Vidant Medical Center’s Multidimensional Approach to Safety Culture Increases Event Reporting

By Whitney Fishburn

By developing an event reporting process based on lessons learned rather than punitive responses, North Carolina’s Vidant Medical Center created a safety-driven culture that has resulted in a 50% increase in overall safety event reporting over the past four years and more than 500 safety catches reported per month at present. In the first year alone, physician-reported safety events increased 100%, with more than 70% of those physicians feeling confident enough to report events without hiding under cover of anonymity.

As a 909-bed tertiary academic medical center serving a population of nearly 1.4 million, VMC required a multidimensional approach to creating the desired safety-driven culture. The primary goal for VMC leadership was to increase all near-miss event reporting from historical levels of about 20% of overall reporting and, as a follow-on to this, to increase physician event reporting from a historical average of about 1.5% of overall event reporting. The secondary goal was to fulfill VMC’s duty as a teaching hospital to incorporate patient safety and event reporting into its graduate medical education program.

Safety Catch Reporting Focused on Recognition

The journey to safety excellence and High Reliability began with reversing the underutilization of VMC’s existing safety catch reporting system, which in 2017 averaged only eight safety catch reports per month. Further, there was a lack of awareness, accessibility, and recognition of reported safety catches.

The most prevalent perceived barriers to safety event reporting at VMC were the lack of feedback after an event was reported and the fear of a punitive response—a fear that was often amplified by the lack of feedback, according to the system’s internal safety culture survey data.

“Instead of focusing our feedback on errors that occurred, we wanted to give feedback and recognition when team members prevented harm,” Cavaliere said. “We determined that by increasing our near-miss and safety catch reporting we could shift the focus to a positive, celebratory light and emphasize learning and prevention.”

Although a safety catch reporting tool already existed, it was difficult to find in VMC’s intranet and was not tied to the event reporting system, Cavaliere said. “We had the right tools, but they weren’t connected, so we decided to put everything in one place,” she explained.

The new system went live in January 2018, and it quickly began averaging more than 200 safety catch reports per month. Linking safety habits and error prevention tools to event reporting enabled team members to easily connect the use of safety habits to the prevention of harm. To further encourage safety catch reporting, VMC now selects one safety catch per week to celebrate throughout the hospital.

In addition, during the monthly department managers’ meeting, a member of the VMC executive leadership team presents a trophy to the department with the most safety catches for that month. “It’s gotten pretty competitive,” said Lauren Webb, RN, a Vidant Health quality nurse specialist for patient safety. “Everyone wants to be recognized for their efforts and contributions to our safety culture.” These efforts are also recognized through an employee appreciation portal.
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that sends a personalized email to each team member who was recognized for a safety catch. Additionally, a monthly email to all VMC managers lists each department with team members being recognized for safety catches.

Within a year, average monthly safety catch reporting exceeded 300 events, said Cavaliere. “The numbers are phenomenal. They speak to how we made the reporting system easier to access and how we emphasize to team members that reporting is about doing the right thing in order to help co-workers, not get them in trouble.”

Standardizing Event Review Identifies System Opportunities

Standardizing how all safety events are classified and reported across departments and then making the response to the event more transparent also helps department managers offer positive, detailed feedback that focuses on what can be learned and dispels fears of punitive action.

Every reported event is now reviewed by the department manager, who also documents lessons learned, factors that contributed to the event, and corrective actions to prevent recurrence. This review is completed within five days of the initial report. “We recognized the value of the department managers’ feedback to ensure the success of our safety culture initiative,” Webb said.

“We have also standardized our department huddles to include discussions about events reported, and to recognize their safety catches to reinforce and enhance safety,” Cavaliere added.

Proposed next steps for VMC’s event reporting system include asking what safety habits could be implemented as a barrier to prevent similar events in the future. “This way, thinking about safety becomes second nature,” Cavaliere said.

To proactively identify systemwide opportunities for improvement, a multidisciplinary management team now meets weekly to review events and look for trends in near-miss and no-harm incidents. According to Cavaliere, more than 60 such opportunities have been identified to date and several systemwide improvements have been implemented. Additionally, there is now a quarterly newsletter for managers and leadership that highlights lessons learned and action items from event analyses, trends in event reporting, and upcoming educational events.

Peer-to-Peer Feedback Improves Rate of Physician-Reported Events

Initially, resident physicians were skeptical of the value of event reporting and were hesitant to report events for fear of jeopardizing relationships with their superiors or nursing staff, said Webb. To decrease their skepticism and meet the goal of training new physicians in safety culture methods while increasing overall physician event reporting, two unit medical directors were identified as part of a pilot program to provide feedback to residents when they reported an event for their assigned units.

“We have found that peer-to-peer and discipline-to-discipline feedback goes further with physicians,” Cavaliere said, noting that the pilot program was immediately successful and has since been rolled out hospital-wide. “We meet monthly with our medical directors to discuss what does and doesn’t work,” she said. In one year, there has been a sustained 100% increase in physician-reported safety events, more than 70% of which are filed directly under the physician’s name. “This has been critical to forming a nonpunitive response to error and event reporting, promoting a system of learning, and ultimately encouraging physicians to feel confident about reporting events.”

The VMC safety culture is further reinforced during managers’ bimonthly training sessions on safety culture and event reporting. Safety camps focused on High Reliability principles and safety habits are offered to front-line team members and managers. Training in the principles of High Reliability Organizing is also provided for all top-level leadership. Since this multidimensional action, training, and recognition program was launched, overall safety event reporting at VMC has increased by more than half. In one year, near-miss reporting was up by 6%.

“If it weren’t for the buy-in and support of our board and executive leaders, and for their commitment to High Reliability, none of this would work,” Cavaliere said.