

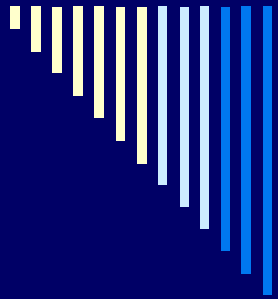


Patient's Safety Culture



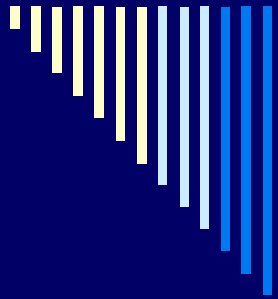
Non-Punitive Approach to Problem Solving

**Mohamad-Ali Hamandi
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Outline

- Definition of terms
- Causes of Human Errors
- Why Errors Are Not Disclosed
- Top 10 Error Prone Activities
- Why Errors are Not reported
- Building a Safety Culture
- Understanding Adverse Incident causes
- Non-punitive Approach:
what we mean and do not mean
- Principles of Error Management
- Response to Errors



Near Miss

Error(s) that almost caused harm but did not

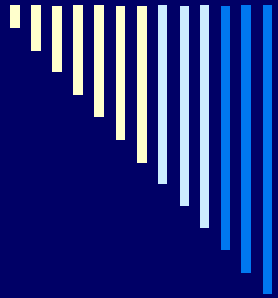
Key features:

- proximity to patient
- severity of potential harm



Adverse Events components

- Injury/harm
- Causation
 - Caused by medical management rather than underlying disease process
- Disability
 - Prolonged LOS
 - Disability at discharge
 - Death



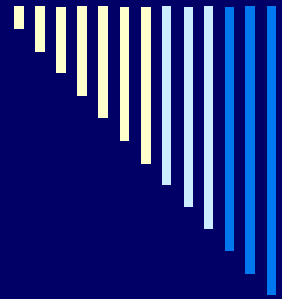
Unanticipated Outcome

- A negative or unexpected result stemming from
 - A diagnostic test, medical judgment or treatment, surgical intervention
 - The failure to perform a necessary test, treatment , or intervention



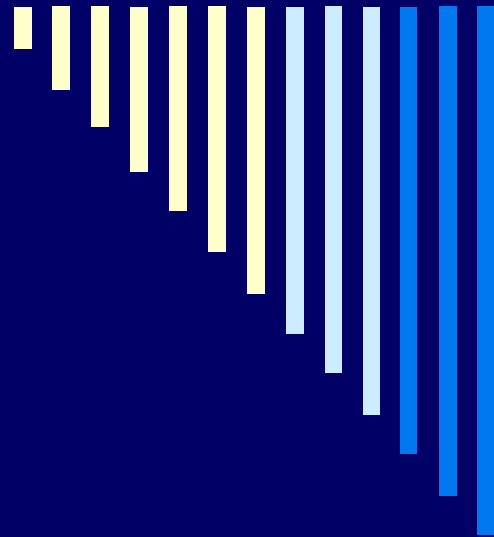
Preventable Adverse Events

- Caused by error(s)
- About 25-50% of adverse events are judged (potentially) preventable



A Few Thoughts About Error

- ◆ No one makes an error on purpose
- ◆ Big errors result from little errors
- ◆ Everyone makes dumb mistakes daily
- ◆ Fear of punishment is NOT irrational

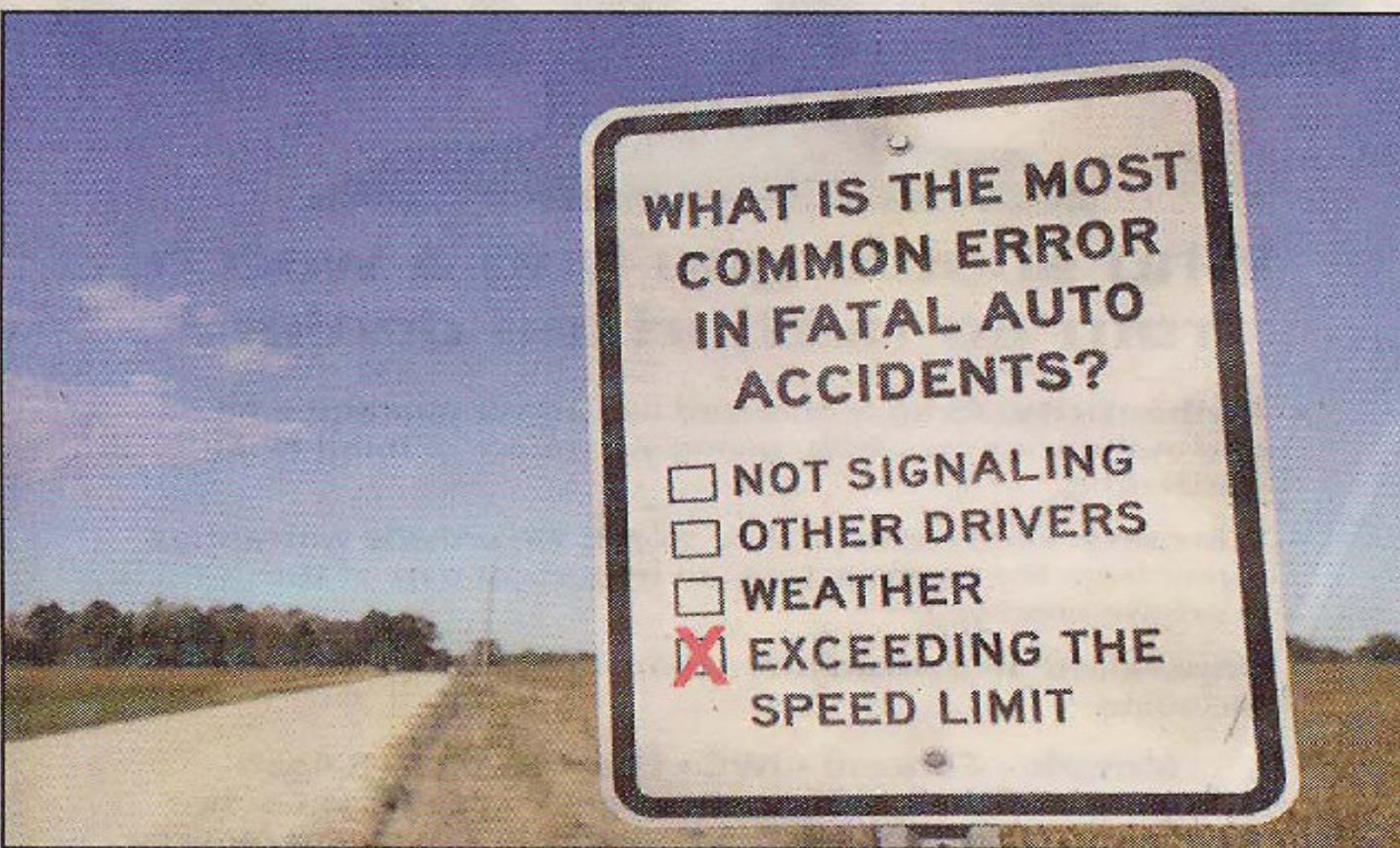


No one admits an error if you punish them for it.



What Impact Human Performance?

- Fatigue
- Lack of sleep
- Illness
- Drugs or alcohol
- Boredom
- Frustration
- Fear
- Stress
- Shift work
- Reliance on memory
- Reliance on vigilance
- Distractions
- Noise
- Heat
- Clutter
- Motion
- Lighting
- Too many handoffs
- Unnatural workflow
- Procedures or devices designed in an accident prone fashion



WHAT IS THE MOST
COMMON ERROR
IN FATAL AUTO
ACCIDENTS?

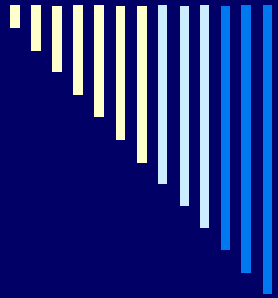
- NOT SIGNALING
- OTHER DRIVERS
- WEATHER
- EXCEEDING THE
SPEED LIMIT

Will your teenager have the right answer?

Knowing what to do behind the wheel can help them avoid a serious accident. For answers on how to start a conversation with your teen about safer driving habits, visit toyotateedriver.com.



TOYOTA | *moving forward ▶ safely*



Complexity Does Not Make Us Safer

- • Reliability means doing the right thing
- (evidence-based care), in the right way, at
- the right time—**every time**.
- • Poor reliability in complex, multi-step
- processes is a major cause of medical
- error.



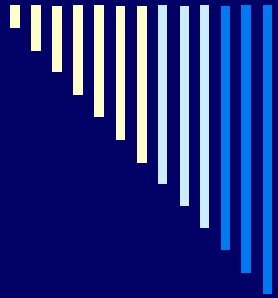
Why Do Errors Happen?

- There are limits to human performance
 - Sensory
 - Cognitive
 - Overestimate abilities, underestimate limits
 - Tendency for behavior to migrate
- Healthcare managers and providers lack teamwork and communication strategies



Causes of Human Error

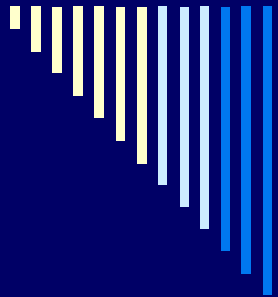
- Human errors occur because of:
 - Inattention
 - Memory lapse
 - Failure to communicate
 - Poorly designed equipment
 - Exhaustion
 - Ignorance
 - Noisy working conditions
 - A number of other personal and environmental factors



Why Do Errors Occur?

Two schools of thought:

- ❑ Individuals make mistakes because they are forgetful, inattentive, slothful, evil, weak...



Why Do Errors Occur?

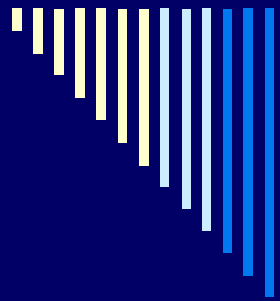
Two schools of thought:

- Every system is perfectly designed to achieve the results that it gets; humans are fallible but systems create the conditions in which humans make mistakes and fails to prevent or mitigate them



Why Errors Are Not Disclosed

- ❑ Don't like to
- ❑ Fear of consequences to self, others
- ❑ Fear of being sued
- ❑ Effort required to report errors (includes not knowing how)
- ❑ No systematic recording of errors
- ❑ Shame of personal failure
- ❑ Cultural Barriers (to follow)



Cultural barriers: shame of personal failure

- ❑ Current system of quality “Name, Blame and Shame”
- ❑ Incidents are viewed as personal failures not system failures
- ❑ No current mechanism for using
- ❑ individual data and aggregate data to
- ❑ change the system



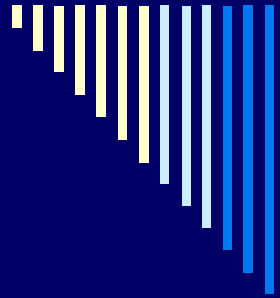
Cultural barriers: sense of urgency

- ❑ Everyone is pushed to be as efficient as possible.
- ❑ No time for safety
- ❑ Safety is many times not a priority
- ❑ Health personnel (nurses) shortages will make this an even bigger problem.



Cultural barriers: Top 10 Error prone activities

1. Time pressure
2. Distracted environment
3. High workload
4. First-time evolution
5. First working day after days off



Human Error Top 10 Traps (cont)

6. One half hour after wake up or meal
7. Vague or incorrect guidance
8. Overconfidence inducers
9. Imprecise communications
10. Work stress



Cultural barriers: Why Errors are Not reported?

- No easy reporting system
- Time-consuming
- Cumbersome
- Disruptive to workflow
- Not standardized
- Difficult to get the data in a usable format
- Difficult to analyze the data
- Difficult to decide priorities

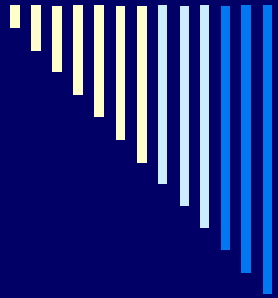


Barriers to Managing Risk in Health Care

- A blaming culture
- Lack of leadership
- Limited personnel engagement

NOT:

- Lack of data
- Lack of know-how



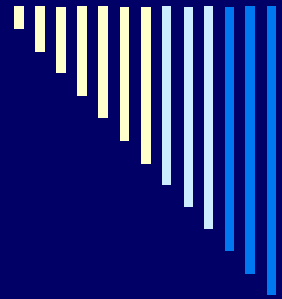
Building a Safety Culture

To err is Human

To cover up is unforgivable

To fail to learn is inexcusable

Sir Liam Donaldson



Seven Steps to Patient Safety

Step 1 - Build a safety culture

Step 2 - Lead & support your staff

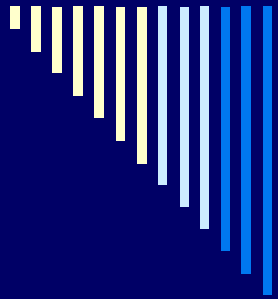
Step 3 - Integrate risk management activity

Step 4 - Promote reporting

Step 5 - Involve & communicate with patients & public

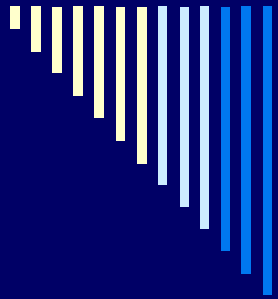
Step 6 - Learn & share safety lessons

Step 7 - Implement solutions to prevent harm



Create a Culture of Safety

- Drive out fear!
- Everyone makes mistakes every day
- Create a non-punitive environment



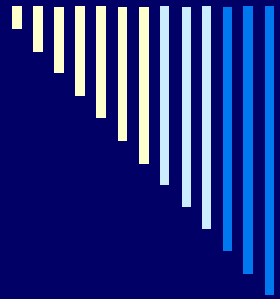
Safety Culture Involves Paradigm Shift

OLD

- Who did it?
- Focus on bad event
- Top down
- Punish bad behavior

NEW

- What happened?
- Focus on Near Miss
- Bottom up
- Fix broken processes



Understanding adverse incident causes

Person centred approach

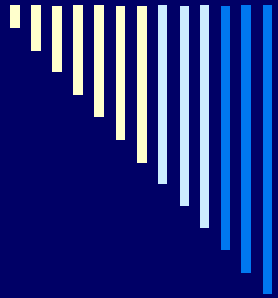
- ❑ Individuals who make errors are 'careless, at fault, reckless'
- ❑ Blame and punish

- ❑ Remove individual = improve safety

Systems approach

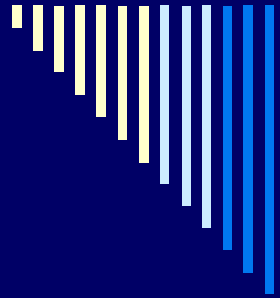
- ❑ Poor organisational design sets people up to fail
- ❑ Focus on the system rather than the individual

- ❑ Change the system = improve safety



The Systems Approach

- Name, blame and shame allows future similar events
- The only change will be people involved
- Adverse events can be reduced by building a system that:
 - does not promote error
 - prevents errors from causing harm



Culture of Safety: Characteristics

- Non-punitive error reporting
- Error-proofing new products, programs, and services
- Training and organizing in teams
- Direct communication
- Fatigue management



What do we mean when we say

“Non-Punitive”?

and

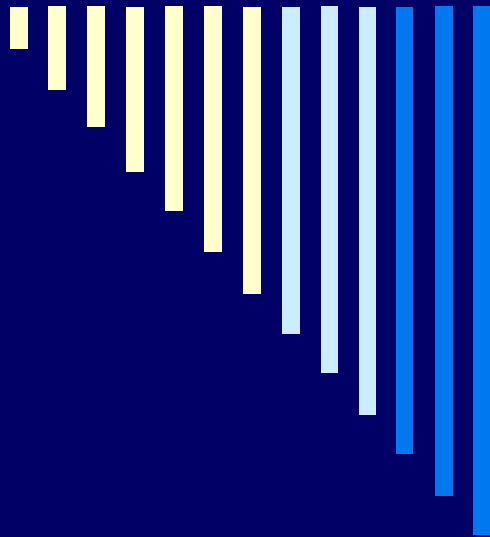
What don't we mean?



What don't we mean?

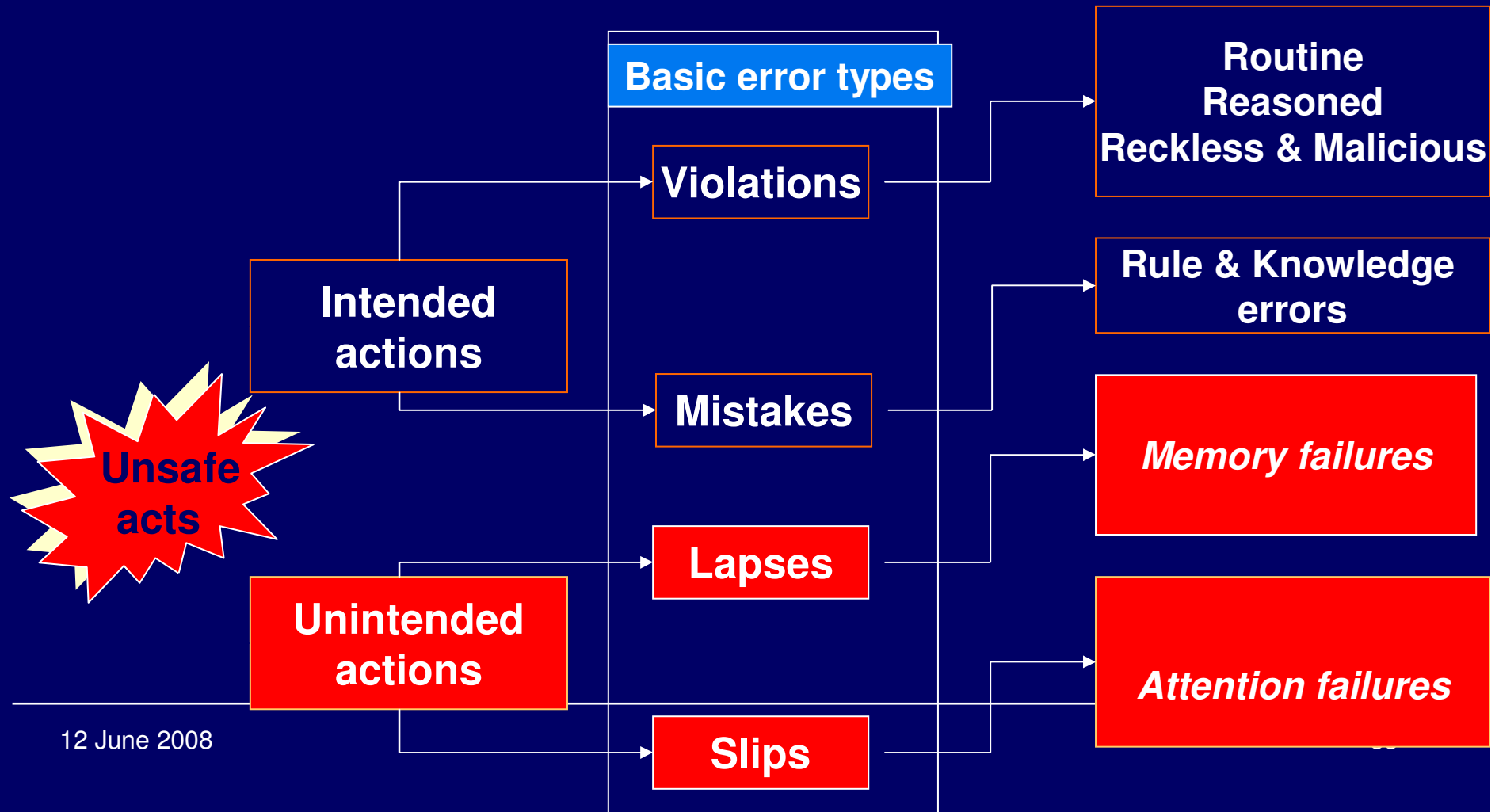
- Abandonment of professional accountability
- Anonymity
- Ignoring
 - gross incompetence
 - gross procedural violations
 - gross insubordination
 - illegal activity
 - practicing under the influence
- Lack of disciplinary action for the failure to report

What do we mean?



A system in which it's difficult to blame individuals for intangible system failures.

ERROR TYPES – based on the work of Reason





Violations

- Routine – how we do things around here!
- Reasoned – he wouldn't have survived if I had adhered to protocol
- Reckless – I took a chance but I didn't intend for that to happen
- Malicious – intending to cause harm

Mistakes

- Rule – I failed to ensure the consent form was signed
- Knowledge – I did not know insulin required a special syringe

Lapses of memory

- I forgot to check allergy status prior to administering medication

Slips in attention

- I did not notice that the tubing had become disconnected



Just Culture: 3 errors

□ **and the response to them**

1. Honest human errors in error-prone environment

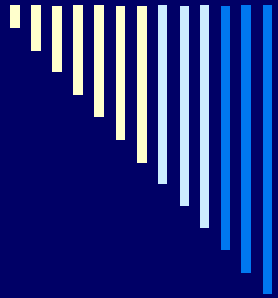
Response: Console error, fix system

1. Errors due to at-risk behavior E.g., short-cutting

Response: fix system; then coach, monitor

1. Errors due to recklessness (impairment, intentional)

Response: punish



What do you expect in a just culture

- self-report honest human errors and at-risk behaviors because they won't be punished.
- hide their reckless behavior, because the just culture is **not** blame free. They will be punished.



Responses to Errors

1. Name, blame and shame:
 - Face validity, feels good, tradition, avoids institutional responsibility
 - Tendency to focus on the sharp end, the last error
 - Leads to a culture of secrecy, ineffective solutions
2. Systems solutions:
 - All can learn from errors
 - Look for latent conditions, underlying factors, root causes
 - Change the system for sustainable results



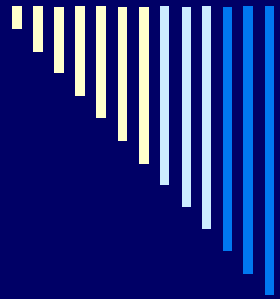
Principles of Error Management

- ❑ The best people can make the worst errors.
- ❑ Short-lived mental states, such as forgetfulness or inattention, are the last & least manageable part of an error sequence.
- ❑ People will always make errors & commit violations.
- ❑ Blaming people for their errors will have no effect on their future fallibility.



Principles of Error Management

- ❑ Errors are unintentional. Management cannot control what people did not intend to do in the first place.
- ❑ Errors arise from informational problems and are best tackled by improving the quality of information.



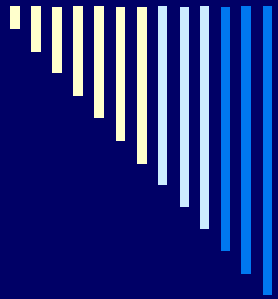
Principles of Error Management

Violations are social & motivational problems. They are best addressed by changing people's norms, beliefs, attitudes, & culture as well as improving the credibility, applicability, availability, and accuracy of the procedures.



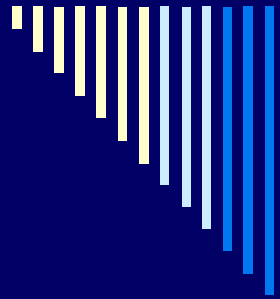
Characteristics of Successful Reporting Systems

- Non-punitive
- Confidential
- Independent
- Expert analysis
- Timely
- Systems-oriented
- Responsive



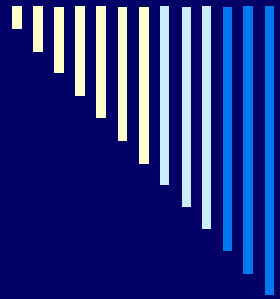
Stages of Problem Recognition

- “The data are wrong.”
- “The data are correct but it isn’t a problem.”
- “The data are right, it is a problem but it isn’t my problem.”
- “I accept the burden of improvement.”



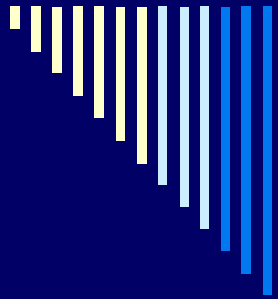
Advantage to Focus on near Misses

- No patient harm, therefore no blame
- No guilt
- Focus on prevention
- No fear of litigation



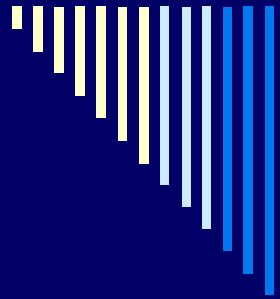
Steps to Follow After Event

- Care for immediate needs of patient
- Preserve evidence (Medical equipment)
- Document in the medical record
- Report (Risk Management)
- Disclose



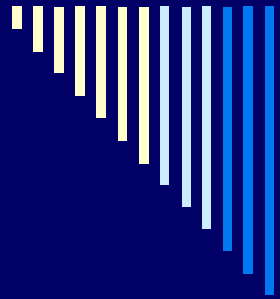
Documentation

- Document only the facts of what occurred and treatment rendered
- DO NOT
 - Blame
 - Subjective feelings, opinions
 - Speculation



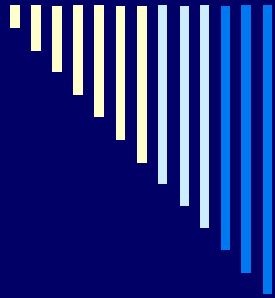
Incident Report

- Complete and submit
- Notify Risk/quality Management
- Begin Root Cause/Intensive analysis to examine process changes that may prevent future events



Health Care Worker Involved in Error

- **AVOID BLAME**
- Provide counseling, if needed
- **Remember:** No one goes to work intending to make a mistake
- staff feel tremendous guilt after event that harms patient



Remember

Most medical accidents are usually the result of complex systems failure.



Reporting system

- ❑ Make it simple and easy-to-use: (make it idiot proof)
- ❑ Non-punitive: Eliminate the name, blame and shame
- ❑ Standardized: Set up common categories



Common Patient Safety Reporting format

- The Discovery:
 - Who, How
 - The Event
 - What, where, when, who, why
 - Risk assessment (severity, Preventability, Recurrence)
- Narrative
- Ancillary information: Product and Patient information
- Analysis
- Lessons Learned



Error Reduction Strategies

- Avoid reliance on memory
- Simplify
- Standardize
- Use constraints/forcing functions
- Use protocols and checklists
- Improve information access
- Reduce handoffs
- Increase feedback
- Decrease look-alikes
- Automate carefully
- Take advantage of habits and patterns



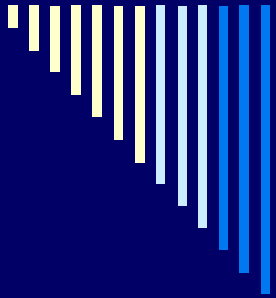
Conclusion

- Culture change is essential
- User-friendly
- Reporting system will help guide future development
- Clinical tools need to be enhanced and developed with error reduction in mind



Conclusion: Culture Changes

- Teamwork exercises
- Focus on systems
- Reward desired behavior
- Develop improved communication techniques



Thank You