Developing a Patient Safety Culture within the NHS

Setting the Scene

Peter Davey
How Do We See Ourselves?

content courtesy of Martin Marshall, Director of Clinical Quality, Health Foundation
## What is Quality in Healthcare?

<table>
<thead>
<tr>
<th>Attitude</th>
<th>Traditional approach</th>
<th>New approach</th>
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<tbody>
<tr>
<td></td>
<td>Quality is what we do</td>
<td>Quality is what we strive for</td>
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<tr>
<td>Scope</td>
<td>Clinical effectiveness and safety</td>
<td>Effective, Safe, Patient Centred, Timely, Equitable, Efficient</td>
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<td>Focus</td>
<td>Patients (populations)</td>
<td>Patients, populations and systems</td>
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<td>Requisites</td>
<td>Standards delivered by high quality education</td>
<td>Continuous improvement through learning</td>
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<td>Knowledge base</td>
<td>Bio-science based on the scientific method</td>
<td>Biomedicine plus behavioural sciences</td>
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<td>Scale</td>
<td>Large scale ‘roll-out’ of evidence</td>
<td>Small scale testing and context-specific spread</td>
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*content courtesy of Martin Marshall, Director of Clinical Quality, Health Foundation*
Why do you need to know about systems in health care?

“The major determinant of our care quality is the systems through which services are delivered - and not the individual care provider.”

Lagasse et al, 1995

Context Matters:

“It’s situational – not dispositional!”
Bureaucratic: Standardise, don’t paralyse

Supporting frontline staff is critical
GRI VAP Prevention Bundle Reliability and VAP rate per 1000 ventilator days

**Aim:** > 95% reliability by March 2009

- Ventilator Associated Pneumonia rate per 1000 ventilator days
- Median over first 6 months
- Ventilator Associated Pneumonia care bundle reliability (%)
- AIM

Script of questions to ask Drs
Retesting at DG sheet; handling script; change DG sheet
Last VAP 02/01/2009

DG sheet
DG sheet change; prompts added
We are increasingly realising not only how critical measurement is to the quality improvement we seek but also how counterproductive it can be to mix measurement for accountability or research with measurement for improvement.
Ninewells AMU Safety Dashboard

Corridor C

CASE IN CHARGE TODAY
Ninewells AMU Safety Dashboard

- Antibiotic prescribing
- Blood culture contamination
- Hand hygiene
- Missed doses
Patient Safety Dashboard – this is audit of everyone’s work, including yours!
Our approach
• What does high quality healthcare look like for you, your team and your service- and what gets in the way of achieving this, all the time?

• What is the first simple thing you have the power to change, immediately, or in the very short term, which would improve the reliability of the quality of the service deliver today?
• What other practical ideas do you have that would improve the experience and outcomes of care for patients, carers and for us all?
• What prevents you from putting this idea into practice?
• What else would it take to make this happen?
Findings

Factors used by leading QI programs to come to improved patients results

- Quality program organisation
- Education
- Leadership development

- Culture:
  - goodwill
  - Measurement
  - Evidence based learning
  - Learning organisation

- Physical symbol of QI program (e.g. institute)

- Program logistics
- Measurement systems
- Information systems

- Priorities maintained during crises
- Stability of general management and program management
- Choosing tools compatible with strategy and culture
Framework: Leadership for Improvement

1. Set Direction: Mission  Vision and Strategy

- Make the status quo uncomfortable
- Make the future attractive

Build Will
- Plan for Improvement
- Set Aims/Allocate Resources
- Measure System Performance
- Provide Encouragement
- Make Financial Linkages
- Learn Subject Matter

Generate Ideas
- Understand Organization as a System
- Read and Scan Widely, Learning from other Industries & Disciplines
- Benchmark to Find Ideas
- Listen to Patients
- Invest in Research & Development
- Manage Knowledge

Execute Change
- Use Model for Improvement for Design and Redesign
- Review and Guide Key Initiatives
- Spread Ideas
- Communicate results
- Sustain improved levels of performance

2. Establish the Foundation

- Reframe Operating Values
- Build Improvement Capability

- Prepare Personally
- Choose and Align the Senior Team

- Build Relationships
- Develop Future Leaders
Research questions

• How do anaesthesia crews adapt the coordination behaviours to changing task requirements (e.g. non-routine events)?

• Do anaesthesia crews with different levels of clinical performance employ different coordination behaviours during a simulated anaesthetic crisis?
Malignant Hyperthemia in Cardiac Surgery

- High performing team
- Poorly performing team

Qualitative analysis of simulations

• Higher scoring crews
  – focus on the coordination of the anaesthesia work process
  – are more specific about work roles
  – prioritize clinical tasks effectively
  – tend to “think out loud”

• Lower scoring crews
  – activate more resources than they can coordinate effectively
  – are more likely to split into sub-crews
  – increase workload based on wrong assumptions
“Just a Routine Operation”

- **April 2005** – Elaine Bromiley died after problems during anesthetic before elective sinus surgery.
- 2 anaesthetists and a surgeon: collective loss of situational awareness, decision making, prioritisation & leadership.
- Did not listen to nurse:
  - “A bed is available in ICU”
  - “Consultants just looked at me like I was over reacting. I cancelled the bed”
“Even when fatigued, I perform effectively during critical periods”
Curriculum Guide Topics

1. What is patient safety?
2. What are human factors and why are they important to patient safety?
3. Understanding systems & the impact of complexity on health care
4. Being an effective team player
5. Understanding and learning from errors
6. Understanding and managing clinical risk
7. Introduction to quality improvement methods
8. Engaging with patients and carers

Cluster topics 9-11
9. Minimising infection
10. Improving safety of invasive procedures
11. Improving medication safety
What are your learning objectives?

1. What are human factors and why are they important?
2. Understanding systems & complexity in health care
3. Being an effective team player
4. Understanding and learning from errors
5. Understanding and managing clinical risk
6. Introduction to quality improvement methods
7. Engaging with patients and carers
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| **1. Definition of the problem** | • Establishes problem magnitude/significance  
• Identifies affected groups  
• Clear statement of the problem  |
| **2. Identification of key stakeholders** | • Evidence of stakeholder consultation  
• Description of impact of proposed intervention on stakeholders |
| **3. Evidence of root cause analysis** | • Prioritizes causal factors  
• Identified systems issues  
• Utilises at least one QI tool (e.g. fishbone, systems walk, mind map) |
| **4. Choice of quality improvement project** | • Likely to result in meaningful improvement to patient care (e.g. clinical outcomes, safety, efficiency or cost)  
• Stimulates further enquiry |
| **5. Potential interventions** | • Prioritization of multiple interventions  
• Effort vs yield analysis |
| **6. Proposed interventions** | • Directly addresses the problem  
• Reasonable potential to change systems for the better  
• Impact on care captures ≥2 of the following (high yield/low effort, innovative, cost-effective, sustainable) |
| **7. Implementation & evaluation of intervention** | • Clear plan and timeline for implementing the intervention  
• Identifies measures of intervention success/effectiveness |