Process Evaluation of Reporting Adverse Events Through the Datix® System

Sheba Luke, DNP, FNP-C, RN

utmb Health School of Nursing

Background

- The Institute of Medicine (IOM) recommends using patient safety reporting systems (PSRS) to evaluate why patients are harmed by medical care (IOM, 2004).
- In 2005, the Joint Commission on Accreditation of Healthcare Organizations enacted a regulation requiring hospitals to report errors (Patient Safety and Quality Improvement Act, 2005).
- Most reporting systems are relatively new and focus solely on collecting data centered on documenting the event; these systems are not utilized to provide meaningful data to health care providers to prevent future errors from happening and to improve patient safety (WHO, 2005).

What is Datix®?

A web-based software program used for reporting clinician related risks, incidents, and other adverse patient events developed by a company in the United Kingdom and adopted by University Healthsystem Consortium (UHC).

Objective

The focus of this quality improvement project is in repurposing and redefining the patient safety net reporting system process at University of Texas Medical Branch (UTMB). The proposed outcome is to develop strategies and improved methods for the identified limitations and variations in the current process, and provide recommendations based on evidence based literature. The outcome from the comprehensive evaluation of the process will help achieve future meaningful use of the information reported to assist in developing initiatives in safety and quality control.

Intervention

Interview and collect anecdotal qualitative evidence from four nurse managers and four medical directors regarding the process of reporting adverse events, and the utilization and usefulness of reported data.

Method

Find a process to improve

Evaluate the process of reporting adverse events through Datix®

Organize a team

The principal investigator; the content expert, the Assistant Director of Quality and Measurement; the faculty sponsor; and the risk management staff

Clarify current knowledge

Meet with the risk management staff, nursing quality director, nurse managers, and medical directors to gain more knowledge regarding the current process

Uncover root causes

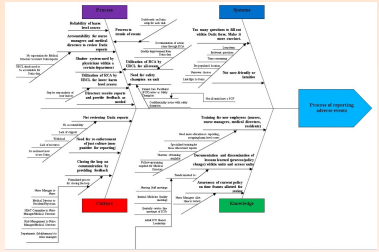
Analyze the interview data from the nurse managers and medical directors

Select a process to improve

Provide recommendations for improvement for the major variations and gaps identified in the current process

Analysis

Interview data were organized and prepared for a detailed analysis with a coding process utilizing Microsoft Excel spreadsheets. A fishbone diagram was created to categorize the overall themes, sub-themes, and specific details among the sub-themes from the respondents to classify deeper levels of causes and indicate causal relationships.



Results

All eight respondents identified three major sub-themes in the interviews: (1) close the loop on communication by providing feedback on multiple levels within the process, (2) make the report form on Datix more succinct and (3) utilize root cause analysis (RCA) for reported events with lower harm level scores.

Conclusion

It is essential to increase patient safety within hospital and all health care systems by learning from reported adverse events and near misses by collecting data reports, conducting meaningful analysis, educating others through the dissemination of the measurable outcomes, and working in collaboration with all stakeholders to make recommendations for process and/or policy changes (Pronovost et al., 2008; World Health Organization, 2005).

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Contact Information of presenter can be found at: http://www.nursing.utmb.edu/