Annual Educators Conference 2016

Workshop Interprofessional Education and Patient Safety

Ground rules for Interprofessional Learning and Working

- Equity all contributions are valued
- Respect differences
- Confidentiality
- Language avoid or explain jargon
- Check understanding



Context: Concerns for quality of care in todays NHS



Case Example: http://www.bbc.co.uk/news/uk-england-stoke-staffordshire-11218638



Activity 2

Why has patient safety developed a greater profile in the last few years?



The Blame culture

'Challenging the fallacy of a quick fix' ... intense concerns for safety places pressure in our systems to fix the problem quickly by:

- Reprimanding the people involved
- Retraining the people involved
- Writing a procedure
- Adding just a little more technology



FALSE!- Why?

- Reprimanding = stops learning; cannot learn and punish
- Retraining = How do you know the people you retrain are the ones you need to retrain. The performance of those involved may be symptomatic of deeper problems
- Writing procedures = fixes the latest hole and assumes a linear trajectory towards the error. Additional procedures creates less transparency and more noncompliance
- More technology = creates new work, new error opportunities, new pathways to breakdown



Activity 3

Select one of the real stories

What do you think went wrong here?

Feedback

- what are the key factors that led to the patient safety failures in the case study and how are they linked?
- How might you address these?



New thinking

- Sir Robert Francis spoke of changing 'culture' in the NHS
- Dekker talks about a 'just culture' being incredibly difficult. He states

"Atmosphere, willingness and a commitment to learn and improve can quickly become compromised by the calls for accountability"



New thinking

• WHO: Patient Safety Guide 2011

http://www.who.int/patientsafety/education/curriculum/en/

- GMC (UK) 2015: Aspirations for patient safety teaching
 - Human factors; team working; safe handovers; improvement science; learning from error and near misses; measurement audit



Summary: IPE and patient safety

Estimation of 98,000 people die each year because of medical errors, mostly attributed to poor systems design of teams, lack of teamwork, distrust amongst healthcare professionals leading to poor communication between professionals and between professionals and patients.

Johnson A, Pothoff S, Carranza L, Swenson H, Platt C and Rathbun J (2006) "Clarion: A novel Approach to Healthcare Education". *Academic Medicine* 81 (3): 252-256.



How can interprofessional education help? What initiatives are you designing?

Discuss and share ideas



Long way to go.....

Messages:

- Regular team-based training
- Develop a mind-set for all employees of the relevance of patient safety
 - Challenges for IPE: Including everyone for example- health and social care professionals porters, administrators, managers etc



Recommended Reads

- Dekker, S. (2014). The Field Guide to Understanding 'Human Error'. Ashgate: Farnham.
- Gordon, S., Mendenhall, P. O'Connor, BB. (2013) Beyond the Checklist: What Else Health Care Can Learn from Aviation Teamwork Safety. Cornell University Press: London.
- Pronovost, P., Vohr, E. (2010). Safe Patients Smart Hospitals. Hudson Street Press: London.



References IPE and patient safety

Anderson, ES., Thorpe, LN., Heney, D. & Petersen, S. (2009). Medical Students benefit from learning about patient safety in an interprofessional team. *Medical Education*, *4*, 542-552.

Cook et al (2011). Technology-enhanced simulation for health professions education: A systematic review and meta-analysis. *Journal of American Medical Association,* 306, 987-988.

Kenaszchuk, C., MacMillan, K., Van Soeren. M. Reeves, S. (2011). Interprofessional simulated learning: Short-term associations between simulation and interprofessional collaboration. *BioMed Central Medicine*, *9*, *29*. doi: 10.1186/1741-7015-9-29

Zhang, C., Thompson, S & Miller, C. (2011). A review of simulationbased interprofessional education. *Clinical simulation in Nursing*, *7*, *e117-e126*