

# Patient Safety: It's Not Rocket Science

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## IOM Goals

- Safe
- Timely
- Efficient
- Effective
- Equitable
- Patient-Centered

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## Patient Safety - The Problem

- Not New
- 1964 - Schimmel (Ann. Int. Med.)
- 1981 - Steel (NEJM)
- 1991 - Harvard Practice Study (NEJM)
- 1995 - Family Practice MDs (JFamPrct)
- 11/99 - IOM Report
  - Deaths due to Preventable Adverse Events greater than MVA, Breast Cancer, or AIDS

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### Where Healthcare Was/Is

- Cottage Industry Mentality
- Virtually Total Reliance on:
  - Professional/Individual Responsibility
  - Individual Perfection
  - Train and Blame
- Little Understanding of Systems Relative to People and Processes
  - Ignorance vs Arrogance

**Culturally Different!!!!**

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### Typical Approach

- New Policies, Regulations, Reporting Systems, Training
- Good First Step But.....
  - Lack of Systems Insight
  - Superficial Solutions (?Answers)
  - Inadequate Follow-Up
  - Lost Opportunity

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### Goal Selection

- Clear
  - Not Confused With Tactics
- Compelling
  - Relevance To Those Who Must Take Action
  - Early Stakeholder Involvement in Goal Definition
- Reinforced By Leadership
  - Visible Participation
    - All levels – not hierarchical

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### Typical Missing Features

- Clear Understanding of Goal
- Preventive Approach
- Field Understanding & Buy-In
- Systems Approach
- Sustainability
- Trust/Culture of Safety

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### Safety System Design

- High Reliability Organizations
- Role of Reporting
  - Learning or Accountability
- Systems-Based Solutions
  - Patient Centered – DUH!!!!
- Importance of Close Calls

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### Guiding Principles For Patient Safety System

- **Learning, Not Accountability System**
- Reporting System Characteristics
  - Non-punitive - Confidential and De-identified
  - Internal and External
- Importance of Close Call
- Reports Should Emphasize Narratives
- Interdisciplinary Review Teams
- About Identifying Vulnerabilities **NOT** Statistics
- Prompt Feedback
- Open to All Comers

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### Safety & Human Error: Challenges

- Healthcare Views Errors as Failings Which Deserve Blame - Fault
- Train and Blame Mentality
- Blind Adherence To Rules
- Corrective Actions Focusing on Individual
- No Blood No Foul Philosophy

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### Safety & Human Error: Cornerstones

- People Don't Come to Work to Hurt Someone or Make a Mistake
- Must Keep Asking "Why?"

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### Patient Safety - Strategy

- Invite People to Play
  - Problem Recognition
  - Remove Barriers (Punitive, Difficulty, Black Hole Effect)
  - Learning **NOT** Accountability System
- Importance of Close Call
- **Blameworthy Definition**
- Training (Middle thru Top Management)  
Leadership At All Levels
- Human Factors Approach
  - Tools That Guide Behavior

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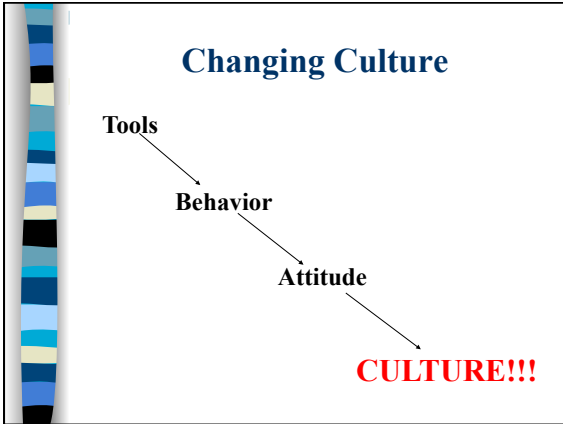
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- Prioritize**
- Risk Based
    - Severity
    - Probability
  - Must Make Sense
    - Business Processes
    - Regulatory Environment

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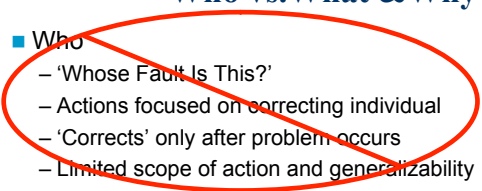
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- Causation/Actions:  
Who vs. What & Why**
- Who
    - 'Whose Fault Is This?'
    - Actions focused on correcting individual
    - 'Corrects' only after problem occurs
    - Limited scope of action and generalizability
  - What & Why
    - Actions focus on systems level causation
    - Widespread applicability
    - Stronger preventive strategy



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### MTT Impact

- N=108; 74 MTT, 34 Control
- MTT 50% greater decrease in mortality than Control
- Dose-response –
  - 0.5 deaths/1000 procedures less per quarter p=0.001
  - 0.6 deaths/1000 procedures per increase in briefing/debriefing p=0.001

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### What Have We Learned?

- Actions needed well before entering the OR
  - Timeout period is too late in many cases
  - Systems-based approaches beyond individual
- Involvement of all disciplines
- Structured communication that drives discussion
  - Briefings & debriefings, **Medical Team Training** essential

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### Action Assessment

- Characteristics of Actions
  - Temporary vs. Permanent
  - Procedural vs. Physical
- Action Evaluation
  - Process
  - Outcome

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### Management Involvement

- Formalized, Not Ad Hoc
  - Regular Part of Agenda For All Levels
- Safety Permeates the Fabric of All Activities
- Relentless

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### Sustainable Systems Approach

- Problem Identification
- Clear Goal Definition
- Involvement Of All Sectors
- Identify Systems Influences
- Identify Systems Controls
- Identify Constraints
- **Critique – Go To Worst Critics Early On**
- Pilot – Volunteers First Then Others
- Evaluate

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### Essential Elements For Sustainable Improvement

- Appropriate Goal Identification & Selection
- Transparent Prioritization
- Identification of Real Causes
- System-based Countermeasures That Address Underlying Causes
- Stronger Actions That Are Explicit
- Measurement of Actions
  - Process & Outcome

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**Leadership -  
What Can You Do Right Now?**

- Lead by Example
- Relentless Drumbeat
- Eliminate 'Whose fault is it?'
- Encourage Skepticism
  - Devil's Advocate is Valued
- Distinguish **Real** Priorities From Official Priorities
- ***What Happened?, What Should Have Happened?, What Usually Happens?***
- Part of Every Agenda

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**Closing Thoughts**

- Not About Errors!!!
- Counting reports **is not** the objective, identifying Vulnerabilities **is**
  - Hope they increase
  - **Analysis, Action, & Feedback are the key**
- Prevention NOT Punishment
- Cultural change is the key – takes time
- ***Safety is the Foundation Upon which Quality is Built***

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