REPORTING PATIENT SAFETY EVENTS TO MITIGATE RISK AND INJURY

BY AMERICAN DATA NETWORK

As a commitment to caring for and keeping patients safe, it is critical that we evaluate and learn from every event reported, including those where no patient harm resulted. This commitment requires a culture of safety that promotes and supports staff in detecting and reporting incidents, near misses, unsafe conditions/ systems as part of their daily work. Patient safety occurs at the point of care, making staff the best source for event reporting.

Leadership responsibility includes assurance that staff recognize all types of events and are supported in their reporting activities. Once near misses and unsafe conditions are identified, there must be further commitment to taking action through design or redesign, implementation and ongoing evaluation of effectiveness for new processes and systems that mitigate patient risk and injury.

Through event reporting, staff learn to identify high risk issues that directly impact the safety of patients.

In order to learn, staff must know

1. **When** to report a patient safety event,
2. **What** constitutes an incident, near miss or unsafe condition, and
3. **Which** critical pieces of information are necessary for assessing the causation and degree of risk that occurred.

Common Formats

The Agency for Healthcare Research and Quality (AHRQ) has coordinated the development and publishing of the Common Formats to be used as a guide for collection of critical event information. The Common Formats allow for standardized patient safety data terminology in order to conduct large scale data aggregation and analytics.

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Event Categories

(as defined by AHRQ)

An **incident** is "a patient safety event that reached a patient and either resulted in no harm or harm. The concept 'reached a patient' encompasses any action by a healthcare practitioner or worker or healthcare circumstance that exposes a patient to harm." For example, a patient receives the wrong medication.

A **near miss** is *"an event that did not reach a patient."* For example, the wrong dose of insulin is discovered by the second verifying nurse prior to patient administration.

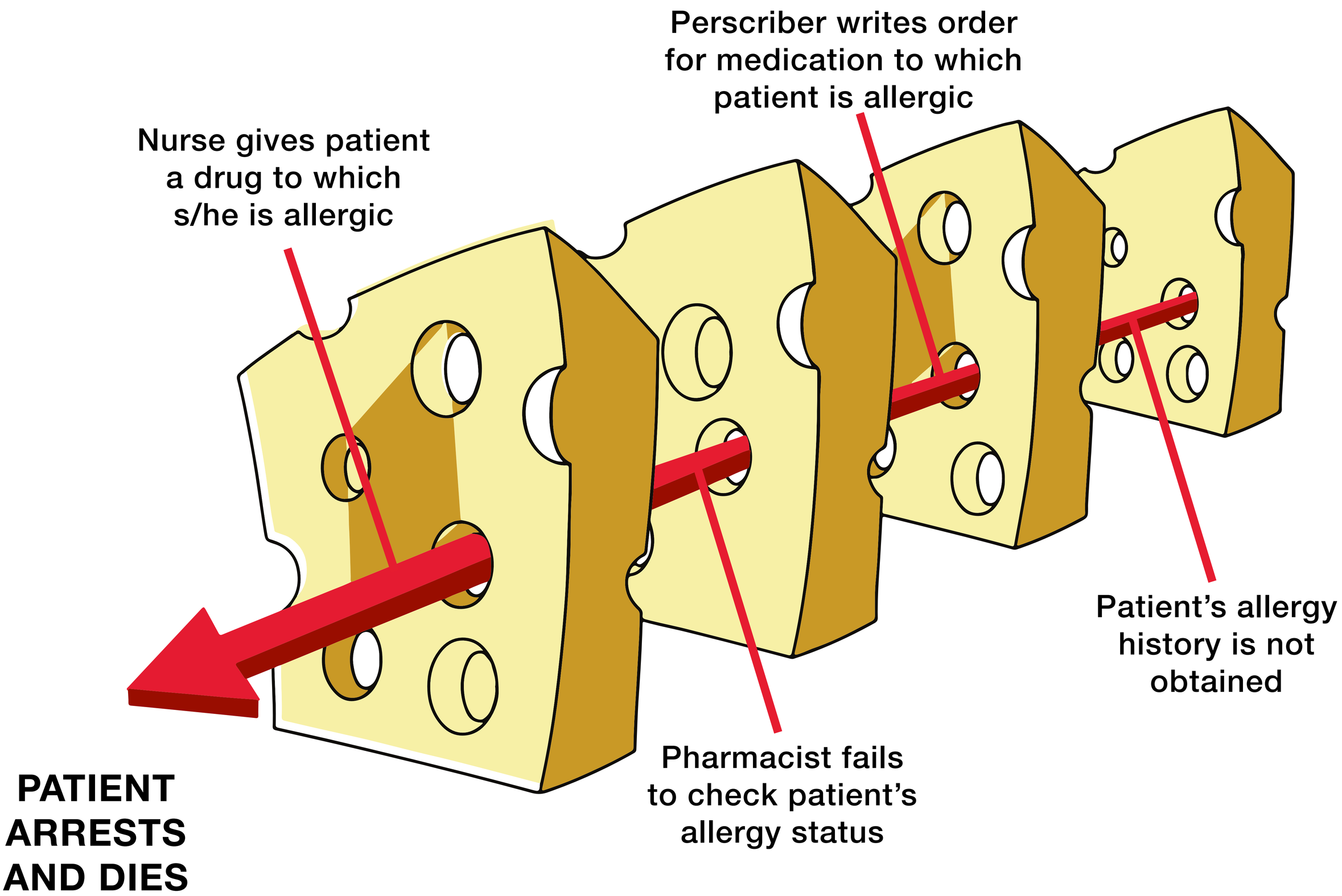
An **unsafe condition** is *"any circumstance that increases the probability of a patient safety event; includes a defective or deficient input to or environment of a care process that increases the risk of an unsafe act, care process failure or error, or patient safety event. An unsafe condition does not involve an identifiable patient."* For example, an out-of-date medicine on a shelf represents an unsafe condition.

Event reporting is essential to identifying, understanding and addressing underlying factors and circumstances that can contribute to medical errors.

An assessment of all events, regardless of the severity or harm level, is necessary to determine the cumulative risk to patients and highlight splintered systems and processes that eventually lead to injury.

In order to identify the causation of an event, start at the end and go backwards. The end is just the beginning of the road to improvement.

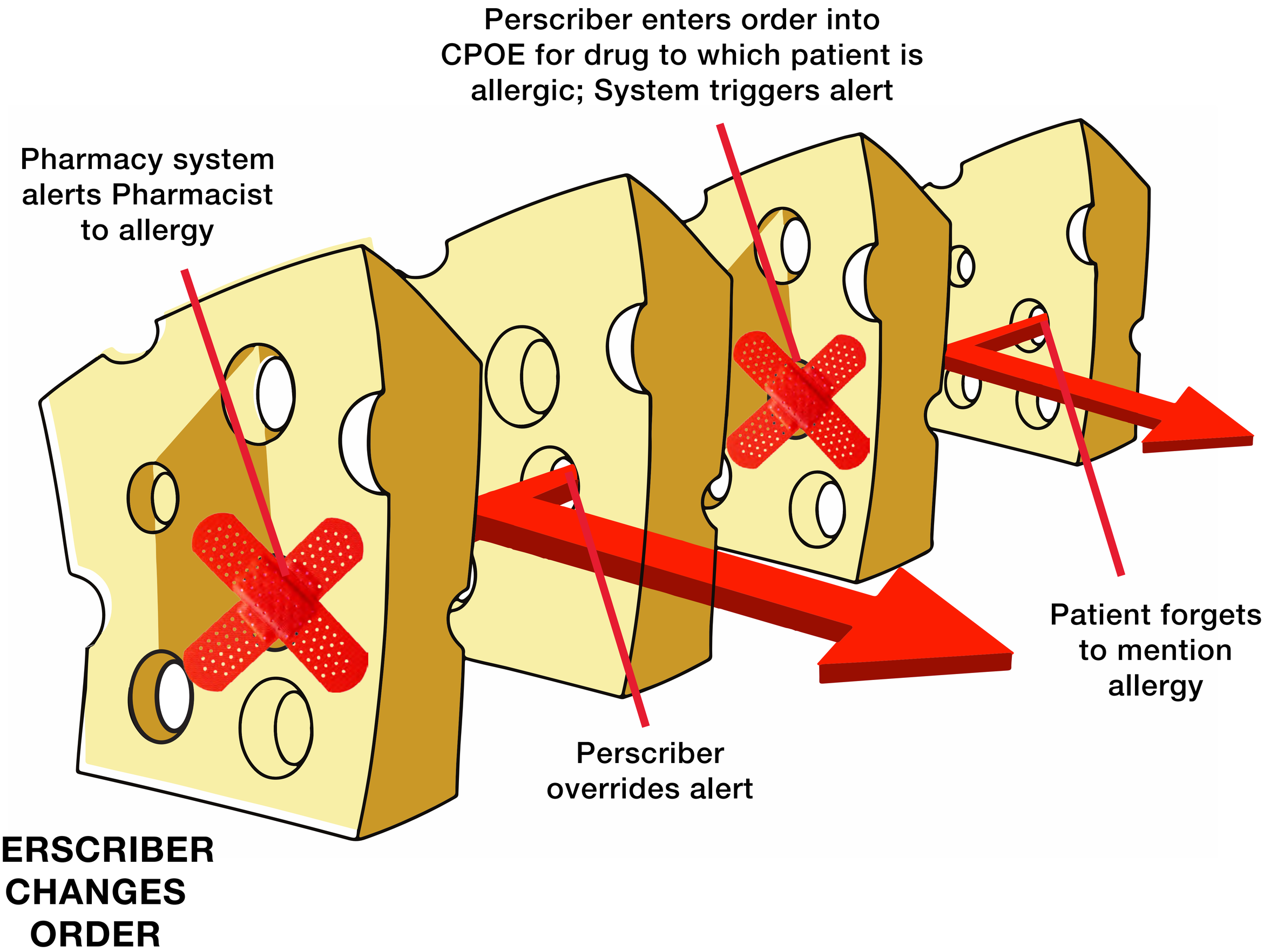
Using the Swiss Cheese Model illustrating the defensive stops of the process, it quickly exposes the multiple failure points that lead to this deadly patient incident.



Reporting of near misses and unsafe conditions offers the greatest opportunity to mitigate risk, as well as provide a fitting opportunity for employee engagement in safety culture. Both near misses and unsafe conditions precede patient involvement and can provide warning signs of weaknesses in processes and systems.

Organizational due diligence is critical in conducting a proactive analyses of the near misses and unsafe conditions to identify any trends or patterns that warrant priority for redesign. Additionally, it is imperative that each event be reviewed for any indication that, without immediate corrective action, would ultimately reach and potentially harm the patient.

The following Swiss Cheese Model depicts a similar situation but accentuates a successful secondary safety system and is reported as a near miss.



LEADERSHIP TO-DO LIST

Every effort should be made to promote a systems approach to patient safety and support staff with reporting of patient safety events for prevention, not punishment. Staff will take an active role in patient safety when they are encouraged to participate in the identification and resolution of fractured systems and processes, becoming patient safety advocates as well as subject matter experts.

Leadership must take an active systems approach to building and promoting an infrastructure that supports a strong patient safety culture. Strategies to consider include:

1. Staff education targeting use of the patient safety event reporting system:

    -What constitutes an incident, near miss and unsafe condition;

    -How to complete a patient safety event report

    -Appropriate notification of events

2. Supplemental education for managers:

    -Steps to follow up investigation;

    -Implementing corrective actions and follow up

    -Submitting recommendations for actions

    -Promoting and encouraging staff to report patient safety events

3. System-wide Patient Safety Awareness Campaign

LEADERSHIP TO-DO LIST CONT'D

4. System-wide Recognition and Reward Patient Safety Advocacy Program

    -Use Near Miss Reporting as a leading indicator of performance and report back to staff/organization on positive steps taken to improve safety

    -Set unit level goals to increase "Near Miss" reporting

    -Recognition and reward innovations in identifying and fixing system weaknesses

    -Celebrate successes

5. Implementation of strategies such as TeamSTEPPS®:

    -Leadership

    -Situation Monitoring

    -Mutual Support

    -Communication

6. Executive Walk-Rounds

7. Unit-Based Patient Safety Initiatives

8. System-wide Evidence-Based Practices

9. Consistent and Ongoing Feedback regarding progress and successes related to patient safety throughout the organization

LEARN TO REPORT AND REPORT TO LEARN

Learning to report and reporting to learn are keys to the success of any organization's Patient Safety Program. By educating staff regarding the importance of reporting, analyzing patient safety event data and implementing patient safety initiatives, progress can be made to mitigate risk and injury to the patients entrusted to the healthcare team and organization.

Get an Event Reporting Demo

The American Data Network **Patient Safety Event Reporting Application** helps you monitor and analyze safety events and near misses to improve clinical processes and curb your organization's risk.

To learn more about the tool or request a demo, contact Sherry Bird at (501) 225-5533.

Learn More **Get a Demo**

About American Data Network Patient Safety Event Reporting Application

The American Data Network Patient Safety Event Reporting Application incorporates the common definitions and reporting formats developed by the Agency for Healthcare Research and Quality (AHRQ) and authorized by the Patient Safety Act. It not only enhances your ability to track events internally, but delivers the opportunity for rapid process improvement through real-time reporting. With ADN's QAC application, quality, patient safety and risk managers can identify key trends and patterns that will allow them to make expedient improvements to processes to reduce their hospital's costs and liabilities.

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