There is Safety in Numbers: Overcoming Barriers to Event Reporting

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Children's National Medical Center
Washington, DC
1870-2016: DC Children’s to Children’s National: from 12 to 313 beds
Driving Improvement through Corporate Goals

Advance delivery of safe care by eliminating serious preventable harm: double safety event and good catch reporting

Driving Improvement: “Safety in Numbers” Committee (SiNC) Structure

Materially improve reporting culture as measured by success with Technology, Safe to Report and Making a Difference
GLOBAL AIM

Improve the culture of safety at Children’s National.

SMART AIM

(Why the change)

Increase the number of submissions in RL from 4,668 to 9,336 by 6/30/2017

KEY DRIVERS

(What to change)

Culture

ACCESSIBILITY

Follow-up

INTERVENTIONS

(How to make the change)

Create distributive model of ownership
Recognize/reward reporting
Apply just culture decision management tree
Put in goals/objectives
Change name of RL (SERS)
Increase visibility of reporting system
Create alternate reporting methods
Increase reporting from non-clinical employees
Create way for patient/family to submit
Create standardized education for staff
Establish that RL is the central reporting hub
Create manager follow-up documentation guidelines
Enhance automated reports
Provide Closed-loop Follow up to staff
Display follow-up actions to department
Publicize hospital wide data

In Progress
Finished
Stopped
Not Started

Revision Date: 10/25/2016

Long Term Safety Goal

Team: SiNC Committee
The Team: Driving Change
Safety In Numbers Committee (SiNC)

SiNC

Technology
Safe to Report
Makes A Difference
Acknowledgements

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

• Ahmed Almuhanna, need title
• Kristen Crandall, Director of Patient Safety
• Tara Floyd, need title
• Nafis Khan, Risk Data Coordinator
• Padma Pavuluri, need title
• Kelvin Potter, Risk Data Manager
• 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
• Laura J. Sigman, MD, JD Emergency Medicine, Legal/Risk Management Departments
• Lisa A. Scafidi, RN Director of Clinical 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

<table>
<thead>
<tr>
<th>The Reporting System</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Barriers</strong> : Lack of time, places &amp; ways to report; <em>and</em> lack of knowledge of how to report</td>
</tr>
<tr>
<td><strong>Motivators</strong> : Keep It Simple-↓ the # of mandatory fields; ↑ ways &amp; knowledge</td>
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<table>
<thead>
<tr>
<th>The People Reporting</th>
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</thead>
<tbody>
<tr>
<td><strong>Barrier</strong> : Lack of follow up information after submission to those who report</td>
</tr>
<tr>
<td><strong>Motivator</strong> : Development of a standard follow-up process to close the loop</td>
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</tbody>
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<thead>
<tr>
<th>Organizational Commitment</th>
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<tbody>
<tr>
<td><strong>Barrier</strong> : Lack of knowledge of how progress is being tracked</td>
</tr>
<tr>
<td><strong>Motivator</strong> : Transparency in hospital-wide tracking</td>
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</table>
Technology

Technology Sub-Committee
Kelvin Potter
Nafis Khan
Report Submission Time

Average Time Taken to Submit Files

<table>
<thead>
<tr>
<th>Time Taken (mm:ss)</th>
<th>Years/Months</th>
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<tr>
<td>20:10</td>
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<tr>
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<td>05:46</td>
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<td>02:53</td>
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Privileged and Confidential
### Technology Changes

Front Line Users and File Managers

"Make it simple but significant."

- Weekly & Monthly Summary Reports to Managers
- Department Submission of Total # Reports to Managers
- Created Mobile Apps for easier report submission
- Renaming the Departments for Easier Look-Ups
- Streamlined Selections of Severity Classifications
- Customization of Department Specific Request
Making it Safe to Report

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

Patient Safety Theory and Safety Event Reporting

*Adapted from Patient Safety and the Just Culture” a Primer for Health Care Executives*
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?
Where we started...

- 2013 Safety Culture Survey
  - 25\textsuperscript{th} 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.
Our Plan

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

Just Culture Training

Performance Decision Management Guide
- Set as an expectation
- Hardwire in Policy and Procedure

Safety Culture Survey
- Identify specific areas for improvement
- Monitor change over time
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

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

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
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
What Happens When a Safety Event is Submitted?

PERCEPTION:
What Happens When a Safety Event is Submitted?

**REALITY:**

1. **Employee Submits a Safety Event**
2. **Manager of Departments Involved** - Review, Investigate, Discuss with Staff
3. **Quality & Safety Directors** - Review, Coordinate with Departments
4. **Risk Management Department** - Review, Categorize, Investigate
5. **RL Sends Email**
   - Acknowledgement Email from RL to Submitter
   - ACA
   - RCA
   - Peer Review
   - Hospital Leadership
   - Legal

**Departmental Event Tracking**

**Safety, Quality, Performance Improvement**
3-Pronged Approach To Encourage Reporting

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

### Drivers

- Manager Follow-Up in RL
- Closed-Loop Communication About Events
- Staff Input of Information

### Interventions

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

Current Email from RL Solutions:

GOAL:
“The file you submitted has been followed-up as below. You may log in to RL and view the notes entered under File ID 13980.”
Follow-Up Field Used 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 Individual Email and Departmental Follow-Up Table
Hospital-Wide Tracking

Provides A Variety Of Ways to View Data for Focused Improvements & Trends

**Departmental Trend Data**

- Top Reporting Departments
- Most Improved Departments in Reporting
- Weekly, Monthly, and Total Number of Reports

**Specific Event Type Data**

- Provides a more organized way to focus process improvement efforts.
Quarter 1: Top 10 Specific Event Types

Pareto Chart
Top 10 Specific Event Type FY17 Q1
How is this Data Being Used?

Improving Metrics for Quality & Performance Improvements and Tracking “Never Events”

Department Level
- Aggregate data from submitters with follow-up responses shared with front-line staff
- Aggregate trended data provided to managers on weekly and monthly basis for PI plans
  - Focus
    - High Risk Events
    - Most Frequent Event Types

Hospital Wide
- Aggregate data available for hospital wide process improvement projects and efforts
  - Examples:
    - Trigger Reports
    - Late Rescue Collaborative
    - Sponge Counts
Follow-Up of Incident Reports

<table>
<thead>
<tr>
<th>2015 Months</th>
<th>No Follow-Up</th>
<th>Follow-Up</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jan</td>
<td>190</td>
<td>155</td>
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<tr>
<td>Feb</td>
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<td>Oct</td>
<td>231</td>
<td>237</td>
</tr>
<tr>
<td>Nov</td>
<td>246</td>
<td>202</td>
</tr>
</tbody>
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Incident Reports Submitted FY2014 – FY2017

- FY14: 4668
- FY15: 5814 (22% increase from FY14)
- FY16: 7105 (54% increase from FY15)
- FY17: 10,971 (increase from FY16)

Bar chart showing the trend from FY14 to FY17.
Take-Home Points

- Low cost, data driven interventions, can be effective
- Success due to creative partnerships
- Transparency is key
- Tracking and trending allows for more focused process improvement efforts
- 3-Pronged Follow-Up Process is important for feedback, and continued engagement
  1. Closed Loop Communication
  2. Departmental Follow-up
  3. Hospital-Wide Tracking