



Cash Cow

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Use Patient Safety to Improve Your Bottom Line

Summary: A culture of safety not only protects the patient from harm but ensures an open, honest and high-quality healthcare system.



David B. Mayer

CEO
Patient Safety Movement
Foundation
USA

Executive Director
MedStar Institute for
Quality and Safety
USA

David.mayer@patient-
safetymovement.org

patientsafetymovement.org/

 @PLAN4ZERO

W. Edward Deming dedicated much of his career studying and analysing various industries and found there are two general approaches to improving quality. In this case, improving patient safety and the quality of care. If the people and organisation focus on managing costs, the quality will be impacted and will decline over time. If an organisation focuses on quality, quality tends to increase and costs decline over time. One reason behind the decrease in cost is that increasing quality can decrease waste and rework. A focus on quality also means investing in the continual improvement of systems, processes and practices.

In the healthcare arena, this begins with establishing a culture of safety and an environment based on transparency, trust and accountability between management, staff, patients and families. For many organisations, this can be a transformational change that requires strong leadership to ensure transparency and encourage accountability. When a patient safety issue arises, it should be addressed openly with the team and resolved as quickly as possible. It's also important to celebrate successes (eg good catches) as you progress to ZERO preventable patient deaths.

A culture of safety allows care teams to learn from the experiences of others, learn from mistakes and improve processes to avoid preventable medical harm. To create a safe environment while maintaining accountability, leadership and staff must recognise and separate failures of the system or processes from harm caused by individual malfeasance. The concept of a safe, transparent environment that follows 'Just Culture' principles is critical to improving quality. As Deming wrote, "Top management should publish a resolution that no one will lose his job for contribution to quality and productivity."

Changing systems and processes can be challenging but changing culture may be the most difficult obstacle to overcome in your quest for quality improvement and cost reductions. To support your

culture of safety, you will need to create an infrastructure that maintains trust and respect, the reporting of unsafe conditions or processes, and continually evaluates and improves processes and systems. The infrastructure should include training, oversight committees, leadership updates an electronic reporting system and even a patient and family advisory committee for quality and safety.

Part of the continual process to eliminate preventable patient harm includes open communication and engagement with patients and their families as well. That's where the CANDOR (Communication and Optimal Resolution) process comes in. This is a structured process that ensures you respond to patients and staff in an open, honest, and timely way. Transparency is a critical component in reducing patient harm, improving outcomes and quality of care. Deming would very much approve. ■

KEY POINTS



- W. Edward Deming found that focusing on quality tends to increase quality and decrease cost over time.
- Patient safety issues should be addressed openly and as quickly as possible.
- To establish a safe environment, failures of the system or processes should be separated from harm caused by individual malfeasance.
- To support safety culture, the healthcare infrastructure should be built on trust and respect, and should also become a place where unsafe conditions are reported and constantly improved upon.
- The CANDOR process is structured so that patients and staff are responded to in an open, honest and timely way.