Patient Safety's Future Through An Organization Theory Lens

Stanford Medicine Center for Improvement, June 22, 2021

Kathleen M. Sutcliffe, PhD
Bloomberg Distinguished Professor
Johns Hopkins University

Conflict of Interest Disclosure:
Presenter has no conflicts of interest.

JOHNS HOPKINS UNIVERSITY

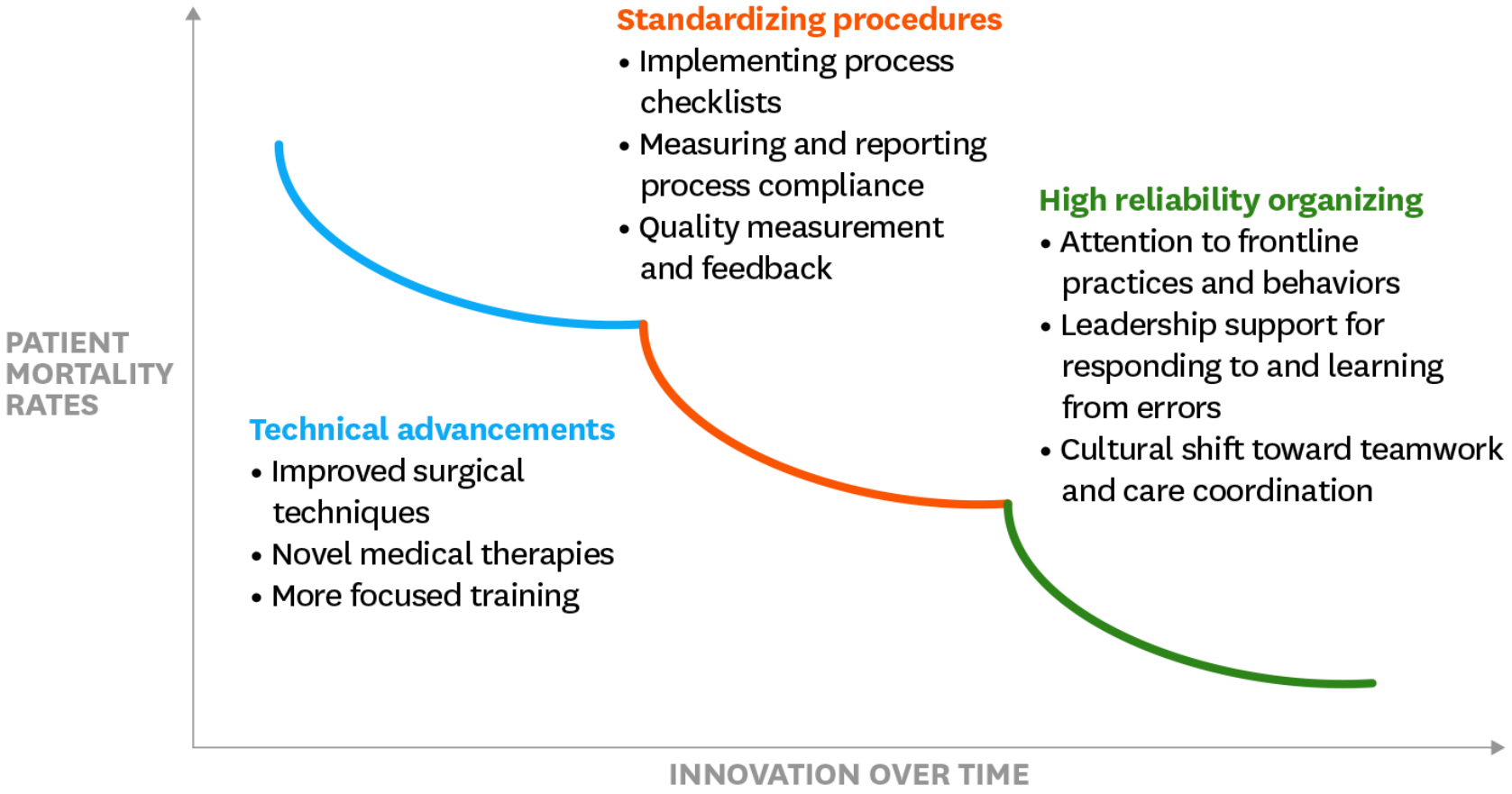
Disclosure

The speaker does not have any relevant financial relationships with commercial interests or affiliations to disclose.

Key Message (In A Nutshell)

The next waves of innovation will focus on improving how people interact with one another and how they organize their day-to-day work.

Organizing For High Reliability **Is** The Future



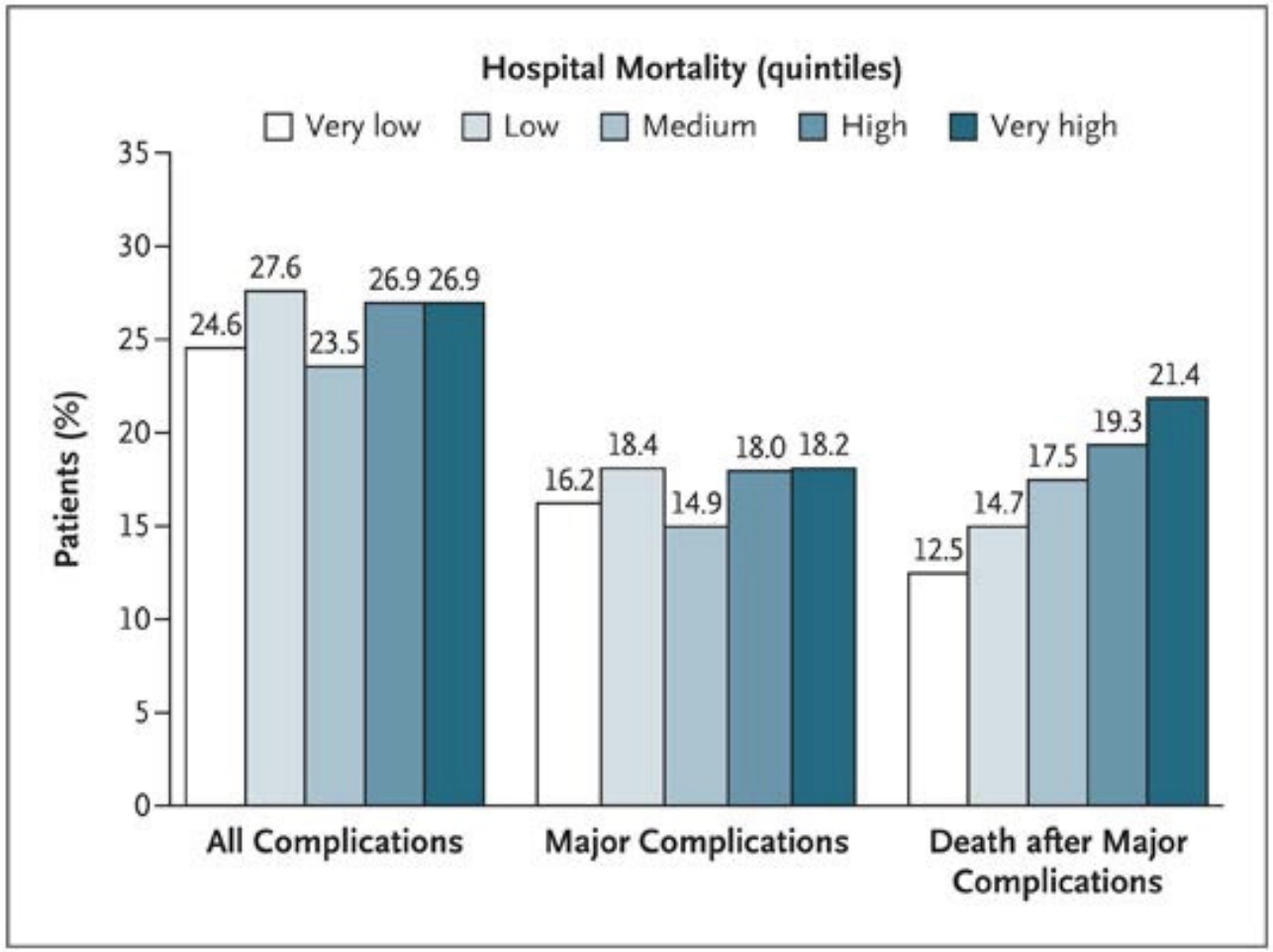
(Ghaferi, Myers, Sutcliffe, & Pronovost, 2016, Harvard Business Review)

What Do We Know?

- **Mortality in surgery patients continues to vary**
  - Large variation: 3% adjusted rates of death at lowest mortality hospitals vs. 7% in very high mortality hospitals
  - Longstanding view: Preventing complications
- Researchers stratified hospitals into 5 groups according to their overall mortality and then examined complication rates across the groups

Ghaferi, Birkmeyer, Dimick, *NEJM/Ann Surg*, 2009

Prevention Alone is Insufficient



Ghaferi, Birkmeyer, Dimick, *NEJM,* 2009

Prevention Alone is Insufficient

- Reducing complication rates alone does not reduce mortality rates
  - Preventing complications certainly helps, but it's not the whole story
- What differs is how hospitals and surgical teams act *before*, *during and after* complications occur
  - **High mortality hospitals FAIL to rescue**. They are unable to effectively sense and manage complications.
  - **Rescuing reflects a more general set of processes that enable sensing, sensemaking, learning and contingently responding as things unfold.**

Ghaferi, Birkmeyer, Dimick,
NEJM, 2009

Rescuing

- Rescuing requires:
  - Timely recognition of failing courses of action
  - Effective interventions
  - Recursive interactions between sensing, interpreting, updating and acting in a dynamic unfolding situation
- These depend on:
  - Trust and respect
  - Speaking up and speaking out
  - Daily habits that keep us focused, alert, aware, and capable of sufficiently understanding an unfolding situation to effectively intervene

In Other Words

Rescuing requires that we

"Organize for High Reliability"

High Reliability Requires

- Making discrepancies visible so that people can act on them before "harm" is caused.
- Designing systems so that people can:
  - anticipate and prevent breakdowns,
  - catch problems in the making,
  - make adjustments before problems grow bigger, AND/OR
  - deal with consequences after they become manifest.

Williams, Gruber, Sutcliffe et al., 'Organizational Response to Adversity', *AoM Annals*, 2017

What Does It Take To "Organize For High Reliability"?

1. Enact bundles of high-performance human resource practices;
2. Build vigilant upstream-downstream coordination;
3. Engage in daily practices (i.e. habits of thought and action) consistent with a set of principles (e.g., attend to failures (pre-work briefings, huddles, handoffs); avoid simplifying assumptions (test assumptions with varied perspectives including patients/families); defer to expertise (rapid response teams); etc.);
4. Actively shape contexts/climates of respect and trust.

See Weick & Sutcliffe, *Managing the Unexpected*, 2015, Wiley; Sutcliffe, Paine, et al., Re-examining high reliability: Actively organizing for safety, *BMJ Quality and Safety*, 26, 248-251, 2017.

Organizing For High Reliability

- Enhances individual alertness
- Fosters team/unit/organizational awareness
- Enables more immediate and effective responses to unfolding events and mishaps
- **Is the essence of productivity** – not working harder or faster; working smarter (contingently responding moment to moment to changing conditions and doing it over and over again)
- Counteracts tendencies toward complacency and vulnerability

Organizational Vulnerability Is Fueled By

Mundane Organizational Imperfections

- tolerance for routine operational errors
- failures in carrying out procedures and policies
- failures in compliance
- weak monitoring and control practices
- increasing weakening and misalignment of organizational culture

Managerial Ignorance

- defensiveness, fallacy of centrality
- simplified world views and assumptions

Patient Safety Through an OT Lens

- Healthcare is a special case of safety—safety that occurs in complex, dynamic, uncertain, and sometimes high-hazard environments.
- Safety is a dynamic non-event:
  - safety is dynamically preserved by timely human adjustments;
  - safety is a nonevent because successful outcomes do not call attention to themselves.
- We will never have a complete understanding of all the factors that are keeping a unit/organization safe (nor all the factors that might go wrong).
- Adaptability is crucial to safe performance.

Patient Safety Through an OT Lens

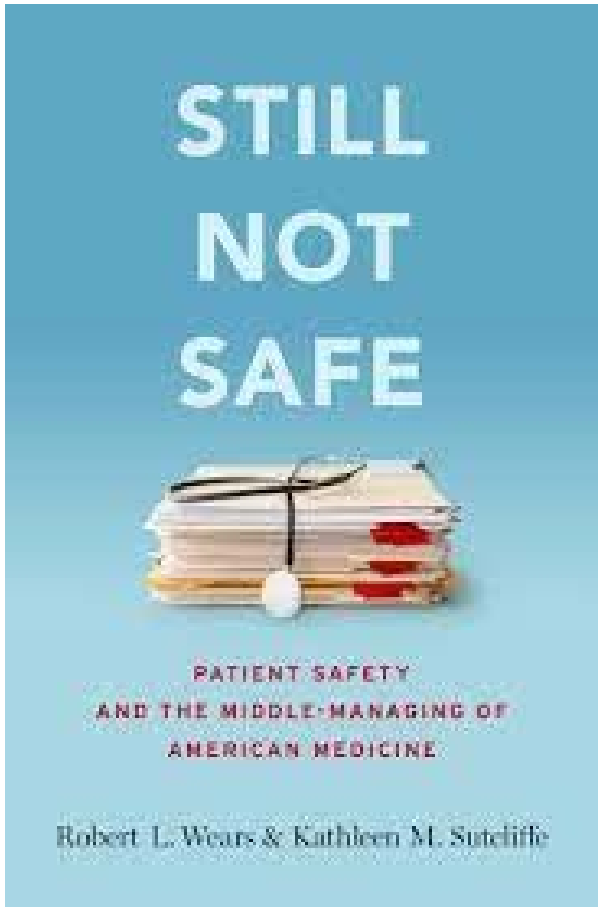
- System safety is an illusory concept. There are no safe systems and organizations because past performance cannot determine the safety of any entity. Transient organizational systems have to be continually reconstituted.
- Adverse outcomes are rarely the result of the actions of any single individual nor the result of a single cause.

How can I critique a movement I care deeply about without undermining it's efforts?

(A. Bobrow-Strain, 2012)

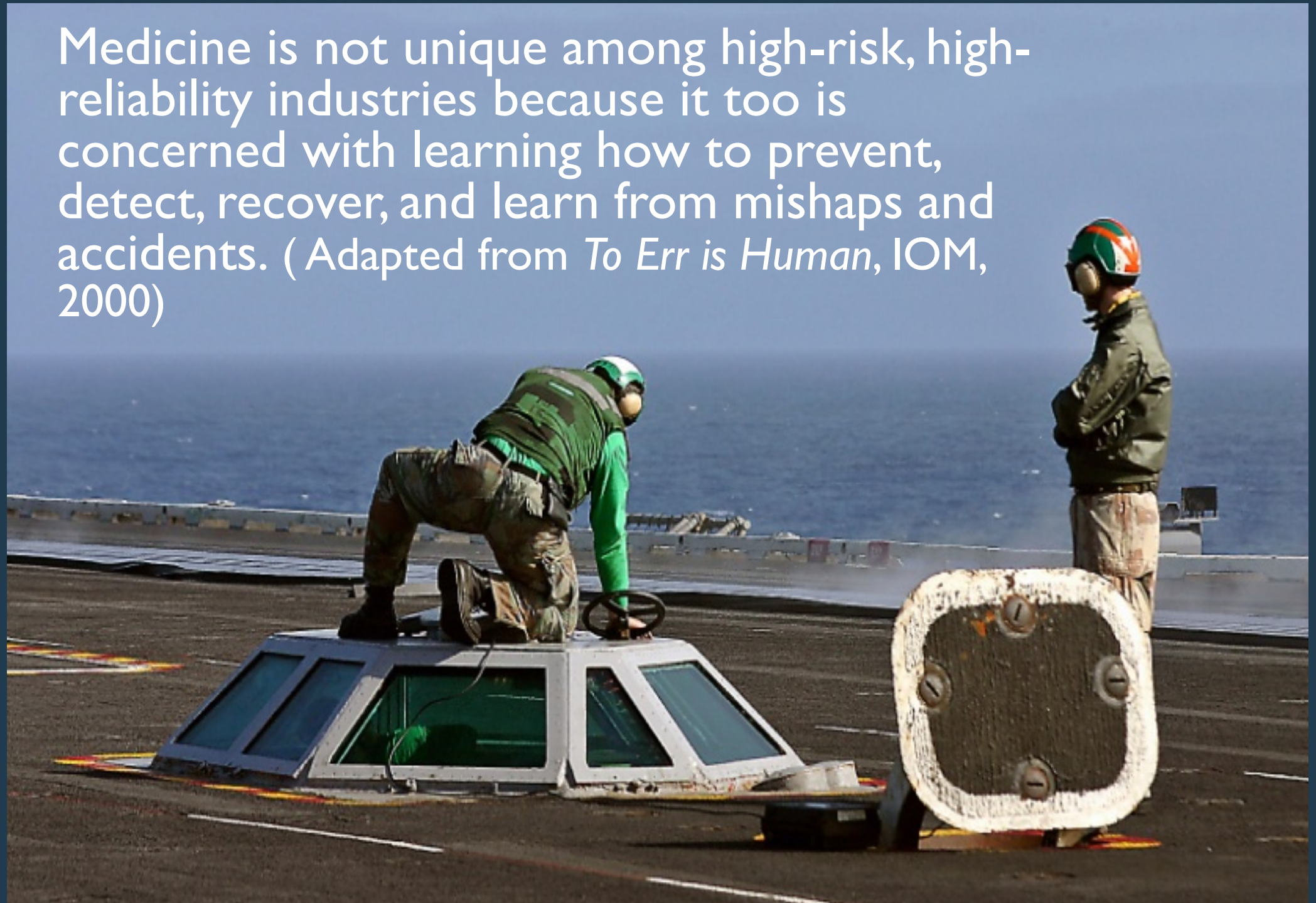
After All These Years…

Robert Wears, MD., MS, PhD
1947-2017



Oxford University Press,
2020

Medicine is not unique among high-risk, high-reliability industries because it too is concerned with learning how to prevent, detect, recover, and learn from mishaps and accidents. (Adapted from *To Err is Human*, IOM, 2000)



In Sum

- Particular organizing principles and practices enable highly reliable performance: These ways of working are "adaptive organizational forms for increasingly complex environments" (Weick, Sutcliffe, Obstfeld, 1999).
- These ways of working:
  - increase the quality of collective attention and the capabilities to act on what is seen, so as to better manage dynamism and prevent unexpected surprises from escalating out of control;
  - enable a strong culture of safety and reliability.

A Cautionary Tale

1. HRO paradigm **=** a lens for understanding how high performance under trying conditions can come about.
2. HRO ≠ a recipe, a formula, or step by step procedure or silver bullet for achieving reliable performance day after day.
3. HRO **=** is something of a misnomer; a good today doesn't guarantee a good tomorrow —thus we emphasize the idea of **organizing rather than organization!**

Thank you!

ksutcliffe@jhu.edu