

# briefing

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## Act on reporting

### Five actions to improve patient safety reporting

#### Key points

- Making services safe for patients is essential in the provision of high-quality health services, but this is not the highest priority for all NHS organisations.
- Key to this is learning from staff who report when patients have, or could have, been harmed.
- Staff need to see that the effort they make to report incidents is worthwhile and results in safer services.
- The response system is more important than the reporting system.
- Boards can use this *Briefing* to see what more they can do to learn from safety incidents and improve patient care.
- High reporting is a mark of 'high reliability' organisations.

This *Briefing* is based on the outcome of a seminar for high-reporting acute organisations held jointly by the National Patient Safety Agency (NPSA) and the NHS Confederation in March 2008. More than 20 organisations in England and Wales identified by the NPSA as consistently high reporters came together to share their experiences. Strong messages emerged about what good reporting looks like and how it can be achieved by all organisations through the implementation of five key changes. Here, we look in detail at the suggested changes, backed up by case studies of good reporting practice. We also propose an action plan for boards to strengthen reporting and learning to make services safer for patients.

#### A top priority

Making services safe for patients is fundamental to the provision of high-quality health services. Yet not all organisations have made this the highest priority. In his foreword to *Safety first* (2006), a review of patient safety in England, the Chief Medical Officer stated: "We are still unable to assure NHS patients that all organisations are learning from experience in ways that prevent harm to future patients."

Key to providing high-quality care is having good systems in place for staff to report when patients have, or could

have, been harmed. Organisations with good levels of reporting are able to:

- **set safety priorities and direct investment**  
Mid Cheshire Hospitals Foundation NHS Trust invested in low beds to prevent injury from falls following a review of patient safety incidents.
- **anticipate problems and reduce costly claims**  
North Tees and Hartlepool NHS Foundation Trust invested heavily in training staff and encouraging reporting. As reporting levels rose, its claims halved as the trust was able to identify problems at an early stage.

- **identify problems and take action**  
Christie Hospital NHS Foundation Trust in Manchester identified wards with high levels of reported drug administration errors. It introduced protected drug rounds, with nurses wearing coloured tabards to minimise interruptions, and the incident rate fell.

At a local level, there is a business case for investing in patient safety reporting.<sup>1</sup> The NPSA also needs this information nationally<sup>2</sup> to identify patterns of events and alert frontline staff to key risks, such as recent guidance on heparin flushes or inserting chest drains.

But not all errors or risks are reported. Staff are busy and may not recognise hazards and risks as patient safety incidents, or they may fear blame. Others may feel that nothing will happen as a result, and some organisations may not actively encourage staff to report incidents or have the systems in place to ensure that information from them is used effectively.

This *Briefing* sets out five key changes that all organisations can make to improve patient safety by strengthening reporting and learning:

*"Where staff see incident reports go into a bureaucratic black hole we have organisational amnesia. Conversely, where local feedback, analysis and action planning is maximised we have organisations that have a memory, learn and adapt to adversity."*

**Dr Douglas Gee, Medical Director, Humber Mental Health NHS Teaching Trust**

- **Change 1: give feedback to staff**
- **Change 2: focus on learning**
- **Change 3: engage frontline staff**
- **Change 4: make it easy to report**
- **Change 5: make reporting matter.**

### Change 1: give feedback to staff

Staff need to see that the effort they make to report incidents is worthwhile and used by the organisation to make services safer. Without feedback, reporting can be seen as a bureaucratic process, rather than a powerful mechanism for change.

It is good practice to acknowledge reports and this in turn helps to engage and motivate staff to continue reporting.

Examples of regular feedback mechanisms include newsletters highlighting incidents which have prompted action; case study reports and patient 'stories'; trend analysis; meetings at ward level to discuss incidents; visits by a central team or champions to give feedback and promote reporting. Some risk-management units prepare tailored feedback reports for ward managers to cascade to staff, addressing particular local issues and contextualising general information. Examples of local feedback are given at [www.npsa.nhs.uk/patientsafety/reporting](http://www.npsa.nhs.uk/patientsafety/reporting)

Results from the Healthcare Commission staff survey show that, on average in England, only a third of staff felt they were given feedback.

*"We used incident data to introduce changes that staff could see made a real difference to patient care and safety – such as low beds after reviewing patient fall incidents and standardising infusion pumps after looking at reported medication errors."*

**Phil Morley, Chief Executive, Mid Cheshire Hospitals NHS Foundation Trust**

*"Medication safety is a key priority for this trust. We validate and review our incidents regularly and have used these to focus our efforts – for example, in the recording of patient allergy information and providing resources to support the safer use of gentamicin. Medication safety isn't just an issue for pharmacy, and this data has helped us to engage with nursing and medical staff to enable multi-disciplinary solutions."*

**Philippa Jones, Chief Pharmacist, Pennine Acute Hospitals NHS Trust**

This rating was increased for high-reporting organisations which could give staff concrete examples of changes which had happened as a result of incident reporting.

### Change 2: focus on learning

The focus of reporting should be on analysing the root causes of incidents, robust local learning and action to mitigate risks to patients, rather than blame. Serious incidents yield important lessons about changing systems and processes to reduce risks; the NPSA has developed resources to strengthen root cause analysis (RCA) investigations at [www.npsa.nhs.uk/patientsafety/reporting](http://www.npsa.nhs.uk/patientsafety/reporting)

Using reporting to drive local safety improvements helps to identify topics or themes for in-depth review. Some

1 Patient safety incidents defined as "any unintended or unexpected incident that could have or did lead to harm for one or more patients receiving NHS-funded healthcare". NPSA: *Seven steps to patient safety* (2004).

2 All NHS organisations have been connected to the National Reporting and Learning System (NRLS) since January 2005. Over 2 million incidents have been received to date; see [www.npsa.nhs.uk](http://www.npsa.nhs.uk)

organisations use topic-based reporting to 'shine the light' on key issues and may boost levels of reporting because this is seen as directly relevant to frontline staff. For instance, a cluster of incidents around resuscitation problems may prompt a review of equipment and training.

Senior staff, particularly clinicians, need to see how reporting can influence organisational decisions and change practice. Without evidence of incident reporting leading to improvements, it is difficult to encourage or sustain good levels of reporting by staff.

*"Incident reports have enabled us to identify and focus on some key issues which will make us safer – such as reducing medication errors and managing deteriorating patients more effectively."*

Judy Gillow, Director of Nursing,  
Southampton University Hospitals NHS Trust

*"A review of emergency care incidents helped us to focus on the management of patients with head injuries and to provide some targeted actions for patients on anti-coagulation to reduce morbidity. Staff reporting helped us to pinpoint problems and understand how they happened from the perspective of the busy doctor or nurse in A&E."*

Allan Cole, Medical Director, University  
Hospitals of Leicester NHS Trust

*"The learning potential from incident reporting is immense, but our experience shows that two things must be in place – a robust feedback loop, and an open reporting culture. Doctors are the group most reluctant to report incidents and that is something we are tackling both for new starters and established staff."*

John Calvert, Deputy Medical Director,  
Abertawe Bro Morgannwg University  
NHS Trust

## Case studies

### Change 1: give feedback to staff

Northern Lincolnshire and Goole Hospitals NHS Trust issues a regular 'Learning Lessons' newsletter, with short, punchy examples of incidents or risks that have occurred and subsequent actions. It also lists resources and available training. The newsletter is issued in an eye-catching, colourful format to display on ward or department noticeboards. Feedback from staff is very positive, with evaluation showing that staff had read the publication and implemented changes. Medical Director Dr Liz Scott says: "Staff need to see what has happened as a result of reporting, and that it makes a difference."

Feedback is also used to highlight data-quality issues at ward or departmental level. "Data quality is taken seriously at our trust," says Jill Mill, Risk Management Coordinator, "with weekly validation of data by the team." This includes a review of completion of key fields and coding of degree of harm which helps to identify wards where further training is needed.

### Change 2: focus on learning

North East Wales NHS Trust asks staff to submit reports on specific monthly medication-related themes, in addition to 'normal' reporting. Simple A4-sized posters are put out in clinical areas, with sample incidents. This themed reporting has been extended to include primary care (including general practices and community pharmacies). Themes have included allergies, anticoagulation, insulin, clinical incidents involving controlled drugs, and paediatrics. One theme of medication-related admissions from primary care has become an ongoing programme and is a standing item at quarterly meetings with GP Prescribing Leads, where incidents are reviewed regularly and learning points extracted.

Janet Thomas, Partnership Pharmacist for the trust/local health board, says: "As well as helping to root out key issues sooner, it advertises to staff that it's alright to report. It can be proactive or reactive to a recent event and has helped us to promote joined-up working across sectors – for instance, supporting the smooth running of the electronic discharge system."

### Change 3: engage frontline staff

The high-reporting organisations in our seminar scored above-average ratings in Healthcare Commission staff surveys relating to safety culture. Most staff knew how to report, felt supported by their organisation and believed they were given feedback.

Training on the 'what, how and why' is key to increasing levels of reporting and getting meaningful data which can be analysed and actioned. Northern Lincolnshire and Goole Hospitals NHS Trust has appointed senior managers in each clinical and non-clinical directorate as safety champions. Mid Cheshire Hospitals NHS Foundation Trust saw a dramatic

## Case studies

### Change 3: engage frontline staff

Mike Proctor, Deputy Chief Executive of York Hospitals NHS Trust, says that one of the keys to achieving high reporting levels is to make sure the right team is in place, getting the balance right between a central team and staff on the wards. He describes his team as “passionate about risk reduction and expert in their field”.

“They offer support rather than act as inspectors. They understand the issues; they don’t criticise staff on the front line.”

Creative use of two vacancies in the central team enabled the hospital to use ten staff from clinical directorates for one day a week each. “Effectively, I got ten full-time people as they took the awareness of risk back to their frontline jobs,” says Mike.

### Change 4: make it easy to report

“We have tried to make it as simple as possible for staff at the front line to report,” says Cambridge University Hospitals NHS Foundation Trust Governance Manager Glenn Pascoe. “We have one form and one system for everything. Report forms are in a book with simple instructions and all forms are sent to our risk-management team.”

Since intranet reporting was introduced in 2005 – 93 per cent of reports are now received by that route – there has been an overall 14 per cent increase in reporting. Staff find it easier to report and there are other benefits, such as automated acknowledgement to reporters and forwarding of information to others who need to take action or know that an incident has occurred. There is also a significant reduction in data entry, with quicker turnaround and response time.

increase in levels of reporting after it trained 300 staff as safety champions.

### Change 4: make it easy to report

Many risk managers in high-reporting organisations had designed forms which were as simple as possible, while capturing required information for analysis and follow-up.

Organisations using web-based systems found greater consistency and efficiency throughout the reporting cycle. Staff may still need the option of

a paper form – for instance, in busy wards where access to computers is restricted. Some organisations have also developed new ways of encouraging staff to report – for instance, by developing a short form on drug trolleys for immediate reporting of medication errors.

Other ways to make it easier for staff include linking reporting systems to centrally held records so that patient and staff information can be entered automatically. This frees up busy staff to spend time on other parts of the form, including key clinical details of the incident.

*“We still lack a good understanding of the nature and extent of patient safety incidents in primary care. Reporting incidents is one way in which we can collect information when things go wrong to try to stop the same thing happening to someone else.”*

Maureen Baker, GP and Honorary Secretary of Council, Royal College of General Practitioners

*“Healthcare organisations with the greatest success in improving quality and safety encourage the reporting of clinical errors so that the same mistake can be avoided. In NHS South West we are focusing on reporting and learning in key areas (such as medicines reconciliation) within and across sectors to transform and improve the experience of all our patients.”*

Dr Mike Durkin, Medical Director, South West Strategic Health Authority

### Change 5: make reporting matter

High-reporting organisations demonstrate strong and visible safety leadership from their boards and senior managers. This means investing in robust systems and using incident data to support decision-making at the highest level.

Data collected through reporting systems can never tell an organisation everything it needs to know about risks to patient safety. High-reporting organisations recognise this and often bring together incident data with other sources. This can be powerful on particular topics, such as infection control, where laboratory surveillance data can be combined with reported incidents, investigations, complaints and other data to identify key risks.

## Case study

### Change 5: make reporting matter

Cardiff and Vale NHS Trust was formed following a merger of three trusts in 2001. The three organisations each had a different incident-reporting system, so the challenge for the new trust was to develop a system that could be used across the trust and, importantly, to merge the cultures. For example, one of the former trusts had a policy of disciplining nurses responsible for medication errors, but not the others. “We needed to show commitment to ensure equity in the way staff were treated across the different organisations and to make sure that staff continued to report,” says Jenny Jones, Clinical Governance Manager.

Hugh Ross, Chief Executive, underlines the benefits of reviewing incident reports: “Incident reporting is an important part of the learning jigsaw – we need to know from frontline staff about the real risks so we can strengthen services.”

## Summary

High reporting is a mark of a ‘high reliability’ organisation. Research shows that trusts with significantly higher levels of incident reporting are more likely to demonstrate other features of a stronger safety culture, such as high NHS Litigation Authority (NHSLA) ratings. A commitment to reporting demonstrates a commitment to patients and their safety. This is recognised in Healthcare Commission core safety standards in England, which include consistency of reporting as one measure, and similar safety governance requirements in Healthcare Standards for Wales.

The changes identified by the high-reporting organisations at our seminar need commitment at the highest level. This is particularly important as the media might misinterpret high rates of reported incidents as being of more concern than a lower rate. Our seminar’s high-reporting organisations urge others to hold their nerve in realising the benefits of effective reporting and learning.

## Confederation viewpoint

The NHS Confederation is pleased to be working with the NPSA and to

## Action checklist: what can your board do?

Where are you now?	<b>Establish current level of reporting</b> What is your rate of reporting – how does it compare with that of similar organisations? How has it changed over time?
Change 1	<b>Give feedback to staff</b> Does your organisation provide feedback to individual reporters and staff? How can this be improved? Have you combined incident data with other sources such as investigations, litigation and complaints to ‘tell the story’ of key risks and challenges?
Change 2	<b>Focus on learning</b> What changes in patient care have been made as a result of reporting? Could your staff give examples of changes following reporting, such as new equipment or practice?
Change 3	<b>Engage frontline staff</b> What formal training do you provide on incident reporting for new and existing staff? Do you have safety champions at directorate or ward level?
Change 4	<b>Make it easy to report</b> How easy is it for staff to report incidents? Do all clinical specialties and staff groups report?
Change 5	<b>Make reporting matter</b> Do staff believe that your reporting systems are focused on improving safety rather than blaming individuals? What do recent staff survey results tell you? How are you assured that incident reporting is being used to ‘close the loop’ and act on the risks identified?
What next?	<b>Acting on reporting</b> Progress against these actions can be reviewed at a board seminar. Particular challenges include, what are your next three patient safety priorities identified from reported incident data?



bring together our members' work on developing cultures that support learning from and prevention of patient safety incidents.

We recognise that to foster and nurture a reporting culture it is important to have:

- skilled governance teams whose role is to work with frontline staff as well as external agencies like the NPSA
- user-friendly reporting systems that produce high-quality data
- feedback and learning underpinned by a 'fair' blame culture.

However, to achieve and maintain a high-reporting status, we have to balance some difficult challenges and tensions. For example, for accountability and to ensure staff are learning from incidents, trusts need to be able to identify where problems are occurring, but high rates of reported incidents can cause concern for patients.

It is important for trusts' communication strategies to consider:

- how trusts manage the messages of being a high-reporting trust

- how those messages are communicated internally to staff but also externally to patients, the public and the media
- how the board can support these tensions.

The case studies in this *Briefing* offer some useful learning and insight into the benefits of reporting, both for improving patient care and in reducing the risk of trusts being subject to costly financial claims. Further work will help to refine this

process, but the wider national system also needs to support trusts in developing an open and fair culture where reporting is valued. And regulators can contribute by educating the media about the importance of reporting in improving patient safety and reiterating that high reporting levels can actually be good news.

For further information, please contact Claire Mallett at [claire.mallett@nhsconfed.org](mailto:claire.mallett@nhsconfed.org)

### The NPSA: further information

The National Patient Safety Agency encompasses the National Research Ethics Service, the Patient Safety Division and the National Clinical Assessment Service. Our vision is to lead and contribute to improved, safe patient care by informing, supporting and influencing healthcare individuals and organisations. Each division works within its sphere of expertise to improve patient outcomes. The Patient Safety Division helps to improve patient care with rapid responses to incidents, analysis of incidents reported to us via the National Reporting and Learning System (NRLS) and the collaborative development of actions that can be implemented locally. We provide reports to organisations every six months with comparative data on reporting levels. We are scoping web-based provision of this feedback. We are also planning further seminars on reporting and learning: for further information, visit [www.npsa.nhs.uk/patientsafety/reporting](http://www.npsa.nhs.uk/patientsafety/reporting) or email [brian.lancashire@npsa.nhs.uk](mailto:brian.lancashire@npsa.nhs.uk)

### The NHS Confederation

The NHS Confederation is the independent membership body for the full range of organisations that make up today's NHS across the UK. Our members include primary care trusts, NHS trusts, NHS foundation trusts and independent providers of NHS services. Our ambition is excellence for patients, the public and staff by supporting leadership of the new NHS.

Together, we help our members improve health and health services by:

- influencing policy, implementation and the public debate
- supporting leaders through networking, sharing information and learning
- promoting excellence in employment.

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