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Speakers: Madge Kaplan, Paul Batalden, Charles Vincent, Maren Batalden

Madge Kaplan 00:00
Welcome to “The Power of Coproduction,” a podcast series that explores the lived experiences of patients and professionals who are redesigning healthcare service to achieve better health through mutual respect, collaboration and science informed practices. Your host and guide is Paul Batalden, Professor Emeritus of the Dartmouth Institute for Health Policy and Clinical Practice and a guest Professor at Jönköping Academy. The Power of Coproduction is produced in partnership with the International Coproduction of Health Network (ICoHN), the Dartmouth Institute, Jönköping Academy and the Health Assessment Lab. On Episode 13, “Safer Together,” Charles Vincent and Maren Batalden describe the ideas and implementation experiences that are helping to shape roles for patients and families in an organization's safety agenda. Here's Paul,

Paul Batalden
Welcome. Today's theme is about the ways that coproduction thinking can help make healthcare safer. Our guests are Charles Vincent, professor emeritus of Oxford University, and Maren Batalden, the Chief Quality Officer at Cambridge Health Alliance in Boston, Massachusetts. Thank you for joining us, and welcome Charles and Maren.

Maren Batalden
Thanks. It's a pleasure to be here.

Charles Vincent
And for me, too. Great pleasure.

Paul Batalden
So Charles, you've had a standard textbook for making healthcare safer for years. And I've used it, many others have. Why did you write this new book,*Safer Healthcare?*

Charles Vincent
Well, I wrote *Safer Healthcare* with my friend and colleague Rene Amalberti, who's worked in many different industries as well as healthcare, which I think is an important part of it. And I think Rene and I, like many other people, thought that the vision of safety that we had was not adequate to the

challenges of healthcare. There was nothing wrong in the vision we had, but it needed to be expanded. Firstly, we've mostly worked in hospitals. That field and we needed to come out and think about the wider community and all the other settings. Secondly, it seemed to us that the safety approach we had in quality, too, was mostly suited to very standardized and fairly predictable environments, and not so much to the more sort of Wild West element of some areas of healthcare where it's all very dynamic and unpredictable. I think most of all, it felt to me that we hadn't taken enough account of the clinical realities. And this is not just us, in the sense that people in any kind of work are always adapting and having to change things through its trade-offs, conflicts and difficulties. And the care is not quite as ideal as one might hope, even though people get there in the end. And I've worked very closely with surgeons for a long time in a hospital. And I saw that firsthand. And of course, Maren will know this much better than me. So from that, we start to think, well, what were the implications of all that, and I suppose there are three things: One is to think about how care varies moment to moment;you know, even over one afternoon, the quality of care can vary for a patient. That's one aspect. Secondly, that safety is achieved very differently in different contexts. You know, if you're in a pharmacy, a very regulated environment, (that) is rather different from how you make things safe in emergency medicine, for instance, not totally different, but it's going to be approached in a different way. And third, and I think most relevant today, the need to think about safety not just in the hospital. You know, when we think about ourselves as patients or family members, we interact with health care just occasionally. And a lot of the safety you have to think about is in our own homes. So you think about the safety and quality of our time over the year. So you get a very different vision. You have different problems: coordination, fragmentation of care, all sorts of things threaten the care that are not so visible to clinicians in hospitals. And that led us to think more about a portfolio of safety strategies of different kinds that you could mix and blend. I think we were less successful in putting that together in a practical way, but that was the sort of vision we tried to unfold. So it's a long answer, but it has led us, if you'd like, to coproduction and patient journey.

Paul Batalden
So Maren, you and your colleagues have had a chance to think about what Charles and Rene have written about and have taken that into the practical world of a health system. And I'm curious, how does that work?

Maren Batalden
Well, I'm incredibly grateful to Charles and his colleague. The book, I think, is a very useful reframing of (the) kind of the challenge of patient safety for the contemporary moment. The Cambridge Health Alliance is a network of clinics, a comprehensive set of behavioral health and substance use disorder services in the community, its three emergency departments, two community hospitals with inpatient medical and surgical services, but also inpatient psychiatric services. And there are many ways in which the traditional frame of safety in the context of medical and surgical inpatient care doesn't speak to the array of services that we provide. I think for me, one of the most useful constructs in the book is this notion that care isn’t either safe or unsafe. That there's a spectrum that care might be considered on a ladder, I guess, of levels of care that at the top, you have optimal care that is envisioned by standards, and at the bottom, you have care that is so poor, that the risks actually outweigh the benefits where harm actually occurs. And in the middle, between kind of level five care that is so poor, and level one care that is optimal, as envisioned by standards, you have this array of care that in the middle is

care that Charles and Rene have called “through the illegal normal,” where it's ordinary care full of imperfections in a complex system. But it's not sort of binary care that’s either safe or unsafe. And for me, the idea of a sort of spectrum of safety from across the care continuum has been very helpful, even just for linking my thoughts about the work of quality and the work of safety, which sometimes end up living in different departments, even in health systems.

So we have an integrated quality and safety department that works to improve care kind of across the spectrum. But for the purposes of our conversation today, thinking about coproduction, I found that frame to be really helpful, even to think about the opportunity for partnering with patients, because I think the work of partnering with patients looks different if you're working on optimizing care at the top of that spectrum, or if you're working on appropriate learning from harm and response to harm at the bottom of that spectrum.

So I teach a course, for example, in the medical school on quality and safety, and I've used that frame to organize the curriculum for the course. The course is a patient engagement in quality and safety course. And we've used that frame to say, what does partnership look like at the top of that spectrum of care? How do we leverage partnerships with patients to optimize care? And also at the bottom of that spectrum, how do we leverage partnership when we think about how to respond in the setting of harm?

Paul Batalden
It's such a basic insight, it seems to me, for complex systems like health care in today's world. My sense is that this way of thinking about the work might actually extend itself into the exploration of events that occur that, in fact, might not be regarded as just exactly what everybody hoped would happen. Because I've used the old checklists in the earlier writings, Charles, and I'd tick the boxes, I had explored the various elements in the framework. And yet, I have a sense that what you're talking about, doesn't lend itself to simply a tick-the-box kind of way of thinking about safety.

Charles Vincent 8:18
We began by thinking about safety very much in terms of specific errors and incidents. And I think that in certain contexts, that's absolutely fine. And I'm not one of the people who say that’s a ridiculous way of looking at it. It's just that it doesn't really work very well when you've got a problem that might happen over three or four months, like a sort of drug overdose that goes on for ages, and it's not exactly an error, you know. It may have been a correct prescription in the first place, but it may come to threaten somebody. So that's one way, it's more fluid over time. And the levels of care, obviously, there's nothing original about thinking about different levels of care. I suppose what's different is to think about it, that this is happening moment to moment. And if you're a patient, you know this very well. You can go and have fantastic treatment, and then you go into the next ward or something and, you know, things are, a bit fragmented and not quite on the case, you know. And what I hadn't thought about- different types of coproduction for different levels-in the creative use that Maren has put them to. But I can see that both sort of moment to moment for patients, we can be involved in different ways. And I suppose sometimes we are trying to make the care best as possible. But as patients, I think, quite often we're trying to pick up the pieces, and we're in the illegal normal, and we're trying to patch up what the health care system is failing. And I suppose our contribution there and as Maren says, if she and her colleagues are having open conversations with patients about that, to me, that is in itself a safety measure, because I'm a

patient faced with a fragmented system. I'm very happy if I've got someone who's talking to me about that system being fragmented, because I think I'm in a much better position there. And if I think about longer term improvements, which Maren also talked about, it's a very hard thing to prove, but I feel both professionally and as a potential patient, that the sort of management of risk approach to health care, sometimes you need that to make sure the care is, you might say, good enough. And as a patient, realistically, what I most want is care that's good enough. If it's not perfect, I can live with that, you know, nowadays, especially, but I do want to avoid that floor when I'm really sort of failed by the system. And I think there's various ways in which interventions can be constructed, which are more about preventing things going wrong than making everything perfect. This is again, not an easy thing to prove. But this is one of the implications of this, I think.

Maren Batalden
Yeah, I think one of the implications of that frame for me in my role is that when you start looking at safety in the way that you do in the book, and through the patient's eyes, not only do you see that safety varies over time, but the scope of safety is just enlarged, right? So for example, I read every comment that we get from our patients on our patient experience of care surveys that we send out, you know, hundreds of surveys every month, and I read the comments. And what you can see when you're looking at our system through our patients' eyes is that you see lots of opportunities related to the care fragmentation, sort of coordination of care dropped balls, things that people didn't understand that they really needed to understand if they were going to play their role in the system, or situations where waits and delays have contributed to bad outcomes, or situations of emotional harm in which people felt they were treated rudely or their concerns were dismissed and not heard. And none of those things show up as incidents in our incident reporting system. But when I read the conversation that we're having with our patients through these surveys, I can see that the scope of our concern related to safety needs to be much bigger than responding to those events that make it into our safety event reporting system.

Paul Batalden
So is there an example or a story, Maren, of a time when healthcare didn't work the way that people had hoped it would work that would illustrate this different relationship?

Maren Batalden
If you take Charles and Rene's framework seriously, you recognize that everyday care is not working perfectly and is not working exactly the way that we intended it to. I think that when we can find ways of seeing what happens through our patients' eyes, we can see differently, not only the scope of opportunities for improvement, but also, you know, very pragmatic, simple steps that we might take to make care safer and better.

One example that comes to mind is a patient who fell in the inpatient environment; he was admitted tothe hospital in the setting of a COVID infection. And he had been on the unit for just a few hours before he attempted to get up to go to the bathroom and fell and hurt himself. He actually broke a facial bone. So he fell hard. And we analyzed the fall as we do with every fall we have a protocol for preventing falls. And we have a checklist of things that we always seek to do to prevent falls; we use that checklist to analyze what happened. And we didn't find any opportunities for improvement. Using our checklists, we felt like we had done all the things that we set out to do to prevent falls. We had

given him a special pair of red socks, which indicate that he's a fall risk. And we had oriented him to the room and the buzzer that we wanted him to use to ask for help when he was going to need to get up to go to the bathroom. We had reviewed his medications to make sure that he wasn't on medications that might increase the risk of a fall. But when I called him, I talked to he and his wife in their home, and they had all sorts of observations about what had happened and what might have gone differently, and better to prevent that from happening. So, his wife was able to tell me that one of the principal reasons for his admission to the hospital was that he had lost his balance at home, was unable to walk and was falling at home. And so it wasn't a surprise to her that he fell in the hospital because he had been falling at home. And that was not a piece of the history that we obtained from the patient. This was a time in which patients were not able to have visitors in the hospital because of our concern about COVID infection. So we had gotten the history only from the patient. And the patient was somewhat confused and delirious at the time of his admission. So he couldn't really explain very thoroughly what was bringing him into the hospital. So there was a piece of information that we didn't have. And then the patient was able to describe an incredible amount of clutter in the room. Some of that clutter was the fact that it was a three bed room and so there were lots of pieces of equipment related to the care of the other patients in the room. Because we were worried about his potential risk of fall, we had moved a plastic commode next to the bedside, there was a bedside table. And because we were managing a whole bunch of PPE (personal protective equipment) in the context of the COVID pandemic, we had special containers for gloves, gowns and other sorts of equipment. And so the room was incredibly cluttered. And that contributed to his fall… that wasn't actually on our checklist. And then after the fall, because he himself was still fairly confused, he didn't really understand what had happened to him medically, he didn't understand the significance of the fall and the fracture to his face. And although we called his wife, she was also left confused about exactly what care needed to happen to make sure that the injury was well cared for. And so just talking to the patient, not only did we learn opportunities for improvement that we could put in place for, for subsequent fall risk prevention work, but we also saw sort of blind spots in our care system where we had not attended to the post fall care in a way that was maximally helpful to the patient.

So I just think when we open up the conversation related to incident analysis, and engage the patient and the family in it, we learn a whole lot. And it's not that hard. I don't always call the patient after an incident, we can't always make that happen. And yet, when we do, it's so rich and not that hard to do. It also gives me an opportunity to express my regret and my empathy for his injury and apologize for the way in which our care was imperfect, that he was even hurt in the context of that care. And he was incredibly receptive to my apology.

Paul Batalden 16.43
Sounds pretty reasonable, doesn't it, Charles?

Charles Vincent
Well, it's wonderful that Maren just phones up because just imagine if you're that patient, and someone calls you to see how you are, I don't know why, in the UK, we don't do that nearly enough, in our very sort of formalized systems. But I think the point that she describes very wonderfully is the amount of information you get, especially when you start thinking, say, you're analyzing something, you're not just thinking about the preceding 48 hours. You think, oh, okay, well, how does this fit into the general

pattern of this person's life and what's going on. Then the question of involving patients and family, it's not just a matter of it being a nice thing to do, or a good principle or something like that. It's just that, you know, when we're patients, we have expertise and knowledge that it's just not available to clinical staff. And that's the key thing. So just as you, you know, sometimes you need a multidisciplinary team to investigate something because you need the different perspectives, and the patient and family is one of them. I think the other thing that comes out from this is, it's great that they have the falls checklist and it's not a failure that it didn't encompass everything; it's inevitable it can't. But here you see one of the things that Maren has described is how a perfectly reasonable management of one type of risk, which is COVID, caused other sorts of problems. And not because it was a mistake to stop visiting, or restrict visiting and clutter the place up with PPE that was obviously probably the right thing to do. But it's a balance, you know. You intervene in one way, and then you cause other problems. And that's one of the reasons we call the new book, safer healthcare, because you're never going to get completely away from that problem, the management of risk, and you know that one intervention will cause some, have benefits and risks at the same time. The fall is an interesting example as well, because in hospital, you obviously want to stop falls if possible. But in the home safety is just one objective, among others. And while sometimes it's very reasonable, I think, to completely prioritize safety and say, well, it overrides everything else, that's not true in somebody's home. And if I'm old and at risk of falling, maybe people say, well, you'd be safer if you went into a supportive living or whatever it might be, you know. And I may say, well, yeah, and I'd rather have my autonomy and risk falling over, you know. And it's a very reasonable trade off to say, well, autonomy and safety, quality of life. That's the balance I choose. And again, that's a risk management perspective: you can make things perfectly safe, but at a cost, and juggling the risks is that sort of thing,(and)it seems to me, a more real perspective.

Maren Batalden 19.10
I love that perspective. I think it's very easy for people to say, you know, safety first and safety is the most important value. But in the real world, it's actually one of many values, both for individual people and for our health system.

Paul Batalden 19.21
So modern healthcare is more than people. It involves computers, as well as people. And yet, it seems to me that sometimes computers don't make the work easier. Computers are wonderful for some parts of the work but for other parts of the work it seems like it just gets harder. How does that fit with this idea of making safer healthcare?

Maren Batalden
I do think that there is, in many ways, as we try to engineer safer healthcare, we try to automate things and to remove the risk of human error by increased automation of processes, but of course we can't automate everything. And in the end, the enterprise of both receiving and offering health care services is a human endeavor. And so we interact with our machines in a way that is increasingly complex. And the way in which we kind of share safe decision making with our computers and our computer algorithms is increasingly complicated. And that's true, whether we're talking about patients engaging the computer, or whether we're talking about healthcare professionals engaging the computer.

You know, when I started medical practice, 20 years ago, I was actually writing orders on a piece of paper. Those orders were faxed with a fax machine, to the radiology department, if I needed an imaging study or to the lab, if I needed a blood draw, or to the pharmacy, if I needed a medication. We don't use paper in that way anymore. Now I enter orders into the computer, and the computer helps me a lot. It gives me best practice alerts, it warns me if I order a medication that the patient has an allergy for, it allows me to review past encounters with the health system and even encounters with the health system in other parts of the country and other parts of the city. I have access to a tremendous amount of stuff about the patient that I didn't have access to back in the day of the paper medical record. But it's also the case that as I interact with the computer, it does some of the thinking for me. And sometimes I'm not sure how much of the thinking it's actually done, whether the thinking that it's done is actually correct, is it giving me good advice? Or is it giving me generic standard advice that doesn't actually apply to this patient? So I have to keep my level of consciousness up around what advice it's giving me and what advice it's not giving me. And so it's really entered into the middle of the clinical thinking process, and also the middle of the relationship between the patient and the health professional.

You know, in many ways, we can improve convenience and safety for patients by allowing people to engage with the electronic medical record directly. In Open Notes, they can read their own notes, and they can amend it, if it's got errors in it, they can schedule an appointment directly using the direct scheduling application. And so there are many ways in which the electronic medical record can improve safety.

But again, it creates its own new generation of safety challenges for patients given that not every patient is equally capable of engaging with the computer effectively. So it's creating new layers of inequity in the way in which people engage. And sometimes we as health professionals assume that patients have understood and learned something because they had access to it through the patient portal on the electronic medical record, but it turns out that they didn't, or they don't understand it or use it. And so it's created, I guess, a third party in the dyadic relationship between the patient and the health professional.

Paul Batalden 23.14
My sense is that this challenge of automation is a challenge for the coproduction of healthcare service, as well as for the isolated use by one party in the healthcare system. I just want to open this space for people as we go forward. Are there any closing comments that either of you would like to make?

Maren Batalden
I think I would offer one thing, which is that in addition to learning from our patients about the scope of safety and the opportunities for improvement, from their perspective, I think we also sometimes underestimate the potential role that patients can play in actually making their own care safer. One example for us in our system is that we were having some trouble with losing laboratory specimens, specimens that were incorrectly labeled. And we had the idea that we could add a step in the process of the drawing of phlebotomy specimens in the outpatient setting where we would ask the phlebotomist to show the specimen and the label to the patient, and ask the patient to confirm that, in fact, that was their name on that tube. And we have dramatically reduced the specimen labeling errors just by adding that step in the process. Because, of course, nobody cares more about getting it right than the patient

whose specimen is actually just been drawn out of their arm with a needle, and they certainly don't want to have to go through that again. It's just a kind of a very simple example of ways that we can engage the patient in partners for improving safety when we remember that patients have capacity and agency and they can bring themselves to the equation.

Another example of that is that we often need patients to behave in a particular way with the health system. But we don't really explain to people exactly what we expect of them. And so for example, we've been working in a variety of different ways to try to keep people out of the emergency department and to get people to use their primary care providers preferentially instead of coming to the emergency department directly. And we have discovered in a couple of different settings, both in our geriatrics care setting and in our primary care clinics, that patients didn't ever get any kind of effective orientation to the on call system. So they really weren't sure who to call, what number to call, who might be available to them, what kinds of problems they could manage over the phone, what they could expect when they did call the phone, that we had urgent care appointments available in the same day. So we ended up seeing people using the emergency department because they don't know that there's any better way to do it. And we get frustrated by that without actually understanding it from a patient's perspective and giving them the kind of information they need to manage their relationship with the healthcare system effectively.

So I think there's a lot of opportunity for partnering more effectively with patients and making the system work better for them and make the system work more safely for them.

Charles Vincent 25.26
I think that's great. And I love the idea of, if you like, that we all need to be prepared and given training, if you'd like, to be a patient, because the healthcare system is so opaque, even to those of us who work in it, getting it to actually work for you is a nightmare. In most countries, I think, whatever the system, I think there's a fine line between helping people or what we're as patients to deal with, the deficiencies of the system, and passing a buck and say (ing), well, we don't need to fix this, because well, we just get the patients to ring up when it all goes wrong, you know. But in the moment, I'm very much in favor of you know what Maren is describing as not so much passing the buck to the patient, but using a patient and family as a sort of extra mechanism, an extra safety check.

I think also the idea of training and preparing people more is going to become increasingly important. And that's because I have a feeling that as more and more care goes into the home, which obviously is beneficial in many, many ways, I feel probably patients and family members are much less prepared for the clinical tasks they have to do than most in the healthcare system–most doctors and nurses– realize. And things that are just kind of ordinary and routine to any young doctor or you know, just things you do a million times, that can be a big challenge. And discharging people early from hospital is great. But of course, what it means is that things that were formally done by nurses, dressing wounds and things, are just suddenly done by family members. And there's a nice example in my own family where somebody was discharged with a wound under the arm which needed to be a dressing change and so on. And in the hospital at 10 o'clock in the morning, the nurse changed the dressing, and the woman's partner leaned over to have a look and (was) trying to help and the nurse sort of shooed him away and

said, no, it's my job to do this. Four o'clock the same afternoon, he was doing the same thing unaided himself at home. And suddenly he's in the role of the professional.

And we've done more work on other things with some people doing very, very complex things at home and with training, preparing the patient for managing in this case, gastrostomy at a surgical site in the stomach. Parents can have to do this with almost no understanding of what they're meant to be doing. But this is a wider conversation. So preparing us to be patients I think is going to be increasingly important.

Maren Batalden
I love that point. I think it's a really important observation that as we recalibrate the nature of the partnership between health professionals and patients who are doing more and more for themselves, there's a lot of learning to be done. I'm reminded of my own aunt who was dealing with an advanced breast cancer and nearing the end of her life, she had a lot of pain from metastases in the bones. She was prescribed narcotics for that pain and the narcotics created constipation. And as a doctor, that's the kind of thing that I see a lot in the hospital and I consider the prescription of medications for constipation to be incredibly ordinary and not very complex. And it is not uncommon to prescribe many different medications for constipation and to say to a patient, take this if you need it, and if it doesn't work, take something else and you're going to have this on top if those first two agents don't work. And what I saw with my aunt, who had really not had chronic medical problems and had never really taken prescription medications, despite the fact that she was an incredibly smart, capable woman, she was completely overwhelmed by figuring out which medication for constipation should I take at night? Which should I take in the morning? What happens if it's been one day? What happens if it's been two days? And sitting with her to describe exactly what might work to manage the constipation just gave me an incredible appreciation for how complex it is to live with the problems that are routine for a health professional, but are actually incredibly overwhelming to live with as a patient. It just illustrated for me the gap between what people often know and what they need to know to make sure that they are able to manage themselves in their own safety at home.

Paul Batalden
You have opened, Charles and Maren, this amazing territory, how we might think about healthcare both today and tomorrow. Thank you so much for taking this time.

Maren Batalden
It's been a pleasure. Thank you.

Charles Vincent
It's been a great pleasure, Paul.

Paul Batalden 31:04
Charles Vincent and Rene Amalberti (in their new book, *Safer Healthcare*) have offered a way of making healthcare safer, not a project. This way is built on the real world reality that patient persons and professional persons can work together to create services that help the patient person improve or maintain their own health across time and geographic setting. This way involves seeking the active

involvement of patients and family members and their insights as harm is being prevented, and when harm that occurred is being explored and more deeply understood. Maren (Batalden) helps us recognize the benefit of the more detailed information available from the direct input of patients and families as she and her colleagues seek a deeper understanding of any unwanted events that occurred.

The temptation for thinking that healthcare is either safe or not safe can hide the reality that a complex set of factors are involved for both the professional person and the patient person, as together they work to make healthcare safer. Acknowledging the patient person as a legitimate co-creator of the service is a place to start. Maren's suggestion about reading what comments patient persons make on surveys, Charles' suggestion that observing or creating a window on systems at work, offer both professional persons and patient persons an opportunity to see risk better.

In some ways, involving the patient person and family is such a simple way to start. They offer a more finely tuned set of insights and contextual information, which can serve as a base for making safer healthcare service.

As computers and automation are increasingly used in healthcare, it becomes even more important in the coproduction of safer healthcare service to explore how computers can make good contributions. And how they may inadvertently contribute to increasing the difficulties of achieving safer health care in these times of riskier healthcare service interventions. The invitation (Charles) Vincent and Amalberti have given to involve patient persons and family persons in the shared journey towards safer health care is an important step and we thank Charles and Maren for their help in understanding what that might involve. Thank you. I am Paul Batalden.

Madge Kaplan 34:06
Thank you for listening to Episode 13 of the podcast series, "The Power of Coproduction" with Paul Batalden. On Episode 14, "Coproduction in The Real World," Paul recaps the entire series and imagines the possibilities that lie ahead with the help of Tina Foster and Christian von Plessen. All podcasts in this series, including an overview of coproduction, are available at ICoHN.org/podcasts. The website is where you'll find supplementary materials, guest bios and brief profiles of the production team. You can subscribe to the podcast series wherever you get your podcasts. Thanks for listening.