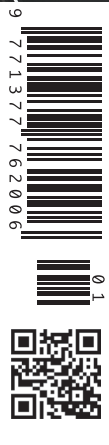




Cover Story:

Reimagined Hospitals



20 **Edward Bluth:** RSNA 2019: Radiologists Can Be Optimistic About AI

28 **Prof. Andrew Walton:** Managing Change to Improve Clinical Outcomes

36 **Adam Gale:** How Far Is the Future?

40 **Christopher Shaw:** Healthcare Design With a Long-Term View

46 **Prof. Christian Lovis:** An Alternative to Costly Tech For Future Healthcare?

50 **Prof. Marcel Levi:** Generalism as a Sustainable Model in New Healthcare Paradigm

52 **Sirpa Arvonen:** Finland's Digital Care Network: Why is it Working So Well?

56 **Marina Gafanovich:** The Empowered Patient – Capitalising on Information and Technology

60 **Chris McCahan:** Building a Better Hospital



Save Lives by Focusing on Patient Safety

Summary: Preventable medical errors are the third leading cause of death in the U.S., and it's time to take action and change from a culture of deny and defend to a just culture of safety. It's the only way we can begin to save lives.

In 1999, the Institute of Medicine released its groundbreaking report, 'To Err is Human,' which shook the healthcare industry to its core. The report found that as many as 100,000 lives were unnecessarily lost each year due to preventable medical errors. Flash forward to today and that number has grown to an estimated 200,000 deaths each year in the U.S. and 4.8 million worldwide. Since we know there are proven processes to reduce, if not eliminate, these deaths, why have deaths continued to climb?

A big part of the problem is the difficulty organisations have with change. Changing from a culture of denial, blame and risk aversion to a just culture of safety that embraces transparency, open communication, trust and compassion can be difficult, but necessary if we're to improve patient care. And it takes commitment from top-level management and the board.

In 2012, we started the Patient Safety Movement Foundation with the mission to eliminate preventable hospital deaths.

From the beginning, our goals were to:

- Unify the healthcare ecosystem (hospitals, healthcare technology companies, government agencies, policymakers, patient advocates, clinicians, engineers, payers, etc).
- Identify the process errors that are harming and killing patients, and develop solutions that are shared freely.
- Get hospitals to implement solutions and processes, like our Actionable Patient Safety Solutions (APSS), that save lives.

- Ask healthcare technology companies to openly share the data they collect.
- Promote transparency, honesty and open communication, within our organisations, and with patients and families.
- Treat patients with dignity and compassion.
- Educate providers, future health professionals, patients and families about patient safety.

Over the last eight years, we have developed 34 free evidence-based solutions (APSS) to help keep patients safe. Nearly 5,000 hospitals have committed to reduce the number of preventable deaths to zero, and approximately 100 have implemented all of the APSS. Also, 90 medical technology companies have pledged to share the data their products are purchased for to pave the way for predictive algorithms and decision support to help clinicians eliminate preventable deaths. But there's still work to do – we're not at zero.

We know from experience that solutions like our APSS can reduce and eliminate preventable deaths, that compassion reduces patient harm, that transparency and embracing a Communication and Optimal Resolution (CANDOR) approach to patient safety allows us to learn from errors and that putting evidence-based processes in place can keep them from happening in the future. And we know by making zero the goal, it forces us to do root cause analysis and improve processes in pursuit of zero. We also know that involving patients and families in a team-based patient-centred

care improves patient outcomes. We need all hospitals to adopt these values and solutions to begin to improve the safety of patients.

We also know, through experience, that apathy exists. But we also know that a patient safety initiative can start with just one person, one champion with the courage to take action and, through successes, create momentum and change the organisation for everyone's benefit.

We have to take action and we have to do it now. Lives are at stake, and even one preventable death is one too many, let alone 4.8 million. ■

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Key Points

- More than 200,000 people die unnecessarily in U.S. hospitals.
- Changing organisational culture is difficult but mandatory if we're to make a difference.
- There are evidence-based processes that have proven to save lives.
- Honesty and transparency let us learn from errors and keep them from happening in the future.