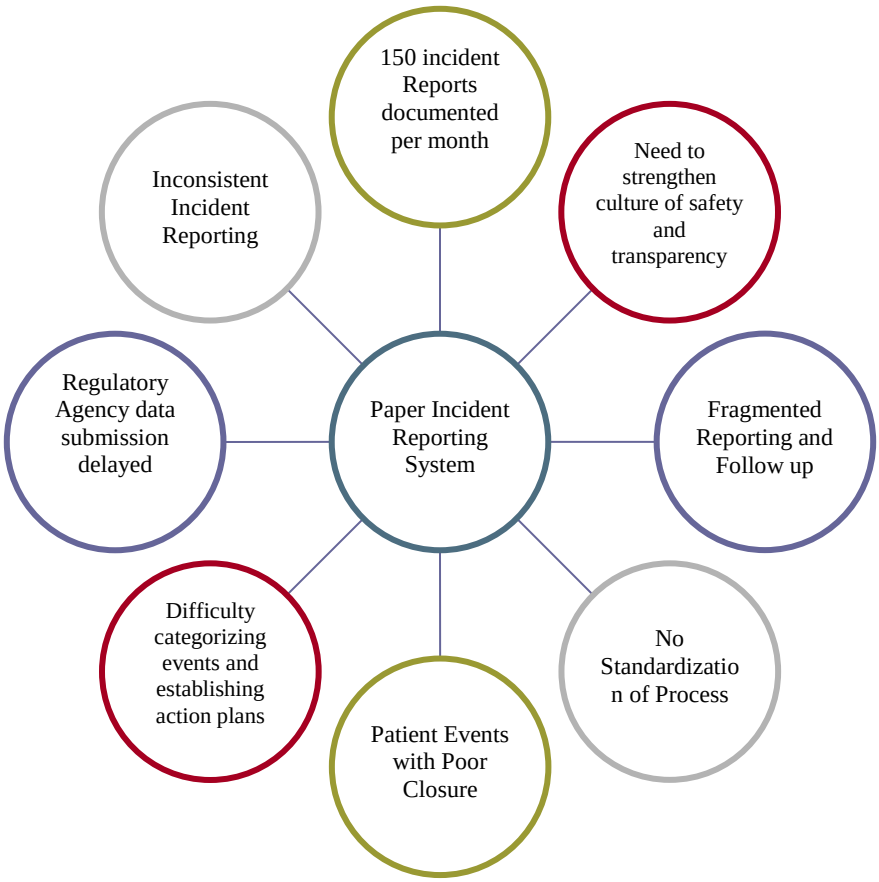
NK9EO. Describe and demonstrate an improvement in practice due nurse involvement in technology and information system decision-making or due to nurse participation in architecture or space design

Jersey City Medical Center provides nurses at all levels with many opportunities to participate in technology and Information Systems-Decision Making. In addition staff nurses are always approached for feed back and trialing of new technologies. Nurse involvement in the design, implementation, and role out of RL solutions an electronic incident reporting system, is a remarkable example of an improvement in practice related to their involvement.

In 2010, Karen Caldas MSN, RN, BC, Risk Manager successfully led a team of nurses in implementing an electronic incident reporting system. This was done because she identified that there was a great need to improve the process of incident reporting at JCMC. The Risk Management Department works collaboratively with all members of the organization to reduce risk. They share knowledge and resources across disciplines to ensure a culture of safety and risk reduction is maintained. The goal of the Risk Management Department is to act proactively to identify organizational risk at all levels and implement action plans to reduce the organization's liability and financial losses. Incident reporting is one method used to identify actual and potential risks to the organization. Previously incident reporting was documented on paper and reviewed manually. A thorough review of the process identified the following opportunities for improvement.



Karen Caldas MSN, RN, BC and Brenda Hall MS, RN, NE-BC, Senior Vice President of Patient Safety, Quality, and Regulatory Affairs evaluated different systems and determined that RL solutions was the best system presented to meet the needs of the organization. In addition to providing an easy electronic document system for JCMC employees, including the nursing staff, this system also has the ability to aid in enhancing the accuracy and timeliness of reporting and following up on all incidents. The data collected through this system generates reports for the NJ Department of Health and Senior Services, as well as NDNQI and other regulatory agencies. It also provides a forum for documentation of patient events and outcomes including timely follow up and corrective actions taken. This system was intended to completely replace paper incident reports and quality referral forms. Once the decision to implement this new system was made a team was developed to lead the project. This team established a timeline for system design, profile build, and staff training

RL Solutions Project Development Team

Name:	Title:
Karen Caldas MSN, RN, BC	Risk Management
Brenda Hall MS, RN, NE-BC,	Senior Vice President of Patient Safety, Quality, and Regulatory Affairs
Laura Wentz MPA, RN, BC	Sr. Clinical Systems Analyst

The team collaborated on user list, email notification set up, system workflow processes, education strategies, and timelines. RL solution profile options were built using input from staff nurses, clinical nurse leaders, and department managers. The Nurse Managers and Nursing Directors were instrumental in providing and bringing feedback from the nursing staff during the system build process. Some examples of customizations that were made based on the feedback provided by the nursing staff included drop down menus selection and mandatory fields revisions.

Karen Caldas stated "*Input from the staff allowed me to see what was important to them and it allowed them to understand the information I needed to build a comprehensive system. I tried to keep the mandatory fields to a minimum and I customized the drop down menus to reflect only necessary information that we really needed. I tried to keep it simple to encourage reporting and to make it easy to use. As time went on, I was able to customize it further based on suggestions made by the staff and managers.*"

The majority of the staff education was provided during two day sessions. Additional sessions were provided to the nursing staff during the night shift by Peggy Petrucelli BSN, RN. Charge nurses, staff nurses, and nurse managers participated in the learning sessions.

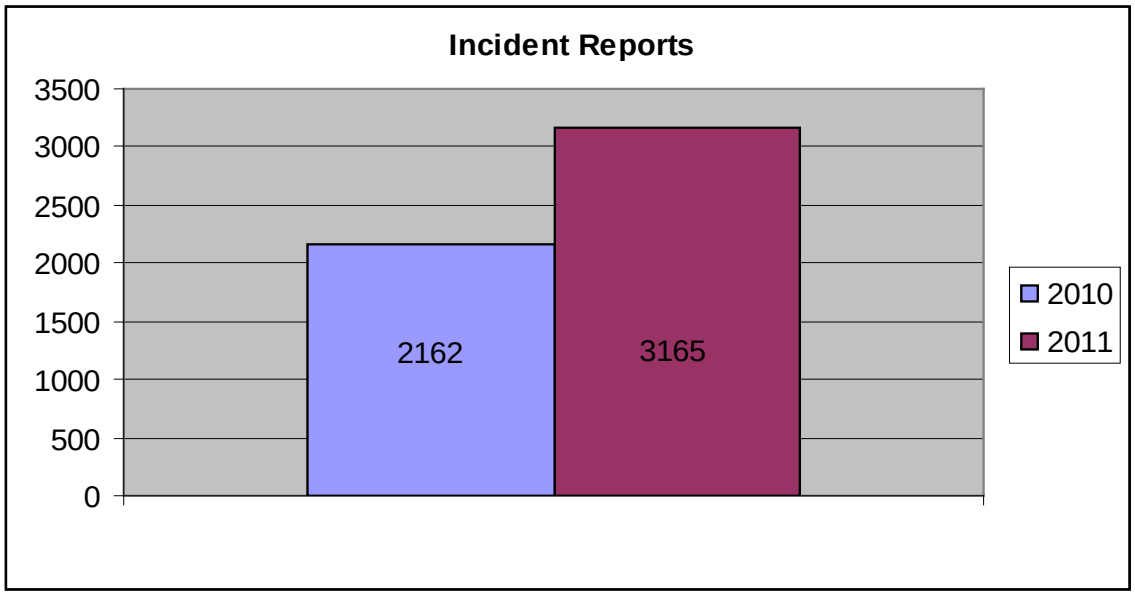
Nurses who were trained provided additional staff education and support as needed during the role out phase. In addition, Nursing Managers, Directors, and Charge Nurses were resources for the nursing staff when needed.

RL Solution Nurse Resources /Champions

Name:	Role:
Cheryl Owens MSN, RN, CNOR	Director of Nursing
Francine Fakih MSN, RN	Director of Nursing
Marilyn Sarnatora MS, RN BC	Nurse Manager 6E telemetry,
Clare Cinelli BSN, RN	Nurse Manager 7E and 7W
Elenita Ajose BSN, RN	Nurse Manager 6W and Renal Department
Kelly Loo BSN, RN, CGRNA	Nurse Manager PACU, SDS
Larissa Seminof BSN, CNOR	Nurse Manager Catheterization Lab
Peggy Petrucelli BSN, RN	Wounds and Falls Prevention Coordinator
Colleen Calero BSN, RN	Charge Nurse 7W
Helen Im BSN, RN	Charge Nurse 7E
Hermela Abrams BSN, RN	Charge Nurse 6E
Marva Babour BSN, RN	Charge Nurse 6W
Amelia Blanco	Charge Nurse 6W

The dedication and involvement of the nursing team led to the implementation of an electronic incident reporting system that continues to be used today. The system is located on the Liberty intranet and is easily accessible by all nursing staff.
The information collected in a patient safety report includes: patient demographics, date and time of occurrence, type of occurrence, location of occurrence, and severity of injury. Additional information that is included in the patient safety report is a brief factual description of the event, contributing factors, and notification of appropriate parties. Once completed, the patient safety report is submitted electronically, reviewed by the Risk Management Department, and sent to the unit manager or department director for follow-up and resolution.

Since implementation of this system the number of incident reporting has increased to 3,165 incident reports in 2011 from 2162 in 2010. This increase in reporting is attributed to the ease of use of the electronic system and ongoing education assistance of the Risk Management Department in identifying reportable events, and staff support. Staff report that the system is easy to use, fast, comprehensive, and easier then the paper forms.



The Quality and Safety Nursing Council continued the momentum and took the lead in encouraging staff nurses to enter near misses and safety concerns into RL solutions. This nursing council assisted in promoting a culture of safety by reinforcing that incident reports are not punitive but an opportunity to identify system breakdowns.

Erin Salmond BSN, RN, Chair of the Research Council States *"The Quality and Safety Council advocates for reporting safety concerns via the use of the electronic reporting system because it can help identify trends. These trends are assessed and a plan is put in place to prevent them from occurring. It is extremely important that nurses at the bedside take part in identifying and reporting their concerns because ultimately this contributes to promoting a culture of safety."*

As indicated previously the paper documentation was cumbersome and difficult to trend and analyze. The new electronic reporting system allows the risk manager to evaluate processes, systems, protocols, and practices. All events entered into the system are classifies events into 20 categories as follows:

- ◊ Adverse Drug Reactions
- ◊ Airway Management
- ◊ Blood/Blood Products
- ◊ Care/Service Coordination
- ◊ Diagnosis/Treatment
- ◊ Diagnostic Test
- ◊ Environment
- ◊ Employee Incidences
- ◊ Falls
- ◊ ID/Documentation/Consent
- ◊ Lab Specimens/Tests
- ◊ Line/Tube
- ◊ Maternal-Child Health
- ◊ Medication/Fluid Errors
- ◊ Product Recalls
- ◊ Restraints
- ◊ Skin/Tissue
- ◊ Surgery/Procedures
- ◊ Safety/Security/Conduct
- ◊ Vascular Access Devise

This electronic reporting system allows incidents to be categorized by level of severity. Evaluating risk severity is important when analyzing actual and potential organizational risk. This allowed us to trend and realize the in 2011 a record number of near misses was reported. This increase led Risk Management Department to participate in developing action plans to address practice issues before a medical error occurs. The following graph illustrates severity levels for 2011.

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2011 Incident Severity Levels