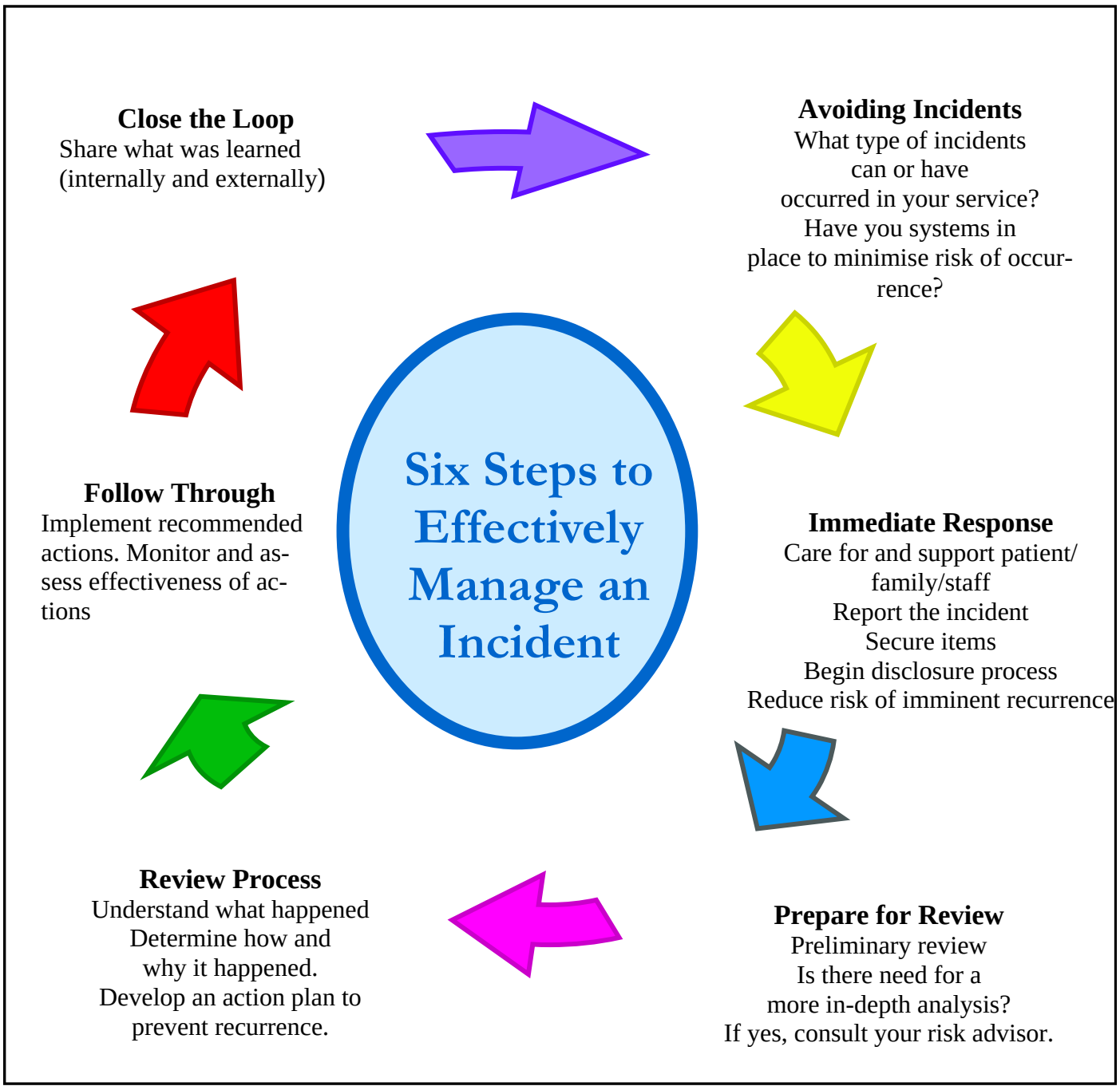
PATIENT SAFETY TOOL BOX TALKS©

LEADERSHIP, GOVERNANCE & MANAGEMENT

MANAGING INCIDENTS

PROCESS OVERVIEW v1.1

The primary objective of incident management is to learn from the incident in order to reduce the risk of recurrence and make care safer for future patients. The goals of incident review are to determine: what happened; how and why it happened; what can be done to reduce the risk of recurrence and make care safer; and, what was learned, This process can be broken down into 6 key steps as set out below:



While there will be some variation in how different services manage patient safety incidents, the basic steps will be consistent. There is interconnectivity and interdependence between the identified activities and some may take place simultaneously.

Avoiding Incidents

- What types of incident have occurred in the past?
- What incidents have occurred in other services similar to yours?
- Do we consider information about incidents as part of our team meetings?
- Have we a quality improvement plan for commonly occurring incidents?

Immediate response

A patient safety incident can be a very traumatic experience for the both the patient and the staff. Generally, the first action, after recognizing that an incident has occurred, is to care for and support the patient and the family, as well as ensuring the safety of other patients who may be at risk. Attending to the safety and well-being of the staff involved and others is also a necessity. The next activity generally includes reporting the incident so that further steps can be taken to manage the incident. Reporting is also the trigger for a chain of internal notifications that will depend of the nature and severity of the incident. Often practical support is needed and contacts should be provided to the patient/ family to facilitate good communication. Disclosure, expressions of compassion and offering an apology are important elements of communication helping both patients/families and staff in healing and in restoring trusting relationships. Local actions to reduce the risk of imminent recurrence may need to be taken immediately; additional actions typically follow after a more thorough analysis has been undertaken. Patients and families should be informed of immediate actions.

Prepare for the Review

In order to determine appropriate follow-up to an incident, including the need for analysis, an initial investigation or fact-finding is needed. Once the initial investigation phase has been completed, a determination of next steps follows. In some cases, it will be clear that further system-based analysis is needed, while in less complex incidents any improvement actions required may be easily determined. Local quality or risk staff should be consulted in relation to those incidents that may require system-based analysis.

Review Process

In conducting the review of an incident the basic principles and steps in the analysis process are the same however, the level of detail and the scope of the review required will depend on the impact and nature of the incident. The first priority is to gather information relevant to the incident. This stage of the process is intended to answer the "What happened?" question and will begin to elucidate how the incident occurred. The review process then moves to analysing 'why it happened' and looks to identify the key contributory factors which assist in the development of actions required to prevent recurrence, 'how to prevent it occurring again'.

Follow through

The implementation of recommended actions is an important step in the incident management process. The purpose of implementing system changes is to make the system safer. However, some recommended actions – even well intentioned and well thought changes – may not have the desired effect in practice. Thus the effectiveness of the implemented recommended actions must be monitored to determine if the changes helped make the system safer, had no or limited impact on the safety of the system, or in the worst-case scenario, the changes actually made the system less safe.

Close the Loop

Sharing the learning both within the service (with patients/families, those involved in the incident, the multidisciplinary team and others as needed) and outside the service is key to preventing additional harm and making care safer. Without learning and sharing, the service is still vulnerable as the same or similar incidents could happen again and no other external systems or services have the benefit of the learning.