

Toward learning from patient safety reporting systems.

January 12, 2011

Pronovost P, Thompson DA, Holzmueller CG, et al. Toward learning from patient safety reporting systems. J Crit Care. 2006;21(4):305-15.

<https://psnet.ahrq.gov/issue/toward-learning-patient-safety-reporting-systems>

This study reports the initial findings from a voluntary, Web-based patient safety [incident reporting](#) system for intensive care units (ICUs). The [system](#), developed through funding by the Agency for Healthcare Research and Quality (AHRQ), collected data on incidents that could have resulted in patient harm. During the study, more than 2000 reports were filed from 23 participating ICUs. A substantial minority (42%) of incidents led to patient harm, and most had multiple contributing factors, such as deficiencies in training or teamwork. The authors note that the science of incident reporting systems is still in its infancy and recommend that future research should study how to use incident reporting data to improve patient safety.