Patient Safety Event Reporting is the way we identify and address issues that impact patient safety. Safety event reports help us prevent harm.

What should be reported?
Anything that harms, or threatens to harm, a patient should be reported.

Who can enter a report?
Any provider or staff member can report a safety event.

What is the risk of reporting?
There are no penalties associated with reporting, in fact, reporting is encouraged and celebrated, since it presents an opportunity to protect patients and improve care processes. The risk of NOT reporting is missing the chance to prevent harm.

How do I enter a report?
Safety events are reported using University of Utah Health Care’s patient safety event reporting system. The patient safety event system is available via:

- Intercomm: Clinical/Patient Care/Patient Safety Net
- EPIC One Chart: EPIC/References/Clinical/Patient Safety Apps

Event reporting does not need to be done in the “heat of the moment,” but should be done as soon as possible after an event occurs or an unsafe condition is identified.

What happens after an event is reported?
All events are reviewed by the Department of Quality and Patient Safety, by managers in the area of occurrence, and by others as appropriate to the event, to identify processes that can be improved to prevent recurrence or improve care.

Example Event Report
A patient walks into a clinic and is waiting to be seen. A patient name is called by staff, once, and then twice. On the second call, the patient stands up and is taken back. A staff member voices concern that the patient has a language barrier and may not understand what is being said. An interpreter is then called. The clinic is busy and while waiting for the interpreter, the provider sees the patient, whom he has not previously met. Hand signals are used to communicate, and the provider proceeds to perform a scheduled outpatient procedure.

What do you think went wrong?
The procedure was performed on the wrong patient.

Why?
To establish the patient’s identity, the patient’s name was read and he was asked if it was correct. He answered in the affirmative, due to a lack of complete understanding. It was later discovered that he had a language barrier, misunderstood the question, and was not the patient on whom the procedure was to be performed. Care proceeded without positively identifying the patient, or addressing an identified concern with communication.

What was changed as a result of this report?
The process for identification was changed to require that the patient be asked to state their name, to prevent a similar problem in the future.

Have you had a patient suffer harm?
Are you aware of something that could potentially harm a patient?
If yes, REPORT IT, by entering a Patient Safety Event Report!