

# the culture of quality & safety

new associate orientation

in this  
session...

- Did you know?
- Why Does Quality Matter
- Safety Culture
- Speaking Up!
- Great catches!

did you know?

did you  
know...

Catholic Health's most important focus is the  
"Right Way to Care" for every patient



did you  
know....

- 4 Hospitals (1,161 licensed beds at 5 campuses)
- 4 Skilled nursing facilities (484 resident capacity)
- 2 Home care agencies (303,000 client visits)

did you  
know....

- Greater than 9,000 associates and more than 1,000 providers
- Oversight of 288 properties (hospitals, offices, etc.)
- **6,000 babies born every year!**



Impacting the  
community



Creating a  
Culture of  
Safety

Why Does Quality Matter?

What Does Quality Mean to You?



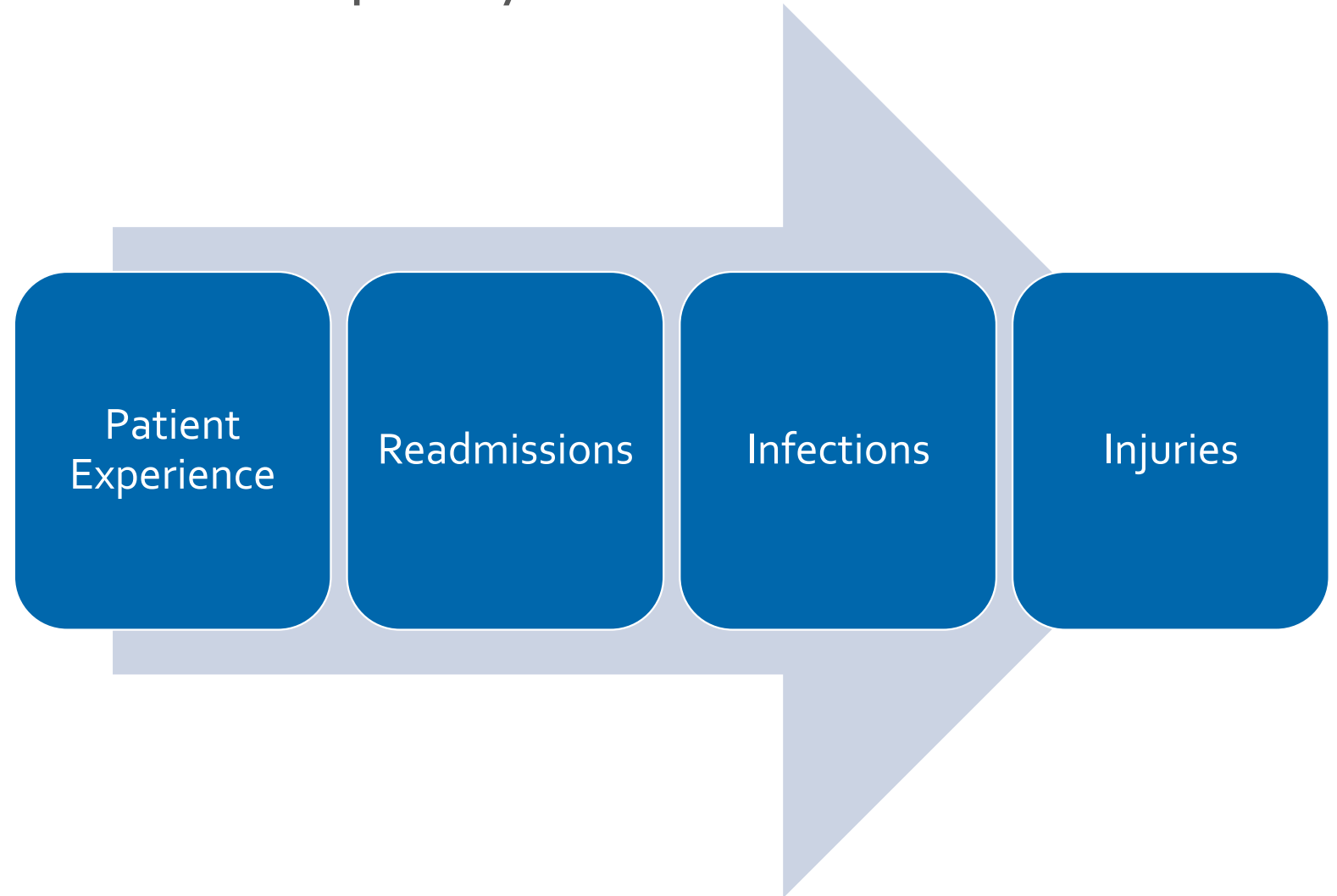
2013



That's more than two jumbo jets full of passengers crashing every day!

Hospitals are increasingly being held financially accountable for outcomes based on established quality measures

did you  
know...

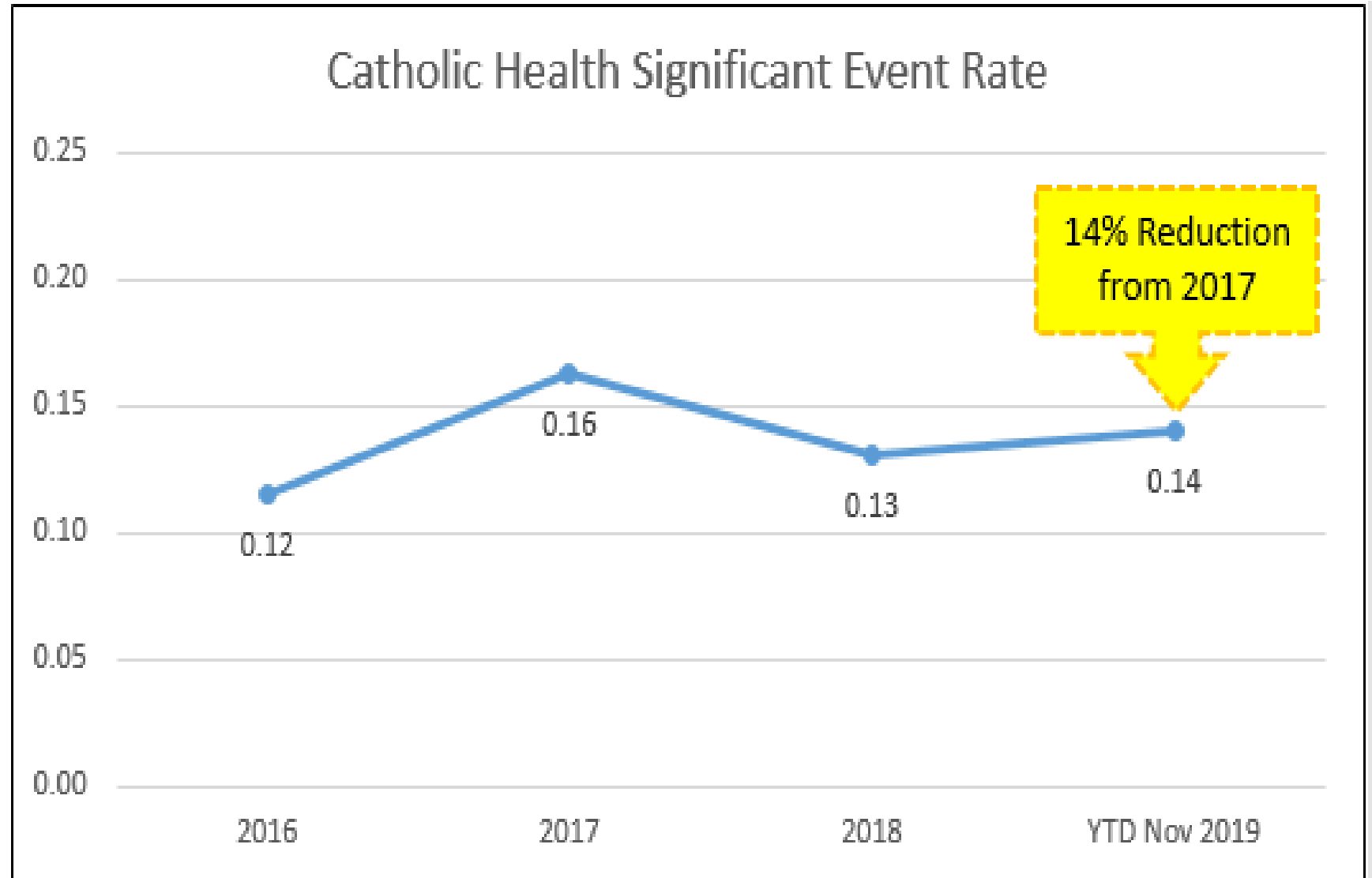


## SIGNIFICANT EVENTS

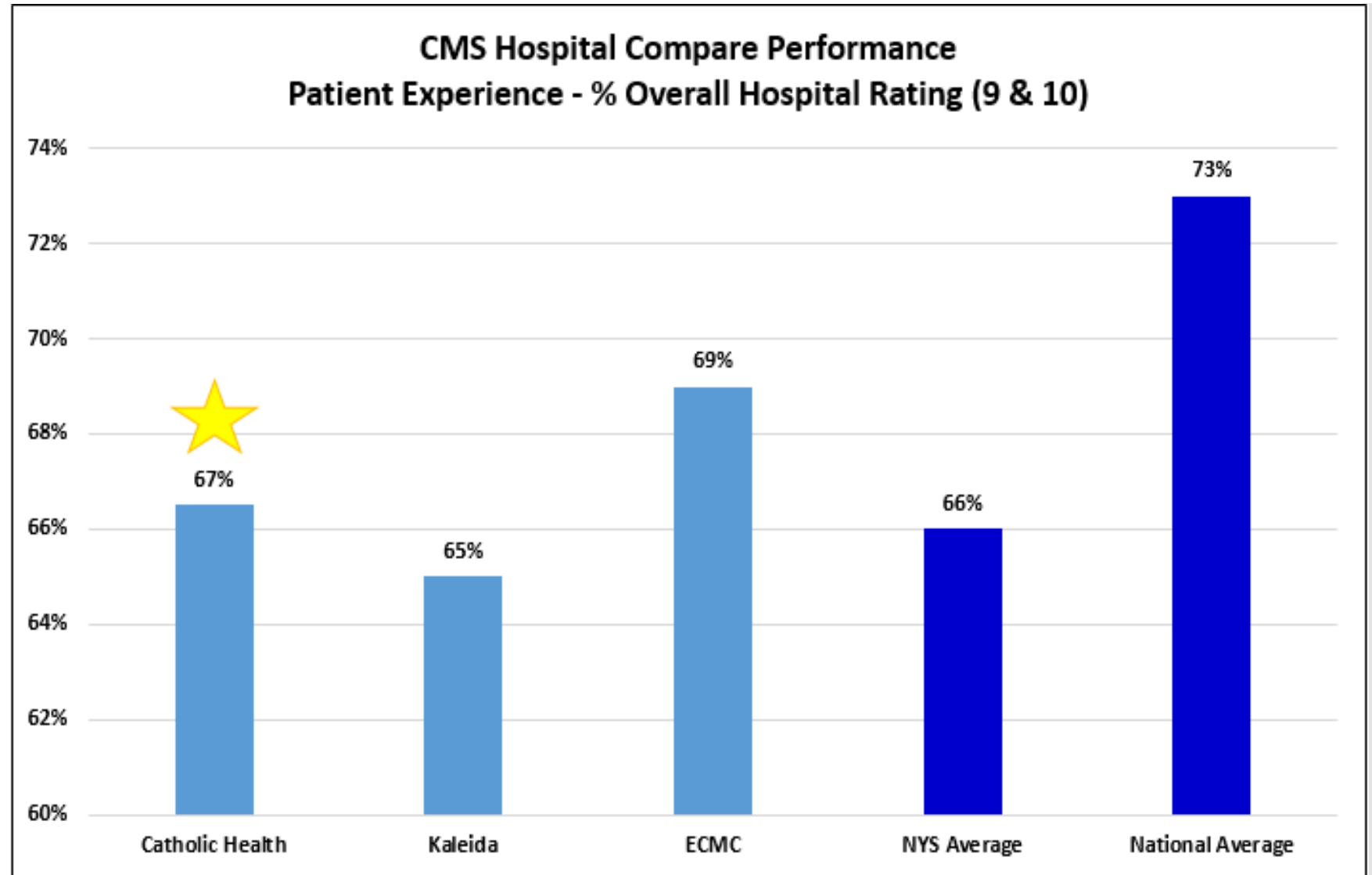
# *What Are Significant Events:*

- *Hospital Acquired Infection (blood stream, surgical site infections, device associated)*
- *Serious Medication Errors*
- *Falls with Serious Injury*
- *Wrong Surgery*
- *Suicide*
- *Injury from Lost Specimens*

reducing harm  
at catholic  
health



did you  
know...



## catholic health stands out

- Region's only Joint Commission Advanced Comprehensive Stroke Center
- Magnet status for excellence in nursing at Kenmore Mercy
- Recognition for cardiac, orthopedic, bariatric and maternity
- Home care rated top 500 out of 9,000 agencies nationally
- All skilled nursing facilities rated top performing nationally



transparency

Catholic Health supports transparency and publically displays our harm events ([www.chsbuffalo.org/about-us/quality](http://www.chsbuffalo.org/about-us/quality))

[Home](#) / [About Us](#) / [Quality](#)

## Quality

Our staff of 50 quality and patient safety specialists track more than 5,000 quality measures throughout our system to tell us where we're excelling and where we can improve.

All hospitals measure quality, but Catholic Health is the only healthcare system in Western New York that makes its quality data available directly to you and your family.

System-wide measures:

- [Adverse Events](#)
- [Patient Experience Overall Rating](#)
- [Patient Falls](#)
- [Pressure Ulcers \(Bed Sores\)](#)
- [Central Line Infections](#)
- [30-day Readmissions](#)
- [Emergency Care](#)

did you  
know...

Catholic Health has a dedicated team of LEAN / Six-sigma black belts focused on process:

DMAIC is essentially the scientific method for process improvement

1. **Define** the problem the team needs to solve.
2. **Measure** the baseline performance.
3. **Analyze** contributing factors in order to identify the root cause.
4. **Improve** the process by implementing solutions that address the root cause(s).
5. **Control** the new process by developing SOP's & actively monitoring performance.





# Safety Culture

a collection of beliefs perceptions and values that employees share in relation to risks within an organization



# Creating a Culture of Safety



speaking up

# barriers to speaking up

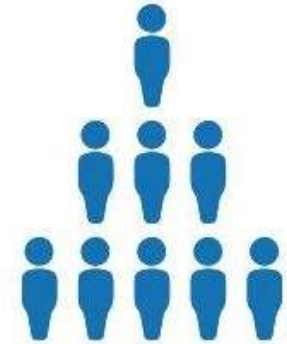
## Top 3 reasons why employees don't speak up:



Fear of being viewed negatively



Feeling as if they don't have enough experience



Feel that the organisation's hierarchy is intimidating/unsupportive

Speaking Up  
For Safety

Speaking up  
for Chocolate

- Human Error can occur at a rate of 1 in 1,000 routine actions
- Speaking Up reduces this to 1 in 1,000,000

## suggestions on how to speak up

- Get the person's attention utilizing their name
- Relay the information expressing that YOU have a CONCERN
- Propose a solution (utilize words like "Check" or "Verify").  
Let the person know that YOU are UNCOMFORTABLE with the situation
- If the response is inadequate to restore safety...
  - You have the authority to Stop the process and get management involved.
  - The appropriate member of management should be contacted. Chain of command should be followed.
  - Escalate your concerns

great catches!

## what is a great catch?

- It is a “near miss”
- Unsafe acts or conditions (errors, procedure violations or hazards) that *could have* seriously harmed a patient, but did not because they were identified, reported, and addressed or eliminated





## why report great catches?

- Near misses occur more frequently than events which cause harm
- Valuable source of data for identifying process failures
- Help to proactively institute measures to prevent adverse events from reaching the patient & causing harm





***Problem:*** Upon assessing vital signs the NA noticed a facial droop on the non neuro patient

Nursing Assistant

actual  
great catch (1)

***Potential for Harm:*** The patient could have progressed to a full stroke

***Solution:***

- Have a *Questioning Attitude* (if something doesn't seem right it most likely isn't)
- *Speak up* ( When you see something wrong tell someone)
- *Work as a Team* (Respect everyone on the Team)



Registered Nurse

actual  
great catch (2)

### ***Problem:***

- The provider wrote an order for the patient to take own controlled substance from home
- The label on the bottle read “home med control 3”
- There were 3 pills in the bottle
- The actual dose of medication is not listed on bottle

***Potential for Harm:*** Overdose: Potential to give 3 pills

### ***Solution:***

- Label for home controlled meds has been changed to “home control A”
- Mechanism put in place for two nurse signature on home control medications
- Pharmacy entry changed to include the actual dose of medication



CH celebrates  
great catches!



Recap!  
two truths & one lie!

## question #1

**"B"**  
**False!**

- A.** Medical errors kill up to the equivalent of two full jumbo jet airliners everyday
- B.** Every year 1 out of 25 patients develops significant hearing loss from noisy hospital floors
- C.** Nationally, focused safety initiatives have saved millions of lives and billions of dollars

## question #2

- A. Culture of Safety includes working with your team
- B. Culture of Safety means making your own rules
- C. Culture of Safety encourages a questioning attitude

**"B"**  
**False!**



### question #3

**"A"**  
**False!**

- A.** Great catches come from associates who rarely get reprimanded for performing workarounds
- B.** Great catches are the result of having a questioning attitude during the performance of their duties
- C.** Great catches have been awarded to many CH associates for paying attention to details and speaking up



## question #4

**"C"**  
**False!**

- A.** Sometimes staff are reluctant to speak up for fear of being wrong or embarrassed
- B.** Speaking up is hard if you believe its not that important or no one will listen
- C.** The term "speaking up" was first utilized in early education classes to encourage quiet children to be more vocal

you are the  
culture of  
catholic health

- ▷ You are the patient's *advocate*
- ▷ You are the patient's *security*
- ▷ You are the patient's *healer*
- ▷ You are the patient's *infection preventionist*
- ▷ You are the patient's *support*
- ▷ You are the patient's *source of comfort*
- ▷ You are the *healthcare team*
  
- ▷ You are the patient's experience

thank you!

WE'RE  
DONE!

thank you!