the patient safety company®
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Blueprints for Quality and Safety Reporting Forms

eBook

Introduction

Collecting data for your healthcare organization's quality and risk management programs isn't just necessary for patient safety and compliance—it's also the right thing to do to foster the delivery of better care by using staff input. There are many ways to collect the information that's vital for quality improvement and risk management. Incident reports, complaints/compliments forms, and satisfaction surveys are just a few of the data-collection tools that have proven successful in healthcare organizations of all types and sizes.

Incident reporting in particular is the preferred way to gain initial insight into the risks in a healthcare institution. And today's accessible, online incident reporting forms provide all the necessary information, while making it easy for staff and others to log reports. Consider that:

- The incident report is the starting point for an investigation into the causes of the incident or a broader analysis of the processes in the institution.
- New insights can lead to an adjustment of workflows, processes, or tasks so that an organization can strive to prevent an incident from happening again in the future.
- Being able to report safely is important for employees, so that they can report a (near) incident without being penalized for it.

This eBook offers examples of the following quality and safety reporting forms, based on our everyday practice with many clients all across the globe:

1. Incident reporting form
2. OHS incident reporting form
3. Form to file a complaint
4. Form to register an improvement action
5. Staff satisfaction survey

In addition to these adaptable blueprints, you can read 14 tips on how to develop an easy-to-use incident reporting form.

Example reporting form for (near) incidents

QHC CARES

QHC Event Reporting Form

Use this form to report a safety event or an unsafe condition. The term event includes both an incident that reaches the patient and a near miss that did not.

Who is the person reporting the Event?*

The person reporting the event.

First name | Last name

Where do you work?*

The site and location where you work.

—Select—

Where did the Event occur?*

—Select—

When did the Event occur?*

What time did the Event occur?*

Who or what did this event involve?*

- ○ Non Person
- ○ Inpatient
- ○ Outpatient
- ○ Staff
- ○ Visitor

When the individual submitting the report answers with "Inpatient," "Outpatient," or "Visitor," then additional drop-down questions appear to request additional details.

Was the event witnessed by non QHC staff?*

For example student, visitor or family member.

- ○ Yes
- ○ No

What type of Event occured?*

- ○ Codes
- ○ Falls
- ○ Infection Prevention and Control
- ○ Medical Device Reprocessing Department (MDRD)
- ○ Nutrition
- ○ Other
- ○ Privacy Breach
- ○ Security
- ○ Surgical Services
- ○ Transportation
- ○ Equipment
- ○ Health Record
- ○ Maintenance
- ○ Medication
- ○ Obstetrical Services
- ○ Patient transfer
- ○ Pressure Injury
- ○ Safe Handling
- ○ Self-injury
- ○ Test/Procedure/Treatment
- ○ Vanessa's Law

Additional drop-down questions appear, depending on the user's answer. For example, when "Health Record" was selected, the following other questions appear.

Health Record

What was the issue with the health record?*

- ○ Incomplete documentation
- ○ Incorrect demographic information
- ○ Medication left in paper record
- ○ Misfiled record
- ○ Obstetrical Documentation
- ○ Original Document/Copy from other hospital
- ○ Scanned to wrong record
- ○ Unable to scan document
- ○ Use of white out
- ○ Wrong patient

Please attach a copy of the document of concern.

What were the contributing factors?*

Select all that apply.

- ☐ Communications
- ☐ Environmental conditions
- ☐ Insufficient staff
- ☐ Language barrier
- ☐ Policy/procedure not available
- ☐ Registration error
- ☐ To be determined

Remaining questions:

What happened? (Please provide facts only)

What was the degree of harm?*

—Select—

What, if anything, would you change?

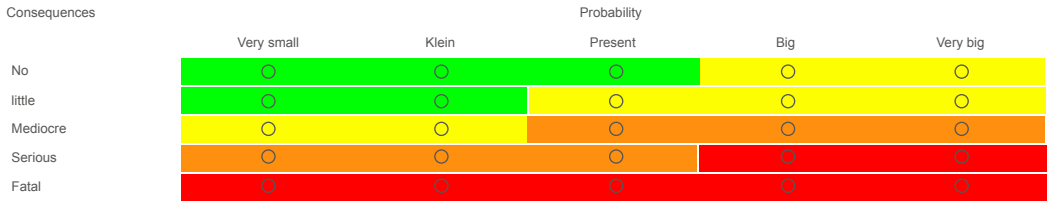
Save draft Send report

Other optional questions we use for some clients are, for example

How was the (near) incident discovered?

- ○ During (routine) check-up of patient
- ○ Noticed (accidentally) by employee
- ◉ Noticed by patient
- ○ Noticed by family/contact
- ○ After equipment alarm
- ○ Advice from other department
- ○ Other
  namely...

Please note: in case of serious incidents and calamities (category red), an anonymized copy will be sent to the CMC and Board of Directors.*



Legend : Risk classification

Legend : Probability

Legend : Consequences

The individual submitting the report can add a risk classification like this one. In some organizations, this is done by the Risk Manager or Quality Manager, after the incident is submitted for follow-up.

Have corrective measures been taken as a result of the (near) incident?

- ○ Yes
  namely...
- ○ No
- ○ Unknown

What preventive measures do you think are necessary to prevent such a (near) incident from happening again?

Multiple options possible.

- ☐ Discuss in (work) consultation
- ☐ Further training
- ☐ Bringing the appointment/protocol to the attention
- ☐ Adjust existing agreement/protocol
- ☐ Coordination with other department and/or discipline
- ☐ Replace/purchase/repair material
- ☐ Other
  namely...

Who was the (near) incident discussed with?

Multiple options possible.

- ☐ Patient
- ☐ Family / contact person
- ☐ (on duty) Doctors
- ☐ Supervisor
- ☐ Work /team meeting
- ☐ Not discussed

Inform colleagues? Click on the magnifying glass to search.

You can optionally add an attachment with additional information

Learn more about our software for incident reporting.

Example reporting form for Occupational Health & Safety (OHS) related incidents

Use this form to report a safety incident that has happened to you or another employee, or to report an unsafe situation in the workplace. Thank you for your valuable feedback. Our health and safety manager will review the report and determine the appropriate follow-up action(s).

Occupational Health & Safety (OHS) reporting form

Date of reporting

01-06-2021

Time of reporting

09:24

Employee information

First Name*

Last Name*

Date of Birth (dd/mm/yyyy)*

Email Address*

Home Phone Number*

Home Address*

City/Town*

Postal Code*

Province*

Your department?

Select an option

Time of occurrence

(format hh:mm, example:13:00)

Date of occurrence

(format dd-mm-yyyy, for instance 25-11-2010)

To whom was the occurrence reported?

Select an option

Who is your immediate manager?

Select an option

Multiple options possible.

What are you reporting?

- ○ **Employee Incident**
  Something happened to you at work.
- ○ **Workplace Hazard**
  A thing or situation with the potential to harm a worker.

Indicate the type of incident that occurred (employee incident) or might have occurred (workplace hazard)?

- ◯ **Struck/Caught**
  - An incident in which a person has been struck abruptly or forcefully by some object in motion.
  - An incident in which a person strikes abruptly or forcefully some stationary object in his/her surroundings.
  - An incident in which a person is: trapped in some type of enclosure; caught in some protruding object; pinched, crushed or otherwise caught between either a moving object and a stationery object or between two or more moving objectives.
- ◯ **Overexertion**
  An incident is one in which a person puts excessive strain on some part of his/her body (e.g. an employee strains his/her back or some other part of the body)
- ◯ **Repetition**
  An incident that develops over a period of time due to the repetitive nature of the task being carried out (e.g. pipetting, keyboarding).
- ◯ **Fire/Explosion**
  An incident in which the employee is subjected to a fire or explosion in the workplace.
- ◯ **Fall**
  A fall on the same level on which a person was standing or walking, or when a person falls to below the level on which he/she was standing or walking.
- ◯ **Harmful Substance/Environmental**
  An incident in which the employee is exposed to harmful conditions (e.g. toxic gases, fumes or vapours, toxic airborne particles; extremes of heat or cold; oxygen deficient atmospheres, radioactive radiation; intense light brightnesses, infectious diseases, blood/blood-stained body fluids, moulds/spores).
- ◯ **Workplace Violence**
  - The exercise of physical force by a person against a worker, in a workplace, that causes or could cause physical injury to the worker, or
  - An attempt to exercise physical force against a worker, in a workplace, that could cause physical injury to the worker, or
  - A verbal threat or behaviour that it is reasonable for a worker to interpret as a threat to exercise physical force against the worker, in a workplace that could cause physical injury to the worker.
- ◯ **Workplace Harassment (Type or Workplace Violence)**
  - Engaging in a course of vexatious comment or conduct against a worker in a workplace.
  - This includes verbal abuse, bullying, intimidating or offensive jokes or innuendos, displaying or circulating offensive pictures or material, or offensive or intimidating phone calls, social media posts or messages, emails, etc.
- ◯ **Slip/Trip**
  The person either slips or trips but does not fall.
- ◯ **Motor Vehicle Incident**
  An incident in which the employee is involved in a motor vehicle incident during the course of his/her work activities.
- ◯ **Other** _____

The unit where the incident occurred or the workplace hazard was identified?

Select an option

Specifically, where the incident occurred or the workplace hazard identified?

Select an option

Were you on the job when the injury/illness occurred?

- ◯ Yes
- ◯ No, please describe/give details about the incident that occurred _____

Did the accident happen on the employer's premises?

- ◯ Yes
- ◯ No

Was equipment involved?

- ◯ No
- ◯ Yes, please identify the size, weight & types of equipment involved _____

Please identify name(s), position(s) & phone number(s) of witness(es) or person(s) having knowledge of the incident.

Was any individual, who does not work for your firm, partially or totally responsible for this accident/illness?

- ◯ No
- ◯ Yes, please provide name(s), position(s) and work phone number(s) _____

State the exact sequence of events leading up to the incident/illness. Include an explanation of what the employee was doing.

What caused the injury/illness?

Was the injury/illness:

- ○ A sudden, specific event/occurrence
- ○ Gradually occurring over time
- ○ An occupational disease
- ○ A fatality

Describe the illness or injury, part of body involved and specify left or right side. If applicable, include any psychological illnesses/injuries you are experiencing.

Are you aware of any prior similar or related problem, injury, or condition?

- ○ Yes, please explain
- ○ No

Did you seek medical attention?

- ○ No
- ○ Yes

Did you visit health service?

- ○ No
- ○ Yes

Did you visit emergency?

- ○ No
- ○ Yes, please provide physician's name and phone number

Did you visit family physician?

- ○ No
- ○ Yes, please provide family physician's name, phone number and address

I certify that the information provided in this Employee Incident Report is true and correct to the best of my knowledge. I further understand that any false claims may result in disciplinary action. I understand that I am responsible for submitting employee incident reports for my own injuries/injuries/occupational illnesses only.

- ☐ Yes

Learn more about our software for reporting OHS incidents.

Example reporting form for complaints and compliments

Add this feedback form to your website so patients and visitors can easily find it and provide valuable feedback. You can also add a link to this form in digital communication like e-mail, SMS, or WhatsApp messages.

Complaint/Compliment form

1. Name of person entering the complaint or compliment*

First name

Last name

E-mail address

2. Reporting date

07-13-2021

3. What are you reporting?*

- ○ Complaint
- ○ Compliment

Based on the reporter's answer to question 3, a few more in-depth questions appear, as the following example shows:

Complaint information

How was the complaint received?*

- ☐ Telephone
- ☐ Letter
- ☐ In person
- ☐ E-mail
- ☐ Hospital website
- ☐ Other

Who is making the complaint?

- ○ Patient
- ○ Family member
- ○ Friend
- ○ Visitor
- ○ Other (specify)

Language of the complaint?

- ☐ English
- ☐ French
- ☐ Other (specify)

Was a consent received by the patient if complainant is not the patient?

- ○ Yes
  - ⓘ Specify if verbal or written and by whom
- ○ No
  - ⓘ Explain the reason

When was the consent received?

People involved in this complaint?

- ☐ Patient
- ☐ Family member
- ☐ Visitor
- ☐ Nursing
- ☐ Allied Health Professionals

Description of the complaint

Immediate action taken?

◯ Yes(Specify)
...

◯ No

The nature of the complaint is:* asterisk means that it is a required field

+☐ Clinical +☐ Management +☐ Relationships

Complainant expectation for resolution of the complaint

The nature of the complaint is:*

−☐ Clinical

− ☑ Quality

- ☐ Examinations
  - ⓘ *(i.e. inadequate patient examination by clinical staff.)*
- ☐ Patient Journey
  - ⓘ *(i.e. Problems in the coordination of treatment in different services by clinical staff)*
- ☐ Quality of Care
  - ⓘ *(i.e. Substandard clinical/nursing care).*
- ☐ Treatment
  - ⓘ *(i.e. Poor or unsuccessful clinical treatment).*

− ☑ Safety

- ☐ Errors in diagnosis
  - ⓘ *(i.e. Erroneous, missed, or slow clinical diagnosis).*
- ☐ Errors in diagnosis
  - ⓘ *(i.e. Errors in prescribing of administering medications).*
- ☐ Safety incidents
  - ⓘ *(i.e. Events or complications that threaten the safety of patients).*
- ☐ Skills and conduct
  - ⓘ *(i.e. Deficiencies in the technical and non-technical skills of staff that compromise safety).*

− ☑ Management

− ☑ Institutional Issues

- ☐ Bureaucracy
  - ⓘ *(i.e. Problems with administrative policies and procedures).*
- ☐ Environment
  - ⓘ *(i.e. Poor accommodation,hygiene or food).*
- ☐ Finance and billing
  - ⓘ *(i.e. Healthcare associated costs, of the billing processes).*
- ☐ Service issues
  - ⓘ *(i.e. Problems with hospital services for supporting patients)*
- ☐ Staffing and resources
  - ⓘ *(i.e. Inadequate hospital staffing and resource levels)*

− ☑ Timing and Access

- ☐ Access and admission
  - ⓘ *(i.e. Lack of access to services or staff).*
- ☐ Wait times
  - ⓘ *(i.e. Delays in admissions or access to treatment).*
- ☐ Discharge
  - ⓘ *(i.e. Early, late, or unplanned discharge from the hospital)*
- ☐ Referrals
  - ⓘ *(i.e. Problems in being referred to a healthcare services)*

− ☑ Relationships

− ☑ Communication

- ☐ Communication breakdown
  - ⓘ *(i.e. Language barriers, inadequate, delayed, or absent communication with patients/family).*
- ☐ Incorrect information
  - ⓘ *(i.e. Communication of wrong, inadequate or conflicting information to patients/ families).*
- ☐ Patient-staff dialogue
  - ⓘ *(i.e. Not listening to patients, lack of shared decision-making and conflict)*

− ☑ Humanness/caring

- ☐ Respect, dignity, and caring
  - ⓘ *(i.e. Rude, disrespectful, insensitive behaviour to patients/families).*
- ☐ Staff attitudes
  - ⓘ *(i.e. poor attitudes towards patients or their families).*

− ☑ Patient rights

- ☐ Abuse
  - ⓘ *(i.e. Physical, sexual, or emotional abuse of patients/families)*
- ☐ Confidentiality
  - ⓘ *(i.e. Breaches of patient confidentiality).*
- ☐ Consent
  - ⓘ *(i.e. Coercing of failing to obtain patient consent).*
- ☐ Discrimination
  - ⓘ *(i.e. Discrimination against patients/ families).*
- ☐ Loss of property

After the more in-depth questions are answered, the form continues with the remaining general questions.

Additional information

Was a consent received by the patient if complainant is not the patient?

First name | Last name

Date of birth | Patient number

-Select- | Admission date

Unit | Email address

Phone Number

4a. Is the patient still admitted?

- ☐ Yes
- ☐ No

5a. Date received | **5b. Date of event (if known)**

6a. Date Involved: -Select- | **6b. Who is most responsible for follow-up?** -Select-

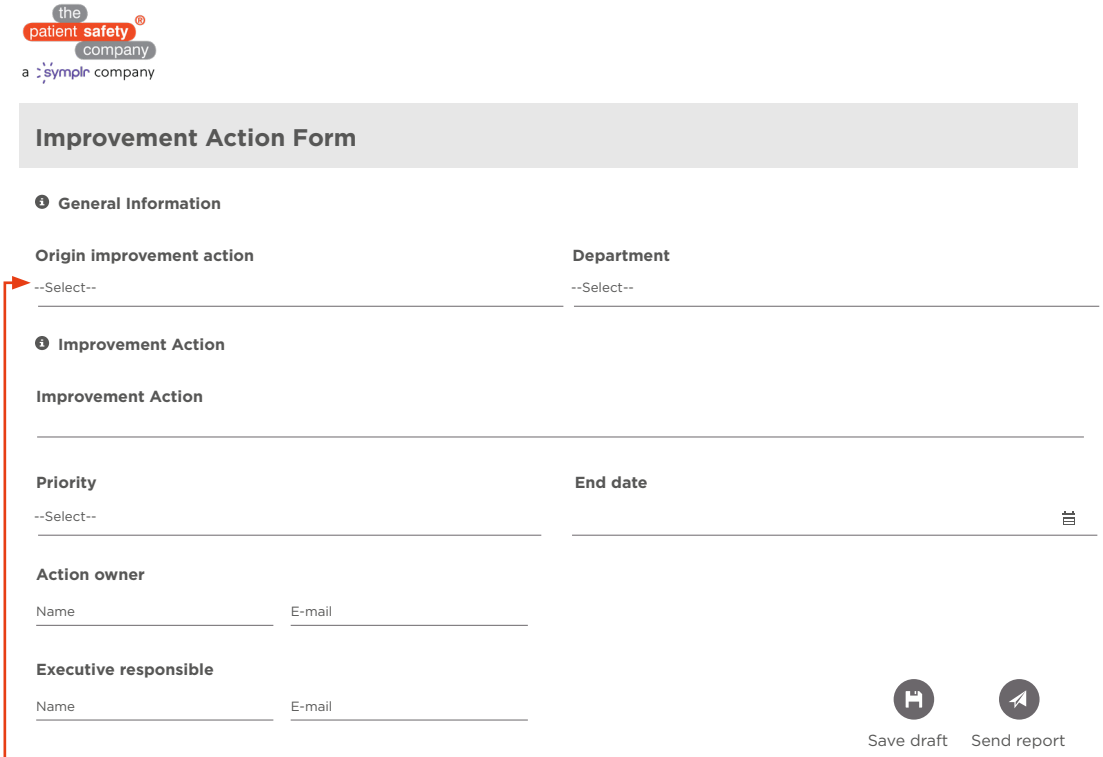
7a. Please add any applicable attachments | **7b. Please add any applicable attachments**

Save draft | Send report

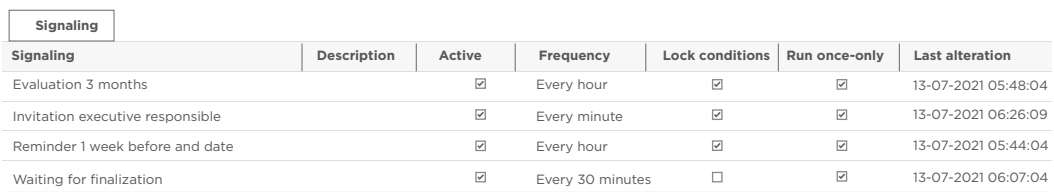
Learn more about our software for the registration of patient feedback.

Example form for the registration of improvement actions

The form to register an improvement action is simple and straightforward, and the intelligence of the registration process is reflected in the follow up process. Within the same software you use to manage all improvement actions, you can also set specific follow-up actions. You have many options available to set up the workflow. It is an easy task that doesn't require the user to have a technical background.



The screenshot below shows some example workflow steps for an improvement action. Other options are, for example: send an email, close the file, send a SOAP message, or adjust user rights for individuals involved in the improvement action.



Signaling

Signaling	Description	Active	Frequency	Lock conditions	Run once-only	Last alteration
Evaluation 3 months		☑	Every hour	☑	☑	13-07-2021 05:48:04
Invitation executive responsible		☑	Every minute	☑	☑	13-07-2021 06:26:09
Reminder 1 week before and date		☑	Every hour	☑	☑	13-07-2021 05:44:04
Waiting for finalization		☑	Every 30 minutes	☐	☑	13-07-2021 06:07:04

Learn more about our software to register and manage improvement actions.

Example form for an employee satisfaction survey

Employee Satisfaction Survey

We are conducting the following employee satisfaction survey to learn about your experiences in caring for COVID-19 patients. Your answers will help improve our approach to patient care and ensure that you feel supported and enjoy coming to work.

All answers will be processed confidetially. We'll start with general, open-ended questions, followed by a list of statements. For each statement, check the box next to the response that most accurately reflects the extent to which you agree with the statement. There are 6 answers to choose from:

- ○ Strongly agree
- ○ Agree
- ○ Neutral
- ○ Disagree
- ○ Strongly disagree
- ○ Does not apply

After you have answered all questions, please submit your answers by clicking on the 'Submit form-icon' at the bottom of the questionnaire.

Thank you in advance for your cooperation!

Today's Date*

06-01-2021

Your Information

Name

E-mail

What is your gender?*

--Select--

What is your age? *

--Select--

What is your job title? *

--Select--

In which department do you work? *

--Select--

How long have you been working in this organisation*

--Select--

The questions regarding job title and department can also be asked in the following way, depending on how the information from the survey will be reported:

What is your position in this hospital?

- +○ Nursing
- +○ Medical
- +○ Other Clinical Position
- +○ Supervisor, Manager, Clinical Leader, Senior Leader
- +○ Support
- ○ Other
  please specify...

Your Unit/Work Area

Think of your "unit" as the work area, department, or clinical area of the hospital where you spend **most of your work time**. What is your primary unit or work aea in this hospital?

- +○ Multiple Units, No specific unit
- +○ Medical/Surgical Units
- +○ Patient Care Units
- +○ Surgical Services
- +○ Clinical Services
- +○ Administration/Management
- +○ Support Services
- ○ Other
  please specify...

Indicate to what extent you agree with the following statements*

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	N/A
I enjoy my work	O	O	O	O	O	O
The atmosphere in my department is good	O	O	O	O	O	O
I have enough time to care for patients	O	O	O	O	O	O
The work pressure in my department is too high	O	O	O	O	O	O
I am supported / guided in my work by my direct supervisor	O	O	O	O	O	O
I am supported in my work by upper management	O	O	O	O	O	O
Most patients are satisfied with the care they receive in my department	O	O	O	O	O	O
I am kept informed of new developments within our institution	O	O	O	O	O	O
In my departent, we actively work on the improvement of care	O	O	O	O	O	O
Communication with other colleagues in my department is good	O	O	O	O	O	O
Communication with colleagues from other department is going well	O	O	O	O	O	O
All policies and procedures are clear and available to me in my department	O	O	O	O	O	O
I have sufficient knowledge and experience for the proper execution of my work	O	O	O	O	O	O
My organization provides me with opportunities to further develop myself in my field	O	O	O	O	O	O
I am given the space for my own initiative and the independent execution of tasks	O	O	O	O	O	O
I am satisfied with the appreciation I receive from my departmental leaders for the work I do	O	O	O	O	O	O

Indicate to what extent you agree with the following statements regarding COVID-19*

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	N/A
All policies and procedures around COVID-19 are clear and available to me	O	O	O	O	O	O
Sufficient personal protective equipment is available to protect employees against COVID-19 in my organization	O	O	O	O	O	O
I have colleagues who have (had) a very tough time mentally or emotionally with treating COVID-19 patients.	O	O	O	O	O	O
I would like to receive the contact details of a counseling professional to discuss processing my COVID-19-related patient care experiences	O	O	O	O	O	O

Would you recommend your organization in your area as a good employer?*

- ○ Yes
- ○ No

What should your organization do to increase your job satisfaction?

What should your organization do to ensure that the quality of patient care improves?

Do you have additional points of view to share, or would you like to clarify your answers to the above statements?

Save draft Send report

Depending on the purpose of the survey you can add specific segments related to certain topics, like patient safety. See some examples:

Communication

Think about your unit/work area

	Never	Rarely	Sometimes	Most of the Time	Always	Does Not Apply or Don't Know
1. We are informed about errors that happen in this unit	○	○	○	○	○	○
2. When errors happen in this unit, we discuss ways to prevent them from happening again	○	○	○	○	○	○
3. In this unit, we are informed about changes that are made based on event reports	○	○	○	○	○	○
4. In this unit, staff speak up if they see something that may negatively affect patient care	○	○	○	○	○	○
5. When staff in this unit see someone with more authority doing something unsafe for patients, they speak up	○	○	○	○	○	○
6. When staff in this unit speak up, those with more authority are open to their patient safety concerns	○	○	○	○	○	○
7. In this unit, staff are afraid to ask questions when something does not seem right	○	○	○	○	○	○

Reporting Patient Safety Events

Think about your unit/work area

	Never	Rarely	Sometimes	Most of the Times	Always	Does Not Apply or Don't Know
1. When a mistake is caught and corrected before reaching the patient, how often is this reported?	O	O	O	O	O	O
2. When a mistake reaches the patient and could have harmed the patient, but did not, how often is this reported?	O	O	O	O	O	O

Patient Safety Rating

How much do you agree or disagree with the following statements about your hospital?

	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree	Does Not Apply or Don't Know
1. The actions of hospital management show that patient safety is a top priority	O	O	O	O	O	O
2. Hospital management provides adequate resources to improve patient safety	O	O	O	O	O	O
3. Hospital management seems interested in patient safety only after an adverse event happens	O	O	O	O	O	O
4. When transferring patients from one unit to another, important information is often left out.	O	O	O	O	O	O
5. During shift changes, important patient care information is often left out	O	O	O	O	O	O
6. During shift changes there is adequate time to exchange all key patient care information	O	O	O	O	O	O

Learn more about our software to carry out satisfaction surveys.

14 Tips for Developing a Useful Incident Reporting Form

When setting up an incident management system, it's important to think about the structure and the questions that you'll ask on the reporting forms. The answers contribute to the ease of analyzing the incident, the management of the reports, and the insights the report will provide into the safety situation within your healthcare organization.

Learn more by applying these 14 tips when setting up a new (incident) reporting form.

Or ask your questions in a free online demo by one of our consultants.

1. Be consistent with everyday practice

Most healthcare institutions already use a preferred method or methods (e.g., paper, Excel, or software) to collect and analyze incidents. It is best to align a new digital reporting form with the basis of this existing working method. This makes it easier for the organization to implement the new incident form organization wide and fosters faster acceptance of it by the employees.

2. Choose an analysis method first

The specific method for analyzing incidents can form the basis for the incident report form, so it's wise to make a decision at an early stage. There are various methods to choose from, such as the PRISMA method or the SIRE method. It's also possible to use different methodologies for different types of incidents. For example, the extensive SIRE method can be used in the event of impactful incidents, while the PRISMA method can be used for incidents with a less serious outcome. It is important to use the same analysis tool for the same type of incidents in all departments, however. The reasons: incidents between departments can ultimately be compared, so that people learn from each other.

3. Streamline the form and limit the number of questions

Make a balanced tradeoff between what the reporter must fill in on the form and what the users in the back office will need to complete the process. While a common complaint from reporters is that the form is too extensive and/or time-consuming, certain information must be included. Strike the right balance by considering ahead of time what data is essential in analyzing a report. Think carefully not only about the questions you include, but also about the structure of the questions on the form.

4. Look at the big picture

Take into account the number and type of reports that you or your department are obligated to deliver per month, quarter, or year—and adjust the forms accordingly. For example, if you do not record necessary steering information anywhere, you cannot report on it. Consider, too, the departments from which the reports will come, the timing and duration of notification, the type of incidents to be expected, and the basic causes of the occurrence of an incident. All of these elements provide very valuable information and guide you in creating a systematic process.

5. Make it easy for the reporter

Make it easy for the reporter by formulating questions clearly, so there is little room for them to misunderstand what data must be filled in. It's even better if you can offer questions with multiple-choice response options so that the reporter spends little time filling in free text fields. You can also simplify the process for the reporter by offering digitally accessible forms via desktop, tablet, and mobile phone. A link on the desktop of every fixed computer is not enough. Ensure that an employee who is not on the premises, or who does not have a computer at their disposal, also knows how to report an incident. Consider offering the reporter the ability to add visual material directly in the incident form. A photo, for example, can further clarify the situation in which the incident occurred. Last, remember that the use of a clean, modern, simple form design will improve the user experience.

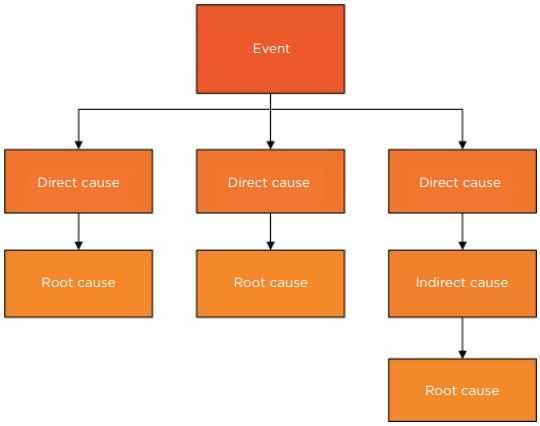
6. Give reporters the tools to make an analysis

Offering one text field with "describe the incident" may be too general of an approach to gather data. Consider splitting that question into sub-questions, so the reporter immediately performs some sort of analysis:

a. Which event led to the incident?
b. Describe the events at the time of the incident.
c. What are the consequences for the patient?
d. What are the consequences for engaged colleagues?

7. Understand the value of root causes

Naturally, data about the incident is the most essential information sought on a report form. But information about the origin of an incident is also very valuable. As a result, ensure that the reporter can log a sufficient description of the (near) incidents by asking the right questions, so that the committee can analyze the incident by means of a cause tree. Use of a cause tree during the analysis stage can help identify which causes, and possibly which factors, played a role in the event or near-incident.



While the origin of an incident often can be traced back to one individual or system process, the question of guilt is irrelevant. Root causes, however, are valuable and highly relevant. During the analysis stage, the search should continue until the root cause(s) have been identified, with the aim of preventing similar incidents from happening again.
Therefore, to help uncover root causes, include a question in the incident form about causes related to, for example:

- Technical aspects
- The organization
- Human actions and behavior of the care provider
- Communication

These examples and other like them can often be traced back to deeper underlying causes. If reporting shows that the root causes lie within the organization, for example, time and resources can be saved by focusing the follow-up activity and investigation at the organizational level to prevent such incidents in the future.

When the root causes have been made clear by the incident analysis, it's possible to create a graph of the basic causes that occur after a number of 30 to 50 analyses. This data can then be used to determine which departments experienced a peak, and targeted improvement actions can be taken there. After a new analysis, the data can be revisited to check for increases or decreases, indicating whether the improvement action(s) worked.

8. Think in terms of processes

When you give the reporter the ability to provide input on which process and where in the process the incident occurred, you immediately identify the interfaces between persons, disciplines, and care teams potentially involved. Questions can then be added to solicit additional or supportive information, such as environmental factors at play, positives of the event, patient laboratory values, etc. For example, in the medication process: Where did something first go wrong—when prescribing, when writing a prescription, during drug preparing or administration?

9. Offer the option to report centrally

Consider giving reporters the option to forward a report to a "central point," instead of decentralizing incidents by department. Research and The Patient Safety Company's experience shows that many (near) incidents go unreported, because the individual does not want it to be known or handled in their own department for fear of reprisal.

10. Make a choice: Is anonymity allowed?

Incident reporting system is intended to gain insight into as many (near) incidents as possible, to improve safety for all participants. Healthcare organizations frequently ask about the pros and cons of allowing a report to be made anonymously to help encourage reporting. But before you allow reporters to remain anonymous, consider that your organization may be sending the wrong signal—that is, giving the impression that logging a report could be unsafe. The choice is complex and dependent on many factors, such as your staff culture and patient population served. However, at the end of the day, your healthcare institution should create a safe reporting culture in which one can speak freely about an incident, thereby promoting a safety culture.

11. Protect the reporter

When introducing a safety management system, one of the most important pillars is the ability to report incidents safely. The primary responsibility for this lies with the healthcare institution to ensure the safety of the reporter by taking the following measures:

- Make a distinction between an incident reporting system (which is aimed at improving patient safety) and systems or procedures aimed at taking measures against individual employees.
- Establish an agreement and make staff aware that information gathered from an incident (within the reporting system) will not be used in the context of procedures that may lead to measures being taken against individual employees.
- Communicate to staff that, once the reporting committee has sufficient information, the report will be stripped of data that makes it possible to trace it back to individuals (i.e., applies to both the patient and the reporter).
- Establish an agreement and make staff aware that information in the reporting system will never be provided to third parties unless the institution is obliged to do so by law or court decision.

12. Move beyond silo solutions

In many organizations, the safety committee analyzes the reported incidents. After recovery of the incident, the improvement actions are then implemented at department level. But to learn from incidents, it's important to share the results of the incident and analysis throughout the organization. Doing so prevents repetition of mistakes and prevents silo solutions that perpetuate safety risks. Working from a central department or quality officer for the assessment of new incident forms can also ensure that there is more uniformity between the various reporting forms organization wide.

13. Use notifications as indicators

While most reports are of the low-risk type, They nevertheless provide important information about safety in the care process—not just for management, but for everyone in the organization. At the other end of the spectrum, notifications for higher-risk incidents can function as indicators. If you don't receive notifications, you won't know what the risks are associated with or where you should focus your attention. Giving managers access to all reports gives them the power to connect the dots across the organization and the ability to speak openly about incidents based on the indicators they're seeing.

14. Provide feedback to the reporter

Incident reporting isn't new, but in many healthcare institutions, it's still experienced as a formal process, because there's often no feedback to the reporter. To guarantee the involvement of the reporter long-term and to foster a willingness to continue reporting, it's leading practice to share data about the reporting process in general, about any settlements, and about any improvement actions taken.

Keeping these tips in mind as you create or evaluate your incident reporting system can keep your organization on track toward making meaningful improvements. Use them to solicit key information that makes patients and staff partners in striving for safety in the care process.

How The Patient Safety Company offers help

Our TPSC Cloud software makes it easier to report incidents and complaints, register improvement plans, and collect data through satisfaction surveys.

Easy-to-use software applications pave the way for reduced risk for clients, patients, and employees—and creates a way to track measurable improvements in care quality. Let TPSC help you better identify and analyze weaknesses in existing processes and optimize improvement actions for maximum safety.

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Reporting incidents and patient feedback

Every employee can report a (near) incident using an easy-to-fill online form, accessible via desktop and mobile devices. This incident form can be quickly put into use, based on our existing templates. Forms can also be completely customized to match your existing internal procedures.

Once an individual completes the reporting form, answers are immediately transferred into an analysis method so your safety committee or health and safety coordinator can easily find out the causes of the incident and initiate improvement actions.

Every step of the incident management process is easy to complete. During the handling of the (near) incidents, TPSC's solutions for incident reporting or collecting patient feedback supports your safety committee through automatic e-mail notifications, alerts, and dashboards.

Management reports

We can also fulfill your organization's need for management reporting, spotting trends, or reporting at the department level, with reports generated in real time and dashboards that reflect up-to-the-minute status to help avoid risk. Managers, team leaders, quality managers, or safety committees receive real-time information from customizable dashboards about the number and type of incidents, the root causes, and more based on their roles.

Analyze

With the support of various analysis methods such as RCA, HFMEA, and Ishikawa, you can easily and quickly gain insight into the root causes of the occurrence of the incident. You can use integrated graphical tools and automatic creation of an analysis report. From within the same software solution, you can easily perform a trend analysis to gain insight into the classified causes for the entire institution or, for example, one of multiple departments.

Improving processes

With the help of incident reporting, analysis, and dashboards, you can easily gain insight into the weak spots of the care processes. This allows you to start improvement actions in a very targeted manner. Within the TPSC Cloud platform, the Improvement Manager module offers the possibility to directly initiate, monitor, and evaluate these improvement actions. Moreover, it is possible to make a calculation of the lead times of the improvement proposals.

Advantages at a glance

- Use an easy and quick-to-complete online reporting form.
- Get step-by-step guidance throughout the whole workflow.
- Access internationally recognized analysis methods.
- Capture and monitor improvement proposals.
- Use customizable management dashboards and reporting capabilities.

Do you want to learn more about the possibilities?

We help more than 500 healthcare organizations worldwide with their incident management and other initiatives related to healthcare quality and risk management. Use our ready-made applications or let us develop custom applications that are tailored to the unique needs of your organization.

Contact sales today for more information or ask for a free online demo of our software.

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