

Incident Management for Patient Safety

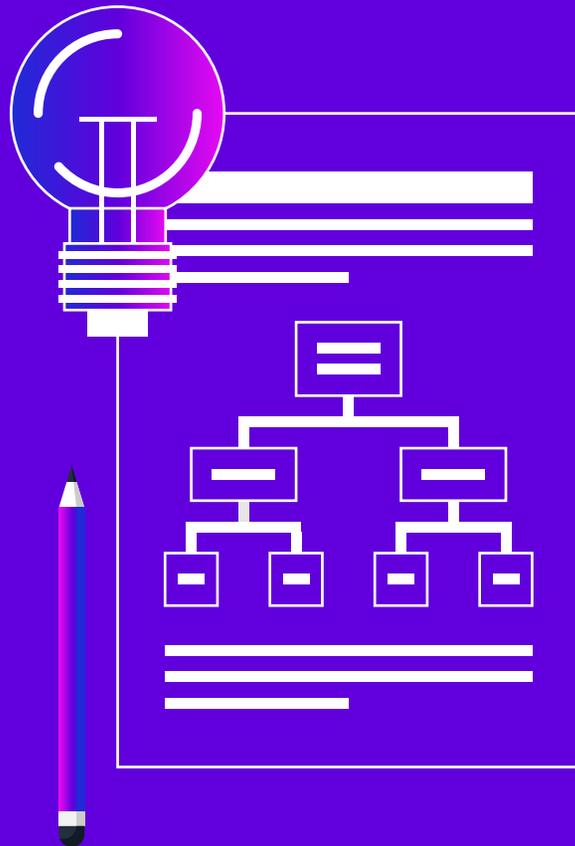


The Importance of Managing Incidents

Patient safety is a journey and not a destination. Despite healthcare's collective efforts to adhere to six elements of quality care (i.e., safety, effectiveness, patient-centeredness, timeliness, efficiency, and equitability) outlined by The Institute of Medicine, medical error statistics today are alarming:

- One in 10 patients worldwide is harmed while receiving hospital care. (World Health Organization)
- Medication errors harm millions of patients worldwide and costs billions annually. (WHO)
- 250,000 people in the U.S. die every year because of medical mistakes, making it the third leading cause of death. (Johns Hopkins Medicine)
- One in 10 physicians (of 6,700 polled) reported having made a major medical error in the three months prior to one survey. (Mayo Clinic Proceedings)

Today's incident management methods require more than tracking incidents or near incidents at the hospital bedside. As practitioners increasingly administer care and services in outpatient, ambulatory, or retail clinics; in specialty centers; and via telemedicine, our safety and quality improvement tools must adapt. In other words, we must follow the patient to prevent harm.



Defining Incident Management

Creating a safer healthcare system challenges providers, payers, legislators, regulators, and others to put patients at the center to achieve quality improvement goals and to reduce errors. (In patient-centered care, an individual's specific health needs and desired health outcomes are the driving force behind healthcare decisions and quality measurements.) Healthcare risk management efforts must be comprehensive. They must encompass technology, legal and administrative policies, practitioner training, and operating and delivery modes.

Because we can't improve what we don't measure, improvement starts with comprehensive tracking and management of quality issues data. As the sheer amount of data we collect increases, it's nearly impossible to manage incidents and near incidents manually using paper forms or Excel documents. Technology is the answer to combine all incident management activities in one place, gain a clear overview of the root causes and the different types of incidents, and ultimately improve quality and safety. Incident management is a process to collect data, analyze and report on it, and learn from incidents toward the goals of greater patient safety and quality.

A complete Incident management strategy:

- Provides the processes and tools to track a healthcare grievance or complaint through analysis to outcome.
- Identifies when a visitor, employee, or practitioner has crossed a threshold and jeopardizes quality, patient safety, or reimbursement.
- Identifies when equipment or processes fail, or when a policy is not adhered to or requires revision.

Alternatively, a well designed incident management strategy is capable of recognizing an individual's positive contribution to safety by acknowledging the action. It's indisputable: Improving our healthcare system also requires recognition of what we're doing right, not just identifying the failures or near misses.

Finally, incident management provides insights across the often disparate functions of:

- Quality issue management
- Risk management
- Patient event reporting
- Provider performance management
- Peer review

Incident reporting is a part of incident management

Incident reporting is defined as the act of documenting all incidents, near incidents, and commendations. Ideally, it employs an online form and workflow to capture details and share the account digitally. (Near) Incidents are also reported through other means such as complaints, audits, and safety rounds.

Robust web forms allow for customization; display only relevant questions based on incident type; enable anonymity; and, support attachments such as photos, videos, or voice recordings. An incident report should be completed at the time an incident occurs and as the organization's policies dictate, no matter how minor an incident may appear.



Transparency in incident disclosure

A recent study showed that in hypothetical situations, 90% of the healthcare providers polled (538 medical students, residents, and physicians) said they would disclose medical errors. But in real circumstances, only 41% actually reported doing so.

Such statistics beg the question: What's holding back our practitioners and organizations from 100% disclosure? Just Culture's aim to manage behavior and design systems that allow anonymity to encourage openness established a promising start. symplr Safety incident management solutions are at the heart of discovering and correcting discrepancies that impede progress in promoting safety.

Effective patient safety and continuous quality improvement efforts that result in fewer incidents will require continued:

- Transparency and disclosure in a voluntary, blame-free, non-punitive environment
- Improved data collection and analysis
- Development of effective systems at the level of direct patient care

Transparency provides a path for collective research into wider prevention of errors based on aggregated data. In the past, concerns about liability, discovery, peer review protections, and privacy concerns have resulted in reluctance or outright refusal to disclose incidents, effectively isolating the data in one facility or system.

Initiatives that promote transparency and reporting

The Patient Safety and Quality Improvement Act of 2005 created Patient Safety Organizations (PSOs) as a solution to encourage voluntary and confidential reporting of incidents. Importantly, PSO protections help to aggregate de-identified data and provide increased safety on an international level. A similar learning network called Project OPEN was established in Europe in 2005 to generate greater transparency.

Additionally, MEDMARX is a voluntary medication error reporting system in the U.S. that has collected valuable research from hospitals nationwide. Good Catch initiatives do not aggregate data, but were formed to recognize and reward staff for reporting near misses or system issues.

Despite initiatives like PSOs created to encourage transparency, research shows that incident disclosure doesn't always happen. In addition to a basic willingness to be open and upfront, it requires a structured approach that values and makes the reporting exercises worthwhile by executing on the data and findings.

The value of a structured, digital incident management system lies in its abilities to:

- Capture patient safety-related incidents
- Gather feedback from those involved in the incident and any third parties
- Provide analytics
- Manage their workflow to resolution
- Implement improvement actions
- Track the efficacy of actions

From Occurrence to Optimization

Best practices to manage and analyze incidents

Traditional patient safety models were designed and implemented under the assumption that an organization's patient safety policies and procedures are properly constructed, understood by all, and that the incidents they account for are predictable. Modern patient safety initiatives like Safety-II recognize that issues often overlooked in the design of the organization's policies and procedures cause most preventable incidents. There are prospective (active) and retrospective (passive) approaches to systematic analysis of incidents and near incidents:

- A prospective risk analysis helps identify how systems or processes can fail. This knowledge can then be used to anticipate potential errors.
- A retrospective analysis looks back on what happened. It's a structured approach that leads to identifying base-level causes of (near) incidents.

Prospective analyses (e.g., Safety-II) account for how people compensate for flawed systems both in everyday and unpredictable situations. The goal is early recognition of potential errors before they even become problems.



Four analytical methods for reported incidents

There are numerous methods to analyze a reported incident to reveal the fundamental cause(s) and/or limit the effects. The following common approaches differ in the degrees to which the incident information is examined and classified:

1. **Systematic Incident Reconstruction and Evaluation (SIRE):** Focused on incidents with serious consequences or those occurring frequently, SIRE offers multiple means of analysis: timeline, process, and barrier. This method is considered labor intensive.
2. **Ishikawa Diagram, also known as a fishbone diagram:** This method entails drawing a cause and effect diagram to identify cause in roughly three steps: name the problem, describe the major causes, divide the major causes into sub-causes. Its advantage is its accessibility.
3. **Prevention and Recovery Information System for Monitoring and Analysis (PRISMA), also known as root cause analysis:** PRISMA analysis requires mapping incidents visually using a "cause tree" to show underlying factors and circumstances. Its advantages include the ability to conduct in-depth analyses and to identify patterns of root causes to deploy targeted improvement actions. PRISMA has demonstrated positive influence on staff willingness to report incidents.
4. **Failure Mode and Effects Analysis (FMEA)—also known as prospective risk analysis:** This systematic and proactive analysis uses a flow chart as part of four steps to analyze as many products, services, and processes as possible to identify potential failure modes and their causes and effects. Its disadvantage is its focus on the how and why of failure, not on whether something will fail. In addition to estimating impacts, it can be used to help limit their effects.
5. **Functional Resonance Analysis Method (FRAM):** The Safety II method is an example of FRAM, which describes outcomes by analyzing variability in performance. It maps the difference between policy and practice by examining daily activity, analyzing workplace situations, and capturing how individuals react when deviations occur. Its advantages include transparency and a focus on prevention. However, not all actions can be recorded in procedures, and procedures aren't always followed.

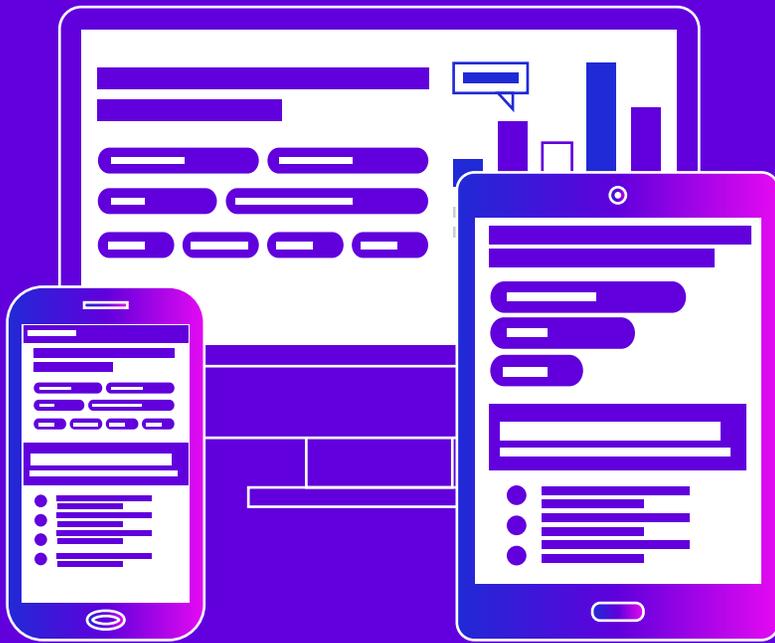
symplr's Safety solution supports multiple analytical methods, recognizing the need for flexibility in an incident management platform.

A complete structure for incident management

How do healthcare organizations ensure successful incident management? symplr's Safety solution has assisted customers worldwide with incident reporting, analysis, process automation, and improvement plans for over 15 years. Our experience in sophisticated health systems with high national patient safety standards has translated to a sound process and supporting technology based on six key points with accompanying best practices.

Report incidents

Best Practice: Use automated, online forms that allow staff and others to quickly report any (near) incident. Make the forms easy to use and accessible by computer, tablet, or smartphone to increase participation and compliance, and to capture details that can become lost as time passes.



Analyze Incidents

Best practice: Regardless of analysis method (e.g., PRISMA, SIRE, etc.), register all incidents and near incidents in a single source of truth patient safety software platform to foster better decision making. Aggregate data and discover trends, such as which type of incidents are more common, and determine which improvements to prioritize.

Ensure a safety culture

Best practice: Contribute to staff awareness of conscious and unconscious behaviors that affect safety by using interventions such as audits, safety rounds, and team-based analysis and discussion of incidents and near incidents. At all levels of the organization, encourage the use of systems supporting blame-free reporting. Consider using the “safety ladder,” a five-step tool to track the evolution of behavior from pathological to reactive, calculating, proactive, and finally progressive.

Communicate strategically

Best practice: Practice these tips when internally disseminating incident or near incident information:

- Enable input from all parties involved to experience the benefits of shared insights and multiple perspectives.
- Share relevant information in a timely manner, condensed as necessary but ensuring that all employees have direct access to vital incident information.
- Roll out improvement actions organization-wide so affected departments can adapt as necessary.

Use (near) incidents to improve

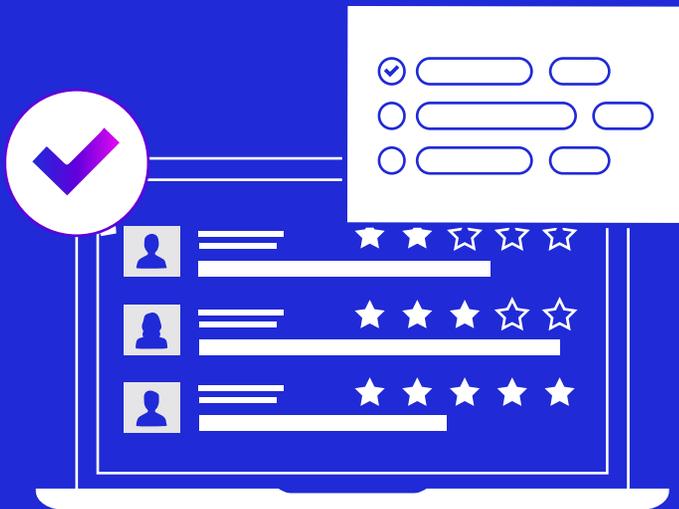
Best practice: Use a digital improvement tracking system that centrally registers organization-wide actions and automates improvement processes using a “Plan-Do-Check-Act” cycle:

- **PLAN:** Establish activities or objectives and create measurement methods for them.
- **DO:** Implement the plan and course-correct if needed with a different approach.
- **CHECK:** Check whether the objectives have been met, evaluate the approach(es), and learn from the experience.
- **ACT:** Adjust your approach based on findings to meet objectives, potentially with less effort, and/or adjust objectives.

Digitize incident management:

Best practice: Ensure that your organization-wide incident management software provides essential features:

- Automated feedback for individuals who report (near) incidents.
- Capability to create improvement plans.
- Guides users based on specific roles and/or provides workflow management depending on the type of (near) incident.
- Provides status updates and notifications.
- Features management dashboards and reporting that highlight trends.



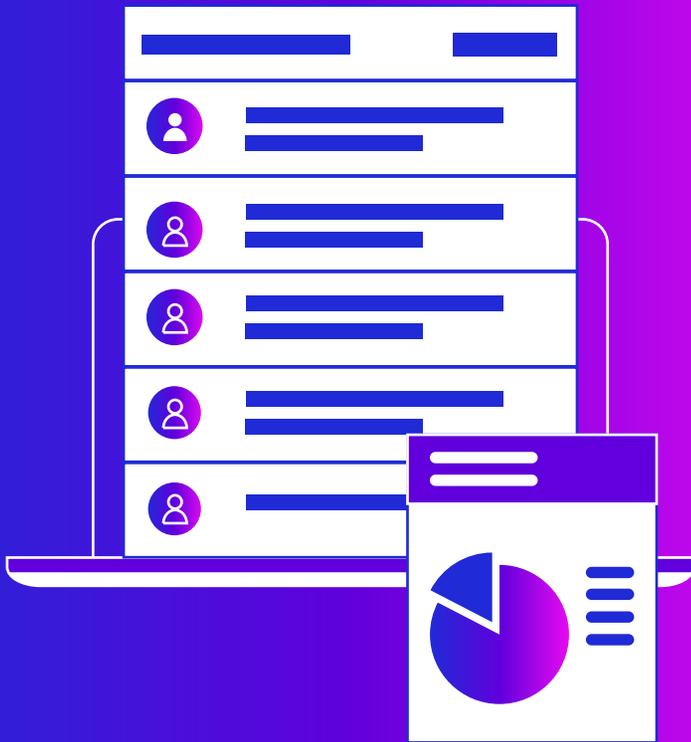
Capitalize on insights from incident management

The knowledge, tools, and data required to improve patient safety and quality keep changing—and your incident management system should keep pace. While every healthcare practitioner, administrator, and staff member has a role in cultivating safety, incident management is an approach uniquely designed for the frontline quality and nursing leaders ultimately responsible for capturing incidents and near incidents as they occur.

The costs of failing to capture and analyze adverse events and near misses are significant. Healthcare organizations that employ a successful incident management system benefit from awareness of risks and increased control over mitigating them, ultimately resulting in a safer environment for all.

What insights into patient safety, quality improvement, risk management, and provider performance would your healthcare organization gain with a software tool to bridge the gaps?

Contact symplr today to learn how symplr Safety solution can help your organization achieve greater quality and patient safety.



About symplr

symplr's comprehensive healthcare operations solutions, anchored in governance, risk management, and compliance, enables our enterprise customers to efficiently navigate the unique complexities of integrating critical business operations in healthcare.

For over 30 years, our customers trust our expertise and depend on our provider data management, workforce and talent management, contract management, spend management, access management, and compliance, quality, safety solutions to help drive better operations for better outcomes.

As your trusted guide, we follow a proven approach to help you achieve your organization's priority outcomes by breaking down silos, optimizing processes, and improving operational systems.

Learn how at www.symplr.com.

