Tackling the deep-rooted stigma of incidence reporting in surgery - A Quality improvement project

Pia Borgas, Subramaniam Guru Naidu
North Middlesex University Hospital, London UK

Background

In the UK NHS critical incidents occur in up to 10% of admissions meaning patients are more likely to die in hospital critical incidents than road traffic accidents (1). Only 10-20% of incidents in healthcare are reported and those that cause harm are often not reported (2). This is a massive patient safety concern and costs the NHS billions for litigations, increased hospital related costs and treatments, with the WHO predicting 20-40% of global healthcare spendings being wasted on poor quality of care (1).

Most incidents do not arise from individual errors but reflect problems in complex systems with which individuals interact (3). Several straightforward and robust mechanisms for reporting surgical safety incidents exist. The functionality of these relies on the contribution of all staff members in order to enhance patient safety. Key barriers to reporting include a general blame culture, fear of punishment, worry over legal ramifications, complexity of reporting and lack of encouragement to report incidents (3, 4).

DATIX is perhaps the most known incident reporting system in the NHS. This quality improvement project (QUIP) investigated the stigma around DATIX incident reporting and common reasons preventing incident reporting at North Middlesex University Hospital (NMUH).

Methods

An anonymous questionnaire was distributed to all surgical staff at NMUH over a period of 2 weeks in October 2021 (cycle 1) and again in June 2022 (cycle 2). Information was gathered surrounding the perceptions, understanding and use of DATIX. After cycle 1, the data was shared with the department and education was provided on the purpose of DATIX and practicalities of how to report incidents. The effect of the intervention was evaluated in cycle 2. Mean percentages for each domain of the questionnaire were compared between doctors and nurses/ allied health professionals (AHPs) and between cycles.

Results

39 surgical staff members (61% doctors, 39% nurses/AHPs) completed the questionnaire in cycle 1 and 44 (45% doctors, 55% nurses/AHPs) in cycle 2.

Doctors were less likely to report an incident than nurses/AHPs with 42% vs 87% respectively. Initially only 45% of doctors knew how to complete a DATIX compared to 98% of nurses/AHPs and most staff did not incident report due to a lack of time. After education 75% of doctors knew how to fill out a DATIX and 60% had now done it before.

Interestingly, doctors were more likely to feel threatened by DATIX compared to nurses/ AHPs (38% vs 20% respectively). After education, the general feeling of threat decreased amongst all surgical staff. Although most surgical staff recognize the purpose of DATIX being making improvements in the system, an opportunity to make change, and improving patient safety, a significant number of staff also believed it to be a way of punishing or complaining about colleagues. This stigma was more prevalent amongst nursing staff/AHPs. Overall, 100% of surgical staff felt DATIX reporting to be important for patient safety.

Conclusion

A deeply rooted stigma exists around incident reporting in the NHS. Overall, this QUIP demonstrated the positive effect of fostering a culture which encourages reporting of patient safety events to reduce preventable harm of surgical patients. We demonstrate a that through simple education a better understanding of the purpose and process of incident reporting can be obtained which aims for system changes that benefit patient safety.

Future studies exploring the effect of DATIX reporting on patient safety outcomes and critical incident rates would be beneficial.

References

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