



Minnesota Hospital Association

## **Patient Safety Manifesto**

### **Introduction**

This patient safety manifesto is a tool that originated from three years of work during the Harvard Executive Session on Patient Safety. The manifesto is leadership driven and is a powerful intervention that executives and boards can implement in order to create a culture of patient safety.

While recognizing the importance of executive hospital leadership in advancing patient safety, it is also important to address the role of all other members of the hospital staff and include the patient and their family. With this in mind, the Minnesota Alliance for Patient Safety (MAPS) Best Practices Subcommittee has adapted this tool to craft an instrument that is relevant to Minnesota Leaders and all those involved in the delivery of health care. The intent is to educate those involved in the delivery of health care about the magnitude and importance of the issue and to provide general suggestions for improving patient safety in their own sphere of influence.

This document has been approved for distribution by the Minnesota Alliance for Patient Safety (MAPS).

### **An Urgent Problem**

Medical errors and accidents take an enormous toll causing patient injuries and deaths among patients in U.S. hospitals. Medical accidents increase costs by \$1.3 billion. The cost of outpatient-related medication errors is estimated to exceed \$70 billion. Medical accident is a public health catastrophe

Patient safety is an ethical imperative for health care providers individually and collectively. Safety (*primum non nocere*) is the essential attribute of quality care.

Although the moral imperative to do no harm is sufficient to drive patient safety efforts, this work makes good business sense as well. It builds consumer confidence and perhaps market share. CEOs should direct their financial officers to examine the financial impact of medical error and accidents in their organizations.

There is substantial evidence that medical accident is a product of risks and latent failures in processes and systems in which care is delivered and received.

Human beings are fallible, and therefore dependent on the teams, processes, and systems that can be barriers to safety and enhance safety.

Despite its prevalence and burden, most health care executives, clinicians, and consumers are unaware of the extent of the problem. This is attributable to several factors including systematic underreporting, the myth of perfect performance, fear of punishment, and acceptance of mediocre performance as standard care.

We must forge a coalition on behalf of patient safety. The coalition should include health care executives, consumer groups, medical and surgical specialty societies, hospital associations, purchasers of health care, and drug and device manufacturers.

### **The Challenge**

Patient safety presents a set of difficult challenges for health care leaders. How do we design and operate processes and systems that protect against error or failure ever harming a patient? How do we gain the cooperation of autonomous professionals? How can we create an infrastructure for improvement? How do we create an environment in which reporting error is the standard and failure to report is the risk? How do we deal with the negative publicity and vulnerability to legal liability associated with open discussions about mistakes, errors, and accidents? How do we help patients, families, and clinicians deal with errors, failures, and accidents that result in patient harm?

### **Executive Leadership (including the Board of Trustees)**

Health care executive leadership must embrace patient safety as a key strategic priority, employing lessons learned from effective executive leadership inside and outside of health care organizations.

Because most medical accidents and error involve problematic processes rather than the incompetence or malice of individual workers, improvement strategies that punish clinicians are misguided. In fact, responsibility for patient safety rests squarely on the shoulders of executives and managers who design and oversee the delivery of care.

Making organizational change requires leaders' time and attention. Patient safety work must become a critical part of the agenda and reviewed regularly with the senior management team.

The work of the executive is to communicate the objective in multiple channels and in a relentless fashion. Improving patient safety is a long-term investment, and the executive must bear personal responsibility for creating a culture of patient safety.

Health care organizations must remain accountable to their patients and to the community by disclosing errors that result in harm, providing fair compensation for injuries and introducing measures to prevent recurrence.

Health care executives should hold themselves accountable for patient safety in the same way they are accountable for financial performance, market share, and consumer satisfaction.

### **All Management (from the Board down to Line/Staff Management)**

Measurement in patient safety is at once problematic and essential. Since underreporting is pervasive, information about error, failure, and near-misses is scarce. Creating a non-punitive reporting system is essential. Sharing information about errors with frontline workers will build collaboration and shared mission. Increasing the frequency of measurement can accelerate the pace of change.

While recognizing the features of health care that make it a distinct environment we can learn much about medical error, accident, and patient safety from safety-minded industries such as aviation, aerospace, manufacturing, and nuclear power. Health care leaders should learn about medical accident by personally investigating a case, consulting with a human factors expert, or reading about human factors engineering and cognitive psychology.

Health care leaders should implement patient safety “best practices” identified by institutions such as, the Institute for Safe Medication Practices (ISMP), the National Patient Safety Foundation, and others. They should inventory their organizations with respect to patient safety initiatives and report the results. Medication safety, falls, and seclusion/restraint are areas that require explicit attention, due to the magnitude of harm and vulnerability of potential victims.

### **All Health Care Stakeholders (including patients and their families)**

Error prevention is the job of every health professional and of everyone who works in a health care organization. Ongoing training and careful recruitment are as essential in health care organizations as they are in other high-reliability organizations.

Health care organizations should embrace the tools of rapid cycle improvement championed by organizations such as the Institute for Healthcare Improvement. Nolan's concepts of "will, ideas, and execution" offer a useful model for thinking about institutional change. (Berwick)

Leaders should strive to create a culture of safety in health care. A safety culture involves the alignment of organizational objectives and rewards. Ingredients of a safety culture include free and open communication, interdisciplinary work teams, elimination of hierarchy, frontline autonomy, blameless reporting, and recruitment and training with patient safety in mind.

Gross negligence and unethical behavior are barriers to patient safety and will not be shielded. Professional misconduct is a grave threat to patient safety and should be dealt with accordingly.

### **Governing Entities (Federal and State Governments, Regulators, Accreditors, etc.)**

Errors that do not result in harm ("non-consummated errors") must be protected from legal discovery so we can learn from them. Fear of discovery and punishment of clinicians' accidents drives information underground and decreases organizational learning.

Regulators and accreditation organizations should embrace initiatives that enhance safety. "Searching for the bad apple" is misguided and counterproductive except in cases of gross professional negligence or ethical breach. Regulations and guidelines should encourage multi-causal analysis and facilitate blameless reporting.

The federal government should play a more active role in patient safety, requiring pharmaceutical and device industries to complete and disclose human factors testing of naming, packaging, and labeling of medications and post-market surveillance of adverse events.

Government should support research in patient safety, modeling this effort on aviation safety and the role of the NASA-Ames Research Laboratory. Research is needed in the management, implementation, and spread of efforts to improve patient safety.

### **Patients and their Families — Partnership with Providers/Accountability/Involvement**

To reduce the likelihood that patients will become the victim of a medical accident, patient and family partnerships are essential. Information,

education, and opportunities for patients and families to be active participants in care can be facilitated by:

- Asking questions.
- Alerting the physician to allergies, discuss the patient's diet, and mention any medications or dietary supplements they take.
- Asking the doctor for copies of their medical records, and bringing them along whenever they see another physician.
- Before taking any medications, asking what they are, what they're for and what they can expect from them.
- Asking the doctor to rewrite a prescription if it is not clear and legible.

Additionally, if facing surgery or another serious medical condition, patients and families should:

- Research the condition and treatment options.
- Consider getting a second opinion.
- Have accompaniment to pre-surgery sessions to help ask questions, take notes and understand what to expect before and after surgery.
- Have accompaniment to the hospital to serve as advocate and help make sure wishes are carried out.

Once admitted to a health care facility (hospital, nursing home, etc.), facility leadership should encourage the following policies:

- "Nothing about me without me." This policy embraces practices and tools to involve the patient and family in decision-making and participation in the care process to the extent they are willing and able.
- "If it looks wrong, it is wrong." This is a policy that not only legitimizes, but also requires anyone who perceives a risk to safety to stop the process, including the patient and family.
- Disclosure and truth telling. This policy provides guidance in working with patient and families in the face of an error or medical accident. Elements of disclosure include:
  - A prompt and compassionate explanation of what is understood about what happened and the probable effects
  - Assurance that a full analysis will take place to reduce the likelihood of a similar event happening to another patient

- What changes are being made based on the analysis
- An apology and acknowledgement of accountability

**Conclusion**

This manifesto should be embraced by all MAPS organizations — it is a call-to-action for all MAPS participants. Patient safety needs to be driven by leadership and relentlessly communicated throughout an organization, with a constant eye to the needs of the patient. This manifesto is a public declaration of the critical importance of improving patient safety and the commitment of all MAPS members to doing so.