

EDITORIAL

Patient safety is everyone's business

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Patient safety is fundamental to healthcare and is everyone's business. Healthcare is complex and inherently unsafe with error rates of 16.6% reported in Australia¹ and 12.9% in New Zealand.² Taking actions to mitigate risks to patients, such as incident reporting and using checklists appropriately, are essential.

Incident reporting is a key safety tool. It has the ability to capture near misses which, if analysed, give invaluable information on what went wrong, how the incident was detected, and harm prevented from reaching the patient. As near misses account for the majority of incidents this is essential safety information which is not readily obtained by other means.

As Denham and Page³ note in their paper in this edition of the journal there are a number of separate incident reporting systems in Australia and data are not collected centrally other than where required by law or regulation. The focus of their paper is radiation incidents, which are important and specific to our areas of work. There are other potentially serious patient safety events (or incidents), such as anaphylactic reactions to contrast media, which can affect radiology and radiation oncology patients. These are just as important and need to be captured and used to inform our practice. A unified, nationwide reporting system which captures information on all events that may affect our patients would help to improve patient safety. The National Reporting and Learning System (NRLS), which was part of the National Patient Safety Agency (NPSA), in the United Kingdom is an example of how this can be achieved.

Collecting data on patient safety events will be improved if the incident reporting system used is accessible, safe and easy to use. This applies to both the system itself and the environment in which it is implemented.

The reporting system needs to be easy to use and to capture relevant information. Many hospital systems are most suited to safety events occurring on the wards. As they are not specifically designed for use in radiology,

radiation oncology or elsewhere where there are specific risks related to the healthcare provided they can be hard to complete and not readily capture the relevant information. This can make them difficult to use especially if there are many forced fields where data entry is mandatory or a selection has to be made from a list that does not contain a relevant response.

Things go wrong despite the best intentions of staff. Complex systems, such as healthcare, have many vulnerabilities. Staff need to feel safe reporting incidents: in particular that they will not be blamed for adverse events. This requires a change from the blame culture that is widespread in healthcare to a just culture. A just culture is one where people are not blamed for errors and mistakes but remain accountable for gross negligence and wilful violations. Safety is at its core with reporting incidents encouraged and learning from error used to make care safer, thereby enabling a safety culture to thrive. A just culture is not a no-blame culture.

There are several studies which show that doctors are more likely to report if able to do so anonymously. This is thought to result from a fear of being blamed and loss of face amongst colleagues.⁴ It is likely that this is also true of other health professionals. Under-reporting is common, even where reporting is mandatory such as a computed tomography (CT) scan where more of the patient was scanned than was intended (i.e. a wrong site event). The ability report anonymously, not just confidentially, is critical especially where there is a blame culture.

One indication of the adoption of a safety culture is an overall increase in the number of incident reports, especially near misses, with a concurrent decrease in the absolute number of reports where harm occurred.

The act of reporting in itself has some benefits. Completing an incident (or patient safety) report requires the practitioner to reflect on the events and what could be done differently.

A greater benefit can be obtained if the learning from patient safety events can be disseminated widely. Denham

and Page³ have helped by analysing radiation adverse event data in the public domain. A properly funded, unified reporting system would include staff who are able to review and analyse the reports and make recommendations on improving safety. The Radiology Events Register (RaER) was intended to be a universal register designed to meet the needs of radiology. Unfortunately a lack of funding means that there are no longer the resources to continue data collection and analysis.

It is of interest that Denham and Page found that the commonest factor underlying incident reports was failure to implement or use a 'time out' process. 'Time out', is the verbal confirmation by all team members of essential details, such as patient identifiers, procedure, site and side immediately before commencing the procedure. In the United Kingdom the use of an appropriately modified version of the World Health Organisation's (WHO) Safe Surgery Checklist has been mandatory for radiology procedures since 2010. The Royal College of Radiologists and the NPSA worked together to produce a checklist fit for purpose.⁵

The National Institute for Health and Care Excellence (NICE) in the United Kingdom includes the use of radiation for diagnosis or treatment in its definition of 'invasive procedure'.⁶ Adopting this definition would expand the use of 'time out' checks to most of our patients. This is not the interpretation commonly used in Australia or New Zealand but, given the issues noted in Denham and Page's paper, perhaps it is time to adopt this broader definition of procedure and fully implement an appropriate 'time out' for all exposures to radiation.

It is not sufficient to mandate the use of 'time out' or other safety checklists. Training, education and support in their correct use and the reasons for using them are essential. If not, they become a 'tick and flick' exercise: the forms are either not completed properly or not done at all. Research into their use has demonstrated that there is poor completion and incorrect use of the safety checklist, including the 'time out' component.⁷

Checklists, when used correctly, are useful safety tools for non-complex repetitive processes, especially those that have several steps. These are widely used in high reliability industries, such as aviation, where critical checks are performed in more than one stage of the checklists. This is also the case with the WHO Safe Surgery Checklist. Appropriate use of the WHO checklist helps ensure that all the preoperative steps have been carried out, e.g. administration of antibiotics, and contingency plans made for potential problems, e.g. having the appropriate equipment readily available. This has helped reduce wrong side, site and patient operations and ensure that essential requirements such as radiology images and blood are available when necessary.

Adapting the WHO checklist for use in our workplaces is necessary to help improve patient safety. This would benefit from collaboration between the professional societies and colleges whose members work in radiology and radiation oncology.

Checklists do not replace the need for staff to be trained and skilled as much of our work is complex and requires us to think about what we do and to be alert to safety. Using checklists helps us in this task by providing aides-memoires and reducing errors from lapses.

Many things can improve patient safety including: creating a just culture that is focussed on safety; improving incident reporting rates; creation of a common incident reporting database that can be analysed and safety recommendations disseminated; and using appropriate checklists, such as 'time out', consistently and correctly. Safety is everyone's business and by working together we can all make a difference.

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