PATIENT SAFETY

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CLAUDE OPPIKOFER, MD – SWITZERLAND
Member, ISAPS Patient Safety Committee

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A former president of the United Stated considered that democracy was threatened whenever we take it for granted.[1] The same threat is true for patient safety. Much too often in medicine we are sure we have everything under control, especially the human factors that contribute to safety.

The aviation industry has recognized the paramount importance of human factors for the safety of air transportation early in their history – and thus the success of the industry! They designed tools like Crew Resource Management (CRM) intended to maximize effectiveness and safety by optimal utilization of all resources of a team, especially the human factor. If *chances of dying from avoidable human error are 10,000 times greater in a hospital than in an airplane*,[2] this is mainly due to a better understanding of these aspects. Yet, in healthcare it is only twenty-five years since someone first published a call to action and stated that *systems that rely on error-free performance are doomed to fail.*[3]

While it may be assumed that ISAPS members master technical knowledge and skills, there is certainly a potential for improvement in the field of non-technical skills (team work, leadership, situational awareness, decision taking, task management, and communication).

Acknowledging that *to err is human*[4], major improvements in avoiding serious complications and adverse events can be made if all members of a surgical team are constantly encouraged to **speak up**. Statistical data shows that up to 50% of caregivers will not speak up to a surgeon and that in more than 90% of incidents someone knew beforehand that an error would happen[5]. Thus, a systematic effort to improve these numbers will be tremendously beneficial for the safety of our patients. The repeated encouragement from us as medical leaders to all members of our team will get them *on board* with safety efforts and is the key to success.

Also, let us not forget to consider the patients as integral to the team and include them in our encouragement to speak up if they have a feeling that something is not normal. In our specialty, where many operations are done under local anesthesia, the patient's input before and during surgery will greatly contribute to quality and safety.

While encouragement to speaking-up can be considered a measure that immediately leads to improvement of safety and better outcomes, it would be dangerous to think that all safety efforts will have such rapid effects. Speaking-up is an important element of safety culture. But further cultural changes need an ongoing effort and resources.

A typical example of a misleading feeling of safety is the introduction of a surgical checklist without team training[6].

The implementation of a surgery checklist cannot be a top-down enforcement but will need customization and also participation of the users in the design. Only then will teams see the real benefit of the checklist and the added value for safety. Reported failures of checklists were always due to the expectations of immediate measurable results following their introduction, when in reality, the process represents a gradual, step-by-step improvement plan.[7]

Today, a requirement for hospitals as well as for surgical offices is the implementation of a Safety Management System (SMS), a systematic approach to managing safety, including the necessary organizational structures, accountabilities, policies and procedures.[8] Such a system must be customized to the needs of each organization, but a major element must always be the assessment of the risks of every activity. A simple table like in Figure 1 will generate a rapid overview of which risks are present. Figure 2 shows examples of risks and measure to be taken.

Safety measures require effort and resources, time and money. It is an ongoing process, but it may well be the best investment for hospitals as well as for surgical practices. Programs and tools are available. Surgeons' leadership is required to promote them, especially in times where *hospital managers and even medical staff appear more preoccupied with survival in the marketplace than with survival of their patients*.[9] Or, as it is often mentioned in aviation:

If you think safety is expensive – try an accident!

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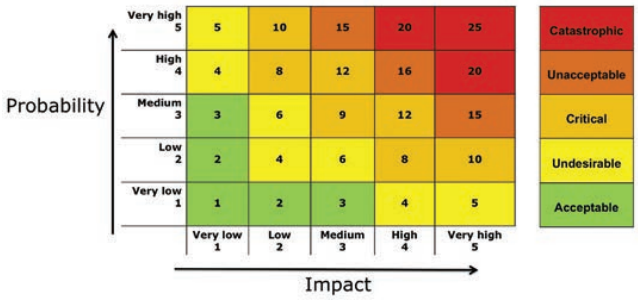

Figure 1 - Risk Analysis: Probability and Impact

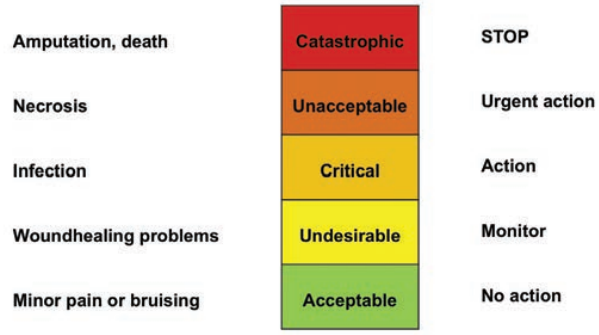

Figure 2 - Risk Analysis: Measures