Adverse Incident Reporting

It was seven years ago this month that a US Airways plane was landed in the Hudson River after having both engines disabled by a flock of birds. Both the pilot and the co-pilot credited the airline industry’s culture of safety for the successful outcome to this adverse event.

What is a culture of safety? Anthropologists describe culture as learned, shared, traditional behavior. Organizational culture has been defined as the pervasive values, beliefs, and attitudes that characterize a company and guide its practices. An industry with a culture of safety then, is one that embeds the understanding that promoting safety is a part of what everyone must do as a matter of course.

The airline industry took deliberate action to ensure that all employees are involved in reporting all variations from normal operating routines. This includes pilots, flight crews, schedulers, ground and air control staff and maintenance.

These reports are then analyzed to identify causal factors and areas for improvement to prevent the likelihood of such
incidents or events in the future. This normalized reporting and on-going analysis of all events, along with training and drills, helped to build a culture of safety.

Health care lags in culture of safety

Correlations are easily made between the importance of safety for airlines and for health care organizations. However, there is long-term evidence that health care has not fully embraced this culture when it comes to adverse incident or event reporting.

A full decade ago, investigators reported¹ that:

- 84% of doctors have seen coworkers take shortcuts that endanger patients.
- 88% of doctors work with people who show poor clinical judgment.
- Fewer than 10% of physicians, nurses, and other clinical staff directly confront their colleagues about their concerns.

In this study, the authors suggest that safety tools and checklists are not enough to prevent adverse incidents or events and perhaps save lives. A subsequent 2012 report² by the Department of Health & Human Services on hospital incident reporting systems concluded that such systems capture only about 14 percent of patient harm events.

If actual incidents of patient harm are underreported, how often do “near misses” or other variances from the standard of care go unreported?

Using AAAHC Standards to improve culture

AAAHC Standards are intended to promote best practices in patient safety and quality of care. The multiple requirements for written policies create a framework for operations and the placement of related Standards under different chapter headings, e.g. Governance, Quality Management and Improvement, demonstrate the interconnectedness of administrative operations and patient care.

Among the many responsibilities of the governing body of a health care organization, few are as important as ensuring that the quality of care is evaluated and that identified problems are appropriately addressed (2016 Std. 2.I.C.7).

The governing body is responsible for the risk management program (Std 5.II.B). This program must include definitions of an incident and of an adverse incident.

The definition of an incident (Std. 5.II.D.1) includes any occurrence that is not consistent with the routine care or operation of the organization.

The definition of an adverse incident (Std. 5.II.D.2) includes
An unexpected occurrence during a health care encounter involving patient death or serious physical or psychological injury or illness not related to the natural course of the patient’s illness or underlying condition.

For example, a thermal injury from incorrect placement of a piece of equipment.

Any process variation for which a recurrence carries a significant chance of a serious adverse outcome.

For example, the surgeon provides an implantable device “for just this one case” that normally would have been sourced by the surgery center and it turns out to be the wrong item.

A breach in medical care, administrative procedures or other events resulting in an outcome that is not the standard of care or acceptable risk.

For example, submitting an incorrect claim form to CMS.

Circumstances or events that could have resulted in an adverse event.

For example, two patients with the same last name being scheduled for surgery on the same day.

Based on these definitions, all incidents are identified, reported, analyzed and acted upon (Stds 5.II.C.2-3, 5.II.D.2).

We invite you to use the Standards as a way to build a positive culture within your organization and, specifically, a culture of safety.

Raymond E. Grundman, MSN, MPA, FNP-BC, CASC, AAAHC
