Reporting of adverse events

Barriers to incident reporting

J Firth-Cozens

Staff must be encouraged to report less serious incidents and near misses as well as more serious errors if lessons are to be learned and patient safety enhanced

A key task in the enhancement of patient safety involves the ability to learn from error.[1] The cultural change needed to achieve this requires staff to report the errors and near misses they commit or see others commit, and to use these data appropriately to change policy and practice. In the UK the National Patient Safety Agency has been set up as a body for the collection of errors so that the lessons—written large at a national rather than a local level—can be appreciated more easily. However, this all depends upon errors being reported, and considerable research shows that this is very far from the case today.

The paper by Lawton and Parker in this issue of *QSHC*[2] is important in showing what types of errors are likely to be reported and by whom—which is useful if we are to bring about change where reporting is not taking place. It shows that nurses and, to a lesser extent, midwives are much more likely to report incidents than doctors; that reporting is more common where protocols are in place and not adhered to; and that reporting is also more likely to occur when patients are harmed by the error.

These results begin to show the ways in which errors are perceived by different groups. They show the importance of protocols, which govern nurses far more than they do doctors, and that near misses are likely to go unreported, as are errors which occur when staff have to improvise outside protocols. This means that the lack of formal recognition of these types of errors may therefore fail to provide the opportunity for the development of new guidelines in this less charted territory. The importance of using *all* types of error to bring about safer care needs emphasising to staff, but this can only be done in an atmosphere of trust.

We may be heartened by the finding that all staff are more likely to report errors that cause actual harm to patients. This may be because they see these areas as the most important to address. However, it is also true that reporting of such incidents is much more difficult to avoid than is the reporting of less serious errors or near misses. Ironically, it is probably easier to learn from incidents which cause only minimal or no harm to patients, and are therefore less emotionally charged, than from serious events which may be surrounded by guilt, anguish, and fear. Staff need to be encouraged to report incidents which lead to less serious outcomes, but this will only happen in a non-punitive atmosphere that allows innovation and learning to flourish.

Qual Saf Health Care 2002;**11**:7

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Medical error disclosure

Telling patients the truth: a systems approach to disclosing adverse events

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The best way to improve disclosure of adverse events to patients and their families is to create a system for overseeing disclosure that is an integral part of the healthcare organisation's patient safety programme

The best way to improve disclosure of adverse events (where the term "adverse event" means injury caused by the provision of health care rather than the patient's illness, whether or not the event resulted from a clearly identifiable error or mistake) to patients and their families is to create a system for overseeing disclosure that is an integral part of a healthcare organisation's patient safety programme. Cultural, legal, regulatory, and financial barriers prevent clinicians and healthcare organisations from disclosing adverse events,[1–3] despite the ethical obligations of clinicians and healthcare organisations to do so.[4–7] Applying a systematic continuous quality improvement model to disclosure of adverse events like the one proposed by Liang[8] in this issue of *QSHC* can help to overcome barriers to disclosure.

Effective disclosure of adverse events requires commitment to honesty and openness even when telling the truth may lead to loss of reputation, legal liability, or regulatory scrutiny. For clinicians the professional responsibilities of telling the truth and patient advocacy support disclosure of adverse events.[6 7] From an organisational perspective, successful disclosure systems require a willingness to put the interests of patients and families first, and to maintain transparency, honesty, and trust. Patient safety systems only work when there is an atmosphere that permits and supports open exchange of information, whether it is through reporting systems, disclosure, or investigation of the root causes of adverse events.[9] Disclosure of adverse events can enhance patient safety by reinforcing the values important to a culture of safety—honesty, respect, and transparency.

Disclosure partly depends on whether other parts of the patient safety system are working. It cannot occur unless adverse events are identified in a timely manner and brought to the attention of the disclosure programme. Without investigation of adverse events, it can be difficult to know what to disclose.

At the heart of an effective disclosure system are clear policies that provide