Improving Clinical Incident Reporting in a District General Hospital Anaesthetic Department

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Although widely recognised as an important mechanism in improving patient safety, critical incident reporting remains widely underutilised.[1] Near-misses represent important learning events, and reporting these at a local level provides an opportunity to learn from the mistakes of others prior to harm occuring.[2] Our project aimed to try and identify the barriers faced by our department to clinical incident reporting, improve the system by which we report incidents as a department and to encourage the reporting of near-misses to facilitate learning discussions at monthly audit meetings.

We collected baseline data on the number of anaesthetic cases discussed at our monthly audit meetings over the period of a year, from 1/10/2023-30/09/2024 and compared these to the total number of anaesthetics over the same period. We then reviewed current literature to look for incidence rates of critical incidents in order to set ourselves a target. We sent out a departmental questionnaire to identify the perceived barriers to reporting and using this data and the common barriers highlighted in the literature, we developed a simple, anonymised critical incident reporting form for near-miss incidents. The form was disseminated throughout the department with the QR code readily available in theatres, and reporting encouraged. We then discussed incidents monthly at clinical governance meetings and agreed action plans. A separate arm of the project looked to improve accessibility and navigation through the more formal datix reporting system, along with creating a ‘cheat sheet’ for form completion and a defined set list of reportable incidents to clarify what warranted a datix.

From the year audited, 1 in 700 anaesthetics involving critical incidents were discussed within the departmental monthly audit meetings. Using the NAP6 data (100% UK NHS hospital involvement) of 3.3 million anaesthetics occuring over a year long reporting period, and comparing this to the Safety Anaesthesia Liasion Group data for the same time period of 42880 reported incidents, we set our target at 1 in 70 anaesthetics, requiring a 10 fold improvement.

We had 17 respondents from our baseline survey data which suggested 25% of respondents did not know how to access current datix forms, 82% were unaware of any criteria as to what qualified for a datix, 88% had not reported an incident as a datix due to the amount of time it takes and 100% would find it useful to hear about the near misses of others and would submit their own if there was an easy and anonymised mechanism in place.

For December 2024, 3 near misses were inputted into our database, all of which have been discussed with action points in our January audit meeting. A total of approximately 520 anaesthetics occured during this time (decreased numbers due to essential building works at our hospital), giving a reporting incidence of 1 in 173. We hope to have continued to improve this incidence by the time of the RCOA patient safety conference in March 2025.

References

1 Pedersen TH, Nabecker S, Greif R, Theiler L, Kleine-Brueggeney M. Critical airway-related incidents and near misses in anaesthesia: a qualitative study of a critical incident reporting system. British Journal of Anaesthesia, Volume 133, Issue 2, 371 - 379

2 Webster CS. Safety improvement requires data: the case for automation and artificial intelligence during incident reporting. British Journal of Anaesthesia, Volume 133, Issue 3, 491-493