Mary Cobos-Gallegos, MBA, HCM, C-ERM
email: mgallegos1@echd.org
Office: (432)640-2487
Cell: (432)204-6205

(you may leave a confidential v-mail)
Office: Cone Building- 4th Floor

Medical Center Health System

Medical Center Hospital System is committed to improving the quality and safety of patient care by:

- Detecting and evaluating errors, near misses, or unsafe conditions that could jeopardize patient safety or cause harm.

- Actively addressing safety concerns and promoting a culture of trust and accountability, MCHS aims to deliver the safest care possible to every patient, consistently.

Why is reporting patient safety events essential?

Reporting is vital for identifying and analyzing errors to determine root causes and patterns, which supports process improvements, risk reduction, and prevention of patient harm. All staff members are encouraged to report any errors ,ear misses and unsafe conditions.

MCHS has a platform called the Patient Safety Event Reporting System. This tool helps you select the event type and guides you through the reporting process.

From the MCH home screen, click the Patient Safety Event shortcut to open a page with several icons. Choose the icon that matches the event and submit your report.

You can also file a "Patient Safety Event" **report anonymously** through any of the following options:

- https://medicalcenter.performancehealth.app/solutions/incident-reporting

- MCHS Intranet Page - "Report a Patient Safety Event"

- Desktop shortcut icon

- Power Chart shortcut - "Report Patient Safety Event"

Task   Edit   View   Patient   Chart   Links   Navigation   Help

Tear Off   Charges   Exit   Calculator   AdHoc   Communicate   Patient Education   Medical Record Request   + Add   Patient Pharmacy   iAware   Discern Reporting Portal   Capacity Management   Documents

CareCompass   Mass Vacc Check-In   Mass Vacc Admin   Patient List   Staff Assignment   Quality Measures Summary   MyExperience   Cardiovascular   Scheduling   Clinical Leader Dashboard   LearningLIVE   Case Selection   DWL

Drug Shortage List   BMM/Transfusion   Reference Documentation   IMMTRAC Consent   uCentral

Nursing Clinical Key   Lexicomp   Vaccine Information Sheets

ZZZ, TEST   ✕

← List   📁 Recent ▾   Name

ZZZ, TEST
Phone:(123)456-7891   Allergies: penicillins
Non-Patient FIN: 1203649967 [Visit Dt: 4/1/2025 14:29:47 CDT]   Visit Reason: labs
Anticipated DC: GMLOS:

Age:29 years
DOB:5/22/1996

Loc:DTC Golder
Isolation:<No Data Available>
Resuscitation:<No Data Available>

Sex:zzUnspecified   MRN:646129821

Attending:
Dose Wt:<No Data Available>
Daily Wt:

Menu   📌

Clinical Notes   + Add

Results Review

Blood Bank Significant History

Allergies   + Add

Diagnosis & Problems

Form Browser

Advanced Growth Chart

Histories

Immunizations

Lines/Tubes/Drains

MAR Summary

Clinical Media   + Add

Patient Information

Plan of Care Summary

Historical Records

Curaspan

Infusion Billing

Log a Ticket

Outside Records

Incident Reporting   ⬅

← → ▾   🏠 Nurse View   ⛶ Full screen   🖨 Print

100%

| Handoff Tool ✕ | Handoff Summary-Nursing ✕ | + |

📌

Allergies (1)
Home Medications (1)
Vital Signs
Clinical Notes (0)
Assessments ...
Medications ...
Labs ...
Imaging ...
IV/Fluids ...
Outstanding Orders ...
Orders ...
Histories ...
Problem List ...

Allergies (1)   + Al

Reverse Allerg

Substance	Sev... ↓	Reactions	Catego...	Status	Reacti...	Source	Comments
penicillins	Mild	Hives	Drug	Active	Allergy	--	--

Reconciliation Status: **Incomplete**   Complete Recon

Home Medications (1)   Al

Reconciliation Status: ⓘ Meds History   ⓘ Admission   ⓘ Discharge   Vie

Medication ↑	Compliance	Supply Re...	Responsible Provider
tirzepatide (tirzepatide 2.5 mg/0.5 mL subcutaneous solution) 2.5 mg, SubCutaneous, qWeek, for 4 doses, Rotate injection ...	--	--	--

Document History: **Incomplete**   Complete

Vital Signs   +   Selected Visit   Last 12 h

Patient Safety Event - Citri...

Incident Reporting

Click here to begin incident reporting.

Medication Event	Unanticipated Event	Patient Complaint, Grievance, & Kudos Reporting	Diagnostics

Employee Injury/Safety	Patient Injury Form	Fall (Patient Fall Form only)	Environment Issues

Mother & Baby	Good Catch	Surgery	Anesthesia

Pressure Injury	Infection Control	Patient Safety Indicator (PSI) PSO/Patient Safety Officer USE Only	Medical Device/Supply Issue or Failure Form

Security Concerns and/or Lost Items	Workplace Violence	For Use of Risk Manager-Log of Patient Property	Visitor or Vendor Injury Form

Patient Safety Event - Citri...

Examples of reportable events:

Adverse Event – a patient safety event that resulted in harm to a patient.

No-harm event- a patient safety event that reaches the patient but does not cause harm. Near miss event (or "good catch") – a patient safety event that did not touch the patient.

Hazardous condition (or unsafe condition)- a circumstance, other that the patient's own disease process or condition, that increases the probability of an adverse event.

A **sentinel event** is a patient safety event (not primarily related to the natural course of the patient's illness or underlying condition) that reaches a patient and results in any of the following:

- **Reportable Events:**
- All Falls- nursing
- All AMA's- nursing
- Employee or other Staff Injuries - needlesticks, sharps injury, falls
- Diagnosis or treatment errors
- **Medication errors, adverse drug events
- **All new, new staged 3 and 4, and all unstageable pressure ulcers acquired after admission/presentation
- Surgical site infections
- Equipment patient injuries
- Patient injury associated with the use of contaminated drugs
- Lost Specimens- include blood
- Diagnostic events leading to delay of care (lab, Radiology, Respiratory)
- ID/Documentation/Consents (wrong MRN, incorrect consent)
- Infection Control Issues
- Environment
- Deviation from policy/protocol (education/training)
- Lost Items such as glasses, dentures, hearing aides **(see policy MCH-4031) use yellow patient belonging bags/label bag with patient sticker)**
- Workplace Violence
- Patient Complaints/Grievances (**Patient Advocate reviews**) report charge nurse
- Other reportable events

Patient Safety Reporting

⍰ What to Report in a Patient Safety Report

✖ Any occurrence not consistent with routine patient care

⚠ Any event outside normal operations

🛑 Any incident that causes patient harm or has the potential to cause harm (includes near misses and good catches)

🛏 Patient Complaints and Grievances

If a patient or family member reports a complaint:
- Try to resolve the issue at the bedside when possible.
- If the complaint involves other staff, report it promptly to the charge nurse.
- A patient advocate is available Monday–Friday to assist patients and help resolve complaints or grievances.

Immediate Response to Patient Safety Events

Patient and Safety First

Stabilize the patient. The first priority is to attend to the patient's immediate safety and well-being. Take immediate action to mitigate further harm.

⚙ Secure evidence.

Involve the **House Supervisor and Charge Nurse** should assist when events:

- ➤ Involves medical equipment or devices
- ➤ Remove it from service immediately, label it, and sequester it for investigation.
- ➤ House Supervisor and/or Charge Nurse can assist to also secure all related records, including monitoring strips, equipment logs, and paper documentation.

❤ Provide emotional support.

- ➤ Offer compassionate and unhurried support to the patient, family, and staff involved, recognizing that all parties may be traumatized.

📖 Fact-Finding and Communication: Seek Facts, Not Fault

⚖ As a team, we must embrace a 'just culture.' Focus on what happened, not who to blame. The goal is to learn from the event to prevent errors, not to punish individuals.

⏱ Gather facts quickly.

➤ The Charge nurse should obtain information from staff as soon as possible while memories are fresh.
➤ Reassure staff the process is confidential and non-punitive.

📝 Use standardized reporting.

Enter the event in the MCHS Patient Safety Reporting System promptly, providing objective facts and avoiding subjective assumptions or opinions.

➤ You can enter the report or call Risk Management and/or charge nurse to assist in entering the report.

🗣 Communicate effectively with the patient and/or surrogate.

➤ Once they are psychologically and physically ready, disclose what is known in a transparent and honest manner:
  - Explain what happened in plain language
➤ Express honesty, empathy, and transparency; avoid premature blame or language that implies legal liability or fault.
➤ A full investigation must be completed by Risk Management and Leadership.
➤ Share known facts that are accurate and verified without speculation
  - Explain ongoing care for the patient-
  - You can state that you will speak with management for next steps in reviewing the event.

👪 Engage with the family.

➤ If the patient cannot communicate, inform the designated family member or healthcare proxy and keep them updated.

When Patients or Families Mention Legal Action

- Stay Calm and Professional- Maintain a respectful, non-defensive tone.

- Avoid showing frustration, anxiety, or dismissiveness.

- Remember: anger or defensiveness may escalate the situation.

- Listen and Acknowledge- Allow the patient/family to express their concerns fully.

- Show empathy: "I understand this is very upsetting for you.

- "Do not argue, debate, or make promises you cannot keep.

- Avoid Speculation or Blame

- Do not assign fault or speculate on causes.

- Stick to facts about the patient's condition and current care.

- Do not admit liability or make legal statements.

- Communicate Transparently, Within Your Role

- Focus on the patient's clinical care and immediate needs.

- Provide clear, honest, and jargon-free updates on what is being done.

- If appropriate, reassure them that their concerns will be taken seriously.

- Escalate Appropriately- Notify your attending physician and the charge nurse immediately.

- Inform the hospital risk management or patient advocacy office.

- Document the conversation factually in the medical record (without personal

- Support the Patient and Family

- Offer to connect them with a patient advocate who can help address grievances.

- Continue to provide compassionate bedside care regardless of the complaint.

Functions and Responsibilities of MCHS Risk Management

🔍 Risk Identification and Assessment

- Monitor, analyze, and evaluate potential risks across hospital operations
- Identify trends from patient safety reports, incident reports, complaints, and claims
- Conduct proactive risk assessments (e.g., failure mode and effects analysis, hazard vulnerability analysis)

📝 Incident Investigation and Reporting

- Review and investigate adverse events, near misses, and patient complaints that involve liability claims
- Ensure accurate, timely documentation in the hospital's risk or safety reporting system
- Preserve evidence, interview involved staff, and coordinate fact-finding

Patient Safety and Quality Improvement

- Collaborate with clinical teams to develop interventions that reduce harm
- Support root cause analyses and ensure corrective action plans are implemented
- Promote a 'just culture' that encourages reporting and learning rather than blame

⚖️ Regulatory and Legal Compliance

- Ensure compliance with accreditation standards (e.g., DNV and CMS) and healthcare regulations
- Work with legal teams on claims management, liability issues, and malpractice prevention
- Maintain confidentiality and ethical handling of sensitive safety and legal data

📚 Education and Training

- Educate staff on risk management policies, patient safety procedures, and reporting systems
- Provide guidance on disclosure and communication

🤝 Communication and Coordination

- Act as a liaison between clinical staff, administration, legal counsel, and patients and patient families
- Communicate transparently with patients and families when adverse events occur
- Collaborate with leadership to keep the hospital board updated on risk issues
- Coordinate with patient advocates to resolve grievances and prevent escalation

Definitions:

Harm-
Impairment of the physical, emotional, or psychological function or structure of the body and/or pain resulting therefrom.

Monitoring-
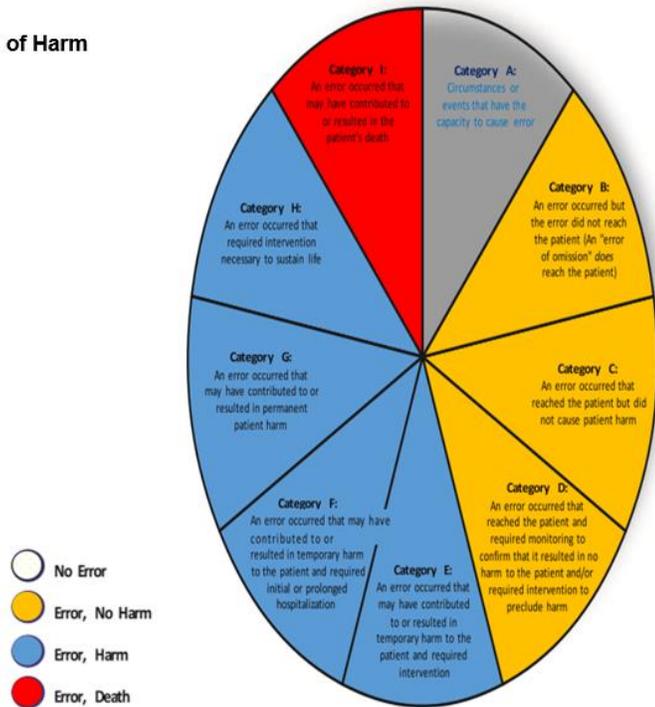To observe or record relevant physiological or psychological signs.

Intervention-
May include change in therapy or active medical/surgical treatment.

**Intervention-
Necessary to
Sustain Life**
Includes cardiovascular and respiratory support (e.g., CPR, defibrillation, intubation, etc.

Levels of Harm

Category I:
An error occurred that may have contributed to or resulted in the patient's death

Category A:
Circumstances or events that have the capacity to cause error

Category H:
An error occurred that required intervention necessary to sustain life

Category B:
An error occurred but the error did not reach the patient (An "error of omission" does reach the patient)

Category G:
An error occurred that may have contributed to or resulted in permanent patient harm

Category C:
An error occurred that reached the patient but did not cause patient harm

Category F:
An error occurred that may have contributed to or resulted in temporary harm to the patient and required initial or prolonged hospitalization

Category E:
An error occurred that may have contributed to or resulted in temporary harm to the patient and required intervention

Category D:
An error occurred that reached the patient and required monitoring to confirm that it resulted in no harm to the patient and/or required intervention to preclude harm

- ○ No Error
- ○ Error, No Harm
- ○ Error, Harm
- ○ Error, Death

Summary: Levels of Patient Harm with Multiple Examples

- ⚠ No Harm / Near Miss – Event occurred but no harm to patient
  Examples:
  - Wrong medication prepared but intercepted before administration
  - Patient almost given wrong wristband but corrected in time
  - Allergy to medication not documented but caught before given

- 🏷 Mild Harm – Minimal, short-term impact, no lasting effects
  Examples:
  - IV infiltration causing small bruise, no treatment needed
  - Minor skin tear during dressing change
  - Mild allergic reaction treated with antihistamine

- 🛏 Moderate Harm – Temporary harm, requires intervention/extended stay
  Examples:
  - Medication error causing low BP, treated with IV fluids
  - Post-op infection requiring IV antibiotics
  - Patient fall causing wrist fracture, treated with casting

- 📛 Severe Harm – Permanent harm or major loss of function
  Examples:
  - Wrong-site surgery leading to permanent disability
  - Stroke after medication error, resulting in long-term impairment
  - Retained surgical instrument requiring reoperation

- Death – Adverse event directly causes patient's death
  Examples:
  - Fatal medication overdose
  - Transfusion of incompatible blood type
  - Missed diagnosis of sepsis leading to multi-organ failure

QUESTIONS OR COMMENTS