Data analysis revealed that 201 patient safety reports relating to the Surgical Suites were entered into PSLS.

- 99% of reports related to non critical events
- 1% of reports related to critical events
- 4.5% of reports were rejected
- 11.5% of reports were entered anonymously
- The mean time to complete follow up was 33 days for reports entered anonymously compared to 37 days for reports entered nominally.

Process mapping revealed that i) primary responsibility for report follow up has resided with the Quality & Safety Leader (QSL), and ii) multiple barriers affecting timely report follow up exist currently (e.g. only 26% of PSLS actions assigned to Clinical Leaders were completed by the Clinical Leader).

Method

- Analysis of PSLS report data, from Jun.1, 2015 to Jan. 31, 2016 was undertaken.
- Consultation with Surgical Suites Clinical Leaders to develop a process map outlining the steps involved in follow up of reports.

Results

- Improved education for staff/physicians about what is and what is not a PSLS reportable event.
- Implement mechanism to ensure weekly screening of the PSLS hold area for Surgical Suites related reports.
- Set up PSLS refresher training for Clinical Leaders.
- Explore feasibility of shifting accountability for individual report follow up. (Trial began March 1, 2016 with Clinical Nurse Leaders assuming accountability for follow up of a subset of non critical events)
- Continued tracking of monthly report follow up rates to measure the effect of process changes implemented.
- Develop processes to trend aggregate data and increase sharing of system learning.

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