Enhance Your Medication Error Reporting Program to Improve Global Medication Safety

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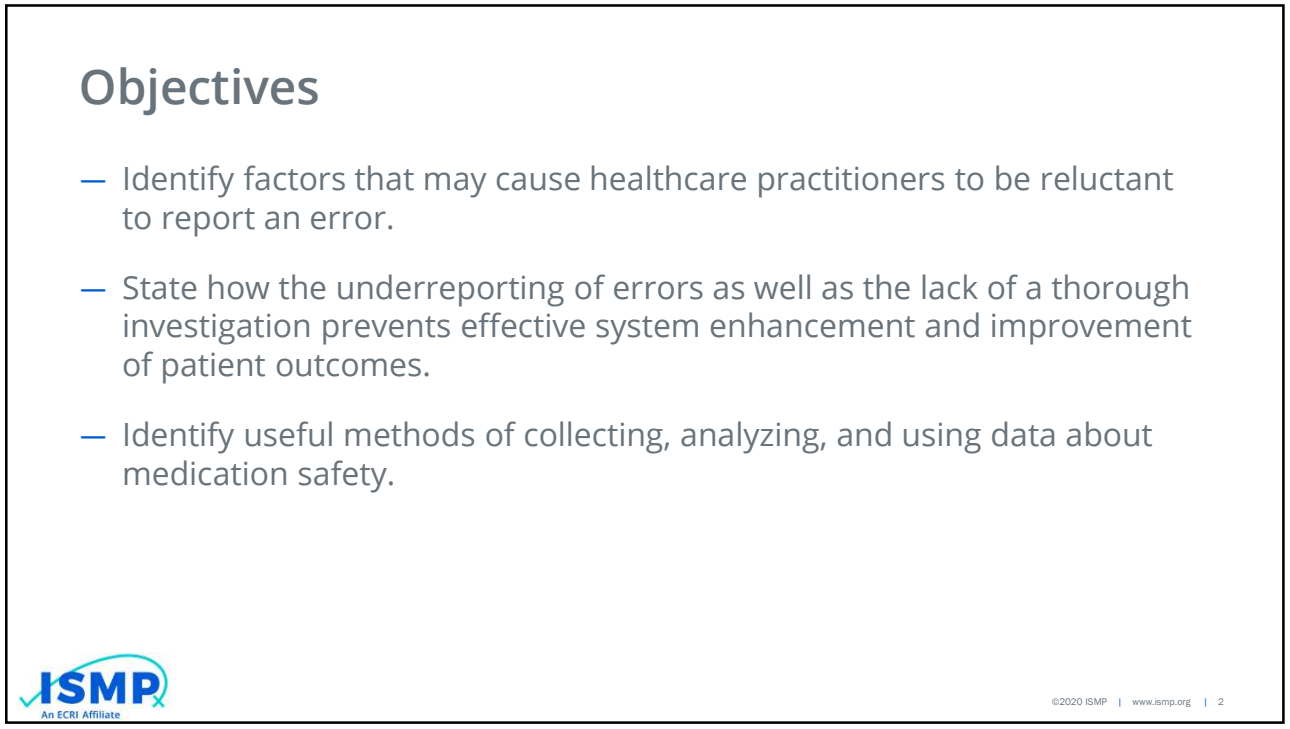

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In order to convince staff to report, we need to know……

Why are we reporting potential and actual medication errors?

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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?

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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"

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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)**

https://www.ismp.org/resources/assess-err-worksheets

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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"

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Ok, that was nice. But…

Why are we not getting many medication error reports?

Why does that same event keep happening?

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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**

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Limitations to Reporting Systems

- Rarely generates in-depth analyses or result in strong interventions to reduce risk con't
  - **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**

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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"

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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

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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."

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Schade, Am J Med Qual. 2006 Sep-Oct;21(5):335-41
O'Neil A et al. Physician reporting compared with medical-record review to identify adverse medical events. Ann Intern Med. 1993;119:370-376

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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."

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- Sari et al. Sensitivity of routine system for reporting patient safety incidents in an NHS hospital: retrospective patient case note review. BMJ 2007;334:79
- Levinson DR. Washington, DC: US Department of Health and Human Services, Office of the Inspector General; January 2012. Hospital Incident Reporting Systems Do Not Capture Most Patient Harm. Report No. OEI-06-09-00091. Available from Internet: https://oig.hhs.gov/oei/reports/oei-06-09-00091.pdf

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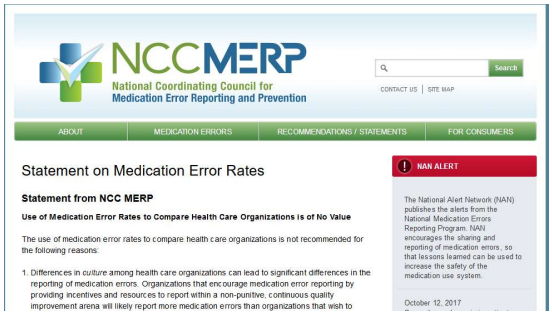
Limitations to Reporting Systems

- 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



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http://www.nccmerp.org/statement-medication-error-rates
https://www.ismp.org/faq.asp#Question_1

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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…cant "benchmark" a reliable "error-rate" to compare against anyone else
- Actually calculating an error reporting rate

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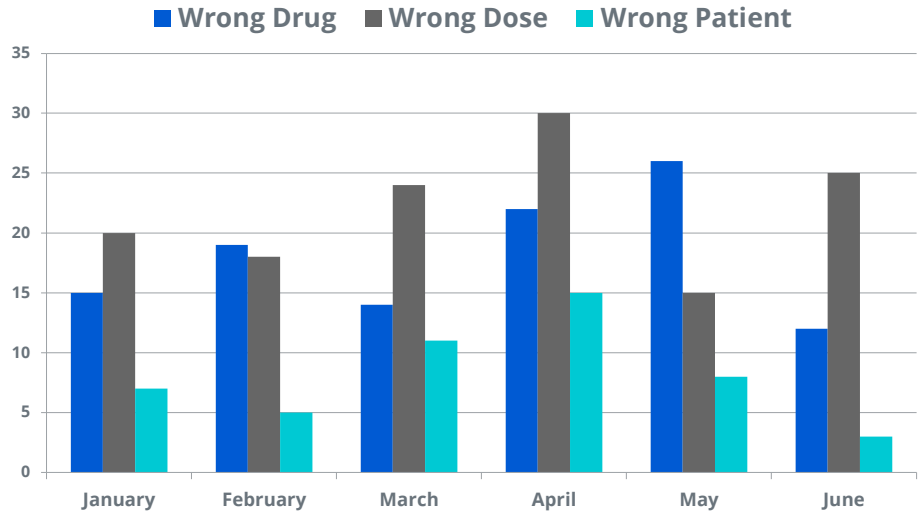
"Trending" of Error Reports



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Which drug classes cause the most amount of harm in your organization?

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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 <u>what</u> happened

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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

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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**

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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

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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.

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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

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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?

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Error reporting is only a starting point…

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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

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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

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Methods of Data Collection

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

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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

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Questions?

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