Improving Patient Safety through Medical Event Reporting

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Introduction: In 2009, thirteen hospitals in RI selected GE MERS as their Patient Safety Organization (PSO) and have recently implemented the Medical Event Reporting System (MERS) software for recording, tracking and trending safety events. This abstract describes Lifespan's journey in this state-wide initiative.

Background: In response to the 1995 Institute of Medicine report "To Err is Human", Congress passed the Patient Safety Act in 2005 which paved the way for entities to form federally certified PSOs. Non-discoverable data are collected in a Common Format that will allow analysis and trending at the local, state, national and international levels.

Methodology: Within each hospital, project leads gathered information from the content experts to build the different forms and sub-forms used in the MERS application. Guided by GE Healthcare, teams from the thirteen hospitals met with each other over several months to agree on terms associated with different types of patient safety events (for example, medication event, fall, invasive procedure, behavioral, etc.). Feedback from the users was welcomed by the vendor and incorporated into the product before the go-live. Each hospital developed a process to handle event reporting. Lifespan began introducing staff to the new "just culture" of reporting, analyzing and learning from the data. At Lifespan, this represented a shift from event management by Risk Managers, to management and analysis by department-level reviewers. The Quality Management staffs are responsible for coding and closing events before they are sent to the PSO. The application roll-out began in the summer of 2010, with 3 of the 4 Lifespan hospitals going first and the rest of the State continuing through the fall and winter.

Outcomes and Lessons Learned: At Lifespan, there has been an increase in reporting of patient safety events some of which have led to changes in safety-related processes. The shift in event management responsibility from Risk to Operations was a significant change for staff. It presented challenges for first and second-level Management Reviewers who are learning how to categorize and follow up on increasing volume of events and to conduct RCAs if necessary. Although staff are beginning to use the built-in reporting and query tools to trend data, additional education is needed. As early adopters of the PSO software, many lessons were learned by both the hospitals as well as by GE Healthcare and MERS. The routing system is complex and a better understanding earlier in the project would have made for less re-work. Having reports in place to track events movement through the review process would have prevented an initial back-log.

Future of the Initiative: As the data accumulate, trends and patterns will emerge. SAS Analytics is collaborating with GE Healthcare to provide PSO member hospitals with information that can be used to identify risks and improve patient safety. Using de-identified PSO data, hospitals will be able to share information without compromising patient privacy.