

A person wearing a white lab coat is holding a tablet computer with both hands, looking at the screen. The background is blurred, showing a white mouse on a desk.

Embedding patient safety into digital health innovation

Clive Flashman
Chief Digital Officer
Patient Safety Learning

19 May 2022

patient
safety
learning

We need to design for safety, not just address harm



Safety is a core purpose

Competency framework for all staff

Leadership commitment to safety

Patient safety and human factors expertise

Safety standards

Engage patients

Design safe systems

Learn from errors and act

Safety comparison data to drive out variation

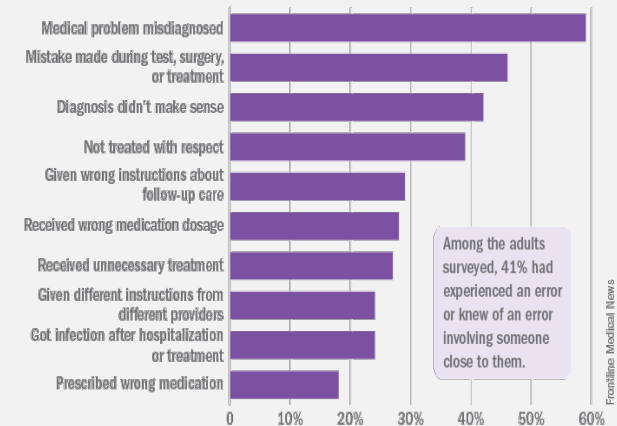
A Just Culture; psychologically safe

Types of errors and issues that cause avoidable harm



- ✓ **Diagnostic errors:** wrong, missed or delayed diagnosis
- ✓ **Medication errors:** prescribing, omission, unauthorised drug, wrong dose, wrong route, deteriorated drug
- ✓ Inadequate **hand hygiene and infection control** leading to hospital acquired infections
- ✓ **Unsafe surgery** such as wrong site surgery – complications in up to 25% of patients (1m deaths a year); 50% unsafe surgery is preventable
- ✓ **Communication** and information errors
- ✓ **Insufficient staff, tired, not properly trained**
- ✓ Very many more.....

Patient survey: 10 most common medical errors



Note: Survey was conducted May 12, 2017, to June 26, 2017, and received 2,536 responses.

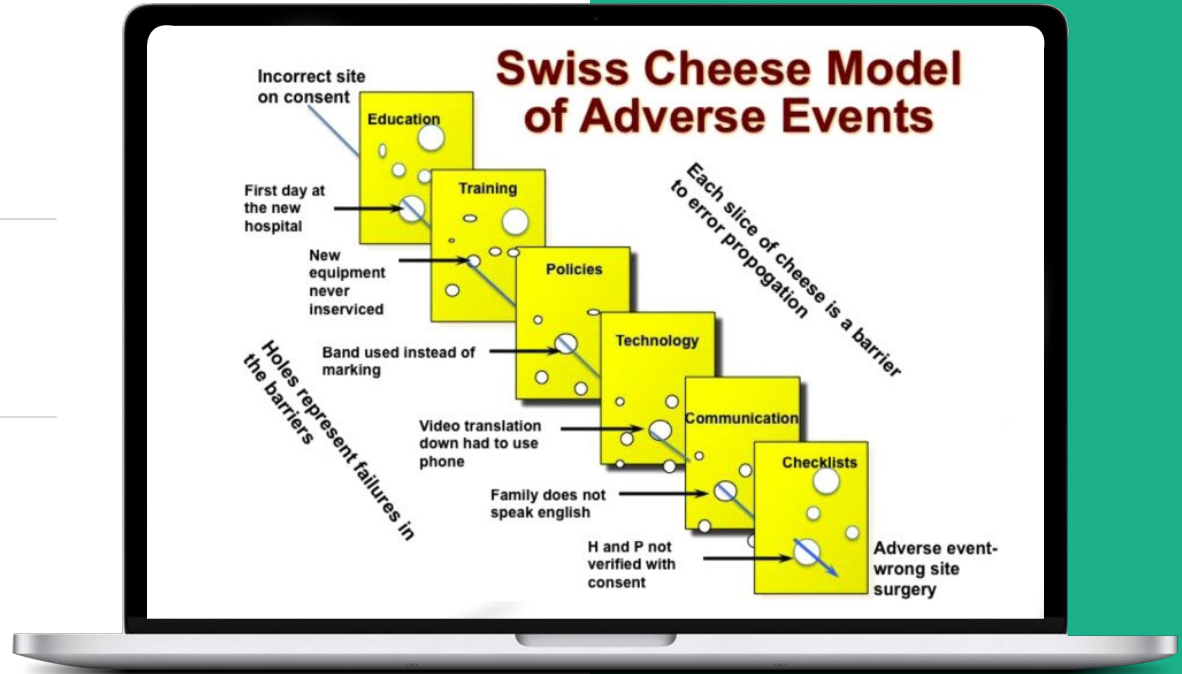
Source: NORC at the University of Chicago and IHI/NPSF Lucian Leape Institute

Why do errors happen?

Model by
Prof. James Reason

Healthcare is
extremely complex

There are holes in the
defences/ cheese slices



Digital health innovation

Generally, founders and innovators have the following priorities:



If the solution is patient facing, then patient safety should also be one of these core aims, but it rarely is.

Developing their idea into a prototype



Ensuring that it addresses a real market problem



Finding places to pilot their solution



Commercialisation – sales and funding



Building a team

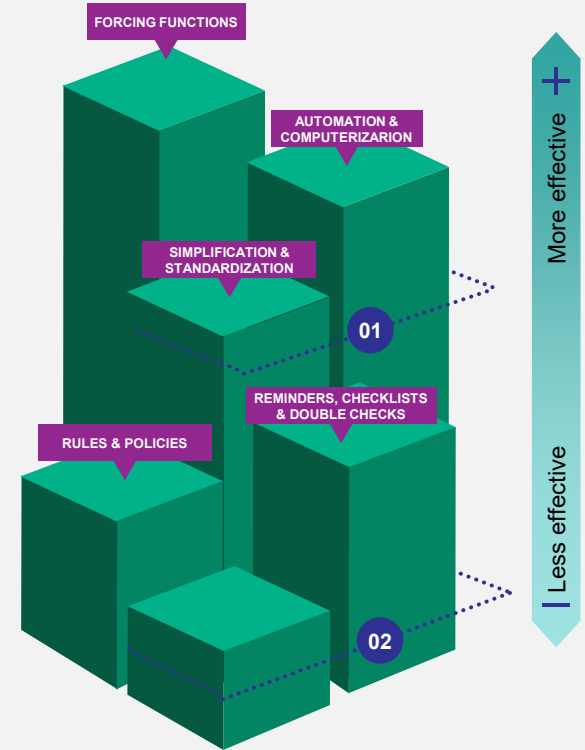


Service and product design should be system focused

Your opportunity

- | | |
|--|--|
| <p>✓ Most effective:
system focused</p> <ul style="list-style-type: none">• Forcing functions• Automation & computerisation• Simplification & standardisation | <p>✓ Least effective:
people focused</p> <ul style="list-style-type: none">• Checklists• Rules and policies• Education and Training |
|--|--|

Hierarchy of Improvement Intervention Effectiveness

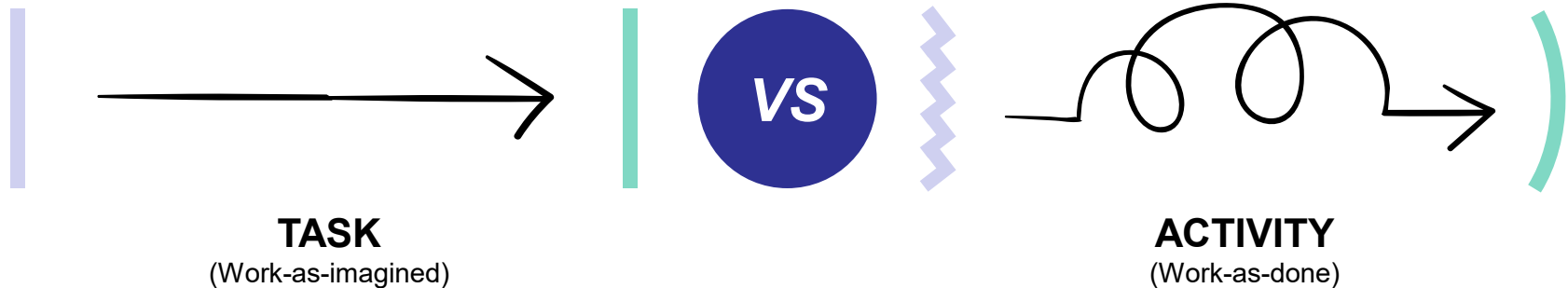


01 System-focused 02 People-focused

Human Factors and Ergonomics takes a systems view

The scientific discipline concerned with the understanding of interactions among humans and other elements of a system, and the profession that applies theory, principles, data, and methods to design in order to optimize human well-being and overall system performance

Chartered Institute of Ergonomics and Human Factors



Human factors and ergonomics takes a systems view

Learning from other industries and High Reliability Organisations



Safety goals need a whole organisation approach



Safety management systems



Detect and understand the hazards and risks



Proactively make changes to minimise risks



Learn from errors order to prevent their reoccurrence



Understand human factors



Innovating in a high reliability industry sector



01

Commitment to resilience



The digital solution must remain accessible during high-demand periods

02

Preoccupation with failure



To avoid failure, plan for it, look for it and be sensitive to early signs of it

03

Reluctance to simplify interpretations



Acceptance that healthcare is complex, and solutions may be used in unexpected ways

04

Deference to expertise



Listen to professionals on the front lines and to patients who know their conditions expertly

05

Sensitivity to operations



Be aware of the context and situations in which the digital solution will be used

5

Very basic principles

patient safety learning

Talk to **ALL** relevant front-line staff who actually do the job



Think about what **can go wrong**



As far as possible, **simplify and standardise**



Always take a **system-wide perspective**



Focus on how we can design work to **make it easier, safer and more efficient**



Paul Bowie,
*NHS Scotland
Education and CIEHF*



Involve patients and the public in design

Patient engagement for patient safety

Every day thousands of patients suffer harm in health care



Be actively involved in your own care



Be informed, ask questions.



Provide full information about your medical history



Speak up
for patient safety!



World Health
Organization



Service or product design



Service or product testing



Designing for improvement



Safety *in use*



If things go wrong;
reporting and learning

HealthTech and patient safety: key issues



Placing patient safety at the heart of design and development

- ✔ Patient safety should be a key priority that helps drive innovation forward.

- ✔ Safety implications should be raised early in the development process with founders and those who support them, such as NHS England Clinical Entrepreneurs Programme and the AHSNs.



Key challenges for HealthTech innovators and companies

- ✔ Balancing embedding safety in development processes without stifling innovation.
- ✔ Ensuring data is as 'joined up' as possible for the benefit of patients and clinicians.
- ✔ Avoiding existing biases being carried over/ amplified in new developments, e.g. AI systems embedding racial biases in diagnosis.
- ✔ Working within the constraints of a health and care system facing serious workforce shortages – developing solutions that take account of this.

My ten top tips for digital health innovators

- 1 Start with the problem, not the solution.
- 2 If your solution is patient-facing, consider how it will be used, and the diversity of potential users.
- 3 Always consider human factors and ergonomics. This is more than just UI/ UX.
- 4 Don't just do a clinical safety review (DCB0129) on launch, do it 1 year post launch too.
- 5 Take patient safety seriously, have a person on the team who understands the potential risks to patients when your solution is used.

- 6 Design safety into your solution from the outset.
- 7 Co-design and co-produce with patients and the public (and health & care staff as appropriate).
- 8 Interoperability is key – by any means necessary.
- 9 Review the new patient safety standards when they are issued and consider the implications for your solution.
- 10 Understand concerns about privacy and data use, balance these against contextualisation.





Embedding patient safety into digital health innovation

Clive Flashman
Chief Digital Officer
Patient Safety Learning

19 May 2022

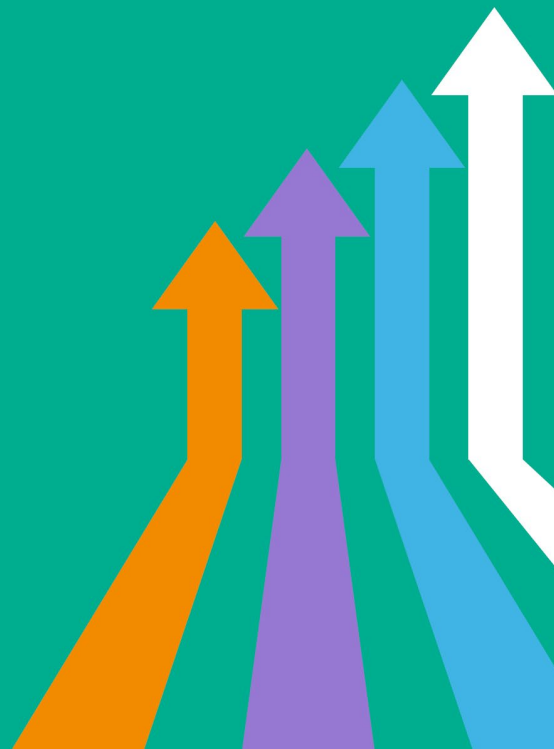
patient
safety
learning }

The new Patient Safety Standards Self-Assessment Toolkit

- ✓ Can be done at organisation (Trust) and/ or unit (hospital) level
- ✓ Covers all 7 foundations, 26 aims and 140+ standards
- ✓ Easily saved and continued later
- ✓ Will create a patient safety-specific document library for you as you add documents and links to the tool

Improve your standards
by meeting ours

Introducing an evidence-based
way to deliver safer patient care



Using the toolkit

Welcome to the Patient Safety Standards Self-Assessment Toolkit.

We hope you find this website valuable in assisting your progress on your journey to improved patient safety within your organisation.

Here you will be able to access a set of unique patient safety standards (and over time support tools too) that can help your organisation not only establish clearly defined safety aims and goals, but also demonstrate your achievements.

View how many standards of each type (Essential, Enhanced, Exemplary) your organisation and units currently meet, and from this create your own goals for improvement.

Within the self-assessment you will be able to upload relevant documents and paste external links to salient materials. These will be brought together in a simple document library that means that all of your organisation-specific patient safety documentation can be curated in a single place

Foundation 1: Leadership and Governance

Aim 1: Patient safety is a core purpose of the organisation (patient safety is central to priorities for service delivery, investment, reporting and

Standard 1.1 - Commitment

Level: ESSENTIAL

There is an explicit commitment to patient safety in the organisation's mission statement, which is made available to the public

Standard 1.1 - You should have... (Outputs & Evidence)

- Document(s) containing the mission statement
- Reference to the mission statement in patient information
- Availability of the mission statement on the organisation's website

Standard 1.1 - You will want to see... (Outcomes & Behaviours)

- Board, Executive and staff members able to articulate the organisation's commitment to patient safety and give examples of what this

Standard 1.1 met?

Choose...

Foundation 2: Culture

Aim 7: The organisation's leadership fosters a patient safety culture and tackles blame and fear (There is a just and learning culture throughout the organisation)

Standard 7.1 - Definition and charter

Level: ESSENTIAL

The Board has defined the culture it wants to deliver safe care, with a charter of principles/values for patient safety culture

Standard 7.1 - You should have... (Outputs & Evidence)

- The Board-approved culture charter is widely disseminated and applied
- Culture reported publicly in annual reports
- Values and principles included in job descriptions for all staff (NHS, contractors, volunteers etc)
- Written principles and standards of behaviour with implementation plan and regular review
- Actions to maintain/improve safety culture

Standard 7.1 - You will want to see... (Outcomes & Behaviours)

- Executives and managers demonstrate the right skills and support to deliver a safety culture, including HR support
- Everyone demonstrates behaviours reflective of a just and learning culture
- Behaviours that don't meet standards are addressed

Standard 7.1 met?

Choose...

Initial Output

