Reported to the Board of Trustees
March 10, 2010

Medical Center Safety Report

to the University of Illinois Board of Trustees

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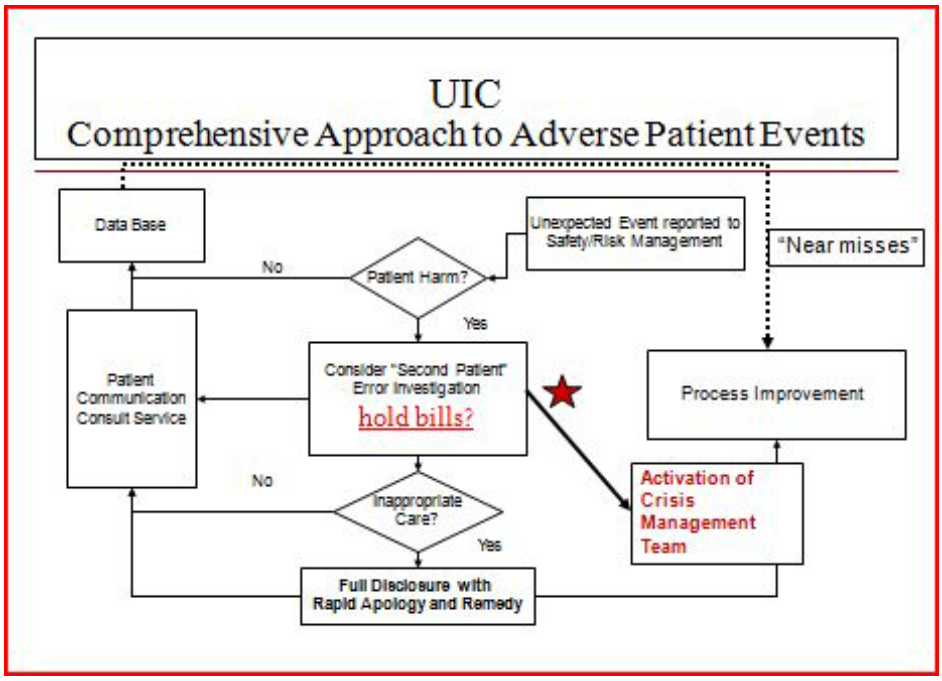
Joint Commission expectations: Report at least annually on -

1. **Process and systems failures**
2. **Sentinel [significant] events**
3. **Communications with patients/families**
4. **Process improvements**



Case example of Patient Safety Process – the UIC Comprehensive Approach

Brief synopsis of case: Patient with history of allergy to non-steroidal anti-inflammatory medication is admitted to UIC Hospital after surgery. Surgery intern, unaware of allergy, orders patient to receive ketorolac [a non-steroidal anti-inflammatory medication.] Patient suffers severe respiratory distress and is admitted for several days to the Intensive Care Unit. Case came to the attention of Safety/Risk Management after patient complained of the invoice she received for the unnecessary ICU care.

Investigation [Root Cause Analysis]: Multiple system and process failures were identified that resulted in a patient receiving a medication to which they were allergic. Some of those failures were:

1. A “work around” allowed physicians to enter allergies in a way that did not trigger a computer-generated alert or hard stop to prescribing and dispensing.
2. The patient’s wrist band did not clearly identify the kind of allergy.
3. The pharmacist did not identify the allergy when dispensing the medication.

Communication: As soon as the event was reported to the Department of Safety and Risk Management a meeting was held with the patient, an apology was offered and the patient was asked to play a role in the solution to the process breakdowns.

Process Improvements: The computerized electronic record was re-designed to “force function” the inclusion of allergies in a manner that would trigger alerts and prevent such medication dispensing from occurring. Arm bands for allergies were altered to allow for the exact medication allergies to be listed.

Follow-up: Data was tracked for a year following the redesign of the computer system. This data was presented at the medical center’s Safety Committee – it showed total elimination of the prior work-around.

Resolution: The patient was compensated through the self-insurance trust for the costs related to the ICU admission and a subsequent necessary surgery. She was notified of the changes she inspired in the electronic medical record system.