Situational Awareness Vital Insights

Support materials for trainers/teachers/lecturers

WHAT IS SAVI?

SAVI has been developed by a team of clinicians and human factors experts to help all staff working with patients to be more situationally aware. There are five films focusing on five high risk areas where good situational awareness is central to patient safety: Misdiagnosis in Primary Care, Deteriorating Patients, Prescribing High Risk Medicine, Team Safety Briefing and Medication Error.

WHO IS SAVI FOR?

The films are aimed at healthcare professionals and support staff with direct patient contact. However the films could also be used as part of undergraduate training for nurses, doctors and other health professionals (i.e. pharmacists). The first film is based in primary care, whilst the other four films are based within secondary care.

WHAT WILLTRAINEES LEARN?

The overall learning objectives for the SAVI resource are:

- To gain a basic understanding of situational awareness
- To be aware of the importance of situational awareness for patient safety
- To understand the value of the team in sharing information to ensure good situational awareness
- To be aware of some of the factors that can reduce situational awareness e.g. lack of clinical knowledge, high workload, poor teamwork, poor communication, information overload, problems with supervision, negative emotions

IS THIS RESOURCE FREE OF CHARGE?

The development costs for this resource have been funded by NHS Yorkshire and Humber, Regional Innovation Fund and the resources are made available through the Improvement Academy.

HOW CAN I USE THIS RESOURCE?

We recommend that the best way to use this resource is as part of an interactive training or teaching session. You, as the trainer, should decide which of the films are most appropriate to the trainees/undergraduates you are working with and the learning objectives you want to address. For example, if you are training GPs and your focus is on decision making then the misdiagnosis film might be most appropriate. If working with a multi-disciplinary group and your focus is on communication, then the team safety briefing film might best meet your needs.

For each topic area (misdiagnosis, deteriorating patient, prescribing high risk medicines, team safety briefing, medication error) there are two versions of the film. The first version of the film simply shows a typical episode of patient care, whilst the second provides an opportunity for trainees to learn about how patient care could have been improved by greater situational awareness and changes in routine practice.

This resource can be used in a variety of ways but we recommend the following steps:

1. Begin by briefly describing what situational awareness is and why it is important (see Appendix 1)
2. Show version 1 of the chosen film (e.g. misdiagnosis)
3. In groups, ask trainees or undergraduates to 1) demonstrate situational awareness by identifying the actual/potential risks to patient safety within the film, and 2) what factors reduced situational awareness within the team (e.g. poor communication, high workload, the organisation of work)
4. Show version 2 of the film (includes expert advice on changes)
5. Ask participants to work in groups to consider the recommendations for action (see Appendix 2) for the specific film they are viewing and encourage the group to think about how these recommendations could be implemented in practice
6. Concluding message: The message from the trainer should be a positive one. We all have responsibility for patient safety. If we see things that are not working, processes that are inefficient or flawed or practices that are unsafe, we shouldn't ignore them and hope they will go away. It is more difficult, upsetting and time consuming to deal with something after it has gone wrong than to try to address the problem now.
7. Repeat steps for each relevant film

Appendix 1: Guidance for Trainers: What is situational awareness?

Situational awareness within a team is about maintaining the ‘‘big picture’’ and thinking ahead to plan and discuss eventualities. This on-going dialogue, which keeps members of the team up to date with what is happening and how they will respond if the situation changes, is a key factor in patient safety.

To have good situational awareness three conditions need to be met:

1. You know what is going on around you - PERCEPTION
2. You know why things are happening - COMPREHENSION
3. You know what is likely to happen next - PROJECTION

Although many people would recognise that this is an important skill in operating theatres, it actually applies to almost any job in healthcare.

If you want to find out more about the theory has been applied in healthcare http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2464840/ http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1765783/pdf/v013p00i85.pdf. Here is an excellent paper about how staff can improve their ‘error wisdom’ http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1765802/pdf/v013p0ii28.pdf

Appendix 2: Recommendations for Action

Misdiagnosis

- Be aware of your own emotional responses to patients
- When working with a challenging patient, ask more questions
- Be prepared to recall the patient if you feel you might have missed something
- Consult a colleague

Deteriorating patient

- Use recognised assessment tools such as MEWS (Modified Early Warning System) to provide an accurate assessment of the patient's condition
- Take time to understand what the information means
- Communicate information concisely to members of the multidisciplinary team to help plan care for the patient
- Recognise when to escalate – ask for help if unsure
- Listen to the views of patients and relatives when conducting your assessment

Prescribing high risk medicines

- Gain as much information as possible about the patient's own insulin prescription, ask them to bring their own insulin into hospital and if feasible ask them to self-administer
- Be aware that patients may not necessarily show any signs of a low blood glucose despite being hypoglycaemic
- Know how to manage insulin in the post-operative patient and monitor its effect - treat hypoglycaemia promptly
- Standardise prescribing and prioritise key details: patient name, insulin type, dose in 'UNITS' (with the word UNITS written in full), timing and form of administration
- Standardise handovers of insulin treatment and monitoring arrangements

Team safety briefing

- Always plan time for a safety briefing - they result in smoother and safer operations
- All members of the team should be introduced and encouraged to speak up
- Considering each case on the list individually allows for planning and problem resolution
- Involve all team members in the safety briefing - the smooth and safe operation of theatres depends on all team members, not just those at the briefings

Medication error

- Recognise the importance of the ward round – allow time for clear, systematic, communication about the patient
- Show respect for each member of the team and recognise and value each team member's expertise
- Recognise that prescribing and administering medication is a high risk, high impact activity – minimise and actively manage interruptions and distractions to reduce the risk of error
- Involve the patient when prescribing and administering medication – encourage them to speak up