Realising our value

by succeeding where others have failed

Professor Joanne Travaglia
Centre for Health Services Research
Faculty of Health
University of Technology Sydney
It is 20 years since the start of the modern patient safety movement. In that time numerous strategies, and millions of dollars and hours have been spent worldwide trying to reduce the rate of errors and improve the quality of care.

While there have been some successes, the grim fact is that the overall rate of errors seems to have remained the same.

Allied Health professionals might provide the answer to reducing errors, preventing harm and improving the quality of care across health and social care systems.
What are the limits to the current approaches to patient safety strategies?

- Limited understanding of patients and the context of errors – current approaches can lead inadvertently to dis-embodied and un-populated perspectives (the De Chirico effect)
- Working assumptions of safety and errors are largely drawn from clinical, organisational and technical perspectives
- Current strategies to improve safety and reduce errors are situated within the same world view
- There is limited understanding of the positive and negative consequences of attempts to improve safety and reduce errors for different types of patients at a population level
BUT as William Osler said in the mid-1800s

‘It is much more important to know what sort of a patient has a disease than to know what kind of a disease a patient has’
Vulnerability

Vulnerability has been called the “elephant in the room” of health care (Hurst, 2008)

Little et al (2000) defined it as:

“… susceptibility to any kind of harm, whether physical, moral or spiritual, at the hands of an agent or agency”
Not ‘simply’ vulnerable individuals or groups but cascading and intersecting vulnerabilities

1. Biological/genetic vulnerabilities
2. Psycho-social vulnerabilities
3. Population vulnerabilities
4. Socio-economic vulnerabilities
5. Cultural vulnerabilities
6. Spatial-temporal vulnerabilities

Inter-personal vulnerabilities
Professional vulnerabilities
Team vulnerabilities
Organisational vulnerabilities
Structural vulnerabilities
Environmental vulnerabilities

Travaglia, 2009
Who is vulnerable within the healthcare system?

1. Clinicians
2. Patients with high acuity and complex system dependence (e.g. dialysis), patients with co-morbidities and chronic illness
3. Those with liminal status (ie prisoners, the homeless, people in palliative care
4. The socially vulnerable
   • The elderly
   • Aboriginal and Torres Strait Islander
   • Immigrants – especially those with limited local language skills
   • People with disabilities, especially cognitive impairments
   • Children and youth
   • Patients with literacy and communication problems
   • People from lower SES
   • Geographically isolated individuals
   • Socially isolated individuals
   • People who are homeless
   • People who are frail and malnourished
5. And ...

Forms of vulnerability

- Structural
- Social
- Epistemic
- Symbolic
- Situational
- Systemic
The evidence base for the impact of vulnerabilities in patient safety is as old as medicine itself.

- Ely Hospital, Wales 1967: elderly persons
- Normansfield Hospital, Essex 1978: People with disabilities
- Shipman Inquiry, UK (2005): elderly women
- Mid-Staffordshire General Hospital, UK (2010, 2013): Elderly persons, dying patients
One example: the Francis Inquiry into Mid-Staffordshire Hospital (2010/2013)

- Target-driven priorities which generated fear
- Disengagement between clinicians and management
- Low staff morale
- Isolation
- Lack of openness
- Acceptance of poor standards of conduct
- Reliance on external assessments
- Denial
- Bullying
- Lack of information about patients’ care or condition
- Lack of involvement in decisions
- Failure of communication between staff
- Lack of engagement with families and friends
There are several versions of the Hippocratic Oath …

The most common translation refers to the commitment of health professionals to “not willing do harm”.

Another says that the commitment is that the oath is that health professionals “not let harm be done” – a different focus.
A patient without an advocate, whether that be a nurse or relative as an advocate, I think that patient is at risk. My dad was in hospital last year and I wouldn’t leave his bed, I wanted to double-check everything that went through, everything he received. Anyone without an advocate I think is at risk.

Senior Nurse Manager

In the second era of healthcare quality (2010s)

… advocates for improving quality, addressing disparities, and achieving health equity began to connect the dots for health care leaders, highlighting that if they really cared about quality and controlling costs, they needed to care about equity.

The safety of people with intellectual disabilities

People with intellectual disabilities are vulnerable in healthcare environments. They experience health and healthcare inequalities, and when admitted to general hospitals are at a greater risk of patient safety incidents. This is well known in specialist services, but less recognized within primary or secondary healthcare. The most significant barriers to safer and better healthcare appear to include ‘invisibility’ of people with intellectual disabilities within health-care systems, widespread lack of staff understanding of intellectual disability, the vulnerabilities of people with intellectual disabilities, and the reasonable adjustment they may need in order to access health-care services.
There's really no such thing as the 'voiceless'.
There are only the deliberately silenced, or the preferably unheard.

Arundhati Roy

Read about Eden and his family experience here:

Eden Camac
People faced with multiple vulnerabilities experience …

**History** of systemic mistreatment by healthcare providers

**Poorer access** to all types and levels of health care, distance to care

**Lower levels of participation** in health care screening and preventative programs (resulting in people arriving at care sicker and with more co-morbidities)

**Lower levels** of referrals and required treatments (errors of omission)

**Poorer quality care** rotating door of providers, skill mix

**Inappropriate environment and design of equipment** (such as the height of examination beds);

**Limited clinician inexperience** and lack of training in working with vulnerable groups

**Assumptions** about individual’s capacity to express their concerns or consent to procedures

‘**Hyper-focus’ on the specific patient characteristic** (ie ethnicity or disability) rather than the individual and their other conditions or concerns

‘**Diagnostic overshadowing**’ where symptoms are thought to be due to the person’s disability rather than an new or unrelated condition

Resulting in an increased probability overall that health conditions to be **misdiagnosed or untreated**

**Patient difficulties** in expressing pain, communicating concerns

**Lower levels of general or health literacy** on the part of patients

**Poor or inadequate communication** on the part of health care providers (mindsets – patients don’t need stethoscopes)

**Lack of recognition of the concerns and roles** of patients and family members
Looking at the care provided for people with intellectual disability: no single or easy answer
Errors have traditionally be conceptualised as belonging to two groups:

- Errors of **commission** (when something goes wrong)
- Errors of **omission** (when patients don’t get the treatments they should

We are adding at third

- Errors of **demission** – defined as the relinquishment or abdication of responsibility, in this case of the search for knowledge about how best to provide safe, high-quality care to one of the most vulnerable and high-risk groups in society.
Realising the value of Allied Health - where to next?
Allied Health Manifesto (Survey conducted at the National Allied Health Conference 2017)  
Trish Bradd, Joanne Travaglia

- As a collective field of practitioners engaged in the delivery and management of health and social care we, as Allied Health Workers:
  - Are part of the frontline response but we also see the patients’/clients’ life after the crisis
  - See the patient/client within their whole, current and future context(s)
  - Are concerned with those aspects of patients’ lives and experiences that make them worth living
  - Spend more time with patients overall, hear more of their stories, roles, aspirations
  - Often have a privileged view of the patients’ and families’ journey
  - Travel across wards, sites and services and because of that often see differences in practices and approaches
  - Are good at relationships and pulling teams together and at the same time
  - Are trained in ways that prepare us to be solution focused, identifying the root causes of problems, developing a range of responses, testing and monitoring change at both individual and organisational levels
  - Have practice intelligence
  - Are diverse in our training and in our approaches to care and we understand that diversity is beneficial when addressing issues of quality and safety
  - Are trained in engagement and coaching
  - Have a critical eye, questioning and reflecting the things we see within and across the system, for groups and for individual patients that are missing or could be improved, which means we are
  - Willing to challenge the status quo, and
  - Are advocates.
A critical perspective of clinical governance

• Clinical governance is still a dynamic, contextual and contested field;
• The location of vulnerability within that field is not set: some individuals, times, spaces, and places are "seen" as a risk or at risk, while others are not;
• Clinical governance needs to be seen as a social as well as technical, legal and managerial practice.
That’s why All of Allied Health is important in the safety of All patients

• History (professions, services, expectations)
• Human behaviour (culture, resistance, tribalism, turf wars, burnout)
• Hegemony (power, structures, taken for granted assumptions about both the health services and patient safety)
• Heuristics (unexamined, rapid or rule of thumb approaches to practice)
Patient safety doesn’t start or end with the clinical interaction

• In terms of malnutrition they say that up to 40 percent of adults and 60 percent of the elderly admitted to hospital are malnourished and they lose weight in hospital and then go home malnourished.

• Data in Australia and around the world has shown that, and basically those patients are at an increased risk of infection, mortality in general, they’re weaker, not able to do their physio, so there are all those other issues as well ... so basically they go home and they’ve got nothing and some of the oldies get even more malnourished at home.

(Allied Health Focus Group)
The biggest deficit that we have in our society and in the world right now is an empathy deficit. We are in need of people who can stand in somebody else's shoes and see the world through their eyes.

Barack Obama
How to address vulnerabilities: the wisdom approach

• Knowing what’s important
• Moral reasoning
• Compassion
• Humility (epistemic, cultural and other)
• Patience
• Dealing with uncertainty

While an ethic of justice proceeds from the premise of equality - that everyone should be treated the same - an ethic of care rests on the premise of nonviolence - that no one should be hurt.

I would like to thank my colleagues and collaborators

• Dr Trish Bradd (NSW) Clinical Excellence Commission
• Dr Deborah Debono University of Technology Sydney
• Ms Georgia Debono University of Technology Sydney
• Dr Hamish Robertson University of Technology Sydney
• Ms Chris Rossiter University of Technology Sydney