Creating and Sustaining the Culture of Patient Safety Through Interdisciplinary Collaboration

PRESENTERS:

Cindy Cassity, RN, BSN, CPPS

Allen Stanton, MT, DLM (ASCP)

BAYLOR UNIVERSITY MEDICAL CENTER

DALLAS, TEXAS

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BAYLOR UNIVERSITY MEDICAL CENTER

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Who is BUMC?

EST. 1903

"Build a Great Humanitarian Hospital."

- *Rev. George Truett | Pastor, First Baptist Church Dallas*

14 ROOM RENOVATED HOUSE

2016

ADMISSIONS	OUTPATIENT VISITS	MEDICAL RESIDENTS
36,077	**147,077**	**244**
BABIES BORN	LICENSED BEDS	EMPLOYEES
4,513	**952**	**5,076**
ER VISITS	PHYSICIANS ON STAFF	DALLAS CAMPUS
106,979	**1,356**	**114.8 acres**

Nationally Recognized

U.S. News & World Report's 2015-2016 "Best Hospitals" Ranking (11 recognitions)

Society of Thoracic Surgeons Three-Star Rating

Third Recognition: Excellence in Nursing Magnet Award

The Joint Commission: COPD Gold Seal

Dallas Child Magazine: 2016 Best Place to Have a Baby

National Pancreas Foundation: National Center of Excellence

DNV National Comprehensive Stroke Center

19th Consecutive Consumer Choice Awards

Learning Objectives

- Discuss the role of teamwork and communication in patient safety.
- Describe how to create a multidisciplinary team as a strategy to improve outcomes through practices, procedures and policies.
- Provide innovative examples of how teamwork and collaboration improved specimen errors (ie: Model 1, Specimen 5 Step, Patient Safety Alert).

A Word to Laboratorians

- Are you “at the table” or are you “on the menu”?
- We have always provided accurate data
- That is no longer enough
- We MUST be engaged and active participants
- Guess what?! The other players in the healthcare team want and need your wisdom and knowledge

Getting Your Message Across

- TIMING is Critical
  - Having a good sense of timing makes a message strike right at the heart of a matter
- PERSISTENCE is Critical
  - Presenting a consistent message multiple times, over weeks, months, even years may be required
- AUDIENCE is Critical
  - Recognizing an informal power structure is as important as appreciating the Org Chart
- FLEXIBILITY is Critical
  - Knowing your truth, but being ready to learn more truth or a new way encourages your peers

- Cal, born healthy baby boy in large accredited hospital
- Jaundiced through visual assessment, but a bilirubin test was not done
- Cal suffered irreparable brain damage known as kernicterus
- Brain damage was 100% preventable
- “Total failure of medical system”

- Pat, died at the age of 45 from misdiagnosed tumor

So…Why are WE here?

- What happened?
- Can you relate?
- Could this happen in your hospital?
- Could this happen to you?
- Could this happen to someone you love who is a patient?

Reliability: Learning from Industry

- Truly exceptional organizations have the same properties
  - Airline and Nuclear Power industries
- Everyone treated with respect every day
- Employees have the tools & flexibility to do the job
- Work is recognized & acknowledged

Human Factors

- Error is inevitable because of human limitations

Crew Resource Management

- Focus on teamwork, communication, flattening hierarchy, managing error, situational awareness, decision making
- Non-punitive reporting of near misses, 500,000 reports over 15 years
- Very open culture regarding error and safety

Team Members

- Physicians
- Nurses
- PCA, PCT
- Transporters
- Laboratory
- Phlebotomy
- Lab processing
- Radiology
- Unit secretaries
- Social workers
- Dietitian & Diet techs
- Pharmacist & Techs
- Chaplains
- Respiratory Care
- PT, OT, ST
- Patients and families

EVERYONE!!!

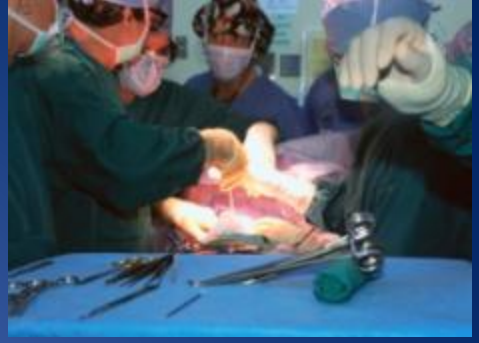
Barriers to Teamwork

- Autonomy
- Lack of team training
- Lack of trust
- Conflict
- Face to face conversations absent
- Lack of time
- Lack of respect

Master Key to Teamwork

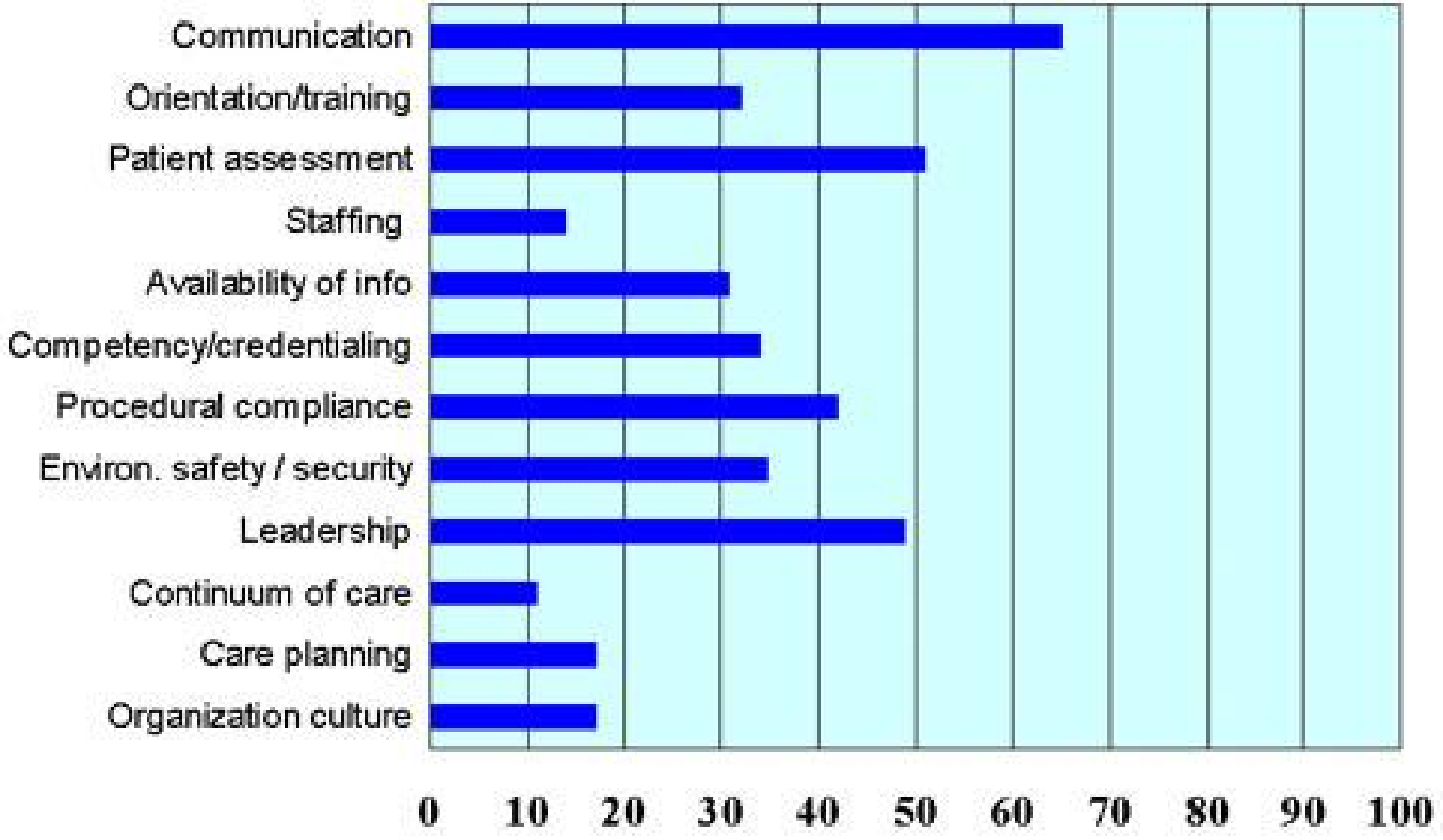
- Effective Communication

Why Improve Communication?



- The overwhelming majority of untoward events involve communication failure
- For instance…wrong site surgery
  - –somebody knows there's a problem but is afraid to speak up
- The clinical environment has evolved beyond the limits of individual human performance

Root Causes: Joint Commission Sentinel Events



Standards of Effective Communication

- Complete
  - all relevant information
- Clear
  - so that is plainly understood
- Brief
  - in a concise manner
- Timely
  - in an appropriate time frame

How to Build the Multidisciplinary Team

BUMC

Nurse Lab Collaboration Committee

Getting started…

- ❑ Engage an executive sponsor, facilitator and physician champion
- ❑ Dedicate a lab and nurse champion (Chairs)
- ❑ Recruit reps for all patient care areas/servicelines
- ❑ Create a priority list to build your agenda
  - Adverse events, good catches
  - Patient safety/experience survey results
  - Issues reported with rounding or huddles

Before you meet…

- ❑ Create agenda
- ❑ Plan for minutes/takeaways
- ❑ What governing body will this team report up to?
- ❑ Determine responsibility of bi-directional communication
- ❑ Determine one or two goals (with metrics)
- ❑ Create dial-in/conference option
- ❑ Make it fun!
- ❑ Food

Sample of Agenda

BAYLOR'S CIRCLE OF CARE

BUMC
Nursing Laboratory Collaboration Workgroup
FY 2017 #9 - Agenda

Ground Rules

- "Be Present" i.e., actively engaged & prepared
- Begin and end on time
- No hidden agendas
- Members must notify leader if unable to attend and make arrangements as necessary (substitutes only when absolutely necessary)
- All team members are equally important
- Team members will speak freely & will listen attentively to others. No interrupting each other.
- Each gets their say, not necessarily their way
- Trust Principles
- Silence equals agreement
- Be on time. No backing up to catch latecomers.
- No distractions (i.e. beepers on vibrate)
- Members respect confidentiality of team
- Once we agree, we will speak with one voice
- Processes will be discussed, analyzed or attacked, not people
- No sidebars
- Always have a timekeeper, facilitator and minute taker
- Purpose identified on the agenda
- Get info and homework out prior to meeting (disseminate information)

Date: Friday, May 5th , 2017	**Time: 12:00 PM**	**Location: 400 Jonsson Classroom - Basement**
VP Sponsor:	**Recorder: Carol Hataway**	**Timekeeper: Carol Hataway**
	Facilitator: Carol Hataway & Shawnette Graham	

Circle of Care	Time	Topic	Person
Consent Items		- Minutes for April 7rd meeting - FY17 WBIT/WSIC & Missing 2 initials Reports - Email from Cindy Cassity Regarding WBIT WSIC-Initials Missing FY 17, sent 5/4/17 - Best Care Presentation	
Quality	12:00 pm	POC Glucose Meter and Data Management Update	Linda Goldberg
Quality	12:10 pm	Lab Divert Project	Cindy Cassity
Quality	12:20 pm	WBIT/WSIC Project	Cindy Cassity
Quality	12:30 pm	Short Samples – BD	Carol Hataway
Quality	12:35 pm	QI Projects involving Nursing and Laboratory - WBIT/WSIC Project – Cindy Cassity - Blood Culture Collection Instructions – Shawnette Graham - Lab Divert Project – Cindy Cassity - Short Samples (new) – Carol Hataway - CLABSI – Pilot w/ 4T with Blood Culture Collection Observations - CAUTI – Provide Lab data, potential evaluation of a urine tube with preservative	Carol Hataway
Quality	12:40 pm	Lab Alerts - Distributed by Mary Rehn to BUMC Educators (Outlook) , Lab Managers/Supervisors, Clinical Managers/VP list provided by Jeff Place and CMC Directors 4/17/2017 – TCT no longer part of the Hemostasis Profile or DIC Panel	Carol Hataway
		Parking Lot - Developing a lab alert tool for nursing	
		Review of Meeting: Assignments, homework **Next Meeting – June 5th, 2017**	

Conference Call-In Line 1-888-458-6153 Password 6915387#

Mislabeled Specimens: Background Refresher

- Patient misidentification is a root cause of healthcare errors.
- One of the more serious mistakes is to incorrectly identify a blood specimen we send to pathology.
- Number of mislabeled specimens are thought to be much higher.
- Nurses do not have handheld positive patient ID technology to collect blood or nonblood specimens.

Mislabeled Specimens: Solutions

1. Model 1
   – blood specimens only
2. Specimen 5 Step
   – all specimens when collected without handheld positive patient ID technology

Example 1: Model 1

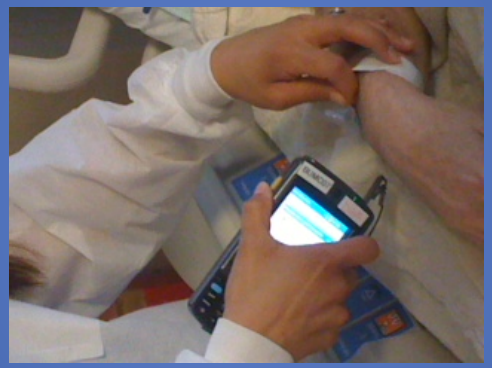
- Process modeling revealed causative factors to be policy/process, human factors, the environment, and education/awareness.
- Prioritization activities using affinity diagrams revealed the need to incorporate technology to nurse blood collections to assure positive patient identification occurred, including the ability to print the patient label at the bedside using a handheld device.

Model 1
Phlebotomy-Assisted Nurse Collects

RN and Phlebotomist must be at patient's bedside before beginning process.

1. Phlebotomist and RN have all needed supplies.

2. Phlebotomist scans patient's armband.



3. Phlebotomist confirms patient NAME and DOB.

4. Phlebotomist prints labels and leaves on printer.

5. RN collects blood appropriately
   &
   Phlebotomist fills tubes in correct order.
6. Phlebotomist inverts tubes.
7. Phlebotomist labels tubes at bedside in presence of RN.
8. Phlebotomist documents RN name in handheld.
9. RN/Phlebotomist confirms labels on specimen before leaving bedside.

Project Overview

The Model 1 process promotes patient safety with improved teamwork and communication between phlebotomy and nursing and reduces:

- Mislabeled blood events; but also
  - blood specimens sent to lab without an order ("no orders"),
  - wrong collection tube used, incorrect specimen handling, and incomplete labeling of specimen,
  - phone calls

The Model 1 process led to a 100% reduction in mislabeled blood specimens which has been sustained more than 56+ weeks.

The Team

Executive Sponsor	JaNeene Jones RN FACHE, BHCS Vice President
Team Leads	Cindy Cassity RN BSN CPPS, Patient Safety Manager
	Mike Newhouse MT(ASCP)SBB, Lab Director
Team	Carol Cather RN BSN CMSRN, Nurse Manager
	Lisa Florida RN BSN CCTN, Nurse Supervisor
	Carol Hataway MT(ASCP), Lab Manager
	Leonard Johnson PBT(ASCP), Phlebotomy Supervisor
	Lisa Jones CLA(ASCP) MT(HEW), Phlebotomy Manager
	Travis Sandidge PBT(ASCP), Phlebotomist
	Missie Verret MT(ASCP), Lab Educator
	Colleen Weaver RN BSN CCRN, Nurse Supervisor
Facilitator	Claudia Wilder DNP RN NEA-BC, Chief Nursing Officer

Financial Implications

Baseline (pre-analytic) turn-around time was 73 minutes.

Current (pre-analytic) turn-around time is 57 minutes (**22%** decrease in time).

This cost reduction was achieved by improving efficiency and quality of the blood collection process.

Cost per collection (two RNs) was $11.40.

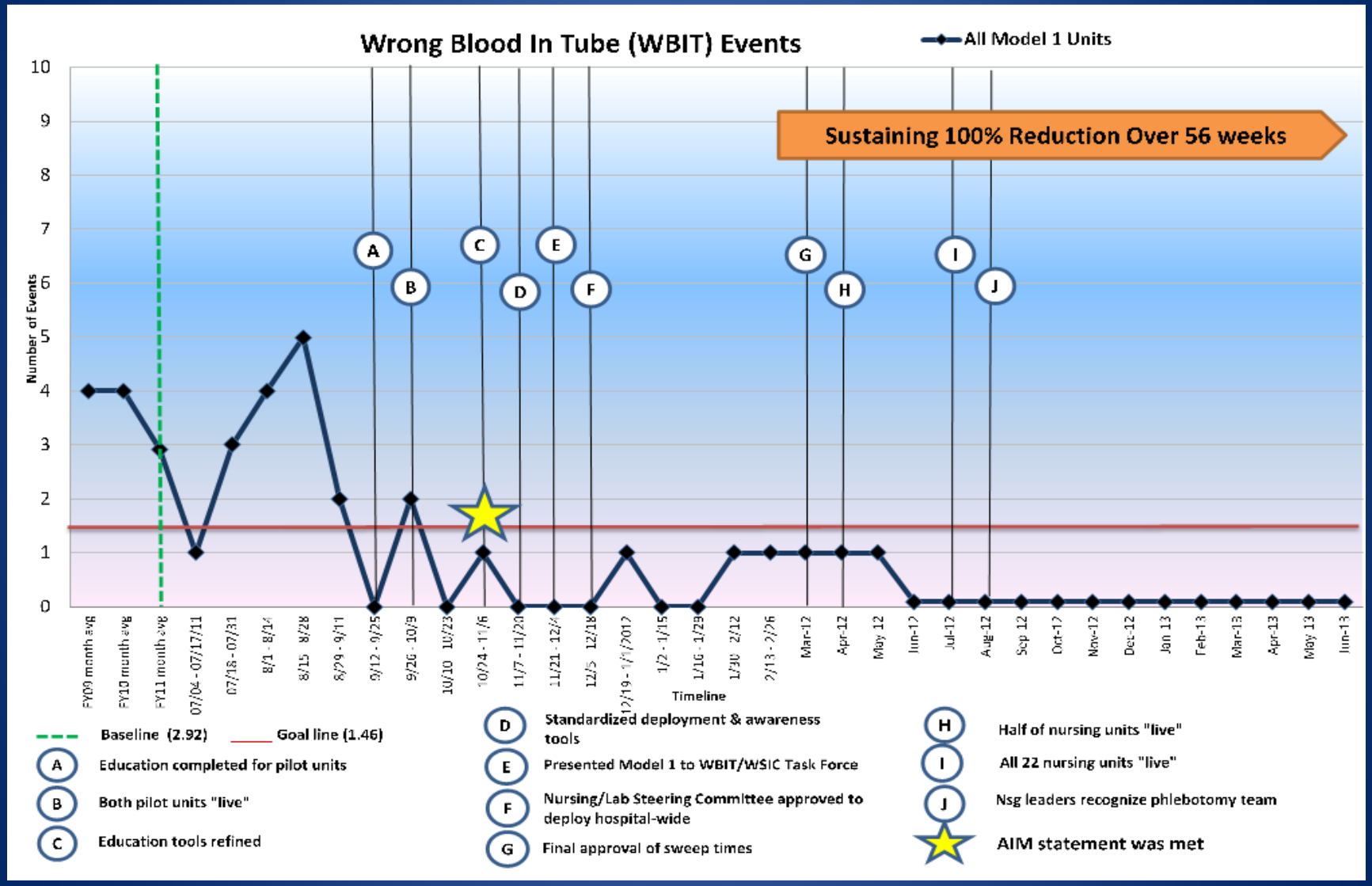
Current cost per collection (one RN, one phlebotomist) is $5.60 (**49%** decrease in cost).

This cost reduction was achieved by replacing 2nd RN witness and by improving efficiency and quality of the blood collection process.

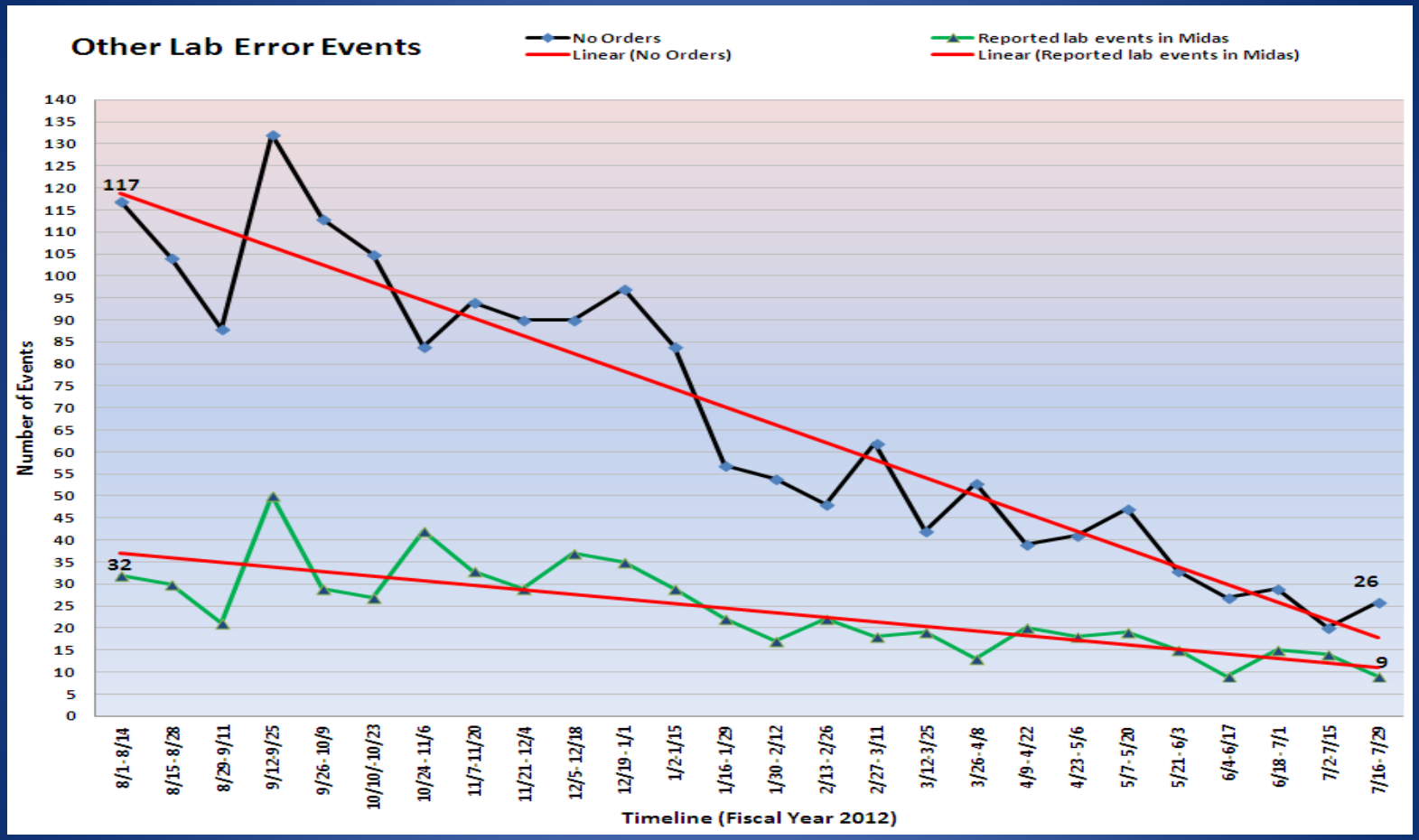
Patient and Family Centeredness

- Patients see model as a “safety check” and feel confident with overall care
- Overall reduction in lab errors has the downstream effect of ensuring correct and prompt lab results, resulting in less delays.

Results


Wrong Blood In Tube (WBIT) Events
All Model 1 Units
Sustaining 100% Reduction Over 56 weeks
Number of Events
Timeline
Baseline (2.92)
Goal line (1.46)
A Education completed for pilot units
B Both pilot units "live"
C Education tools refined
D Standardized deployment & awareness tools
E Presented Model 1 to WBIT/WSIC Task Force
F Nursing/Lab Steering Committee approved to deploy hospital-wide
G Final approval of sweep times
H Half of nursing units "live"
I All 22 nursing units "live"
J Nsg leaders recognize phlebotomy team
AIM statement was met

Balancing Measure



The magnitude of improvement with the Model 1 process produced unintended consequences of other lab error reductions including “no orders” and “reported lab events in MIDAS”.

Lessons Learned

- Seek the right people to be on your team
- Dedicated champions for nursing and phlebotomy will make change easier
- Education/awareness using visual tools is key
- Meet regularly (rounding or huddles) with frontline staff
- Coach “Stop the Line” policy with any deviation of process
- Leadership support to dedicate resources for technology and staffing is important

Technology alone does not improve patient safety – teamwork improves patient safety

Example 2: Specimen 5 Step

- Process modeling revealed causative factors to be policy/process, human factors, the environment, and education/awareness.
- Prioritization activities using spider/affinity diagrams revealed the need to incorporate an independent two person check to assure positive patient identification occurred

Specimen 5-Step

- ❑ Highlights 5 critical elements of specimen collection <u>in specific order</u>
- ❑ Deviations causing mislabeled specimen will prompt invite to Nurse Leadership Executive Team for case review
- ❑ Attestation Statement must be completed/signed in file

Let's do the

SPECIMEN 5-STEP

Grab your partner and learn the Specimen 5-Step! Physicians, nurses and all staff should **follow all 5 steps** when collecting blood and non-blood specimens from BUMC inpatients and outpatients. Practice makes perfect... and perfect protects our patients!

1. Gather supplies for collecting and labeling specimen
2. Perform positive patient ID by asking patient to state full name and birthdate which must match the label, armband, and order
3. Collect specimen
4. At the bedside, label specimen tube/container and write date, time and initials on label
5. Ask patient to initial the label verifying that full name and birthdate are correctly printed on label
   a. If patient unable/unwilling, ask family to verify and initial the label at bedside
   b. As a last resort: If family unable unwilling/absent, ask another healthcare provider to verify and initial the label at bedside

REMINDER | *Before sending to the Lab, confirm two initials, date and time of collection are all on the label!*

Doing the Specimen 5-step helps ensure our patients benefit from prompt and accurate testing, results and treatment! Help protect them from recollection or mistakes due to mislabeled specimens.

Got the 5-step down pat? Help coach your teammates and "stop the line" if you see any deviations. View the specimen labeling policy and information on BUMC Patient Safety's myBaylor page.

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Project Overview

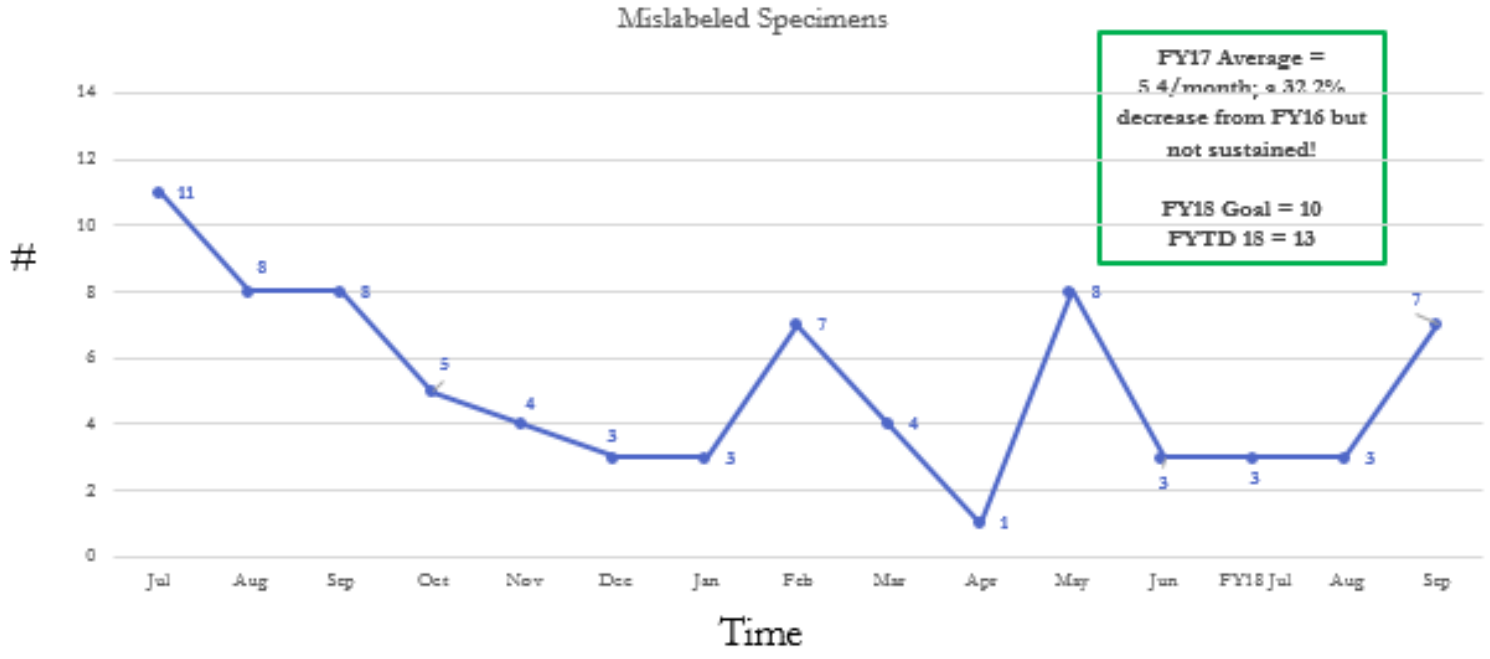
- The Specimen 5-Step process promotes patient safety with improved teamwork and communication between nursing staff, patient/family and other members of the team and reduces:
  - Mislabeled specimens; but also
    - specimens sent to lab without a physician order ("no orders"),
    - phone calls,
    - recollects
- The Specimen 5 Step process led to a xx% reduction in mislabeled non-blood specimens which has been sustained more than xx weeks. -- TBD

Patient and Family Centeredness

- Patients/family see the 5 Step as a "safety check" and want to be a part of this process.
- Overall reduction in lab errors has the downstream effect of ensuring correct and prompt lab results, resulting in less delays.

Results to date

CURRENT RESULTS: MISLABELED SPECIMENS



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Barriers to Success

- Not following 5 critical steps in order
- No full comprehension of what is Positive Patient ID
  - Matching what patient states + armband + label + order
- Rushing/Interruptions (and not starting 5 step over again)
- Patient verifying label doesn't always "catch" error
- No bedside technology in area of high volume/high risk (Emergency Department)

Next Steps

- Continue interventions of Specimen 5-Step program
- Continue NLT mini-case reviews
- Discuss lessons learned with frontline leaders in huddles
- Observational audits of specimen collections (TBD)

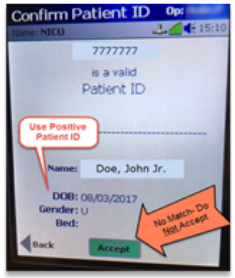
Patient Safety Alert

To: All Nurse Managers
From: Lab Department Leaders
Date: September 26, 2017
Re: *Wrong patient identification entered in glucometer*

Situation: Omitted, delayed or wrong treatment for glucose results may occur when patient identification is not correct in glucometer.

Background: There have been multiple reports of glucose patient MISidentification – different patients, different departments since August. The new glucometer software has uncovered this chronic error.

Assessment: This error occurs in the following situations:
1. Positive patient identification is not performed
2. Transfer patients with old hospital armband
3. RN/UAP scans wrong chart label instead of visit number on armband



Recommendations:

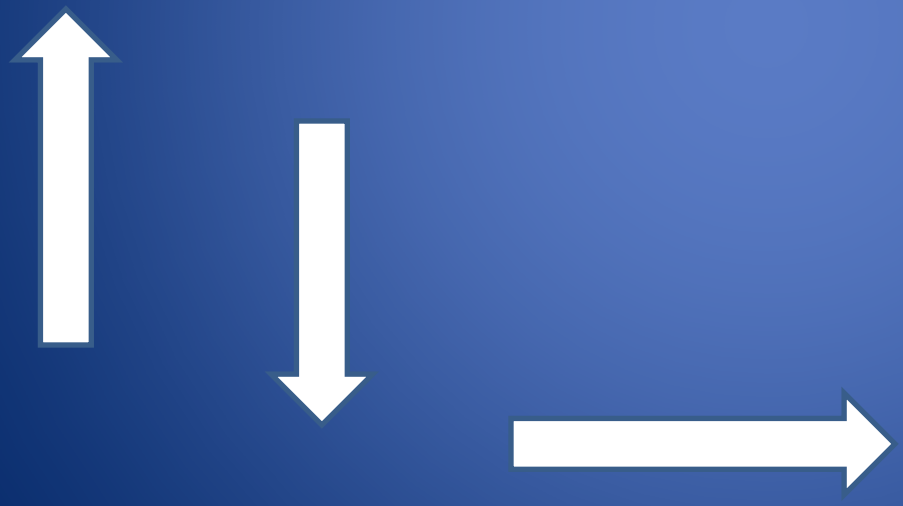
1. Remove non-BUMC patient armbands immediately.
2. Perform positive patient identification (ID) by asking patient to state full name and birthdate which must match glucometer ID, armband and order
3. *Stop the Line* if barcode is scanned and no patient identification or incorrect patient identification shows up on glucometer. Notify the patient's nurse of issue.
   a. Incorrect Patient ID
      - Do not "Accept" wrong patient ID on the glucometer.
      - Notify patient's nurse
      - Use temporary ID - patient's Date of Birth or current date
      - Complete and fax "POC Temporary Patient ID Form" to POC – 27974
   b. No Patient ID (ED or non-registered patients)
      - Use a temporary ID – patient's Date of Birth or current date
      - Continue testing on the glucometer
      - Complete and fax "POC Temporary Patient ID Form" to POC – 27974

09.22.2017 cmc/lg

- Created collaboratively to increase awareness
- Brought to Tier 2 Huddles by lab leaders
- Tier 2 rep takes to Tier 1 huddle to share with frontline staff for one week

Team Structure and Communication

- **ENGAGING AND COMMUNICATING ACROSS SERVICE LINES TO CREATE SUCCESSFUL WORKGROUPS.**



Safety Culture

- A culture where ALL workers accept responsibility for safety of themselves, their coworkers, patients and visitors
- Encourages and rewards the identification, communication and resolution of safety issues
- Encourages non-punitive reporting of errors

Safety Culture (cont'd)

- Provides for organizational learning from accidents
- Provides appropriate resources, structure and accountability to maintain effective safety systems
- Prioritizes safety above financial and operational goals

Questions?

Cindy Cassity, BSN, RN, CPPS
cindy.cassity@bswhealth.org

Allen Stanton, MT, DLM (ASCP)
allen.stanton@bswhealth.org