Improving the culture of safety through an online incident reporting system: a national project

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Background and Purpose

The project involved the hospital pharmacists association network in collecting incident reports near misses related to drugs and medical devices. There are evidences that by reporting errors and analyzing error patterns there could be a reduction in Medication Errors (MEs).

Our aim was to improve safety culture through the development of an online national Incident Reporting System (IRS) in order to decrease potential MEs and increase patient safety.

Material and methods

We performed a literature review of IRSs. We created our national IRS that is available online on our national hospital pharmacists association website. It is composed of three sections (contest; details; causes and consequences). MEs submission is anonymous to guarantee submitters confidentiality. Periodically MEs report is published on the website to implement the knowledge of potential MEs. MEs reported between October 2011 and September 2014 were collected and analyzed. We evaluated the severity of the errors reported using American National Coordinating Council for Medication Error Reporting and Prevention Index (NCCMERPI), that classifies errors in 9 categories according to the severity of caused harm (with increasing severity from A to I).

Results

From quantitative data analysis it comes out that all reports (69 valid out of 84) were referred to drugs and the majority of MEs was head off by pharmacists (50.7%). The riskiest phases turn out to be administration (52.2%), followed by prescription (29%) and distribution (8.7%). From NCCMERPI analysis comes out that the majority of MEs reported is classified in C category (39.1%).

Conclusion

Incident reports collected suggest to increase check phases (double check) over drug’s cycle and to develop specific checklists. We mostly should sensitize healthcare professionals to improve incident reporting. We need to perform specific initiatives on medical devices potential errors because of lack of reporting on this important category.


Keywords: medication errors; incident reporting system; patient safety.