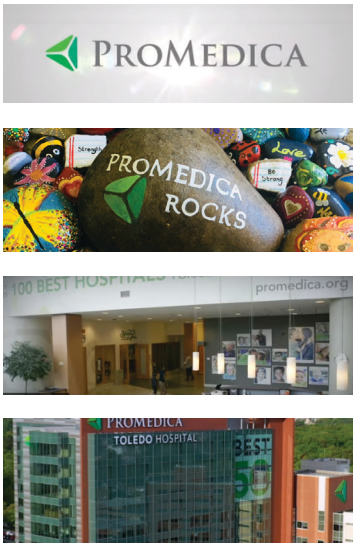
ProMedica: The Journey to Zero Harm Begins by Knowing Where You Are



ProMedica, based in northwest Ohio and southeast Michigan, embarked on their high reliability journey in 2013. A network of 13 hospitals and growing, ProMedica had always focused on the quality and safety of care; but in 2013, they kicked it up a notch. We spoke with Jeremy Cherry, BS, RN, CPPS, Safety Coordinator for System Quality & Safety, about ProMedica's ongoing efforts to reach zero harm.

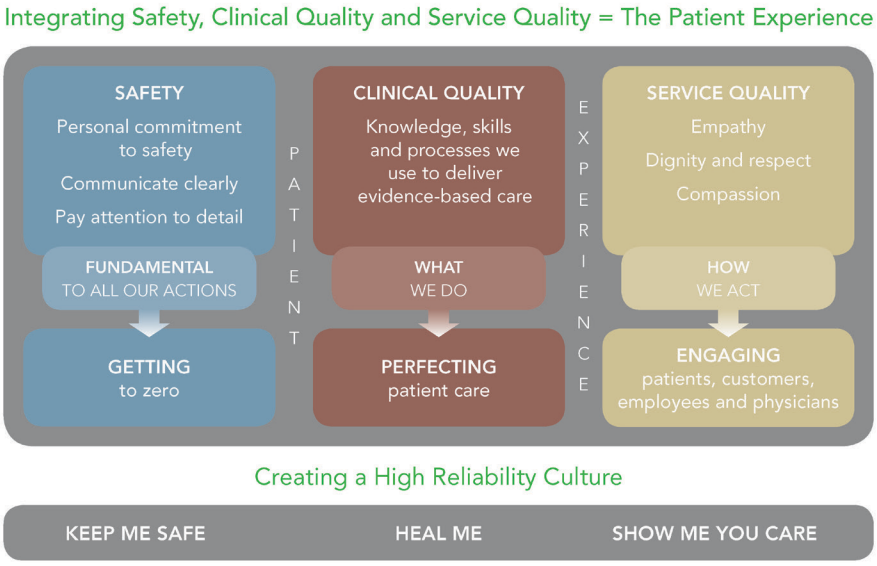
> "ProMedica is committed to zero harm and we see that it is possible."

The first step in any journey is knowing where you are starting from. Similarly, ProMedica's journey to zero harm and high reliability began by figuring out where they stood in terms of safety. To do that, they needed data and lots of it. ProMedica partnered with outside consultants to develop a strategic plan. This included the development of key metrics and data management, as well as the high reliability methods, which would ultimately become the framework of their safety culture. High reliability teams were formed at each of their acute care facilities. These teams were tasked with examining past and present safety events (actual or potential) and classifying them according to a common, systematic approach. From this data, ProMedica compiled a Serious Safety Event (SSE) graph that gave them a visual trendline to track progress and identify commonalities and improvements.

Once they knew where they stood in terms of safety, ProMedica modified their leadership structure to provide dedicated oversight and accountability of their burgeoning safety culture.

The goal of Error Prevention Techniques was to change the way people approach their work. These techniques are intended to be simple and to, collectively, promote the value of three basic concepts: a personal commitment to safety, attention to detail, and communicating clearly. "We want to get people to make these techniques habit, to the extent that it is just the way we do things here," says Jeremy Cherry. ProMedica's 10 Error Prevention Techniques were:

- Speak Up for Safety using ARCC: Ask a question, Request a change, voice a Concern, use the chain of Command.
- Peer checking and peer coaching
- Report problems, errors and events
- Stop, reflect and resolve
- Ask clarifying questions
- Three-way repeat backs/read backs
- Phonetic and numeric clarifications
- SBAR for action: Situation, Background, Assessment, Recommendation/Request
- Handoff effectively using the 5 Ps: Patient/Project, Plan, Part/Purpose, Problems, Precautions
- Self-check using STAR: Stop, Think, Act, Review



SAFETY FIRST. EXCELLENCE ALWAYS.

What We Believe In ... *(Our Safety Behavior Expectations)*	What We Do... *(Our Error Prevention Tools)*
Personal commitment to safety	• **Speak up for safety using ARCC**: **A**sk a question; **R**equest a change; Voice a **C**oncern; Use **C**hain of command • Peer checking and peer coaching • Report problems, errors and events • Stop, reflect and resolve
Communicate clearly	• Ask clarifying questions • Three-way repeat backs/read backs • Phonetic and numeric clarifications • **SBAR** for action: **S**ituation; **B**ackground; **A**ssessment; **R**ecommendation/**R**equest • Handoff effectively using the **5Ps**: **P**atient/**P**roject; **P**lan; **P**ast/**P**urpose; **P**roblems; **P**recautions
Pay attention to detail	• Self-check using **STAR**: **S**top; **T**hink; **A**ct; **R**eview

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To communicate and reinforce these concepts, several consistent tactics were used across the organization:

Error Prevention Training – Mandatory for all staff, both employed and contracted, it focused on the 10 Error Prevention Techniques. To ensure that physicians were taking the training, it was tied to their credentialing. The training was offered both live and online. Since the beginning of their journey, ProMedica has maintained a 100% rate of training for all staff and providers.

Safety Coaching – Each manager/director is encouraged to have a coach in their department to help with sustainability. Safety coaches are frontline staff who receive additional training in error prevention as well as coaching skills. Coaches and managers hold monthly meetings to update each other and discuss how to get staff to adopt Error Prevention Techniques.

Safety Huddles – These are morning calls, attended by leaders from every department, as well as senior operational leaders. These calls provide an opportunity to evaluate and troubleshoot any real or potential threats to patient or employee safety. Most departments have also instituted a morning safety huddle to discuss issues shared in the morning safety call, as well as information more specific to their department, such as patients with similar names or fall risks.

Safety Newsletter – Monthly publication that shares safety related information, including a list of each safety event that occurred that month, in an effort to create awareness and learn as much as possible from these events.

JOE Boards – Journey of Excellence (JOE) bulletin boards placed in every department are a means of aligning system-wide priorities and often feature safety newsletters and Error Prevention Technique of the Month flyers. "We are lucky our leadership lets us be transparent and share our safety stories," says Cherry.

Root Cause Analyses – Root Cause Analysis (RCA) is something the organization has done in the past for sentinel events, per The Joint Commission. "The Joint Commission put root cause analysis top of mind and provides us with research, priorities and initiatives to focus on. They bring important issues to the forefront so organizations can assess where they stand," notes Cherry. As part of their high reliability journey, ProMedica greatly increased their RCA activities. Some ProMedica hospitals recruit and train frontline staff to participate on one of their many RCA teams, which deploy on an as needed and rotating basis. ProMedica views staff engagement in these types of activities as a significant step forward in aligning leadership and staff perspectives around topics such as error/event reporting, just culture, and continuous performance improvement. These RCA teams manage the process from start to finish, including:

- Collecting background information
- Staff interviews
- Meeting with stakeholders to discuss findings and create an action plan
- Sharing results with all staff. An example is "Toledo Talks," open meetings at Toledo Hospital where anyone with a staff ID can hear what was identified, details about the action plan, etc.

Safety Mondays – Every week, safety stories are posted front and center on the system's intranet home page, explaining in detail what went wrong, how the error was caught, how it was mitigated, and what Error Prevention Techniques were used. "Storytelling is a very effective way to get people to pay attention and to recognize the staff involved," says Cherry.

As time went on, the definition of an SSE expanded to include more types of events. While this data may have affected their trendline, overall it provided better and more complete data on safety trends within their organization. ProMedica recently performed a calculation to try to understand how many events of patient harm had been avoided since their high reliability journey began. Through the first half of the year, the number was 419. It may be worth noting that this number includes only serious safety events, which represent moderate to severe harm. Events of minor or no appreciable harm were not included in this calculation.

Finally, ProMedica's high reliability leadership methods were intended to help them mirror the commonly understood characteristics shared by all highly reliable organizations. The 11 Leadership Methods that ProMedica developed include:

- Begin every meeting with safety
- Educate for safety every day
- Encourage error, problem, event reporting
- Communicate lessons from safety events
- Safety coaches
- Safety huddles
- Thank those who voice safety concerns
- Safety first in decisions
- Rounding to influence
- Top 10 lists with action plans
- Fair and just accountability

The Leadership Methods have begun taking hold in the ProMedica culture. "We continue to work to achieve the consistent and complete adoption of these methods throughout our large organization," notes Cherry.

What advice would Cherry give to colleagues interested in working toward high reliability? "You need to have a plan because it's a cultural transformation, not a checklist," says Cherry. "You'll fall down if you don't give things the attention they deserve. Organizations need to prioritize things that would be most effective, and add on as they have time, since you can't do it all at once."

Bottom line according to Cherry? "ProMedica is committed to zero harm and we see that it is possible."