Strengths and weaknesses of incident reporting in nursing

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‘ Problem based learning. Using the nursing process as a model formulate an action plan by critically analysing the strengths and weaknesses of incident reporting in relation to nursing. Identify reasons for a low level of incident reporting and offer a solution to the problem, eg. awareness of incident reporting procedures, accountability, consequences of not reporting incidents. Include professional, ethical and legal practice as it relates to the role of the nurse: continuing professional development following registration.’

Introduction

Problem solving in nursing is often aligned to the ‘ nursing process’, which is the APIE model – assessment, planning, implementation and evaluation. Using this structure in problem solving allows the nurse to assess the problem, by gathering information about it, plan how to address the problem, and also plan how to implement change and evaluate the process. It is important to use structured approaches to problem solving which include evaluation so that the problem can be reassessed and actions changed accordingly.

In this essay, the problem of low levels of incident reporting in clinical practice will be explored, through a review of the literature, and an action plan will be developed which is in line with the professional, legal and ethical imperatives which underlie nursing practice. It is important to identify the problem carefully, understand the potential reasons for the problem, and then to use this information to plan changes in practice which will allow the problem to be resolved, partially or fully.

Discussion

Assessment

Incident reporting serves a number of purposes within clinical practice. It is part of the risk management process, for example, and is focused on improving patient safety (Wagner et al, 2004). “ Incident reporting captures more contextual information about incidents, and, when actively promoted within the clinical setting, it can detect more preventable adverse events than medical record review” (Evans et al, 2006 p 40). Taylor et al (2004) show that reporting allows for the understanding of and prevention of medical and healthcare errors, and provides data on the occurrence, frequency, types and results of such events. Incident reports however can also be used for “ personnel credentialing and review (Taylor et al, 2004).

According to Waring (2005) “ the management of errors requires an acceptance of error with consideration given to the relationship between individual human behaviour and the factors that influence this behaviour” (p 1928). This means that the organisation must be responsive to incident reporting (Waring, 2005).

However, incident reporting activities remain at low rates in many clinical areas, or do not report all of the incidents or the range of incidents that occur (Nuckols et al, 2007). There are limitations to what the incident reporting systems seem to be able to achieve in practice. “ The subjective nature of reports, the lack of consistency and validation of incident data classification, and underreporting constrain incident reporting from being used as a reliable epidemiological tool to measure the frequency of events

and whether interventions are effective in improving patient safety” (Evans et al, 2006 p 40). What this shows is that incident reporting is a very important aspect of the ongoing surveillance and improvement of healthcare practice.

This underreporting may be due to a number of reasons, including a reluctance to admit mistakes or to be seen as being ‘ to blame’, because of a sense of vulnerability on the part of nurses and other professionals (Bolsin et al, 2005). Johnstone and Kanitsaki (2006) state that as disciplinary and legal cases against nursing staff show, reporting nursing-related errors carries a risk for the nurses themselves, which is something which should be addressed in relation to promoting better incident reporting.

It may also, in relation to medical professionals, be because a sense of medical hegemony which leaves doctors feeling invulnerable (Bolsin et al, 2005). However, the NMC (2008) requires nurses to be accountable for their own practice, to put patient needs and safety at the centre of all their actions, and to strive for the highest possible standards of care. Therefore, incident reporting must form a part of good nursing practice. Even the sense of vulnerability that can come from working in unsupportive clinical environments should not erase the legal obligation to report incidents which have adversely affected patients. Organisational culture may limit the incident reporting of the staff involved (Waring, 2005). Also, misconceptions of what constitutes an error may limit reporting activities (Throckmorton and Etchegaray, 2007).

However the literature also suggests other reasons might prevent nurses from reporting adverse clinical incidents, despite the legal, professional and moral imperative to do so. One reason might be that the process of incident reporting is seen as too onerous. “ Traditional narrative methods of documenting adverse incidents are time consuming and may not yield sufficient and accurate data.” (Wagner et al, 2004 p 835). Evans et al (2006) suggest that those incidents which occur most frequently, as well as incidents which are not easy to record using the typical recording systems seen in many clinical areas.

Evans et al (2006) in their research found that barriers to incident reporting for doctors included a lack of feedback from reporting incidents previously, the form used taking far too long to complete, along with a belief that the incidents not reported were too trivial to be reported. Nurses, however, although they also found a lack of feedback prevented them reporting incidents, but unlike doctors, they believed that there was no point in reporting near misses, and they quite often forgot to make a report when the ward was too busy (Evans et al, 2006).

Incident reporting can be related to specific clinical risks for target populations, groups or clinical areas. For example, incident reporting on falls in elderly care settings is a high priority (Wagner et al, 2004). It is also commonly a priority in relation to medication errors (Handler et al, 2007).

The solutions to this problem are potentially diverse. The literature shows that for some clinical areas, for example, changing the documentation to suit the area and the kinds of incidents being reported might improve incident

reporting rates and reduce incident rates (Wagner et al, 2004). Thus, providing streamlined, focused documentation might be a solution, but this would have to be quite specific, and some clinical areas might contain too many diverse risks for this.

Vogus and Sutcliffe (2007) suggest a more managerial approach to improving incident reporting rates, such as bundling safety organizing with leadership (trust in manager) and design (use of care pathways) factors into nursing practice. Their research suggests that managerial approaches which affect the everyday behaviours of nurses can improve incident reporting (Vogus and Sutcliffe, 2007). Handler et al (2007) in their research showed that organizational-level interventions rather than individual-level interventions improved medication error reporting.

Nakajima et al (2005) suggest that incident reporting should form part of patient safety programmes, and suggest the use of a web-based incident reporting system, along with identified staff responsible for incident reporting and support, staff education programmes, and integrated (and varied) feedback mechanisms. They found that this mulit-layered approach helped to improve and support a safety culture, improve multidisciplinary collaboration, and an overall systemic improvement, but that this required strong managerial leadership (Nakajima et al, 2005). Evans et al (2007) also used a similar approach, with identified people at all levels of staffing who supported the process, tailored incident reporting systems, and staff education.

Kingston et al (2004) focus on the use of all kinds of supportive approaches and mechanisms to basically motivate staff to report errors. “ Both medical and nursing participants made comments that a more effective and efficient incident reporting system without threat or blame, providing prompt, relevant feedback and driving improvements in health administration, would possibly motivate medical staff to report” (p 38).

Pierson et al (2007) state that “ web-based or electronic error reporting systems are particularly effective in increasing the quantity and quality fo reporting and yielding the type of information needed for improving care” (p 297). This would suggest that the use of some kind of electronic system would be an appropriate way of improving incident reporting, although this author believes this might depend on the skills and attitudes of staff concerned. Taylor et al (2004) cite similar findings from their research, suggesting that electronic reporting systems could make it easier and quicker, and state that “ a substantial educational effort, aimed at nurses and, in particular, physicians, about which types of events should be reported and how to report errors is needed” (p 734). Dollarhide et al (2007) show the efficacy of a handheld-based electronic reporting tool for clinical incident reporting, showing that this made reporting much easier and more streamlined, but these would be too costly for the NHS setting.

Planning

The change that would be needed is summarised below. The change would be planned to incorporate the following elements:

- Identification of key personnel, including managerial level leaders, and staff across each grade and within each profession, to support the patient safety programme.
- Development of a mission statement encompassing patient safety protocols and incident reporting processes
- Development of incident reporting tools for specific incident reports, and an electronic/digital/web-based or email-available general reporting form.
- Development and implementation of a staff education programme on the new system, and incorporation of training and updating on staff mandatory study days (attended yearly).
- Development of a range of feedback mechanisms to staff are aware of what happens to the cases that are reported upon.

Implementation

All of the above activities should be finalised before the change is implemented. The key personnel will help to disseminate the information about the change, and then implement the change, supporting staff constantly as they adjust to the new procedures for reporting.

Evaluation

Evaluation of the change should be formalised at six monthly intervals for the first two years, but should also be built in to the feedback and reporting mechanisms so that staff themselves are fully involved in the evaluation and can feel that they ‘ own’ this aspect of their work. Involving staff at all levels is likely to improve motivation (Evans et al, 2007). Focusing on practical

solutions which are effective in this environment means that the evaluation should look at suitability, effectiveness and acceptability by the staff concerned.

Conclusion

It would appear from this brief review of the literature that in order to improve incident reporting, it is necessary to motivate staff to report. This can be achieved through education, through better incident reporting tools, which may ideally be electronic, and through managerial level leadership which changes organisational/workplace culture as well as providing better staff involvement, better feedback on reporting, and less threat to staff.

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