

Safety and Risk Management Report

A. The “Seven Pillars” Comprehensive Process for the Prevention and Response to Patient Harm

The nationally-recognized University of Illinois Hospital (UIH) Seven Pillars program, run by the Department of Safety and Risk Management under the Division of Quality & Patient Safety, continues to focus on all seven of the critical elements across the University of Illinois Hospital & Health Sciences System (UI Health) including

- 1.) event reporting
- 2.) rapid and effective communication following harm
- 3.) interdisciplinary investigation
- 4.) waiver of hospital and professional fees when care is deemed inappropriate
- 5.) performance and process improvements
- 6.) data analysis, and
- 7.) education.

The Department continues to track these elements and focus on linkages between effective communication and malpractice claim reduction in conjunction with University Risk Management in Urbana.

B. UIH Data – July through December 2013

1. Occurrence Reporting

Employees are encouraged to report adverse events, unsafe circumstances, and near-misses to the Department of Safety and Risk Management using the Midas occurrence reporting system. Midas reports involving staffing effectiveness are among the reports triaged by Risk Managers and reviewed at weekly Administrator-On-Call (AOC) meetings. Event reports involving actual or potential patient harm trigger an immediate response including escalation to the Patient Care Director of the unit reporting the event and root cause analysis of serious harm or near-miss events.

2. Investigation of Significant Events

Root cause analysis associated with process improvements was conducted in the following areas:

- Performance of C-sections outside of Labor and Delivery
- Care of Psychiatry patients on non-Psychiatry Units
- Management of patients who do not have permission to leave the organization
- Defibrillators

C. Staffing Effectiveness

Staffing Effectiveness is routinely evaluated using Root Cause Analysis to explore a wide range of staffing-related considerations. The analysis involves use of the MORT (Management Oversight Risk Tree Analysis) tool. This provides a framework for identification of human resource and task performance breakdowns by analysis of a wide range of staffing issues including the following:

- ✓ Did the key individuals assigned to the task perform in accordance with standards?
- ✓ Were staff properly qualified and/or credentialed?
- ✓ Were staff properly oriented and trained?
- ✓ Were back-up plans in place for unusual staffing situations?
- ✓ Did supervisor and/or attending physicians have time and all pertinent information to respond to the situation?
- ✓ Were procedures available, workable, intelligible, correct, and routinely used?
- ✓ Did supervisor provide appropriate staff coverage per normal procedure?
- ✓ Were there deficiencies in training, selection, or experience?
- ✓ Was supervisor and/or attending physicians available if needed?
- ✓ Were key individuals working extended (more than 12) hours or consecutive shifts?
- ✓ Was supervisor trained to adequately respond to such a situation?
- ✓ Was fatigue a potentially contributing factor?

Less than 5% of occurrence reports (250) in 2013 were designated as related to staffing effectiveness; this is comparable to reports submitted in 2012. No significant issues related to staffing effectiveness were identified during this time period.

D. Communication Consult Service Support

There was a 33% decrease in number of requests for Safety and Risk Management staff to attend and facilitate patient and family meetings involving communication of adverse events compared to the same time period in 2012 (from 108 to 72). Clinicians trained in the communication of adverse events are now managing this process independently or preparing for communications with coaching from the Department.

E. Care for the Care Provider Support

There was no appreciable increase in the number of adverse event reports generating referrals for care provider peer-to-peer support over the same timeframe in 2012 (from 19 to 20).

F. Medical Staff Review Board

The Medical Staff Review Board (MSRB) is the medical staff committee charged with review and investigation of all significant and sentinel events and endorsement of associated action

plans to identify opportunities to improve patient safety by analyzing root causes of errors and implementing systems and operational changes for improvement. During July through December 2013, the MSRB identified opportunities to improve processes in the following areas:

1. Performance of C-sections outside the Labor and Delivery (L&D) Unit

- ✓ Consider benefit of checklists to facilitate safe transfer of patient and newborn in development
- ✓ Develop triggers for emergency response
- ✓ Standardize hand-offs between units and disciplines under development
- ✓ Ensure an obstetrics nurse is accountable for fetal heart rate monitoring when deliveries are happening outside of the Labor and Delivery Unit
- ✓ Create a Rapid Response Team specific for off-L&D deliveries with Obstetrics, Anesthesia, and Pediatrics
- ✓ Create emergency response phone tree
- ✓ Ensure warmers and C-section kits are present on the unit with the patient
- ✓ Implement drills and simulation for non-L&D C-sections

2. Management of psychiatric patients on non-psychiatry units

- ✓ Evaluate the physical environment for appropriate placement of psychiatric patients who warrant treatment on non-psychiatric units
- ✓ Based on risk assessment, patients deemed an elopement risk will be assessed for need for 1:1 observation, bed alarm, and removal of street clothes
- ✓ Have Nursing Unit or Nursing Resource Office assign observers/ sitters for patients at risk of elopement
- ✓ Ensure that staff who might be staffed as observers/sitters are Crises Prevention Intervention (CPI) certified

3. Conducting routine “mock codes” on Telemetry step-down units to maintain a sufficient level of competence for our clinical staff

G. Culture of Safety Survey Results

During November 2013, the Agency for Healthcare Quality and Research’s Culture of Safety survey was administered to all UI Health clinicians and staff. 1,272 employees completed the survey, representing a 25% response rate. While scores improved in all categories from the last Culture of Safety survey (administered in November 2011), they remain below the 10th percentile compared to national benchmarks.

Our highest- and lowest-scoring areas on the **Hospital Survey** were:¹

Highest

¹ The numbers in parentheses indicate the percent of *positive responses* to the survey questions in each category.

- Teamwork within Units (62%)
- Organizational Learning / Continuous Improvement (60%)
- Manager Expectations & Actions Promoting Patient Safety (58%)
- Management Support for Patient Safety (55%)

Lowest

- Handoffs & Transitions (27%)
- Nonpunitive Response to Error (29%)
- Staffing (38%)
- Teamwork Across Units (39%)

Our highest- and lowest-scoring areas on the **Clinic Survey** were:¹

Highest

- Teamwork (62%)
- Staff Training (54%)
- Organizational Learning (50%)

Lowest

- Work Pressure & Pace (29%)
- Patient Care Tracking & Follow-Up (38%)
- Office Processes and Standardization (39%)

A workgroup has been convened to (1) help communicate survey findings, (2) engage our staff in conversations about their experiences and recommended areas of focus, and (3) develop specific action plans focused on substantially improving our performance during 2014.