Exercise walk-through

13.6
Patient safety and quality

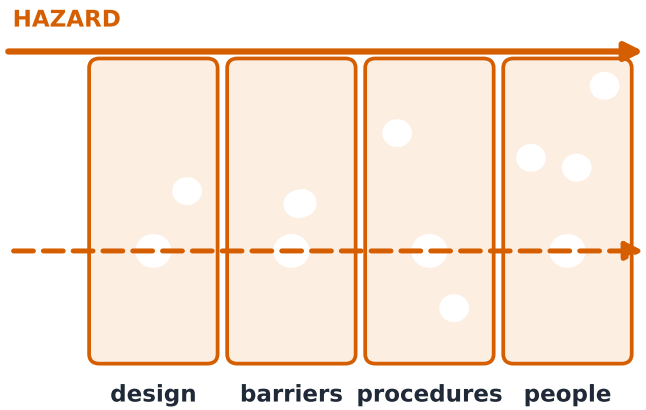
University Medicine

Patient safety and quality: systems, not culprits

1. **Model** Swiss cheese: design, barriers, procedures, people - each with holes; alignment is the failure.
2. **Analysis** London Protocol six domains (patient $\rightarrow$ organisation); **SBAR** for handovers; five rights at the bedside.
3. **Quality** Structure + process + outcome; near-misses are free lessons; tall-man names and do-not-interrupt zones.

The layered-defence error model

harm passes only when the holes align



fixes are design changes (tall-man names, independent checks, do-not-interrupt zones) — not blame

analyse the alignment, not the person

London Protocol — six domains:
patient factors · task & technology ·
individual · team · environment · organisation
SBAR handover: Situation · Background ·
Assessment · Recommendation — a checklist
for conversations; five rights for the bedside

quality = structure + process + outcome;
near-misses are free lessons

> Harm passes only when the holes align - analyse the alignment, not the person.

Exercises 2.1·2.3

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]

Exercises 2.1·2.3

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

2.1

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

2.2 Name the six London Protocol domains. [3]

2.2

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

2.3 What does SBAR stand for? [3]

2.3

- Situation, Background, Assessment, Recommendation ✓.

Exercise 3.1

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]

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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 ✓.

Exercise 3.2

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]

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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 ✓.