

Lynne Cunningham's
Book Review

I just read a great book that I think should be added to your Service Excellence Library.

Book	<i>Why Hospitals Should Fly: the ultimate flight plan to patient safety and quality care</i>
Author	John J. Nance, JD
Pillar of Excellence	All - as safety touches everything we do
Donald M. Berwick, MD, MPP <i>President and CEO Institute for Healthcare Improvement (IHI)</i>	"This book is a <i>tour de force</i> , and no one but John Nance could have written it. He, alone, masters in one mind the fields of aviation, health care safety, medical malpractice law, organizational sociology, media communication, and, as if that were not enough, the art of fine writing. Only he could have made sophisticated, scientifically disciplined instruction about the nature and roots of safety into a page-turner. Medical care has a ton yet to learn from the decades of progress that have brought aviation to unprecedented levels of safety, and, in instructing us all about those lessons, John Nance is not just a bridge-builder – he <i>is</i> the bridge. This book should be required reading for anyone willing to face the facts about what it will take for health care to be as safe as it truly can be."
LC Review	An outstanding book. This is a must read for anyone concerned about healthcare safety with a desire to be part of the solution and support the creation of a Culture of Safety. Written as a healthcare fable, the book tells the story of a hospital that became the center of patient safety. Will's Notes at the end of each chapter are an excellent summary of the key learnings in the book.
Page	<i>Lynne suggests that you pay special attention to some of these features in the book.</i>
iii	More information at www.whyhospitalshouldfly.com
viii+	<p>What we have not done is create a "culture of safety," as has been done so impressively in other industries, such as commercial aviation, nuclear power and chemical manufacturing. These "high-reliability organizations" are intrinsically hazardous enterprises that have succeeded in becoming safe. The culture of healthcare is not only unsafe, it is incredibly dysfunctional. Though the culture of each health care organization is unique, they all suffer many of the same disabilities that have effectively stymied progress: An authoritarian structure that devalues many workers, lack of a sense of personal accountability, autonomous functioning and major barriers to effective community.</p> <p>What is a culture of safety? An underlying theme, a common denominator, is teamwork.</p> <p>We will not achieve safe health care until we value what everyone brings to the patient encounter and rededicate ourselves to a new way of "practicing" our professions.</p> <p>Why haven't health care leaders been up to the challenge? They haven't recognized that the problem is one of relationships, not of know-how or resources.</p>

3	Safety and quality depend on having unified teams of like-minded people willing to put all normal human and professional differences aside to achieve a common goal.
22	The three big error-producing tendencies of professionals are Perception, Assumption and botched Communication.
43	True teamwork depends on collegiality and mutual respect. And patient safety in turn depends, to an inordinate extent, on teamwork.
46	A leader whose control of his or her team is based on hierarchical snobbery and defensiveness can never achieve barrierless communications.
48 – 49	Collegiality is an order of magnitude above collaboration in terms of the ability to communicate, because it's based on mutual respect and understanding and caring, however rudimentary. Humans will always make mistakes regardless of their training, experience or determination. In other words, the universal constant is that human infallibility is impossible.
59	Three tiers of a safety system: perception, assumption and communication. Most medical errors and associated human mistakes arise from miscommunication, disastrous assumptions and misperceptions.
76	Institutionalize and standardize those procedures that we know work best, and reduce variables in practice and response when those variables do nothing to contribute to the quality of decision-making of physicians and nurses.
110	The basic rule in human communications expectation: If it can be misread, misunderstood, misinterpreted, misquantified, or just plain missed, it will be. This is a slightly more eloquent expression of Murphy's Law.
127+	A commander is omnipotent and infallible and must know his job and the jobs of everyone under his command. A commander needs no advice, just facts, and is always ready to bark orders at whomever needs the direction. A commander should be intolerant of failure, especially in himself. A leader, however, gauges himself or herself by how well that leader can extract, orchestrate and utilize all the human talent available to that leader.
132+	Step one – prevent. Step two – anticipate and deflect. Third step – see-saw principle. The Swiss Cheese Model, in which each of the defense methods standing against any systemic catastrophe are stylized as slices of Swiss cheese. Each defense method has holes and exceptions through which an error can pass, so individually, each defense slice is flawed. But if you put enough of the flawed slices together, the holes won't line up.
139	Best definition of leadership: A Leader measures himself or herself by how well that leader extracts orchestrates and utilizes all the human talent available to that leader. Definition of a Commander: One who knows all, sees all, needs no help, and is both omnipotent and infallible – which is, of course, impossible.

144	Checklists and the protocols for safety are not there to order or direct the fine art of a surgeon's abilities; they're there to minimize the chances every patient takes with a surgical procedure while leaving we surgeons free to concentrate on what we do best.	
175	The three tiers of Safety System are: <ol style="list-style-type: none"> 1. Minimize the occurrence of human error through training, system changes, and education as well as cultural change. 2. Despite #1, expect human mistakes and build your system to fully absorb every anticipatable mistake without patient impact. 3. Even with #1 and #2 complete, the third step is to thoroughly redirect the thinking of all team members so as to assign a 50/50 chance of serious error at any given time in a patient's care. 	
193+	We peg the cost of hiring and training one new nurse at about \$80,000.	
202+	They use a Patient Safety Coach to indoctrinate every newly admitted patient and family/friends, along with a well-produced video outlining the patient/family responsibilities and how to interface with the nursing and physician staff.	
Overall rating	Outstanding – buy it. It will be on my best books of the year.	
Publisher and Year Published	2008	Second River Healthcare Press
Price	\$25.00	
Recommended by	Sue Bond, Senior Consultant, Health Grades Studer Group Coach Susan Osborne reviewed this book at our August book club	

This book report is posted at www.studergroup.com. To read additional titles reviewed and recommended by Lynne Cunningham, visit Book Reviews under Tools and Knowledge at www.studergroup.com.