THE UNIVERSITY OF KANSAS HEALTH SYSTEM

Patient Safety Response Team

Immediate response for risk mitigation and care giver support

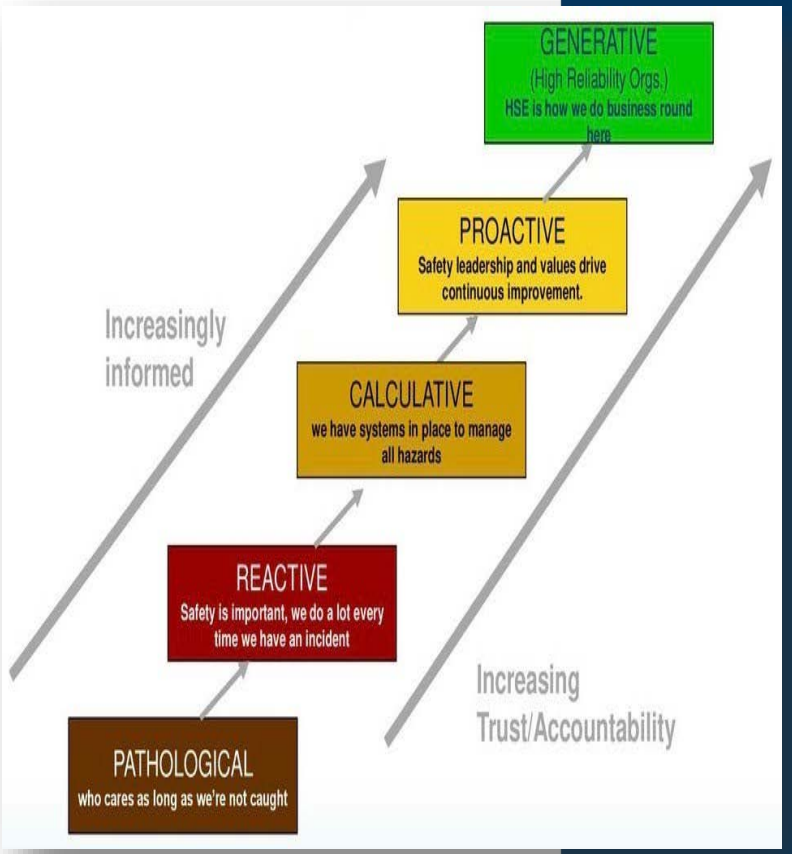
Liz Carton, Vice President, Quality & Safety
Amanda Cackler, Director, Quality, Safety, Infection Prevention & Control
The University of Kansas Health System

Session Objectives

- Discuss a system designed to respond to high harm events or conditions that could cause serious harm
- Describe the standard work developed for investigation, action planning, and learning

Why?

- **Commitment to ZERO Harm**
  Safety Culture
- **Improve Our System & Processes**
- **Stop Reliance on Emails, Curbside Consults, Sifting Through Event Reports**
- **Increase Timeliness & Consistency of Response to Events**
- **Application of Lean Principles to Patient Safety**
- **If We Want A Different Outcome, We Must Try Something Different**



What is a Patient Safety Response Team (PSRT)?

- **Response Team Model** – focus is **not** clinical
  - Deploys resources to the point of care, where the event or conditions exist

- **Primary Goal – STOP the Line**
  - Ensure patient, family, visitors, and staff are safe
  - Assist with disclosures, if needed
  - Ensure harm or conditions don't travel
    - Deploy resources & short-term action plan

- **Secondary Focus – Improve Our System**
  - Begin fact finding & identify contributing factors
  - Establish a long-term action plan with measures for sustainability to prevent repeat events

Potential Triggers for a PSRT Activation: *"Red Events"*

RED EVENTS

- Any defect that has the potential to cause death or serious harm across the health system
- Hemolytic transfusion reaction related to type/cross mismatch
- Contaminated drug, device or biologic
- Equipment related injury
- Falls resulting in serious injury or death
- Fire, flame, or unanticipated smoke, heat, or flashes during patient care
- Electric shock or burn during patient care
- Maternal/Perinatal
  - Unexpected perinatal death
  - Unexpected infant death
  - Unexpected maternal death or serious disability
- Medication error with serious injury or death
- Elopement of patient lacking capacity, danger to self or others, or involuntarily admitted
- Radiation overdose
- Restraint or bedrail use causing death or serious injury
- Unexpected deaths in ambulatory settings (excluding Emergency Department)
- Procedural, perioperative, or diagnostic events
  - Wrong patient, body part, procedure, or diagnostic test performed
  - Unexpected procedural or perioperative serious injury or death
  - Unintentionally retained foreign object
  - Wrong donor sperm or egg
- Security:
  - Disruptive behavior that causes harm or injury to patient or impedes patient care
  - Sexual assault or rape of a patient, visitor or employee
  - Infant discharged to the wrong family
  - Impersonation of a health care professional
  - Patient abduction
- Attempted or actual suicide or homicide of patient, employee, or visitor on health system premises

How to Activate?

Call 917-SAFE

Answered 24/7/365 by Risk Manager

Risk/Safety On-Call, Event Intake & Triage

Activate PSRT Team *(Risk, Quality & Safety, Hospital Administrator, Frontline Leaders, Subject Matter Experts, Providers)*

PSRT Roles & Responsibilities:
Risk Management

Verify Patient is Safety & Clinical Needs are Met:

- RRT, Code Blue, ESTAT, Stroke, Behavioral Response, Patient to Patient Exposure

Verify the area is secure and safe for patients/staff

Sequester malfunctioning equipment and notify Biomed

Contact Clinical Informatics for IT Patient Safety implications

Remove anything/anyone broken or disruptive

PSRT Roles & Responsibilities: *Quality & Safety*

Identify "What has been done so far?"

Facilitate PSRT Discussion

- Reduce/eliminate the potential for harm to other patients, staff, or visitors
- Identify other departments/disciplines that may be impacted
- Identify other campuses that may be impacted
- Mobilize additional staff/resources needed for response
- Identify next steps for prevention measures

PSRT Roles & Responsibilities: *Nursing*

Confirm the patient's attending physician has been notified

Provide ongoing support to patient & family

Coordinate staff support

- Potential relief of patient care responsibilities
- Recruit additional resources (equipment, staff, food)
- Chaplain, HOPE Team

Identify additional departments/directors that need to be notified

Ensure submission of safety event into reporting system

Provide updates to frontline staff involved in the event

PSRT Roles & Responsibilities:
Risk Management with Provider & Department Leadership

Coordinate Patient/Family Disclosure

- Clarify what information has been disclosed to patient and family and facilitate discussion with attending physician and other stakeholders

Coordinate a follow up family meeting, when necessary

- Include attending physician, local executive, risk management, and patient relations
- Be mindful about the number of staff in the family meeting
- Disclose event facts
- Discuss next steps and plan of care with patient/family

PSRT Roles & Responsibilities:
House Supervisor

- **Round on staff and patient/family**
- **Update the NAC Communication Board to ensure handoff of event information**

PSRT Roles & Responsibilities:
Administrator On Call

- Identify and notify the appropriate Executive Sponsor
- Identify how to influence provider behavior
- Facilitate communication to appropriate provider leadership (medical director partner, clinical service chief, resident program director, etc.)
- Contribute to Stop-the-Line decisions

PSRT Activation Action Planning

Event Response Plan

Additional fact finding needed (Risk)	Root Cause Analysis or Failure Mode & Effects Analysis (Safety)	Defer action plan to Local Leadership	Defer action plan to an existing PI Team	Defer to Non-Conforming Product process

Safety Event Follow Up

Confirm meeting cadence and participants needed between PSRT and RCA/ACA or FMEA

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Event Communication Plan

PSRT Notification Email

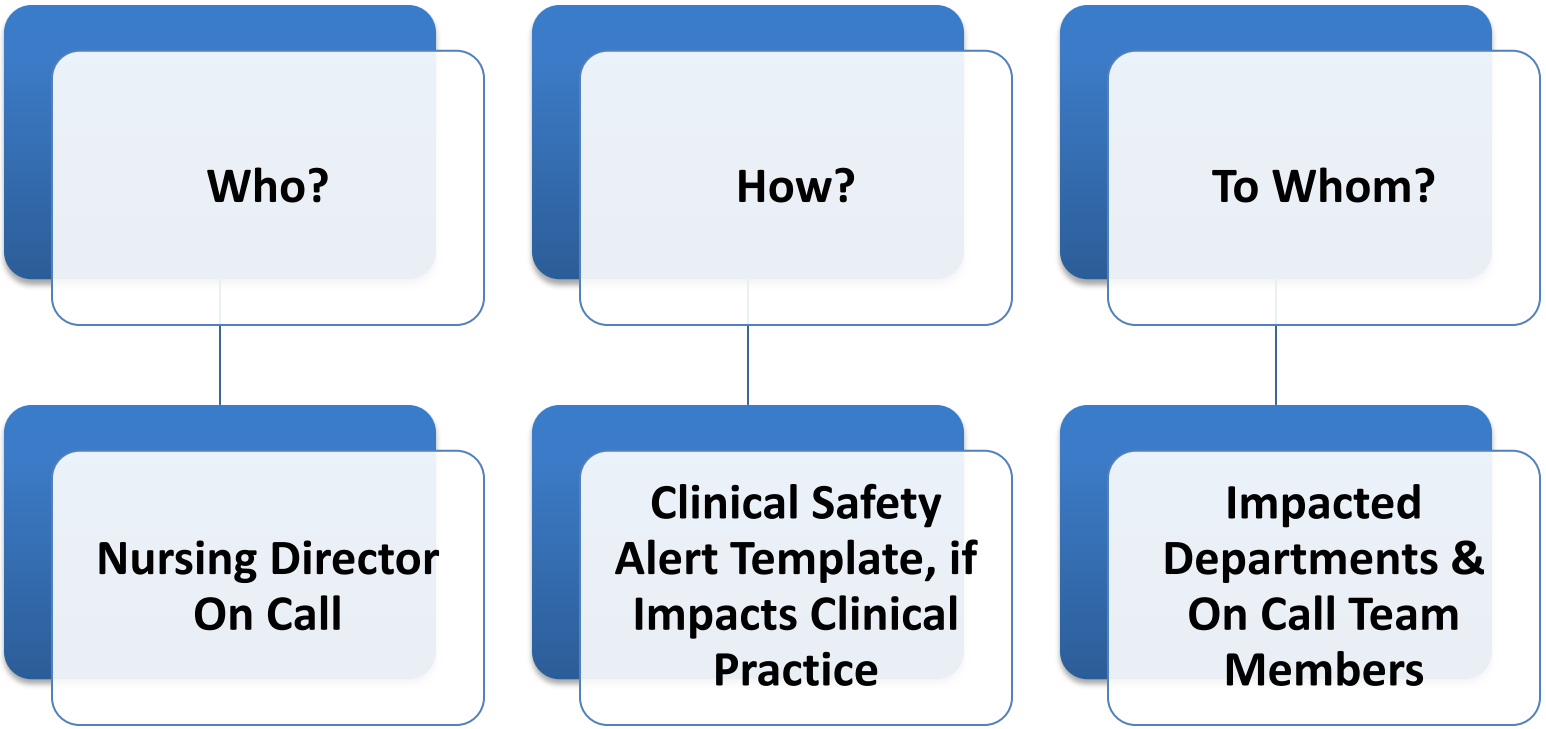
Who? Safety Lead

When? Within 12 Hours of Event

How? Using PSRT Email Template

To Whom? Standard Recipients (PSRT Leadership Email) and Additional Recipients (Executive of Area, Local Leadership, Nursing Administrative Coordinator, On-Call Leaders)

Event Communication Plan
Nursing Lead



Event Communication Plan
Daily Huddles & Leadership Venues

- Daily Safety Briefing
- Executive Safety Huddle
- Friday Quality & Risk Huddle
- Weekly Executive Vis Wall
- Quality & Risk Committee
- Quality Committee of the Board

PSRT TOOLS & TEMPLATES

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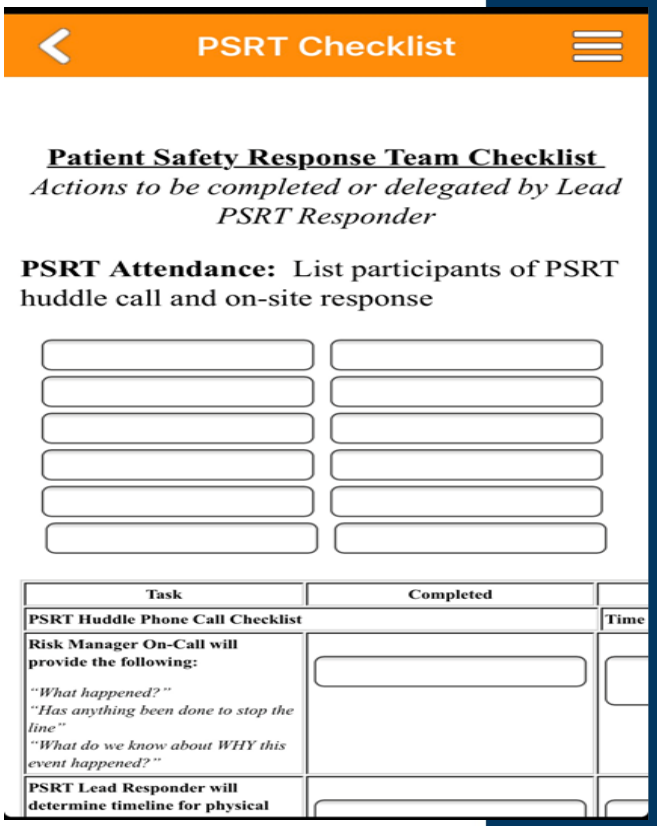
My EOP App

- PSRT Toolkit
- Red Event List
- PSRT Checklist
- PSRT Leadership notification email template
- Stop-the-Line notification email template
- Content Expert Contact List for our system
- HOPE Resources
- Standard Work for all PSRT participants
- On Call Calendar

Mobile Apps

My-EOP

The **MY EOP™** mobile app for iPhone and Android that gives you access to a quick reference guide that helps keep your staff prepared for emergency situations such as bomb threats, fire emergencies, and system failures.


PSRT Checklist

Patient Safety Response Team Checklist

Actions to be completed or delegated by Lead PSRT Responder

PSRT Attendance: List participants of PSRT huddle call and on-site response

Task	Completed	
PSRT Huddle Phone Call Checklist		**Time**
Risk Manager On-Call will provide the following: *"What happened?"* *"Has anything been done to stop the line"* *"What do we know about WHY this event happened?"*		
PSRT Lead Responder will determine timeline for physical		

Other Resources in My EOP app

- Emergency Management
- Diversion Guidelines
- Organ Donation Resources
- Infection Prevention Resources
- Administrative Leave Toolkit
- Full Capacity Resources
- Contact List – Phone Numbers for Departments

Title: PSRT Checklist	**Date:**
Departments who must adopt: PSRT Lead Responders	**Operators who must adopt:** PSRT Lead Responder

NOTE: THIS IS A CONTROLED DOCUMENT THAT SUPPORTS A SPECIFIC PROCESS

Patient Safety Response Team Checklist

Actions to be completed or delegated by Lead PSRT Responder

PSRT Attendance: List participants of PSRT huddle call and on-site response

			Misty Randolph
			Brian North

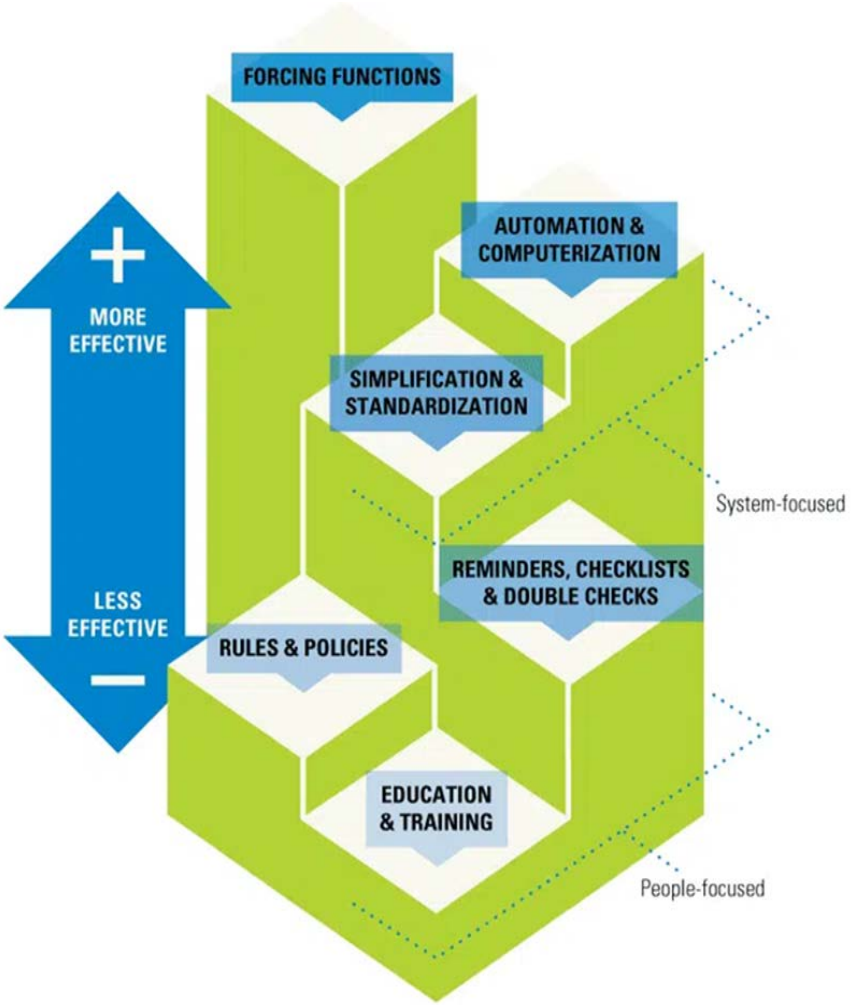
EVENT DATE:

Task	Completed	Notes
PSRT Huddle Phone Call Checklist	**Date/Time of Call**	
Risk Manager On-Call will provide the following: *"What happened?"* *"Has anything been done to stop the line"* *"What do we know about WHY this event happened?"*		
PSRT Lead Responder will determine timeline for physical response to the event location *"Based on the details that we have, we need to respond to the event location immediately. Let's plan on meeting at _1345_ time and __OR_ location."* **When the PSRT is in response to delayed reporting of an event, determine if an immediate physical response is needed or if it would be appropriate to respond by the next business day:** *"Have all unsafe conditions been resolved?"* *"Are there any reasons to suspect unsafe conditions may currently exist"* *Note: If there is uncertainty or concern of existing unsafe conditions, an immediate physical response is needed*		
PSRT Onsite Response Checklist *Goal: Within 1 hour, stabilize situation, eliminate/contain the immediate threat*	**Date/Time Onsite**	*NA*
Verify area is secure and safe for staff and patients. Remove anything/anyone broken or disruptive.		
Verify patient is safe and clinical needs are being met; consider the following resources or event-related policies/procedures: a. RRT/Code blue b. ESTAT c. Behavior response team d. Acute stroke response team e. Patient to Patient exposure, call IPAC on-call f. KUPD g. Call 911 for emergency medical needs of ambulatory patients		
Coordinate the Stop-the-Line Huddle: a. Has the line been stopped? b. Does potential for harm of additional patients/staff/ visitors still exist? If yes, Stop-the-Line and implement immediate stopgap measure(s) c. Does the line need to be stopped in other departments where the event could possibly occur? d. Sequester malfunctioning equipment and notify biomed		

Task	Completed	Notes
e. Notify facilities of any unsafe environmental issues f. Mobilize additional staff to scene, if needed		
Verify the patient's attending physician has been notified		
Patient/Family Disclosure: a. Clarify what information has been disclosed to patient and family b. Coordinate a facilitated patient/family disclosure with attending physician and other providers		
Staff Support (Physical/Emotional) Considerations: • Potential relief of patient care responsibilities • Recruit additional staff • Contact the chaplain on-call for immediate 2nd victim support and scheduled debrief		
Debrief and Assign Ongoing Roles: a. Identify additional departments/directors that need to be contacted: _____ will notify them. b. The patient/family support person is: _____ c. The staff support person is:_____ d. Notify NAC to update NAC communication board for ongoing handoff and event information e. Ensure initial interventions are effective f. Assign responsibility for the submission of safety event report (S.I.) g. Periodically assess ability to restart line		
PSRT Onsite Response Checklist *Goal: Complete within 2 – 6 hours*		
Provide ongoing resource support (next shift staffing, equipment, food/water for staff/family, etc.) as needed.		
Make a plan and schedule follow up family meeting with attending physician, executive, Risk Management, and Patient Relations (when necessary): a. Be mindful about the number of staff in the family meeting. b. Disclose event facts. c. Discuss next steps and plan of care with the patient and/or family.		
Update the frontline staff involved in the event on the current state		
Discuss next steps with involved staff (fact finding, RCA meeting, implementation of action plan)		
Initiate HOPE consult		
Lead PSRT Responder will send PSRT Notification Email using email template		
Determine distribution for Safety Alert and assign DON or other local leader to distribute using the Safety Alert Notification email template.		
Send completed PSRT checklist and ISBARR to on-call Risk Manager within next calendar day		

PSRT Checklist

Action Item Hierarchy



	Action Category	Example
Stronger Actions (these tasks require less reliance on humans to remember to perform the task correctly)	Architectural/physical plant changes	Replace revolving doors at the main patient entrance into the building with powered sliding or swinging doors to reduce patient falls.
	New devices with usability testing	Perform heuristic tests of outpatient blood glucose meters and test strips and select the most appropriate for the patient population being served.
	Engineering control (forcing function)	Eliminate the use of universal adaptors and peripheral devices for medical equipment and use tubing/fittings that can only be connected the correct way (e.g., IV tubing and connectors that cannot physically be connected to sequential compression devices or SCDs).
	Simplify process	Remove unnecessary steps in a process.
	Standardize on equipment or process	Standardize on the make and model of medication pumps used throughout the institution. Use bar coding for medication administration.
	Tangible involvement by leadership	Participate in unit patient safety evaluations and interact with staff; support the RCA² process; purchase needed equipment; ensure staffing and workload are balanced.
Intermediate Actions	Redundancy	Use two RNs to independently calculate high-risk medication dosages.
	Increase in staffing/decrease in workload	Make float staff available to assist when workloads peak during the day.
	Software enhancements, modifications	Use computer alerts for drug-drug interactions.
	Eliminate/reduce distractions	Provide quiet rooms for programming PCA pumps; remove distractions for nurses when programming medication pumps.
	Education using simulation-based training, with periodic refresher sessions and observations	Conduct patient handoffs in a simulation lab/environment, with after action critiques and debriefing.
	Checklist/cognitive aids	Use pre-induction and pre-incision checklists in operating rooms. Use a checklist when reprocessing flexible fiber optic endoscopes.
	Eliminate look- and sound-alikes	Do not store look-alikes next to one another in the unit medication room.
	Standardized communication tools	Use read-back for all critical lab values. Use read-back or repeat-back for all verbal medication orders. Use a standardized patient handoff format.
	Enhanced documentation, communication	Highlight medication name and dose on IV bags.
Weaker Actions (these tasks require more reliance on humans to remember to perform the task correctly)	Double checks	One person calculates dosage, another person reviews their calculation.
	Warnings	Add audible alarms or caution labels.
	New procedure/ memorandum/policy	Remember to check IV sites every 2 hours.
	Training	Demonstrate correct usage of hard-to-use medical equipment.

Action Hierarchy levels and categories are based on *Root Cause Analysis Tools*, VA National Center for Patient Safety, http://www.patientsafety.va.gov/docs/joe/rca_tools_2_15.pdf. Examples are provided here.

PSRT Email Template

Activation:

PSRT findings/Brief Event Summary:

Review of Potential Contributing Factors:

Stop the Line:

Staff Support:

Disclosure:

Recommendations and Next Steps:

Due Diligence

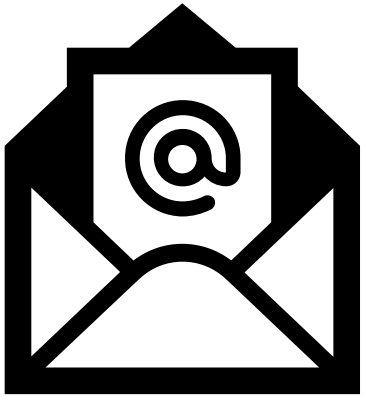
- Just Culture - Focus on the System & Process, Not People
- Identify Contributing Factors
- Establish Short-Term Action Plan to Prevent Similar Event
- Investigation — Chart Review, Interviews, Review Policies, Procedures
- Process Mapping, Cause Mapping
- Gemba Walk — Evaluation of STOP the Line actions
- Root Cause Analysis & Action (RCA^2) –lead by Risk partnered with Quality/Safety coordinator

Examples

- Items Missing From Code Cart
- Significant Medication Errors
- Isotope Administration Outside of Nuclear Medicine
- Transfusion Errors or Near Misses
- Behavioral Health Management
- Instrument Reprocessing Errors
- Ambu Bag Confusion
- Supply Packaging Concerns
- Anesthesia Order Set
- MRI Scrubs with RFID

Lessons Learned

- Take care of the patient/family
- Take care of the team
- Frontline staff involvement and leadership collaboration is key to success
- Ensure the safety of the next patient
- Disclosure is a continuous process and starts during the PSRT
- Err on the side of activating the huddle



Thank You!

Questions?

- Email Liz Carlton lcarlton@kumc.edu
- Email Amanda Cackler acackler@kumc.edu