Rural Patient Safety Culture Project Teleconference Call

Experiences of Critical Access Hospitals (CAHs) in Improving Safety Culture
Thursday, January 5, 2012

Objectives
- Identify challenges in improving safety culture in a critical access hospital and how to overcome them
- Use lessons learned and best practices from critical access hospitals that have successfully applied culture change strategies in their organizations

Presenters
- Nancy Johnson, Pipestone County Medical Center
- Melissa McGinty-Thompson, Chippewa County-Montevideo Hospital
- Marilyn Grafstrom, LifeCare Medical Center

Pipestone County Medical Center and Family Clinic/Avera

Improving Safety Culture
January 5, 2012
Pipestone County Medical Center, Southwest Minnesota

- Critical access hospital
- Clinic (including 2 satellites)
- Home care
- Hospice
- 10 providers
  - 6 family practice physicians
  - 1 general surgeon
  - 2 nurse practitioners
  - 1 physician assistant
- Average activity per year
  - 800 surgical cases (inpatient and outpatient)
  - 600 acute care inpatients
  - 2,250 ER visits
  - 60 babies delivered

Our Team

- Safety committee
- Safety director
- Quality director
- Human resources staff
- Administration

Problem: Safety program needed improvement in goals and direction (2009)

- Higher than average Workman’s Compensation experience
- Incident reporting system outdated
- Safety program needed better organization and support
- Lack of staff education on the how and why of safety issues
- Lack of accountability

Goal

- Build culture of safety based on individual accountability with facility endorsement and support
Success Strategy 1

What: Establish baseline for measurement
Why: Determine where we are and where we want to be
How implemented: Conducted AHRQ Safety Survey in 2009 and 2010
How motivated staff:
- Provided definition
- Developed a general safety theory
- Educated staff in what is involved in “culture of safety”
Barriers:
- Not knowing what we didn’t know
- Educating leaders
- Coordinating results and developing report
Solutions:
- Completed first survey in coordination with Stratis Health
- Provided education for follow-up in 2009-2010

Success Strategy 2

What: Leadership training
Why: Challenge leaders to rethink approach to safety—from “what to why”
How implemented:
- Leadership educational development meetings
- Stratis Health in-service on tools to improve safety following first survey
How motivated staff: Challenged to think about safety in a different way
Barriers:
- Managers have limited time
- Presentations are too long for staff meetings
- Managers are at same the same educational level as most staff; we all need to improve together
Solutions:
- Conduct all culture of safety programs twice during first survey cycle
- Focus on easy-to-apply principles
- Use examples from staff’s work day
- Make staff accountable and give staff permission to use safety tools

Success Strategy 3

What: Improve safety incident and near-miss reporting
Why:
- Improve awareness and communication of safety issues
- Facilitate communication and follow-up incidents and near misses
- Include all staff in identification and prevention of incidents
How implemented: Purchased on-line safety/risk management tool to report, document, follow-up, and track incidents
How motivated staff:
- Training increased awareness of high-risk situations and behaviors
- Gave staff direct input to event reporting and ability to track progress of report follow-up
- Increased accountability of managers to follow through promptly
Barriers:
- Cost
- System upkeep
Solutions: System management duties shared by safety, quality and HR staff

Tools

- Worked safety into Standards for Service Excellence
- Examples:
  - Respond promptly to any form of communication
  - When needed, offer to assist co-workers
  - Report incidents within 24 hours
  - Complete safety training
  - Use PPE as required
  - Maintain safe working environment
Tools: AHRQ toolkit

- Mutual support
- 2 Challenge rule
- CUS
- STAR
- SBAR
- 3-part feedback
- Manage the message
- 3 Ws

Barriers

- Time:
  - Use approaches and meetings that already exist
  - Work safety thinking into day-to-day approach to work
  - Report results back to staff
    - Used e-mail to report basic AHRQ results
    - Sent out a series of 13 short e-mails to report results

What would you recommend to others?

- Start with survey
- Take small training steps directly focused on survey results
- Use training based on staff members’ actual work practices and experiences
- Reinforce “How does this apply to me?”
How will you sustain your improvements?

- Plan third round of AHRQ Safety Culture Survey for April 2012
- Work on areas identified in survey

Questions?

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Chippewa County Montevideo Hospital

- 25-bed Critical Access Hospital
- Southwest Minnesota
- Onsite clinic and 3 satellite clinics
- Provide services across the lifespan
- ED, OB, Med/Surg, ICU, Oncology, Cardiac Rehab, OR, Home Care, Diabetes Care, Dialysis, Mental Health

Chippewa County Montevideo Hospital

Melissa McGinty-Thompson, RN
Our Team

L to R:
Peg Schumacher, Clinic Adm.; Wendy Augason, RN; Ania Zelenka, RN; Carol Lietzau, MD; Vari Nelson, RN; Cathy Brouwer, RN; Melissa McGinley-Thompson, RN

Not pictured:
Amy Rongstad, NP; Mark Paulson, Hosp. Adm.; Linda Nelson, DON; Sue Jerve, RN; Bruce Arnold, MD

Issue/Problem

The survey results drove our projects. Based on these results, we chose to work on:

- Communication
- Team Support

Goal or Aim

Enhance our communication to provide better handoff information that will ensure the patients’ safety continues throughout the facility.

Success Strategy 1

- Interdepartment Transfer Form
- To provide consistent handoff communication between departments
- Provided education and introduction to form facility-wide. Delivered forms to every department
- Motivation: to explain the impact from lack of communication about the patients’ safety
- Verbal resistance
- Continued encouragement and shared success of utilization
Success Strategy 2

- SBAR communication
  - Name badges, forms, telephone notepads
- To improve communication among individuals across the facility
- Education and introduction to all facility employees
- Provided examples of improved communication and its impact on patient and staff satisfaction
- Verbal resistance
- Survey and shared results

Where we were...
Success Path

- Received survey results
- Shared results facility-wide at lunch and learn session
- Asked for participation on workgroups from all departments
- Developed tools
- Implemented tools

Success Path

Results!

Where we are going…

Success Path

- Continue to work on communication
- Awaiting second survey results

What Surprised You?

- The volunteers!
- Commitment and continued follow-through
Tools

• Interdepartment Transfer Form
• SBAR forms
  – Clinical
  – Nonclinical

Barriers

• Another form
• Extra work
• Verbal resistance

What Would You Change?

• Try and get more front-line staff involvement from the beginning
• Physician involvement

What Would You Recommend to Others?

• Get as many different disciplines involved from the beginning and seek input
• Have leadership support
• Communicate, communicate, communicate!
How Will You Sustain Your Improvements?

- Continue to meet monthly
- Developed other processes
- Communication team
- Leadership support

Near Miss/Error Reporting
Non-punitive Response to Errors

Marilyn Grafstrom

Thank you!

Contact Information:
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Roseau

- 25-bed critical access hospital
- Any further north, you'll be in Canada
- Known for hockey and Polaris snowmobiles
Services

- Medical Services: Ambulance, Behavioral Health, Diabetes Center, Emergency Department, Imaging Services, Laboratory, Medical Surgical Nursing, Outpatient Cardiac Services, Outpatient Procedures, Respiratory Care Services, Sleep Studies, Social Services, Surgery

Overview of Project

Hospital Survey on Patient Safety Culture, August 2008
(Rural Patient Safety Culture Project – Stratis Health)

Our targeted areas based on the findings:
- Increase reporting on incidents and near misses
- Improve communicating changes made based on incidents and near misses

Overview of Project, continued

- Make reporting as easy as possible (hot line)
- Reward the reporters
- Provide monthly feedback on incidents and near misses reported, and what has been done to prevent errors (Prove it)
- Reward the readers
- Just Culture education for leaders

Results

Significant improvement in targeted areas of the Hospital Survey on Patient Safety Culture, October 2009
Barriers
- Departmental silos
- Just Culture is not just education… and educating once is not enough

If we did it again, we would …
- Do more work on Just Culture
- Do more team building between leaders of critical departments

Advice
- Look for opportunities to recognize and reward staff members who make safety suggestions—you can’t celebrate too much!
- Prove it—every chance you get
- Make sure all involved leaders are on the same page
- Be patient…culture work takes a long time
- Never, never give up!

Contact Information
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Project questions

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Stratis Health is a nonprofit organization that leads collaboration and innovation in health care quality and safety, and serves as a trusted expert in facilitating improvement for people and communities.
**Inter-departmental Communication**

Place patient/client sticker here

<table>
<thead>
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☐ Return to ________________________________

☐ Patient may leave when done ________________________________

☐ Other ________________________________________________

☐ See Admission Orders

Allergies: ________________________________________________

Vital Signs: ________________________________________________

Narcotics/Sedation/Antiemetic Given/Time: ________________________________

Oxygen: ☐ Yes ☐ No  LPM/Route ________________________________  NPO: ☐ Yes ☐ No

Code Status: ☐ Full ☐ DNR ☐ DNI ☐ Not addressed

Precautions: ☐ Contact ☐ Droplet ☐ Airborne

Mode of Transportation: ☐ Ambulatory ☐ Wheel chair ☐ Cart

Activity Level: ☐ Independent ☐ Assisted

Fall Risk: ☐ Yes ☐ No  Mental Status: ☐ Oriented ☐ Not oriented

Barriers: ☐ HOH ☐ Deaf ☐ Poor Vision ☐ Language ☐ Illiterate

Family/Significant other: name: ___________________________ relationship: ___________________________

Where/how to locate ________________________________________________

Other: ________________________________________________

*Rank by order number where pt. needs to go, sign initial & time when done. If they need to return, indicate as needed. Fill out information that is pertinent. Save form after use & return to department manager. Revised on 12-16-2009 G/drive/common/forms/hand off
SBAR Reporting

BEFORE CALLING:
1. Assess the patient
2. Review the chart for the appropriate physician to call
3. Know the admitting diagnosis
4. Read the most recent Progress Notes and the assessment form the prior shift
5. Have available when speaking with the physician: Chart, Allergies, Meds, IV fluids, Labs/results, Code status
6. If physician is not available and you are expecting a return call, notify coworkers that you are expecting the call and where you can be located.

SITUATION – What is the current problem right now?
State your name and unit
I am calling about: Patient Name and Room Number
The problem I am calling about is:
Briefly state the problem: what it is, when it happened or started and how severe

BACKGROUND – What’s the background on this problem? How did we get to this point?
State the admission diagnosis and date of admission
State the pertinent medical history
A brief synopsis of the treatment to date

ASSESSMENT – What do I think the issue is? Why am I concerned?
Most recent vital signs
BP _______ Pulse_______ Respirations_____ Temperature _____ O2sat _____ I&O _______
The patient □ is or □ is not on oxygen
Wt _______
Any changes from prior assessments, such as:
Mental status Respiratory rate/quality Rhythm changes
Skin color Pulse/BP rate/quality Wound drainage
Neuro changes Pain
Muskuloskeletal (joint deformity, weakness) GI/GU (Nausea/vomiting/ diarrhea/output) Retractions/use of accessory muscles

RECOMMENDATION – What should we do to respond to this situation?
Do you think we should: (state what you would like to see done)

OR
□ I am not sure what the problem is but the patient is deteriorating.
□ The patient seems to be unstable and may get worse. We need to do something.
What do you think the next step should be?
□ Transfer the patient to the ICU
□ Come to see the patient at this time
□ Talk to the patient and/or family about code status
□ Ask for a consultant to see the patient now
□ Other suggestions ____________________________
Are any tests needed?
□ CXR □ ABG □ EKG □ CBC □ BNP □ Others____________________
If a change in treatment is ordered, then ask:
□ How often do you want vital signs? ____________________________
□ If the patient doesn’t improve, when do you want us to call again?

Document the change in condition and the physician notification.
Write all orders directly in the chart and complete the verbal read-back.
Signature: ____________________________ Date: _____ Time: __________
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**Situation:** What is the current problem right now?  
Identify yourself, the patient/problem. State the problem concisely.

**Background:** What’s the background on this problem?  
How did we get to this point?  
Review the chart. Anticipate questions. State the relevant issues.

**Assessment:** What do I think the issue is?  
Why am I concerned?  
Provide your observations and evaluations of the problem’s current state.

**Recommendation:** What should we do to respond to the situation?  
Suggest what should be done to meet the immediate needs.

Signature of person completed form: ___________________________  
Signature of person completed form: ___________________________

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