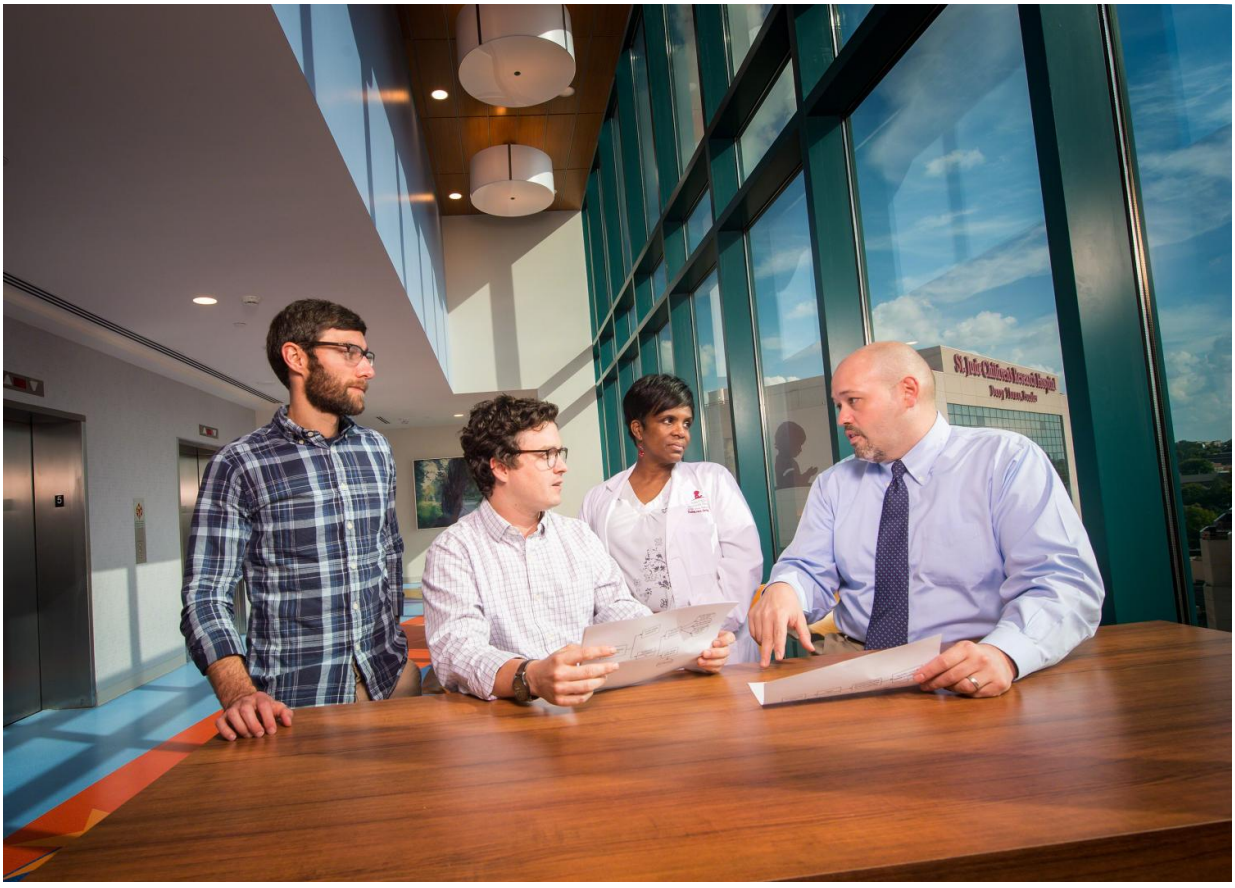
Patient safety benefits when hospitals provide feedback to staff who report errors

November 1 2016



(From left to right) Chris Spencer, first author Jonathan Burlison, Ph.D. and Lori Christion discuss aspects of patient safety with corresponding author James Hoffman, Pharm.D., the hospital's chief patient safety officer. Credit: St. Jude Children's Research Hospital / Peter Barta

Voluntary reporting by hospital staff of errors and patient safety events are a key source of information for improving patient care. A St. Jude Children's Research Hospital analysis suggests that to increase reporting, hospitals should focus on informing staff about how their previous reports have helped enhance patient safety.

"Identifying patient safety opportunities is a fundamental first step to preventing harm and improving patient care, which is why hospitals promote patient safety event reporting," said corresponding author James Hoffman, Pharm.D., an associate member of the St. Jude Department of Pharmaceutical Sciences and the hospital's chief patient safety officer. Patient safety events include mistakes with the potential to harm patients, even if no one is injured.

"Our results suggest that to increase voluntary reporting of all types of errors and patient safety events, regardless of the perceived severity, health care leaders should prioritize establishing feedback mechanisms that demonstrate to staff the value of information learned from the events reported," he said. The research appears today online in the *Journal of Patient Safety*.

The data analyzed by Hoffman and his colleagues came from a survey that hundreds of U.S. hospitals use to assess patient safety culture at the institutional and department or unit level. The survey was developed by the federal Agency for Healthcare Research and Quality, part of the U.S. Department of Health and Human Services.

The study included 2008-2011 data from 223,412 health care professionals working in 7,816 departments or units at 967 hospitals.

The survey asked respondents to indicate the likelihood that three types of patient safety events would be voluntarily reported: those caught before reaching the patient, those with no perceived potential for harm

and those with the perceived potential to cause harm. Previous research has shown that the more serious the error, the more likely it is to be reported.

To assess patient safety culture, the survey focused on 10 factors shown to reflect and influence the culture of patient safety. The factors include providing feedback to staff who report errors, the sense that past mistakes have led to positive changes, perceived management support for patient safety and the opinion of staff that their mistakes are not held against them.

Analytical methods were used to account for perceptions of patient safety culture at the departmental or unit and institutional levels.

Researchers reported that providing feedback about reported errors was the aspect of patient safety culture most strongly associated with voluntary reporting of errors, regardless of the perceived severity. Survey respondents were more likely to voluntarily report if they believed the hospital would try to prevent future errors by improving systems and process versus blaming individuals. Respondents were also more likely to report when mistakes lead to positive changes that are evaluated for their effectiveness.

"There is some prior research establishing the connection between patient safety culture and voluntary event reporting," said first author Jonathan Burlison, Ph.D., St. Jude patient safety project manager. "In this study, we were the first to consider how patient safety culture manifests itself at the unit/ work area level, as well as the institution overall, using a very large data set."

Added Hoffman: "For hospital leaders looking to increase event reporting, it may be as simple as improving mechanisms to increase feedback to staff who report events, such as thanking them for taking

time out of their day to file the report and communicating what is being done in response."

Provided by St. Jude Children's Research Hospital