Pumping up the Volume
Tips for Increasing Error Reporting
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**Problem:** Error-reporting systems represent one of the primary means by which health care professionals learn about:

- potential risks: hazardous conditions that may be hidden in an institution’s processes.
- actual errors: mistakes that occur during the delivery of patient care.
- causes of errors: the underlying weaknesses in systems and processes that explain why an error happened.
- error prevention: ways to prevent recurrent events and, ultimately, patient harm.

Error reporting is a fundamental component of a safety culture, but persuading health care workers to submit reports is no easy task, given the potential deterrents involved. First, people’s reactions to making errors can vary, but candid confessions of mistakes are not very popular. In fact, people have a natural desire to forget that the incident ever happened. Second, even if workers are willing to speak up about errors, they may still believe that the extra work is not worth their time if they feel that no good will come from reporting the mistake. Third, workers are also understandably reluctant to report errors if they are worried that the information will get them or their colleagues in trouble, legally or socially, or will affect their job security.

**Safe Practice Recommendations:**
Regardless of most employees’ natural reluctance to submit error reports, some highly successful internal and external error-reporting systems exist today, including our Medication Errors Reporting Program (MERP) at the Institute for Safe Medication Practices (ISMP). From these systems, we can identify best practices that promote error reporting. These best practices fall into six categories that can affect the quantity and quality of reports.

**Trustworthiness.** Employees who receive and act on error reports must earn the trust of those who report errors. Employers must prove that the program is sensitive to reporters’ concerns, particularly the fear of punishment for making an error and reporting it. Feelings of trust are fostered by leaders who demonstrate an unequivocal passion for safety, who acknowledge the high-risk nature of health care and human fallibility, and who use the disclosure of errors to assess system performance, not staff performance. Organizations need a just culture in which workers are encouraged to provide essential safety information without fear of being judged or treated unfairly in the wake of an error.

**Confidentiality.** Those who receive reports must keep the identity of the reporter, the workers involved in the errors, and the location of the event confidential to prevent undue embarrassment or undesirable attention. Anonymity in reporting is not recommended, because those who receive the report would not be able to talk to the reporter, or to others who were involved in the error, to learn about the possible causes. Anonymity also signals to reporters that it might not be safe to provide their identity or location; such a situation would negate the desired climate of trustworthiness.

**Clear and easy-to-read reports.** Workers who receive reports must pay attention to format and length requirements. If a report is too long, it may stifle reporting by discouraging future reporters from making the attempt. If the report is too short, there might not be enough information to make it useful. Instead of posing broad, general questions, the report’s format should encourage the reporter to write a narrative of the event. It should also prompt questions that are specific to the type of event (e.g., was this a medication error, a fall, or a mistake in the use of a medical device?) so that reporters will be able to convey the most pertinent information about their perceptions, decisions, and actions.

For example, the reporting format should include questions that ask whether the event involved missing information about the patient or the drug or whether there were problems with communication, labeling and packaging, drug storage, or the environment. In this way, the probing questions shift much of the analytical work away from the reporters and make it easier for them to uncover some of the possible causes that led to the error.

**Mechanisms for event reporting** should also be flexible enough to include both formal and informal ways of accepting information, including oral, written, and electronic submissions.

**Recognition of effort.** Although occasional recognition is not as satisfying as the good use of the information provided, organizational leaders and others who receive reports should acknowledge reporters for playing a positive role in patient safety through their efforts. Of course, as implied in the next category, the biggest reward of all is to know that the report resulted in effective action at the system level.

**Credible and useful feedback.** Few things impede reporting more than perceived inaction and failure to use the information contained in a report to improve safety. Thus, supervisors who receive reports must provide timely and comprehensible feedback to workers, throughout departmental lines, and should keep the staff informed about continued on page 23.
how their reports are being used to improve systems in the workplace.

Reinforcement of the imperative to report. Those who receive reports must establish strategies for mentoring new staff members about the error-reporting process. Supervisors can also emphasize the importance of reporting hazards and errors to their employees by including clear expectations for reporting activities on all job descriptions and performance evaluations.

Not too long ago, health care professionals felt too embarrassed or ashamed to divulge medication errors. Some were so fearful of legal and personal reprisal that they followed an unwritten, unspoken, but clearly understood rule: silence is golden.

Thankfully, times are changing. Most workers now realize that disclosing and openly discussing errors may help their organization analyze a situation better, predict behavior more appropriately, and design systems and processes that are more resistant to errors. In fact, many health care personnel are beginning to understand that there might be a greater liability when they do not report errors. By following the steps suggested in this article, organizations can continue to improve reporting methods and their capacity for learning about the human, technical, and environmental factors that determine the safety of the system as a whole.

The reports described in this column were received through the ISMP Medication Errors Reporting Program (MERP). Errors, close calls, or hazardous conditions may be reported on the ISMP Web site (www.ismp.org) or communicated directly to ISMP by calling 1-800-FAILSAFE or via e-mail at ismpinfo@ismp.org.