# Patient safety pearls

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As 2019 draws to a close, the *Journal of Patient Safety and Risk Management* has reached a milestone for a new academic publishing enterprise: we have completed our first two full volumes. These are made up of 12 issues of research, case studies, descriptions of programs and policy, and related scholarship, on patient safety and medicolegal risk.

In the Northern Hemisphere, we are approaching the winter solstice and the longest nights of the year. Also at hand are the corresponding festivities which originally must have been intended at least in part to ward off the dark and cold.

To observe the season, we offer gifts of wisdom on patient safety and health care quality, nominated by our editors and international editorial board.

In medicine, these bon mots are sometimes referred to as "pearls." Although a few are freshly minted, most are venerable. As a rule, their origin is obscure. One of our members described his offerings as grains of sand rather than pearls, suggesting their potential to irritate more than enlighten. But over the years they have been repeated, paraphrased and repackaged on the wards by countless clinicians, much like nursery rhymes reinvented on the playground by generations of small children.

## Teaming up

"The most talented physicians aren't afraid to ask for help"

"If you don't know what you are doing, do nothing," and

"The most important thing for a trainee is to know what you don't know."

For physicians in training, communication is more important than knowledge. Perennial advice is to "Accept advice from nurses."

"When the nurse says something isn't right, believe them." "When a nurse says they are concerned about a patient, drop what you are doing and check on that patient ASAP."

"When a nurse says, 'don't you want to do' the answer is 'yes, you do.'" "When a nurse says 'are you sure you want to do that?' the answer is 'no, you don't.'"

Be humble: "Even if you disagree with their assessment, thank the nurse for being concerned," and "Be kind to nurses, support staff, everyone who works in the hospital."

Form alliances: "Find the senior nurse on each shift and become friends," and

"Ask for help from and listen to the pharmacist."

## Thinking smarter

Related to cognitive tasks, "A short pencil is better than a long memory"; "Don't rely on memory – look it up, use your calculator." In diagnosis "stop equating testing with caring and thoroughness and instead emphasize respectful listening, examination, follow-up, and collaboration with the patient to co-produce diagnoses."[1]

"It is always a good idea to watch yourself thinking and talking – it's the best safeguard against bias."

"When stuck, or any time it matters, try to change the size of the frame around a problem."

## Acting smarter

In critical situations, "When working in the Emergency Room, assume that all women of childbearing age are pregnant." "When a hospitalized patient's condition worsens, err on the side of going to see the patient."

"When dealing with code situations, take your own pulse first."

"Discharging a patient with unexplained abnormal vital signs is dangerous."

"Avoid the cross-cover mindset. Every patient is your patient."

Related to surgery, "the only surgeons without complications are retired or liars." Therefore it pays to "Measure twice, cut once. This is more important in surgery than in carpentry." And important innovations need to be used to be effective: "The checklist only works if the front line team actually uses it."

Related to medication use, "Only add or make one medication change at a time where possible," and "Run a drug-drug interaction profile on every new drug you prescribe." Remember that "As the frequency of medication dosing increases, adherence decreases."

Related to the electronic health record: "Copy/paste causes errors."

## Dealing with failure, when it happens

"Complications happen in medicine and surgery. We are measured by how we deal with them."

Patients need more communication and support in these situations: "Lean in when patients have complications. That's when they need you the most."

"People may not remember exactly what you did, or what you said, but they will always remember how you made them feel."

"Patients understand you can't guarantee a good outcome but they do value knowing you care."

"It is important to learn from mistakes: 'The report of an incident is a contribution for improvement. Reflection upon an incident is a contribution to continuous learning.'"

## Communicating with patients

Be mindful of what you say to patients. They are members of the health care team, and they are an important last line of defense against error. "A patient's self-care – right or wrong – is often the main care provided."

General advice is to "Listen as much as you talk," and to be careful in eliciting the history. How you ask a question can affect the response you get: "Ask 'what happened to you' instead of 'what is wrong with you.'"

"When you ask a patient if they are having a specific symptom and they say '. . .a *little* bit' it really means 'No.'"

"When a (especially male?) patient tells you he is okay, he could actually be saying he thinks he has a serious disease."

"When someone tells you that that the medicines aren't working, it is possible that they aren't taking them."

"Behave as if patients under anesthesia can hear and remember every word you say. Sometimes they can."

Ask about non-medical aspects of the history: "If you skip the social history you risk treating the disease instead of the patient."

Be patient-centered: "When you do a medication review ask 'what matters to you about your medicines' and address in that order."

"Informed consent is not the document, it's the discussion."

## Advice for patients

Your voice counts. "If it doesn't look right, feel right or isn't right, speak up."

"Speak up to report your needs, preferences and concerns to clinicians."

"Write down a list of things you want to tell your doctor before you arrive. Do not leave until you have said them all."

Ask questions: "For any expensive or painful test ask 'Do I need to have this test? What difference will it make?'" "Always ask: 'Do I need to have this treatment?' What alternatives are there? Is doing nothing an alternative?"

## Wisdom for managers

"Safety is the ground on which we need to walk, quality the light that illuminates our path."

Information is important: "You can't manage people if you have never done their job," or know what it is that they actually do.

"Recognize there are two domains of wisdom: Book wisdom such as years trained and experimental wisdom such as time living with a disease. Both domains are important and need to be honored." Too often experiential wisdom is discarded, and someone is hurt.

The impulse to improve, however well-intentioned, does not always go well. "Every improvement requires change, but not every change is an improvement." There is the law of unintended consequences "Whenever you change a system you may defend against some risks but you will inevitably introduce new risks and sometimes degrade safety."

"Everyone involved in procuring technology in healthcare – or even allowing it into any area of healthcare – should ask three questions: Who *isn't* this designed for? What happens when it goes wrong? When shouldn't it be used?"

In understanding systems and planning improvement, focus on "work as" done, not "work as imagined." People often don't do what traditional economic principles suggest they should, so it is important to "Design for 'Humans' not for 'Econs.'"[2] Broaden the perspectives on the team – "You need human factors experts in your team. Get some!"

## For policy makers and politicians

"The real change in patient safety will come when the public understands the current state and demands safe care. Engage them early and often."

"Patient safety is a key component of the human right to a healthy life and universal access to health services."

In this issue of the Journal several of the papers address the search for better information in the hospital setting. Duncan and Haut discuss two competing safety related strategies in the operating room.[3] They argue for the improved communication offered by fabric caps

labeled with the worker's name vs the theoretical reduction of infection associated with disposable caps.

Meguid et al. described the automation of the SURPAS surgical preoperative risk score using data already present in the electronic health record.[4] They found that work is needed to populate more of the predictor variables and increase feasibility of use.

Otchi et al. provided the first data on prevalence of adverse events among hospitalized obstetric clients in Ghana.[5] These data could be used to target future efforts to reduce harm in this population.

Machado-Alba et al. examined reports of medical-surgical device related incidents for a three-year period at hospitals and clinics in Colombia.[6] They found that these were most often caused by mechanical failures and manufacturing defects, suggesting the better quality control measures could reduce device-related harm.

Tan et al. described strategies to embed many of these messages – such as speaking up, and being patient-centered – as part of a culture of patient safety and quality in their academic medical center.[7]

We realize that many of the pearls presented here are most relevant to clinicians-in-training. But every season there are new student nurses, medical students and house-officers, along with new practitioners in the hospital and in ambulatory settings, new managers and policy makers fresh to their positions. So, we are convinced that the advice is evergreen.

We are hopeful this advice will help guide the new arrivals and remind veterans of hard-won wisdom, the last of which we end with, from Donabedian: "Ultimately, the secret of quality is love."

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