

Clinical Governance in Action

Incident reporting improves safety: the use of the RAID process for improving incident reporting and learning within primary care

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Introduction

Since its inception in April 2003, to March 2005, Rhondda Cynon Taff Local Health Board had only received six incident reports from practitioners. This significant under-reporting raised concerns and identified a need to consider how incident reporting could be improved.

Staff from the clinical governance directorate and primary care team at Rhondda Cynon Taff Local Health Board therefore joined forces with the National Patient Safety Agency to participate in the Welsh Assembly Government's RAID programme (Review, Agree, Implement, Demonstrate) to undertake a project to improve incident reporting across Rhondda Cynon Taff.

The purpose of the RAID programme has been to offer practical support to NHS organisations in Wales in their implementation of clinical governance. The aim of the programme is to lead to sustainable

improvements in services to patients by providing an environment for teams to challenge and question current situations and so consider changes for the future.¹ The 18-month programme involves attending five residential workshops which facilitated 'team time' to develop and improve their projects. The programme was based upon the Modernisation Agency's work in England.²

RAID

The RAID model, the design used for the project, has been described in detail elsewhere,² but basically involves:

- reviewing the current reality

- agreeing what changes need to be made
- implementing those changes
- demonstrating improvement.

IRIS

The team named the project IRIS; ‘Incident Reporting Improves Safety’. The aim of the project was ‘to develop a system to encourage primary care contractors to report incidents/near misses and to promote the key message that reporting can improve patient safety’.

The National Patient Safety Agency (NPSA) was set up in 2001 as part of the drive to improve the quality of care in the NHS by establishing and managing a national reporting and learning system for adverse events or near misses. Every day, more than a million people are treated safely and successfully within NHS-funded primary care. However, given the diversity and complexity of the sector, things will and do go wrong, no matter how dedicated and professional staff are.³

Despite Rhondda Cynon Taff Local Health Board being an ‘early adopter’ of the NPSA’s National Reporting and Learning System (NRLS) and ensuring that every GP practice had electronic access to the system, reporting levels remained low; little information was shared with the local health board, and consequently lessons could not be shared across the primary care community.

The IRIS team therefore decided that a more effective methodology for involving primary care in reporting and learning from patient safety incidents was required.

The following benefits of the project were envisaged:

- by identifying near misses and minor problems at an early stage, major patient safety incidents would be reduced, thus providing safer and more effective care for patients, carers and their families

- staff would learn from incidents in a supportive environment
- the organisation would improve the quality of care by sharing lessons learned across practices in Rhondda Cynon Taff, thus meeting its own core objectives and values, as well as contributing towards national learning.

The key objectives of the project were to:

- promote an open and fair culture across the local health board
- raise awareness of the need for reporting incidents
- improve the reporting of patient safety incidents
- ensure that lessons learnt from patient safety incidents are shared across the local health board area.

Review

The review of the current position was multifaceted and is described below.

Literature review

A limited literature review was undertaken, particularly looking at publications from the NPSA and data already collated in-house from significant event audits. Adverse events in the NHS are thought to cost more than £3 billion of limited resources every year. The publication, *Building a Safer NHS for Patients – implementing an organisation with a memory* points out that there are few, if any, quick fixes to this problem, and successful clinical incident reporting and learning from errors and adverse events is the way forward.⁴ An extensive literature search was not completed, as expertise from the NPSA formed part of the project team.

Figure 1 highlights the potential correlation between improved incident reporting and the number

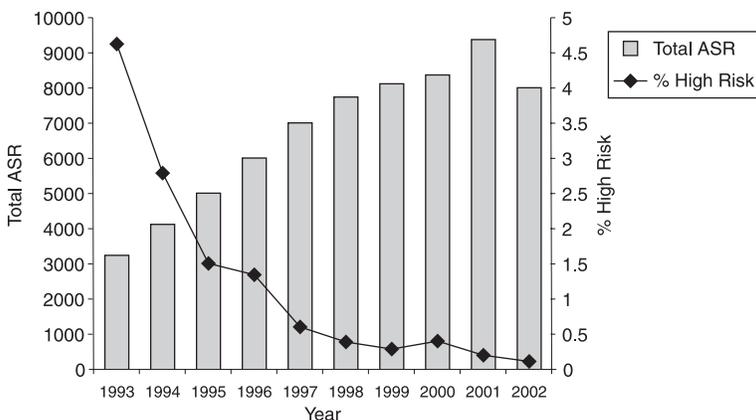


Figure 1 Air safety data (source British Airways Authority)

of high-risk air safety reports over a 10-year period. While some of the improvement may be due to other factors, such as technology improvements, the correlation demonstrated is nevertheless felt to be highly significant.

Deployment flow chart

The deployment flow chart (see Figure 2) indicated the existing situation in the process of incident reporting. It highlights that the process is complex, with many areas where decisions may be made not to report. This complexity is in itself confounded by the data collected on the number of organisations involved with reporting incidents of different natures.

Ishikawa analysis

The team also undertook an Ishikawa analysis (see Figure 3). The main finding was the large number of factors that may contribute to non-reporting to the local health board in all areas of the ‘fishbone’. These included issues with regard to people, the environment, and the methods and means of reporting incidents.

Questionnaire

A questionnaire was developed to assess what might be preventing practices from reporting and what might encourage them to report. A pilot was initially undertaken to ensure face validity. The questionnaire was then sent to all general practitioners (GPs), practice managers and nurses; practices were also asked to distribute the questionnaire to all other staff within their practice. As it was intended to also use focus groups, a second posting was not used. The results are shown in Table 1. Overall, 60 people responded out of a possible total of 237; 26 GPs, 12 practice nurses, 16 practice managers and 6 unknown, who were sent questionnaires. Of these, 55 indicated that they did report incidents. Even though the return rate for the questionnaire was encouraging, very few respondents answered a majority of the questions (hence the low figures outlined).

The common trends that colleagues in the different practices identified as to why they had not reported in the past, or why they had only done so occasionally and what would have encouraged them to do so in the future were as follows:

- to avoid further problems and to eradicate them
- a clear guarantee of confidentiality for all involved
- clear-cut guidelines for reporting.

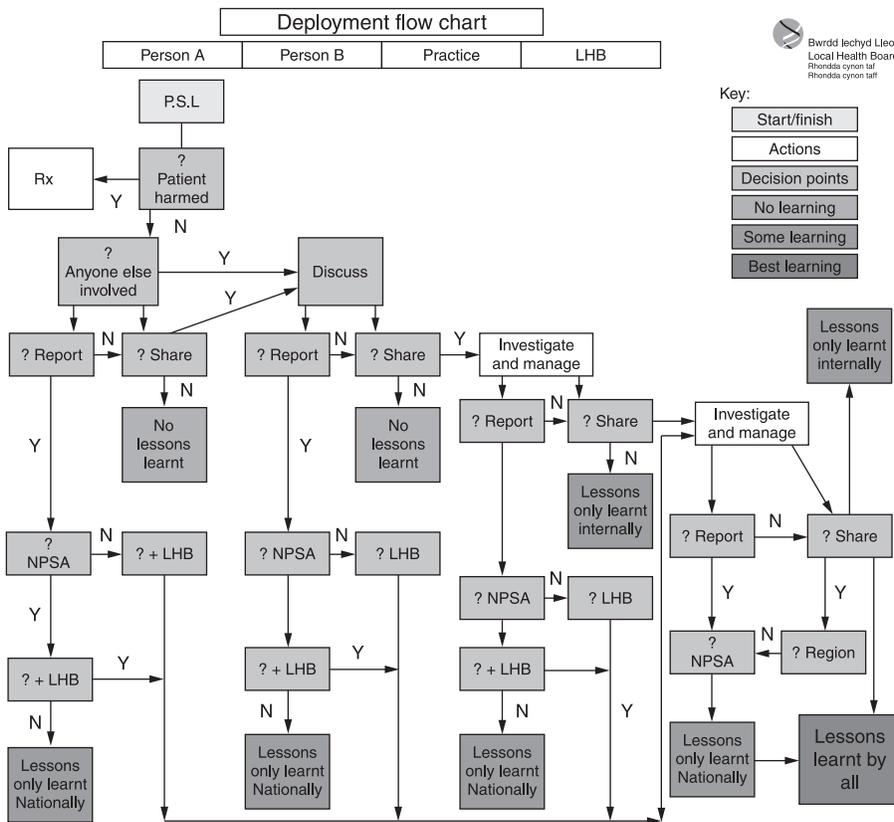


Figure 2 Deployment flow chart

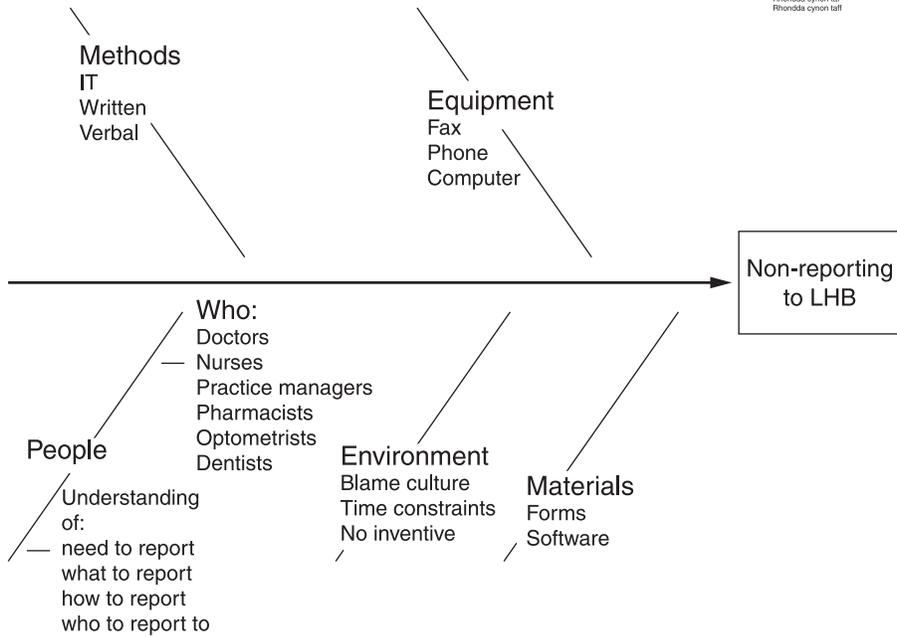


Figure 3 Ishikawa diagram (fishbone)

Table 1 Responses to the questionnaire

	Disagree	Partially disagree	Partially agree	Fully agree
The practice is yet to agree what incidents to report	7	1	1	1
I am unsure who to send the report to	6		1	1
I find it too time consuming	7		1	
I am reluctant to apportion blame	6		2	
I do not like admitting I have made a mistake	2		2	
I am concerned about the implications	5		3	
I have not identified any incidents to report	4	2		2
I am concerned about confidentiality	4	2	1	1
I do not accept the value of reporting incidents	7	1		

Specific groups raised other issues. Administration staff wanted better safety policies for staff and the provision of guidelines and instructions. GPs wanted a simple user-friendly process with clear definitions of the implications of reporting. They also raised the issue of a learning, positive culture which attached no blame to the incident under review. Protected time for the process of incident review and investigation was another theme that GPs raised. Nurses however identified that the process should be inclusive for the whole team, so reducing the risk of bad feeling within the practice when incidents were reported. They also highlighted the need to learn as a team, to improve the workplace and work style, and also to learn from others external to the practice.

In general, the main findings were that there was a lack of knowledge of reporting incidents in general, and in particular of who such incidents should be reported to. Fewer than five practices reported to the NPSA; all other practices demonstrated poor awareness of the NPSA and its process. The local health board itself was only likely to become aware of incidents via submission of the Quality and Outcomes Framework data.

Focus groups

Focus group visits were undertaken at eight randomly selected practices from each of the Rhondda Cynon Taff Valleys. Some focus group participants had responded to the questionnaire previously discussed.

The findings were similar to the responses to the questionnaire and provided confirmation of the responses. However, they also indicated the wide variation in attitude to reporting in practices.

- 'We do not have incidents to report.'
- 'Incidents are reported within practice.'
- 'The practice manager deals with all forms.'
- 'Not sure who incidents need to be reported to, it all sounds very complicated.'
- 'Staff discuss incidents in practice meetings.'

Agree

A team workshop was held to review the findings and compare the available data. The qualitative responses to the questionnaires and focus groups were noted to be particularly helpful in looking at opportunities to improving incident reporting. These were identified into five main themes:

- 1 the knowledge of the need for and the benefits of incident reporting
- 2 confusion regarding the process
- 3 culture within practices
- 4 barriers to reporting
- 5 enablers to reporting.

It was agreed that the main requirement was to develop a simpler process, raise awareness and knowledge of incident reporting amongst practices, and share lessons learnt across Rhondda Cynon Taff to promote the value of incident reporting in the long-term.

Implementation

The themes were used by the team to develop an action plan. The action plan contained specific tasks set within time frames, and nominated individuals responsible for ensuring implementation. The main actions agreed by the team were:

- to develop a simpler system and process for reporting incidents
- to target key individuals who would be influential in ensuring implementation of a reporting system, e.g. GPs and practice managers
- to produce clinical governance newsletters with regular updates of examples of lessons learnt
- to raise awareness during practice development visits and clinical governance visits
- to hold a workshop for all staff to attend in March 2006.

Demonstrate

The team held a workshop in March 2006 for all primary care staff to demonstrate the process and outcomes of the project, highlighting the importance of incident reporting and the sharing of lessons. Early results have indicated that there had been an increase in the number of reported incidents; 80 by GPs, three from out-of-hours services and 17 from the local trust. There was also a wider range in the type of incidents (see Box 1) reported to the local health board; all those submitting reports received individual feedback as well as wider sharing of the lessons learnt through the clinical governance newsletter.

Box 1 Type of incidents reported

- Access, appointment, admission, transfer
- Abusive, violent, disruptive, self-harm
- Accident resulting in personal injury
- Clinical assessment
- Consent, confidentiality, communication
- Delayed or failed diagnosis
- Patient information
- Infrastructure or resources
- Labour or delivery
- Medical device, equipment
- Medication
- Implementation of care or ongoing monitoring
- Other – specify
- Security
- Treatment, procedure

There has also been a shift in the culture associated with incident reporting. Whereas the interviews indicated that practitioners would rather have a guarantee of confidentiality, now practitioners are openly sharing experiences at continuing professional development events. There is an audit planned for later in the year, where the degree of compliance will be measured.

Discussion

The opportunities provided by the RAID process naturally lent themselves to a project-based approach rather than a research study. This could be seen as a limitation to the work outlined above. However, it was felt by the project team that the approach used allowed a less formal line of communication between the local health board and the practices in Rhondda Cynon Taff. This has led to a demonstrable change in attitude and interaction between the local health board and practices.

By having senior management and team commitment and using a structured process such as RAID, Rhondda Cynon Taff Local Health Board has not only developed the processes for incident reporting, they have changed the culture of the patch to actively discuss and share experiences of incidents. 'Incident Reporting Improves Safety' (IRIS) was the basis of this project. There is now a higher awareness of safety issues at local health board level, fed by the frontline practitioners. The local health board is now able to

offer support and practical solutions to its contractors, which are driven by their own and their patients' safety needs.

ACKNOWLEDGEMENTS

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CONFLICTS OF INTEREST

None.

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