TALKING ABOUT PATIENT SAFETY - PLAYDECIDE: PATIENT SAFETY

Welcome to the remote-play version of PlayDecide: Patient Safety.

How to play

Your facilitator will guide you through the game's three phases: **Information gathering**, **discussion**, and **shared group response**.

The session will take approximately 50-60 minutes.

At the start of the session please choose a set of cards from the following pages, to help prompt discussions. Each set includes:

- One **story card**, describing a brief scenario involving a patient safety situation from the perspective of a patient or healthcare worker.
- Two **info cards** featuring information relating to patient safety and error reporting.
- Two **issue cards** featuring key issues relevant to patient safety and error reporting.

At the end of the session, your facilitator will ask you to refer to the **position statements** (see the last page of this document) and choose which one best reflects your position on error reporting and patient safety.

Stages of the PlayDecide: Patient Safety game

1.Information gathering

Clarify your personal view on the subject, reading and selecting the cards which you feel are most important or of interest to you. The facilitator will invite each player to summarise their cards in their own words.
Approx. 20 min.

2. Discussion

Together with the other players, start discussing and identify one or more larger themes that you all feel relevant. Everyone gets a chance to speak. Discuss in-depth themes that the group is most interested in.
Approx. 20 min.

3. Shared group response

Reflect on the theme(s) that the group has identified and the cards that sustain the arguments. As a group, can you reach a positive consensus on a policy position that reflects the group's view? You can formulate a new common policy, if you wish.
Approx. 10 min.

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Discussion guidelines

- You have a right to a voice: speak your truth.
- But not the whole truth: don’t go on and on.
- Value your life learning.
- Respect other people.
- Allow them to finish before you speak.
- Delight in diversity.
- Welcome surprise or confusion as a sign that you’ve let in new thoughts or feelings.
- Look for common ground.
- ‘But’ emphasises difference; ‘and’ emphasises similarity.

Story Card 1

Communication/ Cover-up

Megan is a staff nurse in the Emergency Department.

A patient presented to the Emergency Department with a dislocated shoulder and underwent a reduction procedure to relocate the shoulder. The patient was administered an incorrect drug, stopped breathing and required resuscitation. The Registrar approached me and advised me that he was going to make an entry on the chart that it was a drug allergy because documenting it as a medication error would put both our jobs at risk.

Info Card 11

Open disclosure

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Issue Card 3

Should we speak up about safety concerns?

Interns and Senior House Officers worry about the impact on their careers if they speak up. There needs to be a shared commitment to support and encourage all those who raise honestly held concerns about safety. This will sometimes require acceptance by staff that their performance may be the subject of comment, and that this needs to be seen as an opportunity to learn than a source of criticism. I appreciate this is not always easy (Francis Report, 2015).

Info Card 18

Benefit of reporting is to the patient and patient safety

While you are obliged to report any safety concerns you have it is also important to remember that ultimately it is the interest of patient safety to do so. Patient safety can only be improved when we are aware of and understand situations and events where safety is compromised.

Issue Card 17

Error and harm

Harm is what patients care most about. They will put up with errors in their care, to some extent at least, as long as they do not come to harm. Many errors do not lead to harm and, indeed, may be necessary to the learning and maintenance of safety. Should we still report these errors?

Story Card 2

Deteriorating patient and conflicting priorities

Cathal is a Senior House Officer on-call in busy hospital.

I was treating a patient when I was bleeped to contact Ward 2. The nurse stated that she had a patient she 'didn't like the look of'. I said that I would finish with my patient then go to the Emergency Department to review patients and would be up to Ward 2 after that. The nurse was irate and said she would fill in an Incident Report Form if I did not attend immediately.

Info Card 21

Reporting and knowing where to report

The Irish Society of Chartered Physiotherapists' professional guidance states: "In a situation where you have a concern in relation to conduct, competence or unsafe or potentially unsafe system/s, you must act to prevent any immediate risk to patient safety by taking appropriate steps to notify the relevant authority about your concern as soon as possible. If you are not sure to whom you should report your concerns, ask a senior colleague for advice." (ISCP 2014)

Issue Card 14

Using reporting as a weapon

The hospital incident reporting form is meant to be used to raise genuine concerns about where safety may have been compromised ('near miss') or where it was actually compromised. Sometimes the form can be used as a 'weapon' against certain staff members or categories of staff. Is this acceptable?

Info Card 27

Adverse events often go unreported

The National Incident Management System (NIMS) data for 2011 showed that adverse events were reported in only 1.9% of patient contacts across the Irish Health System. Although the NIMS includes a wider range of settings than the Irish National Adverse Events Study (INAES), there is likely to be significant under-reporting: The INAES found that in hospitals one in eight patients (12.2%) experienced an adverse event.

Issue Card 2

Creating a just culture in healthcare

A blame culture in healthcare has been suggested as a major source of an unacceptably high number of medical errors. A just culture seeks to balance the need to learn from mistakes and the need for accountability. A just culture offers a climate which fosters trust and in which staff are not held accountable for systems failings over which they have no control. What actions should healthcare institutions take to ensure a just culture that protects both patients and staff?

Story Card 3

Misreading situation – Failure to diagnose

Mary is a Senior House Officer and is 3 months into rotation at the Emergency Department.

A 24 year old male presented to the Emergency Department via ambulance smelling of alcohol, with altered level of consciousness, following a fall at a house party. His friend insisted he had not drunk a lot. I was concerned given his level of consciousness and friend's information and raised concerns to the Registrar and the Clinical Nurse Manager. They dismissed me saying the patient was drunk. After a few hours his condition deteriorated and he subsequently died of a sub-dural haemorrhage.

Info Card 9

Safety measures – Early warning scores

Longitudinal patient monitoring systems, for example the Early Warning Score (EWS), are recommended to detect the deteriorating patient in many countries (Griffiths & Kidney, 2012; Smith et al., 2013). In Ireland we have the National EWS recommended for use on the wards in hospitals.

Info Card 24

Serious patient safety incidents must be reported

Serious patient safety incidents are defined in the Patient Safety Bill 2018 as those which result in death or shortening of life expectancy; permanent damage or lasting impairment of bodily, sensory, motor, physical, or intellectual functions; necessitate increased treatment or cause lasting pain or psychological harm; or require treatment to avoid death or the aforementioned harms. (Government of Ireland, 2018)

Issue Card 22

Differences in reporting culture across hospitals

Different hospitals have different safety cultures including differences in what, and when, incidents are reported, how staff are treated following reporting an incident, and what changes and improvements are made as a result of incident reporting. How do we, as junior members of the healthcare team, deal with this?

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Interns and Senior House Officers worry about the impact on their careers if they speak up. There needs to be a shared commitment to support and encourage all those who raise honestly held concerns about safety. This will sometimes require acceptance by staff that their performance may be the subject of comment, and that this needs to be seen as an opportunity to learn than a source of criticism. I appreciate this is not always easy (Francis Report, 2015).

Story Card 4

The power of incident reporting

Alexandru is a Senior House Officer in a large hospital and is responsible for conducting electrocardiograms when on-call.

The electrocardiogram machine was frequently missing, wasting time and causing delays in providing time-critical treatments to patients. Senior House Officers (SHOs) complained for years but nothing changed. I and other SHOs decided that every time we were called to do the ECG and it was missing we would submit an Incident Report Form. After 1 month and numerous reports, 2 additional new ECG machines were purchased and housed in a dedicated central area.

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Issue Card 12

Every hospital needs an escalation system for things that cause 'frustration' to the working lives of doctors/nurses

Frustrations experienced on a daily basis (e.g. not having access to the proper equipment or resources) can build up over time and cause incidents to happen or lead to complacency with poor safety standards. It is important that all staff can highlight when work does not run smoothly. Should this be anonymous?

Story Card 5

Lack of standardised protocol

Julie is a mother of 3.

My eldest son requires frequent hospital admission for administration of Total Parenteral Nutrition (TPN). I observed a lot of variation in the sterile procedure protocol followed by different staff before administration of the TPN. Pre-prepared sterile trolley and sterile gloves were often not used. The equipment and procedures for dressing changes varied. My son developed sepsis from his peripherally inserted central catheter line during one administration.

Info Card 19

Encouraging patient and family members to speak up

An environment that allows for patients and their families to raise issues at the point of care is essential in hospitals. Communications and behaviours need to be reinforced to encourage this. Patients should be informed at first point of contact it is the policy of the hospital that raising concerns about their care will not negatively affect their care or their experience while under care and they should be reassured (Madden Report, 2008).

Info Card 14

Aggregate analysis of near misses

It is the policy of the HSE that there will be aggregate analysis of the causes of low impact safety incidents according to incident type (e.g. falls). Aggregate analysis includes analysis of near miss incidents and incidents that resulted in “negligible”, “minor” or “moderate” harm. It will be overseen by the local quality and safety committee or equivalent, who has access to appropriate expertise to conduct these aggregate analyses (HSE, 2014).

Issue Card 20

Safety measures – Standardised procedures and protocols

The parent of a child with a rare disease was in hospital with their child learning how to do Total Parenteral Nutrition (TPN) following sterile protocol as they would need to do this procedure at home. However, the staff were all doing the procedure in different ways and not all followed sterile protocol. Agency staff in particular were not aware of the protocol. How do we build understanding among staff and patients that standardised protocols make everybody safer?

Issue Card 4

The vulnerability of patients and their relatives

Patients are in a vulnerable position and rely on the expertise of healthcare workers to diagnose and treat their illness. Patients accept conditions in our healthcare system that they would refuse to accept elsewhere, e.g. waiting for hours to be treated, lying on trolleys in corridors with no privacy. Because of this situation patients can feel they are ‘lucky’ to get a bed. It is very difficult for patients or family members to speak up to health workers about their care, as they feel they are reliant on the same people and systems to get better. Can health workers help patients and families to feel empowered to give feedback on their care?

Story Card 6

Air in an intravenous line

Thomas is a 15 year old boy with rare disease requiring frequent hospital admission.

I was prescribed 2 litres of intravenous normal saline. The first bag of saline finished during the night, and when the pump alarm went off, the nurse came in with the second bag. I asked if she wanted to turn on the light, but she didn't, and changed the bag. After she left I switched the light on and saw that the line was full of air. I knew that was dangerous, so I turned off the pump and called the nurse. She then primed the line properly and restarted the pump. She looked shocked, but she didn't say anything about it.

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Open disclosure

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Info Card 4

Types of serious incidents that patients encounter

The frequency of reported safety incidents per hospital admission ranges between 4-16% (SCA, 2013). The most common adverse events in Ireland arise from quality and precision of documentation (e.g. patient charts), failure to notice and manage the deteriorating patient, patient and family (mis-) communication, not observing standard protocols and procedures (Mullen, 2013).

Issue Card 10

The problems of incident reporting

Incident reporting systems in healthcare are poor at reflecting the frequency at which incidents occur. Thus, there is significant under-reporting of incidents. A range of barriers exists, such as poor usage of reporting systems and fear of blame culture (Westbrook et al., 2015). Staff believe very little improves or changes due to reporting. They find their own way to make changes to ensure patient safety (Sujan, 2015). Is it worth reporting at all?

Issue Card 16

Letting safety levels slip

Healthcare is the largest industry in the world and extraordinarily diverse in terms of the activities involved and the manner of its delivery. We are faced with hugely intractable, multifaceted problems which are deeply embedded within our healthcare systems. Does dealing with these problems every day make us more likely to let safety levels slip?

Story Card 7

Recognising clinical deterioration can occur without abnormal observations

Noor is a nurse working night shifts in a hospital ward.

A patient with a rare disease had a peripherally inserted central catheter line in situ during an admission. During the day he had his nasojejunal tube replaced. His mother reported he felt a 'little off' afterwards. Nurses did his observations throughout the day and reported he was fine. During the night he collided with a drip stand en-route to the bathroom, and this brought me into his room. He looked tremulous and reported feeling a 'bit off'. I checked his observations at 2 minute intervals. His temperature increased by 3 degrees in about 10 minutes from a low base. I suspected sepsis, which was confirmed, and started treatment immediately.

Info Card 10

Prevention is better than cure

Early identification of situations that lead to patient harm allows resources to be directed at a more easily addressable problem than what may arise as a result. For example, preventing a fall is preferable and less complex than treating a resulting fracture and the complications that may be associated with treatment.

Issue Card 7

Rare conditions/Atypical presentations

Patients with Rare Diseases/ undiagnosed conditions may present in an atypical way in terms of baseline clinical parameters for heart rate, blood pressure, temperature, and reactions to medication. These presentations, whilst not occurring frequently, are possible. In the case of a diagnosed rare condition, it may well be that the patient or family member is more familiar with the condition than members of their healthcare team. In these situations, should we engage with and listen to the patient or family member in order to prevent unnecessary mishaps or patient deterioration?

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Issue Card 13

The importance of learning from when things go right

Most of the time things go right in healthcare. We need to harness the learning from when things go right. Thus the purpose of incident investigations is not to lay the blame on a person or group but to develop a greater understanding of how things usually go right, since that is the basis for explaining how things occasionally go wrong. What can be done to help team members see themselves as a valuable resource necessary for system flexibility and resilience?

Story Card 8

Ignored patient

John is an intern in a large hospital on surgical rotation.

On a Registrar-led ward round with my team we came to Tom's bed. It was obvious he needed intervention. Tom was lethargic, and had not taken oral fluids or eaten in the previous 24 hours, on a background of chronic diarrhoea. His skin was dark purple and his face was bloated. The Registrar said that Tom was no longer our patient, his care had been transferred to the medical team, so we moved to the next patient. I wanted to intervene, but was afraid what the Registrar might say. Tom died that night.

Info Card 17

Most reports made by nurses but doctors need to report also

Medical professionalism is a core element of being a good doctor. Good medical practice is based on a relationship of trust between the profession and society, in which doctors meet the highest standards of professional practice and behaviour. Pursuing the interests of patients and recognising that patients can be vulnerable means it is necessary for doctors to raise concerns about patient safety, if trust is to be retained (Medical Council 2014).

Issue Card 1

Should junior staff question senior staff when they observe variation in the protocols and procedures?

In some hospitals a strong emphasis on hierarchy, rules, policies and control, potentially inhibits a positive climate for safety due to fear of negative outcomes and blame for reporting safety-related problems (Hartmann et al., 2009). Junior staff would need to be supported in questioning senior staff's lack of adherence to protocols and procedures.

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Story Card 9

Timely review of patient

Sharon is a medical intern on call in a large hospital.

I was bleeped 3 times about a patient who was receiving oral antibiotics for a urinary tract infection and had spiked a fever of 38.5°C. I advised to give paracetamol which the nurse then administered. She bleeped twice again 1 hour later. I didn't respond as I was attending to a patient with chest pain. The Senior House Officer was called, and arrived 1 hour later. The patient had raised heart rate, rapid breathing, and fever with rigors. Because the nurse did not communicate critical information about the history of the patient, I was not aware that they had a liver transplant 2 months previously

Info Card 4

Types of serious incidents that patients encounter

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Info Card 8

Systematic factors in poor patient safety performance

Madden report (2008) identified a number of serious patient safety-related issues in the healthcare system including weak governance structures, poor communication processes, poor working relationships between clinicians and management, lack of senior clinical leadership within organisations and nationally, lack of clarity on reporting relationships and failure to participate in continuous professional development.

Issue Card 11

The importance of learning from incidents

Incidents, serious incidents, adverse events, and near misses are all important learning opportunities. For every serious incident there are usually hundreds of near misses as in the ‘iceberg’ image. If we can learn from the near misses then we can move towards preventing the serious incidents in our own ward, and through knowledge sharing across our hospital and healthcare system. How do we make near misses more visible?

Issue Card 19

The context in which incidents happen matters

Information reported by clinical staff directly involved in an event is more beneficial than that picked up by other detection methods. It provides greater insight into the contributory circumstances and hospital system processes. What can we do to encourage timely and constructive reporting by all staff?

Story Card 10

Lack of equipment

Janice is the daughter of a patient treated in a large hospital.

My mother had a history of stomach ulcers and a brain haemorrhage. I arrived into hospital to see my mother lying face up in the bed, unconscious, making choking sounds with vomited blood in her mouth. She seemed unable to clear the vomit as she was lying face up. I called a nurse who went looking for a suction pump which took minutes to find. The first suction pump did not work and a second had to be found. My mother later died. After a complaint from the family, suction pumps were placed on each ward with a sign saying 'Not to be removed from this ward!'.

Info Card 13

Standardised procedures for investigating incidents

Incidents that result in death/serious harm will be investigated using a systems analysis method. Systems analysis involves collection of data from the literature, records, interviews with those involved and analysis of this data to establish the chronology of events that led up to the incident, identifying the key causal factors that had an effect on the adverse outcome, the contributory factors, and recommended control actions (HSE, 2012).

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Healthcare is the largest industry in the world and extraordinarily diverse in terms of the activities involved and the manner of its delivery. We are faced with hugely intractable, multifaceted problems which are deeply embedded within our healthcare systems. Does dealing with these problems every day make us more likely to let safety levels slip?

Story Card 11

Difficult senior

Amanda is a Senior House Officer on-call in a busy hospital.

I was called to review a hypotensive patient who had been admitted earlier with an upper gastrointestinal bleed. Neither I nor the intern could gain venous access to administer fluids. I informed the Registrar. He was unhappy to be called “unnecessarily”, advised me to contact anaesthetics, and berated me as he was already too busy. Anaesthetics only accepted Registrar-to-Registrar referrals, further delaying treatment.

Info Card 7

Why do doctors not report safety concerns?

When a doctor was aware of a doctor who was impaired or incompetent to practise medicine, 41% of Irish doctors raised that concern with the relevant authority. In the UK 73% of doctors reported that they raised a concern. The reasons doctors gave for not reporting an impaired or incompetent colleague were a belief it would not result in any action (44% compared with 14% in the UK), fear of retribution (25%) and the belief that someone else was dealing with the problem (19%) (Medical Council, 2014).

Info Card 8

Systematic factors in poor patient safety performance

Madden report (2008) identified a number of serious patient safety-related issues in the healthcare system including weak governance structures, poor communication processes, poor working relationships between clinicians and management, lack of senior clinical leadership within organisations and nationally, lack of clarity on reporting relationships and failure to participate in continuous professional development.

Issue Card 12

Every hospital needs an escalation system for things that cause ‘frustration’ to the working lives of doctors/nurses

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Story Card 12

Lack of communication

Rory's father has Parkinson's Disease.

My father was admitted to hospital by ambulance after a choking episode at home. He had aspiration and pneumonia. Both the doctor and the speech and language therapist advised that he stay on a drip for 24 hours and at least until he was strong enough to sit up and remain sitting upright for 30 mins after eating, and only then to be given pureed food. Later that day my Mom and I went out to get something to eat and came back to find my father having just been fed and lying flat on his back. He began aspirating again and the doctor was called. The notes by the doctor and the speech and language therapist in his file had not been read.

Info Card 1

Patient safety is the foundation of good patient care

When a member of your family goes into hospital then above all you want them to be safe. Safety is a touchstone and guide to the care that is given to patients. The clinician or the organisation that keeps safety to the fore in the midst of many other often competing priorities achieves something remarkable and provides the care that we would all want to receive (Vincent, 2011).

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Issue Card 4

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Patients are in a vulnerable position and rely on the expertise of healthcare workers to diagnose and treat their illness. Patients accept conditions in our healthcare system that they would refuse to accept elsewhere, e.g. waiting for hours to be treated, lying on trolleys in corridors with no privacy. Because of this situation patients can feel they are 'lucky' to get a bed. It is very difficult for patients or family members to speak up to health workers about their care, as they feel they are reliant on the same people and systems to get better. Can health workers help patients and families to feel empowered to give feedback on their care?

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Story Card 13

Transparency and accountability over incidents

Zenaida's young son was scheduled to receive a vaccination at a busy hospital.

I brought my eighteen-month-old son to the Day Ward for a vaccination. Due to a past adverse reaction to an injection, our GP recommended medical monitoring in the hospital as a precaution. The consultant who administered the injection seemed very competent, but he told us it had been some time since he had last given a vaccine to a patient. After we got home, the nurse on the ward called me, and told me that my son hadn't received the vaccine at all – only the sterile saline which was supposed to be mixed with the active ingredient just before injection. We went back the next week, and the same consultant offered us a full apology which we accepted. He then administered the proper vaccine without any problems.

Info Card 19

Encouraging patient and family members to speak up

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Error and harm

Harm is what patients care most about. They will put up with errors in their care, to some extent at least, as long as they do not come to harm. Many errors do not lead to harm and, indeed, may be necessary to the learning and maintenance of safety. Should we still report these errors?

Issue Card 24

The process of disclosure

Patients are in a vulnerable position whilst in our care, as they need to trust us to do everything correctly. However, sometimes things go wrong resulting in harm, often due to complex causes that are beyond our control. With open disclosure being mandatory for serious safety incidents, what is the best way to communicate these complex causes to the patients without singling out ourselves, or someone else, for the blame? How do we manage the follow-up with the patients after such an incident has occurred, when trust and willingness to engage in health services could have been damaged?

Story Card 14

Standard procedure vs. real-world conditions

Liang is a nurse working in the Neonatal Intensive Care Unit at a hospital.

I transferred an Expressed Breast Milk (EBM) container ‘A’ from the freezer to a warmer, in advance of feeding Baby ‘A’. Whilst it was warming, I was called to the phone. Upon my return, I removed the container and began feeding Baby ‘A’. However, a second nurse, who had also left the Milk Room briefly to assist a colleague, realised that the EBM she had placed in the warmer for Baby ‘B’ – having removed and set aside bottle ‘A’ as it was warm enough – was being fed to Baby ‘A’. We stopped the feed immediately, and administered fresh batches of the correct milk. The parents were informed, and mother ‘B’ agreed to be tested for any infections which could potentially be transmitted via EBM – which came back negative. An apology was issued and accepted.

Info Card 6

Why do nurses not report safety concerns?

In a recent Irish study it was found that 88% of nurses working in acute hospitals observed an incident of poor care in the previous six months, but only 70% of those reported it. “Fear of retribution” was also the most common reason given by non-reporters for their reluctance to report followed by “not wanting to cause trouble” and “not being sure if it is the right thing to do” (Moore and McAuliffe, 2012).

Info Card 20

Human error

An error means that something has been done which: Was not desired by a set of rules or an external observer; Led the task or system outside acceptable limits and Was not intended by the actor (Senders and Moray, 1991).

Issue Card 11

The importance of learning from incidents

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Issue Card 21

College vs. real world

In college we learned about the best and safest ways of doing things. When we enter the ‘real world’ of the busy hospital, sometimes we can witness and experience things that happen in a different way to how we learned they should. How do we deal with this difference?

Story Card 15

Different perspectives on reporting

Jaheem is Operations Manager of a specialist clinic.

Several consultants emailed me complaining about reduced levels of administrative support at the clinic. It was causing delays in getting letters typed up to send to patients' GPs, and they noted that this was a risk to patient safety. I contacted the Clinical Nurse Manager (CNM) to ask for specific details of any incidents that had occurred. The CNM informed me that they would often take time from their work schedule to contact the GPs directly, and this helped minimise the risk to patient safety. I'm glad that the clinical staff are willing to make the extra effort to help our patients, but I agree that the situation is not ideal. I need the information on incidents to back up our request for additional staff hours – but when I asked for more specific details, the consultants accused me of wasting time and not addressing the actual problem.

Info Card 8

Systematic factors in poor patient safety performance

Madden report (2008) identified a number of serious patient safety-related issues in the healthcare system including weak governance structures, poor communication processes, poor working relationships between clinicians and management, lack of senior clinical leadership within organisations and nationally, lack of clarity on reporting relationships and failure to participate in continuous professional development.

Info Card 13

Standardised procedures for investigating incidents

Incidents that result in death/serious harm will be investigated using a systems analysis method. Systems analysis involves collection of data from the literature, records, interviews with those involved and analysis of this data to establish the chronology of events that led up to the incident, identifying the key causal factors that had an effect on the adverse outcome, the contributory factors, and recommended control actions (HSE, 2012).

Issue Card 14

Using reporting as a weapon

The hospital incident reporting form is meant to be used to raise genuine concerns about where safety may have been compromised ('near miss') or where it was actually compromised. Sometimes the form can be used as a 'weapon' against certain staff members or categories of staff. Is this acceptable?

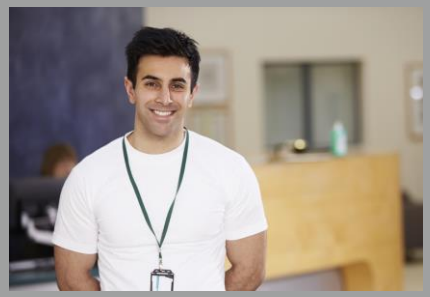
Issue Card 12

Every hospital needs an escalation system for things that cause 'frustration' to the working lives of doctors/nurses

Frustrations experienced on a daily basis (e.g. not having access to the proper equipment or resources) can build up over time and cause incidents to happen or lead to complacency with poor safety standards. It is important that all staff can highlight when work does not run smoothly. Should this be anonymous?

Story Card 16

Conflicting priorities of multidisciplinary team members



Mansur is a Chartered Physiotherapist working at a hospital.

I assessed a patient who had recently undergone surgery, and could not stand up from a chair unaided even with facilitation and assistance. Later the same day, the surgical consultant demonstrated that the patient was able to stand up and move with the aid of a frame. The consultant directed that the patient should be discharged in spite of my concerns that he could not move consistently and would have difficulty coping at home. I told the patient's wife that she would need to assist him heavily, and risked injury to herself from trying to lift him. It's my job to take into account the circumstances and ongoing needs of the patient at home, but my professional opinion was ignored and it seemed that the consultant just wanted the patient to get out of the hospital.

Info Card 10

Prevention is better than cure

Early identification of situations that lead to patient harm allows resources to be directed at a more easily addressable problem than what may arise as a result. For example, preventing a fall is preferable and less complex than treating a resulting fracture and the complications that may be associated with treatment.

Info Card 15

Seven levels of safety framework

Seven levels of safety framework describes how the contributory factors and influences on safety under the following headings: Patient, task, individual, team, environment, organisational and institutional context factors (Vincent et al., 1998).

Issue Card 4

The vulnerability of patients and their relatives

Patients are in a vulnerable position and rely on the expertise of healthcare workers to diagnose and treat their illness. Patients accept conditions in our healthcare system that they would refuse to accept elsewhere, e.g. waiting for hours to be treated, lying on trolleys in corridors with no privacy. Because of this situation patients can feel they are 'lucky' to get a bed. It is very difficult for patients or family members to speak up to health workers about their care, as they feel they are reliant on the same people and systems to get better. Can health workers help patients and families to feel empowered to give feedback on their care?

Issue Card 16

Letting safety levels slip

Healthcare is the largest industry in the world and extraordinarily diverse in terms of the activities involved and the manner of its delivery. We are faced with hugely intractable, multifaceted problems which are deeply embedded within our healthcare systems. Does dealing with these problems every day make us more likely to let safety levels slip?

Story Card 17

Risk due to prescription errors

Grazyna is a recently-qualified pharmacist.

A parent came into our pharmacy during a busy period with a hand-written prescription from their GP, for medicine to help their young child's digestion. I dispensed the medicine and the parent left the pharmacy. A week later, I learned that a complaint had been lodged. The GP hadn't written a zero before the decimal point in the quantity for the medication, and I had misread the prescription, causing the child receive a dose ten times the recommended amount. After overnight monitoring in hospital as a precaution, they were thankfully found to be unharmed. I thought I had thoroughly checked the prescription, but I now know that you can never be too careful. We now make it a point to check together with colleagues to ensure the correct prescription.

Info Card 25

Making the distinction between responsibility for, and cause of, incidents

The Government of Ireland's Patient Safety Bill 2018 notes that:
"Many adverse events and poor outcomes in healthcare arise from several service wide factors acting together, with such incidents rarely attributable to shortcomings or failures on the part of particular individuals."

Info Card 27

Adverse events often go unreported

The National Incident Management System (NIMS) data for 2011 showed that adverse events were reported in only 1.9% of patient contacts across the Irish Health System. Although the NIMS includes a wider range of settings than the Irish National Adverse Events Study (INAES), there is likely to be significant under-reporting: The INAES found that in hospitals one in eight patients (12.2%) experienced an adverse event.

Issue Card 19

The context in which incidents happen matters

Information reported by clinical staff directly involved in an event is more beneficial than that picked up by other detection methods. It provides greater insight into the contributory circumstances and hospital system processes. What can we do to encourage timely and constructive reporting by all staff?

Issue Card 24

The process of disclosure

Patients are in a vulnerable position whilst in our care, as they need to trust us to do everything correctly. However, sometimes things go wrong resulting in harm, often due to complex causes that are beyond our control. With open disclosure being mandatory for serious safety incidents, what is the best way to communicate these complex causes to the patients without singling out ourselves, or someone else, for the blame? How do we manage the follow-up with the patients after such an incident has occurred, when trust and willingness to engage in health services could have been damaged?

Story Card 18

Managing practical concerns around medication during care transitions

Chikelu works at a pharmacy in a small town.

A patient came into our pharmacy one weekend with a prescription from their consultant neurologist for a prolonged release medication for epilepsy. I knew we could not dispense the exact dose prescribed, because the timed release tablets we keep in stock cannot be halved. Doing so would change the rate of release, risking not only overexposure but also increasing chances of a seizure since a gradual release throughout the day could not be guaranteed. It was the weekend, meaning delays if we wanted to order an alternative form of the medication. Weekends are also difficult times to reach consultants, but after many phone calls I eventually reached him and we arranged a suitable dose.

Info Card 18

Benefit of reporting is to the patient and patient safety

While you are obliged to report any safety concerns you have it is also important to remember that ultimately it is the interest of patient safety to do so. Patient safety can only be improved when we are aware of and understand situations and events where safety is compromised.

Issue Card 10

The problems of incident reporting

Incident reporting systems in healthcare are poor at reflecting the frequency at which incidents occur. Thus, there is significant under-reporting of incidents. A range of barriers exists, such as poor usage of reporting systems and fear of blame culture (Westbrook et al., 2015). Staff believe very little improves or changes due to reporting. They find their own way to make changes to ensure patient safety (Sujan, 2015). Is it worth reporting at all?

Info Card 8

Systematic factors in poor patient safety performance

Madden report (2008) identified a number of serious patient safety-related issues in the healthcare system including weak governance structures, poor communication processes, poor working relationships between clinicians and management, lack of senior clinical leadership within organisations and nationally, lack of clarity on reporting relationships and failure to participate in continuous professional development.

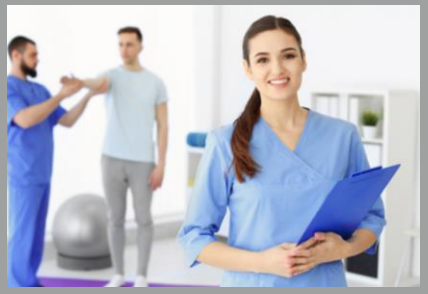
Issue Card 13

The importance of learning from when things go right

Most of the time things go right in healthcare. We need to harness the learning from when things go right. Thus the purpose of incident investigations is not to lay the blame on a person or group but to develop a greater understanding of how things usually go right, since that is the basis for explaining how things occasionally go wrong. What can be done to help team members see themselves as a valuable resource necessary for system flexibility and resilience?

Story Card 19

Who ensures that problems are addressed?



Mehreen is a chartered physiotherapist working in a nursing home.

I was the first person on the scene when one of our very elderly residents, who has a history of dementia and recurring falls, had fallen in the bathroom. After previous incidents, I had recommended that this patient should always be on a fall alarm mat when alone in their room, but on this occasion I found that the mat was not actually plugged in. Previously, I had spoken to a clinical nurse manager about my concern that our care staff were not ensuring that fall mats were connected, but this did not appear to have been addressed. I made senior management aware of the situation, and as a result a fall alarm checklist has been implemented at the home for staff to ensure compliance with use of fall mat alarms.

Info Card 5

Whose responsibility is it to report safety concerns?

All “individuals and groups are encouraged to report, investigate, disseminate and implement learning from safety incidents promptly” (HSE, 2014). All patient safety adverse events directly related to service-user treatment or care, which did or could have (‘near miss’) resulted in an adverse outcome must be reported to the national Clinical Indemnity Scheme (SCA, 2014).

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Issue Card 15

Legal proceedings

The family of a patient harmed in our hospital have said that they are going to sue us. If that is the attitude that they are taking should we take a similar attitude and not tell them anything?

Issue Card 12

Every hospital needs an escalation system for things that cause ‘frustration’ to the working lives of doctors/nurses

Frustrations experienced on a daily basis (e.g. not having access to the proper equipment or resources) can build up over time and cause incidents to happen or lead to complacency with poor safety standards. It is important that all staff can highlight when work does not run smoothly. Should this be anonymous?

Story Card 20

Power relationships between team members

Farhad is a basic grade physiotherapist working at a hospital.

During my first week on the orthopaedic ward, I was due to see a patient who had just undergone a knee replacement. The nurse manager told me during handover that the patient should be mobilised to the bathroom during his physiotherapy session. I knew that it was too soon after his surgery to do so, but the nurse manager insisted that the patient was doing unexpectedly well post-op, and his wishes should be respected. I did as I was told, but urged the patient to be cautious and not to get up without my assistance. He ignored my instruction, and subsequently fell while standing up to flush the toilet. He wasn't injured, but I felt that I had been pressured to obey commands of a senior staff member, leading to a situation that could have been very dangerous.

Info Card 23

Mandatory open disclosure and protection for staff

The Patient Safety Bill 2018 aims to support a culture of openness around patient safety in healthcare. It provides for mandatory open disclosure of serious incidents, and enables protection by ensuring that offering an apology or full information cannot be seen as an admission of liability. (Government of Ireland, 2018)

Info Card 11

Open disclosure

Open Disclosure is a now a requirement as per standard 3.5 of the National Standards for Safer Better Healthcare 2012 which states that: "Service providers fully and openly inform and support service users as soon as possible after an adverse event affecting them has occurred, or becomes known and continue to provide information and support as needed." (HIQA, 2012 p.70).

Issue Card 18

Standardised event reporting

The way incidents are reported and the forms of reporting incidents vary between hospitals. This can be a barrier to reporting for junior staff that may be unfamiliar with the method employed in their workplace due to regular rotation. Should there be a standard reporting form and process across all hospitals?

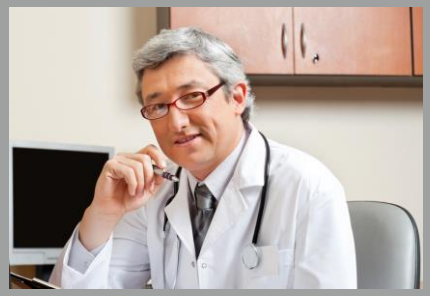
Issue Card 9

Patient practitioner partnerships

Historical views of the patient-doctor relationship assumed that the doctor's role was to act in the best interests of the patient and to direct care and make decisions about treatment on the patient's behalf. Most patients today however want to play an active role in decisions about their health and respect for patient's autonomy is paramount. Should patients participate in their care plan?

Story Card 21

Management of medications



Philip is a GP in a busy rural practice.

I recently reviewed an elderly patient with a number of ongoing medical issues, including mild renal impairment. She had been prescribed an ACE inhibitor along with a non-steroidal anti-inflammatory. On review of her latest blood results, I noted her haemoglobin was quite low, leading me to query a possible bleed. In discussion with the patient, she mentioned that she had been having some additional aches and pains for which she had been taking additional over-the-counter (OTC) anti-inflammatories. I advised her to stop the OTC medications immediately and took the appropriate steps to manage her condition. I hadn't fully considered the implications of inadvertent contraindications and have since initiated a patient education protocol within my practice with regard to medication management.

Info Card 12

Standardised procedures for reporting incidents

Following the identification/ observation of a safety incident, the following steps are the responsibility of the person who identified/observed the incident: Immediately manage, or have someone manage, any safety concerns; Report the safety incident to their line manager; An incident report form should be completed by an employee involved in or who observed a safety incident as soon as possible and at least prior to going off duty (HSE, 2014).

Info Card 26

Finding the baseline to improve patient safety

The Irish National Adverse Events Study (INAES) commenced in 2013 and examined the frequency and nature of adverse events at Irish hospitals, acting as a retrospective baseline of incident rates before HSE established the National Clinical Programmes in 2010. The INAES found that one in eight patients (12.2%) experienced an adverse event in 2009, at an incident rate of 10.3 per 100 admissions.

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Issue Card 23

Connecting with patients during mandatory open disclosure

Mandatory open disclosure regulations will ensure that issuing an apology or information to patients cannot be taken as an admission of liability. This should help to build an open culture around patient safety reporting, but who is responsible for making sure that that patients get informed about serious incidents, and how can we make sure that this happens in a timely manner?

Story Card 22

Raising concerns as an informed patient

Orla is a patient with a lifelong medical condition

I manage my condition at home, including accessing a port for the administration of weekly intravenous medications. I am a member of an international support group for people facing similar challenges. During a recent routine hospital admission, an alert was shared by a support group member in another country regarding possible contamination of one of the IV medications prescribed for me. I brought the issue to the attention of a nurse, who in turn passed the information on to the on-call registrar. The nurse came back to tell me that no alerts had been issued on their system and laughed it off with the comment, 'Dr Google strikes again!'. The medication was administered as usual. A few days after my discharge, I received a letter advising me to discontinue use of the IV medication in question due to a slight risk associated with possible contamination. I'm fine, and suffered no ill-effects but I'm now concerned about the protocol regarding alerts.

Info Card 8

Systematic factors in poor patient safety performance

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Issue Card 7

Rare conditions/Atypical presentations

Patients with Rare Diseases/ undiagnosed conditions may present in an atypical way in terms of baseline clinical parameters for heart rate, blood pressure, temperature, and reactions to medication. These presentations, whilst not occurring frequently, are possible. In the case of a diagnosed rare condition, it may well be that the patient or family member is more familiar with the condition than members of their healthcare team. In these situations, should we engage with and listen to the patient or family member in order to prevent unnecessary mishaps or patient deterioration?

Issue Card 4

The vulnerability of patients and their relatives

Patients are in a vulnerable position and rely on the expertise of healthcare workers to diagnose and treat their illness. Patients accept conditions in our healthcare system that they would refuse to accept elsewhere, e.g. waiting for hours to be treated, lying on trolleys in corridors with no privacy. Because of this situation patients can feel they are 'lucky' to get a bed. It is very difficult for patients or family members to speak up to health workers about their care, as they feel they are reliant on the same people and systems to get better. Can health workers help patients and families to feel empowered to give feedback on their care?

TALKING ABOUT PATIENT SAFETY - PLAYDECIDE: PATIENT SAFETY

Group policy positions on patient safety and error reporting.

POSITION 1. All staff should report all concerns they have regarding patient safety, without fear of recrimination, in the knowledge that learning will happen and the system will be improved. Patient safety should be our top priority as healthcare professionals.

POSITION 2. All staff should report only serious concerns they have regarding patient safety without fear of recrimination, in the knowledge that learning will happen and the system will be improved in relation to serious concerns.

POSITION 3. All concerns regarding patient safety should be reported, but only by senior members of staff. Reporting by more junior members of staff is less likely to be effective.

POSITION 4. Staff cannot be expected to report safety concerns because they are too busy providing care. There is no value in reporting safety concerns if a patient wasn't harmed or placed at risk. It is just a waste of people's time and resources.