

Improve Patient Safety in the Ambulatory Setting

A Focus on Safety Culture, Learning Systems and Failure

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Objectives

Patient Safety in the Ambulatory Setting

- A few statistics and Challenges

Guidance from the Experts

- Focus on Safety Culture and Learning Systems

Challenges to Healthcare Delivery: Safety Culture and Learning Systems!

- Learning from Failures in order to improve Culture and Safety
- Healthcare v. Aviation

Understanding the “why” behind our response to failure in Healthcare

- What makes Healthcare different?

Where do we need to go – what is the solution?

- Next steps – how do we move forward?

Patient Safety in the Ambulatory Setting

Safety Challenges in the Ambulatory Setting

- Fewer studies/less focus on ambulatory setting – less data
- Fewer Resources/technology when compared to Hospital Setting (e.g., IT Team to implement a new EHR in Hospital Setting, etc.)
- Minimal access/expertise in Quality/Risk Management/Pharmacy, IT, etc.
- Difficulty tracking post-discharge events
- Coordination of Care
- Limited face-to-face interactions between patient and provider – “open access concepts”, etc.
- Divergent processes, procedures and workflows across settings
- Decreased Regulatory Scrutiny (at present!)



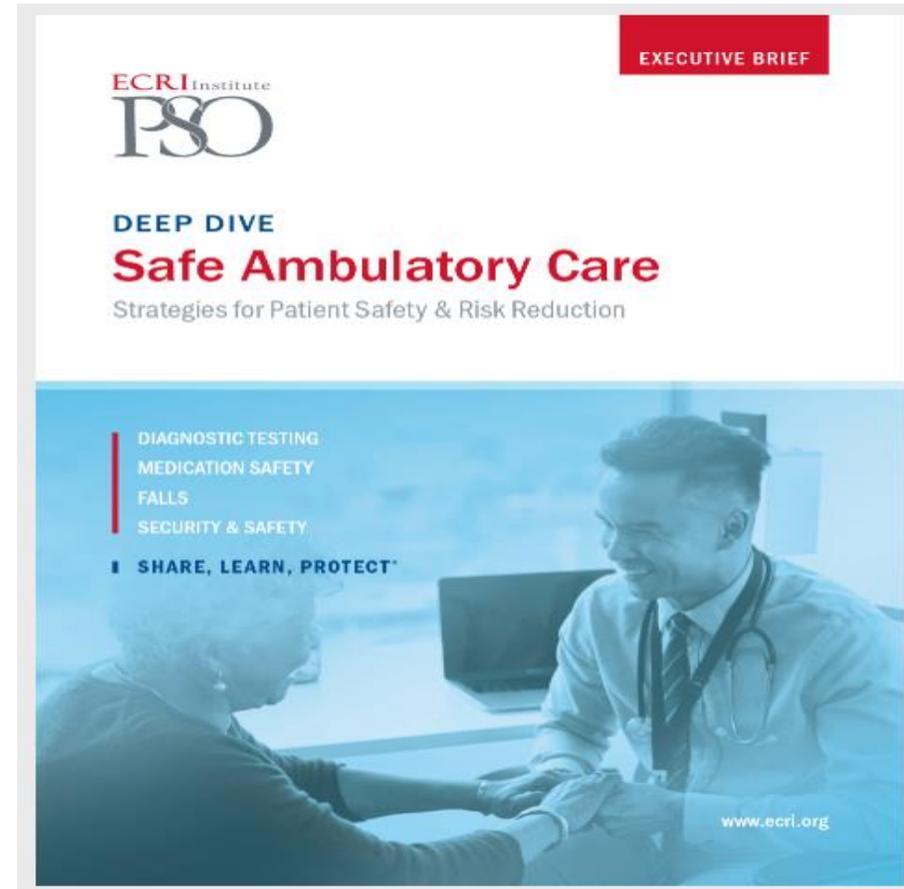
Medical Errors in Ambulatory Settings

Diagnostic Errors/Diagnostic Delays –
47%

Medication Errors (Wrongs and
Monitoring) – 27%

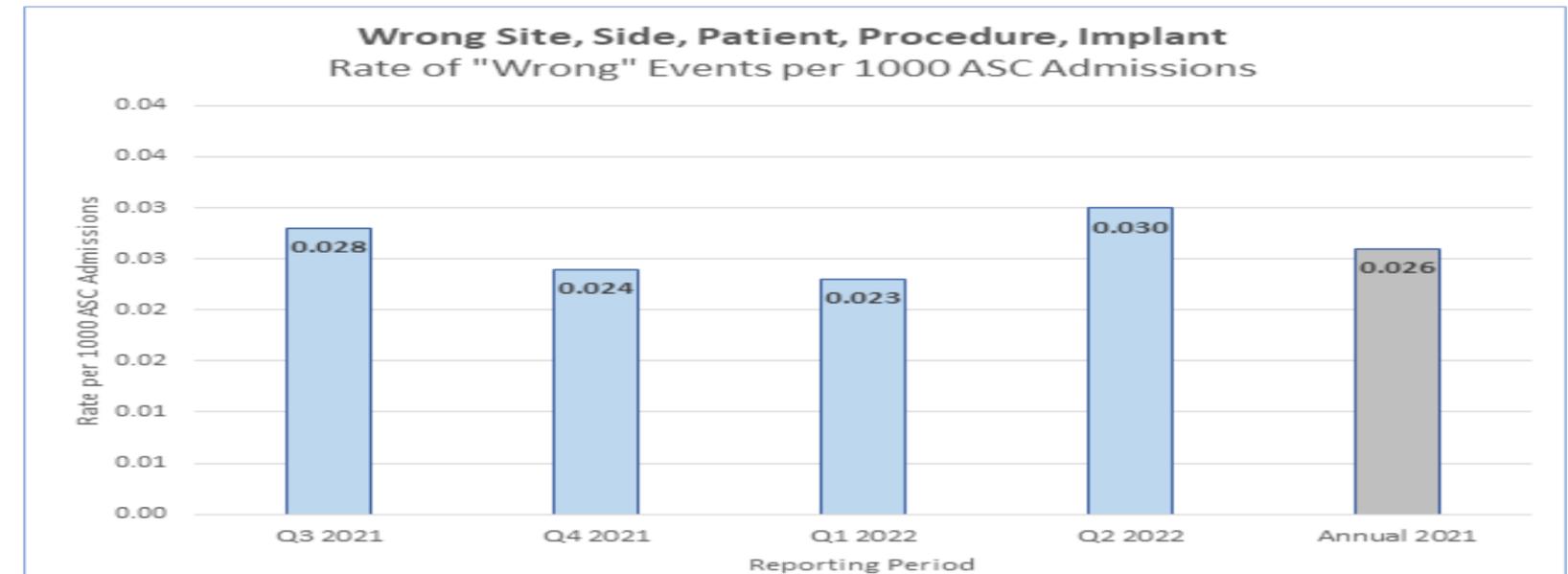
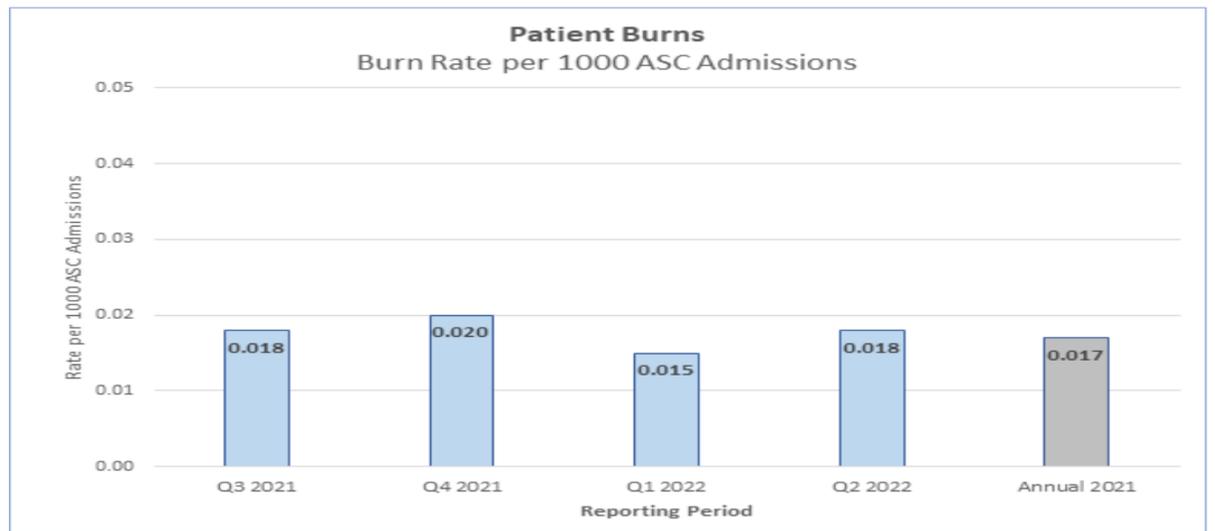
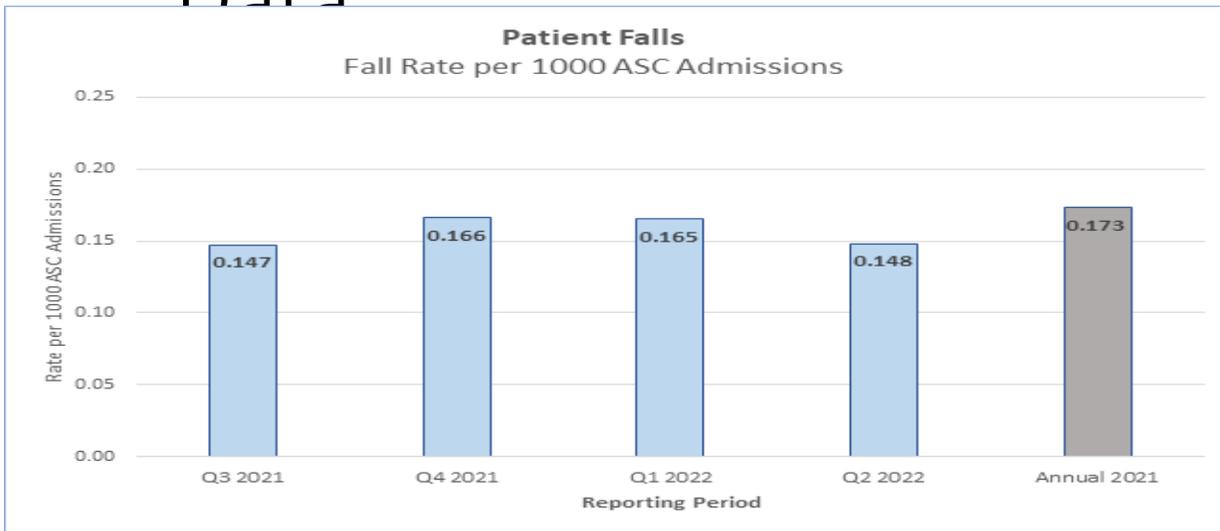
Patient Falls – 14%

HIPPA – 8% & Security Incidents – 5%



[ECRI PSO Deep Dive Safe Ambulatory Care](#)

ASC Quality Collaboration – Some Recent Benchmarking Data



[ASCQC Benchmarking Data](#)

We have room
for
Improvement!



Where to we
need to
focus?

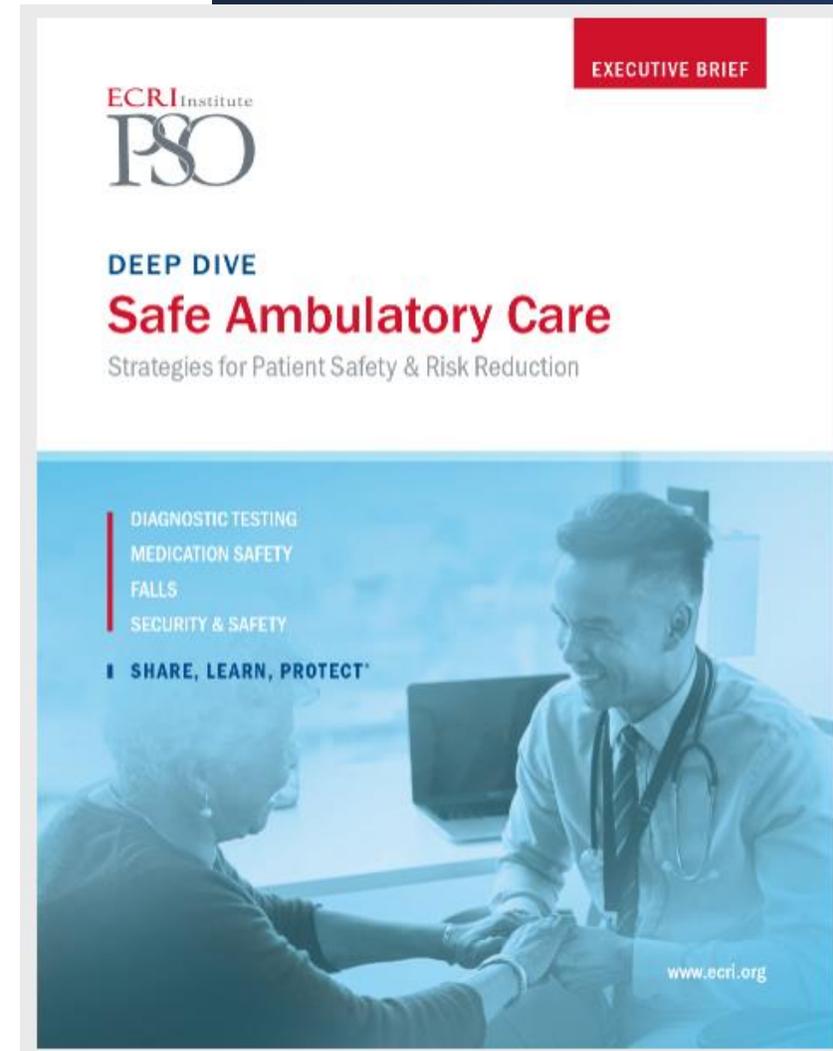


Guidance from the Experts

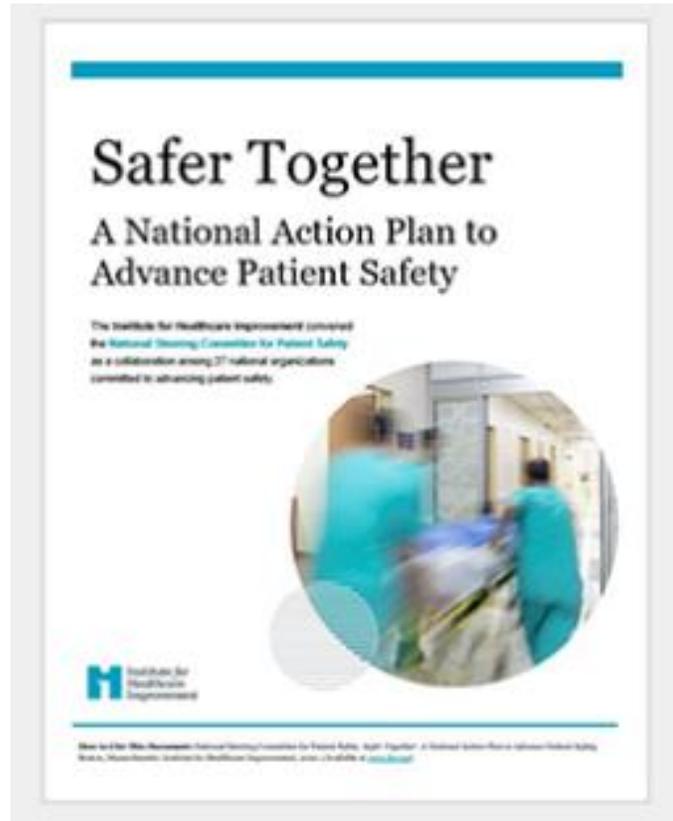
I. ECRI:

“Creating a Strong Culture of Safety that encourages the reporting of safety events is one of the cornerstones of safe patient care.”

- Acknowledge high risk nature of activities with goal of achieving safe operations
- Environment where errors/near misses reported without fear of punishment
- Collaboration across ranks to seek solutions to safety concerns
- Organizational commitment of resources to address safety concerns



Guidance from the Experts



2. IHI – National Action Plan to Advance Patient Safety

Learning System:

“Establishing networked and continuous learning; forging learning system with and across health care organizations at the local, regional, and national levels to encourage widespread sharing, learning and improvement”

[IHI National Action Plan to Advance Patient Safety](#)

A few of the Themes

Safety Culture, Event Reporting, and Learning System

Event Reporting is
Key

Reporting is non-
punitive

Events are acted
upon

Knowledge and
learnings shared

Learning
Environment
essential component
of Safety Culture

Learning is
continuous

Data must be openly
shared – locally,
regionally, nationally

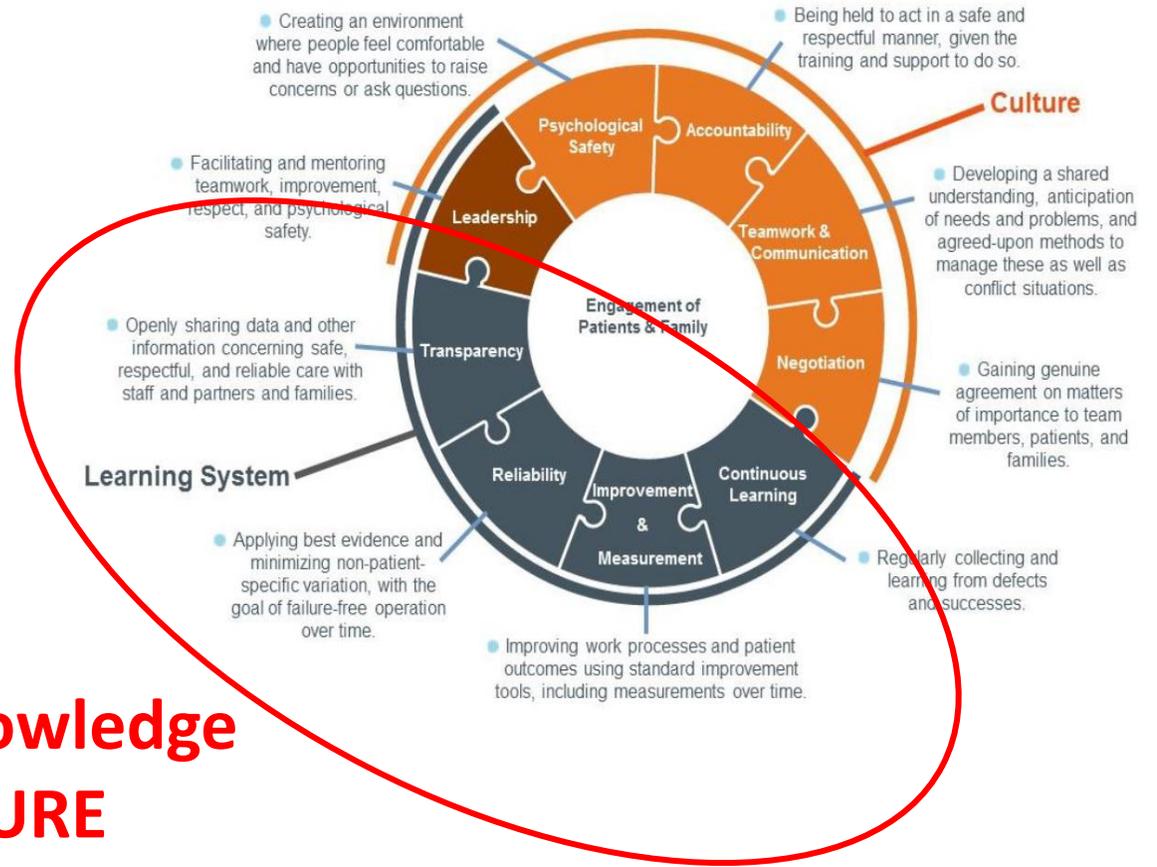
HOW do we Improve Safety Culture and Create Learning Systems?

The Learning System: A Critical Component of a Safety Culture

IHI Framework for Safe, Reliable and Effective Health Care

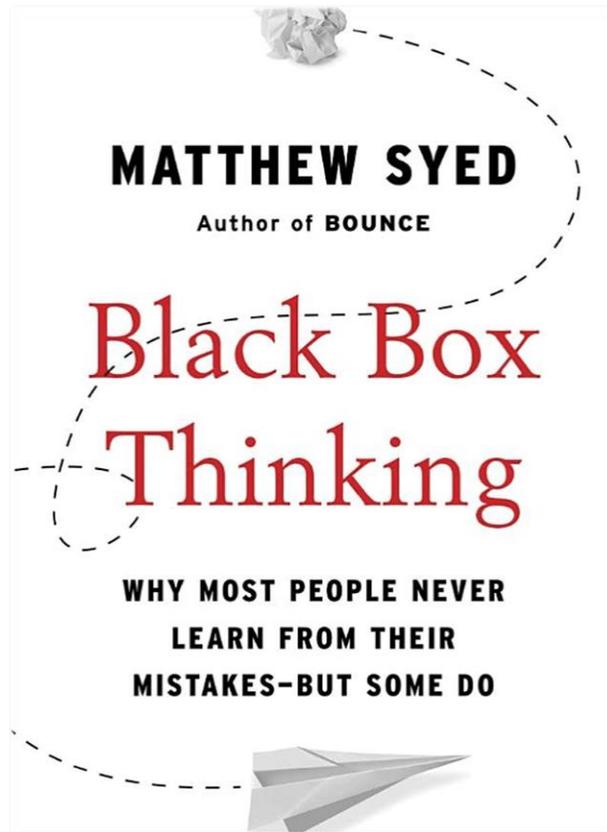


Figure 2. Framework for Safe, Reliable, and Effective Care – with Descriptive Detail for the Components



“Defects”
 “Variation”
 “Failure free operations”
 “Improvement tools”





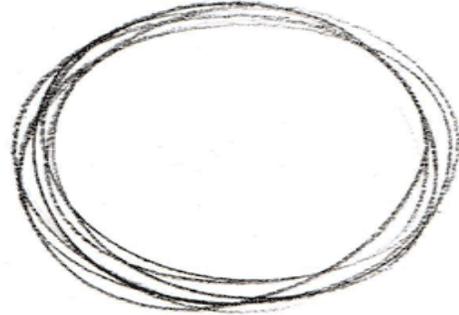
..."A failure to learn from mistakes has been one of the single greatest obstacles to human progress. Health care is just one strand in a long, rich story of evasion.

Confronting this could not only transform healthcare, but business, politics, and much else A progressive attitude to failure turns out to be a cornerstone of success for any institution."

Matthew Syed
Black Box Thinking

How does failure propel us forward?

Concepts from Matthew Syed Black Box Thinking:



- Netflix**: what if people could watch TV and movies anytime, anywhere?
- Uber**: what if you could get an affordable, on-demand chauffeur and not need cash?
- Airbnb**: what if people were willing to stay in private homes instead of hotels?

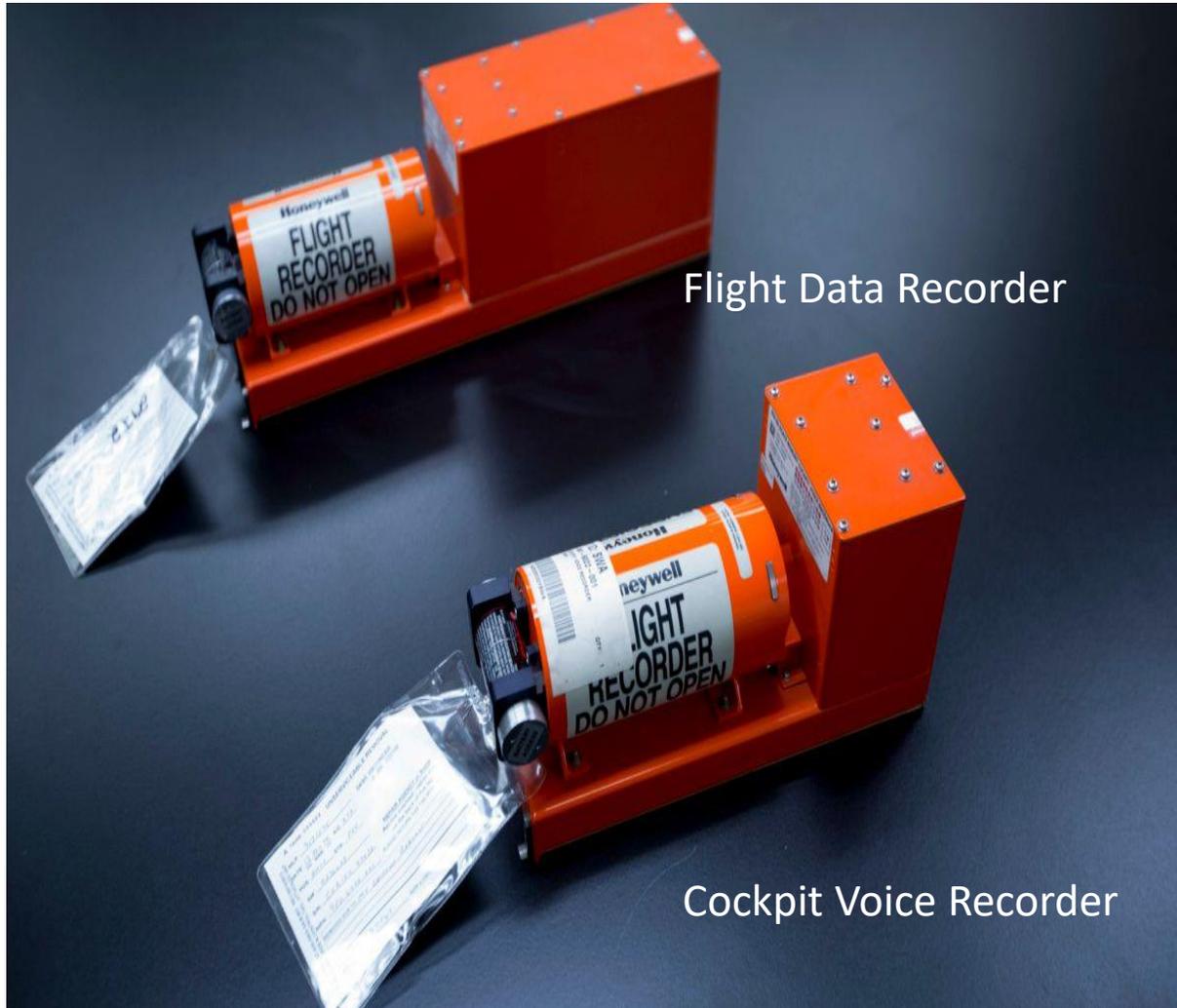
Closed Loop Thinking

Failure doesn't lead to progress because information on errors and weaknesses is misinterpreted or ignored

Open Loop Thinking

Leads to progress because the feedback is rationally acted upon

“Black Box Thinking” Metaphor





Failure drives Innovation

"I have not failed 10,000 times. I have not failed once. I have succeeded in proving that those 10,000 ways will not work. When I have eliminated the ways that will not work, I will find the way that will work."

Thomas Edison

Industry
Response to
Failure
Healthcare v.
Aviation



Let's compare – Healthcare v. Aviation – some stats



Healthcare

- 2013 study by Journal of Patient Safety put number of premature deaths associated with preventable harm more than 400,000 per year¹
- Numbers don't include outpatient settings and non-lethal harm
- Third leading cause of death following heart disease and cancer (pre-COVID)
- Equivalent of two jumbo jets crashing every 24 hours

¹<http://journals.lww.com/journalpatientsafety/Fulltext/2013/09000/A>

² Retrieved from the WW Web 9/2022: [Commercial Aviation Safety Team | Federal Aviation Administration \(faa.gov\)](https://www.faa.gov)

³ Retrieved from the WW Web 9/2022: [Study: Commercial air travel is safer than ever | MIT News | Massachusetts Institute of Technology](https://news.mit.edu)



Aviation

- 1912 – 8 out of 14 US Army pilots died in crashes – more than half
- By 2013 – rate of one accident per 2.4 million flights
- Fatality risk in commercial aviation has decreased 97% since 1997 and inception of CAST (Commercial Aviation Safety Team)
- Compared to other major forms of transportation, safer than train travel (0.04 deaths per million miles traveled). Aviation at 0.01 deaths per million miles traveled²
- Globally, that rate is now one death per 7.9 million passenger boardings, compared to one death per 2.7 million boardings during the period 1998-2007, and one death per 1.3 million boardings during 1988-1997³

Commercial Aviation – History 1958-2021

Fatal



[extension://efaidnbmnnnibpcjpcglclefindmkaj/https://accidentstats.airbus.com/sites/default/files/2022-02/Statistical-Analysis-of-Commercial-Aviation-Accidents-1958-2021.pdf](https://accidentstats.airbus.com/sites/default/files/2022-02/Statistical-Analysis-of-Commercial-Aviation-Accidents-1958-2021.pdf)

Let's compare – Healthcare v. Aviation Culture



Healthcare

- Training/credentials make us infallible, competency = clinical excellence (fixed mindset)
- Individuals are blamed/punished for failure (leads to closed loop thinking)
- When failure occurs: “complications happen”, “it was a one-off”, “unanticipated outcome”, “user error/technical error”.



Aviation

- Profound Respect for Complexity
- View failure as opportunity for improvement
- Investigators independent of airlines (and evidence compiled by accident investigation branch inadmissible in court)
- Real-time data monitoring of parameters (excessive banking, altitude deviation, etc.)
- Findings from errors AND NEAR MISS EVENTS communicated broadly and acted upon.
- Potential changes trialed in simulated conditions with multiple users to detect unforeseen consequence

Black Boxes!

United Flight 173 – One of the most important accidents in aviation history

Resulted in Major changes in the way airline crew members trained:

- Crew Resource Management
- Crew coordination/communication during malfunctions
- Loss of Situational Awareness



“United Airlines 173 was a traumatic incident, but it was also a great leap forward. It is still regarded as a watershed, the moment we grasped the fact that human errors often emerge from poorly designed systems.”

Shawn Pruchnicki
Aviation Expert

WHY are we Failure Averse?

Why is Healthcare Failure Averse?

Internal Fears of Failure

Competence = Clinical Perfection

Self esteem/Ego

“We are Caregivers – do no harm” belief



External Fears of Failure

Scapegoating/Blaming

Punishment – from internal and external sources

“In Healthcare, errors not seen as inevitable consequence of complexity of our system, but as indictment of those who commit them.”

*Matthew Syed
Block Box Thinking*

Fear of Failure/External - Safety Realities



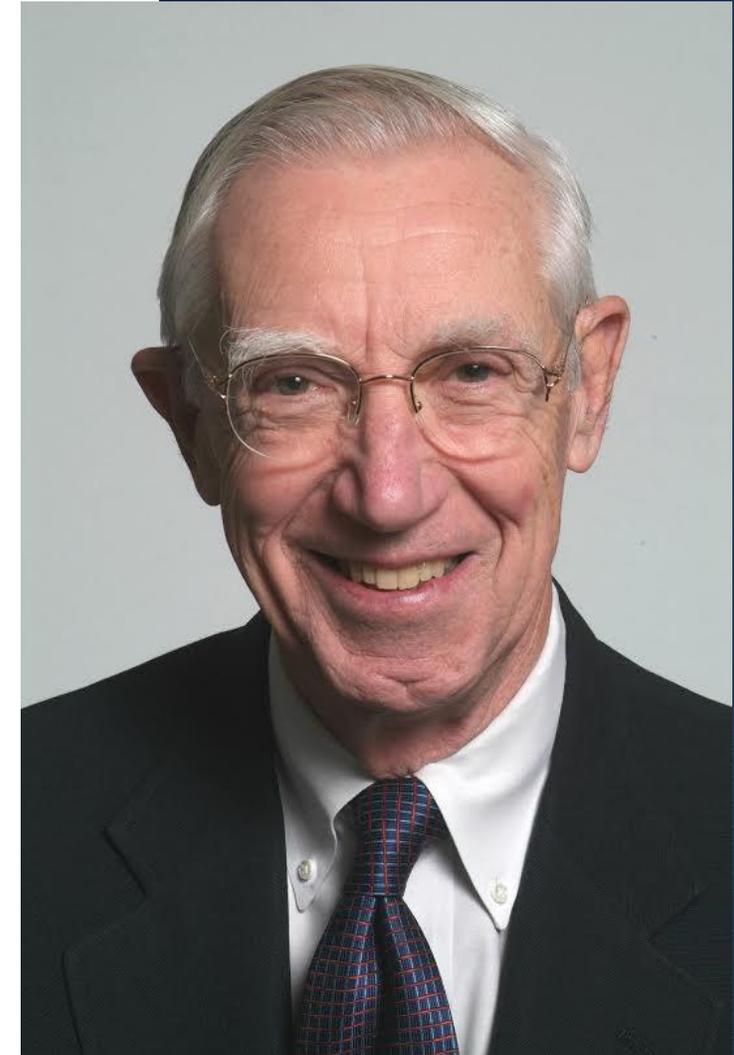
[RaDonda Vaught speaks out | GMA - YouTube](#)

RaDonda Vaught, left, wipes away tears as her attorney, Peter Strianse, right, talks with reporters after a court hearing Wednesday, Feb. 20, 2019, in Nashville, Tenn. Vaught, a former nurse at Vanderbilt University Medical Center, is charged with reckless homicide after a medication error killed a patient. (AP Photo/Mark Humphrey)

How we respond in Healthcare

“The single greatest impediment to error prevention in the medical industry is that we punish people for making mistakes”

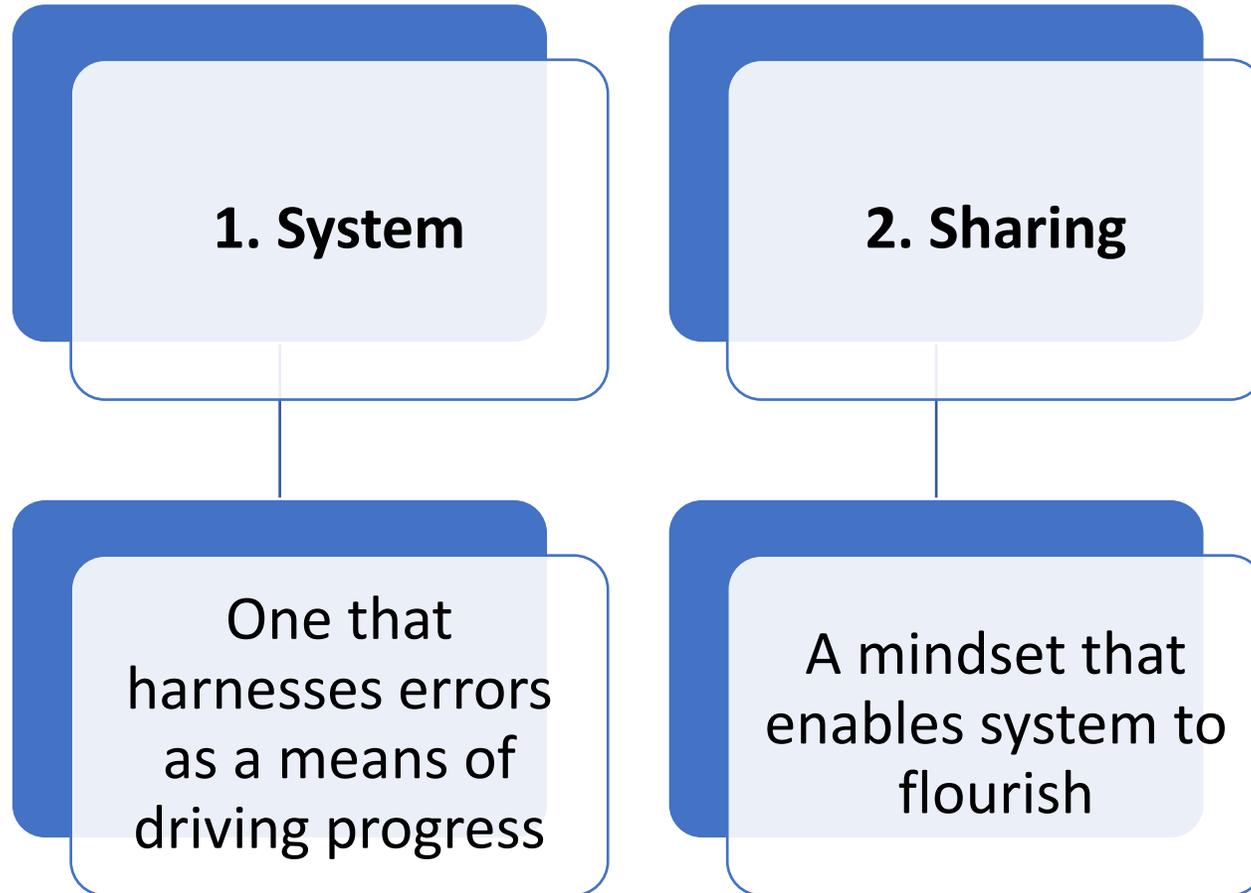
*Dr. Lucian Leape, Professor
Harvard School of Public Health
Testimony before Congress on
Health Care Quality Improvement*



Reframing Failure

How do we move forward?

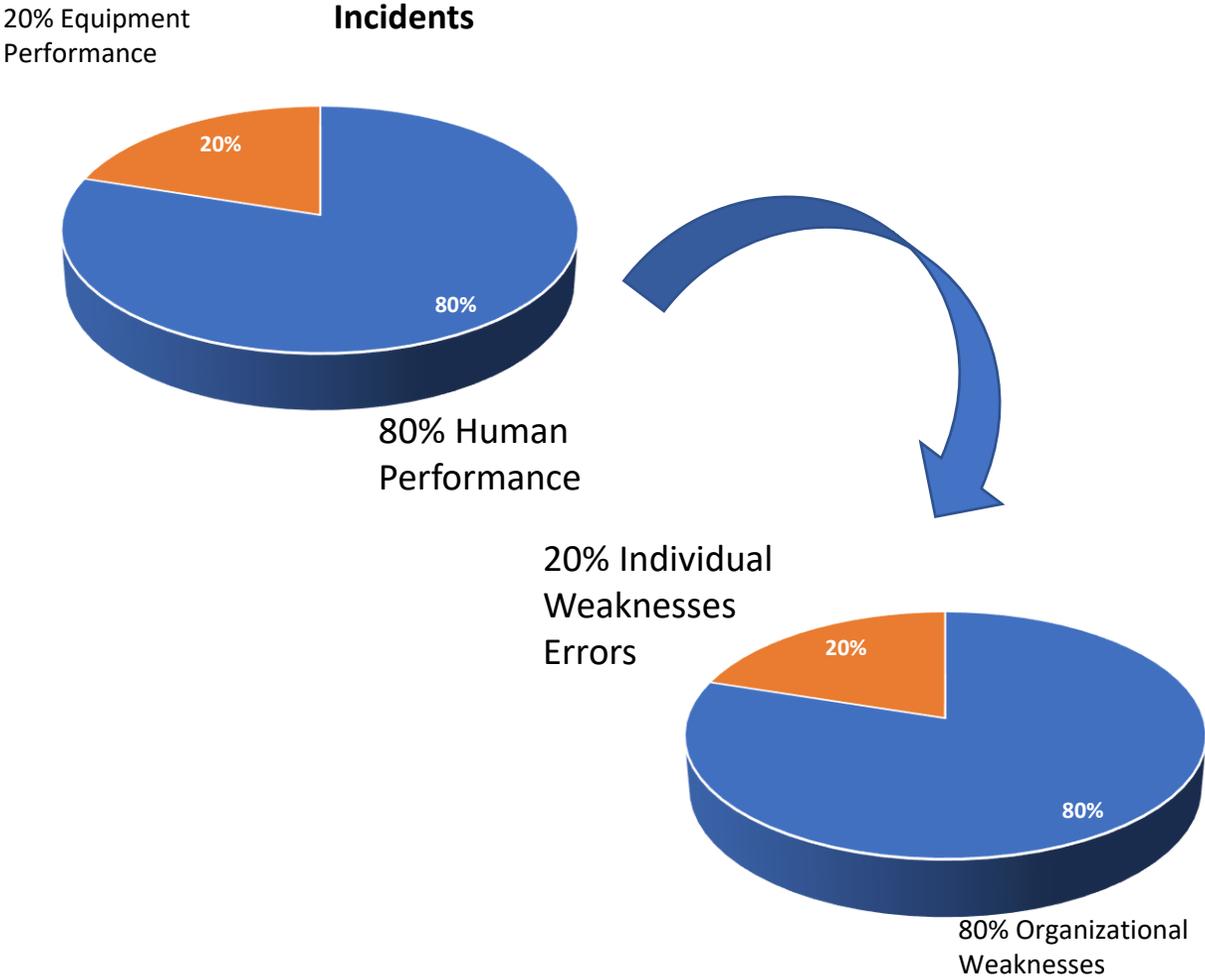
1. Create the Culture & the System – Open Loop Thinking



Tactics for Consideration:

- Participate in Event Reporting Systems – ideally adopting uniform platforms
- Encourage all teammates to report and allow access to all for reporting
- Act upon events and provide feedback
- Share findings at local level (e.g., Daily Huddles) and work to establish mechanisms for sharing on broader level
- Adopt a non-punitive approach to reporting – avoid blame
- Encourage near-miss reporting
- Apply best evidence and reduce variation where possible

2. Accept The HPI (Human Performance Improvement) Approach & Focus on System Improvement



- What can we do?
1. Designing Safety Systems
 2. Helping our Teammates make good Behavioral choices

3. Just and Accountable Culture



AHRQ Defines Culture of Safety as one: *“in which healthcare professionals are held accountable for unprofessional conduct, yet not punished for human mistakes; errors are identified and mitigated before harm occurs; and systems are in place to enable staff to learn from errors and near misses to prevent recurrence”*

[ACHE Framework - Leading a Culture of Safety : A Blueprint for Success](#)

Summary

- A learning Culture is a critical component of a Healthy Culture of Safety
- Unless we accept and act upon Failure we will not progress and improve – internal and external fear of accepting failure must be recognized and addressed
- Closed loop thinking prohibits us from advancing
- Healthcare can continue to learn from Aviation and other High Reliability Industries and adopt safety culture practices
- We must Accept the concept of Human Performance Improvement and Focus on:
 - Designing Safe Systems
 - Helping Teammates make the right choice
- Adopt a Just and Accountable Culture
- Adopt a Growth Mindset and Open Loop Thinking Culture!



Thank You!!

