



Embracing Patient Safety

Improving Your Relationship with Patient Safety Reporting

Jonathan Barko, MD

Assistant Professor, Internal Medicine/Pediatrics

Division of Hospital Medicine, University of Kentucky

Disclosures

- I have no disclosures

Learning Objectives

- Differentiate between the different types of reportable patient safety events
- Describe the importance of increasing physician engagement with error reporting
- Identify common barriers to patient safety event reporting, with a focus on physicians/APPs
- Discover different methods of incorporating patient safety event reporting and discussions into your direct care and/or teaching rounds

Agenda

Why I am talking to you today

Brief review of errors and error reporting

Barriers

Overcoming Barriers

Current Landscape in Hospital Medicine/Next Steps

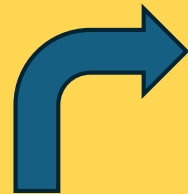
Questions

Audience Participation--PollEV

Join by Web [**PollEv.com/jonathanbarko395**](https://PollEv.com/jonathanbarko395)



Why should you care?



Jonathan Barko,
pre-residency



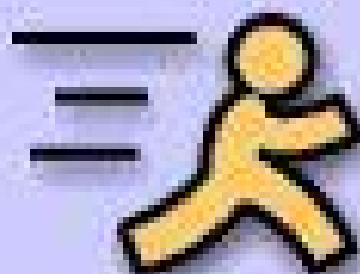






Est. 1990

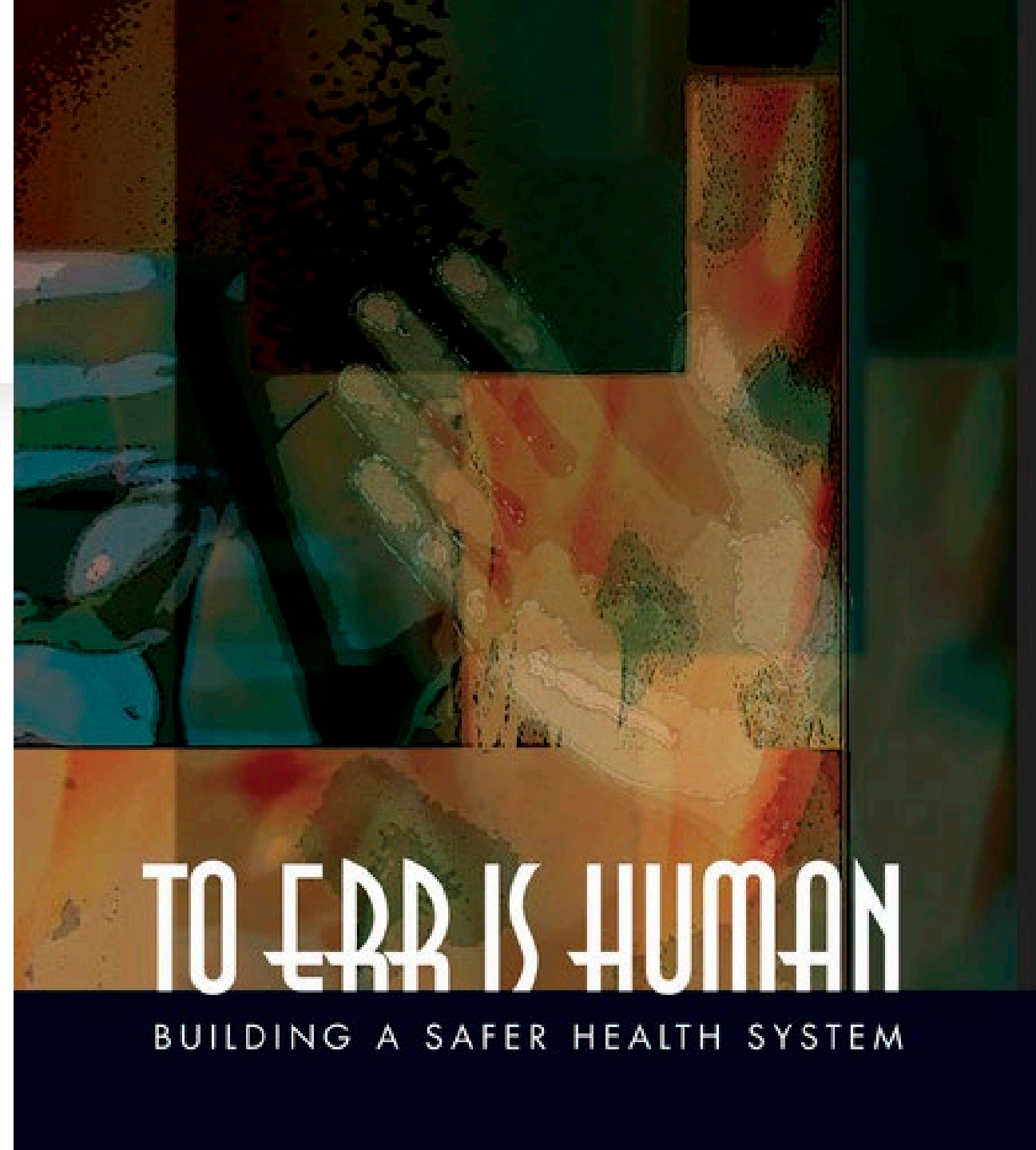




Connected!

1999

- Medical errors are:
 - Common
 - Costly
 - Often preventable
 - Fault of the system, not the individual
 - Can have devastating effects on patients

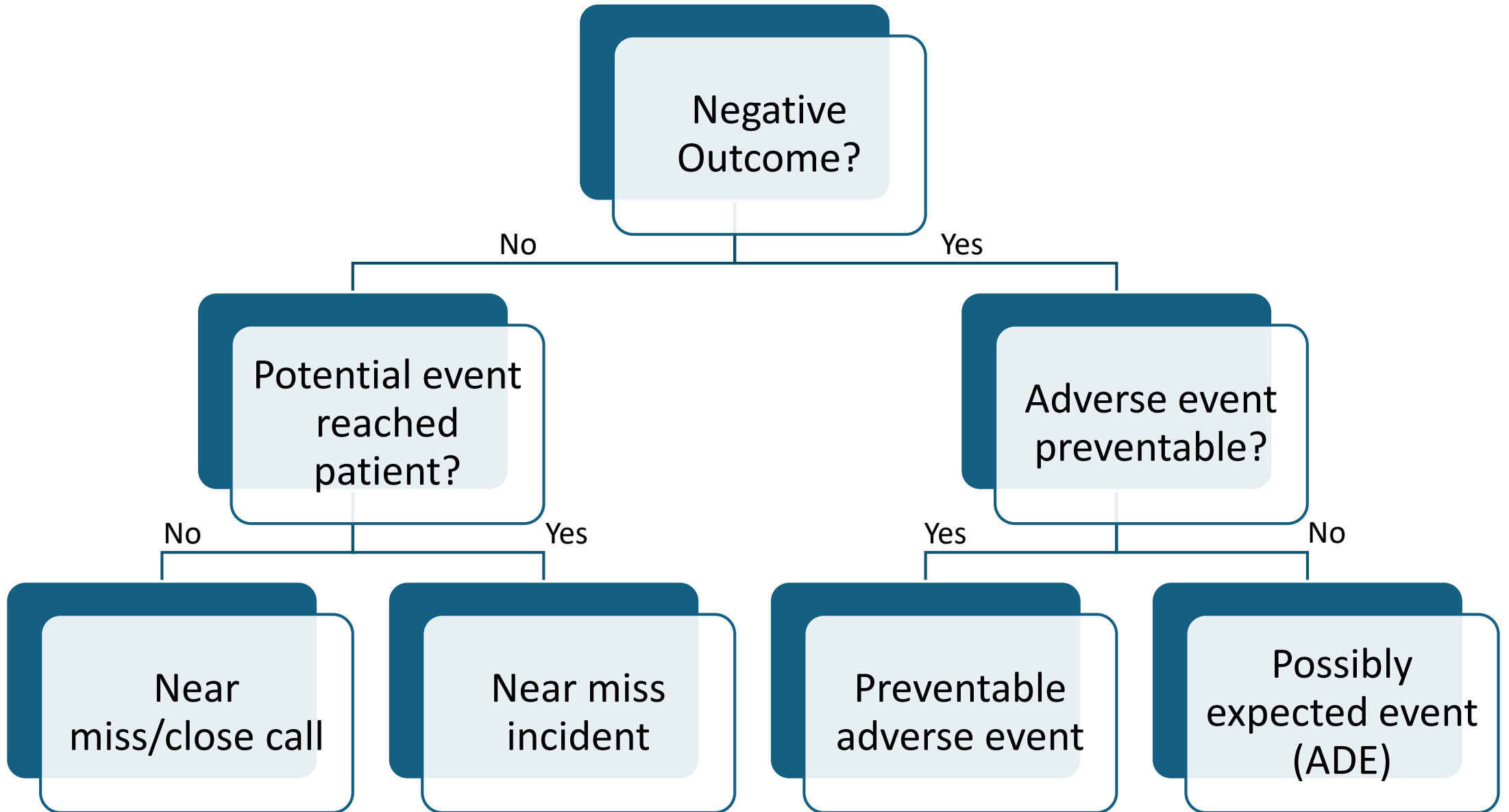




MIND THE GAP

Error

"an act of commission (doing something wrong) or omission (failing to do the right thing) leading to an undesirable outcome or significant potential for such an outcome."



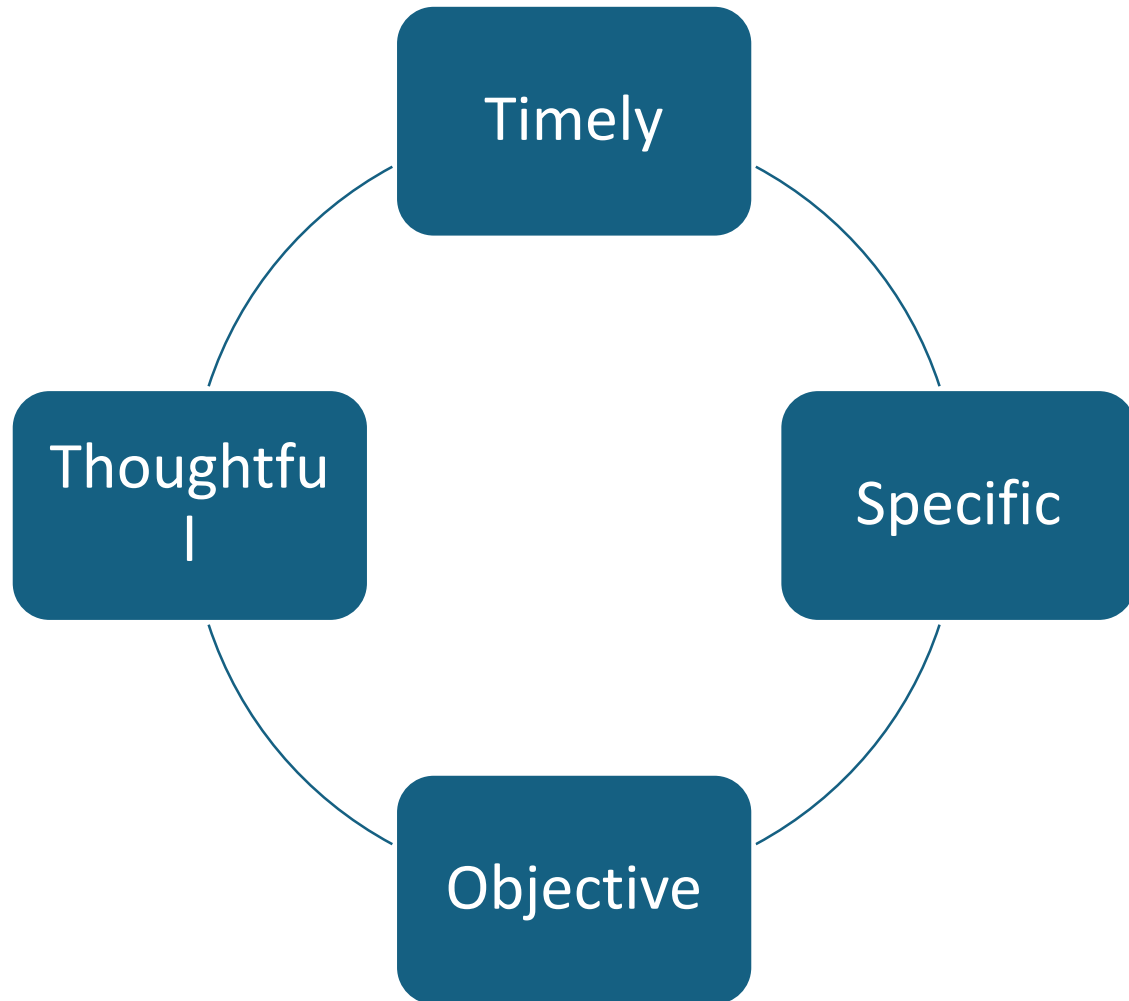
Who Should Report?


- Anyone involved!
- Multiple reports can be helpful
- Different perspectives



 Medical
Team

Logistics of Reporting



New Form | Login | 

NHS Somerset Integrated Care Board (ICB) Incident Report Form

The ICB actively encourages reporting of incidents affecting quality and safety. Our aim is to be a learning organisation and engender an open and fair culture. If you experience any problems reporting an incident please do not hesitate to contact the Patient Safety Team at somccg.datix@nhs.net or 01935 381965

Essential Incident Information

★ Are there any documents to be attached to this record?

For example emails, letters, forms that relate to your incident

Whistleblowing

Is this incident related to Whistleblowing? Please provide as much information in the investigation section to enable us to investigate.

Whistleblowing

Incident details

★ Incident date (dd/MM/yyyy)

Service

★ Unit

This is the service provider who is responsible for the incident.

Specialty

Please select the most appropriate option as listed.

Location

A word cloud graphic with the word "RESOURCES" in large, white, 3D block letters in the center. The background is a cluster of various colored squares (blue, green, yellow, orange, pink, purple) and dashed lines of the same colors, creating a dynamic, network-like pattern.

RESOURCES

Patient Safety
Managers

Quality Dept.

Online
Modules/
Training

Why?

Improved
Patient Safety

Healthcare
Team Leader

Unique
Perspective

Opportunity
for
Scholarship

A woman with dark, curly hair and a white t-shirt is shown from the chest up. She has a questioning or shrugging expression on her face, with her eyebrows slightly raised and her mouth open. Her hands are held out to the sides, palms up, in a shrugging gesture. The background is a solid, muted yellow color.

So why don't we do it?

Table 2 Theoretical framework of factors determining incident reporting

Category	Descriptions
Organisational	Organisational factors that may act as a barrier or facilitator of incident reporting.
Work environment	Features of the work environment that include level of safety, workload, and team dynamics.
Process and systems of reporting	Any characteristics of the reporting process, including the complexity of the process and the availability of reporting systems.
Team factors	Any factor related to the team that may influence incident reporting behaviour, for example, team cohesion, team size, and team composition.
Knowledge and skills	The acquisition of knowledge and skills necessary for incident reporting, including the ability to identify incidents, report incidents, and follow up on incidents.
Individual HCP characteristics	Characteristic of the individual healthcare professional (HCP) that may influence incident reporting behaviour, including seniority, personality, and attitudes.
Professional ethics	The accepted standards of conduct for healthcare professionals, which may influence incident reporting behaviour. For example, the principle of transparency.
Fear of adverse consequences	Any unpleasant or undesirable consequences that may result from incident reporting, which may influence the likelihood of reporting. Examples include fear of blame, fear of retribution, and fear of loss of status.
Incident characteristics	Characteristic of the incident itself that may influence incident reporting behaviour, including the severity of the incident, the level of harm, and the likelihood of detection.

HCP, healthcare professional.

Category

Organisational

Work environment

Process and systems of reporting

Team factors

Knowledge and skills

Individual HCP characteristics

Professional ethics

Fear of adverse consequences

Incident characteristics

HCP, healthcare professional.

assesses any organisational factor which may act as a barrier or facilitator of incident reporting and organisational culture.

incident reporting. Examples of such factors

include the process of incident reporting. This includes the complexity of the reporting process (eg, paper based or electronic).

Team factors influence incident reporting behaviour. For example, team cohesion and communication.

Knowledge and skills. This includes participation in specific (eg, simulation) educational activities.

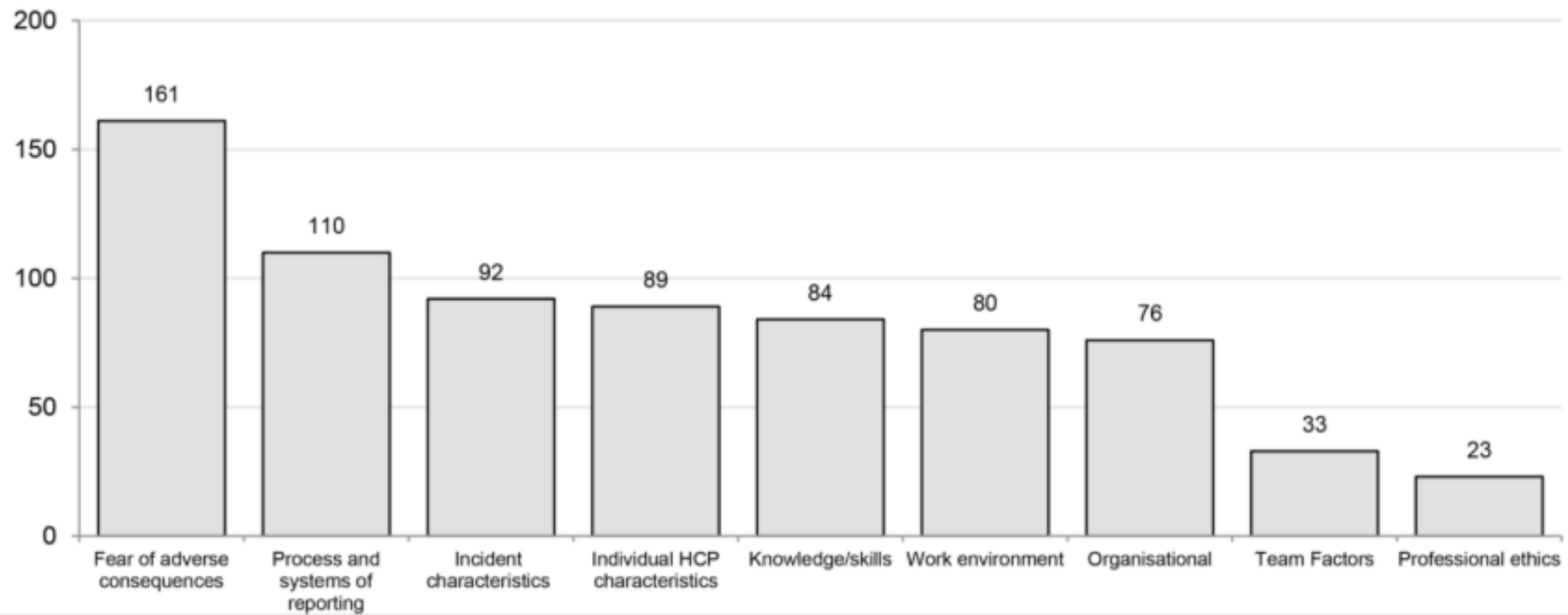
Individual HCP characteristics. Examples of such factors include

seniority, personality, and attitudes. Principles that promote incident reporting. For

example, the principle of transparency influences HCPs' incident reporting behaviour. A reduction in fear of adverse consequences leads to increased incident reporting participation.

Incident characteristics. These include frequency of error, level

Barriers to Reporting



Overcoming Barriers—Process/Systems

- Take the initiative!
 - Familiarize yourself with your local reporting system
- What changes could improve that process?
 - Is it tied to the EMR?
 - Paper or electronic?
 - Confidential option?
 - Simplified forms?
- Share resources with colleagues/trainees

Overcoming Barriers—Knowledge/Skills

- Take any training available (VA, for example, has a module on their TMS training site)
- Get in touch with patient safety or quality dept humans
- Share helpful resources with new faculty, new residents, and other team members

Reporting Examples

- SCDs not placed
- Double ordered medications
- Abx from OSH being re-dosed
- Missed medications
- Labs drawn on the wrong patient
- Labs not resulted due to error
- EMR not flagging critical values

Overcoming Barriers—Incident characteristics

- Focus on near miss/close calls
 - Be purposeful in thinking about mistakes that are brought up by team members
- Consider reporting an event if you think your perspective would add to the conversation or unclear if others will report
- Open communication with other team members about event reporting

Overcoming Barriers—Organizational/Fear

- Culture of safety—non-punitive reporting
- Confidentiality
- Feedback on submitted reports
 - Can sometimes request feedback, need to put contact info
 - Advocate for feedback or get involved as a reviewer
- Attend patient safety forums that work towards building institutional culture of safety

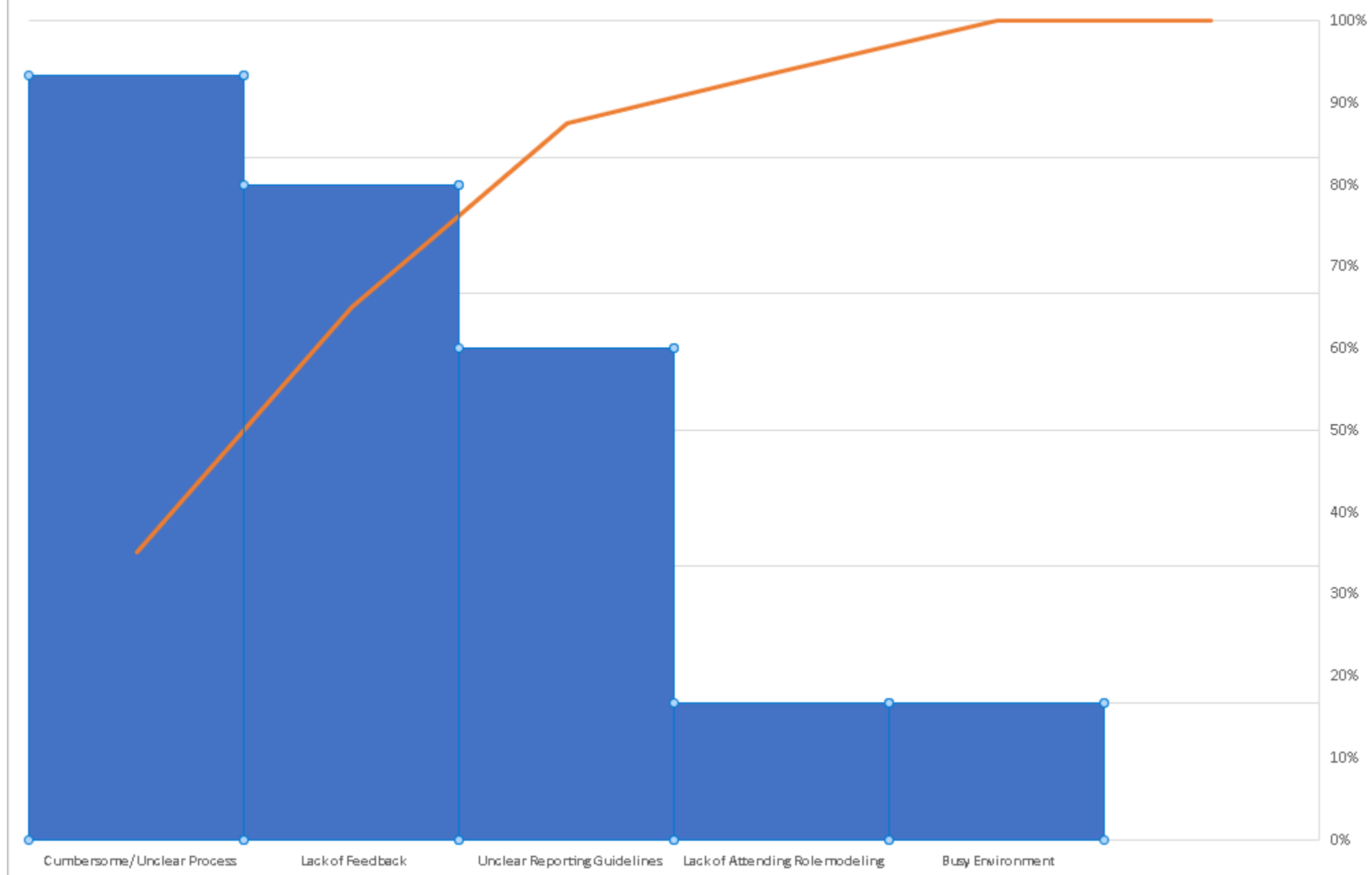
Overcoming Barriers—Work Environment/Team Factors

- Communicate openly with your teams about patient safety events
- Familiarize yourself with the process to reduce effort of time for reporting
- Kindly delegate reporting if appropriate

One Approach—Our Local Project

- Goal: Improve the number of physician-submitted patient safety reports
- Team: Hospital Medicine Track residents, chief medicine resident, hospitalist faculty, several ad-hoc contributors
- Methods: Identify local barriers and develop interventions to target these barriers and employ via PDSA cycles (small cycles of change)

Barriers to JPSR Submission by Physicians at the Lexington VAMC



Interventions

- "How-to" flyers
- Annual noon conference lecture on error reporting
- Monthly trainee trainings
- Quarterly patient safety report feedback sessions
- Staff physician role-modeling—PS rounds and discussions

What We Found

- Results: Exceeded goal and more than doubled the reports submitted by physicians during our study period
- Learned that awareness and reinforcement were likely big contributors to increasing reporting
- Sustainability is difficult but repetition and check-ins can help

A photograph of a small, clear stream flowing through a dense forest. The water is captured with a long exposure, creating a soft, white, cascading effect as it flows over several large, dark rocks. These rocks are heavily covered in vibrant green moss. The surrounding forest floor is also lush with various types of green ferns and other foliage. The lighting is soft and diffused, typical of a forest interior, highlighting the textures of the moss and the movement of the water.

Current Landscape

Current Landscape

Direct Care

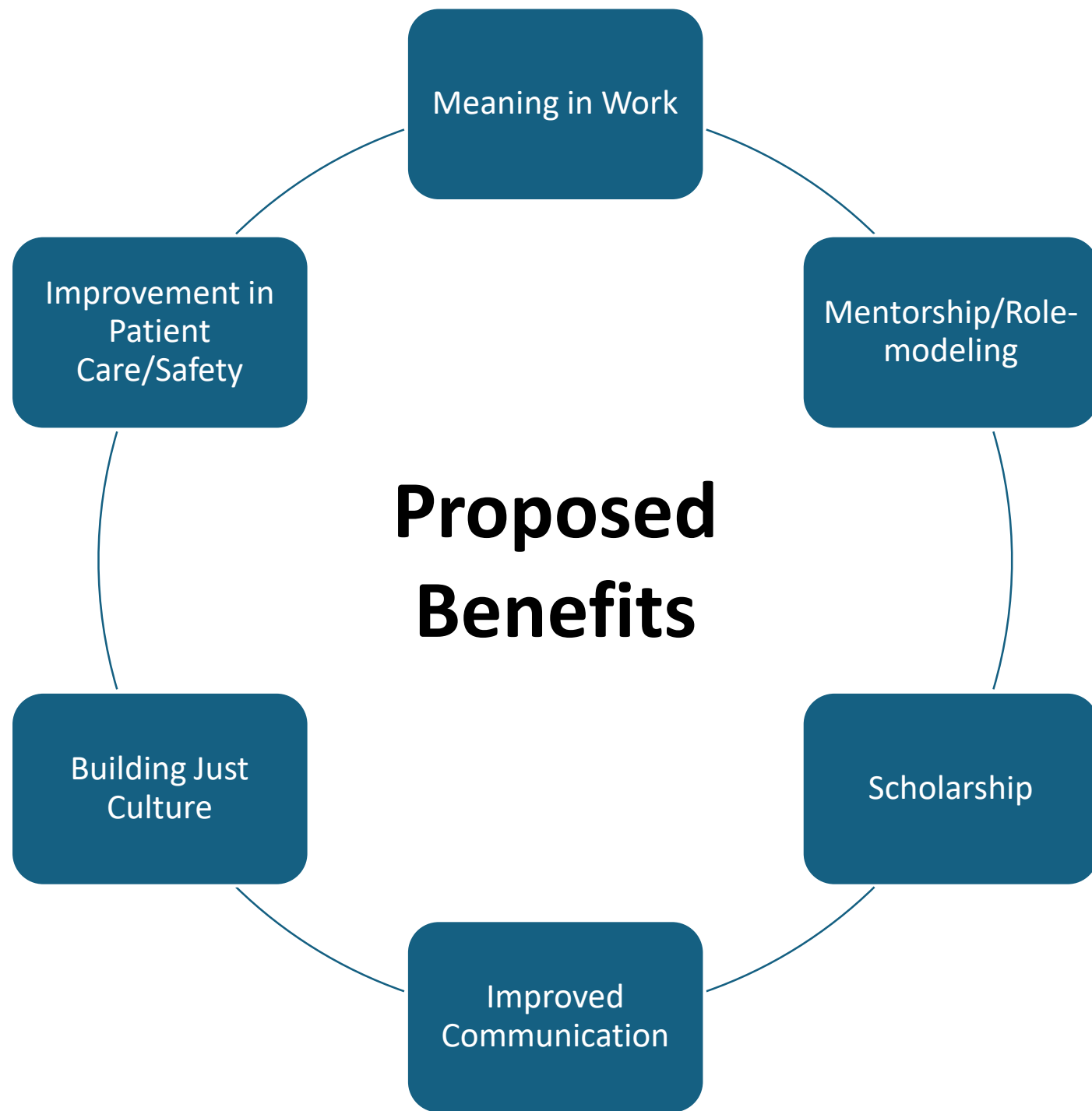
Teaching
Teams

Co-Mgmt
Teams

Multi-Level
Provider
Teams

Admin &
Other Roles





Direct Care

- Adjust your approach to workflow
 - Create an extra checkbox on your daily tasks to review any potential safety events
 - Delegate if appropriate
- Patient Safety Rounds
 - Utilize times with interdisciplinary team members! (while being respectful of their time)
- Open dialogue with other team members—RNs, RTs, pharmacy
- Get involved with committees or report review

Teaching Rounds

- Expectations sheets
- Patient Safety Rounds
 - Build in time to discuss events during rounds or while "running the list"
- Open dialogue with other team members—RNs, RTs, pharmacy
- Incorporate Patient Safety as a teaching topic
 - Diversity in what you are teaching teams
 - Demonstrates your engagement with this topic

Differentiate Error Types

- Near misses/close calls
- Adverse events
 - Never events
 - Sentinel events



Identify Barriers

- Knowledge/skills
- Work environment/team factors
- Fear of adverse consequences
- Organizational culture
- Process and systems of reporting
- Characteristics of the incident and reporter



Physician/APP Engagement

- Unique perspective
- Team Leaders
- Opportunities



Call to Action!

- Patient Safety Rounds
- Critical evaluation of work-arounds and mistakes
- Updating expectations sheets/work flow
- Open communication
- Get involved!



Take Home Points

- Patient safety is patient care!
- Actively think about small mistakes/errors or work-arounds
 - These are often opportunities for reporting and possible change!
- Encourage open communication about patient safety between all care team members
- Evaluate your process and find 1-2 things you can do to incorporate more patient safety discussions or reporting in your practice
- You are a leader and have a unique perspective! Empower yourself to create a safer system for our patients!

Acknowledgements

- UK Hospital Medicine Track Faculty (Sarah Vick, Romil Chadha, Sean Lockwood, Pete Wallenhorst) and residents!
- VHA National Center for Patient Safety's Chief Resident Quality & Safety Program
- Lexington VA Patient Safety Managers—Amanda Borchers and Kevin Veatch
- Dr. Patricia Santos

References

- Aljabari S, Kadhim Z. Common Barriers to Reporting Medical Errors. The Scientific World Journal 2021;2021. doi:10.1155/2021/6494889.
- Archer S, Hull L, Soukup T, et al. Development of a theoretical framework of factors affecting patient safety incident reporting: a theoretical review of the literature. BMJ Open 2017;7:e017155. doi:10.1136/bmjopen-2017-017155.
- Herchline D, Rojas C, Shah AA, Fairchild V, Mehta S, Hart J. A Quality Improvement Initiative to Improve Patient Safety Event Reporting by Residents. Pediatr Qual Saf 2022;7:e519. doi:10.1097/pq9.0000000000000519.
- Jager C, Mohr G, Gokclmen K, et al. Critical incident reporting over time: a retrospective, descriptive analysis of 5493 cases. Swiss Med Wkly 2021;151:w30098. doi:10.4414/SMW.2021.w30098.
- Logio L, Ramanujam R. Medical Trainees' Formal and Informal Incident Reporting Across a Five-Hospital Academic Medical Center. The Joint Commission Journal on Quality and Patient Safety 2010;36(1): 36-42.
- Mahajan, R. Critical Incident Reporting and Learning. British Journal of Anaesthesia 2010;105(1):69-75. doi:10.1093/bja/aeq133.
- Mukherjee S, Roy S, Era N. Safety incident reporting and barriers (SIRaB) study: Strategies and approaches for investigating patient safety events in a hospital set-up. J Eval Clin Prac 2024;30:651-659. doi:10.1111/jep.13990.
- Stewart D, Junn J, Adams M, et al. House Staff Participation in Patient Safety Reporting: Identification of Predominant Barriers and Implementation of a Pilot Program. Southern Medical Journal 2016;109(7):395-400. doi:10.14423/SMJ.0000000000000486
- Turner D, Milne J, Bae J, et al. Improving Resident and Fellow Engagement in Patient Safety Through a Graduate Medical Education Incentive Program. J of Grad Med Educ 2018;10(6):671-675. Doi:10.4300/JGME-D-18-00281.1.

