

Tanker om et nyt UTH system

Henning Boje Andersen

Professor emeritus (DTU)

IDA Risk og DSKS -Dansk Selskab for Kvalitet i Sundhedssektoren

Konference om Hændelsesrapportering og Læring, 2.12.2025, Kbh.

Formålet med rapportering har jo **aldrig** været måling - men at styrke læring / forbedring af sikkerhedskultur. Derimod er måling af sikkerhed relevant og nødvendig.

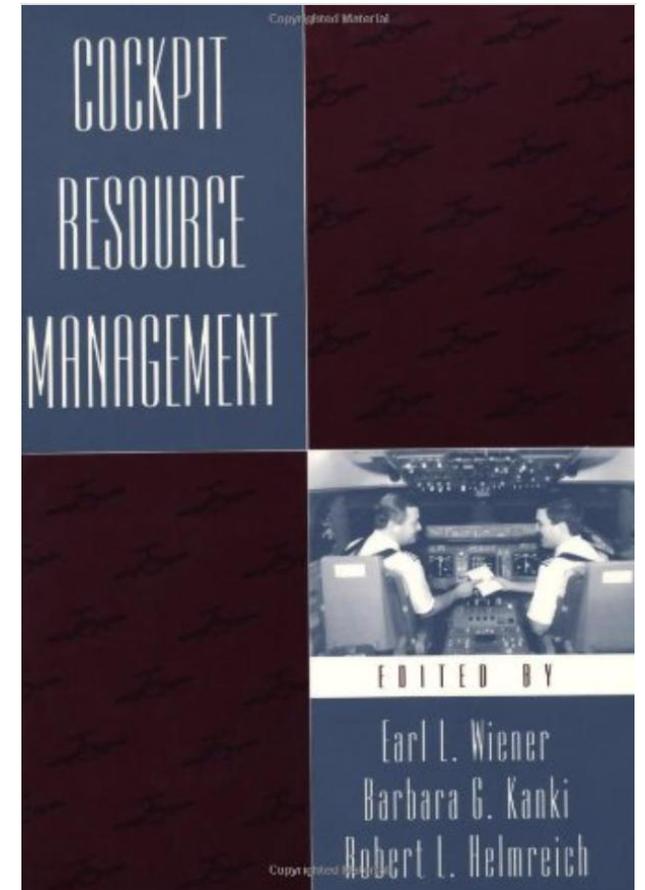
Se fx: Eldridge N, et al. Trends in Adverse Event Rates in Hospitalized Patients, 2010-2019. JAMA. 2022 Jul 12;328(2):173-183.

(Conclusion ” between 2010 and 2019 a significant decrease in the rates of adverse eventsacute myocardial infarction, heart failure, pneumonia, and major surgical procedures and there was a significant decrease in the adjusted rates of adverse events between 2012 and 2019 for all other conditions” – based on 244 542 adult patients hospitalized in 3156 US acute care hospitals)

Ureksemplet – den oprindelige og stadig gyldige tilskyndelse bag ethvert centralt incident-rapporteringssystem

I 1974 bragede **TWA 514** ind i Mt Weather pga misforståelser mellem piloter og flyveleder

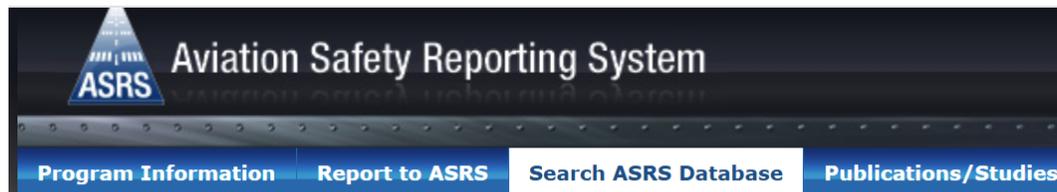
Samme misforståelse, samme sted, samme tårn, indtraf 6 uger tidligere med United Airlines – og piloterne indberettede det til United Airlines **interne sikkerhedssystem** – så selskabets egne piloter kunne tage sig i agt



Cockpit Resource Management
(1st Ed) B G. Kanki, RL Helmreich,
Earl L. Wiener. 1993

TWA 514 ulykken affødte det første centrale system, nationalt/internationalt og på tværs af selskaber:

NASA's Aviation Safety Reporting System (ASRS)



ASRS Database Online

Welcome to the ASRS Database Online! The ASRS database is the world's largest repository of voluntary, confidential safety information provided by aviation's frontline personnel, including pilots, controllers, mechanics, flight attendants, and dispatchers. The database provides a foundation for specific products and subsequent research addressing a variety of aviation safety issues.

ASRS's database includes the narratives submitted by reporters (after they have been sanitized for identifying details). These narratives provide an exceptionally rich source of information for policy development, human factors research, education, training, and more. The database also contains coded information by expert analysts from the original report which is used for data retrieval and analyses.

The mission of ASRS is to disseminate information to the proper authorities who can investigate and determine if action is warranted. NASA ASRS does not verify or validate reports and therefore we are not in a position to confirm the details presented in ASRS reports.



Issue 550

November 2025

The High Stakes of Runway Incursions

A runway incursion is defined as "any occurrence at an aerodrome involving the incorrect presence of an aircraft, vehicle, or person on the protected area of a surface designated for the landing and takeoff of aircraft."¹ Runway incursions are categorized A through D for seriousness using well-defined criteria. Category A incursions are the most serious and are those in which a collision is narrowly avoided. Category D incursions are the least serious and are deemed to have no immediate safety consequences.

Causes can stem from Human Factors affecting pilots, controllers, or other airport vehicle operators. Airport design, markings, traffic, visibility, and environmental phenomena can also be instrumental. Significant work is being done to reduce the incidence of runway incursions and to mitigate the enormous, unacceptable consequences they can present.

This month, *CALLBACK* presents reports of runway incursions that may or may not have been "expected." Examine each incident to identify the threats and errors (TEM)² present in each; then consider how they might have been trapped. Will you expect the unexpected the next time you approach or use a runway? Be ready!

Part 121 – "Know When to Hold"

An A220 First Officer reported a runway incursion having a subtle undertone that is occasionally misunderstood. The

to clear the final, I did not see any aircraft. When we reached the middle of the runway, we both realized that we couldn't clear it because of the traffic ahead associated with Runway XY. It was at that point that I had a feeling we were not in the correct position and that perhaps we were not, in fact, cleared to cross XXL. As I queried the Tower to see if they could move the plane up ahead of us, the Captain noticed a small landing light coming from Aircraft Z approaching XXL. Aircraft Z was then instructed to go around. Traffic moved ahead and we proceeded off the runway.

Part 91 – A Controller's Lament

This Ground Controller reported a runway incursion that combined a skeleton crew, situational awareness, and a dash of training and inexperience in the recipe.

■ *I was working Ground Control combined with Clearance Delivery, and my Local Control position was in training. I certified in Ground about 2 months prior. I had an Aircraft Y taxiing out of the FBO to RWY 19 via C holding short of RWY 19 [at] C. After scanning the field and radar, I believed the RWY 19 was clear to cross. I coordinated with LC (Local Control) for the crossing and was told to cross. While I was transmitting to Aircraft Y to cross, the trainer on LC got my attention and told me to hold, as Aircraft X was cleared for takeoff on RWY 19 and just rotated. In the same transmission (I never unkeyed), I told Aircraft Y to*

Værdifulde roller for et centralt system
(i anerkendelse af lokal læring er mest effektivt):

- Enkelt(e) tilfælde
- Mønstre på tværs – hjulpet af AI
- Trusseltrends
- Facilitering /

- **Enkelt(e) tilfælde (taktisk alert)**

fx utilgængelig ”drift”/”ude af drift” lampe

- **Mønstre på tværs (strategisk alert)**

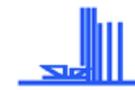
fx gentagne forvekslinger af let-at-forveksle emballering / designfejl/
indkøbspoliti

Anbefalinger udarbejdet for Sundhedsstyrelsen INDEN og til forberedelse af loven om patientsikkerhed blev udarbejdet

Abstract

Denne publikation udgør hovedrapporten fra et **projekt udført 2001-02 for Indenrigs- og Sundhedsministeriet** om krav til et registreringssystem for utilsigtede hændelser på sygehuse og indeholder anbefalinger for hvorledes et system til rapportering af og læring fra utilsigtede hændelser på sygehuse kan tilrettelægges. Anbefalingerne er udarbejdet på grundlag af en gennemgang af internationale erfaringer med registreringssystemer, interviews med og en omfattende spørgeskemaundersøgelse blandt sygeplejersker og læger.

RISØ



Riso-R-1369(DA)

Rekommandationer for rapportering af utilsigtede hændelser på sygehuse

Hovedrapport fra projekt om krav til et registreringssystem for utilsigtede hændelser på sygehuse

Niels Hermann, Henning Boje Andersen, Thomas Schiøler, Marlene Dyrlov Madsen, Doris Østergaard

DSI Institut for Sundhedsvæsen
Forskningscenter Riso
Dansk Institut for Medicinsk Simulation

Forskningscenter Riso, Roskilde
September 2002

Risø-R-1367(DA)

Spørgeskemaundersøgelse af lægers og sygeplejerskers holdninger til rapportering af utilsigtede hændelser på sygehuse

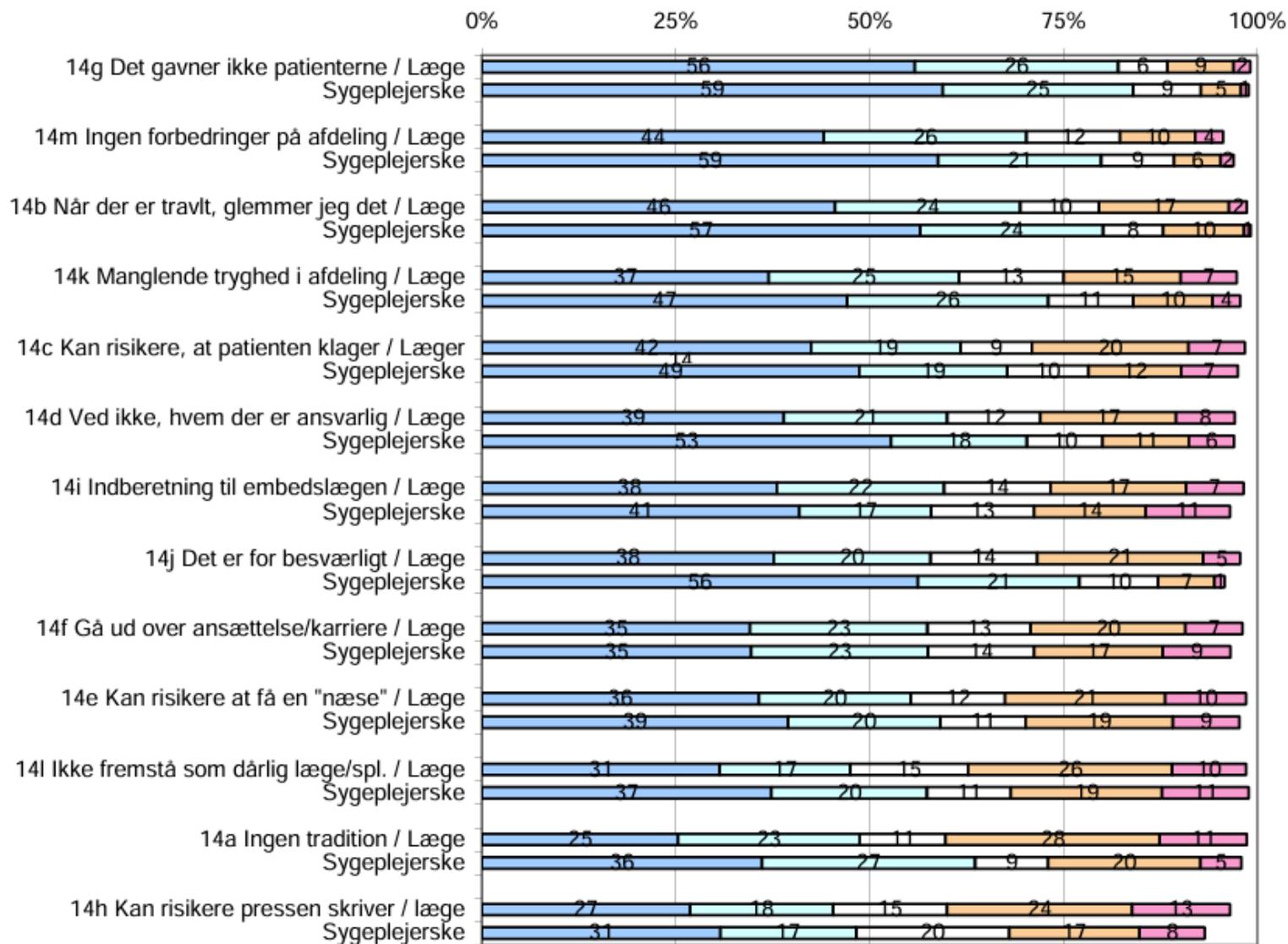
Delrapport II fra projekt om krav til et registreringssystem for utilsigtede hændelser på sygehuse

Marlene Dyrlov Madsen, Henning Boje Andersen, Niels Hermann, Doris Østergaard, Thomas Schiøler

DSI Institut for Sundhedsvæsen
Forskningscenter Risø
Dansk Institut for Medicinsk Simulation

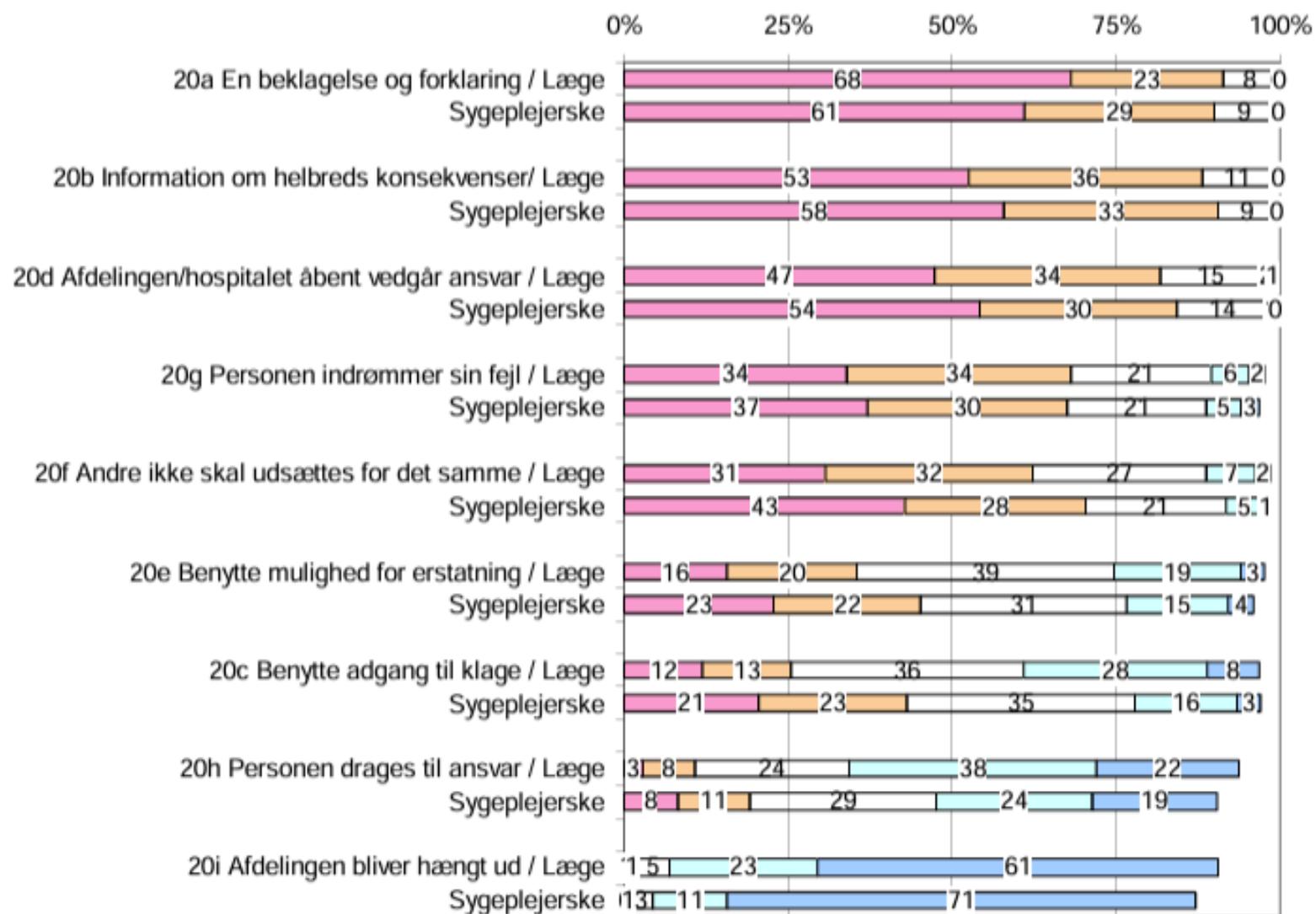
		Antal udsendte	Antal "adresat ukendt"	Antal besvarelser modtaget	Svar-Procent	Antal indskannet
Alle 4 amter	Læger	1607	70	711	46%	703
	Spl.	2501	19	1320	53%	1305
	Total	4108	89	2031	51%	2008

Spm. 14: Grunde til at holde tilbage med at rapportere eller omtale hændelse



Helt uenig
 Noget uenig
 Hverken enig/uenig
 Noget enig
 Helt enig

Spm. 20: Hvad ønsker patienten v. utilsigtet skadevoldende hændelse?



■ Afgørende vigtigt
 ■ Meget vigtigt
 ■ Vigtigt
 ■ En smule vigtigt
 ■ Ikke vigtigt eller ikke ønsket

Spm. 24: Tanken om at begå en fejl, som kan få alvorlige konsekvenser for en patient...

