

Making sense of critical incident reporting

Dr Tony Thomas

February 2012

Topics to be covered.

- Review of current structures and their problems
- Suggested changes to incident reporting
- Information that can be extracted from incident reports
- Incident reporting project
- Questions

Critical incident reporting

- Basic principles well recognised in critical care for over 20 years.
- An incident that could have or did result in harm to a patient is reported by staff.
- The incident is investigated to understand how the incident could have been prevented and changes are instituted to avoid repetition of the event.
- Well described in 'standards for critical incident reporting in critical care'- ICS website.

Role of the National Reporting and Learning Service

- For the last 5 or 6 years all incidents reported in the NHS in England and Wales have been collected in each Trust and stored using commercial software like Datix or Ulysses and reported using an electronic upload system to the NRLS.
- This means that every Trust should have all the incidents reported from that Trust in easily accessible electronic format.
- Although many thousands of incidents are reported from critical care units in England and Wales every year no critical care analysis has been conducted by the NPSA and the incidents have only been used to review a number of areas of clinical practice (for example NG tubes) with no reference to the critical activity of units reporting the incidents.

Why would a national system of incident reporting be useful

- 1. Incidents that cause significant harm to patients are rare- understanding these is only possible if they are collected over a large number of units- a good example of this are catastrophic injuries resultant from problems with tracheostomy tubes.
- 2. Patterns in incident profiles are only evident if you look for them both within units and across units. Identification of these patterns may help deal with them.
- 3. Different units have different ways of doing things- these differences may influence the incidence profiles of different units and we should know about this- examples would be the use of electronic prescribing, provision of pharmacy support, use of capnography.
- 4. If we change things, like capnography, we should know if this results in an improvement or new problems.

New approach linked to clinical activity of individual units.

- Incidents classified using a system that maintains NPSA incident groups but links them to clinical practice in critical care.
- Describes the incident reports in the context of clinical activity and methods of working.

Processes involved

- Identification of incidents reported by individual units.
- Classification of these incidents using a consistent approach.
- Linking of incidents with denominator data around clinical activity, ways of reporting, ways of working and equipment used.
- Provision of information back to units.

Getting the incidents

- Should be simple- all Trusts are required to submit all patient safety incidents to the NPSA using an electronic up load system.
- This requires the location from where the incident was submitted to be described- for Critical care as 'ICU or high dependency'.
- The trust will hold all incidents in a database that is exportable to Excel with a description of incident, location, date of the report and, normally, a manager's report.
- These reports can be put on an Access data base for analysis.

Why is this a problem?

- Some one has to do it and it is most likely they won't work in the ICU.
- They will not be happy about this for several reasons:
 - They won't know how to do it.
 - They are possessive of the data.
 - They are worried about the 'governance issues'
- Once you have the Excel spread sheet it has to be imported into a database and the spread sheet will be different for every trust as the reporting systems are slightly different.

Classification process.

- Uses an Access database to put incidents into main incident groups that are developed from the NPSA system but allow each incident to be put in more than one group.
- The incidents are categorised by the level of harm and the potential or actual seriousness.
- They are also categorised by how preventable they are.
- The incidents are then put into sub-classifications.

Main Menu

Airways Procedure

Communication

Fluids

Medication

Injury to Staff

Treatment Procedure

Disruptive Behaviour

Patient Abuse

Medical Device

Implementation of Care

Infrastructure

Documentation

Patient Accident

Access

Infection

Assessment

Pressure Sore

Classifications - Multiple Selections Allowed

Incident Number:

Local Patient Id Number:

Patient name:

Local Staff Identification:

Hospital Trust Identification:

Specific Unit Identification:

Sex:

Age [yrs]:

Neonatal Gestational Age [mths]:

Date of Incident:

Time of Incident:

Description of Incident:

Please ensure Grade of Patient Harm, Potential / Actual Seriousness and Preventability fields are completed.

Grade of Patient Harm:

Potential/Actual Seriousness:

Preventability:

Manager's Report:

Medical Equipment Report:

Root Cause Analysis Report:

Other Reports:

Access, Admission, Transfer, Discharge (including missing patient)

Airway/Airway Procedure

Clinical Assessment (including diagnosis, scans, tests, assessments)

Consent, Communication, Confidentiality

Disruptive, Aggressive Behaviour or Organic Confusional State

Documentation (including records, identification)

Implementation of Care and ongoing Monitoring/ Review

Infection Control Incident/Infection

Infrastructure (including staffing, facilities, environment)

Medical Device/Equipment

Medication

Medication - Intravenous Fluid/Additive/Parenteral Nutrition

Medication - Enteral Nutrition/Feed/Milk

Patient Abuse (by staff or third party)

Patient Accident

Pressure Sore, Other Iatrogenic Non-Surgical Wound

Self Harm Behaviour

Treatment, Procedure

Other

Other - Injury to Staff

Non-Critical Care (prior to critical care referral)

Repeat Entry Same Incident

Multiple selections are allowed, most selections are the NPSA main classifications, there are some that are added- airway/airway procedure, disruptive behaviour has an addition to include confusional states. It isn't really clear if IV fluids, enteral feeds etc are medications or not so they have separate classifications even if they may subsequently be grouped with other medications. Pressure sore is an additional classification as is staff injury (which isn't supposed to be collected but incidents are submitted by staff anyway). Many incidents occur before ICU admission and this is a separate option.

Classifications - Multiple Selections A

- Access, Admission, Transfer, Discharge (including missing patient)
- Airway/Airway Procedure
- Clinical Assessment (including diagnosis, scans, tests, assessments)
- Consent, Communication, Confidentiality
- Disruptive, Aggressive Behaviour or Organic Confusional State
- Documentation (including records, identification)
- Implementation of Care and ongoing Monitoring/Review
- Infection Control Incident/Infection
- Infrastructure (including staffing, facilities, environment)
- Medical Device/Equipment

- Medication
- Medication - Intravenous Fluid/Additive/Parenteral Nutrition
- Medication - Enteral Nutrition/Feed/Milk
- Patient Abuse (by staff or third party)
- Patient Accident
- Pressure Sore, Other Iatrogenic Non-Surgical Wound
- Self Harm Behaviour
- Treatment, Procedure
- Other
- Other - Injury to Staff
- Non-Critical Care (prior to critical care referral)
- Repeat Entry Same Incident

The selected main classifications can then be classified in more detail. Clicking on the icons at the top of the input form allows access to the detailed sub classifications.

Main Menu

- Airways Procedure
- Communication
- Fluids
- Medication
- Injury to Staff
- Treatment Procedure
- Disruptive Behaviour
- Patient Abuse
- Medical Device
- Implementation of Care
- Infrastructure
- Documentation
- Patient Accident
- Access
- Infection
- Assessment
- Pressure Sore

Classifications - Multiple Selections Allowed

Communication and Confidentiality

Airways Disruptive Behaviour Fluids Medication Injury to Staff Treatment Procedure Patient Abuse Medical Device Implementation of Care Infrastructure **Main Menu**

Documentation Patient Accident Access Infection Assessment Pressure Sore

Incident Number:

Local Patient Id Number:

Patient name:

Local Staff Identification:

Hospital Trust Identification:

Specific Unit Identification:

Sex:

Age [yrs]:

Neonatal Gestational Age [mths]:

Date of Incident:

Time of Incident:

Description of Incident:

Main Group:

Method of Communication (communication incidents):

Staff Groups, Patients, Relatives Involved:

Period in Critical Care Pathway:

Teams Involved:

Help with the classification process

- Presentations with videos of classification process are accessible from the ICS website
- Detailed definitions of each category
- Contact via email (tony.thomas@srft.nhs.uk)
- Identification of questions during the process.

Once the data has been classified.

- The production of reports requires the data to be exported back to Excel, there are instructions on how this should be done.
- There is a separate Excel spread sheet that should be completed with details of clinical activity and ways of working, this is available on the website.
- The completed spread sheets are returned and your report will be generated for you, this will probably take a number of months as the reports will be run in batches.

Information provided from the reports

- A description of the incident profile of an individual unit, an example is shown on the ICS website.
- Provision of comparative data to allow benchmarking with other Trusts.

If you would like your unit or network to take part

- Detailed instructions are available on email request from Dr Antony Thomas, Salford Royal Hospitals (Tony.thomas@srft.nhs.uk).