Safety Measurement, Monitoring & Strategies

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10% patients harmed, half judged preventable

We do not know whether we are making progress or not
Just tell me - are we safe?

The fundamental questions

- Has patient care been safe in the past?
- Are our clinical systems and processes reliable?
- Is care safe today?
- Will care be safe in the future?
- Are we responding and improving?
Case Studies

Has patient care been safe in the past?
Are we responding and improving?
Will care be safe in the future?
Are our clinical systems and processes reliable?
Is care safe today?
Sensitivity to operations

- Clinicians monitor their patients, watching for subtle signs of deterioration or improvement,
- Leaders monitor their teams for signs of discord, fatigue or lapses in standards.
- Managers have to be alert to the impact of staff shortages, equipment breakdowns, sudden increases in patient flow and other problems.

Soft intelligence

- Safety walk-rounds
- Using designated patient safety officers
- Operational meetings, handovers and ward rounds
- Briefings and debriefings
- Day to day conversations
- And above all …. the patient voice
Integration & learning. Are we responding and improving?

Berwick Report

“Most Health care organisations at present have very little capacity to analyse, monitor, or learn from safety and quality information. This gap is costly and should be closed and that early warning signals can be valued and should be maintained and heeded” (Berwick, 2013, p26)
Great Ormond St: team level

- Number of days since the last serious incident (SI) – narrative, lessons learnt and recommendations
- Central venous line, MRSA (MSSA) infection rates
- Hand hygiene compliance rate
- WHO Surgical Safety Checklist compliance rate per clinical unit
- Common themes identified in executive walk-rounds
- Medication errors
- Top three risks from the clinical unit’s risk register.

A framework for the measurement and monitoring of safety

- Are we responding and improving?
  Sources of information to learn from include:
  - automated information management systems
  - highlighting key data at a clinical unit level (e.g., medication errors and hand hygiene compliance rates)
  - at a board level, using dashboards and reports with indicators, set alongside financial and access targets.

- Will care be safe in the future?
  Possible approaches for achieving anticipation and preparedness include:
  - risk registers
  - safety culture analysis and safety climate analysis
  - safety training rates
  - sickness absence rates
  - frequency of sharps injuries per month
  - human reliability analysis (e.g. FMEA)
  - safety cases.

- Has patient care been safe in the past?
  Ways to monitor harm include:
  - mortality statistics (including HSMR and SHMI)
  - record review (including case note review and the Global Trigger Tool)
  - staff reporting (including incident report and ‘never events’)
  - routine databases.

- Are our clinical systems and processes reliable?
  Ways to monitor reliability include:
  - percentage of all inpatient admissions screened for MRSA
  - percentage compliance with all elements of the pressure ulcer care bundle.

- Is care safe today?
  Ways to monitor sensitivity to operations include:
  - safety walk-rounds
  - using designated patient safety officers
  - meetings, handovers and ward rounds
  - day-to-day conversations
  - staffing levels
  - patient interviews to identify threats to safety.

- Are we responding and improving?
  Sources of information to learn from include:
  - automated information management systems
  - highlighting key data at a clinical unit level (e.g., medication errors and hand hygiene compliance rates)
  - at a board level, using dashboards and reports with indicators, set alongside financial and access targets.
Assurance  Inquiry
Our ambition and questions

- Are we thinking about safety in the right way?
- How is safety achieved in different settings?
- A wider range of safety strategies and interventions?
- Can a framework of strategies and interventions be developed?
  - Applicable across contexts? Hospital, home, primary care
  - Across levels? Patient, frontline, organisation, regulation and government?
Targeted at events

Aim is to optimise reliability of basic procedures

Families of safety interventions

Best practice

Optimising Strategies

Improve the system

Risk control

Adapt & respond

Risk Management Strategies

Mitigation
III Risk control

- Withdraw services
- Reduce demand
- Place restrictions on services
- Place restrictions on conditions of operation
- Place restrictions on individuals
- Prioritisation of activities

IV Monitoring, adaptation and response

- Resilient teamwork at the frontline
- Emphasis on adaptation, problem solving, flexibility
- Supportive interventions
  - Patient strategies and ‘safety briefings’
  - Safety monitoring by patients
  - Briefing and de-briefing
  - Team training for cross checking, monitoring
  - In situ simulation
V Mitigation

- Support for patients, families and carers
- Support for staff
- Financial and legal planning
- Management of media
- Response to regulators
A Compendium of Safety Strategies
An Incomplete Taxonomy

A framework of safety strategies and interventions

Best practice
Improve the system
Risk control
Adapt & respond
Mitigation

Improvement Science
Human factors & ergonomics
Regulation & governance
Resilience, team training

Optimising Strategies
Risk Management Strategies