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En7 #qfen7

Institute *for* Healthcare Improvement

BMJ

Safety reviews:

Developing Something Extraordinary

Using Something Quite Ordinary to

Improve Quality of Care, Patient Experience

and Staff Wellbeing

Manoj_K_Kumar

National Clinical Lead SMMP

#qfen7

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Teenager given wrong drug dies

Two doctors could face manslaughter charges after the death yesterday of a teenager from a powerful anti-cancer drug that was wrongly injected into his spine.

The parents of Wayne Jowett, 18, announced his death in a statement released through their lawyers. His father, also called Wayne, and his mother Stella said: "Our son Wayne Matthew Jowett died today at the University hospital in

...skilled non-medical accident investigator was called in...catalogued over **40 weaknesses in the hospital system** that led to the **fatal error**.

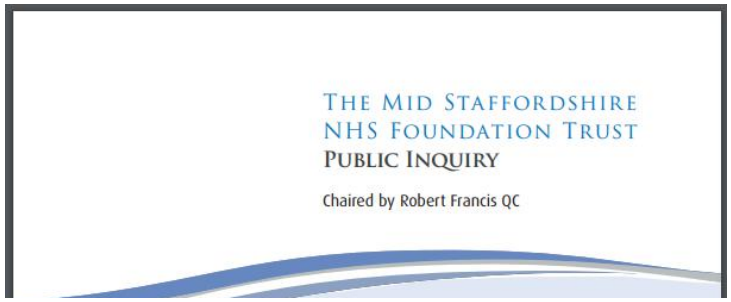
HOME » NEWS » UK NEWS

Doctor who killed cancer patient jailed

By Nick Britten

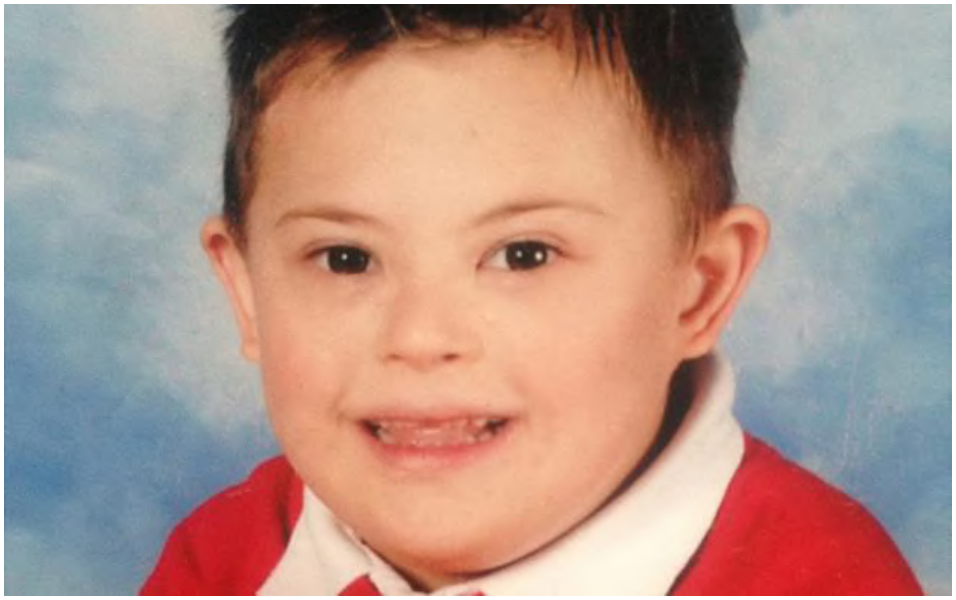
12:01AM BST 24 Sep 2003

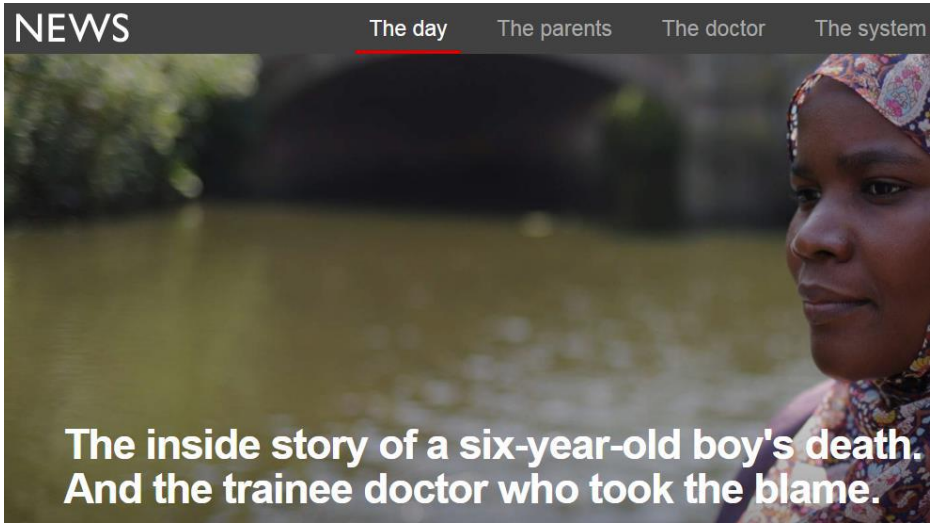
An independent inquiry into the incident concluded that the death of Wayne Jowett, who was on remission from leukaemia, **was caused by a "complex amalgam of human, organisational, technical and social interactions**



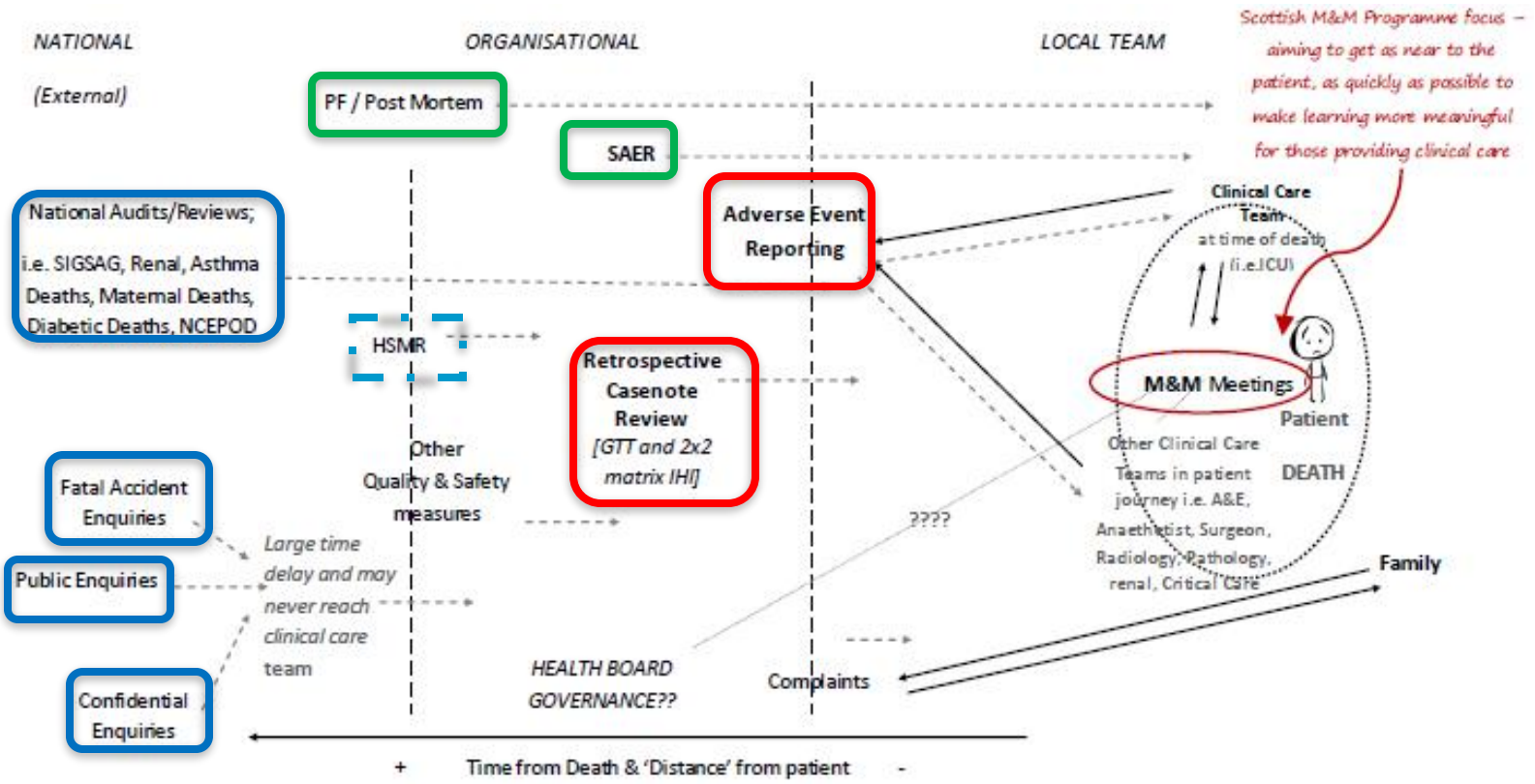
Building on the report of the first inquiry, the story it tells is first and foremost of appalling suffering of many patients. This was primarily caused by a serious failure on the part of a provider Trust Board. It did not listen sufficiently to its patients and staff or ensure the correction of deficiencies brought to the Trust's attention. Above all, it failed to tackle an insidious negative culture involving a tolerance of poor standards and a disengagement from managerial and leadership responsibilities. This failure

Executive summary




NEWS
The day
The parents
The doctor
The system
The inside story of a six-year-old boy's death.
And the trainee doctor who took the blame.

(Learning from) Safety Reviews



Work as Imagined **Work as Done**

QI

SPSP

National Audits

DoC

Patient Feedback

WMTY

Patient (Safety)

TEACHING

MEDICO LEGAL

Mortality /Case Note Reviews

,

TRAINING

Learning From Excellence

COMPLAINTS

PERSONAL REFLECTION

Fatal Accident Inquiry

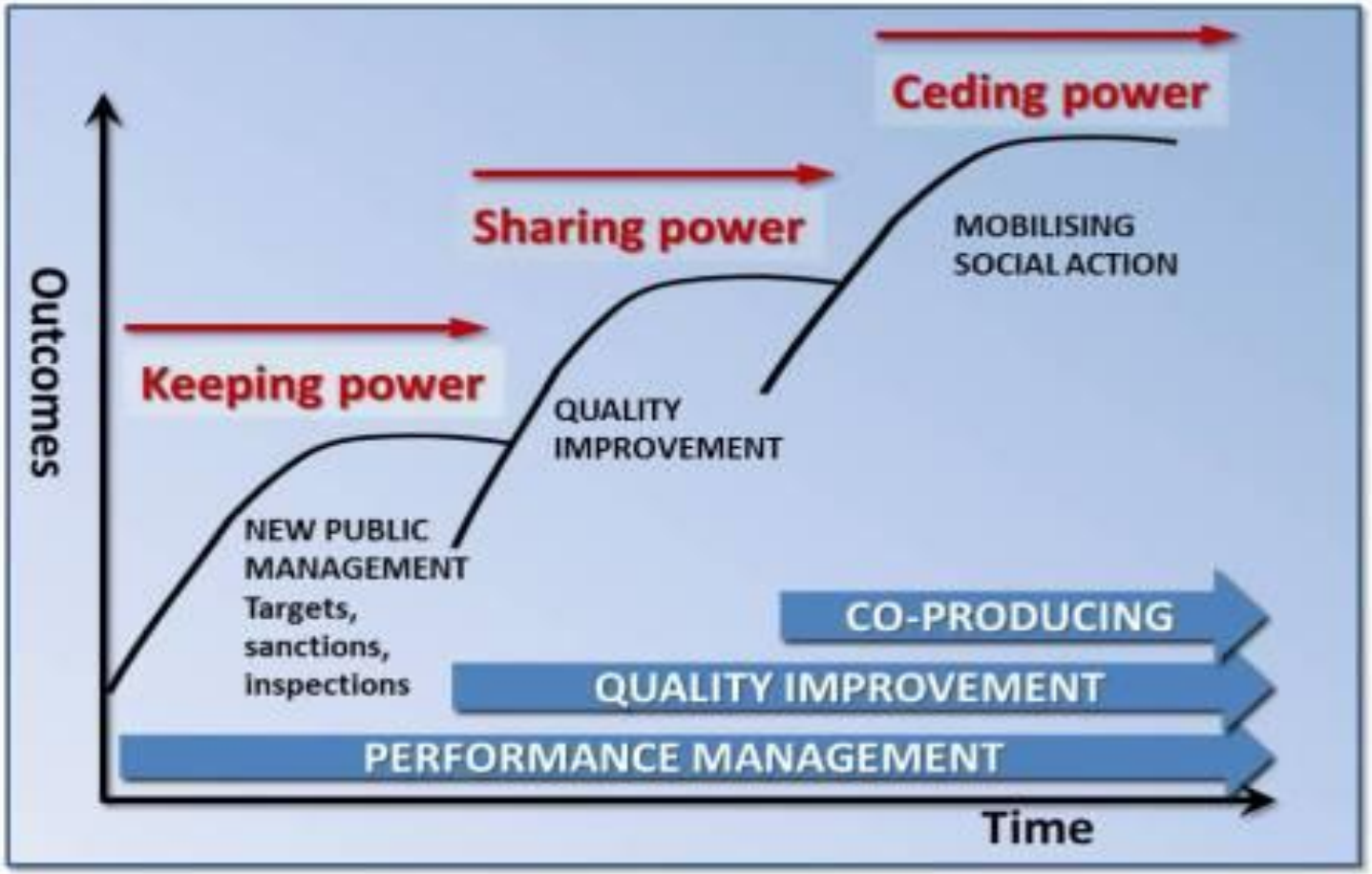
Human Factors/Ergonomics

Adverse Event

External Reviews

Joy in Work

Getting to the Third Curve



http://aws-cdn.internationalforum.bmj.com/pdfs/M11_Feeley_Leitch_Swensen_Dalton.pdf

International Forum on QUALITY & SAFETY in HEALTHCARE

27-29 March 2019
Glasgow

Institute for Healthcare Improvement

BMJ

People Make Change

Join us in Glasgow to meet new colleagues, hear from inspirational speakers, and share ideas on how to deliver exceptional person-centred care.

Harvard
Business
Review

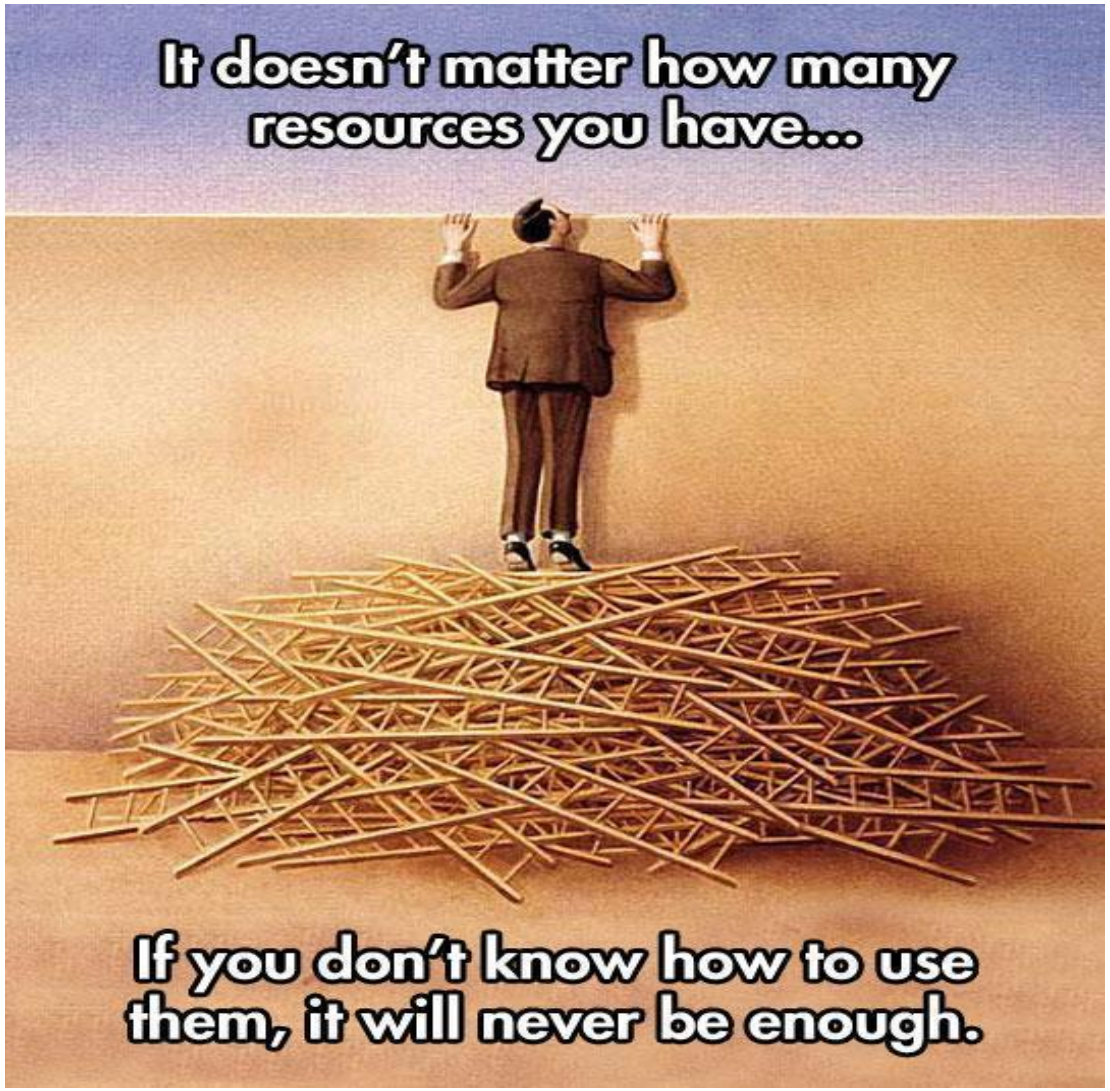
PSYCHOLOGY

Research: Perspective-Taking Doesn't Help You Understand What Others Want

by Tal Eyal, Mary Steffel, and Nicholas Epley

Courtesy: Neil Patel


Our colleagues in this shop have total authority to do whatever they can to give you amazing service.
Jane
Adam
TIMPSON
TIMPSON


It doesn't matter how many resources you have...
If you don't know how to use them, it will never be enough.

What exactly is M&M?

Team Based Reviews – patient/ staff/ service

NOT just M or M - SAFETY IS NOT BINARY

Opportunity to work as a team

- understand complexity in care
- address weakness
- learn from strengths
- Improvement
- train/ teach/ share
- provide our communities with the best possible care

“Tell me and I forget,
teach me and I may remember,
involve me and I learn.”

Benjamin Franklin

Designing Safety

Want to make culture healthy? Make your strategy nutritious and tasty

SMMP National Survey

88.1%

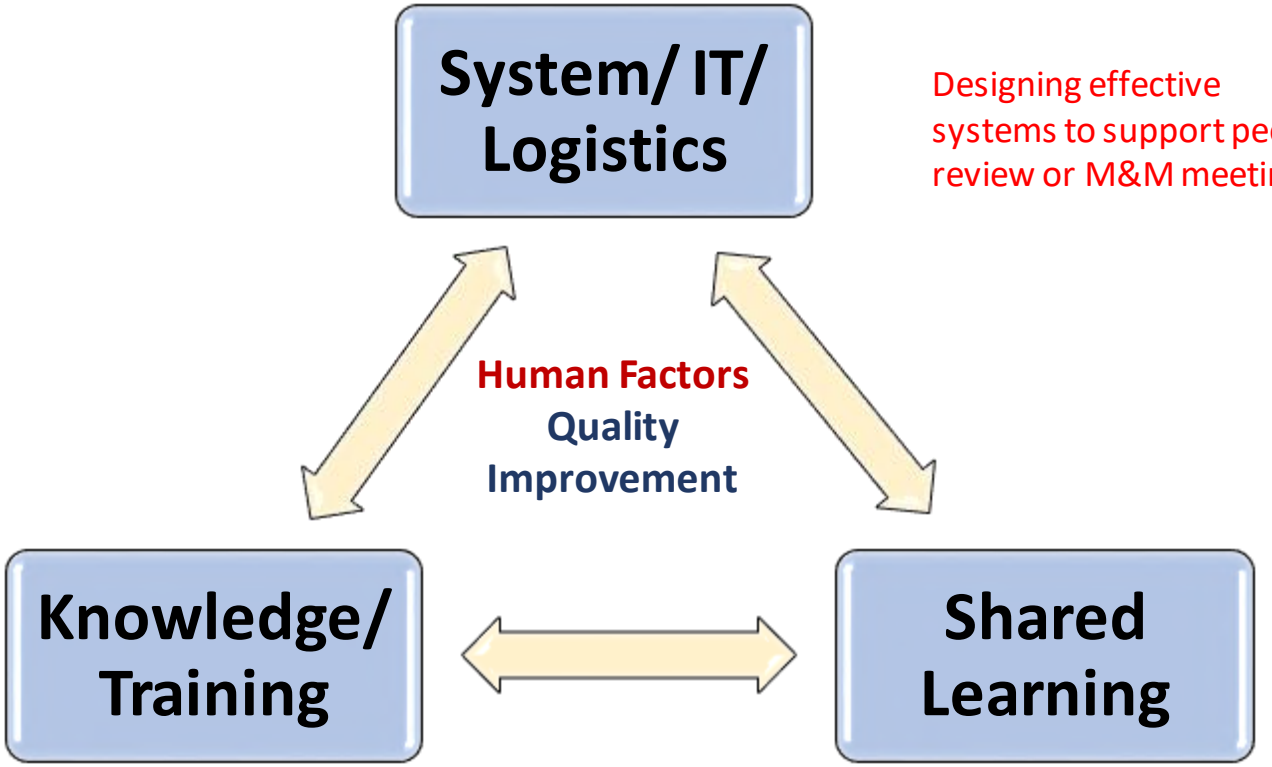
M&M or similar peer review meeting

>50% **Learning - Infrequent/ Rare/ Never**

Significant variation in practice across Scotland

? Output

SMMP
Improving Quality of Team Based Safety Review Processes

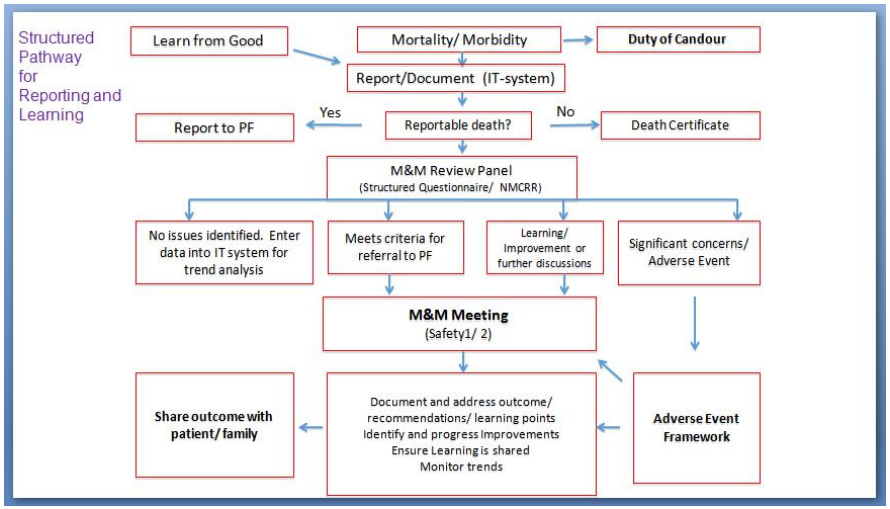


Guidance/ Tools/ Framework

Mortality and Morbidity Reviews

Practice Guide – Working Version

October 2017

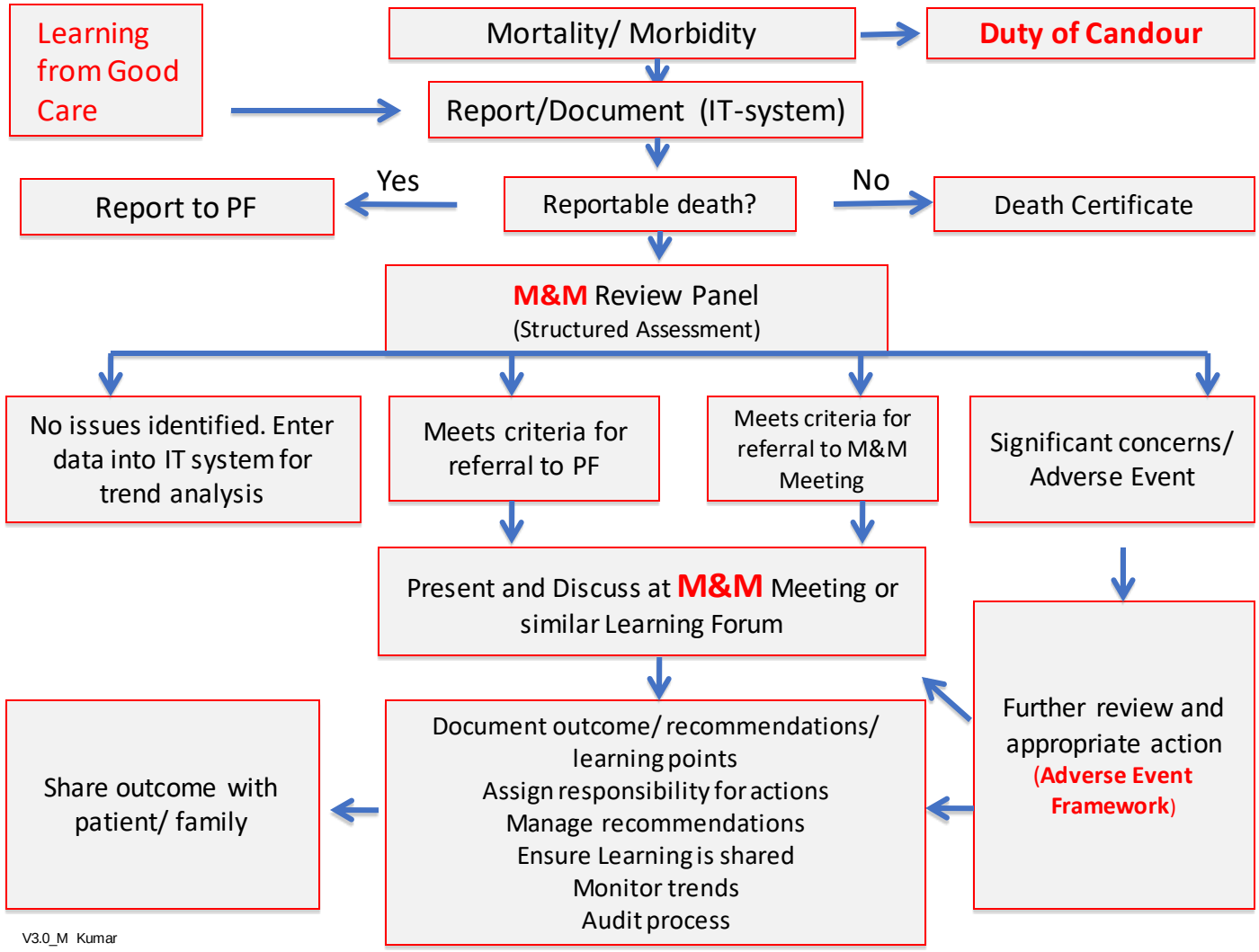


SMMP Workshop

Undergraduate
Professional
Practice Block

A new generation of NHS Scotland workforce

- Safety reviews
- Human Factors/ Ergonomics
- Non-Technical Skills
- QI


Learning from Good Care
Mortality/ Morbidity
Duty of Candour
Report/Document (IT-system)
Yes
Report to PF
Reportable death?
No
Death Certificate
M&M Review Panel
(Structured Assessment)
No issues identified. Enter data into IT system for trend analysis
Meets criteria for referral to PF
Meets criteria for referral to M&M Meeting
Significant concerns/ Adverse Event
Present and Discuss at M&M Meeting or similar Learning Forum
Share outcome with patient/ family
Document outcome/ recommendations/ learning points
Assign responsibility for actions
Manage recommendations
Ensure Learning is shared
Monitor trends
Audit process
Further review and appropriate action
(Adverse Event Framework)
V3.0_M Kumar


GB USA MEX
ONE SIZE
DOES NOT
FIT ALL
30°C
Von links bügeln/ Iron inside out/
repasser sur l'envers

Poor Design

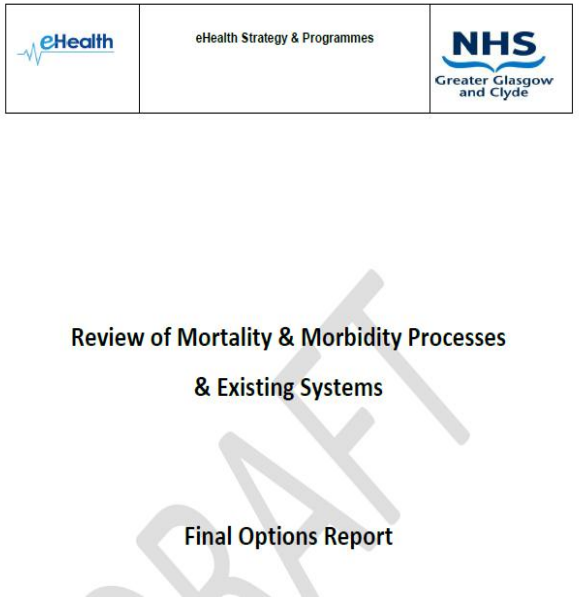
↓

Poor Engagement

↓

Poor Outcome

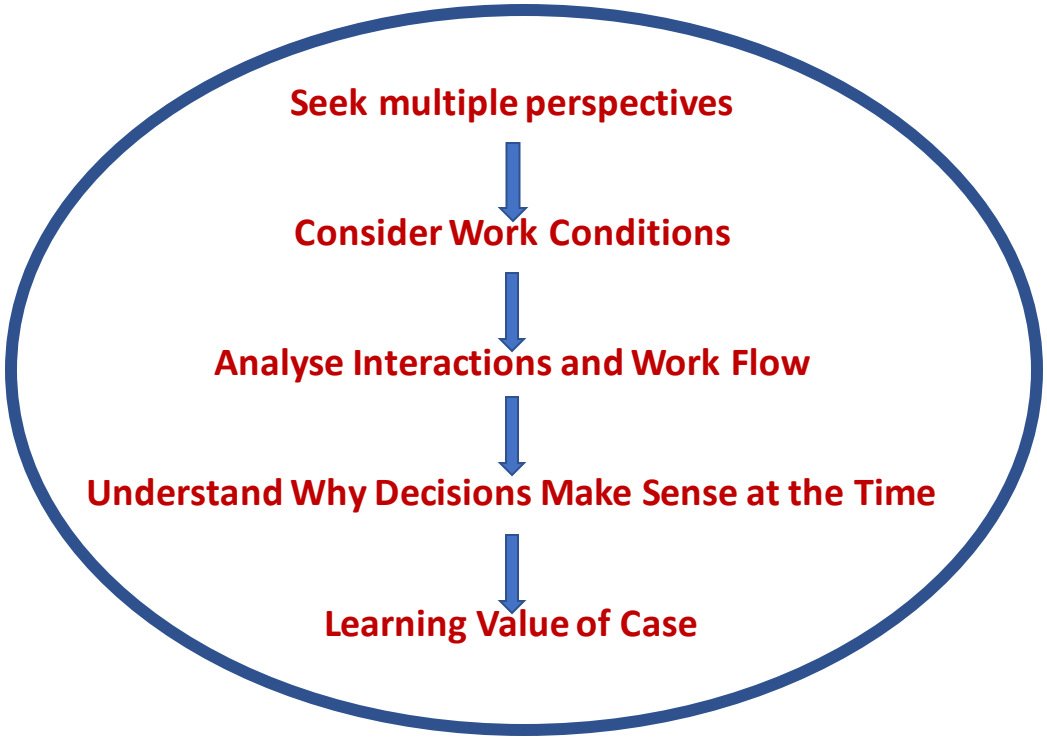
- ✓ Responsive
- ✓ User friendly
- ✓ ‘Memory’
- ✓ Links to simulation/ training
- ✓ Supports Learning & Improvement



Core Dataset

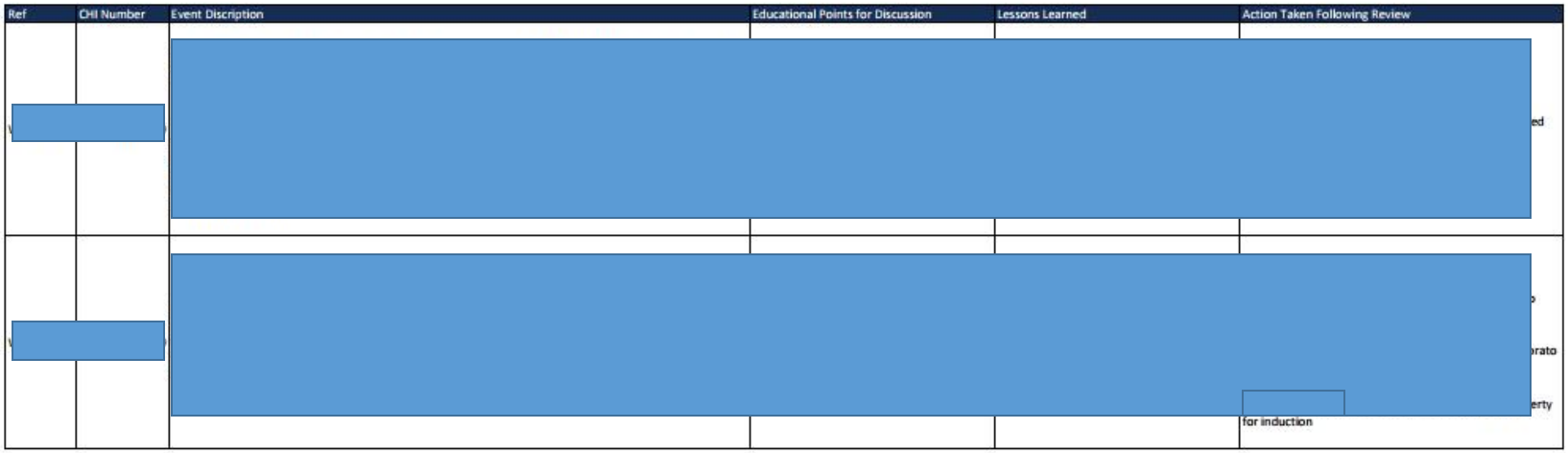
- What went well (Why, How)
- What did not go well (Why, How)
- What can we learn
- What is our action plan
- How are we going to share this learning

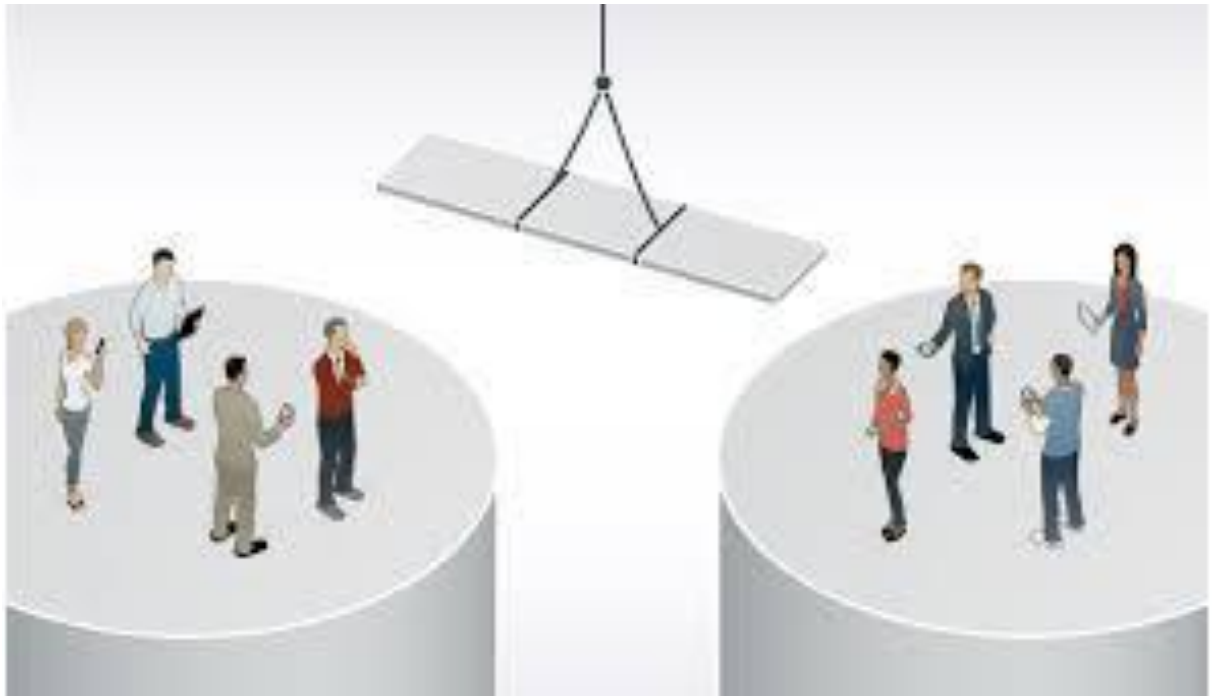
Systems- Based Framework for Safety Review (M&M) Analysis



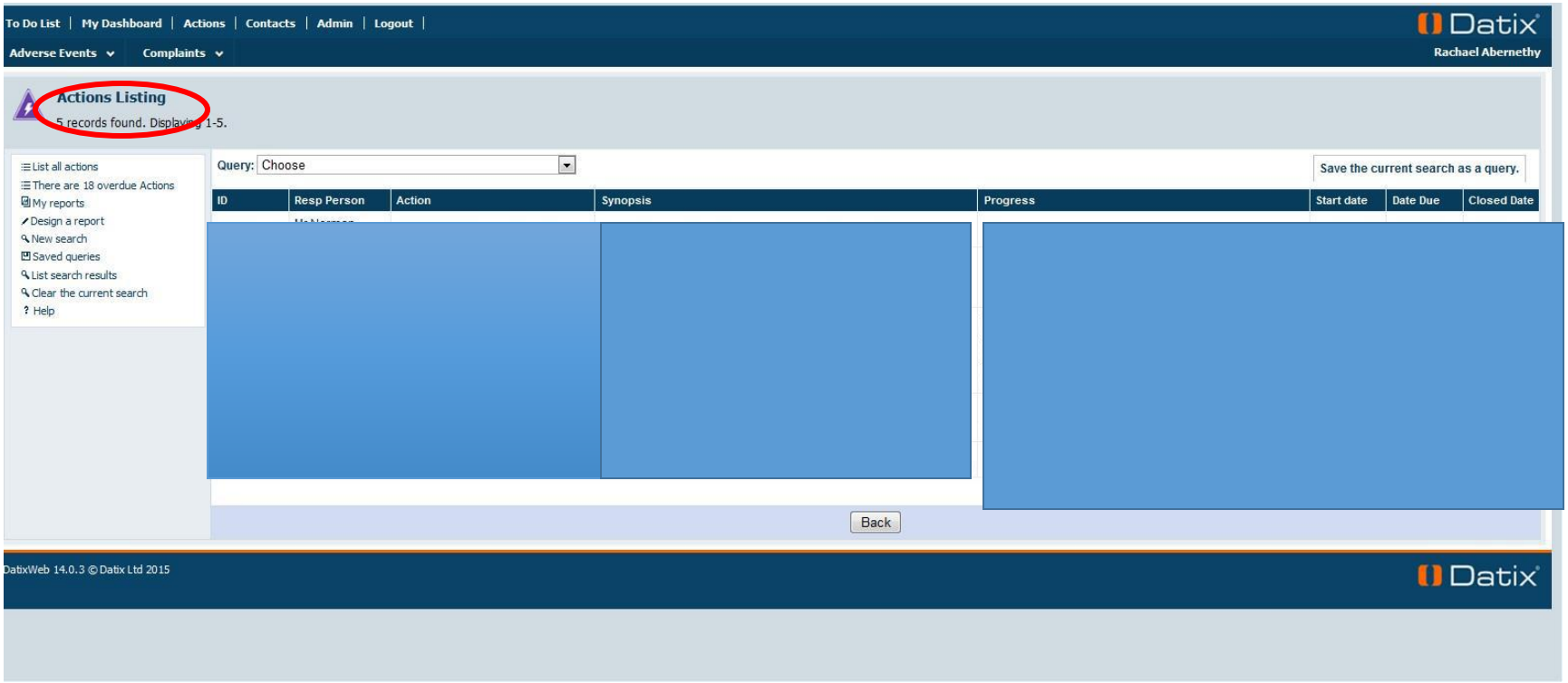
HF/E
Safety 2
QI
Just Culture
Psychological Safety

Team reflection
Shared Learning
Training – Closing the loop
Innovate
Governance
DoC





Generating QI



“You can’t change the culture”

M&M Meetings – ‘Toxic’

How do we close the loop on learning?

> 30% hospital staff don’t feel safe raising a concern

Reasons for not reporting adverse incidents: an empirical study

Charles Vincent, Nicola Stanhope, Margaret Crowley-Murphy

Article first published online: 25 DEC 2001

DOI: 10.1046/j.1365-2753.1999.00147.x

Issue

Journal of Evaluation in Clinical Practice

Volume 5, Issue 1, pages 13–21, February 1999

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essy, M DeWit

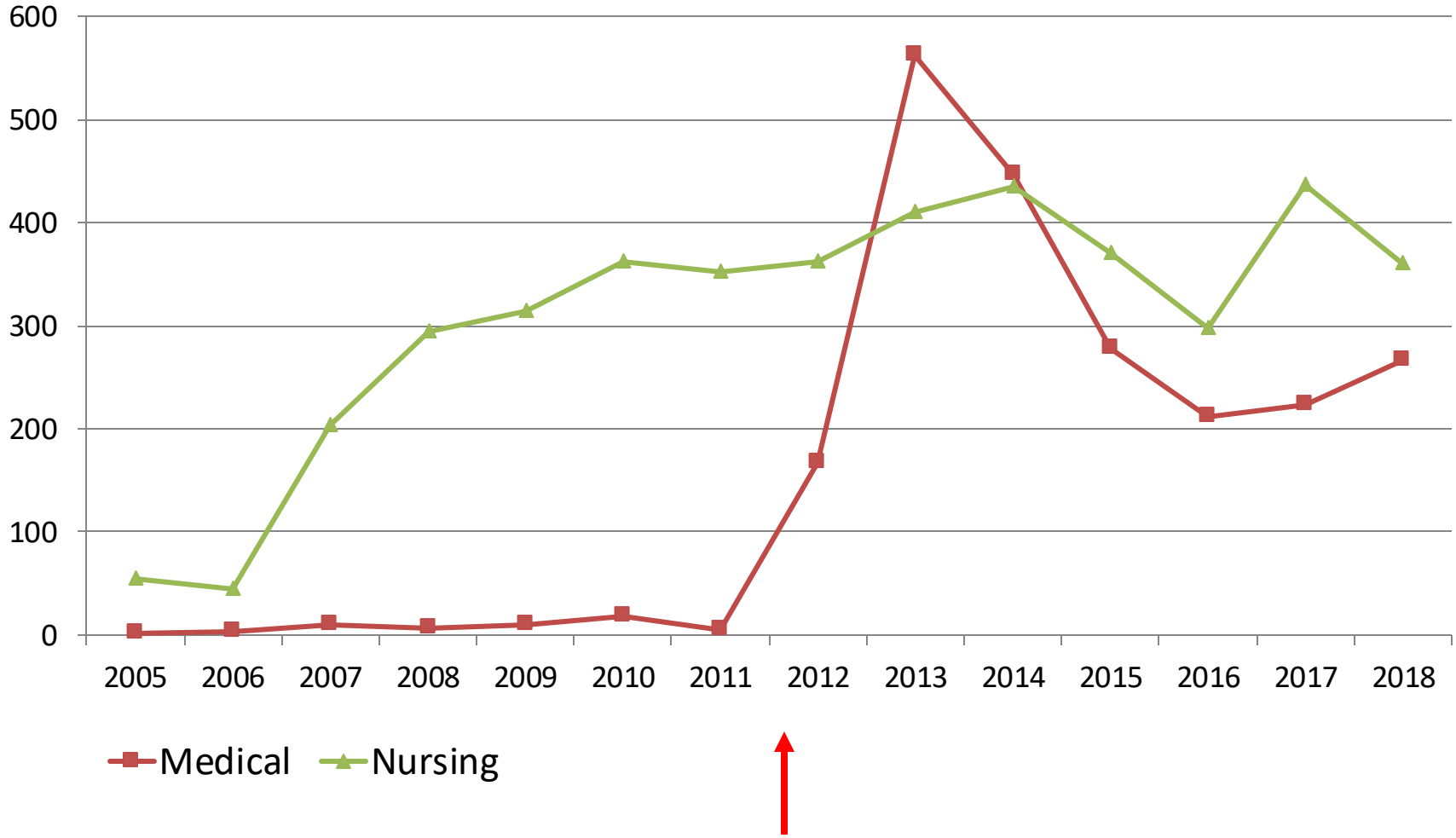
:39–43. doi: 10.1136/qshc.2004.012559

News

Survey of UK doctors highlights blame culture within the NHS

BMJ 2018 ; 362 doi: https://doi.org/10.1136/bmj.k4001 (Published 20 September 2018)

Cite this as: *BMJ* 2018;362:k4001



Integrated Incident Reporting System with
Team based safety review meetings

"The new M&M Process can be non-judgemental, fair and a genuine learning and improvement process" (Trainee)

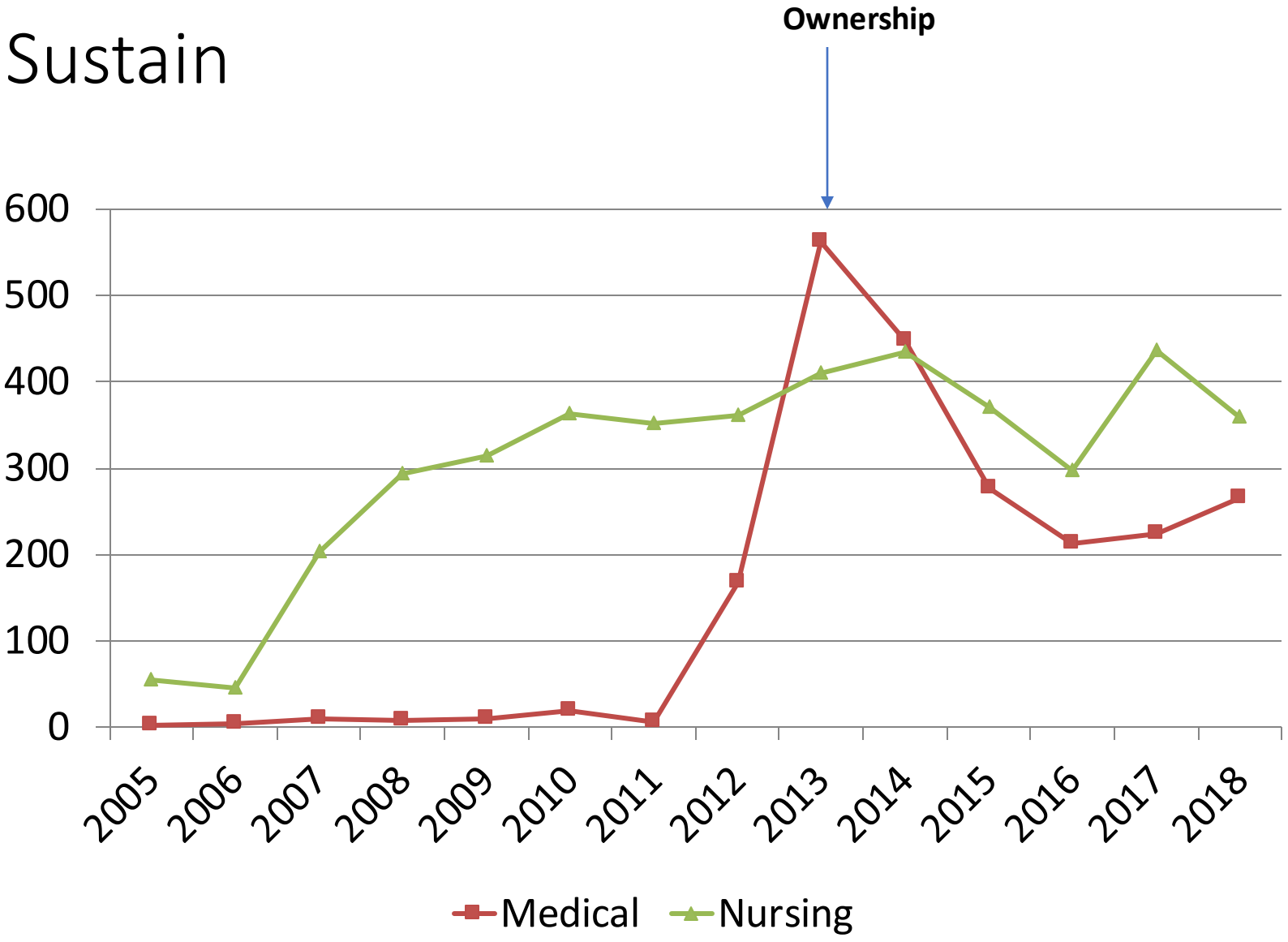
"…. positive effect on trainees/ trainers..". (Trainer)

"….(M&M) process has allowed trainees/ staff to confidently raise concerns ...feel reassured that they will be addressed in a learning environment." – Deanery feedback based on interviewing trainees/ staff

... .We have had some fantastic learning opportunities so here's hoping the process can go from strength to strength.
- Senior Charge Nurse

"We feel that the overt linkage between (IT system) and the QI (M&M) meetings is a particular strength" - Scottish Deanery

Sustain


Ownership
600
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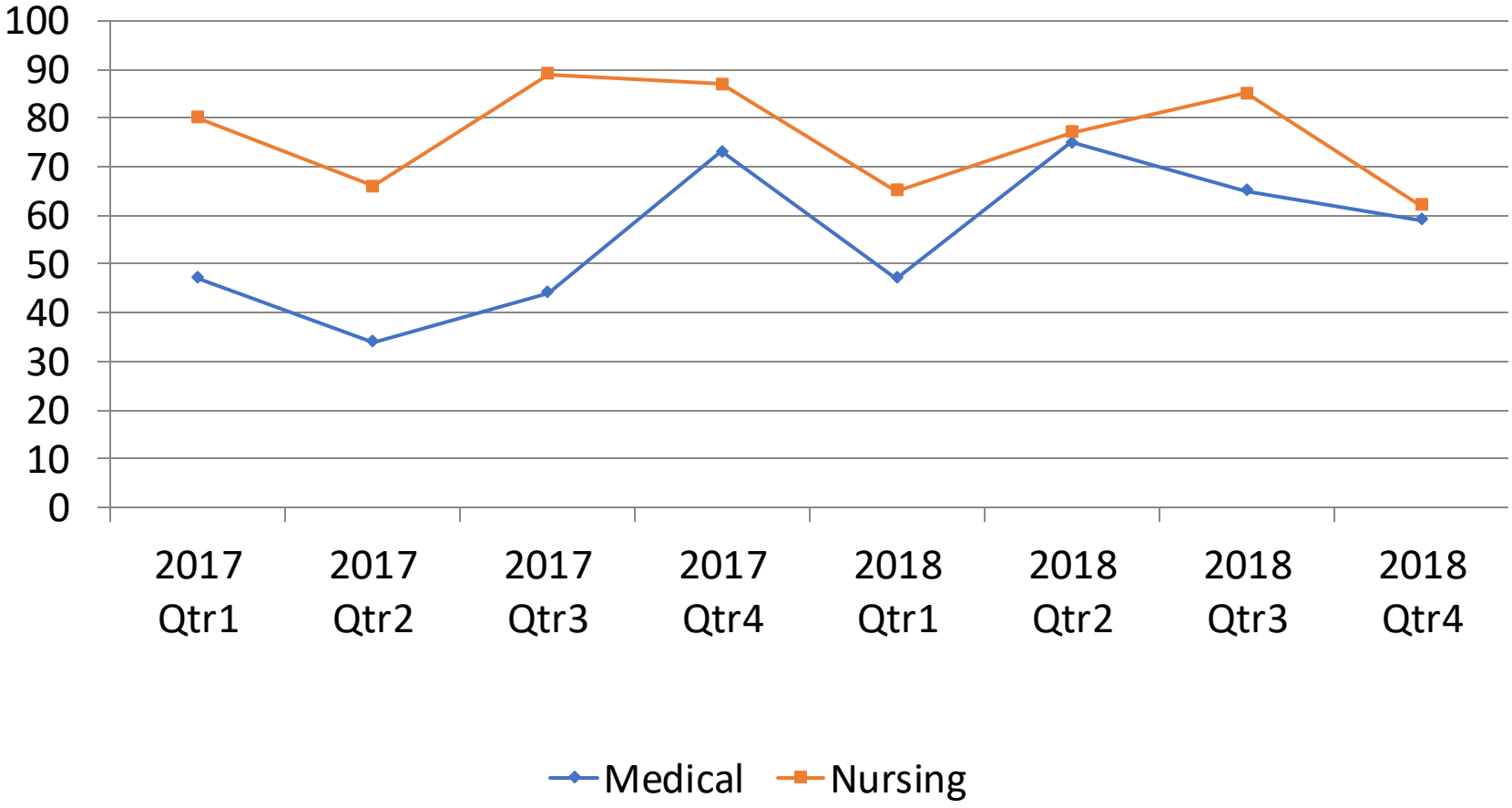
Medical
Nursing


100
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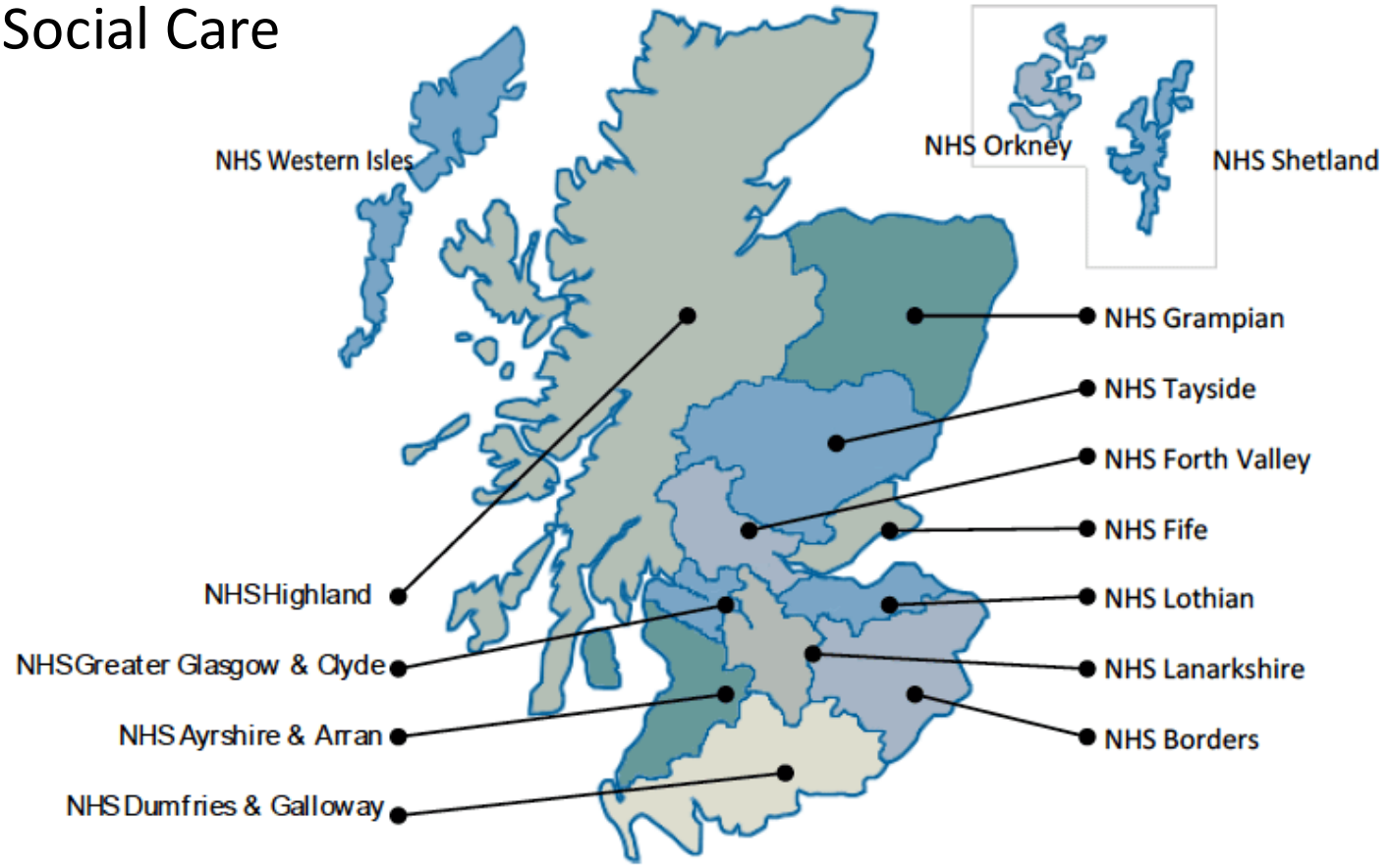
2017 Qtr1
2017 Qtr2
2017 Qtr3
2017 Qtr4
2018 Qtr1
2018 Qtr2
2018 Qtr3
2018 Qtr4
Medical
Nursing

Health and Social Care



Special NHS Boards

NHS Education for Scotland	NHS Health Scotland
NHS National Services Scotland[1]	NHS National Waiting Times Centre
Healthcare Improvement Scotland	NHS 24
Scottish Ambulance Service	The State Hospitals Board for Scotland

Healthcare Improvement Scotland

@Manoj_K_Kumar