



The University of Texas Medical Branch
Audit Services

Audit Report

Patient Safety Net (PSN) Reporting Audit

Engagement Number 2016-016

March 2016

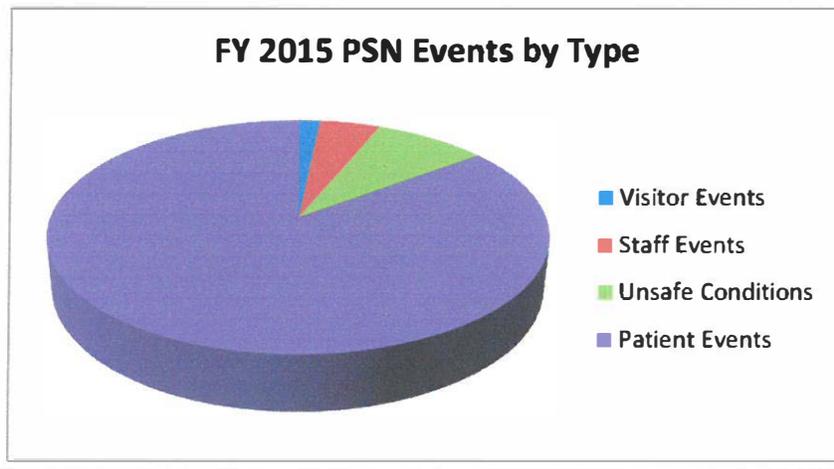
The University of Texas Medical Branch
Audit Services
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**Patient Safety Net (PSN) Reporting
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Background

One of four strategic goals outlined in the University of Texas Medical Branch’s (UTMB Health’s) institutional vision, “The Road Ahead”, is delivering “high-quality outcomes that improve health care delivery”. Identified tactics to achieve this goal include “strengthening Health System and Practice Plans to achieve top-quartile performance in clinical effectiveness and safety”. Attaining this goal requires establishing a culture of trust that empowers employees to actively participate in the identification and correction of incidents and situations that impact or could jeopardize the safety of patients, visitors, and co-workers.

To help facilitate its safety and clinical effectiveness efforts, UTMB Health utilizes the University Healthsystem Consortium’s (UHC’s) Safety Intelligence software application known locally as the “Patient Safety Net” (PSN). PSN is a real time, web-based tool used for reporting patient, visitor, and staff potential and actual safety risks, errors and harmful behavior as well as unsafe conditions at UTMB Health campuses. Individuals reporting events access the PSN tool through UTMB Health’s intranet homepage. Reporting data received from the Quality Management Department’s Risk Management division (Risk Management) indicates 4,659 events were reported during fiscal year (FY) 2015. As illustrated in the table below, patient-related events represented approximately 85% of the total reported:



Ensuring a safe environment and healthcare experience for patients, visitors, and staff is critical to the overall success of UTMB Health.

Audit Objective

The primary objective of this audit was to assess the effectiveness of the Patient Safety Net (PSN) program by reviewing how incident reporting is recorded, monitored, addressed and communicated.

Patient Safety Net (PSN) Reporting Engagement Number: 2016-016

Scope of Work and Methodology

The scope of the engagement included the process surrounding event reporting within the Patient Safety Net (PSN). Our audit methodology included interviewing key personnel; review of relevant documentation; data analysis; and, limited benchmarking.

The audit was conducted in accordance with the *International Standards for the Professional Practice of Internal Auditing* as promulgated by the Institute of Internal Auditors.

Audit Results

Incident Reporting

UTMB Health policies, 9.13.13 *Unusual Event Reporting* and 9.13.16 *Sentinel Events* define unusual, sentinel and adverse events, as well as near misses. However, these policies contain contrasting verbiage that while individually are positive, when considered collectively, could possibly leave the interpreter with varied perspectives on when events are to be reported. The policies “encourage” readers to report; inform them that events “should be” reported; and, instruct that certain events “must be” reported. Interviews with Risk Management staff indicated that employees are not required to report events, rather are encouraged.

Audit Services benchmarking efforts with other healthcare institutions indicated that while they had similar policies, their employees are “expected” to report events. Additionally, employees are expected to report the event within a specific timeframe, i.e., within the same shift or working day. Adjusting the tone of UTMB Health’s event reporting governing policies and establishing target reporting timeframes would further support UTMB’s position of the importance of promoting patient safety and improving the quality of care.

Recommendation 2016-016-01-PL:

The Chief Quality Safety & Clinical Information Officer should review and update existing UTMB Health policies and procedures pertaining to reporting of unusual and sentinel events to ensure they reflect current best practices such including consideration of strengthening the responsibility for reporting and establishing a timeframe for reporting events.

Management’s Response:

The policy will be reviewed and updated to include the recommended language changes. The revised P&P will be communicated to stakeholder groups to ensure knowledge of changes and strengthen responsibilities.

Implementation Date: March 30, 2016

Addressing Incidents/Areas of Concern

After submission, reported events are dispersed within PSN to numerous institutional recipients, including the “Front Line Reporter’s” manager, depending on the nature and criticality/impact or “harm score” of the event. Similar to the initial reporting process noted above, institutional policies “encourage” front line managers to review PSN reports for their area and address items/issues within the report. Benchmarked policies articulated stronger expectations for manager review of PSNs, including establishing a monitoring process notifying

Patient Safety Net (PSN) Reporting Engagement Number: 2016-016

the manager and their immediate supervisor if the review is not completed within defined timeframes.

Recommendation 2016-016-02-PL:

The Chief Quality Safety & Clinical Information Officer should update the documented 'Manager Recommendations for Patient Safety Review' process to incorporate procedures for completion of the reported event form and the communication of results to staff to emphasize the importance of reporting to all levels.

Management's Response:

The policy will be reviewed and updated to include the recommended language changes. The revised P&P will be communicated to stakeholder groups to ensure knowledge of changes and strengthen responsibilities.

Implementation Date: March 30, 2016

In addition to the front line manager, PSN reports are reviewed by unit nurse managers; Ambulatory and Unit-Based Clinical Based Leadership Teams; Safety and Security Management Sub-Committee of Environment of Care (visitor related PSNs); Human Resources; various Quality Committees, and designated Health System Leadership.

Risk Management reviews all reported events on a daily basis, identifying the high harm critical events or events seeming unusual based on the reviewer's professional discretion. If a reported event (case) appears to be an event warranting further investigation, Risk Management then performs an initial investigation of the event which can include interviews with individuals involved in the event or those with pertinent knowledge and review of the medical record as deemed necessary. A case synopsis is prepared and presented to the Safety Event Action Team (SEAT) for further review and discussion.

SEAT is a cross-functional team performing incident triage for the investigation of safety events reported through PSN, Patient Services, and direct communication with clinicians and managers. SEAT members include the Chief Medical Officer and Chief Quality Safety & Clinical Information Officer as well as representatives from Risk Management, Quality Management, Legal Services, Institutional Compliance and other appropriate Health System leadership. SEAT meetings focus on high harm events; repetitive events; potential sentinel events; cases involving potential litigation; or, other events judged by leadership or staff to represent a significant safety concern. During their weekly meeting, SEAT determines the appropriate action and agent accountable for further event review and remediation. Additionally, SEAT can refer events to a department and/or another committee for review or action according to the event scope of responsibility. It is Audit Services understanding that UTMB was an early adopter of this active, interdisciplinary approach.

Near Misses

Institutional policy 9.13.16, Sentinel Events, defines "near miss" as "an event or situation that could have resulted in an accident, injury or illness, but did not, either by chance or through timely intervention". The policy states near misses will receive the same level of scrutiny as adverse events that result in actual injury. Although key personnel interviewed indicated near

Patient Safety Net (PSN) Reporting

Engagement Number: 2016-016

misses may be reviewed by SEAT, most events brought to SEAT hold a higher harm score than near misses. Several interviewees indicated that near misses can be reviewed by SEAT members in their respective hospital departments, on other Quality Committees, by departmental personal or Ambulatory and Unit-Based Clinical Based Leadership Teams as part of their practice of reviewing reported events. However, since near miss incidents often precede loss producing events, periodic review of near misses by SEAT represents an opportunity to strengthen its oversight responsibilities.

Recommendation 2016-016-03-PL:

The Chief Quality Safety & Clinical Information Officer, working with other members of SEAT, should consider establishing a formal process for routinely reviewing a pre-determined number of near miss events on a monthly basis by SEAT or designated leaders..

Management's Response:

A process will be developed in collaboration with SEAT members and health systems operations leadership to complete reviews of a random sampling of safety event reports, including unsafe condition and near miss reports.

Implementation Date: March 30, 2016

Root Cause Analysis

UTMB Health policy states that "A formal root cause analysis (RCA) will be conducted under the auspices of the UTMB Safety Event Action Team (SEAT) for events that meet the definition of sentinel event, adverse event, or near miss." Limited documentation exists outlining the process for conducting an RCA and monitoring outcomes. During the course of audit fieldwork, Audit Services observed a change in the RCA process as well as the Critical Incident Reporting (CIR) process. Process owners interviewed indicated they were unaware when those changes became effective or what next steps may occur.

Recommendation 2016-016-04-PL:

The Chief Quality Safety & Clinical Information Officer should finalize and formally document the RCA and CIR processes and ensure all pertinent staff is informed/educated of processes.

Management's Response:

Existing process documentation for RCA and CIR processes will be reviewed and updated to include but not limited to:

- Definition of RCA and CIR
- Process flow maps
- Procedures on how to conduct and who to include
- Selection Criteria for establishing which/when to use a RCA and/or CIR
- Reporting formats
- Follow-up procedures

Patient Safety Net (PSN) Reporting Engagement Number: 2016-016

Educational Materials will be developed in support of informational sessions led by Risk and Quality staff.
Manager tool kits will be developed for ongoing reference.

Implementation Date: May 31, 2016

Monitoring

In addition to managing PSN reports and reviewing reported events for identified risks and investigating those events deemed critical, Risk Management monitors resolutions of SEAT follow-up items and, if necessary, will assist those responsible to accomplish resolution in a timely manner.

Communication

Communication related to PSN reporting occurs on several levels. SEAT reviews event trends and corrective actions are routinely reported to the Health System Executive Team. Risk Management prepares trend and detailed reports for various institutional committees and leadership. Additionally, Risk Management provides educational sessions and a periodic newsletter advocating safe health care practices. UTMB Health also reports key safety performance measures to several external groups including the Joint Commission and the Centers for Medicare and Medicaid Services (CMS).

Communication back to the Front End Reporter rests with the reviewing Manager and Unit/Ambulatory Based Clinical Leadership dyad. Staff meetings and daily communications with staff are to serve as platforms for discussing PSN reported outcomes and implemented processes resulting from PSN Institutional reviews. Interviews with key personnel and results from a recent employee survey indicate ongoing opportunities to improve consistency of communication to individuals submitting PSN reports.

SEAT

In addition to interviewing a sample of SEAT members, Audit Services attended two SEAT meetings. Based on our observations, we noted opportunities to mature and potentially improve the efficiency of the meetings. These opportunities include establishing a consistent meeting format and agenda process; pre-distribution of materials; and, establishing routine feedback mechanics for the members to provide input for improvement.

The SEAT charter states members are to meet weekly, typically for 1.5 hour duration. Interviews with Risk Management and selected SEAT members indicated that meeting length is dependent upon the number of cases to be reviewed and periodically meetings are cancelled. Audit Services noted during a six week period, 50% of the SEAT meetings were cancelled due to a variety of reasons. Some interviewees indicated these cancellations hinder the ability to perform the routine review of events as charged.

Recommendation 2016-016-05-PM:

The Chief Quality Safety & Clinical Information Officer, working with other members of SEAT, should consider incorporating the following opportunities to further enhance SEAT meetings:

Patient Safety Net (PSN) Reporting Engagement Number: 2016-016

- Implement a standard meeting format for consistency and clarification to team members and invited guests
- Implement a formal agenda to be maintained as documented proof of meeting discussion items and follow-up items
- Review of meeting handouts for completeness prior to the meeting to ensure members are receiving all necessary information for decision making purposes
- Re-structure/refine current structure of event summary provided to team members for ease of use (i.e. consistent format and information provided, page numbers)
- Consider implementing routine feedback/member surveys to meetings to gain insight into team members views of meeting effectiveness and scope, including periodic review/discussion of patient safety trends or events outside of the PSN process
- Consider implementing a contingency plan for unforeseen reasons for cancellations (e.g. holidays, external surveys, etc.) to maintain consistency of meetings and workload for members.
- Consider implementing an reporting event “cap” on meetings to limit case load

Management’s Response:

The SEAT Charter will be reviewed and updated to include recommended changes to include:

- Standard meeting and agenda format with meeting record
- Establish a protected site to post meeting materials (Read Only – Print Prohibited) for SEAT member review prior to meeting
- Develop event summary reporting format to ensure consistency of information and reporting
- Develop an annual SEAT member survey on meeting efficiency and effectiveness
- Develop a calendar to present aggregate institution safety data to the SEAT committee

Implementation Date: June 30, 2016

PSN Account Management

Risk Management serves as UTMB Health’s on-site administrator for PSN, assigning event locations; deactivating users; and, assigning user specifications within the system. Pursuant to applicable UTMB Health Information Services (IS) policies and practice standards, the account management procedures performed by Risk Management for managing PSN user, administrative, and generic accounts generally comply with prescribed governance.

However, Risk Management has not operationalized a process to ensure that local accounts created within PSN by the third party vendor are consistently reviewed for continued appropriateness (i.e., that the user is an active employee and has assigned locations as applicable to user’s role). Audit Services compared the PSN Active User listing to a current IBM

**Patient Safety Net (PSN) Reporting
Engagement Number: 2016-016**

Security Identity Management (ISIM) report to determine whether active users appeared valid. Audit Services identified 25 user roles on the PSN Active User report that were not identified in ISIM:

- 2 roles are generic account names
- 19 users are retired/termed from UTMB (effective dates ranging from 1/18/2014 to 11/1/2015)
- 4 users have different username/email addresses in ISIM than in the PSN system due to name changes.

UTMB Health Practice Standard 1.2 Account Management states “System Administrators must have a formal process for periodically reviewing existing accounts for validity” and that “owners are responsible for periodically reviewing access provided to users based on job and functional requirements”.

Recommendation 2016-016-07-RM:

Risk Management, working with IS, should implement a formal quarterly account review process to validate the continued appropriateness of local PSN user accounts pursuant to applicable governance.

Management’s Response:

Risk Management will determine and develop lists of appropriate administrative, management and faculty staff to receive PSN data and develop a method in collaboration with IS to receive and implement updates to ensure all who require or are responsible for PSN review and action have access.

Implementation Date: August 31, 2016

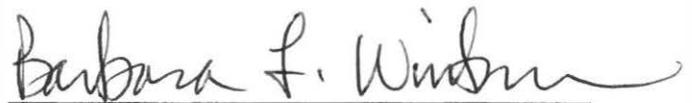
Conclusion

Overall, UTMB Health has policies and procedures in place for the reporting of patient safety events through a dedicated online web tool. Audit Services noted opportunities exist for enhancing these policies for system user accounts review; industry best practices: and clarification of policy verbiage as well as strengthening the structure of processes and documentation of the team charged with triaging reported events.

We greatly appreciate the assistance provided by the Department of Quality & Healthcare Safety staff and hope that the information presented in our report is beneficial.



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