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Patient Safety

Trust me to care

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What is patient safety?

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'The avoidance of unintended or unexpected harm to people during the provision of health care.'

NHS England/Improvement

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Summary of Patient Safety Pledges

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Patient Safety System

Put **safety** first

Embed a **safety culture**

Provide **harm free** care

Continually **learn** and **improve**

Be **honest** and **open**

Work **collaboratively**

Use **quality improvement** methods

Be **supportive** of **staff**

Patient Safety Culture

Strategic Objectives

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What is our role?

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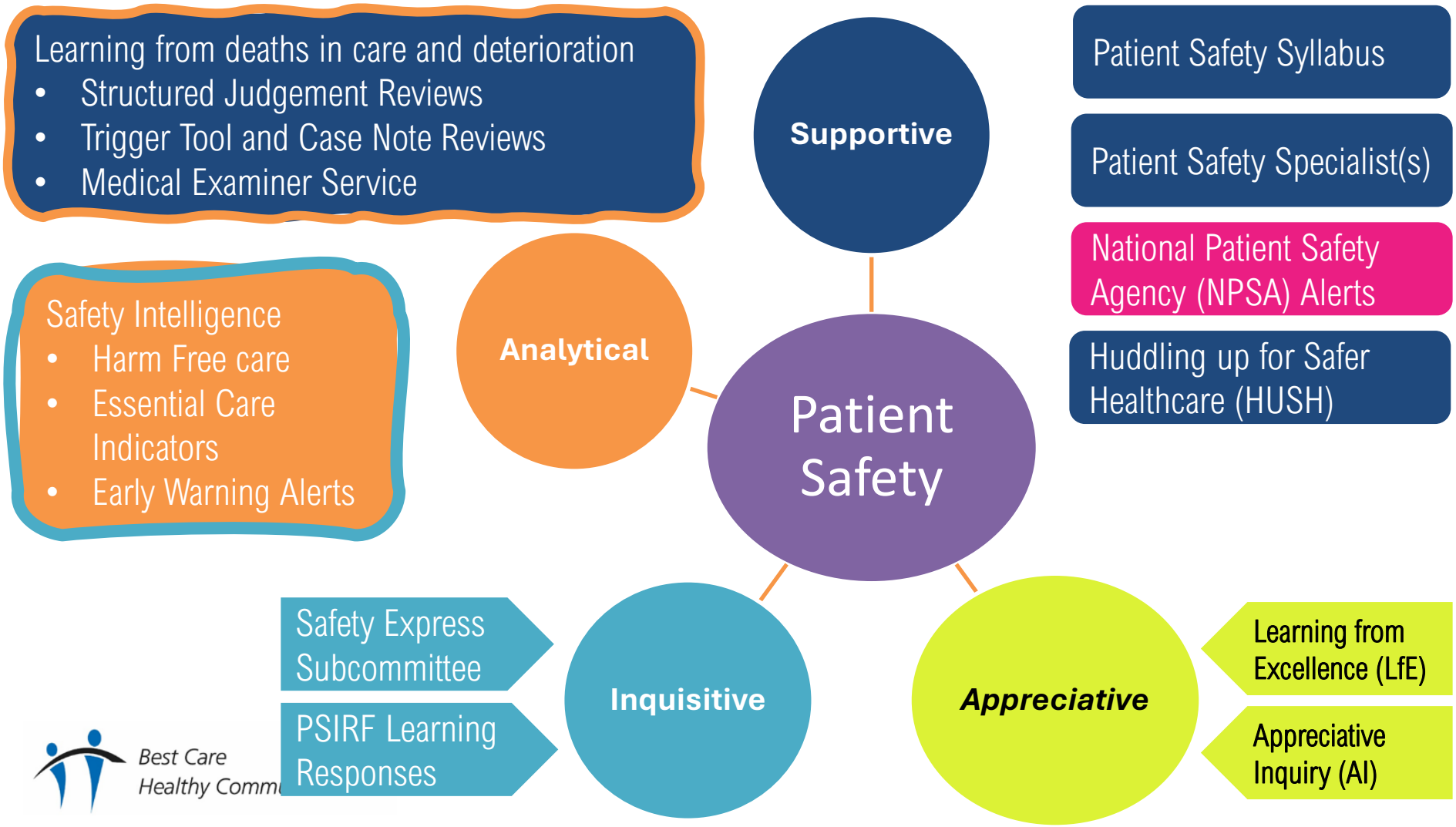

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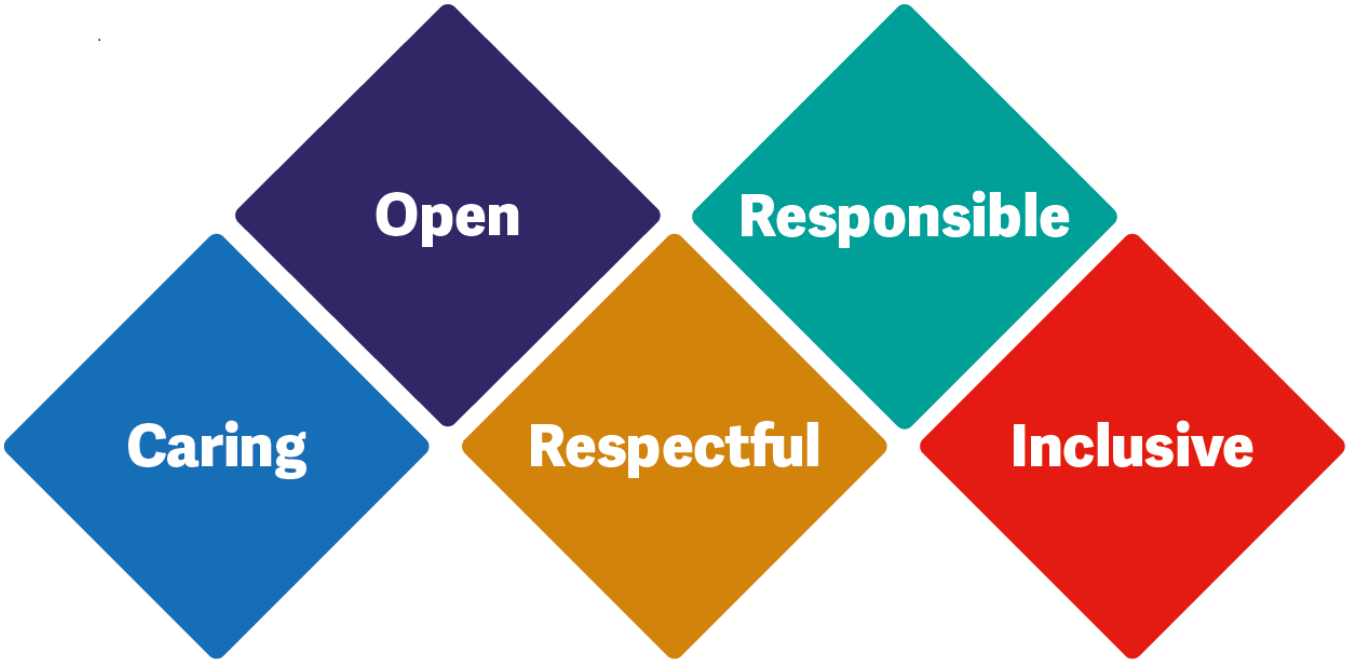

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Essential Care Framework

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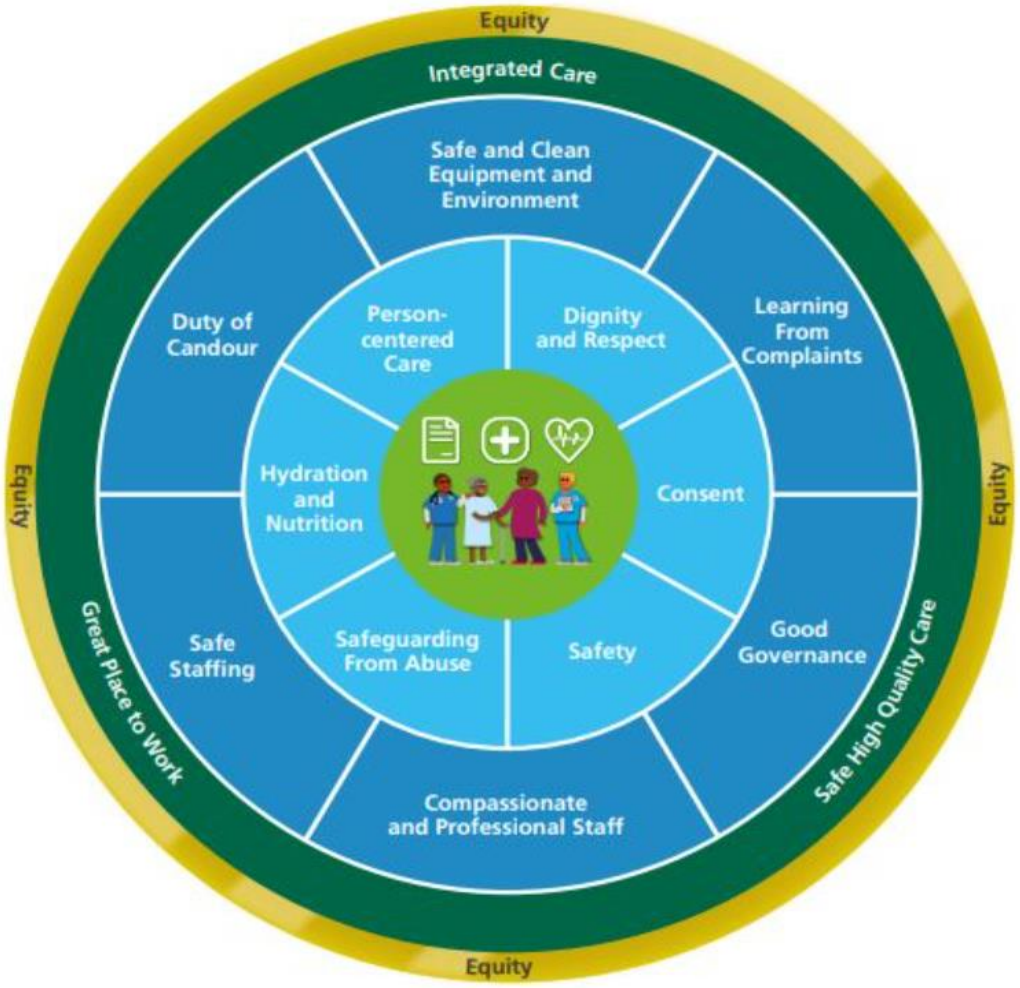

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The bigger picture

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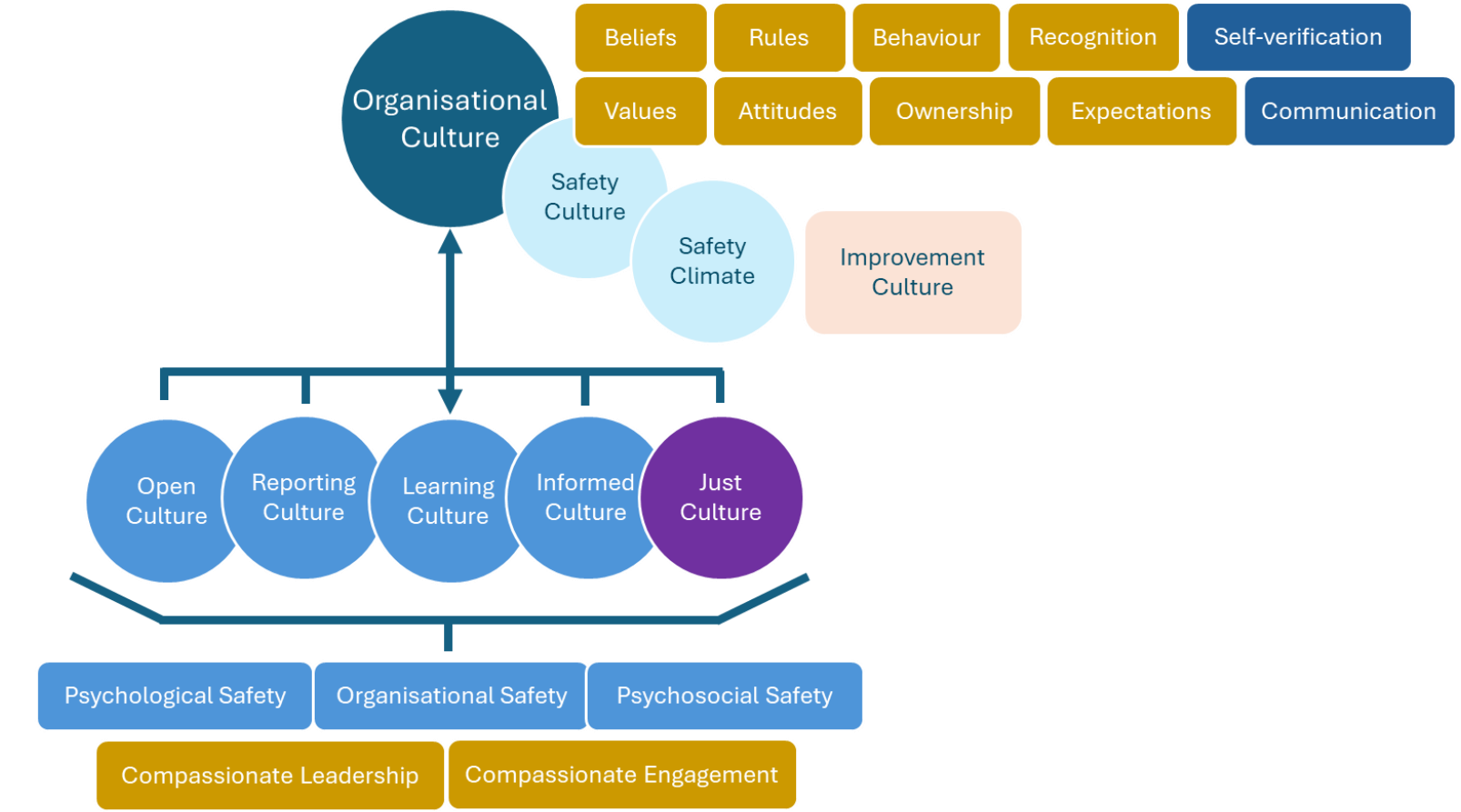

In the news (1)

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Winterbourne View

On 31 May 2011, an undercover investigation by the BBC's Panorama programme revealed criminal abuse by staff of patients at Winterbourne View Hospital near Bristol

DoH Summary Report
CQC Report on Winterbourne View

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In the news (2)

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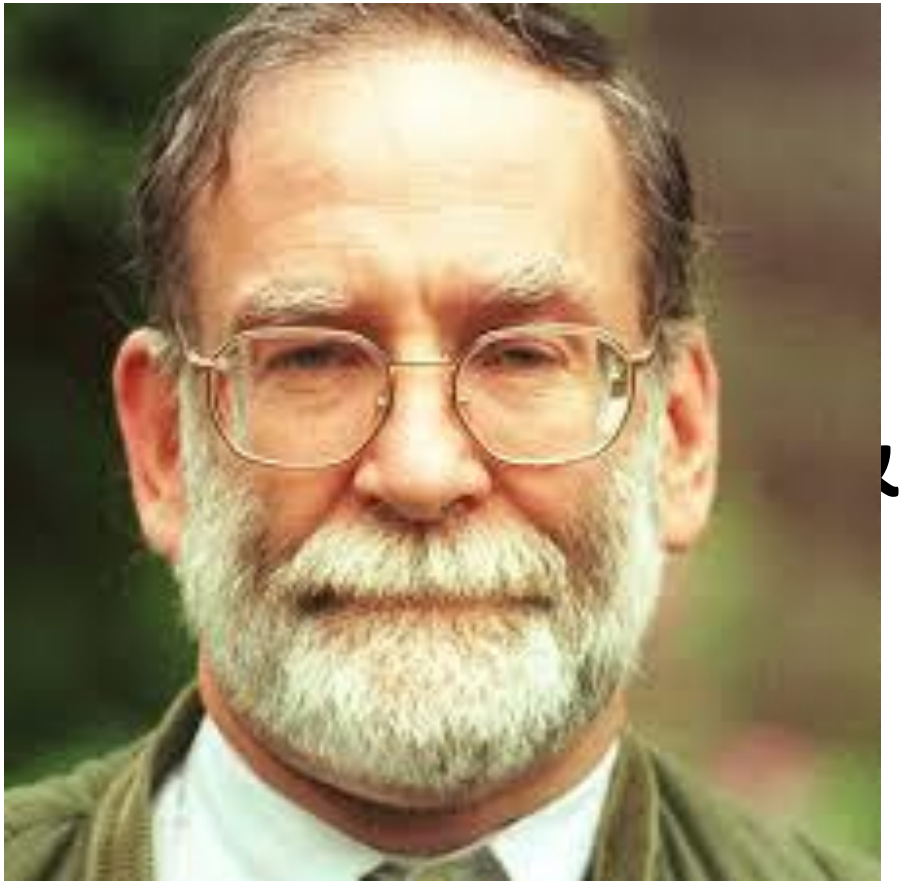

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In the news (2)

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NEWS

One by one the scandals have become etched on the public consciousness. The mass killings by Harold Shipman. The deaths of babies undergoing heart surgery at Bristol Royal Infirmary and born under the care of Morecambe Bay maternity services. The needless suffering of patients at Stafford Hospital.

Now we can add Gosport War Memorial Hospital in Hampshire to that list. News that 456 patients died after they were given opiate painkillers without reason is one of those moments that send a shudder through the NHS - and the nation.

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In the news (3)

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Francis Report

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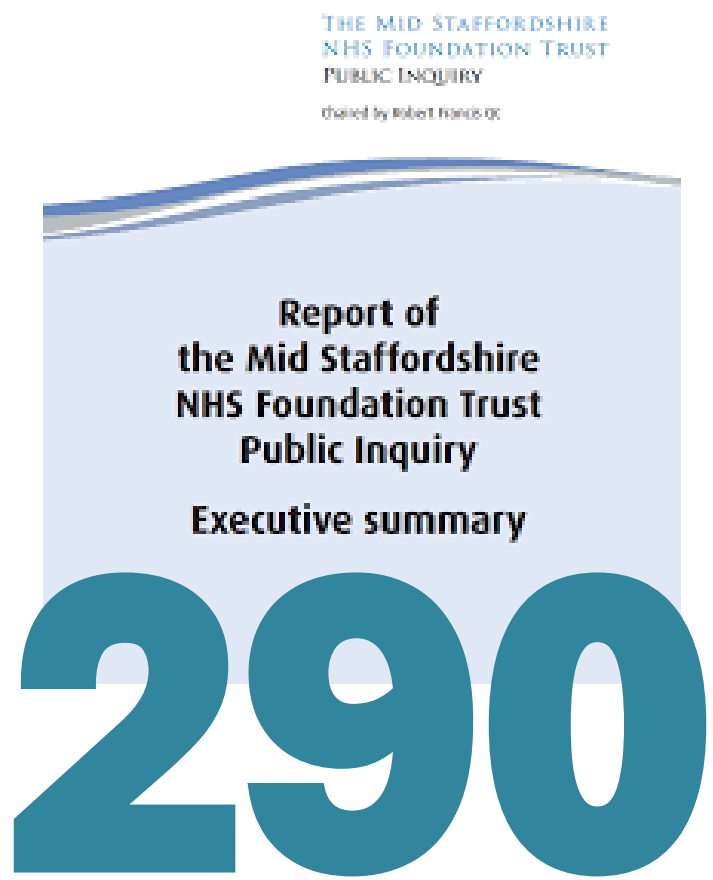

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Divided into five main areas, some of which required new laws:

- New 'fundamental standards' of compliance, with clear means of enforcement
- *Greater openness, transparency and candour*
- *Improved suppor*
  caring and comm
- Accurate, useful
- *Better healthcare*

In the news (4)

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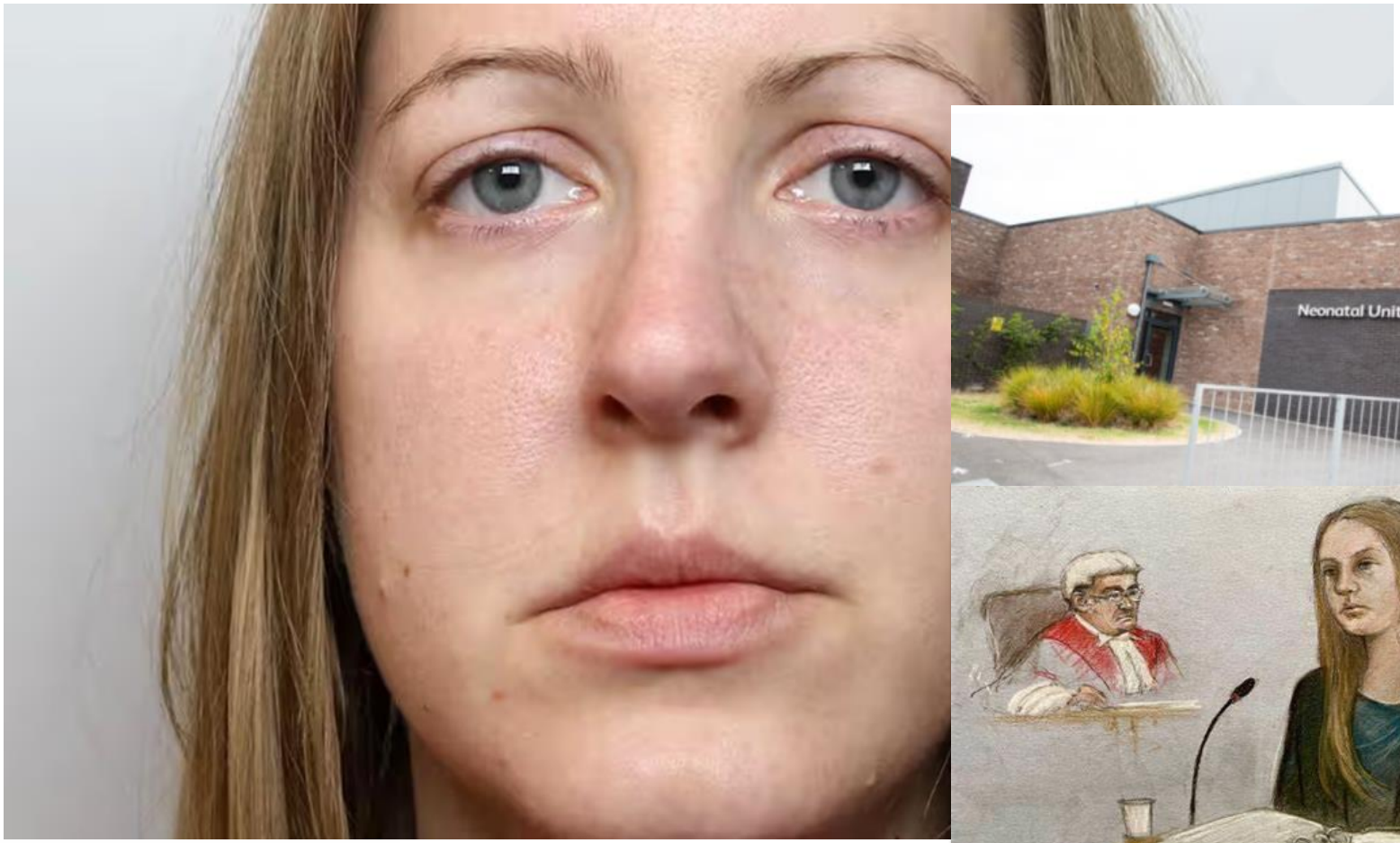

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Voice your concerns

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Safety Civility Inclusion Everyone

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Freedom to Speak Up Guardian

Change in Direction

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Focus on what goes wrong

Safety I approach

- Individuals and errors in focus ('bad apple')
- Aim to reduce number of adverse events
- Finds the 'weakest link' and eliminates this
- Latent systemic failures remain in system
- Learning uses a fraction of the available data
- Safety and core business compete for resource

Focus on what goes right

Safety II approach

- Organisation, system, resources and development in focus
- Several contributing factors behind an event
- Learning is main goal of any review
- Ability to succeed under varying conditions
- Use what goes right to understand everyday performance, do better, and be safer
- Learning uses most of the available data
- Safety and core business work together

Support system and human resilience
Ability to anticipate, cope, recover and learn

Paradigm shift in safety thinking

Change in Human Factors thinking

= OLD THINKING

= NEW THINKING

Safety Culture

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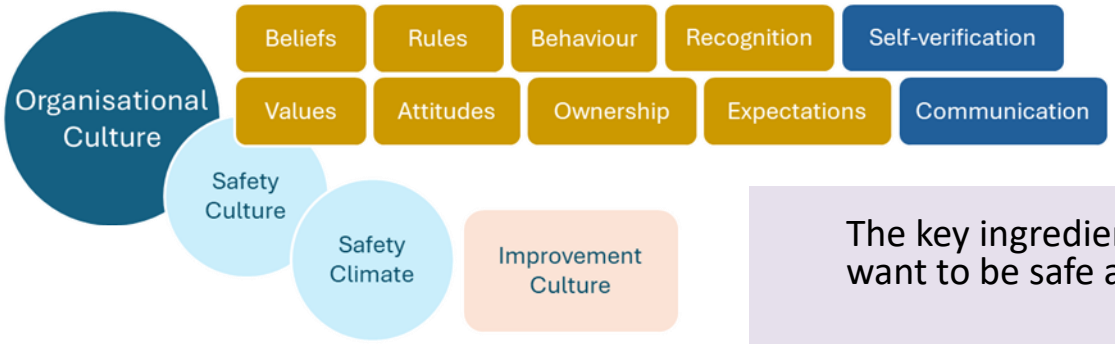

The key ingredients for healthcare organisations that want to be safe are:

Staff who feel – psychologically safe – valuing and respecting diversity; a compelling vision; good leadership at all levels; a sense of teamwork; openness and support for learning.

NHS Patient Safety Strategy – July 2019

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Safety II Implementation

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- Debrief
- Safety Huddles
- Positive feedback to staff to learn from things in a much more balanced way. (LfE)
- Clinical supervision (team approach)
- Reflective practice (team approach)

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Safety Huddles

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Huddle up for safer healthcare
HUSH
PATIENT SAFETY HUDDLES

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Learning from Excellence (LfE)

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Learning from Excellence

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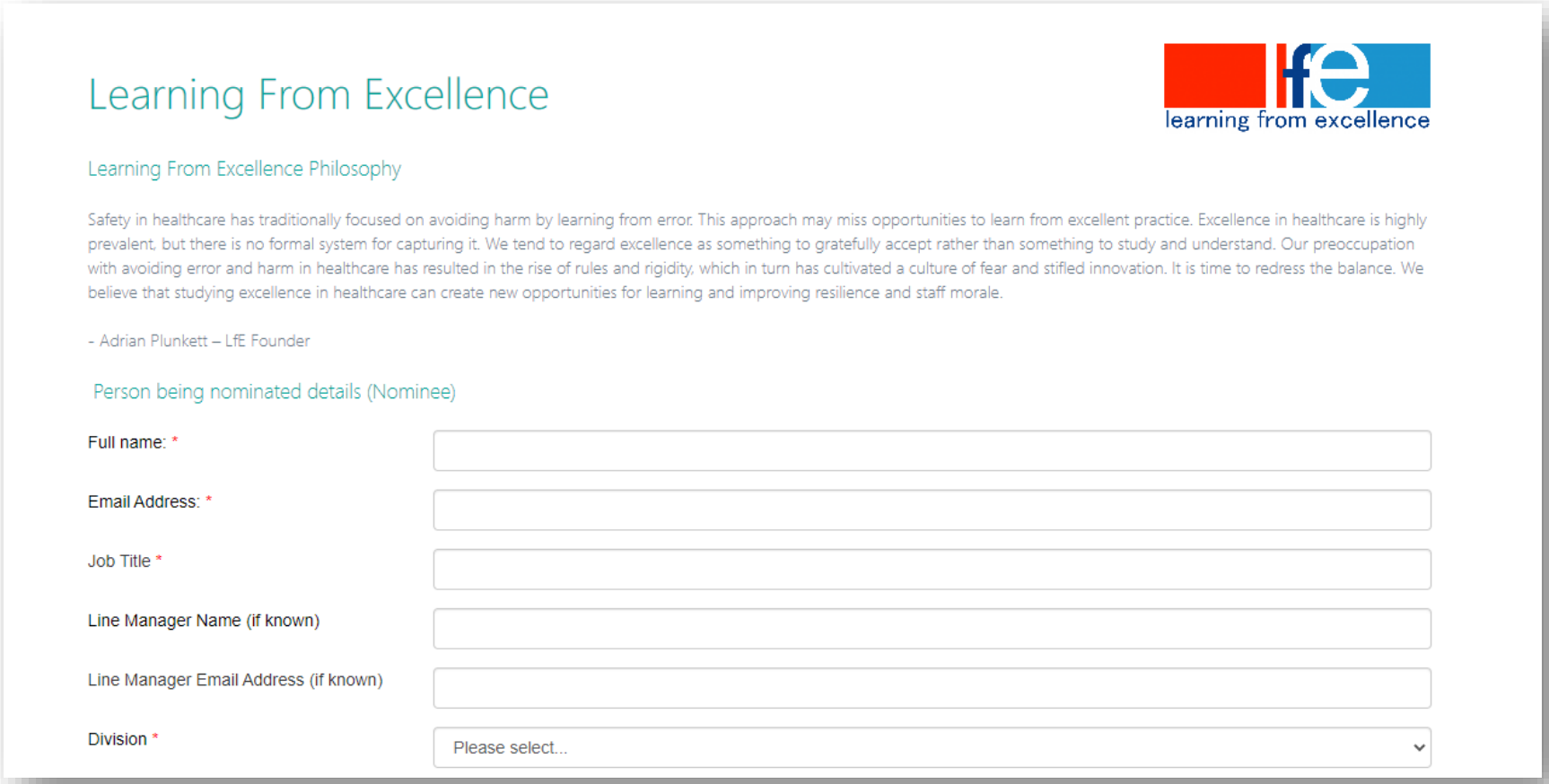

Learning From Excellence

lfe learning from excellence

Learning From Excellence Philosophy

Safety in healthcare has traditionally focused on avoiding harm by learning from error. This approach may miss opportunities to learn from excellent practice. Excellence in healthcare is highly prevalent, but there is no formal system for capturing it. We tend to regard excellence as something to gratefully accept rather than something to study and understand. Our preoccupation with avoiding error and harm in healthcare has resulted in the rise of rules and rigidity, which in turn has cultivated a culture of fear and stifled innovation. It is time to redress the balance. We believe that studying excellence in healthcare can create new opportunities for learning and improving resilience and staff morale.

- Adrian Plunkett – LfE Founder

Person being nominated details (Nominee)

Full name: *

Email Address: *

Job Title *

Line Manager Name (if known)

Line Manager Email Address (if known)

Division * Please select...

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Safety Improvement Plans

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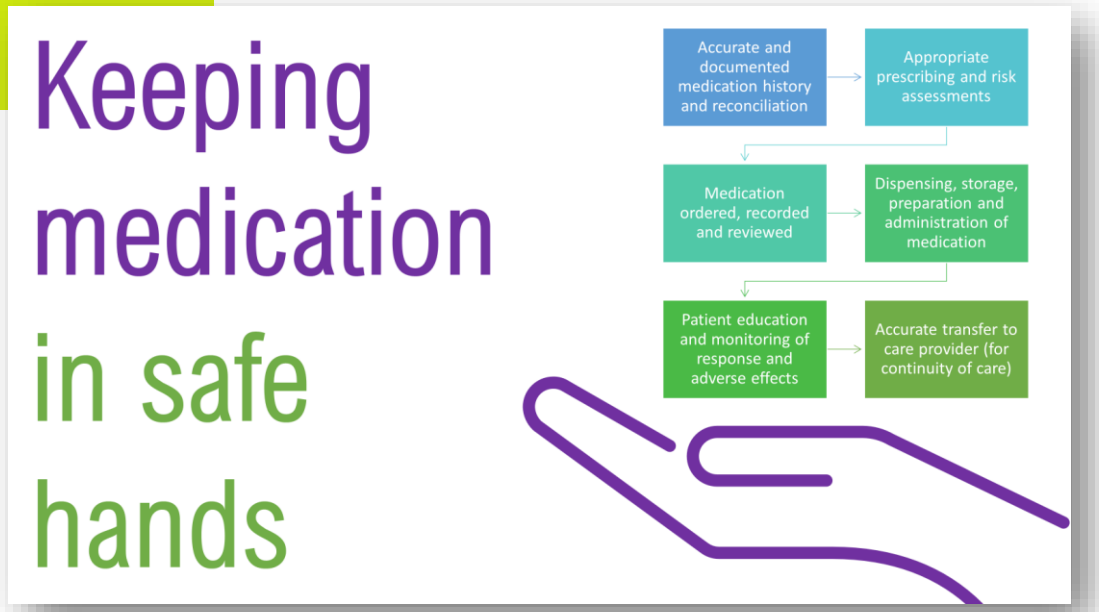
- Falls
- Pressure ulcers
- Suboptimal care
- Medication harm events



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Patient Safety Incident Response Framework (PSIRF)

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What is PSIRF?

- https://www.england.nhs.uk/patient-safety/incident-response-framework/#new-approach

PSIRF replaced the Serious Incident Framework (2015)

- NHS England » Patient Safety Incident Response Framework

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Human Factors

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Human Factors encompass all those factors that can influence **people and their behaviour**.

In a work context, human factors are the environmental, organisational and job factors and individual characteristics which influence **behaviour at work**.

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Moving away…

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… from blame

At its core, a **positive culture** requires, kindness and civility.

The importance of individuals day-to-day behaviour in relation to safety is increasingly recognised.

Studies have shown that where people are rude and disrespectful, safety is compromised.

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Civility Saves Lives

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Training

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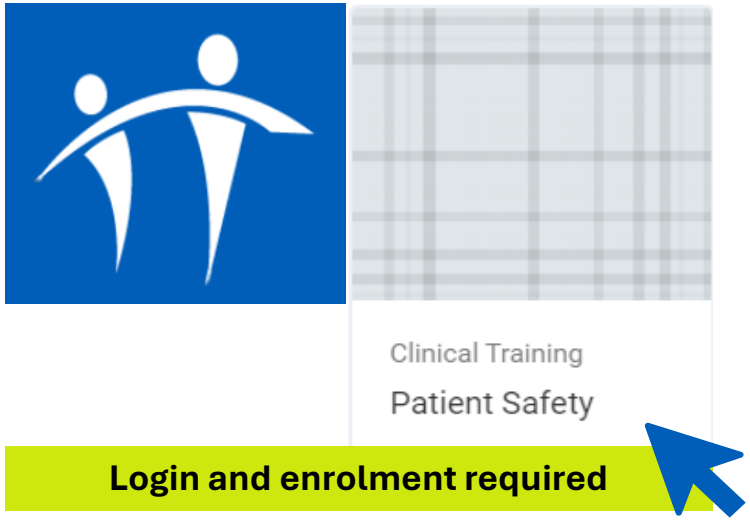
Virtual Campus



Login and enrolment required

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Thank you

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