



# TRANSFORMATION AND CHANGE: MAKING A COMPLEX SYSTEM SAFE AND RIGHT

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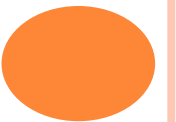
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# TRANSFORMATION AND CHANGE

## MAKING A COMPLEX SYSTEM SAFE AND RIGHT

### Outline

- The healthcare service as a complex system
- Problems associated with complex systems
- Making a complex system safe and right
  - How to eliminate the risks
  - Transformation and Change
- Conclusion







# TRANSFORMATION AND CHANGE: MAKING A COMPLEX SYSTEM SAFE AND RIGHT

- The healthcare service is a complex system rather than a complicated system



# TRANSFORMATION AND CHANGE

## MAKING A COMPLEX SYSTEM SAFE AND RIGHT

### The complexity

- Variation in patient
- No two patients are the same
- Multisystem involvement
- An array of differential diagnosis



# TRANSFORMATION AND CHANGE

## MAKING A COMPLEX SYSTEM SAFE AND RIGHT

### The complexity

- Complex journey to diagnosis and treatment
  - Imaging, laboratory
- Different treatment options
- Personnel of varying skills and expertise
  - Different personnel at each visit
- Consideration of cost-benefit



## TRANSFORMATION AND CHANGE: MAKING A COMPLEX SYSTEM SAFE AND RIGHT

- A common feature in this complex system is the human
- You cannot predict what will happen in a complex system and that increases the risks within the service
- The complexity and human factor involvement makes the health system a high risk service









# THE PATIENT'S JOURNEY

## Cornered

by Mike Baldwin

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"We've tried everything."



# Medical Errors

Human errors and human factors are causes of accidents in a complex system

**Third commonest cause of death in America**

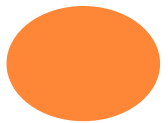
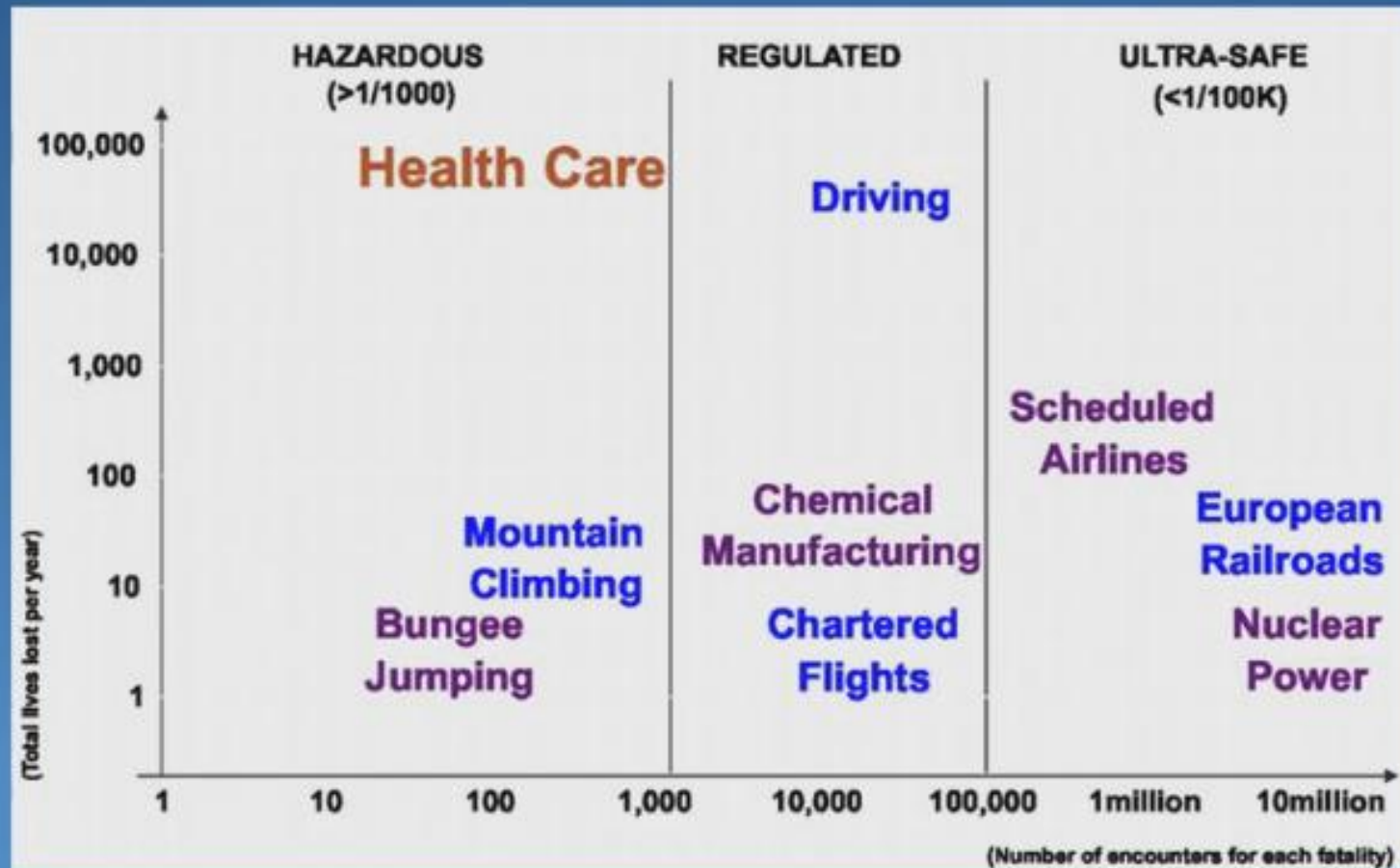
**For lack of data, the rate in Nigeria is open to  
our imagination**



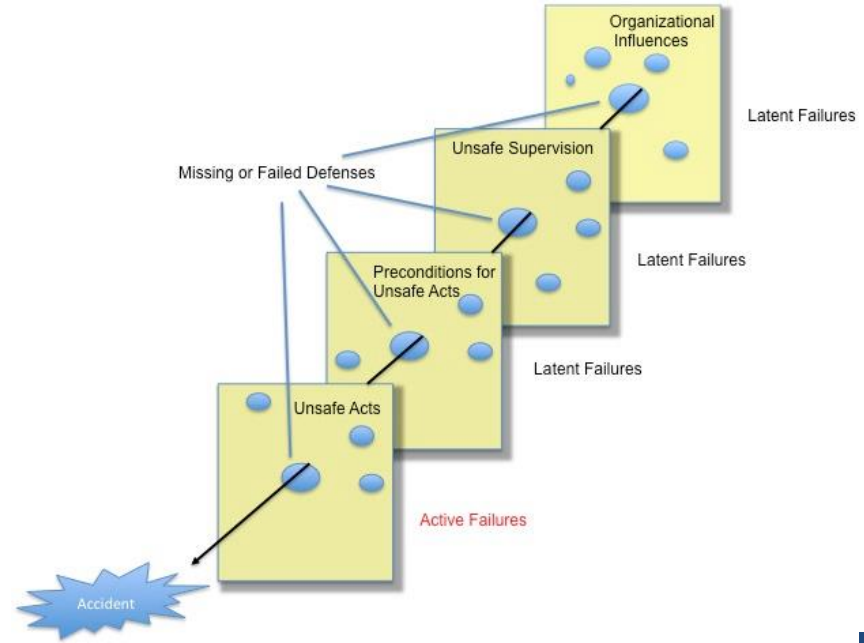
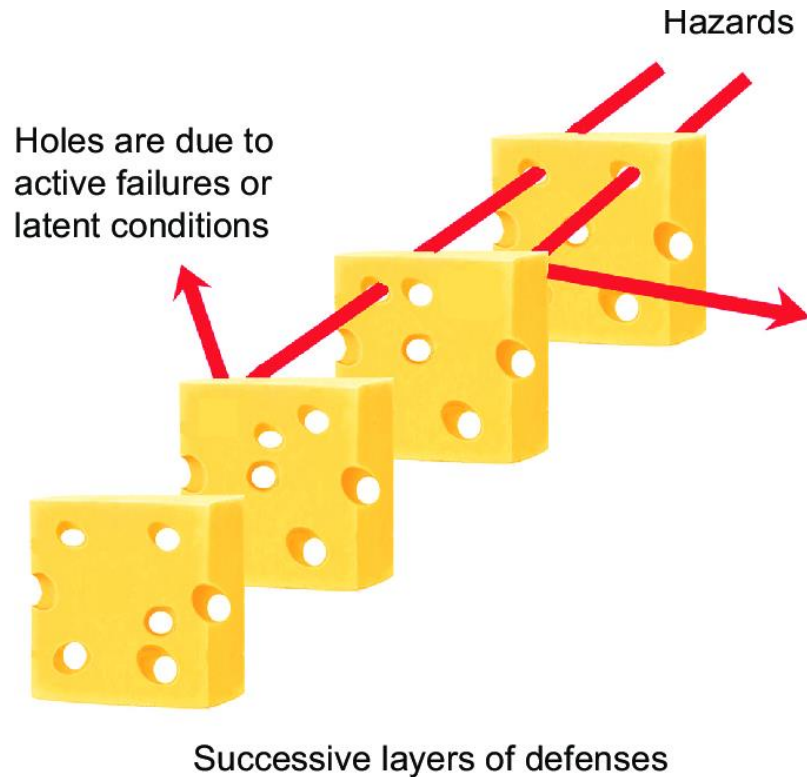
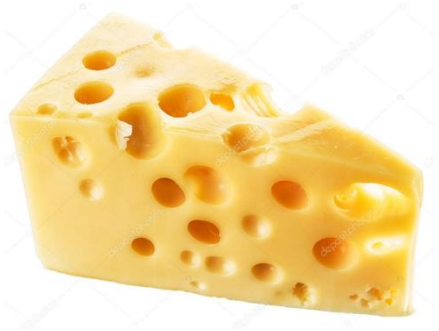
# HEALTHCARE AS A HIGH RISK SYSTEM

Medical Care is not a safe

## Comparative Risks of Healthcare



# Complex System – Components (James Reason)



### Near-miss overdose of warfarin

*modified from James Reason, 1991*

Prescriber wrote an ambiguous order

Patient's current INR was not available to pharmacist

High dose warning in system absent or over-ridden

Nurse lacked knowledge of drug dose & how INR informed the dose

Patient expressed concern & nurse double checked



# MAKING A COMPLEX SYSTEM SAFE AND RIGHT

- Complex systems are driven by the quality of the interactions between the parts, not only the quality of the parts
- Working on discrete parts or processes can impair or impede the performance at a system level
- Never fiddle with a part unless it also improves the system

(@CompleWales)

○ **Transform and Change**



# Complex System - Components

- Personnel
- Clinical Records
- Laboratory Services
- Imaging
- These are component parts and a fault in one can result in harm

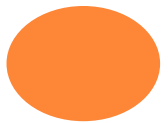


# THE PATIENT'S JOURNEY – MAKING IT SAFE AND RIGHT

## OUR OBJECTIVE



### Healthcare professionals along the patient journey



# MAKING A COMPLEX SYSTEM SAFE AND RIGHT

## Making a complex system safe and right

- It takes time to define the problems
  - Observe – the role of Internal audit and Internal Compliance Assessments
- It also takes time to effect change
  - Effecting change through Quality Improvement is stepwise
  - **Plan – Do – Study – Act Cycle**
    - Multiple PDSA



# Making the healthcare system safe and right

- **What are we trying to achieve?**
  - Effective, Efficient and harm-free healthcare system
- A pragmatic approach is required as we can't blow up the whole system and begin again and expect a favourable outcome





## Making the health system safe

- What you do not know, you cannot plan to transform or change
- The importance of data collection and analysis
- Incident Reporting and Investigation – high reporting industries
  - Root Cause Analysis
  - Learning from Incidents
    - No blame and Fair blame culture
- Focus on problems that cause concern and effect change



# Making a complex system safe and right

- **Understand why accidents happen**
  - **Human Factors**
    - Assumptions, Heroism, Burnout
  - **Service design**
    - Nacl and KCl
    - Cannula design
    - Interoperability of electronic machines
- **Find out what mistakes are happening**
  - Incident Reporting and Trend Analysis



# Making a complex system safe and right

## Change our systems to make it

- Harder to do the wrong thing
  - Use of Clinical Guidelines
  - Effective Handover - **SBAR**
- Easier to do the right thing
  - Provision of hand gel at the point of use
  - Patient Identification Label



# How to change the healthcare system

- The current political mantra is change
- The quest for improved healthcare services requires change as well
- Effective change will require
  - thinking outside the box
  - a clear understanding of the complex health system and restructuring



# Making the healthcare system safe and right

- Our current system lacks adequate policies and clinical guidelines
- It is necessary to introduce and embed of policies, guidelines
- It eliminates variations





# Making the healthcare system **safe** and right

## The Competence of the **Care Providers**

### Maintaining and Upskilling

- Continuous Professional Development – KSP
- Personal Development Plan
- Collaboration through Global Health Linkages
- Research, Travels – Conferences, Self-development



# Making the healthcare system safe and right

- Benchmarking
- External Scrutiny
  - Inspection
  - Openness – Performance Dashboard



# Making the healthcare system safe and right

- **Regulatory Control**
  - Accreditation of services and facilities
    - **SQHN**
  - Accreditation of Personnel
    - MDCN, PSN, NMC



# Making the healthcare system **right**

- Patients are human and deserve to be treated as such
- Patient Experience is important
  - Communication
  - Respect
  - Dignified Care
- Treat with Compassion
- Importance of Consent



# **Making the healthcare system safe and right**

## **Examples of transformation, change and safety**

- **The WHO Surgical Safety Checklist**
- **Infection Control**
  - Handwashing
  - Bare below elbow
- **Recognition of the Deteriorating Patient**
- **Simulation training** – multidisciplinary approach
- **Team working** is essential



# Making the healthcare system safe and right

## Examples of transformation, change and safety

- The WHO Surgical Safety Checklist
- Infection Control
- Recognition of the Deteriorating Patient
- Simulation training – multidisciplinary approach
- Team working is essential

**These interventions are simple and not capital intensive**

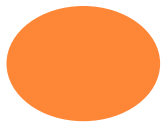




# EFFECTIVE HANDOVER – BOARD ROUNDS

<b>S</b>	<b>Situation:</b> I am (name), (X) nurse on ward (X) I am calling about (patient X) I am calling because I am concerned that... (e.g. BP is low/high, pulse is XX temperature is XX, Early Warning Score is XX)
<b>B</b>	<b>Background:</b> Patient (X) was admitted on (XX date) with (e.g. MI/chest infection) They have had (X operation/procedure/investigation) Patient (X)'s condition has changed in the last (XX mins) Their last set of obs were (XX) Patient (X)'s normal condition is... (e.g. alert/drowsy/confused, pain free)
<b>A</b>	<b>Assessment:</b> I think the problem is (XXX) And I have... (e.g. given O <sub>2</sub> /analgesia, stopped the infusion) OR I am not sure what the problem is but patient (X) is deteriorating OR I don't know what's wrong but I am really worried
<b>R</b>	<b>Recommendation:</b> I need you to... Come to see the patient in the next (XX mins) AND Is there anything I need to do in the mean time? (e.g. stop the fluid/repeat the obs)
Ask receiver to repeat key information to ensure understanding	

The SBAR tool originated from the US Navy and was adapted for use in healthcare by Dr M Leonard and colleagues from Kaiser Permanente, Colorado, USA



# WHO SURGICAL SAFETY CHECKLIST

## Surgical Safety Checklist



Patient Safety  
A World Alliance for Safer Health Care

### Before induction of anaesthesia

(with at least nurse and anaesthetist)

**Has the patient confirmed his/her identity, site, procedure, and consent?**

- Yes

**Is the site marked?**

- Yes  
 Not applicable

**Is the anaesthesia machine and medication check complete?**

- Yes

**Is the pulse oximeter on the patient and functioning?**

- Yes

**Does the patient have a:**

**Known allergy?**

- No  
 Yes

**Difficult airway or aspiration risk?**

- No  
 Yes, and equipment/assistance available

**Risk of >500ml blood loss (7ml/kg in children)?**

- No  
 Yes, and two IVs/central access and fluids planned

### Before skin incision

(with nurse, anaesthetist and surgeon)

**Confirm all team members have introduced themselves by name and role.**

**Confirm the patient's name, procedure, and where the incision will be made.**

**Has antibiotic prophylaxis been given within the last 60 minutes?**

- Yes  
 Not applicable

**Anticipated Critical Events**

**To Surgeon:**

- What are the critical or non-routine steps?  
 How long will the case take?  
 What is the anticipated blood loss?

**To Anaesthetist:**

- Are there any patient-specific concerns?

**To Nursing Team:**

- Has sterility (including indicator results) been confirmed?  
 Are there equipment issues or any concerns?

**Is essential imaging displayed?**

- Yes  
 Not applicable

### Before patient leaves operating room

(with nurse, anaesthetist and surgeon)

**Nurse Verbally Confirms:**

- The name of the procedure  
 Completion of instrument, sponge and needle counts  
 Specimen labelling (read specimen labels aloud, including patient name)  
 Whether there are any equipment problems to be addressed

**To Surgeon, Anaesthetist and Nurse:**

- What are the key concerns for recovery and management of this patient?



# How to transform the healthcare system

## ○ Innovation, Transformation and Change

- Doing the same thing within the old system will be more of the same
- Trying changes within a failed system will not lead to transformation

## ○ Innovation is essential for Transformation and Change

- We might still be struggling with the fundamentals
- Should not deter us from investing in technology



# How to transform the healthcare system

- **Innovation is essential for Transformation and Change**
  - We might still be struggling with the fundamentals
  - Should not deter us from investing in technology

## Examples

- Adapted motorbikes for hard to reach areas
- Use of drones to deliver medicinal and transfusion products
- Mobile Phone technology
  - BP, Blood Sugar monitoring
  - Tele-imaging, Tele-dermatology



# How to transform the healthcare system

- Set clear goals – by 2021, we will **xxxxxxx**
- Changing the Culture of the organisation
  - Attitude
  - Communication
  - Non-Technical Skills
- Leadership by example (Board to Shop Floor)
- Accountability
- Performance Management



# Medical Errors can be reduced if we do the right things and practice safely

Human errors and human factors are causes of accidents in a complex system

**Third commonest cause of death**





# How to transform the healthcare system

## The Future is here

- Artificial Intelligence
- Robotic Surgery
- Virtual Reality
- Personalised Medicine (Genomics)



# How to transform the healthcare system

## The Future is here

- Funding
- Political Will



# TRANSFORMATION AND CHANGE

## MAKING A COMPLEX SYSTEM SAFE AND RIGHT

### Summary

- The healthcare service as a complex system
- Problems associated with complex systems
- Making a complex system safe and right
  - Eliminate the risks
  - Transformation and Change the service



# Conclusion

- Documentation, Documentation, Documentation
- Effective Communication
- Data to drive Safety
- Innovation
- Patient involvement and Patient Empowerment play important parts in Patient Safety



# Conclusion

- Patient Safety is at the core of our business and no patient should come to harm while under our care
- Adherence to Standard Operating Procedures (**Checklist, Guidelines**) prevents patient safety incidents/harm
- Patient involvement and Patient Empowerment play important parts in Patient Safety
- Learning from clinical adverse events is essential



**Each Nigerian Life is Priceless**







# TRANSFORMATION AND CHANGE: MAKING A COMPLEX SYSTEM SAFE AND RIGHT

Thank you

