

PATIENT SAFETY

Where we've been...

Baystate Health (BH) has created a culture that encourages open, non-punitive error reporting, yet with professional accountability, as part of its desire to create a safer environment for patients, visitors and employees. The cornerstone of the safety culture is identifying adverse events. Besides the Safety Reporting System (SRS), in which employees report all events and near-misses, global trigger tools, serious reportable events (SRE), patient safety indicators (PSI), hospital-acquired conditions (HAC), and clinical risk management (claims) are also reliable sources of information. By keeping the data anonymous, BH has focused on understanding the “what” and “how,” and not the “who” behind events.

The SRS provides BH with a timely, standardized system for collecting and processing information on all safety events. With SRS, reported events are classified by event type and cause, using a standardized description and classification scheme and can be compared to other like facilities using the SRS. The current reporting process can be done by completing a paper-based form or by using the web-based data entry application, and provides automated notification of each report to ensure timely attention, and if need be, intervention.

Knowing what actions and decisions led to a safety event is important in order to understand and correct systemic errors and to plan improvements. Trend data is provided to each unit and shared with clinical leadership, the service-specific performance improvement team, the Nursing Clinical Practice Committee, the Performance Improvement Council, and the Board of Trustees.

BH was one of the first health systems in the nation to begin “Senior Leader Safety Walk Rounds.” Senior management makes regular rounds, discussing patient safety issues and SRS reports with direct care staff on all hospital units. This allows senior leaders to see first hand the work environment and potential risks that are encountered every day as well as to dedicate resources in a timely manner.

BH was also one of the early adopters of “learning” from near-miss and actual events. Each event is reviewed and looked at as an opportunity to learn about our processes and why they failed. That information is used to redesign the flawed process and to prevent it from occurring in the future.

The Joint Commission and the National Quality Forum have endorsed a list of “never events.” Never events are incidents so serious they should never happen (e.g., surgery on the wrong body part, mismatched blood transfusion). They occur when there is a failure in the delivery of healthcare services, too often resulting in unintended injury, illness or death.

Sources for Identifying Adverse Events

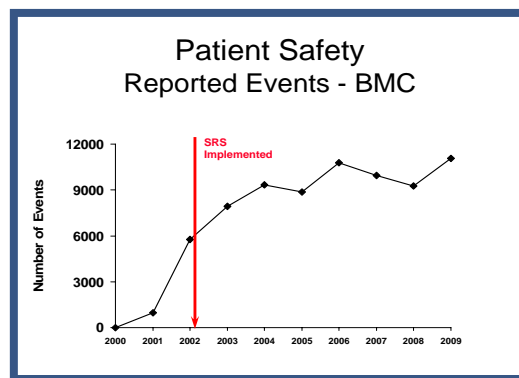


Serious Reportable Events, 2009 (January - July)							
Patient Safety Measures	BH	BMC	BFMC	BMLH	VNA	Amb	BAPO
	2009						
1 Surgical Events							
1A Surgery performed on the wrong body part							
1B Surgery performed on the wrong patient							
1C Wrong surgical procedure performed on a patient							
1D Retention of a foreign object in a patient after surgery or other procedure							
1E Intraoperative or immediately post-operative death in an ASA Class 1 patient							
2 Product or Device Events							
<i>Patient death or serious disability associated with:</i>							
2A The use or function of a device in patient care in which the device is used or functions other than as intended							
2B Intravascular air embolism that occurs while being cared for in a healthcare facility							
3 Patient Protection Events							
3A Patient death or serious disability associated with patient elopement (disappearance) for more than four hours							
3B Patient suicide, or attempted suicide resulting in serious disability, while being cared for in a healthcare facility	1	1					
4 Care Management Events							
<i>Patient death or serious disability associated with:</i>							
4A A medication error (e.g., errors involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation or wrong route of administration)							
4B A hemolytic reaction due to the administration of ABO-incompatible blood or blood products							
4C Stage 3 or 4 pressure ulcers acquired after admission to a healthcare facility	3	3					
5 Environmental Events							
<i>Patient death or serious disability associated with:</i>							
5A A burn incurred from any source while being cared for in a healthcare facility							
5B Patient death associated with a fall while being cared for in a healthcare facility - fatal falls							
5C Patient serious disability associated with a fall while being cared for in a healthcare facility - non fatal falls	6	6					
5D Patient death or serious disability associated with the use of restraints or bedrails while being cared for in a healthcare facility							
6 Criminal Events							
6A Sexual assault on a patient or on the grounds of a healthcare facility							
6B Death or significant injury of a patient or staff member resulting from a physical assault (i.e. battery) that occurs within or on the grounds of a healthcare facility							
Total	10	10	0	0	0	0	0

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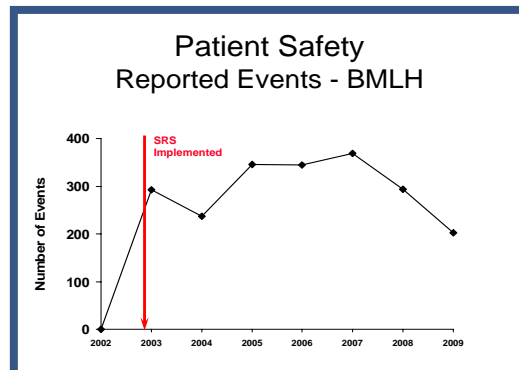
Where we are now...

BAYSTATE MEDICAL CENTER Safety events are analyzed, categorized and used to develop prevention interventions and to drive improvement. Unit-specific information is shared with all staff to help heighten awareness and encourage unit-based problem solving. Of note, specimen management, specifically labeling issues, was identified as an issue through SRS analysis. As a result, interdisciplinary collaboration and interventions (e.g., bar coding, drawing procedures) have led to a 93% decrease in incorrect specimen handling reports. Omissions in care identified through SRS have resulted in the completion of a root cause analysis for vaccine administration and delivery of discharge instructions for selected patient populations. BMC continues to create a safer environment for patients, visitors and employees by increasing staff awareness and providing ongoing staff education, by having unit-based Senior Leader Safety Walk Rounds, and through the development of a patient safety brochure, "Partners in Caring." A patient identification policy, patient ID band checks at change of shift rounds, changes to our computerized physician order entry system, numerous medication safety changes, bar coding to reduce specimen labeling errors and medication administration errors, and the development and implementation of new count and traffic policies in the OR are some of the enhancements that have been put in place. Additionally, the Agency for Healthcare Research and Quality (AHRQ) Safety Culture Survey has been used in selected areas to obtain baseline scores prior to implementing models such as team training. This objective tool helps focus efforts on areas identified to be at high risk.

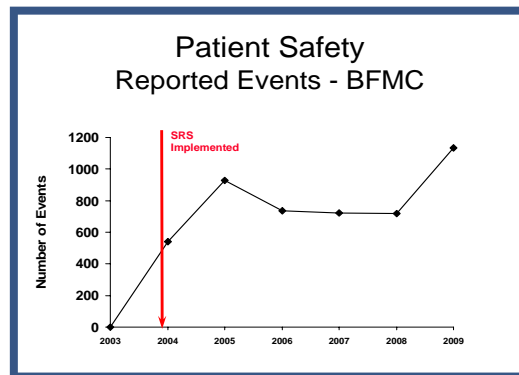


BAYSTATE MARY LANE HOSPITAL Drugs with look-alike or sound-alike similarities have been reorganized and placed on separate shelves within the pharmacy. In some cases, generic names have been used to further separate the pharmaceuticals. In addition, our pharmacy has expanded the use of the TALLMAN/smallman nomenclature for sound-alike drugs to align prepackaged drug labeling with PYXIS for consistency.

Concentrated KCl intravenous replacement and 3% NaCl intravenous solutions have been removed from the floors, and we have limited the amounts of single concentrations of medications stored in the pharmacy. Expanded use of high alert stickers for selected medications (i.e., high dose drugs) has been put in place in the pharmacy and in PYXIS.



BAYSTATE FRANKLIN MEDICAL CENTER Safety events are reviewed and categorized to identify trends and safety issues that need further attention. Unit-specific information is shared to help heighten staff awareness and encourage unit-based reporting. A multidisciplinary committee that has been in place for over 8 years reviews every medication event report to identify performance improvement opportunities. Information from the committee's review is referred back to the appropriate service line team to implement process changes and monitor for improvement. In addition, the participation of a pharmacist in patient care rounds on two medical/surgical units has also contributed to improved and safer use of pharmacologic agents.



Where we are going...

Many safety enhancements have occurred as a result of BH's focus on safety and the Safety Reporting System. The interventions have led to improvements in medical care to achieve the highest levels of patient and employee safety and will continue in 2010.