Improvement in quality
- **Immediate countermeasures**
  - Reduction in rework and over-processing (solving the same issue more than once)

# Idea generation – FECRS

**Redefining Possible**

To better serve our patients and communities, we are redefining possible for PeaceHealth with the vision to develop and implement systems that achieve **100% Perfect Care, Zero Harm.**

- **F**ix
- **E**liminate
- **C**ombine / **C**o-locate / **C**oordinate
- **R**earrange / **R**e-sequence
- **S**implify

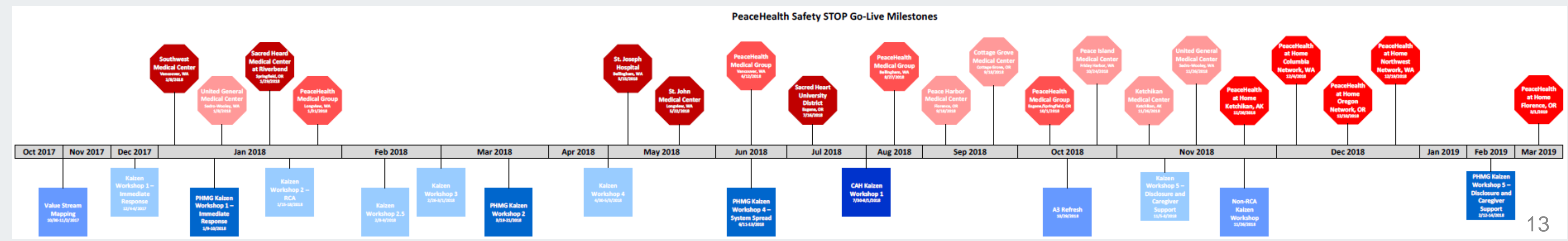


# What is Safety STOP?

- All caregivers & providers are **empowered to “stop the line”**
  - Immediate leadership support and response
  - Countermeasures identified and implemented
- **If prioritization indicates,** may result in root cause analysis (RCA)
- Based on concepts from lean and Toyota Management System

# Our timeline

- **Multiple kaizens** including hospitals, clinics, critical access:
  - **Event response** (stop the line)
  - **Root cause analysis** within 72 hrs
  - **Action plan implementation** within 10 days and evidence of effectiveness
  - **Spread of improvements** across system (still a challenge)
  - **Disclosure and Care for the caregivers**



**1 Safety STOP call.**
In-house leadership arrives within 10 minutes and other responders arrive within 90 minutes.Immediate countermeasures are deployed to ensure safety of patients.

**2 Report to leadership.**
The administrator on call (AOC) or designated ambulatory administrator (DAA) attends local leader huddle to provide a Safety STOP report.

**3 Hand-off huddle.**
Issue management transitions to unit or clinic leadership, who identify the next steps. If RCA is necessary, an executive sponsor and process owner are assigned.

**4 System escalation huddle.**
If system support is needed, the issue is brought to the twice weekly system escalation huddle. Potential for systemwide impacts is also highlighted.

*100% Perfect Care, Zero Harm*

# Safety STOP

*Redefining Possible for PeaceHealth*

PeaceHealth's rapid, reliable and sustainable response to safety events systemwide.

**5 Root cause analysis (RCA).**
Multi-disciplinary team completes RCA, if needed, within 72 hours. The resulting action plan includes follow-up to ensure successful implementation.

**6 Action plan.**
The action plan is implemented within 10 days of the RCA. Leaders round to verify training has taken place and validate the solution is successful.

**7 Close the loop.**
Following successful RCA implementation, the issue is closed. Participating caregivers and teams are recognized for their dedication to patient safety.

**8 Systemwide spread.**
If appropriate, action plans are introduced across the system to ensure patients get the same high-quality care at all of our clinics and medical centers.

# When is a Safety STOP activated?

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**Safety STOP**

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Safety STOP

**An event POTENTIALLY or ACTUALLY caused patient harm.**

**PATIENT CONDITION IS UNSTABLE:**

Dial XXXX to Report "RRT" or "Code Blue"
- Follow appropriate hospital policy

Ensure patient safety:
- Call for additional help if needed
- Remove faulty equipment, furniture, or any other type of hazard
- Initiate other Codes if needed

**PATIENT CONDITION IS STABLE:**

CHECK IF ONE OF THESE SIGNIFICANT EVENTS HAS OCCURRED:
- NQF Never 29 Events (list on back)
- Delay in treatment that resulted in serious harm
- Equipment or facility failure that requires increased physician ordered interventions or escalation to a higher level of care
- Sterile processing failure that reaches the patient
- Any unsafe circumstance that could result in imminent harm

**IF IT APPEARS A SIGNIFICANT EVENT HAS OCCURRED:**
- Call XXXX to initiate a Safety STOP call
- Notify on-duty Charge Nurse immediately
- All involved staff must remain in the area until dismissed by the responding team
- Participate in the investigation as requested
- Be sure to complete a Variance (Electronic Incident) Report

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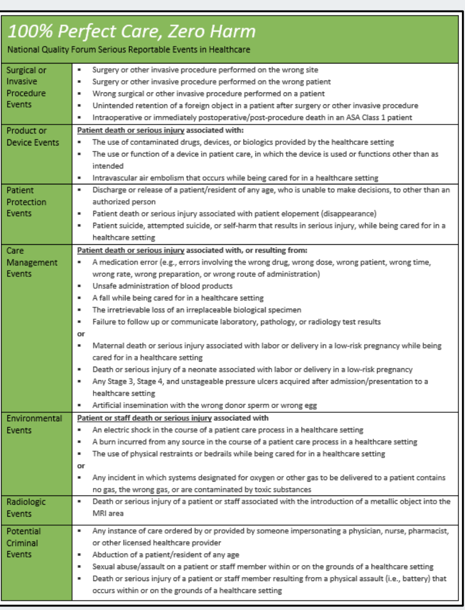
For Safety STOP Checklist and Standard Work Forms please see: Crossroads > System Departments > Patient Safety > Hospital Safety STOP Toolkit



*100% Perfect Care, Zero Harm*

National Quality Forum Serious Reportable Events in Healthcare

| Category | Events |
|---|---|
| Surgical or Invasive Procedure Events | ▪ Surgery or other invasive procedure performed on the wrong site<br>▪ Surgery or other invasive procedure performed on the wrong patient<br>▪ Wrong surgical or other invasive procedure performed on a patient<br>▪ Unintended retention of a foreign object in a patient after surgery or other invasive procedure<br>▪ Intraoperative or immediately postoperative/post-procedure death in an ASA Class 1 patient |
| Product or Device Events | **Patient death or serious injury associated with:**<br>▪ The use of contaminated drugs, devices, or biologics provided by the healthcare setting<br>▪ The use or function of a device in patient care, in which the device is used or functions other than as intended<br>▪ Intravascular air embolism that occurs while being cared for in a healthcare setting |
| Patient Protection Events | ▪ Discharge or release of a patient/resident of any age, who is unable to make decisions, to other than an authorized person<br>▪ Patient death or serious injury associated with patient elopement (disappearance)<br>▪ Patient suicide, attempted suicide, or self-harm that results in serious injury, while being cared for in a healthcare setting |
| Care Management Events | **Patient death or serious injury associated with, or resulting from:**<br>▪ A medication error (e.g., errors involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation, or wrong route of administration)<br>▪ Unsafe administration of blood products<br>▪ A fall while being cared for in a healthcare setting<br>▪ The irretrievable loss of an irreplaceable biological specimen<br>▪ Failure to follow up or communicate laboratory, pathology, or radiology test results<br>**or**<br>▪ Maternal death or serious injury associated with labor or delivery in a low-risk pregnancy while being cared for in a healthcare setting<br>▪ Death or serious injury of a neonate associated with labor or delivery in a low-risk pregnancy<br>▪ Any Stage 3, Stage 4, and unstageable pressure ulcers acquired after admission/presentation to a healthcare setting<br>▪ Artificial insemination with the wrong donor sperm or wrong egg |
| Environmental Events | **Patient or staff death or serious injury associated with**<br>▪ An electric shock in the course of a patient care process in a healthcare setting<br>▪ A burn incurred from any source in the course of a patient care process in a healthcare setting<br>▪ The use of physical restraints or bedrails while being cared for in a healthcare setting<br>**or**<br>▪ Any incident in which systems designated for oxygen or other gas to be delivered to a patient contains no gas, the wrong gas, or are contaminated by toxic substances |
| Radiologic Events | ▪ Death or serious injury of a patient or staff associated with the introduction of a metallic object into the MRI area |
| Potential Criminal Events | ▪ Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed healthcare provider<br>▪ Abduction of a patient/resident of any age<br>▪ Sexual abuse/assault on a patient or staff member within or on the grounds of a healthcare setting<br>▪ Death or serious injury of a patient or staff member resulting from a physical assault (i.e., battery) that occurs within or on the grounds of a healthcare setting |

- **Any Unsafe Circumstance** that could result in harm.
- **Never 29 Events** –Serious safety events defined by the National Quality Forum.
- **Delays in Treatment** that results in serious harm or death, or could have.
- **Equipment or Facility Failure** that requires escalation.
- **Sterile Processing Failure.**
- **Any event** that impacts 3 or more patients.

# Standard work for all roles, centrally located

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'Safety STOP' Operator Standard Work Instructions:
Administrator On-Call (AOC)

Title: AOC (Administrator On-Call)

Departments who must adopt: Administration/Executive level

| Task # | Task Description |
|---|---|
| 1. | Receive notification of 'Safety STOP' by telephone call from designated … For calls originating from PeaceHealth at Home (in-home patient service… time when the caregiver will be returning to the office. Response will not … |
| 2. | Connect with Safety STOP Responder (SSR) to confirm and align timing o… Administrators should confirm arrival times to enable the ideal of respondi… Why is this important? The intent of a team approach is to collab… provider/ caregivers. The AOC and SSR should work together (wit… countermeasures. Clarifying Note: Response time is as soon as possible, but not to … For calls originating from PeaceHealth at Home: • In-home Services: Respond in person to the PeaceHealth at Hom… • Inpatient Hospice Unit: Respond in person |
| 3. | Upon arrival, assume event leader role. Confirm patient is safe and stable. Confirm that someone is assessing the caregiver's wellbeing and providin… Review event details from Immediate Responder, and receive update on… Before proceeding with response, huddle with Safety STOP Responder t… sequestering, additional stakeholders needed, etc.). Can be accomplished … aligned. |

Sponsor/process owners: David Allison, System DIR of Patient Safety and Variance Reporting; Andrea Halliday, System Patient Safety Officer | Origin: Safety STOP Worksho… | …STOP Workshop #2 | Version number: 10 (12/25/2018)

Home
Departments
Patient Safety
- Home
- About Safety STOP
- Critical Access Safety STOP Toolkit
- Hospital Safety STOP Toolkit
- PHMG Safety STOP Toolkit
- PeaceHealth at Home Safety STOP Toolkit
- Orange Event Toolkit
- RCA Toolkit
- RCA Tracker
- Leadership Tools & Instructions
- Safety STOP FAQs
- Standard Work by Role

## Hospital Safety STOP Toolkit

MANAGE PAGE CONTENT

100% Perfect Care. Zero Harm
Safety STOP
Redefining Possible for PeaceHealth
An event POTENTIALLY or ACTUALLY caused patient harm.

**PRINT ALL Immediate Response Forms (PDF)**

Includes the following:
- Safety STOP Checklist/Documentation Form
- Safety STOP Questionnaire
- Safety STOP Interview Form
- As of 8/28/18, the **PRINT ALL** packet no longer includes the standard work documents and the electronic Notification Form

**Quick Links (General Safety STOP Information):**
- Hospital Process Map
- Hospital Flyer
- Safety STOP Infographic - system-wide
- Hospital Safety STOP Algorithm
- SSR On-call Calendars (limited permissions)
- **New!** SSR On-Call Calendar Standard Work
- **New!** Safety STOP Responder (SSR) FAQs

**Standard Work Documents, by Role:**

**Event:**
- Administrator on Call
- Caregiver
- Charge Nurse
- Immediate Responder (e.g., House Supervisor)
- Manager
- Safety STOP Responder

**All Other (RCA and beyond):**
- Chief Medical Officer/Patient Safety Officer
- Clinical Educator
- Executive Assistant
- Executive Sponsor
- Medical Director/Med Staff
- Patient Safety Consultant
- Performance Improvement
- Process Owner
- Quality Leader
- Subject Matter Expert

**Safety STOP Event**
- Safety STOP Checklist/ Doc. Form
- Safety STOP Interview Form
- Safety STOP Questionnaire
- Safety STOP Notification Form
- Process Change Alert & Instr.
- Telecom Notification Checklist

MORE

**Handoff Huddle**
- Handoff Huddle Instructions
- Process Change Alert & Instr.
- RCA Prioritization Tool
- Rounding Post Safety STOP
- SSE and Harm Level Algorithm

**Implementation, Verification & Validation**
- Explanation of the Tools
- Standard Work Template
- DMS Training Matrix
- Process Observation Form Temp...
- Process Observation Tracker Te...
- Abnormality Tracker Template

MORE

*Operator standard work instruction template licensed to PeaceHealth by Moss Adams/Rona Consulting Group. Template copyrighted by Rona Consulting Group.*

# Tools to guide the work

## Safety STOP Checklist / Documentation Form

PATIENT LABEL

**Instructions:** Immediate Responder, Administrator On-Call **(AOC)**/Designated Ambulatory Administrator **(DAA)**, and Safety STOP Responder **(SSR)** complete this form. Ensure form is brought to hand-off huddle.

**Event Details**

Event Date: | Event Time:

Clinic Name: | Department / Unit: | Room #:

**Section A: Immediate Responder (aka "Initial Responder")**

**Immediate Responder Name & Title:** | Response Date and Time:

- ☐ Ensure patient is safe and stable
- ☐ Assess caregiver wellbeing
  - If care / action is required, notify AOC/DAA or SSR
- ☐ Ensure caregivers remain available until officially released from duty by AOC/DAA or SSR

Event description:

**Initiate sequestration of scene and information:**

☐ Photographs ☐ Supplies ☐ Other (please specify):
☐ Packaging ☐ Equipment

**Is the event on the list of NQF Never 29?** ☐ Yes ☐ No **If Yes,** contact Risk Manager via cell phone – check when done: ☐

**Has provider been notified?**
☐ Yes, already notified ☐ No, not required ☐ Notification underway
Provider Name: ____ Method of notification: ____ Time: ____

**Event Participants:**

| Title | Name (first & last) | Title | Name (first & last) |
|---|---|---|---|
| House Supervisor | | Manager | |
| Provider | | Director | |
| Charge RN | | Risk Manager | |
| Primary RN(s) | | Caregiver who called Safety STOP | |
| | | | |
| CNA(s) | | Others: | |
| | | | |
| AOC / DAA | | | |
| Safety STOP Responder | | | |

**Section B: Secondary Responder (Administrator On-Call (AOC) or Designated Ambulatory Administrator (DAA))**

**Secondary Responder Name & Title:** | Response Date and Time:

- ☐ Ensure **Section A** complete
- ☐ As needed, work with SSR to complete **Section C**
- ☐ Assess caregiver wellbeing – Is caregiver okay to continue work? ☐ Yes ☐ No
  Action Taken: ☐ Chaplain notified ☐ Critical Incident Support ☐ Other

Was caregiver relieved of current duties? ☐ Yes ☐ No HR notified? ☐ Yes ☐ No

☐ Ensure Variance Report is complete
**Record #:** ____

**Countermeasures** (Document on Process Change Alert form as appropriate):

Safety STOP
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**Not Part of Medical Record**
Quality Assurance-do not disclose. Confidential information protected by legal privilege and state quality improvement law
Rev Date: 1/22/2019

**Are there additional areas at risk?** ☐ Yes ☐ No | List here, with name of leader(s) advised:

**Are there network / system risks?** ☐ Yes ☐ No | Plans for escalation (who, and when)?

**Event disclosure required?** ☐ Yes ☐ No | Date/Time disclosed: ____ Disclosed to: ☐ Patient ☐ Other

Disclosed by: Executive: ____ Provider: ____ Risk Manager: ____

**External reporting required?** ☐ Yes ☐ No

Action Taken? Explain: ____

Action Required? Explain: ____

☐ **Debrief huddle held with Immediate Responder, AOC/DAA, SSR, and Caregivers** (to confirm countermeasures, close immediate response and confirm next steps).

☐ **Schedule or convene Hand-off Huddle** | Date: ____ Time: ____

**AOC/DAA** sends text to the following:

**Hospital and PeaceHealth at Home:** CNO | CMO | Pt Safety Consultant | Pt Safety Officer | Manager | Director | Risk Manager | Quality Leader
**Clinic:** VP Ops | Division Chief | Pt Safety Consultant | Pt Safety Officer | Manager | Director | Risk Manager | Quality Leader | Section Leads

In cases involving multiple sites, consider including appropriate leaders from other site(s)in handoff huddle text message.

AOC/DAA collects all necessary forms, materials and documents and takes to Handoff Huddle.

AOC/DAA facilitates Handoff Huddle using checklist found on Toolkit site.

**Text message should contain:**

SAFETY STOP NOTIFICATION.
Safety STOP Location:
Handoff Huddle:
Date
Time
Location
PLEASE DO NOT RESPOND.

☐ Text notification sent

**Section C: Safety STOP Responder (SSR)**

**Safety STOP Responder Name & Title:** | Response Date and Time:

- ☐ As needed, work with AOC/DAA to complete **Section B,** ensuring countermeasures are considered, and variance report is complete.
- ☐ Interview key participants using Safety STOP Interview Form.
  - ☐ During conversations, notify caregivers that RCA may occur within next 72 hours and ask if there are any issues with their availability in the next 3-7 days.
- ☐ Complete and distribute Safety STOP Notification form (send via email).

**Record names and contact information for follow-up interviews if required:**

Caregiver Name: ____ Role: ____ Contact Phone: ____
Caregiver Name: ____ Role: ____ Contact Phone: ____
Caregiver Name: ____ Role: ____ Contact Phone: ____
Caregiver Name: ____ Role: ____ Contact Phone: ____
Caregiver Name: ____ Role: ____ Contact Phone: ____

Safety STOP
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**Not Part of Medical Record**
Quality Assurance-do not disclose. Confidential information protected by legal privilege and state quality improvement law
Rev Date: 1/22/2019

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### Safety STOP Standard Interview Form

Caregiver Name and Title: ____

Interview Date: ____ Time: ____

Guidelines for interview questions:

- **Who discovered/reported the event? (roles, not names)**
- **How was the event discovered?**
- Describe any process or policy in place
- Was the process or policy followed?
  - If no, describe barriers
- Where in the care process did the event occur?
- Describe any equipment needed for task
- Was equipment available and in working order?
  - If no, describe barriers

During your discussion, consider the following:

- Environmental factors (e.g. noise, crowded, construction)
- Personal factors (e.g. fatigue, distraction)
- Staffing matrix

Consider utilizing 5 Whys table (see end of form) during interviews to promote root cause thinking and identify issues that may result in repeat events.

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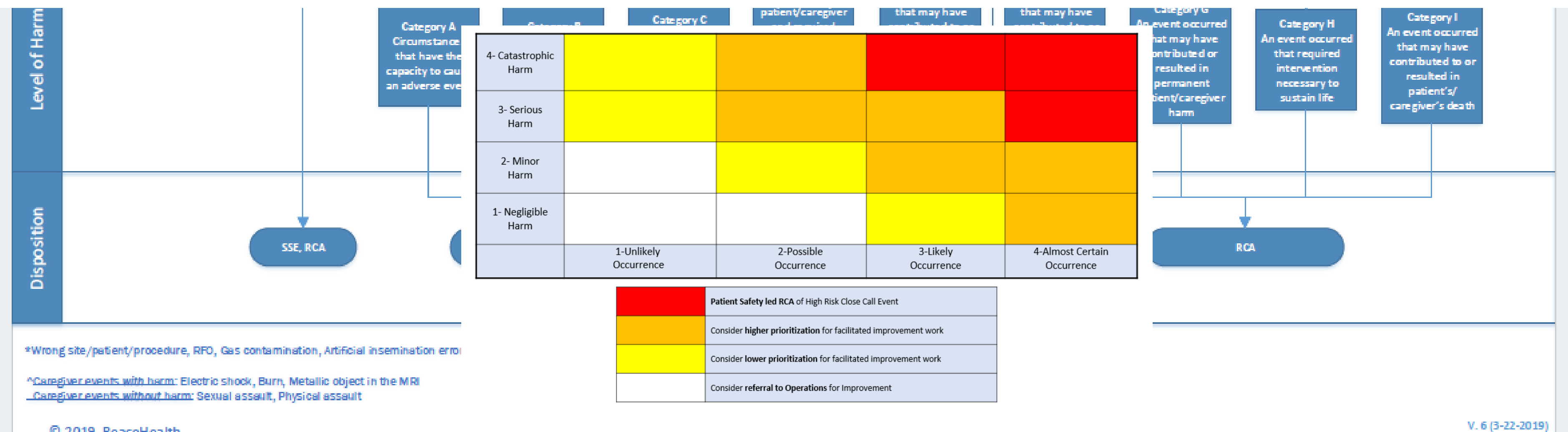
# Handoff Huddle

SSE and Harm Level Algorithm

| | 1 | 2 | 3 | 4 |
|---|---|---|---|---|
| **Event Recurrence** | **Unlikely** | **Possible** | **Likely** | **Almost Certain** |
| Likelihood of *historical or future recurrence* | Less than *1-2 times/year* | Close to *Monthly* | Close to *Weekly* | Close to *Daily* |
| **Event Severity** | **Negligible** | **Minor Harm** | **Serious Harm** | **Catastrophic** |
| Most likely *patient impact* | • Assessment or monitoring to preclude harm<br>• Requires *no or minimal intervention*<br>• *No added length of stay* | • Minor treatment *no significant intervention**<br>• *1 Day* increased length of stay<br>• *Return appointment* to clinic | • *Significant intervention**<br>• *Higher level of care*<br>• Injury lasting *< 6 months*<br>• *> 2 Days* increased length of stay | • *Permanent harm*<br>• Loss of body function or disability requiring *life-sustaining treatment*<br>• *Death*<br>• Injury lasting *> 6 months* |

***Significant intervention/Serious harm** *describes an event that can result in death, loss of a body part, disability, loss of bodily function, or require major intervention for correction (e.g., higher level of care, surgery).* 2011. National Quality Forum



# RCA

- RCA block times
- Standard invitees
- Safe, blame free environment
- One or two latent roots
- Limited action items

## RCA Toolkit

Root Cause Analysis (RCA) (Within 72 hours of the event)

**Facilitation**

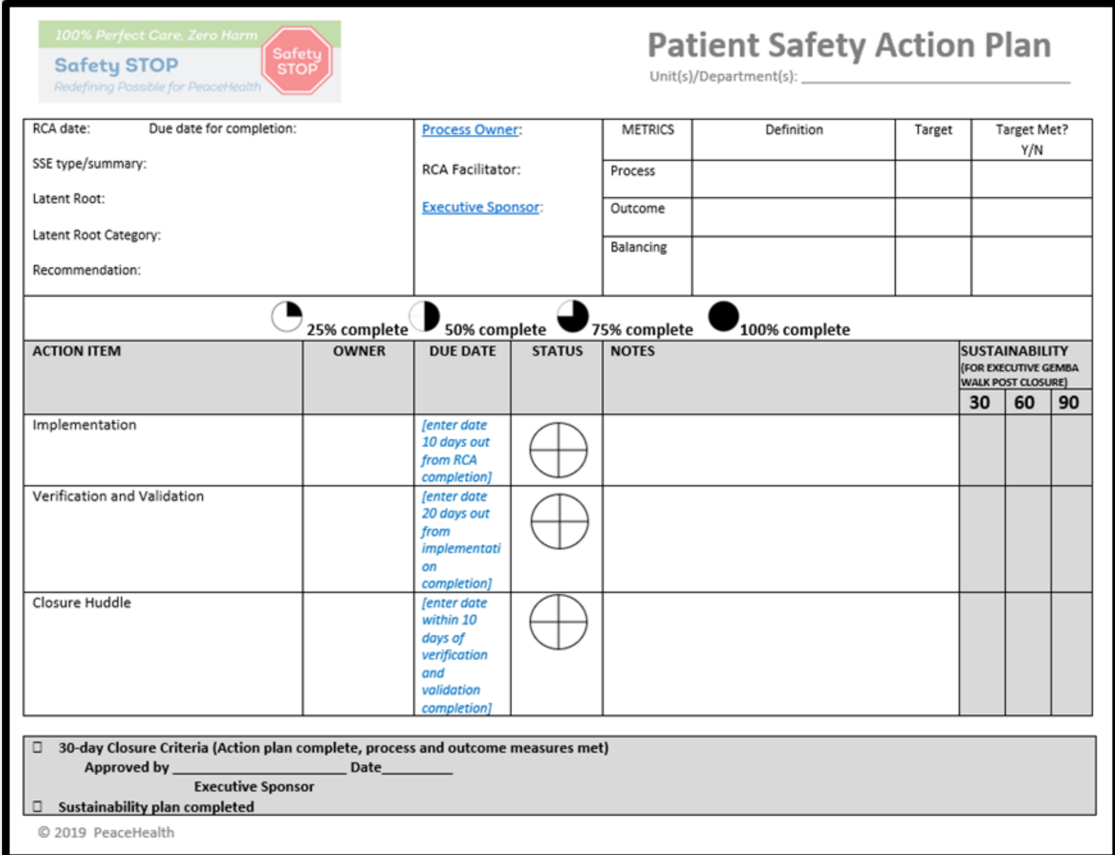
- Patient Safety Consultant Standard Work (including Handoff Huddle and steps to prepare for RCA)
- Patient Safety RCA Action Plan
- Process Map Symbols
- RCA Action Plan Rigor Test
- RCA Agenda
- RCA Confidentiality and Sign-In sheets
- RCA Opportunities for Improvement
- Timeline
- Timeline Swim Lanes
- SSE and Harm Algorithm

**Tools**

- Explanation of Tools (PPT)
- Abnormality Tracker Template
- Daily Management System (DMS) Training Matrix
- PHMG Manager Training Matrix
- Process Observation Form Template
- Process Observation Tracker Template
- Gemba Rounding Calendar Template
- Standard Work Template

# Action Plans

- Action plan is developed during the RCA
- Action plan visibility
- Includes:
  - Action items
  - Verification/Validation
  - Metrics
- Leader rounding



100% Perfect Care, Zero Harm
Safety STOP
Redefining Possible for PeaceHealth
Safety STOP

**Patient Safety Action Plan**
Unit(s)/Department(s): ____________

| RCA date: Due date for completion: | Process Owner: | METRICS | Definition | Target | Target Met? Y/N |
|---|---|---|---|---|---|
| SSE type/summary: | RCA Facilitator: | Process | | | |
| Latent Root: | Executive Sponsor: | Outcome | | | |
| Latent Root Category: | | Balancing | | | |
| Recommendation: | | | | | |

25% complete 50% complete 75% complete 100% complete

| ACTION ITEM | OWNER | DUE DATE | STATUS | NOTES | SUSTAINABILITY (FOR EXECUTIVE GEMBA WALK POST CLOSURE) 30 | 60 | 90 |
|---|---|---|---|---|---|---|---|
| Implementation | | [enter date 10 days out from RCA completion] | | | | | |
| Verification and Validation | | [enter date 20 days out from implementation completion] | | | | | |
| Closure Huddle | | [enter date within 10 days of verification and validation completion] | | | | | |

☐ 30-day Closure Criteria (Action plan complete, process and outcome measures met)
Approved by ____________________ Date________
Executive Sponsor
☐ Sustainability plan completed

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# Closing the Loop

- Closure huddle held following action plan implementation
  - Goal is 33 days after event
- Caregivers involved are recognized

# Where are we now?

- **July ’18 Culture of Safety score:** 3.86 (beyond the goal of 3.84)
- **Process Measures:**

| Measure | Baseline | Today |
|---|---|---|
| Event to RCA with approved action plan | 58.2 days | 3.5 days |
| Event to Action Plan Closure | 9+ months | 39 days |

- Weekly review of RCA barriers at System Tier 1 huddle
- Twice-weekly System Escalation Huddle

*100% Perfect Care, Zero Harm*

January 2018 to March 2019

**1,277** Safety STOPs initiated systemwide

- 85 serious safety events
- 932 close calls
- 124 operational issues
- 4 quality improvement issues
- 132 other safety issues

**145** Trained Safety STOP responders

These caregivers are ready to respond at a moment’s notice when a Safety STOP is initiated.

**3** PeaceHealth networks use Safety STOP

Safety STOP has been implemented in all medical centers, clinics, and home health and hospice services systemwide.

**5** Reasons for calling Safety STOPs

- Never Events
- Delays in treatment
- Equipment or facility failures
- Sterile processing failures
- Any unsafe circumstance

*Crossroads > System Resources > Clinical Excellence*

# Rate of Serious Safety Events

**Numerator:** Count of Serious Safety Events tracked by Kimberly Gale in Issue Tracker #650.
**Denominator:** 10,000 patient days for Inpatients, Observation and Ambulatory Surgery patients.
**Rate:** Count of Serious Safety Events per 10,000 patient days.

**12 Month Rolling Averages:** All the numbers in this report are presented as 12 month rolling averages. So the numerator and denominator are sums over 12 months. The months shown in the charts below mark the final month in each 12 month period.

Source: Centricity, CareConnect, McKesson STAR, Issue Tracker #650 / Data as of 2019-Mar-2

## Systemwide

Safety STOP

**Jan 2018:** First two settings go live with Safety STOP

**July 2018:** All acute care hospitals are live

**Nov 2018:** All hospitals and clinics are live

**Mar 2018:** All settings are live (incl. all home health)

Rate: Events per 10,000 Patient Days

3.5 3 2.5 2 1.5 1 0.5 0

2.8 2.8 2.9 3.1 3.0 3.1 3.3 3.3 3.1 3.2 3.4 3.3 3.4 3.3 3.2 3.1 3.1 2.8 2.6 2.4 2.4 2.3 2.2 1.9 1.6

2017-Mar 2017-May 2017-Jul 2017-Sep 2017-Nov 2018-Jan 2018-Mar 2018-May 2018-Jul 2018-Sep 2018-Nov 2019-Jan 2019-Mar

Month shown is final month of rolling 12 month period

Rate
CL
LCL
UCL

# Safety STOP Outcomes Measures

## Safety STOPs, RCAs and Serious Safety Events

**Jan 2018:** First two settings go live with Safety STOP

Safety STOP

**July 2018:** All acute care hospitals are live

**Nov 2018:** All hospitals and clinics are live

**Mar 2018:** All settings are live (incl. all home health)

Count

0
10
30
40
50

1-Jan 15-Jan 29-Jan 12-Feb 26-Feb 12-Mar 26-Mar 9-Apr 23-Apr 7-May 21-May 4-Jun 18-Jun 2-Jul 16-Jul 30-Jul 13-Aug 27-Aug 10-Sep 24-Sep 8-Oct 22-Oct 5-Nov 19-Nov 3-Dec 17-Dec 31-Dec 14-Jan 28-Jan 11-Feb 25-Feb 11-Mar

2018 2019

Week of Discovery

Values

Safety STOPs RCAs SSEs

## COUNT OF SAFETY STOPS by TYPE, by FACILITY

Color ranges from very light pink to very red, darkest red represents highest count

| Definitions | Hosp A | Hosp B | Hosp C | Hosp D | Hosp E | Hosp F | Hosp G | Hosp H | Hosp I | Hosp J | Hosp K | Clinic Region 1 | Clinic Region 2 | Clinic Region 3 | Grand Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Medication Error | 10 | 28 | 11 | 7 | 8 | | | 5 | 35 | 1 | | 27 | 7 | 7 | 152 |
| Failure to Follow Standard Process | 7 | 18 | 7 | 12 | 1 | | | 18 | 22 | 2 | | 21 | 5 | 12 | 134 |
| Equipment/Device/Supply Failure | 6 | 13 | 5 | 10 | 6 | | | 5 | 16 | 3 | | 9 | 13 | 6 | 92 |
| Technology Failure | 10 | 6 | | 9 | 2 | | | 4 | 17 | 3 | | 6 | 6 | 3 | 66 |
| Communication/ Handoff Failure | 8 | 16 | 1 | 1 | 2 | | 2 | 4 | 7 | 1 | | 3 | 4 | 5 | 58 |
| Facility Failure | 7 | 3 | 2 | 12 | 3 | | | 1 | 6 | 8 | | 4 | 1 | 8 | 57 |
| Delay in Treatment | 1 | 10 | 1 | 11 | | | | 6 | 12 | | 1 | 5 | 3 | 5 | 56 |
| Patient Fall | | 18 | 5 | 5 | 1 | | | | 7 | 2 | | 1 | 2 | 5 | 46 |
| Pressure Injury | 1 | 34 | | 4 | | | | 2 | 4 | | 1 | | | | 46 |
| Failure to Follow-up/Communicate lab, path or I | | 3 | 1 | 3 | | | | | 4 | | | 15 | 14 | 1 | 44 |
| Patient Flow/Delay in Throughput | | 2 | | 8 | | | | 1 | 29 | | | | 1 | | 41 |
| Delayed Orders | 2 | 3 | 6 | 5 | 1 | | | 1 | 14 | | | 4 | 1 | | 37 |
| Equipment/Device/Supply Unavailable | 2 | 10 | 1 | 10 | | 1 | | 3 | 4 | | | 2 | 2 | 1 | 36 |
| Delay in Diagnosis | | 3 | | 5 | 2 | | | 2 | 9 | | | 3 | 4 | 4 | 35 |
| Patient Identification Issue | | 11 | 2 | 2 | 1 | | | 2 | 3 | 1 | | 5 | | | 27 |
| Staffing/Scheduling Issue | 2 | 1 | | 3 | | | | 5 | 14 | | | | | | 25 |
| Physical Assault | 2 | 3 | | 7 | | | | | 2 | 4 | | 2 | 1 | 2 | 23 |
| Contracted Laboratory Issue | | 2 | | | 1 | | | | 2 | | | 11 | | 5 | 22 |
| Delay/Failure to Follow-up In-Basket Ite | 1 | | | | | | | 1 | | | | 14 | 3 | | 21 |
| Contaminated Drugs/ Devices/ Biologic | 1 | 4 | 1 | 8 | 2 | | | | 1 | 1 | | | | | 19 |
| Patient Elopement | | 5 | 1 | | | | | | 12 | 1 | | | | | 19 |
| Delayed Procedure | | 2 | | 4 | | | | 3 | 6 | | | | 2 | | 18 |
| Referral Failure | | | | | | | | 3 | 2 | 1 | | 7 | | 1 | 16 |
| Delay in Transfer | 1 | | 1 | 3 | 4 | | | 4 | 1 | 1 | | | | | 16 |
| **Grand Total** | **73** | **244** | **50** | **146** | **37** | **1** | **2** | **76** | **261** | **31** | **2** | **166** | **74** | **70** | **1277** |

# Ancillary successes and learnings

- **Leadership rounding** at the front line
  - Humble Inquiry (Edgar Schein) in practice
- **Escalation huddle work** – all system owners represented on the call
  - Receive escalation – 165 escalated, 116 closed
  - Status updates on ongoing issues
  - Advisement of issues common across the system
- **Communities pulled for Safety STOP**
  - Such eagerness was not common at that time

# Key learnings, cont.

- **Key to success:** Servant leadership and humility in coaching
- **The miracle of Tier 1**
  - Line of sight; visibility; transparency
  - System COO and CMO following Standard Work; coaching kata

# Acknowledgements


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- **Kim Sinclair**, System Director Lean Transformation
- **Natalie Blum**, System Director Quality
- **Adrienne Watson**, System Director Clinical Education
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- **Executive teams** from all of our hospitals, clinics and home health setting
- **Our AOC, DAA, SSR and Immediate Responder** teams
- **The patients** we serve daily

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