TITLE:

Identifying barriers and challenges in patient safety record

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RESEARCH PROJECT DESCRIPTION

Health care institutions all over the world are involved in an internal struggle: How to improve quality of care and decrease preventable adverse event while maintaining cost and keeping the workforce healthy and happy? One of the cornerstones of the current system of quality improvement and patient safety is the Patient Safety Report system (PSR). The systems first developed following the 1999 publication of the report by the institute of medicine (IOM) "to err is human"[i]. In the United States there is no national reporting system like the ones implemented in countries like Denmark, United Kingdom or Australia. The PSR system relies on self-disclosure by the first line providers involved in the incident. The premise for the establishing of a PRS system is to develop a centralized system to identify areas or processes that can produce an adverse event. Following an unbiased and non-punitive review a set of recommendations are implemented to decrease errors, mitigate variance and decrease reliance in a single factor or person to prevent mistakes[ii]. In the large scale a conversation about what to report, cost burden and implications for payment to health care institutions continues unabated[iii,iv]. In the institutions the conversations are more granular and deal mostly with the daily use of the system. There is a great deal of bias inherent to the system. Studies demonstrate that nurses and auxiliary staff are more likely to make reports than physicians[v]. We want to do in person interviews and questionnaire of a representative sample the hospital staff that use the PSR system. We want to identify barriers for use and the willingness of the stakeholders to adopt or change the way the PSR is used to be a more useful tool

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[i] Kohn LT, Corrigan JM, Donaldson MS, editors. To err is human: building a safer health system. National Academies Press; 2000 Apr 1.

[ii] Pronovost PJ, Holzmueller CG, Young J, Whitney P, Wu AW, Thompson DA, Lubomski LH, Morlock LL. Using incident reporting to improve patient safety: a conceptual model. Journal of patient safety. 2007 Mar 1;3(1):27-33.

[iii] Itoh K, Andersen HB. Analysing medical incident reports by use of a human error taxonomy. InProbabilistic safety assessment and management 2004 (pp. 2714-2719). Springer London.

[iv] Lilford R, Mohammed MA, Spiegelhalter D, Thomson R. Use and misuse of process and outcome data in managing performance of acute medical care: avoiding institutional stigma. The Lancet. 2004 Apr 3;363(9415):1147-54.

[v] Evans SM, Berry JG, Smith BJ, Esterman A, Selim P, O'Shaughnessy J, DeWit M. Attitudes and barriers to incident reporting: a collaborative hospital study. Quality and Safety in Health Care. 2006 Feb 1;15(1):39-43.