



## Healthcare Organization Commitment

### Contact Details

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#### Position

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#### Organization Name

CHOC Children's Hospital

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### Commitment Details

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#### Commitment Name

APSS #1: Creating a Culture of Safety

#### What Patient Safety Challenge does your Commitment address?

Challenge 1 - Culture of Safety

#### Commitment Start Date

01/07/2011

#### How Many Hospitals Will This Commitment Represent

## Commitment Summary

Since at least 2000, CHOC Children's Hospital has been steadfastly working to improve the culture of safety within our organization. While this is a continuous journey, not a destination (James Reason, "Managing the Risks of Organizational Accidents;" Ashgate Publishing Ltd; Hants, England, 1997), one measurable output is the Serious Harm Rate, which objectively measures the most severe types of preventable patient harm. In the mid 2000s, CHOC adopted a quality goal, subsequently an organizational goal in 2011, to Reduce the Serious Harm Rate. It is the highest level measure of the effectiveness of our safety systems and culture to improve the patient safety domain of our organization quality program. Simultaneously, CHOC has been regularly measuring, learning from and responding with action to the validated and widely used Agency for Healthcare Research and Quality (AHRQ) Patient Safety Culture Survey. Patient Safety simply cannot sustain improvement and performance without a relentless approach to recognizing and modifying organizational safety culture. While discrete safety events can often be prevented through best practice adherence and other campaigns, the fundamental imperatives of just culture, error prevention techniques, human factors engineering and high-reliability can neither be effectively introduced nor maintained without cultural buy in. While this is a journey measured in years, not days, it is one in which patients and their families cannot afford the hesitation of a single step.

## Commitment Description & Detail

CHOC Children's uses the Healthcare Performance Improvement (HPI) Inc. Safety Event Classification (SEC) event classification system to label harm and potential harm events. The CHOC Serious Harm Rate uses the denominator of 1000 inpatient days. Potentially preventable patient harm events are identified from multiple sources, including Daily Safety Briefing, the online Safety Reporting System, morbidity and mortality conferences, and peer review. There are three broad categories within the SEC: Serious Harm, Precursor Safety Event, and Near Miss Event (in order of increasing frequency). The five types of serious harm are: Death, Permanent Severe, Temporary Severe, Permanent Moderate and Temporary Moderate (in order of increasing frequency). All serious safety events undergo detailed analysis, typically root cause level. Analytic efforts then lead to answering the fundamental question of how to improve our systems and culture to prevent recurrence and advance reliability. Since inception a decade ago, CHOC Children's has reduced its Serious Harm Rate 97.9% to the current 0.05/1000 patient days. While this is a notable improvement, rates alone can be impersonal. For this reason, we also track and discuss the actual number of such children harmed, which can be very impactful, particularly at leadership and lay levels. In alignment with the Patient Safety Movement Foundation's Actionable Patient Safety Solutions (APSS) checklist, CHOC Children's Hospital is very close to reaching our goal for all of the below checklist items. As the items contain references to "create culture," it is doubtful that such a checklist can - or should - ever be signed off as truly completed.

## Action Plan

Achieving a culture of safety in a healthcare organization requires transformational change which is owned and led by the executive leaders of the organization, including the board, encouraging accountability and transparency. Leadership's primary goal must be to make their hospital a safe haven for patients.

- Address unexpected outcomes with open disclosure and prompt resolution.
- If patient harm results from a preventable medical error, adopt the CANDOR (Communication and Optimal Resolution) or similar approach: apologize as soon as possible, pay for all care related to the preventable harm, seek a just resolution, and provide ongoing support for patients and families. Clinicians (the "second victims" of patient harm events) may also require attention and support (Lambert et al., 2016).

□ Create an open and transparent culture that encourages staff to speak up and self-report

□ Apologize within 60 minutes of discovery

□ No charge for care related to event

□ Incentivize lawyers to settle fast

□ Do event reviews to avoid reoccurrence

□ Within 30 days of any event review disseminate learning out to the patient, family, hospital system and externally

- Create a standard of care to ensure that clinicians speak with family members to explain what will be changed so this event won't happen again. Offer family members an opportunity to be involved and witness the change in procedure, etc.
- Create a reliable means to capture and analyze good catches/near-misses. Set a goal that includes aspirations that all errors and incidents are preventable and that zero is the most important goal.
- Implement an electronic adverse event reporting system that allows for both authored and anonymous reporting, tracking, trending and response to aggregate safety data.
- Implement thoughtful and memorable internal branding to keep safety expectations and aligned behaviors top of mind throughout an organization.

## Commitment Timeline

These patient safety culture checklist items are currently in place at CHOC Children's. Our commitment to this APSS will be ongoing and reported yearly.

## Impact Details

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### Lives Saved

#### Predicted Lives Spared Harm

0.39999999999999985

*For reporting purposes, the number has been rounded up to the nearest whole number.*

*Predicted Lives Spared Harm =*

1