

The Patient Safety Reporting System

The Problem

Our challenge was to implement a reporting infrastructure that allowed for ease of entry for the staff, ease of management of cases by the Managers, Patient Safety Coordinators and Risk Management, ease of trending information for external reports is a challenge. This team implemented a system that resulted in increased reporting and a better understanding of patterns of harm and potential patient harm.

Aim/Goal

An effective patient safety reporting system should quickly identify areas that need improvement to prevent future harm to patients and to increase communication and collaboration among departments. An effective patient safety system should also allow for all staff at BIDMC to appreciate how their reports help to improve patient safety.

The Team

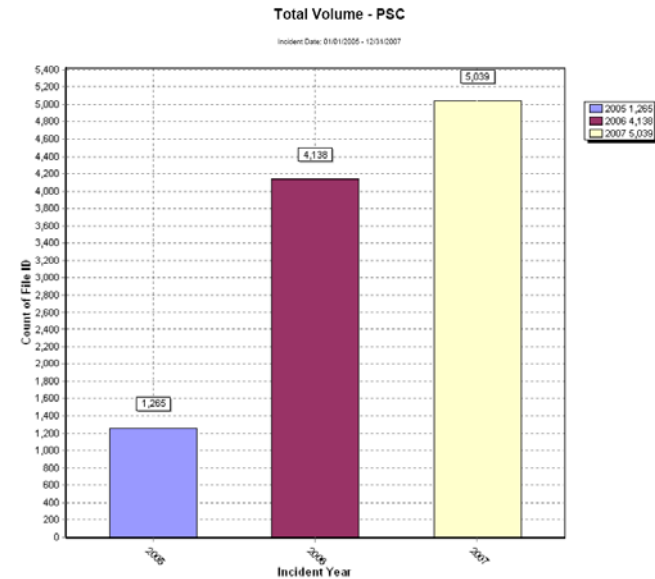
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The Interventions

- Web based reporting system rolled out in 2005
- Reporting infrastructure now supports benchmarking outcomes for NDNQI (National Database for Nursing Quality Indicators); Patient's First and many others

The Results/Progress to Date

- Steady increase in reporting each year



Lessons Learned

- Education of front line managers is key
- Widespread sharing improvements that result from reported events is difficult
- Balancing front end entry screens with back end management remains challenging

Next Steps/What Should Happen Next:

- Develop a consistent way to share "safety stories" – based on reported events
- Re-examine the burden on the "front end" entry and the "back – end" management of cases to further decrease administrative time and allow for more time to be spent on corrective action follow up

