Interventions to Support Physician Incident Reporting in a Culture of Patient Safety

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What happens if we underreport Patient Safety Events?

Studies have shown that only 4% of Patient Safety Events are reported through incident report system which reveals that majority of the events are under reported. This severely constrains monitoring trends of potential errors and progress in patient safety. Besides, it limits usefulness of an epidemiological approach to reporting systems. While analyzing the reporting trends among health care providers, 5 California Healthcare Centers found that only 1.7% of incident reports are completed by physicians. The low physician reporting numbers are the missed opportunities that may have unique impact on improving a specific patient care area or organizational process. These numbers were not much different at UC Davis Medical center (Fig:1).

What is the importance of physician reporting?

Each Physician specialty presents a unique view which better identifies specific types of hazards and their contributing factors. The lack of reporting hinders Patient Safety improvement efforts which leads to misdirection of prioritization of solution development.

What are the common barriers to reporting?

- Structure
  - Unsure who should complete the report
  - Unclear of the definition of an adverse event or near miss
  - Unclear of how the reporting system works
- Process
  - Lack of time to complete the forms
  - Forms too complex
  - Lack of understanding of the benefit of reporting near misses
- Outcome
  - Lack of feedback
  - Makes no difference

Figure 1: Physician Incident Reporting Jan-Dec 2016

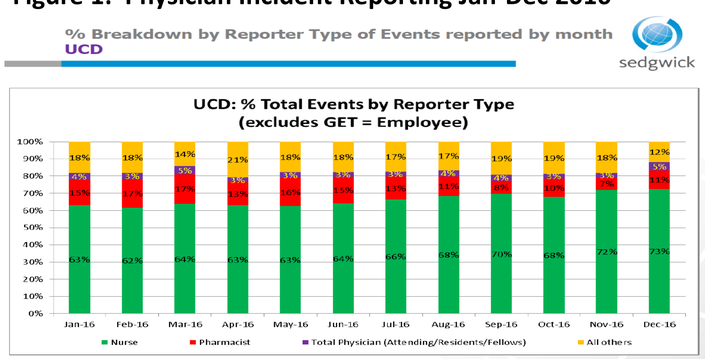

Figure 2: Feedback Loop

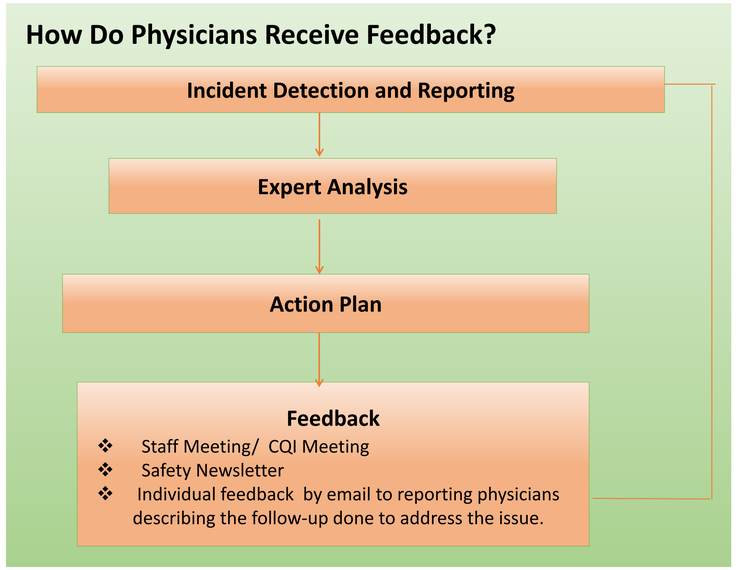

Figure 3: Resident Orientation Patient Safety Presentations

Clinical Department	Date of presentation	Planned Number of Attendees/Requested Badge Buddies
ED	9/26	35
Anesthesia	8/15	75
Pathology	8/29	13
Surgery	8/29	50
FCM	8/2	20
Pediatric	9/22	39
Neurosurgery	8/22	20
OB GYN	8/2	30
Radiology	10/11	11
Neurology	8/23	9
PM&R	8/1	20
Ophthalmology	9/12	11
ENT	6/13	20
Total		353

What we did to improve Physician reporting of safety events?

As lack of feedback and complexity of the form were identified as major barriers in physician reporting of patient safety events, the following initiatives were instituted by the Quality and Safety department.

I. **Individual physician feedback to all patient safety events reported by physicians was initiated in February 2017.**
Individual physician feedback was provided by email describing follow-up done to address the issue reported. From February through August 2017 a total of 211 incident reports were filed by physicians. Email feedback regarding the follow-up completed was provided to the reporting physician for 195 of these incidents (Fig:2).

II. An Incident Reporting Line for House staff was initiated on July 1, 2017
The purpose of Incident Reporting Line is to allow residents an alternate method for reporting patient safety events. By allowing residents to report patient harm and near misses outside of RL Solutions, we hope to increase resident participation in incident reporting, which will allow staff in Quality and Safety and Risk Management to better understand safety opportunities viewed by frontline staff. Physicians currently report between 3% and 5% of all incident reports in RL Solution. From July through August 2017, 12 incidents were reported through the hotline.

III. Patient Safety Culture Presentations Scheduled during Resident Orientation
The Quality and Safety Department conducted Patient Safety Culture presentations for all clinical department Resident orientation programs at UCDMC in August-Sept 2017. The importance of physician reporting of patient safety events in promoting safety and ensuring zero harm to patients were emphasized. The Resident Reporting hotline and it's ease of use was advertised. Badge buddies describing the steps for using the Resident Incident Reporting hotline and the RL Incident Reporting system were distributed (Fig:3)

Conclusion:

Since the institution of the interventions described above, our physician incident reporting rate has shown a steady increase. The barriers to physician reporting of patient safety events were tackled by these interventions. The physician feedback was initiated in February of 2017 and the Resident Incident Reporting Hotline and the Resident Orientation Patient Safety Culture Presentation/badge buddies were initiated in July 2017. Since then the number of patient safety incidents reported by physicians has increased by almost 87% The number of physician reported incident in February 2017 was 31 and the number of incidents reported in August of 2017 was 58 (Fig: 4). The interventions have improved physician incident reporting and thereby increased our chances of identifying, prioritizing and finding solutions to patient safety issues that may have otherwise been unnoticed which in turn increases the risk of harm to patients.

Figure 4: Physician Incident Reporting