



## FEATURE

## QUALITY IMPROVEMENT

## Patient safety lessons from the world's experts

Healthcare improvement leaders from the Netherlands, Saudi Arabia, Sweden, the UK, and the US tell *Jacqui Wise* what their countries have learnt in efforts to deliver safer care

Jacqui Wise *freelance journalist*

London, UK

This year patient safety leaders from five countries met in Saudi Arabia to share successes and challenges in their efforts to improve patient safety at a health system level. Hosted by the BMJ, last April's meeting acknowledged a lack of evidence around what has been effective and the need to learn from global exemplars.

"Although healthcare systems differ from country to country," said Fiona Godlee, editor in chief of *The BMJ* and chair of the meeting in Riyadh, "improving patient safety often faces similar obstacles, and we can learn from what has worked and hasn't worked elsewhere."

After the meeting, some participants travelled to Tokyo to join representatives from 44 countries to sign a declaration acknowledging patient safety as vital to universal health, calling for "high level political momentum" to push for safer care everywhere.<sup>1</sup>

### Engage patients

A key message from the Riyadh meeting was that patient engagement is critical to improving safety. Mike Durkin, senior adviser on patient safety policy and leadership at the Institute for Global Health Innovation at Imperial College London and former national director of patient safety at NHS England, agrees. "Patients can drive the agenda for change—more so than professionals," he says, giving the example of reducing venous thromboembolism in the UK.

Doctors knew that assessing patients for risk and prescribing anticoagulant drugs could help. But only in the late 1990s and early 2000s was there any "real action" to reduce deaths, he told *The BMJ*, resulting from a coalition of patient and parliamentary groups.

In the Netherlands, patients have had an enormous role in creating momentum for change, says Ian Leistikow, an inspector with the Dutch Health and Youth Care Inspectorate, giving the example of highly complex paediatric oncology in the country. "We now have one centre in the Netherlands because patients wanted change," he said. "Doctors used to say patients don't

want to travel—but they do if it means that the quality of care is different."

Göran Henriks, chief executive for learning and innovation at Qulturum, which develops improvement knowledge in Jönköping, Sweden, adds that involving patients directly in their care can reduce risks.

"We have a dialysis process where patients take control and do the whole thing themselves, for example," he told *The BMJ*. "They take the equipment, start the machine, clean the machine afterwards, and so on. As a result, care related infections have disappeared."

Care in Saudi Arabia has scope for more patient involvement, said Bandar Al Knawy, chief executive of the Ministry of National Guard Health Affairs and president of King Saud bin Abdulaziz University for Health Sciences. "Patients are involved in our complaint procedures but not represented on our committees," he said.

Cultural barriers can inhibit patient involvement, warns Don Berwick, president emeritus and senior fellow of the Institute for Healthcare Improvement in Boston in the US. "Norms of politeness and respect for authority or high prestige in society make it harder for people to speak up," he told *The BMJ*.

"A just safety culture is one where everyone can speak up all the time," he says, "where they can say what's wrong and can do so without being blamed."

### Collaboration is key

Another common message among global safety experts is the importance of collaboration, among clinicians, patients, commissioners, and regulators. Leistikow says that the Netherlands excels in "collaborative governance"—that is, collaboration among healthcare professionals and regulators.

An example of success was when the country centralised pancreaticoduodenectomy procedures, says Leistikow. The Enhanced Recovery After Surgery Society started the programme, and the Dutch Healthcare Inspectorate implemented

it. Switching from low to high volume centres was accompanied by a halving in the mortality rate from these procedures in four years.<sup>2</sup>

Sweden also relies on deep collaboration, with the Swedish Association of Local Authorities and Regions coordinating 20 healthcare systems covering 290 communities. “This has raised the general understanding of quality and safety matters,” Henriks says. Every year the association evaluates each system for patient safety and publishes the results.

## A culture of openness

A culture of openness among healthcare staff is crucial for improving patient safety, the experts agree. “The science is clear,” Berwick says, “You can’t have safety and secrecy in the same game.”

England has the world’s largest reporting system, the National Reporting and Learning System, Durkin says, which collects more than two million incident reports a year from NHS staff. One area of improvement is to add the patient perspective of harm into the system, and this is currently underway.

“The idea that staff can report openly and be supported in doing that is paramount to setting the appropriate culture,” he says.

Bandar Al Knawy says of Saudi Arabia: “We have a culture of openness—a no shame, no blame approach.” He cites an electronic system for anonymously reporting safety breaches. “We have a management team that look at them almost instantaneously and then create an action plan.”

Sweden’s Henriks says, “Our indicators and structures for comparison and benchmarking are quite strong.” But he says quicker response is needed. “A lot of patient safety matters are connected to daily work. It is hard to change daily processes if people get the evaluation six months later.”

In 2016 a new law came into force in the Netherlands making safe internal reporting systems mandatory for all healthcare organisations. Adverse events leading to serious harm or death have to be reported to the inspectorate. Leistikow explains that some healthcare providers write their reports for the inspectorate rather than for the patients and employees involved. “These reports are often too extensive and too difficult, and the quality of the recommendations that come out of them is often not very strong,” he says.

Albert Wu, professor of health policy and management at Johns Hopkins School of Public Health in Baltimore, points to problems in the US healthcare system: “Our accountability system, particularly our malpractice system, continues to be broken and creates incentives that are diametrically opposed to openness and the culture of safety that is necessary.

“People are afraid to communicate anything because a lawsuit may be pending.”

In 2000 Wu wrote in *The BMJ* about the importance of the “second victim” in medical error, recognising the psychological impact on the staff member.<sup>3</sup> This led to peer support programmes such as the Resilience in Stressful Events scheme at Johns Hopkins, which has been replicated throughout the US and emulated in several other countries.

## Keep check of checklists

Many fundamental elements of patient safety were first developed in the US—such as root cause analysis, incident reporting, checklists, and surgical time-out procedures—before becoming entrenched in healthcare systems worldwide.

In the Netherlands, Leistikow says, “At the beginning of the patient safety movement we created a lot of rules. This has worked well and reduced mortality and morbidity.” But he warns, “We can’t just keep adding double checks to healthcare process because people won’t adhere to them if too disruptive for workflow.

“There are far too many rules and regulations in healthcare—people don’t know which ones are important.”

Wu, at Johns Hopkins, agrees to a degree. “There is a sweet spot where you ideally make specific elements routine—perhaps the most boring and the most easily forgotten ones—so that people no longer need to think about them.

“When they need to, they are free to improvise and be creative, which in some cases is necessary to find a solution. The checklist ideally liberates you from the drudgery and workaday elements of care.”

## Use technology

The roundtable participants noted the vital role that technology plays in improving patient safety, from data collection and surveillance to monitoring and notification.

Al Knawy says, “Digitisation and automation are key drivers of improvements in patient safety.” He gives the example of quickly communicating critical imaging results, such as a pneumothorax.

“Under our system, once a patient has the imaging done then an email is sent immediately to the physician requesting the result. This creates urgency in their care, and this is how technology drives patient safety.”

Electronic prescribing is another example of technology advancing patient safety by removing transcription errors and putting in automatic checks. For example, once it has been noted that a patient is allergic to a particular drug then systems can automatically prevent its prescription.

Electronic health records should be a good thing, says Wu. But he warns, “In our rush to bring them in we have largely missed an opportunity to improve workflow and efficiency and communication.

“They have been designed so that they add time, reduce efficiency, and increase frustration—and even this can lead to burn out.”

## Financial incentives

Offering small incentive payments can bring about demonstrable improvements, says Durkin. “It can get a change in behaviour embedded.” He says, for example, that 30-40% of patients in England were being risk assessed for venous thromboembolism but within six to nine months of introducing a payment the proportion reached 90-95%.

Wu says, however, that it’s not always clear that these “pay for performance” interventions actually improve safety. He gives an example of an incentive programme in the US where Medicare will not pay for a procedure if a patient develops a catheter bloodstream infection while in hospital. “It is designed to help keep patients safer but it can just change people’s way of documenting things,” he warns.

## Future challenges

All countries have some way to go to tackle patient safety challenges. The roundtable and summit coincided with the publication of a report from the Organisation for Economic

Cooperation and Development, *Flying Blind*, which presented an economic argument for safe, good quality care.<sup>4</sup>

The report stated that 15% of hospital expenditure in wealthy countries is used to correct preventable harm after complications of care. Up to 25% of patients in primary and ambulatory care settings in rich countries experience harm—often from diagnostic error or delay or from adverse drug events. This increased to 40% in low and middle income countries.

“An important challenge is seeing safety, not as a one-off project this quarter or this year,” says Wu, “but building safety more comprehensively into the system.”

Berwick concludes, “The three biggest challenges are leadership, leadership, and leadership. A supportive culture, investment in data, supporting staff, and supporting a culture of openness all depend on leadership—executives, clinical leaders, boards of trustees, government leaders, and trust leaders.”

“Unless leaders take safety seriously and scientifically we won’t see systemic progress.”

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- 1 Third Global Ministerial Summit on Patient Safety. Tokyo declaration on patient safety. 2018. [www.mhlw.go.jp/file/06-Seisakujouhou-10800000-Iseikyoku/0000204005.pdf](http://www.mhlw.go.jp/file/06-Seisakujouhou-10800000-Iseikyoku/0000204005.pdf).
- 2 de Wilde RF, Besselink MG, van der Tweel I, et al/Dutch Pancreatic Cancer Group. Impact of nationwide centralization of pancreaticoduodenectomy on hospital mortality. *Br J Surg* 2012;99:404-10. 10.1002/bjs.8664 22237731
- 3 Wu AW. Medical error: the second victim. The doctor who makes the mistake needs help too. *BMJ* 2000;320:726-7. 10.1136/bmj.320.7237.726 10720336
- 4 Organisation for Economic Cooperation and Development. The economics of patient safety in primary and ambulatory care: flying blind. April 2018. [www.oecd.org/health/health-systems/The-Economics-of-Patient-Safety-in-Primary-and-Ambulatory-Care-April2018.pdf](http://www.oecd.org/health/health-systems/The-Economics-of-Patient-Safety-in-Primary-and-Ambulatory-Care-April2018.pdf).

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