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project risk mgmt • bcr • health & safety • rmis • claims admin • esg • tprm • compliance • policy mgmt • internal audit • erm



The Secret to Improving Incident Reporting Rates

Jill Tice

*Vice President Quality, Safety, Risk Management
Monument Health*



LARGEST HEALTH CARE SYSTEM IN WESTERN SOUTH DAKOTA

5 hospitals | 2 managed hospitals

25 clinic locations

1 assisted living facility | 2 care centers

6 urgent cares

8 specialty treatment centers:

John T. Vucurevich Cancer Care Institute,
Heart & Vascular Institute, Rehabilitation Institutes (2)
Behavioral Health Center, Dialysis Centers (2)
Surgery Center, Orthopedic & Specialty Hospital



RISK UNDER
ONE ROOF

VISION

It starts with heart.

Our vision is to be one team, to listen, to be inclusive,
and to show we care.

To do the right thing. Every time.

VALUES

Trust
Respect
Compassion
Community
Excellence

PRIORITIES

Deliver high-quality care
Provide a caring experience
Be a great place to work
Impact our communities
Be here for generations to come

MISSION

Make a difference. Every day.



THE KEY TO
SAFETY IS **YOU**



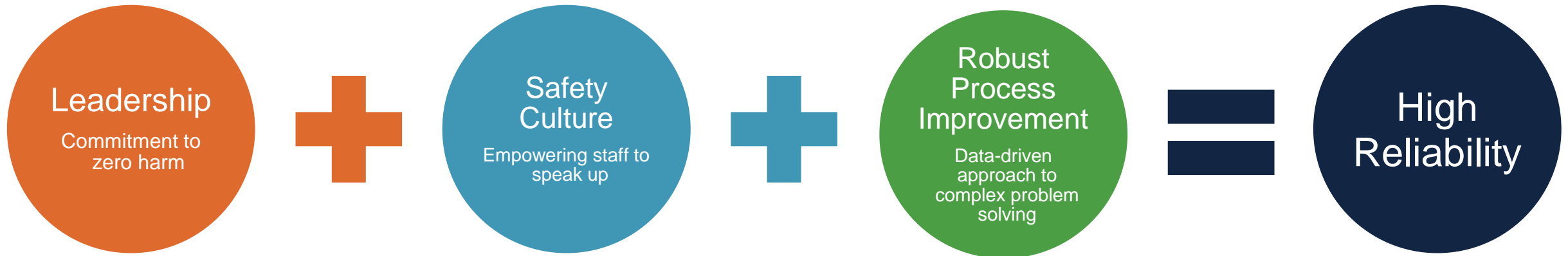


RISK UNDER
ONE **ROOF**





Deliver High Quality Care Strategic Framework



Deliver High Quality Care Strategy

BY JULY 2024:

We will build trust in our communities.

Monument Health will be a highly-reliable and transparent organization. We will share health care performance metrics both internally and externally, resulting in greater accountability, consistency of care and ultimately, improved safety and patient outcomes.



FISCAL YEAR
2020



1 | DELIVER HIGH-QUALITY CARE

Increase in reporting of patient-related safety incidents throughout the system. Measured by year-over-year percentage change in number of incidents reported in the Riskconnect System, Q4 2020 compared to Q4 2019.

ACTUAL



GOAL

20%
Increase

FISCAL YEAR
2021



1 | DELIVER HIGH-QUALITY CARE

Increase in reporting of good catch (near miss) patient-related safety incidents throughout the system. Measured by year-over-year percentage change in number of incidents reported in the Riskconnect system, Q4 2021 compared to Q4 2020.

ACTUAL



GOAL

100%
Increase
in patient-related near-miss safety incidents



Culture of Safety



RISK UNDER
ONE **ROOF**

SAFETY CULTURE

THE KEY TO SAFETY IS YOU

Just Culture

Monument Health's approach to consistently evaluate processes to ensure safety, quality, and accountability

Good Catch

Creates an environment where errors are identified before they occur or become critical (near misses) and are then reported so our organization can learn from the event

Patient Safety Coaches

Frontline caregivers who are knowledgeable and passionate about patient safety

Safety Huddles

Brief, focused conversations that take place every day across Monument Health and allow for elevation of concerns





Just Culture

JUST CULTURE CONCEPTS

- Humans managing complex, imperfect processes
- Look at the process first, not the person
- Applies to clinical and non-clinical
- Confirm behavioral expectations
- ★ Contributes to psychological safety!

Just Culture
Caregivers and providers are human, and we make mistakes - even when we are trying our best.

Just Culture is a framework that helps organizations evaluate human error and imperfect processes and learn from events in order to continuously improve. Just Culture is Monument Health's approach to consistently evaluate processes to ensure safety, quality and accountability. The model applies to everyone - clinical and non-clinical caregivers, leaders and providers. The first step of the Just Culture approach emphasizes evaluating involved processes for failure.

HUMAN/SYSTEM ERRORS	AT-RISK BEHAVIOR	RECKLESS BEHAVIOR
<p>Human Error Inadvertent action: slip, lapse, mistake, part of our design</p> <p>Manage: Change processes Change procedures Change training Change design Change environment</p>	<p>At-Risk Behavior Unintentional risk-taking, a risky choice not recognized or believed justified</p> <p>Manage: Removing incentives for at-risk behaviors Creating incentives for healthy behaviors Increasing situational awareness</p>	<p>Discipline Intentional disregard to policy or process, intentional risk-taking</p> <p>Manage: Remedial action Disciplinary action</p>
Console	Coach	Corrective Action

The Just Culture concept aligns with Monument Health's vision. When we learn from our mistakes and then improve processes, it becomes easier for everyone in our organization to **Do the right thing. Every time.**

MONUMENT HEALTH

SAFETY CULTURE

Safety Huddles

BENEFITS

- Early identification of trends
- Provides better care and service for patients
- Improves communication, respect, and teamwork
- Enhances accountability and transparency
- Promotes Just Culture

FRAMEWORK

- Daily...same time, same place
- All departments, clinical and non-clinical
- 5 Tiers, frontline caregivers up to President/CEO
- Link strategic priorities through use of Daily Management Board



Tiered Safety and Quality Huddle Grid

	Tier				
	1	2	3	4	5
Time	6 - 8:30	8:30-9	9-9:30	9:30-10	10-10:30
Attendance	Frontline	Unit/Department level leadership	Department leadership, AOC, NLOC (0900 Safety Huddle)	VPs, market president, AOC, NLOC	D-Team with Paulette
Face-to-face huddles	x	Preferred	Preferred	Preferred	Preferred
7 days a week/ 365 days of year	x				
Occurs at every major shift change	x				
Huddle leader is identified	x	x	x	x	x
Riskconnect events in the last 24 hours	x	x	Serious safety events only	Serious safety events only	Serious safety events only
Trending safety concerns	x	x	x	x	x
Falls	x	x	x	x	x
Caregiver Injuries	x	x	x	x	x
Dr. Bert	x	x	x	x	x
Good catches	x	x	x	Good catch numbers only	Good catch numbers only
High Risk Suicide	x	x	x	x	x
Diversions			x	x	x
Names for Pause			x	x	x
Unexpected Deaths			x	x	x
Hospital Census			x	x	x
Scheduled Surgery Cases vs Budget					
High Profile Patients					x
Major Patient Experience Issues	x	x	x	x	x
Critical Staffing Issues		x	x	x	x
Critical Supply Shortages		x	x	x	x
Critical Downtime/Computer Alerts	x	x	x	x	x
Critical Legal Issues					x
Critical PR/Marketing Issues					x
Executive information/ metric TBD	x	x	x	x	x
Department specific quality/ operational metrics	x	x	x	x	
Liaison from team is present for daily safety huddle to communicate events			x		
Close the loop for events with staff and caregiver involved	x	x	x		



TIERED SAFETY HUDDLES



Regional Health **DAILY MANAGEMENT BOARD** Team: Mother Baby

Regional Health **DAILY MANAGEMENT BOARD** Team: Peds / Advanced Care Peds

EPIC/ALARIS

- PRV & Vitals at End of Shift → AB IN & VITALS
- Is it Clinically Important? → If not, uncheck
- Meds: START in MAR STOP in PRV
- Remember: If you are starting an antibiotic as secondary + need to hang a new bag of fluids for primary, scan primary fluids first

EVENT UPDATES

- PRV & Vitals were not 100%
- PRV & Vitals were not 100%
- PRV & Vitals were not 100%

OPEN SHIFTS

12/24 DIZ
12/25 DIZ

Don't forget to bring food

SECRET Santa
In Your Hand

Plant Ops has the extra phone chargers 4 for the beds



Good Catch Reporting

- Report of a failure prior to reaching the patient/causing harm
- Education to all caregivers and physicians
 - Examples of good catches
 - Just Culture – commitment to evaluate processes
- Ability to communicate commitment



Patient Safety Coaches

- Program development held during Covid
- Designated caregiver from all departments
- Role
 - The face of patient safety for department
 - Knowledgeable about Riskonnect
 - Communicate safety trends back to departments
 - Promote psychological safety
- Informally in place by caregivers passionate about patient safety



Riskonnnect Optimization

Riskonnnect Optimization

- Updated fields in Patient Event Review to support Just Culture approach
 - Was follow-up with caregiver/physician completed?
 - Gratitude and closing the loop
 - Was this a system/process issue?
 - Aid in investigating with a system lens
 - Aid in retrospectively analyzing events
 - Deviation from acceptable practice?
 - Not all deviation from policy or procedure is solely a human failure or reckless
 - Policy/procedure may be difficult to follow, wasn't trained, obsolete

Review Questions

Review Number: RHPER-2022-079479

Patient Event: RHPE-2022-032838

Assigned Reviewer: [Redacted]

Reviewer Comments: [Redacted]

Followed up with reporter/their leader? *Communicated with reporter or their leader to relay any process changes or follow-up, or to thank them for reporting.*

Was this a system/process issue?

Deviation from acceptable practice?

Followed up with reporter/their leader? *Was there a deviation in generally acceptable practice standards, policy, standard of care?*

Was this a system/process issue?

Deviation from acceptable practice?

Riskconnect Optimization

- Voice of customer to refine fields to collect more relevant data
- Easy access to Riskconnect link
 - SharePoint
 - Epic
- Lean on product efficiencies to manage increased volume of reported events
 - Patient Events, Patient Feedback, Root Cause Analysis, Claims



Results

RESULTS



1 | DELIVER HIGH-QUALITY CARE

Increase in reporting of patient-related safety incidents throughout the system. Measured by year-over-year percentage change in number of incidents reported in the Riskconnect System, Q4 2020 compared to Q4 2019.

ACTUAL

GOAL

82%

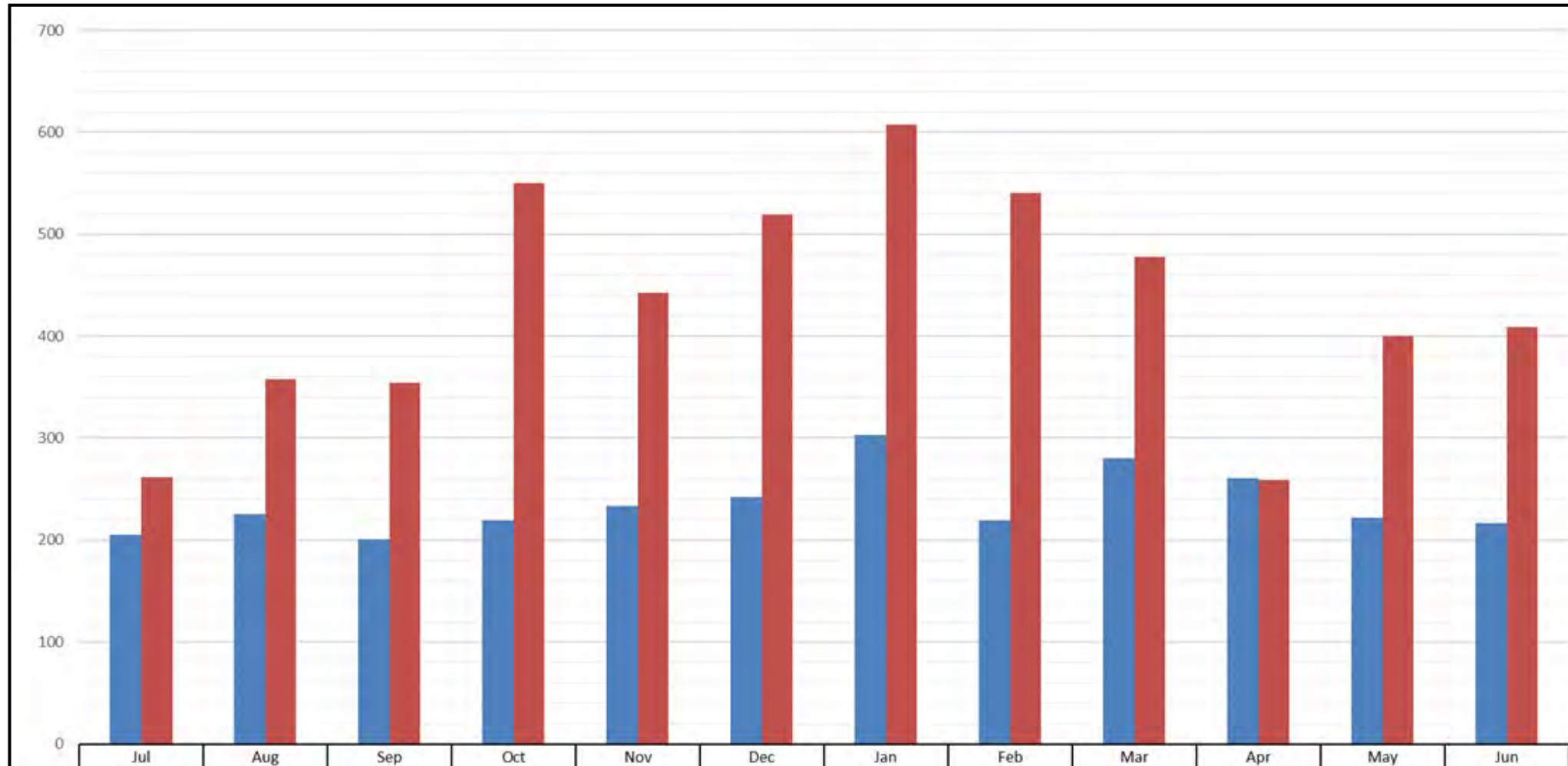
Increase
FY20 Final

20%

Increase

48%

Increase
Q4 Final



RESULTS



1 | DELIVER HIGH-QUALITY CARE

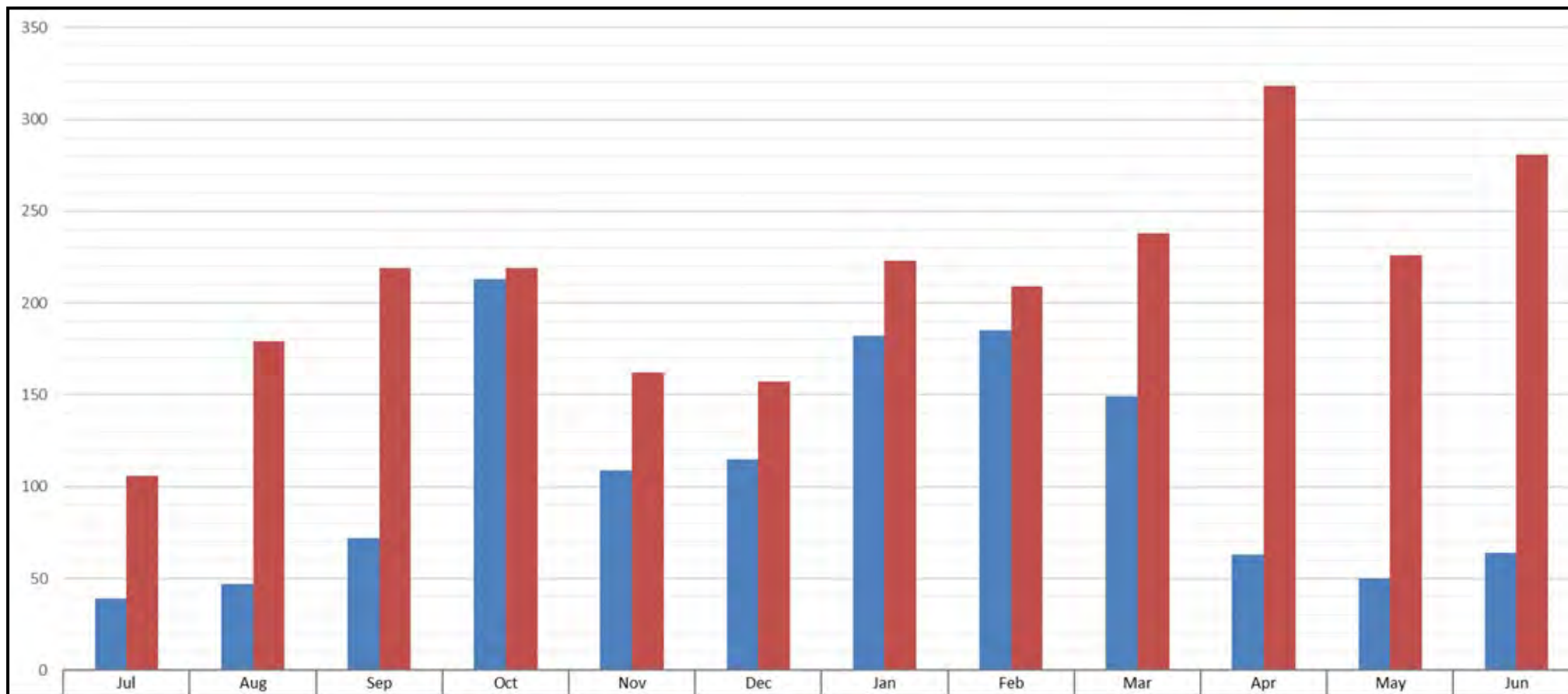
Increase in reporting of good catch (near miss) patient-related safety incidents throughout the system. Measured by year-over-year percentage change in number of incidents reported in the Riskconnect system, Q4 2021 compared to Q4 2020.

ACTUAL

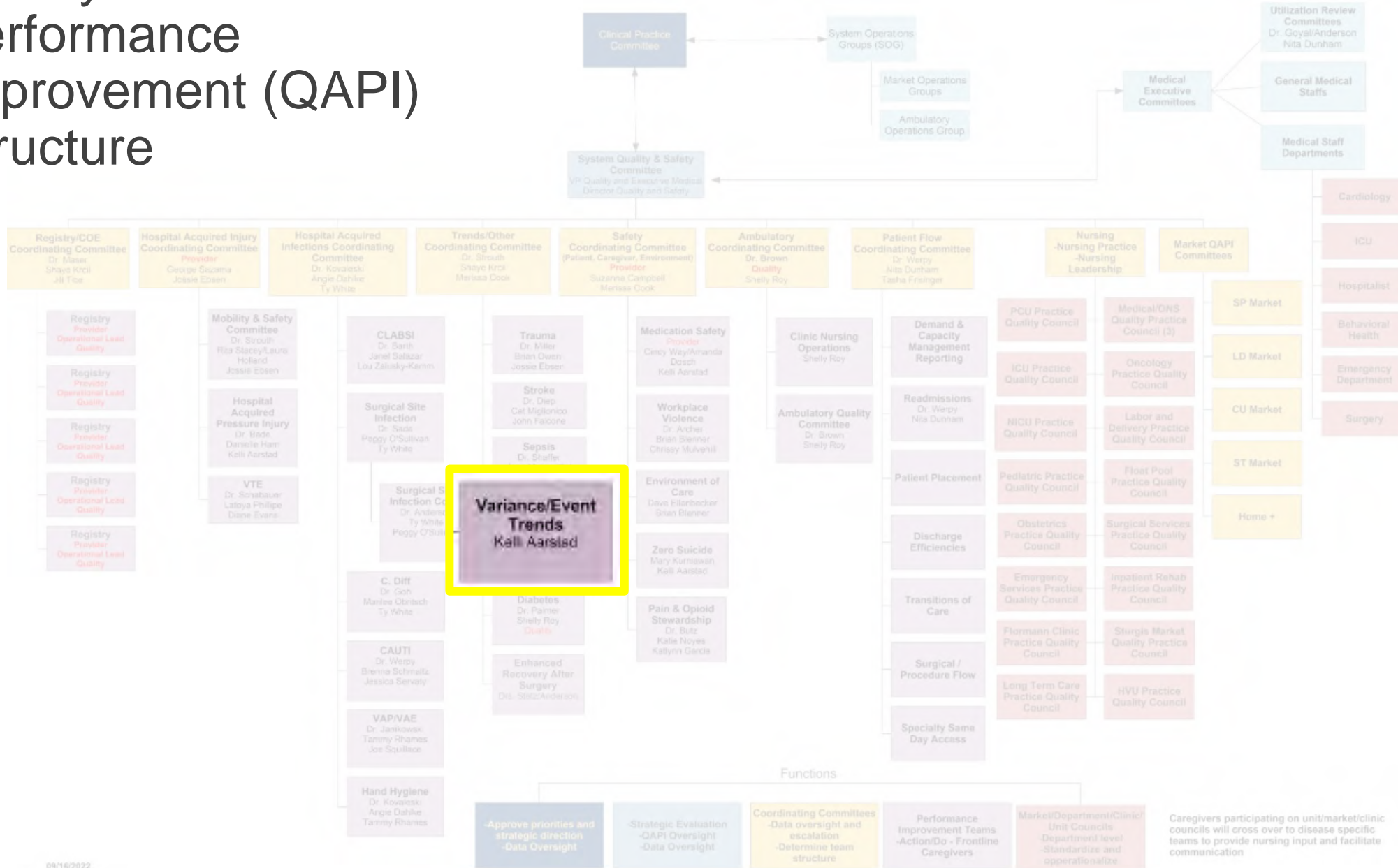
344%
Increase
Q4 Final

GOAL

100%
Increase
in patient-related
near-miss safety
incidents



Quality Assurance Performance Improvement (QAPI) Structure





Current State

- Safety events communicated at daily huddle by reporting department
- Good catch data reported at daily safety huddle
- Patient Safety Coach call to action
- Current goal: Increase number of caregivers and physicians completed Monument Health Lean Belt Program

Next Steps

- Grow the functions of the committee in the QAPI structure
- Continue to monitor enterprise reporting levels
- Ongoing evaluation of Patient Event fields to maintain relevant and efficient data collection

Questions?



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DISCOVER

RISK UNDER
ONE ROOF
Confidential



RISK UNDER
ONE **ROOF**

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