

Nebraska Hospitals Quality Improvement “Quest for Excellence” Award

Name of Organization: The Nebraska Medical Center

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Topic: Patient Safety Executive Roundtables

Category: Process Management/Organizational Performance Results

Overview

The Quality Issue

The Nebraska Medical Center proudly submits its Patient Safety Executive Roundtable Program to be considered for this year's Nebraska Hospital Quality Improvement Quest for Excellence Award. The Patient Safety Executive Roundtable Program was developed to address quality issues at two levels: (1) provide an additional forum for employees to communicate patient safety issues, and (2) improve the processes currently in place for resolving patient safety issues.

Identification of the Issue

Since July 2001, the Nebraska Medical Center has participated in the University Healthcare Consortium's (UHC) Patient Safety Network program to track and trend patient safety issues. The Patient Safety Network is an online system that all employees can access via the hospital intranet to report patient safety incidents. Information submitted to the Patient Safety Network is transmitted to the UHC for national tracking and trending as well as to one of two individuals at the Nebraska Medical Center, the Patient Safety Specialist (RN) or Medication Safety Specialist (Pharmacist). The Safety Specialists review all safety incident reports and identify the appropriate course of action for follow up. In some cases, the appropriate follow up may be to assemble a group to conduct a root cause analysis on the incident in question.

Hundreds of incident reports have been submitted by employees since the Patient Safety Network was implemented. Although pleased with the use of this tool by employees, hospital leadership acknowledged that no system is perfect and that at least some patient safety issues were not being reported. In the organization-wide 2003 Patient Safety Survey, employees identified that the communication of patient safety issues was in need of improvement. As a result, hospital leadership began to explore options for improving the communication of patient safety incidents. Rather than

having safety incidents serve as catalysts for change, hospital leadership explored ways that the organization could be more proactive in its identification of patient safety issues,

Importance of Issue for Organization

The safety and well-being of patients is a primary concern of The Nebraska Medical Center's staff, regardless of whether or not they provide direct patient care. This level of concern is demonstrated by the presence of quality care and patient safety at the heart of both the Mission and Leadership Priorities of The Nebraska Medical Center.

Mission Statement

The Nebraska Medical Center is dedicated to **excellence** and innovation in compassionate, **quality healthcare** through teamwork, education, and research.

Leadership Priorities

Most attractive environment to practice medicine
Most attractive employer
Highest quality of customer service and care
Enhanced clinical quality and patient safety

Project Overview

In the Patient Safety Executive Roundtable Program, Hospital Chief Officers, Vice Presidents, and Executive Directors attend standing meetings held by each department throughout the hospital. The executives use a standardized set of questions to facilitate a staff discussion of issues presenting a safety risk in their work environment. At the end of the meeting, an action plan is developed. The department manager is held accountable for resolving any department-specific items, and the executive facilitator has the responsibility for taking appropriate steps to resolve any cross-departmental issues. A database is maintained to help coordinate these meetings as well as to track and trend the resolution of cross-departmental issues.

Internal stakeholders for this program include hospital executives, department management, hospital staff, and a member of the Continuous Quality Improvement Department, who provides

project management and oversight for the project. The most direct stakeholders for this initiative are the patients of the Nebraska Medical Center and those who provide their care.

Methods

Process used to implement

In the 2002 and 2003, Chief Medical Officer Steve Smith, MD completed the American Hospital Association's Patient Safety Leadership Fellowship. During his participation in this Fellowship, Dr. Smith was exposed to a number of best practices, including the implementation of Patient Safety Executive Rounds at several healthcare organizations. Inspired by these case studies, Dr. Smith submitted and volunteered to sponsor a WorkOut to develop a Patient Executive Safety Rounds program at the Nebraska Medical Center.

Six Sigma and WorkOut at The Nebraska Medical Center

In December 2002, The Nebraska Medical Center initiated a Six Sigma program. General Electric Healthcare provided Six Sigma and WorkOut training as well as guidance on establishing a self-sustaining Six Sigma program.

WorkOuts are facilitated, subject matter expert-driven problem solving sessions. WorkOut sponsors provide WorkOut teams with immediate feedback on suggested solutions. Upon approval, every attempt is made to implement solutions within 30 to 60 days of the WorkOut session(s).

Six Sigma is a data-driven, customer-focused problem solving methodology. Six Sigma project teams analyze and improve processes by systematically reducing variation. The ultimate goal of any Six Sigma project is a process that operates nearly flawlessly. A process operating at a Six Sigma level of quality is 99.9997% error free.

This WorkOut was initiated in February 2004. Participants in this WorkOut included an Executive, two Staff RNs, a Cardiac Rehabilitation Manager, a Lab Specialist, a Lead ED RN, and a Respiratory Care Lead. The team worked to develop recommendations for how the Executive Patient Safety Rounds would be conducted.

After about a month of work by the WorkOut team, Dr. Smith reviewed and accepted the recommendations of the WorkOut group. The original Roundtable format called for two executives to attend a staff meeting. The executives were to follow a set of scripted questions to guide the

conversation and submit a summary of the conversation using a standardized form. Unit managers were not present at these initial meetings.

The program developed by the WorkOut group was similar to best practice examples of Executive Patient Safety Rounds with one significant difference: executives would not tour the work areas to conduct their reviews. The WorkOut group, with feedback from the executive staff, felt that walking around the work area (1) could cause distractions to those providing patient care and completing other tasks, (2) could compromise patient privacy, and (3) would not be the best format for having a focused conversation on patient safety issues. As a result, the program was designed such that an executive would attend a standing department meeting to gather input from employees.

In April 2004, the first Roundtable was held. Over the next several months, 20 subsequent Roundtables were conducted. As implementation of the program continued, it became apparent that several important issues challenged the sustainability of the Patient Safety Executive Roundtable initiative. First, the pairing of executives for each roundtable made for complicated logistics when scheduling meetings. Second, executives were not consistently using the same set of meeting questions and did not consistently document the results of meetings on the same summary form. Third, it was difficult to quickly address many of the issues raised by staff members because the department manager was not present during the roundtable discussion. Over 50% of issues raised in the early Roundtable discussions were within the control of the department manager to address. Finally, on at least one occasion, an executive led a Patient Safety Roundtable for a department under the executive line of authority in the organization. As a result, department staff expressed some hesitation with voicing department-focused patient safety issues in the presence of his/her Vice President.

In the spirit of continuous quality improvement, a group, including some of the original WorkOut team and a number of executives, was assembled to revise the Patient Safety Executive

Roundtable so that the above-mentioned issues could be addressed. Over the course of the next three months, revisions were made to the Patient Safety Executive Roundtable Program. The revised Patient Safety Executive Roundtable Program began in March 2005. Appendix 1 provides a summary of the revised Patient Safety Executive Roundtable Program. Changes made to the program are summarized below.

- (1) Facilitation of roundtables by only one executive
- (2) Simplification of the discussion script (see Appendix 2) and meeting summary form (see Appendix 3),
- (3) Inclusion of department managers in the roundtables
- (4) Clarification of communication flow, including the roles of Executive Support Staff and Quality Improvement Specialist
- (5) Ensuring that executives do not conduct roundtables in areas within his or her direct line of authority
- (6) Assigning executives to areas in the organization to establish continuity for follow up and build a relationship over time
- (7) Limiting the issues tracked in the Patient Safety Executive Roundtable to organization-wide issues, given that managers would now be part of the meeting and could track department-specific issues. All department-specific issues are sent to the area Director/Vice President, who is responsible for ensuring follow through on these issues.

By conducting these Roundtable discussions during established departmental meeting times, a maximal number of employees have the opportunity to participate in the program. When departments hold multiple staff meetings to cover various shifts, executives make every attempt to attend all departmental meeting sessions. Since the inception of the revised program, 562 employees have participated in Patient Safety Roundtable discussions.

Buy-in for this initiative has been addressed in a number of ways. First, it is important to point out that the lack of a detailed communication plan for Patient Safety Executive Roundtables was a barrier to its initial success. As part of the revised Patient Safety Executive Roundtable roll-out, a communication plan was developed. In March 2005, a presentation was made to all managers, directors, and executives at Leadership Briefing, a monthly meeting of all formal hospital leadership. This presentation included a summary of the initiative's purpose as well as why it was important and

necessary for the organization. In the weeks following the Leadership Briefing presentation, all managers attended one of several training sessions held to demonstrate how to prepare staff for the Roundtable in advance (See Attachment 4), to clarify their role in the issue resolution process, and teach them the process for communicating the status of issue resolution. Directors and executives attended a similar training session as well. In addition, Roundtable evaluations are closely monitored to identify any areas where staff buy-in to the process may be a barrier. Staff buy-in has also been established by the addition of a “brag session” to each Roundtable. The “brag session is a 15 minute period when departments are asked to present things they have been working on in the past year to improve the safety and quality of care for patients. These “brag sessions” allow for patient safety dialogue to flow both ways; the executive learns about departmental issues already being addressed and educates the staff on organization-wide issues receiving attention. In many cases thus far, staff have taken a lead role in presenting during their “brag session”.

Five indicators are being tracked to assess the success of this program. These indicators are listed below. Data for each of these indicators is presented in the results section of this application.

- (1) Number of roundtables conducted
- (2) Number of department-specific issues identified (and % resolved)
- (3) Number of organization-wide issues identified (and % resolved)
- (4) Average issue resolution time
- (5) Roundtable participant evaluation ratings

Results

To provide an idea of the breadth and scope of this project, The Nebraska Medical Center has 77 distinct departments. Fourteen executives are assigned between three and eight departments to routinely visit. Executives assigned to patient care giving areas are expected to meet with staff from those departments twice per year. Executives assigned to non-patient care giving areas are expected to meet with staff from those areas once per year. Thus, the annual goal for number of roundtables conducted is 124.

Number of roundtables conducted

For the 12 month tracking period that began in March 2005, 56 Roundtables have been held thus far. In addition, 100 of the 124 Roundtables expected to be conducted from March 2005 to March 2006 have been scheduled. A master assignment list is kept up-to-date and shared at Operations Council meetings (Regular Meeting of Hospital Executives) on a quarterly basis as a pulse-check on the completion of roundtables. Executives are identified individual on this report with respect the percentage of assigned meetings scheduled, completed, and rescheduled. As part of the Patient Safety Executive Roundtable review at Operations Council, trends of issues and locations of issues are discussed as well.

Number of department-specific issues identified and resolved

Since the implementation of this program, 97 department-specific issues have been identified during Roundtable discussions, with at or near 100% of the issues being resolved. In some cases, resolution may mean that work is already in progress to fix a problem or that clarification/improved communication is needed. Below are examples of several of the department-specific issues that have been identified and resolved as a result of this program.

During a Roundtable with the Pathology Department, it was identified that the hospital did not have adequate handicap seating in the cafeterias. As a result, some patients or patients' families were having a difficult time navigating through the chairs and tables in the cafeteria to find a seat. This issue was brought to the attention of the Food and Nutrition Leadership. A designated handicap section of tables was created close to the checkout cashiers in all cafeterias.

During a Roundtable with one of the Medical Surgical Units, it was identified that nursing staff did not have enough knowledge about the operation of some of the "rental beds" used on the floor. These "rental beds" are used when a standard hospital bed will not meet the needs of patients, such as bariatric patients. Not having enough knowledge about these beds is a problem because it delays the

order and delivery of the bed and places both staff and patients at risk of injury if forced to use a standard bed for a period of time. In a follow up to this meeting, a “Bed Fair” was organized with the bed company’s vendor so that all hospital nurses could learn more about the rental beds being used.

Number of organization-wide issues identified and resolved

Since the implementation of this program in March 2005, 213 organization-wide issues have been identified during Roundtable discussions. Thus far, 19% (41) of the issues have been resolved. Another 54% (114) of the issues are currently in the process of being resolved by an identified owner with a specific time frame for completion. Of the remaining identified issues, 15% (31) would require long-term, capital intensive solutions to address. A number of the capital-intensive issues are already in the process of being addressed by the organization, such as inpatient floor renovation, way finding improvements, and information systems upgrades. The final 13% (27) of the issues were closed because there was no action that could be taken or the issue was not patient safety related. An example of a closed issue is, “I don’t like walking across 42nd Street to come to work.” Below are examples of several of the organization-wide issues that have been identified and resolved as a result of this program.

During a Roundtable with the Linen Department, it was identified that collisions and near collisions were occurring throughout the hospital between patients being transported and hospital staff. The collisions most frequently occurred at “blind intersections”. As a result of this feedback, additional reflector domes were installed at problem locations throughout the hospital. Reflector domes work as mirrors to enable a person to see if someone is approach an intersection from another hallway.

During a Roundtable with the Rapid Response group in the Lab, it was identified that mislabeled specimens were arriving to the lab. Data was analyzed to determine where the majority of the mislabeling issues were occurring. Following this analysis, a WorkOut group was assembled

composed of lab and nursing staff to develop solutions for the mislabeling process. The solutions identified by this group are currently in the pilot phase of implementation.

Issue resolution time

Thus far in the program, issues have been resolved within an average of 28 days from the date of the Roundtable meeting. Please see Appendix 5 for a graph depicting the issues identified by category, including the percentage of issues that have been resolved or in process.

Roundtable participant evaluation ratings

Following each Roundtable, staff is given the opportunity to complete a brief evaluation on their impression of the process. These surveys are completed anonymously and routed to a Quality Improvement Specialist to compile the results. Responses from staff who have participated have been extremely positive. To date, 562 evaluations have been completed. Below is a summary of some of the feedback received from the evaluations.

| Roundtable Evaluations | | |
|---|-----|----------------------|
| 93% said the length of the session was just right | | |
| 98% are willing to participate again | | |
| “The roundtable created a safe environment for sharing.” | 4.5 | (on a 5 point scale) |
| “The executive was respectful of my time” | 4.9 | (on a 5 point scale) |
| “The roundtable increased my awareness of pt safety issues” | 4.3 | (on a 5 point scale) |

Lessons Learned

As mentioned previously in the methods section, a number of logistical and consistency challenges were faced by this program early on. This program provides a good example of the value in piloting an improvement, evaluating it, and then refining improvement before engaging in a full-fledged roll-out. Since March 2005, the program has operated much more smoothly. Critical success factors to this program have been the inclusion of department managers in roundtable sessions, a robust tracking system for both issues and meeting completion, and clear role definition for all of those

involved in the program. Maintaining visibility of this program at Executive meetings has been another effective mechanism for ensuring participation and follow-through on issues.

With regard to the sustainability of this program, the future looks to be a positive one for Patient Safety Executive Roundtables. The program continues to have a champion in Chief Medical Officer Steve Smith, MD, who is passionate about improving the safety and quality of care provided to patients at The Nebraska Medical Center. Further, the involvement of other hospital examples speaks to the organization's commitment to the program. Since March 2005, the organization's Chief Financial Officer, Chief Medical Officer, and Chief Operating Officer have facilitated five, five, and four roundtables respectively. In addition to executive commitment, staff response to the program has been positive and motivating given that their suggestions are being put into action for the benefit of patients.

Regardless of hospital size or focus, a program such as the Patient Safety Executive Roundtable Program could be a valuable component in a hospital's patient safety improvement efforts. Involving hospital leadership directly in a proactive patient safety improvement process yields a number of dividends. First, leadership's participation in such a program serves as a tangible reminder of the organization's commitment to patient safety. Second, hospital leaders are in perhaps the best position to remove barriers and roadblocks to the implementation of improvements. Third, hospital leaders gain a deeper understanding of the "pulse" of the organization by speaking directly with those closest to the work. Finally, employees are empowered and motivated by seeing their own or other employee's suggestions get translated into action.

APPENDIX 1

Hospital Executive's Role in the Patient Safety Walk-Around (PSWA) Process

Each hospital executive is assigned to conduct no more than 10 patient safety walk-around meetings per year in a mix of both clinical and non-clinical areas outside of his or her direct accountability.

Clinical area: unit that offers direct patient care. Will receive walk-around **twice** per year.

Non-clinical area: unit that does not offer direct patient care. Will receive walk-around **once** per year.

Hospital Executive Accountability:

Pre-meeting: There are no pre-meeting areas of accountability.

*****Scheduling note:** Because many departments only meet as a full staff once per month, it is important that once the meeting is scheduled, the appointment time is kept.

During meeting:

- Facilitate discussion with staff members utilizing scripted questions provided in meeting packet (Manager/Director in attendance will scribe all of the issues identified on the interview notes form.)
- Assume responsibility for appropriately communicating all identified organization-wide issues to the appropriate owner (Manager/Director in attendance should assume ownership of all department specific issues.)
- Hand out / collect staff meeting evaluation forms.

Post-meeting:

- Communicate all organization-wide issues to appropriate owners within five business days of the meeting via e-mail and **CC: Stephanie Gould** on the correspondence.
 - If an owner is not clear – it should be discussed and assigned at the next Operations Council Meeting and communicated to the owner in the manner described above within 5 business days of assignment.
- When all issue hand offs are complete, turn completed form and staff evaluations over to the respective support staff member.
- Update Operations Council on any newly identified organization-wide issues during weekly safety discussion.

Executive Support Staff Accountability:

Pre-meeting:

- Schedule PSWA meetings in executive's assigned areas as appropriate during the department's regularly scheduled staff meeting time.
- Provide executive with all PSWA meeting materials the day of the walk-around.

Post-meeting:

- Send copy of completed interview notes form to area director, area VP and Stephanie Gould.
- Send employee evaluations to Jim Kieffer.
- Enter all Organization-Wide issues into the PSWA database.

APPENDIX 2

Patient Safety Executive Walk-Around Meeting Format and Discussion Script

Total Meeting Time: 60 Minutes

Meeting Attendees: Executive staff member, area manager or director, as many departmental staff as possible.

Opening the meeting (1- 2 minute opening given by the executive):

- Give clear reasons for the meeting (employee survey results, P.S. We Care Program, furthering an organization-wide culture of patient safety).
- Explain that this is a process of discovery, investigation and bettering the organization, not a format to lay blame.
- Explain meeting goal is for staff to have a format to inform hospital leadership of safety successes and concerns in relation to **patients, employees, the hospital environment and equipment**.
- Explain that meeting will occur once or twice per year (depending on whether or not it is a direct patient care department) and how follow up will occur.
- Explain that there are prepared discussion questions with time for additional questions at the end of the discussion, but the meeting will begin by learning about what patient safety efforts are currently receiving attention in the department.

Presentation from the staff (13 – 15 minutes):

- Staff members inform the executive of all safety-related issues either resolved or focused on through departmental efforts in the last year.

Executive facilitated discussion (30 minutes):

Roles:

- Executive asks scripted questions, keeps conversation focused on safety-related issues, and probes when necessary
- Staff provides feedback
- Manager/Director scribes the issues raised in discussion on the interview notes document

Scripted Questions for Staff:

1. What are the procedural or environmental shortcomings in place at The Nebraska Medical Center that have created near miss situations with patients in which you have been involved, or that you have observed?
 2. Can you think of any recent events that have resulted in patient safety issues?
 - a. What ideas do you have for correcting those issues?
 3. Do you have any ideas or suggestions as to what we can do to prevent the next adverse event?
 4. Do you feel you need any additional training on the incident reporting process?
 5. In regards to patient and employee safety, is there anything we can do to make your job easier?
 6. Do you have any other safety issues or suggestions that have not yet been touched upon?
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Meeting wrap-up (15 minutes)

- Executive hands out meeting evaluations to all staff members and picks them up before he/she leaves.
- Staff completes meeting evaluation and leaves it for the executive.
- Executive and Manager meet to discern the scope of the issues identified in the meeting.
 - Manager assumes ownership and follow up for all department specific issues.
 - Executive assumes responsibility for communicating issues to owners of all organization-wide issues.
- Manager makes a copy of the completed interview notes form for the executive before he/she leaves.

APPENDIX 3 Meeting Summary Form

| Unit(s) Interviewed | | Date: | | Executive Conducting the Meeting: | | | |
|--|--|--|----------------------|---|---------------------------------|---------------------|-------|
| Unit VP: | | Unit Director: | | Unit Manager: | | | |
| Note: Both the manager and executive need to leave the meeting with a copy of the form completed through the Blue columns | | | | | | | |
| Completed by manager during discussion | | Completed by area leadership & exec. in final 15 mins of mtg. | | | Completed by Exec. upon handoff | | |
| Issue Description | Type | Scope | Departments Involved | Estimated Resolution Time Frame | Owner | Date Owner Accepted | Notes |
| | <input type="checkbox"/> Patient Safety <input type="checkbox"/> Staff Safety <input type="checkbox"/> Environment <input type="checkbox"/> Equipment <input type="checkbox"/> Other: <hr/> | Executive Communicates: <input type="checkbox"/> Organization Wide <input type="checkbox"/> Organization Immediate Manager Owns Follow Up: <input type="checkbox"/> Department Only <input type="checkbox"/> Department Immediate | | <input type="checkbox"/> 1 = <14 days <input type="checkbox"/> 2 = 15 - 90 days <input type="checkbox"/> 3 = 91 + days <input type="checkbox"/> 4 = Resolution in progress* <input type="checkbox"/> 5 = No short term solution** | | | |
| | <input type="checkbox"/> Patient Safety <input type="checkbox"/> Staff Safety <input type="checkbox"/> Environment <input type="checkbox"/> Equipment <input type="checkbox"/> Other: <hr/> | Executive Communicates: <input type="checkbox"/> Organization Wide <input type="checkbox"/> Organization Immediate Manager Owns Follow Up: <input type="checkbox"/> Department Only <input type="checkbox"/> Department Immediate | | <input type="checkbox"/> 1 = <14 days <input type="checkbox"/> 2 = 15 - 90 days <input type="checkbox"/> 3 = 91 + days <input type="checkbox"/> 4 = Resolution in progress* <input type="checkbox"/> 5 = No short term solution** | | | |
| | <input type="checkbox"/> Patient Safety <input type="checkbox"/> Staff Safety <input type="checkbox"/> Environment <input type="checkbox"/> Equipment <input type="checkbox"/> Other: <hr/> | Executive Communicates: <input type="checkbox"/> Organization Wide <input type="checkbox"/> Organization Immediate Manager Owns Follow Up: <input type="checkbox"/> Department Only <input type="checkbox"/> Department Immediate | | <input type="checkbox"/> 1 = <14 days <input type="checkbox"/> 2 = 15 - 90 days <input type="checkbox"/> 3 = 91 + days <input type="checkbox"/> 4 = Resolution in progress* <input type="checkbox"/> 5 = No short term solution** | | | |

APPENDIX 4
Roundtable Prep Guide

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| Patient Safety Walk-Around Staff Information Guide |
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Meeting purpose:

Patient Safety Executive Walk-Arounds is a tool designed to enhance a culture of safety at The Nebraska Medical Center.

Meeting goal:

The goal of Patient Safety Executive Walk Arounds is for staff to inform hospital leadership of safety successes and concerns in the following areas:

Patient Safety - This type of issue is any concern that can somehow negatively impact a patient's care.

Staff Safety - A concern of this type signifies an issue that in some way jeopardizes employee safety.

Environment - This issue type means that something inherent in the department's surroundings is causing a safety concern.

Equipment - This type of issue indicates that there is a safety concern with the department's equipment (medical, clerical or otherwise.)

Other - This category is for any **safety-related** issue that does not match any of the above criteria. Please be as descriptive as possible when placing issues into this type so that future categories may be assigned as appropriate.

Meeting format:

The 60 minute meeting format, scheduled during the regular department meeting time, is broken down into three parts:

First 15 minutes – designated for staff to inform executive of all the safety-related issues either resolved or focused on through departmental efforts in the last year.

Middle 30 minutes – facilitated discussion where the executive will ask the following questions:

7. What are the procedural or environmental shortcomings in place at The Nebraska Medical Center that have created near miss situations with patients in which you have been involved, or that you have observed?
8. Can you think of any recent events that have resulted in patient safety issues?
 - a. What ideas do you have for correcting those issues?
9. Do you have any ideas or suggestions as to what we can do to prevent the next adverse event?
10. Do you feel you need any additional training on the incident reporting process?
11. In regards to patient and employee safety, is there anything we can do to make your job easier?
12. Do you have any other safety issues or suggestions that have not yet been touched upon?

Final 15 minutes – designated for staff to provide written feedback on meeting evaluation form while the executive and department manager divide ownership of issue follow up.

Meeting attendees:

The area manager and/or director should be in attendance, as well as the hospital leadership representative and as many department staff members as possible.

APPENDIX 5

Organization-Wide Patient Safety Issues

**Organization-Wide
Patient Safety Executive Round Table Issues
by Type and Status as of July 2005**

