Service Priorities and Programmes

Electronic Presentations

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Impact on attitude of staff on incident reporting after Incident Management workshop

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Introduction

To promote safety culture and nurture our future leaders, the NTE cluster Q&S Training & Education Subcommittee was formed and organized education and training programs for the NTEC staff on incident management. One of the workshops is Essentials in Quality and Safety for Healthcare (EQUALsafe) – Incident Management II (Preventing Recurrence) for supervisory staff.

Objectives

The participants will be able to: (1) appreciate the factors influencing reporting culture in patient safety; (2) to understand the objective and process of Root Cause Analysis for patient safety incident.

Methodology

The content of workshop was divided into 2 parts: Reporting culture and System Change. The participants were exposed to group discussion of reporting culture, system change after incident by Root Cause Analysis. A “Pre” & “Post” design self-evaluation by on-site voting was employed: (1) You are comfortable with AIRS reporting? (2) Patients will benefit from AIRS reporting?

Result

9 workshops were conducted from September 2012 to December 2013, and 274 supervisory staff (26 doctors, 243 nurses, 5 allied healths) attended. 36% of participants reported “not comfortable with AIRS reporting” before the workshop was decreased to 9% after the workshop. 15% of participants reported “not agree with patient will benefit from AIRS reporting” before was significantly dropped to 1%. Positive mind change in AIRS reporting was noted. The safety culture of an organization acts as a guide as to how employees will behave in the workplace. It is to overcome negatives of reporting events, such as skepticism, fear of reprisals, extra work, and lack of effectiveness of present reporting system. Incentives include accountability, transparency, and sustained trust and confidence in the organization, and these must be tied to higher governing values.