Using Incident Data to Improve Safety

North British Patient Safety Symposium

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Background

- Reporting of incidents and near misses seen as crucial means of improving patient safety
- Literature emphasises
  - design of incident reporting systems
  - reporting rates, classification of incidents, no blame culture (eg. Schectman et al. 2006).
- Little research on how incident data can be used to address weaknesses in processes and make care safer

Aims

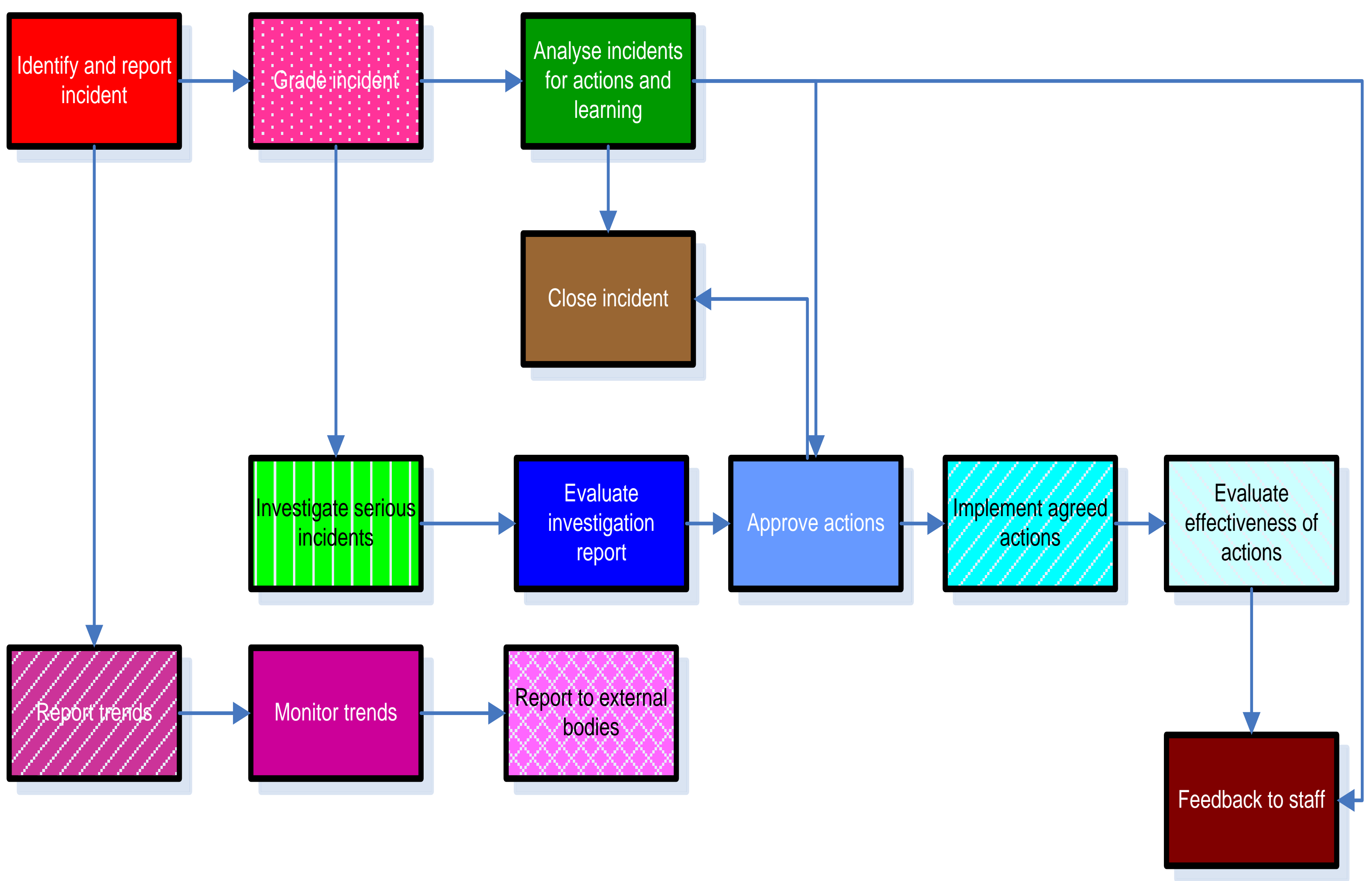
1. Using a multi level system approach, identify how incident data are used at an acute hospital
   - What learning occurs at the organisational level, at the team level and at the individual level?
   - Have system improvements been implemented?
   - How is the effectiveness of interventions measured?

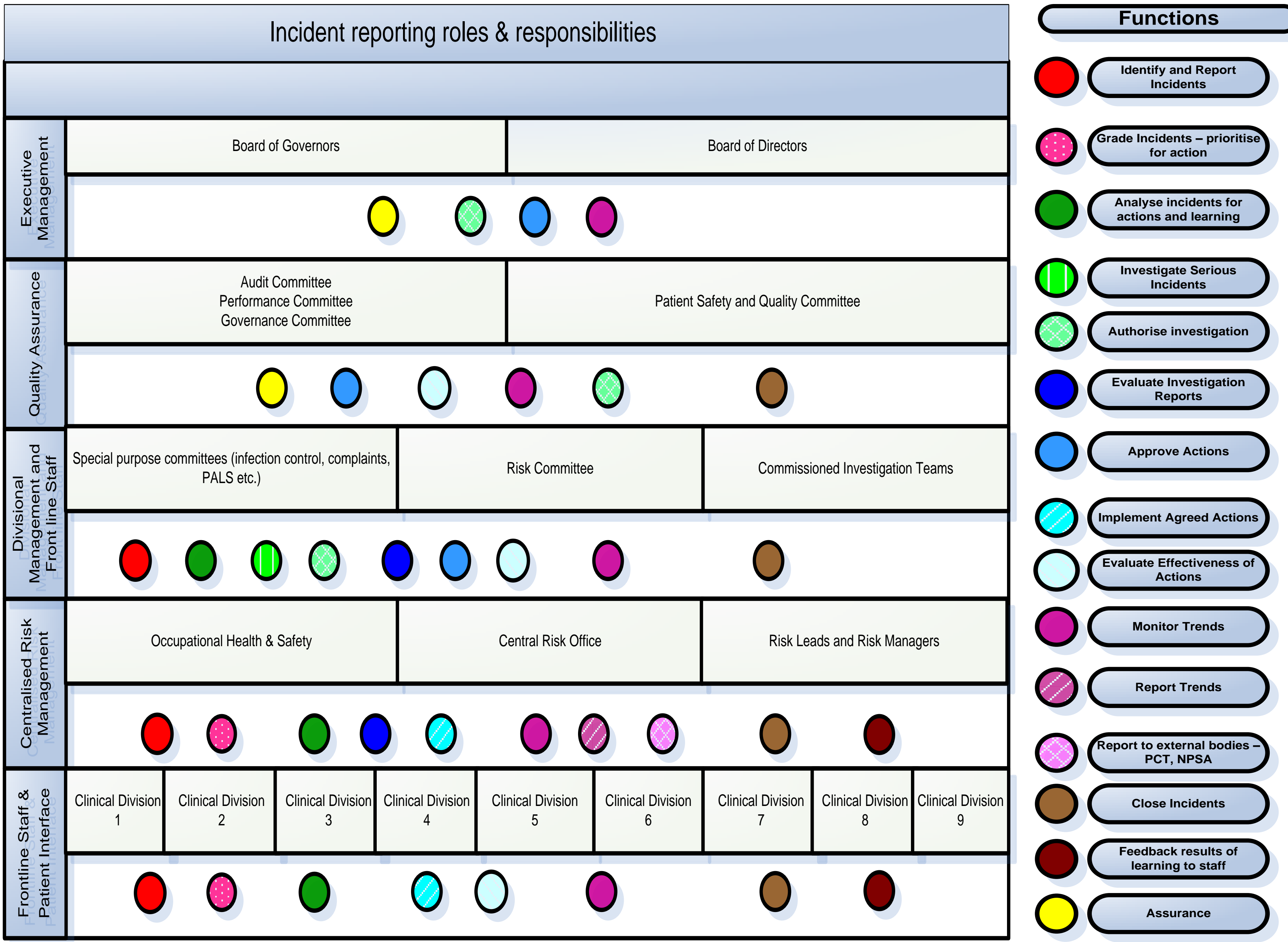
2. Identify how learning from incident data can be improved

Study design

- First phase – Scoping of how the incident reporting system operates, organisational structures and processes – interviews and policy documents
- Second phase – What is documented about learning from incident data - review of risk meeting minutes
- Third phase – How does it work in practice? Observation of risk meetings and interviews with staff

Flow chart of incident reporting





Incident reporting roles & responsibilities
Executive Management
Board of Governors
Board of Directors
Quality Assurance
Audit Committee
Performance Committee
Governance Committee
Patient Safety and Quality Committee
Divisional Management and Front line Staff
Special purpose committees (infection control, complaints, PALS etc.)
Risk Committee
Commissioned Investigation Teams
Centralised Risk Management
Occupational Health & Safety
Central Risk Office
Risk Leads and Risk Managers
Frontline Staff & Patient Interface
Clinical Division 1
Clinical Division 2
Clinical Division 3
Clinical Division 4
Clinical Division 5
Clinical Division 6
Clinical Division 7
Clinical Division 8
Clinical Division 9
Functions
Identify and Report Incidents
Grade Incidents – prioritise for action
Analyse incidents for actions and learning
Investigate Serious Incidents
Authorise investigation
Evaluate Investigation Reports
Approve Actions
Implement Agreed Actions
Evaluate Effectiveness of Actions
Monitor Trends
Report Trends
Report to external bodies – PCT, NPSA
Close Incidents
Feedback results of learning to staff
Assurance

Analysis of meeting minutes

- Meetings
  - Trust-wide Risk Committee
  - 5 Divisional-level Committees
- Reviewed all minutes for June 2007-June 2008

Analysis of meeting minutes

- Minutes coded for
  - Is the incident identified with incident number?
  - Is detail about the incident provided?
  - Was there discussion of the causes and actions?
  - Is there a clear action documented?
  - Is the action assigned to someone?
  - Is there follow up of previous actions?

Results

- Risk Committee
  - High quality minutes
  - Discussion is detailed- includes possible causes and possible actions
  - Actions are assigned to named people and monitored
  - Documents and reports are attached to the minutes
  - Little discussion of cross divisional issues
  - Minutes for two months could not be located

Results

- Divisional meetings
  - Not all the minutes were traceable
  - Minutes are usually not detailed enough to allow understanding of discussion
  - Actions unclear and responsibility often not assigned
  - Incident numbers/date not recorded
  - Grading sometimes not known
  - Some high quality minutes – detailed, systematic, actions documented eg. maternity – specific standards and own incident reporting system

Conclusions

- Highly complex processes and structures
- Lack of clarity in roles and responsibilities
- A large amount of time and resources involved
- Effectiveness of learning from incident data unclear – lack of documentation

Next steps

- Observation of risk meetings
  - Style of the meeting
  - Style of leadership
  - Evidence of high quality discussion
    - Evidence of systems approach
    - Consideration of alternative explanations
    - Inviting participation and alternative views
  - Outcomes – clearly defined actions and responsibilities
- Interviews

For further information

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