Delivering Resilient Health Care: The 2018 Australian Masterclass

Macquarie Graduate School of Management (MGSM)
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Our mission is to enhance local, institutional and international health system decision-making through evidence; and use systems sciences and translational approaches to provide innovative, evidence-based solutions to specified health care delivery problems.
Australian Institute of Health Innovation

PIONEERING | STRATEGIC | IMPACT
• Professor Jeffrey Braithwaite
  Founding Director, AIHI; Director, Centre for Healthcare Resilience and Implementation Science

• Professor Enrico Coiera
  Director, Centre for Health Informatics

• Professor Johanna Westbrook
  Director, Centre for Health Systems and Safety Research
“After decades of improving the health care system, patients still receive care that is highly variable, frequently inappropriate, and too often, unsafe.”

By the way, there is some reassurance: We have been successful e.g. …
Heart bypasses on eighty year olds, key hole surgery, treatment for HIV/AIDS
But the rates of harm haven't reduced far enough
It seems to have flatlined at 10%
So we need new ideas and innovations in thinking about patient safety
New innovations in patient safety: Safety-I and Safety-II
Safety-I and Safety-II
The amazing thing about health care isn’t that it produces adverse events in 10% of all cases, but that it produces safe care in 90% of cases.
Safety-I – where the number of adverse outcomes is as low as possible

Trying to make sure things don’t go wrong
Safety-II – where the number of acceptable outcomes is as high as possible

Trying to make sure things go right
Few people have ever looked at why things go right so often
So:

Can we shift the emphasis to a more positive approach?

To make sure things will go right more often?
Policy-makers, executives, managers, legislators, governments, boards of directors, software designers, safety regulation agencies, teachers, researchers …
The blunt end tries to ... shape, influence, nudge behaviour
What they do seems perfectly logical, obvious and feasible
In health care, those doing WAI have designed, mandated or encouraged a bewildering range of tools, techniques and methods, to reduce harm to patients.
E.g., root cause analysis, hand hygiene campaigns, failure modes effects analysis ...

And there are lots of others ...
Meanwhile work is getting done, often *despite* all the policies, rules and mandates.
Glove placed over a smoke alarm, as it kept going off due to nebulisers in patients’ rooms

A leg strap holding an IV to a pole, as the holding clasp had broken

Plastic bags placed over shoes to workaround the problem a of gumboot (welly) shortage
Doctors in Emergency Departments in a study:

- Were interrupted 6.6 times per hour
- Were interrupted in 11% of all tasks
- Multitasked for 12.8% of the time

[Westbrook et al. 2010. Qual Saf Health Care]
Doctors in EDs in a study:

- Spent on average 1:26 minutes on any one task
- When interrupted, spent more time on tasks
- And … failed to return to approximately 18.5% of interrupted tasks

[Westbrook et al, 2010, Qual Saf Health Care]
And therefore the only real solution is to try and reconcile work-as-imagined (WAI) and work-as-done (WAD)
So work-as-imagined folks often have some sort of linear, mechanistic view of the system.
Instead, health care is a complex adaptive system delivered by people on the front line who flex and adjust to the circumstances.
And don’t deliver care in the way blunt end prescriptivists want them to.
New innovations in patient safety:
Resilient health care: WAI and WAD
WAI and WAD

[Hollnagel, 2015]
Let’s explore this …
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