Safest
Together

Safety in action

Fall 2018 Newsletter

In the spring newsletter we shared the exciting news about Alberta Children's Hospital and the Stollery Children's Hospital joining the Solutions for Patient Safety (SPS) Network, a network of children's hospitals across North America that are working together to eliminate serious harm across all children's hospitals. Our Alberta program *Safest Together* embraces the SPS network approach of *all teach, all learn* and is undertaking the following:

- Implementation of prevention bundles to reduce specific types of patient harm.
- Regular reviews to measure the use of specific interventions and processes.
- Monthly reporting to SPS on process and outcome data.
- Participation in the Culture Wave, a series of workshops to entrench and support a culture of safety within our hospitals.

Patient safety is nothing new to us, and many of the cultural elements being promoted by SPS are already embedded in our daily work. What will be new is a more intentional focus on tracking and measuring our performance (see sidebar), along with additional learning and teaching opportunities for anyone and everyone that has a role in keeping our patients safe.

Throughout 2019 ACH will be running a training course for all staff in error prevention methods, as well as launching a Safety Coach program through the Safest Together initiative. Stollery timelines need to work with the Connect Care roll out, but will start providing the same error prevention training after that. Stay tuned for communication and learning updates.

Work also continues on addressing the hospital acquired conditions (HACs) as we spread harm prevention methods to more inpatient units.

To become involved or to learn more, contact the Safest Together team by email at safest.together@ahs.ca

Serious safety events

A serious safety event (SSE) is an adverse event that:

a. Is caused by a deviation from generally accepted practice standards;
b. Reaches the patient; and
c. Results in moderate to severe harm or death.

All harm events are reviewed by a patient safety team and go through a safety event classification algorithm. Those that meet the above criteria are classified as SSEs.

SSEs are preventable, and examples can include treatment errors, misdiagnoses and hospital-acquired infections. The SSE rate is the ultimate metric of patient safety for Safest Together, and we are striving to reach *zero per cent*.

2017 SSE rates

As a baseline, Safest Together looked at the rate of SSEs since January 2017:

ACH:
1.33 incidents/10,000 days, or one every **45.6 days**.

Stollery:
0.77 incidents/10,000 days, or one every **40.6 days**.

We expect the rate to go *up* as reporting of safety events improves, then to go down—preferably to *zero!*.

Glossary of terms

Wondering what a prevention bundle is? Don't know your HAC from your DART? Healthcare is rife with acronyms and specialized terminology, and the Safest Together program is no exception. Here's a quick guide to some commonly used terms.

HAC: Hospital acquired conditions (HACs) are specific sources of *preventable* patient harm (such as pressure injuries or falls). Safest Together is targeting a number of these.

Prevention bundle: A small number of evidence-based practices shown to prevent harm. Each HAC has an associated prevention bundle that SPS member hospitals are expected to implement.

Bundle reliability: Prevention bundles are only effective if they are reliably followed, and so we track how often we successfully complete each element of the bundle.

K-card: The Kamishibai card (or K-card) is a popular method of ensuring new processes are followed. A HAC's K-card lists the elements of the prevention bundle and serves as a checklist.

PIVIE: One of the HACs, PIVIE stands for Peripheral Intravenous Infiltration & Extravasation, and occurs when a fluid being administered via IV leaks outside the vein into the surrounding tissue.

CLABSI: One of the HACs, a central line-associated bloodstream infection (CLABSI) is a bloodstream infection that occurs when germs (usually bacteria or viruses) enter the bloodstream through the central venous catheter.

Culture Wave: The SPS Network teaches its member hospitals how to prevent patient harm through cultural transformation strategies dubbed the Culture Wave. Some of these strategies include cause analysis, staff safety, and error prevention training.

Cause analysis: The methods and procedures to analyze the specific causes of errors when they occur. Precursor and near-miss events are also analyzed to examine common characteristics and causes.

DART: One way of measuring employee/staff harm is through tracking Days Away, Restricted or Transferred—how many workplace injuries and illnesses required employees to miss work in a year.

Error Prevention training: A program delivered to all staff (clinical and non-clinical) at the hospital that teaches specific behaviors and tools that are proven to effectively prevent errors at all levels of care.

Safety Coach: A team member who is trained to provide feedback and coaching about error prevention behaviours.

High Reliability Organization (HRO): Organizations that have far fewer catastrophes than one would expect given their risk factors and complexity (e.g., airlines, NASA, nuclear power). Healthcare is hyper-complex and rife with opportunities for accidents to occur, thus the interest in applying HRO principles to hospitals.

Site highlights

At the Stollery

The local CLABSI HAC team is discussing the prevention bundle and next steps for achieving best results. The Stollery team is also making plans to roll out the first part of the Culture Wave in December 2018, before the Connect Care training schedule begins.

At the ACH

While our HAC teams are implementing prevention bundles, the ACH has started to roll out Error Prevention training by making the bosses go first: Over 80 leaders, managers and physician leads attended the kick-off session on September 12th, 2018.