Researchers find error reporting improves perceptions of safety and may reduce incidents

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Documenting adverse events improves perceptions of safety and may decrease incidents in multi-site clinical practices, according to a new study from researchers at the Perelman School of Medicine at the University of Pennsylvania. The results of the year-long study, which focused on the Radiation Oncology department's workflow, show a strong correlation between the implementation of a Conditions Reporting System and increasingly positive responses to staff surveys focusing on the culture of safety within the department. The findings of the study will be presented on Tuesday, Oct. 30 at the American Society for Radiation Oncology's (ASTRO) 2012 annual meeting.

"The way an organization reports the workflow process is a key factor to determining safety and quality. Since the process for investigating errors can be associated with perceptions of safety, questions are often raised about these methods in large, multi-site health systems," said Amit Maity, MD, PhD, associate professor of Radiation Oncology in the Perelman School of Medicine at the University of Pennsylvania, and one of the authors of the study. "To examine the safety culture and incident reporting process across our department, our team implemented a Conditions Reporting System that would ensure the continuous examination of any incidents. By utilizing the program, we learn from all reported events, and are able to develop improved safety measures that help us deliver the highest-quality patient care."

Results of the study after one year already show an increasingly open and healthy culture, and improved responses to staff surveys focused on safety. For the duration of the study, staff in all divisions and across all steps in the Radiation Oncology workflow participated in reporting incidents. Researchers measured safety culture using the AHRQ Patient Safety Culture Survey – a tool commonly used to assess the safety culture of a hospital or specific unit within a hospital over time. Comparing survey results at the onset of the study to those gathered one year later, the team saw improvements in eleven of the thirteen categories pertaining to a safe and open environment.

"By providing a conditions reporting program and encouraging our entire staff to be part of the process of improving patient safety, we're reinforcing that safety is a top priority," said Stephen M. Hahn, MD, Henry K. Pancoast Professor of Radiation Oncology, and chair of the Department of Radiation Oncology at the Perelman School of Medicine at the University of Pennsylvania. "What we've learned from reporting events has already led to a number of changes to departmental policies, procedures, and workflow. Ultimately, by reporting and investigating incidents, our faculty and staff are more confident in the care they provide and we're better able to identify any holes in our processes. Moving forward, we hope these systems will aid in preventing adverse events."

Based on their findings, the team plans to continue instituting policies and procedures to ensure that low-level errors are addressed and do not escalate into serious problems that could harm patients.

More information: *Author Disclosure Information: E. Volz: None. P.E. Gabriel: None. H.W. Bergendahl: Q. Leadership; Mr. Bergendahl holds a leadership role in the Bergendahl Institute, LLC which provides consulting services to Radiation Oncology*

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