2024 International Congress
on Integrative Medicine & Health
APRIL 9-13 • CLEVELAND, OH, USA

'First, Do No Harm'

THE CHIROPRACTOR'S PERSPECTIVE ON PATIENT SAFETY FOR INTEGRATIVE MEDICINE AND HEALTH

Katherine Pohlman, DC, MS, PhD
Brian C. Coleman, DC, MHS
Michael Moore, DC, MS
Martha Funabashi, PT, MS, PhD

WORLD FEDERATION OF CHIROPRACTIC
Quarterly World Report
OCTOBER 2023

WFC NEWS

Why is the WFC's focus on patient safety so important?

Patient safety task force chair, Katie Pohlman explains the WFC's latest research initiative.

'What is patient safety?' Patient safety is defined by the World Health Organization (WHO) as "the prevention of errors and adverse effects to patients associated with health care" and more comprehensively "a framework of organized activities that creates cultures, processes, procedures, behaviors, technologies and environments in health care that consistently and sustainably lower risks, reduce the occurrence of avoidable harm, make error less likely and reduce impact of harm when it does occur".

Within all major healthcare organizations, patient safety initiatives exist, which include, but is not limited to, the WHO (World Health Organization): Global Patient Safety Action Plan 2021-2030 (who.int); Agency for Healthcare Research and Quality (AHRQ); PSNet; Healthcare Excellence Canada; Canadian Patient Safety Institute; NHS (National Health Services): The NHS Patient Safety Strategy, and the seminal report written by the IOM (Institutes of Medicine - now the National Academy of Medicine-NAM): *To Err Is Human*.

In May, the WFC Board unanimously voted to support the Global Patient Safety (GPS) Task Force. By doing so, the chiropractic profession has taken a clear stance to unite us with global organizations to promote safe patient care.

So, how is patient safety relevant for the chiropractic profession? We often read of numerous avoidable errors made in hospitals, but as chiropractors, we don't have prescription-related or surgical errors that occur in these environments.

Our environment presents us with different challenges that can impact care with some more profound effects than others, but all constitute a part of our patient safety culture. These challenges include communication, diagnostic errors, and inappropriate care plans – all contribute as mild, moderate and serious adverse events.

Dr Katie Pohlman

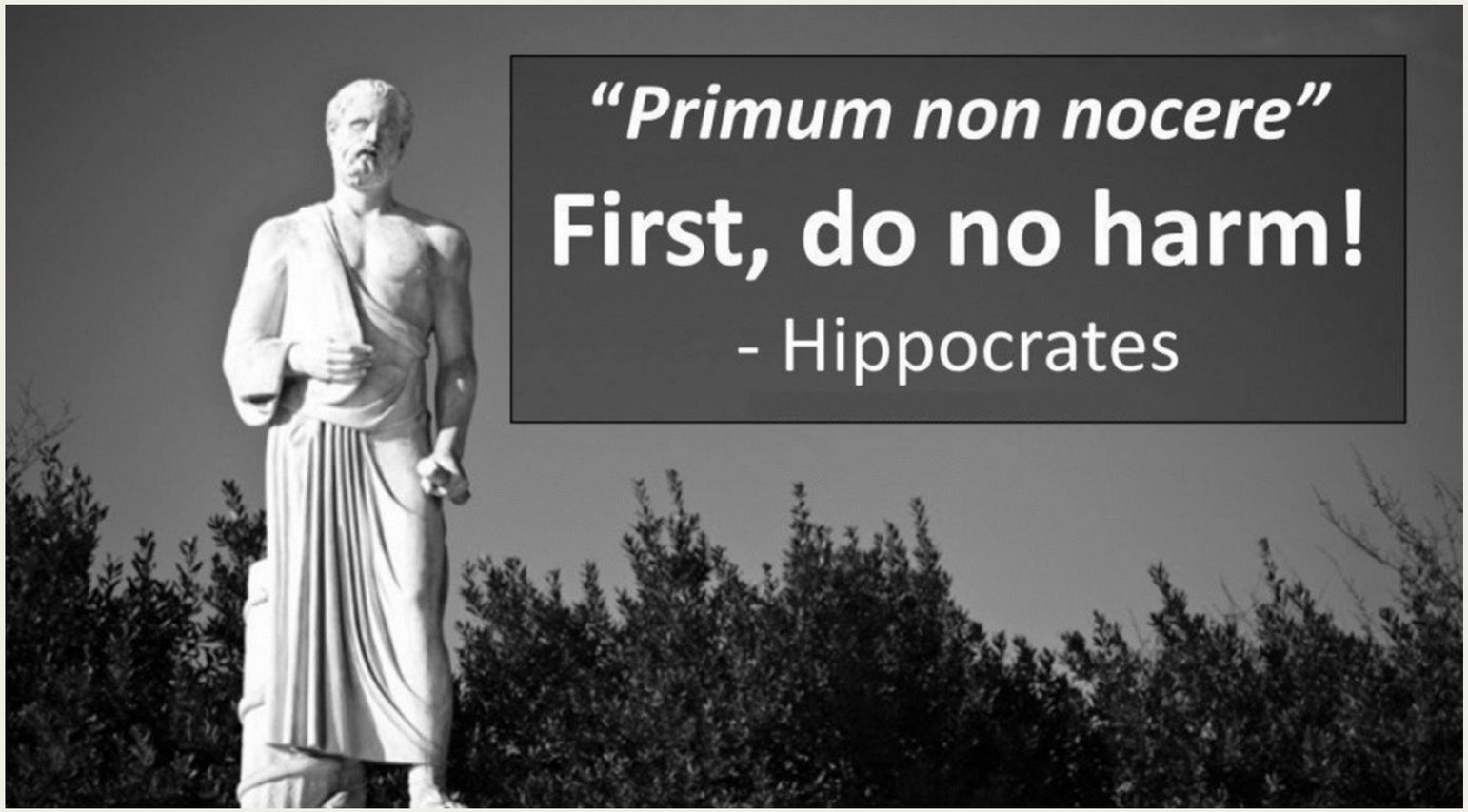
At the heart of all patient safety initiatives are effective communication skills, as communication has been found to be a component of the majority of patient safety incidents. Effective communication is also important to empower patients to detect and report adverse events.

Beyond minimizing errors and engaging patients, efficient communication skills are also critical to disclosure interactions and collective healing, which have been shown to minimize litigation and which are key parts of a supportive, transparent patient safety culture.

Other patient safety concerns that are relevant to chiropractors are diagnostic errors and

WORLD FEDERATION OF CHIROPRACTIC | FÉDÉRATION MONDIALE DE CHIROPRATIQUE | FEDERACIÓN MUNDIAL DE QUIROPRÁCTICA

Global Patient Safety Task Force

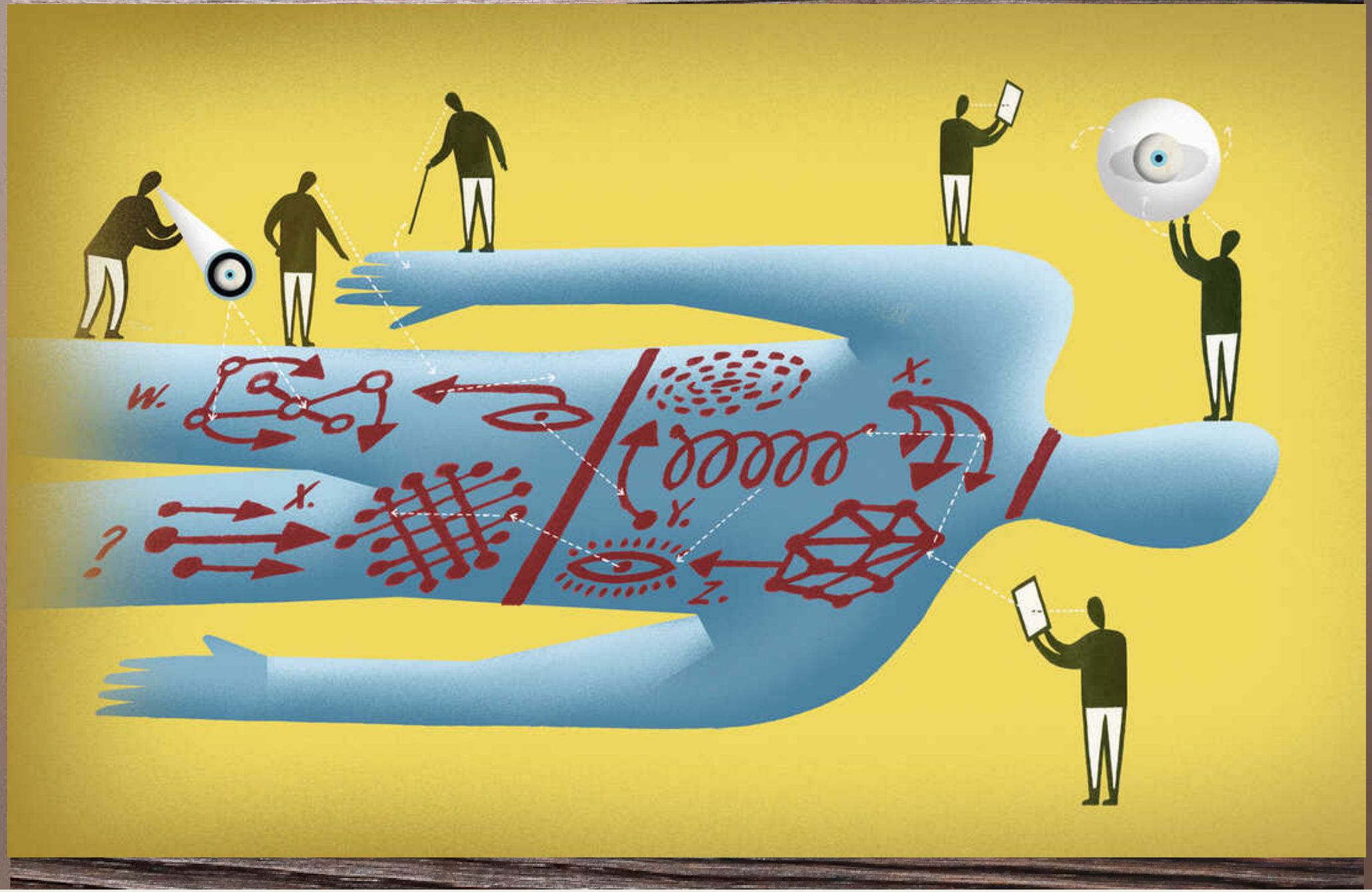


AGENDA

Background

- **Define:**
  - **Patient Safety**
  - **Adverse Events**
- **Patient Safety Culture**
  - **History**
  - **Need**
  - **Frameworks**
- **WHO Global Patient Safety Action Plan**


Patient
Safety


W.
X.
?
Y.
Z.
X.

WHAT IS AN ADVERSE EVENT?

PLOS ONE

OPEN ACCESS PEER-REVIEWED

RESEARCH ARTICLE

Definition and classification for adverse events following spinal and peripheral joint manipulation and mobilization: A scoping review

Martha Funabashi, Lindsay M. Gorrell, Katherine A. Pohlman, Andrea Bergna, Nicola R. Heneghan

Published: July 15, 2022 • https://doi.org/10.1371/journal.pone.0270671

Term	Definition
Adverse event *See also accident, adverse drug event, adverse drug reaction, adverse patient occurrence adverse reaction, adverse serious event, bad outcome, clinical incident, close call, critical incident, dangerous situation, drug misadventure, error, event, harm, hazard, iatrogenic, incident, injury, life threatening adverse drug experience, medical error, medical injury, medical mishap, medical mistake, medication error, misadventure, mistake, near miss, no harm event, patient safety, patient safety incident (incident), potential adverse event, potential event, preparation error, prescribing error, preventable adverse drug event, preventable adverse event, preventable death, preventable error, reportable occurrence, sentinel event, serious event, serious outcome, slip, unexpected adverse drug experience, unpreventable adverse drug event, unpreventable adverse event*	1. An injury that was caused by medical management or complication instead of the underlying disease and that resulted in prolonged hospitalization or disability at the time of discharge from medical care, or both. [23 see also 24] 2. An undesired patient outcome that may or may not be the result of an error. [25] 3. An event or omission arising during clinical care and causing physical or psychological injury to a patient. [26] 4. A negative consequence of care that results in unintended injury or illness which may or may not have been preventable. [27] 5. An injury that was caused by medical management and that results in measurable disability. [28] 6. An injury caused by medical management (rather than by the underlying disease) which prolongs hospitalization, produces a disability at the time of discharge, or both; ... AEs are caused by drug complications, wound infections, and technical complications, and those due to negligence [caused by] diagnostic mishaps, therapeutic mishaps, and events occurring in the emergency room. [3] 7. An untoward, undesirable, and usually unanticipated event, such as death of a patient, an employee, or a visitor in a health care organization. Incidents such as patient falls or improper administration of medications are also considered adverse events even if there is no permanent effect on the patient. [8] 8. Adverse events are untoward incidents, therapeutic misadventures, iatrogenic injuries, or other adverse occurrences directly associated with care or services provided within the jurisdiction of a medical center, outpatient clinic, or other facility. Adverse events may result from acts of commission or omission. [29] 9. An undesirable event occurring in the course of medical care that produces a measurable change in patient status. [30] 10. An event that results in unintended harm to the patient by an act of commission or omission rather than by the underlying disease or condition of the patient. [31] 11. An injury resulting from a medical intervention and not due to the underlying condition of the patient. [1 see also 15,19,22] 12. An unexpected and undesired incident directly associated with the care or services provided to the patient. [5] 13. An incident which results in harm to a patient. [100]

- WHO:

  “Conceptual Framework for the International Classification for Patient Safety”

Technical Report, 2019

PATIENT SAFETY CULTURE:

SMALL PICTURE

Healthcare Excellence Canada Safety Competencies Framework

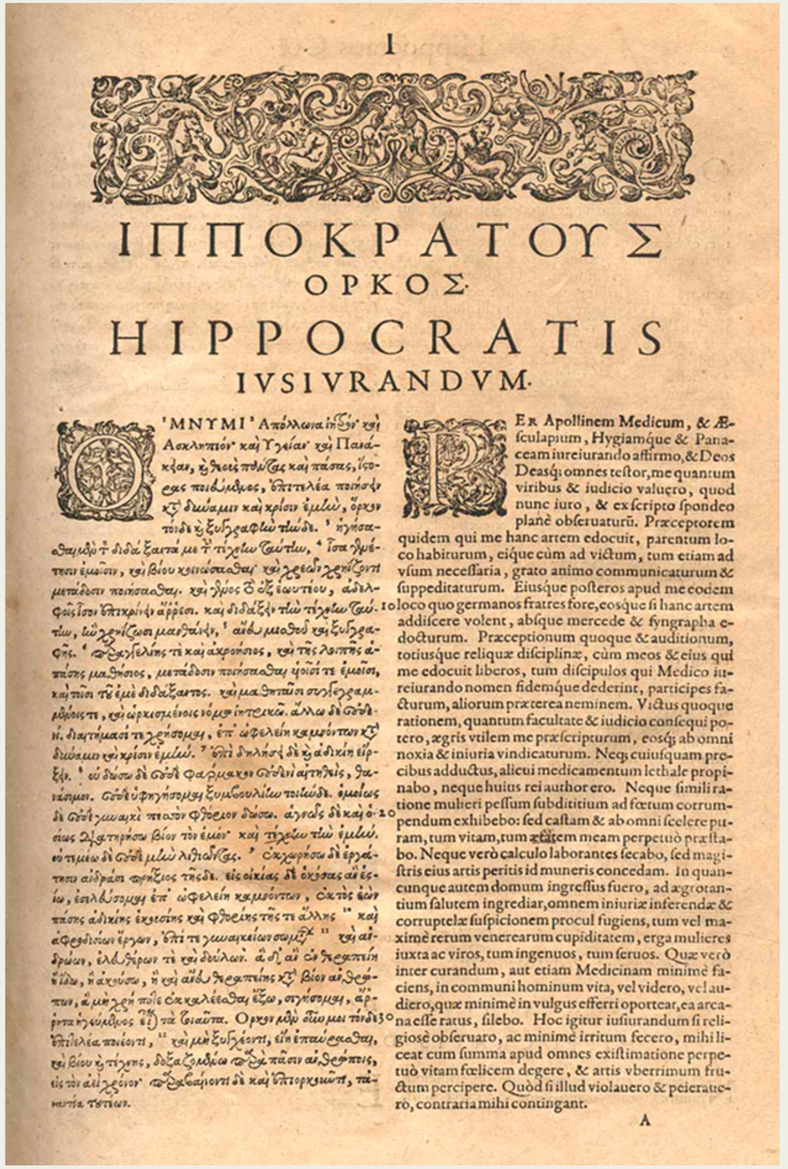
PATIENT SAFETY CULTURE:

BIG PICTURE

Healthcare Excellence Canada Safety Competencies Framework

PATIENT SAFETY:

WHERE IT STARTED



ΙΠΠΟΚΡΑΤΟΥΣ
ΟΡΚΟΣ.

HIPPOCRATIS
IVSIVRANDVM.

'ΟΜΝΥΜΙ' Απόλλωνα ἰητρὸν καὶ Ἀσκληπιὸν καὶ Ὑγείαν καὶ Πανάκεαν, καὶ θεοὺς πάντας τε καὶ πάσας, ἵστορας ποιεύμενος, ἐπιτελέα ποιήσειν κατὰ δύναμιν καὶ κρίσιν ἐμὴν, ὅρκον τόνδε καὶ ξυγγραφὴν τήνδε. ' ἡγήσασθαι μὲν τὸν διδάξαντα με τὴν τέχνην ταύτην, ' ἴσα γενέτῃσιν ἐμοῖσιν, καὶ βίου κοινώσασθαι· καὶ χρεῶν χρῄζοντι μεταδοῦναι ποιήσασθαι· καὶ γένος τὸ ἑωυτοῦ, ἀδελφοῖσιν ὁμοιήσειν ἄῤῥεσι· καὶ διδάξειν τὴν τέχνην ταύτην, ἢν χρήζωσι μανθάνειν, ' ἀκροήματός τε καὶ ξυγγραφῆς. ' παραγγελίης τε καὶ ἀκροήσιος, καὶ τῆς λοιπῆς ἁπάσης μαθήσιος, μεταδοῦναι ποιήσασθαι ἑμοῖσί τε υἱέσι, καὶ τοῖσι τοῦ ἐμὲ διδάξαντος· καὶ μαθητῇσι συγγραμμένοισί τε, καὶ ὡρκισμένοισι νόμῳ ἰητρικῷ· ἄλλῳ δὲ οὐδενί. διαιτήμασί τε χρήσομαι, ἐπ' ὠφελείῃ καμνόντων κατὰ δύναμιν καὶ κρίσιν ἐμὴν. ' ἤν τινα δὲ κλέπτοντα ἢ ἀδικέοντα ὄψιν ἢ ἀκοὴν ἀνθρώπων, ἃ μὴ χρὴ πώποτε ἐκκαλέεσθαι ἔξω, σιγήσομαι, ἄῤῥητα ἡγεύμενος εἶναι τὰ τοιαῦτα. Ὅρκον μὲν οὖν μοι τόνδε ἐπιτελέα ποιοῦντι, " καὶ μὴ ξυγχέοντι, εἴη ἐπαύρασθαι, καὶ βίου καὶ τέχνης, δοξαζομένῳ τοῖς πᾶσιν ἀνθρώποις, εἰς τὸν ἀεὶ χρόνον· παραβαίνοντι δὲ καὶ ἐπιορκοῦντι, τἀναντία τουτέων.

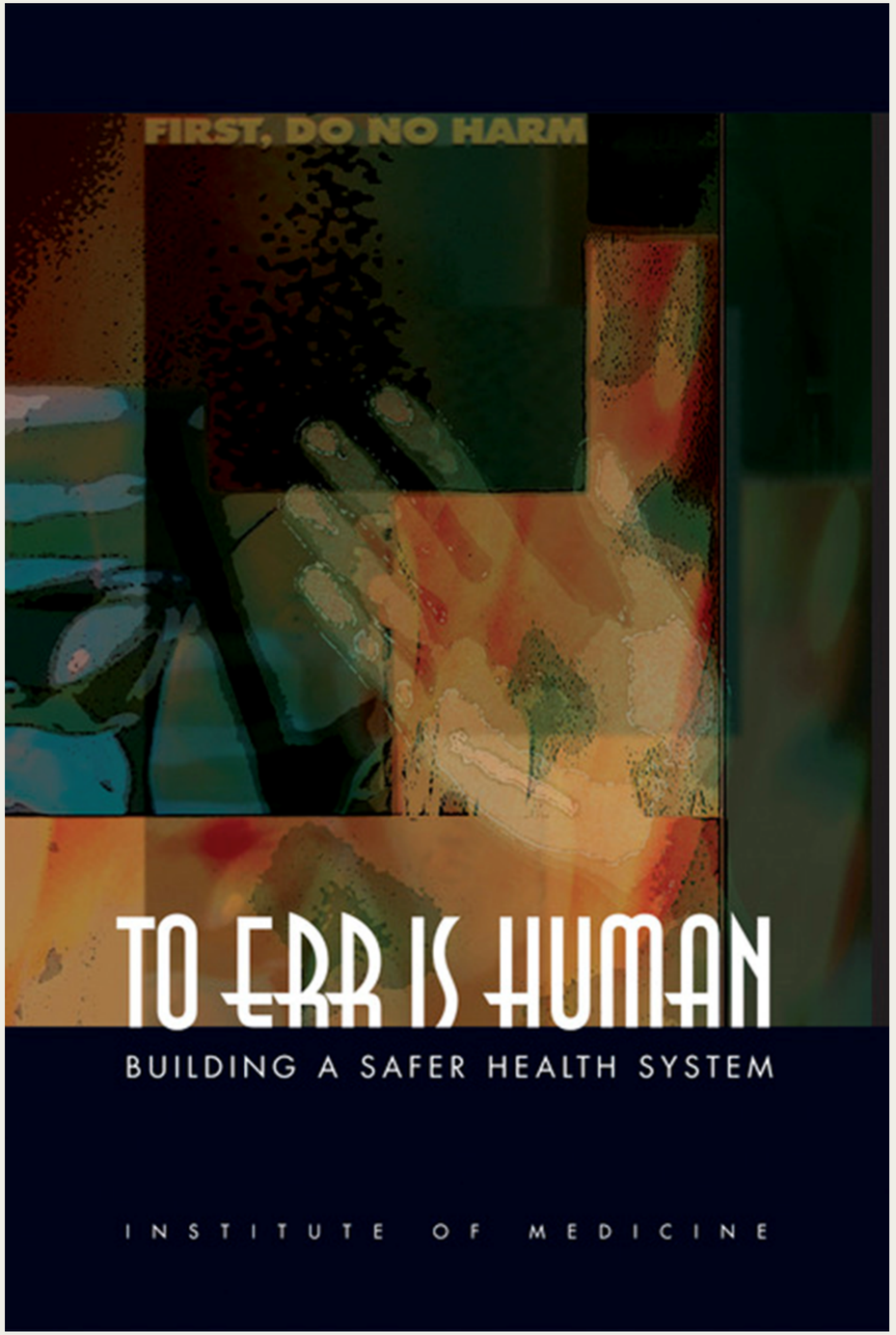
ER Apollinem Medicum, & Æsculapium, Hygiamque & Panaceam iureiurando affirmo, & Deos Deasq; omnes testor, me quantum viribus & iudicio valuero, quod nunc iuro, & ex scripto spondeo planè obseruaturũ. Præceptorem quidem qui me hanc artem edocuit, parentum loco habiturum, eiúe cùm ad victum, tum etiam ad vsum necessaria, grato animo communicaturum & suppeditaturum. Eiusque posteros apud me eodem loco quo germanos fratres fore, eosque si hanc artem addiscere volent, absque mercede & syngrapha edocturum. Præceptionum quoque & auditionum, totiusque reliquæ disciplinæ, cùm meos & eius qui me edocuit liberos, tum discipulos qui Medico iureiurando nomen fidemque dederint, participes facturum, aliorum præterea neminem. Victus quoque rationem, quantum facultate & iudicio consequi potero, ægris vtilem me præscripturum, eosq; ab omni noxia & iniuria vindicaturum. Neq; cuiusquam precibus adductus, alicui medicamentum lethale propinabo, neque huius rei author ero. Neque simili ratione mulieri pessum subdititium ad fœtum corrumpendum exhibebo: sed castam & ab omni scelere puram, tum vitam, tum artem meam perpetuò præstabo. Neque verò calculo laborantes secabo, sed magistris eius artis peritis id muneris concedam. In quancunque autem domum ingressus fuero, ad ægrotantium salutem ingrediar, omnem iniuriæ inferendæ & corruptelæ suspicionem procul fugiens, tum vel maximè rerum venerearum cupiditatem, erga mulieres iuxta ac viros, tum ingenuos, tum seruos. Quæ verò inter curandum, aut etiam Medicinam minimè faciens, in communi hominum vita, vel videro, vel audiero, quæ minimè in vulgus efferri oporteat, ea arcana esse ratus, silebo. Hoc igitur iusiurandum si religiosè obseruaro, ac minimè irritum fecero, mihi liceat cum summa apud omnes existimatione perpetuò vitam fœlicem degere, & artis vberrimum fructum percipere. Quòd si illud violauero & peieraueró, contraria mihi contingant.

A

PATIENT SAFETY:

INCREASING ATTENTION

1999



PATIENT SAFETY CULTURE:

DOES IT STILL MATTER?

PATIENT SAFETY CULTURE:

DOES IT STILL MATTER?

Vikan *et al. BMC Health Services Research* (2023) 23:300
https://doi.org/10.1186/s12913-023-09332-8

BMC Health Services Research

RESEARCH Open Access

The association between patient safety culture and adverse events – a scoping review

Magnhild Vikan[1*], Arvid Steinar Haugen[1,2], Ann Kristin Bjørnnes[1], Berit Taraldsen Valeberg[1,3], Ellen Catharina Tveter Deilkås[4] and Stein Ove Danielsen[1]

PATIENT SAFETY CULTURE:

DOES IT STILL MATTER?

Journal of Operations Management 27 (2009) 390–404

Contents lists available at ScienceDirect

Journal of Operations Management

journal homepage: www.elsevier.com/locate/jom

The patient safety chain: Transformational leadership's effect on patient safety culture, initiatives, and outcomes

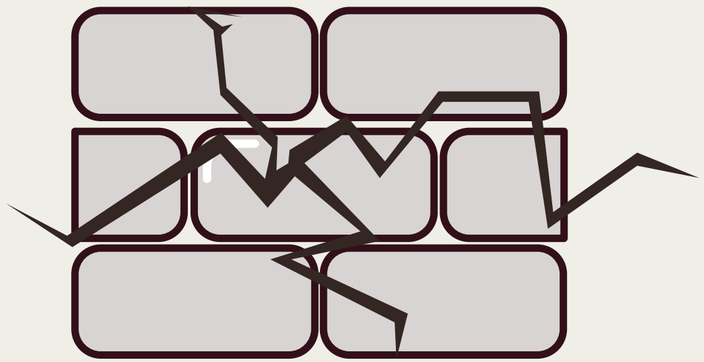
Kathleen L. McFadden [a,*], Stephanie C. Henagan [b], Charles R. Gowen III [b]

[a] *Department of Operations Management and Information Systems, Northern Illinois University, Barsema Hall 328, DeKalb, IL 60115-2854, USA*
[b] *Department of Management, Northern Illinois University, Barsema Hall 245, DeKalb, IL 60115-2854, USA*

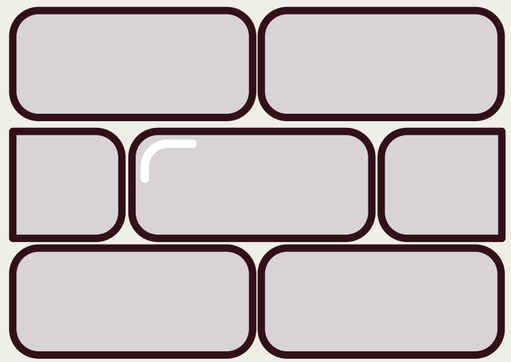
Safety Culture

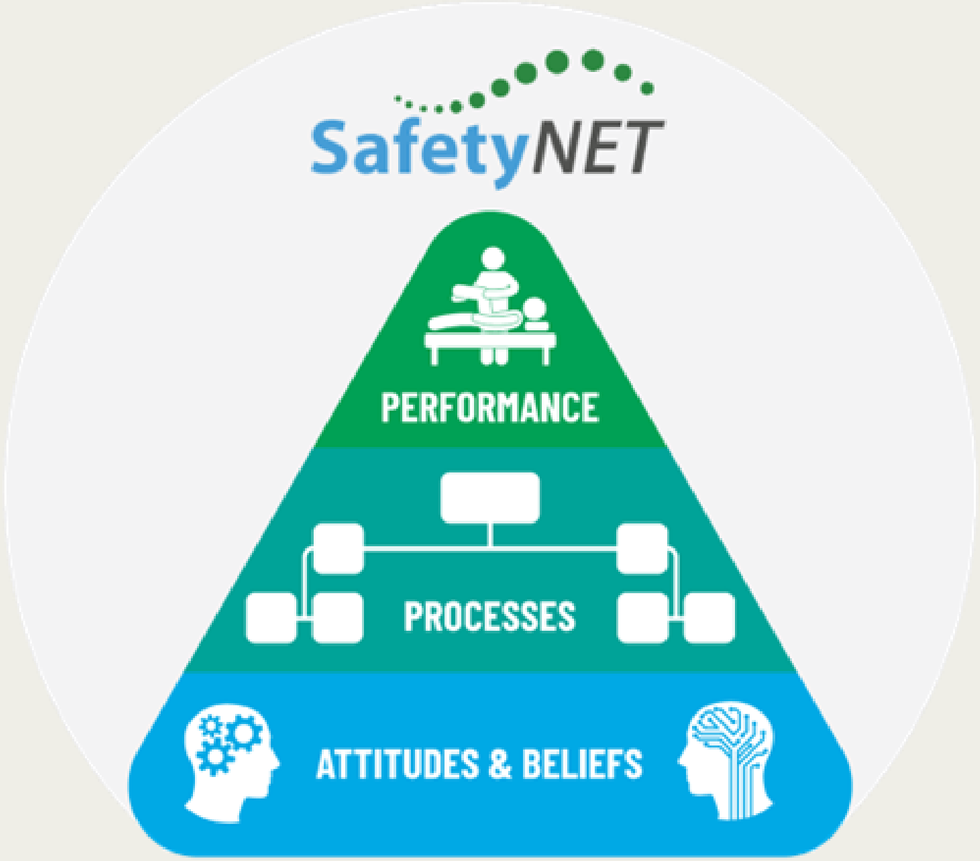
Secretive Blame Reporting Just

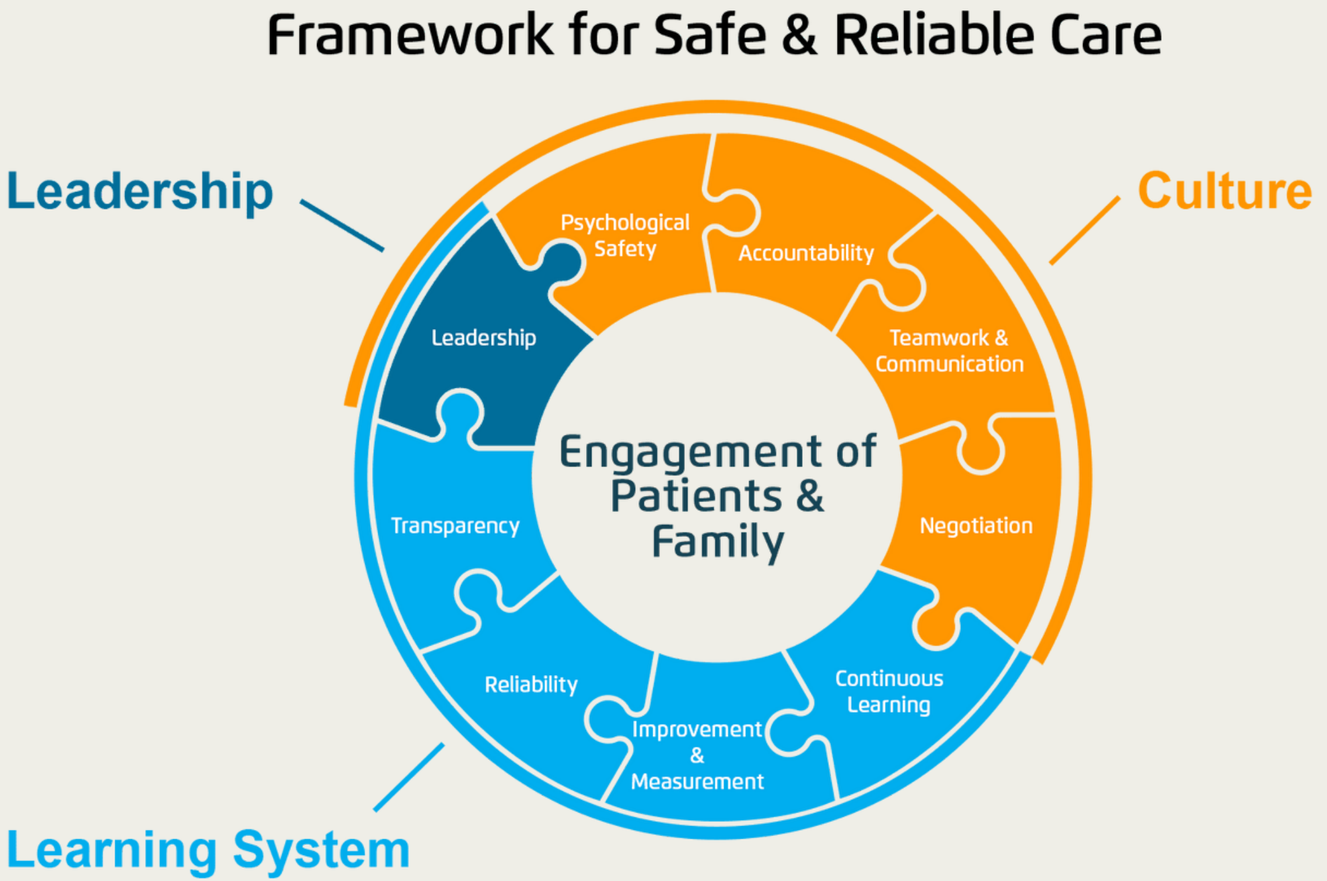
Weak



Robust



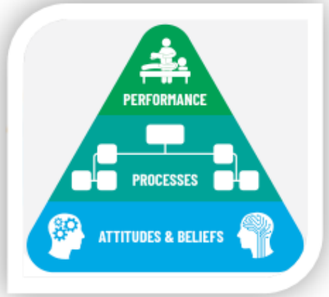




Based on https://www.safeandreliablecare.com/blog/2016/11/29/s-r-sociotechnical-framework-ihi-minicourse

From: Frankel A, Haraden C, Federico F, Lenoci-Edwards J. A Framework for Safe, Reliable, and Effective Care. White Paper. Cambridge, MA: Institute for Healthcare Improvement and Safe & Reliable Healthcare; 2017. (Available at ihi.org)

Safe and Reliable Culture Model



Tipping Point =
Psychological Safety

Generative
Safety is how we do business around here *constantly vigilant and transparent.*

Proactive
Anticipating and preventing problems before they occur; Comfort speaking up.

Systematic
We have systems in place to manage all hazards.

Reactive
Safety is important. We do a lot every time we have an accident.

Unmindful
Who cares as long as we're not caught *chronically complacent.*

Value

Credit: Adapted from 2018 Health Catalyst: A Framework for High Reliability Organizations in Healthcare

SUPPORT SYSTEM AND HUMAN RESILIENCE:
Ability to anticipate, cope, recover and learn.
HELP PEOPLE SUCCEED.

SAFETY I

FACTORS WEAKENING SAFETY

- Unsuccessful actions
- Risks
- Errors

INDIVIDUALS AND ERRORS IN FOCUS

- "Bad Apple Theory"
- "Find the weakest link and throw them away"
- Latent systemic failures remain in system

= OLD THINKING

PARADIGM SHIFT IN SAFETY THINKING

CHANGE IN HF-THINKING

SAFETY II

FACTORS MAINTAINING SAFETY

- Things working well
- Understanding human variation
- Limited resources

ORGANISATION, SYSTEM, RESOURCES AND DEVELOPMENT IN FOCUS

- Several contributing factors behind the cases
- Learning is main goal of investigation
- Human error is starting point for improvement – not the conclusion

= NEW THINKING

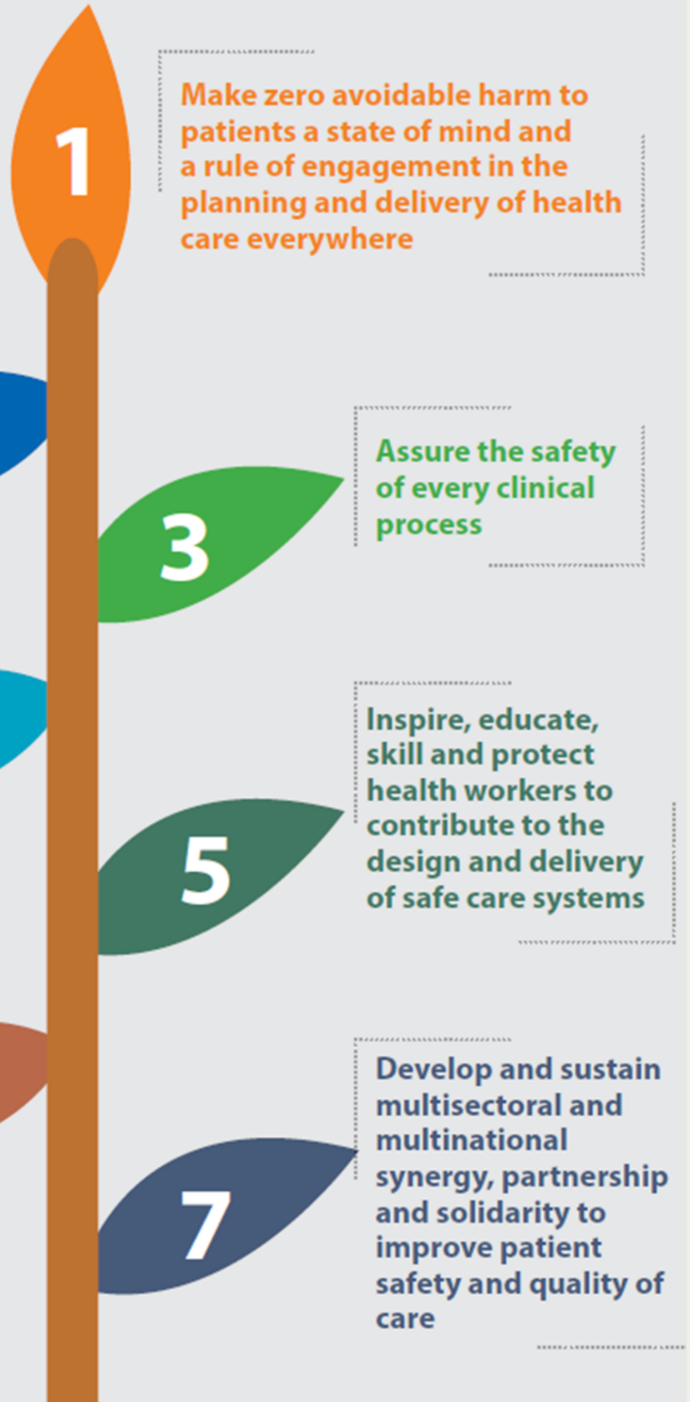
Designed by Elido 2019

World Health Organization

GLOBAL PATIENT SAFETY ACTION PLAN 2021–2030

Towards eliminating avoidable harm in health care

The framework includes seven strategic objectives, which can be achieved through 35 specific strategies:



Reflections on strategic objective:

- After reviewing the text, discuss as a group.
  - Be prepared to describe what your discussions revolved around.
- Then, discuss what actions can be taken to advance the identified strategic objectives?
  - Immediate Action Plans
  - Long-term Plans

REFLECTION

THANK YOU!