The role of healthcare management in improving Patient safety

Beyrouth

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September 9, 2017
Since *To Err is Human* (2000)...

- **An unchanging incidence of Adverse events**
  - ~ 10% of all hospital stays
  - 50% of them are avoidable

  ✓ Wachter RM. Patient safety at ten: unmistakable progress, troubling gaps. Health Affairs, 2010

- **The major role of Organizational causes**
  - ~ 70 % of organizational causes
  (lack of communication/coordination, misunderstanding, etc.)
  - Deming. Quality = 70% Organization+ 30% Best Practices

An hypothesis:

The role of Healthcare management in improving Patient Safety

• A better understanding of the Healthcare organisation

• New methods for Preventing and Assessing Adverse Events
  (evidence-based management)
Health Care Organization: A better understanding

• The process of care: the patient pathway
  – Stochastic (process-outcomes)
  – Diverse/Unique
  – Co-constructed with the patient

  How to manage uniqueness on a large scale?

• The work organization
  – Flexible (balance between standardisation and adaptation)
  – Managerial skills of human resources
  – An important activity of coordination
  – The role of teamwork
  – Involving the patient

✓ Kimberly J., Minvielle E. New England Journal of Medicine, 2017
Methods for Preventing Adverse Events

• A flexible work organization
  – Safety Skills, Teamwork, Learning process, Safety psychological environment

  More than

• A total standardised approach (guidelines, norms, etc.)
  – Too many processes to control
  – Use the guidelines for specific high-risk actions
  – The guidelines must be used as « reminders »
Methods for Preventing Adverse Events
Managing the Implementation of Safety tools

Safety tools: Accreditation, Safety Indicators, Surgical Check-list

Fourcade A., Blache JL., Grenier C., Bourgain JL, Minvielle E., Barriers to staff adoption of a surgical safety checklist. BMJ Quality and Safety, 2012
Methods for Preventing Adverse Events
Managing factors that leads to a REAL USE of Safety tools

Surgical Chek-list

Professionnals context
("Sensemaking" and Practice based Theories)

Randomized trial + Evidence from the aeronautic sector = Mandatory

(Official use)

Work Organisation
(Which representation of the work organisation?)

Improvement

Real Use:
- Bureaucratic activity
- Gaming
- Learning
- Others

Ability to trigger cause of improvements ("actionable")
Methods for Assessing adverse events

- **Safety Indicators must capture organizational aspects**
  - Process measures are not so “old-fashioned”
    - More actionable than outcomes measures (e.g. mortality ratio)
    - Directly connected with the organization of work
    - Rewarding improvements rather than measures

Methods for Assessing adverse events

• Many Adverse Events have a unique mix of causes (Perrow, 2000)

• Root analysis methods must be used for learning and supporting safety skills more than for producing guidelines
Promising Future Directions...

• A relationship between Management Science and Patient safety

✓ The need to develop research at ground level (from the « real practices »)

✓ The question of inter-sectorial transfers (e.g. « check-list »)

✓ Research on specific methods for assessing organizational change on safety issues (not mimic clinical trial)

✓ The emergence of an evidence-based policy (demands from the Ministry of Health, High Authority for Health)
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- 15 Prof., 6 Associate Prof., 16 PhD students and post-doc, MSc Students