LEADING PATIENT SAFETY CULTURE IN HOSPITAL

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Are Hospitals Really Unsafe? Let us look at some data from US

- In Colorado and Utah Adverse event (injuries caused by medical management) were 2.9% and 3.7% respectively

- Attributable preventable adverse events was 58% in New York, and 53% in Colorado and Utah.

- Data extrapolated to 33.6 million admissions in U.S. hospitals in 1997 shows 44,000 to 98,000 Americans die in hospitals annually due to medical errors This exceed the deaths attributable to motor vehicle accidents (43,458), breast cancer (42,297) or AIDS (16,516)

Source IOM study (quoted by journal of nursing scholarship)

More than 6,000 Americans die from workplace injuries every year
Medication errors were at one point estimated to have accounted for about 7,000 deaths in the US.

Very little data available in Indian context. We have miles to go in organizing and reporting

Some definitions

Adverse event

Injury caused by medical management rather than the underlying condition of the patient.

Preventable adverse event

Adverse event attributable to error

Error

Failure of a planned action to be completed as intended (i.e., error of execution)

Use of a wrong plan to achieve an aim (i.e., error of planning)

Negligent adverse event

Care provider failed to meet the standard of care reasonably expected of an average physician qualified to take care of the patient

The spectrum varies with intensity of damage

Defining Safety Culture

The safety culture of an organization is the product of individual and group **values**, **attitudes**, **perceptions**, competencies, and patterns of **behavior** that determine the commitment to, and the style and proficiency of, an organization's health and safety management. (Health and Safety Commission Advisory Committee on the Safety of Nuclear Installations, 1993)

Leadership is about influencing behaviors. Therefore patient safety is directly attributable to management and leadership.

While it is not difficult to express safety culture in words, actually knowing and understanding the characteristics that define a safety culture and its implications to healthcare organizations may be more elusive.

Why Leadership is critical for safety culture in hospitals? Few Quotes

Engaged senior leaders are critical to an organization's successful development of a culture of safety. Engaged leaders drive the culture by designing strategy and building structure that guide safety processes and outcomes. ***(Yates et al., 2005).***

Administrative leadership is one of the most significant facilitators for establishing and promoting a culture of safety. ***(Blake, Kohler, Rask, Davis, & Naylor (2006)***

Culture of safety must begin with the chief executive officer (CEO), but it must also permeate throughout every level of the healthcare system. ***Dickey (2005), in an editorial on "Creating a Culture of Safety,"***

Lack of leadership has been attributed as a barrier to safety culture. In 2002, Dennis O'Leary, then President of The Joint Commission, stated hospital CEOs see no business case for patient safety (***DeWolf, Hatlie, Pugliese, & Wilson, 2003***).

Developing Safety Culture

Six Key attributes,

Drivers, Action points and challenges for leadership

1

Team Work

Key driver
Increasingly complex disease processes increasingly complex treatments and technologies
requiring stronger efforts for involving all caregivers for a common agenda of risk mitigation and safety at all touch points

Action
Applications of teamwork and collaboration among caregivers achieve a system-wide culture of patient safety.

1. Articulate vision
2. Development of quality and safety committees in each specialty.
3. Define general and specialty-specific responsibilities

Challenges
Multi disciplinary and multi generational teams
Defensive posturing and blame game
Time constraints
Conflict and competition among FFS practitioners
New entrants and physician turnover

2

Evidence based healthcare

Key driver
Availability of relevant technology to elicit evidence.
Empowered patients often seek evidence
Empirical treatment varies with experience of physician leading to diverse opinions.

Action
Use of standardized checklists.
Randomized medical audits
Create a hierarchy for questioning.
Authorization for empirical intervention by a group of practitioners

Challenges
Medical model of physician autonomy and
the “art” of medicine is still prevalent, incorporating best practices and standardization may be leadership’s greatest Challenge
Conflicting evidences at times

3 Communication

Key driver
Accreditation Norms promote a number of safety steps

Diverse staff skill levels among caregivers
Documentation errors
Repetitive functioning leads to complacency and Errors.

Action

."Read backs" are an example of structured communication
Time-outs, before an invasive procedure, verify correct procedure, at correct body site, being performed on correct patient.
"Briefings" at the beginning of procedures to assure all parties are introduced and that eqpt, medications, and supporting documents are in place

Challenges
Resource intensive in terms of training inputs
Poor physician participation
Time constraints during emergency
Absence of feedback loops for closure, poor incident reporting

4 Learning

Key driver
Evolution of safety culture
Outcome audits and academic discussions
Leaders demonstrate willingness to learn from inside as well as outside the hospitals

Action
Create a learning platform and create learning sessions
Training passport and mandatory training hours for all
Focus of internal learning from mistakes as well as successes
Root cause analysis team for each incident/near miss

Challenges
Fear of persecution leads to poor reporting
Peer groups shy away from frank discussions
Incentives demanded for learning sessions
Lack of trainers

5 Just Culture

Key driver
People consider “To err is human” as accepted principle
Punitive action at all times leads to poor reporting and highly defensive actions
Conflict between “individual failures or System failures demand fair adjudication

Action
Ask four questions
a)Was the care provider’s behavior malicious? (b) Was the care provider under the influence of alcohol or
drugs? (c) Was the care provider aware he was making a mistake? (d) Would two or three of the care provider’s peers make the same mistake?

Challenges
Investigations are time consuming
Physician and staff might consider this derogatory
Error reporting could be political
Long lead time to create a blame free environment

6 Patient Centricity

Key driver

Internet educated patients demand participation in the medical management

Patients need options and transparency

Patient and immediate relatives participation gives a value for money feel

Transparency and patient participation promotes safety culture

Action

Factor structured interactive sessions between caregivers and patient relatives/patients

Nurse communication before every action or intervention

Enhance psycho social well being through counselors

Community education sessions on patient safety

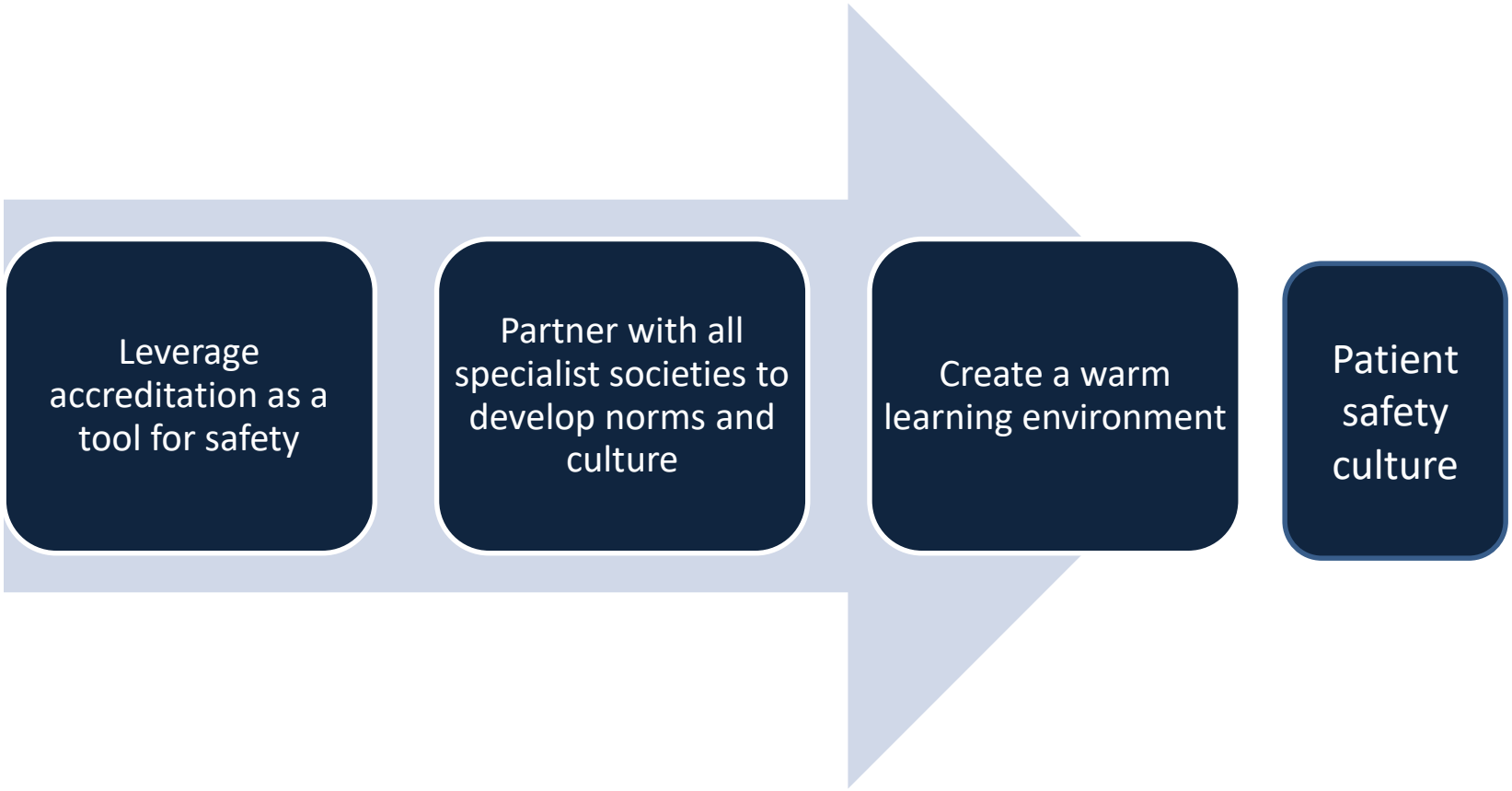
Challenges

In Indian context patient education levels are often poor for comprehension

Linguistic barriers

Excess and repeated briefings may dessuade patient for proceeding with treatment

Three Strategic Steps



Summary

- Patient Safety is a function of leadership
- It involves influencing behavior
- Training on effective and structured communication, such as “read back”, “time out” and Briefings and important tools
- Safety culture must have required investigative toolkits for proving negligence
- Culture should be fair and just and not simply coercive
- Partnership with Clinician groups and societies helps in active participation for evidence based care
- Patient centricity and community participation is important in achieving safety goals
- A rich learning environment and blame free error reporting is key to monitor discuss and improve

THANK YOU