13.6 Patient safety and quality

Name: _____ Class: _____ Date: _____ **Total: 24 marks**

KEY WORDS Swiss cheese model • near-miss • SBAR SBAR

Objective

Read the alignment; analyse across six domains.

1 Key knowledge and worked examples

■ The model

Swiss cheese: design, barriers, procedures, people – each with holes; harm passes when they align ✓. Incidents are analysed systemically.

■ Worked example: the tenfold near-miss

Prescribing (similar names) + dispensing (no independent check) + administration (interruption) aligned; fixes are tall-man lettering, separate stocks, do-not-interrupt zones ✓.

2 Practice

2.1 What must align for harm to pass? [3]

2.2 Name the six London Protocol domains. [3]

2.3 What does SBAR stand for? [3]

3 Exam-style questions

3.1 A fictional tenfold dose reached the patient and was caught by a nurse at the last check.

Analyse across the London Protocol domains (task and technology: similar names; individual: interruption; team: no independent check; environment: interruption zone) ✓. For each hole name one design fix (tall-man lettering, separate stocks, independent double checks, do-not-interrupt zones) ✓. Explain why blame would make the next event MORE likely (holes hide; reporting stops) ✓. [8]

3.2 A fictional service wants to show quality improvement.

Contrast structure, process and outcome measures with one example each (staffing and equipment; handover-SBAR compliance; risk-adjusted outcomes) ✓. Explain why process measures respond fastest and what an outcome measure adds that convinces ✓. State how a near-miss reporting culture feeds both ✓. [7]

Solutions

2.1

- Holes in successive defence layers (design → people) ✓.

2.2

- Patient factors, task and technology, individual, team, environment, organisation ✓.

2.3

- Situation, Background, Assessment, Recommendation ✓.

3.1

- Task/technology: look-alike names → tall-man lettering ✓.
- Individual/team: interruption, no independent check → double checks ✓.
- Environment: interruptible zone → do-not-interrupt rule ✓.
- Blame hides holes and stops reporting – recurrence more likely ✓.

3.2

- Structure: staffing, equipment; process: SBAR/checklist compliance; outcome: risk-adjusted results ✓.
- Process responds fastest (closest to the change); outcome convinces (what patients get) ✓.
- Near-miss culture feeds both: free lessons, real data ✓.