SAFETY FIRST AT CHEO: OUR JOURNEY TO ZERO HARM

MEENA ROBERTS, Chair Of Quality And Safety Committee Of The Board
November 25, 2018

CHEO
uOttawa
Presentation Outline

1. Why did CHEO switch to the zero harm approach?
2. What was the process CHEO took to reach this decision?
3. What tools do you use to monitor and track critical incidents at org and Board level?
4. What is the conversation that the Board should be having related to creating a zero harm culture?
5. What is the Board’s role?
CHEO by the numbers

- 6,638 Admissions to CHEO
- 75,961 Emergency Department visits
- 175,421 Ambulatory Care visits
- 10,879 Medical Day Unit visits
- 7,725 Total number of surgeries
- 144,863 Babies screened by Newborn Screening Ontario
- 250 Researchers
- 2,300 Future physicians trained
- 2,700 Staff including medical staff
- 51% Revenue from Ministry of Health / LHIN
- 20% Other funded programs
Safety First

- Committed to ZERO HARM in 2015
- Includes children/youth/families & staff

**Then**

1 Serious Safety Event every 20 days

**Today**

227 days without a Serious Safety Event

Questions:

Q1: Why Switch to Zero Harm?
Q2: What was the process?
Q3: What tools were used?
Q4: What Board conversations are needed?
Q5: What is the role of the Board
CHEO’s SSER is 0.22

The Serious Safety Event Rate includes both children/youth and staff events. They can also be measured separately.

Q 1: Why Switch to Zero Harm?  
Q2: What was the process?  
Q3: What tools were used?  
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Q5: What is the role of the Board
Staff Safety

Slips, Trips & Falls
Equivalent to one employee either slips, trips or falls every 8 days.

Musculoskeletal Injuries
Equivalent to an employee sustaining an injury from overexertion every 8 days.

Injuries due to Aggression
Equivalent to Patient/family/client aggression causing staff harm occurring once every 5 days.

1 CHEO staff member suffered Serious Harm in 2017 – 2018
Staff Safety

Workplace Violence or Aggression Incidents
Nov 1, 2017-Oct 31, 2018

<table>
<thead>
<tr>
<th>Month</th>
<th>Incidents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nov-17</td>
<td>12</td>
</tr>
<tr>
<td>Dec</td>
<td>4</td>
</tr>
<tr>
<td>Jan-18</td>
<td>2</td>
</tr>
<tr>
<td>Feb</td>
<td>7</td>
</tr>
<tr>
<td>Mar</td>
<td>7</td>
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<td>Apr</td>
<td>6</td>
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<tr>
<td>May</td>
<td>10</td>
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<tr>
<td>Jun</td>
<td>11</td>
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<tr>
<td>Jul</td>
<td>3</td>
</tr>
<tr>
<td>Aug</td>
<td>7</td>
</tr>
<tr>
<td>Sept</td>
<td>17</td>
</tr>
<tr>
<td>Oct</td>
<td>7</td>
</tr>
</tbody>
</table>

Children’s Mental Health Ontario Conference
Our 2018-19 Action Plan

Vision
Our desired future state

Mission
The ‘how’ of achieving our vision

Values
The ideals that bind us together

Strategic Directions
3 – 5 years

Outcomes that Matter
Work with children, youth and families to achieve the results they care about most

Progress from Evidence
Innovate to make things better through research, continuous improvement and activating new knowledge

Partners in Health
Ensure the voice of children, youth and families guides the care we provide and the future of our organization

Connecting Care
Advance the way pediatric care is delivered so that children, youth and families can access services when, where and how they need them

Unlock our Potential
Make the best use of the resources we have and be smart about future investments

Goals
2018-19

Safety First

Improvements Made

Partners in Health

Faster Access

Wise Resourcing

Inspiring Workplace

Transformational Initiatives
3 – 5 years

Healthiest Outcomes
Partner with children, youth and families to reach goals and understand the impact of care

Simpler Journeys
Build towards an integrated pediatric health system that connects care for children, youth, families and providers

Our 2018-19 Action Plan
“primum non nocere”
(first, do no harm)

"First, do no harm. After that, go nuts."

Hippocrates, c. 460-377 BC
Q 1: Why Switch to Zero Harm?

Q 2: What was the process?

Q 3: What tools were used?

Q 4: What Board conversations are needed?

Q 5: What is the role of the Board
<table>
<thead>
<tr>
<th>Our Vision/Mission</th>
<th>How much harm is acceptable in a world class exceptional hospital?</th>
<th>How much harm as we ok with?</th>
</tr>
</thead>
<tbody>
<tr>
<td>We committed to Excellence, Exceptional Patient Care, Best Life Possible, Innovation, Global leadership, World class centre.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Patient Perspective</th>
<th>How much harm are they ok with?</th>
</tr>
</thead>
<tbody>
<tr>
<td>We committed to patient-centered care. Patient perspective became our preoccupation. So we asked them.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Critical Incident Management Review 2013/14</th>
<th>Two Recommendations were directed at the Board.</th>
</tr>
</thead>
<tbody>
<tr>
<td>We realised we needed to improve how we managed serious safety events. We brought in external peer reviewers.</td>
<td>1) Add safety as a strategic goal 2) Consider decreasing, eventually eliminating serious preventable harm</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Our Leadership</th>
<th>Leaders wanted to rally around a target, not process.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Was already involved in major continuous improvement initiatives. Continuous Improvement was nice but nebulous.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Introduction to SPS</th>
<th>HROs commit to Zero harm</th>
</tr>
</thead>
<tbody>
<tr>
<td>We were introduced to Solutions for Patient Safety. Blueprint to becoming a High Reliability Organization (think - airlines, nuclear power plants)</td>
<td></td>
</tr>
</tbody>
</table>

Q 1: Why Switch to Zero Harm?  
Q 2: What was the process?  
Q 3: What tools were used?  
Q 4: What Board conversations are needed?  
Q 5: What is the role of the Board
So, why ZERO HARM?

1. **Aspirational Visions** → aspirational goals
   - Risk tolerance
2. **Exceptional Patient Experience** → no harm
   - Alert, aware, anticipate, mitigate
3. **Continuous Improvement Efforts** → culture of smart risk takers
4. **Experts & Networks** → a road map to follow (plans for addressing risk)

Q1: Why Switch to Zero Harm?
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Language of Risk Mitigation

For us, it was the **RIGHT GOAL** at the **RIGHT TIME**
How did CHEO reach this decision?

The process from 30,000 feet

Q1: Why Switch to Zero Harm?

Q2: What was the process?

Q3: What tools were used?

Q4: What Board conversations are needed?

Q5: What is the role of the Board
Looking from 30,000 feet

- Long process - 6-7 years.
- Started with aspirations and questions
- Consulted, Engaged - All Stakeholders
- Defined Core Principles (Bubble up)
- Invested in Reviews, Plans, and Tools
- Prioritized People - HR capacity, Training, Learning, (Change fatigue)

Q 1: Why Switch to Zero Harm?
Q 2: What was the process?
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Culture of Safety
### Process at 300 feet

<table>
<thead>
<tr>
<th></th>
<th>2011-2012</th>
<th>2012-2015</th>
<th>2016-2018</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Board Committee</strong></td>
<td>Quality Mgmt Council</td>
<td>Quality &amp; Patient Safety Cmte</td>
<td>Quality &amp; Safety Committee</td>
</tr>
<tr>
<td><strong>Mandate of Terms of Reference</strong></td>
<td>• No mention of safety</td>
<td>• Safety added</td>
<td>• Patient Engagement added</td>
</tr>
<tr>
<td></td>
<td>• Receive reports from Patient safety council</td>
<td>• Risk</td>
<td>• Linkages/partnerhips added</td>
</tr>
<tr>
<td><strong>Corporate Priorities</strong></td>
<td>• No safety statement</td>
<td>• <strong>Prevent harm added</strong> in strategic plan and QIP</td>
<td>• <strong>Safety First, zero harm</strong> is now a stated corporate priority</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• QIP same as Corp Plan (strong messaging about Q&amp;S)</td>
<td></td>
</tr>
</tbody>
</table>

**Q 1:** Why Switch to Zero Harm?

**Q 2:** What was the process?

**Q 3:** What tools were used?

**Q 4:** What Board conversations are needed?

**Q 5:** What is the role of the Board?
## Process at 300 feet

<table>
<thead>
<tr>
<th>Goals</th>
<th>2011-2012</th>
<th>2012-2015</th>
<th>2016-2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Reduce harm</td>
<td>• Prevent harm</td>
<td>• Zero Harm</td>
<td></td>
</tr>
<tr>
<td>• Patients</td>
<td>• Patients + Employees</td>
<td>• Patients + Employees</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Approach</th>
<th>2011-2012</th>
<th>2012-2015</th>
<th>2016-2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Hospital centered</td>
<td>• More than Hospital - Partnership approach; Merger with OCTC</td>
<td>• Patient centered - One Door</td>
<td></td>
</tr>
<tr>
<td>• Clinical focus</td>
<td>• Patients Engagement - full swing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Patients consulted</td>
<td>• 3 community members added to our QSC</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Non clinical areas also</td>
<td></td>
<td></td>
</tr>
</tbody>
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Q1: Why Switch to Zero Harm?
Q2: What was the process?
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## Process at 300 feet

<table>
<thead>
<tr>
<th>Performance Data</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>2011-2012</strong></td>
</tr>
<tr>
<td>• 12-17 metrics</td>
</tr>
<tr>
<td>• Some not relevant to paediatrics</td>
</tr>
<tr>
<td>• Quarterly</td>
</tr>
<tr>
<td>• Red/yellow/Green</td>
</tr>
<tr>
<td><strong>2012-2015</strong></td>
</tr>
<tr>
<td>• <strong>Prioritized metrics:</strong> KPI 17→10</td>
</tr>
<tr>
<td>• <strong>Patient-centered questions on metrics and data.</strong></td>
</tr>
<tr>
<td>• Are metrics relevant to us</td>
</tr>
<tr>
<td>• Is data meaningful? What data should we collect?</td>
</tr>
<tr>
<td>• <strong>Deep dive Discussions</strong></td>
</tr>
<tr>
<td><strong>2016-2018</strong></td>
</tr>
<tr>
<td>• <strong>Near misses/Good catches</strong></td>
</tr>
<tr>
<td>• EPIC - alerts</td>
</tr>
<tr>
<td>• Medication - alerts</td>
</tr>
<tr>
<td>• Link to CHEO works</td>
</tr>
<tr>
<td>• Employee SSE</td>
</tr>
<tr>
<td>• Workplace violence</td>
</tr>
</tbody>
</table>

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Q1: Why Switch to Zero Harm?  
Q2: What was the process?  
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# Process at 300 feet

<table>
<thead>
<tr>
<th>Year</th>
<th>2011-2012</th>
<th>2012-2015</th>
<th>2016-2018</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Critical Incident Review</strong></td>
<td>• <strong>About Disclosure</strong>&lt;br&gt;null agenda - 5 min&lt;br&gt;Hindsight discussion&lt;br&gt;Single Incident based</td>
<td>• <strong>About prevention; about learning/changing</strong>&lt;br&gt;Did an external review of critical incident review&lt;br&gt;Implemented 33 recommendations&lt;br&gt;Added resources&lt;br&gt;Changed classification system, meeting structure, feedback loops, follow-ups&lt;br&gt;New data collection and reporting&lt;br&gt;Also added, other tools:&lt;br&gt;Med carts&lt;br&gt;Med errors-bar coding&lt;br&gt;EPIC</td>
<td>• <strong>About Eliminating harm</strong>&lt;br&gt;<strong>Safety/Risk.</strong>&lt;br&gt;Critical incidents first on agenda. As much time as needed.&lt;br&gt;<strong>Root cause analysis</strong> - 3 meeting process - Facts/Factors Fixes&lt;br&gt;<strong>Use Prevention Bundles</strong> to Target Risk areas - CLABSI&lt;br&gt;<strong>New lines of communications</strong>&lt;br&gt;daily briefs, huddles,&lt;br&gt;<strong>Discussion on learnings and mitigation at QSC</strong> Trends in SSEs, horizontal issues. Clinical/nonclinical areas; Beyond our walls - suppliers, contractors, partners, teaching hospital - capacity etc.</td>
</tr>
</tbody>
</table>

**Q1:** Why Switch to Zero Harm?<br><br>**Q2:** What was the process?<br><br>**Q3:** What tools were used?<br><br>**Q4:** What Board conversations are needed?<br><br>**Q5:** What is the role of the Board

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**Children’s Mental Health Ontario Conference**

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Q 1: Why Switch to Zero Harm?

Q 2: What was the process?

Q 3: What tools were used?

Q 4: What Board conversations are needed?

Q 5: What is the role of the Board
Q 1: Why Switch to Zero Harm?

Q 2: What was the process?

Q 3: What tools were used?

Q 4: What Board conversations are needed?

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1. **Framework** - Plan, Partners, and Principles

2. **Measurement** - GREAT data
   - Indicators and classification systems
   - Technology - EPIC
   - Communication Tools - Daily Brief, Huddles

3. **Analyses** to learn and improve from events
   - Root Cause analysis for SSEs
   - Three meeting model - Facts, Factors, Fixes (0-60 days)
   - Sequence of events analysis

4. **Prevention Bundles** to target risk areas

5. **Leadership**
CHEO is Part of Something Bigger

**Mission**
“Working together to eliminate serious harm across all children’s hospitals”

**Safety Culture**
Apply a safety lens to the work we are already doing – building a culture of safety

**Quality Improvement**
Building on existing LEAN structures and process principles to achieve outcomes and enhance safety to decrease harm

**Network & Strategic Alliance**
Has grown to 130+ hospitals in US and Canada including CHEO, SickKids, McMaster, IWK, London Health Sciences Centre & Alberta Children’s

Q 1: Why Switch to Zero Harm?
Q 2: What was the process?
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**Children’s Hospitals’ Solutions for Patient Safety**
Every patient. Every day.

Children’s Mental Health Ontario Conference
Safety First Guides our Work with our Partners
“All Share, All Learn”

Q 1: Why Switch to Zero Harm?
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Children’s Hospitals’ Solutions for Patient Safety
Every patient. Every day.

Kids Health Alliance

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Safety is Achieved Through High Reliability

Examples of success in other industries:

Q1: Why Switch to Zero Harm?
Q2: What was the process?
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Building a High Reliability Organization: 5 Key Principles

- Preoccupation with Failure (Embrace problems as opportunity to improve)
- Sensitivity to Operations (Pay attention to what's happening on the front line)
- Reluctance to Simplify (Encourage diversity in experience, perspective & opinion)
- Commitment to Resilience (Develop capabilities to bounce back from events)
- Deference to Expertise (Support decision-making by those who have the expertise)

Three Principles of Anticipation
Two Principles of Containment

Q1: Why Switch to Zero Harm?
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You Manage What You Measure; Safety is the Absence Of Harm

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Children’s Mental Health Ontario Conference
Q1: Why Switch to Zero Harm?
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Leadership

4. What conversations should the Board be having?

5. What is the Board’s role?
Examples

1. **What is your Vision/ Mission - Lead? Leap? Reap?**
   - What’s your niche in the continuum of care?
   - Can you stay where you are?
   - Are you purpose driven or resource-driven, at present?
   - What do your patients/families want from you?

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Examples

2. How will you set the tone for culture of safety?

3. Are people ready? All staff, all levels.
   — Do you have capacity/culture in your senior leadership?
   — For continuous improvement? For Smart risk-taking? Correcting course?
   — Are you ready to invest in this?
Examples

4. Can you handle failure and false starts?

5. Do you measure useful/meaningful data?
   — Meaningful data is not just quantitative. Qualitative data is rich.
Examples

6. Are you looking beyond your walls?
   — The scope of what we do is getting bigger........ chronic and complex care on a continuum

7. Have you built needed networks?
   — Why reinvent the wheel. Connect, share, borrow, learn

8. How can you resource to achieve 0 harm?
Examples

Change the conversation from Reports to Risks

— From what, where, how much (Reports)
— To what if? why now? what about? how come? (Risks)

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Boards don’t have all the answers...

...but we can ask all the questions

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Safety First

IHI 2008: Retrieved from https://www.youtube.com/watch?v=w2lrlkOqGNAU

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THANK YOU!