An Stiúrthóireacht um Ardchaighdeáin agus Sábháilteacht Othar
Oifig an Phríomhoifigigh Cliniciúil

National Quality and Patient Safety Directorate
Office of the Chief Clinical Officer

QPS TALKTIME

A community of quality and patient safety improvers

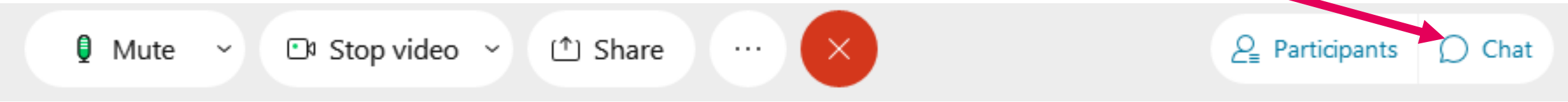
1 February, 2022

Translating theory into action - Lessons from the Situation Awareness For Everyone (SAFE) Programme

CONNECTING PEOPLE INTERESTED IN QUALITY AND PATIENT SAFETY | https://www.hse.ie/eng/about/who/nqpsd/ | @QPSTalktime | @NationalQPS | #QIreland

Welcome

- **Sound:** Computer or dial in:
  - **Telephone no:**
    - **Irish: 01-5260058**
    - **UK: +44-20-7660-8149**
  - **Event number: 2732 540 9439#**
- **Chat box function**
  - Comments/Ideas
  - Keep the questions coming!
- **Recording**
- **Engage with the team**
  - **Twitter: @PeterLachman @johnfitzsimons9 @sineadoneilldul @AvileneCasey @mapflynn @QPSTalktime @NationalQPS #Qireland**
- **Feedback**
  - **Short feedback form after the session, please help us to improve our QPS Talktime Webinars**
  - **A window will pop up before logging out**
- **Confirmation of attendance**
  - **You will receive an email from QPS Talktime**



To get started … we invite you to

Share using the chat box

- Your name, work and where you are joining us from …
- Finish statement: Safety huddles are a way to…

Speakers today

Dr Peter Lachman: Lead Faculty Quality Improvement at the Royal College of Physicians of Ireland (RCPI) where he leads improvement programmes funded by the HSE National Quality and Patient Safety Directorate. Former Chief Executive Officer of the International Society for Quality in Healthcare (ISQua) and previously, Deputy Medical Director with the lead for Patient Safety at Great Ormond Street Hospital.

Sineád O'Neill: CNM2 Sepsis/Deteriorating Patient, Bantry General Hospital. Sineád, **Dr Mark Hannon**, Consultant Endocrinologist and **Sandra Viray**, CNM High Dependency Unit are participating in the ONMSD funded SAFE Collaborative programme designed to improve communication, build a safety culture and enhance outcomes for patients in Irish hospitals.

In conversation with

Dr **John Fitzsimons**: Clinical Director, HSE National Quality and Patient Safety Directorate and Consultant Paediatrician, Children's Health Ireland at Temple Street.

S.A.F.E®

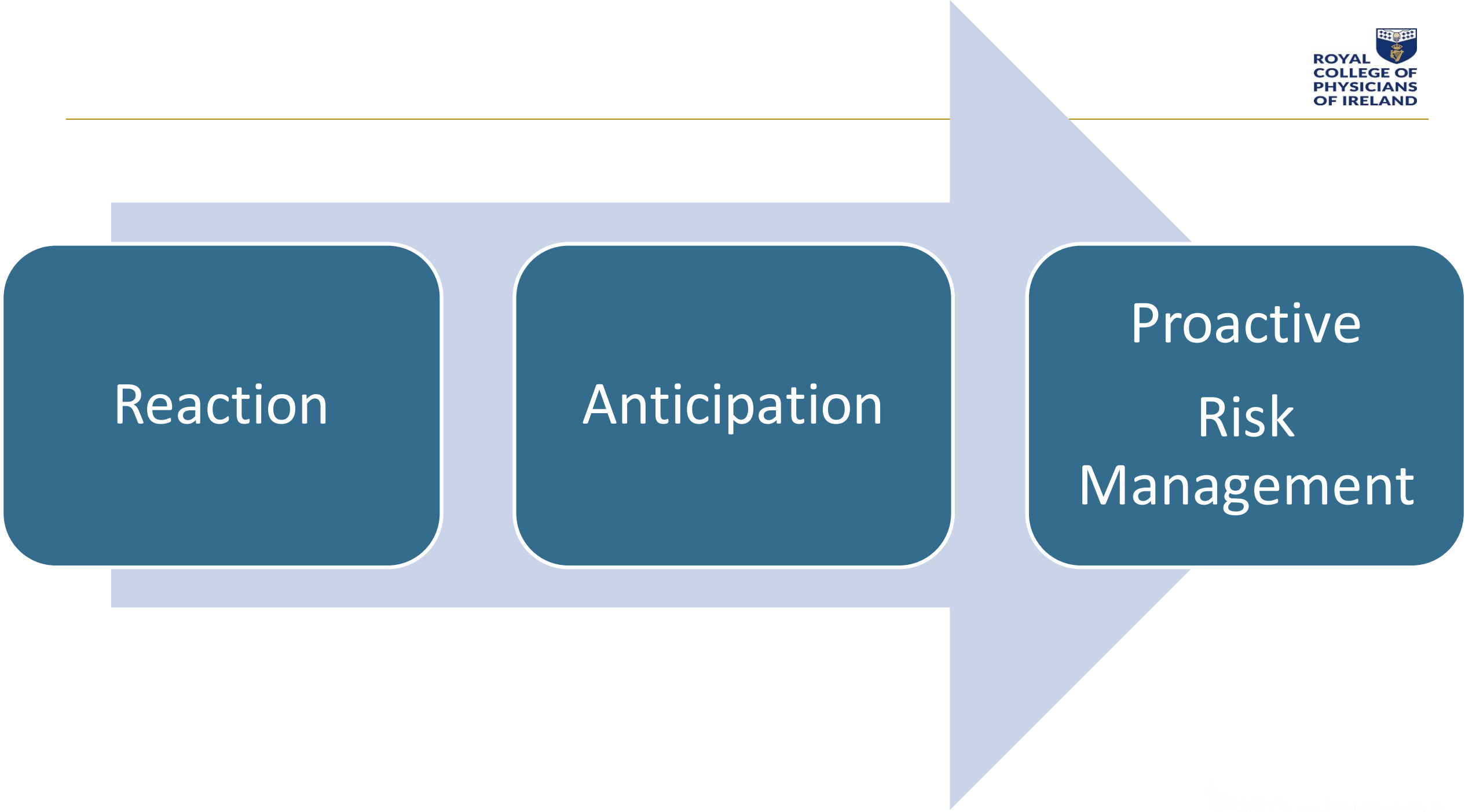
Situation Awareness for Everyone

ROYAL COLLEGE OF PHYSICIANS OF IRELAND

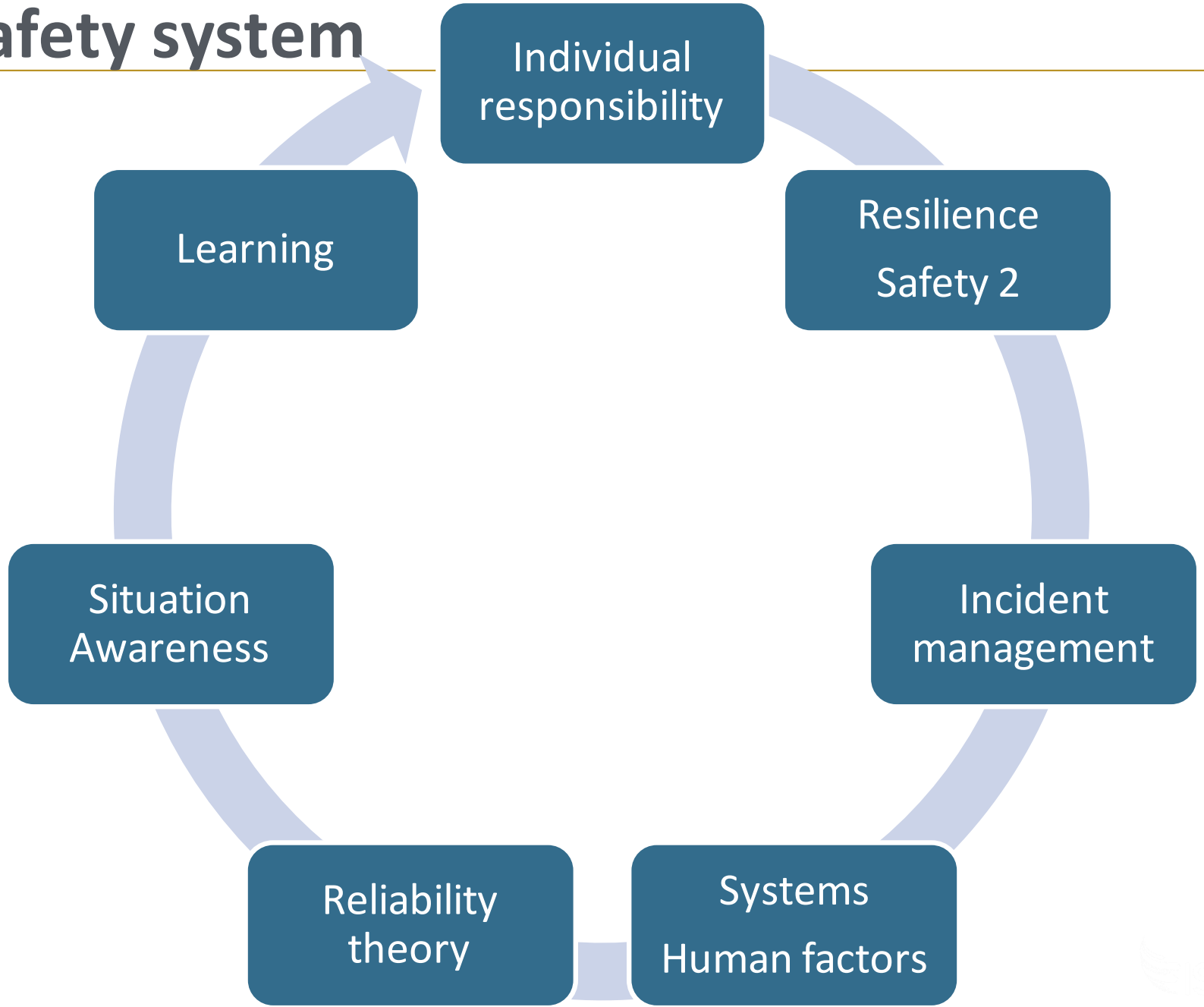
"Safety is the ability of a system to sustain required operations under both expected and unexpected conditions. Safety is what we do every day."

Erik Hollnagel

ROYAL COLLEGE OF PHYSICIANS OF IRELAND



A proactive safety system



Resilience and Safety II An aim of S.A.F.E.

ROYAL COLLEGE OF PHYSICIANS OF IRELAND

"The variability that completed the job safely on one day is the same variability blamed for the accident on the next."

Hollnagel

Resilience and Safety II An aim of S.A.F.E.

ROYAL COLLEGE OF PHYSICIANS OF IRELAND

"The variability that completed the job safely on one day is the same variability blamed for the accident on the next."

Hollnagel

The human face of safety

The power of Positive Deviance

Understanding and mitigating risk An aim of S.A.F.E.

ROYAL COLLEGE OF PHYSICIANS OF IRELAND

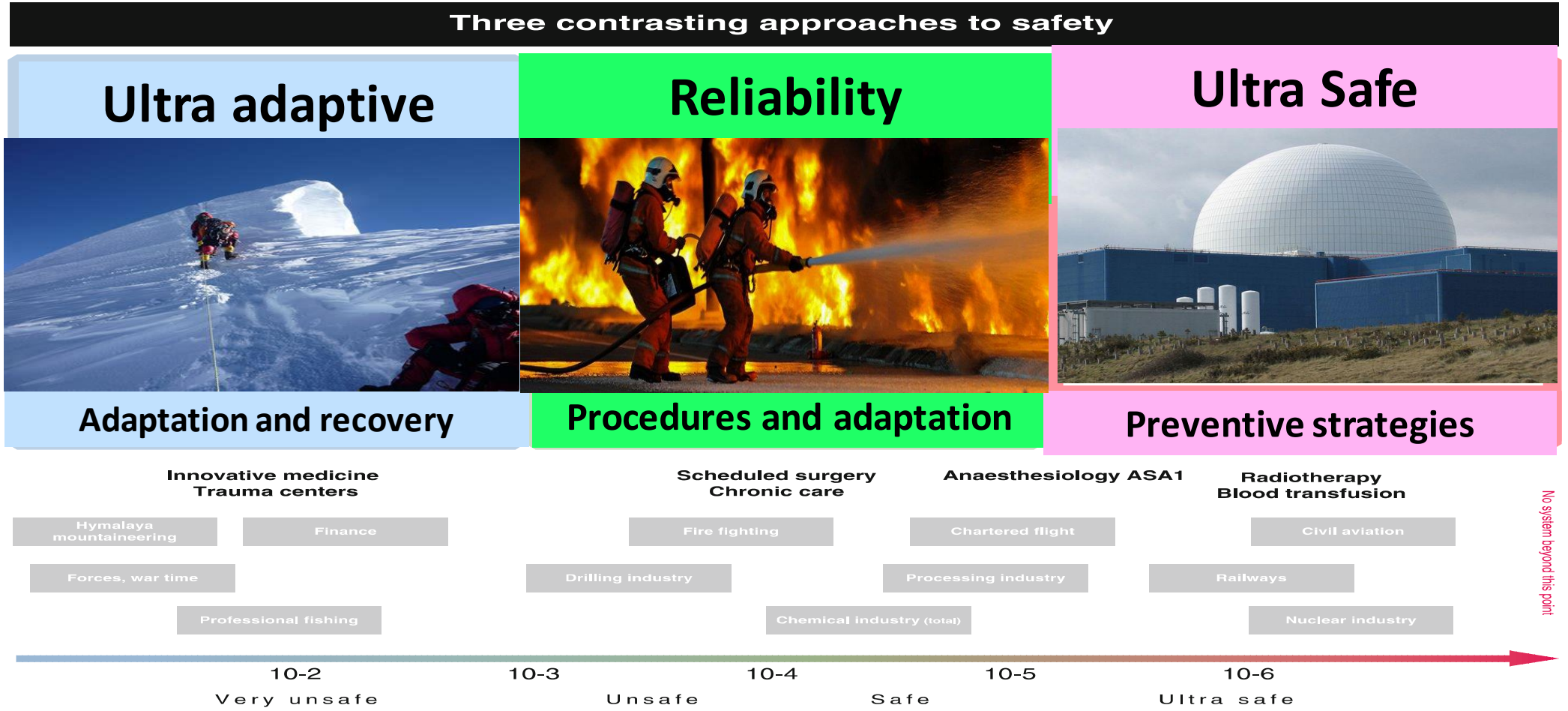
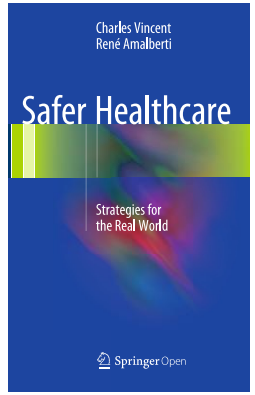


Fig. 3.1 Three contrasting approaches to safety



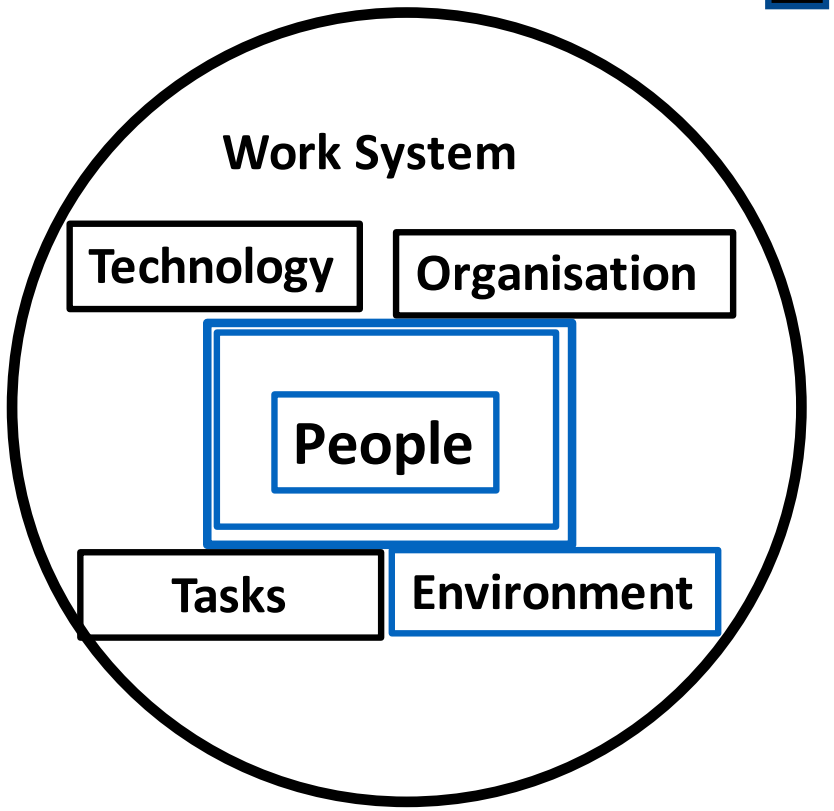
Adapted from
Safer Healthcare Strategies for the Real World
Charles Vincent Rene Amalberti

https://link.springer.com/content/pdf/10.1007%2F978-3-319-25559-0.pdf

Systems and human factors An aim of S.A.F.E.

ROYAL COLLEGE OF PHYSICIANS OF IRELAND

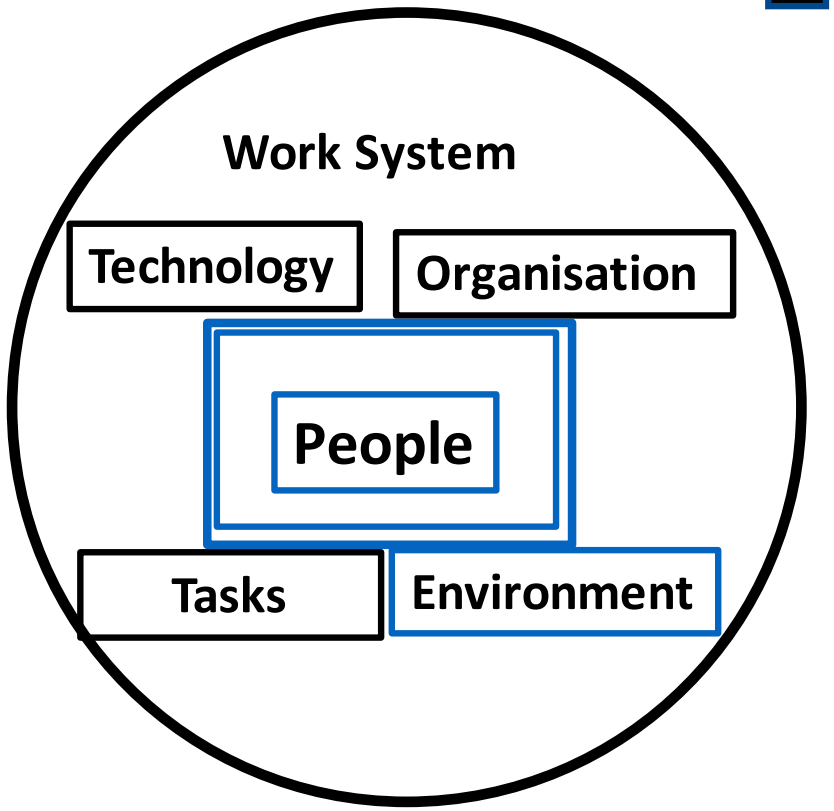
Systems + **Process** = **Outcome**



Systems and human factors An aim of S.A.F.E.

ROYAL COLLEGE OF PHYSICIANS OF IRELAND

Systems + **Process** = **Outcome**



Clinical

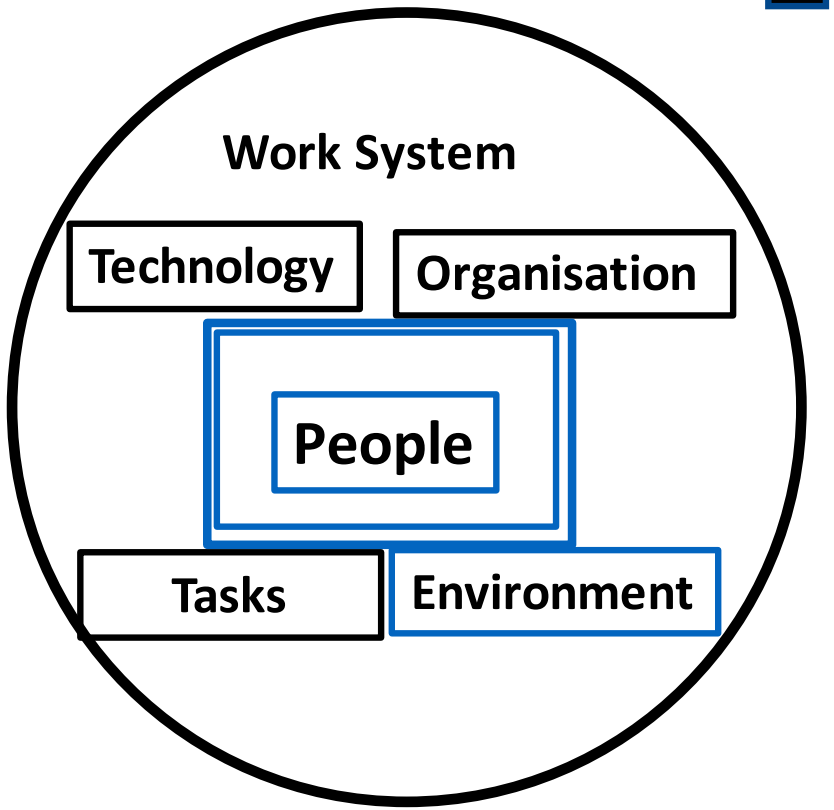
Processes

Patient

Systems and human factors An aim of S.A.F.E.

ROYAL COLLEGE OF PHYSICIANS OF IRELAND

Systems + **Process** = **Outcome**



Clinical

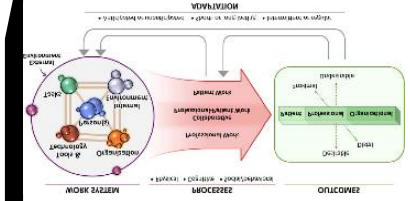
Processes

Patient

Desired outcome

Patient /Organisation /Professional

Undesired outcome



High Reliability An aim of S.A.F.E.

ROYAL COLLEGE OF PHYSICIANS OF IRELAND

Contain

Preoccupation with failure

small errors are symptom that something is wrong

Sensitivity to operations

Pay attention to the **Front-line**

Reluctance to simplify

Encourage **diversity**

perspective, and opinion

Anticipate

Commitment to resilience

Detect, and contain events **Bounce-back**

Deference to expertise

Decision making

at the **Front line**

Situation Awareness An aim of S.A.F.E.

ROYAL COLLEGE OF PHYSICIANS OF IRELAND

Create a World View

Situation Awareness An aim of S.A.F.E.

ROYAL COLLEGE OF PHYSICIANS OF IRELAND

Create a World View

Gather information → Recognise and understands → Anticipate what will happen

Situation Awareness An aim of S.A.F.E.

ROYAL COLLEGE OF PHYSICIANS OF IRELAND

Create a World View

Gather information → Recognise and understands → Anticipate what will happen

Level 1 Perception

Level 2 Comprehension

Level 3 Projection

Action + Decision

Based on Endsley

INEWS IMEWS
IPEWS rising

Family concerns

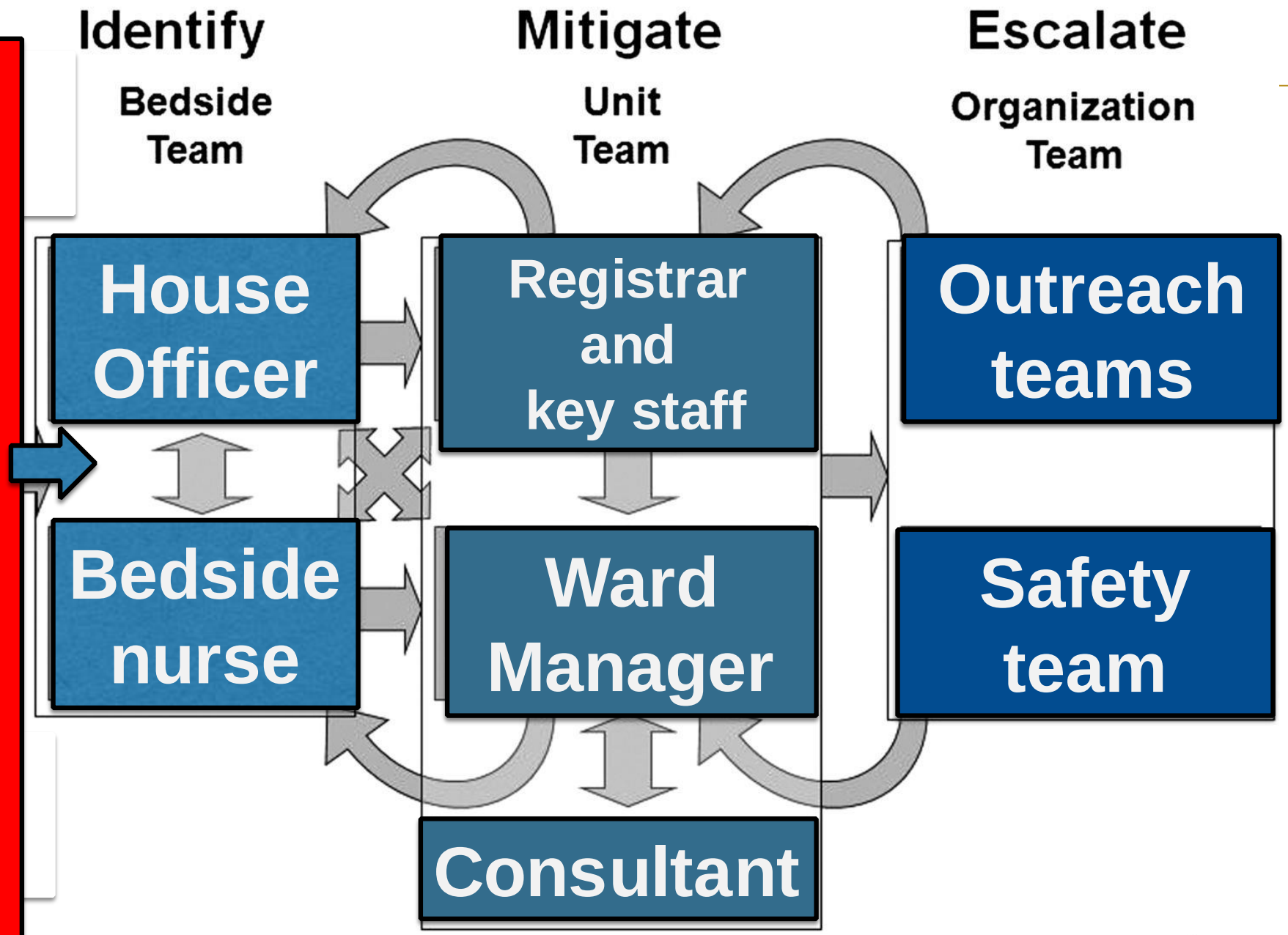
High Risk Meds

"Stable"

Communication issues

In wrong bed

WATCHER



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

The Vincent Model - An aim of S.A.F.E.

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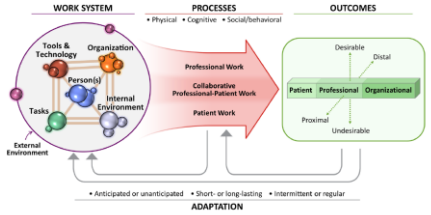
Improvement of processes and systems



Monitoring, adaptation and response (resilience)

Risk control

Mitigation

Aspire to standards – safety as best practice

S.A.F.E Situation Awareness for Everyone

The Health Foundation Inspiring Improvement

Safe & Reliable Culture Maturity Model

Value

Tipping Point =
Psychological Safety

Generative

Safety is how we do business around her
constantly vigilant and transparent.

Proactive

Anticipating and preventing problems before they occur; Comfort speaking up.

Systematic

We have systems in place to manage all hazards.

Reactive

Safety is important. We do a lot every time we have an accident.

Unmindful

Who cares as long as we're not caught *chronically complacent*.

QPS Talktime
SAFE Q.I.
Sustaining the change

SINEAD O'NEILL

CNM2 SEPSIS/DETERIORATING PATIENT

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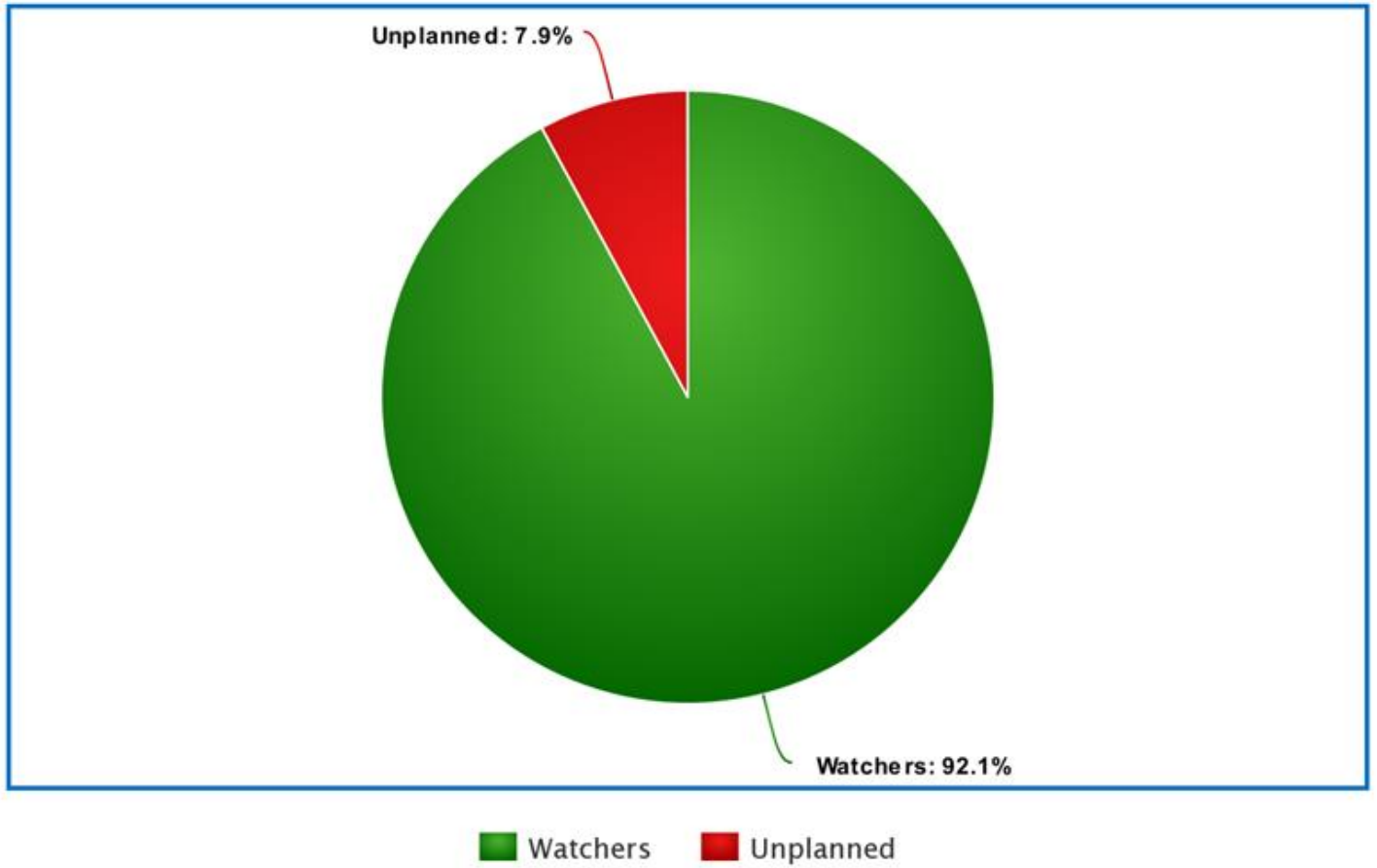
Escalation – Phase 1 (MAU)

- Phase 1- SAFE QI rolled out 8am to 5pm, Monday to Friday.

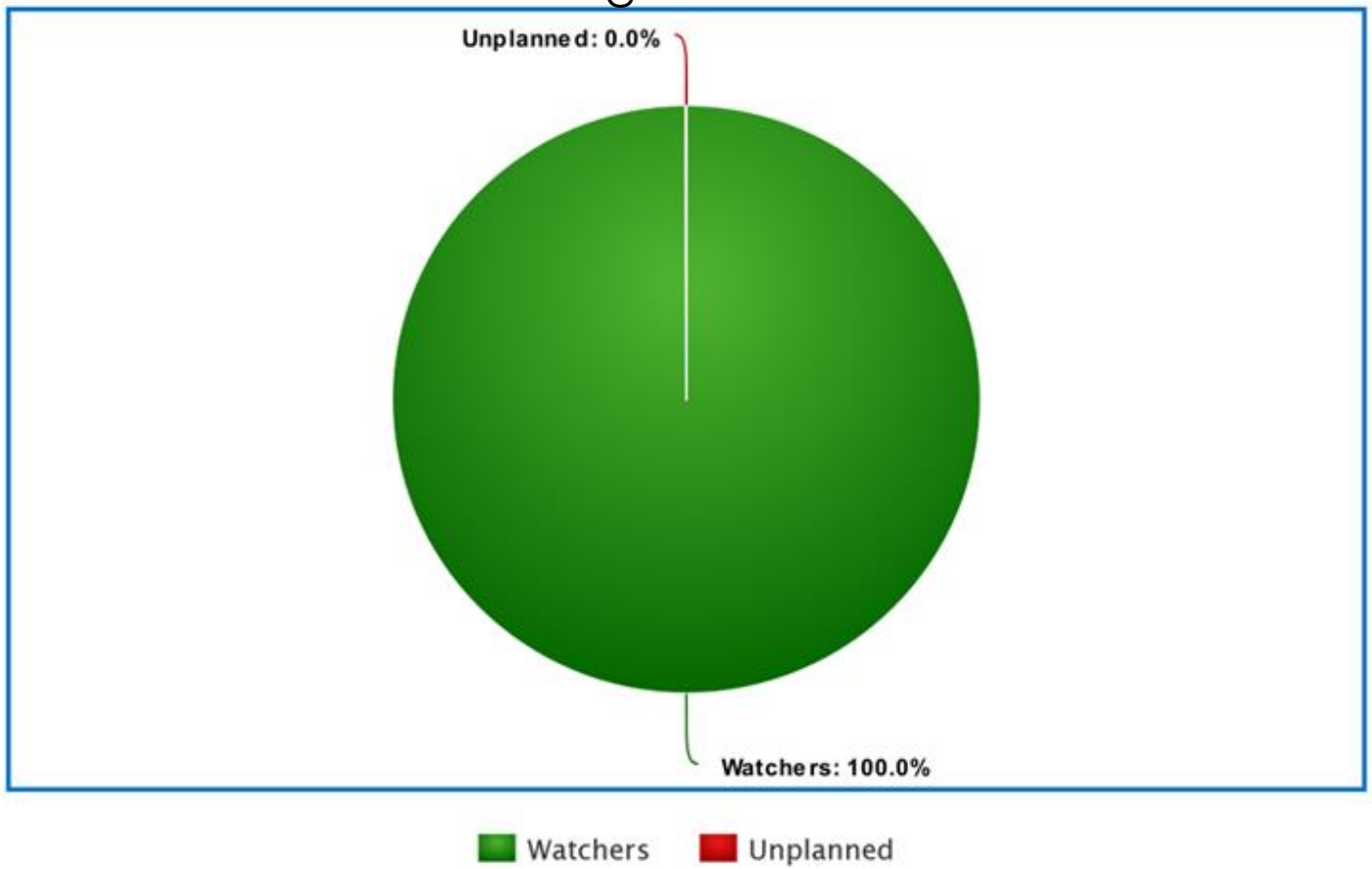
Transfers to higher level of care



Escalation – Phase 2 (MAU)

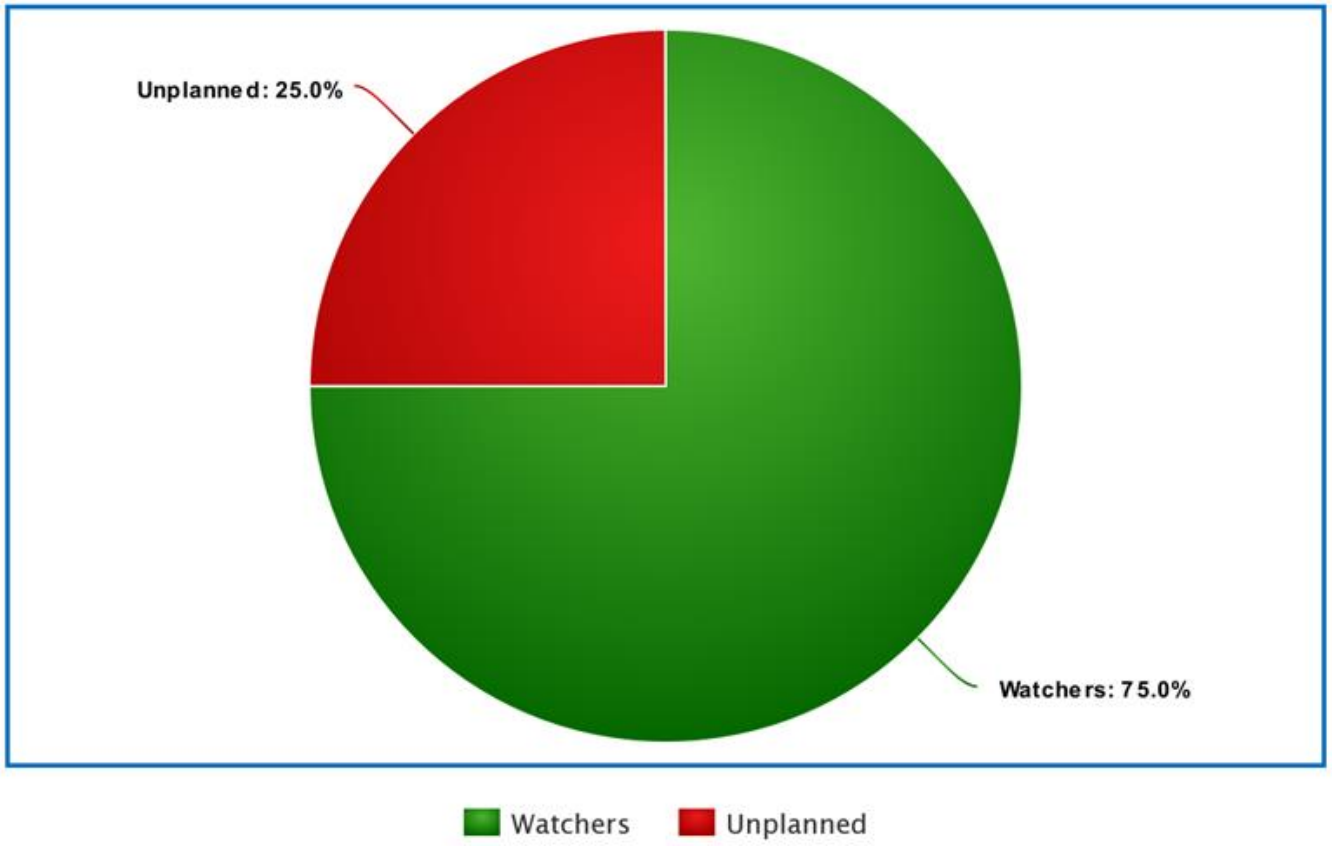
- Phase 2 - SAFE QI running over 24hrs, 7 days a week.

Transfers to higher level of care

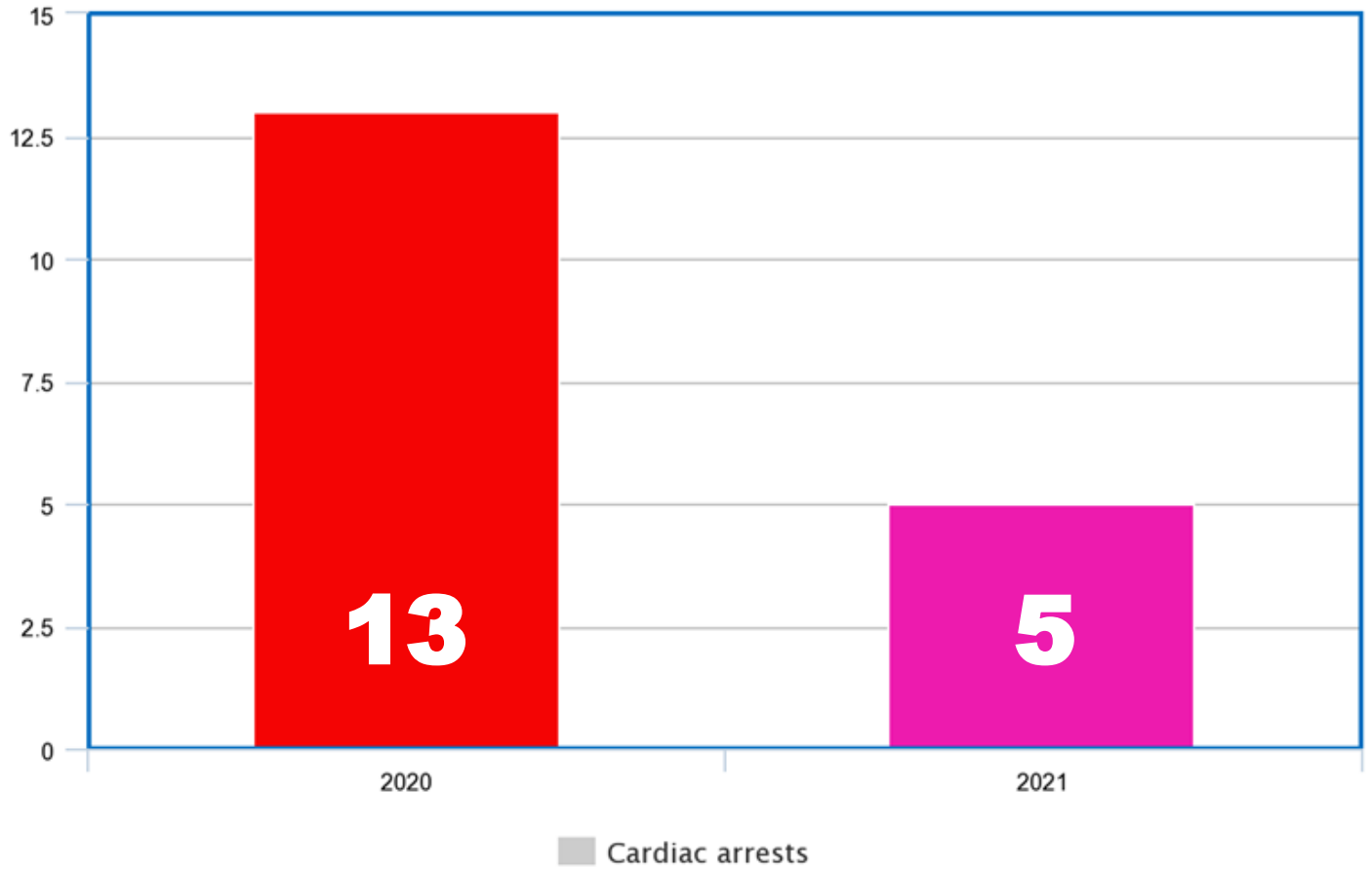


Escalation – Phase 2 (Wards)

Transfers to higher level of care



Cardiac Arrests



Thank you for listening

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Further reading:

- Stapley E, Sharples E, Lachman P, Lakhanpaul M, Wolpert M, Deighton J. Factors to consider in the introduction of huddles on clinical wards: perceptions of staff on the SAFE programme. Int J Qual Health Care. 2018 Feb 1;30(1):44-49.

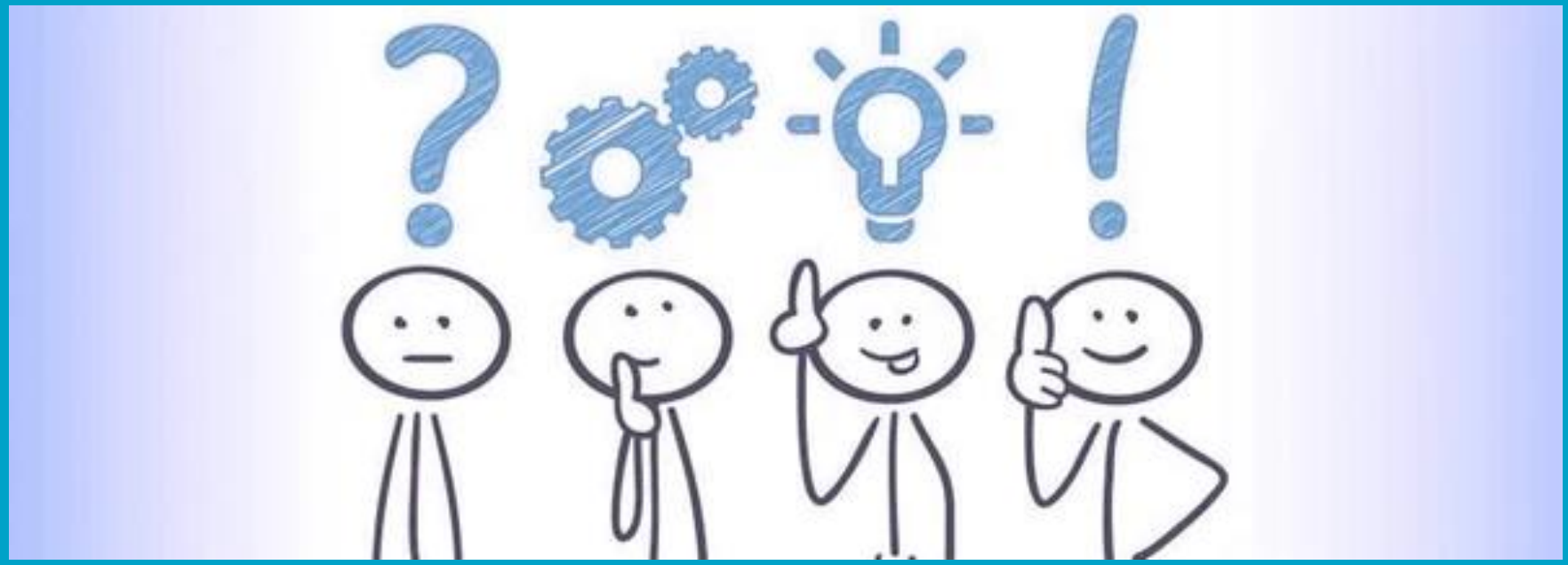
- Cheung R, Roland D, Lachman P. Reclaiming the systems approach to paediatric safety. Arch Dis Child. 2019 Feb 23. pii: archdischild-2018-316401. https://doi:10.1136/archdischild-2018-316401

- Hayes J, Lachman P . Edbrooke Childs J, et al. Assessing risks to paediatric patients: Conversation analysis of situation awareness in huddle meetings in England BMJ Open 2019;9:e023437. https://doi:10.1136/bmjopen-2018-023437

- Lachman P, Gondek D, Edbrooke- Childs J, et al. Perspectives of paediatric hospital staff on factors influencing the sustainability and spread of a safety quality improvement programme. BMJ Open 2021;11:e042163. https://doi:10.1136/bmjopen-2020-042163

- Deighton J, Edbrooke-Childs J, Stapley E, et al. Realistic evaluation of Situation Awareness for Everyone (SAFE) on paediatric wards: study protocol [published correction appears in BMJ Open. 2017 Feb 22;7(2):e014014corr1]. BMJ Open. 2016;6(12):e014014. Published 2016 Dec 30. doi:10.1136/bmjopen-2016-014014

- Edbrooke-Childs J, Hayes J, Sharples E, et al. Development of the Huddle Observation Tool for structured case management discussions to improve situation awareness on inpatient clinical wards. BMJ Qual Saf. 2018;27(5):365-372. doi:10.1136/bmjqs-2017-006513



HEARING YOUR THOUGHTS AND COMMENTS

SAFE PROGRAMME DATES

A new cohort of SAFE will be advertised soon for a September start date, with a number of funded places available.

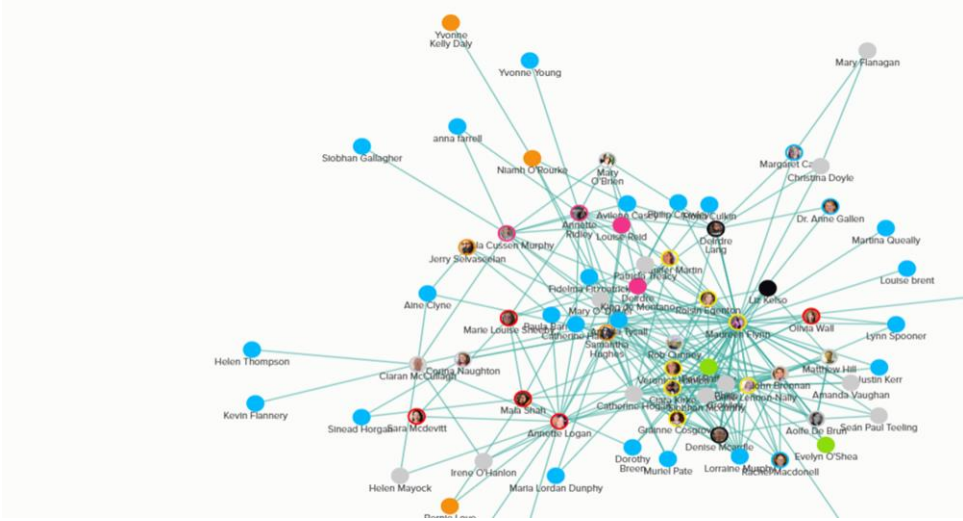
Register interest or find out more at qualityimprovement@rcpi.ie

The QPS Ireland Network Map

To help visualise connections between people interested in quality, safety and improvement across Ireland: https://www.hse.ie/eng/about/who/nqpsd/qps-connect/network-map/

- How to join the map?
  - Visit the HSE website (see link in the chat)
  - Get sent your unique link to the map
  - Enter information about you, your professional characteristics and your interests
  - Log your connections

- How to use the map?
  - Filter the map by role, organisation, interests
  - View individual profiles
  - Connect and collaborate with others



Apply to become a member of Q Community

- All you need to know about applying can be found on the Q website
- You will be invited to complete an online application using the Q online portal
- If you have queries or require support, please contact our colleague via email

Caroline.Lennonnally@hse.ie

Upcoming Webinars: Dates for your diary ….

Dates	Topics	Speakers
15 February	Our Healthcare Service includes everyone: Reflections from Patients for Patient Safety Ireland	Bernie O'Reilly and Mairie Cregan, Patients for Patient Safety Ireland
1 March	Partnering with patients	Mila Whelan, Anne Lawlor and Nicola Williams, National Patient Forum

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https://www.hse.ie/eng/about/who/nqpsd/qps-connect/qps-talktime/qps-talktime.html

Let us know how we did today ….

Reminder: Short questions (pop up) as you sign off, please help us to improve our QPS Talktime Webinars by sharing your feedback

We really appreciate your time, thank you

Contact: Noemi.Palacios@hse.ie to be included on our mailing list to receive QPS Talktime invitations