Panel Discussion 1

Patient Safety Culture

Chair: Donald M. Berwick

Institute for Healthcare Improvement, U.S.A.

Chair Information:

Donald M. Berwick, MD, MPP, FRCP, KBE, is President Emeritus and Senior Fellow at the Institute for Healthcare Improvement (IHI), an organization that Dr. Berwick co-founded and led as President and CEO for 18 years. He is one of the nation's leading authorities on health care quality and improvement. In July, 2010, President Obama appointed Dr. Berwick to the position of Administrator of the Centers for Medicare and Medicaid Services (CMS), which he held until December, 2011. A pediatrician by background, Dr. Berwick has served as Clinical Professor of Pediatrics and Health Care Policy at the Harvard Medical School, Professor of Health Policy and Management at the Harvard School of Public Health, and as a member of the staffs of Boston's Children's Hospital Medical Center, Massachusetts General Hospital, and the Brigham and Women's Hospital. He has also served as vice chair of the U.S. Preventive Services Task Force, the first "Independent Member" of the Board of Trustees of the American Hospital Association, and chair of the National Advisory Council of the Agency for Healthcare Research and Quality. He is an elected member of the American Philosophical Society and of the National Academy of Medicine (formerly the Institute of Medicine). Dr. Berwick served two terms on the IOM's governing Council and was a member of the IOM's Global Health Board. He served on President Clinton's Advisory Commission on Consumer Protection and Quality in the Healthcare Industry. He is a recipient of numerous awards, including the 1999 Joint Commission's Ernest Amory Codman Award, the 2002 American Hospital Association's Award of Honor, the 2006 John M. Eisenberg Patient Safety and Quality Award for Individual Achievement from the National Quality Forum and the Joint Commission on Accreditation of Healthcare Organizations, the 2007 William B. Graham Prize for Health Services Research, the 2007 Heinz Award for Public Policy from the Heinz Family Foundation, the 2012 Gustav O. Lienhard Award from the IOM, and the 2013 Nathan Davis Award from the American Medical Association. In 2005, he was appointed "Honorary Knight Commander of the British Empire" by Queen Elizabeth II, the highest honor awarded by the UK to non-British subjects, in recognition of his work with the British National Health Service. Dr. Berwick is the author or co-author of over 160 scientific articles and six books. He also serves now as Lecturer in the Department of Health Care Policy at Harvard Medical School.

Chair: Chris A. Power

Canadian Patient Safety Institute

Chair Information:

What began as a desire to help those in need 35 years ago has evolved into a mission to improve the quality of healthcare for all Canadians. Chris Power's journey in healthcare began at the bedside as a front-line nurse. Since then, she has grown into one of the preeminent healthcare executives in Canada. Her experiences, her success, and her values have led her to the position of CEO of the Canadian Patient Safety Institute.

Previously, Chris served for eight years as president and CEO of Capital Health, Nova Scotia. She holds significant governance roles including Chair of the Canadian Association for Health Services & Policy Research, Co-Chair of CHLNet and Board member of Colleges & Institutes of Canada.

Most recently Chris participated as a member of the federal advisory panel on healthcare innovation. Her love of family and gift of song keep her grounded in all that she does.

Michael A. Durkin

Institute of Global Health Innovation, Imperial College London, U.K.

Time to Move to a Cultural Era in Patient Safety of Values, Ethics and Leadership at Every Level

Abstract:

Harm within the NHS in the UK is measured at a local and at a national level such that we have a positive reporting culture that is identifying a system that may be open, permissive, and supportive.

The burden of harm that is identified is reducing but not at an appropriate pace or scale. We need patients to be equal partners in our journey to reduce harm as they can shed light on the burden of harm that we as professionals have often failed to see.

The era of safety measurement has brought us knowledge of the known and emerging harms; Falls, Pressure Ulcers, VTE, Infection and Sepsis, Medication Error, Suicides while in Care, Anti-Microbial Resistance and the rise of GM negative infections, Maternal Morbidity and Neonatal Injury.

We are however only just starting to recognize the underlying barriers to safety Improvement such as lack of transparency, sharing of data, a true system of candour from professionals and organisations, and the importance of a truly supportive safety culture, whereby learning from what goes right is as important as learning from harm.

The next years must be a true educational era of value, ethics and leadership at every level in support of a cultural shift to move away from the Professional identity back to an Ethical identity whereby organizational and personal values are of equal importance as fiscal control; and to reduce a reliance on hierarchical expertise and to support the patient being at the heart of their care and in control of their health and care management and outcome.

Keywords:

Patient Safety, Value, Values, Ethics, Leadership, Measurement, Harm, Transaparency, Candour,Trsut, Honsety, Respect, Improvement

Speaker Information:

Dr Mike Durkin was the NHS National Director of Patient Safety from 2012 to 2017 and is the Senior Advisor on Patient Safety Policy and Leadership at the Institute of Global Health Innovation. He has held management, teaching and research appointments in London, Bristol and Yale Universities culminating as the Executive Medical Director of the NHS across the South of England. He was the UK National Director for VTE and is an appointed Expert by ISQua. He led the development of the National Patient Safety Alerting System, the 15 Patient Safety Collaboratives across England and the Q Fellowship to build a community of 5000 quality improvers. He convened the Berwick Advisory Board in 2013 to advise on improving the safety of patients in England and in 2015 he was commissioned to Chair the Expert Advisory Group to advise on the establishment of the Healthcare Safety Investigation Branch.

Hardy Müller

German Coalition for Patient Safety - Aktionsbündnis Patientensicherheit e.V. (APS)

German Coalition for Patient Safety - the Story Behind Safety Culture

Abstract:

The German Coalition for Patient Safety - in German "Aktionsbündnis Patientensicherheit e.V. (APS)" is a non-profit association of individuals and organisations to improve patient safety. The APS was established in 2005 and is overseen by an honorary board. The presentation covers activities and ongoing projects of the APS. Over ten years of activity has shown that independence is an important prerequisite for asking the difficult but necessary questions often associated with patient safety. However, the precarious financing through membership fees and donations is challenging. Basic funding is required to expand and, at the same time, to keep the APS independent.

The extent of adverse events in Germany cannot be rated differently than in comparable countries. Nevertheless, the scientifically established prevalence of these adverse events leads to great public controversy over the extent of the problem. This is often a result of unclear terminology and a poor distinction between epidemiological and legal perspectives in the public debate.

The International Patient Safety Day, initiated by the APS, will take place for the fourth time in Germany this year. We welcome the introduction of a "World Patient Safety Day" and look forward to sharing our experiences. The imperative *primum non nocere* is one of the oldest medical-ethical obligations. It is important we give more weight to this imperative in addressing the current demands of patient safety. To this end we have articulated ethical principles for patient safety. These will be presented in detail and we hope that they can be further developed and adapted by other organisations. A topic for a World Patient Day?

Keywords:

epidemiology, adverse events, ethics, association, terminology, international patient safety day

Speaker Information:

After studying anthropology, sociology and psychology Hardy Müller started his career as a research associate focusing on 'Regional Mortality Differences'. Since 1993 he has worked in the statutory health insurance in various senior positions. Initially he established a health reporting system using routine data and organized the health care management of the biggest German insurance company. Later he developed and implemented strategies for contracts with healthcare providers.

From 2009 to 2011 Hardy Müller was spokesperson for the Department "Patient Information and Participation" in the German Network for Evidence-based Medicine e.V. and in 2010 he was a Member of the Faculty of the Summer Institute on Informed Patient Choice, Dartmouth College, Hanover, USA.

Hardy Müller is a certified healthcare risk manager. He is a member of various advisory boards, e.g. the technical advisory board of the research association "Leibniz Health Technologies". Currently, Hardy Müller is a senior advisor at the TK Scientific Institute of Value and Efficiency in Healthcare (WINEG) and the Honorary Managing Director at the German Coalition for Patient Safety (Aktionsbündnis Patientensicherheit e.V.).

Ton Thanh Tra

Cho Ray hospital, Ho Chi Minh City, Vietnam

Kaizen Activities at a Public Hospital in a Developing Country

Abstract:

Cho Ray is a tertiary teaching hospital, Located at Ho Chi Minh City, Vietnam. Kaizen activitives have been applied for a long time but the strong and most activities have been established when Ministry of health had the regulation on improving health care services in 2013. At that time, all hospitals must have resources for Kaizen activities. Since 2016, thanks to supporting from Japan International Cooperation Agency (JICA) experts, we have applied Kaizen in: Antimicrobial stewardship program, Incident report system, 5 S activities, Respiratory support activities, patient safety training and many procedure compliances audit at Cho Ray hospital. The initial results showed that Kaizen activities were suitable with our condition and should be done at all hospitals. We are continuing to improve our quality of services to meet the customers' demand. The lessons learnt from Kaizen activities were: Leadership, encouragement, training and audit regularly.

Keywords:

Kaizen, hospital quality management, patient safety, Cho Ray hospital

Speaker Information:

Ton Thanh Tra , MD, PhD. Emergency doctor, Head of Quaity management, Cho Ray hospital, Ho Chi Minh City, Vietnam. I graduated Medical University in 1997, Master degree in 2009 and PhD degree in 2018 at Univerisity of Medicine and Pharmacy at Ho Chi Minh City, Vietnam. Working at Cho Ray hospital since 2001. From 2001 - 2007: Physician at Respiratory department. From 2007 - 2013: Emergency doctor. From 2013 to now: Emergency doctor, Head of Quality management department. I have published over 30 articles related to Emergency medicine, quality management and patient safety. Now, I am also the invited lecturer at University of Medicine and Pharmacy, Ho Chi Minh City, Vietnam.

Yutaka Aso

Chairman, Aso Corporation, Japan

Patient Safety Through Kaizen Activities

Abstract:

1. The background of Iizuka Hospital establishment and thoughts on Iizuka Hospital
   - The spirit of establishment in 1917: ”To bring together skilled physicians, and provide the best in medical treatment and provision of medicine for the people of the region”.
   - Our goal is the hospital with the most sincere medical treatment in Japan.
   - We launched our TQM (Total Quality Management) activities in July 1992. The activities are implemented under the theme of better quality and services in healthcare and management.
2. Efficiency by Kaizen activities (eliminating waste) leads to making the mental elbowroom
   - The mission of “We deliver the best” leads to hospital employee satisfaction, and hospital employee satisfaction leads to patient satisfaction.
   - The leader clearly shows this mission, leads the team.
   - We have provided three approaches by which hospital staff can work on Kaizen activities according to the purpose and timeline: the existing QC Circle Activities, the Kaizen Workshop, and the Everyday Kaizen.
3. Example of improving patient safety through Kaizen activities
   - Nursing care system “Lean Workcell Nursing”
4. Kaizen activities has an effect on patient safety

   AIH has been developing TQM through continuous improvements by hospital staffs. In recent healthcare services, which involve complex connections among processes involving various medical specialists, we think that TQM could be an effective tool for every hospital to improve the quality and safety of the healthcare system. The ability to understand the process cultivated through Kaizen activities and the ability to solve problems are connected to the effective resolution of the problem such as the incident. Team work is a Japanese strong competitiveness, once we share the mutual vision and target it brings safety culture into the hospital.

Keywords:

kaizen, safety, quality, custemer satisfaction, hospital employee satisfaction, leader

Speaker Information:

Yutaka Aso served as the CEO of the Aso Corporation from 1979 to 2010 and as Chairman from 2010. This company owns the Iizuka Hospital. Iizuka Hospital has 1000+ beds and fulfills the role of the core hospital serving a population of over 400,000 people. The hospital will celebrate its 100th anniversary in 2018. He leads the hospital following the mission of “We deliver the best” even now.

He is also the Chairman of the Kyushu Economic Federation since 2013 and has a strong commitment to this mission: “Move Japan forward from Kyushu!”.

He is also the author of several books about hospital management.

Ikuko Toyoda

IMS Rehabilitation Center Tokyo Katsushika Hospital, Japan

Positive Impact on Patient Engagement - What I Have Undergone as a Bereaved Family -

Abstract:

I lost my beloved son in 2003 in a medical accident.
At first, the hospital insisted that they had done their best. However, thanks to a whistle-blower, a newspaper revealed that there had been some critical systematic clinical error in the hospital. At the time, my grief and anger were far beyond words. I held the hospital against.
However, gradually I came to feel that indulging in grief and anger would not lead anywhere, so I summoned up the courage to join a workshop. That led me to a fateful encounter with Dr. Yoichi Shimizu, Director of Shin-Katsushika Hospital. He offered me a position as a safety manager at his hospital. I was surprised by the offer and assumed that I could not fulfill the role, as I had suffered bereavement by a medical accident and I had no medical background. However, my strong desire to know what is happening in the medical world overcame my reluctance, so I started. This happened 18 months after my son's death.
At the hospital, in 2006, my first step was to organize a workshop to facilitate dialogue between medical staff and patients. In 2012, the activity was formalized as an NPO called "KAKEHASHI", meaning "bridge". The main activities of the NPO are to serve as a bridge between patients, families and medical staff.
Based on my experience, I also give my opinions on national policies by serving as a member of several national committees.

Keywords:

Patient Support / Family Support / Second Victim / Second Victim Support / Patient Councelling / Patient Councelling Counter / Medical Accident Investigation System / Medical Accident Reporting System / Medical Dialogue / Medical Dialogue Facilitator

Speaker Information:

Present: Director of Patient Safety Unit, IMS Rehabilitation Center Tokyo Katsushika Hospital
Past activities:
Member of the "Study group on the establishment of a no-fault compensation system to improve medical quality" for the Ministry of Health, Labour and Welfare (MHLW)
Member of the Advisory Group for MHLW on "Scheme for investigating medical accidents"
Member of "Study on method for investigating deaths associated with medical treatment," Scientific Research 2014
Member of "Enforcement of medical accident investigation system" Review Committee, MHLW
Member of Drafting Committee for "Guidance on investigating hospital accidents," Medical Safety Promotion Committee, Japan Hospital Association
Current activities:
Chairman of NPO KAKEHASHI (Bridge), connecting patients, families and medical staff
Chief of Secretariat for Medical Safety Liaison Council from the patient's perspective
Member of Cause Analysis Committee, Obstetric Medical Compensation System, Japan Council for Quality Health Care
Member of Comprehensive Investigation Committee, Medical Accident Investigation System, Japan Medical Safety Investigation Agency

Jeffrey Braithwaite

Australian Institute of Health Innovation, Macquarie University

Safety-I, Safety-II and the Resilience of Health Care

Abstract:

Internationally health systems have invested significant resources in the development of policies and programmes to reduce rates of adverse events, yet despite these concerted efforts to make health care safer, rates of harm seem to have flatlined at approximately ten per cent. From an economic standpoint, ten per cent has substantial implications; harm due to medication safety alone costs Australia approx. AUD$1.2 billion (¥98.9 billion) annually.

Improvements in patient safety have been difficult to sustain and spread, partly due to limitations in our thinking. The current approach to patient safety, labelled Safety-I, focuses on identifying when things go wrong after an incident has occurred, and aims to prevent mistakes from reoccurring. This find-and-fix type model is linear in nature and often fails to recognise the complexities of health care. By realigning our focus and giving attention to efforts which enable things to go right, labelled Safety-II, we begin to appreciate the resilience of health care, and that despite numerous challenges, everyday performance succeeds more often than it fails.

A resilient health system is one which flexes and adapts to provide good care under a variety of circumstances. The key to the Safety-II approach is allowing people to learn from everyday clinical work which succeeds as well as harms. It means facilitating work flexibility, and actively trying to increase the capacity of clinicians to deliver care more effectively. During the course of the presentation I endeavour to sharpen understanding of why work-as-imagined is different to work-as-done and discuss the key concepts of complexity science and resilient health care in a patient safety context.

Keywords:

Patient safety; Resilience; Complexity science ; Implementation science; Diffusion; Sustainability; Safety-I; Safety-II

Speaker Information:

Professor Jeffrey Braithwaite, BA, MIR (Hons), MBA, DipLR, PhD, FAIM, FCHSM, FFPHRCP (UK), FAcSS (UK), Hon FRACMA, FAHMS is Foundation Director of the Australian Institute of Health Innovation, Director of the Centre for Healthcare Resilience and Implementation Science, and Professor of Health Systems Research, Faculty of Medicine and Health Sciences, Macquarie University, Sydney, Australia. He has appointments at six other universities internationally including the Canon Institute for Global Studies in Japan; he is a board member and President Elect of the International Society for Quality in Health Care (ISQua) and advisor to the World Health Organisation (WHO) and Global Ministerial Summit on Patient Safety.