Incident Reporting Process Improvement

James Tan, Joshua Lim, Raquel M Llorente, Agnes Hew
Corporate Development

1. Introduction

Incident Reporting is an essential process that provides a holistic view of detecting emerging risks and safety issues with a structured approach so that a collaborative team can devise intervention measures (Macrae, 2016). Particularly, this process is adopted in healthcare or hospital settings (Ramirez, E., Martin, A., Villán, Y, et al, 2018; Petschnig & Haslberger-Baumann, 2017), where patient or client safety is a consistent cause for concern (Mahanaj, 2010). The Workplace Safety Health (WSH) Council has also detailed a set of guidelines for all healthcare institutions to reference as part of incident investigation methods (WSH Council, 2015).

Mahanaj (2010) opines that successful incident reporting frameworks consist of quality reports that detail the chain of events; creating meaningful intervention practices. Fetherston (2015) adds that reports must be objective, sent to the relevant persons and confidentiality is maintained. However, the reporting process is also characterised with multiple challenges including lack of timeliness, data quality, leadership, underreporting, and lack of feedback (Uribe, Schweikhart, Pathak, et al., 2002; Bradley, Holmboe, Mattera, et al., 2004).

2. Background

St Luke’s ElderCare (SLEC) has 22 centres islandwide. Incident reports (IR) from the various centres were previously submitted via email to the Senior Management (SM) for review. The IRs were submitted in either typed or handwritten format.

The incident reporting policy requires IRs to be completed and submitted within 24 hours. However, the compliance level was poor as different centres had different interpretations of report closure.

A sample of 120 IRs submitted between Oct 18 to Mar 19 were reviewed and the findings were:

- The submission of IRs took between 2 to 79 days
- The median time for submission of IRs was 7 working days
- There was 1 incident of an IR sent to an unintended recipient accidentally

Therefore, the main challenges encountered by the current submission process include:

- Inconsistent quality of IRs
- Timeliness of submission
- Security of submission process

A team was formed to improve the IR form and the submission process.

3. Methodology

The team examined the abovementioned 3 challenges and highlighted the 2 areas for improvement: 1) IR template redesign and 2) Submission process revamp.

The IR was re-designed to frame the required details of any particular incident systematically. Instructions are provided on how to write objectively and comprehensive drop-down choices help users streamline options. Further, the team engaged centres for feedback on the redesigned form.

The team revamped the IR submission process by creating a secured and centralised location for submitting IRs – Microsoft SharePoint. Folder accessibility is now controlled for various levels of submission, and IRs are password protected. Alert notifications can be activated for relevant persons to review the IRs.

Time Period

Evaluation Period - Before implementation from Oct 18 - Mar 19 (120 Cases)
Trial Period - After implementation Apr 19 (17 Cases)

Complete Submission was defined as Incident Reports investigated, reviewed and completed by the Head of Department.

4. Results

Generally, the trial period results have shown 3 themes of improvement to the submission process:

Quality of Content Captured

1) Data captured was more accurately accounted for and created ease in conducting more meaningful analyses.

2) Elimination of illegible reports as handwritten reports are no longer accepted.

3) Centre staff members reflected the increased simplicity and user-friendliness of the IR → Quotes include, “Guided pointers help to not miss out details”, and “IR is comprehensive and intuitive to provide important information”.

5. Conclusion

The trial results have encouraged the management to advocate continuing the intervention practices. SLEC seeks to develop a safety-first culture that is suggested by Fetherston (2015) to help encourage frontline caregivers to report incidents objectively without fear of blame.

SLEC also acknowledges the need to install an incident reporting system to further improve organisational incident reporting culture, learning processes, and overall safety. To complement this, establishing a skilled risk manager is highly recommended by Petschnig & Haslberger-Baumann (2017) to champion the incident reporting system and advocate for a safety first culture that dovetails a “no blame” mission behind the submission and analysis of IRs.

References


Pham, J.C., Girard, T., & Pronovost, P.J. (2013). What to do with healthcare incident reporting systems. Journal of public health research, 2(1).

