

Let's keep OUR patients safe!

Office of Clinical Risk Management
and Patient Safety

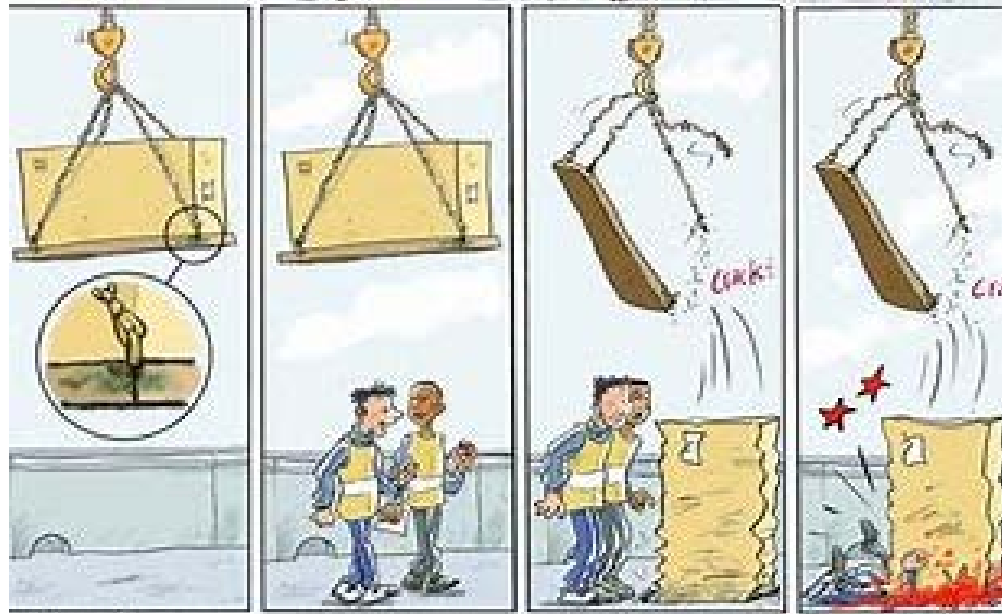


THE UNIVERSITY OF MISSISSIPPI
MEDICAL CENTER

Story



What is an Event?



Unsafe
condition

Unsafe
act

Near miss

Accident

Unexpected outcomes

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

Good Catch
Proactive (prevent harm)

NO 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**



How to Report?



UMMC Intranet

Search the Intranet...



Webmail

38°



Home

A-Z Index

Education

Research

Clinical

Administration

SharePoint

Emergency

Education



Academic Affairs



Bookstore



Bulletin



Canvas - Chrome/Safari



Faculty Affairs



My U Student Portal



Rowland Medical Library



Student Affairs



Student Comments

Research



Centers and Institutes



Clinical Trials Database



Grants.gov



Patient Cohort Explorer



REDCap



Research Core Facilities



Research Enhancement Programs



Research Offices



Research Fast Facts

Clinical



Consent Forms



Contact U On-Call Scheduling



Epic



I CARE Report



Safety / Quality Scorecard



Kronos



Lab Tests



Standard Order Sets



UpToDate Online

Administration



Campus Menus



Document Center



HealthStream



Help Desk



Human Resources



Lawson



Maintenance Request



Shuttle Tracking



Workday

How to Enter an I-CARE?

UHC Safety Intelligence: Event Report

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

Jackson Campus: Elizabeth Toony - etoony@umc.edu
Grenada Campus: James Caldwell - jccaldwell@umc.edu

Generic Event Reporting Form

Event Basics

*** Event Relates to:** Patient
This answer affects your Event Type choices

*** Event Type** ?
CLICK HERE to see a list of available event types

Location of Event:
Location of the Event

Event occurrence date (MM/dd/yyyy) ?

Date Reported 03/20/2018

People affected by the event

*** Type**
For the primary person affected: the response here should match the response above for "Who was affected by the event?"

*** MRN**
Enter MRN first, then click search.
Click "Choose" by the correct patient and the fields below should populate.*

*** Last name**

*** Gender**

Add another

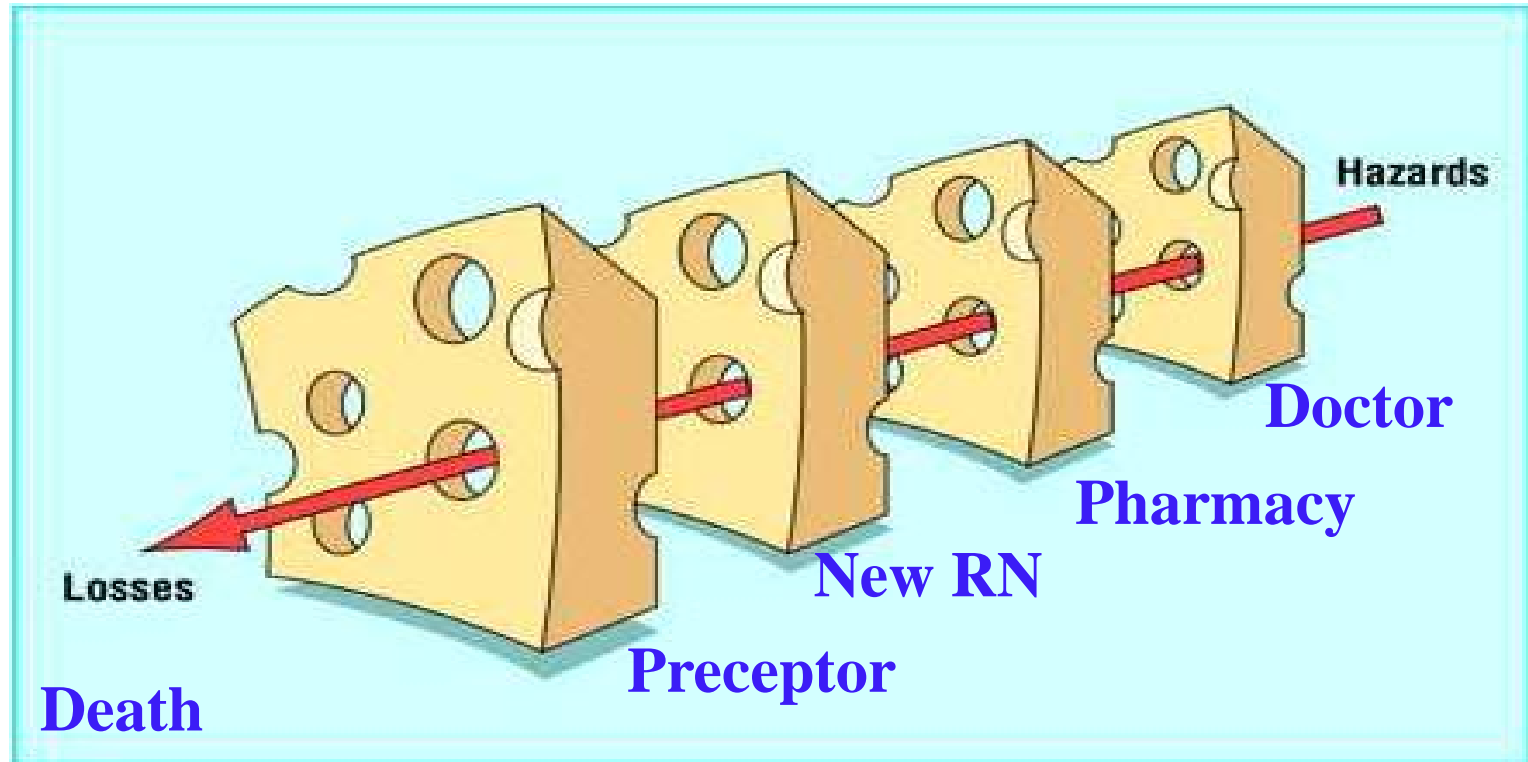
Only 10 brief questions

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>

Misplaced feeding tube

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

How do we rectify these situation?



Available

- 24/7
- Call schedule on contact U
Disclosure

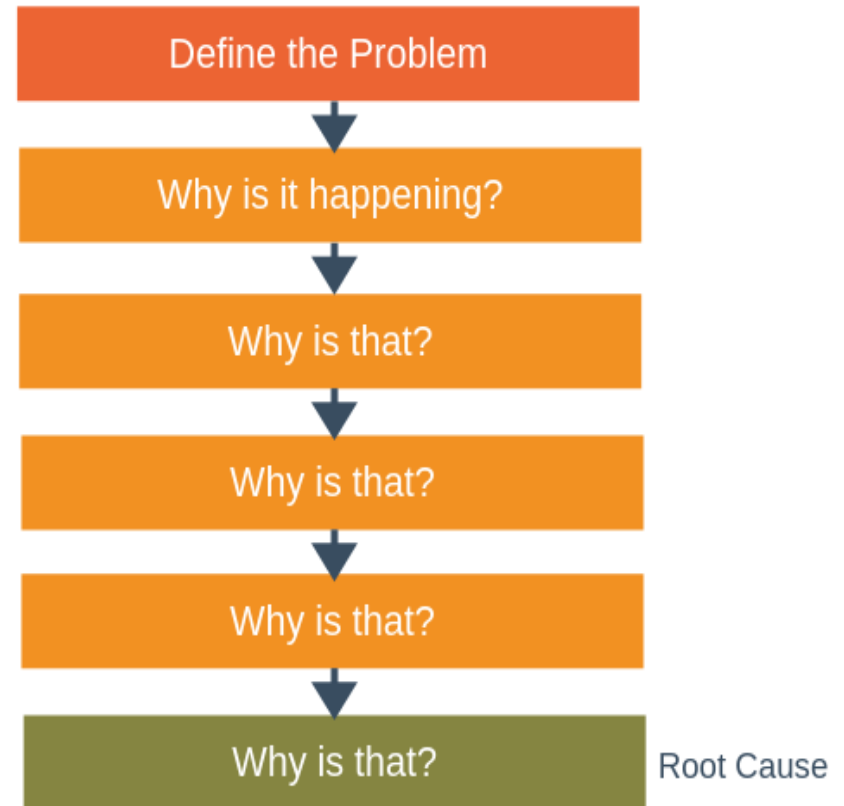


What is a Root Cause Analysis

Meeting



The 5 Whys



UMMC High Reliability Journey

Chasing Zero



ELIMINATING HARM AT UMMC

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



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?



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

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:

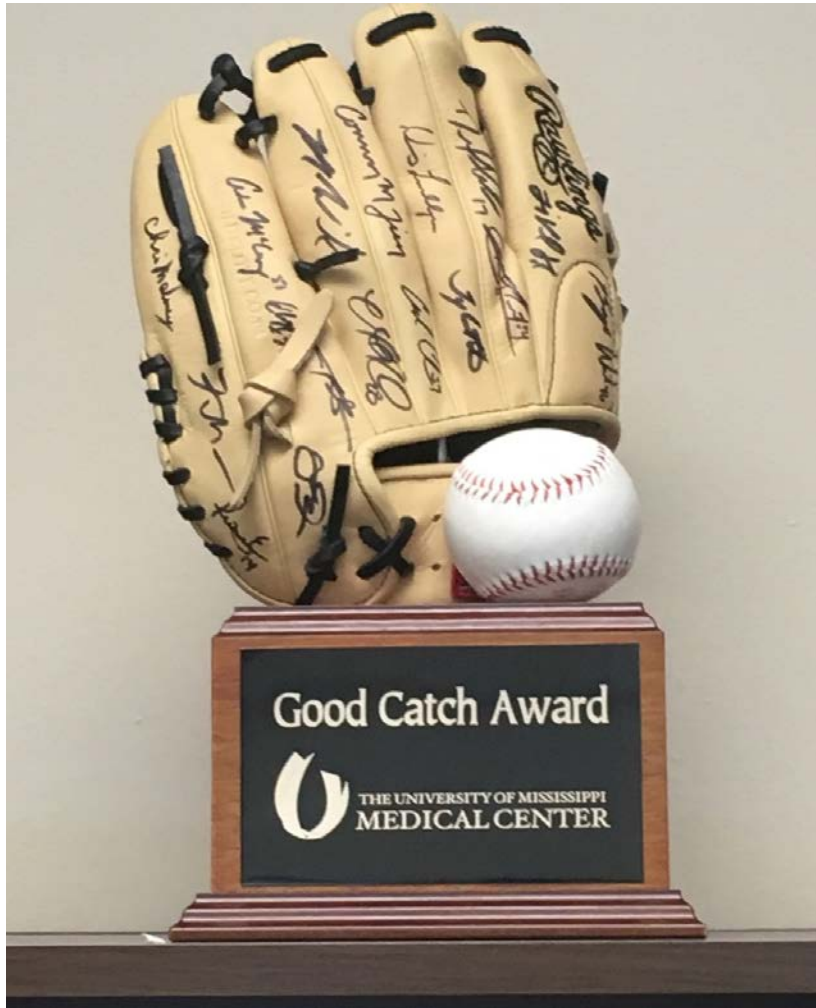
Adhere to the UMMC standardized time out process consistent with policy.



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**



Illustration by Barbara Kelley



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!



TRUTH

or

Scare



Questions



Contact Information



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