

Making New Jersey a Model for Patient Safety

Patient Safety History and Reporting: An Overview

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Advancing Patient Safety: Three Fronts of Engagement

The Challenges...

- ★ Transforming the Internal Environment

- ★ Growing Internal Cultures that Honor Safety & Deliver High Reliability Care

- ★ Transforming the External Environment

- ★ Fostering a New Understanding of Accountability

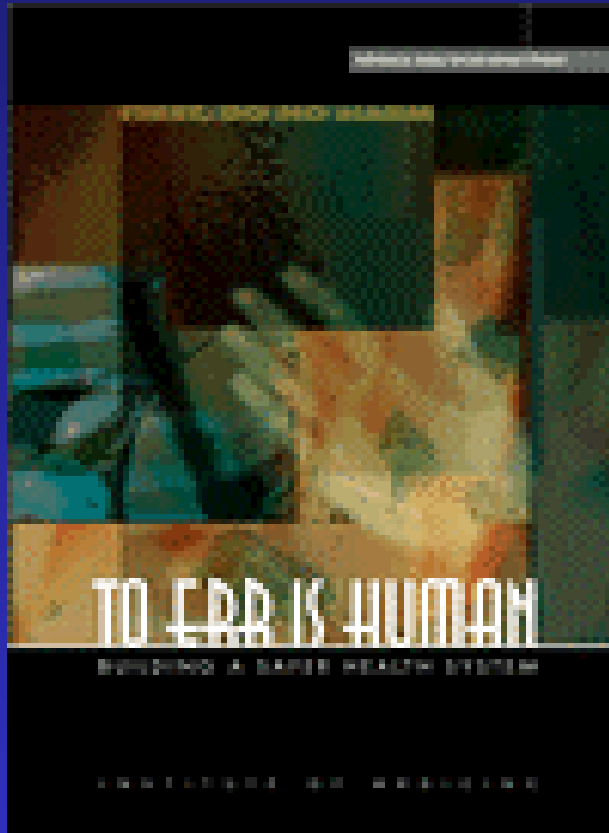
- ★ More Effectively Managing Knowledge

- ★ Capturing Information & Converting it to Practical Tools

Why Patient Safety?

Why now?

The IOM Numbers



- ✧ Medical failure is a public health problem (4th to 8th largest cause of preventable death)
- ✧ Medical failure is a systems problem.
- ✧ One percent of hospital patients experience an error

Advancing Patient Safety: A Snapshot History

- ✱ Libby Zion Case (Sleep-deprived residents)(1984)
- ✱ Lucian Leape's "Error in Medicine" article, *JAMA* (1990)
- ✱ Willie King ("wrong" foot amputated) (1995)
- ✱ Betsy Lehman Case (Dana Farber overdose) (1995-96)
- ✱ Ben Kolb Case (mix-up of meds in the OR) (1995)

- ✱ JCAHO Sentinel Event Initiative launched (1996)
- ✱ National Patient Safety Foundation established(1997)
- ✱ IOM Report (*To Err is Human*) (1999), followed by others...
- ✱ AHRQ support for Patient Safety (\$50 million/year since 2000)

- ✱ Linkage to quality, nursing shortage, tort reform, "gag clause" & physician discipline issues (all on the bubble right now...)
- ✱ Josie King case (Infant death at Johns Hopkins) (2002)
- ✱ Linda McDougal case (Minnesota double mastectomy) (2002)
- ✱ Jessica Santillan case (Transplant error at Duke) (2003)

*What's Driving Patient
Safety?*

Progress and Complexity...

The Patient Safety Paradox

We have...

- New Technological "Miracles" Pushing Health Care Forward
- Ability to Treat Ever Sicker Populations

The Patient Safety Paradox

But we also have...

- Increased Process Complexity
- Escalating Change
- Information Overload
- Increased Expectations for Perfect Outcomes
- New Patient Acuties = New Patient Vulnerabilities

...All of which raise the bar

*Another way to look at
it...*

*What's frustrating patient
safety?*

The "Old Look" Paradigm

- Clinicians are Supposed to be Infallible
- Bad Things Happen *Only* when People Make Mistakes
- People/Organizations that Fail are Bad
- Blame & Punishment *Sufficiently* Motivate Carefulness

The "New Look" from Safety Science

- Risk of Failure is Inherent in Complex Systems
- Risk is always *Emerging*
- Latent Risk is not Foreseeable
- People are Fallible...No Matter How Hard They Try Not to Be
- Systems are Fallible
- Alert, Well-trained Clinicians are Crucial

What is Safety Science?

Where Does it Come from?

Where Does Safety Science Come From ??

- Health Care Research
- Systems Analysis, Engineering & Design
- Cognitive Psychology
- Human Factors/Ergonomics
- Sociology & Organizational Behavior
- Lessons Learned from other Industries
- Quality Improvement
- Complexity Theory

PATIENT SAFETY



Complexity

Human
Factors

Improvement
Quality

Safety as
Core Value =
PATIENT
CENTERED
FOCUS

Lessons
from other
Industries

Professional
Ethics

Risk
Management

What have we Learned from Safety Science's New Look?

The New Look

“Rather than being the main instigators of an accident, operators tend to be the inheritors of systems defects...Their part is that of adding the final garnish to a lethal brew whose ingredients have long been in the cooking.”

...James Reason, *Human Error*
Cambridge University Press, 1990

What Have We Learned from Safety Science?

- ❖ Systems never run perfectly – they are prone to failure and degradation
- ❖ Reliance on vigilance and memory are insufficient to produce reliably good outcomes
- ❖ Errors are rarely due to single “bad apple”
- ❖ Simplification and Standardization = Very Important Tools
- ❖ Errors are inevitable, but prompt “recovery” can greatly reduce adverse events

What is a Safety Culture?

How do we build one?

What is a Safety Culture?

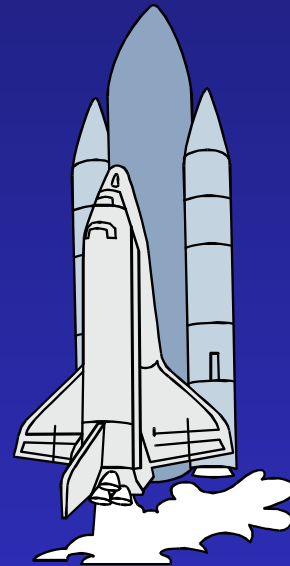
How Do We Build One?

- *Problem* - No Precedents in Health Care
- *Solution?* Look at *High Reliability Service Organizations (HRO)* in other industries
- HRO's are *engineered* to deliver *consistently Good Outcomes in Complex & Dynamic Environments*

Where Is Safety Science Being Applied ?

Other industries:

- NASA
- Aviation
- Nuclear power
- Military
- Banking



How Did Other Industries Achieve High Reliability?

HRO Key Attributes...

- ✱ *Honors Safety as a Core Value*
- ✱ *Reporting Cultures*
- ✱ *Flexibility in Operation*
- ✱ *Perceived to be Just*
- ✱ *Engaged in and dedicated to Continuous Learning*

Activities of High Reliability Organizations

- ❖ Acknowledgement of the Inherent Riskiness of the work
- ❖ Leadership, starting with establishing safety = core value
- ❖ Auditing and Feedback (i.e. Reporting)
- ❖ Process Control
- ❖ Appropriate Rewards for Moving Beyond Blame

*What are the Roles of
Reporting Systems in
Advancing Safety?*

*Is Commercial Aviation a
Model?*

Auditing Risk In Commercial Aviation

❖ Accident Investigation

- o National Transportation Safety Board

❖ "Close Call" Analysis

- o Aviation Safety Reporting System

❖ Reporting/Observation/Inspection

- o FAA & Corporate Programs

❖ Simulation Training to grow expertise

Aviation Safety Reporting System (ASRS)

➤ Type A

- o Death or Damage > \$1Million

➤ Type B

- o Permanent Disability or Damage > \$250k

➤ Type C

- o Lost Time or Damage >\$25k

➤ Incidents

- o Medical Treatment or Damage >\$1,000

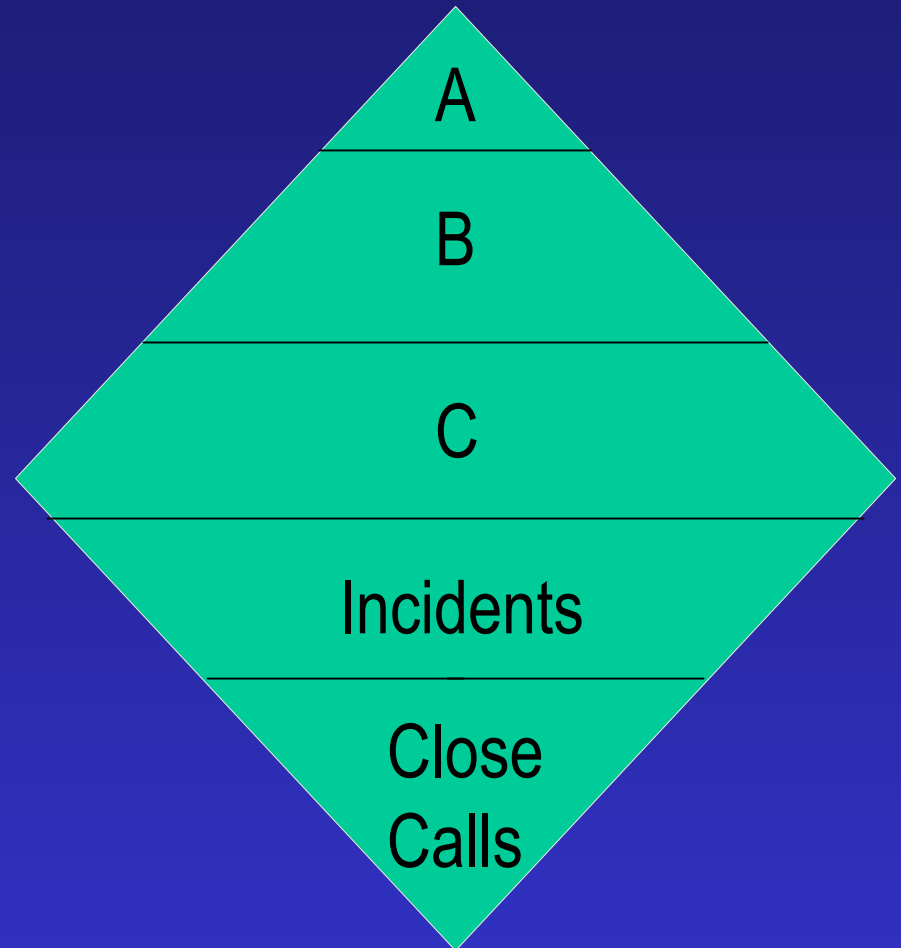
➤ Close Calls -

- o "Almost" a Bad Outcome

"The Mishap Diamond"

Weak Risk Auditing Model

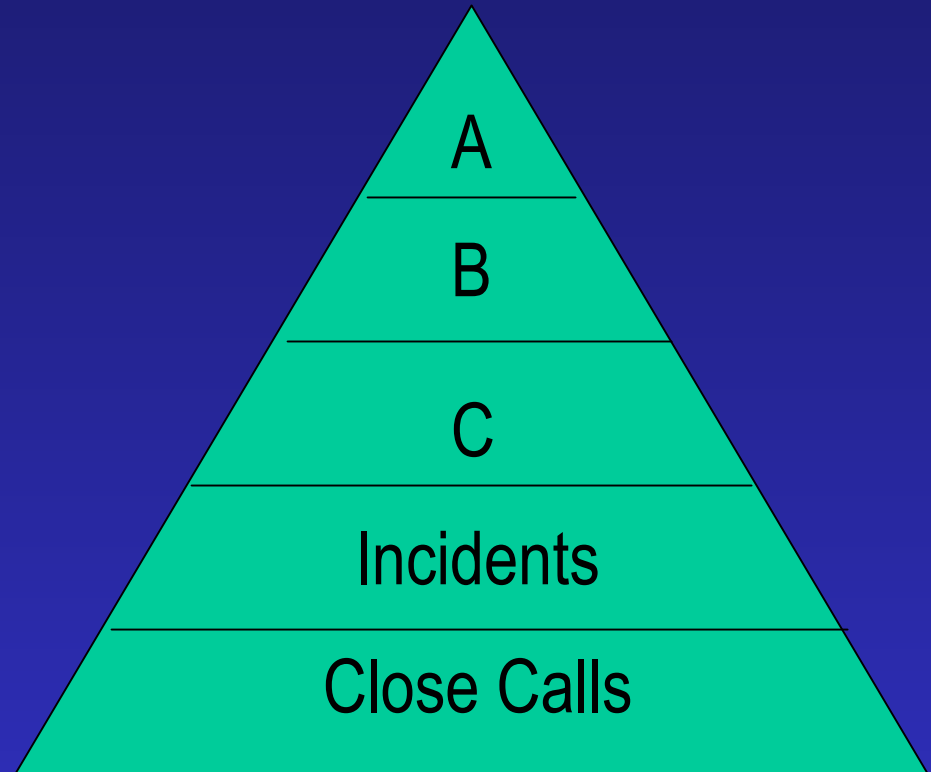
- A = Death
- B = Serious Injury
- C = Lost Time
- Injury
- Incidents
- Close Calls



The "Mishap Pyramid"

Strong Program Model

- A = Death
- B = Serious Injury
- C = Lost Time Injury
- Incidents
- Close Calls



Mandatory vs. Voluntary Reporting...

What's Better?

Mandatory vs. Voluntary Reporting

Voluntary programs are never the whole answer, but they can...

- Be an effective early warning system for emerging risk
- Produce info on risk that mandatory systems won't
- Serve as an important culture carrier

But don't...

- Park them with the regulator
- Under-resource them
- Roll them out without public buy-in

Mandatory vs. Voluntary Reporting

Mandatory programs can...

- Establish a baseline for measurement
- Increase public confidence
- Help identify research/policy/spending priorities
- Identify unsafe environments

...But the problem is compliance

Mandatory vs. Voluntary Reporting

Mandatory programs fail because of...

- Fear of punishment
- Fear of embarrassment
- Administrative burden, including inconsistency among different reporting systems
- Lack of feedback to reporters

...All of which must be addressed.

Mandatory vs. Voluntary Reporting

Mandatory reporting can be encouraged by...

- Auditing adverse events as opposed to errors
- Integrating reporting programs to minimize burden
- Feeding back
- Aligning public policy with the "New Look"

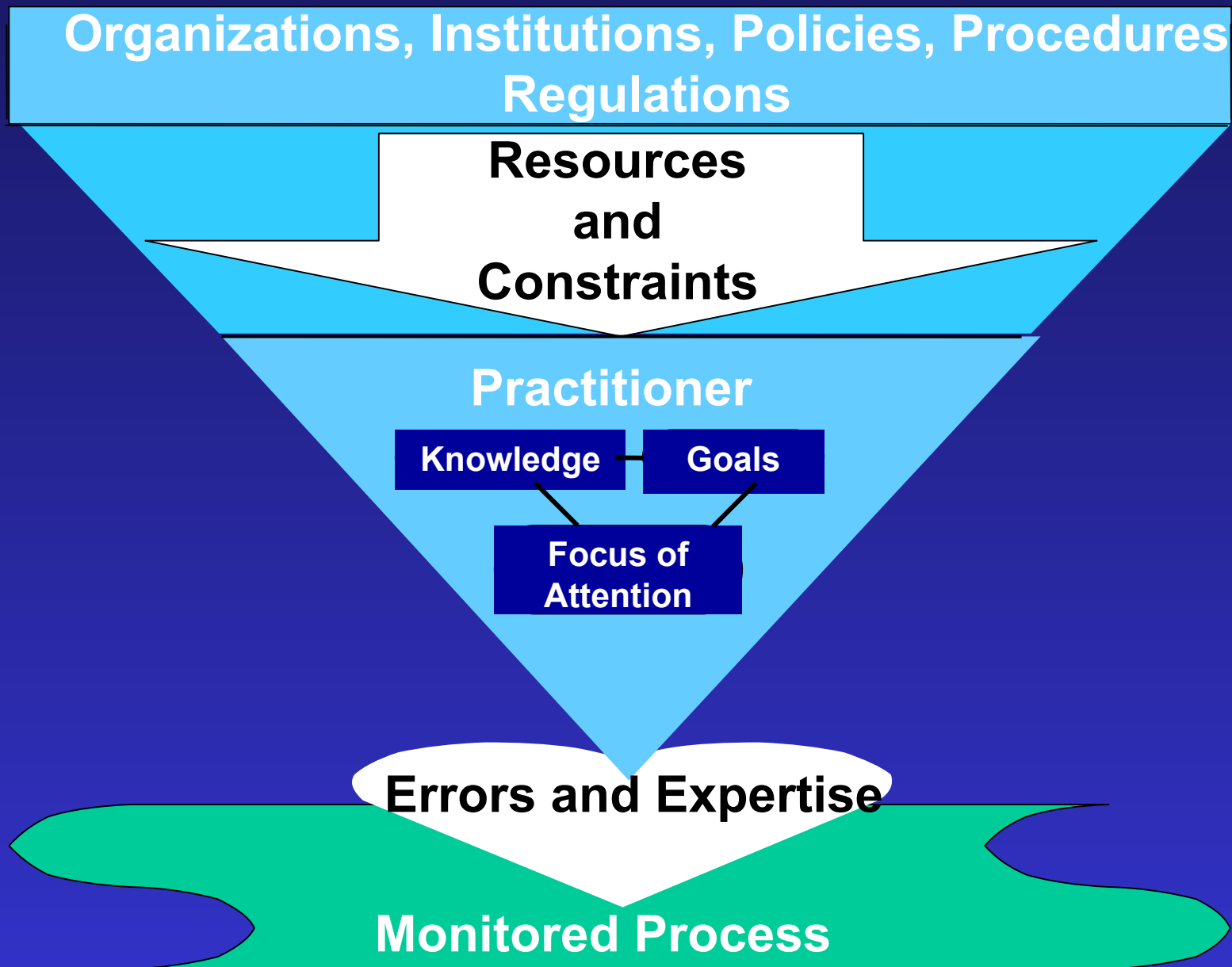
...Massachusetts and Minnesota are the States to watch right now.

*How Do We Achieve
Alignment with the
"New Look"
in the
External Environment?*

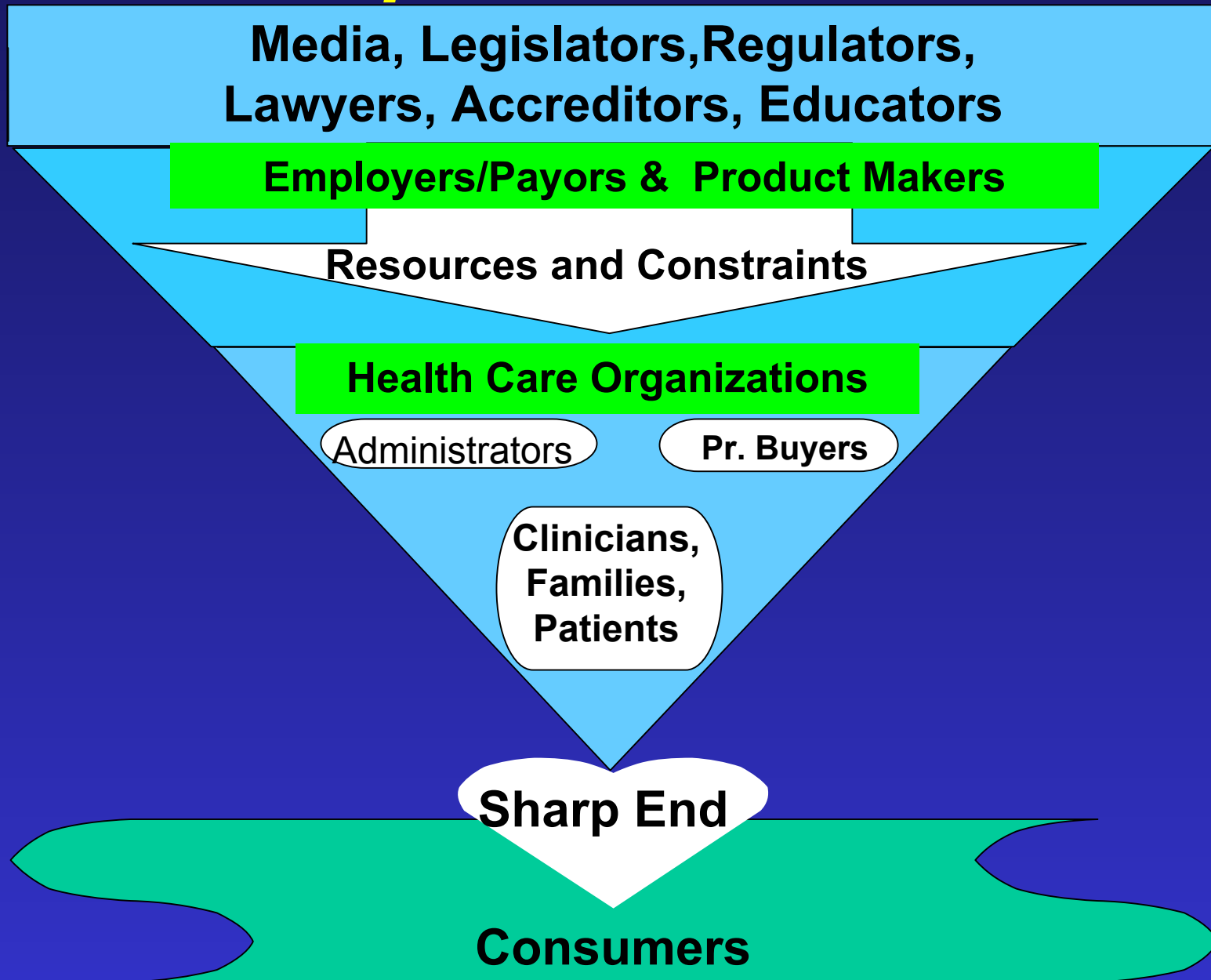
Growing a Safety Culture: The Stakeholders

- Consumers
- The Clinician/Patient/Family Team
- Health Care Administrators including middle, executive & governance layers
- Makers & Purchasers of Medical Products
- Clinician, Administrative & Patient Educators
- Employers, Payors & Managed Care Orgs
- Legislators/Regulators/Lawyers
- Media
- Medical Liability Insurers

Sharp and Blunt Ends



Sharp and Blunt Ends



Growing A Safety Culture: Government Roles

- Promoting Awareness about Inherent Risk & Systems Thinking
- Educating Policymakers about the "New Look"
- Consolidating/Integrating Reporting Programs
- Feeding Back Lessons Learned from Reported Events
- Maintaining the Spotlight to Discourage Complacency

Advancing Patient Safety: Is the Media Helping or Hurting?

- IOM Report, *To Err is Human* (November 1999)
- Boston Globe's Coverage of Betsy Lehman Case (1995 to present)
- Sporadic Coverage of Ben Kolb Case (1995 to present)
- Chicago Tribune Series on Nurses (Summer 2000)
- Children's Hospitals of the Twin Cities Marketing and Culture Carrying Strategies
- Johns Hopkins & Duke Medical Center Stories (2002/03)
- Adverse Events and Tort Reform

What Can We Do to Make Reporting Systems Work? A Lesson from Aviation:

“One reason that an incident reporting system worked in aviation...was that the entire aviation community -- essentially all of the stakeholders, including air passengers -- were involved in the process from the beginning and became advocates for the reporting system (as well as severe, but constructive, critics).”

...Charles E. Billings, MD, Editorial
Arch Pathol Lab Med 1998,121:214-215