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White Paper

Is the Answer to Enhanced Patient Safety Hiding in Plain Sight? The Transformation of "Incident Reporting"

According to the OIG Report (2012), traditional hospital reporting systems capture only an estimated 14% of patient harm events.

We all have these systems, whether paper or electronic, that are supposed to capture incidents that can lead to and/or have resulted in patient harm. Throughout the healthcare industry, they go by various names such as incident reporting system, adverse event reporting system, occurrence reporting system and safety event reporting system. No matter what you call it, almost universally, the users of these systems feel that something is missing – something important – when it comes to whether or not these systems actually enhance patient safety. According to the OIG Report (2012) "Hospital Incident Reporting Systems Do Not Capture Most Patient Harm," traditional hospital reporting systems capture only an estimated 14% of patient harm events. These systems have been in healthcare since the mid-1960s and were largely the purview of the risk management department as a way to inform the organization of events that could potentially lead to a medical malpractice claim. As these systems have advanced from paper to electronic, the number of incidents reported has increased, but according to an article in *BMJ Quality & Safety*, "perhaps a key issue is not whether hospital reporting systems can collect many incidents, but whether the incidents collected reflect the greatest threats to patient safety" (Nuckols, Bell, Liu, Susan, & Hilborne, 2007).

So we have these tools, but they are not working as well as they could be working to support healthcare safety. Within them, we may already have the makings of something that could help enhance patient safety, but this is only if we change our mental model of why we have these systems and what benefit they can bring to us. Healthcare needs **integrated patient safety management**, and now is the time for healthcare providers to take traditional "incident reporting" and transform it into an "integrated patient safety management system." This transformation allows areas of harm and unsafe conditions to emerge in real time so they can be addressed more directly and more quickly.

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What Might Transformation Look Like?

An article entitled "Looking at the Big Picture" by Suzanna Hoppszallern (2011) begins with the question, "do providers have the right information, at the right time, in the right place, to make decisions for effective patient care?" The article discusses using "big data" and "data analytics" on data garnered from highly integrated medical record and billing systems, all tied to enhancing the use of an integrated medical record across the continuum of care. This same question needs to be asked today about our traditional use of incident reporting systems.

The transformation starts with the blending of a robust data collection, follow-up and collaboration system and a culture-of-safety philosophy. The culture needs to embrace the idea that professional staff know when things are not right and probably know how to fix the situation. If we allow them to report what they see, we can obtain important information from across our healthcare systems. Having the power to gather data from across the system of care, and having those data readily accessible to those closest to the delivery of care, creates the power to know things more quickly, and more importantly, to be able to act on things immediately.

We have the opportunity to gain tremendous insights by turning our "incident reporting systems" into organization-wide safety surveillance tools – integrated safety management systems.

With so much time devoted to the establishment of EMRs and meeting meaningful use criteria, we must be careful not to miss the opportunity that is right in front of us. We have the opportunity to gain tremendous insights by turning our "incident reporting systems" into organization-wide safety surveillance tools – integrated safety management systems.

Elements of Transformation: Education and System Selection

There are clear reasons why incident reporting systems may only capture a small percentage of true patient harm. Traditionally, what is considered a "reportable" event may be narrowly interpreted and narrowly understood. Healthcare staff may not receive the proper education and training on how to identify, interpret and report all aspects of patient harm. Perhaps they are told, and it is reinforced through complacency, that they should report objective, easily identifiable incidents such as falls and medication errors, and nothing even remotely vague, indirect or complicated.

As the aforementioned studies and others show, issues like a bad surgery, a difficult delivery or an anesthesia event with poor patient outcome are not generally the types

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of “incidents” that are entered into an incident reporting system. While these more serious events are managed by the healthcare staff, if they are not reported into the event system, they remain single isolated events, islands of information free of any relationship to the system at large, and the ability to see patterns across many areas or similar events is lost. Reporting all types of near misses and real harm needs to become so embedded in the culture that it becomes second nature to the staff.

A core element of the transformation of our traditional incident reporting systems then is education. Healthcare providers need to understand the importance of entering patient safety events into the system and the details surrounding the process including what to report and how to report. Leaders must stress to their staff that they want to see events in the reporting system because these events can affect change and improve care. When reporting events becomes a part of everyday work flow, then it is a natural and necessary part of the work of each professional.

The second element is to have an incident reporting system or data collection tool that allows staff to easily report these types of events and disseminates the information to the right people to foster collaboration and investigative accountability. Staff must also be able to track their investigation within the tool, so it becomes a part of the original event reported and is available for analysis. The tool should capture the entire chain of reporting, investigation, education and follow-up of the event. In addition, this tool, as the cornerstone of an integrated patient safety management system, must easily adapt to the changing needs of the organization.

In the world of integrated patient safety, it is important to continually “close the loop” so that awareness (event reporting) leads to intervention (through data analytics providing actionable information), which leads to changes that can be seen and monitored.

The third element is to use robust data analytics to pull information from the data collection tool. There must be clinical data informatics applied to all events that are reported and investigated in order to garner actionable data that can be used for interventions. In the world of integrated patient safety, it is important to continually “close the loop” so that awareness (event reporting) leads to intervention (through data analytics providing actionable information), which leads to changes that can be seen and monitored. Each time we complete this cycle, we move the organization one rotation closer to creating a spiral of positive change. These types of analytical processes enable the organization to bring solid information to both senior leadership and the board of directors regarding areas of concern and improvement. And, these types of data can lead to the appropriate application of resources to sustain positive change.

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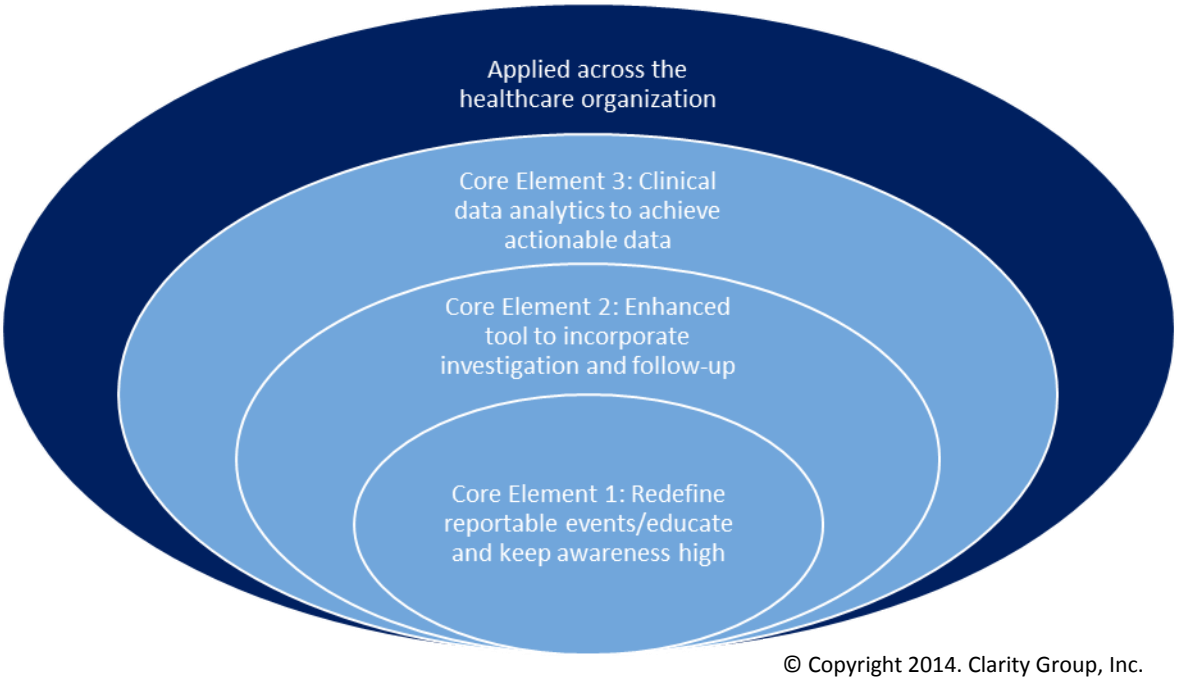
The Integrated Patient Safety Management System:
A Multifaceted Tool Applied Across the Continuum of Care



And it is Not Just the Hospital Anymore

Most of what is written today still focuses on what is done in the hospital setting – a clear indication that we need a lot of work in this area. As it was stated in the "Looking at the Big Picture" article, "most hospitals and health systems are still busy focusing efforts internally and have not addressed the continuum of care." While this article is meant to address the issues of medical record data, it also applies to the collection and analysis of events that have led to or could lead to patient harm (Hoppszallern, 2011).

Our patient safety thinking and our data collection system must extend across the continuum of care. Potential harm exists wherever the patient receives care, regardless of the setting.

Our patient safety thinking and our data collection system must extend across the continuum of care. Potential harm exists wherever the patient receives care, regardless of the setting. As our healthcare organizations grow and add more resources, the sources of potential harm increase. To address patient safety in light of these changes, it is important to:

- Understand that any type of event that indicates harm or potential harm needs to be collected across the continuum of care
- Educate all staff on how to recognize and report those events

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- Put a data collection tool in place that crosses all aspects of the healthcare system – inpatient, outpatient, home and residential care – to capture those events and near misses, allow for analysis across all healthcare settings, and put data in the hands of those at the sharp end of care (Agency for Healthcare Research and Quality, n.d.)
- Have a healthcare data management team comprised of Risk-Quality-Safety staff who can look at all those data to see which areas need further investigation and improvement
- Design an immediate feedback system to keep staff engaged in the process of safety
- Demonstrate results from the data provided and the actions taken

The transformation of incident reporting systems to integrated patient safety management systems is necessary to fully realize the potential of using data to promote safety.

The transformation of incident reporting systems to integrated patient safety management systems is necessary to fully realize the potential of using data to promote safety. As much as the integrated medical record can provide insight into the medical practices and protocols that impact patient outcomes, the integrated safety management system can impact patient safety and enhance quality outcomes. While these systems need to remain separate, it is important that they work parallel to one another. This parallel process offers healthcare providers the best chance at producing safe and high quality care, making the healthcare system a true healthcare safety zone for patients, visitors and staff.

The Gift of the PSQIA to Healthcare Providers

In the transformation process, it is also important to consider the use of a Patient Safety Organization (PSO) as a repository for collecting and analyzing data in a secure environment.

In the transformation process, it is also important to consider the use of a Patient Safety Organization (PSO) as a repository for collecting and analyzing data in a secure environment. A PSO, which stems from the federal Patient Safety and Quality Improvement Act (PSQIA), provides its members with strong privilege and confidentiality protections regarding their data. These protections offer healthcare providers a learning laboratory to look deep into all matters of patient safety that many avoid for fear of discovery. The PSO program also encourages candid learning and collaboration among healthcare providers to improve the quality and safety of care delivery across the industry.

Healthcare providers have this great tool through which they can move the needle on patient safety in very positive ways. It is all done in a protected environment where

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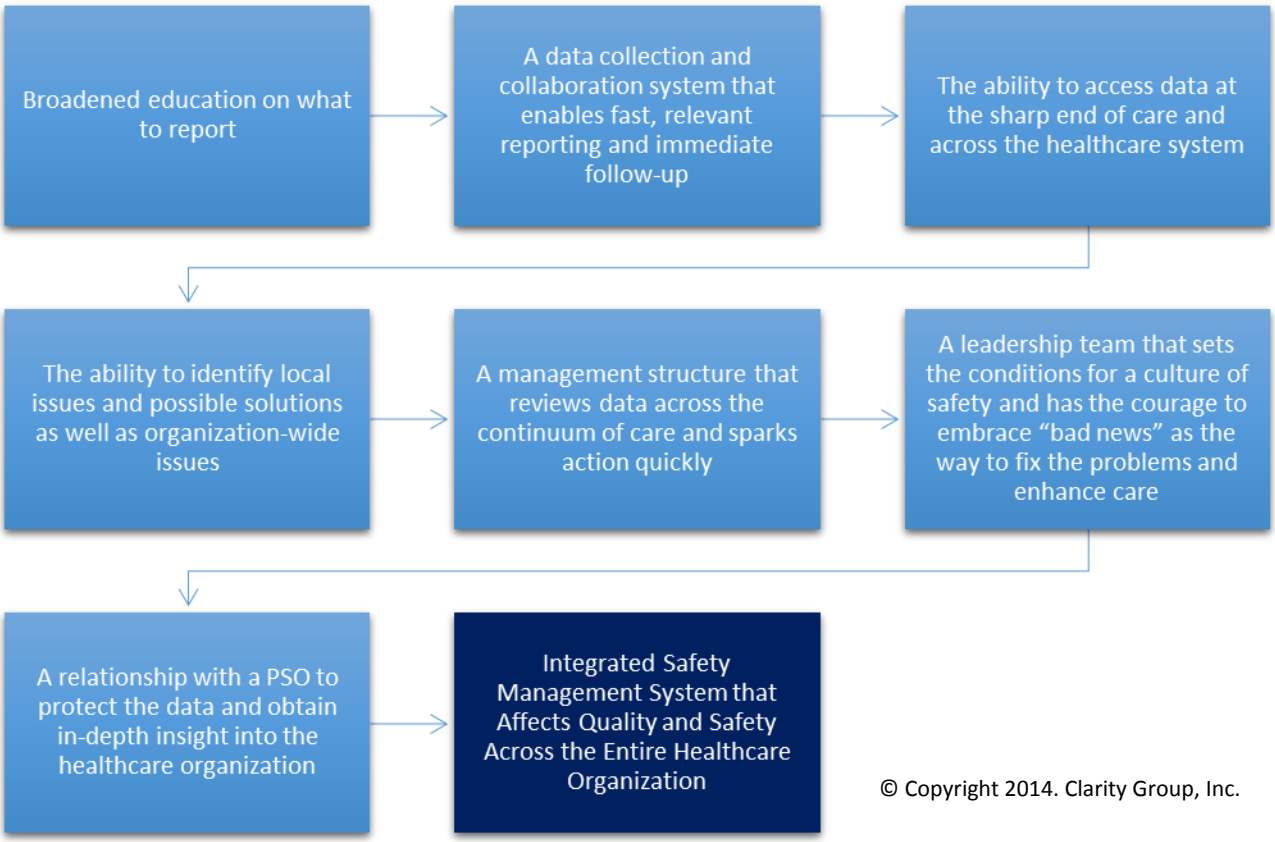
those data are not discoverable and are used for the purposes of fostering a culture of safety and enhancing care processes. A PSO creates exactly the kind of situation healthcare providers need as they experiment with new delivery models and expand resources to care for their community of patients.

To aid in the patient safety improvement process, the Agency for Healthcare Research and Quality (AHRQ) developed the AHRQ Common Formats, a set of standardized reporting templates. By capturing events in a standardized way, it is possible to create comparative analysis and it is easier to identify issues and best practices to mitigate these issues in the future.

A Path to Achieve Transformation



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The full transformation of our traditional mental model of incident reporting systems is complete when the organization views the process of event reporting as a system-wide tool to accomplish integrated patient safety management.

Conclusion

The full transformation of our traditional mental model of incident reporting systems is complete when the organization views the process of event reporting as a system-wide tool to accomplish integrated patient safety management. While the risk management department is a key and active stakeholder in the system, it is the total organization that must look to this reporting system as an early warning of potential patient harm and as a means to reaching its goals for quality and safety.

We can forge trust with our staff by assuring them of our interest in the safety of our healthcare settings and the quality of patient outcomes. There is no better time for this transformation than now, when our whole delivery system is transforming itself to be patient-centered and quality focused. For what can be more patient-centered than the whole organization focused on the protection of patient safety wherever a patient enters or moves through their system of care?

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For more information on Clarity Group, Inc. and our integrated patient safety management products and services, please visit our website: www.claritygrp.com

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