

Incident Reporting Schemes and the Need for a Good Story

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Summary:

Incident reporting is a central strategy for improving safety in the NHS (UK National Health Service). In this paper we discuss incident reporting in Anaesthesia. We discuss four schemes for reporting: longstanding, departmental based schemes; newer, hospital wide schemes; a national scheme; and an inter-departmental scheme (developed by the authors). We also discuss an example report. We argue that this example report gives an expert 'story' of an incident, describing the incident in a way that is useful for the practical activities of maintaining and improving safety. We argue that stories are told and retold in reporting schemes. The reporting schemes are not just there to collect data but to afford the stories of what went wrong. In turn these schemes must be afforded stories by the anaesthetists, safety managers and the organisation at large. We consider how schemes can be designed to afford a 'good' story, one that is useful for the maintaining and improvement of safety.

Keywords

Risk Management -
Hospital Incident Reporting;
Qualitative research;
Anaesthesia department;
Narrative.

1. Introduction

Incident reporting is a core requirement for NHS (UK National Health Service) organisations in efforts to improve patient safety. Incident reporting schemes are socio-technical systems and every such scheme is different in implementation and use. In their comprehensive review of the literature surrounding technology related adverse events in healthcare, Balka et al [1] point to the differences between incident reporting schemes, particularly the lack of definition regarding the scope and nature of adverse events, as the major barrier to extrapolating meaningful data from them at a national or international level. They recognise the potential benefits of large-scale analysis of incident data, but point out that in doing so the situatedness of medical practices can be overlooked and incidents wrongly conceptualised as device or user problems. Balka et al suggest “new forms of governance may be required, that place greater emphasis on socio-technical and systems issues” [1].

Disasters such as a patient death are extreme examples of an incident and although lessons should be learned from these, the ethos of a reporting scheme is to pick up the little incidents such as dysfunctional equipment, unmanageable situations, and (often harmless) mistakes, and to address these so as to circumnavigate disasters [2][3][4]. In the aviation industry (the first industry to adopt incident reporting), evidence¹ from British Airways shows a correlation between high levels of incident reporting with reduced levels of high and medium risk events that actually occur. Disasters, or incidents involving patient distress or harm are usually caused by a combination of smaller issues, have early warning signs or involve repetitions of mistakes or issues that have arisen before [6][7]. Incidents are systems issues, not a chain of events resulting from a failure and leading to an incident. Non-systems models are limited in their ability to account for the incident and support the improvement of safety [2][8].

Reporting schemes are soft systems. They are practical approaches to improving safety in the day to day practices of work in healthcare that are themselves soft. We understand incident reports, not as mirrors of what went wrong, but as constructions that make active sense in the practicalities of improving safety. This construction we say is a ‘story’, and we say a reporting scheme is for the telling and re-telling of

¹ Reported by the National Patient Safety Agency [5].

stories to improve safety. We are particularly interested in how information technologies (including both paper and computer) support reporting schemes and how these can be better designed and organised. From an IT design perspective we look at how incident reporting schemes afford and are afforded stories.

2. Incident Reporting in Anaesthesia

Incident reporting in the NHS is usually seen as a hospital wide, if not national issue. As such, incident reporting schemes being implemented are hospital wide and national. We acknowledge that large-scale analysis of incident data would be extremely beneficial to the improvement of safety, but our work has not been driven by that goal. In this paper we look directly at incident reporting in Anaesthesia, at the issues that anaesthetists face in reporting and how their reports are used in the small scale to maintain and improve everyday safety. We treat incident reporting qualitatively; as Short et al [3] point out, incident reporting schemes themselves are a form of qualitative research. We are interested in the practical aspects of reporting and learning from reports, and thus a focus on the work of clinicians rather than that of their managers and administrators is desirable.

Anaesthesia is the largest single hospital specialty in the NHS, with anaesthetists seeing around two thirds of all admitted patients. Incident reporting has become a contentious issue in anaesthesia. There has been a longstanding tradition of incident reporting in anaesthesia (it being the first profession in healthcare to introduce incident reporting) and attempts to impose new schemes have been disruptive. The older schemes were owned and organised by anaesthetists. Newer schemes have a managerial and legal emphasis and are intended to be standard across hospital departments. By taking incident reporting in anaesthesia as our standpoint we are looking to the expertise and experience anaesthetists have with safety.

2.1. Fieldwork

This paper is based on findings made in a study of incident reporting in anaesthesia and the production of a prototype system to share reports between anaesthetics departments in different hospitals in the

Northwest region of England². This project involved three rounds of semi-structured interviews at five hospitals about incident reporting, a validation workshop for the system and observations of an anaesthetist at work and of audit meetings at two anaesthetics departments. The prototype system was in use over six months. The period of study coincided with the implementation of CNST (Clinical Negligence Schemes for Trusts) standard reporting at several sites and the launch of the NPSA (National Patient Safety Agency) national system. An iterative, multi-round approach was taken to gain a picture of incident reporting schemes as they unfolded and to involve the anaesthetists closely in the design of the prototype, which was designed to suit their requirements. This work has taken place in the context of a much wider study (by the second author) into clinical governance in the NHS, including of incident reporting in other specialties.

2.2. What is an Incident?

An insightful definition given to us by one Anaesthetist is of an incident as an “‘Oh S***!’ moment”. The official definition from the NPSA (National Patient Safety Agency) is “Any unintended or unexpected incident which could have or did harm one or more patients receiving NHS funded healthcare.” [5]. To apply such definitions in practice is subjective. When there has been actual harm to a patient, then events surrounding that harm can normally be thought of as an incident, although there may be exceptions to this, for example a patient or a surgeon may perceive harm (such as distress) where the anaesthetist does not. It is when there is potential for harm that the answer to what is an incident becomes more subjective. Some anaesthetists will see potential for harm where others do not, and some are more willing to write a report. Writing a report is time consuming for a busy anaesthetist. There are some anaesthetists who might never report and others who are quite keen. Reports by the keen include issues well beyond personal mistakes, for example we saw reports concerning incorrect defaults set on machines.

There are also sensitive and controversial issues in reporting. Someone other than those involved in an incident can write reports. Anaesthetists have referred to the possibilities for victimisation, but state the opposite is usually true where anaesthetists are unwilling to write reports about a colleague whose

² This prototype is presented in [5]

practices may be unsafe. Anaesthetists were indignant that reports in the new hospital wide systems can be written by anyone and referred to reports written by nurses and in one case by a cleaner. They felt these others did not understand their work and what is safe practice. A more common issue is that some anaesthetists will 'axe grind' against equipment they would like replaced, or write reports that in some way might enable them to gain new funds or equipment.

We have addressed *when* an incident is perceived, but we should also address *how* an incident is perceived. The author of a report must describe what lead to an incident and how it was handled, and describe what lessons might be learned. Anaesthetists prefer a systems view of incidents, and this view is one echoed by the NPSA. Anaesthesia employs both applied and tacit knowledge [10], and incidents are not simply misapplications or non-applications of knowledge but breakdowns in the tacit "patient-machine-anaesthetist collective" [11][12]. We can see such systems thinking in the example report that is given later. This systems thinking is not shared by all: Anaesthetists complain that reports can be used (by managers) to blame 'the last person who touched the patient'.

2.3. What is a Reporting Scheme?

Reporting involves particular information technologies such as paper, databases, PowerPoint slides, spreadsheets, pens and mailboxes; they involve human actions such as writing reports, analysing and discussing reports and summarising reports; there are guidelines and rules; and there are organisational provisions for reporting and an organisational culture in which reporting takes place. The reporting scheme is the organisation of many parts and processes. A useful reporting scheme will be organised in a way that promotes safety, but not all reporting schemes can be said to be as useful as is possible in this way. In this paper we give an example report, but we emphasise that it is part of a wider process in which an incident is interpreted and reinterpreted and perhaps acted upon.

A reporting scheme is more than the technologies of reporting, and is not about making factual accounts that mirror incidents. There is not a direct correspondence between an incident and a report: the report is a subjective account of the incident, and in turn the report is never static. The incident is told and re-told through reports, through analysis and categorisation and through discussions in meetings. Actions to

maintain or improve safety come after analysis and discussion, but as we will explain with an example report, the maintenance of safety often comes about directly through having a discussion and thus learning and reinforcing knowledge.

There are three schemes that we have encountered in our study, and we discuss these together with a fourth scheme that we have introduced ourselves as an experiment. During our study we found each department to have slightly different implementations of the schemes, but rather than concentrate on these differences we shall address the similarities between the schemes as implemented. At the beginning of our study, each department was running schemes in parallel. At each site the older schemes were being phased out. This was completed by the end of the study at one site, but only after a series of troubles with the first attempt aborted. We now describe the four reporting schemes. Following this we will discuss a specific report.

2.3.1. Reporting Scheme 1: Departmental

The first scheme we describe, we term the departmental scheme. The departmental scheme is the oldest scheme, and was used at each anaesthesia department in the study. This scheme is quite longstanding, and was running in parallel to the second scheme we describe at each study site and is/was in the process of being phased out.

The departmental reporting schemes are based on recommendations by the RCoA (Royal College of Anaesthetists) who provide a standard paper form, and software for reporting. The paper form is printed on one side of paper with a list of categories of contributing factors on the reverse. The form asks for five short items of information (e.g. reporter's name), has four multiple-choice questions about the incident (e.g. severity), and allows up to six categories to be chosen from the reverse. Just under half of the front page allows free text to be entered under the headings: "Please describe what happened" and "How do you think this might be prevented from happening again?" The form is often modified for use by an anaesthetics department, but all that we have seen retain lightweight classification and one half to one third of the form is for free text. These forms will be placed in easily accessible locations. Completed reports are posted into a box to be collected later by an anaesthetist acting as audit manager. These

reports are sometimes further analysed: at one site the audit manager further categorised reports and entered these categories into a spreadsheet, at another a key phrase about the incident was listed. Reports would be discussed at audit meetings, often having the author of the report recounting what happened (and not necessarily reading from the incident form.) The anaesthetists would discuss the issues raised by the incident and if necessary plan further actions to resolve these. Reports may then also be re-written as a narrative summary in the minutes of that meeting. Paper is a convenient medium for anaesthetists to initially report on, and reports are often later typed up in some way. The RCoA provide software for reporting, but it is difficult to use and modify.

As described, the departmental schemes are successful but imperfect. They are successful in that they are routinely used and they have a noticeable effect on patient safety in that anaesthetists are able to determine their own problems and go about solving them. However the system does not allow the solving of problems that lie externally to the department and relies on this problem being communicated to a person or system that may or may not exist. The system is also open to abuse in terms of not reporting, or over reporting. Anaesthetists also find it time consuming to run.

2.3.2. Reporting Scheme 2: Hospital Wide

The second scheme we describe, we term the hospital wide scheme. This scheme is being introduced to all departments studied. This scheme was initiated by requirements from insurance companies.

The hospital wide schemes are run across all hospital departments. Often a large paper form is required to be filled in, but in others a computerised form. These forms ask for detailed information and are reliant on categorisation. Ability to enter free text is limited: one form asks “please describe what happened in detail” but offers a relatively small space in which to do so; another gives a larger space but asks for “clear, one sentence ‘good’ and ‘bad’ facts”. Two carbon copies are made with each paper form, with at least two of the three total copies going to managers. Anaesthetists were generally reluctant to use the hospital wide systems. Anaesthetists are required to write reports on the hospital wide system, but found more value in the departmental system and tended to use them both in parallel. At one site anaesthetists had regular meetings with the clinical risk manager to discuss hospital wide reports but at others they

received little or no feedback. Anaesthetists would use the external system only when they had to, believing their reports to be interpreted negatively and used to blame them. One anaesthetist claimed that anyone writing a lot of reports would be seen as unsafe, and their job put at risk.

At the site most advanced in its implementation, the external scheme was fully realised by the end of the study. This was only after an aborted first attempt and a great number of difficulties, as an anaesthetist from the site explains: “The Trust introduced their own scheme and banned use of the existing (departmental) system. The new forms were badly designed and we had little or no feedback. Rates of reporting fell to about 10% of what they were previously. After much protesting, the Trust system was dropped and the (departmental) system restarted for 3 or 4 months. Six months ago an improved Trust system was implemented and this has been working well for the last 4 to 5 months. They use forms we recognise and there is now a feedback loop, whereby reports are discussed at audit meetings and then emailed to all the clinical staff. There is now also a full time audit manager in the Trust. Managing audits was taking about 3 hours a week of my time, which was too much. I have retained a role in coordinating audits but the manager has taken over most of the work”.

The external schemes have their strengths in that they allow a hospital wide approach to safety, and they use full time managers rather than taking up time of clinicians. However, these schemes have in several cases been badly implemented and run more so because clinicians are required to report than they see value in it. Schemes of this kind are viable, and anaesthetists are not against the idea of a hospital wide scheme in principle. The problems of the schemes are associated with a disregard for the needs of anaesthetists in their day-to-day working practices, and their concerns for control and professional status in their work. The site described above has shown that these schemes can be made to work well.

2.3.3. Reporting Scheme 3: National

The NPSA (National Patient Safety Agency) was set up in 2001 to improve the safety of patients by promoting a culture of reporting and learning from patient safety. The National Learning and Reporting System is central to their strategy with the intention of using it to identify trends and patterns of avoidable incidents and their root causes; develop models of good practice and solutions; to provide feedback and to

support education and learning. The NPSA also provide training in Root Cause Analysis to investigate incidents. As well as providing the system and training they also promote steps towards improved safety [5] including building a safety culture, communicating and learning lessons. They see errors as having a system of causes, and oppose a blame and punishment culture. They encourage a circle of safety that begins with reporting, goes through the management of the safety issues and ends with feedback.

The National Reporting and Learning System was rolled out during 2004. The system was not in use at any study site during our fieldwork. The anaesthetists at each study site were well aware of the NPSA but did not know anything specific about what the NPSA might start doing at the national level and when. We largely agree with the NPSA's portrayal of incidents but, at the local level, they seem to lack the power of the insurers who have their own requirements for incident reporting.

2.3.4. Reporting Scheme 4: Inter Departmental

Reports that are discussed in one anaesthetics department are not usually shared with anaesthetists in different hospitals. Seeing value in a system to do this, we produced an online reporting system [9], designing it around four main requirements: that it should integrate with existing practice, that it should integrate with existing reporting schemes, that it maintain educational value and that it affords trust within the user community. To integrate with existing practices, and existing reporting schemes, it was seen as inappropriate to expect primary reporting to be done on the new system, but rather that reports could later be typed up or cut and pasted into it, perhaps after presentation and discussion at a meeting. It was also noted that web and email use by anaesthetists was occasional, so a lightweight notice board rather than a discussion forum was the most suitable style of presenting reports. The system was in no way intended to replace the existing systems, but to complement them. To maintain educational value, we provided a means for anaesthetists to report what they thought was useful, and a means to discuss reports online or download them for discussion in meetings. To maintain trust we allowed anonymous reporting, and provided a feature to show exactly who had access to the system. The system was basically a secondary reporting scheme in which reports deemed as interesting by an audit manager can be cut and pasted in, and were then available for reading and comment by a known group of users. Anaesthetists participating

in design agreed upon a reporting form similar, but more lightweight, than that recommended by the RCoA.

This system has served as a means of gathering data and testing hypotheses. Anaesthetists told us that they liked the system, and that it contained reports useful to them. However, the system did not live beyond the project. As one anaesthetist explained “Falling in love is easy but staying in love is the problem, and I think that’s true about starting off and trying to keep going... Its one of those things everyone thinks they ought to do [but it] never quite seems to happen.” There are several reasons that could all account in some way for why the system was not adopted by the anaesthetists. These reasons being that the system failed to gain a champion to encourage reporting, that the level of ‘useful’ reports did not reach a critical mass, that the anaesthetists spent limited time with computers and that the uncertainties and problems surrounding the other reporting schemes meant anaesthetists were reluctant to report into any system. The anaesthetist quoted above went on to state “I think it’s a missed opportunity”. The anaesthetists involved in the study believed that reports could be usefully shared, and the design of our system for doing so was good.

2.4. An Example Report

Incident reports in anaesthesia can be made in up to four different systems, with reports usually being duplicated. This can be wasteful, but because of the different purposes and uses of each system, straightforward integration is not possible. British Airways uses two reporting systems, but this is by design and is used to handle more sensitive ‘human factors’ separately from other issues [13]. It remains as a future study to compare reports of the same incident in the different systems described in this paper, but it is likely that while the ‘facts’ remain the same the meaning and significance is changed. It is a difficult task to collect different reports of the same incident, and for the time being we have gathered unconnected reports made on all systems except the national. In this paper we will present one report, taken with permission by the author from the inter-departmental system. We have interviewed the author of the report about the meetings in which it was discussed, and the processes that it triggered. The report concerns a serious incident that involved a mistake in administering drugs that lead to patient harm. This

report is less mundane than some, although fairly typical. Most interviewees cited it as the most interesting report on the inter-departmental system.

Reporter: *Anon*

Patient Sex: *Male*

ASA: *2: Relevant systemic disease*

Urgency: *1: Routine; on distributed list*

Factors: *anaesthetist, organisational*

The incident caused: *3: Transient abnormality with full recovery*

How preventable do you think the incident would be by further resource? *1: Probably within current resource*

What Happened?

The patient was for direct pharyngoscopy, a short but stimulating procedure so the plan was to use boluses of alfentanil and mivacurium. Both these drugs were in correctly labelled 10 ml syringes. Inadvertently I gave the mivavurium prior to induction instead of alfentanil. I did not realise my error for a few minutes. The patient initially appeared drowsy but agitated, breathing became shallow and saturation dropped to 85%. He developed multiple VEs. On realising my error some propofol was given, the trachea intubated and over a short period of time his saturation and ECG returned to normal. We continued with the procedure. On recovery he had recall of what had happened and was quite distressed by it.

Lessons Learned:

- 1. Correctly labelling syringes isnt enough, especially when the colour of the labels is very similar. In this case both the labels that come with the drug are white. We use other visual aids first, syringe size probably being the most important.*
- 2. Avoid drawing up muscle relaxants and induction agents in similar size syringes at the same time as other drugs, ie sux and fentanyl, thiopentone and augmentin.*

3. In this case the part the cause for the error was that I was using a number of drugs that I dont usually use - thats when you should be extra vigilant.

The report begins with some standard information. This gives the reader an orientation to the report and provides standard terms for storing and analysing the report. A more surprising reason that anaesthetists gave for wanting this standard information was that when writing reports, it gives them somewhere to start, and allows them to start thinking about the incident.

The first paragraph gives the story of what went wrong. The scene is set with the surgical procedure and the anaesthetics procedure, with a statement that the procedure began with the correct drugs. The events are then given, beginning with the complicating error and ending with the two part resolution: firstly about how the ECG was returned to normal and secondly about the patient's distress.

The second paragraph concerns the lessons learned. The three lessons concern the procedure of using drugs, and not how to deal with the error. The first two lessons involve the importance of the appearance of syringes for distinguishing between different drugs. The third lesson is that in unusual circumstances the anaesthetist must be extra vigilant. The first two lessons are relevant to procedure and are therefore relevant to the management of safety. The process here can be improved to improve safety. The third lesson is one of education for anaesthetists.

This was a serious incident that led to a patient complaint. The anaesthetist involved was at the only hospital in our study where anaesthetists had a good relationship with the risk managers and the anaesthetist in question told us they did not feel blamed for the error in any way. An investigation had been launched following the reporting of this incident in the hospital wide system, and changes to procedures and visual information were apparently being considered. The report of this incident in the departmental system lead to discussion of how anaesthetists can avoid this kind of mistake, including how the system might be improved, but also sharing the lesson about vigilance. There was also discussion of this report on the inter-departmental system, saying that similar problems had occurred at other sites. The report then does not simply disclose an error or mistake, but provides a story that can be discussed,

interpreted and acted upon. An important part of maintaining safety is through actual discussion of the report, educating anaesthetists about how the issues affect their day to day working practice.

3. Discussion - The Need for a Good Story

To conclude this paper we consider design issues for reporting schemes. Our argument is that a report is not about having data but about allowing an anaesthetist to discuss and consider what happened and what lessons can be learned. Reporting, we believe, can be likened to storytelling. We will consider the report as a story and then consider how existing reporting schemes afford these stories and how they do or can better afford good stories for maintaining and improving safety.

3.1. The Report as a Story

Berg [14] describes the medical record as an active mediator in care rather than a mirror of what happened; Similarly, the incident report does not give the raw facts about an incident but recreates the events and existents (the things), and gives evaluation and opinion in a way that is meaningful to the maintenance and improvement of safety. To aid discussion of this issue, we consider incident reporting as storytelling. Previously, Rooksby and Kay [15] have looked at how work is retold in radiology reports in an idealistic, but more meaningful way for further work. We do not use the term story to somehow diminish the truthfulness or expertise that goes into reporting in medicine, but take it as a concept that brings with it particular analytic possibilities. Storytelling has been found to be a particular way that experts form and communicate information, for example engineers use stories to understand errors in complex equipment [16][17], information systems designers in health use stories to discuss success and failure of systems [18], and scientists in the Life Sciences use stories to communicate between themselves [19]. Medical records in primary care have also been discussed as stories [20][21]. By considering the incident report as a story we do not consider it to be fiction. We do consider it as being something told within a certain context and concerns and to be a expert construction of information to suit the improvement of safety.

The incident report, we have said in this paper, is only one telling of the story that is told and retold. Reports are usually hand written (possibly in two systems), possibly then typed up, usually recounted and

discussed in meetings, and sometimes re-told in the minutes of meetings. To look at how documents are understood and acted upon we must consider both their contents and manifestation [22][23][24], and here we look at contents of a report and consider the different manifestations by which the story is delivered (being pen and paper, network computer, PowerPoint, speech etc). These different manifestations are directly related to the practical needs and activities of maintaining and improving safety. Implied by storytelling is that there is a teller of the story, and hopefully there is an audience to interpret it. We have then a simple framework by which we can talk about the report as a story: content, manifestation, telling and interpreting.

3.2. The Affordance of a Story

As a study of the practical undertaking of work rather than of isolated interactions with technology, incompatibilities with the findings from the field of Human Computer Interaction are inevitable [25]. We use the term 'affordance' here, as it is used in HCI, to allow discussion of how a design allows and encourages certain actions, but by taking a systems view we are in some senses abusing the concept [26]. We use the term affordance to describe how particular technologies, working practices and organisational procedures are aligned to allow a story. We use it to understand how the soft and long term problem of safety is addressed, and we say that technologies must both afford and be afforded a story.

We cannot discuss the national scheme here, which we did not see in action, but we say the other three schemes all afford a story. In the next section we consider whether they actually afford a 'good' story. The content of a report is afforded by an input form in each scheme. The departmental and inter-departmental schemes placed an emphasis on free text. A story however need not be in free text, and we believe that a story is also told in the hospital wide forms, although perhaps not the story as the anaesthetist might wish to tell it. The manifestations of reporting were paper, electronic and speech. Reports were afforded by placing paper forms in operating theatres which were both useful and accessible, and then the electronic versions that were useful for distribution and discussion were afforded by having someone type them up. Talk about reports was afforded by having meetings, or on the inter-departmental system by an online notice board. Interpreting of reports could be done by audit and risk managers by reading reports and others by attending meetings. The mechanism does not determine the

reporting scheme and we must consider that the scheme affords as well as is afforded a story. Anaesthetists do their best to write meaningful content, and time and labour is involved in the writing, re-writing and presentation of reports.

3.3. The Affordance of a *Good Story*

We believe that all reporting schemes involve storytelling in some way and that it is not adequate simply to have or recognise stories. Any inherent 'storyness' is not of interest, as Kelly et al [27] discuss, but rather the practices of storytelling: of building knowledge and making it repeatable and sharable. We consider that schemes might afford a 'good' story for maintaining and improving safety. The departmental scheme we say affords a good story because the mechanism and organisation of the scheme suit and allow the processes of safety. The paper forms allow anaesthetists to write reports, the arrangement of the form itself is in a way anaesthetists find useful, and the trust within anaesthetics departments allows anaesthetists to write reports without fear of inappropriate reprisals. The inter-departmental system was designed to replicate these strengths in affording a good story, but failed to persuade anaesthetists to afford it a story. In the worst cases, the hospital wide systems did not afford such a good story: the contents afforded by the forms was not seen as appropriate; the materials were not appropriate at some sites as they required computer entry; anaesthetists were in most cases discouraged from writing reports because of the blame culture, and little perceived benefit; the interpretation of reports was often not possible for anaesthetists who were not given access to them, and any interpretation by managers that did take place was often invisible.

4. Summary

Incident reporting schemes reflect and enable the practical concerns of improving and maintaining safety, and can usefully be seen as a way of telling stories. These stories must be afforded by the scheme, and also be afforded by those involved. We say that the structure of a report, plus the materials by which reports can be made and remade must afford a (good) story. Anaesthetists, their managers, and the organisation at large, must likewise afford (good) stories to the scheme. What counts as a good story is dependent upon the context of its writing and use. We acknowledge that attempts in the NHS to collect and analyse incident information on a more coherent and widespread basis hold the potential to

significantly increase safety; our argument is not against such attempts but is to state that reporting at its basic level is not the collection of data but the telling and retelling of stories. Reporting schemes at the departmental level in anaesthesia have been successful and we believe the lessons from these should be built upon.

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