CLARITY White Paper

The Patient Safety Act – What's in it for Healthcare Providers?

A Three Part Series on the Patient Safety Act and Patient Safety Organizations

Part 2: The Adoption of the AHRQ Common Formats to Enhance the Benefits of Working with a PSO - A Provider's Perspective

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Introduction

In our first White Paper**,** *Part 1: The Patient Safety Act – What's in it for Healthcare Providers?*, we discussed several reasons why healthcare providers should take advantage of the Patient Safety Quality Improvement Act (PSQIA) enacted into law in 2005. One of the most advantageous reasons is the strong Federal confidentiality and privilege protections afforded by the PSQIA statute. Simply, this legislation encourages any and all healthcare providers to report medical errors, analyze safety events, track and trend quality data, and send this information to an AHRQ listed Patient Safety Organization (PSO), and providers can do so without fear that these events, data, and reports are discoverable in a court of law. With such broad protections afforded to healthcare providers, the question remained, 'what is halting providers nationally from reporting medical errors to a PSO when it presents tremendous opportunities for the advancement in quality and safety?'

Crossing the Quality Chasm, published by the Institute of Medicine (IOM), noted that one of the largest barriers that healthcare faces today in understanding the causes of error is the creation of standards for the exchange of information through the adoption of various clinical information technologies (1). This includes, for example, establishing commonly accepted definitions and nomenclature for the

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collection and reporting of medical errors via incident reporting systems. Not only is there much variation in quality and safety metrics depending on the organization and patients served, but also the requirements for reporting medical errors differ between federal, state and accrediting agencies. In the more than a decade since the IOM report, healthcare providers have devoted much time and effort to understanding medical errors and how to reduce them in daily practice. Through this work, it appears that providers are ready to engage in proactive education that demonstrates how to implement best practices for the adoption of standardized reporting. This leads us to explore the question…how can a PSO support providers in the adoption of standardized event reporting of medical errors? More importantly for providers, what is their return on investment (time, energy and resources) for their efforts?

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In this second White Paper, we explore how providers can begin to remove barriers that may have previously derailed and limited the ability to influence quality and safety efforts through working with a PSO and adopting common nomenclature for the reporting of medical errors. This White Paper gives unique insights into how one large healthcare system successfully adopted the AHRQ Common Formats in their work with Clarity PSO. We present here an interview with Damon Newton, Director of Risk Management at Holmes Regional Medical Center of Health First, Inc. in Rockledge, FL. In this interview, Mr. Newton discusses his organization's process in adopting the AHRQ Common Formats, how these templates addressed human factor issues in the face of a new reporting nomenclature, and how receiving data and reports back from the PSO has been beneficial in improving patient safety in their organization.

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Damon Newton, Director of Risk Management for Holmes Regional Medical Center of Health First, Inc. in Rockledge, FL answers 15 questions to help us understand the process, outcome, and value of adopting the AHRQ Common Formats and reporting to a PSO.

What were the primary motives for your organization to adopt the AHRQ Common Formats?

Mr. Newton: Comparative data. We wanted to be able to utilize the data to do some benchmarking with other PSO members who report safety events via Clarity Group, Inc.'s Healthcare *SafetyZone*® Portal. The advent of the Common Formats and the push by AHRQ gave the impetus for our organization to want to participate since it was likely that the PSO and AHRQ would help facilitate the development of common definitions and reporting structure, which was hard to establish and get consensus on initially.

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What have you found interesting about Clarity PSO reports analyzing and benchmarking Common Format safety events across member providers?

Mr. Newton: That we are really not that different than any other healthcare organization. We have a few areas that could use some improvement but we are also the leader in some areas where others could benefit from improvement.

What do you think other hospitals would find valuable about adopting Common Formats and participating in a PSO?

Mr. Newton: The ability to reliably use the data to know where they stand among similar facilities as well as identifying facility leaders and being able to contact them and get good ideas on how to similarly improve their services.

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How has the PSO provided value for you as it relates to safety event management and reporting?

Mr. Newton: The PSO has given structure to what has been a loosely knit and poorly orchestrated attempt by healthcare systems to network and share information. Some people in various organizations did a much better job than others. Clarity PSO helps to equalize the effort by providing the forum for interaction, breaking down barriers of confidentiality and reticence, and making information readily accessible to both large and small organizations.

How have you used the AHRQ Common Format PSO reports internally?

Mr. Newton: I have provided these reports and used information from them with my risk management committee, medication safety committee, and our Corporate Safety committee. The recommendations provided by the PSO are really quite similar to those produced by The Joint Commission when they send out a Sentinel Event Alert. They give us a formal way to address how processes can be performed better and act as a conversation starter to discuss why we have not implemented some of these recommendations in the past, or at least why we have not been effective in the implementation.

How have you created organizational buy-in for reporting of safety events using the Common Formats?

Mr. Newton: Our CEO wants the benefit of comparative data against which we can reasonably measure our progress. Leadership and those involved in various safety or quality committees have heard the terminology "Common Formats" with enough frequency that they know it is a method by which AHRQ is attempting to facilitate comparative data for use in future quality improvement initiatives. Administration is aware and supports the efforts that are underway.

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What was your process in educating staff on the purpose behind the use of Common Format reporting templates?

Mr. Newton: After initial training, Common Format reporting is simply selecting a different title, or drop down option from the reporting screen. To educate on report template updates, we have distributed "How To" reporting procedures so staff understand the event type to pick from the drop down. Beyond that, it is pretty self-explanatory for the reporter.

How did you train staff members on Common Format reporting?

Mr. Newton: Initial education was done in conjunction with the form builds from AHRQ into our safety management system, the Healthcare *SafetyZone*® Portal (Portal). None of the education takes much time. Some of our training with physicians who are department chairs is done in individual settings so that they can feel comfortable with what their physician groups are expected to do in order to participate. For front-line staff, the education mostly consists of individual training upon submission of an issue that pertains to a Common Format event. Subsequent education is easier as each additional item that is considered has a pre-form outline and is easier to disperse and review with staff.

What obstacles did you face in converting to Common Formats?

Mr. Newton: If we had converted from paper to electronic collection of events through use of Common Formats, then we would have probably gotten a lot more push back from staff. We are long time users of the Healthcare *SafetyZone*® Portal and have gone through three total revisions in the way we collected event data, so the adoption of the AHRQ Common Formats has been insignificant in comparison. The only complaints we have received from staff is the amount of data that they are being asked to report. A decrease in reporting though has not occurred. There is a division in IT that supports in providing physician training; Risk Management provides training to staff.

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What is something you found interesting, sparked a need for change, and/or caught your attention from Clarity PSO's reports analyzing your safety event data related to falls events?

Mr. Newton: It is clear that consistent and purposeful rounding does make a difference in the number of falls and the severity of injury.

In analysis of Common Format fall safety event data, toileting was consistently reported as the most frequent contributing factor leading to falls with patient harm across many PSO hospital facilities. How have you responded to this issue?

Mr. Newton: Just asking the patient "Do you need to go to the bathroom?" is no longer a sufficient way to conduct toileting interventions. We have adopted and implemented the Three-P philosophy (paint, position, potty). We are no longer going to check a box; we are now spending time with the patient, finding out their regular toileting activity initially. For example, we ask when they typically get up at night, do they frequently go the bathroom, and how much do they drink. Based upon the patient's responses, we schedule around the patient's routine. Also, one of the most important pieces of our new purposeful rounding is that we ask the patient "Is there anything else, anything else I can do for you now?" This new process is showing improvement in patient safety. Now we are there when the patient is ready for us to be there.

How did nursing and staff respond to the data and initiative for more meaningful rounding?

Mr. Newton: Initially it was seen as another task by staff, so we tried to explain to them that our initial rounding was not accomplishing a reduction in patient falls. Also, bedside shift reporting was another method to improve handoff communication that wasn't widely adopted with open arms at first by staff. However, our goal was to involve patients in their care delivery. Once we were able to show staff data showing the improvement due to purposeful rounding, now the Three P's are becoming more a thing of our culture - staff want to participate. The feedback from the patients is "the nurses and physicians are

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communicating" and the patient feels they are part of the process in their care delivery; getting the result that they want.

Are there still initiatives you want to get better at?

Mr. Newton: We are working on putting a process in place where we can more effectively identify people who can truly benefit from using a protective device. This is something we will not give up on until we get it right.

Where do you still see room for improvement as it relates to the use of the AHRQ Common Format?

Mr. Newton: Some of the Common Formats request too many data points. Some of the data points are difficult to find and, as a result, they are not completed.

Do you believe that safety event reporting efforts nationally help support creating a just culture?

Mr. Newton: Yes.

Providers nationally are realizing the benefits from adopting Common Format reporting by receiving meaningful benchmarking and data back from Clarity PSO.

Conclusion

Providers nationally are realizing the benefits from adopting Common Format reporting by receiving meaningful benchmarking and data back from Clarity PSO. Although this process of converting to Common Formats may be challenging and still has room for improvement, the value that the PSOs can provide through reports can be at least a conversation starter, a story in which hospitals can see they are not alone in their mistakes. Then through conversations and sharing, we can truly educate healthcare on how to improve and make their healthcare environments safer…preventing that same mistake from continuing to happen at the next hospital down the street.

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Additional Resources

Background: Reporting Safety Events Using the AHRQ Common Formats

As authorized by the PSQIA and the Patient Safety and Quality Improvement Final Rule, the Agency of Healthcare Research and Quality (AHRQ) responded to this need for a standardized taxonomy for the collection and reporting of quality and safety data and developed the AHRQ Common Formats for two settings of healthcare: acute care hospitals and skilled nursing facilities (2). The term "Common Formats" refers to the common definitions and reporting format that allow healthcare providers to collect and report patient safety events that occur in these two settings in a standardized method. The Common Formats serve two purposes 1) for AHRQ to analyze national and regional patient safety event statistics thereby providing information on trends and patterns of safety events occurring across organizations and 2) PSOs to analyze their providers' events, create aggregate reports and provide immediate feedback directly to the provider to support local quality improvement activities. [www.pso.ahrq.gov/]

Best Practice in the Adoption of Common Event Reporting

The benefits of comparative data in the advancement of quality and safety are permeating the healthcare industry…

The benefits of comparative data in the advancement of quality and safety are permeating the healthcare industry as seen in recent federal healthcare legislation as well as federal funding programs that support patient safety initiatives. Through devotion to the mission of the PSQIA and purpose of the Common Formats, Clarity PSO provides healthcare solutions to support the adoption of Common Format safety event reporting:

- Provides education, process and taxonomy for standardized reporting.
- Creates Common Format taxonomy (if current AHRQ Common Formats were not applicable for provider).

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- Streamlines reporting of safety events to Clarity PSO through the use of Clarity Group, Inc.'s safety management tool (Healthcare *SafetyZone*® Portal).
- Provides Patient Safety Work Product analytical reports directly back into the hands of Clarity PSO contracted providers showing benchmarks on how they compare on safety events with like providers along with recommendations for improvements.
- Tracks how provider has performed after incorporation of new safety initiatives are implemented.

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Clarity PSO is an operating Division of Clarity Group, Inc.

For more information, please visit our website at www.claritygrp.com

Sources:

(1) *Crossing the Quality Chasm: A New Health System for the 21st Century*. Washington, D.C.: National Academy, 2001. Print.

(2) *AHRQ Common Formats*. PSO Privacy Protection Center. https://www.psoppc.org/web/patientsafety