



Safety Event Self-Reporting in Ambulatory Care Environments

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Introduction

Most care delivery in the US is provided in ambulatory settings, yet quality improvement and patient safety efforts are heavily weighted towards inpatient settings. It is estimated that 5% of outpatient encounters result in an adverse event, however, efforts to better understand patient safety in our ambulatory departments have been limited by the dearth of reported events. A nursing-led council sought to understand reporting practices to guide fall prevention efforts.

Problem

An ambulatory nursing shared leadership council reviewed safety events during project planning and found a limited number of events reported. This did not align with anecdotal evidence and lived experiences. To understand potential reasons for the disconnect, we looked at reporting barriers and facilitators in this setting.

Methodology

An online survey focused on barriers and facilitators of safety event submission including behavior, perceptions, knowledge, and support was shared with nurses practicing in all ambulatory settings via email. It was open for one month.

Descriptive analytics and basic statistics were used to assess findings and their statistical significance. Results were shared with the committee for feedback and identification of priority areas.

SAFE Survey Questions

Thank you for taking the time to share with us your current understanding and utilization of SAFE Reports. The Ambulatory Shared Leadership Falls Taskforce hopes to utilize the information provided in this survey to understand how ambulatory care teams view SAFE reports as it relates to patient safety and prevention of falls. Before you begin, we'd like to offer up two definitions.

Definition of Just Culture:

Organizations that practice just culture create a learning culture that focuses on improvement of patient care and prevention of future patient safety events. Just culture recognizes that when errors occur, it is rarely the fault of an individual alone. Punishing an individual without changing the system only perpetuates the problem, rather than solving it. Patient care systems have an obligation to collect information about faults in the system that contribute to errors and act upon them to improve patient safety. It is the obligation of individuals within the system to report errors to help identify and prevent opportunities for future errors.

Definition of a Safety Event:

There are several types of safety concerns involving Patients, Care Equipment/Quality Concerns, Fall & Safety Concerns, and Transfers.

7. Does your manager or do your colleagues encourage you to submit SAFE's?

Yes
 No

8. (Optional Question) If you would like to provide additional information or detail related to the question above, please provide it here.

Enter your answer

9. After a patient safety incident, such as a patient fall in the clinic, does your clinic complete a post-incident discussion or review (examples: reviewing what happened, discussing who will fill out the SAFE report)?

Yes
 No

11. What does the discussion or review look like?

Implementation

Ambulatory nurses work across diverse service lines, physical spaces, and schedules. They often have closer connections to their interdisciplinary colleagues than nursing leadership. Collecting survey data required word-of-mouth, email campaign and engagement of the leadership council for success. Frequently, clustered responses developed once a local stakeholder was identified.

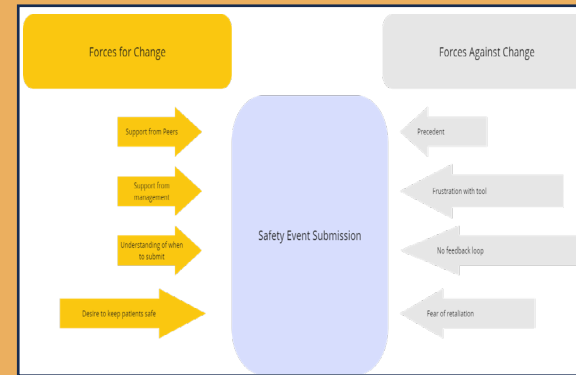
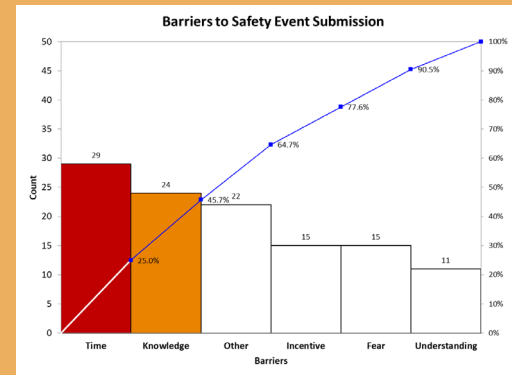
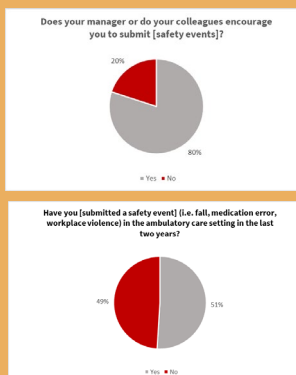
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Results/Discussion

71 nurses from 25 unique clinics responded. Over half had not reported a safety event even though 79% knew events should be reported through the system. Top barriers to reporting included: beliefs reporting is punitive, cumbersome, and linked to employee record.



References

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