

International Patient Safety Trends – an update



Dr Dorothy Jones

WAMSG
Symposium
26th June 2008



Key lessons

- Teamwork & communication
- Collaboration & Collaboratives
- Leadership & context
- Performance – report & redesign
- Redesign at “sharp end”
- Teamwork & communication

Dying for Change

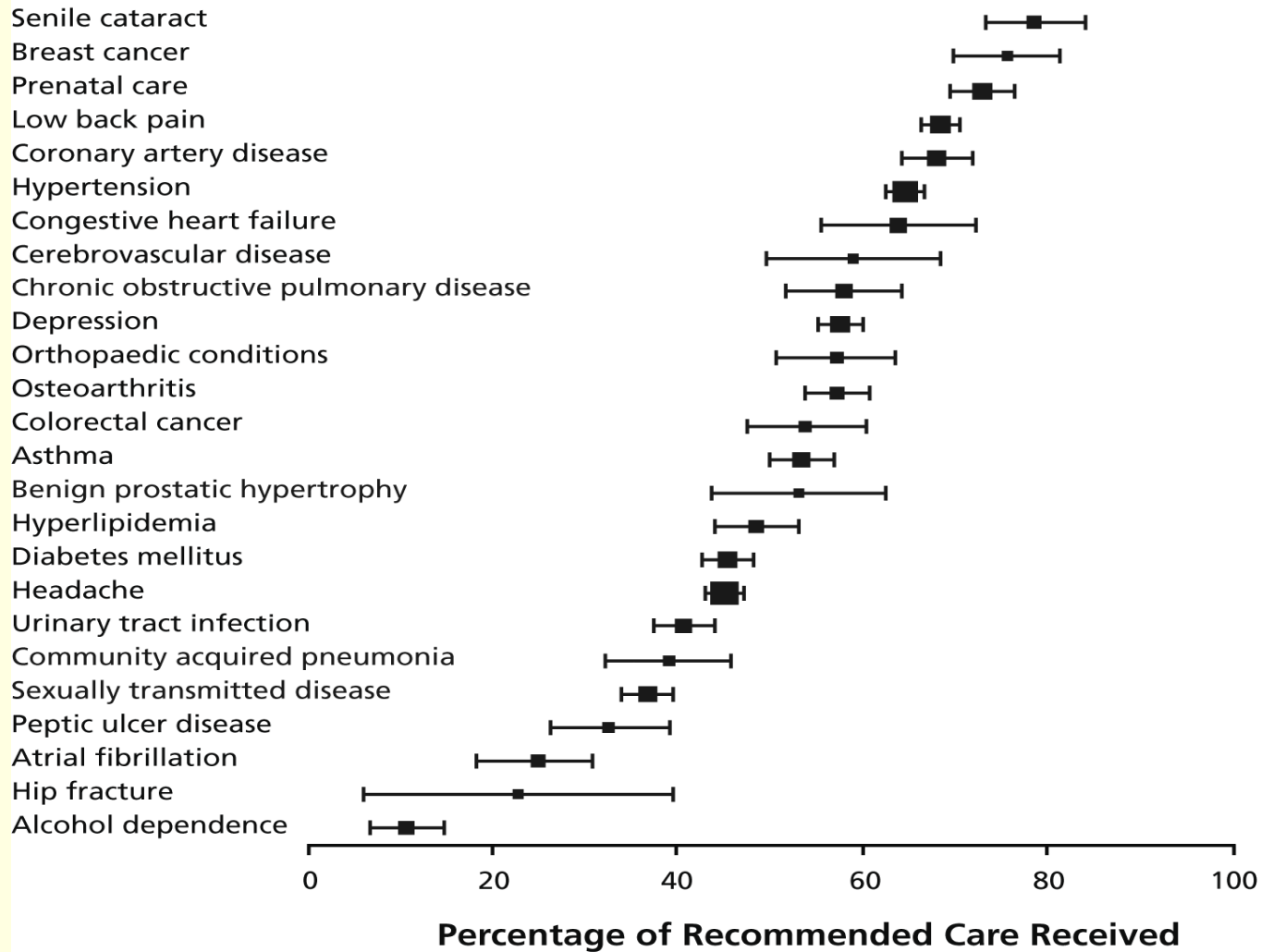
- ❑ “The status quo is *not* acceptable and cannot be tolerated any longer. Despite the cost pressures, liability constraints, resistance to change and other barriers, it is simply not acceptable for patients to be harmed by the health care system that is supposed to offer healing and comfort.”
- ❑ Harm includes
 - ❑ Getting care with errors of execution (slips/lapses & mistakes)
 - ❑ Not getting care based on evidence

The context

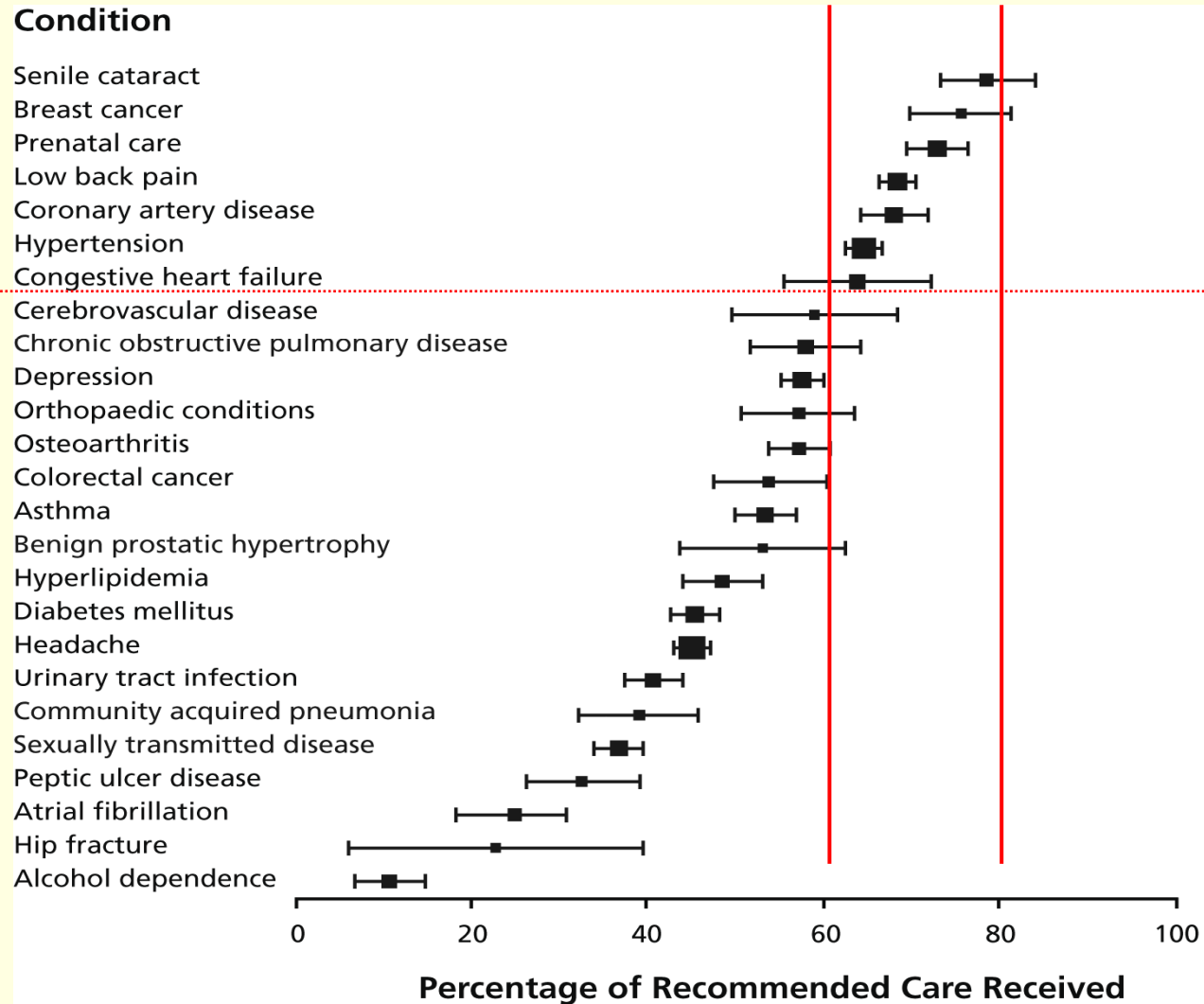
- Global public policy issue (WHO)
- Healthcare causes unintended injury & death
- Evidence that to improve need both
 - Data & improvement science
 - Change & leadership
- Serious challenges & need for change
 - Skilling & enabling health workforce
 - Achieving efficiency
 - Redesign of care (workforce)
 - Managing knowledge
- New types of leadership & partnerships (& workers) are required

One example...

Condition



Who gets care based on evidence?



So – there is a gap between the health care that *research & evidence* says we should have – and the care we actually get.

Why?

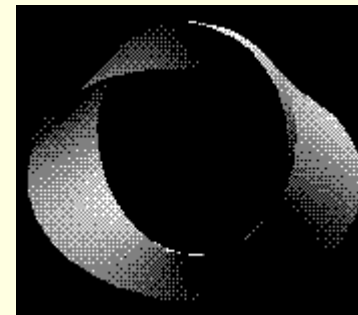
Assessing improvement interventions

- Gap between 'sciences' and 'experience'
 - Or, academia and the real world of delivering care
- Often, a process of social change
 - Sensitive to array of influences
 - LEADERSHIP
 - CHANGING ENVIRONMENTS
 - DETAILS OF IMPLEMENTATION
 - ORGANISATIONAL HISTORY
 - OTHER CONTEXTUAL INFLUENCES
- We need better tools to study complex, unstable, nonlinear, social change

Lunch with Paul & David

- NIH
- All politics is local
- Small organisations do better than large ones

- Evidence + Context => Improvement
- Its all about teams



Perhaps...

The
WHAT

The
HOW

EVIDENCE + CONTEXT => IMPROVEMENT

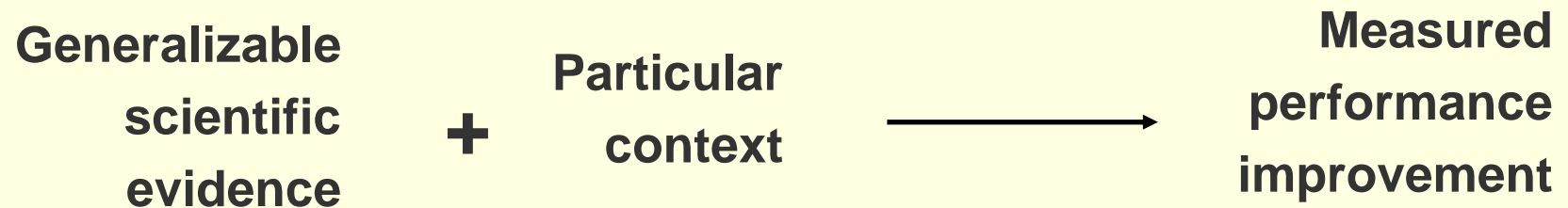
Mechanisms
Ideas Research
Opportunities
Logic, RCTs
Other methods

Social &
Cultural
Conditions
in which
groups work

Assessing improvement interventions

- Gap between 'sciences' and 'experience'
 - Or, academia and the real world of delivering care
- Often, a process of social change
 - Sensitive to array of influences
 - LEADERSHIP
 - CHANGING ENVIRONMENTS
 - DETAILS OF IMPLEMENTATION
 - ORGANISATIONAL HISTORY
 - OTHER CONTEXTUAL INFLUENCES
- We need better tools to study complex, unstable, nonlinear, social change

Quality Improvement



Batalden and Davidoff QSHC Feb 2007

Generalizable Scientific Evidence

- Improvement is search for results, **not** a knowledge search
- Patient safety research evaluates interventions in context (examination of complex problem)
- Traditional studies don't allow for measurement of impact of context (examination of simple problem)
- Requires more sophisticated analysis of evidence

The question about evidence has changed for Paul Batalden



- Not **“Does it work?”** but
- **“When, where and how does what benefit occur...to whom and under what circumstances?”**
- This is not a question an RCT can answer

Four things to accelerate improvement

1. Embrace wider range of methodologies
 - Include social change & context in evaluations
2. Reconsider thresholds for action on evidence (Why oh why only $P < 0.05$?)
 - Can you always weight the status quo – the null?
3. Rethink views on trust and bias
 - Bias might be context, local wisdom
 - Attacks can be seen as questioning sincerity, intelligence
4. Be careful about mood, affect & civility in evaluations
 - Academics & frontline caregivers best serve patients when they are mutually respectful, work together to accelerate the pace of improvement

Brunch with Lucian & Miles

- Leadership is the missing ingredient
- Doctors operate as individuals & don't understand team-work
- Not understanding team-work causes problems
- A small proportion of doctors cause a disproportionate number of problems
- It's all about teams
- Jim Reason is right (understand Human Factors)
- Reporting is necessary but don't let it divert you from team-work

Lucian & Miles 2

- Transparency (public) in measurement & performance is utterly essential
 - Partly for consumers (although the evidence suggests that they don't use it)
 - Mainly for hospitals (managers & clinical staff) in order to get their act together in patient safety & improve their performance

Lucian & Miles 3

- Weed out bullies & psychopaths at every level but especially at undergraduate level
- Legislation is a necessary driver for good health care systems
- Universal insurance is essential
- Must get away from ffs -> pay for care
- P4P - don't pay for bad care
- Protocols **work** (eg IHI bundles; SQuIRe)
- Leadership by CEO crucial

Lucian & Miles 4

- Behaviours in medicine is what counts
- If you change/modify behaviours then culture will follow
- Leadership is demanding certain behaviours
- For most staff, they will take the easiest route and comply with the expectation about safety behaviours

Lucian & Miles 5

- Everyone wants honesty & disclosure when things go wrong
 - Why?
 - So it doesn't happen again!
- Consumers are crucial
 - As irritants to the CEO
 - To unleash their personal experience
 - 2 hospitals can be next door to one another and totally different culture, reputations
 - This is due to Leadership!

Afternoon Tea with Maureen

- IHI now uses a political process and is conscious of creating a social movement to improve patient safety
- They are building their own radio station

Maureen – 5 things you must do

1. Get people together
 - Physically in a room
 - Talk essential but not necessary to over-schedule
2. Create coalitions
3. Name the problem
4. Use the media
5. Use voters/political process

After Maureen Bisognano as advised by Gloria Steinem, April 2008

Accelerating Improvement

- Which issues then become crucial to accelerating the pace of improvement?
 - LEADERSHIP
 - ABILITY TO MANAGE CHANGE

The Change Challenge

- Fundamental & Central role of Leadership behaviours in leading and managing change
- Risky business (especially in isolation)
- One view of change might be that
 - All change is *loss*
 - People do not resist change....
 - People resist *loss*
 - Therefore a leadership role might be to mourn & acknowledge the loss and grief (*then* envision the future)

Technical vs. Adaptive Change

- The single most common mistake leaders make is treating adaptive challenges like technical problems
- Leadership is capacity to deliver adaptive change
- Adaptive problems
 - Beliefs
 - Values
 - Hearts

From Linsky & Heifetz

Technical vs. Adaptive Change

	What is the work?	Who does the work?
Technical change	Apply current know-how (single factor)	Authorities (benign)
Adaptive change	Learn new ways (systemic)	The people with the problem (arouses conflict)

Adapted from Linsky & Heifitz

Resisting the right thing.....

- Adaptive change stimulates resistance because..
 - Loss
 - Disloyalty
 - Feeling incompetent
 - No wonder people resist!

So system change needs Adaptive Leadership, but...

- Challenges Habits, Beliefs, Values
 - Stimulates resistance
 - Asks people to take a loss
 - Creates uncertainty
 - Expresses disloyalty to people & culture
 - Challenges sense of competence

Adaptive Leadership is risky

- Changes the status quo
- Creates new meaning
 - Creates or renews purpose
 - Purpose must be compelling

How can leaders support change?

- WILL
 - the cultivation of will
- IDEAS
 - the supply of ideas for change
- EXECUTION
 - the day-to-day execution of change

Leadership will deliver ...

- Learning
- Improvement
- Accelerated rate of uptake of redesign (change)
- Better outcomes for patients



The improvement dream

- Teamwork & communication
- Collaboration & Collaboratives
- Leadership & context
- Performance – report & redesign
- Redesign at “sharp end”
- Teamwork & communication

Thank you



Visit

www.safetyandquality.health.wa.gov.au/