The Integration of Worker and Patient Safety
“We Share 4 Safety”

Today’s Topic:
HRO / Integration of Worker and Patient Safety

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Presented By:

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Agenda

- Hospital Data Aggregate Review
- Journey to HRO Member Highlight: Aultman Hospital
  - Aultman Team: Brian Swearingen; Laurie Clark
- Journey to HRO Member Highlight: Mount Carmel
  - Mount Carmel Team: David Norris; Tiffany Canter; Greg Hendricks
- Questions
- Next Steps
Data Aggregate Review
## Data Aggregate Review Snapshot

### ALL Hospitals - Combined

<table>
<thead>
<tr>
<th></th>
<th>Baseline Data</th>
<th>Performance Data</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total Incidents</strong></td>
<td>2016</td>
<td>8/17 9/17 10/17</td>
</tr>
<tr>
<td><strong>Total Claims</strong></td>
<td>1,159</td>
<td>83 81 52 1,051</td>
</tr>
<tr>
<td><strong>Frequency Rate</strong></td>
<td>3.53</td>
<td>0.25 0.23 0.16</td>
</tr>
<tr>
<td><strong>Severity Rate</strong></td>
<td>$11,174</td>
<td>$721 $558 $246</td>
</tr>
<tr>
<td><strong>Annualized</strong></td>
<td></td>
<td>3.12 3.12</td>
</tr>
</tbody>
</table>

### Patient Handling Incidents

<table>
<thead>
<tr>
<th></th>
<th>Baseline Data</th>
<th>Performance Data</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total Claims</strong></td>
<td>179</td>
<td>11 8 1 120</td>
</tr>
<tr>
<td><strong>Frequency Rate</strong></td>
<td>0.54</td>
<td>0.03 0.02 0.00</td>
</tr>
<tr>
<td><strong>Severity Rate</strong></td>
<td>$2,420</td>
<td>$73 $42 $8</td>
</tr>
<tr>
<td><strong>Annualized</strong></td>
<td></td>
<td>0.36 0.36</td>
</tr>
</tbody>
</table>

### Aggressive Patient Incidents

<table>
<thead>
<tr>
<th></th>
<th>Baseline Data</th>
<th>Performance Data</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total Claims</strong></td>
<td>101</td>
<td>11 13 7 130</td>
</tr>
<tr>
<td><strong>Frequency Rate</strong></td>
<td>0.31</td>
<td>0.03 0.04 0.02</td>
</tr>
<tr>
<td><strong>Severity Rate</strong></td>
<td>$992</td>
<td>$95 $212 $29</td>
</tr>
<tr>
<td><strong>Annualized</strong></td>
<td></td>
<td>0.38 0.38</td>
</tr>
</tbody>
</table>

### Slips, Trips, Falls

<table>
<thead>
<tr>
<th></th>
<th>Baseline Data</th>
<th>Performance Data</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total Claims</strong></td>
<td>234</td>
<td>8 9 8 151</td>
</tr>
<tr>
<td><strong>Frequency Rate</strong></td>
<td>0.71</td>
<td>0.02 0.03 0.02</td>
</tr>
<tr>
<td><strong>Severity Rate</strong></td>
<td>$4,239</td>
<td>$86 $73 $63</td>
</tr>
<tr>
<td><strong>Annualized</strong></td>
<td></td>
<td>0.45 0.45</td>
</tr>
</tbody>
</table>
Aggregate Data

2017 Total Claims Frequency Rate

2017 PH Frequency Rate

2016 Frequency Rate 3.53
2017 YTD Annualized 3.12

2016 PH Frequency Rate 0.54
2017 PH YTD Annualized 0.36

2017 AB Frequency Rate

2017 STF Frequency Rate

2016 AB Frequency Rate 0.31
2017 AB YTD Annualized 0.38

2016 STF Frequency Rate 0.71
2017 STF YTD Annualized 0.45
Journey to HRO:
Aultman Hospital
HRO and Patient/Employee Safety Integration
Aultman Overview
Aultman Healthcare Delivery System

Health care Delivery System

Aultman Hospital
Aultman Specialty Hospital
Aultman Orrville Hospital
Physician Services
Post-Acute Care
Outpatient Services
HRO Journey
HRO

• Aultman’s Journey
• Doing Things as Intended Consistently over Time
• Applies to all Areas / Things
• Initial Focus on Safety
# Tools and Tones

## SAFETY COUNTS

**TOOLS for High Reliability**

<table>
<thead>
<tr>
<th>WHAT THEY ARE</th>
<th>WHAT WE DO</th>
<th>KEY PHRASES</th>
</tr>
</thead>
</table>
| 1. Pay attention to detail | • Self-check using STAR  
Stop – Think – Act – Review | “Let me repeat that back to you…” |
| 2. Communicate clearly | • 3-way repeat-back and read-back  
• Clarifying questions  
• Phonetic and numeric clarification  
• SBAR to pass information  
Situation – Background – Assessment – Recommendation | “That’s correct.” |
| 3. Think critically | • Questioning attitude  
• Validate and verify | “Let me ask a clarifying question.” |
| 4. Cross monitor | • Peer-checking  
• Peer-coaching  
• S&I feedback, | |
| 5. Speak-up for Safety using ARCC | • Ask a question  
• Request a change  
• Use the safety phrase, “I have a Concern”  
• Use your Chain of command | “I have a concern.” |

## TONES for Teamwork and The Patient Experience

1. Smile and say hello
2. Introduce yourself, your role and refer to others by their preferred name
3. Listen actively with empathy and intent to understand
4. Communicate the positive intent of your actions
5. Provide opportunities for others to ask questions

**YOU CAN COUNT ON ME**
Why take the HRO journey?

- **Joan**: 83 y/o F, Medication Error
- **Robert**: 77 y/o M, Delay in Tx
- **Mindy**: 74 y/o F, Delay in Tx
- **Roger**: 58 y/o M, Delay in Tx
- **Ed**: 71 y/o M, Delay in Tx
- **Martin**: 58 y/o M, Care Mgmt
- **Ted**: 40 y/o M, Medication Error
- **Henry**: 64 y/o M, Medication Error
- **Debbie**: 63 y/o F, Delay in Tx
- **Douglas**: 91 y/o M, Delay in Tx
- **Kyle**: 39 y/o M, Medication Error
- **Linda**: 18 y/o F, Neonatal Death
- **Joanne**: 28 y/o F, Medication Error
- **Ann**: 70 y/o F, Delay in Tx
- **Blake**: 83 y/o M, Delay in Tx
- **Bob**: 70 y/o M, Delay in Tx
- **Scott**: 87 y/o M, Fall
- **Ruth**: 33 y/o F, Delay in Tx
- **Ted**: 40 y/o M, Medication Error
- **Ed**: 71 y/o M, Delay in Tx
- **Jessie**: 71 y/o M, Post Procedure
- **Ann**: 59 y/o F, Delay in Tx
- **Ann**: 59 y/o F, Delay in Tx
- **Joanna**: 41 y/o F, Care Management
- **Linda**: 18 y/o F, Neonatal Death
- **Blake**: 83 y/o M, Delay in Tx
- **Bob**: 70 y/o M, Delay in Tx
- **Martin**: 58 y/o M, Care Mgmt
- **Ted**: 40 y/o M, Medication Error
- **Ed**: 71 y/o M, Delay in Tx
- **Ruth**: 33 y/o F, Delay in Tx
- **Joanna**: 41 y/o F, Care Management
- **Linda**: 18 y/o F, Neonatal Death
Patient/Employees Outcomes

Ed
71 y/o M
Delay in Tx

Ruth
33 y/o F
Delay in Tx

Mindy
74 y/o F
Delay in Tx

Ted
40 y/o M
Medication Error

Scott
87 y/o M
Fall

Donald
71 y/o M
Delay in Tx
HRO Strategies
Daily Check-In

• What Is It
  • A Daily Interaction Among Leaders Throughout an Organization Either in Person or Over the Phone
  • Purpose is to report safety concerns, not to complain or solve issues.

• Why Important
  • Brings Organizational Awareness to Safety Issues That May Have or Are at Risk to Occur, Allows Issues to be Addressed Offline with Results Reported at Future Check In
  • Provides Opportunity to Share Success Stories
  • Provides Opportunity to Recognize Those Using HRO Tools and Tones
Reliability Coaches / Champions

• Volunteer Front Line Staff Super Users of HRO Tools and Tones

• Why Important
  • Real Time Peer to Peer Observations of HRO Tool and Tone Adoption
  • In-the-Unit Resource
  • Enhances Frontline Acceptance and Adoption of HRO
  • Habit Formation

• Integrated Patient and Employee Safety Champion!
HRO Learning Boards

• What Is It
  • A Visual Display Identifying Local System Issues that Impact Safety and Service
  • Department Leaders and Staff Identify and Implement Solutions Together

• Why Important
  • Identifies Issues Important to Front Line Staff
  • Involves Employees at the Point of Contact
  • Engages Employees in the Resolution of Issues
  • A Visual Communication of Progress
  • Displays success

• Integrated Patient and Employee Learning Boards!
Reporting

• Multiple systems
  • Variance/Incident Reports
  • Employee Injury Reports
  • Safety Suggestions
  • Security Reports

• Strategies
  • Validated through Daily Check-In
  • All different systems, used by different departments
  • Requires constant collaboration between quality/patient safety/employee safety/security
  • Ease of Use
Examples

• Safety Events Reported through multiple mechanisms

• Directly impacted both patient safety and employee safety

• Coordinated interventions using multidisciplinary teams
Consistent Practices and Integration
Incident Classification

• Was there a deviation?
  • If no, not a safety event
  • If yes...
• Did it reach the patient/employee?
  • If no, it is a near miss
  • If yes...
• Did it cause moderate severe harm or death?
  • If no, precursor safety event
  • If yes, serious safety event
**Communication of Events**

**Determination and Communication**

Days Since Last Serious Safety Event (SSE)

- **Deviation Required**
  - **Patient Harm**
    - Determined by SSE classification
    - Tracked by SSER
    - (serious safety event rate)
  - **Employee Harm**
    - Determined by OSHA Reportable Events*
    - Tracked by Raw Number
- **No Deviation Required**
  - **Personal Harm**
    - Determined on Individual Basis
    - Tracked by Raw Number
  - **Visitor / Student / Volunteer Harm**
    - Determined by OSHA Reportable Events*
    - Tracked by Raw Number

*OSHA Reportable: Include Employee fatality, Inpatient Admission, Loss of Eye or Amputation
Integration Strategies

- Committee Participation
- Strong Relationships

Consistent Practices
- Reporting processes
- Information Sharing
- SSE Follow-Up
- CCA/RCA

- Perception
Questions?

- Laurie Clark, RN, BSN
  - Patient Safety Officer
  - (330) 363-3923, Laurie.Clark@aultman.com

- Brian Swearingen, CHEP, CHSP
  - Director, Safety, Security, Emergency Management
  - (330) 363-4293, Brian.Swearingen@aultman.com
Questions?
Next Steps

- **Upcoming Events:**
  - Data Submission #13: December 16th, 2017
    - Claims 1/1/16 – 11/30/17; Hours Worked: month of November
  - WPV Action Plan Reviews
    - Update calls ongoing; continue to update Action Plan
  - STF Action Plan Reviews
    - Update calls ongoing; continue to update Action Plan
  - Abbreviated HRO / Integration of Wkr. Safety Gap Analysis:
    - Beginning in January 2018
    - Email / Sign-up using Smartsheet (link to come)
  - Next Webinar: January 5th @ 9:00AM
Conclusion

Thank You For Attending & All You Do To Keep Ohio’s Healthcare Workers, Patients, Visitors & Communities Safe!