

Creating a Culture of Confidence: The Right Response to Reporting

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Behavioral Objectives

At the completion of the poster review the learner will:

- ◆ Identify key elements for creating a culture of confidence
- ◆ Define methods of dramatically increasing reporting
- ◆ Describe the advantages of reporting patient occurrences by developing a large database

Patient safety is at the forefront as a number one public health concern. Errors that occur related to medical care are the fourth leading cause of death in the United States. The most effective way to improve patient safety is the prompt and accurate reporting of all actual and potential (near misses) incidents along with a critical review of the process/processes which may have been a contributing factor with subsequent appropriate action and follow-up. In 2002, The Methodist Hospital of Houston, Texas, took a proactive approach to the reporting of errors and near misses by creating a culture of confidence with the right response to reporting by creating a "blame-free environment" which is the right response to reporting. We anticipated that reporting would increase in such an environment, which focused on processes rather than individuals. The following proactive initiatives were developed, revised and/or taken to encourage reporting.

Board of Directors Resolution

Excellent care and improvement is accomplished in a relationship based:

- ◆ Upon trust, honesty, integrity, and open communication
- ◆ Where proactive improvement in processes is a top priority and the Board supports proactive improvement to ensure patient safety

Bylaws of the Medical Staff

- ◆ Support process improvement and peer review
- ◆ Support a non-punitive environment for reporting

Conflict Resolution Between Medical Staff and Hospital Personnel Policy of TMH

- ◆ Supports a work environment free of all forms of harassment, exploitation, or intimidation

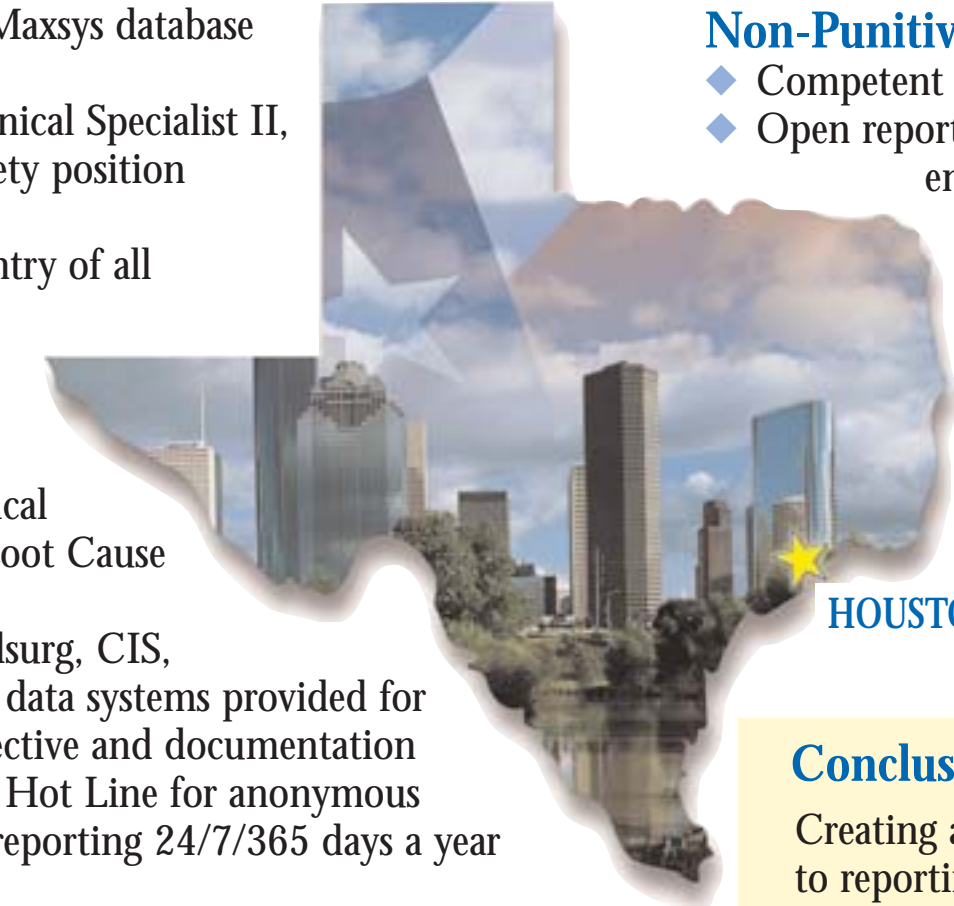
Disclosure of Unanticipated Patient Outcomes

- ◆ Patients are treated with openness and honesty
- ◆ All aspects of care, including unanticipated outcomes, are disclosed
- ◆ Procedure actions for disclosure of unanticipated outcomes include: Who, What, When, How, and Actions

Enhancements for a Blame-Free Environment

- ◆ Administrative, managerial, and staff education
- ◆ Additional in-services on selected high volume/high risk and high reporting departments, i.e., OR's
- ◆ Weekly presentations for orientation of new staff
- ◆ Increased Respiratory Therapy Department participation

- ◆ Training and access to Maxsys database provided to staff
- ◆ Full-time Pharmacy Clinical Specialist II, Patient/ Medication safety position established
- ◆ Pharmacy review and entry of all medication events implemented
- ◆ Active Pharmacy participation on all medication related Critical Incident Reviews and Root Cause Analysis
- ◆ Access to Softmed, Medsurg, CIS, HIS, and Capture EZE data systems provided for multidisciplinary perspective and documentation
- ◆ Access to Patient Safety Hot Line for anonymous reporting 24/7/365 days a year

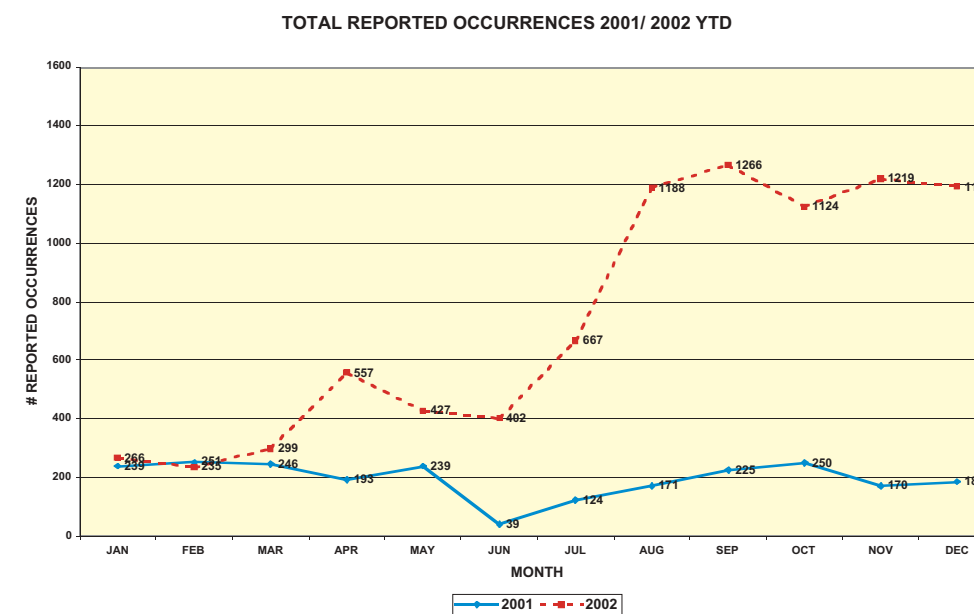


Non-Punitive Reporting Policy

- ◆ Competent and caring professionals make mistakes
- ◆ Open reporting without fear of reprisal is supported and encouraged
 - ◆ Many errors result from poorly designed processes and/or complex systems
 - ◆ Incidents are tracked and analyzed to establish trends and/or patterns
 - ◆ Everyone is expected to participate in reporting and developing improved processes
 - ◆ No punishment or disciplinary action shall be taken for the reporting of any specific error, accident and/or near miss

Conclusions

Creating a culture of confidence with the right response to reporting has resulted in a more blame-free environment in which errors, near misses, and sentinel events are reported without fear of reprisal. This culture has resulted in a phenomenal increase in reporting within one year. The total number of occurrences reported in 2001 was 2,333 as compared to 2002 when the number jumped to 8,883, a 281% increase. The hospital has created an aggregated database, that identifies the different types of errors by severity as well as cost center. This information is used to focus on systems and processes which require immediate attention. In addition, the data may be used in benchmarking within the system as well as at other hospitals. The recent introduction of Patient Safety Net was the next natural step in the process of promoting a culture of safety as we benchmark against other organizations with the assistance of UHC. It takes the cooperation and support of the entire hospital to develop an open reporting system which makes patient safety, satisfaction, and outcomes its number one priority.



Patient Occurrence Report Form Revision

- ◆ Comprehensive and simple
- ◆ Triggers for required information and follow-up
- ◆ Severity ratings match those of ISMP
- ◆ Managerial accountability for proactive measures, suggestions and/or referrals

Patient Occurrence Reporting Policy & Procedure

- ◆ Mirrors new form
- ◆ Outlines reporting structure for confidentiality and protection from discovery