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Learning from mistakes: a review of clinical incidents occurring at Royal Surrey County Hospital and how we can learn from these to improve patient outcomes

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Aims

> *If we are to learn from mistakes, it is essential that errors are reported. We don't want to create a charter for incompetents or informers: we want the health service to learn from errors and make patient care safer*' (NPSA, 2005).

The current method of reporting clinical incidents is via the DATIX system. Despite being available on the intranet within the hospital, reporting of incidents is not always completed. It was also felt that there was a recurrence of certain incidents, indicating that we are not learning from our mistakes. Therefore, we reviewed how the results of incident investigations were cascaded to the teams.

Methods

Using the PDSA cycle (plan, do, study, act), we have reviewed the following:

1 retrospective review of DATIX to assess for trends
2 understanding and experience of DATIX amongst medical staff
3 current methods of communicating incident outcome(s)
4 introduced new processes should they be needed, eg education sessions, feedback.

Results

We have seen trends in some incidents and have a number of presentations to educate medical staff on common errors. We looked at ways in which we can successfully cascade information on incidents that have happened and the outcome.

Conclusions

We faced challenges such as changing the working practice to improve reporting of incidents. When we questioned why staff had not completed an incident that they had witnessed, 70.5% gave the reason of it was too time consuming. We changed the reporting system and reviewed the format of this, as well as the process of reporting incidents, and assessed if we can make the process more streamlined. Another response to not reporting incidents was that they were unsure of how to login to DATIX (41%); this is slightly easier to combat and we decided to incorporate it into the induction day of all new starters and perhaps as a guide available in all clinical areas.

We looked at how feedback is delivered, as 83% of participants from the online survey said they had not received any feedback. While on the outside, this seems relatively easy to improve, it required a change in working practice for those investigating the incident.

This project has provided a wide range of leadership skills.

Due to the importance of this subject matter, it would be useful to continue this project and have the working forum each year, involving a multidisciplinary approach to the investigation and feedback of incidents. ■

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