The role of management in providing safe eye care delivery

In order to deliver high quality, safe eye care to patients and ensure a positive, care-giving attitude among staff members, it is vital that leaders and managers recognise and prioritise patient and staff safety.

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The role of management in ensuring the safety of patients is critical, but it is often overlooked in safety programmes for eye care providers. Health care leadership and management are responsible for creating an environment that protects patients and staff members from avoidable harm and reduces errors in clinical settings.

An organisation that addresses safety (and any errors that may occur) in an open and transparent way demonstrates to staff members and the public that it values their wellbeing.[4] This encourages staff members to prioritise a culture of safety, knowing they have the support of their managers. It also makes the organisation more efficient and the care process more effective. With this in mind, Aravind Eye Hospitals has developed a systematic approach to providing safer eye care delivery by adopting the following principles.

How safe is eye care?

It may be tempting to think of eye care as relatively safe, compared to other medical specialties. However, a recent study of medical errors (adverse events) in US Veterans Health Administration (VHA) medical centres from 2010–2017 showed that the highest number of reported errors or adverse events occurred in ophthalmology (72) followed by dentistry (30) and anaesthesiology (28).[1] Reducing eye care related adverse events is a challenge. In many settings, patient volumes and time pressures are high. The most common eye procedure – cataract surgery – involves many steps, with many opportunities for error: starting with documenting several measurements using multiple equipment (during biometry), then sourcing a non-expired intraocular lens of the correct power, followed by carrying out safe surgery on the correct patient, in the correct eye.[2,3]

Defining safety goals. Safety goals must be defined at an organisational level and adapted to suit individual departments or settings. Initially, Aravind adopted the 2009 Joint commission (USA) hospital patient safety goals,[5] which staff members struggled to relate to their eye care work. Realising this, and based on the incidents that were reported, the authors adapted the Joint Commission (USA) objectives and developed patient safety goals (Figure 1) and department safety goals (Figure 2) specific to eye care.

Figure 1 Eye care safety goals: organisation level

Patient safety goals – Aravind Eye Care system (2021)	
Goal 1	Ensure that the correct patient is receiving the correct procedure in the correct eye
Goal 2	Ensure the correct implant power and correct implant design (for intraocular lenses) is being used
Goal 3	Prevent morbidity and mortality due to systemic conditions
Goal 4	Prevent postoperative & hospital-acquired infections
Goal 5	Eliminate sight-threatening complications
Goal 6	Eliminate medical or diagnostic errors
Goal 7	Ensure the patient receives the correct medication
Goal 8	Ensure the patient receives the correct spectacles
Goal 9	Ensure the physical safety of patients and staff members
Goal 10	Ensure that patients who are at risk of losing vision without intervention receive treatment & follow-up care

Creating systems that enhance patient safety is crucial as errors often happen due to failures in the system. The causes go beyond the individuals who may have made mistakes. Good safety systems ensure standardisation of procedures, specific steps to ensure safety protocols, appropriate delegation of work to the right personnel, and checklists at critical points in the patient's journey.

Standardising and improving work processes progressively reduces risk. Senior clinical staff and managers are responsible for creating standard operating procedures (SOPs) and risk assessments for routine clinical activities and administrative tasks (e.g., booking follow-up appointments). Managers must also ensure that every member of staff is trained in these SOPs and competent to deliver them. SOPs and risk assessments should be made easily accessible to staff members in the form of posters or quick reference guides which are regularly reviewed and updated.

Figure 2 Department-specific safety goals focusing on patient safety. E.g., *Counselling for cataract surgery*

Patient safety goals: Department for cataract surgery (2021)	
Goal 1	Ensure that the patient is correct
Goal 2	Ensure that the eye is correct
Goal 3	Ensure that the biometry measurements are correct
Goal 4	Ensure that the IOL design is correct
Goal 5	Ensure that the IOL power is correct
Goal 6	Ensure that the IOL needed is available
Goal 7	Ensure that pre-operative investigations are complete
Goal 8	Ensure that a physician has checked that patients with systemic conditions are healthy enough to undergo surgery
Goal 9	Obtain consent from the patient or those attending with the patient
Goal 10	Ensure that the correct documentation is available and completed and avoid transcription errors

Choosing suitable equipment and ensuring all staff members are trained appropriately. Routine eye care involves the use of both basic and highly technical instruments and equipment. All staff members who use these should be appropriately trained beforehand, certified, and have access to supporting documentation (SOPs, user manuals, and risk assessments).

Building an organisational structure and process for safety. It is important to develop this structure, at both leadership and operational level. For example, staff members from different job levels can be appointed as 'safety champions' to model safe practices and behaviour. Another approach is to invite staff members and managers to share ideas and experiences to improve processes and share lessons learned in a supportive and positive way.

A culture of reporting errors and near misses is a core element of good clinical practice. Early reporting of errors improves staff and patient safety and makes it possible to investigate and address the root causes of the error.[6] Ideally, a reporting system should make it possible for staff members to report incidents anonymously. This allows others to learn from the situation without fear and enhances the commitment of staff members towards safer care.[7] Create a simple form to record essential details such as time and place, people involved, description of the error, and the possible circumstances that led to the error.

Supporting staff wellbeing. As a service sector, it is vital that leaders and managers recognise the importance of ensuring the wellbeing of staff members. Fatigue, inadequate training, and a stressful work environment can contribute to human errors and affect compliance with SOPs and risk assessments.

One of the factors that contribute to employee stress is unfair treatment or harassment. Managers must establish a culture of respect and dignity in the workplace by demonstrating a respectful attitude to all and getting to knows staff members well.

Ongoing education programmes for staff members and managers that focus on safety are essential, as are **constant monitoring and review** of incidents, safety protocols, and SOPs, so that lessons can be learned in a supportive environment.

Conclusion

Managers and leaders must demonstrate their commitment to safety in everything they do. Safety is not a destination, but a continuous process.

Developing a sustained safety programme is challenging; it must start with the commitment of managers and leaders. Leaders who are passionate about safety should establish the process for achieving the safety outcomes in both clinical and non-clinical areas, build local leadership to take ownership at operational level, foster a safety culture, prioritise safety through proper communication with their teams, and provide appropriate resources to build practices that enhance safety.

Incident reporting system

Aravind originally used a paper-based reporting system, with low reporting rates. A computer-based, online reporting system was set up 8 years ago, and since then more than 16,500 events have been reported. The authors believe this system to be more successful because it is now easier for anyone to report a safety-related incident or near miss anonymously.

The value of any reporting system lies in how useful it is in helping to avoid future incidents. Each incident reported using this system is therefore brought to the attention of the chief medical officer and quality manager instantly, via an automatic e-mail. These senior staff members, who are empowered to address the root causes of safety incidents, can also use the system to carry out detailed analyses and generate actionable reports.

References

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