eBook

A Guide to Improving Your Patient Safety Event Reporting Culture

+ a Leadership Action List

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ADNPSO
AMERICAN DATA NETWORK
PATIENT SAFETY ORGANIZATION

Learn to Report. Report to Learn.

Patient Safety Occurs at the Point of Care

With a commitment to caring for and keeping patients safe, it is critical that we evaluate and learn from every event reported, including those where no patient harm resulted. This commitment requires a culture of safety that promotes and supports staff in detecting and reporting incidents, near misses, and unsafe conditions as part of their daily work. Patient safety occurs at the point of care, making staff the best source for event reporting.

Leadership responsibility includes assurance that staff recognize all types of events and are supported in their reporting activities. Once near misses and unsafe conditions are identified, there must be further commitment to taking action through design or redesign, implementation, and ongoing evaluation of effectiveness for new processes and systems that mitigate patient risk and injury.

Through event reporting, staff learn to identify high-risk issues that directly impact the safety of patients.

In order to learn, staff must know:

1. **When to report a patient safety event,**
2. **What constitutes an incident, near miss or unsafe condition, and**
3. **Which critical pieces of information are necessary for assessing the causation and degree of risk or harm that occurred.**

Event Categories

According to Agency for Healthcare Research and Quality Definitions

An **incident** is “a patient safety event that reached a patient, whether or not there was harm involved.” For example, a patient is administered and ingests an incorrect medication.

A **near miss** or good catch is “a patient safety event that did not reach a patient.” For example, the wrong dose of insulin is discovered by the second verifying nurse prior to patient administration.

An **unsafe condition** is “any circumstance that increases the probability of a patient safety event occurring.” An unsafe condition does not involve an identifiable patient. For example, a surgical time-out is not performed or other features on the surgical checklist are skipped.

Event Analysis & Causation

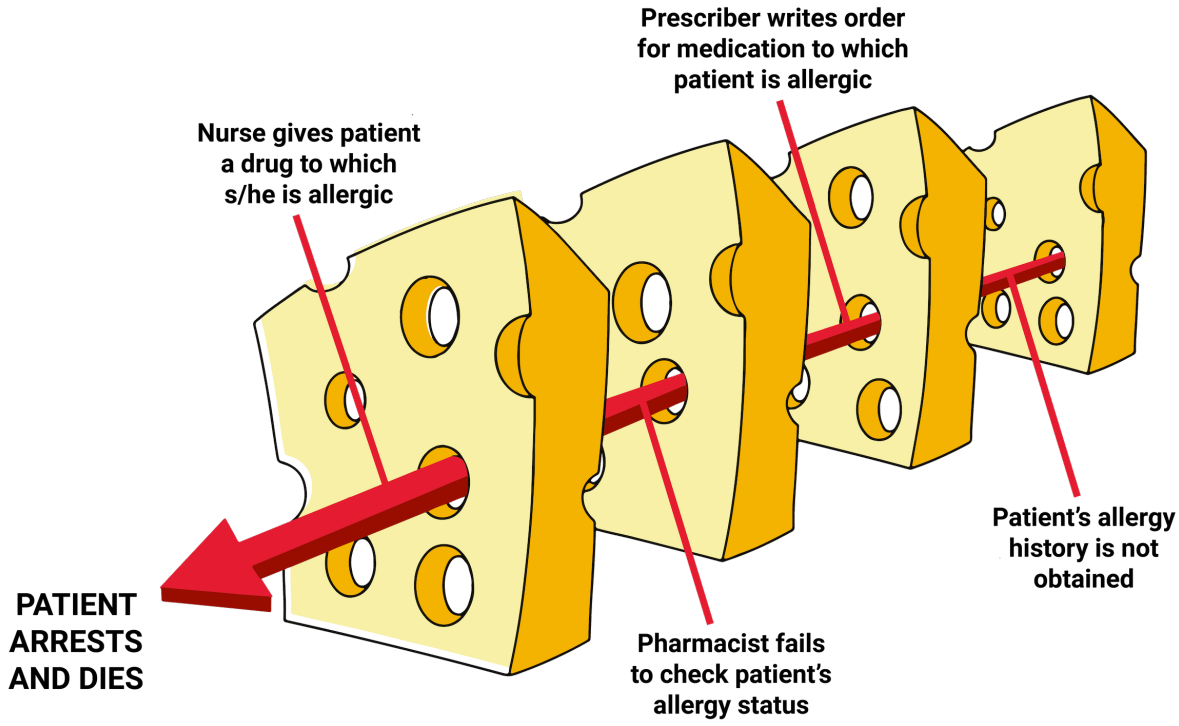
Event reporting is essential to identifying, understanding, and addressing underlying factors and circumstances that contribute to medical errors.

The assessment and aggregate analysis of all events, regardless of severity or harm levels, is necessary to determine the cumulative risk to patients and highlight splintered systems and processes that eventually lead to injury.

The goal is to determine what happened, why it happened, and how to reduce the likelihood of it happening again.

To connect the cause-and-effect relationships and reveal system flaws, start with the end result (incident) and move backward by asking "why" until the flawed process is identified as the root. The end is just the beginning of the road to improvement.

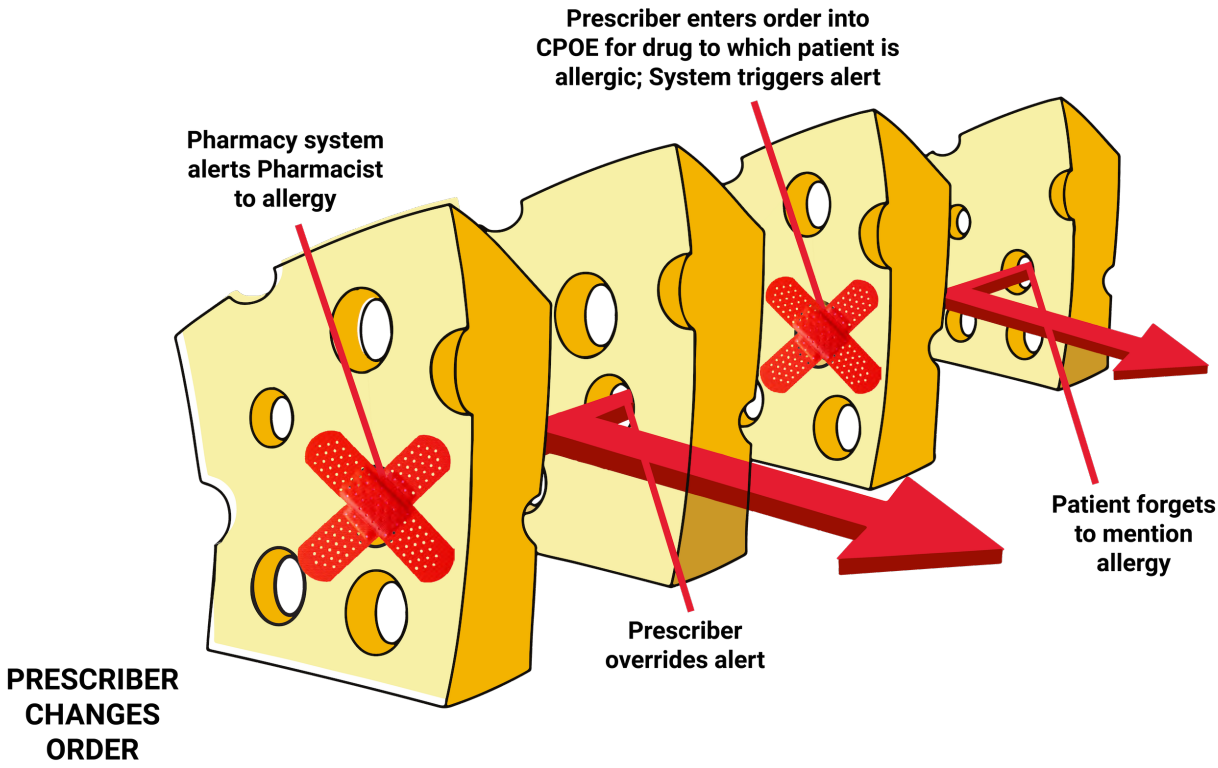
The Swiss Cheese Model of causation illustrates that, even though layers of defense exist within our safety system, the flaws can align and allow the error to occur. This example quickly exposes multiple failure points that can lead to a fatal patient incident.



Reporting of near misses and unsafe conditions offers the greatest opportunity to mitigate potential harm before it occurs, as well as foster employee engagement in safety culture. Near misses and unsafe conditions often occur in larger numbers compared to incidents and are rich sources of data for learning and improvement. Both precede patient involvement and can provide warning signs of weaknesses in processes and systems.

Organizational due diligence is critical in conducting proactive risk analyses of near misses and unsafe conditions to identify any trends or patterns that warrant priority for redesign. Additionally, it is imperative that these events are reviewed for any indication that, without immediate corrective action, would ultimately reach and potentially harm patients.

The following Swiss Cheese Model is similar to the previous example, but this time depicts a successful hard-stop safety system that prevents the patient's arrest and is reported as a near miss.



Leadership Action List

Every effort should be made to promote a Just Culture approach to patient safety and support staff in the reporting of patient safety events for prevention, not punishment. Staff will take a more engaged and empowered role in patient safety when they are encouraged to participate in the identification and resolution of fractured systems and processes, becoming subject matter experts and patient safety advocates.

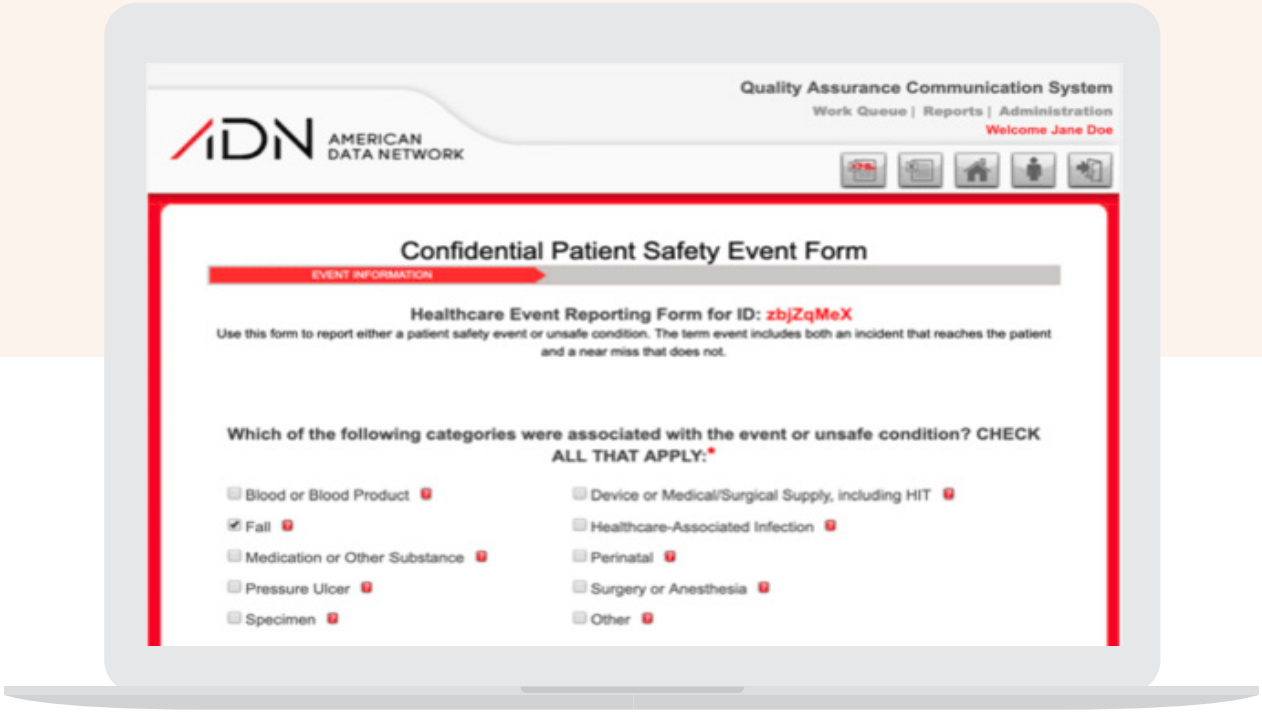
Leadership is recognized as a key factor in creating and sustaining a successful safety culture and program, including building and promoting a supportive infrastructure. Strategies to consider include:

1. **Create** a centralized, coordinated approach to patient safety
2. **Embrace** a Just Culture, Reporting Culture and Learning Culture
3. **Commit** to prioritizing safety and making it visible throughout the organization, including board meetings
4. **Measure** baseline and ongoing safety culture performance using a standardized survey tool
5. **Develop** trust and accountability through an organization-wide, user-friendly electronic event reporting system
6. **Adopt** a common set of safety metrics and utilize insights from survey and event analyses to drive improvements
7. **Require** education for frontline staff and managers to expose to patient safety sciences and optimize event reporting for organizational learning
8. **Invest** in team trainings, resources and technologies devoted to elevating patient safety, such as Patient Safety Champions, Comprehensive Unit-based Safety Programs (CUSP), and TeamSTEPPS®
9. **Conduct** Executive WalkRounds with prompt attention to issues raised by frontline staff
10. **Support** staff as second victims of medical errors
11. **Partner** with patients and families to enhance quality and safety

CONTACT US

Get an Event Reporting Demo

Learning to Report and Reporting to Learn are integral to the success of any patient safety program. By educating staff on the importance of reporting, analyzing the resulting patient safety event data, and implementing targeted actions and initiatives, progress can be made to mitigate risk and injury to the patients entrusted to healthcare teams and organizations.



Smarter, Simpler Patient Safety Event Reporting Application

The American Data Network Patient Safety Event Reporting Application helps you monitor and analyze safety events and near misses to improve clinical processes and curb your organization's risk. To learn more about the tool or request a demo, contact Susan Allen at (501) 225-5533.

About ADN

About American Data Network Patient Safety Event Reporting Application

For more than 25 years, American Data Network (ADN), which is also the parent company to its Patient Safety Organization (ADNPSO), has worked with large data sets from various sources, aggregating and mining data to identify patterns, trends, and priorities within the clinical, financial, quality and patient safety arenas. ADN developed the Quality Assurance Communication (QAC) application, with which hospitals, clinics, rehabs, and other providers record and manage patient safety events. By entering events into ADN's QAC application and submitting them to ADNPSO, information is federally protected and thereby privileged and confidential. These protections provide a safe harbor to learn from mistakes and improve patient safety.

We are proud to serve...

Client Feedback

Hear what our customers say it's like to partner with us.

"Working with ADN has been nothing but a pleasure. My questions and/or concerns are always addressed timely by an attentive team member with kindness and professionalism."

Melanie Hedges Draper
Core Measures Coordinator, Baptist Health Medical Center – Hot Spring County

"I appreciate that your team is so knowledgeable and thorough. I absolutely do not regret my decision to go with ADN! Thanks!"

Marsha Donaldson
Quality & Performance Improvement Manager, Martin Health

To learn more, contact Susan Allen at sallen@americandatanetwork.com or (501) 225-5533.