Creating and maintaining a system-wide safety event classification team

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Description:
An effective, diverse group of team members who serve as the collective body to classify events of harm is essential to building and maintaining the foundation for a culture of safety within any healthcare system. This poster will display tools and a systematic approach for safety event classification. The team works collaboratively to ensure standardization and reliability is achieved with the classification process, which leads to a robust comprehensive systematic analysis.

1. Aim:
At the end of this session, the learner will be able to demystify classifying events of harm within a healthcare system.

2. Actions taken:
Event reporting is an essential process that helps identify healthcare-related risks. As potential or actual incidents occur, team members are to document the event using the event reporting system. In the event reporting system, there is an electronic prompt for risk management notification for events classified at seventy level of safety (V = 1) (identified risk levels of risk). Each event is reviewed to determine if the event meets the sentinel event definition or if deviations from the Generally Accepted Performance Standards (GAPS) has occurred. The Safety Event Classification Team (SECT) meets weekly by phone to review patient-safety-related events. This multidisciplinary team follows an established criteria to determine if an event is considered:

- Sentinel event (SSE1)
- Serious safety event (SSE2)
- Both

Once the safety event is classified, the team uses HPI methodology to determine the level of harm through a robust team discussion. The level of harm experienced may range from a near miss safety event to a serious safety event or a serious safety event (see the diagram to right for details).

If the event is scored as a serious safety event, it is coded SSE3-SSE5 based on the level of harm:

- SSE1 - death
- SSE2 - severe permanent harm
- SSE3 - moderate permanent harm
- SSE4 - severe temporary harm
- SSE5 - moderate temporary harm

In addition, each SSE receives a taxonomy of event types ranging from procedural, environmental, patient protection, care management, product or device, and criminal (HPI, 2013).

The scored event is presented to the facility’s executive team in which the event occurred. The executive core team (president, vice president of nursing, risk management, patient safety, regulator) assigns a team leader and executive sponsor for a comprehensive systematic analysis (i.e., RCA, ACA, etc.). In the event the SECT team is unable to reach consensus on the level of harm, the event is reviewed by the vice presidents of medical affairs (VPMA) to determine the level of harm, if any, for the patient. There is a measure of checks and balances for each case. A separate multidisciplinary validation team reviews each event classified event for consistency in scoring. This team has the final say and has the ability to reverse or change scoring based on evidence presented for the event.

3. Summary of results:
Over time, our team developed an informed approach to determining level of harm. This information is relayed to the appropriate facility team that in turn, is prepared to perform a comprehensive systematic analysis and create a plan of action to prevent like occurrences from reoccurring within our healthcare system. Since 2009 our serious safety event rate (SSER) has decreased from the 2009 baseline of 0.86 to 0.12 SSER through December 2016.

Safety event classification model:

- Serious safety event
  - Reaches the patient
  - Results in moderate to severe harm or death
- Precursor safety event
  - Reaches the patient
  - Results in minimal to no detectable harm
- Near miss safety event
  - Does not reach the patient – error is caught by a West string detection barrier

Serious safety event rate (SSER) per 10,000 adjusted patient days

For more information contact:
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Reference: