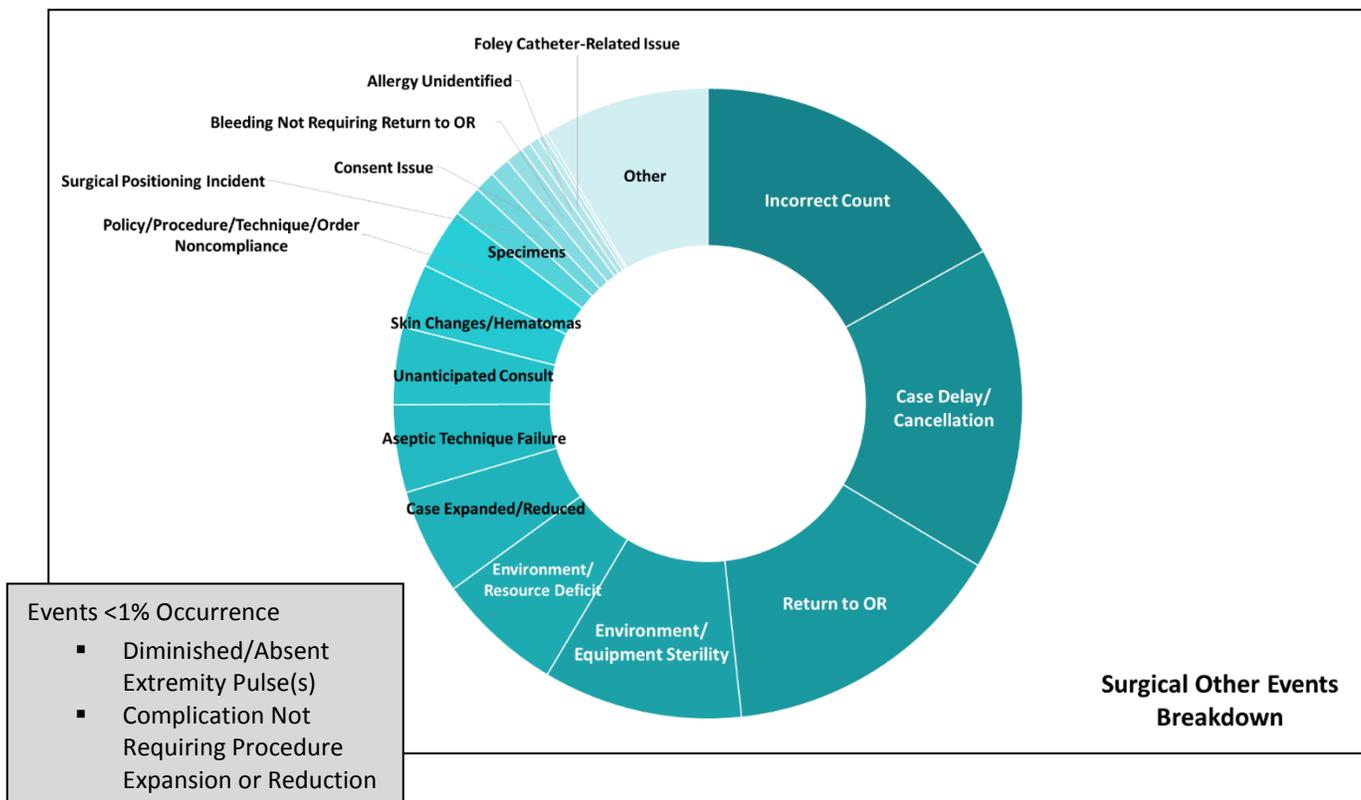


Clarity PSO Learning Series

Topic: Surgery & Anesthesia Safety Event Reporting – “Other” Events

It can be difficult to make sense of and learn from safety events when the high-level description category is reported as “other.” This is often the case with the Common Format template for Surgery and Anesthesia (S&A) because the template is focused solely on the really harmful safety events. Healthcare providers report the common and/or routine occurrences, which are not listed in the template, as “other” making it hard to analyze the different types of event types and identify ways to prevent common errors from occurring.

Over half of the surgical events submitted to Clarity PSO were categorized as “other,” reminding us that while we need to pay attention to the really harmful events, we cannot ignore the common occurrences if we want to improve care delivery. In this PSO Learning Series Report, we investigate the themes and trends buried within these “other” categories in order to create meaningful classifications for errors and their contributing factors. Below describes how the “other” surgical events have been reclassified for better analysis.



As one might expect, the “other” event categories are predominantly related to process failures, which is consistent with the more common causation of errors and failure modes. In other words, the daily/routine work process failures compose the majority of the surgical event database.

Insight and Investigation

Why are process failures so important?

As the domino effect illustrates, these process failures have the potential to have a vast impact on an organization, its front line providers and its patients. Processes have the intention of creating efficiency and high-quality care while maintaining the utmost safety measures. Yet, if we only focus on major, harmful events, we fail to grasp the full scope of root causes. With this being said, the daily process issues that invade the practice of every OR happen on a more frequent basis and are likely to occur further upstream from those major events identified in the Common Format template (i.e. bleeding requiring return to the OR and cardiac or circulatory event). These upstream events provide us with insight as to how major, harmful events actually unravel. For example, if your organization's OR routinely has difficulty obtaining the correct trays or has instrumentation sterility issues, what will happen when an emergency is encountered? It can be very easy to fail to recognize an error that passes through fail safes if we only focus on the end result and not the entire process.

If we pay little attention to the seemingly trivial events and overlook "other," "no harm," or "unknown" harm events, we fail to identify root causes that plague many surgical and anesthesia events, from near misses to deaths.

The success of identifying these process-related events relies upon the organization and department cultures. Without admitting that both we and the system are fallible and flawed, we cannot shift our thinking to be solely learning focused nor can we take a stand to commit to making the necessary and indicated changes. A safety culture requires all of these components. More importantly, the cornerstone of sustainable, positive change is a safety culture.

So, what does this all mean?

While AHRQ identifies the end outcome major events, much of the surgical-related event database is composed of process-related events, which have the tendency to be more upstream and occur more frequently than major, harmful events. It is vital that process-related events are not overlooked simply because they did not cause direct harm to a patient. Eventually these process-related events will lead to harm. Many of these process-related events share similar contributing factors with major, harmful events, therefore addressing these factors within processes will decrease efficiencies and negate harmful events. Finally, a safety culture must be instituted, maintained and constantly evaluated if progress is to be initiated and sustained over time.

Resources

The following are resources related to human factor and process-related events and building a culture of safety:

- Department of Community and Family Medicine at Duke University Medical Center: [Anatomy of an Error](#)
- Comprehensive Unit-based Safety Program (CUSP) toolkit video: [Understand Just Culture](#)
- [AHRQ's Learn from Defects Tool](#)
- White Paper: [Applying Lean Principles to Improve Healthcare Quality and Safety](#)
- Clarity Group White Paper Series: *Journey to an Effective Safety Culture*
 - [Part 1](#) – *Embracing Patient Safety Culture*
 - [Part 2](#) – *Awareness & Assessment of Safety Culture*
 - [Part 3](#) – *Effective Change for Quality Improvement*
- Sample Steps: [Developing a Culture of Safety](#)

References

- Agency for Healthcare Research and Quality. (2012). *Surgery or anesthesia form*. Retrieved from https://www.psoppc.org/psoppc_web/publicpages/supportingDocsV1.2
- Grout, J. R. & Toussaint, J. S. (2010). Mistake-proofing healthcare: Why stopping processes may be a good start. *Business Horizons*, 53. Retrieved from <http://www.sciencedirect.com/science/article/pii/S0007681309001554>