Mortality Reviews and Patient Safety:
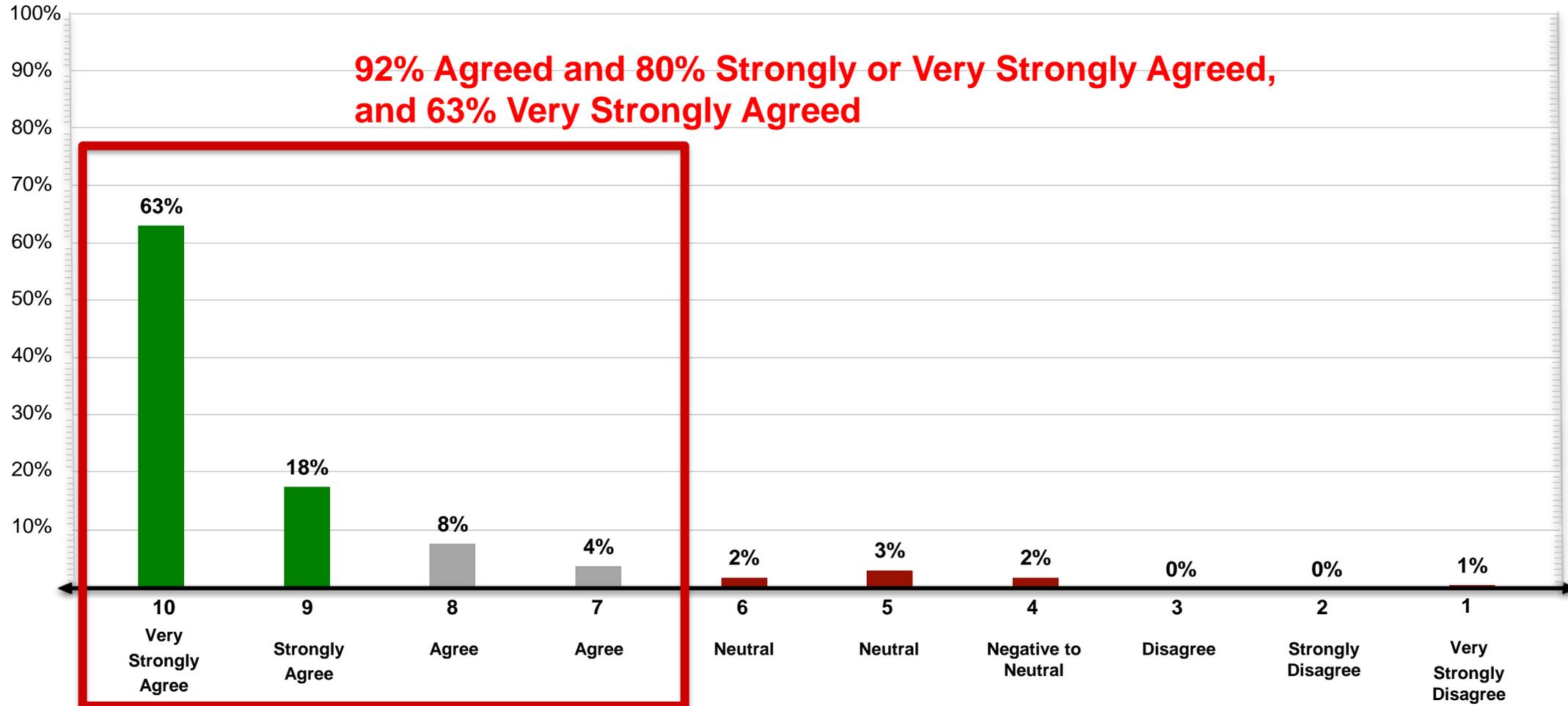
2019 Update

June 20, 2019
Webinar Month 127

For resource downloads go to:
www.safetyleaders.org

Anonymous Survey Questions

I am interested in another webinar presenting MORTALITY REVIEW INFORMATION:

92% Agreed and 80% Strongly or Very Strongly Agreed, and 63% Very Strongly Agreed

Score	10 Very Strongly Agree	9 Strongly Agree	8 Agree	7 Agree	6 Neutral	5 Neutral	4 Negative to Neutral	3 Disagree	2 Strongly Disagree	1 Very Strongly Disagree
%	63%	18%	8%	4%	2%	3%	2%	0%	0%	1%

Source: TMIT High Performer Webinar Series; Mortality Reviews and Patient Safety: 2019 Update – June 20, 2019

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Specific additional MORTALITY REVIEW TOPICS
I would like covered include:

- A hospital's journey
- Closing the Loop
- cognitive bias; changing normalizing to culture shift
- Content of the reviews and more details on the workflow
- Describe POCMA review
- Drill Down on learnings from OFIs
- Embedding end of life discussions to care teams
- Emergency setting
- Engage medical staff; is this being taught in medical schools?
- Evidenced based recommendations
- examples from other places of reviews & how to get started doing examples off specific reviews and how to do reviews at our hospital system
- examples of tools used to guide reviews for OFIs
- family/multidiscipline meeting for end of life discussion
- Finding specific patterns in OFIs
- focus of specific diagnosis such as sepsis
- getting started launching the program
- Hearing from others in the SLS and once they determine an "issue" how to they roll it out and get the "word" out of the lessons learned in the group.
- How organizations are collecting process measure data when it is not present in the EHR database; What specific process measure data are they collecting; What specific questions are being asked during opportunity / mortality reviews; What

- roles are included during opportunity / mortality reviews
- how to change the culture and language around "root cause"
- how to get provider engagement in these reviews, multidisciplinary and multi-specialty
- How to obtain leadership by in for quality improvement programs
- I would like more drill down on process of SLS like what abstraction sheet is used for review, etc...
- if you have developed worksheets for our Mortality Committee to use that helps us to zero in on the issues that you have identified as being most valuable
- improvement projects/information to action
- initiating end of life discussions with families who insist on full code
- Interactive walk through of a Mortality Review Case
- It would be great if Jeanne would present on a routine basis - i.e. annually.
- M & M committee effect in improving quality and safety of care
- missed diagnosis
- more detail on triggers during mortality review; are we overlooking triggers?
- more information about end of life planning. what processes are in place to screen patients for palliative care and hospice services, and how it is effective to connect patients with those services.
- more of the same
- More on Cluster and Common Thread Studies
- More on documentation in the EHR regarding the copying of notes

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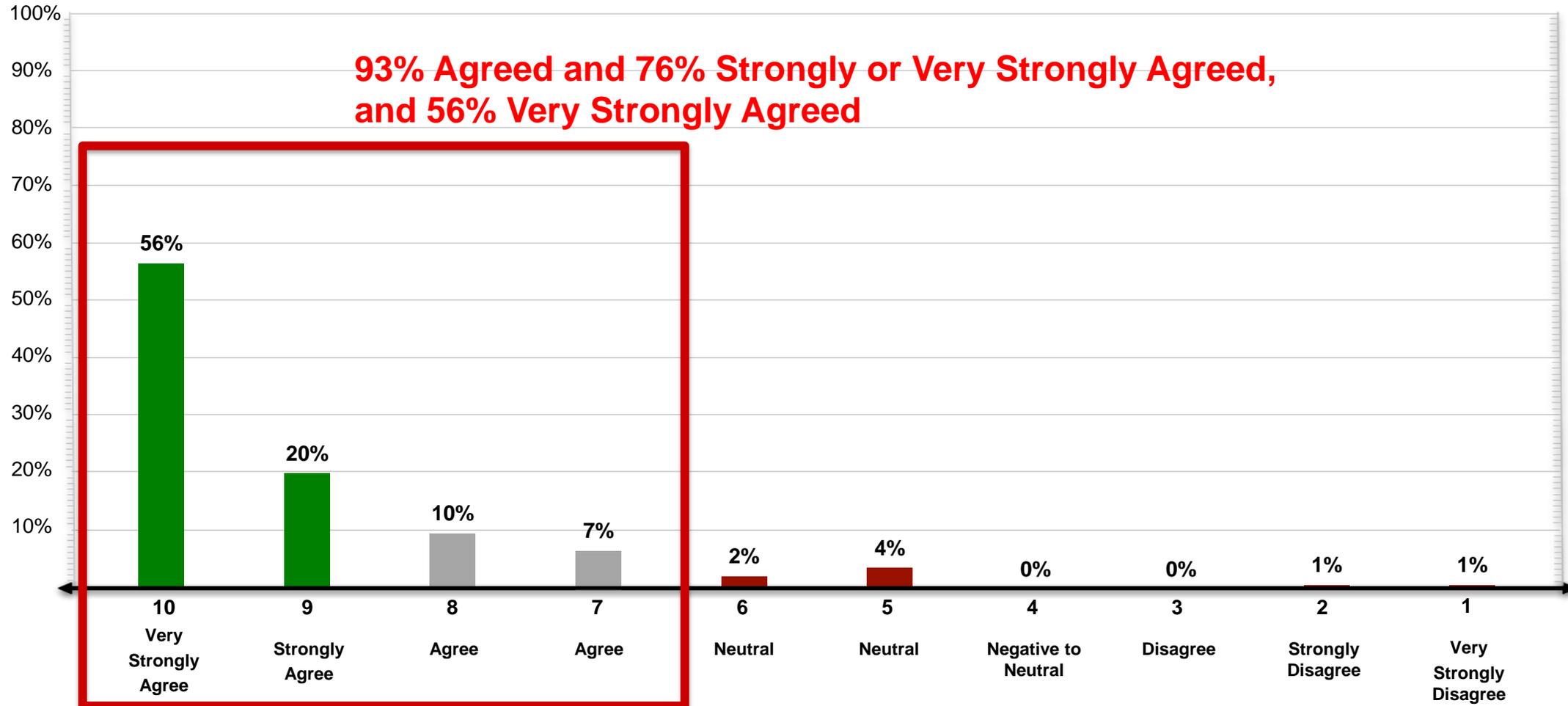
TMIT

Specific additional MORTALITY REVIEW TOPICS I would like covered include:

- Mortality related to end of life care transitions
- Mortality review tools and how to implement changes based on information obtained.
- Mortality secondary to medication errors
- Nurse reviews vs. Physician reviews- screening and referral
- OFIs
- Opportunities for improvement
- Other facilities implemented projects/interventions that led to success.
- Outline of steps to operationalize the "magic" group
- Pulling information together from system and dispersing to appropriate groups/committees.
- Readmission
- Relation of sepsis and mortality
- Reporting
- Results communication issues and solutions. Resurgence of world wide health care concerns.
- Risk adjustment
- Sepsis
- Sepsis cohort
- Sepsis deaths
- Sepsis mortality

- Sepsis patients
- Sepsis, surgical deaths (know complications versus...???)
- Share tools used (templates and documentation for analysis)
- Show how to do a detailed chart review on a mortality.
- Specific mortality review tools and processes resources
- Specific review tools
- Specific to improving documentation
- Specifics on how the actual case reviews are completed. How do you look at cases in a group without pulling up each chart in the meetings? Who dives deep into each chart and how do you know they're pulling all pertinent information for the group to review?
- Successful actions as described today
- Trend identification
- Various identified areas for improvement and how to structure changes to affect mortality topics. Engaging pall care, etc./
- What electronic surveillance resources for are available.
- What elements are included in the record review for both nurse and provider? Are there specific data elements being reviewed and abstracted from the record? Strategy for implementing, performing and sustaining mortality reviews.
- Why does coding have "everyone" dying of sepsis? Seems like coding says sepsis when in deed sepsis was treated and PT dies of their cancer etc.

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Anonymous Survey Questions

I am interested in our upcoming webinar presenting LEADERSHIP OF QUALITY PROGRAMS:

93% Agreed and 76% Strongly or Very Strongly Agreed, and 56% Very Strongly Agreed

	10 Very Strongly Agree	9 Strongly Agree	8 Agree	7 Agree	6 Neutral	5 Neutral	4 Negative to Neutral	3 Disagree	2 Strongly Disagree	1 Very Strongly Disagree
%	56%	20%	10%	7%	2%	4%	0%	0%	1%	1%

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Specific LEADERSHIP in QUALITY TOPICS
I would like covered include:

- Accountability

- Anchoring High Reliability practices

- Any Quality Improvement Topics

- anything on this subject

- balancing quality with finance, building bridges with CEO/CFO, promoting effective goals for quality leaders from CEO/Executive staff.

- Board accountability

- C-suite buy in; interdisciplinary training; culture and change process

- change management and physician engagement

- changing cultures

- changing the culture

- choice of champions and what if chosen, how to remove or replace

- compiling data for submission to reporting agencies, such as Leap Frog

- Cultural intel

- Department and workflow structures in large and small organizations, growing quality professionals

- developing a culture of safety, accountability

- differentiating quality leaders' roles in value based environments

- Dynamics of a leader and staff

- engagement

- FMEA, RCA, ACA and other PI tools (LEAN, 6S, etc.)

- Getting hospital administration buy-in for new processes.

- Getting the message to the "working bees" and how to get them as interested in patient safety while they are in the chaos of patient care.

- highlight guidelines of quality top OIS

- how do we incorporate what Dr. Huddleston described to update leaders/board on the possibilities

- How to build/lead a quality review committee

- How to care for patients with behavior issues in the acute hospital setting

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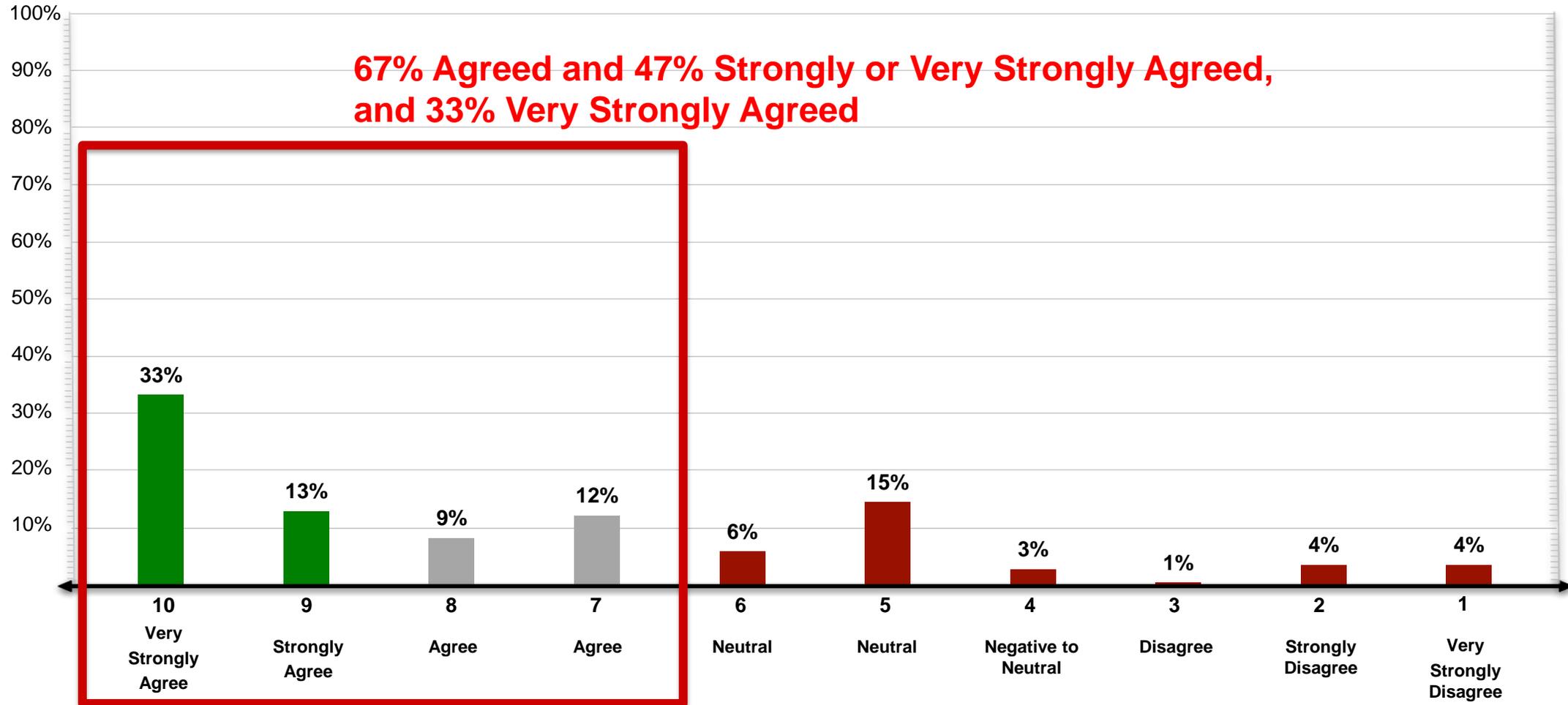
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Specific LEADERSHIP in QUALITY TOPICS I would like covered include:

- How to develop a team approach for quality & mortality reviews.
- How to engage communities in end of life planning. How can leaders within hospitals, nursing homes, primary care offices, etc. all work together to meet the needs of the community
- How to engage leadership in the results of our reviews
- How to handle the unanticipated spikes in quality measures
- How to manage staffing issues
- Implementing a just culture into a punitive culture
- Increasing physician involvement
- Influencing change
- Leadership knowledge vs support
- Leading from the top to achieve changes and best standardized methodologies of change and how they are implemented
- Lean methodology linking CFO/finance into the need for quality improvements. How to make 'soft dollars' important enough to incite action.

- Managing medical staff
- Managing patient/family discontent
- Medication diversion behavior
- Methods to engage providers in quality topics including the review process.
- Multihospital health system quality structure - roles & reporting
- Peer review process
- PI plan metrics
- Projects management
- Quality framework for an organization
- Role of leaders in M & M committee review
- Streamlining mortality reviews to decrease rates of mortality
- Structure of leadership
- Successful leadership in quality.
- The role of the CQO and how to bring new CQOs up to speed.
- Using data to establish targets and drive results
- Would like more on perinatal applications of this methodology

Source: TMIT High Performer Webinar Series; Mortality Reviews and Patient Safety: 2019 Update – June 20, 2019

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Anonymous Survey Questions

I am interested in our upcoming webinar presenting WORKPLACE VIOLENCE IN HEALTHCARE:

67% Agreed and 47% Strongly or Very Strongly Agreed, and 33% Very Strongly Agreed

	10 Very Strongly Agree	9 Strongly Agree	8 Agree	7 Agree	6 Neutral	5 Neutral	4 Negative to Neutral	3 Disagree	2 Strongly Disagree	1 Very Strongly Disagree
	33%	13%	9%	12%	6%	15%	3%	1%	4%	4%

Source: TMIT High Performer Webinar Series; Mortality Reviews and Patient Safety: 2019 Update – June 20, 2019

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Specific WORKPLACE VIOLENCE TOPICS
I would like covered include:

- Active shooter
- Active shooter, manage dementia pts who are violent
- Active shooter
- Administrative and nonclinical approaches in dealing with this issue
- Aggressive pt behaviors
- Anything other than just presenting data on how prevalent it is. More of what facilities that were impacted or even not impacted have done to reduce the likelihood of it happening or happening again. Too much data is not helpful. Want to take back some actionable recommendations. Thanks.
- Appropriate caregiver response to verbal threats
- Basement areas, tunnels between buildings.
- Best practices in staff training to anticipate and deescalate patients and visitors.
- Bullying.
- Current effective security measures.
- De-escalation
- De-escalation techniques - may want to reach out to mitigation dynamics
- Defining, tracking and reporting WPV events for workman compensation programs
- How acute care staff can manage patients with the potential of violence when admitted to a medical/surgical unit
- How are other institutions partnering with law enforcement
- How to assess risk; most effective strategies for training staff in de-escalation; best practices with response teams; hospital role in mitigating community violence; determining when a situation transitions from being a patient care scenario to a law enforcement scenario; managing staff morale related to violent event or high risk.

- How to diagnosis potential issues in advance
- How to keep staff safe in the eds when de-escalation doesn't help
- How to maintain personal safety
- How to prevent
- How to terminate patient relationships and EMTALA implications.
- I am the leader of our preventing workplace violence prevention program and we are just getting started . would like to see some policies from other hospitals on this topic.
- Keeping staff safe in the ICU and ed environment
- Nurse to nurse and provider to nurse bullying.
- Patient on staff, policies/practices and legal aspects of reinforcing a no violence tolerance with patients.
- Prevention
- Prevention techniques
- Prevention, recognition of triggers
- Reasonable proactive safety measures & post event debriefing
- Safety steps and prevention
- Staff perspectives and safety
- Strategies to create safer environment
- Violence (verbal abuse) between co-workers
- Violence against caregivers from patients/family
- Workplace violence occurring in patient care areas. How should healthcare workers respond.

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