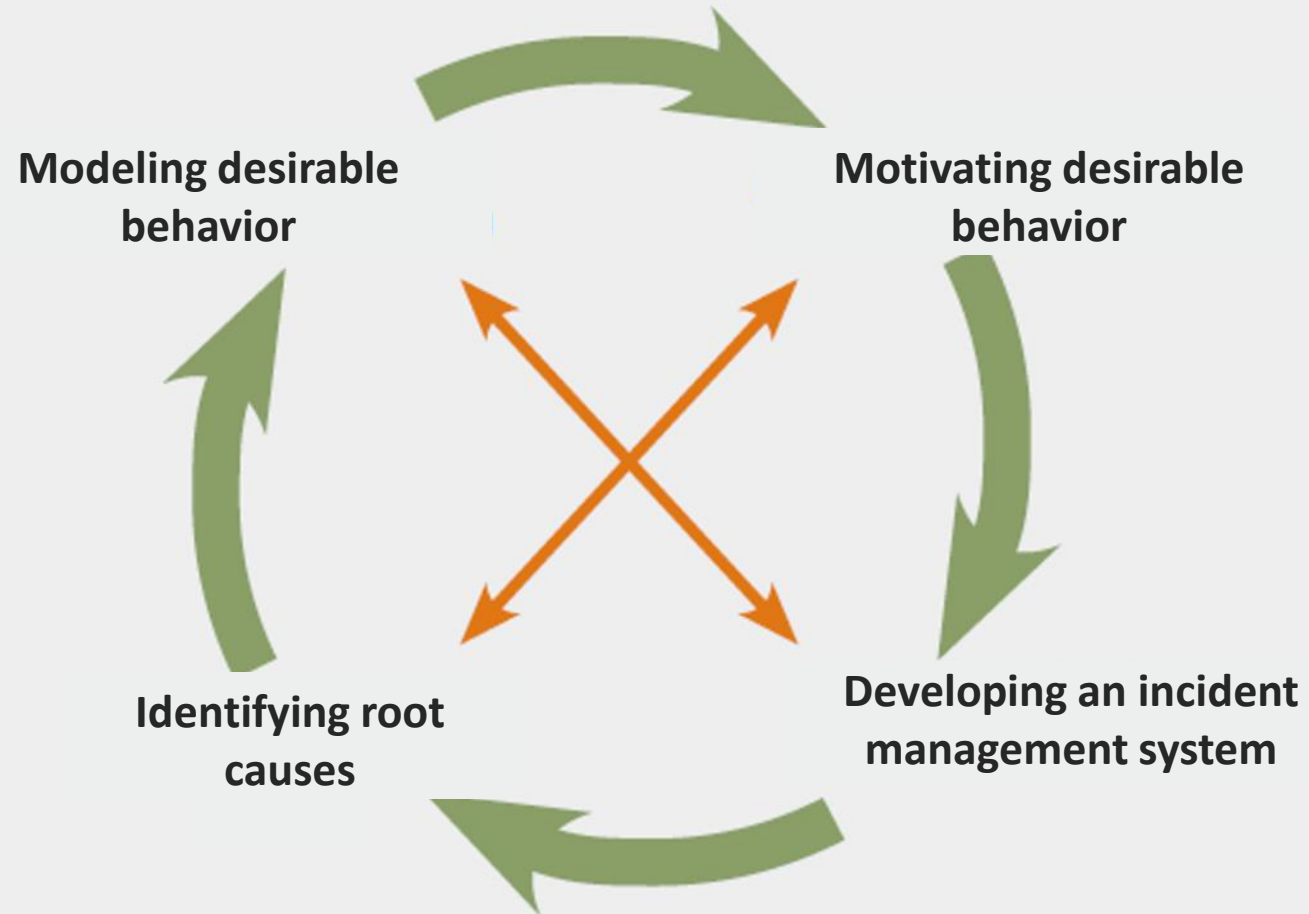


Safety culture

3. Incident management system

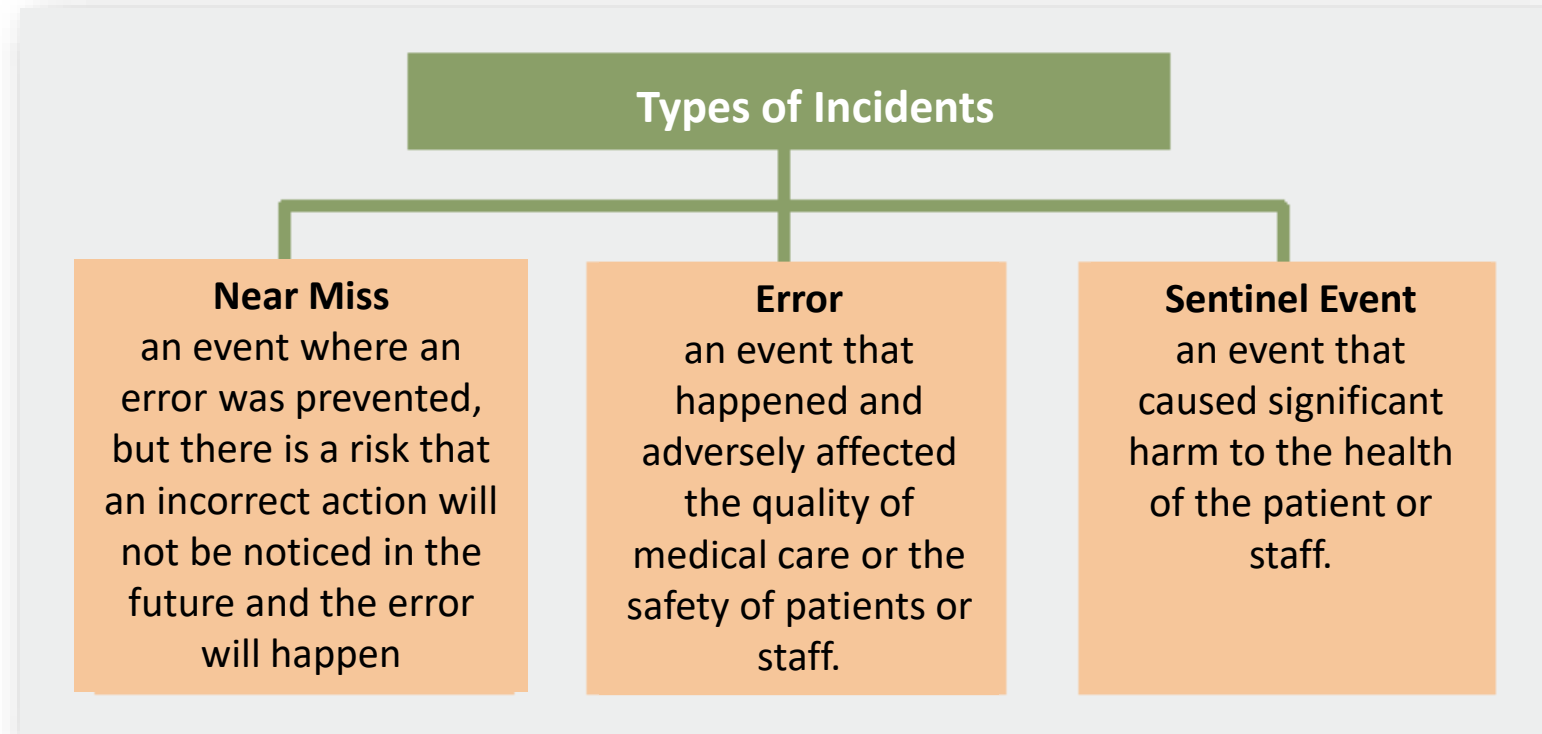
Irina Morozova

Implementing safety culture



What is an incident

An incident is an abnormal, unusual event that leads or could lead to a decrease in the level of safety and quality of medical care, as well as to an adverse outcome.



Incident management system

Incident reporting



Routing to the appropriate review layer



Analysis involving all event participants



Development and implementation of corrective actions



Incident reporting

Goal: To be as fast and simple as possible – for staff convenience.

The option for anonymous reporting (a key indicator for assessing the true safety culture).

Incident Registration Form

General information

Date and time of the incident

Is the report anonymous? (Yes/No)

- If not anonymous:

-- Your full name

-- Contact phone number

-- Email address

-- Your job title

-- Your department

Department associated with the incident

Incident Description

Is a patient involved (Yes/No)?

Narrative of the event (What happened?)

Immediate actions taken to resolve the incident

Additional materials (option to attach files: photos, documents, etc.)

Location of the incident (building, floor, room number)



Incident routing

Key Principles

- Designate a responsible coordinator (preferably specific, dedicated staff member)
- Identify review participants (all direct participants in the incident and relevant independent experts)
- Involve supervisors (the immediate supervisors of the involved staff must be part of the review process for accountability and systemic insight)
- Maintain professional ethics!



Incident analysis

Root Cause Analysis (RCA) is a structured, step-by-step process designed to identify the fundamental factors and/or causes of an incident.

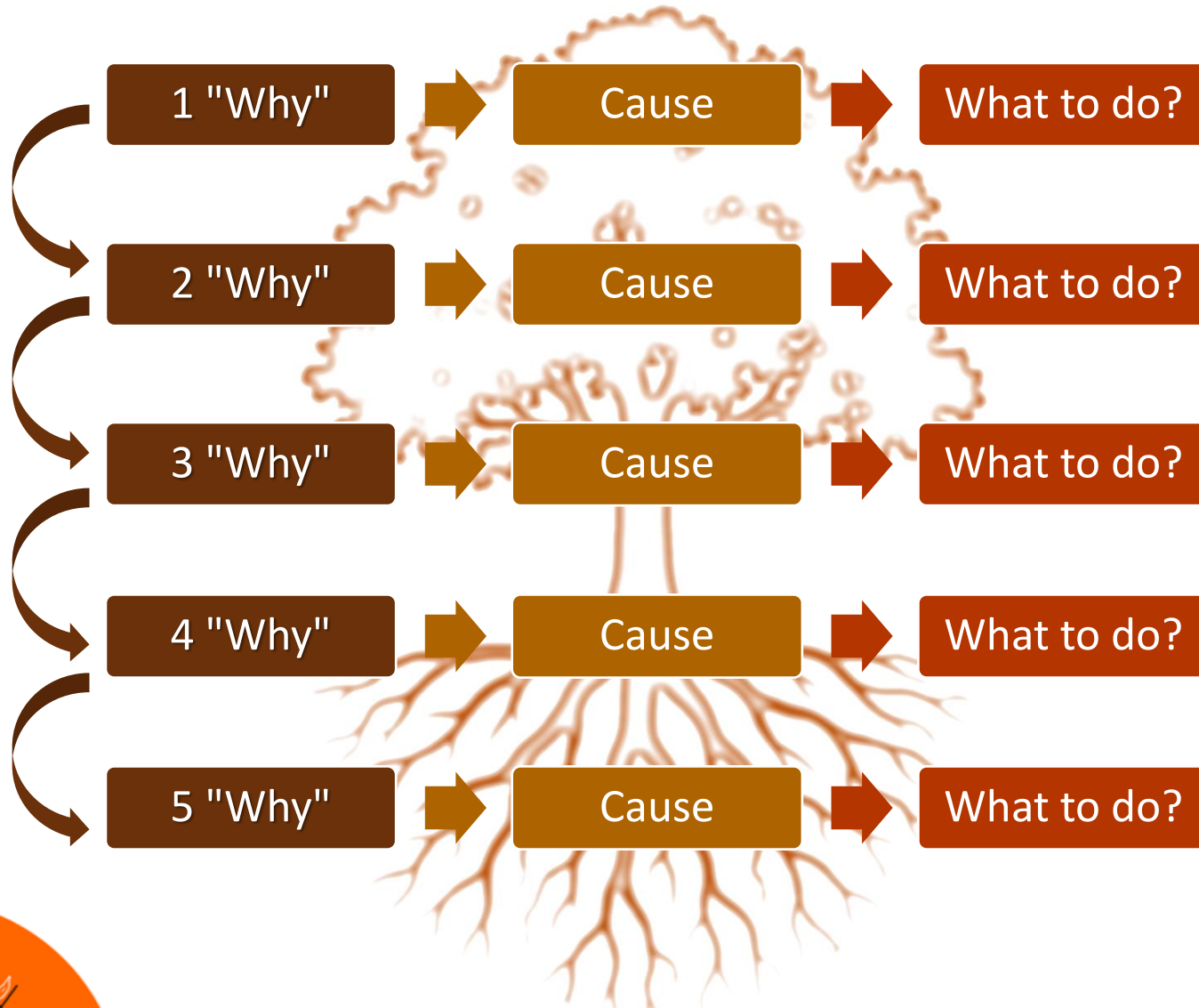
It helps develop an action plan to address the problem and prevent its recurrence in the future.

The goal of RCA is to answer three key questions:

- What happened?
- Why did it happen?
- What needs to be done to prevent it from happening again?



Root cause analysis: the 5 "Why?" method

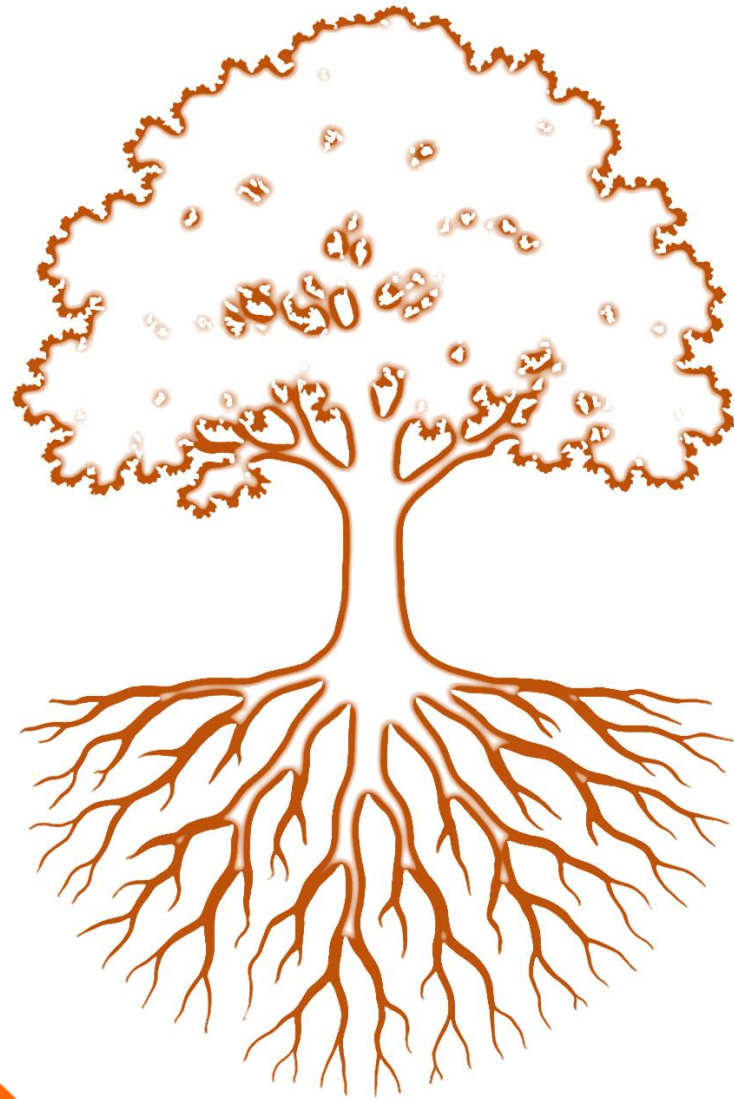


- 1) Assemble a **multidisciplinary** team
- 2) Clearly define the problem
- 3) Ask "why" at least five times until you reach the root cause of the problem

! All answers to the "Why?" questions must be **within the area of responsibility** of the employees involved in the review



The 5 "Why?" method: Example



PROBLEM

I missed my train

Why?

I left the house an hour later than planned

Why?

The wall clock was running but showing the wrong time

Why?

The battery was low and the clock began to lag

Why?

No timely battery check and replacement

Why?

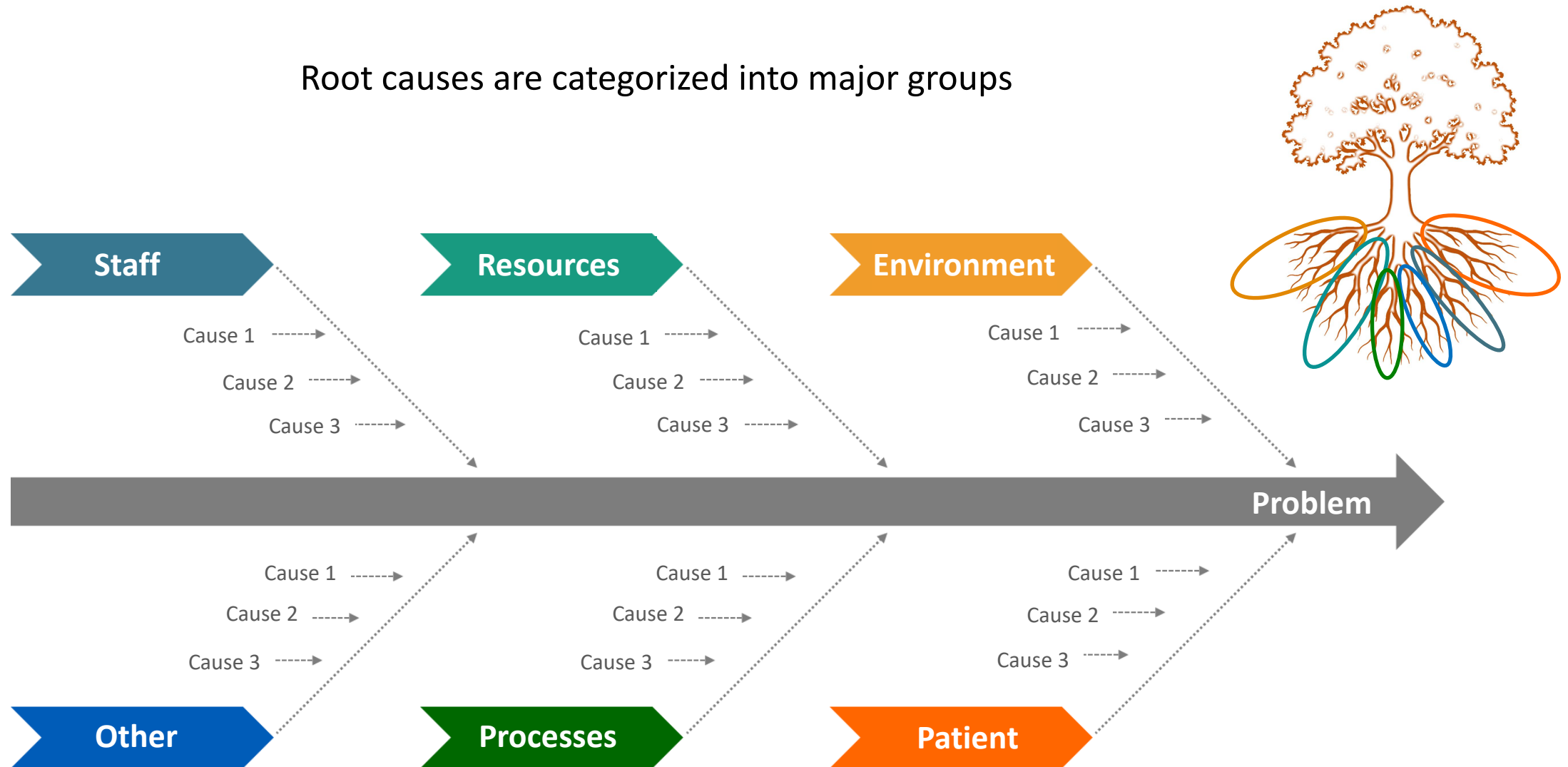
ROOT CAUSE

No scheduled control and preventive replacement plan for the wall clock battery

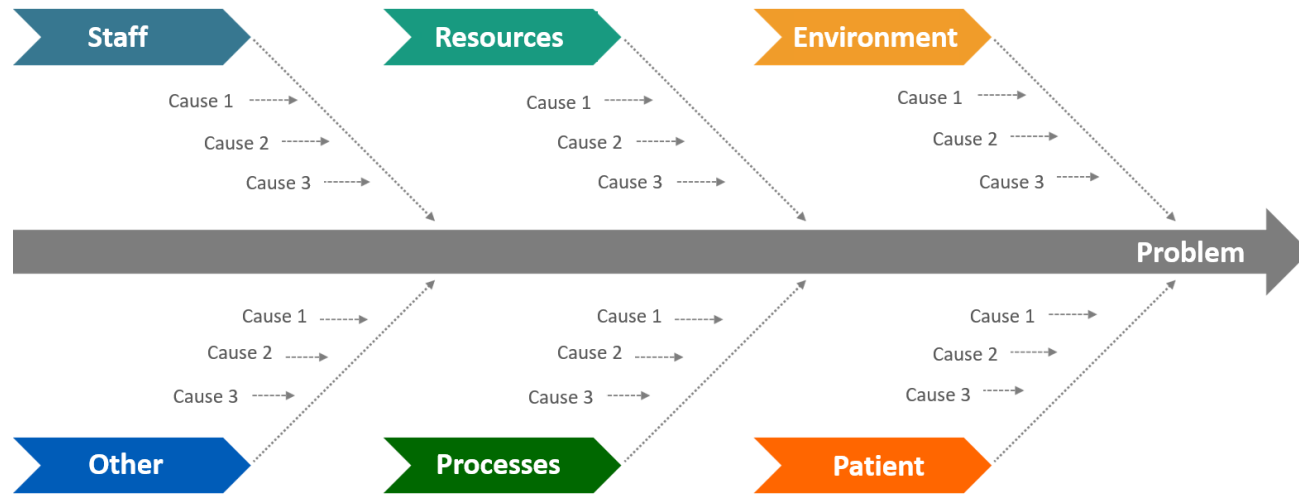


Root cause analysis: Ishikawa diagram

Root causes are categorized into major groups



Ishikawa diagram: Action plan



- 1) Clearly define the problem
- 2) Identify major cause categories
- 3) For each category, list all potential causes and sub-causes

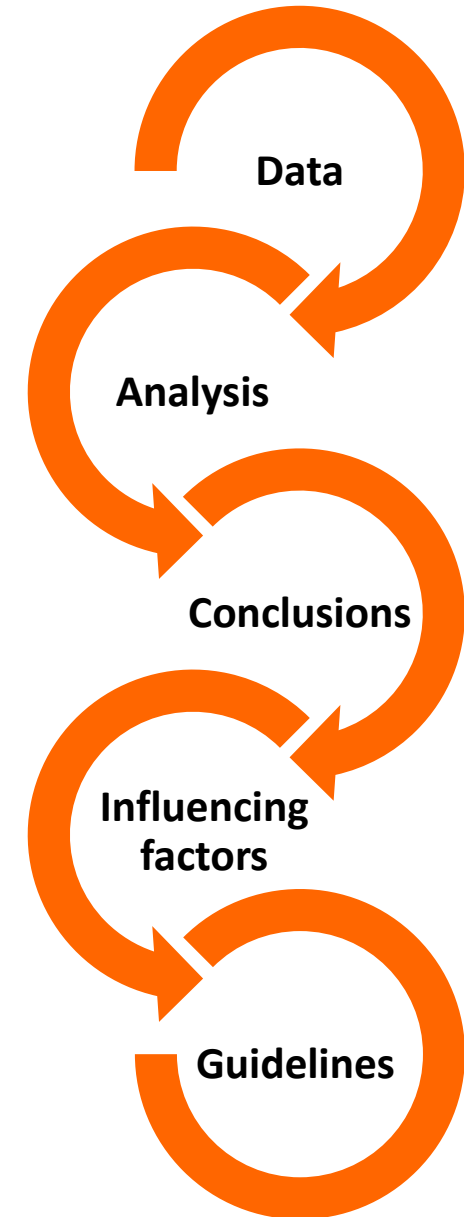
! Key Principle: Ask "Why?" repeatedly until you reach a useful level of detail – when a cause is specific enough to test a change and measure its impact.



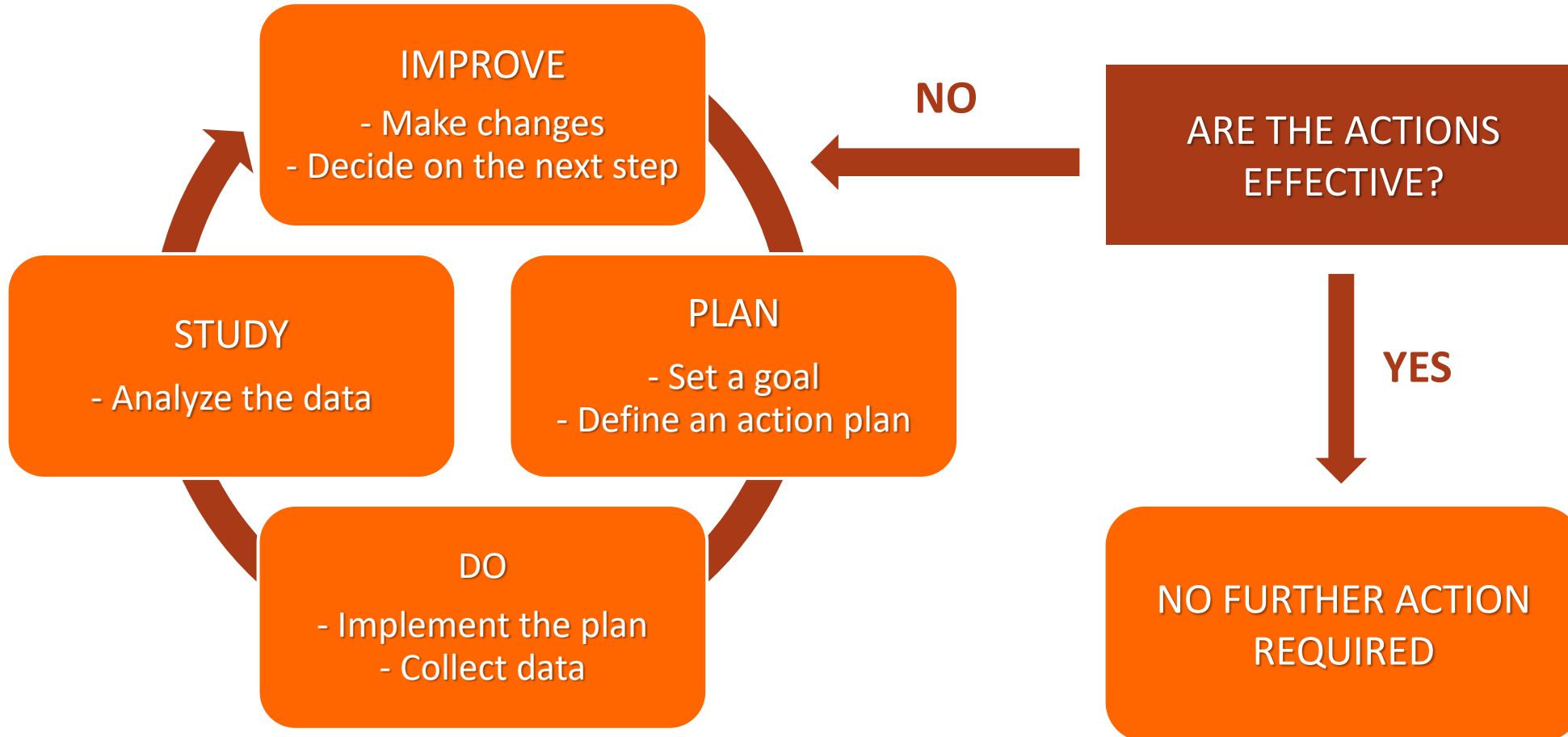
Corrective actions



Evidence-based guidelines must be grounded in the collected data, their analysis, the conclusions drawn from that analysis, and the influencing factors affecting the process.



Implement improvements



and measure results



Feedback and reporting

Incident Review Protocol #...

1. Date of Review
2. Date of Incident Report
3. Incident Reporter(s)
4. Review Coordinator and Participants (invited by the Incident Manager)
5. Incident Description
6. Problem(s) Identified in the Incident Description
7. Root Cause Identification (complete a separate table for each identified problem)

Problem / "Why?" (Cause)	Solution / "How?" (Action) <i>If no solution is identified at a specific stage, mark with a dash</i>
1) Why?	1) How?
2) Why?	2) How?
3) Why?	3) How?
4) Why?	4) How?
5) Why?	5) How?

8. Conclusion: Root Causes of the Problem(s) (based on the identification above)

Root Cause Category	Description of the Root Cause <i>If no specific root cause is identified for a category, mark with a dash</i>
Environment	
Equipment	
People / Staff	
Patient	
Processes	
Other Factors	

9. Corrective Actions

Corrective Action	Responsible Person	Deadline
1)		
2)		
...		

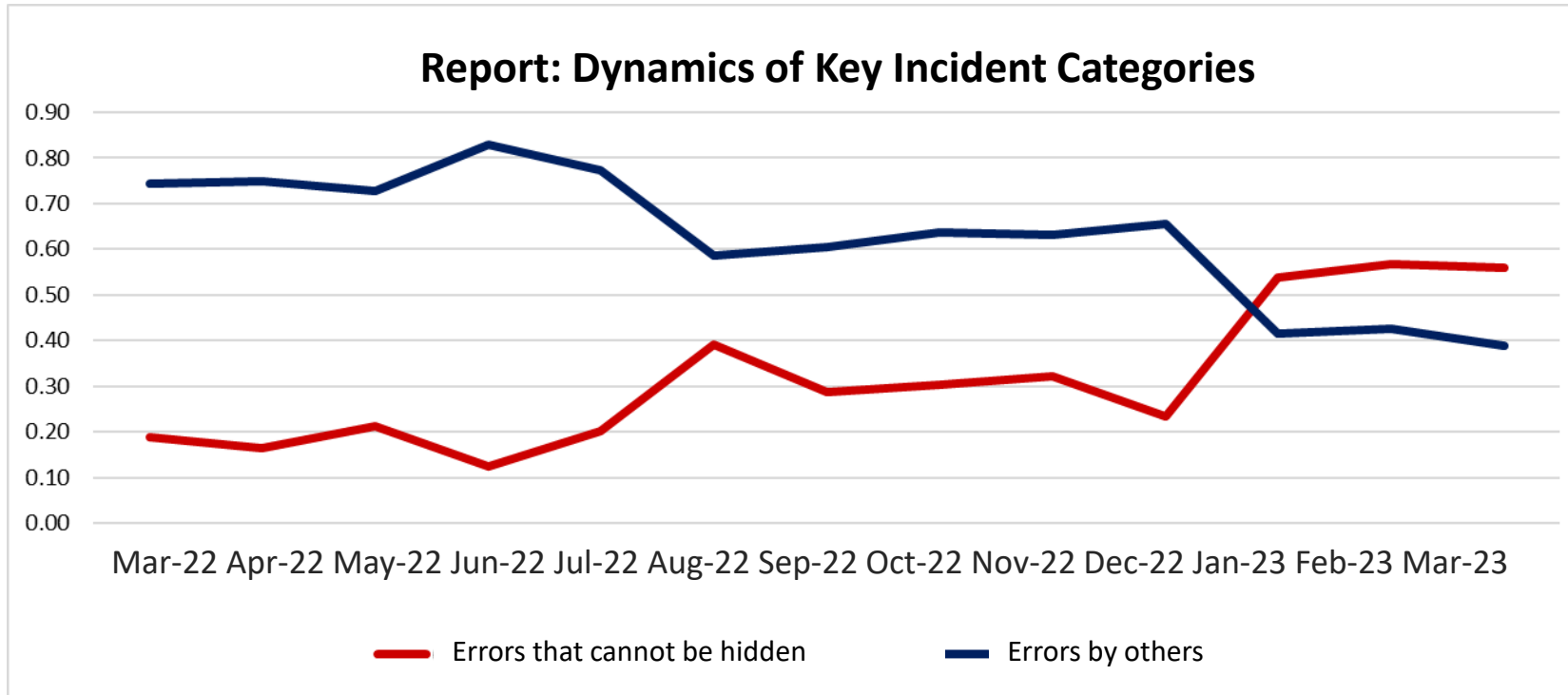
10. Implementation Report (to be completed by the responsible person no later than 3 working days after the implementation deadline).

To whom:

- Incident Reporter(s)
- Incident Participants



Feedback and reporting

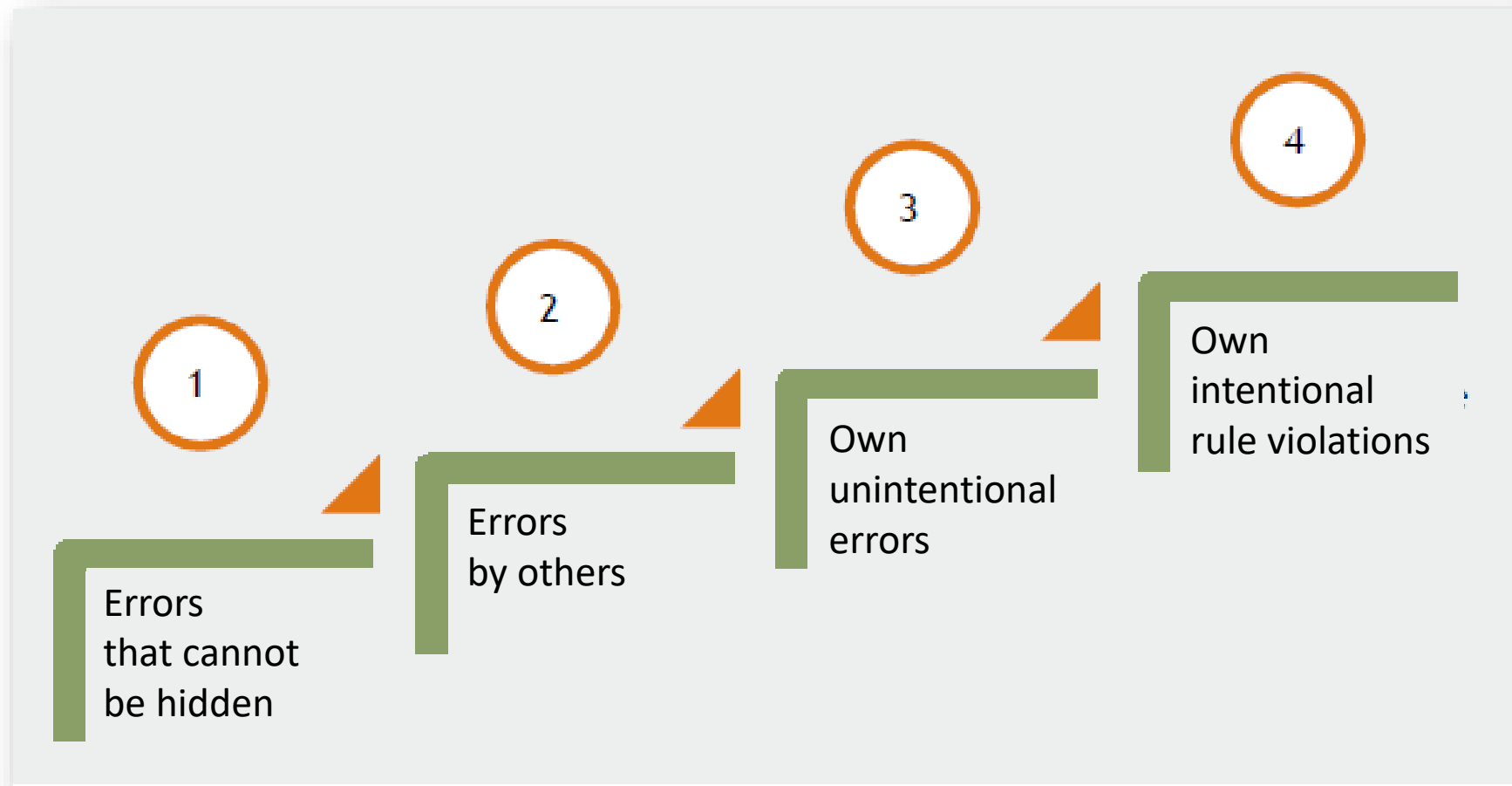


To whom:

Senior management



Evolution of incident reporting culture



This evolution marks the shift from a blame culture to a mature Just Culture, where transparency enables true learning and safety



Reasons for failures

WEAK
SAFETY CULTURE

NO ACTIONABLE RCA
OUTCOMES

LACK OF ANALYTICAL
THINKING

SKILL GAPS

OVER-RELIANCE
ON INTUITION

NO TEAM-BASED
APPROACH



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