

Achieving High Reliability in Harm Prevention



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MEDICINE

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ALL CHILDREN'S HOSPITAL

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Background

Creating and sustaining highly reliable systems for eliminating preventable harm are challenging. A weekly Preventable Harm Huddle was introduced in February of 2017 to provide a forum for a timely response to preventable harm events and to provide structure and process for accountability for action. The Huddle facilitates immediate dialogue among the healthcare acquired condition (HAC) leaders, operational and quality leaders and executive leaders. The focus is on mitigating harm, identifying and resolving challenges, and learning from each event.

Goals/Objectives

Objectives

- Create a forum to discuss recent preventable harm events that occur in the JHACH Health System.
- Provide structure, process and accountability for timely review and response to these events.
- Empower frontline staff leading preventable harm work, sharing lessons learned.

Goal

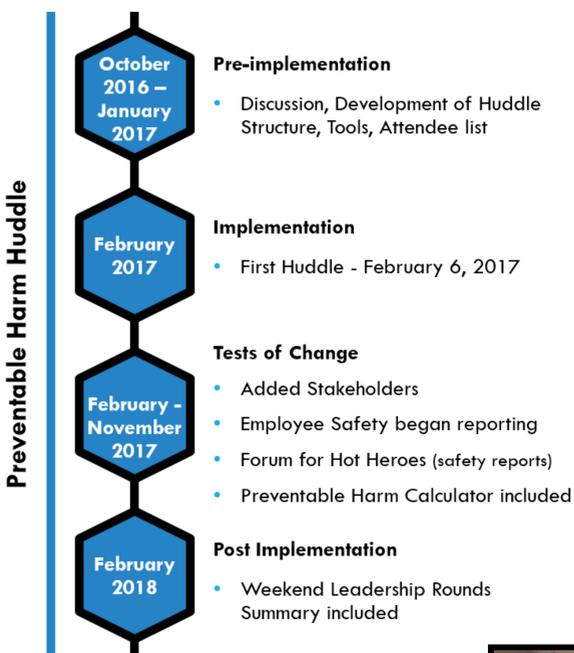
- Reduce Serious Harm Events by 10-30% from July 1, 2017 to June 30, 2018 by implementing a huddle and use of existing preventable harm efforts such as Hospital Acquired Condition Workgroups and use of bundle observation audits (K-cards) .

Methods

Huddle Format

- In-Person Huddle every Monday 0840-0900.
- Facilitated by the Chief Patient Safety Officer, Chief Nursing Officer or Administrator On Call.
- HAC leaders, department leaders, Patient Safety & Quality team, and Infection Prevention team attend.
- Review prior week's events and action plans. Assign accountability for removing barriers. Close the loop on prior actions.

Development: Model for Improvement

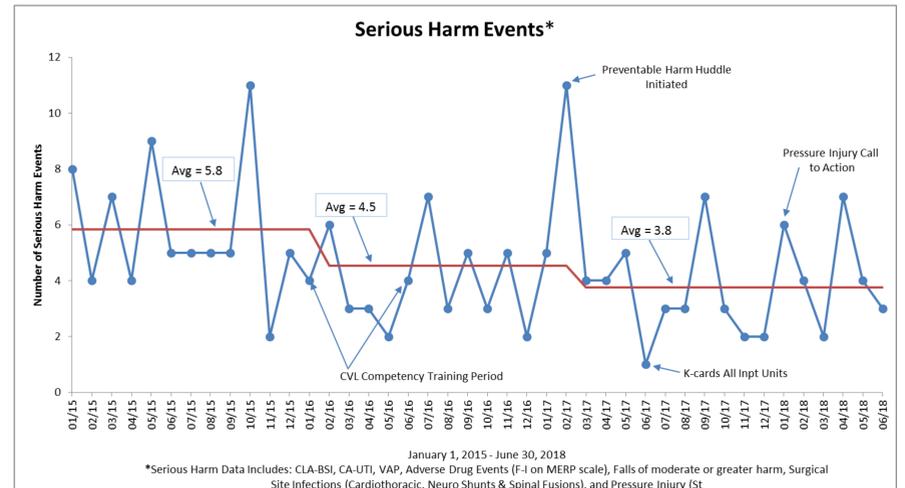


Weekly Preventable Harm Huddle	
Reporting Schedule	
1.	Falls with injury
2.	CLABSI, CAUTI, SSI, C-diff, HAIs
3.	Pressure Injuries (stage 2 and above)
4.	IV Infiltrates
5.	Adverse Drug Events (with harm)
6.	Unplanned extubations
7.	Employee Harm
8.	Other Events (with harm)
9.	AOC Handoff: Patient and Family Issues or other outstanding concerns
10.	Weekend Leadership Rounds
Reporting Elements	
•	Total number of events
•	Immediate actions needed or taken
•	Was a review/drilldown completed or scheduled
•	If a review was completed, provide a brief update on actions
•	Resources and support needed



Results

- In the first 18 months post implementation, significant transformation has occurred. There is increased preoccupation with failure focused on preventable harm events. Events are identified and investigated in a timely manner with an accelerated pace of action planning. Challenges are recognized and resolved in an expedited fashion.
- Accountability has increased; 418 action items have been identified and completed since implementation.
- By end of Fiscal Year 2018, we achieved a 15% reduction in Serious Harm Events.



OVER THE PAST YEAR,

30%

Reduction in Central Line Associated Blood Stream Infections

Reduction In Preventable Harm

The total estimated one year cost savings from these outcomes is **\$700,000.**

OVER THE PAST YEAR,

67%

Reduction in Catheter Associated Urinary Tract Infections

31%

Decrease in Serious Peripheral IV Injuries

27%

Decrease in Patient Falls

11%

Decrease in Serious Pressure Injuries

Conclusions

- Major learning include the importance of meeting face to face frequently with real time data. Further, interprofessional and interdepartmental engagement are essential as is incorporating a structure for closing the loop on outstanding challenges and action items.
- The weekly Preventable Harm Huddle has provided structure and process for empowering staff and creating a culture of accountability for eliminating preventable harm.

Sustainability Plan

- Weekly scheduled Preventable Harm Huddle.
- Report of the last Serious Harm Event every Monday morning on the Daily Operational Call.
- Plans for year 2 of the Preventable Harm Huddle include:
 - Demonstrating deference to expertise by transitioning huddle facilitation to clinical staff champions.
 - Inviting additional key stakeholders.
 - Increasing physician participation.