

BREAKING DOWN BARRIERS TO IMPROVE PATIENT SAFETY EVENT REPORTING

BARRIERS TO REPORTING

TIME: I am very busy, and it takes too long to report events.

EVENT RECOGNITION: What types of safety events am I expected to report?

NO HARM: What is the rationale for reporting the event if no patient harm was involved?

FEAR: I am hesitant to report due to fear of disciplinary actions, potential lawsuits, or guilt of exposing mistakes of others.

FIX & FORGET MENTALITY: Sometimes it is easier for me to fix the error than to report it.

LACK OF UNDERSTANDING: Why is event reporting important to my clinic organization? Who sees my reports and how is the information used?

TIPS TO OVERCOME

On average it takes **5 minutes** to input any event in the QAC electronic reporting system.

Report any unplanned or unintended incident, condition, or circumstance that could have or did result in patient harm (e.g., defective processes, system breakdowns, equipment failures, human errors). **When in doubt, report.**

Staff should report no-harm incidents, near misses, and unsafe conditions to **proactively** identify and fix error-prone processes prior to harming patients.

Our organization is committed to transparency and a **non-punitive culture** in order to learn from reported safety errors. Don't be afraid to speak up.

Even if caught and corrected, others have likely experienced the same error. When reported, like-events are analyzed and **lessons learned** are shared across the clinic system.

Staff have information that, unless reported, remains unknown to the rest of us. Every reported event is reviewed by safety/risk professionals to **drive improvements.**