Charles Vincent
René Amalberti

Safer Healthcare

Strategies for the Real World

Springer Open

Safer Healthcare

Charles Vincent • René Amalberti

Safer Healthcare

Strategies for the Real World

Springer Open

Charles Vincent
University of Oxford
Oxford, United Kingdom

René Amalberti
Haute Autorité de Santé
Paris, France

This work is supported by the Health Foundation, an independent charity working to improve the quality of healthcare.

ISBN 978-3-319-25557-6 ISBN 978-3-319-25559-0 (eBook)
DOI 10.1007/978-3-319-25559-0

Library of Congress Control Number: 2015957594

Springer Cham Heidelberg New York Dordrecht London

Printed on acid-free paper

Springer International Publishing AG Switzerland is part of Springer Science+Business Media (www.springer.com)

To Lucian Leape and James Reason

Preface

Healthcare has brought us extraordinary benefits, but every encounter and every treatment also carries risk of various kinds. The known risks from specific treatments are well established and routinely discussed by clinicians. Yet we also face risks from failures in the healthcare system, some specific to each setting and others from poor coordination of care across settings. For us, as patients, healthcare provides an extraordinary mixture of wonderful achievements and humanity which may be rapidly followed by serious lapses and adverse effects.

Patient safety has been driven by studies of specific incidents in which people have been harmed by healthcare. Eliminating these distressing, sometimes tragic, events remains a priority, but this ambition does not really capture the challenges before us. While patient safety has brought many advances, we believe that we will have to conceptualise the enterprise differently if we are to advance further. We argue that we need to see safety through the patient's eyes, to consider how safety is managed in different contexts and to develop a wider strategic and practical vision in which patient safety is recast as the management of risk over time.

The title may seem curious. Why 'strategies for the real world'? The reason is that as we developed these ideas we came to realise that almost all current safety initiatives are either attempts to improve the reliability of clinical processes or wider system improvement initiatives. We refer to these as 'optimising strategies', and they are important and valuable initiatives. The only problem is that, for a host of reasons, it is often impossible to provide optimal care. We have very few safety strategies which are aimed at managing risk in the often complex and adverse daily working conditions of healthcare. The current strategies work well in a reasonably controlled environment, but they are in a sense idealistic. We argue in this book that they need to be complemented by strategies that are explicitly aimed at managing risk 'in the real world'.

How the Book Came to Be Written

We are friends who have been passionate about safety for many years. We did not meet however until we were invited as faculty members to the memorable Salzburg International seminar on patient safety organised by Don Berwick and Lucian Leape in 2001.

The story of the book began in late 2013 with René's observation that the huge technological and organisational changes emerging in healthcare would have considerable implications for patient safety. Charles suggested that care provided in the home and community were an important focus and we planned papers addressing these subjects. We began to speak and meet on a regular basis, evolving a common vision and set of ideas in numerous emails, telephone calls and meetings. It quickly became evident that a new vision of patient safety was needed now, and that the emerging changes would just accelerate the present requirements. We needed a book to express these ideas in their entirety.

The particular characteristic of this book is that it has been really written by 'four hands'. In many jointly written books, chapters have clearly been divided between authors. In contrast, we made no specific allocations of chapters to either of us at any point. All chapters were imagined and developed together, and the ideas tested and hammered into shape by means of successive iterations and many discussions.

The work matured slowly. The essential ideas emerged quite quickly but it was challenging to find a clear expression, and the implications were much broader than we had imagined. We were also determined to keep the book short and accessible and, as is widely recognised, it is much harder to write a short book than a long one. We completed a first draft in April 2015 which was read by generous colleagues and presented to an invited seminar at the Health Foundation. We received encouragement and enthusiasm and much constructive comment and criticism which helped us enormously in shaping and refining the final version which was delivered to Springer in August 2015.

The Structure of the Book

In the first chapter of this book, we set out some of the principal challenges we face in improving the safety of healthcare. In the second, we outline a simple framework describing different standards of healthcare, not to categorise organisations as good or poor, but suggesting a more dynamic picture in which care can move rapidly from one level to another. We then argue that safety is not, and should not, be approached in the same way in all clinical environments; the strategies for managing safety in highly standardised and controlled environments are necessarily different from those in which clinicians must constantly adapt and respond to changing circumstances. We then propose that patient safety needs to be seen and understood from the perspective of the patient. We are not taking this perspective in order to respond to policy imperatives or demands for customer focus but simply because that is the reality we need to capture. Safety from this perspective involves mapping the risks and benefits of care along the patient's journey through the healthcare system.

The following chapters begin to examine the implications of these ideas for patient safety and the management of risk. In Chap. 5, we build on our previous understanding of the analysis of incidents to propose and illustrate how analyses across clinical contexts and over time might be conducted. The role of the patient and family in selection, analysis and recommendations is highlighted.

Chapter 6 outlines an architecture of safety strategies and associated interventions that can be used both to manage safety on a day-to-day basis and to improve safety over the long term. The strategies are, we believe, applicable at all levels of the healthcare system from the frontline to regulation and governance of the system. As we have mentioned, most safety improvement strategies aim to optimise care. Within this general approach, we distinguish focal safety programmes aimed at specific harms or specific clinical processes and more general attempts to improve work systems and processes. We suggest that these strategies need be complemented by strategies that are more concerned with detecting and responding to risk and which assume, particularly in a time of rising demand and financial austerity, that care will often be delivered in difficult working conditions. These three additional approaches are: risk control; monitoring, adaptation and response; and mitigation. Clinicians, managers and others take action every day to manage risk but curiously this is not generally seen as patient safety. We need to find a vision that brings all the potential ways of managing risk and safety into one broad frame. Optimisation strategies improve efficiency and other aspects of quality as much as they improve safety. In contrast, risk control, adaptation and recovery strategies are most concerned with improving safety.

In Chaps. 7, 8, and 9 we explore the use and value of this strategic framework and consider how safety should be addressed in hospitals, home and in primary care, paying particular attention to safety in the home. We have found it difficult to make hospitals safe, even with a highly trained and professional workforce within a relatively strong regulatory framework. We will shortly be trying to achieve similar standards of safety with a largely untrained workforce (patients and their carers) in settings not designed for healthcare and with almost no effective oversight or supervision. This may prove challenging.

We believe that an expanded vision of patient safety is needed now. However in Chap. 10 we argue that the forthcoming changes in the nature, delivery and organisational forms of healthcare make the transition even more urgent. The healthcare of the future, with much more care being delivered in the home under the patient's direct control, will require a new vision of patient safety necessarily focused on patients and their environment more than on professionals and the hospital environment. Discussions of new technologies and the potential for care being delivered in a patient's home are generally marked by unbridled optimism without any consideration of new risks that will emerge or the potential burden on patients, family and carers as they take on increasing responsibilities. The new scenario will bring great benefits, but also new risks which will be particularly prominent during the transitional period. For an active patient with a single chronic illness, empowerment and control of one's treatment may be an unalloyed benefit, provided professionals are available when required. When one is older, frail or vulnerable, the calculation of risk and benefit may look very different.

In the final two chapters, we draw all the material together and present a compendium of all the safety strategies and interventions discussed in this book. We describe this as an 'incomplete taxonomy' as we are conscious that, if this approach is accepted, there is much to be done to map the landscape of strategies and

interventions. These interventions can be selected, combined and customised to context. We hope that this framework will support frontline leaders, organisations, regulators and government in devising an effective overall strategy for managing safety in the face of austerity and rising demand. In the final chapter, we set out some immediate directions and implications for patients, clinical staff and managers, executives and boards, and those concerned with regulation and policy. Financial pressures and rising demand can often distract organisations from safety and quality improvement which can temporarily become secondary issues. In contrast, we believe that financial pressures provoke new crises in safety and that we urgently need an integrated approach to the management of risk.

We know that these ideas need to be tested in practice and that ultimately the test is whether this approach will lead in a useful direction for patients. We believe very strongly that the proposals we are making can only become effective if a community of people join together to develop the ideas and implications.

Oxford, UK — Charles Vincent
Paris, France — René Amalberti

Acknowledgements and Thanks

We gained great encouragement from the initial responses to an earlier draft of the book. We also received a host of ideas, suggestions and insightful comments which illuminated specific issues or identified flaws, infelicities and things that were just plain wrong. Where we have included specific quotes or examples provided by individuals we have cited them in the text, but all the comments we received were valuable and led to important changes to both the structure and the content of the book. The book you see today is very different from the draft originally circulated. We would like to thank the following people for their insights, suggestions and constructive criticism: Jill Bailey, Nick Barber, Maureen Bisognano, Jane Carthey, Bryony Dean Franklin, John Green, Frances Healey, Goran Henriks, Ammara Hughes, Matt Inada Kim, Jean Luc Harousseau, John Illingworth, Martin Marshall, Phillipe Michel, Wendy Nicklin, Penny Pereira, Anthony Staines and Suzette Woodward.

The Health Foundation is remarkable in encouraging the development of new ideas and giving people the freedom and time to attack challenging problems. We thank the Health Foundation for their enthusiasm and support for this book. Charles would in particular like to thank Jennifer Dixon, Nick Barber, Jo Bibby, Helen Crisp and Penny Pereira for enabling a career transition and for their personal support and encouragement over many years. Michael Howes brought life and colour to our tentative figures. We thank Nathalie Huilleret at Springer for her enthusiasm for the project, her personal oversight of publication and her willingness and encouragement to make this book Open Access and available to all.

Charles Vincent
René Amalberti
Oxford and Paris
August 2015