Patient Safety in Ambulatory Care: Why Reporting Counts
• Group Health provides medical coverage and care to more than 628,000 residents in Washington state and North Idaho who are covered by health plans offered by Group Health Cooperative or its subsidiaries.

• Group Health Cooperative was opened in 1947 by a community coalition dedicated to making quality health care available and affordable. Today it is one of the few health care organizations in the country governed by consumers.

• Group Health owns and operates 26 primary care medical centers, 6 specialty care units and one hospital. Employing over 9000 employees including 900 Specialty and Primary care physicians.
How is Ambulatory Care Different?

- Lack of research
- Patients not as sick
- Patients initiate treatment
- Long term relationships with patients
- Multiple locations not under one roof
- Transitions in care
- Historical lack of electronic medical record system
A Foundation of Safety

- Leadership buy in
- Include in organization’s mission, policies and training programs
- Appropriate resources
- Prioritize and focus improvement efforts
- Ability to measure improvements
March 2009:

“To build a climate of a safe culture takes courage. Our vulnerabilities have to emerge from behind the walls of our clinics, our offices, our hospitals. Each of us can and must challenge others to do better, to learn more, and to ask questions. This is difficult terrain, but we are heartened to have you with us to continue to forge this path together.”

Michael Soman, MD
Chief Medical Director, Group Health
Why assess safety culture?

- Measure impact of patient safety initiatives
- Compare with external benchmarks
- Target opportunities for improvement
- Increase awareness
- Results guide the use of resources and planning
Survey Questions that Measure Reporting Attitudes

• I know how to report patient safety concerns

• Staff will freely speak up if they see something that may negatively impact patient care

• Medical errors are handled appropriately in this area

• I am encouraged by my colleagues to report any patient safety concerns that I have

• I know proper channels to direct question regarding patient safety

(Survey questions from the Safety Climate Survey, Center for Healthcare Quality and Safety - Univ of Texas)
Create a Culture that Supports Reporting

Reporting systems/forms need to:

• be easily accessible
• quick to complete
• have an option for reporting anonymously
• include a mechanism for providing feedback to the reporter
• share learnings and improvement activities
• address staff concerns
Criteria for Designing a Reporting System

- Paperless
- Multiple links
- Quick to complete
- Asks for specifics on event
- Routed directly to manager
- Capable of creating reports - self service
Demonstration of Unusual Occurrence Reporting Tool
Unusual Occurrence Reporting Form

ATTENTION: This is NOT for on the job or employee incidents, this is for patient related unusual occurrences only.

1. Did this occurrence involve a specific Consumer?
   - No
   - Yes

   * Enter Consumer:

2. Choose Location of Occurrence:
   - Blumen
   - Capital Hill - Family Medicine Residency
   - Capital Hill Specialty Clinic
   - Capitol Hill - Primary Care
   - Business Operations
   - Cardiology
   - Consultative Internal Medicine
   - Dermatology

3. Does this occurrence require review by the Pharmacy?
   - No
   - Yes

4. Did the patient experience an adverse drug event?
   - No
   - Yes

Create Report
Patient Safety: Unusual Occurrence
Web Reporting Database

Unusual Occurrence Report
Use this report for any patient or visitor unusual occurrence and near misses.

Location: Capital Hill Specialty Clinic - Consultative Internal Medicine
Manager(s) to Route to: Dennis Lew

ATTENTION: Please verify that the Patient Information is correct. If not, click Cancel and create a new report.

PATIENT INFORMATION
Name: TEST MV
Consumer#: 00123456
Address:
Address2:
City, State, Zip:

Contact Phone:
Alt Phone:
Birthdate:
PCP:
MD:

OCCURRENCE INFORMATION * = Required Field
Today's Date: 03/02/2010
* Date of Occurrence

Briefly describe occurrence in enough detail identifying injuries, effects, individuals involved, equipment involved, medications involved, and any immediate actions taken. Limit to 1000 characters.
Patient Safety: Unusual Occurrence
Web Reporting Database

OCCURRENCE INFORMATION

* = Required Field

Today's Date: 08/02/2010
Date of Occurrence: [ ]

* Briefly describe occurrence in enough detail identifying injuries, effects, individuals involved, equipment involved, medications involved, and any immediate actions taken. Limit to 1000 characters.

[Text box for description]

You have [ ] characters left.

Was MD Notified?

OPTIONAL INFORMATION

Witnesses: [ ]

Reported by: Nurse
Your Job Function: Other

* Would you like to receive follow-up information regarding this case? Yes

* Please enter your email address for follow-up:

[Text box for email address]

[Buttons: Cancel, Submit to Manager, Submit to Patient Safety/Quality]
What to Report

- **Treatment issues** - delay in treatment or consultation; supplies or instruments not available

- **Medication issues** - missed medications; incorrect medication or dosage; illegible documentation/use of unapproved abbreviations; medication given to incorrect patient; adverse drug events

- **Documentation issues** - inadequate or incorrect patient identification; incomplete or inadequate medical information

- **Communication concerns** - hand-offs to other staff; transfer issues involving other facilities; breach of patient confidentiality

- **Equipment failures that pose a threat to patient safety** - exam tables, radiology equipment
Employment Engagement

- Communicate reporting expectations during new employee orientation
- Include in annual competencies
- Provide yearly refresher on reporting expectations
- Include in orientation to any temporary or agency staff
Facility Reporting Rate per 10,000 Encounters

UCL = .75
Average = .46
LCL = .16

UCL - Upper Control Limit
LCL - Lower Control Limit
2009 Patient Safety Manager Cases Not Reviewed in 30 Days

<table>
<thead>
<tr>
<th>Month</th>
<th>Percent</th>
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<tbody>
<tr>
<td>Baseline</td>
<td>34.3%</td>
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<tr>
<td>Jan</td>
<td>15.6%</td>
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<tr>
<td>Feb</td>
<td>16.7%</td>
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<tr>
<td>Mar</td>
<td>22.5%</td>
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<tr>
<td>Apr</td>
<td>16.8%</td>
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<tr>
<td>May</td>
<td>22.9%</td>
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<tr>
<td>Jun</td>
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<td>Jul</td>
<td>19.4%</td>
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<tr>
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<td>15.2%</td>
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<tr>
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<td>17.2%</td>
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<tr>
<td>Oct</td>
<td>24.3%</td>
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<td>Nov</td>
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<tr>
<td>Dec</td>
<td>17.2%</td>
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<tr>
<td>Target</td>
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</tr>
</tbody>
</table>

N values:
- Baseline: 141
- Jan: 204
- Feb: 245
- Mar: 284
- Apr: 231
- May: 316
- Jun: 328
- Jul: 360
- Aug: 387
- Sep: 342
- Oct: 412
- Target: 412
Superstar Award
Superstar Award
I met with a nurse recently who was involved in choosing the wrong medication off the shelf prior to a procedure. There were some key root causes of the error, including look alike bottles and stocking procedures, but what struck me personally was when she said “I wasn’t afraid to report it since I knew it wouldn’t be punitive.”
Our Learning's

- Anonymous reporting
- “Near miss” reporting
- Timely review of concerns
- Transparency
- Involve staff in improvement efforts
- Share learnings/data with senior leaders
Questions???

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