

Is Safety Quality? Is Quality Safety?

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Background. Although healthcare did not, in general, think substantially about patient safety until the collective magnitude of the problem became clear and could no longer be ignored there is now widespread agreement that enhancing patient safety is an important public policy issue (Leape & Berwick, 2005). However, despite political and public pressures and wide-spread implementation of a range of activities and development of specific tools to support organizations to improve patient safety (Berwick, 2006), healthcare has not yet achieved the status of being a high reliability industry (Amalberti, Auroy, Berwick & Barach, 2005). The model often used in healthcare is that accidents are thought to occur when individual components or processes fail to meet criteria. This model of risk and safety builds on the assumption that safety, once established, can be maintained by keeping the performance of a system's parts (human and technical) within certain bounds (e.g. people should not violate rules and procedures) (Dekker, 2006). Dekker (2006) argues that this model – the classic quality model – distorts efforts to achieve safety. The classic quality model was developed to ensure that the system meets pre-specified criteria. The goal of quality assurance activity is to keep performance variability under control. Despite considerable theoretical and empirical evidence to the contrary many in healthcare think safety automatically follows from an emphasis on quality assurance. We believe there are important conceptual and practical reasons to understand the difference between quality and safety. The aim of this research was to begin to explore the extent, and in what ways, safety and quality are conflated in healthcare, at both the sharp and blunt end of care in an acute care institutional setting within a large health authority in Canada. The key questions are: How are the notions of patient safety operationalized through local context?; How is safety thought about and constructed?; How is it discussed?; How is it neglected?

Methods. Critical appraisal of selected literature related to safety in complex systems and interviews with key informants (6 acute care registered nurses; 2 acute care nurse managers; 5 acute care senior decision makers). Qualitative research was used to

uncover actors' perceptions and framework of understanding of safety. Accordingly, semi-structured face-to-face interviews were conducted.

Results. The literature review shows that, in both the US and Canadian healthcare systems, most safety related strategies focus entirely on activities that have more to do with quality than safety. Seven major themes emerged from the analysis: designing robust organizations (with three sub-themes: prescription, compliance, and rules and standardized procedures are important but insufficient to create safety); experience, adaptation and the efficiency-thoroughness trade-off; teamwork and communication; leadership; competing system challenges; trouble-shooting and vigilance; and, learning from near misses and critical incidents. None of the informants hold to a strictly linear model of creating safety, supporting the premise of this research that there are important conceptual and practical reasons to distinguish between quality and safety. However, some traditional thinking about safety persists. For example, although the interplay between robustness and flexibility was acknowledged, senior decision makers tend to focus more on safety as a risk management exercise or as a control problem, where certain behaviors need to be constrained and others encouraged. It was at the sharp end of care that peoples' discussion moved back and forth between the notion of a robust system (marked by simplification and standardization of work flows, such as the formal rules developed for medication administration) and the acknowledgement of the need for flexible work practices. Indeed, the nurses reported that safe practice involves a combination of rules, standards, protocols, education, experience as well as the flexibility to adapt work practices in the face of uncertainty and changing conditions. Furthermore, it was also noted by every nurse that experience is an important ("huge") factor, and the capacity to adapt is most often determined by experience.

Conclusions. Empirical data and expert opinion suggest that the conflation of quality and safety potentially limit the development and scope of relevant solutions. Quality efforts are important and central to good care, but the system shouldn't settle on an illusion that doing more and more of the same will create something conceptually and practically different. The crucial issue not yet fully addressed in this research is the tension between developing a robust organization and allowing for flexibility in practice. Moving forward in patient safety will require that the interplay between robustness and flexibility be openly acknowledged, examined, and better understood.

References

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