

## Appendix D

### Q.7 Countries that report details of local reporting systems.

#### Question 7 – LOCAL INCIDENT REPORTING SYSTEMS : England and Wales

7a) Are healthcare organisations required to have a local incident reporting system? <b>Yes</b> If yes, please answer points b) to h)
b) Please provide details of the requirement to have such a system (eg, is it a national standard, legal requirement, good practice, etc) <b>At a local level, every NHS organisation must have in place a system for 'clinical governance'. This is a clear and formal reporting process which allows organisations to safeguard high standards of care as well as continually improve the quality of their services.</b>
c) Are systems required to collect information on near misses? <b>Yes</b>
d) Is the data protected from legal inquiry? <b>No</b>
e) Are the systems connected in any way to litigation?
f) How is the data collected used? <b>A single overall database for analysing and sharing lessons from incidents and near misses, as well as litigation and complaints data is used to identify common factors and consider specific action necessary in order to reduce risks to patients in the future.</b>
g) If yes to question 7e, what systematic approaches are used? (eg, root cause analysis, process mapping). Please list -
h) Can patients report incidents directly to such local reporting systems <b>Always</b>

In England, you can contact the Patient Advice and Liaison Service PALS for the NHS organisation that your concern relates to. There is a PALS for each area who works directly with the NHS to help patients sort out any problems with their care. PALS can also explain to patients how they can make a formal complaint or report an incident directly to the NHS organisation that the concern relates to.

It is also possible to complain about the NHS through the Independent Complaints Advocacy Service (ICAS).

**QUESTION 7 – LOCAL INCIDENT REPORTING SYSTEM : Ireland**

Are healthcare organisations required to have a local incident reporting system? Yes	<b>Yes</b> (please answer 7a-7g) No – go to question 8
<p>a) Please provide details of the requirement to have such a system (eg, is it a national standard, legal requirement, good practice, etc)</p> <p>Required internally by the Department of Health and Children and the Health Services Executive as part of the requirements for the management of risk and safety. It is also required by indemnity organisations and other external regulatory bodies e.g. Irish Health Services Accreditation Board, Health and Safety Authority, Irish Medicines Board, Mental Health Commission, Social Services Inspectorate etc</p>	
b) Are systems required to collect information on near misses?	<b>Yes</b> No
c) Is the data protected from legal inquiry?	Yes <b>No</b>
d) Are the systems connected in any way to litigation?	<b>Yes</b> No
<p>e) How is the data collected used?</p> <p>Currently there is no uniform way in which data is used and there is a degree of variance nationally. In the main it is used to make decisions regarding the level and type of review required and to identify trends and patterns so that targeted quality improvement strategies can be planned.</p>	
<p>f) If yes to question 7e, what systematic approaches are used? (eg, root cause analysis, process mapping). Please list.....</p> <p>Root cause analysis, data and process mapping, facilitated team reviews, aggregated reporting to services and management,</p>	

g) Can patients report incidents directly to such local reporting systems	Yes No <b><i>Depends on local arrangements</i></b>
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### Question 7 – LOCAL INCIDENT REPORTING SYSTEMS : Sweden

<p>7a) Are healthcare organisations required to have a local incident reporting system?</p> <p>Yes/No</p> <p>If yes, please answer points b) to h)</p>
<p>b) Please provide details of the requirement to have such a system (eg, is it a national standard, legal requirement, good practice, etc)</p> <p><b><u><i>The Regulation SOSFS 2005:12 (see question 4 Guideline 1) requires local systems for reporting and management of adverse events, near misses and risks.</i></u></b></p>
<p>c) Are systems required to collect information on near misses? <b>Yes/No</b></p>
<p>d) Is the data protected from legal inquiry? <b>Yes/No</b></p>
<p>e) Are the systems connected in any way to litigation? <b>Yes/No</b> <b><i>There is a mandatory obligation for healthcare organisations to report adverse events entailing severe patient injury or risk for severe patient injury to the NBHW. The NBHW in turn is under certain circumstances obliged to refer information to the disciplinary board.</i></b></p>
<p>f) How is the data collected used? Please briefly explain</p> <p><b>Data is more and more used to take measures that are aimed to improve patient safety.</b></p>

g) If yes to question 7e, what systematic approaches are used? (eg, root cause analysis and risk, process mapping). Please list

***Referring to question 7f. A national educational material covering analysis of adverse events (Root Cause Analysis) and risk analysis of processes (Healthcare Failure Mode Effect Analysis) has enhanced the use of these methods within healthcare services***

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h) Can patients report incidents directly to such local reporting systems

***Always/Never/Sometimes There are other specific reporting systems for patients***

