# Strategy Group #1 Making Care Safer by Reducing the Harm Caused in the Delivery of Care

### 2024 Education:

- > Facilitated Discussions around:
  - ➤ Increasing event reporting
  - ➤ Workplace Violence
- ➤ Best Practice Sharing around:
  - Readmissions MyMichigan
  - Front Line Education MyMichigan
  - Sepsis Michigan Hospital Medicine Safety Consortium & Aspirus Health

Strategy Group #1 Making Care Safer by Reducing the Harm Caused in the Delivery of Care

## 2025 Education:

- Step 1: Assessment of MI CAH Priorities
- If your organization has not yet completed the survey, please do!



## What are the top patient and safety goals for your organization, in 2025?

- Themes:
- Falls
- Sepsis
- Readmissions
- Glucose Management (severe hypo and hyper glycemia)
- HF Mortality
- Medication Safety (barcode scanning included)
- HAPIs Stage 2 or greater events
- Reinvigorate Safety Culture training and education
- Implement tracking system for quality metrics and associated dollars
- Accelerate performance for success in value-based contracts
- Patient Experience- Responsiveness of Staff and Emergency Likely to Recommend
- Age Specific Populations (age 65 and older), the new CMS

#### measure

- PFAC
- Bloodborne exposures
- Moderate Sedation Compliance
- Hospital Commitment to Health Equity
- 3-hour bundle
- Workplace Safety
- Procedure time outs
- Mortality
- SDOH tracking.
- Hand Hygiene

# What would you identify as a patient safety and/or quality improvement best practice implemented by your organization in the last year?

- > Use of Predictive Model for Falls in EPIC
- > Surgery checklist proving invaluable to OR team
- Multidisciplinary rounding
- > Just in time audits for sepsis and face-to-face coaching if needed.
- Transparent and keeping the quality metrics in front of the teams for their engagement/ownership.
- Falls- implementation of TIPS program in 12/2024.
- > "Improved sepsis care by re-initiating, updating, and monitoring sepsis protocol."
- ➤ Re-implementation of two RN verifications of pediatric patient medications (begins in the ED)
- American Heart Association get with the guidelines initiatives. We are working on submitting data towards achieving Bronze status for 2024.



## What would you identify as a patient safety and/or quality improvement best practice implemented by your organization in the last year?

- Ø PICC/Midline use, Success Cause Analysis
- As follow up to the PRA for the surgery team, we implemented a consent checklist that is completed for every patient. It communicates/tracks/and reports near misses caught by the staff prior to surgery with the preop workflow. The info on the sheet is used in real time for inter communication within the team, and the updated findings are reported to the surgical office staff managers for quality improvement and info sharing.
- Ø Fall-TIPS fall reduction initiative.
- Ø Improving Communication About Medication experience scores with patient education tool.
- Ø Reduction of unassisted falls and or HAPIs by implementing basic prevention checks into daily practice.
- Ø Only focusing on 2-3 priority items per unit at a time for improvement. With accomplishing improvement goal, move next item.
- Ø We began a sepsis initiative. All sepsis cases were reviewed to ensure sepsis was identified, each ED physician and hospitalist was provided a "report card" type document showing their scores and fallouts. This was also discussed in each of the committees monthly.



## What did your most recent Culture of Safety Survey show? What is your organization working on?

- ➤ Safety Event sharing
- ➤ Communication hand-off
- ➤ Psychological Safety
- Change Willingness
- Continued work to support improved transitions of care and discharge planning to reduce readmissions
- Expanding visualization and communication of our outstanding quality scores on a video monitor in high-traffic areas.

- Implement 1:1 meetings with staff that focus on respect and retention.
- ➤ Burnout and Teamwork
- >Employee engagement
- Follow up to safety reporting
- ➤ SDOH and patient equity
- > Falls protocol
- >Improving medication administration

