RLDatix

Safety & Risk Management Case Study

3,290 hours saved: What happens when safety reporting actually works

How Allegheny Health Network streamlined event reporting to save 3,290 clinical hours and dramatically improve patient outcomes over two years

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Results at a glance

3,290

hours saved annually

Equivalent to 1.6 FTEs redirected to patient care in 2024

32%

increase in safety reporting

From 30,069 (2022) to 39,627 (2024), demonstrating stronger reporting culture and earlier hazard identification

The challenge: Unlocking the potential of safety reporting

Allegheny Health Network (AHN) had the commitment and the technology—but their safety reporting system wasn't delivering results that matched their investment. A 2022 comprehensive assessment revealed the problem: clinicians were spending 8-12 minutes per report navigating inconsistent workflows, training quality varied dramatically across facilities and specialty-specific events required generic forms that missed critical details. The administrative burden meant staff were choosing between thorough documentation and timely patient care. They were choosing patients—but unreported near-misses were slipping through undetected.

The cost was measurable. Research shows adverse events can extend hospital stays by up to 24 days—at AHN's scale of 120,000+ annual admissions and 340,000+ emergency visits, even a small percentage of preventable complications represented significant patient harm and millions in avoidable costs. Leadership recognized that their existing approach was leaving both clinical hours and patient safety on the table. The question wasn't whether to change, but how comprehensively to rebuild the system to unlock its potential.

The strategy: Respect time, build trust, remove friction

Over 18 months beginning in early 2023, AHN implemented coordinated improvements to their safety event reporting system that combined technology optimization with deliberate change management. Each change was designed around a core principle: every minute saved in safety reporting is a minute returned to patient care. Success required both technical solutions—streamlined reporting workflows, specialty-specific forms, single-click harm scoring—and cultural shifts to ensure frontline adoption.

Process redesign:

Standardized network-wide training with clear standard operating procedures (SOPs), enhanced specialty-specific reporting forms for high-frequency events (IV catheters, workplace violence, employee health), and introduced single-click harm scoring that eliminated redundant evaluation steps.

Technology optimization:

Collaborated with RLDatix to streamline workflows, protect employee privacy on sensitive reports and build intuitive interfaces that respected clinical time constraints rather than fighting against them.

Cultural transformation:

Embedded Just Culture principles directly into manager evaluations, established rapid feedback loops showing how reports drove improvements, and systematically eliminated fear of punishment. The message shifted from "report to comply" to "report to learn and protect."

Leadership accountability:

Executive sponsors maintained visibility throughout implementation, involved frontline users in solution design, and built sustainability mechanisms to ensure the culture shift would outlast the project phase.

Every minute saved in reporting is a minute returned to patient care.

The results: Efficiency gains that supported better outcomes

The improvements delivered impact across every level of the organization:

Faster, more frequent reporting:

Time-to-file decreased significantly as streamlined processes removed administrative friction. The dual impact: staff filed 32% more safety reports—from 30,069 in 2022 to 39,627 in 2024—while saving 3,290 hours annually. How? Each individual report took less time, freeing staff to file more reports when they identified safety concerns. This increase represents stronger reporting culture and utilization, not more harm events, enabling earlier pattern recognition across the health system.

For clinicians:

Staff reported higher satisfaction with the reporting system in post-implementation surveys, noting that the simplified workflows made it easier to flag safety concerns. The 1.6 FTE equivalent in saved time represented resources redirected from administrative tasks to direct patient care and clinical judgement.

For patients:

Over the same two-year period, length of stay showed improvement as the team could identify and address potential adverse events more proactively. Earlier hazard identification meant safety concerns were flagged and acted on before they could escalate.

For the health system:

Greater reporting transparency enabled proactive hazard identification. Safety trends that previously remained invisible became actionable intelligence, allowing leadership to address systemic issues before they escalated to patient harm.

Why it worked: The virtuous cycle of streamlined reporting

The connection between streamlined processes with improved outcomes and clinical outcomes follows a clear logic: when reporting becomes easier, clinicians participate more consistently. More reports filed in less time means earlier pattern recognition. Earlier pattern recognition enables faster intervention before hazards escalate to harm. Time saved on administrative tasks means more capacity for the clinical judgement that prevents adverse events in the first place.

AHN made reporting more efficient and strategically valuable. Each saved minute compounds into better outcomes. Each filed report strengthens the safety culture. The 3,290 hours saved annually represent the cumulative effect of thousands of small friction points eliminated, freeing clinicians to do what they do best: protect patients.

The strategic imperative: Why this matters now

The margin for error in healthcare leadership has vanished. Severe staffing shortages mean every clinical hour wasted on administrative tasks is a minute stolen from patient care. Burnout threatens retention and patient safety. Regulatory requirements demand robust safety systems. Financial pressures require a demonstrable return on investment for quality initiatives.

AHN's experience demonstrates that investments in safety culture infrastructure address all these imperatives simultaneously. By implementing streamlined reporting processes, standardized training and technology optimization, they created conditions that supported staff wellbeing. By enabling earlier hazard identification through increased reporting, they contributed to improved patient outcomes and strengthened quality metrics. By saving 3,290 reporting hours annually, they demonstrated clear operational efficiency. Most importantly, the correlation between enhanced safety culture and the 59% mortality reduction during this period validates healthcare's fundamental mission: creating systems that protect the patients in their care.