INTERPROFESSIONAL TRANSPARENCY: DISSEMINATION OF SERIOUS SAFETY EVENTS

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DISCLOSURES

- Nothing to Disclose

OBJECTIVES

- At the end of the session, the participant will be able to:
  - List three teaching modalities to engage interprofessional front-line staff in learning from past serious safety events.
  - Apply a successful templates to improve transparency and dissemination of hospital safety events.

SHARP Metropolitan Medical Campus

- Part of integrated healthcare system in San Diego, CA.
- 368 beds
- Magnet designated
- Planetree designated
- HRO Journey
- Most beautiful Hospital (Soliant Health 2010)
- Most wired (Hospitals and Health networks Magazine)

BACKGROUND

- Careful investigation and analysis of patient safety events is essential to reduce risk and prevent patient harm.
- Each safety event is an opportunity to collaborate with safety experts and front line employees

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SERIOUS PATIENT SAFETY EVENTS

Sentinel Events

- Patient Safety Event that reaches a patient and results in any of the following:
  - Death
  - Permanent harm
  - Severe temporary harm
  - Other: suicide, elopement, hemolytic transfusion reaction…

Serious Safety Events

- American Society for Healthcare Risk Management (ASHRM)
- Focus on eliminating preventable harm
- Getting to Zero ™

PATIENT SAFETY EVENTS

- Require immediate investigation
- Causal factors
- Focus on lessons leaned
- Proactive preventative strategies
- HRO tenants

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THE GAP

- No consistent mechanism for Patient Safety Event dissemination
- Typically department/unit level focus
- Barriers: concerns related to confidentiality & liability

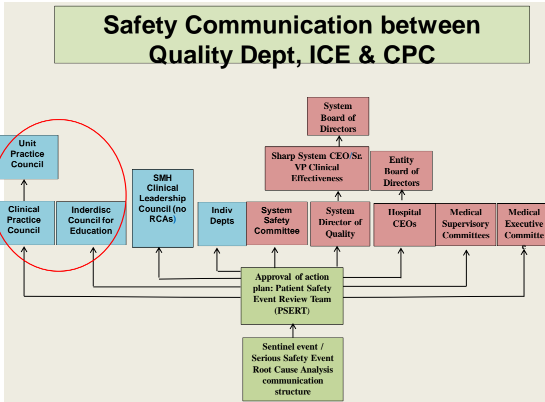
SAMPLE TOPICS

Fall Prevention

Labeling of Lab Specimens

Safe Patient Transport

COLLABORATIVE GOVERNANCE COUNCILS



MULTI MODAL LEARNING

- Review of Literature:
  - Limited studies on best methods to disseminate knowledge on topic of patient safety events
  - Health care employees learn best with *blended* teaching approaches

STRUCTURE > PROCESS > OUTCOMES

- Structure
  - CNS and Quality Dept rep collaborate quarterly assessing for patient safety *trends*
  - Create a cause-and-effect diagram
  - Develop SBAR communication & Educational Tracking Tool with focus on lessons-learned

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QUARTERLY TOPIC SELECTION GUIDELINES

- Inter-professional
- Relevant topics - front line focus
- Pertains to greater than one unit/dept.
- Invite employees to present case
- Visual "cause and effect" diagrams
- Sensitivity: HIPPA and Risk Management
- Focus on awareness and prevention

ENGAGING CLINICAL PRACTICE COUNCIL

PROCESS

- Topic is shared with two committees: Interprofessional Council on Education & Clinical Practice Council
- Train-the-trainer method of dissemination
- Dissemination tools
  - Cause & Effect flow chart (1-2 slides)
  - SBAR with Educational Tracking Tool (one page)
- 3 months to disseminate with method that *best fits* their department's culture

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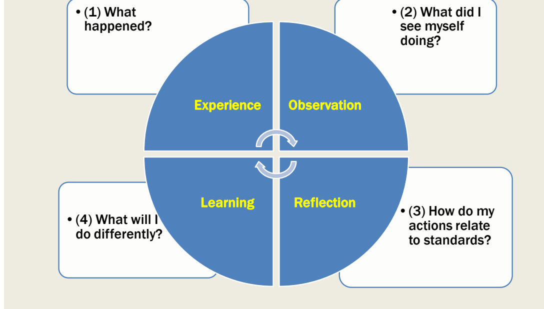
SAMPLE EDUCATION: QUARTERLY CALENDAR

January	February	March	April
Disseminate	Educate CPC on Topic 1 & Disseminate	Disseminate	Disseminate
May	**June**	**July**	**August**
Educate CPC Topic 2 & Disseminate	Disseminate	Disseminate	Educate CPC Topic 3 & Disseminate
September	**October**	**November**	**December**
Disseminate	Disseminate	Educate CPC Topic 4 & Disseminate	Disseminate

REFLECTIVE LEARNING MODEL



PERSONAL COMMITMENTS

Share one change in your personal practice

Identify one improvement in your unit or department

KIRKPATRICK'S LEVELS OF EVALUATION

- Level 1: Reaction
- Level 2: Learning
- Level 3: Behavior – application and implementation
- Level 4: Results

OUTCOMES

- Approximately 450 IP hospital employees receive the quarterly education
- Annual culture of safety survey
  - Higher scores with:
    - in the transparency of events
    - non-punitive work environment

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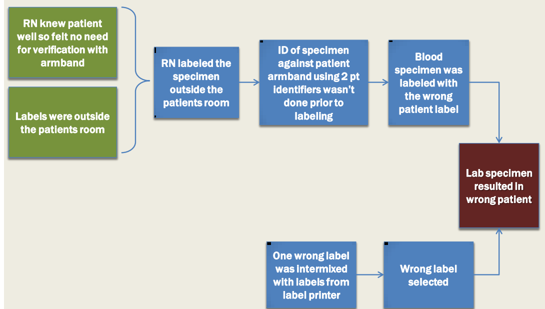
EDUCATIONAL SAMPLES

- Cause and Effect Diagram
- SBAR Communication
- Educational Tracking Tool

EDUCATIONAL SAMPLES



KEY ACTIONS IMPLEMENTED FOR FUTURE PREVENTION

- Follow the (ABCs of Specimen labeling)
  - ***A**ccurate **B**edside **C**onfirmation*
- All supplies gathered prior to entering room to collect specimen
- Verify specimen label against patient armband using 2 identifiers
- Label all specimens in the presence of the patient

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SBAR COMMUNICATION (EXAMPLE)

- Situation: Identification of patients using two patient identifiers is not done consistently.
- Background: Identifying patients without using two approved patient identifiers has been identified as serious patient safety issue
- Assessment: Use of two patient identifiers to verify patient identity will improve patient safety.
- Recommendation:
  - Always verify the correct patient using two approved patient identifiers (MR#, name, DOB, admit #) before any test, treatment or service. Always label specimens in the presence of the patient.

EDUCATIONAL TRACKING

Name of Unit: _______________ Name of person completing this form: ______________________

Educational Method(s)	Approximate # of Staff who Received the Education
☐ Unit Practice Council	
☐ Staff Meeting	
☐ Unit Huddle(s)	
☐ Poster/Bulletin Board	
☐ Practice alert	
☐ Unit Web Page	
☐ Lead Meeting	
☐ Advanced Clinician Meeting	
☐ other ___________________	
☐ other ___________________	

Please return this completed form to Tanna Thomason, RN, CNS or the CPC Chairperson on May 8th or June

REACHING STAFF: BEST METHODS

- ✓Unit practice council meetings
- ✓Staff meetings
- ✓Unit huddles
- ✓Email
- ✓Unit Web page
- ✓Other: Lead meetings, Clinical Leader Meetings

FILLING THE GAP

LESSONS LEARNED

- CNS and quality department = effective team
- Focus on causal factors & prevention
- Expand to include Great Catches/Near Miss
- Keep it simple: simplified SBAR and data collection tools

FUTURE

- Continue to monitor quality data
- Continue to collect data on best dissemination methods
- E-Learning (blended)
- SPO adopted by sister hospitals

SELECT REFERENCES

- Boysen, P. z(2013). Just Culture: a foundation for balanced accountability and patient safety. The Ochsner Journal. 13(3). 400-406.
- High Reliability Organizations (2013). http://www.beckershospitalreview.com/hospital-management-administration/5-traits-of-high-reliability-organizations-how-to-hardwire-each-in-your-organization.html
- Kirkpatrick's Levels of Evaluation: http://www.kirkpatrickpartners.com/OurPhilosophy/tabid/66
- Serious Safety Events ASHRM www.ashrm.org/pubs/files/white_papers/SSE-2_getting_to_zero-9-30-14.pdf
- The Joint Commission www.jointcommission.org/sentinel_event_policy_and_procedures/

CONTACT INFORMATION

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