

LESSONS LEARNT

Building a Safer Foundation

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Central Manchester
Health NHS Trust



Central Manchester
Health NHS Trust

DRAGONS' DEN

From Idea to Implementation

2010



Context

Global drive
to improve
Safety

Growing
evidence for
education

Factors
impacting
delivery

Trainees as
'Agents for
Change'

Aims

Develop, implement & evaluate PS training programme:

Promote structured analysis and learning from PSIs

Improve trainees' patient safety competencies

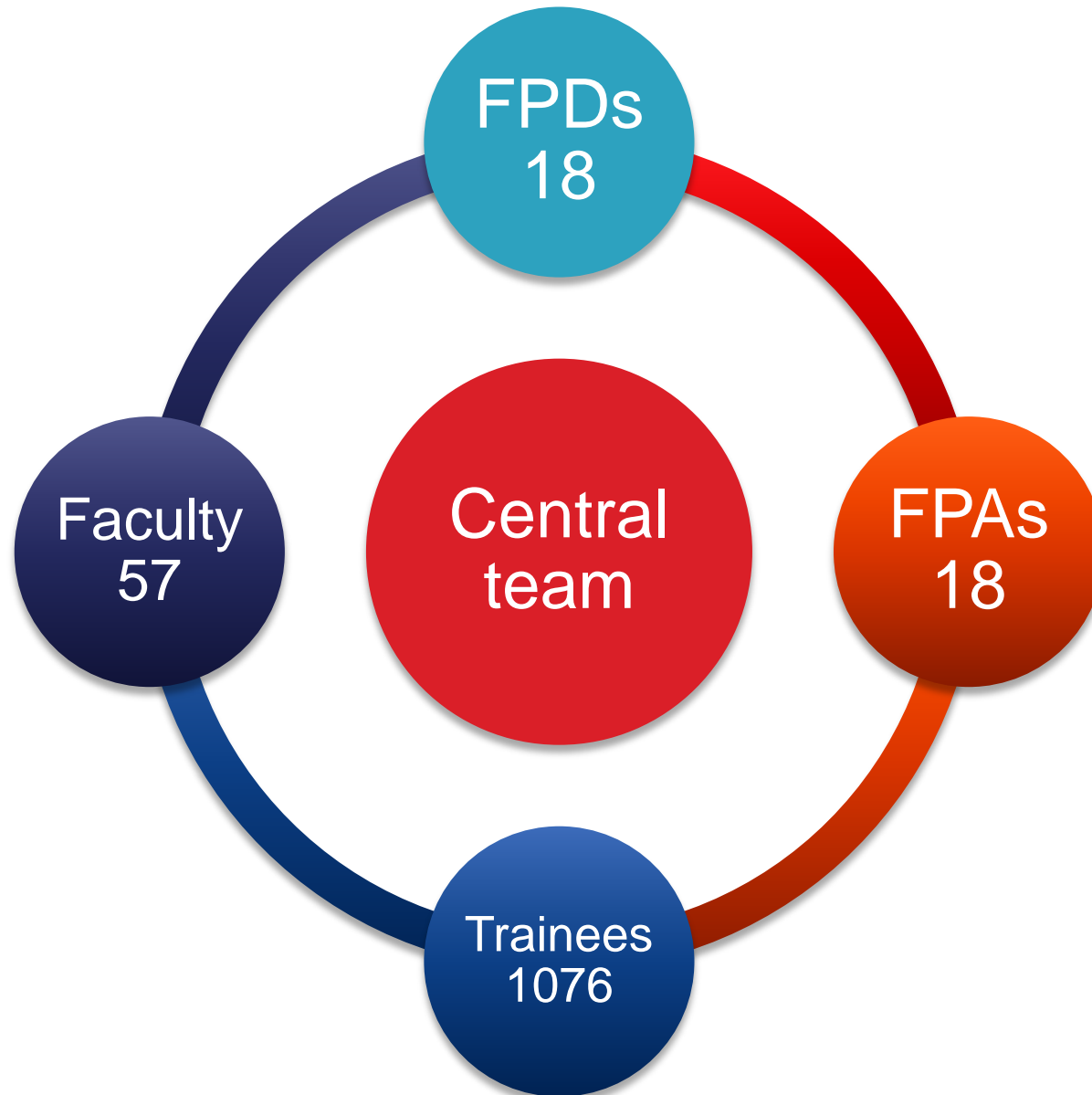
Address barriers to sustainable implementation

Methods

Setting

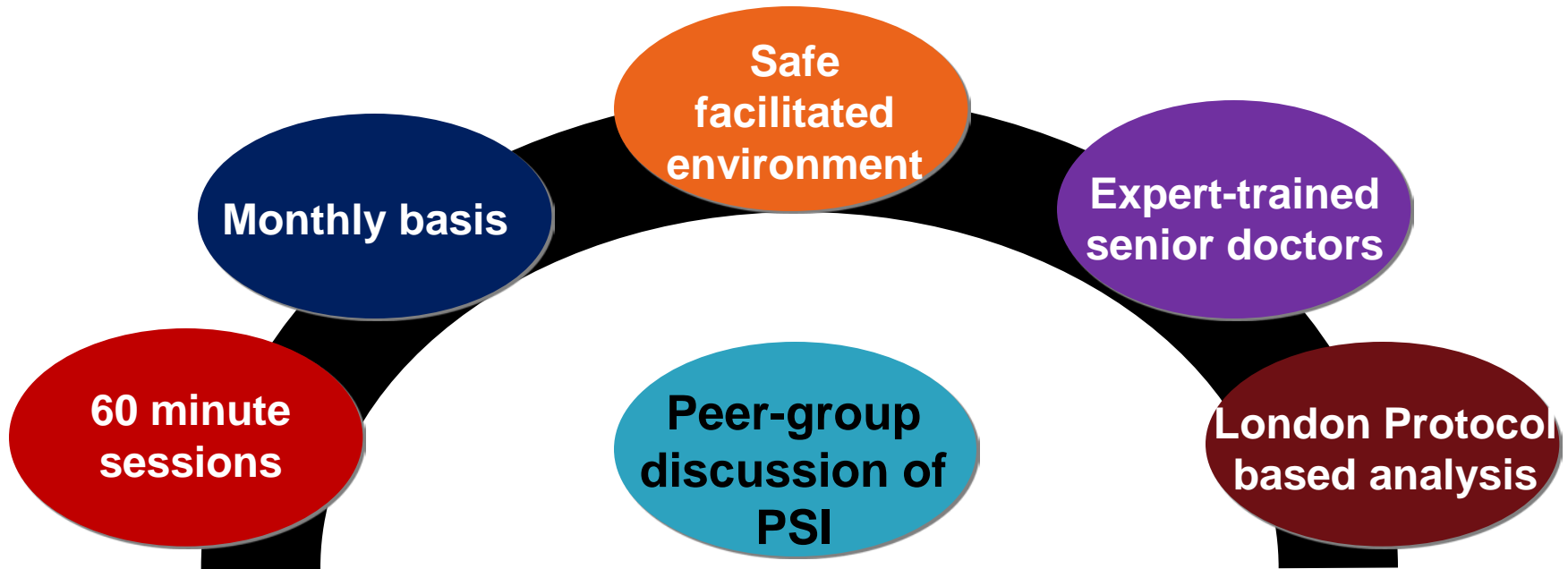


Participants



n=1169

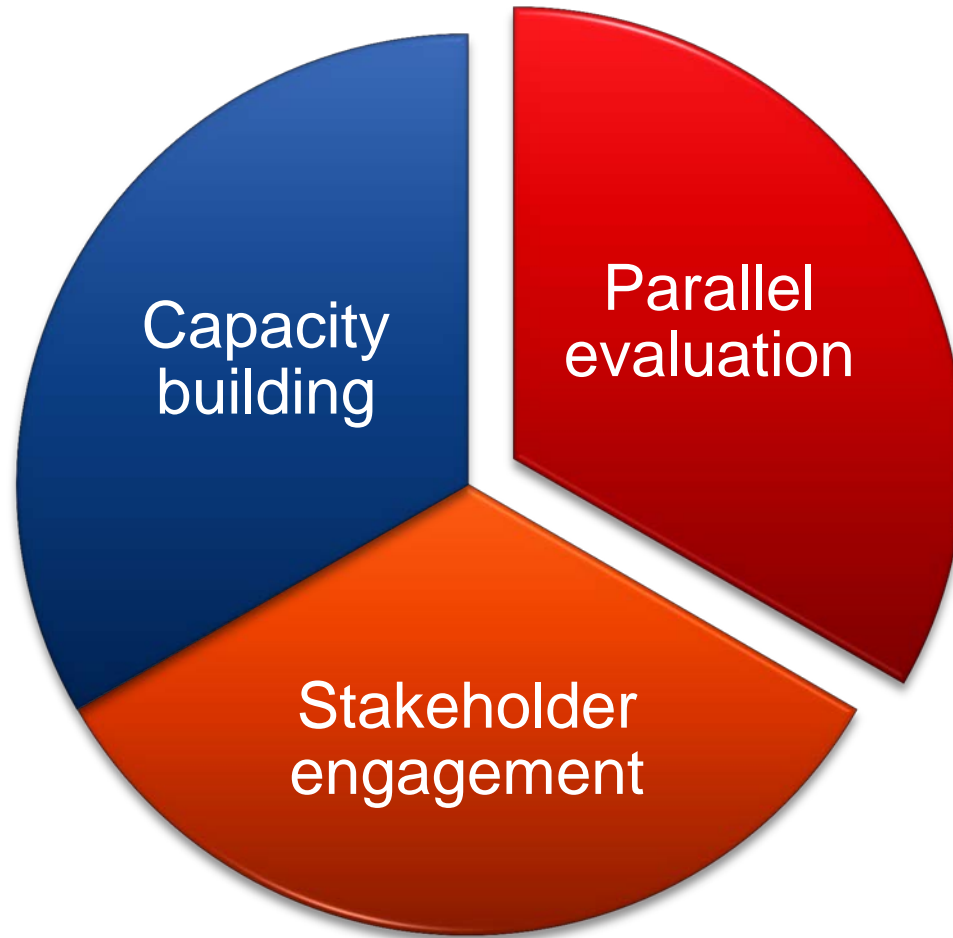
Intervention



Lessons Learnt

Any unintended or unexpected incident that could have or did lead to patient harm (NPSA)

Implementation



Sustainability key

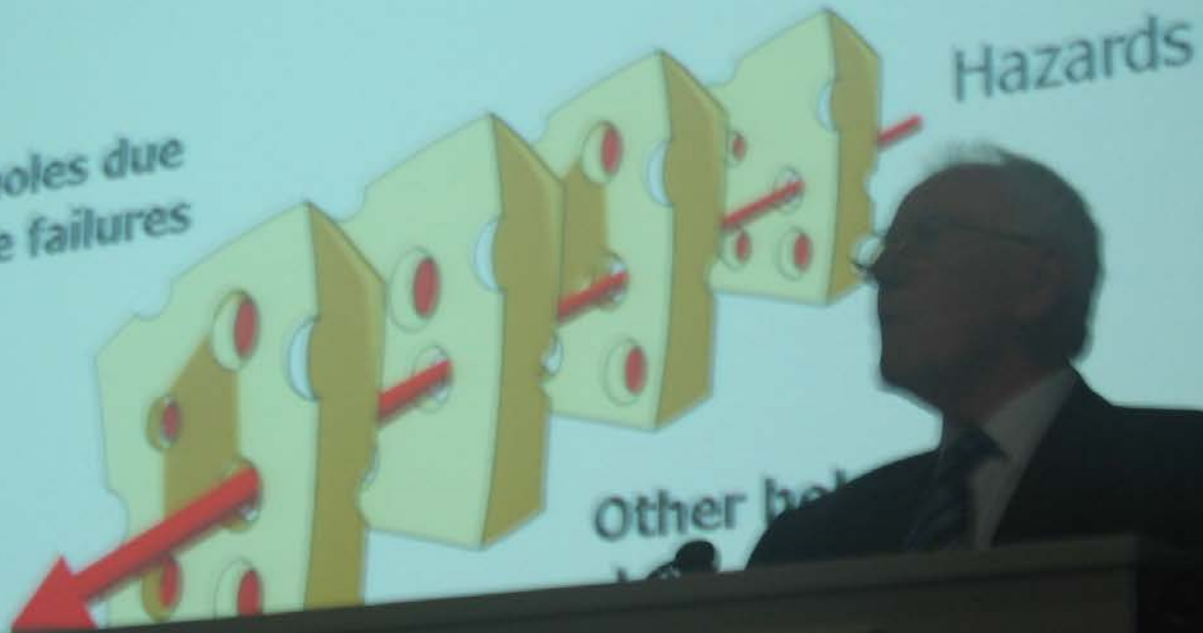
Aug 2010: Lead & Faculty Recruitment



Sept 2010: Launch Conference

The 'Swiss cheese' model
of accident causation

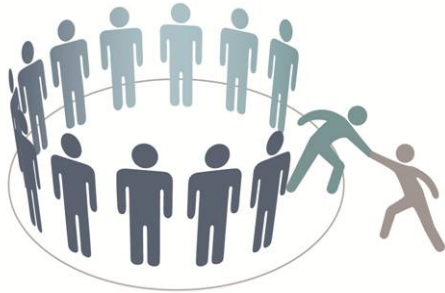
Some holes due
to active failures



Nov 2010: Lead & Faculty training

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Facilitator Handbook

North Western Deanery 


North West

Imperial College
London

CPSSQ

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Lead Handbook

North Western Deanery 


North West

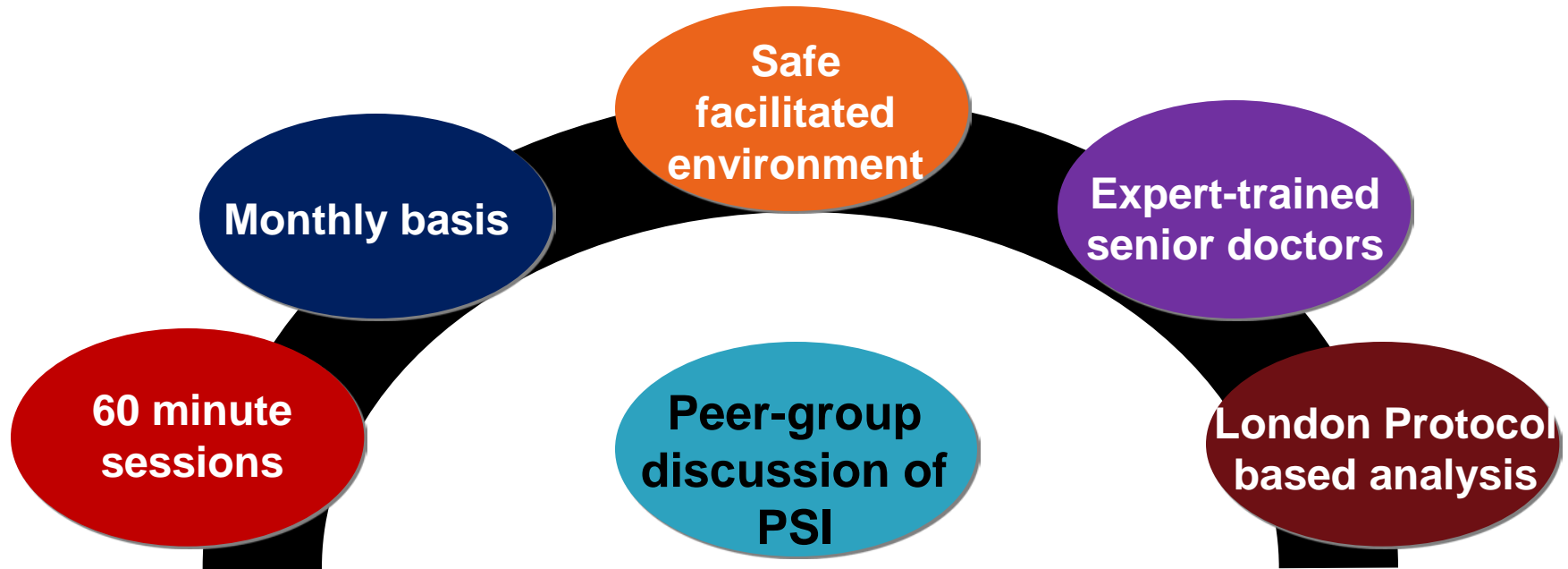
Imperial College
London

CPSSQ

Jan 2011: Local launches

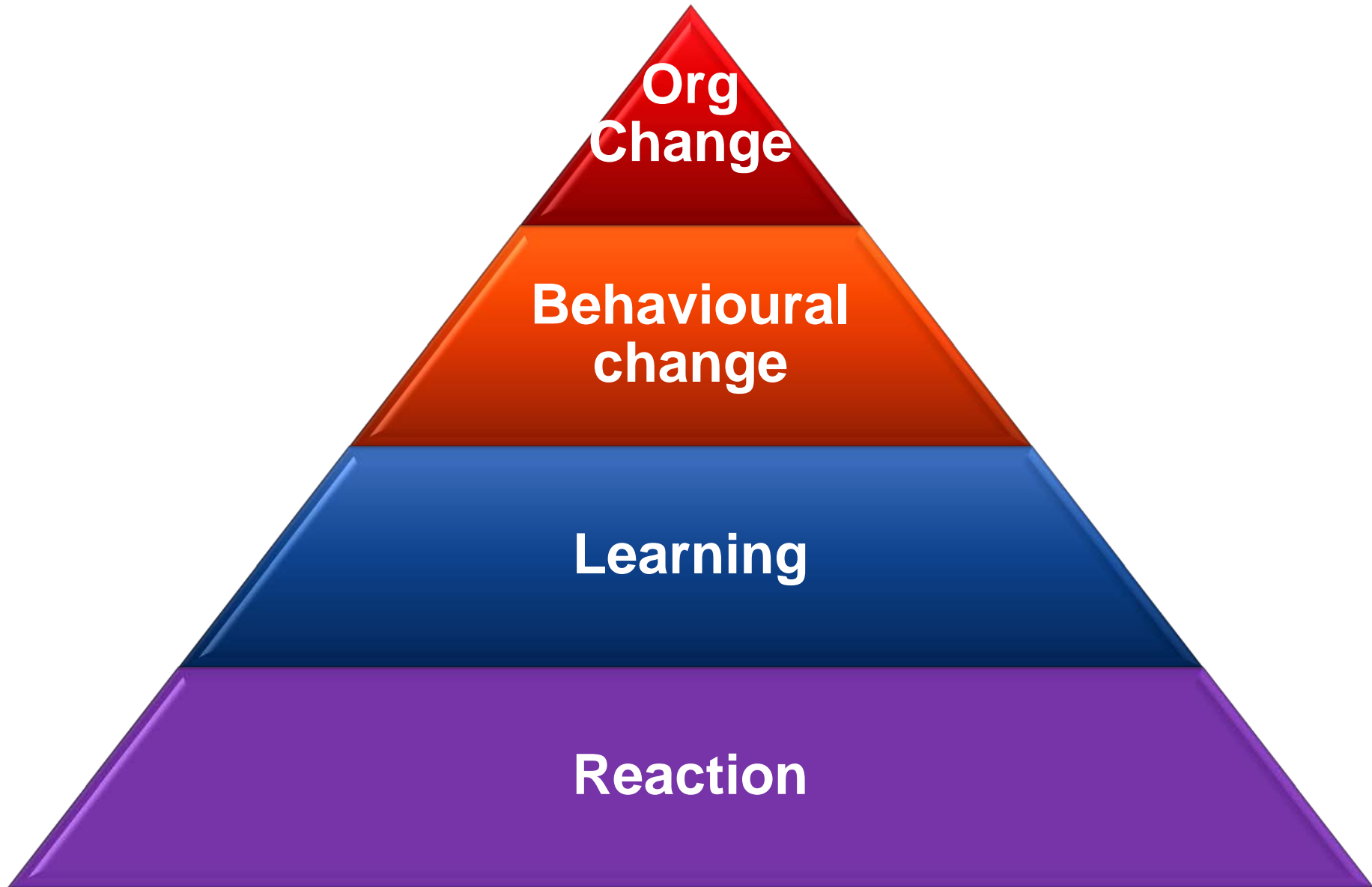


Feb - July 2011: Monthly sessions



Lessons Learnt

Pre-Post Evaluation





Results

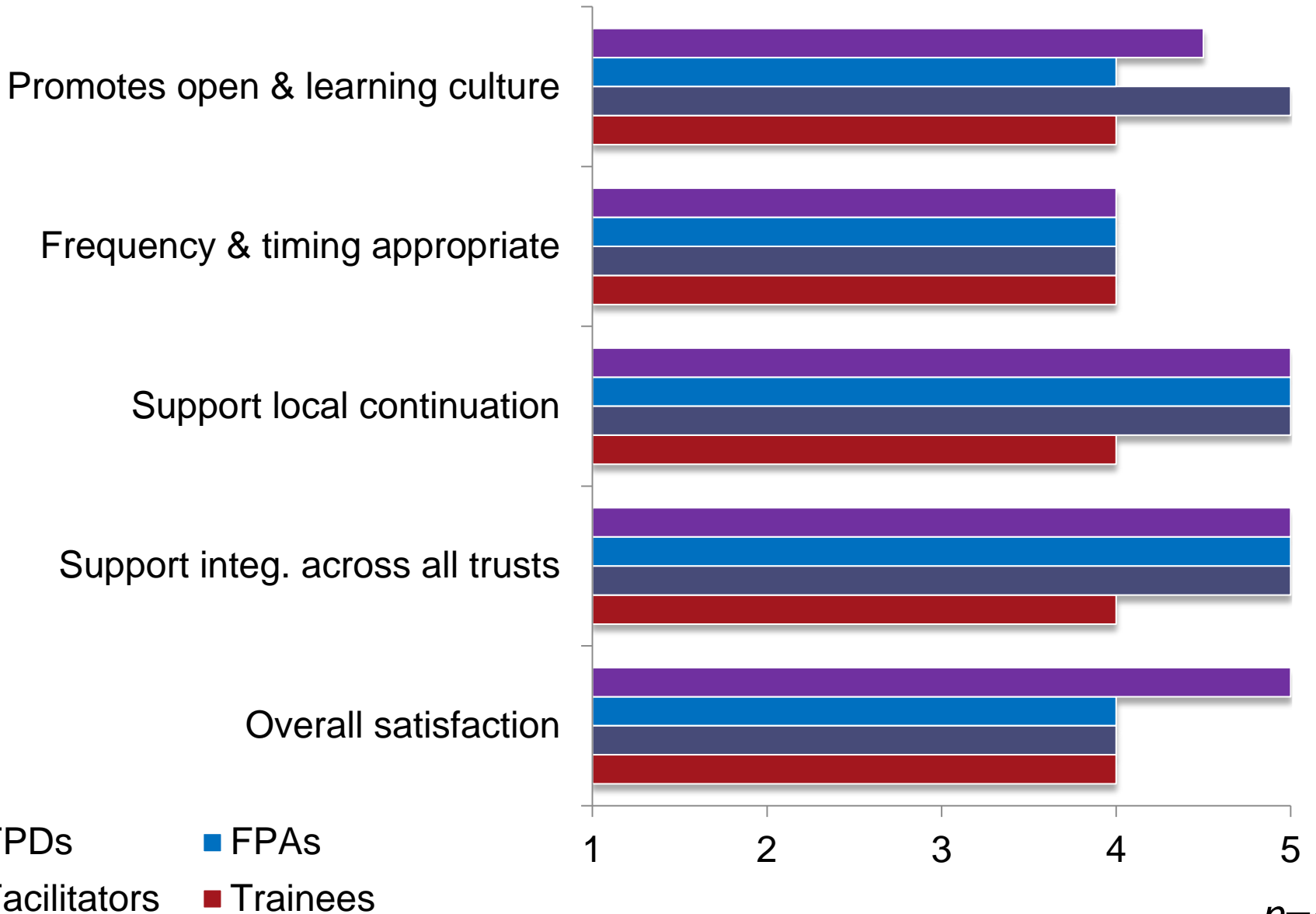
Overview

81% sites (13/16) held five or more sessions

165 sessions held from January to July 2011

Faculty facilitated 1 to 8 sessions each

Satisfaction



n=428

Testimonials

“...The greatest strength of Lessons Learnt is in making changes and improvements from the ground upwards via the foundation trainees...” FPD

“...I absolutely love these sessions. I learn from them as much as the trainees...” Faculty

“...Lessons Learnt sends a clear message that the blame culture has been laid to rest; that patient safety is more important than naming and shaming...” FY1

Knowledge, skills & attitudes

Patient safety knowledge

- Objective: 51.1% to 57.6% $p < 0.001$
- Self-reported: mean 32% increase

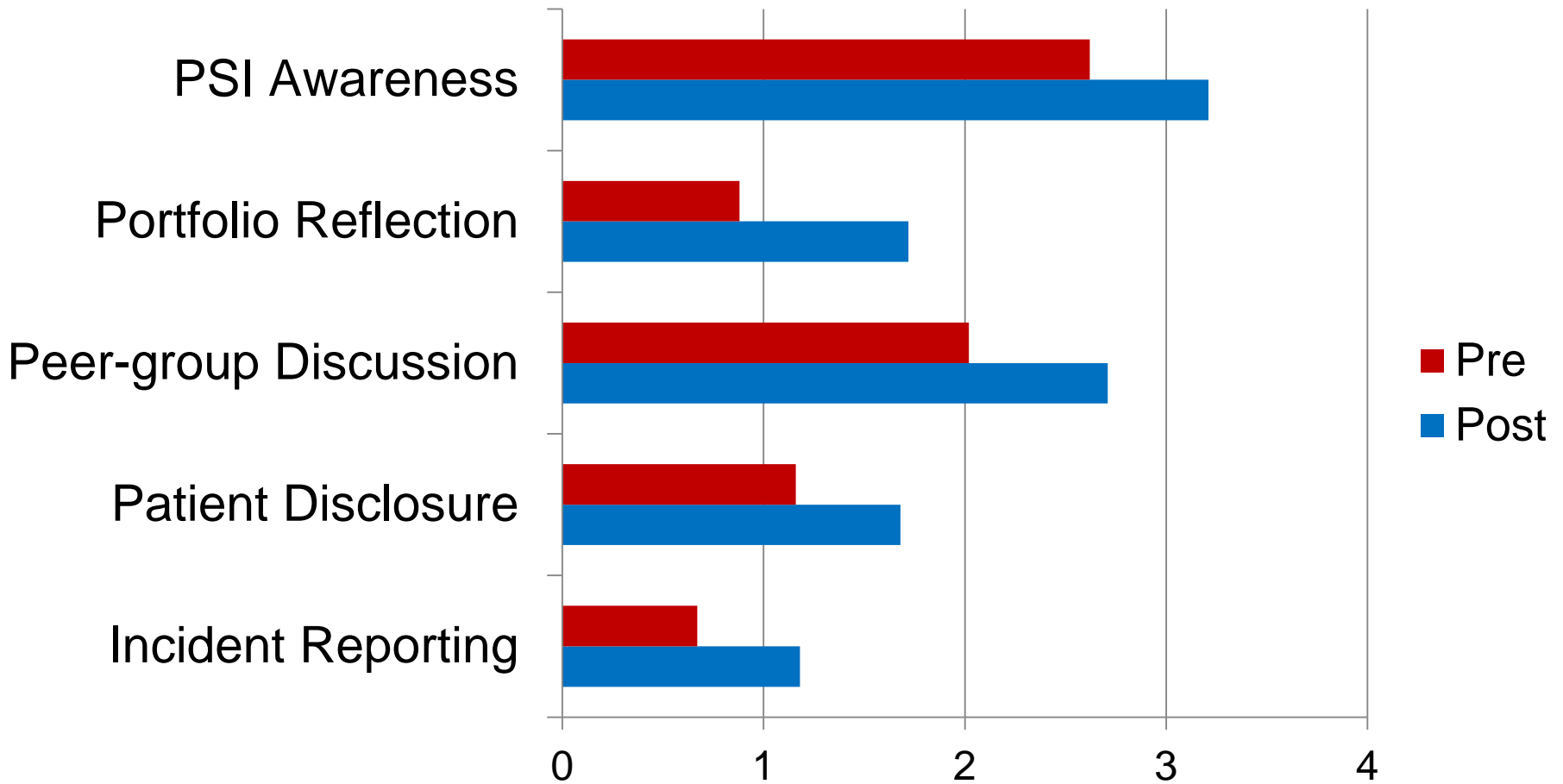
Patient safety skills

- Mean 29% increase

Patient safety attitudes

- Positive baseline attitudes
- Feelings & personal beliefs: no sig shift
- Perceived control: sig improvement
- Behavioural intentions: sig improvement

Behavioural Change



n= 428-737

Improvement Projects

Service Delivery

- Novel protocols/ pathways
- Improved accessibility

Working Conditions

- Rota re-design
- Nurse staffing ratios

Education & Training

- NGT insertion
- Hyperkalaemia management

Clinical Leadership

- Trainees invited onto Trust Board
- Development of QI group

Lessons Learnt

Summary

Large-scale PS training intervention

Improvement in trainees' safety competencies

Senior doctor engagement as faculty

Springboard to quality improvement

Study Limitations

Pre-post intervention design

Lack of comparator group

Self-reported measures (skills & behaviours)

Post-intervention response rate 40-43%

Implementation Challenges

Trainee leadership & engagement

Competing interests of faculty

Central vs local administration

Support for quality improvement

Progress 2011-2014

Sustained across NW Foundation School

Multiple awards

Further spread

- North West Thames Foundation School (NW London)
- South Thames Foundation School (KSS)
- East Anglian Foundation School (East of England)

Acknowledgements

Health Education North West

- Paul Baker
- Jacky Hayden
- Stephenie Tiew

Imperial CPSSQ

- Sonal Arora
- Nick Sevdalis
- Charles Vincent

All local teams

References

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Ahmed M, Arora S, Baker P et al. Building capacity and capability for patient safety education: A train-the-trainers programme for senior doctors. *BMJ Qual Saf* 2013;22:618-25

Ahmed M, Arora S, Baker P et al. Case-based learning for Patient Safety: The Lessons Learnt Program for UK Junior Doctors. *World J Surg* 2012;36:956-8

