Safety and humanity in critical care : are we as good as we think we are?

Report from the Network event on 11 December 2013 and workstream proposals

Part 1	Patient Safety

Presentations

1 **Leadership in critical care: Professor Aiden Halligan**, Director of Education, University College London Hospitals NHS Trust and Principal of UCLP NHS Staff College for leadership development **,** launched the session with a very personal and direct discourse on leadership, inspiration, and responsibility for patient safety, bringing home the vital point that patient safety is not simply an institutional idea but that it *begins and ends with individual behaviour at the bedside*.

2 **Team psychology: what can intensive care learn from safety-critical industries? Dr Tom Reader**, Lecturer in Organisational and Social Psychology, London School of Economics*,* discussed *teamwork and safety* in critical care, beginning with psychological concepts of teamwork and the relevance to ICU. *Half of errors occur due to poor communication*. He surveyed what is known from other *safety-critical industries*, along with the differences between these and ICU. Observational data was presented on the *accuracy of communication in ICU, and on shared situational awareness* and *decision-making on ward rounds*. Finally he covered the essential components of a *team improvement programme* for ICU safety.

3 **Safety in critical care: what can we learn from others? Dr Ganesh Suntharalingam***,* Medical lead, NWL Critical Care Network outlined some potential lessons and solutions from elsewhere in healthcare, covering potential benefits from ward-round checklists, care bundles, visual aids and 'forcing functions', and the limitations of these in the absence of culture change. Other topics covered included team training, organisational factors, and the transparent handling of error information, including disclosure to the patient. Slides available on request.

4 **Building safety and ergonomics into a new unit: Dr Andre Vercueil**, Consultant ICM, Kings Health Partners**,** described the extensive planning and surveys of best practice that have gone into the new unit at King's, and the ways this has informed the design. Important elements include sightlines and circulation routes, and overall layout of the unit to enable flexibility of staffing and safe supervision within and out of hours. Examples of impressive innovation included an outdoor terrace area with electrical and medical gas supply to support an ICU patient, as part of early rehabilitation.

5 **Safety culture in critical care – how do we know we are achieving it? Dr Elizabeth Haxby**, Lead Clinician for Clinical Risk, Royal Brompton & Harefield NHST, outlined the learning from a hospital-wide safety and attitude survey programme at Royal Brompton & Harefield, including the complexities of thorough data collection, and the importance of securing a high return rate in order to obtain meaningful results. This is a dynamic process and part of a comprehensive programme to promote safety culture.

6 **Systematic communication: learning from the military Gezz Van Zwanenberg**, Project Lead NWLCCN & RAF, discussed lessons learned from the military about standardised, concise communication, and the relevance to routine communication as well as crisis management in ICU.

Confirmed at Joint Clinical Forum Board 11.6.14 Item 4.1

Patient safety : table discussions	
7.	Meeting participants were asked to consider actions for Network, units, and individuals, under categories including unit structure and function, organisational tools, information sharing, training and culture. Emerging themes included: **Actions for individuals** a) Individual staff responsibility for incident reporting; active participation in ward rounds; communication; elimination of blame culture. **Actions for units** b) Unit structure and staffing (named link nurse for patient safety, ICU pharmacist) c) Operational methodology and tools (checklists/daily goal sheet/best practice care bundle, SBAR based handover) d) Incident reporting (better feedback of incidents, bimonthly critical incident meetings, common incident themes, audits, action plans, clearly displayed in unit) **Actions for network** e) Structured information-sharing between Trusts (sharing best practice and weaknesses; peer review of safety practice; network-wide incident reporting) f) Guidance and shared documents (quick reference guide/troubleshooting manual for pumps; intrahospital transfer form; SBAR tool; standardised ICU incident reporting format to Trust systems) g) Guidance on unit team structure (as above) h) Network-wide training – team improvement programme, human factors, simulation i) Network guide on safety principles j) Local involvement of stakeholders
8. Work stream development (to be discussed at JCF)	1. Develop mandate – buy-in from unit leads, agreement on action 2. Develop workplan, based on evidence, Network event, expert advice from team improvement programmes (TR) 3. Identify deliverables for first year: quick wins/profile-raising for safety culture change as a theme a. Established and sustainable working group, membership from each Trust, with capability to lead and influence locally b. Safety lead per unit c. Ward round checklist d. Daily goals sheets e. Structured handover f. Infusion pump guide g. Incident reporting / themes analysis – template per unit, and shared headlines? 4. Identify medium/longer term projects – culture, training, peer review