INSTITUTE FOR HEALTHCARE IMPROVEMENT

Clinical Safety and Effectiveness
Session: 5

CENTER FOR PATIENT SAFETY & HEALTH POLICY
UT HEALTH SCIENCE CENTER™
SAN ANTONIO

Educating for Quality Improvement & Patient Safety

Team Members

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What We Are Trying to Accomplish?

OUR AIM STATEMENT

Increase the mean number of variance reports from the 3rd and 6th floor of the CHRISTUS Santa Rosa Children's Hospital by 50% by the end of August 2010.

Goal

- The ultimate goal is to create an environment where the nursing staff feels "safe" in reporting adverse outcomes, errors and near misses. We are striving to promote a "Culture of Safety."

Culture of Safety

A culture of safety implies:

- Acknowledgement of the high-risk, error-prone nature of an organization's activities
- A blame-free environment – a place where staff can report errors and near misses without fear of punishment or reprimand
- Collaboration across the ranks to seek solutions to vulnerabilities
- Organization's willingness to direct resources for addressing safety concerns
  (http://psnet.ahrq.gov/popup_glossary.aspx?name=safety culture)

Background

- One study by Flynn, et. al. compared methods of reporting
  - Direct observation, chart audits and variance reports were compared to determine how medication errors were reported in 2,557 doses administered.
    - 476 errors were reported on direct observations
    - 24 errors were noted during chart audit
    - 1 incident report was filed
    - (Flynn, Barker, Pepper, Bates & Mikeal, 2002)

Background

- Multiple studies have looked at nurses' perceptions of medication error reporting:
  - Nurses in 2 multi-hospital surveys (N=1,300) estimated that only 57% of medication errors were reported (Stratton/Wakefield etal., 1999).
  - Elnitsky, Nichols and Palmer (1997) polled 424 nurses
    - 14% did not believe that variance reports were reliable and valid
    - 14% did not believe that taking time to complete the reports would prevent future occurrences
    - 25% believed that their supervisors would use the variance report against them.

Reasons for Underreporting

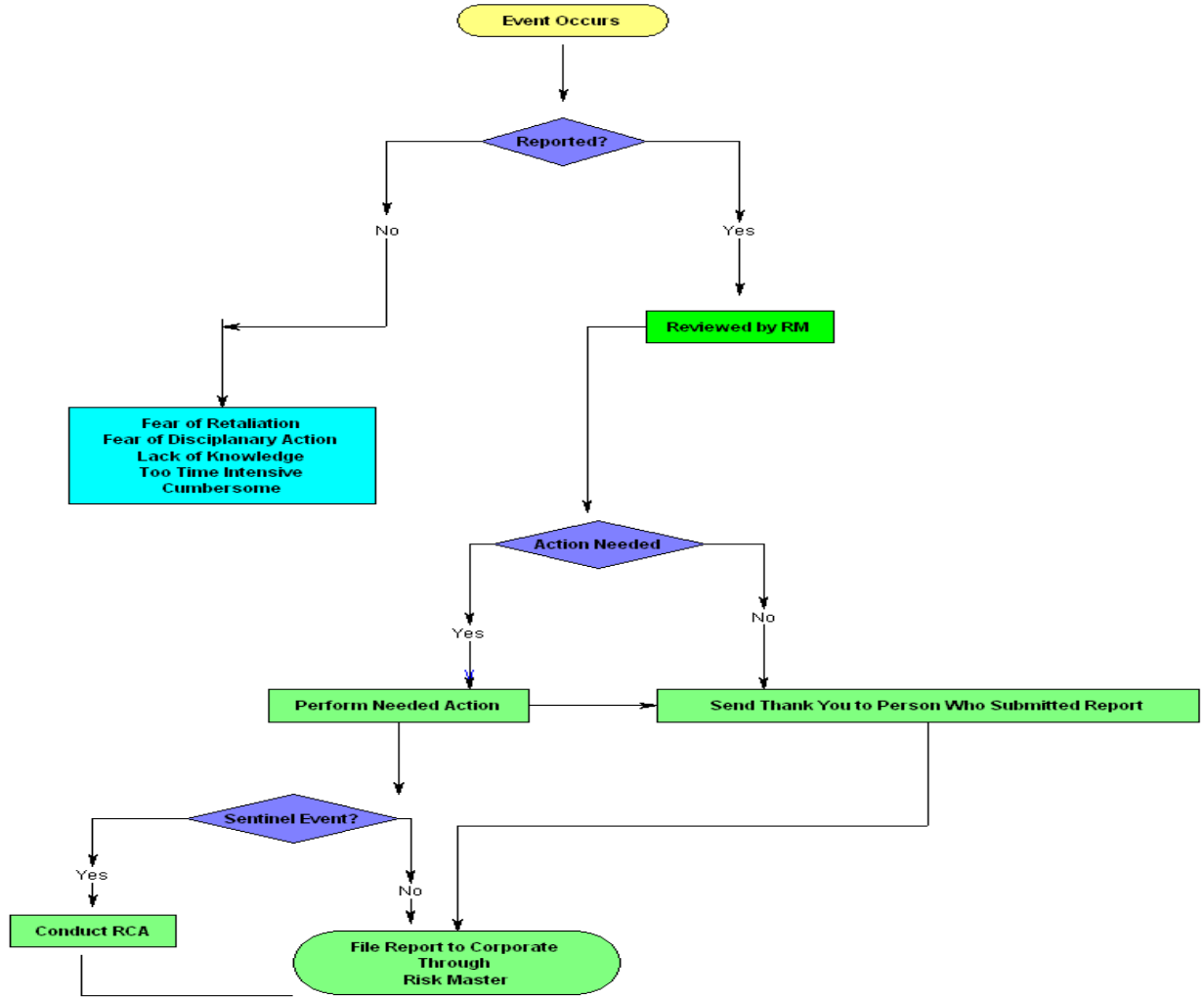
- Unrecognized error
- Error judged to be harmless
- Fear of censure
- System factors discouraged variance reporting
  (Stratton/Wakefield et al., 1996, 1998, 2001)

How Will We Know That a Change is an Improvement?

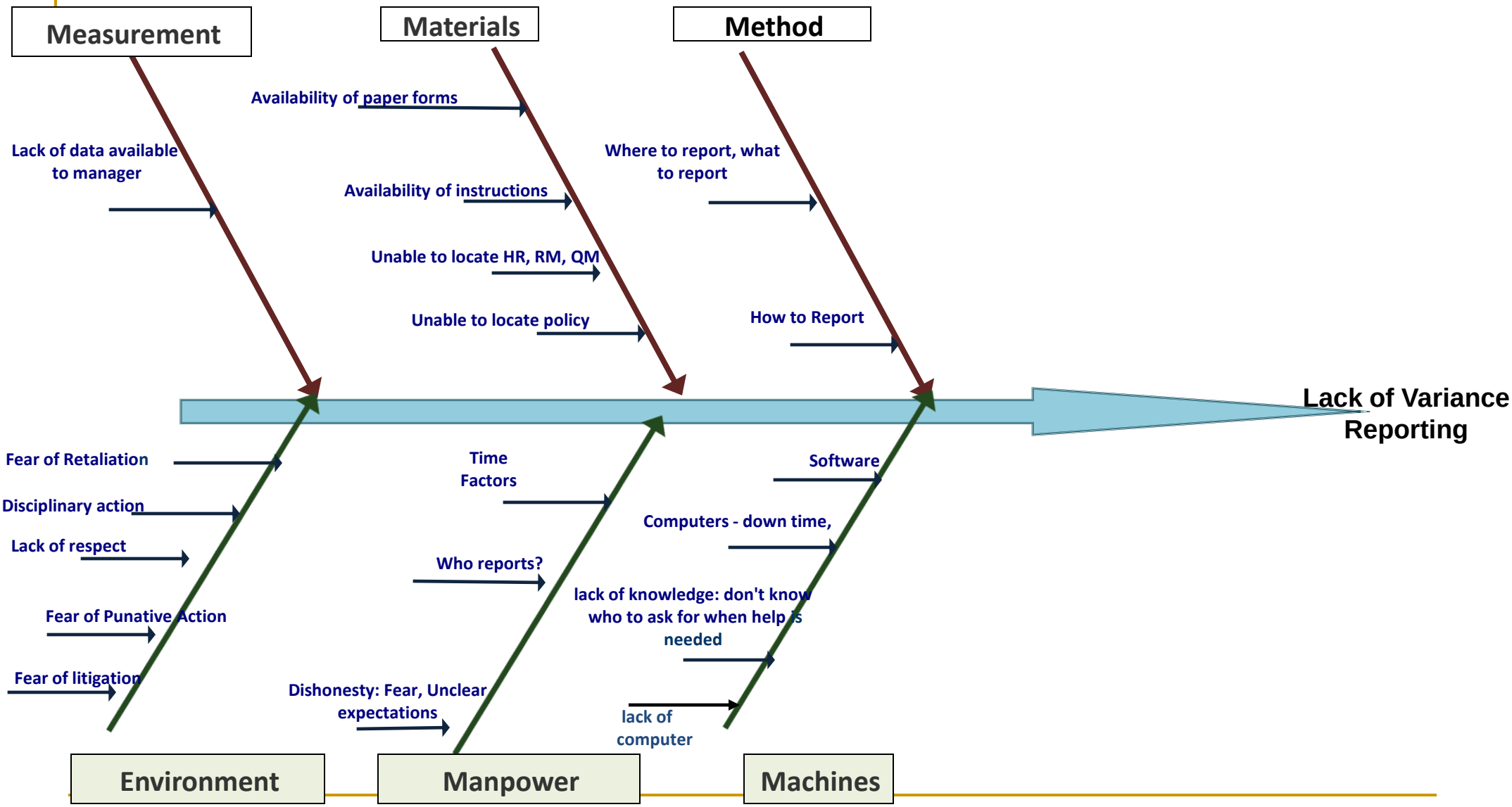
- It is well accepted throughout medicine that improving error and near-miss reporting is beneficial to patients, practitioners, and system-based practices
  - Nothing can be learned from an error that goes unrecognized or unreported
- Promotion of a culture of safety provides a work environment that allows nurses to take responsibility for actions without fear of reprimand
  - Would likely increase job satisfaction

Selected Process Analysis Tools

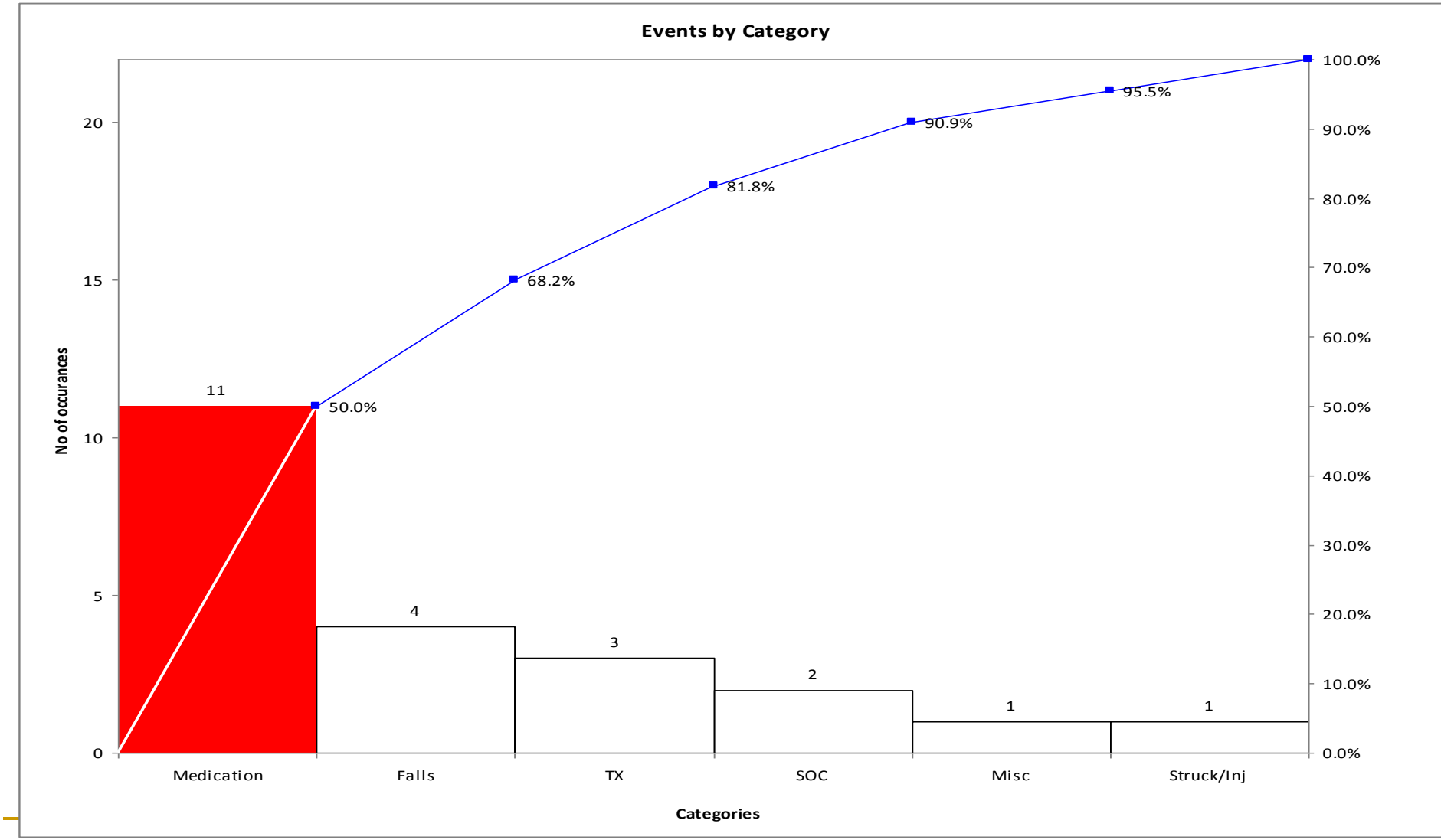
- Flowchart -- allows us to identify the people and processes that contribute to successful variance reporting.
- Fishbone -- allows us to map out the factors that prohibited variance reporting.


Event Occurs
Reported?
No
Yes
Fear of Retaliation
Fear of Disciplanary Action
Lack of Knowledge
Too Time Intensive
Cumbersome
Reviewed by RM
Action Needed
Yes
No
Perform Needed Action
Send Thank You to Person Who Submitted Report
Sentinel Event?
Yes
No
Conduct RCA
File Report to Corporate
Through
Risk Master

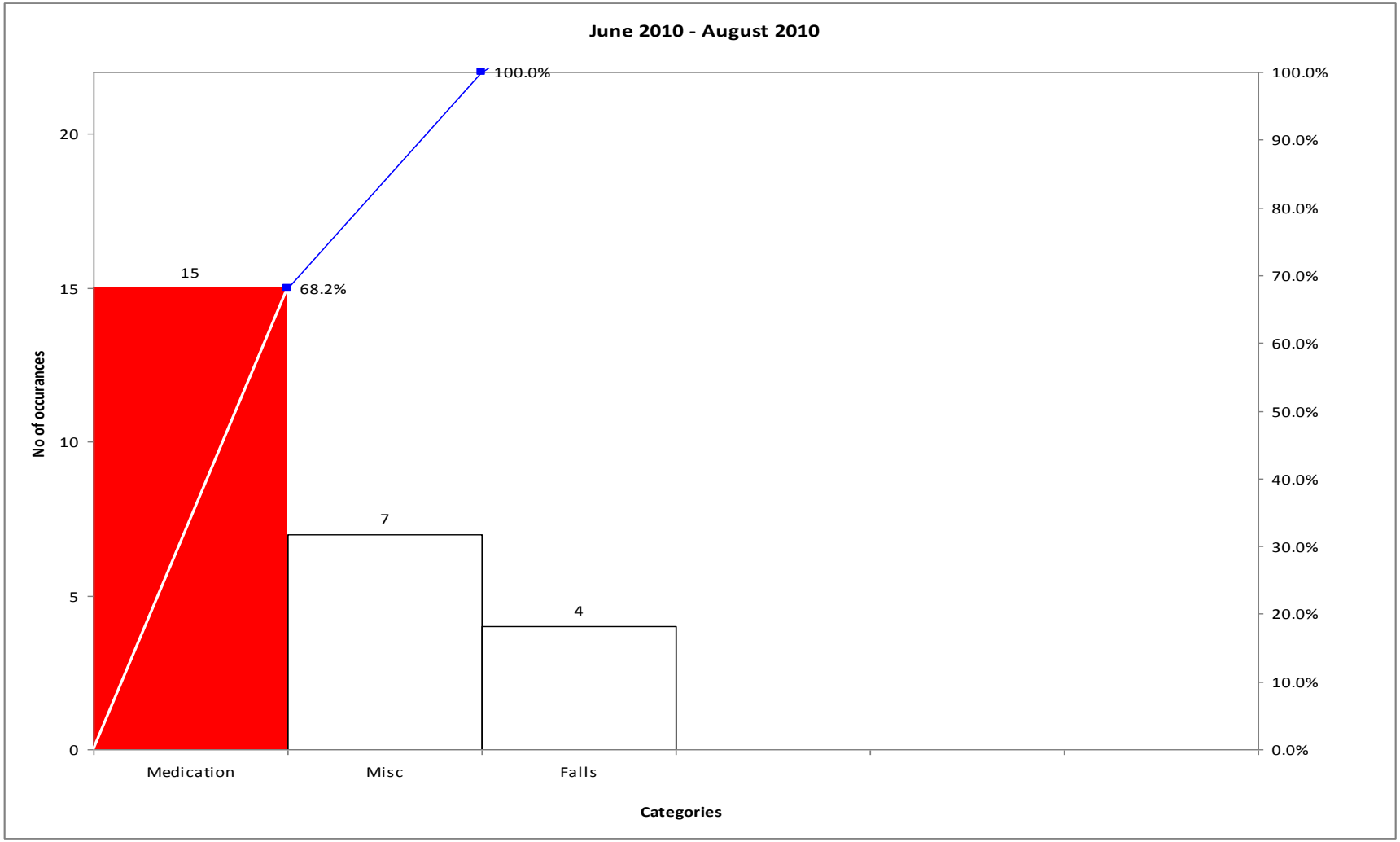
Fishbone Diagram Template: Variance Reporting



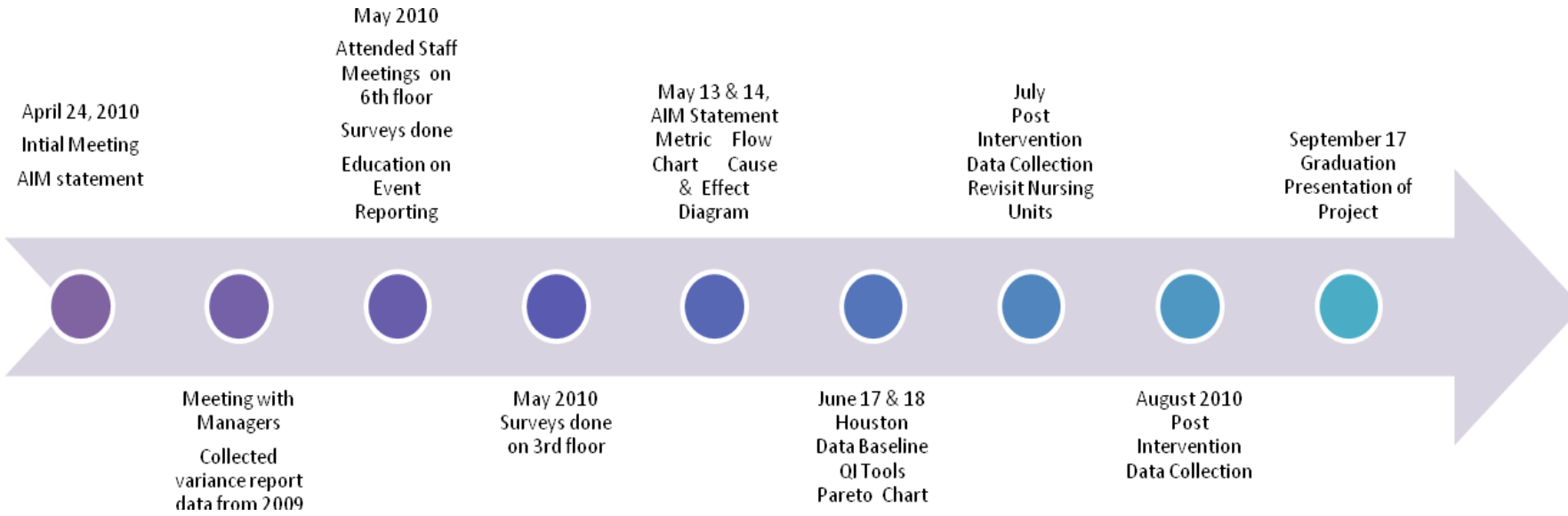
June 2009 - August 2009



June 2010- August 2010



Time Line


April 24, 2010
Intial Meeting
AIM statement
Meeting with Managers
Collected variance report data from 2009
May 2010
Attended Staff Meetings on 6th floor
Surveys done
Education on Event Reporting
May 2010
Surveys done on 3rd floor
May 13 & 14,
AIM Statement
Metric Flow Chart Cause & Effect Diagram
June 17 & 18
Houston
Data Baseline
QI Tools
Pareto Chart
July
Post Intervention Data Collection
Revisit Nursing Units
August 2010
Post Intervention Data Collection
September 17
Graduation
Presentation of Project

Intervention

Plan

- Meet with Nurse Managers
- Survey Associates on 3rd and 6th floors regarding event reporting
- Attend monthly unit council meetings starting in May 2010.
- Create posters educating staff on the need for variance reporting.

Intervention (cont.)

- Share printed screen shots with instructions on how to complete a Meditech Risk Notification
- Review Variance Reporting Policy at unit council meetings
- Obtain and review data for risk reports completed between June 2009 – August 2010
- Send Thank You e-mails to staff when Risk Notification is submitted.
- Reminder flyers posted on each unit during the month of August

Survey

Risk Reporting Survey

Thank you in advance for helping us by completing this survey. The answers are to help us identify why staff report or do not report variances. Please review, complete and return the survey to your manager prior to May 12, 2010.

1. Do you report events?

- □ Yes
- □ No

2. If you do not report events can you chose the reason (s) from the list below or add your reason(s) in the space provided below?

- □ Afraid of retaliation
- □ Afraid of disciplinary action
- □ Do not know what to report
- □ Do not know when to report
- □ Do not know where or how to report
- □ Too cumbersome to complete
- □ Other: _____

Do you feel that you have a responsibility to report adverse outcomes?

- □ Yes
- □ No

4. Do you feel that you have a responsibility to report near misses?

- □ Yes
- □ No

5. What types of events/issues should be reported? Give three examples.

_____

_____

_____

Survey Results

- Twenty one staff nurses responded.
- Twenty of the twenty one stated they reported events.
- Reasons for not reporting:
  - Reporting process was cumbersome
  - Too busy during the shift
- Twenty nurses felt it was their responsibility to report adverse outcomes
- Seventeen nurses felt it was their responsibility to report near misses

Survey Results (cont)

- Issues that Associates felt should be reported:

Falls
Medication errors
Work incidents
Infection
Unsafe practices
Unsafe nursing care
Patient/visitor/employee injury
IV infiltrates
Billing
Bodily fluid exposure

Implementing the Change

Do

- Associate education provided at unit council meetings
- Posters were created and hung on the 3rd and 6th floors of the Children's Hospital
- Continued communication with Nurse Managers
- Thank you e-mails sent to Associates with each completed Risk Notification

Results/Impact

Check

- Reviewed the number of events reported during June- August 2009 and compared the number of events with June – August 2010.
- June – August 2009 there were a total of 16 risk reports generated

Expansion of Our Implementation

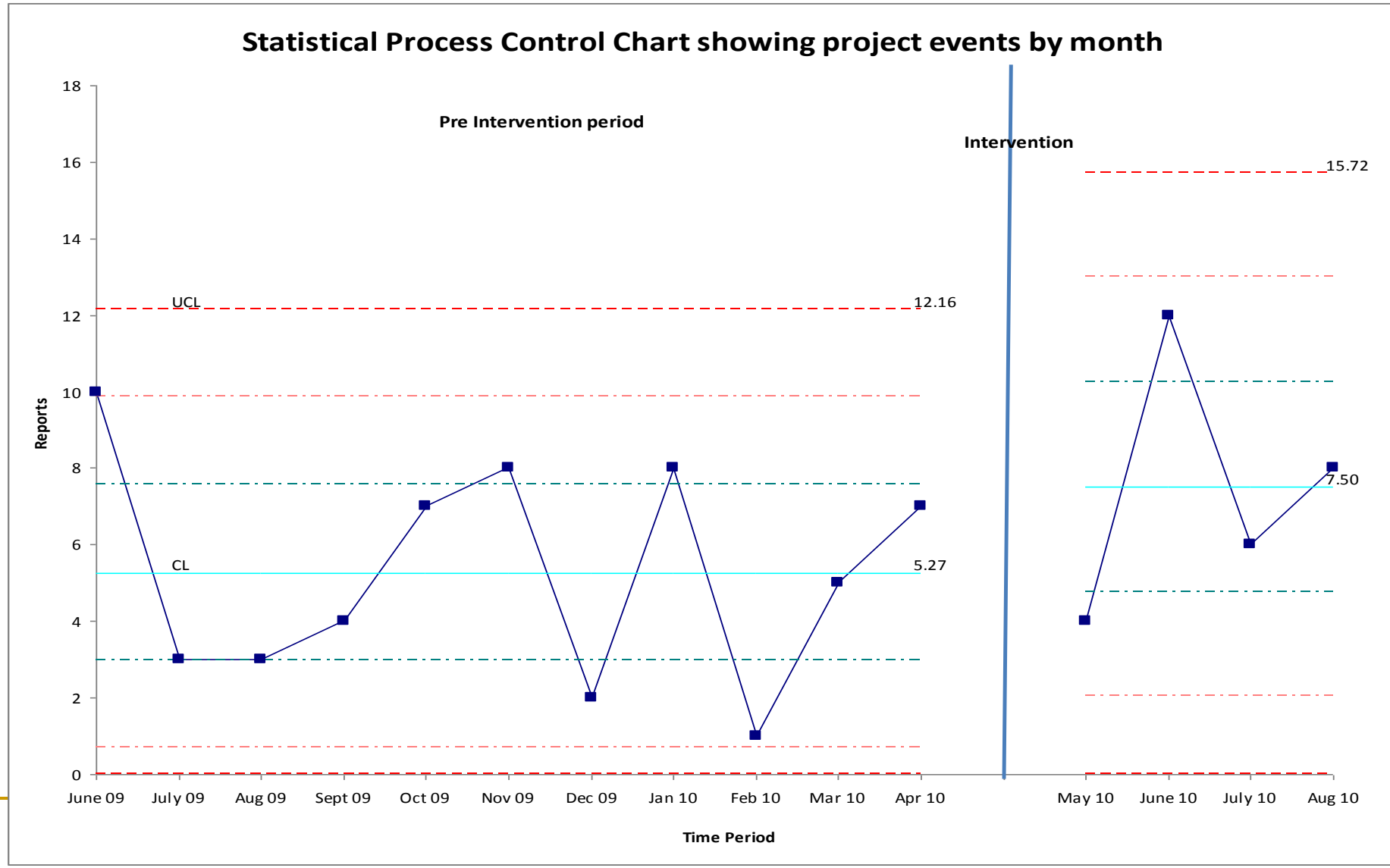
Act

- Continue to track Risk Notifications for 3rd and 6th Floors
- Share Results of the Study with the Directors, PIPS and Senior Leadership of Children's Hospital
- Incorporate plan to include all Nursing Units by educating staff and management.

Return on Investment

- If events are reported within 30 days of event occurrence, this will play into a potential savings of a percentage of 10% of professional liability premium which could result in a cost savings of between $125,000 -$140,000 this year for the organization.

Statistical Process Control Chart



Conclusion

- June – August 2009 vs June – August 2010
  - We increased reporting by 61.5% (from 16 to 26)
- Comparing June 2009 – April 2010 to May-August 2010 shows an increasing trend of reporting post-intervention
  - Mean number of reports made 6/09-4/10 was 5.2 compared to a mean of 7.5 for 5/10-8/10

Conclusion

- Overall we have seen an increase in variance reporting from the nurses on 3rd and 6th floors at The Christus Santa Rosa Children's Hospital
- Culture of Safety
  - Nurses feel more comfortable reporting
  - Nurses are taking responsibility for actions and errors
  - Reporting has been made slightly more user-friendly (Improved system-wide intervention)

Conclusion

- Continuing our interventions should continue to improve rates of variance reporting
- Nurses and physicians can evaluate causes of errors/near-misses and factors that influence their occurrence
  - Both entities can learn from this information
  - System-based practices can be modified
  - Patients and families benefit

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- Jameson P. How Common are Medical Mistakes? http://www.hiltonheadmedctr.com?articles/How-Common-Are-Medical-Mistake-2-html. 2007

- Milch C, Salem, D et al. Voluntary Electronic Reporting of Medical Errors and Adverse Events, An Analysis of 92,547 Reports from 26 Acute Care Hospitals. 2005

- Taylor J, Brownstein D et al. Use of Incident Reports by Physicians and Nurses to Document Medical Errors in Pediatric Patients. http://pediatrics.aapublications.org/cgi/content/abstract/114/3/729

Thank you!

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