Dealing with incident overload: learning to prioritise investigations

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In my last white paper, I wrote about the importance of organisational memory in healthcare, ensuring that when something goes wrong, the organisation undertakes a process to understand the contributory factors and make changes to reduce the chances of the same events occurring again. This means not just writing down recommendations on paper, but embedding changes into policy, procedures, training and everyday practice.

Whilst this may sound straightforward, we know that in reality the complexity of healthcare delivery, constraints on resources and time, together with strong and often knotty cultural influences can result in healthcare organisations failing to take opportunities to learn and the same mistakes being repeated.

If we are to change this, it's vital that organisations foster and support the right organisational culture as well as having good systems and processes in place to ensure risks are swiftly identified, the right level of investigation takes place and that effective and sustainable recommendations are implemented.

This paper discusses some of the challenges healthcare organisations face in achieving this in the context of cost/resource considerations and an increasing trend in the volumes of incident data organisations collect.

In 2000, the Institute of Medicine (IOM) published "To Err is Human: Building a Safer Health System"[1]. This report recommended some sweeping reforms and created a global sense of urgency in efforts to reduce avoidable harm in healthcare. Drawing upon experience in high risk industries such as aviation, the report recommended that healthcare organisations should put in place and encourage the use of incident reporting systems to enable learning from adverse events to mitigate against future errors.

Since 2000 there has been a major increase in the use of incident reporting systems across healthcare organisations internationally. The use of incident reporting systems is now widely perceived by staff to improve patient safety[2] and increased reporting has been shown to positively correlate with independently defined measures of safety culture[3]. However, incident reporting systems also create challenges that without good systems and processes in place, can limit how effective such systems are in driving tangible improvement.

An issue that is often raised is that of "incident overload". As an example, when The John Hopkins Hospital first implemented an incident report system it received about 11,000 reports in year 1 and about 14,000 in year 2[4]. If a singular approach is adopted to the investigation and analysis of each individual incident, it is easy to see the danger of such systems becoming process driven, resource and cost intensive whilst risking the failure to identify common risks that a more systematic analysis across the data as a whole might reveal.

The impact of incident overload was highlighted by a recent Care Quality Commission (CQC) report published in July 2016[7]. CQC carried out a review of a sample of serious incident investigations across 24 NHS acute hospital trusts.

The report found "...a number of investigation reports of the most frequently reported types of incident, such as patient falls (10) and pressure ulcers (6) that took a long time to complete and contained lengthy chronologies. Many of them did not result in clear conclusions or recommendations that could be expected to reduce the likelihood of the incidents happening again. There were also examples that contained no information to explain how the impact or outcome for the patient aligned with the serious incident criteria."

The report recommended that healthcare organisations should prioritise serious incidents that require full investigation and develop alternative methods for managing and learning from other types of incident.

The reality is that most healthcare organisations operate in a cost/resource limited environment and therefore, as the number of reported events increases, organisations must put in place intelligent processes and systems to ensure that investigation and improvement resources are used efficiently. Doing this well will involve a range of different strategies from discussing the event at a multidisciplinary team meeting or a safety huddle[5] through to a full expert led review or Root Cause Analysis investigation.

In addition, it is clear that healthcare organisations would benefit from having a systematic framework to analyse aggregate incident reporting data so that common contributory factors and associated risks across an institution can be identified. The NHS England Serious Incident Framework[7] recommends a multi-incident or aggregate RCA methodology as '...a useful tool for thoroughly investigating reoccurring problems of a similar nature ... in order to identify the common problems (the what?), contributing factors (the how?) and root causes (the why?).

This approach allows for common risks to be addressed with a single action plan and '...moves the focus from repeated investigation to deeper learning and improvement.'

Most incident reporting systems also tend to classify incidents at the point at which the event occurred. Allowing for the classification of the underlying contributory factors as well as the event itself has the potential to add significant value to the ability of such systems to identify and prioritise areas for safety improvement.

A greater focus needs to be placed on prioritising and evaluating proposed patient safety improvement recommendations resulting from such processes. This should involve an evaluation of the cost and other resources involved with implementing the proposal, along with an evaluation of the benefits and the likely effectiveness in eliminating, reducing or controlling risk.

Information technology and tools have the potential to help healthcare organisations develop these systems and processes. This will focus investigations on the right areas to ensure the greatest possible impact in protecting patients from harm.

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![Datix logo](Software for Patient Safety)

About James Titcombe

James Titcombe OBE is a patient safety campaigner and father of Joshua Titcombe, who sadly died nine days after being born at Furness General Hospital in 2008. Following Joshua's death, James campaigned for years to uncover the truth about what happened at the hospital, culminating in the 'Morecambe Bay Investigation Report' in 2015 led by Dr Bill Kirkup.

Since Joshua's loss, James' career has changed dramatically from working as a project manager in the nuclear industry to becoming one of the countries' most respected thought-leaders in patient safety – championing improvements in culture and learning throughout the healthcare environment.

Previously James was working with the Care Quality Commission as their National Advisor on Safety and recently has advised on the establishment of the new Healthcare Safety Investigation Branch (HSIB). Today he works with Datix as Patient Safety Specialist and provides his unique insight to help develop and innovate the world's leading patient safety software.

About Datix

Datix has been a global pioneer in the field of patient safety over the past three decades and today is the leading provider of software for patient safety, risk management and incident reporting for the health care sector. Datix aims to build and promote a culture of safety within healthcare organisations, recruiting professionals who are passionate about improving healthcare and championing technological innovation. Datix continually invests in its software and services maintaining a leadership position at the forefront of the worldwide patient safety movement.

Datix is focused on the health and social care sector. Its customers include public and private hospitals, primary care providers, GP surgeries, mental health and ambulance service providers. Its clients also include organisations delivering care home and domiciliary care services. Within the UK this includes more than 75% of the National Health Service. Internationally the Datix client base is growing rapidly and includes large scale deployments in Canada and the USA as well as clients in Europe, Australia and the Middle East.

Datix has offices in the London, Chicago, Washington and Toronto with partners in the Middle East, Australia and New Zealand.

References

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