2013 Delaware Valley Patient Safety & Quality Award Winners:

WINNER / ABINGTON MEMORIAL HOSPITAL
Reducing Harm

2nd PLACE / PENN PRESBYTERIAN MEDICAL CENTER
Impact of a Clinical Decision Support Tool in the Emergency Department on Antimicrobial Prescribing Patterns for the Treatment of Pneumonia

3rd PLACE / HAHNEMANN UNIVERSITY HOSPITAL
Need for Speed: Collaborative Effort for Early Detection of Septic Patients with a Comprehensive Sepsis Criteria Worksheet
Reducing Preventable Harm: 
*Our Journey to High Reliability*

*Abington Health*
Framework for Excellence

**Vision**
To be the most *trusted* healthcare partner, consistently exceeding expectations for care, comfort and communication

**Mission**
Promote Healing
*Prevent Harm*
Be Kind

**Values**
*Patient Safety First*
Communication is Critical
Always Learn
Do What’s Right
Respect All
Aim:
ZERO Preventable Harm

- Strategic Goals set in 2010

- Short Term:
  Reduce SSER to < 0.20 by 6.30.13

- Long Term:
  Achieve 365 days since last SSE by 2015

SSE – Serious Safety Event
SSER – Serious Safety Event Rate
The Journey that brought us to this Aim

1999
- Institute of Medicine Report “To Err is Human”
- Appointed Chief Patient Safety Officer
- Created Patient Safety Oversight Committee
- Early adopter of PDSA improvement Methodology in healthcare

2000
- Computerized Physician Order Entry (CPOE)
- **Patient Safety** is our first priority
- Encouraged reporting: Culture of Safety Policy
- Appointed Patient Safety Liaisons (coaches)
- Developed WebINR – an internal innovation

2001
- Institute of Medicine: “Crossing the Quality Chasm”: stressed teamwork and communication
- Transparency and openness about errors

2002
- Began our Magnet journey of nursing excellence and empowerment - American Nurses Credentialing Center (ANCC)
- Project on effectiveness of mediation – Pew Charitable Trust

2003
- AMH awarded Magnet Accreditation - 84th in U.S. and 4th in State of PA
- Awarded AHA “Quest for Quality” Awarded to an institution that most effectively demonstrates a culture of safety
- John M. Eisenberg Award for Patient Safety
- VHA team training for OB and Emergency Trauma Center staff

2004
- Adopted Institute for Healthcare Improvement (IHI) 100,000 Lives Campaign - 6 Patient Safety Best Practices
- Instituted widespread education and process improvement for medical, nursing and clinical staff
- Achieved TJC Primary Stroke Accreditation
- Formal Root Cause Analysis introduced
2005
- **Board Chairman** supports patient safety by sending 45 staff/year to IHI
- Patient Safety – **first on every agenda**
- **Baldrige** methodology explored
- Patient Safety **annual lectureship** initiated
Event rate

Serious Safety Events (SSE)- Abington Memorial Hospital
September 2005 - February 2014
Rolling 12-month Serious Safety Events expressed per 10,000 Adjusted pt days

2006
- **TeamSTEPPS** training is required for all clinical staff (*incl. Physicians*)
- Electronic “Daily CARE Plan” designed/implemented
- **Center for Patient Safety and Healthcare Quality** inaugurated
  - First Patient Safety Culture **Survey**

SSER (By Event Date)
2007
- 21 Executive Patient Safety Officers Trained
- Measured harm via use of the IHI Global Trigger Tool
- Interdisciplinary electronic documentation (KBC)
Serious Safety Events (SSE)- *Abington* Memorial Hospital
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2007
- 21 Executive Patient Safety Officers Trained
- Measured harm via use of the IHI Global Trigger Tool
  - Interdisciplinary electronic documentation (KBC)
- Monthly *Patient Safety WalkRounds*

**SSER (By Event Date)**
2008
- Achieved Magnet reaccreditation
- Earned Magnet Prize for the Daily CARE Plan
- Began electronic event reporting
PATIENT SAFETY : a CORE Value

- To better understand harm, the Serious Safety Event Methodology replaces the Global Trigger Tool

- High Reliability journey begins
SSER (By Event Date)

2010
- Submitted first National and State Baldrige Applications
- Made Safety ‘visible’ on the intranet by posting “Days since last SSE”
Rolling 12-month Serious Safety Events expressed per 10,000 Adjusted pt days

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- Made Safety ‘visible’ on the intranet by posting “Days since last SSE”
Serious Safety Events (SSE)- Abington Memorial Hospital
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2010
- Submitted first National and State Baldrige Applications
- Made Safety ‘visible’ on the intranet by posting “Days since last SSE”
- Earned State Baldrige Keystone Excellence Award
Serious Safety Events (SSE) - Abington Memorial Hospital
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2011
- 564 leaders trained on Leadership Behaviors for Reliability.
  Instituted Aug 2011
**ERROR PREVENTION TOOLKIT FOR LEADERSHIP**

<table>
<thead>
<tr>
<th>ABINGTON CORE VALUES</th>
<th>ERROR PREVENTION TOOLS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>We commit to...</strong></td>
<td><strong>By Practicing the Following...</strong></td>
</tr>
</tbody>
</table>
| **PATIENT SAFETY FIRST**  
Prevent harm. Think safe, act safe, be safe and stay safe | **SAFETY MESSAGE FIRST IN EVERY MEETING** |
| **RESPECT ALL**  
Respect for all: every patient, every colleague, every encounter, everyday. Embrace diversity. | **5:1 FEEDBACK** |
| **DO WHAT’S RIGHT**  
Integrity and the highest standards in everything we do and say. Be responsible and accountable. | **CREATE A SAFE DAY**  
using your checklist |
| **COMMUNICATION IS CRITICAL**  
Communicate effectively to ensure success in every interaction. | **UNIT BASED SAFETY BRIEFINGS** |
| **ALWAYS LEARN**  
Create and support an learning environment where growth and experience are valued. | **DAILY CHECK IN**  
9:30 a.m. Safety Call |
| **PATIENT SAFETY WALKROUNDS** | |
Serious Safety Events (SSE)- Abington Memorial Hospital
September 2005 - February 2014
Rolling 12-month Serious Safety Events expressed per 10,000 Adjusted pt days

2011-2012
➢ Over 5000 staff, physicians and residents trained on science of safety and the use of Error Prevention Behaviors and Tools
### Error Prevention Toolkit for Staff

<table>
<thead>
<tr>
<th>Abington Core Values</th>
<th>Safety Behavior Expectations</th>
<th>Error Prevention Tools</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Patient Safety First</strong>&lt;br&gt;Prevent harm. Think safe, act safe, be safe and stay safe.</td>
<td><strong>PAY ATTENTION TO DETAIL</strong>&lt;br&gt;Stop, think, act, review.</td>
<td><strong>Self checking using STAR</strong>&lt;br&gt;Stop, think, act, review.</td>
</tr>
<tr>
<td><strong>Respect All</strong>&lt;br&gt;Respect for all: every patient, every colleague, every encounter, everyday. Embrace diversity.</td>
<td><strong>GOT YOUR BACK!</strong>&lt;br&gt;</td>
<td><strong>Peer checking &amp; peer coaching</strong>&lt;br&gt;In a tone of mutual respect and value for each team member, we will invite and expect...</td>
</tr>
<tr>
<td><strong>Do What's Right</strong>&lt;br&gt;Integrity and the highest standards in everything we do and say. Be responsible and accountable.</td>
<td><strong>SPEAK UP FOR SAFETY</strong>&lt;br&gt;I'm concerned. I'm uncomfortable. Stop, I need clarity.</td>
<td><strong>Use CUS to escalate safety concerns</strong>&lt;br&gt;I'm concerned. I'm uncomfortable. Stop, I need clarity.</td>
</tr>
<tr>
<td><strong>Communication Is Critical</strong>&lt;br&gt;Communicate effectively to ensure success in every interaction.</td>
<td><strong>Communicate Clearly</strong>&lt;br&gt;3-way repeat back &amp; read back. Phonetic &amp; numeric clarifications. Clarifying questions.</td>
<td><strong>Use SBAR to Handoff:</strong>&lt;br&gt;Situation Background Assessment Recommendation.</td>
</tr>
<tr>
<td><strong>Always Learn</strong>&lt;br&gt;Create and support an learning environment where growth and experience are valued.</td>
<td><strong>If in Doubt, Check It Out</strong>&lt;br&gt;</td>
<td><strong>Question &amp; Confirm</strong>&lt;br&gt;<strong>Identify, Investigate, Integrate</strong>.</td>
</tr>
</tbody>
</table>
Serious Safety Events (SSE) - Abington Memorial Hospital
September 2005 - February 2014
Rolling 12-month Serious Safety Events expressed per 10,000 Adjusted pt days

2012
- Reliable Design built into Service Behaviors
- Performance Management System incorporates behavioral expectations for safety and service
- Formal adoption of Baldrige Framework for Excellence
- 3rd Patient Safety Culture Survey
- Implemented SafeTV – "youtube-like" video for staff education
Error Prevention and Service Behaviors Account for **40%** of the Performance Appraisal!
Error Prevention and Service Behavior Performance Worksheet (weight 40%)

Each of the following Error Prevention and Service behaviors and tools are linked to one of AH’s core values. By linking behaviors and tools to the AH values, we can ensure that we are committed to putting AH’s values into action. If the score is anything other than a 3, written explanation must be provided on the reverse side of this worksheet. This worksheet must be reviewed with the employee and submitted to Human Resources with the employee’s completed performance appraisal to be a part of the employee’s record.

Error Prevention

<table>
<thead>
<tr>
<th>AH Core Values</th>
<th>I commit to the following behavior...</th>
<th>by practicing the following error prevention tools.</th>
<th>Performance Rating per Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Safety First</td>
<td>Pay Attention to Detail</td>
<td>Self-Checking using STAR Stop Think Act Review</td>
<td>Score:</td>
</tr>
<tr>
<td>Respect All</td>
<td>Got Your Back!</td>
<td>Peer Checking &amp; Peer Coaching</td>
<td>Score:</td>
</tr>
<tr>
<td>Do What’s Right</td>
<td>Speak Up for Safety</td>
<td>Use CUS to escalate safety concerns I’m Concerned, I’m Uncomfortable, Stop, I need clarity</td>
<td>Score:</td>
</tr>
<tr>
<td>Communication is Critical</td>
<td>Communicate Clearly</td>
<td>- 3-way Repeat Back &amp; Read Back - Phonetic &amp; Numeric Clarifications - Clarifying Questions</td>
<td>Score:</td>
</tr>
<tr>
<td></td>
<td>Handoff Effectively</td>
<td>- Use SBAR to Handoff (Situation, Background, Assessment, Recommendation)</td>
<td>*(Average of four communication tool ratings)</td>
</tr>
<tr>
<td>Always Learn</td>
<td>If in Doubt, Check it Out</td>
<td>Question &amp; Confirm</td>
<td>Score:</td>
</tr>
</tbody>
</table>

Service

<table>
<thead>
<tr>
<th>AH Core Values</th>
<th>I commit to the following behavior...</th>
<th>by practicing the following service tools in my role in the CSQ.</th>
<th>Performance Rating per Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Safety First</td>
<td>Anticipate Needs</td>
<td>P=Periodic Check In’s before leaving/tight staffing C=Closing Calls/visits with “anything else?”</td>
<td>Score:</td>
</tr>
<tr>
<td>Respect All</td>
<td>Individualized our Response</td>
<td>P/C= Commit to Connect; Sit to resolve concerns</td>
<td>Score:</td>
</tr>
<tr>
<td>Do What’s Right</td>
<td>Intent vs. Impact</td>
<td>P= Choose your Attitude Set the Tone for + interactions C= No Pass Zones: walking people call bells on units</td>
<td>Score:</td>
</tr>
<tr>
<td>Communication is Critical</td>
<td>Communicate Consistently</td>
<td>C= AIDET P/C= Key Words at Key Times (CSQ list) P/C= Promote Your Peers</td>
<td>*(Average of four communication tool ratings)</td>
</tr>
<tr>
<td>Always Learn</td>
<td>Reflective Listening</td>
<td>P/C= Thoughtful reflection; sensitivity to intent vs. impact P/C= Open, active listening skills</td>
<td>Score:</td>
</tr>
</tbody>
</table>

Calculate the Error Prevention and Service Performance Total

Add all Performance Rating per Value scores, then divide them by 10, and then multiply by .40. Insert the score here.

Employee: Initial here to indicate that this worksheet has been reviewed with you. Date:
Serious Safety Events (SSE)- *Abington* Memorial Hospital
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2013
- Implemented **Barcoding** for Medication Administration
- **Performance Improvement** tools as Leadership Behaviors
- **Apparent Cause Analysis** for Near Miss/Precursor Events
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- **Performance Improvement** tools as Leadership Behaviors
- **Apparent Cause Analysis** for Near Miss/Precursor Events
Aim: ZERO Preventable Harm

Goal Achievement:

- **Short Term:**
  - Reduce SSER to < 0.20 by 6.30.13
  - **SSER of 0.08 by 6.30.13**

- **Long Term:**
  - Achieve 365 days since last SSE by 2015
  - **365 days since last SSE 9.7.13**

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**SSE** – Serious Safety Event
**SSER** – Serious Safety Event Rate
Serious Safety Events (SSE)- Abington Memorial Hospital
September 2005 - February 2014
Rolling 12-month Serious Safety Events expressed per 10,000 Adjusted pt days

98% decrease in preventable harm
FY 2014

Achieved

437 days

without a

Serious Safety Event
February 14, 2014, we “turned back the clock.”
Commitment to Resilience
A Hallmark of Reliability

- Leverage **Cause Analysis** for learning and improvement
  - *Root Cause Analysis for SSE*
  - *Apparent Cause Analysis for PCE and NMEs*
Resilience

- Focus on the "Next 365 days" -
  - enhancing process, behavioral and human factor design
Resilience

- **Fair and Just Culture**
  - advance reporting, learning *and* enhance personal accountability for behavioral choices
Resilience

- Enhance the **Microsystem**
  - Unit-based ownership and empowerment for preventing, detecting, and reporting harm
  - CUSP units-
    - **Comprehensive Unit-Based Safety Programs**
Lessons Learned

- Provide **“line of sight”** to connect staff to goals.
- Define specific behavioral **expectations** for patient safety, **educate and build skill**, and **reinforce** in multiple venues and methods.
- **Set clear expectations and accountability for leaders:** Round, Reinforce, Coach and Recognize staff ‘in the moment’.
  
  **”Attention is the currency of Leadership”**

- Tell the **stories** that get to ‘the will.’
Thank you!

Maureen Ann Frye, MSN, BC, CRNP

Mfrye@abingtonhealth.org