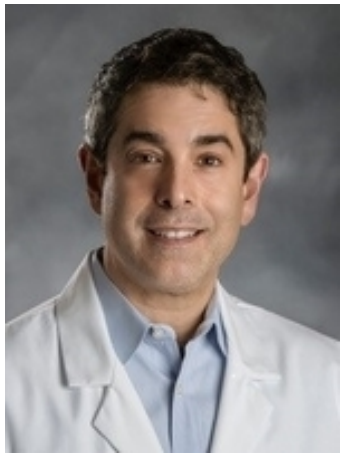
Developing a Reporting Culture Webinar

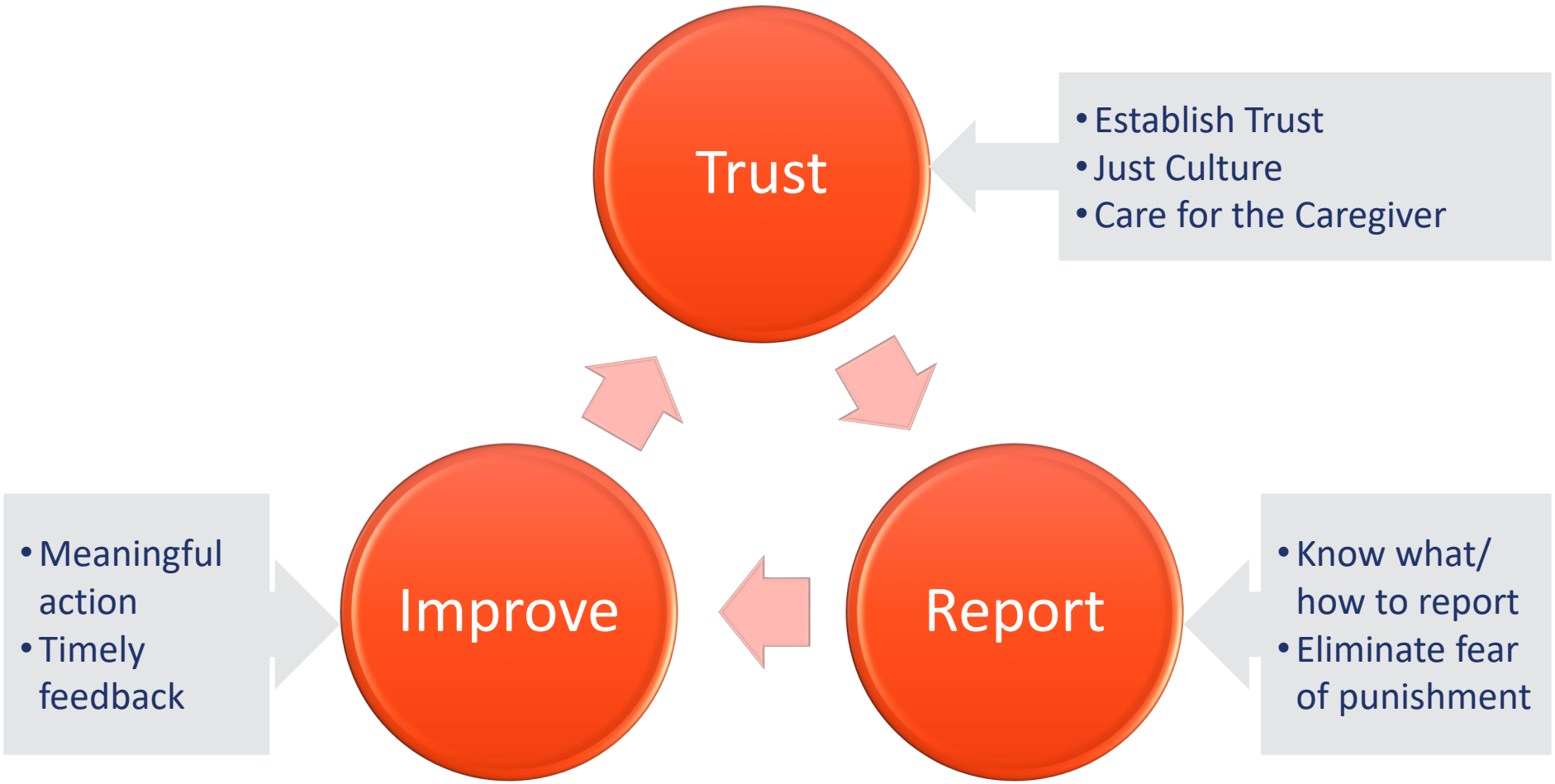
Dr. Edward Pollak, medical director and patient safety officer, The Joint Commission

Erin Lawler, MS, CPPS, human factors engineer, Office of Quality and Patient Safety, The Joint Commission



May 2019

The Joint Commission



The Joint Commission

"We Must Be Curious About the "Why"…..

- Human Factors and Systems Thinking:
  - What is there about the system that allows a person to commit an error
    - What were/are the conditions?
    - What were/are the pressures?
    - What were/are the drivers?
    - Why did an action make sense at the time?
  - Consider people, place, tools/technology, process, interactions, norms, organization
- How can we design a system that is supportive of its users

The Joint Commission

Sentinel Event Alert

A complimentary publication of The Joint Commission

Issue 60, Dec. 11, 2018

Developing a reporting culture: Learning from close calls and ha… …itions

While a pharmacy technician was preparing a pediatric nutritional solution, a two-liter sterile water bag she was using ran out. She obtained another bag that she presumed also was sterile water but was instead a similar looking bag containing Travasol, a highly concentrated amino acid that should not be used on pediatric patients. She proceeded to prepare the nutritional solution with the Travasol. As the incorrect solution was being delivered to multiple locations, she realized that she hung the wrong bag.

"For a few seconds, I couldn't move, I felt panicked," she remembered. "I went to my pharmacist right away and I told her I made a mistake, a big mistake." The deliveries were stopped, and all the bags were retrieved prior to reaching any patients. Later, using an objective accountability assessment tool to determine how the error occurred, hospital leaders determined that the error was a system error and not a blameworthy act. The system error was fixed, and rather than being punished, the pharmacy technician was consoled and thanked for reporting her mistake and saving the lives of patients. "I didn't care what happened to me; I cared about what would happen to the patients," she said.[1]

Establishing trust is essential to improving reporting

The pharmacy technician trusted that her organization would fairly assess the causes of the close call and make just decisions without undue punitive action. Her story is an excellent illustration of the need to thoroughly evaluate all adverse events, particularly close calls (also called near misses or no-harm events) and hazardous conditions, and to use lessons learned from them as opportunities for quality and safety improvement.

Leaders* can help create the personal responsibility demonstrated by the pharmacy technician by establishing trust and clear performance expectations among employees within a psychologically safe environment in which there is no fear of negative consequences for reporting mistakes.[2] When staff report close calls and hazardous conditions, leaders can act by addressing concerns, resulting in improvement and safety.

Published i… accredited or… interested … professionals, *Sentine… Alert* identifies specific types … sentinel and adverse events and high risk conditions, describes their common underlying causes, and recommends steps to reduce risk and prevent future occurrences.

Accredited organizations should consider information in a *Sentinel Event Alert* when designing or redesigning processes and consider implementing relevant suggestions contained in the alert or reasonable alternatives.

Please route this issue to appropriate staff within your organization. *Sentinel Event Alert* may be reproduced if credited to The Joint Commission. To receive by email, or to view past issues, visit www.jointcommission.org.

Identifying and reporting unsafe conditions before they can cause harm, trusting that other staff and leadership will act on the report, and taking personal responsibility for one's actions are critical to creating a safety culture and nurturing high reliability within a health care organization.

Download at: https://www.jointcommission.org/sentinel_event.aspx