PATIENT SAFETY
UPMC Systemwide Annual Mandatory Training
To ensure a great customer experience, we must demonstrate compassion by LISTENING to the needs of patients and CARING for their personal safety.
UPMC’s vision for patient safety is to create an environment that is totally safe and encourages individuals to speak up so we can continuously improve our patient safety.

Patient safety is the foundation of quality patient care and is at the center of everything we do.
The goal of patient safety is to minimize adverse events, eliminate preventable harm to our patients, and enhance the culture of safety across all sites and groups.
How do we get there?

We start by feeling safe to speak up regarding an unsafe patient situation.

We must learn from our errors, near misses, and adverse events.

Finally, we must create an environment of high reliability, where every patient gets the right care, in the right way, at the right time, **EVERY TIME.**
Speaking up is safe to do.

All staff are safe to report anything without fearing they will be treated differently.

We encourage all staff to report because your concerns do matter, and we can only learn as we are made aware of potential problems.
At UPMC, we empower our healthcare professionals to speak up when there is a concern of immediate patient safety. We have adopted the safe phrase, “I need clarity.”

“I need clarity” is a short, recognizable safe phrase that means “I have an immediate concern for this patient’s safety.”

The response to the phrase, “I need clarity” is always to stop the activity and review concerns.
If you have a patient safety issue you need to report, one option is to report it to your patient safety officer. Your patient safety officer’s main responsibility is to support every staff member who has a safety concern.

They also look for trends or patterns in patient safety; teach the importance of reporting all events; and share results of work that occurred because events that were reported.
You may also report concerns to your supervisor or enter it in Riskmaster.

Incident reporting at UPMC is done through the Riskmaster tool.

Riskmaster can be accessed through Cerner, EPIC, or the Infonet.

Incident reporting should be completed any time something out of the ordinary occurs (i.e., patient fall, medication reaction, anesthesia complication, etc.)
In the Quick Links section, click on the A to Z List.

Next Step

Quick Links
A to Z List
Perks
Help Desk
Hospitals
UPMC in the Media
Video Library
A to Z

Use this alphabetical listing of contents on Infonet to locate commonly requested information and links. This is not a complete listing of Infonet content. The new, robust search engine as well as the navigation bars on every page are available to help you find the information you need.

A to Z List

A
ACES
Advance Directives
Animal Friends Chow Wagon Campaign

B
Benefits
Blood Donation

C

Approved Abbreviations
Ask Once

Click on I for “Incident Report” or R for “Riskmaster”
What Happens To The Incident Report?

Incident reporting is submitted via Riskmaster. The event is created by either phone message, online reporting or e-mail with Confidential Header.

The Committee identifies ways to reduce risks by conducting intense analysis. Action plans are created to remove risks. Some action items may include specific education, policy improvements, and workflow enhancements.

Event is routed to hospital’s Patient Safety Officer (PSO), unit director, clinical director and other leadership.

The Patient Safety Committee is made up of the hospital Triad. The Triad consists of the PSO, the Chief Nursing Officer, and the Chief Medical Officer. The appropriate member or the entire team decides on how to improve based on the incident and the follow-up investigation that may be completed.
Only when we take the time to **CARE & LISTEN** to the specific needs and requests of our customers can we provide the right care, at the right time, in the right way, every time.