Patient Safety Conference

Tuesday 23rd April 2019

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SALFORD PROFESSIONAL DEVELOPMENT

Conference Coordinators:
Chris Reynolds,
Sarah Scanlon &
Kerrie Madden

Chair:

Dr Aled Jones, Reader: Patient Safety and Healthcare Quality, University of Cardiff

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Chair

Dr Aled Jones

Reader: Patient Safety and Healthcare Quality, University of Cardiff

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Helen Hughes

Chief Executive,

Patient Safety Learning

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Neal Jones

Assistant Director of Patient Safety (Human Factors),

Royal Liverpool and Broadgreen University Hospital NHS Trust

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Human Factors and Patient Safety

Patient Safety Conference
23rd April 2019

Neal Jones – Assistant Director of Patient Safety & Human Factors

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Clinical Human Factors

Enhancing clinical performance through an understanding of the effects of teamwork, tasks, equipment, workspace, Culture and the organisation on human behaviour and abilities, and application of that knowledge in clinical settings

Ken Catchpole, CHFG

The Royal Liverpool and Broadgreen University Hospitals NHS Trust

RLBUHT Human Factors Strategy 2017-2020

Enhancing Safety, Efficiency and Effectiveness

February 1, 2017

Authored by: Neal Jones - Assistant Director of Patient Safety (Human Factors)

RLBUHT Human Factors Strategy 2017-2020

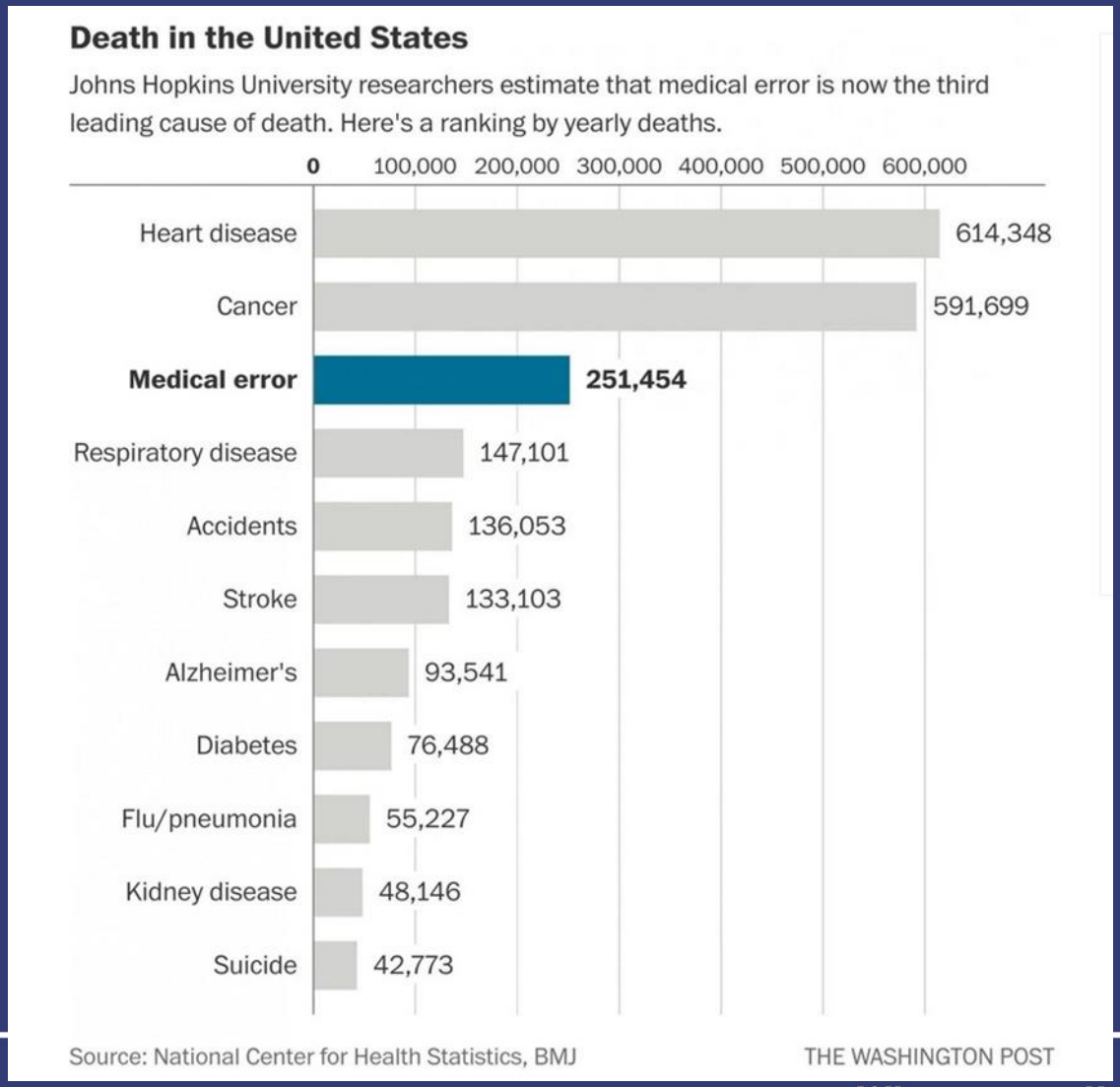
Enhancing Safety, Efficiency and Effectiveness

Contents

- **Why Human Factors**

It is estimated that at least 80% of errors are attributable to human factors at individual level, organisational level, or more commonly both

NPSA 2008


Death in the United States
Johns Hopkins University researchers estimate that medical error is now the third leading cause of death. Here's a ranking by yearly deaths.
0
100,000
200,000
300,000
400,000
500,000
600,000
Heart disease
614,348
Cancer
591,699
Medical error
251,454
Respiratory disease
147,101
Accidents
136,053
Stroke
133,103
Alzheimer's
93,541
Diabetes
76,488
Flu/pneumonia
55,227
Kidney disease
48,146
Suicide
42,773
Source: National Center for Health Statistics, BMJ
THE WASHINGTON POST

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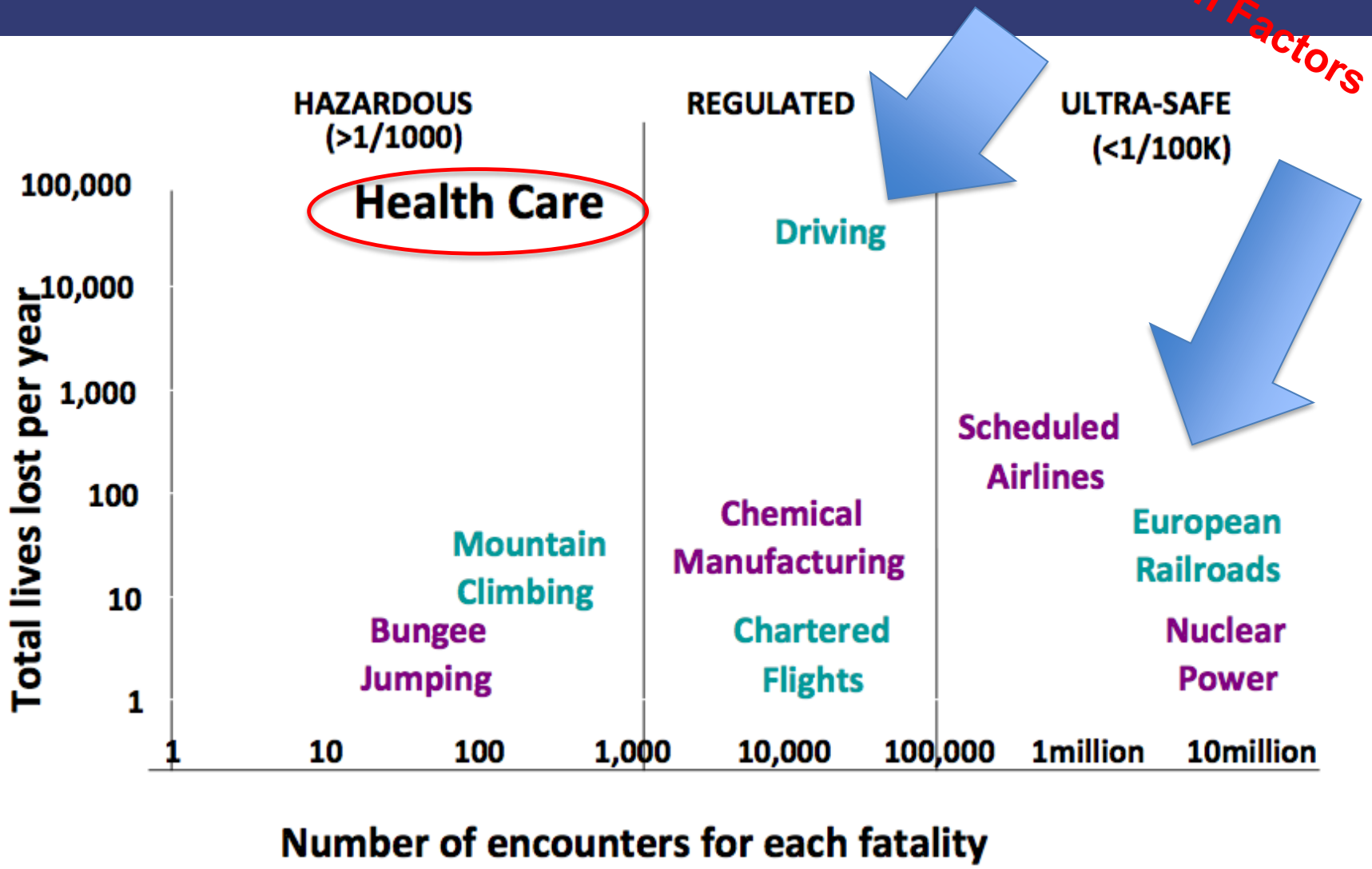

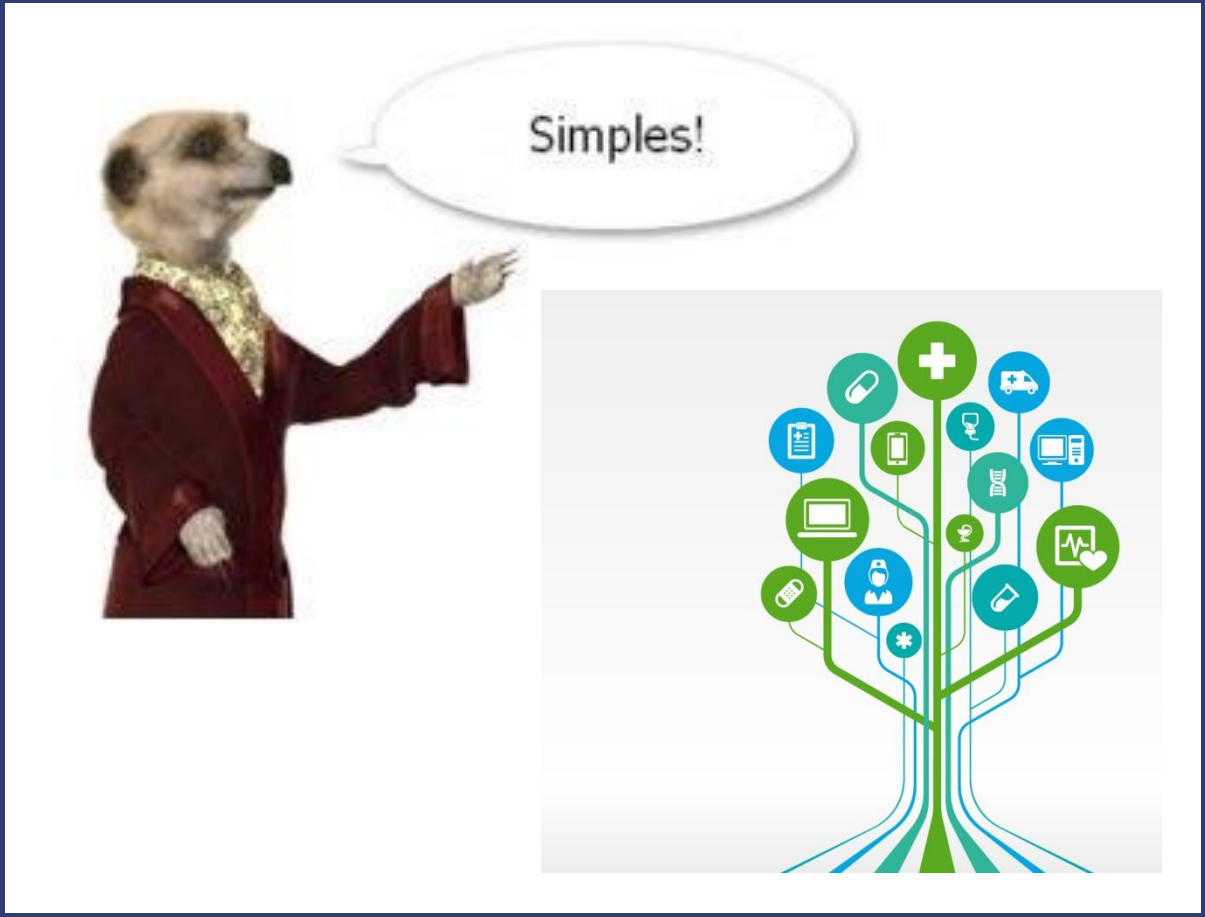
Simples!

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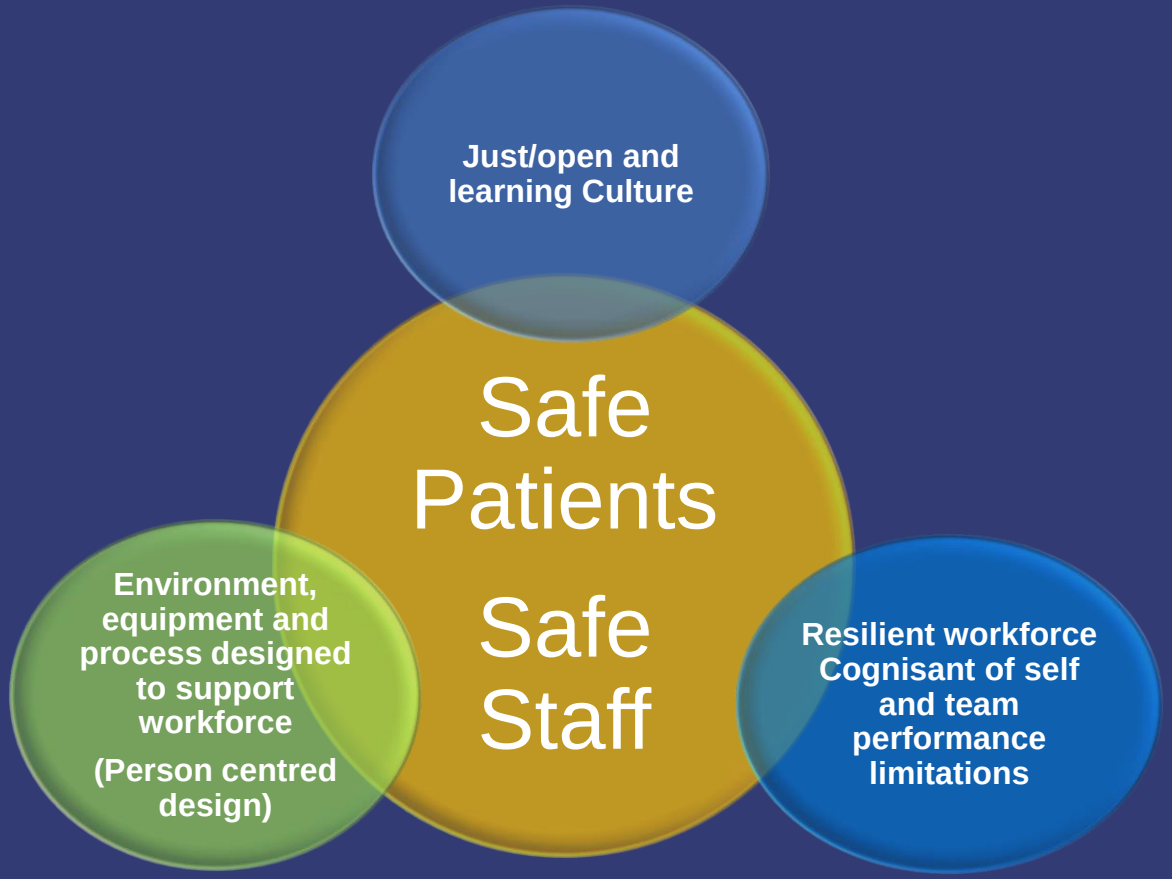
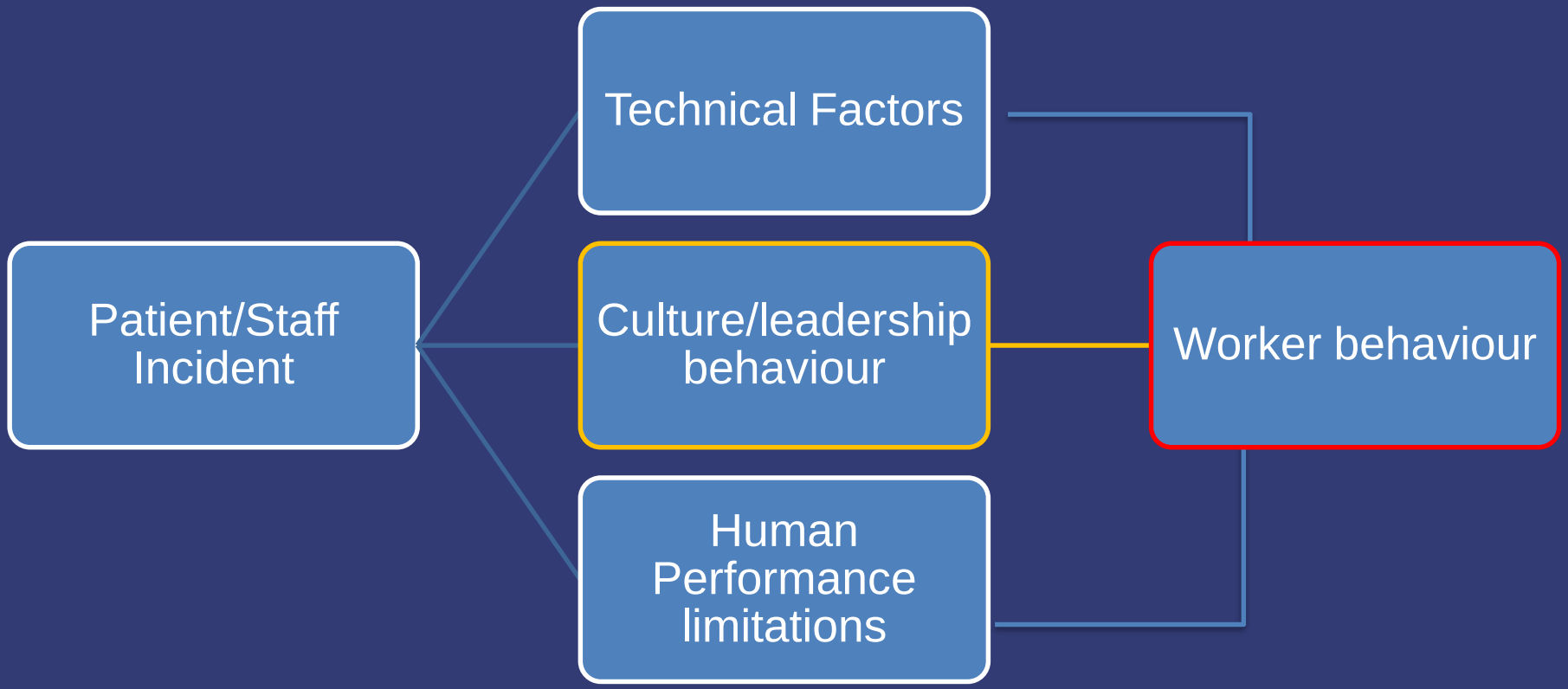
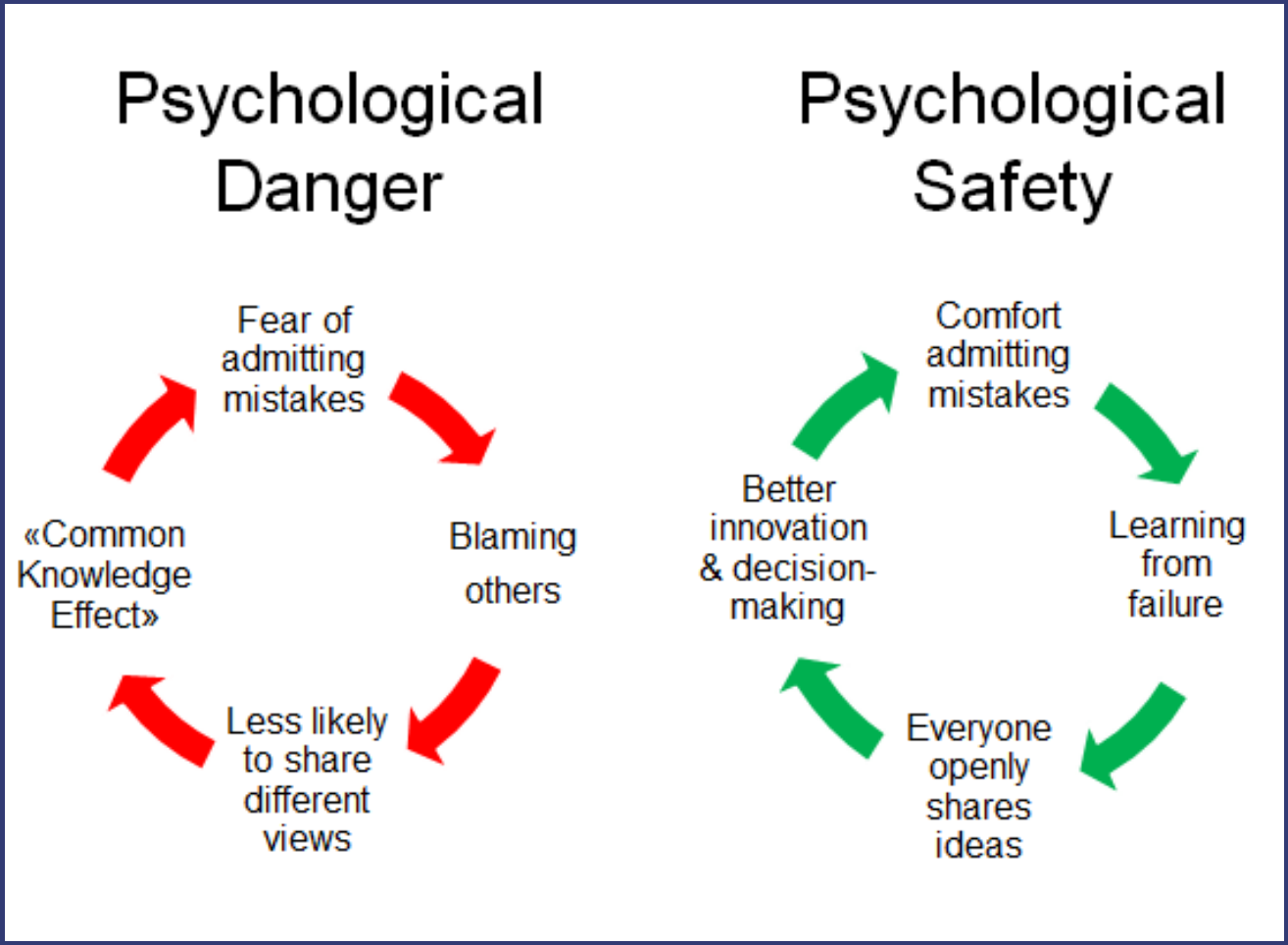
An Integrated Model for Human Factors




Technical Factors
Patient/Staff Incident
Culture/leadership behaviour
Worker behaviour
Human Performance limitations


Psychological Danger
Fear of admitting mistakes
Blaming others
Less likely to share different views
«Common Knowledge Effect»
Psychological Safety
Comfort admitting mistakes
Learning from failure
Everyone openly shares ideas
Better innovation & decision-making

1. Defensive cultures and lack of trust

NHS Improvement

Human error is normal and predictable, and as a result it can be identified and managed.

The likelihood of human error is determined by the condition of a finite number of 'performance influencing factors'.

Investigations often stop at who did or didn't do something and actions are directed at individual staff = blame culture.

"Despite pockets of best practice… incident investigation … falls far short of what patients, their families, clinicians and NHS staff are entitled to expect. A culture of defensiveness and blame, rather than a positive culture of accountability, pervades much of the NHS."

Public Administration Select Committee, Investigating clinical incidents in the NHS, Sixth Report of Session 2014–15 (p54)

http://www.hse.gov.uk/humanfactors/topics/humanfail.htm

- Why don't staff just follow policy/process?
  - Do things the right way first time?
  - And then every time?

Main Theatre LocSSIP Form Specialties

Operation Date	Activity	Anaesthetic Room Sign In Forms Created	Operating Room Care Plan Timeout Forms Created	Operating Room Care Plan Sign Out Forms Created
01/04/19	44	100.0%	100.0%	100.0%
02/04/19	58	100.0%	100.0%	100.0%
03/04/19	52	98.1%	100.0%	100.0%
04/04/19	45	100.0%	100.0%	100.0%
05/04/19	52	100.0%	100.0%	100.0%

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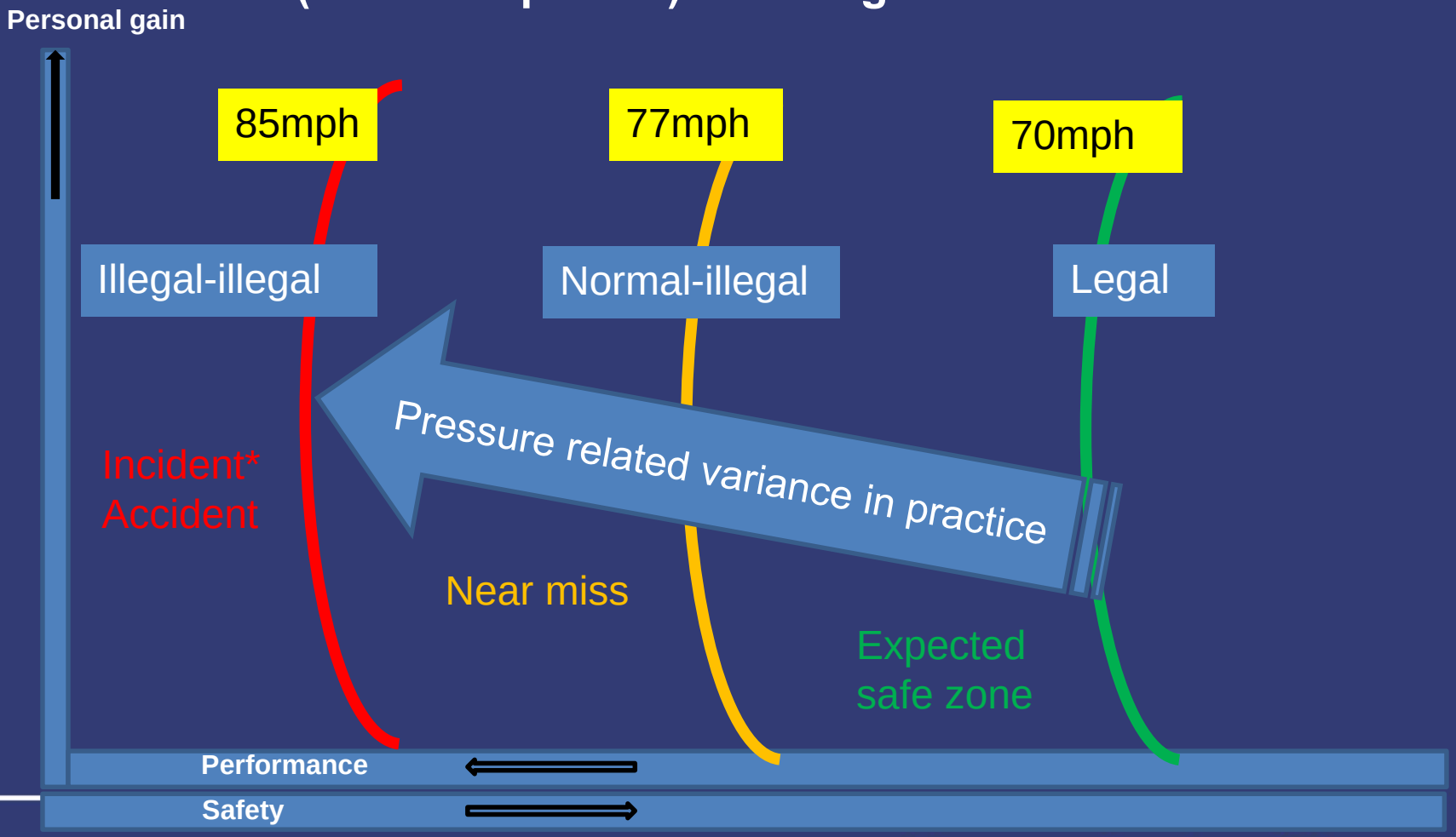
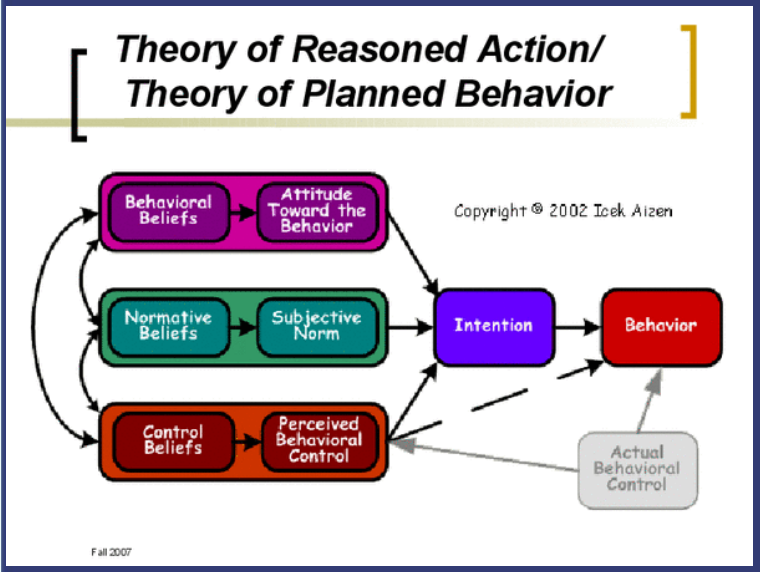
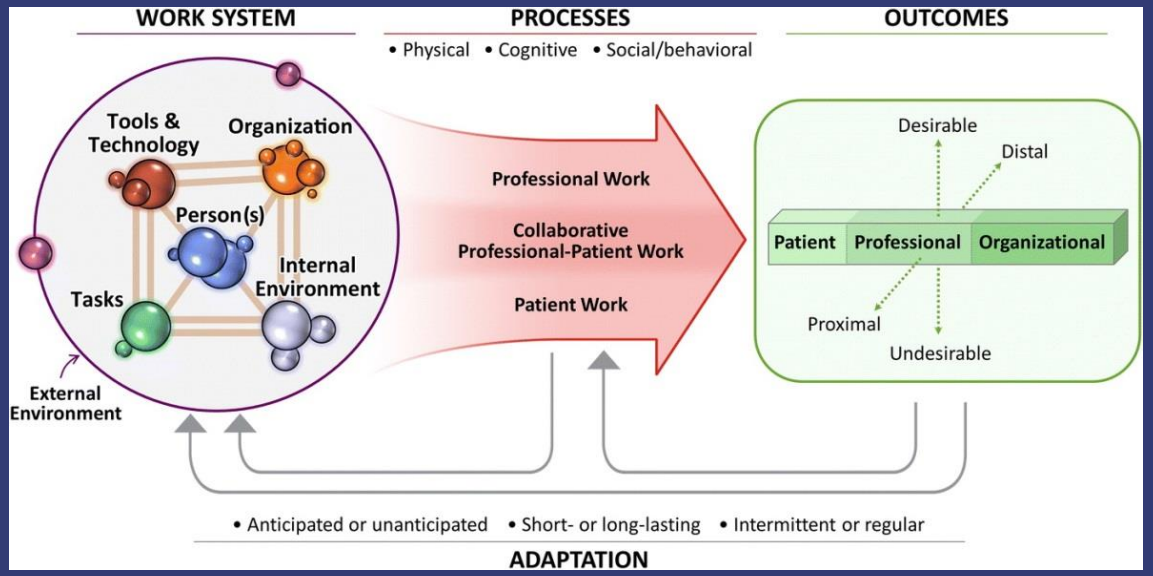
Amalberti – Model of migration and transgression (Risk acceptance) – Driving version



Where we all make a difference

- Examples of a Human Factors approach to designing in reliability





25% of Vanmoof's bikes were damaged in transit and returned to the manufacturer as faulty

How would you tackle this problem?

Televisions had the lowest damage rates of any goods in transit

Vanmoof simply created the illusion of a TV inside their box and the damage rates reduced by 80%

- A member of staff inputs the incorrect rate of administration into an IV pump and the medication is administered significantly faster than would be considered safe.

- Px = 125mls/hr Error = 785mls/hr

- ?? Careless
- ?? Reckless
- ?? Training issue
- ?? Competence issue

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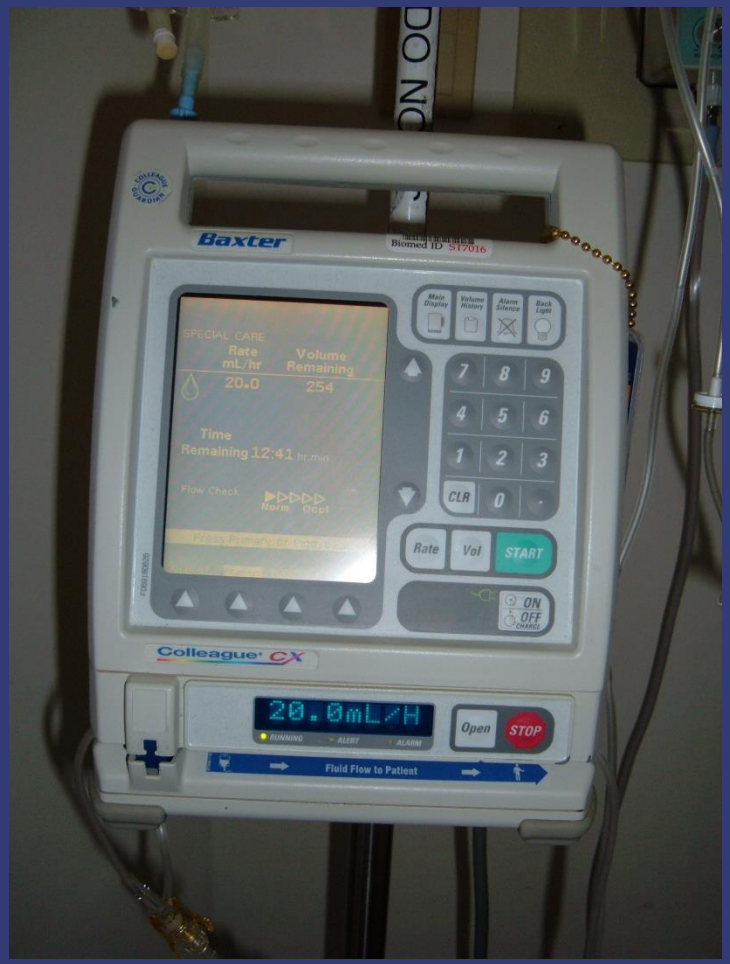

Where we all make a difference

- A member of staff accidently administers protamine(blood clotting agent) instead of heparin (blood thinning agent) leading to serious patient harm

- Careless?
- Reckless?
- Checking process deviated from Policy?
- Distracted?

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Where we all make a difference

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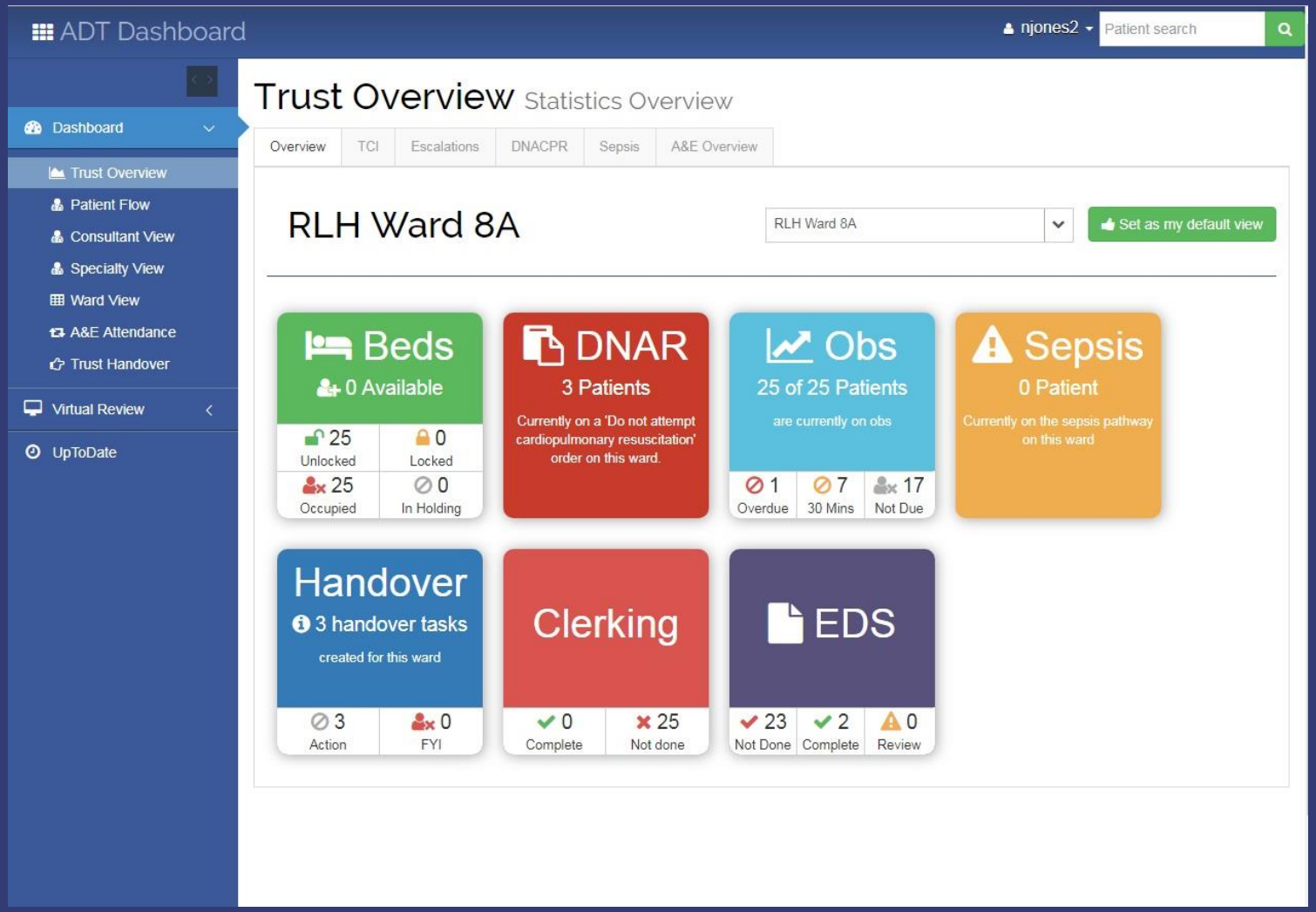

Where we all make a difference

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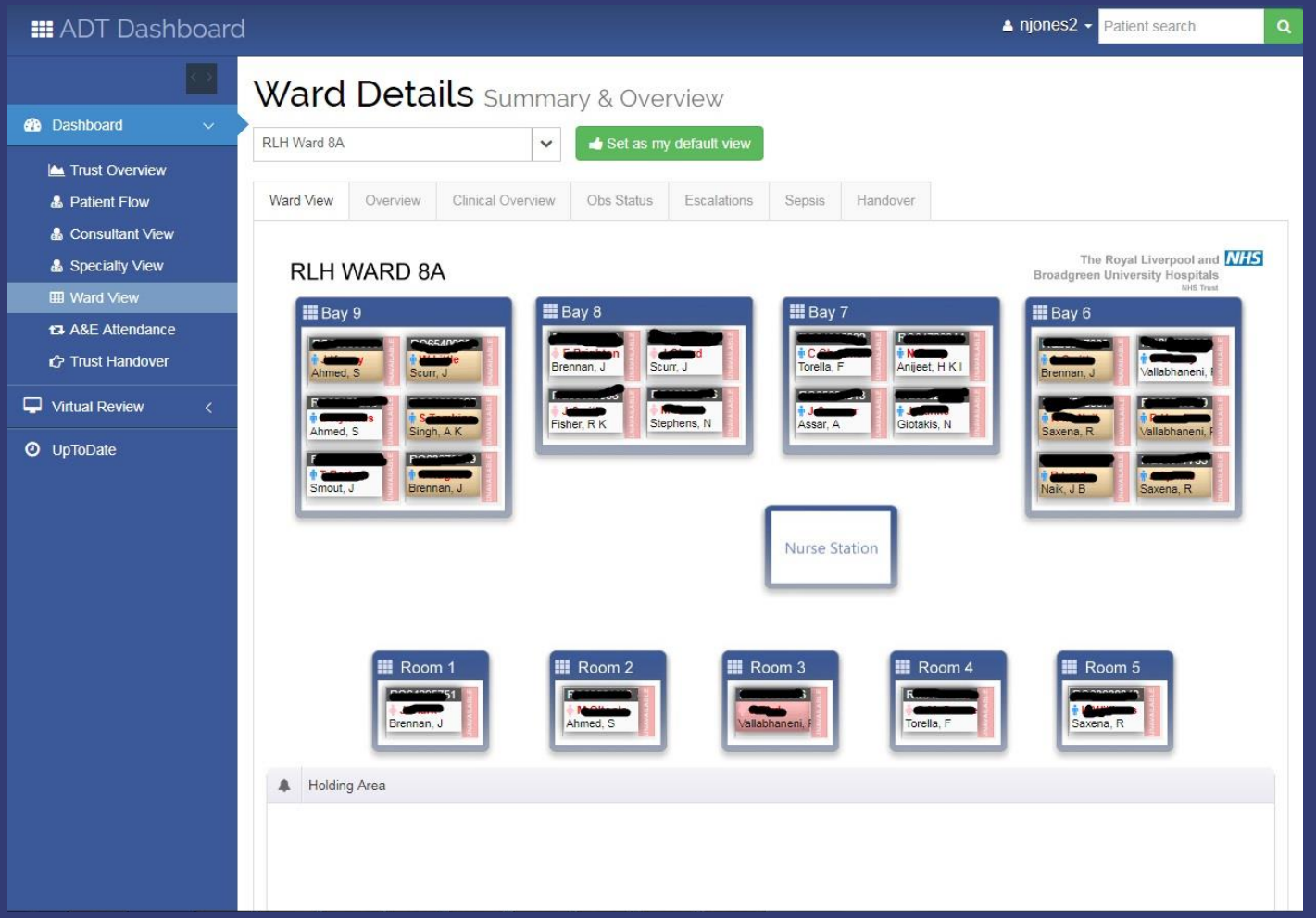
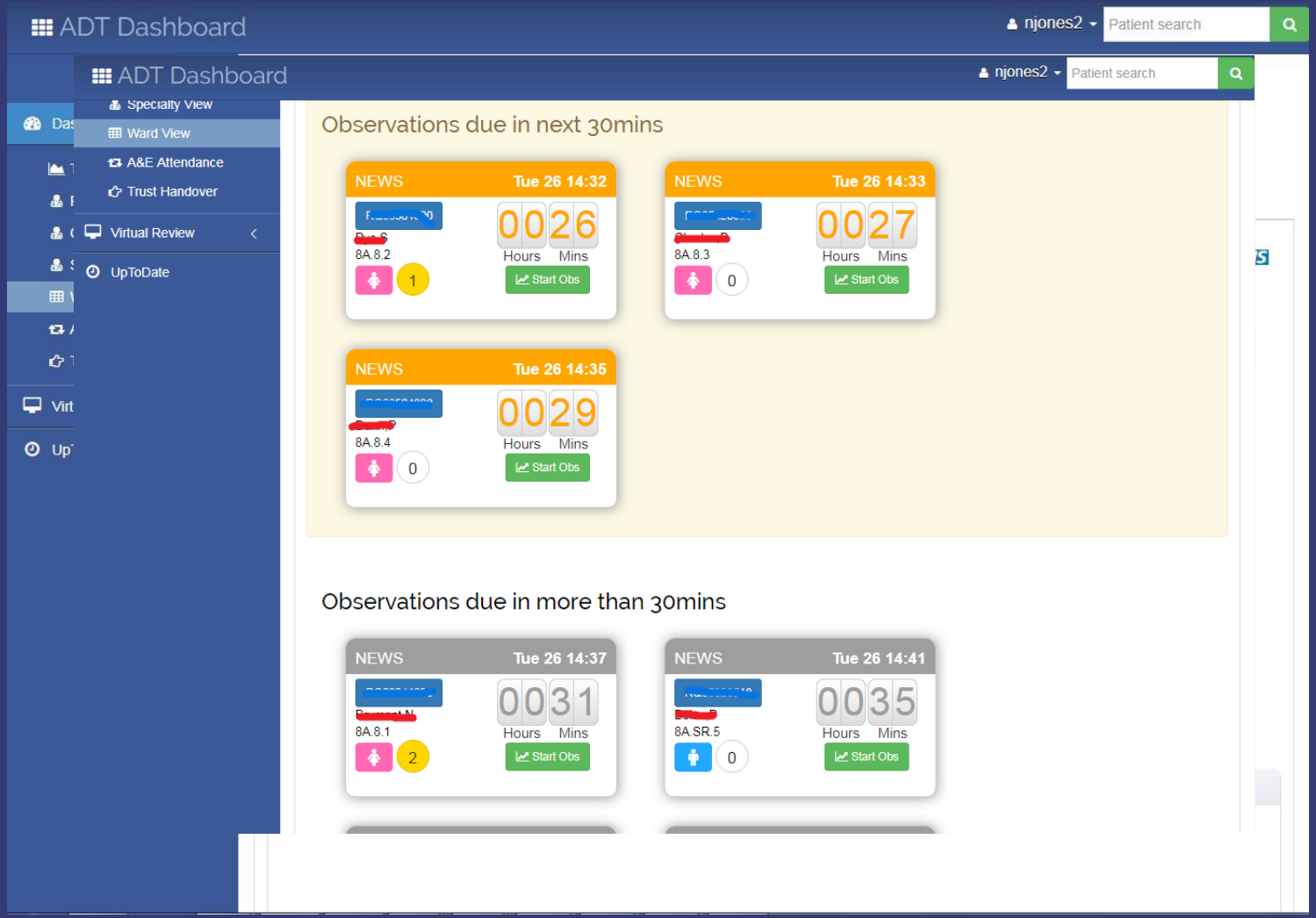


Where we all make a difference


ADT Dashboard
njones2
Patient search
ADT Dashboard
njones2
Patient search
Specialty View
Ward View
A&E Attendance
Trust Handover
Virtual Review
UpToDate
Observations due in next 30mins
NEWS Tue 26 14:32
8A.8.2
0026
Hours Mins
Start Obs
NEWS Tue 26 14:33
8A.8.3
0027
Hours Mins
Start Obs
NEWS Tue 26 14:35
8A.8.4
0029
Hours Mins
Start Obs
Observations due in more than 30mins
NEWS Tue 26 14:37
8A.8.1
0031
Hours Mins
Start Obs
NEWS Tue 26 14:41
8A.SR.5
0035
Hours Mins
Start Obs

- Effectors of Human Performance

- Fatigue
- Stress
- Errors of perception

- Error is inevitable in an industry as complex as healthcare
- Managing/Supporting human performance will help determine the frequency within which errors occur (Creating the conditions for success)

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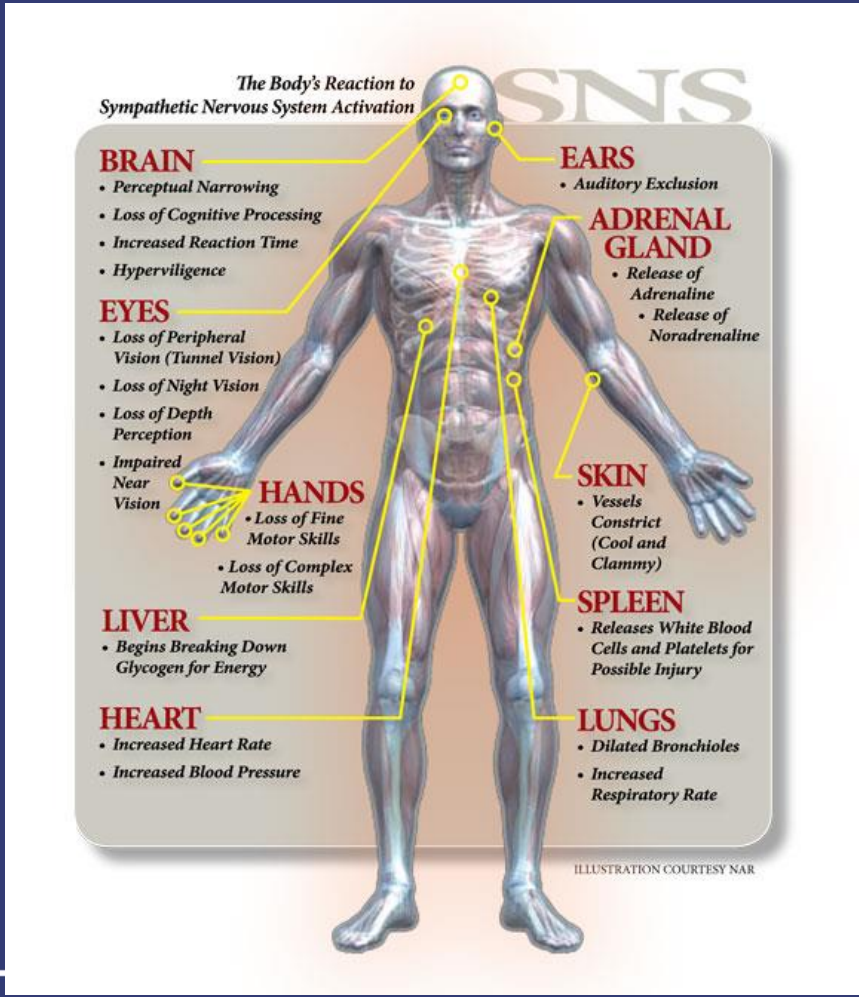
Key messages

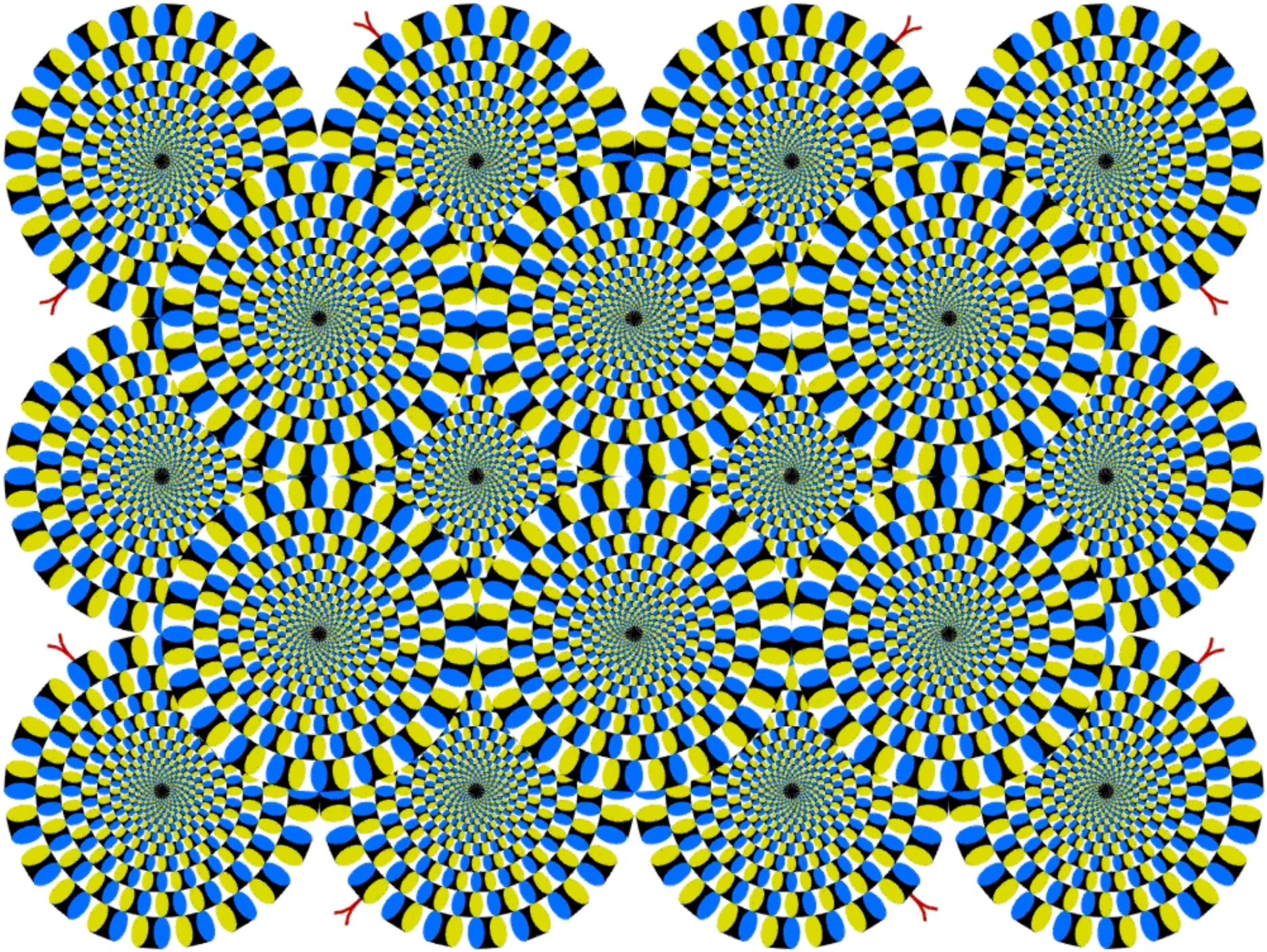
- Doctors (and other clinical staff) are regularly exposed to patterns of work, or specific factors, that can lead to poor quality sleep, and which increase the risk of fatigue.
- They are routinely and increasingly working long hours, with the longer the hours worked, the greater the risk of fatigue. There is some consensus from studies looking at different types of shift worker that longer shifts (12 hours or more) are associated with 25-30% higher risk of accidents or injuries than an 8-hour shift.

BMA Jan 2018 **Fatigue and sleep deprivation – the impact of different working patterns on doctors**

- Stress


The Body's Reaction to
Sympathetic Nervous System Activation
SNS
BRAIN
• Perceptual Narrowing
• Loss of Cognitive Processing
• Increased Reaction Time
• Hyperviligence
EYES
• Loss of Peripheral Vision (Tunnel Vision)
• Loss of Night Vision
• Loss of Depth Perception
• Impaired Near Vision
HANDS
• Loss of Fine Motor Skills
• Loss of Complex Motor Skills
LIVER
• Begins Breaking Down Glycogen for Energy
HEART
• Increased Heart Rate
• Increased Blood Pressure
EARS
• Auditory Exclusion
ADRENAL GLAND
• Release of Adrenaline
• Release of Noradrenaline
SKIN
• Vessels Constrict (Cool and Clammy)
SPLEEN
• Releases White Blood Cells and Platelets for Possible Injury
LUNGS
• Dilated Bronchioles
• Increased Respiratory Rate
ILLUSTRATION COURTESY NAR

- Situational awareness (errors of Perception)



- Are you good with number’s ?? 1 2 3 4 5 6 7 8 9

NHS

Can you find the the mistake?

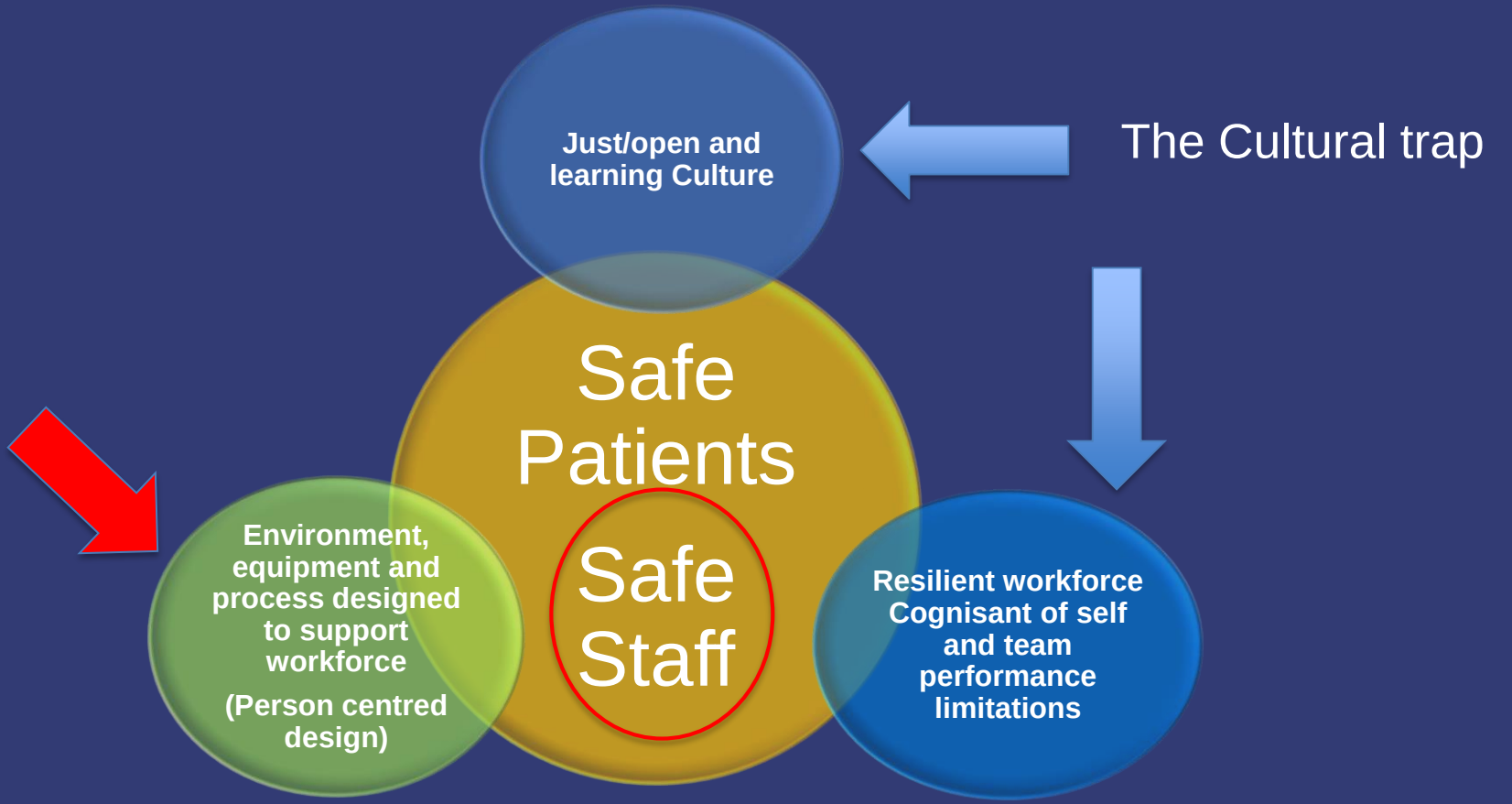
1 2 3 4 5 6 7 8 9 10

Put your hand up if you found it

- Human Factors based education
- Does it make a difference ?

Resilient workforce Cognisant of self and team performance limitations

An Integrated Model for Human Factors



- Thank you for Listening
- Questions?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Coffee and
Networking Break
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Kathryn Whitehill

Principal National Investigator,

Healthcare Safety Investigation Branch

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Please proceed to your seminar choice

Seminar A

The Relationship between Quality Improvement and Patient Safety

Gloucestershire Safety and Quality Improvement Academy

Room

Seminar B

Learning from Deaths

Clare Wade, Programme Manager National Morality Case Record Review and Patient Safety, Royal College of Physicians

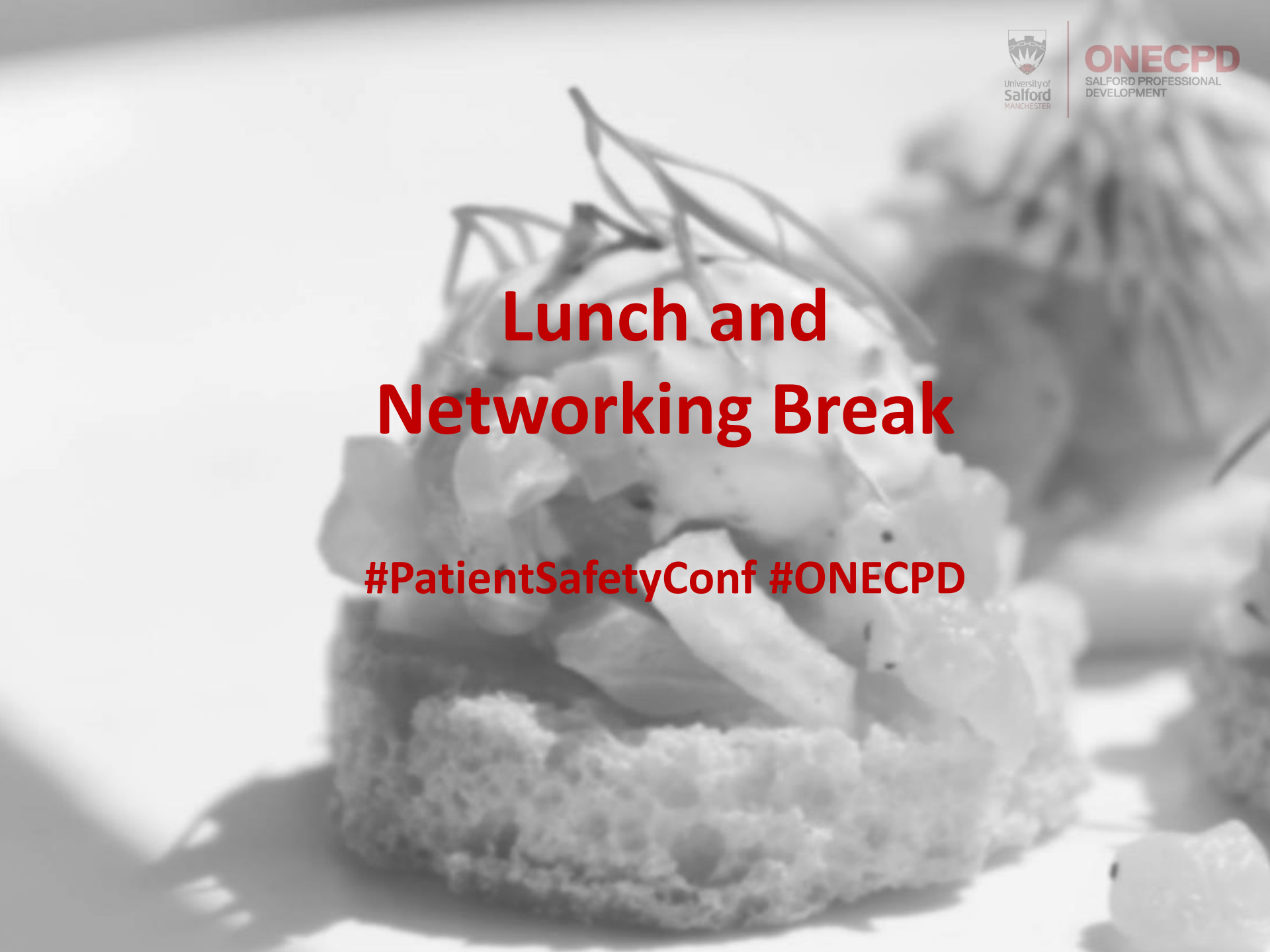
Room

Seminar C

Neonatal and Maternal Patient Safety

Mandy Townsend, Associate Director, Patient Safety, Innovation Agency – North West Coast

Room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Lunch and Networking Break
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Please proceed to your seminar choice

Seminar D

Patient Safety Collaborative: The Value of Partnership

Ursula Clarke, Patient Safety Lead / Senior Programme Manager, Kent Surrey Sussex Patient Safety Collaborative

Room

Seminar E

Patient Safety in Primary Care

Dr Alison Cooper, GP and Clinical Research Fellow, University of Cardiff

Room

Seminar F

Medicines Safety

Jay Hamilton, Associate Director of Health and Implementation, Health Innovation Manchester

Room

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Christine Burkett

Head of Area (North West),

Skills for Care

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Safety in Social Care

Christine Burkett
Head of Area (NW)

Skills for Care - Who we are and what we do

Our Focus is Workforce Development

- Recruitment and Retention
- Learning and Development
- Leadership and Management
- We provide practical resources to support adult social care employers develop their workforce

What is Adult Social Care?

Adult Social Care works with those who need care and support with daily living, ensuring they have the best quality of life possible.

It is underpinned by two key values: that everyone has the right to

- Have choice and control over their own lives
- Be treated with dignity and respect at all times

It is not just about health – an important difference

Who are we working with?

Adult Social Care works primarily with people who have

- Physical disability
- Learning disability
- Mental health issues
- Frailty or infirmity relating to age
- Drug and/or alcohol dependency

Who are likely to have increased health needs – an important similarity

Where does social care happen?

- In people's own home or the homes of others
- Care Homes
- Care Homes with Nursing

Homes not hospitals – another important difference

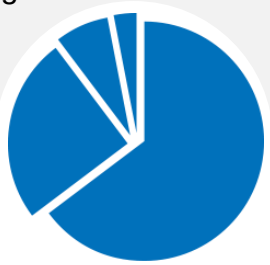
Establishment type

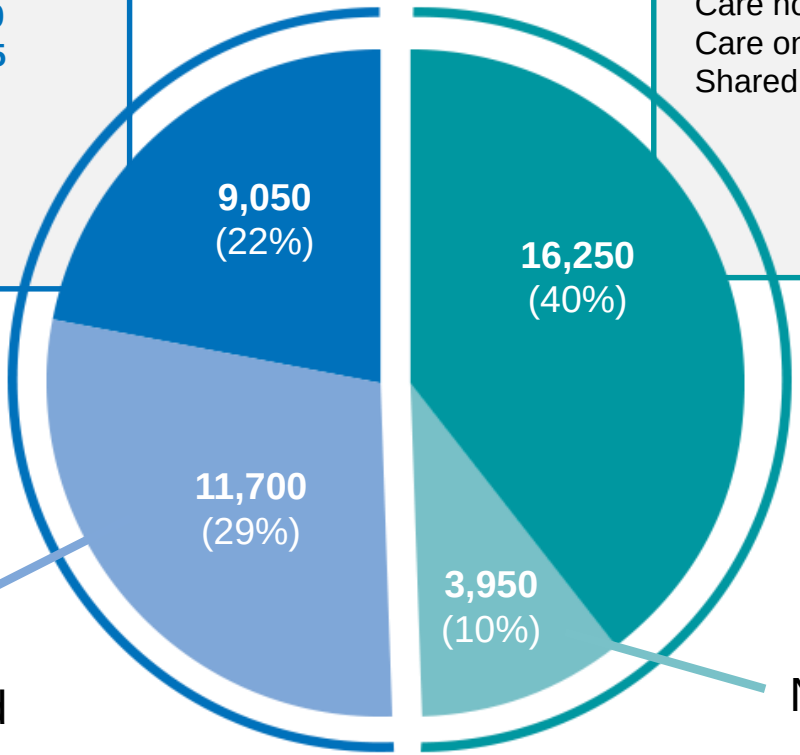
CQC regulated

Domiciliary care services - **8,500**
Supported living services - **1,725**
Extra care housing services **500**
nursing agencies - **200**

CQC regulated

Care homes with nursing - **4,450**
Care only homes - **11,650**
Shared lives services - **135**





Non-residential
20,800 (51%)

Residential
20,200 (49%)

Non-CQC regulated

Non-CQC regulated

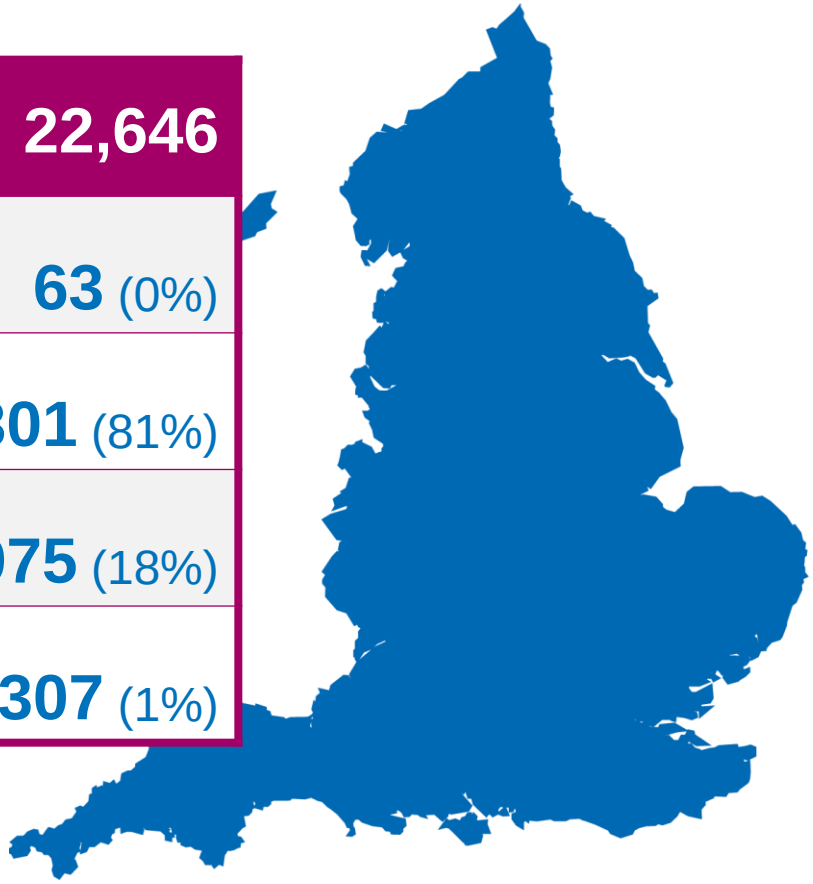
Source – The size and structure of the adult social care sector and workforce in England 2018

What are the key safety concerns in social care?

- Safeguarding
- Risk
- Safe staffing
- Medication
- Infection control
- Learning from practice

KLOE - Safe

Total number of inspections	22,646
Outstanding	63 (0%)
Good	18,301 (81%)
Requires improvement	3,975 (18%)
Inadequate	307 (1%)



Where are we now?

Safeguarding

In 2017/18

- The number of concerns of abuse raised was up by 8.2%
- The number of safeguarding enquiries was down 0.7%
- Section 42 enquires fell by 1.1%
- Older People were more likely to be the subject of Section 42 enquiries
- Most common location of risk was in the person's own home

Employers

21,200
organisations

41,200
establishments

240,000
direct payments

Source – The size and structure of the adult social care sector and workforce in England 2018

What are we doing to improve?

- Nationally: Quality Matters
- Commissioners: Quality improvement initiatives and quality teams
- Providers: Outstanding Society
- Skills for Care: Good and Outstanding Range
  Registered Managers Networks

Collaboration

- Why is collaboration important?
- Who needs to collaborate?
- Building Trust
- Examples of good collaboration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Dr Susan Hrisos

Senior Research Associate,
Institute of Health and Society,
Newcastle University

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ThinkSAFE.
Be safe.

Engaging Patients to Help Improve Quality and Safety

Dr Susan Hrisos
Senior Research Associate

Professor Richard Thomson
Professor of Epidemiology & Public Health
Dr Anu Vaittinen
Research Associate

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NORTH EAST AND NORTH CUMBRIA

NIHR | School for Primary Care Research

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Be safe.

Learning from patient experience to improve safety & increase consistency

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Research shows that patients:

- Can be **vigilant partners** in their healthcare
- Who are **informed & involved** in their care can experience more **satisfying & safer** healthcare
- Are **willing and able to help** improve patient safety by taking on a more active role
- Need their involvement endorsed and **encouraged by the staff** providing their care

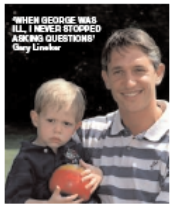
Its not what you do, it's the way that you do it

ThinkSAFE. Be safe.

Please ask

TOP TEN TIPS FOR SAFER PATIENTS

- Find out all you can about your condition or treatment. Ask questions and look for other sources of information, such as on the internet or at the library.
- Ask the doctor or nurse to explain all the treatment options that are open to you, including any potential risks.
- If you're not quite sure what a doctor or nurse is saying, ask them to repeat it. Staff are always happy to explain medical terms in everyday language.
- If you're allergic to anything – or have reacted to a medicine or anaesthetic in the past – make sure your doctors, nurses and pharmacist know about it.



- Always read the instructions. Medication comes with a leaflet that explains how to take it and possible side-effects to watch out for. If it's not clear, ask your pharmacist, doctor or nurse.
- If you or your child are going to have an operation, check all the details on the consent form are correct before you sign it.
- When a family member or friend is in hospital and has trouble speaking for themselves you can ask questions for them.

The National Patient Safety Agency (NPSA) helps the NHS learn from its mistakes so that it can improve patient safety. It does this by collecting reports on errors and other things that go wrong in healthcare so that it can recognise national trends and introduce practical ways of preventing problems.

The NPSA doesn't investigate individual cases or complaints, but it does listen to public concerns and use what you say to im... could help to prevent t... to other people.

Visit www.npsa.nhs.... you can help the NPSA ... place for patients. You ... organisations that can ... complaint about your ...

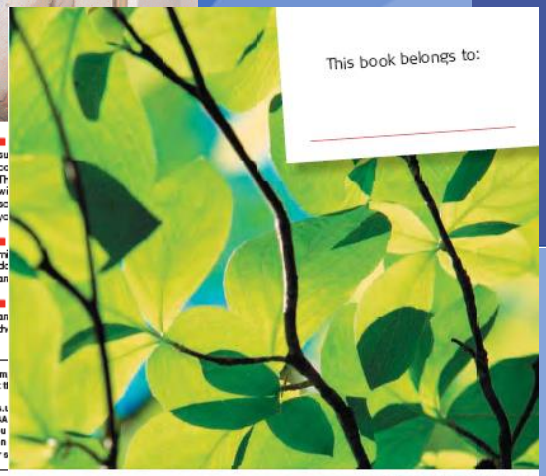
SpeakUP™

To prevent health care errors, patients are urged to...

SpeakUP™

Help Prevent Errors in Your Care

This book belongs to:



Patient Handbook

A patient's guide to a safer hospital stay

Welcome to your **Clean Hands Partner** hospital. This hospital has been chosen as a partner because **all our staff** take infections seriously and are committed to keeping you, our patients, as safe and healthy as possible. This leaflet tells you more about infections and the clean**your**hands campaign for hand hygiene, and invites **you** to be ***our*** **partner** while you are here.

What causes infections? Infections are never caused by dirt – they can be caused by viruses, but mostly by 'bugs' or germs called bacteria that occur naturally all around us. They are sometimes on our skin, and even in our mouths and noses. Most of them don't do us any harm.

But when we are not well or after an operation, our bodies' natural defences are weaker, so more care is needed to protect us. Getting an infection in hospital might mean staying longer while it is treated. Some bacteria – like MRSA – are difficult to fight with antibiotics because they've developed resistance.

We want to prevent our patients getting these infections in the first place.

cleanyourhands® campaign

Its not what you do, it's the way that you do it

Ways in which it could all go wrong

Hrisos & Thomson 2013. *'Seeing it from both sides'* **Plos One**

Healthcare staff	Patients & families
Feel challenged	Fear being labelled
Feel scrutinised	Don't want to:
Suspicion of motives	*"check up"/ "challenge"*
Feel demoralised	Care compromised

Loss of trust

Damage the relationship

Approach needs to be

Collaborative

Its not what you do, it's the way that you do it

'Speaking up' remains a key safety behaviour for patients & families (*Bell & Martinez 2019. BMJ Quality & Safety*)

Evidence that patients & families do not want to 'challenge' or confront health care staff (*Bell et al 2018. BMJ Quality & Safety*)

Staff are more supportive of approaches that encourage co-production of safety rather than confrontation *(Sutton et al 2019,HEX)*

<u>How can patient & family involvement be enabled and supported?</u>

ThinkSAFE.
Be safe.

Upskilling public & patients to fully and actively engage in safety improvement

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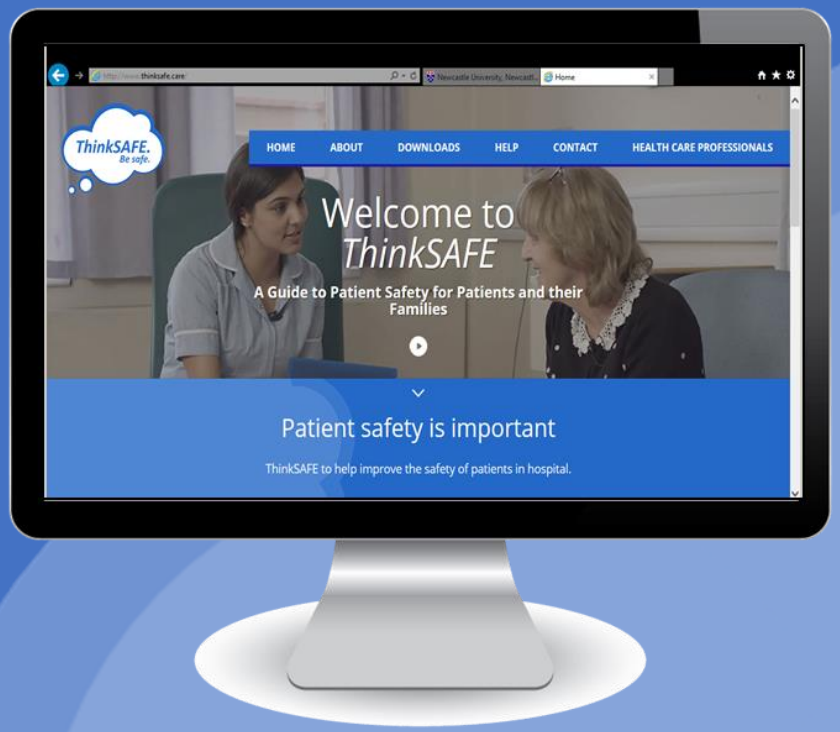
Institute of Health & Society

ThinkSAFE™



http://www.thinksafe.care

- Collaborative improvement of patient safety in hospital
- Grounded in service user & healthcare staff experience
- Underpinned by evidence, best practice & theory
- Supports service user/ professional interactions

MRC Framework Stage / Study Phase	NIHR Research Programme: Patient Involvement in Improving Patient Safety (RP-PG-0108-1004)
Development / **Phase 1**	**Evidence collation (Feb 2010 – Jan 2011)** • ***Qualitative study*** • ***Scoping of ongoing work*** • ***Systematic review of literature*** • ***Identify relevant theory***
Development / Feasibility / **Phase 2**	**Intervention development (Feb – Sept 2011)** • ***Develop conceptual basis for intervention*** • ***Interactive workshops***
Feasibility / Evaluation / **Phase 3**	**Exploratory trial (Oct 2011 – Dec 2012)** • ***Develop prototype materials*** • ***Pilot interventions in acute settings***
Evaluation / **Phase 4**	**Protocol development (Jan 2012 – Jan 2014)** • ***Further funding for next steps***

Knowledge, Capability, Opportunity

Pre-Admission

In-Patient Stay

Pre-Discharge

Patient PATHWAY

Time to Talk
'Meet & Greet'

Time to Talk
'Questions, Concerns'

Time to Talk
'Discharge Counselling'

ThinkSAFE Healthcare Logbook

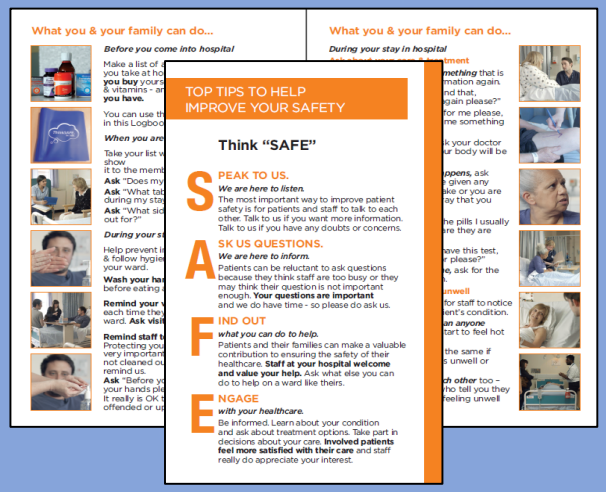
Patient Safety Guidance

- **Video** (8mins run time)
  - **Demonstrates actions**
  - **Behavioural barriers**

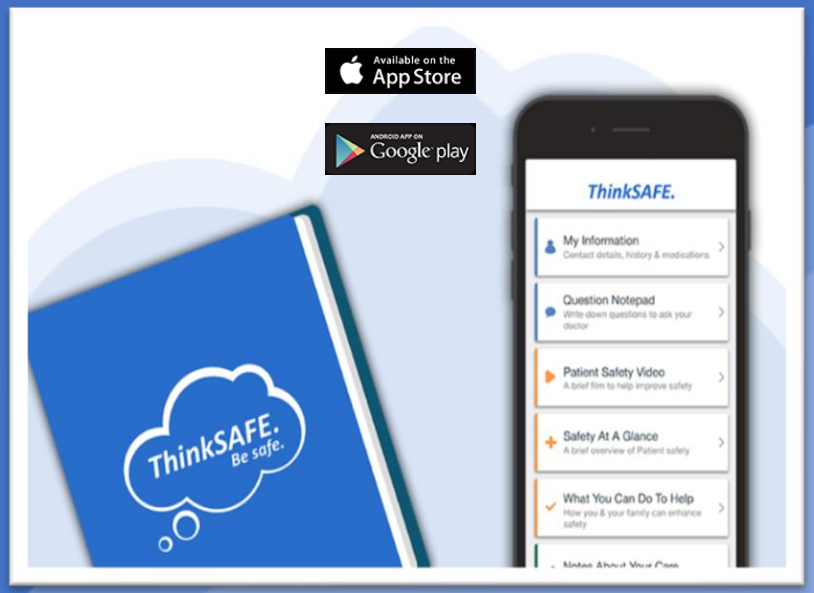
  http://www.thinksafe.care

- **Laminated Card**

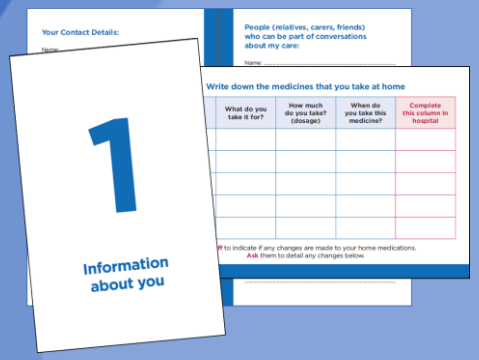
- **Detailed Tip Sheet**

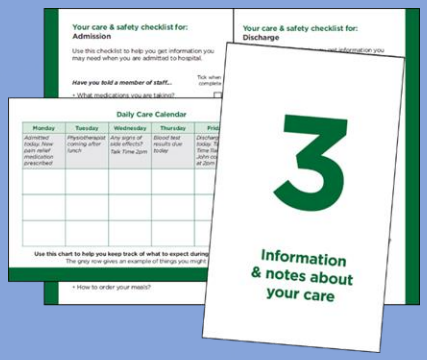


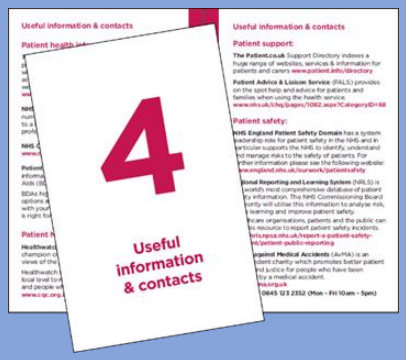
Healthcare Logbook



- **A5 Folder or mobile App**
  http://www.thinksafe.care
  - **Integral tools & information**
  - **Patient Safety guidance**
  - **Question prompts & Tips**







Mobile App (iOS & Android)

Healthcare professional component

Brief evidence & theory-based educational session

Patient Safety is important

- More than a million people are treated successfully each day in the NHS
- Despite best efforts, hospitals are very busy & co… and things still sometimes go wrong
  - Approximately 10% patients are unintentionally h… care they receive [1]
    - Around 6% of such events are avoidable[2]
    - It is estimated that 5.2% of all deaths in hospitals in … preventable (equivalent to 11,859 adult patients eve…
- Adverse events can carry significant consequence… patients, families & staff (personal & emotional), substantial costs to NHS
- There is a need to continually look for ways to im…

[1]Department of Health (DoH). *Building a safer NHS for patients: Implementing an Organisation with a …*
[2]Vincent CA et al. *Adverse events in British hospitals: preliminary retrospective record review.* BMJ 200…
[3]Hogan H et al. *Preventable deaths: due to problems in care in English acute hospitals: a retrospective …* Qual Saf (2012)

What are the benefits of involving patients & families?

- They might know things you don't …
  - Patients are present during every contact with health… important contextualised information with them[1]
  - They know themselves better than anyone else – un…
  - They are often quite expert in self-management, esp…
- They can be an extra barrier to harm
  - Their knowledge about themselves and their care is … staff – an important source of expertise that you can…
  - If patients & healthcare staff work together towards … possible problems can be "nipped in the bud"
- Research shows that involved & informed patient… more satisfying and safer healthcare[2]
  - Informed patients make better decisions & choices
  - Involved patients are more likely to follow treatment…

[1]Schwappach, D.L.B. *Engaging Patients as Vigilant Partners in Safety : A Systematic Review.* Med …
[2]Longtin et al. *Patient Participation: Current Knowledge and Applicability to Patient Safety.* Mayo…

The "ThinkSAFE" approach

Developed in collaboration with ward staff …

Three components:

1) Patient video: *"A guide to patient safety for pa…*
2) Healthcare Logbook, that contains tools… information at key time points during t…
   - **"Patient safety at a glance" card:** *a quick visual… help staff to keep them safe*
   - **Medications list:** *to help staff know what medic…*
   - **Admission & discharge checklists:** *to help patie… key time points*
   - **Daily care calendar:** *to help patients be better i… during their stay in hospital*
   - **"Question note pad":** *to help patients & relativ… they need*
3) "Talk" time: *brief, one to one to sessions for pa… staff, dedicated to addressing patients' queries an… Patients can invite relatives to be part of these ses…*

Your role is crucial to patient involvement

- Patients are willing to help, but …
  - Don't want "to bother busy staff" with questions or concerns
  - Worry that staff will be upset, feel insulted or challenged
  - Fear being labelled "difficult" or "demanding"; a "complainer"
  - Fear their care may be compr…

  *Healthcare staff, when a … themselves, report feeling …
- So the way staff interact with …
  - People are "not quite themse… extremely vulnerable & more…
  - Patients who witness or expe… asking a question or raising a …
  - Patients are reluctant to ask … (e.g. "dismissive", "grumpy"…

How you can foster patient involvement

Evidence suggests that patients are more likely to take a role in improving patient safety if healthcare staff tell them what they can or should do to help, i.e. if staff "permit" their involvement

During the ThinkSAFE pilot study we would like you to actively encourage patient & family involvement by:

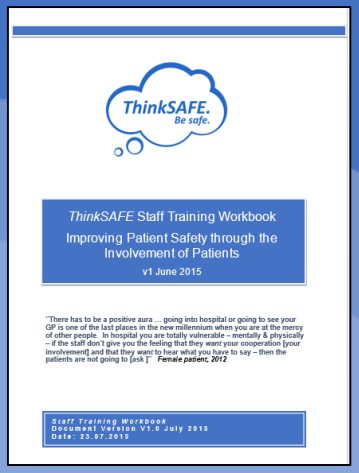
- Saying to patients …
  - *"It is OK to ask me …" "I want you to ask me …" - questions about your care; what I am doing to you & why; if I have washed my hands"*
  - *"It is OK to tell me…" " I want you to tell me … - when something doesn't seem quite right; if you think there has been a mistake"*
- Engaging patients in their care by …
  - *Talking them through what you are doing and why*
  - *Exploring what they understand about their illness, treatment and care*
  - *Providing "opportunistic education" when understanding appears lacking*
  - *Involving them in decisions made about their treatment and care*
- Using the Logbook contents & "Talk Time" sessions - *to sit down with patients to discuss their care and share important information*
  - *E.g. at admission (using the checklist & medication list), during the patient stay (using the Q note pad, helping patients update the information sections of their logbooks) and prior to discharge (using the checklist & medication list)*

By saying to patients …

- *"It is OK to ask me …", "I want you to ask me …"*
- *"It is OK to tell me …", "I want you to tell me …"*

Staff Support

- **Training session**
  - Evidence & theory-based
  - Workbook: planning & rehearsal



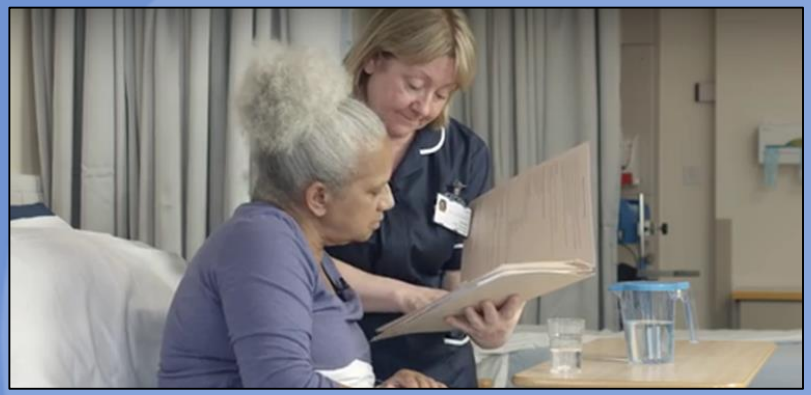
- **Video**
  - Discussion of staff concerns
  - Reassurance

- **E-learning package**
  - Self-guided
  - Reflective practice

Time to Talk

- Opportunity

- Confidence



- Collaborative Culture

Knowledge

Capability

Opportunity

Safety.

Healthcare Logbook

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- Collaborative Culture

Pilot Evaluation

***ThinkSAFE* is feasible & adaptable: context, preference**

Potential to influence process:

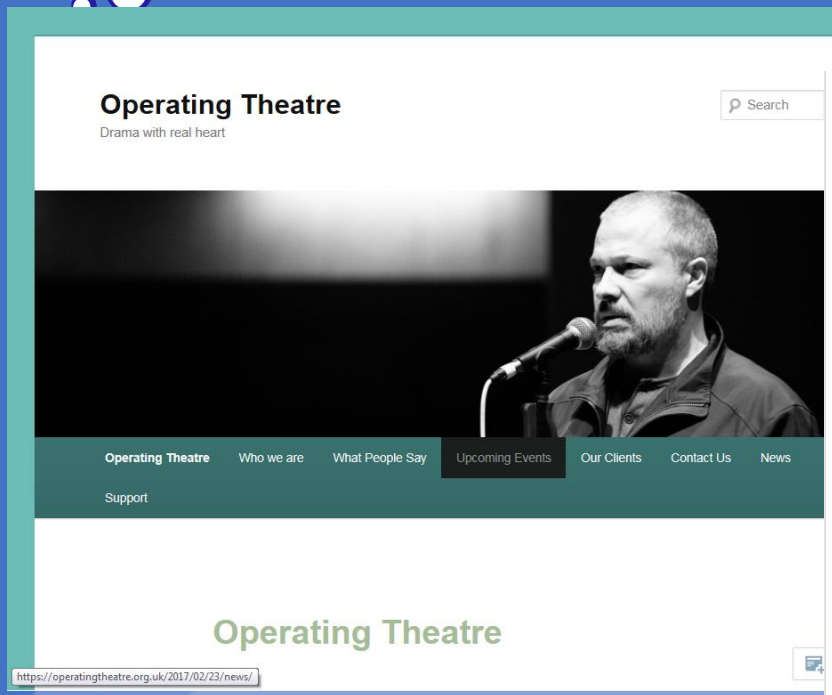
- ***patients felt 'empowered' & were actively engaging with staff about their care***
- ***staff were motivated to 'foster' patient engagement & reported encouraging patient questions***

Potential to improve safety:

- ***Improved medications reconciliation at admission***
  - **fewer prescriptions required pharmacist intervention compared to controls (a reduction in error rate from 62% to 52%, p=0.033)**
  - **prescriptions more likely to contain only one error per patient (73% vs 58%, p=0.024)**

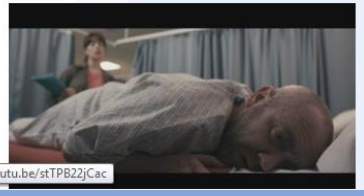
ThinkSAFE.
Be safe.

Whose leg is it anyway?



The sketches are also available as individual video clips. Click on the the sketch title below to access the related video.

- The Grim Reaper
- Patient Safety
- Drains
- Enjoy The Ride
- Keeping Patient Informed
- Whose Leg ... ?
- Can't Be Too Careful
- Doctor Knows Best
- How To Complain



OPERATING THEATRE

www.operatingtheatre.org.uk

EngageFMS

Patient and Public Engagement and Involvement

Newcastle University

Institute of Health & Society

ThinkSAFE.
Be safe.

Developing services around patients & understanding their safety needs

ACADEMIC HEALTH SCIENCE NETWORK
NORTH EAST AND NORTH CUMBRIA

NIHR | School for Primary Care Research

PENNA
FINALIST 2015

Newcastle University
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ThinkSAFE™ Primary Care

- **Most PIPS research has focussed on secondary care setting**
- **Patient safety lapses in the primary care setting are common:**
  - **with approx.4/10 patents reporting a concern**
  - **Approx. half of the global burden originates in primary care (Auraaen et al 2018. OECD Health Working Papers 106).**
- **12month qualitative interview study**
  - Staff & patients from 5 GP practices

➢ **Knowledge and understandings of patient safety in this setting**

➢ **The patient & family role in reducing risk of harm to patients**

➢ **How primary care staff felt about involving patients in improving patient safety in this setting**

Understandings of safety in the primary care setting

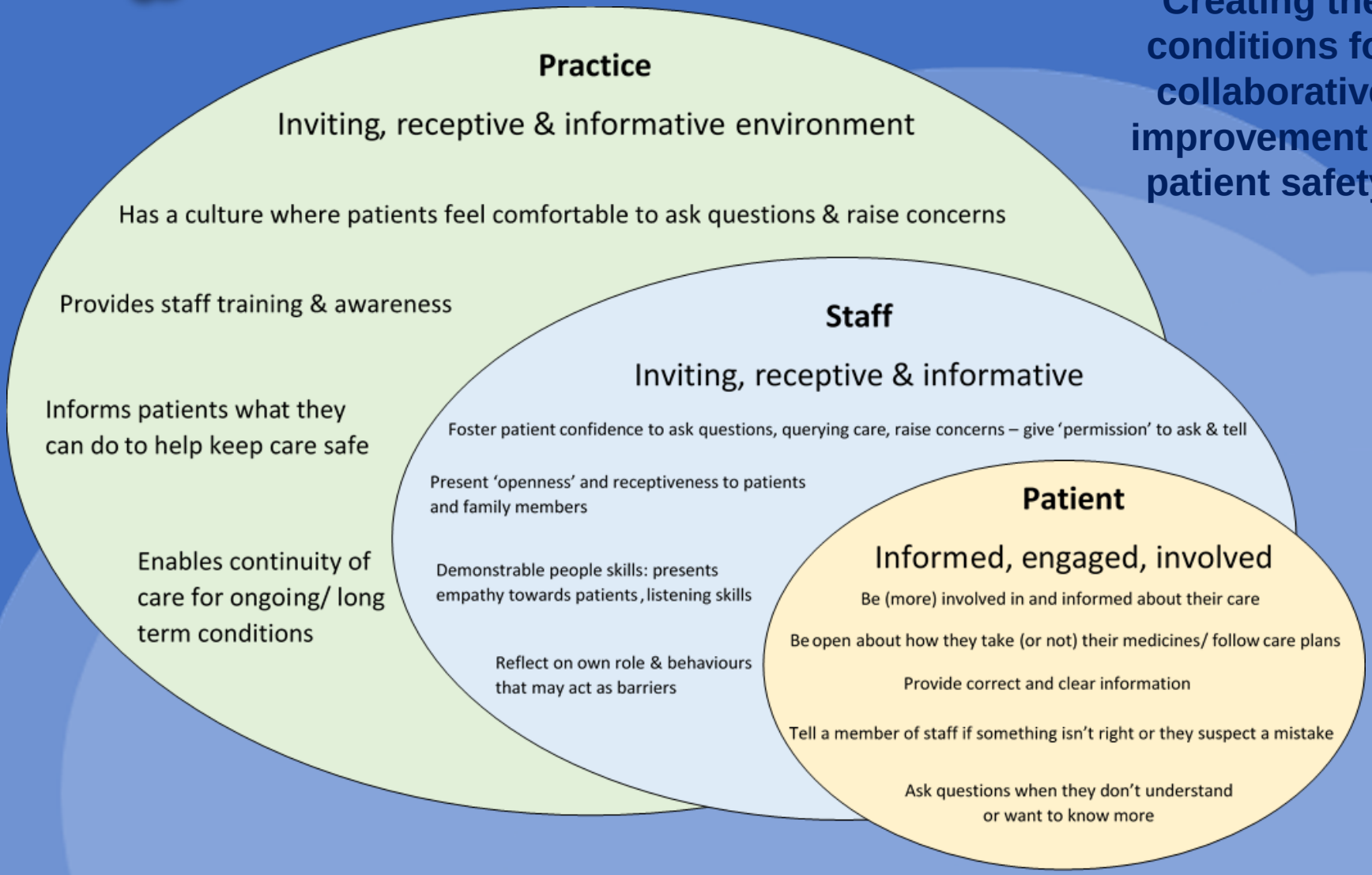
- Staff began from a perspective of care being ***unsafe***
- Patients generally perceived their care as ***safe***
  - but were aware of & vigilant about risk
- Similar understandings about what is a risk & what might cause harm
  - Medication safety was most predominant issue
  - Diagnostic error
  - Delayed diagnosis
  - Missed/lost test results
  - Wrong patient
- Both accept the role of human error and that ‘mistakes happen’
- Patient involvement in their care is important to ensuring safety

Core patient/family/carer role: 'proactive communication'

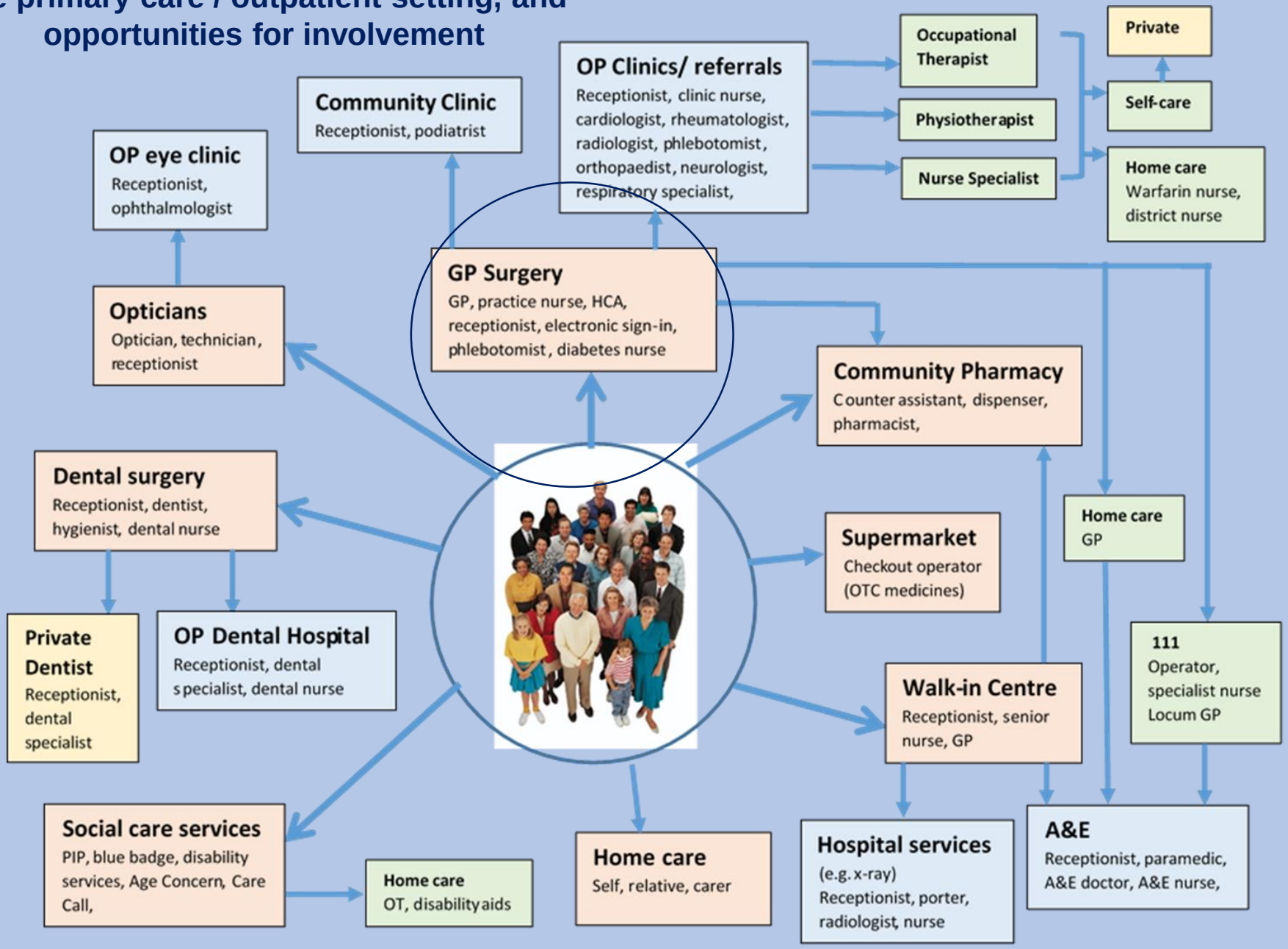
- **Asking questions & querying their care**
  - During their appointment if anything is unclear regarding treatment, investigations or medications – 'being interested'
- **Giving information**
  - Honesty in communications with staff (e.g. inform staff of lifestyle, compliance with medication), use of OTC medicines, allergies
- **Telling staff about any concerns they may have**
  - Speaking up / sharing concerns with staff (e.g. errors in care; reactions to meds)
- **Staff & patients working in partnership to improve safety**
  - Patients sharing their insight, knowledge & experience of their condition with staff

Shared thoughts on what might help address barriers

Creating the conditions for collaborative improvement of patient safety.



Mapping patient healthcare contacts within the primary care / outpatient setting, and opportunities for involvement



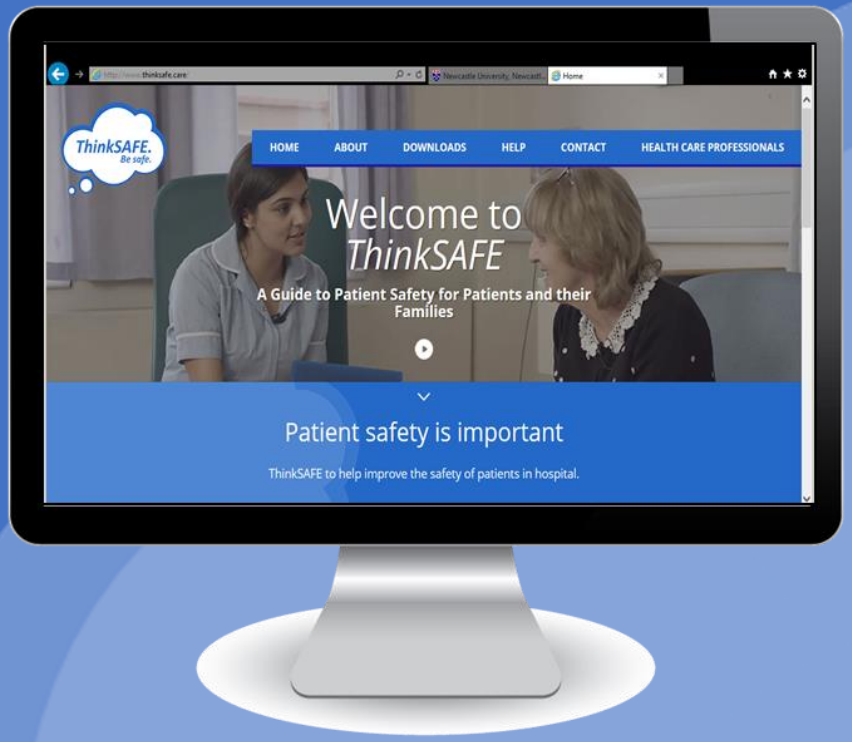
Primary Care *ThinkSAFE®*

- Underpinning ethos same in terms of need to support both staff and patients in changing behaviour & culture
- Guiding principle for intervention design is to promote:
  - Capability
  - Opportunity
  - Knowledge
- Key staff & organisational roles highlighted
- Focus on mechanisms & resources for communicating & sharing safety information:
  - Effectively and efficiently
  - Both within care settings **and** across care boundaries
  - That support, rather than contribute burden to, workload & time

Thank You!

Questions?

Implementation Package



http://www.thinksafe.care

- **Dedicated website**
  - *Patient access to all ThinkSAFE resources*
- **Implementation Support**
  - *Implementation Manual*
    - *Step by step guide*
  - *Implementation case studies*
  - *Monitoring & evaluation tools*
  - *On-line peer chat forum*
  - *Train the trainer manual & information sources*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