Patient Safety and Quality Improvement

Rapid Regulatory 2020

Salinas Valley Memorial Healthcare System

SVMHS Patient Safety

SVMHS's **Patient Safety Plan** outlines how we can improve patient safety and reduce risk as well as how to recognize and respond to medical errors.

An important aspect of this plan is built on a **"just culture"** environment in which healthcare workers are encouraged to communicate errors and near-misses.

If staff communicates errors/near-misses, then we have the opportunity to investigate the errors in the process, discover the causes, and **identify ways to prevent them from occurring in the future.**

Despite constant and committed efforts to provide and improve patient care, it happens from time to time that **patients are harmed rather than helped by health care.**

Another important aspect of this plan is related to **disclosure of unanticipated outcomes** to the patient.

For any system to work well, a **team approach** is necessary.

JUST CULTURE

Patient safety initiative designed to address both system issues and individual behavior.

- Shift from focus on errors and outcomes -to system design and behavioral choices
- Achieve a culture where frontline staff feel comfortable informing us of errors

ACCOUNTABILITY FOR OUR BEHAVIORS

Human Error

Inadvertent actions

"I forgot to ……

Manage through changes in:

Processes
Procedures
Training
Design
Environment

At-Risk Behavior

A choice:

"Everyone else was busy so I did it myself"

Manage through:

Removing incentives

Creating incentives for healthy behaviors

Increasing situational awareness

Reckless Behavior

Intentional Risk Taking

'I didn't do the dressing change because I was tired and too busy."

Manage through:

Disciplinary Action

Console | **Coach** | **Discipline**

What is an Occurrence?

- A situation / event which is NOT, under ordinary circumstances, expected
- May be an actual event involving patient injury or a potential event or other situation which might result in patient injury or harm

It is NOT…

- NOT to be used for reporting staffing concerns or complaints about another individual's behavior

Comprehensive Analysis a.k.a. Root Cause Analysis (RCA)

Is a process for identifying the basic or causal factor(s) that underlie variation in performance, including the occurrence or possible occurrence of a sentinel event.

RCA Steps:

1. List the chronology of the event
2. List contributing factors (root causes)
3. Develop an improvement strategy for each contributing factor
4. Formalize an improvement plan
5. Assign a responsible person for each step in the improvement plan with an implementation date
6. Identify effectiveness measures for each step in the improvement plan and assign staff members to monitor results

Report Quickly

Hospitals must report an Adverse / Never / Sentinel event to the CDPH no later than **five calendar days** after an adverse event has been detected.

Assault or a criminal event is reported by the next calendar day.

Contact the unit leadership / Administrative Supervisor immediately.

Question:

What do you do if you suspect a serious or reportable adverse event happened?

Answer:

1) Staff: Contact your Director/Manager or Administrative Supervisor **as soon as possible after the safety of the patient or staff is cleared** to discuss the event, then enter the event into the Occurrence Reporting System (WeCare).

2) Director/Manager or Administrative Supervisor will then contact Risk Management / Patient Safety Officer for next steps/ Regulatory (as it may need to be reported to CDPH).

Reporting Chain of Command

Remember: Timely reporting is imperative to prevent harm and in order to notify external entities if needed. This means not only reporting in the Occurrence Reporting system, but escalating it **(meeting with your supervisor directly or call them)** as well.

To effectively report a quality or safety concern, take the following steps:

Report to your **immediate supervisor** or to the Administrative Supervisor, if after hours

Report to your **Department Director/Hospital Contact**

Report to **Risk Management / Patient Safety Officer**

Patient Advocate

All persons at SVMHS must be a Patient Advocate

- Recognition of situations which are not in the best interest of the patient, i.e. reporting a questionable drug order to the writing MD
- Reporting an incapacitated healthcare provider
- Failure to report known or suspected instances of patient abuse constitutes unprofessional conduct and is grounds for discipline.

Reporting Takeaways

#1. It's important to report issues or concerns in a timely manner

#2. Any employee/physician who has a safety or quality concern about care provided in the hospital should immediately report concerns to their direct supervisor or, if after hours to the Administrative Supervisor and submit a report via the electronic occurrence reporting system.

#3. Process improvement activities are based on occurrence reporting trends, employee feedback, patient safety surveys and new regulations.

#4. Risk (x3075) / Quality Management (x1863) may be contacted at any time if questions.

What Should be Included in the Occurrence Report?

- List just the facts
  - Leave out unrelated information and **do not** add your thoughts or opinion
  - This narrative will be used for investigation

- This is notification that something unusual may have occurred - reporting a ***SITUATION / EVENT,*** not a ***PERSON***…..
  - This is NOT a forum to "write up so-and-so" or complain.

- NEVER document in the medical record that an occurrence report was filed, but do document the facts surrounding the event

YOUR ROLE IN PATIENT SAFETY

- **LEARN** about Patient/Hospital Safety. Patient Safety is the most important component of health care. All persons should consider themselves as members of the Hospital Safety Team and learn/understand Safety Rules that apply to their job.
- **REPORT** any hazards you see or find. Everyone is responsible for safety and preventing injuries/accidents. Everyone should consider themselves as members of the SVMH Safety Team and report.
- **BE ALERT** for anything that could harm a patient, visitor, or employee (including environment issues).
- **PARTNER WITH YOUR TEAM and PATIENT SAFETY OFFICER** to proactively focus on integrity of processes, analyze incident reports/errors and promote action through mentorship and training of staff as well as implementation of proven methods for maintaining a culture of safety or changing culture where needed through education.

Patient Safety is Everyone's Responsibility

CONGRATULATIONS!

YOU HAVE COMPLETED THIS E-LEARNING OF:

PATIENT SAFETY AND QUALITY IMPROVEMENT