Objectives

— Identify factors that may cause healthcare practitioners to be reluctant to report an error.

— State how the underreporting of errors as well as the lack of a thorough investigation prevents effective system enhancement and improvement of patient outcomes.

— Identify useful methods of collecting, analyzing, and using data about medication safety.
Enhance Your Medication Error Reporting Program to Improve Global Medication Safety

In order to convince staff to report, we need to know......

Why are we reporting potential and actual medication errors?

Why do we have a reporting program?

— “Learn why errors are occurring”
— “Identify trends within our organization”
— “To determine how well we are doing”

Is this happening in your organization?
Purpose of Reporting Systems

— Support a culture of open communication
— Promote the concept that each employee is an important contributor to improvements
— Identify latent and active failures
— Provide a record of the event
— Ineffective way to collect quantitative “data” or "trends"

What can a reporting system do?

— Identify local system hazards;
  • Most valuable lessons can occur from a single report
  • Tools can provide a systematic analytic framework to learn from these events (e.g., ISMP Assess-Err)
— Aggregate experiences for uncommon conditions
  • Patient Safety Organizations (PSOs)
What can a reporting system do?

— Improve patient safety culture
  • How YOUR organization views patient safety
  • Communication with staff could change culture

— Share lessons within and across organizations
  • Lessons learned can be used to prevent the same types of adverse events
  • Use of external sources of information
  • Failure to examine potential for errors
    ◦ “It’s never happened here”

Ok, that was nice. But...

Why are we not getting many medication error reports?

Why does that same event keep happening?
Limitations to Reporting Systems

— Rarely generates in-depth analyses or result in strong interventions

• Unrealistic expectations of what staff will know
  ◦ Staff often have limited training in adverse event investigation

• Lack of time to report
• Filling out a report takes too long
  ◦ Inappropriately designed forms
• Too much emphasis on front line staff to fill out the entire form

— Rarely generates in-depth analyses or result in strong interventions to reduce risk cont’re

• Error investigations and analysis are often superficial
• Superficial analysis = no meaningful change
  ◦ Majority of changes being informing staff and education/training (low level strategy)
• Lack of meaningful change diminishes value of your reporting system
Limitations to Reporting Systems

— May generate too many reports;
  • Reports usually include many that are incomplete and/or inaccurate
    “Nurse gave the wrong drug”
    “Pharmacist dispensed wrong dose”
  • No resources to read or analyze all of these reports.
  • Provides minimal data about medication-use system
  • Reporting used to complain
  • Dissatisfaction from users when “nothing’s changed”

Limitations to Reporting Systems

— Can’t be used to measure safety (error rates);
  • Events are under-reported
  • Why are they under-reported?
    ◦ What is reportable? Definition?
    ◦ Rely on the vigilance, time, honesty, and whim of healthcare providers to
detect and report adverse events
    ◦ Some provider types report adverse events with regularity (nurses), some
  don’t
    ◦ Lack of feedback to staff
    ◦ Fear of punishment or ridicule
Voluntary Reporting

— “We found that less than 4% of all adverse drug events involving use of rescue drugs were reported.”

— “Studies of medical services suggest that only 1.5% of all adverse events result in an incident report and only 6% of adverse drug events are identified through traditional incident reporting or a telephone hotline.”

Voluntary Reporting Systems

— “Routine reporting system implemented in a large hospital missed incidents identified by case note review and detected only 5% of incidents that resulted in patient harm.”

— “Of the events experienced by Medicare beneficiaries discharged in October 2008, hospital incident reporting systems captured only an estimated 14 percent.”


Limitations to Reporting Systems

— Can’t be used to measure change
  • Increase in reports may be due to increased reporting (reporting bias) from increased awareness
  • Decrease may be typical challenges of reporting
— Can’t be used to compare organizations

What is the national medication error rate?

— Numerator = Number of error reports received, but.....you just told me you don’t get all the reports?!?!?
— Therefore...can’t “benchmark” a reliable “error-rate” to compare against anyone else
— Actually calculating an error reporting rate
“Trending” of Error Reports

- Wrong Drug
- Wrong Dose
- Wrong Patient

January  | February | March  | April  | May   | June
0       | 20       | 25    | 30     | 35    | 0

Which drug classes cause the most amount of harm in your organization?
What does aggregated data really mean?

- Shows interesting “trends”
  - Reporting trend or event trend?
- No detail to work with
- Cause unclear at the macro level
  - What really happened?
  - Why did it happen?
- Potential false conclusions
- Event descriptions will tell you what happened

Why do practitioners report to ISMP?

(and how does this apply to me?)

- Motivation is altruism
  - To promote change, prevent recurrences
- Evidence your information will be put to use
- Feedback on product and practice changes
- Trust that identity won’t be revealed
- Confidential, non-punitive, can be anonymous at reporter’s option
Strategies to Maximize Error Reporting

— Make reporting easier
  • Make reporting easy and less burdensome
  • Quick and readily accessible reporting mechanism
  • Requires minimal training
  • Limit number of questions

Strategies to Maximize Error Reporting

— Make reporting meaningful to the reporter
  • Won’t report when identified problems are not remediated

— Supports a culture of open communication

— Promote the concept that each employee is an important contributor to improvements

— More reports = better culture
Make Reporting Meaningful to the Reporter

— Communication

• Provide feedback
• Share reports with staff
• Leaders should devote resources to collect AND analyze events AND mediate risk.
• If staff observe change based upon their feedback, real changes in safety culture start to occur.

Make Reporting Meaningful to the Reporter

— Communication

• Measure the number of successful system changes, not events reported;
• Ultimate measure of success is the amount of harm prevented, not the number of reports received
Strategies to Maximize Error Reporting

— Prioritize which events to investigate
— Focused reporting of a finite set of high-yield events
  • Which drug is YOUR greatest concern?

Error reporting is only a starting point...
Enhance Your Medication Error Reporting Program to Improve Global Medication Safety

Risk Identification

— Many sources of information to detect potential for errors and actual errors
— Many methods to detect potential for errors and actual errors
— Using multiple methods of detecting risk will identify different types of risk that are not commonly reported

Methods of Data Collection

— Proactive Risk Assessment
  • Self Assessments
  • Failure Mode and Effects Analysis (FMEA)
  • External Sources of Data
  • Walkrounds™
  • Staff Meetings, Safety Briefs

— Concurrent Risk Assessment
  • Pharmacy Interventions (clinical or dispensing staff)
  • Nursing Interventions
  • Triggers and Markers
Methods of Data Collection

— Retrospective Risk Assessment
  • Observational methodology
  • Data from technology
  • Chart reviews
  • Internal, voluntary reporting
    ◦ Medication errors
    ◦ Adverse drug reactions (ADR)

Conclusion

— Change your culture so that your staff WANTS to report to you
— Avoid collecting reports for the sake of counting reports
— One error report could be an indication that you have a bigger problem.
— Be realistic about what you are getting and what it means
— Consider a report to be the starting point, not the end point.

https://ismp.org/report-medication-error
Questions?

This activity is supported by Novartis Pharmaceuticals Corporation, Name Creation and Regulatory Strategy.

References

