Anesthesia Quality Institute®
American Society of Anesthesiologists®

Learning From Others: A Case Report from the Anesthesia Incident Reporting System

Case 2021-1: Safe Tables – A New Initiative from the Anesthesia Quality Institute

A 55-year old, slightly overweight female underwent a radical nephrectomy with an IVC thrombectomy. The patient had adequate I.V. access. During the procedure, the patient sustained an irreparable vascular injury and died as a result. The resuscitation efforts were excellent despite the poor outcome. The contributing factors focused on adequate communication between the surgeon, anesthesiologist, and nursing staff on the day of surgery about the plan of care and resources available, including additional surgeons on standby. The department conducted a quality improvement project via a Safe Table and instituted a new communication tool addressing complex cases.

Quality improvement is local. Here, the team reviewed the case, highlighted the contributing factors, and instituted new processes designed to reduce the risk of a poor outcome for future complex cases. This is a great example of a local quality improvement project designed to address the intricacies and culture of the institution.

Please take a moment and ask yourself, is this a risk in your practice?

While the same, exact interventions this team employed may not work in your practice, the themes may be quite relevant – and the need for an intervention before this occurs at your hospital may be real. This is the basis for AIRS, and the concept of learning from others. That said, we know there is a gap, a canyon really, between reading a case report and instituting lasting change to prevent harm at your organization.

The "gap" may be the need to explore what happened at another organization and learn from that experience, avoiding some of the same issues. Or the gap may be simply discussing the case and brainstorming how you can address this risk inside your culture.

AIRS reports are federally protected, a responsibility this committee and the AQI take extremely seriously. If you wrote to us, and requested to reach out to this organization and learn from their approach, we would not release *any* identifying information from the reporting organization (and we may not even have it if they reported anonymously).

That said, it would be great if the Patient Safety Organization could convene a safe, legally protected environment where we could discuss actual cases that occurred, including how to prevent devastating outcomes, between our respective institutions. The committee members who author these articles engage in these discussions frequently, drawing from the expertise of others and leveraging the fact that committee discussions are protected by federal law.

"The AQI has hosted Safe Tables at the ASA annual meetings in 2018 and 2019, to rave reviews."

Now, we want to offer that same opportunity to you

The AQI has hosted Safe Tables at the ASA annual meetings in 2018 and 2019, to rave reviews. Now, we're taking this experience virtually and offering a legally protected forum to discuss adverse events and how organizations have responded. Each session will be hosted by a member of the AIRS Committee, open with an actual case from AIRS, and consist of a moderated discussion. We will continue to host Safe Tables at large annual anesthesiology meetings to provide this service to those who prefer an in-person experience. We plan to offer MOCA credit for both the virtual and in-person experiences.

The remainder of this article addresses the legal framework of how we can safely and securely offer this experience. AIRS was made possible through the Patient Safety and Quality Improvement Act of 2005. The Final Rule (2008) of this act defines the operating requirements of Patient Safety Organizations (*Federal Register* 2008;73:70731-814).The Anesthesia Quality Institute was first registered as a Patient Safety Organization in September 2010 and has recertified three times in the past 10 years.

The Patient Safety Act was conceived to protect a culture of safety and address the findings in the landmark Institute of Medicine report *To Err is Human*: "The biggest challenge to moving toward a safer health system is changing the culture from one of blaming individuals for errors to one in which errors are treated not as personal failures, but as opportunities to improve the system and prevent harm" (*To Err is Human: Building a Safer Health System*. 2000). The act promotes the safe exchange and discussion of adverse events by leveraging federal privilege to protect from legal disclosure the specifics of patient safety events, as well as the response to these events, also known as patient safety work product (PSWP). Put simply, information surrounding cases of harm, or "near misses" if submitted to a listed Patient Safety Organization, is federally protected from disclosure.

As each individual state has laws surrounding the release, disclosure, and legal discoverability of this information, a complex legal framework exists that, in many states, discouraged the discussion of adverse events, and learning from them. The Patient Safety Act supersedes these state-level laws and extends protection that prevents a state-level request for disclosure. This act has been tested in court many times, all with the same result; no entity has been successful at compelling the release of information submitted to a Patient Safety Organization (asamonitor.pub/31PuyeF).

The Patient Safety Act allows for open discussion among PSO participants. For the purposes of our PSO, we define the membership as practicing anesthesiologists in the United States, and cases are submitted via our reporting system. Participation in a Safe Table requires agreement with a confidentiality and non-disclosure statement to protect everyone involved. Participants are free to bring their own cases or commentary to the session, knowing it is legally protected and cannot be used in any legal proceeding.

Safe Tables have been successfully used by many listed Patient Safety Organizations to review and analyze cases, exchange quality improvement success stories, and provide a forum to improve resiliency and reduce second victim harm (asamonitor.pub/2TwXTG9). The AIRS Committee looks forward to partnering with you to support learning from others and improving the quality and safety of anesthesia practice. ■

Review of unusual patient care experiences is a cornerstone of medical education. Each month, the AQI-AIRS Steering Committee abstracts a patient history submitted to the Anesthesia Incident Reporting System (AIRS) and authors a discussion of the safety and human factors challenges involved. Real-life case histories often include multiple clinical decisions, only some of which can be discussed in the space available. Absence of commentary should not be construed as agreement with the clinical decisions described. Feedback regarding this article can be sent by email to **airs@asahq.org**. Report incidents or download the AIRS mobile app at **www.aqiairs.org**.