WORKING TOGETHER TO IMPROVE PATIENT SAFETY

WHY
Healthcare organisations can make mistakes. We need to learn from these mistakes to stop them happening again. “Without knowing there are no learnings, without learnings there can only be risk that it will happen again.” (Kennedy, 2001)

WHAT
- A health system that relies on a perfect staff performance 100% of the time is perfectly designed not to learn and continue to make the same mistakes over and over again. We need to change to a culture of safety.
- All of us must accept responsibility for the safety of ourselves, peers, patients and visitors.
- All of us must prioritise safety improvement.
- All of us must support and develop a positive environment for identification, communication and resolution of safety issues.
- All of us must develop a provision of learnings from accident, error or adverse events.

HOW
- We must be supportive of an open and inclusive culture where education, professional development, research and sharing ideas is a valued practice that is common place.
- We must have quality at the core of our organisational values.
- We must support multidisciplinary team work in all areas, at all levels.
- We must all take ownership of clinical quality and safety.
- We must have strong leadership.

WHEN
Report events as soon as possible. Our memory can distort facts over time to protect us from the uncomfortable.

ROLES AND RESPONSIBILITIES OF YOU AND YOUR MANAGER
- Be proactive and start to investigate adverse events and near misses in your area, inclusive of SAC 1, 2, 3 & 4 events (includes near misses).
- Input your findings into the Datix system, this becomes the central record.
- Enter lessons learnt and action taken to prevent recurrence for all events.
- Closure of SAC 3 & 4 events.
- Remember you can make a real difference and stop the same thing happening again, especially if you share your findings and your improvements.

ROLE AND RESPONSIBILITIES OF NORTHLAND DHB REPORTABLE EVENTS COMMITTEE (REC):
- REC has overview of all patient related SAC 1 & 2 events.
- REC will initiate an independent Systems Analysis Investigation (SAI); including selecting the team for the SAI.
- REC distributes recommendations from the SAI and monitors implementation and progress of any recommendations.
- REC reports via the Quality Improvement Directorate to external agencies, i.e. Health Quality and Safety Commission, MOH, HDC
- REC close SAC 1 & 2 events.

SAC=SEVERITY ASSESSMENT CODE

Speak up for patient safety

Working Together to Improve Patient Safety

A Healthier Northland
He Hauora Mo Te Tai Tokerau

QUALITY & IMPROVEMENT DIRECTORATE

NORTHLAND DISTRICT HEALTH BOARD
Te Pouari Hauora & Rākau O Te Tai Tokerau

Speak up for patient safety