Community Health Systems Takes a Scientific Approach to Improving Patient Safety

By Audrey Doyle

At Tennessee-based Community Health Systems, safety is not an art. “It’s a science that requires consistently practicing proven safety behaviors and measuring and monitoring serious safety events in a structured, highly reliable way,” said Dr. Lynn T. Simon, the organization’s president of clinical services and chief quality officer. “By taking a scientific approach to safety, we’re able to accurately track our safety events, determine their causes, change our procedures to prevent their recurrence and measure and monitor our improvement.”

Assisting CHS in this effort is HPI/Press Ganey, whose methods are based on reliability science—an understanding of human performance in complex systems and the application of this understanding to organizational culture and design. Working in collaboration with HPI/Press Ganey, CHS and its affiliated hospitals have adopted a culture and processes that support High Reliability—and as a result, its legacy hospitals (those that joined the organization prior to 2014) have reduced their Serious Safety Event Rate (SSER) through Q3 2016 by 79.9% from their 2013 baseline.

In an organization as big as CHS, which comprises more than 150 hospitals in 22 states and approximately 27,000 licensed beds, this is an impressive accomplishment. “We’re very pleased that we’ve been able to achieve such a substantial SSER reduction so quickly,” said Dr. Simon. “[Our outcomes] demonstrate the positive effect that the science of safety can have on a large, multihospital health system.”

Consistency Is Key to Success

Headquartered in Franklin, Tenn., CHS was founded in 1985 with its first hospital purchase, and has grown exponentially since that time, with major acquisitions including those of Triad Hospitals, Inc., and Health Management Associates, Inc. Safety had always been an important priority at CHS-affiliated hospitals, but as the organization grew, the need for a standardized approach to safety emerged.

“All of our hospitals were already implementing safety procedures,” explained Dr. Simon. “We wanted to give them a way to practice safety behaviors that was consistent across the organization, and we wanted an accurate and reliable way to measure our progress so that we didn’t just think we had improved the organization’s ability to deliver safe, high-quality care, we could see and show that improvement.”

CHS began its journey toward a standardized approach to safety in 2010, when it started heading down the “parallel paths of developing a Patient Safety Organization, or PSO, and working with HPI/Press Ganey,” said Dr. Simon.

In 2012, CHS PSO, LLC, a component PSO of CHS/Community Health Systems Inc., became a federally listed PSO so that it would be able to provide a secure and confidential environment in which safety data from all of CHS’s affiliated hospitals could be collected, aggregated and analyzed to identify and reduce or eliminate the risks and hazards associated with patient care.

Shortly after forming the PSO, the organization began working with HPI/Press Ganey. “We started collaborating with them because of their safety expertise,” said Terrie Van Buren, CHS PSO’s senior director of patient safety and patient safety officer. “They’ve taken reliability principles used in high-risk environments, like nuclear power and aerospace, and applied them to

AT A GLANCE

- Community Health Systems, a Tennessee-based organization comprising more than 150 hospitals in 22 states, has built a High Reliability safety culture by adopting a standardized approach to practicing safety behaviors.
- In addition to developing a Patient Safety Organization, CHS uses strategies and tactics based on reliability science to improve patient safety and accurately and reliably measure its progress.
- CHS’s standardized approach to safety has helped its legacy hospitals reduce their Serious Safety Event Rate by 79.9% from their 2013 baseline.
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health care. So we knew they could guide us in adopting a High Reliability culture and give us evidence-based tools that would help us improve patient safety and engage our leaders and employees in that effort.”

At the time, CHS already had in place an established initiative called Community Cares that provided a standardized approach to advancing patient engagement and the patient experience systemwide. Rather than adding a separate initiative focusing on High Reliability and safety, CHS used Community Cares as the foundation for its safety work with HPI/Press Ganey. On top of that foundation, CHS layered a number of techniques and tools centered on safety.

Some of these techniques and tools existed as part of Community Cares, but were recast with a focus on safety. For example, the nursing staff at CHS-affiliated hospitals were already rounding on patients hourly with an eye toward advancing patient engagement and the patient experience. “But because hourly rounding can prevent falls, it also sends a pretty compelling safety message,” said Dr. Simon. “So we altered the dynamic of our rounding message from ‘you need to do hourly rounding because it’s a patient satisfaction technique’ to ‘you need to do hourly rounding because it’s a patient safety technique.’”

Likewise, hospital leaders were already learning about issues surrounding patient engagement and patient experience through the organization’s Leadership Development Institute (LDI), a series of hour-long videos broadcast quarterly to the leadership team in each CHS-affiliated hospital. Recognizing that the LDIs also could be used to communicate to and engage hospital leaders in the topic of safety, CHS now begins each LDI with a safety message from the health system’s chair and CEO, Wayne Smith, and includes updates, activities and other topics focusing on safety and High Reliability. Each leader then works with their facility to implement the safety tools and processes that were discussed in the LDIs.

The safety tools and processes being highlighted in the LDIs include putting safety first on every meeting agenda; rewarding and recognizing departments and staff members for safety successes; creating an atmosphere of trust by protecting those who speak up when they see a possible lapse in safety; facilitating a nonpunitive culture for unintended errors or mistakes; and ensuring that there are fair consequences for intended decisions to act against hospital safety rules.

“Leaders also participate in daily safety huddles where they talk about what they need to be aware of to keep patients safe that day, any events that have occurred in the past 24 hours and any prior safety issues they need to follow up on,” said Dr. Simon. “All of these leadership methods have been very effective in building a culture of safety.”

Meanwhile, leaders as well as staff members are taught the safety behaviors and error prevention tools of Support the Team; Speak Up for Safety Using Validate and Verify and ARCC (Ask a question; Request a change; voice a Concern; invoke the Chain of command); Self-Check Using STAR (Stop, Think, Act, Review); and Communicate Effectively Using SBAR (Situation, Background, Assessment, Recommendation). The training recurs every year, to make the use of safety behaviors and error prevention tools a habit among leaders and staff. “Because the message, training and education are consistent, safety has become expected or customary as opposed to ‘the new initiative for the year’ or ‘just another thing we have to do,’” Dr. Simon said.

To further ensure that the use of these behaviors and tools remains habitual, the organization provides additional reinforcement through a Safety Coaches program and a High Reliability Physician Mentors program.

Safety coaches are hospital staff members who volunteer to support their peers by recognizing through positive reinforcement when they use safety behaviors and error prevention tools in the course of care delivery, and coaching them when they appear to need guidance in the use of those behaviors and tools. High Reliability physician mentors are physicians who have been selected by their hospital’s leadership to train and engage the hospital’s medical staff in reliability and safety, as well as to check their progress, provide feedback on challenges and successes, and participate in open discussions.

There are multiple safety coaches and at least one physician mentor in each hospital, and all of them were chosen because they have a passion for safety, Dr. Simon said, adding, “That passion is at the core of these coaching and mentoring programs and it’s what makes the programs so successful in helping to improve safety throughout the organization.”

Safety Simulations and Structured Root Cause Analyses

To reinforce the safety culture, the organization has begun using safety simulations, according to Dr. Simon.

Last fall, prior to opening some new operating rooms, the OR staff at a hospital in Alabama performed a simulated surgery, using a mannequin to represent the patient, to ensure optimal placement of the OR supplies and equipment, familiarity with the new OR workspace and readiness for responding to emergencies. The process provided the OR staff with insight into what might not work well, potentially preventing future patient safety issues from occurring during actual surgeries in their new ORs.
This year, the hospital plans to simulate a scenario designed to teach staff how to detect and treat sepsis in emergency room patients. Moving forward, there are plans to develop additional simulations on an ongoing basis. “Engaging people in real-life simulations will assist us in making sure environments are safe and our people know how to work safely within those environments,” said Dr. Simon.

Also contributing to improved safety is CHS PSO’s use of root cause analyses (RCAs) in the wake of patient safety events to better understand why the events occurred and how to prevent them from recurring. According to Van Buren, CHS PSO follows HPI/Press Ganey’s three-meeting RCA model, which provides structure to the RCA process.

The meetings are led by the organization’s quality and risk management analysts and involve detailed discussions with individuals who were involved in or present at the event. The first meeting is held a day or two after an event occurs and is dedicated to understanding what happened. The second meeting is devoted to determining why the event happened. During the third meeting, the hospital team identifies changes that can be made to existing systems or processes to keep the event from happening again, and then recommends a detailed action plan. CHS PSO shares anonymized lessons learned from the RCAs with other members of the PSO through patient safety alerts.

According to Van Buren, because the RCA process is so structured, the team is able to identify the specific reason or cause of the event, “whether it’s that there wasn’t a good system or protocol in place, or a good system or protocol was in place but people weren’t following it and, more importantly, why they weren’t following it,” she said. “If you don’t do an RCA in an organized, standardized way, your results will be highly variable and not reliable.”

“We share tools, resources, best practices and protocols that are evidence-based, are nationally recognized and have worked for other facilities, and then follow their safety event data over the course of a year or two to see whether they improve,” continued Dr. Simon. “Also, mentor hospitals that have done well in those areas will coach these facilities on what they did to improve. There’s always someone doing something great somewhere and this is an effective way to spread that knowledge.”

According to Dr. Simon, CHS plans to continue to view the delivery of safety as a science. “By doing this, we’ve achieved an almost 80% reduction in our SSER among our legacy hospitals. Practicing safety behaviors and measuring and monitoring safety events in a structured way is a necessity in an organization of our size and will help us achieve our goal of Zero Harm.”