Patient Safety: Some Keys to Creating and Sustaining It?

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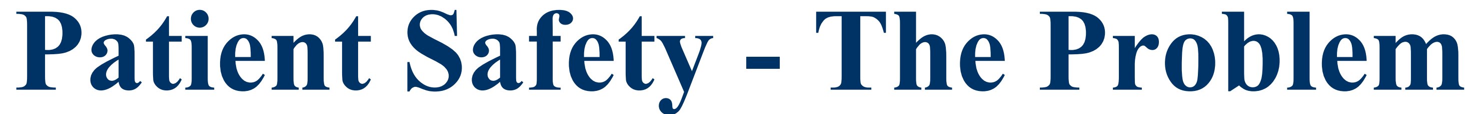
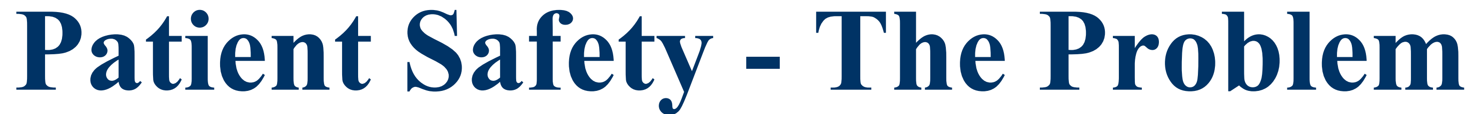
- Overview
  - Problem Identification
  - Goal Selection
  - Obstacles
  - Strategy and Tactics
  - Critical Elements
  - Leadership's Role



- Not New
- 1964 - Schimmel (Ann. Int. Med.)
  - 20% of Univ. Hospital Admissions Injured
    - 20% of those serious/fatal
- 1981 - Steel (NEJM)
  - 36% of Teaching Hosp. Admissions Injured
    - 25% serious or life threatening
- 1989 - Gopher (Proc. Human Factors Society)
  - 1.7 errors/day/patient (29% pot. serious)



- 1991 - Harvard Practice Study (NEJM)
  - 4% of Admissions Injured
    - approx. 0.5% fatal
- 1995 - Family Practice MDs (JFamPrct)
  - approx. 50% committed error resulting in patient death
- 11/99 - IOM Report
  - Deaths due to Preventable Adverse Events greater than, MVA, Breast Cancer, or AIDS

- Good First Step But…..
  - – Lack of Systems Insight
  - – Superficial Solutions (?Answers)
  - – Inadequate Follow-Up
  - – Lost Opportunity

- Clear Understanding of Goal
- Preventive Approach
- Field Understanding & Buy-In
- Trust

- Survey at VHA and Data From Other Private Healthcare Organizations
  - Only 27% Agreed that Errors were a Serious Problem
  - 49% “Ashamed” by Error
- IOM report concurs

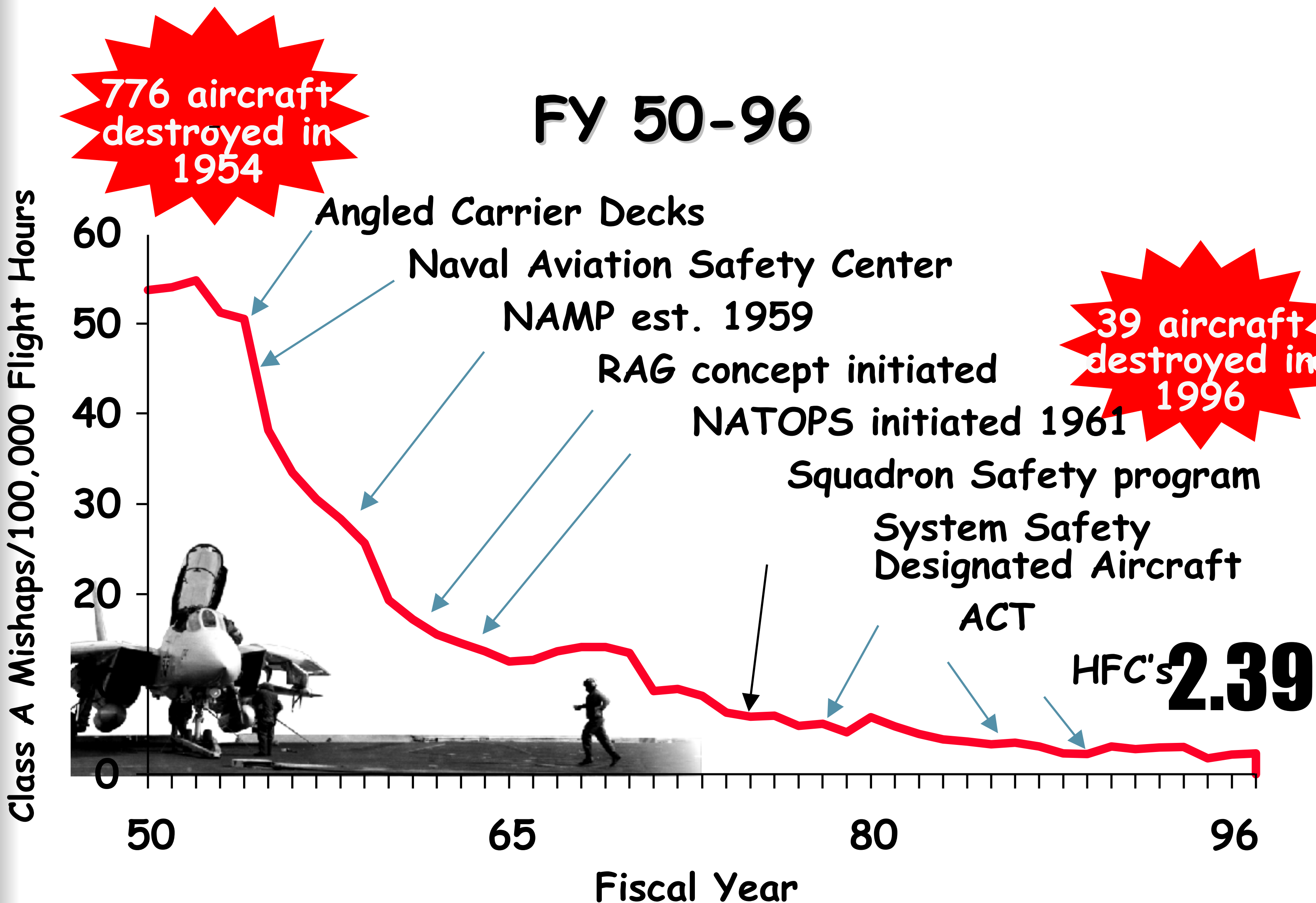
Patient Safety - Human Error Challenges

- **Medicine 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

- People Don’t Come to Work to Hurt Someone or Make a Mistake
- Systems vs. Individual Fault/Problem
- Must Keep Asking “Why?”

- High Reliability Organizations
  - High Hazard
  - Catastrophes Rare
  - Communication, Communication, ….
  - Fault Tolerance

NAVAL AVIATION MISHAP RATE



Patient Safety System Design

- NASA/JSC Close Call Reporting
  - Risk Management - focuses on Preventive Action that is taken to eliminate causes of potential nonconformity, defect, or other undesirable situation in order to prevent occurrence.

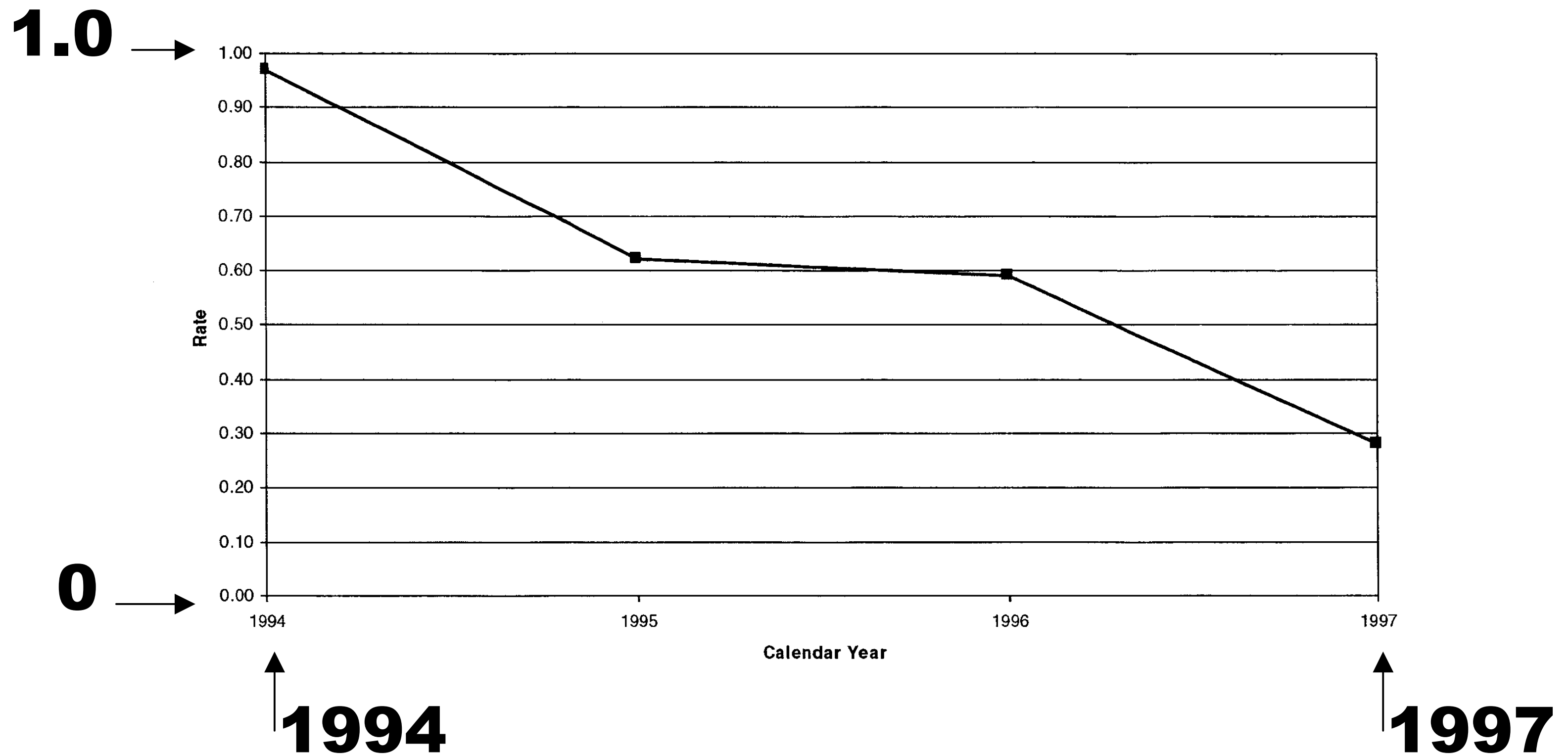
Patient Safety System Design

- NASA/JSC Close Call Reporting
  - Six Major Steps
    - Assess
    - Analyze Hazard Controls
      - Permanent Over Temp.; Physical Over Procedural
    - Request Funding - Coordination
    - Funding
    - Implementation
      - Eliminate/Control/Accept (Accepted Reviewed Cont.)
    - Closure - Tracking System

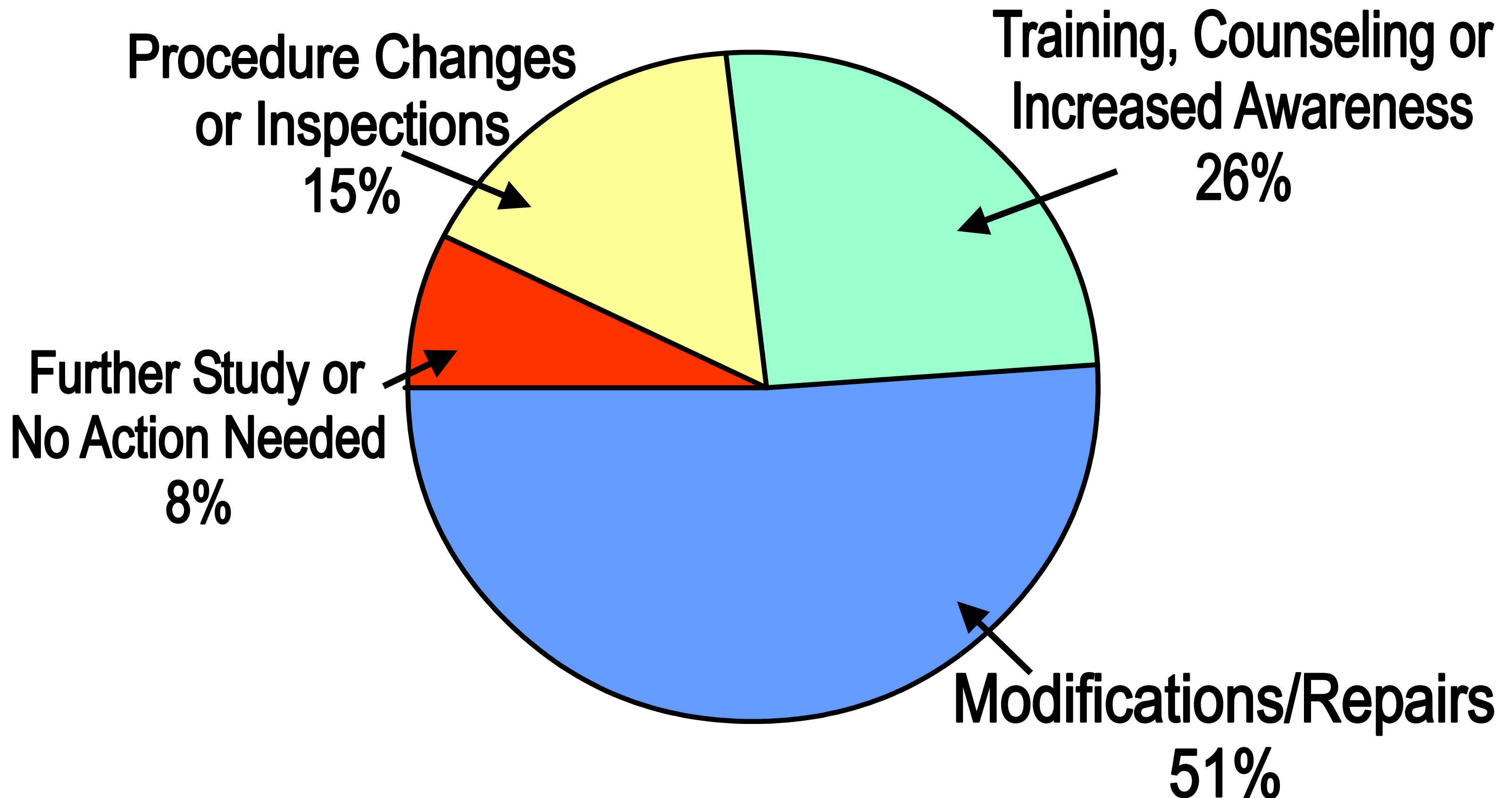
JSC Close Call Reporting System
1994 vs. 1997

1994	**1997**
1 Close Call reported for every **233** employees	**1** Close Call reported for every **54** employees
0.5 Close Calls reported for every lost time injury	**8** Close Calls reported for every lost time injury

Patient Safety System Design

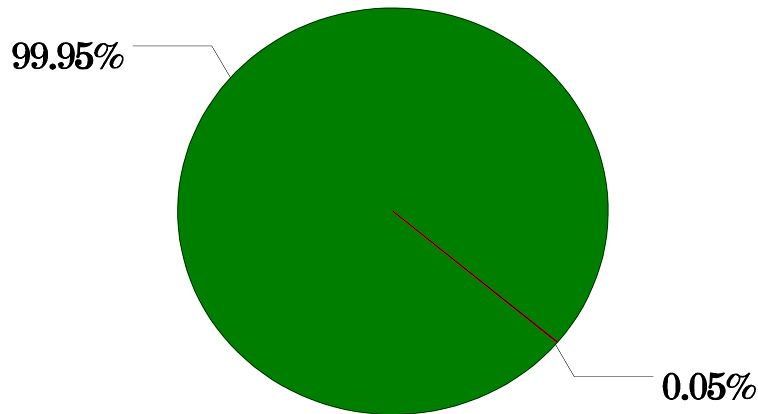


Patient Safety System Design

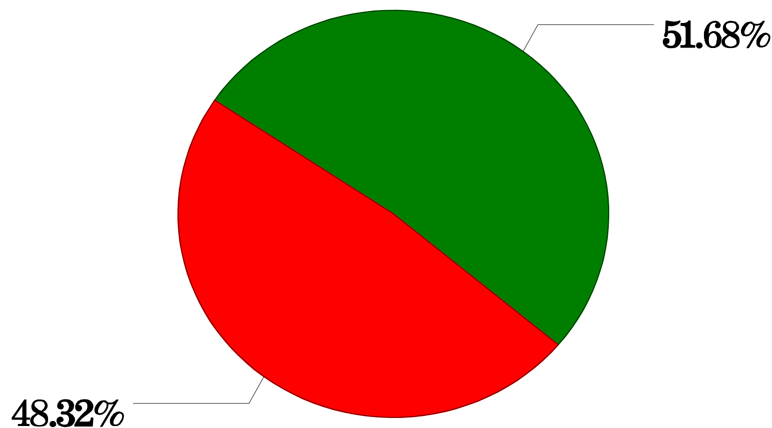


VA Root Cause Analysis Reports from 1998 to November 2002

Event Reports 1998 – 1999

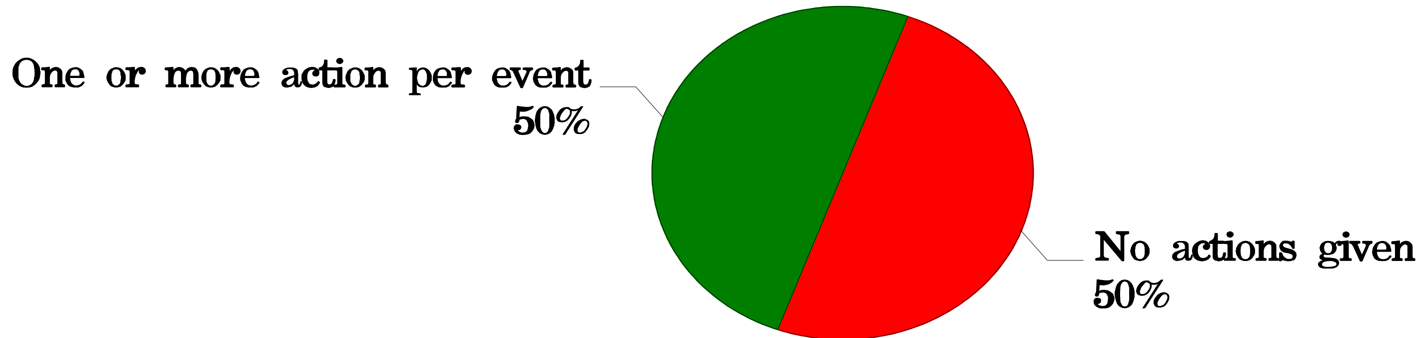


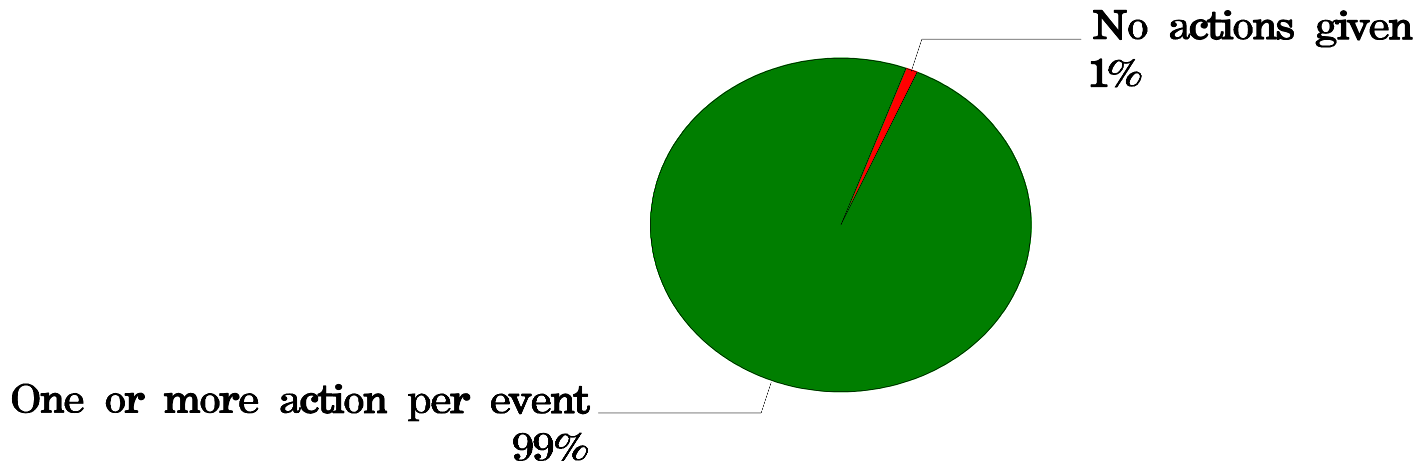
Event Reports 1999 – November 2002



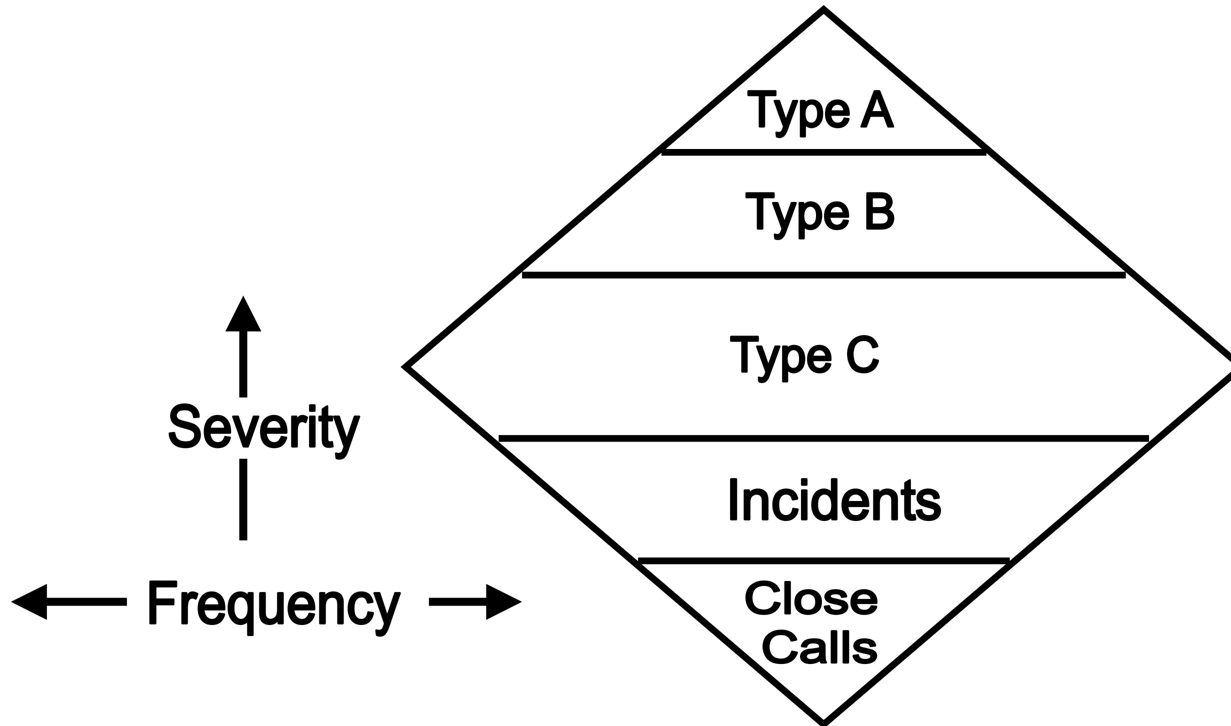
RCA Close Calls
RCA Actual Events

Number of Actions to Eliminate/Control Events (Based on sample estimates from VA events)





Patient Safety System Design



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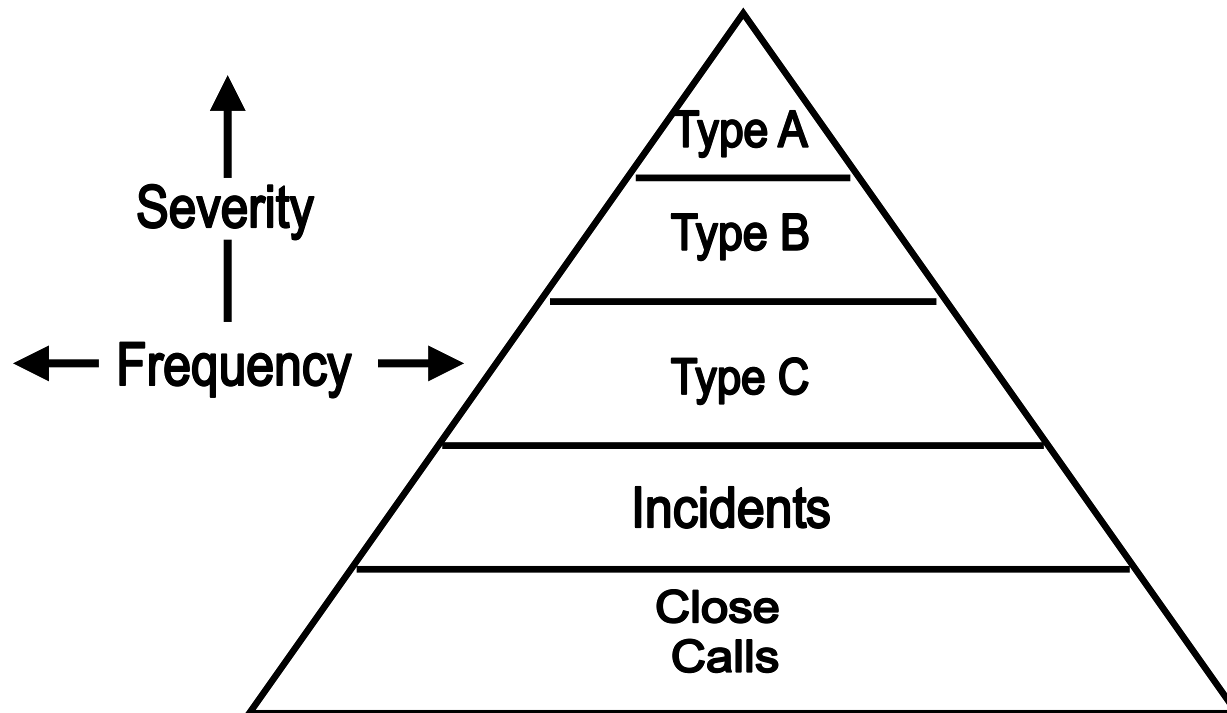
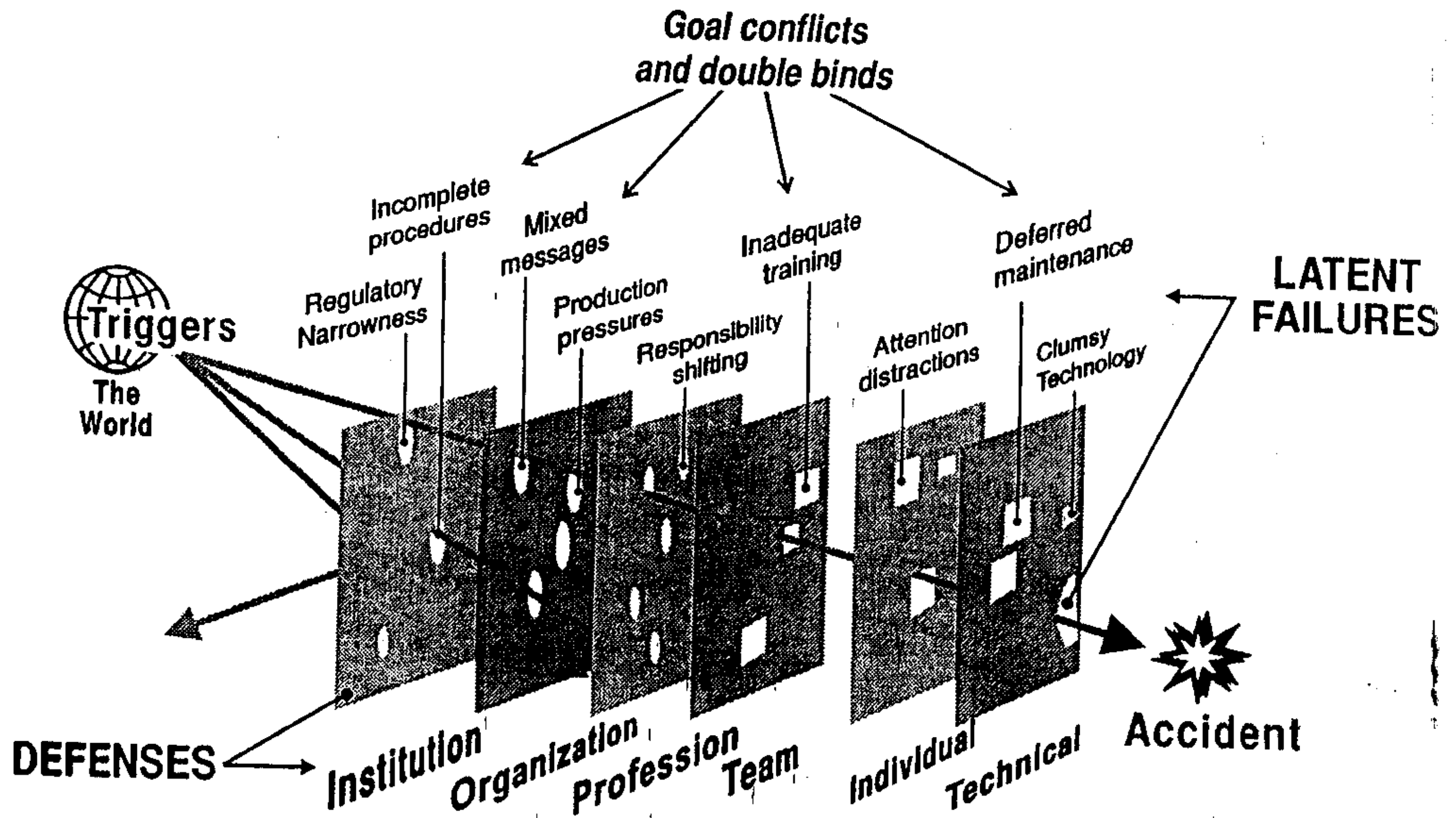
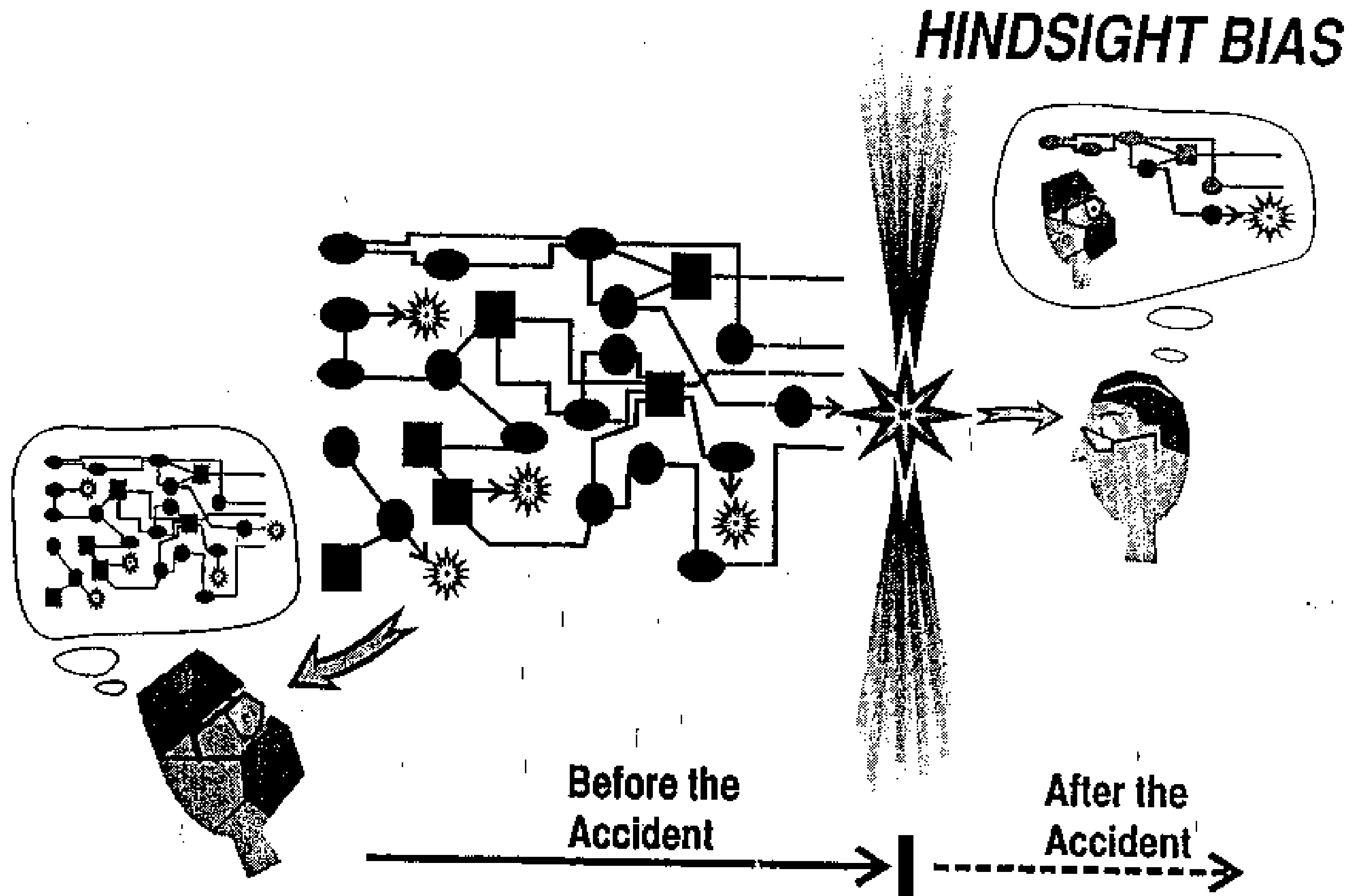


- **Learning**, Not Accountability System
- Reporting System Characteristics
  - Confidential and De-identified
  - Non-punitive
  - Internal and External
- Importance of Close Call
- Reports Should Emphasize Narratives
- Interdisciplinary Review Teams
- About Identifying Vulnerabilities **NOT** Statistics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

Patient Safety - Human Error

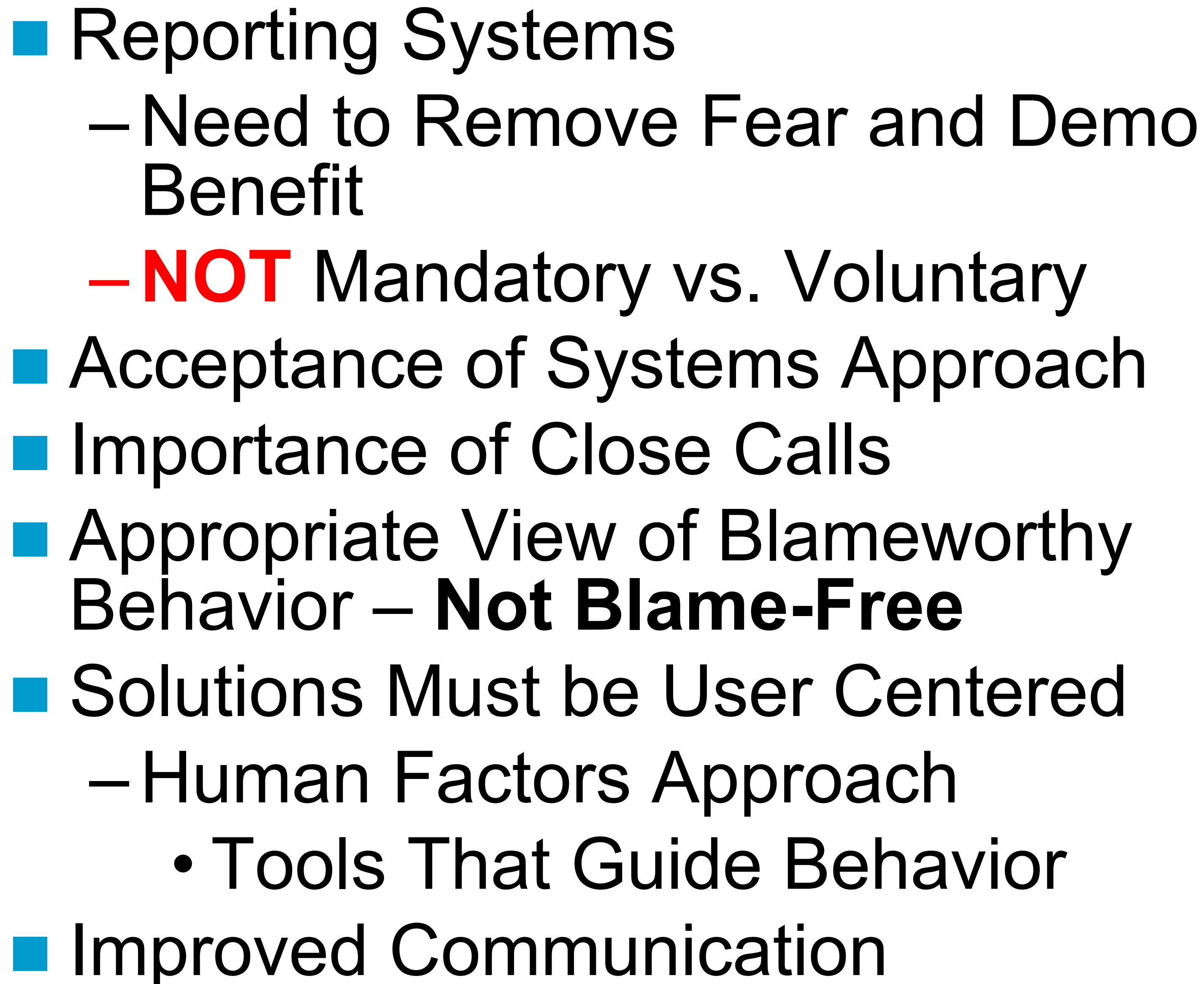


Patient Safety - Human Error



- Eliminate errors? T/F
  - Too limited and restrictive
- Improve probability that desired outcome is achieved? T/F
  - Fault Tolerance, HFMEA, Real Systems Thinking
  - Prevent Harm to Patient, **NOT** necessarily linked to traditional concept of error

Patient Safety - Needs



- Reporting Systems
  - Need to Remove Fear and Demo Benefit
  - **NOT** Mandatory vs. Voluntary
- Acceptance of Systems Approach
- Importance of Close Calls
- Appropriate View of Blameworthy Behavior – **Not Blame-Free**
- Solutions Must be User Centered
  - Human Factors Approach
    - Tools That Guide Behavior
- Improved Communication

- Nurses Felt Their Managers Had Adopted Non-Punitive Approach As A Result of Patient Safety Program
- Comfort Sharing Problems - Increased
- 75% Understood What a Close Call and RCA Were
- 33% Had Been On RCA Team
- Leadership Involvement Highly Correlated With High Performing Program
  - **Visibly Involved**

- Time to Move Beyond Teaching Old Dogs New Tricks
- Curriculum Changes
  - Formalized
  - Integrated
- No Quick Fixes
  - Culture Change for Sustainable Solution
  - Appropriate Use of Mandates
    - e.g., 80 Hour Workweek Rule????

- Cannot mandate culture change – support must be won
  - Must invite folks to play
- Communication is the key
  - Personal, not e-mail or endless lists of goals and objectives
  - Top leadership must maintain the drumbeat
- Target upper and middle management first
- Lead by Example

Leadership - What Can You Do Right Now?

- Lead by Example – Get Involved
  - You Can't Delegate Leadership
- 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

- 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