Parkview's Culture of Safety Journey: Improving Risk Event Reporting

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Parkview Health

PARKVIEW

Objectives

- Understand
  - Parkview and the PH RM team
  - Why PH decided this was important
  - How we increased event reporting volume
  - How we sustained
  - How we use our reporting data
  - Next steps

About Me

- Nurse for 18 years
- Risk Management 12 years
- Parkview 5 years

PARKVIEW HEALTH

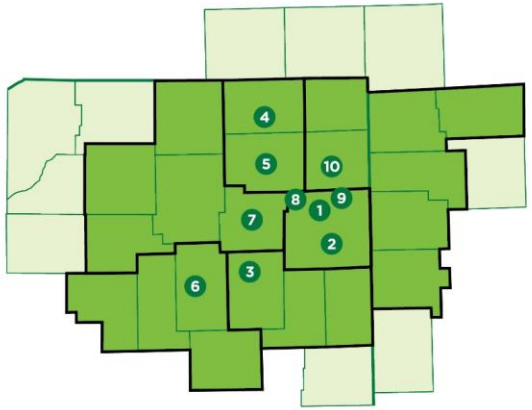
Not-for-profit community healthcare system serving northeast Indiana and northwest Ohio

Parkview Health System was incorporated in May 1995

15,000+
co-workers

1,200+ employed physicians and advanced practice providers

$2.6 billion
Annual revenues



22 counties
in northeast Indiana and northwest Ohio

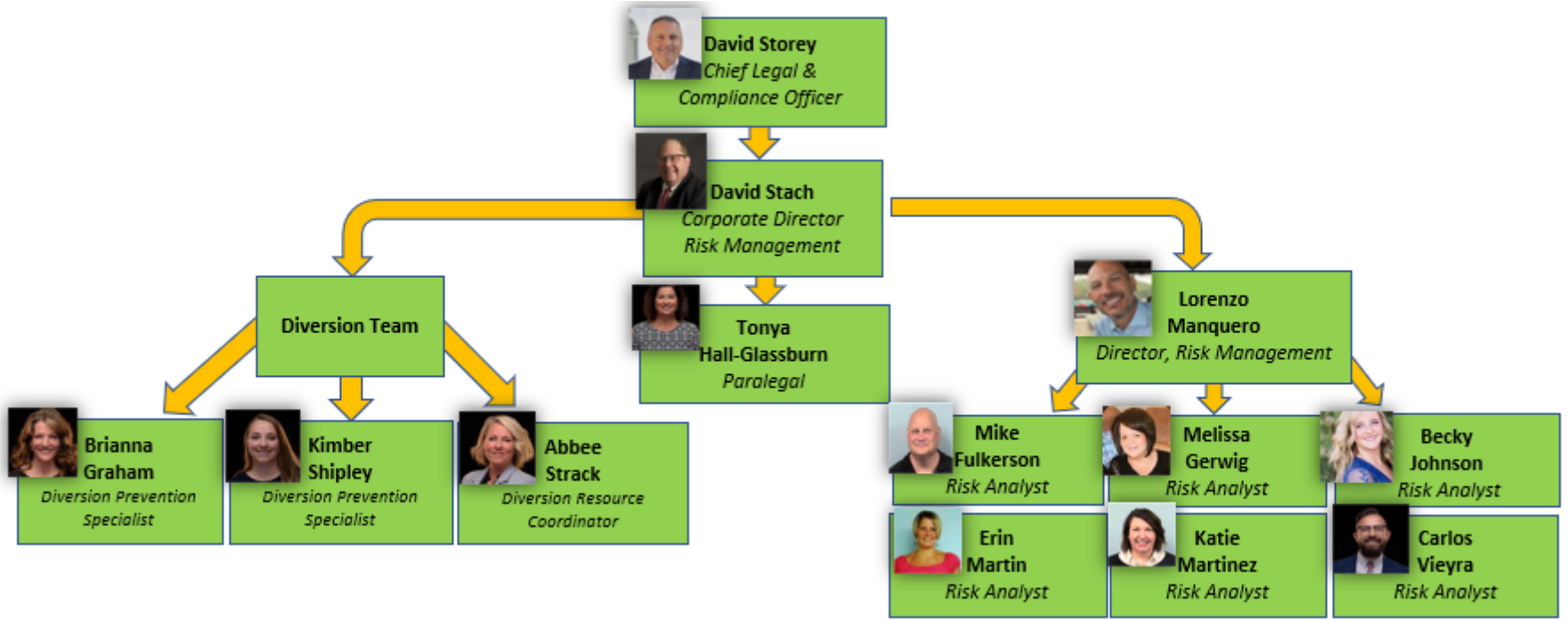
10 hospitals
1095 total beds
(data does not include Parkview Warsaw)

Service area population

1.36M

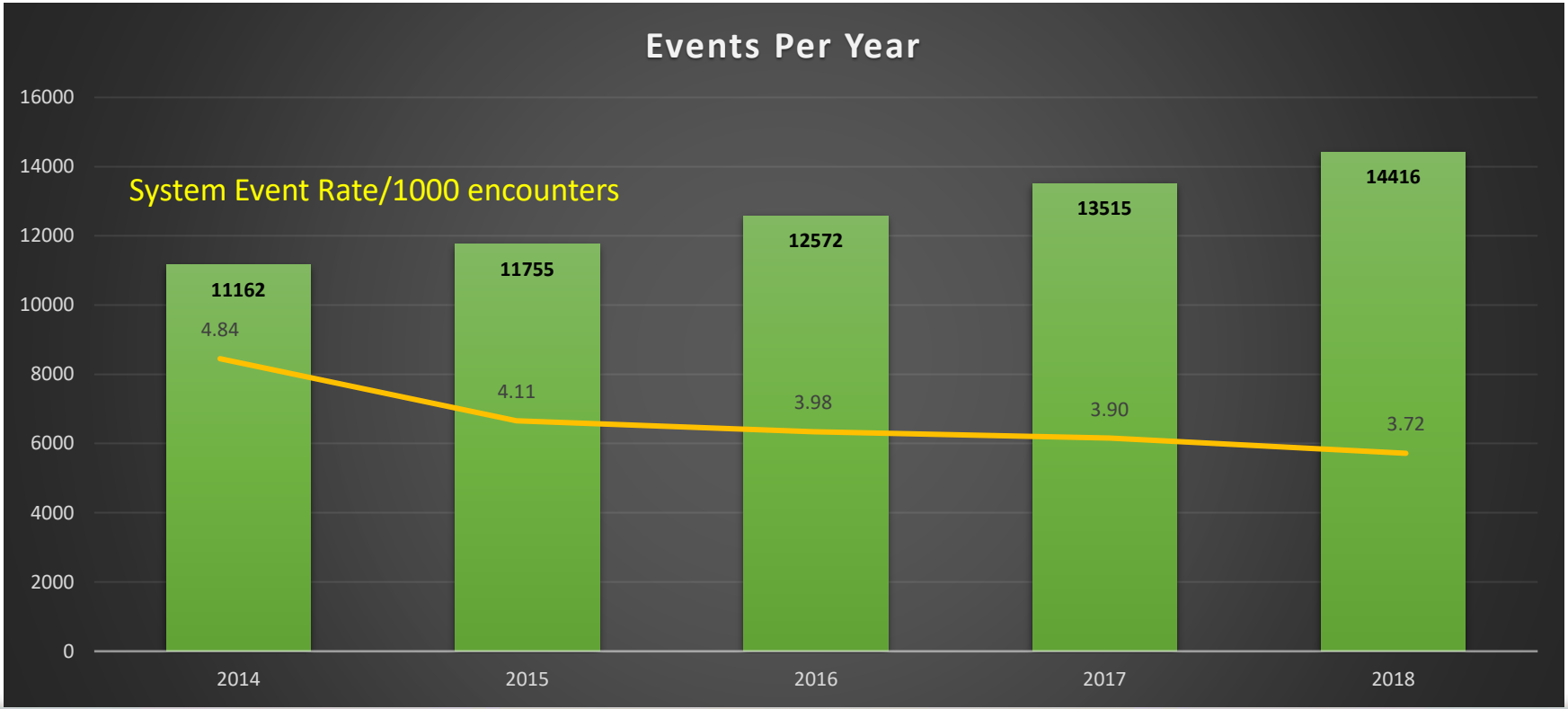
3,600,000+
Patient encounters

Parkview Health Risk Management



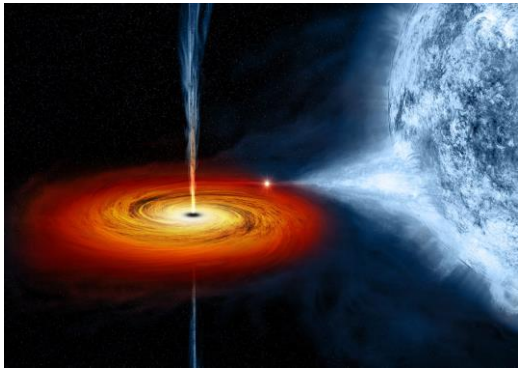
Why Was This Important?

Understanding the Data



Be Curious


現場
GEMBA
OBSERVE
RECOGNIZE
COMMUNICATE
COOPERATE
SOLVE THE PROBLEM
WALK

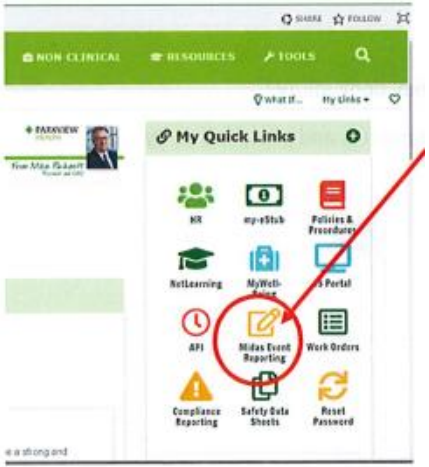


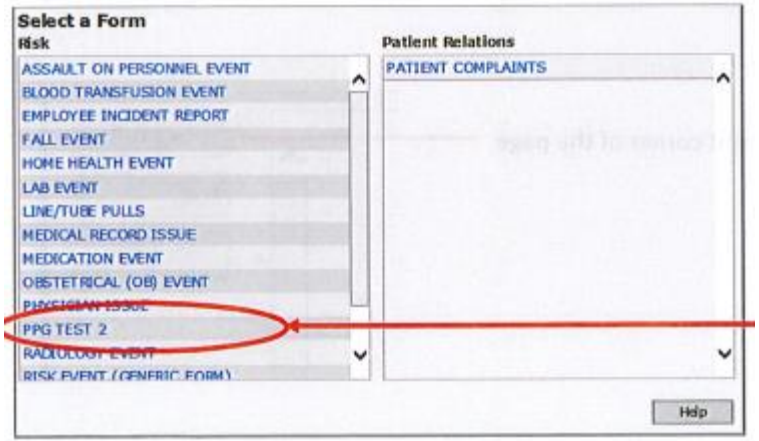

DIFFICULT


Punitive


TOO MANY CHOICES
TOO MANY OPTIONS
imgflip.com

Validate the Concerns

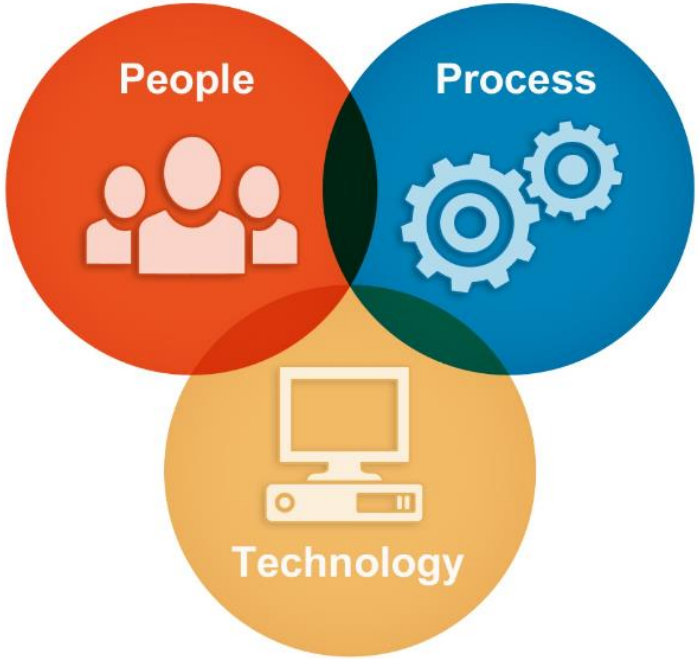




Process Flow:

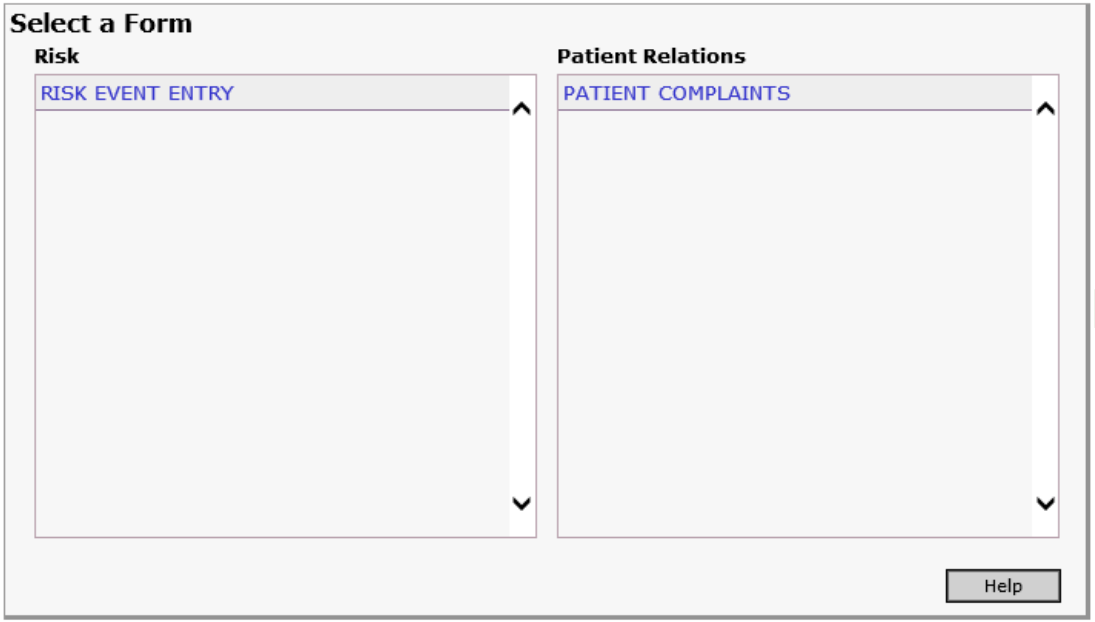
Open Sharepoint →	Click on Midas Icon →	Select the type of event →
Select facility, date, & affected →	Enter patient/non patient ID →	Enter time event occurred →
Enter where event occurred →	Enter witnesses →	Enter provider witness →
Enter event type →	Enter contributing factors →	Type what happened →
Answer who should review →	Enter physician notified →	Enter your name, click submit →

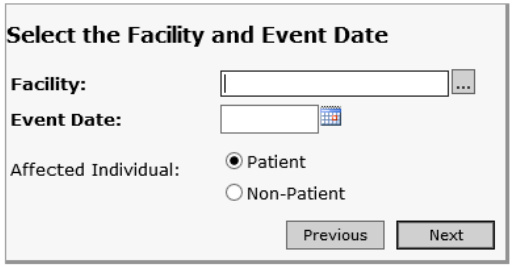
Which Problem?



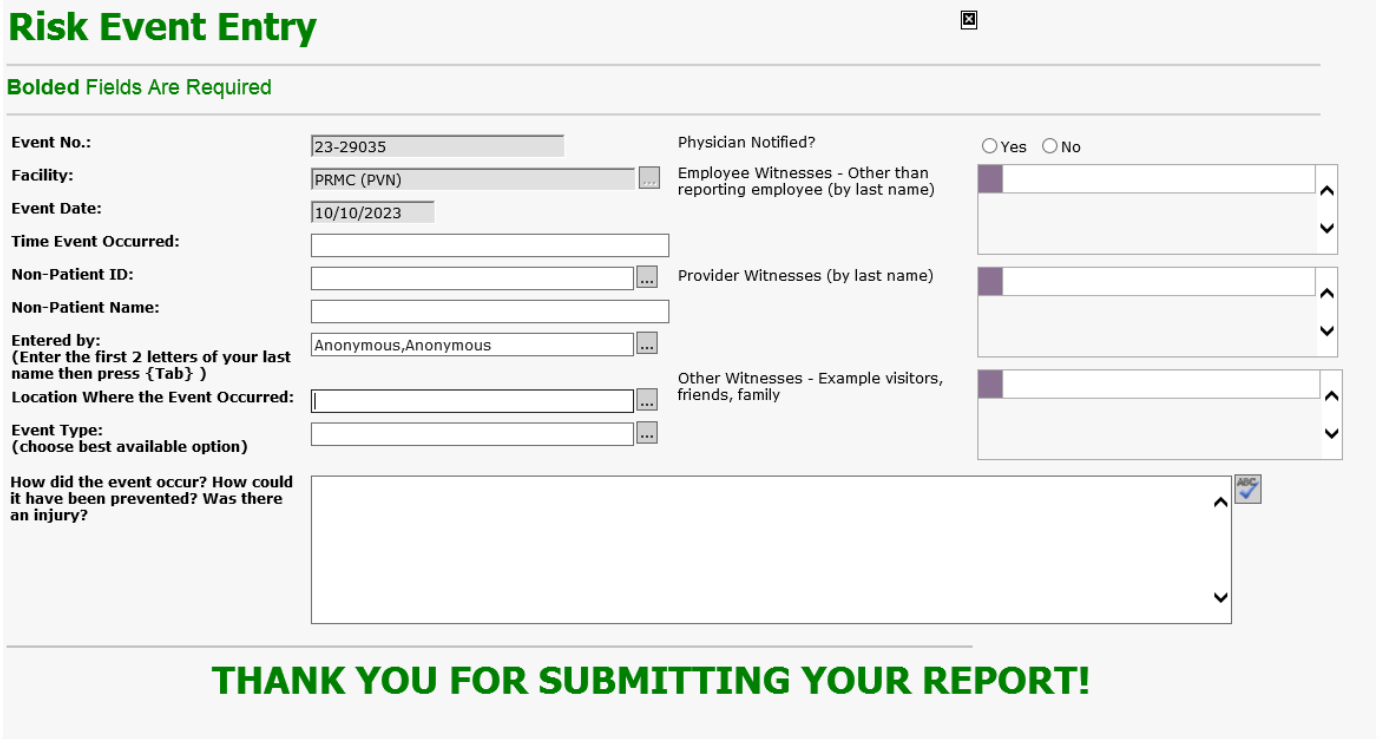
How We Increased Reporting

Simplify


Select a Form
Risk
RISK EVENT ENTRY
Patient Relations
PATIENT COMPLAINTS
Help


Select the Facility and Event Date
Facility:
Event Date:
Affected Individual:
Patient
Non-Patient
Previous
Next

Eliminate Waste



Risk Event Entry

Bolded Fields Are Required

Event No.: 23-29035

Facility: PRMC (PVN)

Event Date: 10/10/2023

Time Event Occurred:

Non-Patient ID:

Non-Patient Name:

Entered by:
(Enter the first 2 letters of your last name then press {Tab}) Anonymous,Anonymous

Location Where the Event Occurred:

Event Type:
(choose best available option)

How did the event occur? How could it have been prevented? Was there an injury?

Physician Notified? ○ Yes ○ No

Employee Witnesses - Other than reporting employee (by last name)

Provider Witnesses (by last name)

Other Witnesses - Example visitors, friends, family

THANK YOU FOR SUBMITTING YOUR REPORT!

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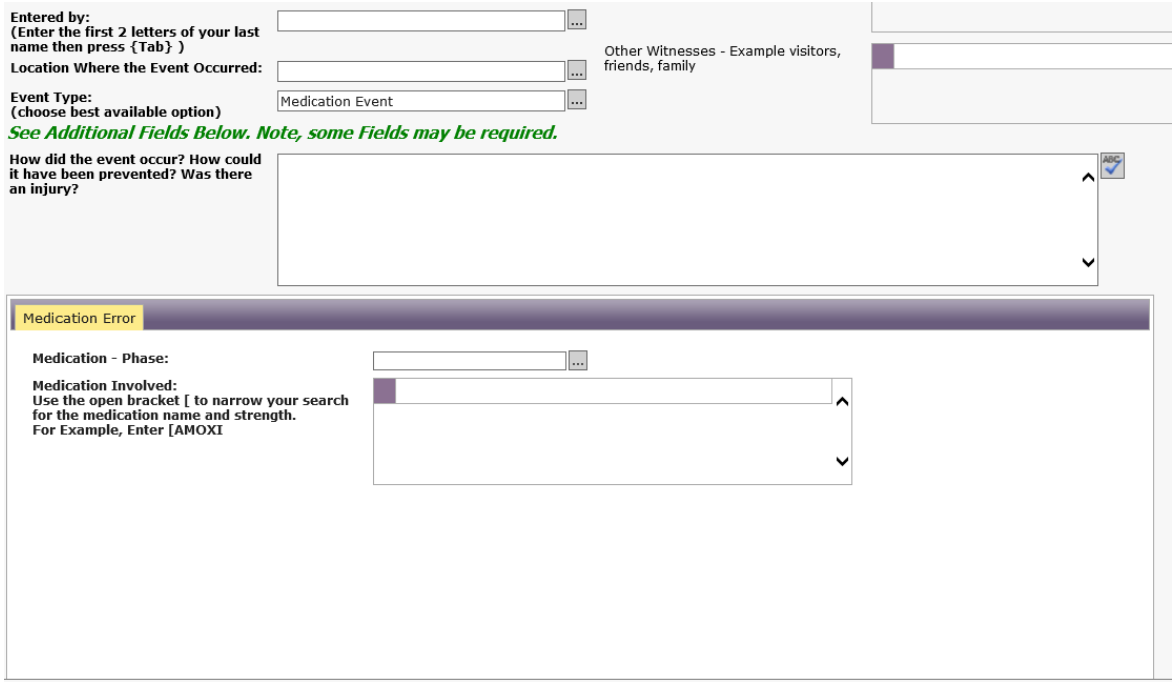
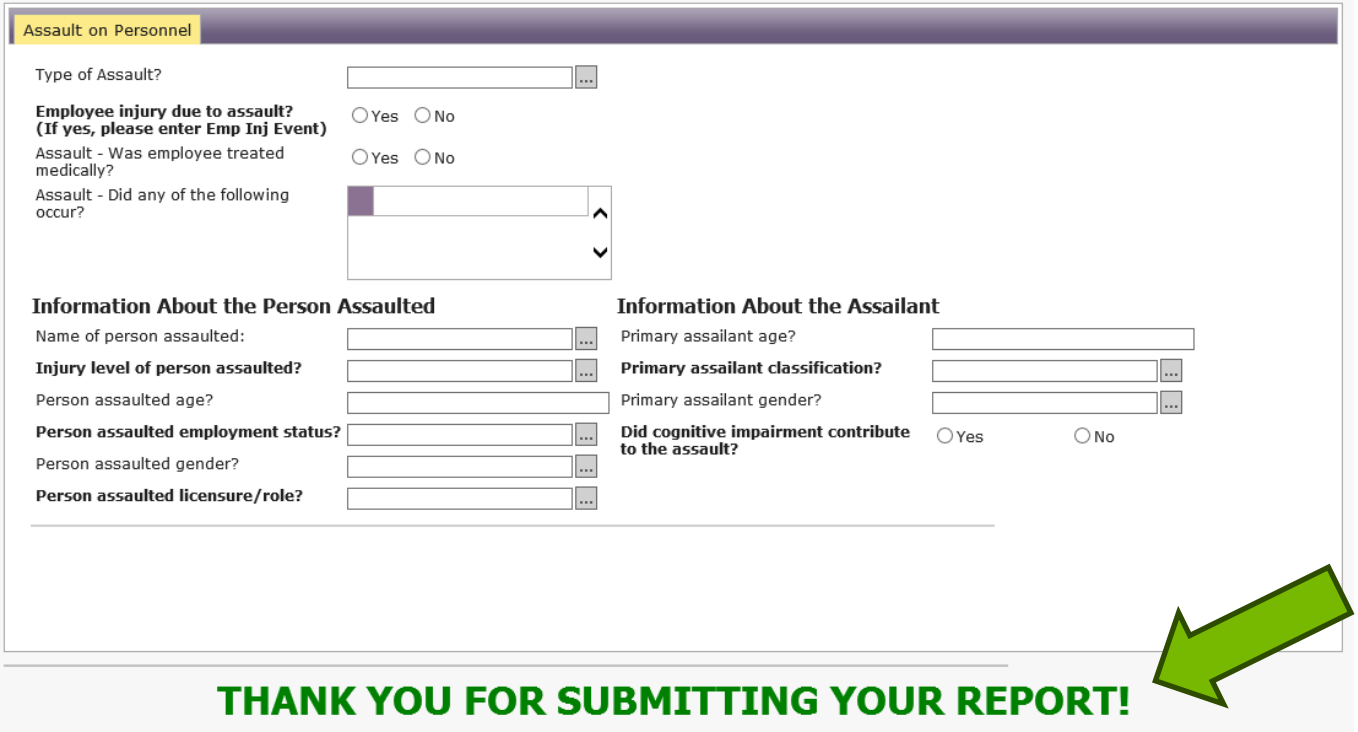
Use Logic


Entered by:
(Enter the first 2 letters of your last name then press {Tab})
Location Where the Event Occurred:
Event Type:
(choose best available option)
Medication Event
Other Witnesses - Example visitors, friends, family
See Additional Fields Below. Note, some Fields may be required.
How did the event occur? How could it have been prevented? Was there an injury?
Medication Error
Medication - Phase:
Medication Involved:
Use the open bracket [to narrow your search for the medication name and strength.
For Example, Enter [AMOXI

Show Gratitude



Set Expectations

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2019 Goal:

- Increase event reporting volume by 18.6%

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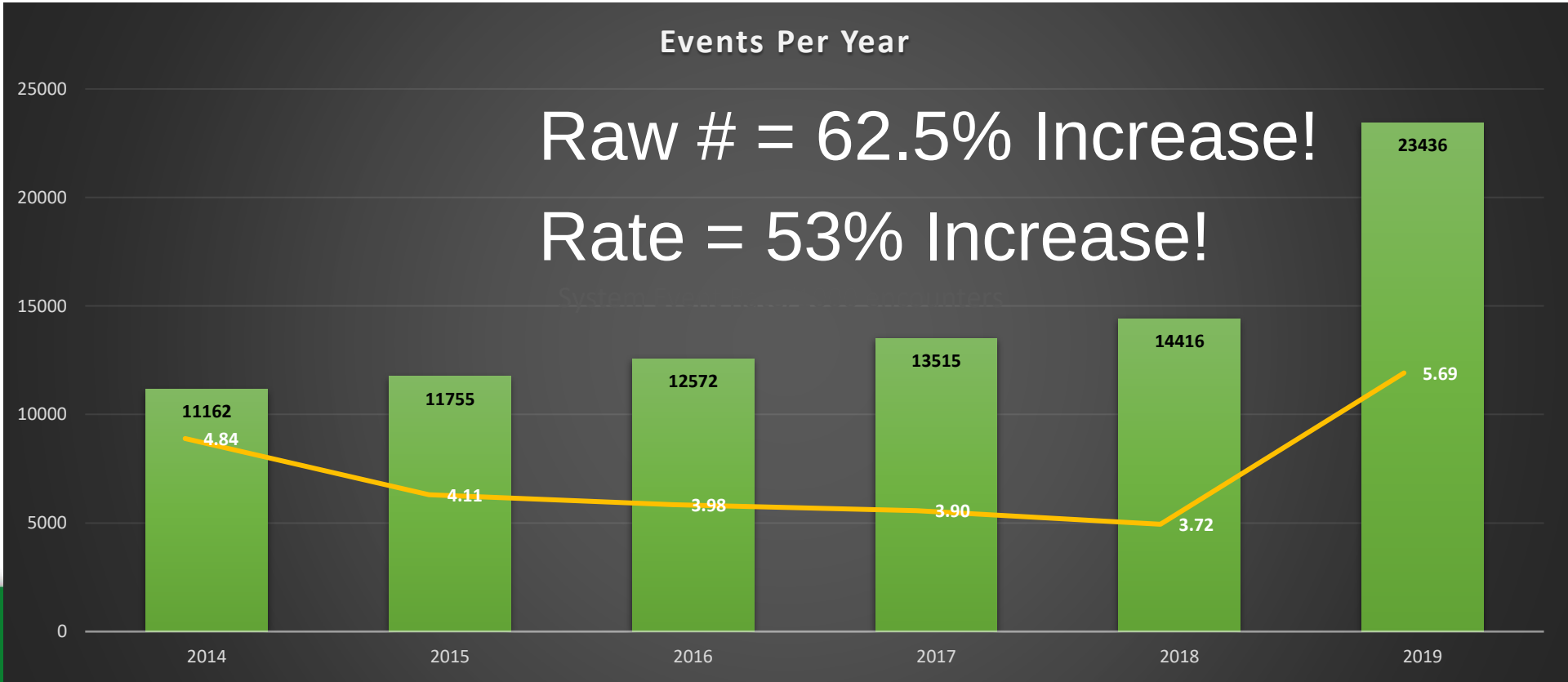
PARKVIEW

Results

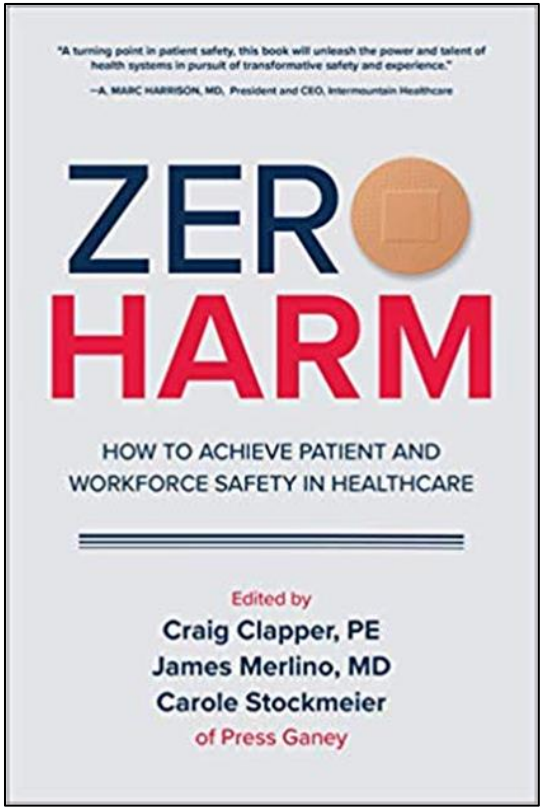

Events Per Year
Raw # = 62.5% Increase!
Rate = 53% Increase!
25000
20000
15000
10000
5000
0
11162
11755
12572
13515
14416
23436
4.84
4.11
3.98
3.90
3.72
5.69
2014
2015
2016
2017
2018
2019

Sustaining the Gain

Address the Culture

Safety Culture Imperatives

- Part of a compelling vision for **high reliability**
- Built on **trust, dignity & respect** for each other
- **Patient and workforce safety** as a core value
- Empowers staff to **speak-up** and report errors, near misses, and recognize unsafe behaviors and conditions
- **Fair and just** system balancing learning with accountability when assessing errors and system flaws



De-Stigmatize Error

Instructions: Pay attention to the written and spoken conversation.

Humans are Fallible

To Err is Human https://www.nap.edu/read/9728/chapter/2

- Report issues in 1999 by the U.S. Institute of Medicine
  - 44,000-98,000 people die each year as a result of PREVENTABLE medical error

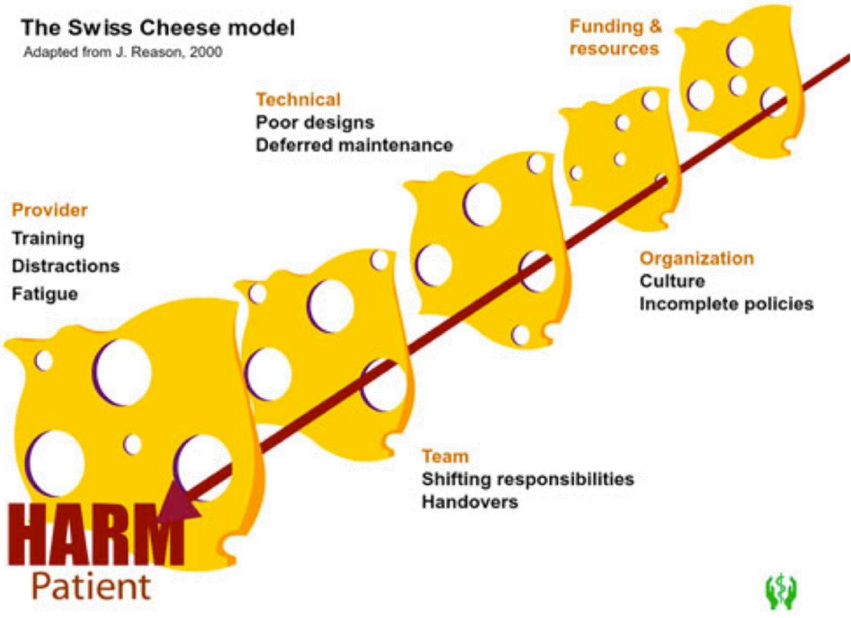
A New, Evidence-based Estimate of Patient Harms Associated with Hospital Care
https://journals.lww.com/journalpatientsafety/Fulltext/2013/09000/A_New,_Evidence_based_Estimate_of_Patient_Harms.2.aspx

- Study in 2013 by John T. James PhD
- Better or Worse?
- 210,000 – 400,000 deaths per year
- Serious harm 10-20 times higher

2016 Update!
Medical Errors are #3 Cause of U.S. Deaths
Dr. Martin Makary, BMJ
https://www.bmj.com/content/353/bmj.i2139

Providing the “Why”

- The goal of all event reporting is to
  - Identify possible process failures
  - Improve those process failure to prevent future errors
- It is not to identify individual failures and punish.
- Symptoms of system failures include:
  - Same error by multiple people
  - No defined policy or process



Investigation tip:

Have a curious mindset when investigating to encourage honest discussion. Words and demeanor matter.

Executive Support!

Make Reporting Personal

Knowledge + Action = Power

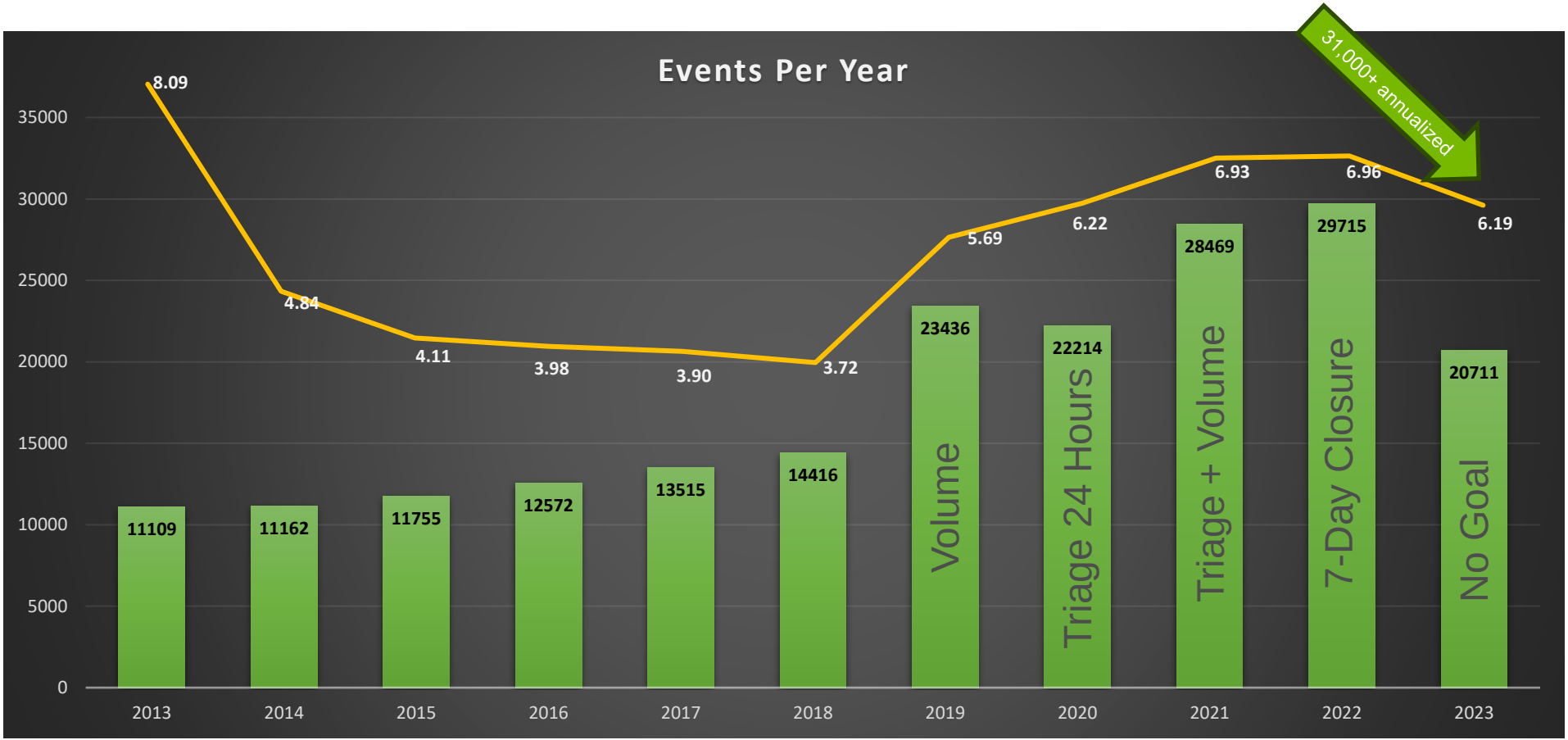
Priority is based on

- Trends/frequency
- Risk of harm
- Risk to operations

What is your personal reason for speaking up?

Set Goals

- 2019 - Volume
- 2020 - Triage within 24 business hours
- 2021 - Triage w/in 24 + Volume
- 2022 - Closure in 7-days
- 2023 – No goal, tracking only


Events Per Year
31,000+ annualized
35000
30000
25000
20000
15000
10000
5000
0
8.09
4.84
4.11
3.98
3.90
3.72
5.69
6.22
6.93
6.96
6.19
11109
11162
11755
12572
13515
14416
23436
22214
28469
29715
20711
Volume
Triage 24 Hours
Triage + Volume
7-Day Closure
No Goal
2013
2014
2015
2016
2017
2018
2019
2020
2021
2022
2023

Newest Great Catch Award Recipients


Parkview Ortho Hospital

- **Parkview Ortho Hospital coworkers Brandy Payton, Edis Miljkovic, Alyssa Klausing, Danita Jones, Sean Ryan, Weaver Tennille** identified an defect with urine catheter tubing resulting in unintended disconnections. Ortho leaders, **Anthony Pulcini and Laurie Meitz,** worked with SCORE to replace the old kit with one which functioned as expected reducing the risk of infection.
- **Parkview Huntington Hospital Cynthia Marshall** partnered with Epic OpTime to investigate a procedure Epic identified as incorrectly needing an inpatient admission. It was discovered that this was built incorrectly in the system and corrected for all facilities.
- **Parkview Heart Institute: Philip Roberts, Michelle Woods & Sterile Processing Jessalynn Kuras** collaborated to ensure proper high level disinfection practices were utilized on all contaminated stylets and that coworkers knew where deliver the devices for timely processing
- **PPG IM Peds: Hilary Osborn** discovered that barcode scanning training was present for travel nurses, but was not incorporated into PPG's AMB100 training courses. **PPG Patient Care & IR Amanda Spicer** updated the course which went live 1/1/2022.
- **PRMC Lab and Blood Bank: Annie Ilnicki, Landers Barbers, Dean Schisler identified that s**pecial requirements for blood products were not transferring into Soft following an interface update. Positioning of comments corrected. Change Management document updated to ensure all changes made in the future are on a checklist for easy troubleshooting reference.


PRMC Lab & Blood Bank


PHI & Sterile Processing

PARKVIEW

We Have Increased Our Reporting Volume, Now What?

Charters, Data, and Dashboards

- Covid changed many things
  - Focus became surviving the pandemic
  - Many transitioned to remote work
  - Old meeting structures stopped working
  - Culture of Safety education plan was defunct

Leverage Improvements

- Midas is a protected vs other forms of communication
- Ease of tracking investigation response
- Midas data for improvement

Collaborate

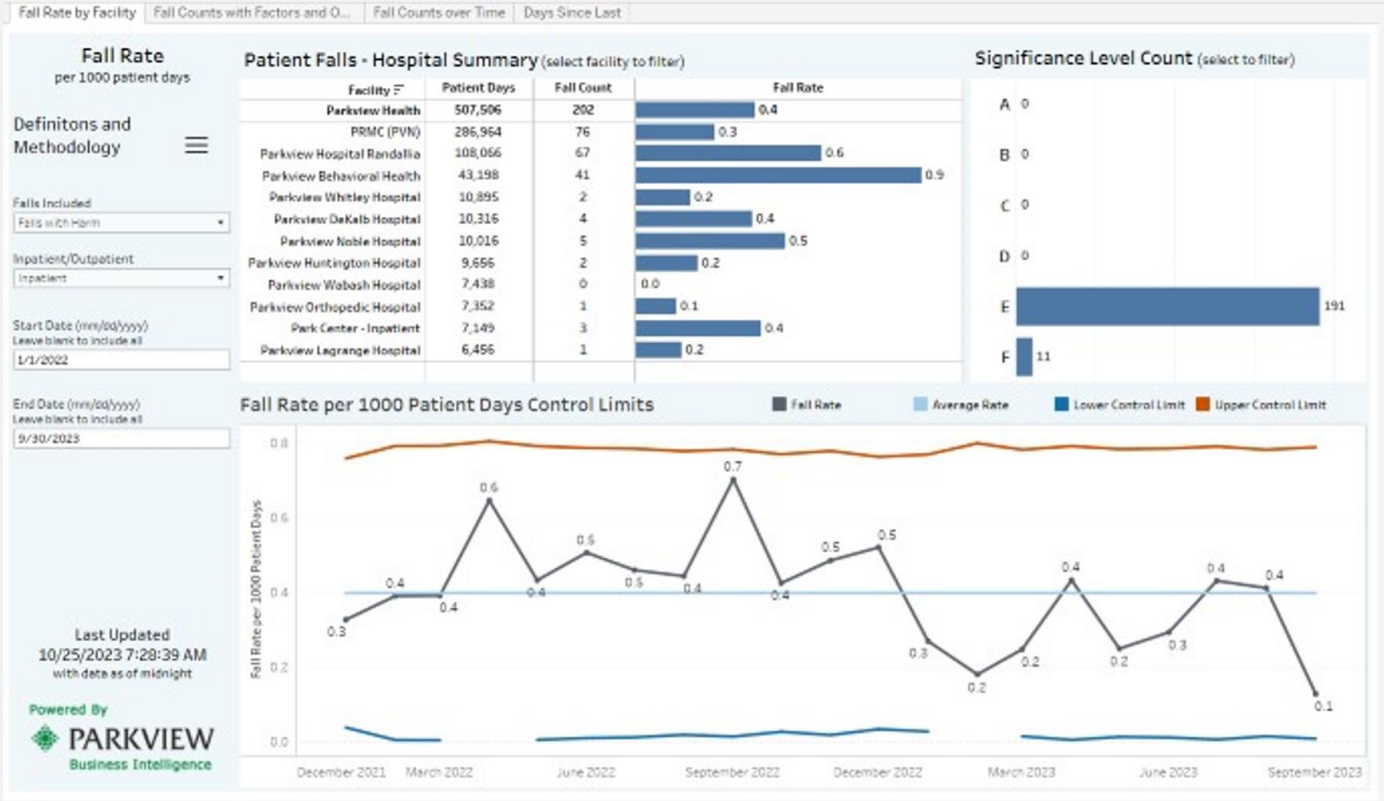
- Charters/Steering teams
  - HAPI
  - FALL
  - CAUTI/CLABSI
  - Workplace violence
  - TeamSTEPPS
  - Medication Safety
  - The list goes on…

Dashboard Redesigns

Virtual Care

Falls with Harm

2022 to 2023 comparison



With the implementation of the Falls Charter and Virtual Sitter program, we have decreased falls withharm by **38%!**

Jan-Sep 2022:

102
Falls with harm

Jan-Sep 2023:

63
Falls with harm

0.2 decrease in rate and 38% decrease in number of falls!

This equates to a reduction in avoidable costs of **$1,365,000 (** based on Nat 'l Library of Medicine, January 2023, *JAMA Health Forum* – using $35,365 direct cost per fall with harm).

Continue Celebrating

- Days since last
- HAPI Heroes
- GCA

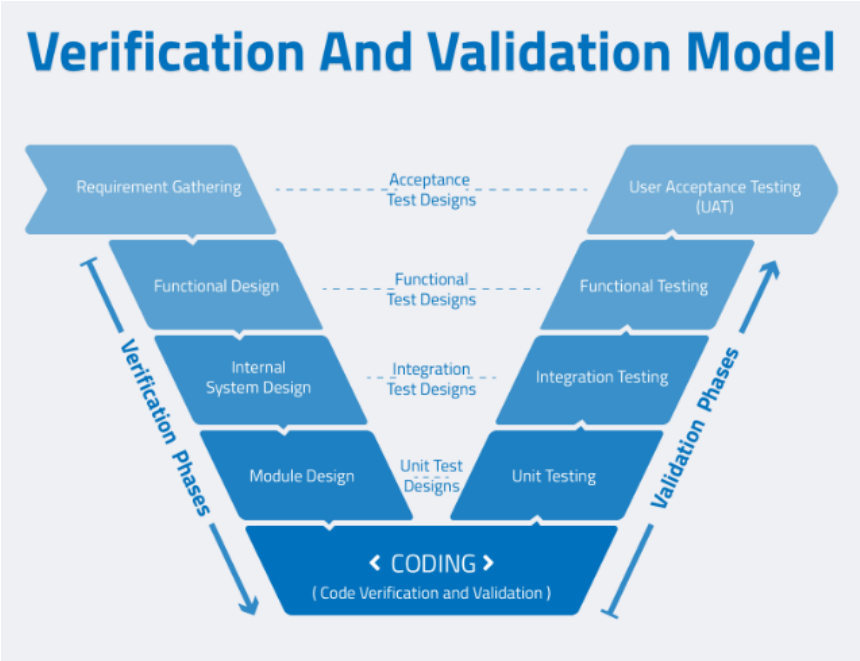
Next Steps

Recognize Data Challenges

- Interface issues
- Unit name changes
- Reporting in real time vs. 7-day completion
- 15000 reporters
- Hundreds of event investigators

Overcoming Challenges

- Data Governance
  - Governors vary per data source
  - Continuous verification and validation
  - Continuous Data Support



Predictability Models

- Current: Sepsis and Deterioration
  - Proactive data for clinicians
  - Data noise reduction
- In-Process: HAPI and Falls
  - Early phases of data modeling
    - Sensitivity and specificity
    - Population review


THANK
YOU

Questions/Comments/Recommendations