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# Quality Improvement Conference: Effect of Patient Safety Intelligence Inservice Training on Resident PSI Entry

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## BACKGROUND

- Hospital administrators rely heavily on incident reporting systems to capture adverse events.<sup>1</sup>
- 13.5% of Medicare beneficiaries discharged in October 2008 experienced adverse events. 62% were not reported because staff did not perceive an event as reportable; 25% were not reported because staff commonly reported but did not report in this case.<sup>1</sup>
- Nurses reported events most often.<sup>1</sup>
- The Patient Safety Intelligence (formerly PSN) is an online adverse event reporting service provided by UNM Hospital.
- System-wide and departmental efforts to improve quality have included attempts to increase PSI reporting.
- A comprehensive educational intervention program for anesthesiology resident physicians at the University of Illinois Medical Center at Chicago increased the number of adverse events reports and improved attitudes of reporting.<sup>2</sup>
- Anyone can report a safety incident.
- All patient safety incidents are reviewed by the parties involved in order to improve quality of care.

## OBJECTIVES

- Assess the rate of PSI reporting by residents before and after PSI in-service training within the Department of Radiology.
- Elucidate knowledge and attitudes about PSI reporting before and after resident PSI in-service training.

## REFERENCES

- Levinson DR. Washington, DC: US Department of Health and Human Services, Office of the Inspector General; January 2012. Report No. OEI-06-09-00091
- Jericho BJ, Tassone RF, Centomani NM, Clary J, Turner C, Sikora M, Mayer D, and McDonald T. An Assessment of an Educational Intervention on Resident Physician Attitudes, Knowledge, and Skills Related to Adverse Event Reporting. Journal of Graduate Medical Education: June 2010, Vol. 2, No. 2, pp. 188-194.

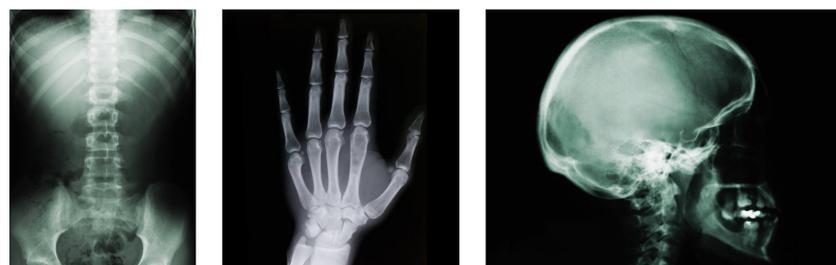
## METHODS

- In-service training on PSI entry was provided by the Radiology Residency Program director and Radiology Quality Committee Chief on 11/17/2015.
- A survey designed to assess attitudes and knowledge about PSI reporting was completed by radiology residents, both pre-training and 6 months post-training.
- PSI entries by radiology residents were reviewed from July 2015 to May 2016.

Residents were asked to rate the following nine survey questions with 1)Strongly disagree 2)disagree 3)neither agree or disagree 4)agree 5) strongly agree immediately before and ~6 months after the in-service training:

- I don't report incidents because I am worried about disciplinary action.
- I don't report incidents because I am worried about litigation.
- I don't report incidents because my colleagues may be unsupportive.
- I don't report incident because I do not know which incidents should be reported.
- I don't report incidents because I do not know how to.
- I don't report incidents because I don't think it's worth reporting.
- Near misses should be disclosed to patients.
- Current systems for reporting patient safety problems by healthcare providers are accurate.
- Hospitals and health care organizations adequately support providers in coping with stress.

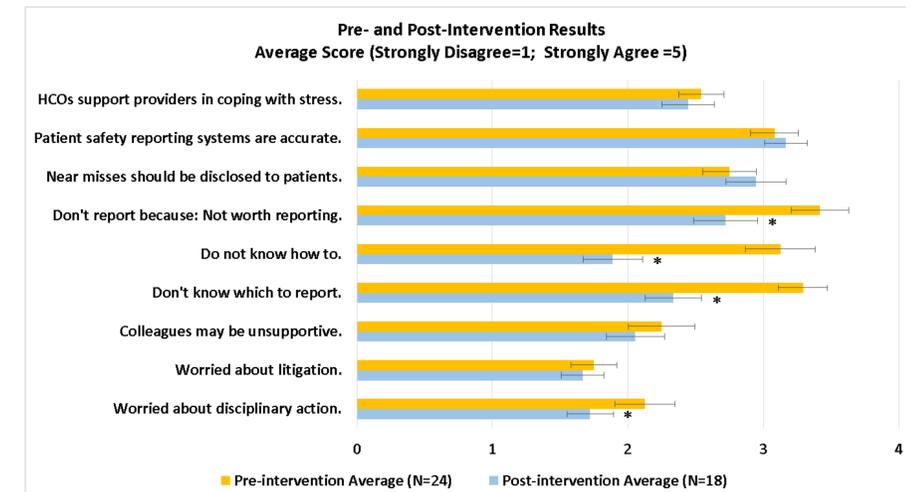
Comments:



## RESULTS

- From July 2015 to PSI training 11/17/2015, there were no PSI submissions by radiology residents.
- After PSI training through May 2016 there were 5 PSI submissions by 2 radiology residents for the following reasons:
  - 11/17/2015: incorrect ordering history provided on ED radiographs
  - 12/18/2015: wrong patient scanned for urgent care head CT under incorrect patient name
  - 2/23/2016: incorrect ordering history provided on outpatient MRI, resulting in incorrect protocol (without contrast)
  - 5/18/2016: incorrect ordering history provided on ED CT
  - 5/26/2016: incorrect ordering history provided on ED radiographs

## RESULTS



**Result: Significant improvements (\*) from pre- to post-intervention in some resident concerns about reporting.**

### Selected Post-Intervention survey comments:

- I think PSI's or any patient centered protection protocol is absolutely appropriate and vital, however there needs to be more efficient implementation.
- I don't report because there isn't enough time
- The main reason I haven't used the PSI system on call is due to the time constraints
- The system is cumbersome, and not well organized for radiology use, very time consuming
- The culture of a department strongly influences what is reported and what is not. If misses and incidents are brought up in regular meetings and treated like an expected occurrence, people would feel less terrible and be more willing to participate. Like a monthly PSI discussion, instead of a yearly RCA that's devastating
- I don't remember what deserves a PSI and too much time.

## CONCLUSIONS

- Overall resident PSI reporting increased after a PSI in-service.
- Although some residents began reporting PSIs after the training (2 out of 29 total residents), most did not.
- Our results trend in the desired direction but were not as pronounced as those previously reported.<sup>2</sup>
- Residents surveyed demonstrated the greatest improvements in "how to report" and "what to report", though time constraints and a cumbersome reporting system were barriers to more PSI reporting.
- Improving the ease of PSI entry and an ease of time constraints may increase the amount of adverse event reporting by radiology residents.