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Stress on the Ward: Evidence of Safety tipping points in hospitals

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Surgical items left inside patients as top cancer hospital has four major blunders in just six weeks

- Other errors include wrong implant fitted and 'wrong site surgery'
- The mistakes were 'never events' - as the NHS classe them as basic errors that should never take place

By CLAIRE BATES
UPDATED: 15:33, 7 November 2011

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A leading cancer specialist hospital is in crisis after staff made patient blunders in just six weeks.

Surgical items were left inside two patients, while a third case 'wrong site surgery' - where surgeons operated via an incor the body.

In a fourth error the wrong implant was fitted inside a patie

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Budget cuts taking their toll, say stressed hospital staff

Charlotte Orson
Thursday, March 8, 2012
10:27 AM

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A HIGH number of surgical infections at Addenbrooke's in Cambridge and a tide of patients being readmitted to the hospital via A&E show patient safety is being jeopardised, hospital workers say.

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And the troubles of Cambridge University Hospitals NHS Foundation Trust (CUH) – which runs Addenbrooke's and the Rosie – are further compounded by the Government insisting it makes a further £43m of efficiency savings over the next year.

"...Crowding is a big issue. I can sense when the hospital becomes unsafe…"

Deputy Medical Director

How do you sense this?

"...our escalation policies don't work any more

…we do not have enough time to make careful decisions

…we make more errors"

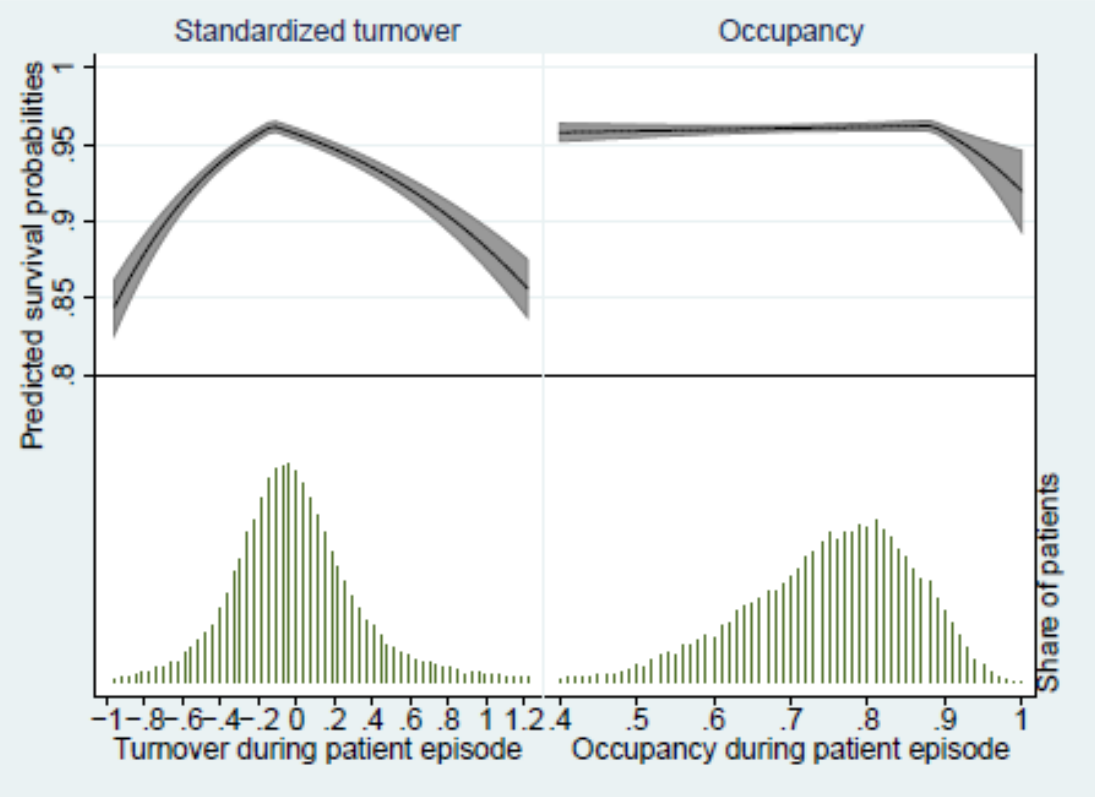
Research question:

Does organizational workload affect safety?

Workload as patient risk factor

- Traditional risk factors:
  - Primary condition, co-morbidities, age, gender, socio-economic status, emergency admission, etc.
- Workload as a risk factor:
  - Average workload in the clinical unit during the patient's stay
- Workload dimensions:
  - Occupancy (% beds occupied)
  - Patient turnover (admissions+discharges)

Sample of ~90,000 patients in 244 clinical departments in 87 German hospitals across six conditions with high-mortality risk (PNE, STR, CHF, AMI, GIH, HIP)



Effect size: **~15%** =~1,335 of ~8,900 in-hospital deaths could have been avoided if no patient had been exposed to workload above the estimated tipping point (*Kuntz/Mennicken/Sch. 2012*)

Impact requires excitement

"I have just reread your figures…this is so dynamite…."

Clinical director X

"If we could identify what factors altered the tipping point we might be some way to understanding how to improve outcomes with less staff – to increase efficiency. What are those factors – cultural, technological, skill mix, experience?"

Clinical director Y

Cambridge Safety Study, based on 4 years of patient data for Addenbrooke's (Freeman, Robinson, Savva, Sch.)

“I keep saying the sexy job in the next ten years will be statisticians. People think I'm joking, but who would've guessed that computer engineers would've been the sexy job of the 1990s?”

Hal Varian, Chief Economist Google
McKinsey Quarterly 2009