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SHIFTtoSafety.com

PUBLIC PROVIDER LEADER

Implementing the Vincent Framework at the Frontline

Jo Thomson, Healthcare Improvement Scotland

Alison McGurt and Morag MacRae Taysiide Trust

Dr. Jonathan Kirk, Healthcare Improvement Scotland

Dr. G. Ross Baker, University of Toronto

cpsi icsp Canadian Patient Safety Institute
Institut canadien pour la sécurité des patients

Speakers

Jo Thomson
Senior Programme Manager, Healthcare Improvement Scotland

Alison McGurk
Clinical Team Manager, GAP
NHS Tayside

Morag MacRae
Patient Safety Development Manager
NHS Tayside

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Speakers

Dr Jonathan Kirk
National Clinical Lead, Measurement and Monitoring of Safety Programme
Healthcare Improvement Scotland

Dr. G. Ross Baker
Institute of Health Policy, Management and Evaluation, University of Toronto

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Welcome

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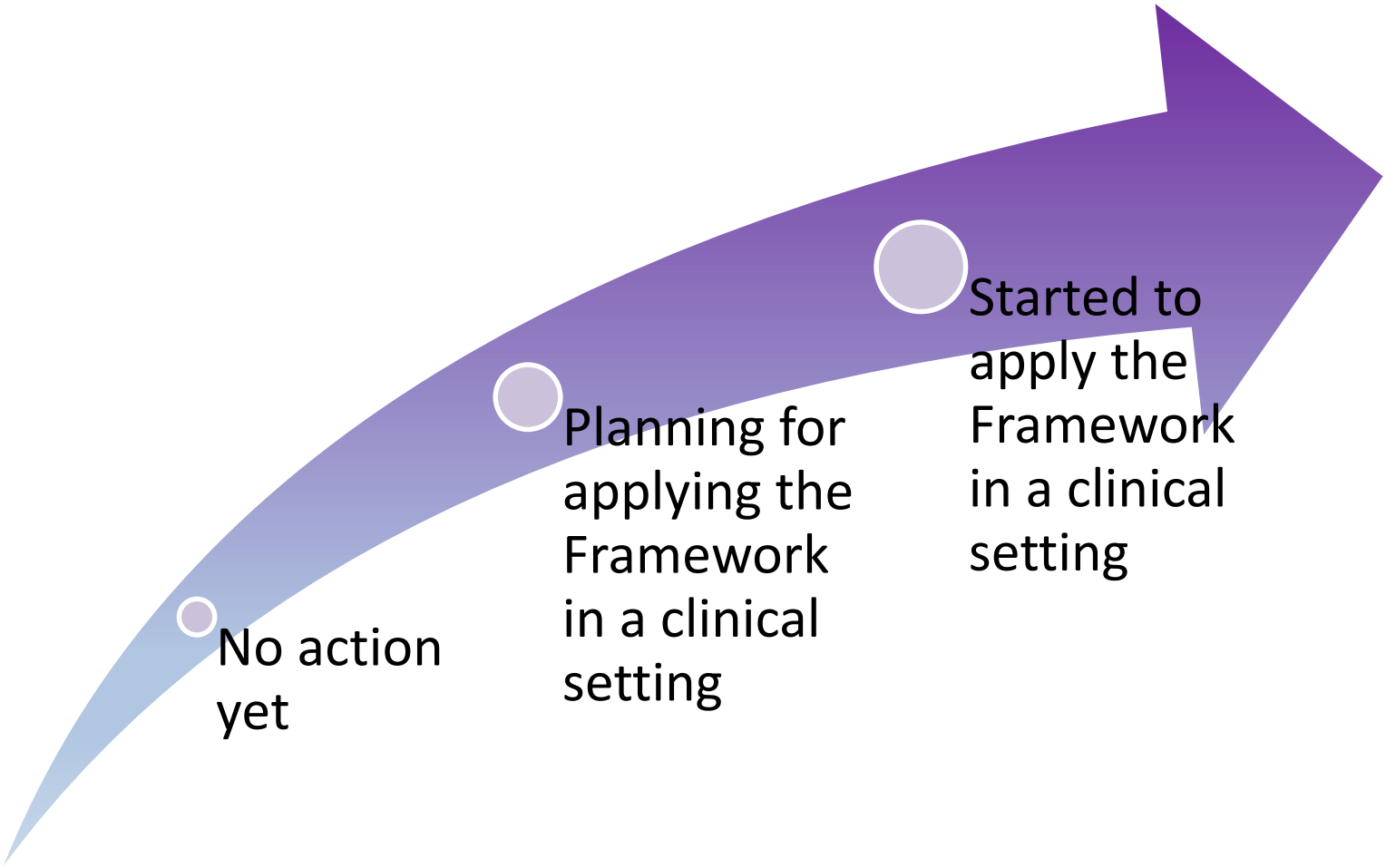
Using the Framework



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Jo Thomson

How Scotland became involved in the Measuring and Monitoring of Safety Framework

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Measurement and Monitoring of Safety Programme

Canadian webex

Thursday 23rd February 2017

Jo Thomson, Senior Programme Manager

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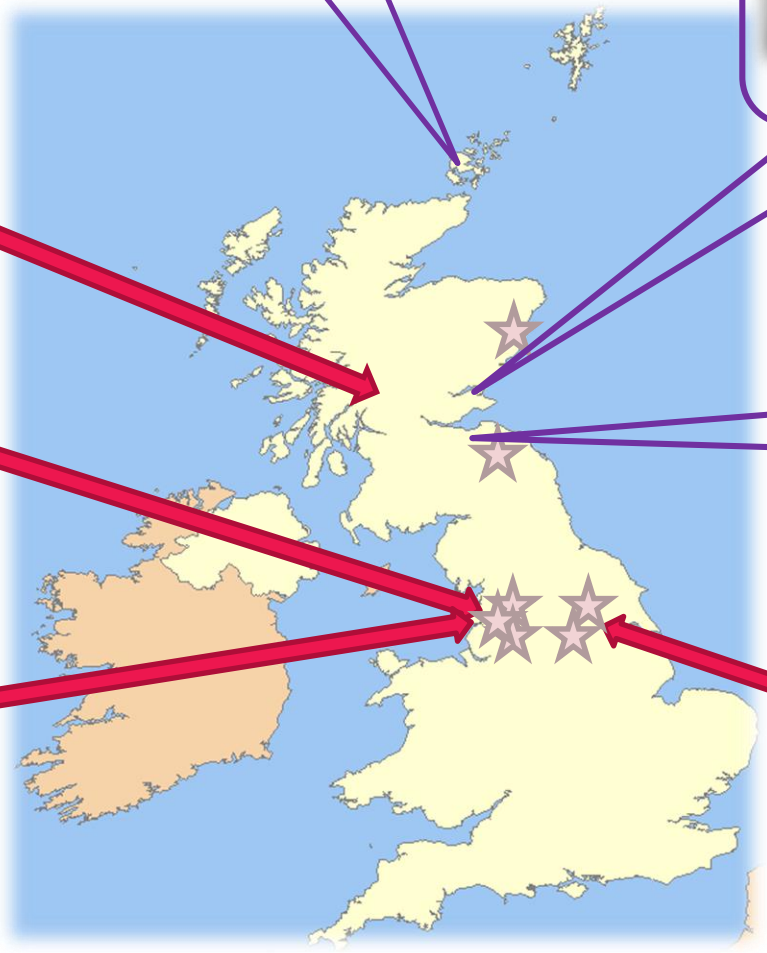
NHSScotland

Healthcare Improvement Scotland

Healthcare Improvement Scotland

AQuA
Advancing Quality Alliance



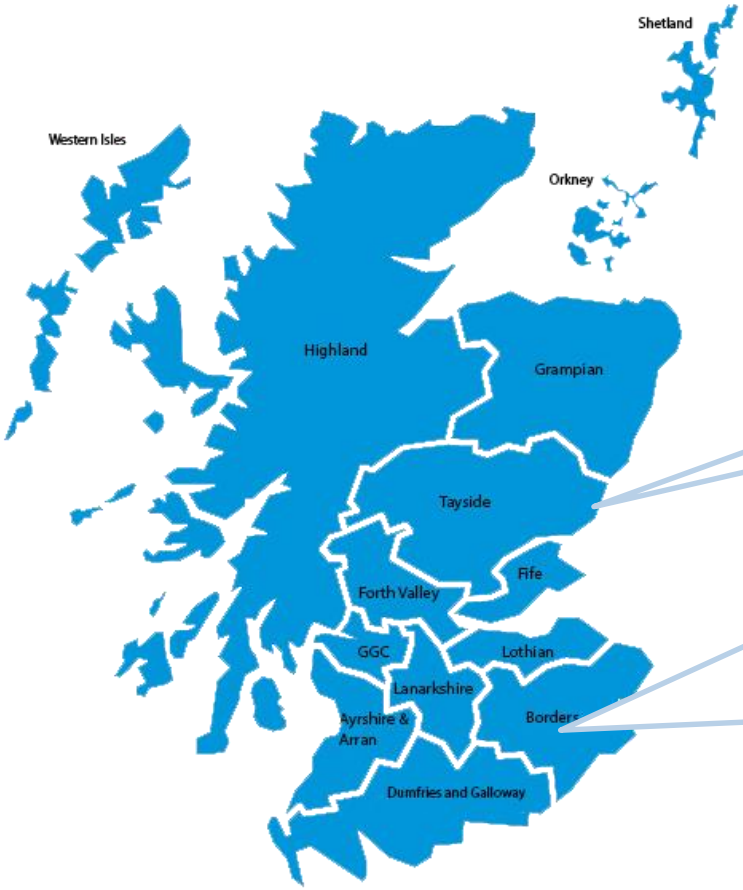
haelo

Improvement Academy
Part of the Yorkshire & Humber AHSN

Test sites

Image https://commons.wikimedia.org/wiki/File:Uk_outline_map.png

Our testing



NHS Tayside

- Mental health unit – initial focus on medicine omissions
- Board performance review process

NHS Borders

- Frailty pathway (point of admission to acute care)
- Ward to Board

Further information

www.howsafeisourcare.com

Monthly calls open to all
(register at www.howsafeisourcare.com)
Next call Wednesday 15th March

Interactive pdf
(from March 2017)

#THFSMP

Keep in touch……

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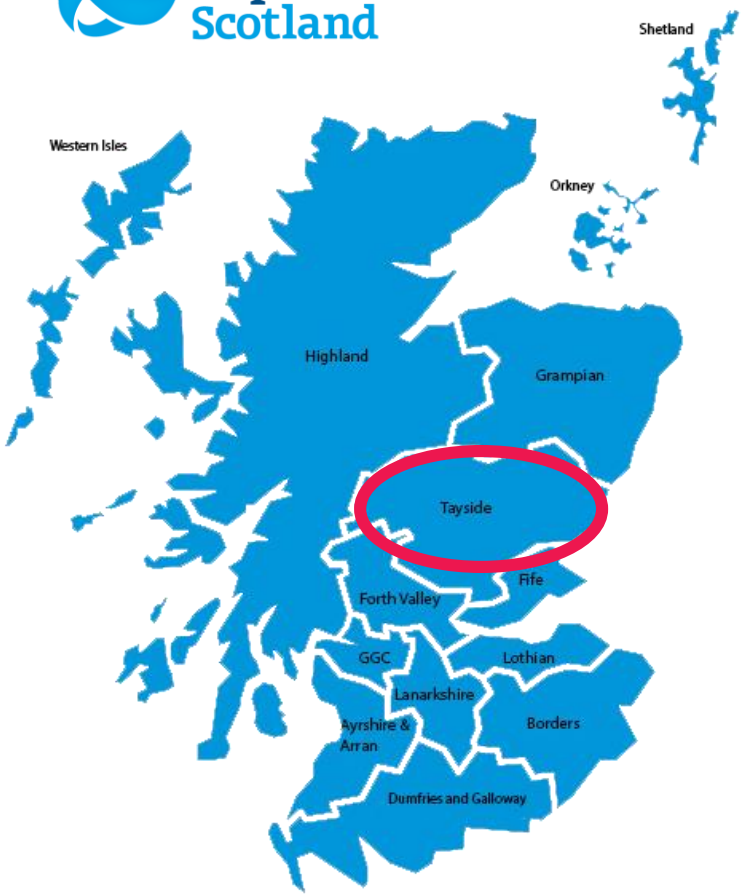
NHS Tayside



Morag MacRae
Patient safety development manager

Alison McGurk
Clinical team manager

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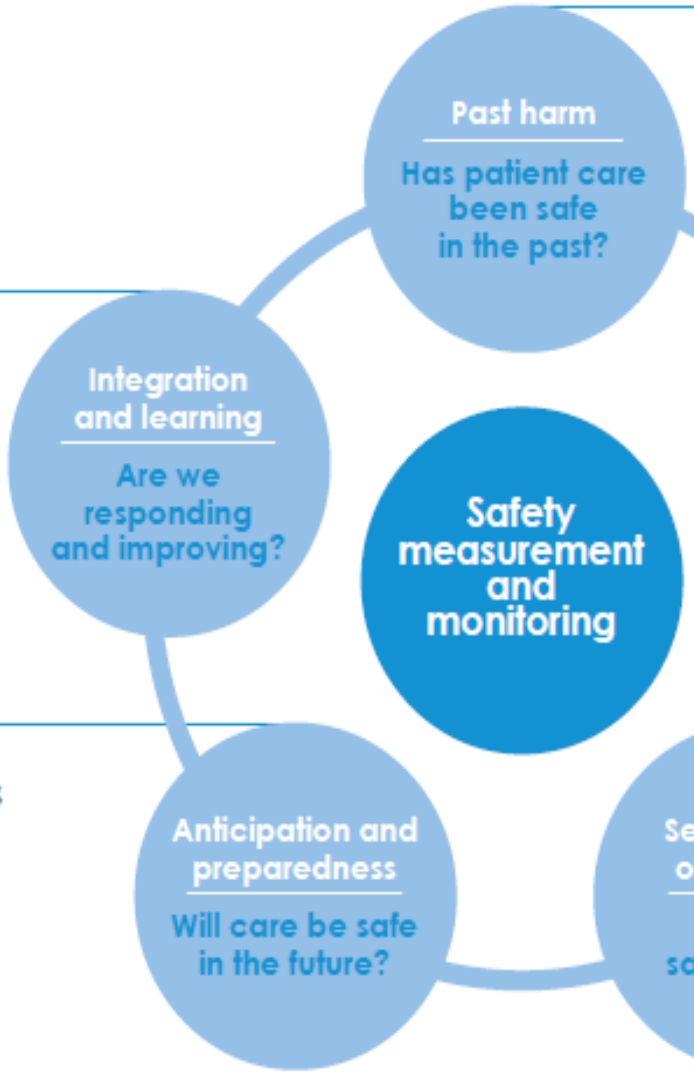
Figure 2: The framework for measuring and monitoring safety – and useful prompts for using it in practice



Prompts

- Identify the different types of harm that can exist in your setting
- Use a range of safety measures, while understanding their strengths and limitations
- Ensure the measures are valid, reliable and specific

Prompts

- Specify the level of reliability you would expect in areas of standardised practice
- Use local and national audits and initiatives to monitor reliability
- Understand what contributes to poor reliability

Prompts

- Select an appropriate mix of formal and informal safety monitoring mechanisms
- Use this information to take timely action to avert safety issues
- Reflect on whether current structures and committees enable timely action to be taken

Prompts

- Don't wait for things to go wrong before trying to improve safety
- Explore new opportunities to develop systematic ways to anticipate future risks
- Use a variety of tools and techniques to build an understanding of the factors that give rise to safety issues

Prompts

- Use the analysis of incidents as a starting point to reveal the wider issues in the system
- Place more emphasis on learning, feedback and action than simply on data collection
- Integrate and tailor information to make it meaningful from the ward to the board


NHS
Tayside
Angus Community Health Partnership
The Susan Carnegie Centre
No Smoking Hospital Site - Please observe our health policy
150
1

Mapping of existing work

- Shaded are suggestions for things that could come under programme/ be formalised
- Then need to consider CRHTT and CMHT connections.

Work Currently Underway

Vincent Framework: Mulberry Dec2014

Past Harm

- Meds Reconciliation
- Zero Tolerance Prescribing
- Meds Omissions
- Mandatory Dataset
- Complaints
- SPSP Outcome Measures
- SRI2, WRAP
- Pt level clinical risk assessments?

Figure 1: A framework for measuring and monitoring safety

Integration and Learning

- Weekly Ward Level Datix Review
- SCEA and SSEA processes
- Mgt/ planning level use of data?

Reliability

- Ward Handover
- Risk Assessment Compliance
- Locked Door Compliance
- What other processes need reliable implementation? We are not agreed on those as yet. Eg Admission criteria, pathways into and out of inpts etc

Anticipation and Preparedness

- Patient Safety Climate Survey
- Staff Safety Climate Survey
- Patient feedback; HYD, Care Question, 360 degree feedback
- Ward environmental assessments?
- Individualised Pt Risk mgt plans?
- How do we get right balance with Positive Risk Taking?
- **Other Predictive factors?** Eg patient mix, occupancy levels, staffing levels, square footage, staff mix, temp staff levels, reconfiguration of community services etc

Sensitivity to operations

- Weekly MHET Red & Amber review
- Daily Safety Briefings
- Patient feedback; HYD, Care Question, 360 degree feedback
- Early Warning Scores? Levels of Obs?
- Escalation procedures in and out of hours?
- Immediacy of data?


The More I Think
The More Confused I Get

Through the eyes of patients

https://www.youtube.com/watch?v=dBUxnyOxW_4

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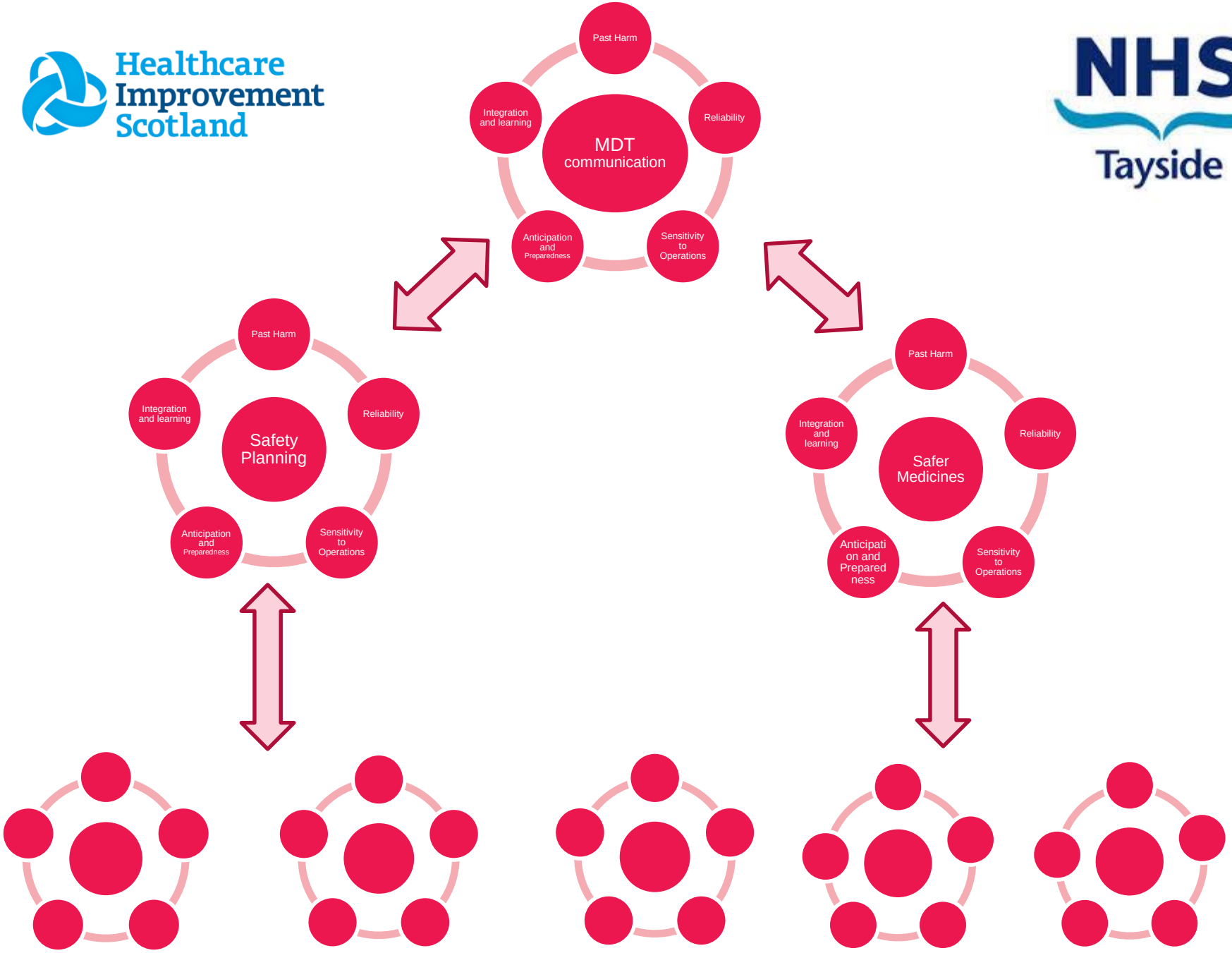
NHS Tayside



Identifying improvements..

1st level

- Medication errors
- Never events/mortality
- Inadequate monitoring of high risk
- Side effects
- Physical health issues

- Patient experience – patient stories
- Incident reviews – formal reporting mechanisms
- Junior doctor/Nursing education in relation to medicines
- Reporting structures e.g Safety, Governance and Risk group

- Med rec on admission
- Med rec on discharge
- Med rec on transfer
- High risk medication checklists
- Adherence to medication policies
- Systems for monitoring and reviewing medications

- MDT knowledge of medicines policy/protocols
- Development and dissemination of policies – organisational challenges
- Professional guidance e.g NMC
- Links across the interfaces – e.g primary care and acute care
- Ward planning and ward rounds e.g meetings lasting 3 hours

- Current monitoring systems
- Person dependant processes
- Variability with processes
- Leadership on ward
- Professional accountability
- Professional responsibility

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NHS Tayside

Outcome/Learning Top Tips
•Involve Everyone
•Pick a date and get started.
•Bottom Up approach

- Administration errors [M]
  - Omissions
  - Wrong dose
  - Wrong medicine
  - Wrong time
  - Wrong route
  - Wrong patient
- Patient experience – e.g. adverse reaction to medication [M]

How we do this rather than measure it
- Sharing good practice/poor practice
- Learning from previous errors
- Datix reviews/verifiers
- Culture of reporting near misses
- Patient learning/responsibility positive risk taking/recovery/self management
- Patient knowledge of Medication and side effects
- Patient self dispensing

- Standardised process
  - Start time/format
  - Checking/rechecking process
  - Attending to emergencies
- Shift planning and delegation of roles
- Response to patient queries
- Having to chase up patients to get their medication / Not all patients come to trolley for medication
- Complying with medicines reconciliation
- Prescribing Errors - Zero Tolerance Criteria [M]
- Unable to read prescription
- Awaiting for medication changes to occur to dispense

- Staffing levels [M]
- Safety briefing – previous errors (M)
- Delegation of known tasks at the beginning of the shift
- Well organised drug dispensary/trolley

- Staff knowledge of patients [measure-monitoring]
- Staff knowledge/confidence
- Dealing with competing priorities on the ward to protect the drug round
- Interruptions from pharmacist, doctor or domestic [M]
- Conversations with patients, what information do they need and want about what to expect?
  (Ward Board & leaflets)
- Get hold of Doctor to make TPAR changes
- Shift planning (Reliability as well as S.T.O.)
  - decide males/females
  - breaks planned better
  - structure for breakfast group, domestic staff, etc.

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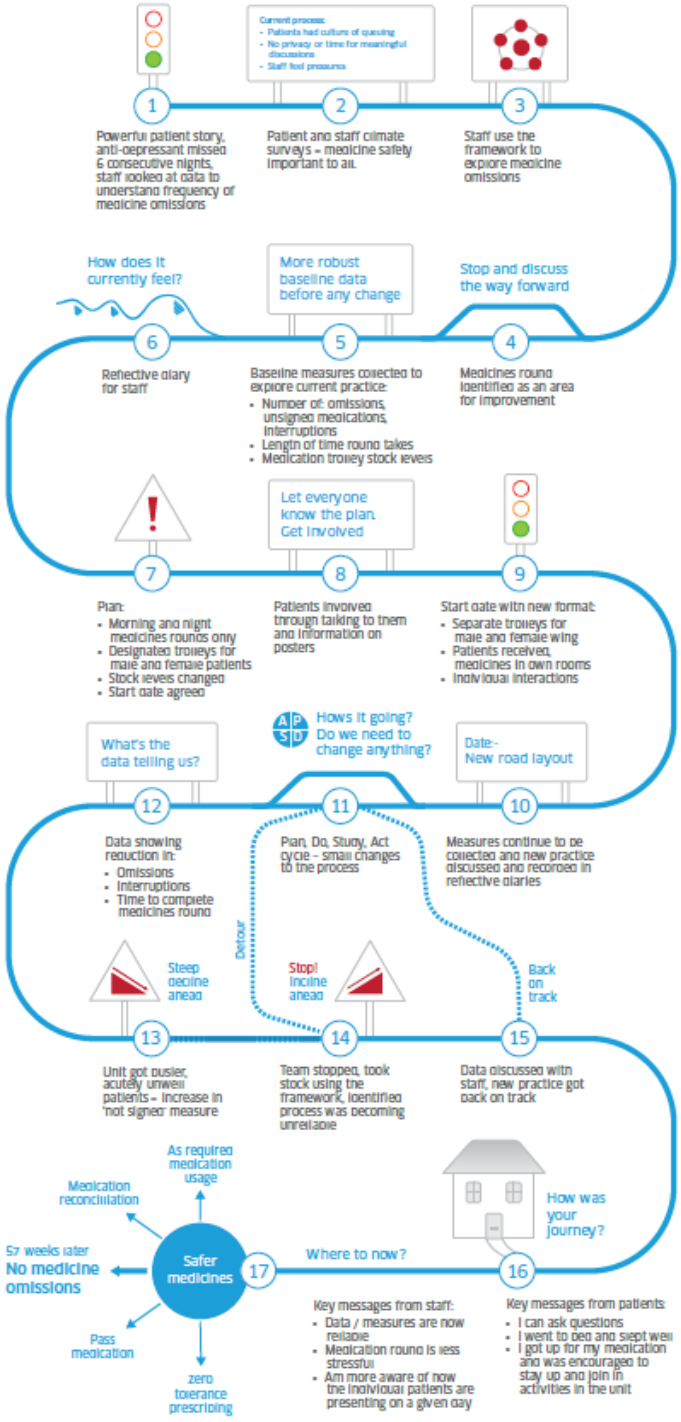
Our approach film
NHS Tayside - Alison McGurk

https://www.youtube.com/watch?v=7IAzMDv56Bo



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Reflect on what you have heard from our story

Past Harm Has patient care been safe in the past?	Reliability Are our clinical systems and processes reliable?	Sensitivity to Operations Is care safe today?	Anticipation and Preparedness Will care be safe in the future?	Integration and Learning Are we responding and improving?
Days between in-patient suicide **Mortality Reviews** • Percentage of deaths reviewed each month • Learning from deaths **Harm Free Care:** •Violence and Aggression •Restraint •Self Harm •Observations • Falls **SCEA's:** • SCEA request numbers submitted over the last 24/12 • how have you responded to the SCEA recommendations and learning **Medicines related harm** • Medication incidents	**Medicines** •Medicine Reconciliation •Clozapine Monitoring •High dose anti-psychotic reviews •Metabolic assessment **Restraint** •Post restraint vital signs monitoring •Post restraint debrief •In-Patient referral to CMHT •In-Patient assessment by CRHTT	•Intelligence from MDT briefings/huddles •Therapeutic engagement activities •Safe staffing levels •Bed occupancy •Patient stories •Unique Care plan •Physical Health Monitoring	Intelligence from Safety Walkrounds **Risks** •directorate operational risks •underpinning service risks •controls for identified risks •Identification of any risk when the score has not changed over the last 6/12 Re-admission Rates at 7 & 28 days Delayed Discharges **Safety Climate** •Intelligence from Patient Safety climate survey •Intelligence from Staff Safety climate survey	GMC Junior Doctor Feedback Data **Feedback** •compliment, concern and complaint numbers Top 5 complaint themes by Speciality and Directorate •significant individual complaints/themes/ward or departmental complaints identified • actions taken following learning from investigations •learning from SPSO recommendations

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NHS Tayside

Take a deep dive in to your projects using the framework

Dr. Jonathan Kirk

Key learnings relative to the frontline implementation of the Vincent framework in Scotland

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Some reflections…..

Dr Jonathan Kirk, National clinical lead
Healthcare Improvement Scotland
@JonathanKirk42 e: Jonathan.Kirk@nhs.net

Reflection 1

‘Not every change results in an improvement’

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Reflection 2

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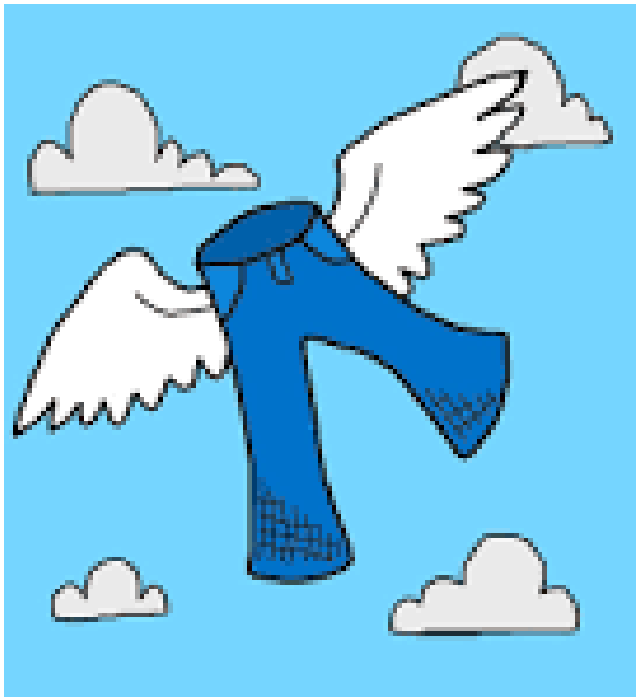
Reflection 3



Reflection 3b

If I was to walk across a road blindfolded I might be lucky and make it to the other side. However, if I kept repeating it, sooner or later it would likely end badly

Reflection 4

What is safe?

Reflection 5

Collaboration:
working together for a common objective.

Cooperation:
openly sharing, without any *quid pro quo*.

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decision

noun

a choice that you make about something after thinking about several possibilities

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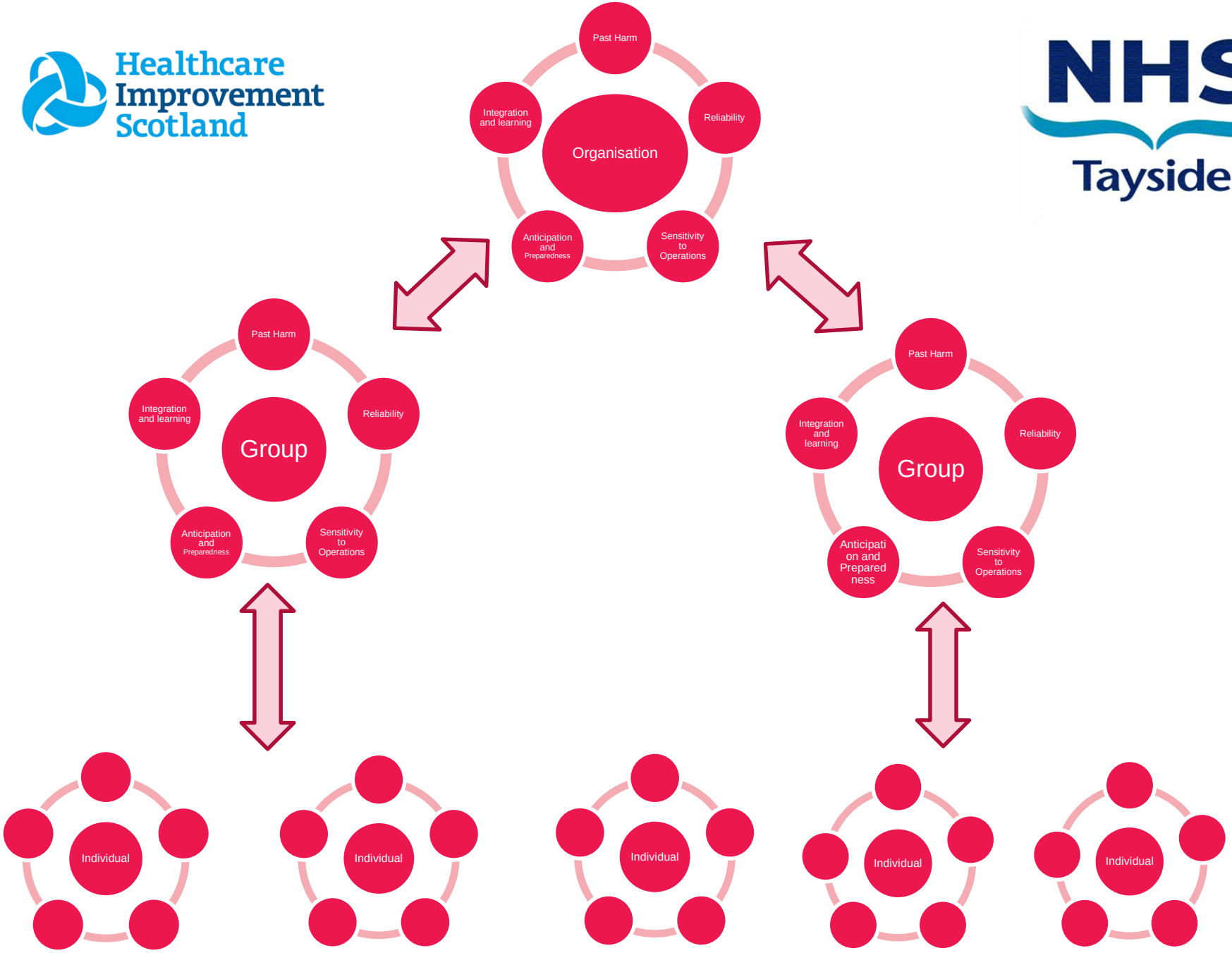
Past Harm
Integration and learning
Reliability
Organisation
Anticipation and Preparedness
Sensitivity to Operations
Past Harm
Integration and learning
Reliability
Group
Anticipation and Preparedness
Sensitivity to Operations
Past Harm
Integration and learning
Reliability
Group
Anticipation and Preparedness
Sensitivity to Operations
Individual
Individual
Individual
Individual
Individual

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Absence of harm

Presence of safety

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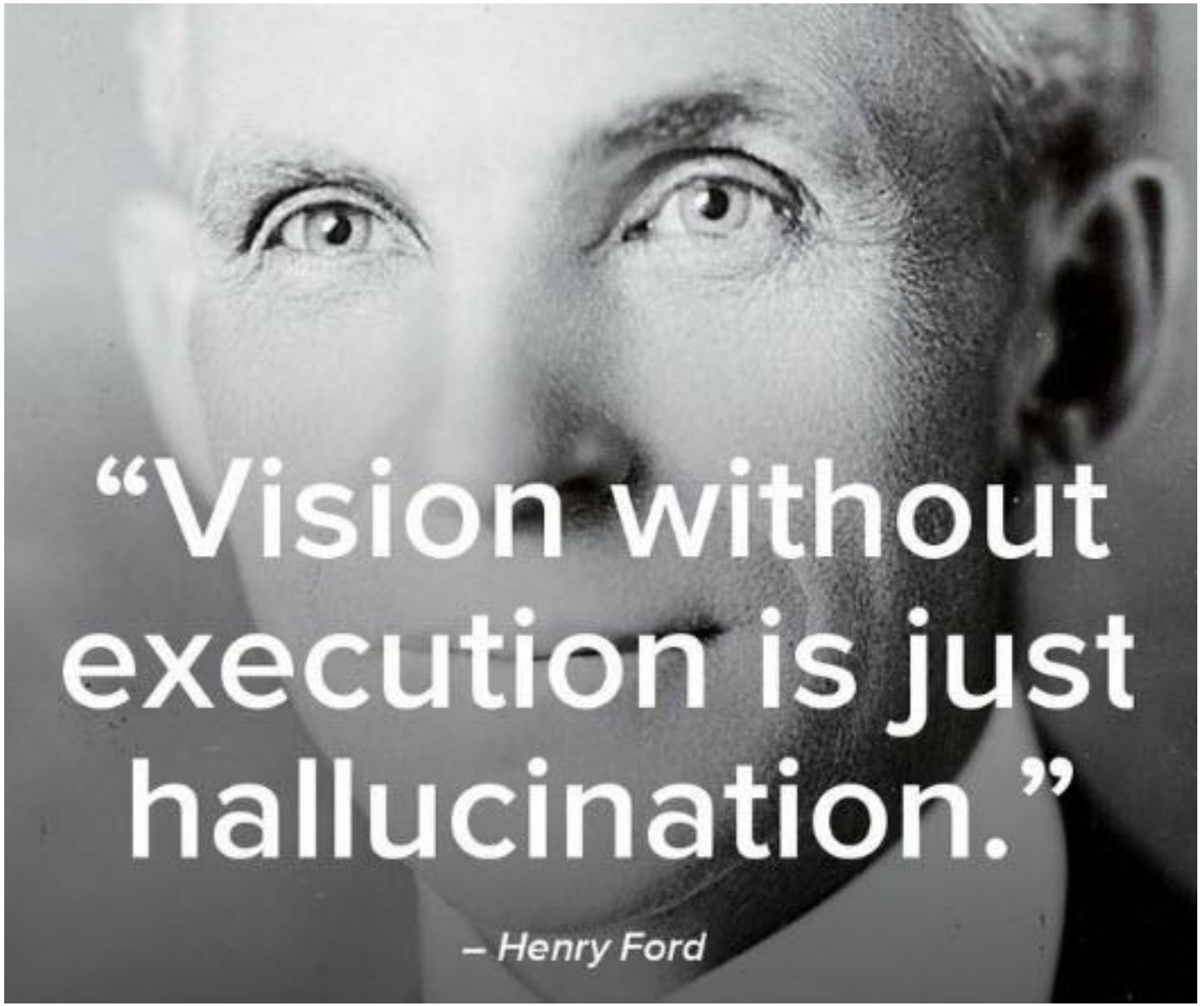
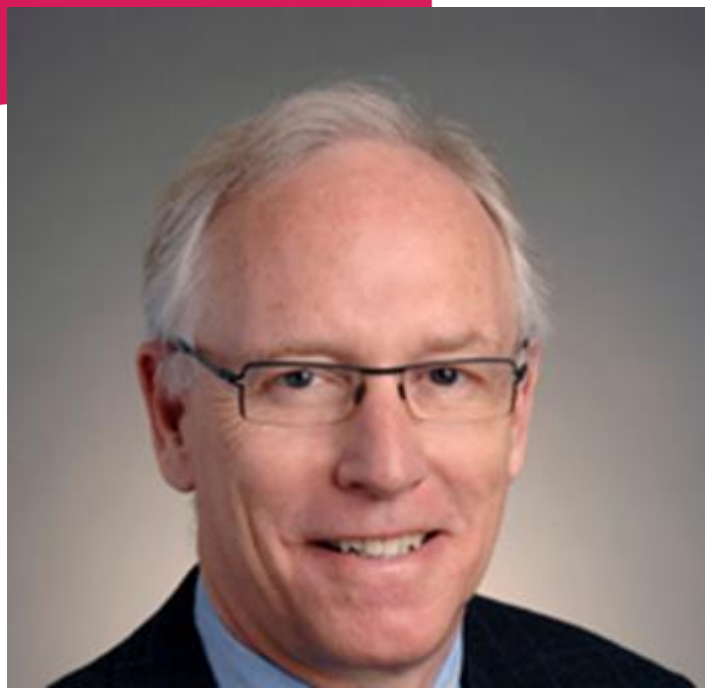


Dr. Ross Baker



How the framework can be used within the Canadian Healthcare Context

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Questions and Answers

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Poll

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Learn more, access Call Recording and CPSI Contacts

To learn more about the framework

http://www.patientsafetyinstitute.ca/en/toolsResources/Measure-Patient-Safety/Pages/default.aspx

To access the slides and recording of the call (available in about 5-7 days)

http://www.patientsafetyinstitute.ca/en/Events/Pages/Implementing-the-Vincent-Framework-at-the-Frontline.aspx

To learn more about SHIFT to Safety

http://www.patientsafetyinstitute.ca/en/About/Programs/shift-to-safety/Pages/provider.aspx

CPSI contacts

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