Let’s keep OUR patients safe!

Office of Clinical Risk Management

and Patient Safety

Story

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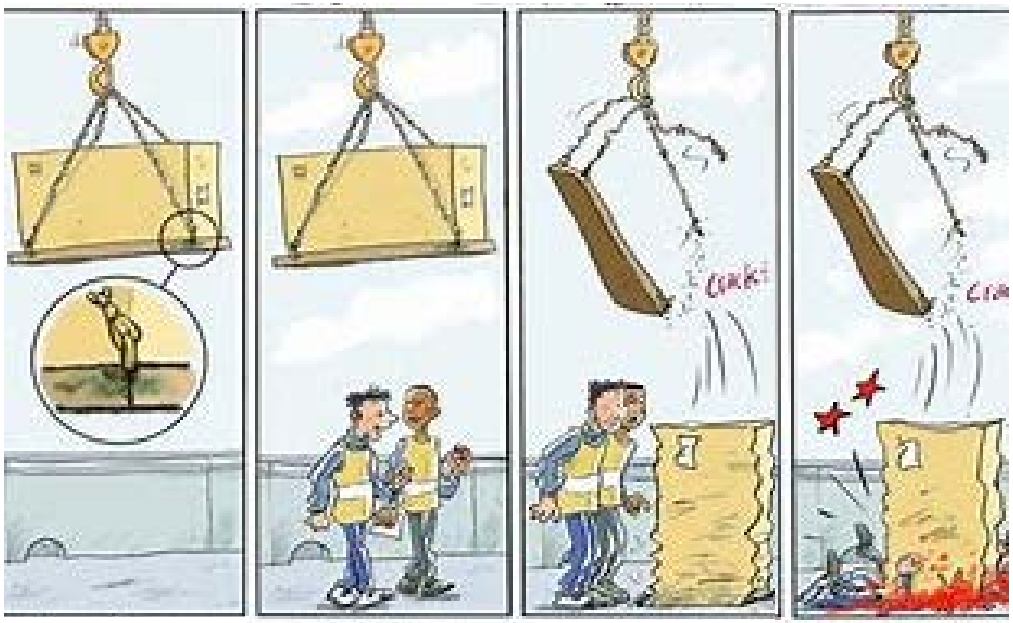
What is an Event?



Unexpected outcomes

- System failure (most frequent)
- Individual failure (uncommon)

NO Harm!

Good Catch

Proactive (prevent harm)

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

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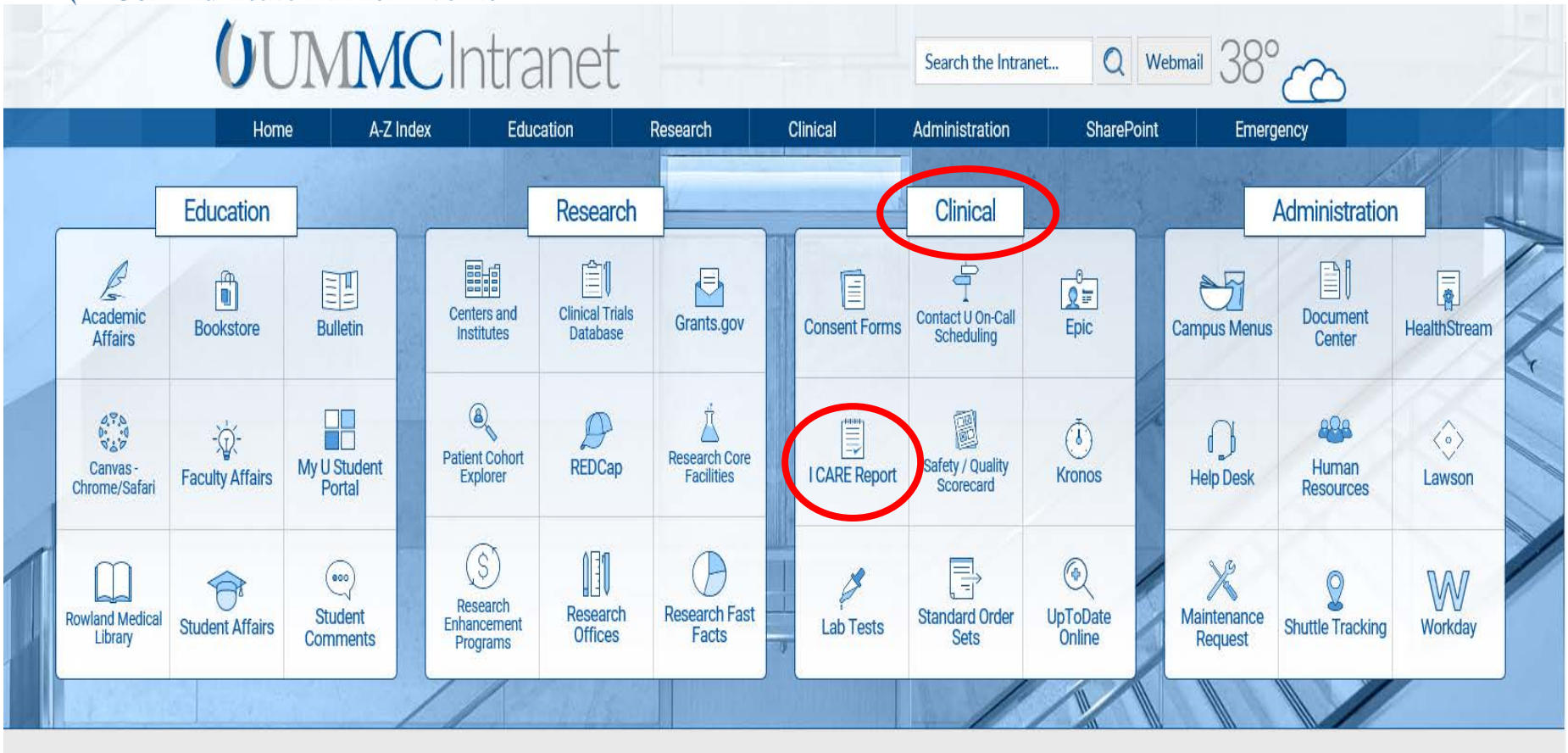
How to Report?

I C.A.R.E.
Communicate At Risk Events



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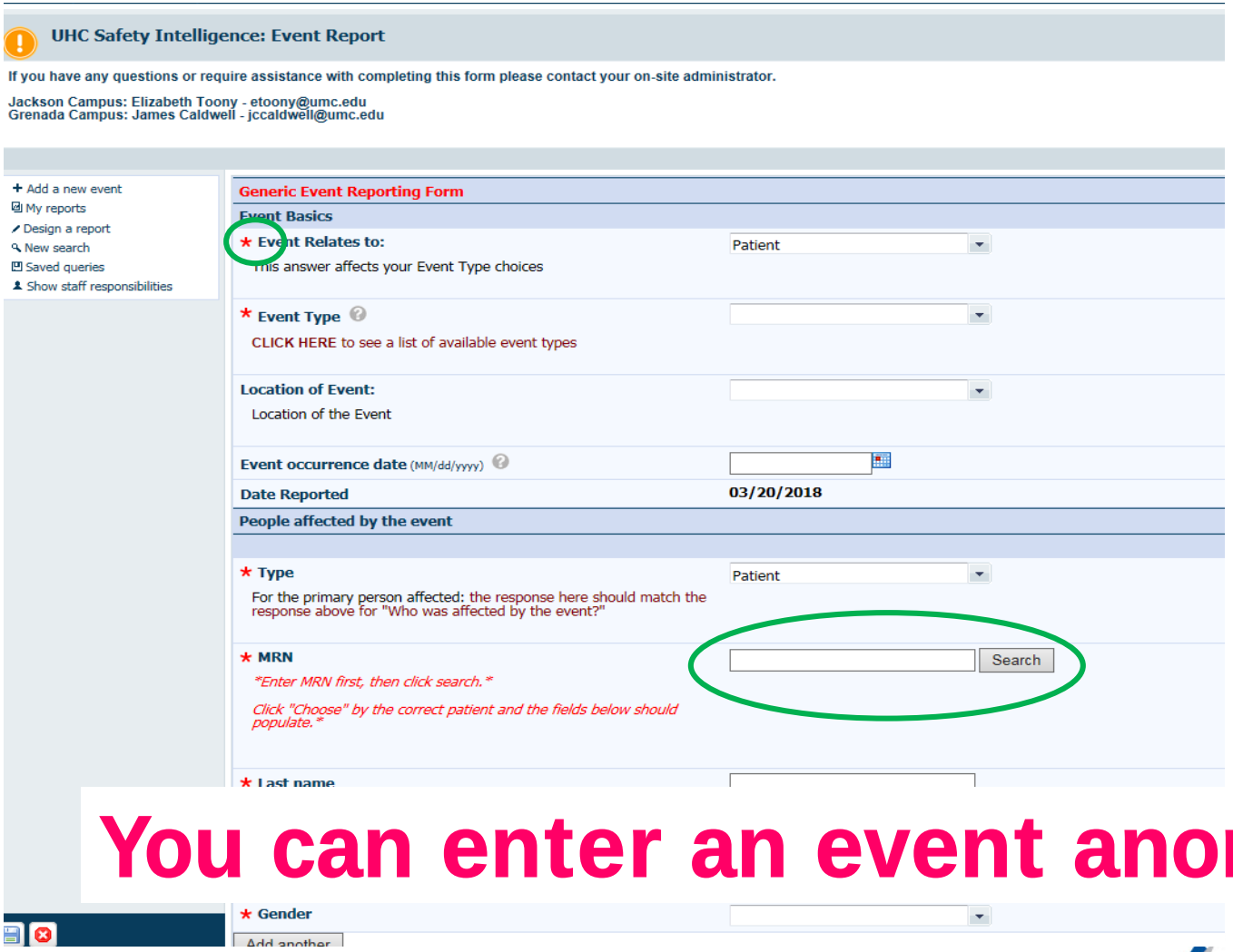
How to Enter an I-CARE?



Only 10 brief questions

Only required to answer the asterisk questions

You can enter an event anonymously

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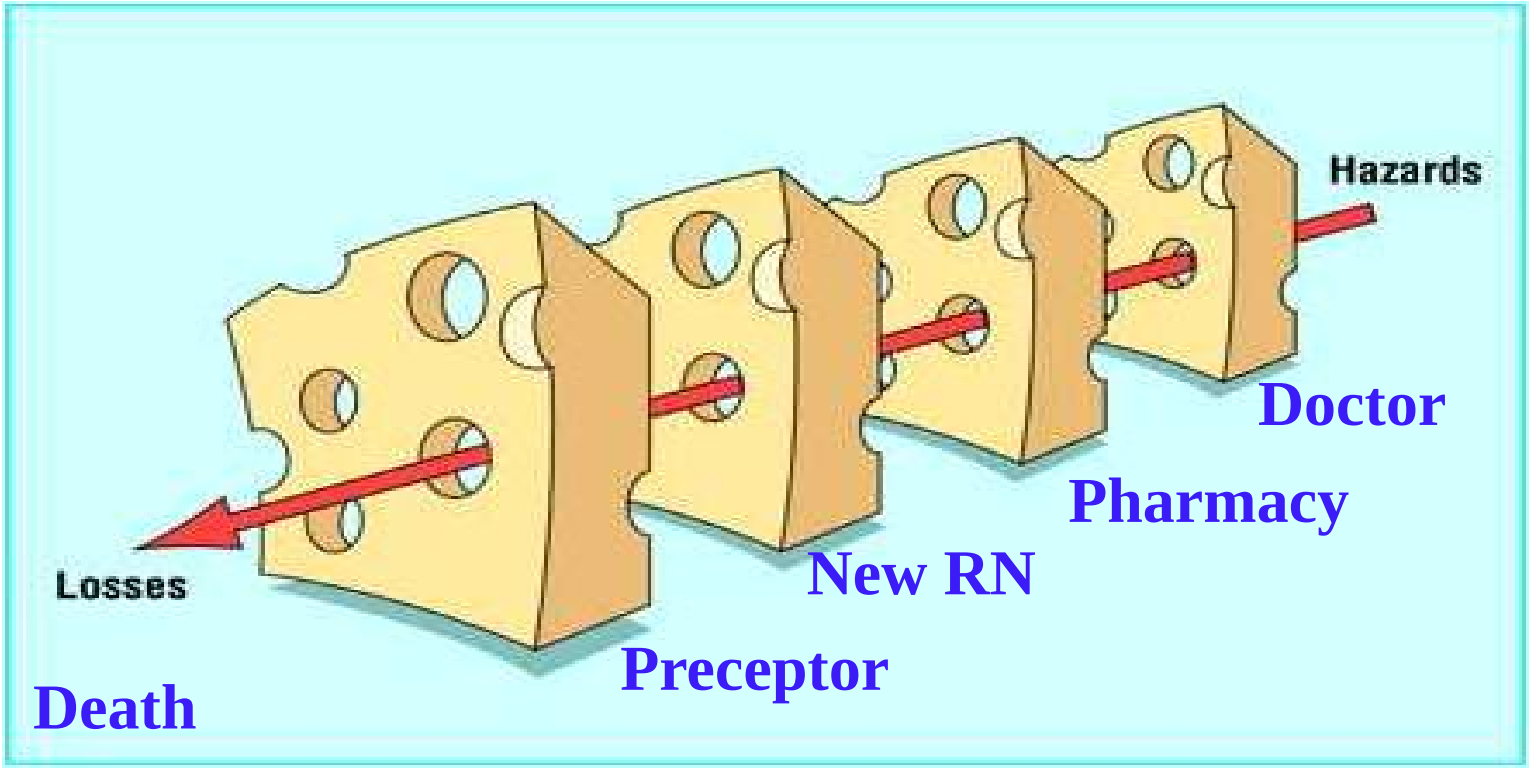
What is a System Failure?

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

Misplaced feeding tube

- https://youtu.be/NBXw-IW5IOQ

How do we rectify these situation?

Available

- 24/7
- Call schedule on contact U
  Disclosure

RISE
Resilience in Stressful Events

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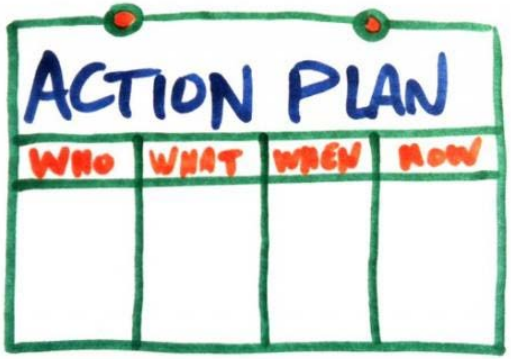
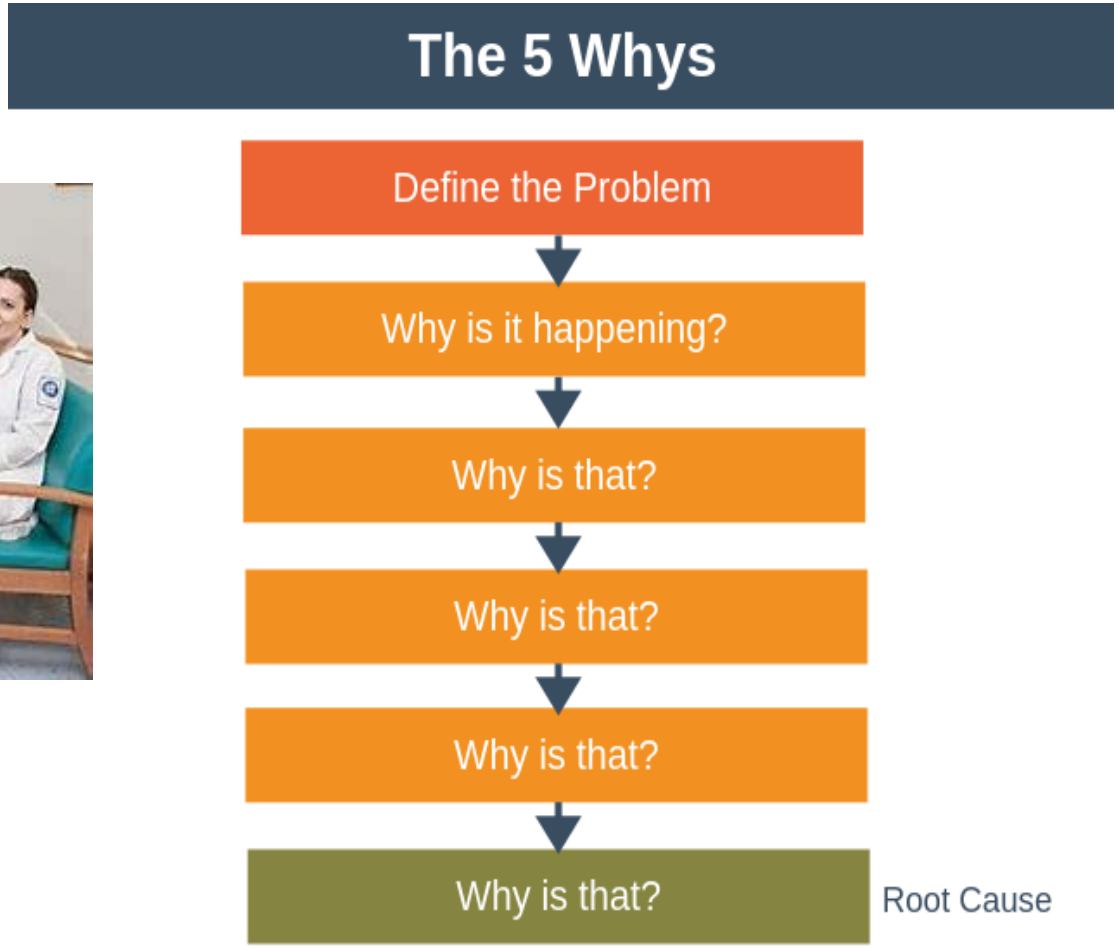
What is a Root Cause Analysis

Meeting





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UMMC High Reliability Journey

Chasing Zero

ELIMINATING HARM AT UMMC

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What is Chasing Zero?

Event Types	2018	2019	2020
Wrong patient/site/procedure	3	0	X
Medication errors resulting in harm	1	8	X
Falls resulting in serious injury or death	2	1	X
Unintended retained foreign body	3	2	X
Irretrievable loss of irreplaceable specimen	1	Retired	X
Administration wrong blood product	1	Retired	Retired
Failure to follow up on critical lab & radiology	NA	1	X
Hospital acquired thermal burn	NA	0	Retired
Total	**11**	**12**	

NA - Not a Chasing Zero event in 2018

Retired - Not a Chasing Zero event in 2019 and 2020

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.

Read More | Safety/Quality Scorecard | Patient Experience Scorecard

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

Chasing Zero
ELIMINATING HARM AT UMMC

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.

Read More

What is Chasing Zero?

UMMC Intranet

Search the Intranet... | Webmail | 51°

Home | A-Z Index | Education | Research | Clinical | Administration | SharePoint | Emergency

Health Care / Clinical Quality / Clinical News / 2020 / January

- January
  - Chasing Zero Resets
  - In 2020, learn to be happy for years to come

Chasing Zero Event

Chasing Zero
ELIMINATING HARM AT UMMC

Published on Monday, January 6, 2020

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.

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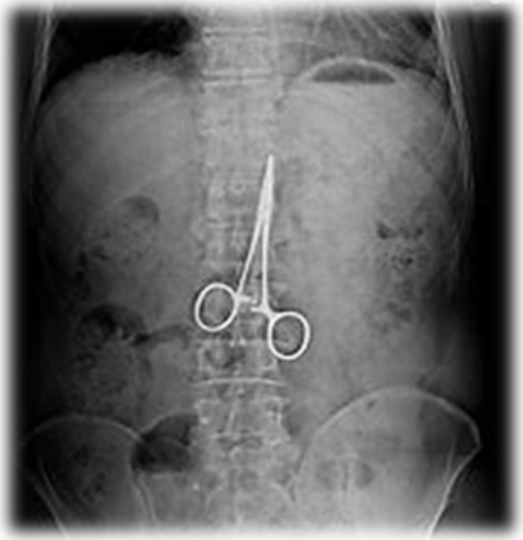
2020 Chasing Zero Events



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Good Catch Program

Who is next?

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MEDICAL CENTER

Who Reports?

We all report!

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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

Illustration by Barbara Kelley

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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.

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What do our patients want?

Don't hurt me

Heal me

Be kind to me

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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!

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or

Scare

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Questions

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