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Gloucestershire Safety & Quality Improvement Academy

Linking Patient Safety & Quality Improvement

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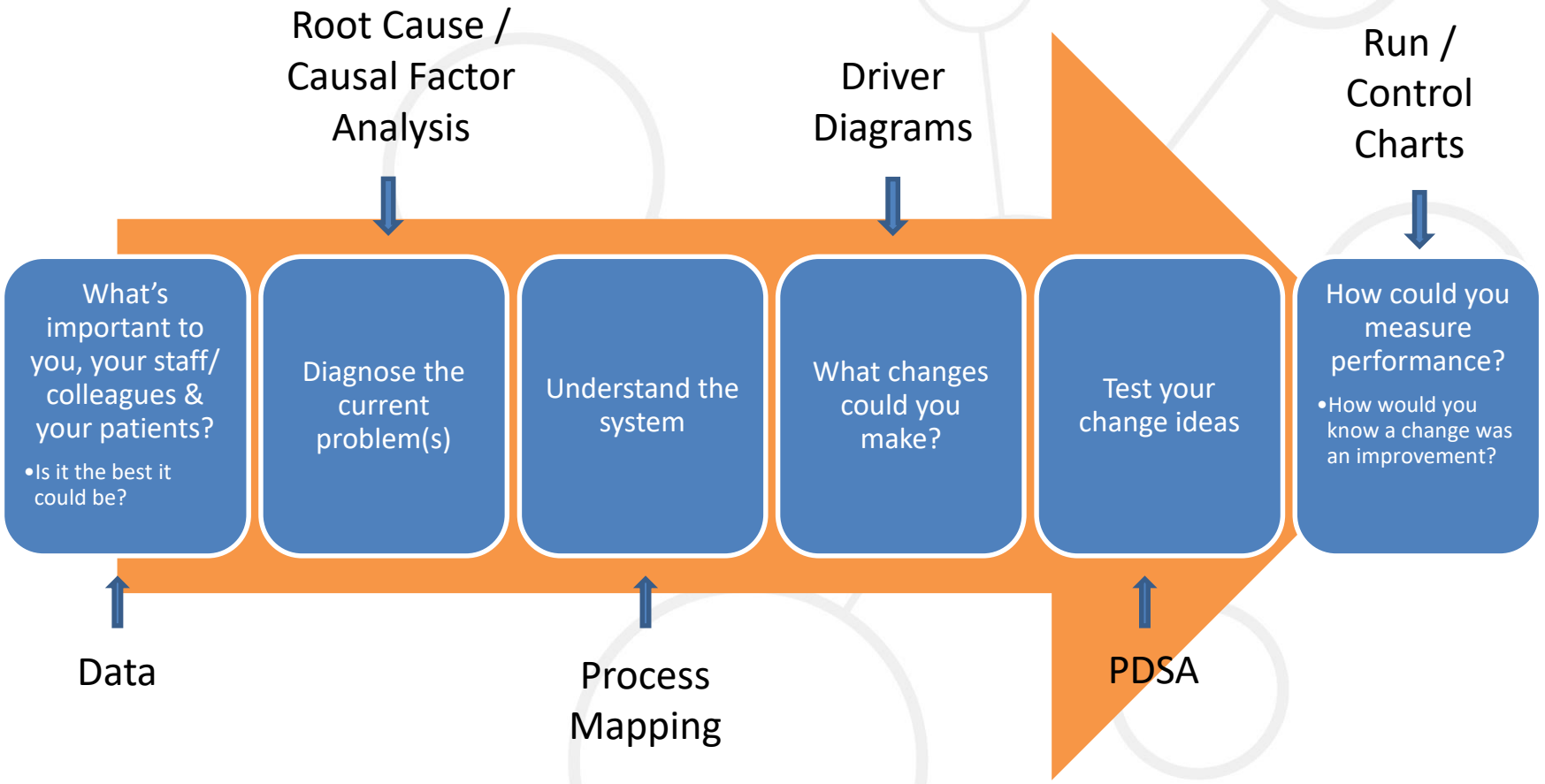
Gloucestershire Safety and Quality Improvement Academy

- The Gloucestershire Safety & Quality Improvement (QI) Academy was created in June 2015;
- It has developed and delivers a variety of QI training programmes and supports QI Projects;
- These have increased QI skills & knowledge, enabling students to make practical improvements to patient care.

Standardising our QI approach



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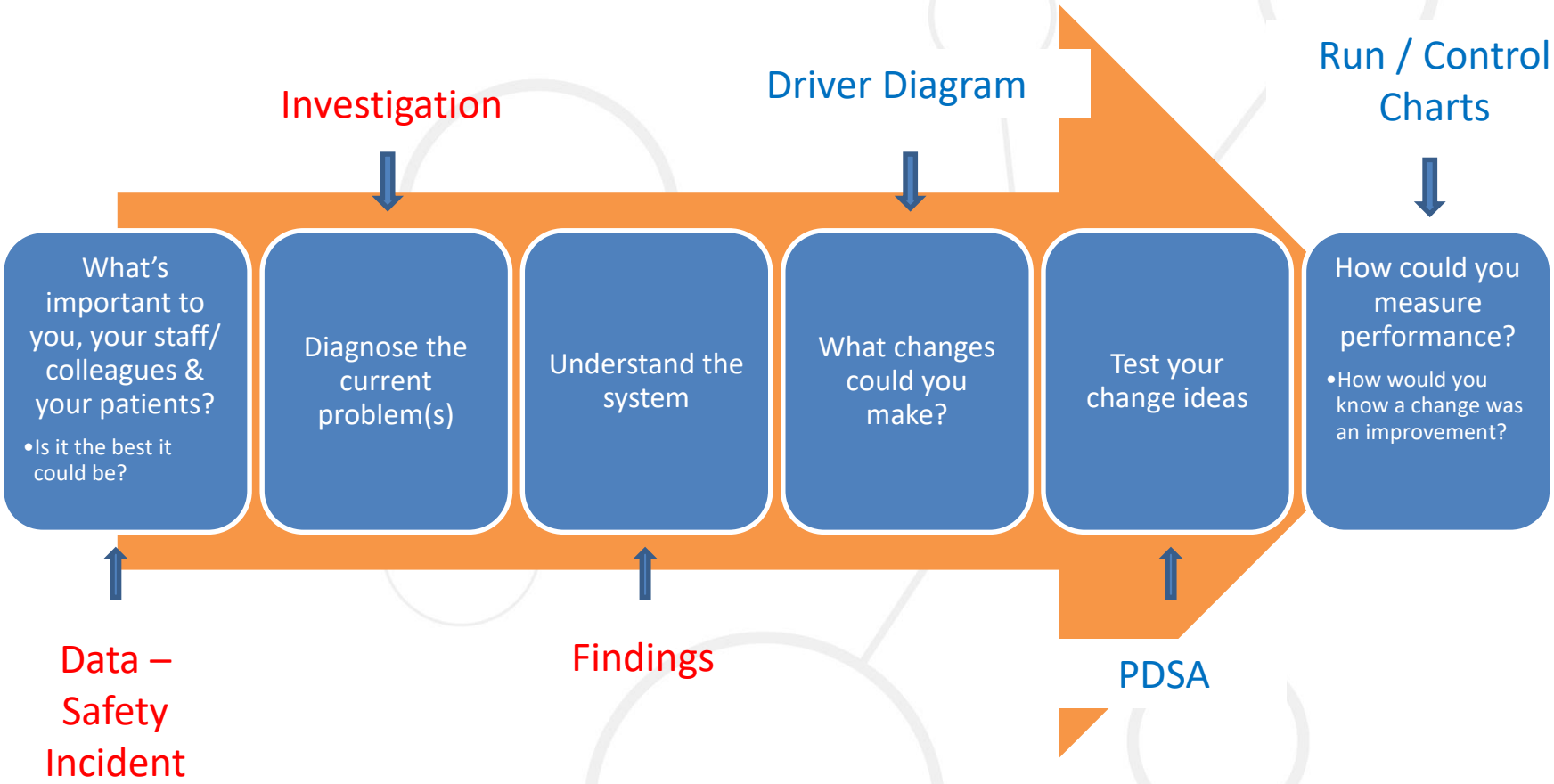
Integrating Safety



Traditional Patient Safety Approach : Recommendations & Action Plans	A Quality Improvement Approach: Driver Diagrams (change ideas) & PDSA
Theoretical solutions.	Theories are subject to testing.
Timescales specified for closure of action plans.	Timescales specified for improvement.
Often made by investigators who are not the subject matter experts	Subject Matter Experts tasked with idea generation around problem solving.
Lack of ownership of the findings & actions.	Change ideas owned by those who generated them.
Lack of data on whether the changes were effective, focus instead on closing actions.	Time ordered data to measure improvement, rather than closure.
Analysis rather than learning.	PDSA process focussed on learning and improvement.
Often defaults to policy amendments, reminders & training.	QI approach ensure changes are linked to overall desired aim.

Scenario

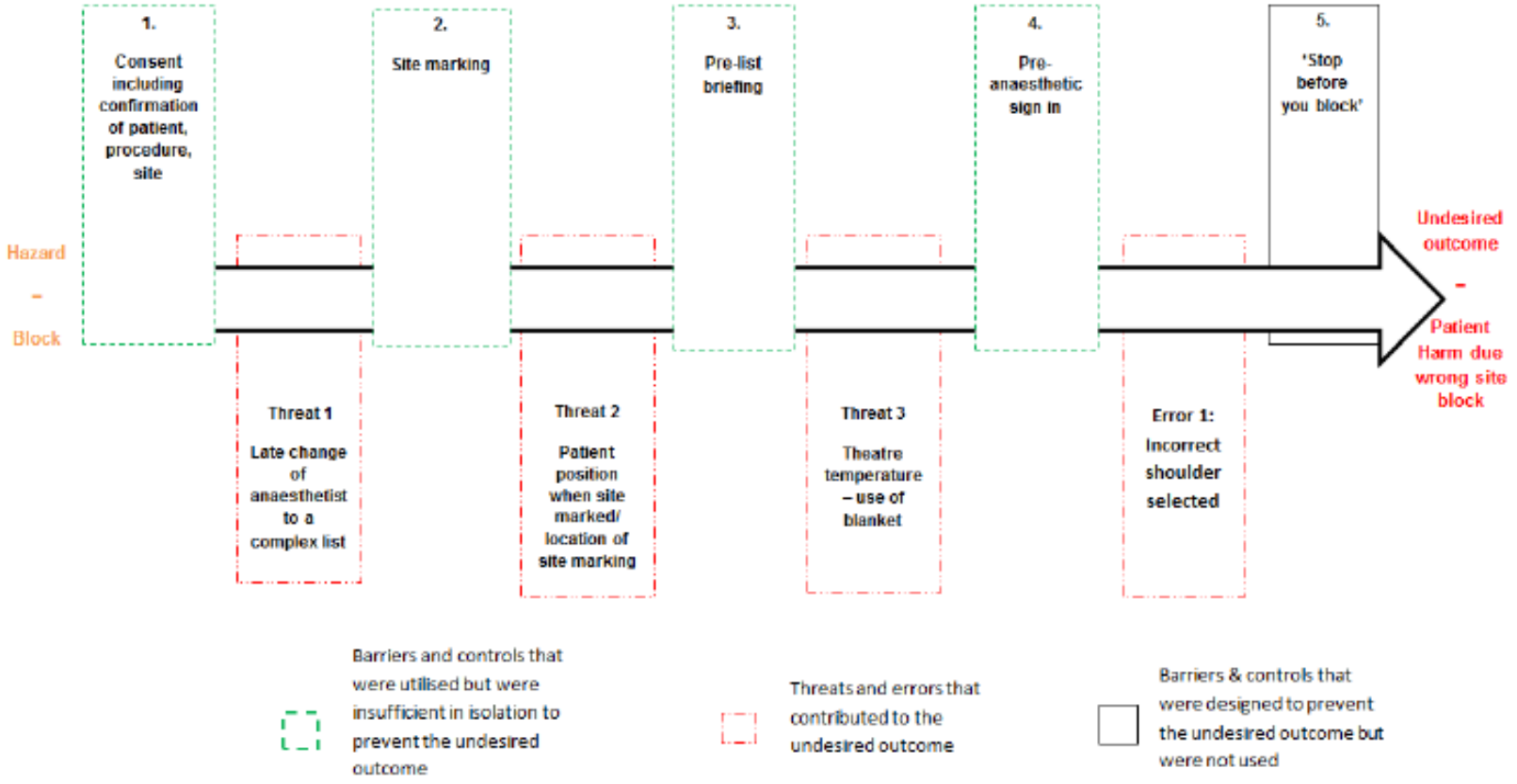
- On the morning of the 26th July 2016 a patient attended Orthopaedic Theatres for a right shoulder replacement.
- The patient was seen before the surgery by the consultant orthopaedic surgeon who confirmed the details of the procedure, obtained consent and marked the intended surgical site. The patient was then collected and taken to the anaesthetic room in theatres where an anaesthetic interscalene nerve block was administered in preparation for the surgery.
- At the completion of the procedure the anaesthetist realised that the block had been administered in error on the opposite side to the planned surgery. The consultant surgeon was informed and the shoulder replacement surgery postponed.

Findings:

- The late allocation of the anaesthetist to a complex list reduced the time for preparation and increased the opportunity for error.
- The change in patient position from seated (when marked) to lying (for the surgery) meant that the surgical site marking was no longer visible during the procedure, negating the usefulness of this as a visual prompt to the anaesthetist.
- The temperature and the resulting provision of a blanket led to only the non-surgical site side of the patient remaining exposed. Without any further prompts or checks this may have led to confirmation bias that the exposed side was the correct side for the surgery.

- Missed communication opportunities between the anaesthetist & anaesthetic assistant limited their shared mental model, reducing the opportunity for error inducing conditions to be identified.
- With the absence of any visual prompts, shared awareness or final checks the incorrect site was selected as a result of human error (a slip).
- Failure to apply the ‘Stop before you block’ protocol negated an opportunity to mitigate the preceding error. It is possible that this is normalised rather than individual practice, although this would require further investigation.

Figure 1: Controls, barriers, threats and errors associated with the wrong site block.



Improvement Planning

- Option 1 – Action Plan
- Option 2 – Driver diagram

Action Plan

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Surgical Division Action Plan
Incident date:
Lead:

Issue	Actions.	Person responsible	Evidence	Date for Completion	Status

Driver Diagram

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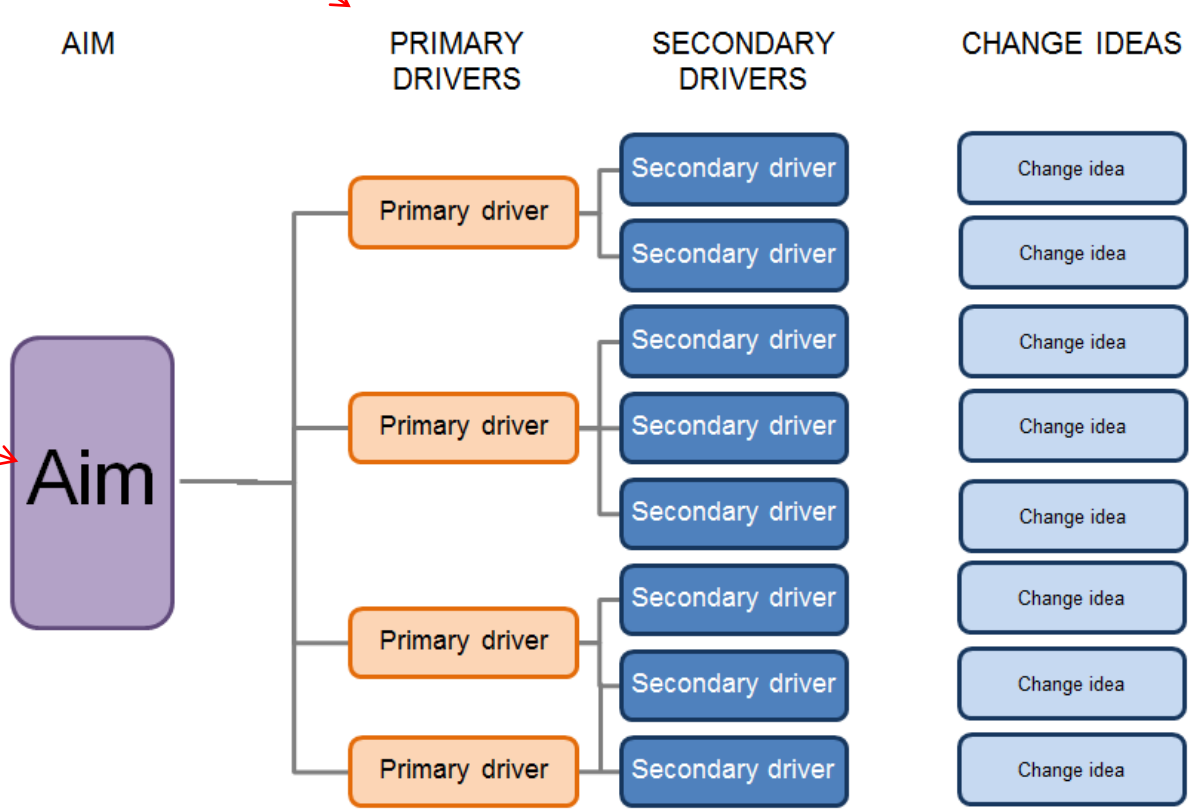
System components that will contribute to or influence achieving your aim

Elements or activities associated with the primary driver that can be used to identify packages of change that affect the aim.

Ideas to be tested that can help you move towards your aim

SMART



An Example

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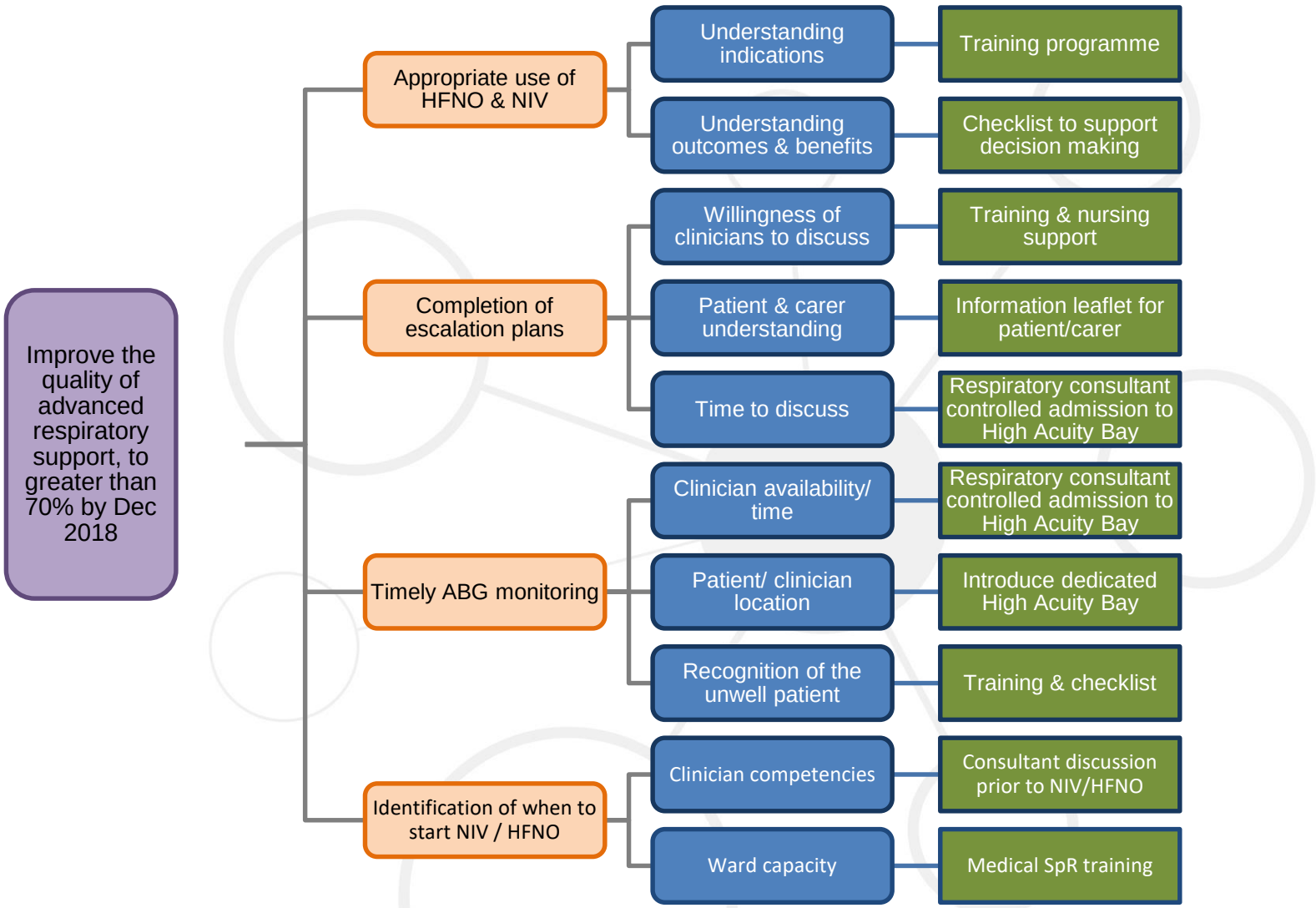


Over to you…..

- You will be given an Action Plan template or a Driver Diagram template to complete
- Use with the investigation findings to plan your improvement.

Quality Model

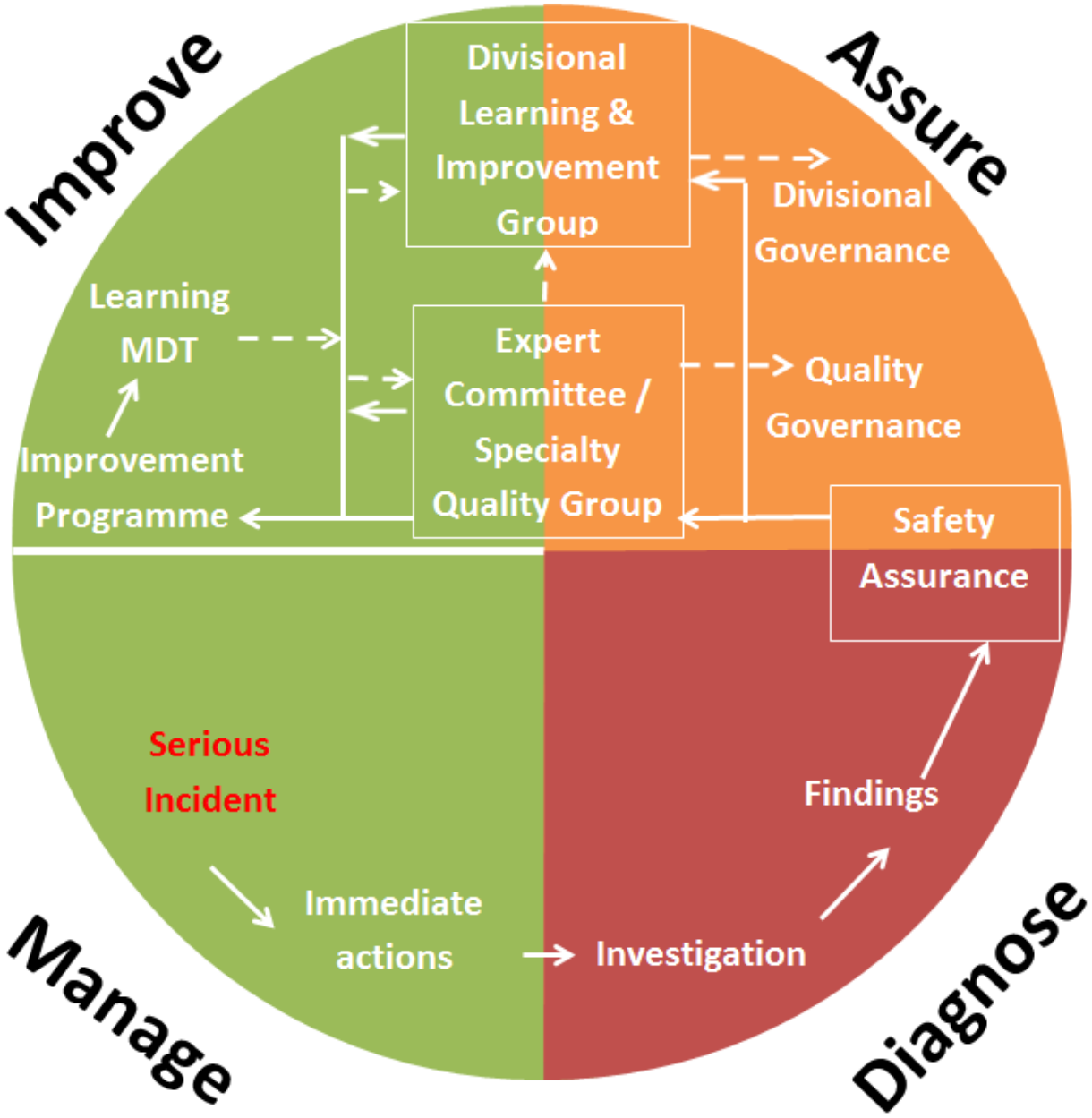
Things we should always monitor

What do we need to improve

Are we safe today

Effective Learning

Learning Model



Any Questions?

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