High 5s Steering Group meeting in the Netherlands 14 & 15 May 2012

By Erica van der Schrieck-de Loos MSc, Project leader, LTA Netherlands

The High 5s Steering Group meeting was held on 14 & 15 May 2012 at the Ministry of Health in the Hague, the Netherlands. Twenty-two participants representing 7 High 5s countries, WHO and JCI/Collaborating Centre were welcomed by Veronique Esman, Director of Curative Care of the Dutch Ministry of Health, Welfare & Sports and by Prof. Dr. ir. Kees Ahaus, CEO, CBO Dutch Institute for Healthcare Improvement.

The countries shared their SOP implementation progress in participating hospitals, started by the Netherlands with an update on the implementation of the SOP for Medication Accuracy. The presentation included information on the SOP status, strategy and ‘surprises’ in a mixed group of 15 academic and (non) teaching hospitals. ‘To SOP or not to SOP’ is not a question anymore: it’s all about ‘when to SOP’ and how to create 24/7 staff to get Best Possible Medication Histories for every patient within 24 hours without discrepancies, including a patient interview about medication use.

Liesbeth Bosma MSc, High 5s project leader and hospital pharmacist in the Dutch Haga hospital, presented her SOP experiences in daily practice and highlighted the challenges for sustainability of results in times of financial cut backs.

Germany, France and Australia presented also their progress on the Med Rec SOP. Seven German hospitals decided to join the international network in 2012. In France the project lead has changed to a cooperative between the HAS and the Observatory of Drugs, Medical Devices and Therapeutic Innovations (OMEDIT). Beside national conferences the seven hospitals will be visited by the French LTA within the next 18 months. Eleven Australian hospitals notice a similar variety of implementation challenges as the other countries such as creating resources for the reconciliation process and quantitative measurements in daily practice, competing priorities and last but not least: the willingness to change!
Summary of the Netherlands meeting

Event Analysis: hospitals will use the final materials.

Publication procedures: Steering Group will review the document.

International hospital meeting 19 October 2012: Steering Group discussed the meeting agenda. 30 hospitals from Australia, France, Germany, the Netherlands and Singapore will participate.

Quarterly and Interim report: Steering Group discussed the status and content of the upcoming reports.

Context survey: LTAs will complete and review the outcome of the SOP’s context surveys.

Heineken brewery safety experience tour 14 May in Zoeterwoude: Steering Group visited the Heineken brewery: a zero tolerance culture, leadership and the importance of reporting near misses.

The importance of qualitative data, in addition to quantitative data, is highlighted for both Med Rec and Correct Site Surgery SOPs. In France the qualitative effect of the SOP for Correct Site Surgery (CSS) shows a potential national movement, because non participating hospitals ask many questions to the LTA about site marking. Hospital specific results are discussed by the French LTA with hospital directors. In Germany there are 13 hospitals with the status of full SOP for CSS implementation. Two hospitals with a partial implementation status will expand the SOP to full implementation soon. Only one hospital is implementing the SOP partially. A national report with performance measure data from the first 6 implementation months has been completed. For the report almost 18,000 checklists applying to 21,000 cases from altogether 14 hospitals were analyzed. In addition, qualitative data has been collected for 11 hospitals. Trinidad & Tobego participates with five public hospitals. The LTA set up the project teams and have collected the demographic profiles. The estimated start of the SOP implementation is scheduled for July 2012.

The two SOP specific break-out discussions during the Steering Group meeting were lead by Margaret Colquhoun, protocol lead, ISMPC, and Rick Croteau, patient safety advisor, JCI.

The Steering Group also prepared the agenda for the upcoming international hospital meeting. This meeting will focus on sharing implementation experiences between participating hospitals. It will take place at WHO in Geneva on 19 October 2012. The High 5s results of the two SOPs since 2010 will be available in the upcoming Interim Report at the end of 2012. The next quarterly report and a summary of the May 2012 meeting are available at www.high5s.org.

Host Country Reporting: High 5s implementation in 15 Dutch hospitals-lessons learned

By Erica van der Schrieck-de Loos MSc, project leader, E: e.vanderschrieck@cbo.nl & Annemieke van Groenestijn, consultant, E: a.vangroenestijn@cbo.nl LEAD TECHNICAL AGENCY NL

Fifteen Dutch hospitals are participating in the High 5s network implementing the Med Rec SOP.

- Antonius Hospital, Sneek/Emmeloord
- Diakonessenhuis, Utrecht/Zeist/Doorn
- Elkerliek Hospital, Helmond
- Franciscus Hospital, Roosendaal
- Gelderse Vallei, Ede
- Haga Hospital, The Hague
- Hospital Group Twente (ZGT), Almelo/Hengelo
- Medical Center Alkmaar,
- Radboud University Medical Centre, Nijmegen
- Rivas Beatrix Hospital, Gorinchem
- Rivierenland Hospital, Tiel
- Sint Franciscus Gasthuis, Rotterdam
- Tergooi Hospitals, Hilversum/Blaricu
- University Medical Center, Groningen
- VU University Medical Center, Amsterdam
**SOP status:** From January 2010 to January 2011 the implementation of the Med Rec SOP started with a first group of eleven hospitals. Multidisciplinary hospital teams were trained during 8 national accredited training conferences. These conferences supported the multidisciplinary hospital teams in writing their project plans, analyzing reconciliation processes, discuss on implementation strategies for their SOP interventions, learn about change management, communication and training on baseline and performance measurements. Most important of these conferences was sharing knowledge and expertise on the implementation progress. The focus of the Dutch implementation strategy is to implement the SOP ‘step by step’ from ward to ward by using the Deming ‘plan, do, check, act’ strategy to create success stories and improvement.

In June 2011 a second group of 2 hospitals started with the implementation process. To train the second group 4 national training conferences were needed in combination with the experience of the first group of hospitals. Site visits to first-group-hospitals were introduced to share implementation lessons. A similar model is used for the two hospitals of the third group. They joined High 5s on 30 March 2012.

To keep all 15 High 5s hospitals in touch with each other, national getting back conferences are organized. These conferences took place on 8 November 2011 and 28 June 2012. The three groups of hospitals meet each other to share knowledge about sustaining and expanding the SOP hospital wide. On 19 October 2012 hospital pharmacists and pharmacy practitioners from nine Dutch hospitals will attend the 1st international hospital meeting at WHO in Geneva.

**SOP strategy:** The first 11 hospitals keep trying to collect performance measurements to evaluate the sustainability of the SOP. These hospitals also started the qualitative data collection. The second and the third group of hospitals are still focusing on the baseline and performance measurements. These groups will start with the qualitative data collection 6 months after SOP implementation. The qualitative part of the data collection shows the implementation progress, barriers and challenges and lessons learnt.

**SOP surprises:** In the Netherlands ‘to SOP or not to SOP’ is not a question anymore. Questions are *when* to start with the implementation on a ward and *which* discipline is creating an accurate medication history for every patient within 24 hours. The SOP is used to implement the national guideline for actual medication histories at transitions in care. The breakthrough model with national conferences and focus on the Deming improvement cycle is used to implement the SOP. To achieve a 75% reduction of medication discrepancies, interviewing patients about how they take their medicine is the most important part of the SOP.

Information about what role patients may have to improve patient safety is available in the CBO research report ‘The role of the client in patient safety. A necessity, not a desirability’. (Van der Schrieck et al. 2009, CBO: Utrecht. NL) [http://www.cbo.nl/en/Patient-Safety/Patient-engagement-empowerment](http://www.cbo.nl/en/Patient-Safety/Patient-engagement-empowerment)

Since 2009 the SOP implementation progress is shared by presentations and workshops on national conferences, by publications, interviews and master classes for quality and safety. Publications are available on the High 5s website [www.high5s.org](http://www.high5s.org)

**Publications/presentations since Sept. 2011**

France: High 5s implementation in hospitals

By Anne Broyart, Charles Bruneau, Margaret Galbraith- HAS

France is involved in the implementation and evaluation of 2 SOPs with a mixed group of sixteen hospitals participating in the High5s network implementing the correct surgery SOP and the MEDREC SOP.

- Centre anticancéreux Léon Bérard (Lyon)
- Saint Joseph - Saint Luc Hospital (Lyon)
- Bourg en Bresse Hospital
- Joseph-Ducuing Hospital (Toulouse)
- Chambéry Hospital
- Cambrésis Hospital
- Cornouaille Quimper-Concarneau Hospital
- Nice University Teaching Hospital

MEDREC
- Association clinique la Croix Blanche Moutier Rozeille
- Nimes University Teaching Hospital
- Saint Marcellin Hospital
- Bichat Claude Bernard (Paris) - University Teaching Hospital
- Grenoble University Teaching Hospital
- Compiègne Hospital
- Strasbourg University Teaching Hospital
- Lunévile Hospital

Update on MEDREC SOP
There are monthly conference calls with the High5s teams of hospitals. An annual cycle of visits has been set up. To date all the hospitals have partially implemented the SOP, with two of them having spread MedRec to other units or departments and with half of them reconciling also at discharge. Their motivation is high and efforts are made to reconcile within 24 hours. Performance measurement data have been collected since July 2011. The coming workshop in September will address two main issues: clinical impact of discrepancies – update and discussion about the on-going projects- and the patient’s interview - a training session set up by the LTA collaborative with one of the university teaching hospitals to be followed by the definition of a patient interview guideline. The results and expertise gained by the MedRec participant organizations are shared on a national level by presentations and workshops at conferences and by publications.

Update and case study on Correct Site Surgery SOP
To reach full implementation for the HCOs involved in the implementation (since 2010) and evaluation (since January 2011) is challenging. To this aim the hospitals receive monthly individualized feedback national benchmarking reports and graphics, tips with key messages as well as additional data on checklist completeness by the LTA (HAS and CEPPRAL). The second round of visits by the LTA includes interviews of teams and senior management and focuses on leadership and communication issues. CEPPRAL is currently producing short videos recording the testimony of the High 5s teams of each participant hospital for purposes of accompanying dissemination. The LTA hosts regular biannual workshops. The last one on July 2012 addressed the issues related to the event analysis and to the site marking guide. There are initiatives to promote surgical site marking on a national level notably through communication and discussion of the site marking guide.

Case study of Joseph Ducuing (Toulouse) general hospital and analysis of the case - Monique Fabre
On day D-1 (i.e the day before the surgery) a patient is hospitalized for a right inguinal hernia in a unit of 10 patients headed by one nurse. The type of surgical intervention is correctly noted in the medical consultation letter, in the personalized booklet concerning the patient care pathway and in the operating “logbook. The patient is admitted by a substitute nurse. She is the only nurse on the ward that day as the regular nurse has called in sick. In order to advance the work of the regular evening nurse, the substitute nurse completes the nursing file. During this process, a transcription error occurred related to the site of intervention: left inguinal hernia. The evening nurse did not check the type and site of the operation with the patient. She did not check the site for surgery during the shaving, since the protocol used for inguinal hernia under coelioscopy includes shaving of both sides. The site is not marked on the day D -1.

The next morning, the patient is prepared by the same nurse who worked the previous evening. She relies on the nursing file without interviewing the patient before sending him to the operating theater. She specifies the left side on the High5s checklist. At the arrival of the patient in the surgical department the specialized nurse notes the discrepancy by checking the information on the personalized booklet and the medical consultation letter. This nurse stops the process, informs the surgeon and together they correct the discordance on the check list. Thanks to High5s the surgeon could operate the correct (right) side and this story has a happy ending.
The analysis revealed:

**Causes linked to environment**
- Substitute nurse unfamiliar with the ward
- No back-up provided by a more experienced nurse in the absence of the regular nurse

**Causes linked to material**
- Personalized patient booklet and intervention specific process unknown by the substitute nurse
- Re-writing the reason for the hospitalization in the data collection
- Non-computerized patient record

**Causes linked to resources**
- A substitute nurse hired for that day alone not familiar with the High 5s SOP
- No supervision by a senior nurse
- Patient Safety culture not enough developed

**Causes linked to methodology**
- The substitute nurse completed the record before the patient’s entry and did not interview the patient
- Rewriting the reason of hospitalization on different papers of the patient file
- Use of abbreviation for right or left inguinal hernia: HID or HIG
- The evening nurse wrongly checked the High5s checklist before the patient’s departure to the operating theater
- Site marking not done at D-1

**Causes linked to the patient**
- While not interviewed the patient did not inquire to assure himself that the site was properly identified

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**HIGHLIGHTS FROM COUNTRIES**

**Australia**

*By Helen Stark, Senior Project Officer and Margaret Duguid, Pharmaceutical Advisor*

**SOP Implementation status:** As of September 2012 ten Australian hospitals were submitting data into the High 5s IMS. Two private hospitals in the group are conducting medication reconciliation but are not collecting data due to resource constraints.

Rates for MR1 vary across the 10 hospitals depending on the stage of implementation, resources available and the spread of the intervention in the organization. Between March 2011 and March 2012 rates for the percentage of eligible patients with medications reconciled within 24 h of admission ranged from 16% to 94% across participating hospitals with an average of around 50%.

The quality of the medication reconciliation is good with the majority of hospitals reporting < 0.3 outstanding medication discrepancies/patient.

Hospitals report that the performance measures are useful for identifying: the quality of the medication reconciliation process, training needs and gaps in their processes.

Five hospitals are collecting two additional measures on the number of discrepancies that remain unresolved 48 hours after the patients’ admission. Two of these hospitals identified that more than 60% of discrepancies identified during the reconciliation process remained unresolved at 48 hours (or more) after admission. The hospitals assigned a level of harm to the unresolved discrepancies using the NCC MERP harm scale. Most discrepancies were reported as causing no harm or a low level of harm.

Hospitals were surprised at the extent of the discrepancies identified during the reconciliation process that remained unresolved after 48 hours. These hospitals have been able to use this information to highlight the issue and considerably reduce the number of outstanding unresolved discrepancies.

**Consumer Resources for Medication Reconciliation**

The Commission has developed a resource to highlight to consumers the importance of knowing about their medicines and having an up-to-date medicines list.

**Consumer Information wallet: Preventing medicine mistakes in and out of hospital**

The consumer information wallet provides helpful tips on how patients can be involved in preventing medicine mistakes when going in and coming out of hospital, changing wards or seeing different health professionals in the community.

The main message is to keep track of all the medicines they’re using with the use of a medicines list and showing this information to all health professionals (the wallet contains a medicines list).

The printed wallets are designed to be provided to patients on discharge from hospital and can hold the discharge medicines list and other medicines information.

An A4 consumer information sheet with the same key messages as the consumer information wallet is available for download from the Commission’s website.
Update on Corret Site Surgery SOP:
The majority of the German hospitals which have implemented the Correct Site Surgery SOP – 13 out of 16 hospitals – have reached full implementation. The focus for these hospitals now lies on improving and sustaining SOP performance. To this aim, the hospitals receive individualized feedback reports on a quarterly basis as well as national benchmark reports containing detailed High 5s performance measures data and additional data on checklist completeness.

In addition, the results of the High 5s Implementation Experience Questionnaire (conducted December 2011-February 2012) and interviews with three High 5s hospital coordinators (conducted March 2012) have been analysed and in a next step will be compared to the results of the other High 5s countries to look for national vs. international patterns in the qualitative data. The Implementation Experience Questionnaire employed for the German hospitals was a modified version of the internationally developed High 5s Implementation Experience Questionnaire in the sense that several SOP-specific questions were added to the instrument. Hospital coordinators of 11 hospitals answered the Questionnaire.

The results of the Questionnaire have been presented at the following conferences: i) Fishman L, Renner D, Gunkel C. Implementation of checklists in the context of the international High 5s Project (Workshop presentation). Annual Meeting of the German Coalition for Patient Safety. Berlin, Germany. 26-27 April 2012. ii) Fishman L, Renner D, Gunkel C, Rothe C, Lessing C, Thomeczek C. Barriers and drivers in implementing a Standard Operating Procedure for the prevention of wrong site surgery in German hospitals (Poster). 9th Conference of the Guidelines International Network. Berlin, Germany. 22-25 August 2012. iii) In addition, a poster summarizing the Questionnaire and interview results will be presented at ISQUA 2012.

Update on Medication Reconciliation SOP:
So far seven hospitals have signed up to implement this High 5s SOP in Germany, whereby three of these hospitals are already participating in the Correct Site Surgery module. The German Med Rec hospitals are:
- City Hospitals of Mönchengladbach - Elisabeth Hospital
- Coburg Hospital
- Diakoniekrankenhaus Friederikenstift, Hannover
- Lüneburg Hospital
- University Hospital Aachen
- University Medical Center Freiburg
- University Medical Center Hamburg-Eppendorf. Currently a national databank is being created for data collection which is modelled after the Dutch version of the database. The database will define the Minimum Data Set and optional data sets for additional data analyses. In addition, a national “BPMH guide” has been produced in collaboration with the participating hospitals to assist them in the implementation of the Best Possible Medication History.

Singapore
By Ms Katherine Soh, Manager (Healthcare Standards), Standards & Quality Improvement Division, Ministry of Health,

SOP IMPLEMENTATION STATUS
The project reached full implementation status for all Public Hospitals in May 2009. To do this, MOH had teamed up with patient safety champions in each hospital


Publications/presentations

Please note: The text contains abbreviations and references that may be specific to the context of the document. For a comprehensive understanding, it would be beneficial to access the original sources or additional information.
to form a local High 5s Network. In addition, MOH funded an executive in each hospital to assist in data collection and gap closure under the existing Healthcare Performance Office (HPO) framework. The project was a joint collaboration between MOH and all public hospitals, involving surgeons, anaesthetists and nurses.

**PROGRESS UPDATE OF THE IMPLEMENTATION PROCESS**

*Gap closures initiated by institutions, 7/2010-3/ 2011:*

- Revising surgical checklists;
- Educating staff on the SOP;
- Developing data collection methods; and
- Developing SOP Scripts and Videos: 3 of our hospitals wrote a ‘Time-Out’ script. These hospitals had marked improvement in compliance to the Time-Out section as staff could follow the step-by-step requirements of the Time-Out drill. 2 of our hospitals prepared instructional video footage of actual time-outs being performed. These received positive feedback as staff learnt the SOP better seeing it played out in real scenarios.

**Change initiatives by MOH included:**

i. **Regular platforms for sharing and learning:** MOH hosted bi-annual sharing platforms for the High 5s Network to reach mutual consensus of changes to be effected. In addition, between Jan to Mar 2011 when data collection was first launched, fortnightly informal meetings were held to assist executives in overcoming problems encountered.

ii. **Standardising data collection:** To standardize data collection, an excel spread-sheet was established for executives to enter data and derive compliance rates. MOH also adapted the WHO checklist for local context including deriving a calculation sheet for institutions’ reference. This adaptation was a core catalyst for institutions to adopt WHO’s checklist and begin data collection.

iii. **Ensuring data validity:** To ensure rigour of the data collected, the executives did monthly observational audits to validate findings from documentation submissions. MOH co-ordinated quarterly Cross Review Validation Exercises (CRVEs) where executives, including MOH staff, visit each institution to perform similar observational audits and ensure a non-bias approach. Discrepancies noted during the observations help executives to drill down differences in actual practice versus paper audits.

**STRATEGY FOR CHANGE**

The executives, though funded by MOH, reported directly to hospital management. The High 5s champions are leaders in their professions such as head surgeons and anaesthetists. As such, initiatives were better disseminated to the ground.

As the SOP meant radical changes to conventional workflows in OTs affecting surgeons, anaesthetists and nurses, it took us about a year to iron out differences in practice (May 2009 to Jun 2010) and another 6 months to conduct staff education, checklist revisions and standardisation of data collection methods (Jul to Dec 2010).

From Jan 2011 onwards, monthly compliance data were reported back to OT staff and senior management. Based on the data, staff noted areas that needed improvement and gradually showed increased compliance to the SOP. Overall, it took two years to implement the SOP and reach steady state in data collection.

**MEASUREMENT OF IMPROVEMENT**

Though our hospitals have not all achieved 100% compliance for CS-1 to 3, their current rates have improved to a plateau at >90%. For CS-5, it was noted that our hospitals tend to let Time-Out discrepancies pass unresolved. MOH will be flagging this out to the local High 5s Network to initiate gap closure.

**POSTER DISPLAYS**


**Trinidad and Tobago**

*By Ingrid Allen*

The Ministry of Health Trinidad and Tobago remains committed to the provision of governance, oversight and support to the five Regional Health Authorities (RHAs) in ensuring institutional strengthening and quality healthcare to the population.

This is in keeping with its mission which is to provide effective leadership for the health sector by focusing on evidenced based policy making, planning, monitoring, evaluation, collaboration and regulation. The Ministry of Health (MoH) establishes national priorities for health and ensures an enabling environment for the delivery of a broad range of high quality, people centered services from a mix of public and private providers.

The signing of the Collaborative Action Statement for the WHO High 5s Patient Safety Project by the MoH in August
2011 signalled the commitment of Trinidad and Tobago towards achieving this Mission. Senior leadership commitments have been obtained from five general public hospitals of the RHAs towards the implementation of the WHO CSS Standard Operating Protocol. Multi-disciplinary Teams have been identified at the five participating public hospitals and these teams are headed by a Project Lead. Each participating hospital is currently at various stages of implementation of the CSS SOP.

At one of the participating hospital, the intrinsic culture of the operating theatre staff was identified as the greatest challenge since the checklist was initially viewed as yet another set of documentation to be completed. The Project Team experienced some resistance from senior clinicians during meetings and planning sessions. Feedback from the staff at the operating theatre was considered, documentation procedures were streamlined and regular team briefings were conducted so that teams were encouraged to take ownership of the project. The implementation team is currently described as being in the ‘study’ phase of the Deming Cycle; this will facilitate reviews and feedback from the staff at the operating theatre towards continuous improvements.

At another hospital, a project coordinator has been appointed and a project team identified. The major components of the High 5s CSS SOP were reviewed in reference to aspects of patient care with which this SOP will interface. The need for IT upgrades such as electronic patient identifiers, electronic media for patient files and automated calculation sets were identified.

A communication strategy was developed to inform staff and also to ensure sensitization of key stakeholders. The project team at this hospital will be communicating with staff through their Quality Circle meetings. The CSS SOP was piloted within the orthopaedics department at another participating hospital in May 2012. Results of this pilot showed 98.2% compliance in the use of the High 5s checklist. This team identified an arrow (← ↑ →↓) for the site marking.

Sensitization sessions continue among staff within anaesthetics, general surgery, urology and paediatric departments as the SOP will be rolled out these service areas.

In an effort to reinforce the information provided during sensitization and to heighten the interest of staff, brochures and flyers were developed and distributed to various surgical units for posting on sign boards within the surgical units.

The Ministry of Health’s Audit Team is currently conducting quality audits of the Surgical Units at all participating hospitals this includes an assessment of the status of implementation of the High 5s CSS SOP. Monitoring and support continues as required through monthly meetings with the Project Leads.

**Publications Procedures**  
*By Agnès Leotsakos*

A draft document on the High5s Publication Procedures was presented and discussed at the Steering Group meeting in the Netherlands. It is anticipated that this document will be finalized by the autumn of 2012.

**Update on Communications**  
*By Erica van der Schrieck-de Loos*

In France the project lead on the SOP for Medication Accuracy at Transitions in Care has changed to a cooperative between the HAS and the Observatory of Drugs, Medical Devices and Therapeutic Innovations.

**Wiki updates**  
*By Scott Williams*

The most recent additions to the High 5’s Information Management System (IMS) include updates to the Event Analysis (EA) materials for both the Med Rec and Correct Site Surgery protocols. These tools can be used by LTAs to gather information related to patient safety events and the analyses surrounding those events. LTAs will continue to summarize (and de-identify) all event related data so that it may be shared with the wider High 5s community. EA materials can be found on the main page of the Toolkit (linked under Event Analysis Materials) or within the data collection tools provided on each protocol page. During the May Steering Group meeting, participants requested a number of modifications and additional features related to the display of performance measure data. Over the next few months, the Collaborating Centre will be experimenting with various approaches to fulfill these requests. You may notice new features and alternative data displays as you access the IMS between August and October. It is important to note that the existing tables and run charts will continue to be available to all participants. As new features are tested, the Collaborating Centre will seek feedback from the Steering Group and the Lead Technical Agencies in each participating country. If you have any thoughts that you would like to share related to the new features (or existing ones), please feel free to post your comments on the discussion board within the Learning Community.