

Implementing Incident Management

– reservations of practice staff

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ABSTRACT

A previous qualitative study had identified a range of themes concerning difficulties in implementing Incident Management (IM) processes in general practice. A quantitative study was undertaken to assess the generalisability of themes that had emerged from this previous study.

Practice nurses, general practitioners and practice managers in the Pinnacle network were invited to participate, with replies received from 250 (88%).

The results suggest that concerns over workload and time commitment, difficulties remembering to use the process, fear of litigation and concern about the public image of the practice were the major barriers to successfully implementing IM. Consideration of these barriers is necessary if IM is to be successfully implemented in general practice.

Keywords

Practice systems, safety, Incident Management

(NZJP 2008; 35: 253–256)

Introduction

There is increasing international interest concerning safety systems and error rates in general practice. A series of high profile cases reported in the New Zealand media have drawn public attention to this often neglected area of health care delivery. A case of systemic failure with tragic consequences in Wellington prompted the Health and Disability Commissioner to state: ‘...it is vital that lessons are learnt from this tragic case and that steps are taken around the country to ensure that patients receive the competent and coordinated care they need and deserve.’¹ Although this comment was made with regard to a secondary care in-

stitution, the message is equally relevant to primary care.

There is recognition that the primary care setting creates challenges in the development of safe systems that are different to the secondary care sector. These challenges include the relatively small size and individual nature of practices, differing levels of managerial support, the brief nature of general practice interactions but continuous nature of the therapeutic relationship and difficulties in defining error in circumstances where time is frequently used as a diagnostic aid. It is important, therefore, to develop systems of safe care that are specific to general practice. Good systems of safe care have

a strong focus on reporting error, taking responsibility for error, adjusting practice systems in response to error and sharing lessons learned. Incident Management (IM) is a well described method for reporting and managing error events.

A qualitative study on implementing Incident Management (IM) in general practice has previously been reported in this journal.² The study sought the opinions of general practitioners, practice nurses and practice managers on factors that would facilitate or impede the implementation of IM. A key outcome was the development of a framework composed of three separate organisational factors that directly influ-

enced the implementation process; the practice environment, the IM process and external factors. Within each of these, the respondents had identified a range of issues that could either facilitate or impede the successful introduction of IM into practice. For the purposes of practice development, it was necessary to understand the significance of each issue. To this end, a survey was developed to quantify the relative importance of the findings of the qualitative study. This paper reports the results of the survey.

Method

Ethical approval was sought and gained. As part of an annual quality plan, the survey was sent to all practices in the Pinnacle network requesting that a general practitioner, a practice nurse and a practice manager complete and return with other quarter four data for 2006. Practice liaison personnel and quality team staff were available to assist with questions concerning both content and process of the survey. The survey was designed to assess the generalisability of relevant findings of the previous qualitative study. It was structured into three sections; the practice environment, the IM process and factors external to the practice. For each of the three components of the framework, respondents were asked to rank the three most important factors that would impede the successful implementation of IM from most important to least important. Respondents were given the opportunity to comment via free text and to make suggestions to facilitate the IM process. As completion of the survey was part of the annual Quality Plan, a small financial incentive was available to the practice for returning the completed survey.

Results

At the time of the survey, 94 practices were identified as part of the organisation. Valid replies were received from 81 general practitioners

Figure 1. Practice environment

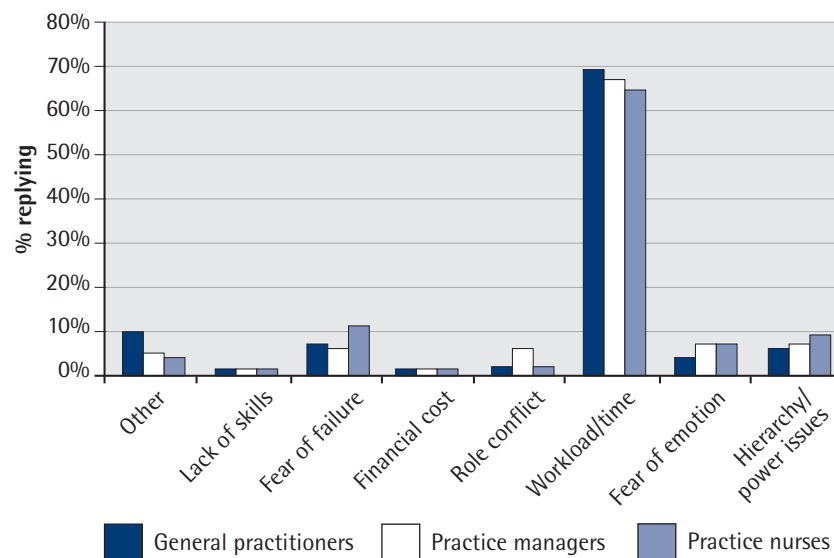
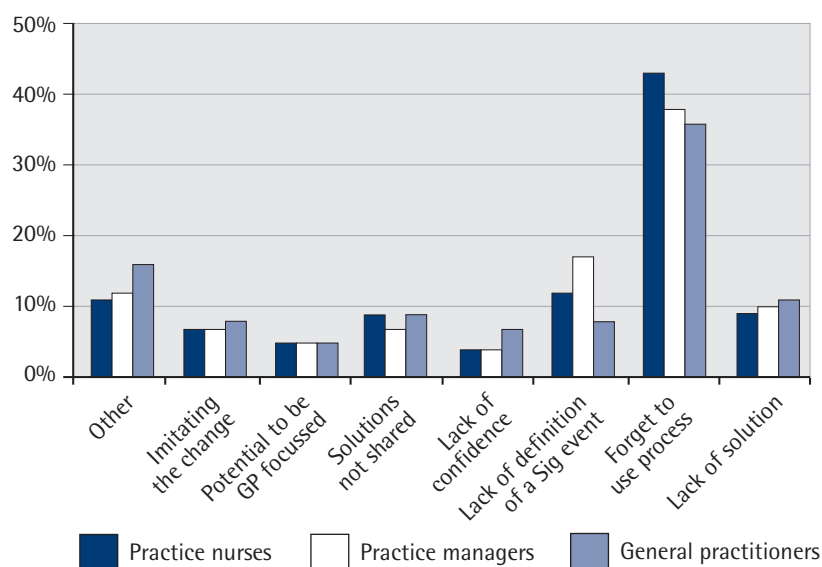


Figure 2. The SEM process



(86%), 84 practice managers (89%) and 85 practice nurses (90%). A total of 250 (88%) completed surveys were returned.

The data are presented in three separate figures. Figure 1 reports the aggregated responses for the most important factor chosen by respondents regarding the practice environment. The data is presented by role in the practice. Clearly, issues of workload and time far exceed all other variables and represent the most prominent barrier in the practice environ-

ment. Figure 2 reports the responses for the process of IM. Simply forgetting to use the process seems to be the most difficult part of successfully implementing IM. Lack of a shared definition of a significant event and lack of a solution to an event were of secondary import. External factors to implementing IM are illustrated in Figure 3. Fear of litigation and damage to professional image were both prominent barriers and negative publicity being of somewhat lesser concern.

The free text comments supported the quantitative data and no new concepts emerged. However, the free text section did highlight the very diverse views on some aspects of IM.

Discussion

The return rate of 88% is exceptionally good for surveys and gives a high degree of confidence in the sampling process and therefore in the reliability of the data. Utilising a routine data collection and feedback method such as an annual quality plan probably contributed materially to the high return rate, as did the financial reward for completed surveys.

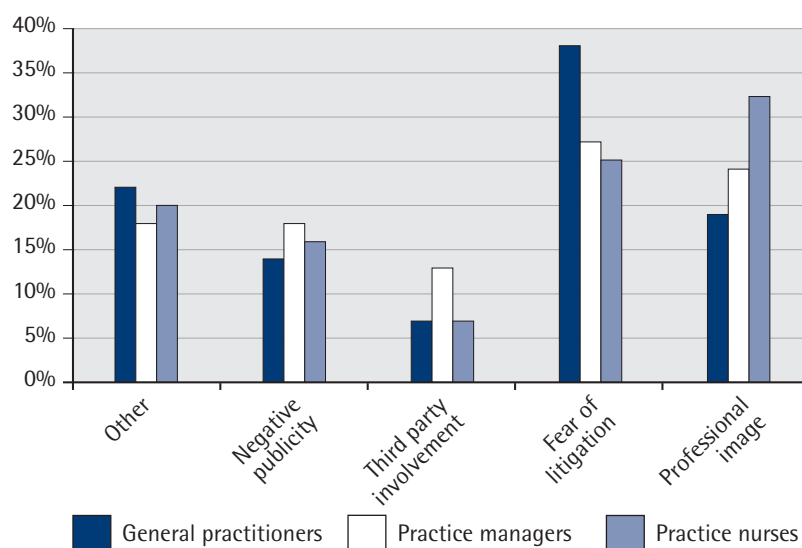
Perceptions of the workload of IM and the time commitment required for the process was the major barrier in the practice environment. This finding was surprising, as issues such as power hierarchies and role conflict are topical and were expected to be more prominent as barriers. The IM process was considered difficult principally because practice staff forgot to use the method. This may reflect a low priority of IM or that practice staff have considerable pressure of time. The initial qualitative phase of this research indicated that IM was considered important by practice staff in maintaining quality. It is likely, therefore, that pressure of work is responsible for this negative impression.

The extra workload and time required to successfully integrate an IM process into a practice also raises a number of other

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issues. Increasing workforce shortages of both practice nurses and general practitioners in many regions of New Zealand already causes significant workload problems. Adding further non-clinical work becomes problematic as such work may not be appropriately prioritised in the face of staff shortages. Utilising staff time to undertake extra work that does not provide practice revenue

Figure 3. External factors



raises issues of responsibility for adequately resourcing such initiatives. Practice incomes are currently under considerable external control with quite limited methods available to compensate for non-revenue gaining activities. Should the responsibility for adequately funding such quality initiatives be the responsibility of the practice, the Primary Health Organisation (PHO) or another funding body? Quality improvement carries financial implications. While there would be unanimous agreement amongst funders, providers and consumers of health services that quality matters, there would be less accord over the issue of who pays.

The data on external factors reveals that concerns in this domain are more widespread with publicity, professional image and fear of litigation all being significant. Interestingly, the domain of external factors produced some differences between the three respondent groups with GPs and practice managers rating fear of litigation first and practice nurses rating concerns over professional image first. However, it is

clear that concerns over litigation remain despite previous reassurance that audit activities were covered against litigation by the Quality Assurance Activity notice that applies across the organisation. Further, the concerns over negative publicity and professional image raise issues around the confidentiality of information held both by the practice and by other organisations that might have access to the reports generated by IM.

Clearly, practices need to have strong reassurance that processes within a management organisation are robust concerning anonymity when collecting data on significant events. There is an implicit tension between a management services organisation and practices. The Health and Disability Commissioner has stated '*...despite claims that our current model of health professional regulation ensures the fitness and competence of individual doctors, in truth current oversight of practice is light-handed and reactive.*'³ Building proactive and robust systems of oversight of both the practice team and the individual practitioner requires trust that such oversight will be appropriately used and will not become a tool of inquisition in the pursuit of legal process where allocation of blame is the desired result.

Excepting the data concerning the domain of external factors, there was remarkable similarity between practice managers, practice nurses and general practitioners concerning factors that could impede the implementation of IM. There was a high degree of concordance between these three groups concerning the extra workload and time commitment of IM and also concerning the difficulty in remembering to use the process. This raises disquiet over what would seem to be a high workload faced by all members of the general practice team.

Overseas research indicates that general practitioners may have positive attitudes to collection of data concerning adverse events. A Scandinavian study of 1198 general practitioners concluded that there was considerable support for a centralised database of adverse events with the proviso that the general practitioner could not be identified.⁴ A North American study of educational outcomes for a graduate medical education programme in family practice revealed barriers to adverse event reporting of time, paperwork and concern regarding personal and career reputation.⁵ The study concluded that educational initiatives

covering safety systems were effective in creating attitudinal changes amongst family medicine residents. Integration of such educational initiatives into a residency curriculum is becoming accepted practice.⁶

However, a qualitative study researching patients' perspectives on medical error in family practice reminds us that not all errors that are of import can be measured.⁷ Patients consider

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issues of inadequate access to care and breakdowns in the doctor-patient relationship as significant incidents, neither of which is easily amenable to measurement. Mandatory reporting of significant incidents may experience resistance and practitioners may be selective over what events are reported.⁸ The selectivity over what is reported may well echo concerns over confidentiality found both in this study and overseas research.⁹ Of considerable interest is the finding that in Glasgow general practices, the uptake of co-ordinated, systematic incident reporting was much higher in training practices than in non-training practices.¹⁰ New Zealand data also supports the notion that teaching practices develop better quality standards than non-teaching practices.¹¹

Conclusion

Although IM is considered to be of value by practice staff, issues of time and workforce capacity at all levels within general practices may impede its successful implementation. At a time of limited workforce capacity and restraints on the ability to increase practice income, adequately resourcing the implementation of IM may be problematical. Methods of reminding practice staff to use the system when appropriate should be developed. Degrees of concern over protection from litigation, negative publicity and professional image remain and need to be managed. The involvement of a management services organisation in promoting and assisting with implementation of IM can be either negative (concerns over privacy if reports are centrally collected) or positive (able to assist with templates, methods of running meetings, sharing of information between practices etc.). The IM process has the potential to improve quality at a practice level and at an organisational level. Careful planning is required to ensure that it meets this potential.

Competing interests

None declared.

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References

1. Seddon M. Safety of patients in New Zealand hospitals: A progress report <http://www.hdc.org.nz/files/hdc/seddon-full-review-DHB-responses.pdf>
2. Lord H, Lillis S. Implementing significant event management in general practice; potential barriers and solutions. *NZ Fam Physician* 2005; 32: 247-250.
3. Paterson R. Mistakes in general practice *NZ Fam Physician* 2007; 34: 7-9.
4. Mikkelsen TH, Sokolowski I, Olesen F. General practitioners' attitudes toward reporting and learning from adverse events: results from a survey. *Scand J Prim Health Care* 2006 Mar; 24(1): 27-32.
5. Coyle YM, Mercer SQ, Murphy-Cullen CL, Schneider GW, Hynan LS. Effectiveness of a graduate medical education program for improving medical event reporting attitude and behavior. *Qual Saf Health Care* 2005 Oct; 14(5): 383-388.
6. Singh R, Naughton B, Taylor JS, Koenigsberg MR, Anderson DR, McCausland LL, Wahler RG, Robinson A, Singh G. A comprehensive collaborative patient safety residency curriculum to address the ACGME core competencies. *Med Educ* 2005 Dec; 39(12): 1195-204.
7. Kuzel AJ, Woolf SH, Gilchrist VJ, Engel JD, LaVeist TA, Vincent C, Frankel RM. Patient reports of preventable problems and harms in primary health care. *Ann Fam Med* 2004 Jul-Aug; 2(4): 292-3.
8. McKay J, Bowie P, Murray L, Lough M. Attitudes to the identification and reporting of Significant Events in general practice. *Clinical Governance* 2004; 9(2): 96-100.
9. Bowie P, McKay J, Dalgetty E, Lough M. A qualitative study of why general practitioners may participate in significant event analysis and educational peer assessment. *Qual Saf Health Care* 2005 Jun; 14(3): 185-9.
10. Bowie P, McKay J, Norrie J, Lough M. Awareness and analysis of a significant event by general practitioners: a cross sectional survey. *Qual Saf Health Care* 2004; 13: 102-107.
11. Lillis S. Quality in general practice and involvement with teaching, is there an association? *NZ Fam Physician* 2004; 31(5): 314-316.