Implementing a Systems Approach to Patient Safety Course

DESCRIPTION

Aims

The course helps patient safety managers, clinical leads for patient safety, and other people with responsibility for patient safety in their healthcare organizations to know:

- the proactive and reactive patient safety systems that should be in place in a healthcare organization
- knowledge, methods and tools to implement best practice in patient safety systems.

Learning objectives

The course helps participants to know key components of robust proactive and reactive patient safety systems and how they link.

Proactive components include **learning from good practice, risk management, failure mode and effects analysis, implementing patient safety practices, and involving patients and patient safety partners**.

Reactive components include **incident reporting and analysis, complaints handling, learning from deaths, learning from data about patient safety, and learning from improving the safety of care**.

The specific learning objectives for each section of the course are as follows. Participants in the course will be able to:

Patient safety overview

- Describe to their colleagues and staff that there are proactive and reactive systems that make up patient safety, including the following:
  - Patient safety culture
  - Learning from and extending good practice
  - Assessing and managing risks
  - Acting to prevent patient safety incidents that could result in harm to patients
  - Measuring and acting on data about the safety of patient care
  - Involving patients and families
  - Reporting and analysing incidents
  - Providing for and learning from duty of candour
  - Handling complaints
  - Learning from deaths
  - Learning from safety alerts, external assessments and evidence-based patient safety practices
  - Learning from assessing, assuring and improving the quality and safety of care
  - Ensuring competency assessment of staff
- Complete a self-assessment on performance of the proactive and reactive systems to support patient safety in a clinical service or healthcare organization

Learning from good practice

- Explain to staff the difference between Safety I and Safety II thinking and the importance of capturing and supporting good practice in patient safety
- Implement one or more methods for learning and spreading good practice within a clinical service
- Explain to staff working in the clinical service how to carry out the method/s selected for learning and spreading good practice within a clinical service

Risk management

- Explain to staff the difference between a risk and an issue and how to describe a risk or an issue properly
- Explain to staff risk ownership and what's involved in being a risk owner
- Review ways of identifying and assessing risks and issues in a clinical service and characteristics of clinical processes that are associated with higher than usual risk to patients
- Review ways of acting on risks (terminating a practice, treating (controlling) the risk situation, transferring the risk, tolerating the risk, or taking a business opportunity to act to reduce the risk)
- Use judgements about inherent and residual level of risk to set targets for risks or issues in the clinical service and relate target risks to risk tolerance in the organization
- Escalate risks properly in accordance with organizational policy
- Maintain the risk register including keeping evidence of the effectiveness of actions on risks and issues up to date
- Assess current risk assessment and management processes in a clinical service and identify if the processes can be strengthened and how

Failure mode and effects analysis

- Explain to staff what's involved in failure mode and effects analysis (FMEA)
- Select an area of practice that would be suitable for an FMEA, particularly planning how to integrate risk and issue assessment and management with FMEA
- Plan how to carry out an FMEA

Learning from evidence-based patient safety practices and other sources

- Explain to staff patient safety practices and safety alerts and the types of action to be taken for each practice
- Review evidence-based patient safety practices from large-scale systematic reviews and identify evidence to be disseminated and compliance to be measured
- Assess the effectiveness of implementing safety alerts in a clinical service and plan any changes in practice that might be indicated
- Assess the level of implementation of relevant patient safety practices from large-scale systematic reviews and plan to disseminate and measure compliance with patient safety practices, as relevant

Involving patients and families

- Identify ways in which patients and families can be involved proactively in patient safety (not only when a serious incident, complaint or duty of candour is involved)
- Consider if the concept of Always Event could apply in a clinical service and decide how an Always Event could be implemented in a clinical service
- Consider if patients and families can be involved in reporting or analysing an incident
- Decide if patients and families could be more actively involved in patient safety in a clinical service and what approaches might be suitable for patients cared for in the service

Incident reporting and analysis

- Explain the principles and key features of the Patient Incident Response Framework and Response Plan, including the following:

    - Types of investigation techniques and benefits and how to select a type of patient safety incident investigation
    - What is involved in the SEIPS (Systems Engineering Initiative for Patient Safety) framework and AcciMap and how the approaches contribute to understanding human factors
    - How patients and families can be involved in the analysis process
    - How to support staff in investigations
    - How to use a practical tool for identifying effective and feasible actions needed to achieve improvement in patient safety
- Anticipate changes in practice to be made in the clinical service to implement the Patient Incident Response Framework and Response Plan

Complaints handling

- Explain types of complaints to colleagues and responses to the types
- Learn early on messages from the complainant to focus the work on the complaint and how to manage interaction with complainants, including considering the personal impact of a complaint
- Describe advocacy services that help complainants
- Analyse and respond to a complaint properly
- Assess responses to complaints in a clinical service to determine if the responses are robust and assess the effectiveness of handling complaints in a clinical service and plan any changes in practice that might be indicated

Learning from deaths

- Explain to staff the importance of analysing and learning from deaths
- Use findings learned from analysis of deaths to suggest clinical audit, quality improvement or patient safety projects
- Explain to staff the medical examiner process
- Assess the effectiveness of learning from deaths in a clinical service and plan any changes in practice that might be indicated

Measuring and acting on data about the safety of patient care

- Use methods used in the evidence base on patient safety to measure patient safety in a clinical service and act on the findings
- Identify one or more methods that could be used in a clinical service to measure directly the safety of patient care and outline how the method could be implemented

Learning from improving the safety of care

- Check if the organization's process for monitoring findings of relevant national and local clinical audits and benchmarking to outcomes is being implemented in a clinical service and act on the findings
- Involve the clinical service in developing and implementing a QI and clinical audit plan
- Explain to staff the contribution to patient safety of competency assessment in appraisals
- Use patient safety data for a clinical service to promote quality improvement projects

Format

About 40 percent of the course time is allocated to practical work on patient safety-related activities, such as doing a FMEA. Course participants usually work in small groups on practical work they can use in their own work places.

In the remainder of the course time, the course leader explains related current evidence, the theory underpinning the activities, and the practical approaches and tools.

Materials

Each participant receives a copy of a comprehensive *Patient Safety Manual* that includes evidence, principles, step-by-step guidance and examples, and other learning materials. Certificates of completion of the course are provided.

Certification

This course is Certified as conforming to Continuing Professional Development (CPD) requirements in the UK by The CPD Certification Service.