Comportment Management in the Hospital: Where Is Patient’s Health Care Station?

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Abstract
This article analyzes the factors that explain the increased use of special reports by hospital facility auditors, such as the structured interview, wondering if they look like evaluation studies. It examines their training, impact, and the institutional use implicit in the performance audit. From an anthropological perspective, the audit could traditionally be considered as “Rituals of Verification,” recognizing the procedure and the evaluation of social effects, in public management. Therefore, sampling represents an effective and efficient tool for carrying out the statutory audit activity in the health care facilities where the coronavirus disease (COVID-19) virus is treated. However, the performance established a regulatory dimension compared to the concept of verification. In addition, auditing practices may often seem “trivial, inevitable part of a bureaucratic process,” but taken together and over time, they are probably part of a distinct cultural artifact. As we have seen, the reasons that justify the activation of a clinical audit can be numerous: patient complaints, occurrence of adverse events such as the case of COVID-19, performance with inadequate results, publication of new guidelines; however, the “bet” is that in the future the awareness that auditing is an irreplaceable part of professional practice will mature among professionals.

Keywords
accountability methodology, clinical audit, clinical risk management COVID-19, clinical organization setting, performance audit and structured interview

Research Model: The Structured Interview
The interview is the tool to collect facts, opinions, and ideas in an objective and sufficiently complete way (1,2). It constitutes, if well engaged, a useful means of interpreting complex and unstructured information and has therefore become of greater importance in the absence of precise formal references (3). The system for conducting the interview, from preparation to conducting the same, significantly affects the final result of the audit activity.

In the preparation phase of the interview, we decided to question:

O: Administrative director and organizer ASL of Sassari.
A: Assistant.

Later in the planning phase, it was decided to structure the interview as follows:

Clinical risk management.
Human resource requirement.

At the beginning, it was decided to make the interview on several points and to articulate it 1 day with a maximum duration of 1 hour.

The interview was conducted by the interviewer who followed the previously agreed questions on the days indicated in respect of the maximum duration.

The closure of the interview took place in accordance with the times and after having examined the issues of greatest interest.

Finally, the interview documentation consists in the memorandum.

In the realization of the interview, we decided to use a quantitative method to capture the most important passages that could give a sufficiently structured and excellent overall view of the topic (Table 1). See the following analysis which reduces the risk of dispersion of the effectiveness of the treated matters (Figure 1).

| O: Administrative director and organizer ASL of Sassari. |
| A: Assistant. |

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Table 1. Quantitative Analysis of the Interview.

| Questions part | Interview | % carryover interview | t test |
|----------------|-----------|-----------------------|--------|
| 1              | A: To begin with, how do you discuss the concept of company corporate risk in a hospital that is part of the national health system? O: The health system is a complex system for several variables, like other systems such as nuclear power plants, aviation, and national defense. Since in any complex organization the error and the possibility of an accident cannot be eliminated, all possible interventions must be used in order to be, at least, controllable. The business risk is proportional to the complexity of the systems themselves and numerous variables are involved: this concept can also be extended to health systems which paradoxically would have a low risk if they provided health care to healthy patients. Numerous tools and standards are shared and adapted to decrease this intrinsic risk. On the other hand, there is a part of risk which we could define as pure risk, which depends on lesser known variables, on occasional circumstances, on the chain of situations that favor the occurrence of an adverse event. And on the latter aspect, whose borders cannot always be delimited by business risk, in recent decades risk management policies have been built to reduce avoidable errors. Starting from the consideration that error is an inevitable component of human reality, it becomes fundamental to recognize that the system can also make mistakes by creating the surroundings for the occurrence of an error, which remain latent until an operator error makes them manifest. If human error cannot be completely eliminated, it is essential to favor ideal working conditions and implement a system of actions that makes it difficult for man to make mistakes, and secondly, to implement defenses that can stem the consequences of an error that occurred. | 3 min (5%) | 2.2*** |
| 2              | A: In this reality what do you mean by clinical risk? O: Clinical risk is the probability that a patient is the victim of an adverse event, that is, suffers any damage or discomfort attributable, even if involuntarily, to the medical care provided during the period of hospitalization, which causes an extension of the period of hospitalization, a worsening of health conditions or death. Clinical risk can be curbed through Risk Management initiatives implemented at the level of the individual healthcare structure, at company, regional, and national level. These initiatives must include work strategies that include the participation of numerous health professionals. An effective Risk Management activity develops in several phases: knowledge and analysis of the error, identification and correction of the causes of error, process analysis, monitoring of the measures put in place for the prevention of the error, implementation, and active support of the proposed solutions. | 1 min (2%) | – 1.8 |
| 3              | A: What are the types of human error found in hospital practice? O: As part of the theories that have developed for the study of error in medicine, that of human error proposes a classification of human behavior in three different types: a. Skill-based behavior: They are automatic behaviors to a given situation. It offers the individual a stimulus to which he reacts mechanically without posing problems of interpretation of the situation itself. This ability develops after the stimulus has repeated itself several times, always in the same way. It is a type of behavior found in routine situations. b. Rules-based behavior: Behaviors are implemented, prescribed by rules, which have been defined as they are considered more suitable to be applied in a particular circumstance. The problem that arises for the individual is to identify the right norm for each specific situation by following a random mental model. c. Knowledge-based behavior: These are behaviors implemented when one is faced with an unknown situation and a plan must be implemented to overcome it. It is the situation that requires the greatest use of knowledge and the activation of a series of mental processes that from symbols will lead to the elaboration of a plan to achieve the objectives. | 2 min (3%) | 2.5* |
| 4              | A: Is Rasmussen’s model correct in identifying errors in medical practice? And you found him in your position? O: Yes, based on the model proposed by Rasmussen (1987), James Reason distinguishes between execution errors and between actions carried out according to the intentions and thus outlines three different types of error: a. Execution errors that occur at the level of skill (slips). In this category are classified all those actions that are performed differently than as planned, that is, the subject knows how he should perform a task, but does not do it, or inadvertently performs it incorrectly. b. Execution errors caused by a memory failure (lapses). In this case, the action has a different result than expected due to a memory failure. Unlike slips, lapses are not directly observable. c. Mistakes not made during the practical execution of the action (mistakes). These are previous errors that develop during the strategy planning processes: The goal is not achieved because the tactics and the means implemented to achieve it do not allow it. | 1 min (5%) | 2.0*** |

(continued)
A: The concept of human error has also been re-examined in recent decades by psychologists and engineers. Accident prevention focuses only on the skill and training of human operators and how can the entire system design be involved?

O: As a consequence of the need to observe human errors from a new point of view, Reason (1990) distinguished active errors, which cause immediate consequences, from latent errors, that is, all the mistakes that remain “silent” in the system as long as a triggering event will not make it manifest in all its potential, causing more or less serious damage. In this case, the human operator is the closest cause to the accidental event, but the so-called root cause is attributable to managerial decisions and wrong organizational choices. To date, most of the efforts made to reduce errors have focused on identifying active errors, ie, material errors made by medical and nursing staff. Lately it has become clear that errors of organizational origin, the so-called latent errors, also play an important role. Not all latent errors produce an active error, nor do all errors cause harm. In fact, for the damage to occur, conditions must exist that allow the error to overcome all the technical and organizational safety barriers set up within the structure to contain the effects of possible errors.

A: How is patient safety related to the complexity of the hospital organization?

O: Patient safety therefore derives from the ability to design and manage organizations capable of both reducing the probability of errors occurring (prevention) and of recovering and containing the effects of errors that occur in any case (protection). The available methodology makes use of two reactive and one proactive analyzes. The reactive analysis involves an a posteriori study of the accidents and is aimed at identifying the causes that allowed their occurrence. The analysis of an accident must therefore be carried out backward with respect to the temporal sequence that generated it in order to have a reconstruction which, from active errors, identifies the risk factors in the workplace and whose final result is aimed at knowing the deep, organizational causes that generated it. The proactive analysis, on the other hand, aims at identifying and eliminating the critical issues of the system before the accident occurs and is based on the analysis of the processes that make up the activity, identifies the critical points with the aim of designing systems sure.(5,6)

A: Incident reporting systems are essential for gathering information on which to base analyses and recommendations, can you give an example?

O: Incident reporting is the voluntary collection of anomalous records for reporting adverse events. Through the error reporting forms and possible errors, it is possible to collect a series of fundamental information to trace the path that allowed the occurrence of the adverse event. The information that is required for each event concerns: the place of occurrence, the people involved, who identified the event, the type of services provided at the time of the error, the severity of the event. In this regard, pending national univocal criteria to define the severity levels of an event, the following method of graduation of the event is highlighted: serious an event that causes death or damage and permanent disability to the interested party; medium an event that entails a temporary disability, a conspicuous increase in the days of hospitalization; a mild event that instead causes the patient only temporary and limited disturbances.

We also collect information on the perception of the causes of the possible error by those who report it: randomness or error, factors involved distinct between human, organizational, technological, and infrastructural.

In order to have a global evaluation of the phenomenon, it is necessary to define standard reporting systems, with standard definitions of what must be reported.

A: What does the empirical evidence of data collection suggest?

O: Unfortunately, not always, the start of the collection of reports, even in some Italian hospitals, has given good results, especially because among the operators there is still high diffidence, the fear of blame, and punishment for those who report an error. This is certainly due to a lack of knowledge of the problem and also to the lack, in our legislation, of a reduction of penalties system aimed at those who report an adverse event. In other countries, progress has been made on this burning issue. Recent is the bill, introduced in the Senate on March 26, 2003, in the United States of America, which aims to improve patient safety by reducing adverse events in medicine, by:

a. The adoption of a system for the collection of adverse event reports by operators;

b. The adoption of patient safety organizations, which must collect and analyze data and propose solutions for improvement;

c. Legal protection for those who report an adverse event;

d. The adoption of a national database, based on the nonidentification of shared information, which allows continuous additions and provides recommendations on patient safety and the quality of care services.
Table 1. (continued)

| Questions part | Interview | % carryover interview | t test |
|----------------|-----------|-----------------------|-------|
| 9 A: Can you give us an internationally recognized example of hospital quality procedures? | O: The use of administrative databases for quality assessment is possible, provided that the limitations inherent in the quality of the data and the critical issues connected with the extraction and synthesis of information and interpretation of results are known. Among the advantages in the use of administrative databases we can highlight: the immediate accessibility, negligible additional cost to recover the information of interest, the exhaustiveness of the content, the ease in identifying the populations of interest. The immediate accessibility negligible additional cost to recover the information of interest, the exhaustiveness of the content, the ease in identifying the populations of interest. The critical issues are represented by coding problems and by the lack of temporal information, which allow to distinguish complications such as pathologies or events. Both of these critical points could be easily overcome. For several years in the United States, the Agency for Healthcare Research and Quality has commissioned the development of a system of quality indicators of care and, among these, indicators of complications of hospitalization. The Agency provides three categories of quality indicators: a. Prevention indicators relating to conditions for which outpatient care is envisaged, including avoidable hospitalization; b. Indicators for hospitalized patients including inter-hospital mortality, procedures with reports of over- and underuse; c. Indicators related to surgical complications or iatrogenic events. | 2 min (3%) | 2.5*** |

10 A: Having identified the error, which hospital scenario analysis is most effective? | O: Root causes analysis (RCA) are analyses that, starting from the errors found in a system, search for the causes through an inductive method that proceeds in depth through questions that explore the reason for each action and every possible deviation. The identified causes are organized into categories, for example, through cause-effect diagrams that graphically show the existing interactions. The RCA focus first on the system and processes and then on personal performance. It is important to underline how every human error is always associated with causes that arise from workplace problems and/or deficiencies in the organization of the system. The analysis of the causes must determine the human factors directly associated with the incident, the sentinel event or adverse events, latent factors associated with them and identify the changes necessary to avoid the recurrence of the event. For RCA, it is essential that the intervention is focused on the cause rather than the problem. Acting on the problem or "symptom," and not on the cause, is probably ineffective. | 1 min (2%) | 2.3*** |

*p < 0.10, **p < 0.05, ***p < 0.01.

Figure 1. Approval of the interview.
Conclusion

The success of the clinical audit depends on an accurate and technically rigorous design, on the involvement of all interested parties, including strategic direction and on an adequate and widespread dissemination of the results and improvement actions identified, in order to promote professional growth and the transfer of national and international experiences (7).

The use of the sampling method must also be considered in other areas, such as in verifying the veracity of company data required in the report that certifies “the truthfulness of the company data and the feasibility of the emergency plan (8).

Authors’ Note

Full paper interview and data analysis. The interview was carried out with the consent of the University of Cagliari and Sassari. Supervisor Professor Andrea Melis.

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Author Biography

Stefano de Nichilo is graduated in Business Economics from the University of Rome “La Sapienza”. He earned his PhD in 2019 from University of Cagliari and today he teach as lectures. In the position that he is currently holding, he deals with both private individuals and small businesses independently, solving management accounting problems. His studies are management accounting and European affairs, for the latter specialization he obtained a Master of Philosophy at the University of Roma Tre.