Strategies to Cultivate a Culture of Reporting

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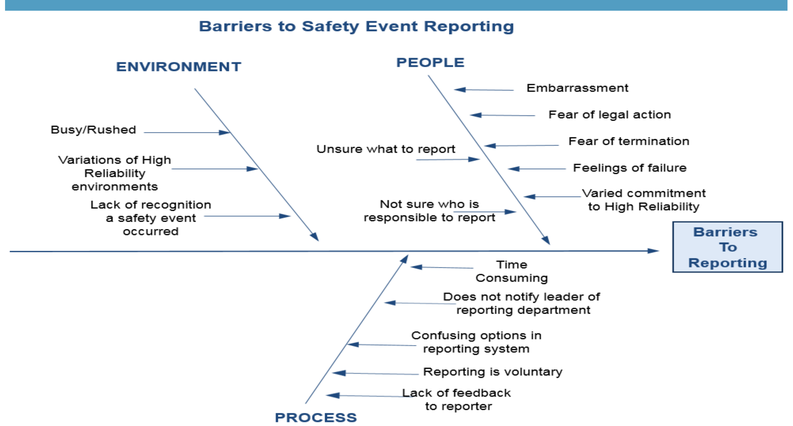
ABSTRACT

Highly Reliable Organizations (HRO) manage to have fewer mishaps and accidents despite operating in complicated environments. By studying events when things go wrong, reliable organizations realize that when things don't go as planned it is because of system and process failures rather than mistakes made by one individual. Healthcare organizations are adopting high reliability principles to improve patient safety. When things go wrong in healthcare patients are harmed. To prevent further harm, events are investigated to identify causal factors. Steps are then taken to prevent future harm by tightening systems and processes. Mature HRO's grow into a proactive approach where mishaps are investigated before they reach patients and cause harm. Investigating close calls and near misses provides an opportunity to fix problems before they reach patients. The key to a proactive approach is robust event reporting. Detecting vulnerabilities before they reach patients improves outcomes and reduces patient harm. At AMITA Health the Patient Safety Specialists aim to increase event reporting by 20% in FY 2018 compared to FY 2017 by employing high reliability strategies to remove barriers, increase awareness of expectations for reporting, and recognize those that have the courage to report.

BACKGROUND

Safety event reporting at AMITA Health Adventist Hinsdale and Lagrange hospitals has historically been encouraged primarily for events where patients or associates have been harmed. Little attention was given to near miss events. In April of 2016 a safety program was launched. As the program gained traction, methods and strategies were implemented to lay a solid platform to build a robust program that would be sustainable. At the start of fiscal year 2018, the focus shifted to increased reporting. The Patient Safety Specialist team identified that increased reporting was critical to cultivate a culture of reliability and safety. In order to fix defects they must be known. Several strategies have been launched to date and have proved to be successful. There has been an increase of 26% at Hinsdale and 34% at Lagrange.

IDENTIFYING BARRIERS TO REPORTING



STRATEGIES

Safety Coaches

- Monthly Meetings (4 options every month)
- 5x5 rounding
- Sharing Safety Stories
- Treasure Chest shopping expeditions

Reward and Recognition

- Good Catch Awards
- Share Safety Stories and Good Catches at Leadership Meetings, Town Halls and Department Meetings.
- Awards inclusive of all departments and disciplines

Safety Huddle Optimization

- Days/Hours since last Serious Safety Event
- Days/Hours since last associate injury
- Number of safety events past 24 hours
- Looking back….Looking forward format

Internal Data Sharing

- Number of events per month by department
- Top 3 categories monthly
- Top 3 event indicators for each category
- Monthly Harm Slide
- Top 10 reporting departments each month
- Common Cause Analysis (annually)

REFERENCES

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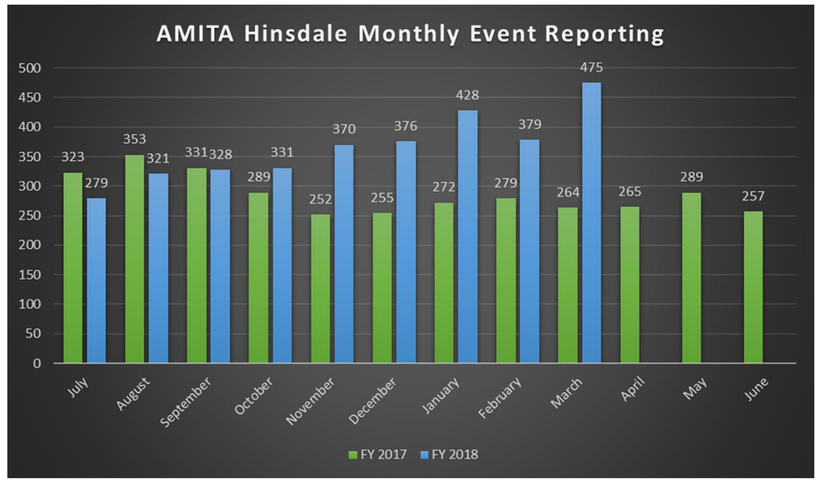
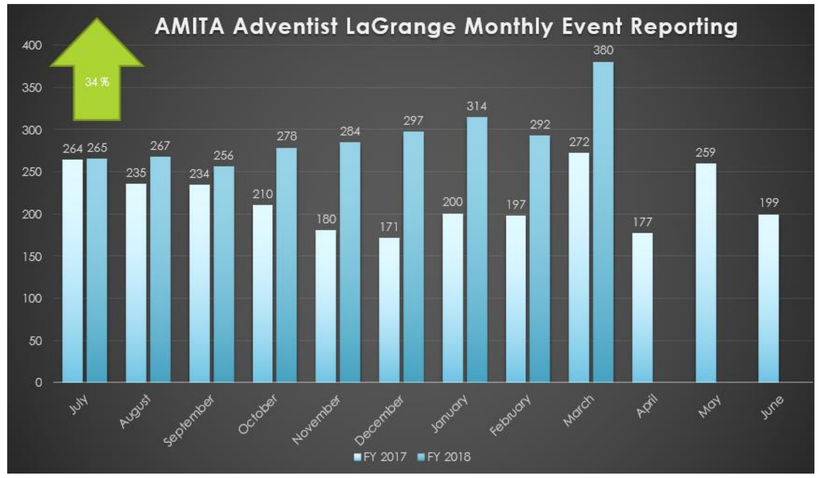
Weick, K., Sutcliffe, K. (2015) Managing the unexpected. Wiley.

RESULTS TO DATE





NEXT STEPS

- Patient Safety Office Hours in Departments
- Enhanced Follow-up/Feedback Program
- Launch To Err is Human Campaign
- Patient Safety Specialist Rounds
- Develop a Transportability Plan
- Enhance 5 x 5 rounding
- Good Catch Hotline
- Safety Symposium