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Patient Safety & Clinical Risk Management

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What is Patient Safety?

- Patient safety is the prevention of harm

We Don't Want to Harm, but Harm Does Occur:

- The occurrence of adverse events due to unsafe care is likely one of the 10 leading causes of death and disability in the world
- In high-income countries, it is estimated that one in every 10 patients is harmed while receiving hospital care. The harm can be caused by a range of adverse events, with nearly 50% of them being preventable

S – Sense the Error

A – Act to Prevent It

F – Follow Safety Guidelines

E – Enquire into Adverse Events

T – Take Appropriate Corrective Measures

Y – Your Responsibility

https://www.who.int/news-room/fact-sheets/detail/patient-safety

What We Monitor & Why

- Medication errors are a leading cause of injury and avoidable harm in health care systems: globally, the cost associated with medication errors has been estimated at US$ 42 billion annually.

- Health care-associated infections occur in 7 and 10 out of every 100 hospitalized patients in high-income countries and low- and middle-income countries, respectively.

- Unsafe surgical care procedures cause complications in up to 25% of patients. Almost 7 million surgical patients suffer significant complications annually, 1 million of whom die during or immediately following surgery.

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Purpose of Patient Safety & Clinical Risk Management

Patient Safety

- The discipline of patient safety is the coordinated efforts to prevent harm to patients, caused by the process of health care itself

Clinical Risk Management

- Clinical risk management specifically is concerned with improving the quality and safety of health- care services by identifying the circumstances and opportunities that put patients at risk of harm and then acting to prevent or control those risk

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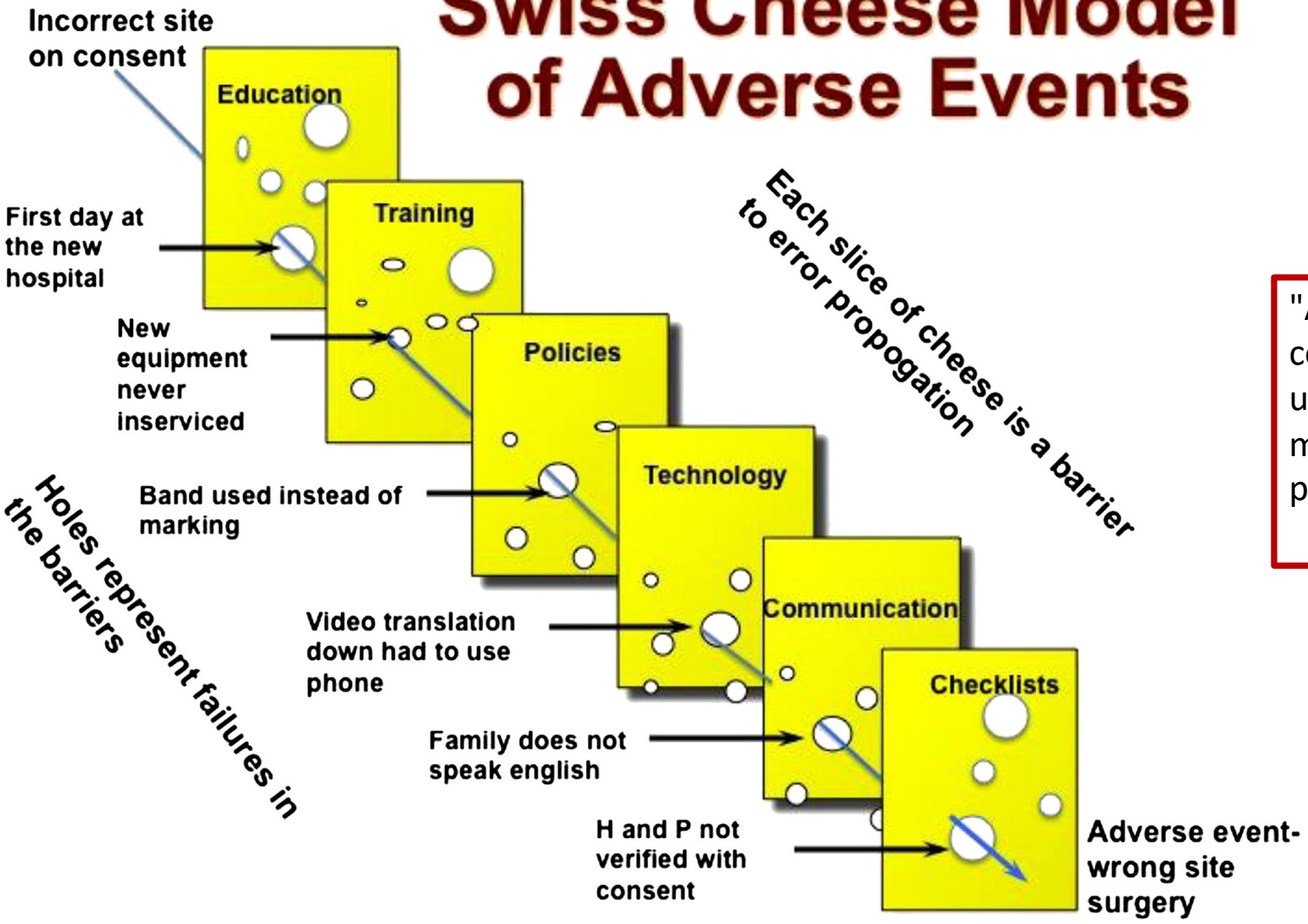
Swiss Cheese Model of Adverse Events



"Adverse event" is a negative consequence of care that results in unintended injury or illness, which may or may not have been preventable.

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What is a Great Catch?

A Near Miss is…

- An event that did not reach the patient because of chance/timely intervention

A Great Catch is a Near Miss+

- An event that did not reach the patient because of chance/timely intervention

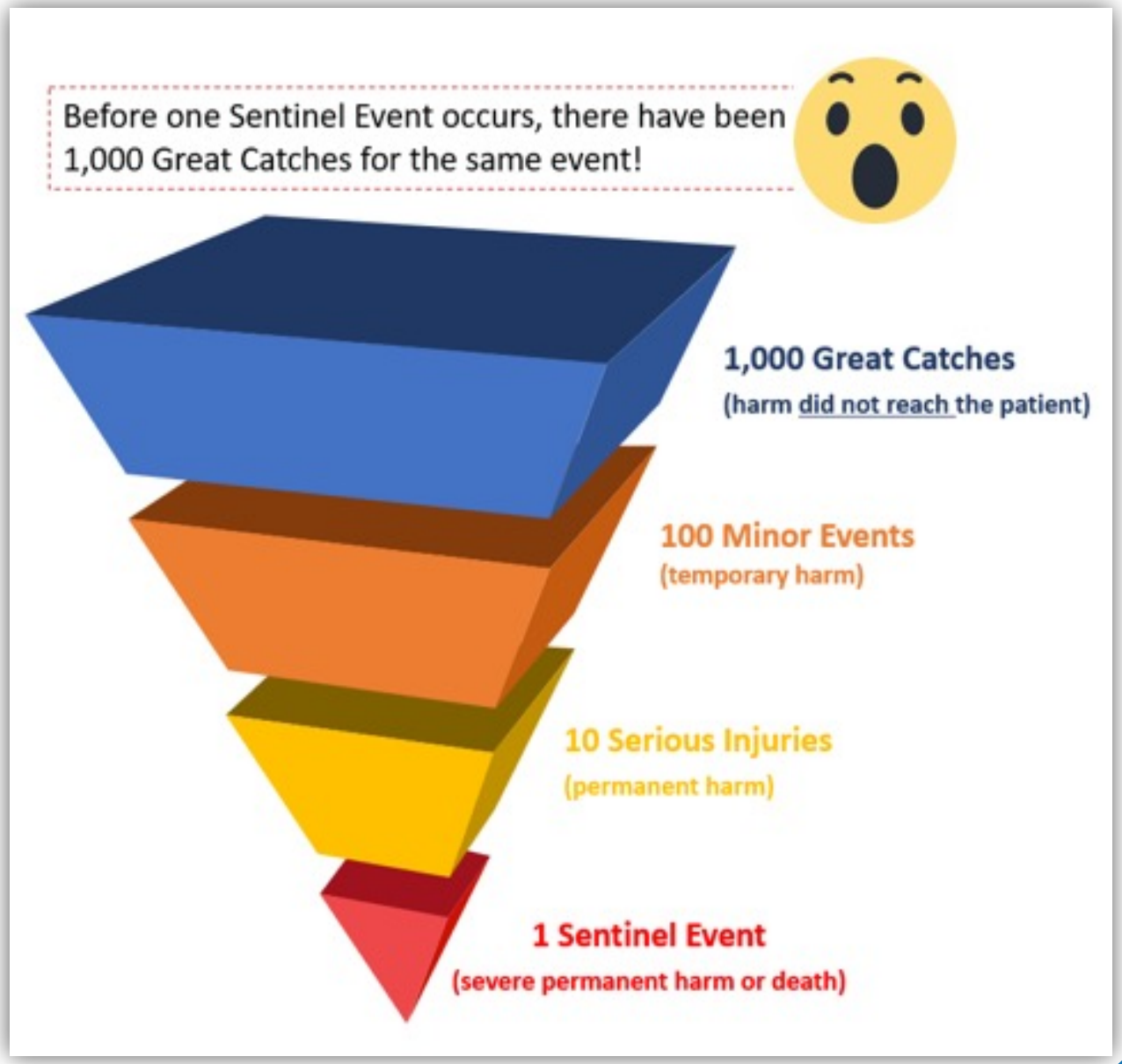
  AND

- Immediate action was taken to contain the situation and protect patient and/or staff

  AND

- Extra steps were taken to follow up

A Great Catch is an opportunity to prevent harm to patients in the future and a method for revealing process and system vulnerabilities.



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You should report events* via the online event reporting system: **Safety Intelligence (SI)**

*This includes near misses/great catches, potential harm events, and harm events.

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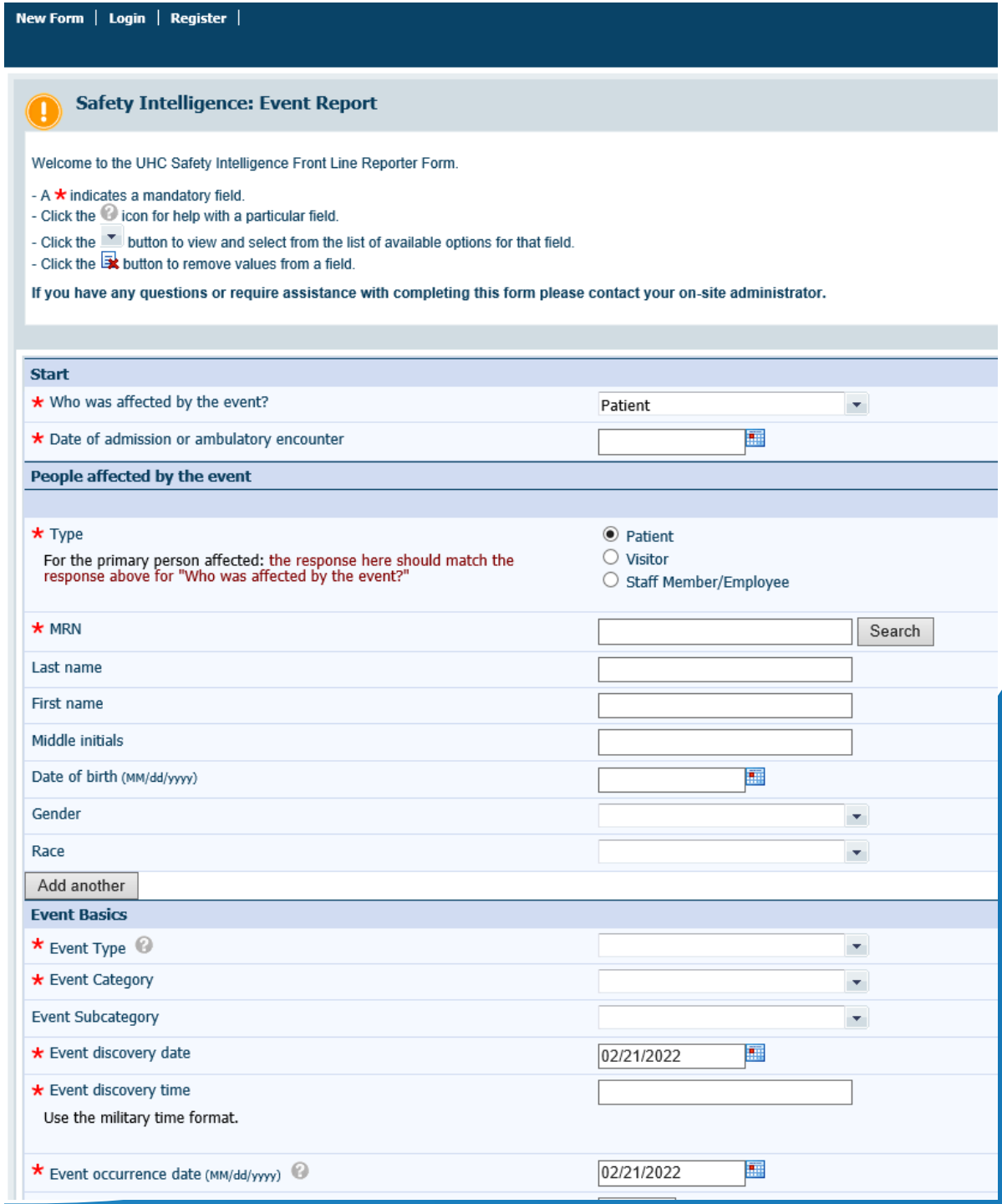


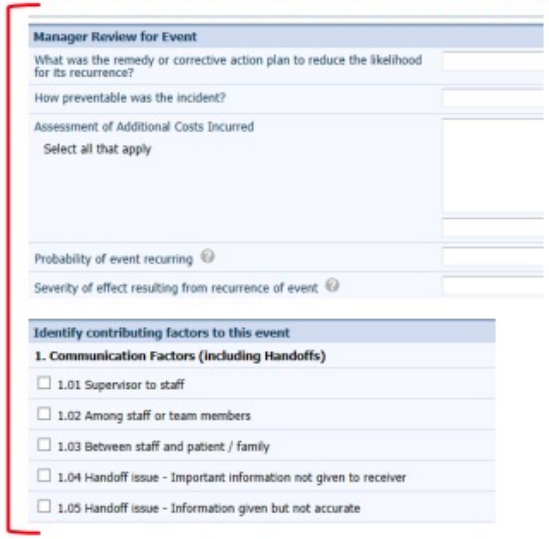
Safety Intelligence (SI) Event Instruction for Event Owners & Consultants

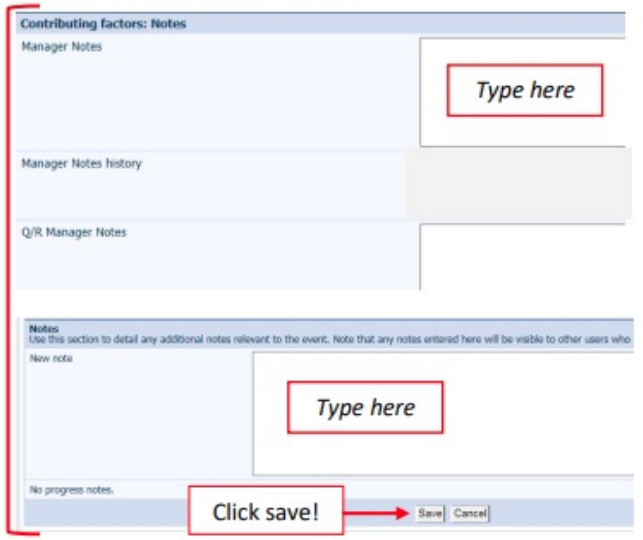
Click the link in the email sent you via the SI system. *The Google Chrome browser is recommended*
You can also access the login page at https://uhnj.datixhostingusa.com/live/index.php?action=login

Basic information regarding the event

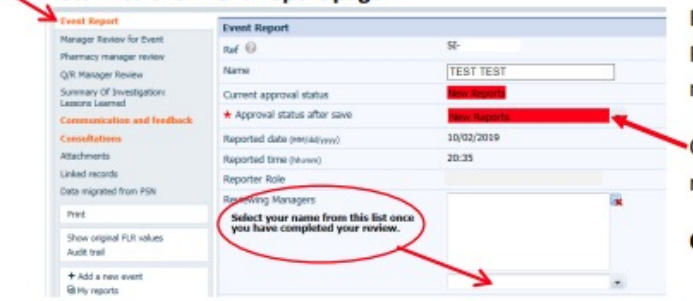
Communication between the Patient Safety Team and you.

On the **Manager Review for Event** page: **Complete all fields**, including Contributing Factors.





Return to the Event Report page.



Enter the first few letters of your last name in the Reviewing Managers drop down box. Double-click your name to enter it into the box.

Change the approval status to **Being Reviewed** if still reviewing or **QRM review** if your review is complete.

Click Save and you are done!

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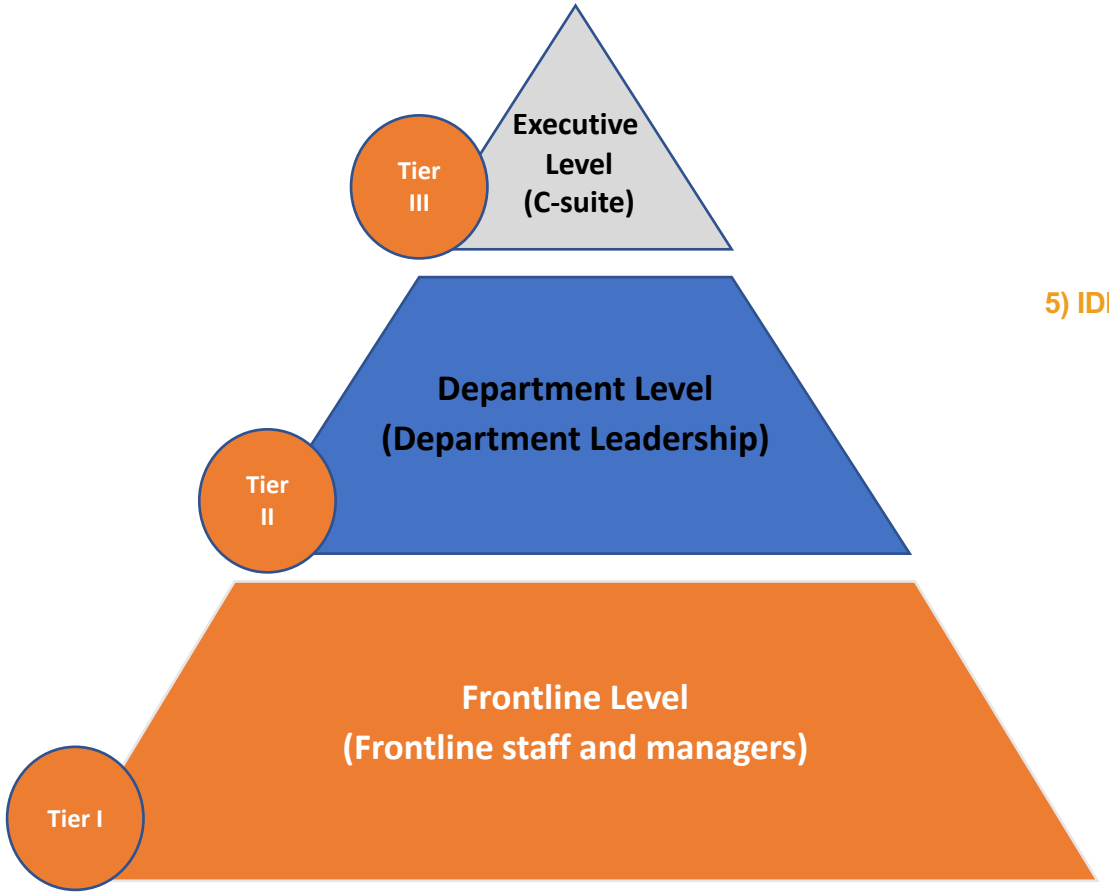
What Are Tiered Huddles?



1) PROBLEM IDENTIFICATION

2) ADDRESS REALTIME ISSUES

3) ESCALATE IF NEEDED

4) REVIEW PERFORMANCE

5) IDENTIFY GREAT CATCHES

6) RECOGNIZE AND CELEBRATE

7) REVIEW PLAN

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Tiered Huddles

Ground Rules

- Huddles last no longer than 15 minutes when fully operational
- Participants physically (or virtually) meet and stand during huddle
- Teams report on the same set of measures daily (at a minimum)
- A designated scribe records action items and follows up

Report issues from your Tier 1 Safety Huddle:

Safety issues

Methods/Procedures

Equipment

Supplies

Staffing

----Tier 2 Safety Huddle ----

1. Department report out (SMESS)
2. Follow-up items
3. Patient Safety Tracker
4. Great Catches
5. Announcements
6. Recognition
7. Post-huddle huddles

- ✓ Issues impacting other departments
- ✓ Issues you are struggling to resolve and you need help from people present
- ✓ High risk situations
- ✓ Harm events
- ✓ Great Catches*
- ✓ Anything that involves police, fire dept, high profile patients, or potential for hig publicity

*A "Great Catch" is an event that had the potential to cause harm but was averted du to an intervention.

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DOH Reportable Events

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Root Cause Analysis Process (RCA2)

Solutions are the focus, not the blame!

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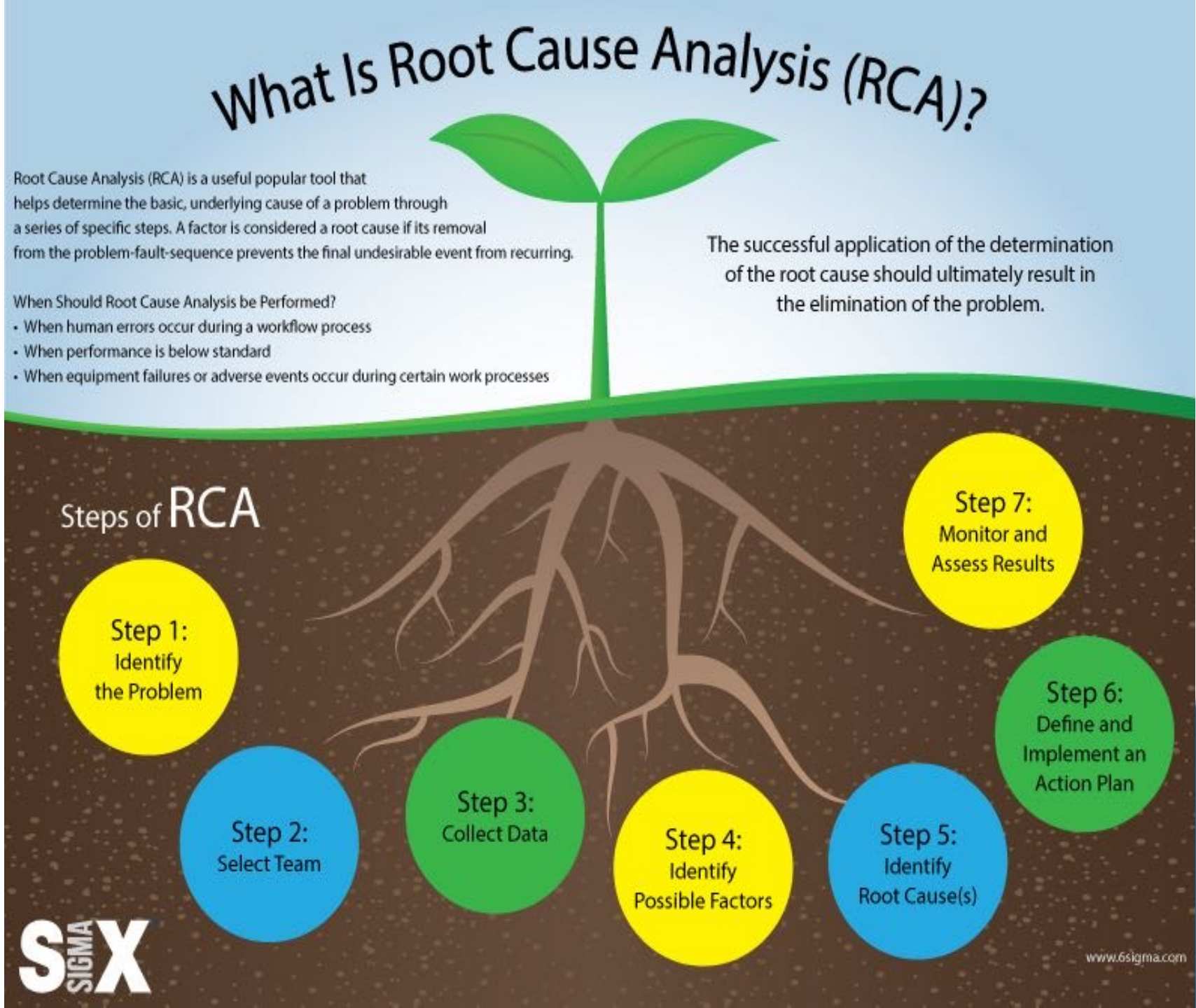

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Root Cause Analysis & Actions (RCA2) Team

What does the RCA2 team do?

- The RCA2 team is officially charged with investigating the adverse event to discover underlying system issues that contributed to or resulted in the event occurring.

Who do you consider to be the team members on an RCA2 team?

- The RCA2 team members are those who are assigned by the organization's leadership to officially serve on the team.
- These are the individuals who attend all of the meetings, conduct the research, interview staff, identify root cause contributing factors, and write the report.
- In most cases this team also identifies the corrective actions and their associated process/outcome measures, though in some organizations an individual or another team may complete this task.

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Root Cause Analysis & Actions (RCA2) Team: Identifying Corrective Actions

RCA2 teams work to identify corrective actions to mitigate root causes of the adverse event using the following steps:

- Causal statements for all identified contributing factors
- For each causal statement, an action is identified that could mitigate the cause and minimize the chances of the event recurring and reduce the severity or consequences should it recur.
  - At least one strong or intermediate action for each identified cause
- Identify an individual responsible for implementation and measurement of each corrective action
- Monitor implementation on an ongoing basis to ensure that changes achieve the desired results

Contact Us

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