



# **PATIENT SAFETY NET**

## **Ambulatory Reports**

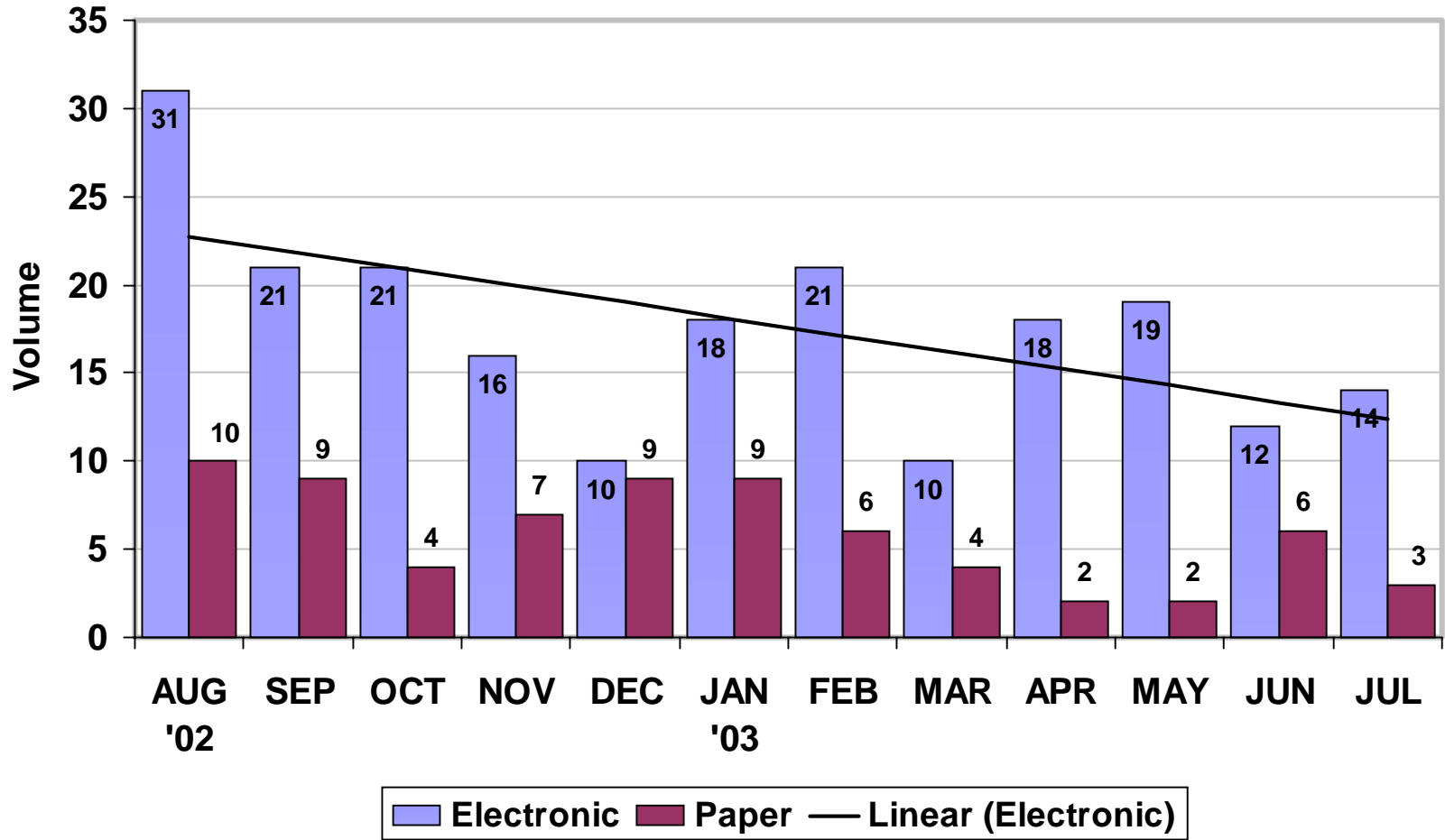
**PRE: Paper (8/1/01 – 7/31/02)**

**POST: Electronic (8/1/02 – 7/31/03)**



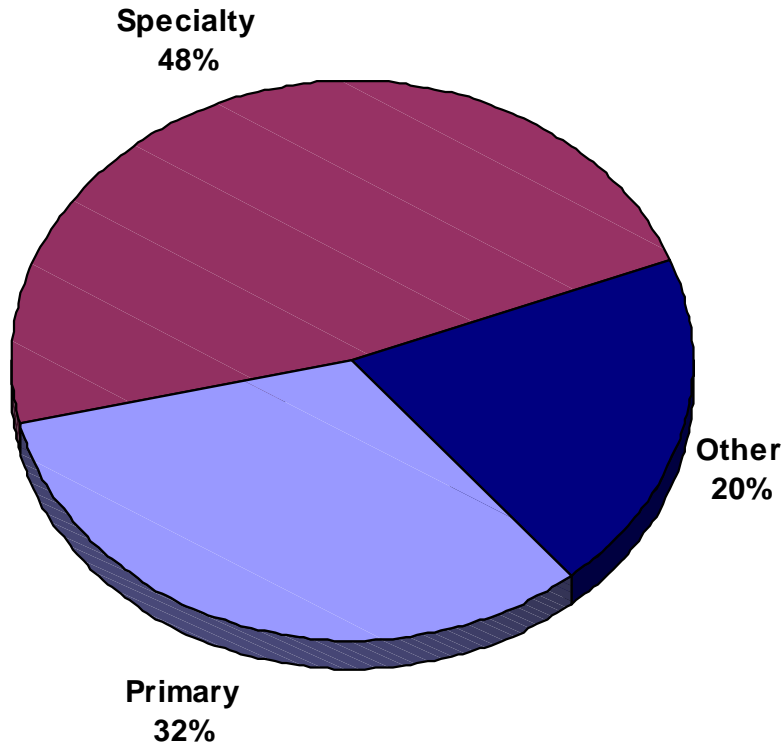
# Ambulatory SAFETY REPORTS

## Electronic (n=211) vs Paper (n=71)

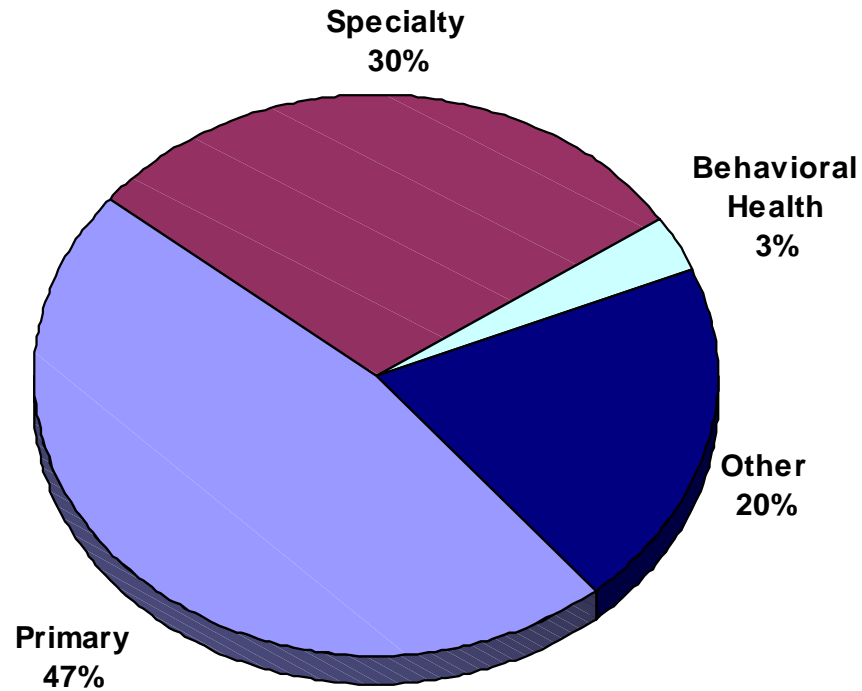


# Ambulatory SAFETY REPORTS By Clinic

PRE (Paper; n=71)

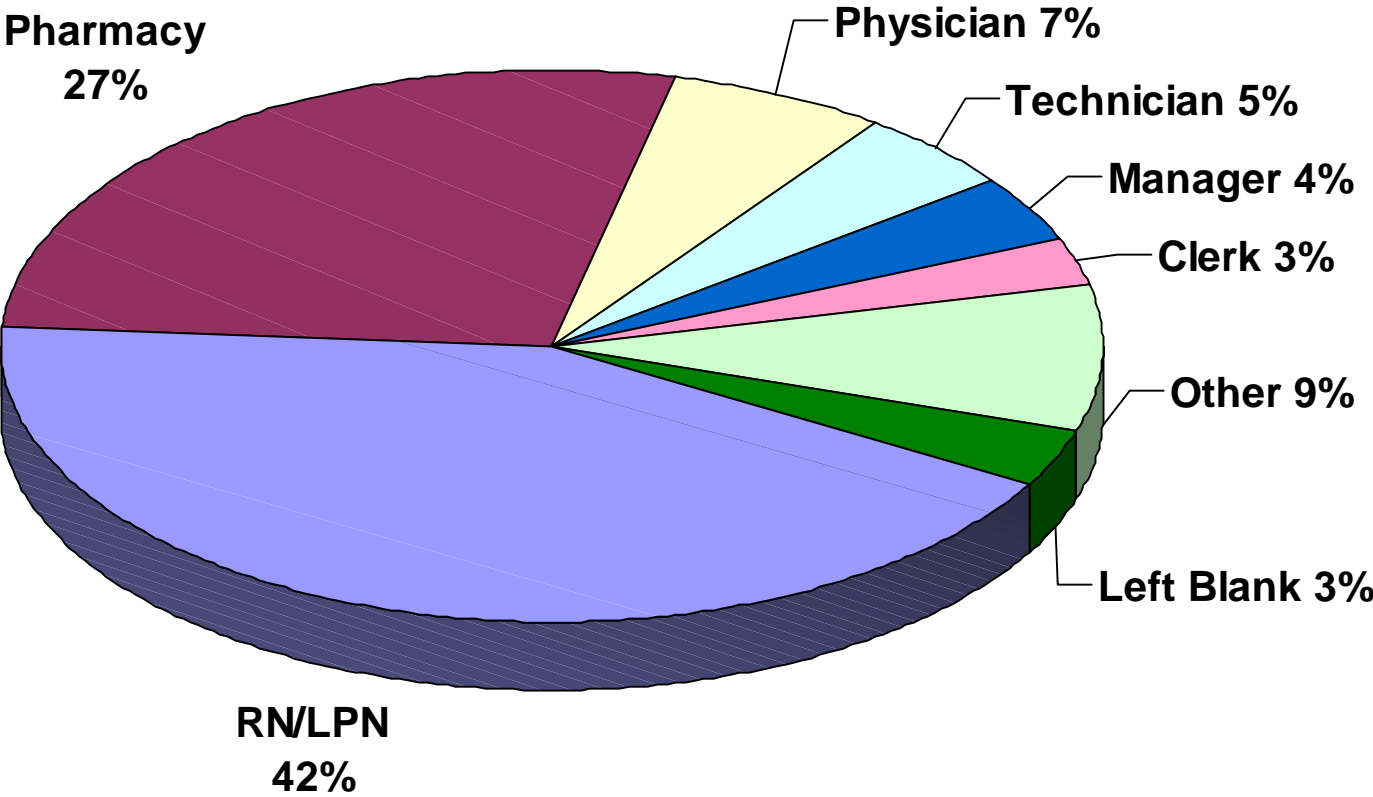


POST (Electronic; n=211)



40% visits primary;  
60% specialty

# Ambulatory Electronic SAFETY REPORTS by Reporter Type (n=211)





# Ambulatory SAFETY REPORT Volume by Incident Type Paper vs Electronic

Paper Incident Types	Volume	Percent	Electronic Incident Types	Volume	Percent
Drug Reaction	2	2.8%	Drug Reaction	3	1.4%
Equipment	1	1.4%	Equipment/Device	1	0.5%
Fall	15	21.1%	Fall	21	10.0%
Medication	6	8.5%	Medication	78	37.0%
Miscellaneous	32	45.1%	Miscellaneous	67	31.8%
Procedure/Test/Treatment	15	21.1%	Procedure/Test/Treatment	41	19.4%
Total 2001	71	100%	Total 2002	211	100%



# Ambulatory SAFETY REPORTS by Harm Scores Paper vs Electronic

PRE (Paper) Safety Report Harm Scores	Volume	Percent	POST (Electronic) Safety Report Harm Scores	Volume	Percent
Error, No Harm (0,1)	63	88.73%	Harm 0	155	73.46%
			Harm 1	39	18.48%
Error, Harm (2,3,4)	8	11.27%	Harm 2	11	5.21%
			Harm 3	6	2.85%
			Harm 4		
Death (5)			Harm 5		
Total Paper	71	100%	Total Electronic	211	100%



# Ambulatory Electronic SAFETY REPORT Resolution

(454 resolutions by managers for 211 Safety Reports)

Actions Taken	Volume	Percent
No further action required	118	33.3%
Staff responded appropriately to minimize harm	46	13.0%
Re-Routed To Appropriate Department	36	10.2%
Does not fit PSR criteria	8	2.3%
Individualized staff counseling/education	60	16.9%
Comprehensive staff training/alerted to safety issue	41	11.6%
Procedure/policy change	16	4.5%
Other	4	1.1%
Referred for systemic intervention	20	5.6%
Labeled patient's record	1	0.3%
Left Blank	4	1.1%

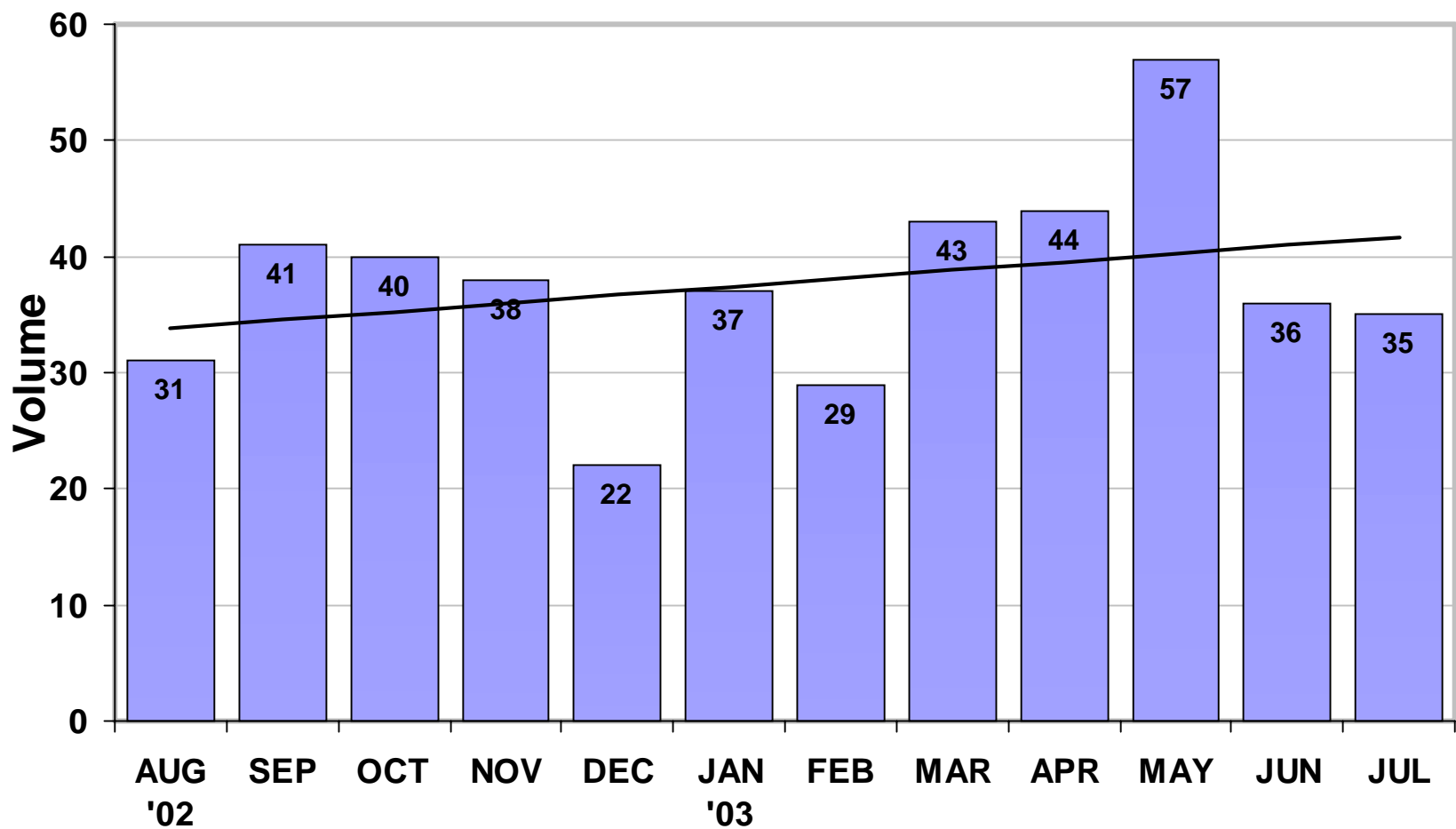


# Ambulatory Electronic SAFETY REPORTS by Manager Report of Patient Impact (n=436)

Impact To Patient	Volume	Percent
No Impact	117	26.8%
Inconvenience for patient	104	23.9%
Additional patient monitoring in current location	28	6.4%
Additional lab testing or diagnostic testing	14	3.2%
Pain or suffering for patient	24	5.5%
Transfer to more intensive level of care	11	2.5%
Hospital/ER admission/readmission	30	6.9%
Increased length of stay	10	2.3%
Minor surgery	1	0.2%
Patient/family requesting compensation	1	0.2%
Unknown	70	16.1%
Left blank	26	6.0%

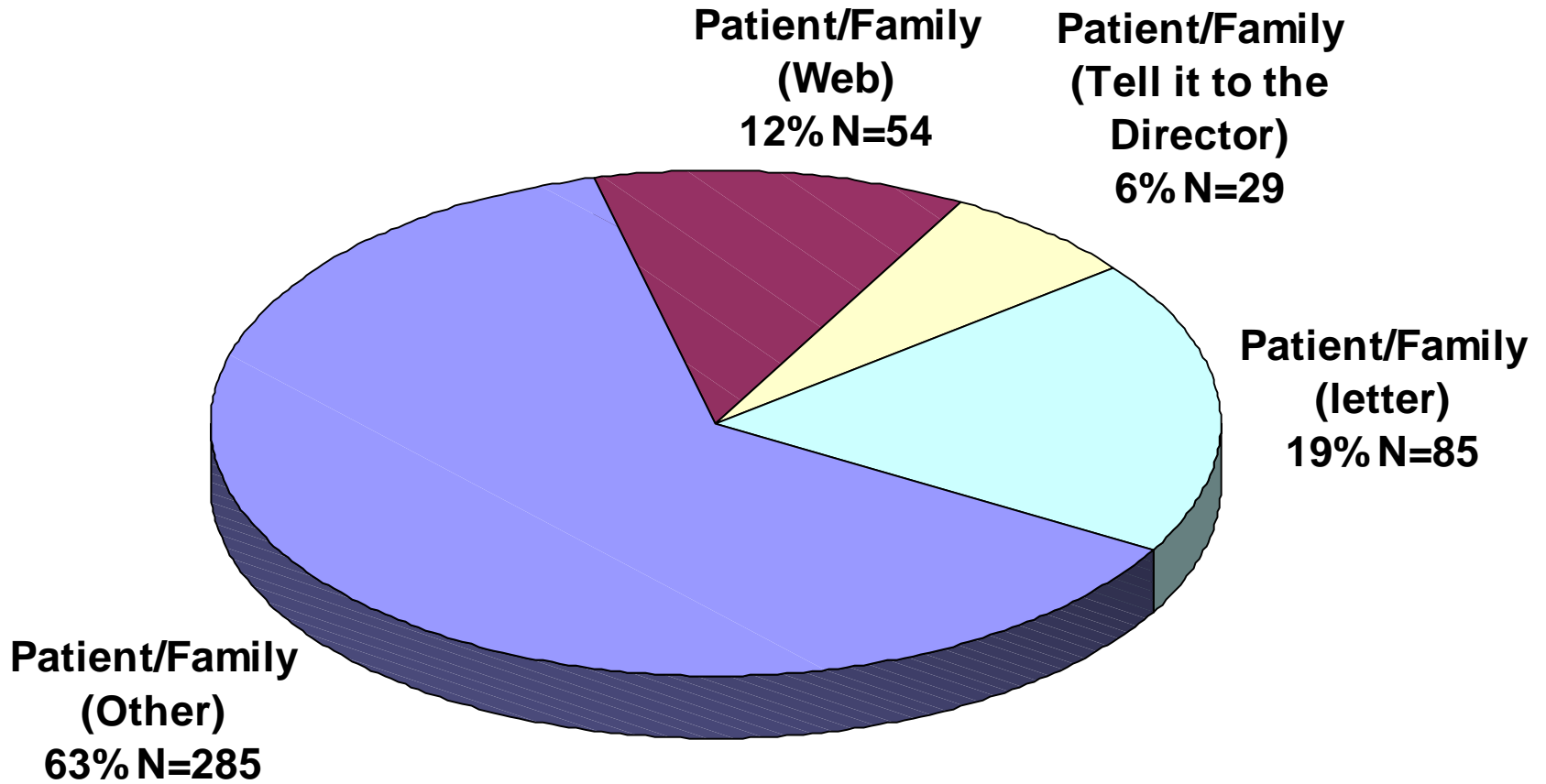


# Ambulatory Electronic COMMENTS (n=453)

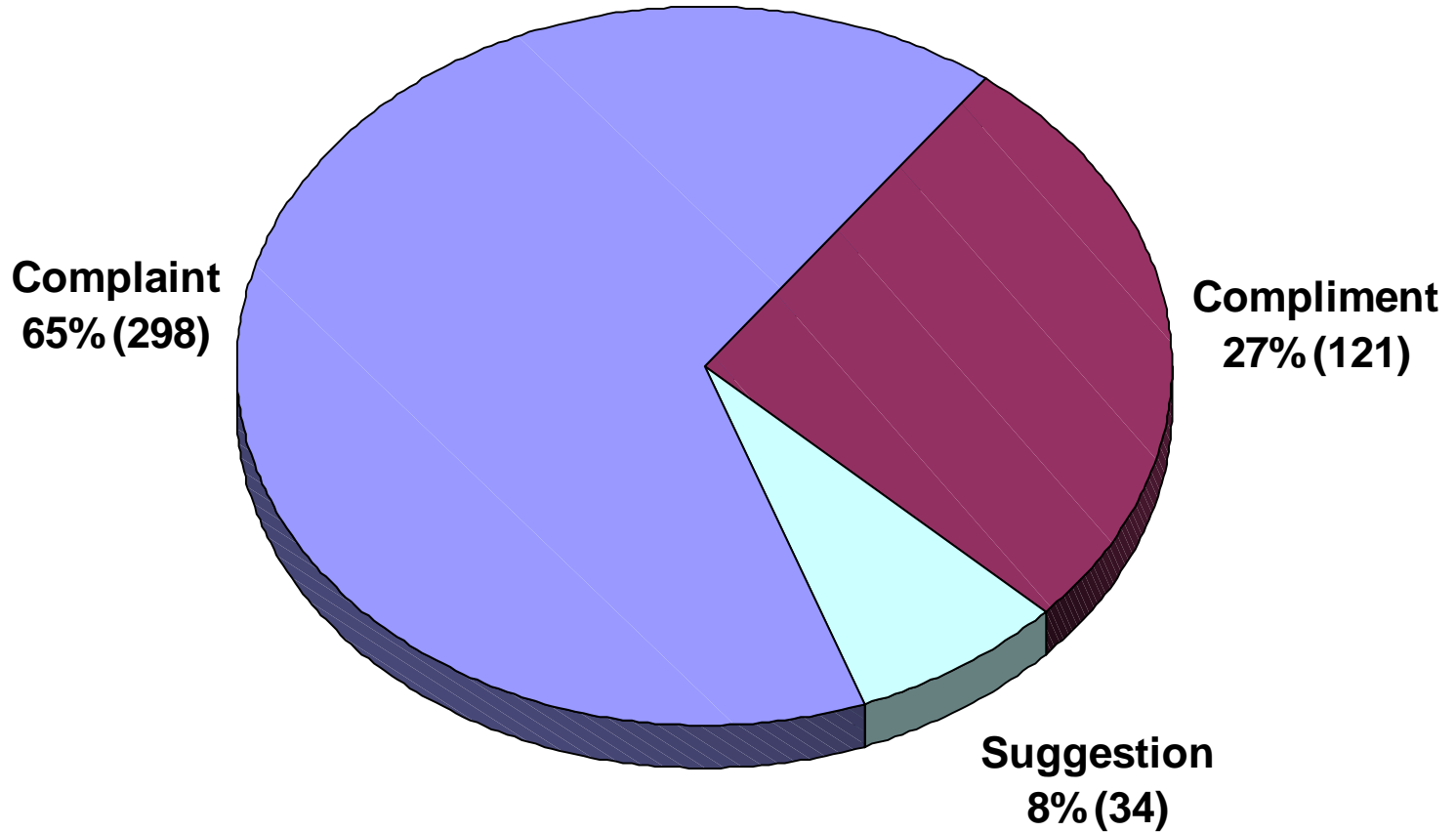


■ Electronic (N=453)      — Linear (Electronic (N=453))

# Ambulatory Electronic COMMENTS by Source (n=453)

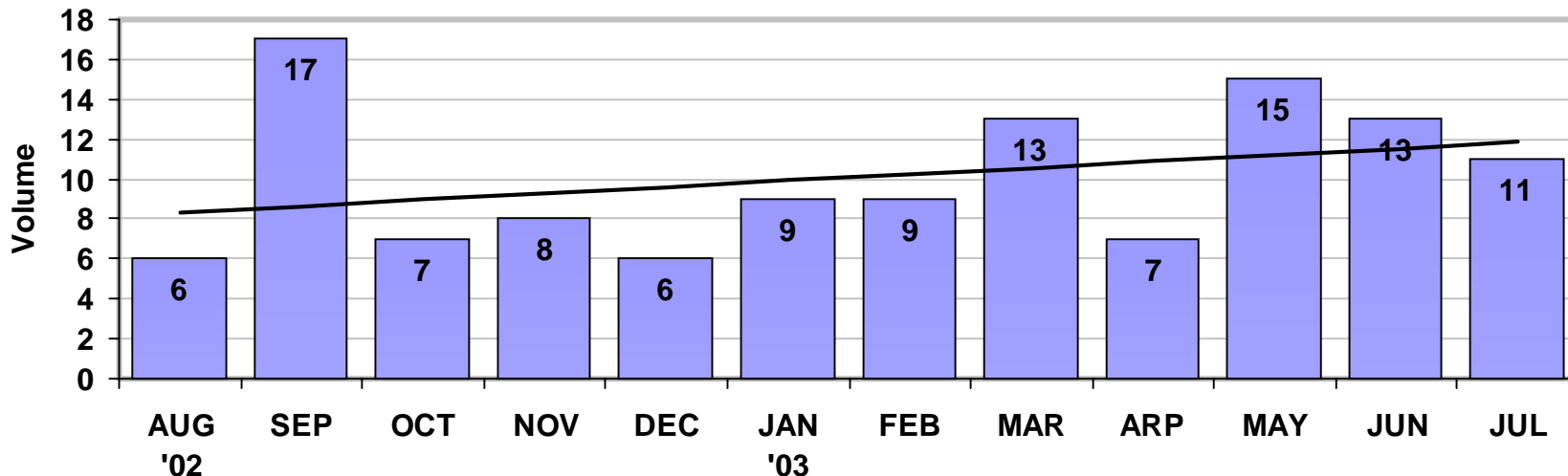


# Ambulatory Electronic COMMENTS By Type (n=453)





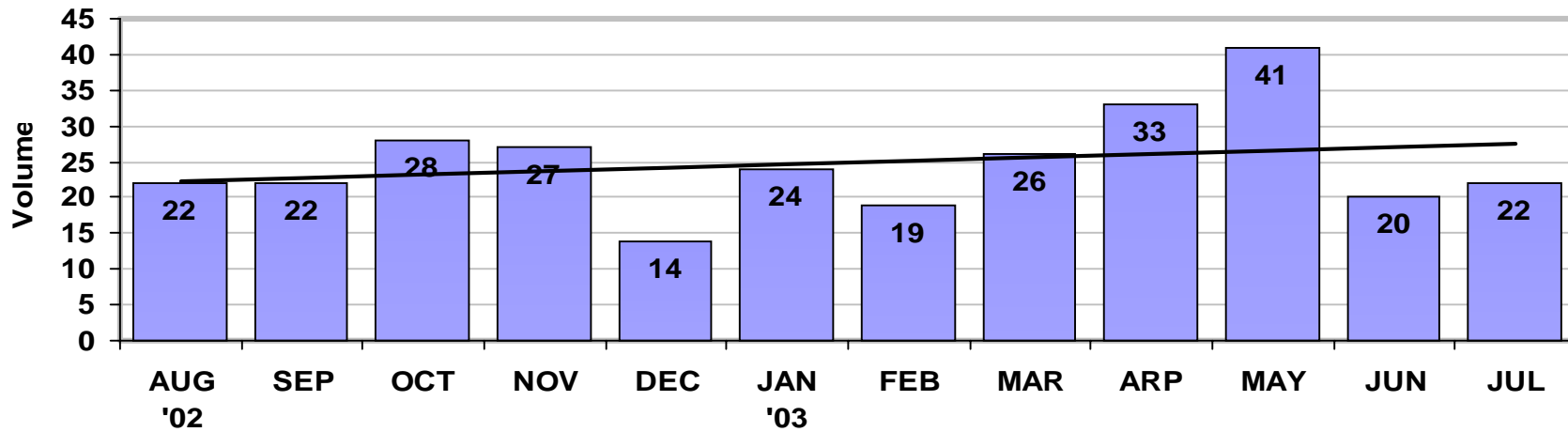
# Ambulatory Electronic COMPLIMENTS (n=121)



Compliment Category	Volume	Percent
Quality of Care	74	58.80%
Staff Behavior/Attitude	18	21.10%
Responsiveness to Needs/Promptness	17	9.30%
Communication	7	2.10%
Billing/cost of care	2	2.70%
Other	2	2.70%
Cleanliness	1	3.00%
<b>Total Compliment Reports</b>	<b>121</b>	<b>100.00%</b>



# Ambulatory Electronic COMPLAINTS (n=298)



Complaint Category	Volume	Percent
Staff Behavior/Attitude	53	20.00%
Quality of Care	54	16.80%
Responsiveness to Needs/Promptness	34	11.60%
Other	16	9.30%
Billing/Cost of Care	44	7.80%
Timeliness of appointment	14	5.20%

# What we're learning

- Problems with patients who fall and those who are misidentified are usually thought of as an inpatient problem. These cross the continuum and can be prevented.
- Patients are catching medication errors. How many are going unnoticed? What are we teaching our patients to help us?
- Problems with scheduling and paperwork lead to patient harm, rework and inefficiency. These are errors!
- Laboratory/Radiology errors have potentially very serious consequences.
- Managers' level of sophistication with system fixes is limited.



## MISCELLANEOUS COMPLAINTS and PSNs

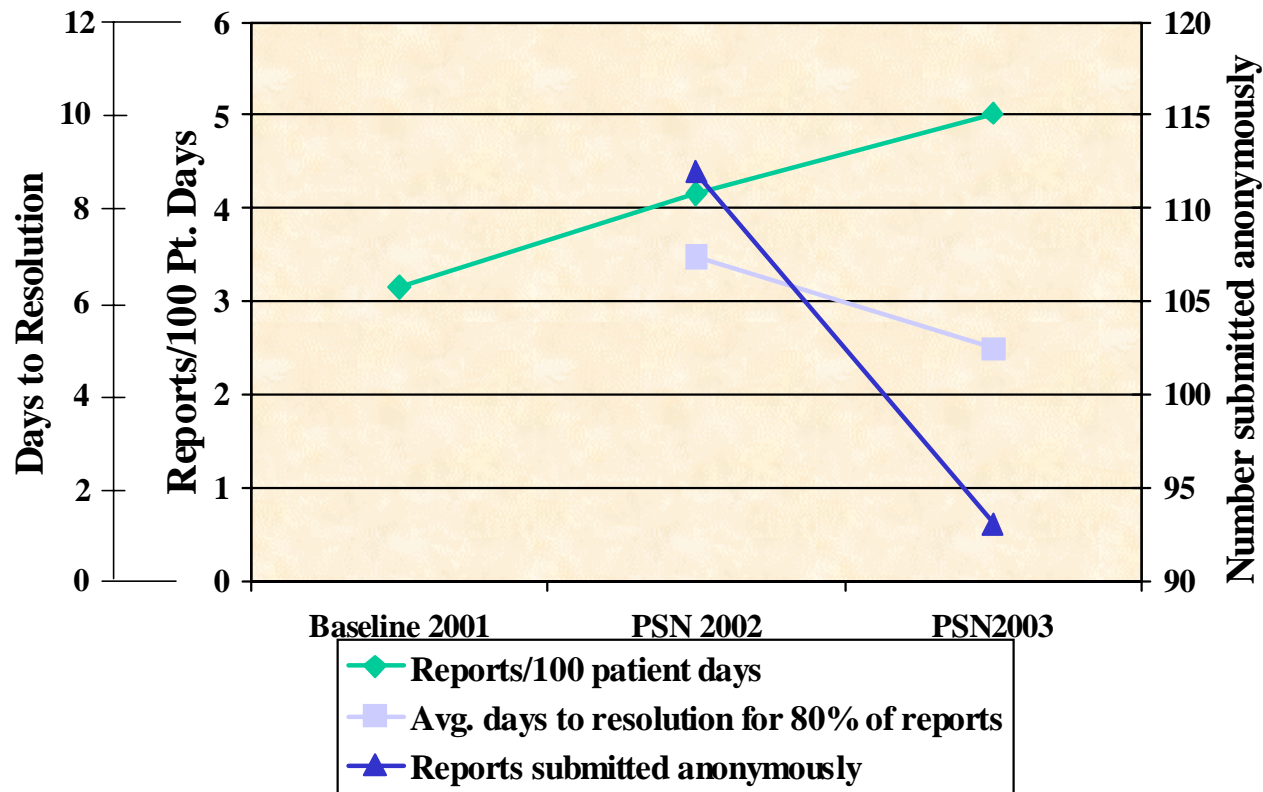
- Medications refilled, Lab results, Xray preps
- Call backs from clinic, Cancelled appointments, Phone hassles
- Clerical rudeness, Wait times
- Hand-offs
- Physician communication
- Quality of care perceptions

# Next Steps

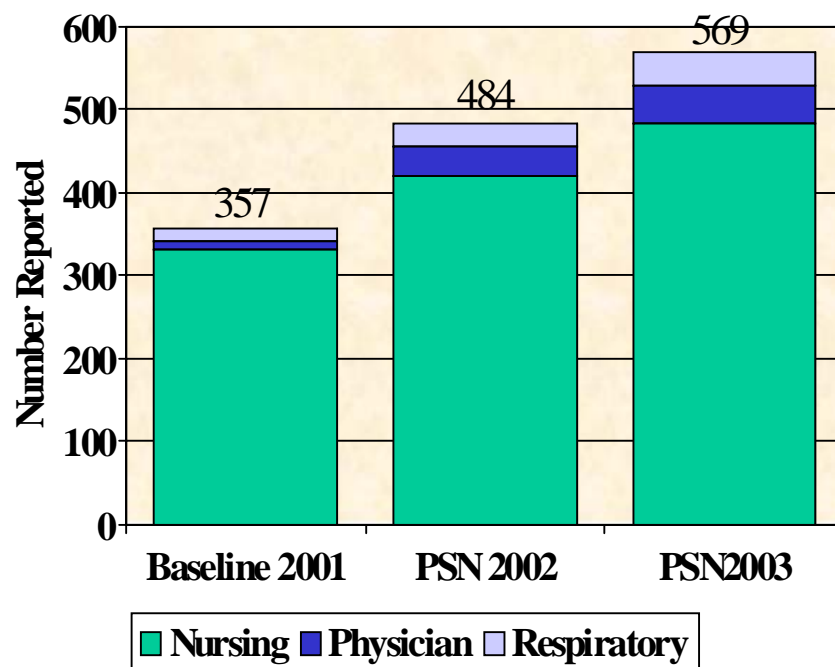
- Targeted efforts to increase reporting
- Taxonomy revisions to better fit “miscellaneous” ambulatory errors
- Facilitate root cause analyses with care team members
- Mentoring and training of managers in system thinking and resolution



**Figure 1. Comparison of Baseline and PSN Rates**  
**January – March each respective year.**



**Figure 2. Reporter Type Comparison of Baseline and PSN  
January – March each respective year**





## COMPLAINT/COMPLIMENT EXAMPLES

- Hives in young child quickly diagnosed and managed with pt ed and after hours contact
- Prompt critical lab follow-up and intervention
- Typing dissatisfaction note on the PSN website while on hold to the clinic for appt!!
- Doctor talked down to patient/family
- Lab lost, tests not done, clinic closed when test finally done
- Missed diagnoses-strep, twins, mono, etc



## PSN EXAMPLES AND RESOLUTION ROBUSTNESS

- HIV wrongly reported as positive(COUNSELED LAB STAFF TO BE MORE CAREFUL)
- Amitriptyline 100 mg vs 10mg(REVIEWED DISPENSING MACHINE TO CHECK FOR FIX//REMINDED OF 5 RULES OF DISPENSING)
- Wrong diagnosis in daughter's Xray-meningioma(Staff counseled)
- BB in face with MRI ordered(discussed with doctors)