The role of healthcare management in improving Patient safety

Beyrouth

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Since *To Err is Human* (2000)…

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

✓ De Vries EN., et al. *Qual Saf Health Care* 2008
✓ Wachter RM. Patient safety at ten: unmistakable progress, troubling gaps. Health Affairs, 2010
✓ Free from Harm: Accelerating Patient Safety Improvement Fifteen Years after To Err Is Human. National Patient Safety Foundation, Boston, 2015.

- **The major role of Organizational causes**
  - ~ 70 % of organizational causes

(lack of communication/coordination, misunderstanding, etc.)

  - Deming. Quality = 70% Organization+ 30% Best Practices

✓Neale G., Woloshynowych M., Vincent C. Exploring the causes of adverse events in NHS hospital practice. Journal of The Royal Society of Medicine. 2001.
✓ Lawton R, et al. BMJ Qual Saf 2012

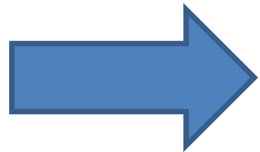
An hypothesis:
The role of Healthcare management in improving Patient Safety

- 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 »

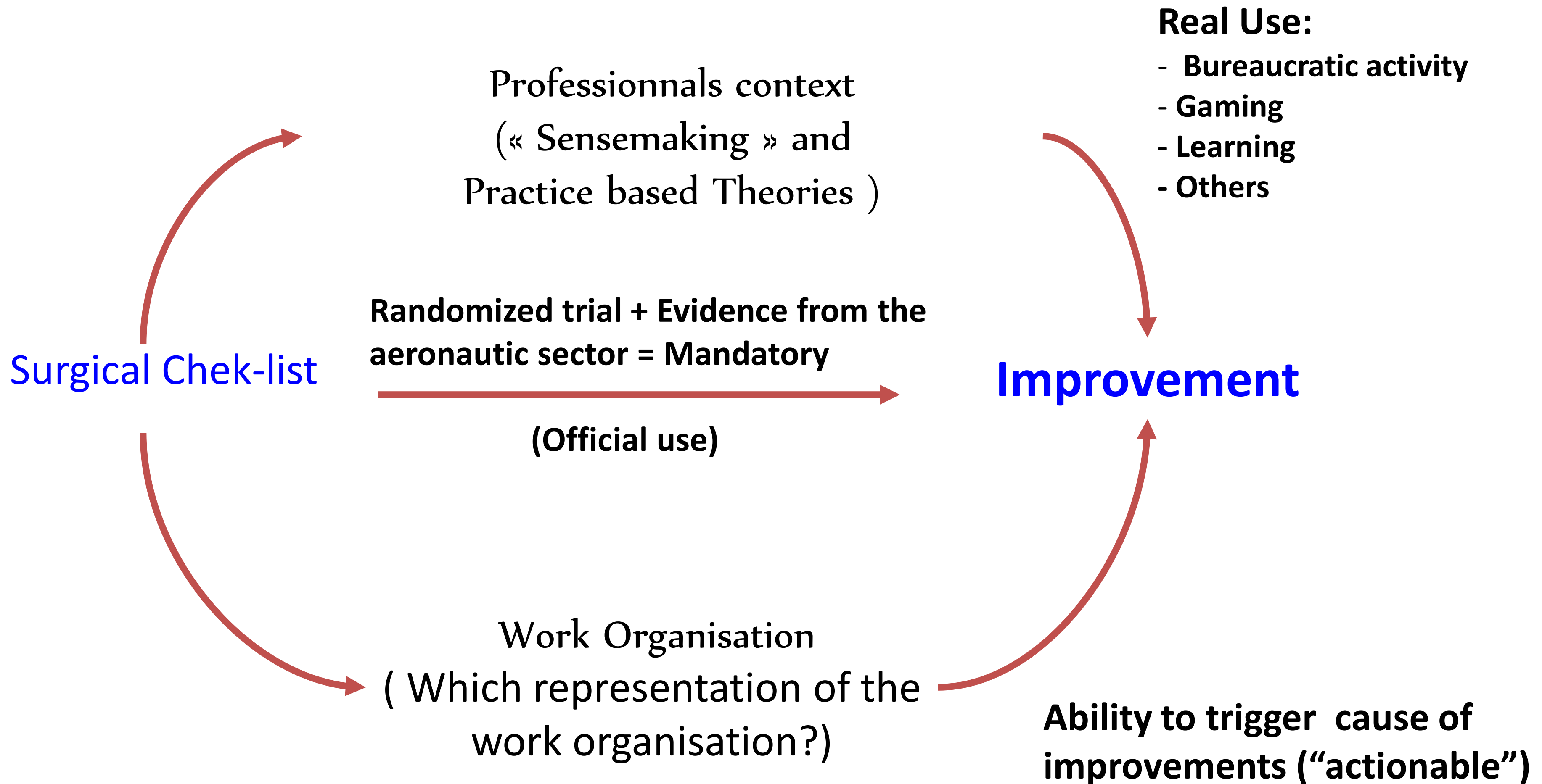
Methods for Preventing Adverse Events

Managing the Implementation of Safety tools

- ✓ Safety tools: Accreditation, Safety Indicators, Surgical Check-list
- ✓ Fou*rcade 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



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

✓ Loirat P, Ferrua M, Fourcade A., Lalloue B., Minvielle E. Should payment for performance depend on mortality? BMJ 2016

✓ *Werner R, Mc Nutt R. A new strategy to improve quality : rewarding actions rather than measures. Jama, 2009*

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

Welcome to France

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