2015 Patient Safety Training
Introduction to Patient Safety

- Our patients’ health and safety are of the highest priority while in our care here at CVMC.
- Whether or not you are in a position of providing direct patient care, you have an important role in assuring safe systems of care for our patients, their families and staff.
- The complexity of patient care alone can create potentially harmful situations.
- The Quality Management Department works with CVMC employees and medical staff to design and implement systems and processes that minimize potential for adverse events and patient injuries. We are committed to improving safety for our patients!
- Refer to policy A-902 Adverse Event/Near Miss Reporting and Analysis
S.A.F.E. (Safety Alert For Events) - CVMC’s Event Reporting System

What should I report?

- Anything that you feel may pose a potential or actual unsafe condition for a patient, visitor, staff member or other individual in our organization.
- A “Sentinel” or “Serious Reportable” event
- Any ‘systems’ or ‘process’ issue that may cause a patient safety risk
- Any “near miss” - an event that could have occurred but didn't because a staff member intervened in the situation
- When in doubt… fill out a report
- Our Good Catch Award recognizes individuals who report a near miss. A “Good Catch” winner will be chosen monthly for the “Good Catch” award.
Event Reporting (S.A.F.E.)

S.A.F.E Reporting:
- is non-punitive - the focus is on our systems, not on individual performance. CVMC’s philosophy is ‘blame free, but accountable’, meaning that we do not punish or blame people for failures of the system, but staff members are accountable for following the policies and procedures of the organization, as well as standards of professional practice.
- increases awareness of potential and actual patient safety and systems issues.
- enables report trending helping us to identify problems proactively, and not have to wait for a patient to be injured to take action.
- allows us to focus on performance improvement
- is everyone’s duty and responsibility
**Sentinel Events**

**Definition:** An unexpected occurrence involving death or serious physical or psychological injury or the risk thereof. Serious injury specifically includes loss of limb or function. *(The Joint Commission)*

Events are called “sentinel” because they signal the need for immediate investigation and response. The terms “sentinel event” and “medical error” are not the same – not all sentinel events occur because of an error and not all errors result in sentinel events.

**Examples:**
- Discharge of an infant to the wrong family
- An unexpected death not related to the patient’s underlying illness
- Unanticipated death of a full-term infant
- Suicide of any patient receiving care, treatment or services in a staffed around the clock care setting or within 72 hours of discharge
Sentinel Events

What Should I do?

- If you are involved in or witness a serious or sentinel event, please notify your manager/supervisor immediately and file a SAFE report. The Quality Management Department will determine the facts and analyze the factors that contributed to the event in order to improve our processes and prevent another similar event.
Serious Reportable Event

In Vermont, the Patient Safety Surveillance Act was passed in 2006. This law requires hospitals to identify any serious reportable events, conduct a thorough analysis of each serious reportable event, disclose the event to the patient, and report the event along with a causal analysis and improvement plan to the Vermont Department of Health. Reports are submitted by the CVMC Quality Management Department.

What Should I do?
If you are involved in or witness a serious or sentinel event, please first, care for the patient. Then notify your manager/supervisor and file a SAFE report. We will determine the facts and analyze the factors that contributed to the event in order to improve our processes and prevent another similar event.
Serious Reportable Event

Definition – “Unambiguous, largely, if not entirely preventable, serious clinical events” (National Quality Forum)

- Look for a pocket card or poster for more information

A Sentinel Event is:
An event that has resulted in an unanticipated death or major permanent loss of function, not related to the natural course of the patient's illness or underlying condition – OR an event that is one of the following (even if the outcome was not death or major permanent loss of function):
- Suicide of any patient receiving care, treatment and services in a staffed around-the-clock care setting or within 72 hours of discharge
- Unanticipated death of a full-term infant
- Abduction of any patient receiving care, treatment and services
- Discharge of an infant to the wrong family
- Rape
- Hemolytic transfusion reaction involving administration of blood or blood products having major blood group incompatibilities (ABO, Rh and other blood groups)

A Serious Reportable Event is:
- Wrong site or wrong patient surgery or other invasive procedure
- Wrong surgical or other invasive procedure
- Unintended retained foreign body after surgery or other procedure
- Intra-op or immediate post-op death of an ASA Class I patient
- Discharge of a patient who is unable to make decisions to other than an authorized person
- Suicide, attempted suicide or self-harm that results in serious injury in the health care setting
- Maternal or neonatal death or serious injury associated with labor or delivery in a low-risk pregnancy
- Stage 3, 4 or unstageable pressure ulcers acquired after admission
- Artificial insemination with wrong donor egg or sperm
- Care provided by someone impersonating a licensed health care provider
- Abduction of a patient
- Sexual abuse or assault on or within the grounds of a health care setting (patient or staff)
- Intentional unsafe act
- Systems designed to deliver oxygen or other gas contain no gas, the wrong gas, or are contaminated by toxic substances
- Death or serious injury associated with:
  - Introduction of a metallic object into MRI (patient or staff)
  - Use of contaminated drugs, devices or biologics (includes change in patient's risk status for life)
  - Device malfunction
  - Intravascular air embolism
  - Patient elopement (disappearance)
  - Medication errors
  - Unsafe administration of blood products
  - Falls
  - Irretrievable loss of an irreplaceable biological specimen
  - Failure to follow up or communicate laboratory, radiology or pathology test results
  - Electric shock (patient or staff)
  - Burn (patient or staff)
  - Use of physical restraints or bedrails
  - Physical assault on or within the grounds of a health care setting (patient or staff)

For More Information
For questions, more information, or to report an event, please call the Quality Management Department at (802) 225-5805
Root Cause Analysis

CVMC uses a multi-disciplinary team approach, known as Root Cause Analysis - RCA - to study health care-related adverse events and close calls. The goal of the RCA process is to find out what happened, why it happened and to determine what can be done to prevent it from happening again. Because our Culture of Safety is based on prevention, not punishment, RCA teams investigate how well patient care systems function. We focus on the "how" and the "why" not on the "who".

The goal of a **Root Cause Analysis** is to find out

- *What happened?*
- *Why did it happen?*
- *What to do to prevent it from happening again.*

**Root Cause Analysis** is a *tool* for identifying prevention strategies. It is a process that is part of the effort to build a *culture of safety* and move beyond the culture of blame.
Disclosure

- Open and ongoing communication with patients about their care and the outcomes of such care is critical to enable patients to be full partners in their health care. Patients or their surrogate decision makers should be provided relevant, easy-to-understand information about all outcomes of care, including adverse events, in a timely manner.

- Patients should receive a truthful and compassionate explanation when an adverse event has resulted in harm and is or may be the result of a deviation from the standard of care. In Vermont, a disclosure conversation is required for any “Serious Reportable Event” as defined by the National Quality Forum.
Disclosures:

- ‘Guidelines for Disclosure Conversations’ policy # A-120 provides a framework to guide and support these conversations. Disclosures should be made to the patient or when appropriate, to the patient’s family or designated decision-maker.

- It is the responsibility of the Attending Physician to have the disclosure conversation with the patient. Please call the Risk Manager in the Quality Management Department (371-5309 or 371-4215) for assistance in providing this information to the patient or family.

- The patient should be encouraged to contact the Risk Manager in the Quality Management Department at any time (371-5309 or 371-4215) or the Patient Advocate (371-4350) if they have any questions or concerns.

- All disclosures should be reported to the Risk Manager. After hours/weekends/holidays consult with the Nursing Supervisor who will inform the Risk Manager.
The Joint Commission – National Patient Safety Goals

Purpose: To set patient safety standards for all Joint Commission accredited hospitals/healthcare organizations.

- Started in 2002 with 7 goals
- New goals are added each year
- Some goals are retired or incorporated into standards each year
- Each goal has one or more requirements for compliance
- Compliance is measured through mock surveys and audits conducted throughout the year
- CVMC Quality Management Department are responsible for organizational oversight of these goals
The Joint Commission – National Patient Safety Goals

- Improve the Accuracy of Patient Identification (Two Patient Identifiers, eliminating transfusion errors)
- Improve the Effectiveness of Communication Among Caregivers (Timeliness of critical results)
- Improve the Safety of Using Medications (Medication Labeling; Anticoagulation Therapy; Medication Reconciliation)
- Reduce the Risk of Health Care-Associated Infections (hand hygiene; prevention of MDRO infections, prevention of central line associated blood stream infections, surgical site infections, prevention of indwelling urinary catheter related infections)
- Improve the safety of clinical alarm systems
- Identify Safety Risks Inherent to its Patient Population (Identifying Individuals at Risk for Suicide)
- Universal Protocol (Conducting a Pre-procedure Verification Process, Procedure Site Marking; Performing a Time-Out)
Conclusion

- Patient Safety is everybody’s responsibility – be aware of the processes and systems you use to provide care.

- Report any actual or potential safety concerns through the SAFE system. The near miss or potential events are treasures that allow us to prevent injury to patients.
Congratulations,
you have completed your review of CVMC’s 2015 Patient Safety Presentation!

You now need to complete the 2015 Patient Safety Exam to demonstrate competency on the material that you just covered. In order to successfully pass, you must receive a score of 80% or greater.