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Building a Quality and Safety Team to Increase Event Reporting for Patient Safety in Radiology

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Background

National attention to patient safety has quickly come to the forefront as a top priority. It is a top corporate objective for hospitals and healthcare settings.

In Radiology, areas with high process variability are most error prone. Errors include incorrect protocol, patient falls, and misadministration of contrast media/radioisotopes

Quality improvement (QI) teams are an essential part of Radiology to aid in event investigations, coach teams on QI methodology, and drive process change.

Creating a leadership team to encourage Just Culture and education was instrumental in the successes of our team.

Objectives

- Describe methods related to quality improvement team staffing model to improve patient safety reporting culture.
- Identify patient safety precursor and near miss events in the department.
- Initiate a robust team dedicated to quality improvement to improve patient safety.

SMART Goal

Increase the number of patient safety event reports within safety event reporting software by 50%, from a baseline mean of 25 event reports per month, within one year.

Results

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Results

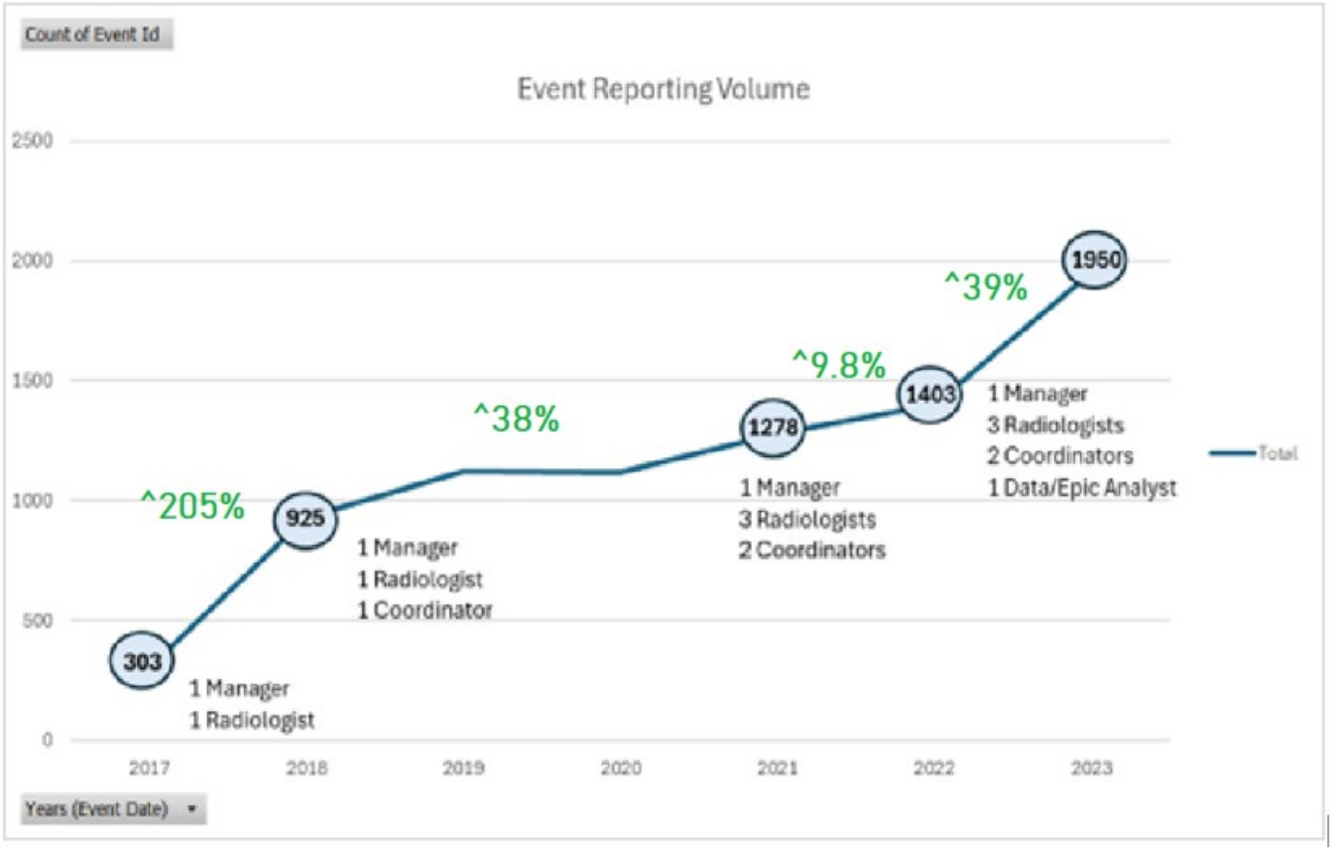

Figure 1- Annual radiology safety event reports received with quality and safety team size.

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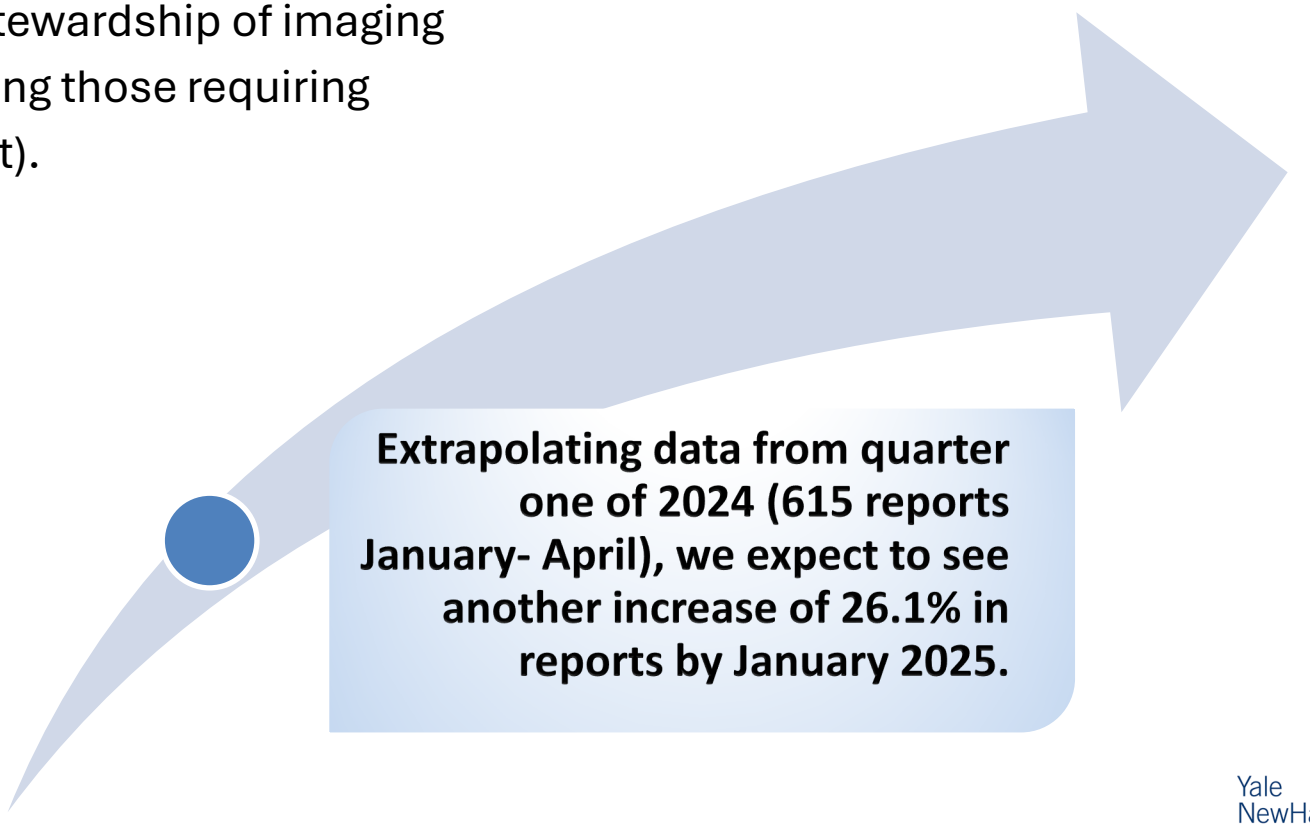
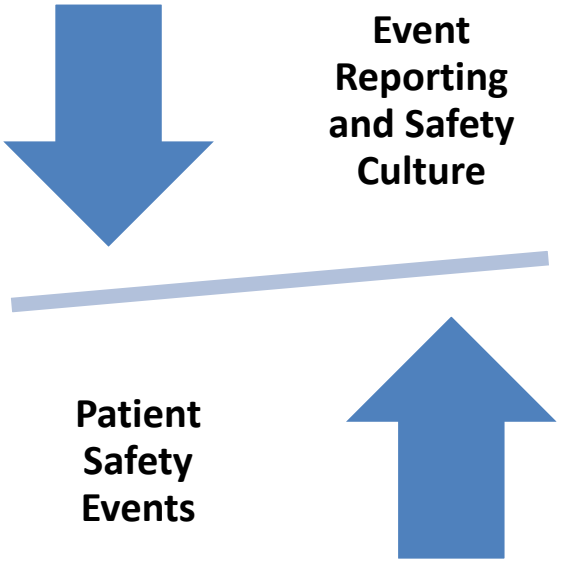
Projections

- The rise in reporting helped our team create quality improvement initiatives and increased stewardship of imaging services (including those requiring ancillary support).



Discussion

- Over the last 7 years, our department has seen a 543% growth in safety event reporting which has correlated with a growth in our team size.
- The growth of our quality and safety team has encouraged reporting as our team has greater resources to address process/safety issues and help support initiatives improving care for patients and front–line staff.
    - With growth of reported events there is need for time/people to investigate the events and ultimately drive improvement initiatives spurred by event reporting



Discussion

- Event reporting is a surrogate success measure of Just Culture theory and High Reliability Organizations. It is important to ensure increased event reporting to support an improved safety culture overall with additional attention to near-miss and precursor events.
- Misuse of event reporting can also lead to spuriously high numbers as the event reporting system may turn into a catch all for “anything”, including HR issues or non-actionable events and normal deviations