Summary scriptie “U hoort van ons” Een verkennend onderzoek naar de rol van feedback op het leren van incidenten in ziekenhuizen

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Introduction

The attention for reporting, registering and analysis of incidents in health care has increased in the past years. The goal of this process is to learn from errors and to prevent reoccurrence of these events. In the Netherlands, blame free reporting (“veilig incident melden”, VIM) at the departmental level has been introduced in several hospitals in the past years. Incidents are reported by health care professionals to a departmental safety committee, which analyses the chain of events to produce guidelines which decrease the chance of reoccurrence of these incidents. Reporting, registration and systematic analysis of events are emerging topics in this field. However, less attention is paid to the process of feedback to the health care professional and the role of feedback in awareness and learning from incidents. Feedback is required to motivate reporting, to improve awareness of risks, to create an open safety culture and to instruct health care professionals. The ideal result of this process is double loop learning, a process in which causes are identified and measures are taken to avoid repetition. The introduction of blame free reporting (VIM) raises the question to what extent feedback is deployed in this process and what type of learning is utilized.

Objectives

The central questions in this qualitatively designed study are: through which means is feedback to health care professionals provided within the blame free reporting (VIM) method, what is the experience with feedback within this system and to which extent does the blame free reporting (VIM) process contribute to learning from incidents.

Methods

10 semi-structured face-to-face interviews were conducted with health care professionals from two departments from different hospitals, which participate in the quality collaborative “Better Faster pillar 3”. In these interviews, the methods and role of feedback and the experiences with learning from incidents were addressed within the blame free reporting (VIM) process.

Results and conclusion

Feedback within the blame free reporting (VIM) method takes mainly place at the individual (the reporter) and the departmental level. The health care professional which reports the

incident receives feedback directly after reporting and after analysis of the incident. At the departmental level, written feedback is provided by a news letter and oral feedback is provided to nurses during the staff meeting. Medical doctors are not provided with structural oral feedback during staff meetings. At the organizational level, the departmental safety committee reports only critical incidents to the organizational safety committee (MIP). Learning from incidents results in two effects: improvement of the health care process at the departmental level and awareness of risks at the individual level. Although blame free reporting (VIM) is designed to result in double loop learning, improving feedback to all health care professionals may increase the efficacy of learning on both individual and departmental level.