The reporting of incidents on the acute mental health unit.

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Background

This project was undertaken due to the large number of incidents involving clinical risk on a typical AMHU, Cork. The nature of admissions to the AMHU tends to result in a wide variety of risk which necessitates vigilant and well informed reporting. Proficiency in incident reporting can vary, this variation is most likely due to staff turnover, staff inconsistencies in reading ward policies and unclear roles in the process of incident reporting. Not only does a lack of reporting result in suboptimal quality assurance/improvement, it can potentially result in deterioration of trust, services, safety or risk of injury to patients. The main aim of this audit was to gain data on the use of the incident reporting tool on AMHU. This collection of data provided information on knowledge that staff have regarding the use, requirement for, storage and submission of incident reporting forms.

Objectives

To complete full audit cycle on knowledge of incident reporting among staff in AMHU.
To consider improvements which could be made to the incident reporting system to ensure optimal knowledge of the process.
To implement changes in order to improve staff knowledge of the process of incident reporting within the psychiatric unit in MUH.

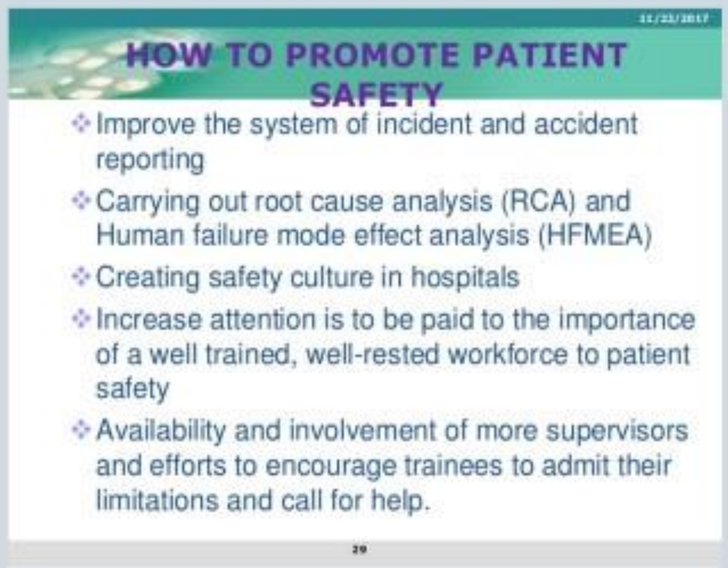

Figure 1: How to promote patient safety. Developing patient safety culture by
reporting adverse incidents and near misses and learning from mistakes. VENODENDHARMARAJAN/patient-safety-82499495

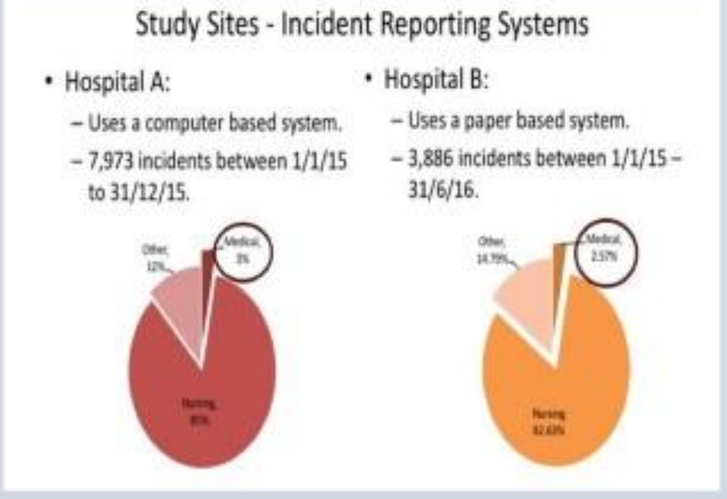

Figure 2: Example of incident reporting differences between two hospitals and staff who commonly report incidents.
https://www.rte.ie/brainstorm/2018/0524/965715-why-are-junior-doctors-reluctant-to-report-unsafe-care/

Methods and Materials

1. Utilised audit tool to apply questions to staff relating to the current knowledge and processes of incident reporting.
2. Audit performed over one week and data collected from nursing staff and NCHDs on AMHU.
3. Re-audit to close cycle performed six months later.

Results

86.5% of all staff had read and signed the risk management policy. Re-audit showed this number had increased to 94%. Nursing staff scored 100% for knowledge of incident reporting on audit and re-audit. NCHDs scores improved from 46.2% to 74% on re-audit for how to report an incident and from 23% to 56% on knowledge of who inputs data into database.

Overall, nurses had knowledge of how to complete incident reporting forms and the later stages of the process for example inputting of detail into a database. Doctors knowledge of the incident reporting process was variable. With reminders, education sessions and the implementation of an incident reporting book, the knowledge of the doctors did improve on re-auditing.

Table 1: Incidents reported which later resulted in complaints.

Information source	Number of incidents (N)	Total number of classified items (incl. 2nd and 3rd category) (N)
Incident reports	736	904
Patient complaints	235	327
Retrospective chart review	44	51
Total	1015	1282

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The above table illustrates how many incidents can result in complaints from patients. It is important to report incidents accurately using the correct procedures and protocols. In this way, further similar incidents can be avoided. A comprehensive overview of medical error in hospitals using incident reporting systems, patient complaints and chart overview of inpatient deaths, de Flijer J.M et al, 2012.
https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0031125

Discussion

The results on first completion of the audit indicated that the knowledge of nursing staff with regard to the process involved, need for and the completion of incident reports was 100%. The knowledge of doctors working on AMHU was variable and was considerably less than the nurses. On implementation of improvements with regard to education and awareness of incident reporting, knowledge did improve however remained at a lower level in comparison to nursing staff. Possible reasons for this include the lack of an equivalent to CNM or ADON in ensuring that doctors have achieved improvement, doctors tend to work as individuals rather than teams and the lack of an online database which doctors and others can input information into directly. The main improvement made was the creation of an incident reporting book available on the unit.
Re-audit will reveal other possible measures which could be implemented to improve the knowledge staff contain regarding the reporting of incidents and avoidance of future serious events/litigation by the process.

Figure 1. An example of how the NHS reports incidents via use of a database 'DatixWeb' printed in Focus on, 2017.

Conclusions

On re-audit, there is an overall improvement in knowledge of incident reporting, incident reporting form and completion of the process of incident reporting among NCHDs on the acute mental health unit. Nursing staff remained more consistent in their knowledge of the process. Improvements in scores on repeat audit of NCHDs correlates with implementation of strategies to improve knowledge and awareness around incident reporting.

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