

*Barriers to reporting: addressing  
concern from the trenches*

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Centre of  
**Research Excellence**  
in Patient Safety



# Barriers to reporting

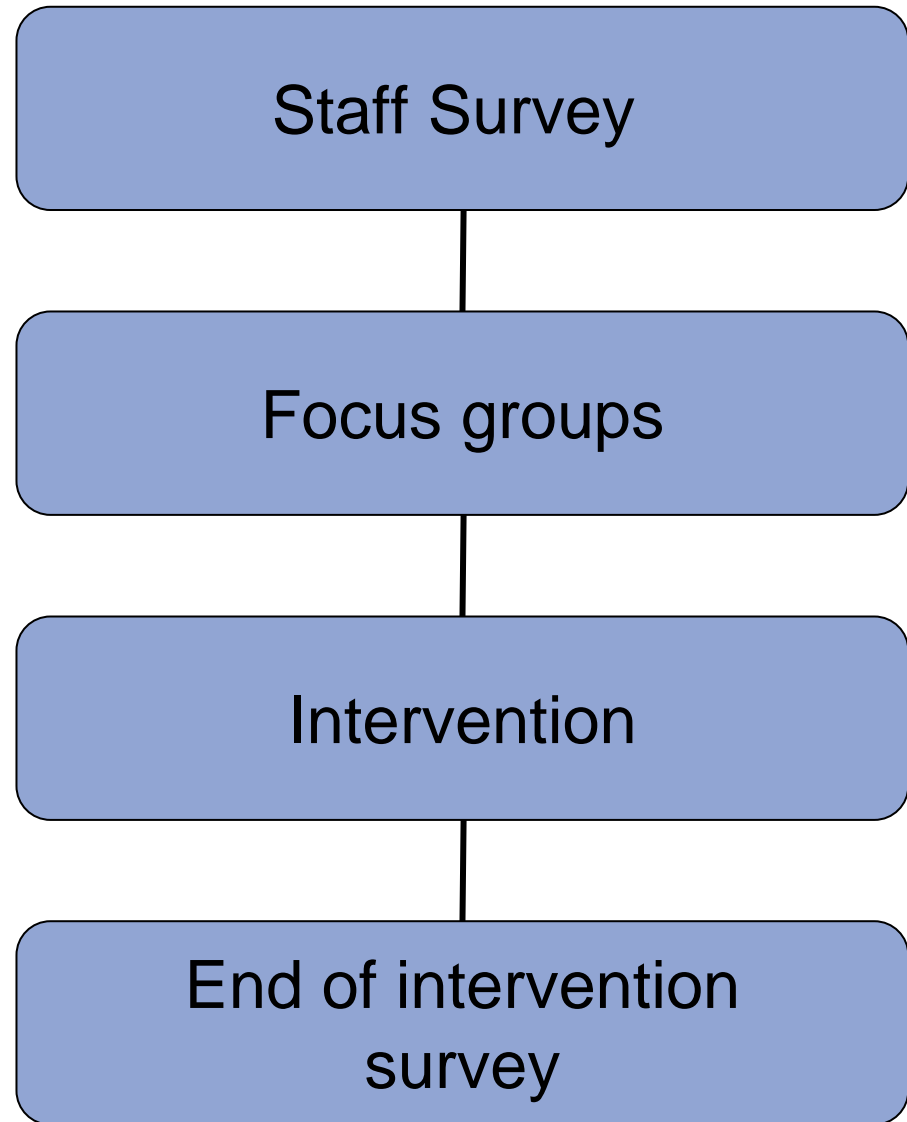
- Recurring themes:
  - Time constraints on busy clinicians; <sup>1-4</sup>
  - Fear of embarrassment or loss of face, punishment, <sup>5-7</sup> and litigation; <sup>8</sup>
  - Inability to report anonymously; <sup>6</sup>
  - Lack of knowledge about what to report and by whom an incident should be reported; <sup>2 6 9</sup>
  - Errors that result in actual harm are more likely to be reported than errors that are caught and corrected before they cause harm; <sup>7,9-12</sup>
  - A perception that incident reports do not result in significant changes; <sup>1-4 6</sup>
  - The culture of medicine, which emphasizes professional collegiality, <sup>13</sup> autonomy and self-regulation;<sup>14</sup>





## ● AIM

- To identify current reporting practice and barriers to reporting
- To develop an intervention which addressed these barriers
- To see whether this intervention improved reporting practice and changed incident profile
- To see whether it addressed identified barriers



# Barriers<sup>1</sup>

n=773 Response rate 72.8%

20 units across 4 metro and 2 rural hospitals

Drs=186 (70.7%) Nurses = 587 (73.6%)

	Drs % agree	Nurses % agree	P
Lack of feedback	58%	62%	0.37
The incident form takes too long and I just don't have the time	54%	44%	0.02
The incident was too trivial	52%	41%	0.03
Don't know how to report	51%	12%	<0.001
When the ward is busy, I forget	47%	48%	0.93
When it's a near miss, I don't see any point	36%	49%	0.003
Incident reporting is unlikely to lead to system changes	29%	30%	0.78
I wonder who else is privy to the information I disclose	27%	33%	0.11

1. Evans SM, Berry JG, Smith BJ *et al.* Attitudes and barriers to incident reporting: a collaborative hospital study. *Quality & Safety in Health Care* 2006; 15(1):39-43.



# Focus groups <sup>2</sup> – Doctors

- **Not something doctors did**

- *I think they're (nurses) better trained in the process than we are...*  
[Consultant]
- *It just doesn't occur to me that an incident report should be made*  
[Registrar]

- **Fear of litigation**

- *So it's not protected information by any means. Unless you have protected, confidential information, you don't get the facts.*  
[Consultant]

<sup>2</sup> Kingston MJ, Evans SM, Smith BJ, Berry JG. Attitudes of doctors and nurses towards incident reporting: a qualitative analysis. Med J Aust 2004; 181(1):36-9.






# Focus groups - Nurses

- Fear of internal discipline
- *"They [nurse colleagues] were too scared to do this [fill in a report] because they thought this was a personal threat because they were told that this stays in your file, and this can be used against you further on" [Junior nurse]*
- *"Why would you want to sign one of these forms if you get caught or something, I wouldn't want to do it." [Junior nurse]*





# Intervention

Barriers		Proposed solutions
Lack of feedback		Scheduled feedback in existing meetings / Bulletins
Time constraints		Simplify process
No point in reporting trivial events		Education/feedback
Don't know how to report		Education/ Posters / Forms accessible/ phone number on phones
Unable to lead to system change		Feedback / Encourage leaders to participate in RCA workshop
Fear of litigation/internal discipline		Education/anon reporting/change reporting channel



**IRIS Form**

This form should be used to identify any event or circumstance that could have or did cause explained harm, suffering, or change within the health care system, so that corrective measures can be developed. Identifying information received on this form is provided free of charge and will not be used for quality assurance purposes. (For VC Health Insurance Amendment Act, 1992) If you think that there is any risk of litigation, complete this form and also report the incident separately to the relevant person in Risk Management. Ensure medical records are accurate and up to date.

Where did the incident occur? Affix CR label here:  
 Hospital: \_\_\_\_\_ Patient name: \_\_\_\_\_  
 Unit/Ward: \_\_\_\_\_ UR number: \_\_\_\_\_  
 Ward: \_\_\_\_\_

OR If you do not see details of the incident forwarded to you please self-assess how likely the Hospital Unit/Ward was when did the incident occur/become apparent? Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Time: \_\_\_\_\_

What happened?  
 \_\_\_\_\_  
 \_\_\_\_\_

Why did the incident happen?  
 \_\_\_\_\_  
 \_\_\_\_\_

How could it have been prevented?  
 \_\_\_\_\_  
 \_\_\_\_\_

If you have a complaint, please see reverse side.

Characterise in terms of report:  Extreme  Major  Moderate  Minor  Insignificant  
 (What was the consequence of this incident?)  
 (Severity of harm or potential length of stay) (Permanent loss of function) (Permanent loss of function, additional surgery or increased length of stay) (Regarded as serious and requires close investigation or referral to specialist) (No increased level of care or length of stay)

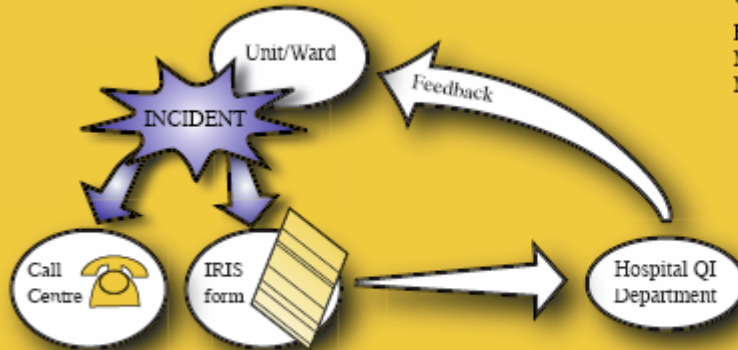
Please tick a box:  
 Probable  Possible  Occasional  Uncommon  Exceptional  Rare  
 (What is the likelihood that this incident will recur?)  
 (Within a few weeks) (Several times a year) (In 1-2 years) (In 3-5 years) (In exceptional circumstances)

Why do you think this incident is important?  
 \_\_\_\_\_  
 \_\_\_\_\_

Requester's name: \_\_\_\_\_  In  No  Specially level \_\_\_\_\_  
 Contact number: \_\_\_\_\_  Yes  Specially level \_\_\_\_\_  
 Email: \_\_\_\_\_  Other  Specially \_\_\_\_\_

Do you know that you can also report through a call centre on 1800-NETTY'S (1800-646-4397)?

### Incident Reporting Process



### Recommended Individual and Unit/Ward Feedback

Extreme /major event	3 working days
Moderate event	2 weeks
Minor event	3 months



If you require further information, refer to the IRIS Education Folder in your area



### IRIS Incident Reporting to Improve Systems

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Issue 1

#### Reporting is the vital first step in quality improvement

Research specifically focused on health care systems suggests that as many as 70% of adverse incidents are preventable. (Department of Health 2009 p26)

The IRIS project is drawing to a close. Please submit your reports by paper or by call centre (1800 666 439) and contribute to patient safety. Thank you to everyone who has been contributing.

A number of security related incident reports have been received, the outcomes arising will be discussed in detail next newsletter. Staff and patient safety relies on adequate security in hospital. Please let us know of any security incidents which will provide us with evidence to improve security for patients and staff and improve our working environment.



All systems are perfectly designed to achieve the results they get

#### The following are examples of nutrition incidents

- Diet not requested
- Problems with modified preparation (not prepared, delay)
- Problem with meal/food delivery (not delivered, delivered to wrong location)
- Food when fasting
- Fasting when not indicated (Patient fasting when it was not necessary)
- Omission meal/food/supplement not given when required

Figure 1

#### Malnutrition in patients

Malnourishment is a problem for hospitalised elderly patients. Studies indicate 26% of elderly patients are affected by malnutrition.<sup>1</sup> Malnutrition affects the postoperative recovery period, contributing to increased length of stay, impaired wound healing and a higher rate of complications.<sup>2</sup> Fasting, the nature of the illness or a change in the capability to feed oneself contributes to a reduction in a patient's intake of food.<sup>3</sup>

The admission process requires a recognition of the at risk patient, in order that a multidisciplinary approach to malnutrition can be undertaken. Interventions include a review of medications, medical history, diet, ensuring that patients are assisted with their food and fluid intake and discharge planning.<sup>1</sup>

We rarely recognise at risk patients<sup>1</sup> and therefore it is not surprising that there are few incident reports about nutrition. We would like to encourage staff to report nutrition based incidents, in order to determine what the concerns are in providing adequate nutrition and to implement changes to overcome these problems. (See Figure 1)

References:  
 1. Whitehead, Craig. Malnutrition in elderly people. *Additional Community Hospital, Clinical Practice Bulletin*, Vol 1 2008 p.4.  
 2. Schneider, Anne & Ward, Cathy. *Nutrition for Malnutrition, Additional Community Hospital, Clinical Practice Bulletin*, Vol 1 2008 p.6.  
 3. Department of Health. *An Organisation with a Mission: Report of an expert group on learning from adverse events in the NHS*, headed by the Chief Medical Officer. London: The Stationery Office; 2000. Accessed Online: <http://www.dh.gov.uk/uknrgp0007>

The incidents discussed below have arisen in any one of the six intervention hospitals. The newsletter also identifies the location of the incident and the subsequent action taken. The aim of this newsletter is to share the circumstances of adverse events and how the system flows have been addressed. In this way all units can review practices that have been implemented by other hospitals.

#### Management of multiple patient transfers from emergency to a general ward

##### Background:

A series of incident reports were reviewed involving the transfer of patients from the Emergency Department (ED) to the ward overnight.  
 Report 1: related to the admission of a patient following a heroin overdose. Presenting to ED at 1900, the patient received four doses of Naloxone before being transferred to the ward at 0430. At 0631, due to verbal aggression and an attempt at physical restraint, a Code Black was called.  
 Report 2: involved the transfer of a terminally ill patient with an arterial line in situ, which should have been removed when a decision was made at 2200 that the patient was for comfort care only. The patient died at 0340.  
 Report 3: detailed the admission of the previous two patients and the transfer of two additional patients, one at 0303hrs on the same morning with a heparin infusion and another patient who arrived on the ward at 0602hrs. The heparin infusion had to be changed over on the ward due to incompatibility of pumps between the ED and the ward. These additional patient admissions from the ED put further workload pressure on ward personnel.

##### Findings:

Report 1: There is a need to increase knowledge regarding management of aggressive or mental health patients in the ward area including issues surrounding detention and duty of care orders.  
 Whilst there is a clear "zero tolerance" towards any form of aggression in ED, it is unclear if this occurs in general ward areas.  
 Naloxone was ordered to be administered if the patient was unresponsive, rather than when the respiratory rate or oxygen saturation level fell to an unacceptable level.  
 Report 2: There is an increased likelihood that errors of omission may occur due to an absence of a tool to ensure that patients are adequately prepared for transfer.  
 Report 3: There was a lack of compatible IV pumps between ED and clinical areas resulting in the need to change infusions and giving sets over when patients are transferred.  
 Overall: There is a knowledge deficit on the causes of delay in patient transfers from when a ward is allocated in the ED until the transfer to the ward is completed.  
 The Nursing Coordinator was unaware of the increased activity levels and events on the ward prior to the Code Black call. The increased workload resulting from the admission of 4 patients to the ward, 3 with a high degree of acuity, created a stressful situation for staff in managing the new admissions and in performing regular morning duties.



##### Recommendations

- ✓ Hospital staff should have the opportunity to receive education in management of aggressive patients. A flow chart should be incorporated into hospital policy.
- ✓ Assessment of the current ED ACES Risk Assessment Tool and Suicide Risk Assessment should be undertaken to ensure that there are clear guidelines for managing patients who may or may not be detained under a duty of care or detention order.
- ✓ Assessment of the need for medical education regarding management of narcotic abuse.
- ✓ An ED Patient to Ward Transfer Checklist should be developed for use by nursing staff in ED.
- ✓ Reasons for delay in transfer (either by the transferring or receiving department) should be documented and audited to identify strategies to improve transfers.
- ✓ In the graduate nurse program, graduate nurses should be encouraged to rotate through the ED.
- ✓ Clarification of the clinical and management role of the Nursing Coordinators, including their ability to provide assistance at times of peak activity on the ward.
- ✓ Review the need to develop a more effective means of communicating between Coordinators and ward staff.

#### Recombinant Tissue Plasminogen Activator

##### Background:

A patient was admitted to ED following a stroke. Thrombolytic therapy with a recombinant tissue plasminogen activator (rtPA) is recommended to be used with caution,<sup>1</sup> within 3 hours of a cerebral vascular event for optimal patient outcomes.<sup>2,3</sup> Stocks of rtPA were not available and treatment was therefore delayed.

##### Factors contributing:

rtPA was not stocked in this department, requiring an order to the hospital pharmacy to be filled before treatment could commence. Although Pharmacy had agreed to supply rtPA within 3 hours, it became apparent that stock at hand in the department would be more appropriate.

##### Outcome:

- ✓ Discussions between Pharmacy, Neurology and Finance, resulted in ED being stocked with rtPA.
- ✓ The development of a "Stroke Kit" was recommended to assist doctors in their treatment of cerebro-vascular accidents.

References:  
 1. *Wardell PH, Ad Page G, Yungnick L, Berg D. Thrombolysis for acute ischaemic stroke. *Cochrane Review for The Cochrane Library*. Issue 2008 (October 18). John Wiley & Sons, Ltd.*

2. Fisher M, Alquist P, Ackelberg P, Scheer C, Black W. *Thrombolytic therapy within 3 hours after onset of ischemic stroke. Valid and standard? Stroke*. 2007 May; 38(5):1371-4.

3. The National Institute of Neurological Disorders and Stroke. *Stroke: NINDS Stroke Study Group. Tissue plasminogen activator for acute ischaemic stroke. *N Engl J Med* 1995; 333:1055-60.*

40 weeks,  
 6 hospitals,  
 10  
 intervention  
 units 10  
 control units



Did it work?



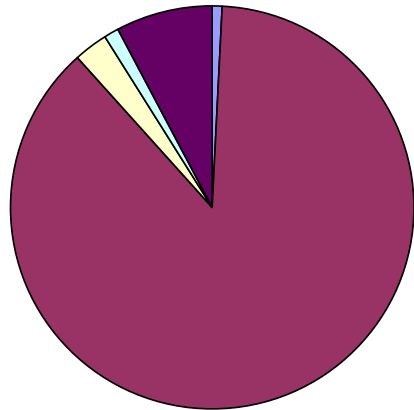
# Reporting rates <sup>3</sup>

	Baseline				End				Sig	Absolute difference in change ± 95% CIs
	Control	Intervention	Rate ratio	95% CI	Control	Intervention	Rate ratio	95% CI		
Reporting rates per 10,000 Occupied Bed Days (OBD)										
ICU	22	89	0.25	0.1 - 0.5	17	118	0.1	0 -0.3	0.094	34 ± 31.7
Surg	39	43	0.9	0.6 - 1.3	72	151	0.5	0.4 -0.6	<0.001	75 ± 29.7
Med	79	97	0.8	0.7 - 1.0	141	243	0.6	0.5 -0.7	<0.001	84 ± 30.4
Reporting rates per 10,000 ED attendances										
ED	21.5	6.3	3.4	2.2 - 5.4	22.2	46.5	0.35	0.3 - 0.5	<0.001	39 ± 11.5
Reporting rates per 10,000 OBDs + ED attendances										
Anon	4.1	0.7	5.9	2.4-13.5	9.4	15.8	0.3	0.2 – 0.5	<0.001	9.8± 3.1

- 30% reports through call centre

3 Evans SM, Smith BJ, Esterman A *et al.* Evaluation of an intervention aimed at improving voluntary incident reporting in hospitals. *Quality & Safety in Health Care* 2007; 16(3):169-75.

Baseline

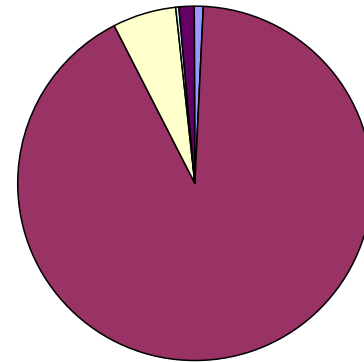


n = 327

# Control

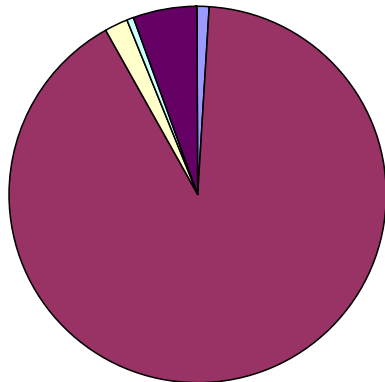
- Doctor
- Nurse
- Allied Health
- Other
- Anonymous

Study period



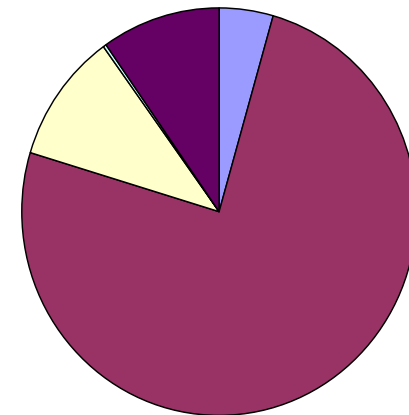
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# Intervention



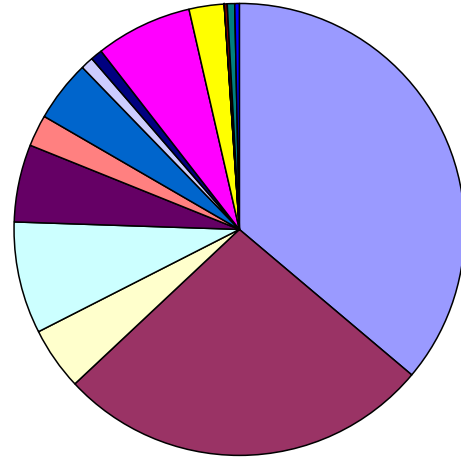
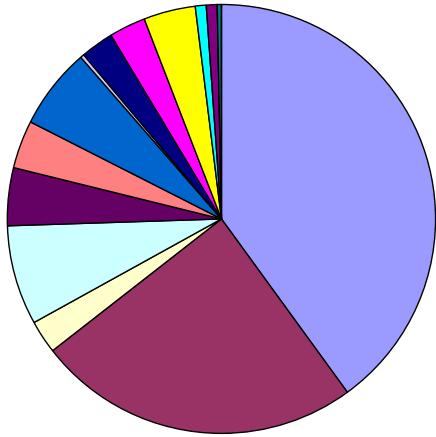
n = 422

- Doctor
- Nurse
- Allied Health
- Other
- Anonymous

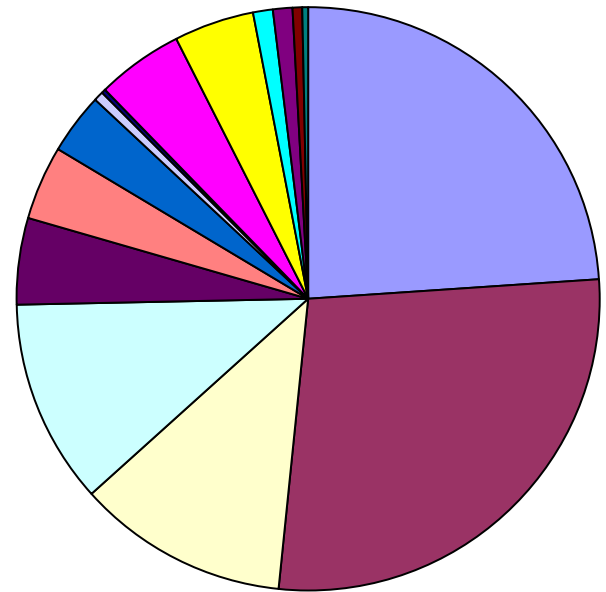
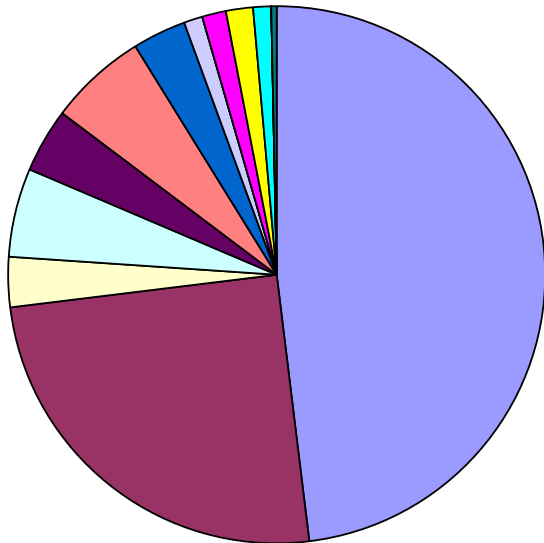


n = 1111

Control



Intervention





Did it change attitude?



n=840 Response rate 74.3%  
 20 units across 4 metro and 2 rural hospitals  
 Drs=208 (76.2%) Nurses = 632 (73.7%)

	Baseline		End		Comparison at end adjusted for Baseline	
	Control	Intervention	Control	Intervention	RR	95% CI
	agree	agree	agree	agree		
Lack of feedback	60%	61%	60%	38%	0.6	0.3-1.0
The form takes too long to fill out & I don't have the time	47%	46%	34%	37%	1.1	0.9-1.3
The incident was too trivial	43%	44%	38%	35%	0.9	0.7-1.1
Drs: don't know how to report	50%	51%	41%	18%	0.6	0.4-0.8
When the ward is busy I forget to make a report	48%	48%	45%	59%	1.3	1.2-1.4
When it is a near miss, I don't see any point in reporting it	48%	44%	38%	26%	0.8	0.6-0.9
Incident reporting is unlikely to lead to system changes	28%	30%	22%	18%	0.8	0.6-0.9
I worry about who is privy to information that I disclose	33%	32%	29%	28%	1.0	0.7-1.5



## Key features of groups with high reporting rate

- Medical HoU attended RCA workshop
- Posters and forms clearly accessible in clinical areas
- Feedback provided for >20 minutes at least every 10 weeks
- Call Centre: proficient capture of data in a timely manner
- Initial education captured majority of Drs





## Take home message

- You can improve reporting rate and change attitude towards reporting
- Find a clinical champion who will support it
- Provide feedback
- Consider changing the reporting process





# Acknowledgements

- Prof Adrian Esterman, Prof Bill Runciman, A/Prof Brian Smith, Prof Guy Maddern
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- Funding body: SA Department of Health: Christy Pirone
- Medical and nursing staff participating in the study



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