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Working Together for Safe, Efficient and Quality Care: Time to Start Improvement Tidal Waves Today

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A transformation autobiography in five chapters
(Author unknown)

Chapter 1
I walk down the street
There is a hole in the sidewalk
I fall in
I am lost...I am helpless.
It isn't my fault.
It takes forever to find a way out.

Chapter 2
I walk down the same street
There is a deep hole in the sidewalk.
I pretend I don't see it.
I fall in again.
I can't believe I am in this same place.
But it isn't my fault.
It still takes a long time to get out.

Chapter 3
I walk down the same street.
There is a deep hole in the sidewalk.
I see it is there.
I fall in, it's a habit...but my
Eyes are open.
I know where I am.
It is my fault. I get out immediately.

Chapter 4
I walk down the same street.
There is a deep hole in the sidewalk.
I walk around it.

Chapter 5
I walk down a different street

I am a lucky guy. In my role with the Canadian Patient Safety Institute I get to hear about and see patient safety excellence delivered by passionate care providers and leaders who dare to transform system failures into learning opportunities and advocate change that will make healthcare safer for all patients.

In the next few pages I will reflect on the patient safety environment in Canada in a broader context, share my personal experience both as a patient and as a leader of an organization created to help the system deliver safe care, and close with highlighting what I believe it will take from all of us to make extraordinary patient safety improvements in healthcare faster.

In other words I will point to some of the holes in the sidewalk, examine them, explain why we keep falling in them and suggest some ways to avoid them. It may feel like a root cause analysis of the status quo.

AN ALARMING AND EMBARRASSING PARADOX
Our business is health, and we are ostensibly the health experts. Day in day out the healthcare system delivers exceptional care through passionate and skilled providers. Yet we have created two serious health issues. First, we have a staggering amount of preventable adverse events and health system delivery errors. Second, *healthcare workers* are among the unhealthiest of all workers.

Between 9,000 and 24,000 Canadian patients or clients die annually from adverse events; a third of these deaths are preventable. Coupled with the fact that something goes wrong in one of 13 Canadian hospital stays - *185,000 errors annually* - the enormity of the problem becomes staggering. Caring for people means caring about results for those people.

Besides failing patients and their families, the Canadian healthcare system has a high rate of occupational injury and absence, resulting in an extraordinary percentage of payrolls lost due to long-term disability, workplace injury and sick leave. Although absenteeism (direct and indirect costs) is often used as the measure for lost productivity, it does not reflect the full scope of the problem.

The term "presenteeism" describes the losses in productivity and quality attributable to the *walking wounded, who are* physically, cognitively or emotionally impaired by illness, injury and work culture. More and more evidence shows that patient safety incidents harm staff and the organization too, especially where incidents are opportunities to blame rather than learn.

For our personal benefit (we are all patients or clients) and, for the long-term benefit of society, we can't afford to lose the people sustaining this system – it's time to understand, learn and improve.

EXPERIENCING PATIENT SAFETY FIRST HAND

This may be little more than common sense, but there is nothing like a little unforeseen field work to confirm its importance. I didn't think part of my orientation would be to spend *my first five days as the CEO of CPSI in hospital.* This was my first time ever as a patient and it was an eye opener. I got to see and feel firsthand the complexity of a hospital system: a busy ER, people on stretchers in hallways waiting for a bed (23 hours in my case), confined quarters, equipment/supplies stacked everywhere, multiple tests, and the tireless efforts of front-line providers.

When you are in an environment that is not your own, among strangers, often unable to leave the confined space where you have been stationed to heal, you become engaged in the lives of those around you. At first, my curiosity began and ended with my own prognosis but, before long, I found myself intertwined with everything in my proximity.

In a room with four beds and, consequently, four individuals partitioned only by curtains, privacy and, at times dignity, go out the window. It is interesting that a government rightly obsessed with privacy on so many levels institutionalizes an astonishing lack of patient privacy in its own facilities. As a small consolation, the absence of privacy makes equally violated bedfellows. We were all sick and all would have rather been somewhere else. I was in a large teaching hospital in a big city where the chance of running into anyone I knew was minimal. I wondered what it would be like to be in a hospital in a small town where the fact that everyone knows everyone else is both a community-building virtue and a privacy-challenging limitation.

In any event, there we were, and I found it extremely difficult to distance myself from the agony, obstacles and progress of those around me. Our difficulties and illnesses became common knowledge as did our treatment and progress. I began to observe the activity inside my room: I was part patient, part amateur medical anthropologist, part informal counsellor. I watched and listened to the care provided to those around me. I learned about their medications, diets, diagnoses and prognoses. I witnessed the interactions with doctors, nurses, food providers, and housekeepers. I was there when there was no one else. I saw the blank stares of roommates trying to make sense of their predicament.

For many, understanding patient safety from the patient's perspective is critical to achieving success in their own organizations.

I urge all senior decision makers, planners, policy makers, theory experts, tool kit designers, ...spend time on the wards, have conversations, see and feel what it is really like.

Lessons learned during my hospital stay

I lived the gap between the theory and practice of patient empowerment. I was a relatively informed patient, but I found it difficult to ask safety related questions.

I also saw and felt the impact of unruly, misplaced and aggressive *patient expectations* and behaviours. I saw family behaviour and its potential impact on my care.

Any economist who persists in believing that healthcare is a market good just like any other has not spent any time as a patient. You give up your body and power to an institution and a team of strangers. They have all of the technical knowledge and you are scared. The last thing you are is a shopper and bargaining agent.

There is nothing new in what I experienced – it is the reality of being a patient in a system that struggles to get things right. Perfection is unattainable, but we will never approach perfection *unless we commit to settling for nothing less.*

Moving forward, here are questions that I believe we need to answer in order to escape the embarrassing paradox in healthcare. Are you disturbed by the time and organizational energy focused on competition among professional, educational, and administrative elites? Ask how they can be aligned and connected so they can function seamlessly without leaving holes in care. Are you disturbed that, to legitimize their actions and personal agenda, they wrap themselves in the cloak of "I am doing this for the patient"? Ask where the common ground is and what is the TRUE common goal?

CHAMPIONING A NEW VISION FOR PATIENT SAFETY

In healthcare organizations across Canada, a new vision of healthcare is slowly evolving. It seeks to leave behind the historical patterns of siloed organizations and command-control hierarchies. This new vision is a system that is owned by, co-created with, and responsive to the community in which it operates. This new vision embodies a system in which healthcare providers, regardless of organizational affiliation or scope of practice are proud to deliver safe, efficient, quality driven patient or client- focused services and are fully enjoying their work. It is a system that is affordable, accessible, and its quality built on the talents and dedication of front-line providers working interprofessionally. Management becomes more focused on self-management in a team setting. Relationships are fundamentally different. The public and patients are central, informed, valued and active participants. They have the information and tools they need to pursue wellness and are given permission and opportunity to ask patient safety questions. The patient and the community will no longer be content to be nameless and faceless victims of patient safety failures; they ask questions about their safety. As owners of the system (taxpayers) they expect and deserve nothing less than excellence as the norm with respect to patient safety.

Many share this vision – indeed, who could oppose it? But articulation is far easier than implementation. We all know more than enough about achieving safer care; we must transform what we know into what we do and must overcome the "knowing-doing Gap."

> What goes on between people defines what a health care organization is and more importantly what it can become.

PATIENT SAFETY TRANSFORMATION

Dramatic improvements in safety will require competent and patient safety focused management and governance, a fully engaged workforce, new conversations and decision-making with patients. It will also require understanding the urgency to act and a sound change strategy.

Patient safety is one of the most significant transformations taking place now in the Canadian health system and around the world. It *brings together disciplines* because it involves both technical and social sciences, combining the insights of engineering and medicine with those of organizational behaviour and workplace dynamics. It *engages all* care providers, patients and clients to work towards a common goal: prevent unnecessary harm. It *crosses through all hierarchical* steps and silos because everyone has a role to play: from board, to CEO, to managers, to providers, to patients and clients.

Patient safety is changing the face of modern medicine and front-line care delivery. *The question is not whether it is changing enough, but is it changing fast enough to stop harm from destroying people's well being?*

Courage and Discipline

To allow the transformation to take place requires courage and discipline:

- *courage to abandon old patterns, structures and processes found to be incompatible with safer care; and*

- *discipline to resist knee-jerk reactions to mini-crisis and fleeting fads; begin with leading self.*

To improve patient safety we must absorb and learn from hard-won lessons about how patient safety is achieved on a constant basis. There are wonderful examples of success that I've heard about and I encourage you to look for them in your organization.

My experience, both professional and as a patient, taught me an important lesson. External controls can achieve some degree of compliance, but the true source of courage and discipline comes from healthy relationships maintained by intrinsic motivation and rooted in truth and real values.

Success = Strong Relationships

To realize a new patient safety vision for the Canadian health system requires everyone's participation in building relationships that connect different levels of the system. This not only includes the relationship between patients and providers, but providers and their colleagues. What goes on between people defines what a healthcare organization is and more importantly what it can become. Nothing good happens when relationships fail, but imagine how much we can achieve through healthy relationships.

Healthcare organizations are often big and very layered. Let's begin at the top. How often have we seen *the top level,* formally responsible for the whole, dissolving the whole into disintegrated domains of responsibility? Boundary and turf issues begin to dominate, peers begin to protect their domains and resist joint problem-solving. By rebuilding connections and emphasizing common goals, I believe it is possible to stop polarization and isolation from becoming the standard operating style.

When this dividing pattern becomes the organizational norm, it signals to those in the organization to focus narrowly on their individual areas, losing sight of the system as a whole. *The mid level* of the organization senses and adopts the top level culture. Horizontal connections begin to erode. The managers mirror the isolationist behaviour of their superiors. The language of "we are unique," "we are different" and "we are the experts" begins to surface. Agreeing that expertise is needed, it is time to agree that each expert is a contributor to the same healthcare system caring for patients and clients with needs spanning across sectors. For the patient or client and the system, unhealthy competition is harmful.

As the top and middle levels become absorbed in their own aspirations, *the front-lines* come to see themselves as the grounded soldiers chafing under the remoteness and perceived dysfunction of their superiors. They, at times, feel caught between competing organizational imperatives that bring them into conflict with their peers. They feel unified as victims and divided by the absence of common direction and purpose. The healthcare system is already suffering from providers' lost capacity and this can't continue. Imagine the benefits everyone could gain if by building bridges between people, this friction and the negative energy is replaced with enthusiasm, hope, and confidence.

Relationships have the power to prevent organizations from falling into holes and find new streets to walking down on. Since people are the vectors of those relationships, understanding and nurturing their intrinsic motivation is key.

Success = Soft Side

Healthcare is in one sense the realm of science and technology – often described as the "hard" side. However, it is possible to excel at the hard side and fail to achieve good quality and safety outcomes. Where this occurs, the cause is failure on the so-called soft side: the irreducible human elements of complex service organizations. Here is where ego, role modeling, integrity, teamwork, attitude, commitment, readiness to change, and a host of other variables come into play.

Persistent and frequent patient safety errors are symptoms of deeper trouble. The healthcare delivery system is only as safe as its weakest patient safety link. The weak link is usually a hidden pattern embedded in the soft side, the domain of systems transformation.

The real healthcare organization that you work in is not the official organizational chart. Organizational charts are static images that imply rigid turf boundaries, whereas high-performing organizations are as dynamic and fluid as the external environment around them. Fundamentally, *health system organizations are patterns of energy:* a web of relationships, conversations and decisions among people.

Permit me to cite another example of the divide between soft and hard. I suggest to you that the relationship between people is what makes the absolute comparison between

> There is no greater enemy of improvement than indifference to failure.

Success, therefore, requires balance: by all means strive for scientific and technocratic excellence, but pay attention to – and measure – the relational and behavioural sides making sure they are supported by a foundation of truth and strong values.

Success = Real Values + Truth

Organizational culture – its customs, traditions, and practices – plays out in day-to-day power and political relationships. We need a new conversation about, and critical appraisal of, how patient-resident-client focused we really are. And we have to be clear about the difference between responsibility and accountability.

Unfortunately, many parts of our health system still hold onto our traditional command-and-control systems, structures and processes, where accountability means finding someone to blame. *Real accountability* is about honouring commitments and working in a safe and effective manner. It is about learning, truth, change and growth. It is not about fear and punishment.

All improvement efforts are confronted by a paradox: the public and media give a remarkably free ride to patient safety failures compared to other industries. A sticky gas

pedal claimed to have caused perhaps 15 deaths worldwide launched a media frenzy. The March 25, 2010 Vancouver Sun front page headlined the recall of 33,000 baby gates whose defects produced no major injuries. By contrast, the fact that 9,000 to 24,000 people die in Canadian hospitals every year because of safety failures elicits only sporadic attention and no public outrage. Something is very wrong here. Someone has to *look the truth in the face* if we are to prevent harm.

There is no greater enemy of improvement than indifference to failure. The challenge for all is to lead, manage, guide and coach others through a patient safety transformation process. This goes much deeper than tinkering with structure and adopting the right rhetoric. It is a sustained effort to embed safety as a defining imperative that permeates both individual behaviour and organizational culture.

EVERY HEALTHCARE ORGANIZATION HAS THE CAPACITY TO DELIVER SAFER CARE

To improve performance, organizations must overcome varying degrees of systemic, cultural, and individual barriers. Leaders have an obligation to identify and nurture the people with courage and discipline to drive improvement and change. They must create healthy environments for the dedicated people who self-select to work in healthcare.

Healthier workplace environments increase the resiliency, adaptability, creativity, satisfaction, morale and productivity of individual workers, leading to safer care. The added bonus is that healthier workplaces and safer care end up costing the system and the tax-payer less.

EVERY INDIVIDUAL HAS THE CAPACITY TO CONTRIBUTE TO THE PATIENT SAFETY TRANSFORMATION

We have all the gifts we need to improve the Canadian healthcare system. Every individual that is part of the system carries the seeds of success: skills, talents, potentialities and enthusiasm. Unfortunately for many front-line care providers and patients, the same seeds also contain too many intellectual, emotional and systemic barriers. Leaders – all of us – need to take action and nurture the growth of those seeds that will allow for a well connected patient safety system.

IMPROVEMENT TIDAL WAVES OF CHANGE

Our biggest mistake is failing to demand more from governance, senior leadership, professional associations and individual practitioners. We turn a blind eye to huge variations in practice and never evaluate them seriously from a behavioural perspective. And this becomes a recipe for substandard quality and patient safety. We need to stop convincing ourselves that the remedy is more money, more technology, more staff and look within ourselves and our organizations for the courage to change.

Since we know what causes many patient safety errors, one of the first steps to make is leveraging the currently available capacities to solve the problem. On one side we have a huge patient safety problem, and the numbers confirm its magnitude and on the other side we have very bright people working in healthcare, we have libraries of patient safety books, studies, research papers, and commissions.

To be sure, we are making incremental progress, but meanwhile the toll of harm rises. *It is time for a sense of urgency* – it's time for tidal waves of change - aggressive and committed action from every individual working in the system: the front lines, management, and leadership in healthcare organizations; and from government.

Building blocks for improvement

My professional and personal experience with patient safety allowed me to see clearly what it really takes to transform our patient safety culture from too much avoidable harm to one where people are proud to be a part of.

- *Denial is our greatest threat* – there is a gap between the patient safety outcomes we see on paper and what patients and providers experience. Silence, unawareness, indifference, and complacency are the greatest enemies of improvement.

- *It is all about relationships* – honest and open relationships between all involved in care, together with a culture that supports healthy interactions and is rooted in true values, are the sources to achieve excellence.

- *Context is everything* - while the capacity to change exists in every individual and every organization, it must align with the organizational history, sense of urgency, readiness for change, culture, and degrees of leadership commitment.

CPSI's Contribution

The role of the Canadian Patient Safety Institute is to work with the Canadian healthcare system to create the right environment to allow transformation to occur. This means aligning our priorities with the system's priorities and making the system's success our success.

CPSI will continue to promote and increase patient safety awareness among stakeholders, patients, clients and the public. This must be done, among other means, by ensuring full disclosure of patient safety incidents, explaining cause and effect, as well as what actions are identified and implemented to reverse the problem.

In addition to awareness building, CPSI will make efforts to bring providers, governors and managers the best resources and knowledge available to assist them in providing safe care. We are aware of the multiple pressures organizations need to deal with: data reporting, accreditation, requirements at different levels, and strategic goals, to name just a few. Therefore, our portfolio of resources aims to support all organizational levels and reduce the pressures.

Many resources are currently available and, as they develop, they will become publicly accessible on our website. Here are a few of interest for you: *Safer Healthcare Now!* provides practical tools grouped in interventions for front-line providers (like Preventing Ventilator Associated Pneumonia), a Governance toolkit that assists boards in making patient safety a priority, to education programs, and a number of tools and resources that support professionals in care settings improve patient safety.

CPSI is serving patients and clients by serving the system, which is why we believe that your successes are our successes. We want to hear about your accomplishments as well as challenges so we can support you better and achieve safe healthcare – our patients and clients deserve no less. *"Knowing is not enough; we must apply. Willing is not enough; we must do" (Goethe)*

Are we brave enough to open our eyes, take responsibility for falling in and find a street with fewer holes?

If you would like to trigger tidal waves of patient safety quality improvement in your healthcare organization, CPSI can help.

www.patientsafetyinstitute.ca/English/Pages/default.aspx