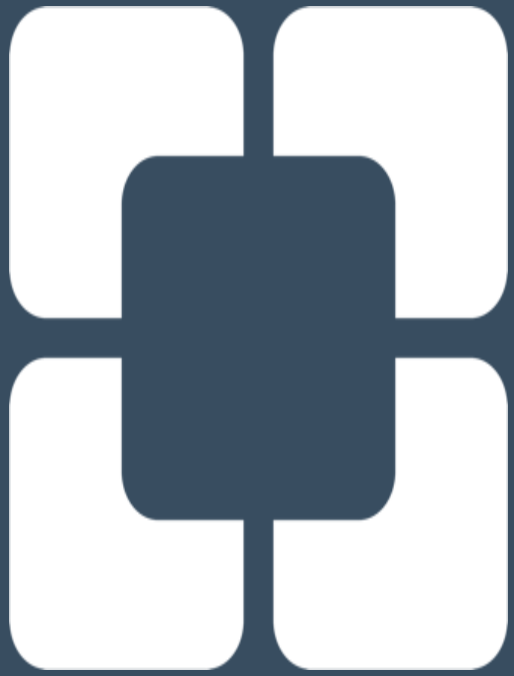
Building Capability to Improve Your Event Management Process

Engaging Nurses and other leaders

Debbie Sears Barnard, Consultant,
JCI International, Abu Dhabi, UAE

~~Dr~~ Nicolas Turrin, Senior Clinical Risk Manager
Quality & Patient Safety Institute, Cleveland Clinic Abu Dhabi, Abu Dhabi, UAE



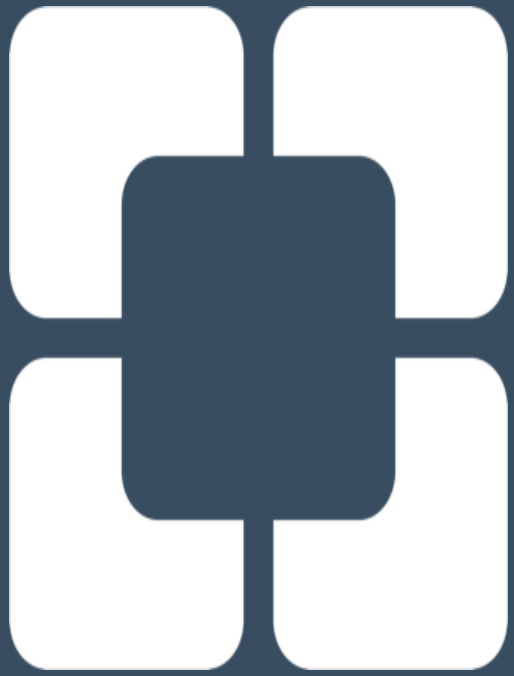
Objectives

Following this presentation, participants will be able to:

- Outline the current state of harm in healthcare
- List the essential steps in an Event Management System
- Give examples of strategies to increase capability of caregivers to effectively implement the Event Management Process

The presenters have no conflicts to declare

The Why

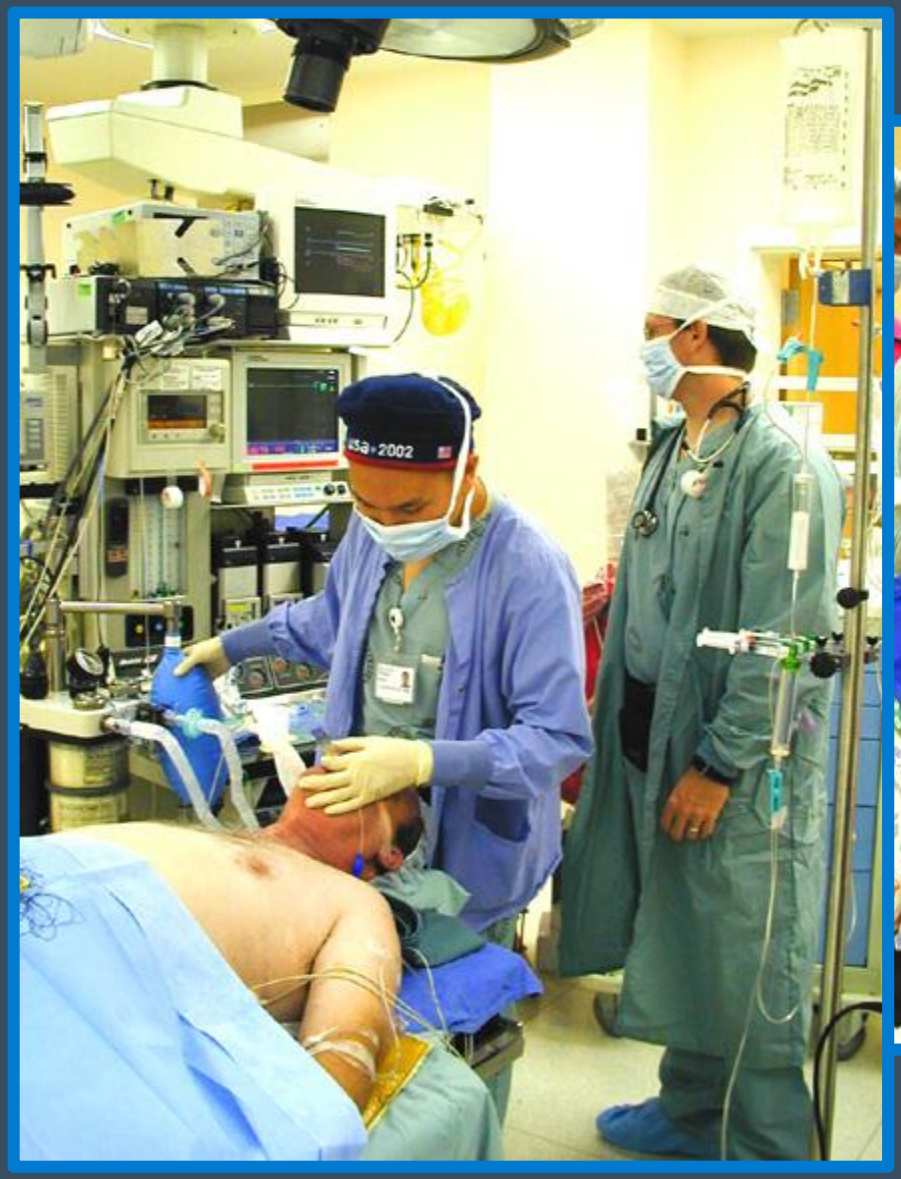


What do we know about Harm in healthcare?

Study	Date of admission	Number of hospital admissions	Adverse event rate (% admissions)
California Insurance Study	1974	20864	**4.65 ***
Harvard Medical Practice Study	1984	30195	**3.7**
Utah-Colorado	1992	14052	**2.9**
Australian	1992	14179	**16.6**
United Kingdom	1999	1014	**10.8**
Denmark	1998	1097	**9.0**
New Zealand	1998	6579	**11.2**
France **	2002	778	**14.5**
Canada	2000	3745	**7.5**

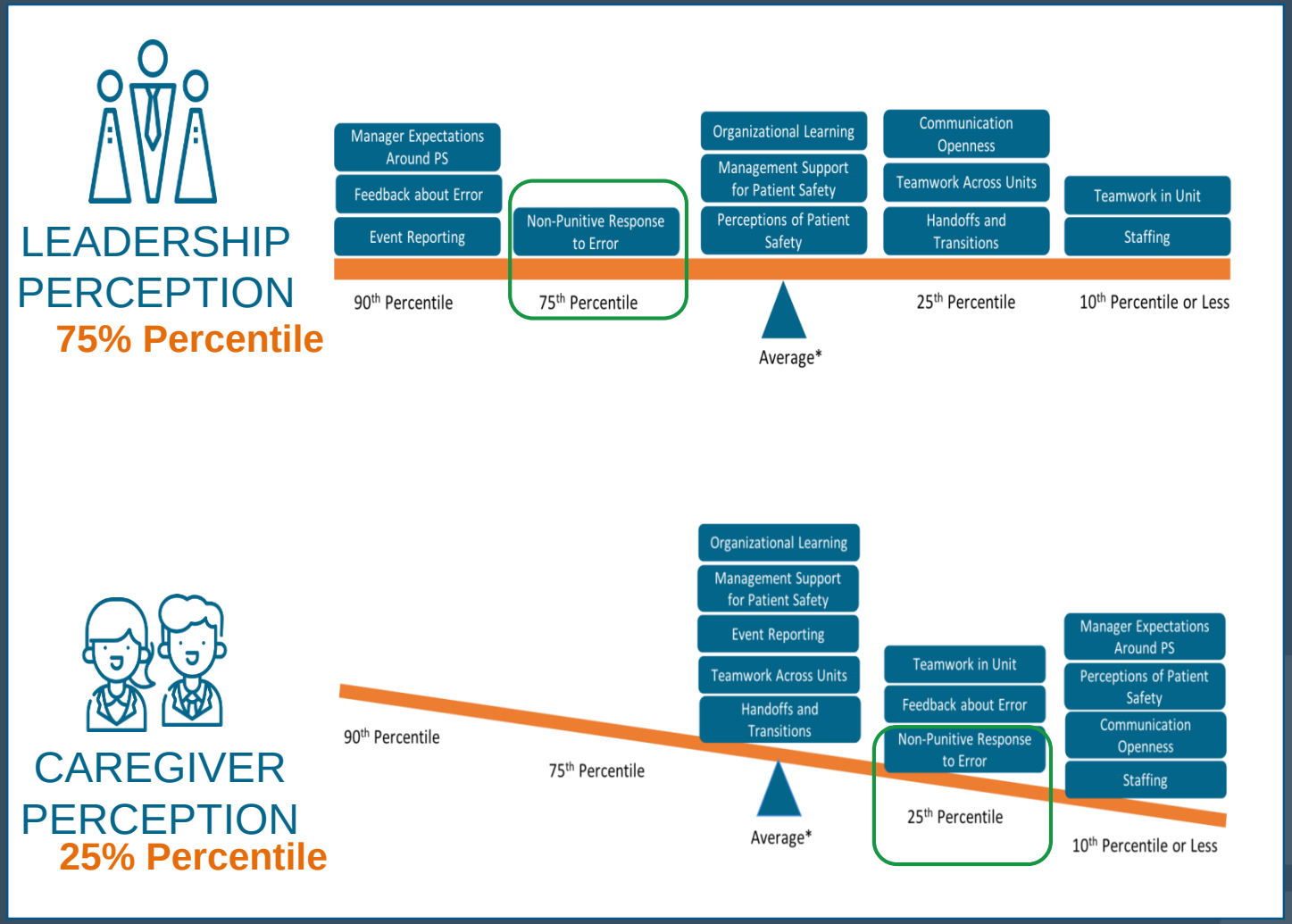
World Health Organization. (2004). *World Alliance for Patient Safety: Forward programme 2005*. Geneva, Switzerland: World Health Organization. Retrieved from World Alliance for Patient Safety- Forward Programme. World Health Organization, 2005 http://www.who.int/patientsafety/en/brochure_final.pdf

Health care is a complex system



Complexity = increased chance of something going wrong!

Gap Analysis- Culture of Safety Survey (2016)



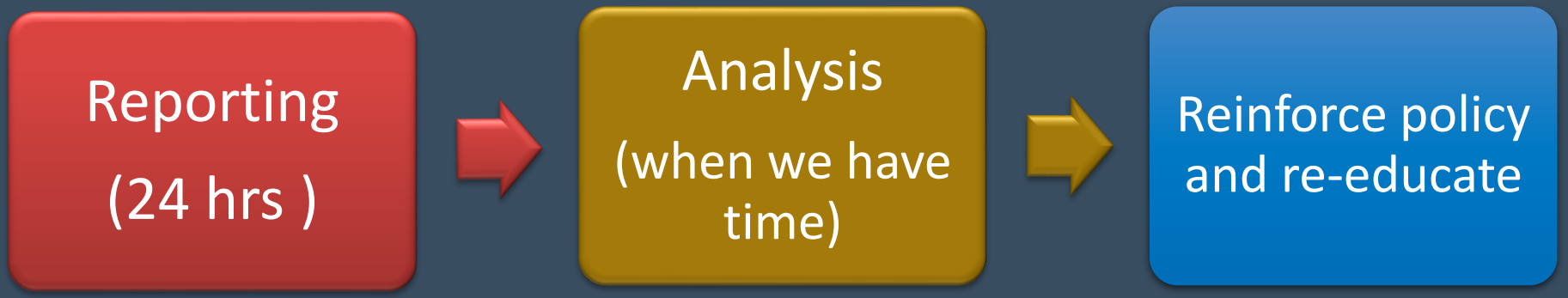
Hospital Survey on Patient Safety (HSOPS)- Agency for Healthcare Research and Quality (AHRQ)

Event Management System

Critical Process to:

- Protect the Patients and Caregivers
- Identify and learn about
  - Process and Systems failures
  - Hazards
  - Risks
- Create a learning culture (action plans are implemented & assessed for effectiveness)
- Ensure alignment with regulatory and accreditation requirements

2017 Current State - Event Management Process



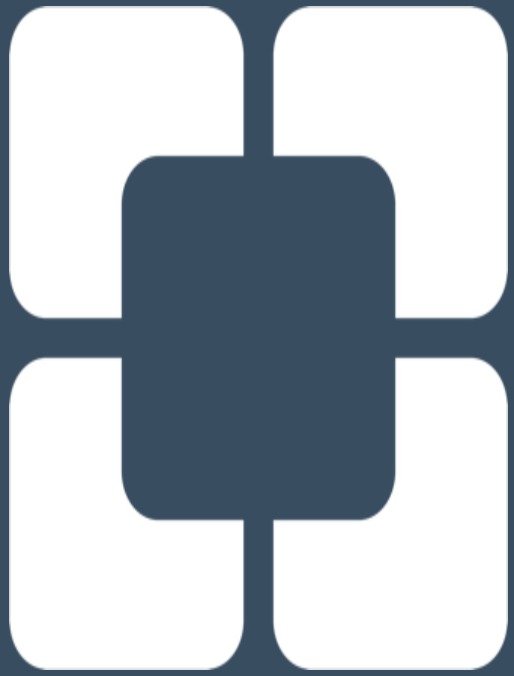
In 2017, CCAD had been opened for only 2 years

- Event management was only standardized for serious (Sentinel) events
- Analysis was not prioritized on the units
- Actions were weak, mostly based on education
- Learnings not shared consistently to reporters, other units and the hospital

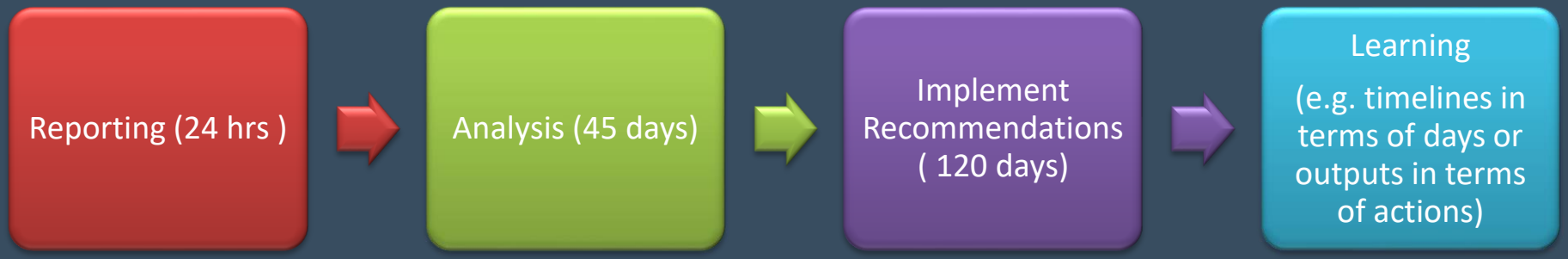
Gap Analysis

- Lack of a standardized approach for event analysis
  - No training for young leaders to complete reviews
  - Failure to identity system level causes
  - Superficial solutions and inconsistent implementation of solutions
  - Risk Manager accountable closing the loop on all events reported
  - Events reported at daily huddle, but no formal follow up process
- Lacked process for purposeful, systematic Executive Leadership rounding focused around safety

Event Management System Core Essentials



Future State - Event Management Process

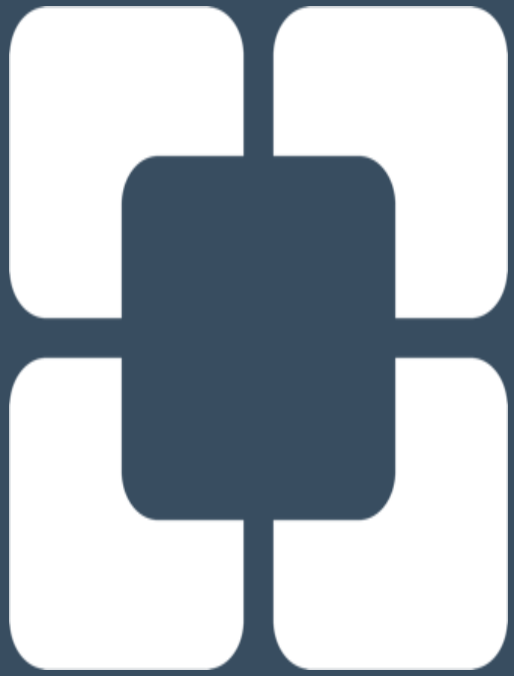


Based on Health Sciences North Adverse Event Analysis process (2017) and Department of Veterans Affairs, Veterans Health Administration, VHA Patient Safety Improvement Handbook 1050.01, March 4, 2011.
http://www1.va.gov/vhapublications/ViewPublication.asp?pub_ID=2389

Action Plan

1. Improve reviewer capability through formal "Root Cause Thinking" workshops
2. Enhance the shared accountability framework through Just Culture workshops
3. Improve the Event management process
4. Optimize daily huddles to discuss and close the loop on Events
5. Celebrate good catches and speaking up
6. Utilize the Unit Base Councils to share learnings from events
7. Establish monthly Executive Leadership Rounding

Strategies to Building Caregiver Capability



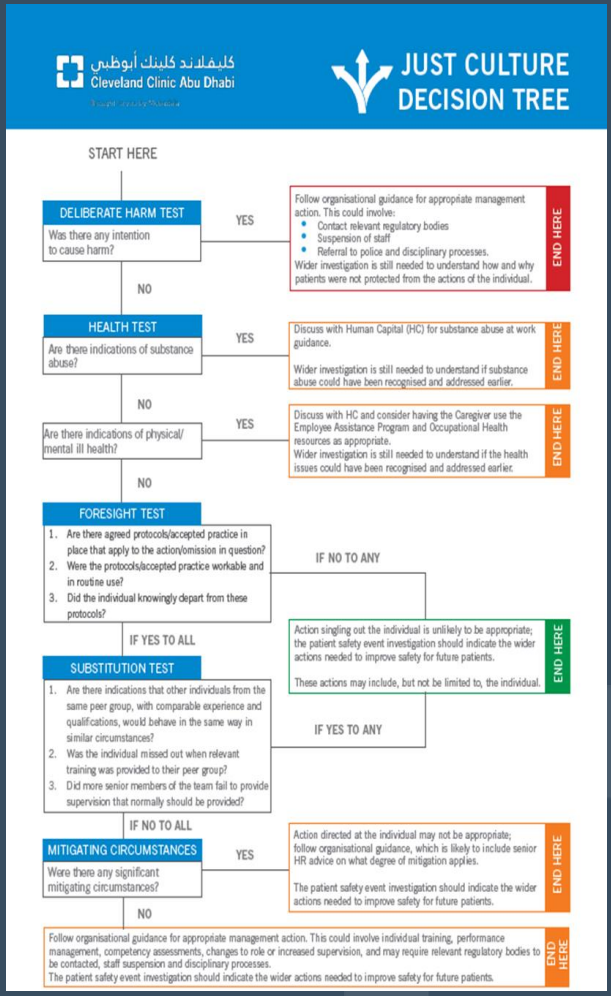
Foundations: Culture of Safety

Based on Reason (1997) The Components of Safety Culture: Definitions of Informed, Reporting, Just, Flexible and Learning Cultures

Root Cause Thinking and Just Culture Workshops

- Root cause thinking workshops
  - Quarterly since 2018 (150+ trained)
  - RCA coaching and support post-workshop
  - Tool kit available online
  - Reduction of RCAs facilitated by Risk Management by 33%

- Just Culture Workshops
  - Standardized approach to establish accountability
  - Adaption of a Just culture decision tree and use of scenarios to apply it
  - Offered to all managers yearly (180 trained in 2018)

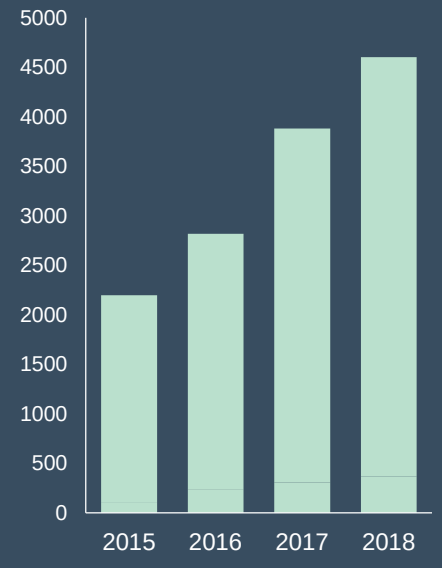


Based on *A Just Culture Guide*. National Health Service, United Kingdom. 2018. https://improvement.nhs.uk/resources/just-culture-guide/

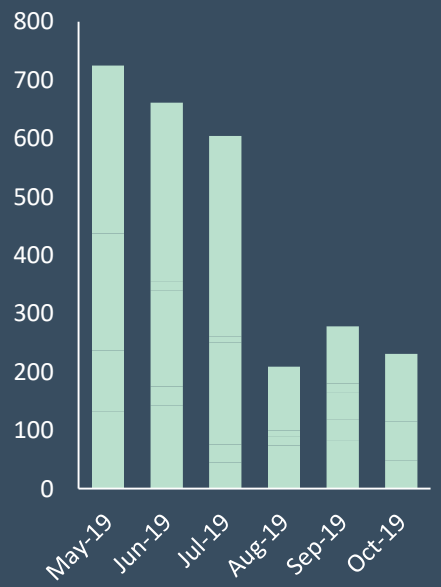
Results - Event Management Process

Reporting (24 hrs) → Analysis (45 days) → Implement Recommendations (120 days) → Learning (e.g. timelines in terms of days or outputs in terms of actions)

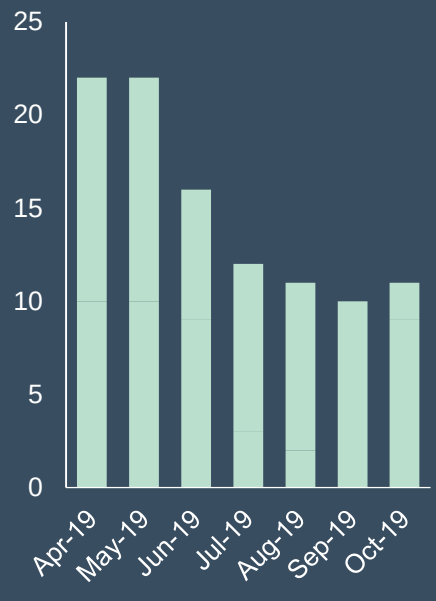
Reported Safety Events by Year

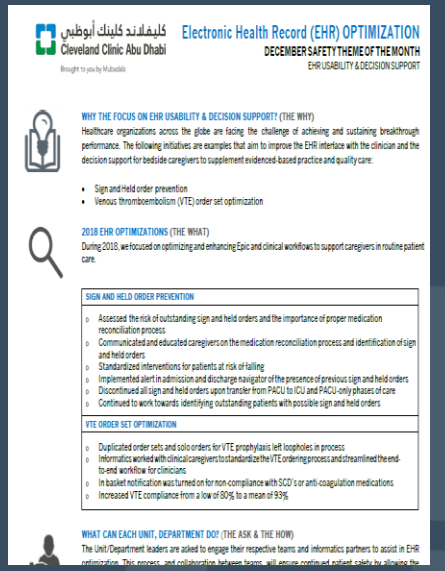


RL reports opened for more than 45 days



RCA Actions Open more than 120 days





كليفلاند كلينك أبوظبي
Cleveland Clinic Abu Dhabi

Electronic Health Record (EHR) OPTIMIZATION

DECEMBER SAFETY THEME OF THE MONTH

EHR USABILITY & DECISION SUPPORT

WHY THE FOCUS ON EHR USABILITY & DECISION SUPPORT? (THE WHY)

Healthcare organizations across the globe are facing the challenge of achieving and sustaining breakthrough performance. The following initiatives are examples that aim to improve the EHR interface with the clinician and the decision support for bedside caregivers to supplement evidenced-based practice and quality care:

- Sign and Held order prevention
- Venous thromboembolism (VTE) order set optimization

2018 EHR OPTIMIZATIONS (THE WHAT)

During 2018, we focused on optimizing and enhancing Epic and clinical workflows to support caregivers in routine patient care.

SIGN AND HELD ORDER PREVENTION

- Assessed the risk of outstanding sign and held orders and the importance of proper medication reconciliation process
- Communicated and educated caregivers on the medication reconciliation process and identification of sign and held orders
- Standardized interventions for patients at risk of falling
- Implemented alert in admission and discharge navigator of the presence of previous sign and held orders
- Discontinued all sign and held orders upon transfer from PACU to ICU and PACU-only phases of care
- Continued to work towards identifying outstanding patients with possible sign and held orders

VTE ORDER SET OPTIMIZATION

- Duplicated order sets and solo orders for VTE prophylaxis left loopholes in process
- Informatics worked with clinical caregivers to standardize the VTE ordering process and streamlined the end-to-end workflow for clinicians
- In basket notification was turned on for non-compliance with SCD's or anti-coagulation medications
- Increased VTE compliance from a low of 80% to a mean of 93%

WHAT CAN EACH UNIT, DEPARTMENT DO? (THE ASK & THE HOW)

The Unit/Department leaders are asked to engage their respective teams and informatics partners to assist in EHR

Conclusion: The future state

- Daily oversight to ensure health of the revised “critical process”
- Analysis of “Weak” versus “Strong” actions to manage events
- Risk (proactive) versus Harm (reactive) approach
- More frequent celebrations of Safety Champions
- Regular caregiver-led safety forums to share success and concerns

References

- World Health Organization. (2004). *World Alliance for Patient Safety: Forward programme 2005*. Geneva, Switzerland: World Health Organization. Retrieved from World Alliance for Patient Safety-Forward Programme. World Health Organization, 2005 http://www.who.int/patientsafety/en/brochure_final.pdf
- Sorra J, Gray L, Streagle S, et al. AHRQ Hospital Survey on Patient Safety Culture: User's Guide. (Prepared by Westat, under Contract No. HHSA290201300003C). AHRQ Publication No. 15-0049-EF (Replaces 04-0041). Rockville, MD: Agency for Healthcare Research and Quality. January 2016. http://www.ahrq.gov/professionals/quality-patientsafety/patientsafetyculture/hospital/index.html
- Based on Health Sciences North Adverse Event Analysis process (2017) and Department of Veterans Affairs, Veterans Health Administration, VHA Patient Safety Improvement Handbook 1050.01, March 4, 2011. http://www1.va.gov/vhapublications/ViewPublication.asp?pub_ID=2389
- Reason, J. The Components of Safety Culture in Managing the risks of Organizational Accidents, pp 195-218. December 1997.
- Based on *A Just Culture Guide*. National Health Service, United Kingdom. 2018. https://improvement.nhs.uk/resources/just-culture-guide

Thank you!

Brought to you by Mubadala

Questions?