PATIENT SAFETY EVENT REPORTING
Why bother?
DOES THIS TOPIC APPLY TO ME?

- Have you ever witnessed a patient being harmed while receiving care?

- Are you aware of something that could potentially harm a patient or visitor?

- Anyone who works in healthcare will at some point be able to answer “yes” to one, or both, of these questions.

This presentation will show you how to help remove risk of harm to patients and visitors by reporting patient safety events.
WHY IS PATIENT SAFETY IMPERATIVE?

• None of us come to work intending to harm a patient and yet patients are still harmed

• No one is exempt from the risk of making a human error

• Preventable harm is a very significant problem in healthcare

• We are forever changed following a patient safety event
WHAT IS A PATIENT SAFETY EVENT?
Anything that harms, or threatens to harm, a patient or visitor.

WHAT IS PATIENT SAFETY EVENT REPORTING?
Entering information about a patient safety event into our event reporting system, to provide an opportunity to improve care processes and prevent recurrence.

WHAT IS PATIENT SAFETY?
A field of expertise that uses safety science and systems thinking to design practices, procedures, and environments to enable the safest care and the avoidance of harm.

National Patient Safety Foundation
PATIENT SAFETY AT U HEALTH

• Each day approximately 40 patient safety events are reported by providers and staff across.

• Each of these reports provides an opportunity for us to improve our care process and decrease preventable harm.

• Serious safety events (SSE): Events which cause, or could potentially cause death, severe permanent harm, or moderate temporary harm, due to a deviation in care.

• Our goal is zero SSE. CY 2017 we had 32 SSE. We have had 15 so far in CY 2018. Our serious safety event rate is 0.35 per 10,000 adjusted patient days.
WHAT IS MY ROLE IN PATIENT SAFETY?

- Learn to **recognize patient safety risk and error**

- Be willing to **speak up and report patient safety events** in our event reporting system (RL)

- Provide front line clinical input into the analysis of serious safety events and action planning to prevent recurrence
WHY SHOULD I REPORT?

- Reporting patient safety events is the **main way we identify and address patient safety issues**
- We can’t fix what we don’t know about
- Reporting **helps us to learn about safety problems so that we can fix them**
- Reporting is **not punitive**
- To prevent the same thing from happening again
WHAT SHOULD I REPORT?

• Anything that has harmed, or has the potential to cause harm to a patient or visitor

• **Unsafe conditions:** Could cause harm if not addressed

• **Near miss situations:** Deviation in care occurred but was caught before it reached the patient

• **Adverse clinical events:** Instances where errors were made and reached the patient whether or not harm occurred

• **Inefficiencies/problems with care delivery**
HOW DO I REPORT?

- Report using RL, our patient safety event reporting system
- RL stands for REPORT and LEARN
- RL can be found:

  ![Diagram showing how to access RL system through various platforms]
IT'S EASY TO REPORT!

Using a computer:

1. Log into RL with your uNID and password
2. Select the icon that best fits the type of event being reported
3. Complete the fields in the form to the best of your ability
4. “Submit”
IT’S EASY TO REPORT!

Using a mobile device:
1. Download RL6 mobile from your app store
2. Select “manual entry” and configure device using this URL:
   rl6-3.rlsolutions.com/Utah_Prod_Mobile
3. Click “connect”
4. Login with uNID and password
5. Fill in fields and submit
WHEN REPORTING, PLEASE DO THE FOLLOWING:

• Provide a short and complete summary of what was witnessed or what occurred, addressing the issue and not the people involved.

• Use objective, professional, nonjudgmental language and avoid placing blame.

• List names of people involved, as appropriate.

• Use direct quotations where appropriate.

Let the patient’s nurse or charge nurse know when an event occurs that affects a patient.
WHAT HAPPENS AFTER I REPORT?

Patient safety event reports are taken very seriously!

• Every report is reviewed by multiple key stakeholders as applicable:
  – Patient Safety
  – Nursing Quality
  – System Quality
  – Physician leadership
  – Leaders in the area in which the event occurred
  – Others, based on the type of event, what occurred and the level of harm

• Most issues are investigated and acted upon at the local level. Issues with the potential to happen in multiple locations, or which are deemed serious, are escalated for system level response.
DOES REPORTING REALLY MAKE A DIFFERENCE?

• Operative and Anesthesia staffing was extended to 24/7 coverage at one of our hospitals in response to reports related to after hour delays.

• A specialized team was created for expert placement of all Corttrak tubes after some complications associated with tube placement.

• Pharmacy changed to an alternative version of an antibiotic, with different packaging, to be stored in a different location, after the wrong medication almost given due to a look-alike issue.

If you want to know what happened in response to a report you submit, please contact Patient Safety @ 1-3850 or patient.safety@hsc.utah.edu or ask the appropriate local leader.
REPORTING

- Is encouraged, appreciated, and applauded

- IS NOT about finding fault or placing blame

- IT IS about identifying opportunities to review and improve how we deliver care as a system

- Helps us prevent harm to our patients

So…SPEAK UP!!!
ADDITIONAL INFORMATION

• **Computer Based Learning Module:**
  Graduate Medical Education (GME) Report and Learn (RL) Training
  
  [https://education.hrit.utah.edu/ITS/IT_1802_GME-RL-Form/index_lms_html5.html](https://education.hrit.utah.edu/ITS/IT_1802_GME-RL-Form/index_lms_html5.html)

• Patient safety site on U Health Intranet site “PULSE”
  
  [www.pulse.utah.edu/PatientSafety](www.pulse.utah.edu/PatientSafety)