



**University**  
HOSPITAL

Newark, NJ



## Patient Safety & Clinical Risk Management

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## What is Patient Safety?

- Patient safety is the prevention of harm

## We Don't Want to Harm, but Harm Does Occur:

- The occurrence of adverse events due to unsafe care is likely one of the 10 leading causes of death and disability in the world
- In high-income countries, it is estimated that one in every 10 patients is harmed while receiving hospital care. The harm can be caused by a range of adverse events, with nearly 50% of them being preventable

**S** – Sense the Error

**A** – Act to Prevent It

**F** – Follow Safety Guidelines

**E** – Enquire into Adverse Events

**T** – Take Appropriate Corrective Measures

**Y** – Your Responsibility

# What We Monitor & Why

- **Medication errors** are a leading cause of injury and avoidable harm in health care systems: globally, the cost associated with medication errors has been estimated at US\$ 42 billion annually.
- **Health care-associated infections** occur in 7 and 10 out of every 100 hospitalized patients in high-income countries and low- and middle-income countries, respectively.
- **Unsafe surgical care procedures** cause complications in up to 25% of patients. Almost 7 million surgical patients suffer significant complications annually, 1 million of whom die during or immediately following surgery.

# Purpose of Patient Safety & Clinical Risk Management

## Patient Safety

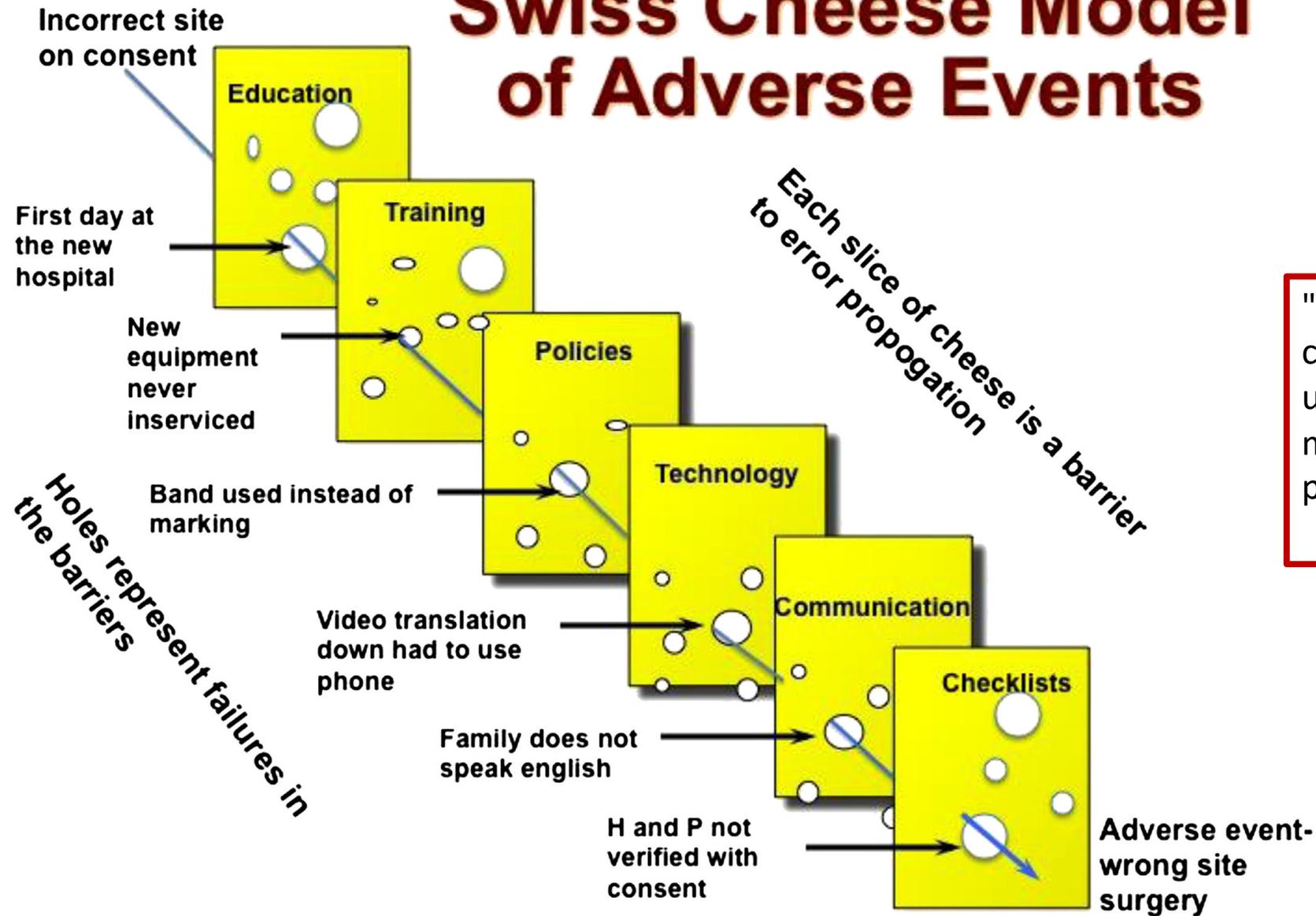
- The discipline of patient safety is the coordinated efforts to prevent harm to patients, caused by the process of health care itself

## Clinical Risk Management

- Clinical risk management specifically is concerned with improving the quality and safety of health-care services by identifying the circumstances and opportunities that put patients at risk of harm and then acting to prevent or control those risk



# Swiss Cheese Model of Adverse Events



"Adverse event" is a negative consequence of care that results in unintended injury or illness, which may or may not have been preventable.

# What is a Great Catch?

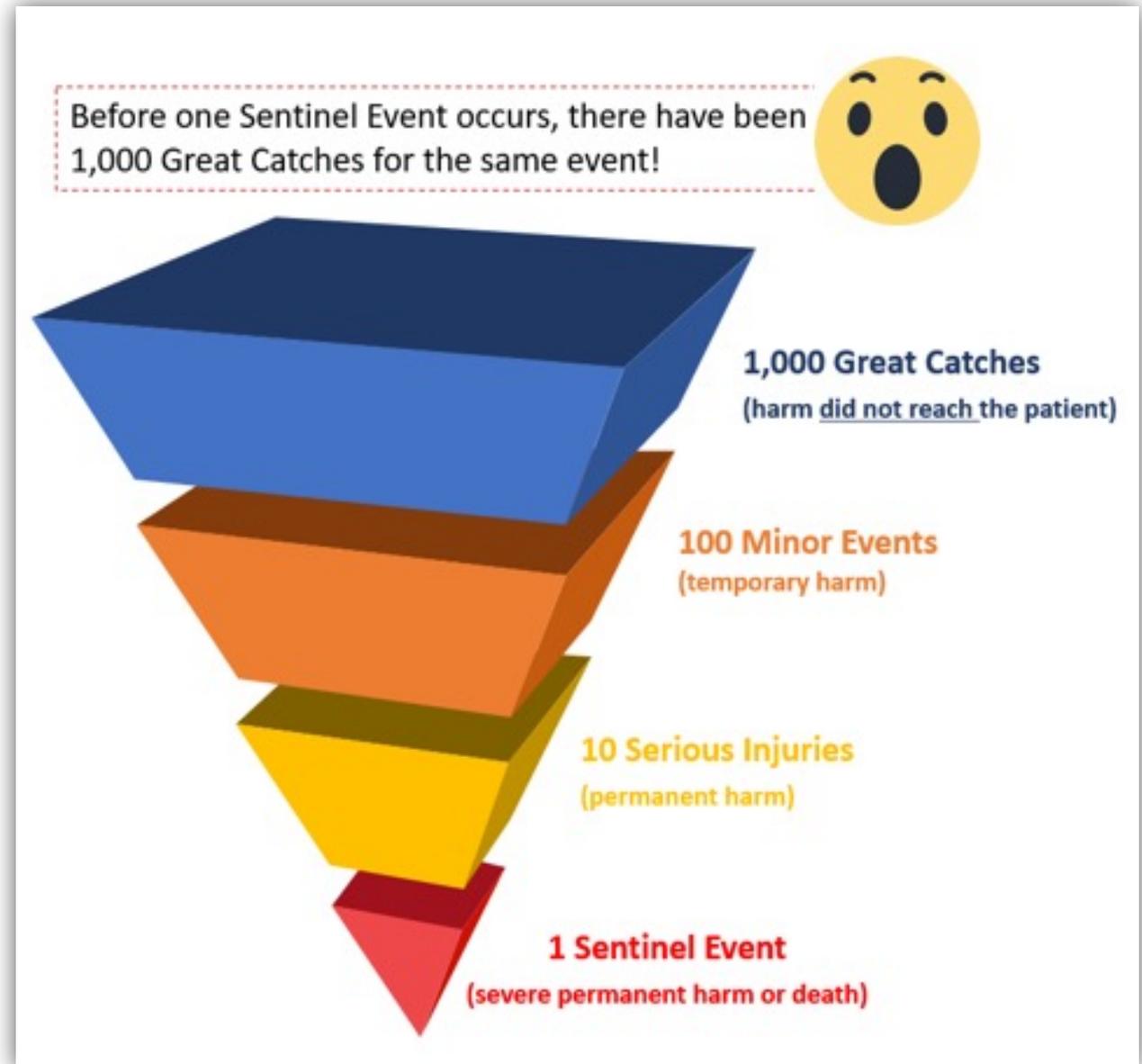
## A Near Miss is...

- An event that did not reach the patient because of chance/timely intervention

## A Great Catch is a Near Miss+

- An event that did not reach the patient because of chance/timely intervention  
AND
- Immediate action was taken to contain the situation and protect patient and/or staff  
AND
- Extra steps were taken to follow up

A Great Catch is an opportunity to prevent harm to patients in the future and a method for revealing process and system vulnerabilities.



# You should report events\* via the online event reporting system: **Safety Intelligence (SI)**

\*This includes near misses/great catches, potential harm events, and harm events.

New Form | Login | Register |

## Safety Intelligence: Event Report

Welcome to the UHC Safety Intelligence Front Line Reporter Form.

- A \* indicates a mandatory field.
- Click the ? icon for help with a particular field.
- Click the ▾ button to view and select from the list of available options for that field.
- Click the ✖ button to remove values from a field.

If you have any questions or require assistance with completing this form please contact your on-site administrator.

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### Start

\* Who was affected by the event? Patient ▾

\* Date of admission or ambulatory encounter [calendar icon]

### People affected by the event

\* Type  Patient  
For the primary person affected: the response here should match the response above for "Who was affected by the event?"  
 Visitor  
 Staff Member/Employee

\* MRN [input] Search

Last name [input]

First name [input]

Middle initials [input]

Date of birth (MM/dd/yyyy) [calendar icon]

Gender [dropdown]

Race [dropdown]

Add another

### Event Basics

\* Event Type [dropdown]

\* Event Category [dropdown]

Event Subcategory [dropdown]

\* Event discovery date 02/21/2022 [calendar icon]

\* Event discovery time [input]  
Use the military time format.

\* Event occurrence date (MM/dd/yyyy) [calendar icon]

# Safety Intelligence (SI) Event Instruction for Event Owners & Consultants

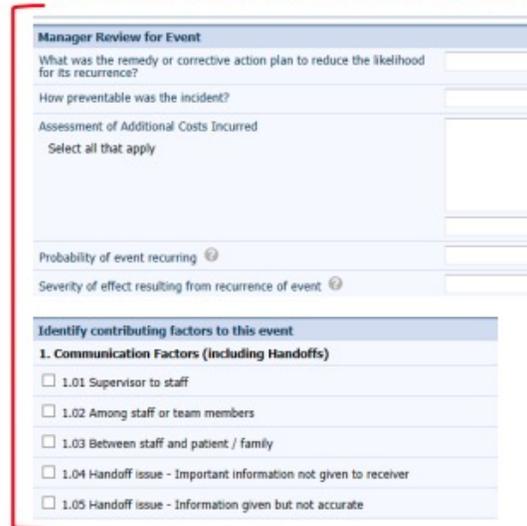
Click the link in the email sent you via the SI system. *The Google Chrome browser is recommended*   
You can also access the login page at <https://uhnj.datixhostingusa.com/live/index.php?action=login>

Basic information regarding the event

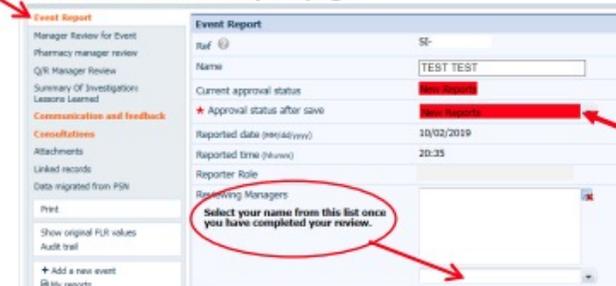
Communication between the Patient Safety Team and you.



On the **Manager Review for Event** page: **Complete all fields**, including Contributing Factors.



Return to the Event Report page.

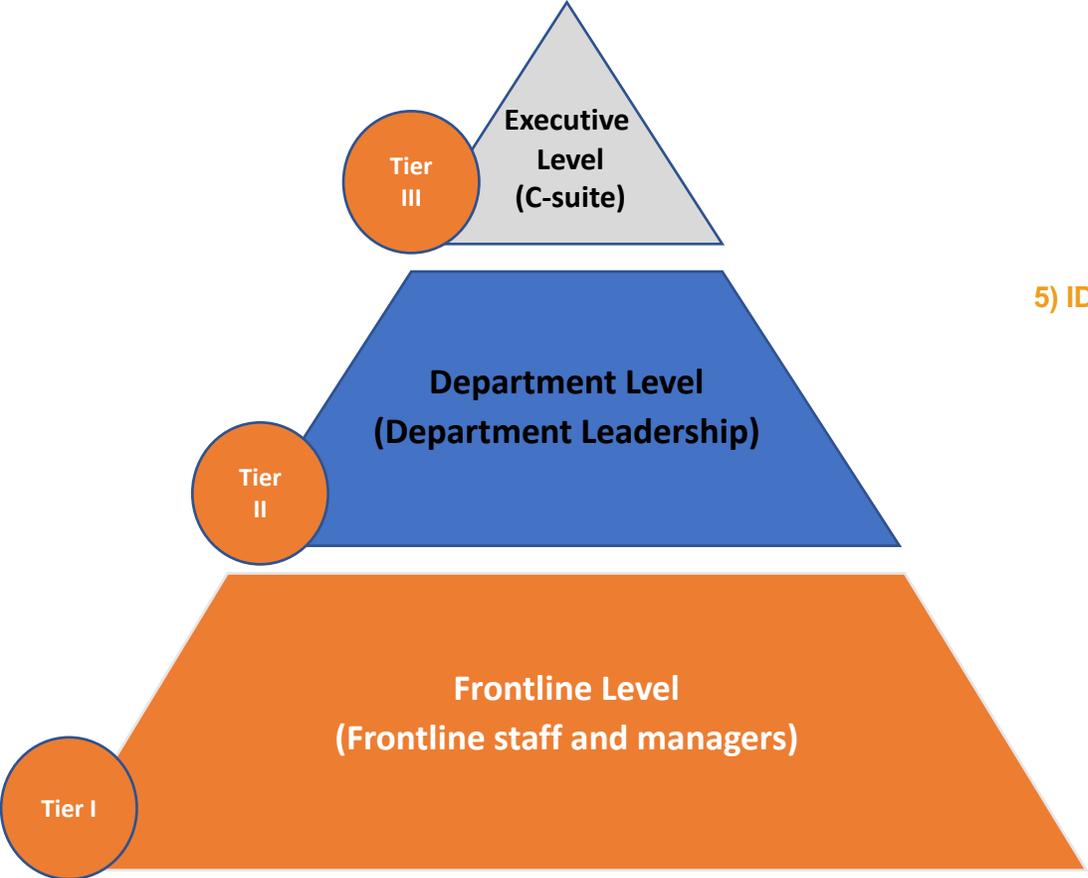


Enter the first few letters of your last name in the Reviewing Managers drop down box. Double-click your name to enter it into the box.

Change the approval status to **Being Reviewed** if still reviewing or **QRM review** if your review is complete.

**Click Save** and you are done!

# What Are Tiered Huddles?



1) PROBLEM IDENTIFICATION



2) ADDRESS REALTIME ISSUES

3) ESCALATE IF NEEDED



4) REVIEW PERFORMANCE

5) IDENTIFY GREAT CATCHES



6) RECOGNIZE AND CELEBRATE

7) REVIEW PLAN



# Tiered Huddles

## Ground Rules

- Huddles last no longer than 15 minutes when fully operational
- Participants physically (or virtually) meet and stand during huddle
- Teams report on the same set of measures daily (at a minimum)
- A designated scribe records action items and follows up

*Report issues from your Tier 1 Safety Huddle:*

**S**safety issues

**M**ethods/Procedures

**E**quipment

**S**upplies

**S**taffing

----Tier 2 Safety Huddle ----

1. Department report out (SMESS)
2. Follow-up items
3. Patient Safety Tracker
4. Great Catches
5. Announcements
6. Recognition
7. Post-huddle huddles

- ✓ Issues impacting other departments
- ✓ Issues you are struggling to resolve and you need help from people present
- ✓ High risk situations
- ✓ Harm events
- ✓ Great Catches\*
- ✓ Anything that involves police, fire dept, high profile patients, or potential for high publicity

*\*A "Great Catch" is an event that had the potential to cause harm but was averted due to an intervention.*

# DOH Reportable Events



# Root Cause Analysis Process (RCA2)

**Solutions are the focus, not the blame!**



“To address this mistake we need to utilise our thorough system of root cause analysis. I will begin, if I may, by pointing out that it’s not my fault”

# What Is Root Cause Analysis (RCA)?

Root Cause Analysis (RCA) is a useful popular tool that helps determine the basic, underlying cause of a problem through a series of specific steps. A factor is considered a root cause if its removal from the problem-fault-sequence prevents the final undesirable event from recurring.

When Should Root Cause Analysis be Performed?

- When human errors occur during a workflow process
- When performance is below standard
- When equipment failures or adverse events occur during certain work processes

The successful application of the determination of the root cause should ultimately result in the elimination of the problem.

## Steps of RCA

Step 1:  
Identify  
the Problem

Step 2:  
Select Team

Step 3:  
Collect Data

Step 4:  
Identify  
Possible Factors

Step 5:  
Identify  
Root Cause(s)

Step 7:  
Monitor and  
Assess Results

Step 6:  
Define and  
Implement an  
Action Plan

# Root Cause Analysis & Actions (RCA2) Team

## What does the RCA2 team do?

- The RCA2 team is officially charged with investigating the adverse event to discover underlying system issues that contributed to or resulted in the event occurring.



## Who do you consider to be the team members on an RCA2 team?

- The RCA2 team members are those who are assigned by the organization's leadership to officially serve on the team.
- These are the individuals who attend all of the meetings, conduct the research, interview staff, identify root cause contributing factors, and write the report.
- In most cases this team also identifies the corrective actions and their associated process/outcome measures, though in some organizations an individual or another team may complete this task.

# Root Cause Analysis & Actions (RCA2) Team: Identifying Corrective Actions

RCA2 teams work to identify corrective actions to mitigate root causes of the adverse event using the following steps:

- Causal statements for all identified contributing factors
- For each causal statement, an action is identified that could mitigate the cause and minimize the chances of the event recurring and reduce the severity or consequences should it recur.
  - At least one strong or intermediate action for each identified cause
- Identify an individual responsible for implementation and measurement of each corrective action
- Monitor implementation on an ongoing basis to ensure that changes achieve the desired results

# Contact Us

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