

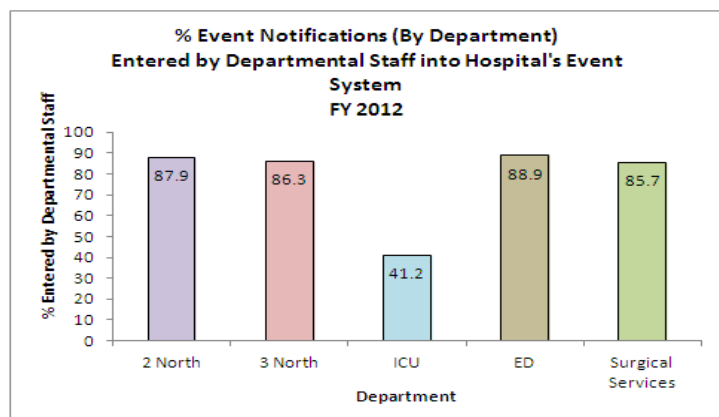
Beth Israel Deaconess Hospital-Milton

Event Notification Reporting in the Intensive Care Unit: Best Practice Spread

The Problem

Beth Israel Deaconess Hospital – Milton’s primary method for identifying potential patient safety Adverse Events is through its online event reporting system. By using this process the hospital can quickly identify and respond to such events and prevent actual harm to patients. Such harm events may negatively impact the hospital’s external quality rating and financial reimbursement.

In FY 2012, the volume of adverse patient safety events reported by staff in the Intensive Care Unit was significantly lower than other nursing departments.



Aim/Goal

Increase ICU staff identification and reporting of Event Notifications in the ICU from 41% to > 80% by June 30, 2013 (3 Months)

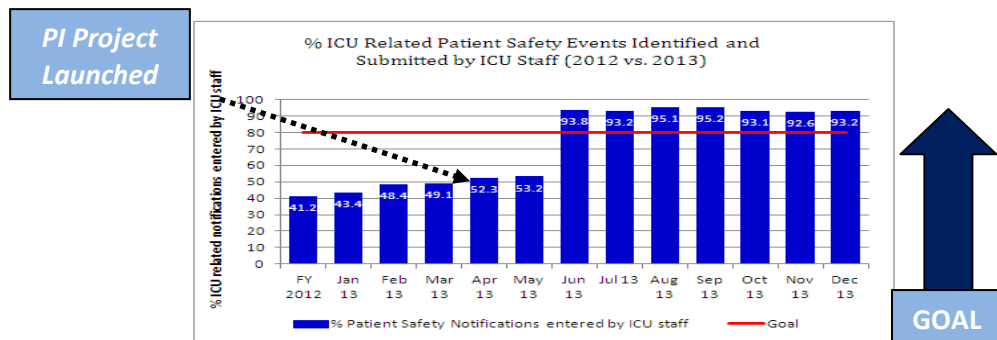
The Team

- Alex Campbell, MSN, RN, CPHQ, NE-BC: Director HCQ and Patient Safety
- Cindy Page, PT, MHP: Vice President Clinical Support Services
- Mark Gronberg: Hospital Controller
- Eileen Beaulieu: MBA, RN: Manager, Risk and Patient Relations
- Ellen Lanza, RN, CCRN: Nurse Manager, ICU
- ICU Nursing Staff

The Interventions (Select Actions Taken)

- Utilized LEAN methodology as foundation for process improvement
- Current Condition/Cause Analysis:
 - **Staff Knowledge Deficit:** Definition of Adverse Event
 - Development of guidelines, tools and policy revision to clarify events that should be included. Ongoing, organizational wide Adverse Event Reporting education as part of the hospital’s CARE program.
 - **Environment & Culture:** Belief that process has potential to punish the individual – ‘Culture of Fear’
 - Elimination of terms that have negative connotation (e.g., Incident/Occurrence Reporting) to more positive-tone term “Event Notifications”
 - Feedback loop closed, i.e., nurse manager sharing notification themes at staff meetings and engaging staff to participate in problem solving
 - **Process/System Logistics:** “Old” online Occurrence System had major limitations and challenging functionality
 - Implementation of new online event notification system – ICU used as pilot site to engage staff in recommending product/process re-design, etc.

The Results/Progress to Date



Lessons Learned

- Barriers/factors identified in the ICU were also present to varying degrees in all areas

Next Steps/What Should Happen Next

- New process spread throughout organization: since August 2013 – increase in event reporting > 25%