

# Designing incident reporting for transitioning to Safety-II

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# Reporting Incidents: the Institute of Medicine

**RECOMMENDATION 5.1** A nationwide mandatory reporting system should be established that provides for the collection of standardized information by state governments about adverse events that result in death or serious harm. Reporting should initially be required of hospitals and eventually be required of other institutional and ambulatory care delivery settings. Congress should

- designate the National Forum for Health Care Quality Measurement and Reporting as the entity responsible for promulgating and maintaining a core set of reporting standards to including a nomenclature and taxonomy for reporting
- require all health care organizations to report information on a defined list of adverse events;
- provide funds and technical expertise for states to establish or adapt their current error reporting systems

**RECOMMENDATION 6.1** Congress should pass legislation to extend peer review protections to data related to patient safety quality improvement that are collected and analyzed by health care organizations for internal use or shared with others for the purposes of improving safety and quality.

**RECOMMENDATION 5.2** The development of voluntary reporting efforts should be encouraged. The Center for Patient Safety should

- describe and disseminate information on external voluntary reporting programs to encourage greater participation in them and track the development of new reporting systems as they form;
- convene sponsors and users of external reporting systems to evaluate what works and what does not work well in the programs, and ways to make them more effective;
- periodically assess whether additional efforts are needed to address gaps in information to improve patient safety and to encourage



# Reporting Incidents, is New Zealand Unique?

- The external view: Understanding the New Zealand experience for shaping the transformational paradigm for full transparent reporting of adverse events in a no-fault compensation system without litigation. (Paterick et al, 2009)
- The local view: “Informs our decision making at the clinical board”, “a trigger for improvement opportunity” , “humanising hospitals”  
“I don’t think we are sharing enough depth”, “its so hard to fill out... why don’t you just lift the phone and leave a message”
- The conclusion: “.. has a limited role in improving quality and patient safety in the NZ context” (Hardy et al, 2014)



# Factors Affecting Performance of Safety Reporting

- **Organisational:** Commitment, financial priority, independent third party, feedback, adequate information technology, professional development
- **Working Environment:** Code of silence, efficient procedures, workload, group or peer influence, local supervision
- **Individual:** Consequences, trust, manageable outcomes, acceptable norms, knowledge of what is to be reported, competence of how to report

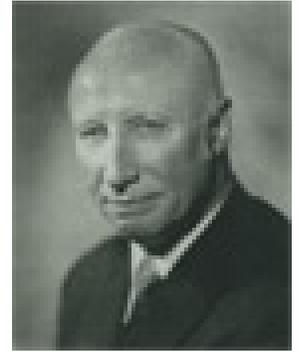


# Where Did Incident Reporting Come from?

- W.D. Wylie, 1975. ‘There, but for the grace of God...’ *Annals of the Royal College of Surgeons of England*
- Jeffery Cooper, PhD, Massachusetts General Hospital
- Conducted interviews with anesthesiologists exploring equipment failure
- Using the Critical Incident Technique, analysis of 47 interviews identified 359 preventable incidents
- Of these 82% were preventable and attributable to “human error” and 14% were “overt equipment failures”



# The Critical Incident Technique



- Described by John C. Flanagan (1954).
- “..a procedure for gathering important facts concerning behaviour in defined situations.”
- “..simple types of judgements are required of the observer, reports from only qualified observers are included, and all observations are evaluated by the observer in terms of an agreed statement of the purpose of the activity.”
- Includes aims, plans and specifications, collecting data, analysing data, and interpreting and reporting

# Safety II: Look for What Goes Right, as Well as What Goes Wrong

- The Critical Incident Technique is an appreciative model that looks at any activity that leads a positive or a negative outcome.
- The Technique analyses the activities leading to an intended or anticipated outcome
- Identifies both intended and unintended actions that are linked to the outcome that is achieved.
- Recognise the value of the near-miss.
- “What you find is not always what you fix”



# Safety II: Focus on Frequent Events

- The Critical Incident Technique requires collection and analysis of data to achieve a saturation.
- Data analysis determines the frame of reference forming the categories that emerge from the data. That is, as the data is compiled, categories are compiled.
- Based on qualitative research methods that support objectivity and repeatability.

# What Can This Tell Us?

1. Treatment delay
2. Missed or delayed diagnosis
3. Treatment injury
4. Medication: Intended drug, correct patient, incorrect dose
5. Acquired infection
6. Treatment to correct, repair, retrieve or reverse previous treatment
7. Remove swab, instrument or device
8. Treatment provided and not required or indicated
9. Failure to provide appropriate care
10. Pressure injury

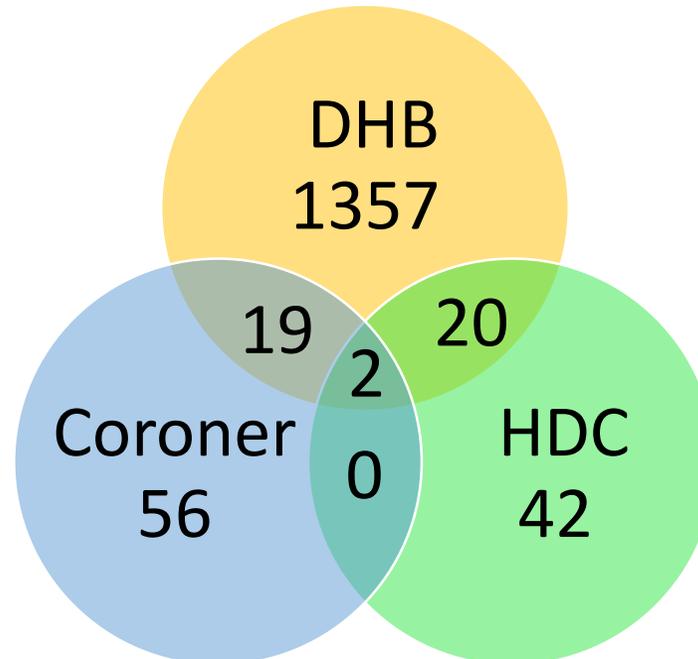
# Remain Sensitive to the Possibility of Failure

- The Critical Incident Technique recognises that it is the intended outcome that is not achieved.
- That is, be as sensitive to procedures not going right and not causing harm as to those procedures that go right but cause harm.
- By applying the scientific principles of the Technique, observers can avoid confirmation bias or focus on optimistic outcomes



# Be Thorough as Well as Efficient

- The Critical Incident Technique recognises the implementation of general aims, plans and specification etc. This requires appropriate resourcing.
- Fewer reports completed more efficiently.
- Interface of the coronial process with DHB and Health and Disability Commissioner reviews



# Investing in Safety, the Gains from Safety

- The Critical Incident Technique is practiced by trained and skilled people.
- A well-intentioned workforce. “Those currently doing work in patient safety and quality are formally trained in medicine, nursing, law, pharmacy and healthcare management, and not formally trained in the emerging profession of patient safety and quality itself”.
- Human factors, ergonomics and innovation. “Relies on knowledge of basic scientific disciplines, such as physiology, sociology and psychology as well as applied sciences such as industrial engineering, business and management”.
- Safety is an investment in productivity.



# In Conclusion

- Safety-I and Safety-II need to coexist
- Incident reporting in Safety-II builds on the achievements of Safety-I
- A framework, such as the Critical Incident Technique, can support the transition to Safety-II

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