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# Improving the Culture of Safety at Banner Health

<b>Track:</b>	SOPS Survey Administration & Interpretation of Results
<b>Session:</b>	Systemwide SOPS Administration and Improvement Priorities
<b>Date &amp; Time:</b>	April 20, 2010, 11:00 am
<b>Track Number:</b>	SOPS T1 – S2



# Objectives

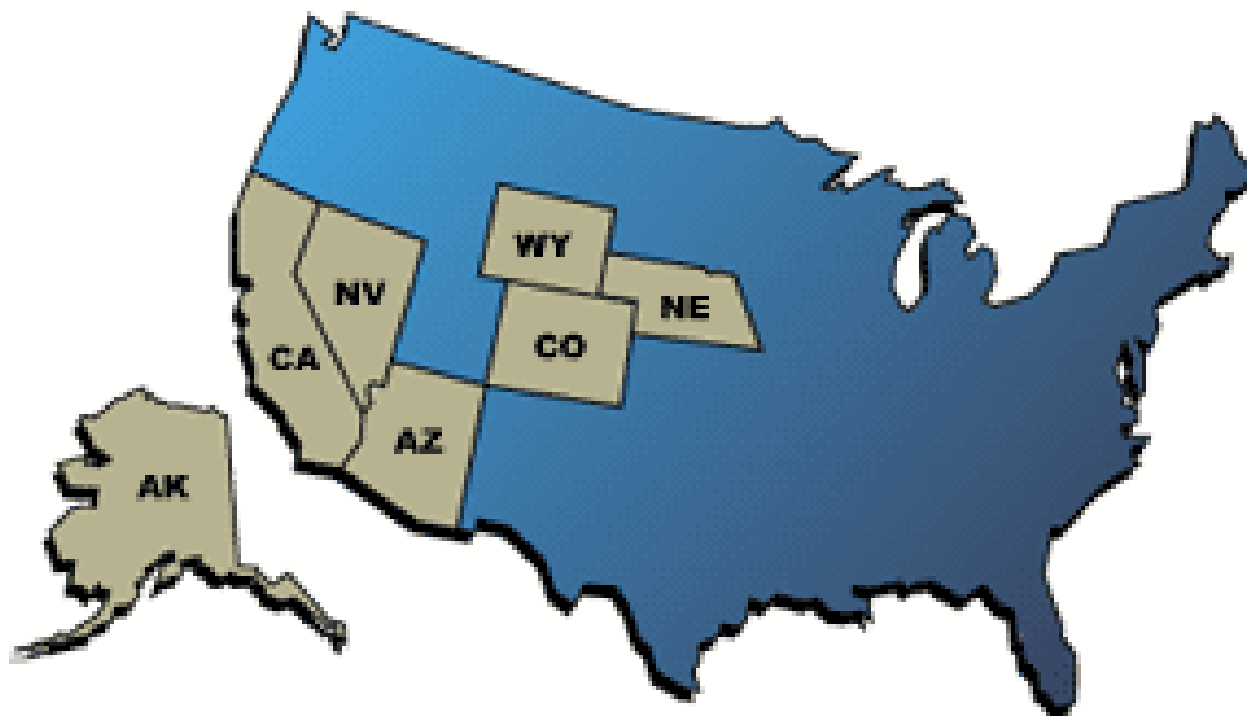
- Describe deployment of AHRQ Survey on Patient Safety across a 22 hospital system
- Discuss the usefulness of the survey as part of a patient safety strategic initiative with focus on improving perceptions of patient safety
- Highlight Banner's journey and successes at driving improvement in the culture of safety at Banner Health



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# About Banner Health

- 22 Facilities in 7 States



# Banner's Mission



*Making a difference in people's lives through  
excellent patient care.*

# Banner's Vision

*Leadership in clinical quality, customer service  
and operational performance*



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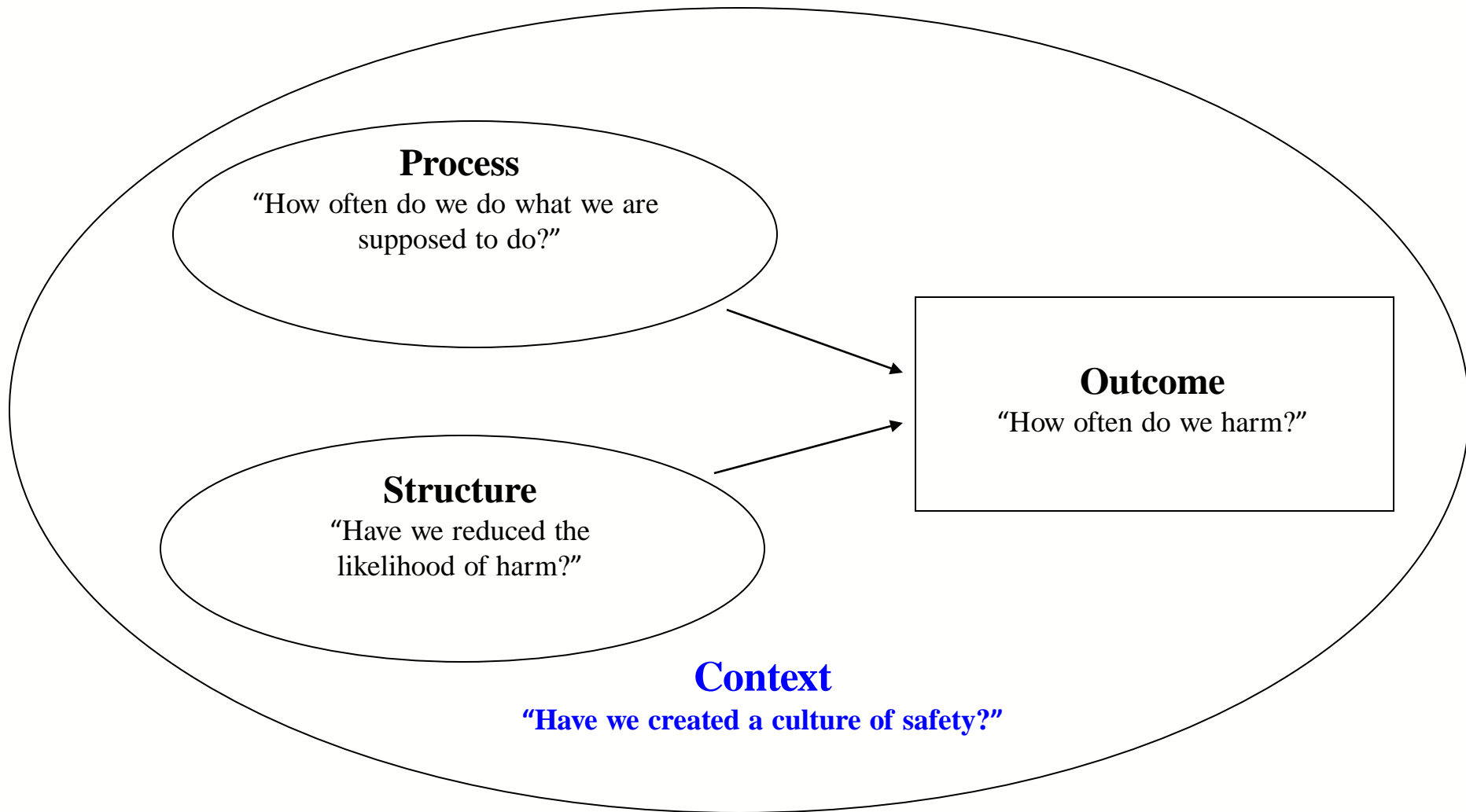
# Achieving Clinical Excellence

- **Deliberate, system-wide effort**
  - Both divisional and team structures
  - Addressing prospective, concurrent, and retrospective views
  - Committed to using technology as a foundation
  - Applying reliability concepts for improvement

# Model for Measuring Safety



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# Our Journey

- 2006 – Increased focus on patient safety
  - Lots of work being done across multiple venues
  - No way to measure our effectiveness
- 2007 & 2008 – SOPS as a strategic initiative
  - Both years exceeded our performance goals
- 2009 – Continued work on patient safety
  - Began work on “Just Culture”
  - Not part of strategic initiative
- 2010 – Hold SOPS
  - Focus on Safety Accountability

# System's Approach To Survey Process



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## Logistics

- Identify appropriate participants
- Vendor selection & deployment of survey

## Communication

- Develop & deploy communication plan
  - Pre-survey
  - During Survey
  - Year Long Focus on Patient Safety Work

## Education & Training

- Develop & deploy facility educational resources for safety survey (presentations, data analysis, tools, action plans)
- Ongoing f/u education throughout the year

## Ongoing Learning

- Facility – facilitated by Leadership (both facility Senior Management Team and Unit Leadership)
  - Measures of success incorporated into unit scorecards
- System (aggregate data) – identify major strengths & opportunities across system with implementation of one system action plan



# Banner's Journey: The early years



	2006	2007	2008
BH Participation	6,058	9,925	14,777
BH Participation Rate	29%	48%	74%
# Benchmark hospitals	NA	365	519
% positive scores	63.3%	64.2%	65.4%

**SUCCESS....**

But we knew better



# 2007-2008 Key Actions

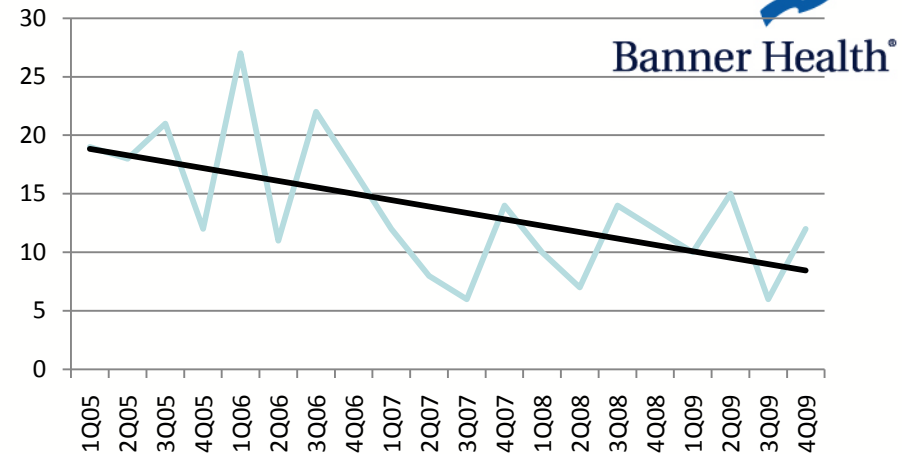
- Implemented Leadership Patient Safety Rounding
  - Define – Design - Implement
  - Deployed at every facility
  - Incorporated into leadership core values & expectations
- Hand Off Communication
  - SBAR
    - Defined as expected practice
    - Designed & Implemented tools
    - Measures of Success
- Pilot Project of TeamSTEPPS
  - One facility one department

# Deliberate Focus on Patient Safety

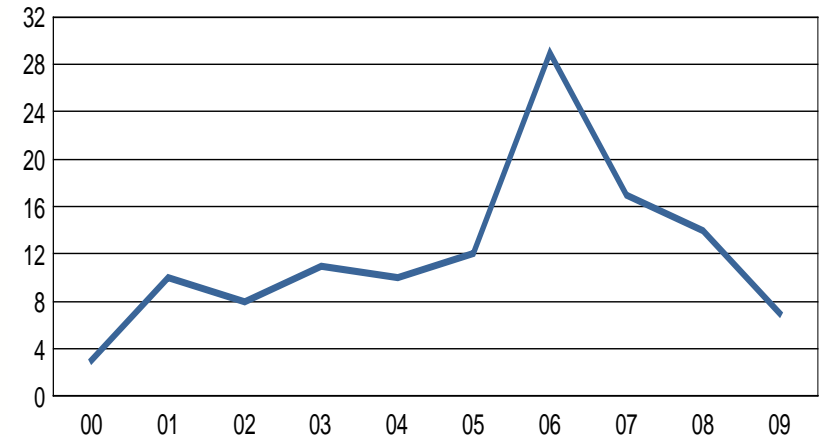
## Sentinel Event RCA Transparency

- Standardize RCA Process
  - Strategic Initiative in 2007 & 2008
- Use PSI & other reports to ensure appropriate identification of events
- Share all RCA's across system
- Human Factor Engineer participates in RCA's
- Decrease in repeatable events
  - Retained Foreign Body
  - Equipment related events
- Near Miss Learning

# of Sentinel Events

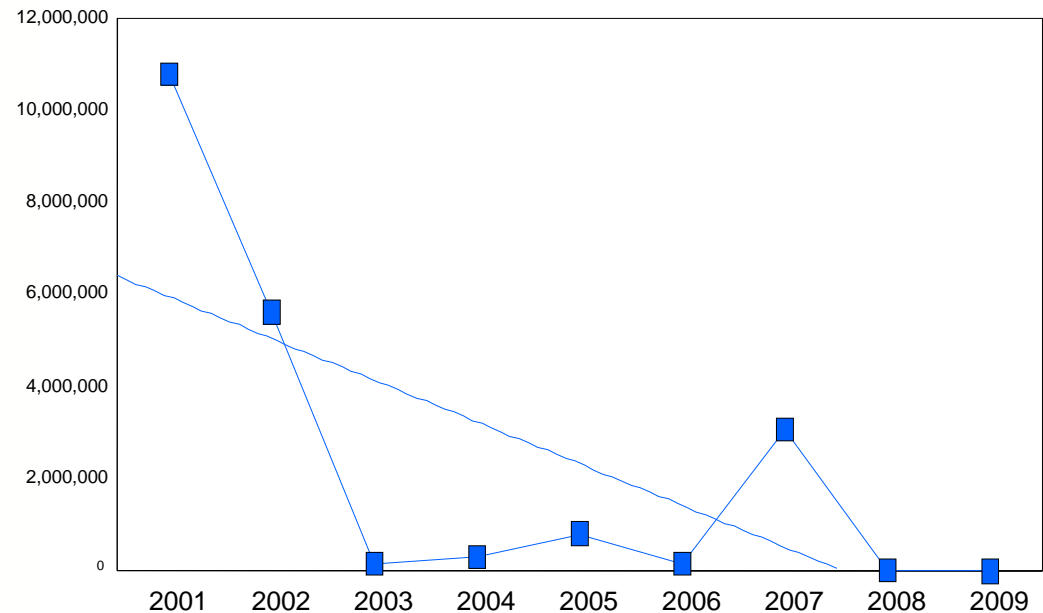


NUMBER OF RETAIN FOREIGN BODY CLAIMS



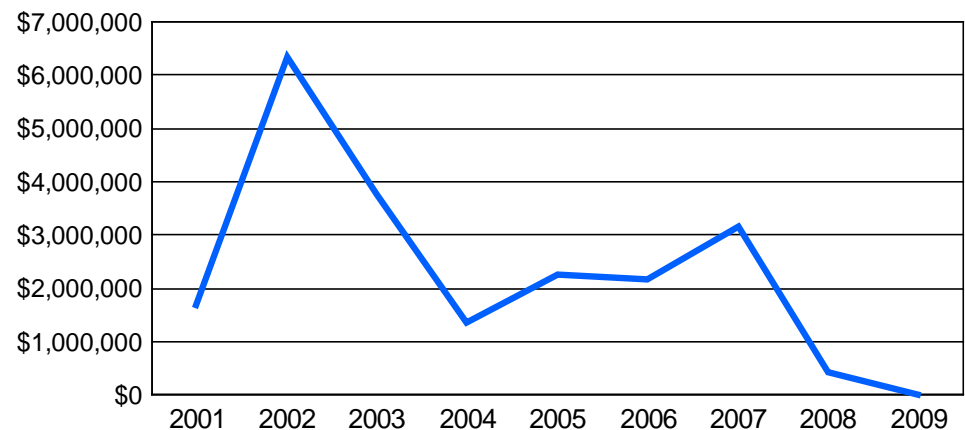
# OB

- Implemented PeriGen
  - Software with built in algorithms to identify high risk situations & prompt appropriate care



# ED

- Identified top risk areas and standardized assessments & documentation
- Implemented CERNER



# Deliberate Focus on Patient Safety

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- **Simulation Center**

- Virtual Hospital
- Standardized nursing, residency & medical staff orientation
- Cognitive learning & critical decision making
- Team training/ communication skills
- Maintenance of provider clinical proficiencies
- Errors reduction in delivery of patient care
- Peer review (OPPE) and evaluation of competencies
- Evaluation of new delivery models for clinical care

- **iCare in 2009**

- 242 beds, plans for 400 in 2010
- Saved 560 more lives than predicted
- Saved Banner approx \$12,375,000

- **eHospital**

- 2009
  - \$18,307,000 in our other Units

# Banner's Journey



	2006	2007	2008	2009
BH Participation	6,058	9,925	14,777	<b>19,689</b>
BH Participation Rate	29%	48%	74%	<b>83%</b>
# Benchmark hospitals	NA	365	519	<b>622</b>
% positive scores	63.3%	64.2%	65.4%	<b>62.7%</b>

# Composite Comparison with 75<sup>th</sup>tile

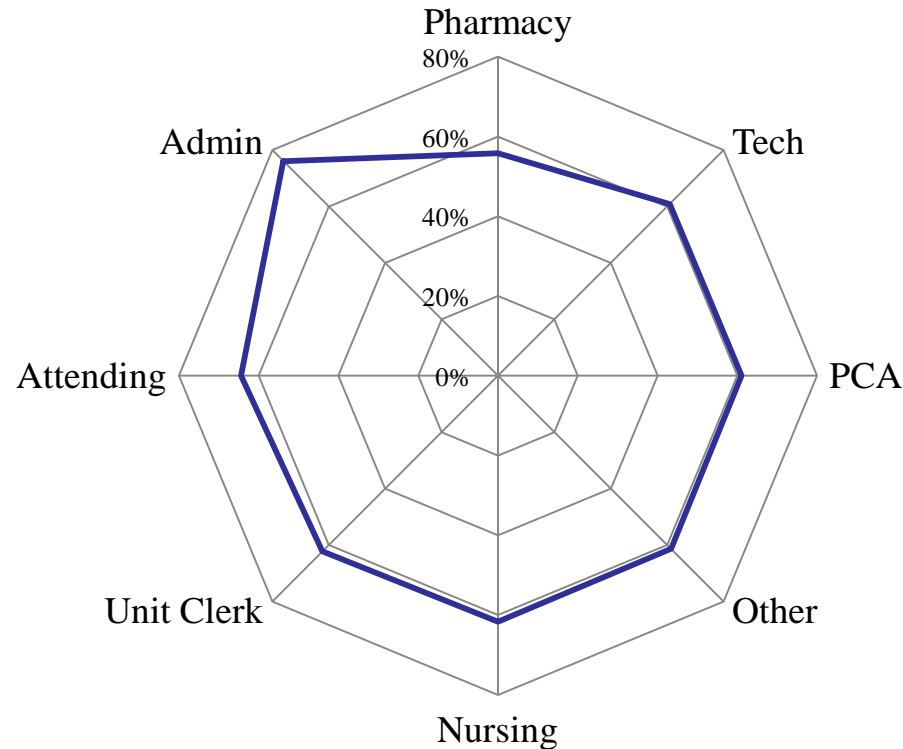


	Safety Dimension Composites	2006	2007	2008	2009	AHRQ 2009 75 <sup>th</sup> %tile	% tile Ranking
1	Overall Perceptions of Safety	65%	67%	68%	<b>65%</b>	70%	<b>50%</b>
2	Frequency of Events Reported	61%	62%	66%	<b>66%</b>	66%	<b>75%</b>
3	Supervisor/Manager Expectations & Actions Promoting Patient Safety	77%	76%	77%	<b>75%</b>	79%	<b>50%</b>
4	Organizational Learning – Continuous Improvement	73%	74%	73%	<b>70%</b>	76%	<b>25%</b>
5	Teamwork Within Units	83%	83%	83%	<b>78%</b>	83%	<b>25%</b>
6	Communication Openness	67%	63%	64%	<b>63%</b>	66%	<b>50%</b>
7	Feedback and Communication About Error	65%	63%	64%	<b>63%</b>	68%	<b>50%</b>
8	Non-punitive Response to Error	50%	50%	51%	<b>49%</b>	49%	<b>75%</b>
9	Staffing	52%	55%	58%	<b>56%</b>	62%	<b>50%</b>
10	Hospital Management Support for Patient Safety	73%	73%	75%	<b>71%</b>	78%	<b>50%</b>
11	Teamwork Across Hospital Unit	55%	58%	60%	<b>55%</b>	65%	<b>25%</b>
12	Hospital Handoffs & Transitions	40%	43%	44%	<b>41%</b>	51%	<b>25%</b>
	Totals	63.3%	64.2%	65.4%	<b>62.7%</b>		



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## Total % Positive by Position



**Administration  
averaged 20%  
above Pharmacy  
& 14% above  
Nursing**

Position	Pharmacy	Tech	PCA	Other	Nursing	Unit Clerk	Attending	Admin
# of Participants:	269	2387	1315	5004	6292	1166	575	1487
Total % positive:	55.8%	60.9%	61.0%	61.4%	61.7%	62.2%	64.4%	76.1%



### Strength

- Participation Rates
- Dimensions:
  - Frequency of Events Reported
  - Non-punitive Response to Error

### Weakness

- Dimensions
  - Teamwork Across Units
  - Hospital Handoff & Transitions
  - Hospital Management Support for Patient Safety
  - Organizational Learning – Continual Improvement

## SWOT Analysis

### Opportunity

- Hospital Management Support for Patient Safety
- Organizational Learning – Continual Improvement

### Threat

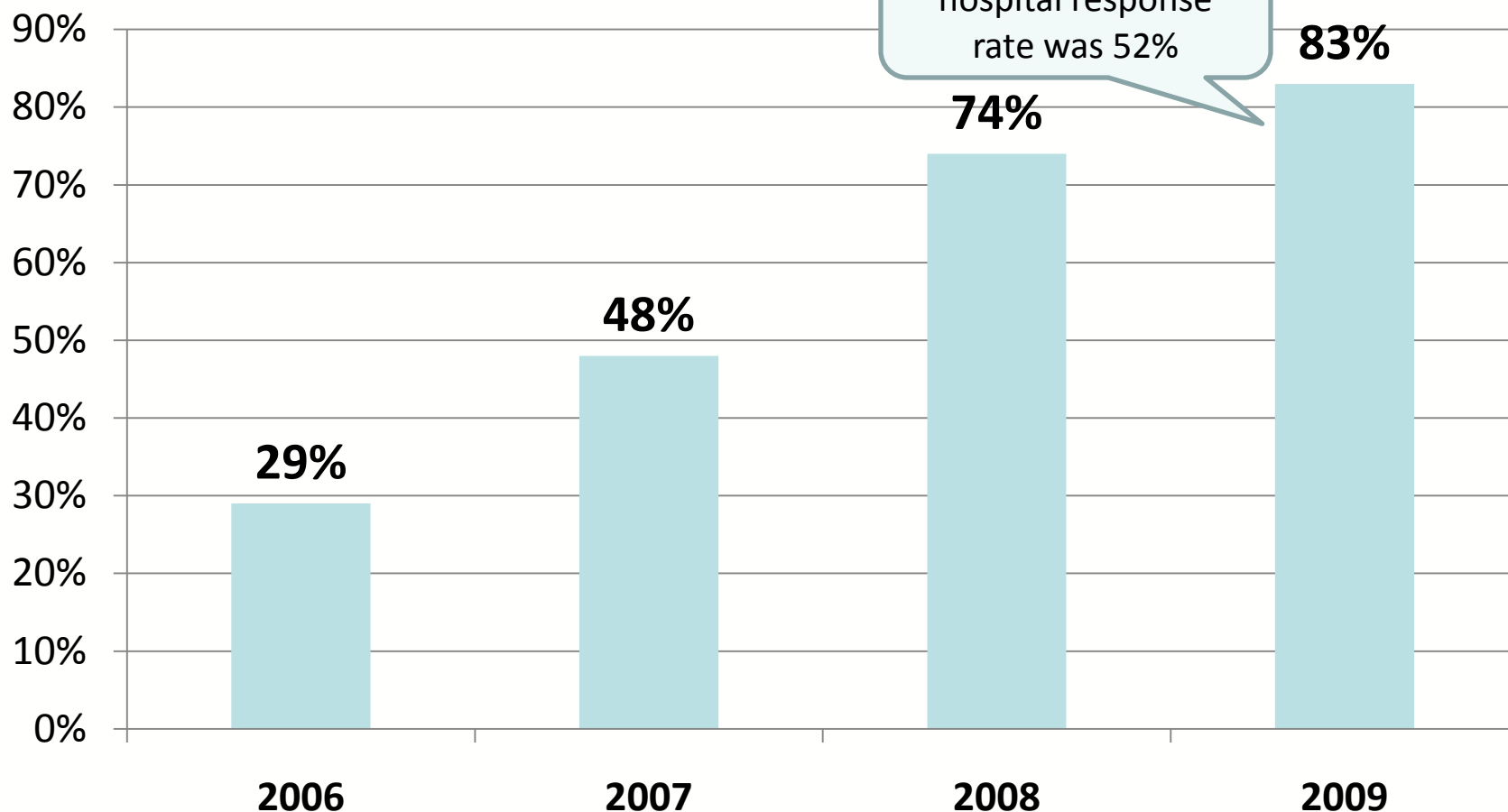
- Comments: Staffing

# 2009 BH Participation Rate: SOPS



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Note average  
hospital response  
rate was 52%



# Success: Participation

- Find Joy in Your Work - Make It Fun!
- Multidisciplinary Team – 4 workgroups
- Daily **communication** of participation rates
- Facility/department competitions
- Leadership “meet and greet” at entrances encouraging employees to take the survey, thanking those who did and expressing commitment to acting upon the feedback from the survey

# Performance at 75%tile

Safety Dimension Composites	2006	2007	2008	2009	AHRQ 2009 Comparative Data  75th %tile
Frequency of Events Reported	61%	62%	66%	<b>66%</b>	66%
Non-punitive Response to Error	50%	50%	51%	<b>49%</b>	49%

**Note: 2009 Comparative Database Reports identifies these 2 dimensions as areas with potential for improvement for most hospitals**

# **Actions: Nonpunitive Response to Error & Number of Events Reported**



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- Standardized electronic event reporting system
- Push data out to facilities and units monthly
- All events must be investigated and closed within 10 days
  - Accountability Reports Monthly
  - Metric included in Quality Scorecard
    - Went from average of 48 days to closure in 2008 to 9 days in 2010
- Best Practice: Event Triage Committee
  - Review every event weekly
  - Appropriateness of actions and closure
  - Identify cases that need escalation to higher level (critical event review team)
- Work on “Just Culture”

# Analysis of Why Performance Dipped in 2009 SOPS



- Larger participation rates
- Financial constraints with productivity focus
- Some normal variation
- Tremendous amount of work on safety but front line employees do not hear about it
- So large, much work, even leadership does not know all the “safety work” being done

# Changes Made 4<sup>th</sup> Work Group



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## Education

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## Safety Planning

- Strategic planning
  - Key tactics, timelines and deliverables
  - Implementation
  - Ongoing Learning



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# Future of SOPS for Banner

- Incorporated Safety Culture into 2010 Sepsis & CLABSI Strategic Initiative
  - Design for Safety
  - Managing Safe Choices
- Focus on Safety Accountability
  - Incorporate Safety Training into Core Leadership Curriculum
  - Facilities
    - Identifying expected practices
    - Identifying human error, at risk behavior & reckless behaviors
    - Managing Safe Choices





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# Questions?