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# From Incident Reporting to Building a Safety Culture


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ISQua  
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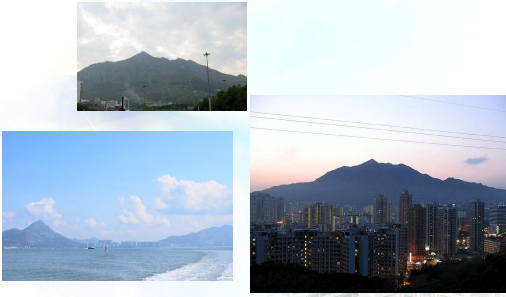
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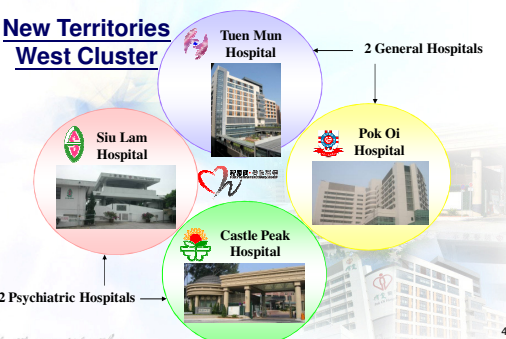
## Castle Peak (583m)



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## New Territories West Cluster



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## Tuen Mun Hospital

- > An acute hospital
- > 1800 hospital beds
- > 126,000 admissions per yr
- > 4900 staff




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## Incident Reporting: World Perspective



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**Incident Reporting:  
HK Public Hospitals Scene**

- AIRS (Advanced Incident Reporting System) – from 2003
- Web based electronic system
- Facilitates reporting, classification, analysis and management of incidents

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**Hospital Authority  
Advanced Incidents Reporting System**

**Login Authentication**


**Please enter Domain ID and Password**

Domain ID:

Password:


1. Technical problems in AIRS (eg. Login problem), please contact our IT colleagues (Mr. Eric Chan at 2456 7872 or Miss Yuki Chan at 2468 5419) during office hours.  
 2. During non-office hours, please inform duty PRM through hospital operator for very urgent and serious incidents.

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**Sentinel Events Policy**

- From 2007
- Wrong patient / body part surgery, retained instrument, ABO incompatible transfusion, medication incident resulting in death / permanent disability, intravascular air embolism, maternal death, inpatient suicide, infant abduction, death not related to natural course of illness
- Report via AIRS within 24 hr


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**Reporting Culture and Practices at Hospital level**

Objective

*To evaluate the knowledge and practices of hospital staff regarding patient safety issues and incident reporting*


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**Subject and methods**

- March to May 2008
- N = 108
- 70% nurses (med, A&E, psych)
- Questionnaire

1. Knowledge on AIRS and SE
2. Attitude on incident reporting
3. Patient safety practices

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**Results**

1. Knowledge on AIRS and SE

Item	% agree
Understands why, when, and how to report on AIRS	93
Thinks that AIRS reporting is user-friendly	81
Understands what SE means / how to report	60 / 56
There is a clear SE policy	52

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## 2. Reporting Attitude

Item	% most of the time / always
Feels comfortable reporting to AIRS	44
Feels comfortable reporting own mistakes	27
Receives feedback to manage the incident after reporting	38

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## 3. Patient Safety Practices

Item	% most of the time / always
Adhere strictly to hand hygiene	76
Use 2 identifiers for patient identification	70
Read-back after receiving verbal order	61
Practice time-out	56
Use SBAR	42

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87% OF THE 58% WHO COMPLETED MORE THAN 23% OF THE SURVEY THOUGHT IT WAS A WASTE OF TIME

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## Way Forward

- Enhance staff understanding of sentinel events
- Provide more positive feedback and support to staff reporting incidents
- Encourage "speak-up"

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## Barriers to Reporting

1. Sense of failure
2. Fear of blame
3. Fear of medico-legal risk
4. Reports being used out of context
5. 'Not my job'

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## Barriers and Incentives to Medical Incident Reporting

	Barriers	Incentives
Legal / Regulatory	reprisals / censure ↑ premiums loss of income bad publicity	confidentiality accountability org image
Cultural	colleagues in trouble skepticism extra work don't want to know	professional values integrity educational
Financial	Wasted resources Not cost effective More bureaucracy	safety saves money

Barach P, Small SD. BMJ vol 320 March 18 2000

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## Incident Reporting: Opposing view

- "The point is that we have no idea which one is true – IRs provide no useful information about the true frequency of errors in an institution."
- For each IR: estimated 20 min in reporting and 60 min of backend work. 5k IRs / yr, 6600 working hours will be used.
- "In addition to undermining effort to monitor for safety problems, lack of meaningful change will negatively impact the culture of the organization in general."

[http://www.thehealthcareblog.com/the\\_health\\_care\\_blog/2009/09/another-look-at-incident-reporting-systems.html](http://www.thehealthcareblog.com/the_health_care_blog/2009/09/another-look-at-incident-reporting-systems.html)

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## Patient Safety Incidents closely linked to Complaints Mgt

- Appropriate response: sequence of events, emotional support
- Staff sentiment and feedback
- Improvement measures

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```

    graph LR
      A[Incident / complaint mgt] --> B[Staff support]
      B --> C[Learn and share safety lessons]
      C --> D[Implement Change]
      C --> E[Patient Safety Culture]
      D --> E
  
```

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## Acknowledgement

Bonnie Wong  
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Thank you for your attention!

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