Patient Safety and Management

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You want quality and safety?
You need good systems and managers who lead
What is the size of the problem?

About 1 in 10 hospital admissions lead to an adverse event
About half of these are preventable
About one third lead to true patient harm
Types of errors

- Diagnostic errors
- Medication errors
- Surgical errors
- Person-machine interaction errors
- Nosocomial infections
- Transition and hand over errors
- Teamwork and communication errors

Areas of safety solutions

- Creating a culture of safety
- Workforce issues
- Training
- Periodic intense safety programmes
- Information technology
- Incident reporting
- Malpractice system and accountability
- Laws and regulations
Organisational culture

When leaders change their responses to mistakes, asking what happened instead of who made the error, the culture in healthcare institutions will also begin to change.

Leadership and management

Leadership is the process of influencing people towards achievement of organizational goals
(Naylor, 2004, p.354)

Management is effective use of resources for achievement of organizational goals
All managers have a role in safety

- team leaders
- middle managers (e.g. heads of units) at a tactical level
- top-level managers (e.g. heads of organisations, CEOs) at the strategic level

What do you expect managers?

- As with all staff, managers need to know what is expected of them
- They need sufficient resources and authority
- They need appropriate tools and guidelines
- They need to be supported and supervised
- Then they can be held accountable for decisions, actions and outcomes
Management for a culture of safety

- Emphasise safety over productivity
- Empower staff to act and communicate
- Get involved in safety initiatives
- Relay the corporate vision for safety
- Ensure compliance with regulatory requirements
- Demonstrate consistent commitment to safety
- Provide resources for safety programmes
- Show concern for staff
- Encourage participatory styles in middle managers and supervisors

Communication and Patient Safety

Communication failures are the leading causes of inadvertent patient harm
Communication problems

- shift change or patient handovers
- quality of information in patient files, case notes and incident reports
- status or hierarchy inhibiting junior staff from speaking up
- difficulties of transmitting information within and between large organisations

Pre-task briefing

- In safety-critical industries, pre-task briefing is also critical
- Briefing tools for healthcare, e.g.
  - Safe handover (BMA)
  - the WHO Surgical Safety checklist
- Creating a culture for all team members to speak up and exchange information is an important element of the briefing
The individual and patient safety

- Situation awareness
- Decision making
- Stress
- Fatigue

Errors - focus on what and why

Most errors are innocent slips committed by competent and committed caregivers and are best dealt with by focusing on improving systems rather than people.

Blaming people side-tracks efforts from fixing system problems to reduce errors.
“No blame” as a tool

The “No blame” approach is a tool to help us achieve safe and high-quality care, for which we will be held accountable.

But for mature, well proven patient-safety practices, it is the wrong tool.

Any tool has to be used at the right time, in the right way.

Getting to the heart of the problem

With a “No blame” approach staff have to be appreciated and supported to explain what happened – step by step

- Looking at each action and sequences

- Asking at each point – “but why” – until there is enough information to diagnose the system problems and plan changes
From “no blame” to accountability

When a safety rule is implemented, individual or team failure to adhere leaves the area of “no blame” and enters the domain of accountability.

When accountable for errors?

1. Safety procedure is evidence-based
2. Staff have been adequately trained on the procedure
3. Systems make it easy to comply
4. Consequences of non compliance have been agreed and understood
5. Fair and transparent auditing
6. Counselling and education after first error
You want quality and safety?

1. Build a safety culture
2. Lead and support your staff
3. Integrate your risk management activity
4. Promote reporting
5. Involve and communicate with patients and the public
6. Learn and share safety lessons
7. Implement solutions to prevent harm