

Bundaberg Review

A Review into allegations with regard to Clinical Incident Reports
at Bundaberg Hospital

Stephen Ayre

February 2009

With thanks to the Staff of the Patient Safety Centre for assistance in the
analysis of PRIME CI reports

Executive Summary

Allegations were made by a hospital staff member with regard to the management of clinical incidents reported at Bundaberg Hospital. Of the alleged 100 incidents recorded only 64 could be verified.

Management response and action was assessed as appropriate in 57 of 64 incidents.

2 of the 7 with an inadequate management response were deemed not reasonable to report. Of the remaining 5, 1 is the subject of an Ethical Standards Unit review. 3 of these 5 incidents reported in PRIME CI should have elicited a management response at the time.

There was poor feedback to incident reporters from line managers. Bundaberg Hospital was significantly different to other QH Hospitals in this regard.

The Hospital has reasonable processes with incidents tabled and as appropriate investigated with actions formulated through a number of Clinical Service Forums (CSFs).

The following recommendations are made

1. The Senior Director Patient Safety Centre, Reform & Development Unit review PRIME CI and assess the opportunity to:
 - a. Provide functionality whereby staff can follow progress of their reported incident through the management process
 - b. Provide functionality for ease of notification to managers and reporters within the system.
2. The Executive Director Medical Services (EDMS) ensure that the Surgical CSF has appropriate representation from medical professionals. The EDMS should attend as an ex officio member and encourage medical leadership within the Surgical Department.
3. HEAPS analysis should be coordinated through the Clinical Governance Unit (CGU) with the EDMS taking responsibility for ensuring the conduct of the HEAPS analysis in the hospital.
4. The EDMS review the structure and function of the morbidity and mortality meetings to ensure they comply with contemporary practice and link these with the clinical governance structure for the hospital.
5. The Executive through the Clinical Governance Unit should monitor management feedback and ensure that this is occurring addressing sub optimal levels with individual managers.
6. Clinical incident reporting should be addressed by raising awareness of the importance to the hospital through a number of means eg marketing strategies, education sessions.
7. Appropriate introduction to incident reporting should occur at entry to the hospital for medical staff to ensure that staff are aware of the importance of incident reporting in the overall clinical governance system

8. The Executive Director Medical Services as the chair of the Clinical Governance Committee should take the lead in maximising the benefit of the clinical incident management system in clinical governance at Bundaberg Hospital.

9. Sensitive discussions should be undertaken with reporting outliers to develop a way forward with regard to the issues raised.

Background

A number of allegations with regard to incident reporting were made to the Member for Burnett, Rob Messenger by a nursing staff member of Bundaberg Hospital. These included specific incidents which are being investigated by other bodies (Ethical Standards Unit and HQCC). The complainant had alleged that they had made more than 100 clinical incident reports to management and that these were not officially acknowledged or appropriately investigated.

Bundaberg Hospital introduced the PRIME clinical incident reporting system (PRIME CI) in late 2005. Staff are able to record a clinical incident or near miss and the system allows managers to track and provide comments, record results of investigations and corrective actions in a central database.

Terms of Reference

1. The appointee is to undertake a review of management actions in relation to incidents logged on the PRIME Incident Reporting System in Bundaberg Hospital by a registered nurse with whom the Director-General met on Wednesday 4 February 2009.
2. Specifically, the review is to consider -
 - a) Whether management responded to the incidents in accordance with QH policy;
 - b) Whether any management responses were adequate and appropriate;
 - c) Whether the management responses were communicated to the registered nurse or other appropriate person.
3. The review is to -
 - a) Maintain patient confidentiality in accordance with the requirements of the *Health Services Act 1991*;
 - b) Report directly to the Director-General of Queensland Health;
 - c) Seek assistance as required from senior executive staff of Queensland Health and the Sunshine Coast-Wide Bay Health Service District.
4. The final report is to include findings and recommendations in regards to -
 - a) the matters mentioned in points 2a);
 - b) individual incidents which require remedial action;
 - c) systemic issues.

Analysis of incident reports

A preliminary analysis of the PRIME incident records by the Patient Safety Centre had been documented in a report to the Director-General. The report revealed 65 incidents reports recorded by the complainant with a further 10 reports where the complainant was not the reporter of the incident but acted as a witness. The investigator undertook further review of these incidents and ascertained that one of the incident reports was a duplicate thus the number of reports made by the complainant reporter was 64. (See Appendix 1 for summary of reports).

Reasonableness to report

The Queensland Health Clinical Incident Management System Implementation Standard 2008 defines a clinical incident as 'any event or circumstance which has actually or could potentially lead to unintended and or unnecessary mental or physical harm to a patient of a Queensland Health service facility'.

The investigator undertook a qualitative analysis of the 64 incidents made by the reporter and determined that 55 of these were reasonable to report. Of the 9 that were deemed not reasonable to report there was no overriding theme (see appendix 1 for summary details) however it is noted that some appeared to be as a result of frustration of the complainant reporter that a patient was not complying with recommended care (32182, 5043) or concern that a complaint would be made against the complainant reporter(39777, 160137).

In interviews with managers at Bundaberg it was noted the difficulty in differentiating whether the PRIME system should be utilised for staff performance or occupational health and safety issues. The PRIME incident reporting system is not appropriate for these incidents (Director Patient Safety Centre) however it is noted that these incidents may impact on patients and thus no judgement was made to exclude these from analysis. The Patient Safety Centre review indicated that few of the incident reports were solely related to a clinical incident alone with 67% involving allegations of staff performance and 24% involving allegations of staff conduct problems.

Of the 55 clinical incidents that were deemed reasonable to report a number of these were very minor and the motivation for reporting may be questioned. The reporting of 6 medication incidents on a single day in 2008 may indicate a frustration with the changed work practice in the inpatient surgical ward (Interview NUM Surgical Ward).

Of the incidents reported the majority resulted in no harm to the patient and the incidents reported were all SAC 2 & 3 (SAC3 is the least serious incident classification).

Management Response

The Patient Safety Centre documentation based review reported that 88% of PRIME incident reports had line manager comments in the incident recording system. The investigator has concluded from review of documentation and discussion with staff that there was line manager response in 98% (63 of 64 incidents) of the incidents reported.

Of the single incident with no management response a management response was recorded in the system but was noted as 3 months past the date of incident and therefore classified as no response (that is the response was not timely). The

issue raised however was already on management's agenda and related to access to the Mental Health team at a time when there was no inpatient Mental Health Service and thus a continuing difficulty for the Emergency Department in accessing mental health care for patients.

Reasonableness of Management Response

A qualitative analysis was undertaken of the response of management to the incidents raised. This analysis was undertaken by interrogating the PRIME incident data, review of internal documentation (for example minutes of meetings) and discussions with managers.

Of the 64 incidents, 57 incidents were deemed to have an appropriate management response.

2 of the remaining 7 were deemed not reasonable to report. Of the remaining 5, 1 incident of an alleged assault of a patient is currently under review by the Ethical Standards Unit (127701) and will not be commented on here other than to say that this incident and 2 others should have been reported to senior management with action and response at the time of occurrence (107390, 11747).

Feedback to reporter

The Patient Safety Centre review indicated only 17 of 65 or 23% of the incidents had feedback to the reporter recorded in the PRIME incidents system. On further review, 19 of the 64 incidents had evidence of direct feedback to the complainant or 29%.

The incidents were recorded for 2 areas, 43 incidents related to the Department of Emergency Medicine and 21 incidents to the Surgical Ward.

The Department of Emergency Medicine from early 2007 has had a Department Leaders Group which has developed into the Emergency Dept Clinical Services Forum - a multidisciplinary group where incidents are tabled, discussed with actions developed. The minutes from this meeting are available to all members of the Department of Emergency Medicine staff and have been available for some time (Interview with DEM NUM). Thus it could be argued that indirect feedback is available for a further 20 incidents.

The feedback provided for incidents reported in the Surgical Ward was not able to be verified from other sources.

The Surgical Ward Unit Manager admitted that she had found it difficult reviewing PRIME incidents and had the habit of only looking at the PRIME system intermittently.

In summary, there were 19 incidents of direct feedback to the reporter with a further 20 incidents where indirect feedback was available should the complainant reporter had followed this up herself by reviewing the minutes of the meetings held in the Department of Emergency Medicine.

The PRIME incident reporting system

The PRIME incident reporting system was introduced at Bundaberg Hospital in September 2005. Since then there have been a number of updates of the software and the hardware. A significant early issue with the system has been that the incident reporters were frequently logged out of the system in the middle of recording a new incident. This has led to a perception that the system is problematic, difficult and clunky.

Staff have had difficulty in saving incomplete reports and cannot follow progress of their own incident report in the system.

A surprising lack of functionality is the inability of the system to automatically notify managers that an incident has been reported for their area. Managers have to remember to log into the system to monitor the incidents in their area. This is particularly a problem if there are a low numbers of incidents reported for an area which result in managers having to log in unnecessarily.

A further deficiency is the inability in the system to assist managers to provide feedback to the reporter. In other systems that the investigator has experienced this is a standard feature. It is likely that this lack of functionality has contributed to the poor feedback to reporters of clinical incidents.

Recommendations

1. The Senior Director Patient Safety Centre, Reform & Development Unit review PRIME CI and assess the opportunity to:
 - a. Provide functionality whereby staff can follow progress of their reported incident through the management process.
 - b. Provide functionality for ease of notification to managers and reporters within the system.

Clinical Incidents investigation and actions

Clinical incidents recorded through PRIME and other clinical incidents are tabled with action plans developed and outcomes monitored at various points at the Bundaberg Hospital.

The Clinical Service Forums are active components of the clinical governance structure. These committees report to the Clinical Governance Committee which is a sub committee of the Hospital Executive. The Clinical Governance Committee is chaired by the Executive Director Medical Services (EDMS). Clinical Service Forums (CSF) are active in Mental Health, Paediatrics, Emergency Medicine, Obstetrics and Gynaecology and Medicine. The CSF's in Surgery and Theatre are currently under review and are likely to be combined in a single CSF. A lack of medical engagement has been an issue in the Surgical area. A feature of the well functioning CSF's in the hospital appears to be medical buy in and leadership.

Root cause analysis (RCA's) are coordinated by the Clinical Governance Unit (CGU). Lower level reviews (for example HEAPS analysis) are the responsibility

of clinical areas with only limited oversight by the Clinical Governance Unit. This is a potential issue with regard to areas investigating their own incidents and variability in quality of analysis between areas.

Morbidity and Mortality meetings (M&M) occur in a number of units throughout the Hospital. There is a tenuous link between the clinical incidents reporting system and discussions at these meetings – that is not all clinical incidents are the subject of M&M meetings and it was difficult to determine if the outcomes of M&M meetings which identify systems issues were recorded in PRIME CI. It would appear that in some units that the M&M meetings are only attended by medical professionals with often no nursing representative (for example Surgery M&M). Presence of other members of the Surgical team would assist in addressing systems issues which impact on patient care.

Recommendations

2. The Executive Director Medical Services ensure that the Surgical CSF has appropriate representation from medical practitioners. The EDMS should attend as an ex officio member and encourage medical leadership within the Surgical Department.
3. HEAPS analysis should be coordinated through the CGU with the EDMS taking responsibility for ensuring the conduct of the HEAPS analysis in the hospital.
4. The EDMS review the structure and function of the morbidity and mortality meetings to ensure they comply with contemporary practice and link these with the clinical governance structure for the hospital.

No blame culture

'A no blame culture' is encouraged in organisations to maximise the reporting of clinical incidents thus alerting the organisation to trends in incidents and system issues or problems which may impact on patient care and outcomes. Where this does not occur there is a lost opportunity to improve patient care and prevent untoward outcomes.

In interviews with senior managers and department heads it was evident that there is a belief staff are reluctant to report incidents because of the likely problems that this may cause for the reporter. This appeared to be unrelated to local management and the fear of retribution from them but rather staff concern with the current Patel case where staff who have recorded information/incidents are now involved in providing evidence to the court. There seems to be little doubt that staff are sensitised to this issue at the current time.

The evidence of incidents reported over the last 3 years however does not support the reluctance of staff to report with 888 incidents reported in 2006 rising to 1204 in 2008 (Appendix 2). Staff are encouraged to report and are reminded when incidents occur of the need to record these in PRIME CI.

Comparative figures provided to the investigator from the Patient Safety Centre indicate that Bundaberg Hospital is not statistically different from other Queensland Hospitals with regard to the numbers of incidents reported (Appendix 3).

Types of incidents reported were also consistent with other organisation's experience with the top 3 incidents being medication errors, pressure ulcers and falls.

Where Bundaberg Hospital is different is in the area of feedback to reporters (Appendix 3). Bundaberg Hospital records lower rates of feedback to staff compared with other Hospitals. This was supported by evidence in the clinical incident reports examined in detail. The importance of feedback as part of the quality cycle was recently the subject of a Director General Special Broadcast (Appendix 4).

Comments with regard to the functionality of the PRIME system have been made earlier with regard to the difficulty managers have in using the system to assist feedback. A number of managers reported that high workloads often mean prioritisation of activities. Also noted was that informal feedback was often used following an incident being raised particularly if the incident was relatively minor and did not cause patient harm. Some managers reported collating incidents and providing feedback to a group of staff eg where a number of incidents occurred discussing these at nursing handover. This was not often formally recorded in the PRIME system.

Recommendations

5. The Executive through the Clinical Governance Unit should monitor management feedback and ensure that this is occurring addressing sub optimal levels with individual managers.

Number of reports by staff member

The number of reports by staff members were reviewed where the reporter was identified (there is an ability to make anonymous reports in PRIME).

Over the last 3 years the nursing group was the most likely profession to report followed by allied health and medical. The range of reports for nursing staff by individual over the 3 year period was from 1 report to 263 (total reports 2369) with the median report number of 10.

For allied health staff the range was from 1 to 14 reports per staff member with the median of 2 (128 total reports).

For medical staff the range by reporter was from 1 to 7 with the median report number of 2 (total reports 90).

In most hospitals nursing is the highest reporter of clinical incidents. While it would be expected that nursing as the largest proportion of the workforce would have the highest number of reports, the numbers per staff member reporting also exceed other groups.

At Bundaberg Hospital numbers would indicate a relative under reporting by medical staff. This was commented on by a number of senior staff interviewed. The reasons for this may be multiple however a number of staff suggested that the lack of medical leadership was the reason for this.

Of note was the high number of reports from the complainant reporter over the period. Interestingly there was a single reporter who had made a significantly higher number of reports than the complainant reporter. This staff member was well known to the Clinical Governance Unit and it was stated "that they were on a mission with regard to an aspect of care – adverse drug reactions". It would appear that there may be higher levels of reporting where staff may have an issue that is important to them resulting in the level of reporting in excess of expected.

The issue of vexatious reporting was raised. Various senior staff commented that if staff are frustrated or there is tension between units or individuals, incidents are more likely to be reported. A senior medical staff member commented that he had the impression that some of the PRIME reports were below the threshold that would normally be reported in other hospitals he had worked.

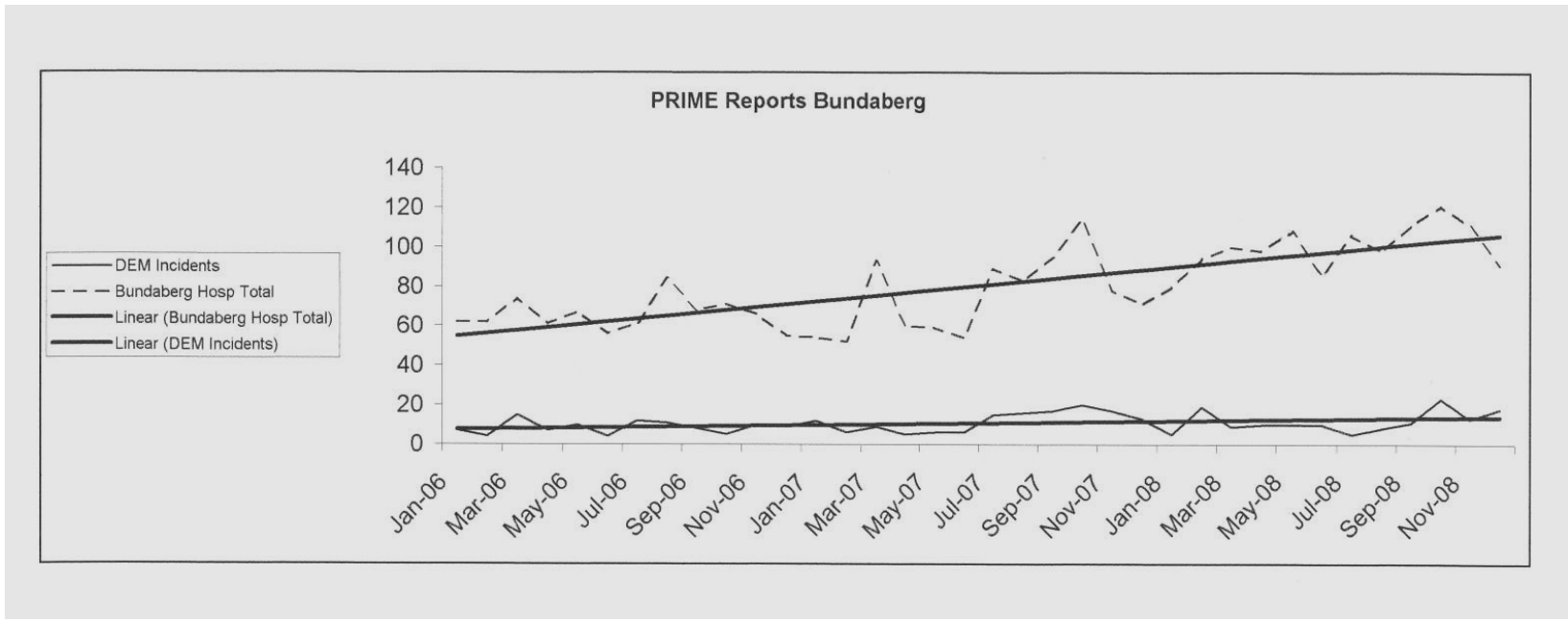
Recommendations

6. Clinical incident reporting should be addressed by raising awareness of the importance to the hospital through a number of means eg marketing strategies, education sessions.
7. Appropriate introduction to incident reporting should occur at orientation to the hospital for medical staff to ensure that staff are aware of the importance of incident reporting in the overall clinical governance system
8. The Executive Director Medical Services as the chair of the Clinical Governance Committee should take the lead in maximising the benefit of the clinical incident management system in clinical governance at Bundaberg Hospital.
9. Sensitive discussions should be undertaken with reporting outliers to develop a way forward with regard to the issues raised.

Appendix 1

URN/O	Date of Incident	Reasonable to Report	Management Response in PRIME	Response Reasonable	Feedback to Reporter	Comments
88094	1/10/2005	Y	Y	Y	Y	Individual staff competency complaint
150558	25/10/2005	Y	Y	Y	Y	Access to Mental Health Team
80105	28/10/2005	Y	Y	Y	Y	Intoxicated difficult ED patient
111235	3/02/2006	Y	Y	Y	Y	Competency of Anaesthetist/Behaviour of anaesthetist
150069	7/03/2006	N	Y	Y	Y	Elderly patient frequent attender/ reporter frustrated with reattendance. All care options in place
149396	11/03/2006	Y	Y	Y	Y	Alleged triage change
152155	13/05/2006	N	Y	Y	N	Management of demanding relatives in ED - routine ED occurrence
146211	6/06/2006	Y	Y	Y	N	Intoxicated patient absconded from DEM, police action patient did not wish to return
7416	4/08/2006	N	Y	Y	N	Patient discharged at own risk
154477	20/08/2006	Y	Y	Y	Y	Medical staff taking responsibility for trauma patient
1	26/08/2006	Y	Y	Y	Y	DEM Medical staff activities
78195	26/10/2006	Y	Y	Y	Y	Removal of Cx Collar by radiographer
1	11/11/2006	Y	Y	Y	N	Access to medical staff
1	12/11/2006	Y	Y	Y	N	Access to medical staff - It would have been more reasonable to escalate the issue at the time through the senior nursing manager on duty to the Director of Medical services
885776	3/12/2006	Y	Y	Y	Y	Access to Mental Health Team
117747	27/01/2007	Y	N	N	N	Management review of file was 3 months after the incident logged. No documented action
157363	29/01/2007	Y	Y	Y	N	Access to radiographers
56535	18/02/2007	Y	Y	Y	N	Access to medical staff - Incident reported to Nurse Duty Manager but no action identified from that person
157946	23/03/2007	Y	Y	Y	N	Competency of medical staff
32987	6/04/2007	N	Y	Y	N	QPS issue with access to client for questioning
97462	29/08/2007	Y	Y	Y	Y	Unacceptable delay in patient handover in Ward
115901	12/09/2007	Y	Y	Y	N	Medical Staff performance -alleged neglect of patient by Medical Reg
1	20/09/2007	Y	Y	N	N	Access to medical staff- incident should have been escalated to the Director of Medical Services for resolution at the time
122024	1/10/2007	Y	Y	Y	N	Access to Security for Mental health patient
1	6/10/2007	Y	Y	Y	N	Access to medical staff - This incident should have been escalated to the Director of Medical Services for resolution at the time
164703	21/10/2007	Y	Y	Y	N	Lack of QAS notification of Trauma patient
67975	25/10/2007	Y	Y	Y	N	Difficulty in calling in Radiographers
133285	6/11/2007	Y	Y	Y	Y	Delay in Medical Ward admission
108513	18/08/2007	Y	Y	N	N	Alleged change of Triage Cat/DEM Consultant potential Code of Conduct issues
46276	21/11/2007	Y	Y	Y	N	Failure to undertake aPTT prior to heparin infusion
18893	25/11/2007	Y	Y	Y	N	Access to radiology reports
146061	15/01/2007	Y	Y	Y	Y	Aggressive noisy relative of patient in DEM
47130	2/02/2008	Y	Y	Y	N	Communication issues with MHT
158767	2/02/2008	Y	Y	N	Y	Brusing/injury to 2 yo patient - this should have been escalated to a senior manager at the time with subsequent referred to ESU
11254	6/02/2008	Y	Y	Y	N	Porterage issue ED
881338	8/02/2008	Y	Y	Y	N	Access to MHT after hours
142746	14/02/2008	Y	Y	Y	N	Wardman staffing in ED
17321	14/02/2008	Y	Y	Y	N	Porterage issue ED
21153	14/02/2008	Y	Y	Y	N	same issue as 129822
779745	20/02/2008	Y	Y	Y	Y	Neonate not reviewed by Paed as per policy
105449	1/03/2008	Y	Y	Y	Y	Competency of nursing staff in care of porta Cath
773328	18/04/2008	N	Y	N	Y	Orthopaedics Reg reporting on Cx Spine Professional issue should not have been in PRIME
170217	21/06/2008	Y	Y	Y	Y	Patient fall in DEM
170403	29/06/2008	Y	Y	N	N	Morphine dose for pain, Incident report indicates legal issue - for chart review. Chart review - legibility of entry of DEM MO poor. No legal issue identified
80395	31/07/2008	N	Y	Y	N	Nurse bumped patient cellulitis leg The incident was entered days after the incident occurred. An appropriate annotation in the patient record would have been all that was required
27917	13/08/2008	Y	Y	Y	N	Access to pain medication for patient
171716	27/08/2008	Y	Y	Y	N	Should have been corrected with prescriber at time
122802	4/09/2008	Y	Y	Y	N	Medication not signed for not given Chart reviewed - no entry by complainant re missed drug
52044	4/09/2008	N	Y	Y	N	Medication not given Patient fasting!
52044	4/09/2008	Y	Y	Y	Y	Medication missed Chart reviewed - no entry by complainant re incident - missed dose
47131	4/09/2008	Y	Y	Y	N	Medication not given Chart Reviewed - no entry by complainant re incident.
153126	7/09/2008	Y	Y	Y	N	Medication not available Chart reviewed - no entry by complainant re incident
168820	15/09/2008	Y	Y	Y	N	Medication missed
168820	15/09/2008	Y	Y	Y	N	Nicotine patch not signed off removed
87671	15/09/2008	N	Y	Y	N	Medication chart writing error
104672	15/09/2008	Y	Y	Y	N	Medication prescription incomplete
16339	15/09/2008	Y	Y	Y	N	Medication not signed for
16339	15/09/2008	Y	Y	Y	N	Medication not signed for not given
112603	16/09/2008	N	Y	N	N	Patient fall - no evidence of fall occurring
163531	21/09/2008	Y	Y	Y	N	Minor issue cream not administered
146252	20/09/2008	Y	Y	Y	N	Medications not given ? Workloads
146252	21/09/2008	Y	Y	Y	N	Medications with held due to surgery according to Line Manager but surgery 3/7 before
146252	21/09/2008	Y	Y	Y	N	Medication missed same patient as 169901 & 169905
146252	21/09/2008					Duplicate of 169907
163531	26/09/2008	Y	Y	Y	N	Medication delayed

Appendix 2



Appendix 3

Extract from Memo to Chief Executive Officer – Centre for Healthcare Improvement (CHI) 16/2/2009

Statistical analysis of reported clinical incidents relating to staff feedback and corrective actions documented in PRIME Clinical Incidents (CI).

Bundaberg Hospital was not statistically different from the rest of Queensland in:

- Percentage of incidents documented as “closed”;
- Percentage of SAC1 incidents with documented feedback to staff;
- Percentage of SAC 1 and SAC 2 incidents with documented corrective actions; and
- Percentage of SAC 1 and SAC 2 incidents with documented incident analysis.

Bundaberg Hospital was statistically different from the rest of Queensland in:

- Having a lower rate of feedback to staff regarding SAC2 and SAC3 incidents;
- Having a lower rate of documented corrective actions for SAC3 incidents; and
- Having a lower rate of documented incident analysis of SAC 3 incidents

Dr John Wakefield
Senior Director – Patient Safety Centre
Queensland Health

Appendix 4

From: Special Broadcast
To: Special Broadcast
Date: 5/2/2009 4:47 pm
Subject: Special Broadcast - Clinical Incident feedback
(This message is best read in HTML View)

Colleagues

Line Managers are reminded of the importance of providing feedback to staff who report clinical incidents about the outcomes of the review of the incident to the staff member who reported it. Confirmation that this feedback has been provided to the staff member must also be recorded within the PRIME Clinical Incident application. This feedback loop is critical to the staff trust of and commitment to patient safety improvement efforts.

Although providing feedback is currently a requirement of the Queensland Health Clinical Incident Management Implementation Standard (2008), the standard is presently being reviewed to ensure this is made clear.

Regards

Michael Reid
Director-General