Optimizing Patient Safety: The Role of Incident Reporting in Healthcare

Dr May Thazin Aye
MBBS, MBA, CPHQ, FISQua
General Manager, Clinical Excellence and Quality
Pun Hlaing Hospitals

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20 December 2024

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Agenda

- ❑ Why Incident Reporting matters
- ❑ Key Benefits of Incident Reporting
- ❑ Common Barriers for Incident Reporting
- ❑ Steps in Incident Management

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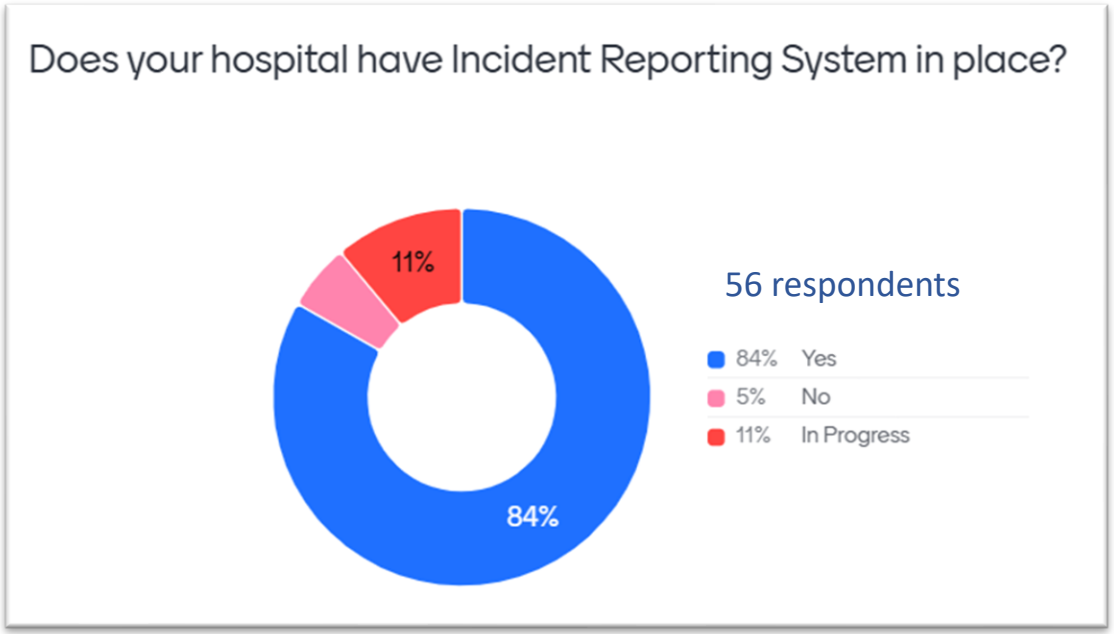
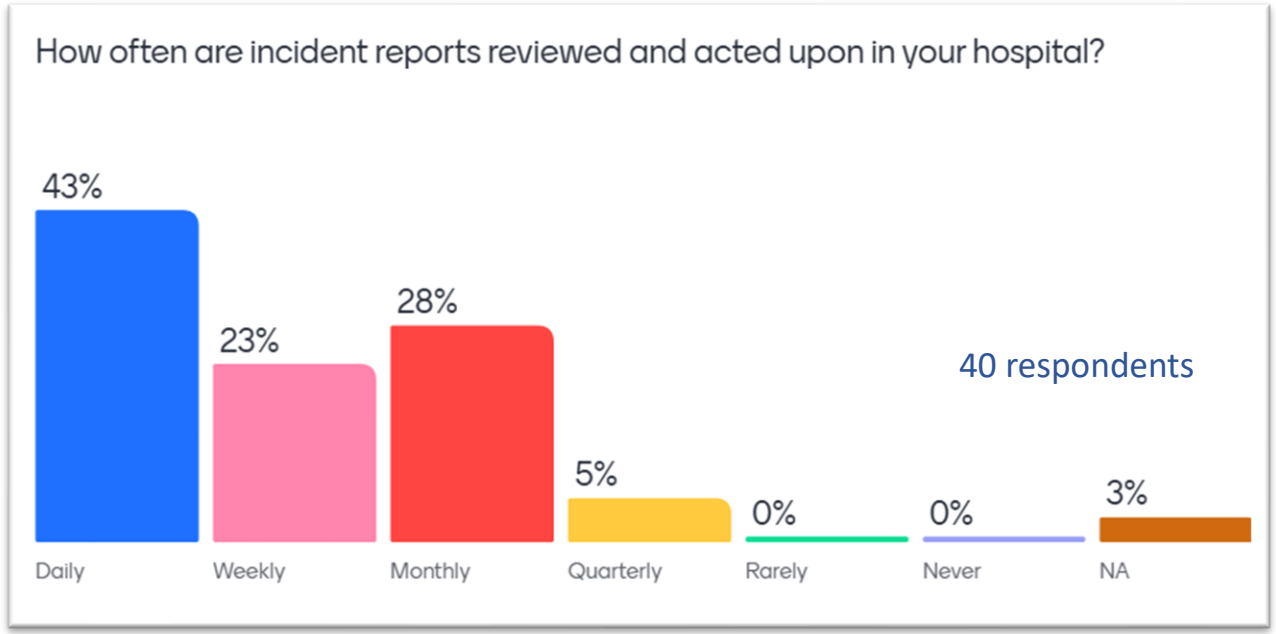
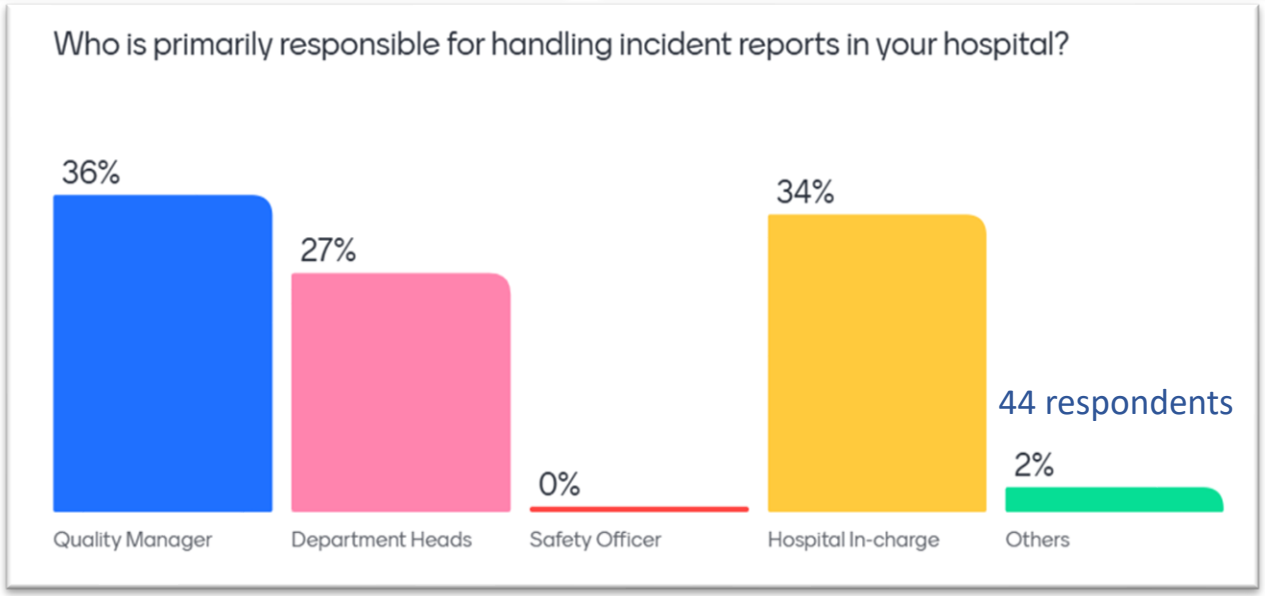
Current Practices in Incident Reporting and Management in MPHA Hospitals



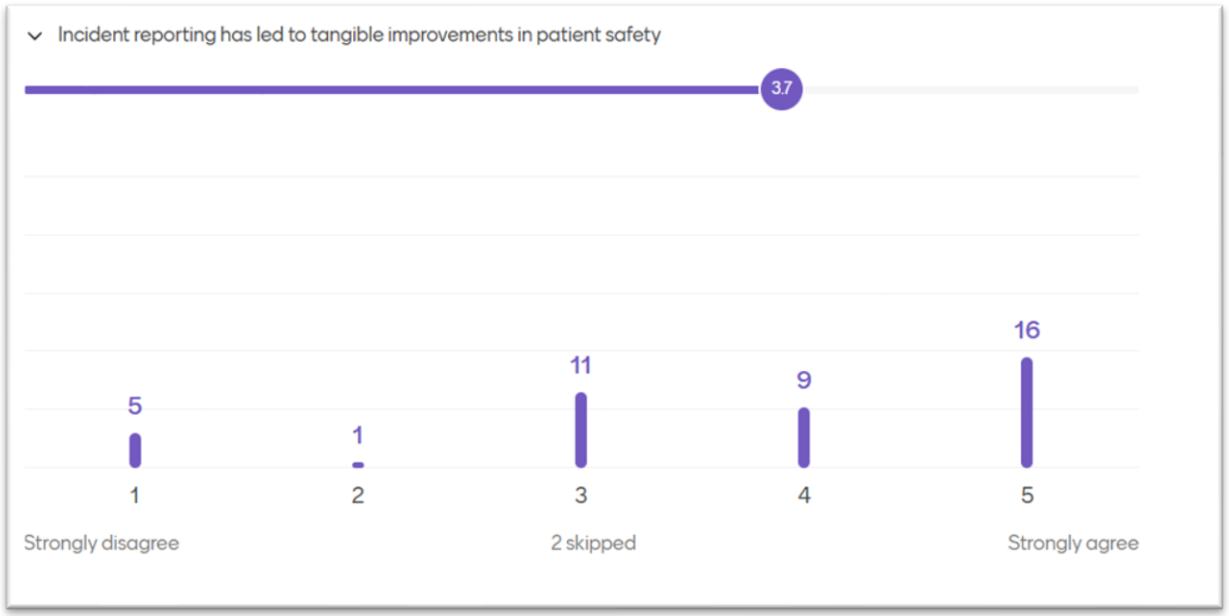




Audience responses during the sharing session

Current Practices in Incident Reporting and Management in MPHA Hospitals

Effectiveness of Incident Reporting in Your Hospital



44 respondents

Audience responses during the sharing session

WHY INCIDENT REPORTING MATTERS

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- Rapid growth and significant transformation of healthcare industry
- Presence of operational failures and mismatch between supply and demand pose challenges to provision of safe and effective care
- Increase the rate of medical errors, third leading cause of death in US following cancer and heart disease [1]
- 44,000 to 98,000 deaths occur in hospitals each year in US due to preventable medical error [1], IOM
- 850,000 medical errors each year in UK, 50% preventable

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WHO report [2023]

- 1 in every 10 patients is harmed in healthcare due to unsafe care [3]
- 50% of harm is preventable, 50% is due to medications. [3]
- LMIC, 4 in 100 people die from unsafe care. [3]
- Common Avoidable patient safety event: medication errors, unsafe surgical procedures, HAI, diagnostic errors, patient falls, pressure ulcers, patient misidentification, unsafe blood transfusion, and VTE.

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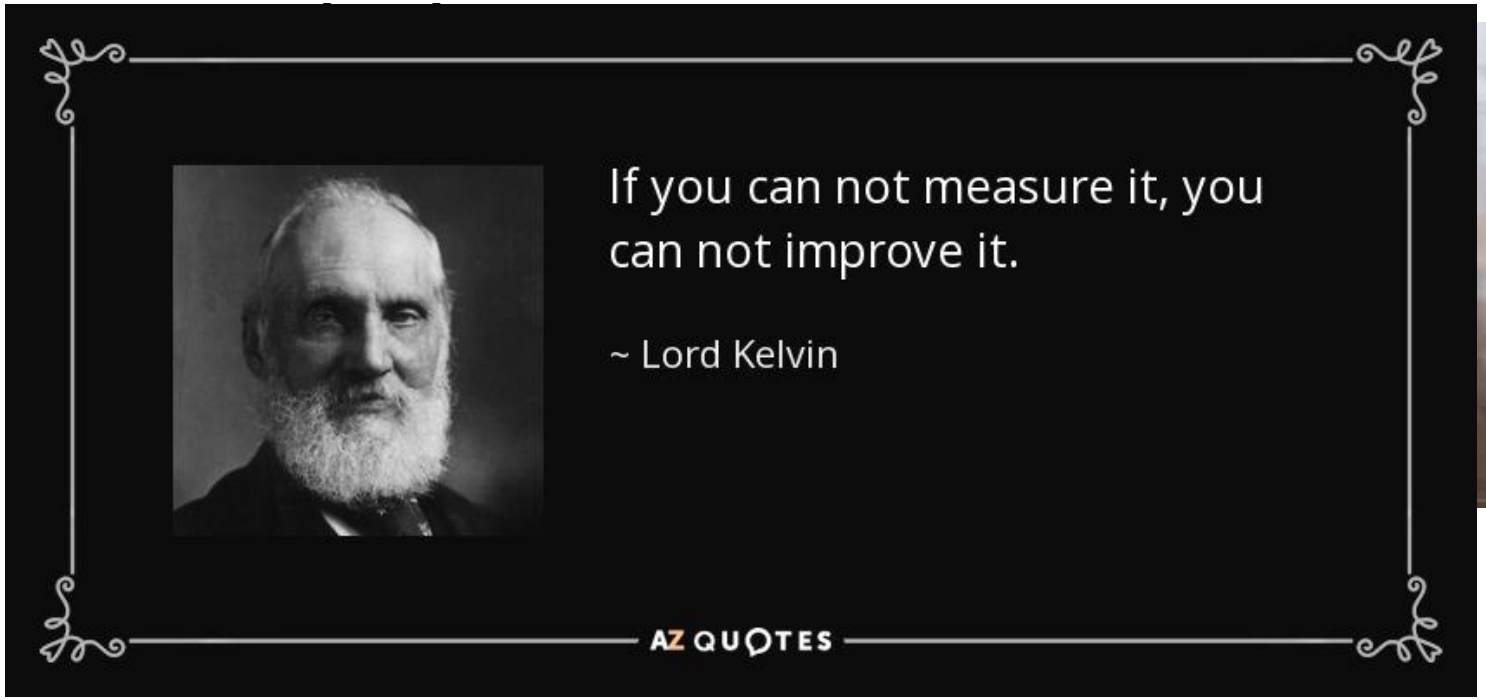

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KEY BENEFITS OF INCIDENT REPORTING

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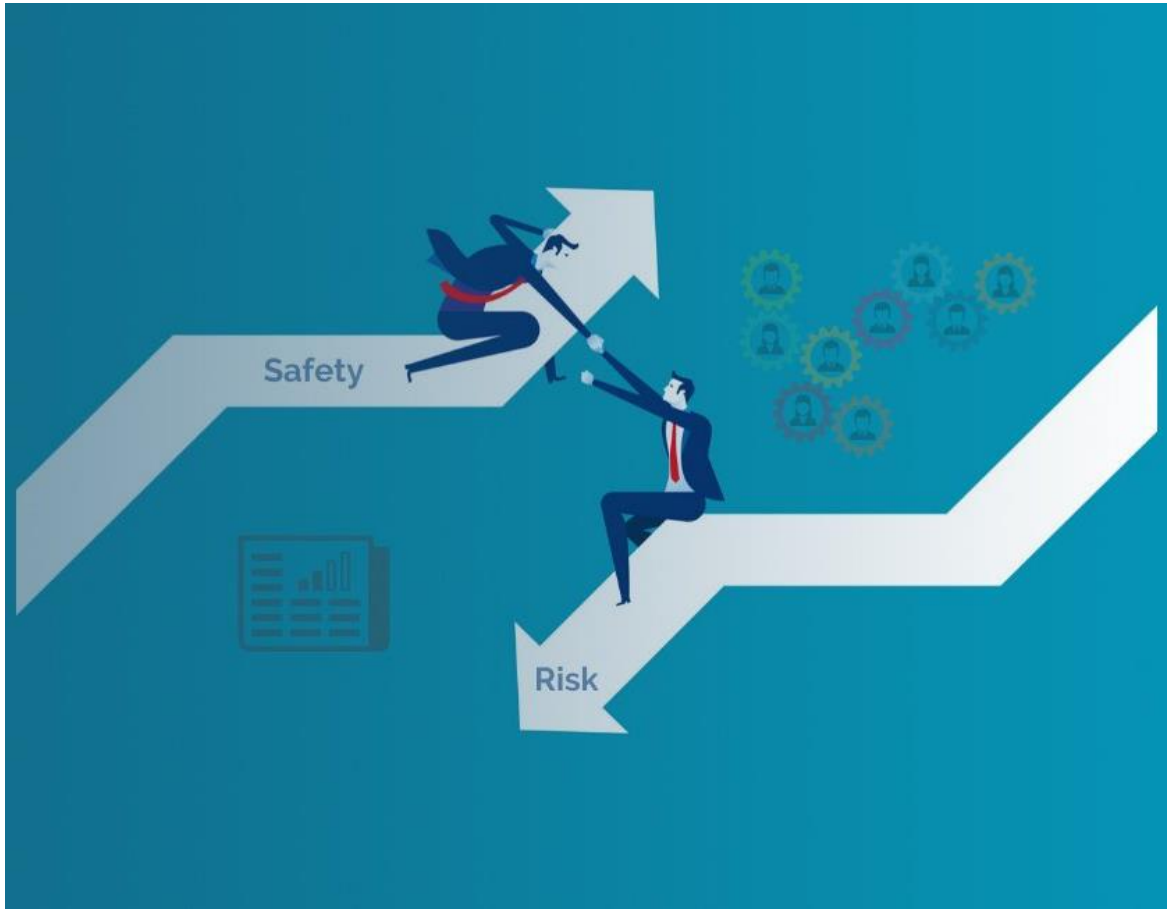

Enhancing Safety and Care Quality

Through reporting, analyzing, acting

- **Identify Risks**: Detect potential hazards that could compromise patient safety.
- **Prevent Future Errors**: Implement corrective actions to prevent the reoccurrence of similar incidents.
- **Improve Care Quality**: Continuously refine practices to ensure the highest standards of care.

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Facilitating Organizational Learning and Continuous Improvement

- Incident reporting is a **valuable tool** for organizational learning.
- Can **identify trends**, **uncover root causes**, and implement **system-wide changes**.

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Promoting a Culture of Transparency

Empowering Healthcare Professionals

- A strong reporting culture empowers healthcare professionals to **speak up** when they see something wrong or right.
- When staff members **feel safe to report** incidents without fear of blame or repercussion, it encourages **open communication** and **collective problem-solving**.
- This not only helps to prevent harm but also fosters a **sense of ownership** and **responsibility** among staff.

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Strengthening Trust with Patients/ Residents

- When health and social care organizations are transparent about incidents and committed to learning from them, it **builds trust** with patients or residents and their families.
- This trust is crucial for maintaining a positive relationship with the communities they serve.

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BARRIERS FOR INCIDENT REPORTING

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Barriers to Incident Reporting

What are the common BARRIERS to Incident Reporting in your hospital?

68 respondents

Audience responses during the sharing session

Barriers to Incident Reporting

Barriers for Incident Reporting

(Each participant was given two stickers and asked to place them on the two barriers they believed were the most significant obstacles to incident reporting.)

Areas For Improvement

s and discussions during the forum, the following areas for improvement have been identified:

ıess: Increase staff awareness about the importance its critical role in maintaining patient safety and

of Incident Notification Forms: Ensure that ms are easily accessible to all staff members, process and encouraging timely submissions.

ıbedding Just Culture Principles: Foster an ı communication about incidents is encouraged,

Develop and implement just cultu ensuring that these principles are co

4. **Strengthening Incident Follow-U** the follow-up and feedback proces staff receive timely and constructi continuous improvement.
5. **Regularly Monitoring and Re** monitoring and review processe

Recommended Improvement Actions

hancing staff awareness

nagers and supervisors play a crucial role in increasing staff awareness of incident reporting, foc owing actions will be implemented:

New Staff Orientation: Educate new staff on what incidents are, the importance of reporting them blame and just culture.

Manager/Supervisor Support: Managers and supervisors guide new staff in incident identif departmental briefings. To proactively follow up on unreported incidents.

Regular Education: Provide ongoing training on the incident management process to keep all staf

Incident Reporting Champions: Appoint champions in each department to promote best practice

Use of Technology: Leverage digital platforms for continuous learning and updates.

Recognition Program: Implement a program to recognize exemplary incident reporting efforts.

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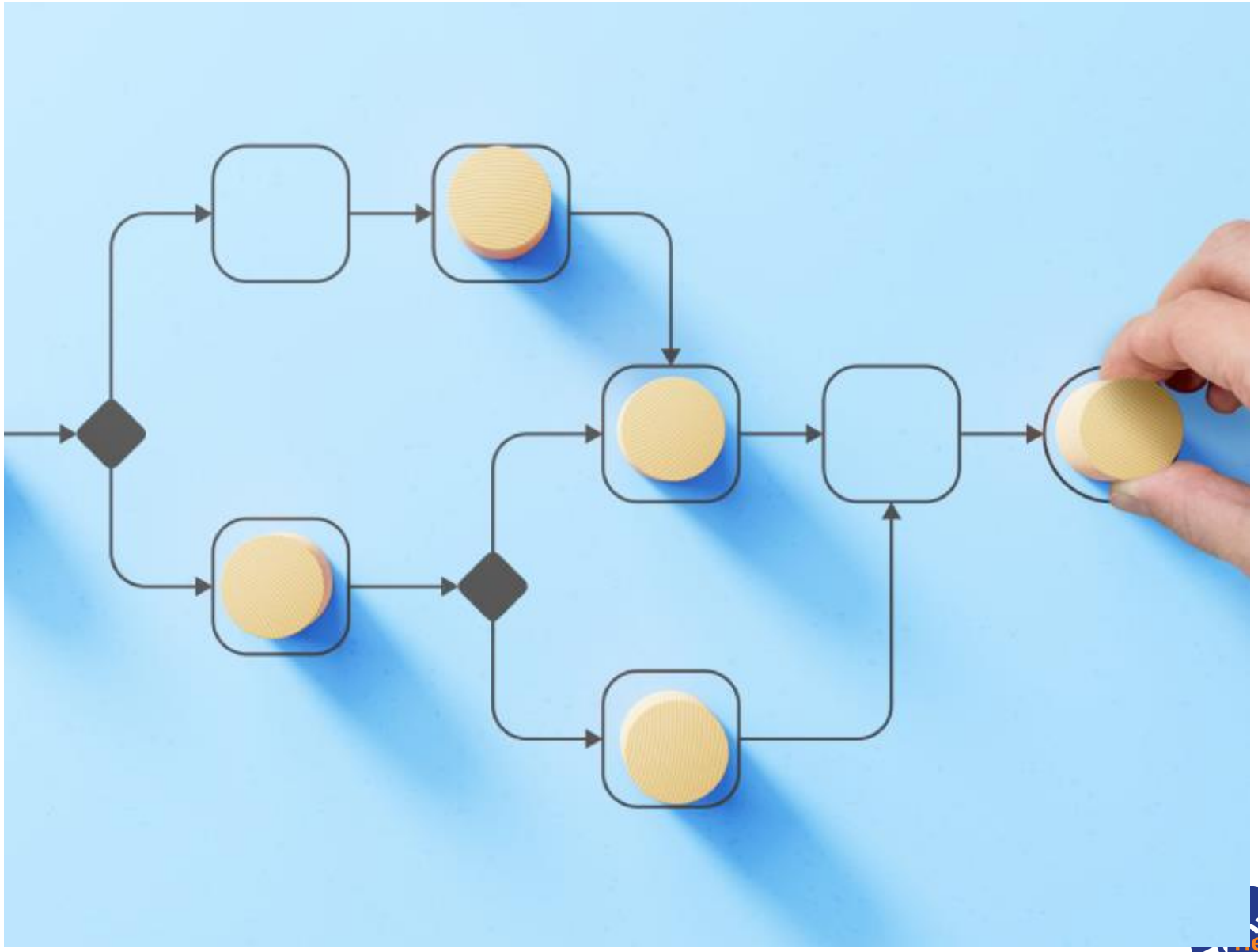
Steps in Incident Management



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Reference: Australian Commission on Safety and Quality in Healthcare, 2021, "Incident Management Guide

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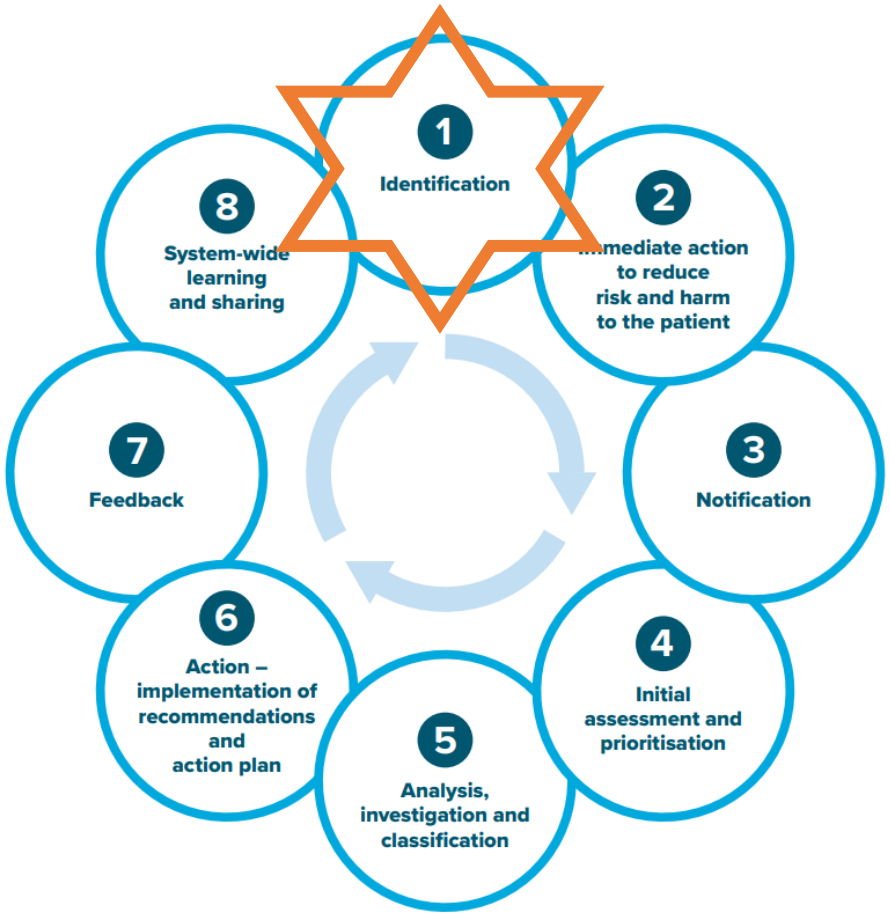
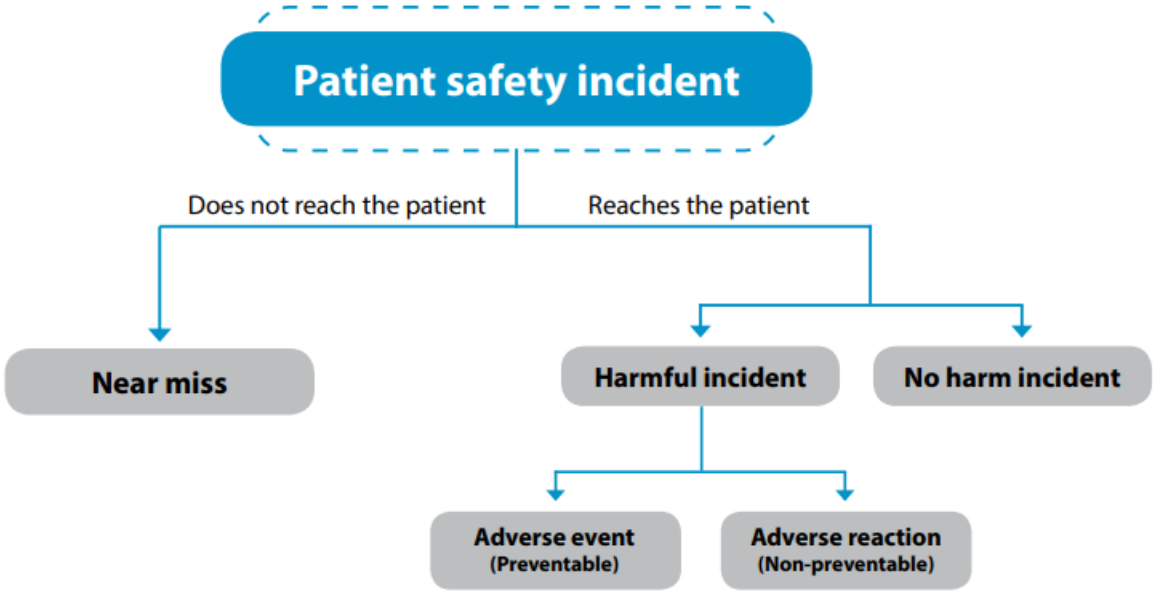


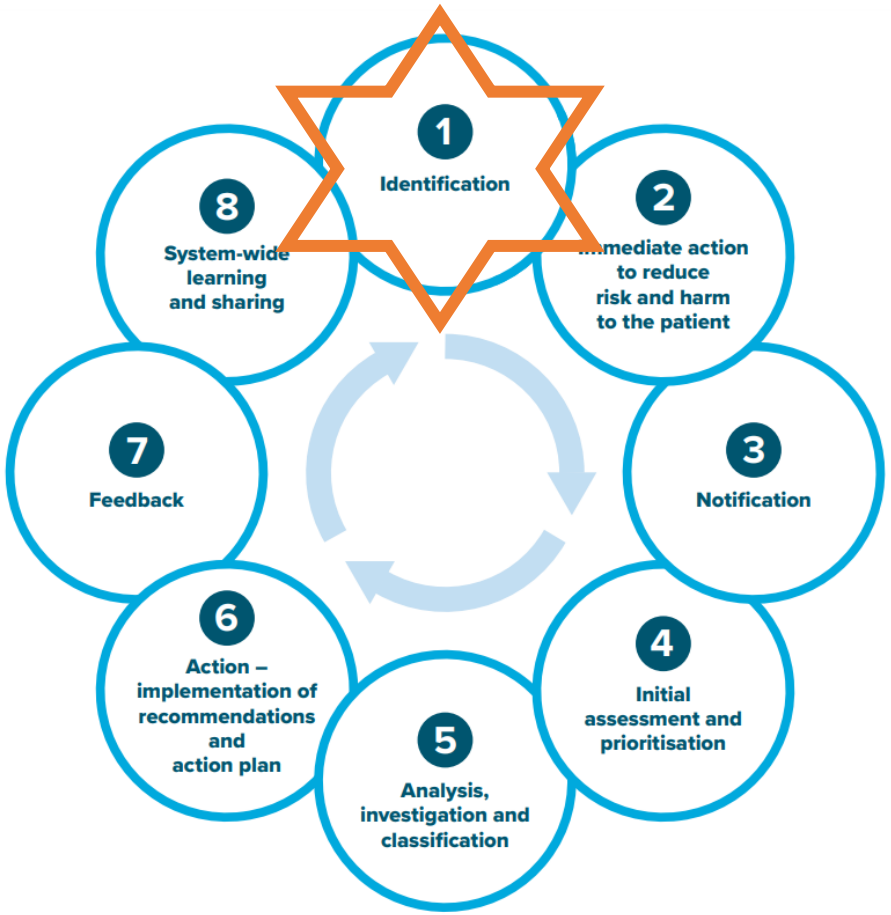
How do we recognize that things have gone wrong?

- Organizations should **define the purpose** of incident management system, what must be reported, **incident definitions**, **communication** to workforce.

Figure 1. Classification of patient safety incidents



Source: World Health Organization



How do we recognize that things have gone wrong?

- Organizations should define the purpose of incident management system, what must be reported, incident definitions, communication to workforce.

- **Sources of incident identification**
  - Direct Observation
  - Team discussion/meeting
  - Clinical review meetings
  - Death review process
  - Complaints
  - Monitoring variation in clinical practice
  - Audits
  - Chart reviews

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How do we minimize the immediate risk?

- Providing **immediate care** to the individuals involved
- Making a **situation/scene safe**
- **Notifying** the responsible manager and medical team as necessary
- Notifying security and authority (if relevant)
- Removing or managing **malfunctioning equipment or supplies**
- **Gathering information** about the chain of events
- Commencing the Open Disclosure Process

Open Disclosure

- **Open discussion of adverse events** that result in harm to a patient while receiving health care with the patient, their family and carers.
- **Not a one-way** provision of information. Open disclosure is a discussion between two parties and an exchange of information.
- Elements
  - an **apology or expression of regret**, which should include the words ‘I am sorry’ or ‘we are sorry’
  - a **factual explanation** of what happened
  - an opportunity for the patient, their family and carers to relate their experience
  - a discussion of the **potential consequences** of the adverse event
  - an explanation of the **steps being taken** to manage the adverse event and prevent recurrence.

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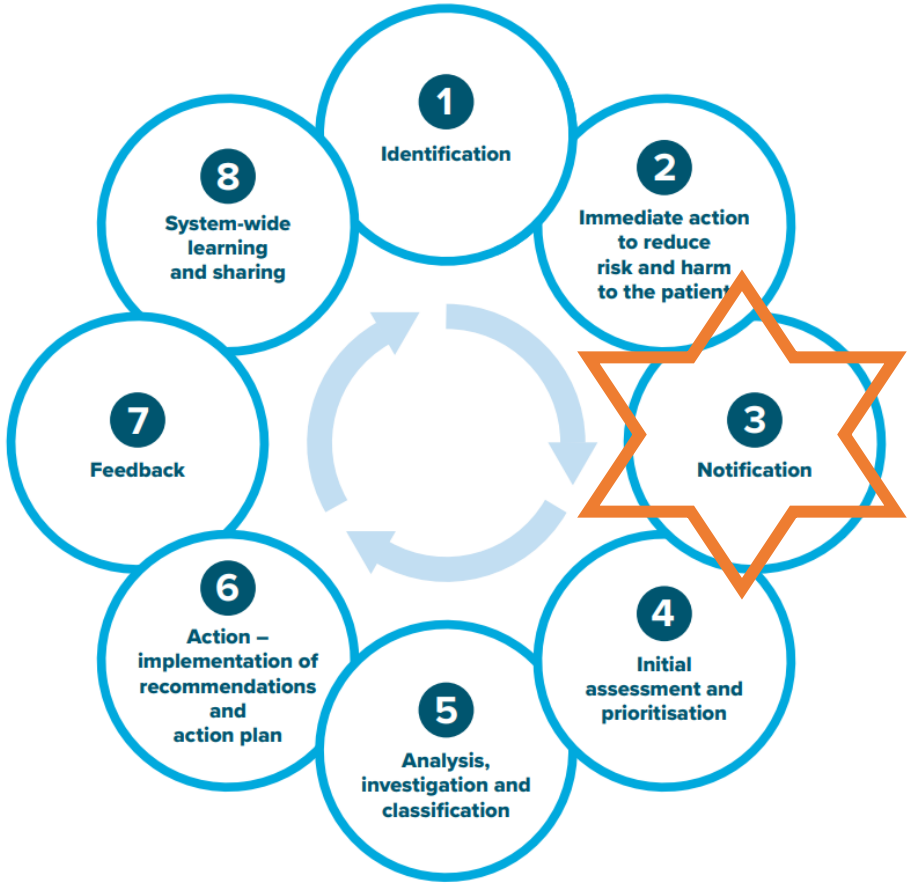

How do we report the incident?

- Notification
  - Simple
  - Minimal time
  - Anonymous option
  - Objective and factual information
  - Reporting timeline
  - Avoid identifiable details

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Do we have all the information we need? How serious is the incident?

- Review the incident within identified timeframe
- Ensure accuracy, quality, completeness of information
- **Severity and Likelihood** Rating
- Decide on level of Open Disclosure
- Ensure **escalation** to Chief Executive(s) if relevant

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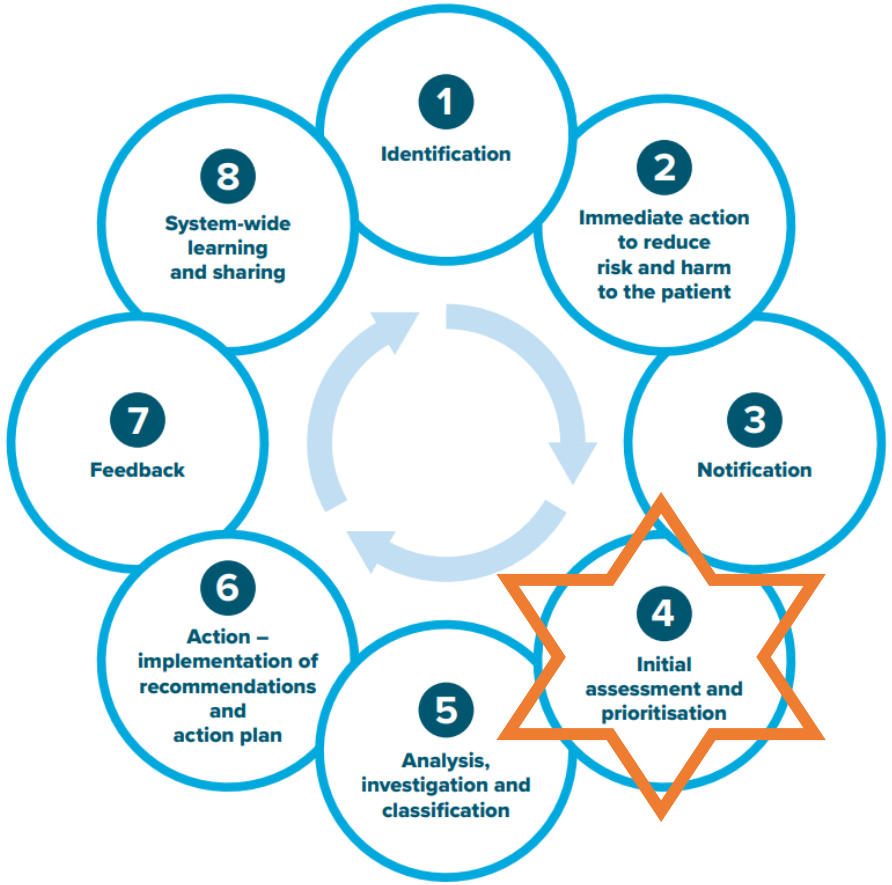

Appendix 6: SAC scoring: SAC matrix

		Consequence				
		Serious	Major	Moderate	Minor	Minimum
Likelihood	Frequent	1	1	2	3	3
	Likely	1	1	2	3	4
	Possible	1	2	2	3	4
	Unlikely	1	2	3	4	4
	Rare	2	3	3	4	4

Consequence Rating	Likelihood Rating	SAC scoring
Moderate	Rare	SAC 3
Minimum	Rare	SAC 4
Minimum	Rare	SAC 4

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What happened?
How and why it happened?
What actions can be taken to prevent similar incidents?

- In-depth and detailed investigation for high severity rating
- Main goal of investigation is **to assess the system**, **not to blame** people involved.
  - Be conducted within the principles of fair procedures and natural justice: **JUST CULTURE** principle
  - Be documented in accordance with policy and procedures
  - Be undertaken by MDT
  - **Validated** methodologies/tools by **Trained** staff
  - Independent investigation (for complex cases)
  - Recommendations of Actions

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What happened?
How and why it happened?
What actions can be taken to prevent similar incidents?

An incident is just the tip of the iceberg, a sign of a much larger problem below the surface.

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How do we improve?
How will we know we have improved?

- Recommendations arising from investigations and analysis
  - Should address the identified **contributing factors**
  - Consider the strength using the **hierarchy of effectiveness**
  - Consider patient perspective and suggestions
  - Consider suggestions from workforce, frontline staff
  - SMART format
  - Responsible person for each action
  - Timeframe for recommendation
  - Approval

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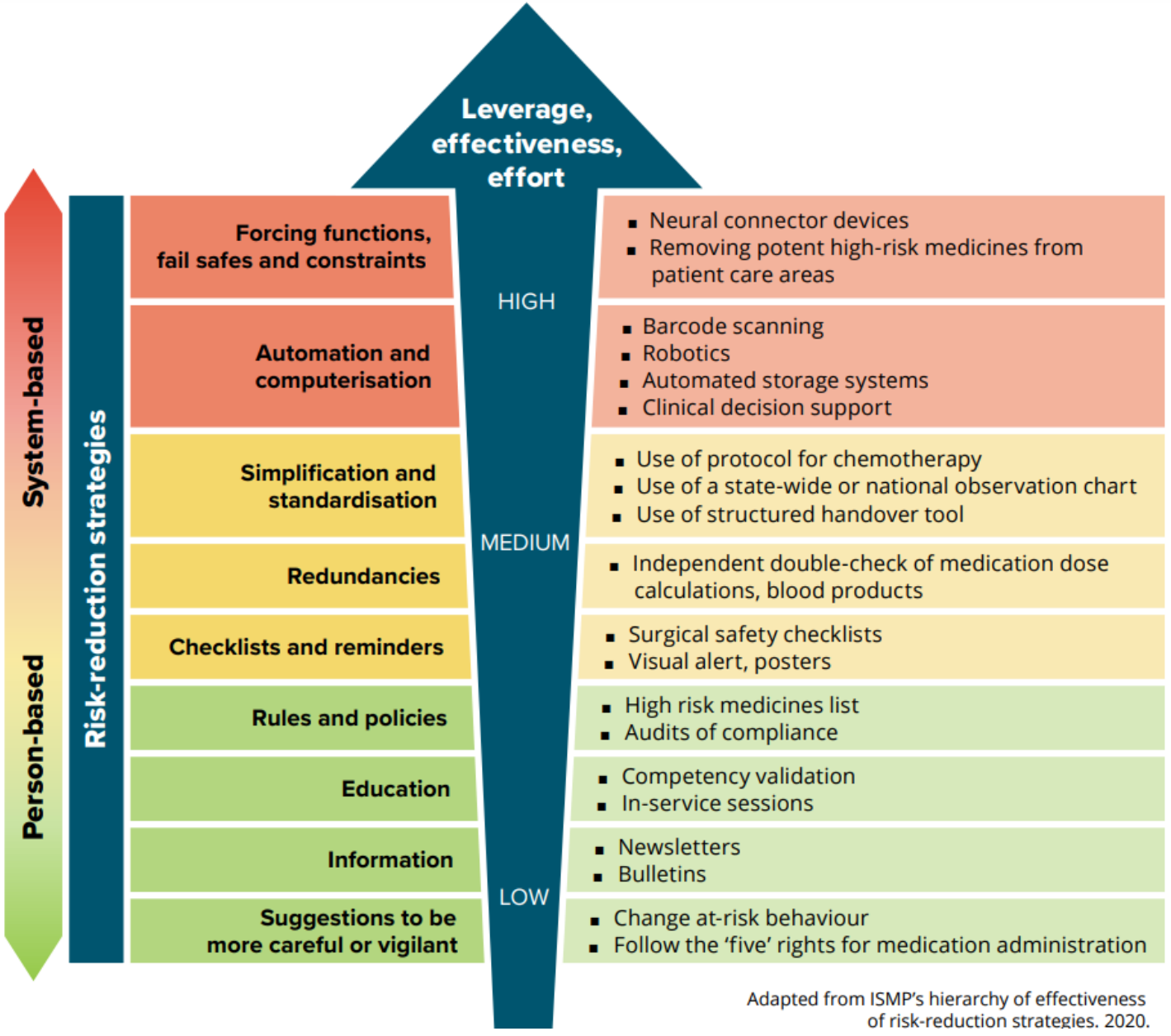
Hierarchy of Effectiveness



Adapted from ISMP's hierarchy of effectiveness of risk-reduction strategies. 2020.

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Action Strength

TABLE A-2. ACTION STRENGTH

Action Strength	Action Category	Example
Stronger Actions (These tasks require less reliance on humans to remember to perform the task correctly)	Architectural/physical plant changes	Replace revolving doors at the main patient entran sliding or swinging doors to reduce patient falls.
	New devices with usability testing	Perform heuristic tests of outpatient blood glucose the most appropriate for the patient population be
	Engineering control (forcing function)	Eliminate the use of universal adaptors and periph equipment and use tubing/fittings that can only be IV tubing and connectors that cannot physically be compression devices [SCDs]).
	Simplify process	Remove unnecessary steps in a process.
	Standardize on equipment or process	Standardize the make and model of medication pu institution. Use bar coding for medication adminis
	Tangible involvement by leadership	Participate in unit patient safety evaluations and in RCA[2] process (root cause analysis and action); pur staffing and workload are balanced.
Intermediate Actions	Redundancy	Use two registered nurses to independently calcula
	Increase in staffing/decrease in workload	Make float staff available to assist when workloads
	Software enhancements, modifications	Use computer alerts for drug–drug interactions.
	Eliminate/reduce	Provide quiet rooms for programming patient-con

Reference: Joint Commission International, 2020, "Framework for RCA and Corrective Actions"

How do we tell people what happened and what we did to improve safety?

- **Timely and meaningful feedback** to stakeholders is a key success factor an incident management system.
- Feedback to:
  - Patients, carers, and families
  - Staff who notified and were involved
  - Safety and quality committees
  - Other members of the workforce

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How do we learn from incidents?
How do we share what we learnt?

- Aggregated analysis of all safety data

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Best Practice Case Study

Best practice case study

This case study has been developed to illustrate the best practice principles outlined in this guide.

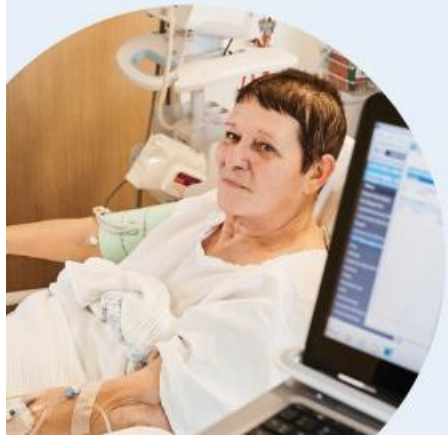
1 Identification

A nurse, Cameron, working on a surgical ward, administered a post-surgical patient, Ms Judith Griffiths, a 10-fold dose of morphine. This was despite a double check being done with another nurse, Julie. Shortly afterwards, Ms Griffiths became drowsy with slurred speech, and had an acute respiratory depression followed by an arrest.

2 Immediate action to reduce risk and harm to the patient

Cameron assessed Ms Griffiths airway, provided oxygen via a mask, supported her jaw, and called for help, and the rapid response team. While the team was managing Ms Griffiths, Cameron realised that a dosing error had occurred. A reversing agent was administered and Ms Griffiths made a full recovery. The nurse unit manager, Joanna, and home medical team were informed.

Joanna offered support to Cameron and Julie and gave both of them information on the hospital's staff counselling service in case they needed it. Joanna also held a debriefing session with all clinicians involved.



3 Notification

Once Cameron was sure that Ms Griffiths was safe, he self-reported the incident into the hospital's electronic incident management system (EIMS). He also updated Ms Griffiths's medical record with a summary of the incident.

4 Initial assessment and prioritisation

Joanna was alerted that the incident had been reported as the EIMS automatically sent her an email. Given that Ms Griffiths made a full recovery but required resuscitation, Joanna assessed the incident as the second highest level of severity or harm.

Joanna and a medical consultant, Michael, had an initial discussion with Ms Griffiths on the day of the incident. Joanna and Michael informed Ms Griffiths that she was inadvertently given a higher than prescribed dose of morphine. Ms Griffiths was assured that she would not have any effects or complications from the overdose. Joanna apologised and informed her that an investigation will be undertaken to identify measures that can be put in place to prevent a similar occurrence. They discussed the nature of the investigation and asked Ms Griffiths about her expectations.

Joanna and Michael checked whether Ms Griffiths had any unanswered questions or concerns and whether she would be willing to be involved in the investigation. Ms Griffiths agreed to be interviewed as part of the investigation. Joanna and Michael also told her that she would be informed of the results of the investigation which were expected in four to six weeks.

5 Analysis, investigation and classification

Joanne interviewed Cameron and Julie separately the next day with a support person present at their request. Cameron described how he was asked to stay late due to a staff member being called in sick. He had just been asked to do a ward round with a doctor, was behind in his medication duties, and was quite tired. He misread the dosage on the computer on wheels. Julie also described how busy the ward was and that she was receiving a handover from the emergency department for two new admissions.

Joanna interviewed Ms Griffiths by telephone one week after her discharge from the hospital. Ms Griffiths said that she felt that the staff were very busy that day and were trying to catch-up all the time. Despite noticing how busy they were, she appreciated that the staff remained professional and caring at all times.

Joanna asked the Safety and Quality Director who she knew had human factors expertise to review the incident. The Director noted that trailing zeros are displayed in the electronic medication chart. According to the **National Guidelines for On-screen Display of Clinical Medicines Information**, trailing zeros are a known risk for 10-fold dosage errors. Joanna also sought advice from the Pharmacy Department, and Information Technology Department on the types of recommendations that would be more likely to be effective and sustainable over time.

In the EIMS, Joanna recorded the incident type:

- Medication type → overdose
- Contributing factors → fatigue, staff shortages, electronic medication management (EMM) system design issue.

6 Action – implementation of recommendations and action plan

Joanna updated the findings from the investigation in the EIMS, including the recommendations with dates of completion, and owners.

Joanna requested that the trailing zeros in the EMM system be placed on the organisational risk register as it was likely to lead to further incidents. One recommendation was that the Safety and Quality Director was to write to the EMM system vendor within two weeks to request a formal change to the software within 12 weeks.

As an interim step, the Pharmacy Department highlighted the inherent risk in the EMM system in their newsletter, and the Director sent an email to all clinicians.

The EMM system vendor developed and tested a fix and included it in their scheduled upgrade which was 12 weeks after the incident. They verified that the trailing zero problem was now no longer appearing for any medications. The risk was removed from the risk register at the hospital's next organisational risk committee meeting. The findings were also fed back to the relevant quality and safety committee. The committee recommended that the Director of Pharmacy and Information Technology Department review the national guidelines and ensure that all of the recommendations were appropriately implemented.

7 Feedback

Joanne and Michael met Ms Griffiths after the investigation was completed when she was attending the hospital for an outpatient appointment. They broadly outlined the investigation's findings and a summary of recommendations. Ms Griffiths was satisfied that the hospital had taken the matter seriously, had investigated thoroughly, and that the recommendations were being put in place so that a similar incident was unlikely to happen again.

Joanna also met with Cameron and Julie to update them on the actions arising from the investigation and their progress. Joanna also asked if they were experiencing any distress and required any further psychological support. Cameron and Julie appreciated the offer of help but did not require any intervention or further support.

Joanna used the staff meeting six months later to remind staff of the changes to the EMM system and that no further incidents have been recorded. Joanna also continues to reinforce to staff on a regular basis the importance of notifying incidents.

In the hospital's bi-monthly safety and quality newsletter the change in the EMM system was explained with a de-identified summary of the incident.

8 System-wide learning and sharing

The Safety and Quality Director informed the Department of Health about the incident and the follow-up action. The Department of Health wrote to all hospitals in the state to review their EMM systems for similar trailing zero issues. Hospitals were also asked to ensure that their systems were consistent with the national guidelines.

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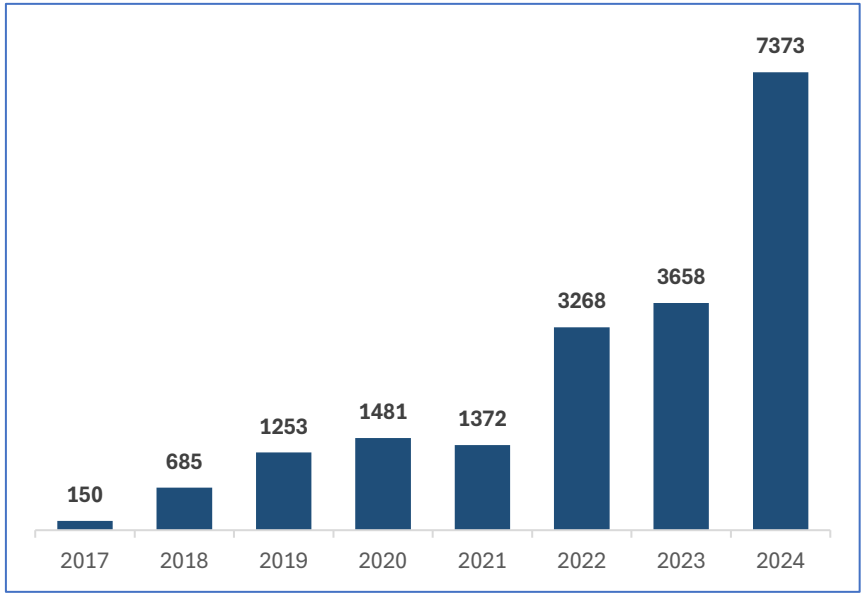
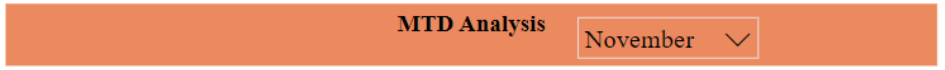
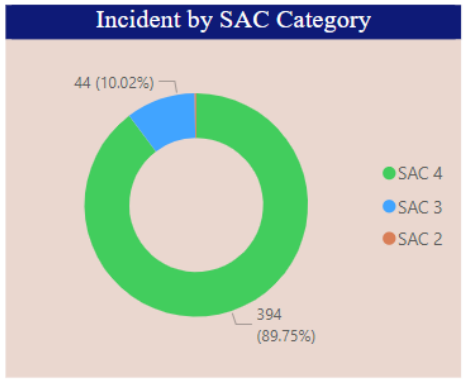
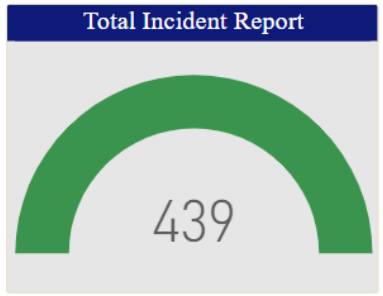
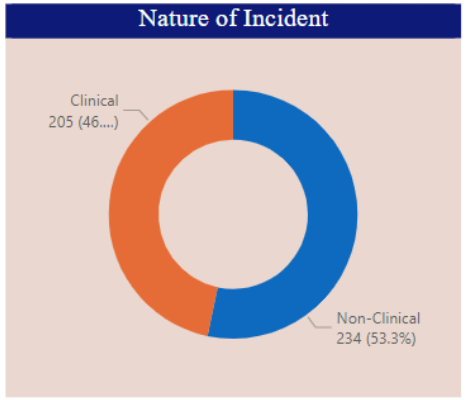


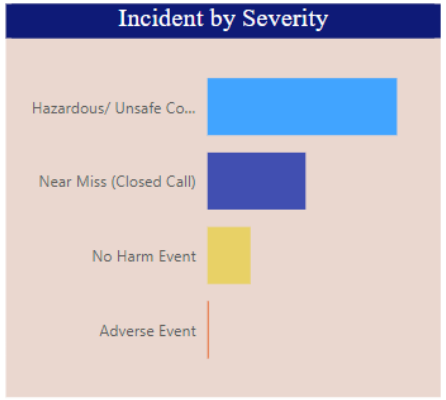
Category	Description of Medication Error
A	Potential error
B	Error, did not reach the patient
C	Error, reach the patient, no harm
D	Error, reach the patient, require monitoring, no harm
E	Error, temporary harm, require intervention
F	Error, temporary harm, require initial or prolonged hospitalisation
G	Error, permanent patient harm
H	Error, require intervention necessary to sustain life
I	Error, patient death.

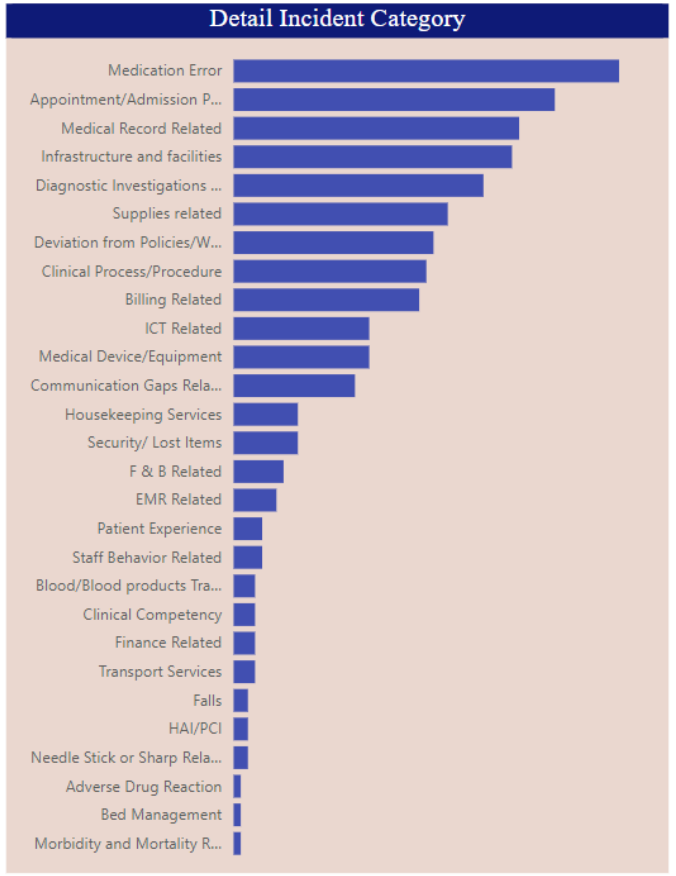


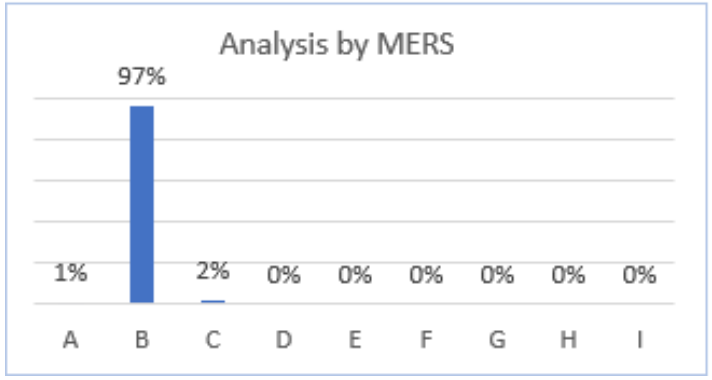












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Sample Analysis and Incident Dashboard

Summary

- ✓ Why Incident Reporting matters
- ✓ Key benefits of Incident Reporting
- ✓ Common Barriers for Incident Reporting
- ✓ Steps in Incident Management
- ➢ Roles and Responsibilities

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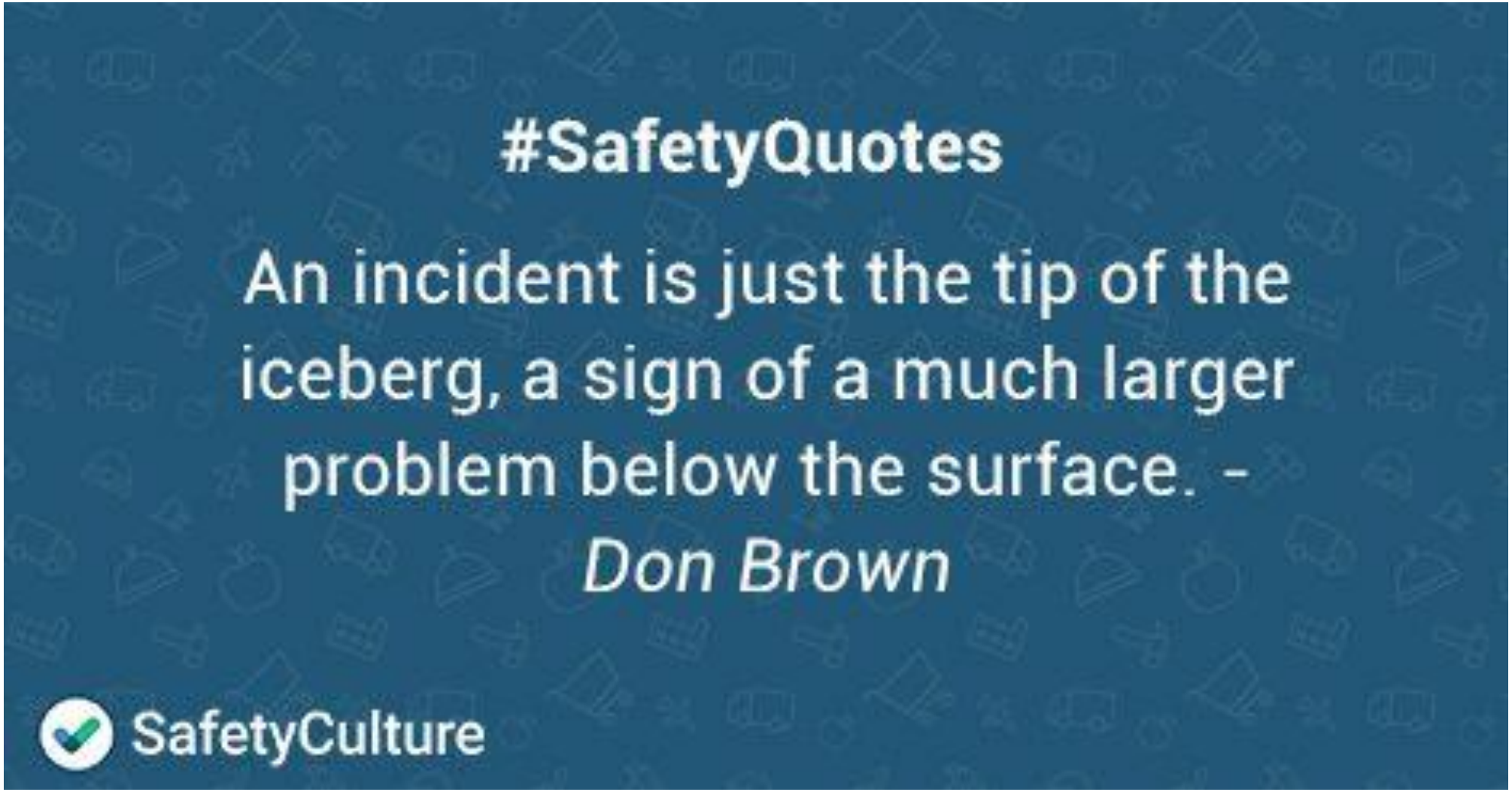
#SafetyQuotes
An incident is just the tip of the iceberg, a sign of a much larger problem below the surface. -
Don Brown
SafetyCulture

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Q&A

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Thank You

www.punhlainghospitals.com

Pun Hlaing Estate Avenue, Hlaing Tharyar Township,
Yangon, Myanmar
Tel: +95 9 772 88 99 22

maythazinaye@punhlainghospitals.com
+95 943074994