



Just culture of safety: How to report and participate in reviews of adverse events

An article for physicians by physicians
Originally published March 2010

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ABSTRACT

A just patient safety culture promises the provision of higher quality and safer care. Advice is provided to CMPA members on participation in reporting and reviews of adverse events and close calls in hospitals and institutions

Could the following occur in your hospital or institution? Would it be reported and what would happen?

A 45-year-old male, being followed for difficult-to-control asthma, presented with cough and fever to his respirologist in a hospital outpatient clinic. The clinical findings were sufficient that a chest X-ray was ordered. Antibiotics were prescribed for a presumptive early pneumonia. The patient was discharged with instructions on symptoms to watch for that would prompt him to seek further medical care. As for the X-ray, the patient was told that “no news is good news,” but if the report was positive then the patient would be telephoned. The encounter was well documented in the medical record. Months later, the patient returned because of worsening symptoms. At that visit, the report of the chest X-ray was discovered in the medical record. An important finding suspicious for lung cancer had not been followed up.

IMPROVING PATIENT SAFETY

Patient safety experts have recognized that more adverse events can be prevented over time by strengthening system protections, which will benefit future patients. Blaming an individual provider most often does not change the factors that contributed to an adverse event. The same problem may recur for another patient and provider unless a real

attempt is made to understand the circumstances and context for action and decision-making at the time of the event.

The challenge is to find the right balance between improving systems of care to help prevent similar events in the future, while fairly addressing any issues of individual provider performance and accountability. Many health care experts have identified the shift to a more balanced approach as establishing a “fair and just” culture of patient safety. (To assist leadership/management in choosing the best type of review for an adverse event, more information is available online [www.cmpa-acpm.ca, search for: just culture] or in print—*Learning from adverse events: Fostering a just culture of safety in Canadian hospitals and health care institutions.*)

ADVICE ON INCIDENT/OCCURRENCE REPORTS

Most hospitals have policies and a system for reporting adverse events and close calls.

These reports are usually not considered quality improvement information and are unlikely to benefit from legislative protection from disclosure in legal, regulatory or other proceedings. Incident/occurrence reports should not be kept in the patient’s medical record, except in Québec, where the law requires a copy be placed in the hospital’s medical record for a patient.¹

CMPA members are encouraged to contact the CMPA about specific medico-legal concerns at 1 800 267-6522.

WHAT IS A JUST CULTURE OF SAFETY?

In a just culture of safety, the leaders and all staff are committed to providing the safest possible care to patients. There is a shared commitment to learn from adverse events and close calls and make improvements. The interests of both patients and providers are protected.

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Reports should therefore contain only facts from the medical record. In a just culture of safety, the reasons for clinical outcomes and events are not prejudged, and any rush to blame individuals is avoided. Reports should, therefore, not contain statements of blame, speculation, opinion or other commentary as to the reasons for what happened, or any recommendations.

While it is important to report adverse events and close calls, what is done with these reports is equally significant.

TYPES OF REVIEWS

There are two types of reviews of adverse events that should be used by leadership/management in Canadian hospitals. If asked to participate in a review, physicians should first determine what type it is. A quality improvement (QI) review looking for system issues? Or an accountability review looking at the specific care by an individual provider, for example the respirologist in the case involving the failure to follow-up on the chest X-ray?

In that case, a quality improvement review is the preferred type of review. Given what is known, accountability reviews focusing on the respirologist or other providers would not be appropriate.

QUALITY IMPROVEMENT REVIEW

These reviews by quality improvement committees² are designed to identify the reasons for adverse events or close calls by looking at the system in which health care is provided.

To encourage the full participation of providers, the legislation in each

province/territory generally protects the work of a quality improvement (QI) committee. The opinions and documents prepared for or generated by a QI committee cannot be used in subsequent legal, regulatory or other proceedings. Following the analysis, a patient should be informed of new facts identified in the analysis of the event and the conclusions as to the reasons for the clinical outcome, but not the deliberations, opinions and speculations leading to these. An apology may be warranted. Patients will often want to learn of any steps that have been implemented to prevent similar harm to others, and it is appropriate to share this information.

The CMPA supports learning from properly structured and conducted quality improvement reviews and encourages its members to participate. Participation by providers in quality improvement reviews may be mandated by law in some provinces/territories or by hospital bylaws.

In the case with the respirologist, the event was used as an opportunity to look at the existing administrative systems of several hospital departments for their follow-up of test and diagnostic imaging reports. The QI review identified several potential failure points waiting to trap other patients and their providers. These vulnerabilities were fixed.

ACCOUNTABILITY REVIEW

At times the hospital/departmental chiefs or other leadership may decide to conduct an accountability review to focus on a specific provider's role in an adverse event. In a just culture of safety, when a deficiency in a provider's performance is identified,

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education and support are the preferred approaches. Sometimes discipline and other sanctions may be necessary.

Health care providers are generally obligated to take part in reviews of their own professional work, if asked to do so. Members should contact the CMPA for advice.

BUILDING A JUST CULTURE OF SAFETY

Identifying and reporting adverse events is a cornerstone of modern patient safety and is vital to improving the quality of care. Properly structured quality improvement reviews are an important way to encourage health care providers to assess and improve the health care system.

THE ROLE OF HINDSIGHT BIAS

In reviewing a patient's clinical outcome, all involved should help gather the facts but avoid blaming themselves or others. Knowing an undesirable outcome has occurred increases the belief that it was predictable and therefore preventable. This "hindsight bias" contributes to the belief that the unexpected outcome was due to carelessness or poor clinical care, rather than the context or specific conditions in which the individual provider was working.

1 Under Québec law, a close call is termed an "incident" and an adverse event an "accident" and both are specifically defined in legislation. The law requires the completion of a report for both incidents and accidents in government-run institutions such as hospitals. A copy of the report is kept in the patient's hospital medical record.

2 Quality improvement committees, depending on the province or territory, may have different titles, for example: Quality of Care, Critical Incident Review, Risk Management.

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GENERAL ADVICE ABOUT ADVERSE EVENTS

Communicating with your patient

Following an adverse event, patients have clinical, emotional and information needs. Find more information in the CMPA's Communicating with your patient about harm: Disclosure of adverse events, available online at www.cmpa-acpm.ca (search for: communicating) or in print by calling the Association at 1 800 267-6522.

Reporting to the hospital/institution

- Be familiar with and follow the policies and procedures regarding the reporting of adverse events and close calls.
- Provide only factual information in incident/occurrence reports and refrain from statements of blame, speculation, opinion or other commentary as to the reasons for what happened.

Participating in quality improvement reviews of adverse events

- Inquire as to whether the quality improvement committee is properly constituted under the relevant legislation and seek assurances that quality improvement reviews will be conducted in a confidential manner. Fully participate in systems-oriented quality improvement reviews.

Participating in an accountability review about your professional work

- Participate, as it is generally an obligation to take part.
- Contact the CMPA for advice.
- Remain factual and do not speculate.

Contact the CMPA for advice if

- You are generally uncertain how to proceed.
- You are obliged to participate in a quality improvement review structured outside the parameters of the relevant provincial/territorial legislation.
- Your privileges are threatened.
- A coroner/medical examiner is requesting information from a review or a regulatory authority (College) disciplinary proceeding in which you are involved.
- You have been threatened with litigation or named in litigation that has already begun.

CMPA members are encouraged to understand the difference between a quality improvement review and an accountability review, in terms of their different purposes, procedures, the likely approach to analysis, information protections and consequences. Read *Learning from adverse events: Fostering a just culture of safety in Canadian hospitals and health care institutions*, available online (www.cmpa-acpm.ca, search for: just culture) or in print by calling the Association at 1 800 267-6522.

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