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# Incident Reporting: A journey from principles to policy and practice

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## The study

- **Aims:** To understand and explore how clinicians *act* and *interact* with each other to deliver safe patient care.
- **Methods:** Ethnographic methods – to observe clinicians at work, and to make sense of that work with them.
  - Observations – field notes, recordings
  - Field interviews
  - Feedback sessions
- **Field site:** 69 clinicians, metropolitan hospital in NSW, Australia.



My PhD research is part of a wider ARC funded Discovery project, and broadly, my aim was to understand and explore what it was that clinicians did to deliver safe patient care.

As such, we used ethnography, in order to observe clinicians at work and to make sense of that work with them.

So, for a total of ten months, I carried out fieldwork in a hospital in two phases, doing observations of clinical work, taking audio recordings of meetings, field interviews and conversations when permissions were granted, and, at the end of each phase of fieldwork, I carried out feedback sessions with my participants, during which I presented some initial thoughts and analyses, and they could then correct, refine and discuss the ideas I was presenting to them.

My participants were 69 clinicians in a hospital in NSW, consisting mainly of a multidisciplinary team of doctors, nurses and allied health staff, as well as the nurses and staff on a ward.

In looking at patient safety, one of the main issues that arose through fieldwork was incident reporting, which I'm talking about today.

# Incident reporting

- Improving patient safety, through:
  - Collecting information about safety incidents (Kohn et al., 2000)!!
  - Finding out what can/does go wrong
  - Organisational feedback, patient safety awareness (MacIntosh-Murray, 2001)
- Implemented in Australia, UK, US, Canada.
- Sounds good, what's the problem?

# The problem

- **Incident under-reporting: < ¼ to ⅓ of incidents reported**

(Barach & Small, 2000; Evans et al., 2006; Kingston et al., 2004; Lawton & Parker, 2002; Pietro et al., 2000; Trevino & Victor, 1992 ; Vincent et al., 1999; Waring, 2005)

- **“Barriers” :**

- **time and workload constraints** (Vincent et al., 1999; Waring, 2005)
- **traditional professional identities/boundaries** (Kingston et al., 2004; Lawton & Parker, 2002; Pietro et al., 2000; Vincent et al., 1999; Waring, 2005)
- **social, group norms and pressures** (Barach & Small, 2000; King, 2001; Trevino & Victor, 1992)
- **lack of feedback** (Evans et al., 2006)

Studies have primarily concentrated on identifying local factors that prevent incident reporting, characterised as barriers. In this study however, we take a different perspective, and look at how the incident reporting system interacts with local practices.

## Processes of incident reporting

- Incident reporting: reducing error through *complementary* processes of *accountability* and *learning* (IoM report: Kohn et al., 2000)
- **Accountability:** mandatory reporting and investigation for serious incidents, penalties where relevant, and visibility to the public.
- **Learning:** “no blame”; voluntary and confidential reporting to provide protected information for learning and quality improvement.

⇒ Complementary processes? How so?

The seminal Institute of Medicine (IOM) report ‘To Err is Human’ (Kohn et al., 2000) outlines these two processes. The first centres on holding health care organisations accountable for their safety performance by implementing mandatory reporting and investigation for serious incidents, penalties where relevant, and some degree of visibility to the public (Kohn et al., 2000). The second purpose, they suggest, is a complementary process of voluntary and confidential reporting designed to provide protected information for learning and quality improvement (Kohn et al., 2000), that is, ‘to gather the necessary information about where and why things are likely to go wrong rather than to identify the people involved’ (Runciman, Merry and McCall Smith, 2001: 298).

This latter process of learning has been characterised as ‘no blame’, in line with the argument that focusing on individual culpability creates a culture of fear that is counterproductive to learning (Bates and Gawande, 2000; Leape & Berwick, 2000; Runciman, Merry & McCall Smith, 2001; Waring, 2005).

These two processes are clearly contradictory at face value. So how are they supposed to be complementary?

# Reconciling the contradictions

- Accountability vs. Learning  
(Bagian, 2005)
  - ‘Just culture’: somewhere between accountability and learning  
(Dekker, 2007, Weiner et al., 2008)
  - “Forward looking” accountability *for* learning and improvement (Sharpe, 2004)
- Separate processes
  - Explicit criteria: ‘blameworthy’ or ‘blameless’  
(Runciman, 2002)

Well, the predominant way of reconciling these two processes has been by conceiving of them as separate processes. Bagian warns that they should not be combined into the same system, because then it becomes all about accountability.

Dekker and several others talk about how a ‘just culture’ is necessary for clinicians to feel comfortable with reporting incidents, and they note that this sits somewhere between blame and no-blame, that both are important. Runciman suggests that there should be explicit criteria to distinguish between ‘blameworthy’ incidents that should be dealt with through accountability and ‘blameless’ incidents that can be used for learning instead.

In a slightly different vein, Sharpe reframes the issue by suggesting that we move away from this ‘backward looking’ accountability that focuses on things that go wrong, and reframe accountability instead in a forward looking sense, as responsibility for learning from error and for improving practices.

As we will see, in the next few slides, the incident reporting system in NSW embodies these approaches to varying degrees.

## The NSW Health IIMS: Incident Information Management System

- Implemented in 2004-2005
- Structured online form
- Participation is mandatory
- Anonymous reporting enabled
- Near misses reported
- Incidents managed locally or formally, based on severity level (SAC code).
- Aggregation of incident reports → NSW Health and the Clinical Excellence Commission → fed back as programs and recommendations.



TO maximise learning from as many incidents as possible, anonymous reporting is allowed and reporting of near misses is also encouraged.

Depending on the severity of an incident, there are different paths to managing and investigating incidents. For example, relatively minor incidents with very minor or no harm caused can be investigated and resolved locally by line managers. However, for sentinel events such as wrong site surgery, the incident is escalated up, through executive management to the department of health, and formal privileged root cause analyses are then carried out to investigate and 'learn from' these incidents.

Finally, another layer of learning happens externally, in the dept of health and the CEC, which take aggregated data from the area health services, analyse them for patterns and trends, and then feed these back as safety recommendations and programs.

## Based on policy 'principles':

(NSW Health, 2007)

"Errors are reported... without fear of inappropriate blame..."

"Emphasis on learning..."

"... obligation to take action to remedy problems..."

"... the limits of individual accountability are clear, individuals understand when they may be held accountable for their actions"



If we look at several of the principles outlined in the policy, regarding the Patient Safety and Clinical Quality Program, we find again the notions of learning, accountability, and accountability for learning expressed together.

So, both the policy and structure of the IIMS seem to embody a kind of blend of learning and accountability. Although the emphasis is strongly on learning and accountability **for** learning, it's not exactly 'no blame' either, and also allows for the possibility of 'appropriate' blame and individual accountability.

Next, we take a look at how these issues manifest in clinicians' experiences of the IIMS.

## What we found

“I see IIMS as a learning thing, not as getting into trouble. (. . .) trying to get across that you’re not... going to punish them. It’s more of a learning thing. I think it’s going to take time.”

- Nurse

“It is very much that they’re trying to encourage a no blame culture, (. . .) but whether they can do it or not is another question.”

- Doctor

Basically, we found that the goals of learning, as well as multiple kinds of accountability, are intertwined in clinicians' experiences of incident reporting, and are not fully reconciled.

For example, clinicians themselves express a dissonance between the message of using the IIMS for learning and the reality of their own experiences.

## Too troublesome to report

“... the manager rings you who obviously has to follow up and the comment is, are you causing trouble again for my staff? ...”

“If it’s a ... silly thing or a [late] medication or... giving the wrong... say, rate of fluid, I don’t even put an IIMS in about it any more. Because one, it takes a lot of time, and two, you get the comment, you making trouble for my staff again? So...”

- Senior Nurse

Taking a closer look at why this dissonance might be felt, we observed the reporting of near misses and minor incidents.

We found that when the threat to safety is not obvious or is minor, the act of reporting can be seen more as a ‘troublesome’ accusation of wrongdoing, something that is punitive because it takes time and effort to resolve, rather than a process of learning. This can then impact on local accountability between colleagues, such as in this case here, which then reduces reporting for such incidents.

## Reporting “at a distance”

i.e., without personal communication:

(from field notes of feedback session with nurses)

- communication between nurses decreases
- responding to / learning from errors takes more time
- nurses are frustrated at not being spoken to directly and corrected earlier

Next, another issue we found was that the IIMS can be used to report incidents ‘at a distance’, that is, without talking to the person or persons involved.

During a feedback session, nurses stated that they dislike this use of the reporting system. They suggested that communication between nurses has decreased as a result, it takes more time to respond to incidents and correct errors, and they generally feel frustrated, and preferred to be spoken to directly about their mistakes rather than finding out indirectly through an IIMS report

# Reporting “at a distance”

## When it might be useful:

(from field notes of feedback session with nurses)

- for “confronting” doctors and others with whom they might not communicate daily.
- junior/less experienced nurses might be less confident about approaching colleagues about an incident.

The nurses, however, also mentioned occasions in which it would be useful to report ‘at a distance’.

For example, they suggested that it could be useful for “confronting” doctors and others with whom they might not communicate daily, and that junior/less experienced nurses might be less confident than senior staff about approaching colleagues about an incident.

## On anonymous reporting

“... [It's saying] it should be IIMS, should be de-identified, where it should actually be, I made a mistake, this is a common mistake that other people would make, let's talk about it.”

- Junior doctor

Keeping that in mind, however, here we have a junior doctor responding to the suggestion by a researcher that a function of the IIMS is to allow people to report incidents without fear of retribution from supervisors and peers.

What she's pointing out is that this actually reinforces the idea that reporting is a shameful and hidden act and goes against the practice of talking about mistakes out in the open.

# Summary

1. Reporting of minor incidents:
  - can be seen more as a 'troublesome' accusation of wrongdoing (punitive) than a process of learning.
2. Reporting 'at a distance':
  - increases reporting by addressing fears of personal accountability (anonymously or without direct communication)
  - threatens socio-professional relationships
  - reinforces punitive conceptions of accountability
  - inhibits / delays learning

Here we have two examples of how learning and accountability are intertwined and in tension.

# Conclusions

1. Accountability is multifaceted and is *intertwined* with learning in incident reporting processes, policy and practice.
2. The effects of (multiple) accountabilities and learning goals are *mediated* through organisational-structural factors: e.g. time, hierarchy, team structures, channels of communication.
3. Demonstrates the value of using ethnography & looking at *in situ* practices, to better understand the *contextually-embedded* use of policy in practice.

Note: In this talk I presented examples where learning and accountability were felt to be in tension, to point out that the conflation of both aims in the one system was problematic, even if 'learning' was always placed at the forefront and 'accountability' was generally put at its service. I want to note however that there were also many examples in my data of when learning and accountability were more confluent, when clinicians did take on the 'forward looking' responsibility of using the IIMS for learning. So what I'm trying to say is not that the IIMS is a bad system, but rather that the goals of learning (and different forms of accountability) are complicated and intertwined, and not easily separated.

Also, the effects of these (multiple) accountabilities and learning goals are *mediated* through organisational/structural factors: e.g. time, hierarchy, team structures, channels of communication.

Finally, this study suggests that when we talk about the impact of incident reporting policy and processes, we need to examine what's happening *in situ*, to approach a more nuanced understanding of how the policy and the IIMS are influencing local practices.

Thank you for listening!



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