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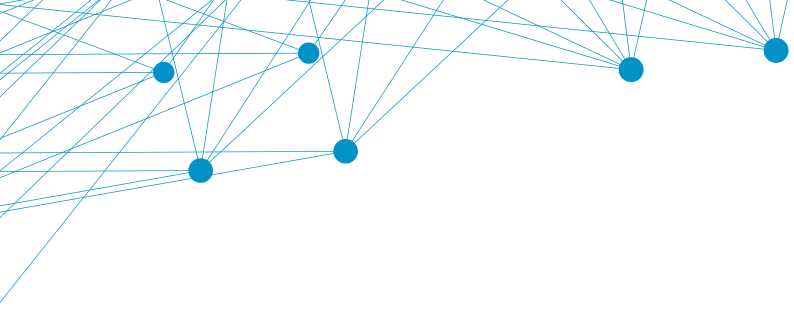
# Patient Safety Incident Reporting and Learning Systems

Technical report and guidance



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## Patient safety incident reporting and learning systems: technical report and guidance

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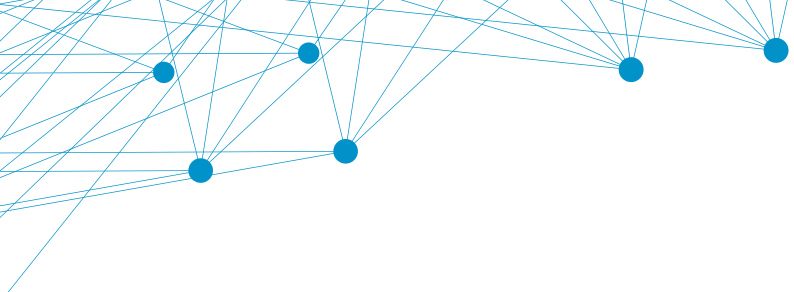
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# Contents

<b>Foreword</b>	<b>v</b>
<b>Acknowledgements</b>	<b>viii</b>
<b>Glossary</b>	<b>xii</b>
<b>Ten facts on reporting and learning systems</b>	<b>xiv</b>
<b>1. Introduction</b>	<b>1</b>
1.1 Background to patient safety	1
1.2 Purpose of this document	2
<b>2. Reporting and learning systems: current status</b>	<b>3</b>
2.1 Reporting seen as central to safety improvement	5
2.2 Weaknesses of most reporting systems in health care	6
2.3 Lessons from incident reporting in other sectors	7
2.4 Improving the process of learning from incidents	10
<b>3. Work of WHO on patient safety incident reporting and learning</b>	<b>12</b>
3.1 Conceptual framework for the International Classification for Patient Safety	12
3.2 Minimal Information Model for Patient Safety Incident Reporting and Learning Systems	14
3.3 WHO consultation on patient safety incident reporting and learning systems	17
<b>4. Developing and operating a reporting and learning system</b>	<b>19</b>
4.1 Understanding a patient safety incident reporting and learning system	19
4.2 Creating a positive environment for reporting	19
4.3 Identification and recording of incidents	20
4.4 Choosing the information to be captured	21
4.5 Uses of incident reports	22
4.6 Review and investigation of individual incidents	22
4.7 Systemic insights from aggregated incident data	27
4.8 Learning, formulating action, and managing change	29
4.9 Openness and independence of data analysis	31
4.10 Information and clinical governance	32
4.11 Engaging patients and families	32



## **5. Guidance 34**

5.1	Understanding a patient safety incident reporting and learning system	34
5.2	Creating a positive environment for reporting	35
5.3	Identification and recording of incidents	36
5.4	Choosing the information to be captured	37
5.5	Uses of incident reports	37
5.6	Review and investigation of individual incidents	37
5.7	Systemic insights from aggregated incident data	38
5.8	Learning, formulating action and managing change	39
5.9	Openness and independence of data analysis	40
5.10	Information and clinical governance	41
5.11	Engaging patients and families	41

## **6. Self-assessment based upon the guidance 43**

## **References 49**

### **Figures**

Figure 1.	Classification of patient safety incidents	4
Figure 2.	Responding to a patient safety incident report	10
Figure 3.	Conceptual framework for the International Classification for Patient Safety	13
Figure 4.	Minimal Information Model for Patient Safety Incident Reporting and Learning Systems (MIM PS)	16
Figure 5.	The Swiss cheese model: system weaknesses and defences	23
Figure 6.	Assessment of patient safety incident reports	25
Figure 7.	Complex combination of factors contributing to Lac-Mégantic runaway train accident	26
Figure 8.	Options for aggregating patient safety incident data	27
Figure 9.	Uses and limitations of aggregated patient safety incident data	29

### **Tables**

Table 1.	Mismatch between principles and practices of incident reporting: other industries and health care	8
Table 2.	Patient safety incident reporting system: a self-assessment	44



## Foreword

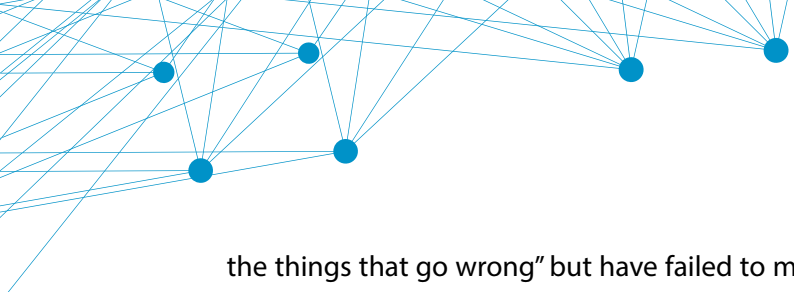
In an ideal world, all events and occurrences in a health service that cause harm or have the potential to cause harm to patients would be quickly recognized and managed appropriately at the point of care by alert, knowledgeable staff. They would carefully document and communicate their observations. They would be enthusiastic about their involvement in this activity because they would have seen many examples of how such reports had been used to improve the safety of care.

Incident reports would be reviewed and analysed by a dedicated team of patient safety specialists to identify the most important risks to patient safety and to coordinate systematic, non-punitive investigations into those problems. The resulting investigation would be impartial and multidisciplinary, involving expertise from relevant clinical specialties but, crucially, also from non-health disciplines that successfully contribute to accident reduction in other fields of safety.

Investigation would be carried out in an atmosphere of trust in which blame and retribution were absent, and disciplinary action or criminal sanctions would be taken only in appropriate and rare circumstances. Action resulting from investigation would lead to the redesign of policies, processes of care, products and procedures, and to changes to clinical care practices and the working styles of individuals and teams. Such actions would usually lead to measurable, sustained reduction of risk for future patients. Some types of harm would be eliminated entirely. There would be agreed processes to aggregate data and produce analyses that point to systemic weaknesses and enable solutions.

However, very few health systems or health facilities in the world can come near to this ideal level of performance in capturing and learning from incidents of avoidable harm. This is so for all sorts of reasons, ranging from an insufficiency of leaders skilled and passionate enough to engage their entire workforce on a quest to make care safer, a lack of transparency, a fear of retribution, the inability of health care professionals to freely report on events and occurrences of harm, errors, near misses and risks, through an inability to investigate properly the volume of reports generated, to the weak evidence base on how to reduce harm.

Many patient safety programmes around the world have raised very high expectations about the potential impact of incident reporting and learning systems. Indeed, many that have been established have been driven by the common-sense reasoning that “we *must* learn from



the things that go wrong” but have failed to meet that expectation because of a belief in the inevitability that “we *will* learn from what goes wrong”. Experience has been disappointing in this respect, as well as in comparison to the track record of other high-risk industries, such as the aviation industry. Some health care organizations and facilities around the world have shown that analysis of patient safety incidents can lead to safety improvements, but this is far from the norm. Most of the experience of patient safety incident reporting and learning systems has been in hospitals in high-income countries. There has been less experience in low- and middle-income countries and in the fields of primary care and mental health.

There are many challenges in trying to deliver greater benefits from patient safety incident reporting and learning systems, but three really stand out.

First, feedback from point of care staff around the world consistently highlights the difficulty that health systems face in establishing a safety culture that is based on blame-free reporting and in which learning is more powerful than judgement. Too often, individuals are held to account when poorly designed systems and processes of care have resulted in errors by conscientious members of staff. The consequences of using an incident of harm or death to track and punish a nurse or doctor are clear. More patients will die since staff will be too fearful to admit mistakes, nothing will be learned, and the source of risk will lie in wait for the next innocent patient to come along.

Second, the core data of many patient safety incident reporting systems are the reports initially made by a member of staff, sometimes with additional local information gathering. Thus, the cause of the incident and the prospects of learning from it are too often a matter of local opinion. Detailed multidisciplinary investigation, including expert inputs, in-depth interviews with those involved and reconstruction of the events that occurred, is less commonly undertaken, even though it would lead to much deeper insights into systemic issues. This is primarily for logistic reasons (too high a volume of incidents), insufficient resources, and lack of coordination to bring the right people together in the right way.

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