



Embedding Patient Safety within healthcare

- ❖ What am I doing here, why me ?
- ❖ The majority of the people in this room will be a patient sometime in your lives, how would you like to be treated ?

Patients For Patient Safety

All information sourced from documents displayed below.





Background

- ❖ In this country everyone has equal access to an affordable healthcare system staffed by skilled and dedicated professionals.

- ❖ It is reasonable for anyone who falls ill to expect and receive a high standard of care.

- ❖ However healthcare relies on a range of complex interactions between people, skills, technologies and drugs.

- ❖ Sometimes things can-and do- go wrong.



Background

- ❖ Based on the best available research, it is estimated that one in ten patients admitted to hospitals in developed countries will be unintentionally the victim of an error.

- ❖ It is thought around 50% of these could have been avoided if lessons from previous incidents had been learned.

- ❖ The same errors and system failures are often repeated causing harm or even death to thousands of patients each year.

- ❖ As well as the human cost there is the huge financial cost to the NHS resulting from such incidents.



Why involve patients and families?

❖ Consumers of healthcare are at the heart of patient safety when things go wrong, they and their families suffer from harm caused.

❖ There is however a second victim.

❖ 38% of staff involved in mistakes or errors suffer trauma. Draft !



Why involve patients and families?

- ❖ Around the world, healthcare organisations that are most successful in improving patient safety are those that encourage close cooperation with patients and their families.
- ❖ Patients and their families have a unique perspective on their experience of healthcare and may provide information and insights that healthcare workers may not otherwise have known.
- ❖ People who have been affected by medical errors are often able to point to how organisations response to errors could be improved, and to communicate the human impact of errors and their aftermath.



Patients For Patient Safety

‘Patient Safety Champions’



What is expected of patient safety champions ?

- ❖ 22 patient champions were selected across the UK in May 2008.
- ❖ A key principle of the initiative is not to duplicate or replace existing work on patient safety or involving patients and the public in patient safety work, but rather to complement and support it.
- ❖ This can be working with the NHS organisations locally, regionally or at national level.
- ❖ Champions will have a passion for patient safety, perhaps gained as a result of their own families experience of medical harm, or through their experience as a patient activist.

My beginnings

- ❖ I left school age 15 with a certificate in woodwork.
- ❖ First job in a garden centre, Anglesey Timber/retained fireman in Holyhead then to Anglesey Aluminium/part of the plant rescue team/Shop steward/Union Safety representative.
- ❖ 1999 Retired by Anglesey Aluminium as I had Bowel Cancer.
- ❖ 2003 Joined Coleg Menai to learn IT skills.
- ❖ July 2008 graduated from Bangor University with BSc (hons) in Psychology with Clinical Health Psychology.





How I became involved

In January 1999 I was working in an Aluminium smelter where I had been for 22 years. I was being treated for stomach pains and had been for approx 9 months e.g. stomach ulcers, colitis, and irritable bowel. I collapsed in pain taken to hospital found bowel cancer, surgery on 1st Feb '99. My wife even though she asked was given no information, only on the discharge day was all revealed. I had lost most of my Bowel along with 11 lymph nodes and told I would have chemotherapy, shown the door.

A month later I started chemotherapy, over the next seven months the standard of treatment I received was of a very high quality.



My outlook on life has changed through my experiences of the NHS.

❖ I believe individuals can change, where necessary, local and Government policies, either by stealth or direct action.

❖ I have been a patients voice for www.beatingbowelcancer.org for the last 6 years.

❖ I am currently (Launched 11th March 2009) involved in setting up a new support service for Cancer patients and carers sponsored by Macmillan.

❖ In August 2008 my experiences with health and hygiene were filmed and recorded on DVD by the 1000 lives campaign to be used as a training aid in the NHS.



My personal involvement

- ❖ I have been part of the North West Wales Cancer partnership group as a patient representative for just over three years
- ❖ I became patient safety champion in May 2008.
- ❖ I am on national data base and have been involved with three national newspapers as well as Sky TV, BBC England and Wales highlighting family risks of bowel cancer and stressing how through knowledge and early detection bowel Cancer need not be a killer.
- ❖ In Llandudno on 28th October 2008 at the launch of the Bowel screening Wales programme I was asked to give a short talk on how Bowel cancer has affected my life and my views on the new test kit.



Embedding Patient Safety within healthcare

What am I doing here.



General Health Interventions

- ❖ Motor cycle crash helmets.
 - ❖ seat belts.
 - ❖ Breath testing for drink drive.
 - ❖ Health and safety in the workplace.
 - ❖ Smoking ban in public places.
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- ❖ All involved a change in attitude and culture.



1000 lives campaign, Wales

- ❖ There are six evidence-based content areas, which have been developed by clinicians working together in Wales, are as follows:

- 1/Improving Leadership for Quality.
- 2/Reducing Healthcare Associated Infections.
- 3/Improving Critical Care.
- 4/Improving Medicines Management.
- 5/Reducing Surgical Complications.
- 6/Improving General Medical and Surgical Care.

- ❖ Two development sites are also being tested during the Campaign: Transforming Care at the Bedside and Pressure Ulcers.
- ❖ In the first six months of the campaign it is estimated 410 lives have been saved
- ❖ [Have a look at the website.](#)



Delivering Patient Safety

- ❖ An effective safety culture is an informed culture, one that knows where the 'edge' is without having to fall over it. To achieve that, we need people to report their 'free lessons', errors and near misses. But they won't do that unless they trust the system and its management. And they certainly won't confess their errors if they get disciplined for it. So, an effective reporting culture depends upon having a just culture. That is, an organisation in which people clearly understand where the line must be drawn between acceptable and unacceptable actions. In short, a just culture lies at the heart of a safe culture.

James reason (2005)

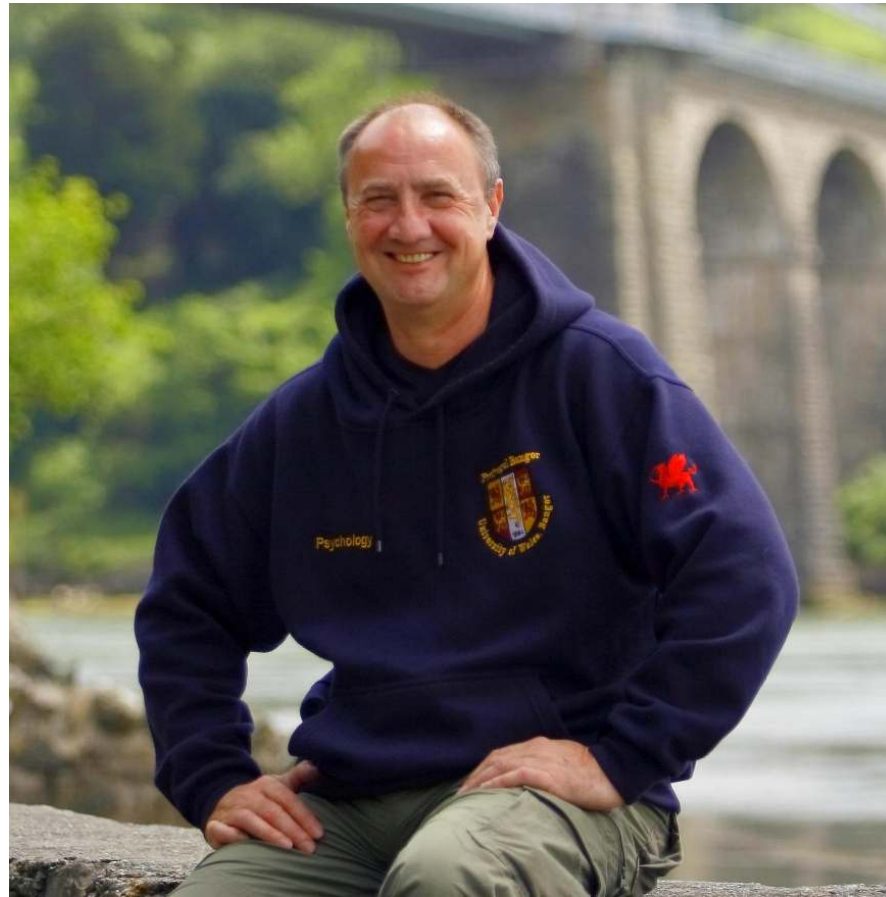


A snapshot from my diary last month

(April 2009)

- ❖ 1st April. Stakeholder group PPI representative, Llandudno.
- ❖ 9th April. Health and social care alliance, Fron Heulog.
- ❖ 15th April Endoscopy user group, YG.
- ❖ 20th April National Patient Safety Agency, web 2.0 London.
- ❖ 22nd April Public and patient safety network, St Asaph.
- ❖ 23rd April Royal College of Physicians, as a patients voice for beatingbowelcancer.org. London.
- ❖ 29th April to 1st May guest of NPSA for the National Patient safety Congress held at the ICC, Birmingham.
- ❖ 6th May for the NPSA tuition on root cause analysis held at the Royal college of radiologists, London.
- ❖ 7th May Patient and public involvement network, North West Wales, St Asaph.
- ❖ 8th May gave presentation on 'Embedding Patient Safety within Healthcare' North Wales nursing conference, Bangor.

Remember every one is unique and has a story to tell





Delivering Patient Safety

- ❖ The single greatest impediment to error prevention is that we punish people for making mistakes.

- ❖ Dr Lucian Leape (May 2009)

Thank you for listening any questions

(Please note: A PowerPoint presentation was not used for the Alarm Healthcare Risk Management Workshop, 26th May 2010. Mr Stevenson has kindly supplied this presentation, which was originally delivered in May 2009, for your reference. Therefore the information contained was true and correct at the time of delivery although may have changed since).