2015 Woodridge Patient Safety Training
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 Woodridge Management Team 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!
S.A.F.E. (Safety Alert For Events) - CVMC’s Event Reporting System

What should I report?

- Patient falls, elopements, injuries, bruises, med errors and resident to resident incidents. Employee injuries. Visitor falls and injuries.
- 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 pro-actively, 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

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:
- Allegation or suspicion of Abuse and injury or bruise of unknown origin: refer to Policy WN-51 Abuse Prohibition, Prevention, Investigation & Reporting.
- Fall with fracture or serious injury.
- Elevated PT/INR requiring Vitamin K.
- Dehydration
- Fecal Impaction
- Elopement
- Pressure Ulcer
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 fill out a sentinel event form. The Interdisciplinary Team will determine the facts and analyze the factors that contributed to the event in order to improve our processes and prevent another similar event.
Event Reporting (S.A.F.E.)

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.
- For any sentinel event, your supervisor needs to be notified immediately.
- Any safe report involving a patient/resident, patient’s MD and POA or person to notify needs to be called.
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 WDR’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 100% or greater.