



## **Hospital Adverse Event Reporting Program: an Initial Evaluation**

When the Patient Safety Commission began the Adverse Event Reporting Program in May, 2006, we promised hospitals we would complete an evaluation within six months. To honor our pledge, we fielded a survey in November. Our goal was to measure progress in creating a reporting program that supports quality improvement activity. We were specifically interested in comments about the reporting template, the impact of the program, and our ability to put the reported data to good use.

To provide a useful evaluation we developed two versions of our survey – one for hospitals that had submitted adverse event reports (24 hospitals as of November, 2006) and one for those that had not (28 hospitals). Our response rates for completed surveys:

- Overall: 32 of 52 hospitals completed surveys ( 60%)
- Among those that had filed an adverse event report: 19 of 24 (79%)
- Among those that had NOT submitted an adverse event report: 13 of 28 (46%)

Following is a brief summary of findings and an overview of our next steps. Complete survey results are available on the Commission's website at [www.oregonpatientsafety.org](http://www.oregonpatientsafety.org). Independent of this evaluation we will publish a report of 2006 adverse event data later in January.

### **Overall Assessment**

In general it seems that the Adverse Event Reporting Program is off to a good start, though we need to continue to raise the visibility of the program. Senior management and boards of directors appear to be more aware of the Reporting Program than hospital clinical staff. Overall there was a clearly articulated need for streamlining the reporting process and for providing hospitals with more results (especially quarterly reports), action items, feedback and training.

Based on our evaluation, we are now ready to make improvements to the reporting program. Planned changes include:

- Shortening the reporting form.
- Providing written guidance on what to include in the form.
- Clarifying definitions of events and harm levels, especially as related to disclosure requirement.
- Initiating discussions with hospitals around how to handle overlap with peer review.
- Identifying Commission announcements more clearly when sending out via E-mail; including all reports/announcements on the website.
- Increasing contact with hospitals to assist in identifying reportable events and providing hospital-specific trainings and support.
- Developing an Advisory Committee for analysis of adverse events and assistance with improving RCAs.

In the coming weeks we will work with our partners to simplify and improve the adverse event reporting program. For further information or comments, please contact:

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## The Reporting Tool and Process

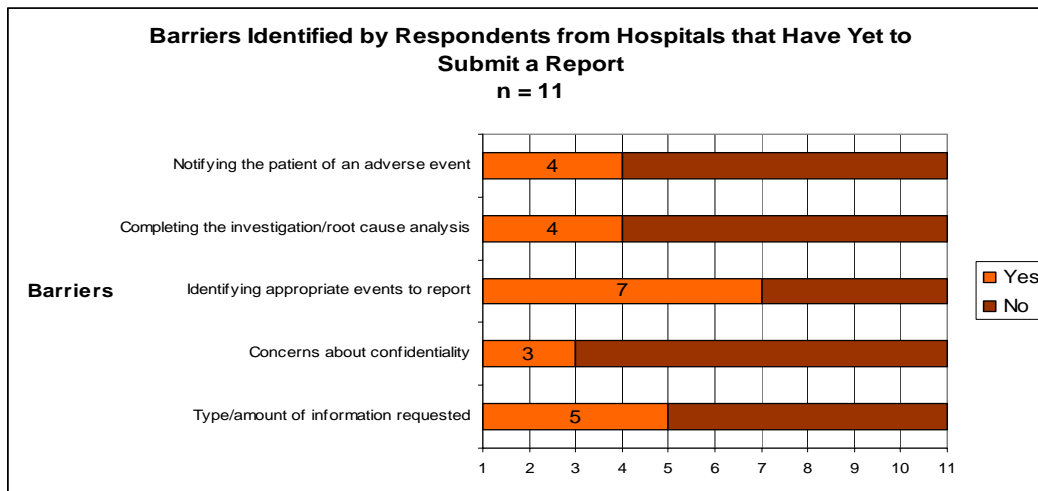
In general, respondents indicated that the Commission’s definitions, reporting tool and process were relatively easy to use and consistent with already-in-place procedures. However, respondents suggested that the Commission:

- clarify definitions of serious, less serious adverse events, harm levels, and reporting “near-misses”;
- recommend how to handle adverse events when the cause is difficult to identify;
- provide understandable boundaries around peer review;
- reduce overlap in categories of contributing factors;
- reconsider action plan categories;
- eliminate need for back and forth communication to clarify reports.

We specifically asked hospitals to help us identify barriers to participation in the reporting program. For hospitals that have submitted reports, 7 of 19 (37%) indicated they faced challenges to full participation. Among the barriers mentioned:

- differing criteria for initiating an RCA, especially for temporary events;
- physician lack of engagement and concern over liability;
- time and resource constraints;
- internal inconsistencies and gaps in policy, procedures.

Among the hospitals that did not submit reports, *identifying an appropriate event to report* was the most frequently cited barrier, followed by the *type/amount of information requested* (see below for frequency of each barrier noted – and please keep in mind the small number of responses):



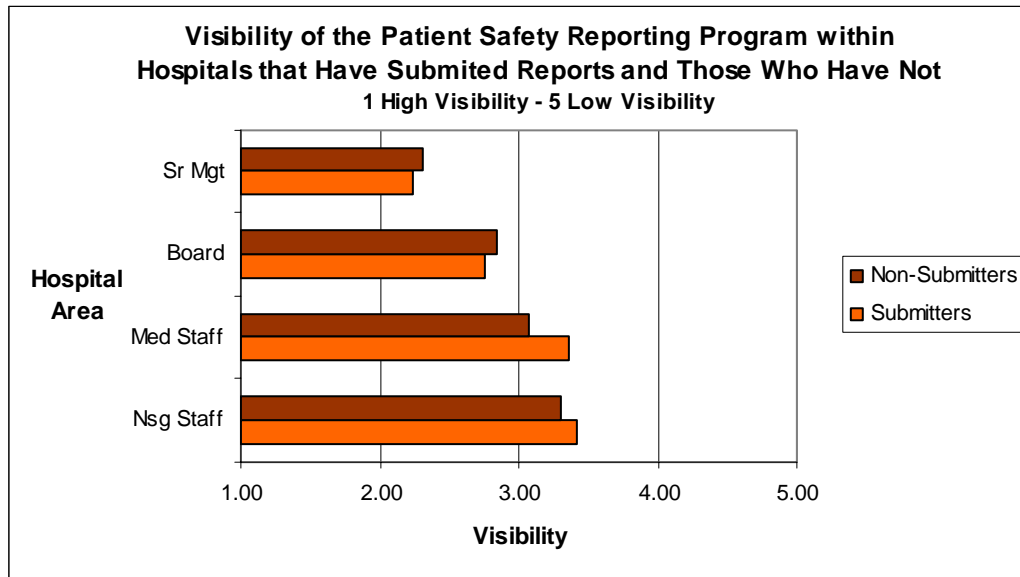
## Program Visibility

To be successful, the Patient Safety Commission’s reporting program needs to be an active and visible part of a hospital’s information structure. To judge our progress, we asked participants to rate our visibility using a five point scale (1 = high visibility; 5 = low visibility). The overall

results suggest we have made progress on the administrative side, but need to continue to reach out to the clinical teams.

Among all hospitals, senior management (2.3) and Boards (2.8) were more likely to know about the Patient Safety Commission and its reporting program than medical or nursing staff (3.2 and 3.4 respectively). Clearly, we have not yet saturated the entire hospital's culture. For example, among hospitals submitting reports, visibility within the reporting department was fairly high (1.9), but in the hospital overall it was lower, averaging 3.6.

Comparison of visibility between those hospitals submitting reports and those who have yet to submit a report is below.



**Program Impact**

To determine if the Commission is beginning to make a real difference we asked participants (who had filed a report), *Has the Patient Safety Commission had an impact on your hospital's...*

	<b>% Yes</b>
Internal Incident Reporting	37%
Investigation of Adverse Events	42%
Ability to learn from Adverse Events	53%
Culture of Safety	58%

Almost 6 in 10 respondents said that the Commission has had a positive impact on their organization's culture of safety; this is a good start. But clearly we can do more.

We also asked the hospitals that had not yet submitted reports to evaluate their organization's overall attitude toward the reporting program (from very positive to very negative). The results

within Risk Management are encouraging, while the results among clinical staff reinforce the need to work more directly with physicians and nurses:

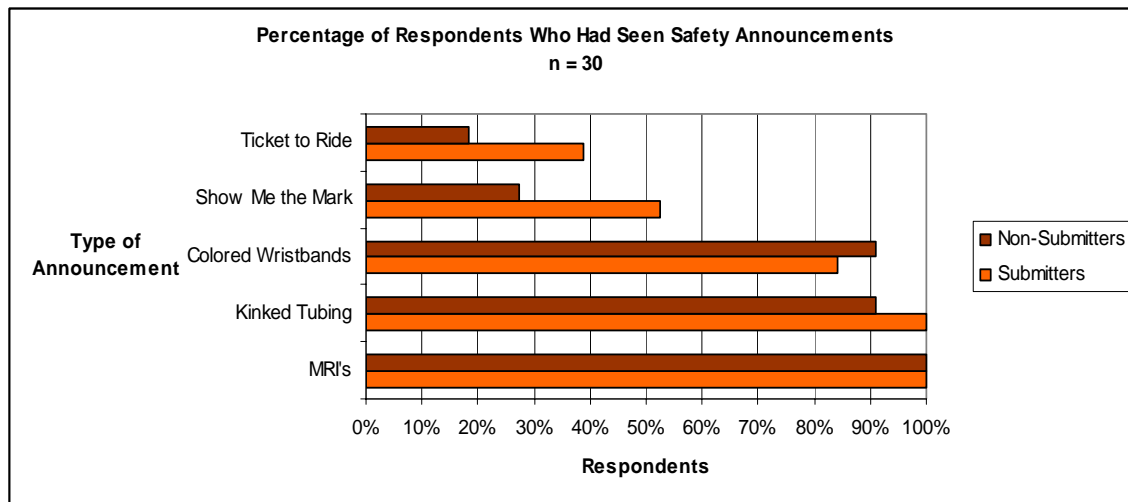
<b>Your Organization's attitude toward the reporting program (Hospitals that have not yet submitted adverse event reports)*</b>			
<b>Department</b>	<b>Very or somewhat positive</b>	<b>Neutral</b>	<b>Somewhat or very negative</b>
Within the risk/legal departments	72.7%	18.2%	9.1% (1/11)
With senior management	63.6%	27.3%	9.1% (1/11)
With nursing staff	27.3%	72.7%	0.0%
With medical staff	18.2%	54.5%	27.3% (3/11)
With the Board of Directors	50.0%	50.0%	0.0%

\* Please keep in mind that only 11 respondents answered this question.

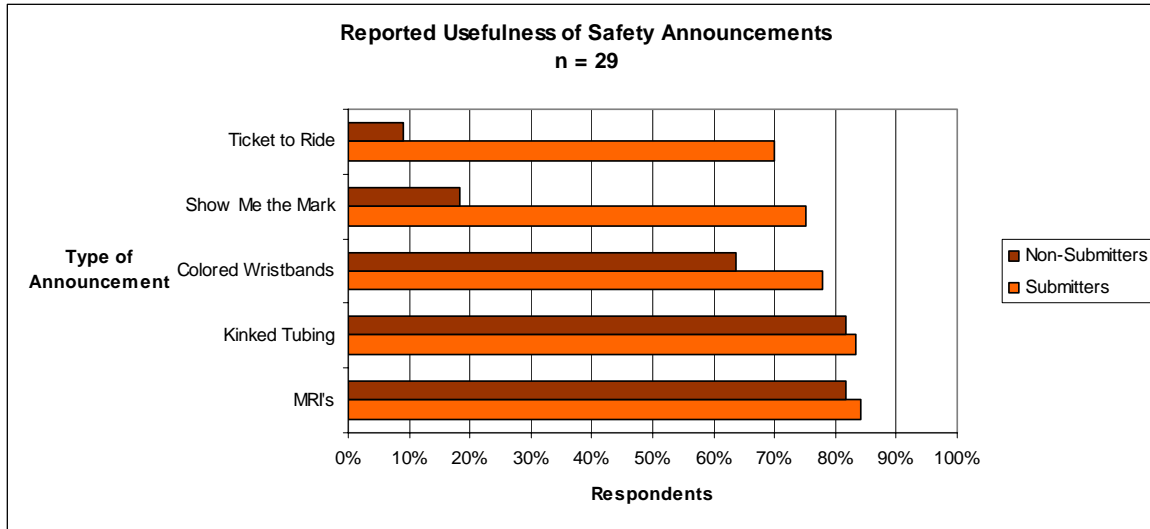
**Program Activities**

As the Commission receives information from participating hospitals it is critical that we put that information to good use. To see how we are doing we asked about our recent program activity. For example, in 2006 we published several types of announcements (Bulletins, Safety Tips), issued a report on Colored Wristband Use, and held two teleconferences for small and rural hospitals.

As the following graph suggests, almost all of the respondents saw the two bulletins, and a large percent also saw the report on Colored Wristband Use. However, a much smaller percent remembered seeing either of the two patient safety tips.



Among respondents who have seen the various announcements a large majority found them helpful. However the perceived usefulness of *safety tips* varied by whether a hospital had submitted reports or not. Those who had were much more positive:



### **Summary**

This informal evaluation of the first six months of the Hospital Reporting Program suggests we have made some real progress in raising awareness and adding value to on-going patient safety efforts. However in 2007 we need to redouble our efforts – to reach out to clinical teams, to offer root cause analysis training, to make thoughtful recommendations based on aggregate data.