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Document :	AEMH 05/020
Title:	Speech at the Patients Safety Conference in Luxembourg 4-5 April 2005 The Hospitals' role in creating a "Culture of Safety".
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Purpose :	Information
Distribution :	AEMH Member Delegations, Participants at the 58th AEMH Plenary Meeting
Date :	12 April 2005

The hospitals' role in creating a "Culture of Safety".

Is patient safety possible?

Every European should be able to rely on that medical care given in European hospitals is safe! But they can't! In complex systems as hospitals where human beings are treating and human beings are being treated, mistakes are made and accidents do happen. There are failures of commission and failures of omission. Even with a good medical education and a long experience is it impossible to always do the right thing and react the right way. No system of safety can protect you all the way but it is important to work on minimizing the number of mistakes and their consequences.

As the mobility increases among the European patients as well as the European health-personal, it is necessary to define a common European view on patient-safety and risk management .We must all be sure that the strive towards safe care is equally important in whatever hospital we receive our medical treatment. Also we must all feel confident that we are working with the similar routines and codes of conduct wherever we go to work. We must have names, rules, guidelines and measurements that are compatible and comparable to be able to trust each other as doctors, employers and producers of high quality medical care.

I want to focus on some points on patient safety and risk management that I think are especially important, out of a hospital doctor view.

Nr One: Let us discuss medical mistakes! Let us face them, analyse them and prevent them as thoroughly as we can.

Medical errors represent neither evilness nor bad luck. Mistakes are done due to hidden traps. There are patterns in making mistakes, patterns to detect and to learn from. Individual doctors and nurses are often made responsible for doing the mistakes even though insufficient routines should be blamed. The focus should lie on avoiding the errors but when someone has made a mistake there must be adequate routines of minimizing the harmful consequences and preventing the mistakes from being repeated. It's human to err but it is unacceptable that someone should be hurt.

How can we change the attitude and establish a learning culture?

In the work of improving medical quality and patient safety in hospitals the most important thing is to change the attitude among professionals. It is necessary to change the culture of blame and shame to a culture of safety in the hospitals but also within the whole society, among journalist and politicians, within jurisdiction and among patients and their relatives. We must work systematically to establish a "non guilt approach" in health care as far as possible without taking away the personal responsibility of the health personal.

It should be like in aviation. When I asked a friend of mine, a pilot working for the SAS if he felt shame as he reported his mistakes he answered: No, no one is afraid of writing a report. There are criteria for what to report and then you just do it, as a routine. If you are rusty at something you get help to practice it. It feels important as you all are on the same plane.

We must systematically approach a culture of safety.

Systems dealing with safety must not be based on punishment but on feedback. The doctor or nurse must dare to report errors and adverse events in the own name. For that it is important that the reports are dealt with confidentially. The person must trust the process enough to describe what they did, why they did it and their conclusion of how it can be avoided. A regular routine must be established and the person reporting must get credit or feedback of the importance and positive consequences of their report.

The reporter should also get immediate access, on the Internet, to the locally and nationally collected experience in the matter together with suggestions of routines that others have had good experience from. In that way you can instantly learn from your mistake and your experience will come to benefit of others. This creates an individual interest of reporting and a learning culture within the organisation.

The local and national supervisory authorities should, for the same reason, focus on bad or insufficient routines of the hospital or the medical organisation rather than blaming the individuals that happened to do the mistake or rather did report it.

How shall we manage risks?

As no security system can be tight enough to protect us from all potential errors we must change the attitudes not only towards making mistakes but also towards dealing with them. We must manage the risks.

How to do the right things is based on medical knowledge and experience. To do, only the right things, is a special skill that you can learn and practice, personally and within the organisation. You must exercise good routines. You must be aware of the scientifically identified factors of risks and know how to work towards reducing them.

Hospital care means meeting a lot of unique situations. An important field of knowledge for young doctors and nurses to learn is the ability to recognize situations that represent potential mistakes. In Sweden the young doctors organisation estimated that about 10 % of the young doctors time at work was spent on “defensive medicine”, measures that could be claimed not necessary out of a medical view. They were done purely to protect themselves from disciplinary actions. That is very costly and rather tragic. One way to avoid this is to reserve sufficient time for daily rounds and regular practices of guidelines together with older colleagues in order to share and grow experience how to do only the right things.

How can we establish a culture of safety?

Errors should be identified

Adverse events should be reported and collected in a confidential report-system, not anonymous but confidential. The coordinators or others responsible for the root cause analysis should know where to find the person involved to be able to collect details and knowledge of what happened but no one else.

Due to the blame and shame attitude there are today a false low number of mistakes reported. As the culture changes the number of mistakes will appear to rise. Everyone must be aware of this.

Errors should be dealt with

The systematic approach of safety shall be implemented that is, should be regularly exercised by the leaders. To establish the no shame, no blame, attitude there should, routinely, be held regular conferences of morbidity among colleagues, young and old, high and low.

Errors should be prevented

Leadership on all levels must be focused on preventing errors and it shall be discussed on a every day basis. There shall be supportive IT-systems integrated with the journal of the patient with checklists and adequate advice. The IT-systems shall include automatic trigger-programs that signalizes pathological test-results and potentially pharmacological dangers.

“Safety coordinators” shall be appointed and work systematically with safety measures.

The patients should also be involved in the process of safety. They shall be instructed to ask, what to ask for and how to interpret it.

There should be action programs for safety at every hospital.

In the process of establishing a learning culture, a good tool is internal rounds of prevention regularly. The rounds shall be based on relevant checklist:

Is the technology functioning all right?

Are the working conditions satisfactory? Are the working schedules good enough to give maximum safety or are some doctors so tired they can't think properly?

Are there sufficient introduction programs?

Is everyone educated in what to do in case of an emergency?

Are the guidelines updated?

Do we know whom to treat? Continuing medical education and continuing professional development CME/CPD is important.

Take care of the “errorist”.

As not all mistakes can be prevented it is of utmost importance that when mistakes are done they are dealt with in a professional and human way.

In a culture of safety it is important to have an action plan of how doctors and nurses that have done a mistake are approached. How are they taken care of?

Even though we all have full responsibility to take care of our workmates I think the boss (chief physician?) has the biggest responsibility when a mistake has been done. The boss should take the initiative to talk to the doctor that made the mistake, out of a medical perspective but also from a supportive view. The boss should give information about the practical routines as well as where to get legal aid and psychological support.

Quite early it should be discussed how to talk about the matter within the working group. Not always shall everything be put on the table immediately. Sometimes it's better to save the discussion until more facts are known and the perspective is somewhat clearer?

The boss also has the responsibility to take action to prevent the mistakes from being repeated. If there is a patient involved the boss is responsible of informing him or her in an appropriate way.

What happened, why did it happen and how will the organisation make sure it will never happen again. This feedback comforts the patient. Someone did listen and someone did bother. Apart from that, the experience and suggestions of the patients is very important for the organisation to collect and learn from.

The responsibility of the boss to take action against repeated mistakes includes the responsibility to stop dangerous doctors. There are doctors that are ill, that are poorly educated, have a bad and wrong attitude. Those doctors must be temporarily or permanently separated from working with patients. The boss has the major responsibility but we must all, as colleagues and as risk managers take the responsibility, identify the risk and deal with it rather than closing our eyes. We are all on the same plane.

Conclusions

Identify the risks and manage them. Make mistakes visible.

Find and analyse errors, mistakes, and accidents that altered the foreseen result of treatment without focusing on guilt. Open minds rather than blame.

Make registration of mistakes made and "almost made" confidential and mandatory. This information should be available to everyone on a national and international level.

Change the attitude among doctors as well as the written law from punishment towards prevention.

Organize and market knowledge about risk management.

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