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4 Ways to Improve Error Reporting and Save Lives

In 1997, Dr. Lucian Leape, a professor at the Harvard School of Public Health and a leader in the patient safety field, said, “The single greatest impediment to error prevention in medicine is that we punish people for making mistakes.”

INTRODUCTION

Dr. Leape's statement speaks to the importance of a "just culture," where organisations are nonpunitive in nature and instead determine culpability more thoughtfully through a series of evaluations and questions. In a just culture, people feel empowered to speak up about safety issues without the fear of punishment or retribution.

A just culture is critical for healthcare organisations. If employees aren't empowered to report errors and mistakes, then we can't learn from those mistakes. Unfortunately, the just culture model isn't widespread throughout the healthcare industry. In fact, although most organisations have incident reporting systems, hospital employees report only one out of seven errors, accidents, and other events.

Patient Safety Reporting Saves Lives

Too often, employees are afraid to come forward when an error is made because they worry it will result in negative repercussions. Across healthcare, nonpunitive response to error is among the lowest-scoring items on safety culture surveys. For example: In the 2021 AHRQ survey, 58% respondents agreed with this statement: “When an event is reported, it feels like the person is being written up, not the problem.” In the 2022 Press Ganey Employee Experience Survey, the statement received a 3.9 positive response (on a 5-point Likert scale).

“Fears of reprisal and punishment have led to a norm of silence,” Zane Robinson Wolf and Ronda G. Hughes write in Patient Safety and Quality: An Evidence-Based Handbook for Nurses. “But silence kills, and healthcare professionals need to have conversations about their concerns at work, including errors and dangerous behaviours of co-workers.”

Acknowledge Patient Safety Events to Learn From Mistakes

Organisations can't improve the processes in place unless leaders know where there are problems or systemic issues.

Take this hypothetical. Suppose an employee in a long-term care facility administers medication for a patient named **Maria** Johnson to a patient named **Marie** Johnson. Afterward, the employee realises their mistake and quickly reports the error so the appropriate care can be given to each patient. When leaders investigate, they learn that the medication had been labeled with only the patient's name and a medical record number from the contract pharmacy—and no other details (such as birthday) to correctly identify the right patient.

Press Ganey's workbook **"Zero Harm: First-Focus Fundamentals for Safety Culture Transformation"** outlines a starting point for establishing the tone for safety culture transformation. These known strategies and tactics to improve culture include leadership commitment to adopting a goal of Zero Harm and messaging on safety, measuring harm and making harm visible, fostering a fair and just culture, and practicing daily check-ins for safety.

Though the employee made a mistake, it was largely because of a systemic issue that could be remedied by ensuring medications were labelled with enough patient-identifying information.

Key Takeaways for Health Care Leaders

Healthcare leaders seeking to implement a just culture and ensure staff feel comfortable to report errors or mistakes should employ these four strategies.

1. **Make reporting easy.**

   Healthcare employees are busy. It takes time to stop what you're doing and make a report—even with the most state-of-the-art incident reporting system in place. While several software options can ease this burden, organisation leaders should also consider implementing other ways to make a report—via QR code link, text, 24/7 hotline, or email.

2. **Increase risk awareness.**

   Often, errors aren't reported because no harm to the patient occurred—so employees' perception of risk is relatively low. But just because a patient wasn't harmed in that instance doesn't mean the non-negative outcome will be the same if the mistake is repeated. Increase your employees' risk awareness by routinely sharing specific stories of how reporting helps the organisation prevent harm.

3. **Give people feedback.**

   A lack of feedback to employees who report mistakes is a barrier to reporting in the first place. When someone takes the time to report a safety incident, we need to follow up with a thank-you message and information on how the event is being handled—as well as the results. This should be done even if there wasn't a problem with the reported situation. In every situation, we must thank employees for speaking up for safety.

4. Offer support.

If an individual self-reports an error or mistake, they need support from leadership and colleagues. The majority of physicians, nurses, and other clinicians entered this field because of a desire to help and care for other people—and causing unintentional harm can be devastating. In Patient Safety and Quality, the authors write that many nurses "accept responsibility and blame themselves for serious-outcome errors." Whether through employee assistance programs, spiritual care, or other avenues, support should be given to employees.

Press Ganey works with healthcare organisations on their road to zero harm. We strive to reduce Serious Safety Event Rates® by 80% (or more) by 2025. Our team of safety consulting experts guides healthcare organisations along their path to improving patient and workforce safety. We can help your team nurture a safety culture and reduce preventable harm..

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