ANALYSIS PAPER

Reporting on Patient Harm and Workplace Violence: Barometers of Safety Culture

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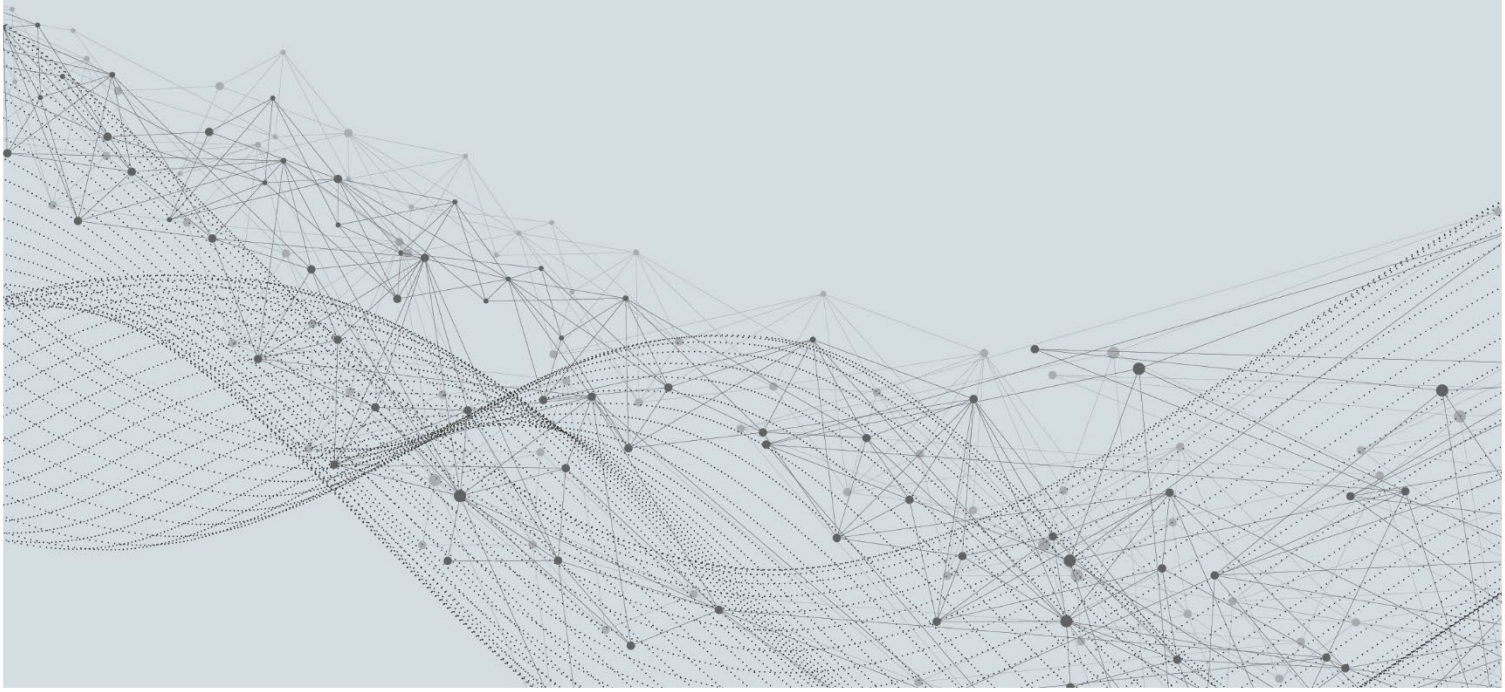

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Leadership in quality and patient safety

EXECUTIVE SUMMARY

A hospital's ability to provide quality care is dependent on ensuring a safe environment for both patients and staff. To achieve patient safety and employee well-being, it is essential for the hospital to effectively identify and study incidents of patient harm and workplace violence. Yet in many organizations, these important indicators go severely underreported.

KEY POINTS

- Hospital staff tend to underreport both patient harm and workplace violence.
- Hospitals cannot build a true culture of safety without dependable reporting.
- Capturing near misses presents an especially valuable — and often untapped — opportunity for hospitals.

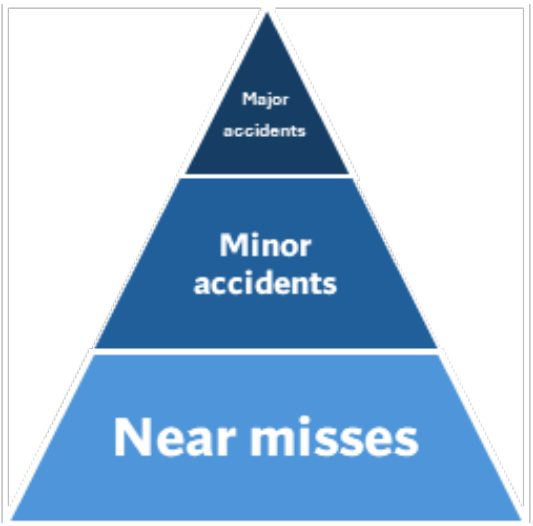
Underreporting of Patient Safety Events

While medical errors are estimated to be the third leading cause of death in the United States, there is evidence that significant patient harm goes underreported in hospital incident report systems. A 2018 study of hospital adverse events found that incident reporting systems captured fewer than 10% of all the adverse events detected by the Global Trigger Tool (BMJ Quality & Safety, 2018). This has confirmed the previous estimates by the Office of Inspector General that hospital incident reporting systems captured only 14% of patient harm events experienced by Medicare beneficiaries (DHHS, Office of Inspector General, 2012).

Such underreporting of safety events has negative implications on multiple levels. Most hospitals submit their (privileged and confidential) patient safety event data to a Patient Safety Organization (PSO) such as HQI's Collaborative Healthcare Patient Safety Organization (CHPSO). PSOs, in turn, aggregate and analyze the hospital data to identify patterns, facilitate shared learning across hospitals, and develop strategies for enhancing patient safety. Any gaps within a hospital's own reporting system will transfer directly to data gaps at the level of their PSO, thus reducing the PSO's ability to assist hospitals with improvement. The better the incident reporting within a hospital, and the better the hospital's reporting to its PSO, the more salient and valuable the PSO's insights will be.

A look into near misses is especially significant in this regard. Almost a century ago, Herbert W. Heinrich conducted research into industrial accidents and found that the ratios of near misses, minor accidents, and major accidents almost always remained constant.

Heinrich's concept of a "safety triangle" (shown at right) has since been applied in various industries — including health care — illustrating that there are far more possibilities to learn from near misses and minor accidents than there are from major accidents that occur only rarely. Consequently, one might assume that hospital incident reporting systems contain more near misses than events of actual harm.

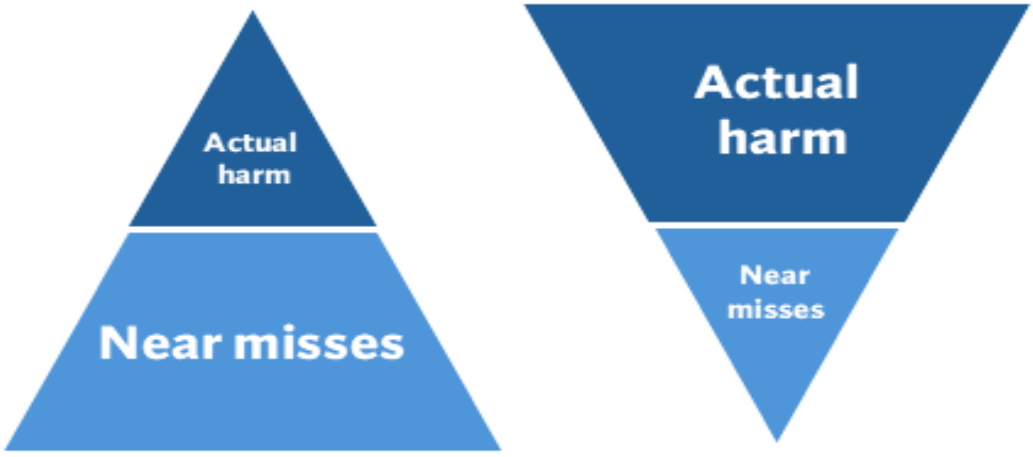


However, there is published evidence refuting this supposition. A 2022 study, for example, found that — in the same cohort of patients — very few near misses were captured in incident reports when compared to the number discussed in daily safety briefings (7.8 vs 31.9 near misses per 1,000 patient days, respectively.)

To examine the veracity of Heinrich's "safety triangle" concept within CHPSO's dataset of several million safety events reported by member hospitals, HQI conducted a study of the frequency of near-miss reports compared to the reports of actual harm. The results showed that when it comes to incident reporting systems, near misses were vastly outnumbered by the actual harm events: only 11% of all reported events were near misses; and a full 45% of all facilities that reported safety events into CHPSO have never reported a near-miss event.

Therefore — assuming that CHPSO aggregate findings mirrored the reporting patterns at the hospital level — our study revealed that when it comes to reporting hospital safety events, Heinrich's "safety triangle" has been turned upside down.

Safety Event Reporting — Ideal State **vs.** **Safety Event Reporting — Reality**



While underreporting of actual harm has obvious negative implications for a hospital's ability to learn from its data and improve patient safety, the finding that near misses are even less likely to be reported represents a valuable, yet largely untapped, opportunity for hospitals. By increasing the reporting of near misses, hospitals have a chance to unmask various threats to safety before they actually materialize. This is a way to learn, improve, and prevent future harm — all without any actual harm occurring. As Lucian Leape once remarked, "the reporting and analysis of near misses provide an invaluable opportunity to improve patient safety. Near misses are often early warning signals of system weaknesses that, if addressed, can prevent actual adverse events."

Underreporting of Workplace Violence

Workplace violence is ubiquitous in hospitals and has been on the rise in recent years. A recent study (2024) by Joanne DeSanto Iennaco and colleagues found that, on average, hospital staff experience one aggressive event for every 40 hours worked.

Links between workplace violence and patient safety are deep. A study by Kim, et al (2023) found that nurses who reported being subject to more workplace violence were more likely to experience burnout and more likely to assign a low patient safety rating to their unit. From disruptions in care delivery to staffing shortages, from provider disengagement to distress

and burnout in the workforce, from communication breakdowns to creating an atmosphere of fear, tension, and insecurity, workplace violence poses significant risks to patient safety, staff well-being, and organizational integrity.

However, while it jeopardizes both the wellness of the workforce and the quality of patient care, workplace violence also tends to be widely underreported by the hospital staff. Formally reported incidents often capture only the most serious events that require time off for medical attention and/or recuperation. In one study, only 12% of healthcare workers who had experienced a violent event in the past year said they had reported it (Arnetz et al., 2015); another study estimated that only about 19% of incidents were officially reported (Pompeii et al., 2016).

Underreporting of workplace violence makes its prevalence harder to estimate, undermines the potential for developing and deploying effective prevention strategies, and makes the impact of interventions difficult to measure. It also diminishes the ability of hospitals to obtain public and legislative support for the resources and measures needed to curb workplace violence.

A Culture of Safety Is a Culture of Reporting

A strong culture of safety reflects a hospital's commitment to protecting both patients and employees from harm. Reporting is at the foundation of such a culture. Complete and accurate reporting of harm, near misses, and workplace violence provides an opportunity for early identification of vulnerabilities in systems and processes, for better understanding of why events occur, and for deploying more effective improvement strategies. Ultimately, strong reporting into a hospital's incident reporting systems suggests that the hospital is a place where staff members feel empowered to identify, flag, and address potential risks proactively without fear of reprisal.

Barriers to Reporting

Common factors for underreporting include the following:

- Inconvenience/Time Constraints: Busy hospital staff working under high-stress conditions could perceive reporting as overly time-consuming and difficult to do. Reporting systems that are seen as cumbersome, time-consuming, or inefficient can deter staff from documenting incidents.
- Perceived Lack of Value: Staff may see reporting on patient safety and workplace violence as unnecessary or unimportant, especially if no physical harm occurred to either the patient or the staff. In addition, if events were reported in the past but no feedback was provided and there was no visible response, employees could perceive that reporting does not lead to improvements, which could further demotivate them to report future events.
- Culture of Blame and Fear of Reprisal: A punitive approach can discourage disclosure, transparency, open communication, and learning from mistakes. In environments characterized by blame, where individuals are commonly held accountable for systemic issues, staff may be reluctant to report safety concerns because they are afraid of being punished, scapegoated, and stigmatized. This can affect reporting of patient safety events as well as workplace violence.
- Concerns About Reputation: Hospital staff may be hesitant to report issues due to concerns about reputational damage, liability, or public scrutiny. There may be a tendency to prioritize protecting the organization's image over transparently acknowledging and addressing safety concerns.
- Normalization of Deviance: When certain unsafe behaviors or practices are tolerated or overlooked over time, healthcare workers may become desensitized to them and perceive them as routine or inevitable occurrences. This normalization of deviance can lead to complacency and a lack of urgency in reporting and addressing unsafe practices or violence in the workplace. An additional factor for nonreporting of workplace violence is a prevalent

cultural belief among health care workers that a certain amount of violence should be accepted as simply "part of the job." This is further complicated by the challenges of holding patients who are not in their "right mind" accountable for their actions (e.g., patients under the influence of drugs or alcohol or individuals suffering from mental illness, cognitive impairment, dementia, or delirium).

- Confusion About Definitions: Without a clear set of guidelines, staff may not understand what qualifies as a patient safety event to be reported. Likewise, varying definitions can also be at play in creating ambiguity about what is reportable workplace violence (e.g., verbal abuse, bullying, threats, physical assault, etc.). Incidents with no physical injury or time lost, for example, may be seen by staff as not reportable.

Strategies to Increase Reporting

To increase reporting, hospitals must address the above barriers while at the same time — at all levels of the organization — intentionally socialize the values of continuous learning, open communication, psychological safety, and trust. Specific strategies include the following:

- Educating Employees:
    - Increase employee awareness of patient safety near misses and why reporting them can make care safer.
    - Emphasize that addressing workplace violence is a top organizational priority, clarify various forms of workplace, firmly establish that no violence is acceptable, and train employees on the reporting systems and protocols.
- Reducing the Burden of Reporting:
    - Simplify and streamline reporting processes to make it easy and more efficient for employees to report.
    - Demonstrate to employees that their reports are valued by providing paid time and workload adjustments to enable submission.
    - Encourage employee feedback about the existing reporting systems/protocols and involve them in co-designing improvements.
- Building a Just and Learning Culture:
    - Help staff feel comfortable and encouraged to report on patient harm, near misses, and workplace violence without fear of blame, shame, retaliation, or punishment.
    - Focus on illuminating systemic issues rather than individual mistakes.
    - Emphasize the organization's commitment to learning from reports to prevent future safety events.
- Providing Feedback and Follow-Up:
    - Provide timely feedback to staff who report near misses and thank them for reporting.
    - Ensure corrective actions are taken to address the underlying issues.
- Leading From the Top:
    - Leadership support can make or break any improvement initiative. Leaders at all levels of the organization should actively support staff reporting.
    - Implement safety walkrounds in which senior leaders regularly discuss safety concerns with front-line staff during all shifts and days of the week. Implemented well, such rounds can help change the culture from blame to praise for identifying and reporting safety concerns.
    - Allocate adequate resources to support stronger reporting.

CONCLUSION

In summary, underreporting weakens hospitals' efforts to build a culture of safety. Increasing the reporting of patient safety events and incidents of workplace violence will strengthen patient and employee safety.

ABOUT US

The Hospital Quality Institute (HQI) is dedicated to advancing patient safety and quality of care for all Californians. Through strategic partnerships and innovative programs, HQI supports hospitals in achieving excellence by providing data analytics, educational resources, and statewide initiatives focused on performance improvement. HQI oversees and coordinates the Collaborative Health Care Patient Safety Organization (CHPSO).