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Setting higher standards

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

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Key Concepts in Patient Safety

Harm

Risk

Systems

Human Factors

Errors and Failures

Reporting and Learning

Safety Culture

Measuring Safety

Improvement

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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

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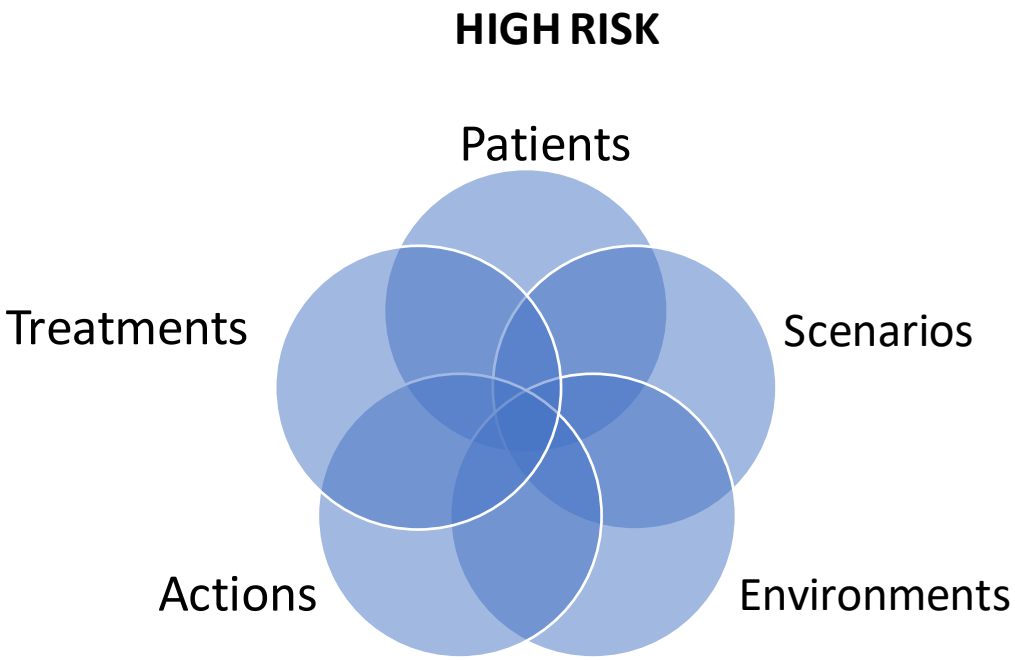
Risk - the chance that any activity or action could cause harm

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

A common part of clinical practice

Looking forwards



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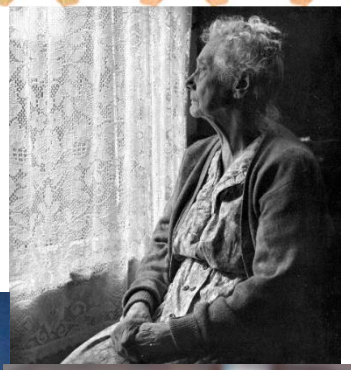
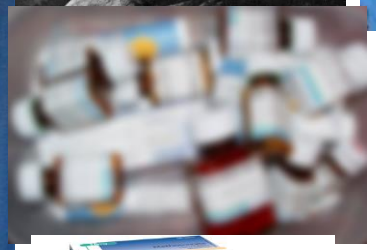
SYSTEMS

Complex	Complicated
Unknown unknowns	Known unknowns
Chaotic	**Simple**
Unknowable unknowns	Known knowns





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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

Cognitive Biases

Functions

Heuristics

Resilience

Situational awareness

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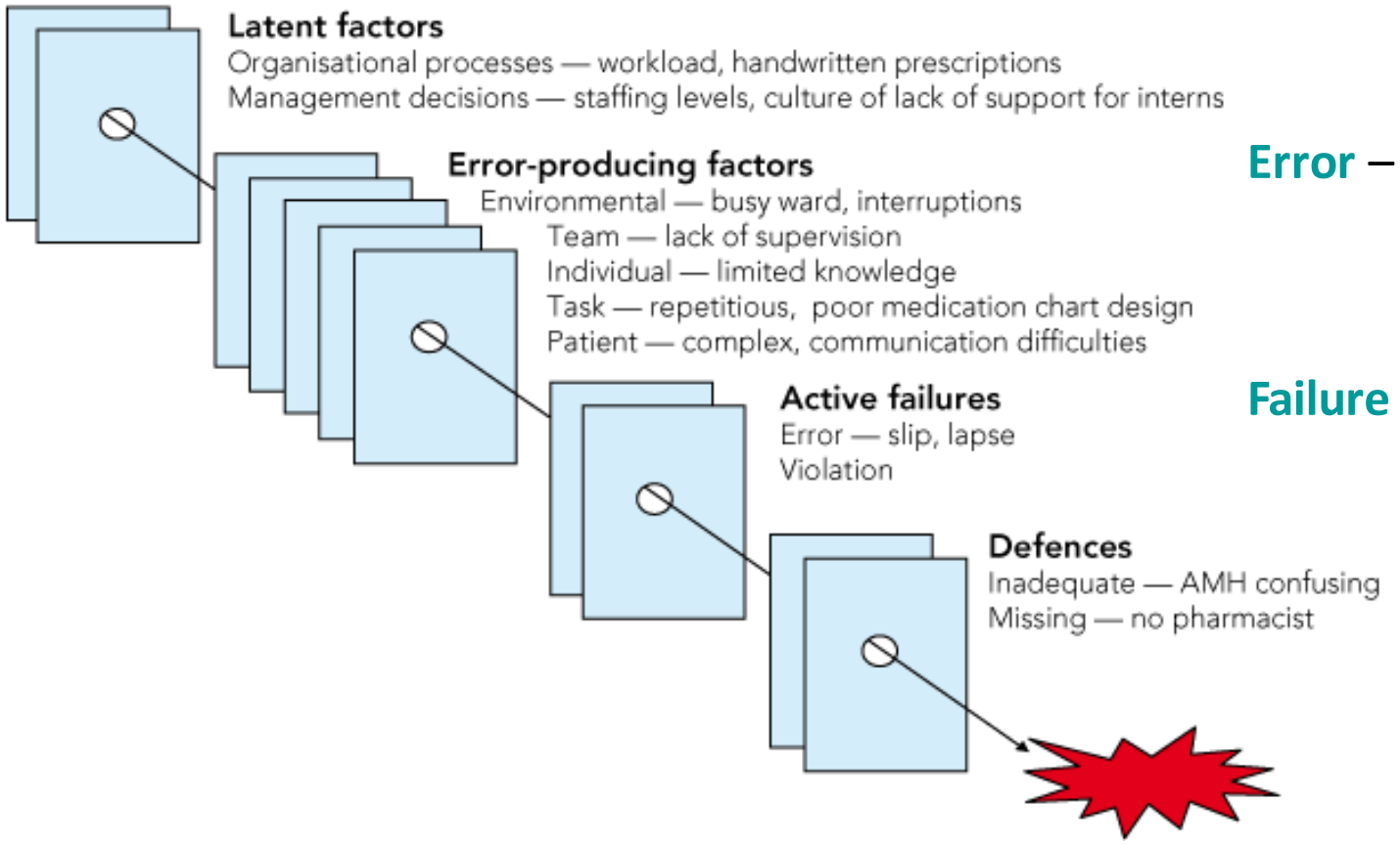
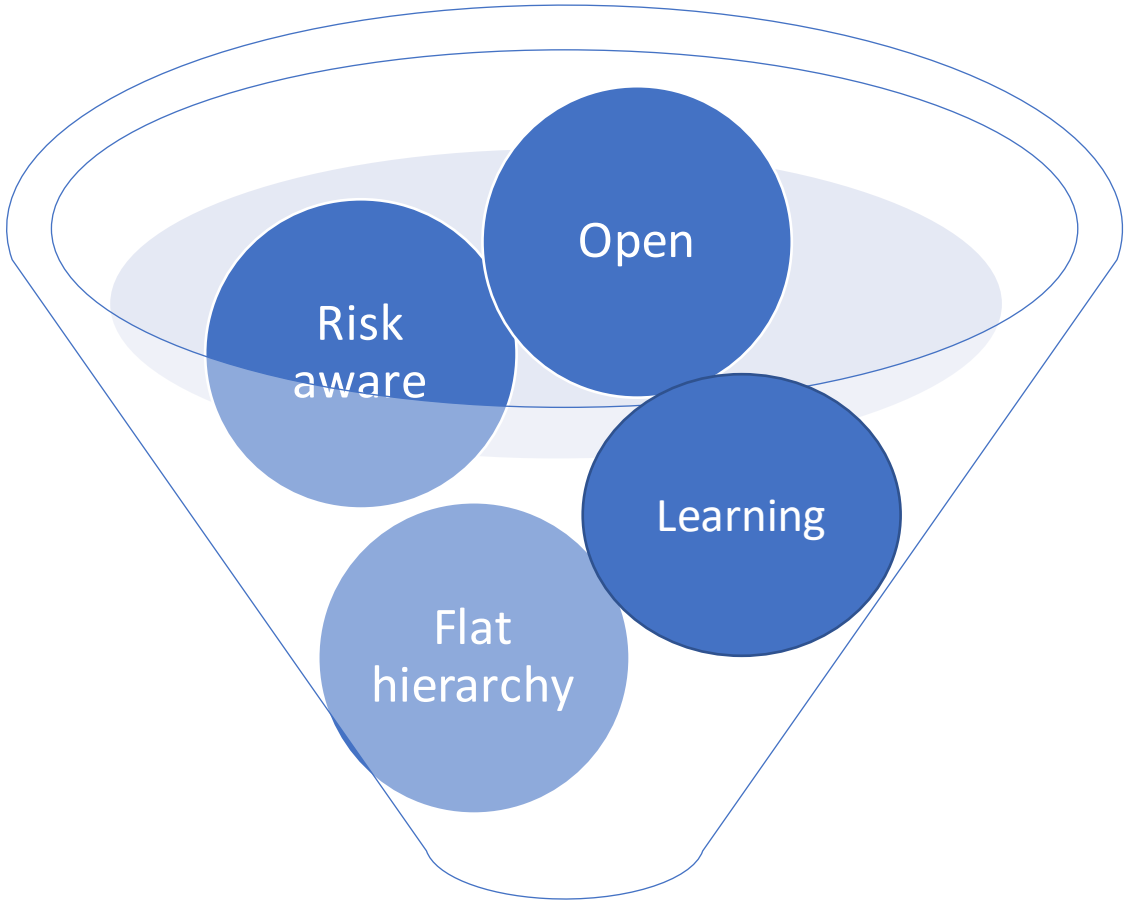
Errors and failures



Error – not doing the expected task

Failure – error results in harm

Safety Culture



Safer Care

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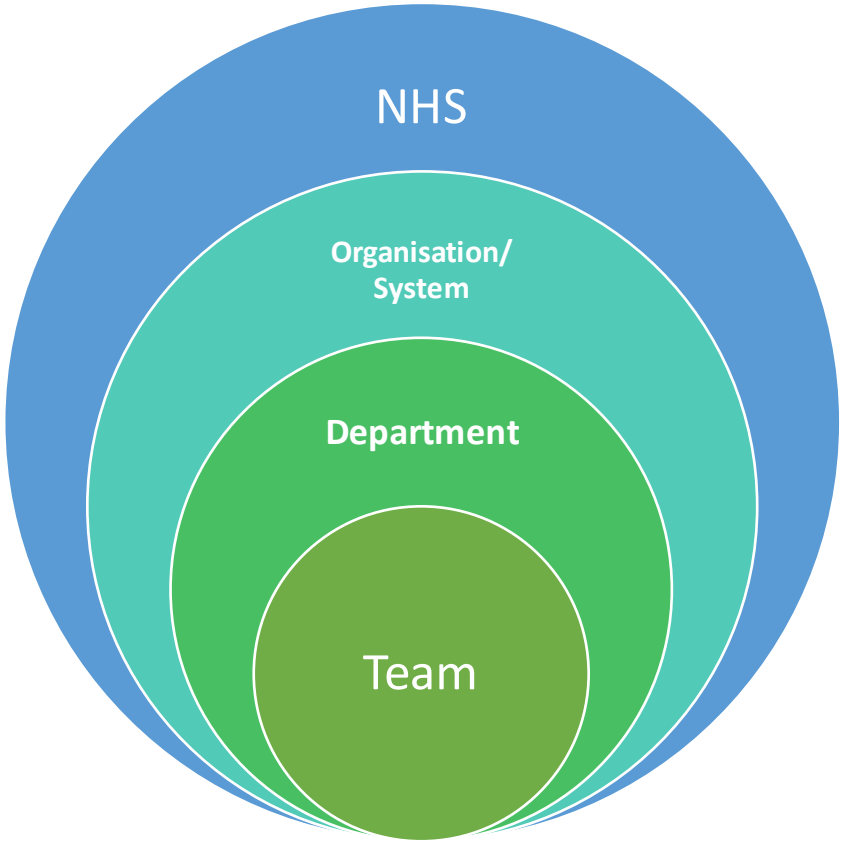
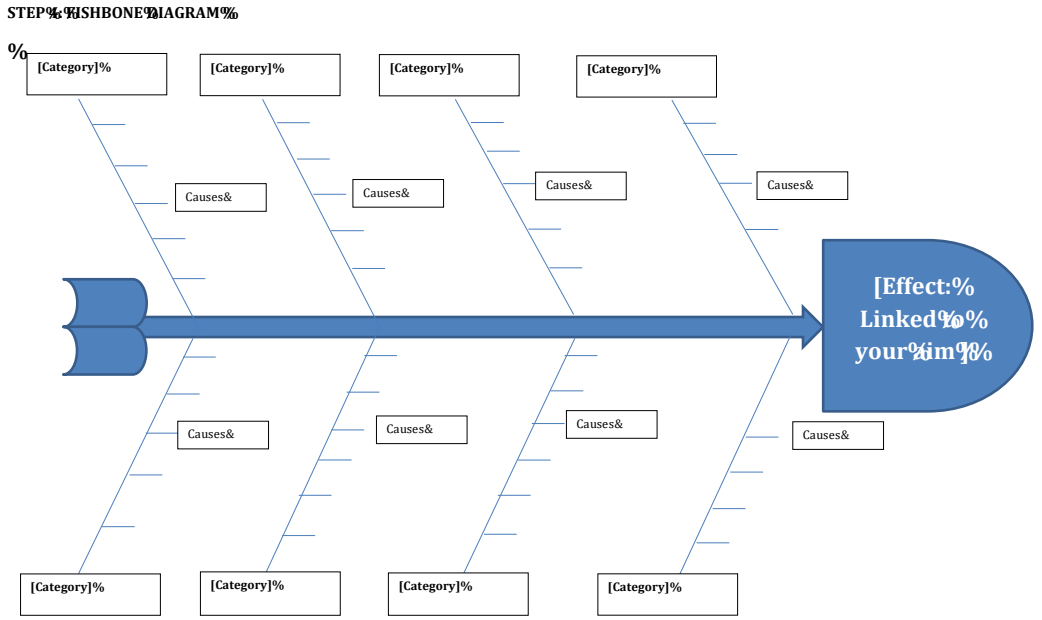
Reporting and Learning





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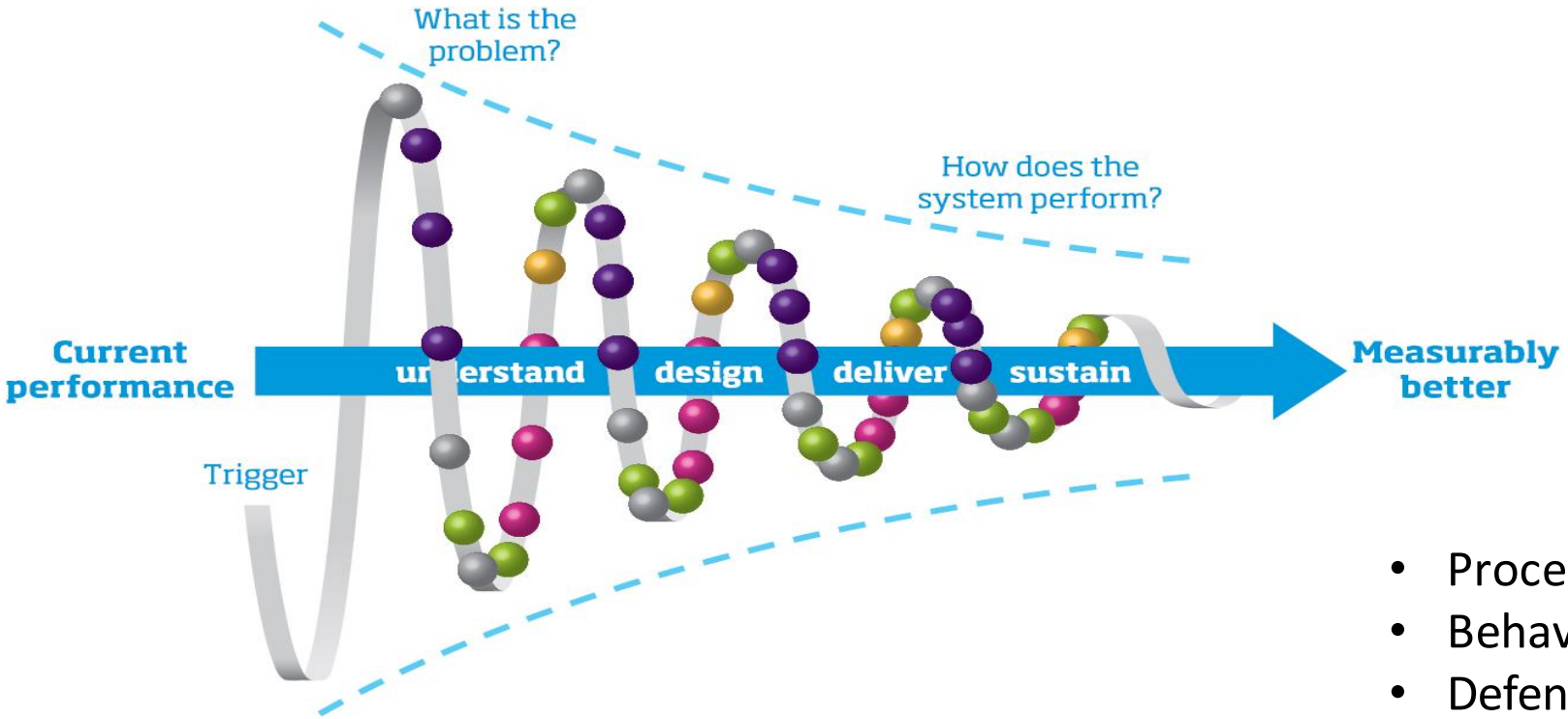
Improvement



- Processes
- Behaviours
- Defences

Measuring and monitoring Safety

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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

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INVOLVEMENT

Acquiring the skills to improve patient safety

- Patient Safety Partners
- Patients as Partners
- Patient Safety Training
- Patient Safety Specialists

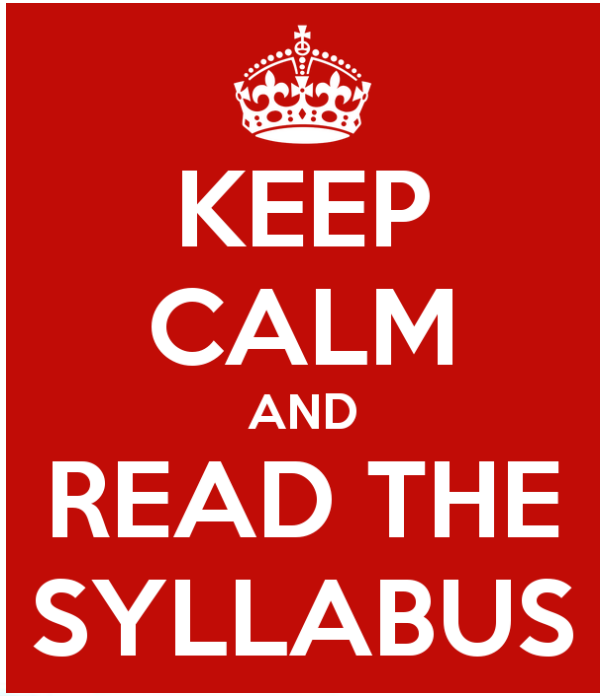
Systems approach to Patient Safety

Learning from incidents

Human factors and Safety Management

Creating safe systems

Being sure about Safety



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IMPROVEMENT

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

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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.

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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

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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.

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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