

Applying Safety Science to Healthcare

Prioritize the Incidents & Focus on the Right Errors

CAHO Webinar November 5, 2024

Kathryn (Kate) Kellogg, MD MPH Vice President, Patient Safety & Infection Prevention, MedStar Health, Columbia, MD USA Assistant Professor of Emergency Medicine, Georgetown University School of Medicine

Agenda

- The State of Patient Safety
- Key Human Factors Engineering Concepts
- 3 Crucial Opportunities to Incorporate Human Factors into Patient Safety



The State of Patient Safety



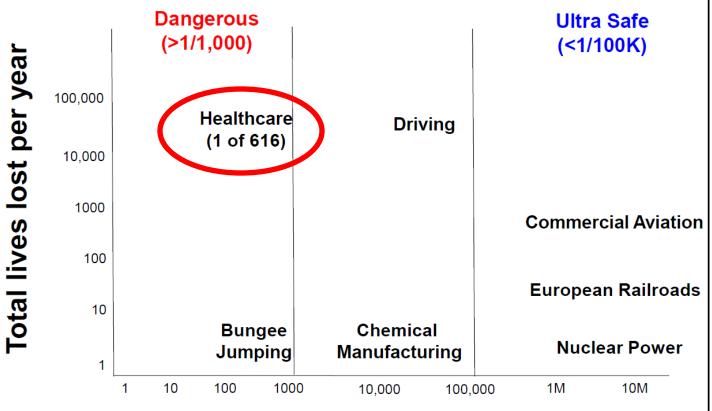
Medicine used to be simple, ineffective, and relatively safe.

Now it is complex, effective, and potentially dangerous

Sir Cyril Chantler



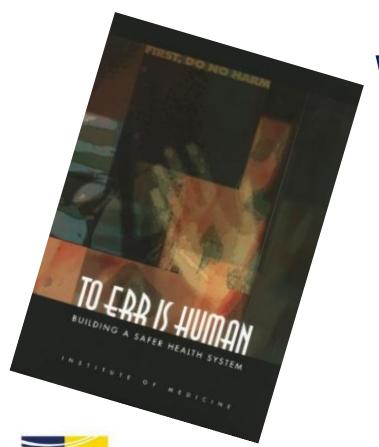
Chart Credit: Modified from L. Leape











MedStar Health

What has happened since?

- Legislation & regulations
- Research funding
- New journals, associations, meetings
- Engagement with patients and families
- Patient safety organizations (PSOs)
- Education and Certification
- Public and media attention
- Attempts at Metrics

Are we getting safer?

The NEW ENGLAND JOURNAL of MEDICINE

SPECIAL ARTICLE

The Safety of Inpatient Health Care

David W. Bates, M.D., David M. Levine, M.D., M.P.H., Hojjat Salmasian, M.D., Ph.D., M.P.H., Ania Syrowatka, Ph.D., David M. Shahian, M.D., Stuart Lipsitz, Sc.D., Jonathan P. Zebrowski, M.D., M.H.Q.S., Laura C. Myers, M.D., M.P.H., Merranda S. Logan, M.D., M.P.H.,

Christopher G. Roy, M.D., M.P.I-

Journal of Patient Safety and Risk Management

Editorial

Who killed patient safety?

Carole Hemmelgarn 1 , Martin Hatlie , Susan Sheridan , and Beth Daley Ullem 4

Lynn A. Volk, M.H.S., Sevan Du Heba H. Edrees, Pharm.D.
Jonathan S. Einbind and El

Adverse Events in Hospitals: A Quarter of Medicare Patients Experienced Harm in October 2018

05-09-2022 | OEI-06-18-00400 | Complete Report

JAMA Network[™]

JAMA | Original Investigation

Trends in Adverse Event Rates in Hospitalized Patients, 2010-2019

Noel Eldridge, MS; Yun Wang, PhD; Mark Metersky, MD; Sheila Eckenrode, MA, RN; Jasie Mathew, MBA; Nancy Sonnenfeld, PhD; Jade Perdue-Puli, MPA; David Hunt, MD; P. Jeffrey Brady, MD, MPH; Paul McGann, MD; Erin Grace, MHA; David Rodrick, PhD; Elizabeth Drye, MD, SM; Harlan M. Krumholz, MD, SM

Quality and Safety:

Two distinct meanings which require different approaches, skills, training, competencies, and expertise

Quality: (quantitative)

 Degree of excellence measured against an established benchmark.

Safety:

 Freedom from harm, danger, or risk. (qualitative)





Institute of Medicine (IOM). Crossing the Quality Chasm: A New Health System for the 21st Century. Washington, D.C: National Academy Press; 2001.

Quality Skills

















Data Analytics









Care for the Caregiver





lonest unication



Teamwork Training

Resilience

Engineering



Effective, Durable Risk Mitigation





Just Culture









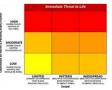




chological Sa



Risk Assessment



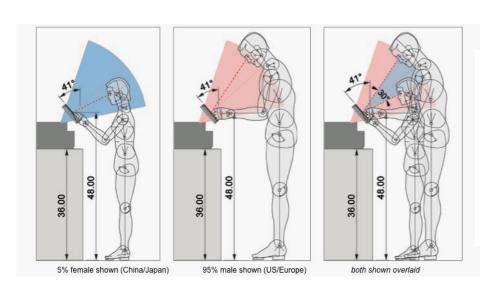


Human Factors Engineering & Safety Science



What is Human Factors?

The understanding and application of information about human behavior, abilities, and other characteristics to the design of tools, machines, systems, tasks, jobs, and environments for productive, safe, comfortable, and effective human use.



I am sans.
I am serif.

Why Human Factors?

How many of you have...

– Pushed on a door when you should have pulled?





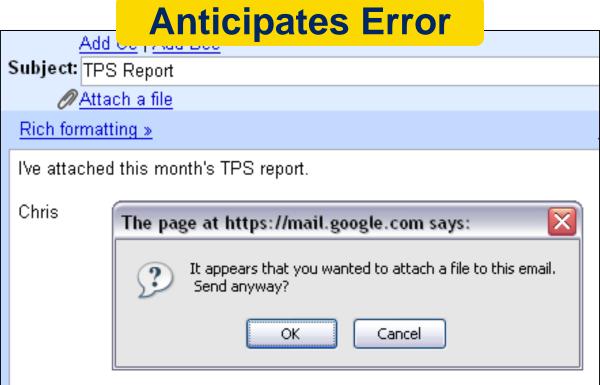
How many of you have...

 Ever purchased the wrong grocery item because the labels looked similar?





Human Factors Influenced Design





Human Factors Influenced Design

Makes it hard to do the wrong thing





Human Factors Influenced Design

Makes it impossible to do the wrong thing





Human Factors Engineering

We don't redesign humans.

We redesign the system within which humans work





Human Factors in Healthcare is all about:

Designing systems, processes, devices, software, and tools that:



Account for the complexity of the system



Fit human capabilities and limitations



Support the user through usable design



Human Factors in Healthcare is all about:

Designing systems, processes, devices, software, and tools that:



Account for the complexity of the system













MIND THE GAP

Work as Performed:
How the work is actually being done

Human Factors in Healthcare is all about:

Designing systems, processes, devices, software, and tools that:



Fit human capabilities and limitations



Principles of Human Performance

- 1. Humans are fallible and even the best make mistakes.
- 2. Error-likely situations are predictable, manageable, and preventable.
- 3. Individual behavior is influenced by organizational processes and values.
- **4. Events can be avoided** by understanding the reasons mistakes occur.





Types of Error



Knowledge Based



Rule Based





Types of Error



Knowledge Based



Rule Based

Intended Actions



Skills Based

Unintended Actions



Types of Errors



Knowledge Based





Rule Basec





Types of Errors



Knowledge Based



Rule Based







Types of Errors

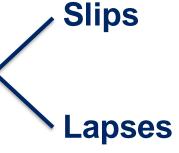


Knowledge Based



Rule Basec







Skills Based Errors

Slips



Lapses



Human Factors in Healthcare is all about:

Designing systems, processes, devices, software, and tools that:



Support the user through usable design



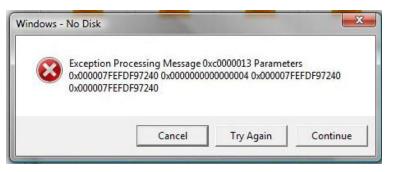
What does it mean to be usable? Easy to do the right thing, hard to do the wrong thing





Everyday Usability





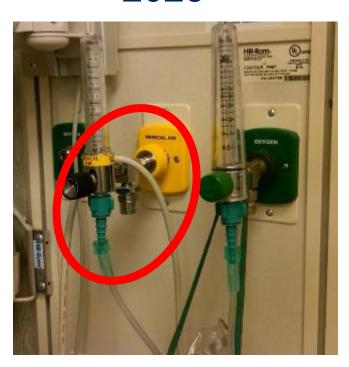




2004 OXYGEN EDICAL AIR

David M. Gaba, MD | October 1, 2004, web M&M https://psnet.ahrq.gov/web-mm/thin-air

2023





Human Factors Influenced Design





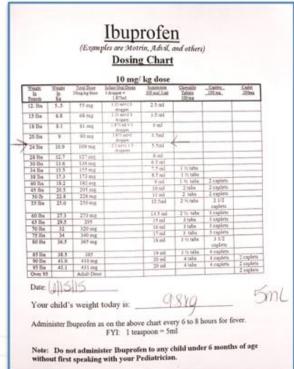
Usability in Healthcare

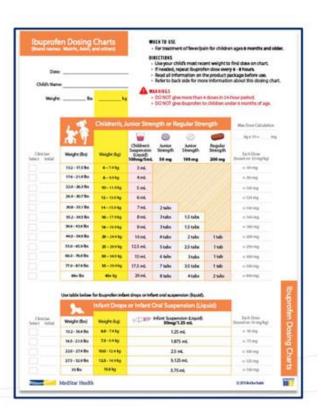
22 mmol/L





Design with Usability in Mind







Human Factors in Healthcare is all about:

Designing systems, processes, devices, software, and tools that:



Account for the complexity of the system



Fit human capabilities and limitations



Support the user through usable design



BLAME

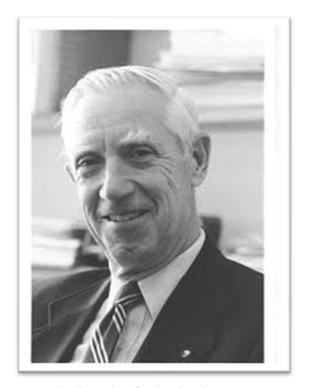
SHAME

TRAIN

Human Performance in Healthcare

"Incompetent people are, at most, 1% of the problem.

The other 99% are good people trying to do a good job, who make very simple mistakes and it's the processes that set them up to make these mistakes."



Attributed to Dr. Lucian Leape Harvard School of Public Health



Key Takeaways

- Humans are fallible
- The world around us strongly influences our performance

"We don't redesign humans; We redesign the system within which humans work"



Integrating Human Factors & Safety Science Into Patient Safety



Three Critical Opportunities for Safety Science

- After an event
 - Understanding the WHY
 - Developing strong solutions
- Before an event
 - Becoming proactive & designing safe systems



MedStar Health's Innovative Event Review Process

- Learning focused process
- Based in Safety Science A
- Approach identifies true contributing factors and durable, effective solutions
- Shapes the culture of the organization







Finding the "Actual Whys": Identifying Contributing Factors





















Strong Actions

Architectural/physical plant changes

New devices with usability testing

Engineering control (forcing function)

Simplify process

Standardize equipment or process

Tangible involvement by leadership

Intermediate Actions

Redundancy

Software enhancements, modifications

Eliminate/reduce distractions

Simulation-based education, with periodic refresher sessions/observations

Checklist/cognitive aids

Eliminate look and sound-alikes

Standardized communication tools

Enhanced documentation/communication

Weaker Actions

Double checks

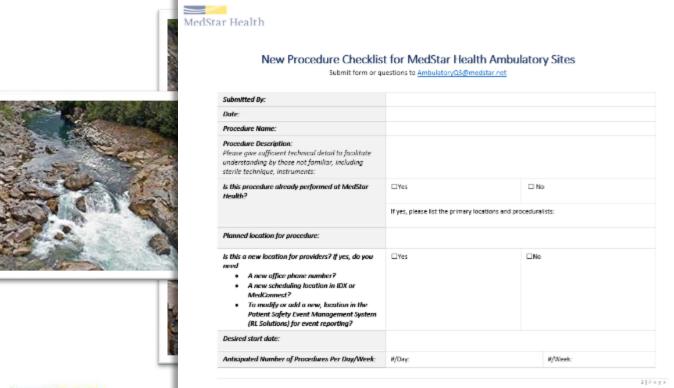
Warnings

New procedure/memorandum policy

Training



What Does Proactive Safety Look Like?







Thinking Differently Tomorrow



Thank you.

Kate Kellogg, MD MPH
Vice President, Patient Safety & Infection
Prevention, MedStar Health
Assistant Professor, Georgetown
University School of Medicine

kate.m.kellogg@medstar.net @katekelloggMD

It's how we treat people.

