

halifax Health Services

**Advancing Healthcare Safety:
Where do we go from here?**

How to advance the culture of safety

Getting engagement from the top

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The Questions

Is the C-suite involved?

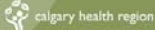
Does the C-Suite need to be involved?

How do you involve the C-suite?

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C-Suite

Are they involved?

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H6 Attendance Stats

- Total registered delegates - 553
- No. of Healthcare Delivery Organizations - 71
- No. of delegates from HCD Organizations – 324 (59%)
- No. of C-Suite delegates – 25 (8%)
- No. of HCD Orgs with C-Suite delegates – 10 (15%)
- No. of Board delegates – 15 (8%)
- No. of HCD Orgs with Board delegates – 6 (8%)

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C-Suite

Do they need to be involved?

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Leadership Involvement

- **Sir Liam**
 - Stoke Mandeville (C Diff infection) vs Air Industry (Airport)
- **Dianne Parker**
 - Senior management commitment → SMS
- **Dorothy Jones**
 - Strategic plan required for adopting a SMS

Organizational Narcissism



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Leadership Involvement

- **Leadership**
 - Culture
 - Transparency → Disclosure / Informing
 - Approach to providers involved in adverse events
 - Where is Safety on the agenda?
 - Dictates whether safety management is adopted
 - Resource allocation

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C-Suite

If they aren't involved – why not?
(How do you get them involved?)

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Inattentional Blindness

Even if we are looking at something we don't necessarily see it

There is no conscious perception without attention

Our affective reactions are often our very first reactions

- Occurring automatically
- Subsequently guiding information processing, judgement and decision making

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Getting people's attention

Approach 1 - Shocking statistics

Risk of dying

- Airlines 1/3,000,000 → 1/10,000,000
- Hospitalization 1/300 → 1/300

Some Math

- Calgary Health Region – 110,00 discharges/yr (less L&D – 30,000)
- 80,000 discharges / year = **267** deaths / year

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Serious Outcome = Serious Adverse Event? Due Primarily to System Failure?

Approach 1 - Shocking statistics

1. Was the patient harmed?
 - Did an injury result primarily as a result of the care received?
2. Were there active failures in the system of care?
 - System
 - Individual

Recognized
Complication
No System
Failure

Clear System
Failure

3. How direct is the relationship between *outcome & the active failures*?

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Aviation & Healthcare Analogies

Helpful or distracting?

Incremental Risk

- Airlines


- Hospital



Comparing  and 

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Getting people's attention
Approach 2 – Affective reactions

Our affective reactions are often our very first reactions


Telling stories

- Open the mind by opening the heart
- Patient / Family involvement

Its not a number at the end of the harm

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Getting people's attention
Approach 3 – Gap (Chasm) Analysis

Practice-based evidence		Research-based evidence
You manage what you measure		What you are trying to accomplish
<ul style="list-style-type: none"> • Outcomes • Processes • Cost 		

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Gap (Chasm) Analysis

- **Research** → **Best practice**
 - Effectiveness (outcomes)
 - Cost
 - Safety
 - Staff retention

Business Case

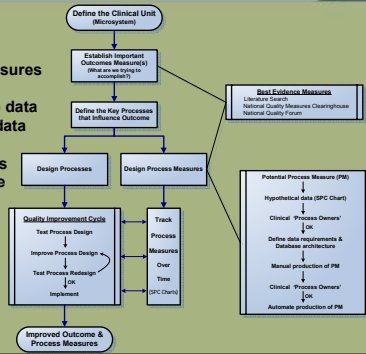
‘What’s good for patients is good for business’

‘What’s good for providers is good for business’

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Measurement of Key Clinical Processes

- Identify Key Units
- Define Outcome Measures
- Identify KPMs
- How you will capture data
- How you will report data
- AUTOMATE
- INVEST in IT Systems
- INVEST in knowledge



Culture Carriers

Leadership involvement

- Policies for safety
- Leadership Walkrounds
- Set priorities for improvement → demand & review data

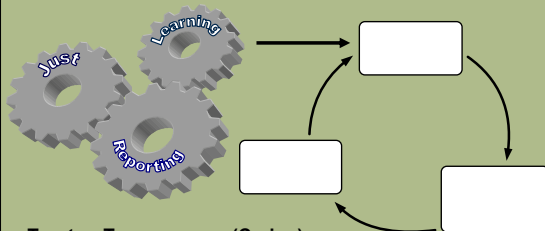
Direct-Care Provider involvement

- Reporting systems
- Safety Analysis
- Safety Action Teams

Patients are culture carriers

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Safety Culture ↔ Safety Management



- Trust ← Transparency (Caring)**
- patients / families (disclosure)
 - stakeholders (informing)

J Reason & A Hobbs. *Managing Maintenance Error*. 2003

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