

Book: *Achieving Safe and Reliable Healthcare: Strategies and Solutions*

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Publisher: Health Administration Press, © 2004, Chicago, IL

ISBN: 1567932274

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Book Review

This book provides a guide to health facility leaders and managers for improving patient safety through successful techniques that the authors have applied during the course of their careers in health organizations. The authors have provided a practical resource that is a comprehensive blueprint for building and supporting a culture of patient safety. The book includes contributions from experts in leading organizations including the renowned Institute of Healthcare Improvement and is a valuable resource to effective change.

On the back cover of the book a startling statistic is brought to the reader's attention, and that is that medical errors cause as many as 98,000 deaths a year in our nation's hospitals. These failures are not due to unqualified clinicians or the lack of technology—instead, evidence indicates that at least 80 percent of medical error is system derived, meaning that system flaws are setting good people up to fail. Every healthcare organization must address the issue of medical error or face the negative response of the public, the media, and regulatory bodies. The authors have identified the current challenges that make cultural change so difficult in today's health organizations and describe how to go about making change happen. The book is divided into four easy to follow parts.

Part I introduces the concept of a high reliability organization, which is defined as organization that is known to be complex and risky yet safe and effective and how it acknowledges the complexity of their systems, create an environment in which individuals can communicate openly about concerns, and design systems that make it difficult for failures to occur. The authors cite the experience of the Aviation Industry in the late 1970s and the studies of human factors in how they relate to safety.

Part II begins with stating the fact that in medicine, skilled practitioners work as team in very complex environments. The dynamic of the team interaction and communication not only affects safety but also has a profound influence on the quality of the work experience. This section goes on to discuss the fundamental components of a safety culture, including effective teamwork, structured systems, complete patient involvement, and open communication surround errors.

The first two parts provide some guidance on how to develop the characteristics of a safety culture.

Part III discusses the importance of knowing that before launching such an effort, it is important to overhaul a culture to assess the current state of the environment and determine a baseline to see what changes are necessary. It is in Part III that suggestions about how to establish a safety culture, including how to measure a culture's perceptions toward safety, set up reporting systems and involve leadership in change are provided. This section provides the strategies and tools to assess the safety climate using a tool used at more than 300 hospitals. It tells how to optimize teamwork and communication among staff members; and how to build practical and effective safeguards into clinical care systems.

Part III provides guidance on developing policies that hold staff accountable for their own performance but not for system flaws. There is thorough discussion on communicating openly with patients and family when an error occurs. It gives details on developing an executive "WalkRounds" program that involves meeting with staff and engaging in a two-way conversation about safety.

Part IV puts theory into practice. This final chapter discusses the challenges of implementing the good ideas, such as, cultural barriers, perceptual mismatches, lack of leadership, and failure to follow through; all are common pitfalls that can take a patient safety initiative off track. This section leads you through translating opportunities to improve patient safety into tangible change requiring a systematic and methodical approach. At the conclusion of this book is a brief discussion of the six steps involved in successfully implementing patient safety projects.

As I stated at the beginning of this review, this book is a valuable resource to effect change. We all know effective change is never quick or easy. As the author's state, "Healthcare can follow aviation into the world of high reliability". Buy this book and get started.