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**

Why should you care?

Jonathan Barko, pre-residency


33

Est. 1990

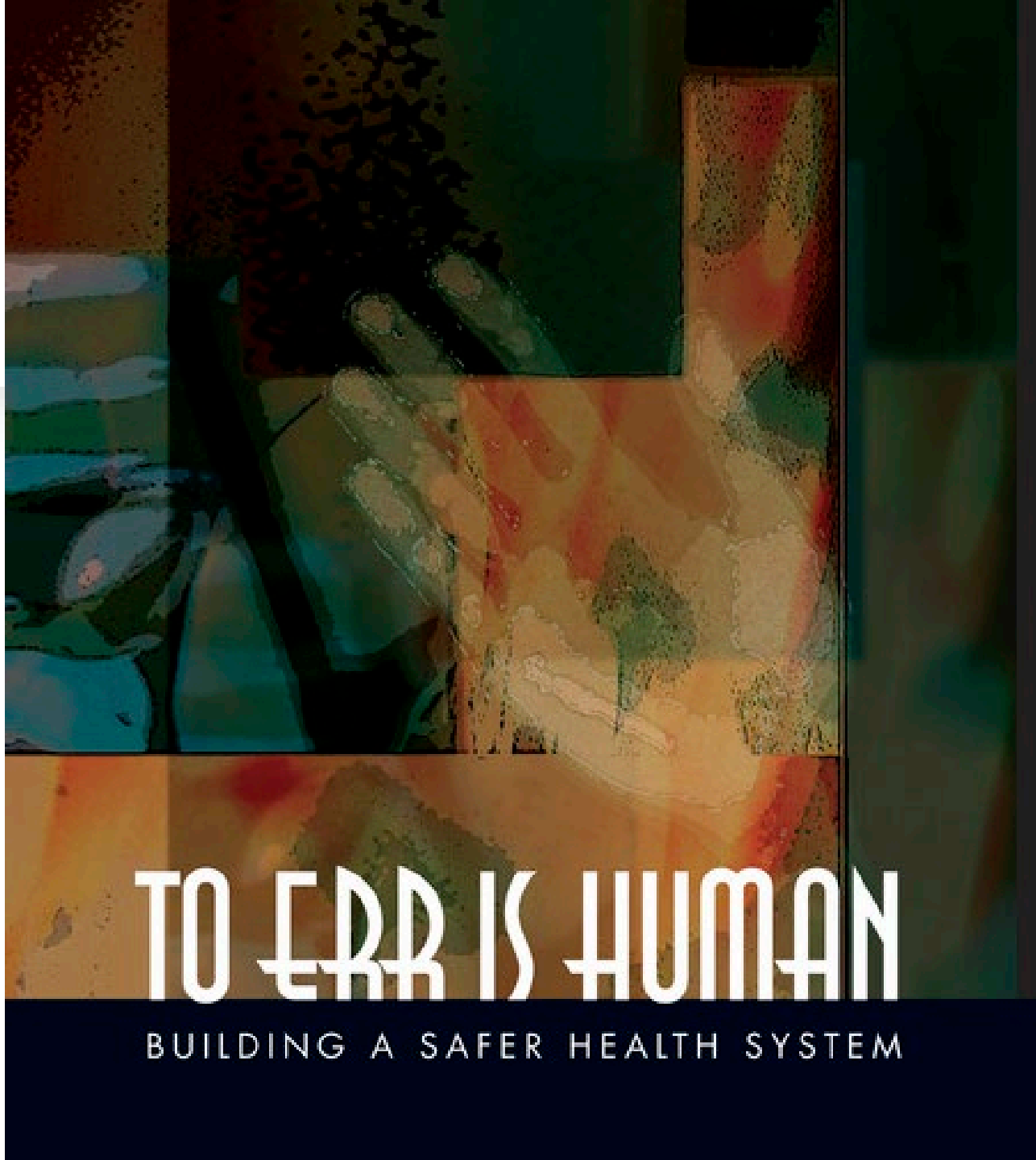

TAMAGOTCHI

AMERICA Online

Connected!

1999

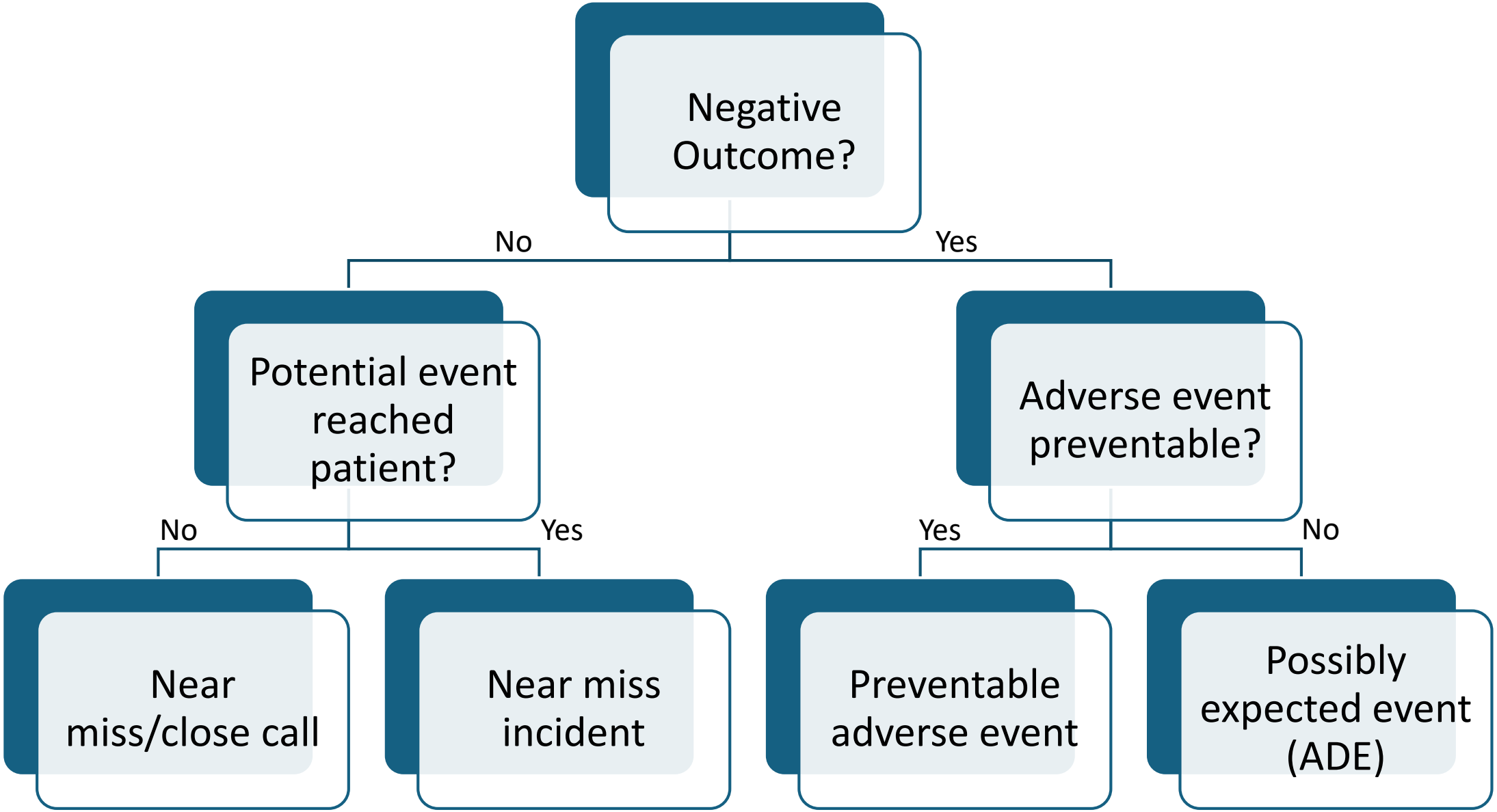
- Medical errors are:
  - Common
  - Costly
  - Often preventable
  - Fault of the system, not the individual
  - Can have devastating effects on patients




MIND THE GAP

Error

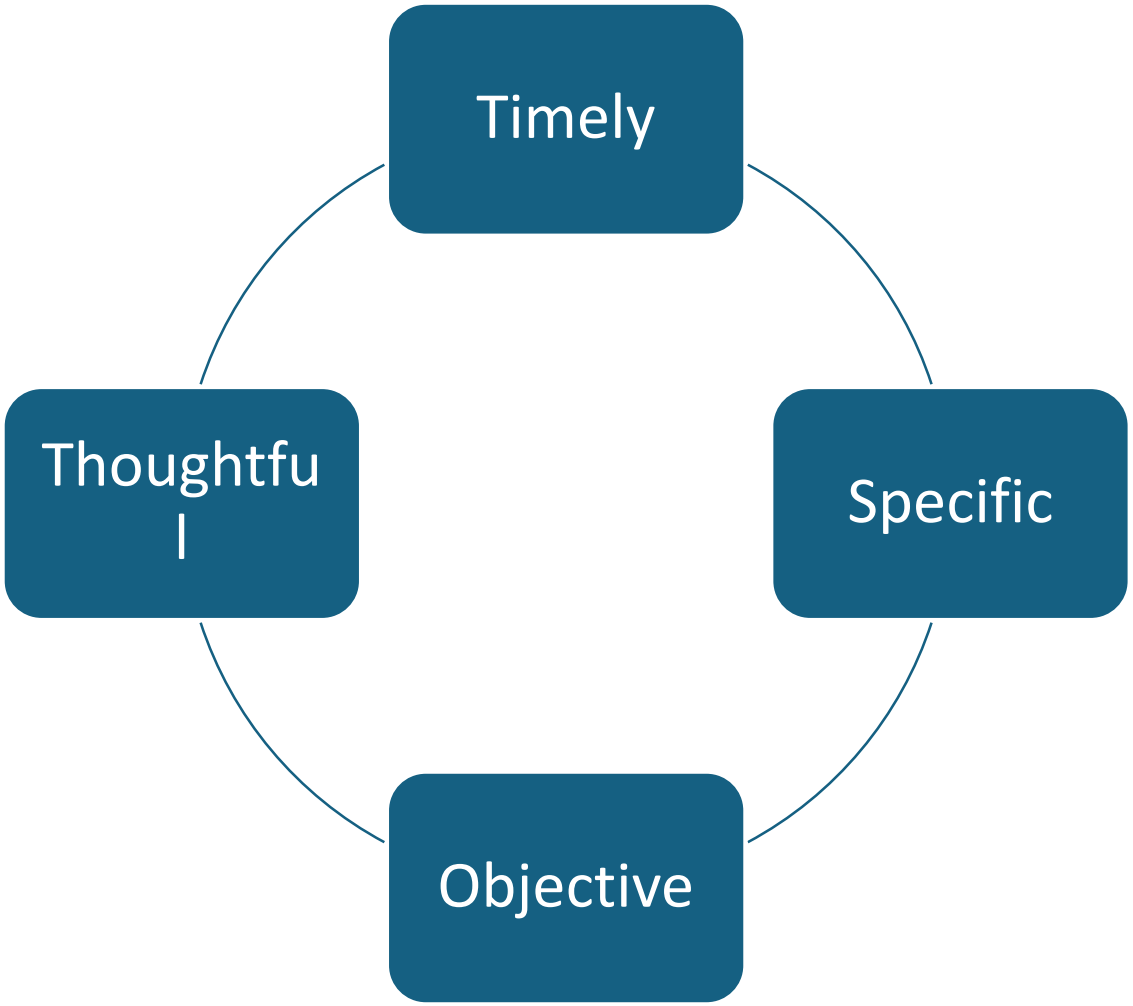
"an act of commission (doing something wrong) or omission (failing to do the right thing) leading to an undesirable outcome or significant potential for such an outcome."


Negative Outcome?
No
Yes
Potential event reached patient?
Adverse event preventable?
No
Yes
Yes
No
Near miss/close call
Near miss incident
Preventable adverse event
Possibly expected event (ADE)

Who Should Report?

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

Logistics of Reporting



Patient Safety Managers

Quality Dept.

Online Modules/ Training

Why?

Improved Patient Safety

Healthcare Team Leader

Unique Perspective

Opportunity for Scholarship


So why don't we do it?

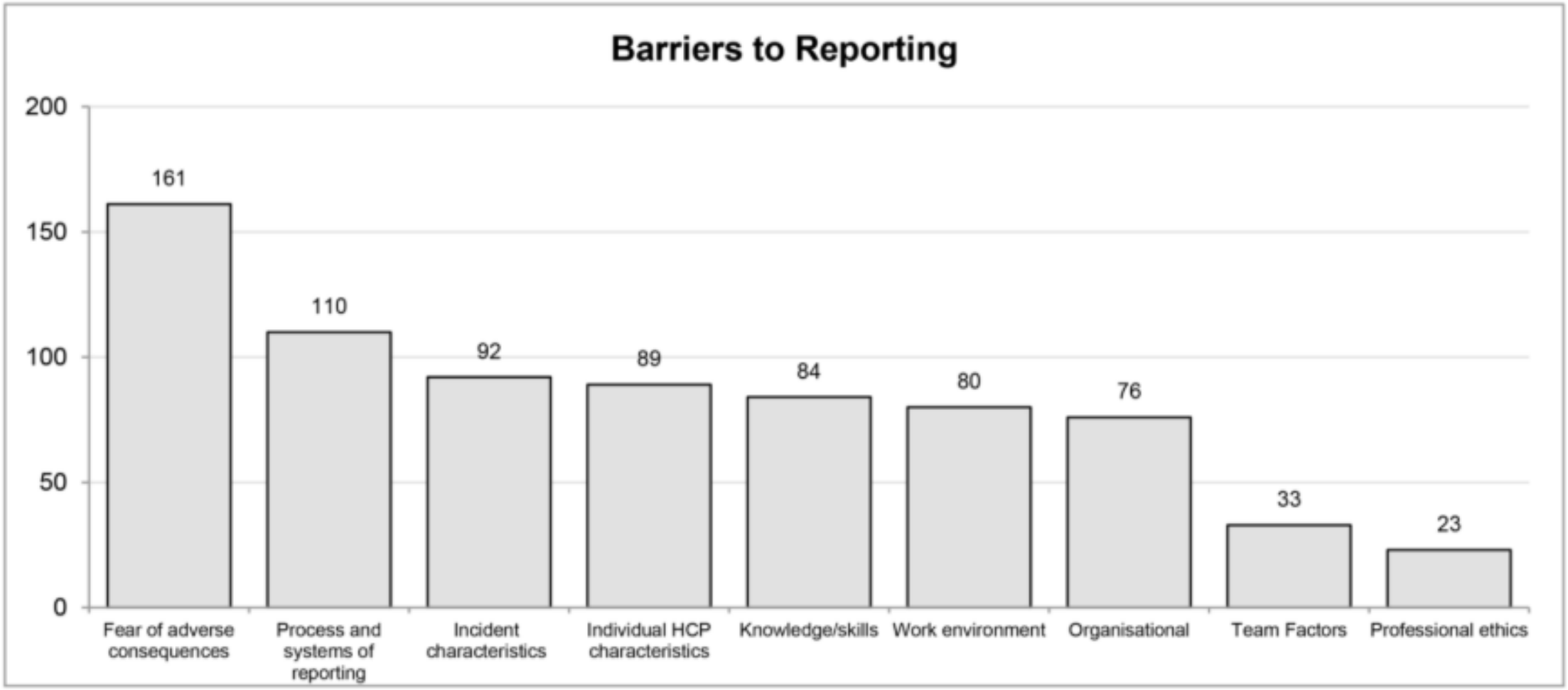
Table 2 Theoretical framework of factors determ

Category	Descriptions
Organisational	Organisationa as a barrier or
Work environment	Features of th include level c
Process and systems of reporting	Any character complexity of
Team factors	Any factor rela example, supp
Knowledge and skills	The acquisitio form completi
Individual HCP characteristics	Characteristic seniority, pers
Professional ethics	The accepted example, the
Fear of adverse consequences	Any unpleasa in the likelihoo
Incident characteristics	Characteristic of harm and t

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.


Barriers to Reporting
200
150
100
50
0
161
110
92
89
84
80
76
33
23
Fear of adverse consequences
Process and systems of reporting
Incident characteristics
Individual HCP characteristics
Knowledge/skills
Work environment
Organisational
Team Factors
Professional ethics

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

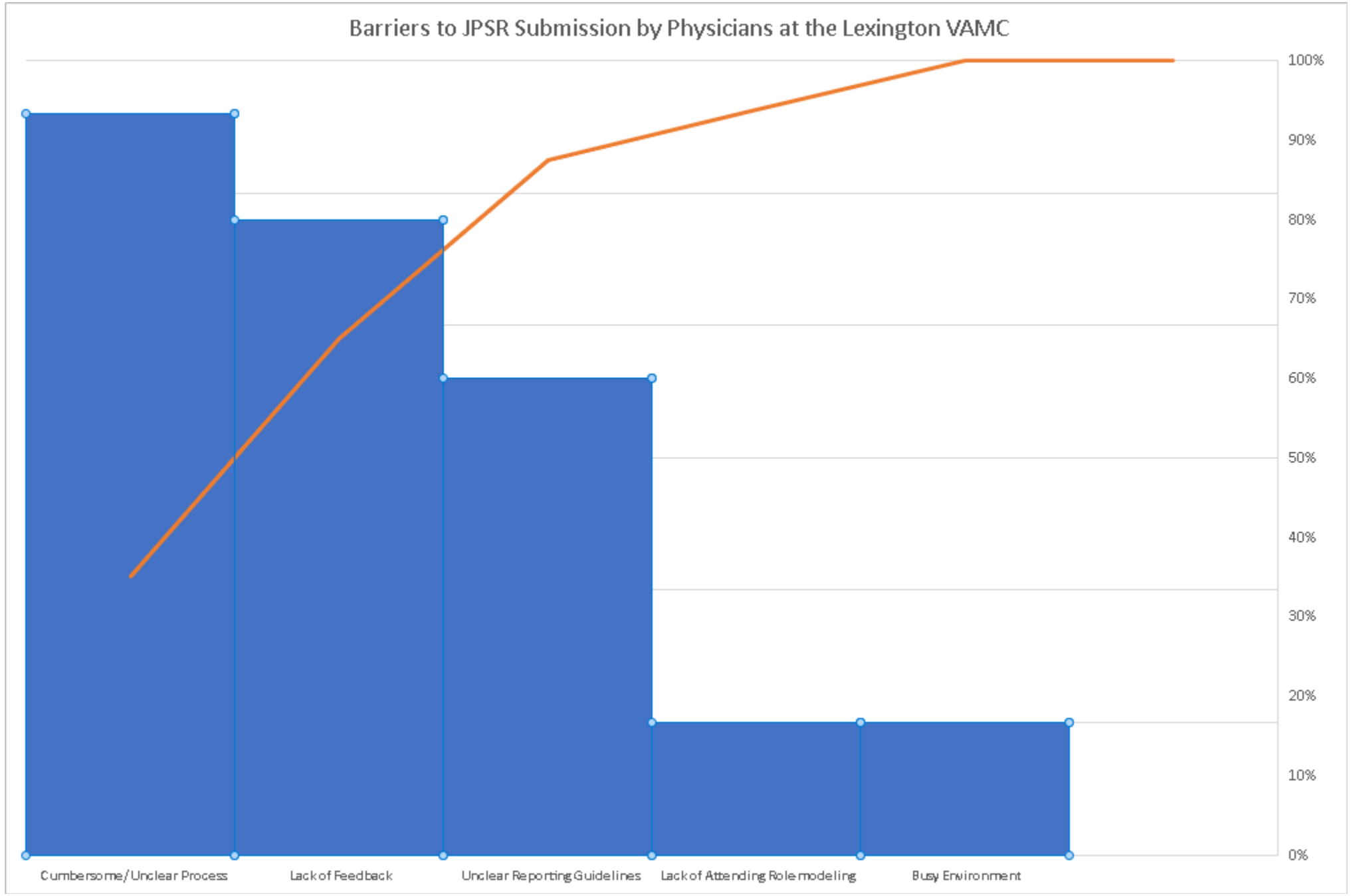
- Culture of safety—non-punitive reporting
- Confidentiality
- Feedback on submitted reports
  - Can sometimes request feedback, need to put contact info
  - Advocate for feedback or get involved as a reviewer
- Attend patient safety forums that work towards building institutional culture of safety

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
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Cumbersome/Unclear Process
Lack of Feedback
Unclear Reporting Guidelines
Lack of Attending Role modeling
Busy Environment

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


Current Landscape

Current Landscape

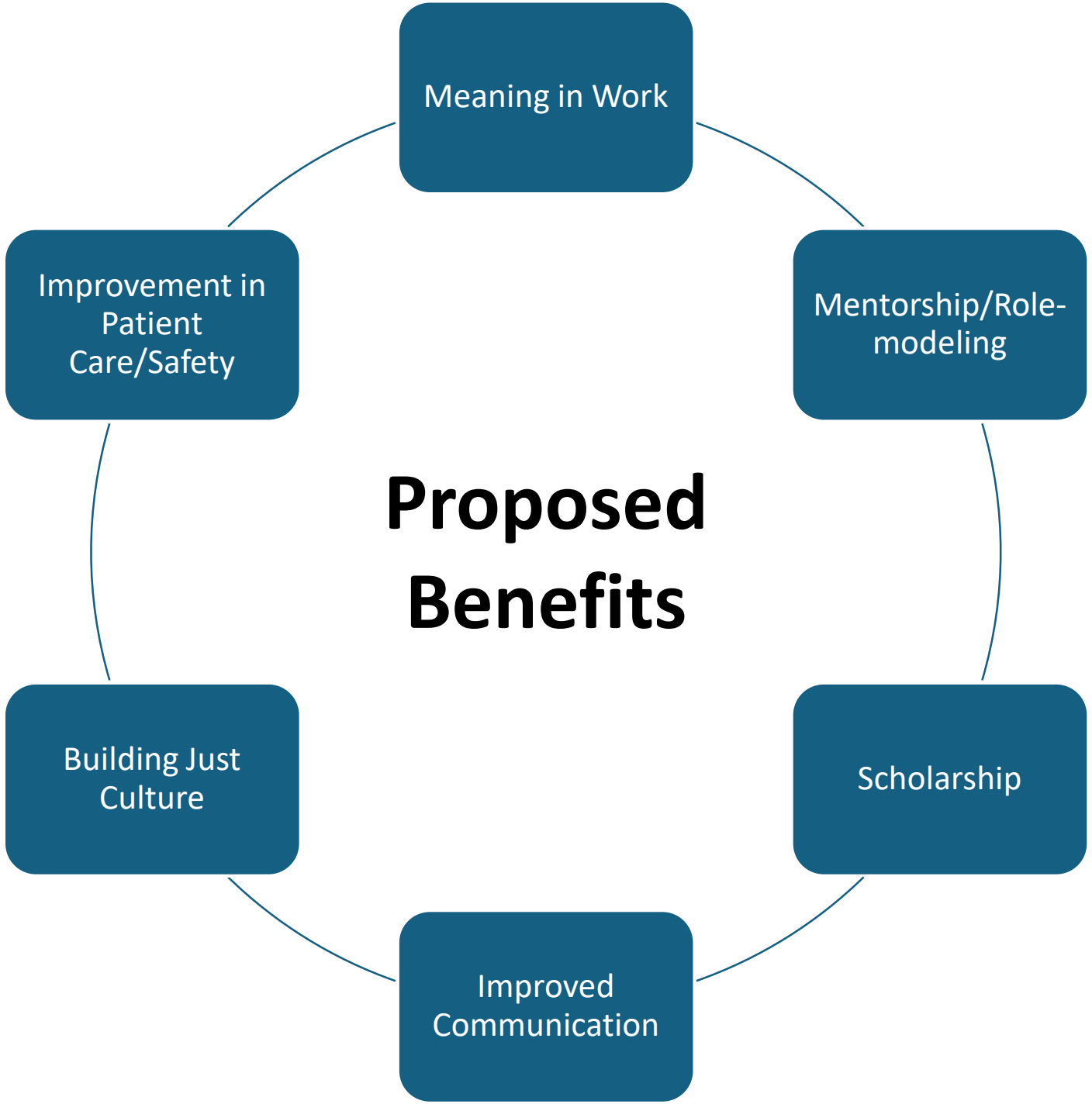
Direct Care

Teaching Teams

Co-Mgmt Teams

Multi-Level Provider Teams

Admin & Other Roles


Meaning in Work
Mentorship/Role-modeling
Scholarship
Improved Communication
Building Just Culture
Improvement in Patient Care/Safety
Proposed Benefits

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.