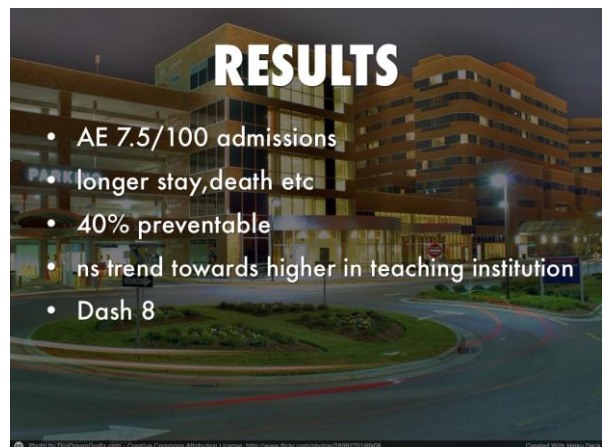


## Changing Perspectives

Christina Aquino Parsons  
Radiation Oncologist  
Vancouver Cancer Center

## Change

- Medication:
  - Acute: antibiotics
  - Chronic: Insulin/antihypertensive/cholesterol/antidepressants
  - Patient: OCP
  - Doctors :pain medication/anesthesia
- Technology
  - Diagnostic radiology
  - Pathology
  - Genetic medicine
  - Prenatal
  - Information: pt vs MD



## How did we get here?

- Education: Association of Errors/ Mistakes
- learn to get ahead by being perfectionist or over achiever
- if make mistakes: you are lazy, bad apple, trouble makers....
- freak out at the possibility of getting something worn.
- alone, ashamed and unsupported
- handle stress vs those who can't
- those who handle sleep deprived and those not
- those who make mistakes and those who don't
- good outcomes and bad
- drive those who make mistakes out... strive for perfection



## Recap

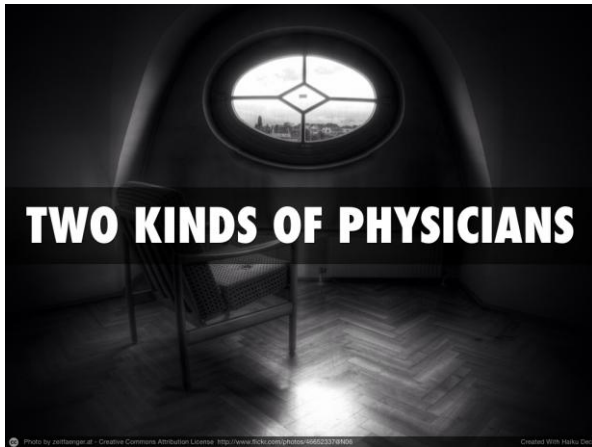
<http://www.youtube.com/watch?v=L3QkaS249Bc>

- Atul Gawande:
  - previously
    - Hospital: nuns/ symptoms
    - MD : looking for dx that they have tx for
    - What was known could be known: you plate/dx: craftsman/ daring/ autonomy was valued
    - Currently: tx for multiple conditions but takes extensive drugs/ procedures: to provide care for ALL
    - MD 1970: 2-FTE vs now 15 FTE for
  - Currently have a narrow area of expertise
    - We have trained/ hired and rewarded people to be "cowboy" but its PIT crews that are required
    - We have amazing clinicians and technologies
    - Systems with excellent components but it needs to recognize success/failure, devise solutions/ tools to help make experts better and be able to implement these changes

## "OLD SCHOOL" System

- MD are autonomous: /legal captain of the ship
- Physician as personal identity. What we do is WHAT we are.... we describe ourselves by our role therefore our mistakes are personal fails.
- Fear of being shunned and need to belong.
- Trained to improve OUR performance: experiential Quality Improvement





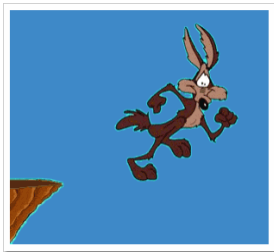
## Being Right

- Thrill
- Regardless of subject matter
- Stakes
- Positive or negative opinion
- Most of life feels right!!



## BEING WRONG: defensive strategies

- Shame, embarrassed
- Guilt
- Minimize
- Intellectual wrongness is associated with evil, weakness
- Denial
- Alone
- "not like ourselves"



## Some causes of errors

- Workload fluctuations
- Interruption
- Fatigue
- Multitasking
- Not following protocol
- Target fixation/tunnel vision
- Complacency
- Halo Effect
- Hazardous Attitudes (antiauthority, impulsiveness, invulnerability, machismo, or resignation)



## Culture Shift

### patient safety:

Canadian Patient Safety Week  
October 27th – 31st, 2014  
Ask. Listen. Talk.

patient centered care (LEAN)

patient as partners  
Kingston General



[http://video.who.int/streaming/patientsafety/Margaret\\_Murphy.wmv](http://video.who.int/streaming/patientsafety/Margaret_Murphy.wmv)

MARGARET MURPHY - WHO PATIENTS FOR PATIENT SAFETY CHAMPION - SPEAKS ABOUT HOW PATIENT STORIES OF THEIR CARE EXPERIENCES CAN BE POWERFUL MOTIVATORS FOR CHANGE AND HOW SUCH STORIES CAN BE USED EFFECTIVELY TO DRIVE QUALITY IMPROVEMENT.

## Perspectives

### Competence Problem

- Human error is the *cause* of adverse events.
- Human error is the conclusion
- System is safe: It needs protection from unreliable humans.

### Organizational Problem

- Human error is a *symptom* of trouble deeper inside the organization or system.
- Human error is a starting point for deeper investigation.
- Healthcare is *not* inherently safe. Only people can create safety by reconciling the multiple goals, pressures, constraints, and complexities.

## Systems are designed to get the results they produce

- A poorly designed system will be difficult to use and be prone to adverse events
- A perfectly designed system will be easy to use, effective, and minimize adverse events

## Canadian Patient Safety Initiative

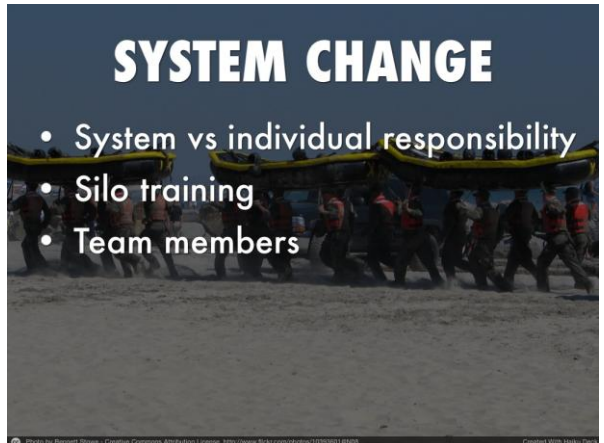
- Health care work environments are unhealthy
- Anxiety and stress related claims on the rise
- Presenteeism on the rise, the cognitively impaired who come to work
- *Every healthcare workers carry seeds of success: skills, talents, potentialities and enthusiasm. Unfortunately for many front line providers, the same seeds contain too many intellectual, emotional and systemic barriers.*

## Complex System



## SYSTEM CHANGE

- System vs individual responsibility
- Silo training
- Team members



## System solution example

- Pause points
- Id issues
- Reminder of key things that get missed if not checked
- Surgical checklist: not recipe for surgery but for team to deal with the unexpected..
- Death rate fell >45%
- Forces us to embrace humility/ discipline/ teamwork
- Vs independence/ self sufficiency and autonomy
- Making systems work task of our generation: complexity and specialization

## Human Factors

- Human Factors methods evaluate these differences and make recommendations for improvement to support human work
- Human Factors engineering: the application of human factors information to the design of tools, machines, systems, tasks, jobs, and environments for safe, comfortable and effective human use

## Example



<http://www.cromwell-intl.com/toilet/netherlands.html>



We cannot change  
the human  
condition,

but we can change  
the conditions under  
which humans work

James Reason  
(*BMJ* 2000;320:768)

## Being Wrong vs Being right

- Lucien Leape: the single greatest impediment to error prevention in the medical industry is that we punish people for making mistakes.

- strive to learn one thing to pass on

Why are you doing this? To make things better? improvement To make a difference?

## 2<sup>nd</sup> Victim

### 6 step recovery process

- (1) chaos and accident response,
- (2) intrusive reflections,
- (3) restoring personal integrity,
- (4) enduring the inquisition,
- (5) obtaining emotional "first aid,"
- (6) moving on. ? Researchers classified three ways: dropping out (i.e., leaving health care altogether); surviving (i.e., emotionally burying the incident); or thriving (i.e., learning from the incident in order to become a better clinician).

How does one move on?

- 1) dropping out (i.e., leaving health care altogether);
- 2) surviving (i.e., emotionally burying the incident);
- 3) thriving (i.e., learning from the incident in order to become a better clinician).





## Safety competencies: Domain 1

Contribute to a Culture of Patient Safety

A **commitment** to applying core patient safety knowledge, skills and attitudes **to everyday work**.

1. Commit to patient and provider safety through safe, competent, high-quality daily practice
2. Describe the fundamental elements of patient safety
3. Maintain and enhance patient safety practices through ongoing learning
4. Demonstrate a questioning attitude as a fundamental aspect of professional practice and patient

## Safety competencies: Domain 2

Working within **interprofessional teams** to optimize both patient safety and quality of care.

1. Participate effectively and appropriately in an interprofessional health care team to optimize patient safety
2. Meaningfully engage patients as the central participants in their health care teams
3. Appropriately **share authority, leadership, and decision-making**
4. Work effectively with other health care professionals to manage interprofessional conflict.



## Safety competencies: Domain 3

Promoting patient safety through effective health care **communication**.

1. Demonstrate effective verbal and non-verbal communication abilities to prevent adverse events
2. Communicate effectively in special high-risk situations to ensure the safety of patients
3. Use effective written communications for patient safety
4. Apply communication technologies appropriately and effectively to provide safe patient care.

## Safety competencies: Domain 4

### Manage Safety Risks

Anticipating, recognizing and managing situations that place patients at risk.

1. Recognize routine situations and settings in which safety problems may arise
2. Systematically identify, implement, and evaluate context-specific safety solutions
3. Anticipate, identify and manage high-risk situations



## Safety competencies: Domain 5

### Optimize Human and Environmental Factors

Managing the relationship between individual and environmental characteristics in order to optimize patient safety.

1. Describe the individual and environmental factors that can affect human performance
2. Apply techniques in critical thinking to make decisions safely
3. Appreciate the impact of the human/technology interface on safe care

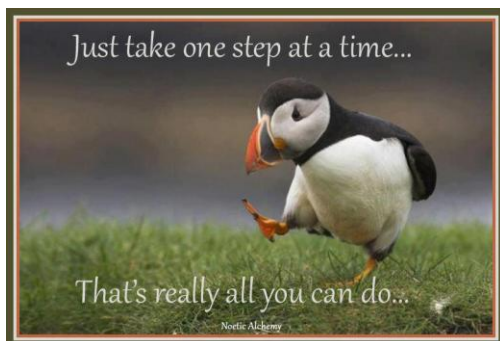


## Safety competencies: Domain 6

### Recognize, Respond to and Disclose Adverse Events

Recognizing the occurrence of an adverse event or close call and responding effectively to mitigate harm to the patient, ensure disclosure, and prevent recurrence.

1. Recognize the occurrence of an adverse event or close call
2. Mitigate harm and address immediate risks for patients and others affected by adverse events and close calls
3. Disclose the occurrence of an adverse event to the patient and/or their families as appropriate and in keeping with relevant legislation
4. Report the occurrence of an adverse event or close call
5. Participate in timely event analysis, reflective practice and planning for the prevention of recurrence



## SAFE and JUST CULTURE

- *not punitive or blame free accepting of honest errors*
- *Want a reporting culture: free learning opportunity ; this allows for an organization with memory... inherent in what we do... based on prior experience.*
- *Continuous improvement in safe guards/ defenses*
- *Flexible and able to change according to work flow*

## Summary

- A Safe and Just culture is best for all: patients and HCP
- We are the culture change
- It's the RIGHT thing

