

Error Reporting Systems: Feedback and Communication

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Welcome

Welcome to the fifth issue of *Patient Safety Tools*, IPRO's electronic newsletter designed to provide information and resources on patient safety to health care providers across New York State.

We have adopted this format to increase the reach and effectiveness of our efforts to communicate a range of useful, current information regarding patient safety initiatives sponsored by IPRO and others. We hope that by bringing key findings, lessons learned, workable strategies, and practical tools to your attention, these newsletters will highlight proven ways to apply quality improvement processes to achieve transformational advances in patient safety.

Introduction and Purpose

In each newsletter, we are presenting information focused around one of the twelve safety dimensions for hospitals defined by the Agency for Healthcare Research and Quality (AHRQ) as implemented in their [Patient Safety Climate Survey](#). This is a valuable survey that is currently being used by IPRO in a CMS directed rural hospital initiative to promote an improved hospital patient safety environment and is available for any hospital to use. The survey identifies specific patient safety strengths and vulnerabilities associated with each of the twelve measured dimensions and can facilitate a data-driven plan to engage senior leadership to promote safety improvement activities using specific evidence-based, proven interventions.

The patient safety dimensions that reflect various hospital processes are the following:

- Overall perceptions of safety
- Event reporting
- Supervisor/manager expectations and actions promoting patient safety
- Organizational learning-continuous improvement
- Teamwork within units
- Communication
- Feedback and communication about error
- Non-punitive response to error
- Staffing
- Hospital management support for patient safety
- Teamwork across hospital units
- Hospital handoffs and transitions

The first issue focused on using the SBAR technique to improve communication during the many handoffs and transitions that occur during any hospital stay. The second issue highlighted the absolute need for active and visible participation by hospital senior leadership, especially the CEO, in driving safety culture change efforts and provided tools that will permit busy executives to do so. The third issue examined how the prevailing and toxic environment of blame in hospitals prevents understanding how errors occur within systems. We provided thoughts, techniques, and resources that permit establishing a “just culture” in which organizational learning can take place. In this issue we will consider the necessity for more effective error reporting systems (including a better understanding and definition of “error”); the benefits of transparency and honest communication; and, the power of open disclosure and forgiveness in a just culture. We will also look at the existing “cultural” barriers to achieving these objectives and ways to overcome them.

How do we communicate the data provided by enhanced error reporting systems to make care delivery better and safer? In this issue we're going to examine and propose answers to the question, "Now that I have good data, how do I proceed?"

Findings from the American Healthcare Research and Quality (AHRQ) Hospital Survey on Patient Safety indicate that we don't provide enough communication and feedback about errors

More than 103,000 individuals in 382 hospitals were included in AHRQ's [Hospital Survey on Patient Safety Culture Comparative Database](#). Three specific items on the survey were designed to determine how positively individuals feel about feedback and communication regarding errors that occur on their units. The average positive response for this dimension was 62% (R 19%-86%).

The individuals surveyed said they:

- were informed about errors occurring in their unit about 64% of the time (R 21%-100%);
- discussed ways to prevent those errors from happening again 69% of the time (R 13%-100%); and,
- were given feedback about changes implemented 52% of the time (R 19%-87%).

The good news is that 60-70% of the health care workers surveyed feel positively about the frequency of feedback and communication about errors in their areas. They are not only informed when errors occur but they also discuss ways to prevent those errors from happening again. Conversely, about 30-40% claim that they are not informed when errors occur and further state in the unlikely event that they are informed, they do not discuss ways to prevent those errors from happening again.

We must continue to work to prevent harm to patients. And that will require a fully engaged health care system to recognize when errors occur, be comfortable with sharing this information, and committed to the development of processes to prevent future errors.

The importance of feedback in shaping human behavior

From a systems perspective, feedback is the process of receiving input from the environment based on the output of the system. Feedback can be positive-in which case the system continues to function as before -or negative-in which case the system should be subjected to some kind of corrective action. Applied to human behavior, feedback is either positive (i.e., the behavior is reinforced, strengthened and maintained) or negative, (i.e., the behavior is inhibited, weakened or extinguished).

You may remember Ed Koch, mayor of New York City, 1979-1989, who made famous a question that had previously been rarely asked by elected officials. "How'm I doing?" He asked all the time-in person, on television, in print-so much that it became his personal trademark. His purpose was a political one. By seeking feedback from his constituents about his performance as mayor, he was able to better connect with them and understand what he needed to do to keep or gain the approval of the voters. In doing so, he was reelected twice-in 1981 with 75% of the vote and in 1985 with 78% of the vote. Feedback was important to Mayor Koch and probably helped him achieve these landslide wins.

Feedback is more important to all of us than we may imagine. We all have an internal sense of how we're doing in our professional and personal lives. This perception of our performance will either drive us to continue what we're doing or make changes. This internal sense is derived from the way we personally process information gathered by our own observations, thoughts, feelings, and opinions. There is evidence that many of us have a higher opinion of our performance than may be warranted by the facts. Without objective, external feedback we do not have sufficient information to understand the impact of our behavior, either positive or negative.

The importance of error reporting feedback in health care

Our health care system is a complex network of people, environments, machines, technology, knowledge, and rules. If the enemy of safety is complexity, we need to ask how we're doing more frequently. The importance of providing substantial and immediate feedback to correct and prevent the recurrence of health care errors is well-founded. Here's why:

- Error reporting is not the end point of the process; it is the beginning. The end point is the prevention of harm to patients following the development of safer practices.
- Errors cannot and will not be prevented unless we hear about and learn from the safe practice recommendations that result from a comprehensive analysis of error and near miss reports.
- Reporting will occur only if practitioners feel safe in doing so and receive positive feedback that their reporting is valued, appreciated and has made a difference in preventing harm to patients.
- Reporting is perceived to have immense value when those who report an error, near miss, or potentially hazardous situation can readily see that the information is swiftly acted upon and used confidentially and proactively to develop and publish safe practice recommendations which prevent further errors.
- Rapid communication of accurate, valid and expertly reviewed information provides credible evidence that the information is being used appropriately and effectively, which in turn stimulates further error reporting.

Using error reporting to reduce harm to patients

How can an error reporting system be structured to encourage individuals to use it? The Institute of Medicine notes, "Reporting systems without adequate resources for analysis and follow-up action are not useful . . . and may even be counterproductive in that they weaken support for constructive responses." When you have a system for collecting data and either don't take immediate action on the findings or don't disseminate the type of action you're taking in a timely way, it defeats the intended purpose and the objective is lost.

Presented below are integral features of an effective error reporting system: -

- Ensure useful trending and expert, timely analysis of data.
- Identify and explore improvement opportunities revealed.
- Rapidly disseminate performance improvement information to those who need it. All practitioners and other staff members who are involved with or could be affected by the system should be informed. Communication must be direct, prompt and effective. Communication vehicles include, among others, e-mail alerts, written or posted notices, and Web-based networks.
- Provide reporters with feedback on how their reports were used to identify improvement interventions that benefited others.
- Track interventions that work and share them universally. As part of their mission, reporting systems should include a formally-sanctioned print and/or electronic communication function to provide crucial information directly, promptly and effectively to health care professionals, organizations, and others in the health care community.
- Communicate, communicate, communicate.

All error reporting systems are not created equal

A list of some of the better error and near miss reporting systems that include appropriate communication and feedback processes follows:

1. [Institute for Safe Medical Practices \(ISMP\) Medication Error Reporting System](#) -- Operated by the United States Pharmacopeia (USP) in cooperation with the Institute for Safe Medication Practices (ISMP), this site is a confidential national voluntary reporting program that provides expert analysis of the system causes of medication errors and disseminates recommendations for prevention.
2. [Medical Event Reporting System - Transfusion Medicine](#) -- An event reporting system that strives for the continued improvement of blood product safety through the systematic collection, analysis, and interpretation of information about events occurring at transfusion medicine sites.
3. [Medwatch Online Voluntary Reporting Form \(3500\)](#) -- The FDA Medical Products Reporting online form is available for the voluntary reporting of serious adverse events, potential and actual medical product errors, and product quality problems associated with the use of FDA-regulated drugs, biologics, devices and dietary supplements.
4. [Patient Safety Reporting System \(PSRS\)](#) -- A voluntary, confidential, non-punitive program available to all VA employees for the reporting of events and concerns related to patient safety.
5. [SafetyNet](#) -- A near-miss online reporting tool sponsored by the Association of Perioperative Registered Nurses (AORN).
6. [Vaccine Adverse Event Reporting System \(VAERS\)](#) --A cooperative program for vaccine safety of the Centers for Disease Control and Prevention (CDC) and the Food and Drug Administration (FDA). VAERS is a post-marketing safety surveillance program, collecting information about adverse events (possible side effects) that occur after the administration of US licensed vaccines.

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