Standard in brief

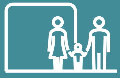
Patient safety & hygiene practice

Threat, error and success reporting: How to effectively practice error management

Schwindt E, Hogeveen M, Härting H, Jessie M, Pateisky N, Schwindt J

Statement of the standard

Incident reporting systems must be mandatory for all neonatal wards and have to be **embedded in comprehensive safety programmes** to effectively improve healthcare safety.



For parents and family

- Parents and families are informed about safety programmes (e.g. existence of CIRS, how to use it, contact information).
- Parents and family members are encouraged to speak up and to participate in re-porting errors, threats and successes, and are provided with information on how to do so.

For healthcare professionals

- A local interdisciplinary and interprofessional safety team with special educa-tion/training in healthcare safety (safety officer), is created. Members are non-superiors, bed-side employees, and include all neonate-related medical professions (nurses, doctors, midwives, pharmacologists, psychologists).
- All employees receive basic education and recurrent training in system safety, safety culture, human factors, organisational factors and feedback.
- There are clearly defined adverse events, which compulsorily have to be reported by employees.
- Employees are trained in how, when and what to report (training frequency of 6 to 12 months recommended).
- Employees are able to report threat and errors anonymously in reporting systems that are easily available and accessible.
- Employees are invited to participate in the investigation process and receive feed-back following their reports for follow-up.
- All employees receive regular feedback on long-term safety improvements and key performance indicators.

For health service

- Healthcare safety is embedded in current educational curricula for all occupational groups in the healthcare system.
- Certified education and training programmes for healthcare safety are available ("Safety Officer").

Benefits

Short-term benefits:

- Reduced preventable harm (adverse events, e.g. medication errors, incompatible blood transfusions)
- Improved safety culture and better identified threats for patient and employee safety
- Provides the possibility for wards and institutions to learn from each other
- Identifies fields with need for medical training
- Identifies areas where implementation of technologies supports medical teams to avoid medical errors

Long-term benefits:

- Optimised processed, less workload, reduced conflicts and stress for employees, reduced employee fluctuation, less sick-leave and, consequently reduced recruiting and training costs for hospitals
- Increased satisfaction of parents and families with ongoing treatments as well with response to errors/failures that have taken place
- Enhanced patient and employee safety
- Improved staff well-being and safety
- Reduced level and length of intensive care treatment and length of total hospital stay
- Improved long-term patient outcome, therefore, higher quality of life, and, consequently, reduced costs for families and communities
- Reduced costs for treatment, lawsuits and insurance costs

For neonatal unit

- A local interdisciplinary and interprofessional safety team with special educa-tion/training in healthcare safety is in place.
- The members of the local safety team are selected deliberately according to their personal knowledge, skills and attitude, non-technical competencies and level of ex-perience in the according medical field.
- The local safety team is provided with sufficient time and resources within normal working hours to perform safety work. Time for safety work is made available exclu-sively, not in addi-tion to usual bed-side care and other already existing duties.
- Management commitment is given in written form that reports of threats, errors and adverse events, will never lead to any consequences and impact on personal or pro-fessional levels according to just culture principles.

For hospital

- The hospital provides easy access to a system for incident reporting.
- The reporting system is operated by specifically educated and trained safety officers with a background in the according medical field and is hosted externally.
- Sufficient time and financial resources are provided for education and training of all employees in healthcare safety issues.
- Full-time jobs are created for specifically trained employees to focus exclusively on healthcare safety (systemic investigations, implemen-tation and follow-up).
- Regular reports on safety key performance indicators (KPI) have to be provided to hospital management by local safety teams.

european standards of care for newborn health

Here you can access the full standard:
https://newborn-health-standards.org/standards/standards-english/patient-safety-hygiene-practice/threat-error-and-success-reporting-how-to-effectively-practice-error-management/

EFCNI european foundation for the care of newborn infants