Case Study: Incident Reporting

Introduction

Incident reporting is often one of the first steps undertaken when an organisation seeks to improve patient safety. Incident reporting involves healthcare staff recording information on events or circumstances which have potentially, or did lead to harm to patients. Reporting of a serious incident should trigger an in-depth investigation to identify underlying systems failures. The process of incident reporting cannot directly improve the safety of patients; a constructive response to incidents is critical. At a minimum, this entails feedback of findings to reporters and undertaking local actions. Ideally, for incidents with a serious or potential serious outcome, it also includes recommendations for changes in processes and redesign of systems to prevent recurrence. This case study concentrates on “voluntary” and “non-punitive” incident reporting for learning, whilst acknowledging the requirement for systems run by external regulatory agencies to monitor performance and to ensure public accountability.

The process of planning and implementing an incident reporting system should be undertaken in the context of an institutional-wide or department-wide patient safety or quality strategy. The strategy should include:

- Aims and objectives (what you what to achieve);
- Rationale for choosing the strategy (why you are going to do it);
- Outline its components or activities (what you are going to do);
- Timelines (when you are doing to it); and
- Cost and resources that will be required.

The key purpose and strength of incident reporting is to alert organisations of problems, to describe, characterise, and to act upon them. Conversely, incident reporting systems should not be used to “count” the number of incidents and infer a rate of harm as they are likely to be under-reported.

Barriers

One of the most important barriers to reporters is lack of meaningful feedback on actions and responses to incidents. Other barriers include fear of reprisal, concerns over litigation, concerns over anonymity, confusion over what constitutes an adverse event or incident, and demonstrating that the system is having an impact. During planning and implementation, measures to design these barriers out should be considered.

Considerations when implementing incident reporting

When designing incident reporting to maximise learning and reduce patient harm, some important factors are leadership support, organisational readiness, methods for collecting and managing incidents, what information to collect and classify, confidentiality, prioritisation and how to respond.

Leadership support is crucial for the success of an incident reporting and response program – and all safety initiatives. Clinical and managerial leaders must demonstrate their desire to use the system, to make it safe to report, and to lead on responses and actions. Public formal and informal gestures of support from leaders are necessary for staff to feel that is safe to report. Leaders must be willing to lead by example and put their hands up if they are involved in an incident.
Organisation readiness is strongly associated with patient safety culture (ie is the organisation ready to support a system that will potentially expose weaknesses in patient care?) but has a broader context and may include technological elements such as IT systems readiness (if implementing an electronic system, are there sufficient computer terminals to access the system? Is there sufficient administrative and IT personnel to support the program?).

Methods for submitting and managing incidents vary according to local infrastructure and technology and can include email, internet, fax, paper, and phone calls. Current electronic systems are ideal as they are capable of web-based reporting and management, sending automatic notifications to individuals, operating work-flows to manage investigations, and running sophisticated analytics and reports.

The information that you wish to collect determines the structure and type of data collection elements. A combination of coded data and narrative information is optimal. Narrative information is crucial as much of what promotes learning in patient safety is the rich context and storyline that allow the conditions that contributed to the error to be explored and understood. However, open-ended narrative requires significant resources to meaningfully analyse and interpret the information. The three most important questions for incident reporters to answer are:

- What happened?
- What contributed to the incident occurring?
- How could the incident have been prevented?

The use of a classification structure to standardise the collection of information across time, institutions and specialty allows comparisons to be developed, and for similar incidents to be characterised and for solutions to be developed. Classifying incidents into meaningful categories is the first step for analysis and developing strategies to reduce the risk to other patients. The World Health Organisation (WHO) has developed a conceptual framework called the International Patient Safety Classification (ICPS) that describes ten domains that can fully describe an incident. Ideally incidents should be analysed by experts familiar with the clinical circumstances under which incidents occur and who have training in systems factors.

Patient and reporter confidentiality should be designed such that identifying information is only used solely to internally manage an incident. This may include a process for de-identifying reports upon their receipt or after an investigation has occurred. Confidentiality protection against unauthorized access should be implemented with a data security system and clearly this is easier with a secure electronic system.

The purpose of prioritisation is to ensure that actions taken in response to incidents are proportionate. The Severity Assessment Code (SAC) is a matrix that applies a numerical rating taking into account both the consequences of the incident and its likelihood of recurrence. The SAC score can indicate the appropriate level of investigation, such as a root cause analysis for a severe and relatively common incident, and the need for additional information to be gathered.

Responses to incidents can include providing regular feedback to reporters and local areas on individual incidents, common incident type trends and implementation status of recommendations. Thematic reviews undertaken on cluster of incidents can inform quality improvement efforts at an organisational-wide level, or even across multiple organisations.
Questions

1. How would you determine what are the key barriers to incident reporting in your organisation? (150 words)

2. What is the level of leadership support for incident reporting and other safety initiatives in your organisation? Does this need improving and how will you know that it has improved? (150 words)

3. What are the processes for responding to incidents in your organisation at ward, department and organisation levels? How effective are they? (150 words)