What's New in the Patient Safety World

June 2016

ISMP Article on Workarounds

Regular readers of our columns recognize that when we identify occurrence of a "workaround", which is often detrimental to patient safety, we always need to investigate and identify the reason(s) why that healthcare worker had to do a workaround.

Last month, ISMP had a great column (ISMP 2016) on the need to turn "first-order thinking" (i.e. the workaround) into second-order thinking where the organization learns and institutes long-term solutions rather than just tolerating short-term fixes that will not prevent recurrences.

The ISMP column notes that we value ingenuity and creativity in healthcare. We have all seen cases where a physician or nurse has encountered an obstacle and found an immediate solution to save a patient's life or otherwise prevent harm. The problem, of course, is that individuals who use the creativity to develop a workaround or quick fix to a problem do not often enough bring the issues to the greater attention of the organization. As a result, there is no systemic learning and the same set of circumstances that led to the workaround are likely to recur. The next time they recur there may not be as creative a healthcare worker to intervene.

We've demonstrated how workarounds may adversely impact patient safety in our Patient Safety Tips of the Week for June 17, 2008 "Technology Workarounds Defeat Safety Intent", September 15, 2009 "ETTO's: Efficiency-Thoroughness Trade-Offs", and April 5, 2016 "Workarounds Overriding Safety" and several other columns listed below.

One question we always ask healthcare workers when we are doing **Patient Safety Walkrounds** is "Can you tell us one workaround that you have used recently?" (see our October 7, 2014 Patient Safety Tip of the Week "Our Take on Patient Safety Walk Rounds"). We have emphasized that when you identify issues on Patient Safety Walkrounds you need to follow them to closure in a timely fashion and communicate back to the front line staff that you have developed and implemented solutions. That is a point also emphasized in the ISMP column.

Another good venue in which to identify workarounds are your **post-op debriefings** (see our multiple previous columns on debriefings listed below).

Some workarounds are effective, others are maladaptive. Either way, they serve to identify a system vulnerability that needs to be fixed. So when you identify a workaround is occurring you need to assess the root cause(s) of the problem and come up with solutions. The solution might, in fact, be the one the creative healthcare worker has used. So you need to consider that solution and others. The most important point in the ISMP column is that we need to create cultures that encourage healthcare workers to come forward whenever they have had to create a workaround. If the problems leading to use of that workaround are not brought to the attention of others, those problems will ultimately impact care of other patients.

Some of our prior columns related to workarounds:

September 4, 2007 "Workarounds as a Safety Issue"
May 2008 "UK NPSA Alert on Heparin Flushes"
June 17, 2008 "Technology Workarounds Defeat Safety Intent"
September 15, 2009 "ETTO's: Efficiency-Thoroughness Trade-Offs"
August 24, 2010 "The BP Oil Spill - Analogies in Healthcare"
March 6, 2012 "Lab Error"
July 2, 2013 "Issues in Alarm Management"
April 8, 2014 "FMEA to Avoid Breastmilk Mixups"
October 7, 2014 "Our Take on Patient Safety Walk Rounds"
April 5, 2016 "Workarounds Overriding Safety" among other columns.

See our prior columns on huddles, briefings, and debriefings:

- April 9, 2007 "Make Your Surgical Timeouts More Useful"
- May 22, 2007 "More on TeamSTEPPS™"
- December 9, 2008 "Huddles in Healthcare"
- March 10, 2009 "Prolonged Surgical Duration and Time Awareness"
- January 11, 2011 "NPSA (UK) 'How to Guide': Five Steps to Safer Surgery"
- March 2009 "Surgical Team Training"
- April 2012 "Operating Room Briefings and Debriefings"
- July 31, 2012 "Surgical Case Duration and Miscommunications"
- January 2014 "A Tool to Assess Pre-op Briefings"
- July 22, 2014 "More on Operating Room Briefings and Debriefings"
- March 17, 2015"Distractions in the OR"

References:

ISMP (Institute for Safe Medication Practices). Reporting and second-order problem solving can turn short-term fixes into long-term remedies. ISMP Medication Safety Alert! Acute Care Edition. 2016; May 19, 2016
http://www.ismp.org/newsletters/acutecare/showarticle.aspx?id=1139

Healthcare Consulting
www.patientsafetysolutions.com

http://www.patientsafetysolutions.com/

Home

Tip of the Week Archive

What's New in the Patient Safety World Archive