Event Reporting: A Paradigm Shift That Works!

Lisa Cuccio MSN, RN, NE-BC
lcuccio@lifespan.org
Ellen Cerullo MS, RN
ecerullo@lifespan.org
The Miriam Hospital
A Lifespan Partner
164 Summit Ave, Providence, Rhode Island

ISSUE

Because hospitals rely on incident reporting systems to track and analyze events, improving the usefulness of these systems is critical to hospitals' efforts to improve patient safety. A report from the Office of the Inspector General states: Hospital incident reporting systems capture only an estimated 14% of patient harm events.

BACKGROUND

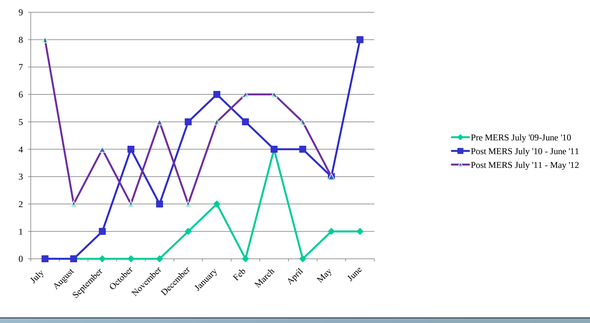
In 2009 The State of Rhode Island Department of Health mandated all hospitals secure access to a State and Federally certified Patient Safety Organization. Coalitions sponsored by the Hospital Association of Rhode Island selected GE /Medical Event Reporting System (MERS) as the single state wide reporting structure. For aggregating and reporting data, MERS uses several common formats: Agency for Healthcare Research and Quality, National Database of Nursing Quality.

The Chief Nurse seized an opportunity to realign event reporting from Risk Management to operations. MERS, championed by an experienced nurse leader, provides oversight, triage and rapid review of events. Processes include manager analysis, trending, and action planning.

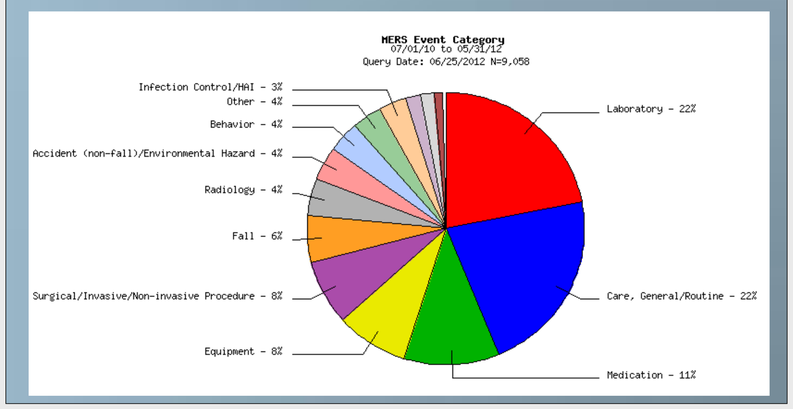
Shifting paradigms lead to a 303% increase in reporting during the inaugural year. 72% of our Root Cause Analyses (RCA) are voluntary, 18% are state mandated. Outcomes include Information Systems changes, revision of policies and procedures, purchasing new equipment, and improved workplace safety structures.

Staff quoted "'Everyone is encouraged to complete event reports, not only for actual mistakes, but for what is considered a near miss, "'I hear more direct response from events, which has been both encouraging and inspiring"'.

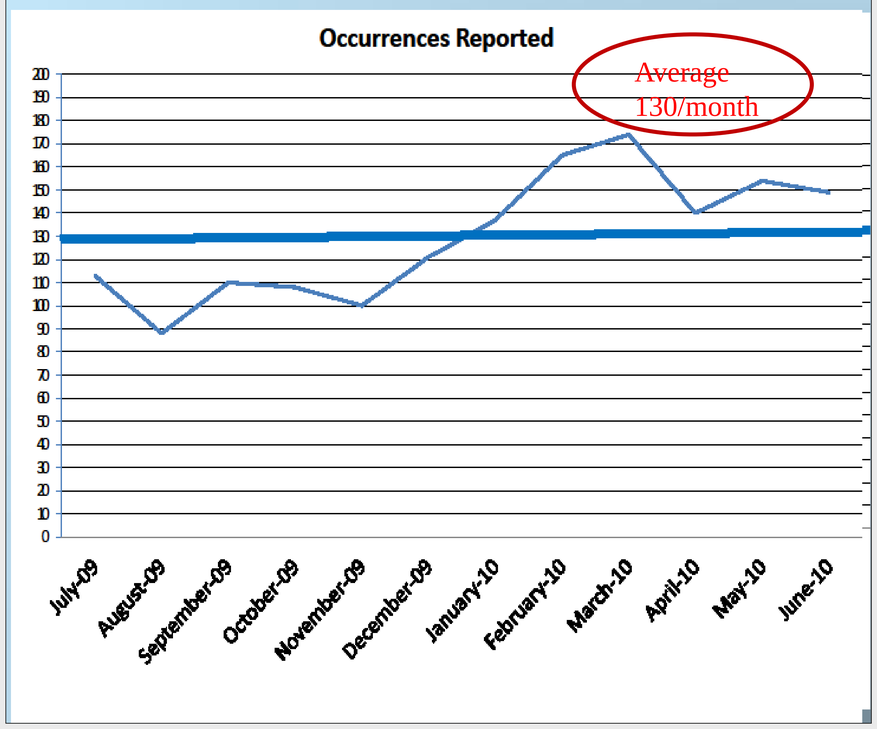
ROOT CAUSE ANALYSIS



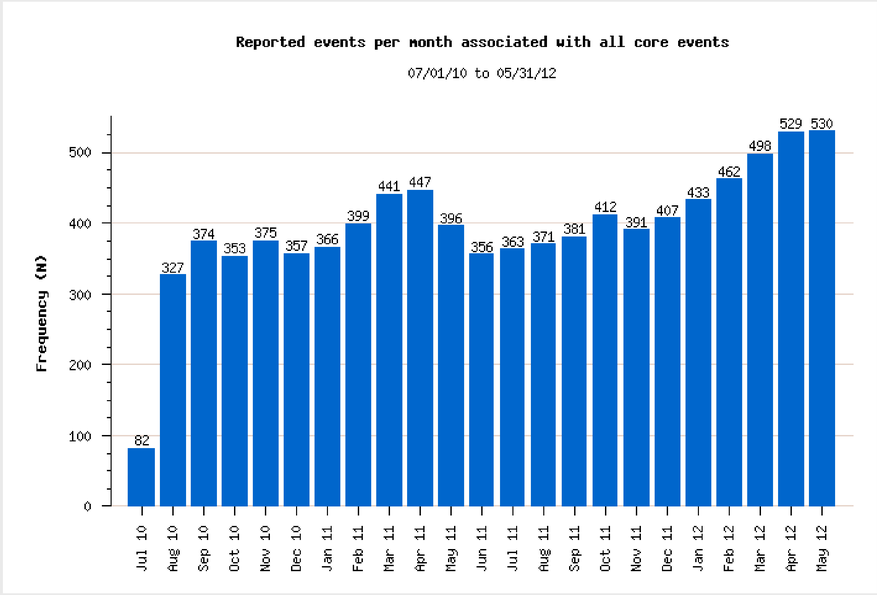
EVENT CATEGORIES



EVENT REPORTING PRE MERS UNDER RISK MANAGEMENT



EVENT REPORTING POST MERS UNDER OPERATIONS



Our MERS system at The Miriam Hospital went live on July 26th 2010. The chart above represents all events logged into the system as of that date.

Total reports in 2011=4730. Average reports per month were ***394.2***. This was a ***303%*** increase over baseline (130/month prior to MERS).

Utilizing the first five months of data, average events posted per month for 2012 were ***490.4/month***. This was a ***377%*** increase from baseline (130 prior to MERS go live).

LESSONS LEARNED/ IMPROVEMENTS

What We Have Learned
- •Quality of reporting is improved based on just in time feedback.
- •Looking at reports daily is essential to prioritize information.
- •Analyzing and grouping trends has led to voluntary RCA's.
- •Partnering with Risk is beneficial.
- •Our environment is not always safe; to protect our patients we need to report events.
- •Transparency is paramount.
- •Creating policies and holding people accountable can not be underestimated.
- •Changes can be made with one report by one individual.
- •Ensuring staff receive feedback is critical to success.
- •Sharing lessons learned in a multitude of venues helps the cause.
- •It takes a village to change culture!

Improvements/RCA's Lead To System Changes
- • Information Services Fixes
  - •Laboratory- enhanced fonts on labels
  - •Non Invasive Vascular Lab – worksheet enhancements
  - •Radiology- worksheet enhancements
  - •Continuity of Care Form – upgrade done for medication reconciliation process
- •More Equipment
  - •Additional patient lifting equipment
  - •Additional printers
  - •New carts for dialysis
  - •New GYN cart
  - •MRI compatible O2 tanks and holders
  - •Backup generators for off campus buildings
  - •Patients Medications Safe
  - •More badge readers for secure areas
- •Policy Creation / Changes
  - •Insulin Administration
  - •RN's Travel to Diagnostic Areas With Patient Post Falls
  - •Dietary Guidelines Revisions Related to Patients With Allergies – Introduction of "Allergy Alert" Stickers
  - •Infection Control / Lab – new guidelines on reporting of patients with MRSA/VRE
  - •Blood Bank – enhancements to past history of blood type
  - •Central Line Documentation Policy
  - •Wound Vacuum Assisted Closure (VAC) Policy
- •Education
  - •MD Standardized Education r/t Information Systems and Order Entry
  - •Change in education program for the total joint population

NEXT STEPS/FUTURE DIRECTIONS

•Enhance reporting capacity
- Unit Level
- Department Level
- Organization Level
- System Level
- State Level

•Analyze, trend RCAs with actionable plans to improve safety
- Phase 2 – Work with Quality to help ensure metrics are established as needed.
- Work with Risk and hospital leadership on system issues.

•Enhance RCA process by asking "Patient/Family" centered questions

•Increase reporting by all staff/MDs, enforce the "Staff Responsibility for Safety" and "Event Reporting and Analysis" Policies

•Capture the moment and work on fixes for near misses/good catches

•Share all lessons learned in as many venues as possible – spread the word

•Work with GE PSO to enhance the MERS product in general and reporting capabilities in particular