Innovator's corner: A fresh take on safety investigations

Times are tough. Leaders seek more from already strained resources and limited budgets. Experts in health systems have shown us that investments in safety innovations can elevate our outcomes and pay off in terms of increased throughput, higher patient satisfaction, and engaged, happy employees. Especially when such investments can be cost neutral.

What safety researchers say

- Safety event reporting was never intended to measure safety problems in a health care system. The adverse event rate in a hospital at any point in time is a composite of distinct event types, ranging from common to very infrequent harms, and with varying potentials for improvement[1].

- Event reports by themselves matter less than the subsequent work of investigating the specific occurrence in a health care system and then making the necessary improvements. Not surprisingly, the current focus on quantity of adverse events reported rather than the quality of investigation and improvement activities has slowed outcome improvements[2].

- Root Cause Analyses (RCAs) in health care use limited methods, consider single cases to arrive at conclusions, are constrained by time and limited resources, and make the best of limited training and skills. These factors can prevent the discovery of all factors contributing to a safety event[3].

- The role of patients and relatives in the investigative process needs to be recognized and valued. Such engagement has the potential to generate a unique perspective of the service provided from the end-user's perspective[4].

Reimagining voluntary safety event reporting

A robust safety event management system can help identify and prioritize underlying risks, including risks that may not be obvious from the event report alone. Such a system can assist staff

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[1] Shojania K., G, Marang-van de Mheen P. J. (2020) Identifying adverse events: Reflections on an imperfect gold standard after 20 years of patient safety research. BMJ Qual Saf 29, pp:265–270. doi:10.1136/bmjqs-2019-009731

[2] Macrae C. (2016). The problem with incident reporting. BMJ Qual Saf, 25, pp:71–75. doi:10.1136/bmjqs-2015-004732.

[3] Trbovich P., Shojania K.G. (2017). Root-cause analysis: swatting at mosquitoes versus draining the swamp. BMJ Qual Saf. 26, pp:350–353. doi:10.1136/bmjqs-2016-006229

[4] Peerally M.F., et al. (2017). The problem with root cause analysis. BMJ Qual Saf. 26, pp:417–422. doi:10.1136/bmjqs-2016-005511.

with the organization of investigative and improvement activities. Event reports are the start of a journey of learning and improvement. Unfortunately, safety event reporting is often reduced to a simple process of information transfer between reporters and reviewers/management. Processes to keep executive leaders informed of lurking risks are often underdeveloped. Instead, organizations spend time and energy to add details to reported events rather than focusing energies on carrying out in-depth investigations. Unsurprisingly, this results in an increased burden on staff and insufficient time to adequately address safety concerns.

Limits of current investigative practices

Investigations in health care are intended to identify the latent and active factors involved in a particular adverse event, but they end up failing to account for the many interacting contributory factors and miss similar events. Improving outcomes in a health system requires safety leaders to obtain the mandate and the needed budgetary support. When a mandate is missing, corrective actions are limited to changing human behavior because they fail to adequately identify and explore systemic contributory factors. RCA approaches in health systems suffer from outcome bias, lack of trained staff, time constraints, and scheduling challenges. Organizations are unable to assess the complexity of investigations, and the feasibility of actions indicated. Unsurprisingly, analyses of RCA efforts have shown that events similar to the ones investigated recur over time.

Making safety investigations less burdensome

Creating safer outcomes for patients requires us to embrace the complexity inherent in each event, take a fresh approach to safety event reporting and management, close the feedback loop with frontline staff, upgrade existing tools and processes, and share learnings across the organization. That is easier said than done. However, organizations can make incremental improvements and unlock staff capacity by making event investigations less burdensome for safety professionals, transparent to stakeholders, and by implementing changes that make it easy for caregivers to do the right thing.

Here are 10 recommendations as you embark on a journey to making your investigations workflows less burdensome.

1. **Follow the signals in your data**: Unlock insights hidden in your data using advanced analytics. Shine a light on signals identified from event investigations that can help improve other operational processes. Use data and insights to illuminate your path.

2. **Embrace the complexity**: It is time we stopped oversimplifying the reporting of safety events by tagging them with a single category. Often, more than one category is involved, and more than one barrier has been crossed before a patient experiences an adverse event.

3. **Go deep and wide**: Investigating events, one event at a time, is necessary but insufficient for designing corrective actions. It is important to pursue insights into all contributing factors by looking at events that are similar in nature. This helps an organization identify actions that have the greatest potential for improvement as well as preserve what is working well.

4. **Share insights widely**: Often, lessons learned in one area are not known or communicated to other care environments. It is time to improve our investigation processes and workflows by asking these questions during your investigation: "Could this event happen somewhere else in our organization?" and "Has this or a similar event occurred in the past?"

5. **Use complaints data**: Generally, complaints and grievances are investigated separately from safety events. Consider the perspective of the patient and family when investigating safety events and designing improvements. Incorporate patient complaints and grievances data into event investigations, collaborative action planning, action tracking, and shared learning.

6. **Make it easy for staff**: Identify bottlenecks in the investigation and action planning stages and create resolution pathways.

7. **Make it easy for leaders**: Use tools and tracking mechanisms that create visibility into staff bandwidth for investigating concerns so you can help with cross coverage.

8. **Error proof your strategy**: Adopt tools and processes that can assist with identifying robust error proofing strategies and assess the feasibility of corrective actions before action items are assigned to stakeholders.

9. **Share learnings frequently**: Provide a digital commons area for frontline staff to learn about outcomes of investigation of events they reported, about system changes that might impact their work, and about the risks they need to be on the lookout for.

10. **Use the right tools**: Upgrade to a solution that provides a library of investigation tools (e.g.: RCA, CSA, LFD) and help investigators to select the right tools for their investigations needs.

Times are tough. Advanced technologies and tools are now available for us to use as we march toward a better future for patients in our care.

We are happy to chat if you have questions. Reach us at hello@safetower.com or call us at 502-202-5255. Or visit our website at www.safetower.com to learn more. We also invite you to 'follow' us on LinkedIn.