How Human Factors can be applied to Medication Use to Improve Safety

Medication Safety Group Workshop 9th June 2016

Report

Twenty-one people gathered to learn about Systems Theoretic Accident Model and Processes (STAMP) from Dr Thomas Jun, Lecturer at Loughborough Design School, and colleagues. Attendees were from a range of professions and LIIPS organisations (patient partner, NHS, academia) along with a few guests from Nottingham and Kettering. Following introductions, including stating reasons for attending which included desire to apply learning to education courses and to clinical practice, Suzanne Khalid gave an overview of the need to review recommendations made following serious incident (SI) reports to ensure they have impact in practice. The advantage of the mix of people present was to bring different perspectives on the same area for improvement.

The very interesting presentation included a review of other accident models including the ‘Swiss Cheese’ model followed by an explanation of Systems Theoretic Accident Model and Processes (STAMP). STAMP focuses on understanding failure of ‘control actions’ and offers a new approach to analysing accidents (see publication and pdf of slides). A case of incorrect prescribing and administration of insulin, which resulted in a SI report, was used again (see March 2016 meeting report) to apply STAMP to a realistic scenario. Groups worked with an academic facilitator to apply this approach to the example and identify control failures.

Feedback from the groups was that it was a useful model which demonstrates the complexity of clinical practice. Recommendations emerging from the group discussions included:

- Need clear and comprehensive documentation / communication
  - Who designs / controls documentation?
  - Starting patient on new treatment to be included in handover
  - Agree pathway for steroid induced hyperglycaemia
  - Communication needed that new patient on insulin
  - Advice given on transfer
  - Better communication between diabetic specialist nurse and the prescriber

- Who has overall coordination of care?
The whole group discussion included the role of the Insulin passport and need for a collaborative LLR approach to an insulin strategy both of which formed actions for group members.

Shazia Patel, (East Leicestershire and Rutland CCG) fed back on the meeting and agreed actions of the LIIPS Medication Safety subgroup who are working together to produce a standardised insulin chart to use across LLR.

Feedback was very positive for the meeting with much praise for the content, group discussion and wider discussions and the opportunity to networking and learn from others.

Plans are to build on this initial work and to analyse the difference in recommendations generated using this approach compared to the original recommendations.

For more details please contact liips@ac.uk.