Crowdsourcing knowledge
Learning from the Patient Safety Event Reporting Tool

We all have a wealth of experiences that guide our individual medical wisdom and decision-making process. How much more could our collective wisdom help us all troubleshoot and improve processes in our individual practice environments? There is much to be learned from our combined experiences.

In 2014, the American Academy of Otolaryngology—Head and Neck Surgery (AAO-HNS) launched a web-based Patient Safety Event Reporting Tool (PSERT), accessible through the Academy’s website www.entnet.org with member login. This reporting tool was modeled partly after a similar system used by the Federal Aviation Administration and was intended for use both as a resource for Academy members to learn from others’ experiences and as a tool to identify developing trends. Digital safeguards have been designed in the database to ensure anonymity.

The AAO-HNS Patient Safety and Quality Improvement (PSQI) Committee helped develop and test the platform prior to launch. The first report of the project published by Vila et al in 2017, reviewed 53 events collected from its inception January 7, 2014, to October 7, 2015. The authors reported that most entries resulted in harm to the patient, and the most common events were technical errors.

A more recent review of the database performed by the PSQI Committee evaluated cases through December 2016. There was a cumulative total of 88 separate reports entered into the portal. Like the previous progress report, most cases resulted in harm to the patient, and most occurred in the operating room or in the hospital. One-third of entered cases involved an additional procedure for the patient and 11 percent involved the death of the patient. Interestingly, almost 60 percent involved what could be classified as a known sequela of a procedure. Fourteen entries reported system or process errors, and 14 included defensive language or placed blame on another individual or a piece of equipment.

Subspecialty breakdown of reported cases reveals that most cases involved head and neck surgery (25), followed by neurootology (11), and laryngology (11). This is, of course, not an indicator for frequency of events in our subspecialties.

“Big data” collection initiatives such as Reg-ent™, the American College of Surgeons National Surgical Quality Improvement Program, and Medicare/insurance claims data are systematic and broad in their collection of data. However, these databases are unable to capture situational detail, system/process issues, and communication factors that inform our understanding of safety events. In contrast, PSERT intentionally queries physicians for these details, without which root cause analysis is difficult.

Qualitative rather than quantitative analysis is the objective. The intent is neither
to statistically measure the incidence of nor
derive the statistical significance of otolar-
yngic complications. Rather, the tool allows
members to share knowledge and learn from
each others' events. While the reporting of any
patient safety issue is welcome, we especially
courage sharing events that highlight:

• Medical/surgical technique problems
• System/process issues
• Knowledge gaps
• Issues requiring further attention by
AAO-HNS leadership

The fruits of this project require voluntary
contributions by physicians from all practice
types: academic and private, solo and group,
rural and urban, and civilian and military.
Practices big and small review patient safety
issues in a variety of ways. Hospital-based and
academic-based practices have traditionally
held “Morbidity and Mortality” conferences.
Many smaller practices hold safety and quality
reviews routinely during business meetings.

To facilitate data collection and reporting
of events, physicians can download and print
out a hard copy of the PSERT questionnaire
located on the PSERT landing page. Having the
printed form is helpful to structure discussion
during safety and quality conferences and/or to
ensure that proper richness of detail is collected
regarding each event discussed. Use of the
form can be customized to the needs of each
organization. For example, physicians could
utilize the form to submit events for discus-

Alternatively, the form could be used as a
structured way to take minutes. Either way, data
collected on the form can later be transferred to
the online database.

The PSQI Committee will periodically
review PSERT data and report to the AAO-
HNS membership through both summative
articles and case-specific articles written in
the Bulletin to highlight areas of interest and
need. Information will also be shared with the
Education Committees to provide feedback for
physician-reported knowledge gaps so
that educational offerings can be created to
address deficiencies.

One recent interesting case from PSERT
featured a pediatric tracheostomy tube that was
inserted upside down in surgery. The Bivona®
brand tube is flexible throughout its cannula
shaft. Prior to insertion of the trach, a rigid
obturator with a blunt-tipped end is inserted in
the flexible trach shaft to provide some rigidity
during placement. In this instance, the obturator
was inserted into the trach upside down (rotated
180 degrees). As the pediatric Bivona trach
shaft is flexible, the tube conformed to the
curve of the misinserted obturator. The trach
was inserted into the patient (upside down). The
mal-intubation was discovered post-operatively
after ventilation difficulties were encountered.
The tube was removed, rotated 180 degrees,
and reinserted with good ventilation ability.
This case provided feedback and education to
the operating room staff, was applicable to all
facets of the procedure, and identified areas for
study and improvement.

The PSERT has proven an effective tool for
the Academy membership to report adverse
events. Your continued participation and
contributions will help strengthen its utility as
we all work together toward the common goal
of improving patient safety. We need YOU to
contribute and share with us your experiences.
For more information, please contact us at
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References
  Safety Event Reporting Tool in Otolaryngology. Otolaryngol