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In the name of safety? – identifying and letting go of low-value safety practices

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Yorkshire and Humber Patient Safety Translational Research Centre

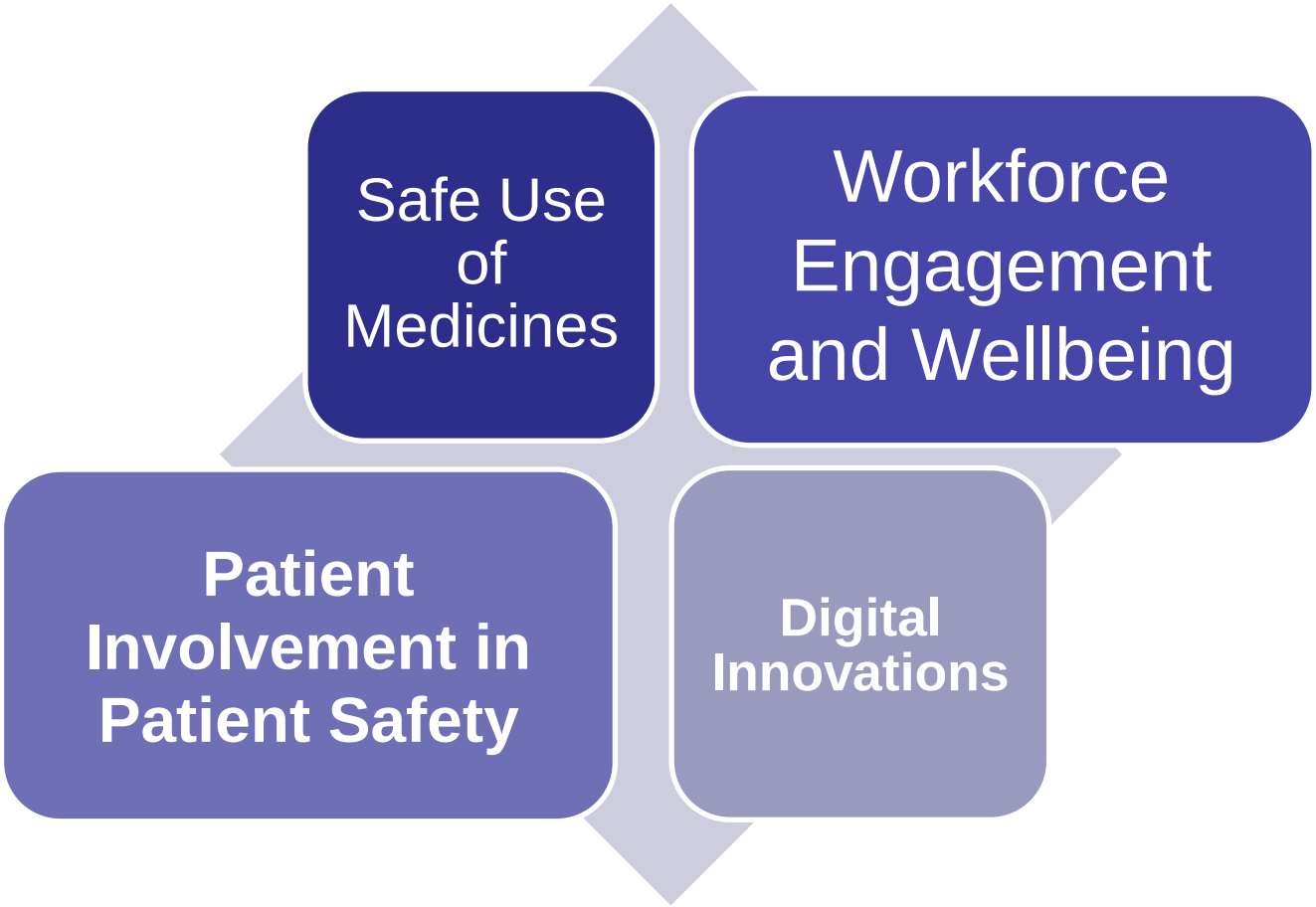
Partners

- Bradford Teaching Hospitals NHS Foundation Trust
- University of Leeds
- University of Bradford

Vision

- Addressing NHS and patient priorities
- Creating innovative solutions to complex problems
- Recognised for research excellence
- Collaborative academic environment

Research themes



Background

- Constant pressure on staff to do more
- Up to 30% healthcare spending is wasted[1] and not necessarily evidence-based
- Choose Wisely campaign - but need to consider non-clinical practices too[2]

Challenges:

- Lacking a common language[3,4]
- Stopping accepted practice is unfamiliar and difficult[5]
- “Mindful forgetting” is required[6] but little understood[7,4]

Four-phased study

Phase 1: Citizen-science-based crowdsourcing approach to generate ideas from NHS healthcare staff

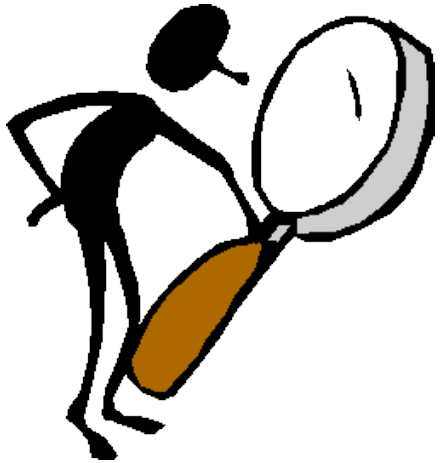
Phase 2: Identifying 2-3 target patient safety practices for stopping

Phase 3: Testing and evaluating “mindful forgetting” of target patient safety practices

Phase 4: Provide insights for developing a “programmatically decommissioning” Learning Health System[6]

Aim

To identify **non-clinical patient safety practices** used in healthcare settings that staff perceive could be stopped because they have **little to no benefit for safety**



Method

Procedure

Online survey promoted via social media and professional networks (mid April – Dec 2018)

NHS staff were asked:

'It is a waste of time doing 'X' because it doesn't make care safer. Please tell us what 'X' is below. You can list more than one answer.'

Analysis

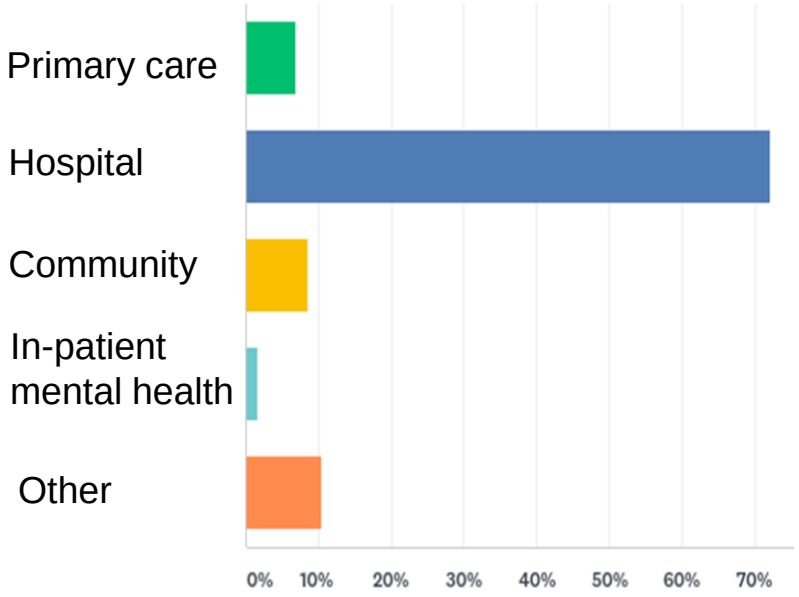
Content analysis was used to analyse the survey responses[8] and responses were grouped in to categories

Results

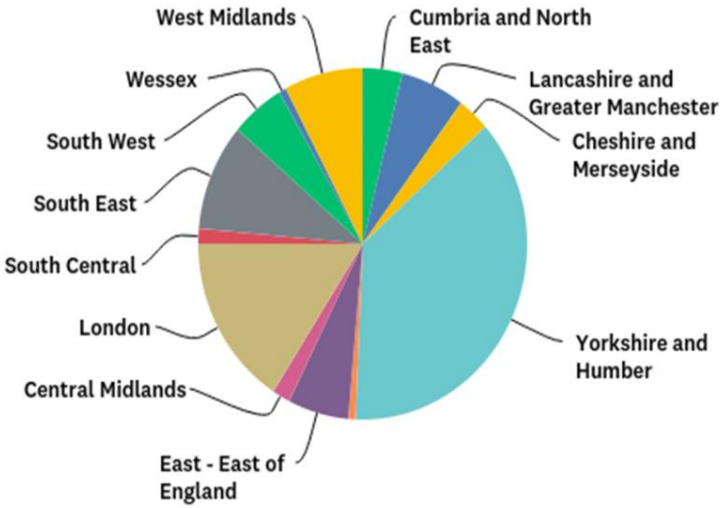
Survey responses: 287 individual responses including 318 ideas

Summary demographics

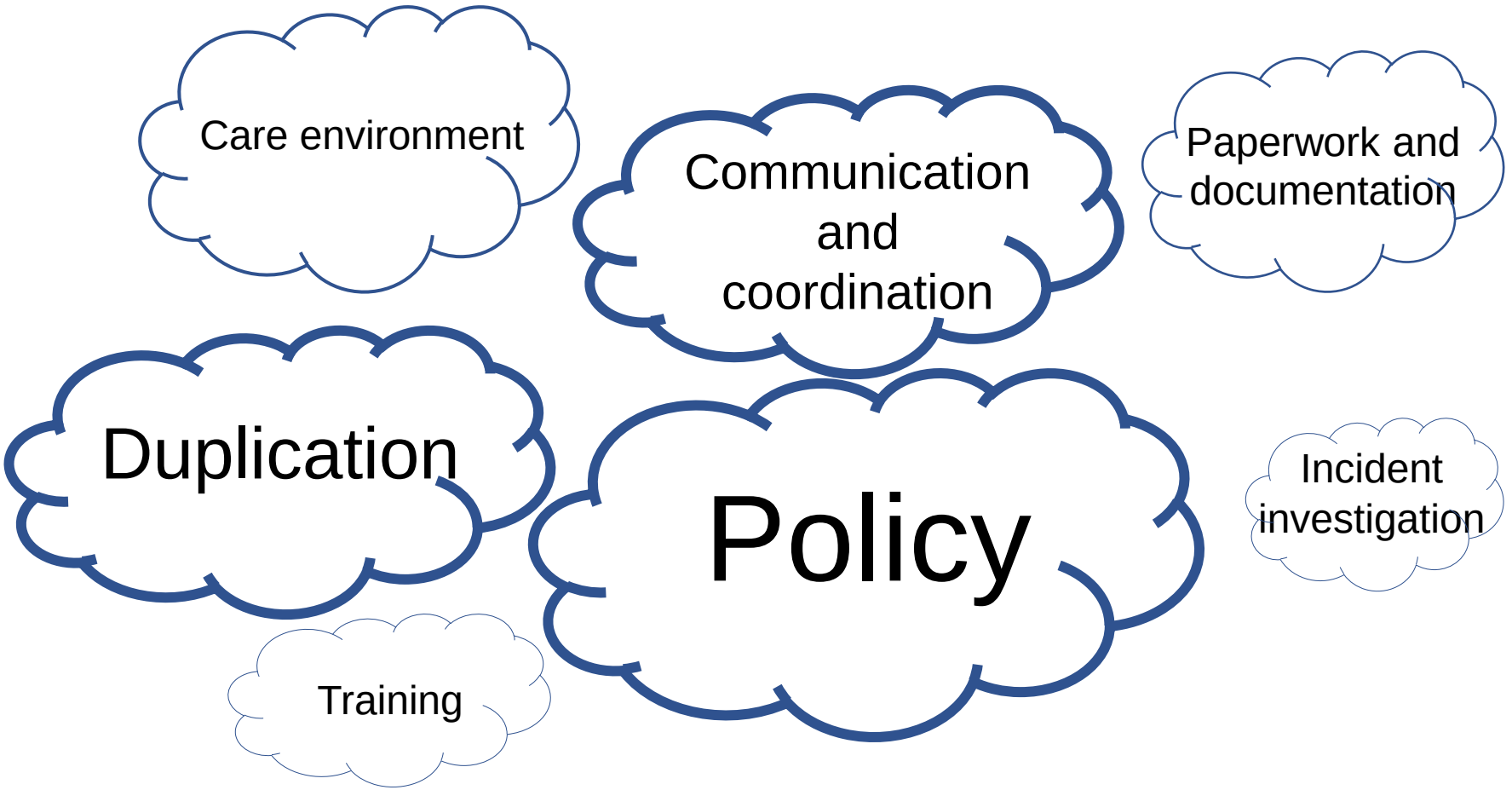
Which best describes where you are based most of your time at work?



Which NHS region do you work in?



Results


Care environment
Communication and coordination
Paperwork and documentation
Duplication
Policy
Incident investigation
Training

Results: Category development

Survey responses	Sub-categories	Category
Repeated identity checks on patients	Double checking	Duplication
All the theatre pre-op/STOP checks		
Double checking common oral meds		
Rewriting handover notes in multiple places	Duplicating documentation	
Rewriting lists of medicines that patients take in multiple health records and communication documents		
Printing out assessments after completing them on the electronic record system		

Conclusion

- Frontline NHS staff are willing and able to identify low-value safety practices that could potentially be stopped

- As the study progresses it will provide insight into the little understood topic of stopping established non-clinical patient safety practices

- Will enable staff to focus on delivering safe care
  - Improving patient safety and staff wellbeing
  - Optimising stewardship of NHS resources

Next steps

Phase 1: Citizen-science-based crowdsourcing approach to generate ideas from NHS healthcare staff

Phase 2: Identifying 2-3 patient safety practices for stopping

Phase 3: Testing and evaluating “mindful forgetting” of target patient safety practices

Phase 4: Provide insights for developing a “programmatically decommissioning” Learning Health System[6]

References

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Thank you for listening

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