Moving to a Higher Reliability Process in Event Management Review

UCSF University of California San Francisco

Mary C. Sullivan RN, MS, CNS, CPHQ; Paige Porter MPH; Julie Nguyen PharmD, CPPS;
Rejeanna Matear MHA, BSN, RN, LSSGB, CPHQ, CPPS, CPHRM; Andrea Ledoux MA, MS, MBA; Ampreet Gosal MHA

UCSF Health Department of Quality and Patient Safety

Significance and Background

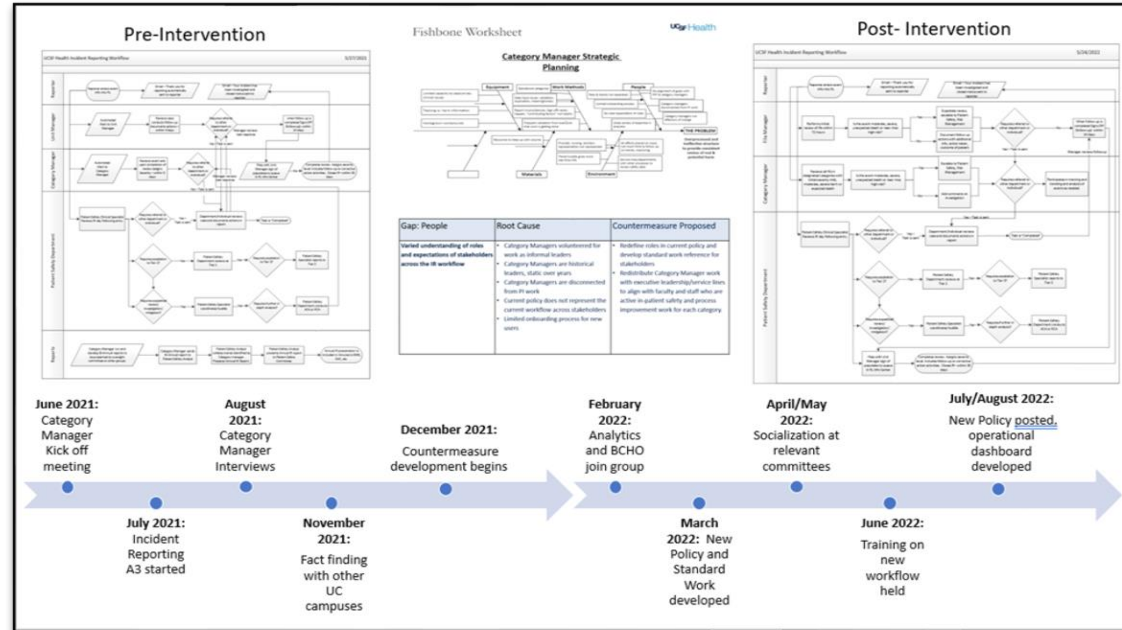
- UCSF uses an event management system to identify and catalog patient safety events. These events are then reviewed, investigated, and escalated to the appropriate staff.
- Even with this formal process, UCSF continues to observe patient safety events with insufficient identification of risk, escalation, and inadequate follow up.
- These events not only impact UCSF Health Strategic goals, but they also impact external ratings, reimbursement, and UCSF reputation as some of these events are publicly reported.
- In 2021, a workgroup convened to perform a gap analysis of the current event management process and identify improvement strategies

Goal

Create a streamlined and efficient process to provide consistent review of harm events that allows all users the opportunity to provide timely responses to patient harm events and mitigate risk of reoccurance.

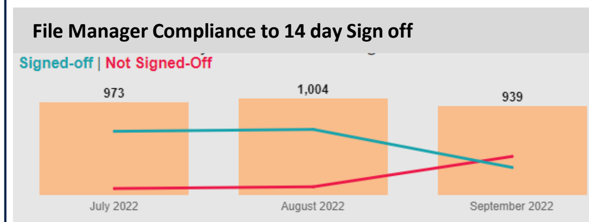
Solutions

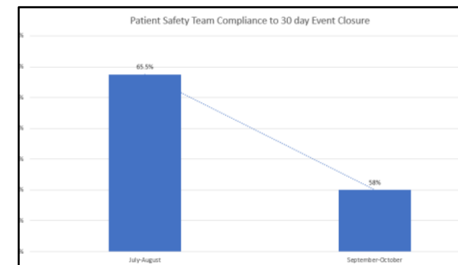
- Lean strategies were utilized to reduce waste and focus on those activities that add value for "the customer"
- A gap analysis was performed through interviews with various stakeholders about the current state of event management (see Fishbone Diagram)
- The Incident/Safety Event Reporting policy was revised to support a new workflow with clear roles and expectations for file managers, category managers, and the patient safety team.
- The event management process was redesigned to reduce overprocessing and optimize expertise from different stakeholders.
- Dissemination of new workflows and reinforcement of expectations was achieved via email communications, presentations at various forums, and daily virtual training sessions.



Results

- Revised policy was published on July 1, 2022. New reporting process sends a daily report to File Managers of a summary of the events from their area in the last 24 hours. Automatic alerts are sent to File Managers for events that are reported having moderate, severe, unexpected death, or near miss high risk.
- Adoption of the new workflow was measured through a process metric related to sign-off by File Managers within 14 days. Early data from new operational dashboard shows the compliance to new workflows
- Patient Safety Team continues to adapt to the new expectation of closing events withinin 30 days.





Lessons Learned and Challenges

- The thorough gap was essential to fully understand the issues and helped identify improvement opportunities in the complex, multifaceted process.
- Communication with stakeholders was key in understanding best practices and challenges within the current process.
- Leveraging leadership support was critical to support the project plan, hold stakeholders accountable and remove barriers.
- Importance of developing partnerships across the organization as event management reaches far beyond the patient safety team
- Expectations on sign off and event closures may need to be adjusted as new workflows are tested in real working conditions.

Sustaining Progress

- Operational dashboards are being developed to monitor adherence to new workflows and identify opportunities for improvement
- Training has been developed and Patient Safety Office Hours will be implemented to provide support, assistance and education to managers
- RLDatix forms will be optimized to collect key elements for initial understanding of event and drive towards standardized follow up
- Lessons learned from this process will benefit the RL Datix instance merge with Benioff Children's Hospital Oakland.

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