HEALTH QUALITY & SAFETY COMMISSION NEW ZEALAND

HEALTH QUALITY & SAFETY COMMISSION NEW ZEALAND

Kupu Taurangi Hauora o Aotearoa

Is Safety-II Clinician-Safety Too?

Medicolegal considerations in Safety-II

Wellington, December 13, 2018

Denys Court
MBChB, LLB, MRCOG, FRANZCOG, FACLM

Which statement(s) is/are true?

1. S-II *will make healthcare providers* (HCP) safer* as a consequence of making patients safer.

2. S-II *will raise the (legal) standard of care* and therefore will increase the risk of adverse findings against HCPs

3. S-II *increases expectations* of safety (in patients and communities) and may therefore increase the demand for HCP accountability when things go wrong

*clinicians, leaders, managers etc

An assertion –

For Safety-II to reach tipping point in healthcare, becoming an every-day-every-HCP system, it will necessitate ensuring that it is seen as supportive of the care we provide rather than increasing our accountability.

About clinician safety –

- Clinician safety is about both reality and perception:
  - Perceived/actual risk of litigation/complaint
  - Feeling supported in one's workplace
- A Just Culture is essential
  - Personal accountability appropriate for reckless behaviour

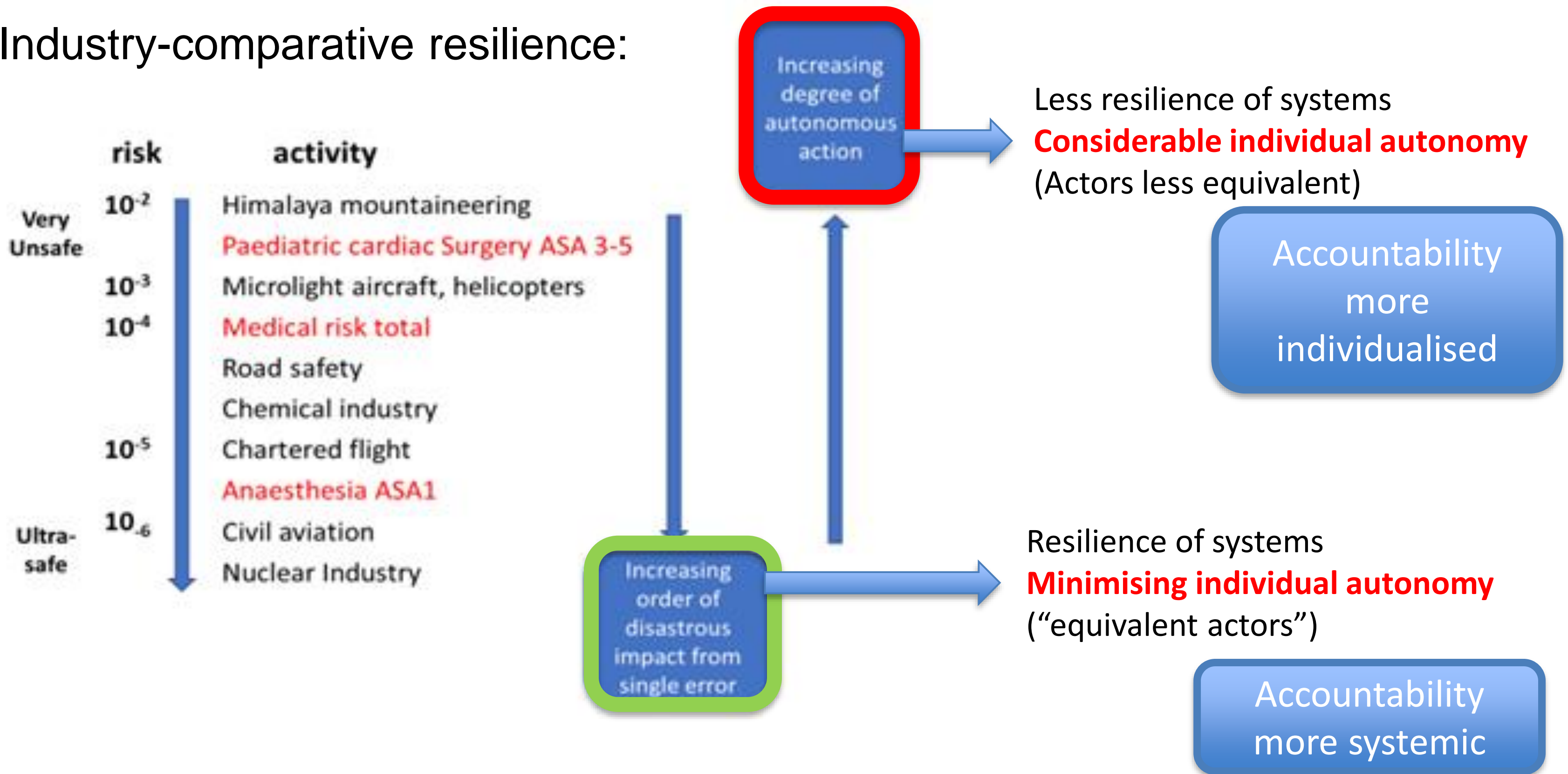
Essential elements of a Just Culture –

- Console the human error
- Coach the at-risk behaviour
- Punish the reckless behaviour

Important for implementing S-II

These are elements of S-I,
will S-II be perceived as changing them?

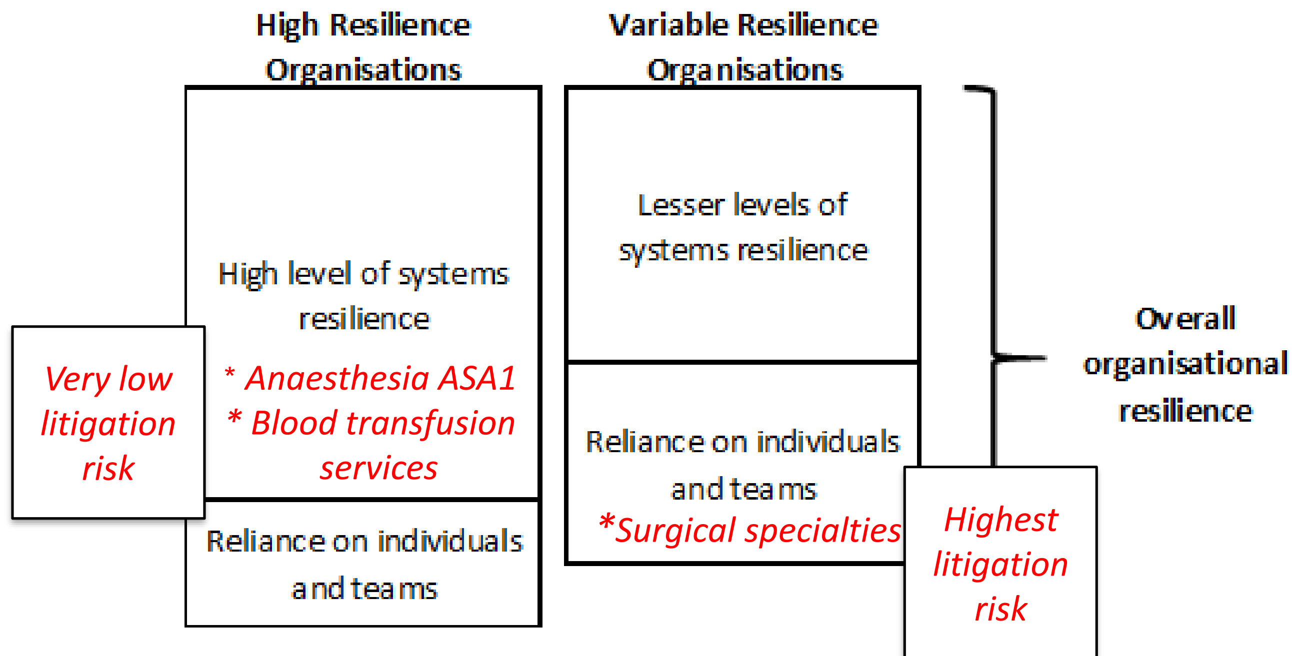
Q1: Safer patients = safer HCPs



Adapted from Amalberti, Auroy, Berwick, and Barach.

Ann Intern Med. 2005;142:756-764

Relative resilience in healthcare?



Where organisational resilience is high, there is less dependence on individuals and their teams for safety. Where reliance on individuals is greater, total industry resilience is likely to be lower

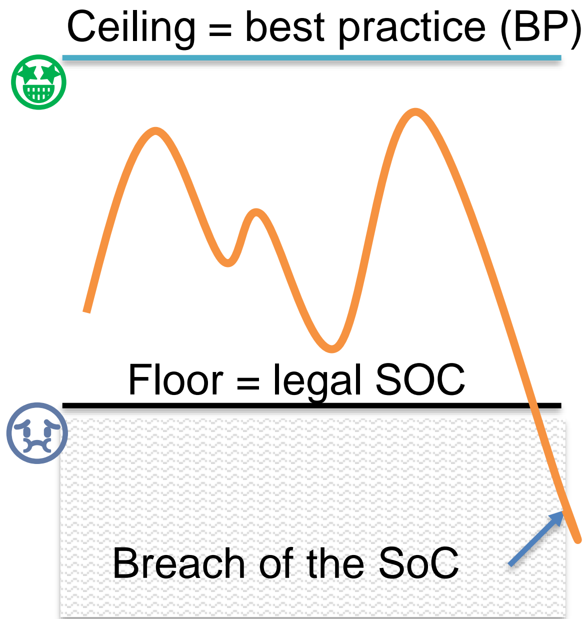
Statement 1 summary –

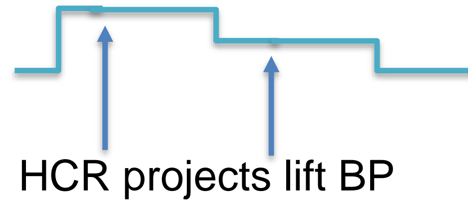
S-II will make healthcare providers (HCP) safer as a consequence of making patients safer.*

Conceptually, by increasing resilience in healthcare, Safety-II should increase clinician safety.

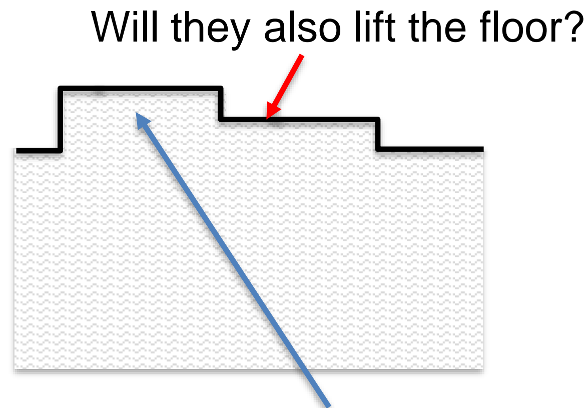
As resilience grows, accountability becomes more about systems and less about individuals

Q2: The (legal) Standard of Care –





Will they also lift the floor?



Some clinicians self-harm by demonstrating resistance to evidence-based improvements in care

A pivotal issue is education of expert witnesses

What will this mean for expectations related to safety and accountability?
[Q3] – very circumstance-specific

HEALTH QUALITY & SAFETY COMMISSION NEW ZEALAND

An example –

- Woman in labour about to commence "pushing" (expulsive effort)
- On antibiotics for prolonged ruptured membranes; second dose due
- Realised she'd be very busy administering the antibiotic intravenously, coaching the patient through second stage labour, conducting the birth, and providing intravenous oxytocin around the time of the birth of the placenta to minimise the chance for haemorrhage
- Had drawn up the oxytocin into an unlabelled syringe, placed in the same "kidney dish" as the previously drawn up antibiotic, also unlabelled but a bigger syringe
- Supposed antibiotic syringe connected to the intravenous cannula and administered by slow push. However, it was actually the oxytocin
- A tetanic uterine contraction occurred followed by fetal bradycardia
- Senior obstetric resident was nearby and in the space of five minutes performed a safe instrumental birth
- No physical harm to mother or newborn.

Two approaches –

1. Traditional S-I
2. An amalgam:
   – What do we normally do?
   – Is that the right way?
   – What did we do this time?
   – Why was it done that way?

Q3: Lets assume S-II may increase expectations of safety and may increase the drive for accountability. Let's reframe it:

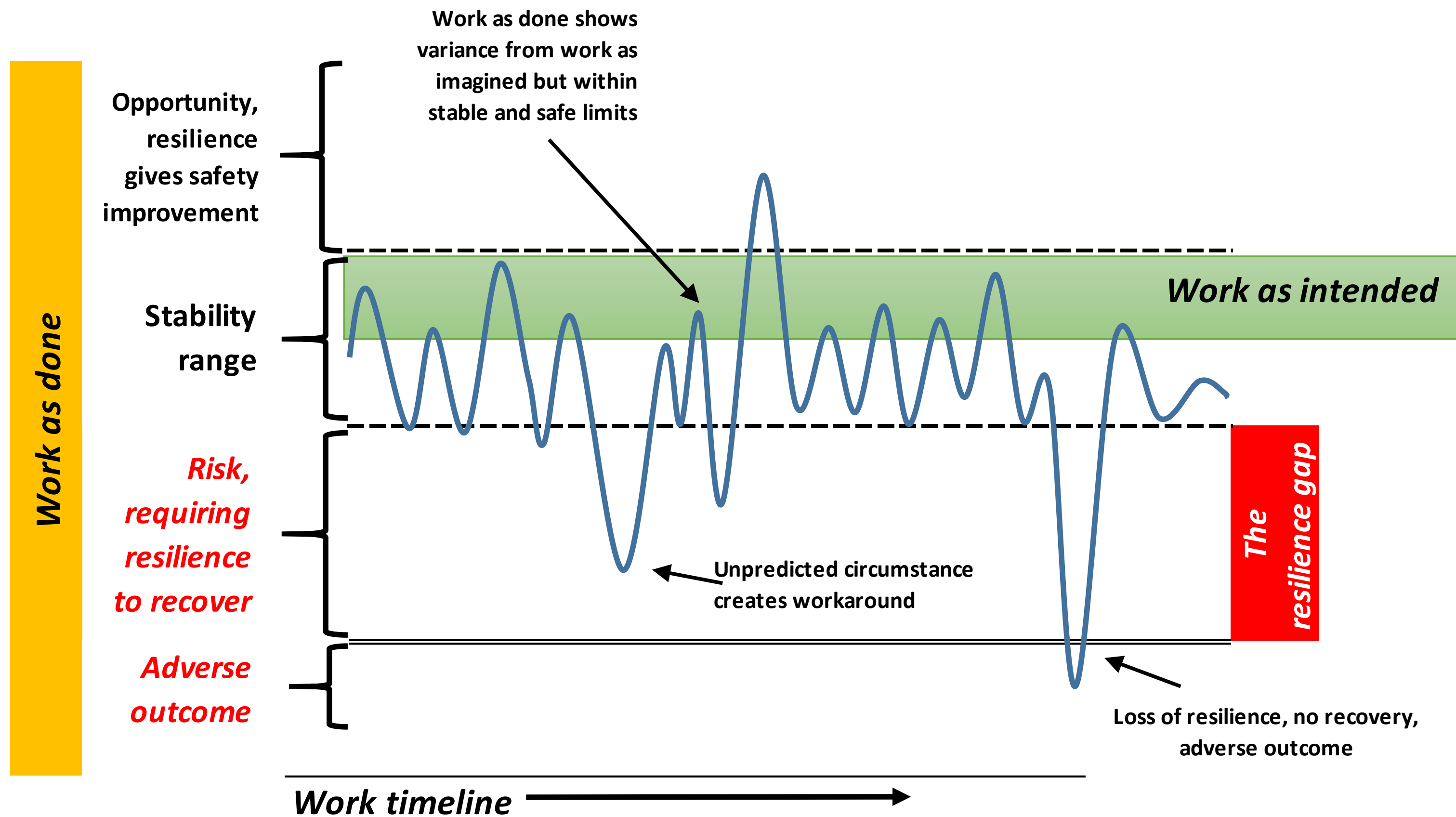
Does Safety-II provide us with a model for dissecting out circumstantial factors for which systems rather than individuals should be accountable?

The resilience gap –

- High resilience organisations show minimal variance between work as intended (WAI) and work as done (WAD)
- Healthcare is of variable resilience WAD often varies from WAI
- The 'gap' between WAI and WAD = the resilience gap
  - *HCPs have to fill that gap with personal resilience, such as by mindfulness.*
- The 'gap' will involve
  - *Workarounds, efficiency-thoroughness trade-offs (Eric Hollnagel)*
  - *Adapting to changing conditions, recovering from mistakes and shocks (Rasmussen)*

The resilience gap –

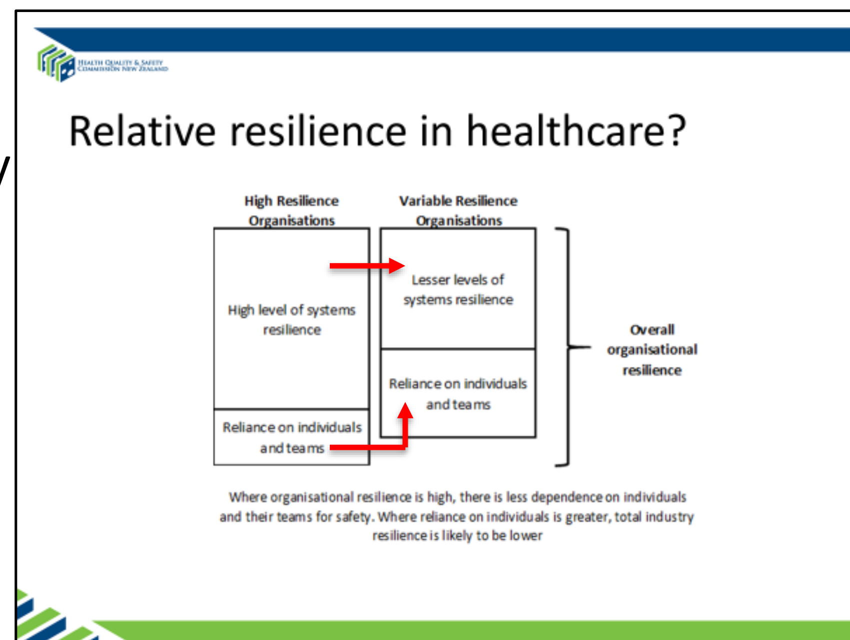
Relationship between work as intended, work as done, resilience, stability and adverse outcome



Workarounds are commonplace –

- Feeling time pressured
- Seeking solutions to shortcomings in staffing, equipment, supplies
- Solving problems for which clinicians have had no guidance
- Sidestepping 'problematic' rules which are seen to be impracticable

- Address poor workflow design and organisational and system issues
- Compensate for inadequate technology
- Clinicians feeling 'controlled' by the system and developing "end user resistance"
- Poor inter-professional relationships
- Burnout



Q3 – *Does Safety-II provide us with a model for dissecting out circumstantial factors for which systems rather than individuals should be accountable?*

Viewed through a resilience lens, more objectivity should be possible in relationship to the balance between systems and individual accountability where healthcare-delivery circumstances are not ideal

Code of Health and Disability Services Consumers' Rights
Clause 3; Provider compliance
(1) A provider is not in breach of this Code if the provider has taken reasonable actions in the circumstances to give effect to the rights, and comply with the duties, in this Code.
(2) The onus is on the provider to prove it took reasonable actions.
(3) For the purposes of this clause, the circumstances means all the relevant circumstances, including the consumer's clinical circumstances and the provider's resource constraints.

The crunch issue –

For Safety-II to reach tipping point in clinical practice, becoming an every-day-every-HCP system, it will necessitate ensuring that it is seen as supportive of the care HCPs do provide rather than increasing their accountability.

Three realities –

In my view:

1. The greater accountability risk will be for those who have systems responsibility
2. There are major implications for funders – S-II cannot be effective with poor healthcare recruitment and retention
3. Most clinicians are not familiar with S-II –
   - Our experience with S-I should remind us that education and understanding will be important

Before I summarise, let’s revisit –

1. S-II will make healthcare providers* (HCP) safer as a consequence of making patients safer.

2. S-II will raise the (legal) standard of care and therefore will increase the risk of adverse findings against HCPs

3. S-II increases expectations of safety (in patients and communities) and may therefore increase the demand for HCP accountability when things go wrong

Conclusions –

1. The more resilient healthcare becomes, the more safety enquiry will focus on systems rather than individuals
2. Patient safety and clinician safety are linked. Safety-II, by increasing patient safety, should inherently increase clinician safety
3. How expert witnesses perceive change to the legal standard of care will significantly influence clinician acceptance
4. Education of expert witnesses and clinicians is pivotal
5. A healthcare sector that struggles with staff recruitment, retention and support will struggle to implement S-II as an every-day-every-clinician culture

…on point 5 –

- Staffing: when a plane does not have a full complement of crew, the plane does not fly. When a ward does not have a full staff complement it is not declared ‘not fit to fly’.
- How can being on call for 24 hours possibly be compatible with developing HCR?
- How do we address our high rates of burnout?

A holistic viewpoint –

- Medicolegal risk is less about standards of care than whether a patient values the relationship they have with us
- It is communication skills that most accurately correlate with patient satisfaction; and correlate inversely with complaint/litigation
- Patients are forgiving when things go wrong if we are open and caring
- An essential part of being caring is doing what we can to make things go right more often – Safety-II