Let’s keep OUR patients safe!

Office of Clinical Risk Management
and Patient Safety

The University of Mississippi Medical Center
Story
What is an Event?

Unexpected outcomes:
- System failure (most frequent)
- Individual failure (uncommon)

Unsafe condition
Unsafe act
Near miss
Accident

Good Catch
Proactive (prevent harm)

NO Harm!

Unexpected outcomes:
- System failure (most frequent)
- Individual failure (uncommon)
What should be reported?

• Unexpected outcomes in care
• Unsafe conditions
• Patient safety issues
• Near miss events
• Good catch events
• Behavioral events
• Work place violence
• Abuse, neglect & exploitation
• Visitor events

Timely reporting is essential
How to Report?
How to Enter an I-CARE?

You can enter an event anonymously. Only 10 brief questions are required. Only required to answer the asterisk questions.

You can enter an event anonymously.
What is a System Failure?

James Reason - Swiss Cheese Model

Events do not happen as the result of a single source of failure, but from many sources. When they all line up, an event can occur.
A Patient Safety Event

Near Fatal: A Patient Safety Story

• [https://youtu.be/pcQUnGiuhzM](https://youtu.be/pcQUnGiuhzM)

Misplaced feeding tube

• [https://youtu.be/NBXw-IW5lOQ](https://youtu.be/NBXw-IW5lOQ)
How do we rectify these situation?

Available
- 24/7
- Call schedule on contact U

Disclosure

Disclosure is defined as the act of revealing or something that is.

An example of disclosure is the announcement of a family secret which is told.
What is a Root Cause Analysis Meeting

The 5 Whys

Define the Problem
Why is it happening?
Why is that?
Why is that?
Why is that?
Root Cause
UMMC High Reliability Journey

Chasing Zero

ELIMINATING HARM AT UMMC
What is Chasing Zero?

Days since last serious safety event:
2 days, 19 hours, 19 minutes, 26 seconds

Previous Record is 98 days

Latest Event: Wrong procedure done resulting in an additional procedure
An order was placed for an inpatient with kidney disease to receive a “tunneled catheter” for renal failure. The provider in preop reviewed the chart and appropriately consented the patient for a dialysis catheter. However, a different provider did the procedure, misread the consent during the time out, and placed a PICC line.

Chasing Zero explained: Here's why we stop the clock
Thanks to an evolving culture of transparency, UMMC caregivers are increasingly reporting harm that happens to patients in our hospitals. That’s essential to the Medical Center’s journey toward zero patient harm, because we learn from each reported event, from procedures on the wrong patient or site to medication errors resulting in harm.
Chasing Zero Event

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Latest Event: The wrong procedure was done on a patient resulting in an additional procedure.

What happened?
An order was placed for an inpatient with kidney disease to receive a “tunneled catheter” for renal failure. The provider in preop reviewed the chart and appropriately consented the patient for a dialysis catheter.

However, a different provider did the procedure, misread the consent during the time out, and placed a PICC line. Since this does not meet the need for dialysis, the patient had to undergo a second procedure to remove the incorrect line and place the correct tunneled dialysis catheter.

Root cause:
The standardized time out process was not followed.

Action plan:
Adhere to the UMMC standardized time out process consistent with policy.
2020 Chasing Zero Events
Good Catch Program

Who is next?
Who Reports?

We all report!
Abuse, Neglect or Exploitation

To comply with Mississippi Laws mandating reporting of possible abuse, neglect, and exploitation of patients at UMMC.

All patients at UMMC, regardless of age are vulnerable
What should I do if I see abuse?

Report immediately to one of the following:
- Charge Nurse
- Immediate Supervisor
- Administrative House Supervisor
- Risk Management (#601-815-1994)

**Always** complete an I-CARE report

Risk Management will lead the investigation.
What do our patients want?

Don't hurt me
Heal me
Be kind to me
Coming Soon...  Team Safety Training

1. **Everyone** Makes a Personal Commitment to Safety

2. **Everyone** is accountable for Clear and Complete Communication

3. **Everyone** Supports a Questioning Attitude

Safety Belongs to ALL of Us!
or

Scare
Elizabeth Toony, MHA, BSN, RN, CPHRM, CPPS
Director – Clinical Risk Management
etony@umc.edu
Office 601-815-1994
Cell 248-672-6380

Amy Appel, BSN, RN, CPPS
Coordinator – Clinical Risk Management
aappel@umc.edu
601-984-2465

Tina Gelston, MSN, RN-BC
Coordinator – Clinical Risk Management
tgelston@umc.edu
601-815-1995

Ramie Polk, BSN, RN
Coordinator – Clinical Risk Management
rpolk2@umc.edu
601-815-5370