
CHARTIS
Preventing adverse events through learning
Monthly webinar series
July 2024
The webinar will start at the top of the hour.

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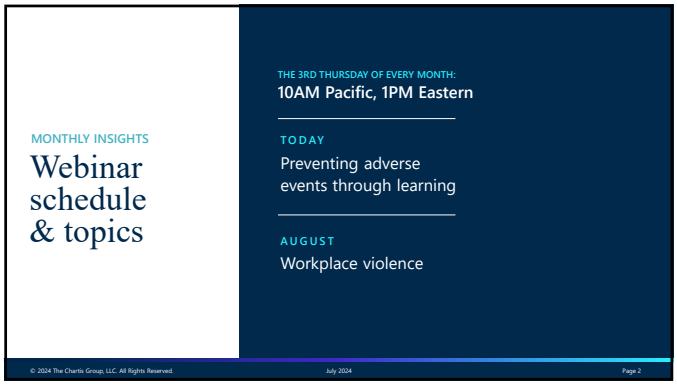
MONTHLY INSIGHTS
Webinar schedule & topics
THE 3RD THURSDAY OF EVERY MONTH:
10AM Pacific, 1PM Eastern
TODAY
Preventing adverse events through learning
AUGUST
Workplace violence
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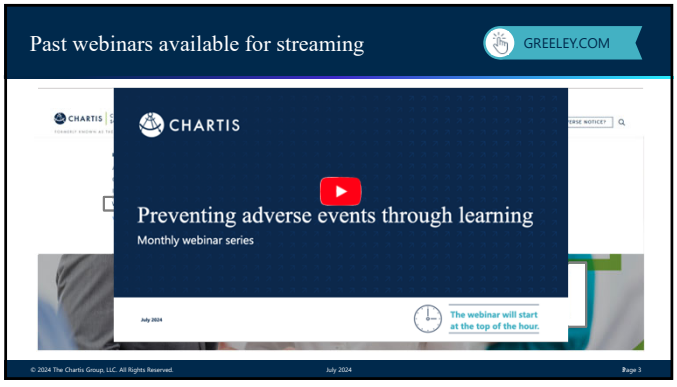
Past webinars available for streaming
GREELEY.COM
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Navigating the Zoom interface

Handouts:

Check the chat function for copies of the slides for note taking and any other handouts.

Questions and comments:

Please participate in the discussion by asking question through the Q&A function during the webinar.

There will also be a survey you will receive immediately after the webinar that will give you an opportunity to ask additional questions or make comments.

Any questions not answered during the webinar will be addressed in a follow-up email or posting.

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Healthcare challenges are not siloed. *Neither are we.*

Chartis has **six practices** that together craft **singular solutions**.

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High Reliability Care

Unparalleled Breadth and Depth

Our clients are all striving toward the same goal of providing safe, high-quality care—something that's becoming even more important with the many distractions and disruptions in healthcare today. We help clients achieve their organizational reliability, quality, and safety goals, leading to results in areas that matter most—improved care outcomes, staff engagement, operational stability, and total cost of care, enhanced reputation, and better patient experience.

High Reliability Organization (HRO)

- High Reliability Organizational Design and Infrastructure
- Quality, Value, and Performance Improvement
- Quality Ratings and Rankings Optimization
- Patient Safety / Harm Reduction / Safety and Reliability Culture
- Adverse Event Response and Remediation / RCA
- High Fidelity Measurement / CDI
- Care Facilitation

Clinical Compliance, Regulatory, and Physical Environment Solutions

- Adverse Event Response
- Adverse Action Regulatory Response and Remediation
- Accrediting Body Readiness Assessment
- Regulatory Readiness Rehearsal / Mock Surveys
- Life Safety and Environment of Care Assessment
- Policy Simplification
- Infection Prevention Program

Bylaws, Rules and Regulations, and Peer Review

- Bylaws and Rules and Regulations Assessment and Redesign
- Peer Review Assessment and Redesign
- Medical Staff / Medical Director Structure and Governance
- Credentialing, OPPE

External Peer Review

- Physician/Advanced Practice Professional External Peer Review
- Focused Professional Practice Evaluation (FPPE)
- Ongoing Case Review in Support of OPPE/FPPE
- Medical Necessity Reviews
- Patient Safety/Care Quality Case Reviews

Membership and Professional Education Services

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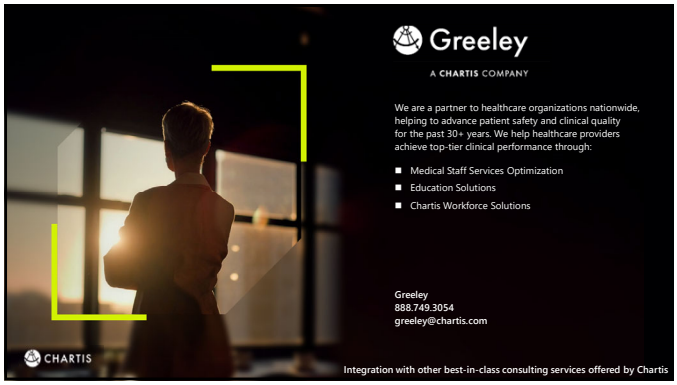
Greeley
A CHARTIS COMPANY
We are a partner to healthcare organizations nationwide, helping to advance patient safety and clinical quality for the past 30+ years. We help healthcare providers achieve top-tier clinical performance through:
Medical Staff Services Optimization
Education Solutions
Chartis Workforce Solutions
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CHARTIS
Integration with other best-in-class consulting services offered by Chartis

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What is your *role*?
Chief Quality Officer
Other Executive Leader
Quality Manager
Patient Safety Officer
Risk Manager
Accreditation/Regulatory Compliance
Consultant
Other
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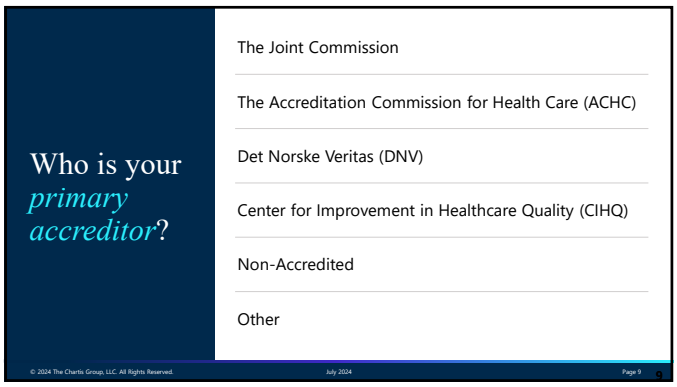
Who is your *primary accreditor*?
The Joint Commission
The Accreditation Commission for Health Care (ACHC)
Det Norske Veritas (DNV)
Center for Improvement in Healthcare Quality (CIHQ)
Non-Accredited
Other
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Today's *discussion*

An introduction into the importance of adverse event reporting and the organizational culture that supports robust reporting and learning from medical errors.

Steve Mrozowski, MHA, CPPS, FACHE
Partner,
High Reliability Care

Joshua Cartwright, DHA, MHL, CPHQ, FACHDM
Associate Partner,
High Reliability Care & Compliance

"Keeping up with change, planning for tomorrow

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Today's *agenda*

- Overview & why reporting
- How to maximize reporting culture
- Maximizing learning & transparency

Questions should be posted in the webinar interface throughout the presentation.
We will respond to any unanswered questions in writing following the webinar.

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Overview & why reporting matters

01

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Definitions

Adverse event	defined as an injury caused by medical management rather than by the underlying disease or condition of the patient.
Preventable adverse event	defined as an adverse event injury that could have been avoided as a result of an error or system design flaw.
Near miss	any event that could have had adverse consequences but did not and was indistinguishable from fully fledged adverse events in all but outcome.

Internally reportable? It depends…

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WHAT IS HIGH RELIABILITY?

Lessons from other industries

A high reliability organization is one that operates in a complex, dynamic, high-consequence environment for long periods without serious accidents or failures.



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What does it mean to be a high reliability organization?

1. HROs understand that they operate in a **hypercomplex and high-risk environment**
2. There is tight coupling from the **board to the bedside** and **across units** supported by **clear communication**, **information**, and **alignment** to a **unified mission**
3. Through consistent compliance with expected behavior bundles, there is a degree of **accountability** that does not exist in most organizations
4. They maintain constant **situational awareness** and identify small failures and **near misses**, viewing each as an opportunity for **learning** and **improvement**

HROs embrace a culture where core values and behaviors reflect a collective mindfulness and commitment by all that emphasizes quality and safety over competing priorities

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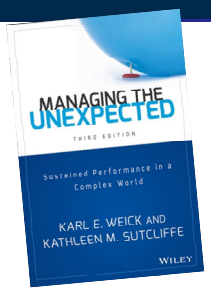
Adverse events and high reliability organizing



- **Preoccupation with failure**
- Reluctance to simplify
- **Sensitivity to operations**
- Deference to expertise
- **Commitment to resilience**

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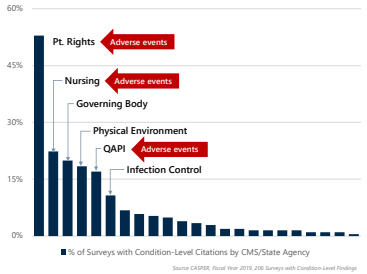
Regulatory impact

- The most highly cited regulation leading to CMS termination actions for accredited hospitals is **EMTALA**.
- The highest cited Conditions of Participation are **Patient Rights** and **Nursing Services**, both of which are associated with adverse event and medical error.
- Recent CMS interpretive guidelines have further emphasized the importance of error prevention.
- ~90% of CMS involvement with healthcare organizations has something to do with adverse events



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The state of *safety*

Since the IOM Report "To Err is Human" in 1999, any subsequent publication and study has painted a generally grim picture on the state of patient safety in the US that estimate preventable patient deaths anywhere from 45,000 – 440,000 annually.

2022: OIG

- 25% of study patients experienced events resulting in harm during their hospitalization. About half of these were "temporary harm events" and half were "adverse events."
- 41% of these occurrences were preventable.

2023: The Safety of Inpatient Health Care, NEJM, Bates et. Al.

- 2800+ hospital admissions
- 24% experienced an adverse event, 32% of which were serious harm
- 23% determined to be preventable

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The *importance* of reporting

ACTIVITY:
Discuss "why" reporting is not as frequent as it could/should be in healthcare?

> Healthcare workers "recognize and report only **one out of seven errors**, accidents and other events of harm.
>
> — Department of Health and Human Services

What to report:

- Events *(even when there is no harm or injury)*
- Safety issues or concerns *(accidents waiting to happen)*

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POLL QUESTION:

Which safety/adverse event reporting platform are you *currently utilizing*?

MIDAS	RL Solutions	Origami
Press Ganey/HPI/Next Plane	Paper Process	Other Electronic
I'm not sure		

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CHAT QUESTION:

What makes your event reporting platform and process the *best*?

What would you *change*?

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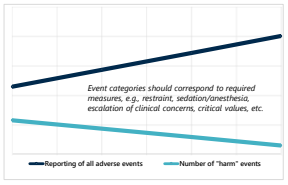
About adverse events

The organization may rely on adverse event/situation reporting instead of proactive data collection ONLY to the extent that reporting, analysis, and improvements are credible.



To optimize the value of incident reports as a credible monitor of quality and safety there MUST be a high level of inter-rater reliability (consistency) in the designation of incident categories and level of harm/analysis.

Sifting Through Adverse Events

Score in the higher episode level

ESS	Description	Infrastructure	Harm?	Analysis
Zero (0)	**No Variance**: No known or suspected error or adverse state. Includes recommendation for improvement.	✔	No Harm	Fact Finding
A	**Unsafe**: There was in increased capacity for error, even though no error was identified.	✔	No Harm	Fact Finding
B	**Captured**: An error occurred but it did not reach a person or infrastructure.	✔	No Harm	Fact Finding
C	**No Monitoring**: An error occurred that reached a person or the infrastructure, but there was *no need* for monitoring or intervention.	✔	No Harm	Fact Finding
D	**Monitoring** was necessary to look for potential signs of harm or damage. Monitoring includes non-invasive diagnostic testing.	✔	No Harm	Fact Finding
E	An **Intervention** was necessary to avoid further harm to the patient or infrastructure.	✔	Harm	ACA* (Sample)
F	The error lead to an initial or prolonged **hospitalization**.		Harm	ACA (Sample)
G	The error contributed to **permanent harm** to a person or the infrastructure.	✔	Harm	RCA*
H	**Resuscitation:** Intervention necessary to sustain life that involved advanced life support protocols.		Harm	RCA
I	**Death**		Harm	RCA
S	Defined **Sentinel Event**		Harm	RCA

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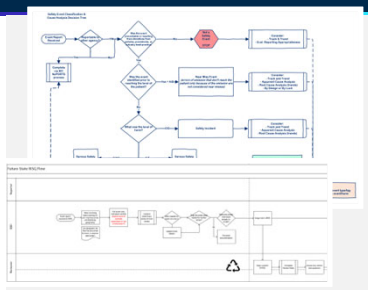
C-SUITES

All about standard process

- Standard process for intake
- Standard classification and scoring
  - What about employee harm events?
- Standard approach to reporting requirements
- Standard approach to review and cause analysis
  - CMOs: "slow down, calm down, trust the process"
  - Employee harm events?
  - Must leverage the experience at the sharp end of the work – "deference to expertise"
- Just Culture
  - Wrong Knee Event



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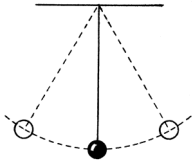
DON'T FORGET JUST CULTURE

A balanced approach to accountability

FAIR OR JUST CULTURE

Culture of Blame

- Errors are punished
- Offenders are removed from system
- Only errors that can't be covered up are reported
- **Errors continue because system cannot learn from mistakes**



Blame Free Culture

- Errors are forgiven
- Offenders remain in system
- Errors reporting is high
- **Errors continue because there is no accountability for performance**

> "..an atmosphere of trust in which people are encouraged (even rewarded) for providing essential safety-related information, but in which they are also clear about where the line must be drawn between acceptable and unacceptable behavior.
>
> — J. Reason

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POLL QUESTION:

Who administratively *"owns"* just culture accountability in your organization?

Safety/Quality/Risk	Regulatory	Human Resources
Nursing	Medical Staff Office	We don't have any sort of Just Culture program

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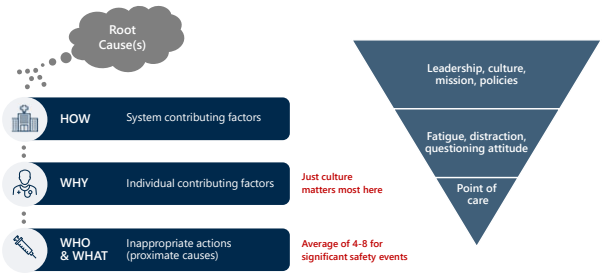
Digging deep enough

INDIVIDUAL AND SYSTEM CONTRIBUTORS

Thorough event investigations will often uncover proximate causes or individual contributing factors. It is incumbent on those conducting event investigations to determine why and how those individual failure points were able to occur



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Maximizing reporting culture

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Making harm *visible*

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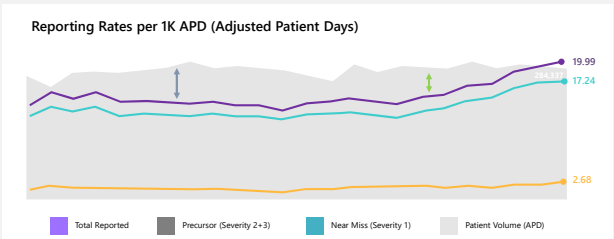
SSER vs. Rate of Reporting



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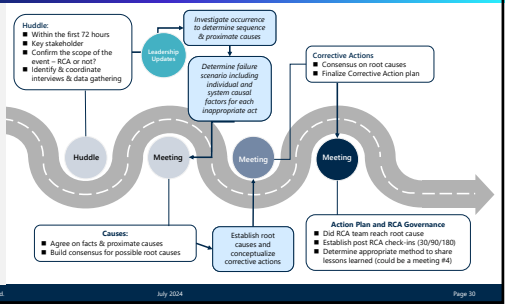
RCAs are more than 1-hour meetings

RCA journey
Our recommended approach

The RCA (Root Cause Analysis) journey is a process that aims to help local leaders and subject matter experts solve problems in a structured manner. The Chartis model provides a framework to validate the facts of an event, present review findings, reach consensus on the root cause, implement corrective actions, and establish long-term governance and education for sustained improvement.

Subsequent benefits of a robust cause analysis program include: reduction in backlogs of event routing, improved expectations of local leaders and those involved, and standardized communication across the board.



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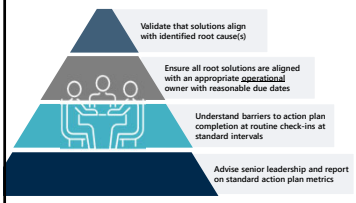
CLINICAL AND OPERATIONAL PROCESSES

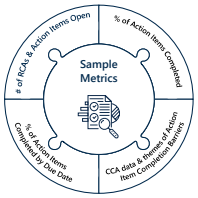
Action plan accountability

Develop a cause analysis action plan oversight committee with associated metrics and integrate into overall alignment and accountability structure.

Action Plan Oversight Committee



Measure Impact



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Maximizing learning and transparency

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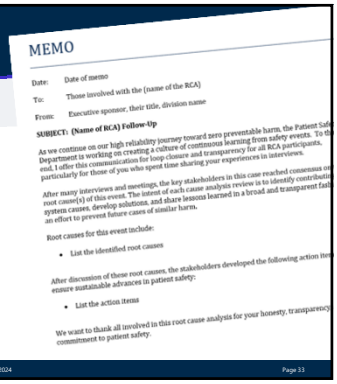
RCA close-out memos

Demonstrate actions taken from event reports

- Sent from the C-suite to RCA participants
- Provide a detailed enough summary of the event for those who only participated in interviews
- Describe what was found to be the cause(s) and the actions taken



MEMO

Date: Date of memo

To: Those involved with the (name of the RCA)

From: Executive sponsor, their title, division name

SUBJECT: (Name of RCA) Follow-Up

As we continue on our high reliability journey toward zero preventable harm, the Patient Safe... Department is working on creating a culture of continuous learning from safety events. To th... end, I offer this communication for loop closure and transparency for all RCA participants, ... particularly for those of you who spent time sharing your experiences in interviews.

After many interviews and meetings, the key stakeholders in this case reached consensus on ... root cause(s) of this event. The intent of each cause analysis review is to identify contributin... system causes, develop solutions, and share lessons learned in a broad and transparent fash... an effort to prevent future cases of similar harm.

Root causes for this event include:

- List the identified root causes

After discussion of these root causes, the stakeholders developed the following action item... ensure sustainable advances in patient safety:

- List the action items

We want to thank all involved in this root cause analysis for your honesty, transparency ... commitment to patient safety.

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Event reporting feedback loops


Dear Ima Nurse,

Thank you for submitting your Patient Safety Event Report #19-12776 on 05/15/2019 concerning C - Comp post surg/proc -other (specify in Other - 3 field). This event has been reviewed by the Patient Safety Department and this event has led to initiating an Apparent Cause Analysis/Root Cause Analysis.

To provide continuous quality improvement around patient safety event reporting we are providing feedback to the reporters on the submitted event information. Our goal is to provide objective feedback to assist you in reporting timely, succinct, factual, accurate, and professional details in an event report. More information can be found at https://infonet.pennstatehershey.net/midasfeedback.

Reporter Feedback Loop	
Clarity	Incomplete, difficult to understand, or complex
Objectivity	Assistive/Appropriate
Accuracy	Some details were inaccurate (i.e. location of event, Event type, OOS, Patient, etc.
Language/ Professionalism	No finger pointing or direct blame placed on other parties

When entering a Midas, please make sure to include "what was done to remediate the issue". The Location should be the location/department where the incident occurred and not the location/department where it was discovered. Location was changed to ED01.

All reports are saved so that themes and trends can be identified. Should you desire follow-up on your individual report, please **include the report number identified above** in an email to patientsafety@pennstatehealth.psu.edu.

Thank you,

Department of Patient Safety

- Automate as much as possible
- Personalized response
- Provides an opportunity for coaching reporters
- Consider leveraging ERS technologies
- Objective and Subjective Feedback
  - Clarity
  - Objectivity
  - Accuracy
  - Language/Professionalism
  - "What we're doing next…"
- PUSH not pull
- Does not replace manager-to-employee conversations and loop closure

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Tying lessons to high reliability behaviors

Make the lessons relatable with a clear tie to actions that caregivers can take to prevent recurrence

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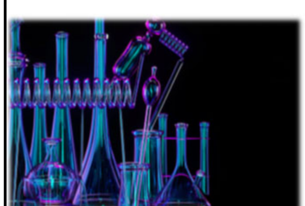
Learning: The peak of maturity in quality/safety



- Education as an action item is incorrectly referred to as synonymous with organizational learning
- If items aren't relatable to the masses, practice won't change
- Be proactive: CCA Data (at least annually) – de' ja vu events/CCA themes
- Tag within ERS for any event tied to institutional quality/performance improvement goals
- RCA'ing of successes and "non-events" – use those learnings to prioritize activities
- Think about how your organization can measure learning

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In *summary*

- Clearly and broadly define reporting expectations
- It is incumbent on leaders to model and reinforce those expectations with zero tolerance for negative repercussions
- Just culture must exist throughout the organization
- Each event must follow the same, consistent, pathway
- Be transparent and close the loop with relatable, meaningful, and actionable information that is delivered in a timely way
- Always consider how to maximize learning

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Questions/concerns?

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Thank *you*

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