Attitudes and barriers to incident reporting: a collaborative hospital study

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How do incidents happen?

• Human error is the major contributing factor in about 80% of incidents in hazardous environments

• Health care is a hazardous environment

• Need to recognise the difference between ACTIVE and LATENT failure

(Lawton & Parker, 2002)
Active and latent failures

Latent failure
- Made by managers/designers/accountants

Active failure
- Made by nurses/doctors

(Patton & Parker, 2002)
Active and latent failures

Active failure
- Consequences often immediate and visible
- PATIENT

Latent failure
- Very difficult to identify

(Lawton & Parker, 2002)
How do we address this?

- A non-punitive process to incident investigation
- Need to learn from our incidents!
- First step in the process have been recognised to be the REPORTING of incidents
- More than 90% of consumers believe that healthcare workers should report errors
- Quality and safety organisations believe that incident reporting facilitates better understanding of error and identification of the whole error process (latent and active failures)
Which incidents should be reported?

- All of them!
  - Adverse events
  - Near misses
  - Complaints

- Need to report as medical record review alone leads to many incidents being missed.

- For example: Near misses are rarely documented but occur more frequently than actual events = more learning possible at decreased cost to the patient!
BUT many incidents are not reported...

– Many incidents are not recognised as being incidents
– Others are simply not reported correctly

...Leads to incident reporting being less effective and less reliable.
THE IDENTIFIED NEED:
For incident reporting to become more reliable – Achieved by nurses and doctors providing a more accurate representation of incidents that occur.

OBJECTIVES OF THIS STUDY:
To investigate:
1. The awareness and use of current incident reporting system
2. The types of incidents that people reported and believed should be reported
3. The barriers to reporting
Methodology

• Cross sectional survey of doctors and nurses

• November 2001 – June 2003

• A modified anonymous questionnaires distributed/poster to rostered staff

• 72.8% response rate achieved
The setting

• Three principle referral hospitals (>300 acute beds)
• One major referral hospital (>200 acute beds)
• Two major rural base hospitals (>150 acute beds)
• ALL in South Australia
The sample

Those invited to participate were:

- Doctors and nurses (permanent and agency) working in:
  - One or more of the four ICUs
  - Four emergency units
  - Five surgical units
  - Seven medical units
Content of the questionnaire

• Asked if knew if hospital had a incident reporting system
  – If yes, which form? Location of form? What to do with completed form?

• Asked to estimate frequency of reporting a set of 11 commonly occurring incidents and how often they should be reported (never, <50% of occasions, >50%, always)
1. Patient injury due to a fall
2. Drug error requiring corrective treatment
3. Patient received wrong treatment or procedure
4. Equipment fault resulting in patient harm
5. Drug error not requiring corrective treatment
6. Patient did not receive necessary treatment
7. Breach in confidentiality
8. Hospital acquired infection
9. Post-operative DVT due to inadequate prophylaxis
10. Drug error made, not given to patient
11. Pressure sore
Content of the questionnaire

• Asked if knew if hospital had a incident reporting system
  – If yes, which form? Location of form? What to do with completed form?

• Asked to estimate frequency of reporting a set of 11 commonly occurring incidents and how often they should be reported (never, <50% of occasions, >50%, always)

• Asked to rate potential 19 potential barriers to not reporting (1= strongly agree, 5=strongly disagree)
List of potential barriers

1. Lack of feedback on resultant action is taken
2. The incident form takes too long to fill out - no time
3. Incident too trivial
4. Ward too busy so forget to fill in form
5. Unclear whose responsibility it is to write a report
6. No point in reporting a near miss
7. Form too complicated and requires too much detail
8. Junior staff often blamed unfairly for adverse incidents
9. Adverse incident reporting is unlikely to lead to system changes
10. Concern about who else reads the information given
11. Case discussed with person involved and so no need to write form
12. Not confident that the form is kept anonymous
13. Worried about litigation
14. Not my responsibility to report somebody else’s mistakes
15. Unsupportive co-workers
16. Not wanting to get into trouble
17. Will be tracked down even if the report isn’t written
18. Worried about disciplinary action
19. Don’t want the case discussed in meetings
Analysis of data

- Comparisons made for doctors and nurses by:
  - Profession
  - Level of qualification
  - Years post entry level spent in the acute health sector
  - Location (rural or city)
Results

- 799 nurses asked to participate
- 587 responded (73.5%)
- 482 from city hospitals and 105 from rural hospitals
  - CITY HOSPITALS: 41 clinical managers, 353 clinical nurses, 74 enrolled nurses, 14 agency nurses
  - RURAL HOSPITALS: 12 clinical managers, 68 clinical nurses, 25 enrolled nurses
Results: knowledge of the reporting system

- Know how to access a form
- Know what to do with it
- Have ever filled one out

- Senior nurses (nurse managers + clinical nurses) > junior nurses
- Permanently employed > Agency
- Nurses with greater than 5 years post entry experience > Less experience
Results: Nurse reporting practices

- Patient injury due a fall was the most frequently reported and pressure sores were the least frequently reported.

- Patient injury due to a fall was also the incident that people most frequently thought *should* be reported and near miss drug errors were the incident that people least frequently thought should be reported.

- Post-operative DVT was the incident that demonstrated the greatest difference between what nurses thought *should* be reported and those that actually were reported.
Results: Barriers to reporting

• Factors perceived to be barriers to reporting:
  – Lack of feedback on resultant action is taken (61.8%)
  – No point in reporting a near miss (49.0%)
  – Ward too busy so forget to fill in form (48.1%)

• Factors least perceived to be barriers to reporting:
  – Unclear whose responsibility it is to write a report (10.8%)
  – Case discussed with person involved and so no need to write form (11.5%)
  – Don’t want the case discussed in meetings (15.5%)
Discussion

- Incident rates estimated to 2.9% to 16.6% of acute care hospital admissions
- Nearly 100% of nurses knew that an incident reporting system existed
- BUT 12% of nurses did not know how to access a form and nearly 20% of nurses did not know what to do with it once completed.
- Approx. 11% had never completed a form.
- More nurses than doctors reported incidents, but agency nurses were less likely to report than permanent staff.
• Most cases reporting of incidents matched nurse opinion of whether incidents should be reported
• This was in keeping with the concept of active and latent failure

- Patient falls
- Medication error requiring treatment
  Immediate, witnessed ACTIVE incident → commonly reported

- Pressure sore
- Nosicomial infection
  Develop gradually, not attributable to a single event, LATENT incident → less commonly reported

- DVT
• Approx. 40% believed that near-miss medication error should be reported and approx. 17% actually reported that they always do Missing opportunities to learn from our mistakes at no harm to the patient.
• Factors most regarded as barriers to reporting were ORGANISATIONAL
  – Lack of feedback
  – Long forms
  – Ward too busy so forget
  – Form too complicated
Concerns raised by the study

• Why do doctors report less than nurses?
• Why particularly do senior doctors not appear to support incident reporting?
• Why are nosicomal incidents (DVT, infections, pressure sores) reported less frequently?
• Why are near-misses less frequently reported?
• What impact will the increased use of agency nurses have on the reliability of incident reporting?
Conclusion

• To increase the reliability of incident reporting in acute care hospitals, it is necessary to:
  ✓ Decrease the organisational barriers of reporting
  ✓ Increase the feedback disseminated to nurses and doctors
What are your thoughts?

• Are you all aware and competent at using the incident reporting system in-situ at your hospital?
  • How frequently do you report incidents?
• Who reports most of the incidents in your ward?
• Which incidents do you think we should report?
  • Which incidents do you actually report?
• What do you think are barriers to incident reporting here at your hospital?
Thank you!

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