

A System of Safety

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This presenter has nothing to disclose.

“Safety is not a war we can fight and win. It is guerilla warfare, constantly changing and going underground.”

James Reason

What does 'being safe' look like? To clinicians, patients, leaders? How do we know we are safe?

Quality and Safety at Celenese



Establish a culture of dissatisfaction

Continually redefine what 'good' is

Upgrade the system to 'see' risk

It is my responsibility

Metrics drive performance

Visible and engaged leadership

Establish as core value

Is it acceptable to be safe
'sometimes' and in 'some
places'?

A Safety System

1. A Continuous Learning Process that generates reliable care by applying best evidence and minimizing variation everywhere

2. Reliable Care Processes continuously improved, owned by frontline providers and managers

3. Formal Improvement Methods and Measurement to improve quality and eliminate and mitigate defects

4. Transparency where the learning efforts are known to all and discussed as a daily part of work

A Learning System

A Safety System

1. Leaders who facilitate and mentor teamwork, improvement, respect and psychological safety

2. Teams who contribute to the game plan, plan forward, reflect back and agree upon specific behaviors

A Culture of Safety

3. Communication where transmission and reception of information is correct and reliable

4. Accountability that supports psychological safety because employees believe that they'll be treated fairly

We want to be reassured that...

- What happened last week in operating theater 1 could not happen again in another operating theater.
- Policies, procedures and clinical guidelines are actually useable and used making staff work-arounds obsolete
- Staff and leadership have current data on the safety and reliability of their clinical processes to inform their decision making.

Reliability (safety) is a
dynamic non-event

- ‘Dynamic’ because safe outcomes (non-events) are achieved through timely adaptations and compensations i.e. *the current status of the system changes constantly*:
 - Resources
 - Patient census
 - Patient condition
- How do we know? How do we change in response?

Are we driving the car using
the rear view mirror?

No Event = Safety = Excellence

We read 'non-events' as 'the system is safe.'

HOWEVER

When we look at the underlying processes driving the outcome, they are often unreliable.

THEREFORE

What appears as safe and reliable is often a infrequent event just waiting to happen.

And when it does....

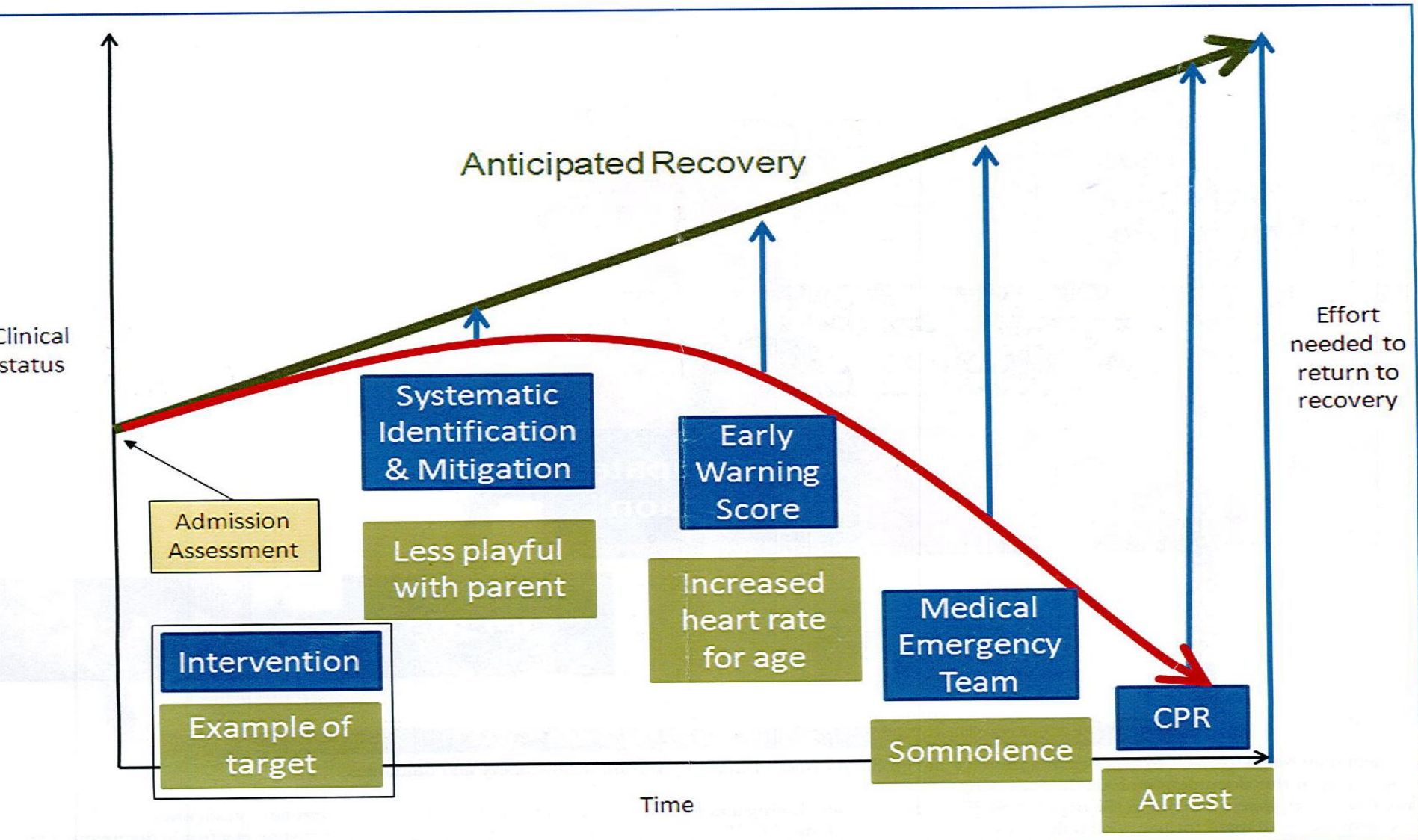
We are often surprised.

But it was just that once... it looks like special cause variation.

It will happen again unless the processes that improve the outcome become reliable.

Some Important Tools

- Planning for today: Safety Huddles at the start of every shift AT LEAST
- Planning for tomorrow and beyond...
- Multidisciplinary rounds
- Ask the patient and family- has anything changed?
- Handover at the bedside
- SBAR and other structured communication tools



Encouraging adaptability and resilience

- Standardize that which is standardize-able and nothing more
- Allow improvisation and adaptation as methods to cope with the unknown
- Cultivate a culture where these adaptations are not 'breaking the rules'
- **INSIST ON DISCUSSION AND LEARNING** from both standardization and adaptation

Adaptations

- Variability that adds value.
- Based on expert judgment that the standard process will not work or is not appropriate.
- Keeps us safe in novel situations that are truly rare and unpredictable.
- Must be understood so that we might all learn.

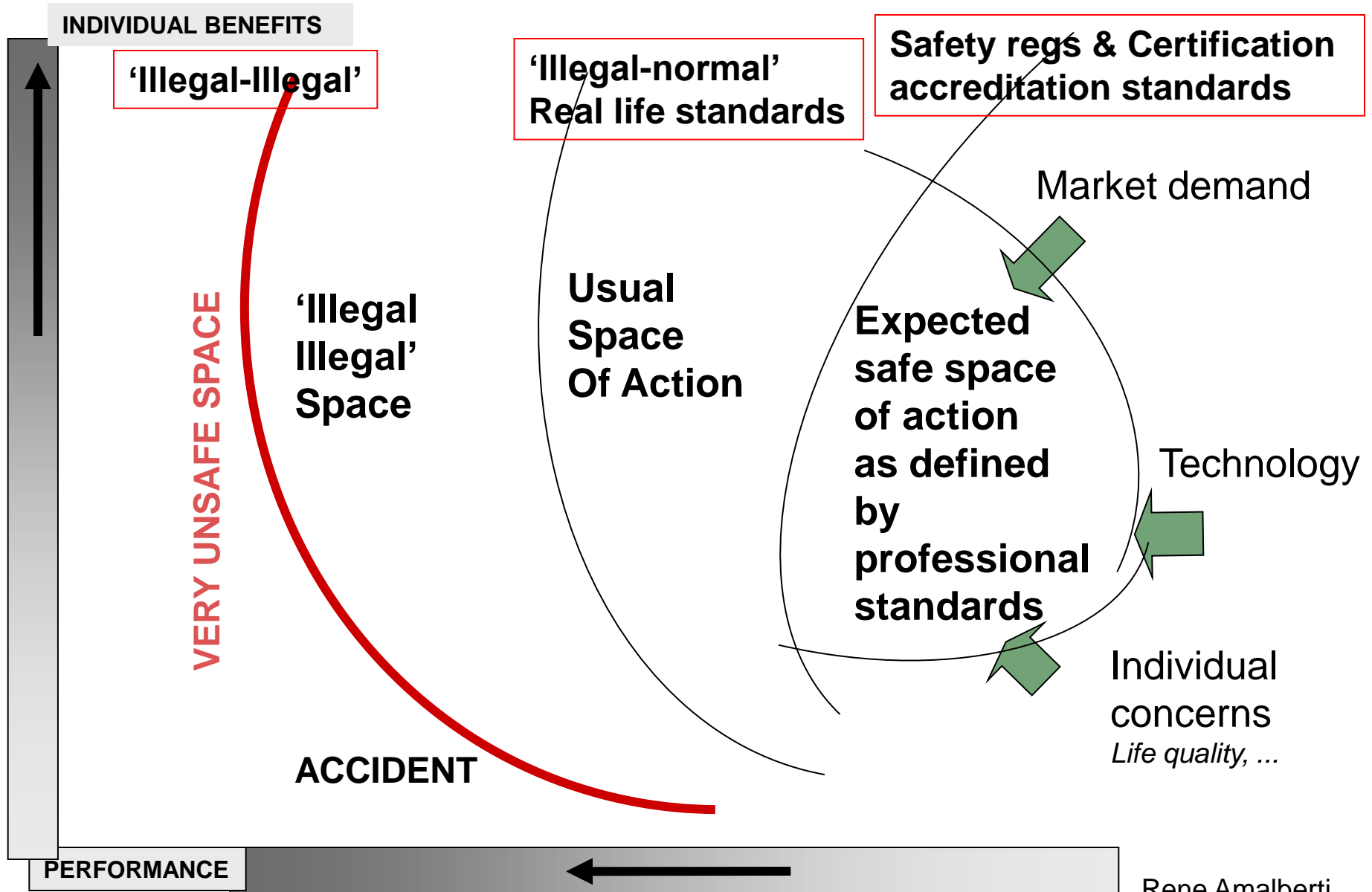
Deep Safety: Deeply Understanding the Current Realities and Risks

Getting Leaders Out
on the Shop Floor

Questions worth asking...

- Have you ever been in a situation when you could not follow a policy or procedure designed to make care safe?
- Have you even been in a situation when you have had off-service patients on your unit? How did you manage to safely care for them?

Systemic Migration to Boundaries



The history of foam-problem decisions shows how NASA first began and then continued flying with foam losses, so that flying with these deviations from design specifications was viewed as normal and acceptable...The parallels (with Challenger) are striking.

The acceptance of events that are not supposed to happen is known as “normalization of deviance.”

With each successful landing, it appears that NASA engineers and managers increasingly regarded the foam-shedding as inevitable, and either unlikely to jeopardize safety or simply an acceptable risk.

$$S_t \text{ (Safety total)} = S_i \text{ (Safety imposed)} + S_m \text{ (Expertise, Safety managed)}$$

Understanding Resilience $S_t = S_i + S_m$

S_t (safety total) = S_i (safety imposed) + S_m (expertise, safety managed)

NORMS / QUALITY + **EXPERTISE: RESILIENCE**

**Observed
Safety**

=

**Best practices
Rules
Constraints**

**Surprise
management**

**Based on
human expertise**

**Adaptive learning
systems**

Paradoxes of Resilience

Significant safety improvements always detrimental to S_m

Craftman industry

$$S_t = S_i + S_m$$

Safety Improvement



Ultrasafe systems

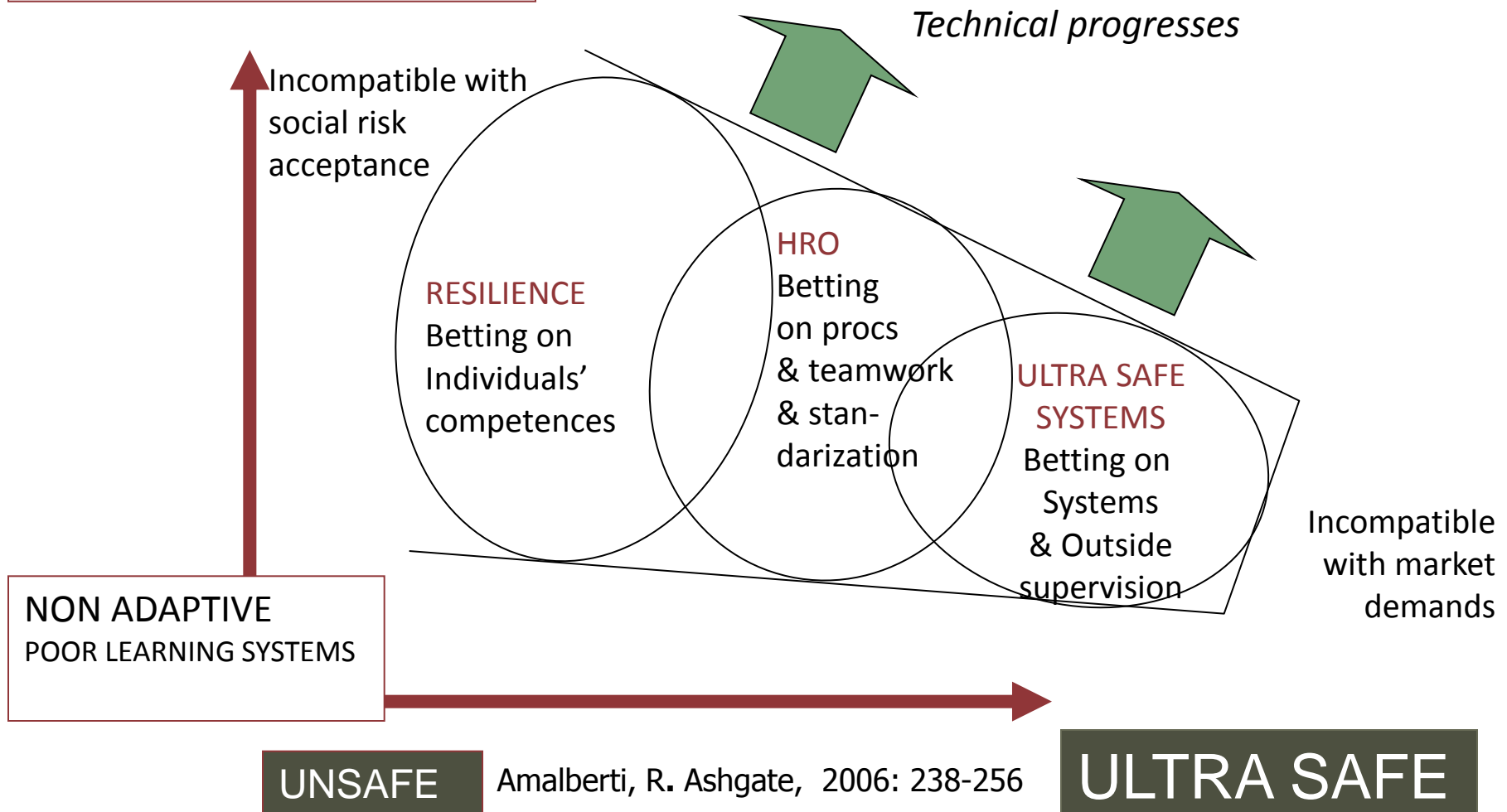
$$S_t = S_i + S_m$$

The next challenge : Preserving S_m while Improving S_i

$$S_t = S_i + S_m$$

Toward a strategic view on medical safety – a tentative mapping exercise

ULTRA ADAPTIVE
to MARKET DEMANDS & NON
STANDARD CASES - LEARNING SYSTEMS



What do you need to do to become reassured that care is safe and reliable at your organisation?