Leading the way: improving patient safety as a network

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PATIENT SAFETY
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The role that simulation training plays in improving patient safety is well supported by literature. Investment in low/high fidelity equipment, protected staff time to participate and resources to implement lessons learned from simulation training is costly. This expenditure is difficult to measure in terms of return on investment yet it is widely recognised to be critical in improving safety and team work in both maternity and neonatal settings.

The article by Lok et al (page 160) in this issue of *Infant* highlights several important points:

- That innovative use of simulation broadens the potential impact simulation can offer teams. The Yorkshire and Humber Children and Neonatal Simulation Network identified additional learning from simulation to include formal identification of predetermined latent risks.
- Using the simulation session to identify learning such as latent risks beyond that of the planned clinical scenario, provides the opportunity to maximise improvements and safety in a single training session.
- The model described allows for both local and regional learning, where learning from serious incidents occurring anywhere within the network can be used to prevent those same incidents occurring elsewhere.
- Similarly, pre-identification of latent risks offers other units the opportunity to design similar simulation-based scenarios to test whether the same issues might arise locally, pre-empting adverse incidents occurring in other units by early shared learning.
- Culture plays an important role in how teams learn; not only from their own incidents but in how they might embrace learning from others. Culture change is a priority for the NHS, where a positive organisational culture is recognised as a key contributory factor in highly functioning, safe teams.

In the discussion section of their article Lok et al highlight challenges in influencing individual hospitals to implement suggested remedial actions for identified latent risks that might have been determined elsewhere in the region. Whereas the article reports a more immediate response to locally-identified risks, those occurring elsewhere appear to lack the desired responsiveness.

Several reasons may account for this lack of response. There may be a perception by others that safety systems are different or more robust within their own units and therefore the same issues could not happen locally. This perception could be tested using an *ad hoc*, unannounced simulation session as described in the article. Alternatively, this could be due to lack of 'ownership', where those who have not experienced the issue directly may not appreciate the necessity of the required improvements. Additionally, resources may be employed for responding to locally identified risks, leaving no capacity for tackling latent issues that have been identified elsewhere. Finally, the unit culture may be reluctant to reflect on and challenge local practice. Encouragingly, the authors state an ambition to further their research in this area. The fact that the region as a whole has invested in such a valuable programme demonstrates a commendable commitment to improving patient safety as a network.

Join us to help improve patient safety

In collaboration with BAPM, *Infant* journal is keen to help improve patient safety and raise awareness of issues affecting neonatal patients, their families and staff by devoting a specific section to patient safety in each edition of the journal. Anyone can submit an article so if you have ideas for highlighting safety aspects to improve care, please do let us know.

If you would like to submit a patient safety article to *Infant*, please email lisa@infantgrapevine.co.uk
If you have any incidents for national learning, please contact BAPM by emailing bapm@rcpch.ac.uk