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HPI PRESS GANEY PSO DATA INSIGHTS

The Pandemic Six
A Review of COVID-Related Safety Events Submitted to the HPI Press Ganey PSO

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SUMMARY

The COVID pandemic has battle-tested every organization in the health care industry. Care providers and those who enable the provision of care, weary from both the weight and duration of the crisis, have suffered the strain on everything from resources to resilience. And as COVID impacts the safety, quality, and experience of the health care workforce, it of course also impacts the safety, quality and experience of the patients we serve.

This brief examines quantitative and qualitative evidence of COVID impact in a total of 419 serious safety events, precursor safety events, and near-miss events submitted to the HPI Press Ganey PSO within the initial three months of the COVID pandemic. Insights regarding six pandemic-related key processes are offered.

The HPI Press Ganey PSO is a federally listed Patient Safety Organization by the Agency for Healthcare Research & Quality (AHRQ). At the publication time of this brief, the HPI Press Ganey PSO database includes more than 1.6 million event submissions from a membership of 450 acute care settings and 1,300 ambulatory and other settings.

A challenge for any patient safety organization is transcending differences in organizational approaches to event cause analysis and harm measurement to provide meaningful aggregate insights. The HPI Press Ganey PSO is the first and only PSO in the industry guided by Press Ganey's proven HPI methods for event cause analysis coding, Safety Event Classification® (SEC®), and Serious Safety Event Rate® (SSER®) harm measurement. Appended to the native event analysis and harm measurement processes of PSO members, these methodologies enable the HPI Press Ganey PSO to optimize learning from events across member organizations. Our members are provided access to methodology-based education and training as well as safety and reliability learning forums facilitated by experts in high reliability organizing.

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Methods

Cases in this assessment were submitted from March 10, 2020 through June 9, 2020. A keyword search was used to identify safety reports including a COVID citation. Of those safety reports, a total of 419 safety events, primarily from the acute care and emergency department settings, were identified with the classification of: serious safety event (a deficiency in care that reached the patient and resulted in moderate to severe harm or death), precursor safety event (a deficiency in care that reached the patient and resulted in minimal or no detectable harm), or near-miss event (a deficiency in care that was caught before it reached the patient). Of the 419 safety events, the following data fields were assessed:

Event Description	As submitted by the PSO Member
Level of Harm (Serious Safety Event, Precursor Safety Event, Near-Miss Event)	Assigned by the PSO Member
Safety Event Type (HPI Taxonomy of Safety Events in Health Care)	Assigned by the PSO Member
Key Process* Associated with the Safety Event Failure Mechanism	Assigned by an HPI Press Ganey PSO Safety & Reliability Expert Following Event Description Review

The PSO COVID safety event data were assessed and compared with a known pre-COVID dataset routinely used as a point of aggregate comparison, the HPICompare database. The current HPICompare database includes more than 2,800 safety events from 171 facilities analyzed from 2017-2018.

*Key Process – HPI Key Process List for Healthcare; A defined, goal-oriented sequence of key activities that is critical to the facility's ability to effectively deliver care and service.

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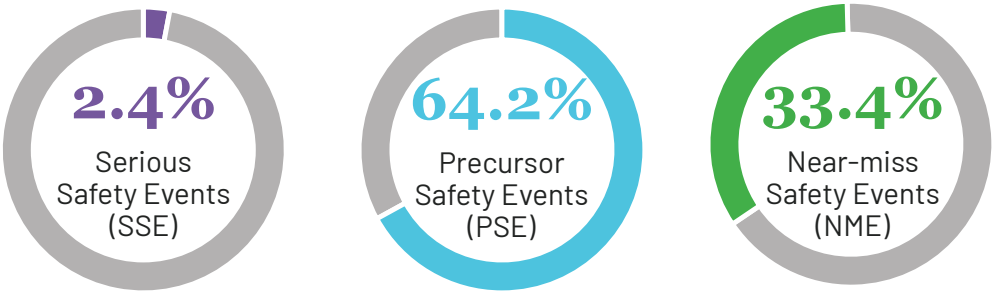
Findings

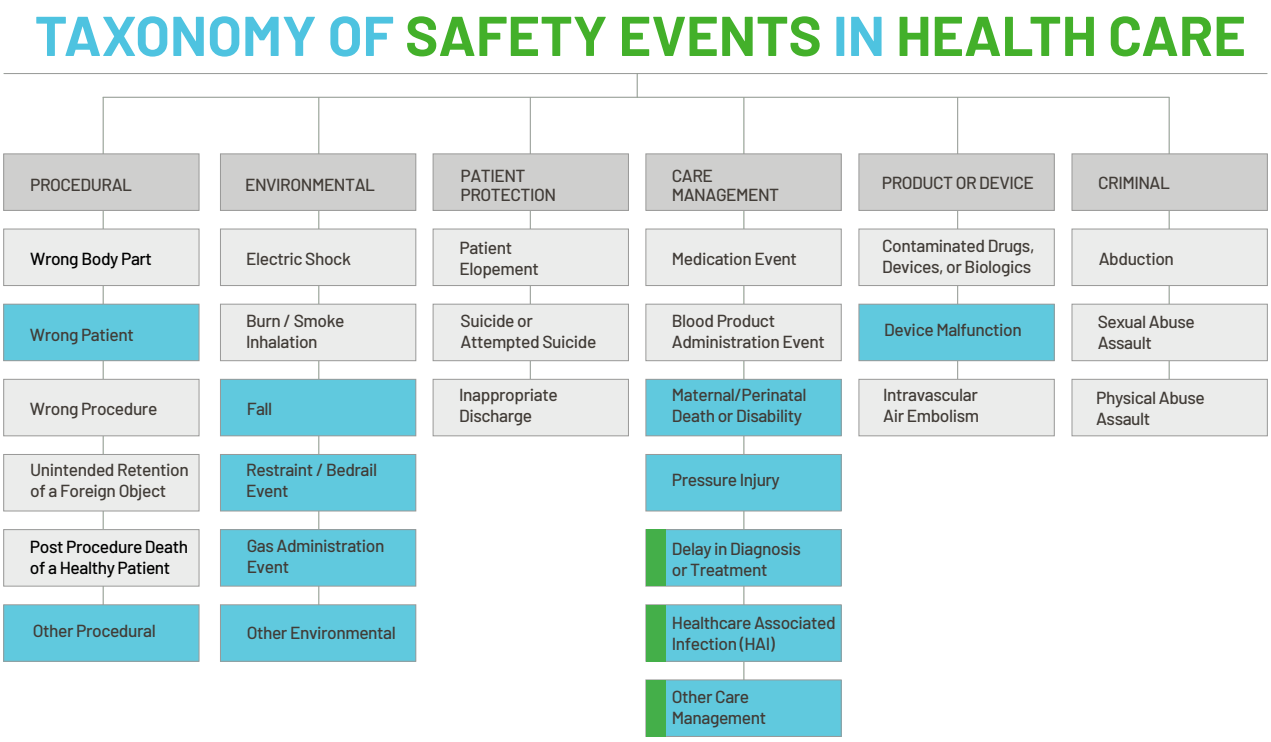
Of the 419 events, 10 events (2.4%) were serious safety events, 269 events (64.2%) were precursor safety events, and 140 events (33.4%) were near-miss events. (Figure 1)

Figure 1. | PSO COVID-Related Events



The distribution of PSO COVID cases across safety event types is shown below. (Figure 2)

Figure 2. | Safety Event Types of PSO COVID-Related Cases



The majority of PSO COVID cases – 363 of 419 cases (86.6%) – are concentrated in the Care Management category. Furthermore, and in contrast to pre-COVID comparative datasets, 77% of all PSO COVID cases fall into only three safety event types:

- **34.8% Other Care Management**
  Example: patient discharge delayed due to communication issues and process change due to COVID
- **25.3% Delay in Diagnosis or Treatment**
  Example: unlabeled COVID test rejected, resulting in delayed treatment/diagnosis
- **16.9% Health Care-Associated Infection**
  Example: Patient admitted, initial E. coli screening negative, became symptomatic with positive results 9 days later

The Fear Factor: Impact of COVID on Emotional & Psychological Harm of the Workforce

In reviewing the COVID-related cases in the PSO, our expert reviewers were able to palpably feel the fear and emotions of the caregivers who were observing and reporting safety issues. Examples included:

- Reluctance of some care providers to enter patient rooms and perform assessment
- Agitation due to worker separation from family
- Confusion due to unknown, rapidly changing processes, and lack of adherence to protocols
- Overwhelmed feeling due to death, patient volume, rapid process changes, and changes in routine due to limited staff resources coupled with increased care demands
- Frustration due to lack of clearly outlined and/or poorly communicated changes in protocols (e.g. patients transported to radiology prior to COVID testing, risking exposure to other caregivers)
- Exhaustion from the stress and patient volumes

Workforce physical and emotional safety is a precondition to achieving patient safety. Identification and mitigation of these harms must be a key focus for organizations as we move beyond the pandemic, which will require leadership commitment as well as leadership skills and universal skills to strengthen the trust of the workforce. Read more about the four critical elements to building trust with and among clinicians, leadership, and other health care personnel in Building Workforce Trust: Lessons from COVID-19.

Six key processes (of a total of 23 key processes in the HPI Key Process List for Healthcare) were associated with 84.7% of the PSO COVID events.

These six key processes are listed and defined on the next page, with evidentiary examples of the processes within the COVID dataset as well as cross-supporting safety culture and high reliability organizing enabling considerations. (Figure 3)

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Top-Ranking PSO COVID-Related Key Processes – "The Pandemic Six"

Figure 3. | Top-Ranking PSO COVID-Related Key Processes – "The Pandemic Six"

Key Process	As Evidenced in PSO COVID Cases
22.7% **Specimen Management & Control** Activities associated with collecting specimens from a patient (but not involving invasive means), maintaining control of the specimen, and analyzing specimens	• Confusion regarding COVID specimen delivery, specimen management, and testing protocols and processes internally as well as in relation to external testing resources • Mislabeled and unlabeled COVID specimens associated with resource and distraction-related inattention • Confusion resulting from differences between COVID specimen processes (red dots, double bagged, do not deliver through pneumatic tube) and routine specimen processes
21.2% **Coordinating Care** Activities associated with the coordination and integration of multiple caregivers, departments, and process that are part of providing care to the patient.	• Knowledge and communication of patient-specific status between departments internally as well as with external agencies/facilities
14.3% **Worker Safety Processes** Activities associated with the prevention and mitigation of harm to staff, including the proper posting of restricted areas and the specification and use of personal protective equipment.	• Missing, inadequate, and incorrect signage regarding COVID restrictions • Non-use and misuse of PPE by care providers • Scarce PPE resources and lack of clarity in resource allocation and distribution
10.5% **Patient Monitoring & Assessment** Activities associated with monitoring and assessing patient status.	• Breakdown in routine conduct of bedside shift reports • Misdiagnosis or delayed diagnosis of other conditions due to COVID-focused tunnel vision and cognitive bias • Impact of bundled care, resource availability, and exposure concerns resulting in delays in recognizing and responding to deterioration in patient condition • Increases in falls due to closed doors, delays in room entry due to donning/doffing PPE, elimination/reduction of sitter use
9.1% **Infection Control** Activities associated with the control and prevention of infection and communicable diseases.	• COVID-positive patient movement within facility without PPE • COVID testing protocol not followed/delay in testing resulting in patient transfers within a short period of time after unit arrival, creating additional exposure of staff/other patients • Lots of confusion on patient COVID status – no one clear reliable source for patient status
.9% **Medication & Nutrition** Activities associated with the ordering, preparing, and administering of medications, blood, oxygen, and nutrition.	• Breakdowns in medication reconciliation and administration of home medications • Delays in medication administration associated with changes in med administration scheduling to minimize staff/patient contact • Errors in medication administration resulting from infection control process changes in bedside barcode reading

Discussion & Insights for Consideration

The quantitative and qualitative findings above can inform actions to better handle times of crisis and to strengthen emergency preparedness plans specifically related to pandemic conditions.

The Pandemic Six: Start first by reflecting on the Pandemic Six key processes. Consider how your organization's experience compares with the aggregate findings and experience of HPI Press Ganey PSO members. Where are there similarities, and where does the experience of your organization differ? Use this retrospective insight for pandemic-related, process-specific strengthening.

While process-specific improvement is important, performance outcomes are the result of the intersection between process design and individual and team behaviors within those processes. Let's take a look at the catalytic role of safety culture and high reliability organizing in optimizing performance during routine operations as well as crisis management.

Safety Culture & High Reliability Organizing Implications: Almost immediately upon onset of the COVID pandemic, health care providers found themselves in a crisis characterized by the following:

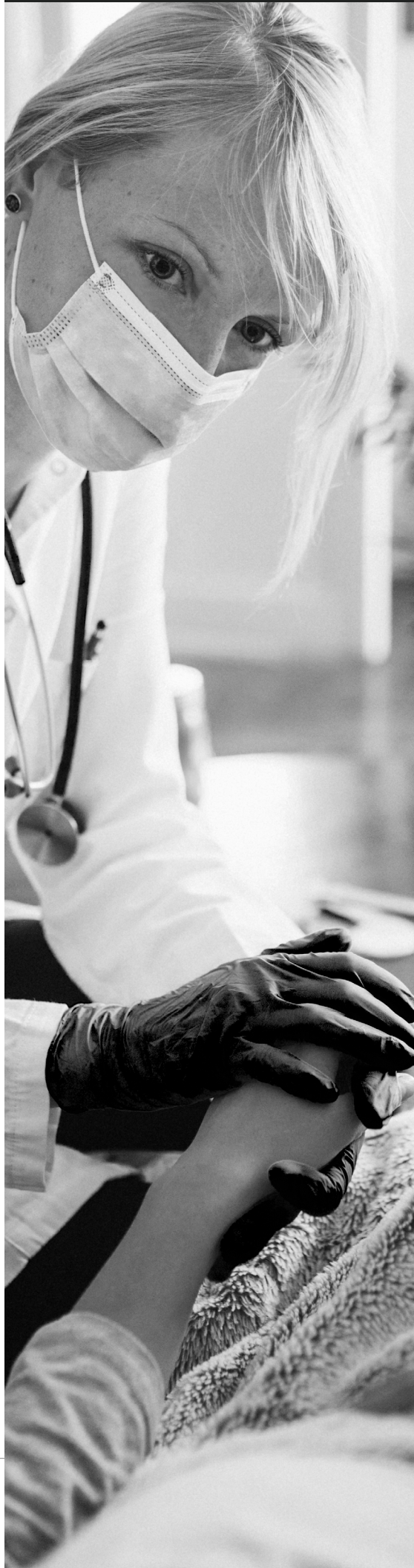
- High-risk and high-consequence conditions impacting the health and safety of everyone, including patients and workforce
- Uncharted territory
- Rapidly changing conditions
- Lack of resources of all kinds, including workforce, equipment, and supplies
- External interfacing with governments and agencies at the local level, federal level, and in some cases international level
- Fear for self and others

These conditions point to the importance of safety culture and high reliability organizing as a strategic imperative for optimizing performance during routine operations as well as for surviving turbulent times. The effectiveness of this "high reliability organizing" will determine overall resiliency through COVID times, as it provides an infrastructure for crisis management. Organizations that are more

mature in this area are a step ahead because they already have in place leadership structures and processes as well as behavior expectations for all that promote empathy; effective communications; situational awareness and anticipation; analytical problem solving; and accountability. Here are just a few examples:

- System-level and facility-level daily check-in and unit level huddles that help your teams understand COVID-related issues of the past 12 to 24 hours and risks in the next 12 to 24 hours, and help mobilize them for action
- 60-second safety moments at the start of every meeting, which keep the safety and well-being of associates, patients, and families top of mind during crisis and chaos
- A fair and just culture – where leaders value and show appreciation for reporting – ensuring that associates readily raise concerns and issues
- Engrained habits in peer checking and peer coaching that provide robustness in cross-checking across professions and authority gradients on PPE donning and doffing
- Robust processes for rapidly identifying process and system causes of events (as outlined above) and developing strong, human-factors-based improvements

For organizations engaged in high reliability organizing, the COVID pandemic has validated the foundational role and importance of reliability principles and practices in managing the unexpected. These principles and practices will help organizations be better able to address future crises and whatever new and unique challenges they may bring.



Evaluating how well-prepared your leadership and workforce are to maintain safe and highly reliable care amid a crisis begins with honestly answering these questions.

- Do you have a culture instilled with leader behaviors and associate behaviors and habits for maintaining a "safety first" mindset?

- Do you have a structured process for maintaining situational awareness and managing problem identification/mitigation at the facility level and the department level, as well as across facilities if part of a multi-facility system?

- When process changes are made, do you have a formal process for c Calling them into question and considering, "What impact will this change have on patient safety and workforce safety?"

- Do you have established reliability habits for attention to detail, clear communications, critical thinking, and peer checking/coaching to provide robustness in individual actions and team interactions?

- Do you ensure a caring, empathetic connection with patients and families to build trust and confidence in delivering care according to the best knowledge within changing conditions?

- Do you ensure a caring, empathetic connection with colleagues to build camaraderie and to reduce the negative effects of power distance and authority gradient?

Acknowledgements

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