Annual Educators Conference 2016

Workshop
Interprofessional Education and Patient Safety

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Ground rules for Interprofessional Learning and Working

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

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Context: Concerns for quality of care in today's NHS

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

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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 non-compliance

- **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?
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

  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

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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.

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

References IPE and patient safety


