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Measures to Foster a Safety Culture for Physicians

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INTRODUCTION

Incident reporting is an important tool in medical safety. In our hospital, a hospital wide operation was initiated in 2010 to increase incident reporting. The ideal number of incident reports is five times the number of inpatients [1-5]. Because our hospital is a 1,345-bed university hospital, at least 6,725 cases should be reported; however, only 1,210 cases were reported in 2012. Therefore, to increase the number of reports, safety managers were assigned to each department in the hospital and medical safety training sessions were held. As a result, the number of reports increased to 16,603 in 2021.

However, most of the reports were non-physician reports, as were those from many institutions, and the number of physician reports did not seem to increase. Therefore, the Safety Management Office has implemented various measures to increase the number of physician reports. As a result, the number of reports has recently increased, although not substantially. The hospital, which is internationally accredited by the Joint Commission International (JCI), encourages and educates all employees on medical safety as a part of its culture. A safety culture consists of four factors:

1. A culture of continuous reporting
2. A culture of justice
3. A culture of flexibility
4. A culture of continuous learning.

While the understanding of non-physician staff has been improving every year in terms of the safety activities mentioned above, the Safety Management Office has established various measures centered on the safety culture of physicians, especially the culture of continuous reporting. However, because no studies have sufficiently examined the effectiveness of such measures to increase the number of physician reports, we examined those measures in this study based on our experience at our hospital.

METHODS

We examined the numbers of physicians' incident reports (at Fujita Health University Hospital) from April 2014 to March 2021. We focused on the reporting rate by physicians out of all incident reports, the number of reports by department, and the number of reports per person by department. We also evaluated the effect of measures and events on improving the increase in incident reports. These include a medical accident investigation system started in 2015, a simplified reporting system established in 2016 for easy reporting, complication reporting standards stipulated in 2017, awareness raising activities at the training and liaison meetings since 2019, reporting by residents mandated in 2020, and detailed case conferences and feedback for each of the other events. The results were also comparatively examined against the results of safety culture surveys conducted by each department during the same period.

RESULTS

Physicians' incident reporting began to increase in 2015, increasing further with the stipulation of reporting standards in 2017. When it became mandatory for residents to report at least 10 cases per year in 2020, reporting by junior residents increased markedly (**Figure 1**). Each department, including accident investigation in the clinical department, had a tendency to increase by case. Departments with a high number of reports performed better in the safety culture survey. While the number of patient complaints at hospitals has been increasing nationwide, it has been decreasing at our hospital; this is

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thought to be one of the effects of these measures (**Figure 2**).

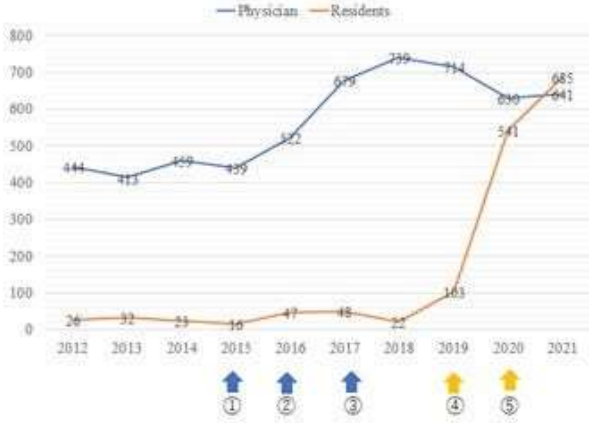

Figure 1: The trend in the number of annual physician reports. Physicians (blue line), blue arrow (1) Medical accident investigating system was initiated, (2) Simplified reporting was established, (3) Complication reporting standards were stipulated. Residents (orange line), orange arrow (4) Awareness-raising activities at training and liaison meetings and (5) Reporting by residents mandated. Each of these measures was found to be effective.

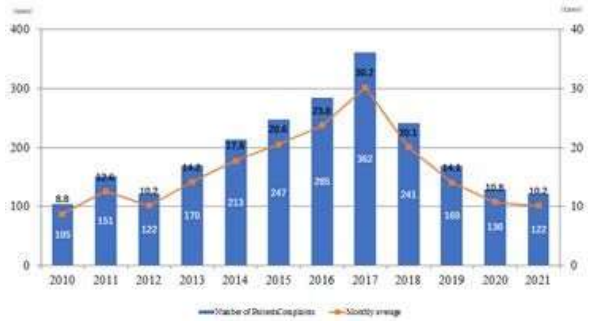

Figure 2: Number of complaints. It has improved dramatically since 2017

CONCLUSION

Incident reporting is indispensable in fostering a safety culture among physicians. The survey results indicated that in order to increase the number of incident reports as much as possible, it is important to clearly define the items to be reported. Furthermore, the Safety Office should establish a system for each case and develop a remedial action plan.

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None

CONFLICT OF INTEREST

The author declares there is no conflict of interest in publishing this article has been read and approved by all named authors.

ETHICS APPROVAL AND CONSENT TO PARTICIPATE

This study was not applicable for ethical approval.

CONSENT FOR PUBLICATION

Not applicable.

AVAILABILITY OF DATA AND MATERIALS

All data generated or analysed during this study are included in this published article.

COMPETING INTERESTS

The authors declare that they have no competing interests.

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AUTHORS' CONTRIBUTIONS

MI conceived the study. MI analysed the data. MI and AH and TS supervised the findings of this study. MI took the lead in writing the manuscript. All authors provided critical feedback and helped shape the research, analysis, and manuscript.

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