Patient safety

Patient safety at 10 years: How far have we come? What’s next?

If you were to give patient safety a grade on progress over the past 5 or 10 years, what would it be? OR leaders and their colleagues have participated in an array of initiatives since the Institute of Medicine published its well-known 1999 report, *To Err is Human*. They include the Joint Commission’s Universal Protocol, the WHO Surgical Safety Checklist, and the Surgical Care Improvement Project (SCIP), to name a few.

Is it making a difference? Are patients safer than they were a decade ago? Robert Wachter, MD, a leading patient safety expert, thinks the movement is bringing up its grade. He gives patient safety an overall B- up from the C+ he awarded 5 years ago, and a big jump over the D he says he would have assigned in 1999. In a recent review in the journal *Health Affairs*, he grades the field of patient safety in 10 domains, such as regulation and accreditation, information technology, and workplace and training issues.

*OR Manager* talked with Dr Wachter about where we stand and what comes next. He is a founder of the hospitalist movement and edits the Agency for Healthcare Research and Quality’s WebM&M, which spotlights and analyzes patient safety cases. Dr Wachter is professor and associate chair of the Department of Medicine at the University of California, San Francisco.

**Q** You gave patient safety efforts a B- compared with a C+ 5 years ago. Do you see that as a pretty good improvement, or are you disappointed?

**Dr Wachter:** I think it depends on whether you are a glass-half-empty or a glass-half-full person. If you view patient safety through the lens of a patient and ask, “Is my health care safe enough?” the answer is no. So I find that’s disappointing.

But if you were to view patient safety through the lens of a policy maker or an observer of the health care scene, which is part of what I do, I think you’d have to be pretty impressed.

If you had asked me 10 years ago how much progress we would see in this new field called patient safety and gone through the 10 domains I reviewed in the article, I would have underestimated what we have accomplished in virtually every category. These are very hard issues. They involve information technology, new processes and procedures, thinking about our work in an entirely new way, and altering patterns of communication and culture.

One of the things that has emerged is the National Quality Forum never events. [NQF, a nonprofit organization, has published a list of 28 serious reportable events to increase public accountability and give consumers
access to information about health care performance. The NQF was only founded 10 years ago. We needed research to tell us, “What are the things we should be doing?”

The federal budget for patient safety research in 1999 was in the hundreds of thousands of dollars. In 2009, the Agency for Healthcare Research and Quality’s budget for research on costs, quality, and outcomes was $267 million.

We had a lot of catchup ball to play. I think we’ve made progress. But there is plenty more to do.

**Q** OR leaders have been through a lot of initiatives. Sometimes they feel over-whelmed with all of these projects. What do you think is needed to get to the next level?

**Dr Wachter:** I think we are getting to a tricky phase. I hear people say all the time, “There just comes a point where asking human beings to build a new procedure or insert a new step into their work is too much to do.” Even if they believe some of these things are useful, at some point the house of cards begins to fall.

What’s exciting is that this is the natural way these kinds of efforts go. In the beginning, it is always our natural inclination to say, “Just do this one little extra thing, this one bit of extra training.” Then organizations begin to realize it’s not working any more. Their workforce is demoralized. People are doing workarounds. They can’t get their work done.

What that leads to in most rational organizations is a leap to more strategic decision making. For example, what are we currently doing with people that we could use a computer to do if we just had the right computer? How can we be more thoughtful about organizing this work so we meet the goals of providing the safest care at the lowest cost?

It is politics and policy. You always see this when you hear, “Just do this one thing. Then just do this one more extra thing.” It is when you realize this is not going to get you to the goal that you step back and try to re-engineer the work.

**Q** Do you see that work of re-engineering going on now? Or will it take new ways of educating clinicians, or even a generational shift?

**Dr Wachter:** Part of our challenge now is to figure out how we can train nurses and doctors and others to think about work in a different way. We have made progress in getting people to think about systems rather than looking at an error and saying, “Somebody screwed up.”

But we have not done what’s needed to train front-line people and managers in the science of improving systems. They do that reasonably well in business school and engineering school, but it has not been part of the core training of many people in health care, and I think it’s going to have to be.

In the past, we thought it was OK for clinicians to function in individual silos. Of course, that was wrong, but it didn’t feel wrong.

Then we began to realize that virtually every medical error is about communication or a lack of teamwork. We can no longer get away with the old silo approach. We realize we have to train nurses and doctors and others in ways that create teamwork and communication styles that get things accomplished safely.
We need people who can analyze their work and think about new models of organizing work and changing culture. My fantasy is that we will deliver this curriculum to nursing and medical students together, in the same room. As a byproduct, they would not only learn the core curriculum but also learn that we are colleagues.

We are basically saying that people working in the complex delivery of health care not only need to be good at the clinical aspects of their jobs. They need to be good at making the system they work in work better. We can’t expect them to do that if they don’t have the skill set. Whether it is the Toyota Production System, Lean, or Six Sigma is less important than the message that you are the system, and you are responsible for making it work better.

I never learned about this in medical school. I’m sure most nurses never learned about this in nursing school. We just thought it would happen. Now we know that is completely wrong.

Q Another interesting piece you published in the past few months was a commentary with Peter Pronovost about balancing “no blame” with accountability. What has the reaction been? How does that fit with what you’re thinking about?

[In the piece in the New England Journal of Medicine, Drs Wachter and Pronovost say the emphasis in patient safety has been on creating a “no-blame culture” and fixing systems that allow errors to happen. Now they say it’s time to hold clinicians accountable who “habitually and willfully” fail to follow accepted practices like hand hygiene or the time-out before surgery.]

Dr Wachter: The reaction has been shockingly positive. When I first started writing and being honest about some of the problems we have in health care, I thought it would be risky. Any change in medicine is hard, and it’s difficult to think of any other issue that has as much emotional resonance as errors and killing people.

But I have been shocked by how well it has gone. I really believe that physicians, nurses, and health care administrators knew there was a problem and felt uncomfortable keeping it under wraps. They realized that at some point we had to go through an Alcoholics Anonymous-like stage of admitting to everyone this is a real problem, and we need help fixing it.

When I wrote the article about accountability with Peter Pronovost, I was purposely being provocative. I have always felt a little uncomfortable with the unabashed systems approach—always saying it’s about the system—because at times, I thought someone really did screw up badly or was incompetent. But I was reluctant to push on that point of view earlier in the safety movement because we were making such a huge paradigm shift in the way we were approaching this work, it was most important to focus on systems to engage people.

You have to realize that we were shifting from a model where prior to the year 2000, if you said “medical errors” to physicians, the thought that entered their brains was “malpractice.”

So we really made a conscious decision to focus on “no blame” and to approach problems as mostly systems problems.
Now I think we’ve reached a maturational phase in the movement where you can become a little more nuanced. You can say no-blame is right most of the time, but every now and then, it’s wrong. And if you say it’s right, but you know it’s wrong, eventually you will lose credibility in a field where there is a lot of outside scrutiny, whether from the media, Congress, or elsewhere. Losing credibility is a bad thing because then you might hear, “We can’t trust you to do this work. We’ll do it for you.”

So the time felt right. How can you argue that a 60% hand hygiene rate in a hospital that has gel dispensers every 2 feet is a systems problem? To us, it was so obviously an accountability problem.

I do think the systems approach is mostly right. But on issues like the time-out or hand hygiene—where there is general agreement on the safety practice—most of what I have heard is, “Thank you. How are we going to get this done?” In the article, we just intended to get the conversation started.

Read the Wachter’s World blog at http://community.the-hospitalist.org/blogs/

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