A Focused Review of Harmful Events

Presented By:

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About Clarity Group, Inc.

Clarity Group empowers healthcare providers to manage professional liability risk and become the patient-centered, high-reliability organizations they strive to be via our powerful suite of risk-quality-safety software solutions, consulting services, captive design and management, and PSO. Our flagship Healthcare SafetyZone® software enables event reporting and management within an integrated system of workflow management and analytics.

About Clarity PSO

- Parent Company: Clarity Group, Inc.
  - Vision: Healthcare delivery that is free of preventable harm
  - Mission: To empower healthcare providers to manage professional liability risk and reach their vision for enhanced healthcare quality and safety across their entire system of care
- Formation of Clarity PSO is a logical extension of our philosophy that quality and safety are the only true mitigating forces in preventing harm and potential medical malpractice litigation
- One of the first PSOs listed in 2008 (P0015 - 3yr re-listing through 2017-2020)
- Tailored and specialized provider focus related to patient safety and quality initiatives

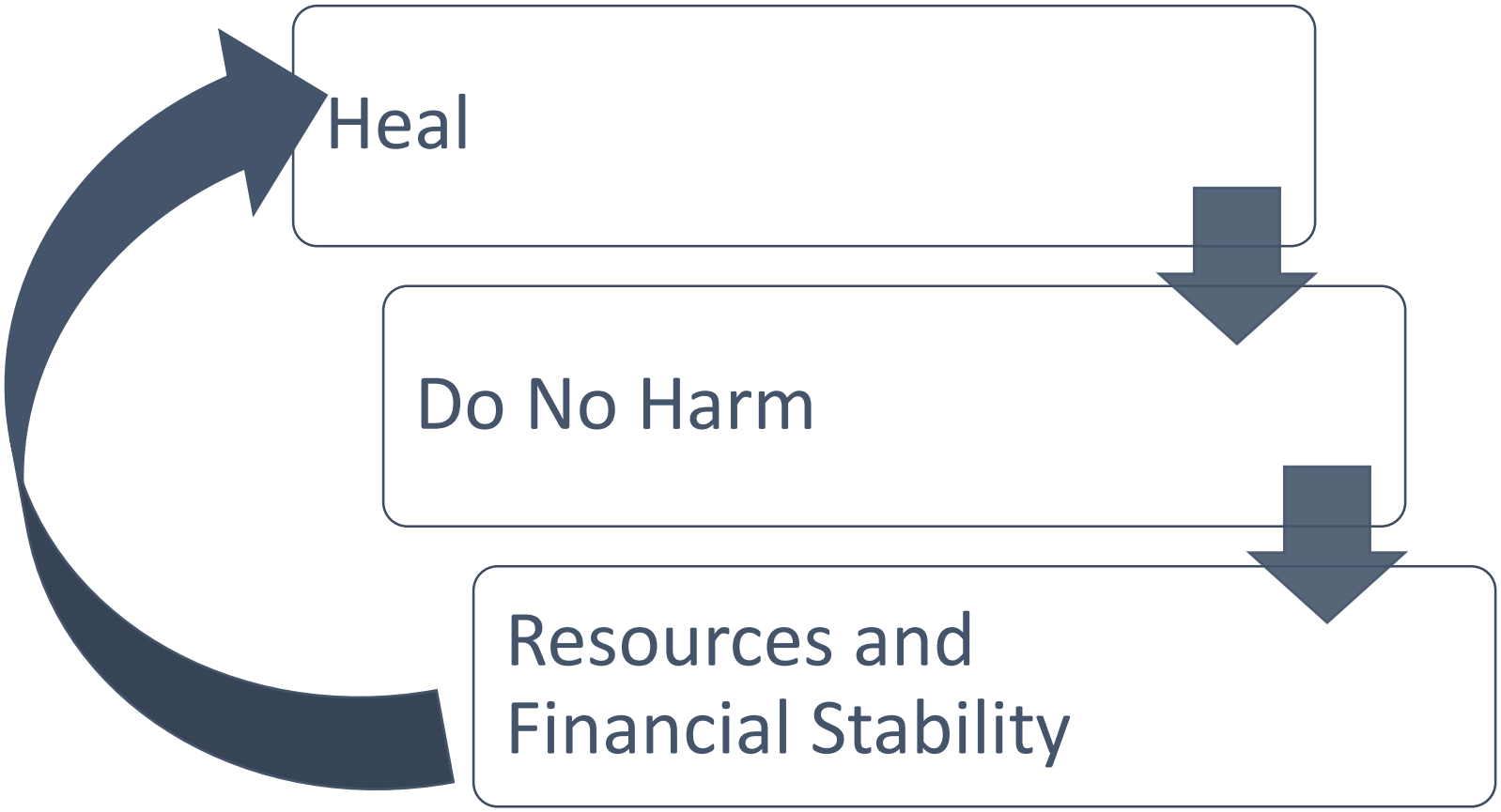
Clarity PSO Experience

- Involved from the PSQIA beginnings - educating providers on statute, implementing guidelines and participation
- AHRQ relationship: Planning committees and national presentations
- Legal Relationships
  - PSO content experts
  - Participation in amicus briefs
- PSO Facilitator Services:
  - Review and critique of other listed PSO operations
  - PSO data collection support with the Healthcare SafetyZone® Portal
- Common Format reports - the very first PSO to produce aggregate Common Format reports using AHRQ Common Format Aggregate Report Templates

Premise

The healthcare industry is…

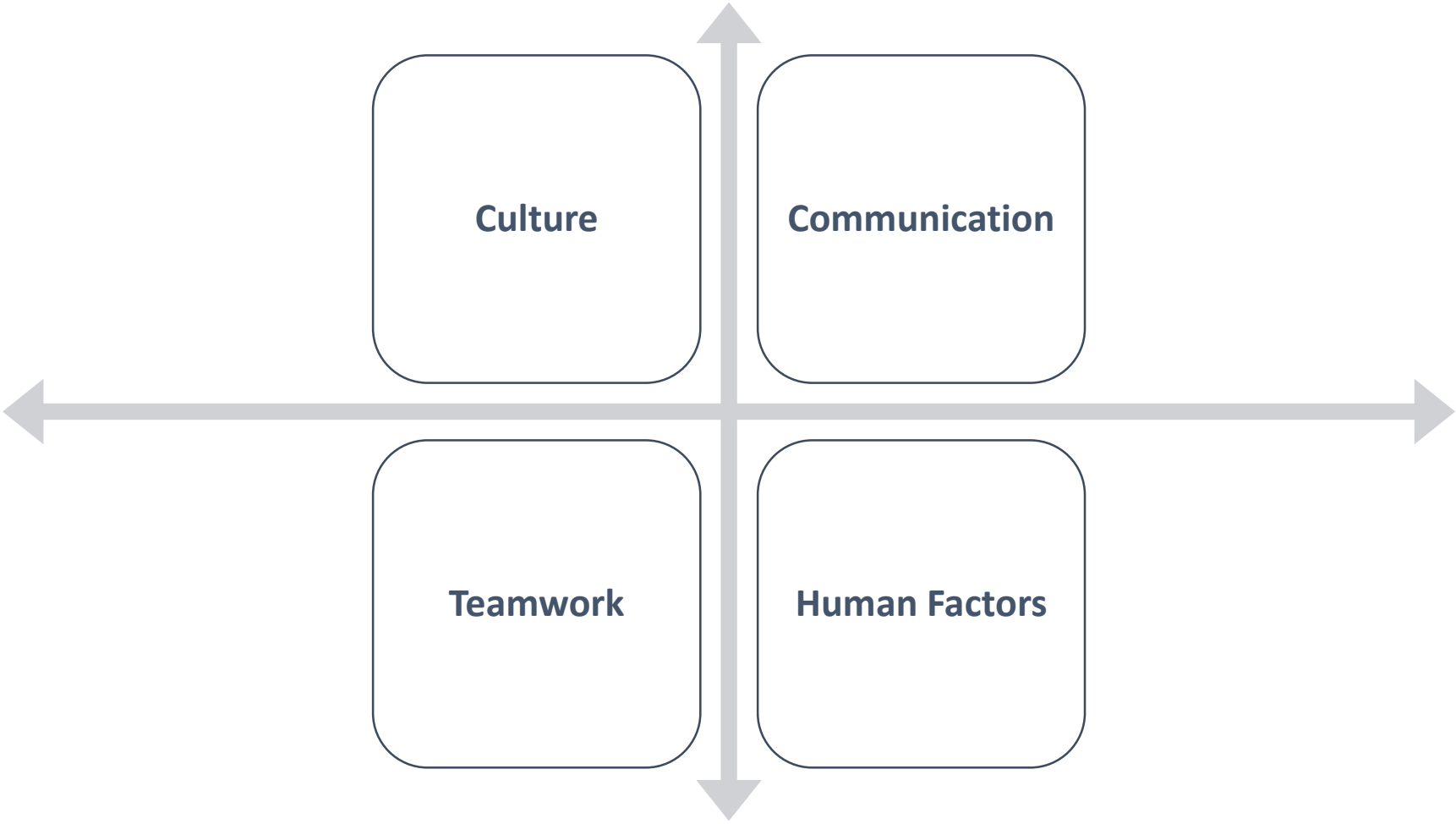
Healthcare's Primary Purpose



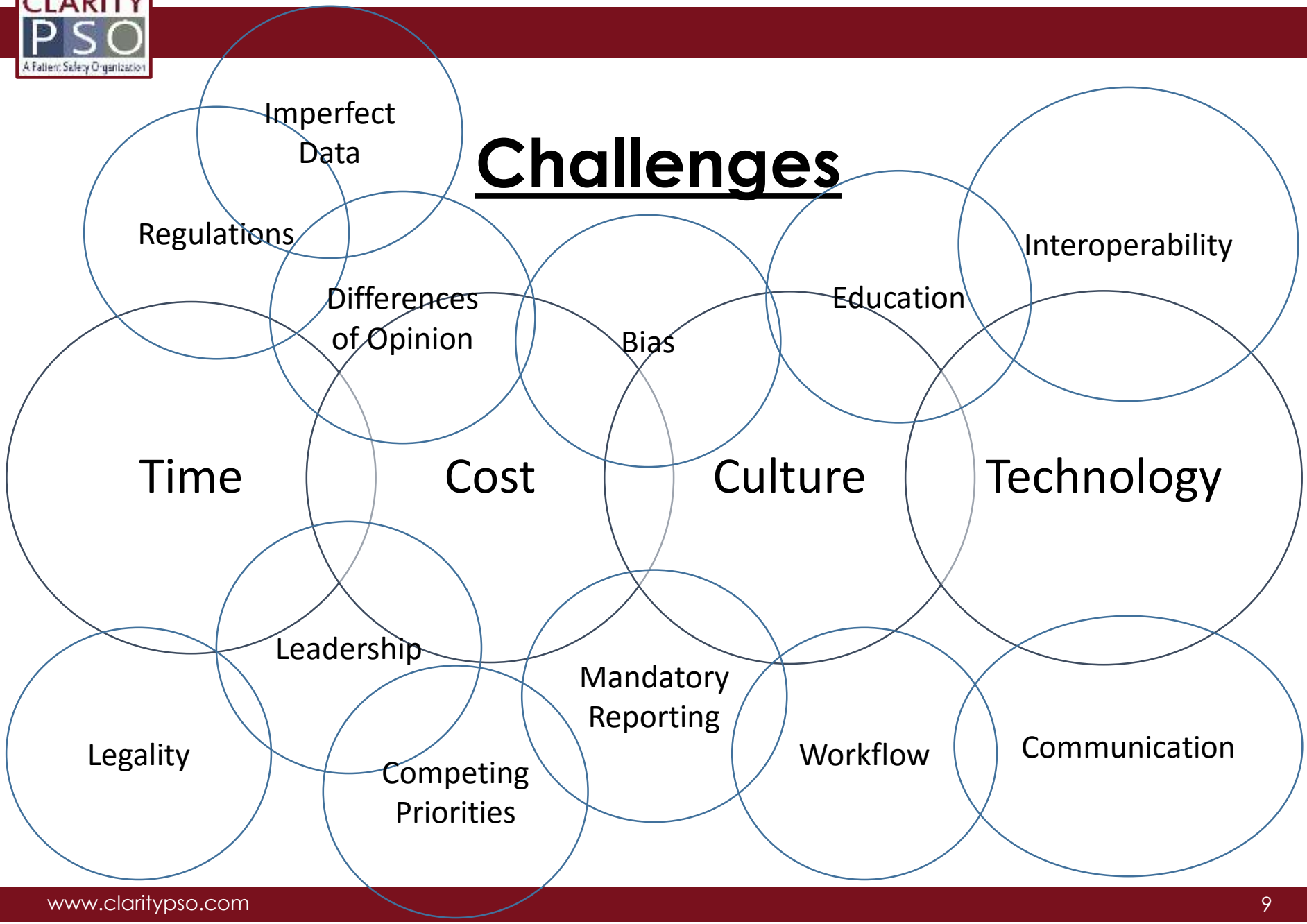
"Distractors"?

Number of Deaths from Preventable Medical Errors	• 44,000-98,000[1] • 195,000[2] • Over 200,000[3] • Over 400,000[4] • 210,000-400,000[4]
Cost	• $17 billion[5]
Incident Reports	• Law interpretation • Malpractice claims • Litigation
Harm	• ~22% of PSO database

Going Beyond "Distractors"

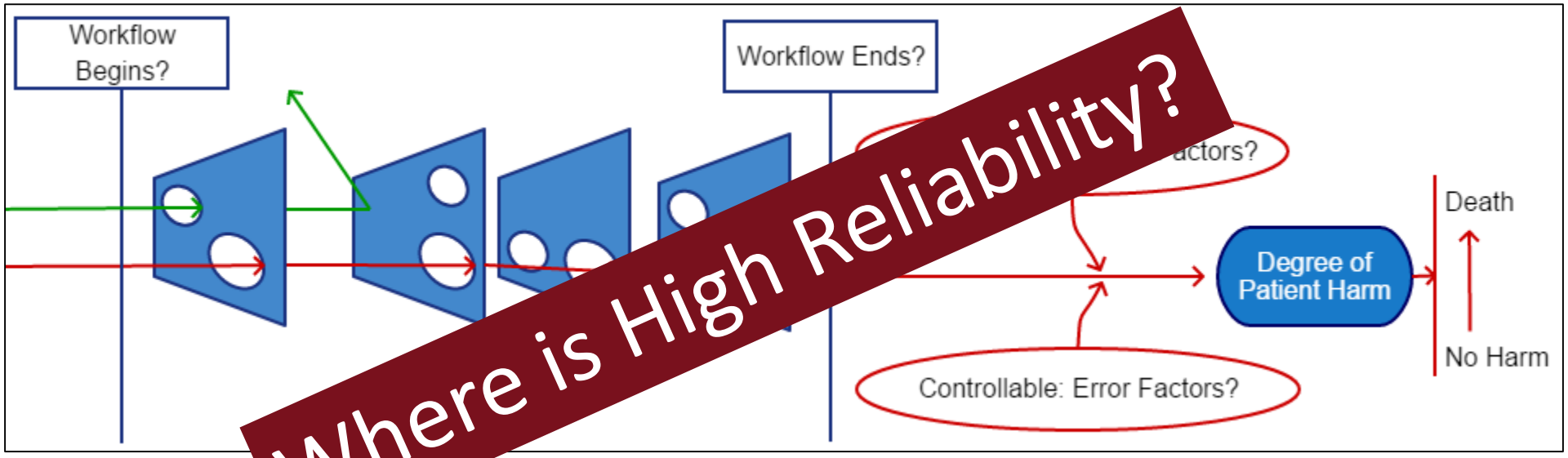


Challenges



Is There A Solution to Zero Harm?

Care Process Interrupted



Adapted from James Reason's Swiss cheese model[8]

How critical is the checkpoint?

Is it the right checkpoint barrier?

Where do near misses/good catches fall?

Could it be prevented?

A Look at Harm Data

Report Composition

- Over 82,000 Safety Incidents
- Over 5 Years
- Across Nearly All Settings of Care

Documentation of Harm
AHRQ Common Format

Event ID: _____

Initial Report Date (HERF Q1): _____

7. After discovery of the incident, and any subsequent intervention, what was the extent of harm to the patient (i.e., extent to which the patient's functional ability is expected to be impaired subsequent to the incident and any attempts to minimize adverse consequences)? CHECK FIRST APPLICABLE:

AHRQ Harm Scale

a. ☐ **Death:** Dead at time of assessment. → ANSWER QUESTION 9

b. ☐ **Severe harm:** Bodily or psychological injury (including pain or disfigurement) that interferes significantly with functional ability or quality of life.

c. ☐ **Moderate harm:** Bodily or psychological injury adversely affecting functional ability or quality of life, but not at the level of severe harm.

d. ☐ **Mild harm:** Minimal symptoms or loss of function, or injury limited to additional treatment, monitoring, and/or increased length of stay.

e. ☐ **No harm:** Event reached patient, but no harm was evident. → ANSWER QUESTION 9

f. ☐ Unknown

AHRQ Common Format Harm Scale[6]

Documentation of Harm NCC MERP

Category A	No Error	
Category A	No Error	Circumstances or events that have the capacity to cause error
Category B - D	**Error, No Harm**	
Category B	Error, No Harm	An error occurred but the error did not reach the patient (An "error of omission" does reach the patient.)
Category C	Error, No	An error occurred that reached the patient, but did not cause patient harm Medication reaches the patient and is administered
Category D	Error, No Harm	An error occurred that reached the patient and required monitoring to confirm that it resulted in no harm to the patient and/or required intervention to preclude harm

Category E - H	Error, Harm	
Category E	Error, Harm	An error occurred that may have contributed to or resulted in temporary harm to the patient and required intervention
Category F	Error, Harm	An error occurred that may have contributed to or resulted in temporary harm to the patient and required initial or prolonged hospitalization
Category G	Error, Harm	An error occurred that may have contributed to or resulted in permanent patient harm
Category H	Error, Harm	An error occurred that required intervention necessary to sustain life
Category I	**Death**	
Category I	Death	An error occurred that may have contributed to or resulted in the patient's death.

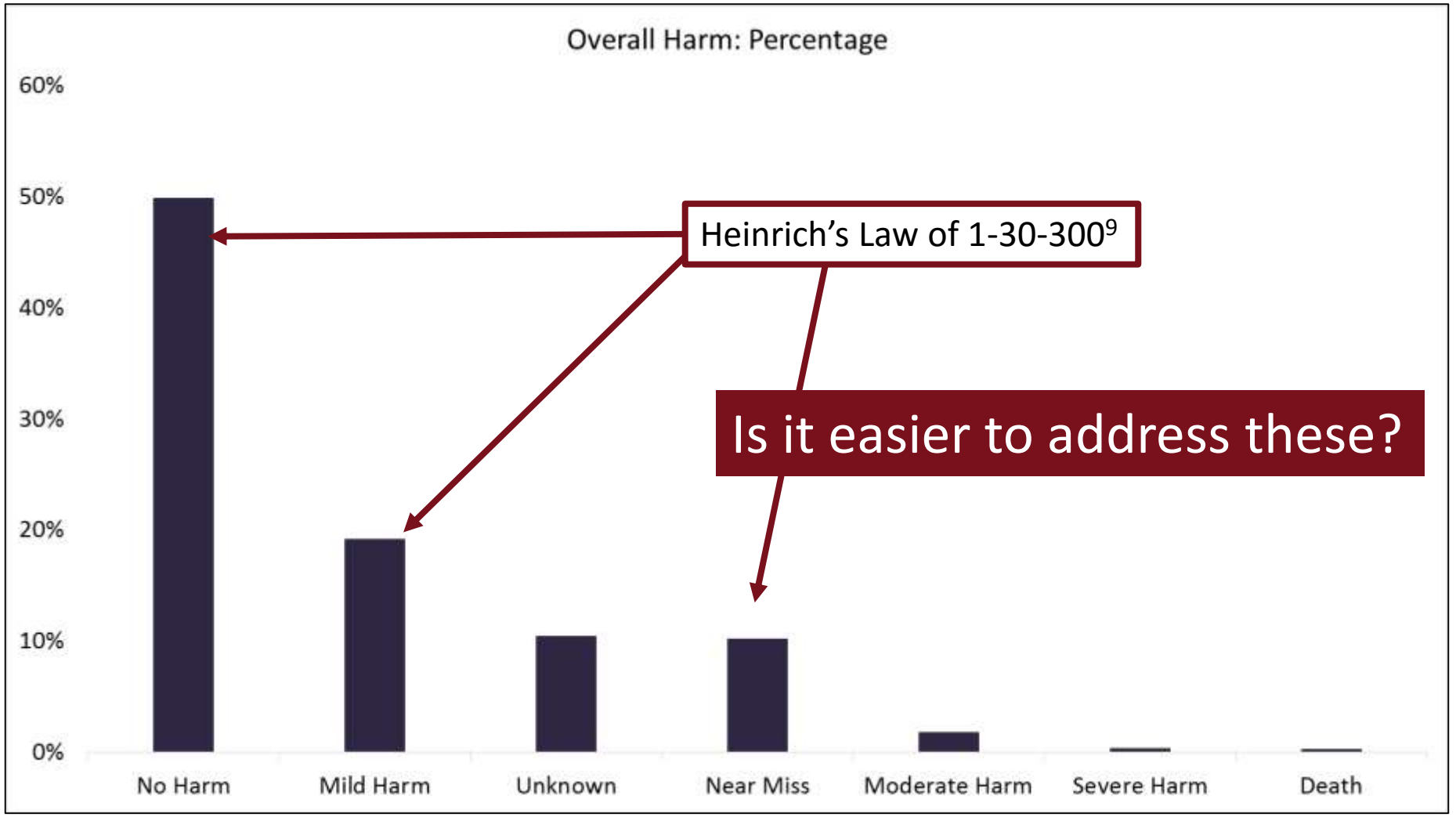
National Coordinating Council for Medication Error Reporting and Prevention (NCC MERP)[7]

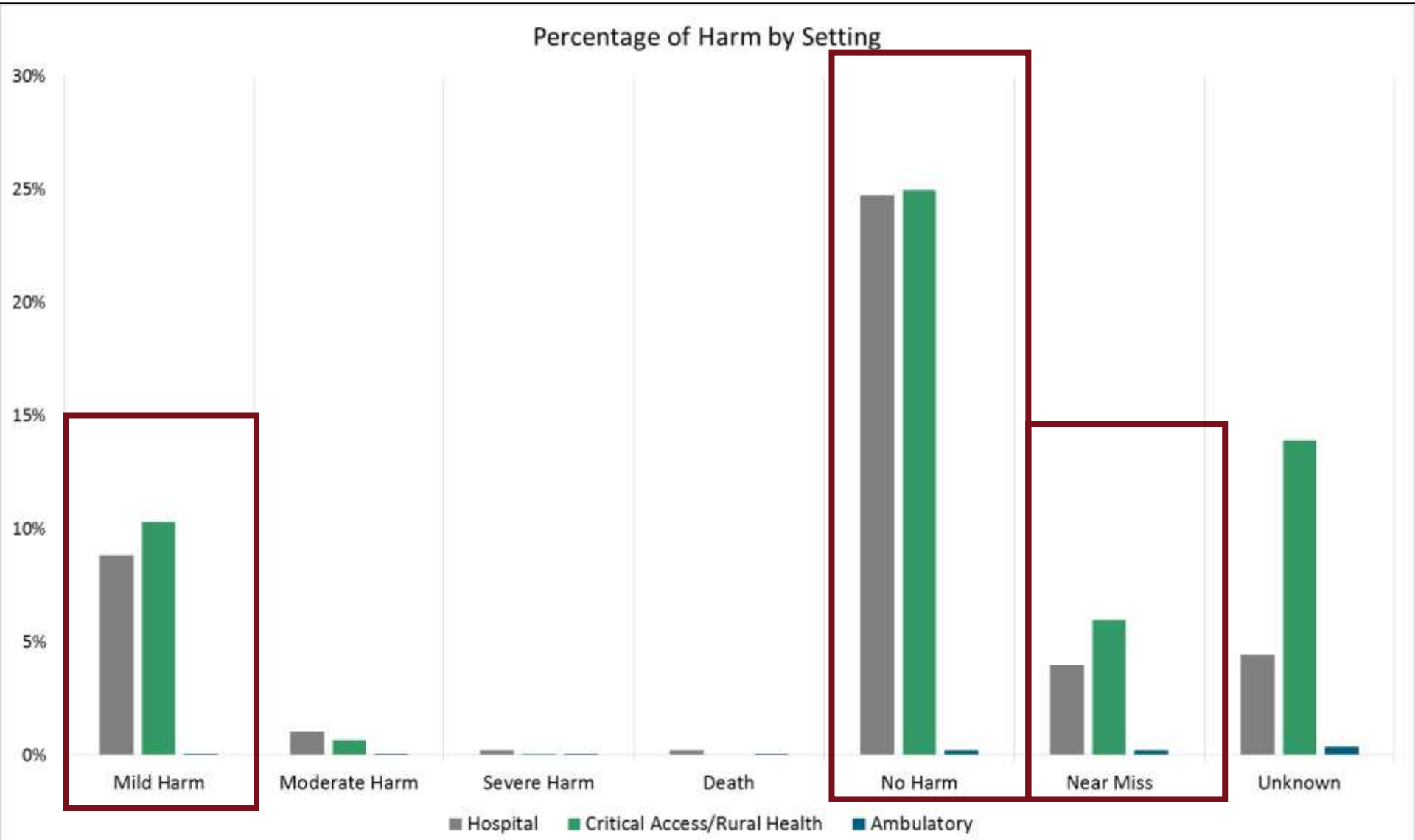
Documentation of Harm Individual Health System

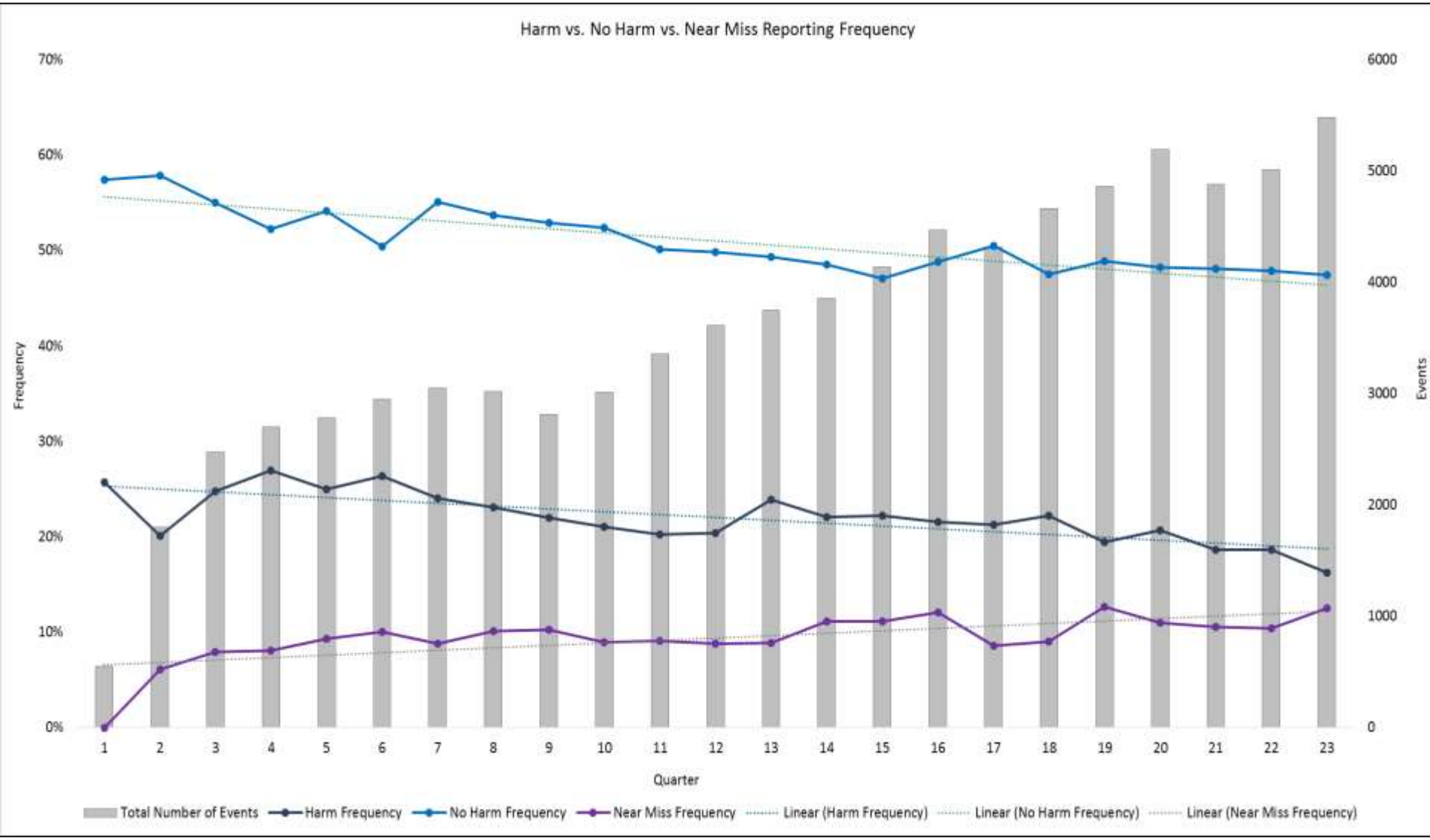
0. Error detected but did not reach the person
1. Error reached the person, but resulted in no harm
2. Resulted in need for monitoring person, no change in vital signs
3. Resulted in change in vital signs, need for continued monitoring
4. Resulted in increased length of stay, temporary harm to person
5. Resulted in permanent harm to person
6. Resulted in or contributed to person death

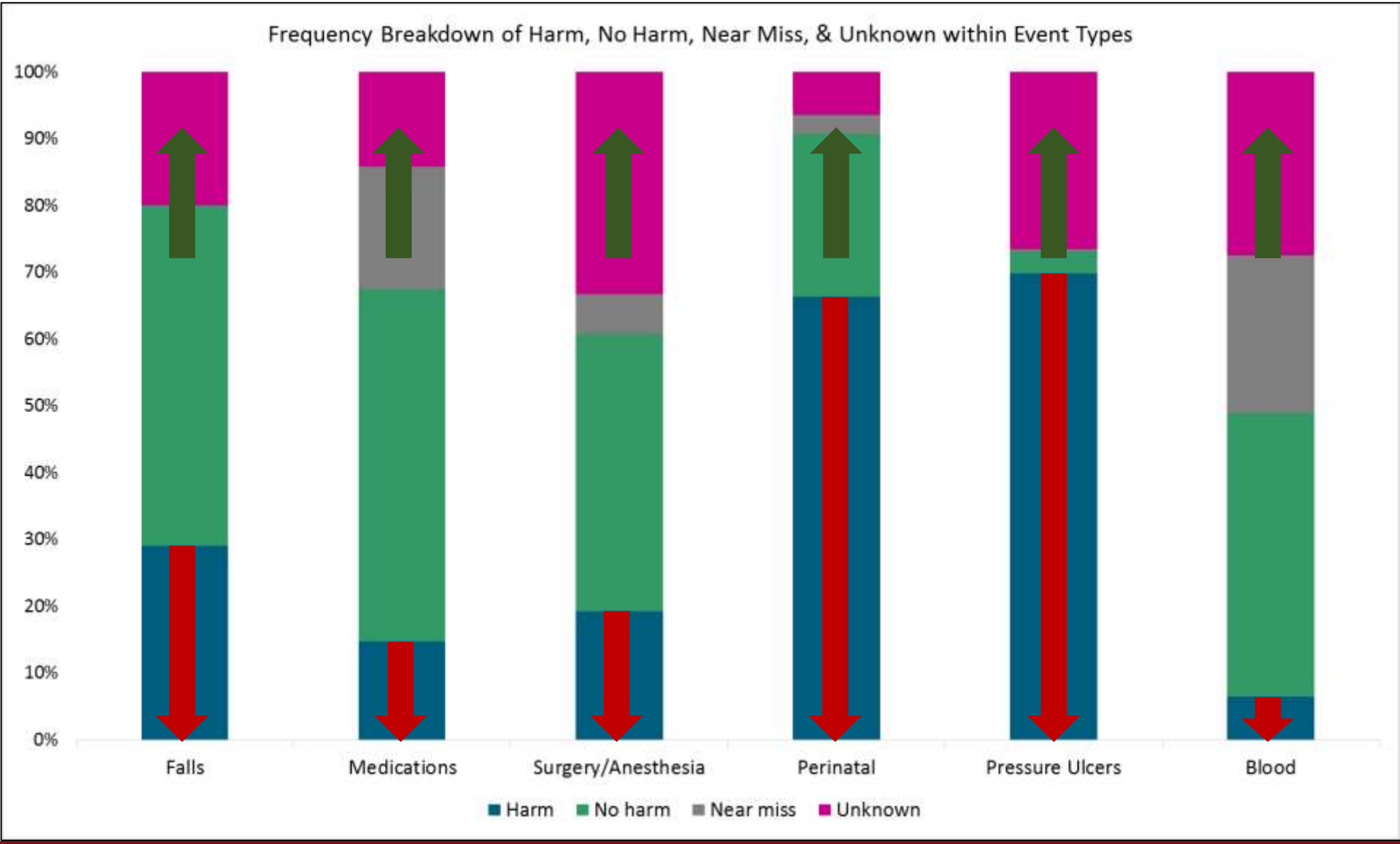
N/A

Unable to determine for reivew





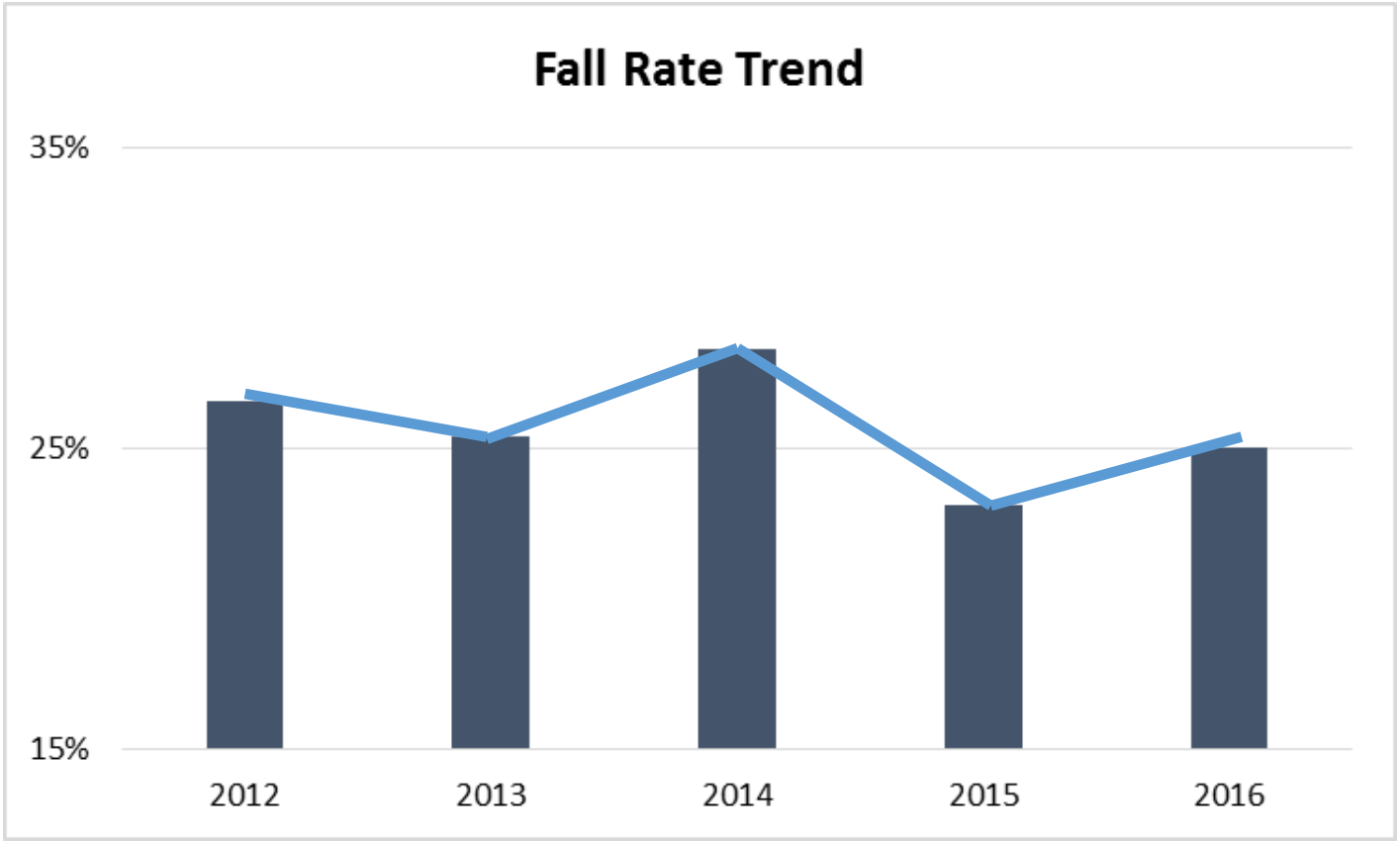




The Complexity Effect

Harm	No Harm	Near Miss
1. Antibiotic	1. Antibiotic	1. Antibiotic
2. Anticoagulant	2. Anticoagulant	2. Narcotic
3. Narcotic	3. Narcotic	3. Cardiovascular
4. Glycemic	4. Cardiovascular	4. Anticoagulant
5. Cardiovascular	5. Supplement	5. Supplement
6. Preventive Agent	6. Analgesic	6. Preventive Agent

The Oscillation Effect



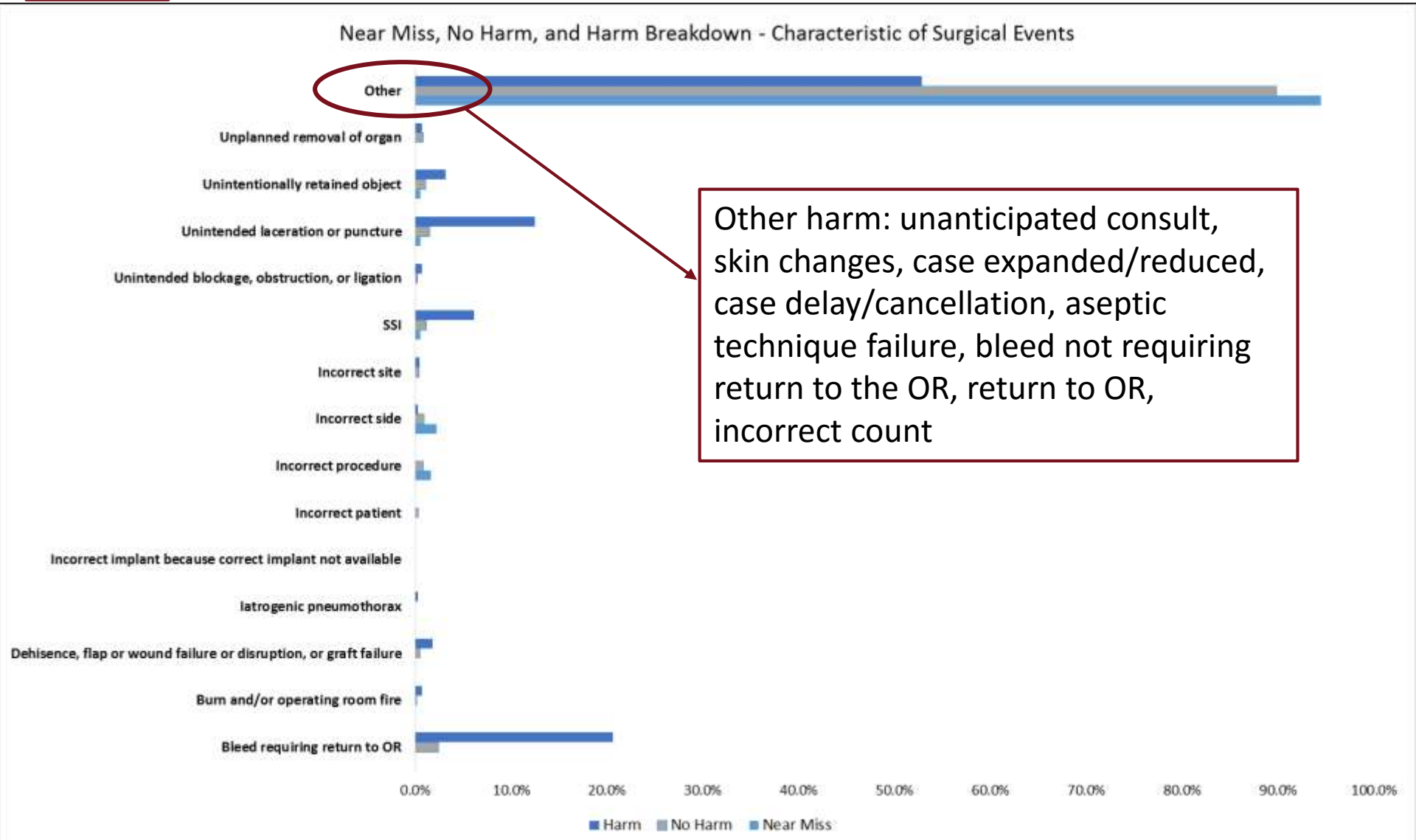
Occurs about every 18 months

Why?

Easy to become de-sensitized

New Initiatives

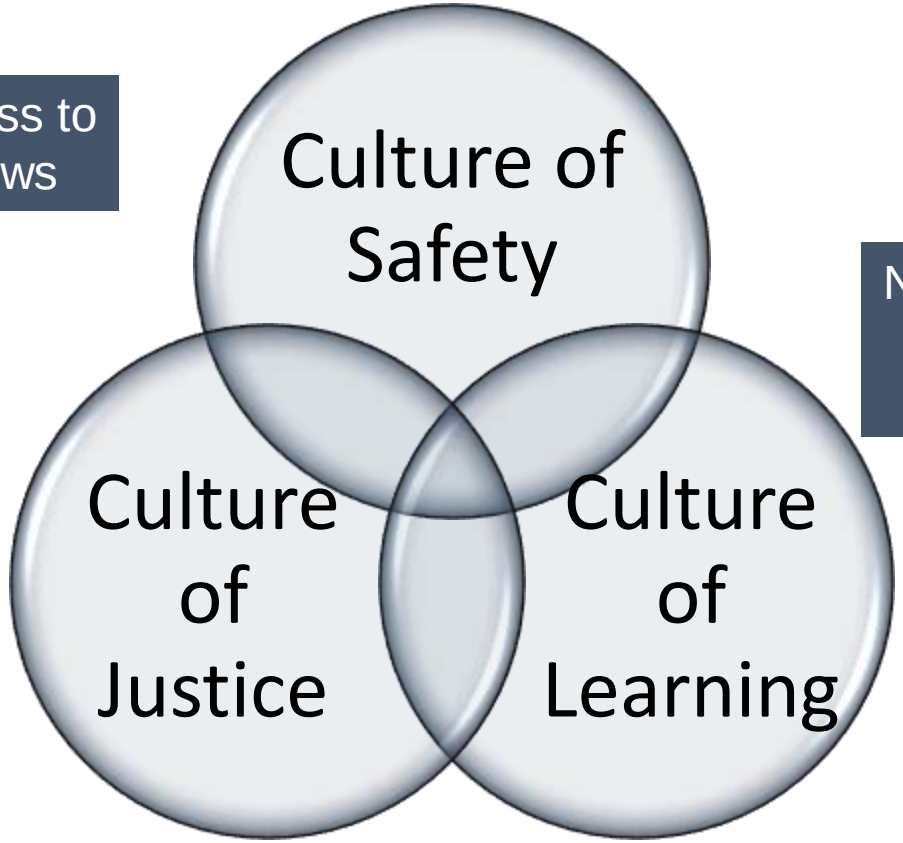
Argument that falls can never be zero



Other harm: unanticipated consult, skin changes, case expanded/reduced, case delay/cancellation, aseptic technique failure, bleed not requiring return to the OR, return to OR, incorrect count

The Journey to a Safe Culture

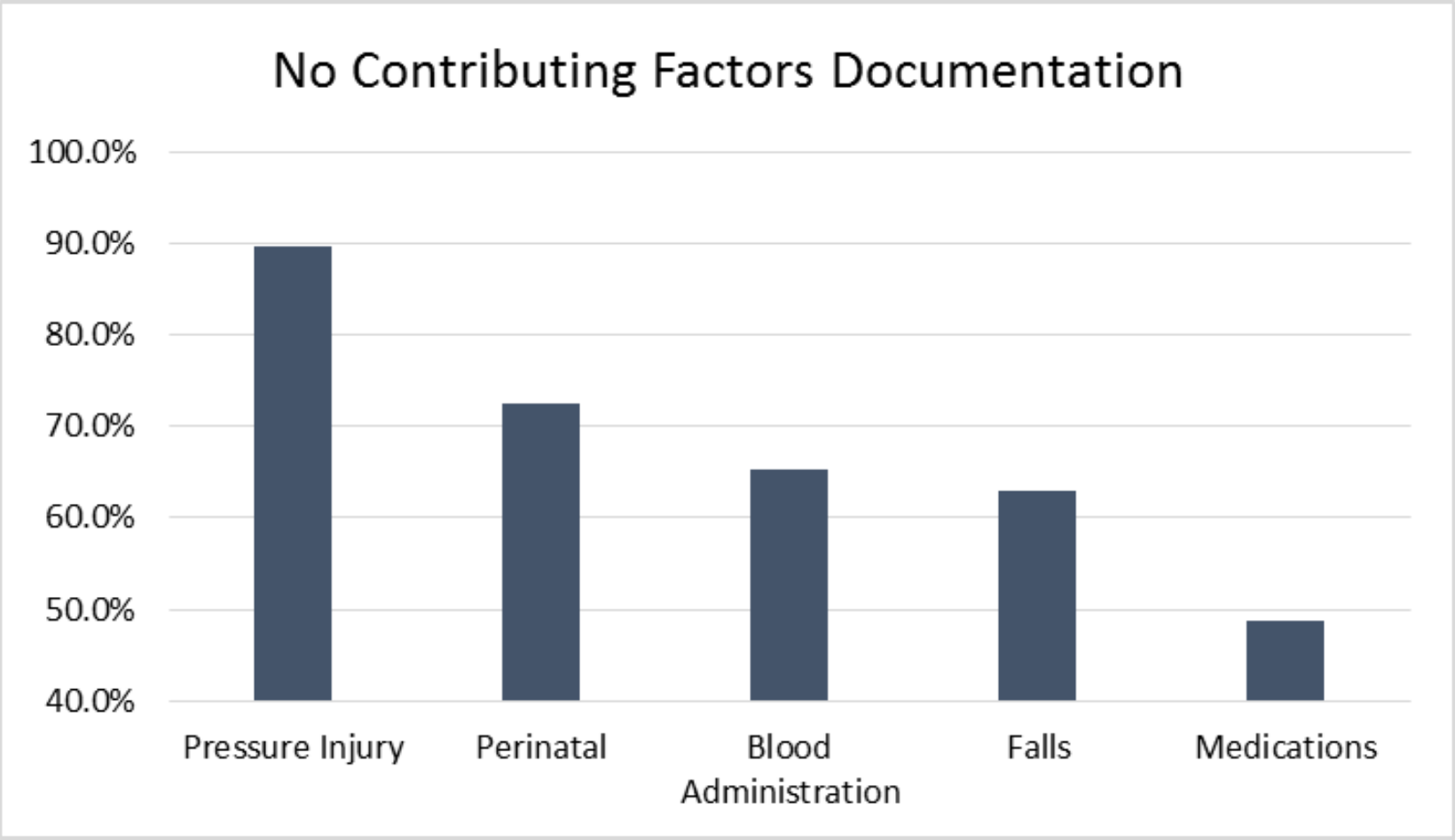
Allows the Boss to hear bad news



No finger pointing and remove or fix broken systems

Be accountable for what needs to be changed

Culture and Data



Contributing Factors?

Event ID: __

Initial Report Date (HERF Q1): __

8. Are any contributing factors to the event known? CHECK ONE:

- a. ☐ Yes
- b. ☐ No
- c. ☐ Unknown

9. What factor(s) contributed to the event? CHECK ALL THAT APPLY:

Environment
- a. ☐ Culture of safety, management
- b. ☐ Physical surroundings (e.g., lighting, noise)

Staff qualifications
- c. ☐ Competence (e.g., qualifications, experience)
- d. ☐ Training

Supervision/support
- e. ☐ Clinical supervision
- f. ☐ Managerial supervision

Policies and procedures, includes clinical protocols
- g. ☐ Presence of policies
- h. ☐ Clarity of policies

Data
- i. ☐ Availability
- j. ☐ Accuracy
- k. ☐ Legibility

Communication
- l. ☐ Supervisor to staff
- m. ☐ Among staff or team members
- n. ☐ Staff to patient (or family)

Human factors
- o. ☐ Fatigue
- p. ☐ Stress
- q. ☐ Inattention
- r. ☐ Cognitive factors
- s. ☐ Health issues

Other
- t. ☐ Other: PLEASE SPECIFY _____

AHRQ Common Format Contributing Factors[10]

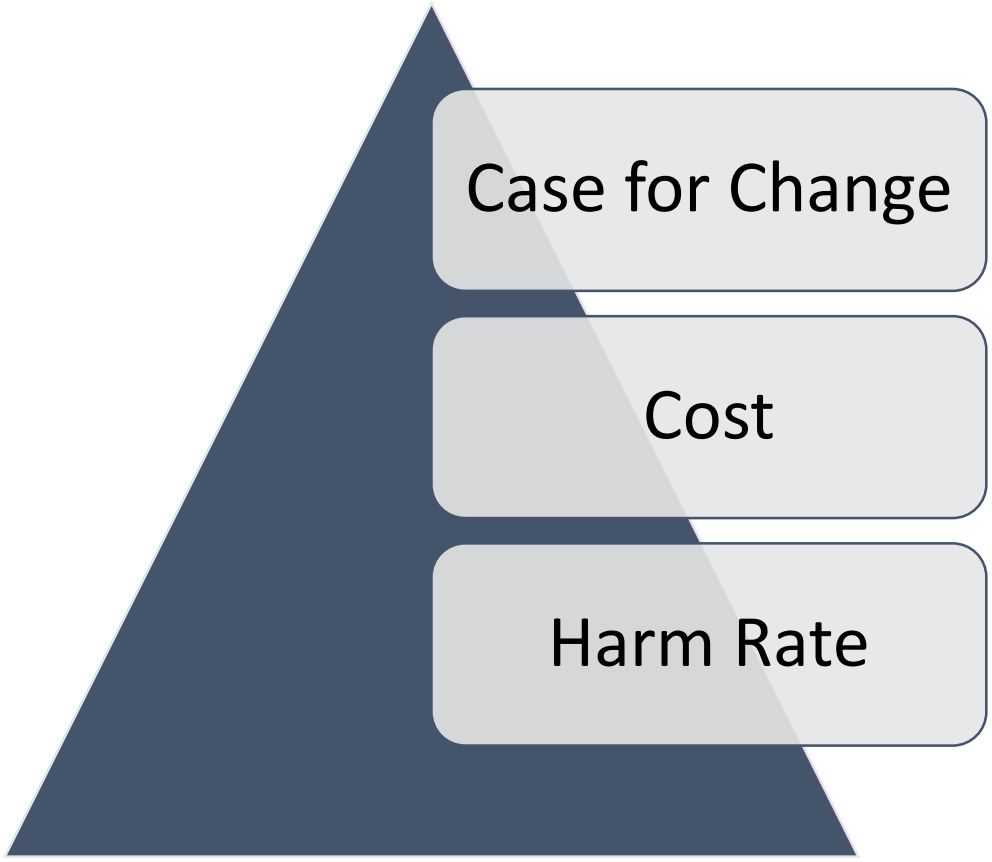
General Themes and Issues in Harm Reporting

- High volume practices
  - More opportunities for defects/errors - influences data
  - Should have very refined preventive practices
- No national standard for error rate
- Culture eats strategy
- Patient centered care
  - May require deviations from normal operating procedures
  - Requires special awareness attention
- Underlying factors associated with harm
- Understanding the difference between preventable harm and patient outcomes

Next Steps

1. Emphasize reporting of no harm and near miss events
2. Setup a classification system to quickly analyze the global contributing factors within these events
3. Include deep analysis of no harm and near miss events within your PI projects
4. Utilize your champions and councils in the analysis of events
5. Perform leadership training for your champions and managers
6. Hold each other accountable for the institutional culture
7. Look beyond the distractors

To Be Continued…



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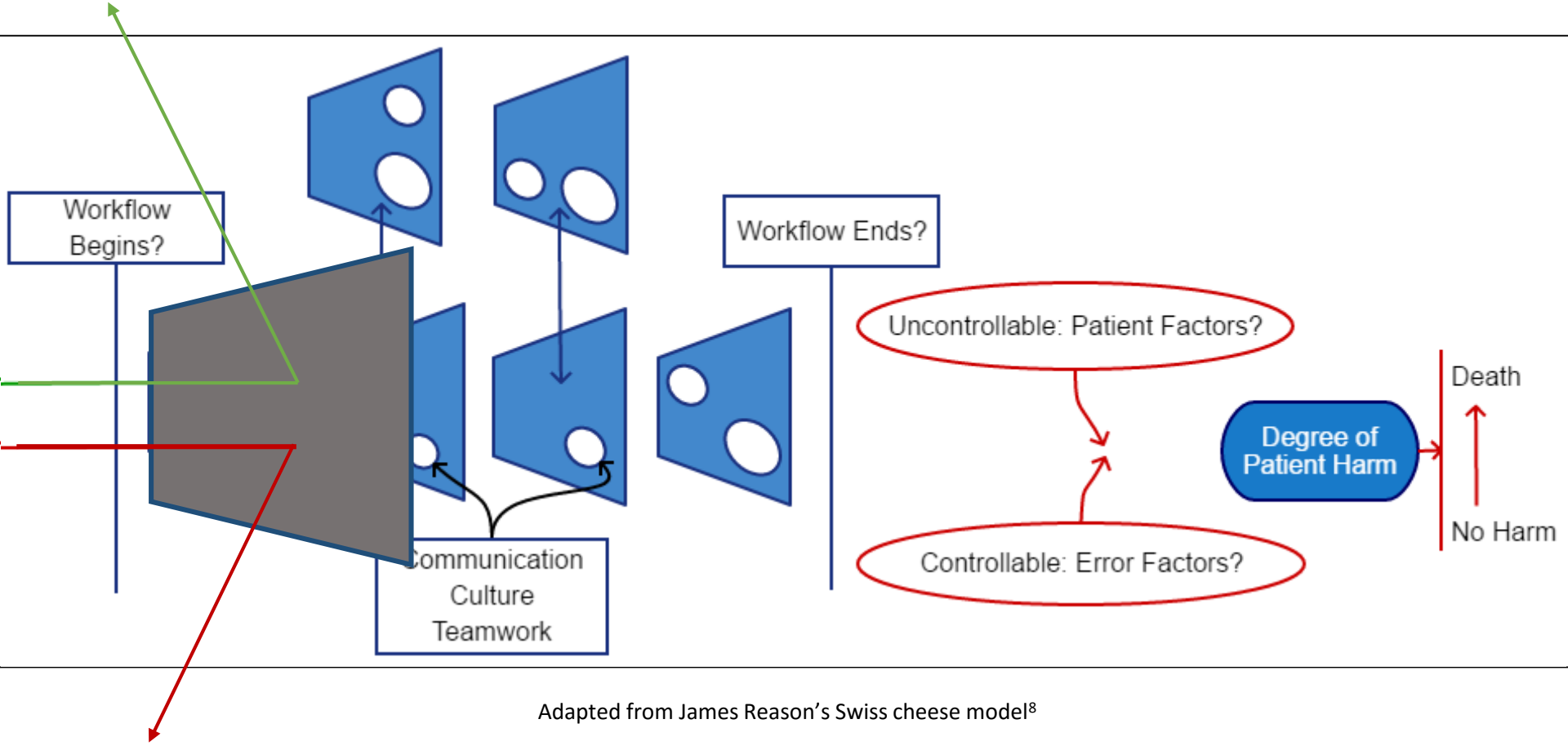

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Thank You!

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