Medical Staff Role in Patient Safety

Edited from
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Issues to be Addressed

• The importance of medical staff involvement in hospital patient safety programs
• The responsibilities of medical staff to ensure a culture of safety in hospitals
• How Medical staff can be involved with the development and implementation of programs
• The importance for hospitals to develop non-punitive safety reporting systems
• The evolving business aspects relevant for organized medical staff and safety activities.
Patient Safety Issues

• Causes of errors are diverse, often complex and rarely attributable to single actions, events or individuals

• Causes are related to inherently unsafe systems rather than caregivers specifically

• Systems supporting health care professionals are ineffective
Swiss Cheese Model of Adverse Event Causation

There may be many reasons why personal protective equipment alone may not be sufficient to protect against potential exposures.
Swiss Cheese Model

- Multiple layers in a system, each evaluating self, but not the whole system
Issues for Health Care

- Highly complex processes
- Unique Problems and Patient Variability
- Loosely knit team system
- Multiple outcomes measures
- Incomplete evidence base
- Variable layers of Responsibility
- Unpredictable Workloads and case mix
- Work hours, fatigue and variable employee support systems
Issues for Health Care

• “The acute care hospital is the most complex organization to lead and manage”
• “This complexity is compounded by academic missions and by an increasingly broad range of single and multi-site organizations, public/private mix of providers and a highly professional and autonomous cadre of knowledge workers”.

» Peter Drucker
Non Health Industry

• Aviation, Banking, Chemicals, Manufacturing, Military Services
• Commitment to safety with emphasis on safe practices, commitment of management, non-punitive environment with a focus on simplified reporting, feedback and analyses
• Crew resource management
• Standardization of Practices
• High reliability organizations
• Root Cause analysis vs FMEA
Issues to be Addressed

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Issues for Health Care

• Beginning in 2000 the IOM reports have facilitated a greater understanding for the public, government and health care industry that safety, quality and efficiency are not guaranteed.

• In fact, there is considerable cause for concern regarding the systems efficiencies of health care and there is now an evolving consensus that the health care system needs aggressive revision and reengineering on multiple levels.
Issues for Health Care

• Precipitating further change in societal and public culture toward an increased awareness that safer care is possible and realistic

• Aggressive education for health care organization leadership—including boards of directors, trustees, executive and medical staff leadership, regarding the importance of patient safety and to stimulate the structuring of financial incentive activities
Issues for Health Care

• Breakdown educational skills for health care in such a fashion that realignment of the educational programs and professional schools provide integrated care delivery systems.

• Alignment of financial reward and support systems for both the individual and institutional providers is required in order to stimulate effective patient safety initiatives.
Issues for Health Care

• Reform of medical liability coverage will be critical to the support of all Patient Safety initiatives because the current system provides dominant disincentives for change.

• Physicians continue to be the predominant driving force for health care practices and so improved engagement of all practitioners is a necessary priority for perpetuating long term improvement for patient safety.
Integrating Definition

• Leadership involves a social influence process whereby intentional influence is exerted by one person over other people to structure the activities and relationships in the group organization.

• Physicians need to be leaders not merely managers of practices
Managers versus Leaders

- Managers
  - Oriented toward stability
  - Get people to do things more efficiently

- Leaders
  - Oriented toward innovation
  - Get people to agree about what things should be done
Patient Safety

• Two essential elements
  – Culture of safety
  – Leadership
Issues for Health Care

• Multi-professional manpower shortages already exist and are anticipated to continue through the immediate short term and this creates longer term patient safety concerns primarily due to the inherent delays for creating environments appealing for workforce re entry to health care
Issues for Health Care

• In the interim systems re-engineering and novel technology applications will be required in order to invent and the provide new models of care that will offset the loss of manpower
Culture of Safety

• “A culture of safety is an integrated pattern of individual and organizational behaviors based on shared beliefs and values that continuously seeks to minimize patient harm that may result from the processes of care delivery.” (Kizer, 1999)
Culture of Safety

• Key: establishing an environment where reporting of errors is encouraged
  – Not an environment where reporting is first step in a disciplinary process

• IOM has established that most medical errors result from systems and process issues
Medical Staff Involvement

• Medical staff committees
• Root Cause analysis teams
• Peer review process
• Physician champions
Principles for Patient Safety

• Standardize
• Simplify processes
• Include patient in design
  – Ones who have experienced systems or process first hand
• Design mechanisms for reporting and learning from errors
  – You can not fix what you do not know is broken
Principles of Patient Safety

• Seek redundancy through use of technology to support clinical decision making

• Avoid reliance on memory
  • Forcing functions (Most effective)
  • Automation, computerization
  • Protocols and preprinted orders
  • Checklist
  • Rules and double checking
  • Education
  • Information (Least effective)
Principles for Patient Safety

• Use constraints and forcing functions
• Simulate planned and unplanned events for how people interact with each other and technology
• Plan for failure and design for recovery
• Provide access to a core set of integrated clinical information at time and point of decision making
Principles for Patient Safety

• Hospital boards together with management and the medical staff are responsible and accountable if the organization’s culture, environment and/or process design could, but fails to, prevent or minimize health care-related injury or death.
What Boards Should Know About Their Organization

• What are we doing to create a “culture of safety?”
• What are we doing to ensure that staff are kept current regarding the latest safety techniques?
• What do our staff suggest for improving patient safety?
What Boards Should Know About Their Organization

• What do we do to encourage the reporting of health care errors, and how do we know that health care errors are being reported?
• Do staff feel safe about reporting health care errors, injuries or death?
• What happens when a health care error occurs?
• What serious care related adverse events have occurred during the past year?
What Boards Should Know About Their Organization

• What did we learn from these events? What did we do?

• How is the medical staff involved in patient safety interventions?

• Are we rewarding staff who step up to the plate by reporting or proactively initiating activities to improve patient safety?
How does the Board evaluate their effectiveness?

<table>
<thead>
<tr>
<th>Pathological Culture</th>
<th>Bureaucratic Culture</th>
<th>Generative Culture</th>
</tr>
</thead>
<tbody>
<tr>
<td>Don’t want to know</td>
<td>May not find out</td>
<td>Actively seek it</td>
</tr>
<tr>
<td>Messengers (Whistle Blowers) are “shot”</td>
<td>Messengers are listened to if they arrive</td>
<td>Messengers are trained and rewarded</td>
</tr>
<tr>
<td>Failure is punished</td>
<td>Failure leads to local repairs</td>
<td>Failures lead to far reaching returns</td>
</tr>
<tr>
<td>New ideas are actively discouraged</td>
<td>New ideas often present problems</td>
<td>New ideas are welcomed</td>
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Strategies

- Structure drives behavior; therefore, the proper structure leads to fast, decisive action
- Focus on the significant few, not the trivial many
- Don’t argue the facts
- Work on changing the process—not changing the people
- Every process is uniquely designed to produce the results it gets
Every system is perfectly designed to achieve exactly the results it gets.

Don Berwick, MD
The end

• Please proceed to the post test
• Complete the post test
• Return the post test responses to
  – Dr. Sandra Oliver
  – 407i TAMUII
Post Test - Question One

Circle the correct answer:

1. Causes of error are
   A. directly attributable to single actions, events or individuals
   B. related to inherently unsafe systems
Post Test - Question Two

Indicated the most correct answer:

2. Physicians are called to be leaders in patient safety. Leaders
   A. are oriented toward stability
   B. get people to do things more efficiently
   C. are focused on innovation.
Post Test - Question Three

3. Residents at a local hospital refuse to report correct duty hours for fear of the repercussions. The hospital culture most likely is a:

A. Pathological culture
B. Bureaucratic culture
C. Generative culture