Health Innovation Network South London

NHS

National Patient Safety Improvement Programmes

Medicines

Premortem Session as a Medicine Safety Change Intervention: The Health Innovation Network's work with four care homes with expertise across adult nursing, Dementia and learning disabilities

> **The premortem session was interactive and has helped unearth overlapping issues in other areas of care**
>
> Care Home Manager

A Chike-Michael[1], A White[1], B Warner[2], G Dakin[1], L Yankey, C Butterworth[1]
[1]Health Innovation Network (HIN), London, UK; [2]Guy's and St Thomas' NHS Foundation Trust, London, UK.

Overview

In 2019, NHS England and Improvement established the National Patient Safety Improvement Programmes and commissioned Patient Safety Collaboratives to deliver safety and quality improvements (QI) across the NHS in England.

One of the five programmes is the Medicines Safety Improvement Programme which addresses the most important causes of severe harm associated with medicines most of which has been known about for years but continue to challenge the health and care systems in England.

Aim

The aim of the programme is **to reduce medicine administration errors in care homes by 50% by March 2024**, through medicines optimisation and quality improvement.

The premortem is a type of learning Safety Huddle that focusses on learning by reflecting on examples of incidents or near misses that have occurred at another care home and imagining the same scenario happening in their care home. The premortem tool provides the opportunity to create a space where staff re-imagine the future and learn from failure before it happens.

Method

The premortem session is run as a four-step structured but interactive workshop guided by an adapted toolkit.

Step 1: Individual reflection

Present the case study and allow for individual reflection and be ready to share with your group

Step 2: Breakout discussions

Nominate facilitator to guide discussions, scribe to capture

Step 3: Feedback to wider group

Facilitator, scribe or any other team member tells the wider group the main points of the smaller group's discussion

Step 4: Follow up

Acknowledge fishbone diagram analysis, teams should reconvene in a short while to discuss in more details what was captured as concerns and care teams be responsible for working on mitigating actions

The Health Innovation Network (HIN) provided a toolkit to capture data and baseline findings. This included the Safety Attitude Questionnaire (SAQ), designed to be completed anonymously by staff as a gauge of the safety culture within the care home. The effectiveness of the premortem sessions was measured both quantitatively and qualitatively.

Results

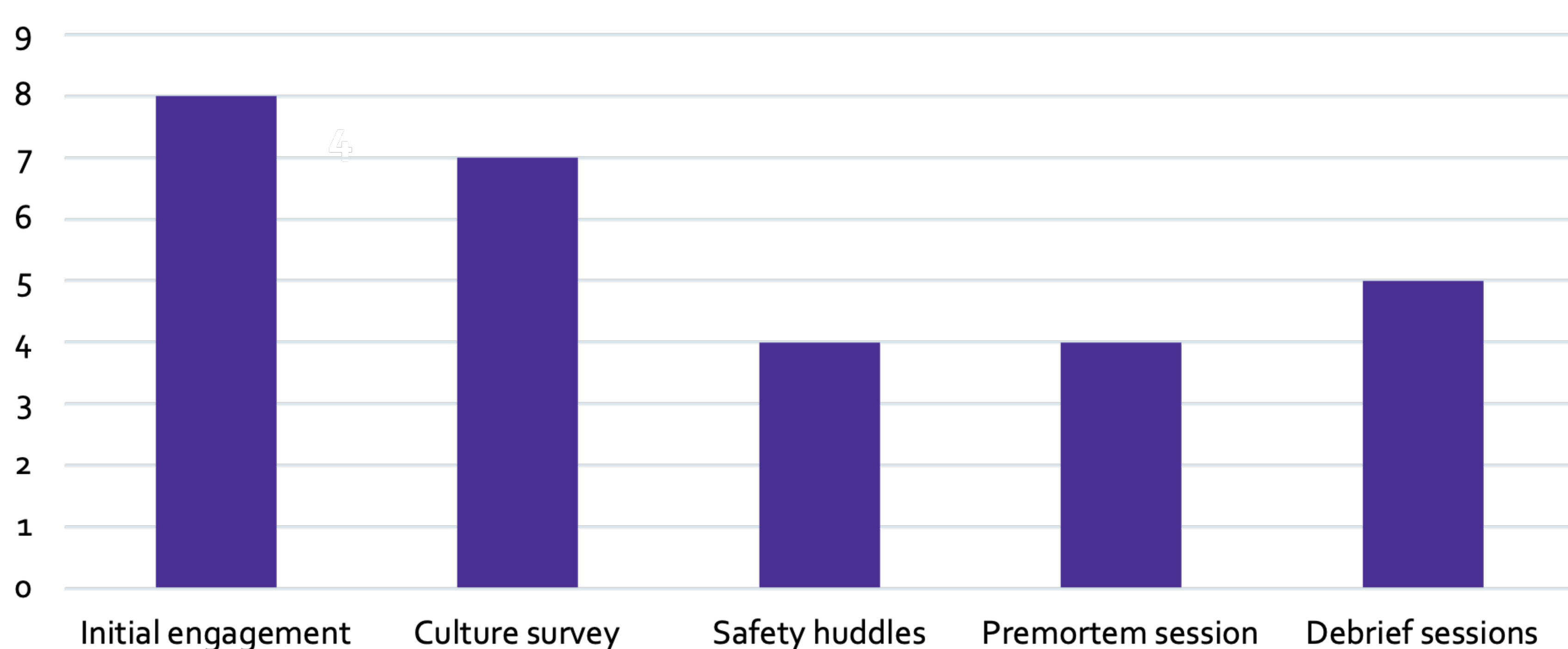
Quality deliberations - The premortem workshops enabled rich conversations. Medicine safety concerns were drawn from the case studies presented and mitigation actions were discussed

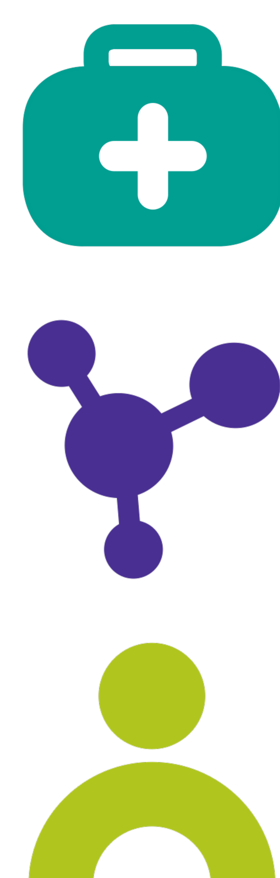
QI tools - Care homes found the Plan, Do, Study, Act (PDSA), fish bone diagram and medicine safety cross very useful to identify, understand and solve medicine safety related issues

Collaborative working - It was beneficial for the care home pharmacist to be part of the facilitators in the premortem session and offer ongoing support

Culture surveys (SAQs) - The results were helpful in providing an approximate culture of the care home

Medicine Safety Change Interventions in 8 South London Care Homes (March 2022)





Conclusion

All care homes who tested the learning from errors safety huddle (Premortem) recommended that the sessions are regularly carried out in their homes.

It was also interactive, encouraging every member of staff in attendance to contribute to the conversations.

Health Innovation Network South London

Contact Details

@HINSouthLondon
healthinnovationnetwork.com
ayobola.chike-michael@nhs.net

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