

## Delivering Quality Care and Patient Safety – A New Paradigm

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### Abstract

Quality in healthcare is imperative and not optional. To deliver continuous process improvement, the focus must be on the patient from start to finish, as often the patient's experience of receiving care is the product of the process as in doctor consultation setting. Value healthcare can be formulated as an equation: quality divided by cost. Sometimes to do less is to achieve more, as beyond the point of optimal healthcare, adverse effects will outweigh perceived benefits. Patient safety is proportional to process quality; hence the overarching importance of focusing on quality. However, costs must always be harnessed to ensure we achieve optimality of healthcare delivery.

**Keywords** Change management, errors, events reporting, frontline staff, harm events, healthcare delivery, information flow, leadership, near misses, patient safety, quality care, risk management, process improvement, system data.

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**List of abbreviation:** PSO = Patient safety organizations

Hippocrates got it right more than two thousand years ago when he said: first do no harm (see Bibliography below). He has, and quite rightly so, put patient safety at the heart of all priorities for physicians. However, fast forward to today, we can easily see that healthcare has developed huge inefficiencies which in turn compromised patient safety.

Healthcare planners have recognized that the delivery of quality care is a function of organization design and not down to individual effort. No longer weaving the whole system of healthcare around surgeons and physicians; rather we are truly moving towards patient (or person) centric model. Health is no longer defined as the absence of illness; healthcare today focuses as much on wellbeing as it did on illnesses and disorders.

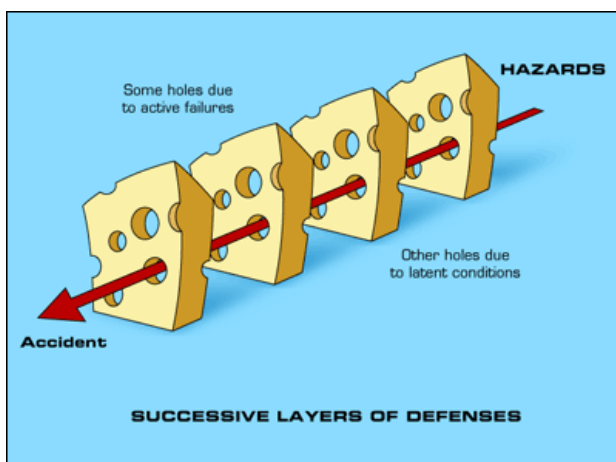
In 2006, I wrote in the BMJ about simple change, big gain: a call to focus on low-hanging fruit to implement changes that would really bring about improvement. All healthcare processes start and end with the patient; and patient's experience is as important as the outcome of the process. Hence using techniques like value stream mapping provides the ability to implement system-thinking to identify bottlenecks (both capacity constraints and time-traps as examples of drivers of process efficiency), rather than shifting issues from one department to another.

### The Five Bad Habits of Healthcare: More vs Better

Drawing on the work of the 2010-2011 World Economic Forum Healthcare Industry Global Agenda Council, the team identified five important and pervasive "bad habits", which contribute to this spending problem:

1. Favoring current practice over the best available evidence.
2. Following what others are doing even when it is wrong.
3. Behaving as if more healthcare is identical to better healthcare.
4. Focusing on illness at the expense of prevention.
5. Failing to present information or choices effectively.

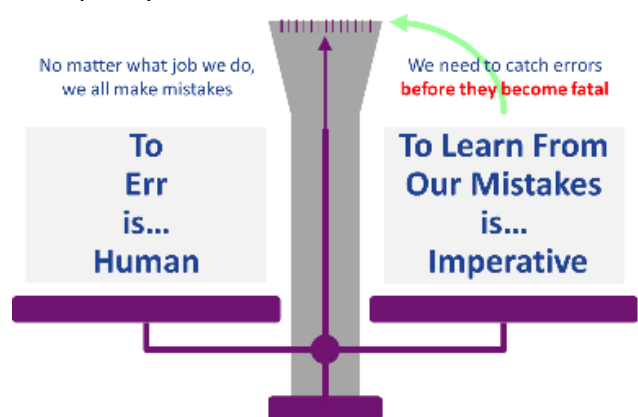
It is easy to miss a step or omit a check as an oversight, an issue that can be addressed by something as simple as a “checklist manifesto.” Having said that, you will rarely find checklists indoctrinated into healthcare delivery even in teaching hospitals because they are trapped in the “five bad habits.” Even when you have in place more than one layer of checks, there is still the typical example of what’s known as Swiss cheese model. Every step in a process has the potential for failure, to varying degrees. The ideal system is analogous to a stack of slices of Swiss cheese. Consider the holes to be opportunities for a process to fail, and each of the slices as “defensive layers” in the process. An error may allow a problem to pass through a hole in one layer, but in the next layer the holes are in different places, and the problem should be caught. Each layer is a defense mechanism against potential error impacting the outcome.



### Patients don't care how much you know until they know how much you care

While patients are sometimes forgiving and always understanding, efforts to improve quality of care and patient safety still have a long way to go. “I know you didn’t mean to hurt me” said Elizabeth, an eight-years old, paralyzed from the waist down after a recurrence of cancer was missed (excerpted from R. Gibson, “Wall of Science”). Betsy Lehman, Boston Globe health reporter, died from an overdose during chemotherapy. Willie King had the wrong leg amputated. Ben Kolb was eight years old when he died during “minor” surgery due to a drug mix-up. Globally, improving health care safety is still plagued by fear, gripped by reluctance, crippled by punishment. According to OpenSafety.org, only 44% of hospital workers are sure that they will not face punishment for mistakes.

The root cause for the many healthcare delivery errors cited above is the fear of admitting and owning up to incidents. Punishment is a huge hindrance and must be overcome if progress is to be made in patient safety and quality care. We need to always remind ourselves that non-harm events herald harm ones. If we can encourage staff to be candid and report back all events as and when they occur, we will significantly improve safety and quality.



Admitting mistakes and taking ownership can be achieved through self-leadership and staff empowerment: to take the initiative to fix and prevent errors, and educate others not to fall

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in the same trap. Self-leadership is just the starting point: by acting as a role model for others and through institutionalizing this behavior, the change in culture will be the foundation for future improvements in patient safety.

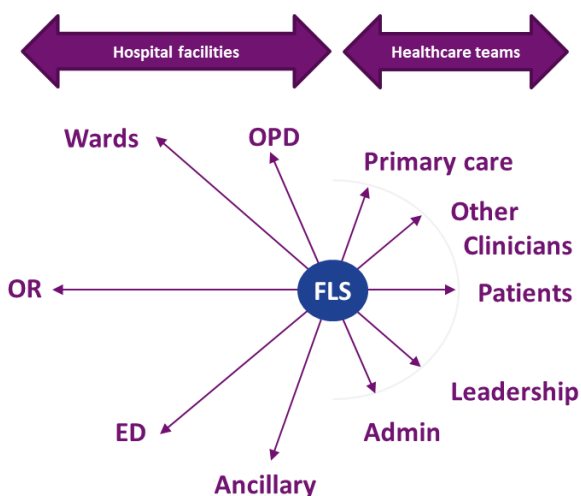
### Patient Safety in Numbers

\$4.5 billion Adverse drug events and patient falls cost US hospitals annually. 780,000 surgical site infections occur in the US each year, up to 60 percent of them preventable.

250,000 Ventilator-associated pneumonia (VAP) accounts for up to 18% of all hospital-acquired infections, causing 1.75 million excess hospital days (US).

### Frontline Staff – A Pivotal Role in Patient Safety

Frontline staff (FLS), those in direct contact with patients, are the focal point of healthcare delivery channels and information flow. They are the single-most important area to work with when it comes to improving patient safety. Among other clinicians, front-line healthcare givers are the ones who spend the most time interacting and care for patient. This group includes all non-manager workforce who are out there day in day out working with patients at the bedside, on the ward, in labs, pharmacies and ancillary services.

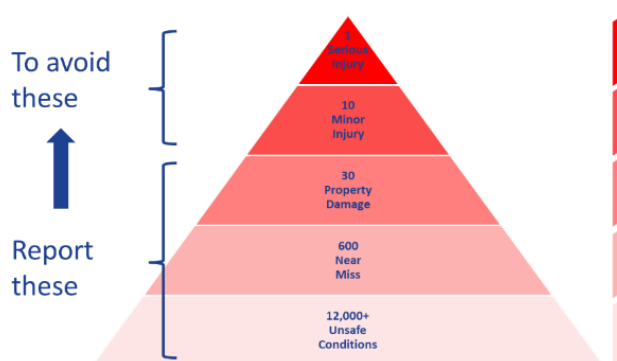


### The Events Pyramid

By reporting near misses and unsafe conditions we can take corrective action and avoid serious injuries. For every serious injury event, more than 12,000 unsafe conditions occur.

The aim is to move from considering error reporting a task to making it recognized as a duty. That's the cultural change we are trying to achieve.

Owning up to mistakes takes a bottom-up approach (vs top-down). It embodies self-leadership – especially taking the initiative and demonstrates leading by example – role model for others. It educates staff by bridging the gap between knowledge and know-how and empowers them to voice concerns. It's not "Project of the Month" ... this is change for good... "Change is the new culture"



### Delivering Quality Care – It's a State of Mind

Changing mindsets is not as hard as it sounds. It can be achieved by combining the four elements together: purpose, feedback, skills and role-models. Start by developing a story describing the end-game and assign "deliverables" to various teams to write their own part of the story. Review the "story" regularly to ensure it remains meaningful to all involved. Ensure information flow to be both downstream as well as upstream. Ensure buy-in by making the story tell how life will be better for all.

Transpersonal psychology suggests that the innate desire to develop and grow infuses human beings with energy. The overarching aim is to achieve higher performance: employees will not put sustained effort into a

new kind of behavior if they have only a rational understanding of why it matters to the organization; it must mean something much deeper to them, something that they know will influence their personal growth; giving change a personal meaning for participants. Saving lives and preventing errors is a powerful purpose that provides deep meaning to frontline staff.

Once success is realized and results are at hand, provide transformational workshops for a small group over a brief period, the graduates

of such workshops will create a critical mass who willingly embrace the new behavior and culture to make it sustainable by taking it on a roadshow throughout your organization.

### **Safety and Management – The Paradox**

It sometimes appears that the aim of improving safety goes against management theory concepts. Our priority is safety: first and foremost. However, there are at least two aspects as viewed through patient safety lens when compared to management:

<b>SAFETY CULTURE</b>	<b>MANAGEMENT THEORY</b>
Make it hard for operators to err	Simplify process
Make "alerting and event management" systems sophisticated to capture as much information as possible when errors occur	Streamline systems
Prepare for the unanticipated	Implement standard operating procedures (the anticipated)
Stop on errors to investigate and do root cause analysis	Do not first, fix it later
Achieve higher quality first and foremost	Meet targets
Document errors with as much details as possible – capture lessons learned and share knowledge	Document best practices and build organization-wide "gold standard" knowledge base
One event is enough to invoke analysis and learn lessons to prevent future ones	Require large sample to run statistical analysis and define average and then make decisions

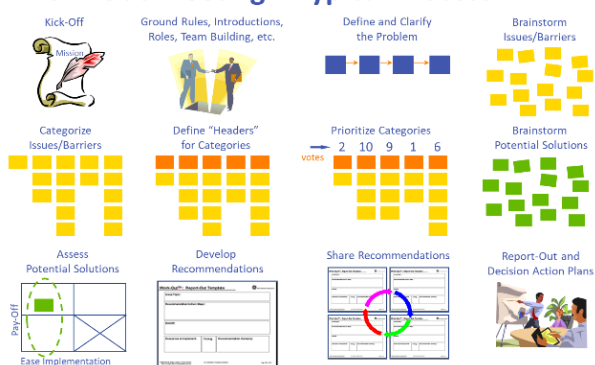
### **Change Won't Happen by Itself**

Changes that have been identified as improvements require strong leadership and won't happen by themselves. We need to introduce methods, tools and even sometimes new technology to embed change. To identify the way forward and try new ideas with a cross-functional multi-disciplinary team, we will need to expedite change implementation (avoid going into analysis paralysis). We can start with a pilot hospital and create a blueprint to take it forward to other areas/teams/departments. To ensure governance, we may need to deploy a system to capture and report out on medical events.

One method is known as kaizen (Japanese for change for better), sometimes referred to as action work-out: a process of concentrated

team-based decision-making and empowerment used to resolve issues and improve processes. A team of experienced, knowledgeable people with a stake in an issue is chartered to develop solutions and action plans. The team is empowered by their sponsor to proceed with implementation and is accountable for implementing their action plans. The sponsor removes barriers and provides support and follow-up. Kaizen provide a process to drive improvement; an opportunity to empower people; and are results-based to inform decisions, ensure accountability with timely follow-ups.

**Work-Out Meeting – Typical Process**



**How Not to be Trapped in the Blame Game?**

No-Blame System enables a culture of candor. The system is based on “High Reliability Organizations” HRO’s (like aviation industry) which encourages the reporting of errors and near misses, exploiting these incidents to improve their operative processes. No-Blame System consists of three main components:

1. Reporting: to create a “Book of Learning” which is usually referred to as “Book of Errors”: we want here to emphasize not only logging events but the fact that learning and not blaming is the aim
2. Debriefing: once events are documented (Book of Learning), teams can review and group events
3. Narrative: this is all about “story-telling” to help others avoid running through the same conditions that caused the errors logged and analyzed (steps 1 and 2).

**Healthcare is Too Complex**

“Our systems are too complex to expect merely extraordinary people to perform perfectly 100 percent of the time. We as leaders have a responsibility to put in place systems to support safe practice.”- James Conway, IHI Senior Fellow; former Executive Vice President and Chief Operating Officer, Dana-Farber Cancer Institute. To address the inherent complexity in healthcare delivery, patient safety organizations (PSO) provide its members a single common medical event reporting platform with a comprehensive set of data analytics and an advisory support to identify the root causes of risk. PSO’s help hospitals

make lasting safety improvements. In the US, PSO’s are certified by the US Secretary of Health and Human Services (HHS) as part of the Agency for Healthcare Research and Quality (AHRQ). PSO’s serve as independent, external entities that collect, analyze and aggregate information on patient safety events. They give confidential advice to health care providers seeking to understand and minimize the risks in delivering patient care. Importantly, PSO’s are evaluated by the quality of the data collected and the insights provided.

PSO’s distinguish themselves itself by the way they capture data and analyze it, by their ability to pinpoint the risks of patient harm. PSO help develop new knowledge by first providing every member with a common event reporting system that captures data in the richest possible manner. Then, database is organized so that we run analytics tools and by using the expertise of PSO members to find those critical insights. The risks of harm are systemic, myriad, and complex.

**Patient Safety is at the Heart of Quality Care**

Delivering improved healthcare is all about providing quality care with widest access from a reasonable cost base. This can be realized by deploying event or incident management where data is captured through an event reporting system that is used by all the PSO members. The system enables members to not only capture more event reports and near misses, but to also capture more data in each report. The result is a powerful dataset that is aggregated and protected in the PSO.

The power of analytics: to make use of the information captured, we need to create the infrastructure necessary to anonymize and analyze the data. Analytical tools in data integration will enable the PSO to identify and share insights within the membership.



Benefit Realization: PSO's will provide insights to hospital administrators, providers, and policymakers to assist them in identifying and isolating factors that contribute to medical errors. In particular, the PSO will focus on the complex root causes of risk. For example, what environmental factors should be monitored to reduce risk for a certain type of procedure? How have some members been successful at reducing rates of ventilator associated pneumonia? Why have others been less successful?

### The Shape of Success

So, what is it we are trying to accomplish? The aim is to deliver empowered, up-skilled and toolkit-equipped front-line staff ready to voice their concerns; to setup or join a PSO with the benefit of having access to world-class knowledge-base and research on patient safety; to have an in-house core team who can spread the word, disseminate acquired

knowledge, skills and realized benefits to other teams; establish data collection mechanism to show (prove) improvement in patient safety: "Book of Learning" to capture all events related to patient safety (number of harm events reported, number of non-harm events reported and number of near misses reported). Eventually we will have an open culture and conducive environment to make best use of the above and will be a model for others to follow.

### Bibliography and Suggested Readings and References

- Jimmerson C. A3 Problem solving for healthcare. 1<sup>st</sup> ed. Productivity Press; 2007.
- Kobus RL, Skaggs RL, Bobrow M, et al. Building type basics for healthcare facilities. 2<sup>nd</sup> ed. John Wiley & Sons; 2008.
- Millenson ML. Demanding medical excellence. 1<sup>st</sup> ed. University of Chicago Press; 1996.
- Birjandi A, Bragg L. Discharge planning handbook. 1<sup>st</sup> ed. CRC Press; 2009.
- Groopman J. How doctors think. Reprint ed. Mariner Books; 2008.
- Chalice R. Improving healthcare using Toyota lean production methods. 1<sup>st</sup> ed. ASQ Quality Press; 2007.
- Grayban M. Lean Hospitals. 3<sup>rd</sup> ed. CRC Press; 2016.
- Berry L, Seltaman KD. Management lessons from the mayo clinic. 1<sup>st</sup> ed. McGraw Hill; 2008.
- Bauter JC, Hagland M. Paradox and Imperatives in Health Care. 2<sup>nd</sup> ed. Productivity Press; 2014.
- Chalice R. stop rising healthcare cost using Toyota lean production methods. 1<sup>st</sup> ed. Productivity Press; 2005.
- Kenney C. The Best practice, how the new quality movement is transforming medicine. Reprint ed. Public Affairs; 2010.
- Hadfield D, Holmes S. The Lean healthcare pocket guide. Tools for the elimination of waste in hospitals, clinics and other healthcare facilities. 5<sup>th</sup> ed. MCS Media; 2014.

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