Reported to the Board of Trustees
September 14, 2012

Safety and Risk Management Board Report
September 2012

"Seven Pillars" –Comprehensive Process for the Prevention and Response to Patient Harm
The nationally-recognized Seven Pillars program at the University of Illinois Hospital and Health Sciences System, run by the Department of Safety and Risk Management, continues to focus on all seven of the critical elements with the Hospital and Health Sciences System 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 focus on linkages between effective communication and malpractice claim reduction in conjunction with the Vice President of Health Affairs and University Risk Management in Urbana.

University of Illinois Hospital and Health Sciences System Data
January through June 2012

Occurrence Reports – continue to increase with staff reporting near-misses and unsafe conditions

Investigation of Significant Events – root cause analysis associated with process improvements in the following areas:

- infant security
- home birth delivery
- retained surgical objects
- central line associated blood stream infections
- medication reconciliation
- observation of psychiatric patients

Communication Consult Service Support -23 cases

Care for the Care Provider Support -7 cases generating referrals on behalf of multiple care providers

Staffing Effectiveness-review of staffing related issues is continuously incorporated into the analysis of patient occurrences. Initiatives to improve

Safety will focus on development of highly effective teams and optimizing resources to achieve best clinical outcomes using a Team STEPPS approach.

Verbal Orders

Work continues in area of improving communication

DOCUMENTATION COMPLIANCE UPDATE – VERBAL ORDERS

Month	Compliance rate
January	90%
February	87%
March	87%
April	83%
May	86%
June	**96%**

- Compliance dropped below 90% for signing verbal orders within 48 hours
- Action plan for TJC compliance developed
- Non-compliant areas notified by HIM on a weekly basis starting in June

Patient Safety Initiative: Reduction in Overall Hospital Mortality

FY12 mortality data indicated 327 hospital inpatient mortalities. The event data is sorted by time, location, and clinical service.

UHC Teaching Hospitals

	Jan - Mar 2012 (Q1)						Apr 2011 - Mar 2012 (recent year)					
	Relative Performance	Denom (Cases)	Obs Mort(%)	Obs/Exp Ratio	UHC Median	Rank	Relative Performance	Denom (Cases)	Obs Mort(%)	Obs/Exp Ratio	UHC Median	Rank
Summary												
Post-Surgical		995	1.91	0.99	0.88	77/114		4,004	2.85	1.37**	0.91	113/115
Quality and Accountability Aggregate		4,271	1.33	0.74	0.87	19/116		16,242	1.71	0.97	0.92	78/116
Total Inpatient		5,339	1.18	0.84	0.90	41/117		20,293	1.50	1.04	0.93	92/116

A major 2013 patient safety initiative focuses on achieving a substantial reduction in overall in patient mortality. To that end, the Department of Safety and Risk Management has worked with Information Service to provide weekly mortality reports sorted by location, clinical service, admitting diagnosis and days of hospitalization.

Upon receipt of the these reports, a physician research assistant will summarize the pertinent clinical issues and submit these to the primary clinical service involved in the care of the patient at the time of death.

Each clinical service will conduct a review of all mortalities, concentrating on the various phases of patient care. In event of a patient's death is associated with an invasive procedure within the prior 30 days, these focused reviews will address the pre-procedure phase [including judgment related to patient choice, timing and risk/benefit of procedure], the intraoperative or intra-procedure management, post-procedure management [with special focus on surgical site infections and central line associated blood stream infections], and discharge planning for the patient.

A determination of complications, possibility for how complications could have been avoided and assessment of the death will occur. In all cases, whenever the adverse outcome is deemed avoidable, processes for prevention of future similar events will be provided. The Department of Safety and Risk Management will help facilitate these reviews.

An on-line database for the aggregation, analysis, follow-up, and accountability for these events will be used in this process.

Ancillary Support:

Medical Malpractice – the Department continues to maintain a detailed, frequently updated database of all medical malpractice claims involving University of Illinois employees within and outside the Hospital and Health Sciences System.

a) Nine lawsuits were filed between January and June 2012 for the Chicago and Rockford campuses. Faculty in the Departments of Medicine, Neurosurgery, Radiology, Psychiatry, Obstetrics and Gynecology, and Family Medicine were named in the suits.
b) Two general liability suits were also filed between January and June 2012. Both involved falls at the Chicago campus.

Research:

AHRQ grants – Four members of the Department engaged in grant activity with ten Chicago area hospitals and have achieved significant milestones necessary for successful implementation of the Seven Pillars process at the performance sites.

Education:

Masters in Patient Safety Leadership – Department staff continue to participate and develop experiential education for MPSL students. Newly developed program material focuses on a comprehensive approach to the study and implementation of the UIH Seven Pillars process and key elements of the program.

Graduate Medical Education – the Department supports ongoing accreditation of Graduate Medical Education programs. Detailed reports are provided for onsite surveys highlighting engagement of physician residents in Quality and Safety education and process improvements.