Why are Safety Stories Important?

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Editor's Note

Joint Commission's December 10, 2018, Sentinel Event Alert (https://www.jointcommission.org/sentinel_event_alert_60_developing_a_reporting_culture_learning_from_close_call_s_and_hazardous_conditions/) about developing a reporting culture included information and strategies from the Pennsylvania Patient Safety Authority. One example included by the Joint Commission was the Authority's patient safety topic about "Good Catches." (/pst/Pages/Good_Catches/hm.aspx) This topic includes resources as well as all of the Safety Stories published through the Pennsylvania Patient Safety Advisory.

A Privileged Perspective

For healthcare professionals, intimate participation in the lives of patients and their families is both an awesome privilege and a tremendous responsibility—immensely rewarding and sometimes incredibly difficult. Healthcare providers who strive to provide the best, safest patient care must keep up with the increasing complexity of healthcare delivery and ever-escalating societal expectations.

Embracing new data, new procedures, new equipment, new medications, and new treatment algorithms requires lifelong learning. Fortunately, "people working in health care are among the most educated and dedicated workforce in any industry."¹ Most of us are eager to acquire new knowledge and refine our skills. However, the continuous desire to improve implies that there is always more we could know or do to enhance patient care. We work hard to provide the best patient care, but in pursuit of perfection, we can be very self-critical.

This penchant to criticize our actions is often reflected in our approach to patient safety. The healthcare safety movement has made progress by looking beyond criticism of the "sharp end" provider, the individual whose direct act of commission or omission may have contributed to an adverse outcome for an individual patient. The "Swiss cheese" model popularized by Reason² brought attention to the insight that any event that reached a patient had also been impacted by choices made at the "blunt end," by decisions that affect organizational goals, priorities, and resource allocation. However, this approach still focuses on events with undesirable outcomes and inherently criticizes individuals, alone or in groups, who make decisions and initiate actions—albeit on a different scale from healthcare providers interacting directly with patients.
A Safety-II Perspective

The traditional approach to safety, sometimes called Safety-I, emphasizes understanding and mitigating factors that contribute to patient harm. While this is important, it is insufficient. The Safety-II perspective developed by Hollnagel, Wears, and colleagues is a refreshing complement to Safety-I, because it values also learning from events with desired outcomes, allowing us to reinforce and learn from success. Both ordinary events that go well most of the time, and extraordinary successes in the face of unusual challenges result from system capacities combined with provider knowledge, skills and adaptability. We may learn and improve the most by seeking to understand the spectrum of patient care outcomes, such as by conducting success analyses as well as root cause analyses.

The Safety Stories published in the *Pennsylvania Patient Safety Advisory* are intended to support learning and reinforce activities that may enhance resilient performance. The stories represent a small sample of the efforts that healthcare providers, ancillary staff, and organizational leaders make every day to try to provide safe outcomes for patients. The Pennsylvania Patient Safety Authority staff reviews the Incident and Serious Event reports that are submitted through the Pennsylvania Patient Safety Reporting System (PA-PSRS) in accordance with the Medical Care Availability and Reduction of Error (MCARE) Act. We sometimes find events with terrible outcomes for patients and families, such as those described in the article "Are You Ready to Respond? Reports of High Harm Complications after Surgery and Invasive Procedures (/ADVISORIES/Pages/201812_HighHarm.aspx)" in this issue. However, we also find events that demonstrate outstanding insight and exceptional commitment.

Aligned with Safety-II principles, which speak to humans as the assets and the problem solvers in healthcare (and other fields), the Authority publishes exemplar Safety Stories in the *Advisory*. The Authority also regularly reviews events that describe safe patient care processes and outcomes and sends letters of appreciation to the reporting facilities. Sometimes the highlighted event demonstrates admirable actions and a wonderful outcome. Sometimes the patient outcome is not as favorable as would be desired, but the response to the event includes learning and improvement. In both our publications and our analysis of event reports, events for discussion are selected for a variety of admirable and important characteristics, as evidenced in the deidentified descriptions below.

**Situational Awareness, Vigilance, Expertise**

* A pharmacist recognized an unlikely change in a patient's weight and investigated to prevent a dosing error.
* A patient care assistant identified a discrepancy in a patient's medication list, investigated to determine the cause, and followed up to ensure the patient's safety.
* A clinician was suspicious that a laboratory result did not align with a patient's condition and requested a repeat study.

**Effective Teamwork, Collaboration**

* Nursing and Pharmacy personnel worked together to resolve an error identified by the bar-code medication administration system.
* Medical, Nursing, and Pharmacy personnel collaborated to determine the source of incorrect information that could have led to a medication error.

**System-wide Solutions**

* A team of nurses reviewing educational material found a discrepancy and evaluated related documents to ensure consistent corrections.
  Recently implemented equipment did not function as intended. The reporter investigated possible product recalls and established a monitoring process to determine whether the event was isolated or whether additional similar events are occurring.
Success Analysis

Staff responded effectively to a patient care emergency outside of the building, but still conducted a debriefing, which identified opportunities for further improvement.

* The details of the PA-PSRS event narratives in this article have been contextually deidentified to preserve confidentiality.

Stories Worth Telling

The Safety Stories project aligns with current local and national initiatives that link healthcare quality and patient safety with provider wellness and the need to find gratification and meaning in work. Providers who do not find professional satisfaction in their work are at risk of burnout, and the meta-analysis by Salyers and colleagues confirms what many suspect—that a negative relationship exists between provider burnout and the quality and safety of patient care. Focusing only on patient safety failures, without acknowledging and understanding patient safety successes, may contribute to provider burnout. As providers, staff, and leaders seek lifelong learning and ongoing improvement, they may find valuable lessons in understanding "what went well." Examining examples of success may promote satisfaction, additional success, and perhaps even joy! If Safety Stories enhance safety for future patients then Safety Stories are worth telling.

Notes

7. Safety stories: telemetry. Pa Patient Saf Advis. 2018 Jun;15(2) Also available:  


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