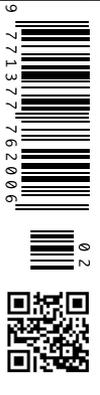




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Future of Patient Safety: What We've Learned from Pandemic

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The COVID-19 pandemic has resulted in an unprecedented level of public scrutiny of patient care, and developing highly reliable systems is no longer going to be optional for organisations in the future. Healthcare leaders are now challenged to implement new cultures focussed on sustaining safe, person-centred care for both patients and health workers.



Key Points

- Despite a focus on high reliability for the past 20 years, healthcare remains prone to error.
- Most organisations have not yet established high reliability systems because it requires a change in the culture that is embedded from the frontline to the boardroom.
- Leaders must complete an honest assessment of their organisational cultures before planning for improvement.
- The Patient Safety Movement Foundation provides free resources to assist organisations in becoming highly reliable.

The COVID-19 pandemic has stressed healthcare delivery beyond anything we have seen in modern times and has exposed the foundational gaps that most systems continue to have in safety and reliability. For years, the nuclear power and aviation industries have shown us that it *is* possible for high-risk organisations to operate error-free for very long periods of time. In healthcare, we have resisted embracing these concepts for several reasons, and patient care remains prone to error and fraught with risk.

If we have learned anything from this pandemic, it is that being highly reliable is no longer optional. This poses a great challenge for healthcare leaders, who are dealing not just with the realities of the financial, quality and safety implications of the pandemic, but also with severe staffing issues due to clinician burnout, illness, and in some cases, death. However, the public has begun

to *demand* better, safer care, and their voices will only become louder in the coming years. Our reality is that we now have no choice but to do the difficult work of truly adopting a culture of safety while also managing the resource issues that so many currently have.

Those leaders who are well versed in quality improvement concepts know that a problem cannot be effectively solved unless the root cause is first identified. This then begs the question: what is the root cause of *why* most hospitals have not yet established safer and more reliable systems? Understanding the answer to that can go a long way in helping organisations to improve, and the answer is this: *because it's really, really hard to do*.

Background

Our modern healthcare culture has always been paternalistic, and clinicians have historically seen themselves as the

experts who were here to heal people. Patients and families, intimidated by their lack of knowledge, readily accepted that the doctor was in charge and rarely questioned their expertise. Nurses were taught to do 'what was best for the patient,' even if this sometimes was not aligned with the patient or family's goals and desires. This clinician-centred culture is completely opposite to the patient-centred culture of safety that is inherent in highly reliable systems.

As clinicians, we were taught that independent, autonomous practice was our responsibility, and that making mistakes was definitely not acceptable. Most of us learned through fear and intimidation, and those who couldn't handle it often left their profession completely. Unmasking safety concerns was considered a slight against colleagues, and we were encouraged to limit incident reporting to minimise liability for the hospital.



Many consider errors in healthcare to be part of the cost of doing business and dispute the statistics that preventable error results in millions of deaths across the globe each year. Some don't think that zero harm is possible, and so have focussed more on improving medical outcomes with new drugs and treatments than improving *system* and *process* outcomes. The resulting complexity in the care environment makes it very difficult for the frontline to consistently and reliably follow the standards of care.

Consider how many documents you have in your organisation that guide clinical practice. How many policies, procedures, protocols, order sets, standard work, pathways, education modules and newsletters do you have that the frontline needs to know about and apply to their own practice? If you're like most, it's

hold their teams accountable, then you will be equally unsuccessful.

Consider the atmosphere of respect, honesty and trust in your organisation. Do your team members feel safe admitting that they made a mistake? Is the process of reporting errors and near misses an easy one? Do nurses and technicians feel comfortable respectfully challenging others with a higher level of perceived authority? If not, then such behaviour must be addressed first. Sometimes this means making difficult decisions about who remains on the team. Clinicians who are highly skilled experts but create toxic work environments cannot be tolerated.

Observe the complexity of the care environment. Is it easy for the frontline to access what they need to know about what is expected of them, or do they rely on 'group think' and do whatever their

are required to report, that they fail to see the bigger picture. Patients generally have more than one problem; they are not impacted by a single metric, and it is critical to understand the interconnectedness of all outcomes.

Conclusion

You cannot complete an assessment of your culture from your office or desk. Although this requires deep data analysis, it also involves going to the point of care to understand what is happening. Ask open-ended questions, provide a safe space for answers, and quietly observe without judgement. No one organisation has exactly the same issues as another, so your journey to becoming highly reliable needs to be based upon the root causes you uncover during your assessment and analysis. Only then can you begin to prior-

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a complicated web of information that requires its own level of expertise to efficiently manage and understand.

Patient safety, and health worker safety, will never improve until we change this reality by becoming more highly reliable. Creating a foundation for safe and reliable care includes three critical components: a person-centred culture of safety, a holistic continuous improvement framework, and a model for sustainment. Each of these components is relatively new in healthcare and requires a significant shift in behaviour at every level of the organisation to be effectively implemented.

Becoming Highly Reliable

So, where do organisations begin? Start with an honest assessment of your leadership team's commitment to becoming more highly reliable. If such a transition is not supported by the governing body and executive team, it will not be successful. If your frontline leaders do not have the ability to effectively manage change and

peers are doing? Are care processes standardised, or does each physician practice differently, therefore requiring nurses and other clinical staff to learn multiple different ways of managing care? Is everyone involved in a patient's care considered part of the team, or are some disciplines excluded from collaboration and communication? Effective teamwork and the development of more efficient care processes that simplify the expectations of staff is critical in creating a safe environment.

Finally, how do you measure improvement? Examine how you collect data, when and why. Are you able to trend different quality and safety measures to tell a story about the overall health of the organisation and care processes? Have you validated the integrity of the data, and are they accurate? Are you measuring just for the sake of measuring, or using those data to inform your improvement work? Many leaders are so focussed on specific metrics, especially those they

itise and plan your next steps. Although the work is difficult, it is not impossible. A united leadership team that supports their clinicians and respects the voice of the patient can do this much more easily and successfully.

With public scrutiny of the management of this pandemic at an all-time high, the World Health Organization is [calling](#) on global leaders to focus on health worker and patient safety on 17 September 2020 for World Patient Safety Day. Both are necessary to create highly reliable systems. The level of awareness about healthcare safety that this annual event will create over the next several years will force organisations to improve. Do it now; don't wait until you are obligated. The Patient Safety Movement Foundation provides free resources that can help. Visit us at patientsafetymovement.org to learn more.

Conflict of Interest

None. ■