Resilient health care: re-conceptualising patient safety
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It is widely believed that to improve patient safety we need to reduce medical errors, but it is not always clear how to do this effectively and efficiently. Over the last two decades health systems have adopted techniques including teamwork training, checklists and standardisation from other industries, seeking high levels of reliability. While these interventions have shown promise in reducing some types of errors in specific circumstances, they are not always applicable across health care as a whole, and the impact has sometimes been disappointing, with spread and sustainability not well demonstrated. Research has shown that large, system-wide interventions, such as the introduction of Medical Emergency Teams to identify and manage deteriorating patients, have met with some – but often variable – success. This presentation will examine what the current evidence tells us about how to reduce medical errors, what techniques work, and where. We will examine two different types of thinking about patient safety – Safety-I and Safety-II approaches – that help us understand how best to manage errors in complex health care environments. We review traditional techniques such as the Swiss cheese model, and present newer ideas, such as the Resilience Analysis Grid, to enhance our understanding of how patient safety can be improved. The Safety-II approach argues: instead of focusing on things going wrong, we must also direct our attention to things going right. We will discuss this new paradigm, and its potential for widespread application.
Resilient health care: re-conceptualising patient safety

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It is widely believed that to improve patient safety we need to reduce medical errors, but it is not always clear how to do this effectively and efficiently.[1] Over the last two decades health systems have adopted techniques including teamwork training,[2, 3] checklists[4] and standardisation[5] from other industries, seeking high levels of reliability. While these interventions have shown promise in reducing some types of errors in specific circumstances,[5, 6, 7, 8] they are not always applicable across health care as a whole, and the impact has sometimes been disappointing, with spread and sustainability not well demonstrated. Research has shown that large, system-wide interventions, such as the introduction of Medical Emergency Teams to identify and manage deteriorating patients,[9, 10] have met with some – but often variable – success. This presentation will examine what the current evidence tells us about how to reduce medical errors, what techniques work, and where. We will examine two different types of thinking about patient safety – Safety-I and Safety-II approaches[11] – that help us understand how best to manage errors in complex health care environments.[12] We review traditional techniques such as the Swiss cheese model,[13] and present newer ideas, such as the Resilience Analysis Grid,[14] to enhance our understanding of how patient safety can be improved. The Safety-II approach argues: instead of focusing on things going wrong, we must also direct our attention to things going right. We will discuss this new paradigm, and its potential for widespread application.

References
The presenters

Professor Jeffrey Braithwaite, BA, MIR (Hons), MBA, DipLR, PhD, FAIM, FCHSM, FFPHRCP (UK) is Foundation Director, Australian Institute of Health Innovation, Director, Centre for Healthcare Resilience and Implementation Science and Professor of Health Systems Research, Faculty of Medicine and Health Sciences, Macquarie University, Sydney, Australia. His research examines the changing nature of health systems, particularly patient safety, standards and accreditation, leadership and management, the structure and culture of organisations and their network characteristics, attracting funding of more than AUD$59 million (EUR€40 million, GBP£33 million).

Professor Braithwaite has published extensively (more than 600 total publications) and he has presented at international and national conferences on more than 600 occasions, including over 70 keynote addresses. His research appears in journals such as British Medical Journal, The Lancet, Social Science & Medicine, BMJ Quality and Safety, International Journal of Quality in Health Care, Journal of Managerial Psychology, Journal of the American Medical Informatics Association, and many other prestigious journals. Professor Braithwaite has received numerous national and international awards for his teaching and research. Further details are available at his Wikipedia entry: http://en.wikipedia.org/wiki/Jeffrey_Braithwaite.

He has conducted a great deal of work over two decades on clinical and organizational performance, health systems improvement and patient safety. Professor Braithwaite was author of a major study into health care inquiries, Patient safety: a comparative analysis of eight inquiries in six countries, UNSW, 2006 and another on the appropriateness of care in Australia (BMJ Open, 2012 and Medical Journal of Australia, 2012).

Professor Braithwaite recently co-edited a book with Professors Erik Hollnagel in Denmark and Bob Wears in the United States (Resilient Health Care, Ashgate, 2013), which proposes new models for tackling patient safety in acute settings and a second book in the series, The Resilience of Everyday Clinical Work, was published in 2015. His book on health reform in 30 countries with Professors Julie Johnson in the US, Yukihiro Matsuyama in Japan and Russell Mannion in the UK was published in 2015. Another, on new sociological perspectives on patient safety with Professors Davina Allen at Cardiff University, Jane Sandall at King’s College, London and Justin Waring at Nottingham University, will be published in 2016.