The Introduction of S.A.F.E.R: Safety, Action, Feedback, Evaluation & Reporting

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Introduction

Current systems for the identification of safety and quality issues in maternity are recognised to be deficient. SAFER Maternity was developed to provide a package of measures that facilitate easy identification of opportunities for improvement, collaborative case review and structured, regular staff feedback to support better care.

Background

SAFER was developed to address the concerns that existing systems for identification of opportunities for improvement are ineffective:

- Inconsistent reporting processes using the Victorian Health Incident Management System (VHIMS).
- Inadequate feedback methods from lessons learnt.
- Lack of translation into improvement in care delivery.

Conceptualised in 2016, the SAFER pilot reported here commenced in December 2017.

Methods

SAFER Maternity comprises:

1. CASE IDENTIFICATION

Cases for review are collected by a nominated SAFER representative at each morning handover meeting or via the designated email address SAFERmaternity@wh.org.au that staff are encouraged to use.

2. CASE TRIAGE & REVIEW

A Collaborative Improvement Review Group (CIRG), comprising a multidisciplinary team of midwives and obstetricians undertakes a detailed case review to identify opportunities for improvement.

3. FEEDBACK OF RECOMMENDATIONS & LESSONS LEARNT

Feedback is incorporated into 'business as usual' through:

- SAFER M&M comprises:
    1. Collaborative review meeting
    2. Midwifery peer review meeting
- CTG M&M
- SAFER Tuesday Handover Slides
- Maternity meetings slides
- SAFER maternity newsletter
- Individual reflective feedback to clinicians
- Antenatal team clinic meeting

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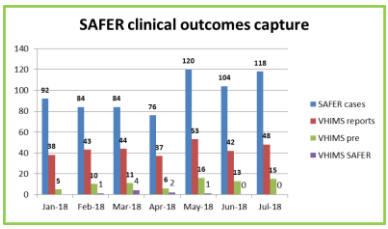
Results

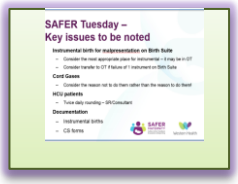
These pilot data have confirmed the utility of having a nominated clinician at clinical handovers meetings to identify cases for review. The graph below illustrates the number of cases identified through the SAFER process compared to the usual process of completing a VHIMS.



With over 50% of cases generating practice improvement recommendations, there is a widespread sense of improved issue identification. The feedback loop is well received and staff engagement with risk identification is positive. A thematic analysis and Safety Attitudes Questionnaire will follow full implementation.

SAFER: The Facts

- **678 cases identified during pilot**
- **17 review members (9 obstetric, 8 midwifery)**
- **85 cases/issues referred by staff via SAFER email**



CIRG: The Facts

- **Weekly committee meetings**
- **288 case reviews completed**
- **531 actions generated**

Discussion

SAFER Maternity is improving clinical governance. A greater understanding of risk within the maternity service has been achieved. Feedback mechanisms of case reviews and identified issues have been established and are well received.

Whilst the review processes adapted in SAFER provide an avenue for learning and development for midwives and other clinicians, the most important aspect is the innovative methods used for providing feedback and the introduction of the concept of peer clinical review to midwifery staff.

Conclusion

SAFER has been developed so that it is easily able to be translated to other areas of health. SAFER has far reaching capability as an organisational wide strategy by the nature of the collaboration in the review process which is inclusive of a broad range of clinicians who have knowledge of the women who come into the service.

Contact: SAFERmaternity@wh.org.au

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