

“Safety Fatigue”: Symptoms, Causes, Solutions

John M. Kessler, B. S. Pharm., Pharm. D.

Founder and Chief Clinical Officer. Second Story Health, LLC. USA
 www.secondstoryhealth.com
 Address correspondence to jkessler@secondstoryhealth.com

I have had the pleasure of many visits to Brazil since 2001. During these visits, I have collaborated with ANVISA on training programs at the start of the Sentinel Hospital program. I have lectured on medication safety topics to students, practitioners, private companies, and healthcare administrators. I have worked closely with safety organizations such as ISMP- Brazil, a national leader in promoting safety awareness and safe practices. I have seen Brazil experience an awakening to the problems of safety in healthcare. Over these last 16 years, good things have happened because of the personal dedication of professionals, leaders, and organizations devoted to safety. There have been well-attended local, regional and national congresses on safety. In general, there is an appetite for learning how to be safer and how to make changes that improve quality.

Brazil is part of a larger global movement to improve healthcare safety. As one indicator of how the safety movement is growing, you can study the number of internet hits on this topic. A Google search of the English term “medication safety” returned only 46,100 hits from 1980-1999, compared to an astonishing 27,300,000 hits from the years 2000-2017; nearly a 600-fold increase. It does not take an expert to recognize that we are talking and publishing much more about safety. The volume of this information raises 2 important questions however, 1) how can anyone stay current with safety topics and 2) has the “talk” about safety overwhelmed our motivations and actions to improve safety?

As a practitioner, you already know about the priorities, resources, and “talk” devoted to improving safety. Safety, in its many forms, is a familiar part of the healthcare vocabulary and a significant

part of our healthcare conversation. Look around your organization. Safety alerts (also called safety messaging) seems to be everywhere. They can be found in hallway posters, bathroom signs, stickers, forms, newsletters, policies, procedures, handoffs, accreditation standards, repeat-backs, double-checks, timeouts, job titles, performance evaluation criteria, safety scores, culture surveys, safety congresses, training, continuing education, and endless meetings. Managers repeatedly tell practitioners to “be safe”, “be vigilant” and “be careful”.

All this is good – right? Without doubt, the safety agenda has a new visibility and higher priority than ever before. Now, more than 15 years into our safety journey, I believe the NEW challenge for leaders, managers and practitioners is to maintain or grow the positive gains – resisting the natural forces of a phenomenon that I call “safety fatigue”. Safety fatigue is a negative force that diminishes the value and effectiveness of your programs. It can jeopardize or even reverse progress. It can create new problems with motivation. How do you know if safety fatigue exists in your organization? Let’s start with a 4 symptom checklist that could help diagnose a more serious underlying problem.

1. The curiosity is gone.

Leaders fail to ask and practitioners fail to tell the real stories about safety, “good catches”, and “close calls”. Managers are reluctant to ask questions and pursue details of the error. The cause of the error is too readily explained by human mistake, without consideration of the systems that contributed to the problem. The instinct to want to learn more about the error disappears.

2. Safety project teams and committees lack focus, meetings are cancelled, and attendance drops.

Key members fail to attend, completion times are extended or unmet, and the group goes through the motions of its work – without purpose, inspiration or sense of goal. Minutes, if even recorded, are one paragraph in length. Action plans are reduced to “we will meet again in 1 month”. The same small group of practitioners and managers are members on all the safety teams. Multiple safety teams are formed, yet their work is not coordinated and no single team is responsible for improved outcomes.

3. Safety reporting and analysis efforts stagnate or decrease.

The same charts and adverse event statistics could be used every month – only replacing the title and dates to keep the report current. No one asks why the same 5 drugs and the same 5 types of error appear on the summary report for 24 consecutive months. The “near miss” or “good catch” reporting system, in the planning stages for 2 years, is never launched. Organizational attention shifts to other problems while failing to promote and effectively use data from safety surveillance programs. Safety surveillance champions have a “crisis of confidence” in themselves, their systems and data – reluctantly yielding to conclusions based on anecdotes and bias. The safety surveillance system fails to document the organization’s actions and recovery steps following errors or adverse events. In brief, organizational learning has slowed or stopped.

4. Problems outweigh accomplishments

When you can name the top 3 medication related problems, yet you cannot name the 3 most important safety improvement accomplishments – you might be experiencing safety fatigue. For years, the traditional model of measuring safety has been to count adverse events and errors. Despite the well known problems in measuring and interpreting adverse event rates and error rates, it remains surprising that organizations continue to depend on these

metrics to demonstrate safety. Organizations need to use better metrics, so that they can answer the important questions, “Are we safer today than we were last year?” and “How can we be sure?”

What are the possible causes of “safety fatigue”?

Safety fatigue is not a term that you will find in a Google or literature search. Nonetheless, I have seen this fatigue in organizations that use their limited resources and give endless attention to running perpetual safety campaigns, chasing accreditation standards, and deploying the latest highly promoted and often expensive technology. Safety leaders and managers drown in the numbers and detail of each individual report, failing to spend their valuable time looking at the bigger picture. Perhaps the most important cause of safety fatigue is an extraordinary focus on the problems, with a failure to focus on innovation and learning. The “noise” of safety (problems/error/messaging) becomes desensitizing. Front line practitioners retreat to simply providing care and managers retreat to managing budgets and people.

What are the possible solutions?

In this brief article, I will propose 4 possible solutions to avoid or recover from safety fatigue.

1. Rethink the need for and effectiveness of constant safety messaging such as posters, stickers, warning notes, interaction/compatibility charts, and similar passive background tools. These messaging tools might appear to solve a problem but are well known to lose their impact value within days – becoming “invisible”, outdated and potentially dangerous, while also breeding complacency. By any measure, constant safety messages become a form of “alert fatigue” and we know the harms from this type of problem.

2. Use appreciative inquiry techniques instead of only solving a problem: The antidote against fixating on problems (and solving them – something that males especially value) is to sharpen the focus on identifying and learning from the many thin-

gs that work well in patient safety. The method of using “appreciative inquiry” establishes a goal for patient safety, based on the stories, past successes, and strengths already present in the organization. Regardless of your practice site, when leaders ask frontline practitioners about how safety is created, at least 2 good outcomes are likely. 1) Practitioners are reminded and energized by their successes in creating safety, and 2) These successes are more likely to spread to other areas in the organization. Experiment at your next meeting or when reviewing the next adverse event/error summary. Give the necessary attention to the rare serious harmful error, yet also take time to discuss the successes and carefully study the reasons why, for example, some locations have high error reporting rates with low harm rates. It’s also a good time to discuss the acceptability of the recovery actions that have been taken. Then, take these lessons to other places in your organization.

3. Launch or re-energize your near-miss reporting system: By whatever name, a near-miss (good catch, close-call, intervention) reporting system helps an organization learn valuable lessons not found in the typical adverse event or error reporting systems. Unfortunately, the use of near-miss reporting systems lags behind traditional adverse event and error reporting systems. Among its many benefits, near-miss reporting systems help to identify the strengths in your safety processes and provide a rich source of success stories to tell practitioners, managers, and others. Success stories are easy and low-cost antidotes to safety fatigue.

4. Develop a recovery database: Recovery databases track your organization’s behaviors and response to each safety event. An effective recovery database will describe your corrective actions by type and category. As an example, types of corrective actions include “software change”, “education”, “vendor change”, and “process changes”. Categories of the type of action are further described as either “systems-based” vs “non-systems-based”. Analyzing your recovery database can provide insight to the organization’s culture and the innovation and scope of its safety responses. When corrective ac-

tions become “repetitive” or when the imagination and enthusiasm for making improvements becomes sluggish, a fresh look at your underlying behavior may be needed to overcome the safety fatigue that has set in.

Conclusions

Admittedly, safety fatigue is a term not found in the peer-reviewed literature. My attempts to explain what I see are sincere and well-intentioned. The proposed causes and solutions are based on observation and empiricism. There are no villains in this story. Rather, my story is a cautionary tale about the natural forces that work against the gains you have made in safety. Failing to recognize, imagine and prevent the adverse effects of safety fatigue is perhaps a larger problem than being satisfied with the status quo.