Safety II: Actuated

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We seek to…

- Explore events that go right (particularly in high risk situations)

- Understand the process, decisions, actions, adaptations of those who are successful around a particular process or event

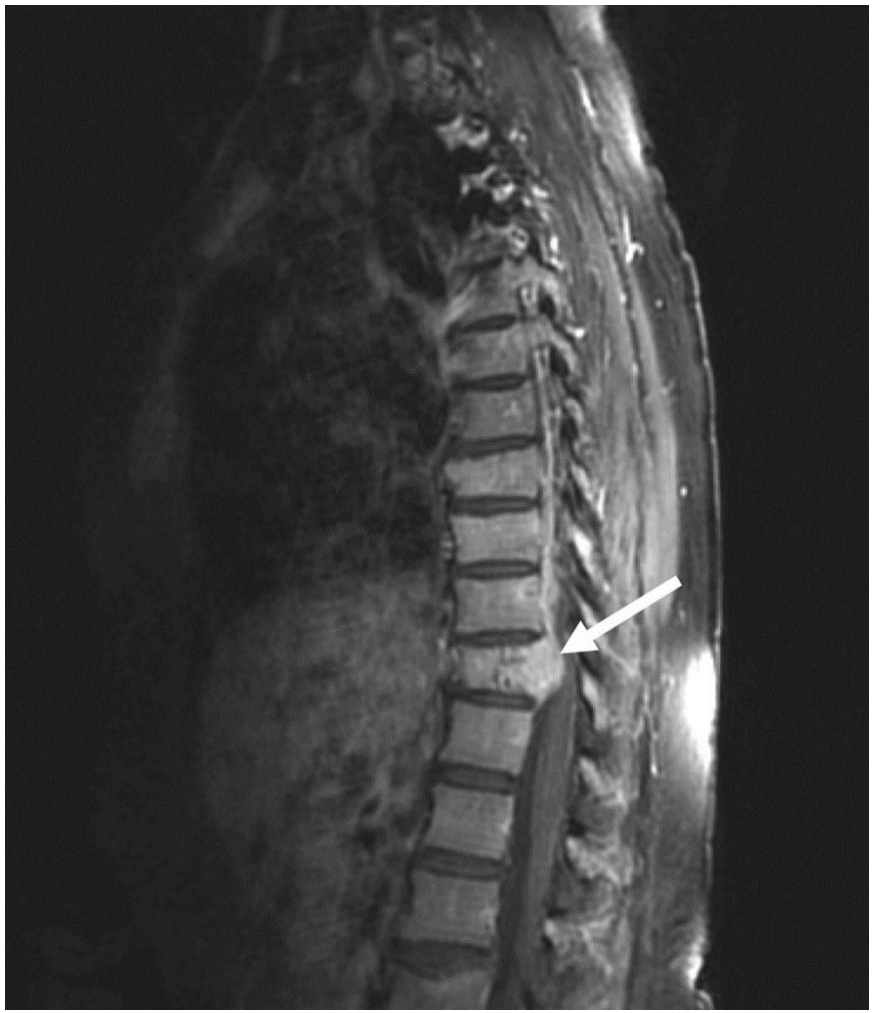
Safety I?

- Hospitals are reactive, and seek closure
  - Determine how the undesired event happened
  - Prevent it from happening again

- Identify the hazard
  - Mitigate specific hazards

What we learn when things go right

- Cluster of missed spinal cord compression cases
- Asked why some people don't miss them
- Looked at cases in which spinal cord compression not missed
  - Recognized in timely fashion
  - Appropriate intervention
- Need knowledge of:
  - Clinical subject matter
  - Sociotechnical factors
  - Safety II perspective



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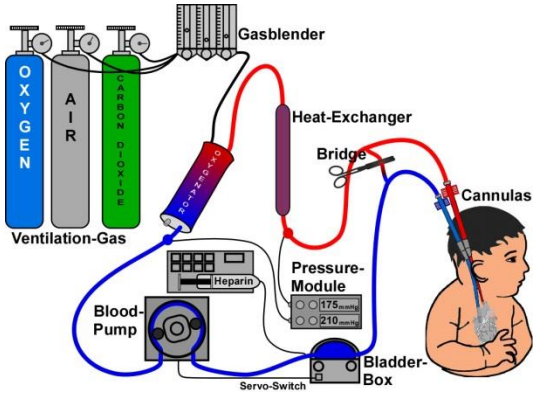
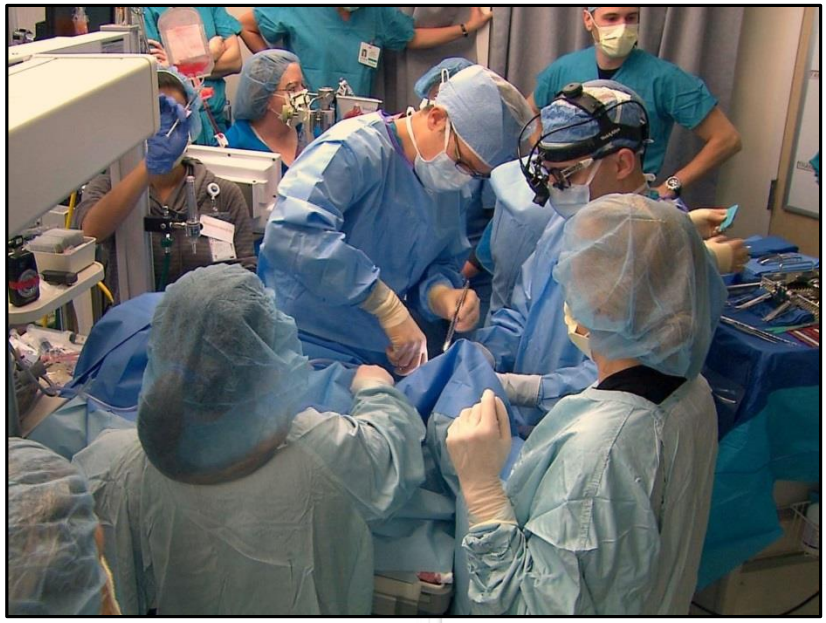
Patient Requires emergency ECMO
Tale of Two Safeties:



- Critical Care physicians had time to look at cardiac tracings from the ED in real time and observe deterioration
- Critical Care able to send physician to the ED to assist
- Pediatric Surgeon in house and asked for help
- CV surgeon came to ED



http://www.king5.com/story/news/health/childrens-healthlink/2014/12/27/pushing-limits-saving-lives/20658435/ and https://upload.wikimedia.org/wikipedia/commons/1/14/Ecmo_schema-1-.jpg

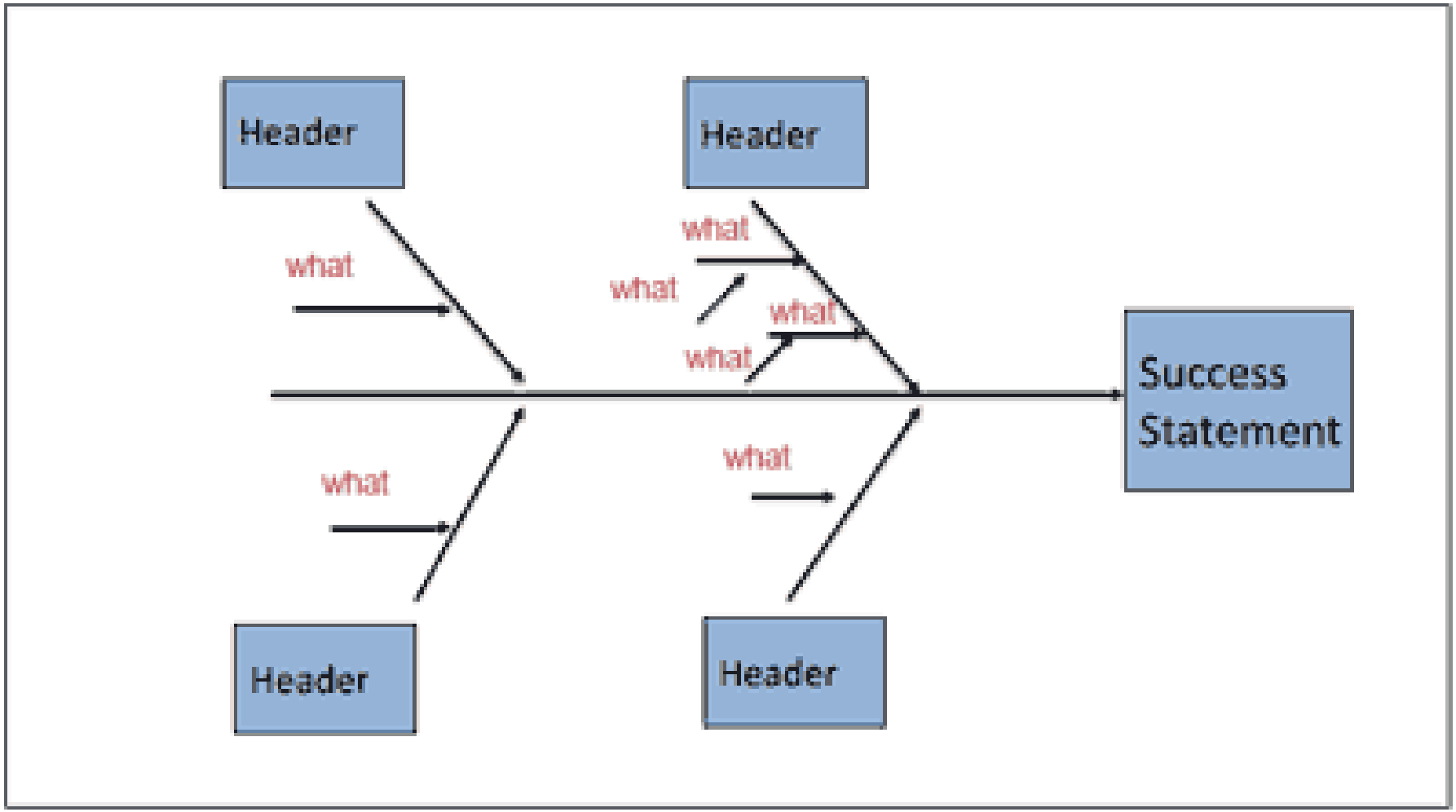
Emergency Department and Critical Care Reviewed Event

- Stretch capacity
  - not always available
- Able to monitor ED bed from PICU remotely
- Learned from prior adverse event
- Did they go to ECMO too soon?
- Review not guided
- Leadership reinforced decision to go to ECMO
  - Saved patient's life

Paradigm shift

- Easiest to react to bad outcomes
  - And accept the process which resulted in a good outcome
- How do we prioritize debriefing what is successful?
- How do we replace complacency with urgency?
- How can we integrate this approach into the fabric of hospital structure and system?
  - One Root Success Analysis (RSA) for every RCA?
  - Align with ongoing processes?

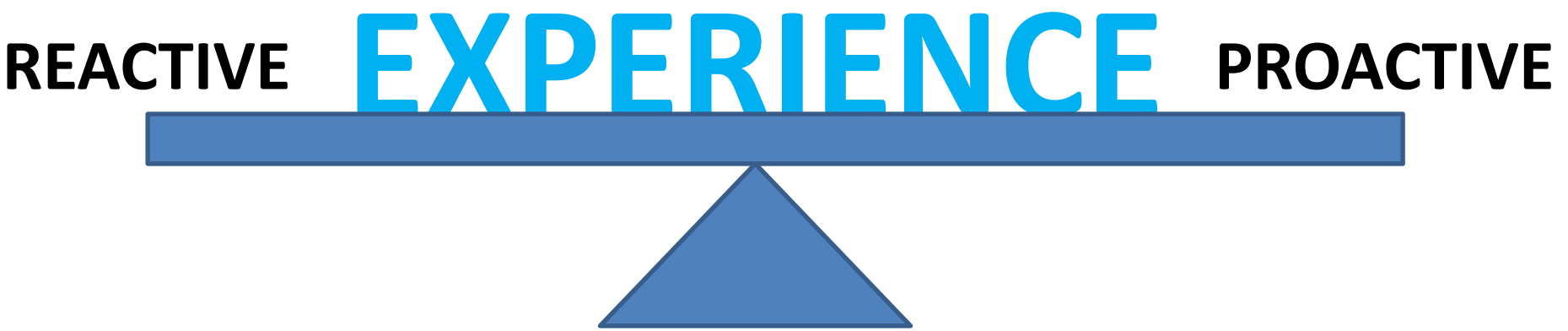
Root Success Analysis (simplified)



http://asq.org/img/healthcare/success-effect.gif

Success Modes Effects Analysis

- Identify resources that are at risk
- Maintain margin / slack
- Identify resource needs proactively
- Identify activities that contribute to margin of maneuver that worker is using but may not be visible to administration
- Identify necessary resources proactively



- No action will be entirely proactive or reactive except at extremes- always based on some experience –either primary or by word of mouth

Safety II actuated

- How do people effect the change and make it fit into what they already do?

- Culture of everyday work
  - Integrate into familiar processes
  - Shift paradigms deliberately, consciously, and thoughtfully