

## Using incident data to improve patient safety - King's PSSQ project summary

### **Overview:-**

Reporting adverse incidents in order to learn from past mistakes and improve safety is now embedded in NHS culture.

However, researchers have barely begun to tackle the question of how such reporting improves safety and how well staff, especially those who work directly with patients, learn from it.

The term 'incidents' covers accidents and near misses, including surgical, prescribing and drug errors, drips becoming detached and patients falling or becoming malnourished. We are studying how incidents are reported and used to improve safety at an organisational level and by clinical teams and individual employees at two London NHS foundation trusts; a mental health trust and an acute trust.

Doctors, nurses and managers have told us how they think reporting incidents improves safety. We have also analysed policy and strategy documents and observed meetings - from the level of clinical teams up - where adverse incidents are discussed.

Staff were on the whole positive about the effect that reporting incidents had on care: some said it helped them reflect on how they did their work, some felt it helped to build a team's awareness of risks or set goals for improving safety. They gave concrete examples of improvements, such as:

- The introduction of standardised suction sets
- A change in the clerking of re-admissions
- Guidelines being drawn up to help cross-departmental co-ordination
- A change in referral forms.

Mental health staff felt that they sometimes did not have the resources to conduct lengthy, in-depth investigations. Determining what action should be taken following an incident could be difficult, they said. The negative headlines that accompany high-profile investigations into community care failures added to the pressure they felt.

### **Our research has shown that improvements could be made in:-**

- Exchanging information between departments about how to avoid similar incidents
- Feeding back to departments from senior meetings
- Keeping frontline staff informed and communicating the lessons of incident reporting to them.

The Head of Risk at one of the participating trusts comments; *"This important study has generated many ideas to improve learning from adverse incidents and reduce future recurrences."*

We now plan to study how staff who do the daily, hands-on care can be kept informed about safety and how to communicate safety information effectively to them.