Great Plains Health

Not Just for Football Anymore: Huddle Up for Safety and Quality Outcomes

Barbara Petersen APRN, MSN, CPHQ

Wendy Ward BSN, RN, HACP

Objectives

- Best Practice for Safety Huddles
- Closing the loop on safety events
- Engaging frontline staff for culture of safety
- Malcolm Baldrige Framework

Daily Safety Huddle Template

Great Plains Health

THE SAFETY HUDDLE

APRIL 24, 2024
CONFERENCE ROOMS

MISSION

To inspire health and healing by putting patients first-always.

VISION

To be the region's most trusted healthcare community.

VALUES

We are genuine. We are passionate. We have integrity. We listen. We are a team.

Quarterly Value in Action: **We are a Team**

- *Demonstrate high commitment to making things better for the organization*
- *Does not create we/they*
- *Problem solves*
- *Coaches and encourages their team*
- *Hold everyone accountable*

Clinic Visits: **649**	Clinic Procedures: **46**	Outreach: **38**
House Supervisor:	Census:	Discharges:
Surgeries: **29**	ED Visits Yesterday:	AOC: **Lance**

VOICE OF A PATIENT

Strength- **Everyone was very upbeat and positive. Helpful and friendly. (Press Ganey-Surgery)**

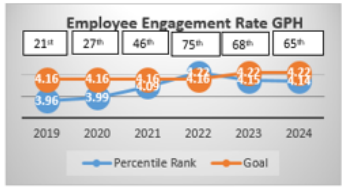
STRATEGIC OBJECTIVES

- Ensure access to quality care.
- Deploy innovation to improve organizational outcomes.
- Grow services to exceed our region's needs.
- Live our mission, vision, and values.
- Maintain the independence of healthcare within our region.

Employee Engagement

Updated 3/4/2024

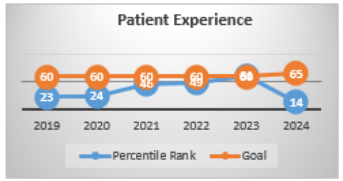
- Goal: 75th Percentile
- Current YTD: 4.14 65th Percentile



Patient Experience

Updated 4/3/2024

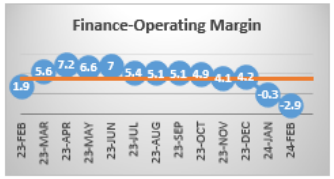
- Goal: 65th Percentile
- Year to Date: 14th Percentile



Finance

Updated 3/29/2024

- Goal for Employee Bonus: 3.05%
- Current Month: -2.9%



Medicare 5 star rating

Current results from 7/2018 – 3/2022

- Goal: 5 Star
- Current YTD: 2 Star

DEPARTMENT SAFETY REPORT

Women's/Children's:_____
ICU/PCU:_____
Med/Surg:_____
BHS:_____
Bio Med:_____
Cancer Center:_____
Case Management: ___ % DC before 1pm
___ patients DC before 11am
___ patients 10 days stay or greater
___ patients 21 days stay or greater
Care Coordination:_____
CVS:_____
Brain/Spine:_____
DI:_____
ER:_____
Engineering:_____
Security:_____
EVS:_____
Nutrition:_____
Oak Street Building/Rheum:_____
Centennial Building:_____
IT:_____
Education:_____
Lab:_____
Materials Mgt:_____
Patient Experience:_____
Pharmacy:_____
Rehab:_____
Respiratory:_____
Surgery:_____
Urgent Care:_____
Ophthalmology:_____
ENT:_____
Wound:_____
Orthopedics:_____
2nd floor Pavilion:_____
HME:_____
Research:_____
Compliance/HIPAA:_____
HR/Employee Injuries:_____
Quality:_____

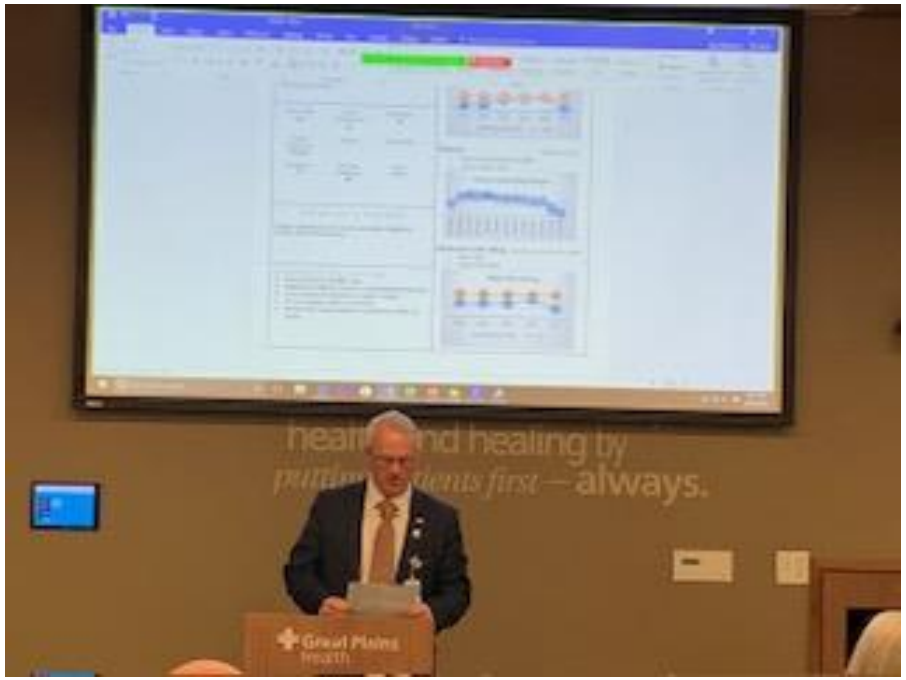
- **Days since last fall:**
  Inpatient: ____ **Outpatient:** ____

NO SAFETY CONCERNS

Safety Huddle Messages/Highlights:

Administrator on Call: Lance Arterburn
Physician Rounding: Nephrology/Pain Management

Safety Huddle Attendance




Did you know that some sharks, like the Spotted Wobbegong, often rest in groups, lying on top of each other on the ocean floor? It's almost like a group cuddle session, challenging our typical perception of these mighty predators!

All employees receive

Great Plains Health

THE SAFETY HUDDLE

APRIL 23, 2024
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- *Coaches and encourages their team*
- *Hold everyone accountable*

Clinic Visits: 726	Clinic Procedures: 50	Outreach: 32
House Supervisor: Rebekah	Census: 65	Discharges: 6
Surgeries: 40	ED Visits Yesterday: 31	AOC: Lance

VOICE OF A PATIENT

Opportunity- **It seemed like she wasn't listening as well as she could have.**

Strength- **The nurses caring for me were EXCELLENT both at night and during the day. John, Cole (Colton), Annie, Amber, Analisa were a credit to their profession. (Press Ganey-Med/Surg)**

STRATEGIC OBJECTIVES
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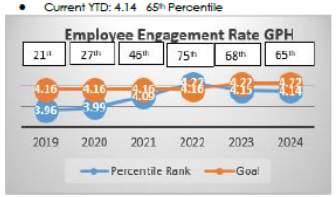

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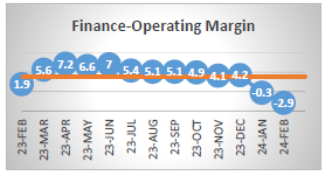


Medicare 5 star rating Current results from 7/2018 – 3/2022
- Goal: 5 Star
- Current YTD: 2 Star

DEPARTMENT SAFETY REPORT

Women's/Children's: 1 Fall Risk. Action Cues: Cord blood tube-overfilled and spilled in biohazard bag with other lab specimen. Discharged patient and infant concern with car seat base not placed correctly.

ICU/PCU: 16/19 Fall Risk. 1 Foley. 4 Central Lines. Action Cue: Wrong med administered-Lactated Ringers running instead of ordered Amiodarone.

Med/Surg: 22/25 Fall Risk. 2 Foleys. 5 Central Lines. Action Cues: Concern for medication variance-timely administration. Medication variance-dose amount needed on override.

BHS: 9 patients. 1 flight risk.

Case Management: 40 % DC before 1pm
1 patients DC before 11am
4 patients 10 days stay or greater
1 patients 21 days stay or greater

Care Coordination: 196 patients enrolled. (36 Transitional care management)

ER: Action Cue: Medication variance-med removed from Pyxis-no charting, waste, or return.

Engineering: Pressures at Cancer Center were corrected.

Pharmacy: Dilaudid syringe was found in the OR return bin.

Respiratory: Action Cue: Medication removed from Pyxis-no order.

Surgery: Action Cue: Anesthesia- medication variance- Lidocaine documentation.

- **Days since last fall:**
  Inpatient: 1 **Outpatient**: 9

NO SAFETY CONCERNS

Bio Med, Cancer Center, CVS, Brain/Spine, DI, Security, EVS, Nutrition, Oak Street Building/Rheumatology, Centennial Building, IT, Education, Lab, Materials Mgt, Patient Experience, Rehab, Urgent Care, Ophthalmology, ENT, Wound, Orthopaedics, 2nd Floor Pavilion, HME, Research, Compliance/HIPAA, HR/Employee Inj, Quality

Safety Huddle Messages/Highlights:

Administrator on Call: Lance Arterburn
Physician Rounding: Nephrology/Pain Management

For the past week-

Readmissions
- 8 readmits
- Average day from discharge to readmit was – 10.8 (did not include the BHS patient)
- 7 from home, 1 from nursing home
- 1 oncology patient
- Insurance – 5 Medicare, 1 Wellcare MA, 1 UHC Community, 1 Aetna

Mortalities
- 4 mortalities. (All inpatient with the following primary payer)
- Wellcare Medicare Advantage
- Optum VA Community Care Network
- Palmetto GBA Railroad Medicare
- Medicare

Building culture committed to safety- open issues

Great Plains Health

Safety Huddle Issues List
2024

Building a culture committed to safety and focused on quality outcomes.

Color Key= Within time allotment according to the severity | Past due date according to the severity

Our continuous goal of commitment to safety is present in our entire organization. Great Plains Health is working internally to improve our performance excellence. In order to achieve our vision to become the region's most trusted healthcare community. During Safety Huddles, actionable items may be identified. Utilize the below log to track completion of action items.

Date Assigned	Safety Action Item	Assigned Leader	Update	Date Resolved	Severity	Due Date r/t Severity	Status	EDU
4/17/2024	Labeling of ABGs. Respiratory access to Collection Manager	Nikki	Elisha will put in ticket for Education. Will discuss at education huddle (4/18). Meeting on 4/23		D2	4/24/2024		

Closed Issues List

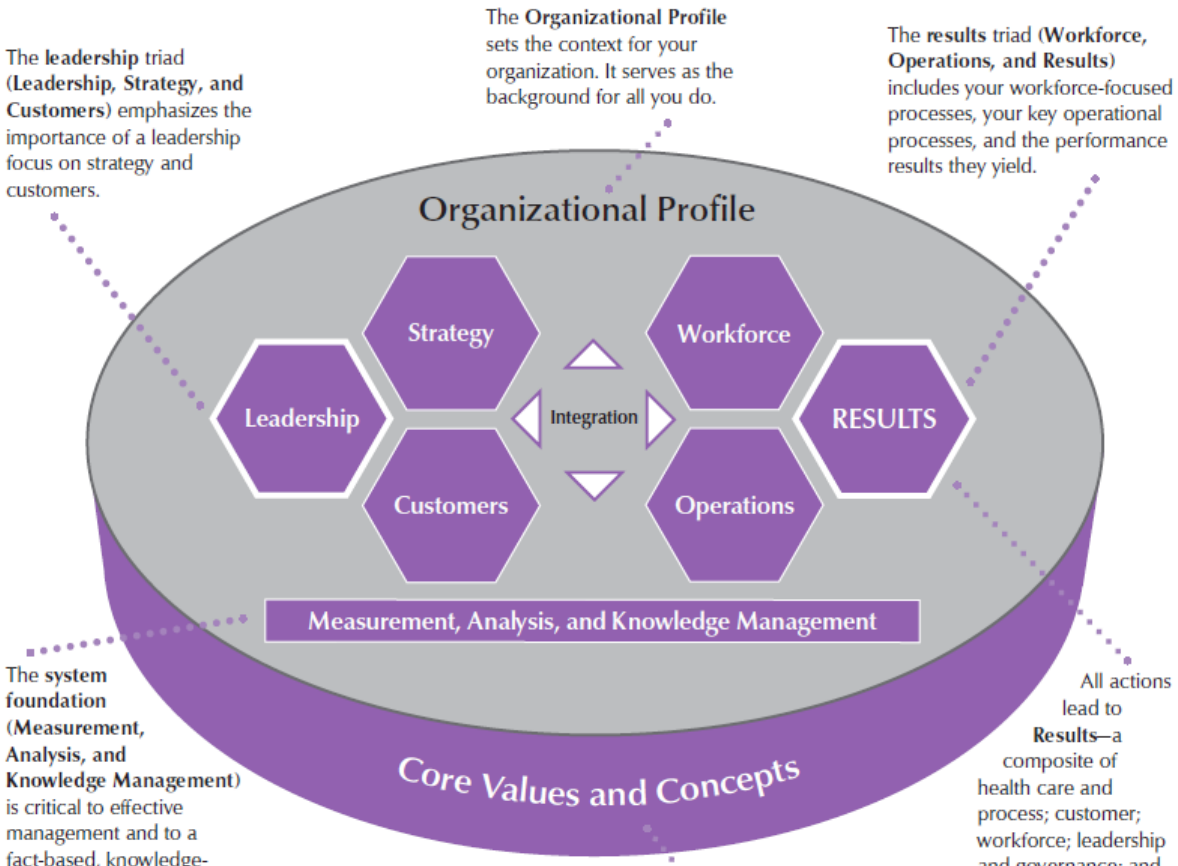
Building a culture committed to safety and focused on quality outcomes.

Our continuous goal of commitment to safety is present in our entire organization. Great Plains Health is working internally to improve our performance excellence through the Malcolm Baldrige Framework for Excellence in order to achieve our vision to become the region's most trusted healthcare community. During Safety Huddles, actionable items may be identified. Utilize the below log to track completion of action items.

Date Reported	Safety Action Item	Assigned Leader	Resolution	Date Resolved	Severity	Due Date r/t Severity	Status
4/5/2024	EKG Issues in ED	Alex	Met with team on 3/8. Another meeting scheduled for 4/9/2024. Process in place.	4/9/2024	D2	4/12/2024	
4/12/2024	PKU documentation	Michelle/Ashley	Meeting on 4/15. Plan in place and will be putting in Action Cues for near misses.	4/16/2024	D2	4/16/2024	
4/17/2024	IV Pump Issues	Brandon	Fixed		F2	4/19/2024	
4/16/2024	Range Orders	Jason	Ticket Submitted. Process in place.		O2	4/18/2024	


Amazon CEO Jeff Bezos reportedly requires all of his senior executives to take a two-pizza rule, meaning that any team that can't be fed with two pizzas is too big and should be broken into smaller teams.

Baldrige Framework



Scope & Severity Grid

Scope & Severity Grid for Safety Huddles

During Safety or Unit huddles, actionable items may be identified. Utilize the below template to depict the level of urgency and a timeline required for action plans.

	Department	Facility	Organization
Level 4	D4	F4	O4
Level 3	D3	F3	O3
Level 2	D2	F2	O2
Level 1	D1	F1	O1

Action Plan Timeline:	
Level 4:	2 hours, report to CEO and AOC
Level 3:	24 hours
Level 2:	1 week
Level 1:	Initial follow-up within 10 days to Safety Huddle

Guidance on Severity Levels:		Examples:
Level 4:	Extremely high potential for danger/death	(severe weather, deadly epidemic)
Level 3:	Very high potential or actual harm	(volatile patient/family, safety risks)
Level 2:	Medium potential or actual disruption of care	(medication supply problem)
Level 1:	Low, minimal, or minor impact	(construction in patient care area)

**Modified from CMS State Operations Manual – Memorial Hospital and Health Care Center Jasper, Indiana

In the NHL, if the goalie and backup goalie can't play, the team can use any available goalie who doesn't have a professional contract with another team. A facilities manager, an accountant, and an equipment manager have all suited up and taken the ice under this rule.

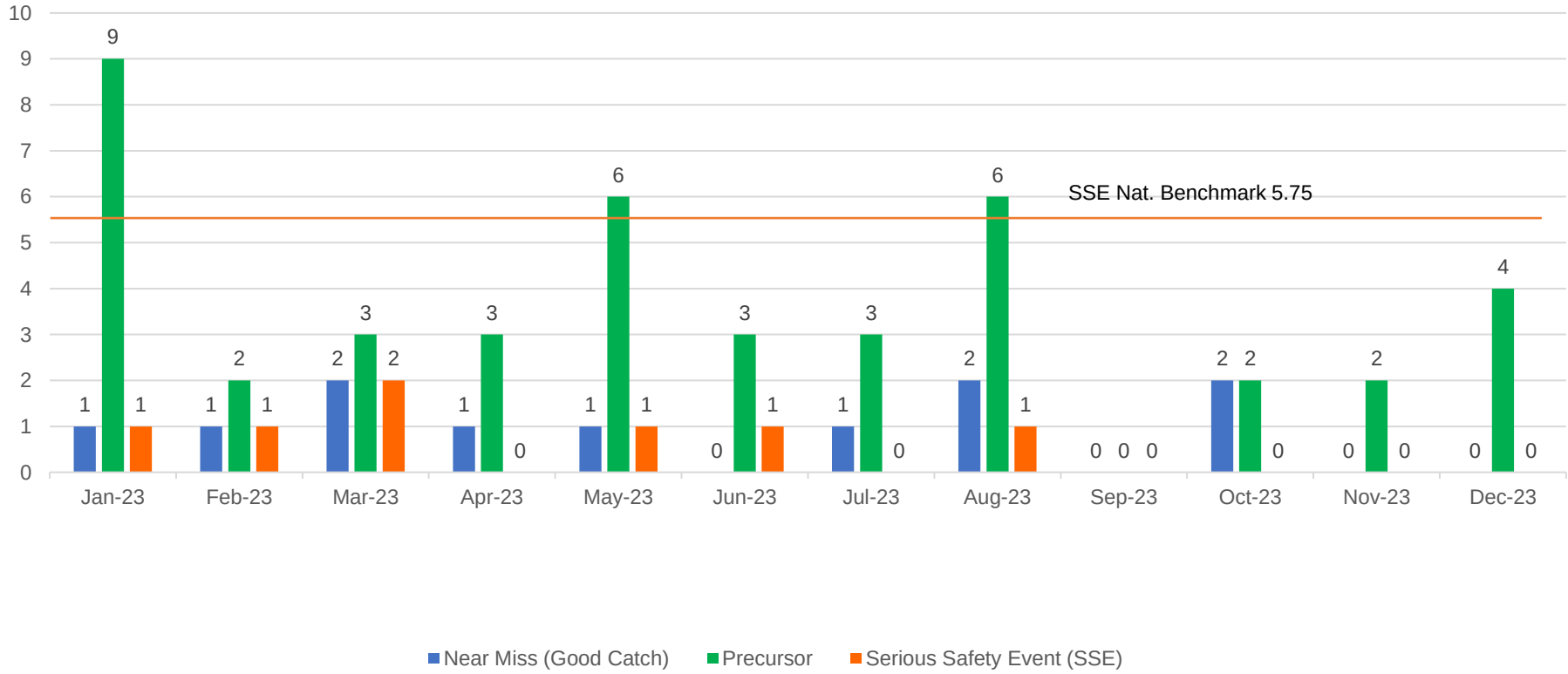
SSE- Definition

Safety Event classification applies if a deviation from Generally Accepted Performance Standards (GAPS) causes, or results in, the event

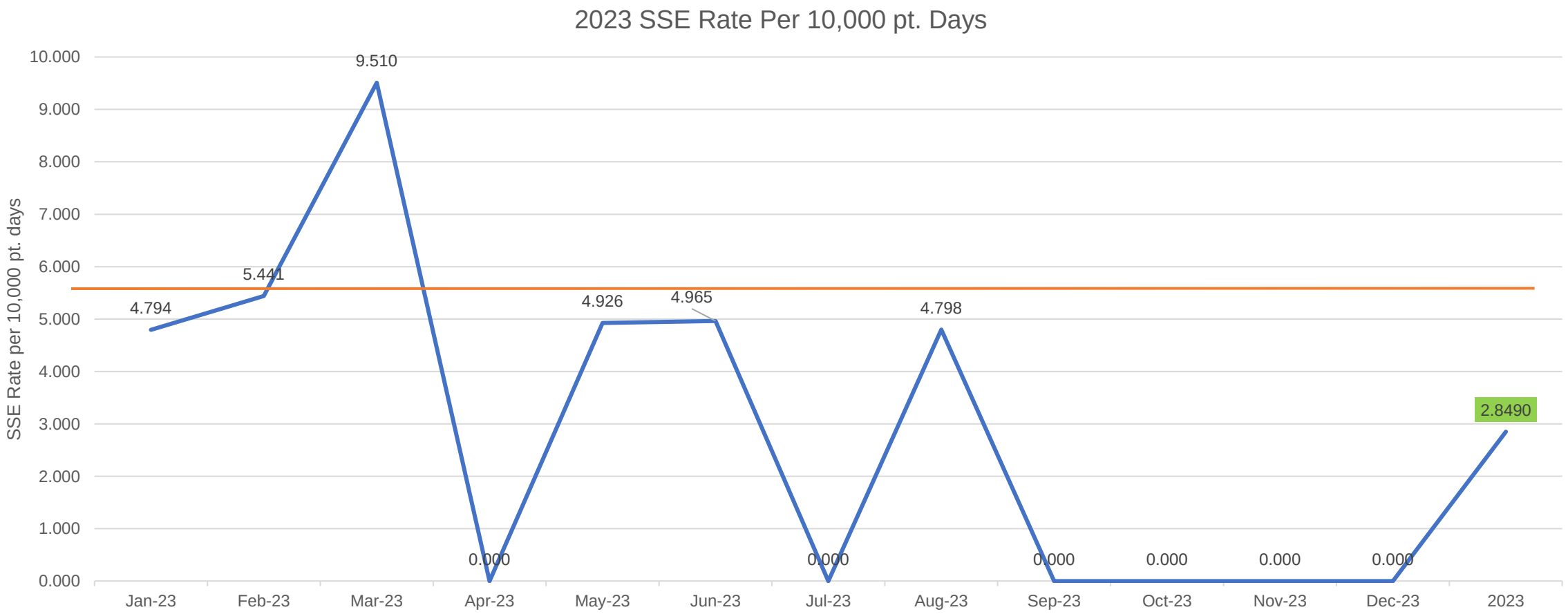
	Code	Level of Harm	Description
Serious Safety Event	SSE 1	Death	A deviation in GAPS resulting in death
	SSE 2	Severe Permanent Harm	A deviation in GAPS resulting in critical, life-changing harm with no expected change in clinical status; includes events resulting in permanent loss of organ, limb, or vital physiologic or neurologic function Example - Wrong site procedure resulting in removal of healthy limb - Missed diagnosis of stroke resulting in permanent impairment - Uterine rupture resulting in loss of uterus - Anoxic brain injury resulting in permanent brain damage - Incorrect radiologic contrast dosing resulting in need for permanent dialysis
	SSE 3	Moderate Permanent Harm	A deviation in GAPS resulting in significant harm with no expected change in clinical condition yet not sufficiently severe to impact activities of daily living or business functioning; includes events that result in permanent reduction in physiologic reserve, disfigurement, and impaired or aided sense or function Examples - Incorrect radiology contrast dosing resulting in reduced renal function - Inadvertent injury to spleen during abdominal surgery requiring removal of the spleen - Delay in treatment of limb ischemia requiring fasciotomy that results in minimal loss of function but disfiguring scars - Inappropriate intra-arterial medication injection resulting in loss of a finger, other than the thumb or 2nd finger which may qualify the event as SSE 2
	SSE 4	Severe Temporary Harm	A deviation in GAPS resulting in critical, potentially life-threatening harm yet lasting for a limited time with no permanent residual; requires prolonged transfer to a higher level of care/monitoring, transfer to a higher level of care for a life-threatening condition, or an additional major surgery, procedure, or treatment to resolve the condition Examples - Induced condition that requires resuscitation - Unrecognized fluid overload that progresses to pulmonary edema requiring transfer to the ICU for treatment - Failure to diagnose respiratory insufficiency resulting in temporary intubation where earlier recognition of the condition would have avoided the intubation - Preventable fall with hip fracture that requires surgical repair - Retained object that requires return to the operating room
	SSE 5	Moderate Temporary Harm	A deviation in GAPS resulting in significant harm lasting for a limited time; requires a higher level of care/monitoring or an additional minor procedure or treatment to resolve the condition Examples - Failure to treat a low potassium level that results in an arrhythmia requiring administration of intravenous anti-arrythmic drug, but with continued arrhythmia requiring extended monitoring and a higher intensity of care - Incorrect dose of dilaudid for pain resulting in over-sedation and requiring transfer to ICU for treatment and monitoring after narcan was ineffective in treating - Failure to routinely assess IV site resulting in an infection at IV site or (septic phlebitis) requiring extensive surgical incision and drainage to resolve - Incision made on the right knee instead of the left knee during an schedule knee replacement surgery

HPI Safety Event Classification (SEC) Levels of Harm Appendix D – Page 1 of 2
The HPI SEC & SSER Patient Safety Measurement System for Healthcare (HPI 2009-001)

	Code	Level of Harm	Description
Precursor Safety Event	PSE 1	Minimal Permanent Harm	A deviation in GAPS resulting in minor harm with no expected change in clinical status; requires little or no intervention Examples - Inadequate protection of ulnar nerve during an operation resulting in numbness of 4th and 5th fingers - Excess radiation therapy resulting in skin color change in non-critical cosmetic area
	PSE 2	Minimal Temporary Harm	A deviation in GAPS resulting in minor harm lasting for a limited time only; requires little or no intervention Examples - Failure to assess IV site resulting in bruising or swelling - Retained sponge in vaginal cavity found and removed during office exam and resulting in no or minor infection - Administration of low dose insulin to a non-diabetic patient requiring only a glucose check and drink of orange juice - Incorrect dose of dilaudid for pain resulting in over-sedation and narcan resuscitation with immediate resolution - An anesthetic nerve block was performed on the right knee instead of the left knee in a scheduled knee replacement surgery before it was realized the wrong side had been anesthetized
	PSE 3	No Detectable Harm	A deviation in GAPS that reaches the patient yet without ability to determine the existence or fact of harm, yet harm may exist; includes events where the onset of harm may occur later in time Example - Procedure performed with un-sterile instruments with no detectable post-procedure complications or infection - Inappropriate technique resulting in losing coronary artery stent into systemic circulation with no evidence of limb or organ ischemia
	PSE 4	No Harm	A deviation in GAPS that reaches the patient yet results in no harm, with sufficient information available to determine that no harm occurred Example - Transfusion of blood intended for another patient yet of the correct blood type - Administration of an adult dose of vitamin K to a full term newborn infant with no resulting damage
Near Miss Event	NME 1	Unplanned Barrier Catch	A deviation in GAPS that passes through all error detection barriers and does not reach the patient because it is caught by chance or a barrier not designed into the system Example - Family member who reminds of a known medication allergy immediately before the medication is to be administered to the patient - Environment Services Associate points out the need to perform a time out prior to a bedside procedure resulting in awareness that the procedure was about to be performed on the incorrect limb - Food Services Associate notices pills in waste basket, thrown away by the patient, and alerts the patient's nurse who ensures medication administration
	NME 2	Last Strong Barrier Catch	A deviation in GAPS that passes through early error detection barriers and is caught by a last strong error detection barrier designed into the system Example - Medication error caught by nurse performing "5 Rights" prior to administration - Wrong patient brought to the OR and identified during the team time out
	NME 3	Early Barrier Catch	A deviation in GAPS that is caught by an early error detection barrier designed into the system's defense in depth Example - Medication error identified when a contraindication alert fires in the pharmacy order entry system - During bedside shift change report, care team identifies that multiple IV lines in a complex ICU patient are not labeled and makes the correction to minimize risk of confusion

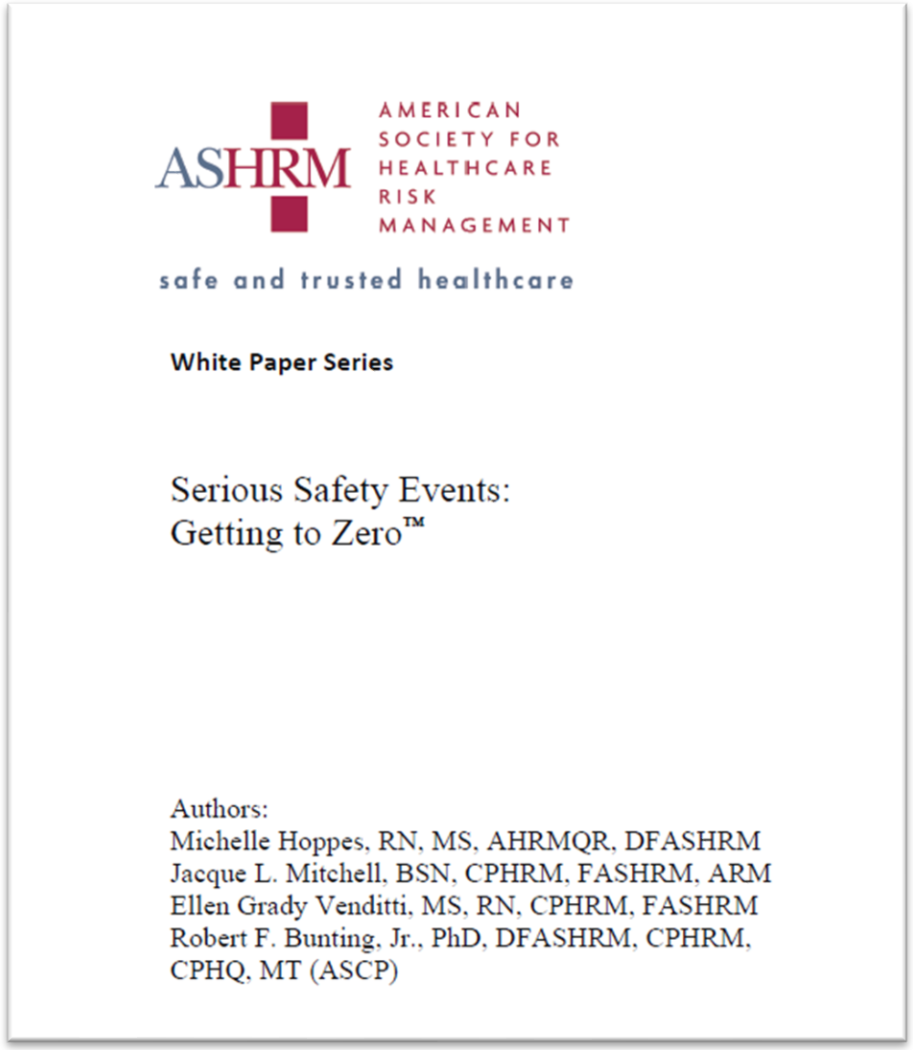

GPH Healthcare Performance Improvement Safety Event Classification 2023 by Month
10
9
8
7
6
5
4
3
2
1
0
SSE Nat. Benchmark 5.75
Jan-23: 1, 9, 1
Feb-23: 1, 2, 1
Mar-23: 2, 3, 2
Apr-23: 1, 3, 0
May-23: 1, 6, 1
Jun-23: 0, 3, 1
Jul-23: 1, 3, 0
Aug-23: 2, 6, 1
Sep-23: 0, 0, 0
Oct-23: 2, 2, 0
Nov-23: 0, 2, 0
Dec-23: 0, 4, 0
Near Miss (Good Catch)
Precursor
Serious Safety Event (SSE)

Serious Safety Event (SSE)

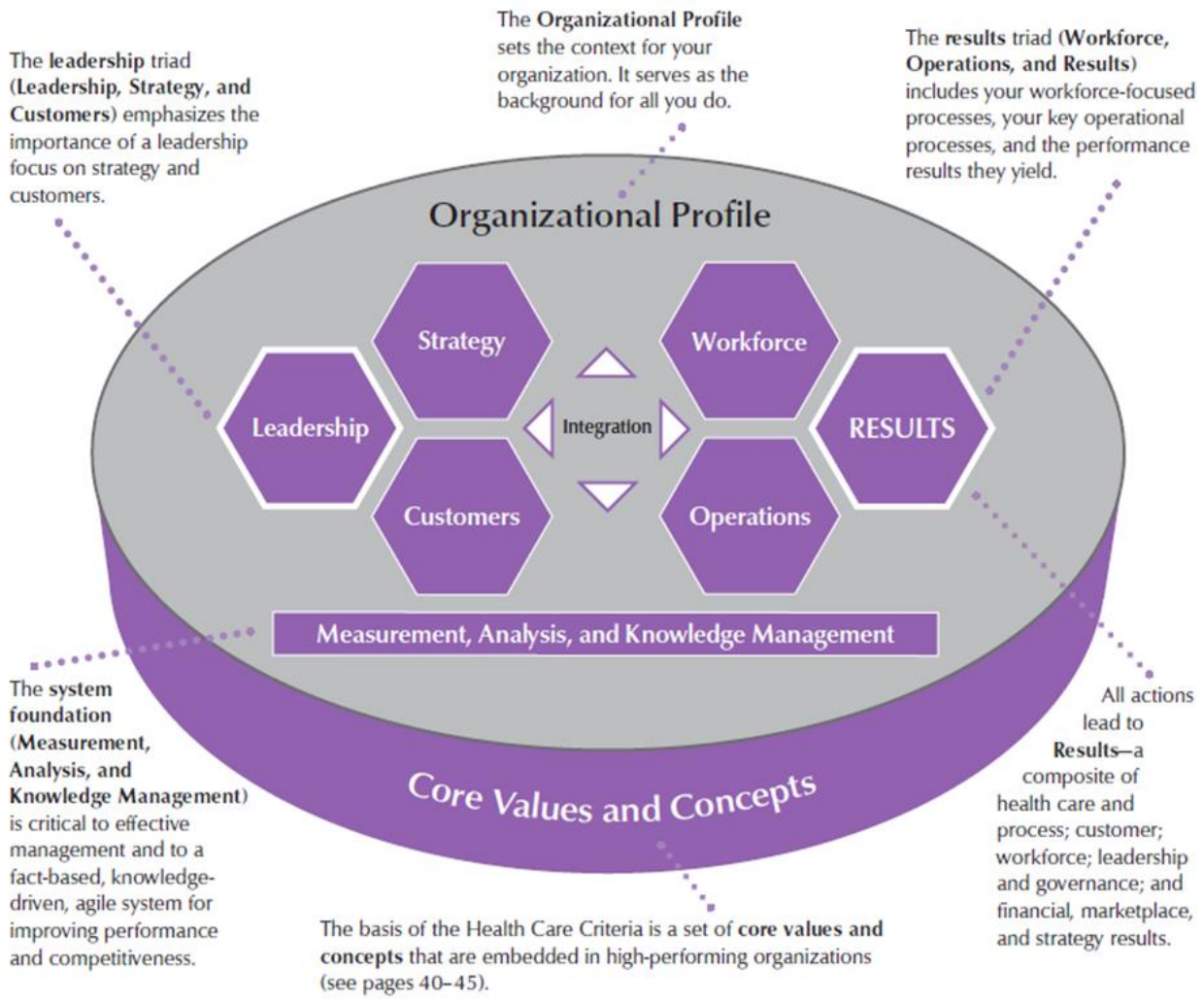


SSE Benchmark-

2023	Inpatient Days	Outpatient Days	Total Patient Days	Serious Safety Event (SSE)	Overall SSE Rate Per 10,000 pt. Days
Jan	1907	179	2086	1	4.794
Feb	1644	194	1838	1	5.441
Mar	1912	191	2103	2	9.510
1Q 2023	**5463**	**564**	**6027**	**4**	**6.582**
Apr	1690	188	1878	0	0.000
May	1821	209	2030	1	4.926
June	1707	307	2014	1	4.965
2Q2023	**5218**	**704**	**5922**	**2**	**9.891**
July	1852	197	2049	0	0.000
August	1891	193	2084	1	4.798
Septmeber	1852	180	2032	0	0.000
3Q2023	**5595**	**570**	**6165**	**1**	**4.798**
October	2006	247	2253	0	0
November	1824	273	2097	0	0
December	1878	228	2106	0	0
4Q2023	5708	748	6456	0	0



Baldrige


The leadership triad (Leadership, Strategy, and Customers) emphasizes the importance of a leadership focus on strategy and customers.
The Organizational Profile sets the context for your organization. It serves as the background for all you do.
The results triad (Workforce, Operations, and Results) includes your workforce-focused processes, your key operational processes, and the performance results they yield.
Organizational Profile
Strategy
Workforce
Leadership
Integration
RESULTS
Customers
Operations
Measurement, Analysis, and Knowledge Management
The system foundation (Measurement, Analysis, and Knowledge Management) is critical to effective management and to a fact-based, knowledge-driven, agile system for improving performance and competitiveness.
All actions lead to Results—a composite of health care and process; customer; workforce; leadership and governance; and financial, marketplace, and strategy results.
Core Values and Concepts
The basis of the Health Care Criteria is a set of core values and concepts that are embedded in high-performing organizations (see pages 40–45).

Baldrige Review

From Fighting Fires to Innovation: An Analogy for Learning

Learning is an essential attribute of high-performing organizations. Effective, well-deployed organizational learning can help an organization improve from the early stages of reacting to problems to the highest levels of organization-wide improvement, refinement, and innovation.

1

Reacting to the problem (0–5%)

Run with the hose and put out the fire.

2

General improvement orientation (10–25%)

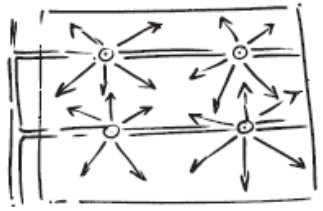
Install more fire hoses to get to the fires quickly and reduce their impact.

3

Systematic evaluation and improvement (30–45%)

Evaluate which locations are most susceptible to fire. Install heat sensors and sprinklers in those locations.

4



Learning and strategic improvement (50–65%)

Install systemwide heat sensors and a sprinkler system that is activated by the heat preceding fires.

5

Organizational analysis and innovation (70–100%)

Use fireproof and fire-retardant materials. Replace combustible liquids with water-based liquids. Prevention is the primary approach for protection, with sensors and sprinklers as the secondary line of protection. This approach has been shared with all facilities and is practiced in all locations.

Great Plains Health

Questions?