



Context and Vision: Patient Safety and Quality at Duke

**5th Annual Patient Safety and Quality Conference
January 14, 2010**

Overview

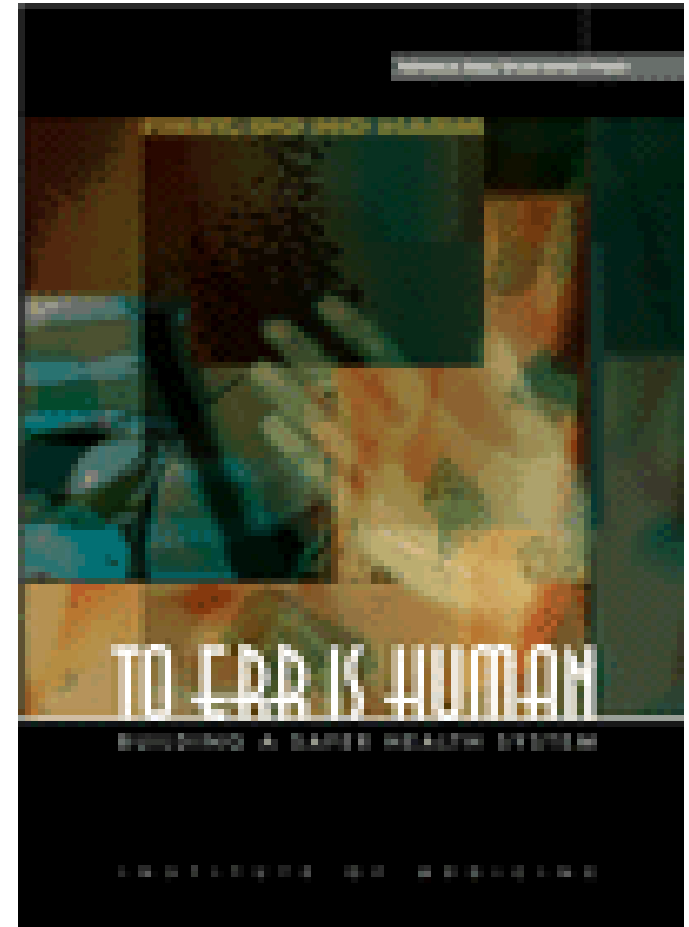


- Acknowledge history of excellence
- Review our framework to support improvement efforts in safety and quality
- Celebrate accomplishments and successes over the past 5 years across Duke Medicine
- Discuss future goals and priorities



Context for Patient Safety and Quality Care

- History of excellence, yet need for continued improvement in safety and quality
- Patient Safety
 - Identify and mitigate risk, to prevent harm
 - Requires a culture in which *everyone* is committed to and accountable for safety
- Quality
 - Degree to which health care services increase the likelihood of (patient's) desired health outcomes and are consistent with current professional knowledge



Framework for Safe, High Quality Care at Duke Medicine



- Identify leaders at all levels of organization
 - DUHS Board of Directors, Senior leaders, Departments, CSU, Unit level
 - Provide necessary training and tools
- Develop robust risk identification and mitigation strategies
 - SRS, Safety Walkrounds, RASMAS
- Address systems issues (fix defects)
 - Highly complex system: standardize and simplify
 - IT systems to enhance safety
 - CPOE, EHR, Barcoding, Surveillance
- Create a culture to enhance safety and quality
 - Human Factors, Teamwork and Communication, Accountability and Behavioral Choices, Patient Centric



Leadership and Attributes of the Right Stuff

- Organizations highly successful in safety were also generally successful in operational performance
- Engagement at all levels of the organization
- Understand crucial aspects of human performance
- To continuously improve performance and achieve superior results the organizational culture must change – meaning behavioral change
- They address and align the behaviors of everyone

Krause – Leading with Safety 2005

Safety Leadership Training



- Senior Leaders
 - PSCQ Committee of BoD, Executive Partnerships
 - Physician Leaders, Managers, PSO Training
- Graduate Medical Education
 - Program Directors, Senior Residents, Fellows
 - 1st Fellow, ACR Safety and Quality Fellowship
- Health Professions Schools
 - Core content in patient safety and quality
 - Interdisciplinary teamwork training (SoN and SoM)
 - IHI Open School Chapter
 - Recognized at National IHI Forum
 - Hosting first NC Regional IHI Forum

Risk Identification and Mitigation



- Safety Walkrounds
 - Hospitals
 - Outlying Clinics
 - Home Health
- RASMAS
 - Computerized alert system
 - Nearly 3,000 alerts yearly
 - Drugs, equipment, devices
 - Senior Recall and Response Team
- Computerized Safety Reporting System
 - Over 1,200 reports per month



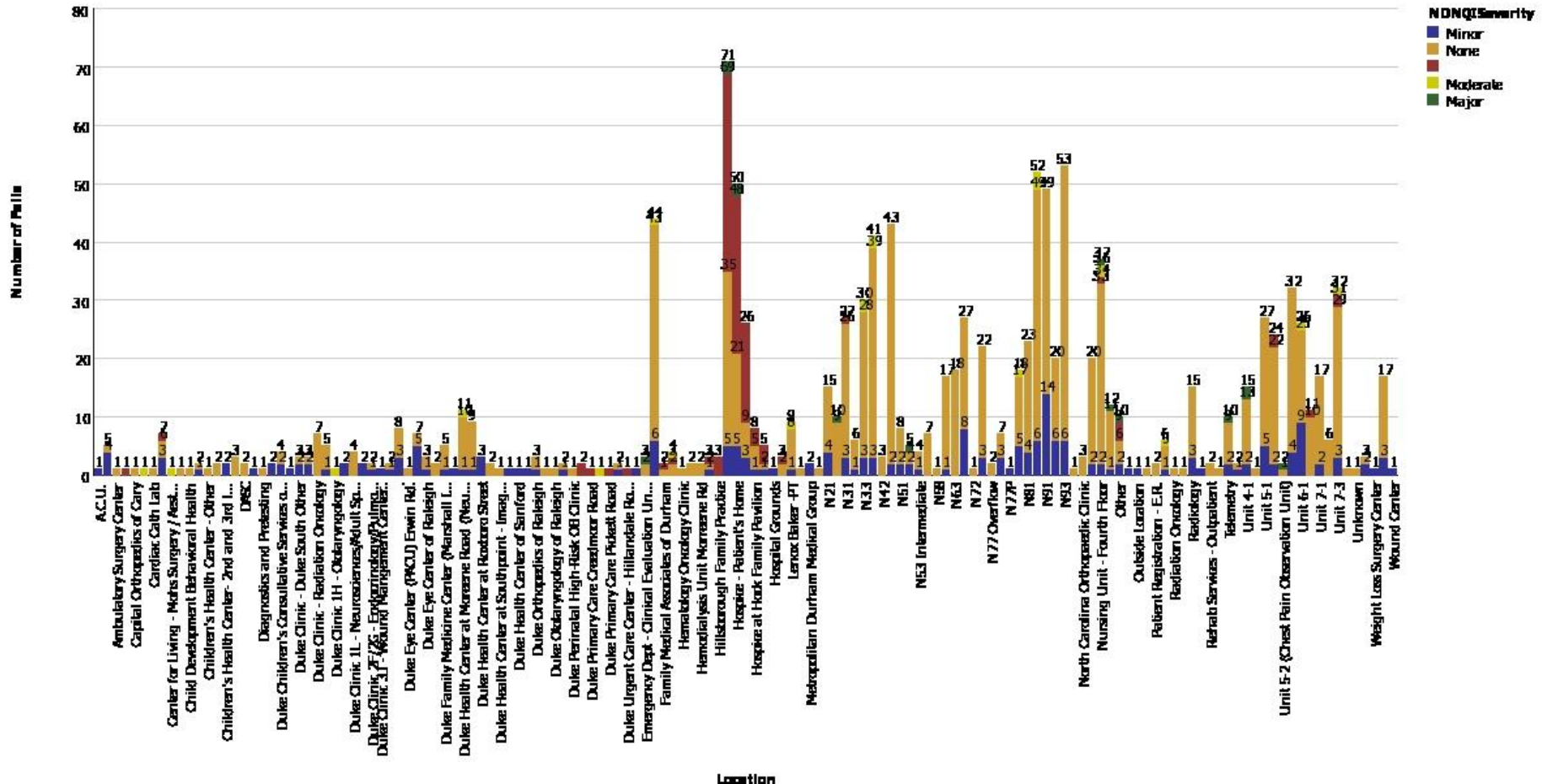
Risk Identification and Mitigation

SRS: Falls – Injury level and location



Falls by Injury Level and Location

Incident Date Range: On or after Apr 16, 2009 12:00 AM,

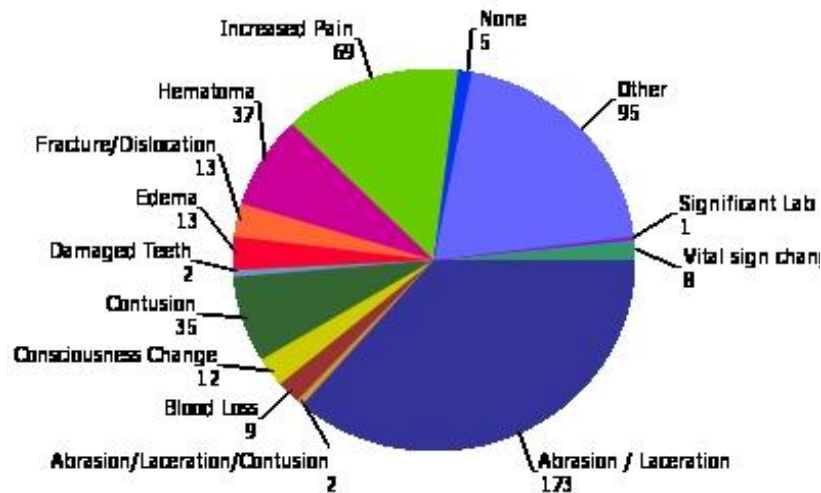




SRS: Falls – Type and Severity

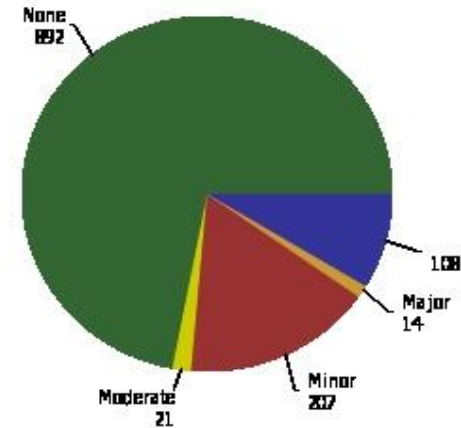
Type of Injury

Incident Date Range: On or after Apr 16, 2009 12:00 AM,



Falls by NDNQI Severity Level

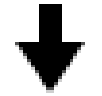
Incident Date Range: On or after Apr 16, 2009 12:00 AM,



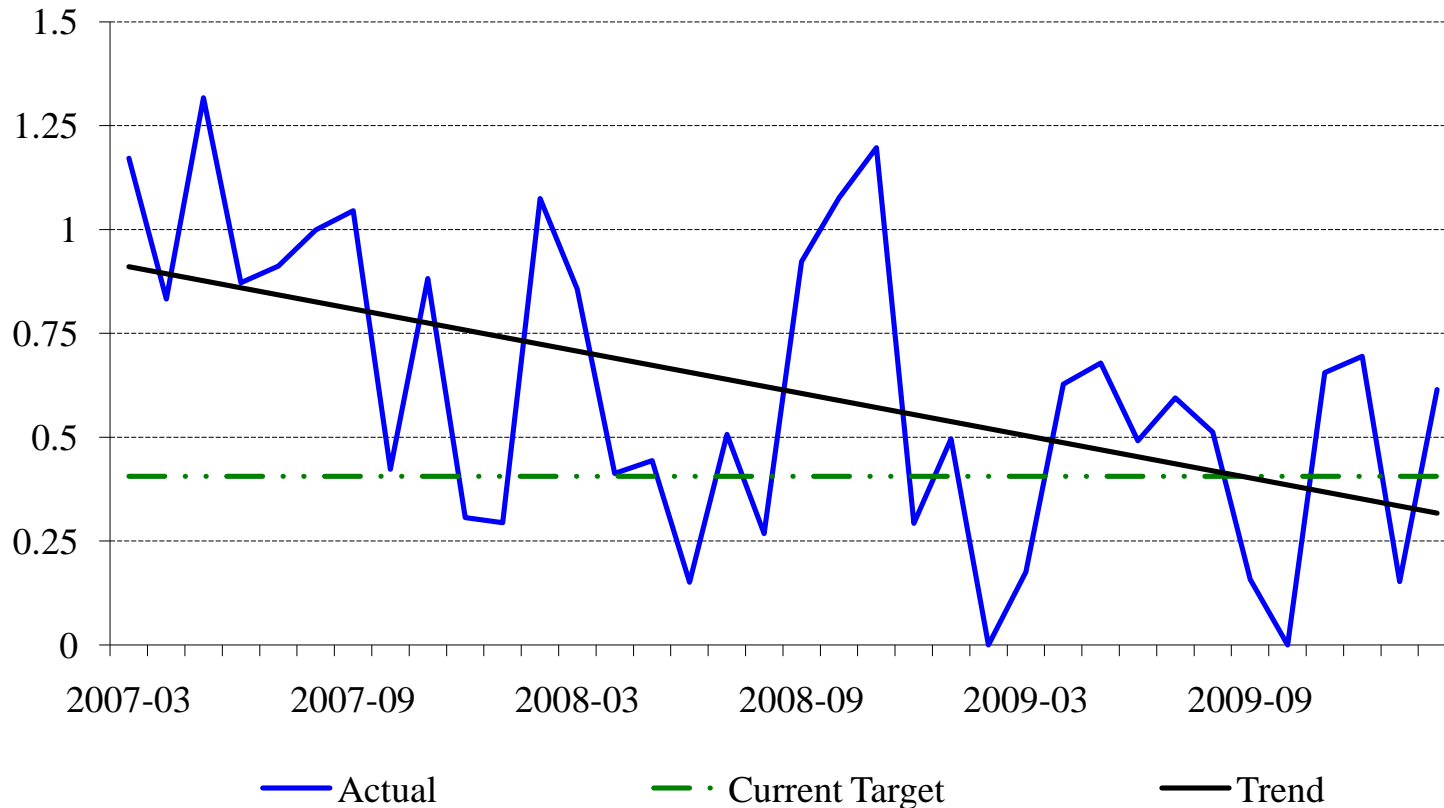
Durham Regional Hospital



Patient Falls With Injury per 1000 Pt Days



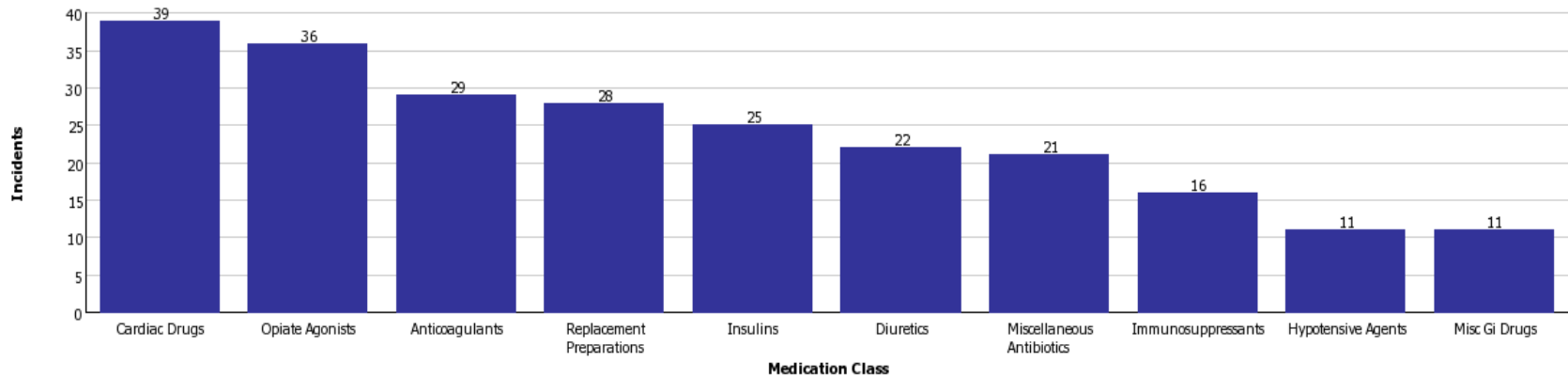
Better





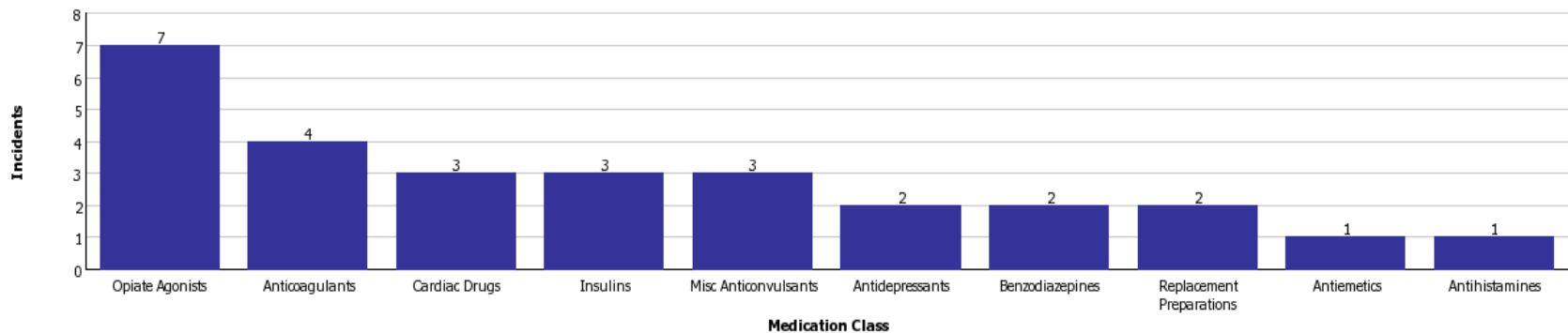
Risk Identification and Mitigation: SRS: Medication Events

Top 10 Medication Categories



Top 10 Medication Categories that injured patients

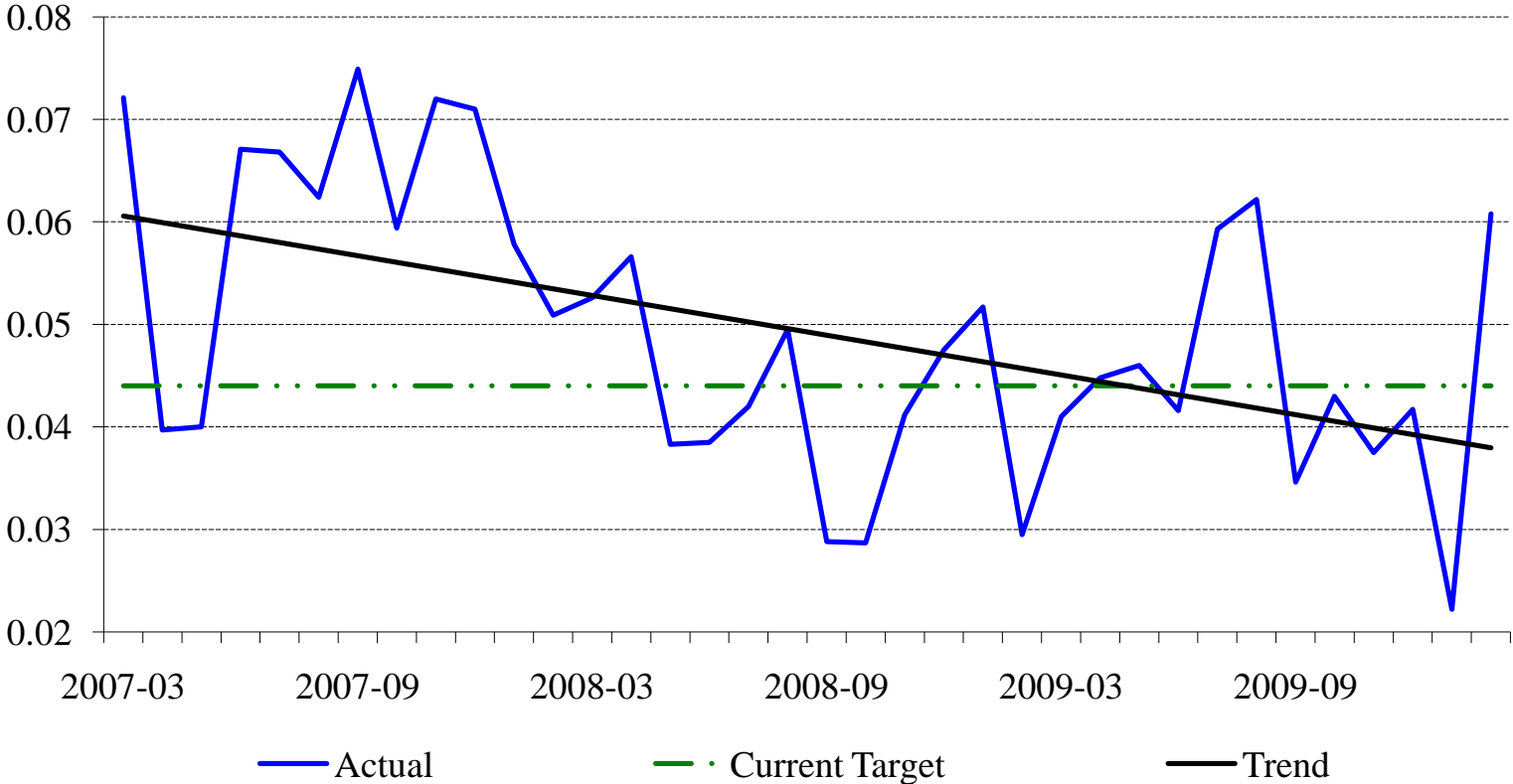
Injury is defined as a Severity classification of 3 or higher by medication safety pharmacists and peer reviewers.



Duke Raleigh Hospital



Med Safety: Total Preventable ADEs With SI > 2 as a % of Total ADEs



Systems Issues

- Implement IT safety systems
 - Computerized SRS
 - CPOE, EHR
 - Automated Surveillance
 - Bar Coding, Smart Pumps
 - Patient Portal
- Standardize, simplify, learn from defects
 - Implement best practices
 - Use of checklists
 - CA-BSI Bundle

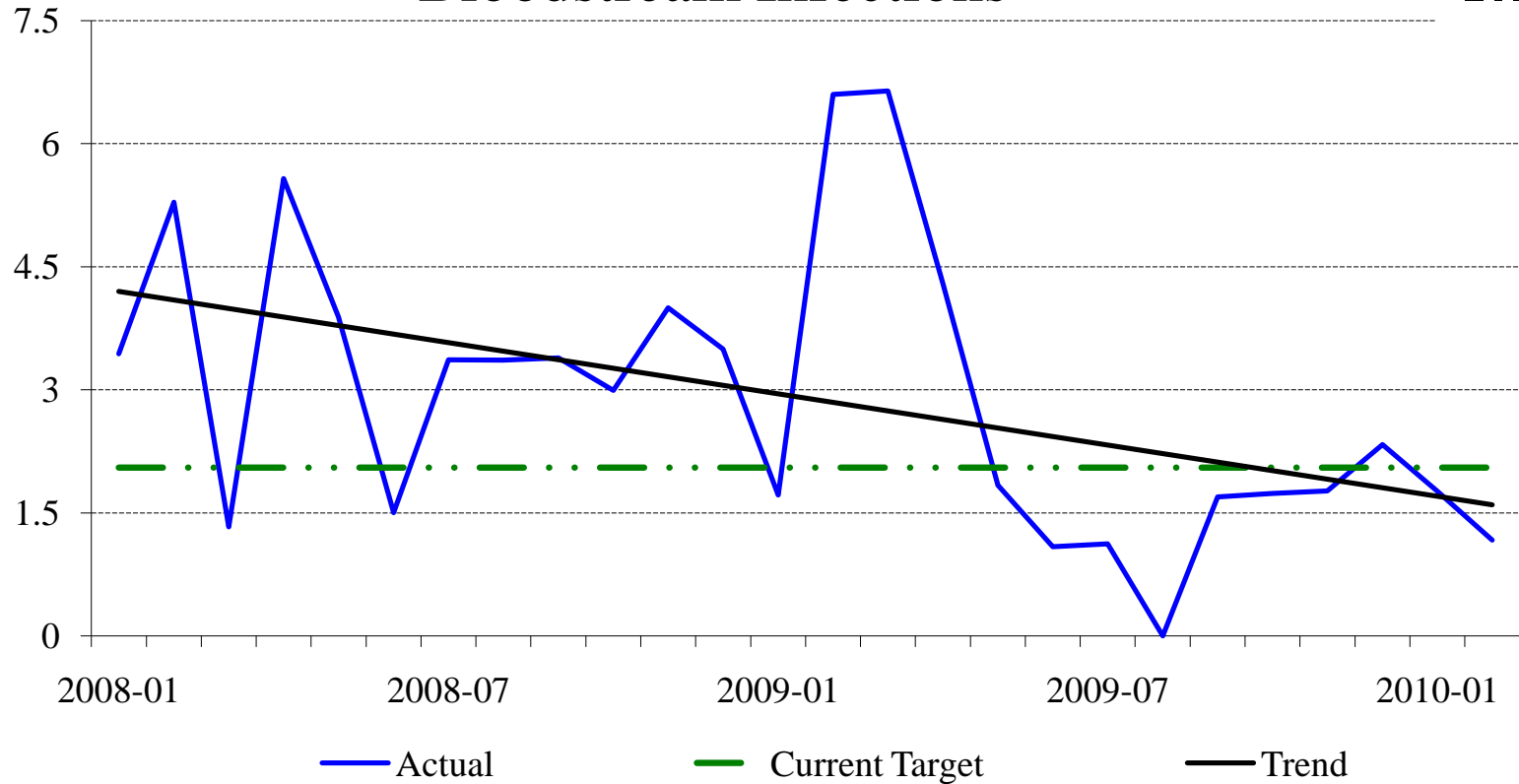
Why we need checklists



Duke University Hospital



Infection Control: Catheter Associated Bloodstream Infections



Culture: Teamwork, Communication and Behavioral Choices



- National training site for TeamSTEPPS
 - Nearly 100 Master Trainers at Duke
 - Master Trainers from 44 institutions in 20 states
 - Effective communication; Environment of mutual respect
- Safe Choices
 - DUH: 1,700 staff and faculty have participated
 - 2010: spread across DUHS
- Just Culture
 - 25 Trainers
 - Standard algorithm used during event review
 - Focus on accountability but avoid blame
- Transparency and Disclosure



Patient Centered Culture

- Patient Advocacy Council
 - Created in 2006
 - 14 members, >1000 hours service
- Activities
 - Patient portal
 - Condition H
 - TeamSTEPPS for patients and families
 - Patient-centered care for students and trainees



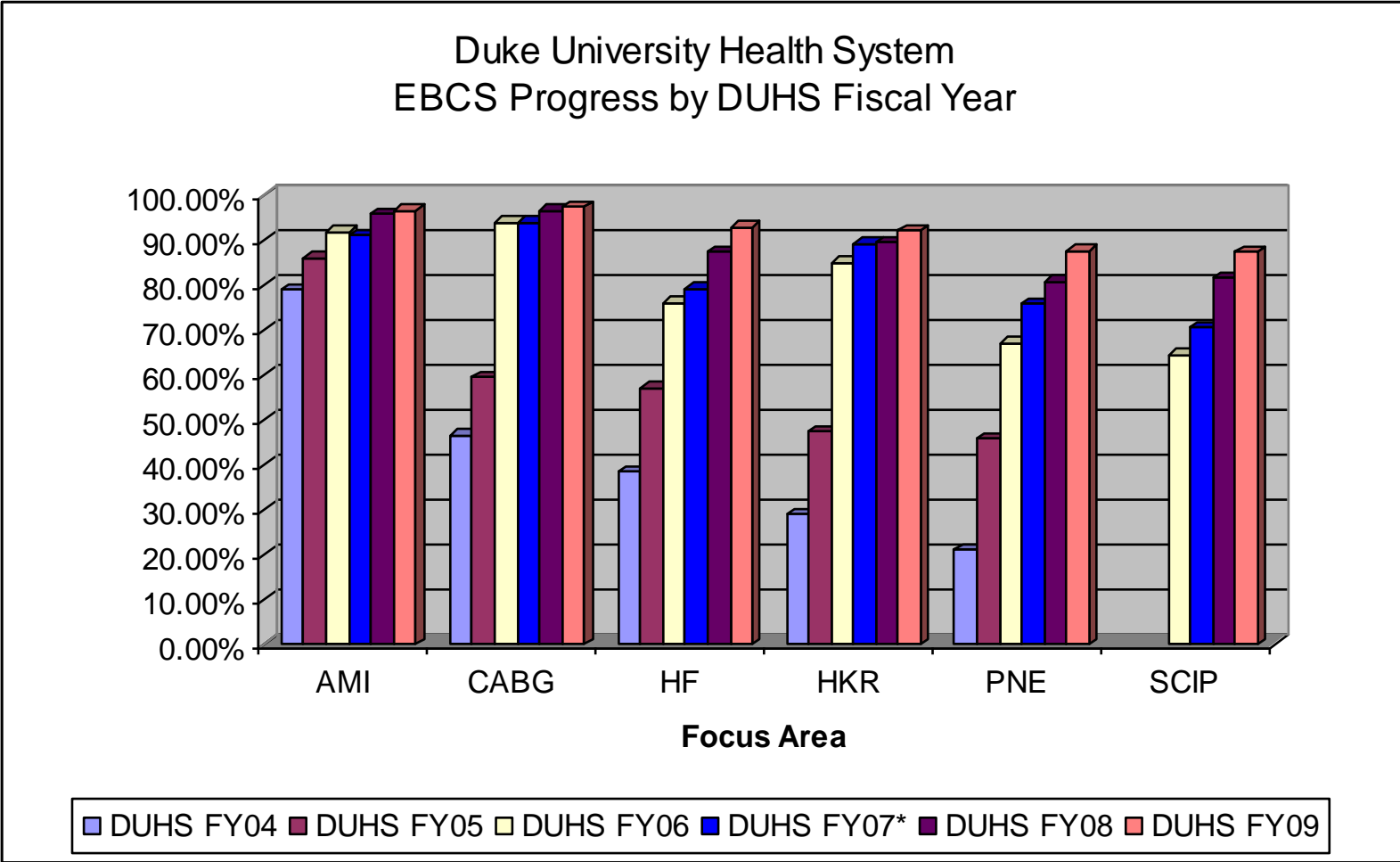
Patient Advocacy Week

April 12 - 18, 2009 www.shca-aha.org

Celebrating the heart of our h♥spitals



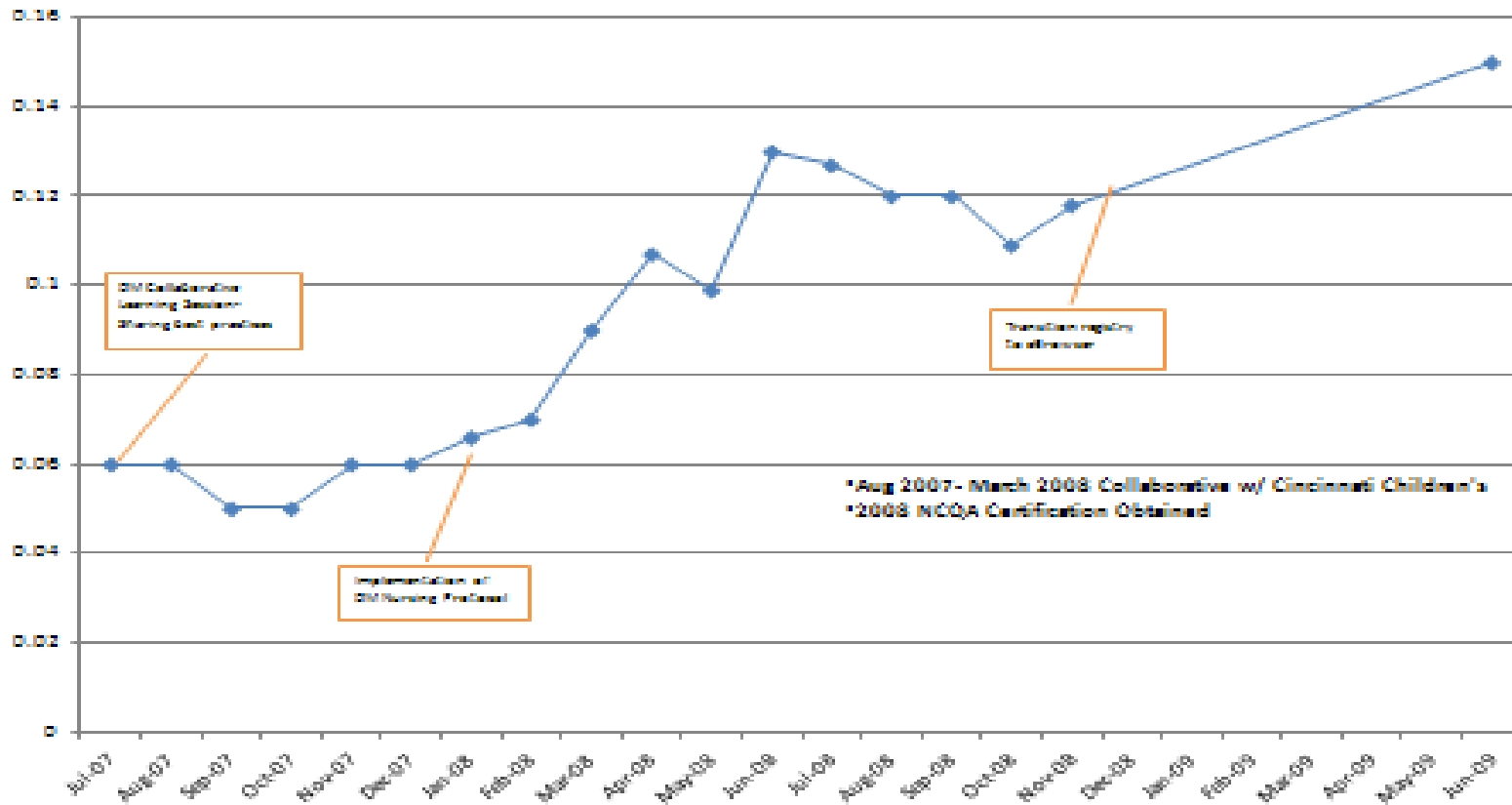
Measuring our Progress: CMS Publically Reported Measures



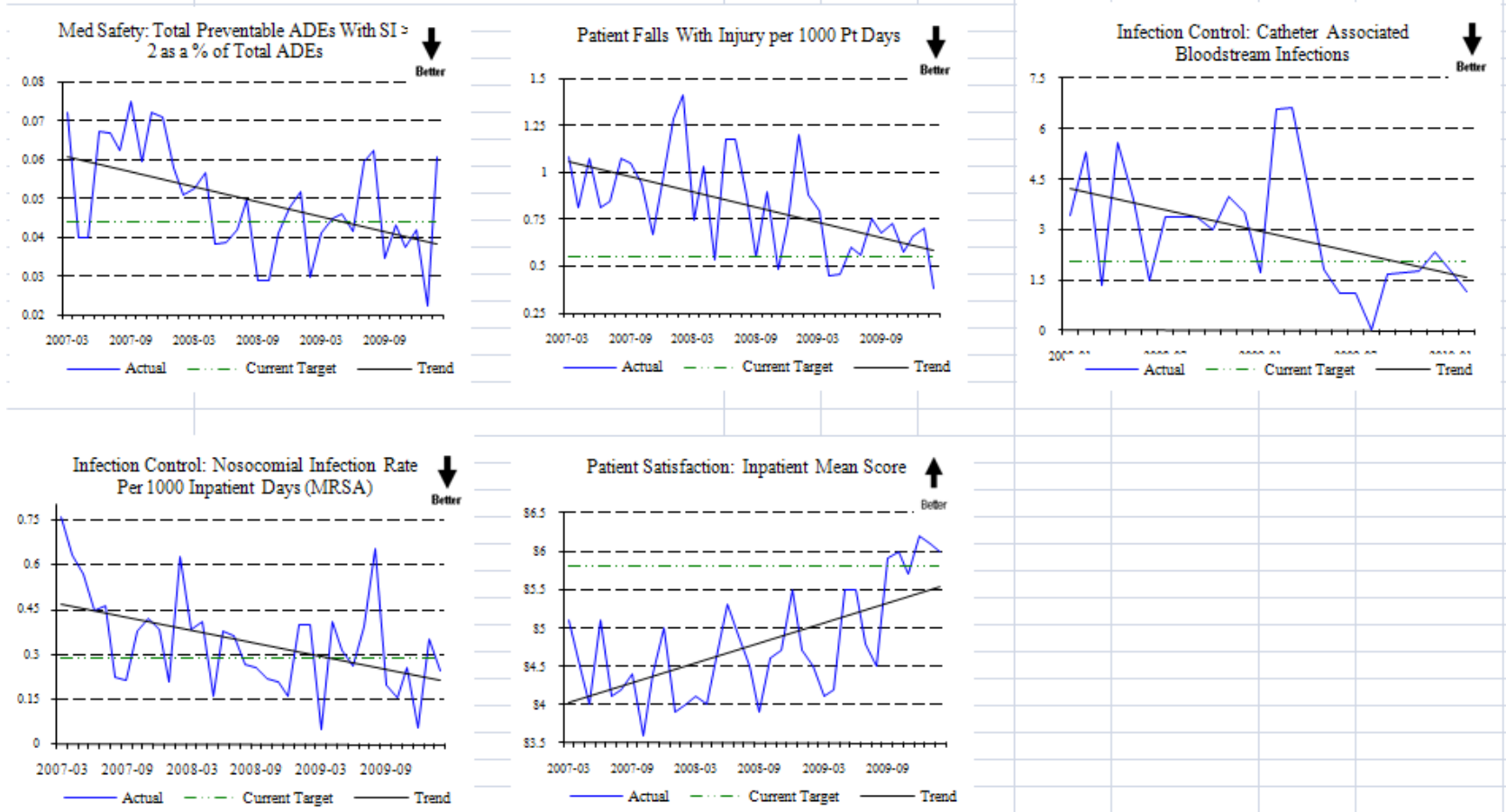
Diabetes “Perfect Care”



DPC: DM Perfect Care
A1C<7, LDL<100, Non-Smoker, Aspirin, BP<130/80



Patient Safety & Quality Summary Report - DUH Critical Success Factor Trends



Duke Medicine Quality & Safety Web Site

dukehealth.org/quality



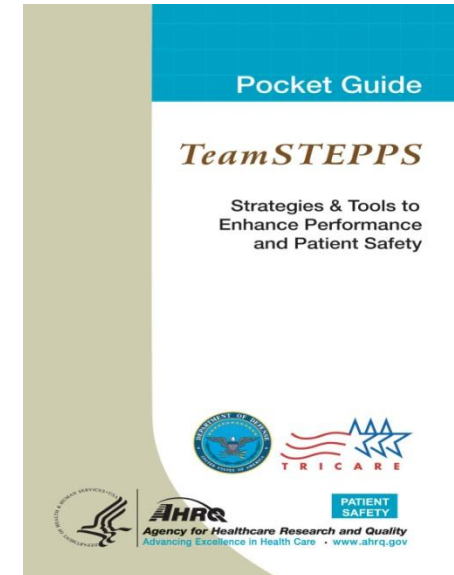
- 22,921 pageviews (Jan-Oct 2009)
- 85% increase in traffic in 10 months
- Silver Award for "Best Quality & Safety Communication," 2009 eHealthcare Leadership Awards

The screenshot shows the DukeHealth.org website. The header includes the DukeHealth.org logo and the tagline "Connect with your health care at Duke Medicine". A search bar is located in the top right corner. The main navigation menu on the left lists various services, with "Quality and Safety" highlighted. The main content area features a breadcrumb trail: "Home > About Duke Medicine > Quality and Safety > Patient Care Quality and Safety". Below this is a "Quality and Safety" section with a sub-header "Patient Care Quality and Safety" and a list of links: "Performance Measures", "Safety and Quality Awards", "Improvement Initiatives", and "Contact Us with Concerns". A large blue banner with a photo of a building contains the text: "At Duke University Health System, we pledge to provide you with the highest quality health care and to maintain a safe environment. Explore the information in this section to see ways in which we strive to ensure safe, quality care for every patient we serve." To the right of the banner is a "Quality Stories" section with a sub-header "A NICHE for Geriatric Nursing Care" and a link "Helping Uninsured Patients".



Leading in safety and quality

- IOM Committees
- NPSF Board of Directors
- TJC Pediatric Patient Safety Panel
- NQF Panel for PSO Common Formats
- Josie King Foundation Board of Directors
- IHI Faculty
- DoD, AHRQ National Training Site
- ACR First Annual PSQ Fellowship
- DUH 2009 AHA - McKesson
Quest for Quality Citation of Merit
- Award winning abstracts from DUHS!



American Hospital Association - McKesson
Quest for Quality Prize®

Hospitals in Pursuit of Excellence

Looking to the Future: Duke Patient Safety Center



- To help individuals, clinical areas, hospitals, ambulatory centers and others who want to improve quality and patient safety. We aim to:
 - Spread best practices inside and outside Duke University Health System
 - Generate new knowledge
 - Bring joy back to work
- We work to develop and support quality and safety related roles, committees, training, tools, research, strategies, data and other resources through our interdisciplinary team. We strive to balance the clinical, administrative, psychological, spiritual and service needs of our organization, our frontline workers and the patients that we serve.
 - www.dukepatientsafetycenter.com



Dr. Bryan Sexton