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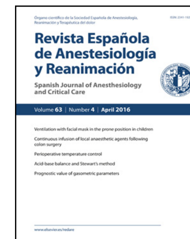
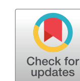


ORIGINAL ARTICLE

What have we learned from reporting safety incidents in the Surgical Block?: Cross-sectional descriptive study of two-years of activity of a multidisciplinary analytical group[☆]



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KEYWORDS
Surgical patient safety;
Incident reporting systems;
Organizational learning;
Risk management

Abstract
Background and objectives: Incident reporting systems (IRS) are considered a tool that facilitates learning and safety culture. Using the experience gained with SENSAR, we evaluated the feasibility and the activity of a multidisciplinary group analyzing incidents in the surgical patient notified to a general community system, that of the Observatory for Patient Safety (OPS).
Material and method: Cross-sectional observational study planned for two years. After training in the analysis, a multidisciplinary group was created in terms of specialties and professional categories, which would analyse the incidents in the surgical patient notified to the OPS. Incidents are classified and their circumstances analysed.

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Results: Between March 2015 and 2017, 95 incidents were reported (4 by non-professionals). Doctors reported more than nurses, at 54 (56.84%) vs. 37 (38.94%). The anaesthesia unit reported most at 46 (48.42%) ($p = 0.025$). The types of incidents mainly related to the care procedure (30.52%); to the preoperative period (42.10%); and to the place, the surgical area (48.42%). Significant differences were detected according to the origin of the notifier ($p = 0.03$). No harm, or minor morbidity, constituted 88% of the incidents. Errors were identified in 79%. The analysis of the incidents directed the measures to be taken.
Conclusions: The activity undertaken by the multidisciplinary analytical group during the period of study facilitated knowledge of the system among the professionals and enabled the identification of areas for improvement in the Surgical Block at different levels.
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PALABRAS CLAVE
Seguridad del paciente quirúrgico;
Sistemas de notificación de incidentes;
Aprendizaje organizativo;
Gestión de riesgos

¿Qué hemos aprendido de la notificación de incidentes de seguridad en el Bloque Quirúrgico?: estudio descriptivo transversal de 2 años de actividad de un grupo analizador multidisciplinar

Resumen
Antecedentes y objetivos: Los sistemas de notificación de incidentes (SNI) se consideran una herramienta que facilita el aprendizaje y la cultura de seguridad. Utilizando la experiencia adquirida con SENSAR, evaluamos la viabilidad y la actividad de un grupo multidisciplinar analizador de incidentes en el paciente quirúrgico notificados a un sistema general comunitario, el del Observatorio para la Seguridad del Paciente (OSP).
Material y método: Estudio observacional descriptivo transversal planificado a 2 años. Previa formación en el análisis, se crea un grupo multidisciplinar en cuanto a especialidades y categorías profesionales, que analizarían los incidentes en el paciente quirúrgico notificados al OSP. Se clasifican los incidentes y se analizan sus circunstancias.
Resultados: Entre los meses de marzo de 2015 y 2017 se notificaron 95 incidentes (4 por no profesionales). Los facultativos notificaron más que la enfermería, 54 (56,8%) vs. 37 (38,9%). La unidad que más notificó fue Anestesia con 46 (48,4%) ($p = 0,025$). Los tipos de incidentes se relacionaron principalmente con el procedimiento asistencial (30,5%); el momento, con el preoperatorio (42,1%) y el lugar, con el área quirúrgica (48,4%), detectándose diferencias significativas en función de la filiación del notificante ($p = 0,03$). No daño, o morbilidad menor, presentaron el 88% de los incidentes. Se identificaron errores en el 79%. El análisis de los incidentes dirigió las medidas a tomar.
Conclusiones: La actividad que mantuvo el grupo multidisciplinar de análisis durante el periodo de estudio propició el conocimiento del sistema entre los profesionales y permitió identificar elementos de mejora en el Bloque Quirúrgico a diferentes niveles.
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Introduction

Incident reporting systems (IRS) originated in the industrial sector but are now a part of patient safety improvement strategies and are recommended by agencies,[1,2] international organisations[3,4] and health authorities.[5] Despite their limitations and the lack of solid evidence to support their usefulness, some experts believe that IRS, though far from an epidemiological tool, are effective in promoting a safety culture[6] and in detecting areas of improvement in health organisations. However, they need to be further developed and perfected before they reach their maximum potential.[7–10]

IRS have been introduced in general health care (primary care and hospital care), in specialties (e.g., anaesthesiology) and for particular aspects of care (e.g., medication[11]). They have also been developed on a national, regional or local level by different institutions, scientific societies, associations, centres or other organisations that frequently work together. In Spain, the Ministry of Health, Social Security and Equality has developed a general IRS, the Patient Safety Reporting and Learning System (SiNASP).[12]

Anaesthesiology has been among the specialties spearheading the implementation of safe practices and in the introduction of IRS in hospitals. Spain and Germany have implemented anonymous, voluntary IRS in the field of anaesthesiology. In other European countries, such as Switzerland, Denmark, Finland or the United Kingdom, anaesthesia-related safety incidents are reported in a general register. In some countries, notification of critical incidents is

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