The presentation will begin shortly.

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Children's Colorado and its AHA/McKesson prize playbook

Daniel Hyman, MD, MMM
Chief Quality/Patient Safety Officer;
Children's Hospital Colorado

The speaker has no financial conflicts to disclose.

(and any pictures of Colorado are not meant as a recruitment strategy)

Objectives

- Who are we?
- Key enabling strategies for CHCO in our quality journey
- Leadership
- Safety: Target Zero
- Patient/Family Centeredness- “Board to bedside”
- Innovations in Data use
- Areas of “opportunity”- equity, effectiveness
- Discussion/Questions

Children's Hospital Colorado
WELCOME TO ONE OF THE
TOP 5
best children's hospitals
IN THE NATION
BEST

Children's Hospital Colorado
North Campus
ON AIR
EXIT
seacrest
STUDIOS

Leadership

Our “board is on board”

Role of Senior management

How we got them to be “All in”

Leadership

Our “board is on board”

Role of Senior management

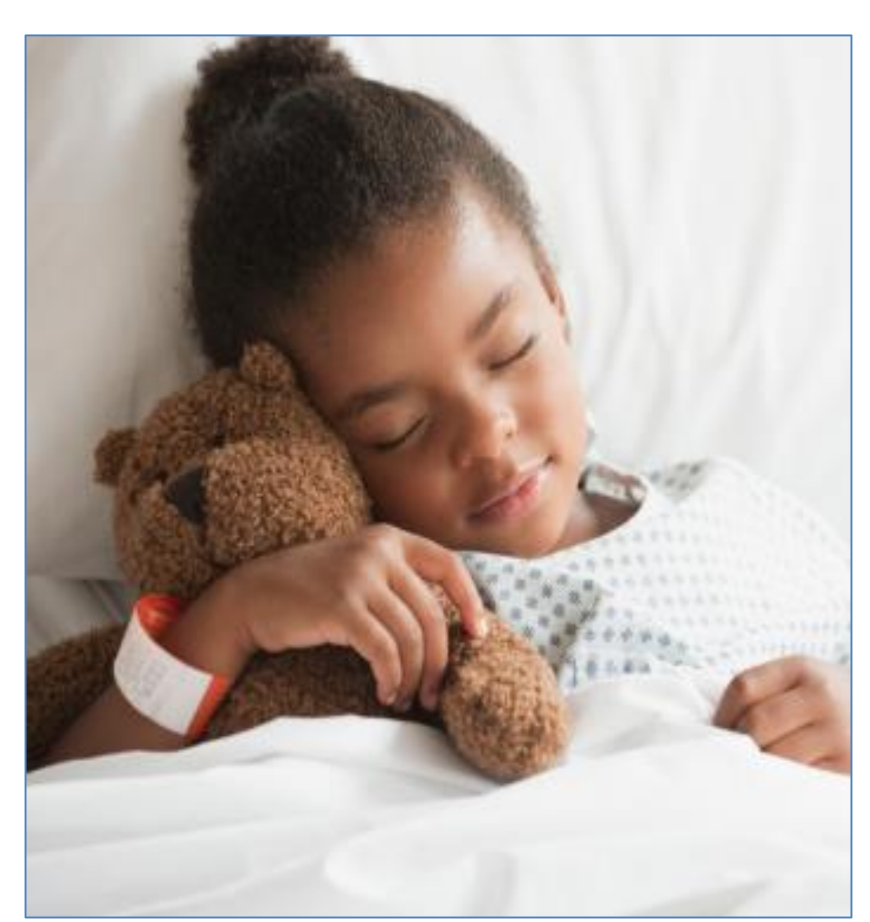
How we got them to be “All in”

SAFETY

Solutions for Patient Safety

Our Mission:

Working together
to eliminate serious harm across
all children's hospitals



Scale

2014
82+

(2013->)

(2012->)

Develop Ohio Network

Initial HAC improvement work

SSE reduction; efforts to address organizational culture

Creation of pediatric patient harm index

Create National Children's Network

Expand network to include 25 leading children's hospitals outside Ohio **(Phase I)**

Active improvement work on 10 HACs

Efforts to address organizational culture

"All Teach, All Learn"

Develop mentor hospitals

Begin to publicly disseminate change efforts

Spread

Add 50 hospitals **(Phase II**) to data sharing and network learning opportunities (2013); expand to 82+ hospitals nationwide (2014)

Share network best practices with all (2012->)

Disseminate at national meetings (2012->)

Develop strategies with national organizations (2012->)

Establish other regional collaboratives (2013)

Working Together

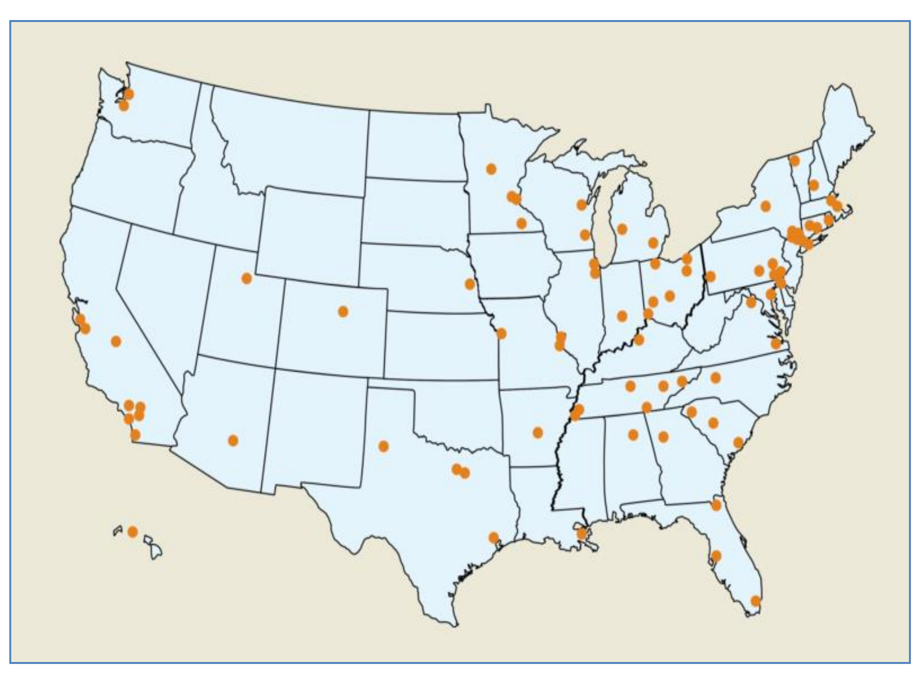
Leadership Matters

Our mission motivates all that we do

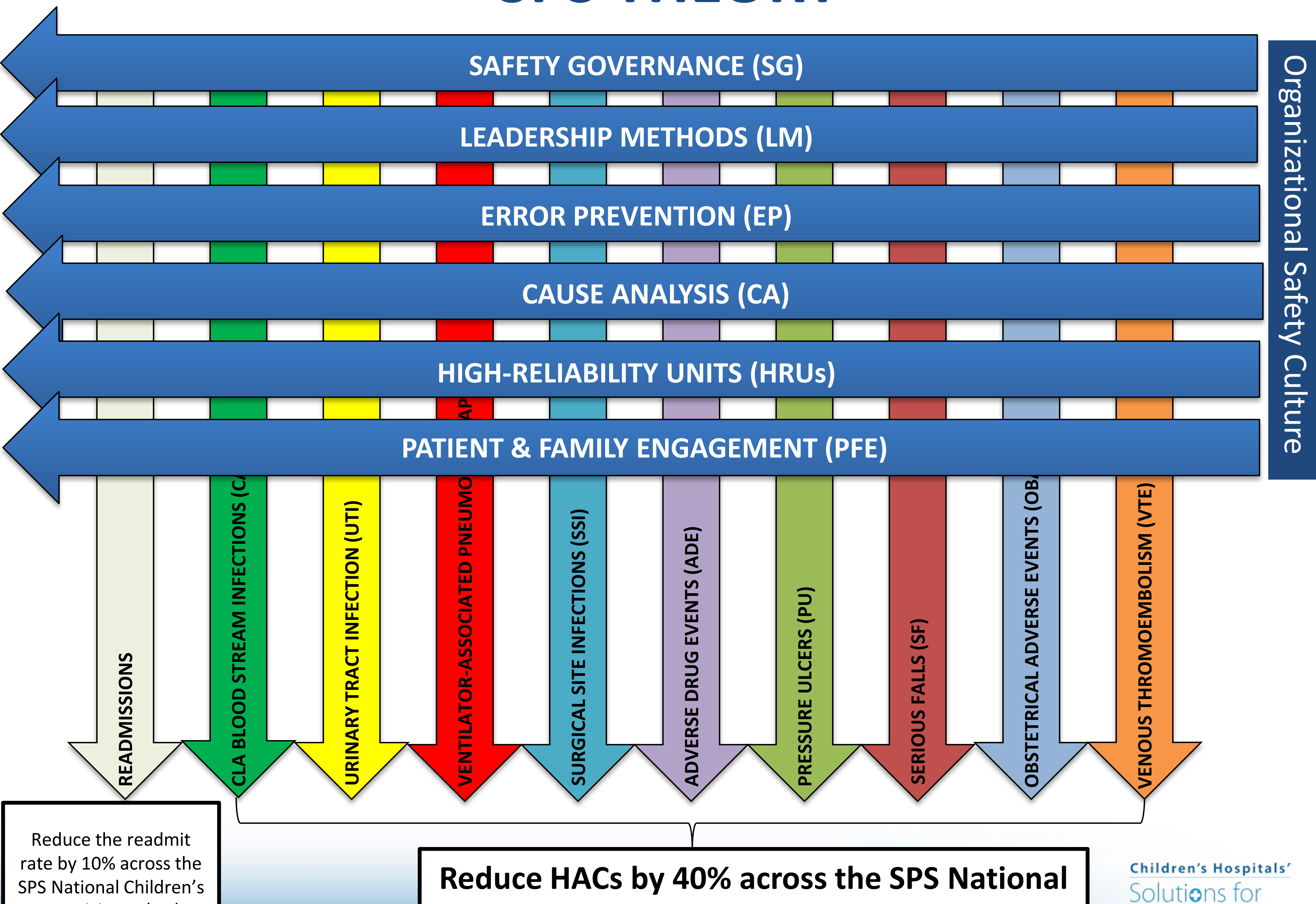
Network hospitals will NOT compete on safety

All Teach/All Learn

Network hospitals must commit to building a "culture of safety"

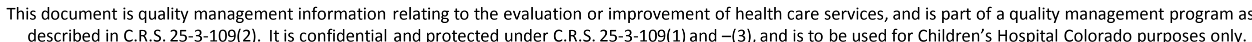


SPS THEORY



What is Target Zero?

Target Zero is a multi-year effort to **progressively eliminate preventable harm** at Children's Hospital Colorado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How the Pieces Fit Together

Best-practice clinical care

supported by

Behaviors designed to prevent error

reinforced by

Leaders who model, support, recognize and redirect

informed by

Ongoing measurement/analysis to show what's happening, and ongoing learning about what needs to happen next on the journey

will achieve

70+% decrease in preventable harm in 4 years

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Information about Bundles

- Development:
  - best-available evidence
  - cross-functional groups of subject matter experts
- Available on Target Zero site on Planet
- All bundles follow standard format:
  - Bundle trigger
  - Bundle elements
  - Process Steps

Bundle Trigger: Pressure Ulcers: Braden Q Score is between 17 and 22 indicating Moderate Risk for Skin Breakdown

Bundle Elements	Apply Mepilex border sacrum dressing	Reposition Patient every 2 Hours	Reposition Movable Devices every Shift	Z flo Positioners
Process Steps	•Mepilex border sacrum comes in two sizes 7.2 and 9.2 The 7.2 would be for a smaller child, while the 9.2 would be for a teenager or adult. •Mepilex border sacrum can be ordered in EPIC under "order entry" by typing 194068 for the 7.2 and 194069 for the 9.2 •For an infant or toddler, mepilex border 4x4 dressing can be placed if a Mepilex Sacrum drsg is too large. -Dressings should be changed at least	•Pt should be turned from their L side to supine to R side every 2 hours. •Repositioning can be done with use of pillows or Z flo positioners to offload pressure. •NICU patients should be repositioned with cares so as not to over stimulate.	•Movable devices such as pulse oximetry probes and blood pressure cuffs should be rotated from extremity to extremity each shift to reduce pressure to one area. •Devices that cannot be moved should be padded with mepilex or duoderm	•Z flo positioners should be placed under bony prominences in bed bound patients. Examples of bony prominences to consider are heels and elbows. They can also be used under the occiput in infants or toddlers. •Z flo positioners can be ordered through central supply under "order entry" in EPIC by typing 211375 for the 12x20 size and 211377 for the 7x10 size

Target Zero: Safety Practices and Tools

Personal Commitment

Introductions

Pause to Care

ARCC: Ask, Request, CUS, Chain of Command

Clear, Complete Respectful Communication

SBAR, Read-backs (Repeat backs)

Questioning Attitude

ART, Stop and Resolve

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Target Zero Leadership Practices

Practices which leaders use to ensure a reliably safe environment:

1. **JUST CULTURE:** Respond to errors and deviations in practice in ways that promote learning and are perceived to be fair and just
2. **ROUNDING TO INFLUENCE:** Actively observe and speak with staff about safety practices
3. **EFFECTIVE FEEDBACK:** Give positive feedback when safety practices are demonstrated, corrective feedback when not

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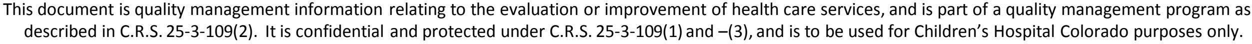
Cause Analysis

Ongoing measurement and analysis to identify root cause and apparent cause of errors and deviations in practice

Explores both individual and systemic causes

Identifies specific opportunities for ongoing learning about becoming safer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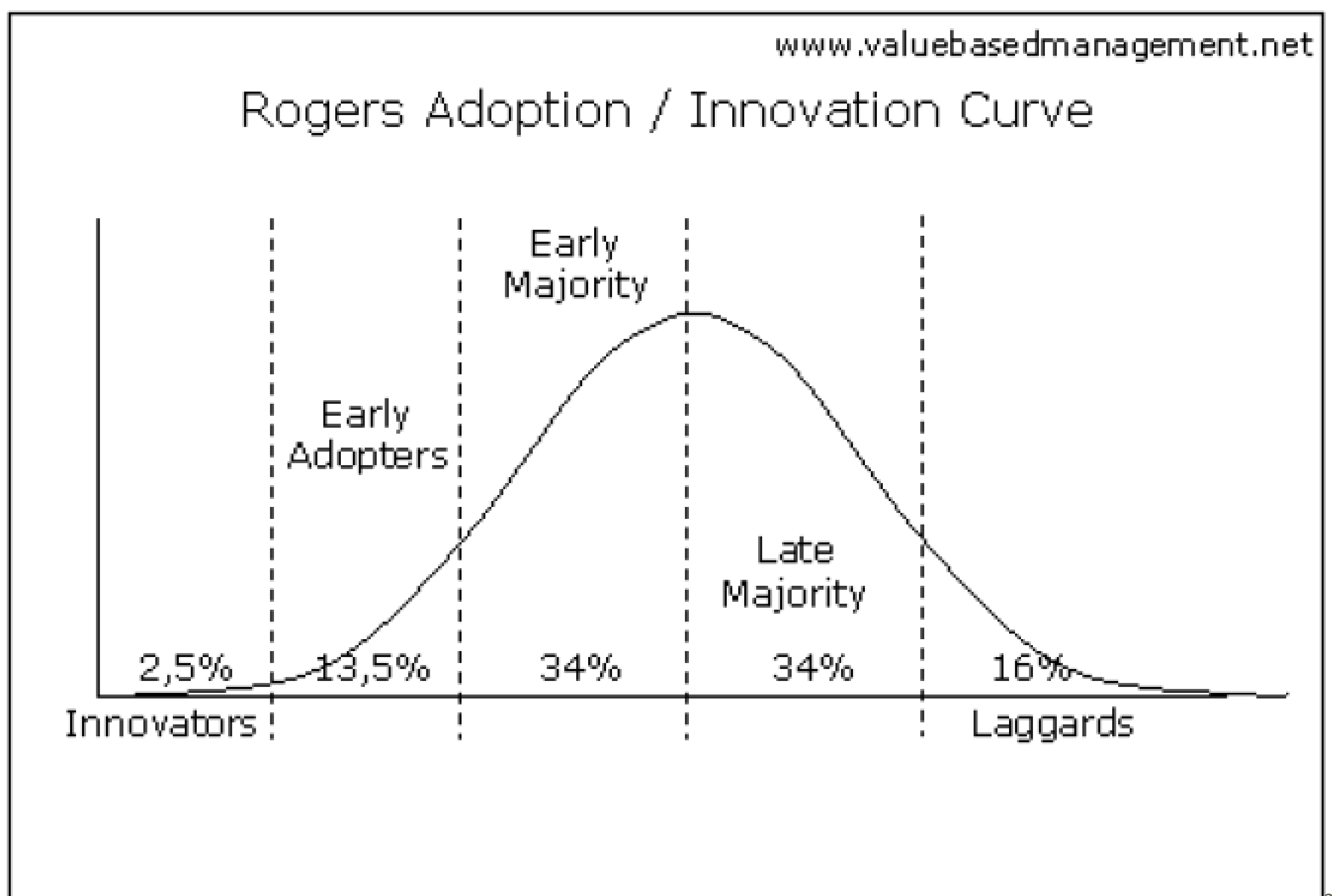
Patient Family Engagement

Adoption of Change



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AHRQ 2012 report

Contract Final Report

Guide to Patient and Family Engagement: Environmental Scan Report

Prepared for:

Agency for Healthcare Research and Quality
Rockville, MD

Contract HHSA 290-200-600019

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Parent Partnership, Children's Colorado

Family Advisory Council	Focus Areas 2012-15: Family Advocacy Policy/Procedure: from Input to Development Marketing of FAC/partnership opportunities Target Zero Care Coordination
Governance/Quality Councils	-Quality/Safety Committee of the Board -Quality safety and Performance Improvement Council -Patient Safety Committee
Service Lines, Projects/Initiatives, etc.	"Target Zero"; Heart Institute and other service lines; "Speak Up"; Hand hygiene; Patient ID; DNAR policy; teamwork/communication/consult coordination; CF, etc.
"HACs"	(ADE, CA-UTI, Falls, Pressure Ulcers…

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Partnership for Patient Safety

The Children's Hospital is staffed by some of the best health care providers in pediatric care, and our dedicated team is committed to delivering safe and appropriate care to your child. As part of our commitment, The Children's Hospital Staff works in partnership with patients and their families to provide a safe and satisfying experience during their visit. If you feel there is anything unsafe about your child's situation, contact us immediately. You know your child best.

Your child's health care is a team effort and you are an important member of the team. Always remember that your opinion counts. By working together, we can achieve the goal of providing safe health care for your child.

SHARE

Share Important Information:

- **Tell** your child's caregiver about the current medications your child takes at home.
- **Tell** your child's caregiver about any allergies or reactions to medicines, foods or other things.
- **Tell** your child's caregiver any other information you think is important in the care of your child.
- **Tell** your health care team if there is something you don't understand.
- **Expect** your health care team to check your child's ID band before any care is provided.
- **Expect** all staff to have an ID badge and to introduce themselves.

SPEAK UP

Speak Up:

- **If** you have questions about your child's medications.
- **If** something does not seem right.
- **If** your child's health care providers did not wash their hands.
- **If** you need a medical interpreter.
- **If** something doesn't make sense.
- **If** you feel the caregiver has confused your child with another patient.
- **If** you think your child is getting worse *and you are not getting the response you need.*

ACT

Act On Your Gut Feeling

We recognize that you know your child best! If you are concerned or worried about a change or sudden decline in your child's condition, please tell us!

- Please notify your child's nurse or physician. Tell them what concerns you!
- **If you feel your child's condition is getting worse, *and you are not getting the response you need,* you can call for a Rapid Response Team (RRT) Evaluation by dialing 75555 on any in-house phone.**
- If you do not feel comfortable calling the RRT, please ask a caregiver to call for you.

Our Rapid Response Team consists of specially trained physicians and nurses from the intensive care unit. They will come to your child's bedside to address your concerns. They will work with your child's health care team to develop a plan of care to address your concerns.

If you have questions about our Rapid Response Team, please ask your nurse or any team member.

The Children's Hospital

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PATIENT SAFETY

WHAT PATIENTS AND FAMILIES NEED TO KNOW!

HAND WASHING

This is the most important way to prevent the spread of infections in the hospital and at home.

What can you do?

→ Expect everyone to wash their hands or use hand sanitizer when entering and leaving your room. If you are unsure, please ask.

→ Wash your hands:
- When entering and leaving your child's room
- Before and after preparing food, eating, or feeding your child
- After using the bathroom or changing a diaper

"Excuse me, I didn't see you wash your hands. I'd like to be sure everyone's hands are clean. Please wash them before caring for my child."

RAPID RESPONSE TEAM (RRT)

This is a team of healthcare providers from our intensive care areas. They can be contacted anytime you are concerned that your child's medical condition is worsening and you are worried that the situation is not being addressed by the patient's primary team.

What can you do?

→ Recognize when you have a gut feeling that something just doesn't seem right with your child's medical condition.

→ CALL AN RRT by dialing 7-5555 FROM THE NEAREST PHONE and tell the operator that you are asking for an RRT for your child. Give the child's full name and room number.

"I am concerned that my child's medical condition is worsening. I am calling an RRT and dialing 7-5555."

PATIENT IDENTIFICATION (PATIENT I.D.)

This is our way to confirm that we are providing the correct care to your child. We require two forms of identification, like name and date of birth, to be used with each test, treatment, or medication.

What can you do?

→ Make sure your child is wearing their patient I.D. armband at all times, and that the name and date of birth are correct. The armband should be on your child and not in the crib or bed.

→ Ask to see your child's photo in the medical record.

→ Participate in our patient I.D. process:
- Expect staff to confirm name and date of birth.
- Stop us if you don't see us check your child's armband when we are about to give a test, treatment or medication.
- *Ask questions* if a caregiver wants to do something that you are not expecting (test, treatment, medication or transport, etc.).

"Excuse me, I did not see you check or ask for my child's two forms of identification. Please double-check."

FALLS

These are common causes of injuries in hospitals and most can be prevented. All children are at risk for falls.

Your child is at higher risk for falling if he/she:

→ Is 5 years old or younger

→ Is connected to any type of wires or tubing such as IV's, feeding tubes, monitors, or drain tubes

→ Is receiving medication that makes them sleepy or dizzy

→ Has a condition that affects their balance and ability to walk safely on their own

What can you do?

→ Call for help when you move your child from one place to another.

→ Keep side rails up at all times.

→ Make sure your child is assisted while using the bathroom.

"I am concerned that my child might fall. Please tell me what I can do."

PRESSURE ULCERS (BED SORES)

These are caused by pressure from sitting or lying in one position too long. They can also be caused by a cord or device that puts pressure on the skin. They are most likely to happen on skin over bony areas.

What can you do?

→ Help your child change positions regularly to help avoid pressure ulcers. Call your nurse if you need help moving your child.

→ Call a nurse to help change the position of any devices that put pressure on your child's skin.

→ Keep your child's skin clean and moisturized.

→ Change your child's diaper often.

→ Pay close attention to your child's body, especially in areas where they have no feeling.

"I am concerned about my child's skin. Please look at it with me."

QUESTIONS?

Be an active member in your child's healthcare team and **SPEAK UP** if you have any questions or concerns.

Approved by the Patient Family Education Committee
Sept. 2012

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QPS_12029/0113

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Best Practice/Lessons Learned: Quality and Safety Committee, Board of Directors

Hospital:	Parent/Family:
What might the parent be thinking? Ask what they are thinking!	Keep the focus of the meeting on why we are all here (our children)
Managing Jargon, sitting together, recruit in pairs	Provide unique perspective on high-level strategy and decisions
Debriefing especially early on	Give board members a reality check
Encourage parents to challenge us	Provide first hand experience on discussed issues
Seriousness of purpose and acceleration of impact	Make a “welcoming” environment for Parents. Board meetings can be intimidating.

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Bedside:

- White board – Family Section
- Target Zero
- Speak Up! Campaign
- Family journal
- Provider diagrams
- RRT
- Rounding – Care team/hourly/leadership

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______'S CARE PLAN

Su equipo de atención médica

Date: Fecha

Room: Habitación

Parent/Guardian: Padres/Tutor

Attending: Médico responsable

Phone: Telefono

Nurse: Enfermera/o

Other providers: Otros proveedores

Other team members: Otros integrantes del equipo

Comfort Plan: Regimen para la comodidad

Daily Goals: Metas diarias

Discharge Goals: Metas al darle el alta

SPEAK UP · TARGET ZERO

Target Zero Partnering with Families for Safety

Right care, tests, and treatments	Infections	Room/Bed Safety	Other
☑ Right patient	☐ CLABSI	☐ Pressure Ulcers (sores)	☐ Clots (VTE)
☑ Right drug, dose	☐ CA-UTI	☐ Falls	☐ PIV
☑ Right plan of care	☐ Other Infections		
	☑ Hand hygiene		

FAMILY SECTION

Sección para la familia

SPEAK UP

Please include me in: Agradezco se me incluya en: (wake me up if I'm sleeping)

Daily care team rounds Visitas médicas diarias — Yes / No

Nursing bedside shift report Informe de enfermería al cambio de turno — **AM** Yes / No — **PM** Yes / No

My goal today is: Hoy, mi meta es:

My questions today are: Hoy, las preguntas que tengo son:

Today I'm noticing: Hoy advertí que:

To go home, I need to: Para regresar a casa necesito:

Schedule appointments with my: Concertar citas con mi:

☐ **primary care physician** médico de cabecera

☐ **specialists** especialistas

☐ **Have my prescriptions filled or faxed to my home pharmacy.** Surtir mis recetas o enviarlas por fax a mi farmacia local

'S CARE PLAN
Su equipo de atención médica
Date: Fecha
Room: Habitación
Parent/Guardian: Padres/Tutor
Attending: Médico responsable
Phone: Telefono
Nurse: Enfermera/o
Other providers: Otros proveedores
Other team members: Otros integrantes del equipo
Comfort Plan: Regimen para la comodidad
Daily Goals: Metas diarias
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Target Zero Partnering with Families for Safety
FAMILY SECTION
Sección para la familia
Please include me in:
Daily care team rounds
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My goal today is:
My questions today are:
Today I'm noticing:
To go home, I need to:
Schedule appointments with my:
primary care physician
specialists
Have my prescriptions filled or faxed to my home pharmacy.

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Target Zero Partnering with Families for Safety

Right care, tests, and treatments	Infections	Room/Bed Safety	Other
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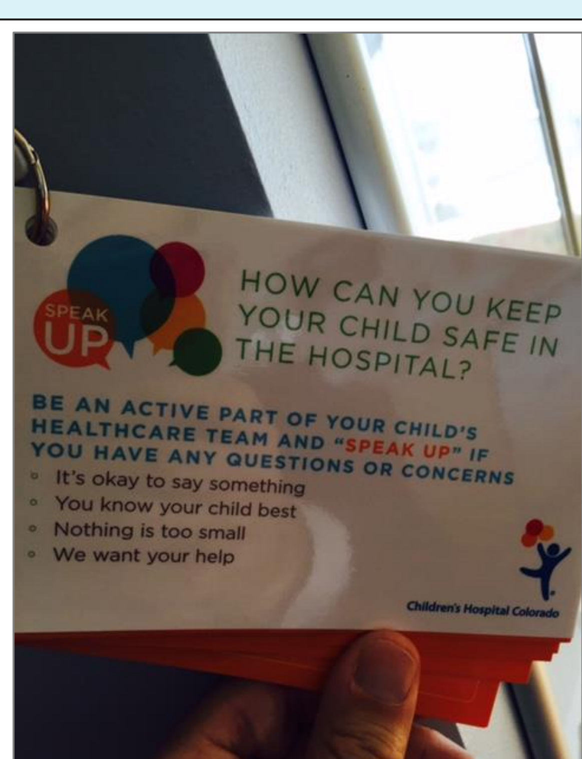
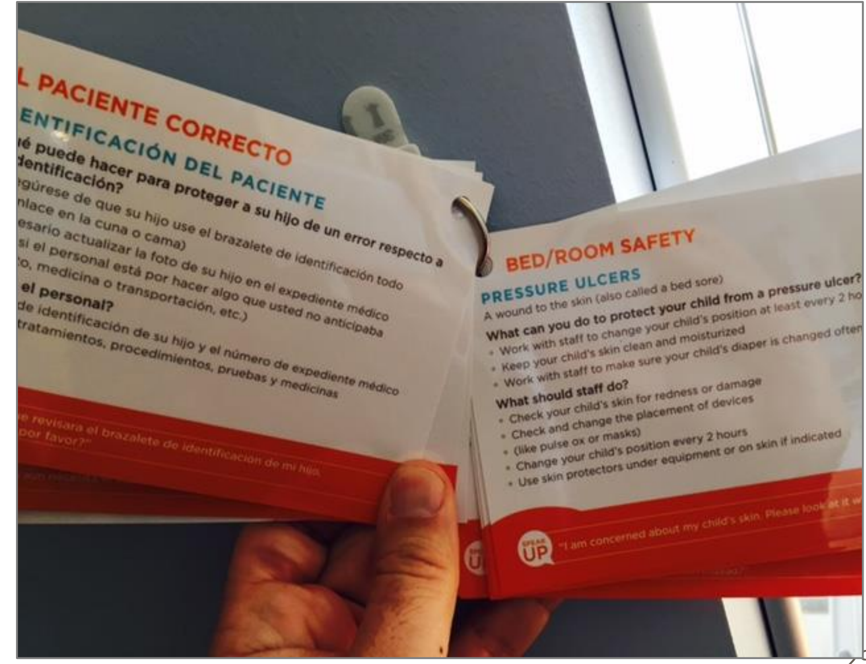
☑ Right plan of care	☐ Other infections		
	☑ Hand hygiene		





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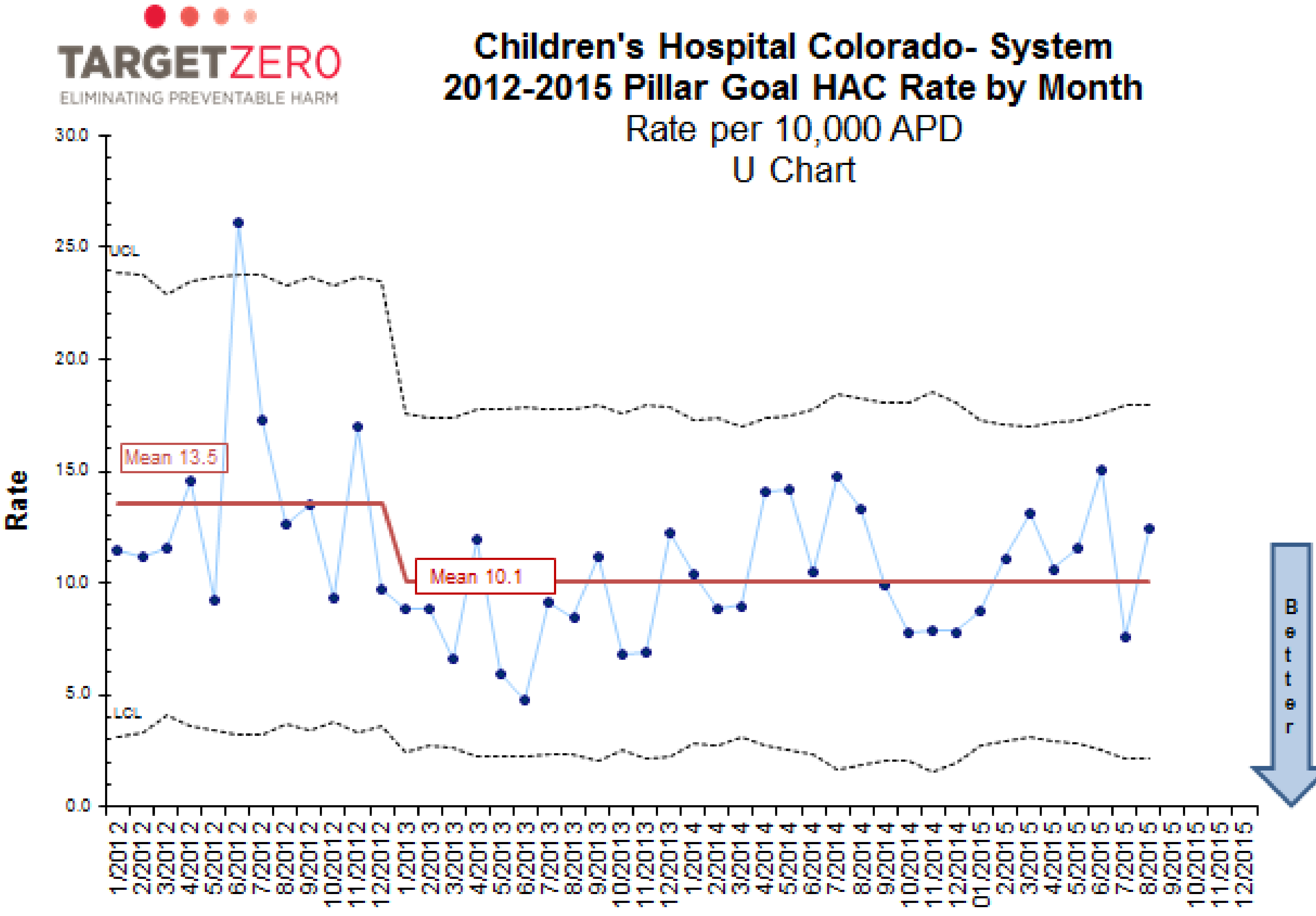
Results: Innovative and transparent use of Data



*This chart does not include Memorial days from 6/4/2014-12/31/2014 and after 6/4/2015

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20 Preventable Harm Events, August 2015

- CAUTI
  - *Patient name* *(Unit)*
- CLABSI
  - *Patient name* *(Unit)*
  - *Patient name* *(Unit)*
  - *Patient name* *(Unit)*
  - *Patient name* *(Unit)*
  - *Patient name* *(Unit)*
  - *Patient name* *(Unit)*
  - *Patient name* *(Unit)*
  - *Patient name* *(Unit)*
- CODES
  - *Patient name* *(Unit)*
  - *Patient name* *(Unit)*
- Falls
  - *Patient name* *(Unit)*
- Patient ID
  - *Patient name* *(Unit)*
  - *Patient name* *(Unit)*
  - *Patient name* *(Unit)*
  - *Patient name* *(Unit)*
  - *Patient name* *(Unit)*
- Pressure Ulcer
  - *Patient name* *(Unit)*
- VTE
  - *Patient name* *(Unit)*
  - *Patient name* *(Unit)*

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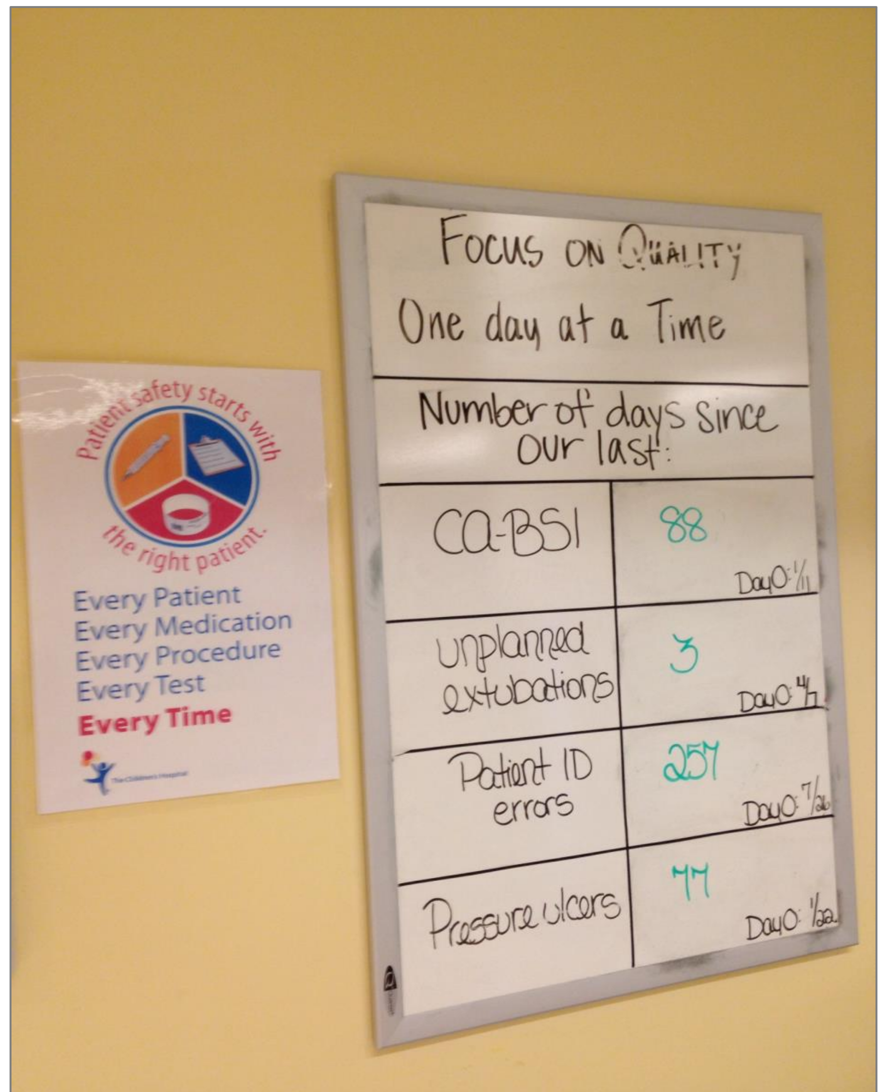
Making performance visible - unit outcomes



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Colorado Data in Action

Children's Hospital Colorado uses its data to create an internal **Dynamic Dashboard**.

Features:

- Accessible to all
- Timely bundle compliance data – refreshed hourly
- Drill down capability
- Filters
- Dynamic filtering
- Related Links

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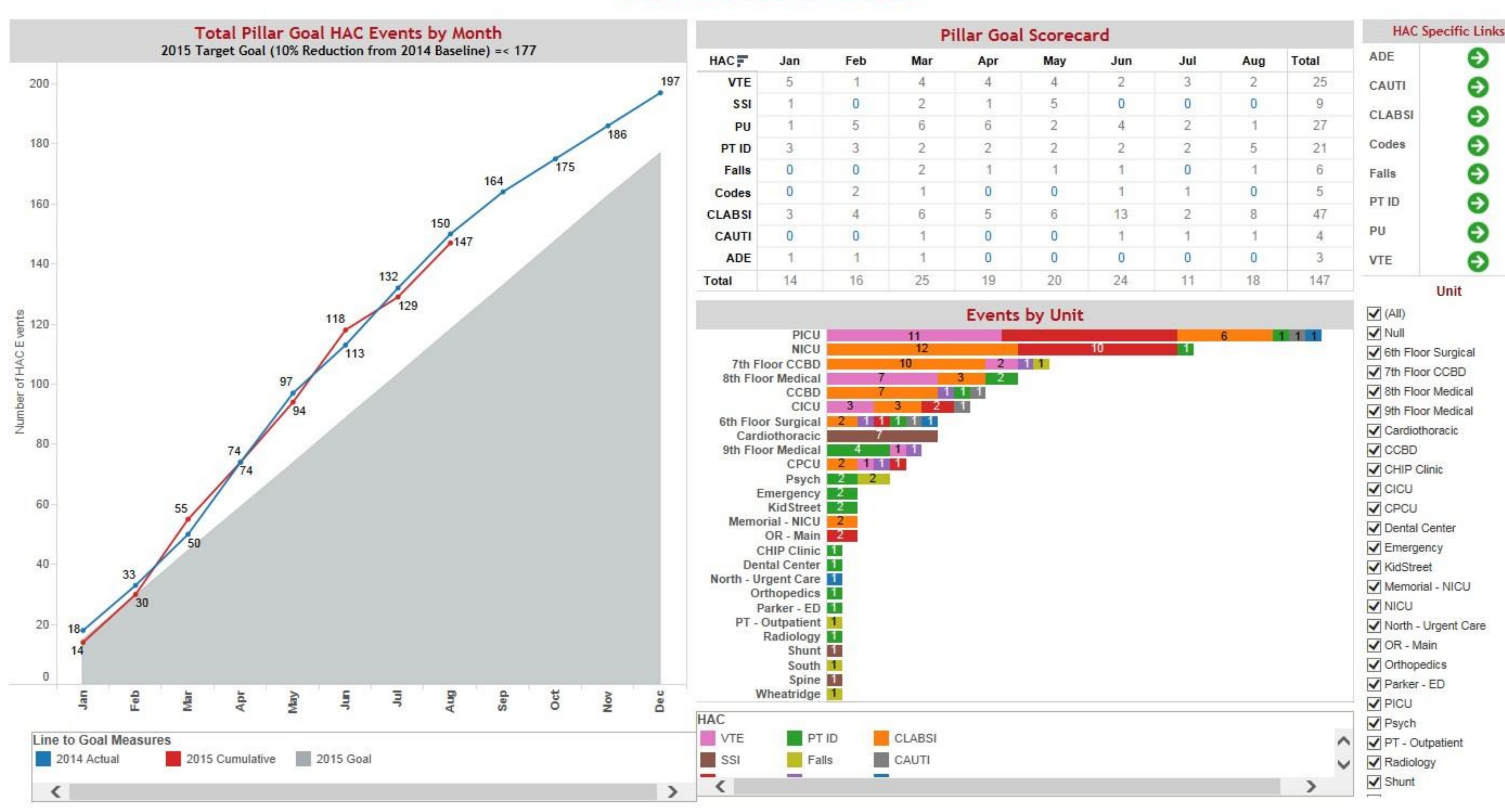
CHCO Outcomes Dashboard



HAC	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Total
VTE	5	1	4	4	4	2	3	2	25
SSI	1	0	2	1	5	0	0	0	9
PU	1	5	6	6	2	4	2	1	27
PT ID	3	3	2	2	2	2	2	5	21
Falls	0	0	2	1	1	1	0	1	6
Codes	0	2	1	0	0	1	1	0	5
CLABSI	3	4	6	5	6	13	2	8	47
CAUTI	0	0	1	0	0	1	1	1	4
ADE	1	1	1	0	0	0	0	0	3
Total	14	16	25	19	20	24	11	18	147

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CHCO Process Dashboard

House-wide Bundle Compliance Dashboard

✓	90% or greater compliance
!	Greater than or equal 80% compliance, less than 90%
✗	Less than 80% compliance

Go to Target Zero HAC Outcome Dashboard

Welcome to the Unit Level Multi-HAC Bundle Compliance Dashboard which provides an at-a-glance status of all Target Zero HAC's. Use the Select Unit and Select Date Range filters to display HAC statuses for specific units and time ranges such as for month-to-date, last month, or year-to-date. **Blank or missing graphics mean there is no data available for the time period and unit selected.**

Patient ID	CAUTI	VAP
64.1%	75.3%	95.7%

VTE	Falls	Pressure Ulcer High Risk
91.1%	35.4%	84.3%

CLABSI	PIV
62.1%	85.2%

Select Unit

(All)

Select Date Range

Year to Date

Related Links:

Other Target Zero HAC Unit-level Data

Provide Feedback Here

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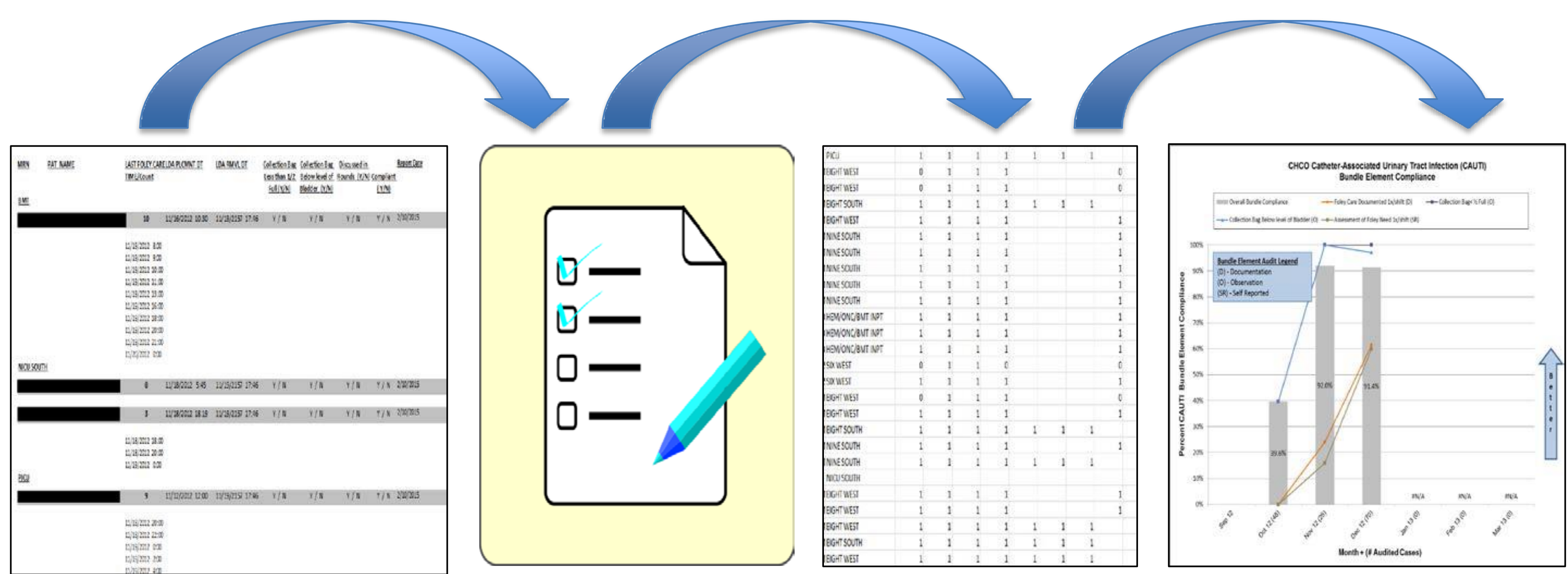
Audits to Dynamic Dashboards

- Paper audits with manual entry
- Documentation reports from EMR
- Audits entered into RedCap

- Data stored in EDW

- Data displayed in Tableau dashboard



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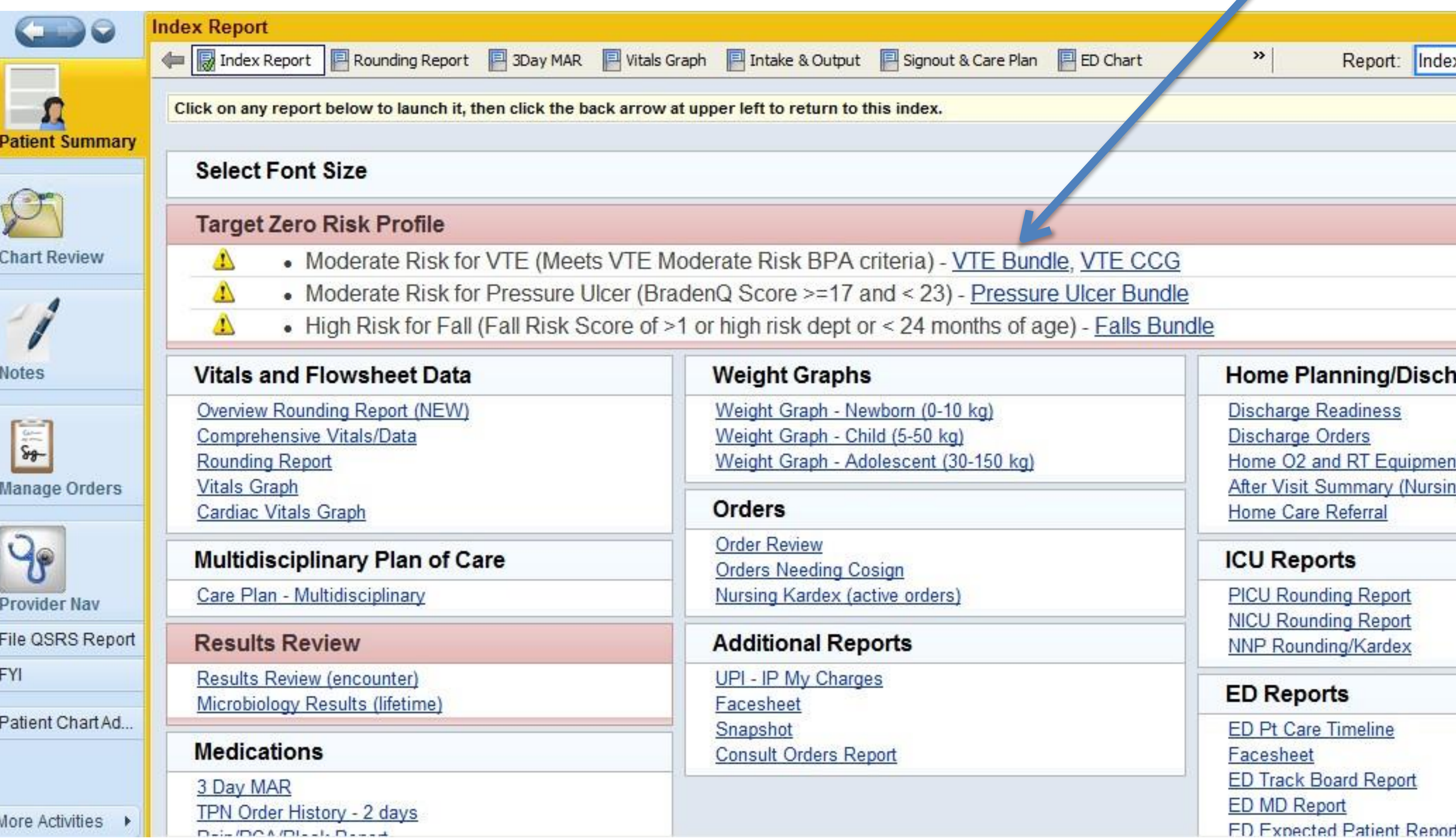
Risk Profile in the Patient's Chart



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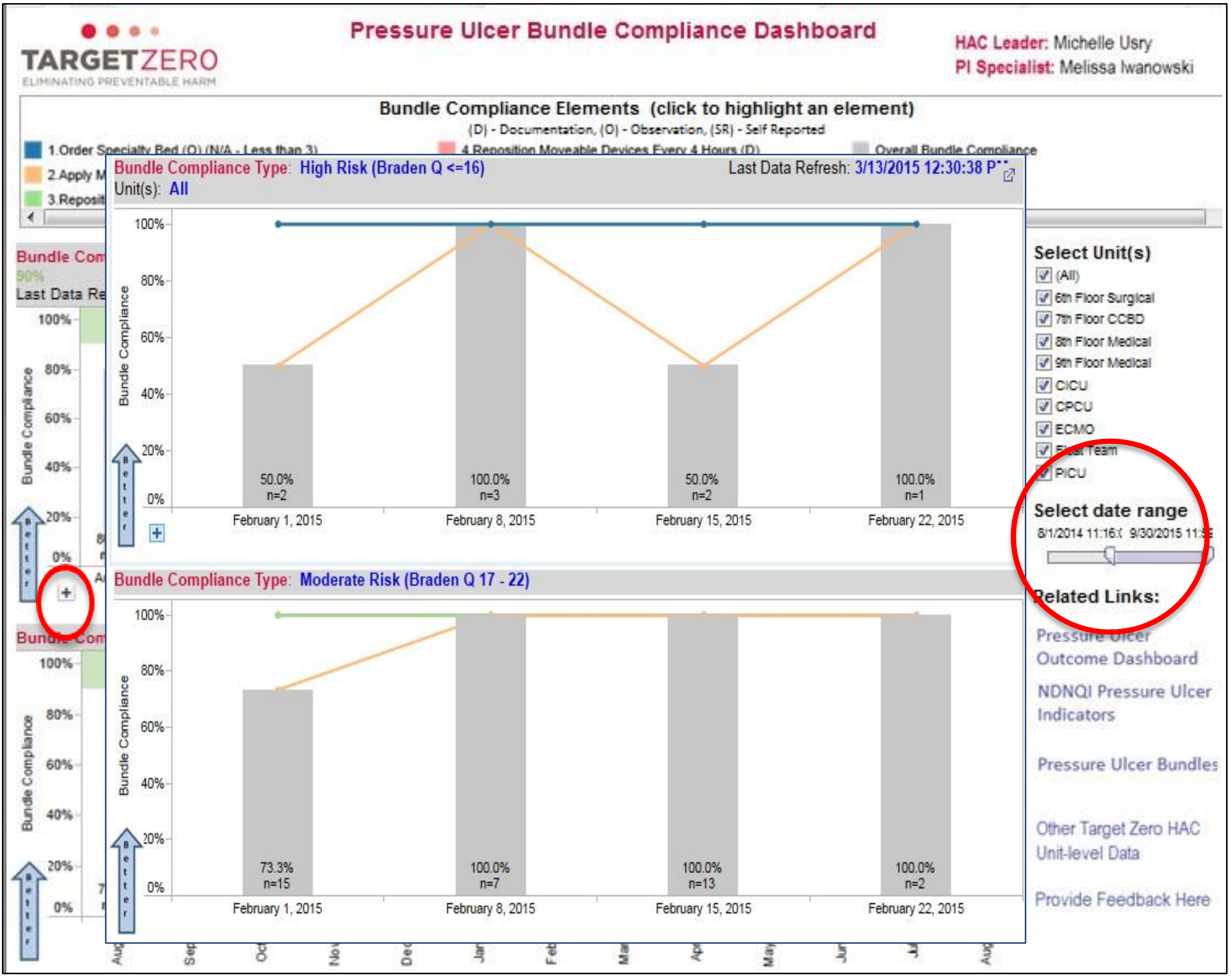

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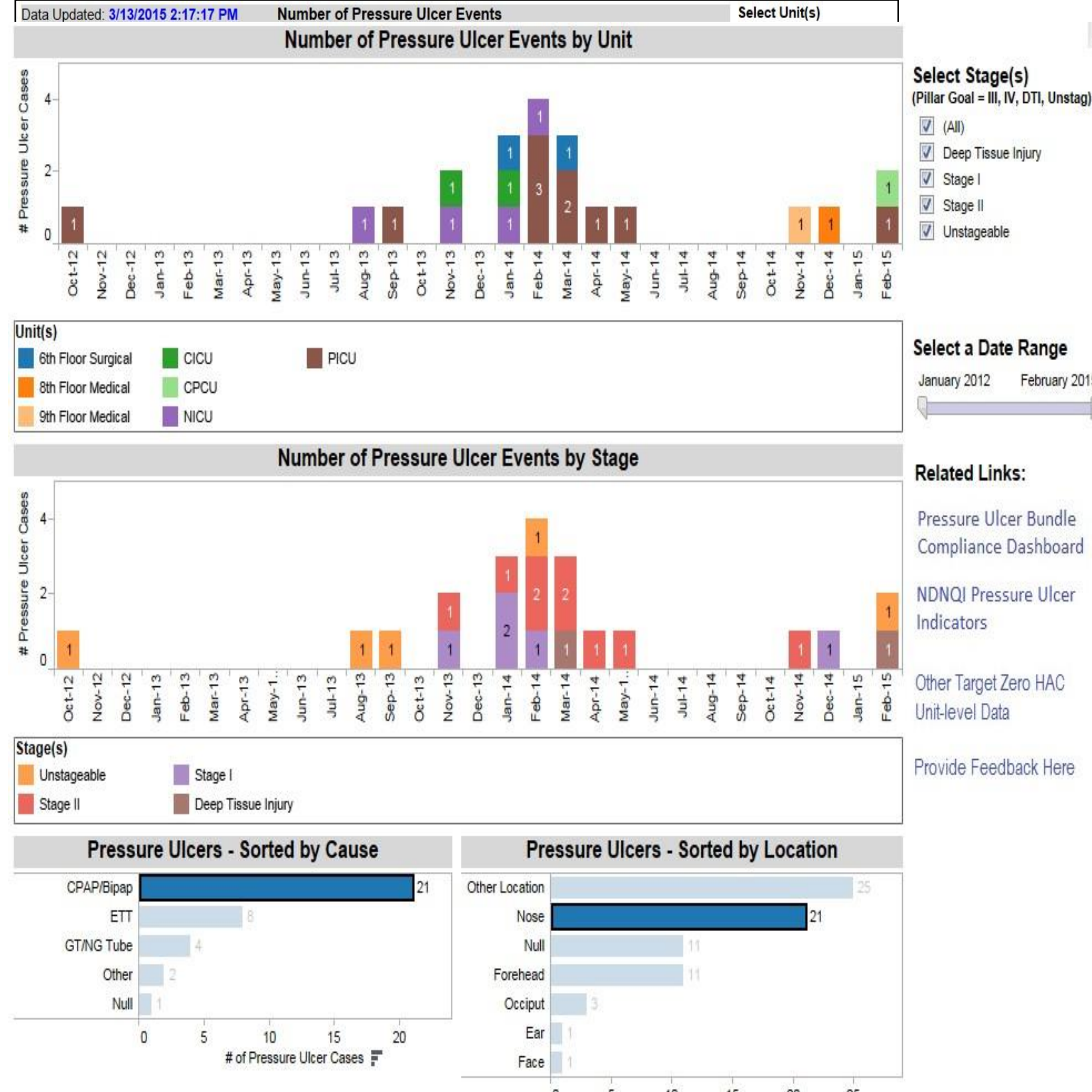
Pressure Ulcer Outcome Dashboard



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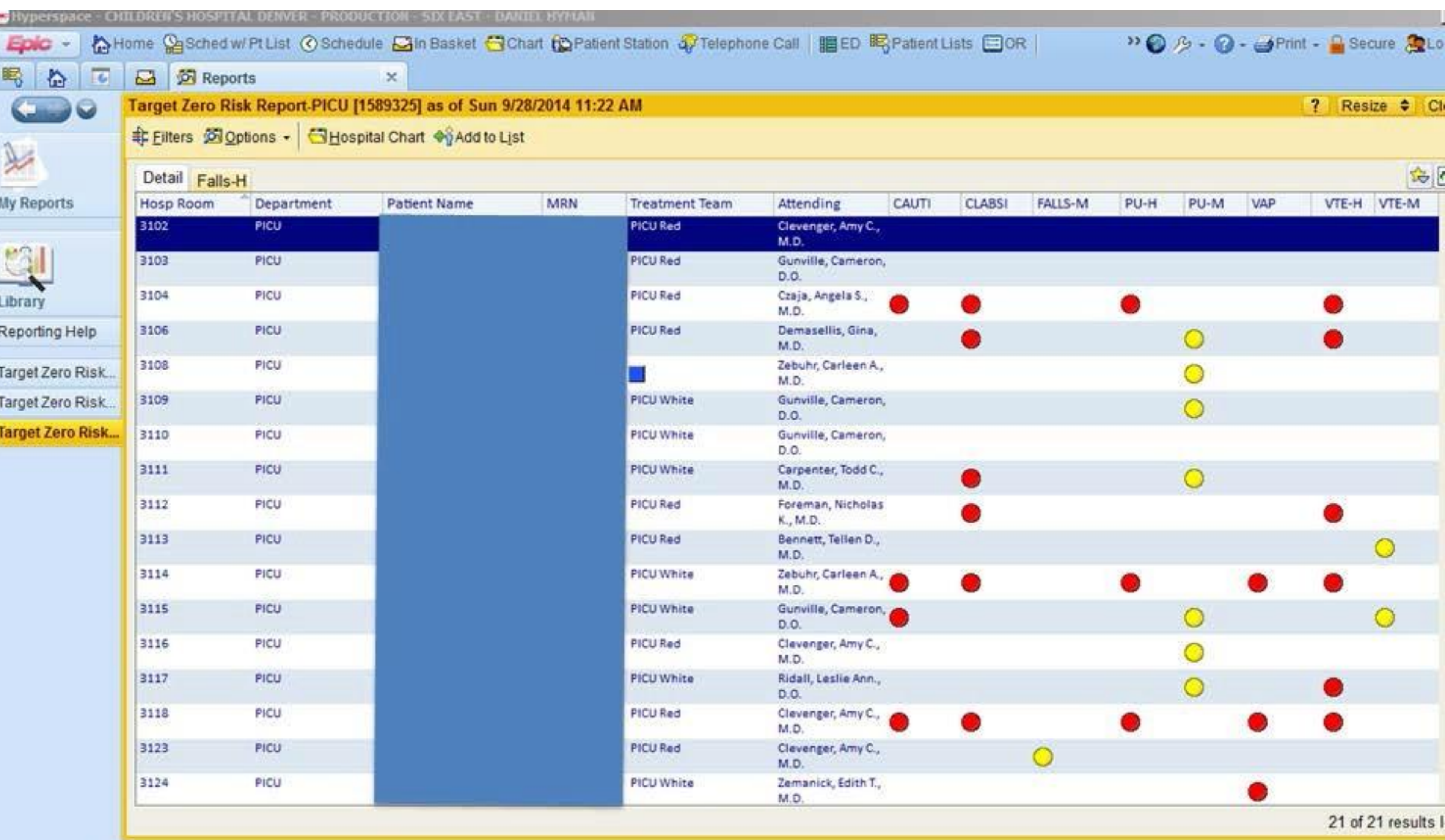
Focused Rounding Reports by Unit



Hosp Room	Department	Patient Name	MRN	Treatment Team	Attending	CAUTI	CLABSI	FALLS-M	PU-H	PU-M	VAP	VTE-H	VTE-M
3102	PICU			PICU Red	Clevenger, Amy C., M.D.								
3103	PICU			PICU Red	Gunville, Cameron, D.O.								
3104	PICU			PICU Red	Czaja, Angela S., M.D.								
3106	PICU			PICU Red	Demasellis, Gina, M.D.								
3108	PICU				Zebuhr, Carleen A., M.D.								
3109	PICU			PICU White	Gunville, Cameron, D.O.								
3110	PICU			PICU White	Gunville, Cameron, D.O.								
3111	PICU			PICU White	Carpenter, Todd C., M.D.								
3112	PICU			PICU Red	Foreman, Nicholas K., M.D.								
3113	PICU			PICU Red	Bennett, Tellen D., M.D.								
3114	PICU			PICU White	Zebuhr, Carleen A., M.D.								
3115	PICU			PICU White	Gunville, Cameron, D.O.								
3116	PICU			PICU Red	Clevenger, Amy C., M.D.								
3117	PICU			PICU White	Ridall, Leslie Ann., D.O.								
3118	PICU			PICU Red	Clevenger, Amy C., M.D.								
3123	PICU			PICU Red	Clevenger, Amy C., M.D.								
3124	PICU			PICU White	Zemanick, Edith T., M.D.								

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Opportunities/What's next
Equity
Effectiveness
High Reliability Organization in practice

Conclusions for us

- Leadership at a board and senior team level is necessary to launch a full scale program to advance patient safety organization wide
- Integrating training of staff and leaders in culture and improvement methods is necessary and enhanced with a strong cause analysis program
- Collaboration is a huge plus- externally and internally
- Family and patient engagement is a huge plus
- After training >7500 staff members over 3 years, we are safer, but not safe enough…. The **Target** is **ZERO**
- The AHA/McKesson prize is a springboard for ongoing improvement

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QUESTIONS?

Daniel Hyman, MD, MMM
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Nationwide Children's Quality and Safety Journey: Evolution of a program

Richard J. Brilli, M.D., F.A.A.P., M.C.C.M.
Chief Medical Officer - Nationwide Children's Hospital
Professor, Pediatrics - Division of Pediatric Critical Care Medicine
The Ohio State University College of Medicine

Nationwide Children’s Hospital

Nationwide Children's Hospital

- 468 beds + 140 off-site beds
- 17,200 inpatient discharges
- 26,200 surgical procedures at 3 sites
- 1.1M total patient visits
- 10,000 employees
- Top 5 freestanding pediatric research programs
- 3 research buildings
- $2.0B Gross patient revenue

Organizational Quality and Safety Strategic Approaches

Institute of Medicine

Quality / Safety Organizational Approach

Safe	Effective	Patient Centered
Timely	Efficient	Equitable
Access	Care Coordination	

Patient/Family Centered Quality Strategic Plan (approved by NCH Hospital Board in 2009)

Keep Us Well	Navigate Our Care	Do Not Harm Me	Heal Me Cure Me	Treat Us w Respect

Brilli et al. Revisiting the Quality Chasm. *Pediatrics 2014. v133:p763*

Patient/Family Centered Quality Strategic Plan

Keep Us Well	Navigate My Care	Do Not Harm Me	Heal Me Cure Me	Treat Me w Respect
Equitable	Timely	Safety	Effective	Patient Centered
Access	Efficient			Equitable
Care Coordinated	Care Coordinated			

Brilli et al. Revisiting the Quality Chasm. *Pediatrics 2014;v133:p763*

Patient/Family Centered Quality Strategic Plan (approved by Hospital Board in 2009)

Keep Us Well	Navigate Our Care	Do Not Harm Me	Heal Me Cure Me	Treat Us w Respect

First Things First

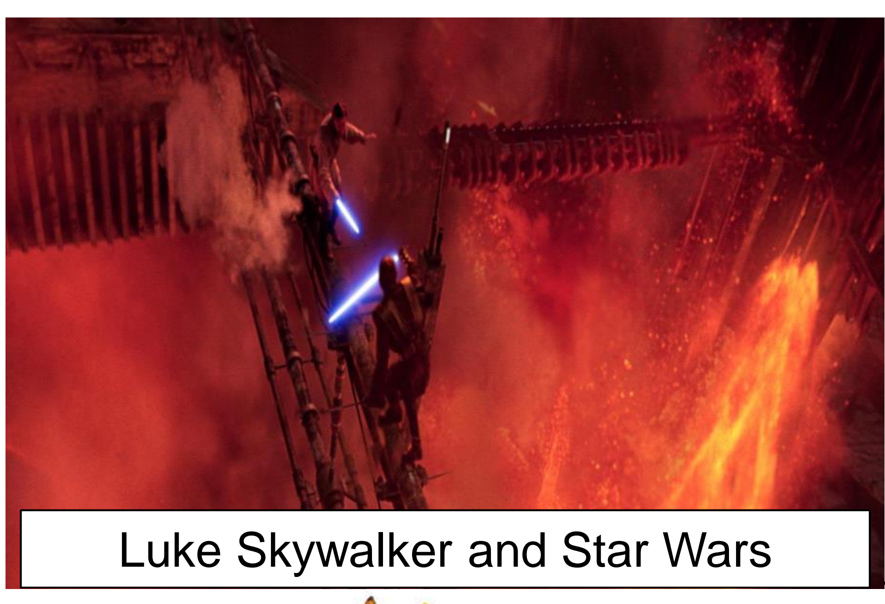
2008-2009 – Safety Program Launched

- Goal: <u>*Eliminate*</u> preventable harm
  - Not an easy sell to the Board
  - Is it really possible? Set up for failure?
  - Aspirational; the only legitimate goal

  - NCH first children's hospital to publically aspire to eliminate preventable harm

NCH Burning Platform

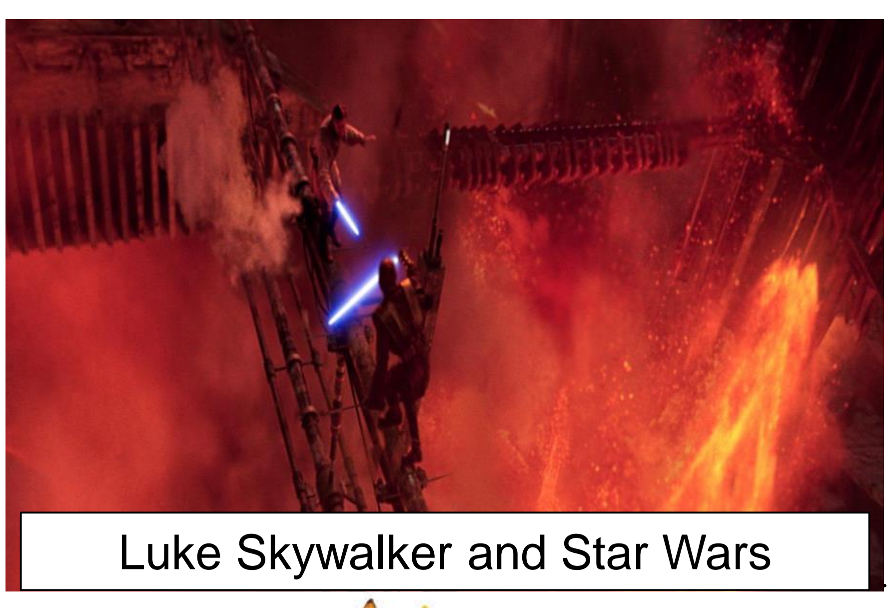
- Dramatic action required
- Inaction not an option


Luke Skywalker and Star Wars

514 Children harmed in 2007

NCH Burning Platform

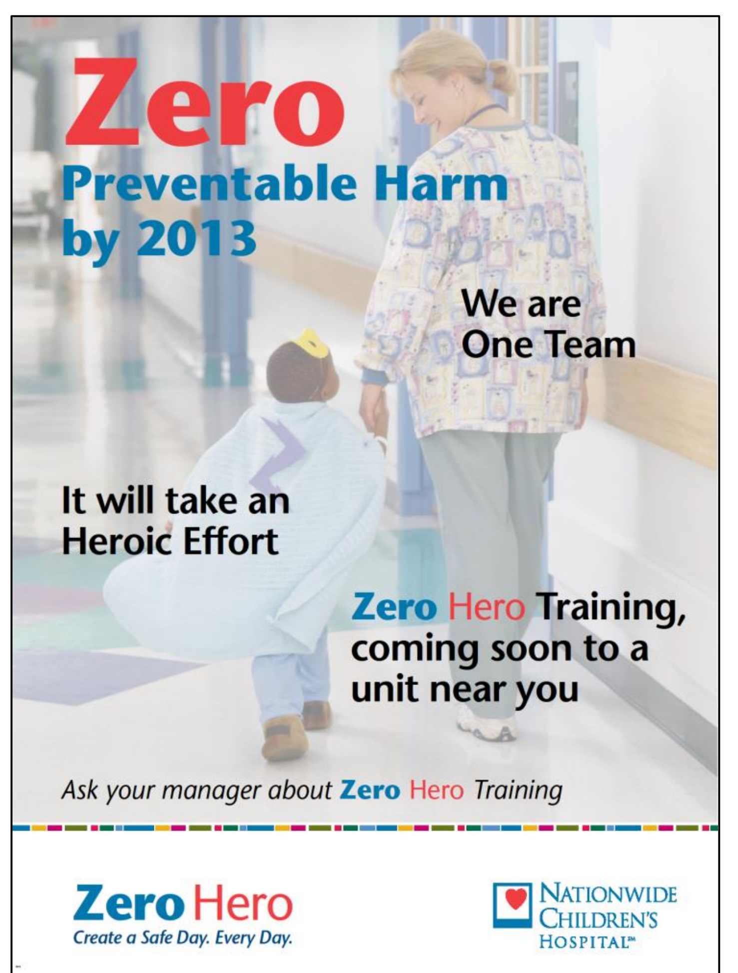
- Dramatic action required
- Inaction not an option

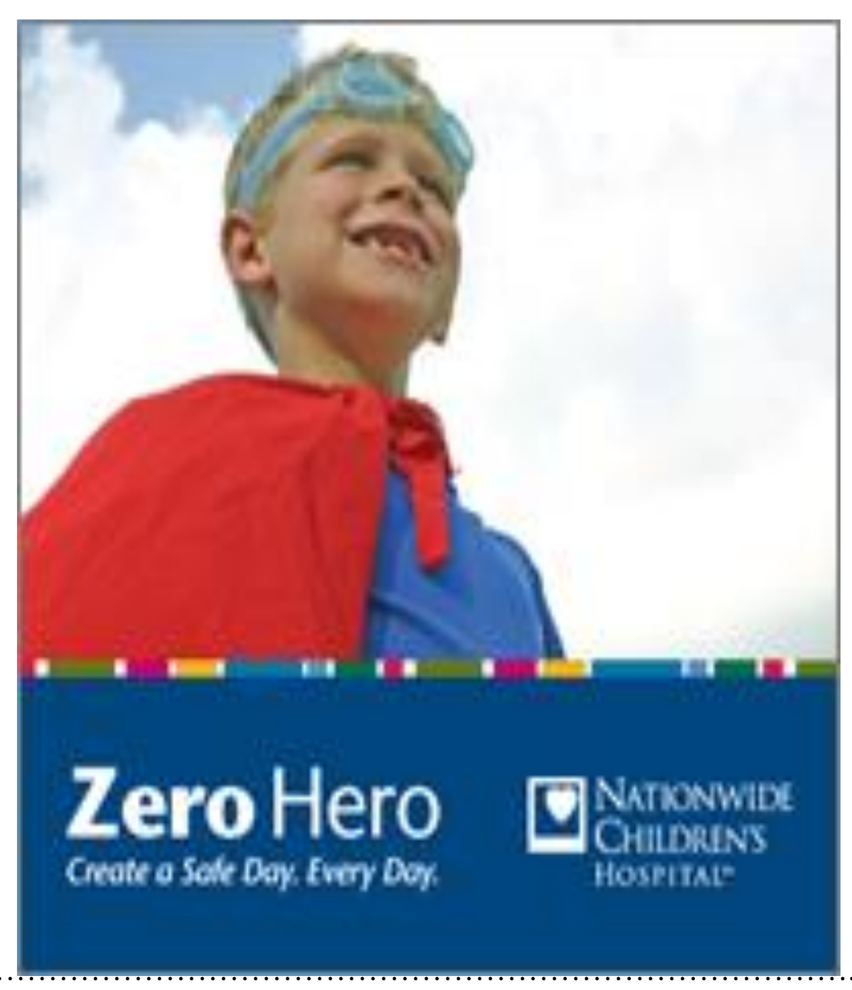


Luke Skywalker and Star Wars

Serious Safety Event every 11 days

Importance of branding





Children's Hospital Colorado

Zero in on Zero Harm

National Children's Medical Center

Cohen Children's Hospital - NYC

Children's Healthcare of Atlanta

Nationwide Children's Hospital

Lucile Packard at Stanford

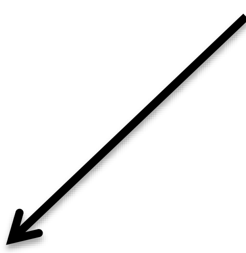
Zero Hero Quality-Safety Program

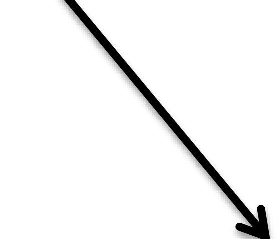
Senior Executives and Board of Directors MUST support the work.

Will fail without their complete buy-in

Zero Hero Quality-Safety Program

Two Prong Approach





System Culture

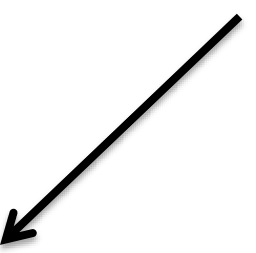
Implement High Reliability Principals (HRO)

Project Work Teams

Standardized Improvement methodology: IHI Model for Improvement

Zero Hero Safety Program

Two Prong Approach



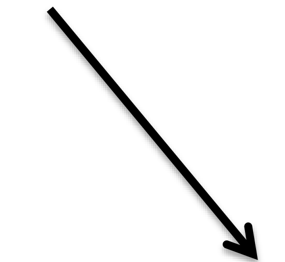
<u>System Culture</u>

Implement High Reliability Principals (HRO)

- All employees trained
- Error prevention for all
- Reinforcement techniques for management
- 40,000 person hours in training
- HRO principals taught/emphasized

Zero Hero Safety Program

Two Prong Approach

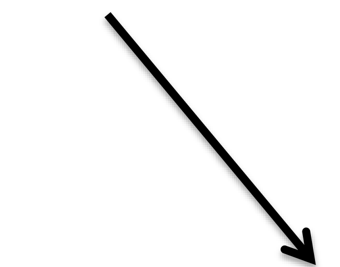


<u>Project Work Teams</u>

Standardized Improvement methodology: IHI Model for Improvement

Zero Hero Safety Program

Two Prong Approach



- ↑QI infrastructure
  - 8 FTE -> 37 FTE
  - $0.7M -> $4M
- Multidisciplinary unit based teams
- 140 active projects
- Physician MOC

<u>Project Work Teams</u>

Standardized Improvement methodology: IHI Model for Improvement

Zero Hero Quality-Safety Program

- Unit Safety Coaches reinforce use of tools
  - Peer to peer, mostly front line coaches
  - 300 active coaches
  - All units, all shifts

Zero Hero Quality-Safety Program

- Unit Safety Coaches reinforce use of tools
  - Peer to peer, mostly front line coaches
  - 300 active coaches
  - All units, all shifts
- Rigorous Root Cause Analysis process
  - Includes all stakeholders – 3 meetings for each event
  - Identifies Individual and System Failures
  - Individuals accountable for solutions w timeline are identified

Inspirational in its simplicity - easily understood

Preventable Harm Index℠	**2016**
Total Hospital Acquired Infections	**n**
Total Adverse Drug Events (4-9)	**n**
ACT Preventable Codes	**n**
Preventable Surgical Complications	**n**
Total Serious Falls	**n**
Hospital Acquired Pressure Ulcers	**n**
Miscellaneous Harm	**n**
Total Serious Safety Events	**n**
Sum of Harm Events	**Sum of n's**

THE JOURNAL OF PEDIATRICS • www.jpeds.com COMMENTARY

The Preventable Harm Index: An Effective Motivator to Facilitate the Drive to Zero

Richard J. Brilli, MD, FAAP, FCCM, Richard E. McClead, Jr., MD, Terrance Davis, MD, Linda Stoverock, RN, MSN, NEA-BC, Anamarie Rayburn, MSPH, CPHQ, and Janet C. Berry, RN, MBA

Nearly a decade ago, the Institute of Medicine's (IOM) report on the state of American Healthcare focused attention on the need to develop systems and processes to improve patient safety in hospitals.[1,2] Although initially debated, it is now generally accepted that preventable medical errors are common and preventable deaths occur.[3,4]

personnel. Furthermore, it suggested that the tool for measuring its success or failure needed to be straightforward and understandable by individuals at all levels in the organization. In other words, the answer to the question, "How will we know when we get there?" demands a metric that is accurate, understandable, and motivational.

Ascension used a "priorities for action" tool consisting of 8

J Pediatr 2010 v157p681

Zero Hero℠
Create a safe day. Every day.

Data Transparency: Internal (INTRAnet)

ANCHOR

access nationwide children's hospital online resources

LOGIN | HELP CENTER | FAVORITE | TEXT | E-MAIL | PRINT

zero hero

Days since last serious safety event 070

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Share Our New Local Commercial
Our latest TV commercial is now airing in Central Ohio and will run through the end of the year. The commercial features authentic voices of our patients encouraging local giving to support lifesaving care and research. Share on Facebook and Twitter using #Give2NCH.

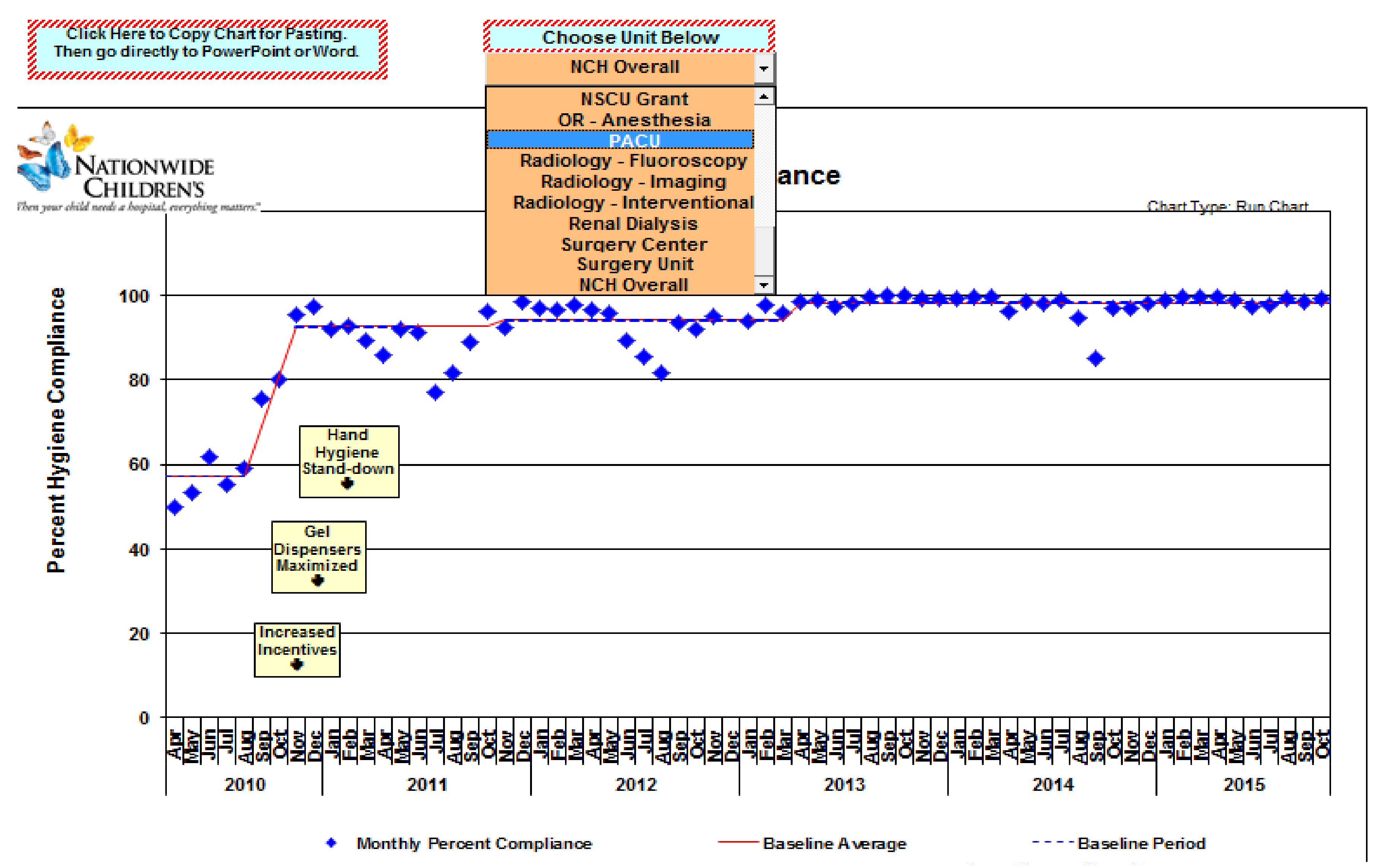
Celebrate Our Veterans
With respect, honor and gratitude, thank you veterans. Join us to celebrate our employees that serve our country by coming to our Veterans Day Celebration on Tuesday, November 10 from noon to 1 p.m. We will also be hosting a Veterans Day job fair on Thursday, November 12 from noon to 3 p.m.

Benefit Open Enrollment is Here
Open Enrollment has begun and will continue through November 25. Click here to view the 2016 benefits details and guide.

6 Things You Need to Know About Code Blue
Code Blue gets used regularly for a variety of reasons, including some reasons you may not expect. Take three minutes to review this list to ensure you are making the best use of calling a Code Blue.

Transparency: Internal (INTRAnet)

Run/Control Charts by unit (e.g. Hand Hygiene compliance)



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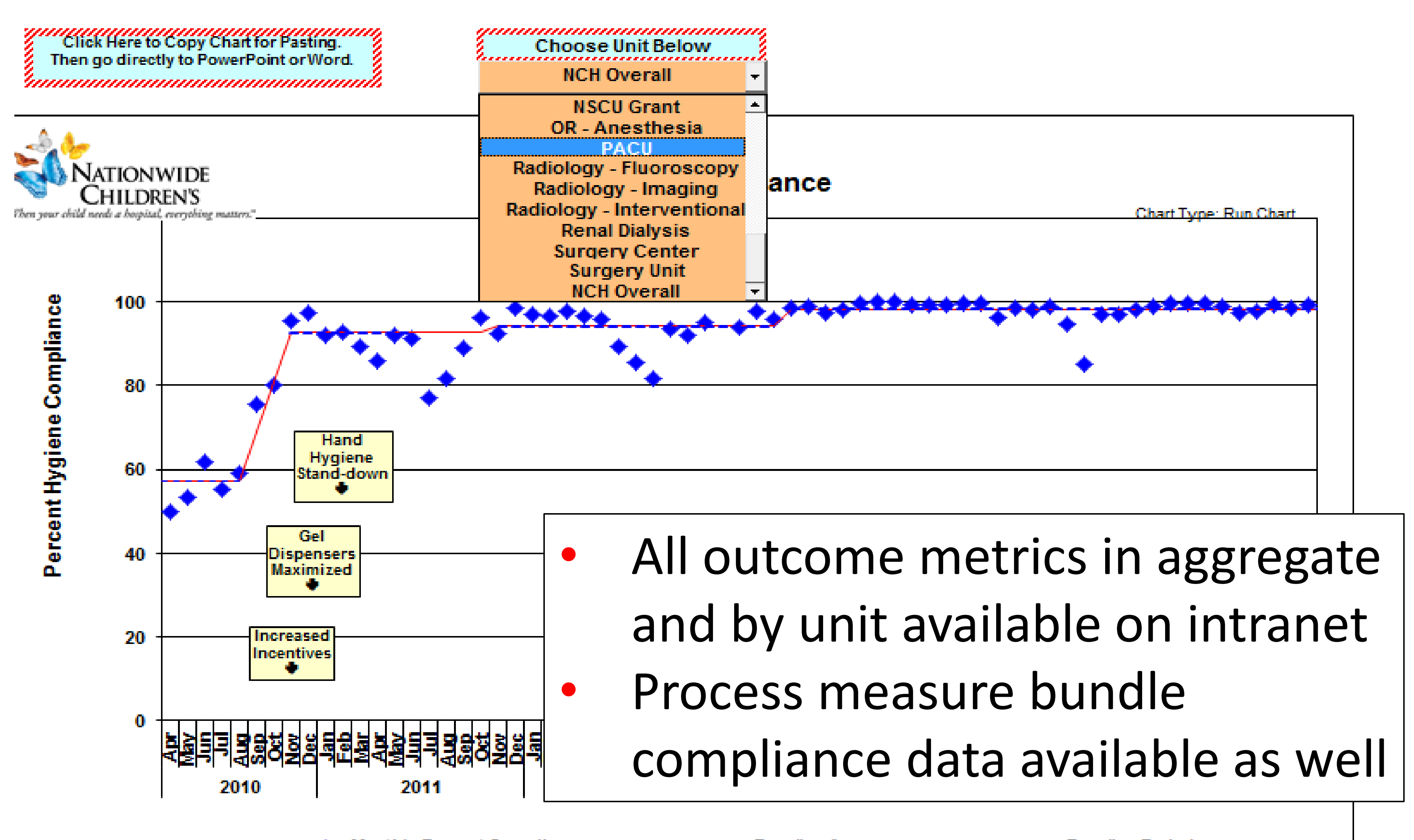


- All outcome metrics in aggregate and by unit available on intranet
- Process measure bundle compliance data available as well

Transparency: External (INTERnet)

Current metrics including Serious Safety Event Rate

How do I read this chart?

Quality & Safety

Do Not Harm Me

- **Adverse Drug Events**
- Surgical Site Infections
- CA-BSI
- Ventilator-Associated Pneumonia
- Hand Hygiene Compliance (Cleaning Hands)
- Serious Safety Event Rate (SSER)

NATIONWIDE CHILDREN'S
When your child needs a hospital, everything matters.

Short-Term Causing Adverse Drug Events
Clinical Severity 4-6

Desired Direction

Chart Type: u-Chart

ADEs per 1,000 Dispensed Doses

0.3
0.25
0.2
0.15
0.1
0.05
0

Q1 Q2 Q3 Q4 2010
Q1 Q2 Q3 Q4 2011
Q1 Q2 Q3 Q4 2012
Q1 Q2 Q3 Q4 2013
Q1 Q2 Q3 Q4 2014
Q1 Q2 Q3 2015

ADEs — Baseline Mean(s) — Baseline Periods — Control Limits

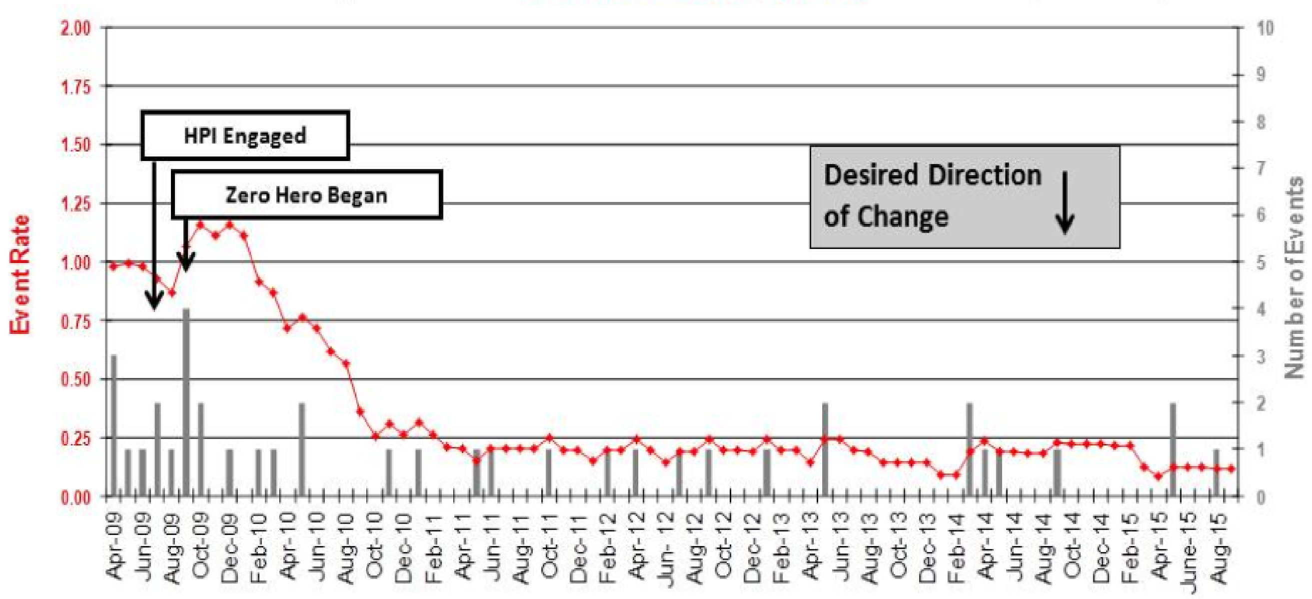
Transparency: External (INTERnet)

Current metrics including Serious Safety Event Rate

Quality & Safety

Do Not Harm Me

- Adverse Drug Events
- Surgical Site Infections
- CA-BSI
- Ventilator-Associated Pneumonia
- Hand Hygiene Compliance (Cleaning Hands)
- **Serious Safety Event Rate (SSER)**



Evolution of Quality/Safety at NCH

Zero Hero Quality Safety Program . . .

- Employee Safety added in 2012
  - Outcome metrics
    - Employee serious safety event rate (eSSER)
    - Employee Preventable Harm Index (ePHI)
    - OSHA metrics tracked and reported but not emphasized

Evolution of Quality/Safety at NCH

Zero Hero Quality Safety Program . . .

- Employee Safety added in 2012
  - Same outcome metrics
    - Employee serious safety event rate (eSSER)
    - Employee Preventable Harm Index (ePHI)
    - OSHA metrics tracked and reported but not emphasized
  - Same HRO behaviors and tools employed to achieve results

Evolution of Quality/Safety at NCH

Expansion to other strategic plan pillars

Keep Us Well	Navigate My Care	Do Not Harm Me	Heal Me Cure Me	Treat Me w Respect

Do Not Harm Me

1. OR MRI safety compliance
2. Anesthesia OR timeout
3. ↓ CLABSIs
4. ↓ CAUTI
5. ↓ VAP
6. ↓ ADEs
7. Post-Op ACTs
8. ↓ immunization ADEs
9. ↓1^0 Care needle sticks
10. ↑ MRI safety protocols
11. ↑ appropriate A1c levels
12. ↑ Acute care clinic vs. ED visits or admits
13. ↓ Emergency transfers
14. ↓ homecare falls
15. ID- antimicrobial stewardship
16. ID - ↓ CT neck for infex
17. ↑ Tb Mask compliance
18. ↓ hemodialysis catheter bacteremia
19. ↑ timely Abx for febrile oncology patients
20. ↓ OR skin injuries
21. ↓ CTs for appendicitis
22. ↑ ENT contact no-shows
23. ↑ airway cx on intubated pts.

Evolution of Quality/Safety at NCH

Active projects in all domains

Keep Us Well

1. PACU pain resolution
2. MRI AED administration
3. Asthma –↓ER visits
4. ↓ childhood obesity
5. ↑ 1^0 care immun rates
6. Improve ADHD Dx/Rx
7. ↑ Adol Med MyChart %
8. Diabetic sick and well day management
9. ↑ new onset diabetes inpatient teaching
10. Improve quality of AVS
11. ↑ depression screening for diabetics
12. ↑ urine screening for microalbumin
13. ↑CHG bath compliance- heme/onc
14. ↑1-2-3 compliance for AML and low counts
15. ↑ flu vaccine-mult svcs
16. ↑ incent spirom in H/O
17.. Standard d/c instrux for abscesses
18. ↑ BMI in CF pts
19. ↑ asthma action plan
20. Standardize d/c instrux for absesses

Navigate My Care

1. Anesthesia- ↓ DOS cancellations and delays
2. ↓ wait time for specialty clinic appts
3. ↓ teen pregnancies
4. ↑ Menactra vaccinations
5. ↓ Endo Clinic LOS
6. Endo – establish young adult transition clinics
7. Inpatient d/c order time – Nephrology
8. ↑ pulmonary clinic access
9. Anesthesia protocol for lap appy cases
10. Improve surgical d/c order and d/c times
11. ↑ simple appendicitis same day discharges
12. ↓ over-triaging for level II traumas
13. ↑ radiology d/c from ED for intussusception
14. ↓ no-show rate in flouro
15. ↓ ED LOS for acuity 4-5 patients
16. ↓ turnaround time in Holter monitor clinic
17. ↑ ACHD xition education

Do Not Harm Me

1. OR MRI safety compliance
2. Anesthesia OR timeout
3. ↓ CLABSIs
4. ↓ CAUTI
5. ↓ VAP
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Heal Me Cure Me

1. ↑MATA program retention
2. Accurate insulin dosing
3. ↑ appropriate Endo consults
4. ↓Cancer Care Index
5. Develop ChemoRX maps
6. O^2 protocol for pneumonia
7. ↓ Chronic Kidney Disease Care Index
8. Develop and ↓ perioperative care index
9. ↓ PICC lines in complex appendicitis
10. ↑ complex appy protocol compliance
11. ↓ total disability days for appendicitis
12. ↓ # of post appy absesses
13. ↑ EtOH and drug screens in adolescent trauma
14. Develop and ↓ Tracheostomy Care Index
15. ↓ CT scans for abdominal pain
16. ↓ time to Abx for sickle cell pts with fever

Treat Me w Respect

1. ↑ 1^0 Care patient satisfaction
2. Direct dial line for interpreter - endo
3. ↑ family centered rounds – multiple svcs
4. New pts seen <14 days- heme onc
5. ↑ nursing presence at rounds – multiple svcs
6. ↑ periop homegoing instruction responses
7. ↑ Press Ganey pain scores on H05
8. Improve ENT phone triage times
9. ↑ Press Ganey scores of 5 for ED visits
10. Streamline d/c process on H11b
11. Improve perception of nurses and doctors – H11b
12. ↑Advance directives for Heart Center patients
13. ↑ use of teach back in cardiac clinic

Improvement Science Training - Essential

“Quality Improvement Essentials” Course

- Build a critical mass of individuals trained in QI Science (Model for Improvement)
- Multi-professional (MD/DO, RN, RT, Administrators)

NATIONWIDE CHILDREN'S
When your child needs a hospital, everything matters.℠

Improvement Science Training - Essential

“Quality Improvement Essentials” Course

- Build a critical mass of individuals trained in QI Science (Model for Improvement)
- Multi-professional (MD/DO, RN, RT, Administrators)
- Increase amount and quality of QI activity
- Increase contributions to the medical literature as well

Steve Allen
Administration
Kelly Kelleher
Research Institute
Terry Davis
Administration
Rick Miller

Evolution of Quality/Safety at NCH

"Quality Improvement Essentials" Course

- 4 month long course
  - 36 hours of didactics
  - Student must initiate and lead a QI project
  - Each students gets 2 mentors and a "QI Tools Coach"

Evolution of Quality/Safety at NCH

<u>"Quality Improvement Essentials" Course</u>

- 4 month long course
  - 36 hours of didactics
  - Student must initiate and lead a QI project
  - Each students gets 2 mentors and a "QI Tools Coach"
- 170 graduates over 9 cycles
- Students coming from other institutions

Quality Improvement Essentials

Participants

Category	Count
Nurses	38
Others	27
Doctors	94

Others:
- Administration
- Pharmacy
- Research
- QIS
- RT, OT, Etc

Zero Hero
Create a safe day. Every day.

Evolution of Quality/Safety at NCH

Some QI Course Outcomes

- Significant improvement in self-assessed competency in multiple QI domains

Evolution of Quality/Safety at NCH

Some QI Course Outcomes

- Significant improvement in self-assessed competency in multiple QI domains
- Increased
  - Presentations outside NCH
  - Publications of their QI work
  - Teaching of QI – internally/externally

Results: NCH peer reviewed QI publications

Number of QI publications

Year	Number of QI publications
2011	6
2012	3
2013	8
2014	35
ytd 2015	26

Evolution of Quality/Safety at NCH

Expansion of the Clinical Care Index Concept

- Overall evaluation of quality of a program (e.g. oncology care) for all patients

Evolution of Quality/Safety at NCH

Expansion of the Care Index Concept

- Overall evaluation of quality of a program (e.g. oncology care) for all patients
- Measures total number of unwanted events during a time frame

Clinical Care Index:

- Compilation of missed opportunities for "optimal care"

Clinical Care Index:

- Compilation of missed opportunities for "optimal care"
  - events that SHOULD have happened (e.g. a test or consult) but did not
  - events that SHOULD NOT have happened (e.g. a hospital acquired infection) but did
- Ultimate goal of "0" missed opportunities

Clinical Care Index:

An approach to:

- Decrease variation (define "optimal care")
- Increase reliability (measure adherence with "optimal care")

. . . for an entire program including the full spectrum of different diseases within the program

Clinical Care Index:

An approach to:

- Decrease variation (define “optimal care”)
- Increase reliability (measure adherence with “optimal care”)

. . . for an entire program including the full spectrum of different diseases within the program

The Cancer Care Index (CCI)

CCI: 15 Domains in 3 areas

- Optimal Diagnosis and treatment (6 domains)
  - e.g. Accurate measure of height and weight
  - e.g. Fertility discussion when appropriate
- Freedom from harm (5 domains)
  - e.g. No hospital acquired infections
- Psychosocial Support (4 domains)
  - e.g. Referrals to Psychology and social work

CCI: key elements

- Lower number = better care
- Baseline year – 2012
  - Harm events 60
  - Missed opportunities 218
  - Total CCI 278
- We were not as good as we thought we were!

Cancer Care Index 2012 – 2014

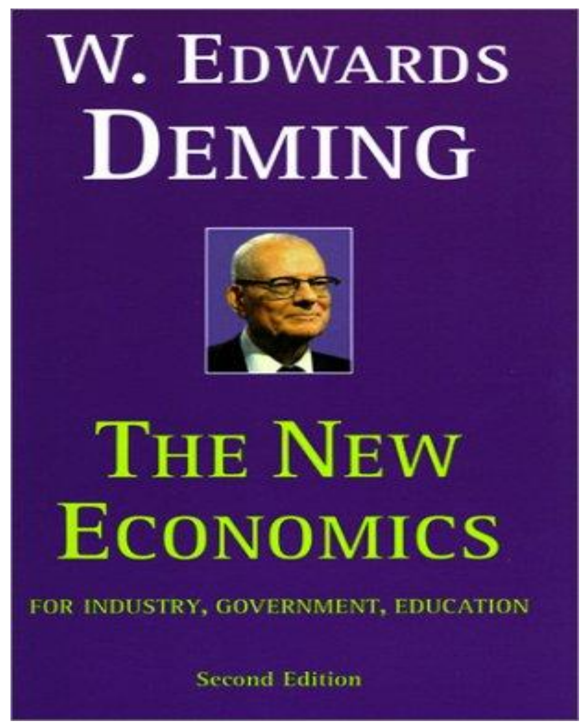
69% reduction over 3 years

Manuscript accepted pending revisions; *J Pat Safety*

Year	Cancer Care Index
2012	278
2103	195
2104	160
2015-projected	87

Other indices under development

- Perioperative Care Index
- Chronic Kidney Disease Index
- Tracheostomy Care Index
- Transplant Care Index
- Bone Marrow Transplant Index



"In God we trust, all others bring data."

W. Edwards Deming

Safety Attitudes Questionnaire '09-'15

82
80
78
76
74
72
70
68
66

Safety Climate
Teamwork Climate

72*
71
75*
72
79
73
80*
75

2009
2011
2013
2015

*p<0.05 compared to '09 and '11

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Copyedited by: Jay Bagcal

J Patient Saf 2015; in press

ORIGINAL ARTICLE

Improved Safety Culture and Teamwork Climate Are Associated With Decreases in Patient Harm and Hospital Mortality Across a Hospital System

*Janet C. Berry, DNP, RN, MBA,**†‡ John Terrance Davis, MD,‡§ Thomas Bartman, MD, PhD,‡||¶ Cindy C. Hafer, MBA, MHA, CPHQ,‡ Lindsay M. Lieb, BSH,‡ Nadeem Khan, MD,** and Richard J. Brilli, MD, FAAP, MCCM‡§¶***

Objectives: Improved safety and teamwork culture has been associated with decreased patient harm within specific units in hospitals or hospital groups. Most studies have focused on a specific harm type. This study's ob-

in 2009. Before our study, SAQ results of culture change had only been reported in specific unit types (e.g., intensive care unit) in multiple institutions.[12] Furthermore, safety outcome metrics in

Serious Harm by Quarter

65% decrease from peak;
$p<0.001$

Number of Events (0–80)

Zero Hero Began (Q4 2009)

Quarter	Number of Events
Q1 2009	61
Q2 2009	53
Q3 2009	70
Q4 2009	71
Q1 2010	58
Q2 2010	62
Q3 2010	58
Q4 2010	35
Q1 2011	46
Q2 2011	34
Q3 2011	46
Q4 2011	30
Q1 2012	27
Q2 2012	24
Q3 2012	40
Q4 2012	18
Q1 2013	16
Q2 2013	33
Q3 2013	21
Q4 2013	17
Q1 2014	31
Q2 2014	23
Q3 2014	22
Q4 2014	21
Q1 2015	21
Q2 2015	32
Q3 2015	27

Removes the minor medication errors and pressure ulcers

Serious Safety Event Rate

12-Month Rolling Average

NCH experiences a Serious Safety Event once every 122 days

Zero Hero Program

2009 baseline

118 Fewer SSEs Than 2009 Baseline Would Have Produced.

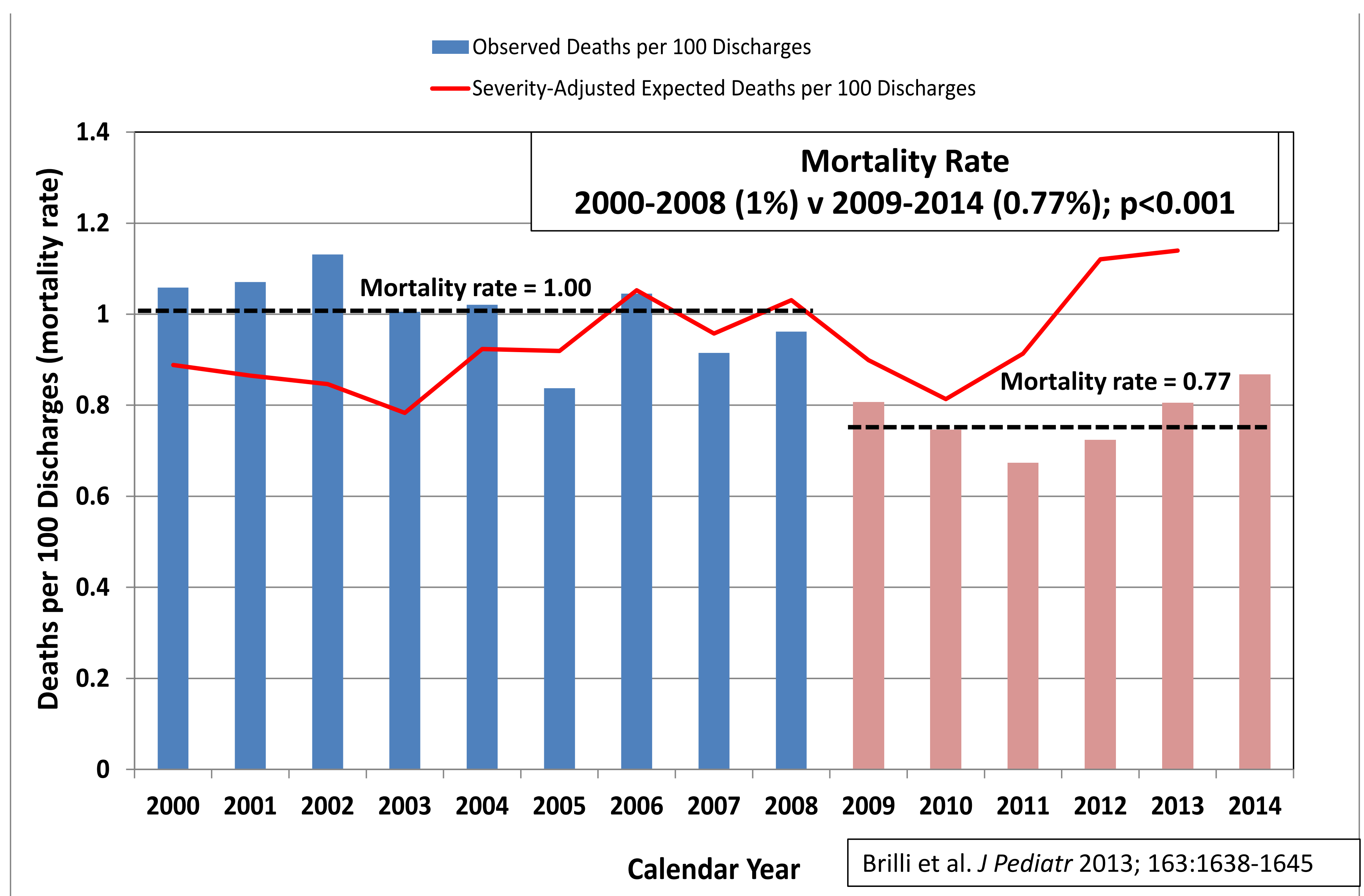
SSEs per 10,000 Adj Patient Days: 0.0, 0.2, 0.4, 0.6, 0.8, 1.0, 1.2, 1.4

Number of Events: 0, 1, 2, 3, 4, 5, 6

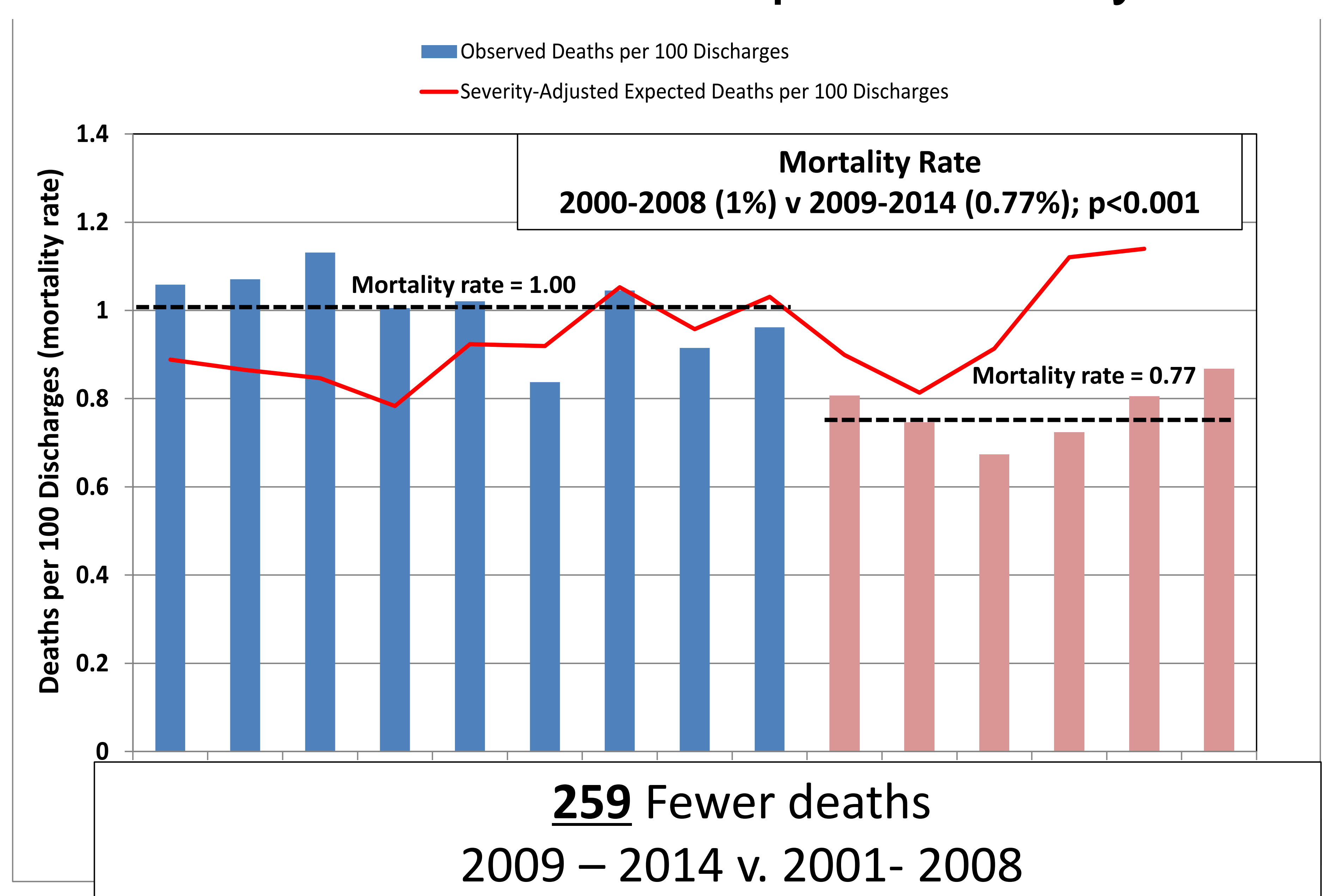
2009: Jan, Mar, May, Jul, Sep, Nov
2010: Jan, Mar, May, Jul, Sep, Nov
2011: Jan, Mar, May, Jul, Sep, Nov
2012: Jan, Mar, May, Jul, Sep, Nov
2013: Jan, Mar, May, Jul, Sep, Nov
2014: Jan, Mar, May, July, Sept, Nov
2015: Jan, Mar, May, July, Sept

Lowest SSER since inception of ZH Program

Results: Overall Hospital Mortality



Results: Overall Hospital Mortality



ORIGINAL ARTICLES

The JOURNAL of PEDIATRICS

A Comprehensive Patient Safety Program Can Significantly Reduce Preventable Harm, Associated Costs, and Hospital Mortality

Richard J. Brilli, MD, FAAP, FCCM[1,2], Richard E. McClead, Jr., MD[1,2], Wallace V. Crandall, MD[1,2], Linda Stoverock, RN, MSN, NEA-BC[3], Janet C. Berry, RN, MBA[3], T. Arthur Wheeler, MS, MSES, MBA[1], and J. Terrance Davis, MD[1]

Objective To evaluate the effectiveness of a hospital-wide initiative to improve patient safety by implementing high-reliability practices as part of a quality improvement (QI) program aimed at reducing all preventable harm.

Study design A hospital wide quasi-experimental time series QI initiative using high-reliability concepts, microsystem-based multidisciplinary teams, and QI science tools to reduce hospital acquired harm was implemented. Extensive error prevention training was provided for all employees. Change concepts were enacted using the Institute for Healthcare Improvement's Model for Improvement. Compliance with change packages was measured.

Results Between 2010 and 2012, the serious safety event rate decreased from 1.15 events to 0.19 event per 10 000 adjusted hospital-days, an 83.3% reduction (P < .001). Preventable harm events decreased by 53%, from a quarterly peak of 150 in the first quarter of 2010 to 71 in the fourth quarter of 2012 (P < .01). Observed hospital mortality decreased from 1.0% to 0.75% (P < .001), although severity-adjusted expected mortality actually increased slightly, and estimated harm-related hospital costs decreased by 22.0%. Hospital-wide safety climate scores increased significantly.

Conclusion Substantial reductions in serious safety event rate, preventable harm, hospital mortality, and cost were seen after implementation of our multifaceted approach. Measurable improvements in the safety culture were noted as well. *(J Pediatr 2013;163:1638-45)*.

What's next?

- Fellowship in Pediatric Quality and Safety
  - Includes Masters in Business Operational Excellence (OSU)
  - Commences July 2016

What's next?

- Fellowship in Pediatric Quality and Safety
  - Includes Masters in Business Operational Excellence (OSU)
  - Commences July 2016
- *Journal of Pediatric Quality and Safety (PQS)*
  - First pediatric specific journal focusing on Quality and Safety
  - 54 editors and associate editors
  - Volume 1, Issue 1 Q1 2016

……. …….

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