病人安全文化～從頭說起

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2008.10.21

推動病人安全4大原則

1.以病人為中心(Patient-centric)

2.系統導向　(Systems thinking)

3.全體參與　(Involve all stakeholders)

4.從失敗中學習(Learn from mistakes)

2009 JC Leadership Standards

LD.4.260
The Hospital implements an integrated, hospital-wide Patient Safety Program.

The scope of the program includes the full range of safety issues.

All departments, services and programs within The hospital participate.

The Hospital conducts proactive risk assessments.

Why Safety Culture?

- Patient safety can best be achieved through the adoption of a culture of safety (IOM)
- Safety culture = good business sense
- Many experts agree that a safety culture is necessary before other patient safety practices are introduced.
- The key to building a safer health system is to develop, maintain and nurture a safety culture
- Measure of culture could be leading indicators of migration toward accidents
- The JC 2008 Leadership Standards require that "leaders regularly evaluate the culture of safety and quality using valid and reliable tools"
- Patient safety is ultimately a culture issue
- Safety cultures are the holy grails in any risky industry

為何要談安全文化？

- 藉由安全文化的建立才能達成最佳的病人安全
- 安全文化是良好的商業意識
- 許多專家一致認為了解病人安全之前必需先導入安全文化
- 最嚴重的事故涉及人為錯誤
- 測量的文化可當做導致事故的重要指標
- 2008年JC評鑑標準主管領導能力的要求，“醫院高層需定期評估安全文化和品質的使用有效和可靠的工具。”
- 患者安全最終是文化問題
- 安全文化對任何有危險的行業而言如同聖杯(如:達文西密碼)

What do we mean by a Culture of Patient Safety?

- The institutional attitude toward patient safety and toward improving patient safety.
- Any clinical entity working as a cohesive unit on behalf of patients' safety is a culture of safety.
- An environment in which patients, their families, and org. staff/leaders can identify and manage actual and potential risks to patient safety.
- The product of the individual and groups values, attitudes, competencies and patterns of behavior that determine the commitment to safety programs.
- The shared commitment of management and employees to ensure the safety of the work environment.
- Safety culture is usually defined in terms of a set of ideal characteristics.

安全文化的定義

- 全院對病人安全及對改善病人安全的態度
- 一個能使病人及其家屬或各級醫護人員辨別處理實際和潛在病人風險的環境
- 全體員工對病人安全文及改善病人安全的態度。
- 經營管理者及員工皆能致力於確保工作環境的安全，也是個人和團體對決家投入安全計劃的價值觀、態度、能力及行為模式的整體表現
- 安全文化通常是以一套理想的特點來界定

Purposes of a Safety Culture

1. Reduce adverse events
2. Create behavioral norms around safety
3. Increase individual commitment to patient safety
4. Ensure safety issues receive the attention warranted by their significance
5. Ensure that organizational members share same ideas about risks

安全文化的目的

1. 減少不良事件的發生
2. 建立關於安全的行為規範
3. 提高個人對病人安全的承諾
4. 確保安全問題，因為它的意義而得到重視
5. 確保組織成員對風險都有同樣的想法

- Patient Safety Goals 1/(5)
  CCHSA, Canada
- Path to Patient Safety, Step 1/(7)
  NPSA, U.K.
- Best (Safe) Practices 1/(30)
  AHRQ, NQF, USA

建立安全文化的重要性

- 病人安全目標1/（5）
  CCHSA，加拿大
- 病人安全路徑，步驟1/（7）
  NPSA，英國
- 最佳（安全）行為1/（30）
  AHRQ，NQF，美國

安全文化的特性

- 成熟和誠實的溝通
- 團隊合作
- 信任和開放
- 注重系統性及人為因素的分析法
- 非懲罰性的自願通報系統
- 病人參與
- 有充分休息的人力資源
- 足夠的人力和稱職的工作人員
- 各層級皆負責
- 能確保持續品質改進的領導
- 階級平坦化
- 安全文化（報告，學習，公正，靈活，謹慎）
- 遵守規章程序及工作規範

Key Attributes and Characteristics of High Reliability Organizations

- Have clarity regarding goals
- Have logical decision analysis based on SOPs
- Compel adherence to SOPs
- Anticipate failures
- Have resilient and redundant system
- Safety cultures(reporting, flexible, just, learning)
- Extensive training(team training using simulation)
- Reward for honesty and positive sanctions
- Reliability > efficiency
- Willingness to change
- Cope with complexity

高可靠性組織的屬性和特點

- 有明確的目標
- 有合理的決策分析的基礎上標準作業程序
- 遵守標準作業程序
- 預測失敗
- 有彈性和系統
- 安全文化

（報告，靈活，公正，學習）

- 廣泛培訓（利用團隊培訓）
- 獎勵的誠實和積極的制裁
- 可靠性“效率

Interdependent Culture Types Found in HRO

Reason, 1997

Reporting Culture:
- willing to report errors and non-compliances

Learning Culture:
- the org. learns from its mistakes

Just Culture:
- people know what constitutes acceptable behavior

Flexible Culture:
- the org. can cope with new challenges
- everyone is empowered to steer the ship away from an iceberg

Wary Culture:
(Hudson, 2001)
- the org. anticipates the unexpected

Changing Culture and Changing the Paradigm

From:	To:
•Focus on individual	•Focus on team
•Authoritarian culture	•Communitarian culture
•Fear, defensiveness	•Openness and support
•Secrecy, silence	•Transparency, apology
•Shame and blame (finger-pointing)	•Systems thinking and support
•Humiliation	•Mutual respect
•Only some participate	•Everyone participates

文化的改變與機轉

從：	到：
■ 個人主義	• 焦點擺在團隊
■ 威權文化	• 社群文化
■ 恐懼，為自己辯白	• 開放和支持
■ 保密，沉默	• 透明公開，道歉
■ 恥辱和指責（被貼標籤）	• 系統的思維和支持
■ 屈辱	• 相互尊重
■ 只有部份員工參加	• 人人參與

病人安全的基本架構

- 領導
- 一個熱心的病人安全委員會
- 通報系統
- 改進實施方案
- 正式的病人安全教育/培訓

SWOT

S- 優勢

安全可以被行銷
成爲產品（賣點）

O – 機會

?

W – 弱勢

各種大小不同的
“絆腳石”

T – 威脅

- 績效矛盾現象（被健保罰扣）
- 財務困境
- 醫護人員不被信賴
- 病患預後差
- 因違法.違規(Non-compliance)被罰
- 密告爆料（Whistle blowing）
- 困難通過評鑑

Key Steps to Create a Safety Culture (Safety Culture Transformation)

Step 1: Assess where your are now
Step 2: Create the vision
Step 3: Engage leadership
Step 4: Build the right team
Step 5: Focus and set goals/expectations
Step 6: Educate and train for teamwork
Step 7: Collect data and analyze
Step 8: Disseminate the results
Step 9: Re-survey safety culture
Step10: Reinforce and build sustainability

建置安全文化的關鍵步驟

（安全文化的轉變）

第1步：評估現況
第2步：宣示願景
第3步：先由高層領導人做起
第4步：成立正確的團隊
第5步：設定目標/期望
第6步：團隊教育與培訓
第7步：收集數據與分析
第8步：公開研究成果
第9步：重新調查安全文化
第10步：建立和加強可持續性

Strategies for Creating a Strong Safety Culture

1. Leadership commitment
2. Systems thinking
3. No-blame culture
4. Transparency
5. Involve patients and families
6. Improve communication by use of briefings
7. Standardize the process, use protocols,SOPs
8. Move toward electronic medical records
9. Minimize reliance on memory, use checklist

1. 領導層的承諾
2. 系統思維
3. 不責怪的文化
4. 透明度
5. 將病人和家屬當做夥伴
6. 改善溝通並善用簡報
7. 使用標準作業程序
8. 邁向電子病歷
9. 盡量減少依賴記憶，使用核對表

Strategies for Creating a Strong Safety Culture

10.重視職員的工作
11.處理人力短缺的問題
12.改善職場環境
13.獎勵通報
14.減少交接
15.提升認證制度的門檻
16.執行全國性病人安全目標
17.使用團隊方式以錯誤預防
18.教導人因工程學

10. Address workforce fatigue
11. Manage staff shortage
12. Enhance the environment
13. Reward error reporting
14. Reduce hand-offs
15. Refine credentialing process
16. Apply national patient safety goals
17. Use team approach to error prevention
18. Teach human factors science

Some Ideas for Patient Safety Culture Change

1. Strengthen leadership's commitment e.g. Boards on Board intervention
2. Provide incentives to team members and division leaders
3. Measure adverse event reporting
4. Establish a safety culture survey baseline and repeat regularly
5. Encourage the sharing of patient safety information across the organization
6. Educate and train physicians to develop better communication skills
7. Reward staff for fixing underlying problems
8. Remove barriers and build trust
9. Speak Up campaign
10. Patient Safety Executive Walkrounds
11. Education on incident reporting for nursing and new employee orientation
12. Embrace simulation medicine

如何評價JAH的醫療品質

1. Structure
2. Process
3. Outcome

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4. Personality

The Pathological Organization

* Information is hidden
* Messengers are shot
* Responsibilities are shirked
* Bridging is discouraged
* Failure is covered up
* New ideas are crushed
* Disruptive behaviors are common

-modified from JCI

有病的醫療機構

- 訊息被隱匿
- 提供訊息者被處罰
- 推卸責任
- 阻止溝通管道
- 掩蓋失敗／失策
- 新的創意被抹煞
- 常見破壞性行為

Dx : Infrastructure Failure

An undesirable or unintended event occurrence, or situation involving the infrastructure of a medical facility or the discontinuation or significant disruption of a service, which could seriously compromise patient safety.

Barriers to Creating a Culture of Safety

* lack of motivation
* lack of leadership
* lack of funds and other resources
* lack of skills
* lack of knowledge
* lack of communication
* lack of transparency

安全文化的障礙物

- 缺乏動力
- 缺乏領導能力
- 缺乏資金和其他資源
- 缺乏技能
- 缺乏知識
- 缺乏溝通
- 缺乏透明性

Barriers to Creating a Culture of Safety

* culture of low expectation
* culture of blame
* understaffing
* poor health literacy
* disruptive behaviors
* resistance to change
* silo mentality

安全文化的障礙物

- ☑ 低期望的文化
- ☑ 懲罰怪罪的文化
- ☑ 人員不足
- ☑ 健康知能低落
- ☑ 破壞性行為
- ☑ 抵制變革
- ☑ 本位主義

Critical Success Factors

* Trustworthy leadership
* Communication
* Teamwork
* Accountable culture
* Systems thinking
* Staff buy-in
* Capable champions/middle managers
- Just culture environment
- Respect
- Involve everyone
- Align with other organizational priorities
- Patient centeredness

成功的關鍵因素

- 值得信賴的領導
- 溝通
- 團隊合作
- 負起說明責任的文化
- 系統思維
- 員工的肯定
- 有才能的擁護者 /中層管理人員
- 公正文化環境
- 讓每個人都參與
- 與組織其他的優先目標並列
- 以病人為中心

The single most important marker of safety is the COMMITMENT by the organization's LEADERSHIP.

"Knowing is not enough;
you must apply.
Willing is not enough;
you must do."

Von Goethe

"Be responsible for what we are doing, but also for what we are NOT doing "

(Albert Schweitzer)

結論

- 病安是永無止盡的旅程
- **BETTER SAFE THAN SORRY**
- **BETTER LATE THAN NEVER**
- **JAH**在安全管理上要有危機意識


Thank you
for
your attention