Canterbury
District Health Board
Te Poari Hauora ō Waitaha

Improving Patient Safety and Care by Learning from Minor-Moderate Adverse Events

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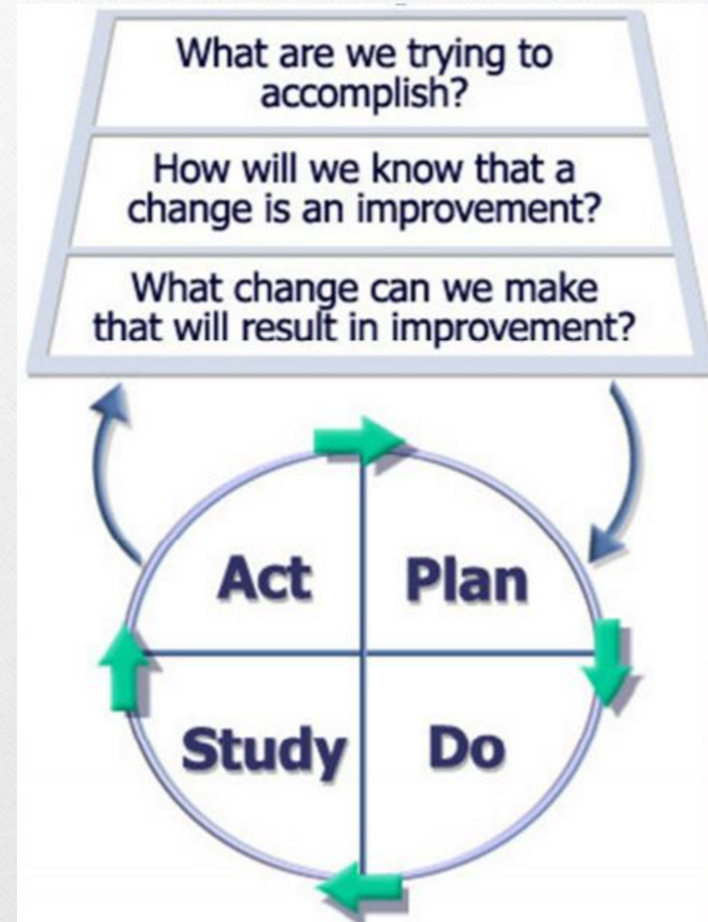
The Issue

- CDHB's Specialist Mental Health Service receives an average of **120** minor-moderate incident (Safety 1st) forms per week.

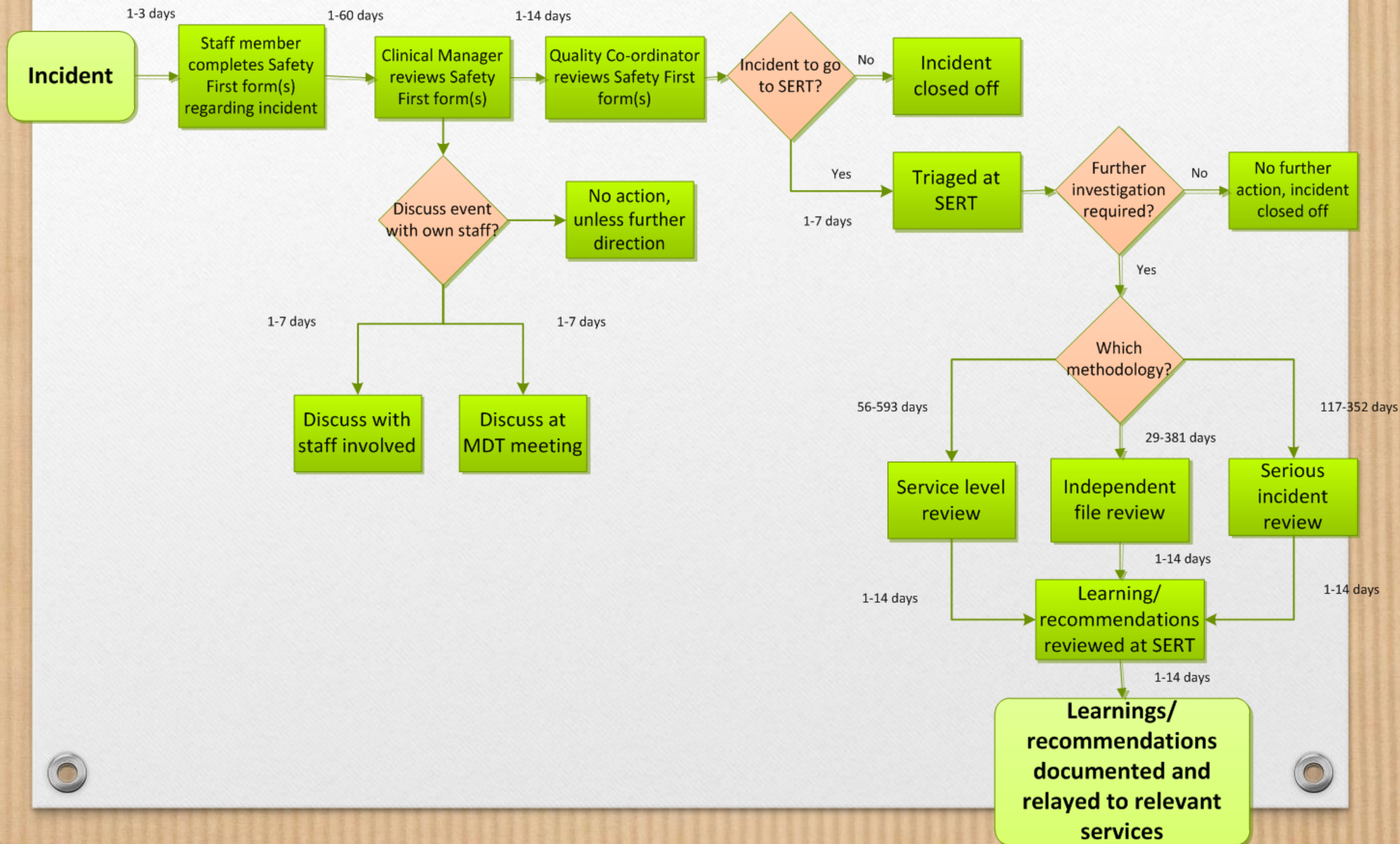
- An efficient way to extract organisational learnings from these SAC3s and 4s was needed

Intervention

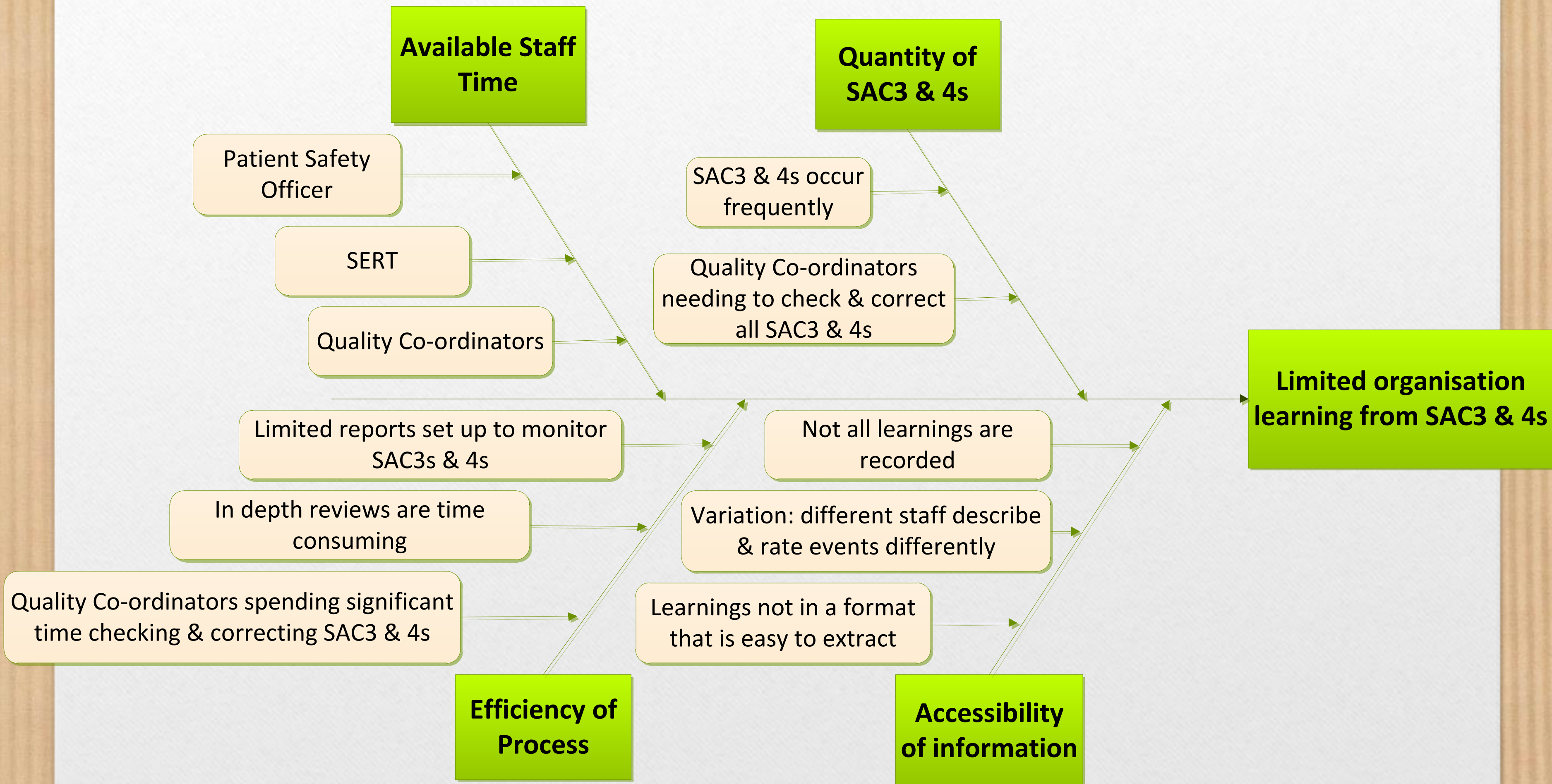
- Project team formed
- The Model for Improvement utilised
- Family of measures selected to monitor change



Process map of the SAC3 & 4 incident process



Ishikawa diagram to examine why there was limited organisation learning from SAC3 & 4s



Driver Diagram

AIM

To increase the number of learnings from SAC3 & 4s by March 2018

PRIMARY DRIVERS

- Available Staff Time
- Quantity of SAC3 & 4s
- Efficiency of Review Process
- Accessibility of Information

SECONDARY DRIVERS

- Patient Safety Officer available time
- SERT available time
- Other staff available time
- Number of incidents
- Staff understanding of when and how to use Safety 1st
- Time taken to review events
- Is information present on learnings?
- Extractability of learning related information

CHANGE IDEAS

- Increase FTE
- Meet more frequently or for longer
- Have appointed subgroup review SAC3s & 4s
- Clinical teams review SAC3s & 4s at MDTs
- Review only SAC3s and 4s which promise greatest gains in organisational learning
- Review only SAC3s and 4s with potential for greater harm
- Review similar events together
- Review events for the same patient together
- Review events with similar contributing factors together
- Review events which occur in similar services together
- Add a specific field to record learnings
- Change how the information is recorded to make it easier to extract

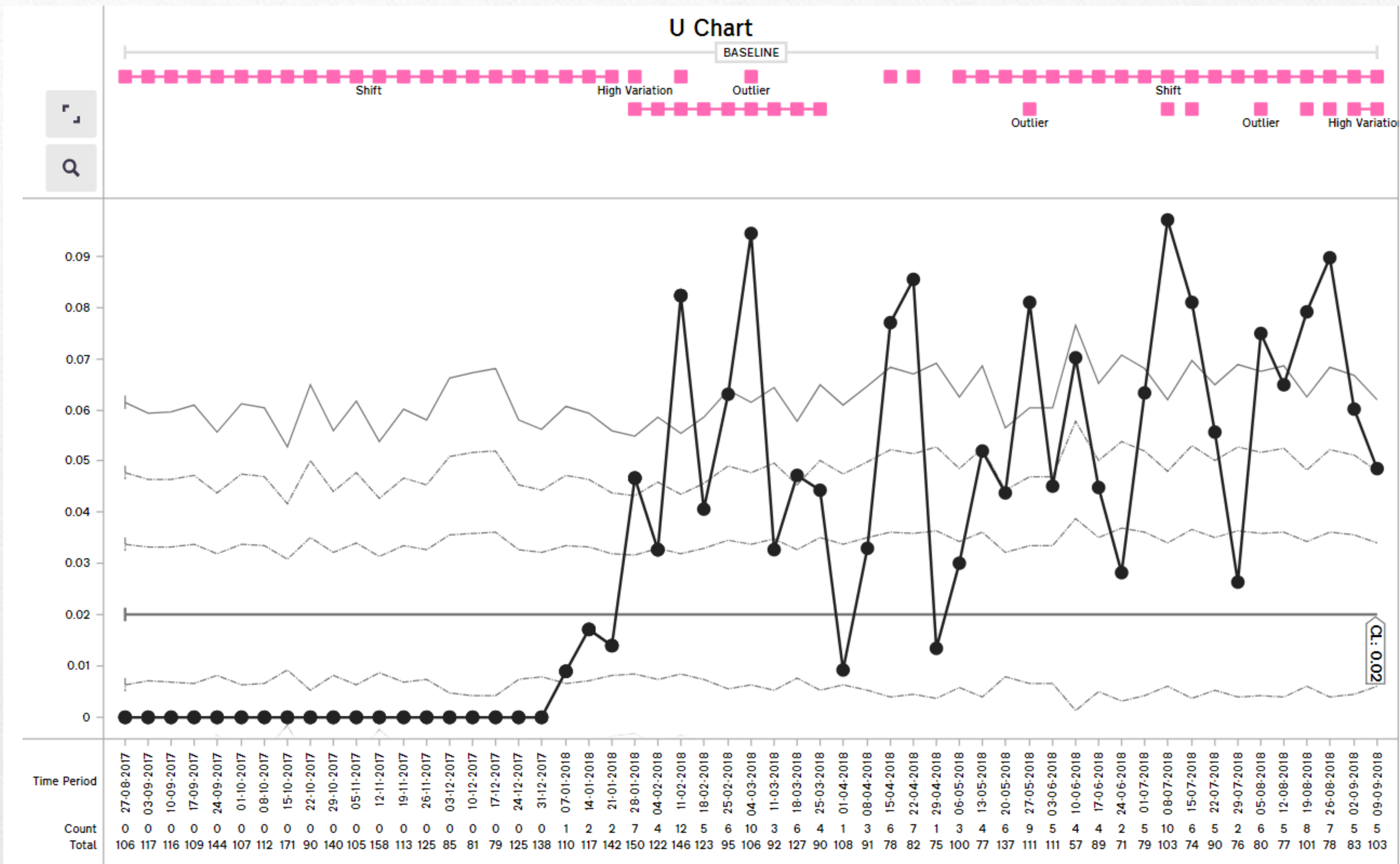
Change Idea 1: Suggestions/improvement ideas field added to incident form

Suggestions/Improvements

Thank you for taking the time to submit this event. If you have suggestions/improvement ideas to stop this type of event recurring, please let us know.

Suggestions/Improvement ideas

U Chart – Suggestions for change in SAC3s and 4s to prevent a reoccurrence



Change Idea 2: Quality Co-ordinators review SAC3 & 4s which contain the greatest opportunities for organisational learning

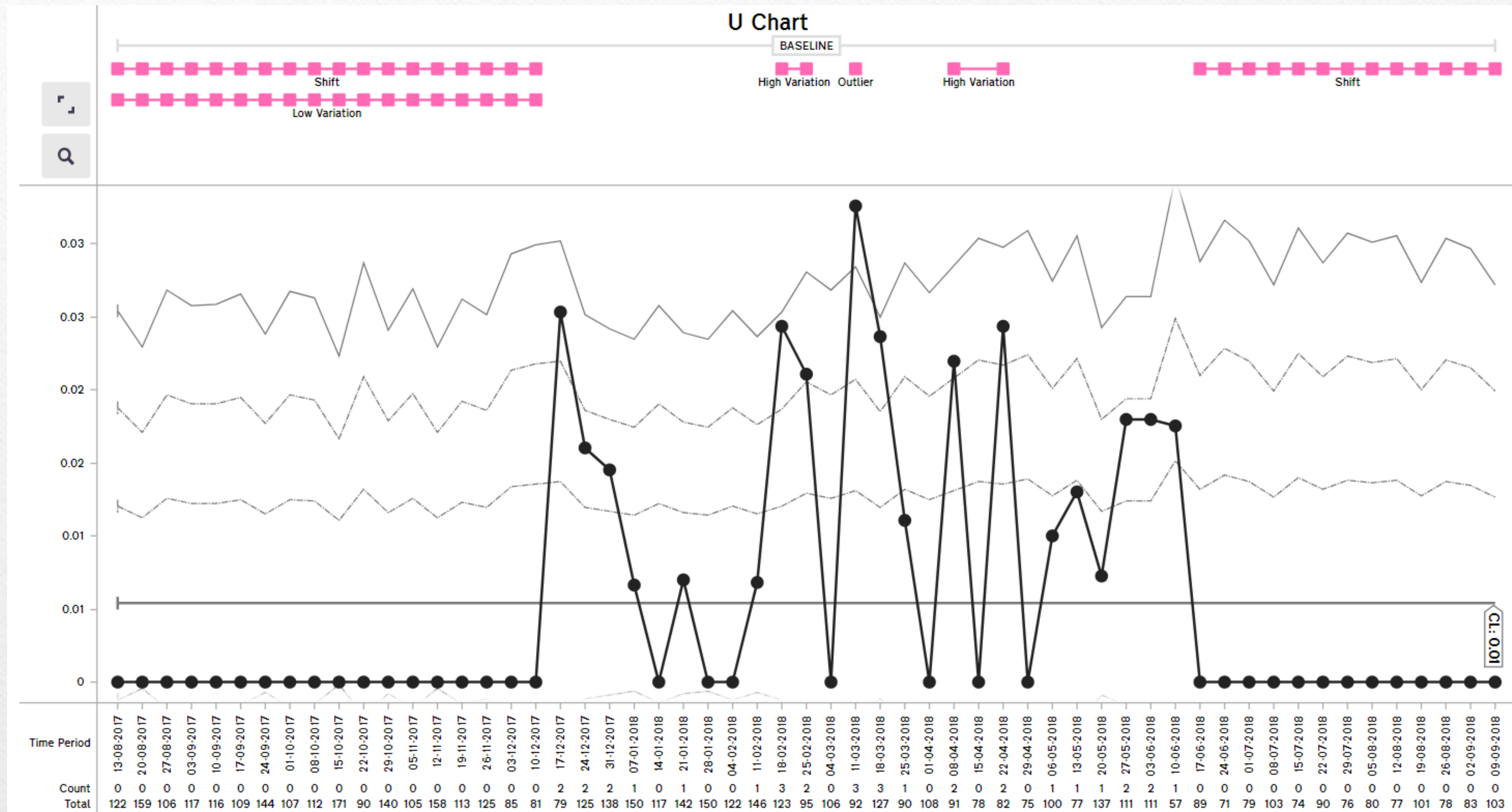
Report created to select only:

- Incidents requiring a transfer to Christchurch Hospital
-'Provision of Care' and 'Medication' incidents
- Other incident types where harm has/may have occurred and there are contributing factors identified which are within SMHS control

Quality Co-ordinators consider:

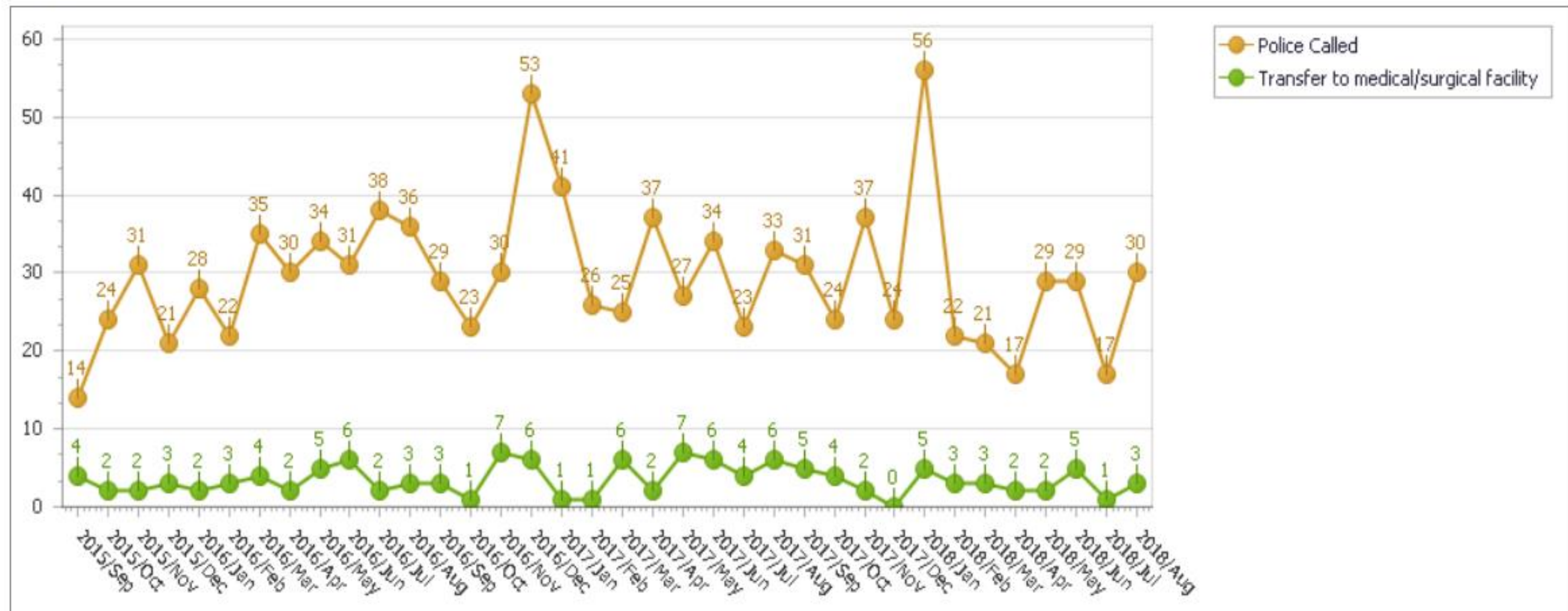
- Staff process and response
- Referral onto the Serious Event Review Team
- Applicability of learnings to other areas

U Chart – Number of Learnings
(SAC3s & 4s reviewed by Quality Co-ordinators)

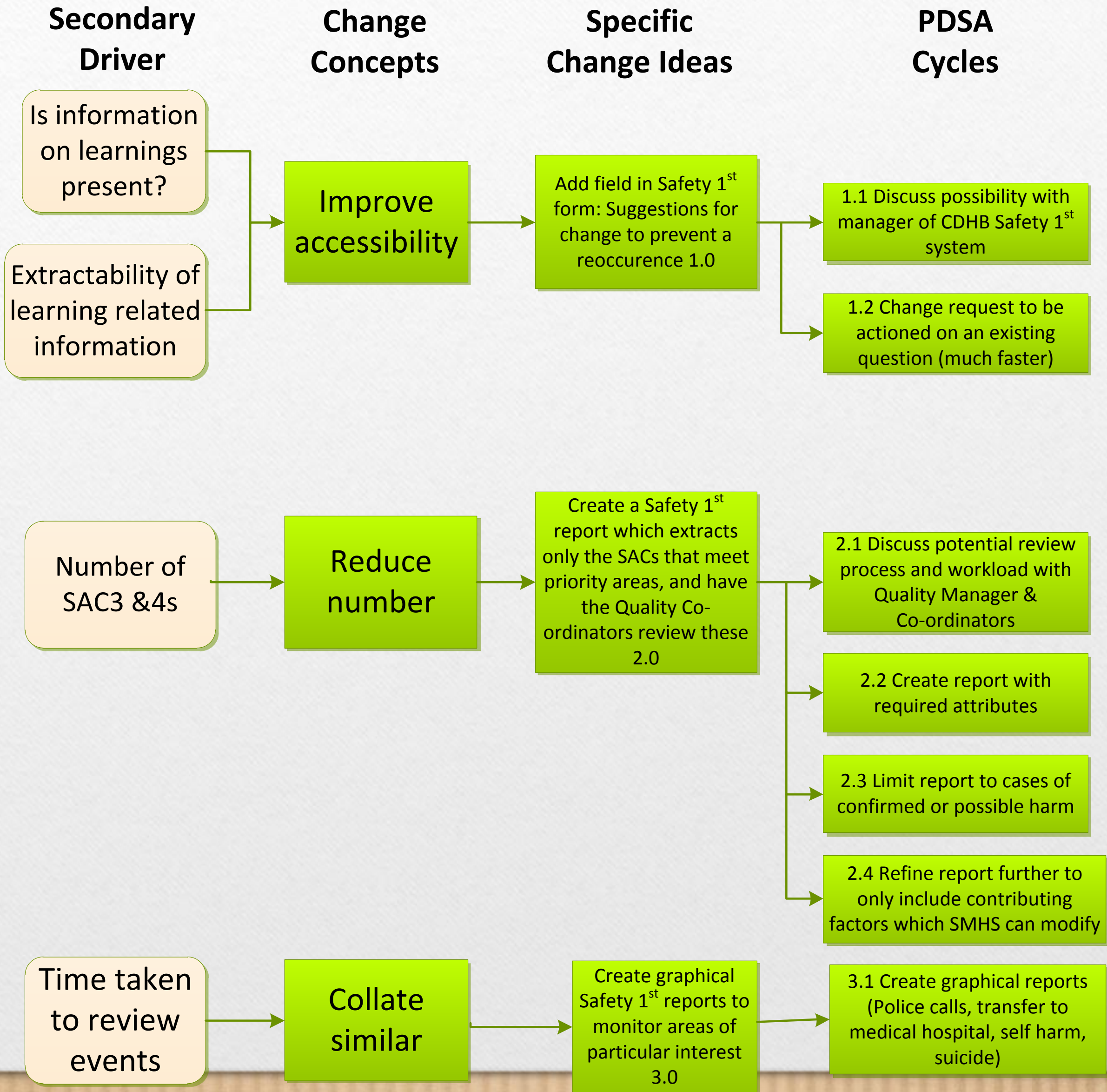


Change Idea 3: Graphs to monitor priority areas

Investigate/drill down into any changes (e.g. "Police called" outlier for January 2018) to examine causes.



PDSA Tree



Challenges & Lessons Learned

- Process improvement tools make the job easier
- Allow extra time for unexpected events
- Work hard to engage your stakeholders
- Ensure your outcome measures fit your needs
- You may need to change tack in response to new information

Acknowledgements

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