New Caregiver Orientation

Performance Improvement
Quality – Safety – Risk

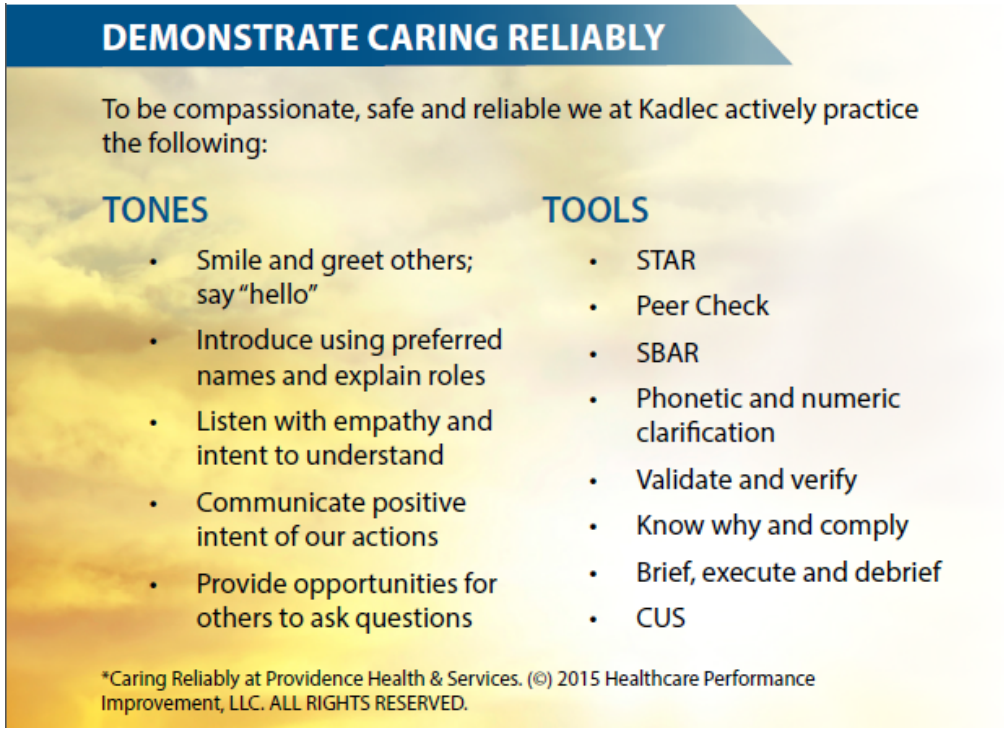
Safety and Quality

- At Providence, we define quality as the degree to which health services increase the likelihood of desired outcomes and are consistent with professional knowledge. We believe that all health care should be:
  - Safe, as to avoid injuries to patients from the care that is intended to help them
  - Timely, to reduce waits and potentially harmful delays for those who receive care
  - Effective, in that we match care to science to provide appropriate care
  - Efficient, by avoiding waste in order to maximize value
  - Equitable, to ensure care does not vary in quality, regardless of patient characteristics
  - Patient and family centered, to honor the individual and respect choice

Universal Behaviors and Safety

- Universal behaviors are behaviors that have been proven to assist with safety and communication. They can be found in the Standards of Excellence on page 3 and 4.
  - Pay Attention
  - Communicate Clearly
  - Have a Questioning Attitude
  - Operate as a Team
  - Speak up for Safety

- We have tones and tools to help you with these five behaviors



Safety Support and Communication

- **Reliability Coach Program**: people on the front line that are specially trained to actively promote our high reliability tones, behaviors, and tools
- **Safety Huddle**: tiered huddles that take place every day accounting for the previous and future 24 hours. Huddles take place at all levels of the organization to allow for escalation of issues if needed
- **Caregiver Newsletter**: contains information regarding safety. This is emailed out weekly on Thursdays
- **Safety Stories**: share your safety stories to help us remember and to learn from them

Our Patients and Risk Resolution

Sometimes you may encounter a patient or family member who is upset.

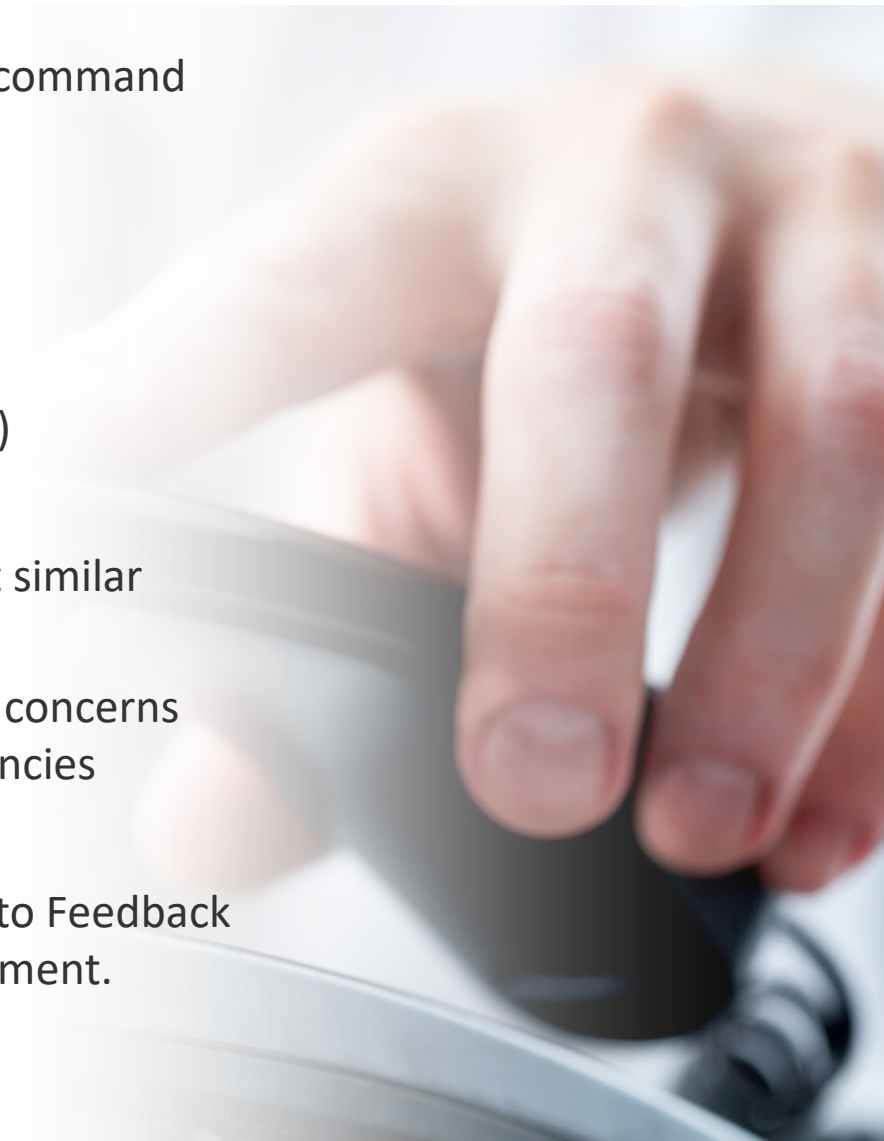
What would you do?

- The longer you wait or avoid the issue, the more complicated the issue becomes. It could create a unsafe environment or negative patient outcomes.
- This is your opportunity to act promptly to resolve the issue. YOU can be the hero for that patient!
- You must have the courage to ask the question – “You seem to be worried about something, tell me what is going on so I can help.” Show empathy.
- Don’t ever criticize another staff member or get defensive.
- Listen to understand – not to respond. Make sure you understand their concerns and restate to confirm. Tell them your plan, get their buy-in and carry it out.
- If the discussion loses focus, try saying “Let’s take a step back. How you feel about your care and service is important to me and I want to understand.”

What if that doesn't work?

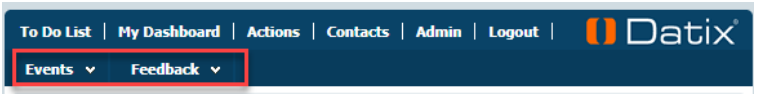
- Get help – reach out or move up the chain of command
  Reach out to:
  - Family members
  - Peers or leaders
  - Patient Care Coordinator (PCC)
  - Patient Advocates (509-942-2171 or 2830)
- Complete a Feedback QRR when appropriate
  - Used to learn from situations and prevent similar incidents in the future
- Patients have the right to reach out with their concerns through Risk Management and regulatory agencies

There are different types of reporting in addition to Feedback QRRs that we use for performance improvement.



KADLEC

Quality Review Report (QRR)



- Reporting system to collect feedback and safety event information
- All staff are responsible for submitting QRR's in addition to reporting their concerns through their chain of command
- Safety Event reporting is a non-punitive process to improve the overall care at Kadlec
- All QRR's are reviewed by Risk Management and department managers
- QRR's are used for tracking and for trending issues and to improve processes

Quality Review Report (QRR)

Safety Event Definition

- Any event placing patients and/or others at risk of harm or possible harm
- Any event which is not consistent with routine operation of a healthcare system or routine care of a particular patient
- Events that did not reach the patient or did reach the patient and caused minimal to no harm should be reported through the QRR system

Purpose of Reporting

- Identify opportunities to improve the quality of patient care
- Identify events or unsafe conditions
- To advise Risk Management

Examples of when to complete a QRR

- Medication errors or adverse drug reaction
- Patient fall
- Equipment failure that did or could have resulted in injury
- Delay in treatment

Quality Review Report (QRR)

Definition of Sentinel and Adverse Events

Sentinel Event – A Sentinel Event is defined by The Joint Commission (TJC) as any unanticipated event in a healthcare setting resulting in death or serious physical or psychological injury to a patient or patients, not related to the natural course of the patient's illness.

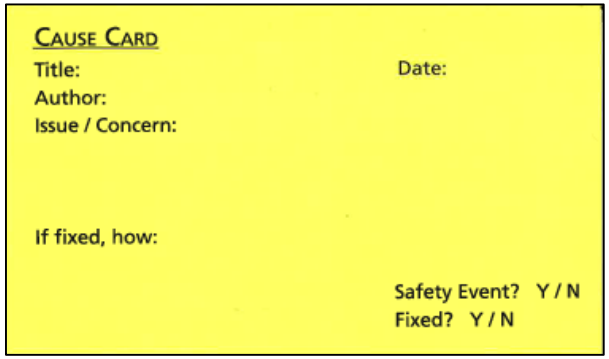
Adverse Event – Adverse events are medical errors that healthcare facilities could and should have avoided. The National Quality Forum (NQF) defines these errors, which are also called serious reportable events. The events may result in patient death or serious disability. Washington State law requires healthcare facilities to report to the Department of Health whenever they confirm an adverse event.

Refer to policies:

- Adverse Event Plan, 192.00
- Quality Review Reporting (QRR), 1906
- KASC Quality Review Reporting (QRR)

Ideas for Improvement

- **Performance Improvement**: Continuous performance improvement is a process of reviewing data collected on daily processes, identifying problems, and developing countermeasures to address the problems so that the system of care delivery can be improved. Methods used to analyze events include:
  - Failure Mode Effect Analysis (proactive)
  - Apparent Cause and Root Cause Analysis (reactive)
- **Improvement Boards/Cause Card**: When you have an idea for an improvement fill out a "cause card" or a STP – Situation, Target, Proposal card. Your manager will collect the ideas and work on identifying issues and processes that may need to change.



- **Standard Work**: Your concern may bring about standard work (the current best way to perform a task or process). The standard work process ensures work is done consistently and the best way every time which creates quality results.

Improvement Boards

- Improvement boards are located in locations where the public will not see the information
- They are used to communicate non-safety event concerns to your supervisor
- Fill out a yellow cause card with your name, date and concern and place on the improvement board
- The department supervisor will review the cause card and place in the appropriate section on the improvement board
- Your supervisor may ask you to participate in process improvement activities
- Report safety events (Near Miss, Good Catch, Minimal or no harm) using the QRR system

Questions???

- Reach out to Teresa Robinson, Patient Safety Program Manager

  Teresa.Robinson@providence.org