Service user involvement to strengthen the organ donation and transplantation clinical governance process of incident reporting, understanding what happened and sharing learning with the wider community.

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Introduction

The ODT electronic incident reporting system is a central data capture tool which enables incidents across the pathway to be examined in depth to understand what happened in order for staff to identify learning and implement changes to strengthen the processes within which they work in order that organ donation and transplantation is safer, more effective and patient-centred.

The clinical governance process had never been reviewed from a user perspective previously. The aim of this service improvement project was to gain feedback and comments from a wide range of users to streamline and strengthen the process of incident reporting, investigating and sharing learning. To be effective and achieve the outcome of enhancing patient safety and quality, changes cannot be made in isolation; service users are integral to the clinical governance process redesign.

The Berwick Report (2013) “A promise to learn – a commitment to act: improving the safety of patients in England” highlighted that the “most important single change in the NHS in response to this report would be for it to become, more than ever before, a system devoted to continual learning and improvement of patient care, top to bottom and end to end.”

Method

A number of questions via a SurveyMonkey were sent to key stakeholders from across the pathway requesting feedback on all aspects of the clinical governance process such as use of the electronic incident reporting form, the management of reported incidents, the feedback received and the wider learning.

Results

The results demonstrated responses from a wide range of healthcare professionals across the organ donation and transplantation pathway.

The findings were very informative and highlighted areas for improvement with the electronic reporting system. There were also user recommendations in relation to the incident investigation, the outcome responses and the wider shared learning. Additional feedback which is currently being explored is the value of learning from when processes and practice ‘go well’ and the option of an incident reporting application for mobile devices.

Discussion

Following a review of all the SurveyMonkey responses and feedback a number of changes have been made:

1. Suggested electronic incident reporting form changes – increased word count in the ‘incident details’ section, removed irrelevant data fields and highlighted the ‘mandatory’ fields to make the form simpler and more logical for the user.

2. Investigation Summary Template - 85% of the SurveyMonkey respondents recommended the use of a template to guide a review of what happened and to identify the learning. An investigation summary template has been developed and utilised well within ODT Hub Operations and following feedback has been further streamlined and will soon be available for wider use.

3. ‘More sharing of incidents across the community to encourage shared reflection and learning’

The ODT Clinical Governance team and the National Clinical Lead for Governance have redesigned the bi-annual organ advisory group governance reports in order that there is a clear focus on the identified learning as well as what happened.

Cautionary Tales, a quarterly publication circulated internally and available on the ODT clinical website aims to provide insight into incidents reported by sharing anonymously and without blame what happened and the key learning identified to improve outcomes for patients. 74% of survey respondents believed this publication to be either ‘extremely beneficial’ or ‘beneficial’.

4. ‘Evidence of implementing change’ – the Clinical Governance Team works closely with the SNOD Professional Development Team in order that learning from incidents informs current and future SNOD training and development.

Overall the results from the survey monkey were reassuring that a positive and transparent culture of incident reporting and sharing learning is developing across the pathway – 77% of survey respondents had reported an incident to ODT within the last 12 months. As Berwick (2013) highlights ‘rules, standards, regulations and enforcement have a place in the pursuit of quality, but they pale in potential compared to the power of pervasive and constant learning.

Acknowledgements

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References