Patient & Staff Risks: The Need for Change

South East Coast Regional Transfusion Committee Education Conference

> 17th October 2018 University of Sussex, Brighton

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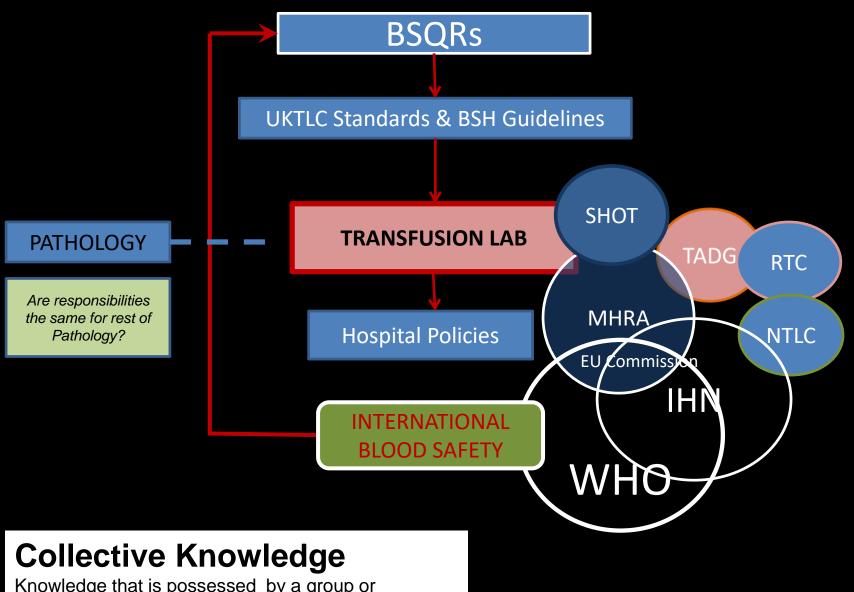
The Past

- No SOPs, regulations, guidelines or standards
- No error reporting
- Patient safety issues
- No blood traceability
- 32 hour working day, full 1hr cross-matching.
- Mentoring and sharing knowledge.





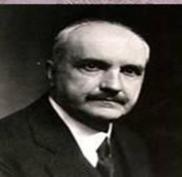




Knowledge that is possessed by a group or organisation and allows access to subject matter experts (SME). For Blood, this 'body of knowledge' influences decisions on public health.

THOSE WHO DO NOT LEARN FROM HISTORY ARE DOOMED TO REPEAT IT.

QuoteHD.com



George Santayana

Spanish Philosopher 1863-1952

The Present: Patient Safety & Care

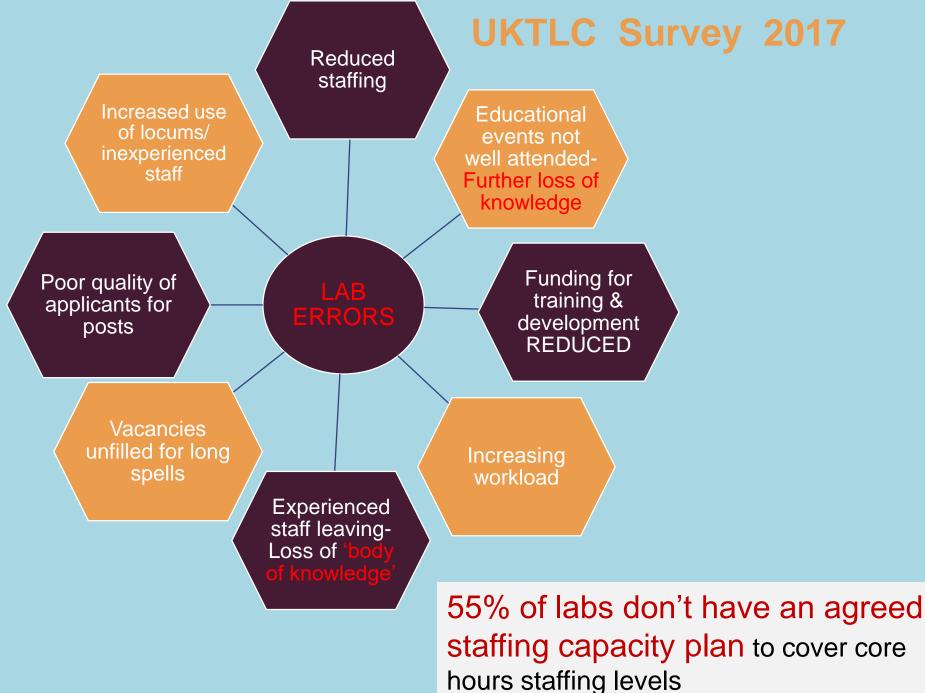


GOOD

- Regulations & standards
- Patient safety standards
- Innovation & improvements
- Teams

CHALLENGES

- Fractured & stressed
 teams
- Friction/ hierarchies
- Culture & Behaviours
- Resistance
- Financial pressures
- Regulations & Standards
- Line management
 structures









Improving the Safety of Patients in England

National Advisory Group on the Safety of Patients in England

Dr Don Berwick

- We are dealing with a demoralised workforce and especially demoralisation among our future workforce, which is a sign of enormous distress
 - We should continually and forever reduce patient harm by embracing wholeheartedly an ethic of learning

We should ensure that staff are present in appropriate numbers to provide safe care at all times and are well-supported.

"It's great. I'm great. Everything's just great."

The Future: Need for change

1. Effective resource management

2. Culture changes

3. Staff Capacity Planning- Mike Dawe's presentation

Effective Resource Management

- Produce weekly and shift rotas <u>well</u> in advance.
- Plan attendance at external meetings in advance.
- Review staff tea breaks/ lunch to meet service needs.
- Restrict staff leave for large planned projects
- Develop staff at the lower grades.
- Work cooperatively MHRA BLOOD FORUM

Culture Changes

- Improve non-conformance reporting- build a picture
- Remove barriers between staff
- Be open and transparent about issues
- Reflect on own behaviours and set standards.
- Remove blame
- Leadership and development at ALL levels

The Regulations: BSQRs

GPG 2.2 (Good Practice Guidelines)

The organisation should have an <u>adequate number of personnel</u> with the <u>necessary qualifications and experience</u>.

Management has the ultimate responsibility to determine and provide adequate and appropriate resources

The responsibilities placed on any one individual should not be so extensive as to present any risk to quality.

Communication



Medicines and Healthcare products Regulatory Agency



Forum What's new?

🕈 Forum 🎍 Blood Forum

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Forum: Blood Forum

Threads 1 to 2 of 2

Advenced Seerc

The MHRA Blood forum has been created as a tool to help those involved in blood component collection, processing, testing and distribution to comply with the EU Blood Directives, UK Statutory Instruments and good practice requirements. It provides the ideal opportunity for extended communication between peers and allows users to put forward their comments and get "real-life" examples of ways in which they can manage robust quality procedures that ensure compliance and which dovetail with their own business needs and resources.

This forum should not be used for direct questions to the GMP Inspectorate, reporting significant deviations or making formal complaints. These should follow the formal routes that are already in place.

Please read the Blood Forum introduction and Rules before posting on this forum.

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MHRA Blood Forum: http://forums.mhra.gov.uk/forum.php

All anyone asks for is a chance to work with pride.

W. Edwards Deming