



VA National Center for Patient Safety Topics in Patient Safety®

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The Patient Safety Huddle Board: A new tool for an old-fashioned business practice

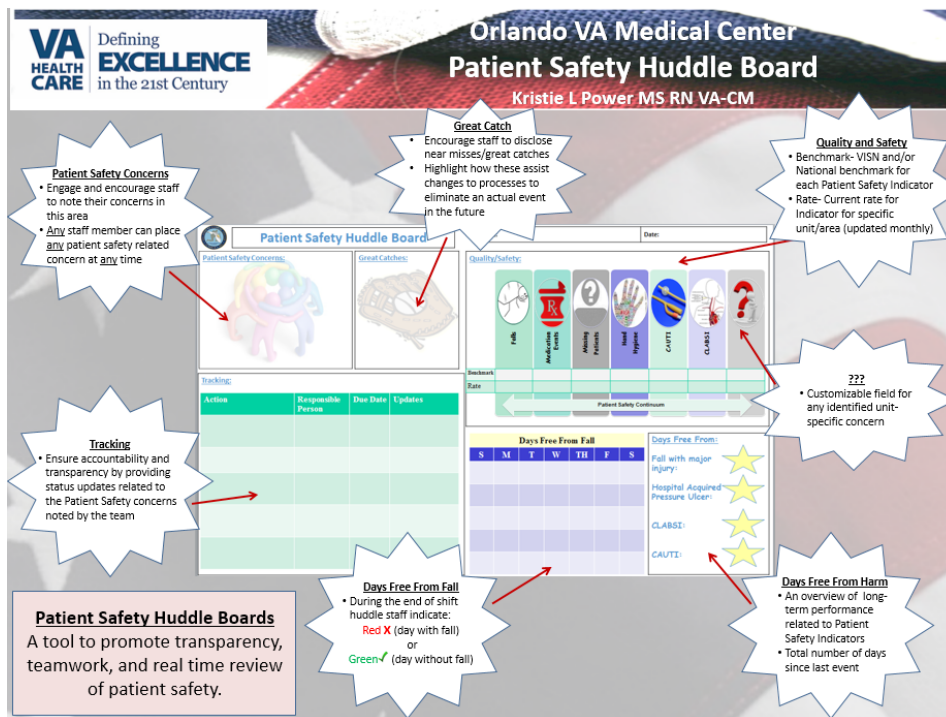
Kristie L. Power, MS, RN, VHA-CM, patient safety manager, Orlando VA Medical Center

In summer 2016, the Orlando VA Medical Center (OVAMC) integrated a Patient Safety Huddle Board into its acute, critical and long-term care areas. This was a positive step for OVAMC in its fulfillment of VA's effort to be a data-driven organization and improve upon patient safety. The Patient Safety Huddle Board is a tool used to promote transparency, teamwork and provide a patient safety overview in real time. It tracks quality indicators, such as: falls, medication events, missing patients, hand hygiene, CAUTIs /CLABSI (catheter-associated urinary tract infections and central line-associated bloodstream infections), great catches, and allows front-line staff to identify any patient safety concerns. It ensures follow-through, accountability and sustainability through the use of the action tracker. The quality indicators can be changed depending on the particular unit and its specific needs.

The creation of the Patient Safety Huddle Board was driven by the proactive redesign of the inpatient fall prevention program. It was an effort to integrate patient safety and lean process improvement principles with the goal of engaging and empowering front-line staff to develop a sense of ownership around patient safety. Staff are empowered to identify opportunities for improvement in their own work and make the needed sustainable changes.

The OVAMC's prototype Patient Safety Huddle Board is a simple, laminated poster that functions as an interactive dry-erase board. When deciding on the modality of the huddle board, several factors were considered, such as configuration time, ease of use and implementation cost. Even though there were electronic modalities available, such as Smart Boards, it was determined that the end users would be too pressed for time for an electronic configuration. Additionally, the poster allowed for the display of data that could easily be referred to without having to turn on a computer. Ultimately, the goal was for the tool to be user-friendly and visible at all times.

A huddle is a daily micro-meeting that keeps teams united and informed. It's an old-fashioned business practice used in both large and small businesses. A huddle is streamlined, customizable and an incredible opportunity to encourage teamwork. These meetings are brief (five to 15 minutes long) with all members of the team present at the beginning of a shift. They build teamwork through communication and cooperative problem solving, help increase and maintain situational awareness, improve knowledge of front-line operations and transparency of patient safety performance. A huddle also allows team members to identify and communicate the urgency of



The Orlando VA Patient Safety Huddle Board

resolving patient safety issues, deliver timely recognition and resolution of problems, and provide an increased focus on operational safety issues for all members of the team.

When the Patient Safety Huddle Board was first implemented, units were provided with key points for success, which were: to ensure leadership attendance, maintain consistency in start time and frequency, establish accountability by making attendance mandatory, assign problem solvers for identified issues, close the loop/follow-up on identified issues until they are resolved and to keep the focus on safety-critical issues. The effectiveness of the Patient Safety Huddle Board would be determined by evaluation of the quantifiable metrics identified on the huddle board itself, as well as anecdotal feedback from end users. A staff nurse on the inpatient unit stated: "The positive, objective data associated with teamwork through the patient safety huddles heightens our situational awareness, individual patient and staff needs, improves communications regarding supply

and demand, prevents patient safety issues, communicates staff concerns and allows us as a team to anticipate needs at the beginning of each shift or throughout the shift, so as a team we have embraced this process because it helps us as a unit to facilitate positive outcomes."

Overall, the units embraced the Patient Safety Huddle Board and saw value in its ability to facilitate positive outcomes. Continuous improvements in clinical indicators, such as fall rates, pressure ulcers and CAUTIs were noted by leads on the units and by the OVAMC patient safety office. The objective data, associated with teamwork through the Patient Safety Huddle Board, created a greater sense of awareness in patient and staff needs, improved communication, helped prevent patient safety issues, and allowed staff to communicate concerns. Teams were motivated by the board's visual trackers of days since last fall, a truly compelling scoreboard for sustainable success. The emergency department recently became the latest service line to utilize the

huddle board. They determined what clinical indicators were critical for tracking in their environment/population and helped customize their board. The Mental Health Residential Rehabilitation Treatment Program is the next area expected to implement the Patient Safety Huddle Board. Only time will tell what further benefits are realized from the patient safety huddle boards.

Components of OVAMC's Patient Safety Huddle Board

The patient safety concerns area engages staff and encourages them to put their concerns in writing. Any staff member can place any patient safety-related concern at any time.

The tracking section ensures accountability and transparency by providing status updates related to patient safety concerns noted by the team.

The great catch component encourages staff to disclose near misses and great catches as mechanisms to identify vulnerabilities in a process. It also highlights how they improve processes to eliminate an actual event in the future.

The quality and safety corner of the huddle board compares OVAMC data against VISN and/or national patient safety indicator benchmarks. It also displays the current specific unit rates for each safety metric. This section also has a customizable field for unit-specific identified concerns or focus areas.

The days free from harm area is an overview of long-term performance related to patient safety indicators and total number of days since last event.

Staff indicate a red "X" or a day with a fall or a green checkmark for a day without a fall in the days free from falls component.

Please contact Kristie.Power@va.gov for more information about how patient safety huddle boards could help your facility.

Standardizing timeouts at the Phoenix VA Health Care System

Marnonette Marallag, M.D., chief resident in quality and patient safety; Adebisi Alli, D.O., director, quality improvement and patient safety education program, Phoenix VA Health Care System

The Phoenix VA Health Care System (PVAHCS) has a dedicated inpatient and outpatient Chief Resident in Quality and Patient Safety (CRQS). The chief residents lead a local three-legged curriculum teaching concepts in quality improvement and patient safety to internal medicine residents at the University of Arizona College of Medicine, Banner University Medical Center and PVAHCS.

The three-legged curriculum includes:

- Residents and medical students on VA inpatient rotations are taught about adverse events and near-misses during weekly Electronic Patient Event Reporting (EPER) "happy hours." These sessions promote electronic patient event reporting and related resident-driven projects.
- The Patient Safety Consult Service (PSCS) consists of senior residents spending a month investigating adverse events and/or close calls. Stakeholders from various departments meet to discuss causal analysis based on the residents' Gemba walk and fishbone diagram, and propose plausible system-level interventions to prevent recurrence of the patient safety event.
- The Patient Safety Conference (PSC) is a monthly training event open to all facility staff. At the PSC, each chief resident leads a one-hour interactive session to address a particular patient safety event. PSCS and PSC involve inter-professional discussions among various departments, including internal medicine residents, nurses, pharmacists, laboratory technicians, radiologists,

informatics specialists, medicine subspecialties, VA leadership and faculty.

Through the PSCS, second-year resident Dr. Emma Simpson investigated a patient event involving a wrong-site thoracentesis and identified the lack of standardized approaches to resident procedures and the importance of timeouts. The Joint Commission states that pre-procedure timeouts immediately prior to the start of invasive procedures reduce wrong site procedures.¹

Despite evidence and guidelines to support the use of medical timeouts before invasive procedures, utilization of timeouts among local internal medicine residents is low. Through Dr. Simpson's survey of 42 internal medicine residents and fellows, only 19 percent (n = 8/42) reported consistently performing pre-procedure timeouts. Common reasons for not performing a timeout were: 1) forgetting, 2) not knowing it was required prior to procedures, and 3) poor understanding of how to perform a timeout.

Based on the survey results, Dr. Simpson and CRQS Dr. Marnonette Marallag collaborated during the November PSC to improve awareness and standardized utilization of medical timeouts for resident procedures.

After attending Dr. Douglas Paull's simulation module at the CRQS Bootcamp in September 2017, Dr. Marallag used a similar approach to highlight the importance of performing pre-procedure timeouts:

- A conference was conferred including an audience of residents, medical students, faculty and nurses. Inter-professional teams of six were tasked to perform a

thoracentesis on a simulation mannequin. However, the patient information given to teams was mismatched. Consequently, nine of 10 teams performed incorrect procedures on the wrong patient because they did not identify the correct patient by name. The audience's disappointment in their performance underscored the value of this PSC topic.

- As part of the intervention, groups were then introduced to the concept of checklists and their role in the design of pre-procedure timeouts.
- The audience applied the concept of 5S as a workplace tool for organization (i.e., sort, set in order, shine, standardize, and sustain).
- Each group created a checklist using 5S methods and presented to the larger group.

In summary, the audience reported a greater understanding of the importance of timeouts. A combination of the different checklist designs will be applied at the annual internal medicine intern simulation workshop this spring. For more information on the PVAHCS CRQS curriculum, please contact Dr. Marnonette Marallag at 602-277-5551, ext. 6404.

1. The Joint Commission. (2018). 2018 National Patient Safety Goals. Retrieved from https://www.jointcommission.org/standards_information/npsgs.aspx

2018 National Patient Safety Goals (NPSGs)

AMB	BHC	DME	HAP	LAB	Description	Goal ID
					Goal 1: Improve the accuracy of patient identification	
x	x	x	x	x	Use at least two ways to identify patients when providing care, treatment and services.	NPSG 01.01.01
x			x		Eliminate transfusion errors related to patient misidentification.	NPSG 01.03.01
					Goal 2: Improve the effectiveness of communication among caregivers	
			x	x	Report critical results of tests and diagnostic procedures on a timely basis.	NPSG 02.03.01
					Goal 3: Improve the safety of using medications	
x			x		Label all medications, medication containers and other solutions on and off the sterile field in perioperative and other procedural settings.	NPSG 03.04.01
x			x		Reduce the likelihood of patient harm associated with the use of anticoagulant therapy.	NPSG 03.05.01
x	x	x	x		Maintain and communicate accurate patient medication information.	NPSG 03.06.01
					Goal 6: Reduce the harm associated with clinical alarm systems	
			x		Improve the safety of clinical alarm systems.	NPSG 06.01.01
					Goal 7: Reduce the risk of health care-associated infections	
x	x	x	x	x	Comply with either the current Centers for Disease Control (CDC) hand hygiene guidelines or the current World Health Organization (WHO) hand hygiene guidelines.	NPSG 07.01.01
			x		Implement evidence-based practices to prevent health care-associated infections due to multidrug-resistant organisms in acute care hospitals.	NPSG 07.03.01
			x		Implement evidence-based practices to prevent central line-associated bloodstream infections.	NPSG 07.04.01
x			x		Implement evidence-based practices for preventing surgical site infections.	NPSG 07.05.01
			x		Implement evidence-based practices to prevent indwelling catheter-associated urinary tract infections (CAUTI).	NPSG 07.06.01
					Goal 9: Reduce the risk of patient harm resulting from falls	
		x			Reduce the risk of falls.	NPSG 09.02.01
					Goal 15: The hospital identifies safety risks inherent in its patient population	
	x		x		Identify patients at risk of suicide.	NPSG 15.01.01
		x			Identify risks associated with home oxygen therapy such as home fires.	NPSG 15.02.01
					Universal Protocol	
x			x		Conduct a preprocedure verification process.	UP 01.01.01
x			x		Mark the procedure site.	UP 01.02.01
x			x		A time-out is performed before the procedure.	UP 01.03.01

KEY: AMB=Ambulatory Care; BHC=Behavioral Health Care; DME=Home Care; HAP=Hospital; LAB=Laboratory; "X"=Active

Created by External Accreditation Services and Programs (EASP) and VA National Center for Patient Safety (NCPS)

For questions, please contact wendy.morrish@va.gov • For the exact language of the goals, please visit www.jointcommission.org