Understanding Barriers to Timely Patient Safety Report Follow-Up

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Background

- Reporting systems can be used to collect important information about hazards, near misses, and adverse events. The action of reporting, in itself, does not improve patient safety. Timely follow up of reports, feedback with reporters about changes that resulted from reporting, and broadly sharing learnings are key to facilitating system change and improving patient safety.
- BCCH staff/physicians report patient safety information to the BC Patient Safety & Learning System (PSLS), operated by PHSA.
- Follow up of non critical patient safety reports must be completed within 30 days of the date the report was entered and follow up of critical patient safety reports must be completed within 60 days of the date the report was entered.
- From Jun.1 to Aug. 31, 2015, 55% of Surgical Suites patient safety report follow up was completed within the PHSA identified timeframes.

Objective

- To better understand the current report follow up process, identify critical steps that increase time to complete follow up and identify opportunities for improvement.
- To increase the proportion of patient safety reports that have follow up completed within acceptable timeframes from 55% to 90% by June 1, 2016.

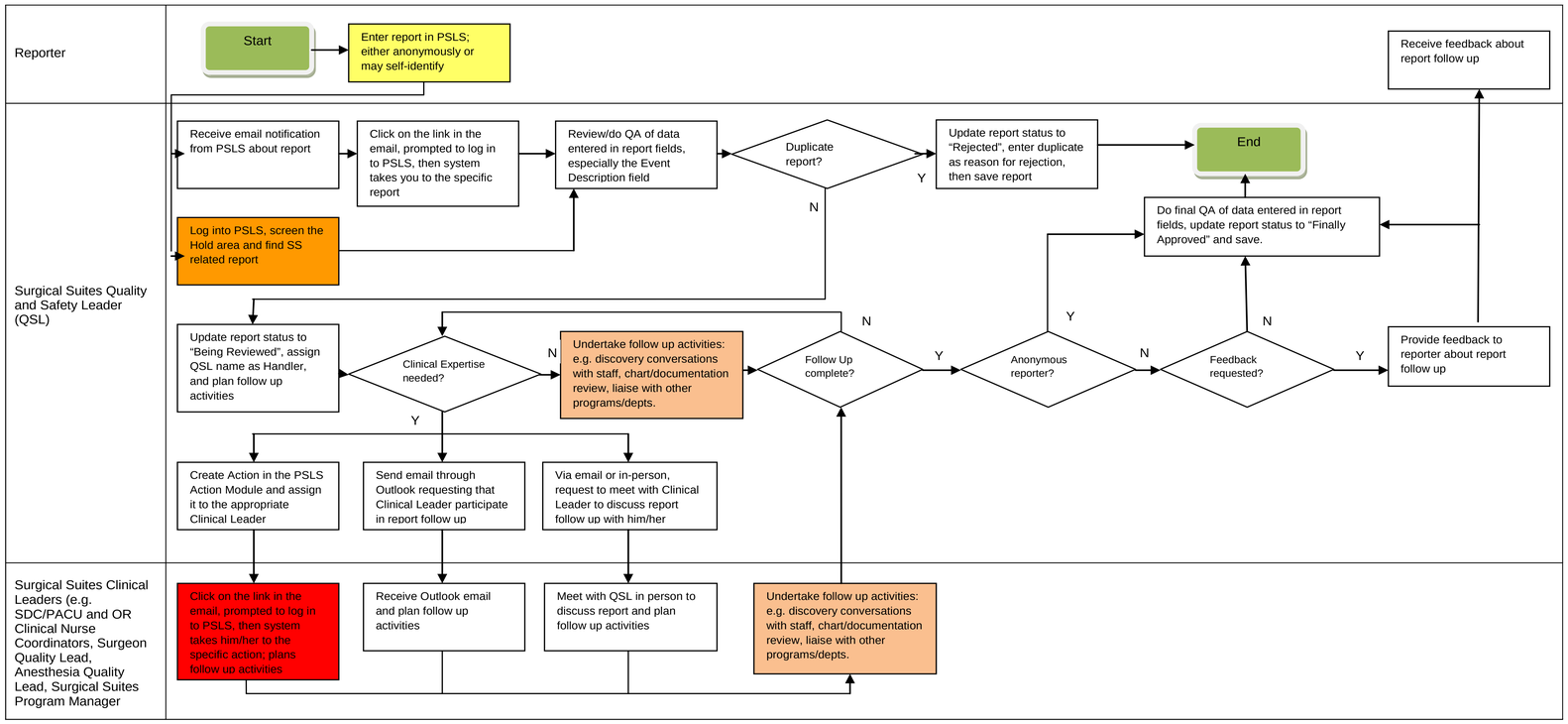
Methods

- 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

- 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).

Surgical Suites Program Patient Safety Report Follow-up Process Map (January 2016)



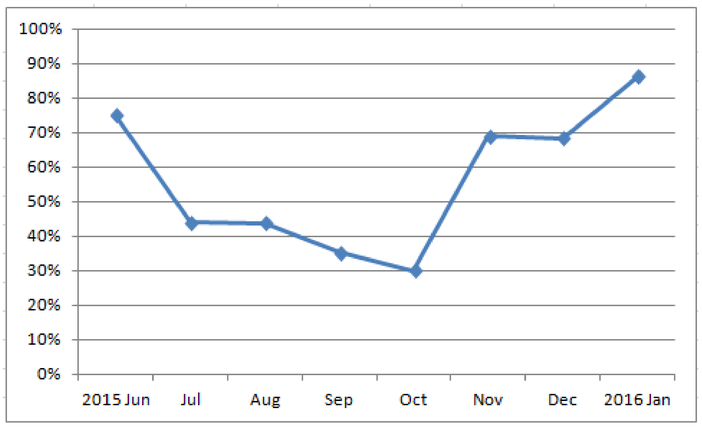
Legend: Barriers to Timely Report Follow Up

Non PSLS reportable events are entered in PSLS.	Clinical Leaders unable to log in or unfamiliar with PSLS; actions left incomplete	Inconsistent, or delayed screening of the PSLS Hold area	Staff unavailable or patient's chart unavailable

Recommendations

- 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.

Rate of report follow up completed within PHSA timeframes.



Acknowledgements

Dr. K. Afshar, Dr. S. Whyte, Ms. Trish Page, Ms. Lisa Lupien, Ms. Lorinda Pickup, Ms. Jana Kaiser, Ms. Sara Hanney, Ms. Vanja Bodor, Ms. Krystal Kersch, Ms. Tricia McBain, Ms. Lisa Strosher