TMIT National Research Test Bed High Performer Webinar SafetyLeaders.org

Welcome to

Learn from Mortality Review AND the Living

Part 2 – A Deeper Dive

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Welcome

Charles Denham, MD

Chairman, TMIT

TMIT High Performer Webinar
August 18, 2016

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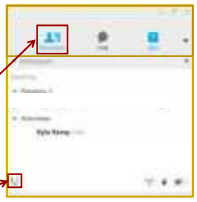

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Also, go to: www.facebook.com/SafetyLeaders and related sites

TMIT Purpose Statement

Our Purpose:
We will measure our success by how we protect and enrich the lives of families…patients AND caregivers.

Our Mission:
To accelerate performance solutions that save lives, save money, and create value in the communities we serve and ventures we undertake.

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Disclosure Statement

The following panelists certify:
that unless otherwise noted below, each presenter provided full disclosure information; does not intend to discuss an unapproved/investigative use of a commercial product/device; and has no significant financial relationship(s) to disclose. If unapproved uses of products are discussed, presenters are expected to disclose this to participants.

Jeanne M. Huddleston, MD, FACP, FHM, is a past President of the Society of Hospital Medicine, the founder of Hospital Medicine and past Program Director of the Hospital Medicine Fellowship at Mayo Clinic, Rochester, MN. She is Chairperson of Mayo Clinic's Mortality Review Subcommittee, a multi-disciplinary group of providers that review every death in search of where the health care delivery system may have failed the providers and/or the patient. She has nothing to disclose.

Dan Ford, MBA, is a patient/patient safety advocate; retired Vice President of Furst Group, a healthcare executive search firm; nationally known speaker on patient safety, has served and is serving on a number of national and regional patient safety and quality, PFE and PFAC boards/committees, serves as a patient/family advisor on LEAN process improvement events at Spectrum Health, and is a writer on patient safety and leadership. He has nothing to disclose.

Jennifer Dingman realized, after her mother's death in 1995 due to errors in medical diagnoses and treatment, that there is little to no help available for patients and their families in similar situations. This life-changing experience left her feeling vulnerable, and she decided to dedicate her life to help prevent medical tragedies from happening to others. She has nothing to disclose.

Charles Denham, MD, is the Chairman of TMIT; a former TMIT education grantee of CareFusion and AORN with co-production by Discovery Channel for *Chasing Zero* documentary and Toolbox including models; and an education grantee of GE with co-production by Discovery Channel for *Surfing the Healthcare Tsunami* documentary and Toolbox, including models. HCC is a former contractor for GE and CareFusion, and a former contractor with Siemens and Nanosonics, which produces a sterilization device, Trophon. HCC is a former contractor with Senior Care Centers. HCC is a former contractor for ByoPlanet, a producer of sanitation devices for multiple industries. Dr. Denham is a collaborator with Professor Christensen.

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Speakers and Reactors


Jeanne Huddleston


Dan Ford


Jennifer Dingman


Charles Denham

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Voice of the Patient and Family

Dan Ford

Retired Vice President, Furst Group (Rockford, IL, healthcare executive search)
Spectrum Health EPFAC (Grand Rapids, MI)
Michigan Hospital Association Keystone Center PFE Advisory Committee
TMIT Patient Advocate Team Member
Patient Safety Advocate
Rockford, Michigan

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In the News and Polling Highlights:

News Update for August and July 2016 Webinar Polling

Charles Denham, MD

Chairman, TMIT

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Disclosure of Medical Error

JAMA

August 16, 2016

Disclosure of Medical Error

Wendy Levinson, MD; Jensen Yeung, MD; Shiphra Ginsburg, MD

Bottom Line

1. When errors occur, the patient should be told about the error and an apology provided. Information about errors should never be withheld from patients.
2. All personnel involved should participate in the review of the error and in solving any systems problems that contributed to the occurrence of the error.
3. Contact the institution's quality assurance department, risk management group, and/or malpractice carrier to inform them of the error.

Source: Levinson W MD, Young J MD, et al. Disclosure of Medical Error. JAMA. 2016 Aug 16.

Vital Signs Are Still Vital: Instability on Discharge and the Risk of Post-Discharge Adverse Outcomes

JGIM

August 8, 2016

Vital Signs Are Still Vital: Instability on Discharge and the Risk of Post-Discharge Adverse Outcomes

Twenty percent of people hospitalized are released before all vital signs are stable, a pattern that is associated with an increased risk of death and hospital readmission, a new study from the University of Texas Southwestern Medical Center shows. The findings were published in the *Journal of General Internal Medicine.*

32,835 patients at six Dallas–Fort Worth area hospitals

"We found that nearly one in five hospitalized adults is discharged with one or more vital sign instabilities, such as an elevated heart rate or low blood pressure,"....

... "patients who had vital sign abnormalities on the day of discharge had higher rates of hospital readmission and death within 30 days..."

Source: Nguyen OK MD MAS, Makam AN MD MAS, et al. Vital Signs Are Still Vital: Instability on Discharge and the Risk of Post-Discharge Adverse Outcomes. JGIM, 2016 Aug 8.

Best Practices: Addressing errors with Candor

Best Practices: Addressing Errors with Candor

Backed by the Agency for Healthcare Research and Quality, CANDOR, is short for Communication AND Optimal Resolution.

Modern Healthcare

August 13, 2016

"If we can't be open and honest about these events, we're never going to learn from them and be able to fix our processes and systems," said Dr. David Mayer, vice president for quality and safety at MedStar Health, eight of whose 10 hospitals, located in the Baltimore-Washington area, participated in a pilot program for the Candor toolkit.

Source: Whitman E. Best Practices: Addressing errors with Candor. Modern Healthcare, 2016 Aug 13.

The Next Wave of Hospital Innovation to Make Patients Safer

Harvard Business Review

August 8, 2016

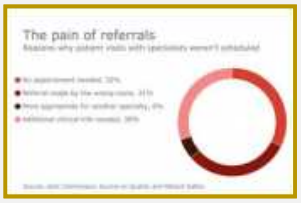
The Next Wave of Hospital Innovation to Make Patients Safer

Source: Ghaferi, AA, Myers, CG, et al. The Next Wave of Hospital Innovation to Make Patients Safer. Harvard Business Review, 2016 Aug 8.

Minding the Gaps: Assessing Communication Outcomes of Electronic Preconsultation Exchange

August 2016

Minding the Gaps: Assessing Communication Outcomes of Electronic Preconsultation Exchange



"Historically, especially in the pre-EHR era, primary care physicians referred patients to specialty providers by filling out a piece of paper and faxing it somewhere. It was in no way closed-loop communication, so you never knew what happened with a referral," says Erika Leemann Price, MD, hospitalist at San Francisco Veterans Affairs Medical Center and primary author of the study.

"As demand for electronic consultation and referral platforms increases, it is vital that close attention be paid to these aspects of pre-consultation exchange to optimize patient safety."

Source: Price EL MD, Sewell JL MD MPH, et al. Minding the Gaps: Assessing Communication Outcomes of Electronic Preconsultation Exchange. The Joint Commission, 2016 Aug.

Headline-Grabbing Study Brings Attention Back to Medical Errors

August 16, 2016

Headline-Grabbing Study Brings Attention Back to Medical Errors

To make systemwide progress, leaders will have to establish and sustain a culture of safety in the face of a dizzying array of competing priorities—mergers, bundled payments, and costcutting among them.

Inconsistent attention to the problem by hospital executives, clinical leaders, and boards of trustees is one big impediment to preventing medical injury today, Berwick said. "This is going to have to become and remain a strategic imperative over time, endlessly forever," he added. "It's not something you can take your eye off."

The study by Makary and Daniel served to bring much needed public attention back to medical errors, Wachter said. "There may be some effort in rebalancing the priorities and making sure that medical mistakes and patient safety have as high a priority as they deserve."

Source: Abbasi J. Headline Grabbing Study Brings Attention Back to Medical Errors. JAMA. 2016 Aug 16.

Patient Safety Harm: 3rd Leading Cause of Death?

ANALYSIS

Medical error—the third leading cause of death in the US

Medical error is not included on death certificates or in rankings of cause of death. **Martin Makary** and **Michael Daniel** assess its contribution to mortality and call for better reporting

Martin A Makary *professor*, Michael Daniel *research fellow*

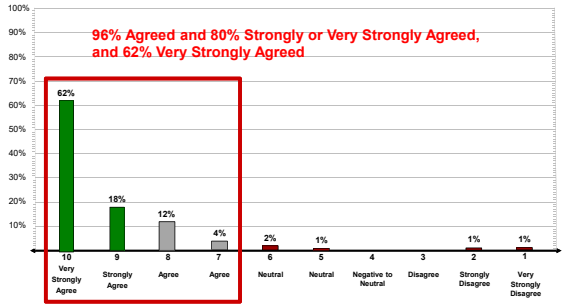
Source: BMJ. 2016 May 3;353:i2139. doi: 10.1136/bmj.i2139.
Medical error-the third leading cause of death in the US. Makary and Daniel

Patient Safety Harm: 3rd Leading Cause of Death?

Source: BMJ. 2016 May 3;353:i2139. doi: 10.1136/bmj.i2139.
Medical error-the third leading cause of death in the US. Makary and Daniel

Anonymous Polling Questions

I would like a consolidated review of patient safety harms of inpatient and outpatient studies in order to understand "leading causes of death numbers".



Source: TMIT High Performer Webinar Series; Learn from Mortality Review AND the Living: Next Generation Safety Learning System– July 21, 2016

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Learn from Mortality Review AND the Living: Next Generation Safety Learning System Part 1

Jeanne M. Huddleston, MD, FACP, FHM

Hospitalist
Chairperson of Mortality Review Subcommittee
Mayo Clinic
Rochester, MN

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July 21, 2016

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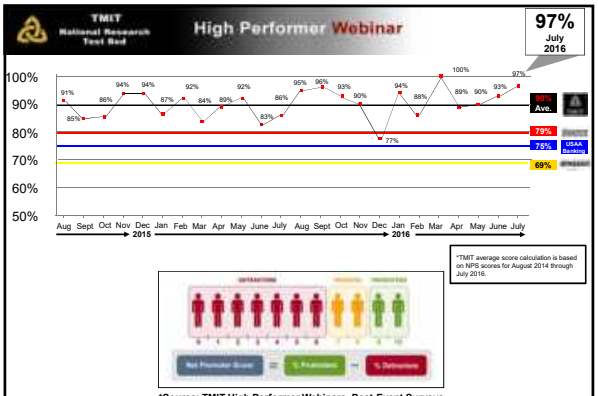
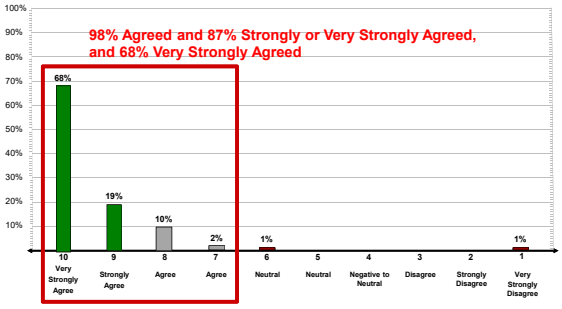


*Source: TMIT High Performer Webinars, Post-Event Surveys

*Statametrix. Net Promoter 2015 U.S. Benchmark Charts. Vers 1. March, 2017. US Data. Available at: http://www.satmetrix.com/in-the-news/costco-

Anonymous Polling Questions

I am interested in DEEP DIVE webinars on Mortality Reviews and Safety Learning Systems



Source: TMIT High Performer Webinar Series; Learn from Mortality Review AND the Living: Next Generation Safety Learning System– July 21, 2016

The topics in Learning from Mortality Reviews I would like covered in future are:

- Are there trigger points that happen before a patient expires
- blood transfusion related mortalities.
- c. diff
- Cardiac related
- Cardiothoracic surgery mortalities blood transfusion related mortalities.
- case example.
- communication
- communication between all departments. Care of patient on Friday, Saturdays and Sundays vs the rest of the week. Respect of physician for nurses opinions.
- Delays in consulting and consulting responsiveness. Fragmented communications among specialists
- developing data for actionable changes
- Different case studies
- Do your patients become DNR's on the day of death? Is that common?
- Early Warning/Notification Systems; Basic or Preventable Errors that lead to patient deaths most often; Research Studies for applying lessons learned from mortality reviews to optimize QI/PI;
- ED mortalities
- Emotionally Difficult patients & family
- end of life pain; opioid overdose- pain protocols
- engaging physicians/nurses in review, process of forming review
- Example of preventive action taken and the resulting outcome chages
- failure to recognize issues and solutions
- Failure to Rescue
- failure to rescue
- Failure to rescue--how to increase awareness
- Focus on the omissions - how to identify them during the review.
- From review to action, sustainability
- Helping staff to deal with errors and patient deaths.
- Honestly--I thought this was a webinar about how to live longer :)
- Hospital acquired infections; c Dif
- How do you disseminate findings to physicians?
- How to conduct the review; how do you get physician engagement?
- How to disseminate info learned to coworkers
- how to exclude comfort care patients who come in and change coded to DNR/DNI?
- How to get a better grip on expected vs observed deaths especially with patients who are transitioned to end of life/palliative care after they were initially assessed and fell into the unexpected bucket.
- "How to identify omissions (not generally in the patient record). "
- How to obtain buy in from major share holders for a more change centered mortality review, as opposed to a number focused mortality review

Source: TMIT High Performer Webinar Series; Learn from Mortality Review AND the Living: Next Generation Safety Learning System– July 21, 2016

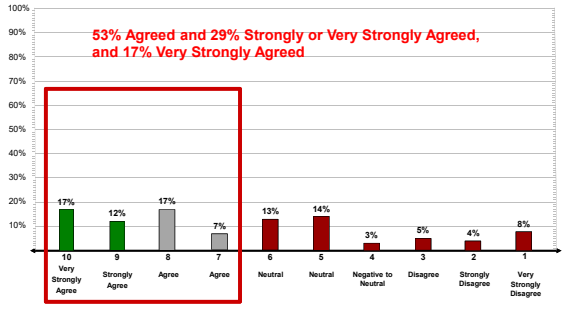
The topics in Learning from Mortality Reviews I would like covered in future are:

- How to recruit physicians, residents and mid-levels to participate in the mortality review process. Everyone is so busy in our organization, it's really challenging to get these clinicians involved and get face time with them (although desperately needed).
- Identifying coding inaccuracies
- Implantation of a no blame approach vs opportunity to improve
- Integrating processes for larger health systems with multiple hospitals
- Logistics of mortality review in smaller community hospitals, challenges with smaller, close medical staff
- Medication errors
- Medication errors
- Missed/misdiagnosis diagnosis
- More about committee structure, activity, etc; criteria or guidelines used if any for case reviews,
- More infections/rare as well
- More info from leaders in mortality review and patient safety.
- N/a
- Omissions
- Once again recognizing sepsis early in patients.
- Opioid overdose, transporting DNR patients to a higher acuity facility, using bipap in DNR patients.
- Peer review and mortality issues found- how to best affect peer review
- Post op respiratory failure
- RCA approach should use the same principles and glad that is being used here- makes sense
- Reporting on the issues identified, presentation methods to clinicians of the issues, action plans to prevent recurrence
- Review matrix development - guide the reviewers through a comprehensive case review and ensure standardized review of care provided.
- Same info with deep dive, forms used.....
- Second victim programs
- Sepsis
- Sepsis
- Sepsis
- Sepsis cases
- Sepsis identification & management
- Sepsis, AMI,
- Specific data collection examples
- Step by step process of setting up an effective mortality review process.
- Surgical complications - punctures, tears, etc.
- Tools used for mortality reviews
- Top issues and what was done to prevent them
- Translating data to action
- Unintentional surgical errors
- Where should we start our focus to improve our mortality review process.

Source: TMIT High Performer Webinar Series; Learn from Mortality Review AND the Living: Next Generation Safety Learning System– July 21, 2016

Anonymous Polling Questions

Would your hospital be interested in participating in a 100-case safety learning system collaborative



Source: TMIT High Performer Webinar Series; Learn from Mortality Review AND the Living: Next Generation Safety Learning System– July 21, 2016

All Cause Threat and Harm: To those who serve and those we serve

Those WHO serve: Our Caregivers and Staff

Those WE serve: Patients and their Families

The topics regarding ALL CAUSE THREATS and HARMS at hospitals are:

- Active shooter, bombing, robbery
- AHRQ patient safety indicators (especially 12 and 15) VTE prophylaxis and treatment, post op respiratory failure, palliative care and hospice care, hospital acquired infections, readmissions.
- Anti-Coagulation medications that are difficult to reverse
- CLABSI prevention, medical marijuana use
- Communication between disciplines
- Communication between nurse and physician concerning patient care. Delay in care by physician.
- Communication/ hand offs
- Continuing to provide care for pts. (And analyze data) the same way it's always been done; change management is CRITICAL to patient safety & quality & performance improvements in 21st century medicine
- Create learning opportunities to learn and prevent preventable harm
- Cyber crime and cybersecurity
- Delayed or missed orders. Delayed diagnostic testing/imaging
- DNR
- Documentation and communication among healthcare team
- Drug events - opiate toxicity
- Drug overdoses and suicides are another increasing cause of death nationally, however not as easy to obtain this data.

Inpatient mortality data is more accessible as you'd mentioned.

- Failure to rescue
- Failure to rescue
- Failure to respond, staffing ratios r/t care
- Getting involvement and commitment from all involved in patient care
- Heroin addiction
- Hostile work environment
- How folks have taken this data and made it actionable and reaped benefits
- How to get started in these reviews with scare resources
- Improving communication between caregivers
- Management of kidney injury
- Med errors that threaten lives,
- Med reconciliation
- Medication errors
- Medication errors
- Medication reconciliation
- Missed and delayed diagnosisNarcotics
- New grads, too many steps to a process, communication among multiple depts.
- Not of interest to me.

Source: TMIT High Performer Webinar Series; Learn from Mortality Review AND the Living: Next Generation Safety Learning System– July 21, 2016

The topics regarding ALL CAUSE THREATS and HARMS at hospitals are:

- Nurse staffing levels, Physician's commitment to more than one facility, Communication failures.
- opioids use in the elderly
- OSA, sepsis (esp. because now we are over coding sepsis)
- Over Sedation -
- Over sedation, airway management
- Patient Safety Indicators
- patient violence towards staff, systems failures
- Pediatric Medication Errors
- pneumonia; AMI
- Pressure ulcers
- PSIs, especially PSI-04
- Remote telemetry;
- Retained foreign objects, pressure injuries in the OR,
- security in the hospital setting;
- Sepsis
- Sepsis, Med Events, competency
- Sepsis, pressure ulcers, falls
- sepsis, resp. failure, ADEs, high cost cases...
- Septic shock
- Severe Sepsis/Septic Shock and Recognizing they Symptoms
- timely recognition of acute condition
- Unintentional
- valuable learning - needed now
- very important in optimizing patient outcomes
- Workplace Violence

Source: TMIT High Performer Webinar Series; Learn from Mortality Review AND the Living: Next Generation Safety Learning System– July 21, 2016

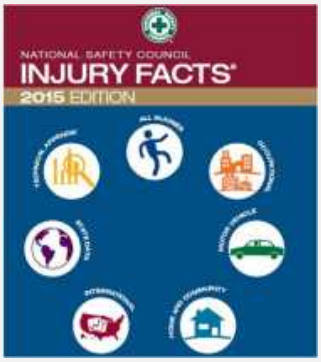
High Impact Care Hazards to Patients, Students, and Employees

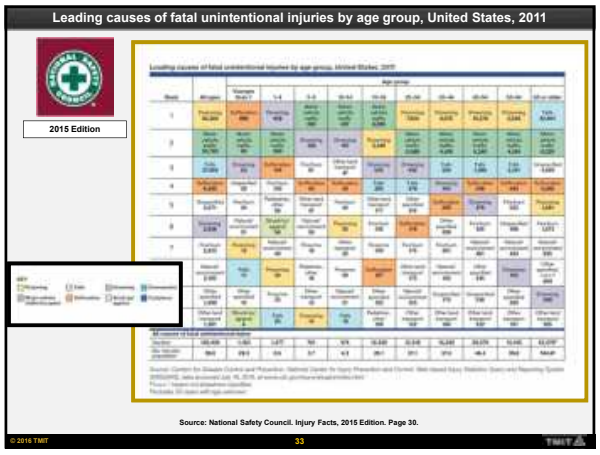
- Cardiac Arrest
- Choking and Drowning
- Opioid Overdose
- Anaphylaxis
- Active Shooter
- Non-trans Accidents
- Transportation Accidents
- Bullying

A Medical-Tactical Approach undertaken by clinical and non-clinical people can have enormous impact on loss of life and harm from very common hazards:

- **High Impact Care Hazards are frequent, severe, preventable, and measurable.**
- **Lifeline Behaviors undertaken by anyone can save lives.**

Injury Facts: National Safety Council:




Leading causes of fatal unintentional injuries by age group, United States, 2011
2015 Edition
Source: National Safety Council. Injury Facts, 2015 Edition. Page 30.
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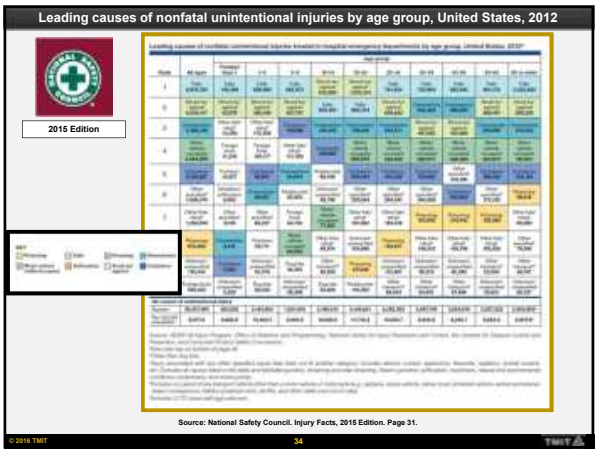
Leading causes of nonfatal unintentional injuries by age group, United States, 2012
2015 Edition
Source: National Safety Council. Injury Facts, 2015 Edition. Page 31.
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10 Leading Causes of Death by Age Group, United States - 2014
Age Groups
Rank
<1
1-4
5-9
10-14
15-24
25-34
35-44
45-54
55-64
65+
Total


10 Leading Causes of Injury Deaths by Age Group Highlighting
Unintentional Injury Deaths, United States - 2014
Age Groups
Rank
<1
1-4
5-9
10-14
15-24
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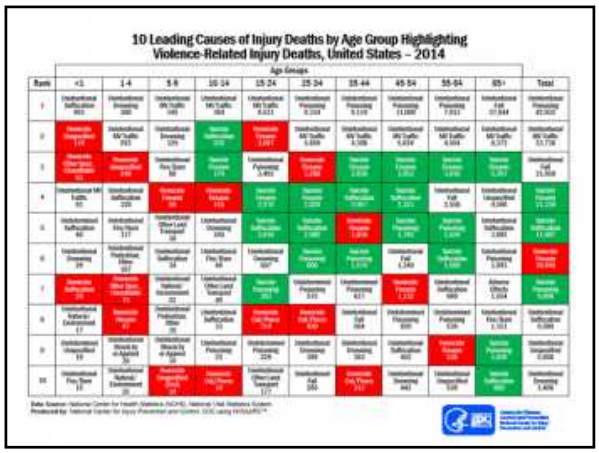
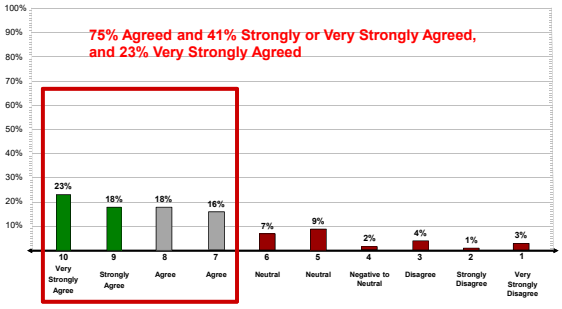
65+
Total



Anonymous Polling Questions

I am interested in DEEP DIVE webinars on the Med Tac Program topics.



Source: TMIT High Performer Webinar Series; Learn from Mortality Review AND the Living: Next Generation Safety Learning System– July 21, 2016

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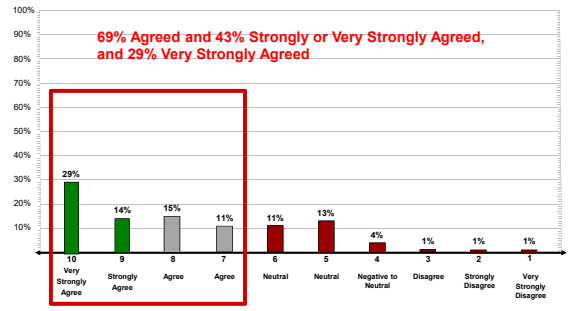
Anonymous Polling Questions

The recent events have stimulated interest in Active Shooter Readiness – we need briefings on best practices.



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CARE Huddle Concept: A Resource for Group Events (eg. Schools or Meetings)

CARE Huddle™

Critical Actions in Response to Emergencies

- ❑ Scene Safety
- ❑ Call 911
- ❑ Medical Response
  - ❑ CPR
  - ❑ Automatic External Defibrillator (AED)
  - ❑ Stop The Bleed Kit
  - ❑ EpiPen® Kit
  - ❑ Narcan® Kit
  - ❑ First Aid Kit
- ❑ Meet First Responders
- ❑ Find a Caregiver On-site
- ❑ Find the Parent

CARE Huddle™

C – Critical
A – Actions in
R – Response to
E – Emergencies

The CARE Huddle is a preparedness strategy.

It helps you assign life saving actions to participants at events.

It helps you execute critical actions to common emergencies.

Make sure everyone with an assignment knows what to do and has a copy of the CARE Huddle.

Hazards Assessment

- ❑ Location _____
- ❑ Time of Day _____
- ❑ Weather Conditions _____
- ❑ Facilities _____
- ❑ Access Routes _____
- ❑ Threats _____
- ❑ Injury Potential _____
- ❑ Known Hazards _____

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Emergency Code Harmonization:

STANDARDIZED CODES:

- RED for fire
- BLUE for adult medical emergency
- WHITE for pediatric medical emergency
- PINK for infant abduction
- PURPLE for child abduction
- YELLOW for bomb threat
- GRAY for a combative person
- SILVER for a person with a weapon and/or hostage situation
- ORANGE for a hazardous material spill/release
- TRIAGE INTERNAL for internal disaster
- TRIAGE EXTERNAL for external disaster

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Learn from Mortality Review AND the Living: Part 2 - A Deeper Dive

Jeanne M. Huddleston, MD, FACP, FHM

Hospitalist
Chairperson of Mortality Review Subcommittee
Mayo Clinic
Rochester, MN

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MAYO CLINIC

Learn from Mortality Review AND the Living: Part 2, a Deeper Dive

Jeanne M Huddleston, MD, MS
Associate Professor of Medicine
Chair, Morbidity & Mortality Council
Mayo Clinic, MN, USA

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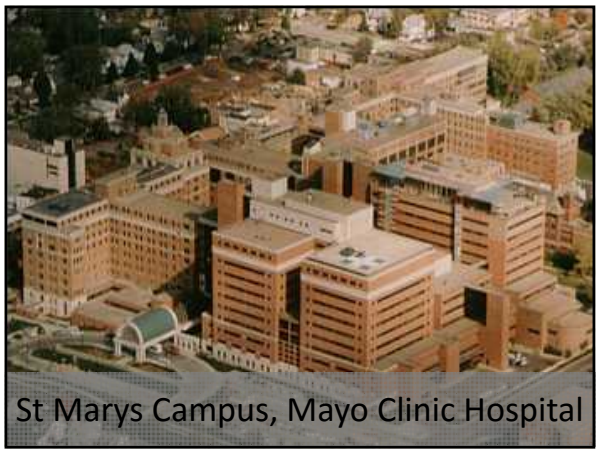
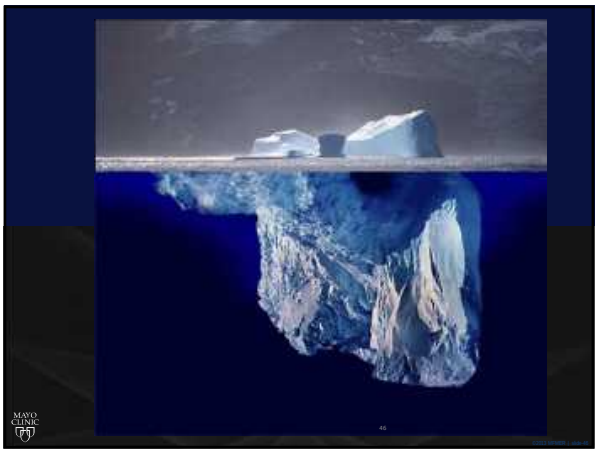
Agenda

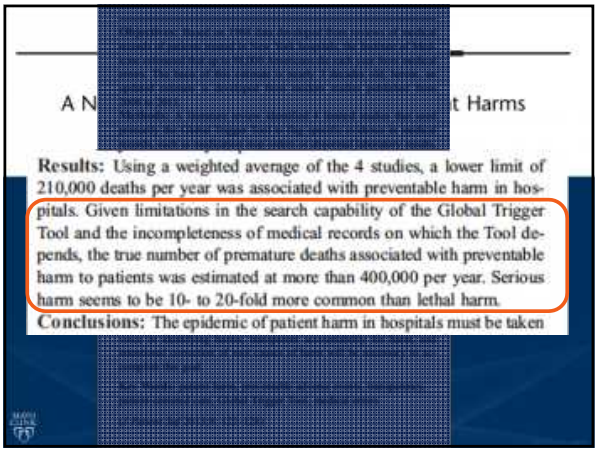
1. Mayo Clinic experience with Mortality Review
2. Step by Step
3. Case Studies
4. Safety Learning System Collaborative Invitation


St Marys Campus, Mayo Clinic Hospital



Original Charge from Hospital Leadership

1. To create a meaningful mechanism to review deaths at MCR hospitals:
   - Thoroughly understandable
   - Measurable
   - Improvable
2. To identify and quantify unanticipated deaths
3. To identify rate of adverse events in patients who die in MCR hospitals
4. To classify and quantify system level changes which will improve mortality rate.

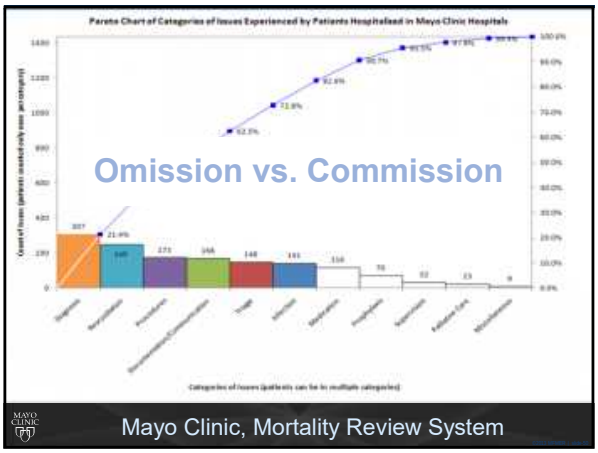

A N t Harms

Results: Using a weighted average of the 4 studies, a lower limit of 210,000 deaths per year was associated with preventable harm in hospitals. Given limitations in the search capability of the Global Trigger Tool and the incompleteness of medical records on which the Tool depends, the true number of premature deaths associated with preventable harm to patients was estimated at more than 400,000 per year. Serious harm seems to be 10- to 20-fold more common than lethal harm.

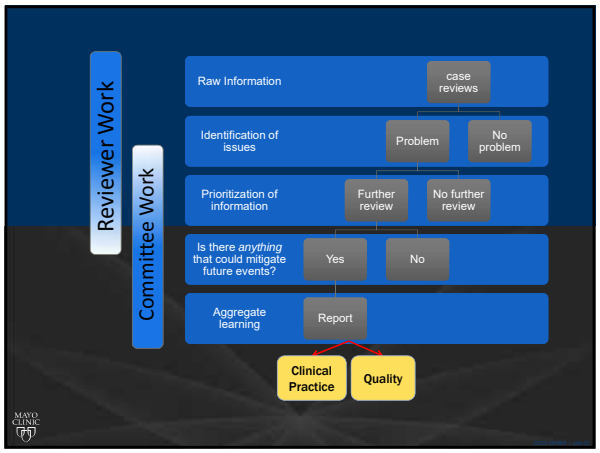
Conclusions: The epidemic of patient harm in hospitals must be taken

Guiding Principles: *Not Negotiable*

1. System review (not peer review)
2. Deference to expertise: Every case is reviewed by a practicing nurse and physician
3. All findings are recorded in the central registry
4. Multidisciplinary, multispecialty sessions used to build consensus re: findings
5. Implementation is local



Mayo Clinic, Mortality Review System



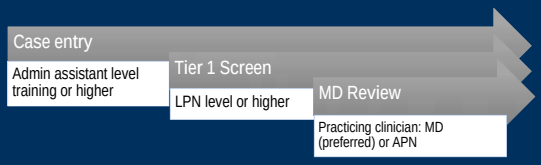
Step 1: Case Entry and Assignment

Case Entry

- Demographics
- Admission details
- Discharge details
- Clinical summary
  - Timeline
  - Copy/Paste DC summary

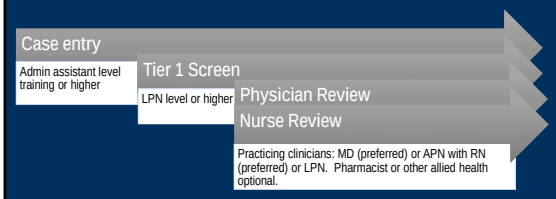
SLS Case Review Scenarios

Option #1: Screening for cases to be reviewed by a physician



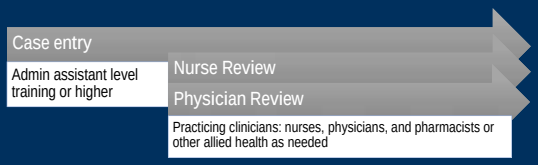
SLS Case Review Scenarios

Option #2: Screening for cases to be reviewed by physician and nurse



SLS Case Review Scenarios

Option #3: All cases assigned to nurse and physician for review



Step 2: Provider Reviews

Reviewer Characteristics

- Be a system thinker that supports transparency for system learning
- Be brutally honest and believe in 'tough love' for one's organization because we know it can be better
- Can review patients experience and where the system failed the patient rather than reviewing just peer's care
- Professionalism is critical. Reviewers are expected to maintain the confidence of the staff whose cases they review.

Reviewer Responsibilities

- Timely completion of assigned chart reviews of the patient journey & documentation in SLS
- Identify places where processes and systems have failed the patient and/or providers
- Participate in monthly review meetings to share expertise and assist in identifying issues affecting patient care, patient outcomes, and mortality rate.
- Remove personal blame – as the system and process of care failures can happen to any patient, and therefore, to any nurse or any provider.
- Support transparency for system learning across the organization

Principles of Identifying Opportunities

- NOT about preventability
  - Opportunity for improvement (OFI)
  - No opportunity for improvement
- NOT about causality
- NOT about attribution
- Did the care meet the standard of care at this institution?
- Would you have wanted your loved one to receive the same care?

Step 3: Reconciliation and Committee Prep

Reconciliation and Committee Prep

- Work done by those facilitating the case discussion
- Did the reviewers find the same thing or different things?
- Are the reviewers' descriptions clear?
  - If not, review case to fill in details

Step 4: Committee Case Discussions

SLS Multidisciplinary Team Principles

§ Operates under Chatham House Rule

> *When a meeting, or part thereof, is held under the* **Chatham House Rule**, *participants are free to use the information received, but neither the identity nor the affiliation of the speaker(s), nor that of any other participant, may be revealed.*

- Participants free to use all information available
- Identity of patient and providers may NOT be revealed
- Identity of persons discussing the case in committee may NOT be revealed

Step 5: Consensus Driven Classification of Opportunities for Improvement

59 year old female underwent TAH

POD #3 – AKI, urinary retention with new abdominal distension and pain

POD #4 – AKI worse, significant abdominal pain – narcotics stopped. Episode of PAF (130's)

POD #5 – hypotensive (70/45) with diaphoresis and nausea

RRT called but no blood pressure on their arrival

Code called with > 1hr of resuscitation efforts

On autopsy, abdomen filled with pus and a knick in the small bowel.

- Communication Issues
- Documentation Issues
- Delayed or missed diagnosis
- Treatment Issues
- Delayed rescue of deteriorating patient
- Procedural complication
- Palliation issues
- Triage or transition of care issues

82 year old male with severe COPD and pancreatic cancer was hospitalized for bowel obstruction.

Postoperative delirium
Postoperative respiratory failure
Pain meds held

Per nursing notes
- patient routinely called out in pain
- family members consistently asked that he be kept comfortable.

Average pain score was 8/10 in the 24 hours preceding death.

Patient was made comfort care only and died within hours.

- Communication Issues
- Documentation Issues
- Delayed or missed diagnosis
- Treatment Issues
- Delayed rescue of deteriorating patient
- Procedural complication
- Palliation issues
- Triage or transition of care issues

Step 6: Synthesis of all inputs into concise summary of patient's journey under your care

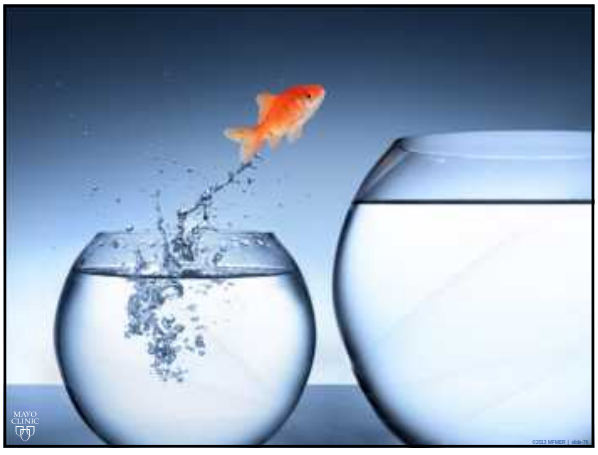
Example of Final Case Summary

"No one should ever suffer or die as a result of failures in our systems or processes of healthcare delivery."

MC Mortality Review Subcommittee, May 2007

Why are we spending so much time and effort on this?

What is it that we are really trying to accomplish?



~~Data~~

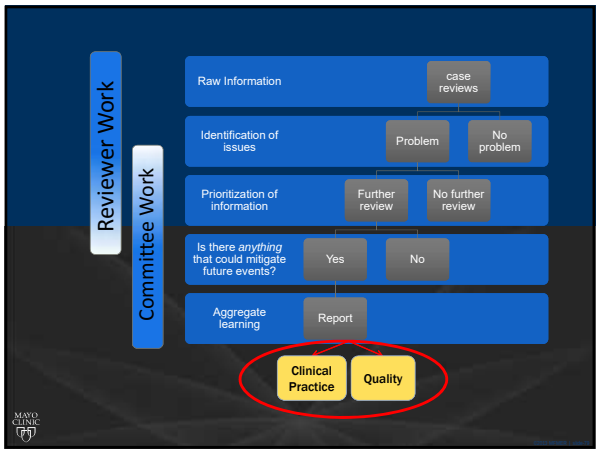
~~Stories~~

Data + Stories =

Actionable Information

Organizational Structure

MCR Quality Dept	CPQOS	
Mortality Structure	MORT	M&M Council
Activity that leads to "actionable information"	Review oversight and Monthly case discussion committee	Analysis, Interpretation, and Reports
	Patient Stories	Data integration into other safety activities

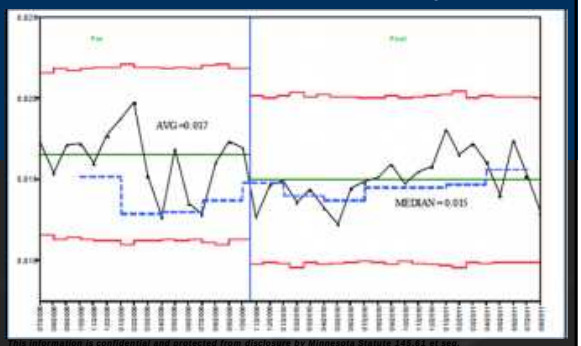


Sharing Knowledge to Inspire Change

1. Case Reports (stories)
   - Distributed to clinical leaders of each department whose providers cared for the patient
   - Allowed grass roots response
2. Quarterly Reports (data)
   - Distributed to all members of hospital practice and quality committees
   - Distributed to all clinical department chairs
   - Distributed to all nursing units (nurse manager)
3. Quarterly Presentation (data + stories)

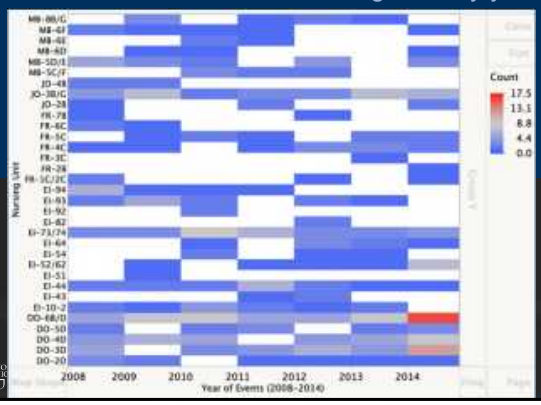
Morbidity and Mortality Council

SPC p-chart of MCR mortality rate

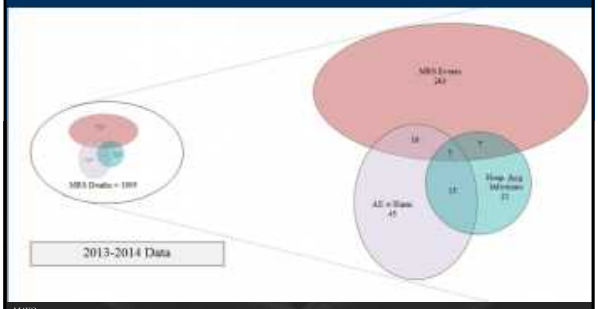


Data source: DSS and UHC

FTRR events for non-ICU nursing units by year



"It takes too much time and resource."



Why does the structure work?

- Moves away from insular peer review
- Promotes culture change
- It's NOT about adverse events
  - Identifying process of care and system failures
  - Identifying opportunities for improvement
  - Inspiring action through stories
- Right size quality improvement initiatives

"What about the living?"

Paula Santrach, MD

Chief Quality Officer, Mayo Clinic

Safety Learning System

- Next generation organizational learning
- Identification of opportunities for improvement
- Application of lessons learned from Mortality Review to other "challenging" cohorts
- Addition of human factors taxonomy

Learning from the Living: Other Challenging Cohorts

- Readmissions
- High cost cases
- Respiratory failure
- "Hot spots"
- Sepsis
- PSI-4

Tenets of a Safety Learning System

1. Multidisciplinary reviews
   - Nurses have equal voice
   - Multiple perspectives on patient journey
   - Identification of "contributing factors" (HF nomenclature)
2. Practicing providers & Deference to expertise
   - Omissions provide bigger opportunities
   - Increases physician involvement
3. Multispecialty, multidisciplinary case discussions
4. Actionable Information and Influence
   - Case-based teaching with patient stories
   - Six Sigma structure and analytics
   - Leading "up" to influence and inspire change

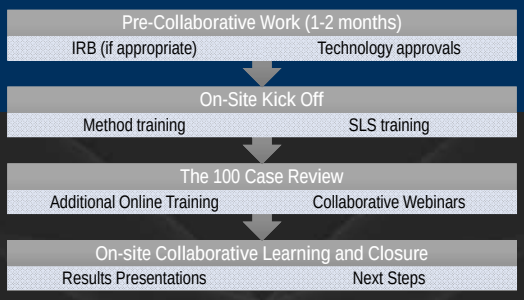
Safety Learning System Research Collaborative

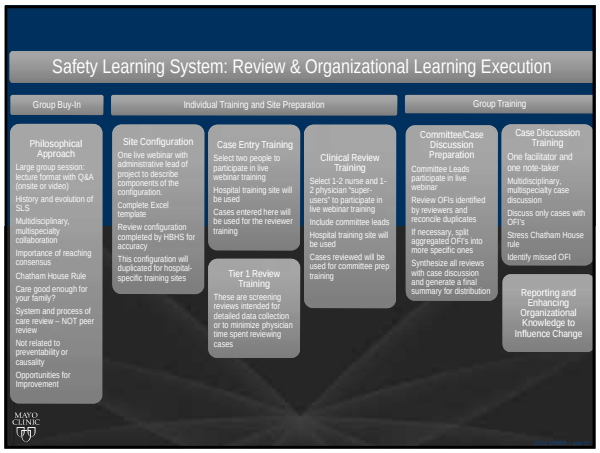
- Mayo Clinic Rochester
- Regions Hospital, Minneapolis
- Beaumont Health, Michigan
- Sharp HealthCare
- MedStar Health
- University of Mississippi Medical Center
- University of Washington Medical Center
- Penn State Hershey Medical Center
- Tasmania, Australia

Growing the SLS Collaborative

- New hospitals joining in Q4 2016
- Goal = identify opportunities for improvement
  - 100 case review
  - Cohort of your choice (could be deaths)
  - Learn within and across organizations
- Timeline
  - Q4: Local approval process
    - IRB approval if would like to participate in multicenter publications
  - Q1 2017: begin 100-case review
  - End Q2 2017: OFI analysis and learning

SLS Collaborative Timeline





SLS Collaborative Cost

- TMIT Webinar Participants: $12,500
- Non-TMIT: $15,050
- Single institutions who are not participating in the collaborative: $32,850 first year and $17,800 annually

Collaborative Participants Receive:

- Two ONSITE training visits by Dr. Huddleston
- Dr. Huddleston's consulting time as needed and 2x/month webinars for training and collaborative learning
- Materials for standardized case review training
- Project management support
- Study design, data aggregation and analysis
- Manuscript coordination, publication costs
- Site-specific report generation and benchmarking
- Safety Learning System (SLS) configuration & support
- Use of SLS at no cost (no license fee) for duration of collaborative (provided by HB Healthcare Safety, SBC)

What are you doing to learn from process of care and system failures?

JOIN US!!

@jmhuddleston huddleston.jeanne@mayo.edu

Questions & Discussion

@jmhuddleston huddleston.jeanne@mayo.edu

Literature/Resources

SPECIAL ARTICLE

Learning From Every Death

Jeanne M. Huddleston, MD,† Daniel A. Diedrich, MD,‡ Gail C. Kinsey, RN,‖ Mark J. Enzler, MD,‡ and Dennis M. Manning, MD**

The concepts of peer review and the venerable morbidity and mortality conference are familiar improvement approaches to health care providers. These 2 entities are typically provider or patient centric and are not typically extended within hospitals and health systems as a tool for organizational learning for care process or system failures. Out of a desire to deepen our understanding and accelerate learning about quality and safety opportunities in our hospitals, Mayo Clinic embarked on journey to analyze the stories of all patient deaths. This paper illuminates the lessons learned through the development and evolution of the Mayo Clinic Mortality Review System (Rochester, MN).

Guiding principle of Mayo Clinic Mortality Review System:
"No one should ever suffer or die as the result of process of care or system failure."

Journal of Patient Safety, April 2014

Safety Science

journal homepage: www.elsevier.com/locate/ssci

Learning from patient safety incidents in incident review meetings: Organisational factors and indicators of analytic process effectiveness

Janet E. Anderson, Naonori Kodate

A 100% Departmental Mortality Review Improves Observed-to-Expected Mortality Ratios and University HealthSystem Consortium Rankings

Martin J Heslin, MD, MSHA, FACS, Benjamin Taylor, MD, Mary T Hawn, MD, MPH, FACS, James E Davies, MD, FACS, Ryan T Heslin, Andrew H Mims, John E Morgan, R Luke Rabun, W Andrew Smedley, Melanie S Morris, MD, FACS, Donald A Reiff, MD, FACS, Gerald McGwin, PhD, Kirby I Bland, MD, FACS, Loring W Rue, MD, FACS

The Joint Commission Journal on Quality and Patient Safety

Methods and Tools

Saving Lives by Studying Deaths: Using Standardized Mortality Reviews to Improve Inpatient Safety

Helen Lau, R.N., M.H.R.O.D.; Kerry C. Litman, M.D.

The Joint Commission Journal on Quality and Patient Safety

Methods, Tools, and Strategies

The Mortality Review Committee: A Novel and Scalable Approach to Reducing Inpatient Mortality

John S. Barbieri, BA; Barry D. Fuchs, MD, MS, FACP; Neil Fishman, MD; Carolyn Crane Cataldi, RN, PhD-c, MSN, ONC, CRRN; Craig A. Umscheid, MD, MSCE; Craig Kean, MS; Sherine Kosby, MHA, RHIA, CCS; Patricia Garcia Sullivan, PhD; PJ Brennan, MD; Rachel R. Kelz, MD, MSCE

Polling Questions

I am interested in a webinar with speakers who have launched Mortality Review from scratch

10	9	8	7	6	5	4	3	2	1
Very Strongly Agree	Strongly Agree	Agree	Agree	Neutral	Neutral	Negative to Neutral	Disagree	Strongly Disagree	Very Strongly Disagree

The Mortality Review topics I want to learn more about are:

Polling Questions

I am interested in DEEP DIVE webinars on The Med Tac Causes of Death of Healthy People

10	9	8	7	6	5	4	3	2	1
Very Strongly Agree	Strongly Agree	Agree	Agree	Neutral	Neutral	Negative to Neutral	Disagree	Strongly Disagree	Very Strongly Disagree

I am interested in participating in a Community of Practice developing the Med Tac tools such as the C.A.R.E. Huddle

10	9	8	7	6	5	4	3	2	1
Very Strongly Agree	Strongly Agree	Agree	Agree	Neutral	Neutral	Negative to Neutral	Disagree	Strongly Disagree	Very Strongly Disagree

Polling Questions

I am interested in a webinar on ALL CAUSE HARM to those we serve (patients) and those who serve (our caregivers)

10	9	8	7	6	5	4	3	2	1
Very Strongly Agree	Strongly Agree	Agree	Agree	Neutral	Neutral	Negative to Neutral	Disagree	Strongly Disagree	Very Strongly Disagree

I am interested in a webinar addressing EMERGENCY CODE HARMONIZATION

10	9	8	7	6	5	4	3	2	1
Very Strongly Agree	Strongly Agree	Agree	Agree	Neutral	Neutral	Negative to Neutral	Disagree	Strongly Disagree	Very Strongly Disagree

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Polling Questions

The patient safety topics (ANY) that are keeping me up at night are:

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TMIT National Research Test Bed — High Performer Webinar — SafetyLeaders.org

Speakers and Reactors


Jeanne Huddleston


Dan Ford


Jennifer Dingman


Charles Denham

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TMIT National Research Test Bed — High Performer Webinar — SafetyLeaders.org

Voice of the Patient and Family

Dan Ford

Retired Vice President, Furst Group (Rockford, IL, healthcare executive search)
Spectrum Health EPFAC (Grand Rapids, MI)
Michigan Hospital Association Keystone Center PFE Advisory Committee
TMIT Patient Advocate Team Member
Patient Safety Advocate
Rockford, Michigan

TMIT High Performer Webinar
August 18, 2016

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