

APPD Quality Improvement Award 2015 - Abstract

TEACHING TEAM INTEGRATION IN THE RECOGNITION AND REPORTING OF PATIENT SAFETY EVENTS

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Background: Medical errors are a public health problem in the United States. In addition, errors in pediatric patients are significantly underreported, particularly by physicians. The ACGME CLER patient safety pathways emphasize the role of residents and faculty in recognizing and reporting safety events. Our baseline data demonstrated that physician entries accounted for 4% of all pediatric events entered into our hospital's electronic event reporting system. Aim Statement: We planned to increase physician recognition and reporting of safety events on pediatric services by 50% over a 9 month period. Methods: We used the model for improvement and serial PDSA cycles to test changes that we predicted would improve physician recognition and reporting of events. The primary outcome measure was the percentage of total pediatric event reports entered in the electronic event reporting system by physicians (residents or faculty). Individual PDSA cycles studied secondary or process measures to assess tests of change or inform subsequent change cycles. Initial teaching team process changes included text message prompted Patient Safety Rounds on teaching services and an inpatient ward Superintendent rotation with core patient safety responsibilities. We predicted that routine patient safety rounds would improve event recognition by improving communication around patient safety topics and that the superintendent rotation would improve event reporting through the integration of reporting in resident workflow. The IHI assessment scale for collaboratives has been used to track progress throughout the project. Results: Physician reporting increased significantly in the initial 5 months of the project exceeding the improvement goal set in our aim statement (5 month mean 16%; range 2% [month 1] to 27% [month 5]). Patient Safety rounds and the superintendent rotation were tested in months 1 and 2, and the superintendent rotation was implemented in month 3. Process measures indicate continued patient safety discussions on rounds (38 to 58%) after initial test cycle, a significant increase in resident event reporting in the electronic event reporting system, but unchanged faculty reporting rates. Qualitative data collected during cycles suggest that accessibility, complexity, and knowledge of the electronic reporting system may be a barrier to physician reporting. After 5 months the project scores a 3.0 to 3.5 (modest improvement to improvement) out of 5 on the IHI assessment scale due to completion initial PDSA cycles and change in outcome measure. Conclusion: Incorporating patient safety discussions and event reporting into teaching team workflow can increase physician event reporting. Additional cycles are planned to test spread of the superintendent model to outpatient reporting, test methods of structured feedback on reported events, and implement topic-driven Patient Safety Rounds with faculty development around patient safety and event reporting delivered at the point of teaching (Faculty Development On the Go).