Design, construction and renovation: Realizing a Blueprint for Patient Safety

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Agenda

- Where do we start?
  - Joint Commission sample plan

- SickKids Blueprint 2002-08; Design and Construction
  - Impetus
  - Concepts
  - Plan

- SickKids 2009 Blueprint; Renovation
  - Best practices review / consultation
  - Key concepts, projects and initiatives
Why Do We Need a Plan?

The Tower of Babel - Brueghel
Where Do We Start?
Sample Patient Safety Plan:
Part A – The Foundation

Patient education
Informing patients about their care

Management of the Program
Components (safety-related offices, committees, functions)
Interdisciplinary participation
Oversight

Activities & functions relating to patient safety
Participating sites, settings, and services

Safety-related orientation & training
Team training
Expectations for reporting

Among components of the Program
Among the professional disciplines
Across the organization

Consistent with organization mission

<table>
<thead>
<tr>
<th>Communicating with Patients</th>
<th>Staff Education</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Structure</strong></td>
<td><strong>Coordination</strong></td>
</tr>
<tr>
<td>Program Scope</td>
<td>Program Goals</td>
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</table>

www.jointcommission.org/PatientSafety/pt_safety_plan.htm
Sample Patient Safety Plan:
Part B – Safety Improvement Activities

- Reporting of Results
- Proactive Risk Reduction
- ID, Reporting & Management of Sentinel Events
- Routine Safety-related Data Collection & Analysis
- Prioritization of Improvement Activities
- Definition of Terms

Communicating with Patients | Staff Education
---|---
Structure
Program Scope
Coordination
Program Goals

www.jointcommission.org/PatientSafety/pt_safety_plan.htm
The Blueprint for Patient Safety
@ SickKids
SickKids – One of the Top Children’s Hospitals in the World

- We have “world-class” doctors, nurses, health-care professionals and administrators
- We provide outstanding and innovative care
- We treat the most difficult and challenging cases
- Our research is world-class
- We attract trainees from around the world and have alumni across the globe
- But…
Despite our best efforts, serious harm occurs:

SB - Our Burning Platform

- 16 yr. old girl with sickle cell disease
- Very complicated history
- Early June 2000 - discharged from hospital
- Late June - Sickle cell clinic visit, Hgb 85
- July - General surgery clinic visit - OR date set for August
- August - Surgery cancelled
- September – Same day admission, “routine” lap chole (gall bladder surgery), post-op deterioration → death
- Coroner’s Inquest
Sick Kids at the Crossroads - 2001

Traditional risk management approach
(self-protection / prevention of real or potential loss)

A Better Way?
Patient Safety Learning Model

Leadership, culture, communication, coordination

Externa l info.

ID unsafe practices & vulnerabilities

Make changes

Evaluate and audit

Communicate and report

Internal info.
Quality Improvement vs. Patient Safety

Quality Improvement (raising the ceiling)

High

Low

Patient Safety (raising the floor)
# SickKids Blueprint for Patient Safety 2002-2008

<table>
<thead>
<tr>
<th>Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>Evaluation &amp; research</td>
</tr>
<tr>
<td>Education &amp; training</td>
</tr>
<tr>
<td>Partnering with patients and families</td>
</tr>
<tr>
<td>Risk assessment &amp; prioritized improvement projects</td>
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<tr>
<td>Policies, procedures, &amp; clinical practice guidelines</td>
</tr>
<tr>
<td>Management of critical occurrences</td>
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<tr>
<td>External &amp; internal surveillance</td>
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<tr>
<td>Communication &amp; teamwork</td>
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<tr>
<td>Program coordination &amp; collaboration</td>
</tr>
<tr>
<td>Leadership, culture &amp; accountability</td>
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</table>
Construction – It Takes Time!

- On-line P&P database
- Systems approach to error adopted
- Patent Safety Blueprint & Disclosure Policy
- On-line Hazard Alerts system
- On-line Safety Reporting system
- PIPS Program Launch
- Annual Symposium
- Medical Director Role
- QM Program Reports
- Executive Walkarounds
- Committees
- CPG focus
- Quality vs. REB
- Culture Survey
- M&M database
- QM database
- PIPSQC
- PS Centre

'00 '01 '02 '03 '04 '05 '06 '07 '08
Blueprint 2009 - Renovations

- Best practices review
- Consultation with stakeholders
- Key concepts
- Mandatory initiatives
- The plan – projects and initiatives
Blueprint 2009 – Best Practices Review

- Board Leadership in Patient Safety
- Senior Management Leadership in Patient Safety
- Formal Patient Safety Plan
- Focus on Execution of Strategic Patient Safety Initiatives
- Department / Program / Team Leadership in Patient Safety
- Physician Engagement
- Patient and Family Focus
- Staff Focus
- Evidence-based care Focus
- Measurement and Reporting
- External Collaboration
Consultation with families: factors contributing to parents’ safety concerns

- Task: 38%
  - Accuracy, Appropriateness, Timeliness, Patient ID, Clinical, Care, Medications

- Team: 8%
  - Communication

- Organization & Management: 76%
  - Safety culture, Translational, Physical injury, Checkpoint

- Patient: 3%

- Individual: 8%

- Environment: 23%
Blueprint 2009 – Key Concepts

- Leadership
- Systems approach
- High reliability
- Prioritization and execution of initiatives
# Blueprint 2009 – Safety Projects

**Aim:** *Eliminate critical incidents and “never events”*

<table>
<thead>
<tr>
<th>Drivers</th>
<th>Projects / Initiatives</th>
<th>Measures</th>
<th>Areas Involved</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infection prevention and control</td>
<td>1. SSI</td>
<td>1% antibiotic within 1 hour cut time</td>
<td>Perioperative clinics and units</td>
</tr>
<tr>
<td></td>
<td>2. VAP</td>
<td>VAP rate; % compliance daily “bundle”</td>
<td>Critical care units</td>
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<tr>
<td></td>
<td>3. CLA-BSI</td>
<td>CLA-BSI rate; % compliance insertion bundle; % compliance maintenance bundle</td>
<td>Critical care units</td>
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<tr>
<td></td>
<td>4. Hand hygiene</td>
<td>% compliance</td>
<td>All areas</td>
</tr>
<tr>
<td>Medication manage.</td>
<td>5. Medication reconciliation</td>
<td>% compliance</td>
<td>All inpatient areas, pre-op clinics</td>
</tr>
<tr>
<td>Commun. and teamwork</td>
<td>6. Communication in OR (huddle, pause, briefings)</td>
<td># wrong site / patient / procedure events</td>
<td>Operating room</td>
</tr>
</tbody>
</table>

**Critical incidents** = any unintended event that occurs when a patient receives treatment that, (a) results in death, or serious disability, injury or harm to the patient, and (b) does not result primarily from the patient’s underlying medical condition or from a known risk inherent in providing the treatment.
Blueprint 2009 – Other Initiatives

- University of Toronto – Centre for Patient Safety; SickKids one or two operational hubs
University of Toronto – Centre for Patient Safety

“It will foster novel research and education projects aimed at improving patient safety both locally and internationally. The Centre will provide a focus for collaboration across the Toronto Academic Health Science Network including all the affiliated hospitals and all of the health science and related programs at the University.”
Blueprint 2009 – Other Initiatives

- University of Toronto – Centre for Patient Safety; SickKids one or two operational hubs
- Canadian Patient Safety Institute; Patient Safety Core Dimensions – curriculum development
- Disclosure policy and process review & revision
- Critical incident policy and process review & revision
Lessons Learned

- Leverage the crisis
  - (& the near miss)
- Engage & involve leaders
  - E.g. Critical incident review leadership “triad”; project sponsorship
- Engage & involve families
- Integrate / build on successful traditions
  - E.g. QI, RM, M&M, REB
- Prioritize & follow up
  - Projects, recommendations
- Collaborate & learn with others
  - “If you want to go fast, go alone; if you want to go far, go together”
THANK YOU SO MUCH!
Additional Slides and References
# Mandatory Initiatives / Measures – Ontario

<table>
<thead>
<tr>
<th>Organization / Body</th>
<th>AC</th>
<th>Wait</th>
<th>PS</th>
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</thead>
<tbody>
<tr>
<td><strong>Culture / Measurement</strong></td>
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<tr>
<td>1. Patient safety a strategic priority/goal</td>
<td>X</td>
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<tr>
<td>2. Board Quality Committee</td>
<td></td>
<td>X</td>
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<td>3. Quarterly reports to Board</td>
<td>X</td>
<td>X</td>
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<td>4. Reporting system for adverse events</td>
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<td>5. Hospital Standardized Mortality Ratio (HSMR)</td>
<td>NA</td>
<td>NA</td>
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<td>6. Status of patients waiting longer that the wait time targets reported to board</td>
<td></td>
<td>X</td>
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<tr>
<td>7. Policy and process for disclosure of adverse events</td>
<td>X</td>
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<td>8. Prospective analysis (FMEA)</td>
<td>X</td>
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<tr>
<td><strong>Communication</strong></td>
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<tr>
<td>9. Patient/client education</td>
<td>X</td>
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<td>10. Information transfer</td>
<td>X</td>
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<tr>
<td>11. Verification processes for high-risk activities</td>
<td>X</td>
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<tr>
<td>12. Medication reconciliation at admission</td>
<td>X</td>
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<tr>
<td>13. Medication reconciliation at referral/transfer</td>
<td>X</td>
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<tr>
<td>15. Dangerous abbreviations</td>
<td>X</td>
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<tr>
<td><strong>Medication Use</strong></td>
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<tr>
<td>16. Removal of concentrated electrolytes</td>
<td>X</td>
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<tr>
<td>17. Standardize and limit drug concentrations</td>
<td>X</td>
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<tr>
<td>18. Training on infusion pumps</td>
<td>X</td>
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<td>19. Heparin safety</td>
<td>X</td>
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<tr>
<td>20. Narcotic safety</td>
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*AC = Accreditation Canada*
*Wait = Ont. Wait times initiative*
*PS = Ont. Mandatory patient safety indicators.*
## Mandatory Initiatives / Measures – Ontario

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<th>PS</th>
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<tbody>
<tr>
<td><strong>Worklife / Workforce</strong></td>
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<tr>
<td>21. Training on patient/client safety</td>
<td>X</td>
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<tr>
<td>22. Patient safety plan</td>
<td>X</td>
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<td>23. Roles and responsibilities established for patient/client care and safety</td>
<td>X</td>
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<tr>
<td>24. Preventive maintenance program</td>
<td>X</td>
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<tr>
<td><strong>Infection Control</strong></td>
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<tr>
<td>25. Infection control guidelines</td>
<td>X</td>
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<tr>
<td>26. Education/training on hand-hygiene</td>
<td>X</td>
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<tr>
<td>27. Infection rates</td>
<td>X</td>
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<tr>
<td>28. Sterilization of equipment and facilities</td>
<td>X</td>
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<td>29. Influenza vaccine</td>
<td>X</td>
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<td>30. Hand-hygiene compliance</td>
<td>X</td>
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<tr>
<td>31. Clostridium difficile (C. difficile)</td>
<td>X</td>
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<td>32. Methicillin-resistant Staphylococcus aureus (MRSA)</td>
<td>X</td>
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<td>33. Vancomycin-resistant Enterococci (VRE)</td>
<td>X</td>
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<td>34. Rates of ventilator-associated pneumonia (VAP)</td>
<td>X</td>
<td>X</td>
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<tr>
<td>35. Rates of central line infections (CLA-BSI)</td>
<td>X</td>
<td>X</td>
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<tr>
<td>36. Rates of surgical site infections (SSI)</td>
<td>X</td>
<td>X</td>
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<tr>
<td><strong>Fall Prevention</strong></td>
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<tr>
<td>37. Fall prevention strategy</td>
<td>X</td>
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<tr>
<td><strong>Risk Assessment</strong></td>
<td></td>
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<tr>
<td>38. Suicide prevention strategy</td>
<td>X</td>
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Canadian Patient Safety Institute – Safety Competencies

The Safety Competencies
First Edition

Enhancing Patient Safety Across the Health Professions

Domain 1
Contribute to a Culture of Patient Safety

Domain 2
Work in Teams for Patient Safety

Domain 3
Communicate Effectively for Patient Safety

Domain 4
Manage Safety Risks

Domain 5
Optimize Human and Environmental Factors

Domain 6
Recognize, Respond to and Disclose Adverse Events

Patient safety is a critical aspect of high quality health care.

www.patientssafetyinstitute.ca
Illustration B: Determining the Type of Event and the Requirements for Disclosure

Harm has occurred

Event in Patient’s Healthcare

A Potential for Harm Exists or No Harm is Apparent

INITIAL DISCLOSURE
Initial communication required as soon as reasonably possible

Analysis

Harm is found to result from or be from a combination of:

- Natural progression of patient’s underlying medical condition
- Inherent risks of investigations or treatments
- System Failures
- Provider Performance

POST-ANALYSIS DISCLOSURE**

Event Reached Patient

Close Call***
The event did not reach the patient

Generally need not be communicated unless ongoing safety risk for that patient, or patient already aware

Potential for Harm Exists

No Potential for Harm

Should be disclosed to the patient

Generally should be communicated

---

* Refers to harm known to be associated with the investigation or treatment

** Management in consultation with providers to determine what further information is to be disclosed

*** It is strongly encouraged that close calls be reported to healthcare organizations