National Anaesthesia Specific Critical Incident Reporting, Collaboration or Coercion?

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THE PROJECT

The aim was to design and pilot an electronic incident reporting system for anaesthesia from which we hoped to create shared learning between RCoA/AAGBI and the National Patient Safety Agency (NPSA) resulting from the analysis of incident data. We also hoped to re-engage the anaesthetic profession in reporting patient safety incidents and to maximise learning for NHS staff from incidents. We started the project build in December 2007 and had the pilot running from May 2008 to September 2008 involving 12 NHS Trusts in England and Wales as pilot sites.

The following sources of information were used to evaluate the pilot once it was completed:

- Questionnaires completed by staff at pilot sites, which included members of the anaesthetic team (49 questionnaires from 9 sites) and risk managers (9 questionnaires).
- Discussion groups with anaesthetic department staff and risk managers at 2 pilot sites.
- Anaesthetic incidents recorded by NHS staff in pilot sites during the pilot period.
- Project documentation and views of project group members.

The results, coupled with 'hands on' use and reports from RCoA/AAGBI testers, led to:

- The (re)design of the classification system for anaesthesia incidents.
- The development of an anaesthetic e-form, to run as a web application e-form.
- The set up of a process for receiving and anonymising the incidents reported by e-form from pilot sites, and preparing the data for analysis.
- The regular review of anaesthetic e-form incidents by NPSA staff in discussion with an RCoA member, in order to identify learning opportunities.

INCIDENTS

There were 153 incidents reported during the 5 months of the pilot. Over half the anaesthetic e-form reports were submitted within 24 hours of the incident occurring. The content of the free text description of incidents reported using the anaesthetic e-form was assessed as being of a good standard and the level of completeness of the optional fields was high.

RESPONSE TO INCIDENTS

There were not enough reports to assess the value to analysis of the anaesthetic specialty categories, but the pilot period was an opportunity for NPSA to work collaboratively with the RCoA to examine opportunities for learning from incidents using the free text description.

INTERFACE WITH LOCAL RISK MANAGEMENT SYSTEMS (LRMS)

Risk managers were supportive of the pilot and accepted that additional work might be necessary during the pilot to integrate the e-form with local risk management systems, and they expressed the hope that integration would be possible in the future. They also stressed the importance of maintaining their responsibilities, though. For example, if there were a serious incident that required further investigation.

REVIEW OF PROGRESS TOWARDS DESIRED OUTCOMES

The majority of e-form reports were from doctors, and comments from medical staff suggest that doctors are more likely to report using a specialist reporting route. There are a number of factors, however, affecting the willingness of doctors in general to report, including fear of blame; professional and organisational culture; and the expectation that there will be learning from reporting.

The Safe Anaesthesia Liaison Group led by the RCoA has been established to take forward the aim of maximising learning from the analysis of anaesthetic incident reports.

FUTURE DEVELOPMENTS

During the course of the pilot, the Reporting and Learning System (RLS) strategy group identified the need to align the e-form pilot with the RLS dataset. NPSA staff identified the changes required to the anaesthetic e-form and to the RLS dataset in order to achieve an integrated e-form. The integrated e-form will be available to NHS staff on the NPSA website in late 2009. There is, however, a risk of duplication of integrated e-form reports and LRMS reports, which will be mitigated by clear instructions and engagement with user sites.