Time to take our eyes off the targets

Dr Al Ross (C. Psychol)

@Dr_Al_Ross
Lean Clients

OLYMPIC MEDICAL CENTER
Mount Sinai
Eastern Maine Medical Center
Glencoe Regional Health Services
Adventist Health
INTEGRIS Baptist
COMMUNITY MEDICAL CENTER
St. Luke's
From day one.

The Mount Sinai Hospital
Upper Allegheny Health System
St. John's Foundation
Vancouver CoastalHealth
Norman Regional Health System
IASIS Healthcare
Stephenville Medical & Surgical Clinic

Johnson & Johnson
Flagstaff Medical Center
Promoting wellness. Ensuring care.
IPCA
Intermountain Healthcare
St. Vincent Healthcare
frasierhealth

Baton Rouge General
St. James Healthcare
KALISPELL REGIONAL MEDICAL CENTER
NORTHWEST REGIONAL PRIMARY CARE ASSOCIATION
Centennial Medical Center

Raven's Nest Foundation
Eagle Ridge Hospital Foundation
Pella Regional Health Center
Centennial Medical Center
Providence St. Patrick Hospital

Saint Joseph Hospital
Penn State Hershey
Tri-State Healt Network
CARONDELET HEALTH NETWORK
Lake Health

Skagit Valley Hospital Foundation
Milton S. Hershey Medical Center
Saskatoon Health Region
University of Saskatchewan Health

Herman Miller
Seattle Children's Hospital - Research - Foundation
Paris Regional Medical Center
BryanLGH
St. Anthony Hospital

University of Glasgow Dental School
Patient Safety in Practice

HOW TO MANAGE RISKS TO PATIENT SAFETY AND QUALITY IN EUROPEAN HEALTHCARE

11 June 2013 - The Hague, The Netherlands
A NVZ/NFU Conference in collaboration with HOPE

The Resilient Health Care Net
RHCN Summer Meeting, 26th–28th August 2013
Hindsgavl Castle, Middelfart, Denmark

The Resilience of Everyday Clinical Work

Patient Safety Workshop

Reducing MEDICAL ERRORS
Opportunities & Challenges

On 24th April 2011 | Time: 9 AM – 5 PM

University of Glasgow Dental School

Second Tawam’s Patient Safety Conference
June 15–16, 2011
Dariffat Al Ain Resort

2014 MAPS Patient Safety Conference
October 23rd & 24th, 2014 at the Marriott Northwest

PATIENT SAFETY FORUM 2013
9 – 11 April

6th Annual SAFE Healthcare Conference 2013
Monday, May 13 & Tuesday, May 14
Canad Inns Destination Centre Club Regent Casino Hotel, Winnipeg, MB

International Forum on QUALITY & SAFETY in HEALTHCARE
Paris 2014
Pedia-Poser: fast, gentle and secure positioning for pediatric X-ray. Chair rotates for multiple imaging options, high-quality lockable casters provide mobility and stability.

Multi-Step platform: place patients in the optimal position for easy capture of the highest quality weight-bearing x-ray images. 1, 2, & 3 step options.

C-Arm/U-Arm platform: the 2-Step Platform for C-arm Radiography permits patients to be positioned over a variety of C-arm digital radiography systems, including those made by Swissray, IMIX, IDC, + others.

Panel protectors: Use your CR & DR panels for weight-bearing imaging. Maximize patient safety while avoiding expensive equipment damage.
It's the lawyers who benefit from NHS compensation fund

YOU don't have to read too much about the Mid Staffordshire hospitals scandal to appreciate that there are some very genuine victims of malpractice who quite properly deserve to be compensated for the appalling treatment which they received.

By: Ross Clark
Published: Tue, September 24, 2013

More Express Comment

Greenpeace’s true aim is to destroy industrialised life

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Patient Safety is not disinterested
Inpatient diabetes care: complexity, resilience and quality of care

A. J. Ross, J. E. Anderson, N. Kodate, K. Thompson, A. Cox, R. Malik

Simulation training for impro for older people: an independent innovative programme for in

Simulation training for geriatric medicine

Zehra Mehdi1, Angela Roots1, Thomas Ernst1, Jonathan Birns1, Alastair Ross2, Gabriel Reedy2 and Peter Jaye2

The attitudes and awareness of emergency department (ED) physicians towards the management of common dentofacial emergencies

Chetan Trivedy1,2, Naonori Kodate1, Alastair Ross1, Harrith Al-Rawi2,3, Thilagarajan Jaiganesh2,4, Tim Harris3,6 and Janet E Anderson1

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Dental Traumatology
Volume 28, Issue 2, pages 121–126. April 2012
• In ancient times scholars worked for their own improvement; nowadays they seek only to win the approval of others

Lepper (1973) *JPSP* 28(1)129-137
Patient Safety is evidence-biased
Evidence - biased

• This is about innovation
  – Replication is not a priority

• Cross section abounds
  – Longitudinal studies are rare

• It’s all a bit linear
Be Assertive for Patient Safety

1. Get Person’s Attention
2. Express Concern
3. State Problem
4. Propose Action
5. Reach Decision

Practice Respectful and Direct Communication to Improve Safety

Speak Up for Patient Safety

See it  Say it  Fix it

Empower Your Voice: Speak up, Be Heard, Get Action.

Teaching people how to speak up and creating a dynamic environment where they will express their concerns is a key factor in establishing a culture of patient safety. Frequently the lack of a common mental model or perceived hierarchy gets in the way of people saying what they should. Team members need to state a problem or potential hazard politely and persuasively with the goal of correction. This common practice of speaking directly (the “see-say-fix” cycle) is thought with risk. It is important to focus on the problem at hand and avoid the issue of who is right and who is wrong.
Our Culture Is Patient Safety

Building a Culture of Patient Safety

Patient Safety Culture Questionnaire
**Don’t Forget**

*Right Patient – Right Care*

- From Saturday 1st March 2008, patients **MUST** wear an ID band or be identified using another approved method.
- No band – no test/treatment/transfer.

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**Match the Patient to their Test**

- This means:
  - Patient is identified
  - Sample taken and labeled
  - All details checked and signed as correct

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**Patient misidentification can be fatal**

YOU will need to Rescind Pathology Specimen if the Patient Declaration is not completed in full following your collection.

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**Medication safety**

**Remember…**

- Right time
- Right drug
- Right patient

No distractions during medicine rounds

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**University of Glasgow**

**Dental School**
Start every meeting with a safety moment.

- Tell a safety story related to risks at work, home or in the community.
- Ask yourself: How can I prevent accidents?
- Review company safety rules.

Our safety goal is zero accidents.
It’s In Your Hands...

BALANCING creativity + evidence FOR PATIENT SAFETY
You are an important part of patient safety!
WORLD ALLIANCE FOR PATIENT SAFETY

ALLIANCE MONDIALE POUR LA SÉCURITÉ DES PATIENTS

9 SOLUTIONS:

1. LOOK-ALIKE, SOUND-ALIKE MEDICATION NAMES (LSAM)
   - Ensure that medications are visually and acoustically distinct from others to reduce errors of selection.

2. PATIENT IDENTIFICATION
   - Identification of the patient.

3. COMMUNICATION DURING PATIENT HAND-OFFS
   - Effective communication between healthcare providers to ensure continuity of care.

4. PERFORMANCE OF CORRECT PROCEDURES AT CORRECT BODY SITE
   - Pracitce correct procedures at the correct body site to prevent errors.

5. CONTROL OF CONCENTRATED ELECTROLYTE SOLUTIONS
   - Control of concentrated electrolyte solutions to prevent errors.

6. ASSURING MEDICATION ACCURACY AT TRANSITIONS IN CARE
   - Ensuring accuracy of medication at the transition of care.

7. AVOIDING CATHETER AND TUBING MIS-CONNECTIONS
   - Preventing mis-connections of catheters, tubes, and lines to avoid errors.

8. SINGLE USE OF INJECTION DEVICES
   - Use of single-use injection devices to prevent contamination and errors.

9. IMPROVED HAND HYGIENE TO PREVENT HEALTH CARE-ASSOCIATED INFECTIONS
   - Enhance hand hygiene protocols to prevent healthcare-associated infections.
Note to self

I’m supposed to be talking about targets
 Targets are often invalid
4

Targets obscure what is important
The safety cliff

• Let us imagine a group of people on a cliff-top path, with a large drop to the ocean below

  – Our job is to move people along the path continuously
  – But at the same time we want to stop people falling off the cliff
Monitoring as part of resilient process

- Here, we are up on the cliff top
  - We are shepherds
  - We are monitoring the process of cliff-top walking
  - The purpose of monitoring is to prevent people falling off where we possibly can
Monitoring as outcome control

• Here, we sit on the beach below
  – Every time someone falls, we log this.
  – *Thunk!!*
  – We are monitoring negative outcomes
  – The purpose of monitoring is to react to falls and fix their causes so they don’t happen again
**Outcome monitoring:** counting falls; retroactive investigation; intermittent negative feedback after failure.

**Process monitoring:** close observation of performance including any drift towards the edge; prevention of falls where possible; constant feedback on behaviour.
2014 Milestone Targets & Events - Olympic & Paralympic Sports

OLYMPIC SPORTS
OVERALL MEDAL RANGE 2014
90-120
MIN | MAX

PARALYMPIC SPORTS
OVERALL MEDAL RANGE 2014
106-152
MIN | MAX

#RoadtoRio

LOTTERY FUNDED
5
Reactive safety leads to a misperception
• 80% of adverse events are caused by Human Error
• The chances of error causing harm are not the same as the chances of error given harm has been identified.
p \ [x/y] \neq p \ [y/x]
• The evidence shows that a significant proportion of errors (probably the majority) do not result in harm for the patient, either because they are detected and mitigated or they are trivial.
Safety is more than 1-failure
‘Safety I’

- Traditional Safety tries to eliminating what can go wrong
- It tries to get away from something by fixating on it

- When you try to get away from something, almost any direction will do
‘Safety II’

• Safety II tries to ensure that as much as possible goes right

• Safety-II tries to approach something, namely a safe state

• To approach something, you need to look where you are going
Be brave!

• If processes are good, then outcomes will follow suit and targets will be met

• If they don’t and they aren’t, then they are the wrong outcomes and targets
  – They are uncoupled from process

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