The impact that Incident Reporting had on our (safety) culture.

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Our new multidisciplinary veterinary hospital underwent a period of rapid growth, resulting in a doubling, then tripling of staff size to accommodate a growing patient base. Early on, slips in patient care were managed by individuals modifying their behaviour; however, a "Swiss cheese" event (a catastrophic error that occurred despite multiple protective barriers) precipitated a reassessment of incident reporting and analysis.

Development of Framework:

Using human factors principles (Catchpole), we developed a reporting system to log adverse events. This evolved from a linear cause-effect model to trying to understand the systemic factors causing error in a clinical workplace, using a modification of the Yorkshire Contributing Factors framework. The prototype involved staff self-reporting to Adverse Event Champions but rapidly evolved using simple tools and technology (SharePoint) to provide an easy way to capture adverse events.

Adverse Event reporting schemes are prone to failure because of poor reporting compliance and fatigue. We tackled this by improving staff awareness about what categorized as an adverse event, developing a safety culture (removing the fear of reprimand and promoting error as a means to learn), and making the system very easy to use. We also developed regular feedback loops with thematic analysis and quarterly adverse event rounds to focus on reflective practice (individual) and systems improvements.

Benefits of this approach

We evolved into a Safety Culture because we grew both a Just Culture and Learning Culture concurrently. Staff understand why reporting is so important, and most reports are self-reports. There is the regular ability to capture and learn from near-miss events, which are enthusiastically logged and celebrated. Changing organizational systems and involving staff in the solutions is more effective than modifying policy and procedure.

Challenges of this approach

Safety culture needs to be led from the top, modeled by management and leaders. It requires an understanding that "work as imagined" is not the same as "work as done". The concept of reflective practice is complex, but guided tools help our staff use reflective practice in a way that they are comfortable. It is normal to react to what went wrong (Safety 1) instead of focusing on why it mostly goes right (Safety 2) (Hollanagel). Continuing to engage staff in solving complex problems requires agile human-centred leaders who are not afraid to demonstrate vulnerability and be curious.

Lessons for Radiology

We have not yet developed a radiology-specific adverse event log or quality control, although this could be a future step. It might require increasing follow-up on cases, which can be challenging in an outpatient or teleradiology environment. It requires careful classification of radiological error (missed or misdiagnosis, versus discrepant diagnosis), often in an environment where there may not be a gold standard diagnosis (Brady). It requires insight into the limitations of the test and other inputs (specifically the information provided at the time of the study). Focusing on strategic and cultural causes of radiological error still requires bigger-picture (systems) thinking, as the radiologist does not report in a vacuum. The benefits of error/discrepancy reporting will potentially improve both radiologist learning and patient safety, but will require significant time investment.

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