

IMPROVING PATIENT SAFETY – EVERYONE’S RESPONSIBILITY

Overview

- * Texas Health Resources is a large north Texas, faith-based nonprofit system of 25 acute-care, transitional, rehabilitation, and short-stay hospitals and 18 outpatient facilities with 21,100 employees and more than 5,500 physicians.
- * Texas Health adopted a systemwide approach to three important patient safety activities: hand hygiene, two-patient ID, and time out. These results linked to Success Sharing for all employees.
- * An innovative measurement approach that began in 2008, it uses a 2-tiered observation process independently to measure adherence to the 3 patient safety measures and provides feedback for targeted improvement from these observations.

Background

- * Three important patient safety processes have been identified as key factors in reducing hospital acquired infections and catastrophic events: hand hygiene, wrong-site surgeries, and patient misidentification.
 - The Institute of Medicine reports that 90,000 patients die each year from hospital-acquired infections linked closely to poor hand hygiene. Yet, only about 40% of all healthcare workers comply with hand hygiene rules.
 - The Cost of treating hospital-acquired infections in the U.S. approaches \$4.5 billion annually.
 - Wrong-site surgery is a rare catastrophic event that is caused by failures in communication, procedural noncompliance, and ineffective leadership.
 - Errors related to misidentifying patients are not well-reported but can result in medication, blood, and other laboratory-related errors.

Description

- * In 2006, Texas Health studied the Nuclear Regulatory Commission’s observation techniques in order to observe the medical process better without being seen as observers.
- * These observation processes allowed Texas Health to provide feedback on three patient safety measures that are traditionally very difficult to measure and for which self-reporting was unreliable.
- * Texas Health created and trained two teams of observers: hospital teams and systemwide teams. This 2-tier strategy allowed hospitals to use the methodology as an improvement technique, and system observers collected patterns of systemwide opportunity in performance.
- * They also implemented Success Sharing, a bonus structure, for all full-time employees based on performance measured by the independent observers.

Metrics

- * Performance improved on all 3 patient safety indicators from the baseline of 88% compliance to 94% during the 3 years of Success Sharing.
- * Hand Hygiene compliance improved, even when the observation and compliance rate expanded from staff to include volunteers and the independent medical staff. Central Line Associated Blood Stream Infections (CLABSI) declined significantly in all areas after observation of hand hygiene began.
- * Two methods of patient identification are a key safety check prior to administering medications, conducting tests, or drawing specimens. Failures in patient identification are closely linked to errors in these processes. Texas Health measured significant improvement along with a marked decrease in adverse drug events – particularly related to “wrong patient” issues.

* Time out in the procedural areas is both a teamwork and communication safety step. This process is measured in the preoperative holding area, the procedure room and finally as the patient is exiting the procedure area. Texas Health used a process of involving physicians (anesthesiologists and surgeons) along with procedural staff in the design of the information shared and when and how it was shared. Time out compliance has increased significantly, and wrong site surgery decreased.

* Central Line Associated Blood Stream Infections (CLABSI) rates declined from 3.5/1000 line days to 0.6/1000 line days. Return on investment from this improvement was roughly \$16,500 for each of about 290 patients.

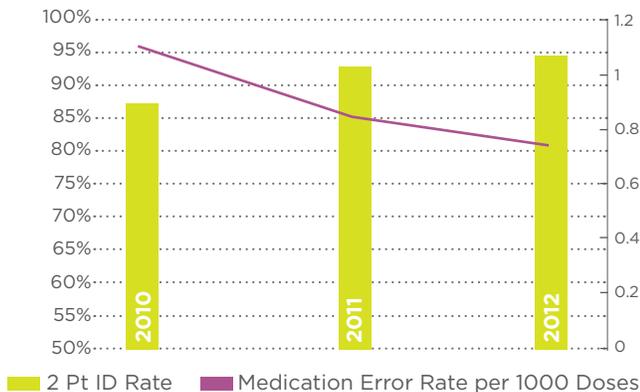
* Two-patient ID improved from 90% to 95%, reducing medication errors from 1.1/1,000 doses to 0.8/1,000 doses administered. This reduced registered medication errors by 724 per year, which results in potential savings of \$2,000 per medication error.

* Time out compliance increased from 86% to 94% for avoiding wrong-site surgeries. The actual reduction in wrong-site surgeries was 3 each year.

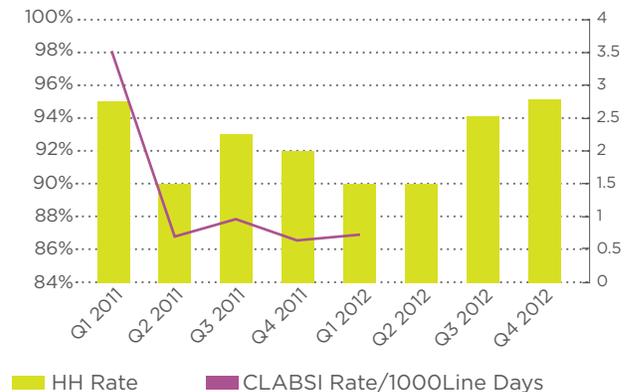
Value

* Improvement from baseline measurement of 88% compliance with hand hygiene, two-patient ID, and time out to 94%.

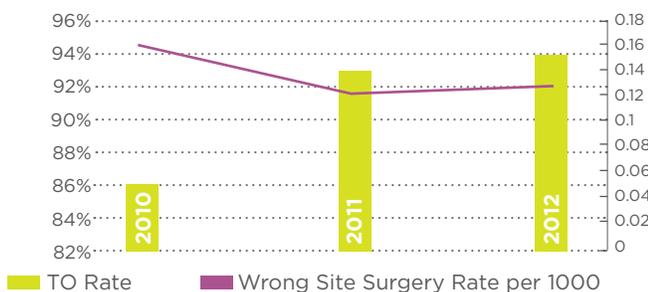
THR COMPLIANCE WITH 2 PATIENT ID'S



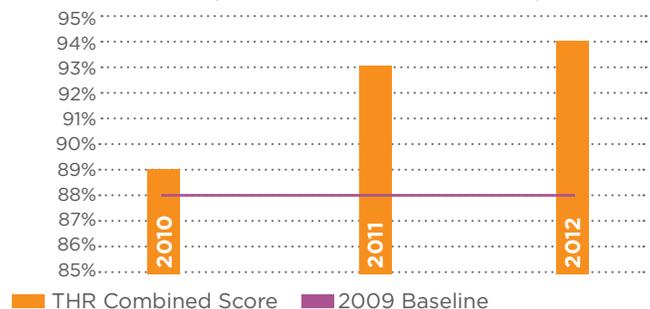
THR COMPLIANCE WITH HAND HYGIENE



THR COMPLIANCE WITH TIME OUTS



THR COMPLIANCE WITH PATIENT SAFETY INDICATORS: HAND HYGIENE, PATIENT IDENTIFICATION, TIME OUT



Improving Patient Safety

Everyone's Responsibility

Overview

- Texas Health Resources is a large north Texas, faith-based nonprofit system
 - 25 acute care hospitals
 - 1 Long-term acute care hospital
 - 2 Behavioral health hospitals
 - 1 Rehabilitation hospital
 - 4 Short stay surgical hospitals
 - Ambulatory surgery centers and outpatient testing
 - 800+ employed physicians
- All employees earn incentives based on performance of patient safety process measures

Background

2002

- Contacted Institute of Nuclear Power Operations (INPO)
- Piloted and designed observation methods in partnership with INPO

2003

- Piloted observation of patient safety processes at 2 hospitals

2004

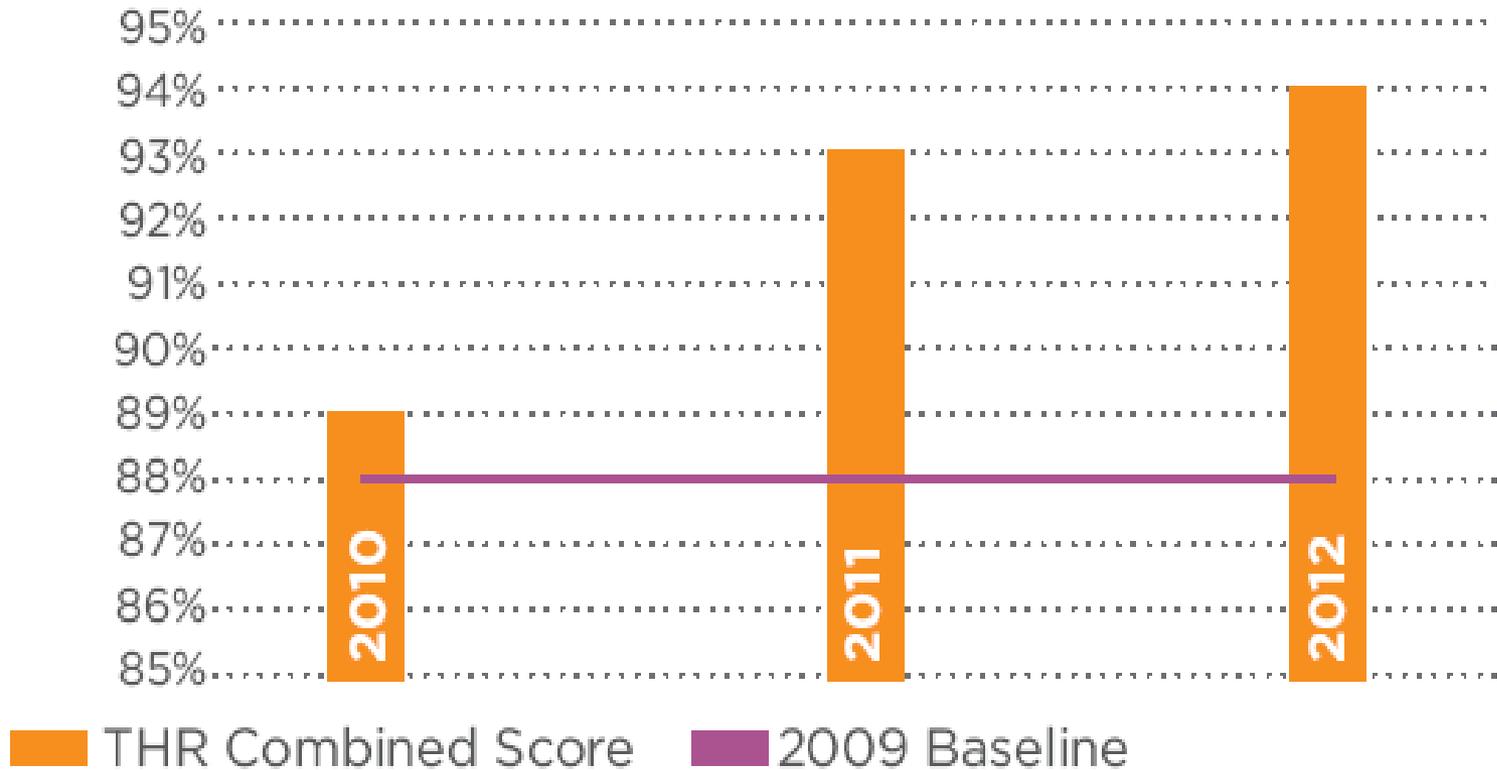
- Tier 1 and Tier 2 Observers
- Full implementation of patient safety observations and Patient Safety Culture Initiative surveys

Process

- Focus on employee initiated patient safety processes:
 - Hand washing
 - Two patient identifiers prior to any type of procedure, treatment or test
 - Surgical checklist
- Tier 1 observers
 - Observe throughout their hospital
 - Focus on system and hospital-specific patient safety initiatives
- Tier 2 observers
 - Observe at other THR hospitals
 - Measurement for system-wide patient safety initiatives
 - Conduct Patient Safety Culture Initiative surveys

Results

THR COMPLIANCE WITH PATIENT SAFETY INDICATORS: HAND HYGIENE, PATIENT IDENTIFICATION, TIME OUT



Next Steps

- Continue to align the observation process with system-wide strategy and key performance indicators
- Align Patient Safety Culture Initiative with key opportunities identified from:
 - External survey findings
 - New evidence-based patient safety expectations
 - Key safety processes not easily measured
 - New safety rules (CMS, State, TJC)