
Do No Harm: *Best Practices of Safety Cultures*

The commitment to “always doing the right thing” and the dedication to actively preventing “wrong things” are necessary in safety cultures. The following article discusses best practices used by safety cultures founded upon the principal of “first, do no harm.”

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Many Americans might consider 2008 a less than stellar year. Aside from the down-turned economy and geopolitical events, we can't ignore the alarming fact that our healthcare system is failing to keep patients safe. The Joint Commission reports that 815 individual sentinel events occurred in 2008, with approximately 70% resulting in patient deaths.

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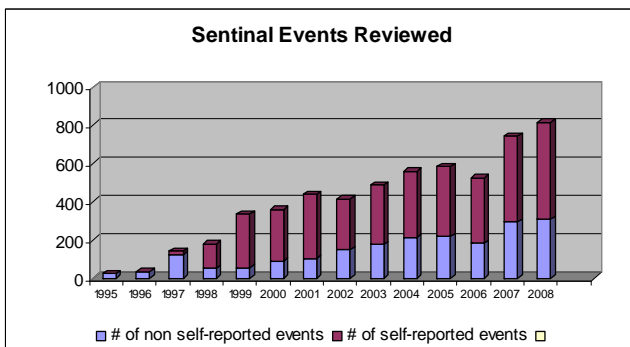
Joint Commission
Sentinel Event Statistics as of December 31, 2008

Each of these events was unique, with its own set of circumstances, its own clinical setting, and its own clinicians. Each tragedy had its own victims, including the families, loved ones, and “secondary victims,” the clinicians involved. Moreover, millions of dollars were paid out by hospitals for these mistakes; dollars that could have been spent on error prevention.

Only the bitterest cynic would suggest that any of these untoward outcomes were intentional. In fairness to the healthcare teams involved, each member, if asked, would likely state that they did all they could to “do the right thing” to achieve the desired outcome for the patient. This mindset, although necessary to achieve high quality care, is insufficient to assure safe healthcare.

Put another way, the purpose of performing a Root Cause Analysis following sentinel events is to discover answers to what are often very difficult questions: *“How could this happen? What’s wrong with our training? Who is to blame?”* Even in the aggregate, it’s challenging to identify an overarching “Universal Root Cause” simply because every case is different. The best approach to finding this “Holy Grail” of patient safety may begin by focusing less on what happened in these events, and more upon what didn’t happen.

A successful parenting technique I used when addressing the undesirable outcomes of low grades, dents in the family car, and missed curfews, involved the purposeful avoidance of punitive questioning. Rather, I posed my questions in the form of analytical tools, i.e. “Did you do



everything you could to prevent this?” Doing so enabled me to elicit a different perspective and better outcomes.

Imagine using this same questioning technique, coupled with a compassionate and non-judgmental tone, and asking each of the clinicians involved in the 815 tragedies that occurred this year, “Did you do everything you could to prevent this?”

Their thoughtful and honest response would too often be, “No, in retrospect, I did not.”

This is more than just semantics. There is a subtle difference between cultures that “always do the right things,” and those that also actively do what they must to prevent the “wrong things”. The latter culture is a safety culture; one specifically prescribed by “first, do no harm”.

What Are Best Practices of Safety Cultures?

1 - Ask Others to Check Your Work

This behavior, although incredibly simple, is surprisingly difficult for some to adopt. Admitting you are human and therefore fallible is the first step toward asking others to check your work. Captain Robert “Hoot” Gibson, an astronaut with five Space Shuttle flights under his belt, often invoked “Hoot’s Laws,” during his tenure as the head of the astronaut office. These “laws” were a set of best practices that he’d come to understand over many years in high-risk endeavors. One of his immutable laws for ensuring success in an unforgiving environment, such as healthcare or space flight, is *“If it’s critical for mission success, then two sets of eyes need to be on it.”* Even when working with the best and the brightest, there was an open admission that mistakes could be made.

In healthcare, it may not always be obvious when to ask for a second set of eyes. Nor should we expect all clinicians to know how to effectively make these types of requests. Dr. Jon Coen is an orthopedic surgeon in Oregon who ensures that he always has a second set of eyes on what he does by taking a mere five seconds after the surgical pause, making eye contact around the OR and saying something like, “Hey listen guys, don’t let me fall off a cliff.” This simple and yet personal statement, sincerely conveys to the team the basic message of “I might make a mistake. I’m counting on you to not let that happen.” I asked Jon where he learned to say something like this and, not surprisingly, he learned it in another culture... a high reliability, safety culture. Jon served as a flight surgeon tending to the needs of the Air Force pilots who were flying the F-117, the stealth fighter. These pilots were the cream of the crop, the very best the Air Force had to offer, and yet they freely admitted that each and every one was only one mistake away from a highly undesirable outcome that would abruptly end their professional practice. This experience stayed with him and he built it into his medical practice.

2 - Use Standardized Behaviors Unfailingly

Everyone knows, in a general sense, what ought to be done to deliver the best care possible. What’s interesting is that when those best practices are built into a checklist and that checklist is unfailingly followed, the undesirable outcomes plummet, or even disappear completely. Dr. Peter Pronovost has demonstrated this with his central line bundle and the World Health Organization has similarly published convincing results for the Surgical Safety Checklist. These practices aren’t cutting edge, sexy, or brilliant; in fact, they’re somewhat mundane and that seems to be their undoing. Many react to these practices by saying “Surely something so simple can’t have this kind of impact.” For those unimpressed with simple interventions, perhaps the installation of seatbelts in all automobiles may serve as a lesson. When universally used, fatalities decreased, period.

Reality is that at one time or another, nearly all clinicians fight fatigue, stress, system complexity, miscommunication, frustrating regulations, etc. *Standardization of processes mitigates the impact of these impediments. Best practices become “standard” and free clinicians to focus on “doing what’s right” as well as actively preventing “wrong things” from happening.*

3 - Embrace “Always”

There are industries that have successfully adopted the use of “Always” and it makes sense that we learn from their lessons. Quint Studer says, *“Always leads to Never” and the two practices above, if practiced by individuals, will result in better outcomes because they’ll avoid the so-called “Never Events”*. Simply put, if some of us use these practices and some don’t, these variable behaviors will result in variable outcomes. Who among us is content with entrusting ourselves or our loved ones to a “Sometimes” culture, and “Essentially” culture, or even a “Usually” culture? “Always” will only happen when patients, physicians, and staff insist upon it. We all must demand a culture that leaves no stone unturned to ensure that these non-technical, very human, best practices are being used unflinchingly, day and night, by every clinician and with every patient.

Statistically speaking, over the last 48 hours, three people have died in the United States simply because they entrusted their life to a system that insisted upon human infallibility, and unfettered license to individual preference. *We are morally obligated to do all that we can to prevent this.*

About LifeWings Partners LLC

LifeWings Partners was founded by a former U.S. Navy Top Gun instructor, a commercial airline pilot, and two physicians who are former NASA astronauts. LifeWings’ practical and effective teamwork training programs are highly effective in reducing human error and currently involve the training of more than 13,000 high-performance medical team members per year. Measurable results are found in all LifeWings’ initiatives. To find out more, please visit www.SaferPatients.com.

Steve Montague is a Vice President for LifeWings and has worked with many clients, including Vanderbilt University Medical Center, Missouri University Health Center, Vassar Brothers Medical Center, and University of California - Los Angeles, to implement LifeWings aviation-based safety programs and trainings. A former Naval Aviator, Steve served as a fighter pilot, flight instructor, course developer, procurement consultant, and Program Model Manager at the U.S. Navy’s Landing Signal Officer School. He has over 12,000 flight hours and more than 350 carrier landings and currently serves as a Captain and First Officer for a major international airline. A graduate of the U.S. Naval Academy with a Bachelor of Science degree in Aerospace Engineering, Steve has an Airline Transport Pilot rating and is qualified in the MD80, B757, B767, DC10, and MD11.

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