



Almost every hospital reports having an adverse-event reporting system.⁽¹⁾ The question is: How many collect enough information to be effective?

Perceived Problems:

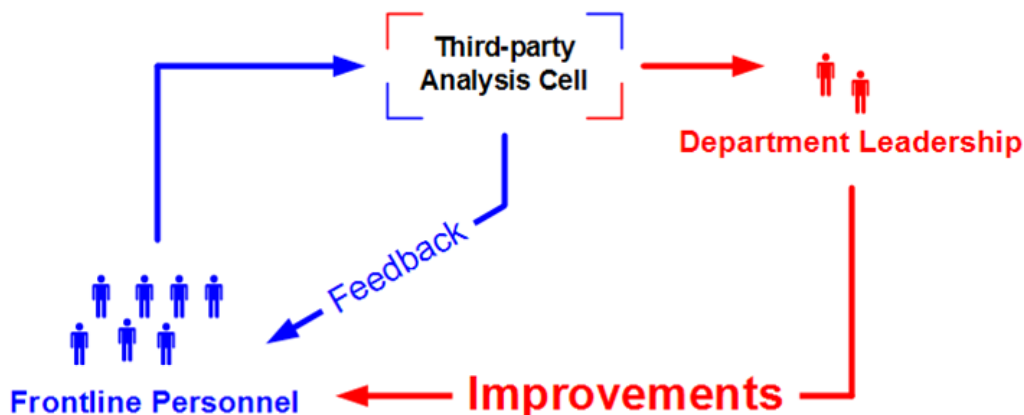
- A significant number of patient safety issues are routinely under-reported or not reported at all
- Most reporting programs fail to address well known barriers to participation (particularly for MDs)
- It's easier to "blame" MDs (for not reporting) than it is to field a user-friendly reporting process
- Medical management personnel have little time (and often little interest) in becoming data analysts

Demonstrated Solutions:

- MDs have shown a willingness to use a reporting process that can be completed in 3 min. or less
- Reporting systems that are non-punitive, focus on "local" improvements and provide feedback get used
- Programs that accommodate the intended users (not just the analysis process) are more likely to succeed
- A fully supported reporting process allows medical management to *focus on fixes*, versus administrivia

The Frontline Improvement™ program:

Helmet Fire, Inc. has fielded effective hazard-identification and process-improvement programs for (9) separate organizations involving (3) separate domains. Each system has employed the solutions described above, and has utilized the services of a third-party analysis cell as depicted below.



Usage information from a recently fielded ED program:

ED Size	Participants	Time Period	No. of Sessions	Avg. Session Time
~100k visits per year	MDs only	First (90) days	273	02:32

Said one MD Participant:

"Bottom line is that this is the first system I've ever witnessed that actually collects sufficient quantities of data from the frontlines – not just from the supervisors, and not just about events they feel obligated to report – to allow meaningful conclusions to be drawn about how to improve the safety of the system. This system was incredibly effective in the Emergency Medicine environment."

(1) Adverse-event-reporting practices by US hospitals: results of a national survey Farley et al. Qual Saf Health Care. 2008

Simple (and anonymous) Data Collection

Intuitive and Easy-to-use

Touchscreen Based

Short Session Times



0 2 : 3 7

**Average Creation Time
for 300 Sessions**

Medical Management Survey Comments

Excellent way for the front line providers to relay concerns and trends. Be ready for the reports - lots of information that will require follow through.

The fact that the data is processed and comes to me in a meaningful manner made all the difference -- as opposed to a database full of data that is hard to make sense of.

An evaluation system that is complete in its ability to collect data, compile it and return it in an organized, systematic format with the minimal input on the director's end.

Allows for near real time reporting of hazards and resident evaluations⁽¹⁾. Excellent for tracking trends!

Note (1): An optional Resident Evaluation System (RES) can be fielded in conjunction with the Improvement-Loop™ program.

Example MD Inputs

Pt sent to [name removed] for stat head ct, concern for avm bleed, s/p embolization. Informed that ct was being held for trauma, but that pt would be next. After numerous calls, almost 2 hours later, told that [urine pregnancy test] had not been recorded and that was reason for delay. When told that it was urgent, tech told resident that no contrast could be administered even in face of urgency. Dangerous delay in scan.

Concern for isolated labs that are "pending" for an excessive length of time, often for "confirmation" of an abnormal value. Provider is completely unaware that an extremely abnormal lab value might be pending and will be resulted EXTREMELY LATE compared to the rest of the labs.

Vital signs are no longer added to [EDIS]. They are only put in the nurses notebooks. We are too busy to run around collecting vital signs on the patients. We are not necessarily notified when they are abnormal. We need to be able to check this data regularly and frequently. We need to view it as a team during signouts. Vital signs are not just for the lawyers and the nurses notebooks; they need to be readily accessible to the team in a convenient manner!

70 yo woman chief complaint of chest pain, still active upon arrival to room: did not get triage EKG, MD was not notified pt was in pain, nursing staff unaware that pt was in room.

Example Analysis Report Excerpts

Hazard Alert / Error Awareness Prompt(s)

Lab-related delays are increasing during this period

Multiple delays in obtaining lab results have been reported over the past (60) days. A noticeable uptick has occurred this reporting period. Possible causal factors include: nursing workload, MD/RN miscommunications, documentation errors, samples not sent/received, processing errors, etc.

Monitors are not being promptly attached to at-risk Pts

Incidents in which monitors have not been attached, or not been attached in a timely manner, have been repeatedly reported over the past (60) days.

Radiology-related Issues Contribute to Delays in Pt Care

Radiology-related issues have been referenced in 19% (47 of 248) of all ED sessions to-date. There has been a noticeable up-tick in these types of sessions over the past (3) weeks (see trend line below). Notable issues include: (29.8%) miscommunications (verbal, written and electronic); (8.5%) errors (in reading films or Pt handling); (29.8%) processing delays (in scheduling or actual Pt flow); (19.1%) reads/results taking too long (multiple, repeated requests required for results); and (12.8%) transportation issues.

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