Patient Safety:
by CHOICE not by CHANCE!

Marge Kerns, RPh
Director, Medical Safety
LRGHealthcare

OBJECTIVES

- Identify three common threads in organizational accidents.
- Compare/Contrast how organizational cultures handle safety information.
- Define three necessary features of safety cultures.
- Describe three individual characteristics that support safe environments.

What is Safety?

- Safety is more defined by its ABSENCE than its PRESENCE
- The absence of negative effects
- It is a dynamic non-event
- We can't see safety; but we readily see the lack of it
- Safety is never absolute/no total freedom from danger

Organizational Accidents in High Risk Industries

- Can be devastating
- Occur rarely
- Hard to predict – luck plays a part
- Technological innovations – system/human interface

Common Threads in Organizational Accidents

- Economic drivers to stay afloat
- Establishment of latent conditions
- Often front line error, breach, or slip
- Lack of respect for accident potential
- Deterioration of defenses/holes in the swiss cheese

Organizational Dynamics

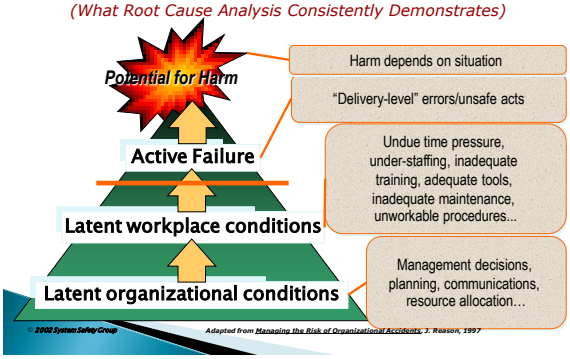
- Production vs Protection
- Production is necessary to allow for protection – need a balance
- It is in the short term that conflicts occur
- Can apply this concept to individuals
- Choices are made; most cases no bad effects; process becomes habitual; vulnerability

Latent Conditions/Error Precursors

- Management decisions
  - based on strategic goals; can't foresee everything; forecasting, budgeting, planning
- Resource allocation, scheduling
- Inadequate training
- Equipment failures/lack of equipment
- Unworkable procedures/lack of procedure
- Ambiguity in procedures
- Undue time pressure/elimination of OT
- Development of work-arounds

The Failure Sequence in High Risk Systems

(What Root Cause Analysis Consistently Demonstrates)



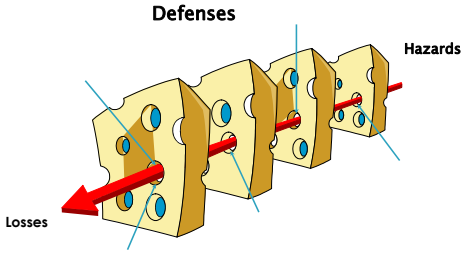
Forgetting to be Afraid

- Bad outcomes are rare; few have direct experience with them
- Act as if we are invulnerable; our upbringing as skilled clinicians
- Reliance on other disciplines being perfect
- Nothing has happened therefore nothing will happen

Forgetting to be Afraid

- "Accidents occur not because we gamble and lose,
  - Accidents occur because people do not believe that the accident that is about to occur is at all possible."
    - Wagenaar and Groeneweg
    - Reason, Managing the Risks of Organizational Accidents

System Failure Leading to Error



8. **Pronovost PJ, Wu Aw, Sexton, JB et al.**, Ann Int Med, 2004.
9. **Reason J, Hobbs A.**, 2000.

How Do Organizational Cultures Handle Safety Information?

Organizational Cultures

- **Pathologic** –
  - don't want to know; shoot the messenger; failure is punished; new ideas discouraged
- **Bureaucratic** –
  - may or may not find out; local fixes; new ideas present problems
- **Generative/High Reliability** –
  - Actively seek; messengers rewarded; failure leads to global reforms; new ideas welcomed

Hallmarks of High Reliability Organizations (HROs)

- Sensitivity to Operations
- Preoccupation with Failure – what could go wrong?
- Reluctance to Simplify – it could happen here
- Commitment to Resilience – pick yourself back up; coping with the unexpected
- Deference to Expertise – ask for help

Safety Culture

- Emerges gradually
  - Process of collective learning
- Persistent and successful application of practical and down to earth measures
- Guiding values are crystal clear to those on the front lines; flexible
- Informed (data driven), reporting, and just

Features of Safety Cultures

- **Systems thinking**
- Planning– Huddles, Checklists, Drills, Simulations
- Workload Management
  - Re-positioning, Assignments, Acuity/task checks
- Successful consultation
  - Willingness to speak up and a willingness to listen
- Situation Awareness – in the same movie
- Collective Mindfulness/Support of individual mindfulness

Features of Safety Cultures

- Systems thinking
- **Planning– Huddles, Checklists, Drills, Simulations**
- Workload Management
  - Re-positioning, Assignments, Acuity/task checks
- Successful consultation
  - Willingness to speak up and a willingness to listen
- Situation Awareness – in the same movie
- Collective Mindfulness/Support of individual mindfulness

Features of Safety Cultures

- Systems thinking
- Planning– Huddles, Checklists, Drills, Simulations
- **Workload Management**
  - **Re-positioning, Assignments, Acuity/task checks**
- Successful consultation
  - Willingness to speak up and a willingness to listen
- Situation Awareness – in the same movie
- Collective Mindfulness/Support of individual mindfulness

Features of Safety Cultures

- Systems thinking
- Planning- Huddles, Checklists, Drills, Simulations
- Workload Management
  - Re-positioning, Assignments, Acuity/task checks
- **Successful consultation**
  - **Willingness to speak up and a willingness to listen**
- Situation Awareness – in the same movie
- Collective Mindfulness/Support of individual mindfulness

Collective Mindfulness

- Assumes that error is not isolated
- Believes in the convergence of contributing factors
- Generalizes "fixes"
- Does not take the past as an infallible guide to the future
- Pre-occupied with the possibility of failure

What are the Individual Characteristics that Support Safe Environments?

Human Contributions to Safety

- Behavioral Choices
- Teamwork/Communication
- Assessing Risky Situations
- Taking a Stand – willingness and commitment to go the extra mile (red rules)
- Effort, diligence, and attention to details make a difference (discipline)
- Realistic optimism – the power of positive thinking; confidence

Emphasizing Behavioral Choices

- At-risk behaviors – choice to drift
  - Production vs Protection – rewarded at times
  - No intent for bad outcomes
  - Perception of risk fades or is believed justified
  - Coach
- Reckless behaviors – cross the line
  - Knowingly put people in harms way
  - Conscious disregard
  - Self only
  - Punishment

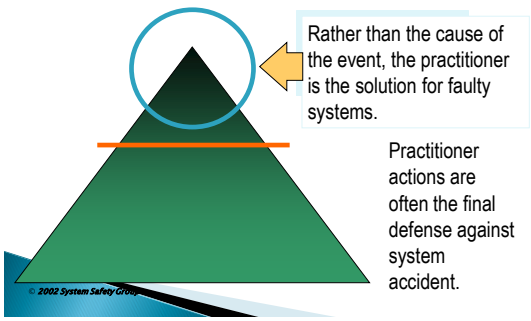
The 3 Faces of Violations

- Skill Based
  - Corner cutting, routine, inelegant procedures
  - Rarely punish violation or reward compliance
- Rule Based
  - Can be necessary and situational
  - Benefits seen as outweighing the costs
  - Workplace deficiencies
- Knowledge Based – novel situations with little or no guidance

Human as Hero

- Becoming "error wise"
- Individual mindfulness
  - A mindset that expects unpleasant surprise
  - Aware of hazards, contingencies in place
  - Respectful of the dangers
- Paradox of safety management

Optimizing Front Line Performance

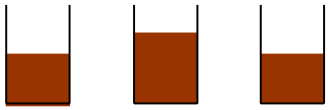


Downside of Human as Hero

- Nursing culture of "ploughing through to get the job done"
- Fixing things on the local level/work-arounds obscure organizational shortcomings
- Seeking assistance from a peer rather than a manager who can affect system change

Acquiring Error Wisdom

Three Bucket Model



Self

- Generally stable
- Bad stuff
  - Inexperience, fatigue, life events etc.
- Good Stuff
  - Experience, knowledge, fitness etc.
  - Custodial attention
  - Discretional energy

Nature of the Context

- Labile
- Bad stuff
  - Distractions
  - Interruptions
  - Lack of time
- Good stuff
  - Good teamwork
  - Ability to question

Error Potential of the Task

- Labile
- Steps within task may vary
- Less likely to be assessed objectively

Human Contributions to Safety

- Behavioral Choices
- Teamwork/Communication
- Assessing Risky Situations
- ***Taking a Stand – willingness and commitment to go the extra mile (red rules)***
- Effort, diligence, and attention to details make a difference (discipline)
- Realistic optimism – the power of positive thinking; confidence

Human Contributions to Safety

- Behavioral Choices
- Teamwork/Communication
- Assessing Risky Situations
- Taking a Stand – willingness and commitment to go the extra mile (red rules)
- ***Effort, diligence, and attention to details make a difference (discipline)***
- Realistic optimism – the power of positive thinking; confidence

Human Contributions to Safety

- Behavioral Choices
- Teamwork/Communication
- Assessing Risky Situations
- Taking a Stand – willingness and commitment to go the extra mile (red rules)
- Effort, diligence, and attention to details make a difference (discipline)
- ***Realistic optimism – the power of positive thinking; confidence***

Effective Safety Management

- Balance of Proactive and Reactive Measures
- Commitment
  - Motivation – a model or just staying ahead of regulation
  - Resources – factor of money
- Competence
- Cognizance
  - State of Intelligent Wariness
- Long term "fitness program"
  - constantly assessing and improving basic procedures/part of the core business

Goal of Safety Management

- Attainment and preservation of a state of maximum practicable resistance to operational hazards.