PreMieRE
Prevent Mistakes by Reflecting on Error

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PATIENT SAFETY ATTITUDE & CLIMATE QUESTIONNAIRE- PSACQ

- Develop Scale assessing:
  - Awareness of safety concepts
  - Attitudes to patient safety
  - Perception of workplace safety climate

- Apply scale in trainees
  - from multiple specialities
  - to evaluate baseline in above domains

OUR BRIEF

- Commissioned by East Midlands LETB to
  - investigate Doctors and Patient Safety
  - develop and pilot an intervention
  - assess impact
  - make recommendations

METHODS

- Multi-dimensional 40 item scale with 3 Themes
  - (dichotomous yes/no response options or 5-point Likert-type options)

- Disseminated to 527 trainees
  - Foundation trainees, GP trainees, Hospital Core & Speciality trainees

- Seniority determined by grade
  - FY – Foundation Year, CT – Core Trainee, Reg – Registrars/ST3+

- Analysis
  - Chi-squared ($\chi^2$) test used to evaluate differences for dichotomous items;
  - ANOVA for differences in means for Likert-type items
**ATTITUDES TO PATIENT SAFETY DOMAIN I**

- Strongest disagreement with ‘most medical errors result from careless nurses’  
  (mean 1.95, p<0.001)
- Strongest agreement with ‘even most experienced and competent doctors make errors’  
  (mean 4.54, p<0.001)
- Senior trainees more inclined to agree with ‘medical error is a sign of incompetence’  
  (mean FY 1.95, CT 2.33, ST 4.54, p<0.001)

**ATTITUDES TO PATIENT SAFETY DOMAIN II**

- Surgical trainees agreed more strongly that ‘learning about patient safety not as important as the skill based aspects of being a doctor’  
  (mean Med 2.12, Surg 3.82, p<0.001)
- Surgical trainees agreed more strongly that ‘medical error is a sign of incompetence’ vs. medical trainees  
  (mean Med 2.00, Surg 3.94, p<0.001)
- Medical trainees agreed more strongly with ‘number of hours doctors work increases likelihood of making errors’ vs. surgical trainees  
  (mean Med 3.86, Surg 3.31, p<0.006)

**PATIENT SAFETY - M&M MEETINGS**

- 5-minute overview of the project
- Case presentation of PSI by the trainee  
  – Facilitated discussion highlighting key patient safety issues
- Agreed actions of changes needed  
  – Recorded on a defined form
  – Completed on each occasion
THE WHO CURRICULUM GUIDE TOPICS

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<tr>
<th>Topic</th>
<th>Title</th>
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<tr>
<td>1</td>
<td>What is patient safety?</td>
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<td>2</td>
<td>Why applying human factors is important for patient safety</td>
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<td>3</td>
<td>Understanding systems and the effect of complexity on patient care</td>
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<td>4</td>
<td>Being an effective team player</td>
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<td>5</td>
<td>Learning from errors to prevent harm</td>
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<td>Understanding and managing clinical risk</td>
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<td>Infection prevention and control</td>
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<td>10</td>
<td>Patient safety and invasive procedures</td>
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<td>11</td>
<td>Improving medication safety</td>
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PATIENT SAFETY EVENTS - IMPACT OF PATIENT SAFETY INTERVENTION
**DEFINITION**

**Adverse Event**
- an unintended injury
- causing disability and/or prolonged hospital stay
- caused by healthcare management – not underlying disease process
- reported during admission

**Patient Safety Incident**
- an unintended injury
- causing disability and/or prolonged hospital stay
- caused by healthcare management – not underlying disease process
- reported during admission

**PSI**

- Patient Safety incidents
  - Datix-Safety
  - SUI
  - Never events

- **Denominator**
  - the numbers of procedures performed

- **Site**
  - Trauma
  - Planned

**PSI**

**MEDICAL VS NURSING PS EVENTS**

Patient Safety Events in Pilot

- Before
- During
- After

Rate / 1000 PSI Medical
Rate / 1000 PSI Nurses
Rate / 1000 ALL Nurses
**PUBLICATIONS**

1. Effect of patient safety incident review and reflection in an extended morbidity and mortality meeting.

2. The PreMiERE project: Enhancing Morbidity and Mortality Meeting and Patient Safety Education for Specialist Trainees.

**RECOMMENDATIONS**

**CLINICIANS**

1. Patient safety discussion should be an integral part of the extended mortality and morbidity meetings and run as a PDSA cycle.
   1. Describe and discuss case
   2. Present related WHO teaching
   3. Reflect in portfolio
   4. Review actions

2. This should be introduced in all morbidity and mortality meetings in hospitals to discuss error and deliver related WHO curriculum.

3. Specific emphasis is placed on patient safety in the acute setting.

4. Quarterly meetings MUST include all clinical staff in a Multi-professional Patient Safety Forum (MPSF).
   1. nursing staff, physiotherapist, occupational therapist, plaster technician, managers, clinic and theatre coordinators and supporting staff.

5. Actions recommended in the previous three meetings should be reviewed at each quarterly meeting.

**HOSPITAL**

1. The Trust Board should
   1. note this report and
   2. support implementation of the Patient Safety Focus in Mortality and Morbidity meetings

2. Managers must report to the NHS hospital executive on the implementation of recommendations made by the extended M&M meetings.

3. The senior hospital executive should receive an annual report on PSIs AND the improvements made.

4. The knowledge, attitude and climate on patient safety be assessed regularly at an organisational level and reported to the hospital board with emphasis on the “Climate” of safety.

**LETB & UNIVERSITY**

1. The culture of transparent exploration of adverse events MUST be strengthened by including this within curricula.

2. All training clinicians must attend the extended M&M meeting.
   1. medical and non-medical
   2. undergraduate and postgraduate.

3. All postgraduates MUST include their reflection on patient safety discussions and actions from the M&M meetings in their portfolio.

4. This should be reviewed annually as part of the ARCP.

5. The knowledge, attitude and climate on patient safety should be assessed regularly at school level and reported to the LETB.