



VITALS

A Weekly Safety Newsletter For Medical Transport Professionals

Mike Szczygiel (Segal)
888-969-8033
meszczygiel@thomcoins.com

Error Reporting: It's Not Just Medications

The Institute for Safe Medical Practices (ISMP) has identified error reporting systems as one of the processes that help us learn about:

- *Potential Risks*- hazards that are hidden in processes
- *Actual Errors*- mistakes that have actually happened
- *Causes of Errors*- flaws in systems or processes that explain why the error occurred
- *Error Prevention*- stop events from occurring and recurring



Although error reporting in this context was originally intended to deal with medication errors, it has great applicability in any safety context, even safe-driving. Are we willing to report our mistakes that cause "near misses"? When it comes to driving, most of us have a natural tendency to not recognize our driving errors. If we don't recognize them, how can we admit them? The ISMP describes six characteristics of a good error reporting system.

Trustworthy - Can reporters trust that the people that receive the error reports will act on them by assessing system-not personnel-performance? Can workers trust that they won't be judged or treated unfairly?

Confidential - Do we keep the identity of the reporter, the workers and the location confidential to minimize embarrassment? Remember event reporting can be confidential without being anonymous. If the report is anonymous, how can you do adequate follow ups?

Clear and Easy - Keep the format and the length of the report reasonable and practical. If you're not going to do something with information, don't ask for it. When possible, accept oral, written and electronic submissions.

Rewarding - Do something with the information you receive to make your organization safer and let everybody know about it.

Credible and Useful - Your response should be timely. Don't let delays diminish the effectiveness of your response by moving so slowly that you appear inactive.

Reinforced Imperative - Make sure there are mechanisms in place so that new staff is mentored and brought into the error reporting process.

Take a look at or think about your most recent crashes. Do they have characteristics that might have been better recognized if similar situations were reported as near misses? Could the use of error reporting have been an early warning system that could have prevented the crash?