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Resident Doctors Attitude and Behavior towards Medical Error Reportingin A Tertiary Care Teaching Hospital

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Abstract
INTRODUCTION
Medical errors are one of the most important quality problems in health care today. A medical error *is a preventable adverse effect of care whether or not it is evident or harmful to the patient. Reporting errors is fundamental to error prevention[1]. Reporting both errors and near misses has been key to improve safety. It sets up a process so that errors and near misses can be communicated to key stakeholders. Once data are compiled, health care agencies can then evaluate causes and revise and create processes to reduce the risk of errors.*
A crosssectional descriptive study was done by adopting a 27 itemed questionnaire regarding the opinion of resident doctors working in tertiary care teaching hospital about improving patient safety by reporting medical errors.Data was analyzed using Microsoft Excel 2007 version statistical software. Period of the study was from May 2019 to July 2019.
Key Words: *Patient safety, Medical error, error reporting, quality patient care*

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I. Introduction:

A medical error is a preventable adverse effect of medical care, whether or not it is evident or harmful to the patient.High error rates with serious consequences are most likely to occur in intensive care units, operating rooms, and emergency departments. Medical errors are also associated with extremes of age, new procedures, urgency, and the severity of the medical condition being treated.Among the problems that commonly occur during providing health care are adverse drug events and improper transfusions, misdiagnosis, under and over treatment, surgical injuries and wrong-site surgery,falls, burns, pressure ulcers, and mistaken patient identities.*Medication error is a part of medical error* which is an error (of commission or omission) at any step along the pathway that begins when a clinician prescribes a medication and ends when the patient actually receives the medication.

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II. Aims And Objectives:

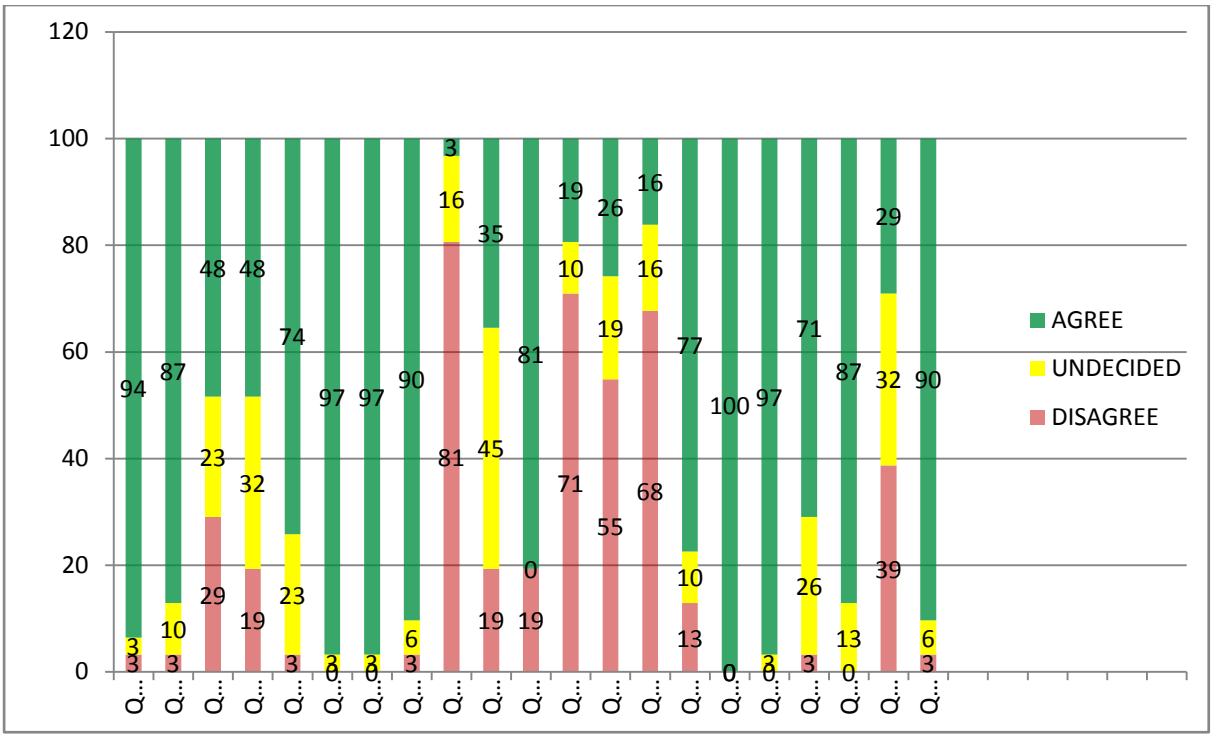
To assess the knowledge and attitude of resident doctors towards importance of reporting medical errors in improving patient safety.

III. Methodology:

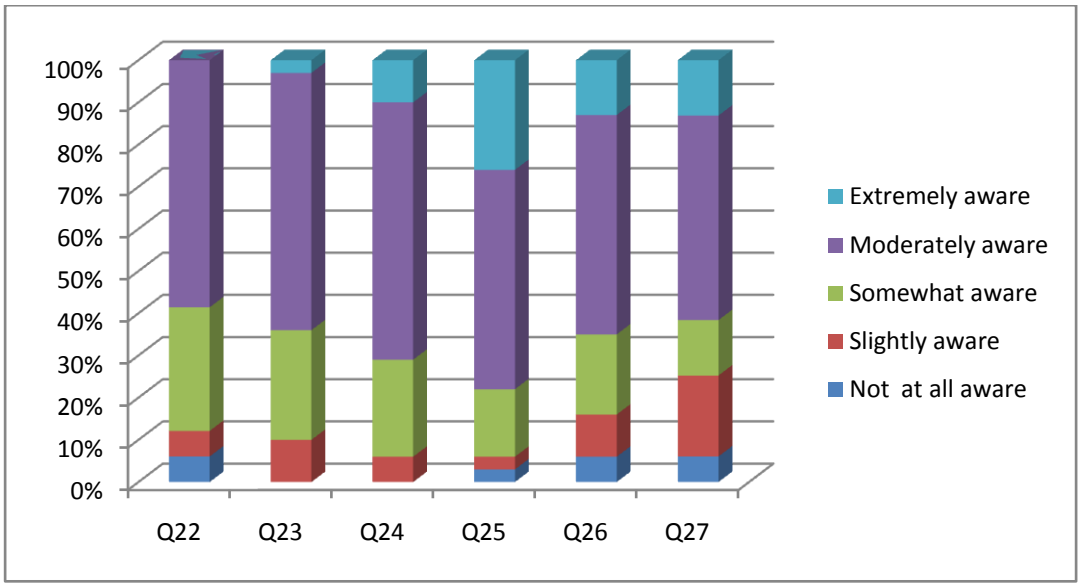
A cross-sectional descriptive study was conducted in the year 2019 among the postgraduate students of tertiary care teaching hospital. Subjects were fully informed aboutthe design and purpose of the study. A verbal informed consent was obtained from each participant and anonymity of the participants was maintained throughout the study. Data was collected on a pretested structured questionnaire distributed among these students, and they were asked to fill the questionnaire. Questionnaire was taken from British Medical Journal (attitude to patient safety questionnaire) . Questionnaire consisted of questions to assess the knowledge and attitude towards the importance of medical error reporting in improving patient safety. Data was analyzed using Microsoft Excel 2007 version statistical software. Period of the study was from May 2019 to July 2019.

IV. Results And Discussion

Current study sought to explore the knowledge, attitude and practices of post graduate resident doctors towards improving patient safety by reporting medical errors in a tertiary care teaching hospital. About **94%**of resident doctors agree that the present training is preparing to understand the causes of medical errors. Only **48%** of students agree that they feel comfortable reporting any errors they had made, no matter how serious the outcome had been for the patient. Remaining**23%** students remain undecided.**48%** feel comfortable reporting errors their peers had made. About **97%** of students strongly agree that by not taking regular breaks during shifts, doctors are at increased risk of making errors. **90%**of residents agreethat even the most experienced and competent doctors make errors.Only **35%** agree that most medical errors result from careless nurses. Remaining **45%** remain undecided depending on the situation. **81%** agree that if people paid more attention at work, medical errors would be avoided.**71 %** disagreethat most medical errors result from careless doctors**. 55%** disagree that medical errors are a sign of incompetence. About **68%**disagree that it is not necessary to report errors which do not result in adverse outcomes for the patient. Only **77%** agree that all medical errors should be reported.**100%** agree that better multi-disciplinary teamwork will reduce medical errors.**71 %** agree that patients have an important role in preventing medical errors and opine that encouraging patients to be more involved in their care can help to reduce the risk of medical errors occurring. Only **39%** agree that patient safety issues cannot be taught and can only be learned by clinical experience when qualified.**90%**agree that learning about patient safety issues before I qualify will enable me to become a more effective doctor.



58 % of residents are moderately aware of different types of human error. **3%** opine that they are well aware and **61%** are moderately aware of factors contributing to human error. **61%** are moderately aware of factors influencing patient safety. Only **26%** resident doctors are well aware and **52%** are moderately aware of what should happen if an error is made. Only **13%** are very well aware **52%** are moderately of how to report an error. **48%** are moderately aware of the role of healthcare organisations (e.g. hospitals, general practitioners) in error reporting.



There are many reasons for avoiding error reporting, including legal and institutional concerns, as well as personal guilt and regret. Other examples are damage to professional prestige, risk of job loss and fear of getting reprimanded or questioned [4, 5]The IOM (Institute of medicine US)defines two types of error reporting systems mandatory and voluntary reporting of health care errors. Reporting systems that focus on safety improvement are "voluntary reporting systems." The focus of voluntary systems is usually on errors that resulted in no harm (sometimes referred to as "near misses") or very minimal patient harm. Reports are usually submitted in confidence outside of the public arena and no penalties or fines are issued around a specific case[3].

Mandatory reporting systems should focus on detection of errors that result in serious patient harm or death. Adequate attention must be devoted to taking appropriate follow-up action to hold health care organizations accountable[2].

Physicians traditionally use a Morbidity & Mortality (M&M) conference format for reporting and discussing unsafe situations and adverse events, especially in academic teaching hospitals and schools where young trainees are taught[3].

V. Recommendations

- Adopting a simple and easy-to-use reporting system can be an obvious key to success.
- More recent approaches have been focusing on increasing and simplifying error reporting, and automating the detection of errors, including creating Web-based forms or adapted standard spreadsheets to reveal patterns of errors.[6]
- Eliminating extended work shifts for resident doctors can reduce serious medical errors.
- Creating a non -punitive reporting environment will not only lead to increased error reporting, but it can also help you look for potential breakdowns in the process.[7]
- Using checklists and other tools to make sure nothing's missed during handoff conversations is crucial to preventing mistakes.
- Encouraging patients to be more involved in their care can help to reduce the risk of medical errors occurring.
- Both financial and non-financial incentives to employees who reported errors are a highly effective form of encouragement that works quite well.
- A periodic review meeting to be held to discuss various types of medical errors and ways to prevent them.
- Feedback of the patient safety data, and what was being done with the data, made it easier to identify gaps in care and implement improvement initiatives.

VI. Conclusion

As less than halfof resident doctors feel comfortable to report errors, embracing a non-punitive culture and institutionalizing a culture of safety would encourage medical error reporting. Combined responsibility of patient, nursing staff and the doctors could help in reducing errors. All medical errors and near misses need to be reported. To err is human[8], even the most competent doctors commit errors. Medical errors need not be treated as a sign of incompetence, instead quality improvement efforts supported by shared learning will prevent similar

future errors. Proper training of different aspects of medical error reporting is advised as most of the resident doctors are moderately aware of these issues. Heavy workload on resident doctors increases the risk of making errors, regular breaks during shifts will improve quality patient care. Learning about patient safety issues before qualifying will enable to become an effective doctor.

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