Effectively Engaging Staff in Patient Safety Reporting Systems

A robust reporting system for patient safety events is essential to improving quality and safety in hospitals. When staff report patient safety issues or process failures, the hospital is able to identify problems and solutions, implement sustainable improvements, and disseminate the lessons learned. A reporting system is required within a hospital by Joint Commission Leadership (LD) Standard **LD.04.04.05**, EP 6, which states, "The leaders provide and encourage the use of systems for blame-free internal reporting of a system or process failure, or the results of a proactive risk assessment."

Engaging medical staff (many of whom may be working in the hospital under contract) in reporting systems has been an ongoing challenge for many hospitals. It's often difficult to foster buy-in on reporting because staff may fear being reprimanded or singled out for reporting a mistake they've made. In some instances a staff member may report a process

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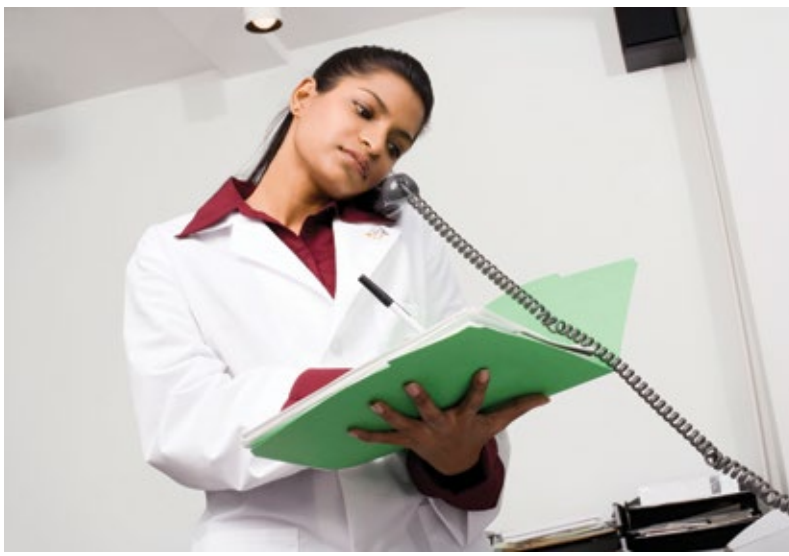

When an organization has an effective safety culture, staff feel comfortable reporting patient safety events.

error he or she has witnessed, but leadership fails to take any action to fix the problem. To create a quality reporting system, it is vital that staff feel comfortable reporting situations without reprisal and know that leadership takes reporting seriously. To do this, a robust organizational safety culture must be in place.[1]

Culture Club

Increasingly, evidence links safety culture to improved patient care and a safer work environment. Creating this culture of safety often means making a shift in the way staff view their health care organization and their roles within it. This challenge often begins at the top.

"Leadership has to set the bar so the organization understands patient-related harm. They need to own the issue," says Ronald Wyatt, MD, medical director of the Division of Healthcare Improvement at The Joint Commission. "One of the best ways we can understand patient-related harm is if we know about it in a timely fashion. It has to be reported. Then it has to be acted upon so we can ensure improvement over time."

Wyatt says that the creation of a safety culture requires engagement of the next level of leadership–physicians, physician leaders, unit managers, and division heads. However, engaging physicians in improvement initiatives can be difficult for health care organizations. Hospital leaders have typically tackled performance improvement with help from their administrative, nursing, and other clinical staff, but exclude physicians. However, without their engagement, safety improvement efforts can have trouble getting off the ground and will be difficult to sustain. If organization leadership can show physicians that new processes will give them more time and make patients safer, then they may be more likely to support improvements.[1]

Peter Fleischut, MD, associate chief innovation officer for New York-Presbyterian Hospital, cautions that it's also important to focus on the frontline of nurses, physician assistants, information technology (IT) professionals, quality and patient safety officers. "Giving front line staff a voice and a way to align initiatives and priorities with senior leadership is an essential component. It's vital to not get too complicated and focus on one or two key initiatives, especially when it comes to residents' time. If they aren't overwhelmed they can really push the needle on those issues."

Wyatt says it's important to have a small group who will champion the effort and be fully engaged, with an understanding of the part reporting has to play in a safety culture. Being fully engaged with this awareness means the reporting process needs to be communicated in a way that is not punitive.

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For medical staff to embrace reporting they can't fear it. They need to know leadership is focused on improvement, not penalties. "Make it clear that reporting is voluntary, anonymous (if possible), and nonpunitive. Then guarantee that action will be taken," says Wyatt. "It's not enough to have a reporting system that you spend millions of dollars on, it's how it's going to be used. That has to be clearly communicated down to the front lines."

Reporting Process

The process for reporting should be specified in detail, including the items to be reported and to whom the report should be made. Reports should include the name of the reporter, the names of the individuals involved, the date and time of the incident, a description of the incident, and the names of any witnesses.[2] Providing anonymity to the reporter may not always be possible. The details of any report should be made known to the individuals involved in the patient safety event, and the patient safety specialist (or equivalent personnel) will likely need to consult both sides.

An organization should always respond to reports seriously and send a report about follow-up actions to the person who made the report. Publicizing the response to the health care staff is also important. Without mentioning names, making an abstract of the case and the outcome available demonstrates accountability and commitment from leadership.[2] This demonstrates to staff that leaders take reports seriously and that reporting can lead to positive change.

After a reporting system has been created and the intent and process has been made clear to staff, it's important to continue monitoring that system and the reports. Has there been a reporting increase in one unit or a decrease in another unit? Wyatt says that may be a signal of system vulnerability. "If you have a unit that is a big reporter of events in one quarter, and then in another quarter they are not, then you want to understand why that is. Look at the data to

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understand where your reports are coming from, what's being reported, and continue to go back to understand what the system is trying to say. Signals require a rapid response in order to mitigate risk and identify vulnerability. This makes the organization more resilient."

Transparency and Accountability

Wyatt says that a positive outlook on reporting can be transmitted through internal channels, executive walkarounds, huddles, or department meetings. Providing this kind of transparency helps to break down the barriers in reporting. A transparent organization does not try to hide errors. Instead it acknowledges that mistakes do occur and that it's important to fix systems that might cause them. Openly discussing and analyzing issues, errors, and risks with frontline staff, medical staff, patients, families, and the public helps to make the environment more conducive to sharing information and reporting problems.[1] "A great example is Cincinnati Children's Hospital, where they have morning leadership huddles that are actually videotaped. They are broadcast throughout the facility and show unit leaders discussing what happened last night. They openly report that and share it with the organization," Wyatt says.

Transparency also comes in the form of rewarding those who come forward and report a near miss, a close call, or unsafe condition. Wyatt says that even the reporter directly involved in the event should be rewarded for speaking up. "It will probably surprise people how little a reward it takes," Wyatt says. "In some cases it's just a 'thank you very much for reporting.'"

Wyatt says that in military health care facilities coins are often given out as rewards for reporting injuries, and that system has spilled over into some other organizations. Other facilities may offer different incentives like gift cards or a cup of coffee. "You can get so far with just those simple things. Most people don't understand that," Wyatt says. "I think that sometimes we make it more complicated than it needs to be. People like to be acknowledged for doing what's right."

When people are recognized for doing the right thing, it is often surprising how fast that information is communicated across a facility. But Wyatt stresses it's important to make sure everyone in the organization realizes the reason for reporting is to improve safety. At the same time if an organization decides, that there is a blame-worthy event (such as negligence, criminal behavior, or substance abuse), those issues must also be addressed in an active way. "As best you can, communicate that fact out to staff so then you start to build a culture where there is psychological safety. If you do, people won't just bury their heads in the sand," Wyatt says. "If they see something, they will say something. That's where you want to get to."

Achieving the level of accountability Wyatt envisions will enable an organization to balance learning and discipline. It's important that organizations look objectively at errors and make it clear to staff what to expect when an error occurs and how they will be held accountable. This accountability system is important because people will make mistakes, no matter how skilled or experienced. Given the constant distractions in the health care environment, as well as stress and fatigue, it's easy to see how staff may overestimate their abilities and underestimate their limitations.[1] How an organization reacts to the errors that will occur makes a world of difference.

"Accountability has to go from the top down and bottom up," Wyatt says. "You flatten out that hierarchy, and then you start to approach the kind of culture you want to have to decrease harm and error." Wyatt says that he always remembers a story his mentor told him. While attending at Boston Children's Hospital, a physician was

Defining *Safety Culture*

Defining *safety culture* can often be complex, but in its simplest form it is a health care environment in which everyone's nonnegotiable goal is optimal, safe care. In addition, the following conditions should be present:[1]

- No one is hesitant to voice a concern about a patient because it is psychologically safe to do so.
- There is a simple model of accountability that clearly differentiates "unsafe" individuals from competent, conscientious individuals who "fall victim to" system errors. People need to know they're safe before they're going to be comfortable talking about errors, near misses, and system failures.
- There is a continual focus on identifying and mitigating sources of risks and hazards.
- When individuals do voice concerns, they know they will be treated with respect, and leadership will address their concerns and take action.
- After leaders have taken action or looked into the matter, they will close the loop and provide feedback to the person who raised the concern.

about to examine a patient when someone in the room said, "You can't do that here." He turned around to the face the speaker and asked, "What are you talking about?" And the housekeeper said, "We wash our hands here before we touch patients."

"That's a housekeeper talking to a senior, academic attending physician specializing in infectious diseases at Boston Children's," Wyatt says. "[At that hospital], leadership told staff to do that. They let everyone know that they are important and have a role to play in preventing patient-related harm and error."

Creating a culture in which a housekeeper is comfortable correcting an attending physician admittedly takes time. But Wyatt points out that just saying it takes times is not an excuse. "A leader that's interested in a learning organization and a culture of safety isn't going to say it will take us five years to get there. He will say, 'The time is now. We don't want to hurt anyone. Our goal is zero, and you are a valuable part of that.'"

When an organization has engaged leadership that's visible, staff start to believe in the culture. Patients also start to believe it. Today there are organizations that ask patients and their family members to go on walkarounds with the health care team (and sometimes top organizational leaders), so they can learn from them. Performing these types of multidisciplinary rounds offers a health care organization a fresh perspective on safety and can help the team to be more proactive rather than reactionary. Typically, the hospital bedside is the optimal location for these rounds, which should take place at least twice a day at shift changes. Within these rounds, teams should discuss care for each patient.[1]

"We want patients engaged in changing the culture. We want patients' families involved in teaching us. What are the things you see that we don't see?" Wyatt adds.

A multidisciplinary approach is something that New York-Presbyterian Hospital is familiar with. "We wanted to engage the residents that are on the front lines, dealing with the patients," Fleischut says. "We put together a multidisciplinary council of all the residents—nurses, physician assistants, IT professionals, quality and patient safety officers—so they would have a voice in the organization, and also the organization, through the hospital, would have a voice through the frontline staff. It was a two-way communication that helped create the culture."

Team Training and Respect

Ensuring that a strong safety culture continues means continuous team training and communication, supported by leadership in clinical units. Along with multidisciplinary sessions, education on team behaviors, communication strategies, and structures for communication using relatable scenarios are good methods. It's important to also have staff practice using the behaviors and strategies.[2]

Effective team training in safety requires an environment of psychological safety in which everyone is comfortable voicing an opinion. Creating a culture of respect in health care is part of the larger challenge of creating a culture of safety. A culture of respect requires an organization and its leaders to develop methods for responding to disrespectful behavior and to actively prevent it from occurring.[2]

Wyatt says that disrespectful behavior can render ineffective any safety culture strategies an organization may have. "At most organizations, around 20% of the medical staff are habitually disrespectful people. Leadership has to be willing to step in and have the courage to say, 'No. Not here. Not in our culture.'"

The culture that engaged leaders do want is a transparent one, free of fear and full of cooperation, in which everyone feels they can actively discuss safety concerns. By effectively demonstrating engagement and giving medical staff a stake in improving safety for patients, leaders can strengthen commitment and make reporting a seamless part of the culture. TS

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