

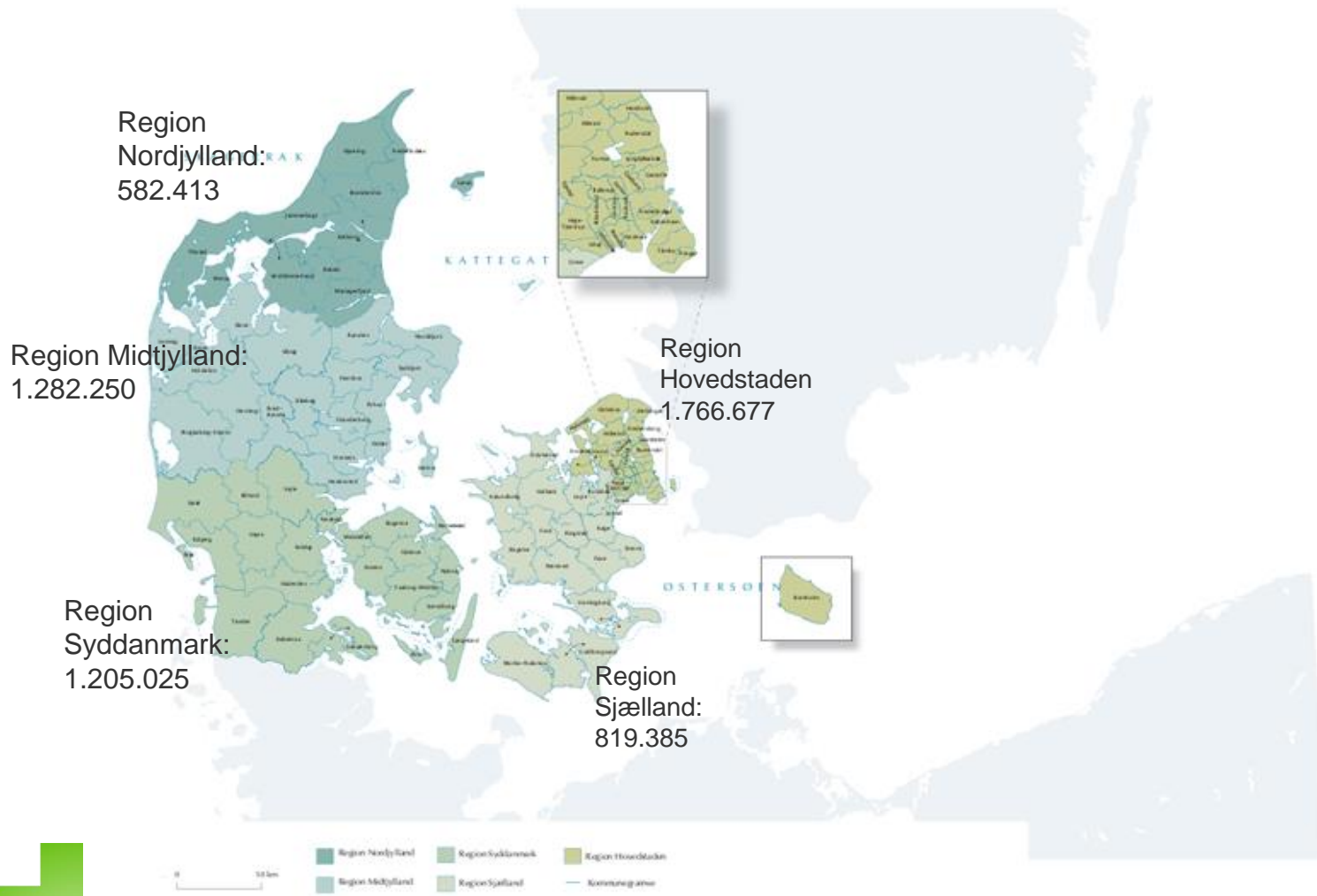
Use of the FRAM as Analysis tool in Risk Management, Mental Health Services – Capital Region of Denmark.

Presentation for the 10th FRAM workshop, June 1-3
2016 University of Lisbon, Portugal
From Safety 1 to Safety 2.

Disposition

- Presentation
- Case
- From safety 1 to safety 2: FRAM
- Action plan and effect
- Discussion

Denmark – 5 regions

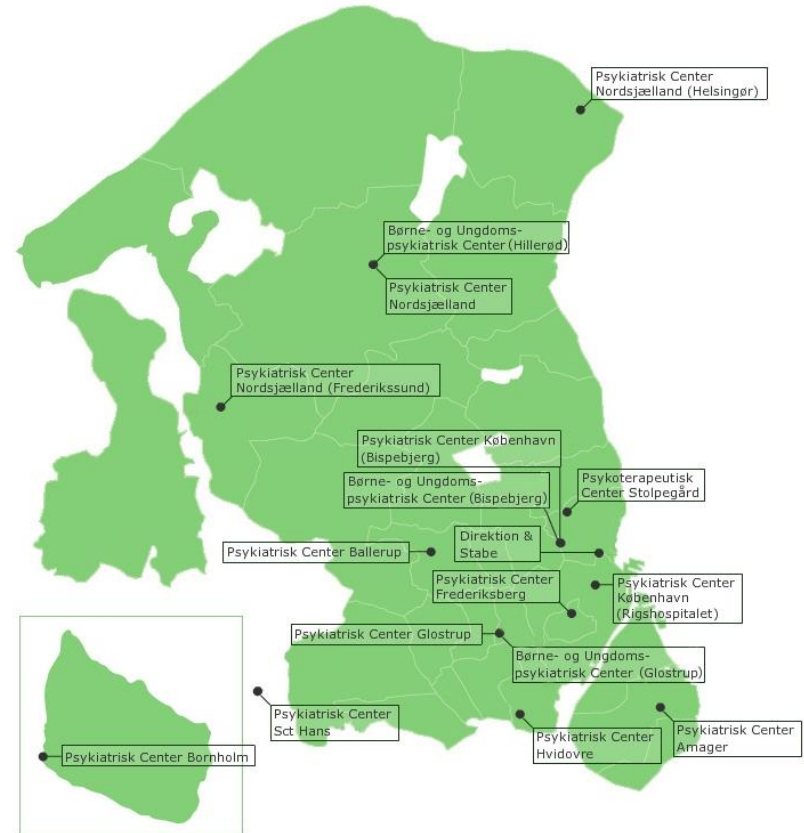


The Mental Health Service in The Capital Region

– the biggest in the country

Responsible for all mental health services in the Capital Region

- Mental Health Centres located around the region
- Approx. 5.000 employees
- Two specialities:
 - Psychiatry
 - Child and adolescent psychiatry



Is that so

- As Risk Managers we received an enquiry from the Unit for Elderly patients. Their concern was patients falling despite their many years of focusing on prevention with extended screening and nursing care plans.
- Why do patients fall anyway?

Case

A 88 year old woman, slim build, demented and with many fall episodes. The patient is hospitalized in Unit for Elderly patients. She falls and breaks her hip.

The unit already implements preventive action such as nutrition, non-slip socks, bed in low position, physical environment, appropriate medication, lighting etc.



From Safety 1 to Safety 2.

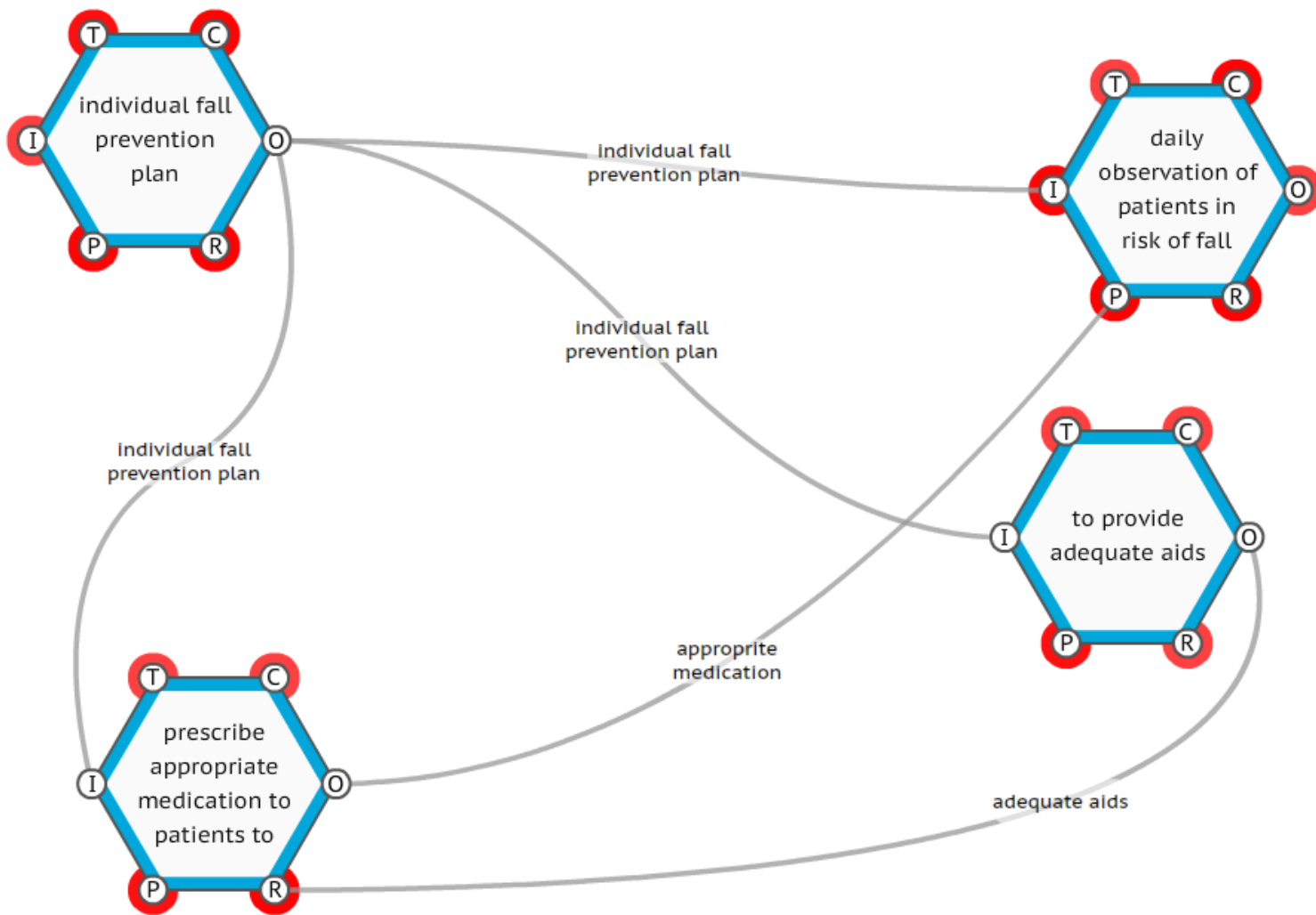
- We have for some time wanted to challenge the cause-effect premise, since many Adverse Events must be seen in a more systemic perspective, which recognizes that situations are part of a context, and that the relationship between people plays a big role.
- There is a need to look at the problem in a new perspective, and to move the focus from individual to systemic perspective.

So what

- We made an interview guide, ref. Jeanette Hounsgaard 2015, asking for input, output, precondition, resources, time and control.
- At the first meeting with the Nursing Head of Unit we presented FRAM and got data about: work as imagined, screening for risk of fall, nursing care plans of fall, organization, nursing skills, staffing, and cooperation with other healthcare professionals.

Action plan

- We carried through the analysis with the Nursing Head of Unit and the Clinical Nurse Specialist. Together we outlined the hexagons, FRAM Model Visualizer and their connections / dependences.
- Finally we described an action plan based on topics that needed to be expanded, such as focus on choice of drugs and doses to elderly persons, focus on interdisciplinary discussions of the patient's situation and supervision on the nursing care plans made by the staff.



Effect of the action plans using FRAM

- High risk medication is an integral part of fall prevention plans
- Supervision for doctors of the side effect profile of medication
- All patients are assessed by a physiotherapist for strength / balance training and aids
- Aid can be provided on weekends



Focus in a Root Cause Analysis

- The staff was busy elsewhere and could not observe the patient and thus prevent the fall.
- There is prescribed inappropriate medicine.
- Lack of therapist resources means that the patient is not strength / balance tested.
- There was not obtained appropriate aids.

Conclusion could be: The responsibility is placed with the staff and what they didn't do.

SUMMARY

- We found that it has become easier to maintain the perspective on systemic learning.
- Using FRAM offers a focus on dynamic interactions in socio-technical systems. A non linear method focused on a general perspective.
- Root Cause Analysis is best for simple cause-effect relationships. A linear method focused what and when in a specific situation.

How to avoid discussing errors?

- We continue to get feedback as follows:
The senior doctor find it difficult to see that there are any procedure / assessment errors. It is therefore doubtful whether we can learn anything from analysing the adverse event.

Questions for discussions

For us the starting point is always a serious adverse event.

- What is the FRAM model's strength to work with serious adverse events without focusing on blame?
- Can the model remove the blame from the individual?
- How can the model enhance the global understanding of the incident is not caused by one individual?
- Does the model hold the human factor related to the patient?
For example: the demented patient, the autistic patient, the unpredictable patient
- What are the limits of the model?