Resilient healthcare in patient safety

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INTRODUCTION

The World Health Organization (WHO) defines patient safety as "the prevention of errors and adverse effects to patients associated with healthcare".[1] In the yesteryears of medicine, when medicine was more of an art than a science, fatal outcomes were accepted as part and parcel of the practice of medicine. However, as medicine evolved to be more of a science that an art, expectations by both the patients and the practitioners increased.

The Concept of Safety-1

Improving safety in healthcare is reactive and safety is defined as an absence of errors or adverse events.[2,3] A common method of addressing errors that can result in the compromise of patient care and to minimise the recurrence of these errors is by conducting Root Cause Analysis (RCA). These concepts of using the RCA as the starting point to address and rectify the issues of patient safety is the basis of what is now termed *"Safety-1" which focuses on what went wrong and why*. Based on this method, the intervention is either to suggest ways to eliminate it from recurring or to redo the process with checks and balances, so as to minimise it from recurring. This may be appropriate where patient safety was compromised due to human error, for reasons such as pure carelessness or work fatigue.

This question remains, whether in today's practice of medicine, this method of addressing issues that resulted from the interaction of multiple complex systems that functions in both an independent yet independent manner, will be sufficient to provide the needed answers.

Where are we now?

Despite the patient safety movement being around since the 1990's, there still remains a lot to be done. McGlynn et al. reported that only 55% of the United States population received appropriate care between years 1998-2000.[4] In Australia, after almost a decade of healthcare restructuring that involved the implementation of new policies and guidelines that were intended to improve patient safety, it was noted that only 57% of the population studied by Runciman et al. actually received the appropriate healthcare that had been recommended.[5] These studies reflect that even in developed nations, improving healthcare is a complex and challenging process.

Need relook at concepts of patient safety

Today, in a quest for reliability and reproducibility, not only have we become more dependent on guidelines but we are also using more technology to replace human activities. Technology is used to design predictability and safety of an apparatus or a system but it cannot as yet be designed to ensure how the healthcare provider should use the apparatus. This factor emphasises, even more, the fact that though many activities are been seen as independent e.g. hand washing in infection control; in reality the reduction of nosocomial infection due to hand washing is part of interdependent activities of multiple stakeholders, from the nurse to the consultant.

Should we study why things work?

All over the world, on a daily basis, in the delivery of healthcare, there are far more things that go right than that go wrong. We assume that the reason that this happens is because we have put various safeguards in place. However, in clinical medicine, at times clinicians are faced with situations which are not addressed by management guidelines and as such they are forced to innovate or to make decisions based on past clinical acumen. The ability to have variability is a component of Safety-2 and should be studied to improve and sustain patient safety.

Resilient (Safety-2) approach

The Resilient or Safety-2 approach is a provocative approach, which looks at why things go right. It is now apparent, that to ensure patient safety, it is equally important to study and learn from 'what went right' and not to just focus on 'why it went wrong'[6]. Most healthcare staff are of the opinion that they are always delivering quality healthcare, which most of the time is true and is taken for granted and not appreciated.

The *proactive management approach* of Safety-2 hopes to develop a deeper understanding of day-to-day activities, allowing room for improved performance variability, yet not restraining the emergence of expertise.[6] In building a resilient healthcare system, it is crucial to understand the interactions within the cohort of healthcare workers with varying levels of competencies, it *is an adaptive system* which nurture its staff to be automated efficient experts – unconsciously competent.[7]

Why a resilient or Safety-2 approach

Does the fact that although the clinician did not follow a prescribed set of guidelines and the patient did not suffer a morbidity or mortality make it a non-compliance of patient safety? Or should the fact that despite non-conformance the patient had a good outcome be the basis for an investigation (Safety-2 approach)? At the end of the day, as providers of healthcare ensuring as much as possible, what goes right in the delivery of healthcare at all our facilities is what matters most. It should not have occurred just by chance alone but

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should be the end result of the various Standard Operating Procedures (SOPs) practised by all level of healthcare staff.

SUMMARY

At present, although the rate error in healthcare seems stable, increasing demand for health services, and the increasing intensity and complexity of those services[8] imply that the number of patients harmed while receiving care will only increase, unless we find new and better ways to improve safety.[6]

We need to build on positive health patterns by identifying good 'assets' rather than look at deficits; health leaders shall work to create tipping points for change, reconnecting people so that everyone becomes a co-producer of a resilient healthcare system. This new proactive management would reflect and have a deep understanding of day to day activities, allowing room for improved performance variability, yet not restraining the emergence of expertise, hence enhancing patient safety.

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