Safety Huddle
Improves Safety Culture

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John Phillips, FACHE, President & CEO
Methodist Mansfield Medical Center

- 254 beds Community Hospital
- Full Service, Acute Care
- 51,000 ED Visits
- Part of the Methodist Health System
- 11 years old
- Magnet Facility
Objectives

• Define Purpose of Safety Huddles

• Describe at least 3 ways a Safety Huddle could impact your organization’s Safety Culture

• Describe how Safety Huddle and Patient Flow work together
1. AIM 2. MEASURE 3. CHANGE

- Real Time Communication
- Leadership Awareness
- Problem Identification & Resolution-Improved teamwork
- Proactive approach to prevent harm to patients
- Culture change, Accountability for Safety-Transparency
• Decrease Serious Safety Events by increasing “Days Since” serious safety event to 30 days by Feb. 2013
• Days since Serious Safety Events noted daily
• Survey Monkey Leadership Team in Feb 2013
1. AIM
2. MEASURE
3. CHANGE

- CEO, CNO, CFO and Quality Director did literature review
- Committed to Culture change
- Agreed to Trial Daily Safety Huddle
- Educated manager & directors to expectations
What’s next? NOT this
Barriers-address the “elephant”

- “Another Meeting”
- Share “issues” with all-Really? (Transparency)
- Call in versus attending in person
- Leaders concerned their work hours was in question (trust)
Barriers

• Redundancy with Bed Board
• What will I share/report?
- *3E, 4E, 5E
- *ICU
- *Emergency Department
- *Surgical Services
- *Women’s Services – NICU, L & D, FCC
- *Social Workers
- *Hospitalists
- *House Supervisors
- *EVS

- Patient Access
- Bio Med
- Care Management
- Cardiopulmonary Lab
- Education
- Facilities/Engineering
- Food Svc. & Dietary
- HIM

- Human Resources
- Infection Prevention/Control
- IS/IT
- Lab, Blood Bank
- Materials Management
- Medical Staff Office
- Pastoral Care
- Pharmacy
- Physical Medicine
- Public Relations
- Radiology-Transport
- Respiratory
- Risk Management
- Quality Services
- Police
- Volunteer

- *Bed Board Dept-30%
Bed Board

Current Census
Bed Placement/shortages
Staffing for current & next shift
ADT's
DNR Status
Restraints
Suicide precautions
Sitter Needs
Chemo or PICC needs
Falls-patient, visitor
HAPU's
Core Measure issues/concerns

Name Alert

New Procedure-Robotics, Crani's

Potential concern:
Malignant hypertension
Forensic patient

New codes-trauma alert, sepsis

Safety Huddle: look back--next 24

1. External events that may cause unsafe/stressful conditions ie weather, race, fire
2. Medication Events, med shortages
3. Patients with the same name on a unit
4. Miscommunication among care givers
5. Incomplete Handoffs
6. Any unsafe condition
7. Any event of harm to a patient
8. Delay in treatment or deficiencies
9. Disruptive patients, physicians, other professionals
10. Patient or employee security issues
11. Power failures, computer down times
12. Equipment shortages, failures
13. Shortage of supplies/on back order
14. Codes, RRT, MERTs results, opportunities, SteMI times
15. Major change in status of the patient
16. Mislabeled specimen
17. Infections and pressure ulcers
18. Patient death
19. New procedure, staff trained, high risk procedure?
20. Make sure you communicate great catches
21. Make sure you thank your team when they go beyond the call of duty
22. Other Quality issues or risks, ie Core Measure, outcomes
23. Great Catches
24. Service Recovery
25. Days since last Patient Serious Safety Event
26. Days since last Employee Serious Safety Event
• **Daily**
  – 8:30 - 8:45 am

• **Who:**
  – All Leaders or designee

• **Led By:**
  – CEO, CNO, COO, Quality Director  M-F
  – House Supervisor  Saturday & Sunday
<table>
<thead>
<tr>
<th>Department</th>
<th>Supervisor</th>
<th>Days Since Injury</th>
<th>Injury Description</th>
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<td>Days Since</td>
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Daily Report Form

GREAT CATCHES & KUDOS

Employee Injury

Days Since
3 months post initiation

- Meeting Objective
- Impact on Hospital Operations
- Impact on Communication
- Impact on Patient Safety
- Impact on Leader Effectiveness
- Next Steps

Director/Manager (N=41) vs. Frontline (N=12)
Changes post survey

• Stay within 15 minute timeframe
• Revised agenda-Non-Critical areas do not have to report everyday
  – i.e. HR, Education, EVS, HIM
• Remember the “follow-up” items
DO NOT STOP!!!

“ Alone we can do so little; together we can do so much. ”

Helen Keller
MORE WINS

- CPOE
- Construction
- Slips in Process-Clarification of Policy
- Surveyors welcome to attend
- Spread to MHS system
AHRQ Safety Culture Survey

Management support for patient safety
• 75%tile to 90% tile

Feedback & Communication about error
• 75%tile to 90% tile

Communication Openness:
• 75%tile to 90% tile

Non-Punitive Response to Error:
• Median to 90% tile

Patient Safety Grade: benchmark 77%
• 87%, Top Quartile
Days Since SSE

Methodist Mansfield Medical Center
Dates of Last Serious Patient Safety Event

Days Since SSE:
- 200 days
- 132 days
- >100 days

Graph indicates a rising trend in days since the last serious patient safety event.
Surveys-positive

Hallelujah
Next Generation

• Patient Flow-ED throughput
  – Holds, LWOBs, BIB, BOB, OR- late starts

• Trauma
  – #O negative blood on hand

• Mindfulness exercise
<table>
<thead>
<tr>
<th>Department</th>
<th>Census/Patient Flow</th>
<th>Safety Concerns (Previous/Future) 24 hours</th>
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<tbody>
<tr>
<td>House Supervisor+</td>
<td>*BOB: 1pm</td>
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<tr>
<td>ED+</td>
<td>*BIB: nurses</td>
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<td>ICU +</td>
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<td>OR: GI: MD:</td>
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<td>BIB: MD decision</td>
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Days since last patient serious safety event:        Days since last patient serious CAUTI event:        Days since last patient serious CLABSI event: