Delivering Safe Care today, and Safer Care tomorrow.

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Workshop Overview

- Key Concepts and Headlines in Patient Safety – Presentation
- Group Discussion – your patient safety practice
- Training in Patient Safety – Potential activities
- Group Discussion – Training in Patient Safety
- Assessing Patient Safety practice
- Group Discussion – Assessments
- Summary of Key Messages
Key Concepts in Patient Safety

Harm

Risk

Systems

Human Factors

Errors and Failures

Reporting and Learning

Safety Culture

Improvement

Measuring Safety
Harm - unintended physical injury resulting from or contributed to by medical care (including the absence of indicated medical treatment), that requires additional monitoring, treatment or hospitalization, or that results in death

Physical and psychological harm.

- 2-25% of healthcare episodes result in Physical harm – case record review
- Around 50% if omitted treatments
- How do we identify psychological harm?

Known side effect or complications of care – predictable and monitored
Preventable – 50%

Looking backwards
Risk - the chance that any activity or action could cause harm

- Frequency vs Severity
- High or low risk
- Risk Tolerance
- Mitigation

A common part of clinical practice

Looking forwards
Human Factors

“Human Factors (also called ergonomics) is a discipline that considers both the physical and mental characteristics of people as well as the organisational factors or wider socio-technical system.

It is the application of scientific methods to the design and evaluation of tasks, jobs, equipment, environments and systems to make them more compatible with the needs, capabilities and limitations of people.”

Clinical Human Factors Group

- Team working (resource management)
- User interfaces
- Cognition
- Mental models
- Heuristics
- Functions
- Situational awareness
- Cognitive Biases
- Resilience
Errors and failures

**Latent factors**
- Organisational processes — workload, handwritten prescriptions
- Management decisions — staffing levels, culture of lack of support for interns

**Error-producing factors**
- Environmental — busy ward, interruptions
- Team — lack of supervision
- Individual — limited knowledge
- Task — repetitious, poor medication chart design
- Patient — complex, communication difficulties

**Active failures**
- Error — slip, lapse
- Violation

**Defences**
- Inadequate — AMH confusing
- Missing — no pharmacist

**Error** — not doing the expected task

**Failure** — error results in harm
Safety Culture

- Risk aware
- Open
- Learning
- Flat hierarchy

Safer Care
Reporting and Learning

NHS Organisation/System
Department
Team

STEP% FISHBONE DIAGRAM%

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Improvement

- Processes
- Behaviours
- Defences
Measuring and monitoring Safety

- Past harm: Has patient care been safe in the past?
- Reliability: Are our clinical systems and processes reliable?
- Safety measurement and monitoring
- Integration and learning: Are we responding and improving?
- Anticipation and preparedness: Will care be safe in the future?
- Sensitivity to operations: Is care safe today?
NHS Patient Safety Strategy

The three pillars of the strategy in simple terms:

• Gaining an **INSIGHT** into the metrics of safety

• Ensuring the **INVOLVEMENT** of patients and healthcare workers

• Seeing **IMPROVEMENT** through the successful delivery of specific healthcare programmes

**Culture of learning and openness – just culture**
INSIGHT

Refreshing the **tools** and **metrics** of patient safety:

- PS Incident Management System (PSIMS) to replace NRLS
- PS Incident Response Framework (PSIRF) to replace SIF
- HSIB
- Medical Examiner System to implement by April 2021
- GIRFT
IN Volvement

Acquiring the skills to improve patient safety

• Patient Safety Partners
• Patients as Partners
• Patient Safety Training
• Patient Safety Specialists
The development and support of patient safety programmes will focus on 4 national priorities:
• Deterioration and Sepsis
• Medicines Safety
• Adoption and Spread of tested Interventions
• Maternal and Neonatal Safety
General Professional Capability – GMC Domain 6

Participate in and promote activity to improve the quality and safety of patient care and outcomes.

- **raise safety concerns** appropriately through clinical governance systems*
- understand the **importance of raising and acting on concerns and sharing good practice**
- demonstrate and apply basic **Human Factors principles and practice** at individual, team, organisational and system levels (non technical skills, crisis resource management, fixation error, unconscious and cognitive biases)
- reflect on their **personal behaviour and practice**
- demonstrate effective multidisciplinary and **interprofessional team working**
- promote and participate in **interprofessional learning, making changes to their practice** in response to learning opportunities
- promote **patient involvement in safety** and quality improvement reviews
- understand **risk, including risk identification (clinical and system), management or mitigation**
- effectively **pre-brief, debrief and learn from their own performance and that of others**
- be able to keep **accurate, structured** and where appropriate **standardised records. † *\)
Group Discussion 1

How do you demonstrate patients safety in your daily practice?
- Systems and processes around high risk areas
- Sensitivity to operations – how safe are we today?
- Reporting and learning
- Safety Culture

- Feedback 3 key points.
Training in patient safety.

High risk practice
- Prescribing
- Procedures
- Monitoring

Human Factors
- Simulation
- Reading and discussions
- Situational awareness

Culture
- Risk awareness in practice
- Role modelling
- Flattened hierarchy
- Systems thinking

Communication
- SBAR
- Team
- Openness
- Patients and families – including risk and shared decision making
- Briefing and debriefing
- Documentation
- Transitions in care

Reporting and learning
- Understanding the problem and changing processes and practice
- Lessons learned
- Case review
Group Discussion 2

What training in patient safety are you involved in?

What areas would you like to develop?

What areas are less commonly delivered in programmes/practice?

- Feedback 3 key points.
Assessments in patient safety practice

- Reflective reports
- Supervisors reports
- Directly Observed Non Clinical Skills
- Case Based Discussions
- ARCPs
- Clinical Exams
- Other
Group Discussion 3

How do you assess a trainee’s capabilities on Patient Safety?

What areas would you like to develop?

What areas of assessment need development?

- Feedback 3 key points.
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Key Points