



**August 27, 2020**

# **Patient Safety Report**

## **QPSC**

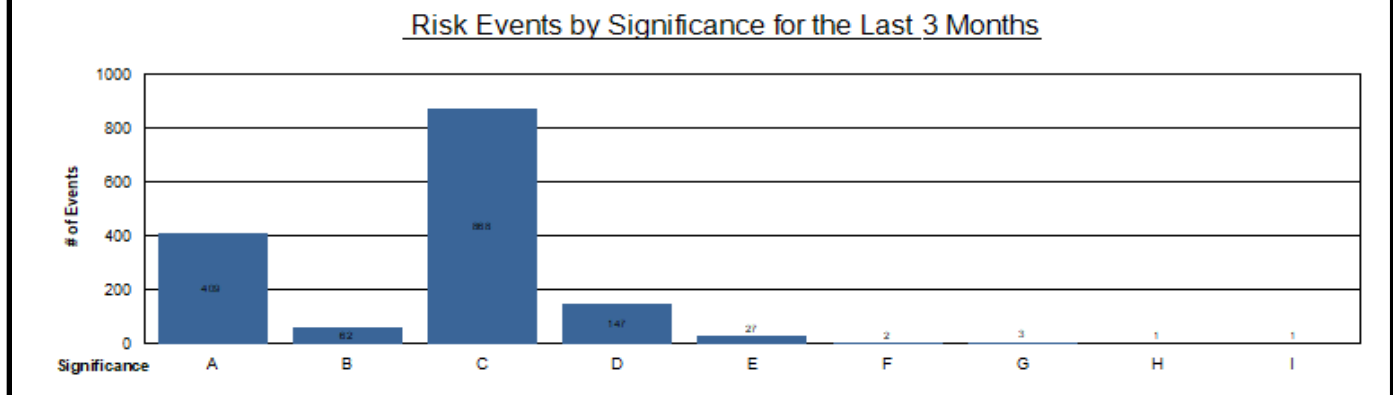
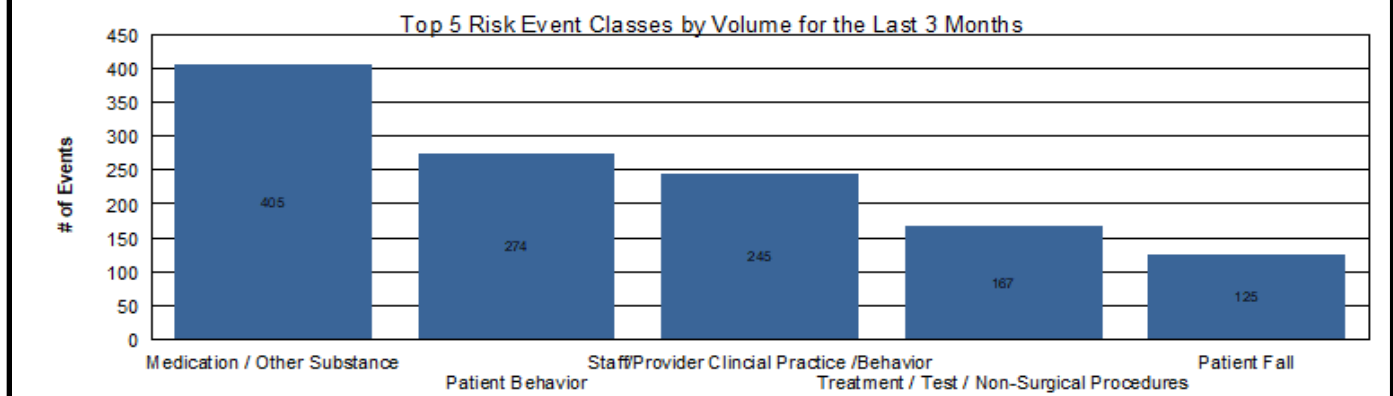
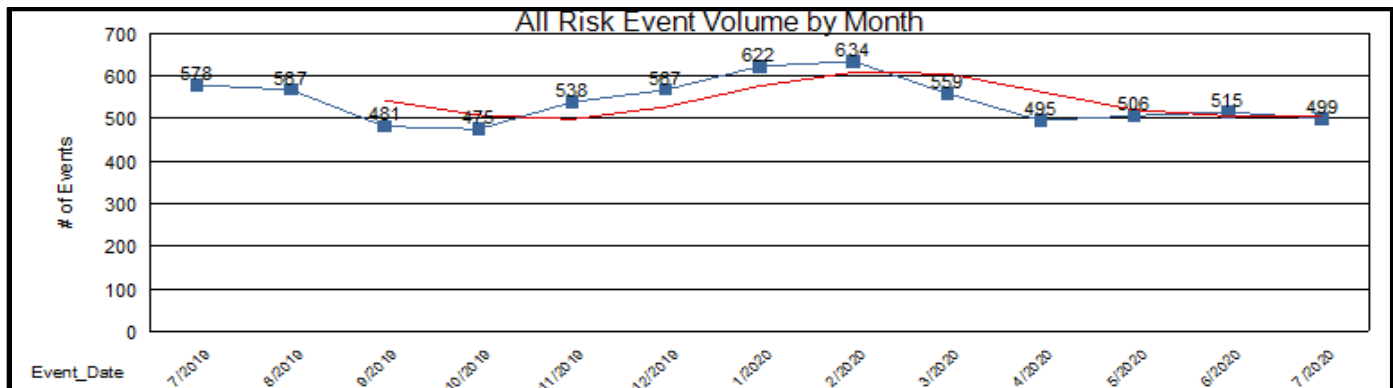
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System Director of Patient Safety**

**ALAMEDA HEALTH SYSTEM**

## AHS PATIENT SAFETY REPORT – SYSTEM WIDE

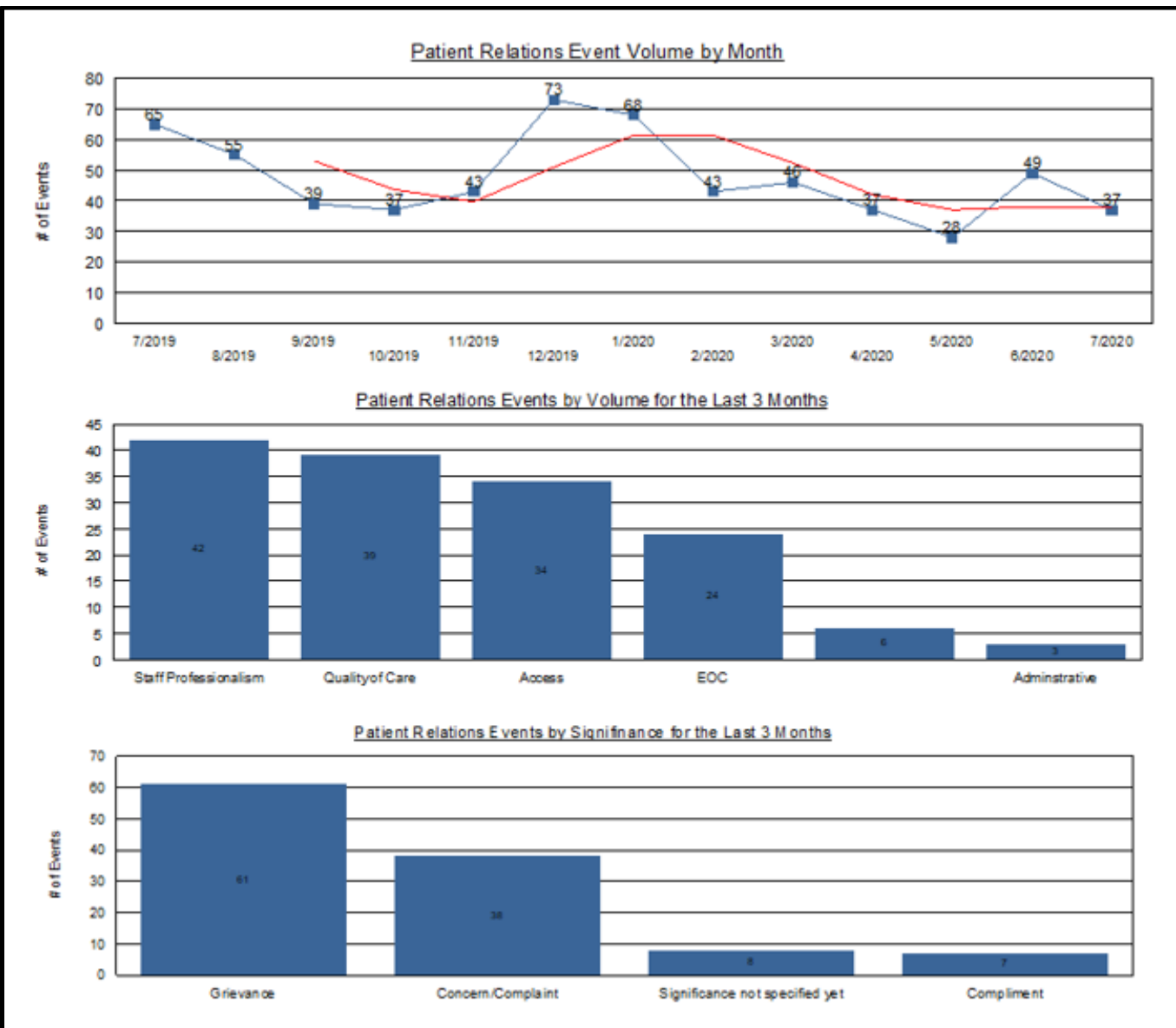
### I. RISK EVENTS:

AHS Pillar	Safety Alert Focus Areas	Metrics	FY 18	FY 19	FY 20	FYTD 21
Quality: Patient Safety, Risk Mgmt	Safety Alert Reporting - Risk Events	Total Reported Events	7,050	7,310	6,537	499
		Total SA Events Significance E or Greater*	6.1% 426 Events	4.4% 286 Events	2.6% 171 Events	2.6% 13 Events
	Safety Alert Risk Event Follow Up	Median Time From Event to Close (Target 10 days)	20	25	3	2



## II. PATIENT RELATION EVENTS:

AHS Pillar	Safety Alert Focus Areas	Metrics	FY 18	FY 19	FY 20	FYTD 21
Patient Experience	Safety Alert Reporting - Patient Relations	Total Patient Relation Events	735	785	583	37
		Complaints	360	242	196	16
		Grievances	333	504	372	21
		Compliments	42	39	19	0
	Grievance Follow Up	Median Time From Event to Close <i>(Target 30 days)</i>	69	39	38	9



### III. CAUSAL INVESTIGATIONS:

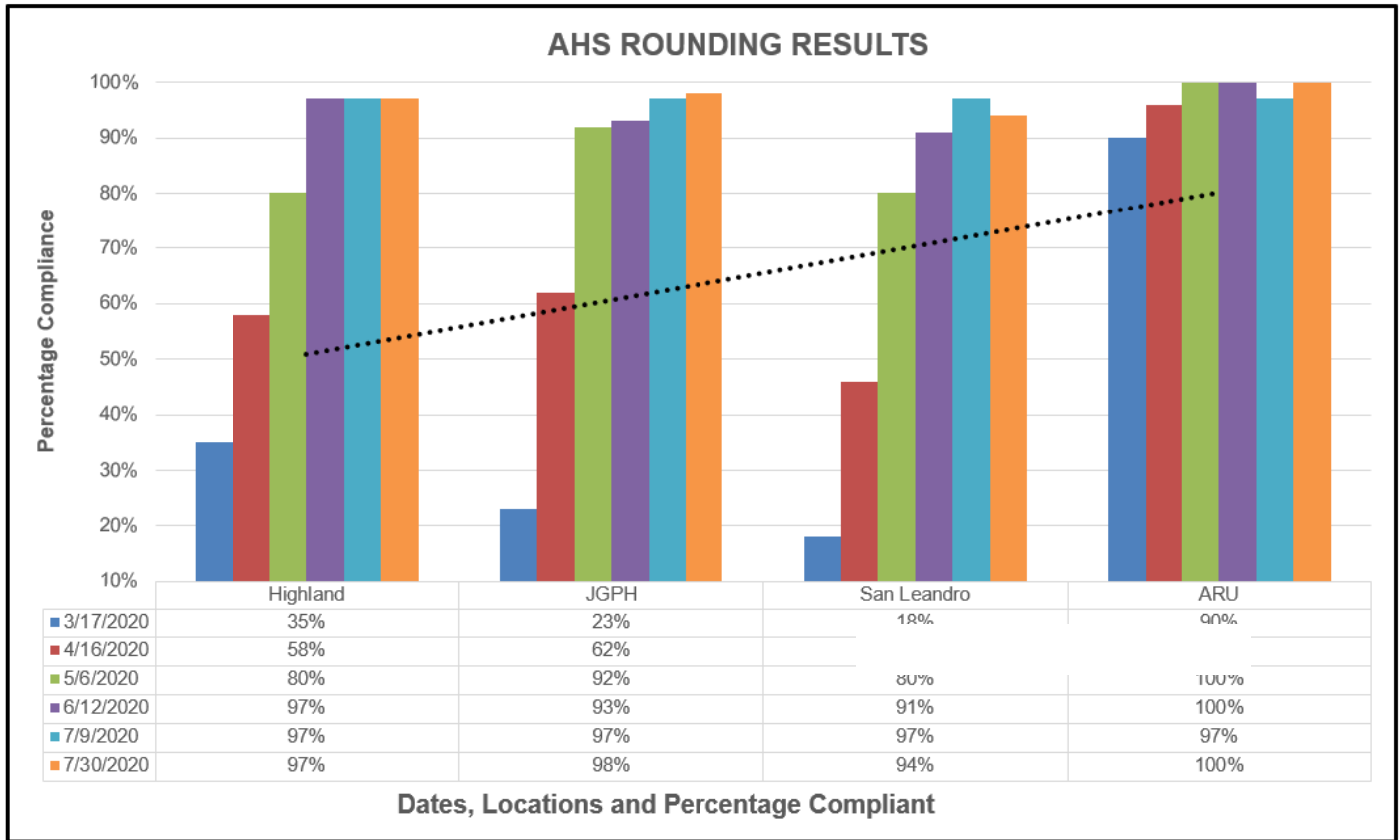
#### 2020 SENTINEL, REPORTABLE OR HIGH-RISK EVENTS

Below is a list of recent causal investigations conducted on Sentinel Events, Reportable Events or high-risk events that require further investigation and intervention to prevent patient harm.

- |              |      |  |
|--------------|------|--|
| 1- Jan 2020  | HGH  | Alleged Retained Foreign Object                |
| 2- Feb 2020  | HGH  | Retained Foreign Object (Reportable Event)     |
| 3- Apr 2020  | JGPH | Patient Elopement (Reportable Event)           |
| 4- July 2020 | HGH  | Retained Foreign Object, retrieved while in OR |

2019 Events	Date of Incident, Reportable Event	Facility	Event Type	Continuous Readiness Analysis	Continuous Readiness Action Plan	Action Plan Status
4	July 2020	HGH	Retained Foreign Object  RFO retrieved prior to extubating the patient.	Long case with multiple staff and providers throughout the case, contributing to several handoffs.  RFO identified due to following proper recounting and imaging procedure.	Engineered, standard pauses for verbal agreement between surgical team at critical junctions.  Implementation of enhanced safety communication tools.  Staff, provider, and resident training on new processes.	In Progress

## IV. QUALITY CONTINUOUS READINESS ROUNDING PLAN



## V. 2021 DRAFT PATIENT SAFETY PLAN TIMELINE

