

A Mixed Method Approach to Understanding the Incident Reporting and Learning Process at the Frontline in a Saskatchewan Hospital

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Background

Incident reporting and learning systems have been successfully implemented in healthcare organizations to capture and correct errors within their systems in an effort to mitigate harm to patients¹. Incident report analysis can uncover some of the causes of error in order to identify solutions and measures at a system level to prevent error recurrence². Studies have also shown that the greatest learning potential comes from near miss events when reported within the incident reporting and learning systems^{3,4,5}. However, frontline nurses have identified that healthcare organizations have difficulty in establishing learning from incidents which results in poor organizational learning and system change^{6,7}.

Project Details

Problem statement: To examine if current incident reporting processes were resulting in optimal system change and organizational learning.

Aim: To understand the incident reporting process according to frontline managers and nursing staff by identifying strengths and areas for improvement.

Setting: Acute care units in a Saskatchewan tertiary hospital.

Sample: Stakeholder participants: Frontline Managers, Staff nurses, and the Quality Management Department.

Method: Mixed

Part I: Qualitative - In depth interviews of each frontline manager and the Quality Management Department (Interview questions based on the Canadian Incident Analysis Framework⁸).

Part II: Quantitative - Survey staff nurses on each acute care unit (Patient Safety Climate Survey⁹)

Analysis: Part I: Thematic Analysis

Part II: Descriptive Statistics

Mix both data sets

Manager Interview Results

Strengths

- Safety culture was improving. E.g. "Near misses are being reported more, so that's a good sign".

- Units learn from incidents. E.g. "Most incidents are opportunities for learning, huddles, topic for discussion".

- The LEAN system has taught them more about system processes and waste. E.g. "I learned how to take things down to smaller steps and to drill down deep".

Areas for Improvement

- Senior leadership support was lacking. E.g. "There doesn't seem to be a heck of a lot of support from them".

- Training in incident management was "learn as you go".

- The roles and responsibilities of the Quality Management department was largely unknown by the frontline managers.

Staff Survey Results

Strengths

- Learning culture. 80% of nurses agreed that on their units, they learn from incidents. E.g. After a serious error has occurred, they think about how it came about and how to prevent the same mistake from happening again in the future.

- Frontline manager leadership for safety. 66% agreed that their manager says a good word when the staff use established safety procedures and seriously considered staff suggestions for improving patient safety

Areas for Improvement

- Blame culture. 66% of nurses believed that making a serious error would lead to disciplinary action, cause them to lose their jobs, or limit their career options within the health region.

- Support for safety by senior leadership. 48% disagree that senior leaders have a clear picture of the risk associated with patient care; provide a climate that promotes patient safety; consider patient safety when program changes are discussed; and balance the need for patient safety and the need for productivity.

Discussion

Both the acute care managers and nurses had the same perspective about learning from incidents. They also seem to have the same opinion on the perceived lack of support by senior leadership for patient safety. In contrast, the managers identified that the unit safety culture was improving, however staff nurses showed that a blame culture was firmly in place. When both data sets were compared to the perspective of the Quality Management department, it was evident that there was confusion about the roles and responsibilities of each group.

Recommendations

1. Staff: Education about the incident reporting system with a strong focus on the processes after the incident is reported including the positive consequences of reporting incidents. To ensure an integrated and cooperative team environment, the manager should be present and participate in the sessions. Discussions using past de-identified incidents should be used to enhance practical learning.

2. Managers: An in-depth course in incident management with a hands-on practical component. A standardized process of incident management should be the goal with the course. The Quality Management Department should deliver the course and include a clear overview of each group's roles and responsibilities in incident management.

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