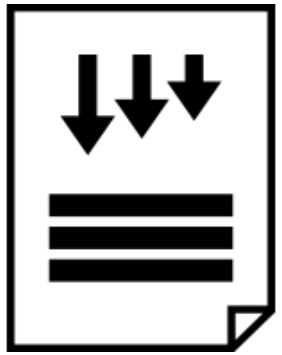
UNC HEALTH CARE

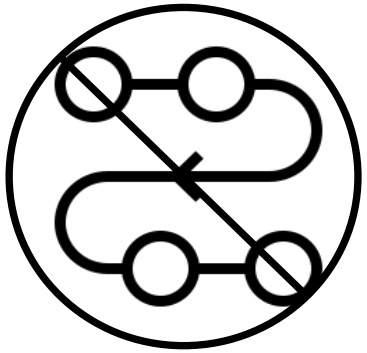
Culture of Safety Improvement Project
UNC Medical Center

Where were we? 2017



Low reporting

Risk use only



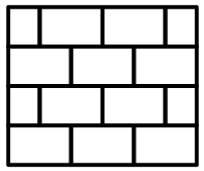
Lack of standard process

What do we report?

Where were we? UNC Hospitals Scores Compared to the AHRQ SOPS Database Teaching Hospitals Scores

Patient Safety Culture Survey Composite Measures	UNC Hospitals Avg % Positive 2015	UNC Hospitals Avg % Positive 2017	Database Teaching Hospitals Avg % Positive 2016
Teamwork Within	86	86	80
Supervisor Expectations	78	81	77
Feedback About Error	65	69	66
Event Reporting	59	62	64
Nonpunitive Response	53	55	43

Initial steps



Surveyed front line users to determine barriers

Found influencers and champions

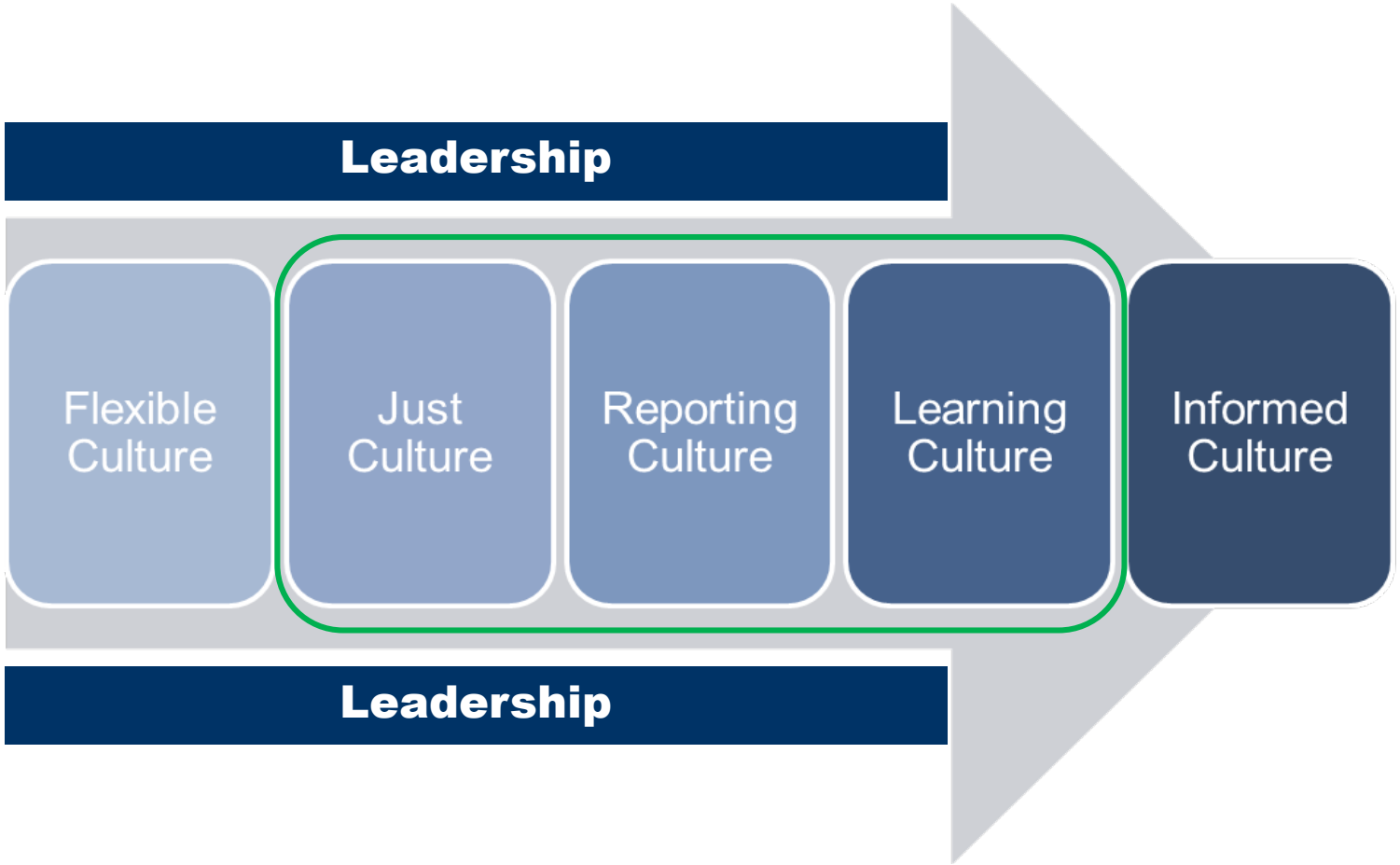
Evaluated reporting systems across the organization

Formed a work group

Perceived barriers to event reporting

AHRQ funded study in 2008 found similar barriers to event reporting.

Promoting Safety Culture



Safety Culture

Source: Reason, J. from Managing the Risk of Organizational Accidents, Ashgate 1997.

Patient Safety Event Reporting System Improvement Project

Working Project Goal:

To redesign the patient safety reporting framework at UNCMC that:

- Supports a Culture of Safety
- Establishes operations and structure for analyzing reports, developing action plans, implementation of action plans, and monitoring effectiveness in order to improve health care quality
- Provides timely feedback
- Aligns risk management and continuous improvement efforts
- Utilizes effective patient safety event reporting software
- Double event report submissions by 100% within three years
- Increase SOPS scores in Feedback, Nonpunitive response and Event Reporting by 2021

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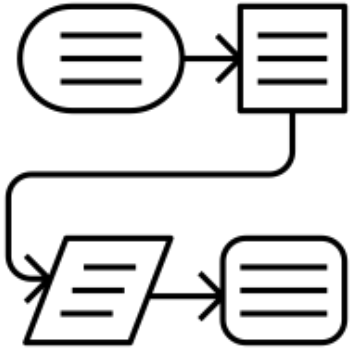
Redesigning the Patient Safety Reporting System

Project Sponsors
Stephenie Fenton-Wilhelm and Lukasz Mazur

Project Manager
Alison Amos

Culture of Safety Workgroup:
Develop operations and structure for supporting culture of safety

Event Reporting Software Usability Workgroup:
Develop optimized interface for software portal for event reporting, communication, analytics and feedback



Policies and Procedures Workgroup:
Develop standard work for patient safety reporting system

Safety Culture Recommendations

Accountability

- Expectation for completion of Patient Safety Culture education
- Expectation for manager to complete action plan for Survey on Patient Safety Culture (SOPS) composite measures or additional resilience measure < 60%
- Add to Taleo Leader Standard specific examples of contributing to Culture of Safety

Dashboard

- WES (Workforce Engagement Survey) Safety Score measures
- Patient Safety Culture Survey measures
- Monthly safety event reports data

Resources

- AHRQ Hospital SOPS
- Provide SOPS with same resources as WES to prep for administration, analyze results, distribute results and support managers with action planning for SOPS Total Percent Positive or additional resilience measure < 60%.
- Dashboard Design by Enterprise Analytics
- Education Design and Delivery

Improved Usability of Event Reporting Platform

Goal: To develop optimized interface for our event reporting software for event reporting, communication, analytics and feedback

- Study details: (55 hours of design and data collection)
  - 10 participants, 2 events to submit
  - Measurements: time to submit, number of clicks, eye movements

- **Workgroup recommended ~17 changes to current setup of event reporting software platform**

- Risk, Quality, ISD representatives determining feasibility, priority & timeline to implement recommendations

- **Key improvement: August of 2019 we achieved EHR integration with event reporting software platform**

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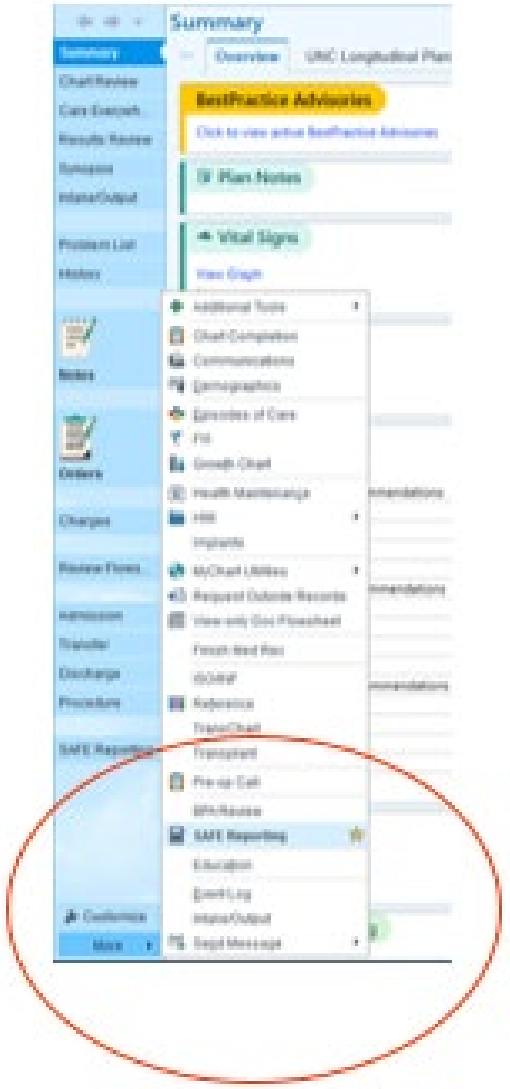
EHR access for Safety Awareness for Everyone (SAFE)

The EHR link for SAFE went live August 15, 2019



Process Workgroup Summary

Goal

A standard program for reporting, communication, feedback, and analysis aligned with risk management, using event reporting software platform as reporting portal.
Deliverables include:

1) cross-functional (or swim lane) process map and
2) updated policies and procedures documents, both of which will include roles and responsibilities for clinical teams, risk management, quality, etc.

Scope

Report entered (all severity levels) → Report closed, including review and follow-up communication

Process Workgroup Summary

Workgroup Accomplishments

1. Gathered stakeholder input throughout
2. Assessed current state
3. Compiled best practices from high-functioning organizations/areas
4. Conducted process mapping workshop
5. Produced high-level and detailed ideal state process maps
6. Developed charters for local and central review committees
7. Developed recommendations for quality & safety system policies

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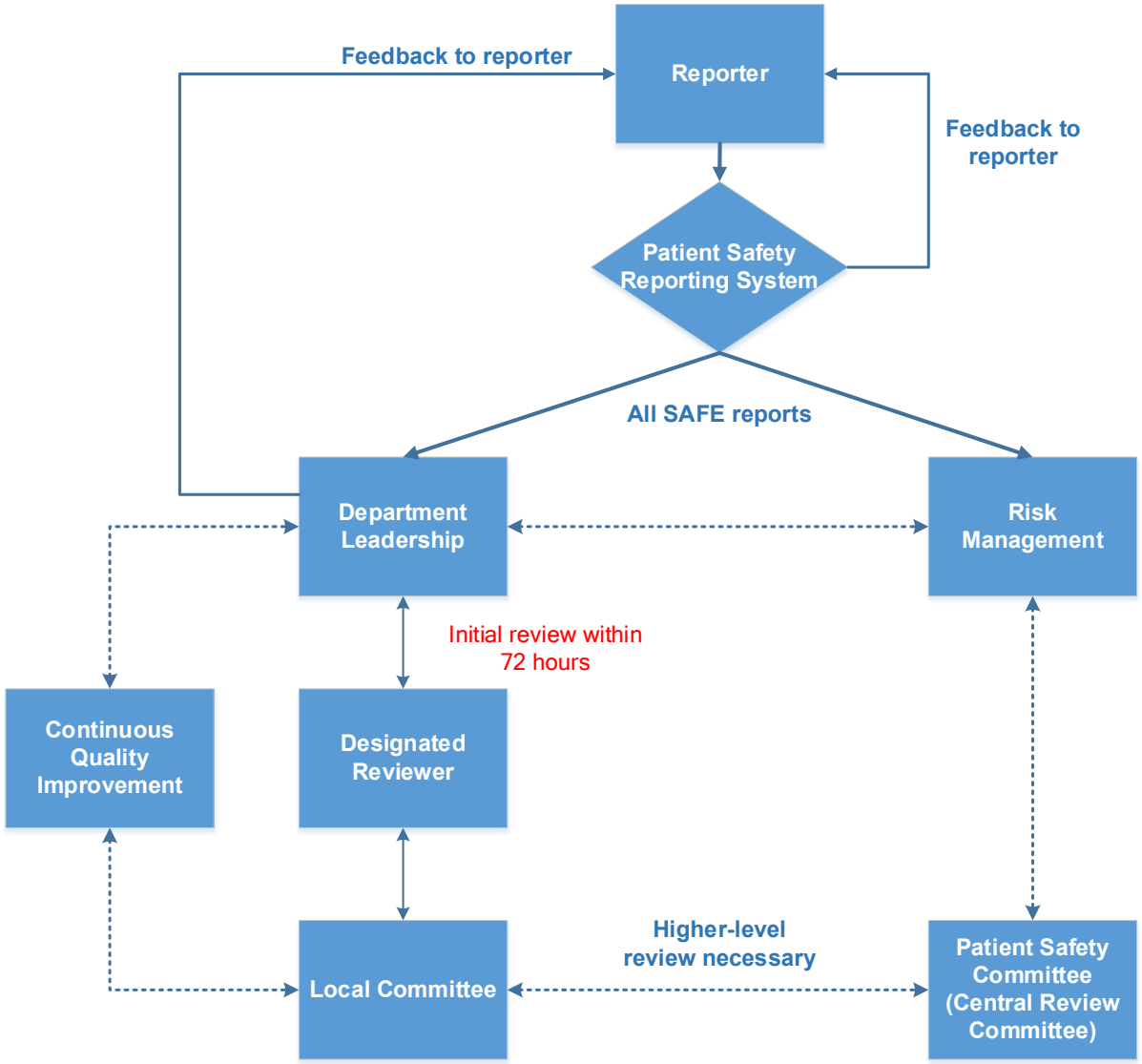
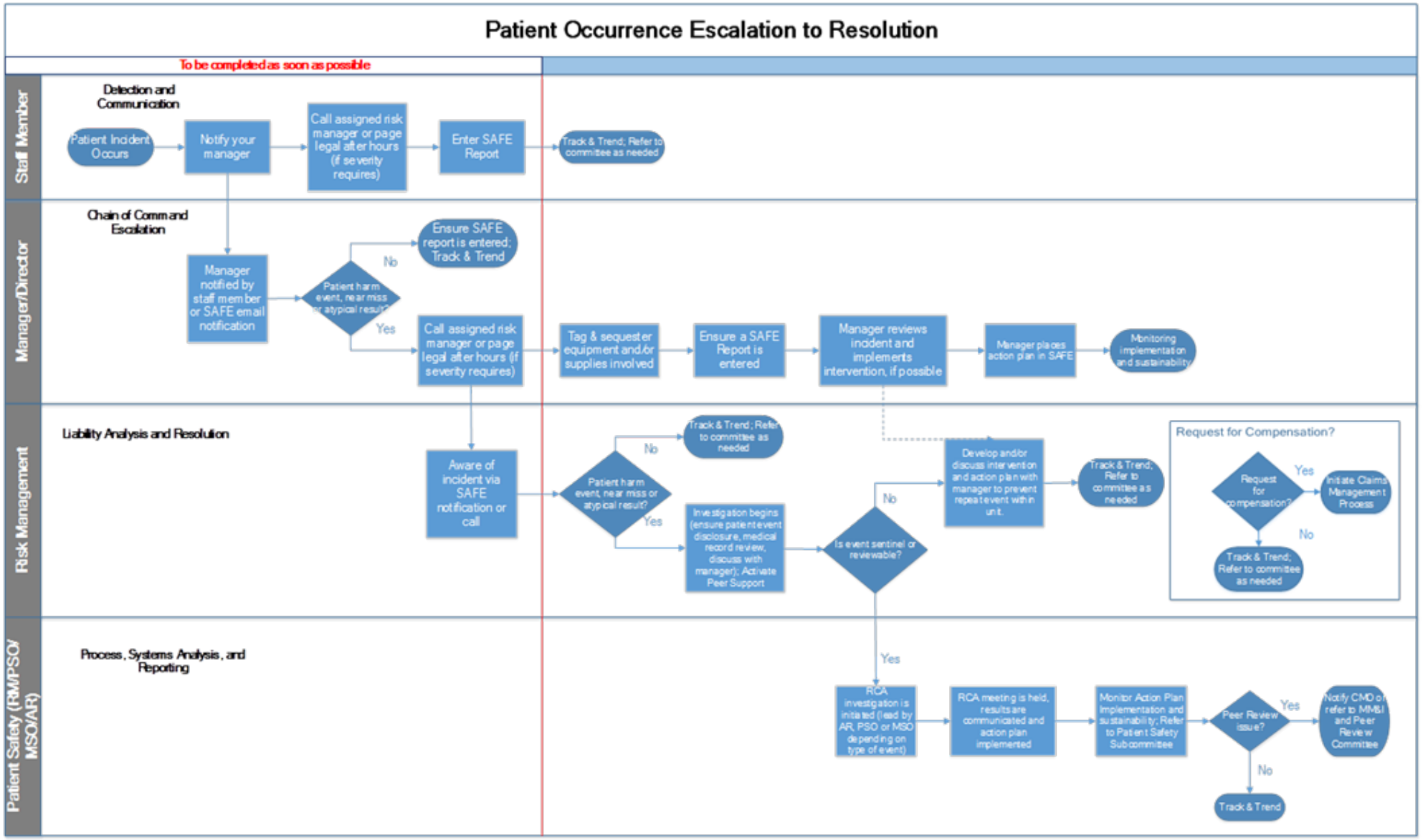
Quality & Safety Reporting System Information Flow



UNC's Ideal State Cross-Functional Process Map



Safety Assessment Code (SAC) Matrix

Probability and Severity	Catastrophic	Major	Moderate	Minor
Frequent	3	3	2	1
Occasional	3	2	1	1
Uncommon	3	2	1	1
Remote	3	2	1	1

Severity Categories: Catastrophic (death or major loss of function), Major (permanent lessening of bodily functioning), Moderate (increased length of stay or level of care), Minor (no injury, nor increased length of stay nor increased level of care)

Probability Categories: Frequent (likely to occur immediately or within a short period of time), Occasional (probably will occur), Uncommon (possible to occur), Remote (unlikely to occur)

How the SAC Matrix Works: When a severity category is paired with a probability category for either an actual event or close call, a ranked matrix score (3 = highest risk, 2 = intermediate risk, 1 = lowest risk) results. These ranks, or SACs, can then be used for doing comparative analysis and for deciding who needs to be notified about the event.

VA National Center for Patient Safety

Process Launch

Launch Steps

- Marketing Roadshow – Join us!
- Created Education for nurses and physicians

- Launch process:
  - Chose Launch Areas
  - Provided education to inpatient and outpatient launch groups on process & software platform
  - Created new Local Committees or utilized existing safety committees to integrate event reviews
    - SAC scores utilized as triggers to bring events to the Safety Committee
    - Perform Learning from Defects (LFD) tool for those reports assigned with a SAC 2 and 3

Areas

Inpatient:

- Hillsborough Campus
- Peri-Op
- Oncology
- Coming soon: Psychiatry and Children's

Outpatient:

- Oncology Safety Committee
- Gynecology Oncology
- Internal Medicine Clinic
- Neurology Clinic

Achievement Summary

- Optimized reporting software event submission forms
- Integrated EHR and reporting software for easier submission
- Created a new process for event review
- Launched new process in 7 areas both inpatient and outpatient, with planned launch in all areas within a year
- Re-launched our Patient Safety Committee to align with the new process
- Reached our initial reporting goal in half the time expected

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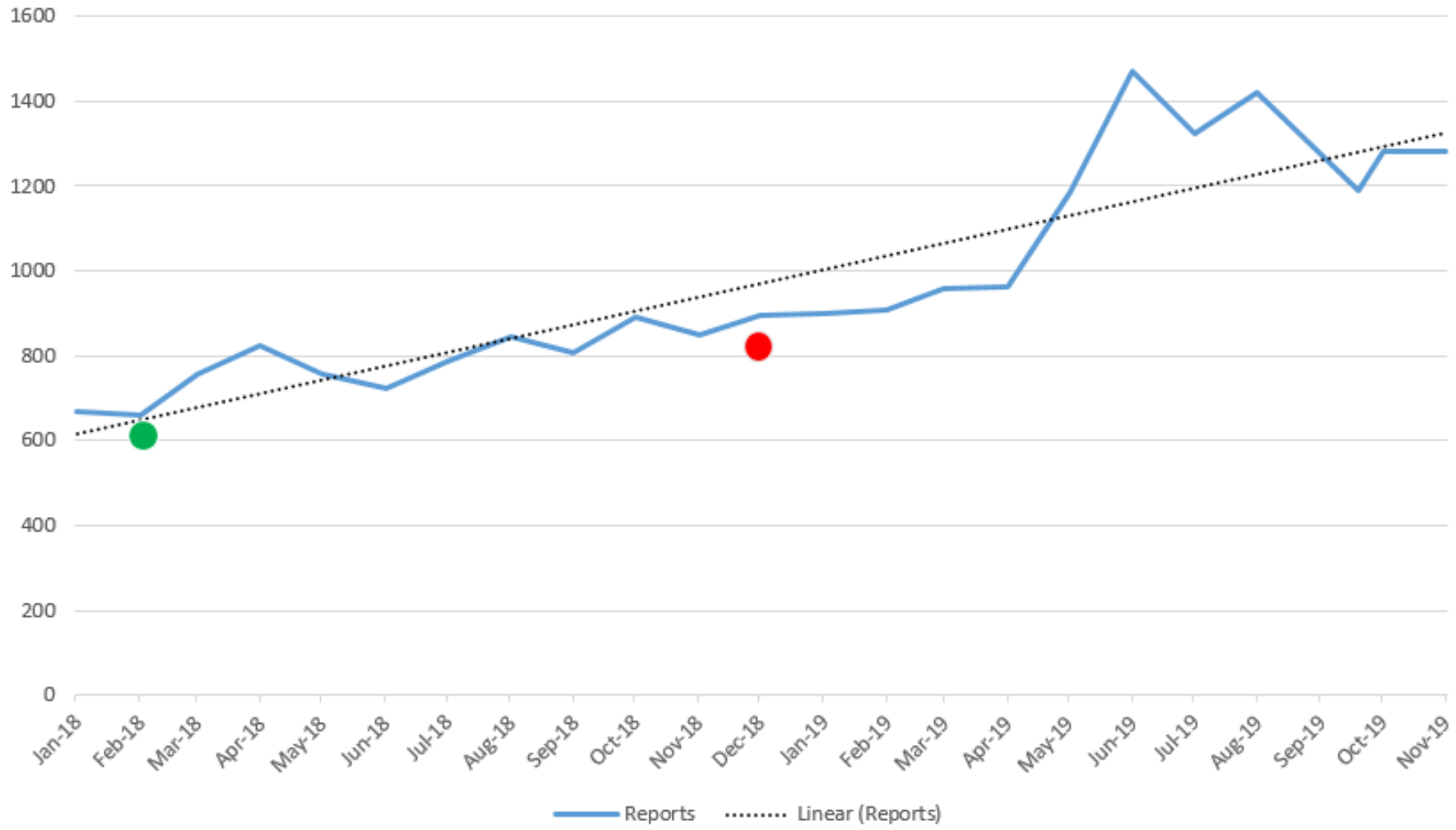
Where are we now?



What's next?

- Building Board and Senior Executive Safety Culture training modules
- Continuing to develop and implement Just Culture and Safety Culture education
- Implement process throughout the Medical Center within one year

Thank you for your time, we're happy to answer questions!