PA PSRS
Pennsylvania Patient Safety Reporting System

Patient Safety Advisory

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Why Near-Miss Reporting Matters

Two recent articles in the national press highlighted the importance of "near-miss" reporting to assuring safety in our daily lives.

Early this month, a Pittsburgh-based reporter for a leading wire service described a new national database for near-misses that are reported by fire departments around the country. As the article noted, "The scene is played out in firehouses every day: firefighters return from a blaze or rescue call and talk about a near-miss that could have injured or killed someone. Now, the International Association of Fire Chiefs wants firefighters nationwide to learn from those stories through the National Fire Fighter Near-Miss Reporting System. The new Web site lets firefighters report near-misses anonymously and without fear of punishment—in hopes others can learn from them." This innovative program will benefit firefighters and other first responders around the country, and the story was picked up by many newspapers, electronic news services and websites.

The following day, the *Wall Street Journal* carried a story about airline safety on its travel page. The headline: "Addressing Small Errors in the Cockpit: Majority of Flights See Mistakes, Research Shows; Reducing Goofs by 70%." Much of the article described the research conducted by Robert Helmreich, professor at the University of Texas, who has written widely on aviation safety and whose findings have frequently been applied to healthcare. By observing more than 10,000 pilots within the cockpit, Dr. Helmreich and his team conclude that errors occur in more than 60% of all flights. Most errors are inconsequential, but, as the article notes, "little goofs can add up to big trouble."

There is a lesson here: reporting near-misses can be beneficial to you and your organization if you look at the details in the near-miss report and implement corrective measures to prevent a reoccurrence. This principle holds true for firefighters (and the people whom they serve), for pilots (and airline passengers) and for healthcare facilities and individual providers (and their patients). Complete, open and honest reporting of both actual events

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Lost Surgical Specimens, Lost Opportunities

At least 30 reports have been submitted to PA-PSRS involving surgical pathology specimens that were lost somewhere between specimen retrieval from the patient and processing in the laboratory. Some specimens can be repeated, such as a bowel biopsy to rule out inflammation or celiac disease. However, doing so places the patient at risk from the additional procedure and imposes a greater burden on the healthcare system through additional costs, time, and labor.

Of greater concern are specimens that cannot be replaced, such as fully excised tumors, skin lesions, or organs. The loss of such specimens may result in inappropriate or unnecessary treatment.[1] Furthermore, lost specimens may delay diagnosis, increase patient anxiety, or be a source of potential litigation.[2]

PA-PSRS Reports

The following examples of PA-PSRS narrative descriptions reflect the scope of the problem:

> *An OR specimen was transported to laboratory. The cutting room called to say there was no specimen in the container. The specimen was a completely excised ovary mass.*

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In This Issue

Editorial Policy
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Why Near Miss Reporting Matters (Continued)

and near-misses—"Serious Events" and "Incidents" within the PA-PSRS system—is essential to ensure the success of patient safety efforts in Pennsylvania.

We have received almost 200,000 reports since PA-PSRS was implemented 15 months ago, and we have learned a great deal from analyzing the Serious Events and Incidents reported by more than 445 facilities in the Commonwealth. More important, we strive to share those lessons with healthcare workers and institutions through quarterly and supplementary *Patient Safety Advisories*. "You can't eliminate human error," notes Dr. Helmreich. "But you can minimize the consequences."

We have received positive feedback from healthcare professionals throughout Pennsylvania and around the country about the utility and practicality of *Advisory* articles. Much of the success of those articles and the clinical guidance they include can be attributed to the willingness of many patient safety officers and other facility staff to share their official findings following a root cause analysis or when PA-PSRS analytical staff have contacted them for additional information about a specific report. We appreciate their commitment to sharing their knowledge and best practices with others.

As we frequently note, the success of the PA-PSRS system is not in the number of reports submitted, but in what facilities do in response to what they learn through the system.

Alan B.K. Rabinowitz
Administrator, Patient Safety Authority

Lost Surgical Specimens, Lost Opportunities (Continued)

A patient underwent a liver biopsy. The pathology lab notified radiology that the patient's specimen bottle was empty. It was discovered that another patient had two specimens in his bottle. The patient had a repeat biopsy performed.

A patient had two specimens excised from her breast. The specimens were sent to radiology for x-ray. The lab reported that only one specimen was received. Unable to locate the other specimen.

The surgeon dissected the patient's ovary and tube and placed it in the cul-de-sac during a (laparoscopically assisted) vaginal hysterectomy. The ovary and tube were not ultimately removed from the cul-de-sac. Upon pathology review it was identified that the ovary and tube were missing. The patient returned to the OR, where the ovary and tube were located and removed.

Specimen was lost for 5 days. Specimen was left in the cooler.

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