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Centre-based incident reporting in Dutch general practice: why and how?

Useful guideline [1] to start implementation of a new system to improve patient safety

Introduction

Doctors are professionals who normally devote much effort to preventing minor or major incidents in patient care. If their organisation becomes larger and more complex, due to growing numbers of part-timers, state laws and procedures, the risks for patient safety will increase. We need to monitor patient safety as well as our own effort: we should do this together, but how?
Incident reporting is a tool with which to uncover (near-)misses in daily practice. By registration and analysis of these unintended events, organisational learning and patient safety can be improved. Developments such as incident reporting in secondary care as a tool for management of patient safety are already quite common. Dutch primary care, and more specifically general practitioners, have started to develop tools to manage patient safety as well, preparatory to the audit system of NHG Practice Accreditation [2].
At the September 2009 Wonca Europe conference the author and his referent[1] presented and discussed guidelines for startup of an incident reporting procedure in general practice, as proposed by the Dutch College of GPs. There were two plenary and interactive presentations, a short discussion and an exercise in small groups.

Definition

An incident is an unintended or unexpected event which could have led or did lead to harm for one or more patients receiving care.
An incident can be used and is helpful in the same way as a complaint, but it follows another route (within the practice) and deals more with facts and handling than with patient feelings and anger (in complaints). Also it is possible that a complaint is a reason for reporting an incident and that both need to be analysed.

Essentials of patient safety – Swiss cheese

It will be obvious that we can and should always learn from incidents. In order to prevent incidents we have to (be able to) observe, one must notice them, or be aware. They also have to be analysed, because even a very minor error can have serious consequences and vice versa. Preventing human error is not always possible, but reducing (the risk of) harm due to human error is always possible.
The facilitating and impeding factors which play a role in observing and analysing incidents are explained by the Swiss Cheese model of James Reason (fig. 1). He is a psychologist and has done a large amount of research on human error. Most of the time there are failure-facilitating factors, or latent failures, in an organisation. These are risky situations in which a human easily makes mistakes. Most of the time things go well (by accident) but since humans are limited one has only to wait until the mistake is made. If you only focus on the last layer of cheese, which is most of the time human, and you fire him, for example, your organisation will not be safer because another person will take his place and the same process will be repeated.

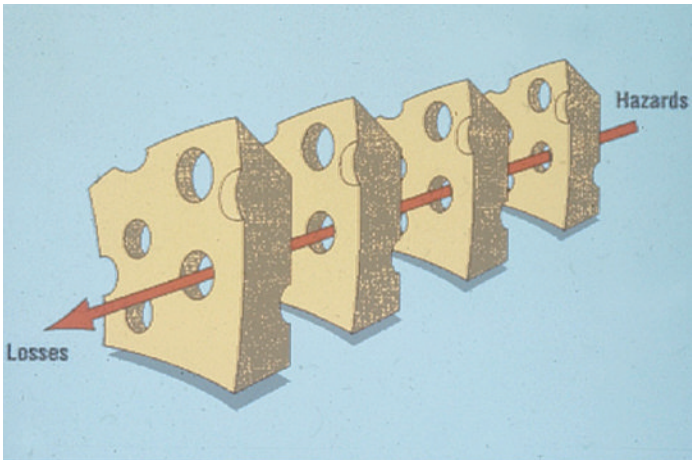

Figure 1
Swiss Cheese model of James Reason.

Reason argues that we should look upstream for these latent failures and eliminate them from our organisation. In this way we lessen the chance of incidents taking place. Trying to prevent human error is only slightly effective, and trying to prevent human error from causing harm is a more effective way to make the organisation safer. The important issue of improving patient safety is about *what* happened and *why*, never about *who* was responsible for the last step!

The Dutch guideline

The procedure / guideline of the Dutch College of GPs is based on the literature and on the results of a Dutch study called SPIEGEL [3]. In this prospective observational study the implementation of a centre-based incident reporting procedure in five general practice health care centres was evaluated.
This product contains a short explanation on patient safety and the meaning of incident reporting. The user can also look for the digital examples of a to-do list, a procedure and a system for collection of reports, and he will be able to change and adapt the files to his own practice. Users can make their own changes to adapt this procedure to their own practice.
According to the essentials as explained, it is important to prepare the start of incident reporting with attention to the following:

- Sense of urgency: this is only possible when employees and colleagues understand the essentials of patient safety and are motivated for active reporting.
- Safe culture: the employees and colleagues feel safe themselves in reporting near or real misses: it is important to invest in team meetings and discuss these conditions and feelings. Everyone needs to feel free to report incidents without risking being condemned.
- Step by step: it is safer to start with a minor and essential step of the procedure than to lose oneself in a exhausting struggle to do different steps at the same time: negative energy does not motivate people to continue this procedure.

[1] Dorien Zwart, MD, GP, Research fellow, Julius Center and Patient Safety Center, University Medical Center, Utrecht.

It is important to pay attention to the conditions before starting the procedure:

- Employees and colleagues share knowledge on the essentials of incident reporting and the steps of the procedure before they make the first report.
- It is difficult to categorise and analyse the incident if there are insufficient written notes in the report. It also makes clearer feedback possible.
- Confidentiality and safety about the discussion and anonymity in the outside world is perhaps the most essential aspect of this procedure.
- Every reported incident can be used and must be taken seriously.

To estimate the potential severity of harm ("what could have happened") and the incident's frequency of occurrence, the risk score can be determined using the RCA (Root Cause Analysis) method and this risk assessment matrix in a particular way (tab. 1).
More analysis is needed when the severity score is 3 or more (if one assesses what could have happened).
It is possible to use methods such as RCA (Systematic Incident Reconstruction and Evaluation [4]) and PRISMA (Prevention and Recovery Information System for Monitoring and Analysis [5]).
As operational steps to implement an incident reporting system and make it operational it is important to:

- Inform the team and answer questions on procedure.
- Change or adapt your own procedure.
- Choose and train the report coordinator.
- Compose materials to be used in the procedure.
- Plan time slots for discussion of the reports.
- Inform patients and others involved.

Table 1
Risk assessment matrix.

Frequency	Severity of harm			
	Catastrophic	Major	Moderate	Minor
Weekly	4	3	3	2
Monthly	4	3	2	1
Yearly	4	2	1	1
Less than yearly	3	2	1	1

Development of patient safety systems in Dutch primary care

At this moment many primary care centres in the Netherlands, especially those with general practitioners, are actively implementing this system, particularly if they are trainers of GPs or are participating in NHG-Practice Accreditation®, a commonly used audit system for quality improvement in Dutch Family Medicine (up till now 25% of all GPs have been certificated). Also, facilitating projects and learning programmes are running to implement these systems at out-of-hours centres, in larger primary care organisations and in co-operation with hospitals.

Report of the workshop

The essentials and benefits of incident reporting to improve patient safety were discussed. In an exercise the presenters allowed the participants to make unintended and unconscious errors and thus learn that to err is human.
This was followed by a short explanation of the content and use of the Dutch Guideline for implementation of an incident reporting system in general practice.
Questions to be answered concerned the safety for the colleagues and employees of reporting and the risk of incurring blame and condemnation. The importance of continuity in reporting was also an issue.

Summary

Learning goals in the workshop were a deeper understanding of the principles of patient safety, increased knowledge of different approaches to management of patient safety, familiarity with guidelines for startup of an incident reporting procedure in general practice, as proposed by the Dutch College of GPs, and knowledge of facilitators of and barriers to the implementation of incident reporting. After this workshop participants were able to start implementing an incident reporting system in their general practices. The take home messages were: Support the key points of patient safety, do it together, prepare the procedure well, take small steps at a time and share the results with each other in your practice.
In this way incident reporting could be energy saving by supporting systematic learning from daily reality in your practice!

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