Reported to the Board of Trustees
November 14, 2007

Safety Report to the University of Illinois Board of Trustees for FY 2007

As previously presented to the Board of Trustees, we adapted a safety tool developed by the Atomic Energy Commission as a template for investigations into Sentinel (unexpected occurrence resulting in death or serious physical or psychological injury or risk thereof) and Significant (potentially compensable event involving significant patient harm but not necessarily medical error) events. Faculty and staff are strongly encouraged to report either event and are supported by the Department of Safety and Risk Management in doing so. Questions are attached to each of the categories below to elucidate the problem in a standardized manner:

1. Were **Guidelines and Policies** adequate?
2. Was **Information Management and Communications** effective?
3. Was the **Equipment** faulty?
4. Were **Medication Procedures** followed correctly?
5. Did the **Physical Environment** play a role?
6. Were there problems with **Task Performance?**
7. Was the supervisor **Supervising?**
8. Were problems identified with the **Care Process**?
9. How much **Risk** did the patient present?
10. Was this a clear medical error and was there **Full Disclosure**?

This process was applied to investigations of 15 confirmed sentinel and significant events this year. The investigations led to 46 process improvements over the full range of categories.

In addition, a consult team was established to enhance communication and drive the full disclosure process endorsed by the Board last year. In the 18 months since the Patient Communication Consult Service was begun we have had:

1. 62 Patient Communication Consults proactively initiated
2. 20 were in the past two months and are indicative of the faculty and staff embracing the changing culture of safety at the University of Illinois Medical Center at Chicago
3. 19 clear errors with “full disclosure”
4. Three settlements without claims filed. One of those settlements required Board approval.
5. One claim has been filed after “full disclosure” to the patient and family.

The program coincides with a significant reduction in our risk as measured by claims and assessed by the actuaries. We experienced a two million dollar malpractice premium reduction this year!

Conclusion: This robust program has been implemented as a resounding success; identifying problems, driving solutions, improving patient relations, gaining a national reputation, and firmly establishing a culture of safety at the University of Illinois Medical Center at Chicago. Far from

increasing our financial risk, we believe it has enhanced our ability to deal with error and reduced our risk as demonstrated by a reduction in malpractice premiums.