Designing For Safe Care

Angie Nisbet
Director
Care by Design, UK

FreeFoto.com

‘Ey up’ = Hello

‘Ey up me duck’ = Hello Dear/ Darling

‘You rite?’ = How are you?

Why Should You Act?

- Hospitalists, by definition, introduce discontinuity in care as patients transition from outpatient provider, to the hospital medicine service, and then back to outpatient provider.

- Inadequately performed care transition can lead to multiple negative consequences such as decreased patient understanding, medication errors, increased stress on the caregiver, increased readmission rates, and an increase in care costs.

- Collaboration between health care providers has been shown to improve these outcomes, as well as patient satisfaction and quality of life.

BOOST(Better Outcomes for Older adults through Safe Transitions; Society for Hospital Medicine

Aged and Community Care Services

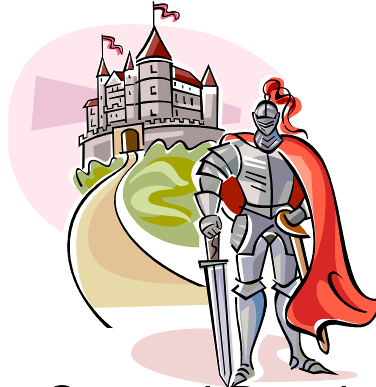
A Complex Adaptive System!

a collection of individual agents with the freedom to act in ways that are not always predictable

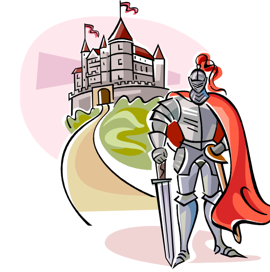
….and whose actions are interconnected so that one agent’s actions changes the context for other agents

Different Tribes!!!!

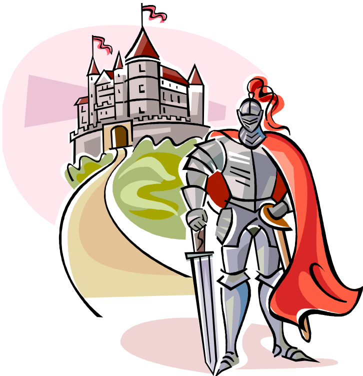
Community Care



General Practice



Clinical Governance

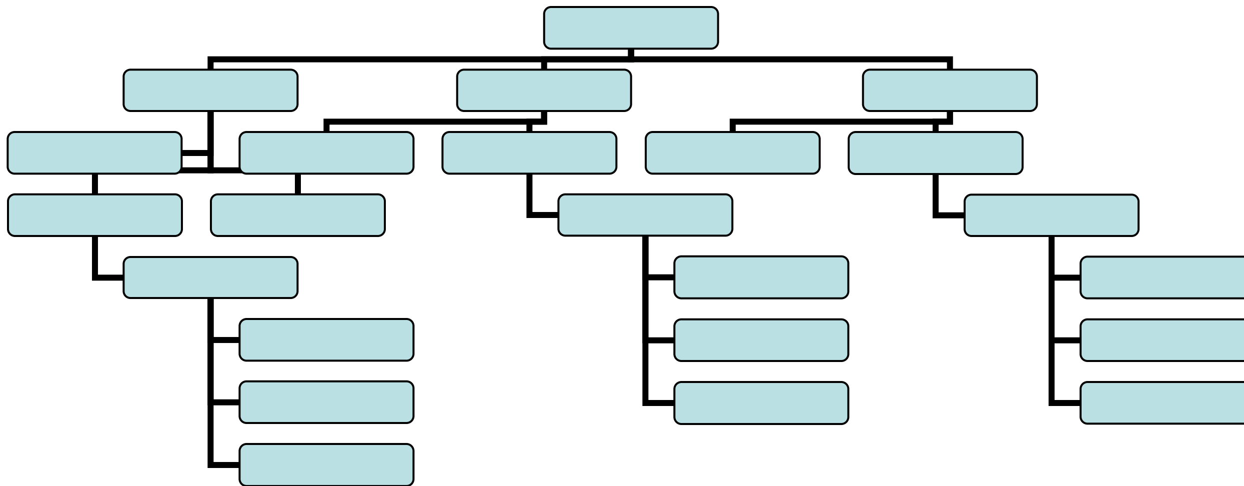


Mental Health

Rehab Services

Acute Hospitals

Add to that….the Hierarchy!

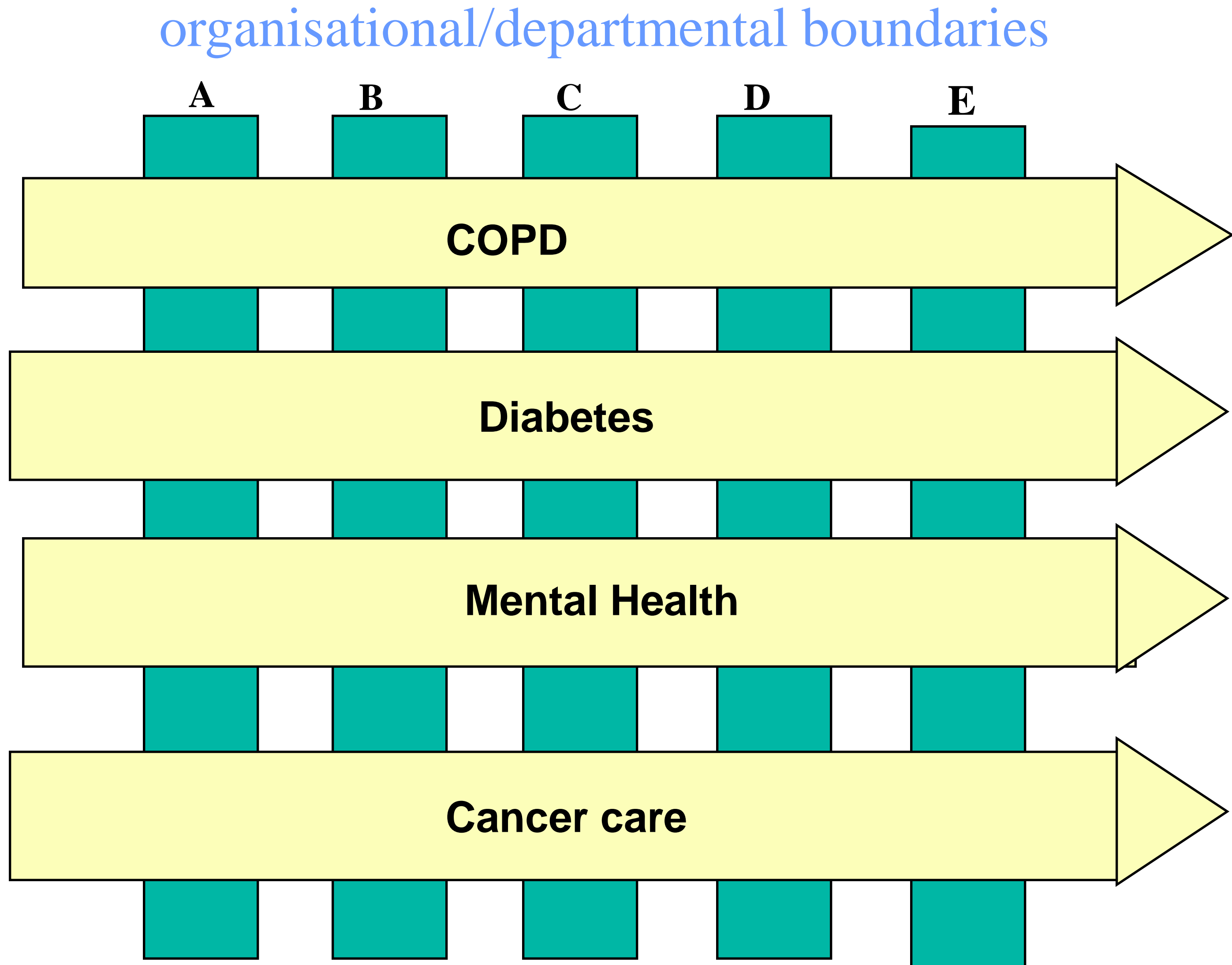


An Industrial Model in a Knowledge Worker/ Relationship Age

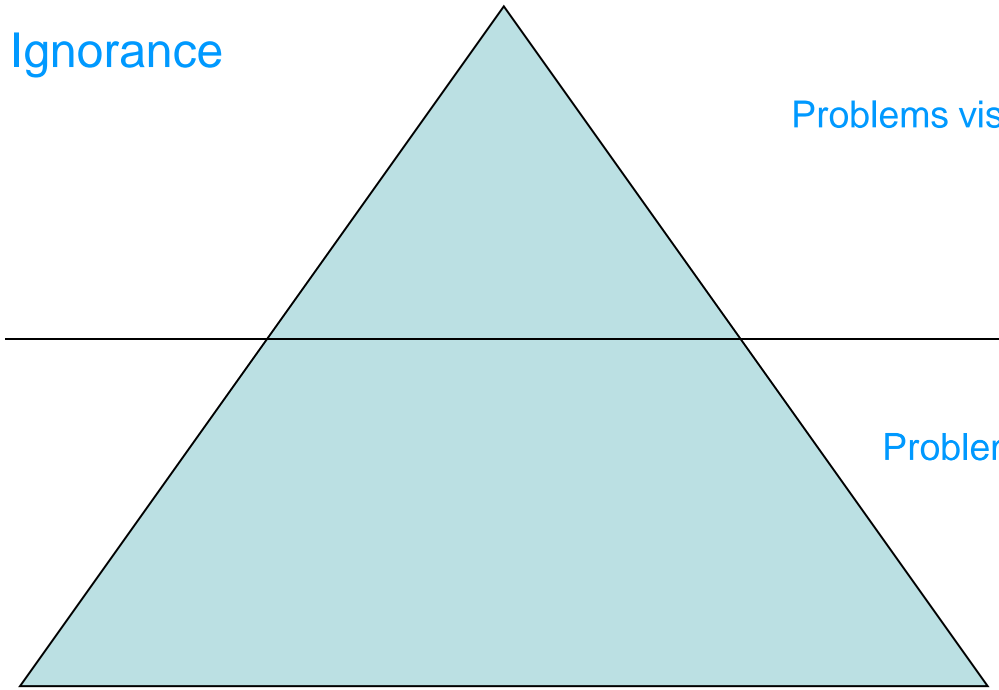
known as the *'tree of blame'*

All this Driving Variation; Waste and Potential for Error!!

- 30 - 70% of work doesn't add value for patient
- up to 50% of process steps involve a "handoff", leading to error, duplication or delay
- no one is accountable for the service user "end to end" experience
- job roles tend to be narrow and fragmented
- Who listens to the voice of service users and carers



The Iceberg of Ignorance



Problems visible to senior managers

Problems visible to front line staff

Each bus holds 73 passengers

What are we trying to achieve?

Getting patients better faster and safer

Safety

Ideal Care

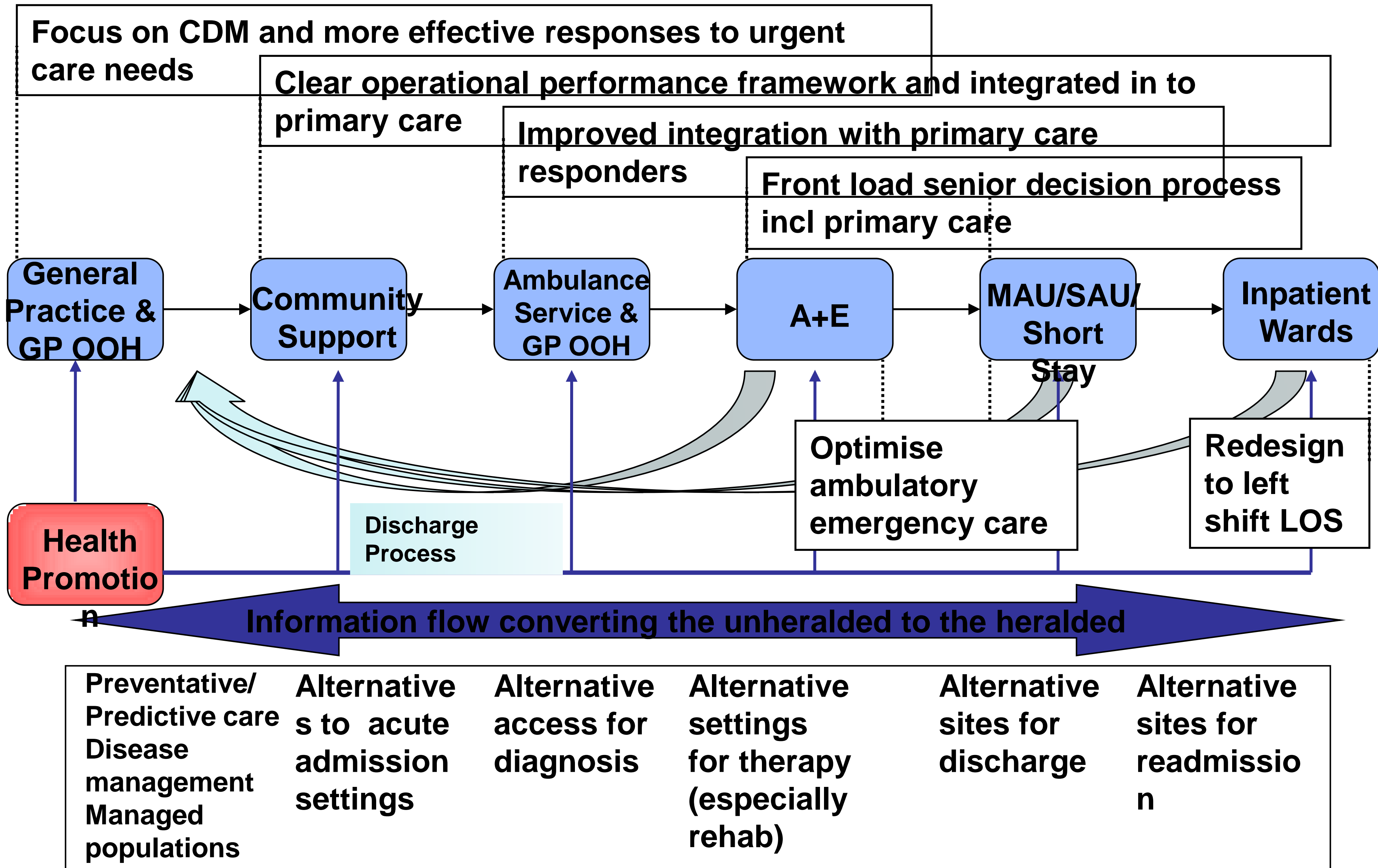
Flow

Reliability

Pursuing Perfection

- No avoidable deaths
- No harm
- No unnecessary pain
- No waste
- No delays
- No feelings of helplessness
- No inequality

A whole system perspective *



*Slide Courtesy of Dr Ian Sturgess, Assoc Med Dir – Patient Safety, East Kent Hospitals University NHS Foundation Trust, Clinical Lead ECIST

Simple Rules for Better Health Care System in the 21st Century	
Current Approach	**New Rule**
Care is based primarily on visits	Care is based on continuous healing relationships
Professional autonomy drives variability	Care is customised according to patients' needs and values
Professionals control care	The patient is the source of control
Information is a record	Knowledge is shared and information freely flows
Decision making is based in training and experience	Decision making is evidence based
Do no harm is an individual responsibility	Safety is a system property
Secrecy is necessary	Transparency is necessary
The system reacts to needs	Needs are anticipated
Cost reduction is sought	Waste is continuously decreased
Preference is given to professional roles over the system	Cooperation amongst clinicians is a priority

Figure 1 *Source: Institute of Medicine Committee on Quality Healthcare in America*

Paris
In the
the spring

The Magic Number!

7 + or -2

Our Coping Strategies

- Generalisation
- Deletion
- Distortion

1.Preoccupation with failure – all potential problems or errors identified/analysed

- ‘*don’t accept the ordinary as ok*’

Dr Gordon Caldwell; West Sussex NHS Trust

Karl Weick’s five key organisational operating principles required to create an organisational infrastructure for reliability.

2.Reluctance to Simplify Interpretations- nothing taken for granted. Checks happen in Multiple ways

* Cockpit checklists*

Western Sussex Hospitals Wards Round Considerative Checklist

Make one member of the team the “Safety Checker” who uses this checklist before leaving each patient.

The checker must highlight anything omitted, speak up and get it done!

Key = <u>these sections must be checked in all patients</u>

Date	Checker’s Name	Checker’s Status	Signed	Clinical Team	Type of Round
…/…./2010					Routine/Post take
Start time	Finish time	Number of patients	Number of doctors on team		

Aspect of Care										
		Item done	√		Not yet done	O		Not applicable	-------	
Patient Initials										
Bed number										
<u>Preparatory Discussions</u>	**Preparation Before Going to the Bedside**									
Filed Notes in Main Notes										
Checked New Results										
<u>Clinical Thinking</u>										
* **Nurse present during discussion**										
<u>Consultation</u>	**Patient Consultation**									
Ask and Listen										
Focussed exam										
Pain or discomfort?										
Eating and Drinking										
Diarrhoea / Constipation										
Urine / catheter										
Cannula and iv lines										
Skin mouth + eye care										
DVT prophylaxis										
Wounds and Drains										
Nurse present at bedside?										
<u>Charts</u>	**Check All Relevant Bedside Charts**									
Vital Signs (TPR etc)										
Drugs Chart										
Fluid Prescription/Balance										
Weight										
Diabetes / Glucose										
<u>Discharge Planning</u>	**Start Discharge Planning**									
EDD in notes?										
Discharge Team?										
Write TTOs now?										
<u>Ceiling of Care</u>										
And CPR Status										
<u>Planning</u>	**Agree Blood Tests, Radiology, Consider Need for Senior Advice or Referral**									
Agree Future Tests										
Referral or Senior Help?										
<u>Documentation</u>	**Write in the notes, consider need for night or weekend handover**									
Today’s Note written? **Weekend or Night Plan Needed?**										
<u>Sum up to</u>: Patient										
Report back to Nurse										
Spoke with relatives?										

*** Mark tick for nurse present during preparatory discussions**

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Designing Healthcare Around the Human Factor

3. **Sensitivity to operations** – all observe ops, have continuous communication

Patient checklists

* Door to Doctor Time*

Karl Weick's five key organisational operating principles required to create an organisational infrastructure for reliability.

4. Commitment to resilience - the ability/agility to respond to the unexpected.

Karl Weick's five key organisational operating principles required to create an organisational infrastructure for reliability.

5. Deference to expertise – decisions are made away from formal authority toward expertise and experience

Ideal safe healthcare systems tended to focus on two critical aspects

1. The use of technology and automation

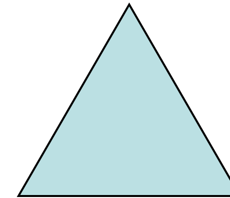
2. The establishment of a safety culture

James Reason, Jim Baigen

What management model do you have in your mind?

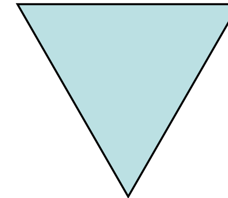
- That of Command and Control

Vision 1920



- Or that of Coordinate and Cultivate

Vision 2000

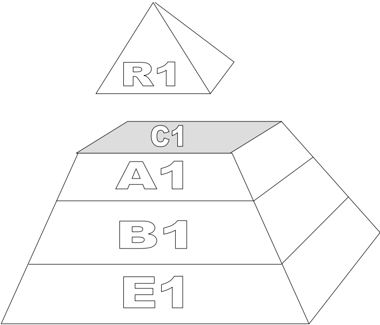


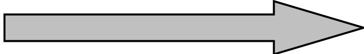
Coordination focuses on activities that need to be done
Cultivation focuses on the people doing these activities

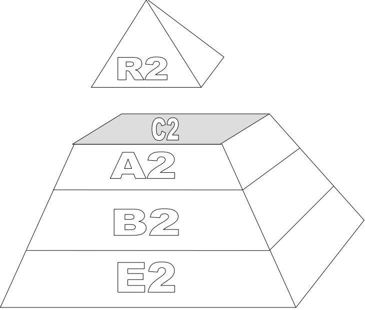
Designing Healthcare Around the Human Factor

R1 – Unsafe Care

R2 - Safer Care







Results Pyramid- Roger Connors: Tom Smith

The Chain of Effect in Improving Healthcare Quality

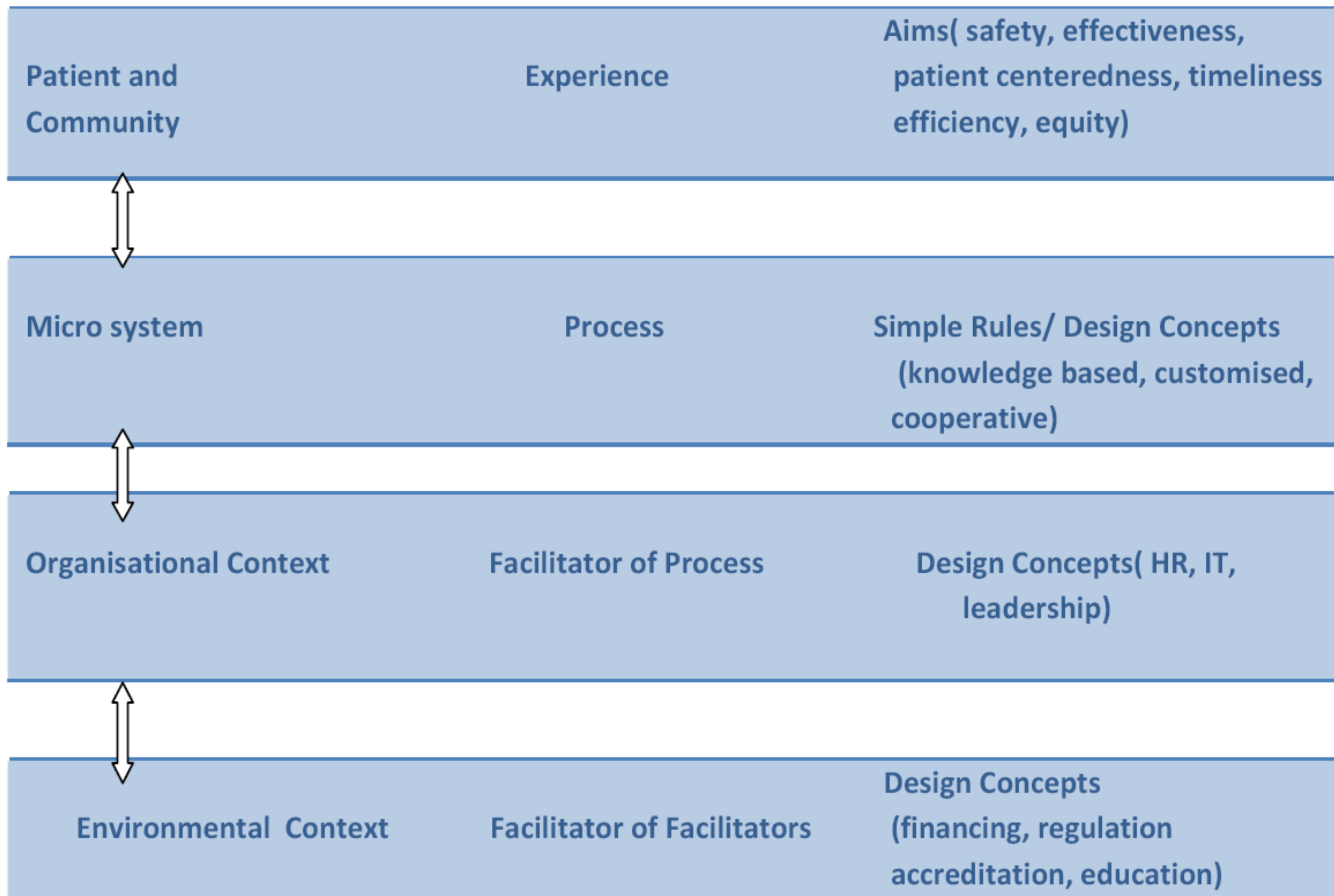
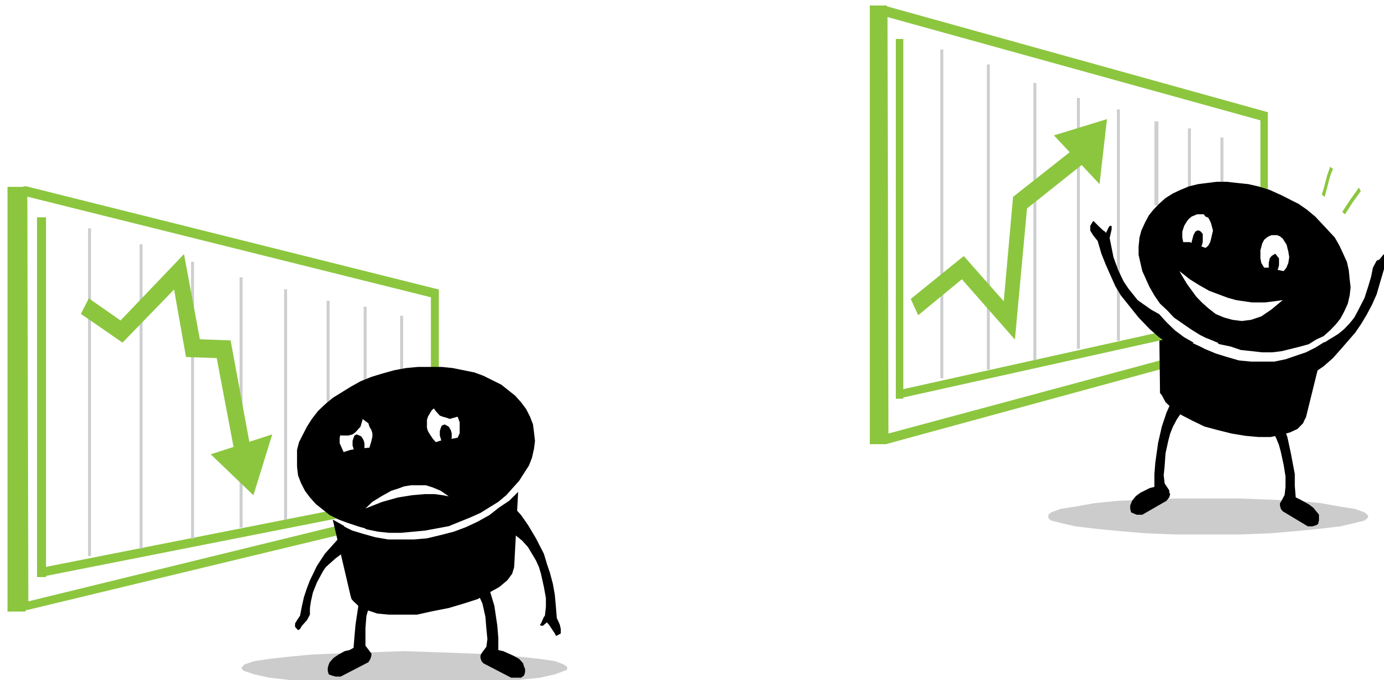


Figure 2; Framework for Pursuing Perfection, Institute of Medicine's March Report 2001, Across the Quality Chasm, presented by Dr Donald Berwick IHI Conference November 2001

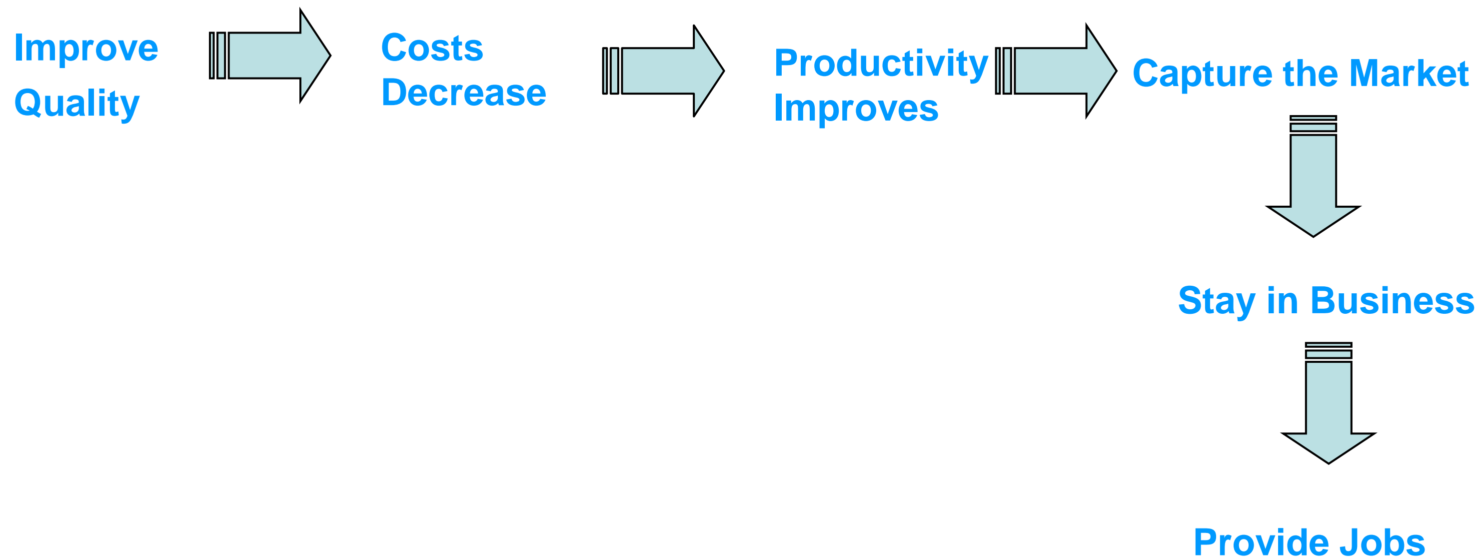
Using Information to Understand System Variation and its Impact on Service Delivery



Curious Questions

Deming’s Chain Reaction

In 1950 Dr W E Deming used the diagram below to describe to his students the benefits of building quality into the system



The organisation that seeks to decrease costs, improve quality – without first building quality into the systems- is gambling long term survival for – at best – short term gains.

What Does it Mean for Me/ My Team/ My Organisation?

- Start by understanding your system – is ordinary ok?
- Look at some patient notes – what does it tell you?
- Ask your staff if they feel the work processes assure safety
- Is it easy for agency staff to come into the organisation and work safely?
- Observe the clinical areas; talk to patients about their experiences
- Have lessons from incidents near misses been learnt? or re they repeated?
- Is technology used to help safety?
- Is the patient involved in assuring the safety of their care?
- Is it easy for staff to get it right? Or easier to get it wrong?

Remember

You will never solve the problem with the mindset that created it