How to make patient safety your number one priority

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My story....
Patient safety incident: Any unintended or unexpected incident(s) that could have or did lead to harm for one or more persons receiving NHS-funded healthcare.²

Patient safety is a serious global public health issue. Estimates show that in developed countries as many as one in 10 patients are harmed while receiving hospital care.
Landmarks...

• To err is human
• An organisation with a memory
• The National Patient Safety Agency
• Safety First
Seven Steps to Patient Safety
Step 1. Safety Culture

- Organisational safety culture
  - The attitudes of employees to safety
  - Their perceptions about risk and their beliefs in the need to control risks
  - Constant vigilance
  - Reliability – systems that are constant over time
  - Resilience – systems that adapt to unexpected events
Tools to help

Foresight Training handout

This quick reference guide will help you remember the principles of foresight during Foresight Training, as well as in your everyday tasks. It includes a set of questions to help you identify factors that may increase the likelihood of a patient safety incident occurring.

Foresight

Awareness of the ability to:

- recognize potential patient safety risks in the healthcare setting
- identify and respond to initial indications that a patient safety incident could be developing
- analyze, and act on, to prevent a patient safety incident.

Evaluating your situation and preventing harm

Use this three-technique approach to evaluate the factors that might contribute to a patient safety incident in your workplace:

1. **Self**: How safely are you actually working?
2. **Context**: How safely is your working environment?
3. **Task**: How well are you prepared for the task you are completing?

It’s more important to ask up the chain of the likelihood of an error or patient safety incident occurring being raised to the top through and a strong foresight plan is essential to prevent or manage the risk factors in place.

2.40

SELF  CONTEXT  TASK

Putting Patient Safety First
Step 2. Leadership and teamwork

- Demonstrable leadership to show you are putting the safety of your patients as your highest priority
  - Leadership walkabouts
  - A specific aim to reduce harm this year
  - An explicit, public commitment to measurable quality and patient safety improvement
  - Assigned Executive and Non-Executive accountability for quality and patient safety
  - Reviewing progress toward safer care as the first agenda item at every board meeting

- Systems and human factors – the balanced approach
  - **Human factors** helps us understand how system design can affect patient safety, and helps us to design those systems to fit the way people work in relation to...
  - Communication
  - Team working
  - Decision making
    - **Example** of a risky situation – ‘handover’ …..
How not to...

You can take over... there are a few things going on, but you’ll find out... Good night...
How good could it be...
However…. 
Step 3. Learn from all your data

- **Ensure your organisation has identified and established a system for monitoring safety indicators:**
  - **Set realistic targets to measure success**
  - **Examples:**
    - review your safety culture
    - incident rates per admissions
    - risk-adjusted mortality
    - near miss and actual ‘things that go wrong’
    - local incident reports [compared to national data]
    - case note triggers, complaints and claims
  - **Measure the successful implementation and impact of guidance/solutions**
Step 4. Create a reporting culture

2.3 million incidents reported over 4 years
By care setting in one year

- 117,655 Learning disabilities service
- 68,596 Community nursing, medical and therapy service (incl. community hospital)
- 117,655 Mental health service
- 3,581 Community pharmacy
- 2,675 General practice
- 2,637 Ambulance service
- 222 Community and general dental service
- 3 Community optometry / optician service

- 589,135 Acute / general hospital
- 811,746 Total no. of incidents
By level of harm

- No harm: 535,000
- Low harm: 218,162
- Moderate harm: 48,430
- Severe harm: 6,824
- Death: 3,285

Total no. of incidents: 811,701
Step 5

- 34% want an apology or explanation
- 23% want an inquiry into the causes
- 17% want support to cope with the consequences
- 11% want financial compensation
- 6% want disciplinary action

Ref: Making Amends
Step 6

• Investigate using tools to help you see beyond the obvious
• Learn together
• Share your lessons
Step 7 The Solutions
Guidance
Implementation

• 31,486 research papers every week in healthcare – which ones do you implement?
• It takes on average 17 years to turn 14% of original research findings into practice
• There is a failure rate of up to 70%
• Current approaches rely mainly on passive diffusion of information
• This is doomed to failure in a global environment of well over 2 million outputs published annually
What we know works

• Providing people with the evidence for change
• Understanding the costs, benefits and impact provides reasons for change and helps planning and resource allocation
• Understanding the people you want to change is vital
• Involving the people you want to change is even more so
• Be creative in thinking of new ways to create change
Campaigns

Your 5 moments for hand hygiene at the point of care

1. BEFORE patient CONTACT
   - WASH hands before touching a patient when: preparing for handing over care or adapting to specific patient needs
   - | WASH hands with soap and dry thoroughly| WASH hands with alcohol hand rub
   - | WASH hands with alcohol hand rub

2. BEFORE ASEPSIC TASK
   - WASH hands with soap and dry thoroughly
   - WASH hands with soap and dry thoroughly

3. AFTER BODY FLUID EXPOSURE RISK
   - WASH hands immediately after exposure risk to body fluids and after removing PPE
   - WASH hands with soap and dry thoroughly

4. AFTER PATIENT CONTACT
   - WASH hands after touching a patient and their immediate surroundings
   - WASH hands with soap and dry thoroughly

5. AFTER HANDLING CONTAMINATED ENVIRONMENTAL SURFACES
   - WASH hands after touching any objects or surfaces in the patient's immediate environment when not wearing PPE
   - WASH hands with soap and dry thoroughly

Putting Patient Safety First
The patient safety first campaign in England
Standardisation

Putting Patient Safety First
Mistake proofing

Putting Patient Safety First
“We need to redouble our efforts to implement systems and interventions that actively and continuously reduce risk to patients”

Sir Liam Donaldson, Chief Medical Officer
Safety First
Department of Health 2006
Thank you

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