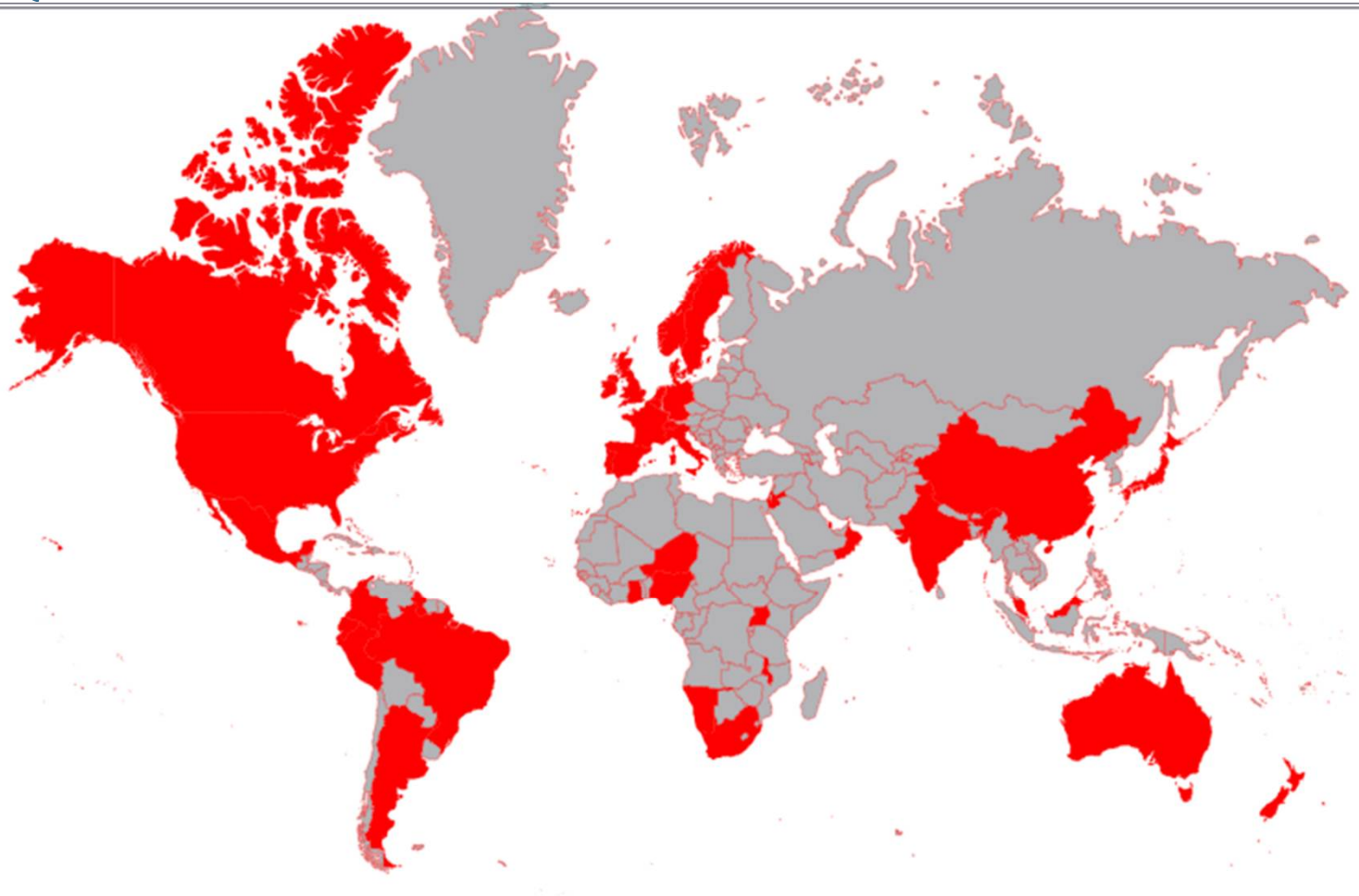
Developing a safety and quality movement for the future From theory to action

Peter Lachman

CEO

ISQua's Networks



countries

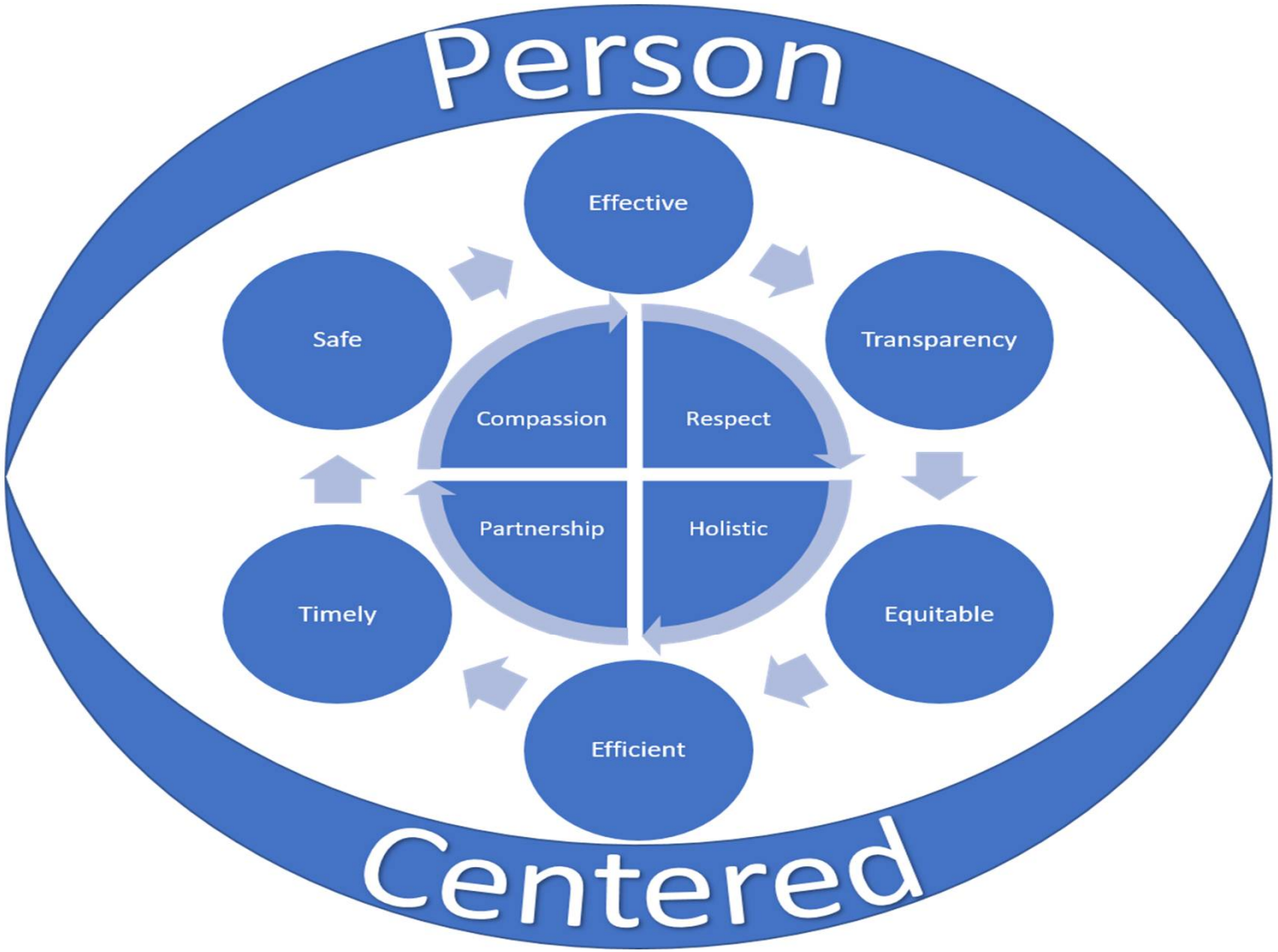
Learning objectives

- The problem of safety
- The business case
- The theories of patient safety
- The Implementation of reliable interventions
- The social movement for safety – from theory to action

Tokyo Declaration 2018

- Recognizing the need to promote and implement patient safety as a fundamental requirement of all service delivery systems, at all levels of health care and in all health care settings, we will:
  - Affirm our strong commitment to maintain a high level of political momentum on “Global action on Patient Safety”
  - Support safety at all levels of care
  - Building capacity in leadership and management to support patient-centered care, implement and strengthen patient safety systems and processes, create a culture of safety and transparency.

The quality system



Our mission – is to ensure the provision of high quality, sustainable healthcare services to the community we serve.

•Our vision - is to provide an outstanding experience and the best outcome for our patients and the team.

Every patient will say:

- I was treated with compassion;
- I was involved in a plan for my care which was understood and followed; and
- I was treated in a safe way, without delay.
- And every member of our team will feel able to give their best and feel valued for doing so.

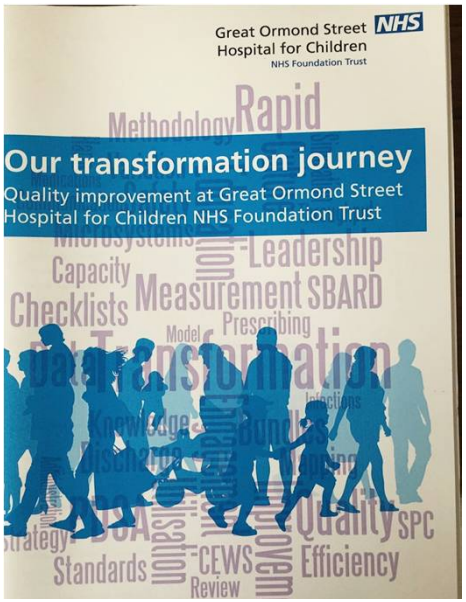
Pillars

- **Quality of Care:** Creating a learning organisation and culture of continuous improvement to reduce repeated harms and improve patient experience.
- **People**: Being a great place to work and be a patient, where we listen, empower and value everyone.
- **Modern Healthcare:** Delivering the most effective and efficient treatment and care by standardising the delivery outcome and clinical services.
- **Digital:** Using digital technology and innovations to improve clinical pathways, safety and efficiency, and empower patients.
- **Collaborate**: Working with our partners in health and care to ensure provision of high quality, sustainable NHS to the communities we serve.

Where I started understanding safety

Institute for Healthcare Improvement

NHS Institute for Innovation and Improvement



Transformation
working together towards
zero harm•no waste•no waits

Part 1
The Problem

Reliable person centred care

Right bed

Right Place

Right nurse

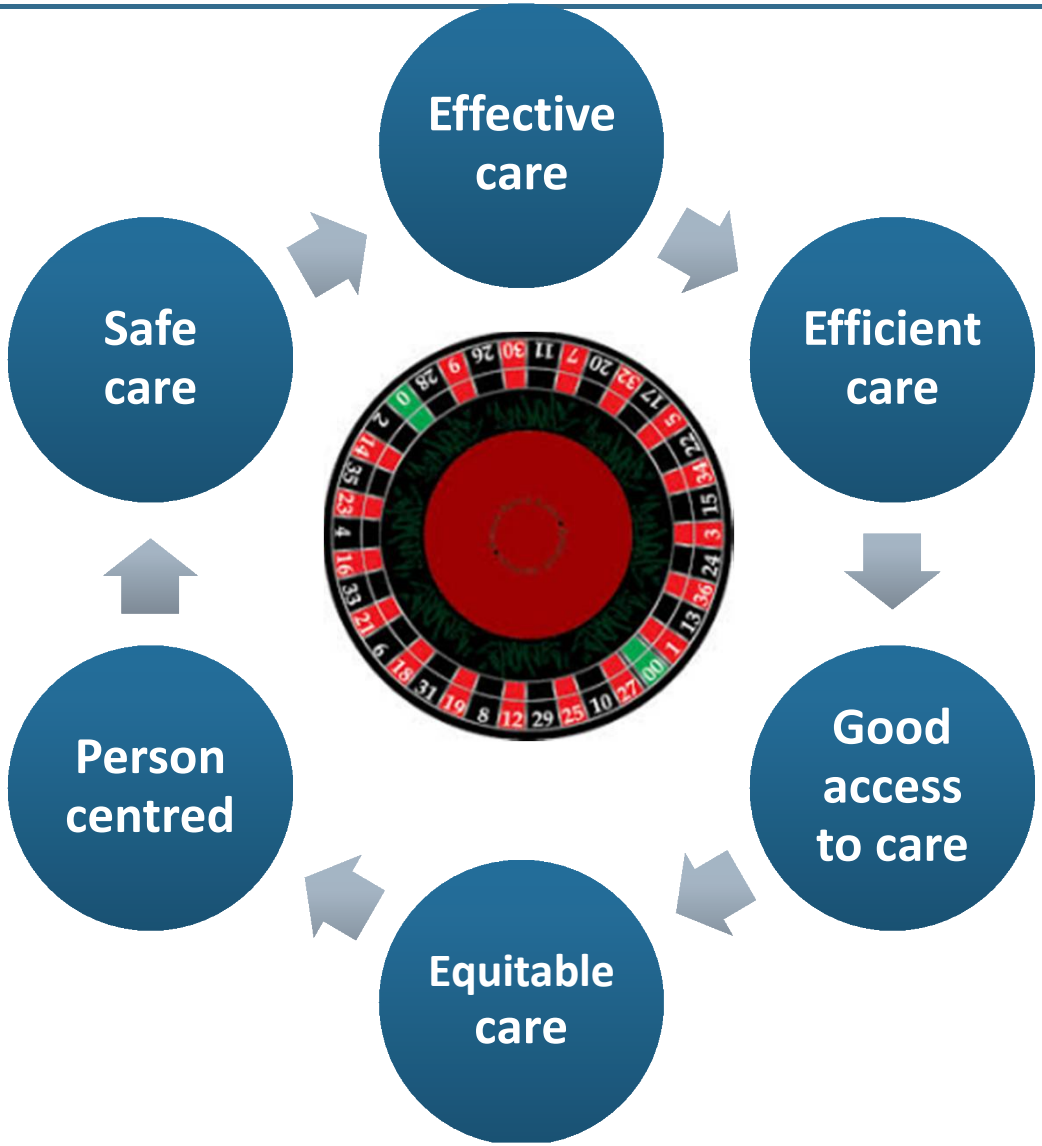
No delays

The person receives the right care the first time every time

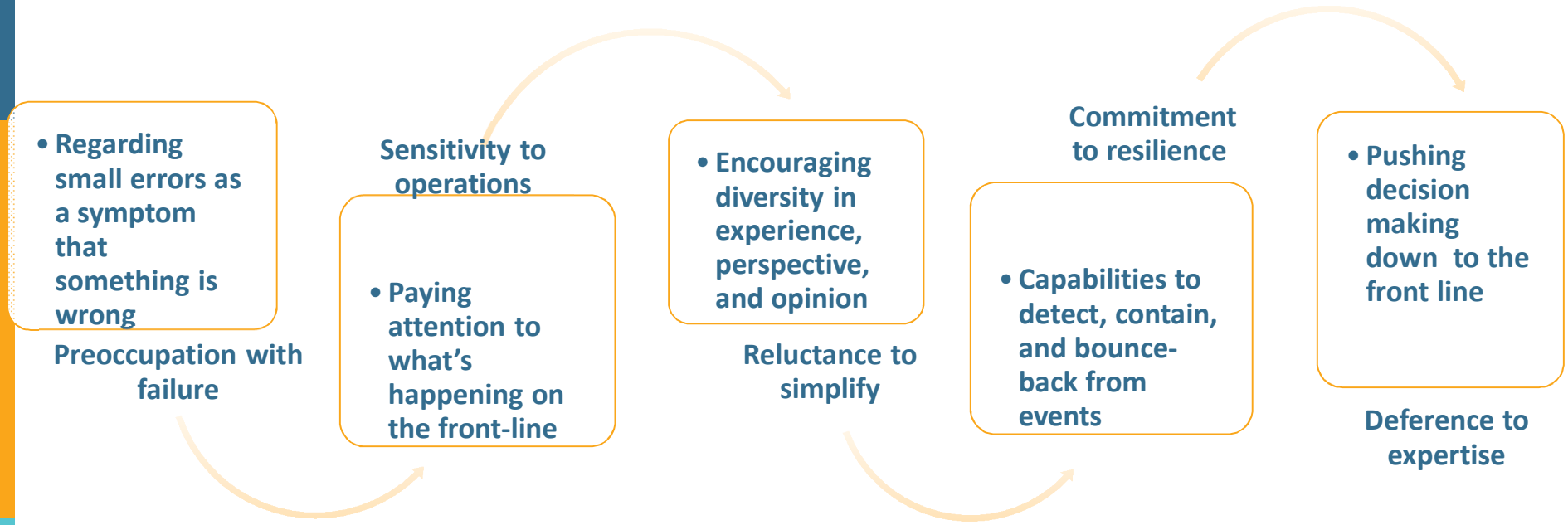
Right treatment

Coordinated and Safe

Patient Safety and Quality is up to chance



Aim for high reliability



Based on Weick and Sutcliffe

The state of play 2003

SPECIAL ARTICLE

The Quality of Health Care Delivered to Adults in the United States

Elizabeth A. McGlynn, Ph.D., Steven M. Asch, M.D., M.P.H., John Adams, Ph.D., Joan Keesey, B.A., Jennifer Hicks, M.P.H., Ph.D., Alison DeCristofaro, M.P.H., and Eve A. Kerr, M.D., M.P.H.

ABSTRACT

54%

chance of good quality evidenced based care

And in 2018

JAMA | Original Investigation

Quality ... ia, 2012-2013

Jeffrey Braithwa
Christopher T. C
Gavin Wheaton,
Louise K. Wiles,
Tamara D. Hoop
Annette Schmie
Ed Kelley, PhD; F

Key Points

Question Is health care for children in Australia consistent with quality standards?

Findings In this study of 6689 Australian children aged 15 years and younger, a comparison of clinical records against quality indicators for 17 important child health conditions, such as asthma and type 1 diabetes, estimated that overall adherence was 59.8%, with substantial variation across conditions.

Meaning For many important child health conditions, the quality of care in Australia may not be optimal.

IMPORTAN
single setti

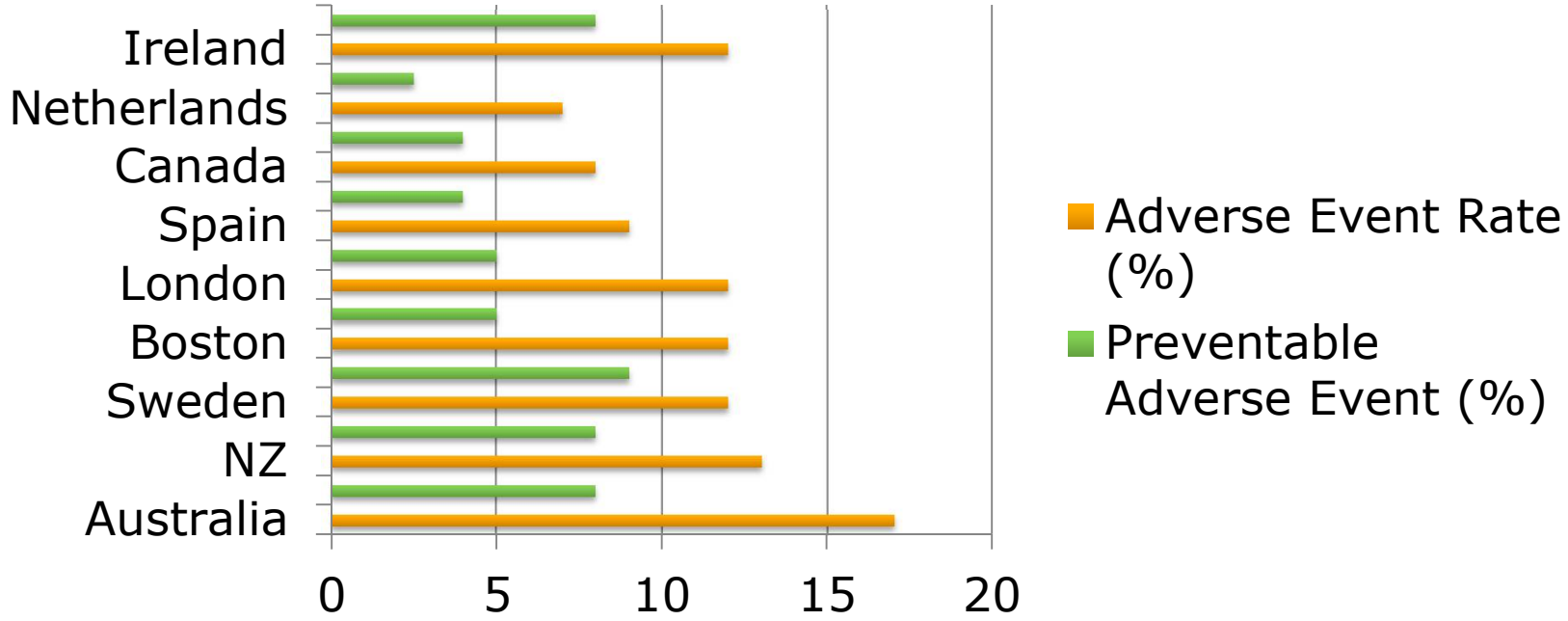
OBJECTIVE
ambulatory health care settings.

Editorial page 1096
Supplemental content
CME Quiz at jamanetwork.com/learning

59.8%

Braithwaite J, Hibbert PD, Jaffe A, et al. Quality of Health Care for Children in Australia, 2012-2013. JAMA. 2018;319(11):1113–1124. doi:10.1001/jama.2018.0162

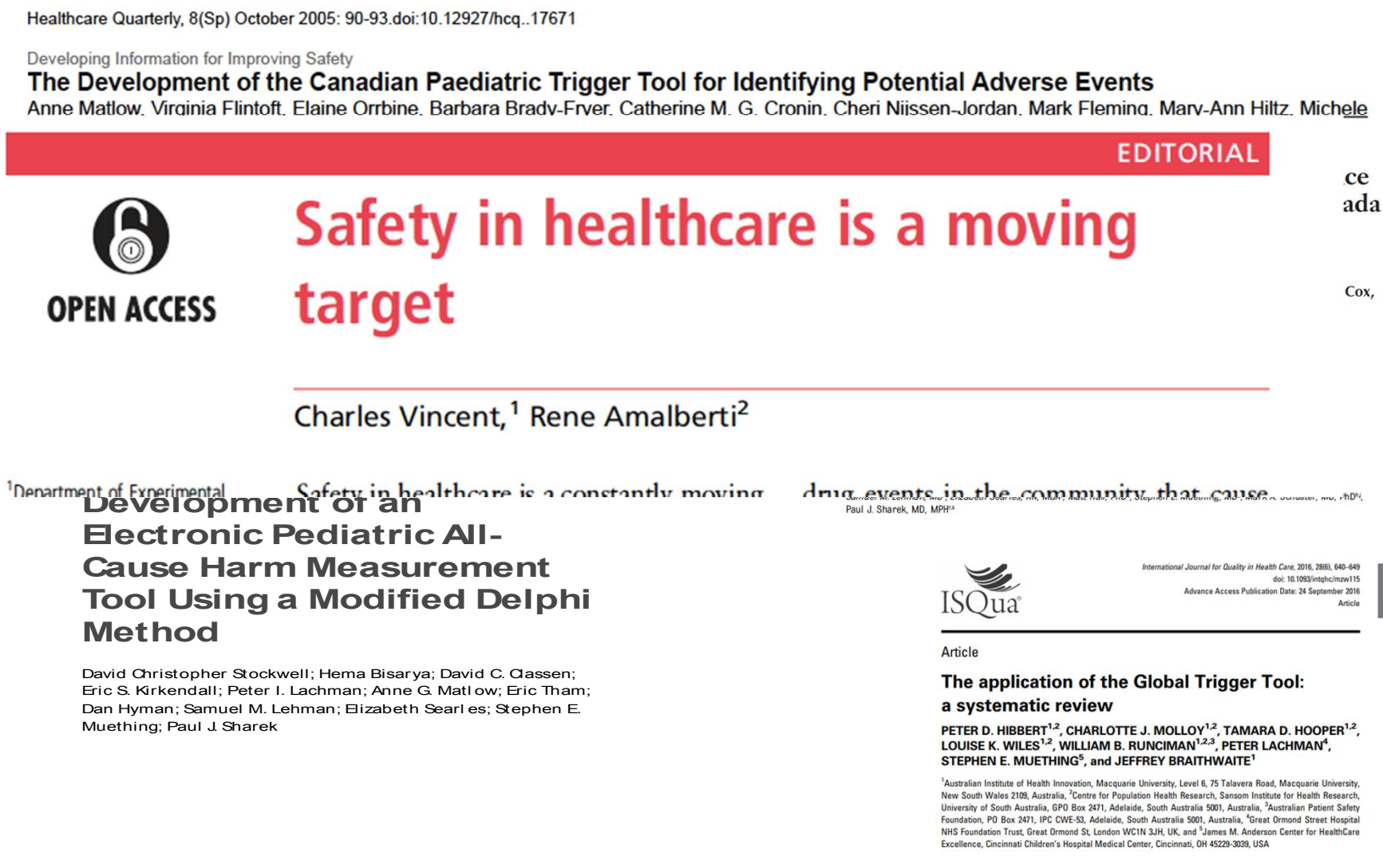
Comparative adverse event rates



Rafter N, Hickey A, Condell S, Conroy R, O'Connor P, Vaughan D, et al. Adverse events in healthcare: learning from mistakes. QJM. 2015 Mar 26;108(4):273–7
Rafter N, Hickey A, Conroy RM, Condell S, O'Connor P, Vaughan D, et al. The Irish National Adverse Events Study (INAES). BMJ Qual Saf. 2016 Feb 9

From David Vaughan

The real rate is 10-15%?



Healthcare Quarterly, 8(Sp) October 2005: 90-93.doi:10.12927/hcq..17671

Developing Information for Improving Safety

The Development of the Canadian Paediatric Trigger Tool for Identifying Potential Adverse Events

Anne Matlow, Virginia Flintoft, Elaine Orrbine, Barbara Brady-Fryer, Catherine M. G. Cronin, Cheri Nijssen-Jordan, Mark Fleming, Mary-Ann Hiltz, Michele

EDITORIAL

ce
ada

OPEN ACCESS

Safety in healthcare is a moving target

Cox,

Charles Vincent,[1] Rene Amalberti[2]

[1]Department of Experimental

Safety in healthcare is a constantly moving

drug events in the community that cause

Paul J. Sharek, MD, MPH[2,3]

Development of an Electronic Pediatric All-Cause Harm Measurement Tool Using a Modified Delphi Method

David Christopher Stockwell; Hema Bisarya; David C. Classen; Eric S. Kirkendall; Peter I. Lachman; Anne G. Matlow; Eric Tham; Dan Hyman; Samuel M. Lehman; Elizabeth Searles; Stephen E. Muething; Paul J. Sharek

ISQua

International Journal for Quality in Health Care, 2016, 28(6), 640–649
doi: 10.1093/intqhc/mzw115
Advance Access Publication Date: 24 September 2016
Article

OXFORD

Article

The application of the Global Trigger Tool: a systematic review

PETER D. HIBBERT[1,2], CHARLOTTE J. MOLLOY[1,2], TAMARA D. HOOPER[1,2], LOUISE K. WILES[1,2], WILLIAM B. RUNCIMAN[1,2,3], PETER LACHMAN[4], STEPHEN E. MUETHING[5], and JEFFREY BRAITHWAITE[1]

[1]Australian Institute of Health Innovation, Macquarie University, Level 6, 75 Talavera Road, Macquarie University, New South Wales 2109, Australia, [2]Centre for Population Health Research, Sansom Institute for Health Research, University of South Australia, GPO Box 2471, Adelaide, South Australia 5001, Australia, [3]Australian Patient Safety Foundation, PO Box 2471, IPC CWE-53, Adelaide, South Australia 5001, Australia, [4]Great Ormond Street Hospital NHS Foundation Trust, Great Ormond St, London WC1N 3JH, UK, and [5]James M. Anderson Center for HealthCare Excellence, Cincinnati Children's Hospital Medical Center, Cincinnati, OH 45229-3039, USA

Part 2
The business case for safety

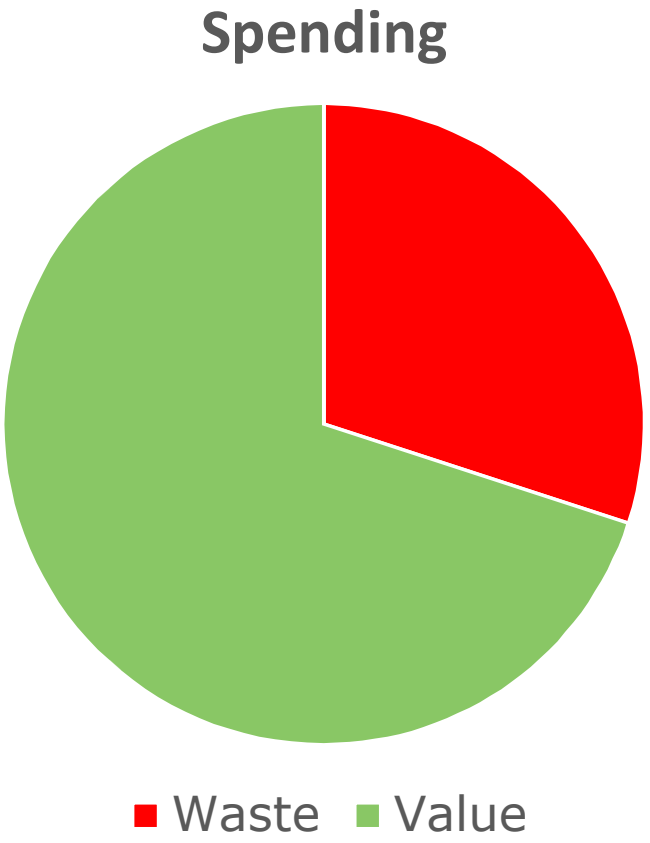
The economics of safety

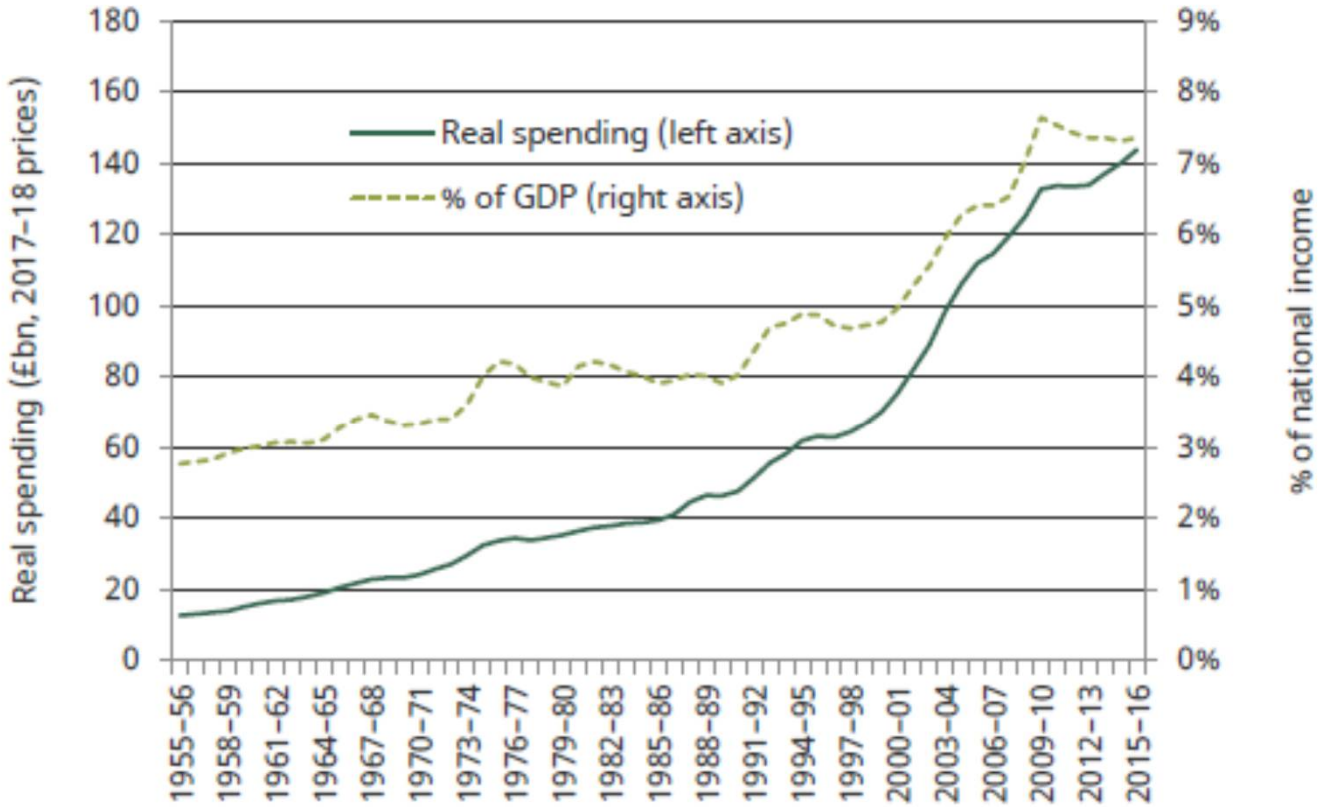
Estimating the costs of lapses in patient safety. Costs are quantified in terms of

- Disease burden (morbidity and mortality),
- Financial and resource impact on the healthcare system.

Cost of failure is more expensive than cost of interventions

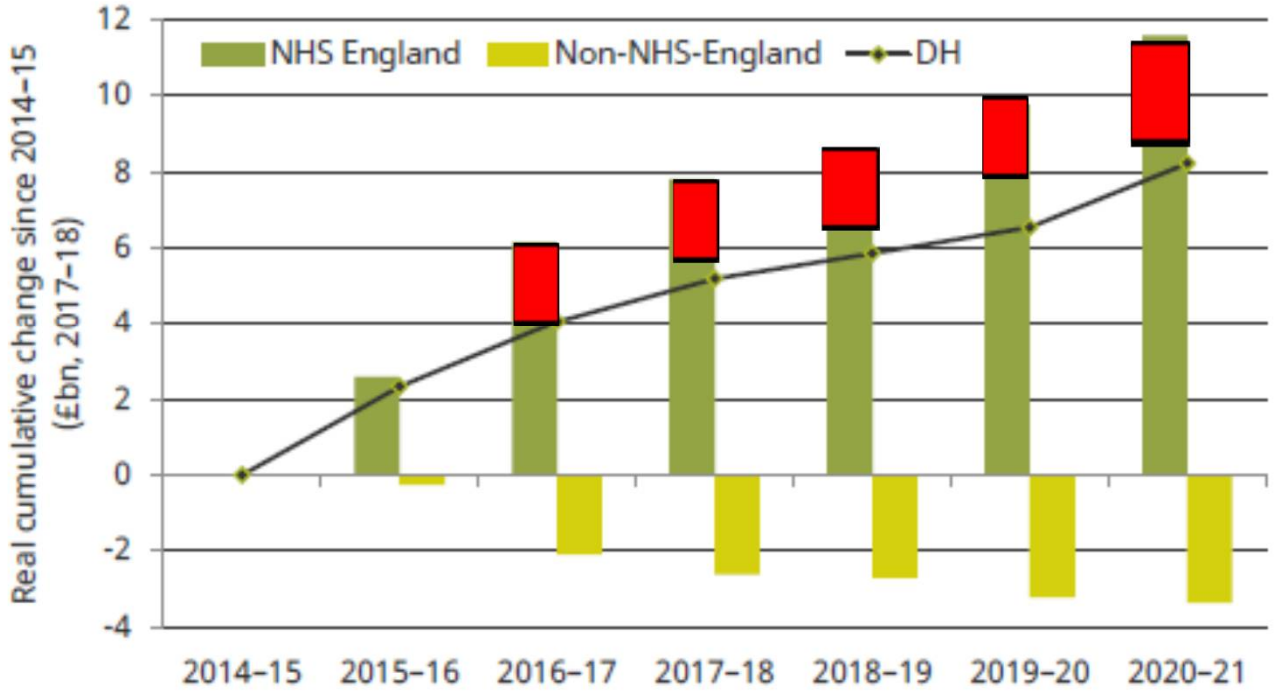
About 20%–40% of all health spending is wasted due to poor quality care




Real spending (£bn, 2017–18 prices)
% of national income
Real spending (left axis)
% of GDP (right axis)
180
160
140
120
100
80
60
40
20
0
9%
8%
7%
6%
5%
4%
3%
2%
1%
0%
1955–56
1958–59
1961–62
1964–65
1967–68
1970–71
1973–74
1976–77
1979–80
1982–83
1985–86
1988–89
1991–92
1994–95
1997–98
2000–01
2003–04
2006–07
2009–10
2012–13
2015–16

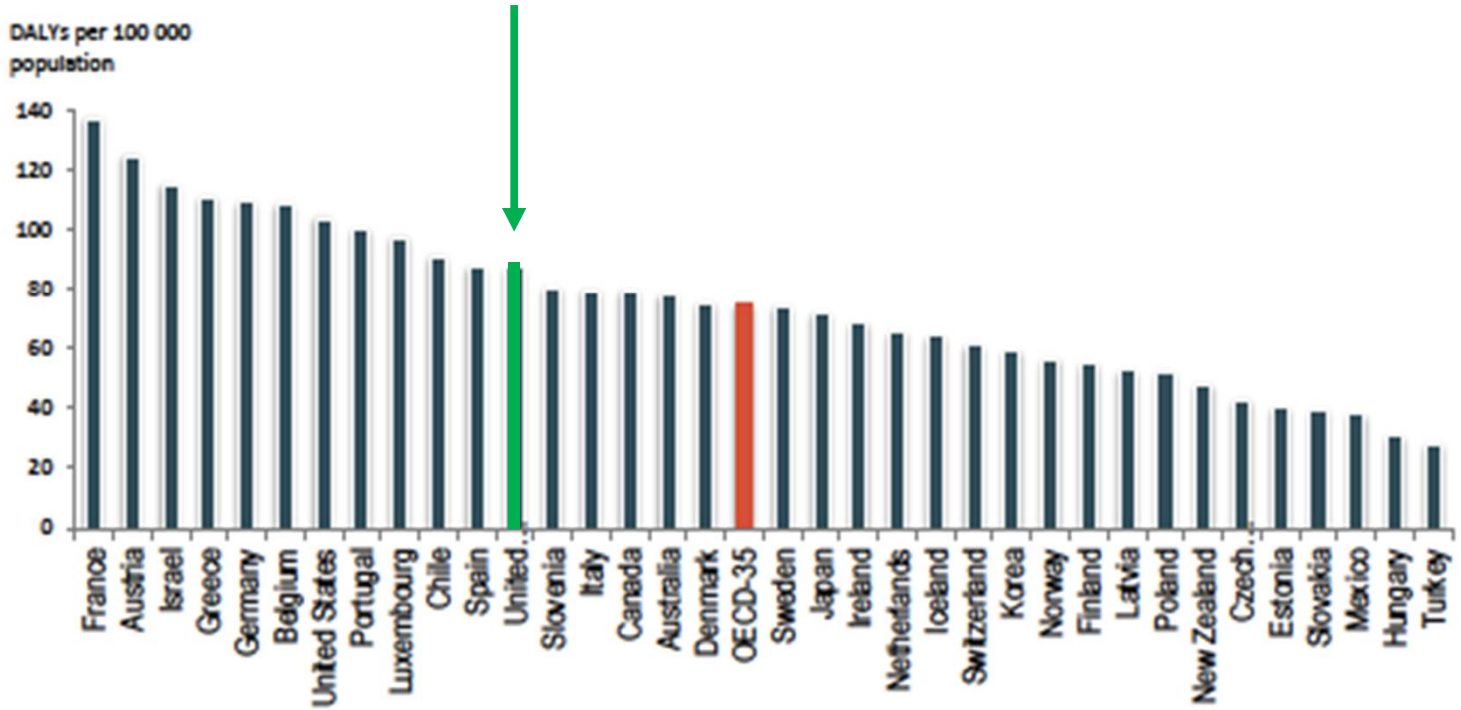
Waste due to harm

Figure 4. Cumulative real changes to Department of Health spending set out by the 2015 Spending Review, 2014–15 to 2020–21, £ billion (2017–18 prices)



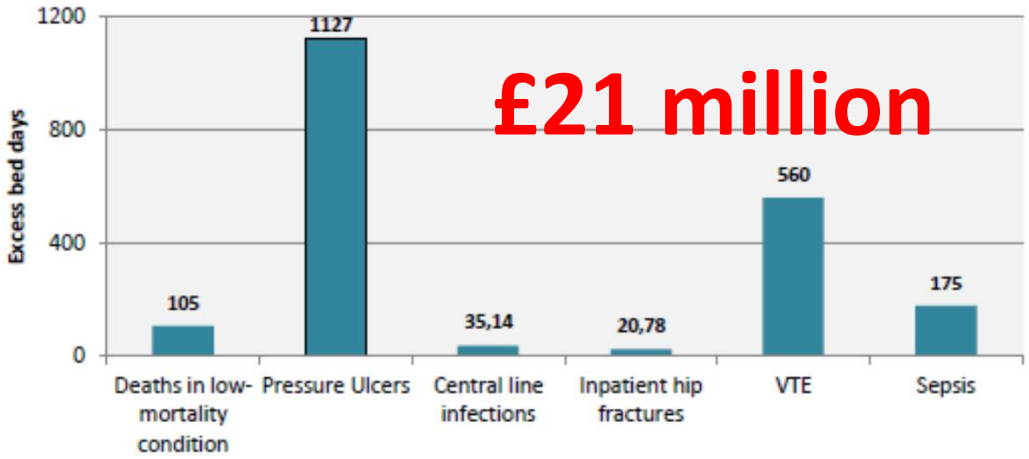
Disability Adjusted Life Years lost

Figure 2. DALYs attributable to patient harm in OECD countries (2015)



Disability Adjusted Life Years (DALYs) [3], which measures the total number of years lost due to specific diseases and risk factors - in this case iatrogenic harm. Second, the financial cost exerted by patient harm

Figure 4. Bed days lost due to six adverse events, annual totals for a typical English hospital



£21 million

Source: Hauck et al (2017)

37. These excess bed days amount to GBP 21.3 million.[9] This equates to over 2,000 salaried GPs and more than 3,500 hospital nurses across the country. Expressed in a more local context, 2,024 bed-days - or GBP 617,000 - are consumed by these six events in the average English hospital each year. This equates to 285 potential admissions foregone per year. Alternatively, 9 salaried general practitioners or 15 hospital nurses could be employed for this sum (Table 5).[10]

Table 4. Financial burden due to specific adverse events or conditions (as share of public hospital spending)

Adverse drug events and medication safety			**Share of public hospital budgets**
Rottenkobler, D. et al (2012)	Germany	Nationwide extrapolation of adverse drug events occurring in German hospitals resulted in annual total treatment costs of €1.058 billion in 2008.	1.7%
Roughhead L et al (2013)	Australia	$AUS 1.2 billion costs of patient harm due to medication safety in 2011	3.95%
Healthcare-associated infections			
Department of Health (2000)	United Kingdom	Hospital associated infections are estimated to cost NHS £1 billion.	2.6%
Vrijens F, et al (2009)	Belgium	Hospital associated infections were estimated to cost in overall excess median cost is 204.3mill€, mean 384.3mill€.	3.95% (3.2%)
Venous thromboembolism (VTE)			
Mahan, C. et al (2011	United States	VTE cost models ranged total cost from USD 5 – 26.5 billion	1% -6%
Barco, S. et al (2016).	EU-28	Total costs ranged from 1.5 – 13.2 billion EUR 2014 PPP	0.4%-3.8%

£One Billion

Highest Cost

- Healthcare-associate[illegible]tions (HAI)
- Venous thrombo[illegible]ism (VTE)
- Pressure ulc[illegible]
- Medicat[illegible]rors
- Wr[illegible] delayed diagnosis

Cheaper to prevent

Part 3
Theories of Patient Safety

When I started - First do no Harm

1

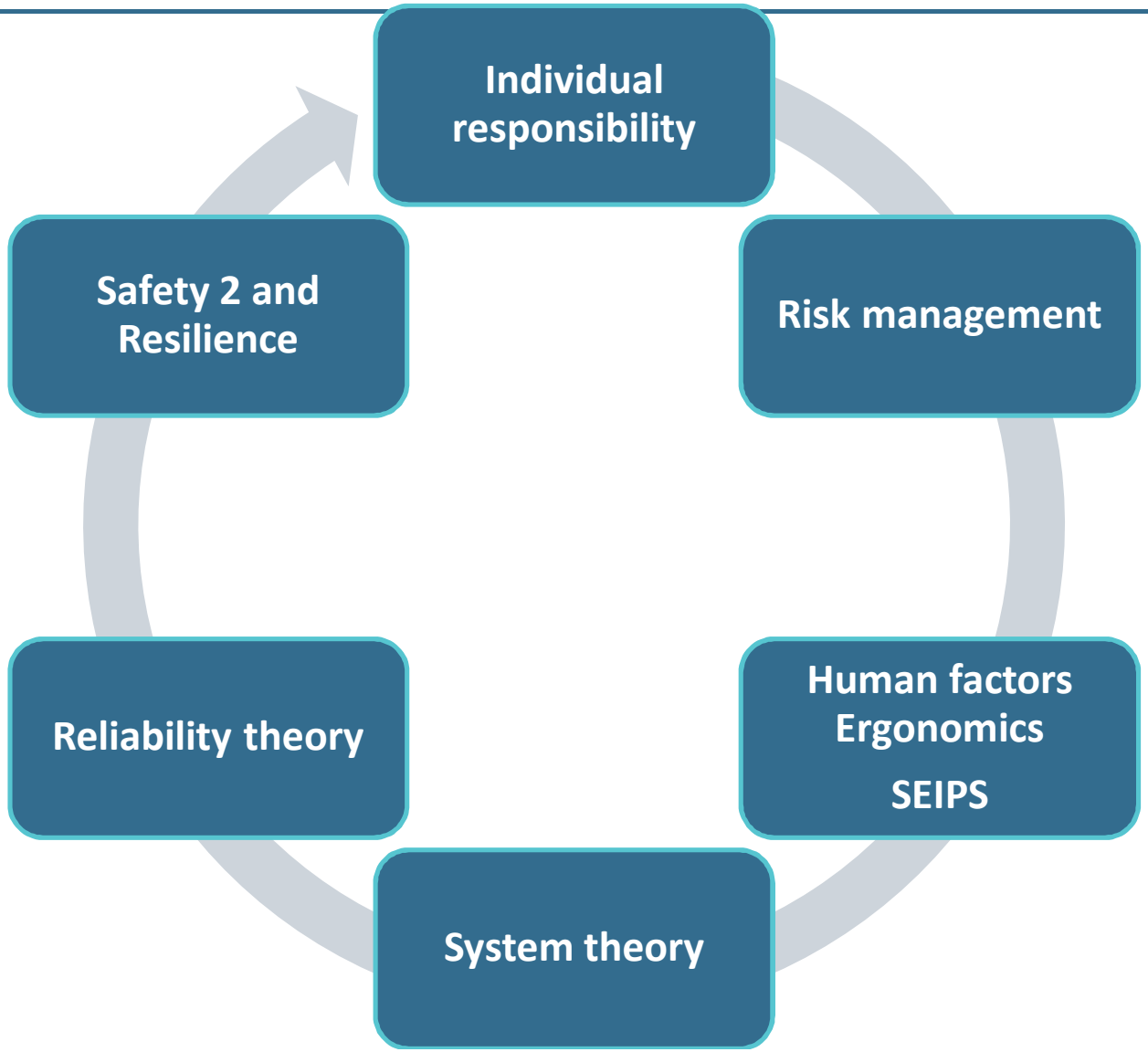
ΙΠΠΟΚΡΑΤΟΥΣ

ΟΡΚΟΣ

HIPPOCRATIS

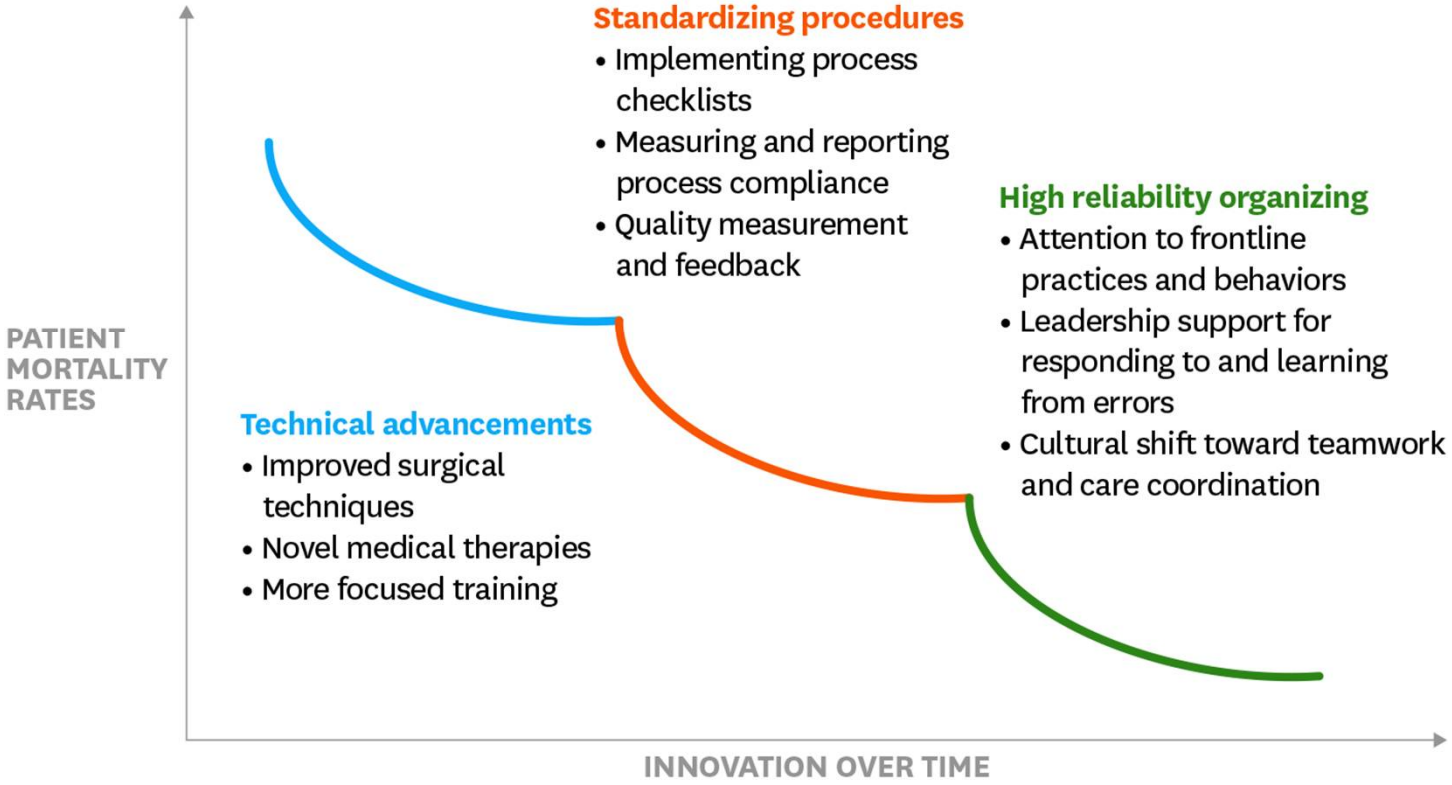
IVSIVRANDVM

Theory of safety has advanced



3 Waves of Innovation in Patient Safety

Technical and procedural improvements have made surgery safer, but future innovation will focus on reliably organizing the work of patient care.

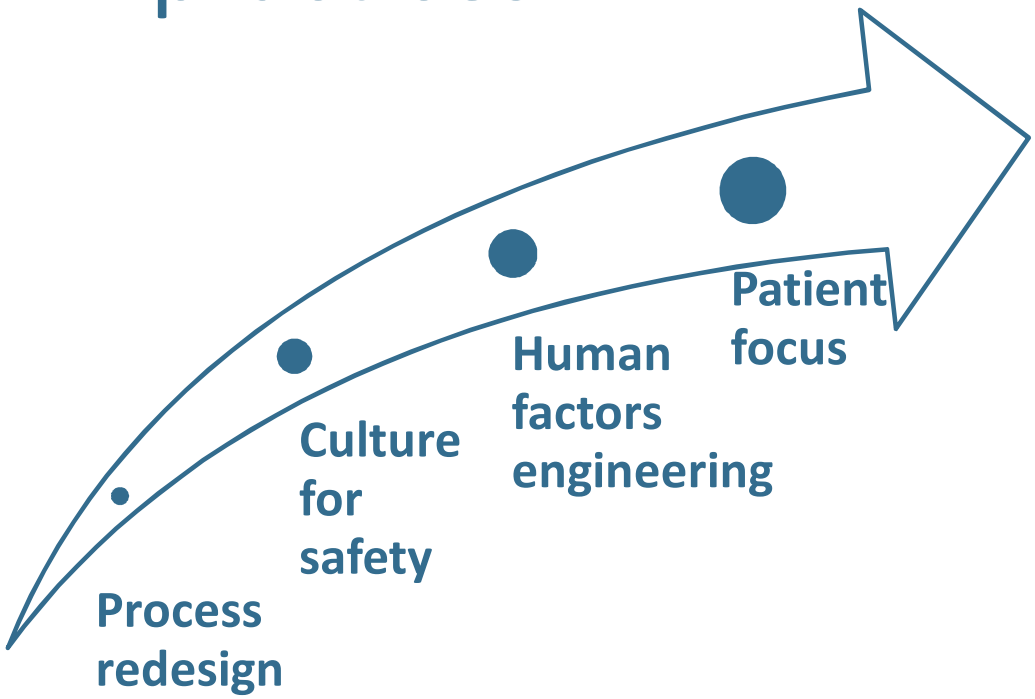


SOURCE AMIR GHAFERI ET AL.

https://hbr.org/2016/08/the-next-wave-of-hospital-innovation-to-make-patients-safer

Reliability as the aim for safety

Excellence in a system is determined by the reliable delivery of established best practices



"Safety" is the ability of a system to sustain required operations under both expected and unexpected conditions.

Safety is what we must do every day

Hollnagel E., Wears R.L. and Braithwaite J. From Safety-I to Safety-II: A White Paper. The Resilient Health Care Net
Published simultaneously by the University of Southern Denmark, University of Florida, USA, and Macquarie University, Australia.

What is a system?

A system is the realization of a capability that cannot be achieved by any of its sub-parts alone

To manage a system effectively, focus on the interaction of the parts rather than on the behaviors taken separately

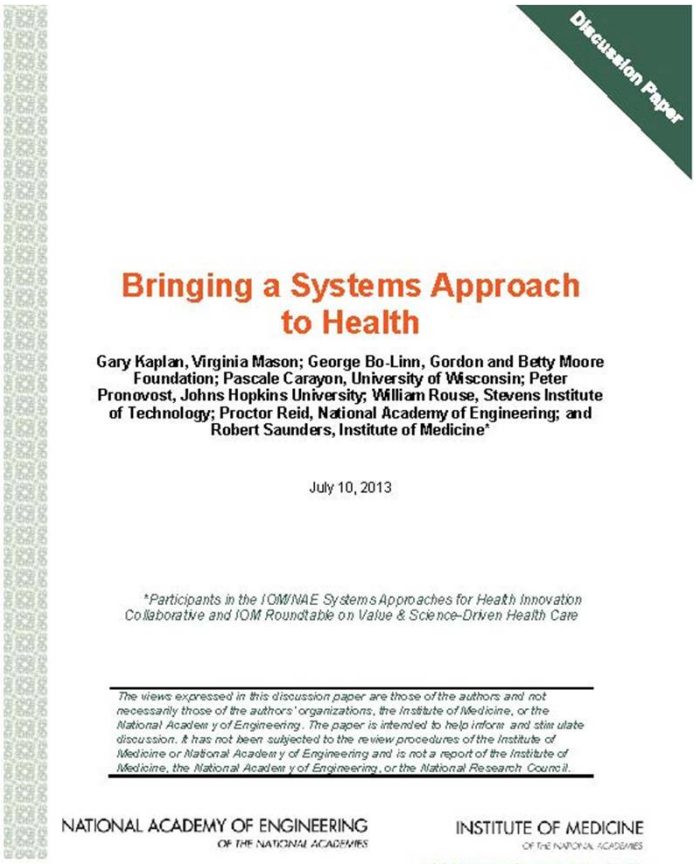
Ackoff

Slide from David Vaughan

Systems approach to healthcare

A systems approach

- Applies scientific knowledge to understand the elements that influence health outcomes
- Understand the relationships between those elements
- Changes the design to maximise outcomes


Discussion Paper

Bringing a Systems Approach to Health

Gary Kaplan, Virginia Mason; George Bo-Linn, Gordon and Betty Moore Foundation; Pascale Carayon, University of Wisconsin; Peter Pronovost, Johns Hopkins University; William Rouse, Stevens Institute of Technology; Proctor Reid, National Academy of Engineering; and Robert Saunders, Institute of Medicine*

July 10, 2013

*Participants in the IOM/NAE Systems Approaches for Health Innovation Collaborative and IOM Roundtable on Value & Science-Driven Health Care

The views expressed in this discussion paper are those of the authors and not necessarily those of the authors' organizations, the Institute of Medicine, or the National Academy of Engineering. The paper is intended to help inform and stimulate discussion. It has not been subjected to the review procedures of the Institute of Medicine or National Academy of Engineering and is not a report of the Institute of Medicine, the National Academy of Engineering, or the National Research Council.

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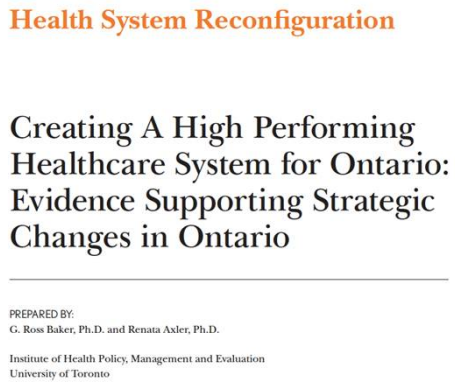
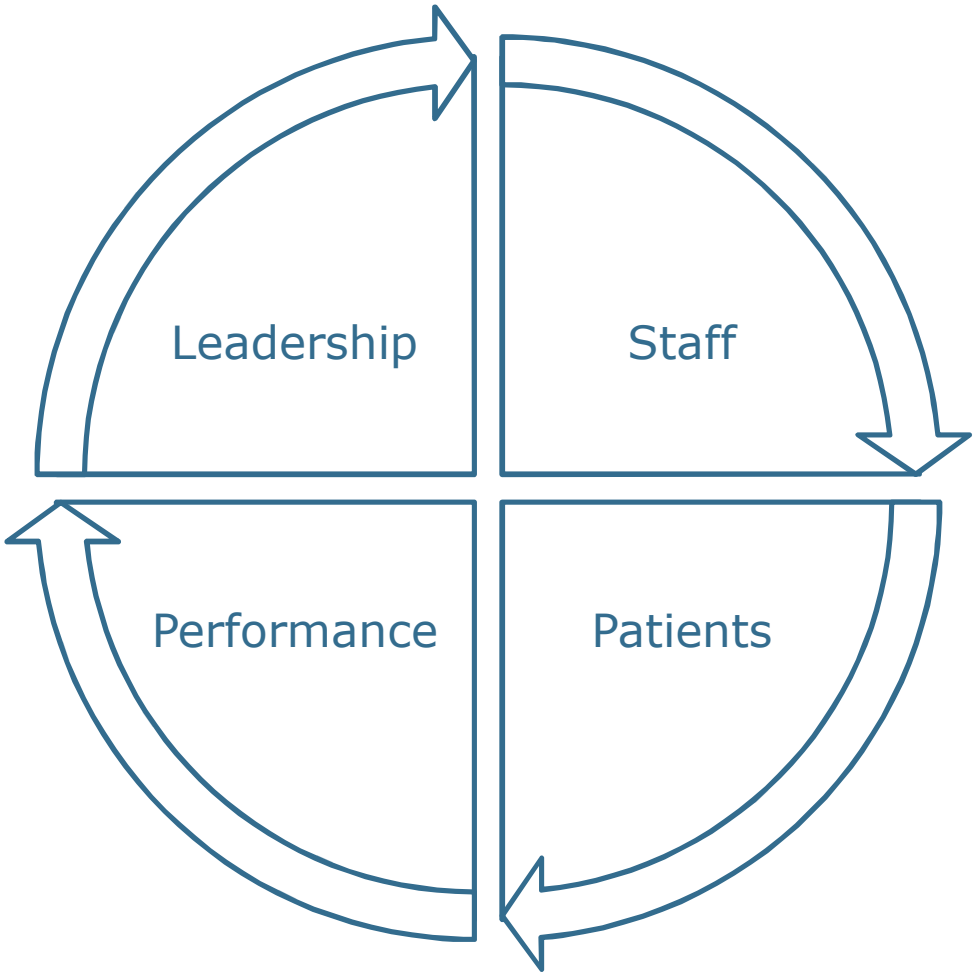
https://www.nae.edu/File.aspx?id=86344

12 Key Attributes of High Performing Healthcare Systems

1. Focusing on Quality and System I**mprovement** as the Core Strategy
2. Developing **Leadership** Skills
3. Enhancing System **Governance**
4. Investing in **Capacity** to Support Improvement
5. Improving Accountability and Performance **Measurement**
6. Enabling Comprehensive **Information** Infrastructures
7. Strengthening **Primary Care**
8. Improving **Integration** and Care Transitions
9. Enhancing Professional Cultures and **Engaging Clinicians**
10. Engaging **Patients, Caregivers** and the Public
11. Attending to **Access and Equity** Issues
12. Considering **Population Health** and **Chronic Disease Managemen**t in Care Management Strategies



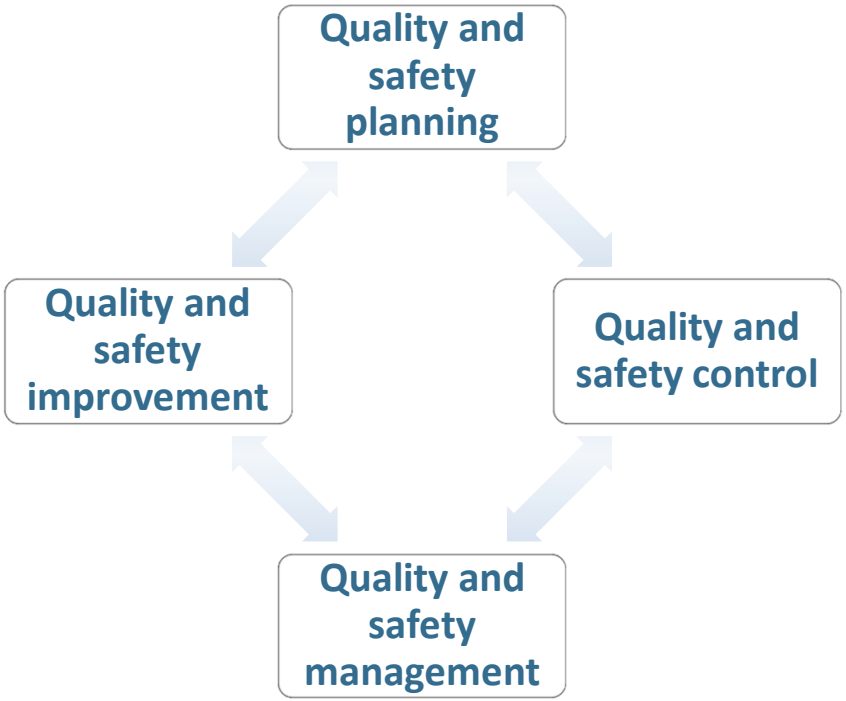
The microsystems of care

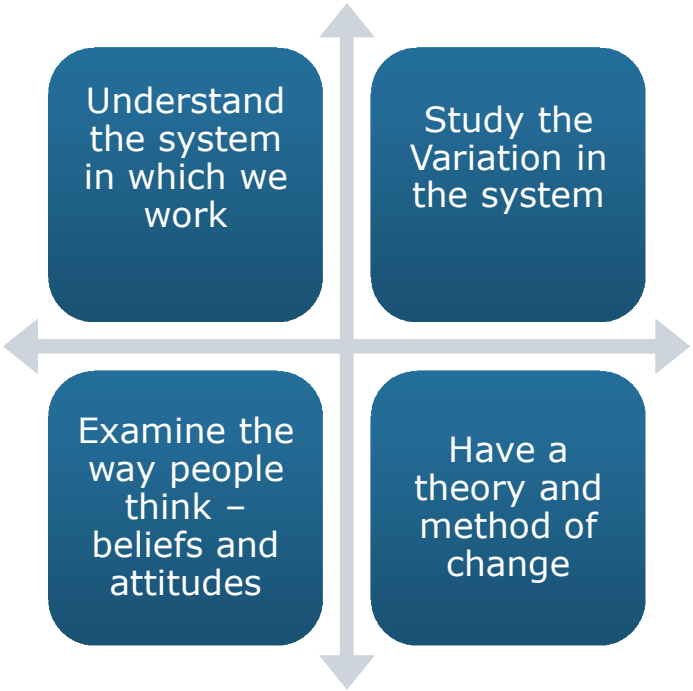


- Strong Leadership
- Great Organizational Support
- Focus on Staff (Professionals)
- Education and Training of Staff
- Interdependence of Care Team
- **Performance Result Focused**
- Process Improvement Focused
- Patient-Centered (Patient Focus)
- Community and System Focus
- Information & Information Technology Orientation

Reference Nelson et al 2008

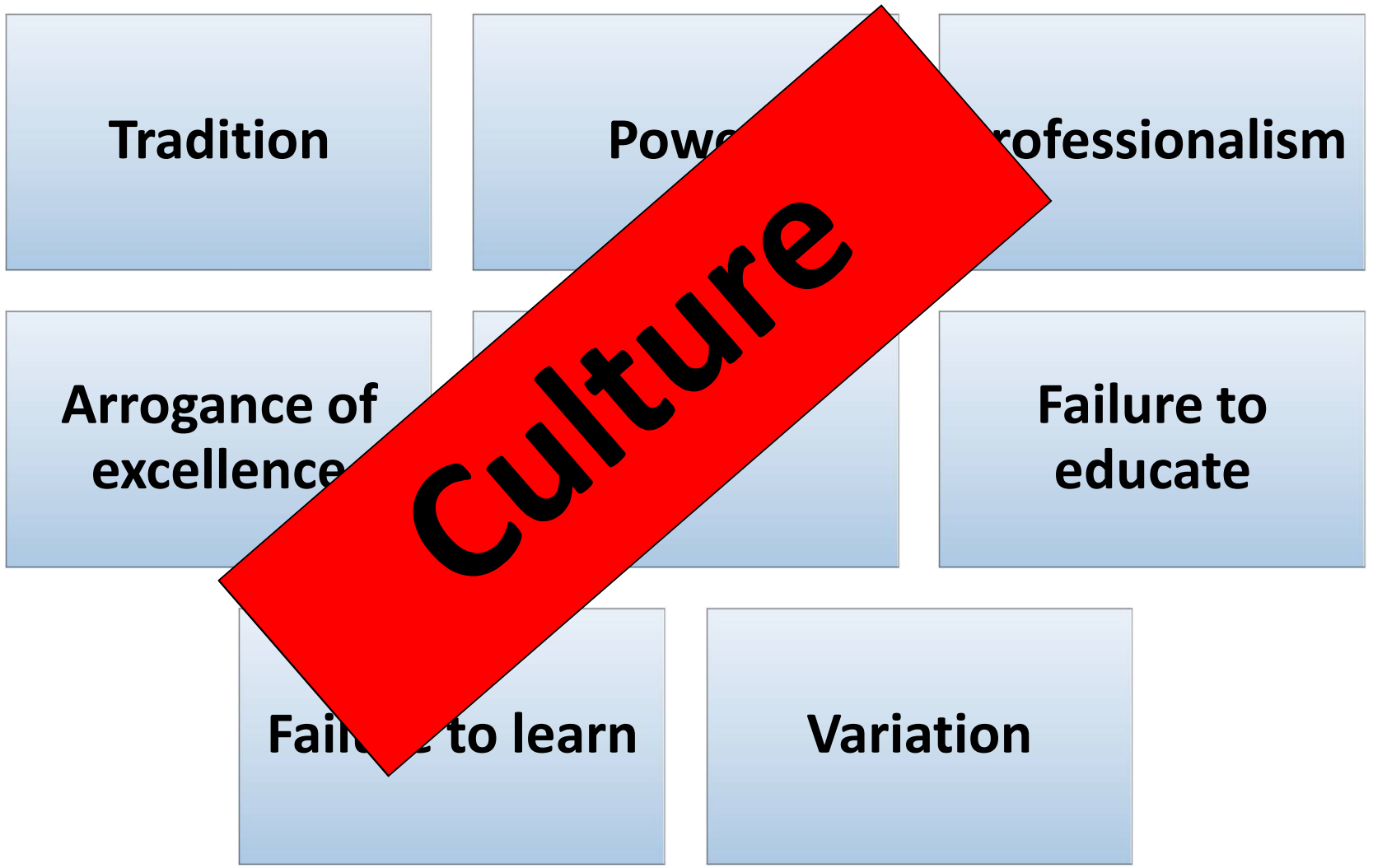
Theories of system change



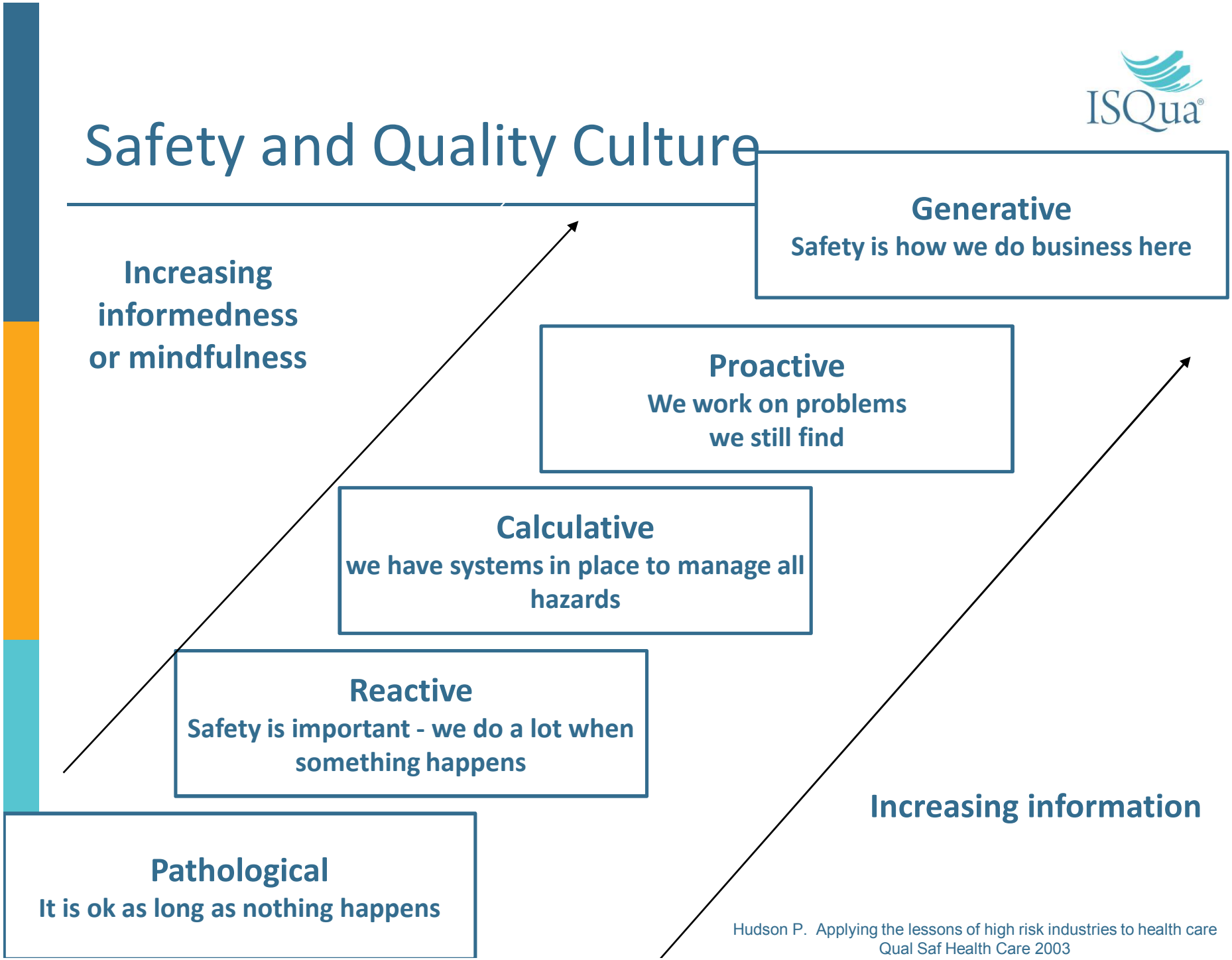


Based on Deming and Juran

The barriers to system change



Safety and Quality Culture



Hudson P. Applying the lessons of high risk industries to health care
Qual Saf Health Care 2003

Annals of Internal Medicine | SUPPLEMENT

Promoting a Culture of Safety as a Patient Safety Strategy

A Systematic Review

Sallie J. Weaver, PhD; Lisa H. Lubomksi, PhD; Renee F. Wilson, MS; Elizabeth R. Pfoh, MPH; Kathryn A. Martinez, PD, MPH; and Sydney M. Dy, MD, MSc

Developing a culture of safety is a core element of many efforts to improve patient safety and care quality. This systematic review identifies and assesses interventions used to promote safety culture or climate in acute care settings. The authors searched MEDLINE, CINAHL, PsycINFO, Cochrane, and EMBASE to identify relevant English-language studies published from January 2000 to October 2012. They selected studies that targeted health care workers practicing in inpatient settings and included data about change in patient safety culture or climate after a targeted intervention. Two raters independently screened 3679 abstracts (which yielded 33 eligible studies in 35 articles), extracted study data, and rated study quality and strength of evidence. Eight studies included executive walk rounds or interdisciplinary rounds; 8 evaluated multicomponent, unit-based interventions; and 20 included team training or communication initiatives. Twenty-nine studies reported some improvement in safety culture or patient outcomes, but measured outcomes were highly heterogeneous. Strength of evidence was low, and most studies were pre–post evaluations of low to moderate quality. Within these limits, evidence suggests that interventions can improve perceptions of safety culture and potentially reduce patient harm.

Ann Intern Med. 2013;158:369-374.
For author affiliations, see end of text.
www.annals.org

Cultu

Commentary

Establis
Values:

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DOI: 10.1177/1062860611424332
http://ajmq.sagepub.com
SAGE

Simon C. Mathews, MD,[1] and Peter J. Pronovost, MD, PhD[1]

REVIEW ARTICLE

Quality and Safety in Pediatric Anesthesia

Anna M. Varughese, MD, MPH,* Sally E. Rampersad, MB, FRCA,† Gina M. Whitne
Randall P. Flick, MD, MPH,§ Blair Anton, MLIS, MS,‖ and Eugenie S. Heitmiller, MI

Health care quality and value are leading issues in medicine today for patients, h
professionals, and policy makers. Outcome, safety, and service—the components o
have been used to define value when placed in the context of cost. Health care org
and professionals are faced with the challenge of improving quality while reducing h
related costs to improve value. Measurement of quality is essential for assessing wh
tive and what is not when working toward improving quality and value. However, the
tools currently for assessing quality of care, and clinicians often lack the resources
required to conduct quality improvement work. In this article, we provide a brief reviev
improvement as a discipline and describe these efforts within pediatric anesthesiolo
Analg 2013;117:1408–18)

► Additional data (Appendix 1) are published online only. To view these files please visit the journal online (http://fn.bmj.com/content/97/2.toc).

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[2]Section of Health Services Research, Department of Medicine, Baylor College of Medicine, Houston, Texas, USA
[3]Houston Veterans Affairs (VA) Health Services Research and Development Center of Excellence, Health Policy and Quality Program, Michael E DeBakey VA Medical Center, Houston, Texas, USA
[4]University of Texas – Memorial Hermann Center for Healthcare Quality and Safety, University of Texas Medical

Neonatal intensive care unit safety culture varies widely

Jochen Profit,[1–3] Jason Etchegaray,[4] Laura A Petersen,[2,3] J Bryan Sexton,[5] Sylvia J Hysong,[2,3] Minghua Mei,[2,3] Eric J Thomas[4]

Abstract
Background Variation in healthcare delivery and outcomes in neonatal intensive care units (NICUs) may be partly explained by differences in safety culture.
Objective To describe NICU care giver assessments of safety culture, explore variability within and between NICUs on safety culture domains, and test for association with care giver characteristics.
Methods NICU care givers in 12 hospitals were surveyed using the Safety Attitudes Questionnaire (SAQ), which has six scales: teamwork climate, safety climate, job satisfaction, stress recognition, perception of management and working conditions. Scale means, SDs and percent positives (percent agreement) were calculated for each NICU.
Results There was substantial variation in safety culture domains among NICUs. Composite mean score across the six domains ranged from 56.3 to 77.8 on a 100-point scale and NICUs in the top four NICUs were significantly different from the bottom four ($p<0.001$). Across the six domains, respondent assessments varied widely, but were least positive on perceptions

What is already known on this topic

- Patients receiving care in adult and neonatal intensive care units (ICUs) experience wide variation in clinical care and outcomes.
- In adult ICU settings, higher safety culture ratings have been associated with safer care and better clinical outcomes.

What this study adds

- In this sample of neonatal intensive care units (NICUs), safety culture varied significantly and revealed widespread opportunities for improvement.
- NICUs generally had higher safety culture domain scores than adult ICUs.

WHAT WE PERMIT
WE PROMOTE

Complexity of health care means we need to focus on new solutions and new designs

Complexity

- 60% of care is based on evidence or guidelines;
- We waste about 30% of all health expenditure;
- 10% of patients experience an adverse event
- Top down tools such as - policy, regulation, restructuring, KPI etc. have not worked
- We must move instead towards a learning system that applies more nuanced systems thinking to systems.

QUALITY IMPROVEMENT

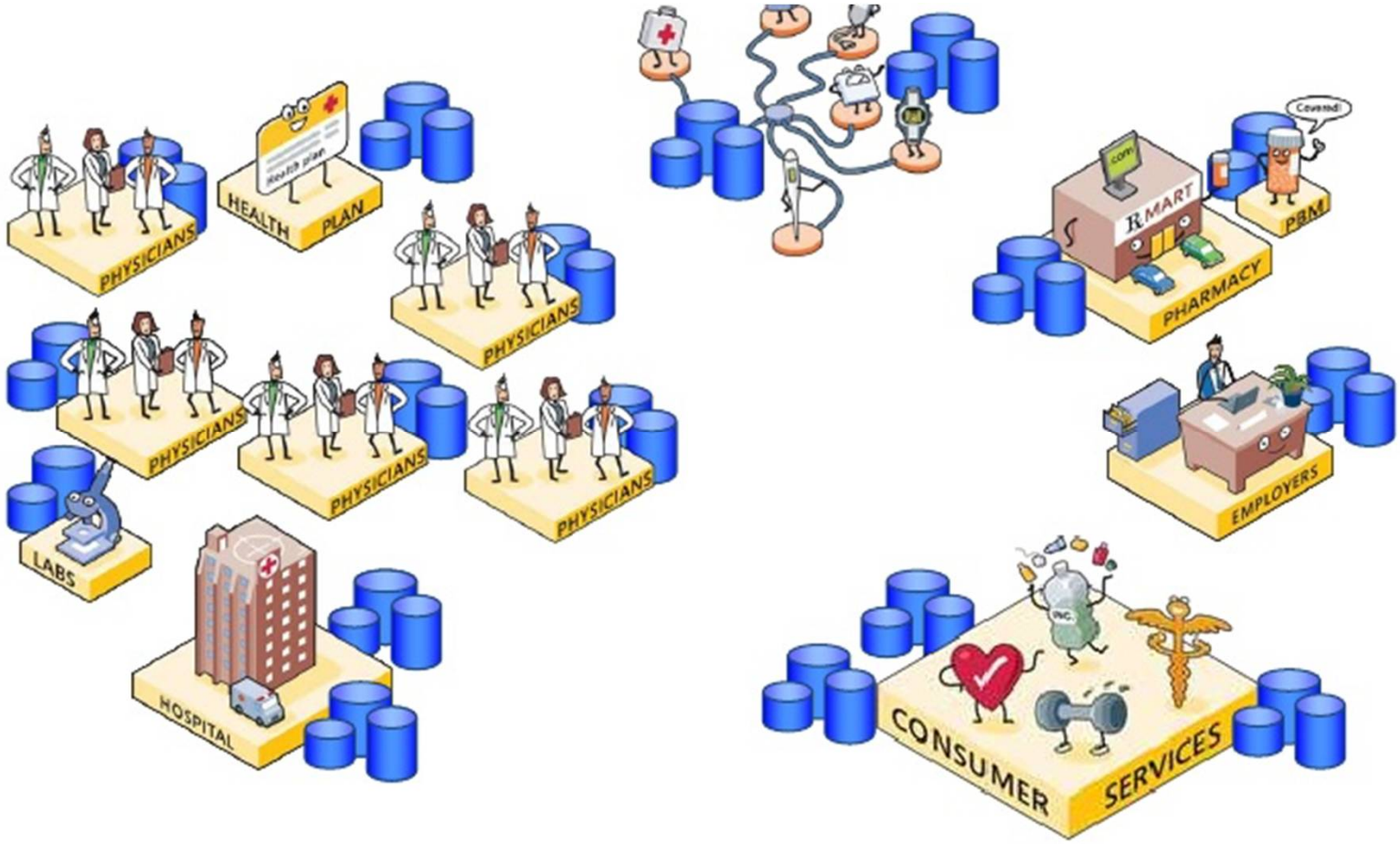
Changing how we think about healthcare improvement

Complexity science offers ways to change our collective mindset about healthcare systems, enabling us to improve performance that is otherwise stagnant, argues **Jeffrey Braithwaite**

For all the talk about quality healthcare, systems performance has frozen in time. Only 50-60% of adaptive system, meaning that the system's performance and behaviour changes over time and cannot be completely understood make it hard to impose order. And health systems are indeterministic—meaning that the future cannot be predicted by

BMJ 2018;361:k2014

Health care is delivered in silos



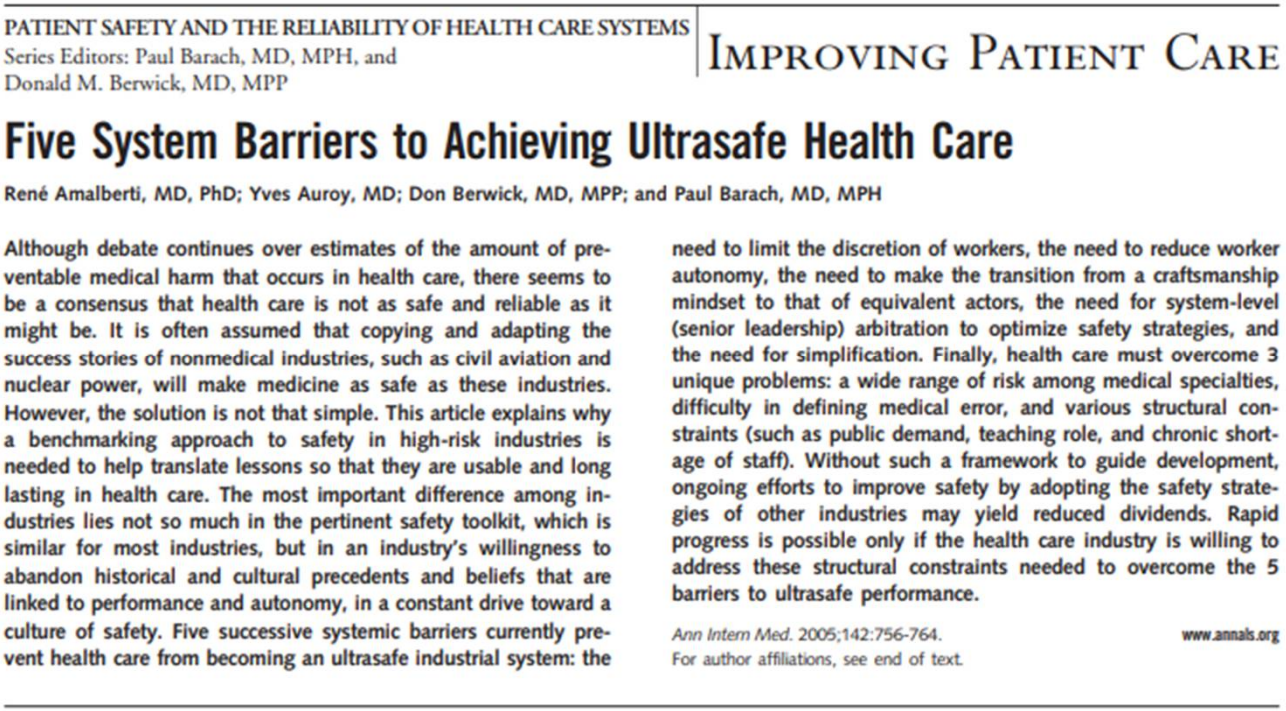
Vaibhav Bhandari, Program Manager in Microsoft Health Solutions Group
(https://www.slideshare.net/vaibhavbhandari/programming-healthcare-silos/3-Silos_of_Health_Informationbr)

The reality is straightforward. The power of existing interventions is not matched by the power of health systems to deliver them to those in greatest need, in a comprehensive way, and at an adequate scale.

Margaret Chan
Former Director General
World Health Organization

Key actions to move to Ultra safe care

- Acceptance of limitations on maximum performance
- Abandonment of professional autonomy
- Transition from the mindset of craftsman to that of an equivalent actor
- Need for system-level arbitration to optimize safety strategies
- The need to simplify professional rules and regulations



PATIENT SAFETY AND THE RELIABILITY OF HEALTH CARE SYSTEMS
Series Editors: Paul Barach, MD, MPH, and Donald M. Berwick, MD, MPP

IMPROVING PATIENT CARE

Five System Barriers to Achieving Ultrasafe Health Care

René Amalberti, MD, PhD; Yves Auroy, MD; Don Berwick, MD, MPP; and Paul Barach, MD, MPH

Although debate continues over estimates of the amount of preventable medical harm that occurs in health care, there seems to be a consensus that health care is not as safe and reliable as it might be. It is often assumed that copying and adapting the success stories of nonmedical industries, such as civil aviation and nuclear power, will make medicine as safe as these industries. However, the solution is not that simple. This article explains why a benchmarking approach to safety in high-risk industries is needed to help translate lessons so that they are usable and long lasting in health care. The most important difference among industries lies not so much in the pertinent safety toolkit, which is similar for most industries, but in an industry's willingness to abandon historical and cultural precedents and beliefs that are linked to performance and autonomy, in a constant drive toward a culture of safety. Five successive systemic barriers currently prevent health care from becoming an ultrasafe industrial system: the need to limit the discretion of workers, the need to reduce worker autonomy, the need to make the transition from a craftsmanship mindset to that of equivalent actors, the need for system-level (senior leadership) arbitration to optimize safety strategies, and the need for simplification. Finally, health care must overcome 3 unique problems: a wide range of risk among medical specialties, difficulty in defining medical error, and various structural constraints (such as public demand, teaching role, and chronic shortage of staff). Without such a framework to guide development, ongoing efforts to improve safety by adopting the safety strategies of other industries may yield reduced dividends. Rapid progress is possible only if the health care industry is willing to address these structural constraints needed to overcome the 5 barriers to ultrasafe performance.

Ann Intern Med. 2005;142:756-764. www.annals.org
For author affiliations, see end of text.

Optimal Benefit

1. Optimal care & adherence to standards

2. Compliance to standards

3. Unreliable care -no harm

4. Poor care, minor harm, overall benefit

5. Harm exceeds benefits

Increased risk of harm

Area of quality

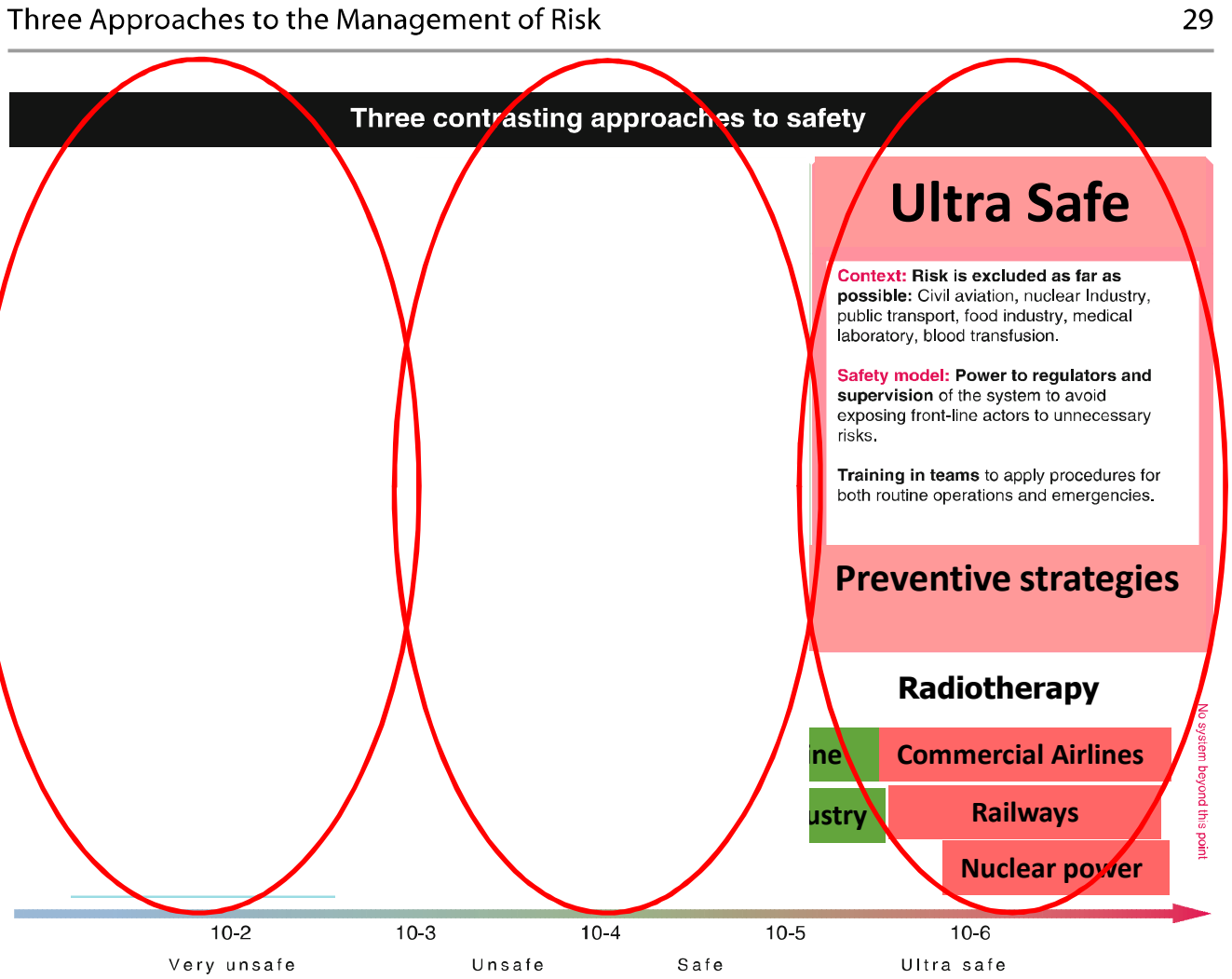
Illegal Normal

Area of Safety

Charles Vincent, René Amalberti. Safer Healthcare Strategies for the Real World. Springer 2016

https://link.springer.com/content/pdf/10.1007%2F978-3-319-25559-0.pdf

Complexity of safety at a system level



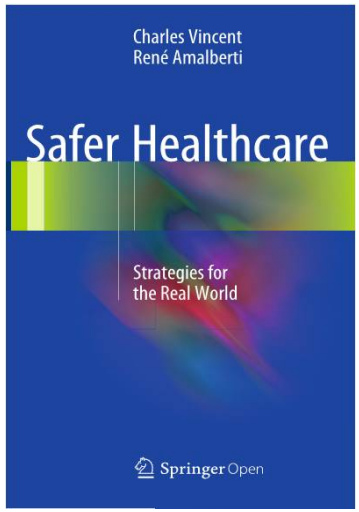


Fig. 3.1 Three contrasting approaches to safety

https://link.springer.com/content/pdf/10.1007%2F978-3-319-25559-0.pdf

Box 6.1 Five Safety Strategies

Safety as best practice: aspire to standards – Reducing specific harms and improving clinical processes

Improving healthcare processes and system – Intervening to support individuals and teams, improve working conditions and organisational practices

Risk control – Placing restrictions on performance, demand or working conditions

Improving capacity for monitoring, adaptation and response.

Mitigation – Planning for potential harm and recovery.

Reporting is useful, but more emphasis is needed on measurement and safety improvement programmes

Safety I vs. Safety II

	Safety I	Safety II
Definition	Few things go wrong as possible	As many things go right as possible
Principle	Reactive and respond to risk	Proactive and anticipate
Human factors	Humans are a hazard and produce risk	Humans are a resource and minimise risk
Accident investigation	Caused by failure and malfunction and identify cause	Study why things go right as a basis for those that do not
Risk assessment	Accidents caused by failure	Understand variability in performance under difficult circumstances difficult to control

Hollnagel et al

Resilience and learning

From Safety-I to Safety-II: A White Paper

Professor Erik Hollnagel
University of Southern Denmark, Institute for Regional Health Research (IRS), Denmark
Center for Quality, Region of Southern Denmark

Professor Robert L Wears
University of Florida Health Science Center Jacksonville, United States of America

Professor Jeffrey Braithwaite
Australian Institute of Health Innovation, Macquarie University, Australia

Figure 9: Event probability and safety focus

Figure 5: Things that go right and things that go wrong happen in the same way

To achieve resilience we need to care

Medical error: the second victim

The doctor who makes the mistake needs help too

When I was a house officer another resident failed to identify the electrocardiographic signs of the pericardial tamponade that would rush the patient to the operating room late that night. The news spread rapidly, the case tried repeatedly before an incredulous jury of peers, who returned a improvements that could decrease errors. Many errors are built into existing routines and devices, setting up the unwitting physician and patient for disaster. And, although patients are the first and obvious victims of medical mistakes, doctors are wounded by the same errors: they are the second victims.

Personal view
p 812

https://www.bmj.com/content/320/7237/726

DISCUSSION PAPER

Burnout Among Health Care Professionals

A Call to Explore and Address This Underrecognized Threat to Safe, High-Quality Care

Lotte N. Dyrbye, MD, MHPE, Mayo Clinic; **Tait D. Shanafelt, MD,** Mayo Clinic; **Christine A. Sinsky, MD,** American Medical Association; **Pamela F. Cipriano, PhD, RN, NEA-BC, FAAN,** American Nurses Association; **Jay Bhatt, DO, MPH, MPA,** American Hospital Association; **Alexander Ommaya, DSc,** Association of American Medical Colleges; **Colin P. West, MD, PhD,** Mayo Clinic; **David Meyers, MD,** Agency for Healthcare Research and Quality

July 5, 2017

The US health care system is rapidly changing in an effort to deliver better

ismp CANADA
Institute for Safe Medication Practices Canada
REPORT MEDICATION INCIDENTS
Online: www.ismp-canada.org/err_index.htm
Phone: 1-866-544-7672
A KEY PARTNER IN
CMIRPS SCDPIM

ISMP Canada Safety Bulletin

Volume 17 • Issue 9 • October 31, 2017

The Second Victim:
Sharing the Journey toward Healing

Healthcare organizations typically take a structured approach to providing care and support to patients and their families when an unintended event results in patient harm. However, healthcare practitioners involved in a critical incident also experience consequences, from sadness and concern to suffering and anguish, which often go unrecognized and overlooked. The term "second victim" (where the

Second Victim Healthcare Practitioners:

- *Whenever possible, participate in disclosure*
- *Be a part of the solution*
- *Seek help from your organization or from peers*
- *Share your story*

Healthcare Organizations:

CLINICS

CLINICAL SCIENCE

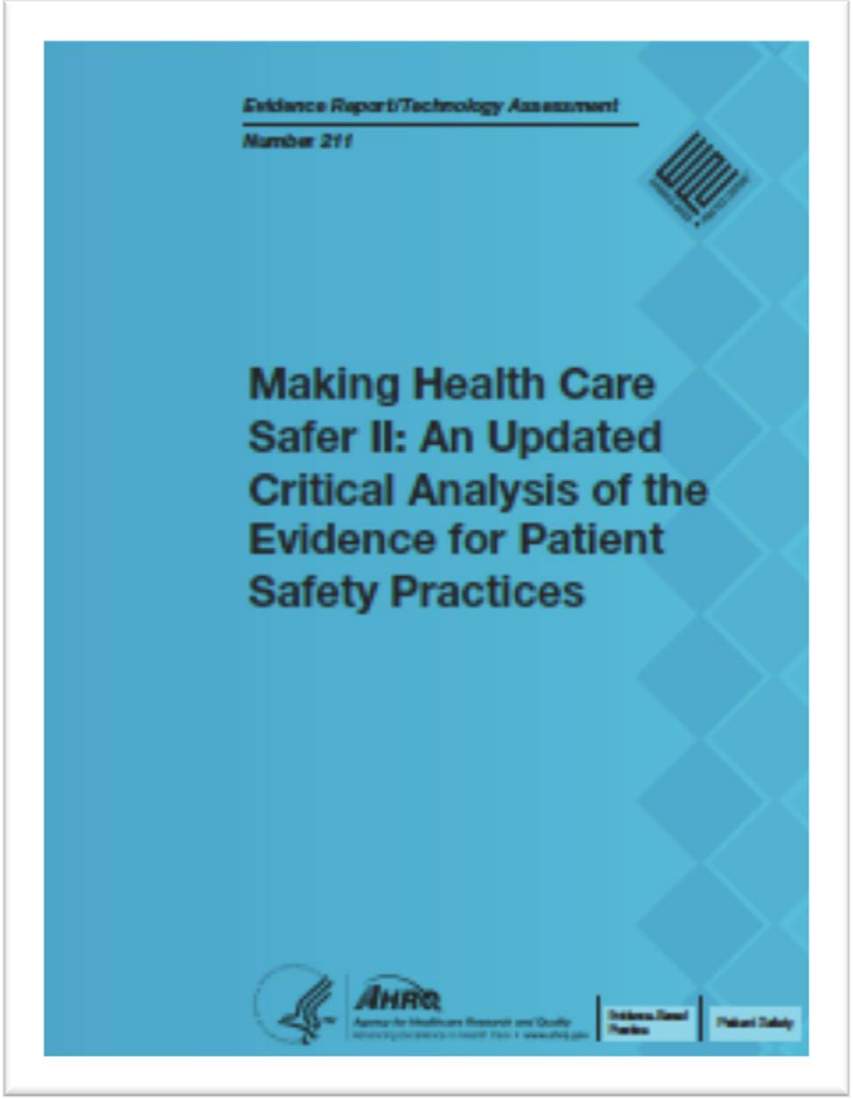
Burnout syndrome in health-care professionals in a university hospital

Lucila Corsino de Paiva,[I] Ana Carla Gomes Canário,[I,II] Eneluzia Lavynnya Corsino de Paiva China,[I] Ana Katherine Gonçalves[I,*]

[I] Universidade Federal do Rio Grande do Norte, Natal, RN, BR. [II] Faculdade Mauricio de Nassau, Natal, RN, BR.

Part 3
The Interventions for reliability

Development of interventions

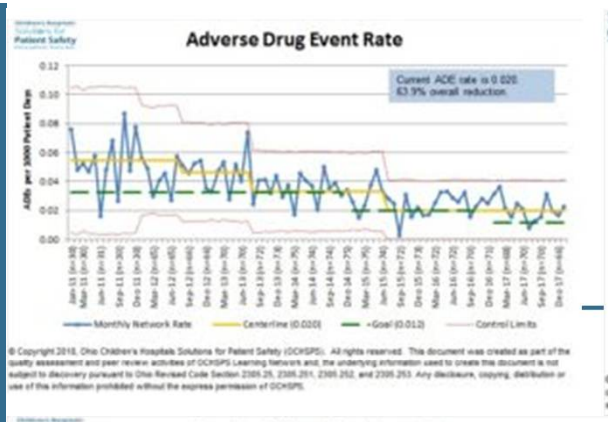


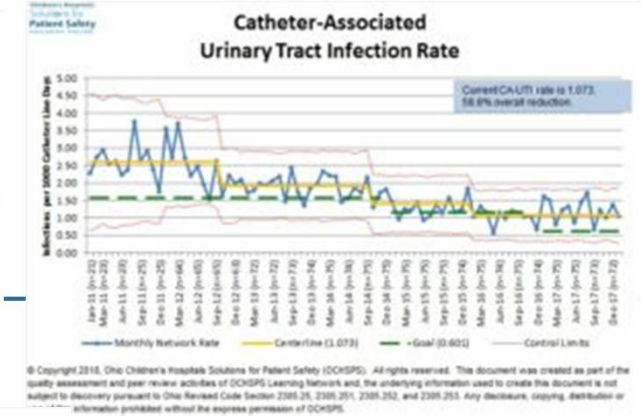
Know what works

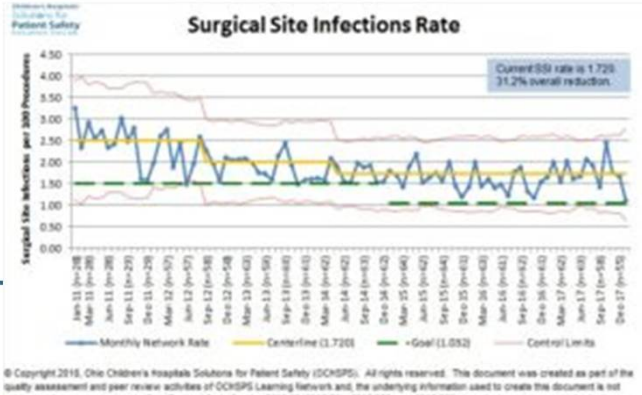
1. Preoperative checklist
2. Bundles such as CLABSI
3. Interventions to decrease urinary catheter use
4. VAP bundle
5. Hand hygiene
6. “Do not” list for hazardous abbreviations
7. Barrier precautions for HAI
8. Pressure ulcer intervention
9. Real time ultrasonography for CVL placement
10. VTE prophylaxis

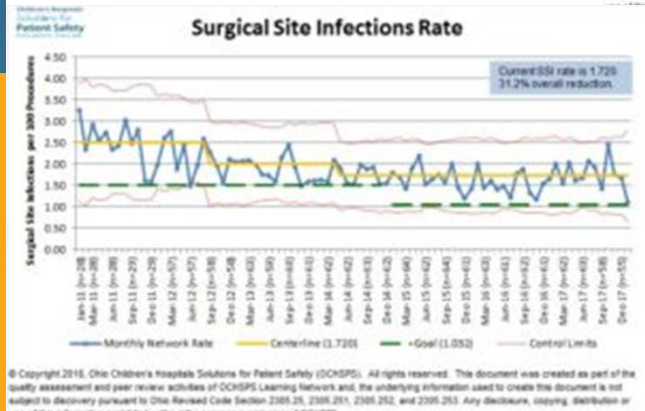
1. Falls prevention
2. Clinical pharmacists to decrease ADE
3. Informed consent
4. Team training
5. Medication reconciliation
6. Rapid response teams
7. Surgical outcome report cards
8. CPOE or improved medical records
9. Simulation
10. Decrease investigation exposure
11. Measure adverse events

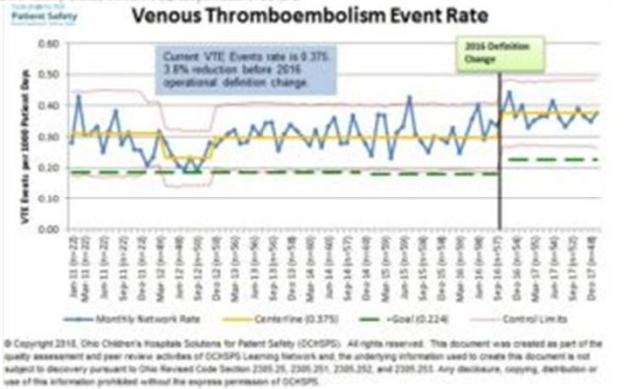
Paul G. Shekelle et al *Ann Intern Med*. 2013;158:365-368.l











Children's Hospitals' Solutions for **Patient Safety**

Every patient. Every day.

Part 4
The next phase
Build a social movement

We cannot continue to work the same way

We need to think differently to improve

We need a system redesign based on current needs rather than those of the past

It is about the person and provider, not the patient

Lead for safety

- Person centred is the culture
- Reliability is the goal
- Educate for quality
- Safety is the business case
- Network learning is the spread

ORIGINAL ARTICLE

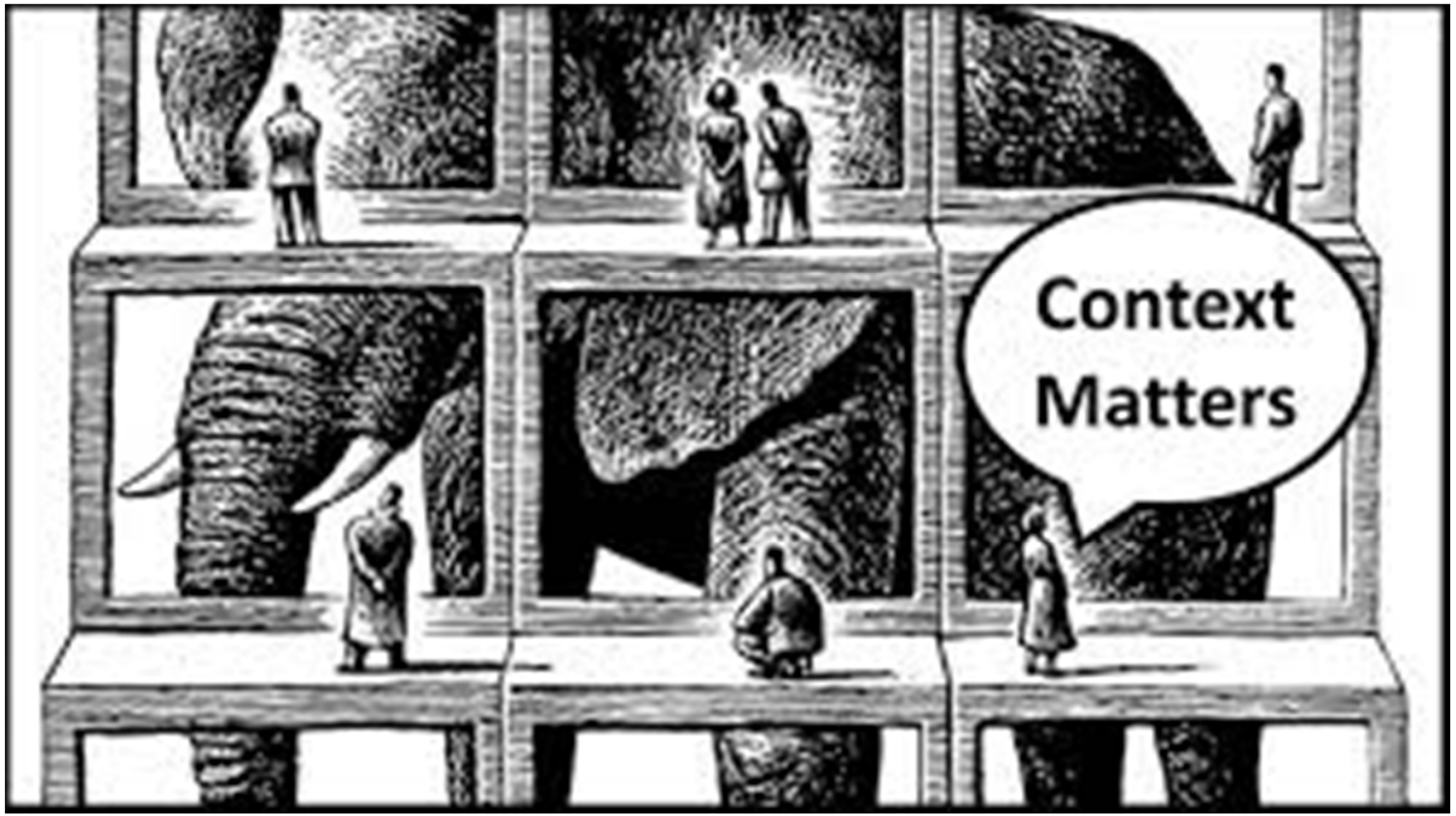
Effectively leading for quality

Peter Lachman, MD, MPH, MMed, MBBCh, BA, FRCPCH, FRCPI, FCP(SA)[1] and Wendy Nicklin, RN, BN, MSc(A), CHE, FACHE, FISQUA, ICD.D.[1]

Healthcare Management For
2017, Vol. 30(5) 233-236

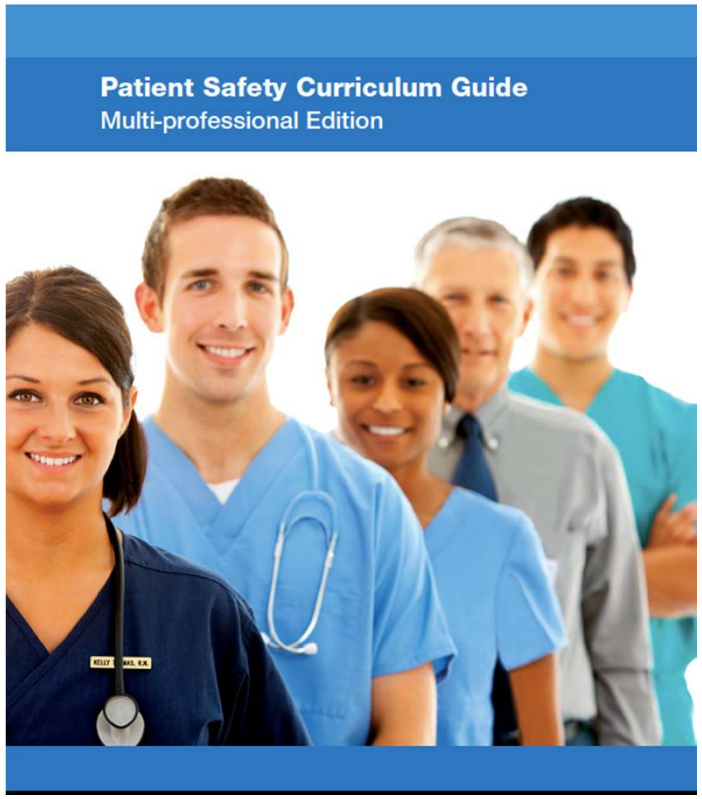
DOI: 10.1177/08404704177
journals.sagepub.com/home/

Understand context for safety



Educate for safety

World Health Organization | Patient Safety



Patient Safety: A Curriculum for Teaching Patient Safety in Emergency Medicine

Karen S. Cosby, MD, Pat Croskerry, MD, PhD

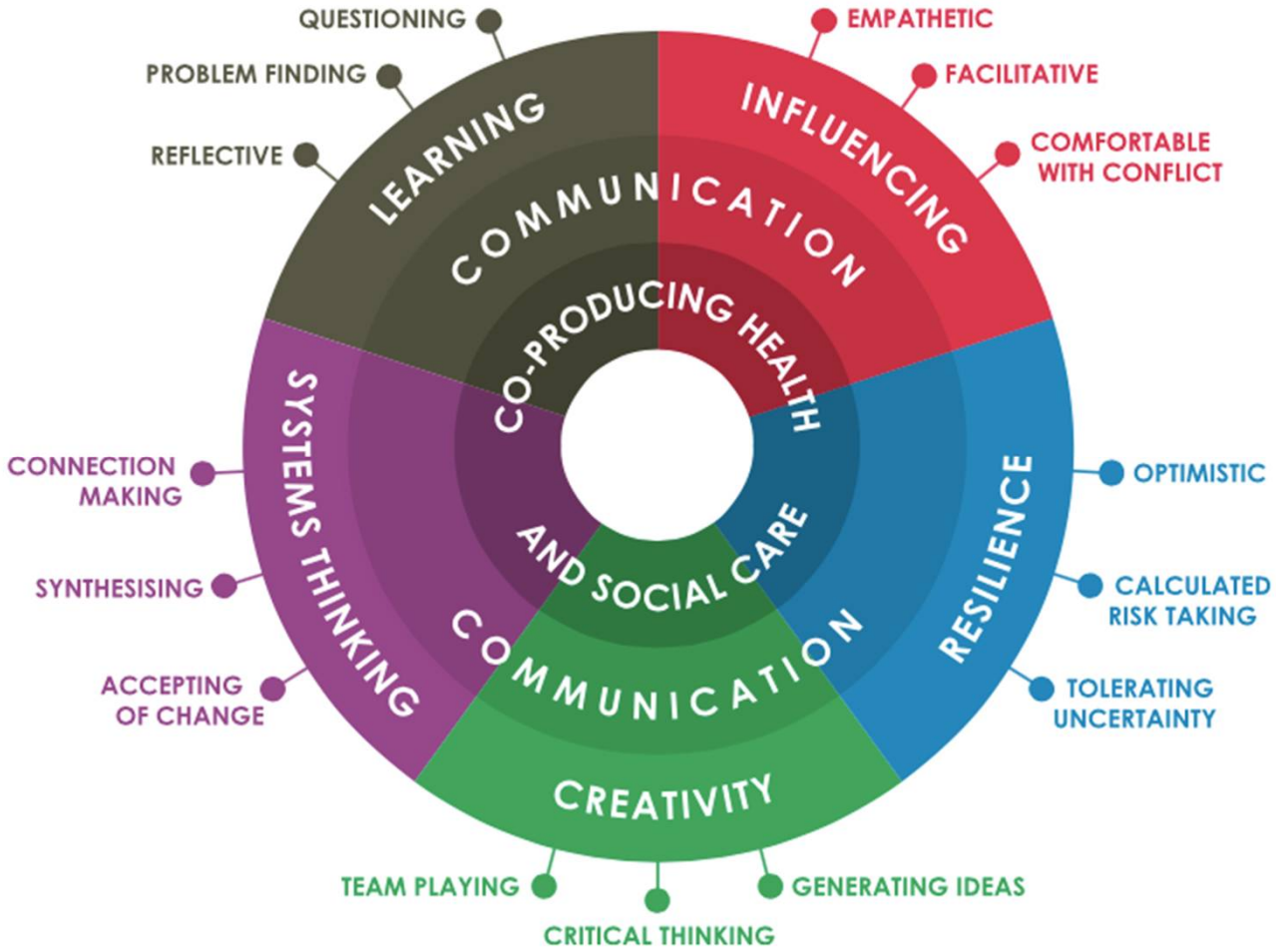
Abstract

The last decade has witnessed a growing awareness of medical error and the inadequacies of our health care delivery systems. The Harvard Practice Study and subsequent Institute of Medicine Reports brought national attention to long-overlooked problems with health care quality and patient safety. The Committee on Quality of Health Care in America challenged professional societies to develop curriculums on patient safety and adopt patient safety teaching into their training and certification requirements. The Patient Safety Task Force of the Society for Academic Emergency Medicine (SAEM) was charged with that mission. The curriculum presented here offers an approach to teaching patient safety in emergency medicine. **Key words:** patient safety; curriculum; emergency medicine. ACADEMIC EMERGENCY MEDICINE 2003; 10:69–78.

https://onlinelibrary.wiley.com/doi/abs/10.1197/aemj.10.1.69

Make quality and safety a habit

Figure 2 – The habits of improvers



http://www.health.org.uk/publication/habits-improver

Learn for safety

https://academic.oup.com/intqhc/issue/30/suppl_1

Social Movements for Safety in paediatrics

Making It Safer Together

A Professional Collaborative Sharing Experiences, Tools & Ideas to Enhance Safe Care for Children in Hospital

http://www.mist-collaborative.net

Meds IQ

Sharing QI resources for paediatric medication safety

http://www.medsiq.org

S.A.F.E

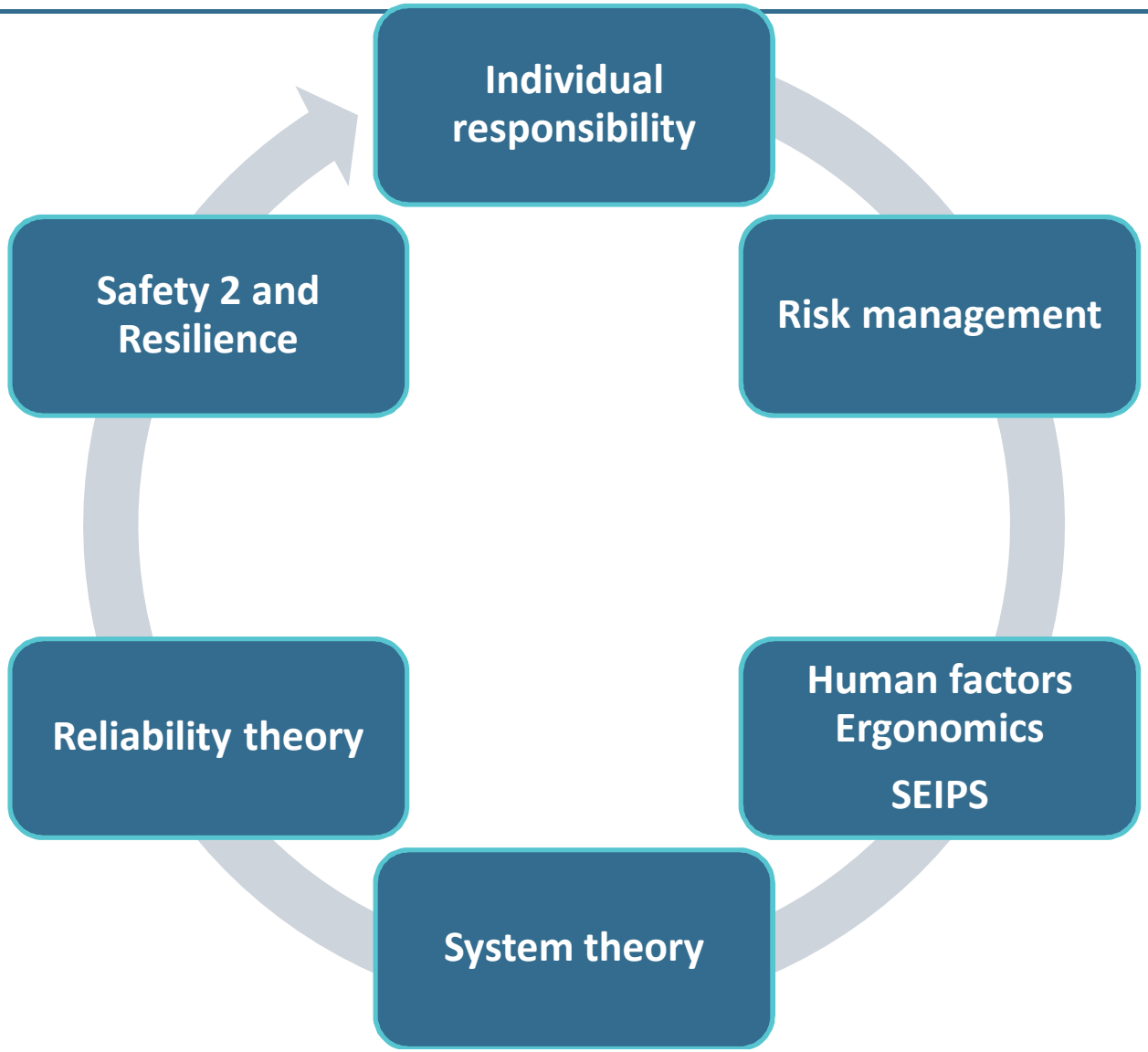
Situation Awareness for Everyone

https://www.rcpch.ac.uk/resources/situation-awareness-everyone-safe-resource-introduction

Children's Hospitals' Solutions for Patient Safety

Every patient. Every day.

Integrate the theory into daily work



Share ideas across the movement

Huddling for high reliability and situation awareness

BMJ Qual Saf 2013;22: 899–906.

Linda M Goldenhar,[1] Patrick W Brady,[2,3] Kathleen M Sutcliffe,[4] Stephen E Muething[1]

Huddle Up to Improve Health Care

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South Texas Veterans Health Care System

Health Care Management Review. 40(1):2–12, JAN 2015

Improving Situation Awareness to Reduce Unrecognized Clinical Deterioration and Serious Safety Events

abstract

BACKGROUND AND OBJECTIVE: Failure to recognize and treat clinical deterioration remains a source of serious preventable harm for hospitalized patients. We designed a system to identify, mitigate, and escalate patient risk by using principles of high-reliability organizations. We hypothesized that our novel care system would decrease transfers

AUTHORS: Patrick W. Brady, MD, MSc,[a,b] Stephen Muething, MD,[a,b] Uma Kotagal, MBBS, MSc,[b] Marshall Ashby, MHA, MBA,[b] Regan Gallagher, MSN,[e] Dawn Hall, BSN, MHA,[e] Marty Goodfriend, BSN, MEd,[d,e] Christine White, MD, MAT,[e] Tracey M. Bracke, MS,[b] Victoria DeCastro, MSN, MBA,[e] Maria Geiser, BSN, Jodi Simon, MHA,[f] Karen M. Tucker, MSN, RN,[e] Jason Olivea, MS, MPA,[b] Patrick H. Conway, MD, MSc,[a,g] and Derek S. Wheeler, MD[b,c]

Pediatrics. 2013 Jan; 131(1): e298–e308.

BMJ Open 2017;7:e014497.

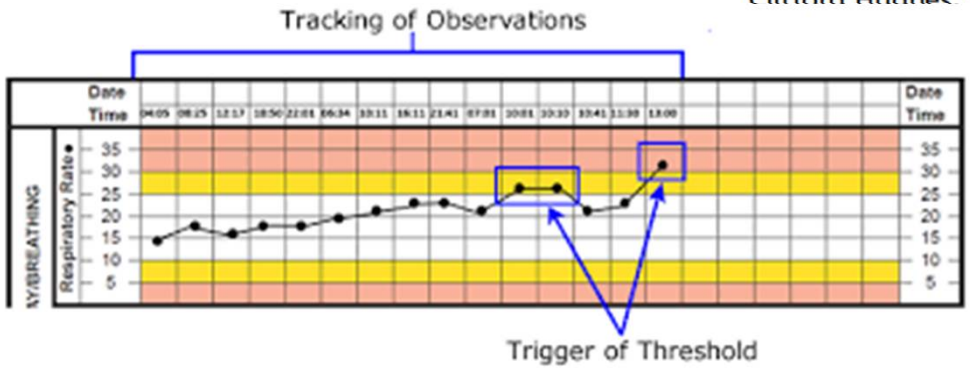
Open Access Research

BMJ Open Paediatric early warning systems for detecting and responding to clinical deterioration in children: a systematic review

Veronica Lambert,[1] Anne Matthews,[1] Rachel MacDonell,[2] John Fitzsimons[3]

'Between the flags': implementing a rapid response system at scale

Clifford Hughes,[1] Charles Pain,[2] Jeffrey Braithwaite,[3] Kenneth Hillman[4]



BMJ QS 2014 Sep;23(9):714-7.

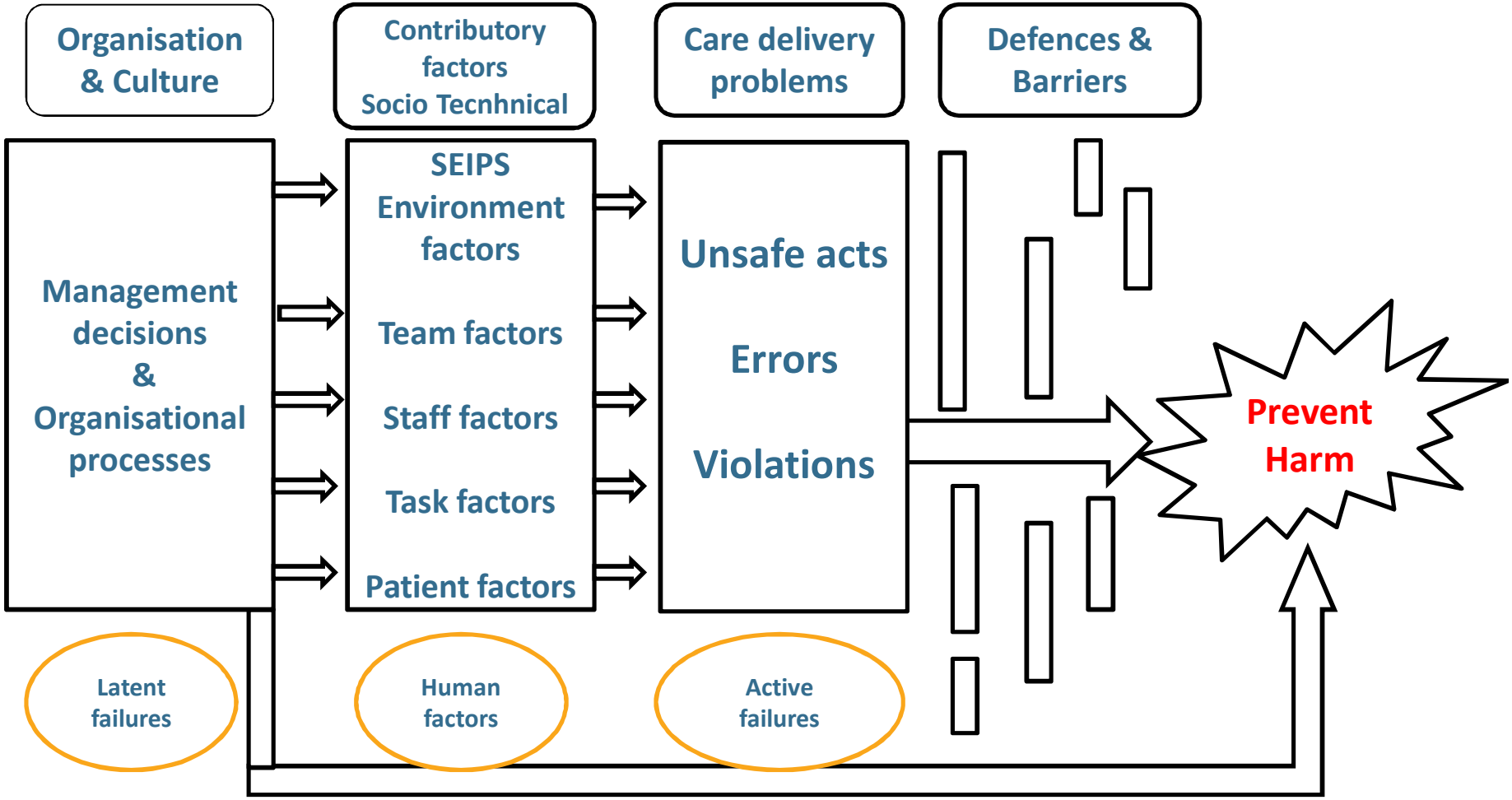
Applying safety at a macro and micro system level

Measurement and monitoring of safety: impact and challenges of putting a conceptual framework into practice

Eleanor Chatburn,[1] Carl Macrae,[1] Jane Carthey,[2] Charles Vincent[1]

Source: Vincent C, Burnett S, Carthey J. *The measurement and monitoring of safety.* The Health Foundation, 2013. www.health.org.uk/publications/the-measurement-and-monitoring-of-safety

Assess every 6-8 hour in every unit



Adapted from Charles Vincent and SEIPS System Model Carayon 2006

ORIGINAL RESEARCH

OPEN ACCESS

Development of the Huddle Observation Tool for structured case management discussions to improve situation awareness on inpatient clinical wards

Julian Edbrooke-Childs,[1] Jacqueline Hayes,[2] Evelyn Sharples,[1] Dawid Gondek,[1] Emily Stapley,[1] Nick Sevdalis,[3] Peter Lachman,[4,5] Jessica Deighton[1]


HUDDLE OBSERVATION TOOL


HUDDLE OBSERVATION TOOL

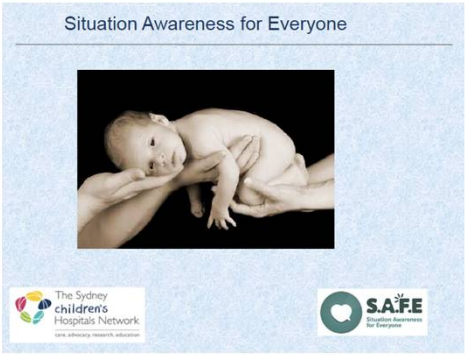
ISQua

Open Access Protocol

BMJ Open

Realistic evaluation of Situation Awareness for Everyone (SAFE) on paediatric wards: study protocol

J Deighton,[1] J Edbrooke-Childs,[1] E Stapley,[1] N Sevdalis,[2] J Hayes,[3] D Gondek,[1] E Sharples,[1] P Lachman[4]



ISQua

International Journal for Quality in Health Care, 2018, 30(1), 44–49
doi: 10.1093/intqhc/mzx162
Advance Access Publication Date: 13 December 2017
Article

OXFORD

S.A.F.E
Situation Awareness for Everyone

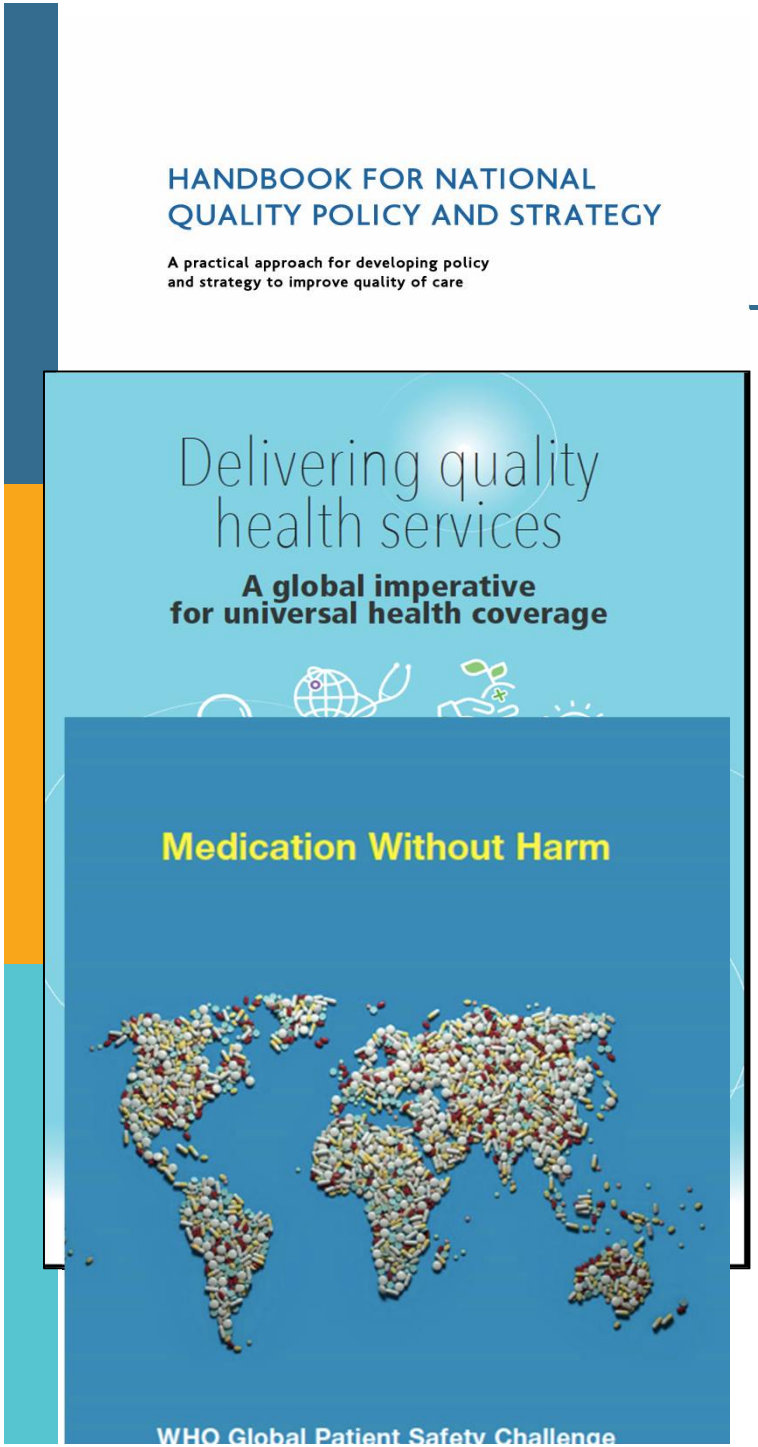
Article

Factors to consider in the introduction of huddles on clinical wards: perceptions of staff on the SAFE programme

EMILY STAPLEY[1], EVELYN SHARPLES[1], PETER LACHMAN[2], MONICA LAKHANPAUL[3], MIRANDA WOLPERT[1], and JESSICA DEIGHTON[1]

[1]Evidence Based Practice Unit, Anna Freud National Centre for Children and Families and University College

WHO initiatives

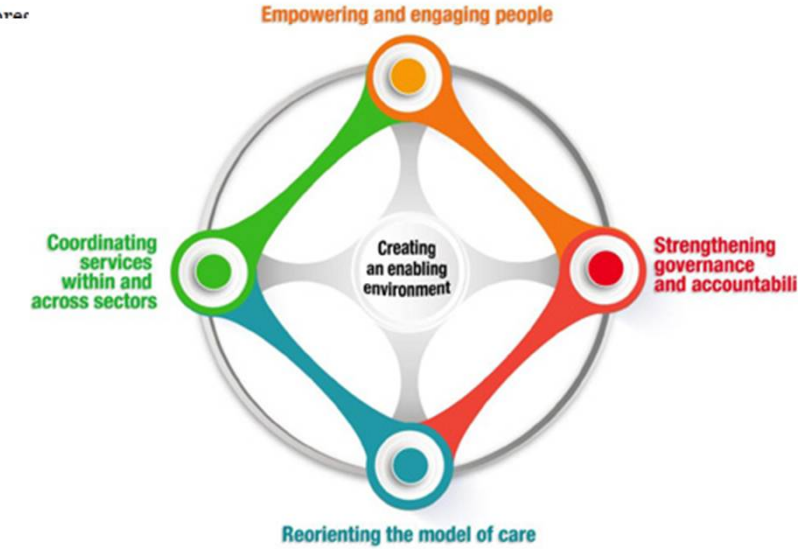


New WHO standards for improving the quality of healthcare for children and adolescents

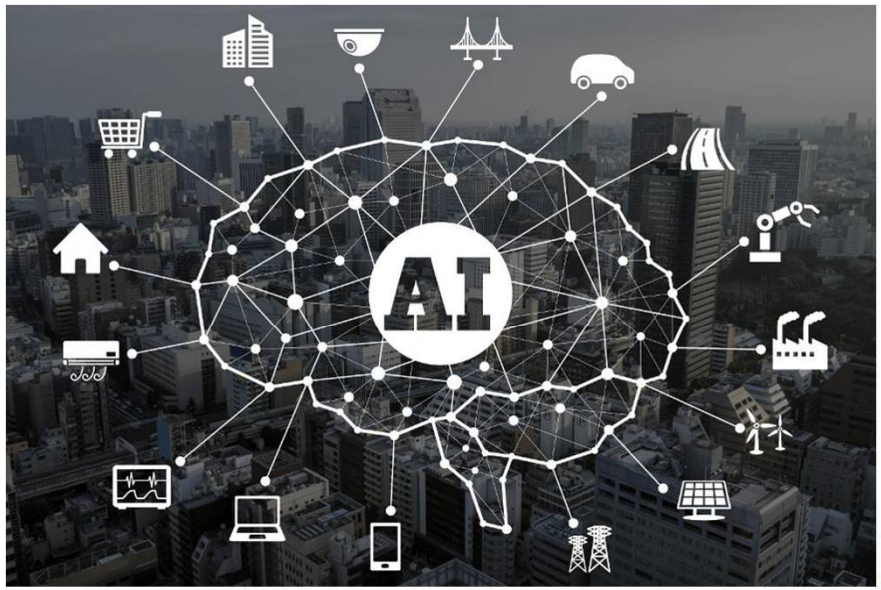
Trevor Duke[1,2]

In the last 25 years there has been an increasing recognition of the importance of quality of health services as a public health issue.[1,2] Quality in healthcare is now repres

Box 1 WHO standards for improving the quality of care for children and young adolescents in health facilities



The future


AI


Transforming Health Care
Through Big Data
Strategies for leveraging big data in the health care industry

Make Safety and Quality our Business

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7. The Person
8. Education Through Learning and Sharing
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10. Patient Safety
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Call for Papers opens on 4th October 2017
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