Incident Reporting Line for Housestaff: 4-7050

Purpose of Incident Reporting Line: To allow residents an alternate method for reporting patient safety events. By allowing residents to report patient harm and near misses outside of RL Solutions, we hope to increase resident participation in incident reporting, which will allow staff in Quality and Safety and Risk Management to better understand safety opportunities viewed by frontline staff. Residents/attendings currently report between 3% and 5% of all incident reports in RL Solution.

% Breakdown by Reporter Type of Events reported by month

UCD: % Total Events by Reporter Type
(excludes GET = Employee)

Procedure for Resident Use of IR Line:

1. Call the incident reporting line at 4-7050
2. Provide the following information, speaking slowly and clearly, in your recorded message. (This line will not be answered by a live person.):
   a. Patient name
   b. Medical record number
   c. Date and time of event
   d. Patient care concern (provide as much detail as possible)
   e. Reporter’s name
   f. Reporter’s department
   g. Reporter’s phone number/pager
3. Quality and Safety staff will check the phone line for messages at close of business during regular work days (ie, Monday through Friday minus University holidays). A Quality and Safety
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staff member will return the reporter’s call within two business days of retrieving the message to provide confirmation of receipt/follow-up.

Points to Emphasize:

1. It is still most ideal to use RL Solutions for incident reporting. The reporting line is to be used if the resident is too busy to make an entry or is away from a computing station where he/she can invoke RL Solutions.
2. This project will begin as a feasibility study and may be terminated if resident participation is low. Our goal is for resident reporting to increase by 50%.
3. This project is independent of morbidity and mortality (M&M) reviews; M&M reviews will occur per departmental standard operating procedures. It is possible that some cases will fit criteria for incident reporting and M&M reviews. Questions about this should be directed to the department Clinical Quality Improvement (CQI) chair.

Frequently Asked Questions:

1. Why are you requiring the resident to leave his/her name and contact details?

   Although anonymous reporting may be preferred by people who fear that their reports will be used for disciplinary purposes, anonymous reports yield less useful information, especially if we have questions about the patient’s name or MRN. Collecting the reporter’s name and contact details also allows us the opportunity to follow up with the reporter on the outcome of the case.

2. How will you track use of the line?

   We will transcribe all phone messages and enter them into an Access database. The point of the Access database is to create written record of the voice messages and to track the volume of reports generated by the “pilot”. For example, near misses are an important category to track because they tend to become future patient safety events. For the hospital, near misses account for about 10% of all incident reports.

3. Why are we providing the resident follow-up on the report? To my knowledge, we do not give that option to individuals who are reporting directly into the RL Solutions system.

   This is a best practice that’s been adopted by hospitals trying to increase resident participation in incident reporting. (I actually have a Q/S nurse track all attending/resident reports submitted in RL Solutions for feedback as part of her workflow.) The feeling is that if residents/attendings see us taking their concerns seriously, it reinforces the benefits of reporting and thereby encourages future reporting.