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Safe incident reporting in out-of-hours primary care: an exploratory study

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Objectives: The goal of safe incident reporting (SIR) is to recognize avoidable incidents to prevent future harm. Data on the use of SIR in Belgium's out-of-hours primary care (OOHC) services are lacking. We investigated a priori attitudes of managers and GPs, and their willingness to report in OOHC services. We mapped which methods are used.

Methods: A telephone questionnaire was conducted with the managers of all 27 OOHC centers in Flanders. It assessed the design of used reporting systems and the attitudes towards SIR. A paper survey was administered to assess GPs' attitudes in two large out-of-hours primary care centers.

Results: All managers participated ($N = 23$). Seventy percent used some form of incident reporting system, with a large design variation. All managers thought SIR is important to improve quality and safety. Seven managers predicted that GPs would be hesitant to use SIR.

In the GPs' survey (response rate 58%), 69.7% of responders had experienced an incident and 74.5% would tend to report it. 81.1% agreed that an incident has to be analyzed, discussed, and should lead to an improvement plan. The majority believed SIR could create openness about adverse events and would improve job satisfaction. One out of five feared that it would make their job more difficult, and 39% were afraid the report could be used against the reporter.

Conclusion: OOHC center managers and GPs show positive attitudes towards SIR. There is a large variation in the currently used methods. Future projects could focus on interventions of implementation of SIR in OOHC.

Keywords: Safe incident reporting, Learning from adverse events, Quality of care, Out-of-hours primary care, Patient safety

Introduction

In health care worldwide, there is an increasing interest in quality management, patient safety, and risk assessment. Incident reporting has its origins in aviation, and is being applied in many other industries like petrochemistry. Research has shown that companies with open and constructive attitudes towards incidents reach a higher performance level.¹ As part of the reporting process, professionals conduct an incident analysis to create an improvement strategy. The reporting of the incident is the first step, followed by a more or less exhaustive analysis and an improvement plan. Not all incidents have to be analyzed in detail. It depends on the gravity of (possible) consequences of the incident.

The goal of safe incident reporting (SIR) is to recognize avoidable incidents in order to prevent future harm. Further, SIR can contribute to patient safety and job satisfaction and provide a way to process incidents together as a team. Incident reporting differs notably from patient complaints. In contrast to a complaint procedure, for SIR,

the health care worker himself reports the incidents. 'Safe' stands for a safe working climate, where contributors can report blame free. However, at this time, research about the effect of incident reporting on patient safety in primary care is lacking.¹⁻⁴

Implementation of SIR systems varies widely. Singapore and Denmark implemented laws in order to exclude judicial consequences to incident reporting. In Germany, health care professionals' use of incident reporting and a system's approach to errors is not in current practice.⁵ In the Netherlands, Nivel, the Dutch institute for research in health care, introduced an SIR model in the country's health care in 2008.⁶ Systematic incident analysis and transparency to patients has become routine, and the Dutch health care system is highly committed to patient safety.^{2,7,8} Every hospital is obligated to follow an SIR procedure and there are frequent studies in hospital settings.^{2,9,10} In contrast, in Belgium, research shows that health care workers report far too few incidents, for example medication errors.¹¹ However, in 2007, the federal public service of health introduced a patient safety and quality

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program for hospital care. By 2011, 179 of the 197 Belgian hospitals signed a governmental contract that includes a form of incident reporting and analyzing system.¹²

The next step is bringing incident reporting to all levels of health care. Patient safety reporting systems appear to be transferable from hospitals into primary care. They may provide insights into the more serious and rare threats to patient safety.^{4,6,13} The European Practice Assessment (EPA 2005), an international instrument to assess the quality of European general practice, includes an incident registration system. In one general practice survey, 26% of Belgian practices and 28% of Dutch practices used such an incident register. In the UK, where quality management traditionally is high, this reaches 89%.¹⁴ In 2011, the Dutch Society of General Practitioners (NHG) published a guideline for deployment of an SIR procedure in general practice,¹ and SIR is a criterion in the accreditation inspection of General Practice (GP) practices.

Over the years, in many countries, large-scale general practice-led services are becoming the main vector to deliver primary care during out-of-hours. Typically these services are covering a large area and serve over 80,000 inhabitants.^{15,16} As the patients are often not known to the GP on call and patients may be more ill, quality management is needed to reduce error sources. In some countries, SIR is also used in these out-of-hours cooperatives.¹⁷ Data

on the current use of incident reporting procedures in out-of-hours primary care services in many countries are lacking. In this exploratory study, we investigated the a priori attitudes of managers and GPs' attitudes and willingness to report and learn from adverse events in OOH services in Belgium (Flanders). In this country, a quality culture is emerging. A majority of the GPs work in private solo practice during daytime. Overall, about 70% of the population is now covered by out-of-hours services during the weekends and public holidays.¹⁸

Methods

The University of Antwerp ethical committee approved this research (ref: 14/14/164). It consists of two parts. The first focuses on the opinion and current policy of the out-of-hours primary care centers' managers. The second part focuses on GPs' attitudes about incident reporting. At the time of this study, 27 out-of-hours primary care centers were operational in the Dutch-speaking part of Belgium (Flanders).

A telephone questionnaire was designed to investigate the methods of incident reporting among managers of out-of-hours primary care centers in Belgium (Flanders). A paper survey was constructed to assess the attending GPs' attitudes and willingness to report and learn from adverse events. The same questions were asked to both GPs (paper) and managers (telephone) (Table 1).

Table 1 GPs' and managers' attitudes towards SIR in out-of-hours primary care

	Respondent	Totally agree	Partially agree	Partially disagree	Totally disagree	N
An organization, like an OOH center, can learn from mistakes	Manager	95.7	4.3	0.0	0.0	23
	GP	83.0	16.0	0.0	0.9	106
SIR can play a role in learning from mistakes	Manager	95.7	4.3	0.0	0.0	23
	GP	64.2	35.8	0.0	0.0	106
Structured SIR would contribute to improved patient safety	Manager	52.2	43.5	4.3	0.0	23
	GP	54.7	43.4	1.9	0.0	106
An incident in OOH has to be analyzed, discussed in a board meeting, and result in a plan for improvement	Manager	40.9	36.4	18.2	4.5	22
	GP	37.7	43.4	16.0	2.8	106
I am/our center is positive regarding a structured incident reporting system, provided that the report will not result in penalties for the reporter	Manager	63.6	18.2	13.6	4.5	22
	GP	69.8	29.2	0.9	0.0	106
All staff members have to be able to report incidents	Manager	100.0	0.0	0.0	0.0	23
	GP	39.4	51.0	5.8	3.8	104
Patients have to be able to report incidents	Manager	100.0	0.0	0.0	0.0	23
	GP	30.5	50.5	15.2	3.8	105

^aPercentages calculated after exclusion of missing answers.

Managers' survey

During the months of July, August, and September 2014, the telephone questionnaire was conducted with the managers of the OOHC centers. The survey was based on a Danish study investigating general practitioners' attitudes towards reporting and learning from adverse events during daily practice.¹⁹ Items were added to allow more specific information about the OOHC setting. The questions addressed demographic data of the OOHC centers, the annual number of patient contacts, and the number of attending general practitioners. The survey assessed whether there was an existing incident reporting system and how it was conducted. Managers were asked about their interest in incident reporting and if they thought it was important in improving quality. Further questions were asked about the number of reported incidents. Other topics included the presence of an ombudsperson, the possibility to give feedback to colleagues, future plans with incident reporting if applicable. Finally, eight quotes were presented to probe willingness to start the use of SIR in their service. The interviews were recorded and analyzed qualitatively (interpretation of the open questions) and quantitatively (statistical analysis of data).

GPs' survey

A paper survey was conducted in two large out-of-hours primary care centers in Flanders: Turnhout (182,200 inhabitants) and Zuiderkempen (253,058 inhabitants). During five consecutive weekends in January–February 2015, all attending general practitioners were given the paper questionnaire upon arrival in the OOHC center. They were asked to return the survey by the end of their working day. The survey started with a little explanation about SIR. Demographic data, questions about their working model (alone, with one other colleague, or in a group) and if they were a GP in training, were included. The doctors were asked whether they had an incident before, if they would tend to report it, and their preference between reporting anonymously or confidentially. Finally, they were asked their opinion on the same quotes as the managers, using a four-point agree/do not agree scale.

Pilot

The study design was co-created by the professional umbrella organization of the out-of-hours services in Flanders. The study design was presented and approved during their board meeting.

Statistical analysis

The two study questionnaires were transformed into two digital data-sets. Data were analyzed statistically using SPSS® 20.0. A chi-squared (χ^2) or Fisher's exact test was used for descriptive statistics. A student *t*-test was used for continuous variables, such as age. A significance level of $p < 0.05$ was considered statistically significant.

Missing fields were excluded from the calculations. The open answers from the managers' questionnaire conducted by telephone were incorporated as citations to give background information.

Results

Managers' survey

Characteristics

All 23 managers of the 27 OOHC centers participated in this survey. The mean interview time was 17 min. The reported annual number of patient contacts varied from 1369 to 21,000 patient contacts. Six OOHC centers had been operating for less than 2 years, and their number of patient contacts was not included. The average number of attending GPs was 112 (minimum 29, maximum 300). According to the manager responses, 70% of OOHC centers have a kind of incident reporting procedure.

How are incidents reported and managed?

The number of reported incidents varied from 1 to 72 incidents per year (mean 12). Eight managers could not confirm the number of incidents reported. On average, 56.7% of the occurring problems in the OOHC centers were presented and settled at a board meeting. In 54.4% of the reported incidents, the incident was being analyzed and a plan for improvement is being set up. If involved, the health worker was informed on average 85.0% of incidents. In 14.2% of cases, the incident was recorded while awaiting similar incidents to occur. In 9.6% of incidents, no further action was undertaken.

The current methods of incident reporting in the OOHC centers varied widely in way of reporting, in person who was initially filtering and dealing with the incidents and in outcome. The used procedures varied from no-incident procedure at all to a fully extended SIR system with regular analysis, development of scripts and regular feedback to staff members. Two managers stated they had never encountered an incident. In five centers, only a complaint procedure was being used. Most of the incident reporting systems described lacked structured analysis and registration.

With regard to the methods of incident reporting, almost half of the centers worked with a communication book/logbook/incident book/suggestion book that was analyzed every Monday. Different books were usually used for GPs than for other employees. Some GPs got an email after their shifts with the opportunity to give feedback. In 21.7% (5 centers), incidents were reported by email only. In 4.3% (one center) only paper incident reports were accepted (an incident book or form). In 30.4% ($N = 7$), incidents were reported by email and paper forms, in 21.7% ($N = 5$) by email and telephone. In two centers, incident reporting occurred by paper forms and telephone, and in another two centers, the combination of email, paper forms and telephone was used. In one center, incidents were reported

by email, a paper form, or via the software program. At the time of the survey, none of the out-of-hours primary care centers used a software platform where doctors or staff could give or ask for feedback on their performance. Four centers had a procedure that required contacting the manager or director immediately if an important incident occurred on the weekend. Text box 1.

Text box 1. Citations of answers of the managers on the open question: ‘Describe your SIR-procedure.’^a

- ‘Either, it is serious and it is reported to the Order of Physicians (a federal juridical organization of all physicians red.) or via a written letter ... or it is less serious ... and it is reported via the reception ... They have a communication book.’
- ‘Sometimes we collect a couple of mistakes which have happened, in order to report them together.’
- ‘Actually, it is reported in different ways; sometimes you are addressed personally, we also have a suggestion book for the doctors and we have an information document which they can put in my mailbox ... So we do a number of things, but I have to admit that I think it’s too poorly structured.’
- ‘No, but we are creating a logbook ... from the moment we notice reoccurring (incidents red.), we take care to notice the pattern, analyze it and make policy decisions ...’

^aCitations have been translated from Dutch to English.

Eighteen managers filtered the incoming incident reports and decided which incidents have to be discussed at a board meeting or if immediate action was necessary. The ombudsperson, approachable for patients and staff in 39.1% of centers, could fulfill the same function. Three centers chose to discuss every incident at a board meeting. In three centers, the center director handled all incidents. In four centers, a dispute committee existed to settle conflicts between colleagues.

After discussing the incidents in four centers, procedures were put in place to prevent similar adverse events. The majority of the centers guaranteed feedback to the involved GP/reporter. Three centers analyzed the reported incidents in order to examine repeating adverse events and/or structural causes.

During the interviews, uncertainty existed about the definition of an incident. For example, for some managers a problem with equipment or supplies could not be called an incident, while others chose to include these in order to avoid preventable material causes of adverse events.

How do managers perceive SIR?

All of the managers thought it was important that incidents are reported in OOHC. 95.7% believed SIR can improve

the quality of OOHC, while 91% of managers showed interest in establishing SIR procedures. During the telephone survey, 15 managers emphasized spontaneously the importance of SIR in OOHC (Text box 2).

Text box 2. Citations of managers emphasizing the importance of SIR.^a

- ‘Absolutely! We see so many patients and we have so many doctors. We have to make it happen for both sides. It’s important for us to be well informed, otherwise it’s impossible to make any adjustments.’
- ‘Very important. If one doesn’t report (an incident red.), how trivial it may seem, than I can’t intervene and therefore it can’t be improved.’
- ‘It’s by keeping a close eye on it ... you can adjust as quickly as possible. That’s the goal: reporting an incident today, taking care of a solution and preventing it from happening again in the future.’
- ‘Every serious company investigates its own product quality. In the end this is how we have to look at ourselves. If we don’t measure it (quality red.), we don’t know if we’re doing a good job.’

^aCitations have been translated from Dutch to English.

All of the respondents partially or completely agreed with the quote that an OOHC center can learn from mistakes. They all stated that SIR can play a role in learning from mistakes, and that it can entail positive changes in an OOHC center. 95.7% of managers felt that SIR would contribute to improved patient safety. The respondents in 77.3%, partially or completely, agreed with the quote that an incident in OOHC has to be analyzed, discussed in a board meeting, and result in a plan for improvement.

81.8% of managers were positive about a structured incident reporting system, provided that the report will not result in penalties for the reporter. However, during the telephone survey, four managers noted spontaneously that incident reporting does not always have to be blame free. They thought penalties should be possible if the reporter is involved in an important adverse event. All the respondents agreed that patients and all staff members have to be able to report incidents. The results on the common quotes with the GPs’ questionnaire are depicted in Table 1.

What are the barriers encountered in SIR?

Seven managers predicted their GPs would not be willing to report incidents. One manager said the board lacks time to pay attention to SIR. One manager stated clearly that the GPs are very positive about cooperating in their incident reporting system. Another manager noted that regular reminders are necessary to maintain incident reporting. Text box 3.

Text box 3. Citations of managers talking about the barriers to SIR.^a

- ‘I have the impression that they (GPs red.) don’t do it enough (reporting red.). In their opinion they think their ideas are irrelevant or nitpicking, but for us it would make a contribution to quality improvement of the out-of-hours care center.’
- ‘GPs giving each other feedback? That doesn’t happen very often, because I think it’s not in their culture.’
- ‘They (all staff members red.) don’t dare to contact me because of a fear in regard to collegiality. ... Particularly amongst fellow doctors we notice a very big resistance.’

^aCitations have been translated from Dutch to English.

Do OOHC centers have future plans for SIR?

For one manager, the study interview was the first introduction to SIR. Nine managers were satisfied with the way SIR is handled or had a lack of interest now. Fourteen managers were planning an optimization of their procedure. For example, they planned the search for new documents or structures, a revision of the current procedure, compilation, and revision of past incidents or design of a new procedure. They saw possibilities in learning from experiences in other OOHC centers and they were receptive to new ideas or plans. According to the respondents, an acceptable model for SIR would have to be practical, simple, and fast. Text box 4.

Text box 4. Citations of managers talking about their future plans for SIR.^a

- ‘You have to deal with 120 individualists, people who all have their own way of working. And now you want to try to improve their working? This can only be achieved by doing it in a structured manner.’
- ‘We are already doing a few things, but there is definitely room for improvement.’
- ‘I’m going to search for the Dutch documents. ... have it structured right away. So you have a clear view on how frequent something happens.’

^aCitations have been translated from Dutch to English.

GPs’ survey Characteristics

In total, 106 respondents completed the survey (response rate 58%). There were no statistically significant differences between the two respondent groups (Turnhout and Zuidekempen) regarding response rate, sex, age, number of GPs in training or working model. Considering this, the results were analyzed as one group. There were 58.5% male respondents. The mean age was 46.4 years old, with a range of 25–69. 54.7% of respondents were younger than 50 years of age. A minority (7.6%) of the respondents was a GP in training (number of respondents to this question

$N=105$). With regard to the working model, 27.6% of the GPs worked alone, 27.6% in pairs and 44.8% in groups ($N=105$).

How do GPs perceive SIR?

69.7% of respondents had experienced an incident during professional activities ($N=99$). Three-quarters of the GPs would be inclined to report an incident ($N=94$). The majority (81.5%) preferred reporting confidentially, above anonymously ($N=92$).

Almost all of the respondents (99%), partially or completely, agreed with the two quotes that an OOHC center can learn from mistakes and that SIR can play a role in learning from mistakes. Ninety-eight percent of the GPs felt that SIR would contribute to improved patient safety. 81.1% agreed with the quote that an incident in OOHC has to be analyzed, discussed in a board meeting, and result in a plan for improvement. 99.1% of GPs were positive about a structured reporting system provided that the physician cannot be punished for reporting an adverse event. 83.7% agreed that a reporting system would enable more openness among colleagues about medical errors. About three-quarters expected that structured analysis and discussion of incidents would enhance job satisfaction (78.1%). However, one out of five respondents expected that a reporting system would make it more difficult to be a GP and 39.4% feared that the incident report could be used against the reporting physician (Table 1).

What are GPs’ practical experiences with incidents?

64.3% of respondents had experienced adverse events in their clinic that have made them change their procedures. 84.7% believed that colleagues could learn from these adverse events. 63.7% had changed their procedures based on other GPs’ experience. 62.5% would report an incident in which a colleague is involved (51.9% partially agreed, 10.6% fully agreed).

Who can report an incident?

The majority of the respondents agreed that all staff members have to be able to report incidents (90.4%, of which 51.0% partially agreed and 39.4% fully agreed). 81.0% thought that patients have to have the opportunity to report incidents.

Influencing factors on SIR

Sex, age, working model, and being in training had no significant influence on the tendency to report incidents, or on the attitude towards a structured reporting system. There was no significant relationship between these variables and being afraid that reporting an incident could be used against the reporting physician. According to the answers on the quotes, there was no significant relationship between demographic factors and the outcome variables.

Discussion

In Flanders, there is large variability in how incidents are reported in general practice out-of-hours services. Moreover, future plans for incident reporting, if any, differ. For some managers the concept of SIR was new. We acknowledge that four of the OOH centers were opened recently, and their organizational level is not mature. Overall, the managers were very interested in developing SIR and future possibilities. They were positive about the future use of SIR in OOH.

The GPs show positive attitudes towards quality improvement through reporting incidents, provided that they do not risk exposure to sanctions. The results of this GP survey are similar to those of the Danish study in daytime practice on which the questionnaire was partially based.¹⁹ The differences between age, sex, working model, being in training groups were small and insignificant. This could be explained by the smaller sample size in the present study.

The difference between official patient complaints and SIR was not always clear. For a substantial number of the managers, it was very difficult to detect the number of recorded incidents during the past year. In contrast, the official complaints were very well registered and analyzed. This may explain the large variation in number of occurring incidents. It was, in fact, difficult to form a uniform definition of an 'incident,' and would be important that all contributors are well informed about 'what to report.' In the NHG guideline, clear definitions are used.^{1,20}

During the questionnaire, it was frequently remarked that the management of the OOH center was interested in establishing an SIR system, but they felt that the GPs would not tend to cooperate. Notably, unlike the expectations and concerns of the managers, participating GPs are clearly positive towards SIR. They agree that reporting incidents could enhance openness concerning the fact that GPs make errors and could improve job satisfaction.

Some managers were more skeptical about the reporter of the incident not being at risk for personal sanctions. A few managers noted that if the incident has major consequences, disciplinary action should be possible even if the involved GP self-report the incident. Perhaps a positive incentive system for the out-of-hour care centers could be a solution, to avoid discouraging GPs from reporting.

Despite the positive perception of incident reporting, one out of five GPs believed SIR could make the job more difficult. 37.5% would avoid reporting an incident in which a colleague is involved. 39.4% feared that it could be used punitively. This is in line with findings in the literature.²¹ Previous studies showed some additional barriers: lack of time, extra paperwork, concern about career and reputation, fear of punitive action, poor safety culture, lack of understanding about what should be reported, lack of awareness of how the incidents will be analyzed, and how it would lead to changes.^{21,22} Furthermore, critics warn that

SIR can be expensive, people do not like using them and that they do not deliver pure epidemiological data.³

In order to be successful, SIR systems need to have low reporting burden, have good clarity regarding the information requested, provide direct benefit through feedback and take into account error severity and personal responsibility.²³ Feedback directly to the clinicians is extremely important for continuous engagement.^{21,24} Furthermore, this research showed clear definitions of an incident and its severity are necessary. Considering the importance of a safe atmosphere as a prerequisite for successful incident reporting, these barriers are important to take into account while establishing a reporting system. Open communication between all the contributors will remain important.¹

Survey respondents preferred confidential above anonymous reporting, as in the Danish study.¹⁹ Fernald et al. affirmed that information from confidential reports appears to be superior and may be more useful in understanding errors.²⁵ Interestingly, an American study advises that reporting should be anonymous,^{25,26} though differences in culture, legal system, and accusation tendency could have an influence. In the literature, discussion arises about reporting locally versus centrally. Reporting locally (unit-based, in the out-of-hours primary care center itself) would increase the willingness to report, while reporting centrally (e.g., to a committee of directors of multiple collaborating OOH centers) creates opportunities on addressing recurring safety issues.²⁷ Our survey did not address this matter.

Strengths and limitations

This was the first exploratory study about the opinion of managers and attending GPs on SIR in Flanders' OOH. The 100% response rate from the managers' questionnaire makes it a valuable instrument in the discussion about the organization and quality of future OOH. However, there was no intervention and improvement cycle in this study and future interventional research is necessary to assess the effect of SIR in out-of-hours primary care. A next step could be to identify how the services deal with collected incidents. More work is needed to study the processes after an incident is reported. A very important question is whether incident reporting and subsequent analysis is capable of changing habits and in the end improves the quality of care.

This study reports a description of perceptions and views of managers and GPs. For instance, we did not study the reasons why GPs self-report or not. More work is needed to see which barriers prevent GPs from reporting, and how to get around them.

Respondents may have given socially acceptable answers to the questionnaire. By doing the managers' interviews telephonically, we tried to get as much as background information as possible to minimize this effect. This telephone technique also guaranteed 100% response rate. However, we did not ask about the background or

experience of the manager, which could have had an influence on their answers. Although translations were done by two investigators, translation of the quotes could have resulted in an imperfect transfer of nuances.

The GP study is limited by a responders' bias. The respondents are likely to be the GPs who are interested in quality management. Taking this into account, our results could overestimate the enthusiasm and positivity towards SIR. The response rate of the GPs' questionnaire was 57.9% and no information is available for non-responders. In 2013, 8330 GPs were working in Flanders.²⁸ Thus, our sample might not be representative to make generalized conclusions about the GP population. The two participating centers are very alike in demographic and geographic characteristics, and we cannot make extrapolations to other settings, for example, a more urban region.

By dichotomizing the answers on the four-point scale multiple-choice questions, a polarization of opinions could have occurred. By including questions from the Danish study, we were able to explore differences and similarities in the two study samples. Nevertheless, some small nuances could have slightly changed by translating the questions in Dutch.

Conclusion

OOHC center managers and GPs in this research study showed positive attitudes towards SIR and learning from adverse events in order to improve quality of care. There seems to be a safe atmosphere in which SIR could take place. However, there are some barriers, and these should be taken into account and discussed while establishing an incident reporting system.

Respondents were positive about incidents being reported by GPs, other health care workers, and patients. In order to improve quality of care, SIR can be used to improve performance rather than being seen as a threat. Ideally, a safe culture should be created, where incidents can be openly discussed among staff; GPs shouldn't be hesitant to comment on the performance of their colleagues and where positive feedback allows improvement of procedures.

These results, together with the current literature and experiences in our neighboring countries, could encourage OOHC centers to think about establishing their structured incident reporting system. We suggest future research focus on clear definitions and standardized criteria for incidents, analysis of registered incidents, and cooperation between the different OOHC centers. Reporting best practices may be an avenue for further improving the mindset towards SIR.

Geographical information

This research project was conducted in Flanders (Belgium).

Contributorship statement

This work was part of the thesis of Nele Augustyns in order to obtain the Master of General Practice degree. Nele

Augustyns, Caroline Lesaffer, and Roy Remmen designed the study. Nele Augustyns, Stefan Teughels, and Hilde Philips helped to collect data. Nele Augustyns and Roy Remmen analyzed qualitative data. All authors worked on and approved the subsequent and final version of the manuscript.

Disclosure statement

No potential conflict of interest was reported by the authors.

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