QUALITY ASSURANCE & CRITICAL INCIDENT REPORTING PRINCE OF WALES HOSPITAL INTENSIVE CARE UNIT

Introduction

The aims of critical incident reporting include:-
1. To prevent recurrence of incidents and decrease possible morbidity and mortality
2. To document frequency of events
3. Identify causes of incidents and develop preventative strategies
4. Improve equipment and work environment as indicated.

Staff are encouraged to report incidents as it is through a safety culture that we can make the ICU a safer place for our patients.

There are 2 systems for critical incident reporting in the PWH Intensive Care Unit.
1. The Hospital Authority Advanced Incident Reporting System (AIRS)
2. The PWH ICU internal confidential critical incident reporting system (CIRS)

AIRS

- This is a web-based electronic reporting system serving as a tool to support risk management by facilitating the reporting, classification, analysis and management of incidents
- It is the HA risk management policy that frontline staff have an **obligation** to report incidents
- Reporting is non-anonymous
- Categories for reportable incidents include
  - o Patient safety related incidents
  - o Incidents of specific medicolegal implications
  - o Incidents that require immediate management intervention
- The above criteria is not exhaustive
- How to report?
  - o You need a HA computer portal
  - o Follow prompts on display on the screen
- The hospital risk management team will screen the reports and those incidents that require attention/action will be reported to relevant parties including the COS and Director, or where appropriate the Department Operations Manager of the department involved
- After collecting appropriate written documentation, the investigation process examines the following:
  - o System faults

- o Environmental problems
- o Personnel faults
- o Possibility of no fault

- System changes, if required, are instituted

CIRS

- This is our own in-house ICU reporting system for purposes of quality assurance
- Aims to improve patient safety and prevent/minimize similar incidents from happening in the future
- It is strictly confidential and reporting is on a **voluntary** basis
- What incidents should be reported?
- ICU staff members (nursing and medical) are encouraged to report any events that occurs during their practice in ICU which could have reduced, or did reduce the safety margin for the patient under their care
- Regular reminders are distributed every 3 months
- There are 2 methods of reporting:
  - o By filling out a standardized <u>critical incident form</u> and placing the completed report in a locked postbox in the ICU, located at the ICU nurses' station
  - o On-line reporting – the ICU has set-up a web-based database that will allow direct, anonymous, online reporting by the ICU staff. You can access it from one of the 2 CUHK computers located in the X-ray viewing room in the ICU. To start, click the icon on the desktop with CIRS logo

- All information is kept confidential and anonymous.
- The ICU has a designated ICU doctor as the coordinator in charge of critical incident reporting.
  - o The role of the coordinator is to be available should there be any queries, collect the completed forms, input the data into the computer for subsequent storage and retrieval, and analyze the data
  - o To ensure that incident monitoring results in improved patient safety, the reported incidents are followed up in unit review meetings every 3 months for both the nurses and the doctors as a forum for discussion. A poster will also be put up in the staff room
  - o During these meetings, reporting statistics are reviewed. Incidents in the preceding 3 months are presented and new/recurrent problems are identified. All staff members are invited to participate in order to suggest preventative strategies

- Staff members are updated on actions that have ensued from previous meetings and their follow-up, and new staff to the ICU is orientated to the reporting system

The ICU acknowledged that there are time constraints to report BOTH AIRS and CIRS for each incident. Hence we have developed a Reporter's Guide and an ICU Incidents Reporting Flowchart for reference. The posters are available in the staff room. You can also find them in the ICU Good Practice Guidelines page in the PWH Anaesthesia and Intensive Care website. Note that you need a password to access this page.