Implementation of a patient safety incident management procedure at Tartu University Hospital and staff opinions on patient safety and patient safety incident management

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BACKGROUND

From 2012 to 2020, more than 5,500 incidents have been reported in the Patient safety incident reporting system (PSRS) of Tartu University Hospital (TUH). Although the number of reported incidents has increased significantly over the years, the need arose to audit the use of the system.

OBJECTIVE

The aim of the audit was 1) to analyse the compliance of the management of patient safety incidents with the procedure in place in TUH, 2) to identify staff's opinions of patient safety and the management of incidents, and 3) to make recommendations for improving the reporting and management of patient safety incidents.

METHODS

1) To analyse the management of patient safety incidents, the medication-related incidents were selected due to the limited scope of the audit. 24 evaluation criteria were used to analyse the medication-related incidents based on the procedure „Patient safety incidents management at Tartu University Hospital (PKL-170)". The descriptions of incidents, management and decisions were analysed. 2) To find out staff opinions about patient safety and the management of patient safety incidents, an online survey was carried out in September 2020 using the Agency for Healthcare Research and Quality (AHRQ) Patient Safety Culture (SOPS) Hospital Survey. SPSS and Microsoft Excel were used to analyse the data.

RESULTS (1)

The management of patient safety incidents according to the procedure „Patient safety incidents management at Tartu University Hospital (PKL-170)" was assessed using 24 evaluation criteria. A total of 49 medication-related incidents were reported at TUH in 2019. Of the reported incidents, 72% were adverse incidents, 20% were near miss incidents and 8% of the incidents were not clear from the description what the impact was on the patient or staff.

In more than half of the cases (77%) the incident was reported within the department, while 23% of the cases were referred to another department. Referral was appropriate in all cases. In most cases (88%) the incidents were reported in a non-personalised form and the incident was sufficiently described (96%) to initiate the management of the incident. In 94% of the cases, the incident report did not contain any suggestions how to prevent the recurrence of the incident in the future.

The management of patient safety incident was started within two working days in 65% of cases, according to the procedure in TUH, and the incident was mostly managed by a senior or a head nurse (94%), with the head of the department or clinic also involved in 29% of cases. Incident decisions were directed towards improvement in 84% of cases.

RESULTS (2)

In the patient safety survey, which was aimed to identify staffs' perceptions of patient safety and the management of incidents, 479 employees from 28 clinics and services took part. Of the respondents, 24% were doctors, 55% nurses, 5% care workers and 16% other staff; 79% of respondents worked full-time and the majority (84%) had direct contact with patients.

Of the respondents, 65% had not reported any incidents in the last 12 months, 25% had reported 1–2 incidents, 7% 3–5 incidents and 3% 6 or more incidents. The results showed that 77% of respondents rated patient safety in their department as good, very good or excellent.

The majority of respondents felt that changes in work processes take into account the need to improve patient safety (85%), that departments monitor the implementation of changes following an incident (76%), and that the management of the incident focuses on learning rather than blaming the employee who caused the incident (70%).

Although the PSRS has been in use for years, some respondents (35%) consider reporting incidents as complaining and feel that incident reporting causes a negative attitude of colleagues (37%). At the same time, respondents believe that their line manager takes into account suggestions from staff to improve patient safety (80%) and that the manager deals with the incidents that have become known to him/her (86%).

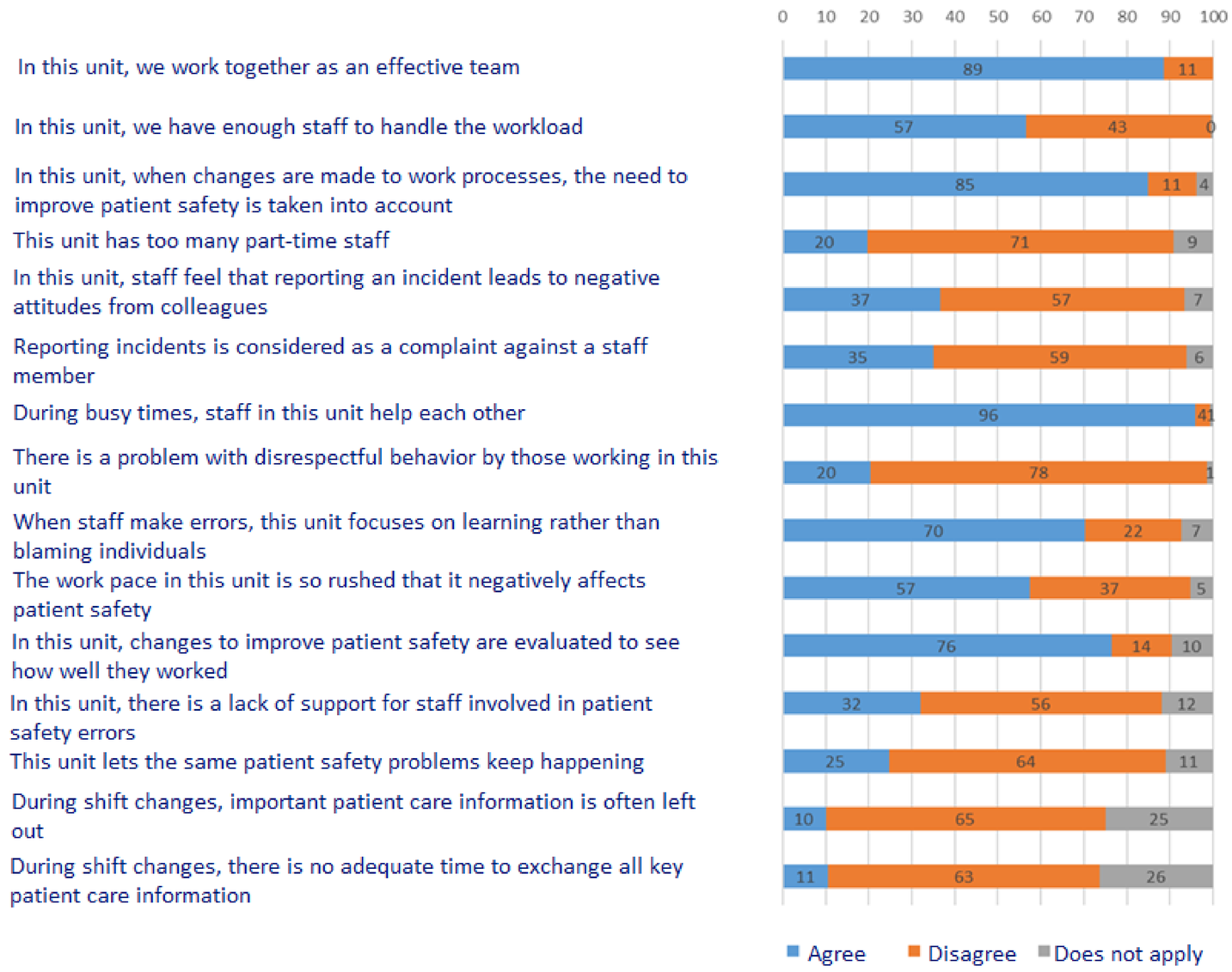

Figure 1. Staff opinions on patient safety and patient safety incident management

CONCLUSIONS

In developing the Patient safety incident reporting system, attention should be paid to the effective feedback and training of staff to ensure proficient use of the system and to achieve a common understanding that the reporting of the incidents is an essential measure to ensure patient safety and quality of healthcare. To reduce negative attitudes and sense of complaint, improved teamwork in departments would be necessary, as the study showed that in departments with good teamwork, reported incidents led to less negative attitudes, less sense of complaint and more focus on learning when managing incidents. They were also more likely to offer support to staff involved in the incident, more likely to monitor the implementation of post-incident changes, and less likely to repeat the same patient safety problems.

Further development of the PSRS should also take into account the guidance provided in the WHO 2020 report, which emphasizes patient information, appropriate communication and, where appropriate, compensation. In the future, it should also be possible for patients and their relatives to report patient safety incidents.

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