Patient Safety: the joker yet to be played

Dr David Gerrett
Senior Pharmacists NPSA
Director B.E.A.M, EAHP

European Association of Hospital Pharmacists

The European Association of Hospital Pharmacists (EAHP) is accredited by the Accreditation Council for Pharmacy Education as a provider of continuing pharmacy education
UPN 475-000-09-017-L04-P

Disclaimer

To the Conference: conflicts None
To Industry: conflicts None
To the GPhC body: conflicts None

Personal views expressed are those of a registered practising pharmacist and healthcare practitioner in the NHS. Personal views may not be taken as representative or prescriptive of NPSA policy.

Schedule

- 9:00 to 10:30 principles and methodology of risk management
- 11:00 to 12:30 risk analysis: tools and how to use
- 14:00 to 15:30 medication errors
- 16:00 to 18:00 workshop, presentation and discussion of results

Set the scene

- Hands up all those that interact with patients?

Do you hand out prescriptions to patients as they are discharged?

Number | Number

Set the scene

- Hands up all those that have corrected a prescribers error?

We are the patients safety system for drugs!

Number | Number

Set the scene

- Hands up all those that have a system for recording the near misses?

Do you think we might be missing something here?

Number　　Number

Let me rant on for 5 minutes, a history lesson

Pt　　US　　Pt

Set the scene

If you do nothing else after this weekend you MUST MUST start recording and tracking the patient safety work you do in correcting errors

Errors do patient harm
– you can't morally or professionally allow that

Errors cost money – you can use that to make the case

A fundamental truth

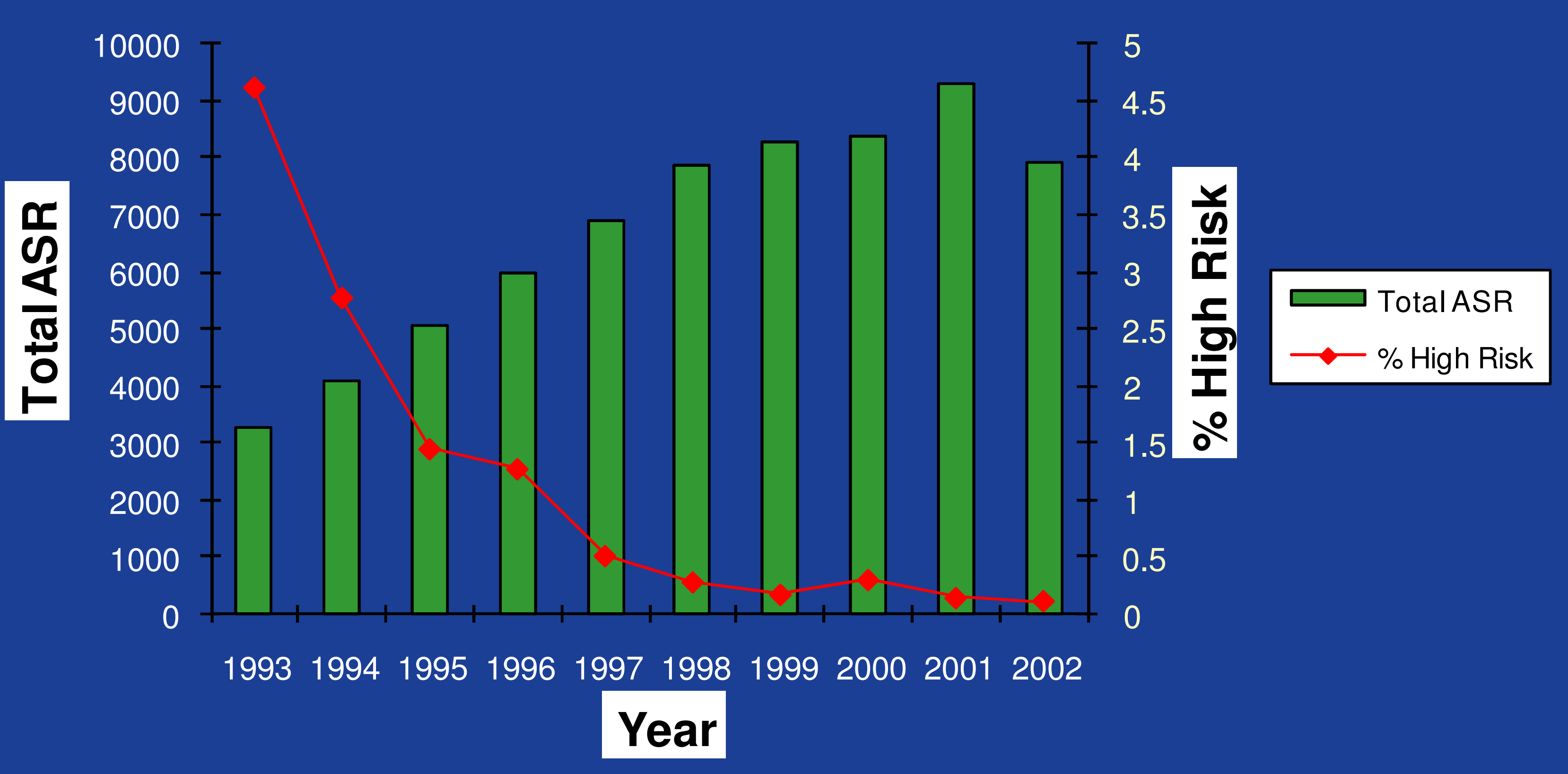
- You can't start looking at risk, making it safe for patients if the organisation does not accept it has a problem!

Discuss!

Agree? Number

Disagree? Number

Air Safety Reports (ASR): Volume and Risk



Summary points

Two approaches to the problem of human fallibility exist: the person and the system approaches

The person approach focuses on the errors of individuals, blaming them for forgetfulness, inattention, or moral weakness

The system approach concentrates on the conditions under which individuals work and tries to build defences to avert errors or mitigate their effects

High reliability organisations—which have less than their fair share of accidents—recognise that human variability is a force to harness in averting errors, but they work hard to focus that variability and are constantly preoccupied with the possibility of failure

Reason J. Human error: models and management . BMJ 2000;320 768-70

The Systems Approach

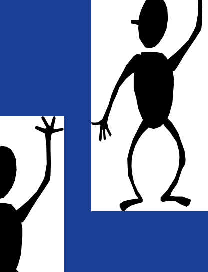
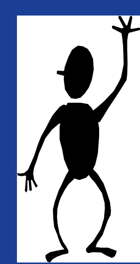
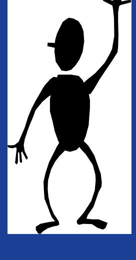
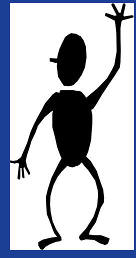
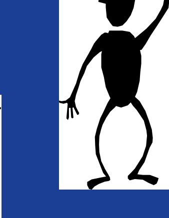
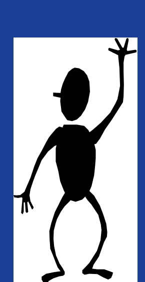
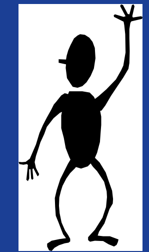
‘We must stop blaming people and start looking at our systems. We must look at how we do things that cause errors and keep us from discovering them…..before they cause further injury’

Leape L. Error in Medicine JAMA 1994 :272 1851-1857

What do you do with this?

Being Open

- Hands up everyone who has made a mistake?

task..... take 5 minutes and talk to your colleague about your personal error!

Being open
Communicating with patients and carers after patient safety incidents

What is Being open?

Being open involves apologising and explaining what happened to patients who have been harmed as a result of a patient safety incident.

It encompasses communications between healthcare professionals, patients, families and their carers.

2005 - 2009

NHS
National Patient Safety Agency

Safer practice notice 10

Notice

15 September 2005

Immediate action	☐
Action	☑
Update	☐
Information request	☐

Ref: NPSA/2005/10

Being open when patients are harmed

Being open simply means apologising and explaining what happened to patients and/or their carers who have been involved in a patient safety incident.

Communicating effectively with patients and/or their carers is a vital part of the process of dealing with errors or problems in their treatment. In doing so, NHS organisations can mitigate the trauma suffered by patients and potentially reduce complaints. Effective communication, however, is not always provided.

As the Department of Health's 2003 *Making Amends* consultation document states, "The individual who has suffered harm as a result of the healthcare they have received must get an apology." The principles of *Being open* are fully supported by a wide range of royal colleges and professional organisations.

Action for the NHS

To improve the quality and consistency of communication when patients are involved in an incident, all NHS organisations (including Foundation Trusts) providing patient care in England and Wales should:

1. Develop a local policy, based on the NPSA's *Being open* policy, but adapted to suit local requirements, by **June 2006**. Local policies should be integrated with existing risk management and clinical governance structures. Organisations with policies already in place are encouraged to review their policy in line with *Being open*.
2. Raise awareness of the local policy amongst healthcare staff and provide them with the appropriate information and support. The NPSA has developed tools to help. See page 3.

For response by:
- All NHS organisations (including Foundation Trusts) providing patient care in England and Wales

For action by:
- Clinical governance leads

We recommend you also inform:
- Directors of nursing
- Medical directors
- HR directors
- Heads of medical training/induction
- Clinical directors
- Risk managers
- Communications leads
- Bereavement officers/counselling teams
- Complaints management
- Patient Advice and Liaison Service (PALS) staff
- Claims managers
- Your solicitors
- Patient and public involvement leads

The NPSA has informed:
- Chief executives and chairs of NHS organisations in England and Wales
- Chief executives and clinical governance leads of strategic health authorities (England) and Regional Offices (Wales)
- Healthcare Commission
- Healthcare Inspectorate Wales
- General Social Care Council
- Commission for Social Care Inspection
- Social Services Inspectorate for Wales
- Social Care Institute for Excellence
- Association of Directors of Social Services
- Care Standards Inspectorate for Wales
- NHS Litigation Authority
- Welsh Risk Pool
- General Medical Council
- Royal colleges, societies and defence unions
- NHS Direct
- Relevant patient organisations and Community Health Councils in Wales
- Health Service Ombudsman
- Cruse bereavement care
- Independent Healthcare Forum
- NHS Clinical Governance Support Team
- Clinical Government Support and Development Unit (Wales)
- The Commission for Patient and Public Involvement in Health
- Quality Improvement Scotland and DHSSPS Northern Ireland

Patient Safety Alert

NPSA/2009/PSA003
19 November 2009

NHS
National Patient Safety Agency
National Reporting and Learning Service

Being Open

Communicating with patients, their families and carers following a patient safety incident

Being open is a set of principles that healthcare staff should use when communicating with patients, their families and carers following a patient safety incident in which the patient was harmed.

Being open supports a culture of openness, honesty and transparency, and includes apologising and explaining what happened.

In 2005, the National Patient Safety Agency (NPSA) issued a Safer Practice Notice advising the NHS to develop a local *Being open* policy and to raise awareness of this policy with all healthcare staff.

The guidance has now been revised in response to changes in the healthcare environment and in order to strengthen *Being open* throughout the NHS.

The revised *Being open* framework (available at **www.nrls.npsa.nhs.uk/beingopen**) should be used in conjunction with this Alert to help develop and embed *Being open* in each NHS organisation.

The *Being open* principles are fully supported by a wide range of royal colleges and professional organisations, including the Medical Defence Union, Medical Protection Society, NHS Litigation Authority and Welsh Risk Pool.

Tools to support organisations in the implementation of this Alert are available at: **www.nrls.npsa.nhs.uk/beingopen**

Endorsed by:
Action Against Medical Accidents
Department of Health
Healthcare Inspectorate Wales
NHS Confederation (England)
NHS Confederation (Wales)
NHS Litigation Authority
Medical Defence Union
Medical Protection Society
Royal College of General Practitioners
Royal College of Nursing
Royal College of Obstetricians and Gynaecologists
Royal College of Physicians
Royal College of Psychiatrists
Welsh Assembly Government
Welsh Risk Pool

Action for the NHS

For action by Chief Executives of organisations commissioning and providing healthcare.

Deadlines:
- Actions underway: **22 February 2010**
- Actions completed: **23 November 2010**

Actions:
1) **Local policy:** Review and strengthen local policies to ensure they are aligned with the *Being open* framework and embedded with your risk management and clinical governance processes.
2) **Leadership:** Make a board-level public commitment to implementing the principles of *Being open*.
3) **Responsibilities:** Nominate executive and non-executive leads responsible for leading your local policy. These can be leads with existing responsibilities for clinical governance.
4) **Training and support:** Identify senior clinical counsellors who will mentor and support fellow clinicians. Develop and implement a strategy for training these staff and provide ongoing support.
5) **Visibility:** Raise awareness and understanding of the *Being open* principles and your local policy among staff, patients and the public, making information visible to all.
6) **Supporting patients:** Ensure Patient Advice and Liaison Services (PALS), and other staff have the information, skills and processes in place to support patients through the *Being open* process.

This Alert replaces the *Being Open Safer Practice Notice* (2005)

© National Patient Safety Agency 2009. Copyright and other intellectual property rights in this material belong to the NPSA and all rights are reserved. The NPSA authorises UK healthcare organisations to reproduce this material for educational and non-commercial use.

National Reporting and Learning Service
National Patient Safety Agency
4-8 Maple Street, London, W1T 5HD
T: 020 7927 9500 F: 020 7927 9501
www.nrls.npsa.nhs.uk

Actions from Patient Safety Alert

1. Local policy
2. Leadership
3. Responsibilities
4. Training and support
5. Visibility
6. Supporting patients

NPSA/2009/PSA003
19 November 2009

NHS
National Patient Safety Agency
National Reporting and Learning Service

Being Open

Communicating with patients, their families and carers following a patient safety incident

Being open is a set of principles that healthcare staff should use when communicating with patients, their families and carers following a patient safety incident in which the patient was harmed.

Being open supports a culture of openness, honesty and transparency, and includes apologising and explaining what happened.

In 2005, the National Patient Safety Agency (NPSA) issued a Safer Practice Notice advising the NHS to develop a local *Being open* policy and to raise awareness of this policy with all healthcare staff.

The guidance has now been revised in response to changes in the healthcare environment and in order to strengthen *Being open* throughout the NHS.

The revised *Being open* framework (available at: **www.nrls.npsa.nhs.uk/beingopen**) should be used in conjunction with this Alert to help develop and embed Being open in each NHS organisation.

The *Being open* principles are fully supported by a wide range of royal colleges and professional organisations, including the Medical Defence Union, Medical Protection Society, NHS Litigation Authority and Welsh Risk Pool.

Tools to support organisations in implementation of this Alert are available from: **www.nrls.npsa.nhs.uk/beingopen**

Endorsed by:
Action Against Medical Accidents (AvMA)
Care Quality Commission (CQC): Department of Health
Healthcare Inspectorate Wales
NHS Confederation (England)
NHS Confederation (Wales)
NHS Litigation Authority
Medical Defence Union
Medical Protection Society
Royal College of General Practitioners
Royal College of Nursing
Royal College of Obstetricians and Gynaecologists
Royal College of Physicians
Royal College of Psychiatrists
Royal College of Surgeons
Welsh Assembly Government
Welsh Risk Pool

Action for the NHS

For action by Chief Executives of organisations commissioning and providing healthcare.

Deadlines

- Actions underway: **22 February 2010**
- Actions completed: **23 November 2010**

Actions:

1) **Local policy:** Review and strengthen local policies to ensure they are aligned with the *Being open* framework and embedded with your risk management and clinical governance processes.
2) **Leadership:** Make a board-level public commitment to implementing the principles of *Being open*.
3) **Responsibilities:** Nominate executive and non-executive leads responsible for leading your local policy. These can be leads with existing responsibilities for clinical governance.
4) **Training and support:** Identify senior clinical counsellors who will mentor and support fellow clinicians. Develop and implement a strategy for training these staff and provide ongoing support.
5) **Visibility**: Raise awareness and understanding of the *Being open* principles and your local policy among staff, patients and the public, making information visible to all.
6) **Supporting patients:** Ensure Patient Advice and Liaison Services (PALS), and other staff have the information, skills and processes in place to support patients through the *Being open* process.

This Alert replaces the Being Open Safer Practice Notice (2005)

National Reporting and Learning Service
National Patient Safety Agency
4-8 Maple Street, London, W1T 5HD
T: 020 7927 9500 F: 020 7927 9501
www.nrls.npsa.nhs.uk

Actions from Patient Safety Alert

1) **Local policy:** Review and strengthen local policies to ensure they are aligned with the *Being open* framework and embedded with your risk management and clinical governance processes.
2) **Leadership:** Make a board-level public commitment to implementing the principles of *Being open*.
3) **Responsibilities:** Nominate executive and non-executive leads responsible for leading your local policy. These can be leads with existing responsibilities for clinical governance.
4) **Training and support:** Identify senior clinical counsellors who will mentor and support fellow clinicians. Develop and implement a strategy for training these staff and provide ongoing support.
5) **Visibility:** Raise awareness and understanding of the *Being open* principles and your local policy among staff, patients and the public, making information visible to all.
6) **Supporting patients:** Ensure Patient Advice and Liaison Services (PALS), and other staff have the information, skills and processes in place to support patients through the *Being open* process.

Being open involves

- Acknowledging, apologising and explaining when things go wrong;
- Conducting a thorough investigation into the incident;
- Reassuring patients, their families and carers that lessons learned will help prevent the incident recurring;
- Providing support to those involved to cope with the physical and psychological consequences of what happened.

10 Principles of *Being open*

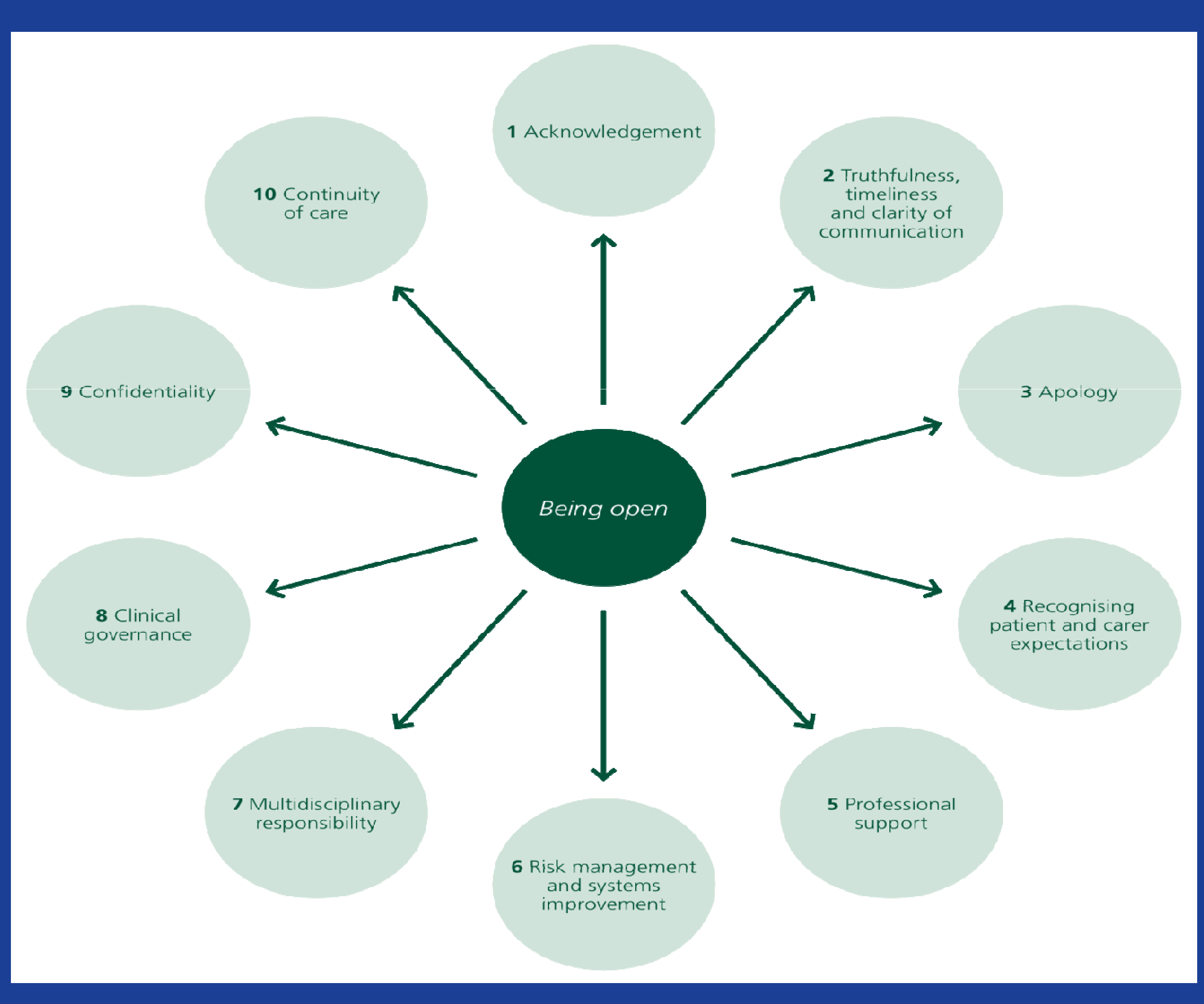


Table 1. Disclosure Barriers and Potential Solutions

Barriers	Potential Solutions
Clinician barriers[3,11,12,37,52,54]	
Fear that disclosure will prompt litigation	Learn about relationship between disclosure and litigation
Concern that disclosure will not benefit patient	Understand patients' preferences for disclosure, consequences of failed disclosure on patient-physician relationship
Lack of confidence in communication skills	Seek disclosure skills training Use disclosure coaches
Shame/embarrassment about error	Use institutional support resources
Institutional barriers[9,15,58]	
Concern that clinicians are not skilled in disclosure	Institute a disclosure support system, including training, coaching, and emotional support
Lack of awareness about deficiencies in current disclosure practices	Measure quality of actual disclosures
Perception that disclosure is a risk management rather than patient safety activity[47]	Engage patients in safety and quality activities, including event analysis

Gallagher TH. A 62-year-old woman with skin cancer who experienced wrong-site surgery JAMA 2009;302:669-77

The importance of *Being open*

- It is what patients want
- It is ethically and morally the right thing to do
- It can reduce the cost of litigation
- It is a vehicle for winning back the confidence of patients, their families and carers
- It is consistent with good clinical practice
- It is a pledge to patients within the NHS Constitution for England

What patients want

- The English public want:
  - 34% an apology or explanation
  - 23% an enquiry into the causes
  - 17% support in coping with the consequences
- Less important were:
  - 11% financial compensation
  - 6% disciplinary action

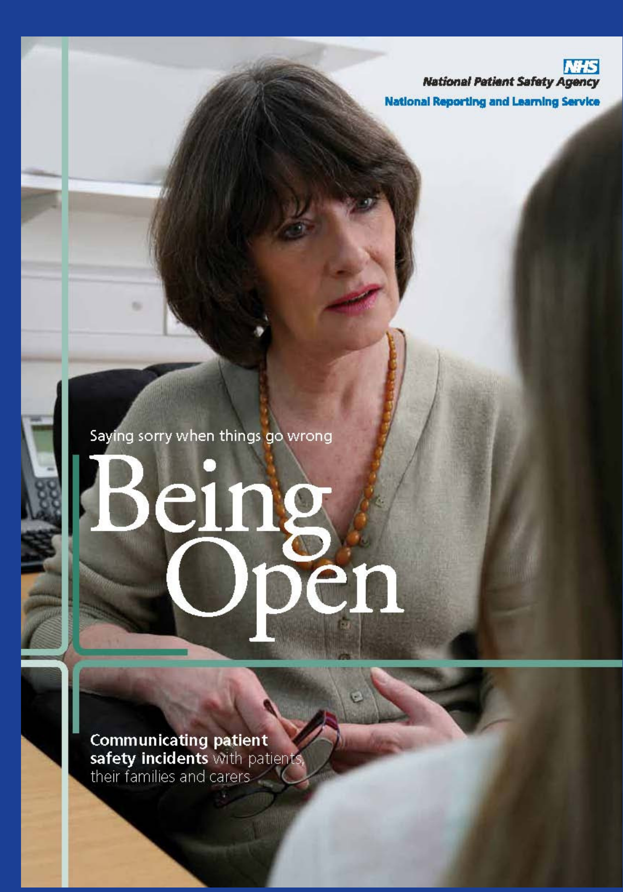
MORI survey commissioned for the 'Making Amends' report, DH, 2002

Things to note and remember

- If the apology does not come early the patient, their family and carers may be more angry.
- A meaningful apology is better than an expression of sympathy.
- Being prepared is essential.
- Remember to answer the patient’s, their family’s and carers’ questions.
- The language you use may be meaningless to the patient, their family and carers.
- Don’t inadvertently attribute blame or speculate.
- Provide the patient, their family and carers with a contact.

Further information – from the NPSA

- Revised *Being open* framework
- *Being open* at a glance
- Dedicated site: www.nrls.npsa.nhs.uk/beingopen
- Free online training tool on website above
- Email - beingopen@npsa.nhs.uk



Summary points

Two approaches to the problem of human fallibility exist: the person and the system approaches

The person approach focuses on the errors of individuals, blaming them for forgetfulness, inattention, or moral weakness

The system approach concentrates on the conditions under which individuals work and tries to build defences to avert errors or mitigate their effects

High reliability organisations—which have less than their fair share of accidents—recognise that human variability is a force to harness in averting errors, but they work hard to focus that variability and are constantly preoccupied with the possibility of failure

Reason J. Human error: models and management . BMJ 2000;320 768-70

Schedule

- 9:00 to 10:30 principles and methodology of risk management
- 11:00 to 12:30 risk analysis: tools and how to use
- 14:00 to 15:30 medication errors
- 16:00 to 18:00 workshop, presentation and discussion of results

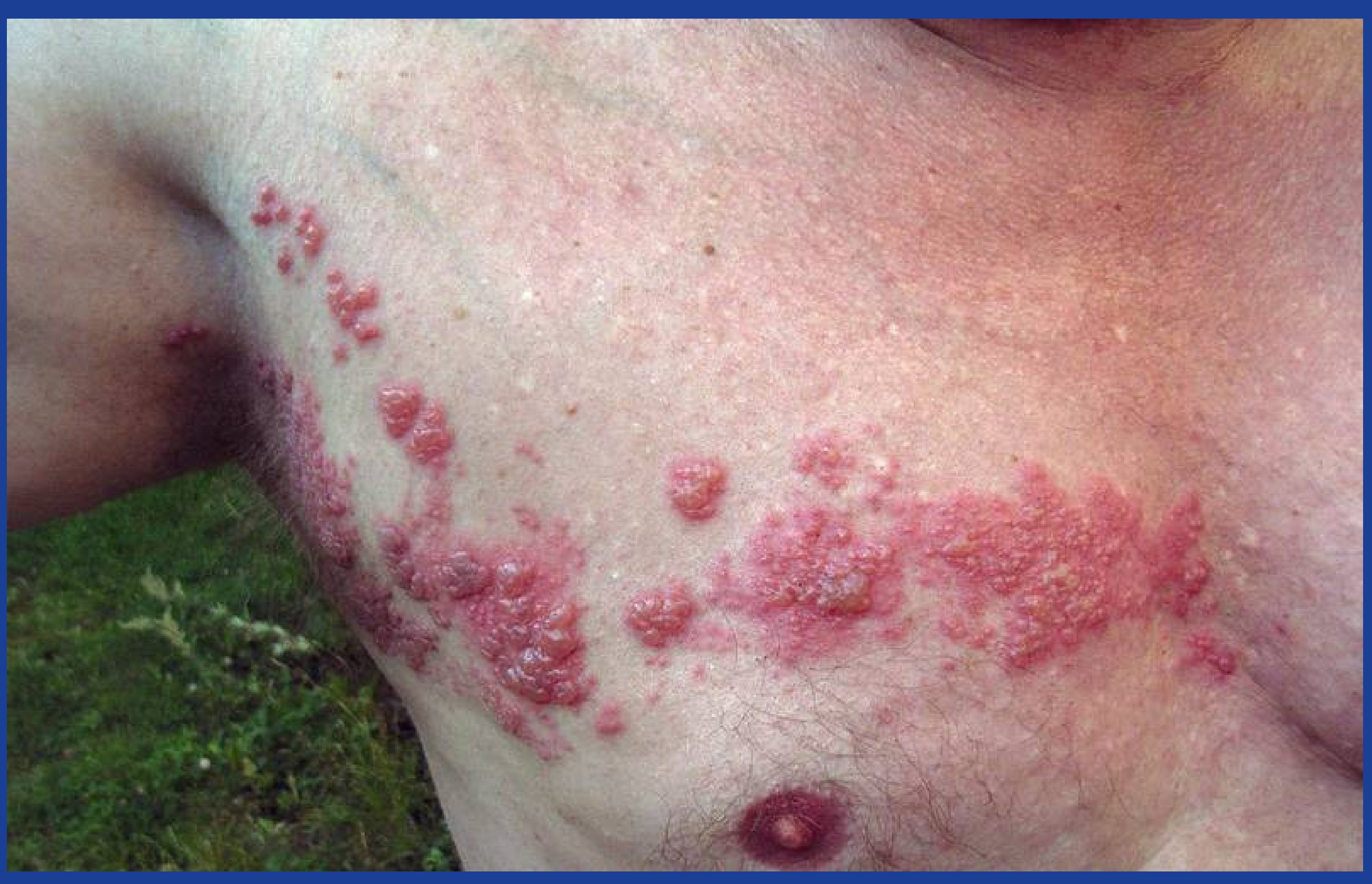
Another fundamental truth

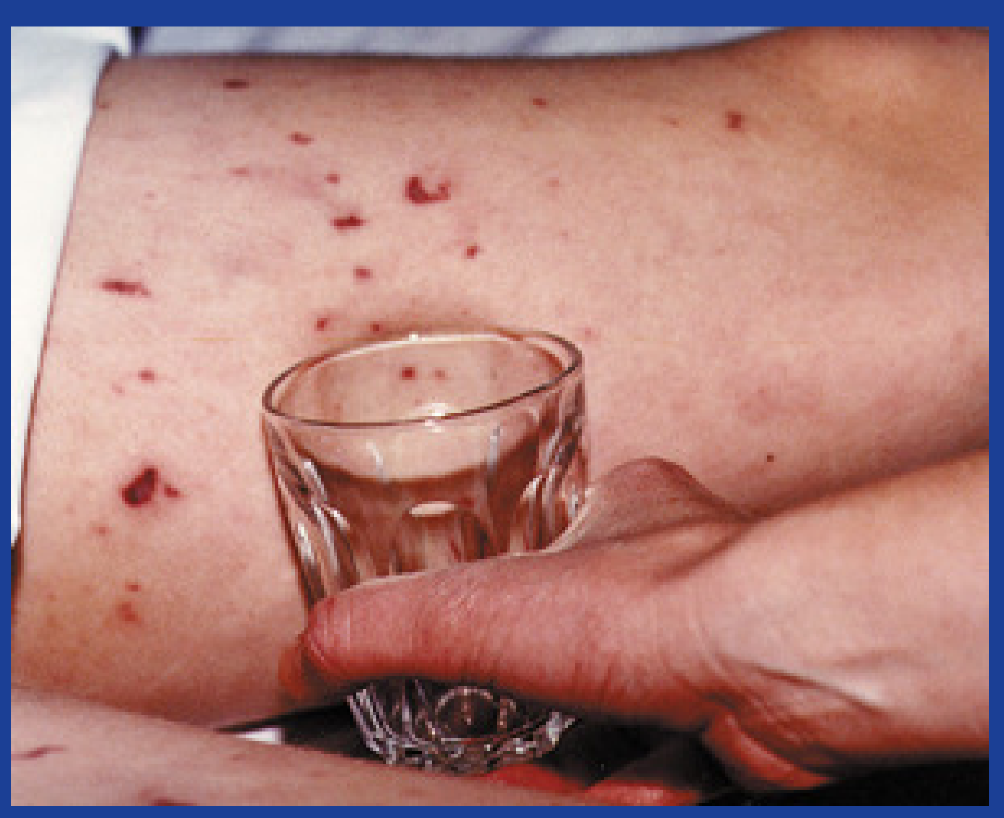
- People don't understand how any <u>real</u> professional can make an error!

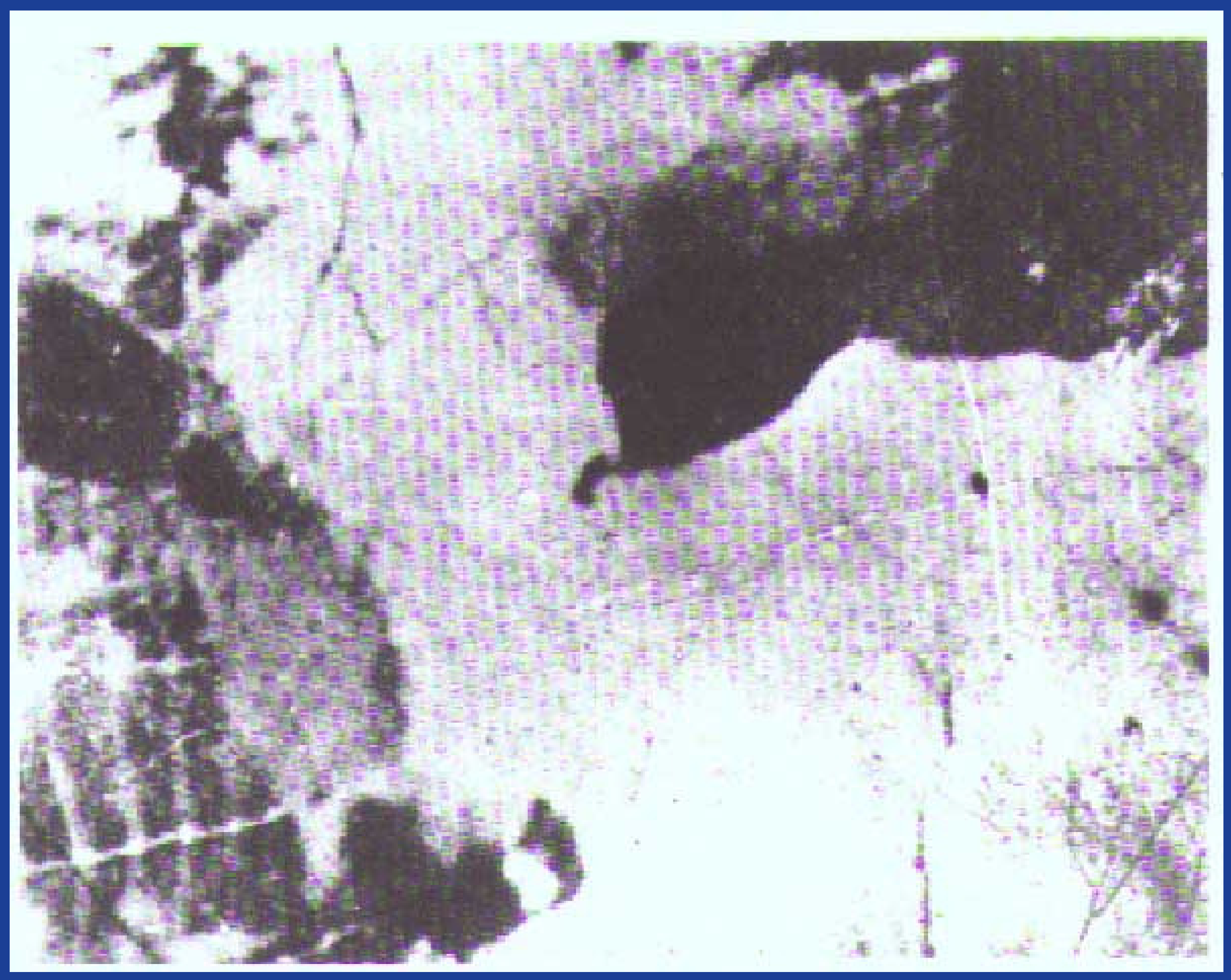
Discuss!

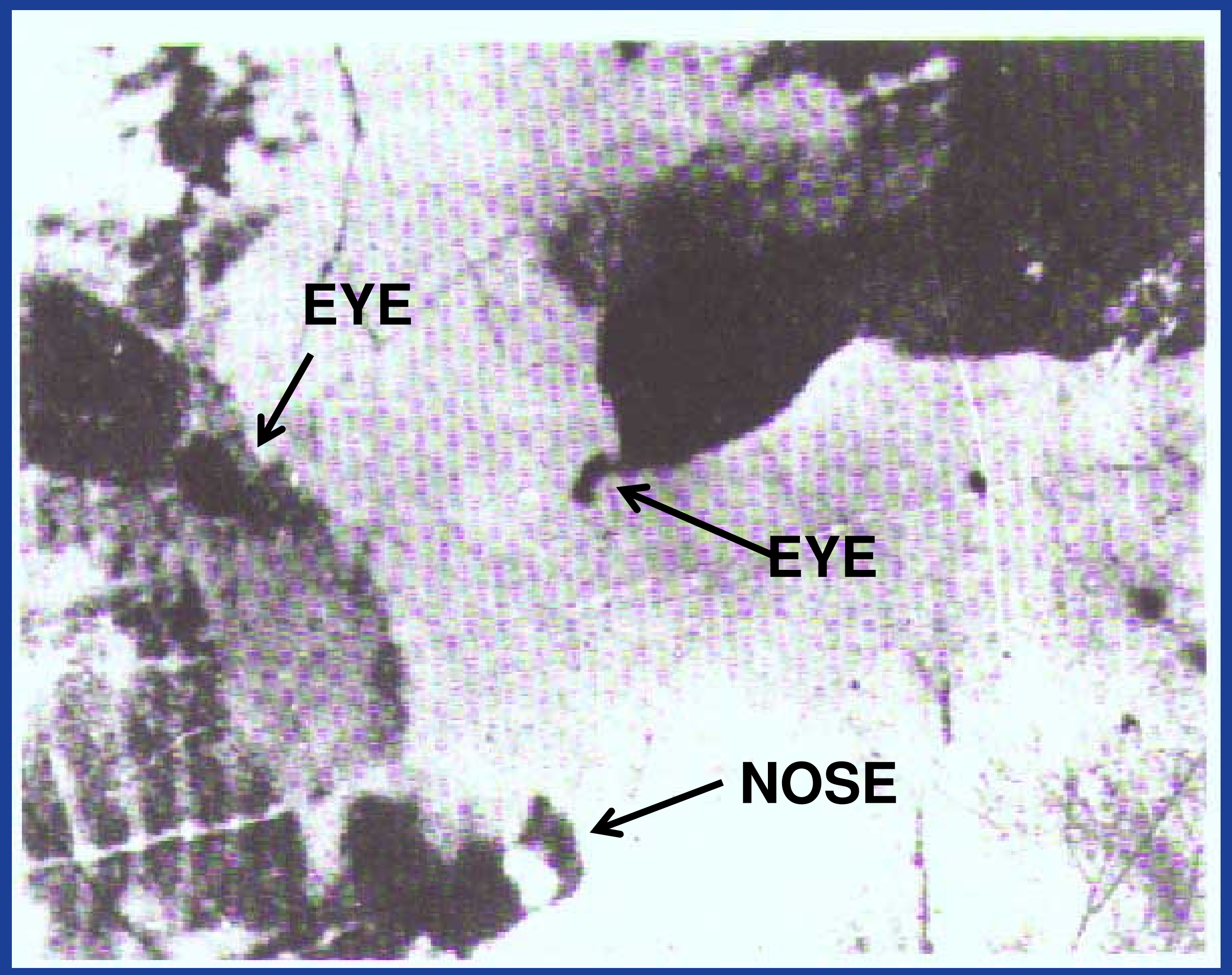
Agree? Number

Disagree? Number








EYE
EYE
NOSE

Yet another fundamental truth

- People ‘see’ things differently!

Discuss!

Agree? Number

Disagree? Number

What is Evidence-Based Practice?

Recognise lack of certainty

Time - again

1. Formulate question

Searching is hard, takes time, lots of results or no results

5. Evaluate performance

2. Efficiently track down best available evidence

4. Implement changes In practice

3. Critically review the validity and usefulness of the evidence

It's hard! I don't do it often enough and I don't have the time

Do we do this?

Where do I find relevant, valid, high quality summaries of evidence?

How do we make decisions?

How do we determine which patients want to play an active part in decision making?

Information Mastery

Clinical decision making

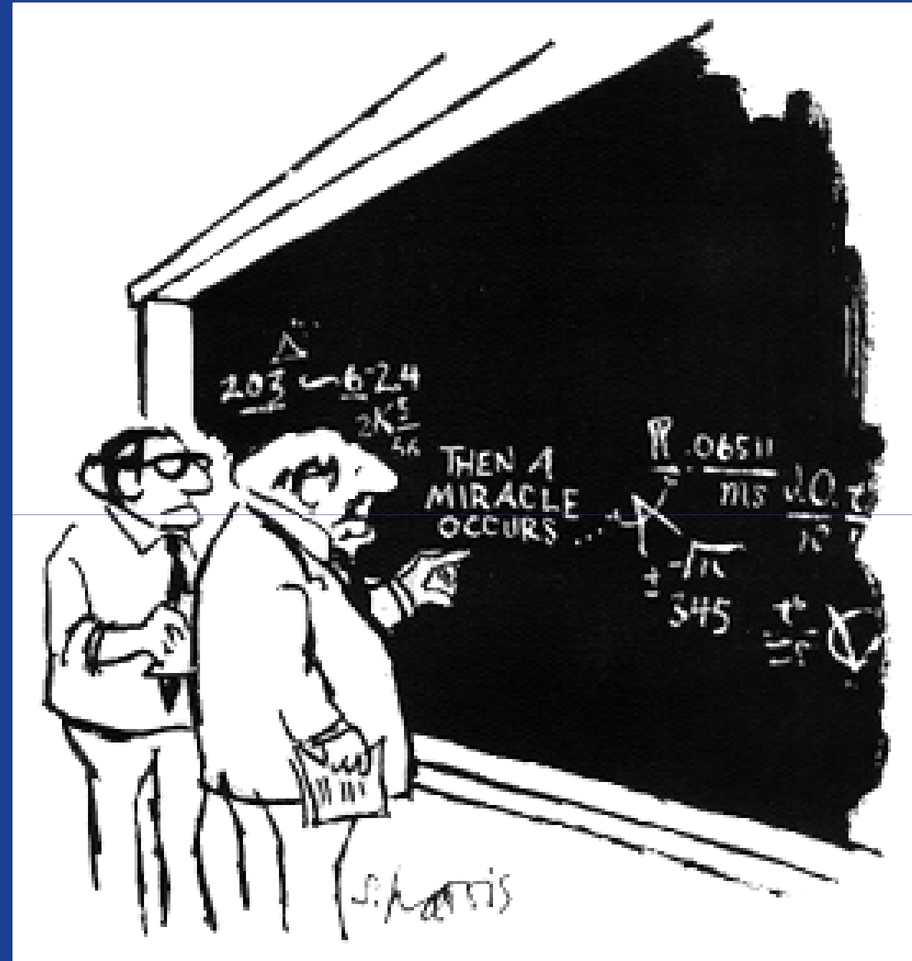
Shared decision making

What skills are required to understand summaries of evidence?

How can we make better use of evidence when making decisions?

How can we optimally describe risks and benefits when sharing information to inform decision making?

Well that is the plan!

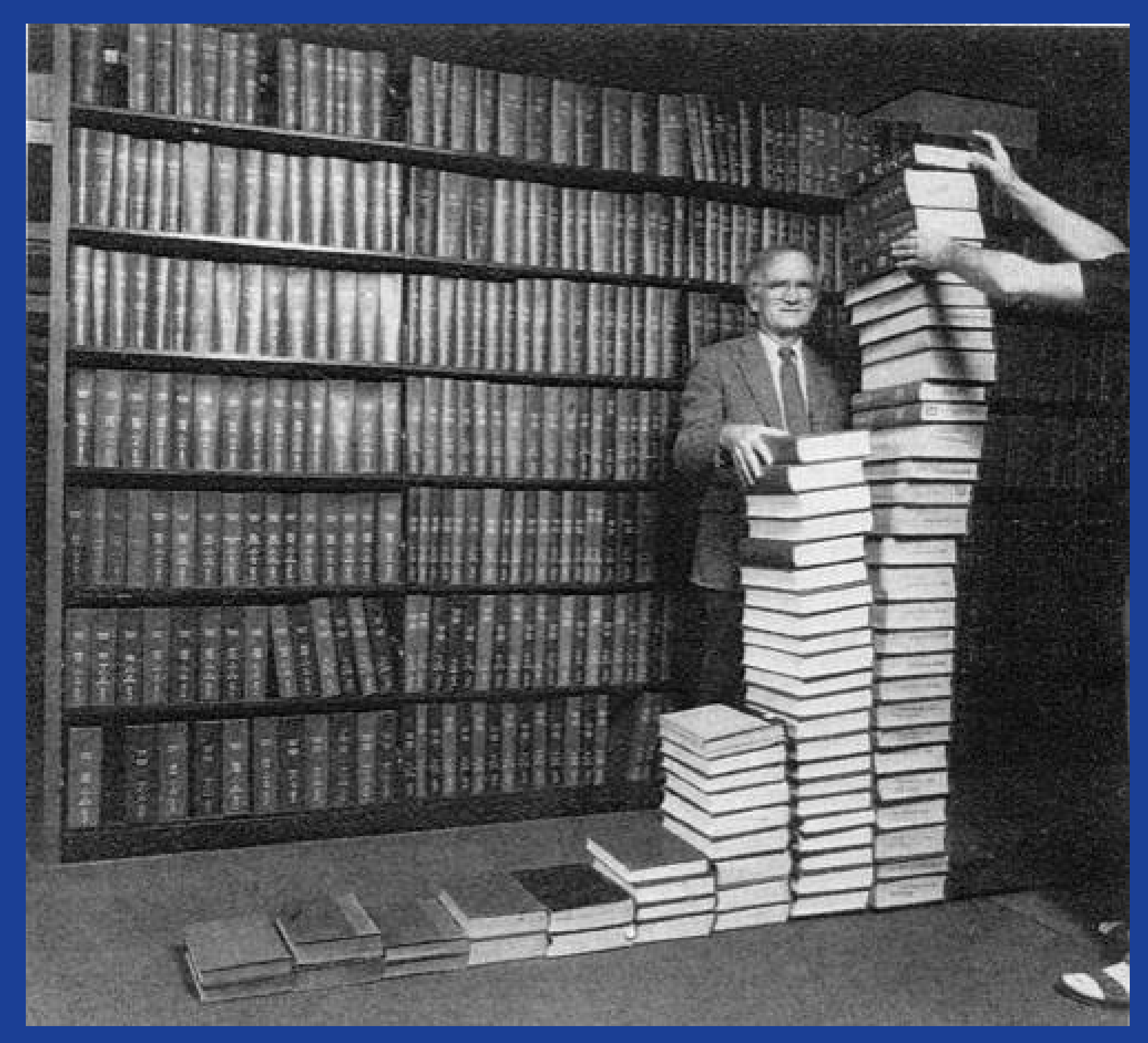


"I think you should be more explicit here in step two."

Reprinted w/permission from Sidney Harris

Information Management

I keep up to date by............?



More reading?

- Potential journals 10,000
- Potential new articles per week 40,000
- Even if 97% are not relevant (no POOs) 1,200
- Time to read each article 15minutes

- 10h a day, 6 days a week = 240 articles.

- So at the end of the first week you are about 4 weeks behind in your reading.
- At the end of the first month, you are 4 months behind in your reading.
- And at the end of the first year you are almost 5 years behind in your reading.

"I remember doing it as one of the things…*[at medical school]* it's a distant memory, and to do it again at that level would be just… *[sigh]*"

GPST West Yorkshire 2010

"I certainly don't do any of it, you know – don't remember the last time I really looked at a paper. I have a pile of BMJs at home this high *[gesture]* but I don't ever read them. I sometimes carry them around in my bag in case I kind of osmotically get the information *[ironic expression]* but you know, time-wise it's easier to look on GP Notebook."

GPST West Yorkshire 2010

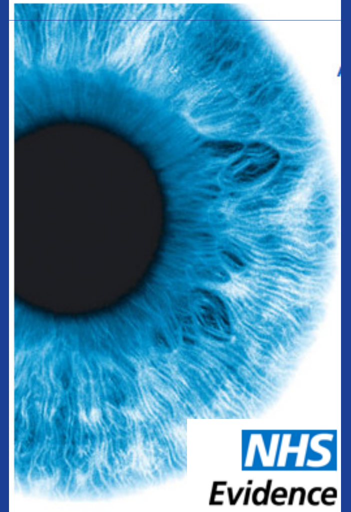
"We surveyed one acute medical take in our hospital. In a relatively quiet take, we saw 18 patients with a total of 44 diagnoses. The guidelines that the on-call physician should have read remembered and applied correctly for those conditions came to 3,679 pages. This number included only NICE, the Royal Colleges and major societies from the last 3 years. If it takes 2 minutes to read each page, the physician on call will have to spend 122 hours reading to keep abreast of the guidelines" (for one 24h on-call period).

Allen D, Harkins KJ. Lancet 2005; 365: 1768

- Information Mastery requires two different approaches to managing information:
  - Foraging - a method of being alerted to new **relevant, valid** information when it is published
  - Hunting - a method of finding information when it is needed

- NPC would add a third:-
  - Hot-synching – clinicians rapidly checking once or, at the most, twice a year that their key approaches for the management of conditions they see commonly still match the best evidence

Pre-digested sources of evidence from trusted sources:



bnf.org

Finding the ‘best answer’, first time

Slawson DC and Shaughnessy AF

That last fundamental truth

- People don't understand how any <u>real</u> professional can make an error!
- There is so much information errors are inevitable!

Agree? Number

Disagree? Number

Need to understand how people make decisions

- Healthcare professionals are logical, thinking, rational individuals that weigh up the advantages and disadvantages then make a decision!

Agree? Number

Disagree? Number

Cognitive Psychology

How do we make decisions?

ERROR: undefined
OFFENDING COMMAND: f‘~

STACK: