Part II. A. In Fall of 2011 Our Lady of Peace, a part of KentuckyOne Health, set out on a "Journey to High Reliability". This journey, simply known as safety first placed the emphasis on safety being the priority in providing patient care. We define quality as providing safety first to reduce harm to our patients. We know that patients want us to: 1. keep them safe, 2. heal them, 3. be nice to them; and in that order. When we do this we will create a *safe* hospital experience. Our Lady of Peace embraces safety as the highest priority of providing patient care and sets quality goals highlighting this initiative. The quality goal of initiating a Safety First Program is a prime example of how important leadership determined the focus needed to be in our hospital and made the commitment to have every employee and physician participate in this safety goal.

A set of shared values and beliefs that reinforce the behavior expectations is necessary for the desired outcome to be achieved -- no patient harm. Our senior leaders communicate that safety is the foundation upon which all other aspects of quality care are built. We recognize that safety is the keystone of our hospital to which all other aspects of care and service such as patient satisfaction, employee/ physician satisfaction, quality, time, and cost are impacted. Our data signifies the success when placing safety first, errors do decrease and our goals for quality care are achieved.

KentuckyOne Health™ SafetyFirst

Our Lady of Peace
Safety First Dashboard

Report run date: 01/24/2014

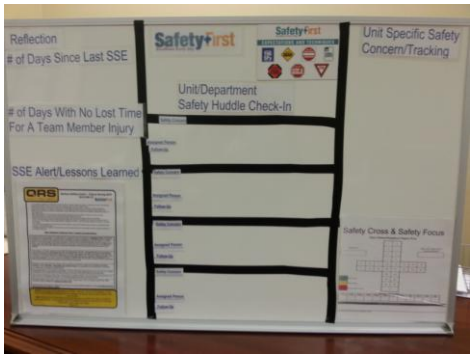
Safety First Metrics	Dec-12	2012 Total	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	2013 Total
SSE - Serious Safety Event	0	6	0	0	0	0	1	0	0	0	0	0	0	0	1
HPI-1 Serious Safety Event Rate	0.75	0.75	0.50	0.50	0.38	0.38	0.51	0.39	0.39	0.26	0.13	0.13	0.13	0.14	0.14
HPI-2 Average Days Between SSE	60.8	60.8	91.3	91.3	121.7	121.7	91.3	121.7	121.7	182.5	365.0	365.0	365.0	365.0	365.0
HPI-3 Events Identified Externally	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
HPI-4 % Change in Incident Report	-19%	1.5%	4%	25%	-3%	1%	12%	-13%	-20%	4%	12%	0%	-11%	-30%	0.0%
HPI-4b Number of Incidents Reported	312	3736	323	404	393	395	442	383	307	320	357	357	319	223	4223
HPI-5 #SSEs per 100 PSEs or NMEs	0.00	0.28	0.00	0.00	0.00	0.00	0.36	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.12
HPI-5b #SSEs per 100 PSEs	0.00	0.30	0.00	0.00	0.00	0.00	0.40	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.04
HPI-5c #SSEs per 1000 NMEs	0.00	41.67	0.00	0.00	0.00	0.00	38.46	0.00	0.00	0.00	0.00	0.00	0.00	0.00	4.18
Adjusted Patient Days	6742	80218	6414	5803	7035	6751	6711	5738	5531	5427	5987	6131	6199	5546	73273

Definitions:
HPI-1: Rolling 12-month average of number of SSEs per 10,000 patient days
HPI-2: Rolling 12-month average number of days between SSEs (# of days in period/# of SSEs in period)
HPI-3: Number of events of harm initially identified from an external source
HPI-4: Percent overall increase or decrease in incident report (IRIS) volume
HPI-4b: Total incident report (IRIS) volume
HPI-5: Number of SSEs per 100 Precursor Safety Events or Near Miss Events
HPI-5b: Number of SSEs per 100 Precursor Safety Events
HPI-5c: Number of SSEs per 1000 Near Miss Events
Incident Count by Event Type
All Event Type Pulled by Report Date

It is imperative for all employees to be engaged in the Safety First program. We accomplish this is through "Rounding to Influence" and "Safety Check-In's/Huddles."

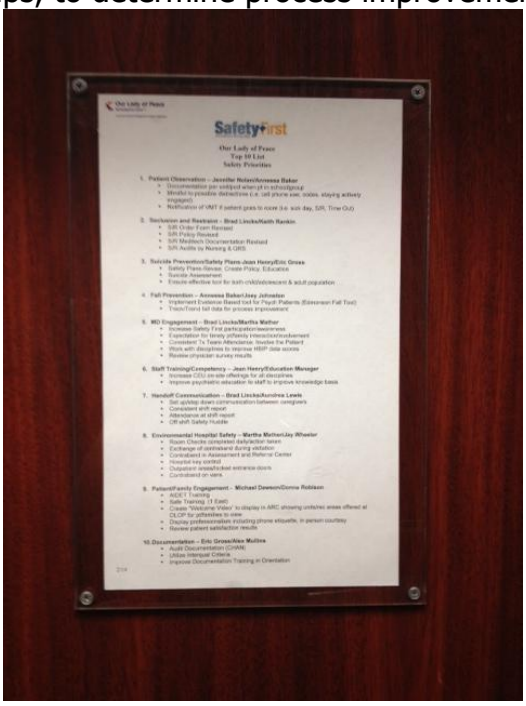
Rounding to Influence involves Leaders rounding with staff to ensure the safety tools are being utilized and to hear any safety concerns. The visibility of leaders demonstrates the priority of safety in our organization and safety concerns are heard and acted upon with a sense of urgency to prevent an adverse event from occurring.

Safety Huddles are conducted both on the leadership level as well as the department level with the goal of staff members to identify safety issues/concerns and receive safety communication. The goal is to find and fix safety concerns. The concerns are not fixed in the meeting, but instead assigned to someone with a sense of urgency to work on and report back to the group on the outcome and/or barriers, so that this safety concern can be alleviated. The concerns may be placed on a "Top Ten List" as well.



(White boards are used to conduct Department Huddles so that Safety info is communicated to the entire team)

Leadership, physician and front line staff member's input created our Top Ten Safety List. The list compiled of items our hospital wants to focus on related to safety to provide safe, quality of care to our patients and promote safety for our staff members. This list allows for a centralized focus and quality goals to be set on these safety concerns with actions taken to put processes in place to make systems safer. Physicians, leaders and front line staff members are involved in the 10 initiatives, working in task groups, to determine process improvements.



(In effort to be transparent of our safety concerns, the Top Ten List posted throughout hospital; in elevators & meeting rooms, to remind staff, visitors, MD's of safety priorities.)

Part II. B. It is essential that every employee and physician understand their role and commit to become highly reliable. Building the foundation of a culture of safety is not achieved quickly, but through consistency and accountability. During training we communicate the staggering statistics released from the *Institute of Medicine* that as many as 98,000 patient deaths occur annually from errors and almost 4% of all hospitalized patients experience an unfavorable event. This is comparable to a 747 jet crashing 80 times each year or two times per week. As healthcare providers, we have chosen this field of work to help people. Yet hearing these statistics and/or being involved in some way with someone who has had an adverse outcome at a hospital, we know that this is not what we want for our patients.

Key points of training session included:

- What if we could significantly reduce our errors?
- What if there were more tools and fewer rules?
- What if we came to work knowing exactly what is expected of us?
- What if we felt empowered to fix a problem or voice a concern related to safety?
- What if we could leave work feeling absolutely confident that we delivered the best possible care and services to our patients?

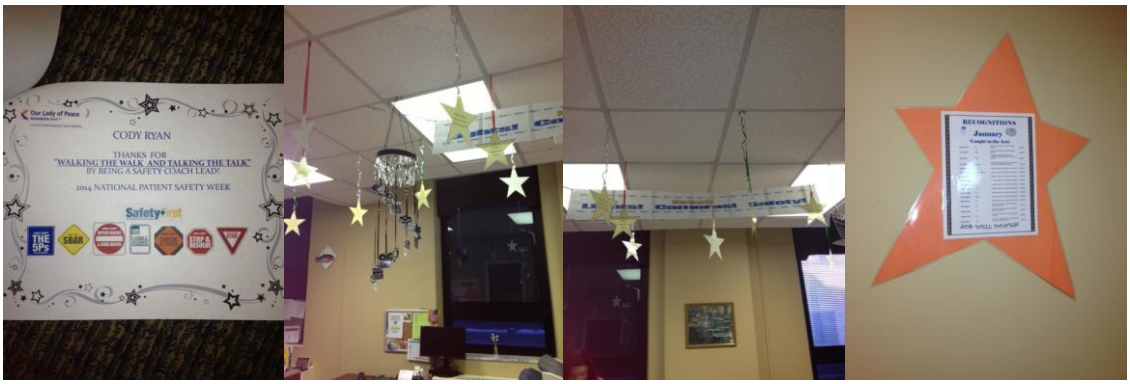
The Safety First Program empowered each employee with three key strategies:

1) Recognize high-risk situations (i.e. new equipment, untrained staff, high workload, distractions, fatigue, look alike medications/patient names) and improve processes to reduce risk.
2) Practice safety behaviors to prevent human error - no high risk behaviors (i.e. failure to use repeat/read back, proceeding in the face of uncertainty, taking shortcuts, bypassing safety devices) in high risk situations.
3) **Stop** when unsure and find an expert.

The training outlines specific, common sense expectations and techniques. Seven simple, common sense techniques called Error Prevention Techniques are demonstrated to employees with examples of how to implement both in clinical and non-clinical hospital settings. By incorporating these Error Prevention Techniques into habit errors were less likely to occur.

In January 2013, our employees participated in a Safety Survey so we could assess the pulse of safety in our hospitals. Using this feedback, we will be able to continue to improve quality and safety for our patients. The survey, conducted every two years, will keep us focused on our journey and allow for continual efforts to be made for safety.

It is important as well to keep employees energized and passionate about the Safety First Program. Safety information is communicated in our weekly newsletter, meeting agendas and hospital town halls with the key message of "Speak Up for Safety."
. Catchy, fun phrases, celebrating wins along with communicating lessons learned from serious events are needed to achieve and maintain a culture of safety and one where staff feel comfortable to speak up for safety!



(Pictures from National Patient Safety Week 2014 highlighting Safety First Techniques though safety trivia, crossword puzzles, word searches and Safety Coach Recognitions!)

Part II. C. The key message of training -- "empowerment." Employees were given permission to "stop the line" when something did not feel right to prevent the next error from occurring. Each employee that speaks up for safety would be heard and more importantly with a sense of urgency. It is essential when safety concerns are voiced that actions are taken promptly to address the concern. This not only validates the concern brought forth, but allows for process improvement to be sought for the issue/concern identified. Leaders and physicians walk the walk and talk the talk using the Error Prevention Techniques to demonstrate and model that safety is our priority.

By using these techniques, the goal is to avoid a Serious Safety Event (SSE) - defined as deviation from best practice care causing moderate to severe harm or death. Examples of SSEs may include falls with fractures, peer to peer aggression with significant injury, suicide attempt/suicide, delayed diagnosis, or medication error. We also learned that Precursor Safety Events, events that reach the patient and result in minimal or no detectable harm; and Near Miss Safety Events that do not reach the patient and are caught by detection barrier or chance; are important for employees to report.

A key in reducing SSE's is for employees to understand the importance of reporting Actual and Near Miss incidents. It is through these reports that safety issues can be detected and process improvements can be made to improve the quality of care. The goal with the reports of near misses or no patient harm incidents is that, if action is needed for improvement, this can occur proactively before a Serious Safety Event occurs. We encourage and reward and recognize staff for this reporting. This is an area that takes investment of leaders to get staff's understanding. Often our employees perceive reporting incidents with a negative connotation, but when employees understand the "whys", the outcome is achieved. The whys for reporting incidents was simply the more incidents that both the leader and risk management know about, the better our opportunity to review the incident for individual and/or system failures; and determine what actions are needed to prevent the incidents or similar incidents from occurring again. Once staff see that actions are being taken from reports made they feel a part of the change for improved safety and quality of care to our patients and continue to report incidents.

Similar to when a safety concern is reported, it is vital that when incidents are reported we as leaders review and investigate these promptly to identify opportunities for improvement and communicate back to our team. One example of how we do this at Our Lady of Peace is through weekly Safety First Snap Shot distributed each Monday at our Leadership Safety Huddle meeting. This snapshot includes three safety concerns identified at the meeting the week prior, connecting it to an Error Prevention Technique to bring to the staff's attention for heighten awareness, highlight one of the seven Error Prevention Techniques, then provide lessons learned from investigations/incidents reviewed from the previous week (see below).

Our Lady of Peace
KentuckyOne Health™
A service of Jewish Hospital & St. Mary's HealthCare

Safety First
Excellence Every Day

Weekly Safety First Snap Shot
2/21/14

1) **S**top, **T**hink, **A**ct and **R**eview- Be mindful when leaving units of doors closing behind you. This is an opportunity for patient elopement. Staff should wait for doors and elevator doors to close before leaving the area to promote safety.
2) **S**top and **R**esolve - Please consider wearing safety sleeves for protection against physical bites
3) **S**top **T**hink **A**ct and **R**evie**w -** Remember to protect patient information and follow our policy for encrypting emails sent outside of the organization.

SBAR
Situation, Background, Assessment, Recommendation

Did you know that 70-80% of medical errors are related to interpersonal communication issues.

Situation: What is the situation, patient or project?

Background: What is the important information, problems, and precautions?

Assessment: What is your read of the situation, problems, and precautions?

Recommendation: What is your recommendation, request, or plan?

SBAR is helpful for anyone when a decision is needed.

Safety First
Excellence Every Day

Lessons Learned from Recent Incidents

2/15/14 IRIS Event Review - patient engaged in SIB
- Remind staff to ensure patient safety during SIB events

2/13/14 Abuse Investigation - peer to peer aggression
- Remind nurse to include photograph of injury when documenting injuries

2/13/14 IRIS Event Review – accidental injury requiring medical follow up greater than first aid.
- No lessons learned

2/14/14 Abuse Investigation – allegation against team member
- No lessons learned

2/16/14 IRIS Event Review - team member concern
- Remind team members to only use approved SCM techniques when escorting patients for safety
- Remind team members to be mindful of voice/body language when intervening with an agitated patient

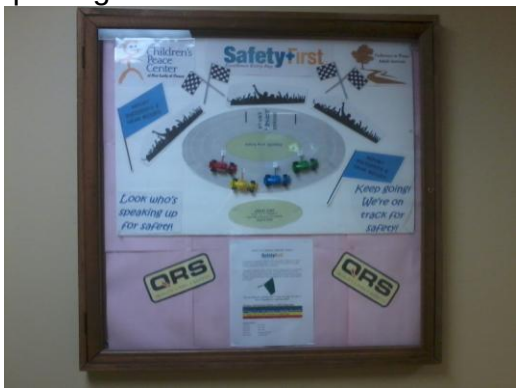
2/18/14 Apparent Cause Analysis - patient elopement
- Remind team members to assess areas for safety/breakdowns during times of construction
- Remember to use the EPT 5 P's for complete handoff communication when transferring/transitioning patients between services and/or team members
- Remind team members to escalate significant incidents and review our policy on Administration Notification of Serious Incidents

Employees are continuing to report incidents. Our team and leaders have indeed realized this as well, and continues to promote safety through incident reporting.

9/11	**10/11**	**11/11**	**12/11**	**1/12**	**2/12**	**3/12**	**4/12**	**5/12**	**6/12**	**7/12**	**8/12**	**9/12**	**10/12**	**11/12**	**12/12**	**1/13**
203	298	397	333	349	286	314	258	287	235	249	266	273	458	336	254	258
2/13	**3/13**	**4/13**	**5/13**	**6/13**	**7/13**	**8/13**	**9/13**	**10/13**	**11/13**	**12/13**	**1/14**	**2/14**				
404	393	395	442	383	307	320	357	357	319	223	288	333				

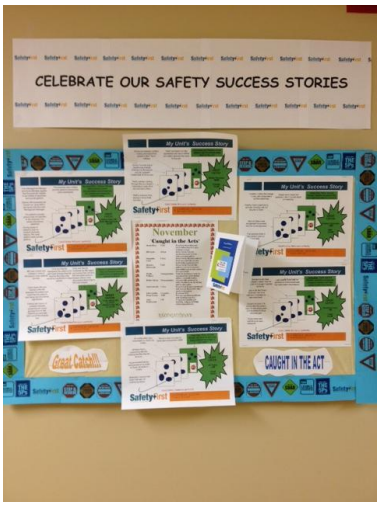
(Incident Data Sept 2011-Feb 2014)

To help our staff realize the importance of reporting incidents we created a Safety First Speedway bulletin (see below) board and communication of results. This is displayed to demonstrate visually units with increase in incident reporting.



Safety First is about building a culture of transparency; When a significant incident of harm or a near miss incident occurs, it is investigated, lessons learned identified and action plans developed and executed in a timely manner to prevent reoccurrence. A thorough root cause analysis is performed to identify individual and/or system failures. Communication of use of an Error Prevention Technique to use to prevent reoccurrence is pertinent to prevent reoccurrence.

As we continue on our Journey to High Reliability it is important to communicate and celebrate "wins"! Great Catches are employees utilizing the Error Prevention techniques to promote safety. It is important to highlight and recognize the employee for using the techniques and to communicate these Great Catches so others can learn from these examples and incorporate the Error Prevention techniques into their work habits. Sharing our great catches will help others prevent errors and harm. We have recognized over 100 staff for Great Catches!
We also recognize staff for promoting patient or staff by the Quality, Risk and Safety Team sending that staff a "Caught in the Act" card.



In conclusion, while no one intends to hurt patients, safety events are the leading cause of harm. Healthcare is high risk and is the 3rd leading cause of death. It is our responsibility to assure our patients that we have processes in place that will keep them safe while in our care. We need to acknowledge human error is not the cause of failure, but a symptom of failure; and conduct a thorough root cause analysis of all serious safety events to determine how to prevent reoccurrence through lessons learned from the event and breakdowns that led up to the event. The Journey to High Reliability continues for us and will never be complete as safety can not be compromised and will always need to remain the priority and focus. By doing this, we will make lasting improvements that protect our patients and staff members from harm, thus providing quality, safe care!