

S.A.F.E
Situation Awareness For Everyone

Closing the Gap in Paediatric Safety





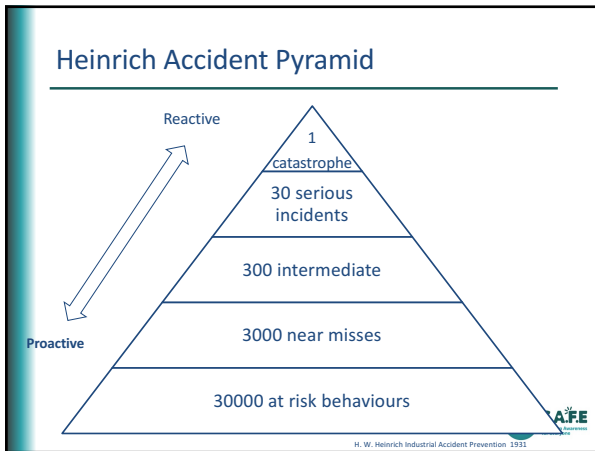
What is does
Safety really
mean?



We harm 10-15% of patients

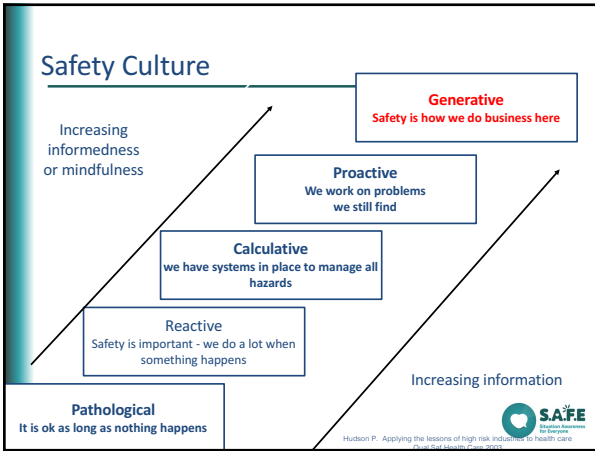
http://www.health.org.uk/sites/health/files/LevelsOfHarm_0.pdf



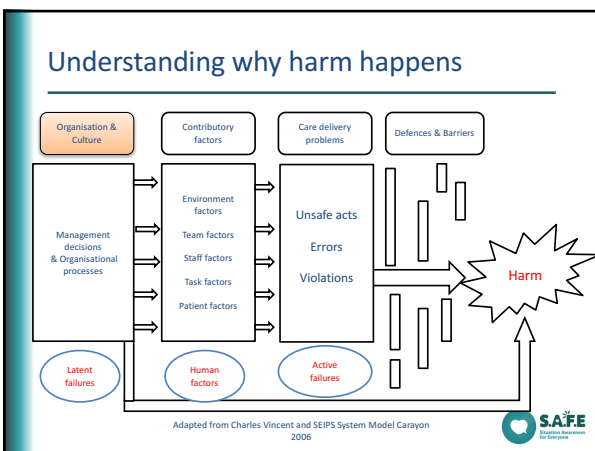


Why should we understand the harm we can cause?

- ### Causes to explore
- Human factors
 - Clinical complexity factors
 - System failures
-







Move to Ultra safe care

- Acceptance of limitations on maximum performance
- Abandonment of professional autonomy
- Transition from the mindset of craftsman to that of an equivalent actor
- Need for system-level arbitration to optimize safety strategies
- The need to simplify professional rules and regulations

PATIENT SAFETY AND THE RELIABILITY OF HEALTH CARE SYSTEMS
Series Editors: Paul Renssch, MD, MPH, and
Donald M. Berwick, MD, MPH

IMPROVING PATIENT CARE

Five System Barriers to Achieving Ultra-safe Health Care

Rene Anshel, MD, PhD; Yoon Auye, MD; Don Berwick, MD, MPH; and Paul Renssch, MD, MPH

Although debate continues over estimates of the annual of preventable medical errors that occur in health care, there seems to be a consensus that health care is not as safe and reliable as it might be. It is often assumed that copying and adapting the success stories of commercial industries, such as civil aviation and nuclear power, will make medicine as safe as these industries. However, the solution is not that simple. This article explains why a benchmarking approach to safety in high-risk industries is needed to help translate lessons so that they are usable and long lasting in health care. The most important difference among industries lies not so much in the perfect safety toolset, which is similar for most industries, but in an industry's willingness to abandon historical and cultural precedents and beliefs that are linked to performance and autonomy. In a constant drive toward a culture of safety, five successive systemic barriers currently prevent health care from becoming an ultra-safe industrial system: the

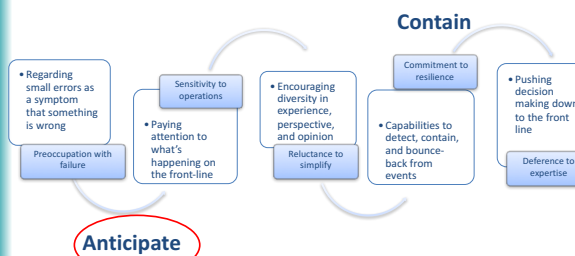
need to limit the discretion of workers, the need to reduce worker autonomy, the need to make the transition from a craftsmanship mindset to that of equivalent action, the need for system-level (center leadership) arbitration to optimize safety strategies, and the need for simplification. Finally, health care must overcome 3 unique problems: a wide range of risk among medical specialties, difficulty in defining medical error, and reform structural constraints (such as public demand, teaching role, and chronic shortage of staff). Without such a benchmark to guide development, ongoing efforts to improve safety by adopting the safety strategies of other industries may yield reduced dividends. Rapid progress is possible only if the health care industry is willing to address these structural constraints needed to overcome the 5 barriers to ultra-safe performance.

Ann Intern Med. 2005;142:756-764.
For author affiliations, see end of text.

www.aafp.org



Aiming for reliability



Resilience safety 2

“Safety” is the ability of a system to sustain required operations under both expected and unexpected conditions.

Safety is not a commodity that can be counted;
it is what we do every day

Hollnagel E., Wears R.L., and Braithwaite J. From Safety-I to Safety-II: A White Paper. The Resilient Health Care Net
Published simultaneously by the University of Southern Denmark, University of Florida, USA, and Macquarie University, Australia.



Look at safety differently

Focus is on what goes right.

Use that to understand normal performance, to do better and to be safer.

Safety and core business help each other.

Learning uses most of the data available



10-4 := 9,999 non-failures in 10,000 events

0-4 := 1 failure in 10,000 events

Hollnagel E., Wears R.L. and Braithwaite J. From Safety-I to Safety-II: A White Paper. The Resilient Health Care Net
Published simultaneously by the University of Southern Denmark, University of Florida, USA, and Macquarie University, Australia.



Why do we accept our inability to deliver the right care at the right time every time?



Reliable and safe person centred care

Right care giver

Right place
Where, how and when

Right treatment

Personalised

Right ward
or clinic

No delays





S.A.F.E. Partnership

 **The Health Foundation**
Inspiring Improvement

Closing the Gap in Patient Safety

This programme was part of the Health Foundation's Closing the Gap in Patient Safety programme.

RCPCH
Royal College of Paediatrics and Child Health
Leading Improving Children's Health

Great Ormond Street NHS
Hospital for Children
NHS Trust

CAMHS
Camden and Maudsley Hospital
Child and Adolescent Mental Health Service

Anna Freud Centre
UCL Institute of Child Health

UCL
University College London

UCLPartners
Academic Health Science Partnership



 **The Health Foundation**
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Closing the Gap in Patient Safety

RCPCH
Royal College of Paediatrics and Child Health
Leading Improving Children's Health

Wave 1
12 Hospitals

Wave 2
8 Hospitals

Wave 3
8 Hospitals

Wave 4 to start
56 hospitals

CAMHS
Camden and Maudsley Hospital
Child and Adolescent Mental Health Service

Anna Freud Centre
UCL Institute of Child Health

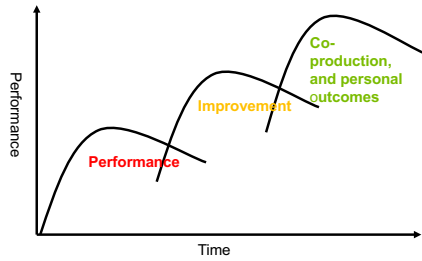
UCL
University College London

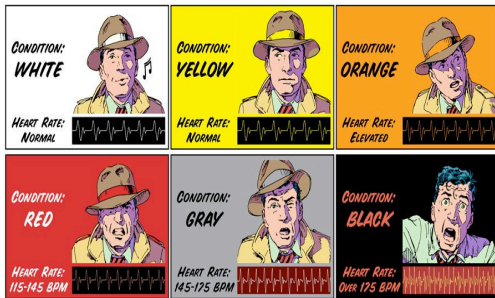
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Getting to the Third Curve





Jeff Cooper Principles of Personal Defense Paperback ~ 2006





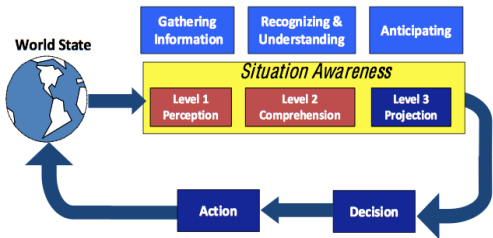
SITUATIONAL AWARENESS
SOME LESSONS CAN ONLY BE LEARNED ONCE!



Mindfulness



What is Situation Awareness?



Situation Awareness is the Perception of the Elements in the Environment within a Volume of Time and Space, the Comprehension of their Meaning, and the Projection of their Status in the Near Future. Endsley, 1988

Thank you to Steve Muething



Evidence in healthcare

A qualitative study examining the influences on situation awareness and the identification, mitigation and escalation of recognised patient risk

Patrick W Brady,¹ Linda M Goldenhar²

Huddling for high reliability and situation awareness

Linda M Goldenhar,¹ Patrick W Brady,^{2,3} Kathleen M Sutcliffe,⁴ Stephen E Muething¹

Improving Situation Awareness to Reduce Unrecognized Clinical Deterioration and Serious Safety Events

abstract **Health care huddles: Managing complexity to achieve high reliability**

BACKGROUND AND OBJECTIVE: Failure deterioration remains a source of se-
pitalized patients. We designed a s-
escalate patient risk by using huddles.
We hypothesized that our novel care:

Shannon M. Provost
Holly J. Latham
Luci K. Levkum

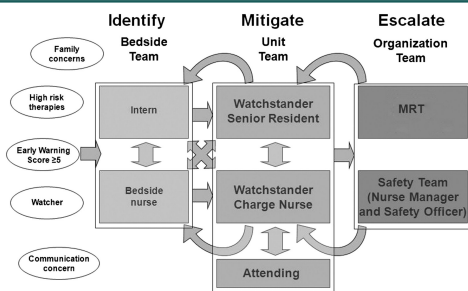


Situation Awareness or knowing what is going on in real time is defined as
 “The perception of elements in the environment within a volume of time and space, the comprehension of their meaning, and the projection of their status in the near future.”

Endsley MR. Measurement of situation awareness in dynamic systems. Hum Factors. 1995;37(1): 32-84



The Cincinnati Model



Brady P W et al. Pediatrics 2013;131:e298-e308
 © 2013 by American Academy of Pediatrics



Situation Awareness

Perception

Identify
via SA

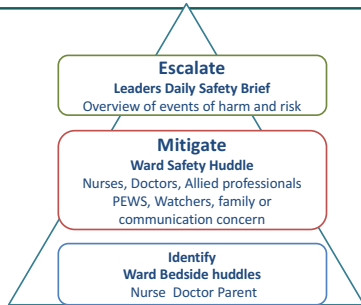
Mitigate

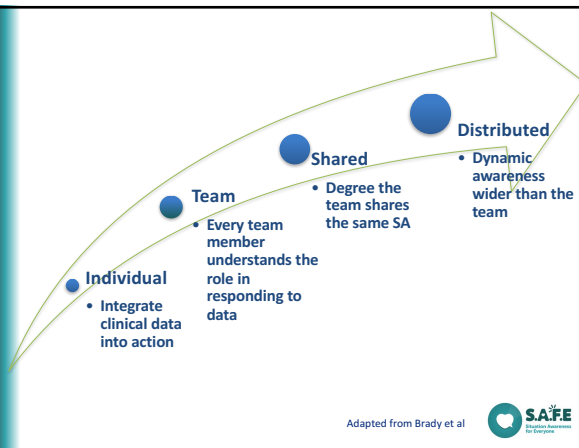
Escalate

Projection



The 'huddle' suite to achieve SA



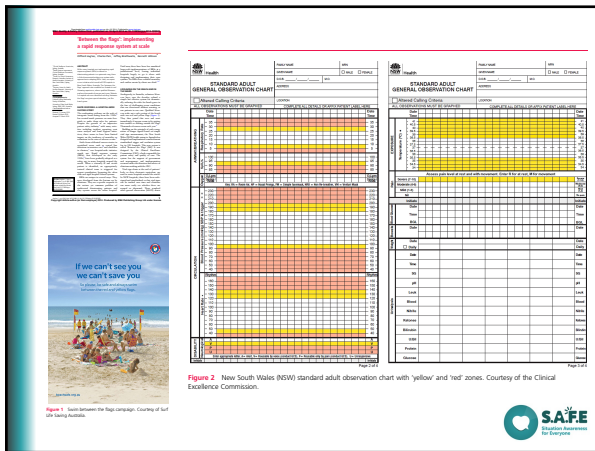


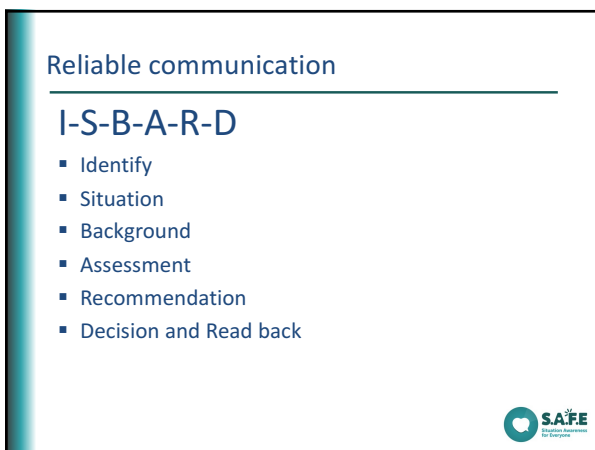
Adapted from Brady et al

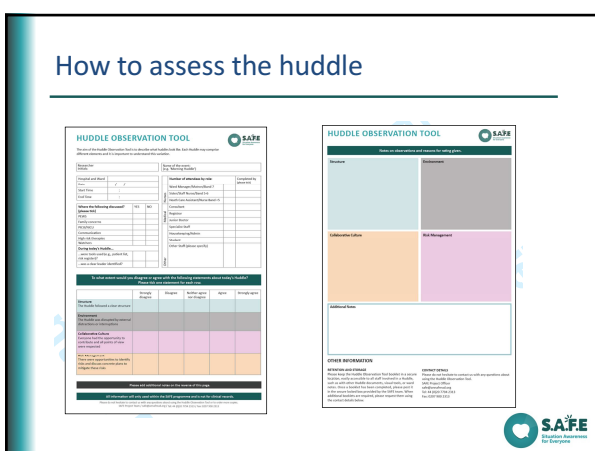


DAILY SAFETY REPORTING TOOL				
FAMILIES AND PATIENTS (16 years and over) TO COMPLETE THE BELOW				
Ward:				
Bed #:				
Medication Communication & Information Equipment Unsuspected complications of care Hygiene / Cleanliness Other safety problems What are your safety issues today? Please tick in the relevant box				
Ward number	Date	Please add any additional comments about issues raised today:	Has any actual harm been caused? Please tick	If actual harm has been caused, please describe:
1			Yes / No	
2			Yes / No	

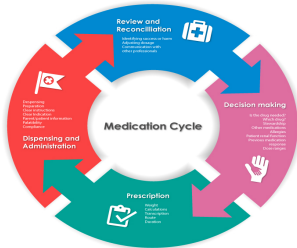








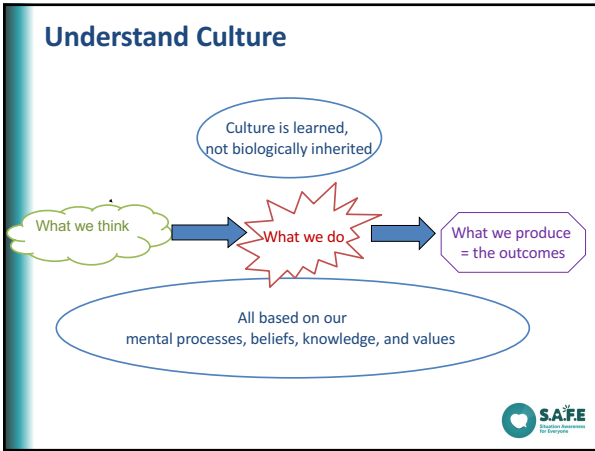
Meds IQ – www.medsiq.org

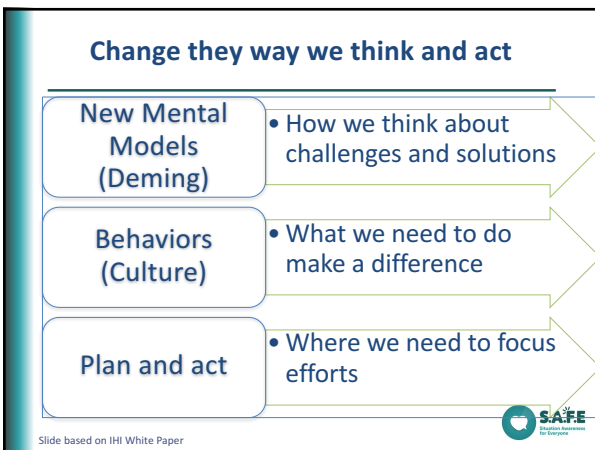


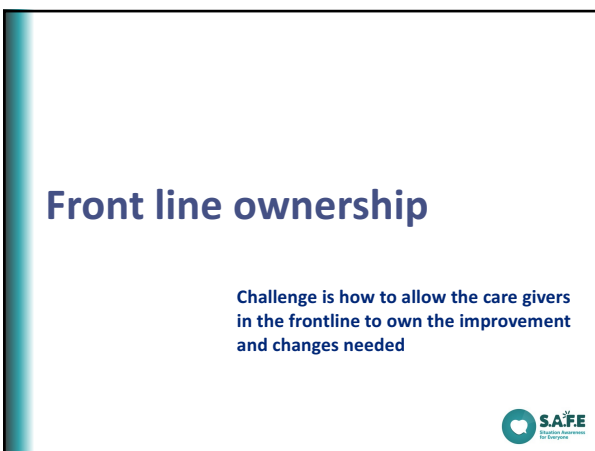


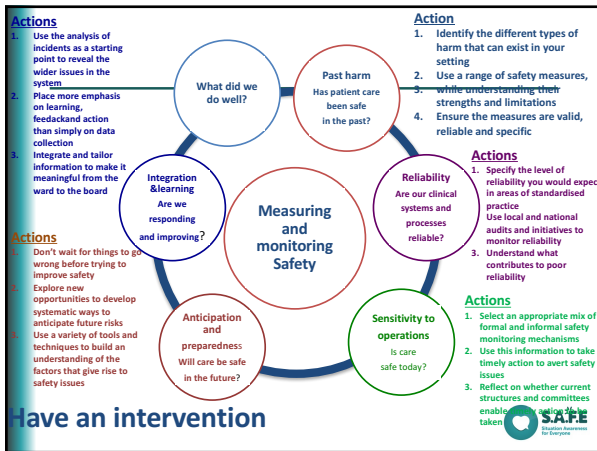
So what is needed?











Daily questions to ask at all levels

- What did we do well?
 - So we can replicate
- 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?

SAFE
Sustainable Approaches for Everyone

S.A.F.E

S.A.F.E Toolbox – A Sustainable Product

- Six chapters
 - Introducing Quality Improvement
 - Theories of Patient Safety
 - Structured Communication
 - Recognising Deterioration Early
 - Implementing Huddles
 - Evaluating Impact

<http://www.rcpch.ac.uk/safe-resource/introduction-resource-pack/introduction-safe-resource-pack>

SAFE
Sustainable Approaches for Everyone



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plachman@isqua.org

<http://www.rcpch.ac.uk/safe>

<http://www.health.org.uk/programmes/closing-gap-patient-safety/projects/closing-gap-paediatric-safety>