MANAGING IMPROVEMENT OF THE POTENTIAL FOR RESILIENCE – IS IT POSSIBLE?

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There has to be some kind of management in health care – doesn’t it?
If the potential for resilience is intrinsic, is trying to manage safety contradictory to the ideas of resilience?
Background - Region Jönköping County

Approximately 350,000 inhabitants
13 cities/municipalities
3 hospital
45 primary healthcare facilities
## Region Jönköping County management

### Balanced scorecard model

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Patient safety work in RJC

• “Safer Health care – all the time, every time”

• Incident reporting and learning
Model of socio-technical systems

Dynamics

- Changing political climate, and public awareness
- Changing market conditions and financial pressure
- Fast pace of technological change

Level 1: Government
- Regulators, associations
- Company, health care organisations
- Management, hospital level
- Management, department level
- Staff, workplace

Rasmussen 1997
Model of socio-technical systems

Rasmussen 1997

Government
Regulators, associations
Company, health care organisations
Management, hospital level
Management, department level
Staff, workplace

Macrosystem
Mesosystem
Microsystem
• It’s in the microsystem where Patient Safety is happening

• The Concept “Safer Health care – all the time, every time” support the work in the microsystem

• Indicators are followed at all levels.
Moving from Safety I to Safety II
RJC Patient Safety Strategy \textit{revised}

- Develop and use best practices and guidelines according to evidence and proven experience
- Continuously improve processes and systems to support safe care
- Develop and use methods for risk management
- Develop and use methods for control, adaptation and response in the dynamic health care
- Limit the effects of adverse events if they occur (to patients, relatives and healthcare professionals)
"Safety measurement and monitoring in healthcare: a framework to guide clinical teams and healthcare organisations in maintaining safety"

The measurement and monitoring of safety
The Health foundation, April 2014

Figure 1  A framework for safety measurement and monitoring.
Indicators

Past harm
- Proportion of harm in GTT
- Health care acquired infections rate
- Pressure ulcer rate

Reliability of safety
- WHO Safe Surgical Checklist
- Medication audits
- Suicide risk assessment
- Vital Signs

Safety measurement and monitoring

Integration and learning
- Incident Reporting
- Green Cross
- Lex Maria
- Reflection on the indicators

Anticipation and preparedness
- Vital Signs and CPR
- Staff and Patient Safety Culture
- Risk Analysis
- Risk Awareness
- Reported observations/risks

Sensitivity to operations
- Daily briefing – hospital
- Patient Safety Walkarounds
- Safety Briefing/Risk Management
- Patient feedback

Region Jönköpings län
Sensitivity to operations

- Daily briefing – hospital
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• Reflection on the indicators
Questions for discussion

• Can a transition from Safety I to Safety II be managed?
• Can such a transition be enacted by a Balanced scorecard taking account of the ideas of resilience?
• Is microsystem thinking a way of enacting resilience?

• If the potential for resilience is intrinsic (something that is “hidden” in the system), is trying to manage safety contradictory to the ideas of resilience?
References

2 http://clinicalmicrosystems.org