Survey on Medical Error Reporting Systems in Korean Hospitals

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Abstract

Background: Recent data suggest that medical injuries, or adverse events, represent an important international problem, and that many are caused by errors. Spontaneous reporting is the main tool used to detect errors and adverse events in most countries, and reporting systems are believed to be important for improving patient safety. Increasingly, such reporting can be done using information systems, and information systems are widely used in Korea. However, few data are available regarding the use of electronic medical error reporting systems in Korea.

Objectives: The objectives of this study were to investigate the present status of reporting system of Korean hospitals, and to compare the current status of medical error reporting systems with that of other health information sub systems.

Methods: The chairs of nursing departments of all 283 hospitals nationwide with more than 100 beds were surveyed using a structured questionnaire. The response rate was 35%. In addition, 2 reports on the national use of health information systems in Korea from 1999 and 2003 were analyzed.

Results: Among reporting hospitals (n=99), medical errors were reported on paper in 75 hospitals (77%), verbally in 30 hospitals (30%), using word processing in 13 hospitals (13%), and using the hospital information system in only 3 hospitals (3%). In contrast, there was widespread and increasing use of health information technology (HIT) in areas such as medication administration, inpatient and outpatient order entry, and radiology.

Conclusions: While HIT is increasingly widely used in Korea in many areas, it is not being used for error reporting. Increasing the use of electronic reporting systems, and systemically evaluating the medical errors and adverse events reported, represent essential steps for reducing systemic errors and improving patient safety.

Key words: safety, medical errors, hospital information system (HIS), hospital incident reporting