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Voluntary Incident and Near-Miss Reporting

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Voluntary Incident and Near-Miss Reporting by Direct Care Support Staff

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Background

Baptist Health South Florida (BHSF) is the largest not-for-profit healthcare organization in South Florida that is comprised of six hospitals. Mariners Hospital is part of BHSF and is located 65 miles south of Miami in the Florida Keys. It is a 25 Bed Critical Access Hospital that in fiscal year 2013 treated 597 inpatients, 11,514 emergency visits, 20,740 outpatients, and 5,000 encounters in the employed physician's offices. With our desire to provide the highest quality of care, it is crucial to have any unanticipated or near-miss events reported.

Incident reports provide valuable information for quality improvement. Not all hospital employees know what events should be reported. Under reporting of incidents remains a serious issue in healthcare. Nationally there are 5-20% of incidents never reported [2].

Project Aim

- 2% increase in voluntary incident reporting by direct care support staff, including near-misses.
- Collaborate with the Patient Safety Partnership and Risk Management.
- Share aggregate year end results with all staff.

Objectives

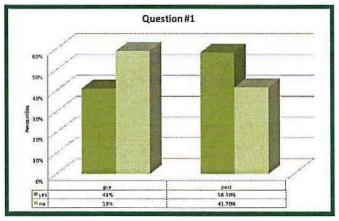
The purpose of this study was to improve education and reporting of incidents, including near misses, by direct care support staff (clinical partners, unit clerks, telemetry technicians, dietary, and staff of the employed physician's offices).

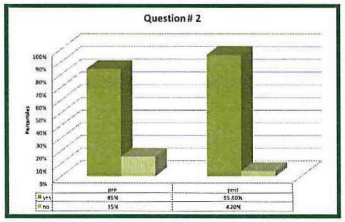
Methods of Implementation

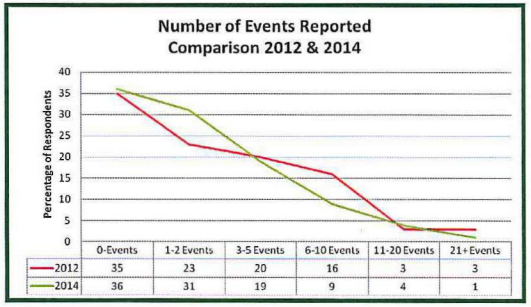
- Retrospective review of Agency for Healthcare Research and Quality's (AHRQ) 2012 incidents reported by direct care support staff were reviewed for number of incident reports that were completed by job code.
- Retrospective review of number of incident reports completed by employed physician's offices for 2012.
- Anonymous pre-survey conducted immediately prior to staff education on incident and near-miss reporting (39 surveys returned).

Pre/Post Survey questions were:
1. Have you ever completed an incident report?
2. Do you know where to go online to report an incident?
3. Who can you call to get help with incident reporting?
4. Whose job is it to complete an incident report?

- 1 hour voluntary incident and near-miss reporting education was given to all of the direct care support staff.
- 6 months later a post-survey was sent out to the same groups of direct care support staff (24 surveys returned).
- Retrospective review of number of incident reports completed by employed physician's offices for 2013.
- Retrospective review of 2013 AHRQ incidents reported by direct care support staff was reviewed for number of incident reports completed by job code.







Results

- The study resulted in a trend towards improvement in staff understanding of voluntary incident reporting.
- Rates of voluntary reporting were increased dramatically.
- Trends for questions 1 & 2 were towards improvement. Answers to questions 3 & 4 were identical pre and post incident report education.
- In the employed physician offices, the reporting rate increased from 0.4 per 1000 patient encounters in 2012 to 2.48 per 1000 patient encounters in 2013.

Discussion

Prior to study approval it is imperative to involve the hospital system's risk management, patient safety organization, and the legal department.

The focus of this educational intervention included:
- who is required to complete an incident or near-miss report
- non-punitive reporting
- specific examples of what is appropriate to report

The next steps will be to:
- Focus on how to complete an online incident report through the Midas™ System.
- Educate additional direct care support staff, such as maintenance and environmental services.
- Disseminate findings both hospital and system-wide.

Lack of reporting or poor quality of documentation of patient incidents "is a lost opportunity to improve patient-care" [1]. Educating all hospital employees on this process will help to reduce patient harm and save lives.

References

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2. Joint Commission Resources. (2011). The Value of Close Calls in Improving Patient Safety: Learning How to Avoid and Mitigate Patient Harm. Oak Brook, IL: Wu, A.W.
3. Outcome Engineering LLC. (2008). Just Culture: Training for the Healthcare Managers. Plano, TX.