“Urgent! Near Miss Event Reporting”

Faculty Development Series

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OUR VALUES: EXCELLENCE · RESPECT · LEADERSHIP · ACCOUNTABILITY · NURTURING · GENEROSITY · ETHICS · RECOGNITION
Improve quality, safety & service
Advance operational excellence
Improve access & drive service line growth
Enhance associate & physician engagement
Improve financial performance
MISSION
We compassionately care for people.
VISION
Erlanger is a nationally-acclaimed health system anchored by a leading academic medical center. As such we will deliver the highest quality, to diverse populations, at the lowest cost, through personalized patient experiences across all patient access points. Through innovation and growth, we will sustain our success and spark economic development across the Chattanooga region.

High Reliability Organizations

Naval Aviation

Commercial Aviation

Nuclear Power

"High Reliability Organizations operate under very trying conditions all the time ***and yet manage*** to have fewer than their fair share of accidents."

Managing the Unexpected (Weick & Sutcliffe)

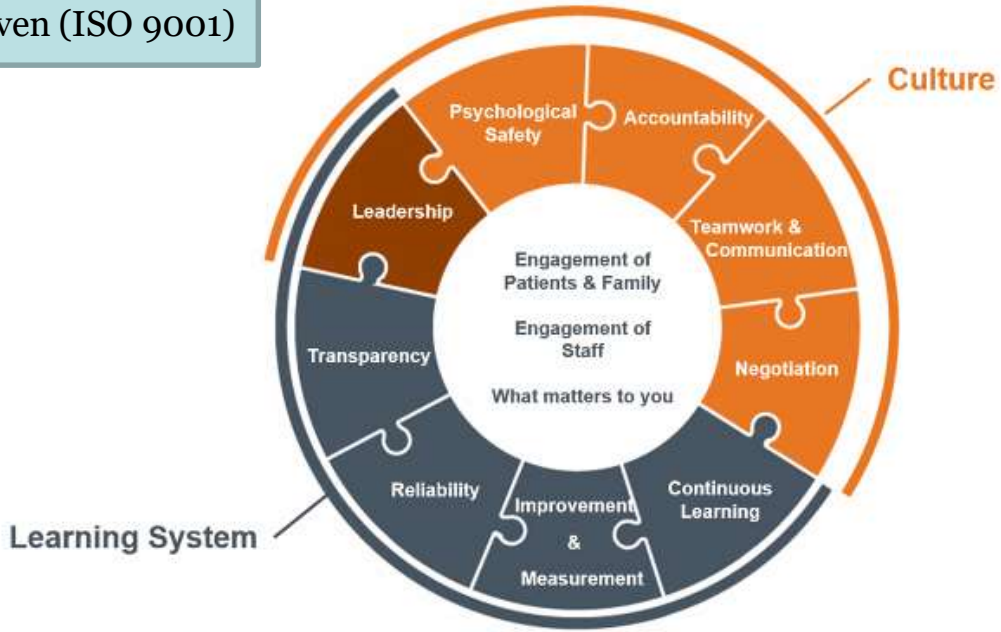
Risk = *probability* x *consequence*

Weick and Sutcliffe
MINDFULNESS

F	Preoccupation with Failure	**Operating proactively with much concern about unforeseen circumstances that can affect safety performance**
O	Sensitivity to Operations	**Constantly seek the opinion of front line staff in order to get a realistic picture of operation status within the organization**
R	Reluctance to Simplify	**Gathering information that can be used to monitor activities, identify warning signals, and analyze incidents and near misses in order to enhance safety performance**
C	Commitment to Resilience	**Ability to successfully recover from failures, which is achieved by a real commitment to learning from past incidents**
E	Deference to Expertise	**Shifting decision making in the event of an emergency to the most experienced person or team**

Framework for Safe, Reliable and Effective Health Care

Leader-driven (ISO 9001)



Source: Frankel A, Haraden C, Federico F, Lenoci-Edwards J. A Framework for Safe, Reliable, and Effective Care. White Paper. Cambridge, MA: Institute for Healthcare Improvement and Safe & Reliable Healthcare; 2017. (Available at ihi.org)

Culture of Safety

- Defined by IHI as
  - *“an environment in which providers can discuss errors, near misses, and harm openly, knowing that they won’t be unfairly punished and have confidence that reporting safety events will lead to improvement”*

A just culture focuses on identifying and addressing systems issues that lead individuals to engage in unsafe behaviors, while maintaining individual accountability by establishing zero tolerance for reckless behavior.

- It distinguishes between human error, at-risk behavior, and reckless behavior.

AHRQ, Culture of Safety Primer, 2019

Human Error	• Slip, lapse, mistake
At Risk Behavior	• Intentional behavioral choice (i.e., shortcut) that increases risk • Know what the rules are but feel safe breaking them • Risk is not recognized or is mistakenly believed to be justified
Reckless Behavior	• A behavioral choice to consciously disregard a substantial and significant risk • Choosing to put others in harms way

EHS Confidentiality

- The Patient Safety Event System allows us to communicate confidentially about safety and complaint events within this protected reporting system.

- The eSafe report is our protected information, not part of the medical record and is not shared with the patient/family.

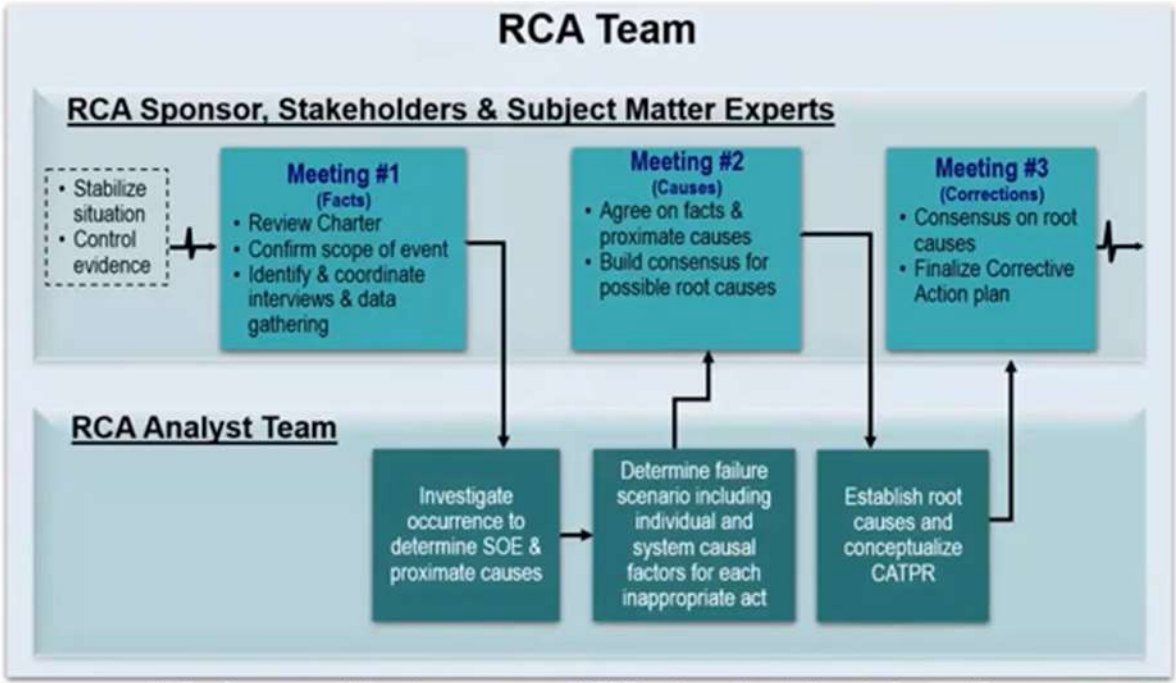
This material is protected pursuant to the TN Patient Safety and Quality Improvement Act of 2011.

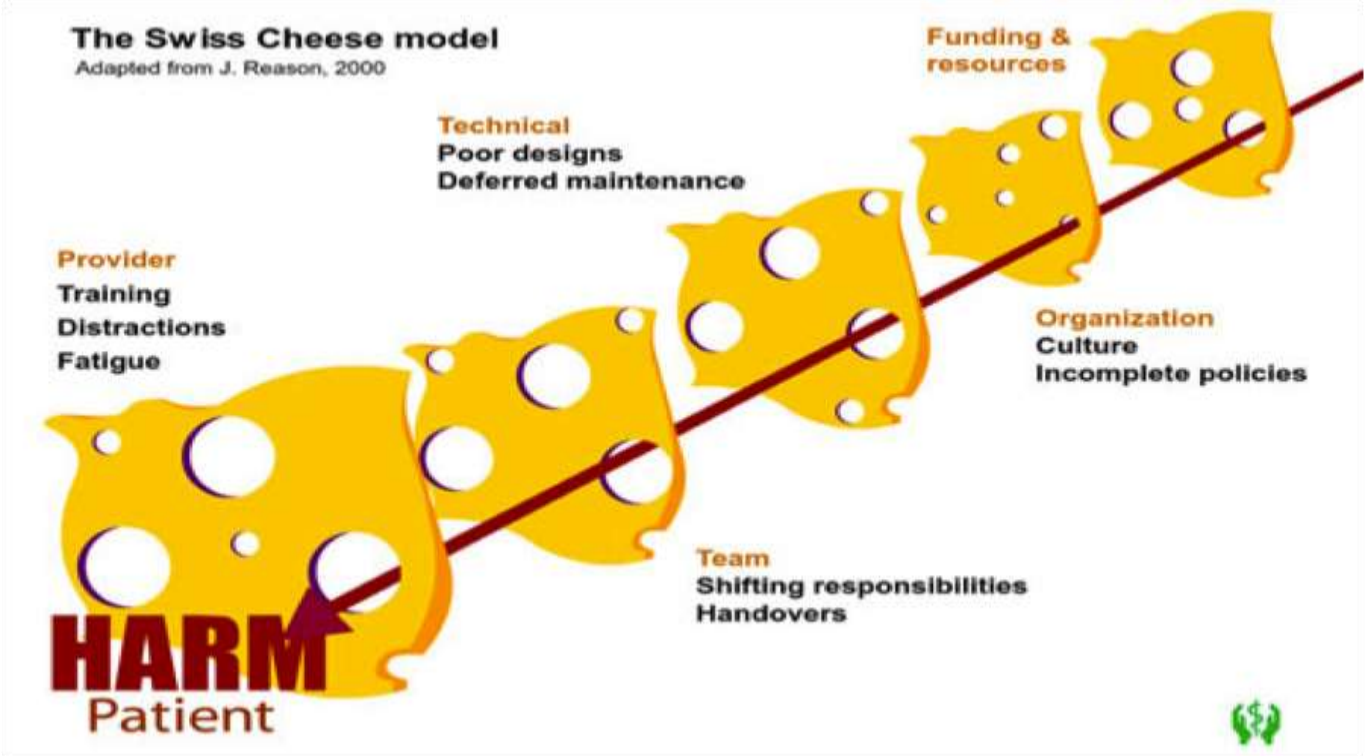
If a Patient Safety Event Occurs

- **Take care of the patient first -** Depending on the extent or suspected extent of a patient injury, a physician should examine the patient immediately or at the very least a physician should be notified. The results of any exam should be documented in the medical record and include the mechanism of injury, treatment performed and disclosure.

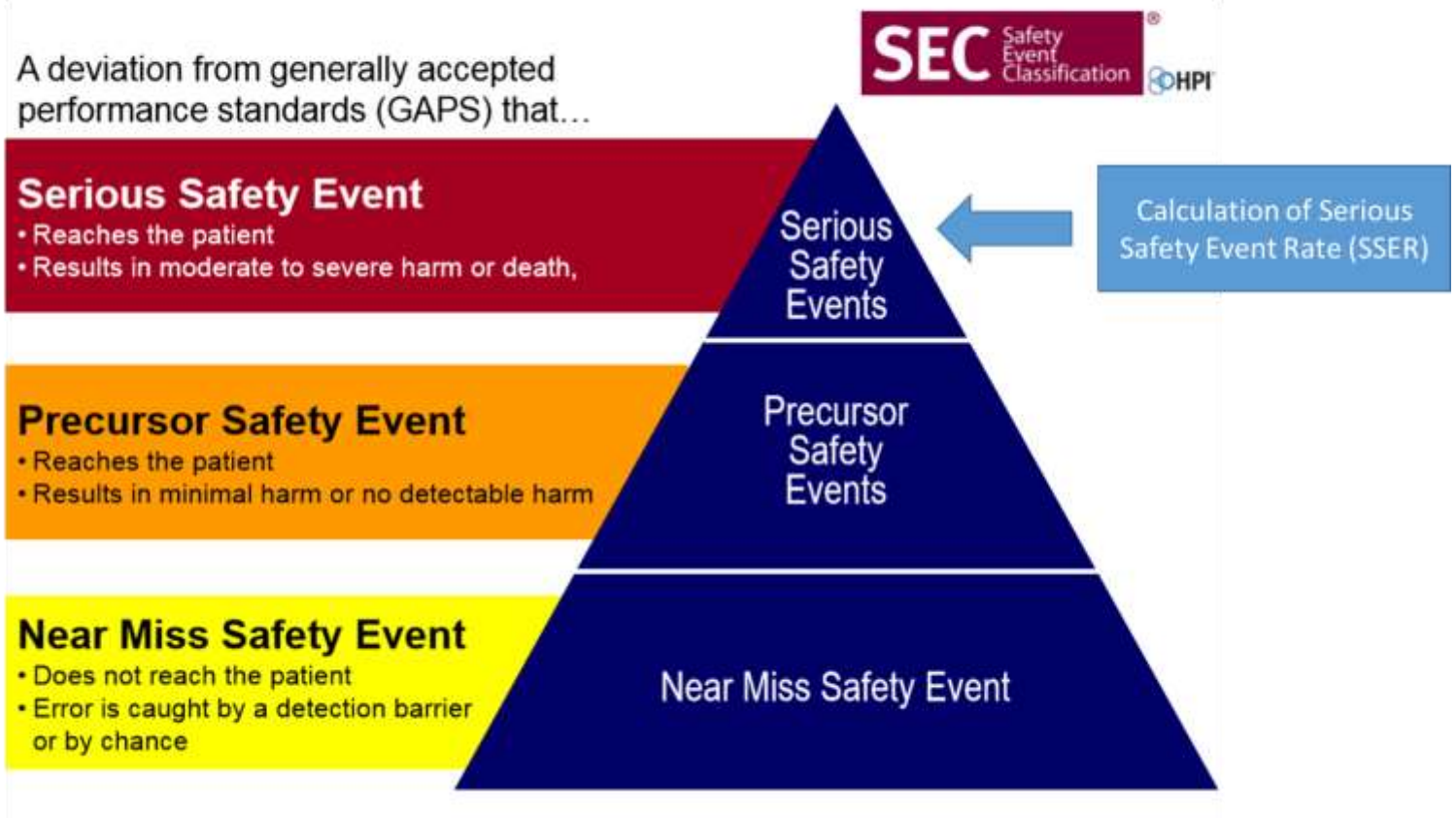
- Please **do not** document in the medical record ***" an incident report was filled out"*** or write an order stating ***"fill out an incident report"***.

The Three-Meeting Model



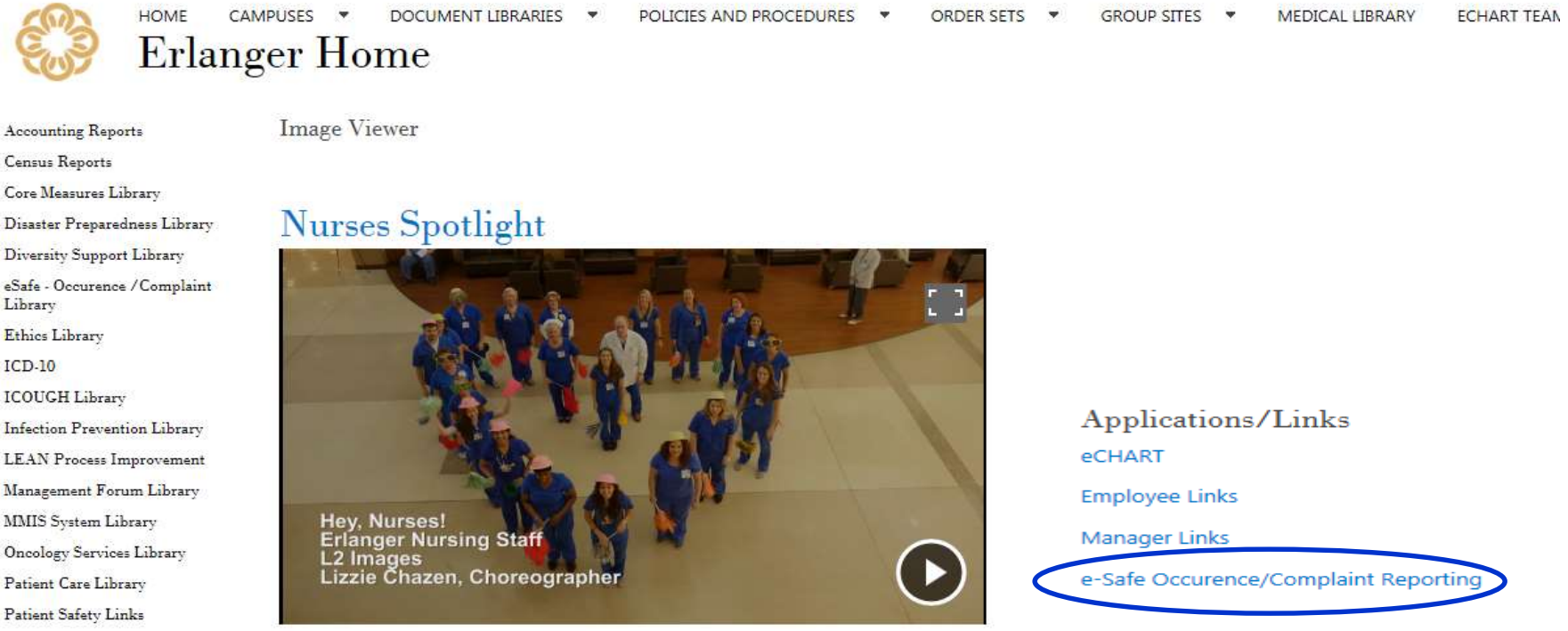

The Swiss Cheese model
Adapted from J. Reason, 2000
Funding & resources
Technical
Poor designs
Deferred maintenance
Provider
Training
Distractions
Fatigue
Organization
Culture
Incomplete policies
Team
Shifting responsibilities
Handovers
HARM
Patient

Safety Event Classification



Occurrence and Complaint Reporting System

eSafe



Occurrence/Complaint Management System

Procedure

1. Network name – Erlanger Network

2. "**Username:**" your system username/ network ID

3. "**Password:**" your system/ network password

4. Click "**Login**"

5. "**Anonymous**" option to report with anonymity ***(not recommended)***

eSafe: Initiate a File

Procedure

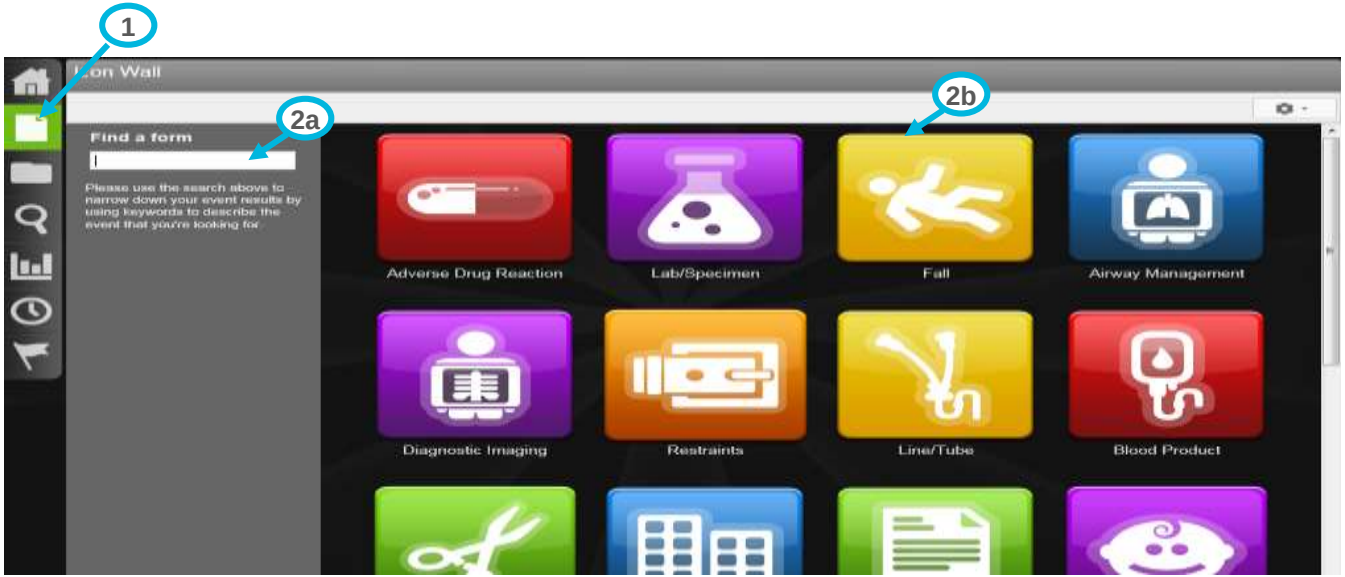
1. New File button on the Navigation Toolbar.

2. To find a specific form:

a. **"Find a form" Enter keywords and Icons will filter to match search criteria**

OR

b. **Select an icon to view the submission form.**



eSafe

Access/Training/Clinical Questions?

Access/Training?
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