IMPROVING THE REPORTING OF ADVERSE EVENTS AND NEAR MISSES IN MENTAL HEALTH SERVICES

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This research has been commissioned by the West Kent NHS and Social Care Trust in order to improve the reporting of adverse clinical incidents and ‘near misses’ within the Trust. We would like to thank everyone who has contributed to this research, but particular thanks are due to all those members of staff who agreed to be interviewed. In order to protect their confidentiality, we cannot, of course, name them in this report.

We would however, like to thank in person Dr Claude Pendaries, Director of Corporate Affairs, who commissioned the research on behalf of the Trust, and Helen Buttivant, Clinical Risk Analyst, who provided background information on the Trust’s reporting system.
EXECUTIVE SUMMARY

Introduction

This report is based on research carried out in the West Kent NHS and Social Care Trust during the spring and early summer of 2004. The main aim of the research is to improve the reporting of adverse clinical incidents and ‘near misses’ within the Trust, which has recently introduced a ‘no-blame’ reporting policy across the organisation. This approach, which is in line with current government policy, is part of a ‘whole systems’ approach to risk management within the Trust, from which it is hoped that “lessons from adverse events in one directorate are learnt across the Trust, and eventually, across the NHS as a whole.” (West Kent NHS and Social Care Trust, 2002)

To support this work, the Trust has developed its own, in-house incident reporting system, and appointed a clinical risk analyst. Analysis of reporting data, however, has raised a number of questions that cannot be answered using existing figures. For example, there appears to be considerable variation in levels of reporting across the Trust, a phenomenon with a number of possible explanations. Is this, for example, simply a reflection of different numbers of actual incidents occurring in different parts of the Trust, or does it provide evidence of under-reporting? If it does indicate under-reporting, what factors might be influencing this? Clearly, further investigation is required to gain a deeper insight into the factors influencing the levels of reporting within the Trust.

Aim

The main aim of this study was to gain a deeper understanding of the factors influencing the reporting of adverse clinical incidents and near misses within the West Kent NHS and Social Care Trust.

Approach

This study uses a qualitative research design to explore participants’ understandings, experiences and perceptions of the Trust’s reporting policy and practice. The main method of data collection was face-to-face, in-depth interviews with Trust staff from a range of clinical and managerial backgrounds, working in different parts of the organisation. Additional information was gained from a review of the policy and research literature in relation to clinical incident reporting, and informal interviews with key informants within the Trust’s clinical governance and risk management structure.
Conclusions

There is no consensus on what should be reported

One of the first questions posed by the statistics produced by the Trust’s reporting system, was the extent to which this might reflect the actual level of incidents and near misses occurring across the Trust. This question makes a number of assumptions, the first of which is that there is shared agreement as to what constitutes a reportable incident. However, as this small study shows, there is still no consensus across the organisation as to what, precisely, should be reported.

Research interviews highlighted that the meaning of terms such as ‘adverse event’ ‘adverse clinical incident and ‘serious untoward incident’ were quite fluid, and frequently contested. This suggests that ‘adverse clinical incidents’ (now redefined as ‘patient safety incidents’ NRLA, 2004) are not stable realities. They are constructed and interpreted within specific organisational and professional contexts – and there may be discrepancies between ‘official’ and ‘unofficial’ meanings, or between meanings attributed by different professional groups, or within different services, at any given point in time. Furthermore, some incidents can only be seen to be such retrospectively – that is, they only become an incident because of their consequences. Arriving at a shared definition, which can be enforced across the whole organisation, may be unachievable – especially in the short to medium term.

The purpose of reporting needs clarification and communication

As well as the difficulties encountered in deciding what to report, the purpose of reporting is often called into question. Within the risk management literature, for example, this is frequently seen in terms of its potential for reducing legislation, as well as improving patient care. Whilst this is acknowledged as containing some potential tensions, the clinical governance agenda is expected to overcome these by integrating risk management, clinical audit, clinical complaints and so on into “a more coherent and corporately owned approach to quality improvement.” (Walsh, 2001, p. 58) This focus on quality of care, Walsh argues, is “more likely to secure the support and involvement of clinical professionals, because it better reflects their purpose and values.” (Walsh, 2001, p.46) Nevertheless, reporting mechanisms are largely a reactive approach to risk management, and are often described in the literature in terms of their benefits to the organisation, rather than to the individual patient or member of staff.

This small study suggests that staff may take a rather different perspective, in which the purpose of a reporting system is seen as largely to protect the organisation, whilst allocating blame to the individual health professional. Reduction of harm to patients, and the potential for individual or organisational learning from incidents and near misses, were somewhat less evident. The perceived benefits of reporting would therefore seem currently to be outweighed by the perceived barriers – with fear of blame, and adherence to professional or team loyalty, taking precedence over taking the opportunity to raise the alarm in relation to potential risks. This would suggest that positive reasons for reporting may not be being adequately communicated to staff; or that positive action to address reported incidents may not be sufficiently visible to act as a further incentive. Greater promotion of reporting as an essential part
of a ‘whole systems’ approach to risk management may also be helpful, as evidence suggests that “the best way to reduce error rates is to target underlying system failures, rather than to take action against individual members of staff.” (NPSA, 2004, p.5)

Awareness of the reporting process is good, but there are some problems

As well as knowing what to report, and why reporting is important, staff need to know how to report a patient care incident. Recent national guidance advises healthcare organisations to “ensure that their staff can report incidents easily, using both local and national systems.” (NPSA, 2004) To do this, they need to be familiar with these systems, and how to use them. Staff interviewed for the purpose of this study demonstrated good levels of awareness of their local reporting system and knew how to use it, but were often confused about how it fitted with other systems, within as well as beyond their own organisation. The use of a single form across the organisation was mostly welcomed, but the time taken to complete it was not. Overall, the whole process was felt to be somewhat time-consuming and rather bureaucratic in operation.

Organisational culture

Recent NPSA guidance stresses that the key to a successful reporting system is an open and fair reporting culture, where “reporting is congratulated and individuals are not blamed of penalised for speaking out.’ (National Patient Safety Agency, 2004) However, despite the assurance from the Trust’s Chief Executive, this study suggests that there is still a strong perception of a ‘blame culture’ within parts of the organisation. Whilst this perception may well be rooted in past experience rather than current practice, the perceived consequences of reporting do appear to be a major deterrent to increasing current reporting levels. As the NPSA guidance acknowledges, “Staff will not report incidents if they believe that they are going to place themselves or their colleagues at risk of being disciplined or punished.” (National Patient Safety Agency, 2004) However, changing an organisational culture takes time, and there is a need to understand the existing culture before it can be changed. Various tools are now available from the NPSA website to support a safety culture assessment. These provide a ‘snapshot’ of the culture at a given point in time, and need to be repeated regularly to assess progress. (National Patient Safety Agency, 2004)

Conclusion

Behind the statistics produced by the reporting system lies a web of decisions and non-decisions, made by health and social care professionals and managers on a daily basis. The outcome of these individual decisions – about what constitutes a reportable incident (or near miss); whether this should be reported or dealt with in some other way (or both); what reporting might actually achieve (for patients, for the organisation, and for the individuals concerned); and what the consequences of reporting might be, for the member(s) of staff involved – are all key stages in the reporting process. If reporting is to be promoted as a proactive (rather than reactive) component of risk management in health and social care, these individual and organisational influences, and how they might be changed, need to be part of the debate.
RECOMMENDATIONS

Recent national guidance (National Patient Safety Agency, 2004) already addresses many of the steps that can be taken by healthcare organisations to improve their levels of incident reporting. Below are some further recommendations based on the findings from the study described above:

- Consideration could be given to the development of locally-agreed examples of ‘reportable incidents’ and ‘reportable near misses’ in order to assist local interpretation, and encourage some consistency at a service-specific level.

- The purpose of reporting could be made more transparent. For staff to become fully committed to reporting, its primary purpose needs to be improvement in patient care.

- The benefits of reporting – to themselves, to other staff, to patients, and to the overall quality of the service – also need more emphasis.

- Opportunities for streamlining the reporting process, or for dealing with minor incidents at a local level, may be worth further exploration.

- The development of a ‘blame-free’ culture needs further work. Incidents are still being interpreted as resulting from individual action, rather than systems failure. Training staff in a ‘whole systems’ approach may help.

- The Trust also needs to think through how blame is handled, when it is necessary to deal with it – for example, where cases of actual or potential clinical negligence or poor clinical (or managerial) practice are identified. Current processes are not perceived as fair and equitable across professional groups.

- The risk register might usefully collect data on who reports – not by name (which must be confidential) but by clinical/professional group. This would help to confirm or dispel perceptions that some professional groups do not report. If it is found that some professional groups are not reporting, reasons for this need to be explored, and appropriate action put in place.
GLOSSARY

Adverse clinical event – an event or omission arising during clinical care and causing physical or psychological injury (CLIN.GOV.12.01)

Adverse health care event - an event or omission arising during clinical care and causing physical or psychological injury to a patient (DH, 2000)

Adverse incident – an event or omission arising during clinical care and causing physical or psychological injury to a patient. (BMA, 2002)

Clinical governance – a framework through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish. (Department of Health, 1998)

Clinical incident – an event or omission arising during clinical care and causing physical or psychological injury. (West Kent NHS and Social Care Trust, ‘Strategy for the management of Clinical Risk’)

Clinical risk – refers to a risk alert that has been 1) assessed 2) the object of an action plan 3) logged in the Clinical Risk Register. There are two sorts of clinical risk, contributory risks and supraordinal risks (see definitions below). (West Kent NHS and Social Care Trust, ‘Strategy for the Management of Clinical Risk’)

Clinical risk register – refers to the list of supra-ordinal risks and their respective contributory factors. (West Kent NHS and Social Care Trust, ‘Strategy for the Management of Clinical Risk’)

Contributory risk – refers to the causal factors that have been identified as a result of a pattern of incidents. (West Kent NHS and Social Care Trust, ‘Strategy for the Management of Clinical Risk’)

Error – the failure to complete a planned action as intended, or the use of an incorrect plan of action to achieve a given aim. (BMA, 2002)

Hazard – anything that causes harm. (DH, 2000)

Health care near miss – a situation in which an event or omission, or a sequence of events or omissions, arising during clinical care fails to develop further, whether or not as the result of compensating action, thus preventing injury to a patient. (DH, 2000)

Internal inquiry – refers to the formal internal inquiry that often follows Serious Untoward Incidents. Internal inquiries are lead by a non-executive director and result in the formation of an action plan presented to the Board. (West Kent NHS and Social Care Trust, ‘Strategy for the Management of Clinical Risk’)

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**Near miss** – a situation in which an event or omission arising during clinical care fails to develop further, whether or not as the result of compensating action, thus preventing injury to a patient. (West Kent NHS and Social Care Trust, ‘Strategy for the Management of Clinical Risk’)

**Near miss** – a situation in which an event or omission, or sequence of events or omissions, could have resulted in injury to a patient if allowed to progress further or in different circumstances. (BMA, 2002)

**Risk** – the chance of something happening that will have an impact on objectives, measured as a produce of consequences (or impact) and likelihood (or probability). (BMA, 2002)

**Risk** – the likelihood, high or low, that somebody or something will be harmed by a hazard, multiplied by the severity of the potential harm. (DH, 2000)

**Risk alert** – any clinical incident brought to the attention of the Trust by staff, patients, relatives, visitors, or members of the public. It could take the form of an IRIS form, a complaint, a letter or even a phone call. (West Kent NHS and Social Care Trust, ‘Strategy for the Management of Clinical Risk’)

**Risk management** – the culture, processes and structures that are directed towards the effective management of potential opportunities and adverse effects. (BMA, 2002)

**Safety** – freedom from accidental injury; ensuring patient safety involves the establishment of operational systems and processes that minimise the likelihood of errors and maximise the likelihood of intercepting them when they occur. (BMA, 2002)

**Serious untoward incident (SUI)** – a clinical incident resulting in the death of the patient or another person (eg suicide and homicide)

**Service review** – refers to the informal inquiry that follows systematically all serious clinical incidents. Service reviews always result in an action plan. (West Kent NHS and Social Care Trust, ‘Strategy for the Management of Clinical Risk’)

**Supra-ordinal risk** – grouped categories of risk sharing similarities

**System** – set of interdependent elements interacting to achieve a common aim. These elements may be both human and non-human (equipment, technologies etc.) (DH, 2000)
INTRODUCTION

This report is based on research carried out in the West Kent NHS and Social Care Trust during the spring and early summer of 2004. The main aim of the research is to improve the reporting of adverse clinical incidents and ‘near misses’ within the Trust, which has recently introduced a ‘no-blame’ reporting policy across the organisation. This approach, which is in line with current government policy, is part of a ‘whole systems’ approach to risk management within the Trust, from which it is hoped that “lessons from adverse events in one directorate are learnt across the Trust, and eventually, across the NHS as a whole.” (West Kent NHS and Social Care Trust, 2002)

To support this work, the Trust has developed its own, in-house incident reporting system, and appointed a clinical risk analyst. Analysis of reporting data, however, has raised a number of questions that cannot be answered using existing figures. For example, there appears to be considerable variation in levels of reporting across the Trust, a phenomenon with a number of possible explanations. Is this, for example, simply a reflection of different numbers of actual incidents occurring in different parts of the Trust, or does it provide evidence of under-reporting? If it does indicate under-reporting, what factors might be influencing this? Clearly, further investigation is required to gain a deeper insight into the factors influencing the levels of reporting within the Trust.

This next section of this report describes the policy and organisational background to the investigation in more detail, and includes an overview of the national and local policy that has informed the introduction of the adverse event reporting system in the West Kent NHS and Social Care Trust. This is followed by a brief review of relevant research already undertaken in this area. The methods used to undertake the study are then described and assessed. This is followed by the research findings, broken down into four major themes: definitions and meanings; the purpose of reporting; the reporting mechanism; and organisational culture. The final section of the report contains a discussion of the main findings, and draws some conclusions that lead into recommendations for improving the implementation of local reporting policy, and suggestions for further research.
BACKGROUND

The West Kent NHS and Social Care Trust

The West Kent NHS and Social Care Trust is a combined health and social care organisation, currently providing acute and community mental health services to a population of around one million people living in West Kent. The Trust covers a wide geographical area, extending from the Thames Gateway area in the north to the Sussex Border in the south, encompassing both urban and rural populations. It employs over 3,000 people, with its clinical staff being drawn from a number of professional groups – including psychiatry, clinical psychology and specialist psychotherapy, mental health nursing, and social work. Trust management includes staff with a professional, as well as a general management background, and a number of senior staff combine both clinical and managerial roles.

The Trust was established in April 2002, following the merger of the former Invicta Community Care NHS Trust, Thames Gateway NHS Trust, and the mental health services formerly provided by the Social Services Departments of Kent County Council and Medway Council. During the merger, social services staff were initially seconded into the NHS for a period of three years, an arrangement which, at the time of the study, was about to be extended. A CHI clinical governance review undertaken in January 2003 reported that different localities within the Trust were at different stages of integration, and that there were “significant differences” in resources, in service provision and in user experience. Furthermore, CHI reported, implementation of the care programme approach (CPA) was also variable, and there was scope developing a more coordinated approach to clinical governance. (Commission for Health Improvement, 2003) Implementation of incident reporting mechanisms was not included in the CHI review.

The Trust’s clinical governance framework

A multi-level clinical governance framework has been established throughout the Trust, encompassing both health and social care. This includes a central Clinical Governance Committee, supported by Clinical Governance Committees within each Directorate, and a series of Specialist Committees dealing with cross-directorate issues. Clinical risk management is firmly located within this framework, as a cross-directorate responsibility, and the establishment and maintenance of a suitable system for the reporting of adverse events and near misses comes under this remit.

However, clinical governance is not the only factor driving the establishment of adverse event reporting within the Trust. Changes in the ways in which Trusts indemnify themselves against litigation are also important. As Walshe (2001) has argued, the main impetus for the introduction of risk management into the NHS during the 1990s was the rising cost of litigation; the establishment of the Clinical Negligence Scheme for Trusts (CNST), which made risk management a requirement,

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1 Medway Council is a unitary authority
2 This framework is set out in the Trust’s Clinical Governance Strategy (2002-2005), which has been jointly published by West Kent NHS and Social Care Trust, Kent County Council, and Medway Council.
provided further incentives. Clinical incident reporting systems are now also a requirement of CNST.

**National policy on the reporting of adverse events and near misses**

The monitoring of adverse clinical events and ‘near misses’ is currently high on the NHS policy agenda. Following publication of *An organisation with a memory* (DH, 2000) in which an expert group, led by the Chief Medical Officer, examined the issue of serious failures in clinical care, the Government published two further policy documents, *Building a safer NHS for patients* (DH, 2001) and *Doing less harm* (DH and NPSA, 2001.) Together, these two documents set out the government’s response to *An organisation with a memory*. This response has included the setting up of a new organisation, the National Patient Safety Agency, with a specific remit to improve the quality of care through reporting, analysing and learning from patient safety incidents (ie adverse clinical events and near misses) occurring in the NHS or in NHS funded care. (NPSA, 2003)

To achieve this objective, a national incident reporting and learning system (NRLS) is currently being developed and implemented. Officially launched in February 2004, the NRLS, which covers England and Wales, claims to be the world’s first such national reporting system in the health care sector. Over time, it is expected that the NRLS will enable staff, patients and carers to report adverse clinical incidents and near misses that they are themselves involved in, or which they witness happening. (NPSA, 2003) In order to avoid creating an additional burden for busy NHS staff, however, the NRLS has been designed to extract to information from existing local risk management systems. The NPSA does not itself investigate incidents, or become involved in any aspect of disciplinary procedures. Data is collected in an anonymous form, and neither individual members of staff, nor their patients, are identified at any stage of the NRLS process. (NPSA, 2004.)

**Local policy on the reporting of adverse events and near misses**

West Kent NHS and Social Care Trust’s policy on the Reporting of Adverse Clinical Events (CLIN.GOV.12.01) was developed at Board level, with the Director of Corporate Affairs acting as policy sponsor. An early draft was shared with all Executive Directors and some senior managers. The final version is one of over 40 policies relating to clinical governance, all of which are accessible from the Trust’s intranet. This policy, and the reporting mechanism which goes with it, were developed in response to the requirements of the National Health Service Litigation Authority, which (among other things) indemnifies NHS Trusts in respect of clinical negligence through the Clinical Negligence Scheme for Trusts. CNST reporting guidelines clearly require trusts to have in place “effective and integrated processes for risk management and for health care governance which operate across the entire service” (CNST, 2002).  

The policy itself is fairly brief. As well as outlining staff responsibilities in relation to the reporting of adverse clinical incidents and near misses, it contains definitions of both an adverse event and a near miss (both taken from *An Organisation with a Memory* Department of Health, 2000); details of the procedure to be followed when reporting an incident or a near miss; and a guarantee, signed by the Trust’s Chief
Executive, that staff will not be blamed for reporting an incident or near miss. The promotion of a ‘no-blame’ approach to incident reporting is, again, in line with current government policy. However, unlike the NRLS, the West Kent reporting mechanism is not anonymous. Any member of Trust staff reporting incidents or near misses are expected to provide their name, job title and work telephone number, so that incidents can be followed up by the Clinical Risk Analyst if further information is required.

The policy also has two appendices. The first provides general guidelines for reporting adverse healthcare events and near misses when risk-specific forms (usually the IRIS forms, see below) are not available. The second offers a list of examples of adverse health care events, most of which are based on real incidents extracted from previously reported events. These include things like medication errors, incidents of self-harm or harm to others, missing or incorrect patient records, and patient leaving the premises without permission. However, the list contains no examples of a ‘near miss.’

Incidents can be reported in a variety of ways. The preferred approach is the so-called IRIS form (NHS Incident Record Form IR1); but this is not the only mechanism in use. For example, medication errors may be reported on a different form, devised by the Trust’s Drugs and Therapeutics Committee. This form, which was piloted in the learning disability service for a year, has now been adopted across the Trust as the appropriate instrument for all incidents involving medications. In addition, general guidance for reporting incidents when the appropriate form is unavailable, is contained in an appendix to the Trust’s reporting policy.

All IRIS forms submitted find their way to an IRIS Review Group via the Trust’s Shared Services Agency – which deals with Health and Safety reporting. Each Directorate appears to have different arrangements for processing IRIS forms prior to this stage, but the final outcome is the same. Incident reports are collected, collated and analysed by the Clinical Risk Analyst, before being screened for potential inclusion onto the Clinical Risk Register. This register contains a list of ‘supra ordinal’ risks (compiled from an analysis of reported clinical incidents and near misses) and their respective contributory risks (see following section for more details). Incidents can also find their way onto the register via a number of other reporting mechanisms, including the Trust’s complaints procedure; case reviews; internal and external inquiries; medical devices alerts; Mental Health Act visit reports and minutes of Mental Health Act managers meetings; medical device alerts and the Caldicott Review Group.

**Policy implementation in West Kent NHS and Social Care Trust**

The process for policy implementation has changed since the Trust merger. In the past, policies were circulated manually, in hard copy format, to Directors. Copies were then cascaded within Directorates as appropriate. Since the Trust merger, all policies have also been accessible via the Trust’s intranet, and over 80 policies are now listed and available electronically (half of these relate to clinical governance).

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All new staff are informed of this process during their induction, and the addition of new policies is drawn to the attention of existing staff in team briefing meetings.

However, this system is clearly not working effectively. Analysis of risk alerts, case reviews and internal inquiries has highlighted the non-observance of Trust policies as a serious recurring problem, accounting for a large number of adverse incidents. The extent of this problem is reflected in the fact that ‘Breach of Trust Policies’ is included as a ‘supra-ordinal risk’ within the Trust’s risk management strategy. Contributory causes cited include factors such as lack of awareness, conscious breach, and ineffective dissemination.

To address this problem, a number of initiatives are currently being put in place. These include a concerted information campaign, via the Trust’s intranet, the staff newsletter and via senior managers. The other is the introduction of a system of ‘policy keepers’ across the organisation. These named individuals will be responsible for keeping an updated register of all Trust policies (either electronically, for those connected to the intranet, or manually, for those not yet connected) and for ensuring that all staff within their ward, department or team know of the existence of the register, and how to access it.
RESEARCH CONTEXT

Adverse events and near misses: the extent of the problem

Research into the area of medical error, adverse events and patient safety is a relatively young field in which many of the research questions needing to be addressed are quite fundamental. (Department of Health, 2001) Little is known, for example, about the extent of the problem. Estimates based on extrapolation from available data suggests that, nationally, as many as 400 people die or are seriously injured every year in adverse events relating to medical devices, nearly 10,000 experience serious adverse reactions to prescribed drugs, and around 1,150 people who have been in recent contact with mental health services commit suicide (Department of Health, 2000).

Locally, the number of incidents and near misses reported by staff within the West Kent Mental Health and Social Care Trust, is currently estimated at approximately 4,000 to 5,000 a year. All incident reports, medication error forms and relevant complaints are assessed against two parameters (Actual or potential impact, and likelihood of the event recurring) using the matrix developed by the National Patient Safety Agency. Identified risks are then grouped into categories (‘supra ordinale’ risks), and prioritised by the Clinical Risk Committee. The following 12 strategic priorities have recently been identified for action: (in order of priority)

- Management of self harm
- Poor implementation of CPA
- Medication errors
- Interface between services
- Inadequate admission and discharge arrangements
- Poor quality of clinical entries in patient notes
- Incomplete/ineffective reduction of potential ligature points
- Staff attitudes
- Resource deficits
- Non-respect of Trust policies
- Absence of systematic approach to the prevention/management of falls in the elderly
- Adult protection risks

How does this local data compare with previous research? Findings from a recent epidemiological review, which looked at the prevalence and consequences of medical errors, suggest that clinicians, patients and policy-makers may underestimate the magnitude of risk and the extent of harm (Weingart et al, 2000). Few robust studies are available, however, and comparison between studies is difficult, because research methods are not standardised. Thomas and Brennan (2001), for example, in their overview of previous research into errors and adverse events in medicine, concluded that, “almost every study uses different methods, terms and definitions” (Thomas and Brennan, 2001).
Any findings from these studies, therefore, need to be interpreted with caution. Great care also needs to taken when determining whether or not any particular service has a problem compared with another service.

“Ideally, we could directly compare among hospitals or clinics in order to focus quality improvement and risk management efforts. But determining whether or not one clinic has a problem compared to another depends on what definition of injury was used, how data were collected, and upon the patient populations in each setting.” (Thomas and Brennan, 2001, p. 32)

In addition to the problems of definition and methodology outlined above, there are also problems of the setting in which this work has taken place:

“Experience of adverse incidents is almost entirely based on their occurrence in secondary care. It could be argued that they are more likely to happen in the organisationally complex, high technology environment of a hospital. The truth is, we simply do not know…” (Department of Health, 2000, p.6)

In terms of mental health services, apart from national data arising from the Confidential Enquiry into Suicides and Homicides, there does not appear to be any robust data on the extent of adverse events and near misses, whether delivered in an acute or community setting.

As the Department of Health has acknowledged,

“…in this country, basic epidemiological research is now needed to establish the size, pattern and nature of medical error, adverse events and near misses in different kinds of healthcare settings.” (Department of Health, 2001, p. 60)

However, such epidemiological research will require clear definitions of what constitutes an ‘error’, an ‘adverse event’ and a ‘near miss’ in different health care settings, as well as accurate reporting systems to capture the necessary data.

**Incident reporting systems: a review of the literature**

Whilst accurate data on the scale of the problem of adverse incidents and near misses in a mental health setting may currently be unavailable, there is some research evidence available on incident reporting systems. A recent systematic review of the patient safety literature (Westwood et al, 2002) which drew on structured searches across fifteen data-bases and initially identified over four thousand papers, finally identified 385 papers which fitted its inclusion criteria. Of these, 46 papers focussed on the development and implementation of adverse event reporting systems, but not all of these were within the health care sector. Of those that were, the majority were undertaken in secondary or tertiary care. None were undertaken in mental health services.

Most of the studies reviewed within this in this category were observational (ie descriptive) in design and of variable quality, leading the reviewers to conclude that, in general, the quality of studies relating to adverse event reporting systems was low. Very few studies had attempted to evaluate both the effectiveness of reporting
systems for information gathering purposes, and the usefulness of the data gathered for informing the development and implementation of strategies to reduce the occurrence of adverse events and near misses. The review concluded:

“There is little evidence about the comparative benefits of different systems, and there is little research relating to the implementation of these systems and their acceptability to health professionals.” (Westwood, Rodgers and Sowden, 2002, p. 5)

This systematic review also identified 32 empirical studies investigating various aspects of organisational culture, including attitudes toward error and error reporting and barriers to the reporting of errors. Most of these were small-scale surveys of clinical staff, and the majority were undertaken in a single hospital. The research instruments (usually survey questionnaires) had mostly been designed specifically for use in each particular study, with little information given to enable the reviewers to make an accurate assessment of their validity or reliability. Findings therefore need to be treated with some degree of caution. Nevertheless, from their review of these studies, the authors conclude:

“Overall, the factors which emerged most frequently appeared to be linked to individuals, such as blame, fear of reprisal, unwillingness to accept responsibility when several individuals may have been involved and loss of clinical confidence.” (Westwood, Rodgers and Sowden, 2002, p. 42)

Despite the number of studies that highlighted the importance of organisational culture (particularly the need to focus on the establishment of ‘safety cultures’) Westwood and colleagues also report that they were unable to identify any research that had attempted to either implement or evaluate interventions to promote a safety culture. They conclude that:

“Interventions specifically targeting the identified beliefs about and barriers to reporting errors could be developed and evaluated, particularly if adverse event reporting systems are to be implemented successfully.” (Westwood, Rodgers and Sowden, 2002, p. 49)

Identifying the beliefs about, and barriers to, reporting in the West Kent NHS and Social Care Trust, with the aim of improving the implementation of the Trust’s reporting system, is the focus of this study. The study design and the research methods used are described in the following section of this report.
METHODOLOGY

The specific areas to be addressed by the research were derived from discussions between academic staff within CISS and the Trust’s Director of Corporate Affairs, who was responsible for commissioning the study. Reviews of the relevant literature were then undertaken to provide background information for the study, to inform the development of the interview schedule and, finally, to support the interpretation of the main findings and to set these in a wider theoretical context.

Research design

As the purpose of the study was to gain a deeper understanding of the factors influencing the reporting of adverse clinical incidents and near misses in a clinical setting, a qualitative research design was considered the most appropriate methodology for this study. Qualitative research methods have a long history in the social sciences, and are becoming increasingly used in health services research, where they are considered appropriate where the aim of a study is to gain access to participants’ meanings, experiences and perceptions of the phenomenon under scrutiny. (Mays and Pope, 1996; Green and Thorogood, 2004)

In health services research, qualitative study designs are also used to compliment quantitative studies – either as an essential preliminary stage (for example, exploring meanings and concepts to be used in a survey questionnaire); as ‘triangulation’ (to improve the validity of a study); as part of a multi-method approach (in which different types of investigation are needed for different aspects of the research); or to explore areas not amenable to quantitative analysis (Mays and Pope, 1996).

In the case of error reporting in West Kent, quantitative data analysis by the Clinical Risk Analyst has highlighted the fact there are considerable differences in the total numbers of errors being reported by different Directorates across the Trust (these are as great as 2:1 in some instances). Analysis of this reporting data, however, raises questions that cannot be answered using existing figures alone. Is this variation, for example, a reflection of different numbers of actual incidents, or does it provide evidence of under-reporting? If it does indicate under-reporting, what factors might be influencing this? Clearly, further investigation, using a qualitative approach is needed to gain deeper insights into the factors influencing the levels of reporting within the Trust, by capturing participants’ views of the reporting process.

Additional information was gained from a review of current national and local policy, (see above) the research literature, and existing data produced by the Clinical Risk Analyst. Informal interviews were also undertaken with the Director of Corporate Affairs and the Clinical Risk Analyst on the development and implementation of the Trust’s reporting policy and clinical risk strategy. This information helped inform the development of the interview schedule and interpretation of the data.
Research participants

Initial plans for the identification of potential research participants were modified following discussion with the Research Ethics Committee, and participants were subsequently recruited according to a protocol agreed with the local research ethics committee (see Appendix A). The final sampling frame was rather more limited than the research team had hoped to achieve, as not all Directorates within the Trust agreed to take part. Letters of invitation were initially sent out to 25 individual from three service areas, selected to cover a range of geographical locations. (Within Clinical Directorates, services are arranged on a locality basis.) A total of 12 applicants initially agreed to take part, but it was not possible to interview all of these. Some interviews had to be cancelled due to work commitments, sickness or changes of job, and it was not always possible to rearrange these within the timeframe allocated for data collection. The final study sample included staff from different professional backgrounds, made up as follows: psychiatry (1), clinical psychology (2), nursing (2), social work (2) and management (2). People from similar professional backgrounds were working in different parts of the Trust, with different levels and combinations of clinical and managerial responsibility.

Methods used for data collection and analysis

Data was collected by means of face-to-face interviews, undertaken by the researcher, in the participant’s usual place of work. All interviews were conducted over an eight-week period in the summer of 2004. Each interviews followed a semi-structured interview guide, devised by the researcher and approved by the local research ethics committee (Appendix B). This allowed for in-depth exploration of issues such as: participants’ own understanding of the terms ‘adverse event’ ‘adverse clinical incident’ and ‘near miss’; recent involvement in actual incidents or near misses; the rationale for any subsequent decision to report or not report; awareness of Trust reporting policy and procedures; experience of using these procedures; consequences of using the reporting process (or perceived consequences, if they had not used them.) Interviews were tape-recorded and transcribed verbatim. Transcripts were analysed using a mix of qualitative approaches.

Ethical issues

Permission to undertake the study was sought and obtained from the Kent and Medway Research Ethics Committee and the West Kent NHS and Social Care Trust’s Research and Clinical Effectiveness Committee, and the researcher had an honorary contract with the Trust for the purpose of undertaking the research.

Reporting of adverse events and near misses is a sensitive research area, and all staff who agreed to be interviewed were reassured that all reasonable steps would be taken to maintain their confidentiality at all times. Participation was entirely voluntary. Written information sheets were sent out with letters of invitation, and signed consent forms were obtained prior to each interview taking place. The initial recruitment strategy, which had been agreed between the client and CHSS, was also modified in accordance with the requirements of the local research ethics committee, to ensure that the Trust management had no way of knowing who had been invited to take part.
(The LREC approved recruitment protocol is attached as Appendix A.) Research findings have been presented in a non-attributable form, with identifying details such as professional background or service location omitted or changed where necessary to maintain anonymity.

**Research limitations**

This was a very small study, undertaken in one location, which used a qualitative methodology for exploring some of the factors that might lie behind variations the reporting of adverse clinical incidents and ‘near misses’ in an integrated mental health care setting. Findings need to be considered as indicative rather than conclusive, and may not be generalisable to other settings. Nevertheless, the strength of qualitative studies, which provide “well-grounded, rich descriptions and explanations of processes in identifiable local contexts,” (Miles and Huberman, 1994) means that studies such as this can be used to inform policy development and implementation at a local level.
DEFINITIONS AND MEANINGS

One of the key problems with existing clinical error reporting systems is the lack of consensus on what to report. As government policy documentation acknowledges,

“Few of the systems are based on a simple, easily communicable definition of what it is that should be reported. Few are governed by any clear reporting protocol that all staff are aware of, understand and are trained to use.”
(Department of Health, 2000, p. 74)

To overcome this problem, An Organisation with a Memory provides a glossary of key terms (Department of Health, 2000, p. xii), which includes a definition of an ‘adverse health care event’ and a ‘near miss’. These definitions have subsequently become widely used across the NHS, and have been incorporated into local policy documents, such as that governing West Kent’s reporting mechanism. Furthermore, Doing Less Harm emphasises the need for all staff, whether directly or indirectly involved in patient care, to be “aware of what constitutes an adverse incident.”
(Department of Health and National Patient Safety Agency, 2001, p. 9)

From an individual’s perspective, however, things do not appear quite so straightforward. Asked to explain, in their own words, what they understood by the terms ‘adverse incident’ (including variations of this term, such as ‘adverse event’ or ‘adverse clinical incident’) – using specific examples to illustrate their understandings if they would find this helpful – was not an easy task for most people, and a range of understandings emerged as the interviews progressed.

*Adverse event as hazard, or harm*

Some respondents clearly understood adverse events and adverse clinical incidents in terms of harm – specifically harm which might befall patients in their care.

“At an adverse clinical incident would be where actual harm has occurred, or almost occurred,” one interviewee explained, without giving any more details. Another, who used the term, ‘danger,’ went into more details:

“An adverse event could be something that could lead on, I believe, to something that’s quite dangerous…and within that, I see that as physical danger, but psychological danger as well.”

Examples of harm, or danger, offered by interviewees included circumstances where staff might put patients in danger through their actions, or alternatively, their failure to act. These included examples such as: differences of clinical opinion as to whether a patient was to be admitted or discharged; failure to undertake an adequate risk assessment, or failure to act on a risk assessment undertaken by another member of staff; allowing someone detained under the Mental Health Act to go on leave without informing the relevant community team; and failing to ask pertinent questions about issues of adult or child protection.
Staff attitudes towards patients also fell into this category, though respondents clearly found these difficult to talk about:

“...there are also incidents where...interactions between patients and staff have actually put patients in some form of psychological danger...incidents where staff have reacted quite badly towards patients”

But examples also included not acting on signs that a patient was likely to be a danger to themselves:

“you know, you’re sat with a person in an interview, and you see that they’ve been cutting their arms, or they’ve revealed that they’ve got...a suitcase load of pills under their bed or something”

However, not everyone interviewed restricted their definition to hazardous events. Others had a broader understanding, which included any unintended event, or unintended outcome of clinical care, whether hazardous or not. In some cases, this was as broad as to encompass any discrepancy between the intended and the unintended nature of the consequences of care that were perceived to be ‘adverse’; in other cases, the meaning encompasses mainly undesirable behaviour or events:

“The way I see it, [an] adverse event is anything that happens, or nearly happens, and should not have happened. This is, I think, very broad. Its not just about deaths and suicides, its also about near misses, [and] failures. For example, failure – failure to follow policies, or something that people say they’ll do but don’t do...anything undesirable, I guess.

Failure to follow Trust policies has been highlighted as a ‘supraordinal risk’ by the Trust, and is evident at a number of points during the interviews undertaken during this study, and this point will be picked up again under discussion of ‘near misses’.

Adverse events as natural causes

There was also the sense that some adverse outcomes were simply beyond the control of the service. Some suicides, one respondent felt, came into this category:

“...something we may have no control over, may be adverse. So, for example, in mental health a suicide may be due to actions, or lack of actions, of the staff. It may also be just a fact of nature. That somebody chooses to take that action.”

The ‘fact of nature’ explanation for adverse outcomes was also applied in cases where death was deemed to have occurred as the result of natural causes. Inevitably, in a larger service, which includes caring for the mental health of older people, patients known to the service will sometimes die from old age, or coexisting physical illness. Whether, and in what circumstances, these deaths should be treated as adverse events, or even serious untoward events (SUIs) is currently under discussion within the Trust.

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4 Whenever an interviewee expressed any reservations about disclosure, or seemed otherwise uncomfortable about something they were saying, the researcher offered to turn off the tape recorder. None of those interviewed took this offer.
“We have a healthy debate, at the moment” one respondent told me, “about whether the death of one of our patients, who is known to our service, but dies in the community due to natural causes, should be an SUI or an IRIS.” Another respondent echoed this debate, explaining how a death, from natural causes, of an older adult, had been flagged up as a serious incident. He clearly felt this was inappropriate. “You know, we don’t really want to treat every death as though…something went wrong.” Nevertheless, the outcome of this debate, at least, at the time of our study, was that all deaths to patients known to the service, should be reported on IRIS forms. Whether they should then be redefined as Serious Untoward Incidents, and consequently subjected to full Clinical Service Review process (see below) would depend on the outcome of initial investigation.

Clinical v ‘organisational’ meanings

One respondent, who first attempted to recall the ‘official’ Trust definition (which they were unable to do) then suggested, “going back to first principles.” A dictionary definition would be the best thing to go by, they said, with the caveat that this should be “clinically applied.” Asked whether they felt it would be possible to reach a shared understanding across the Trust, this respondent concluded, “I think, clinically, it might be difficult. But in terms of how we design and devise systems to work through, we could agree on a definition.”

This difficulty of gaining a shared understanding between clinicians and ‘the organisation’ also arose in another interview, with a different respondent (at a similar managerial level, but from a different professional background) in a different part of the Trust. This respondent also felt there was a difference between the organisational definitions and the ways in which these might be interpreted in a clinical setting:

“I do quite often get caught up with what I consider the Trust would consider an adverse event, and what I would clinically consider an adverse event, but essentially, my understanding is that its something that places somebody, or a group of people, in imminent danger…”

Clinical v social care meanings

Problems with different meanings and understandings do not only arise as a result of difficulties arising in translating managerial definitions into professional practice, however. There are also issues around the different language used to describe these things between health services and social care staff. As one respondent from a social service background expressed it:

“I think the problem lies with the terminology…because I don’t think there’s any doubt that, for a lot of social care staff, the term ‘clinical’ conjures up a health model. And I think, similarly…with ‘clinical’ adverse incidents or whatever, the very use of the term ‘clinical’ kind of…puts a frame in people’s minds.”

Use of the term ‘serious untoward incident’ (in common usage within social services prior to the merger with health services) was a bit more “social care friendly, in some ways” this respondent argued. This need to incorporate the language of social care
organisations was raised a number of times, including in discussion of clinical governance, where one respondent remarked proudly, “We’ve just reached the point where we are now going to talk about clinical and social care governance.”

Use of the term ‘serious untoward incident’ however, was not without its problems.

“I think the…the trouble with the whole process, is that, at least when we had terminology like ‘serious untoward incident’ – it was. You know, by definition, it was usually potential for violence, or self-harm, or, you know, some sort of embarrassment to Social Services. Whereas the IRIS form of course, covers everything! You know, from medication errors…through to the impact shortages of staff on a ward…how long it took to get a consultant psychiatrist – a whole spectrum.”

This extension of reporting to a wider range of events and incidents, it is suggested here, may be causing some uncertainly around what constitutes a reportable incident. “You know, is it serious? Is it not?”

Demarcation between ‘adverse event’ and SUI

For NHS staff, the demarcation between an adverse event and a serious untoward incident is also sometimes contested. Whilst some respondents felt the attribution of the SUI category was reasonably clear (“its death, really, or near death”) others felt even this definition was open to differences of interpretation. “There’s no definition of what constitutes and SUI. I mean, on the actual form, it says, ‘homicide, suicide, other…’ but the incident I had the other day…” This respondent then went on to describe an incident in which a patient under treatment died, but the coroner had subsequently given a verdict of death from natural causes. Whilst there was a suggestion (internally, within the Trust) that the treatment could have contributed to this death in some way, it was felt that it was up to the coroner to pick this up. “If it goes to a coroner, the coroner should indicate whether we need to do an internal enquiry,” this respondent concluded.

This view that it was up to the coroner to decide on the cause of death was echoed by another respondent, this time in discussion of suicide, “its up to the coroner to tell us which is suicides and which is deaths...” they said. These retrospective debates about cause of death do not only apply when cases have been referred to the coroner, however. In another interview, I was told about a letter the interviewee had received from another manager within the Trust, “where something had happened on one of our wards…that they felt was an SUI, and should be reported.” However, “to my way of thinking, that hadn’t been an SUI” they continued. Asked about this difference of definition, the respondent continued, “I think once people start analysing an incident, they can analyse that something potential could have happened.”

It would therefore seem that serious untoward incidents can only be accurately identified in retrospect, after a death has been defined as suicide, homicide, or due to some other potentially avoidable event. Until this point, they can only be ascribed the term ‘adverse event’ and, where appropriate, subjected to further investigation.
Nevertheless, interviewees who had been involved in clinical practice reviews frequently talked about the need to capture incidents further ‘upstream’ in the process of care, where “along the pathway, things have gone wrong, or things weren’t followed through.” One respondent summarised this as follows:

“When I do a clinical review, after, for example, a suicide, you can see near misses happening along the pathway…but what I’m finding is that people are not reporting those issues, because they don’t see them as an ‘adverse event.’

Again, there would seem to be evidence here of a difference between ‘official’ and ‘unofficial’ definitions of adverse events. This respondent was keen to point out that, for her, adverse events included things that didn’t happen, but should have done – such as the failure to follow agreed policies, for example, around undertaking risk assessment on patients.

‘Near misses’

Unsurprisingly, the concept of a ‘near miss’ was the most difficult of the terms we explored in the interviews. Although the Trust’s reporting policy offers an official definition, it fails to give any specific examples. “Well, I know there has been some debate [in the Trust] as to what constitutes a near miss” one respondent began, before going on to tell me that “a new definition has come” from the Clinical Governance Committee, and that “we are going to be given some information as to what is the new definition.” Other respondents found it easier to illustrate their answer with a specific example:

“One that immediately springs to mind is, we’re supposed to be a ligature-free environment. There was an incident where…a patient tried to hang herself from a shower-head. Fortunately, she failed. That was a near miss.”

The ‘near miss’ in this case was not just the patient’s failure to kill herself, but the organisation’s failure to notice that the particular design of shower-head provided a potential ligature point. Whilst all shower curtain rails had been replaced (in line with current recommendations), nobody had spotted the potential danger associated with the particular design of shower-heads installed in the building. (These have subsequently been changed.)

Another interviewee who also clearly found this concept difficult, used a number of illustrative examples:

“I think, you know, an obvious answer would be, you know, somebody who makes a threat – either physical or verbal, may not carry them out, but none the less, should be flagged up…I think people who continually talk in terms of self-harm, but maybe don’t act on it, I think that can be construed as a near miss.”

Others felt “there isn’t enough clarity about near misses” or expressed the view that “that’s very much more subjective.” They are the things where, “usually, ninety-nine times out of a hundred, they end up satisfactorily.”
There were also concerns about the increasing tendency to overextend the concept of ‘near miss’ – perhaps, it was suggested, “because of the culture of accountability and litigation, there’s almost a feeling that you’ve got to document everything.” This respondent argued for a balance approach:

“I think you’ve got to exercise some judgement here. Because anybody carrying out their professional function, you could argue, that they’re potentially in a position where they might encounter a near miss…”

It’s much easier to react to things that happen, I was told, than to things that might have happened, but didn’t – either due to chance, or to an appropriate early intervention, “because, on the whole, people kind of think, ‘well that’s everyday.’”

Whilst government and local policy documents all contain definitions of the various terms currently in use in relation to the reporting of adverse events and near misses, it would seem that the ways in which these definitions are interpreted within a clinical setting is subject to considerable variation. Indeed, we would argue that serious untoward incidents, adverse events and near misses are not stable realities, but are defined and redefined within an specific organisational and professional context.

Furthermore we would also suggest that how they are defined at any given time, or within any given organisation (or part thereof) may well influence the actions that health and social care professionals take in response to such an incident occurring (or ‘nearly’ occurring) in their day-to-day practice.

Other factors likely to influence the actions that people take in deciding whether to report an incident or near miss (assuming they agree that this has occurred) include the ways in which they perceive the reporting system, and the consequences that they believe are likely to occur as a result of reporting. However, before moving on to describing the findings from these two areas of investigation, it would be useful to look in more detail at the purpose of reporting, and how this is perceived by the staff who took part in our study.
THE PURPOSE OF REPORTING

Secker-Walker and Taylor-Adams (2001) are clear that “The primary purpose of incident reporting in clinical risk management is to reduce injuries to patients and staff. (p. 423) Additional advantages of reporting systems, these authors suggest, is that they can act as ‘early warning’ systems for the Trust, identifying potential negligence claims. This enables organisations to undertake early investigation of an incident, whilst recollection is still fresh, and to secure all the relevant patient records. There is also some empirical evidence that incident reporting can improve claims management and lead to substantial savings in legal costs. Structured analysis of specific incidents, the authors conclude, also facilitates organisational learning.

This description of the purpose of clinical incident reporting systems appears straightforward and uncontroversial. However, as Department of Health acknowledges, these different purposes (it lists four – spotting potential clinical negligence claims; identifying trends; handling media coverage; and organisational learning) are “potentially conflicting” (Department of Health, 2000, p.74).

Whilst eliciting staff’s views on the purpose of incident reporting systems was not initially part of our research brief (and we had not included any specific questions on this in the interview schedule), a number of interviewees nevertheless raised this issue spontaneously. Where they did so, this line of investigation was followed, and yielded some interesting insights, especially as the purposes identified in the literature, such as spotting potential negligence claims, handling media coverage and acting as the first stage in organisational learning were not highlighted explicitly by research participants.

Indeed, many of those interviewed tended either to take an individual, rather than an organisational, approach to any discussion of ‘purpose.’ Others talked of both organisational and individual reasons for reporting. Some discussed the purpose of the reporting system in general. Others talked only about their own reasons for reporting (or failing to report) a specific incident. From this data, a number of sub-themes emerge, which can be broadly summarised as follows:

Harm reduction

Certainly, part of the primary purpose of incident reporting, reducing harm to patients, was in evidence in some of the interviews. One respondent, describing a serious incident that had occurred some years earlier, following a difference of professional opinion, explained that she had reported the incident “for several reasons.” The most important of these was “for the client…because I felt that, if it was reported, maybe someone would intervene, and actually review the situation.”

The purpose of reducing harm to staff was also evident, though views on the extent to which people used the reporting system as a means of handling this varied. One clinician, who had failed to report an incident where he had been assaulted by a patient, said

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5 Secker-Walker and Taylor-Adams are drawing on evidence from one empirical study, by Lindgreen et al, (1991) to support this claim.
“I think there is a great reluctance on the part of health professionals to report against patients, because it is part of our care, to tolerate a certain amount of distress in the patient.”

Another respondent also picked up this point, describing how in the past, when he’d been an operational manager, he would sometimes come across staff “who had been subject to the most appalling abuse, or had been terrified.” However, because they either thought this was part of the job, or didn’t want to make a fuss, or perhaps, had seen it as a failure in themselves, they hadn’t reported this behaviour to anyone. Staff were now being actively encouraged to report incidents such as racial abuse, aggression and violence, he felt – whereas in the past, they might have felt they were inadequate either personally or professionally if they couldn’t handle such behaviour.

A manager who saw a number of incident reports as part of his job felt that this situation was changing. When asked about situations where staff may be put at risk by patients, he responded, “We get plenty of those! You know, abuse, aggression towards staff...people are beginning to be able to [report] that, yes.” This change appears to have been brought about following changes in NHS policy, which the respondent believed has had a positive impact on staff reporting incidents against them:

“There used to be a time when staff were very annoyed, when the Trust could not sue the patient, and they could not understand why not. But now there’s a system. The government Department of Health has a system, and we can use that.”

Identifying trends

Some respondents also commented on the ways in which incident reporting data was being used at an aggregated level:

“because that’s the only way, at the end of the day, that the Trust is going to know what works and what doesn’t. What the trends are, you know, where the service shortfalls are, is if they’ve got evidence.

This evidence was being used

“In a number of forums, including Clinical Governance, but also the Suicide and Homicide Committee, we look at the outcome of the reports. You know, what trends seem to be emerging.”

However, not everyone we spoke to had faith in the accuracy or usefulness of this data. A nurse manager commented, “If you are working with medical staff, and psychology – who are very used to statistical data – they laugh in the face of our clinical risk register.” Reasons for this scepticism clearly related to the ways in which the statistics were ‘socially constructed.’

There were not only concerns about the observed variations in levels of reporting between different parts of the Trust, and questions about the extent to which these reflect actual variations in the number of incidents occurring, or alternatively could be
explained by variations in reporting behaviour in different services – a concern that underpins the rationale for this research study. But there were also concerns about the way in which the current reporting system fails to differentiate between multiple incidents of a similar type in a similar location, and multiple incidents to the same patient. As one respondent commented, “I’ve suddenly realised that [in] one particular ward, where we’re getting a lot of falls…there’s no way to pick out how many falls each patient was involved in.”

Also, the way data is presented is not always perceived as putting numbers of incidents into an appropriate context:

“For example, medication errors… I mean, basically, it looks like a lot, in relation to other clinical incidents. But if you think that, on a typical ward, there might be thirty patients, who are on medication four times a day, that’s a hundred and twenty administrations of medicine. If you multiply that by the number of wards…”

The way the numbers are presented adds to this, “There’s no percentages, of how many, of what the percent of errors are.” This failure to put number of medication errors into the context of the number of times medications are administered, this respondent felt, undermined the validity of making medication errors as priority, as did the failure to take account of the seriousness of the errors themselves. “Its just ‘medication errors’ quantified as a significant risk, as a priority.”

The tendency to ‘measure the measurable’ and the problem of under-reporting are also likely to influence the quality of the data used to compile the Clinical Risk Register, and these two factors both arose in discussion of medication errors, though they are likely to have contradictory effects. High levels of recorded medication errors could be explained, one respondent suggested, because “medication’s easy, cause its concrete. Its there on the card.”

Reporting as an end in itself

There were also some concerns that reporting was becoming an end in itself, rather than a means to an end. As one respondent put it, “if they call it incident reporting, that’s what they’re doing. They’re reporting it!” Perhaps, he thought, this was not entirely staff’s fault. After all, he continued, “we call the book the reporting book. That tells them what to do.” There was a sense in which this action then passed responsibility for dealing with an incident ‘up the line’ – “all they need to do is complete these [forms] and senior managers will be told about it.”

In this sense, the process was also becoming seen as bureaucratic. As another respondent put it, “Its ticking boxes, I think.” This could, of course, become counterproductive, as “they’re so desperate to fill in the right forms, so they don’t get a rap over the knuckles, that they’re not using their clinical skills, and they’re not reporting the subtleties of risk.”

Again, in another interview, following discussion of the Care Programme Approach, and comparison of this with the adverse event reporting system, a respondent
observed, “you know, that seems to be the care, not the care. The forms have become the care, not the care itself.”

**Reporting as ‘organisational reassurance’**

Staff working within mental health services often work under considerable pressure, and there is a strong perception that the service is under-resourced. However, there is also a concern that resource issues are not being openly acknowledged across the organisation. Indeed, one respondent expressed the view that there was “massive collusion about how under-resourced we are.” This meant staff were often under strain. This factor, combined with the need to meet demanding targets, led to an over-emphasis on risk management, rather than service quality. Because of this, “we miss some of this…early process stuff…that is basically good practice, that, because people are so stretched, does build up, and then we do have these near misses or incidents.” In this sense, this interviewee suggested, the purpose of the incident reporting system was to provide the organisational reassurance:

“I think we’re sort of – we partly feel better because we’ve got this, you know, huge mechanism…to capture these things. So, in a way, as an organisation, we feel better. But I think, in a way, it’s a defence against all these other things, that are bubbling away under the surface.”

**Reporting as a ‘professional cover’ (or professional exposure)**

This notion of reporting as a defence mechanism was not, however, restricted to the organisation. There was considerable evidence in the interviews that clinical staff used the reporting mechanism to cover themselves where disagreements occurred within multi-disciplinary teams, or where they felt that they might be blamed for someone else’s action (or inaction). One example was, again, where a clinician reported a professional difference of opinion over the discharge of a patient. After arguing strongly, “people will avoid reporting at all costs,” this respondent then went on to qualify their statement:

“Well, not at all costs. But if – and this is a really difficult thing to talk about – but my sense is that people use reporting to protect themselves, one way or another.”

Further probing led into a further discussion of how difficult it is for people to report, and what it feels like to actually do it. This respondent continued,

“That’s what it feels like. Its like – they’ll find a way of not reporting because they feel it will expose them. Or they feel they absolutely have to report, because they might, um, you know, something might befall them”

Reporting is clearly not an action undertaken lightly, and many individuals feel that they would have to have a very good reason for doing so. In this case, the respondent was asked what they felt people might be protecting themselves from, if they were to report an incident. Their reply, “making sure the blame isn’t pinned on them” is also significant in terms of understanding staff’s attitudes towards the Trust’s ‘no-blame’ culture – a theme dealt with in more detail under later in this report.
Reporting as ‘reflective practice’

The only respondent who acknowledged the ‘early warning’ function of adverse event reporting, had specific responsibility for clinical governance in their part of the Trust, so was it possible that they had the early warning of a potential complaint or clinical negligence claim in mind when they said, “Every time you see an incident, or fill in an incident form, or sign one…it should raise some alarms.” Further probing, however, was more in line with a focus on the potential implications for individual clinical practice, clearly locating the purpose of reporting within service quality agenda:

“If I was a manager, if I was in charge of a ward and an incident happened, I would expect the individual to have looked at the incident, to find out what had happened, what contributed to it…and to have taken some immediate action to contain that, hopefully to prevent its recurrence.”

This view of ‘purpose’ seems to have as more in common with the concept of ‘reflective practice’ – a specific requirement of professions such as nursing, as with concept of ‘organisational learning’ at the centre of much of the patient safety literature.

Reporting as ‘organisational learning’

The concept of ‘organisational learning’ did not arise spontaneously in any of the interviews, and when specifically raised by the interviewer, there was either little response, or some scepticism expressed. One interviewee remarked,

“I don’t feel that the whole reporting mechanism, and the way it explained within the Trust, supports a learning culture at all. I think it’s – people see it as – pinning the blame.”

Again, this strongly suggests that the concept of a ‘learning organisation’ is not widely understood or accepted across the organisation, and that the Trust’s ‘no-blame’ policy is seen as rhetoric, rather than reality. These two issues will be returned to in the final section of this report. However, before moving on to a discussion of organisational culture, it would be useful to explore people’s awareness and perception of the reporting system itself.
THE REPORTING MECHANISM

The rationale for the introduction of an incident reporting system within the Trust has been described above, in discussion of the national policy context. Its intended structure is set out in the local policy documentation, also discussed in the background to this study. The system has clearly been designed to follow Department of Health and National Patient Safety guidelines, and to fulfil the requirements of the Clinical Negligence Scheme for Trusts. In theory, it fulfils these objectives to a high standard.

However, in practice, implementation is showing some difficulties (see Background, above). Failure to comply with Trust policies (including, presumably, the Trust’s policy on the reporting of adverse events and near misses) has been highlighted as a ‘risk alert’ within the Trust’s risk management structure, based on evidence from case reviews and internal inquiries. In addition, variations in levels of reporting across the organisation are leading to a strong managerial perception of under-reporting in some areas. This section of the report will explore the reporting system in more detail, from a participant’s perspective, based on interviewees’ responses to questions about their knowledge and ownership of the reporting policy, and their experience of using the reporting process.

Awareness and ‘ownership’ of reporting policy

Awareness of the existence of the reporting policy was high, but detailed knowledge of how it worked in practice was rather more limited. Some respondents saw IRIS forms as part of their job, but few of those interviewed had actually used the process themselves to report an incident (although some reflected that perhaps, with hindsight, there were occasions when they probably should have done).

Ownership of the process was variable, with some feeling that they had been involved in the process of development, either commenting on drafts of the policy document, or taking part in meetings where the issues were discussed:

“I’ve not been involved, but reasonable. I would say the ownership’s reasonable. I mean, it gets discussed at clinical governance, there’s a level of consultation that you’ve been through”…

Another, who had seen and responded to a draft, commented “It’s unlikely that all staff down through will have seen the draft, but it certainly went to the senior management.” This view was echoed on both the health and social care side of the organisation, with an interviewee from a social care background commenting, “I’ve had an impact into draft documents, trying to make them more social care inclusive.”

There also seemed to be a level of confidence that changes could be made during the implementation process, should this be necessary, “its one of those documents that grows in using, I think” another respondent observed. “I think within governance [ie the Clinical Governance Committee] we were reasonably consulted about how it’s developed. We’ve changed it about six times!”

However, this view was by no means unchallenged. Other, more critical voices expressed the view that the policy process within the trust was somewhat ‘top-down’
in its approach, though one respondent specifically asked not to be quoted on this matter. Someone elsewhere echoed this view, “I mean, this is a very driven reporting culture. It’s a very ‘top down’ Trust, not ‘bottom up.’

A more balanced view was also apparent. One respondent, who also felt that ownership was an issue, expressed the view that this was because there was more work that needed to be done:

“My own view is that there is a large pool of very interested people, with high levels of energy...[but] we need to explore robust mechanisms, which have to be owned...by both clinicians and non-clinicians, so that the impetus is there to drive the change forward.”

This person felt that resistance to change was rather inevitable, “because we like inertia” and if you have to move things forward, “you have got to move it from as many angles as you can.”

Existence of alternative mechanisms

At a number of points in the interviews, the existence of alternative reporting mechanism became apparent. In some cases, these were also ‘formal’ systems, such as the national Confidential Enquiry into Suicides and Homicides (which collects data on suicides and homicides by people who have been in contact with mental health services with the 12 month period preceding the event), and the Medicines Control Agency (which collects data on adverse drug reactions). It was not possible, within the interviews, to explore whether people were using these national mechanisms rather than the local one, or in addition to it – though this may be an area worth further investigation.

Alternative systems also existed as part of the legacy of the recent merger, though there was confidence that this was being overcome as systems were being integrated. The two former NHS Community Trusts were both using the IRIS system at the time of the merger, although reporting rates were very different in the two organisations. Social Services staff, on the other hand, had their own reporting process prior to the merger, but this was only used for reporting serious untoward incidents (see above). As a result,

“in the early days of the merger, we had social workers filling in their forms, and health staff filling in the IRIS form, and we actually – a decision was taken that we would use a common form, with the proviso that, where incidents involve social care staff, that copies of that form would actually go to Kent County Council health and safety advisers, so that...they could keep a track on what was happening to social care staff.”

Whilst instances still arise where a member of the social care staff will fill in the old serious untoward incident form, rather than the IRIS form, awareness of the new procedure is now felt to be gaining ground. There is even some suggestion that it is

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6 Social care staff are technically employed by Kent County Council, but on secondment to the Trust.
leading to an increase in reporting, as the scope of what constitutes a reportable incident has broadened (see above.)

In addition to the IRIS system, the Trust has now also introduced a form specifically for the purpose of reporting medication errors. This was initially piloted in one Clinical Directorate with a high level of reported medication errors, and its use has subsequently been extended across the whole organisation. However, this does seem to be causing some confusion, “there are a number of procedures in place with regard to medical errors” one person said, “we have the yellow forms, the BNF…” “We have our medication error policy, which the Drugs and Therapeutics Committee is developing.” There was also confusion about whether the new forms should be completed in addition to the IRIS forms,

“that pad should be a secondary pad. If someone completes an IRIS, then the manager should review it, and if there’s a need to move on to a medication-specific investigation, then it should be done. But having two pads – when you start – well, I think that’s why there’s the under-reporting. It’s that second pad.”

The final alternative is not really an alternative system, as such, but an alternative course of action. This particularly applies to near misses. As one respondent explained, “If they’ve got a near miss, and they’ve managed it, they don’t put it in a form.” However, there were also a number of examples cited during the interviews, where people described actions taken to resolve actual adverse events without reporting them, for example, when discovering prescribing errors made by doctors:

“Doctors frequently prescribe incorrectly, or don’t date entries, or give wrong doses. The nurse will bring it to their attention, and it’ll be changed. But in theory, that’s an IRIS reporting incident, but it doesn’t happen. They just correct it.”

In cases such as these (and others examples were given) action is taken to deal with the situation, but reporting is not considered an option for a number of reasons, some of which are described elsewhere (taboos on reporting against colleagues; the power differential between different professional groups, for example – see next section.)

When talking about health professionals reluctance to report on their patients, however, in a situation where the interviewee had not reported an incident where a patient had been violent to her, another interviewee remarked, “my experience is that there are mechanisms where my colleagues feel free to come and tell me… it’s done in an atmosphere where – it’s done confidentially, protecting the person. That’s my experience, anyway.” The confidentiality of these informal processes may be a significant factor, especially in a situation where formal processes are not anonymous.

Using the IRIS mechanism

A number of respondents commented on the time it took to complete IRIS forms, “especially now that we do the back.” (Completion of the back of the form, which asks for additional information on any local investigation or analysis of an incident, and details of any action taken, is a relatively recent requirement, but one that is not
always followed.) “The IRIS form’s good” one interviewee commented, “but its just very time consuming.” “You know, we’re taking clinicians’ time,” another added, “legitimately, I think, but you know, they do take a long time to fill in.”

There are also some concerns that the form does not capture everything. Whilst it’s alright for “most incidents” such as medication errors, faulty equipment, violence and such like, it has its limitations – “I think, in mental health, there’s a lot of subjective stuff, that may never appear on an IRIS form.”

Processing the forms is also a lengthy procedure. “It really is too slow” one respondent complained. Another tried to explain the reasons for this:

“It can go through the ward manager, the nurse in charge of the ward, then the ward manager, and then the service manager, then the inpatient manager, and then the service manager – and then a copy goes to Health and Safety, and two months, nothing happens. And two months later I receive a copy!”

Managers are perceived to allow the forms to accumulate before passing them on through the next stage in the process, but the sheer volume of forms is also an issue. “Something is blocking people…people say they’re too busy…[it’s] impossible for some reason.” These delays are a particular concern in terms of dealing with ‘near miss’ situations.

Levels of reporting

The perception of under-reporting was mentioned on a number of occasions, but when asked to explain the basis for this perception, interviewees were rather vague. “I’m confident that there’s a lot of under-reporting. I’m quite confident about that” one person said, “I think staff do report a lot of things, but I’m sure they’re unaware of some of the other ones that they should be reporting.” This perception would seem to link to the issue of what constitutes a reportable incident (see above), but also raises questions about the possible barriers to reporting, some of which have already been discussed (for example, those related to the purpose of reporting). Others are clearly linked to individual’s perceptions of the consequences (or perceived consequences) of reporting, which are discussed in the final section of this report.

Accuracy of the data produced as a result of the reporting mechanism was also called into question. For example, one respondent asked, “where do you stop and start reporting falls? I’m quite sure that my nurses, on occasion, report one fall and will loop two or three other falls together – because you might have someone who’s a persistent faller.” This tendency to roll a number of incidents into one report was mentioned on a number of occasions, and might well account for some of the perceptions of under-reporting.

However, there were challenges to this perception. One respondent thought that levels of reporting had increased since the introduction of the new system, “I think we’re probably reporting far more now” they said, adding that this was due to the introduction of the new mechanism, with a broader definition of what should be reported, and the fact that “the whole reporting system is pretty tight.”
There was also a perception that it might already be too high:

“I think that there’s a danger that we do over-analyse ourselves…I think we should be getting the real, obvious risk factors right first, before we start looking to go beyond that. At the moment, we just seem to be trying to encompass everything.”

Some respondents clearly thought this reflected a culture of litigation, in which the tendency to report everything was interfering with the process of care. These perceptions will be discussed in more detail in the following section, which explores the organisational culture within which the reporting system is embedded.

Perceptions of who reports

The issue of who reports also arose quite frequently (and unsolicited) during interviews. There was a very strong perception within the health care professions that nurses reported far more frequently than doctors. “Some doctors, you know, they do not report drug errors” one respondent stated. Another observed, “I’ve never seen and IRIS form completed by a medic. Ever. Or a psychologist, I don’t think.”

When asked why not, one interviewee suggested “either they don’t know about it, which I find very surprising…or they don’t see it as their job.” Giving a specific example, this person continued, “and I’ve had this before, in another incident…I told [the doctor] that I needed an incident form. He instructed the ward staff to do it!” Another observed that “the medics are very comfortable with the risks they manage.”

Asked who does report, there was general consensus that this was “mainly nurses.” One explanation for this was given as follows, “because the risk analysts and clinical governance coordinators are nurses, the Directors tend to be nurses or social workers, there’s much more emphasis put on the largest part of the workforce.” But this did not seem to be without its problems, as “doctors are the weak link in our risk analysis” one respondent added.

These perceptions of professional differences also arose in discussion of the consequences of reporting, which are also discussed in the following section.
ORGANISATIONAL CULTURE

Government policy documents such as An Organisation with a Memory (Department of Health, 2000) Building a Safer NHS for Patients (Department of Health 2001) and Doing Less Harm (Department of Health and National Patient Safety Agency) are attempting to ensure that all NHS organisations move from away from a ‘culture of blame’ and become ‘safety cultures’ in which organisational learning can flourish. The rationale for this approach is rooted in the ‘systems’ approach to the management of patient safety, which acknowledges that, whilst human error may sometimes precipitate serious failures, “there are usually deeper, systematic factors at work which, if addressed, would have prevented the error or acted as a safety-net to mitigate its consequences.” (Department of Health, 2000) Arguing that activities to enable organisations to learn from and prevent failures need to address these deeper causes, An Organisation with a Memory (Department of Health, 2000) identifies the importance of organisational culture in this process:

“There is evidence…that ‘safety cultures’, where open reporting and balance analysis are encouraged in principle and by example, can have a positive and quantifiable impact on the performance of organisations. ‘Blame cultures’ on the other hand can encourage people to cover up errors for fear of retribution and act against the true causes of failure, because they focus heavily on individual actions and largely ignore the role of underlying systems. The NHS still errs to much towards the latter.” (Department of Health, 2000, p. ix)

In response to this, the Trust in which this research took place has introduced a ‘no-blame reporting policy, in which there is a clearly stated guarantee from the Trust’s Chief Executive, inviting staff to report all clinical incidents and near misses, and offering them a personal guarantee that,

“In order to encourage a culture of openness and constructive criticism…staff will not be blamed nor disciplined for reporting such incidents, unless, of course, there are reasons to believe that such incidents happened as a result of malicious intent, professional misconduct or that they constitute a repetition of serious incidents.” (CLIN.GOV.12.01)

Staff perceptions of the Trust’s ‘no-blame’ culture

Evidence from the research interviews would seem to suggest that many staff are either unaware of the Trust’s attempts to move towards a ‘no-blame’ culture, or are not convinced that this exists in practice. One respondent was particularly forthright in their criticism, saying simply “I don’t think its worth the paper its written on, really.” Another, equally sceptical, “People know ‘no-blame’ doesn’t work. Because people will always be to blame.”

The notion of systems failure seemed poorly understood by some respondents. One respondent described a distinction between an adverse event occurring as the result of “misadventure” (where a “genuine mistake” had been made) and one occurring as a result of clinical negligence. “No-blame is where there’s a misadventure area, you’ve made a genuine mistake, rather than a clinical negligence issue. Its only no blame if
people don’t do clinical negligence.” This notion of wrong-doing (as opposed to system failure) was quite pervasive in some interviews, “If you’ve done something wrong, then you’re going to be blamed, there’s no point in trying to pretend otherwise.”

A particularly salient example was given, “If someone commits suicide because someone hasn’t done a risk assessment, or they’ve ignored the outcome of a risk assessment, then they have to be blamed.” People have to be individually accountable for their actions, it was argued, and “if they’ve done something that breaches their code of conduct” they need to take sole responsibility for this. “We wouldn’t have the GMC and the Nursing and Midwifery Council if it wasn’t for the fact that – that’s exactly what they’re there for.”

Others were a little more circumspect, implying that perhaps people had not (yet) established a level of trust in the ‘no blame’ policy, or that there was a gap between the rhetoric and the reality:

“I suppose, I mean the problem is, however you wrap it up, however much you say, you know, we’re working in a blame-free culture here, and that the object is to learn lessons, the reality is, people are extremely sensitive…”

The way incidents were dealt with, or had been dealt with in the past was felt to contribute to this, particularly in relation to internal enquiries and clinical reviews (of SUIs). As one respondent, a social worker, explained, the process itself can be perceived as giving somewhat mixed messages:

“you know, almost straight away, you get this sort of feeling, of well, you know, ‘they’ve taken our files’ and ‘they’re scrutinising them’ – but they’re saying its ‘blame free.’ That’s a hard one. Its really hard.”

The role of formal processes in attributing blame was highlighted on more than one occasion. For example, some parts of the Trust used to undertake suicide audits, “but these were seen as blame, so they were stopped.” All suicides (along with all other SUIs) are now subject to Clinical Practice Review (CPR). These are undertaken internally, within the Trust. However, according to one respondent, this had made little difference to the ‘blamist’ culture, as “an internal review may well be where the blame is identified.”

An alternative view of the Clinical Practice Review System was presented by a respondent with a background in Social Services:

“For me, the framework of the clinical practice review is just basic common sense. You know, it’s, ‘When did the event take place? What was it? Background, you know, who was involved, positive and negative practice issues. You know, in a structured sort of a way. And its actually quite helpful”

This respondent suggested that the Clinical Practice Review process worked well when reviews were undertaken in pairs, particularly if someone from health services worked alongside someone from social care, “You can’t always do that, but I’ve certainly found that very helpful. I’m much more comfortable picking up Mental
Health Act issues, social care issues. But when you start getting down to the details of the medication that was prescribed...those sorts of things, its actually much better to have a health colleague.”

**Staff’s perceptions of the consequences of reporting**

Perceptions about what might (or might not) happen as a consequence of reporting are also important in understanding why people may not report incidents. As the review of the patient safety literature (Westwood, Rodgers and Sowden 2002) has shown, in previous research into attitudes towards errors, barriers to error-reporting, and the organisational influences on these, factors such as blame, fear of reprisals, and unwillingness to accept responsibility for the actions of others all feature heavily.

These same factors also featured in the research interviews. Although reporting may, in extreme circumstances, be deployed as a ‘blame avoidance’ strategy (see section on the purpose of reporting, above), evidence from our study suggests that it is far more common for people to avoid reporting if this is at all possible. A number of respondents talked about cultural factors that are perceived to inhibit people from reporting. One respondent describes such actions “tabooogenic” (sic) and went on:

“It’s like a violation of something, and you’re crossing a boundary. There is a built in resistance, to violate an unwritten law, or a code, or a boundary...to transgress.”

Another likened it to “whistle blowing.” There were also strong feelings of team loyalty, “People get very defensive, working in a team. It’s about ‘snitching’ and all that stuff.”

**Differential attribution of blame**

Team working, however, brought up other issues in relation to the attribution of blame, particularly those arising from the different accountability structures within different health and social service professions. One respondent recalled reading the report of an enquiry in another Trust, but felt that the findings had lessons locally:

“What this enquiry highlighted...and to condense what he [the QC] was saying, was more or less, ‘Well, the CPA’s all very well, and know you’re told to do this by the Government, you know, and the Department of Health reports on delivering joint care, and you know, one stop shops and all the rest of it, but, just because you’re part of an integrated service, it doesn’t mean that you as social care workers lose your accountability under the law.”

What this report had highlighted, this respondent believed, was a “real dilemma” around integration of services and the blurring of roles and responsibilities.

“You know, we’ve got community psychiatric nurses who will take on a care management role; we’ve got social workers who engage in therapy – but we also simultaneously have got to recognise that we carry more statutory baggage as social care workers, than our health colleagues do.”
When things go wrong, “if there isn’t somebody who’s keeping an eye on that, we’re clearly going to come unstuck.” In the report that had raised this issue, it was the social worker, not the CPN, who had been blamed for the incident under investigation, on the grounds that they had failed to fulfil their statutory duty.

Differential consequences of reporting

There were also some strong feelings that the consequences of reporting may not be evenly distributed across the organisation. For example, when discussing the management of clinical errors within the Trust, one respondent suggested that these depend on a number of factors, such as the seriousness of the event, the popularity of the individual or the professional group to which they belonged. ‘No-blame’ approaches, they argued, were reserved for minor errors:

“If it’s something trivial, you’ll get off, and people will say, ‘hey, we’re a ‘no-blame’ culture. But if it’s a serious incident, somebody will be hung out to dry.”

However, the seriousness of the error was not the only factor influencing the organisational response. Pre-existing attitudes towards the member of staff in question were also felt to play a significant part:

“then it comes down to popularity. If you like them, and they’re usually a good bloke, and you think they’ve probably had this one-off mistake, they might get off. But if it someone they wanted to get rid of anyway, you can – their feet won’t touch the floor.”

Whilst these are obviously difficult assertions to verify, the fact that these perceptions exist is itself an indication of a lack of trust in the ways in which errors are handled within the organisation.

However, another factor raised in discussion of error-management would seem to be in line with previous research. The handling of clinical negligence cases, for example, is seen as “very arbitrary” with clearly different approaches taken towards medical and nursing staff. As one of our respondents remarked:

“I mean, looking at the medical suspensions, nationally, nobody ever seems to know how to manage a doctor’s suspension, even though, to everyone else, they look like open and shut cases. And there’s two years suspension, and then, quite often, reinstatement. Or somebody moves to another job.”

If it was a nurse involved, however, it was suggested, “the case would be sorted very quickly.”

This perception would seem to be based on evidence from a specific example, which had been referred to earlier during this interview. Referring back to this, respondent reflected, “I mean, the nurse was done and out within a month, but the consultant…a year on, they’re still deciding…who’d hear it, and who’d be on the panel, and all those sorts of things.
External culture of blame

However, it is not only blame within their own organisation that staff are afraid of, “It’s the national blame, I think, that worries people, more than the internal blame” one respondent stated. “I think we constantly work under this fear of doing something that’s going to become a national enquiry.” Another voiced similar concerns, “I think a lot of staff, if they’re going to keep something quiet, its because they want to keep it quiet internally. Its more they are worried about external influences.”

These external influences are perceived to exert pressure at a number of levels, including influencing internal inquiries. One respondent, when talking about the opportunities for organisational learning arising from these procedures, reflected, “because we’re trying to protect the Trust from litigation, we’re not as open and honest about the facts of things as we could be.” This was not a deliberate process, the interviewee continued, but “a sort of subconscious or unconscious slant” on things. “There’s a lot of, how can I put it? ‘Oh yes, well, but this explains that, so we won’t get into that, will we?’ sort of thing.”

This ‘image management’ of the Trust was linked to media interest. “We’re a very press-conscious Trust,” someone said, when discussing a case in a neighbouring organisation, which had received unwelcome press coverage. “And I think it just helps, if you’re ‘press aware’ I mean, in [a nearby trust] for example, they get a lot of hostile press, even though they seem to be one step ahead of things.” There are echoes here of the earlier discussion on the purpose of reporting, where the literature highlights the benefits in terms of handling media coverage, as well as to some of the interviews where the purpose of reporting was discussed (for example, where the purpose for the organisation was seen as providing ‘organisational reassurance’).
CONCLUSIONS

In line with national policy on improving patient safety, the West Kent NHS and Social Care Trust has recently introduced a pro-active incident reporting system, supported by a ‘no-blame’ policy. The aim of this study is to support the implementation of the policy, by developing a deeper understanding of the factors that influence the reporting (or the failure to report) adverse incidents and ‘near misses’. This has been done through a series of in-depth interviews with trust staff, to explore their views and feelings in relation to the reporting process. Analysis of the interview data has identified a number of themes and sub-themes, which have been described and discussed in the previous sections of this report. This final section draws together the key messages emerging from the analysis, and locates them in the context of the most recent guidance emerging from the National Patient Safety Agency, *Seven steps to patient safety* (NPSA, 2004) and related literature. These conclusions are followed by a number of recommendations for the Trust to consider.

*There is no consensus on what should be reported*

One of the first questions posed by the statistics produced by the Trust’s reporting system, was the extent to which this might reflect the actual level of incidents and near misses occurring across the Trust. This question makes a number of assumptions, the first of which is that there is shared agreement as to what constitutes a reportable incident. However, as this small study shows, there is still no consensus across the organisation as to what, precisely, should be reported. In an attempt to create a common language, ‘official’ definitions used in national and local policy documents have themselves been subject to much debate, and continue to undergo modification. The most recent guidance, for example, uses the term ‘patient safety incident’ as follows:

*Patient safety incident*: any unintended or unexpected incident that could have or did lead to harm for one or more patients receiving NHS-funded healthcare. The terms ‘patient safety incident’ and ‘patient safety incident (prevented)’ will be used to describe ‘adverse events/clinical errors and ‘near misses’ respectively.” (National Patient Safety Agency, 2004)

This issue of terminology is clearly seen as important by national policy-makers, as the work of the NPSA and the NRLS demonstrates. It was also highlighted in the research interviews, where the meaning of terms such as ‘adverse event’ ‘adverse clinical incident and ‘serious untoward incident’ were quite fluid, and frequently contested. This suggests that ‘adverse clinical incidents’ (now redefined as ‘patient safety incidents’) are not stable realities. They are constructed and interpreted within specific organisational and professional contexts – and there may be discrepancies between ‘official’ and ‘ unofficial’ meanings, or between meanings attributed by different professional groups, or within different services, at any given point in time. Furthermore, some incidents can only be seen to be such retrospectively – that is, they only become an incident because of their consequences. Arriving at a shared definition, which can be enforced across the whole organisation, may be unachievable – especially in the short to medium term.
The purpose of reporting needs clarification and communication

As well as the difficulties encountered in deciding what to report, the purpose of reporting is often called into question. Within the risk management literature, for example, this is frequently seen in terms of its purpose for the organisation. Whilst this is acknowledged as containing some potential tensions – for example, between reporting as a strategy for reducing litigation and reporting as a means of improving clinical quality, the clinical governance agenda is expected to overcome these by integrating risk management, clinical audit, clinical complaints and so on into “a more coherent and corporately owned approach to quality improvement.” (Walshe, 2001, p. 58) This focus on quality of care, Walshe argues, is “more likely to secure the support and involvement of clinical professionals, because it better reflects their purpose and values.” (Walshe, 2001, p.46) Nevertheless, reporting mechanisms are largely a reactive approach to risk management, and are often described in the literature in terms of their benefits to the organisation, rather than to the individual patient or member of staff.

This small study suggests that staff may take a rather different perspective, in which the purpose of a reporting system is seen as largely to protect the organisation, whilst allocating blame to the individual health professional. Reduction of harm to patients, and the potential for individual or organisational learning from incidents and near misses, were somewhat less evident. The perceived benefits of reporting would therefore seem currently to be outweighed by the perceived barriers – with fear of blame, and adherence to professional or team loyalty, taking precedence over taking the opportunity to raise the alarm in relation to potential risks. This would suggest that positive reasons for reporting may not be being adequately communicated to staff; or that positive action to address reported incidents may not be sufficiently visible to act as a further incentive. Greater promotion of reporting as an essential part of a ‘whole systems’ approach to risk management may also be helpful, as evidence suggests that “the best way to reduce error rates is to target underlying system failures, rather than to take action against individual members of staff.” (NPSA, 2004, p.5)

Awareness of the reporting process is good, but there are some problems

As well as knowing what to report, and why reporting is important, staff need to know how to report a patient care incident. Recent national guidance advises healthcare organisations to “ensure that their staff can report incidents easily, using both local and national systems.” (NPSA, 2004) To do this, they need to be familiar with these systems, and how to use them. Staff interviewed for the purpose of this study demonstrated good levels of awareness of their local reporting system and knew how to use it, but were often confused about how it fitted with other systems, within as well as beyond their own organisation. The use of a single form across the organisation was mostly welcomed, but the time taken to complete it was not. Overall, the whole process was felt to be somewhat time-consuming and rather bureaucratic in operation.
Organisational culture

Recent NPSA guidance stresses that the key to a successful reporting system is an open and fair reporting culture, where “reporting is congratulated and individuals are not blamed of penalised for speaking out.” (National Patient Safety Agency, 2004) However, despite the assurance from the Trust’s Chief Executive, this study suggests that there is still a strong perception of a ‘blame culture’ within parts of the organisation. Whilst this perception may well be rooted in past experience rather than current practice, the perceived consequences of reporting do appear to be a major deterrent to increasing current reporting levels. As the NPSA guidance acknowledges, “Staff will not report incidents if they believe that they are going to place themselves or their colleagues at risk of being disciplined or punished.” (National Patient Safety Agency, 2004) However, changing an organisational culture takes time, and there is a need to understand the existing culture before it can be changed. Various tools are now available from the NPSA website to support a safety culture assessment. These provide a ‘snapshot’ of the culture at a given point in time, and need to be repeated regularly to assess progress. (National Patient Safety Agency, 2004)

Conclusion

Behind the statistics produced by the reporting system lies a web of decisions and non-decisions, made by health and social care professionals and managers on a daily basis. The outcome of these individual decisions – about what constitutes a reportable incident (or near miss); whether this should be reported or dealt with in some other way (or both); what reporting might actually achieve (for patients, for the organisation, and for the individuals concerned); and what the consequences of reporting might be, for the member(s) of staff involved – are all key stages in the reporting process. If reporting is to be promoted as a proactive (rather than reactive) component of risk management in health and social care, these individual and organisational influences, and how they might be changed, need to be part of the debate.
RECOMMENDATIONS

Recent national guidance (National Patient Safety Agency, 2004) already addresses many of the steps that can be taken by healthcare organisations to improve their levels of incident reporting. Below are some further recommendations based on the findings from the study described above:

- Consideration could be given to the development of locally-agreed examples of ‘reportable incidents’ and ‘reportable near misses’ in order to assist local interpretation, and encourage some consistency at a service-specific level.

- The purpose of reporting could be made more transparent. For staff to become fully committed to reporting, its primary purpose needs to be improvement in patient care.

- The benefits of reporting – to themselves, to other staff, to patients, and to the overall quality of the service – also need more emphasis.

- Opportunities for streamlining the reporting process, or for dealing with minor incidents at a local level, may be worth further exploration.

- The development of a ‘blame-free’ culture needs further work. Incidents are still being interpreted as resulting from individual action, rather than systems failure. Training staff in a ‘whole systems’ approach may help.

- The Trust also needs to think through how blame is handled, when it is necessary to deal with it – for example, where cases of actual or potential clinical negligence or poor clinical (or managerial) practice are identified. Current processes are not perceived as fair and equitable across professional groups.

- The risk register might usefully collect data on who reports – not by name (which must be confidential) but by clinical/professional group. This would help to confirm or dispel perceptions that some professional groups do not report. If it is found that some professional groups are not reporting, reasons for this need to be explored, and appropriate action put in place.
References


National Patient Safety Agency (April 2004) *Seven steps to Patient Safety, an overview guide for NHS Staff* (2nd print)


Appendix A

Recruitment Protocol

Study Title: Improving the Reporting of Adverse Clinical Events

Rationale

This research has been designed to improve our understanding of the professional and organisational factors which influence levels of reporting adverse events and near misses in a community setting. To gain this understanding, a qualitative approach, which will elicit participants’ views and experiences is essential. The principle method of data collection will therefore be in-depth, face-to-face interviews with individual members of staff. These will be held in private, on a one-to-one basis. Participants’ confidentiality is assured at all times (see accompanying Information for Participants.)

Sampling frame

The West Kent NHS and Social Care Trust is a complex and geographically spread organisation. It is also relatively new - having been formed in April 2002 following the merger of two former NHS trusts and parts of two LA Social Services departments. Services within the Trust include: adult mental health; mental health of older people; child and adolescent mental health; forensic psychiatry; and special services (which includes neuro-rehabilitation and substance misuse). For management purposes, these services are arranged in five Clinical Directorates, as follows:

- Mental Health East (adult and older people)
- Mental Health West (adult and older people)
- Forensic Psychiatry
- Child and Adolescent Mental Health and Specialist Services
- People with Learning Disability

Clinical care staff working within the Trust come from professional backgrounds in both health and social services, including

- Psychiatry
- Clinical psychology
- Nursing
- Psychiatric nursing
- Occupational therapy
- Social work
- Residential social work

The literature review which has informed this study strongly suggests that we can anticipate a range of views and experiences in relation to our research questions – between staff with backgrounds in the different organisational cultures of health and social services; between those working in services catering for different client groups; and between different professional groups. We therefore need a sampling strategy that
will enable us to adequately capture the heterogeneity of views and experiences of our research subjects, as well as (we hope) permitting some comparison between groups from different organisational or professional background, or with different current roles and responsibilities.

To ensure that the full range of possible views and experiences are explored in the research, it will therefore be important to use a purposive sampling technique, that is, one which will enable the researcher to select settings and individuals that can provide answers to the research questions. We will therefore need to select participants from all five clinical directorates, and all seven main professional groups. In addition to this, we hope to be able to interview staff with different current roles and levels of responsibility; for example, we would hope to include those whose primary role is managerial, as well as those with mainly clinical responsibility. Support workers, where appropriate, also need to be included. However, because of the sensitive nature of this research, it is essential that staff are recruited on a voluntary basis only – and this may well limit the final sample size as well as its composition.

Recruitment process

The first stage in the recruitment process will therefore be to make contact with each of the Clinical Directors, and ask them to provide the researchers with a list of staff, by professional group, within their Directorate.

The second stage will be undertaken by the researchers, who will select names from these lists, and send out letters of invitation. We will invite more than we need, to allow for non-responders. If insufficient staff are recruited at this stage, another round of invitations will be issued, to a different sample of staff. There will be no pressure on any staff to take part (see Participant Information, attached.) Staff within directorates will therefore be recruited on a voluntary basis, until the required numbers in each section of the sampling matrix has been achieved.

Dr Yvonne Cornish
CHSS, July 03
Appendix B

Improving the Reporting of Adverse Clinical Events

Interview Topic Guide

As you know, we are currently undertaking some research into the reporting of adverse clinical events and ‘near misses’ within this Trust. This interview will give you an opportunity to share your views on this topic with me, in confidence. Whilst I have a number of specific questions I need to cover, please feel free to tell me about anything else that you think is important in relation to this topic.

1. To begin, can you just clarify for me what you understand by the term ‘adverse event’? (Use specific examples, if this helps you)

2. Could you describe an example of a ‘near miss’?

3. Using your own definitions, how many ‘adverse events’ and ‘near misses’ can you recall being involved in during the last three months?

4. Did you report these incidents to anyone else? (Within or beyond the Trust?)

5. If so, can you tell me a bit more about the reporting process you followed?

6. If not, can you tell me a bit more about why you didn’t report the incident?

7. Do you know whether the Trust has a policy on reporting (a) adverse events and/or (b) near misses?

8. What can you tell me about this policy/these policies? (eg how it was developed, who was consulted, how it works in practice, what staff in general think or feel about it)

9. Have you used any of these procedures yourself following either an adverse event or a near miss?

10. If yes, what happened as a consequence? If no, what do you think might have happened if you had?

11. Is there anything else about the reporting of adverse events and near misses that you would like to tell me about?

Thank you for your time.

Yvonne Cornish
CHSS
July 03

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