Sentinel Event Alert

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Developing a reporting culture: Learning from close calls and hazardous conditions

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.

Every year, The Joint Commission receives reports from health care staff of unsafe conditions in their organizations. The majority of these reports indicate that leadership had not been responsive to these and to other early warnings, even though their response may have prevented harm events from occurring. Typically, the most serious of these reports lead to an on-site evaluation by The Joint Commission.

Published for Joint Commission accredited organizations and interested health care professionals, *Sentinel Event Alert* identifies specific types of 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.

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*The Joint Commission accreditation manual glossary defines a leader as "an individual who sets expectations, develops plans, and implements procedures to assess and improve the quality of the organization's governance, management, and clinical and support functions and processes. At a minimum, leaders include members of the governing body and medical staff, the chief executive officer and other senior managers, the nurse executive, clinical leaders, and staff members in leadership positions within the organization."

The Joint Commission

However, the inaction of organization leadership to staff reports of unsafe conditions demonstrates an unacceptable complacency toward risk. This kind of culture seeps down to the front lines where a "no harm, no foul" attitude may leave a near miss or at-risk behavior unreported, fostering conditions that may eventually result in harm.[3]

Many organizations have begun to acknowledge or give positive recognition to staff members who report errors or recognize unsafe conditions. "Good catch" programs and similar types of initiatives, which have become more common at organizations across the nation, reinforce this notion. These programs also include mechanisms that close the feedback loop by giving reporters information on how their report led to improvement in the organization (see suggested action #3).

"It's been said that change progresses at the speed of trust," according to Peter Pronovost,[4] which is why leaders must engage all staff in an effort to promote trust and improve reporting results.

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.[5,6] See Sidebar 1 for examples.

Sidebar 1: Examples of establishing trust

Memorial Hermann Health System calls it a "good catch" when a report causes clinicians to identify a potentially harmful action and intervene prior to causing harm. Good catches occur about 1,000 times a month in the system's hospitals.

Medical University of South Carolina Health (MUSC Health) issues a daily email highlighting a near-miss, error or unsafe condition and each month recognizes "safety stars" – employees who have made these reports. If care team members want closure in the reporting structure, they can ask to be personally notified with a result at the conclusion of the review.

Adopting a just culture is critical to eliminating fear of punishment

"The single greatest impediment to error prevention in the medical industry is that we punish people for making mistakes," said Lucian Leape, a professor at the Harvard School of Public Health.

The importance of drawing clear lines between human error and at-risk or reckless behaviors as part of a just culture is discussed in *Sentinel Event Alert* #57, "The essential role of leadership in developing a safety culture." Leadership must gradually change the culture so that the need to report and do something about a safety issue outweighs the fear of being punished. Providing employees with the psychological safety to speak up and engage in process improvement can have a positive impact on these efforts.[7] This psychological safety does not currently exist in most health care settings, according to the U.S. Agency for Healthcare Research and Quality (AHRQ) Patient Safety Surveys. Its 2018 database report indicated that 47 percent of respondents said that it feels like unsafe event reports are held against them. Fifty percent of respondents indicated that, after an event is reported, it feels like the person is being written up, not the problem.[8]

All staff must see that those making human errors will be consoled, those responsible for at-risk behaviors will be coached, and those committing reckless acts will be disciplined fairly and equitably,[3,9] no matter the outcome of the reckless act. Senior leaders, unit leaders, physicians, nurses, and all other staff must be held to the same standards.[10,11]

The use of objective accountability evaluation/ assessment tools can help determine what happened as well as whether actions taken were blameless or blameworthy. Two just culture decision trees – one developed by James Reason[12] and the second by David Marx[9] – serve as a primary basis for distinguishing between errors that occur because we are imperfect humans who make mistakes and actions considered to be at-risk or reckless. To make these decision trees work best within their

particular settings, many health care organizations have modified them and built upon them by developing additional tools. See Sidebar 2 for examples.

Close calls reveal more than you know – better reporting is needed

Sentinel Event Alert #57, "The essential role of leadership in developing a safety culture," introduced the concept of a reporting culture and stressed its importance in suggested action #1: "*Absolutely crucial is a transparent, non-punitive approach to reporting and learning from adverse events, close calls and unsafe conditions*."

Reporting close calls is a step toward developing the ability to respond to "weak signals" or poorly detected risks. Close calls are defined as unsafe acts or conditions — errors, procedure violations or hazards — that could have seriously harmed a patient but did not because they were identified, reported, and addressed or eliminated.

Reporting close calls is important for these reasons:

- They provide information on active and potential weaknesses in health care safety systems.
- They are more frequent than events causing harm and provide information about errors from the perspective of health care workers in different positions.
- Analysis of high-frequency or high-potential-severity near miss reports makes it possible to identify system weaknesses and learn from them in the context of daily workflow or systems use.[13]

See Sidebar 3 for an example of learning from a close call report. Learning from adverse events, close calls and unsafe conditions requires analyzing data, communicating what was learned, and taking effective actions to reduce risk; otherwise there is no incentive for staff to report. After gathering data from close calls and hazardous conditions, use it to:

- Identify error-prone situations within the organization. Specifically, organizations should consider frequency and potential severity to determine what to address.
- Identify how the people and system succeeded in preventing an event from occurring. This learning will help

Sidebar 2: Examples of adopting a just culture to encourage reporting

Montefiore Medical Center created a user-friendly version of the just culture decision tree to encourage its use in everyday situations. The use of this tool and the rollout of an electronic event reporting system were a part of a transformational change to a just and learning culture that improved reporting of adverse events from 6,097 in 2014 to nearly 9,000 in 2017, including increased reporting by groups that traditionally would not be involved in reporting, such as attending physicians, who made 542 reports in 2017. Through training and empowering staff across the health system, including members of 50 peer review committees, Montefiore increased root cause analyses from 60 a year to several every day. Near miss and unsafe conditions reporting went up from 681 in 2014 to 2,493 in 2017. This improved reporting has saved lives and has pointed to additional systemic safety issues that the organization can address and improve.

Medical University of South Carolina Health (MUSC Health) first engaged what it refers to as the "just culture backbone" of human resources, risk management, legal and compliance because these four teams are the ones usually consulted for advice when the cause of an error or hazardous condition is being determined. These four teams make sure all policies and procedures are in alignment with just culture protocols. After embedding a just culture algorithm into its online reporting system, the center increased its reporting 20 to 30 percent per year for the last few years, now averaging about 1,400 reports per month. During the same time period, the center decreased the percentage of the reports that represent harm, showing that the reporting is catching errors before they reach the patient.

Kent Hospital, a Care New England Health System member organization, revised human resources policies and procedures to add just culture language to them. This careful use of language contributed toward making its just culture initiative into an anchor supporting performance management and safety improvements.

determine ways to strengthen protective processes and help staff identify the factors that lead up to a situation and what to look out for in similar situations in the future.

For more information, see the Pennsylvania Patient Safety Authority Good Catch program.

Leadership engagement encourages reporting

Sentinel Event Alert #57, "The essential role of leadership in developing a safety culture," focused on the role of leaders in establishing and continuously improving the five components of a safety culture defined by Chassin and Loeb: trust, accountability, identifying unsafe conditions, strengthening systems, and assessment.[5] While leaders may know about a safety concern, they may discount the severity of the risk, since harm has not occurred. This is confirmed by increasing recommendations for improvement (RFIs) in the area of leadership during Joint Commission surveys.

It's important for leaders to be strong role models and be among the first to raise their own hands and say "I made a mistake." Staff and unit managers will start to model this accountability when they see the engagement of leadership.[8,15,16] See Sidebar 4 for examples of leadership engagement.

In a safety culture, health care organization leaders are ultimately responsible for developing highly reliable systems. In turn, staff members are personally responsible for what is considered largely under their control – making good choices when working within these systems.

By building trust and encouraging reporting, leaders empower an organization's most valuable resource – its people – to be always vigilant for hazards in the face of varying conditions.[17] Showing or making a video is an excellent way for chief executives to communicate their commitment to just, reporting and learning cultures. See Sidebar 5 for some videos that illustrate this type of commitment. What matters is that each leader finds a method

Sidebar 3: Examples of learning from close call reporting

The Pennsylvania Patient Safety Authority emphasizes the power of one close call report in its "Why Reporting Matters" program. One hospital reported that staff nearly failed to rescue a patient who had suffered a heart attack and had mistakenly been designated as DNR (do not resuscitate) with a yellow wristband. A nurse had placed this wristband on the patient because yellow signified "restricted extremity" (do not use arm for drawing blood) at a facility where she previously worked. Another clinician identified the mistake and rescued the patient. As a result of this close call report, Pennsylvania adopted a standardized system for color-coded wrist bands and, subsequently, 41 states and the U.S. military have adopted standardized colors.[14]

Sidebar 4: Examples of leadership engagement and accountability

Adventist Hinsdale Hospital improved its error and near-miss reporting and decreased events causing harm after senior leader communication, access and visibility increased. Senior leaders began rounding regularly on all three shifts to assess and respond to safety concerns, and they began advocating for stopping the line, implementing the chain of command, and other staff-driven safety interventions. Senior leaders also regularly attended staff meetings, worked with nurses side by side, and publicized decisions made for safety purposes in multiple forums. As a result, the culture of safety survey demonstrated an improvement in the senior leadership domain in four of six units. Another survey demonstrated that staff members recognized changes that senior leaders had made and felt that these changes positively impacted the culture of safety.[16]

Cincinnati Children's Hospital assigns all root cause analyses of adverse events to teams, each led by two clinical leaders and sponsored by a senior leader who reports to the CEO and holds the team accountable. Each team reports to a safety oversight group on the results of their analysis, how the safety issue is being addressed, and how safety measures were improved. Anyone within the organization can attend these monthly, hour-long presentations. Attendees are challenged to find ways to improve safety in their units. Over the past 10 years, this process has decreased adverse events by 90 percent and increased reporting by more than 300 percent.

to convey this important message throughout the organization.

Actions suggested by The Joint Commission
The Joint Commission recommends that organizational leaders take the following actions to increase trust, reporting and responsibility/ accountability of all staff in support of a safety culture with the ultimate goal to protect patients from harm.

1. Review *Sentinel Event Alert* #57 along with this alert and commit to implementing a safety culture at your organization. These two alerts provide basic guidance and resources that can help.

2. Communicate leadership's commitment to building trust and reporting through a safety culture (see Sidebar 5). Making this commitment, with the support of governance, provides an excellent opportunity for an organization to explain to employees how a just, reporting and learning culture work together to form the main elements of a safety culture.[18] The Joint Commission Center for Transforming Healthcare's Oro® 2.0 is an online organizational assessment that guides leadership through the high reliability journey, specifically in the areas of leadership commitment, safety culture, and Robust Process Improvement® (see Resources).

3. Develop an incident reporting system, including close calls and hazardous conditions, that encourages reporting. This system should include a recognition program (see Sidebar 1), and provide a feedback loop so staff know that action is being taken to address or fix the identified flaw.

- Make the incident reporting system accessible by all staff, easy to use, and enable data analysis to be done in a timely fashion. Make sure that staff members understand that those who report human errors and at-risk behaviors will not be punished so that the organization can learn and make improvements.[3]
- Prepare for an increased volume of reports as reporting close calls and hazardous conditions as well as incidents causing harm becomes part of the organization's culture.
- Define what incidents should be reported. Staff may not recognize that a daily annoyance is actually an unsafe event or unsafe condition.
- Use the data to identify error-prone situations, the frequency at which they occur, and their potential severity. Also use the data to identify successes of the staff and the system. These learnings help determine what to address, strengthen the protective processes within the system, and help staff identify the factors that lead up to a situation and what to look out for in similar situations in the future.

4. Hold managers, leaders, and where appropriate, staff, accountable for addressing and eliminating errors and hazards identified by reporting and for continually improving the safety of the patient care environment (see Sidebar 4).

- Sustain continual improvement and support robust reporting by recognizing the contributions of those who report adverse events and by communicating safety improvement success stories, especially success stories about errors

Sidebar 5: Videos communicating leadership commitment to just, reporting and learning cultures

Montefiore Medical Center: This video explains Montefiore's just culture initiative; it includes the story of the pharmacy technician used at the beginning of this alert, and a second story about how a staff member admitting a medication error led to the improved organization of a unit's medication drawer.

Brigham and Women's Hospital: This video describes Brigham and Women's just culture initiative.

Lehigh Valley Health Network: This video is an excellent example of how to explain and introduce a just culture commitment organization-wide to staff. The video explains the difference between human errors, at-risk behaviors and reckless behaviors and the differences in the consequences of each.

or unsafe conditions that were reported by staff.
- Encourage staff to find and test solutions to everyday problems. Engaging those at the point of care not only involves those with the best knowledge of the process (deference to expertise), it also results in local ownership that contributes to adoption and sustainability.
- When errors or unsafe conditions are not reported prior to patient harm or if staff express trepidation in making reports via safety culture surveys, examine why events are not being reported. Consider if staff understand what to report and whether or not managers or superiors previously punished or intimidated those making reports.

5. Assure that leaders at all levels of the organization apply a standardized accountability process to assess the difference between system flaws, which are the cause of most errors and hazardous conditions, and at-risk or reckless behaviors.
- Examples of this kind of process are the Reason and Marx just culture decision trees mentioned earlier in this alert.
- To produce a fair result when using a decision tree, provide formal training in its use and incorporate the perspective of staff working within the system where the error or action occurred. Because the decision tree may point to a system flaw, avoid having the manager in charge of the system administer the tool (see Sidebar 2).

Related Joint Commission requirements

The Leadership (LD) chapter of the Joint Commission's accreditation manuals for all accreditation programs provide detailed information on designing or redesigning a patient-centered system to improve quality of care and patient safety, an approach that aligns with the Joint Commission's mission and its standards. The LD chapter includes the following standards and elements of performance (EP) that are specific to leadership:

LD.03.01.01: Leaders create and maintain a culture of safety and quality throughout the organization.

EP 1: Leaders regularly evaluate the culture of safety and quality using valid and reliable tools.

EP 2: Leaders prioritize and implement changes identified by the evaluation.

EP 4: Leaders develop a code of conduct that defines acceptable behavior and behaviors that undermine a culture of safety.

EP 5: Leaders create and implement a process for managing behaviors that undermine a culture of safety.

[Note: The following requirements include revised EPs that are effective Jan. 1, 2019.]

LD.03.03.01: Leaders use organizationwide planning to establish structures and processes that focus on safety and quality.

EP 1: Planning activities focus on the following:
-Improving patient safety and health care quality
-Supporting a culture of safety and quality
-Adapting to changes in the environment
[Applies to all accreditation programs, except for Nursing Care Centers.]

EP 2: Planning is organizationwide, systematic, and involves designated individuals and information sources.

LD.03.09.01: The [organization] has an organizationwide, integrated patient safety program within its performance improvement activities.

EP 1: The leaders implement an organizationwide patient safety program as follows:
-One or more qualified individuals manage the safety program.
-All departments, programs, and services within the organization participate in the safety program.
-The scope of the safety program includes the full range of safety issues, from potential or no-

harm errors (sometimes referred to as close calls ["near misses"] or good catches) to hazardous conditions and sentinel events.
[Applies to all accreditation programs, except for Laboratories.]

EP 2: As part of the safety program, the leaders create procedures for responding to system or process failures. (See also PI.03.01.01, EP 10)
Note: Responses might include continuing to provide care, treatment, or services to those affected, containing the risk, and preserving factual information for subsequent analysis.

EP 3: The scope of the safety program includes the full range of safety issues, from potential or no-harm errors (sometimes referred to as close calls ["near misses"] or good catches) to hazardous conditions and sentinel events.
[Applies to all accreditation programs, except for Laboratories.]

EP 4: All departments, programs, and services within the [organization] participate in the safety program. *[Applies to all accreditation programs, except for Laboratories.]*

EP 5: As part of the safety program, the leaders create procedures for responding to system or process failures.
Note: Responses might include continuing to provide care, treatment, and services to those affected, containing the risk to others, and preserving factual information for subsequent analysis.
[Applies to all accreditation programs, except for Laboratories.]

EP 6: The leaders provide and encourage the use of systems for blame-free internal reporting of a system or process failure, or the results of a proactive risk assessment. (See also LD.03.04.01, EP 5; LD.04.04.03, EP 3; PI.01.01.01, EP 8)
Note: This EP is intended to minimize staff reluctance to report errors in order to help an organization understand the source and results of system and process failures. The EP does not conflict with holding individuals accountable for their blameworthy errors.

Resources

The Joint Commission: *Sentinel Event Alert* #57, "The essential role of leadership in developing a safety culture."

Joint Commission Center for Transforming Healthcare: Oro® 2.0 High Reliability Organizational Assessment and Resources tool — The ability to feel comfortable enough to report mistakes in an effort to protect patients from harm is one of the characteristics of an advancing safety culture, according to the Oro® 2.0 High Reliability Organizational Assessment and Resources tool, which includes a safety culture maturity model.

Pennsylvania Patient Safety Authority: Good Catch program — Following aggregate event analysis and facility interviews, the Pennsylvania Patient Safety Authority concluded that good catch programs can help hospitals more effectively analyze reported data and implement risk reduction strategies.

"Managing the Risks of Organizational Accidents, by James Reason, 1997, Ashgate.

"Whack A Mole. The Price We Pay for Expecting Perfection," by David Marx, 2009, By Your Side Studios.

"Dave's Subs: A Novel Story about Workplace Accountability," by David Marx, 2015, By Your Side Studios.

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