Enhancing the Culture of Safety Through Incident/Event Reporting

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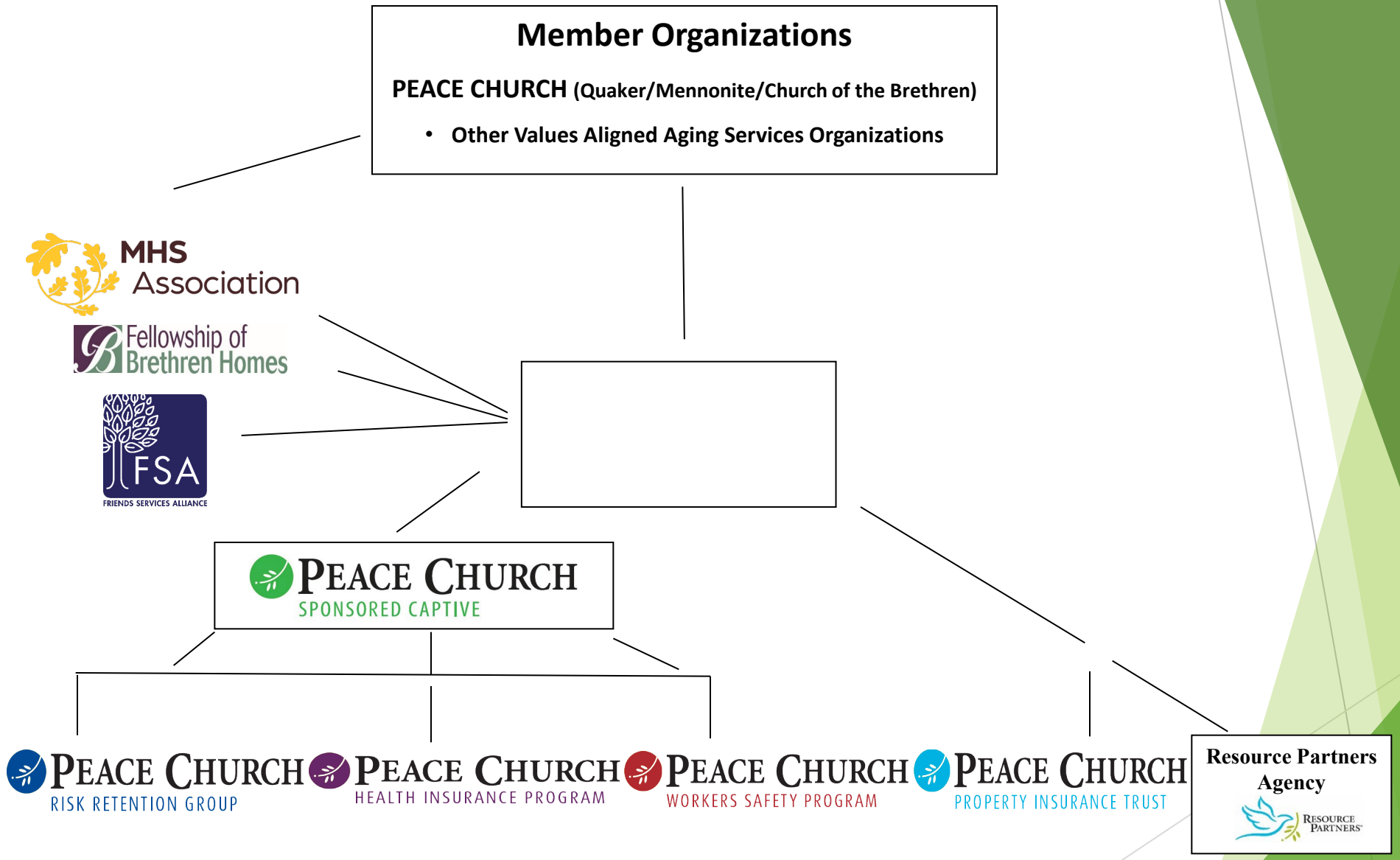
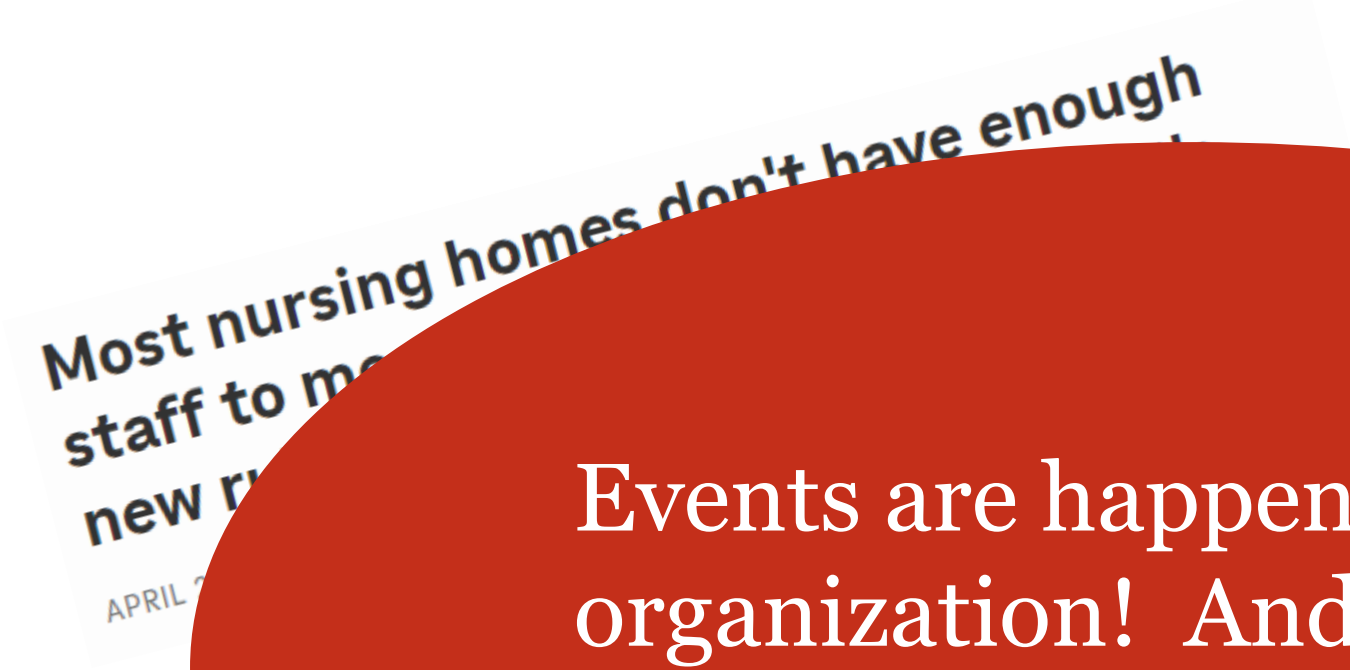

Member Organizations
PEACE CHURCH (Quaker/Mennonite/Church of the Brethren)
• Other Values Aligned Aging Services Organizations
MHS Association
Fellowship of Brethren Homes
FSA
FRIENDS SERVICES ALLIANCE
PEACE CHURCH
SPONSORED CAPTIVE
PEACE CHURCH
RISK RETENTION GROUP
PEACE CHURCH
HEALTH INSURANCE PROGRAM
PEACE CHURCH
WORKERS SAFETY PROGRAM
PEACE CHURCH
PROPERTY INSURANCE TRUST
Resource Partners Agency
RESOURCE PARTNERS



Events are happening at your organization! And not just in your licensed care households and neighborhoods.

Last fall, The Republic revealed Heritage Vill ng center in the state with nearly 150 over three years. The investigation exposed ly assaults and deaths largely among residents with dementia.

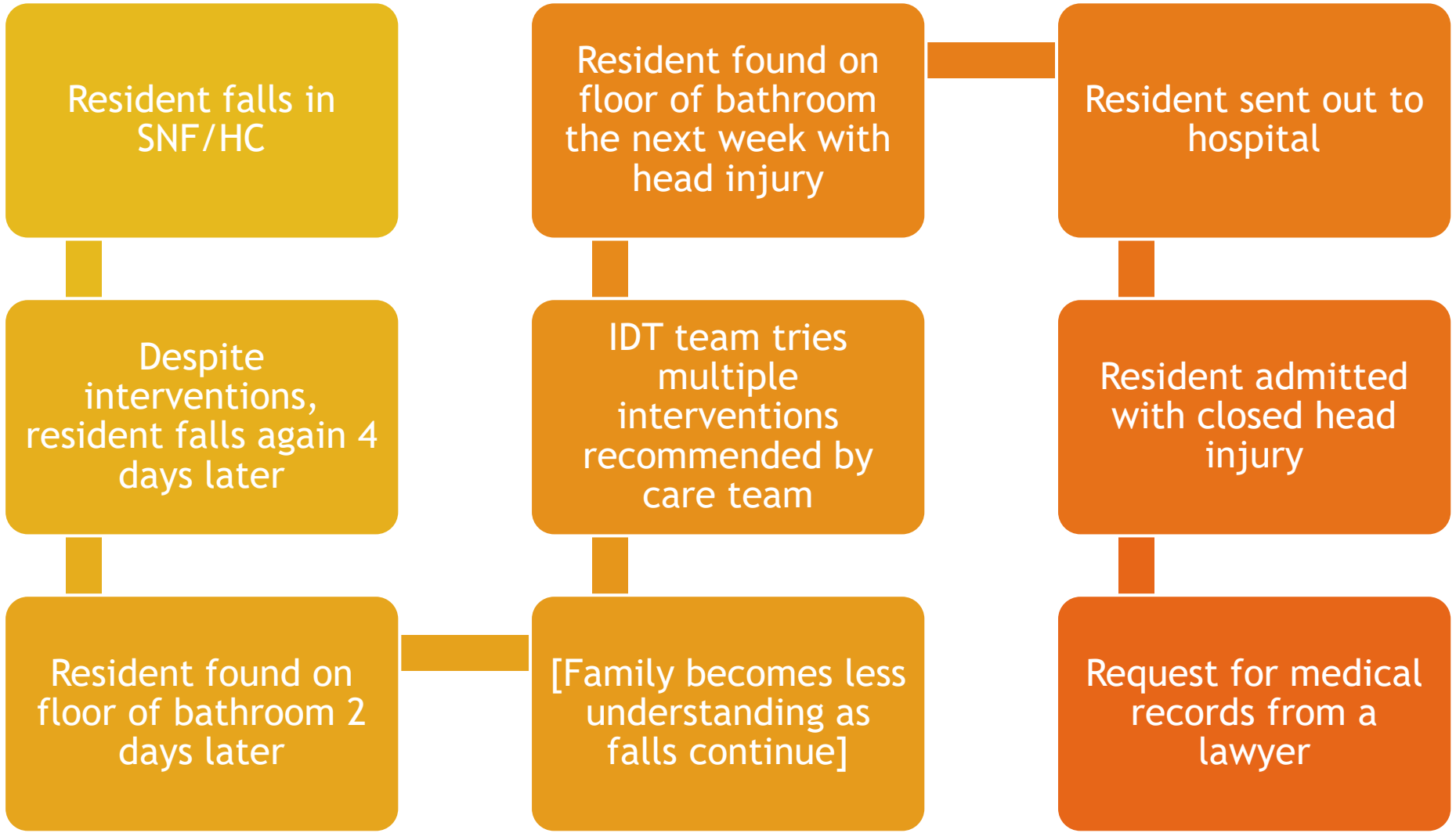
> In an ideal world, all events and occurrences in a health service that cause harm or have the potential to cause harm to patients would be quickly recognized and managed appropriately at the point of care by alert, knowledgeable staff.

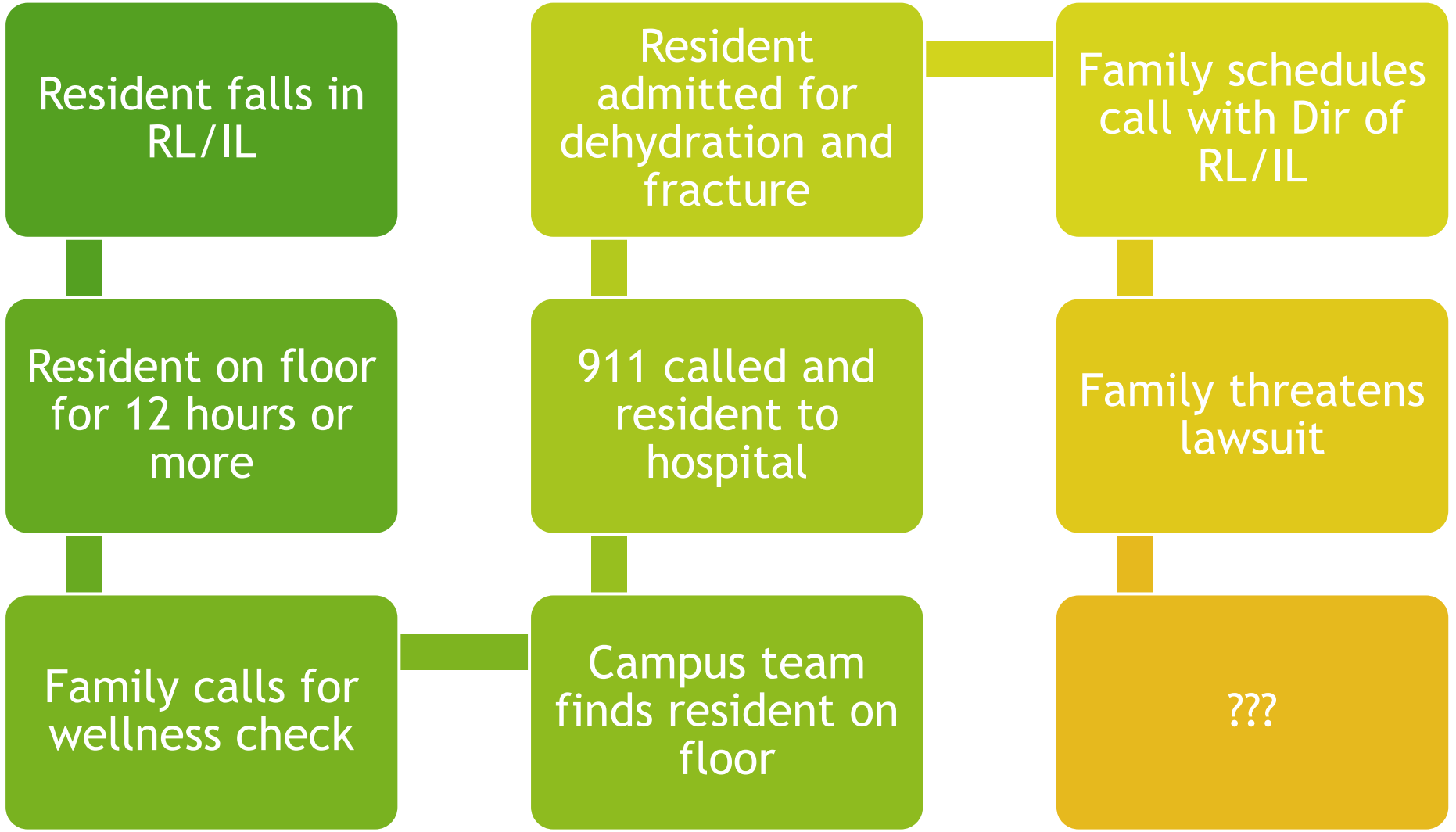
Sir Liam Donaldson, Patient Safety Envoy, World Health Organization

Patient Safety Incident Reporting and Learning Systems
Technical report and guidance
World Health Organization, 2020

Objectives

- Define an event/incident
- Why investigate?
- The investigation
- Best practices
- Get to the root cause(s)
- Spark creativity with interventions


Resident falls in SNF/HC
Despite interventions, resident falls again 4 days later
Resident found on floor of bathroom 2 days later
[Family becomes less understanding as falls continue]
IDT team tries multiple interventions recommended by care team
Resident found on floor of bathroom the next week with head injury
Resident sent out to hospital
Resident admitted with closed head injury
Request for medical records from a lawyer


Resident falls in RL/IL
Resident on floor for 12 hours or more
Family calls for wellness check
Campus team finds resident on floor
911 called and resident to hospital
Resident admitted for dehydration and fracture
Family schedules call with Dir of RL/IL
Family threatens lawsuit
???

What is an event/incident?

- Something that happens that SHOULDN'T happen during the normal course of care and services.
- Patient Safety Event: An event, incident, or condition that could have resulted or did result in harm to a patient. (Joint Commission)
- Incident: any deviation from usual medical care that either causes an injury to the patient or poses a risk of harm, including errors, preventable adverse events and hazards. (World Health Organization)

Why report incidents?

- Improve safety
- Valuable insight
- Prevent future events
- Shows commitment to culture of safety across organization
- Data tells an important story
- Foundation for learning and improvement

Barriers to Reporting

- Psychological safety
- Culture of safety
- Time
- Accessibility of reporting systems
- Insufficient feedback
- Disruptive behaviors

Why investigate?

Figure 2. Responding to a patient safety incident report

Source: World Health Organization

Why investigate?

Learn from incident

Prevent harm

Complex systems and processes

Federal and state regulations

If you don’t investigate, someone else will fill in the blanks and create their own version of what happened

The investigation

The investigation

- Timely
- System-focused/systems-based
- Unbiased
- Multi-disciplinary
- Well-defined
- Clearly outlined when outside officials must be notified

The investigation

- What is the method of analysis?
- Was input gathered from employees directly involved?
- Was input gathered from other staff with knowledge about the care/service process?
- Does the description of the event give a complete picture of the “scene?”
- Were guidelines/protocols followed?

The investigation

Table 1: Behavior Classification

Normal Error (Human Error)	**At-risk Behavior**	**Reckless Behavior**
Inadvertent action such as a slip, lapse, or mistake. **Manage by changing:** • Processes. • Procedures. • Design. • Environment.	Individual is not educated about potential risk and sees no value in established policies to prevent it. **Manage by:** • Removing incentives for at-risk behaviors. • Creating incentives for positive behaviors. • Educate about potential risks. • Redesign of system factors.	Conscious and deliberate violations of procedures and policies. **Manage through:** • Remedial action. • Punitive action.
SUPPORT	**COACH**	**SANCTION**

Adapted from: Marx D., New York, NY, Columbia University, *Patient Safety and the "Just Culture": A Primer for Health Care Executives*, 2001

"You cannot change the human condition. But you can change the conditions in which humans work."
James Reason, professor of psychology at the University of Manchester

The investigation

Guidelines on post-incident investigation are key.

What did the resident/client or individual say happen?

What was (or was not) in the environment?

What statements should be collected? And how? And by whom?

Who talks to the resident/client and family with the outcome of the investigation? Why is that important?

The investigation

Three features determine the extent to which investigation of an incident results in a reduction in the likelihood of a recurrence:

- How deep the investigation delves into understanding the true systemic issues that caused something to go wrong;
- How systemic the investigation's focus is in considering where else a similar problem could have occurred beyond the local context in which it did occur;
- How strong the corrective actions are in actually, and sustainably, reducing the risk of a repeat.

(WHO)

Best practices

Best practices - leadership

Nursing care center leaders provide the foundation for an effective patient and resident safety system by doing the following:

- Promoting learning
- Motivating staff to uphold a fair and just safety culture
- Providing a transparent environment in which quality measures and learnings about patient or resident harm events are freely shared with staff
- Modeling professional behavior
- Addressing intimidating behavior that might undermine the safety culture
- Providing the resources and training necessary to take on improvement initiatives

Best practices - communication

- Share what your organization does with the data entered into your incident report system
- Share outcomes when incident and investigation data is used in PIP
- Say thank you to those reporting events making a connection to keeping residents/clients/members safe and their work on the reports

Best practices – good catch/near miss/close call

- Don’t forget good catches
  - Communication
  - Ease of reporting
  - Taking action
  - Recognition program

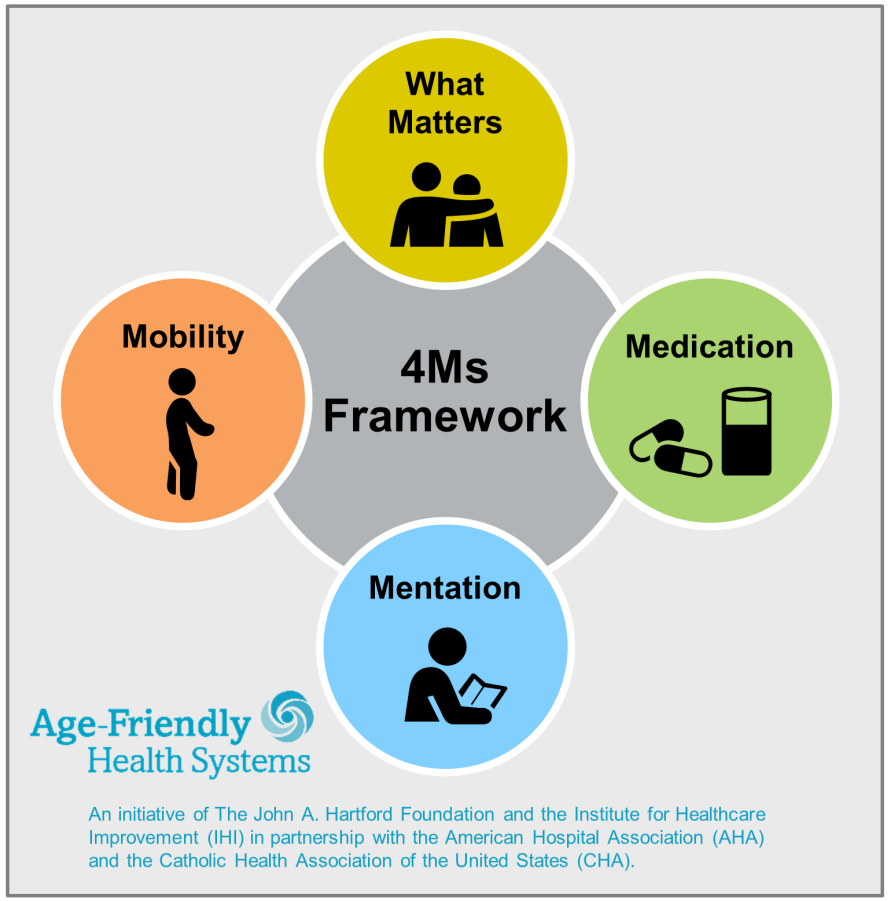
Best practices – proactive hazard analysis

- Proactive hazardous condition analysis
  - Preconditions
  - Supervisory influences
  - Organization influences

- Proactive risk management tools
  - ISMP Guidance and Tools (ecri.org)
  - Contingency Diagram | Digital Healthcare Research (ahrq.gov)
  - Potential Problem Analysis | Digital Healthcare Research (ahrq.gov)
  - Process Decision Program Chart | Digital Healthcare Research (ahrq.gov)
  - What is a Process Decision Program Chart (PDPC)? | ASQ

Best practices - aftercare

- Residents/clients should be provided with support and care after an event.
- Don’t forget the aftercare of the team members involved! Staff involved in serious incidents should receive counseling and support in the aftermath of the events that led to harm.



What Matters

Know and align care with each older adult's specific health outcome goals and care preferences including, but not limited to, end-of-life care, and across settings of care.

Medication

If medication is necessary, use Age-Friendly medication that does not interfere with What Matters to the older adult, Mobility, or Mentation across settings of care.

Mentation

Prevent, identify, treat, and manage dementia, depression, and delirium across settings of care.

Mobility

Ensure that older adults move safely every day in order to maintain function and do What Matters.

Best practices – age-friendly

What Matters Most - Age-Friendly Health Systems movement

Get to the root cause(s)

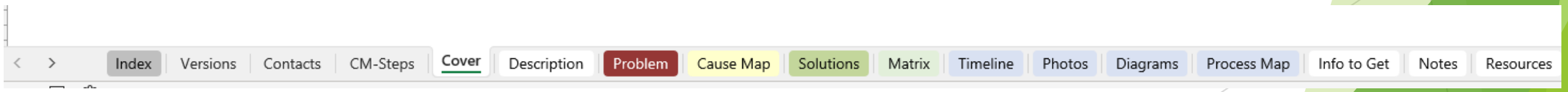
Get to the root cause(s)

- How?
  - Find the right tools (one size does not fit all)
  - Practice
  - Define when (not just sentinel events)
  - Create a safe environment for the team

Get to the root cause(s)

Cause mapping

- Root Cause Analysis Training
  Destination: ThinkReliability



Get to the root cause(s) - with a little best practices thrown in

- Success Cause Analysis

Learning from what works!

Root Cause Resources

Here are some of the more popular healthcare root cause analysis education sites:

- www.cms.gov/medicare/...
- www.health.state.mn.us/facilities/patientsafety/...
- www.jointcommission.org/-/media/tjc/documents/resources/...
- www.cec.health.nsw.gov.au/__data/assets/pdf_file/0009/...
- www.ihi.org/resources/tools/...
- patientsafety.pa.gov/pst/Pages/Root_Cause_Analysis/...
- www.patientsafety.va.gov/docs/...
- www.patientsafety.va.gov/docs/joe/...
- www.patientsafety.va.gov/professionals/onthejob/rca.asp

Get to the root cause

- Quality Management and Improvement

[Quality Tools & Templates - List of Quality Tools | ASQ]

Spark creativity with interventions

Spark creativity with interventions

- Figuring out the unmet needs of individuals in your care
- Evidence-based
- Faith-informed
- Look at connecting factors – vision, hearing, balance
- Focus on falls
- Looking at the environment

Spark creativity with interventions

Final thoughts

- Culture of safety
- Reduce the risk of harm
- Set a goal and check-in
- Learn
- Be prepared
- Collaborate

Resources

- NuclearVerdicts_RGB_FINAL.pdf (instituteforlegalreform.com)
- Enhancing Safety Culture Through Improved Incident Reporting: A Case Study In Translational Research | Health Affairs
- https://data.cms.gov/provider-data/
- Evolution-of-SCORE-to-SCORE-II.pdf (dukehealth.org)
- Napoli G. Perceptions and knowledge of nurses on incident reporting systems: Exploratory study in three Northeastern Italian Departments. *J Healthc Risk Manag*. 2022; 42: 16-23. https://doi.org/10.1002/jhrm.21504
- world health organization patient safety incident reporting and learning systems.pdf (who.int)
- The Top 3 Emerging Risks in Senior Living in 2023 - Senior Housing News
- Patient Safety Systems (jointcommission.org)
- Age-Friendly Health Systems | Institute for Healthcare Improvement (ihi.org)
- Unlocking Better Care by Asking What Matters | Institute for Healthcare Improvement (ihi.org)

Resources

- Age-Friendly Health Systems: Guide to Care of Older Adults in Nursing Homes (hubspotusercontent-na1.net)
- Age-Friendly Health Systems: A Workbook for Nursing Home Teams (hubspotusercontent-na1.net)
- Systems-based models for investigating patient safety incidents - BJA Education
- System-Focused Event Investigation and Analysis Guide | Agency for Healthcare Research and Quality (ahrq.gov)
- Learning from incidents in healthcare: the journey, not the arrival, matters | BMJ Quality & Safety
- Quality Tools & Templates - List of Quality Tools | ASQ
- Success Cause Analysis: Learning from What Works to Advance Safety | Institute for Healthcare Improvement (ihi.org)

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