On the first full day of Moving Measurement into Action: Designing Global Principles for Measuring Patient Safety, participants took part in five sessions, featuring presentations and small group discussions, putting patient safety into further context.

On Friday morning, participants considered the definitions which would guide the program, what is meant by a guiding principle, plus the key characteristics of existing safety measurement frameworks.

The aim of the global principles, participants heard, was to enable stakeholders to develop a comprehensive set of measures which help them monitor, understand and improve the state of patient safety in their respective organizations and environments.

Participants moved on to consider the different audiences of safety measures and what stories should be put across. Key safety measurement stakeholders could include patients and families; frontline care providers; operational managers; senior leaders of hospitals and care centers; senior leaders of health care systems; insurers; industry; political leaders; ministers of health; national and international regulatory agencies; and international organizations. Each stakeholder has a slightly different "want" or purpose, but all want to have the safest care possible.

In the next session, participants looked at the current state of patient safety measurement. They heard there was a lack of accepted and effective measures for assessing patient safety, that there were unintended consequences of measurement, and some existing methods were retrospective and reactive. Several participants delved deeper into these issues by presenting the work they were undertaking and the paths forward they had identified.

There are challenges to effective measurement, and these were explored in more detail after lunch. In small table discussions, participants considered eight challenges including the roles of data designers; measurement incentives and managing unintended consequences; the burden of data collection; actionable data for different stakeholders and levels of staff; designing and dissemination of actionable reports; managing comparability across the world; the response burden; and deciding between retrospective and prospective data.

In the final session, participants explored “the Ideal State” and tried to answer, “What should we measure that would be most informative about the state of patient safety?”
Making Health Care Safer for Different Stakeholders

Patient safety researcher Charles Vincent explores several of the program's key questions

Mirabelle Morah

“Mostly, when we try to measure safety over time, you want to think: ‘How often has this hospital caused harm? Do they do things properly? Is care reliable?’ These are the sort of classical measures of safety and quality of care,” says Charles Vincent.

Vincent, director of Oxford Healthcare Improvement Centre, UK, is a trained clinical psychologist and has carried out numerous researches on the causes of harm to patients as well as methods for improving safety across health care systems.

He has returned to Salzburg to take part in a new program, Moving Measurement into Action: Designing Global Principles for Measuring Patient Safety. He served on the faculty of another Salzburg Global Seminar program in 2001, Patient Safety and Medical Error. So, what does the picture look like 18 years later?

“All the time, things are changing in certain areas...” says Vincent. “So the safety challenges also keep changing, and this makes it quite difficult to think about the question overall. You can think about, ‘Is a specific process or is a specific operation... getting safer?’, and that makes sense. But the question, ‘Is health care getting safer overall?’ is complicated because it’s a moving target.”

Vincent is considered a leading figure in the patient safety field and has dedicated much of his working life to discovering how to make health care safer.

In 2013, he authored a report with Susan Burnett and Jane Cartthey on “The measurement and monitoring of safety.” The authors highlight five dimensions to be included in “any safety and monitoring approach in order to give a comprehensive and rounded picture of an organisation’s safety.” These dimensions include past harm, reliability, sensitivity to operations, anticipation and preparedness, and integration and learning.

One of the key questions for this year’s program in Salzburg is “What is the role of patients in measurement?” Vincent says, “I think patients can do lots of different things although, while

I’m a patient, I don’t want the burden of feeling I’m also responsible for the safety of the organization. I’d like the doctors and nurses to sort that out and not worry me about it.

“But I think it’s very important... if you’re redesigning a service, say you want to start changing how your outpatient clinic works, you’ll learn a lot from talking to patients and families about what the experience is like…”

Complicated care doesn’t take place just in hospitals and health clinics, however. It can also take place at home. Vincent believes this is a big challenge for patients and families which hasn’t been fully thought about. He says, “They have all the problems that doctors and nurses have, except they don’t have the training...”

Another key question global health leaders in Salzburg have been asking over the past few days is how organizations can measure psychological safety not only for patients but also for staff and clinicians.

With his expertise as a clinical psychologist, Vincent explains psychological safety can mean different things to different people, but one of the most important meanings in the context of this program is that staff and clinicians feel free to speak up about their problems or the problems of the organization when they can see that patients are being harmed.

“One of the characteristics of a hospital that you or I would want to go to is that staff would feel they could have an open conversation about problems they see. And the most dangerous organizations are the ones where everything is hidden, and you can’t say anything... So psychological safety is something you have to have...”

Vincent says. In addition to the psychological safety of staff and clinicians, participants have been asked to consider if there are potential measures for physical safety as well. Vincent says, “I think there are physical hazards that we can measure, like falls [and] back problems. For nurses, there is a lot of lifting people...”

“Many doctors and nurses get very, very stressed, and fatigued by their work, and we don’t really measure that. We just see people leaving and wonder why. So, potentially, there’s lots of things we could do along that line as well.”
Identifying the Elephant in the Room and Global Principles

Following an intensive day of presentations and discussions, participants spent Friday evening considering “big points” which had emerged during the program so far.

One participant, tasked with synthesizing the day’s discussions, indicated a lot of progress had been made globally since the Salzburg Global Seminar program, *Patient Safety and Medical Error*, which took place in 2001. They said there is a greater awareness of the burden, systems thinking, governmental and ministerial investment, evolving national policy frameworks, and numerous metrics. But too many people have continued to die from defects in care.

The speaker identified a dozen “big points” which had emerged in the participants’ conversations. This included reducing the burden and measuring less, paying attention to the patient’s voice, automating when possible, removing penalties, and understanding safety as a continually emerging property of a dynamic system. Participants heard several suggested principles from the speaker tied with each “big point,” but they also listened to the speaker identify a potential elephant in the room. The speaker posited: Is there any dimension of excellence in health and health care that is NOT “safety”? Does “patient safety” equal “quality of care”?

On Saturday morning, participants were asked to consider what their “distinctive contribution” would be as a result of the program and how they would get there. One participant reflected on the massive range of expertise within the room and the decades of previous experience. They voiced concern that the discussion so far had surrounded familiar territory already mapped. What could be taken off the table? How could the topic be narrowed down further?

Highlighting the work of Shunryu Suzuki, the speaker referenced his words: “In the beginner’s mind there are many possibilities, but in the expert’s there are few.”

Several participants provided feedback. One said, “Principles are the first line of defense to keep things rational, sane, and simple.” Another added, “The principles are important, but think through what the consequences could be.” Participants were also reminded the world would be different in 2025, with one participant expressing concern the world is heading into a “decade with incredible turbulence.”

As participants considered ways to narrow the focus, the idea was raised to recommend changes to how measurement is being approached. What are the two or three fundamental changes that are preventing professionals from leaping forward? On this line of conversation, a participant called for others to be provocative by coming forth with ideas that will change the world.

On Sunday, participants worked in smaller groups focused on topics including culture; technology; practicality, patients, families, and communities; evidence; cross-continuum; geographic context; and proactivity. Each group is focusing on a key topic in the measurement of patient safety, constructing two or three “global principles” for that area.

Participants have since begun working in smaller groups focused on topics including culture; technology; practicality, patients, families, and communities; evidence; cross-continuum; geographic context; and proactivity. Each group is focusing on a key topic in the measurement of patient safety, constructing two or three “global principles” for that area.

Participants were asked to consider the importance of their topic to achieving the ideal state of patient safety measurement, the scope for their topic, what other topics it may relate to, and potential challenges.

In addition, participants were asked to think how their suggested principles could apply across all levels of measurement, how they could affect practicality, how their principles take equity into consideration, and the potential for unintended consequences.

Working groups will present their findings on Sunday, as participants continue to determine the how.
Hot Topic:
“What Role do Patients Play in Measuring Harm and System Safety?”

Mirabelle Morah

“First of all, the patient’s role cannot be overemphasized because patients are critical partners in ensuring safe care. To the patient, when they go into care, they assume it’s safe, and they know that they’re in the hands of the right people. But unfortunately, this is not [always] the case.

So patients have invaluable perceptions, information, and experiences, and these are very critical to the patient safety process. Mainly because they, the patients, happen to be the receivers of care, and when things go wrong, they’re the ones who suffer harm. So their role in all this is to provide that critical information, the critical perspectives which informs the system of their concerns, their worries, and their experiences. This whole process of sharing the knowledge and experiences helps in preventing harm.”

Mariam Kamoga Namata,
Executive director of CHAIN Uganda; patient safety champion under the WHO Patient for Patient Safety program

“Generally, in Ghana, we have a national health care quality strategy, and objective three proposes the inclusion of patient and community in the way that service is being provided. That said, we mean that they as the patients and community are supposed to participate in their care and if they do this, it’s a patient safety tool to be able to identify harm because once they are part of it, then they will be able to self-identify and even support the health system to be able to identify when harm is going to happen and probably to put an intervention to stop it from happening. So we’ve developed what we call a community scorecard. The community scorecard gives an opportunity to give feedback....

The Ministry [of Health] recognizes the fact that the patient and community are no longer passive receivers of the service but active consumers of the service. Now we are also promoting through civil society organizations and patient groups, the need for patients to be active consumers of the service... They will be able to ask questions, they can also make suggestions, and they will have the option of choosing whichever services are available.”

Ernest Konadu Asiedu
Improvement advisor of the Institute for Healthcare Improvement (IHI); head of the Quality Management Unit at Ghana’s Ministry of Health

“The role of patients is indispensable for sure, but we need to help them to be contributive. And I have a sense that patients have similar problems all over the world with the health care system. But the behavior is very different because I would say that the level of maturity of societies is different around the world. I have the impression that in certain parts of the world, I will site from my country mostly, patient safety certainly is not acknowledged by citizens. So inevitably, it’s indispensable for them to contribute for many reasons. We need to learn from each other on how to make their role more contributive. And still I would say that problems are similar, but behaviors are still different and we need to evolve to make society more participatory in patient safety.”

Ezequiel Garcia Elorrio,
Founder, board member and director of Health Care Quality and Patient Safety, Institute for Clinical Effectiveness and Health Policy

“Patient safety is about the patient, and really that’s a battle that we’ve been fighting for all these years just to get a lot of professionals to understand this in a visceral way. A lot of people don’t. They think it is their profession. They see it from their perspective rather than a patient’s perspective.”

Helen Haskell,
Co-chair of the World Health Organization’s Patients for Patient Safety Advisory Group; president of Mothers Against Medical Error and Consumers Advancing Patient Safety

#FacesOfLeadership

“So today [September 6, 2019] is my son’s 34th birthday. He died 18 years and 10 months ago today, and that was what brought me to patient safety. I always had a totally different life before then. And when I started trying to understand why that happened to him, everywhere I went, I found the problem was so much bigger than I ever imagined. The only thing I could think to do for him was to try to work on this problem. So I’ve been working on it now for nearly 19 years, and it has improved a lot, but we still have a long way to go. It’s a never-ending project. This is a good thing to be doing on his birthday, I think.

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