Transforming Organisational Safety Culture

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UHCW Improvement System

Education

Service Improvement
Service Improvement

• Value Streams
  – Patient Safety
  – Theatres
  – Ophthalmology outpatients
  – Pre-op
  – Simple discharge

• Rapid Process Improvement Workshops (RPIW)
Rapid Process Improvement Workshops (RPIW)

- Five-day workshop facilitated by the Kaizen Promotion Office – created during our partnership with Virginia Mason Institute.
- People who do the work are empowered to eliminate waste and reduce the burden of work.
- A team of staff from all levels who are involved in the process.
- A process owner and a sponsor.
- A patient partner.
Patient Safety Incidents

“some staff did not feel confident in completing incident reports and said they did not always get feedback”

“action plans following investigations were not always completed in a timely manner” (Mar 2015)

NRLS - lowest 25% of reporters (Apr–Sep 2016)

“Faults in trust investigation of brain surgery deaths”

NHS Staff Survey evaluation of fairness and effectiveness of incident reporting in 2016
RPIW outputs

- Clinician designed incident form
- Patient Safety Huddles
- Patient Safety Response
- Revised SI Process & Learning Teams
Clinician designed incident form

Old form 8 minutes

New form 3 ½ minutes
Benefits of the new form

• Flows logically for clinical staff
• Removed unnecessary fields
• Removed ambiguity
• Level of harm entered at time of incident entry
Patient Safety Response (PSR)

- multi-professional team: nurse, doctor and patient safety team
- attend clinical areas where moderate harm (or above) has occurred:
  - Is the patient and area safe?
  - Are staff supported?
  - Has Duty of Candour notification occurred?
  - Why did it happen and what investigation is required?
Patient Safety Response (PSR)

Benefits:

• Reduced time to commence investigation
• Swifter and more thorough DoC notification
• Better decisions about investigations
• Support for staff – positive feedback
Patient Safety Huddle

UHCW Patient Safety Huddle

Standard Work

A daily multi-disciplinary safety huddle will be run utilising DataX reports to discuss safety incidents in the past 24 hours. These will help identify any immediate lessons that can be learnt to protect our patients and staff.

Standard questions to ask:
1. What happened yesterday?
2. What went well?
3. What did not go well?
4. What are we going to do differently today?

A weekly safety huddle will be run to identify common lessons and themes from incidents that may become risks. This will also provide a wider forum to discuss solutions and share successes where lessons have protected patients and staff.

Standard questions to ask:
1. What are the themes and trends?
2. Should anything be escalated for the risk register?

For more information, contact the Patient Safety Team on extension 25176.

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Serious Incident Investigation Process

• Immediate initial response – secure key data
• Support staff through process
• RCA and Learning Team as parallel processes
• Fewer investigators with enhanced training
• Concise, plain English report
• SMART Actions
Human Factors and RCA investigation eLearning

Incident Investigator Training

Report Writing

Many organisations provide a standardised template for incident reports. A good report should be concise, and contain an overview of the events, the contributory factors and clear root cause statements.

Every detail in the report needs to contribute to identifying the root cause(s), or ruling out other possibilities.

Objective, non-judgemental language should be used throughout.

If supporting evidence or documentation is included it should be de-identified and included as an appendix rather than in the body of the report.

An effective report provides clear justification for the Action Plan that results from it.
Quality Department

Duty of Candour

Information for patients who may have been involved in a Duty of Candour safety incident that has caused them harm.

We are sorry that you may have been subject to an incident that has caused you harm while in our care.
Learning teams

• Learning teams allow staff who are involved in an incident to develop solutions to it

• Two facilitated workshops attended by the multi-professional team:
  – The first session maps out the process and identifies what could go wrong. Followed by soak time: a period of reflection
  – The second workshop brings the team back to explore solutions and develop a plan for fixing the process
Other methods of learning

• Weekly safety messages
• Incident dashboards
• Incident reporter emails
• Grand Round
• Learning library
• Junior doctor presentations
Weekly Safety Message

• Rapid, brief summary of topical safety issues
• Distributed to: Doctors in Training, Consultants, CDs, ADNs, Matrons, Ward Managers, Ops team, GMs, Trust Board members
• >140 Messages distributed
• Messages included on Datix dashboards and QIPS reports

Archive available online
Incident Dashboards & feedback

Response to reporter Letter

Thank you for embracing the Trust Values by submitting the above incident form regarding the following:

Details of Incident HERE

We have reviewed your form and believe that the following learning is going to improve the safety and experience for patients.

Lessons Learned HERE

Should you require any further information about this incident please contact the Quality Department on extension 25172 quoting your reference number.
# Shared Learning Hub

**Incident Summary:**

**Incident ID:** SSQ 1215
**Date of Incident:** 14/11/2016
**Relevant Specialties:** Neurosurgery, General Medicine and Critical Care
**Relevant Staff:** Various Staff Members

**What Happened:**

- Patient developed DKA due to staff not providing patient's usual insulin regime.

**Lessons from the Investigation:**

- For those patients who have been admitted with raised BMI - this must be explored and reflected in medical plans.
- BMI charts to be commenced with all patients who have been admitted with raised BMI.
- Glucose tests to be done, where patient presents with high sugars.
- Handover and referral processes require improvement and evidence they have been acted upon.
- Improve documentation of observations and acting on them appropriately.

**What Actions Do I Need to Take?**

- Proposal for remote glucose monitoring to be implemented. This will flag up high blood sugars to the diabetes team in patients with diabetes.
- Key learning points to be disseminated as a safety alert to the Trust.

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**Further Reading**

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### Morbidity Scorecard

**Morbidity Specialty Scorecard**

Please select Financial Year: 2017/18  
Select Treatment Specialty: Breast Surgery, Cardiac Surgery

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**UHCW - Morbidity Register for Surgical Specialties**

Click on the Information Icon to see the definition

Click on this for Surgical Specialties Included

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Evaluation
Patient Safety Incidents per 1,000 bed days

- Critical care pilot

Graph showing the number of patient safety incidents per 1,000 bed days from October 2015 to March 2018.
PSR Feedback

“The information was still in mind and not lost in time, the staff involved although nervous felt it positive and constructive.

Given the complexity of this incident I know we were all worrying, bringing us all together so quickly was perfect.”

“The team were easy to talk to, supportive and enabling honest conversations”

“As a team we feel more confident in our actions and also they nor I have to spend weeks worrying about it.”

“Staff who were involved with [my husband’s] care were wonderful. We were kept up to date. The lead nurse was wonderful. She was very caring and gave us a leaflet and told us everything.”

Patient's relative

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Effectiveness of actions

The Hierarchy of Intervention Effectiveness

Source: Joseph A. Cafasso and Olivier St-Cyr. Healthcare Quarterly, April 2012: 24-29. doi:10.12927
Average number of actions per investigation

- Traditional RCA method:
  - People focused: 3
  - System focused: 1

- RCA with Learning Team:
  - People focused: 4
  - System focused: 5
Results: no longer ‘waiting to learn’

Overdue Serious Incident Investigations

Number of overdue actions from Serious Incidents

Source UHCW Trust data April 2018
Top 20% of trusts

Statistically significant increase

Source NHS National Staff Survey 2017
Summary

We are improving patient safety culture by:

• Viewing the process form the patient perspective
• Respecting, involving and empowering clinical staff
• Challenging existing methods and testing new ideas
• Making this a part of Executive & Board ‘gemba rounds’
• We are committed to continuous improvement