How safe is our practice ?

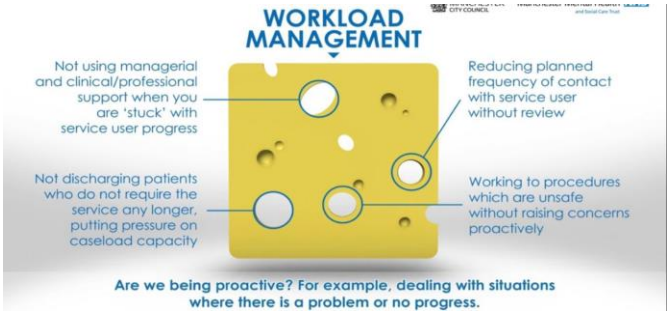
How do we make sure patients we work with are safe? how could we prevent a serious incident occurring ?

we recognize that we work in a high pressured high-risk environment and that even with the best risk management policies and procedures we cannot make everything safe. However we also know that if we consider human factors that is the interaction between people and systems we can reduce the likelihood of harm occurring. For example, being aware of and acting on processes and environment that increase risk and sticking to basic principles of good practice can help.

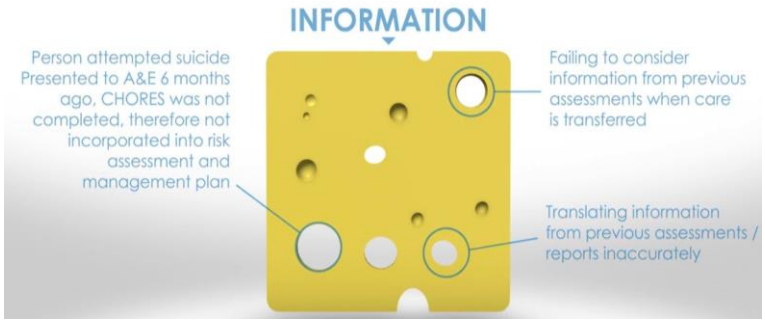
We reviewed 40 series over the past year and we found that there were repeating things, we have used some real examples in this film let's take a simple model known as the Swiss cheese model developed by Professor James Reason , and think about how this can help ensure our practices are as safe as they can be.

Each slice of cheese is a protective factor which can reduce the likelihood of an incident occurring , and the holes in the cheese or the errors or gaps in expected practice . we already have protective factors in a place to prevent incidents but we need to ensure these are working effectively. let's look at what we know protective factors :

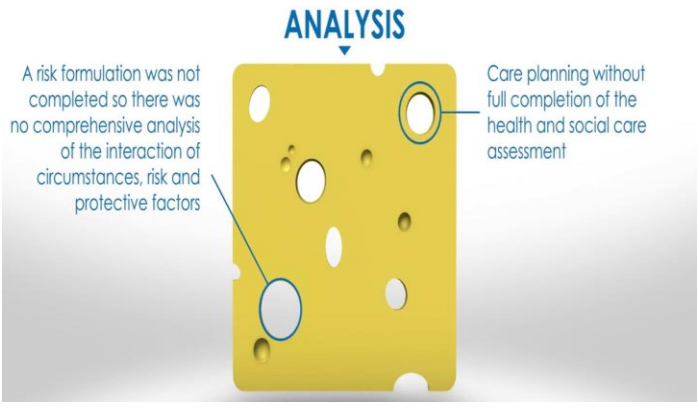
- **Work load management** , knowing and effectively managing our workload:



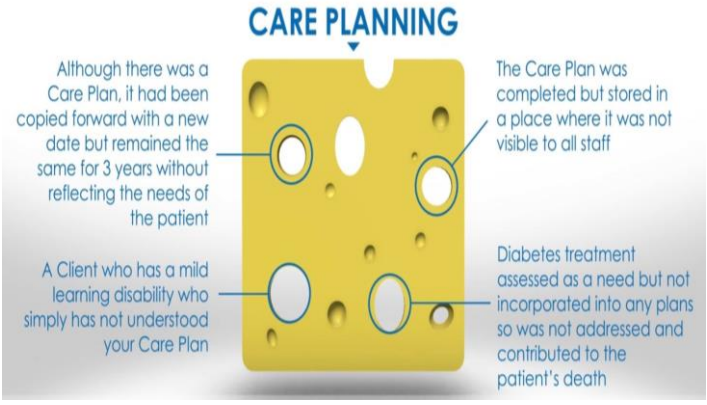
- **Information :** do we have all the information we need ? is it up-to-date and accurate? for example have we fully considered services use of use carer or family views results and previous assessments?



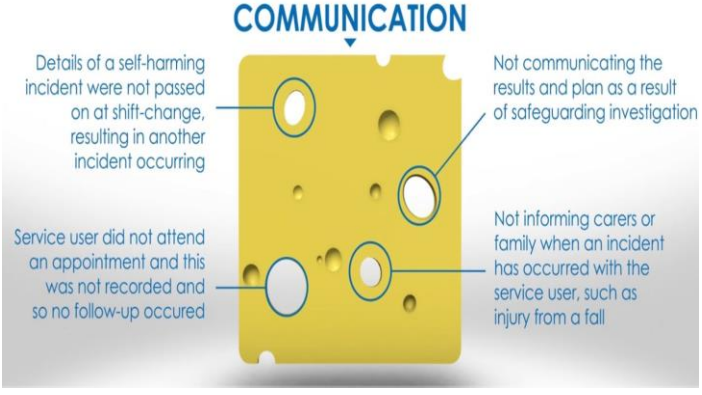
- **Analysis** : do we know enough to analyze the information formulate or contribute to a team formulation? analysis includes knowledge of theory research evidence guidance and best practice .



- **Care planning :** effective care planning relies on sound information and analysis. There should be a clear thread from the assessment through formulation to any plan. Care planning must be executed in partnership with patients through a process of shared decisions making .



- **Communication underpins everything :** this incorporates affective verbal communication with patients, family carers and the team. It also means accurate and timely record-keeping, any other relevant professional should be able to pick the patient record, understand the plan, understand why decisions have been made , and continue with support and treatment effectively in our absence.



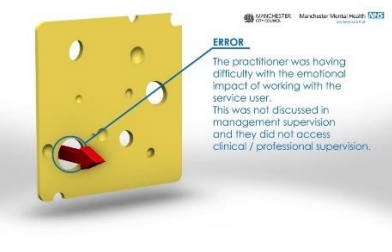
>>> Now lets apply this to a specific scenario , to see how a serious incident can happen when there are errors and omissions :

Let's consider the following example of a 23 year old man who :

- has a diagnosis of schizophrenia
- he lives alone
- his mistrusting of care stuff
- has a history of self harm

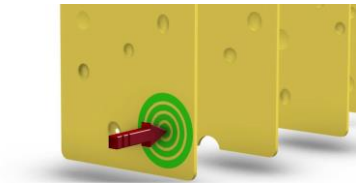
Error :

1. The practitioner was having difficulty with the emotional impact of working with a service user this was not discussed in management supervision and they did not access clinical or professional supervision
2. The young man attempt to jump off a bridge this time last year , it is a special anniversary , his family recognized his becoming low when he stop taking his medication and isolates himself ,
3. A risk formulation was not completed, so there was no comprehensive analysis of the interaction of circumstances risk and protective factors.
4. care planning without full completion of health and social assessment
5. how the family interact with the service user was not recorded or communicated to the team - is there an unknown agenda? for example , no other home to go if the client has to move .

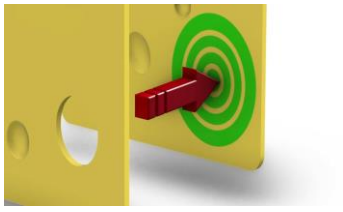


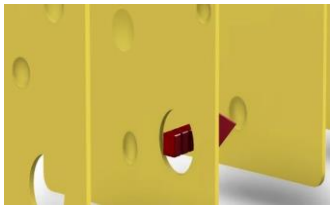
>> Because of these various errors and omissions ,because the holes line up , we are now dealing with a serious incident .

>> Now let's look at how by getting the basics right and by making small incremental changes we can minimize or even illuminate errors and so prevent serious incidents ocuring.



- if there are no holes or smaller holes in the cheese this means that we have reduced or eliminated the likelihood of errors and a potential incident is prevented.





- if an error or omission does occurre in the first slice, perhaps due to a patient service user missing or failing to attend an appointment or another factor out of your control , the next sliced or protective factor again stops the incidents from progressing ,in this way we can see that the arrow could feasibly pass through for layers, but still be stopped at the last layer.
- this would be an unusual coincidence of unforeseen or uncontrollable incidence, but as long as the protective factors are properly in place, we could still avoid serious incident

We all try to get things right , but we should also recognize occasionally we can all make mistakes too. it is not necessarily about making big altertion to our practice but rather small incremental changes that add up to the larger positive outcomes . it's about sticking to the basic principles of good practice. if we all do this we can dramatically reduce the likelihood of harm occurring .

With this in mind, how safe is our practice ? what things can we do today to illuminate or reduce the size of holes in the cheese , the errors, or emissions in our practice ?

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