Annual Patient Safety Report

Ántonia Cash, Sri Bose

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Utah Department of Health & Human Services

Variable Name	Frequency	Percentage(%)
Gender		
Male	179	46.56
Female	197	52.12
Other	5	1.32
Race		
White	160	42.33
Black	4	1.06
Asian	3	0.8
AI/AN/NH/OPI/Other	14	3.7
Unknown/Missing	197	52.12

Variable Name	Frequency	Percentage(%)
Medicaid		
No	355	94.2
Yes	22	5.8
Missing	1	
Ethnicity		
Hispanic	22	5.82
Non-Hispanic	149	39.42
Unknown/Missing	207	54.76
Age (years)		
<18	51	13.49
18-34	55	14.55
35-49	69	18.25
50-64	82	21.69
65+	121	32.01

Patient Safety Event Demographic Characteristics 2021 - 2022

Variable Name	Frequency	%
Type of events		
Care Management	189	50
Surgical	68	17.99
Product Device	53	14.02
Patient Protection	43	11.38
Criminal	11	2.91
Environmental	10	2.65
Radiological	4	1.06

Variable Name (Type of events)	Freq	%
Care management		
Fall	84	44.68
Pressure Ulcer	35	18.62
Labor/Delivery	27	14.36
Medication Error	27	14.36
Surgical		
Wrong Body Part	27	39.71
Unretained foreign object	18	26.47
Incorrect Surgery or Procedure	16	23.53
Product Device		
Unexpected Flame or Smoke	48	90.57
Patient Protection		
Patient Suicide/unsuccessful attempt	21	48.84
Unexpected Death	17	39.53

Patient Safety Adverse Event Characteristics 2021 - 2022

Patient Outcome	Frequency	Percentage (%)
Temp Harm - Req non-life threatening Intervention	81	21.49
Temp Harm - Reg Hospitalization	74	19.63
No Harm	62	16.45
Patient Death	54	14.32
Intervention to Sustain Life	32	8.49
Additional Monitoring/Treatment to Prevent Harm	31	8.22
Permanent Patient Harm	28	7.43
Unsafe Conditions	5	1.33
Near Miss (event stopped prior to reaching patient)	5	1.33
Other	3	0.8
No additional medical care and treatment.	1	0.27
Patient was not harmed - caregivers were hurt	1	0.27
Missing	1	0.27

Patient Safety Event Characteristics 2021 - 2022

Logistic Regression Results

Care Management Event

- There is a 59.3% reduction in the odds of a care management event among patients in age group<18 years compared to age 65+ years.
- There is 64.6% reduction in the odds of a care management event among patients in age group of 35-50 years compared to patients age 65+ years.
- There is a 65.4% increase in the odds of care management event among patients with an adverse outcome compared to non adverse outcome

Adverse patient outcome-I - Patient Death, G - Permanent Patient Harm or H - Intervention to Sustain Life

Logistic Regression Results

Surgical Event

- There is a 87.8% decrease in the odds of surgical events among patients with an adverse outcome compared to non adverse outcome

Adverse patient outcome-"I - Patient Death, G - Permanent Patient Harm or H - Intervention to Sustain Life

Logistic Regression Results

Product Device Event

- The risk of product device event is 3 times more likely among age group 35-50 years compared to age 65+ years patient.
- There is a 81.7% reduction in product device event among patients with adverse patient outcome compared to non adverse

Adverse patient outcome-I - Patient Death, G - Permanent Patient Harm or H - Intervention to Sustain Life

Logistic Regression Results

Patient Protection Event

- There is 85.7% reduction in the odds of a patient protection event among patients in age group of <18 years compared to patients age 65+ years.
- There is 27% increase in the odds of a patient protection event among patients in age group of 35-50 years compared to patients age 65+ years.
- There is a 65.1% decrease in the odds of patient protection events among females compared to males.
- The risk of patient protection event is 15 times more among patients with adverse outcome compared to non adverse outcome

Adverse patient outcome-I - Patient Death, G - Permanent Patient Harm or H - Intervention to Sustain Life

Contributing Factors

Care Management Event: Falls

Human Factors	39
Others	19
Communication	16
Lack of monitoring	14

- Staff did not share fall protocol with provider.
- Patient fell asleep with baby in the arms.
- Failure to assess patient abilities prior to care and provide necessary safety measure.
- **Bed Alarm was not reset for care**
- Patient was in altered mental status
- Patient did not have non slip footwear or socks
- Low staffing ratio
- Ineffective assessment of fall risk
- Patient non compliant.
- Patient tripped on IV pole
- Night time staffing led to unwitnessed fall
- Communication was not done with family members that caregiver needed to know when patient left bedside
- OT left patient in the shower
- Nursing fall score and rehab scoring tools contradict
- Failed to reset chair alarm
- Nurse failed to hear alarm
- Miscommunication among staff

Contributing Factors

Surgical Event: Wrong Body Part

Human Factors	15
Process Breakdown	12
Communication	9

- Residents were overwhelmed. Did not follow policy (attending)
- Student error
- Lapse/habit intrusion/reflex with cognition.
- Failed to follow policy
- Lack of site marking verification
- Communication breakdown
- APP was distracted by conversation with the pt
- Surgeon experienced memory slip
- **Timeout not performed correctly**
- Orders do not currently contain discrete fields for specific lung nodules or targets for biopsy
- Incorrect site was performed because there was inattention during team time out to identify the correct site, drape not marked with correct site, and inadequate team culture of accountability to follow time-out.
- Lack of site marking verification
- Surgeon distracted with another procedure/Anesthesiologist distracted/ Inconsistency in Scrub tech from when case started and ended

Contributing Factors

Product Device Event: Unexpected Flame or Smoke

Human Factors	8
Device breakdown	6
Equipment used	6

- Provider had not viewed the updated fire prevention education. Bovie set down on surgical field while hot.
- Physician behavior/plan not followed
- Inattention to work environment, cautery placed too close to flammable material
- Distraction, lapse in thinking
- MD did not use Bovie correctly with Haney clamp.
- Provider touched tip of Bovie to the raytec during cautery. When raytec was being removed and came in contact with O2 it caught fire.
- Tech assisting forgot to place the sheath on the device.
- Orienting nurse did not follow surgical safety plan
- Device removed and sent to manufacturer
- Product failure
- Fire during procedure at electrical cord
- The belmont rapid infusion started to smoke.
- Physician not aware the product had a dry time.
- Malfunctioned vent.
- The heating element was not moved before imaging. The x-ray machine needed a reboot and was not moved from under the heating unit during reboot.
- Device malfunction

Contributing Factors

Patient Protection Event: Patient Suicide/ Unsuccessful Attempt

Other	8
Continuum of care	3
Factor care planning	3

- Process not established
- Lack of family involvement and homelessness
- Family/support system involved at discharge homelessness
- Chronic mental health issues for years.
- Patients Disease Course
- Tele Care Management was not available 24/7 at the time of this event to be a resource for staff.
- Provider extubated patient without having appropriate staff to sit with patient.
- Assessment/documentation - not obtaining a complete assessment prior to engaging in a safety plan.
- Previous ED visits in the same day
- Columbia Suicide Risk Assessment (CSSRS) completed on triage as a "moderate" risk. This was documented by nursing however the score was not communicated with the ED physician nor with care manager.
- Patient was able to get between security wall to the rock climbing wall to climb up.
- The patient was extremly anxious related to her daughter's suicide attempt.
- The patient had visited the ED Insta-Care, Family Practice and the ED on his final visit with % SOB.
- Patient appeared competent but did mention wife's death. Insisted on going home. Social work opportunity to evaluate support system.

Actions Taken

Falls

Education	**56**
Workflow Process Redesign	**16**
Policy and Procedure Addition/Revision	**10**
Staffing Changes	**4**
Other	**17**

Falls - #1 Action Taken: Education Staff Education & Patient/Family Education 56 of 84 Falls Actions Taken	
Staff Education	
Who	**Where**
• Sitters • Falls champion • Educators • Falls committee • Staff: nurses, providers, occupational therapy, and techs	• Huddles • Staff meetings • Visual reminders -patient whiteboards, hallways, huddle boards, signs on doors with time/date of most recent fall • Lunch-n-learn

Actions Taken Falls (Continued)

What
• Balance autonomy with safety • Falls risk assessment and use of magnets • Fall Prevention Program: bed and chair alarms • Coaching on moving patients to bathroom and when to call for help (safety over privacy), especially when patient has lots of lines • Review resources and documentation with educator • Simulations on how to manage uncomfortable experiences with patients and still ensure safety • Share lessons across similar departments (gero-psych, outpatient therapy) • Hourly rounding with 4 Ps • Gait belt training/refresher • Which patients are high risk for falls • Escalate problem • Treatment agreement for noncompliant patients • Educate on when a patient should have a longer inpatient stay • Share story with staff - event, documentation, post falls care • Training on when to escalate problem

Actions Taken Falls (Continued)

Patient & Family Education
• Call light compliance - “Call, don’t fall!” • Sign in bathroom with call light usage instructions • Explain the “why” - especially regarding trip hazards • Prepare patients for shift changes • Boppy pillow education for breastfeeding mothers • Explain interventions to family

Actions Taken

Wrong Body Part

Workflow Process Redesign	**11**
Education	**9**
Policy and Procedure Addition/Revision	**5**
Other	**5**

Wrong Body Part Surgery -
#1 Action Taken: Workflow Process Redesign
11 of 27 Wrong Site Surgeries Actions Taken

Objects

- Reference images for hardware insertion
- Pre-printed foot diagram
- Whiteboard schematic of the eye
- Mark on diagram appropriate joint
- Diagram placed by monitor

Actions

- Pause prior to procedure
- Physician will verbalize procedure, nurse/tech will repeat
- Mark location with tech
- Use visuals to stay oriented during the procedure
- Schedule patients sooner before the biopsy area has healed when a repeat procedure is need for a positive biopsy
- All draping complete prior to team time out, will require 1st instrument handed to surgeon will be a marker to mark correct site on drape or skin
- Technologist and provider review diagram simultaneously

Actions Taken

Unexpected Flame or Smoke

Education	**16**
Equipment taken out of service	**12**
Other	**6**
Workflow Process Redesign	**4**

Unexpected Flame or Smoke - #1 Action Taken: Education
16 of 48 Unexpected Flame or Smoke Actions Taken

Operating Room

- Ensure that all OR caregivers and physicians receive education
- Education on unit level, stories passed to OR huddles across the system
- Short training video to possibly become part of credentialing
- Review of fire safety education
- Education about documentation of injury during OR cases, use of safety tool ARCC, and psychological safety provided to surgeons and caregivers
- Audit on education provided to new nurses/staff
- Cavilon dry time is 90 seconds before using any cautery
- Ensure bovie does not come in contact with the drape, place in holder when not in use
- Extra precautions when using dehydrated alcohol during procedures

Actions Taken

Unexpected Flame or Smoke (Continued)

Non Operating Room
• Education for nurses on caring for patients with a history of smoking and on oxygen • Annual pass off for defibrillation: need to shave patient before applying shock pads • Education provided to imaging techs and NICU staff to always move the heating element before imaging or rebooting imaging machine

Actions Taken

Patient Suicide/ Unsuccessful Attempt

Other	**10**
Education	**8**
Staffing Changes	**3**
Workflow Process Redesign	**3**

Patient Suicide -
#1 Action Taken: Other
10 of 21 Patient Suicides Actions Taken

- Debrief staff
- Interview those involved
- Investigate prior work concerning suicides at institution
- Tele-crisis better staffed
- TeleCare Management available 24/7 as a resource for staff
- Brainstorm mental health care access in rural Utah
- Secure environment for safety - in this case, a rock climbing wall
- Place patient on 1 to 1
- If patient is trans and is disturbed at having a roommate of the opposite sex of what the patient identifies as, consider other options such as no roommate
- None (4)

Nevada

- Decrease falls: Fall risk assessment completed on admission, every Friday, and with every change of condition
- Patient orientation to new environment and fall prevention upon admission

Wyoming

- Decrease patient protection events: Mental health first aid classes for first responders

Colorado

- Decrease all events: Use of Patient Family Advisory Councils to effectively receive and respond to feedback for all patient safety adverse events

Oregon

- Decrease all events: Focus on addressing health inequities to improve patient safety for all

Actions Taken

In Other States

Resources on fall prevention

AHRQ fall prevention activities:

- Universal fall precautions, including scheduled rounding protocols.
- Standardized assessment of fall risk factors.
- Care planning and interventions that address the identified risk factors within the overall care plan for the patient.
- Post-fall procedures, including a clinical review and root cause analysis.

Preventing Falls in Hospitals: Which fall prevention practices do you want to use

Preventing Falls in Hospitalized patients: State of the Science

Thank You

DHHS Patient Safety Website

Utah Department of Health & Human Services