Unit Based Safety Clinicians: The High Reliability Journey

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Background

- The University Of Maryland Medical Center (UMMC) is a level one, tertiary, urban academic medical center based in downtown Baltimore, Maryland. UMMC has an 801 bed capacity; the hospital provides comprehensive care for the West Baltimore community and tertiary care for Maryland and the surrounding areas. The hospital has more intensive care beds than any other hospital in Maryland. UMMC has a robust Patient Safety and Quality department that works in close collaboration with the Maryland Medicine Comprehensive Insurance Program (MMICP) Office of Risk Management leadership.

- Commensurate with its efforts to become and sustain itself as a high reliability organization, UMMC proposes to enhance safety and quality efforts via a novel, clinically based workforce (Unit-Based Safety Clinicians) to provide foundational support to ongoing safety and quality efforts.

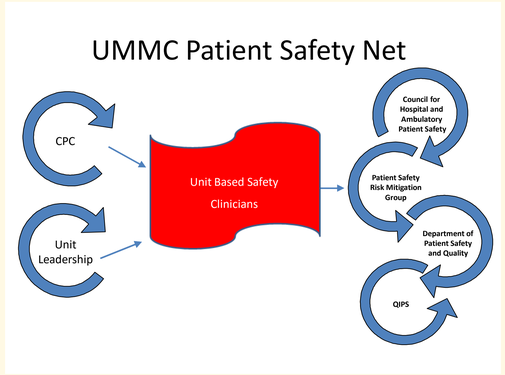
Methods

- The Unit-Based Safety Clinicians (UBSCs) will primarily be recruited from either those individuals who have demonstrated initiative for enhancing patient safety and/or those who have expressed significant interest in patient safety, from the UMMC-based RN, Advanced Practice Provider and Certified Registered Nurse Anesthetist (CRNA) populations. Those eligible will have current or recent clinically-oriented roles on respective units. The expectation is that each clinician will provide an additional 8 working hours, per month, principally dedicated to patient safety within their respective units.

- These Safety Clinicians will be introduced to and be integrated as a part of each respective unit's leadership team, also reporting to the Medical Director and the Nurse Manager. Each unit based safety clinician is expected to meet weekly with both the Medical Director and Nurse Manager to summarize all findings and plans for enhancing unit based safety.

- A robust, streamlined process for application and vetting once nominated is in place and includes: A 300 word essay indicating rationale for interest and documentation of prior or ongoing safety/quality initiatives on the nominees' respective units. Selection will take place in March, 2016.

- Selected participants will receive instruction via didactic and online modules amended from the Institute for Healthcare Improvement (IHI) and National Patient Safety Foundation (NPSF) core safety and quality improvement principles, taught by an interdisciplinary staff. Education will include a focus on root cause analysis methods, standardization of unit based safety metrics for the creation of dashboards, unit debriefing instruction and structured SBAR implementation for each respective unit.



Outcomes

- Expected outcomes include: An increase in the number of adverse event and "near miss" reports for each unit; an increase in number of reports which were actionable and led to improvement; enhanced safety culture perceptions (pre and post 2015 AHRQ results); pre and post perceptions of safety on each respective unit for presentation; development of a unit debriefing process and development and implementation of a structured communication process (SBAR) on each unit. Outcomes will be measured pre and 6 months post implementation of the UBSCs.