



This slide features a white header bar at the top containing the Spectrum Health logo and the text "SPECTRUM HEALTH". Below the header, the main content area has a dark blue background with a pattern of larger, semi-transparent blue circles. The title "Safety Culture Journey" is centered in a large, white, sans-serif font. Below the title, the speaker's name and title are listed in a smaller, white, sans-serif font: "Barb Wainright, RN BSN", "Director Patient Safety and Quality", and "Spectrum Health Gerber Memorial". A thin yellow horizontal line is positioned near the bottom of the slide.

Safety Culture Journey

- Began in 2003 with participation with MHA ICU Keystone project to reduce central line infections
- Utilized the CUSP (Comprehensive Unit-based Safety Program)
- Utilized MHA Safety Culture Survey with PASCAL Metrics

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Safety Culture Journey cont.

- 2012 Healthcare Performance Improvement (HPI) conducted our first safety culture assessment
- Learnings:
 - Highly visible CEO and executive staff continuously emphasizing patient safety as a core value
 - A manager/safety coach team continuously monitoring error prevention techniques through discussions (rounding for influence) and 5:1 feedback
 - Physician champions demonstrating and teaching error prevention techniques and modeling teamwork
 - The frontline associates integrated into the team through reward and information

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Safety Culture Journey cont.

Action:

- Daily Safety Call – 7 days a week
- A safety story at every meeting
- Developed Safety Coach Program to reinforce newly learned safety behaviors
- Electronic Event Reporting
- Provided Safety Culture education to board, Medical Staff, leaders, and staff

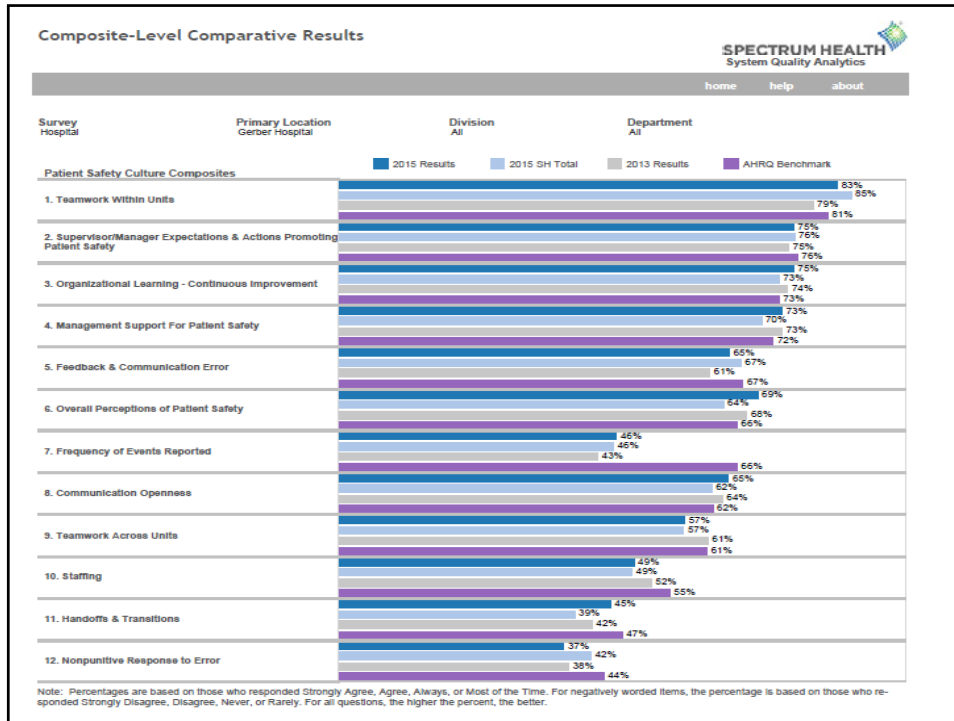
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Safety Culture Journey cont.

- Spectrum Health System changed to use safety culture survey questions by Agency for Healthcare Research and Quality (AHRQ)
- 2013/2015 Bi-annual safety culture survey was completed

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SPECTRUM HEALTH

Safety Culture Journey cont.

2015 Safety Culture Feedback - Hospital:

- Questioned adequate staffing to ensure patient safety
- Non-punitive error responses
- Frequency of event reports
- Hand off and transitions
- Teamwork across departments

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Safety Culture Journey cont.

Action:

- Provided education to staff, providers, and leadership the purpose of event reporting was for process improvement to keep patient safe – not punitive.
- Develop Patient Safety Chain of Command policy. When you utilize safety behavior ARCC say “I have a concern”, everyone stops and listens.
- Created model for leaders to communicate feedback to staff on events with harm or near misses. This process allows staff voices to be heard.

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Safety Culture Journey cont.

- Conducted Root Cause Analysis (RCA)
 - (2) with harm
 - (14) with no harm

“The way the RCA’s are conducted is non-punitive, we learn so much to make it better.” Staff are engaged.


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SPECTRUM HEALTH 

Safety Culture Journey cont.

- Safety Coach Members responsibilities:
 - Promote safety behavior of the month
 - Develop a fun ways to reinforce the use of safety behaviors
 - Co-owner of new internal Safety Central website
 - Works with manager or leader to promote safety stories within their department

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SPECTRUM HEALTH 

Safety Culture Journey cont.

InSite Departments Clinical Connection The Hub Tools and Resources My Life Help

Quality + Safety SHGM Safety and Quality Following in ~ 2 streams Leave group

Overview Content People Projects Reports Calendar Actions About Share Manage

COUNTDOWN
Counting down to Patient Safety Culture Survey Due Date Monday, July 24, 2017
It is here!!


SAFETY BEHAVIOR OF THE MONTH
★ STAR


ONLY SAFETY CALL
Dial-in: 1-877-453-1320
Code: 2438466538


☎ Safety Calls take place 7 days a week at 9 am.
Add in the Administration office on M,W,F.

PROMOTING SAFETY CULTURE
Transforming Health Care into a High Reliability Industry With The Joint Commission on Venous Thromboembolism (VTE) Risk Reduction: The Joint Commission on Venous Thromboembolism (VTE) Risk Reduction: Why High Reliability Matters from The Joint Commission on Venous Thromboembolism (VTE) Risk Reduction.

SAFETY AT GERBER


Safety Behaviors


High Reliability



Quality at Gerber

GOING ABOVE AND BEYOND FOR SAFETY

Celebrating Safety! in SHGM Safety and Quality
Posted by James Hyman, Jul 5, 2017

Drumroll please... the Gerber winners of the 2017 safety story competition are: Theresa Heltinger (1st place), Amy Smith (2nd place), Jennifer Prewett (16th place), and Nancy Hills (17th place). Please see the individual ways that they made sure safety was optimal. Congratulations, ladies!

Safety Hero



Safety Story

Patient was scheduled for an MRI of the Brain. The MRI technologist was verifying the orders for that patient and realized it was an incorrect order for that diagnosis. She handed me the change order form to fax to physician office and to get new order. My usual protocol is to make sure of patient labs, prior imaging and to be sure that there is not a reason that the test was ordered a certain way. I looked into PACS to see if patient has ever had an MRI or had a CT, XRAY etc. On this particular patient I went into PACS, seen that the patient had a CT of his brain. I then checked the report, it stated that the patient had aneurysm clips in his brain. I got a hold of the MRI technologist to see if she could verify what I believed to be true about the patient not being able to have a MRI. I then called the patients physician to see if there were records of patient having clips in the brain. Office did not find any records of this surgery but did have a record of the patient seeing a neurologist in 1996. I called the office, had the records faxed and then verified again with the MRI tech that the patient could not have an MRI ever. There

SAFETY COACH CORNER

[Safety Coach Description](#)
[Meet Your Fellow Safety Coaches](#)
[Safety Story Form](#)

NEXT SAFETY COACH MEETING

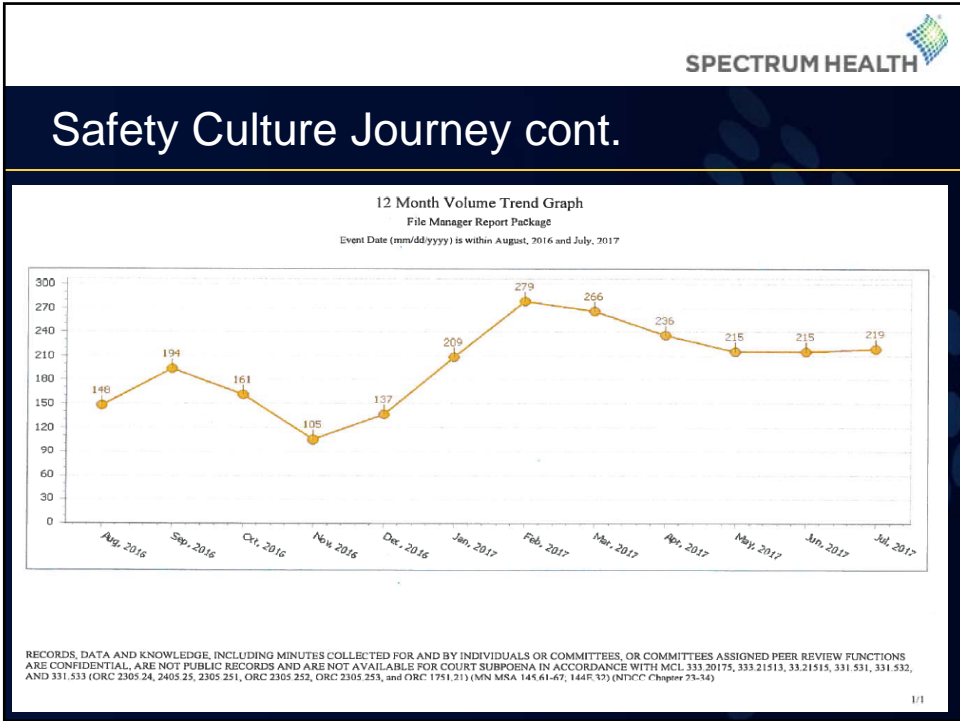
[Safety Coach Meeting 8/23/17 @ 9:30 AM](#)
[Safety Coach Meeting 11/14/17 @ 9:30 AM](#)

POPULAR LINKS

[Employee Safety Page \(System\)](#)
[Event Reporting @ JCI](#)
[Joint Commission Center for Transforming Health Care @ @DeltaTech](#)

ASK SHOW SAFETY AND QUALITY

Type your question



- SPECTRUM HEALTH 
- ## Safety Culture Journey Cont.
- May 2017 requested a reassessment of safety culture by HPI
 - Just completed bi-annual safety culture survey July 2017.
 - 82% response rate from hospital and provider offices.
 - Zero harm is truly our goal
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