What’s so tough about patient safety?

Mary Dixon-Woods
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• It’s hard to know whether care is safe
• Fugitive knowledge and structural secrecy
• Ironies of measurement
• Magical thinking in safety improvement
• Getting the technical stuff and the implementation right
• The problem of many hands
It’s hard to know whether care is safe
No single measure
National Hospital Ratings Systems Share Few Common Scores And May Generate Confusion Instead Of Clarity

ABSTRACT Attempts to assess the quality and safety of hospitals have proliferated, including a growing number of consumer-directed hospital rating systems. However, relatively little is known about what these rating systems reveal. To better understand differences in hospital ratings, we compared four national rating systems. We designated “high” and “low” performers for each rating system and examined the overlap among rating systems and how hospital characteristics corresponded with performance on each. No hospital was rated as a high performer by all four national rating systems. Only 10 percent of the 844 hospitals rated as a high performer by one rating system were rated as a high performer by any of the other rating systems. The lack of agreement among the national hospital rating systems is likely explained by the fact that each system uses its own rating methods, has a different focus to its
Measuring rates of harm

• Very easy to underestimate the technical difficulties of measurement
• Instrumentation is poor and difficult to use
What Counts? An Ethnographic Study of Infection Data Reported to a Patient Safety Program

MARY DIXON-WOODS, ¹ MYLES LESLIE, ² JULIAN BION, ³ AND CAROLYN TARRANT ¹
Measuring harms

• Challenges in establishing data collection systems are formidable

• Issues of comparability poorly understood
Past harm

• Important but imperfect good guide to current safety
Incubation period

- Latent errors and events accumulate
- Failures of intelligence
- Drifts in what is considered acceptable or unacceptable
- Discounting of warning signs
Another cause of defect in the art of medicine and consequently of its contempt is that there have not been Hospitalls for the accommodating of sick people, Rich as well as Poor, so instituted and fitted as to encourage all sick persons to resort unto them—Every sort of such hospitalls to differ only in splendor, but not at all in the Sufficiency for the means and remedy for the Patient’s health. For by such means the most able understandings might be encouraged, equally with the best of the professions, to spend and to dedicate themselves wholly to this faculty; and a man shall learn in a well regulated hospital, where he may within halfe an hower’s time observe his choice of 1000 patients, more in one yeare than in ten without it, even by reading the best Books that can be written. For, as one may learn to know and distinguish a face better by one minut’s Inspection than by reading ten sheets of paper in the description of it, So wee may learn more of sick people by the Joynt assistance of all our sensces together than by the lame descriptions of words alone.”
Safer Clinical Systems: evaluation findings

Learning from the independent evaluation of the second phase of the Safer Clinical Systems programme

Mary Dixon-Woods, Graham Martin, Carolyn Tarrant, Julian Bion, Chris Coeuchel, Peter Promvont, Liz Brownlee, Liz Shone, Liz Sutton, Janet Williams, Diana Kerirty, Tom Woodcock

Evaluation
December 2014

http://www.health.org.uk/
Healthcare systems

• Piecemeal systems – nobody has ever designed them
• How they function in practice is often poorly understood
• Ad hoc improvisations and adaptations are the norm
• Limited understanding of what it takes to achieve peak performance
• The blunt end often has very poor grasp of the operational detail at the sharp end
We designed the next studies to include a variety of norms in order to address two questions. We wanted to determine whether the cross-norm inhibition effect was restricted to generally accepted social norms or whether, as expected by the goal-framing theory, it also extended to local ordinances by the police or even to normative requests set up by private companies. We also wanted to determine how far the influence would go. In other words, would a norm violation just affect relatively light infractions, such as littering, or would it go so far as to affect the willingness to violate such serious norms as “thou shalt not steal”?

For study 2, we used a police ordinance as a contextual norm and “no trespassing” (as ordered by the police) as the target norm in the setting of a car park. Thus, both contextual and target norms were not general social norms but rules set up by the local police for a particular local situation. A temporary fence (set up by us) closed off the main entrance for people who came to pick up their car, but a gap of about 50 cm was left open in the fence (Fig. 2). We attached two signs to the temporary fence: just 60 cm apart and directly next to the gap. The right sign (our contextual norm) indicated that it was prohibited to lock bicycles to the fence. The left sign (our target norm) made clear that it was prohibited to use this entrance and that people had to use an alternative entrance to the car park, which required walking a 200-m detour. In the order condition, four bicycles standing 1 m before the fence were ostensibly not locked to the fence.

In the disorder condition, four bicycles were locked to the fence for everyone to see. The dependent variable was whether pedestrians conformed to the “no throughway” sign (the target
Fugitive knowledge and structural secrecy
Fugitive knowledge

- Evades capture
- May be forbidden
- Uncertain evidence
Silencing and secrecy

“the way that patterns of information, organizational structure, processes, and transactions, and the structure of regulatory relations systematically undermines the attempt to know” (Vaughan: The Challenger Launch Decision)
Normalization of deviance

- Poorly designed systems
- Workarounds and short-cuts
- No harm, no foul mentality makes it hard to challenge

http://30yearoldninja.com/10-absurd-cartoons-inspire-disturb/
Culture and behaviour in the English National Health Service: overview of lessons from a large multimethod study

Mary Dixon-Woods, Richard Baker, Kathryn Charles, Jeremy Dawson, Gabi Jerzembek, Graham Martin, Imelda McCarthy, Lorna McKee, Joel Minion, Piotr Ozieranski, Janet Willars, Patricia Wilkie, Michael West

ABSTRACT
Background Problems of quality and safety

High-quality care. Organisations need to put the patient at the centre of all they do. Get smart.
Intelligence

• Problem-sensing versus comfort-seeking behaviours
1795, Aberdeen

A TREATISE ON THE EPIDEMIC PUERPERAL FEVER OF ABERDEEN.

BY ALEXANDER GORDON, M.D.
PHYSICIAN TO THE DISPENSARY.

LONDON: PRINTED FOR J. AND W. ROBINSON, PATERNOSTER ROW. 1795.
1843, Boston
“Doctors are gentlemen, and a gentleman’s hands are clean.”
(Charles Meigs)
1861, Vienna
Entitlement to speak

• Job status or experience
• Evidentiary support
• Ability to use personal social capital and tolerate threats to it

https://www.flickr.com/photos/medilldc/5815309247
Avoiding conflict is often a priority
Listening is not a simple function of hearing
The problem of many voices
January 2005, Texas

- Exceptional degree of fear of catastrophic incidents
- Workers feeling blamed when they got hurt
- Production pressures
- Managers forced to make compromises
March 2005, Texas

- Hydrocarbon vapour cloud explosion kills 15, injures 170 more
April 20 2010, Gulf of Mexico

• Senior officials visited the rig to celebrate zero personal injuries for 7 years
The oil rig

- Senior officials visited the rig to celebrate zero personal injuries for 7 years
- Later that day, the rig caught fire
The oil rig

• Senior officials visited the rig to celebrate zero personal injuries for 7 years
• Later that day, the rig caught fire
• Two days later, it sank
The oil rig

• Senior officials visited the rig to celebrate zero personal injuries for 7 years
• Later that day, the rig caught fire
• Two days later, it sank
• The oil spill caused the worst environmental disaster in US history
March 2010, Gulf of Mexico

Study: Deepwater Horizon workers were afraid to report safety issues

By Allan Chernoff, CNN
July 22, 2010 7:08 p.m. EDT

(CNN) -- A confidential report on safety conditions aboard the Deepwater Horizon oil rig, conducted about one month before the rig's explosion, points to widespread fear of reprisal for reporting employee mistakes that could undermine safety aboard the rig.

"There was a stated fear of reprisal related specifically to the reporting of dropped objects," states an executive summary of the report obtained by CNN.

Study highlights:
- 46.3 percent of participants felt that, if their actions led to a potentially risky situation (e.g., forgetting to do something, damaging equipment, dropping an object from height), they could report it
Ironies of measurement
Policy space

• Multiple bodies can exercise control functions in a healthcare system
• *Even* when they are not explicitly defined as regulators
Policy incentives

• Too often the incentives conflict, compete, or fail to cohere

• Unintended or unwanted consequences
Measuring too much

• In the US, National Quality Forum measures went from 200 in 2005 to over 700 in 2011
• US CMS introduced 65 new measures in 2011 alone
• At MGH, measuring consumes 1% of net patient service revenue
Priority thickets

• Too many externally imposed priorities
• Distraction, frustration, loss of focus and energy
Surgical Skill and Complication Rates after Bariatric Surgery

John D. Birkmeyer, M.D., Jonathan F. Finks, M.D., Amanda O'Reilly, R.N., M.S., Mary Oerline, M.S., Arthur M. Carlin, M.D., Andre R. Nunn, M.D., Justin Dimick, M.D., M.P.H., Mousumi Banerjee, Ph.D., and Nancy J.O. Birkmeyer, Ph.D., for the Michigan Bariatric Surgery Collaborative

ABSTRACT

BACKGROUND

Clinical outcomes after many complex surgical procedures vary widely across hospitals and surgeons. Although it has been assumed that the proficiency of the operating surgeon is an important factor underlying such variation, empirical data are lacking on the relationships between technical skill and postoperative outcomes.
• Clarity of goals
• Importance of warm, supportive human resources management
• Well-functioning teams
Walkrounds in Practice: Corrupting or Enhancing a Quality Improvement Intervention?

A Qualitative Study

Graham P. Martin, Piotr Ozieranski, Janet Willars, Lorna McKee, Kathryn Charles, Joel T. Minion, Mary Dixon-Woods
Measurement done badly

• Illusion of control
• Blindsight
Performativity of measurement
The reactivity of measurement

• Measurement acts on what it measures

Rankings and Reactivity: How Public Measures Recreate Social Worlds

Wendy Nelson Espeland
Northwestern University

Michael Sauder
University of Iowa

Recently, there has been a proliferation of measures responding to demands for accountability and transparency. Using the example of media rankings of law schools, this article argues that the methodological concept of reactivity—the idea that people change their behavior in reaction to being evaluated, observed, or measured—offers a useful lens for disclosing how these measures effect change. A framework is proposed for investigating the consequences, both
Two known reactive effects

- Gaming and effort substitution
Targets and terror

• People become adept at working out what they need to do to survive performance management.
Eroding the Denominator
The Incomplete Story of Door-to-Balloon Time Reporting

To the Editor: Door-to-balloon time (DTB) is the focus of national guidelines, and intense efforts to reduce it have been a core component of many national quality improvement campaigns. Recently, it has been the high point of advertisement campaigns by hospital systems and ultimately might be used to reward performance by payers. It is now publicly reported by the Centers for Medicare & Medicaid Services (CMS) and thus=h

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![Image of a balloon帮你到床边](image.png)
Effort substitution

• Focusing effort on the thing being measured
• Taking your eye off other balls
Outbreaks of unmonitored infections

- May occur when some infections are monitored but others are not

Other managerial imperatives were given greater priority than the control of infection. At the most senior level of management, there was a lack of effective leadership, accountability and support for the control of infection. The director of infection prevention and control had not persuaded the board to give sufficient priority to the control of infection in general and to the control of *C. Difficile* in particular. The achievement of the Government's targets was seen as more important than the management of the clinical risk inherent in the outbreaks of *C. Difficile*.

Improving Quality and Safety of Care Using “Technovigilance”: An Ethnographic Case Study of Secondary Use of Data from an Electronic Prescribing and Decision Support System

MARY DIXON-WOODS,¹ SABI REDWOOD,² MYLES LESLIE,³ JOEL MINION,¹ GRAHAM P. MARTIN,¹ and JAMIE J. COLEMAN⁴

¹University of Leicester; ²School of Health and Population Sciences, University of Birmingham; ³Armstrong Institute for Patient Safety and Quality, Johns Hopkins Medicine; ⁴University of Birmingham
Bureaucratised, defensive management

• Reactive
• Focused on auditable moments and visible traces of compliance
• Proliferation of forms, procedures and rules
Magical thinking in safety improvement
Conspiracy of enthusiasm

- Specific reforms are advocated as though they were certain to be successful...We must be able to advocate without that excess of commitment that blinds us to reality testing” (Donald Campbell, 1969: 72)
Magical thinking in improvement programs
Demystifying theory and its use in improvement

Frank Davidoff,1 Mary Dixon-Woods,2 Laura Leviton,3 Susan Michie4

ABSTRACT
The role and value of theory in improvement work in healthcare has been seriously underrecognised. We join others in proposing that more informed use of theory can strengthen improvement programmes and facilitate the evaluation of their effectiveness. Many professionals, including improvement practitioners, are unfortunately mystified—and alienated—by theory, which discourages them from using it in their work. In an effort to demystify theory we make the point in this paper that, far from being discretionary or superfluous, theory ('reason-giving'), both informal and formal, is intimately woven into virtually all human endeavour. We explore the special characteristics of grand, mid-range and programme theory, consider the consequences advantage of informal and formal theory in planning and executing improvement efforts.3 It is of course possible to achieve high levels of quality and safety on the basis of intuition derived from experience alone, with little evident help from formal theory. The few successful examples that exist do not, however, help to build a science. In this article, we join others in arguing that the explicit application of theory could shorten the time needed to develop improvement interventions, optimise their design, identify conditions of context necessary for their success, and enhance learning from those efforts.4-9 The need for more effective use of formal theory in improvement is increasingly pressing, because personal
Introduce an incident reporting system

Errors go down
Then a miracle occurs.

Introduce an incident reporting system.

Errors go down.
Not optimising design of interventions
Failure to be aware of unintended consequences

• Ironies of automation
In safety improvement work....

- Limited understanding of the mechanisms
- Poor descriptions of intervention, implementation and context
- Discounting of the organisational, social and emotional work
A Surgical Safety Checklist to Reduce Morbidity and Mortality in a Global Population

Alex B. Haynes, M.D., M.P.H., Thomas G. Weiser, M.D., M.P.H.,
William R. Berry, M.D., M.P.H., Stuart R. Lipsitz, Sc.D.,
Abdel-Hadi S. Breizat, M.D., Ph.D., E. Patchen Dellinger, M.D.,
Teodoro Herbosa, M.D., Sudhir Joseph, M.S., Pascience L. Kibatala, M.D.,
Marie Carmela M. Lapitan, M.D., Alan F. Merry, M.B., Ch.B., F.A.N.Z.C.A., F.R.C.A.,
Krishna Moorthy, M.D., F.R.C.S., Richard K. Reznick, M.D., M.Ed., Bryce Taylor, M.D.,
and Atul A. Gawande, M.D., M.P.H., for the Safe Surgery Saves Lives Study Group*
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**P value** 0.003 < 0.001

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<td>Before</td>
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**P value** < 0.001
Methods, Tools, and Strategies

Incorporating the World Health Organization Surgical Safety Checklist into Practice at Two Hospitals in Liberia

Christina T. Yuan, MPH; Denise Walsh, PhD, RN; James L. Tomarken, MD; Rachelle Alpern, BA; John Shakpeh, CRNA; Elizabeth H. Bradley, PhD

An estimated 234 million major surgical operations are performed annually throughout the world, making surgical care both an integral part of health care and a major source of complications and death. Although the risk of complications

Article-at-a-Glance

Background: The impact of the World Health Organization's Patient Safety Programme's 19-item Surgical Safety
• In hospital 1, the checklist associated with improved outcomes but not improved compliance

• In hospital 2, improved compliance but not improved outcomes
Introduction of Surgical Safety Checklists in Ontario, Canada

David R. Urbach, M.D., Anand Govindarajan, M.D., Refik Saskin, M.Sc., Andrew S. Wilton, M.Sc., and Nancy N. Baxter, M.D., Ph.D.

ABSTRACT

BACKGROUND
Evidence from observational studies that the use of surgical safety checklists results in striking improvements in surgical outcomes led to the rapid adoption of such checklists worldwide. However, the effect of mandatory adoption of surgical safety checklists is unclear. A policy encouraging the universal adoption of checklists by hospitals in Ontario, Canada, provided a natural experiment to assess the effectiveness of checklists in typical practice settings.

METHODS
We surveyed all acute care hospitals in Ontario to determine when surgical safety checklists were adopted. Using administrative health data, we compared operative mortality, rate of surgical complications, length of hospital stay, and rates of hospital readmission and emergency department visits within 30 days after discharge among patients undergoing a variety of surgical procedures before and after adoption of a checklist.

RESULTS
During 3-month periods before and after adoption of a surgical safety checklist, a total of 101 hospitals performed 109,341 and 106,370 procedures, respectively.

From the Institute for Clinical Evaluative Sciences (D.R.U., A.G., R.S., A.S.W., N.N.B.), the Department of Surgery (D.R.U., A.G., N.N.B.) and Institute of Health Policy, Management and Evaluation (D.R.U., N.N.B.), University of Toronto, the University Health Network (D.R.U.), Mount Sinai Hospital (A.G.), and Keenan Research Centre, Li Ka Shing Knowledge Institute, Department of Surgery, St. Michael's Hospital (N.N.B.) — all in Toronto. Address reprint requests to Dr. Urbach at 200 Elizabeth St., 10-214, Toronto, ON M5G 2C4, Canada, or at david.urbach@uhn.ca.

Drs. Urbach and Baxter contributed equally to this article.

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Evaluation of the Effectiveness of a Surgical Checklist in Medicare Patients.

Reames BN¹, Scally CP, Thumma JR, Dimick JB.

Abstract

BACKGROUND:: Surgical checklists are increasingly used to improve compliance with evidence-based processes in the perioperative period. Although enthusiasm exists for using checklists to improve outcomes, recent studies have questioned their effectiveness in large populations.

OBJECTIVE:: We sought to examine the association of Keystone Surgery, a statewide implementation of an evidence-based checklist and Comprehensive Unit-based Safety Program, on surgical outcomes and health care costs.

METHOD:: We performed a study using national Medicare claims data for patients undergoing general and vascular surgery (n=1,002,241) from 2006 to 2011. A difference-in-differences approach was used to evaluate whether implementation was associated with improved surgical outcomes and decreased costs when compared with a national cohort of nonparticipating hospitals. Propensity score matching was used to select 10 control hospitals for each participating hospital. Costs were assessed using price-standardized 30-day Medicare payments for acute hospitalizations, readmissions, and high-cost outliers.

RESULTS:: Keystone Surgery implementation in participating centers (N=95 hospitals) was not associated with improved outcomes. Difference-in-differences analysis accounting for trends in nonparticipating hospitals (N=950 hospitals) revealed no differences in adjusted rates of 30-day mortality (relative risk (RR)=1.03; 95% confidence intervals (CI), 0.97-1.09), any complication (RR=1.03; 95% CI, 0.99-1.07), reoperations (RR=0.89; 95% CI, 0.56-1.22), or readmissions (RR=1.01; 95% CI, 0.97-1.05). Medicare payments for the index admission increased following implementation ($516 average increase in payments; 95% CI, $210-$823 increase), as did readmission payments ($564 increase; 95% CI, $89-$1040 increase). High-outlier payments ($965 increase; 95% CI, $974 decrease to $2904 increase) did not change.

CONCLUSIONS:: Implementation of Keystone Surgery in Michigan was not associated with improved outcomes or decreased costs in Medicare patients.

ABSTRACT
Objective: Bold claims have been made for the ability of the WHO surgical checklist to reduce surgical morbidity and mortality and improve patient safety regardless of the setting. Little is known about how far the challenges faced by low-income countries are the same as those in high-income countries or different. We aimed to identify and compare the influences on checklist implementation and compliance in the UK and Africa.

Design: Ethnographic study involving observations, interviews and collection of documents. Thematic analysis of the data.

Setting: Operating theatres in one African university hospital and two UK university hospitals.

Participants: 112 h of observations were undertaken. Interviews with 39 theatre and administrative staff were conducted.
• No doubt the principles behind the checklist are good ones
• But the mechanisms through which it works (technical, implementation, context) need to be clearer
• It’s not as simple as saying “here it is, off you go”
Getting the technical stuff and the implementation right
Some simple but often neglected questions

• Does the technical intervention work?
• Does the implementation strategy work?
• Were there features of context that intervened?
Consider the treatment that Charles II endured by the physicians of his day: “A pint of blood was extracted from his right arm, and a half-pint from his left shoulder, followed by an emetic, two physics, and an enema comprising fifteen substances; the royal head was then shaved and a blister raised; then a sneezing powder, more emetics, and bleeding, soothing potions, a plaster of pitch and pigeon dung on his feet, potions containing ten different substances, chiefly herbs, finally forty drops of extract of human skull, and the application of bezoar stone; after which his majesty died.” (Van Dyke, 1947; for a more complete description, see Haggard, 1929).
Learning from mistakes in clinical practice guidelines: the case of perioperative β-blockade

Mark D Neuman¹,², Charles L Bokš¹,²,³, Lee A Fleisher¹,²

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Published Online First 18 August 2014
Implementation thwarted

The Joint Commission Journal on Quality and Patient Safety

Infection Prevention and Control

How Active Resisters and Organizational Constipators Affect Health Care–Acquired Infection Prevention Efforts


Health care–associated infection (HAI) is a common and costly patient safety problem. The Centers for Disease Control and Prevention (CDC) estimates that HAI leads to approximately 99,000 deaths per year in hospitals in the United States and an annual attributable cost of $6.7 billion. Given the potential for prevention, the Centers for Medicare & Medicaid Services (CMS) will no longer reimburse hospitals for the extra cost of caring for patients who develop certain infections during hospitalization, such as infection due to either urinary or vascular catheter use.

Catheter-associated urinary tract infection (CAUTI), central venous catheter–related bloodstream infection (CRBSI), and...
Effect of Medicare’s Nonpayment for Hospital-Acquired Conditions Lessons for Future Policy

Teresa M. Waters, PhD1; Michael J. Daniels, ScD2,3; Gloria J. Bazzoli, PhD4; Eli Perencevich, MD5,6; Nancy Dunton, PhD7; Vincent S. Staggs, PhD8; Catima Potter, MPH7; Naleef Fareed, PhD9; Minzhao Liu, MS, PhD10; Ronald I. Shorr, MD, MS11,12

The problem of many hands
QI is an essential capacity for healthcare organisations
QI as the solution to patient safety?
The problem of ‘many hands’

“when many hands are involved... the profusion of agents obscures the location of agency”  (Thompson, 2014)
• Many of the issues underlying safety and quality are BIG and HAIRY
Healthcare

• Consistently treats patient safety as an organizational problem
• Not an institutional or global one.
Structural amnesia: 1986
METHOTREXATE
4-Amino-N^10^-methyl
pteroylglutamic acid
TABLETS
2.5 mg.

WARNING: Blood counts should be taken weekly. Discontinue or reduce dosage immediately at first sign of ulceration or bleeding in mouth, gastrointestinal ulceration or bleeding, diarrhea or marked depression of bone marrow.

CAUTION: Federal law prohibits dispensing without prescription.

LEDERLE LABORATORIES DIVISION
American Cyanamid Company,
Pearl River, N.Y.
Regional Tender Award for ID Bands

South Eastern Health and Social Care Trust
Local, non-scaled solutions can be dangerous
Conclusions
Patient safety as a social problem

• Many bad outcomes are socially organized – in principle they can be anticipated, prevented or mitigated

• Organizational and institutional sclerosis obscures danger and frustrates rapid response
Intelligence

• If you’re not measuring, you’re not managing
Intelligence

• If you’re not measuring, you’re not managing
Intelligence

• If you’re not measuring, you’re not managing
• If you’re measuring stupidly, you’re not managing
Intelligence

• If you’re not measuring, you’re not managing
• If you’re measuring stupidly, you’re not managing
• If you’re only measuring, you’re not managing
Coordinating action

• Sometimes elements of system need close alignment and integration, sometimes need to operate largely independently
• Need identified points of authority and arrangements for coordination, but also agility

https://www.flickr.com/photos/artotemsco/4761551981/
Conclusions

• The science of patient safety needs to mature
• Better intelligence
• Better design of improvement efforts
• Better evaluation
• Better understanding of relationship between blunt end and sharp end of systems
Thanks

• Some research reported here was funded as an independent programme by the Policy Research Programme in the Department of Health. The views and opinions expressed in this report are those of the authors and do not necessarily reflect those of the Policy Research Programme, nor the Department of Health.

• Health Foundation
• Wellcome Trust
• Wellcome Trust Image Collection