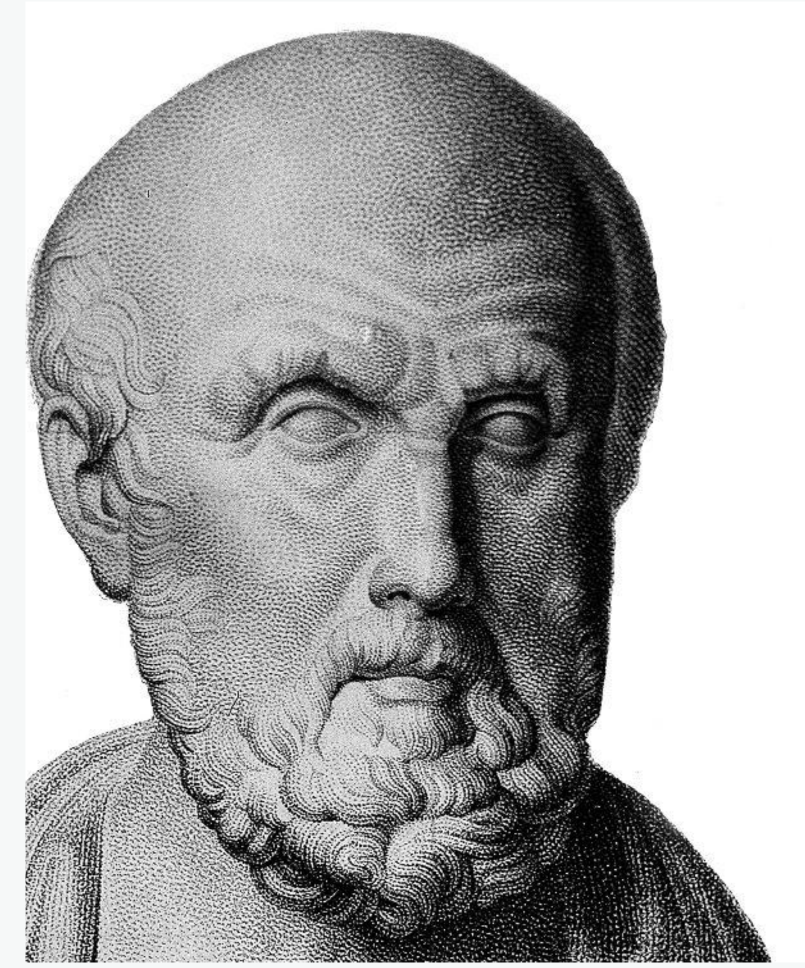
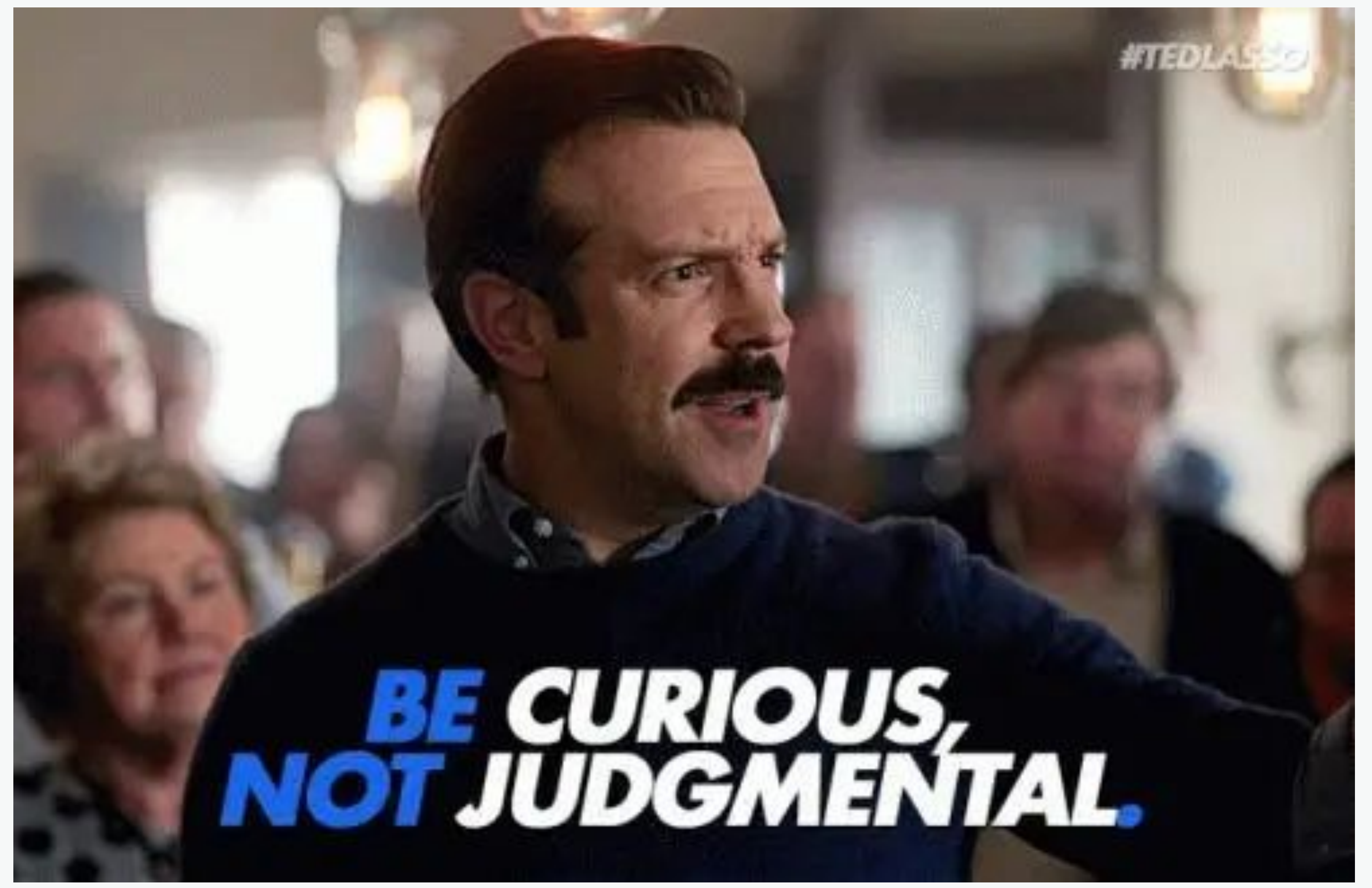
IHI/BMJ Quality Forum 2024
Patient Safety Breakfast Session

Friday 12th April 2024

First do no harm

- Hippocrates? (245)
- He actually said "I will abstain from all intentional wrongdoing and harm"
- Primum non nocere (? 17th century)



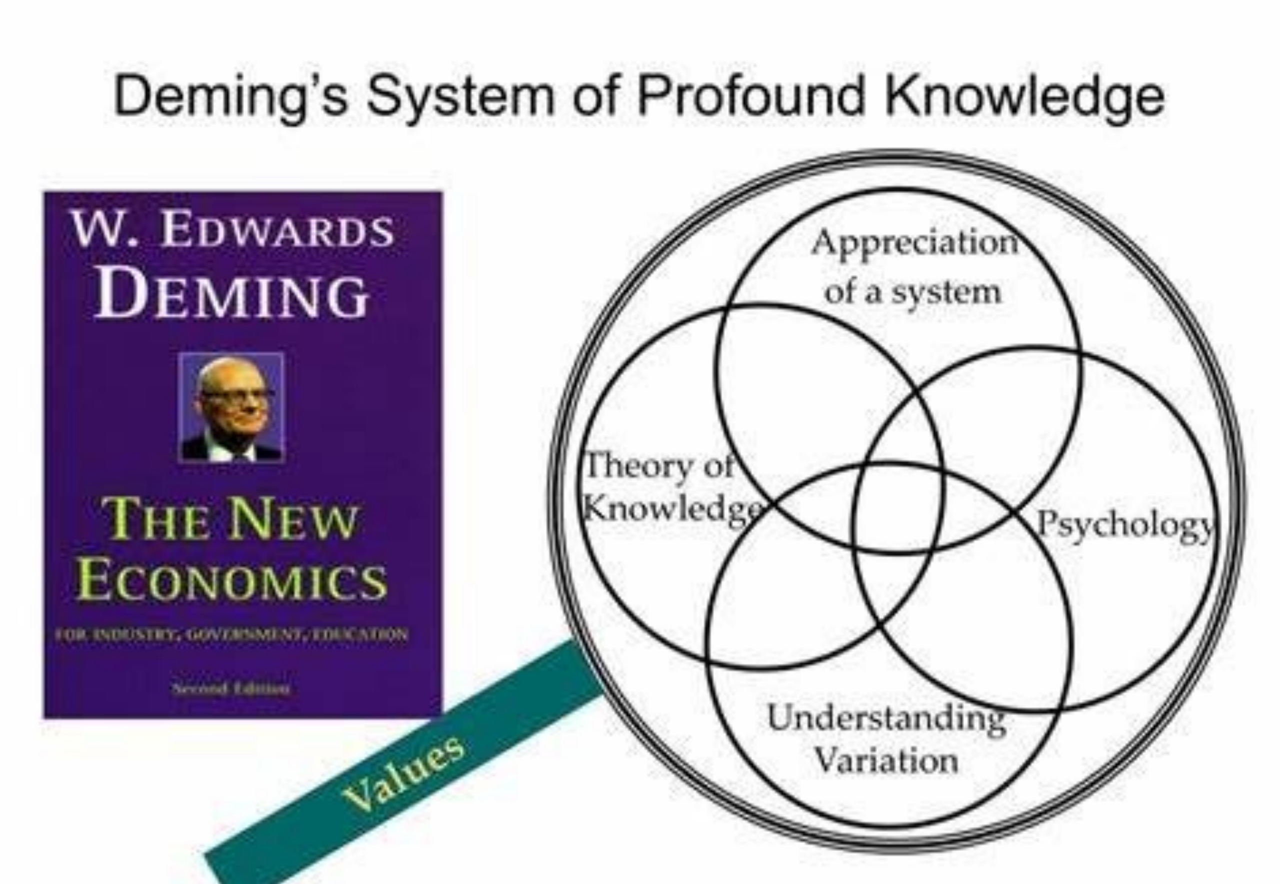

#TEDLASSO
BE CURIOUS,
NOT JUDGMENTAL.

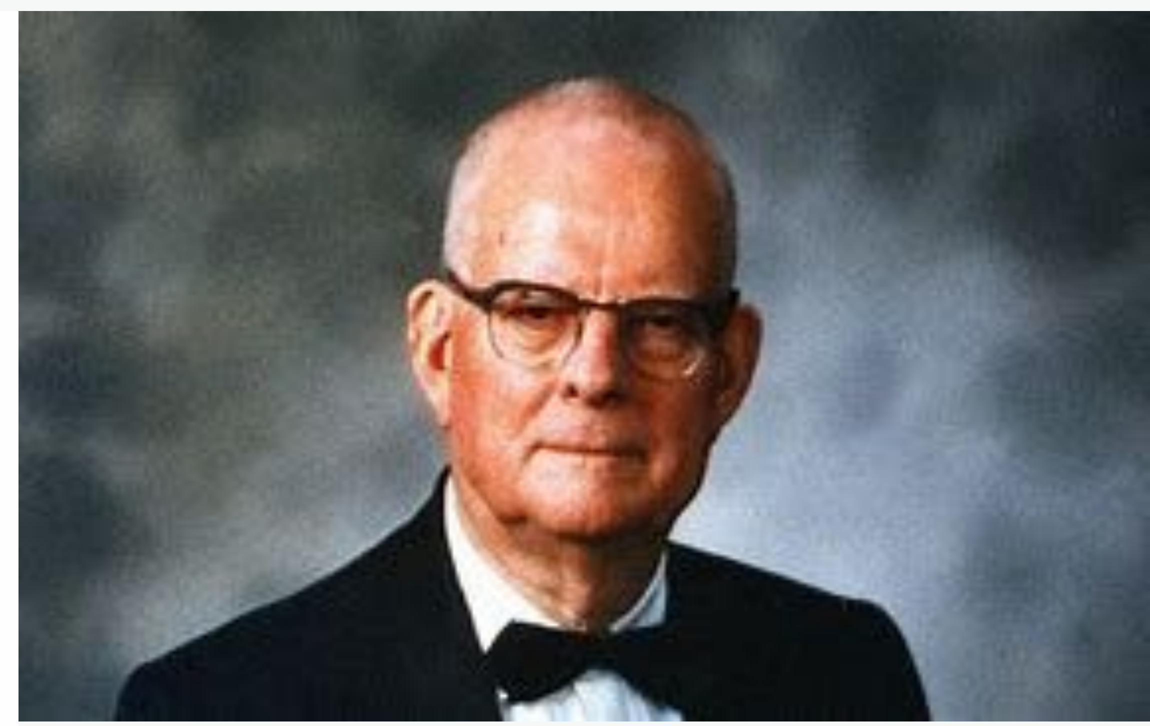
Juran’s Trilogy

The Juran Trilogy®

Quality Planning
Quality Control (During Operations)
Sporadic Spike
(RCA/SCA)
40
Original Zone of
Quality Control
Quality
Improvement
20
R6σ
New Zone of
Quality Control
Operations
Begin
Cost of Poor Quality
Chronic Waste
0
0
Time
Lessons Learned

What’s in a name?





Quality management systems

Multiple models available

For healthcare it means…..

Understand your current state of performance – audit

Understand what good looks like – research, exemplars, you at your best etc.

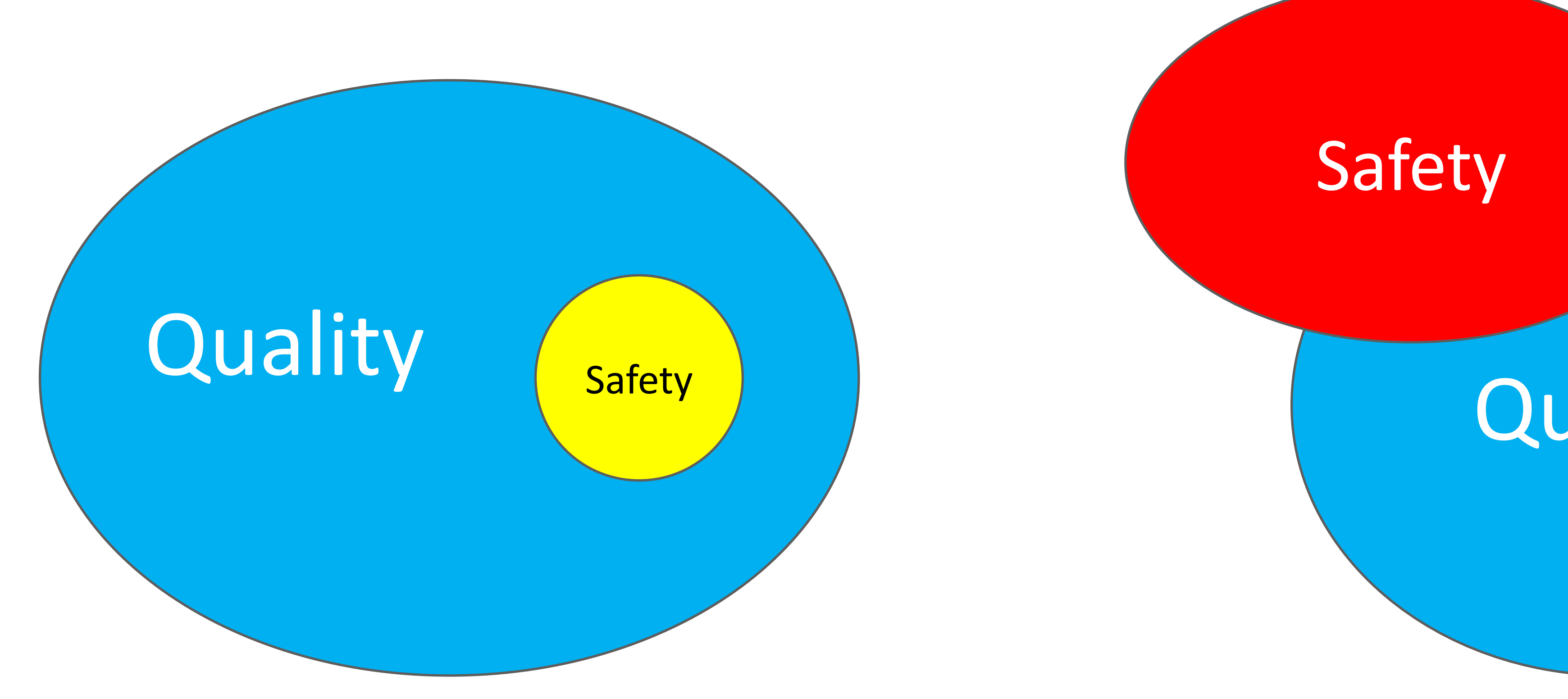
Understand the change ideas that get you from one to the other – QI

Be empowered and supported to make the change as close to the activity as possible – Service line

Leadership support for the above and governance linked

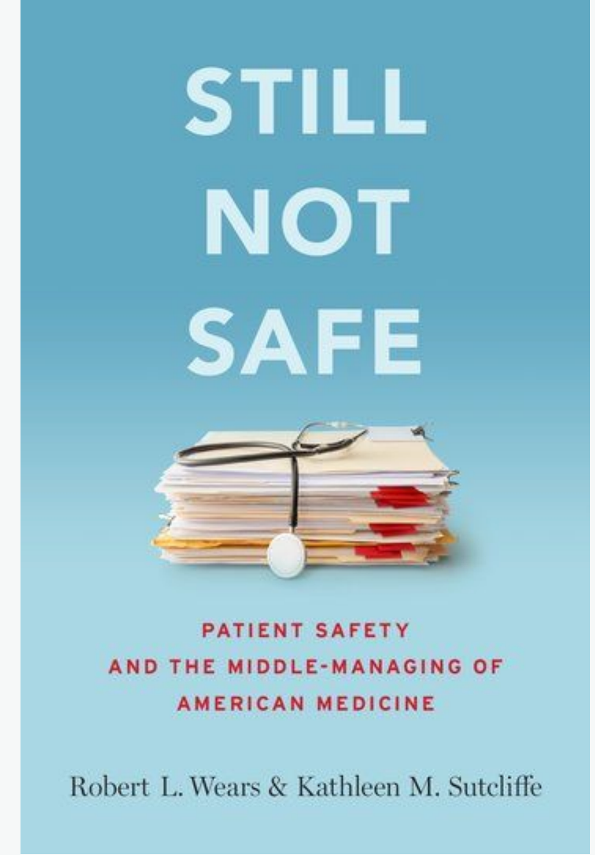
The more able to perform this role the better as healthcare has millions of processes…….

Quality vs Safety, two perspectives



Do we need to reframe safety?

- This text suggests we have over “medicalised” safety and neglected safety science



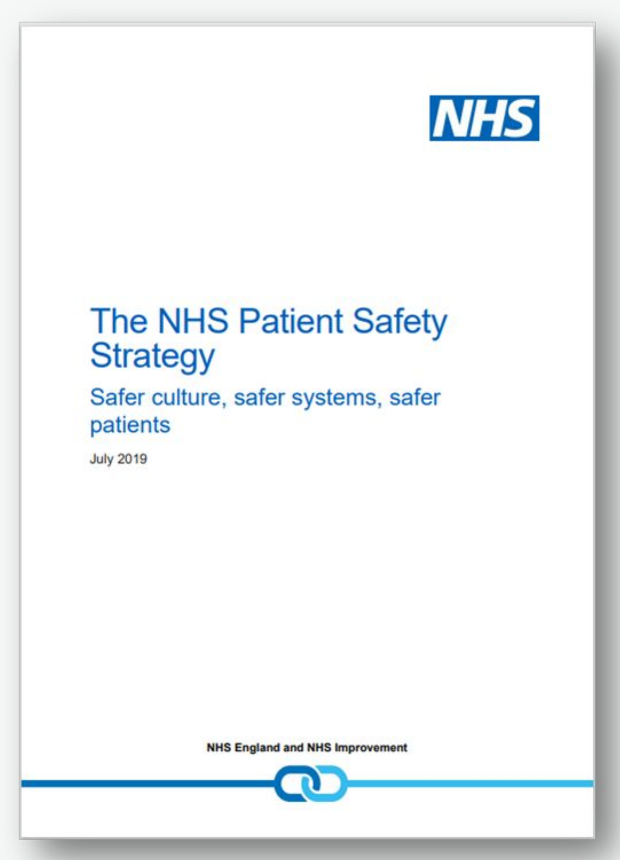
Safety Management Systems

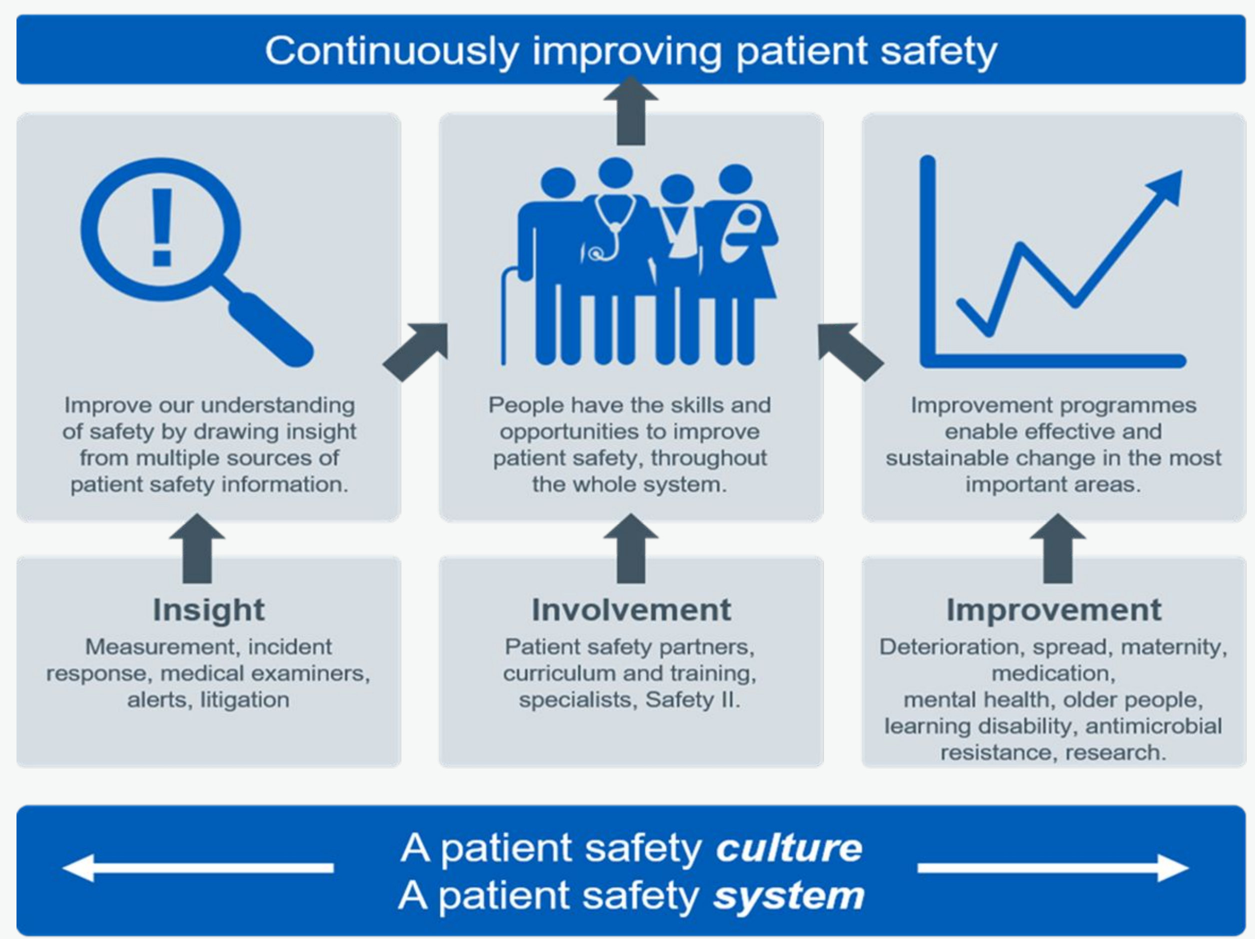
Often described as below

Main differences from QMS

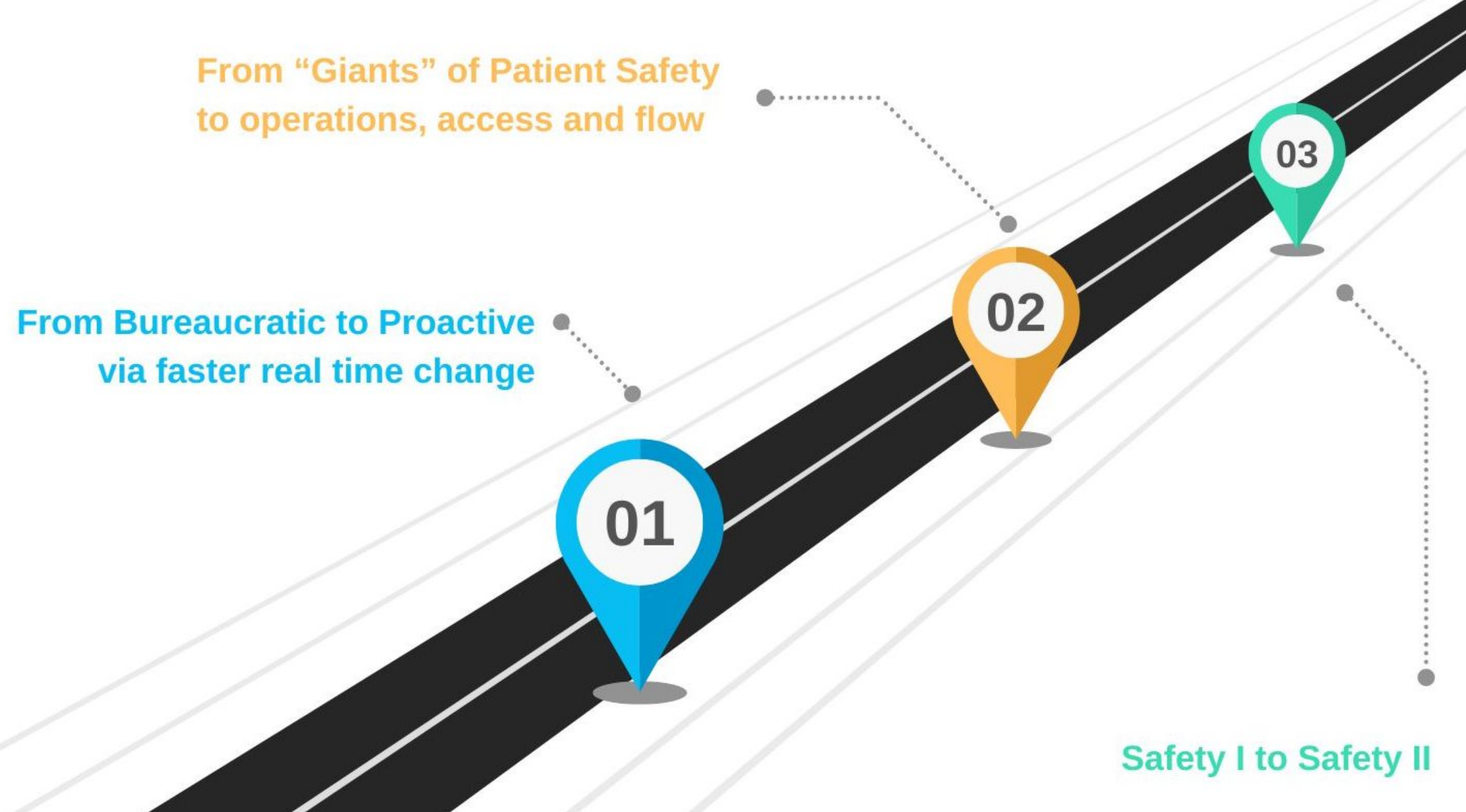
- Risk assessment and reduction
- Measurement often through incident reporting
- Needs us to understand safety science, human factors

The NHS Patient Safety Strategy 2019





A shift in how we work



Developed from Westrum 2003 (A typology of organisational cultures | BMJ Quality & Safety)
Improving safety culture
Why waste our time on safety?
We take safety seriously and respond when there is an incident.
We have systems in place to manage risks, respond to incidents and collect data.
We are always on the lookout for emerging risks and try to anticipate and mitigate problems before they occur.
Patient safety is an integral part of everything we do. We synthesise information from different sources to improve systems continuously.
Pathological
Reactive
Bureaucratic
Proactive
Generative

Action on patient safety can reduce health inequalities

Box 2: Selected solutions to reduce inequalities in patient safety through action by individual healthcare professionals, healthcare leaders and system level action

Individuals

- More routine involvement of advocates from patients' communities in healthcare interactions to reinforce communication and ongoing support in care
- Purposeful consideration of how the social background of a patient may dictate risk of harm from healthcare, and adjust management and follow-up plans accordingly
- Use of culturally and linguistically appropriate shared decision making tools to empower involvement of marginalised patient groups in their care and safety

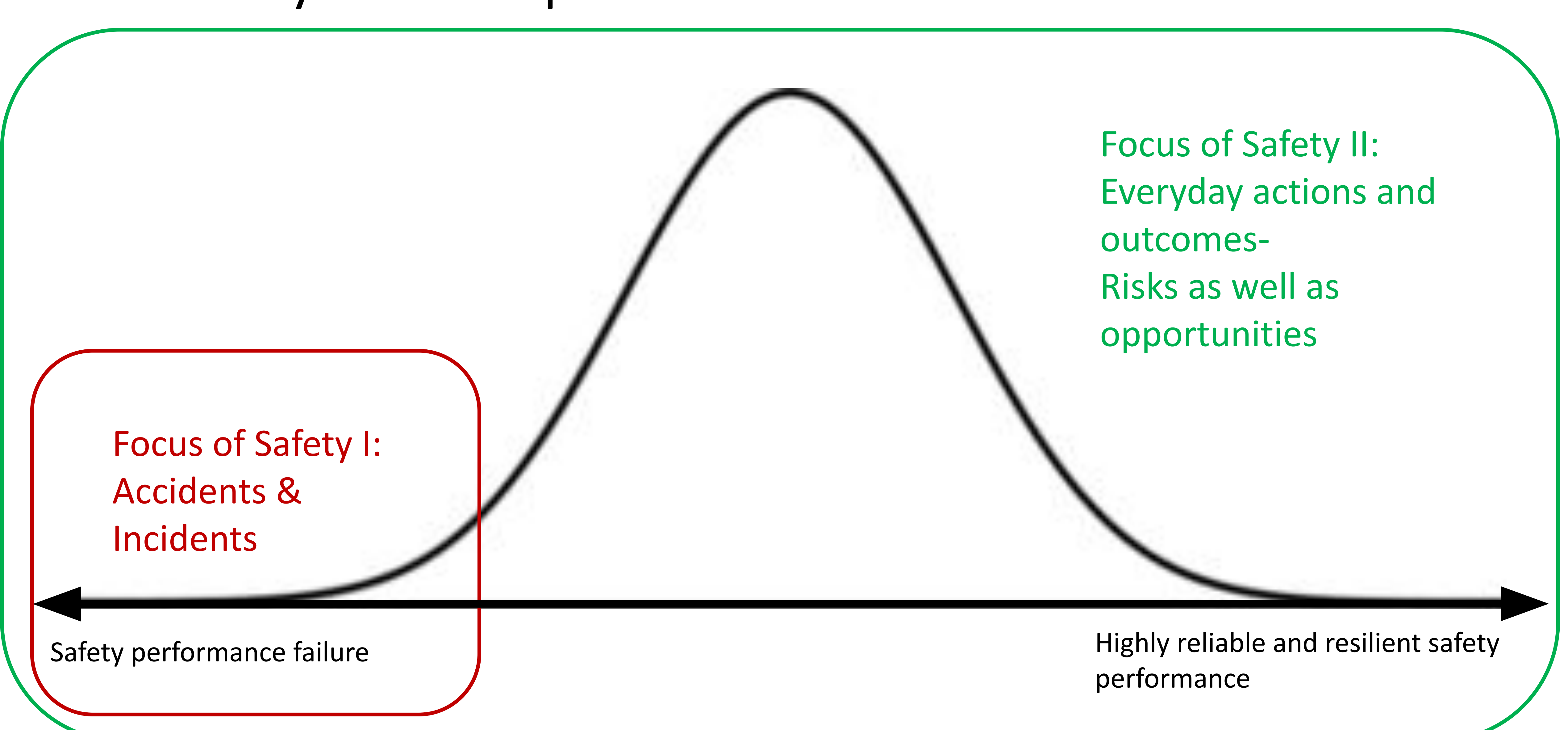
Healthcare leaders

- Support a diverse healthcare leadership that pushes these issues into the consciousness of the workforce and mobilises the system towards meaningful action
- Race conscious approaches to healthcare education with greater emphasis on racism and discrimination (rather than race) as determinants of disease
- Systematised co-design of clinical services and clinical information with members of marginalised patient communities

System level action

- Avoid using systematically biased clinical prediction tools and algorithms unless clear empirical justification for race adjustment has been established
- Strengthen capabilities for stratified analysis of patient safety event reports according to important patient characteristics and the translation of these data into tangible action
- Clinical trials must recruit an appropriately diverse cohort, report relevant social determinant characteristics, and conduct relevant stratified analyses that determine effectiveness and safety of drugs and devices

How Safety II can help



Risk assessment and balancing

Optimal individual discharge point =

Discharge risks < (nosocomial + deconditioning risks)

X < Y+Z

Optimal discharge point for system risk overall may be earlier

↑ **Risk** of deconditioning per day

Y

Inpatient journey: length of stay

Admission

Risks:

↑ Delay = increased SI/Mortality

↑ **Risk** of nosocomial harm **Z**

↑ VTE, falls, HAPU, HCAI, CAUTI

Discharge X

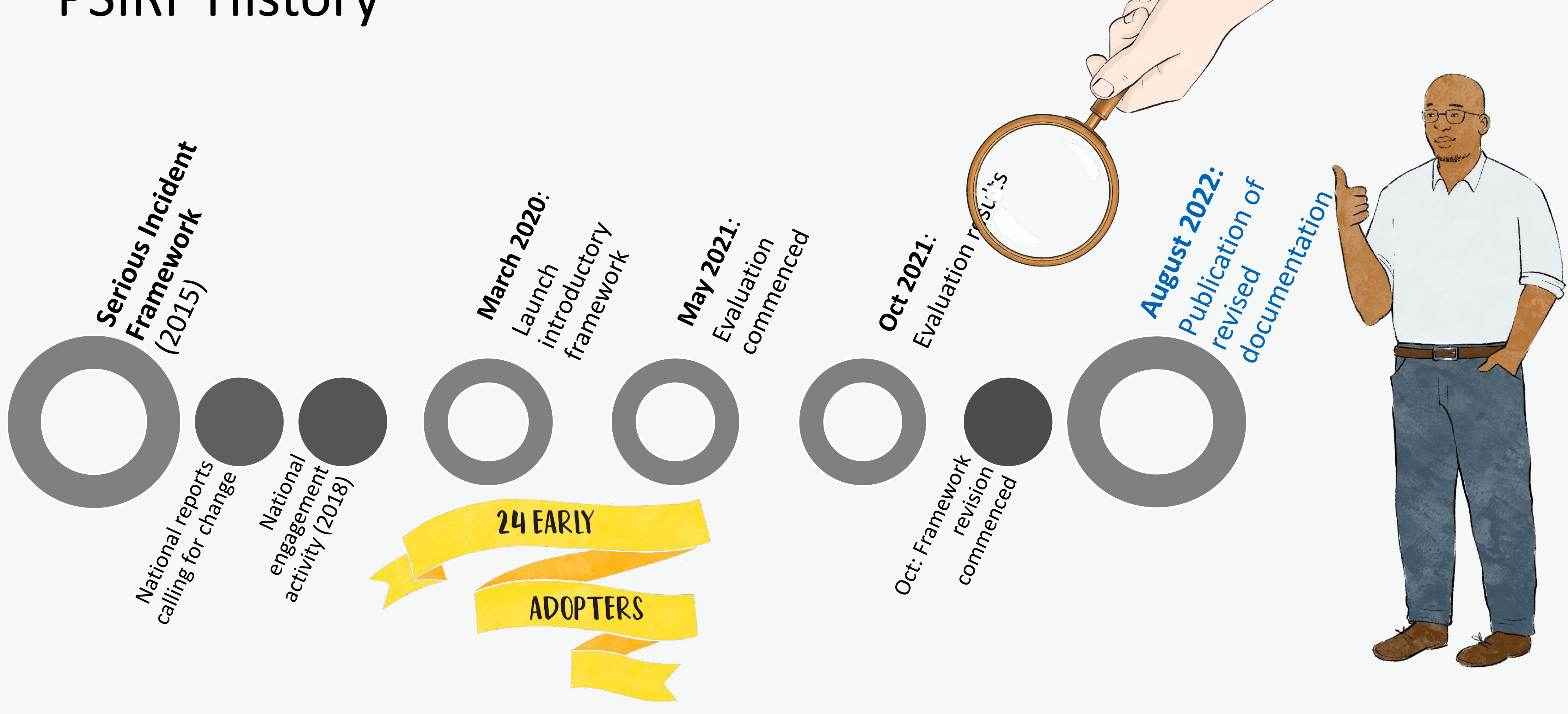
Early discharge risks:

↑ Harm at home eg falls

↑ Deterioration

↑ Re-admission

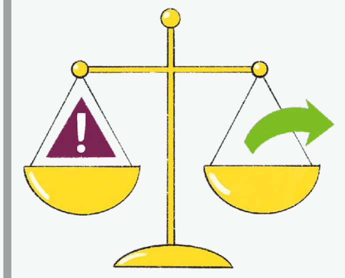
PSIRF History



What does PSIRF hope to achieve?

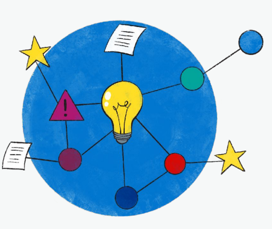
Improved experience for those affected:

- Expectations are clearly set for informing, involving, and supporting those affected, particularly patients, families and staff.



More proportionate and effective response:

- Better resource planning.
- Supports organisations to be more proportionate, sensitive and considered in their approach.



Better range of methods for learning:

- Promotes a range of methods for responding to and learning from patient safety incidents.
- Moves away from RCA.
- Timelines more flexible and set in consultation with the patient and family.
- Quality of response and resulting improvement work is the priority.

Strengthened governance and oversight:

- Regulators and bodies like ICSs will consider the strength and effectiveness of organisations' incident response.
- Makes leaders of organisations providing healthcare accountable.