There is Safety in Numbers: Overcoming Barriers to Event Reporting

Lisbeth Fahey, MSN, RN
Executive Director, Quality, Safety, Accreditation & Emergency Preparedness

Deborah Freiburg, MS, RN, NE-BC
Director of Medical Nursing

Sonal Kalburgi, DO, MSHS
Division of Hospitalist Medicine

DiAnthia Patrick, BS, PharmD
Medication Safety Coordinator, Division of Pharmacy

Rahul K. Shah, MD, MBA
Vice-President, Chief Quality and Safety Officer

Laura J. Sigman, MD, JD
Emergency Medicine, Legal/Risk Management Departments

We have no financial conflicts to disclose.
This is a project undertaken as a Quality Improvement Initiative at Children's National and it does not constitute human subjects research.
As such it was not under the oversight of the Institutional Review Board.

Objectives

• Address common barriers to safety event reporting
• Develop strategies to apply Just Culture principles in a hospital environment
• Integrate a follow-up process to engage employees so that reporting makes a difference
• Develop ways to improve the usefulness of a reporting system to provide more meaningful information
1870-2016: DC Children’s to Children’s National: from 12 to 313 beds

Evolution of Safety Culture

UNMINDFUL
“We show up, don’t we?” Chronically Complacent

REACTIVE
“Safety is important. We do a lot every time we have an accident”

SYSTEMATIC
Systems being put into place to manage most hazards

PROACTIVE
“We methodically anticipate”—prevent problems before they occur

GENERATIVE
Organizational Culture “Genetically wired” to produce safety

Best Patient Outcomes
Driving Improvement through Corporate Goals

"Advance delivery of safe care by eliminating serious preventable harm: Develop system-wide habit and custom around preoccupation with defects".

Aim: double safety event and good catch reporting


- FY14: 4668, 25%
- FY15: 5814, 22%
- FY16: 7105, 31%
- FY17: 9336
The Team Driving Change: Safety In Numbers Committee (SiNC)
Goal: Materially improve reporting culture as measured by success with Technology, Safe to Report, and Making a Difference

Acknowledgements
We would like to recognize members of the Safety in Numbers Committee, especially the contributions of:

• Ahmed Almuhanna, Patient Safety Coordinator
• Kristen Crandall, Patient Safety Director
• Tara Floyd, Director NICU/PICU
• Nafis Khan, Risk Data Coordinator
• Padma Pavuluri, Director of Medical Quality
• Kelvin Potter, Risk Information Systems Manager
• Lisa Scafidi, Director of Risk Management
Our Starting Point: What Staff Are Saying

“It takes too long to log in and fill in all the fields.”
- Hospital Nurse

“There’s a culture here that reporting means ‘getting in trouble.’”
- ICU Nurse

“Why should I submit a report; it makes no difference.”
- ED Physician

“I have a lack of confidence in the follow up process, that the formal process will really help to educate prescribers”
- Pharmacist

Source: surveys and risk assessment conversations, 2015

How Can We Change This?
Barriers and Motivators to Reporting

The Reporting System
- **Barriers:** Lack of time, places & ways to report; and lack of knowledge of how
- **Motivators:** Keep It Simple: ↓ the # of mandatory fields; ↑ ways & knowledge

The People Reporting
- **Barrier:** Lack of follow-up information after submission to those who report
- **Motivator:** Development of a standard follow-up process to close the loop

Organizational Commitment
- **Barrier:** Lack of knowledge of how progress is being tracked
- **Motivator:** Transparency in hospital-wide tracking
Technology Changes: Making It Easier to Report

- Decreased the number of mandatory fields needed to complete a report
- Creation of Mobile App quick reporting tool
- Customization of reports for department-specific tracking & trending
- Automatic weekly and monthly Summary Reports emailed to managers
- Trend Reports- Total Reports Submitted by Department used for reward & recognition
- Identified redundant reporting systems in the organization, worked to align them with our safety event reporting system

Note:
- 1.6% out of 14000+ files took more than an hour to submit. Removed for being outliers.
- Only interventions that affects file submissions have been taken into account here
- Interventions include but are not limited to: reducing mandatory fields, software version upgrades, database
Making it Safe to Report

Safe to Report Sub-Committee
Sonal Kalburgi, DO, MSHS
Debbie Freiburg, MS, RN, NE-BC

Overview

• Building our Improvement Team
• Bringing Just Culture to Safety Event Reporting
• Measuring Reporting Culture
• Performance Board Pilots
How do you improve your reporting culture?

• Which staff members report at your organization?
• How do you recognize and reward reporting?
• How are reports handled?
• How can organizations integrate Leape’s concept that the “single greatest impediment to error prevention is that we punish people for making mistakes”?


Safe to Report Sub-Committee

- Hospitalist Division
- Nursing
- Risk Management
- Human Resources
- Nursing Safety Champion
- Nursing Development
- Social Work
- Patient Experience
- Respiratory Therapy
Committee Feedback

• Managers often receive poor quality incident reports
  – focused on assigning blame
• Providers not held to same accountability as other staff
• Vague memory of Just Culture
  – applies to HR situations not patient care
• How can we apply Just Culture to change reporting culture?

Why We Need Just Culture

• Have you ever made a mistake and worried that it was going to be used unfairly against you?
• Have you ever made or seen a mistake that you did not report?
• Have you ever seen a process that was broken and people were blamed but the errors could have been prevented by changing the process?
• Have you seen patterns of poor behavior where the individual was not held accountable?
Where we started...

- 2013 Safety Culture Survey
  - 25th percentile for “staff perception of non-punitive response to error”
- 2014 Employee Engagement Survey
  - 48% for holding staff accountable for low performance

In order to have a strong reporting culture, Just Culture must be present

Just Culture Means...

- Staff are accountable for their actions but are not blamed for system failures beyond their control
- Employees are held accountable, in a fair and equitable way for good performance and behaviors regardless of their position or level within the organization.
What is the Performance Management Decision Guide?

Our Plan

- Just Culture and the Performance Management Decision guide rarely used outside of Human Resources
Performance Management Decisions in Just Culture

- Includes instructions to apply Decision Guide in clinical and non-clinical settings
- Accessible via Patient Safety intranet and the HR Manager Resource Kit via the organization’s central educational platform

Building our Just Culture

- Develop a training module
- Train hospital leaders and managers

Performance Decision Management Guide

- Set as an expectation
- Hardwire in Policy and Procedure
- Identify specific areas for improvement
- Monitor change over time

Just Culture Training

Safety Culture Survey
How do you measure your reporting culture?

- Surveys
  - Safety Culture Survey
  - Employee Engagement Survey
  - Human Resources

- Potential reporting metrics:
  - Volume
  - Diversity of submitters
  - Types or quality of reports submitted
  - First-time reporters
  - Anonymously authored reports

Anonymously Authored Reporting

- ~30% of all annual reports
- Decreases report usability
- Lost opportunity
- Serve as a proxy measure for a safe reporting culture

- Anonymous reporting “pulse check” with response themes:
  - Fear of retribution
  - Time
  - Confusion
  - Misperception that anonymous is preferred
Safe to Report Key Driver Diagram

Aim

Decrease Anonymously Authored reports by 1.5% by 2017

Drivers

Just Culture

Hospital Policy and Procedure

Anonymous Reporting

Unit Leadership

Interventions

- Management apply Just Culture Decision Tree
- Develop educational tool
- Management and staff training

- Identify relevant policy and procedures
- Hardwire Just Culture Decision Tree
- Staff training

- Suggests staff fearful to report
- Lost opportunity for follow up
- Performance board pilot on 3 units FY16 Q4

- Apply Just Culture Decision Management tree
- Include reporting in safety dialogue
- Reward reporting

Measures

Structure Measure
(1) Hardwire Just Culture decision tree management into procedure

Process Measure
(2) Manager and Safety coach Just Culture training

Outcome Measure
(3) Decrease rate of anonymously authored incident reports

Performance Board Pilot

• 3 Units: 4 Main, CICU, Respiratory Therapy for 90 days

• Interventions
  – Weekly graphs on reporting
  – Safety topic in staff meetings

• Pilot Aims
  – ↑ Total unit safety event reporting
  – ↓ Anonymous authored reporting
Performance Board Examples

Performance Board Pilot Results

- Decreased aggregate anonymous reporting by 39%
Performance Board Pilot Results

• Increased aggregate pilot unit reporting by 27%

Take Home Points

• Lessons Learned
  • Success due to creative partnerships
  • Low cost, data driven interventions can be effective
• Next Steps
  • Disseminate performance boards to organizational level
  • Monitor manager compliance with Just Culture Training
  • Link reporting performance with annual unit incentive goals
  • Increase engagement with non-clinical staff and trainees
Reporting **Does** Make a Difference

**Makes a Difference Sub-Committee**
DiAnthia Patrick, BS, PharmD
Laura Sigman, MD, JD

**Our Process**

- Assess perception of our reporting system
- Implement a 3-pronged approach to address barriers
  - Closed-Loop Communication
  - Departmental Follow-Up
  - Hospital-Wide Tracking
- Develop tools and collaborations for success
What Happens to a Submitted Safety Event?

**PERCEPTION:**

**REALITY:**

Employee Submits a Safety Event

Managers of Departments Involved
- Review, Investigate, Discuss with Staff

Quality & Safety Directors
- Review, Coordinate with Departments

Risk Management Department
- Review, Categorize, Investigate

ACA, RCA, Peer Review

Hospital Leadership, Legal

System Sends Email

Automatic Acknowledgement Email to Submitter

Departmental Event Tracking, Safety, Quality, Performance Improvement

ACA, RCA, Peer Review

Hospital Leadership, Legal
3-Pronged Approach To Encourage Reporting

Goals:
- Staff feedback is appreciated and responded to and drives change
- Reporting leads to safety and performance improvements

Global Aim
Advance Safety through Event Reporting and Follow-Up

AIM
Increase follow-up of event reports, in all hospital units, from 40% in 2015 to 90% by the end of 2017.

Makes a Difference Key Driver Diagram

Drivers
Manager Follow-Up in Reporting System
Closed-Loop Communication About Events
Staff Input of Information

Interventions
Provide Guidelines on How to Use System for File Managers
Create Interactive Info Center for Tracking Workflow
Partner with RN Safety Champions & Departmental Safety Groups
Distribute Follow-Up Tables in Units
Send Follow-Up Info from System to Involved Staff
Track Reporting By Unit Hospital-Wide
Provide Guidelines on Information to Include in Submissions
Increase System & Help Icon Visibility
Individual Follow-Up

Standard Email from RL Solutions:

Your submitted file (File ID 13980) has a state of “Closed”

To: Sigman, Laura

Your submitted file, file ID 13980, has changed state to Closed.

“The file you submitted has been followed-up by a manager. You may log in to view results. File ID 13980.”

Follow-Up Field to Provide Feedback to Staff

Instructions Targeted to Managers:

• “This field will be used to provide feedback to staff. Please use neutral language and avoid including confidential information or PHI.”

• Include in Departmental Follow-Up Table
Departmental Follow-Up Table

4 Main Safety Event Follow-Ups
Event Date is within April, 2016 and May, 2016

<table>
<thead>
<tr>
<th>File ID</th>
<th>Event Date</th>
<th>Specific Event Type</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>12345</td>
<td>11/1/16</td>
<td>Wrong Medication</td>
<td>Hydroxyzine ordered Hydralazine dispensed. LASA error. Immediate actions: Drugs physically separated in Rx storage location. LASA alert stickers placed on both bins with new labels color coding the TALL man lettering for each. ( hyDROXYzine) and ( hyDRAzine).</td>
</tr>
<tr>
<td>12456</td>
<td>11/12/16</td>
<td>CAT</td>
<td>Patient assessment and escalation of care appropriate.</td>
</tr>
<tr>
<td>13000</td>
<td>11/16/16</td>
<td>Medication Supply</td>
<td>2 vials of Cefazolin stocked instead of Ceftazidime. Rx operations evaluating how tech separate &amp; pack drugs for deliver to the unit. Both drugs were brought to the unit to be stocked. Tech stocked 1 bin correctly &amp; the 2nd only partially correctly. Action Plan (30-days). Scan on refill automation will be implemented in Rx.</td>
</tr>
</tbody>
</table>

Confidential Notice: All activities associated with incident report management should be considered privileged and confidential and protected under any and all applicable peer review statute(s). This report is for internal use by Children’s National only.
Department-Specific Improvements

<table>
<thead>
<tr>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
<th>E</th>
<th>F</th>
<th>G</th>
<th>H</th>
<th>I</th>
<th>J</th>
<th>K</th>
<th>L</th>
<th>M</th>
<th>N</th>
<th>O</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>IR file #</td>
<td>15-Jul</td>
<td>15-Aug</td>
<td>16-Feb</td>
<td>16-Mar</td>
<td>16-Apr</td>
<td>16-May</td>
<td>Specimen with 2 different pt labels done with tech</td>
<td>Unknown pt with 2 different pt labels</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12255</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11587</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Department-Related Tracking by Quality & Safety

- Primary Involved Department: Emergency Department
- Additional Department: [Blank]
- ED Specific Categories: PID Error
- Was Trainee Involved? [Blank]
- Person Affected Details: Use the Magnifying Glass may encounter errors.

Use the Magnifying Glass may encounter errors.

Details of the person affected by the event:

- PID Error
- PID error - wrong intervention
- Specimen labeling
- Allergy status
- Radiology error
- Incorrect order lab

Department-Level Tracking by Quality & Safety

- EMTC's Weekly Goal for FY17
- CTNS Event Report Sales by Category
- CTNS Event Report Sales by Category
- Event Report by Hospital

Confidential and Privileged
Monthly Reports to Departments

<table>
<thead>
<tr>
<th>File ID</th>
<th>Event Date</th>
<th>Person Affected MRN</th>
<th>Specific Event Type</th>
<th>Severity Level (Actual)</th>
<th>Brief Factual Description</th>
<th>Follow-up By</th>
<th>Follow-Up Comment</th>
</tr>
</thead>
</table>

Hospital-Wide Tracking

Provides Ways to View Data for Focused Improvements & Trends

1) Trend Data
   - Top Reporting Departments
   - Most Improved Departments in Reporting
   - Weekly, Monthly, and Total Number of Reports

2) Specific Event Type Data
   - Provides a more organized way to focus process improvement efforts.
Aggregate Data for Focused Process

How Are We Doing with Follow-Up?
Making It Easier to Follow-Up Event Reports

1) Staff Training
   • Online modules
   • Focused, formalized training and education for managers
   • Help icon within the reporting system application
     • Guide for File Managers: How to Use Follow-Up Functions
     • Guide for Submitters: How to Submit a Safety Event
       (Suggested SBAR format)

2) Partnering with Nursing Safety Champions
   • To help facilitate & encourage reporting & follow-up

Looking Ahead...Next Steps

Technology Changes: 2017 Reporting System Updates
   • Interactive Info Center Table
   • Allow easier management of events

Name Change of the “Process” of Report Submission
   • Eliminate the punitive sound of “reporting”
     → “submit a safety event”
   • Make it catchy, inspiring, non-punitive

Performance Board Monitors in Unit Staff Break Rooms
   • Display hospital-wide trends in all departments
   • Customize at the department level to provide feedback
   • Provide consistent, updated reminders of safety issues and prevention
Summary: How Reporting Can Make a Difference

• **3-Pronged Follow-Up** provides feedback and engagement
  1. Closed Loop Communication with Staff
  2. Departmental Follow-up
  3. Hospital-Wide Tracking

• **Tracking & trending** allows for focused improvement efforts
  • High Risk Events
  • Most Frequent Event Types

Are We Making A Difference?

• **Reporting is**

• **SSE - Serious Safety Events remain**

• **Quality of the Reports remain meaningful**
Take Home Points

1. Make it **easy** to report
2. Make it **safe** to report
3. Reporting **makes a difference**

Stop by our Storyboard in the Exhibit Hall or during the Reception from 4:30-6:30 Today
Questions, Comments, Feedback......