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HOW INCIDENT REPORTING HAS CHANGED IN 10 YEARS AND A SURVEY OF CONSULTANT ANAESTHETIST'S VIEWS ON REPORTING IN A TERTIARY PAEDIATRIC CENTRE

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Introduction and aims:

Learning from incidents is a key component to patient safety. The incident reporting system in our department has changed in the last 10 years, from a local departmental reporting system to the trust reporting system. We analysed how incident reporting by anaesthetists within our department has changed in this period and explored anaesthetist's views on the current reporting system.

Methods:

We reviewed all incidents reported by anaesthetists in 2012 and 2022 and compared the incidents by type and severity. We sent a survey to consultant anaesthetists in the department which was anonymous and gathered opinions on barriers to reporting, perception of support following an incident and how reporting could be improved.

Results:

- More incidents were reported by anaesthetists in 2012 than 2022 (142 vs 54).
- Most reports were classified as no or minor harm (92% in 2012 and 93% in 2022).
- In 2012, 95 incidents were related to cardiorespiratory complications, in comparison to 15 in 2022.
- 14 anaesthetic procedural complications were reported in 2012 compared to 1 in 2022.
- Medication error reports were similar (5 in 2012 vs 4 in 2022), but medication side effects/allergy were reported more in 2012 (8 vs 1).
- More reports in 2022 were related to equipment issues, extravasation and needlestick/splash injuries.

The survey was open for two weeks and sent to 36 consultants, of which 26 responded. The most frequently mentioned barrier to reporting was the incident reporting system itself, specifically its usability, lack of mobile phone access and time taken to complete. Feedback desired included gratitude, offers of support, investigation findings and learning outcomes. Many anaesthetists stated that they felt well supported after an incident. Some commented on a perception of blame culture, lack of a clear formal support structure and deficiencies in feedback. Suggested ways to improve incident reporting included having an option to report events locally within the department, improving feedback, improving support and easier access to view learning outcomes.

Discussion and conclusion:

In comparison to 10 years ago, anaesthetists in our department report less critical incidents. However, as this study only reviewed incidents reported by anaesthetists, it will have missed incidents reported by others after an anaesthetic event. In 2012 there were more reports of what could be termed 'clinical anaesthetic events', for example cardiorespiratory events, which may have contained learning points for other anaesthetists but perhaps wouldn't be thought worth reporting in a Trustwide system. There would be benefit in finding a way to capture these 'lost' clinical incidents.

The survey suggests a need for a simpler user interface on the trust reporting system which could be accessed via mobile. Although many felt supported after an incident, this survey suggests a need to review why some don't.