2018 NCSBN Scientific Symposium - Practice: Patient Safety Culture and Barriers to Adverse Event Reporting: A National Survey of Nurse Executives Video Transcript

of when and [[00:02:00]] where it's appropriate to report as a nurse, how are they doing that and, you know, what possibly could be driving that.

So, the survey instrument itself was designed by NCSBN research staff. It was based on the key findings from the day of dialogue, so those really informed the content. We then did decide, however, to pilot it with six nurse executives because really what we wanted to make sure is that we were still catching the

sure that we can kind of sass out what we really thought the intent of the underlying response was so, in the end, we had one code for each response.

For the fixed item responses, we employed univariable, multivariable, ordinal, logistic regression, and we did this to really focus in on one of the questions that we had asked. So, it was, what do you do?

So, we still have all the, you know, the fun statistics over here. So, this is the actual, you know, that the odds ratio here, the confidence interval, and the P value, so you get the same thing that you would get out of a table. But what this visualization allows you to do is to stay anchored [[00:13:00]] in what the scale of an odds ratio is. So, an odds ratio is measured on a scale of zero to infinity with anything from zero to one indicating lower odds of the event occurring and anything greater than one to infinity indicating increased odds of the event occurring. When the confidence interval overlaps one or includes an odds ratio of one, that's where you're going to get a P value greater than 0.05. So, that's when it's basically saying it's no greater than chance, the association between the risk factor in the outcome.

So, what you're able to [[00:13:30]] see here, for instance, is we tested many, many variables. So, all those things that we were talking about earlier, facility characteristics, executive characteristics, we tested all those variables, ultimately, many of those P values greater than 0.2. So, to keep this efficient for the purposes of reporting, we just broke this down to those variables on a kind of a unit variable scale. So, just looking at the independent risk factor, what was either significant or marginally

Now, when we get into the barriers, you'll see that there are four listed here. This is where it was a little less heartening. So, there are four barriers that were ultimately significant obstacles to external reporting in these types of situations. [[00:16:30]] We only asked five, so four of the five, 80% essentially emerged the significant barriers. The other one wasn't surprising that it kind of fell by the wayside. It was positioned at the facility. So, as I said, we kind of hit our target demographic. Three-quarters said that they were the person who was delegated authority at their institution to make this decision, so ultimately, position was not an obstacle for this respondent sample. However, what to report emerged. So, just simply nuts and bolts, what constitutes [[00:17:00]] reportable issue ultimately led to a 70% decline in external reporting. Similarly, how to make a report resulted in a 61% decline. Concerns regarding legal ramifications was about 50%.

And then facility culture, this was really the big one. This was 74%. And the reason why I say it was really the big one is one of the things that we hypothesized about these barriers is that there would be a fair degree of overlap among them and that there might be some kind of interactions that are taking place, [[00:17:30]] you know, if you don't know what to report, chances are you might also have some gaps on how to report. So, what we wanted to do is we wanted to do a multivariable analysis and we had sufficient sample size to look at other variables too. But what we did is we converged on essentially a multivariable model that only included the barriers in the end and we found is that essentially, what to report in facility culture where the real to that kind of remained in the model. So, how to make a report and concerns regarding possible legal ramifications [[00:18:00]] once you kind of clear the playing field a little bit. It was really about what constituted something. So, essentially, kind of 50% of this is low hanging fruit. It's something where essentially, we might get back into that area where outreach communication education could really be beneficial for that part. And then facility culture, which is obviously, in particular, for kind of the regulatory side, the much heavier left. And I will say, just to give you a little bit more insight into that, we did ask what it was about facility culture and most of the times, in [[00:18:30]] some instances, people would actually report that they treated all adverse events as non-reportable at some facilities, which was a little bit concerning to say the least.

But so, what were the key takeaways? This was actually one of the most interesting analyses I've ever been part of. And I'm not sayi
we always do in this type of analysis is we just do a descriptive summary of what's going on in the analysis. And the first thing we saw was that three and four respondents said they had a guideline and pretty much the [[00:19:00]] same proportion among that subset said that they were somewhat or extremely satisfied. And so we basically thought, "Okay, there's nothing here. You know, we're not going to be able to assess anything out." However, on another item, basically, 9 and 10 indicated that they wanted additional guidance. They thought that that would be very or extremely helpful. And so, when we asked them to kind of organically identify for us what they thought would be most beneficial, they ultimately settled on an official policy or decision tree, additional communication, additional information on the website, etc. etc. So [[00:19:30]] they really were looking for that outreach. They really were looking for that guidance. And so, kind of, you can kind of see the arc of the project came right back to where it began with AONE members. They really did want that additional guidance. So, that does conclude the part of the presentation. But I did want to show you, this is essentially where we are kind of moving with NCSBN, so a little bit of a sneak peek. We're going to be doing a research study

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