Welcome to

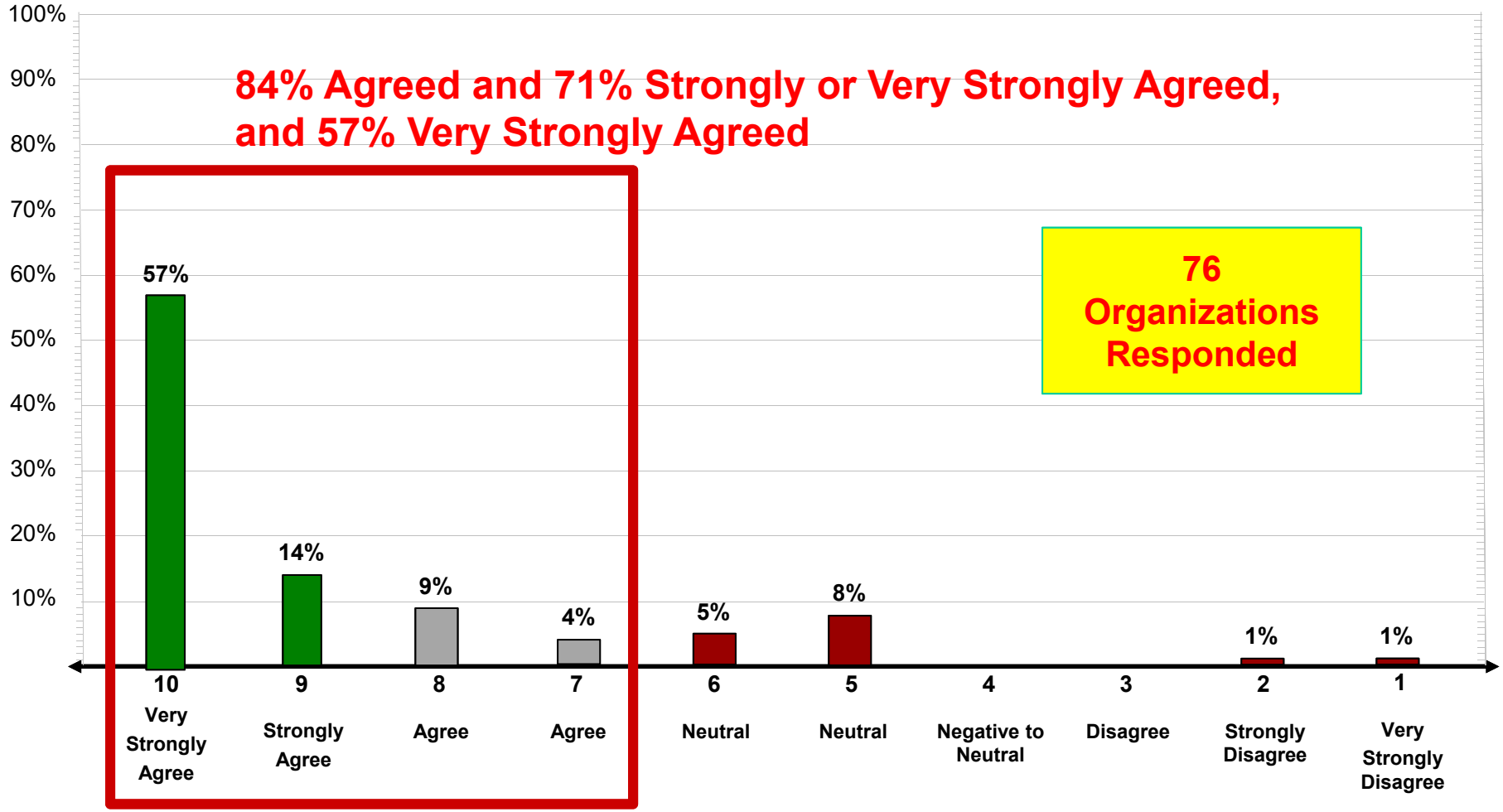
Learn from Mortality Review AND the Living

Part 2 – A Deeper Dive

For resource downloads go to:
www.safetyleaders.org

Anonymous Polling Questions

I am interested in a webinar with speakers who have launched Mortality Review from scratch



Source: TMIT High Performer Webinar Series; Learn from Mortality Review AND the Living: Part 2 – A Deeper Dive – August 18, 2016

The Mortality Review topics I want to learn more about are:

- 30 Day Heart Failure and Pneumonia Mortality
- Adverse event prevention tools and education that have worked
- all that can impact improved patient care and hospital processes
- AMI within 24h
- AMI's Sepsis
- CARE huddles
- categorizing system issues in a meaningful way
- differentiating preventable vs. non-preventable death
- DNR/DNI Timeframe
- Engaging physicians
- failure to rescue
- Heart Failure
- Hospital acquired infections
- How can Nursing and other disciplines facilitate the physician diagnosis more effectively, based on what you have learned?
- How they were completed and communicated with leaders of the organization. Also how do you evaluate the results/benefit of conducting such reviews.
- how to engage patients and family members since hospitals are being strongly encouraged to have them at the table.
- How to get MD champions and MD buy in
- How to present to properly present it to physician in Medicine Committee.
- How to recognize the infection in post-op patient and timely treatment
- Identified trends in mortality
- IS there a difference in quality of care for patients < 65 vs >65?
- Missed Diagnosis
- none
- OR, Procedure Room culture
- physician involvement
- report examples
- reviewer engagement
- reviewing highly invasive procedures in patients at end of life
- sepsis
- Sepsis
- "Sepsis "
- Shock, Sepsis, missed potassium variability
- starting from scratch
- STEMI- post PCI mortality
- the actual review process and any tools you feel you can share
- too many to type here now-a list is helpful
- tools used for the reviews
- What are the criteria you use for sending cases from LPN or admin. to the physicians?
- what data is collected and how is it presented (data and stories)

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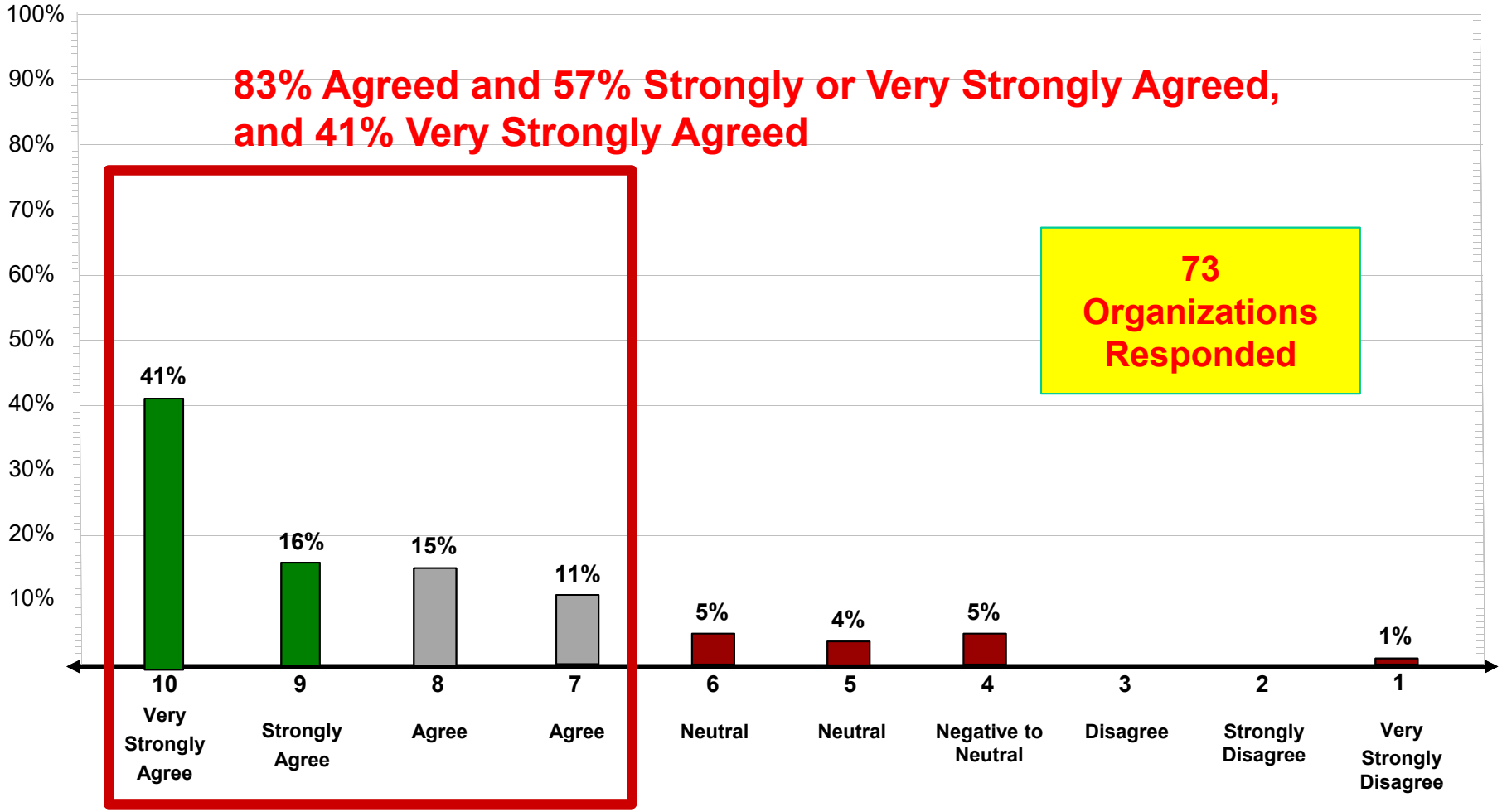
Anonymous Polling Questions

I am interested in DEEP DIVE webinars on the Med Tac Causes of Death of Healthy People



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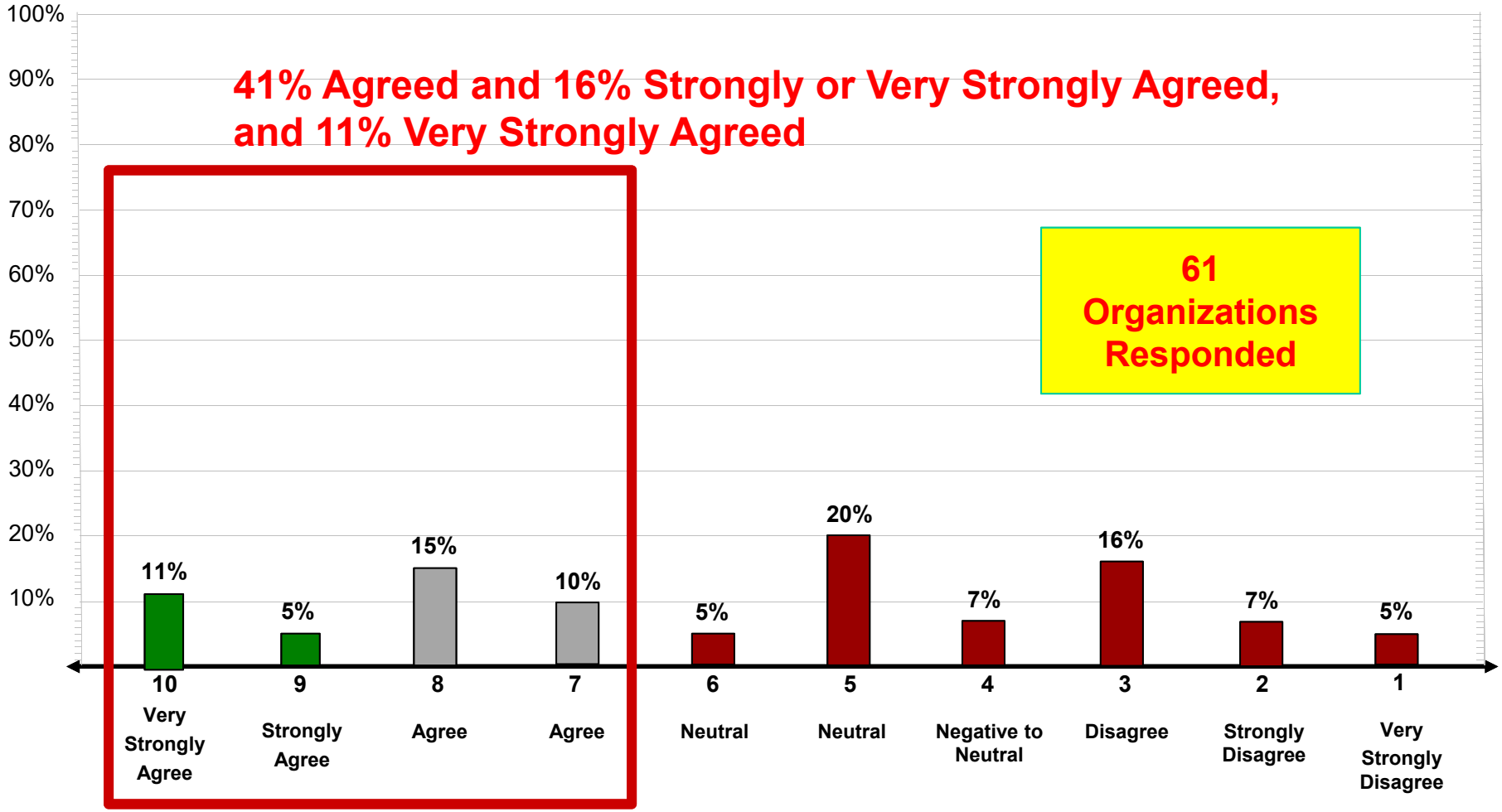
I am interested in participating in a Community of Practice developing the Med Tac tools such as the C.A.R.E. Huddle



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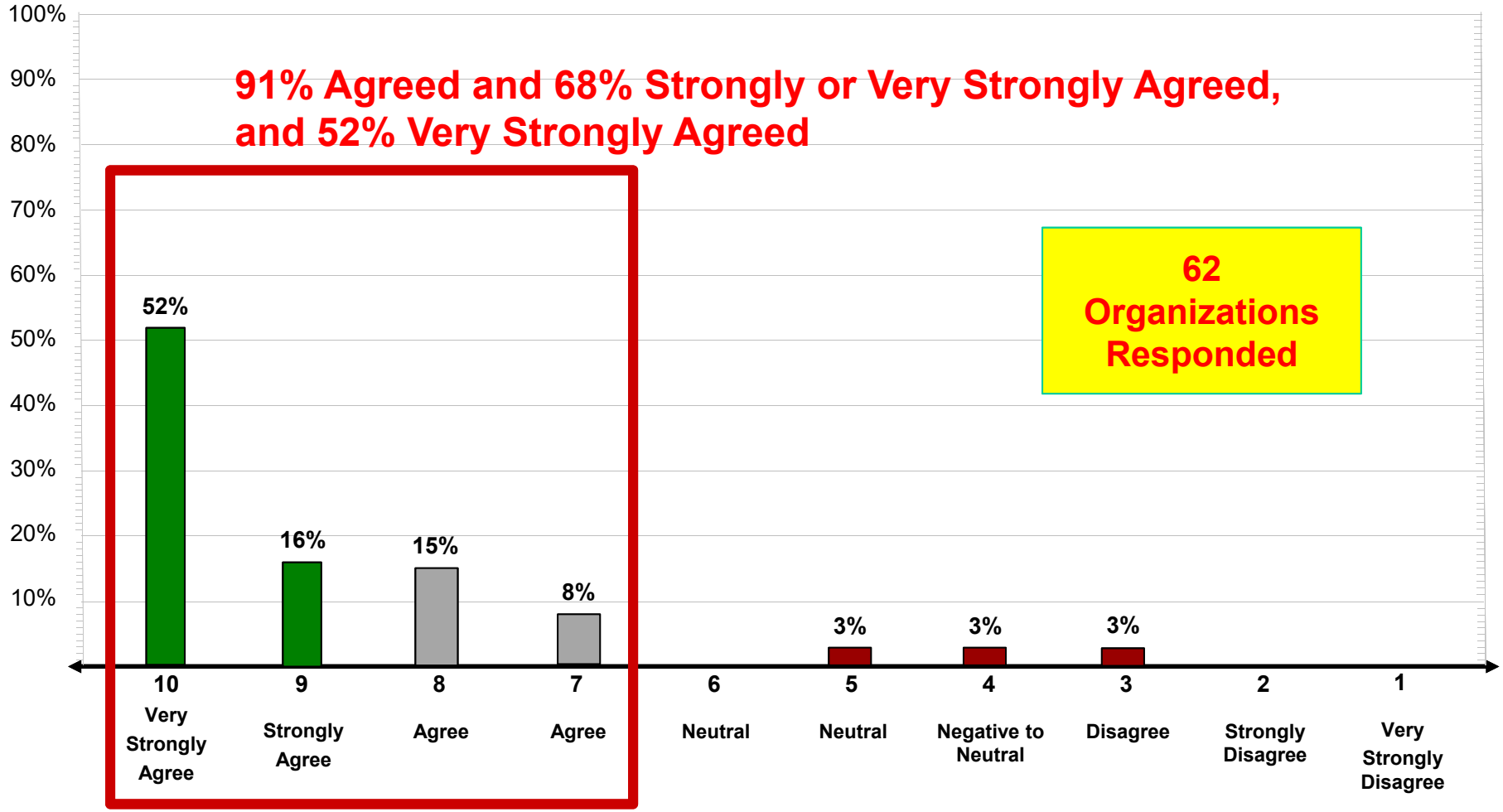
I am interested in a webinar on ALL CAUSE HARM to those we serve (patients) and those who serve (our caregivers)



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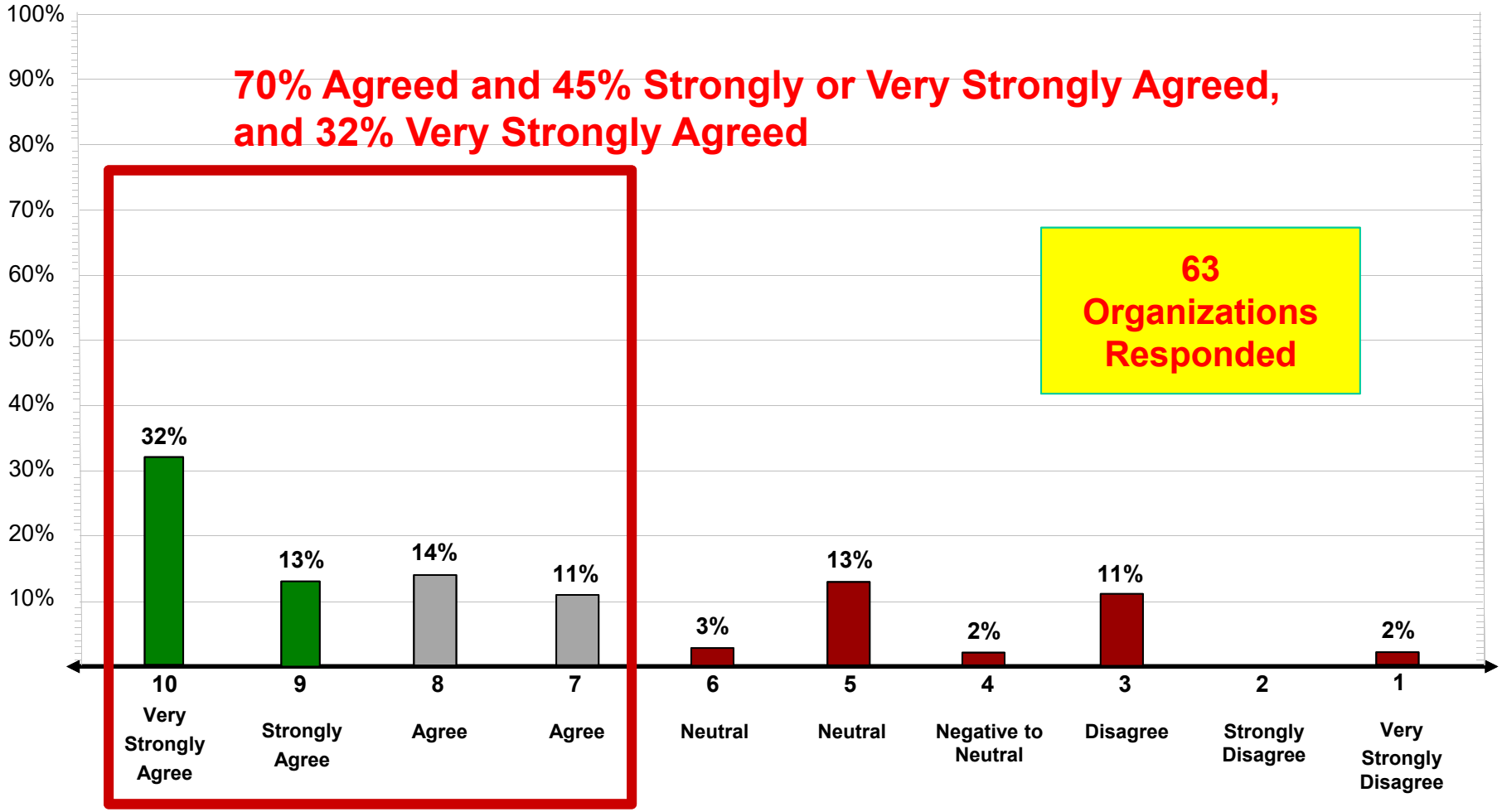
Anonymous Polling Questions

I am interested in a webinar addressing EMERGENCY CODE HARMONIZATION



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The patient safety topics (ANY) that are keeping me up at night are:

- After 45 years in the medical arena, I have learned to sleep most nights.Thank you for affording me the opportunity to continue being a part of the solutions.
- Amiodarone errors, missed sepsis and shock
- Are we truly capturing all the clinical indicators and the treatment the patient recived
- Clinicians not keeping up with evidence-based care due to their perceived lack of time
- Communication, suicide after discharge
- Delay in dx - sepsis
- Discharging patients back to rural and indigent communities which have very few resources, e.G. Shortage of primary care providers to follow them after they leave the hospital
- Documentation and use of standardized templates for preventive exams
- EHR use in office and hospital physician/RN records and progress notes copy & paste""
- Having meaningful goals of care discussions at the right time in a patient's care journey
- Hospital acquired infections
- Hospital acquired infections
- How can care improve rather then decrease in the coming challenges of financial costs increasing?
- How can we support the early diagnosis of conditions? What advise
- How orgnizations support clinicians involved in the cases been reviewed?
- How to engage the physicians in the mortality review process as a separate entity from peer review
- I am interested in reviews of mortality and harm that use real clinical definitions and not surveillance
- I am unable to participate d/t non-hospital provider setting. Theses sessions have extraordinary!
- Infection in post-op patients
- Lack of leadership engagement, (it often seems as if leadership does not understand the correlation between cost, quality, patient and employee satisfaction.... I am a consultant and the ceo of a large hospital said to me, i ag the unwillingness to hold every individual accountable for their practice (ie nurses are held accountable for washing their hands, too ofter physicians are not)"
- Medication safety
- Missed STEMI diagnosis in ed
- Missing the warning signs of patients deteriorating b/c of being so task oriented--lack of critical thinking skills, lack of communication--during handoffs, etc. The simple things that prevent so much such as hand hygiene or lack of it,
- Needing more nurses in number, with stong clinical skills, with strong backbones. This generally is a time and experience type of growth. However, this is the problem...We need them now and in the future. A nightmare.
- Nursing sensitive adverse events
- Opioid prescribing rates
- Physicians who do not answer calls, residents

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The patient safety topics (ANY) that are keeping me up at night are:

- Quality measures and if you have a system that would help in a post do you have a system that would work in a post acute care environment.
- Restraints
- Sepsis
- Sepsis
- Sepsis, postop resp failure
- Sse
- We just send cases to medical staff peer review and not look into the system failures
- Why culture of medical staff is difficult change? Difficult to get medical staff to lead safety changes.
- You've touched on it - readmissions!!

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