Getting it Right: Improve Patient Safety through Incident Reporting

By Dennis Muse

Deaths due to medical errors have developed into an epidemic for healthcare organizations. Medical errors are becoming all too prevalent with healthcare organizations left holding the check. However, there are new ways to prevent, detect, and investigate medical errors leading to reduced cost of life and resources. By utilizing an incident reporting system to report and track medical errors, an organization has the opportunity improve patient safety which can translate to substantial cost savings.

The Cost and Cause of Medical Errors

The 2000 Institute of Medicine Report *To Err is Human: Building a Safer Health System* estimated medical errors to be the eighth leading cause of deaths in the U.S., approximately 9,800 annually. The report also stated that these errors cost the country up to $2.9 billion a year in direct medical costs and lost income and productivity. This accounts for 30 percent of the price of healthcare and up to 15 percent of a hospital's annual budget. These shocking statistics make it imperative for healthcare organizations to devise a strategic plan for decreasing medical errors and enhancing patient safety.

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Organizations must determine the types and reasons for errors. In Healthcare Information and Management Systems Society's *Patient Safety and Primer Fact Sheet*, the most common errors were adverse drug events, hospital acquired infections, procedural complications, and falls. Errors also occurred with handwritten physician orders that were either without a signature or order time, incomplete, or illegible. Knowing the source of errors is a beginning to reducing them, but more action must be executed.

Legislation Encourages Reporting

In an attempt to improve patient safety, the Patient Safety and Quality Improvement Act of 2005 was enacted. The Act provides legal protection of information voluntarily reported to federally-certified Patient Safety Organizations (PSOs) in an effort to analyze collected data and develop policies for improving patient safety. The Act further provides that accrediting bodies may not take an accreditation action against a provider who voluntarily submits information and that no adverse employment action will be taken.

In addition to the federal Act, 20 states have similar legislation to encourage individuals to come forward with information without threat of retribution.

Organizations Embrace Act with Anonymous Incident Reporting

In response to the Act and as a means to prevent, detect, and investigate medical errors, healthcare organizations have begun to establish incident reporting systems to gather anonymous reports of patient incident data. This data can be utilized extensively by executive management in analysis, trending, and reporting.

The importance of incident hotlines was also advocated by the American Academy of Family Physicians who submitted these principles for patient safety reporting:

- *Creating an Environment for Safety:* Non-punitive culture for reporting healthcare errors that focuses on preventing and correcting system failures, not on individual or organizational culpability
- *Data Analysis:* Information submitted to reporting systems must be comprehensively analyzed to identify actions that would minimize the risk that the reported event could or would re-occur
- *Confidentiality:* Confidentiality protections for patients, healthcare professionals, and healthcare organizations are essential to the ability of any reporting system to learn about errors and effect their reduction
- *Information Sharing:* Reporting systems should facilitate the sharing of patient safety information among healthcare organizations and foster confidential collaboration with other healthcare reporting systems
- *Legal Status of Reporting System Information:* Information developed in connection with reporting systems should be privileged for purposes of federal and state judicial proceedings in civil matters, and for purposes of federal and state administrative proceedings

Putting the Plan into Action

Several healthcare organizations have implemented a Patient Safety Information System with success. The Department of Veteran's Affairs (VA) established a National Center for Patient Safety (NCPS) that was responsible for developing an internal, confidential, and non-punitive reporting and analysis system, the Patient Safety Information System (PSIS). The system permits VA employees to report both adverse events and close-calls without fear of retribution.

After implementation, NCPS saw a 900-fold increase in reports of close-calls and a 30-fold increase in reporting adverse events. The PSIS now serves as a benchmark and is being utilized and emulated by other healthcare programs, both nationally and internationally.

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Stanford Hospitals and Clinics created an online event-reporting system well before enactment of legislation. The system was intended for the reporting of any incidents, behaviors, practices, and/or policies leading to actual or potential medical errors that may cause harm to any patient or employee. Stanford Hospitals and Clinics found the system to have major advantages over the prior paper-based system including fewer delays, transmission to several departments simultaneously, and a data analysis mechanism which helped in identifying broad patterns of error.

The reason these systems have had such success is due to the proactive approach to medical errors and other unanticipated incidents in line with quality improvement processes and reinforcement of a culture of safety and care. These systems also support employees' observation and reporting of clinical performance in a non-punitive manner. In addition, the systems can be used to transmit patient safety data to the federally-credited PSOs, which assists in the task of assisting healthcare organizations nationwide in the prevention, detection, and investigation of medical errors.

Case Study: The Impact of Incident Reporting

South Jersey Healthcare, a charitable non-profit healthcare organization providing an array of hospital, patient, and specialty services, initiated an incident reporting system, which was launched as part of its action plan to improve patient safety. In addition to the incident and close-call reporting system, medication safety, automated production/equipment alerts, and a recall program were also implemented.

A committee was established to oversee the components of the action plan. The committee placed considerable concern on incident reporting. The committee felt the organization's employees would be fearful of reporting incidents. To combat this issue, educational sessions were held for all departments and all shifts on the importance of reporting not only medical errors but close-calls as well.

In the first nine months of the program, the number of reported incidents did not increase as expected, however, the timeliness of reporting dramatically increased. Incidents were being reported as soon as they occurred allowing for quicker response time from all parties. Issues were resolved with little delay creating an organized well-run system. The program has now been in place for six years with calls increasing from 360 in 2001 to 783 in 2002 and 1528 in 2003. Since 2003, the number has continued to increase with an average of 425 reports per quarter. These numbers include reports made by phone as well as online. The proof is in the numbers for South Jersey Healthcare, which has identified the program as a success and as a resource to provide better patient safety.

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Where Does Internal Audit Fit?

Patient safety is everyone's concern and is not only a clinician's issue. Internal auditors are in an excellent position to address safety across the institution. Performance of audits and reviews of systems, processes, and procedures is an auditor's expertise. Few functions have access to the organization like an internal auditor does, and fewer-still have the in-depth understanding of how all the pieces work together to form patient outcomes.

Patient safety should be an integral part of any direct patient-care activity audit and of any activity directly supporting patient care through products or services. Audit programs should review corporate and department mission statements and annual goals to ensure sufficient regard to patient safety is promoted. What gets measured gets attention, and audit steps should consider how organization and department metrics reflect safety achievement. What's behind the measurement? What control mechanisms ensure metrics accurately reflect the reality of activities measured? These questions and others should be considered by the auditor.

Patient safety is no accident. It is a function of the extent to which workforce members consider it important. As such, how rewards and other compensation incentives are aligned with safety concerns is an important consideration. Breakdowns are more prone where communication between groups is a key ingredient to success, or where hand-offs happen. An audit should pay particular attention to these points, looking for potential disconnects. Policies and procedures and other written communications should be complete and unambiguous. Auditors should look at training, or the lack thereof, provided to individuals and teams to ensure it includes effective communication techniques and recognition of impending adverse situations. Does the organization train and reward staff to speak-up when there is a concern that actions, processes, or behaviors may lead or contribute to an error? The role of internal audit is an important one and when it comes to patient safety issues nothing should be considered outside of scope.

Best Practice Incident Reporting System Features and Benefits

Incident Hotline and Web Intake

- An outsourced hotline/web intake provider with 24/7/365 availability.
- Provider should document initial intake and follow-up reports.
- International coverage with multiple language greetings.
- Scripted and customized interview process to pinpoint the details most pertinent to your organization.

Information Management Features and Benefits

Choose a provider with:

- Seamless integration of hotline and web reports housed in a central data repository.
- 24-hour, real-time access to information for online viewing of reports, editing of reports, and incremental report entry from anywhere Internet access is available.
- Revision tracking during report review or modification allows the addition of supplementary information following the initial report.
- Search functionality enables filtering of report data for analysis.
- Inherent search functionality of the data repository further enables filtering of the data for output into graphs or charts enabling analysis and executive reporting.
- Optional monthly management reports provide a summary of reported incidents for ongoing analysis.

Conclusion

With an incident reporting system healthcare organizations have the ability to alleviate the epidemic of patient deaths associated with medical errors. Optimum patient care and safety is the goal of every healthcare organization, and initiating an incident reporting system is an important tool to help your organization ensure patient safety. **NP**

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