PATIENT SAFETY GROUP UPDATE

Manoj Kumar examines the process of delivering quality and safe healthcare through effective team-based reviews

The delivery of consistently high-quality, safe and effective care within an ever-increasing complex and dynamic environment, faced with rising costs, continues to be a challenge in healthcare[1,2,3]. In our pursuit to improve the quality and safety of health and social care we have developed multiple initiatives[4]. However, the commitment required by such initiatives can be overwhelming to the already busy clinician.

There is a process that provides us with the opportunity to deliver an effective review and learning process, and is able to incorporate existing safety or quality initiatives; one that is closest to patient care and involves every member of the team. The term 'mortality and morbidity meetings' may, however, come with a negative connotation of what it used to be rather than what it can be.

Mortality and morbidity meetings – or, perhaps more appropriately, team-based quality reviews – are our opportunity to work as a team to apply a 'Systems Thinking' approach to reviews[5], understand strengths or weaknesses within the system, address concerns or complaints, and identify areas for improvement. They provide an opportunity to seek multiple perspectives from those who may have a better understanding of the complexities and challenges faced at the time of decision-making. It enables us to ensure patients or their next of kin are given the opportunity to share feedback of care as well as provide them with a valid assessment of care that was offered. This process functions as a platform to innovate, focus available resources, monitor outcomes, teach and share learning. It also serves as an opportunity to update teams on relevant initiatives or research studies, and apply its relevance within a local context. When carried out well it promotes the opportunity for anyone to speak up or ask for help and more.

The Scottish Mortality and Morbidity Programme (SMMP)[6] aims to improve the quality, governance and structure of team-based quality and safety reviews through co-production, where safe care, shared learning, quality improvement and a 'just culture' are at the forefront. The SMMP is working to support this critical but under-resourced process to create a workforce that has the competencies (underpinned by an understanding of human factors or ergonomics and quality-improvement methodology) and tools to participate and lead effective reviews. Our current focus is on improving three key areas to develop this process:

- **Training** Development of a learning programme to deliver the necessary skills and understanding to design and participate in effective, structured team-based quality reviews.
- **Supporting the development of effective IT systems** Improve capture of data or relevant intelligence (organisational memory) and translate this information into meaningful impact including in its use to deliver educational activities and simulation.
- **Improving governance and shared learning** Collaborating with professional bodies and health boards to ensure an acceptable standard of reviews and provision of a national platform for sharing learning for the purpose of improvement in care.

The relevance of a well-designed and structured team-based safety and quality review process, with an understanding of its true purpose of shared learning and improvement, is critical in ensuring continuous advancement in safety[4,5,7,8]. This is especially relevant as improvements in health and social care lie with the overall process, not solely the investigations or the generated reports by themselves[4]. The SMMP is working to optimise that process.

Mr Manoj Kumar
Consultant Surgeon, Aberdeen Royal Infirmary, and National Clinical Lead for the Scottish Mortality and Morbidity Programme

References

1. Mitchell I, Schuster A, Smith K, et al. Patient safety incident reporting: a qualitative study of thoughts and perceptions of experts 15 years after 'To Err is Human'. *BMJ Qual Saf* 2016; 25: 92–99
2. Stemn E, Bofinger C, Cliff D, et al. Failure to learn from safety incidents. https://doi.org/10.1016/j.ssci.2017.09.018
3. Sinclair A, Guérin A, Robin C, et al. Investigating the cost and efficiency of incident reporting in a specialist paediatric NHS hospital and impact on patient safety. *Eur J Hosp Pharm* 2017; 24: 91–95
4. Macrae C. The problem with incident reporting. *BMJ Qual Saf* 2016; 25: 71–75
5. Carayon P, Schoofs Hundt A, Karsh BT, *et al*. Work system design for patient safety: the SEIPS model. *Qual Saf Health Care* 2006; 15 (Suppl I): i50–i58. doi: 10.1136/qshc.2005.015842
6. http://www.healthcareimprovementscotland.org/our_work/patient_safety/scottish_mortality_morbidity.aspx
7. Dekker SWA, Hugh TB. A just culture after Mid Staffordshire. *BMJ Qual Saf* 2014; 23: 356–358
8. Martin GP, Dixon-Woods M. After Mid Staffordshire: from acknowledgement, through learning, to improvement. *BMJ Qual Saf* 2014; 23: 706–708. Published online first 18 July 2014. doi: 10.1136/bmjqs-2014-003359

The Patient Safety Group exists to ensure that RCSEd's core professional standards, training and education activities are focused on continuously improving patient safety and reducing harm. For details visit rcsed.ac.uk/patientsafetygroup