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Abstract

Background: Medical errors frequently occur in health care facilities, jeopardizing patient safety and increasing associated costs.

Aims: This cross-sectional investigation examined the rates of and reasons for non-reporting of medical errors at Nemazee Hospital, Shiraz, Islamic Republic of Iran.

Methods: Self-administered questionnaires were completed by 283 staff members, including physicians, nurses and medical students. One-way analysis of variance, Fisher's least significant difference post hoc, Spearman correlation coefficient and intraclass correlation tests were used for statistical analyses.

Results: Almost all (95.8%) participants had observed at least 1 medical error during the previous year, with over half (50.5%) observing 3–10 errors. The preferred method for reporting medical errors among physicians and medical students was verbal and informal (40.3% and 41.8% respectively), while nurses preferred written forms (45.7%). The results indicated significant differences between groups concerning individual and organizational barriers in general, and among all sub-categories (P

Conclusion: Concerns of legal entanglements and confidentiality issues were recognized as the main barriers to reporting medical errors.

Keywords: medical errors, non-reporting, patient safety, hospitals, health care workers

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Introduction

More than 16 years after the landmark report by the Institute of Medicine, serious concerns about patient safety continue to exist (1–3). Medical errors are estimated to be the third leading cause of death in the United States of America (4). There have been 4 major studies conducted since the Institute of Medicine study concerning deaths associated with medical errors.

Together they cover over 37 million patient admissions with a 3.1% rate of adverse events and a 0.7% mortality rate (5–7).

Efficiency, security of care, care giver reactivity and patient contentment are safety parameters that are at the core of health care quality (3). The most crucial factor, however, is a comprehensive understanding of medical errors (8). Gathering meticulous evidence via transparent incident reporting, free sharing of data and the creation of a culture of learning from our mistakes are indispensable in the development of medical error reduction plans and improving patient safety (2,5,9). The backbone of the movement towards an enhanced culture of safety is a well-organized error reporting system (10).

A survey in 6 South Australian hospitals reported that even though 98.3% of respondents were aware of their facility's incident reporting systems, more than 40% had never filed a report (11). Another study reported 84.3% of 338 internal medicine physicians and residents believed that reporting medical errors improved quality. However, their rate for reporting minor errors was only 16.9% and for major errors 3.8% (12). Understanding the multiple factors that influence reporting errors among health care workers is crucial to supplying missing elements of an effective communication programme. Such barriers can damage the transparency of a safety climate and a culture of learning from errors (8,13,14).

A perfectionist belief is that only poor physicians make mistakes (2,13). Several studies indicate that there is a lack of knowledge concerning reportable incidences. Many physicians and nurses often do not consider near misses and medication omissions as being reportable (2). In one study, 25% of participants did not know how to retrieve their facility's incident reporting form (11).

At the institutional level, the safety climate often determines front-line provider attitudes (13). Loss of malpractice insurance coverage, fear of punitive actions, time constraints, poorly designed reporting systems, negative feedback, lack of confidentiality and a power hierarchy within professional groups are factors that negatively affect error reporting (2,8,13,14). Other factors can be even more specific, such as fear of disciplinary action and threats to positive evaluations and promotion, especially among nurses (2,13,15).

In a study of 20 hospitals in the north of the Islamic Republic of Iran, 182 (0.06% of 317 966 admissions) medical errors were reported. The lack of a reliable reporting system, negative attitudes toward reporting among staff and managers and a punitive culture were mentioned as

the potential causes (16). The rate of non-reporting was estimated at 78.9% within the nursing staff of a teaching hospital in Kermanshah (17). There were comparable results in 2 other independent surveys among nurses at Imam Khomeini Hospital in Tehran (18,19).

Barriers to medical error reporting were investigated among health care providers in the Islamic Republic of Iran in 2012. The study reported a high incidence of mishaps with lower rates of reporting (