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Utilizing feedback as a mechanism to improve resident event reporting rates

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Background

Preventable medical errors are responsible for significant patient morbidity and mortality. As a result, improving voluntary reporting of such events has been a long standing goal of the Institute of Medicine (IOM), with an aim to reduce patient harm. In 2015-2016, the Housestaff Quality and Safety Committee (HQSLC) focused on educating housestaff on the value of event reporting. Despite this, the proportion of reported events entered by housestaff remains stagnant at ~3%.

Underreporting by housestaff is a common problem in teaching hospitals across the US. Proposed reasons for this are:

- Fear of blame and retribution
- Uncertainty about what should be reported
- Lack of feedback once an incident has been reported (Jasti et al 2009).

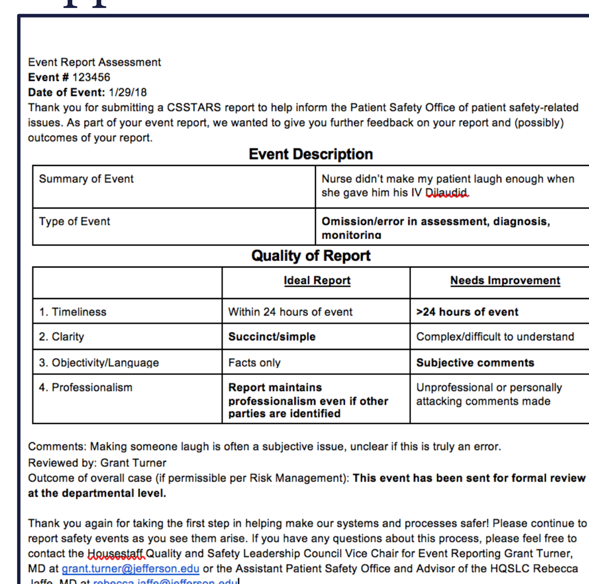
During the 2017 Clinical Learning Environment Review (CLER) visit to TJUH, 97% of housestaff felt the culture for reporting errors was supporting and non-punitive, but only 27% of residents had received feedback on the event. This suggests that improving feedback around event reports entered might improve our rate of voluntary reporting by housestaff.

Objectives

- Provide feedback to 100% of residents entering a report between December 2017 and March 2018
- Evaluate the degree to which residents value the feedback we were able to provide
- Assess a pilot process for sustainability on a larger scale

Methods

- A standardized form was adapted (Figure 1) to provide structured feedback to the reporter on elements of their report, including timeliness, clarity, objectivity and professionalism
- Information regarding actions taken at local (unit or department) or institutional levels to address the event were supplied when available
- If follow actions were not reportable due to ongoing investigation, standardized phrases developed with Risk Management were used to assure reporters that follow up was ongoing
- Feedback forms were reviewed by Risk Management prior to distribution back to the reporter
- Reporters were surveyed regarding their satisfaction with the process



Event Report Assessment
Event # 123456
Date of Event: 1/29/18
Thank you for submitting a CSSTARS report to help inform the Patient Safety Office of patient safety-related issues. As part of your event report, we wanted to give you further feedback on your report and (possibly) outcomes of your report.

Event Description

Summary of Event	Nurse didn't make my patient laugh enough when she gave him his IV Dilaudid.
Type of Event	**Omission/error in assessment, diagnosis, monitoring**

Quality of Report

	Ideal Report	Needs Improvement
1. Timeliness	Within 24 hours of event	**>24 hours of event**
2. Clarity	**Succinct/simple**	Complex/difficult to understand
3. Objectivity/Language	Facts only	**Subjective comments**
4. Professionalism	**Report maintains professionalism even if other parties are identified**	Unprofessional or personally attacking comments made

Comments: Making someone laugh is often a subjective issue, unclear if this is truly an error.
Reviewed by: Grant Turner
Outcome of overall case (if permissible per Risk Management): **This event has been sent for formal review at the departmental level.**

Thank you again for taking the first step in helping make our systems and processes safer! Please continue to report safety events as you see them arise. If you have any questions about this process, please feel free to contact the Housestaff Quality and Safety Leadership Council Vice Chair for Event Reporting Grant Turner, MD at grant.turner@jefferson.edu or the Assistant Patient Safety Office and Advisor of the HQSLC Rebecca Jaffe, MD at rebecca.jaffe@jefferson.edu

Figure 1: Feedback form, adapted from Boike et al and Dr. Michelle Brooks of VCU

Results

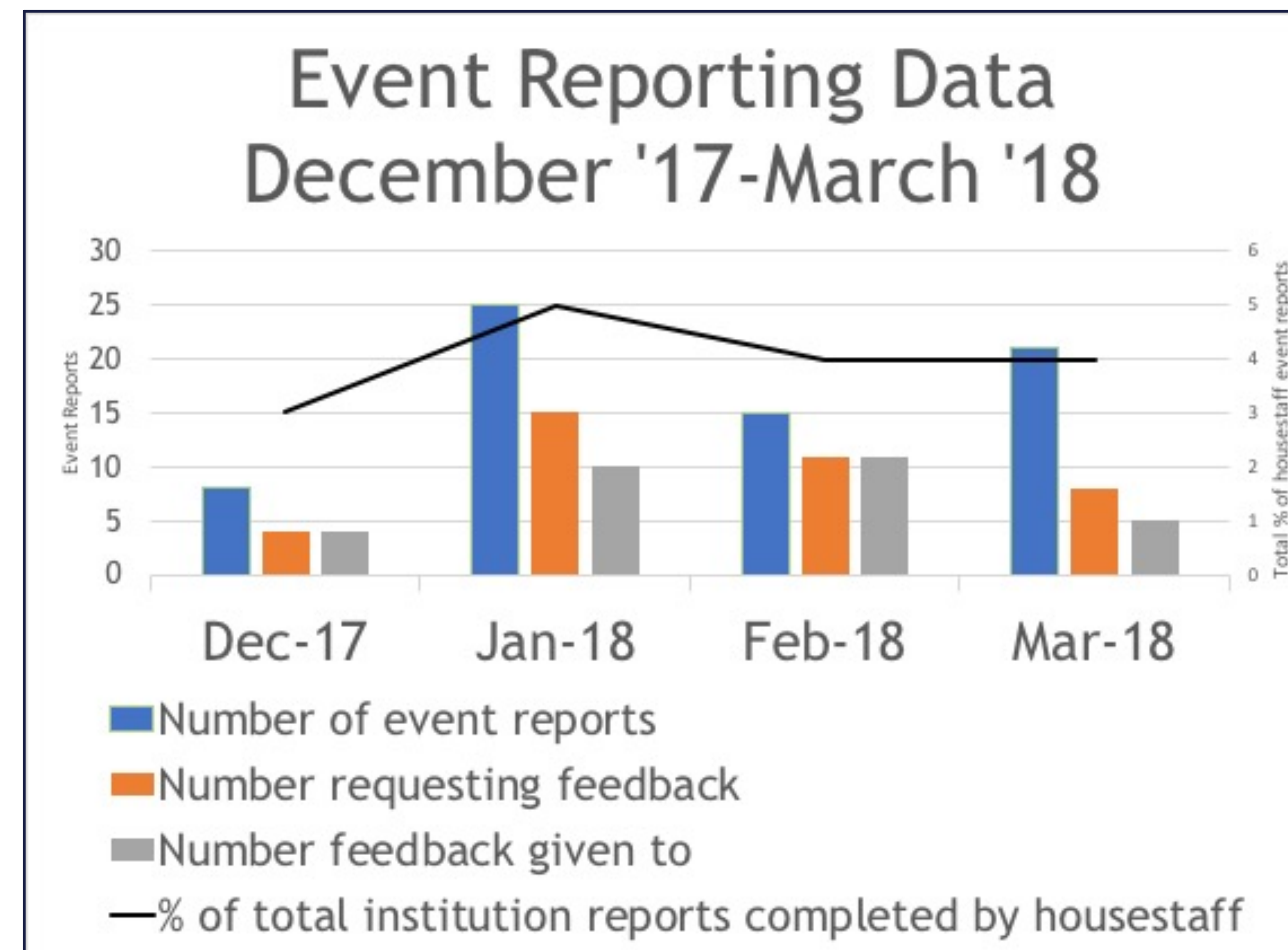


Figure 2: The number of event reports from housestaff during each month of the study period, including the proportion that requested and received feedback through the HQSLC process. Secondary axis demonstrates the percentage of reports made by housestaff compared to all other event reports institutionally.

A total of 69 event reports were entered during the pilot period, of which 38 requested feedback. We were able to provide feedback for 30 (79%). Reasons contributing to <100% performance were:

- Event reports can be entered anonymously, in which case feedback cannot be provided
- Follow up information existed but could not be shared with the reporter (ie, to protect privacy of patient or providers, significant legal concerns)
- No specific follow up information existed for the event

Of the events where feedback could be given, 47% were provided specific information regarding institutional process changes resulting from the reported event. The remainder of reporters received approved stock phrases (Figure 3)

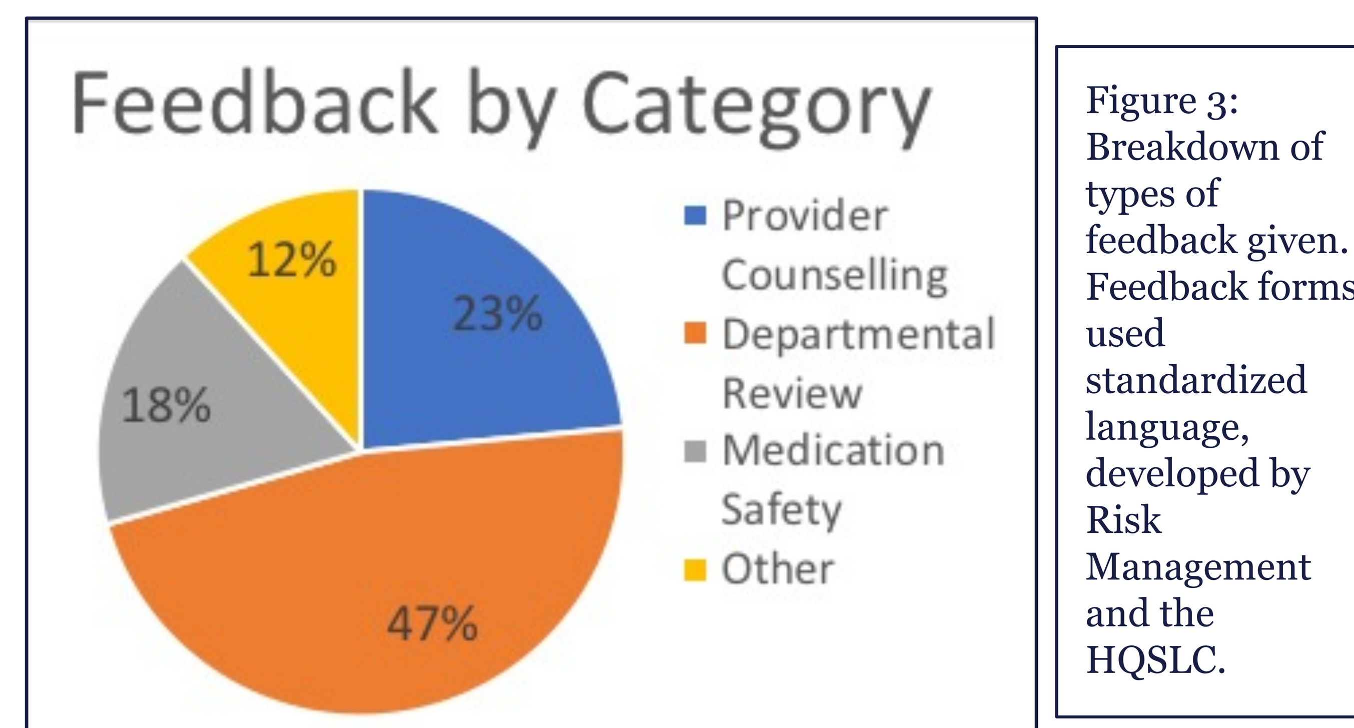


Figure 3: Breakdown of types of feedback given. Feedback forms used standardized language, developed by Risk Management and the HQSLC.

Results (Con't)

After feedback was provided, each reporter was asked to complete a brief survey (completion rate 20%)

- 83% of residents who received feedback forms had submitted an event report prior to the current report
- Average score of 3.8 for quality of feedback on event report

(1 = not useful, 5 = very useful)

- 67% of residents felt that the feedback they received encouraged them to report more events in the future
- 50% of residents felt that there was an adequate institutional response to their report

Conclusions/Future Directions

Challenges

- Membership buy-in for completing forms
- Time commitment for both form completion and risk management investigation
- Investigations may not yield information anticipated by the the reporter
- Medical/legal limitations outside scope of HQSLC

Intermediate Solutions

- The HQSLC plan to continue this project in 2018/19
- Use standardized language to reduce administrative burden
- Use specific peer protection language to address legal concerns

Future Directions

- Investigate other modalities of providing feedback: Phone, in person conferences, peer to peer
- Collaboration with other institutions who have successfully provided feedback to reporters

Special Thanks

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References

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