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. ¹
- 13.5% of Medicare beneficiaries discharged in October 2008 experienced adverse events. ²
- Nurses reported events most often. ¹
- 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. ²
- Anyone can report a safety incident. ³
- 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**

3. I don’t remember what deserves a PSI and too much time.
4. I think PSI’s or any patient centered protection protocol is absolutely appropriate and vital, however there needs to be more efficient implementation.
5. I don’t report because there isn’t enough time
6. 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.
7. I don’t report incidents because I am worried about disciplinary action.
8. I don’t report because I am worried about litigation.
9. The main reason I haven’t used the PSI system on call is due to the time constraints and “what to report”, though time constraints and a cumbersome reporting protocol (without contrast) is more than just a barrier to PSI reporting.
10. I don’t report incidents because I do not know how to.
11. Don’t report because I don’t think it’s worth reporting.
12. Don’t report because I am worried about disciplinary action.
13. Don’t report because I am worried about litigation.
14. Don’t report because I do not know which incidents should be reported.

**RESULTS**

**CONCLUSIONS**

- 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

- 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. ²
- 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.

- **Results**: 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.