HARRISHEALTH SYSTEM

Creating a Culture of Patient Safety: Patient Safety Executive Rounds

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Purpose of PSER

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Patient Safety Executive Rounds (PSER) are designed to enhance the health care team's knowledge of and ability to identify and solve point of service patient safety concerns through an interdisciplinary process that

- advances collaborative relationships while allowing administrators, nurse leaders and the patient care providers to explore all relevant patient safety perspectives

- develops solutions and achieves desirable outcomes regarding

Harris Health System

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Volume

- Is the 3rd largest public health system in the country with

  over 1,000,000 outpatient visits annually

Unduplicated Patients

- Approximately 300,000

Payer Mix

- 60% Non-funded (self-pay)
- 24% Medicaid
- 8% Medicare
- 8% Other funding

FY 10 Statistics

Harris Health Services

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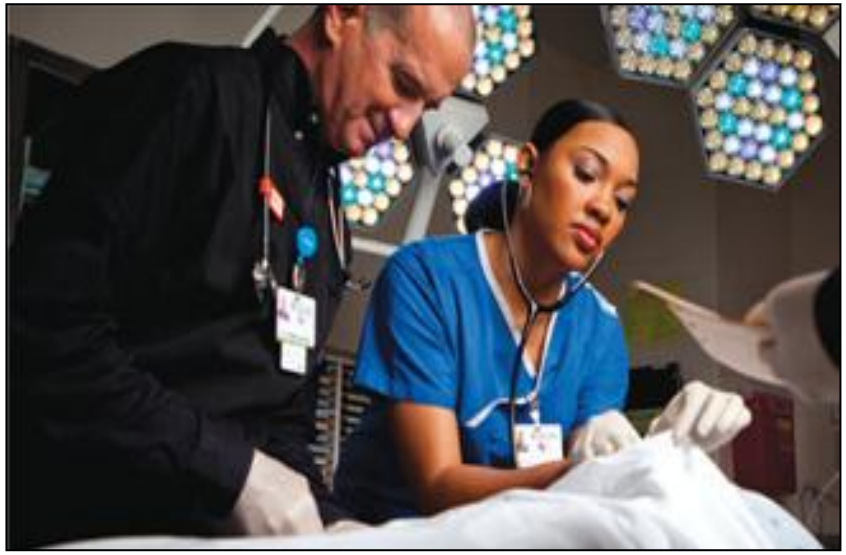
A typical year at Harris Health System



- 170,000 emergency room visits
- 41,000 admissions
- 9,000 deliveries
- 21,000 operative procedures
- 315,000 specialty clinic visits
- 891,000 outpatient visits

Combined services include 960 beds
Staffed by 2 medical schools
- Baylor College of Medicine
- University of Texas

Our Organization

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- Highly complex
  - Large, integrated healthcare system
  - Two medical schools
- Hierarchical
  - Engaged in culture change to move attributes to those of a “learning organization”
- Bureaucratic
  - County entity
- Political
  - Board of Managers appointed by elected county commissioners
- Competitive
  - Three hospitals, extensive ambulatory environment
  - Location

Why PSER?

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- Demonstrates an organization's commitment to patient safety
- Fuels culture for change pertaining to patient safety
- Provides opportunities for senior executives to learn about patient safety concerns at the point of care
- Identifies opportunities for improving patient safety
- Establishes lines of communication about patient safety and feedback loop closure (employees – executives – managers – employees)
- Establishes a framework for safety based rapid cycle improvements

Adapted from the Institute of Healthcare Improvement and The University of Michigan Hospitals and Health Centers

Who conducts PSER?

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A Supportive Executive Leadership Team

The Strategy

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- Highly interactive and engaging
- Move quickly - six to eight week process
- Promote staff feedback about patient safety concerns through multiple venues
- Fuel desire as active participants in creating a culture of patient safety
- Facilitated by the director of quality and patient safety, the program
- Involves all disciplines including medical staff, nursing, and ancillary staff as well as the hospital's executive leadership team

Focus Areas

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- Implemented in three phases in the hospital's busiest and highest acuity patient care areas
  - Phase One - Trauma Surgical Intensive Care Unit
    - 62 unduplicated issues
  - Phase Two - Perioperative Services
    - 85 unduplicated patient safety concerns
  - Phase Three - Emergency Center
    - 133 unduplicated concerns about safety including significant issues related to privacy and overcrowding

Week One - Implementation

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- Administration introduces concept to interdisciplinary team Quick, to the point description of the process
- Leaves flipcharts with 4 questions in the unit's off stage area where there is access to the interdisciplinary team
  1. Can you think of a time when your intervention stopped/prevented a patient from being harmed?
  2. Is there anything we could do to prevent the next adverse event?
  3. If you could change one thing to improve patient safety, what would it be?
  4. Other concerns/issues?

Week 2 – Bucket List

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Trauma/Surgical ICU Experience

- During Week One, team members identified sixty-two (62) unduplicated issues.
- Patient safety concerns on flipcharts are "bucketed into one (or more) of the eight themes identified
  - Communication
  - Teamwork
  - Medication
  - Technology/EMR
  - Equipment
  - Practice
  - Policy/Protocols/Process
  - Environment

Weeks 3-4 Action Planning

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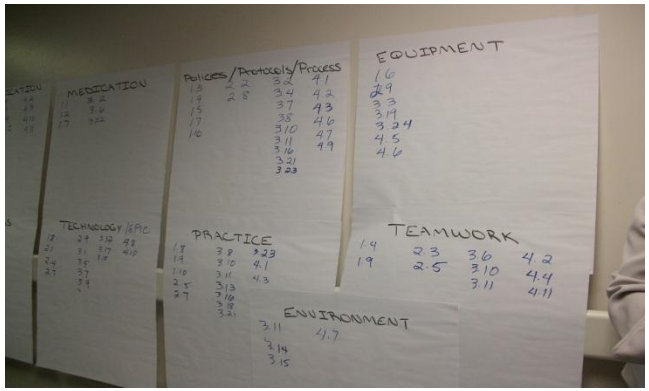
- Sixty-two issues were drilled down and fell into four main categories. These included Communication, Equipment, Technology and Practice/Policy/Protocol



Week 4

- Presentation of categories to staff
- Assignment of teams and leaders

Week 4-6 Collaborative Meetings

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Week 7 – Progress Report

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- Twelve (12) task forces were generated involving thirteen (13) departments, holding eighteen meetings
- Of the sixty-two issues addressed, 85% of the action items were complete and were in an “effective now” status
- Five percent were near completion
- Decision was made to carry long term and future plan action items forward to the 2011-2012 TSICU Performance Improvement plan

Selected PSER Outcomes

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OR Team:

Emergency access to OR blood products for massive transfusion protocol.

Radiology Team:

Safe transport of critical patients to CT/MRI with safe coordination as a result of planned time and avoidance of high risk times, specifically change of shift.

Increased collaborative effort (radiology tech-RN-RT) for improved quality of radiology chest films.

Pharmacy Team:

Prevention of unsafe IV drips through a new collaborative sign-off process with pharmacy to validate correct concentrate for double concentrate drips.

Increased timeliness of 0900 medication administration through a revised pharmacy fill time strategy.

Materials Management Team:

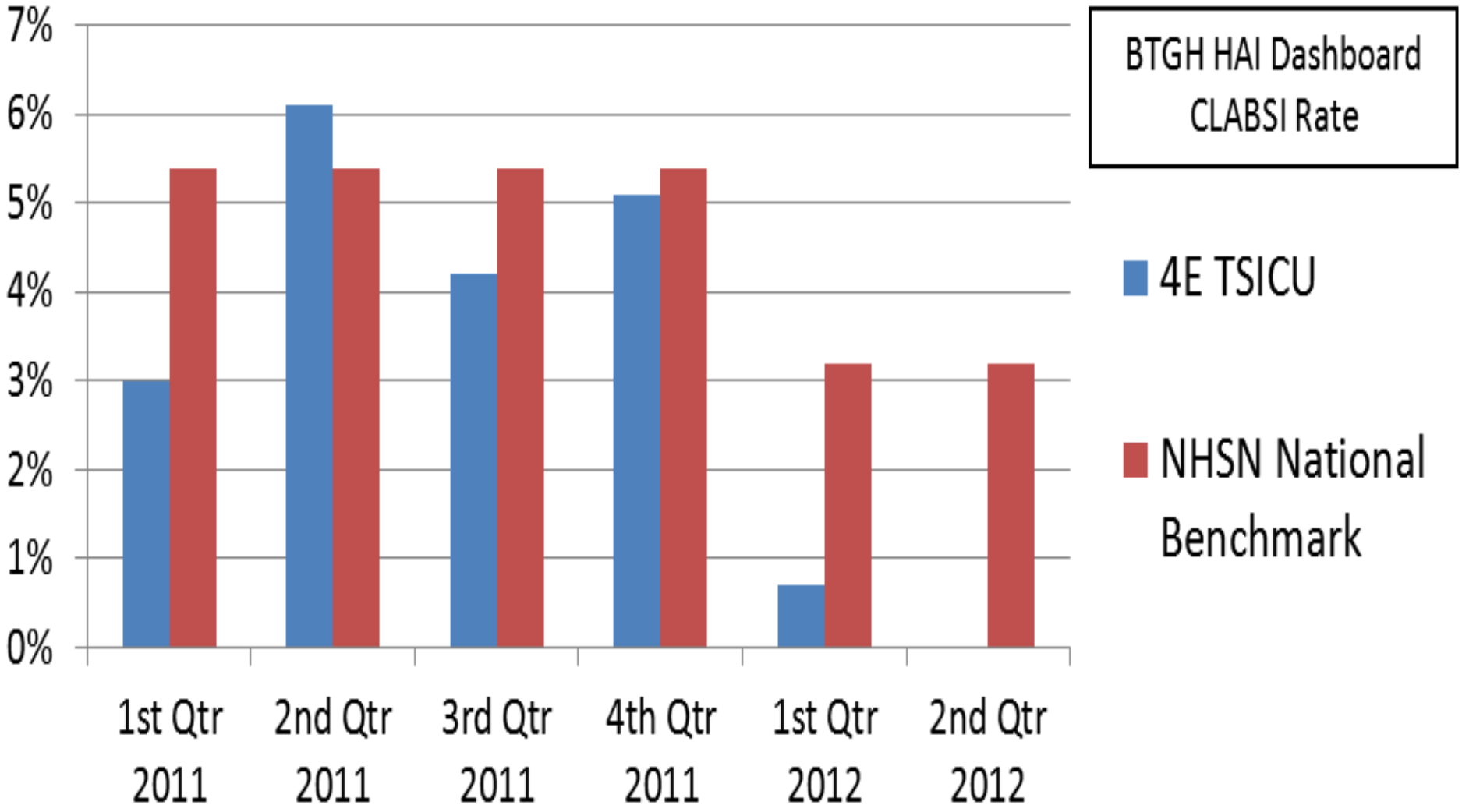
Improved emergency access to supplies through availability of stand-by equipment, Pyxis access to unlicensed users, and re-established Central Supply delivery times.

Information Technology Team:

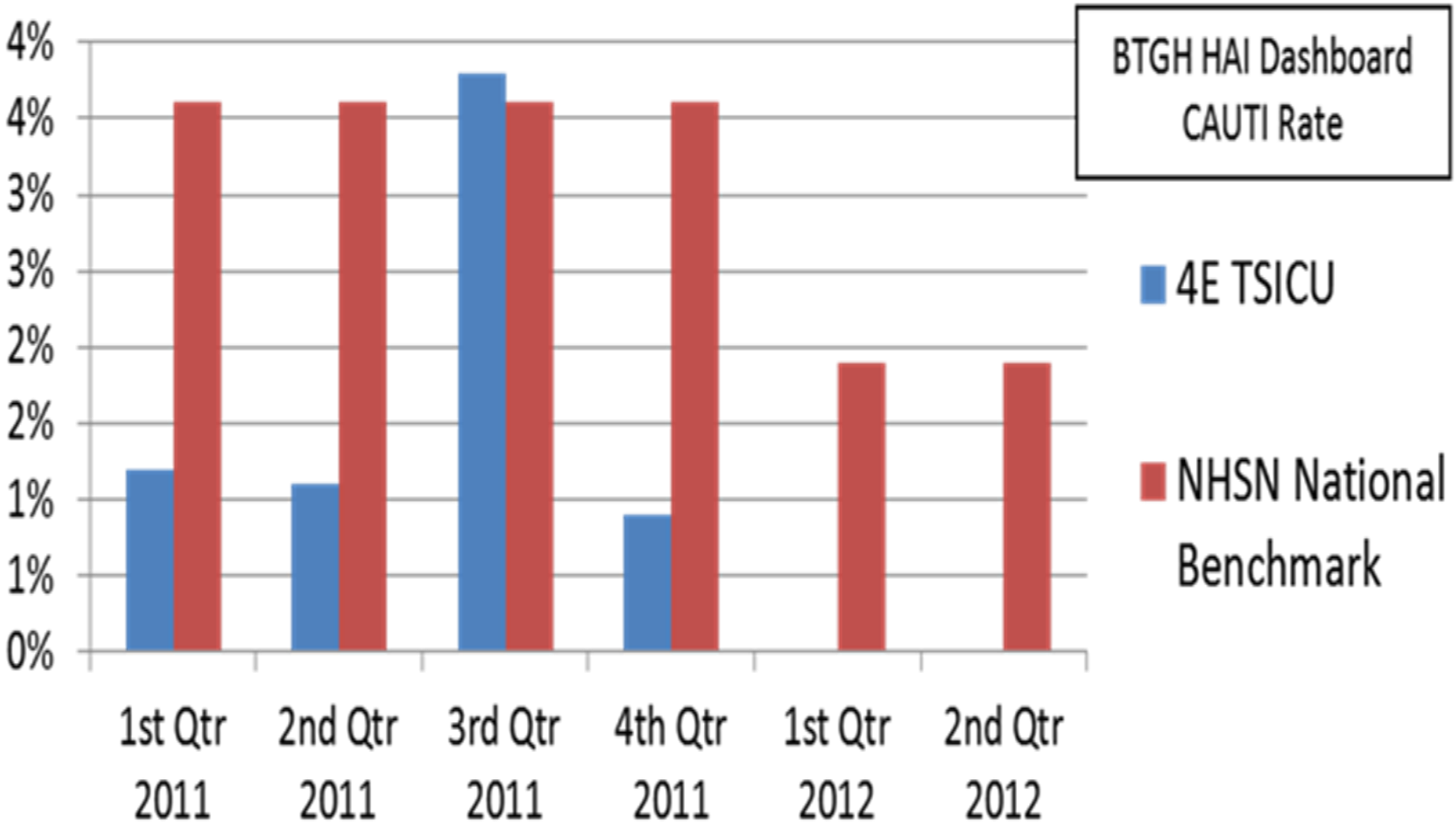
Increased flexibility of EMR to support Critical Care SOP (in process).

Establishment of a TSICU Pilot EPIC team to facilitate streamlined EMR workflow processes for increased direct patient care time (in process).

Clinical Outcomes



Clinical Outcomes



Clinical Outcomes

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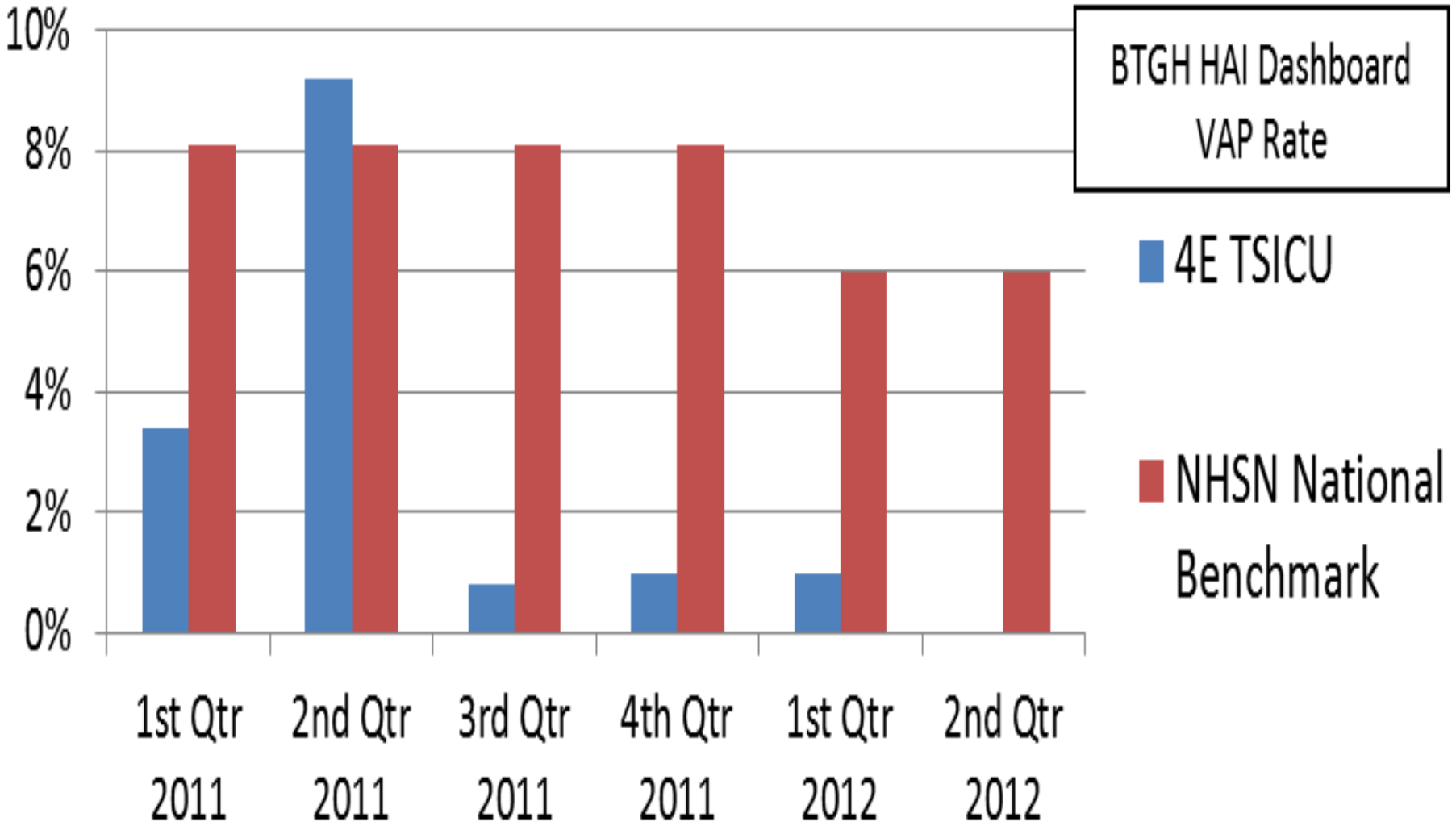

Clinical Outcomes

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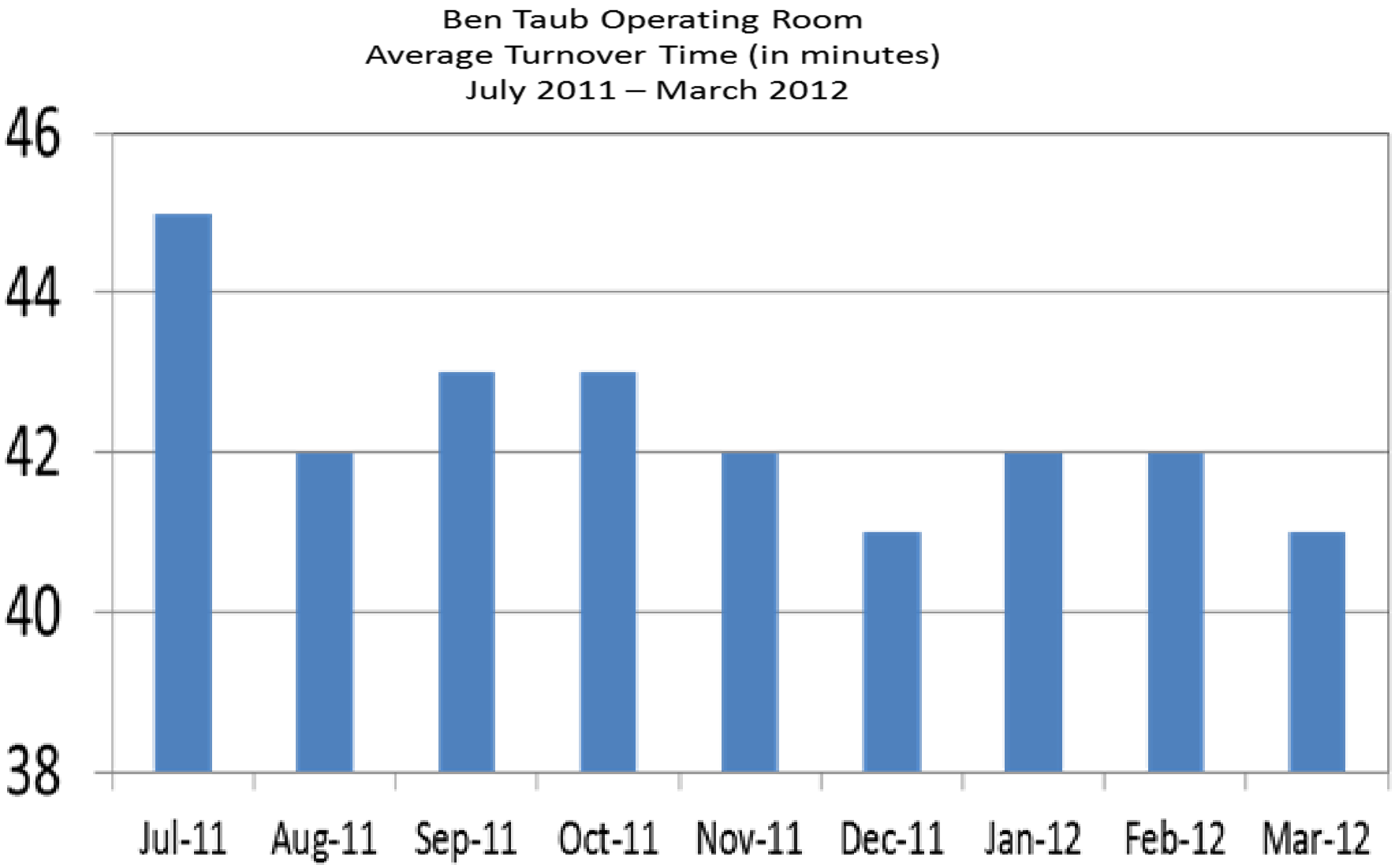

Clinical Outcomes

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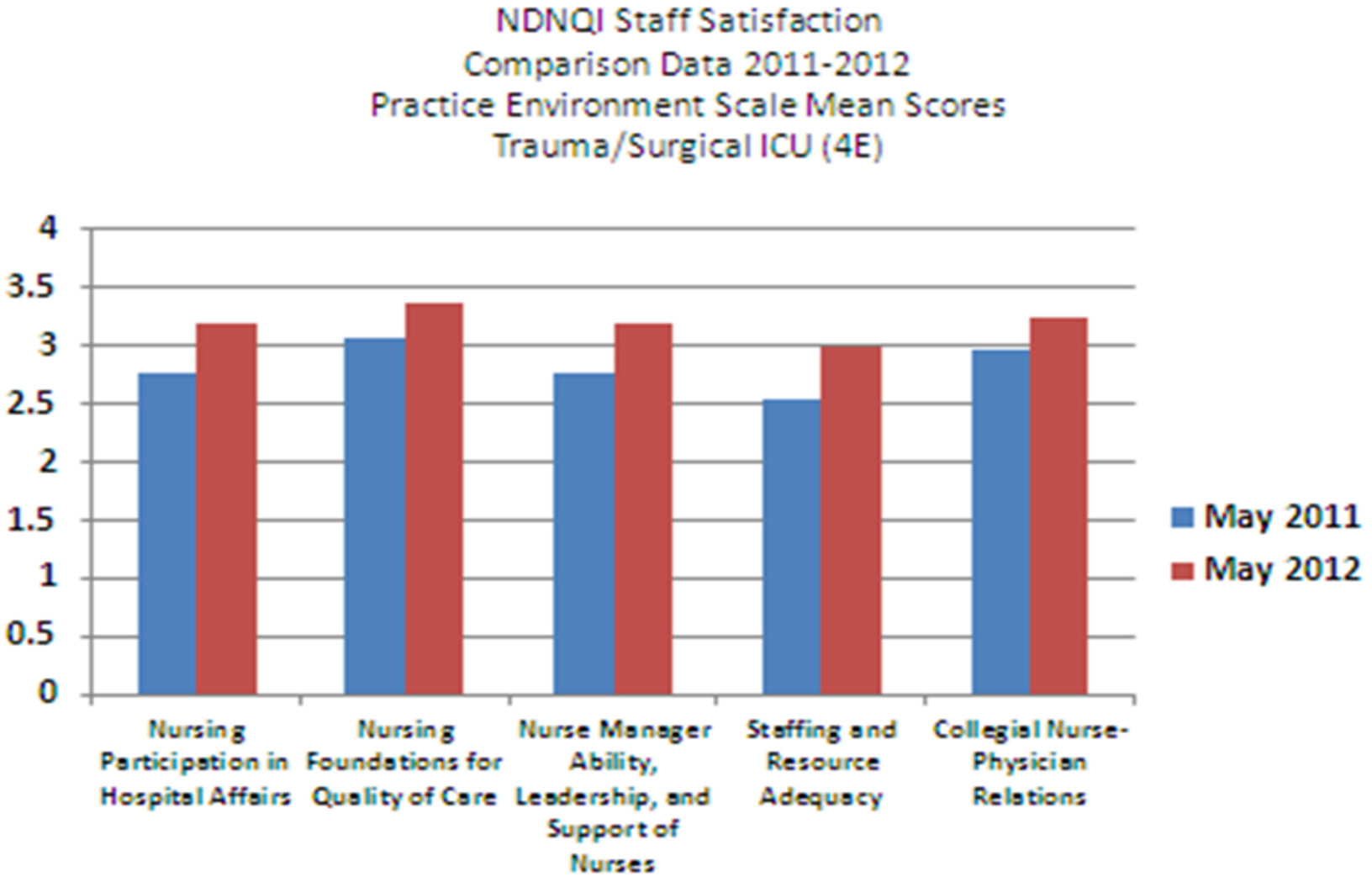

Clinical Outcomes

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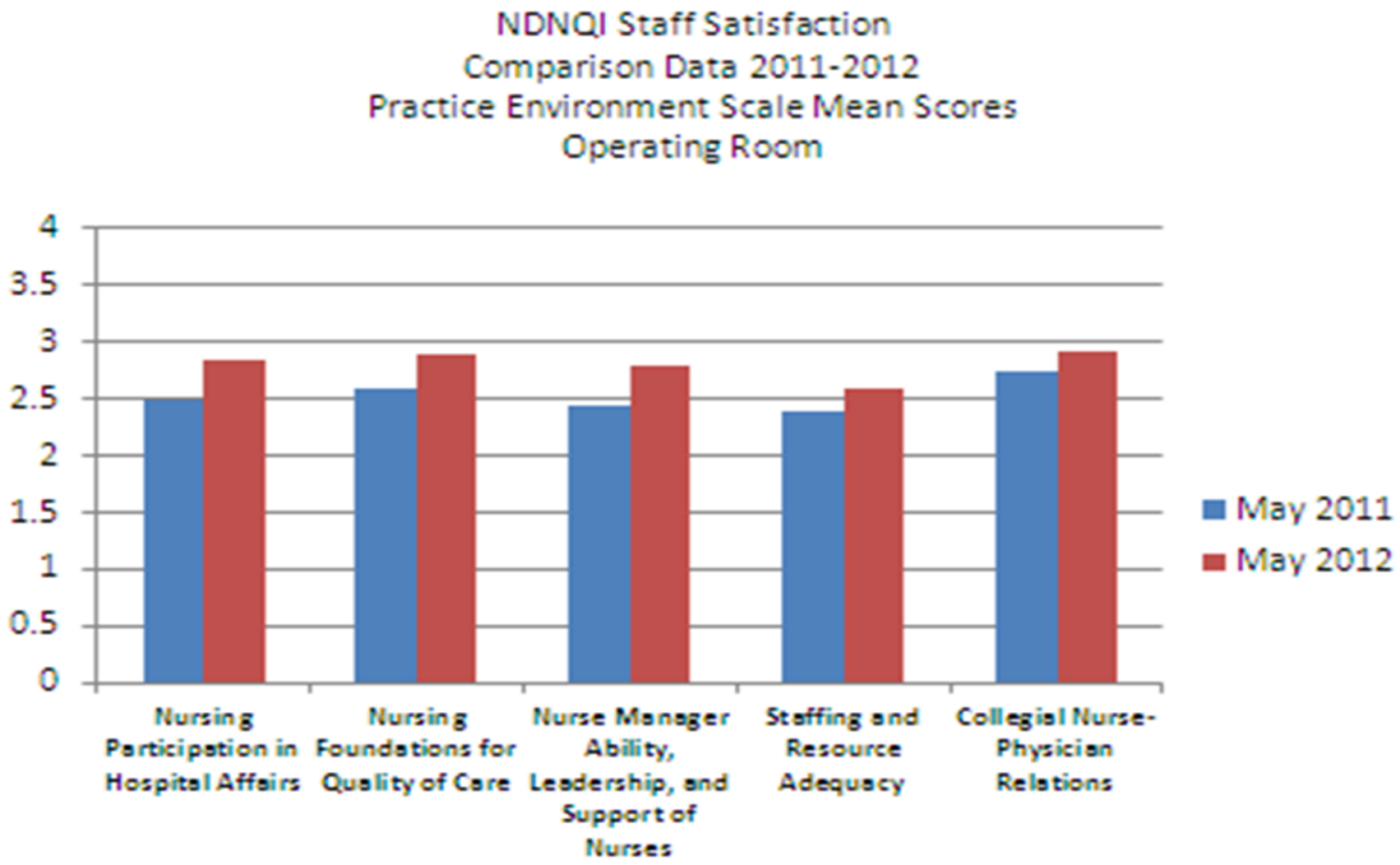

PSER Synopsis

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- Initiated in 2011 in TSICU to create a culture of safety through a collaborative strategy with the executive leadership team and broad-based partnerships that resulted in the momentum healthcare providers to address sixty-two patient safety issues.
- The shared leadership model with a rapid cycle solution framework and staff-nurse led interdisciplinary teams created an environment of successful collaboration, where team leaders are seen as influential change agents who participate in effective collegial, mutually goal related discussions with their colleagues.
- One year follow-up revealed data to support evidence of a sustained collaborative environment with improvement in patient safety initiatives

PSER Workflow

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