Best Evidence Statement (BESt)

Date: March 11, 2013

Title: A formal follow-up process in the safety reporting system

Clinical Question:

P	*(Population/Problem)*	Among nurses in the hospital setting
I	*(Intervention)*	does the use of a formal follow-up process*for safety reporting
C	*(Comparison)*	versus no follow-up process
O	*(Outcome)*	improve nurses' knowledge* and awareness* of the outcomes, resolution and best practices for the safety issues reported?

***Definitions** for terms marked with * may be found in the Supporting Information section.*

Target Population for the Recommendation:
All nurses in the hospital setting

Recommendation:

It is strongly recommended that a formal follow-up process be used to improve nurses' knowledge and awareness of the outcomes, resolution and best practices for safety issues reported (Benn, Koutantji, Wallace, Spurgeon, Rejman, Healey,Vincent 2009[2a]; Wallace, Spurgeon, Benn, Koutantji, & Vincent 2009 [2a]; Gandhi, Graydon-Baker, Neppl, Whittemore, & Gustafson, 2005 [5b]).

> **Note:** This follow-up process could take the form of any one or more of the following: replying reliably to the reporter within a reasonable timeframe, replying immediately to the reporter, using the event to raise awareness through formal staff communication channels regarding the event and/or action taken (Benn, et al., 2009, [2a]; Wallace,et al., 2009 [2a]; and Gandhi, et al., 2005, [5b]).

Discussion/Synthesis of Evidence related to the recommendation:

Many studies demonstrated that the follow-up process is one of the main concepts necessary to "close the loop" in safety reporting systems (Benn, et al., 2009, [2a]; Wallace,et al., 2009 [2a]; and Gandhi, et al., 2005, [5b]). Gandhi (2005 [5b]) discovered it is the feedback to the reporter that perpetuates the influx of information and closes the loop. Without feedback, the reporter sees little value in reporting.

Benn, et al., (2009 [2a]), showed that formal safety feedback fulfills a number of functions and may be divided into several different modes: Mode A: Bounce back - getting a reply back; Mode B: Rapid response - immediate response to solve a problem; Mode C: Raise risk awareness - inform staff of events; Mode D: Inform staff of action taken - make actions known to staff; Mode E: Improve work systems safety - make changes to the system where needed. In a mixed methods study, three modes of formal safety feedback were found to be used most often (Benn, et al., 2009 [2a]). Seventy percent of 23 systems reported incorporating rapid feedback (Mode B) capabilities for implementing an immediate or provisional response to a reported incident into their reporting system (Benn, et al. (2009 [2a]). Additionally, Benn, et al. (2009 [2a]) found 90% of reporting systems employed newsletters and generic safety awareness publications to disseminate information to front-line personal regarding operational risk (Mode C). The same authors found that of 23 systems reviewed, 39% reported back specific information concerning incident outcomes and progress on the safety issue directly to the original reporter (Mode D) (Benn, et al., 2009 [2a]).

Several authors found a positive learning culture including feedback from staff, staff involvement (actual writing of safety reports), and managers' dissemination of information increases staff knowledge of safety concerns (Benn, et al. 2009 [2a]; Wallace, et al (2009) [2a]; Gandhi, et al (2005) [5b]). Gray and Williams (2011 [4b]) demonstrated that in order for a person to have a positive learning experience, an adverse event must occur. The adverse event will provide positive information that can be learned through reframing a negative event (e.g. highlighting the positive aspects of a negative experience).

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Reference List:

Awareness. (2013). In Merriam-Webster's online dictionary. Retrieved from http://merriam-webster.com/dictionary/awareness

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Gandhi, T., Graydon-Baker, E., Neppl, C., Whittemore, A., and Gustafson, M. (2005). Closing the loop: Follow-up and feedback in the patient safety program. *Joint Commission Journal on Quality and Patient Safety*, *31*(11), 614-621. [5b]

Gray, D., Williams, S. (2011). From blaming to learning: Re-framing organizational learning from adverse incidents. *The Learning Organization*, *18*(6), 438-453. [4b]

Knowledge. (2013). In Merriam-Webster's online dictionary. Retrieved from http://merriam-webster.com/dictionary/knowledge

Wallace, L. Spurgeon, P., Benn, J., Koutantji, M., and Vincent, C. (2009). Improving patient safety incident reporting systems by focusing upon feedback- lessons from English and Welsh trusts. *Health Services Management Research*, *22,* 129-135. [2a]

IMPLEMENTATION

Applicability Issues:

Tools for Implementation

- Create a process for feedback within the current safety reporting system

Potential facilitators and barriers

- Time: staff not having enough time to write a report within the allotted time
- Knowledge: not knowing when a safety report needs to be written; for example, a report about "near misses or small issues"
- Fear of recrimination: staff not wanting to report/write incidents due to the possibility of "getting into trouble" with managers and other staff members

Potential resource implications

- Safety Reporting databases: to track and trend safety reports
- Personnel: to collect and report the data

Other challenges to implementing the recommendation

- Confidentiality Issues: All safety reports are confidential. Suggest collaboration with the organization's legal department to allow these reports to be viewed by managers and then tracked and trended for appropriate follow-up

Relevant CCHMC Tools for Implementation:

To find out more about relevant CCHMC safety methodology follow this link:
http://www.cincinnatichildrens.org/service/j/anderson-center/safety/default/

The current Safety Reporting system is available to employees through CenterLink
http://mcriskmgmt/rmweb3/riskweb3.dll/FrmLogin

Outcome or Process Measure:

Disseminate tracked and trended safety reports: to increase nurses' awareness and knowledge of the current safety issues and decrease the number of reports being written regarding the same safety issues.

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Supporting Information

Background/Purpose of BESt Development:

Staff has raised concerns when they have not received timely information about the resolution of safety reports they have written. Inconsistencies were noted by nurses regarding the follow-up process for safety reports between different units; including the resolutions and best practices about the reports written.

Definitions:

Formal follow-up process: the element of the safety reporting system that provides feedback to the original reporter of the safety event

Knowledge: the fact or condition of knowing something with familiarity gained through experience or association. Merriam-Webster

Awareness: having or showing realization, perception, or knowledge. Merriam-Webster

Search Strategy:

Databases: PubMed: Medline, ERIC, Scopus, and Google Scholar
Search Terms: Safety reports, incident report, standardized process, knowledge, process, risk management, closing loop, incident reporting hospitals, knowledge and process, feedback, evaluations, incident reporting and root analysis, incident reports and evaluation, health care reporting systems, incident reporting and feedback, standard process of incident reporting, evaluations
Filters: English Language, any date filters: articles published after 2000
Search Date: 8/30/12

Relevant CCHMC Evidence-Based Documents:

None were found

Group/Team Members*:*

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Conflicts of Interest were declared for each team member:

- ☒ No financial or intellectual conflicts of interest were found.
- ☒ No external funding was received for development of this BESt.
- ☐ The following conflicts of interest were disclosed:

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Note: Full tables of the LEGEND evidence evaluation system are available in separate documents:

- Table of Evidence Levels of Individual Studies by Domain, Study Design, & Quality *(abbreviated table below)*
- Grading a Body of Evidence to Answer a Clinical Question
- Judging the Strength of a Recommendation *(dimensions table below)*

Table of Evidence Levels *(see note above)*:

Quality level	*Definition*
1a† or 1b†	Systematic review, meta-analysis, or meta-synthesis of multiple studies
2a or 2b	Best study design for domain
3a or 3b	Fair study design for domain
4a or 4b	Weak study design for domain
5a or 5b	General review, expert opinion, case report, consensus report, or guideline
5	Local Consensus

†a = good quality study; b = lesser quality study

Table of Language and Definitions for Recommendation Strength *(see note above)*:

Language for Strength	*Definition*
It is strongly recommended that… It is strongly recommended that… not…	When the dimensions for judging the strength of the evidence are applied, there is high support that benefits clearly outweigh risks and burdens. *(or visa-versa for negative recommendations)*
It is recommended that… It is recommended that… not…	When the dimensions for judging the strength of the evidence are applied, there is moderate support that benefits are closely balanced with risks and burdens.
There is insufficient evidence and a lack of consensus to make a recommendation…	

Given the dimensions below and that more answers to the left of the scales indicate support for a stronger recommendation, the recommendation statement above reflects the strength of the recommendation as judged by the development group.
(Note that for negative recommendations, the left/right logic may be reversed for one or more dimensions.)

Rationale for judgment and selection of each dimension:

1. Grade of the Body of Evidence	☒ High	☐ Moderate	☐ Low
Rationale:			
2. Safety / Harm (Side Effects and Risks)	☒ Minimal	☐ Moderate	☐ Serious
Rationale: The nurse will acknowledge the safety issues which will minimize negative effects on patients' safety.			
3. Health benefit to patient	☐ Significant	☒ Moderate	☐ Minimal
Rationale: Patients would benefit from the written reports because the nurses would have the knowledge and awareness to mitigate or avoid the same safety issues.			
4. Burden on nurse to adhere to recommendation	☐ Low	☐ Unable to determine	☒ High
Rationale: The writing of safety reports is time consuming for nurses.			
5. Cost-effectiveness to healthcare system	☐ Cost-effective	☒ Inconclusive	☐ Not cost-effective
Rationale:			
6. Directness of the evidence for this target population	☒ Directly relates	☐ Some concern of directness	☐ Indirectly relates
Rationale:			
7. Impact on morbidity/mortality or quality of life	☐ High	☒ Medium	☐ Low
Rationale: The impact on morbidity/mortality or quality of life may depend on the safety issues involved, their resolution and the resulting best practices.			

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Copies of this Best Evidence Statement (BESt) and related tools (if applicable, e.g., screening tools, algorithms, etc.) are available online and may be distributed by any organization for the global purpose of improving child health outcomes.
Website address: http://www.cincinnatichildrens.org/service/j/anderson-center/evidence-based-care/bests/
Examples of approved uses of the BESt include the following:

- Copies may be provided to anyone involved in the organization's process for developing and implementing evidence based care;
- Hyperlinks to the CCHMC website may be placed on the organization's website;
- The BESt may be adopted or adapted for use within the organization, provided that CCHMC receives appropriate attribution on all written or electronic documents; and
- Copies may be provided to patients and the clinicians who manage their care.

Notification of CCHMC at **EBDMinfo@cchmc.org** for any BESt adopted, adapted, implemented, or hyperlinked by the organization is appreciated.

Please cite as: McCarron, C., Cincinnati Children's Hospital Medical Center: Best Evidence Statement A formal follow-up process in the safety reporting system, http://www.cincinnatichildrens.org/svc/alpha/h/health-policy/best.htm, BESt 158, pages 1-5, 3/11/13.

This Best Evidence Statement has been reviewed against quality criteria by two independent reviewers from the CCHMC Evidence Collaboration. Conflict of interest declaration forms are filed with the CCHMC EBDM group.

Once the BESt has been in place for five years, the development team reconvenes to explore the continued validity of the guideline. This phase can be initiated at any point that evidence indicates a critical change is needed. CCHMC EBDM staff performs a quarterly search for new evidence in an horizon scanning process. If new evidence arises related to this BESt, authors are contacted to evaluate and revise, if necessary.

For more information about CCHMC Best Evidence Statements and the development process, contact the Evidence Collaboration at EBDMinfo@cchmc.org.

Note

This Best Evidence Statement addresses only key points of care for the target population; it is not intended to be a comprehensive practice guideline. These recommendations result from review of literature and practices current at the time of their formulation. This Best Evidence Statement does not preclude using care modalities proven efficacious in studies published subsequent to the current revision of this document. This document is not intended to impose standards of care preventing selective variances from the recommendations to meet the specific and unique requirements of individual patients. Adherence to this Statement is voluntary. The clinician in light of the individual circumstances presented by the patient must make the ultimate judgment regarding the priority of any specific procedure.

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