Iran J Public Health, Vol. 45, No.5, May 2016, pp.713-714

Letter to the Editor

Improving Medical Error Reporting: A Successful Experience from Iran

Firoozeh BAIRAMI [1], Yasamin MOLAVI TALEGHANI [2]

1. *Dept. of Health Management and Economics, School of Public Health, Tehran University of Medical Sciences, Tehran, Iran*
2. *Health Services Administration, Health Management and Economics Research Center, School of Management and Medical Information, Isfahan University of Medical Sciences, Isfahan, Iran*

***Corresponding Author:** Email: fbairami@student.tums.ac.ir

(Received 05 Jan 2016; accepted 15 Feb 2016)

Dear Editor-in-Chief

Medical errors are a common problem that make a massive burden on health care systems and often are avoidable with implementing effective patient safety policies. One of the main policies to prevent from repeating the medical errors is that health care workers (HCWs) should be informed about what happens as the harm or near miss errors in hospital by their peers (1). To address such errors the patient safety team should know about the frequency, severity, and causes of medical errors and this would be possible through reporting (2). In spite of universal action to persuade people working in hospitals that reporting errors is the first step toward controlling them, yet the rate of medical errors reporting is very low. HCWs fear to report their errors due to further feedbacks of their peers and managers including reprimand, legal actions, and deterioration of their professional image at work.

We hypothesized that improving the culture of error reporting can be helpful through a change agent. Therefore we employed a new staff in a reference pediatric hospital as a change agent. The delegate was taught to be active, patient and run every ward in a day to ask if any error has been happened (even any minor ones) in the last 24 h. If their response was no, then she would give them options of some possible errors with using a self-constructed medical error form, like "didn't you have any fall, medication error or a bad phlebotomy in the last 24 hrs.?" and through this discussion she could obtain some error reports.

This method was conducted for one month. During this period the reporting increased from monthly average of 11 error reports before the start of intervention to 34 in the first intervention month.

After the first month the change agent asked from HCWs to bring their error reports to her office and she also run wards every week to make sure there is no hidden error in wards. In second month the number of reports was increased to 54. We observed the rate of error reports for 15 months with this method and the results showed that after month four when the HCWs saw managerial supports, lessons learnt from reported medical errors and practiced root cause analysis, the rate became steady with average of 55 medical error reports for every month.

A change agent can be effective in changing the culture of medical error reporting and imbed this culture in system's body to improve error reporting.

Acknowledgements

The authors declare that there is no conflict of interests.

References

1. Murphy JG, Stee L, McEvoy MT, Oshiro J (2007). Journal Reporting of Medical Errors: The Wisdom of Solomon, the Bravery of Achilles, and the Foolishness of Pan. *Chest,* 131:890-896.
2. Kaldjian LC, Jones EW, Wu BJ, Forman-Hoffman VL, Levi BH, Rosenthal GE (2008). Reporting medical errors to improve patient safety: a survey of physicians in teaching hospitals. *Arch Intern Med*, 168 (1):40–46.