The Establishment of an Electronic Opportunity Reporting System at King Fahad Medical City

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Variance or Opportunity!

Occurrence Variance Reporting systems are used by health care organizations to internally document unusual events which occur to the patient and may have a direct effect on patient safety

Are Patients Safe!!!

- Nearly 200’000 people die from potentially preventable medical errors each year in the US
- 70’000 hospital admissions are associated with adverse events in Canada

Why Report??

- To get accredited …

OR

- To improve patient safety?

Objective

To design and implement an Electronic Opportunity Reporting System, as part of a positive blame-free culture, that will contribute to improving patient safety in KFMC

Analyzing the Gap

- Paper system
- Ineffective
- Underutilized
- Non-systematic
- Blame assignment tool

Analyzing the requirements

- An open blame free culture
- A self learning organization
- A tool for hospital-wide collection of information on opportunities for improving patient and staff safety, and overall organizational effectiveness
- A systematic multidisciplinary way in dealing with reports

Designing the system

- Designing the content
- Developing the coding system
- Developing the algorithm

Implementing the system: Phase I

- Assigning and training representatives
- Training users
- Developing Policy and procedures
- Publishing the system on the Intranet

Implementing the system: Phase II

- Included administrative and financial departments
- Automation of patient and staff safety forms
- Automatic routing of reports based on already created codes and algorithms

Implementing the system: Phase III

- Automatic generation and follow up of opportunity reports

Training

Numbers of staff attending the educational classes	
Type of Class	Number of staff
ORS Class (All Employees)	
Medical Staff	133
Para Medical Staff	212
Nursing Staff	940
General Nursing Orientation Class	
January	47
April	51
June	66
July	102
August	102
September	133
October	26
December	60

Results

	Paper based	EORS			
	2005	2006	% change from 2005	2007	% change from 2006
Jan		18	NA	56	300%
Feb		36	NA	83	230%
Mar		45	NA	88	200%
Apr		58	NA	175	300%
May		67	NA	150	220%
Jun		74	NA	86	120%
Jul	6	82	1300%	80	98%
Aug	15	45	300%	88	200%
Sep	10	48	480%	83	170%
Oct	32 (10)	39	120%	60	150%
Nov	14 (9)	73	520%	68	93%
Dec	8 (19)	72	900%	73	100%

Effects of the Change

- Both the number of reports and the timeliness of reports improved.
- Communication among directors and head of departments was enhanced.
- Change in the attitude of reporting of unwanted event was noticed by the number of potential reports that were received.
- Culture of reporting changed from fear of reporting to a culture of supporting quality improvement in terms of reporting unwanted events.

What does it take to establish a new system

- Lots of preparation and communication
- Lots of collaboration esp. IT
- Lots of organization and follow-up
- Lots of feedback and involvement
- Lots of respect and recognition

Thank You