

Be Mindful: Patient Safety is More Than a List of Safe Practices and Goals

Deborah M. Nadzam, PhD, FAAN
Practice Leader, Patient Safety Services
Joint Commission Resources

The Joint Commission's National Patient Safety Goals, the National Quality Forum's 30 safe practices, and the Institute for Health Care Improvement's strategies have shined the light on critically important safe practices, each having earned its place on these initial lists of strategies for minimizing harm to patients. Also on these lists is the promotion of leaders' involvement and development of a culture of safety, emphasizing the need to expand our thinking back from the sharp end of frontline practice to the blunt end of organizational structure and support. Yet I still can't help but wonder if 'the lists' have inadvertently narrowed the definition of 'patient safety' for some organizations and professionals.

This weekend as I watched a family member recover from major surgery, I was again reminded that there is absolutely no substitute for keen clinical observation skills, anticipatory awareness of what *might* go wrong and quick action to prevent or treat. And let's not forget listening to the patient or family who says 'something isn't right'. In our rush to assess and treat as many patients as we can, and our attempt to put all the safe practices in place, have we set aside *mindfulness* -- staff being ever vigilant and alert for the possibility of error?

High reliability organizations (HRO) are adept at managing the unexpected. We think of the characteristics of HROs as new to health care, and perhaps they are at the organization-level. However, as health care professionals, we were taught to be observant, to monitor the patient for evidence of response to treatment, to consider the patient's description of his condition, to notice when something is not going as expected. Weick and Sutcliff formally define mindfulness as "a rich awareness of discriminatory detail", indicating that when people act they are fully aware of the context within which they are acting and of the details of the moment that differ from expectations.¹ Mindfulness is about the "quality of attention", and is "focused on clear and detailed comprehension of emerging

threats and on factors that interfere with such comprehension”.¹ Mindfulness is a characteristic of the climate of an organization and evident through behaviors that question uncertainty in an effort to eliminate it. While the practice and extent of mindfulness within a hospital may be related to the leaders’ expectations and behaviors, it is also highly dependent upon the individual’s ability and willingness to stop the action... to question the situation at hand and ‘exploit the power of uncertainty instead of trying to reduce it’.²

So here we are again at National Patient Safety Week - the week during which health care organizations raise awareness about ways to minimize harm and provide safer care to patients. Of course we all know that the intent of this week is to be more public and demonstrative about our efforts to provide safe care. But in fact, patient safety must be attended to every week, every day, every hour, every minute for every patient. There likely will never be lists that are all inclusive of practices we can and must do to minimize harm to patients. And just because you and your organization have done everything on the current lists doesn’t mean your patients will be safe from all adverse events.

We must be in-the-moment, not just working off of lists. As we implement safer ways to deliver a medication, prevent an infection, or enhance the culture, let’s remind each other that our eyes and ears, and our clinical knowledge and intuition are not to be ignored. This week is a good time to reinforce with each other that keeping patients safe is within each of us. Let’s commit to trust each other enough to respectfully ‘mistrust’ each other or the apparent stable situation. Let’s stop each other, stop ourselves, follow our own hunch and chase down the details of the situation that differ from our expectation or raise any question of doubt. To paraphrase a much quoted phrase, “Be Mindful Out There!”

¹ Weick KE and Sutcliffe KM (2007). Managing the unexpected. Jossey-Bass: San Francisco.

² Gary L (2003). Tested by fire: what high-reliability organizations know. Harvard Management Update, December 2003: 3-5.