System Change Reports

Eileen Kasda, DrPH, MHS
Assistant Director, Patient Safety Analytics
Redonda Miller
President of The Johns Hopkins Hospital

“Throughout my career at Johns Hopkins, I have served in many roles, including Vice Chair for Clinical Operations, Vice President for Medical Affairs, and since July 2016, as President of The Johns Hopkins Hospital. In each of these roles, one of my areas of responsibility has been patient safety. Consequently, I have had the opportunity over many years to work closely with our Medication Safety Officers (MSOs). With this collaboration, I have always been impressed by their specialized understanding of the medication-use system and the many medication-related error mechanisms encountered in our complex hospital environment. Their ability to use this knowledge to implement system changes across many disciplines has led to improved patient safety throughout our institution. While it is not possible to calculate the savings associated with their efforts, I have no doubt that our MSOs are a cost effective and valuable asset, and without them, our ongoing patient safety efforts would be at a disadvantage.”

(ISMP White Paper: Case for Medication Safety Officers)
Event Reporting System

MANAGEMENT

SAFETY MANAGEMENT

BLACK HOLE

NO FEEDBACK
Why Have a System Change Report

- Debunk the black hole myth with frontline staff
- Learning from HROs, provide transparency into improvement efforts is part of an important enabling infrastructure
- Systems are flawed and constantly changing
- Identifying and correcting system flaws is an ongoing effort
- Tool to educate senior leadership about your efforts
The Signal

Bi-monthly “newsletter” designed to:

• Dispel the event reporting “black hole” myth by sharing deep dives and quality improvement project successes

• Support a learning environment across the health system by sharing systems changes and lessons learned that historically only lived in local infrastructures
Collection and Dissemination

- Sent to CUSP facilitators and HERO reporting leads across the health system via e-mail
- Posted on event reporting website, accessible to all HERO reviewing managers
**Systems Change Reports**

**Johns Hopkins Health System**

**Systems Change Report**

<table>
<thead>
<tr>
<th>Locations Impacted</th>
<th>What We Heard</th>
<th>What We Did</th>
<th>Error Proofing Strategies</th>
</tr>
</thead>
<tbody>
<tr>
<td>JHHS – Johns Hopkins Health System</td>
<td>JHACH – Johns Hopkins All Children’s Hospital</td>
<td>Error Proofing Strategies: These are categories of actions taken which prevent or diminish the frequency of an event (&quot;What We Heard&quot;) from reoccurring. Forcing Function: Eliminates the opportunity for harm. Example: Tubing/fittings that can only be physically connected the right way. Simplify: Removes unnecessary steps or materials. Example: Eliminating non-value added and/or distracting labeling. Standardize: Maintains and institutionalizes organization and orderliness. Example: Organizing crash cart tools the same way in every cart. Redundancies: Incorporates duplicate steps to force additional checks in the system. Example: Using both brand and generic names when communicating medication information. Checklist/Memory Aides: Using visual/audible cues to make important information readily available. Example: Following a urinary catheter insertion checklist to prevent CAUTIs. Double Checks: Having a second person review for accuracy. Example: Requiring multiple staff to confirm the correct site for a paravertebral block. Warnings: Reminding a person they are not following the correct protocol. Example: Letting a clinician know they did not wash their hands appropriately. Training: Demonstrating the correct process/usage. Example: Showing a new employee the correct way to properly sterilize surgical instruments.</td>
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<td>JHH – Johns Hopkins Hospital</td>
<td>HCGH – Howard County General Hospital</td>
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<td>JHCP – Johns Hopkins Community Physicians</td>
<td>Sibley – Sibley Memorial Hospital</td>
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<td>JHHC – Johns Hopkins Home Care</td>
<td>Suburban – Suburban Hospital</td>
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<td>JHBMC – Johns Hopkins Bayview Medical Center</td>
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</tbody>
</table>

**Location(s) Impacted and Responsible Teams**

- JHHS
- JHH
- JHCP
- JHHC
- JHBMC

**Responsible Team/Committee**

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Lessons Learned

• Keep it simple and clear through the use of standardized template
• Consider the audience for your system change reports
• Don’t include changes that haven’t been implemented as they may never be implemented and will decrease credibility
• More changes isn’t necessarily better, be careful what you incentivize and make substantive changes
• Avoid using jargon that may make sense at the sharp end but not to a senior leader and vice versa
• To support peer review privileged protections, partner with legal on plan for report design and dissemination
• Collect feedback about the usefulness of the report and iterate
Challenges

- Different interpretations on what meets criteria for a system change
- Different perceptions on the error proofing strategies used
- Striving for higher-level system changes is hard work
- Dissemination due to peer review privileged information
- Quantifying the value and impact of changes implemented
“Safety Lives In System Changes”
~E. Robert Feroli
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