



EHSSSENTIALS 2017

Environmental, Health & Safety Symposium for Healthcare

MAY 11, 2017
LOS ANGELES, CALIFORNIA
UCLA



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Creating an Incident Investigation System from Scratch



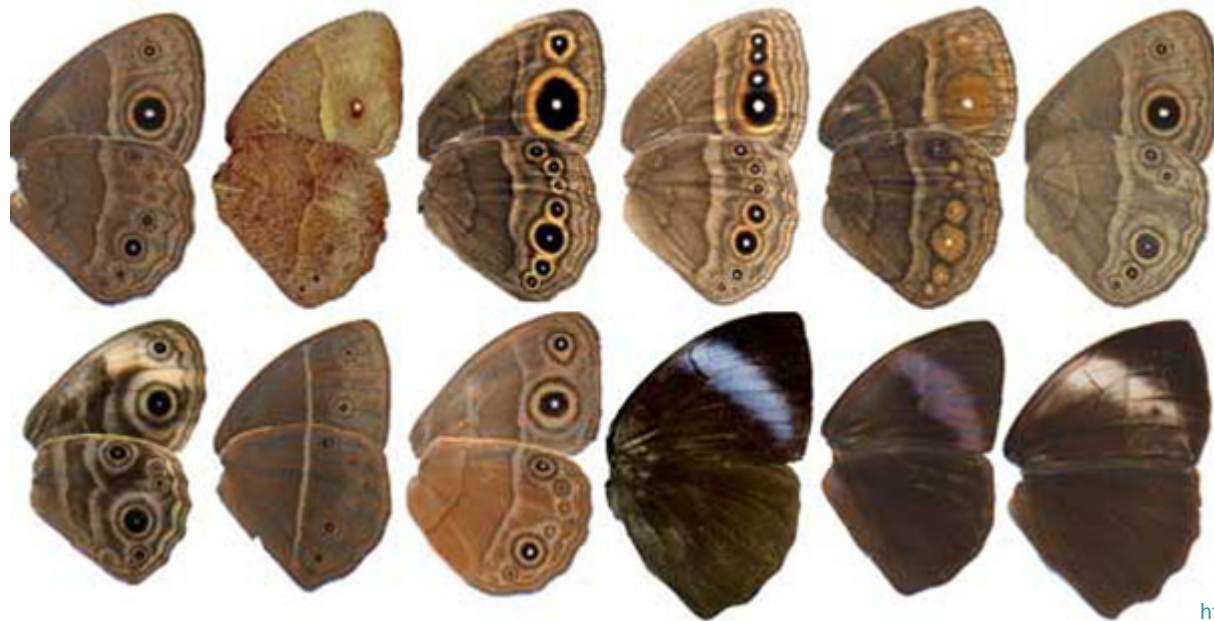
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Our Variation



<http://www.darwinwasright.org/genetics.html>

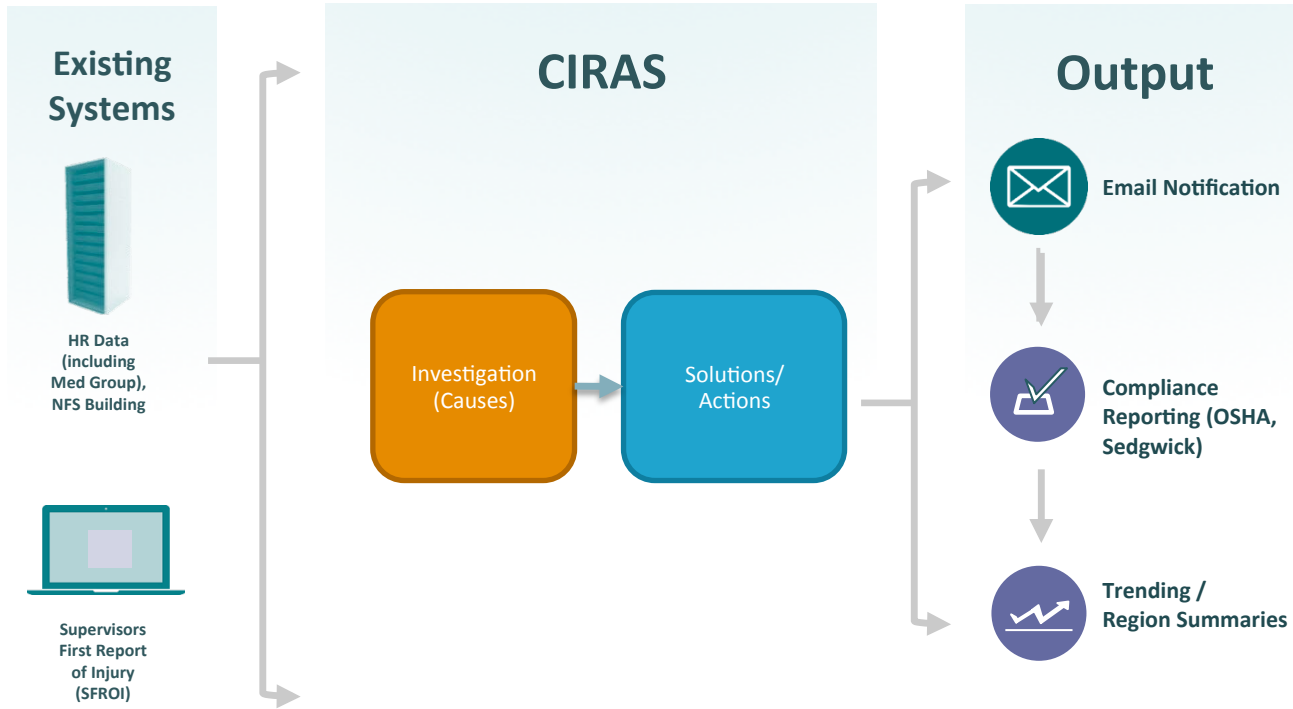
Reduce Variation



What our customers wanted..

- **System:** Develop a incident analysis technology system that is linked to **existing KP Systems**
- **Investigation:** Facilitates identification of **causes** and documents **solutions**
- **Actions:** Document and track **actions**
- **Reporting/Dashboarding:** Generate **investigation** and **summary** reports

Putting the pieces together



Email will alert managers to **Begin Investigation**

Incident page.
Fields are editable as needed to correct initial reports

Add Team members
by typing and pausing for suggestions to populate drop down

1 Incident 2 Analysis 3 Solution 4 Submit

Incident Title
Short description of the incident

Event Date and Time
Date and time of when incident happened

Location of the incident
Select the building/department where the incident occurred

Incident Description
Detailed step-by-step description of what happened

Task Being Performed
Briefly describe task being performed when injury occurred

Anything unusual or unique
State if anything about incident was different, unusual, or unique

Incident Type
Select the incident type that best fits.

Outcome/Disposition of the Incident
Check all that apply

Workplace Violence Event
Check if this incident triggered the prevention of workplace violence reporting No Yes

Investigation Team Members
People who have access to view and change this investigation

View Initial Reports

Analysis Process

Switch between either the cause factors list or the cause-effect mapping feature. Drag and drop functionality on both the lists and the mapping feature make identifying causes easy to visualize and modify.

Incident #: 164554
Incident Type:
Incident Date: 3/16/2017 10:15:00 PM
Location: Patient Transportation
Status: Overdue

Print

Prompts investigators with open ended questions

- Environment Factors
- Equipment Factors
- Procedure Factors
- People Factors

1 Incident 2 Analysis 3 Solution 4 Submit

Show Map

List

View Incident Information

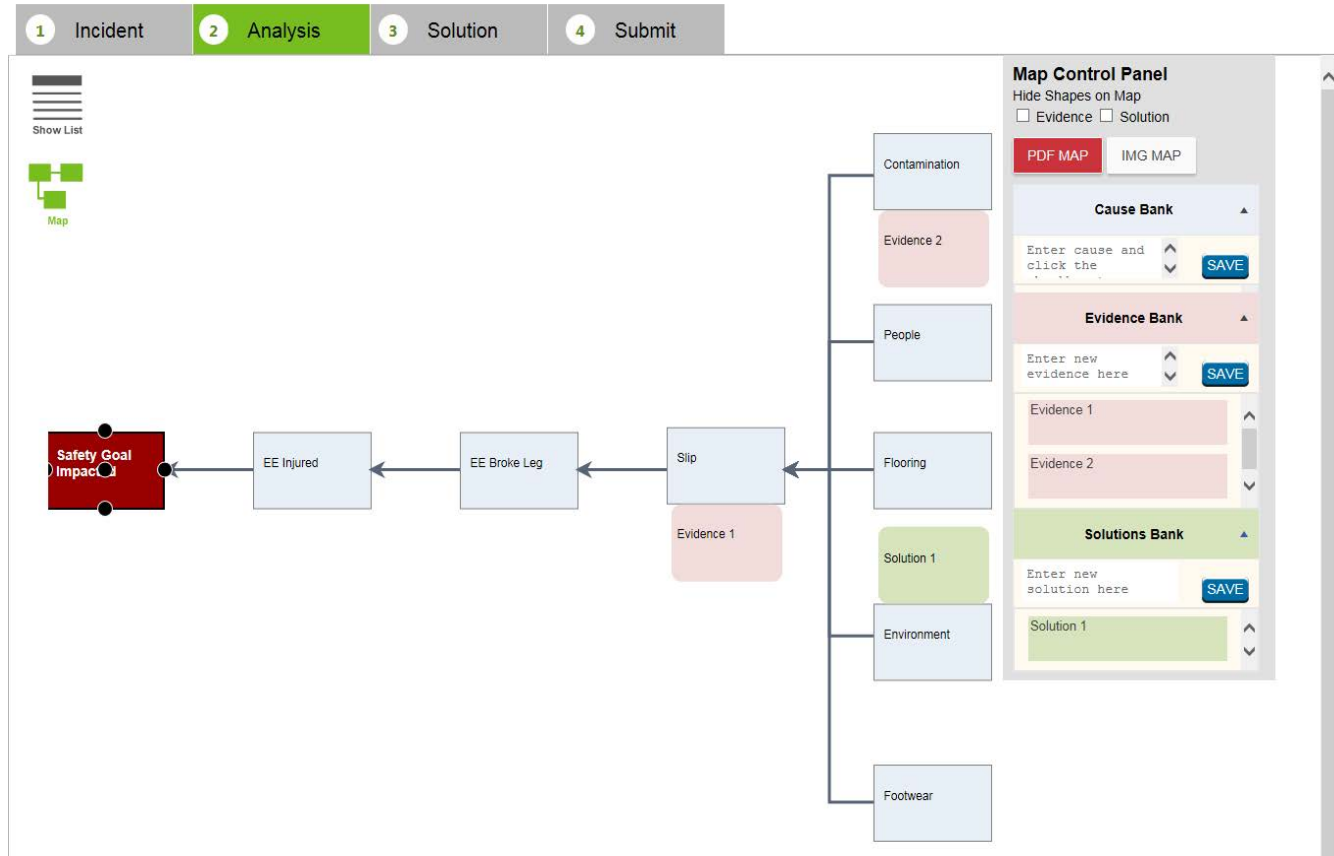
Environment Factors	Equipment Factors	Procedure Factors	People Factors
Anything out of place or broken? Lack of space? Machines moved to new location. Changes to computer configuration, ergonomic changes.	Proper equipment used? New equipment in place? Equipment malfunction? Additional tools needed?	Written procedure in place? Break down in procedure steps? Which procedural step was involved in the incident?	Time/speed a factor? Employee provided adequate training? Employee challenged by complex tasks or fatigue?
Enter cause and click the <input type="checkbox"/> SAVE	Enter cause and click the <input type="checkbox"/> SAVE	Enter cause and click the <input type="checkbox"/> SAVE	Enter cause and click the <input type="checkbox"/> SAVE

Unspecified Factors

Are there any causes that don't fit the existing factors? Are there new factors to consider? Enter cause and click the checkbox to save **SAVE**

Cause-Effect Mapping

- Use the causes identified
- Identify Evidence
- Identify Solutions



Solutions are identified to mitigate the future occurrence

Action identified for each solution with specific due dates and owners

Action items are **sent via email** and reminders are created

Solution Action Plan

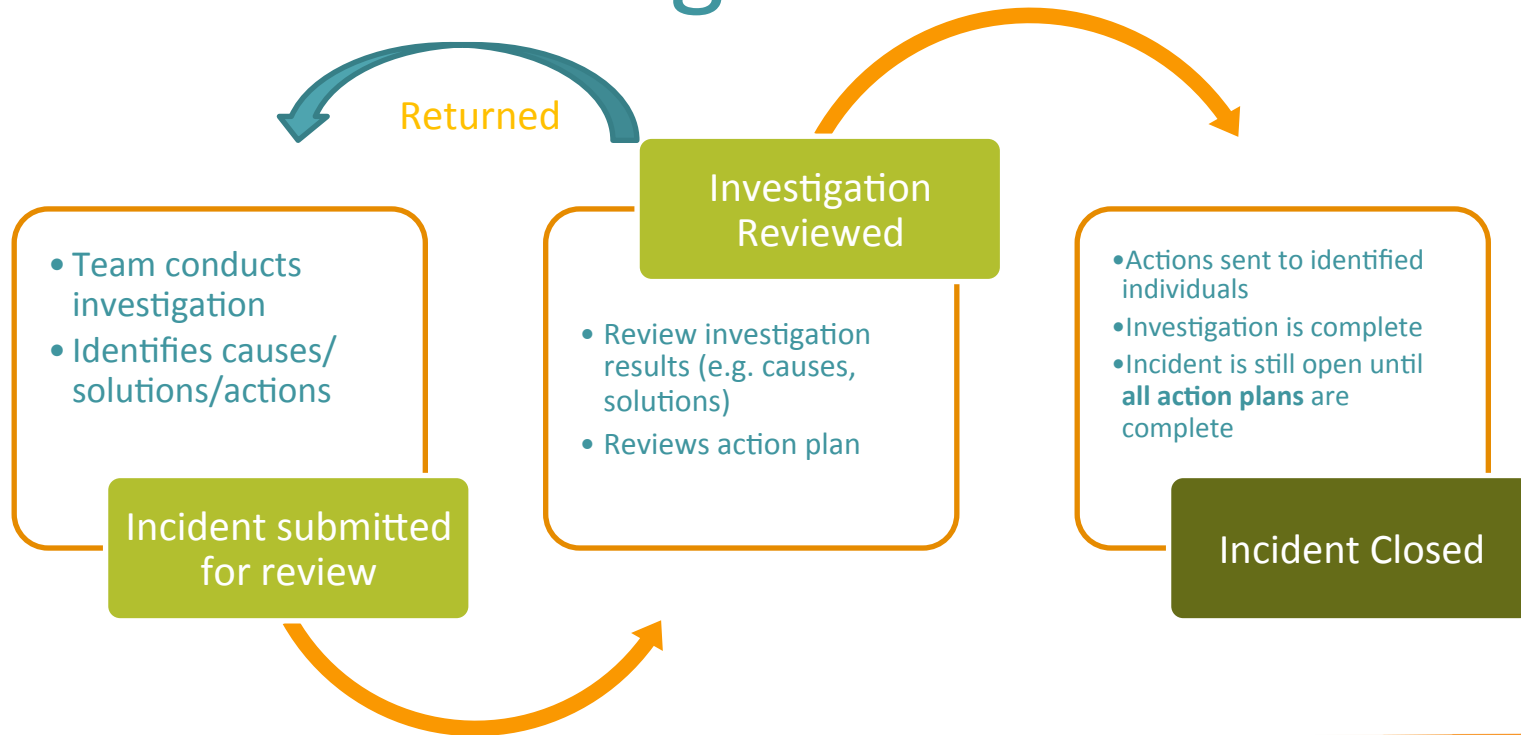
After completing the analysis, use this form to categorize solutions and create action plans to reduce the risk of future incidents.

- 1 Incident
- 2 Analysis
- 3 Solution
- 4 Submit

+ Solution

	Solution Description	Type of Solution	Causes Controlled	Edit			
▼ Action Plan NOTE: Drag & drop rows to reorder	Test	<ul style="list-style-type: none">EngineeringSubstitution	<ul style="list-style-type: none">FlooringPeople				
+ Action Refresh							
	Action Recommended	Action Taken	Due	Status	Completion	Owners	Edit
	122			In Development			
	sss			In Development			
> Action Plan	fgfsdgd		<ul style="list-style-type: none">PPESubstitution				
> Action Plan	afdsafdsa		<ul style="list-style-type: none">Administrative			<ul style="list-style-type: none">ContaminationDjhjkljlsalkfd	
> Action Plan	gfgdfgdc						

Incident Investigation Review



Design to Implementation

- Proof of Concept
- Feedback from Regions and Medical Centers
- Test Medical Centers
- Regional Implementation

What worked well?

Usability and Training

- Functional/live system
- Some managers can use it with minimal/no training
- Able to quickly create reports
- Can create cause-effect map

Information and Processes

- Data Feeds from SFR/HR working
- Users like notification and reminder features
- Assignment of Actions

Feedback

- Timely identification and resolution of “bugs”
- Added some enhancements since launch
- Created “sand box” version

Some lessons learned

Usability and Training

- Training on demand
- Impact on safety department

Information and Processes

- Manager familiarity of with “Safety” Jargon
- How existing processes interface with technology
- Developing/sustaining quality

Feedback

- Identify reports that your users want (e.g. leading indicators, Aging Performance, etc.)
- Identify Needs vs Wants

Thank you!