NEW ZEALAND HEALTH & Hospital
January - February 2009

| Inside

Optimising the Patient Journey in Waitemata

Adept? You could secure a $50,000 award

And news from around the nation

management

Hospital incidents report highlights adverse events but why does this happen?

The Series and Sentinel Events list published recently by the Ministry of Health's Quality Improvement Committee, which reported 258 incidents, including 76 deaths, is alarming but it simply highlights the stressful environment of hospitals in this country.

This is the opinion of Werner Naef, a stress management specialist, who works with high-risk professions such as aviation, health, defence, occupational health and safety and high-speed rail in Europe, New Zealand and Australia. Mr Naef, who is a former international airline pilot and human factors training manager, says that while incidents inevitably do occur, it is not correct to just blame them on process or technology failure.

"Human Error is a major contributing factor for most of these incidents. They occur when individuals are under pressure or stress. In these situations, training sometimes goes out the window as a strange dominant logic takes over, and professional people who have a proven record of high quality performance start displaying really odd behaviours and their decision making becomes impaired," said Mr Naef.

"We have seen this in aviation many times, and often this has resulted in a major air accident. When the analysis of such accident is completed, it becomes clear that the very well-trained professional who has spent hours in the simulator going through the procedure was still not able to handle the stressful situation in real life. Why does this occur? It is the human factor which comes into play, involving a mix of personality, psychometric state of mind, other stresses which the individual may be carrying, and even experiences from his or her childhood which becomes evident."

Mr Naef said the lessons learned in aviation and other high risk professions also applied to the health sector and hospitals.

"Hospital operating theatres are a stressful environment. There are a number of reported incidents worldwide involving arguments, disruptive behaviours, even physical attack and stabbings which have occurred directly as a result of stress in this situation.

"Behind every one of these cases on the Series and Sentinel Events list, it is important to investigate what happened and what were the circumstances and events leading up to the incidents. I am sure many will related to human error in crisis situations as a result of stress and distress."

Mr Naef, who is based in Wellington, has been involved in stress management and human factors training for the past 30 years. He is a proponent of the process communication model (PCM), which was developed for NASA astronauts, and is now being introduced to various occupational fields in New Zealand and Australia.

"People management and managing their behaviours is becoming such a big aspect of the commercial world. More and more companies recognise the importance of understanding their staff, knowing what makes them tick, and using the right techniques to motivate them to get the best results for the organisation.

"Human factors knowledge and training used to be a desirable extra. Now it is a mainstream requirement in recruitment, promotion, safety and dealing with emergencies."

Werner Naef (pictured) is a former Swiss airline captain and airforce pilot/commander/colonel and an airline instructor, fleet and training manager, with 32 years' experience. He holds a postgraduate degree in psychotherapy (1981), was a board member of the European Association for Aviation Psychology (EAAP) and a Swiss CAA and European JAA human factors expert. He continues to be a EAAP registered aviation human factors specialist and a NZ CAA approved exam writer in human factors.

He has conducted research for the Daimler-Benz-Foundation and worked lecturing and consulting in Europe, before coming to New Zealand as a Human Factors Investigator with Air New Zealand.

Last year Mr Naef was the recipient of the 2008 EAAP Award. He is only the third ever winner of this award in the Association's 28-year history.

The health industry has recognised this and Mr Naef now works with a number of hospitals and medical groups in New Zealand, Australia and in Europe. This has given him an insight into the medical professionals, and the relationships they have with each other, and how they network into a team in the operating theatre.

"If the team is functioning well, with good communication, co-operation and motivation, and a focus on the task in hand, then the risk for incidents is greatly reduced. That happens in the majority of cases, as the 900,000 patients who were successfully treated and discharged across the country last year can attest. But the 258 cases of incident were all preventable as Mr Snedden, chair of both the Quality Improvement Committee and Auckland District Health Board, said, so that is where the focus must fall," Mr Naef said.

Russell Blakelock, Paediatric Surgeon at Christchurch Hospital and Senior Lecturer Surgery with the University of Otago, sees the benefits of the PCM approach both in the

workplace as well as in his personal life. "PCM has given me immense personal insight into by own and others behaviours, by giving me an understanding about what motivates us all. In stressful encounters or situations, PCM has enabled me to both be present in the encounter and also to have a 'helicopter view' of the situation. This helps to stop me from behaving in a maladaptive manner and to realise that other people's poor communication are mostly about them, their motivation and their psychological needs. PCM has enabled me to respond in such situations with clarity, without personal psychological baggage, and at times, to diffuse difficult situations. It has revolutionised the way I think about interpersonal communication, at home and in my work environment."

"PCM training is all about preparing people for stressful situations, and helping managers to identify stress in staff members at an early stage, decoding their behaviour, intervening with appropriate support, and helping people to make the U-turn back into positive behaviour," says Mr Naef.

See National reporting framework for serious and sentinel events 2007/08, page 37.

About the Process Communication Model

The Process Communication Model® (PCM) was developed in the early 1970s as the result of clinical research in US psychiatric hospitals. In 1977 Dr Taibi Kahler received the Eric Berne Memorial Award in recognition of his achievements and from 1978 the model was in use with NASA. Mission control needed to know how individuals might behave if they start to dysfunction under stress, and what they could do about it.

Key to PCM is a questionnaire that identifies the personality traits of an individual person. It is based on the premise that people's preferred way of communicating is predictable and based on personality. Under pressure people abandon learned behaviour and respond on the basis of personality.

The PCM model identifies the different behavioural patterns people show whether they are under slight pressure or under severe stress. It provides mechanisms for stress management. These include the ability to:

- Achieve listening skills to a mastery level.
- Have an effective (mass) communication model.
- Decode and understand other people's behaviour.
- Predict and identify the onset of behavioural failure patterns.
- Intervene constructively through communication and motivation.
- Detect and correct miscommunication before it contributes to the incident or accident.
- Find out why something has happened.
- Respond quickly to situations and defuse stress or amplify safety messages.
- Assist people to turn away from potential harm back into safe behaviour.

conferences

The 10th Annual Medical Law Conference

A vital update for medico-legal professionals

27 & 28 May 2009 Intercontinental Hotel, Wellington

The 10th Annual Medical Law Conference will examine the critical issues including:

- Health and Disability Commissioner Act Review
- ACC Review of treatment injury reforms
- Saviour Siblings – my sister's keeper?
- Consent, privacy, and treatment issues relating to children and young people
- Advanced directives and clinical discretion

The Inaugural Patient Safety Conference

Improving patient safety by effective clinical management

29 May 2009 Intercontinental Hotel, Wellington

The Inaugural Patient Safety Conference will bring expert presenters from patient safety and emergency medical practice to discuss such issues as:

- Examining the NZ Incident Management System
- Disclosure issues in adverse events
- Overcrowding in Emergency Departments and the impact on Patient Safety
- Examining our increasing reliance on high tech modalities of diagnosis/ assessment and its impact on the patient

Lean Healthcare Summit

Sustaining momentum and raising the bar further for improved service, patient safety and reduced costs

8th – 9th June 2009, Duxton Hotel, Wellington

International Keynotes:

Institute for Healthcare Improvement (USA)

Professor David Ben-Tovim, Flinders Medical Centre (Aus)

Local speakers include:

Dr Jonathan Coleman, Associate Minister for Health