

PATIENT SAFETY

If you have any questions regarding patient safety you may contact Mr. Pete Nicholas, Risk Management Coordinator, Clinical Quality Management Service at 214 -857-0456 or John Bender Patient Safety Manager, Executive Service at telephone number 214 -857-0417.

1. Sentinel Events as defined by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) are unexpected occurrences involving death or serious physical or psychological injury, or risk thereof. Examples of Sentinel Events include death resulting from a medication error or treatment error, suicide of a patient in a setting where they receive around-the-clock care, surgery on the wrong patient or body part regardless of the magnitude of the operation, and hemolytic transfusion reaction involving the administration of blood or blood products having major blood group incompatibilities.

2. Root Cause Analysis is a process for identifying the basic or contributing causal factors that underlie variation in performance. It is a focused review with the following characteristics:

- a. The review is interdisciplinary in nature with involvement of those closest to the process.
- b. The analysis focuses primarily on systems and processes rather than individual performance.
- c. The analysis digs deeper by asking “what” and “why” until all aspects of the process are reviewed and contributing factors are considered.
- d. The analysis changes could be made in systems and processes through either redesign or development of new processes or systems that would improve performance and reduce the risk of recurrence.

3. Healthcare Failure Mode and Effect Analysis (HFMEA) is a systematic process of identifying and preventing problems BEFORE they occur. The Veterans Health Administration (VHA) is conducting an HFMEA on at least one hospital wide activity per year as directed by the Joint Commission.

SIMILARITIES AND DIFFERENCES BETWEEN HEALTHCARE FAILURE MODE EFFECT ANALYSIS AND ROOT CAUSE ANALYSIS

SIMILARITIES

Interdisciplinary Team
Develop flow diagram
Focus on systems issues
Actions and outcome measures
Use of triage triggering

DIFFERENCES

HFMEA uses a process not chronological flow diagram

HFMEA uses prospective (what if) analysis

HFMEA allows the facility to choose the topic of evaluation

HFMEA includes whether a system vulnerability is detectable or critical

HFMEA has emphasis on testing, cause & effect diagram and brainstorming

4. The process for Root Cause Analyses (RCA) set up by the National Center for Patient Safety meets Joint Commission standards for reporting and assessing the adverse events. RCAs are “confidential” and protected by Title 38 United States Code (USC) 5705. Employees who are interviewed during a RCA are protected in that nothing discovered in the course of an RCA can be used for disciplinary purposes and can never be revealed by the RCA team.

5. Adverse Events are untoward incidents or any other adverse occurrences directly associated with care or services provided within the jurisdiction of a medical center, patient clinic or other Veterans Health Administration (VHA) facility. Some examples of adverse events include: patient falls, medication errors, procedural errors/complication, completed suicides, parasuicidal behaviors (attempts, gestures, threats and missing patients).

6. A Close Call (“Near Miss”) is an event or situation that could have resulted in an incident, injury or illness, but did not, either by chance or through timely intervention. An example of a Close Call would be a surgical or other procedure almost performed on the wrong patient due to lapses in verification of patient identification. Close Calls are opportunities for learning and afford the chance to develop preventive strategies and actions.

7. The goal of the Patient Safety Program is to prevent injuries to patients, visitors, and personnel in a non-punitive environment. This is accomplished by taking small steps in how we do things so that we establish trust from our patients and employees in our system.

8. Intentionally Unsafe Acts (IUA), as they pertain to patients, are any events that result from a criminal act, purposefully unsafe act, activity related to alcohol or substance abuse by an impaired healthcare provider or staff person, or events involving alleged or suspected patient abuse of any kind. If during a Root Cause Analysis (RCA) facts emerge that indicate Intentional Unsafe Act(s) occurred, the RCA process is stopped and upper management is notified in confidence as required in 38 USC 5705.

9. Sentinel Event Alerts is a newsletter that shares “lessons learned” and provides recommendations to prevent future medical/health care errors in health care organizations. They are sent out by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) on an irregular basis as needed. Sentinel Event Alert notify health care organizations of actual or potential problems identified in other health care systems and reported to JCAHO. These alerts allow healthcare systems like VA North

Texas Health Care System (VANTHCS) to contact the departments/services that might be affected by a Sentinel Event Alert. This allows for correction of potential issues and prevention of identified problems. This newsletter is available on the Library homepage.

10. Patient Safety Program is part of Executive Service at VA North

Texas Health Care System (VANTHCS). The committee responsible for patient safety oversight is the Patient Safety Committee. Patient safety policies are addressed in Medical Center Memorandum PS-2. Employees should report all adverse patient events as well as "Close Calls" to their supervisor or the Patient Safety Manager through the VistA electronic incident report package. Upon review of such reports a briefing is given to Leadership, and a Root Cause Analysis may be conducted. Patient Safety is everybody's business.