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Why a Reporting Culture Matters

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High reliability organizations, or HROs, are organizations that have achieved success in avoiding catastrophes within environments where normal accidents can be expected due to risk factors and complexity. Their success evolves from two essential characteristics: 1. HROs constantly confront and are prepared for the unexpected, and 2. HROs operate with remarkable consistency and effectiveness.

The ability to respond to unpredictable challenges and find system level solutions is achieved by first building effective organizational culture and situational awareness and then supporting the ability to successfully communicate critical information through structured tools and processes. American Anesthesiology has supported the leadership training and education necessary to create a culture of reporting within the organization, as well as provided the tools to assist the clinician to be able to report in a timely and efficient manner. One tool that is used is our "safety concern report," available in mobile app and paper report forms.

The power of a reporting culture was recently illustrated by the following safety concern report:

Report On: 12/08/2014
Report By: JENNIFER
Event Date:
12/08/2014Practice: (PRIVATE) HOSPITAL ANESTHESIA PRACTICE
Facility: (Private) Hospital
Location: Labor & Delivery

Event Description: Discovered Malignant Hyperthermia cart with no key immediately available to access Dantrolene. HIGHLY UNSAFE situation Cart poorly stocked.

The concern report was received on December 8, 2014 and forwarded to the hospital for immediate action. Within three days, a new Malignant Hyperthermia cart was placed in Labor & Delivery, fully stocked with combination access.

On December 30, 2014, just three weeks later, a patient underwent an emergency cesarean section under general anesthesia. She developed fulminant Malignant Hyperthermia, a rare, but catastrophic complication of anesthesia, after induction, which was successfully treated with a combination

of preparedness, teamwork and expertise. The patient was discharged home to join her healthy baby and family 10 days later.

Early recognition and treatment of Malignant Hyperthermia is imperative for successful outcomes, and effective treatment requires immediately available supplies and equipment.

In HROs, catastrophic failures are buffered by multiple, small adjustments through attention to operations. To prevent the accumulation of errors is to reduce the chance that any one error will align with others preventing a catastrophic event. Having a high sensitivity to operations and understanding how processes affect patient care provides insight into the health of the whole system, and prepares those involved for the unexpected.

In this situation, having an integrated HRO strategy helped create a high level of situational awareness, and enabled the team to be optimally prepared to treat this catastrophic event. HROs are aware of how processes and systems affect patient care. Empowering the individual to speak freely and providing the communication tools to report concerns help to maintain operational and cognitive integration of patient care.

Ultimately, leadership must be committed to creating an environment where the individual is not only encouraged to embrace the culture change required for high reliability, but take action when needed.

The benefit to our organization in developing a reporting culture is that the culture exposes valuable information that otherwise might not be discussed. It also enables us to proactively address safety concerns before patient care errors occur. Further, it engages clinicians at all levels in problem-solving and helps develop a positive attitude and culture surrounding safety.

Lastly, but most importantly, a reporting culture supports a closed loop of communication and action: The clinician that reports a safety concern can see that the submission of a report results in a system or process change that leads to measurable and optimal outcomes for patient care. As in this example, what was initially thought to be a "good catch" report describing a concern ultimately became a life saving intervention that reflects on our developing HRO status.

A safe culture is an informed culture, which requires an effective reporting culture. One fundamental characteristic of a strong safety culture is that everyone feels responsible for identifying, reporting and reducing potential patient safety concerns. By supporting and enabling early reporting of unsafe conditions and process issues, organizations can greatly improve their ability to take proactive corrective actions before errors happen.