The AHSN Network

NHS Improvement

# Nurturing a Safety Culture Across Our Healthcare System

Greater Manchester & Eastern Cheshire

Patient Safety Collaborative

Health Innovation Manchester

European Union
European Regional Development Fund

February 2019

The AHSN Network

NHS Improvement

# Jay Hamilton

## Associate Director
## Greater Manchester and Eastern Cheshire
## Patient Safety Collaborative

Greater Manchester & Eastern Cheshire
Patient Safety Collaborative

Health Innovation Manchester

European Union
European Regional Development Fund

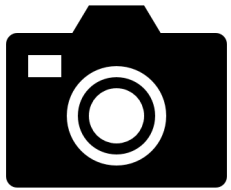
# Housekeeping

@GMEC_PSC

@healthinnovmcr

#GMECDetPat

#GMECMatNeo



# WIFI (FREE)

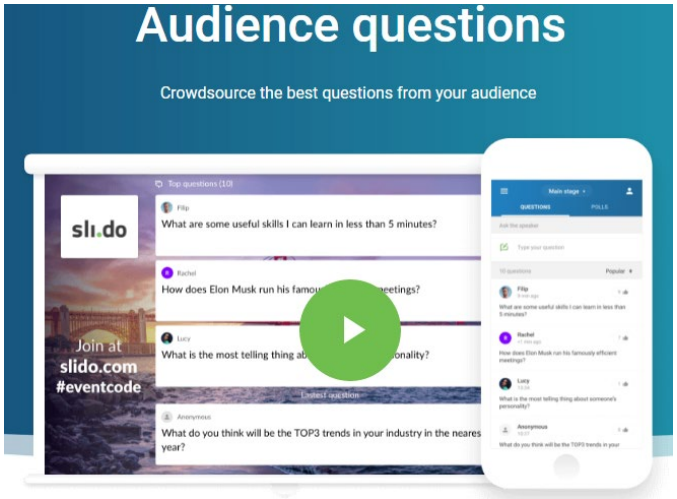
**Network name**: Kings House

**Password**: Welcome247

@GMEC_PSC

# Questions?

- **Questions for experts**




- **Questions for the PSC**


@GMEC_PSC

# ‘Slido’ details

Join at

slido.com

#G635

# Healthcare - A Human Service


The AHSN Network
NHS
Improvement
A Patient's Perspective
Jen Gilroy-Cheetham
Patient Representative
Greater Manchester & Eastern Cheshire
Patient Safety Collaborative
Health Innovation Manchester
European Union
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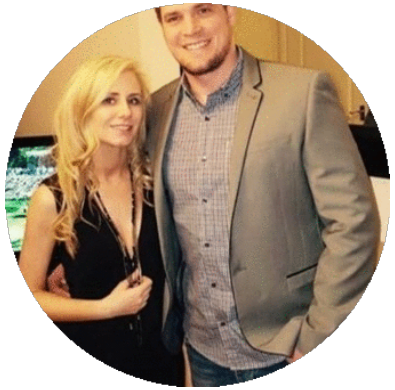
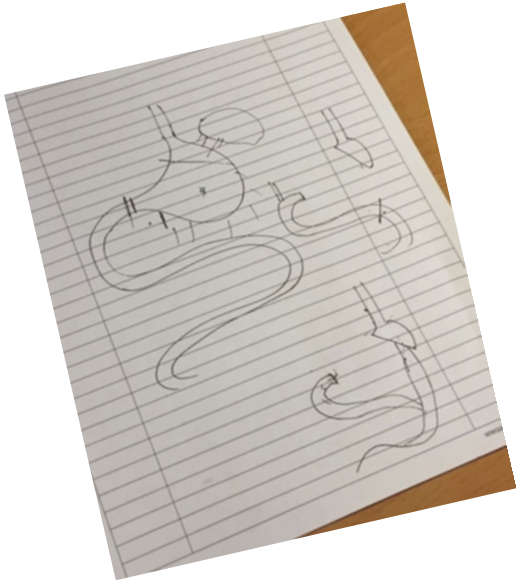
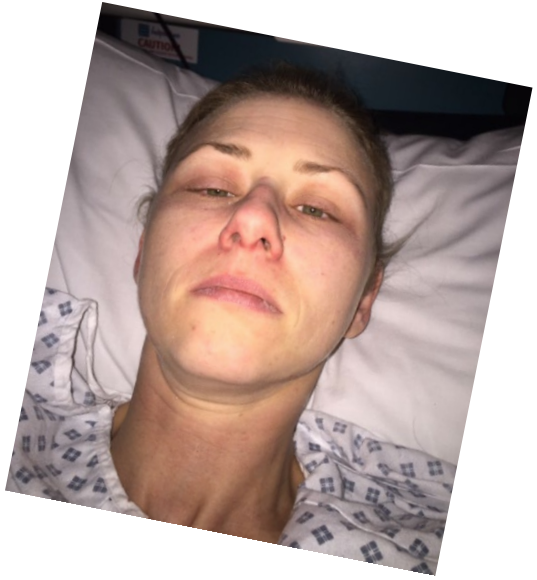
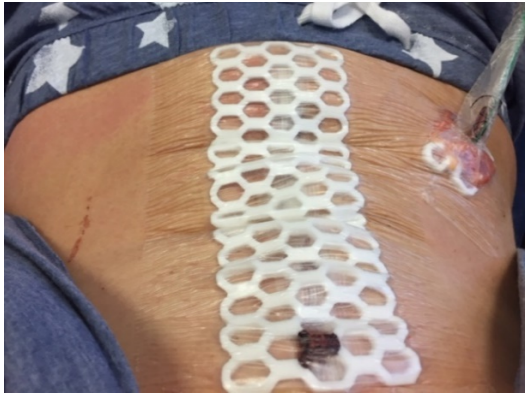


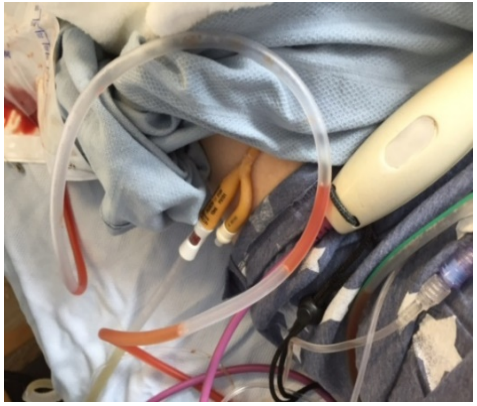
# 31st March 2017

## “Surgery”









# 28th April 2017

(Bank Holiday weekend)

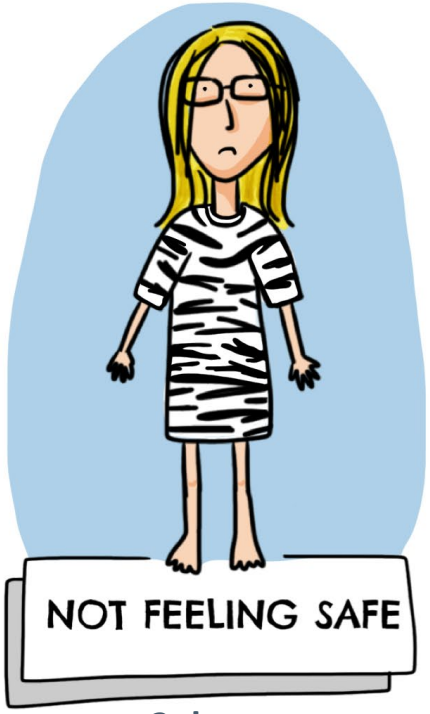
## WARD “A”

TheAHSNNet

Medicine nurse interrupted


Not enough staff

No staff introductions




3 days

Repetition

I have just had surgery
I have just had surgery
I have just had surgery
I have just had surgery
I have just had surgery
I have just had surgery
I have just had surgery
I have just had surgery
I have just had surgery

No medical staff


Patient alarms ringing

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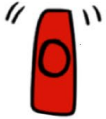
# 2nd May 2017

(Tuesday after Bank Holiday weekend)

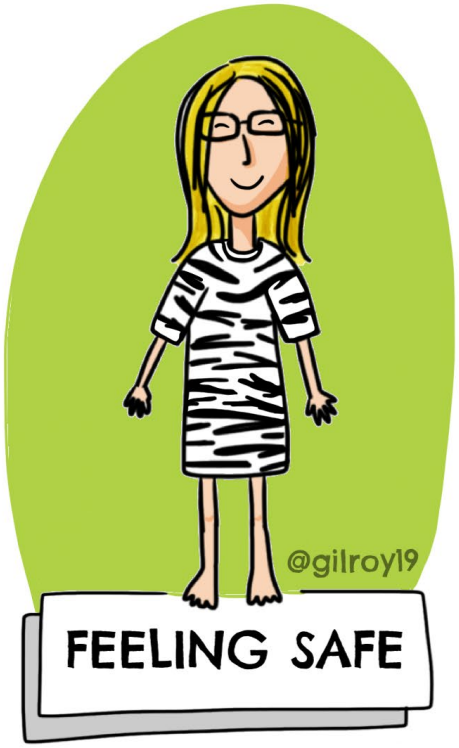
# Ward “B”

Right medicines
Nurse not interrupted

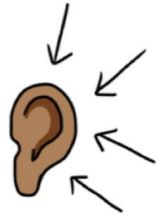



Buzzers were answered

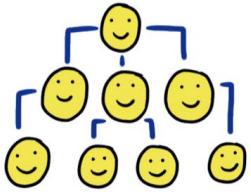
I knew the staff names
and their roles



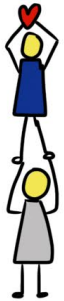

23 days



Listened to
Feelings acknowledged



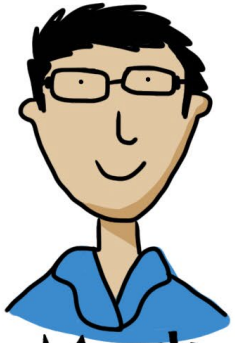
It was clear who
was in charge of my care



Staff worked as
a team

sketchnote by @krimaitis

# Little things that make the big difference….



**Mark**

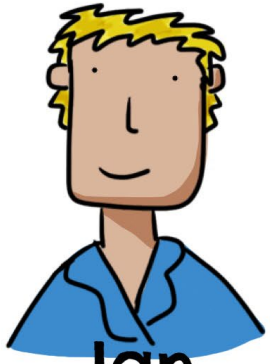
polite, #hellomynameis

**Eva**

gave me a commode
when she knew I was weak

**Donna**

made time to talk



**Ian**

made me a cup of tea
when he knew I hadnt
drank much

**Kate**

went out of her way
to get me a pillow

**Vida**

treated me as a human
gave me control of my care

@gilroy19

sketchnote by @krimaitis

## Sebastian

kept patients laughing and smiling, encouraged patients to try food

## Kieran

I couldn't of coped without him, he held my hand throughout it all

## Surgeon

sat next to me having a chat not on ward round

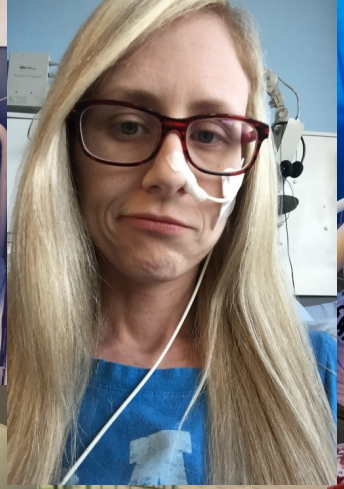
## Gemma

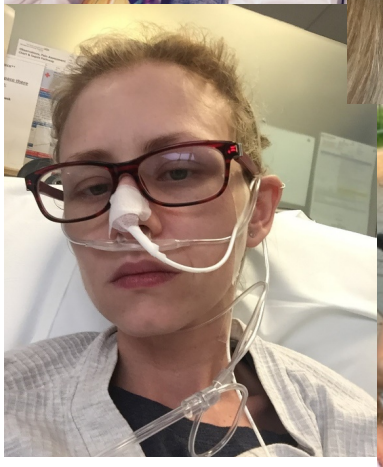
## Tom

## Angela

## Megan

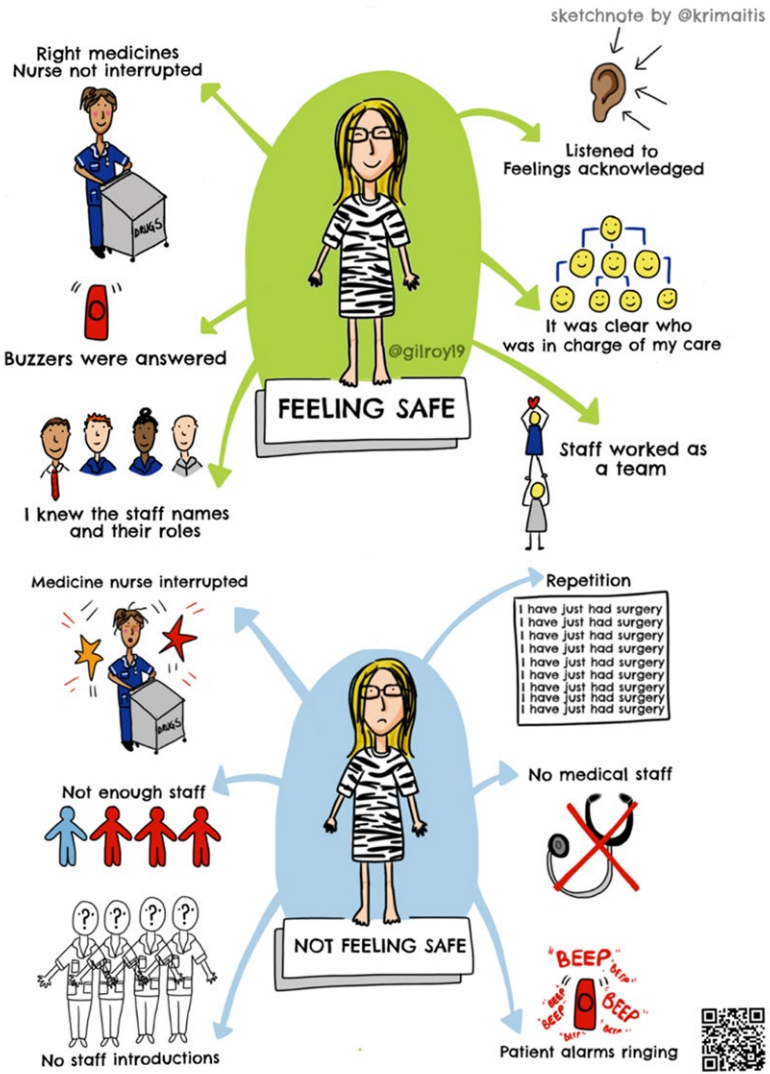
ALL caring nurses - very very attentive, always smiling and treated patients as humans





iNNOVATION AGENCY
Academic Health Science Network
for the North West Coast

NHS

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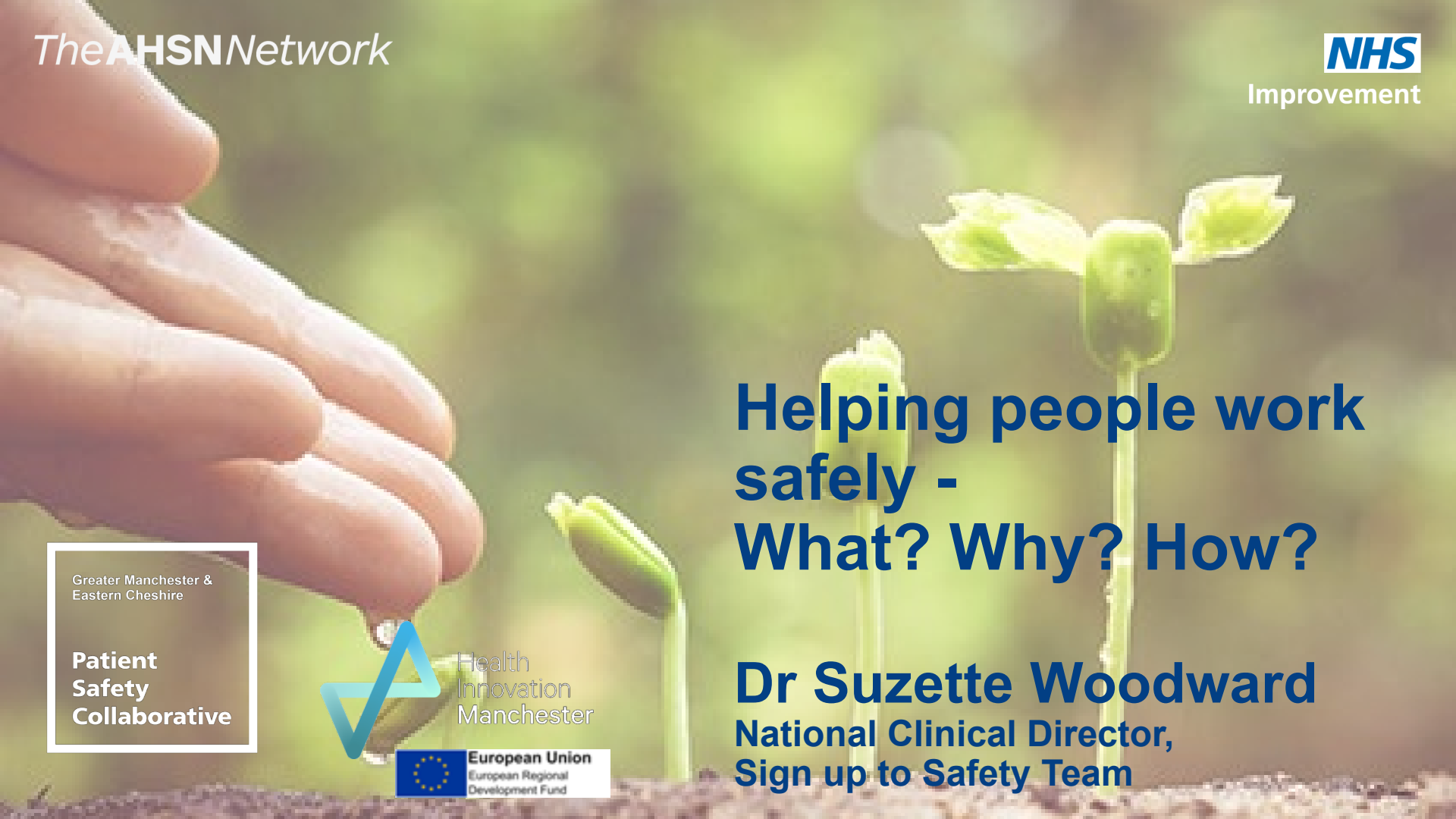
# Thank you

@gilroy19

https://wordpress.com/view/reflectionsfromwithin.blog




# Helping people work safely - What? Why? How?

**Dr Suzette Woodward**
National Clinical Director,
Sign up to Safety Team

# Three things we need to do now

1. Integrate safety I with safety II
2. Urgently tackle the blame culture
3. Care for the people who work across health and social care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# 1

# Integrate safety I with safety II

# Safety I principles

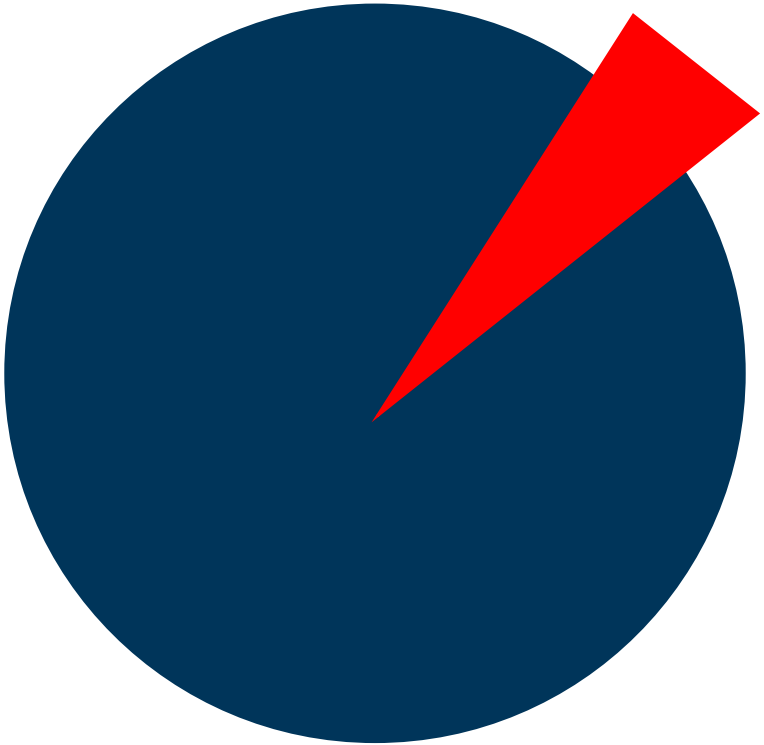
- Capture and investigate everything that goes wrong – known as ‘incidents’
- We will know the truth about these incidents if we study them and they must have ‘root’ causes which can be found and fixed
- All incidents should be preventable

# Safety I – issues

- Safety I is reactive and with the amount of incidents being reported learning is superficial
- Safety I aim is to increase the number of incidents reported
- Safety I is tackled with a primarily analytical approach


HARM
HARM
HARM
HARM
HARM
HARM

# Why only look at what goes wrong?



10 / 90

## Safety I

## Safety II, Learning from Excellence, Appreciative Inquiry

Never events, significant and serious incidents, deaths

Most incidents and accidents

Normal day to day performance

Exceptional performance

- Our decisions and actions in the main work ok but sometimes they combine in unexpected and emergent ways
- We tend to adapt, adjust and stretch to make things work
- We strive to create order in a system that is fundamentally disordered and ‘imagined from afar’

- If people adjust what they do to match the situation and conditions they work in

- Then…performance variability is inevitable and necessary – study and celebrate this

Erik Hollnagel

# Safety II

- Help people succeed under varying conditions
- Understanding ‘work as done’ in order to prevent things from going wrong and use design to change the system
- Understand the everyday in order to replicate and optimise what we do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work as done

versus

work as imagined

work as prescribed

# What should we do?

- Study on all forms of work and all outcomes
- Learn about not only how things go wrong or well but as much on ‘how things go’
- The aim is to understand the whole picture and to understand how the system is functioning everyday

# Change the language
# Change the mindset

| | |
|---|---|
| Patient Safety | Working Safely |
| Human Error | Performance variability |
| Zero harm | Natural variation |
| Improvement | Strengthen |
| Violations | Adjustments |

# The balance

Safety I

Reduce the number of things going wrong

Safety I & II

Help people to succeed under varying conditions

Safety II

Increase the number of things going right


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People make countless adjustments during their work

Most of these lead to success, some lead to failure

This is just work

Take the blame out of failure


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# 2

# Urgently tackle the blame culture

# Defined by one bad day

- When something has gone wrong ..
  - it is probably true to say it has gone right many times before ..
  - and that it will go right many times in the future
  - and yet people are judged by one error or incident for the rest of their careers


© Alistair Heap

# Conditions



- Returned from 14 months maternity leave
- No formal induction
- Unaware of any changes to policies
- Not enough doctors on the rota
- Interrupted morning handover
- Inexperienced staff

# Ongoing conditions throughout the day

- Bleeped incessantly
- Dashing to the nearest phone to answer the bleep
- Constant distractions
- Running up and down flights of stairs
- Covering all highly skilled technical procedures
- IT systems failure

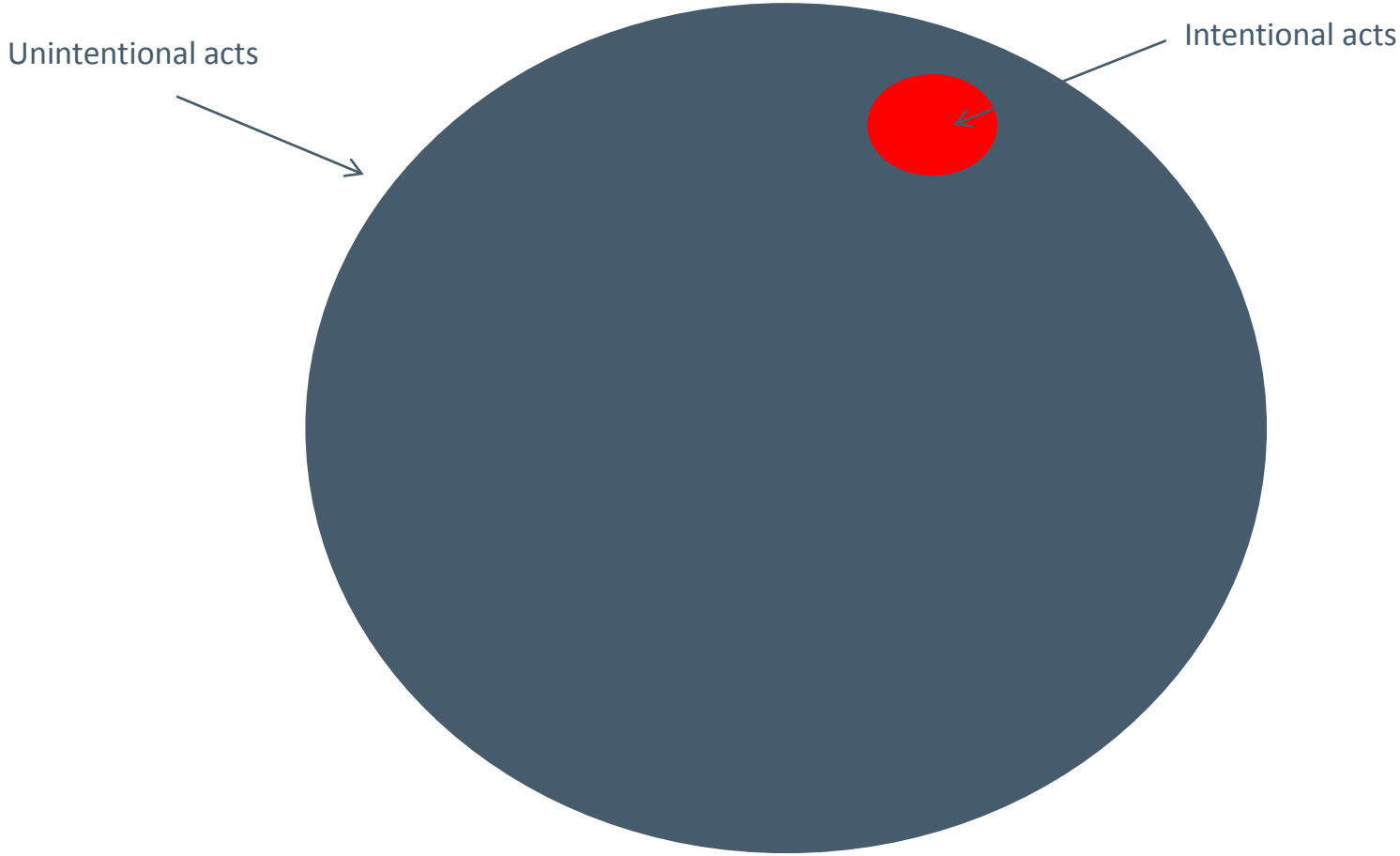
- Should we remove people from practice who work hard but are so physically and mentally exhausted by their working conditions that they fail to make a sound professional judgement?

- Should they be deleted from the register for making mistakes that are a result of being so overworked and under-resourced that they cannot provide the care that is safest, best and most appropriate for their patient?

- How many of us would survive the microscopic scrutiny of our actions on one of our less successful days when things could or should have gone better?

- Pursuing justice will always produce truths and lies, losers and winners, adversaries and supporters

- By treating error as a crime, we ensure that there will always be losers whatever the outcome


Unintentional acts
Intentional acts

# Restorative Just Culture

- People are not the problem and usually the solution – when something goes wrong ask….

  - Who was hurt?
  - What do they need?
  - Whose obligation is it to meet the need?

Sidney Dekker

# Restorative Just Culture

**RESTORATIVE JUST CULTURE CHECKLIST**

Restorative Just Culture aims to repair trust and relationships damaged after an incident. It allows all parties to discuss how they have been affected, and collaboratively decide what should be done to repair the harm.

**WHO IS HURT?** — ACKNOWLEDGED: NO / YES

*Have you acknowledged how the following parties have been hurt:*

- **First victim(s)** – patients, passengers, colleagues, consumers, clients
- **Second victim(s)** – the practitioner(s) involved in the incident
- **Organisation(s)** – may have suffered reputational or other harm
- **Community** – who witnessed or were affected by the incident
- **Others** – please specify

**WHAT DO THEY NEED?** — EXPLORED: NO / YES

*Have you collaboratively explored the needs arising from harms done:*

- **First victim(s)** – information, access, restitution, reassurance of prevention
- **Second victim(s)** – psychological first aid, compassion, reinstatement
- **Organization(s)** – information, leverage for change, reputational repair
- **Community** – information about incident and aftermath, reassurance
- **Others** – please specify

**WHOSE OBLIGATION IS IT TO MEET THE NEED?** — IDENTIFIED: NO / YES

*Have you explored the needs arising from the harms above:*

- **First victim(s)** – tell their story and willing to participate in restorative process
- **Second victim(s)** – willing to tell truth, express remorse, contribute to learning
- **Organisation(s)** – willing to participate, offered help, explored systemic fixes
- **Community** – willing to participate in restorative process and forgiveness
- **Others** – please specify

**READY TO FORGIVE?** — NO / YES

*Forgiveness is not a simple act, but a process between people:*

- **Confession** – telling the truth of what happened and disclosing own role in it
- **Remorse** – expressing regret for harms caused and how to put things right
- **Forgiveness** – moving beyond event, reinvesting in trust and future together

**ACHIEVED GOALS OF RESTORATIVE JUSTICE?** — ACHIEVED: NO / YES

*Your response is restorative if you have:*

- **Moral engagement** – engaged parties in considering the right thing to do now
- **Emotional healing** – helped cope with guilt, humiliation; offered empathy
- **Reintegrating practitioner** – done what is needed to get person back in job
- **Organizational learning** – explored and addressed systemic causes of harm

Public Domain. By Professor Sidney Dekker—Griffith University, Delft University and Art of Work. sidneydekker.com

Sidney Dekker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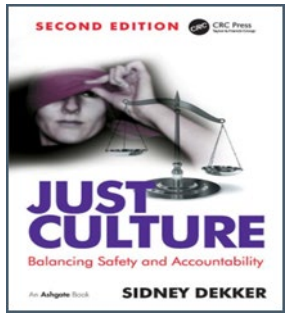
# The story of Mersey Care

## Creating a restorative learning culture

## http://sidneydekker.com/just-culture

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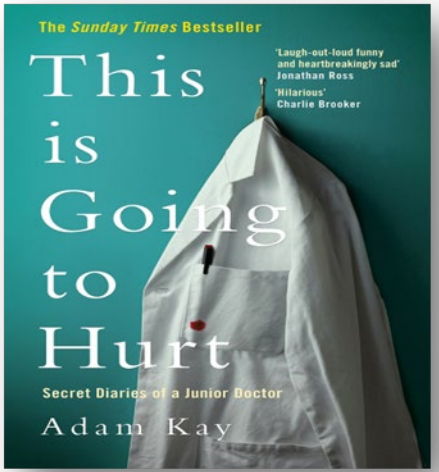
# 3

# Care for the people who work across health and social care

"IT IS NOT JUST
ABOUT SAFETY
IT IS ABOUT
EVERYTHING"

CARL HORSLEY
@HorsleyCar


UNACCEPTABLE CONDITIONS
STAFFING
MESS
HUNGER
FATIQUE
TARGETS




# Immediately address:

- Fatigue
- Hunger
- Memory loss
- Distractions
- Shame and grief

- Sort out breaks and make it acceptable to eat and drink
- Make dedicated time for people to talk to each other and have someone to turn to
- Provide places for people to sleep (even micro sleeps have been proven to work)
- Its ok to laugh and have fun

# Stop being rude to each other

- Minor incivility can lead to..
  - an immediate loss of cognitive capacity
  - reduction in the quality and time of people's work
  - potentially knock on impact on service users
  - an impacts on onlookers

CIVILITY SAVES LIVES

civilitysaveslives.com
@civilitysaves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# Be kind

## People see kindness as weakness, but it's the most unbelievable strength if you use it in the right way


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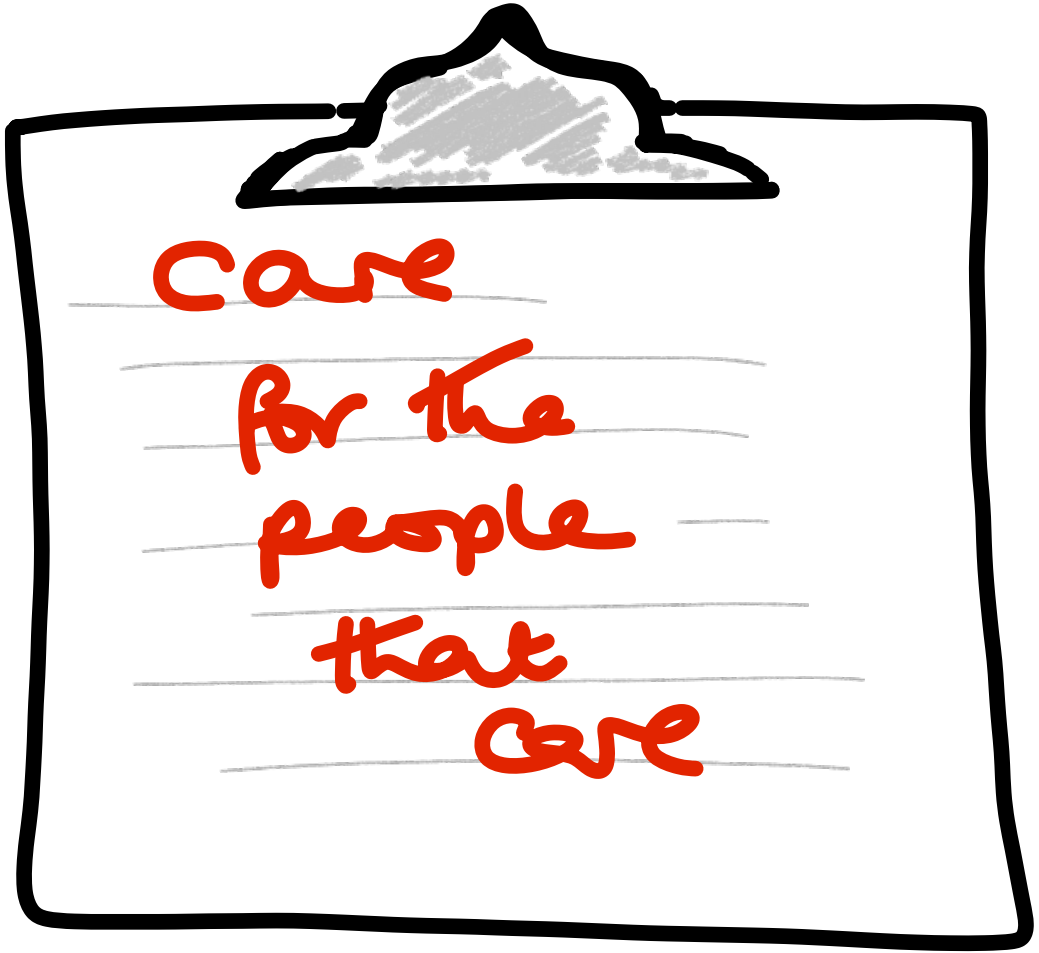
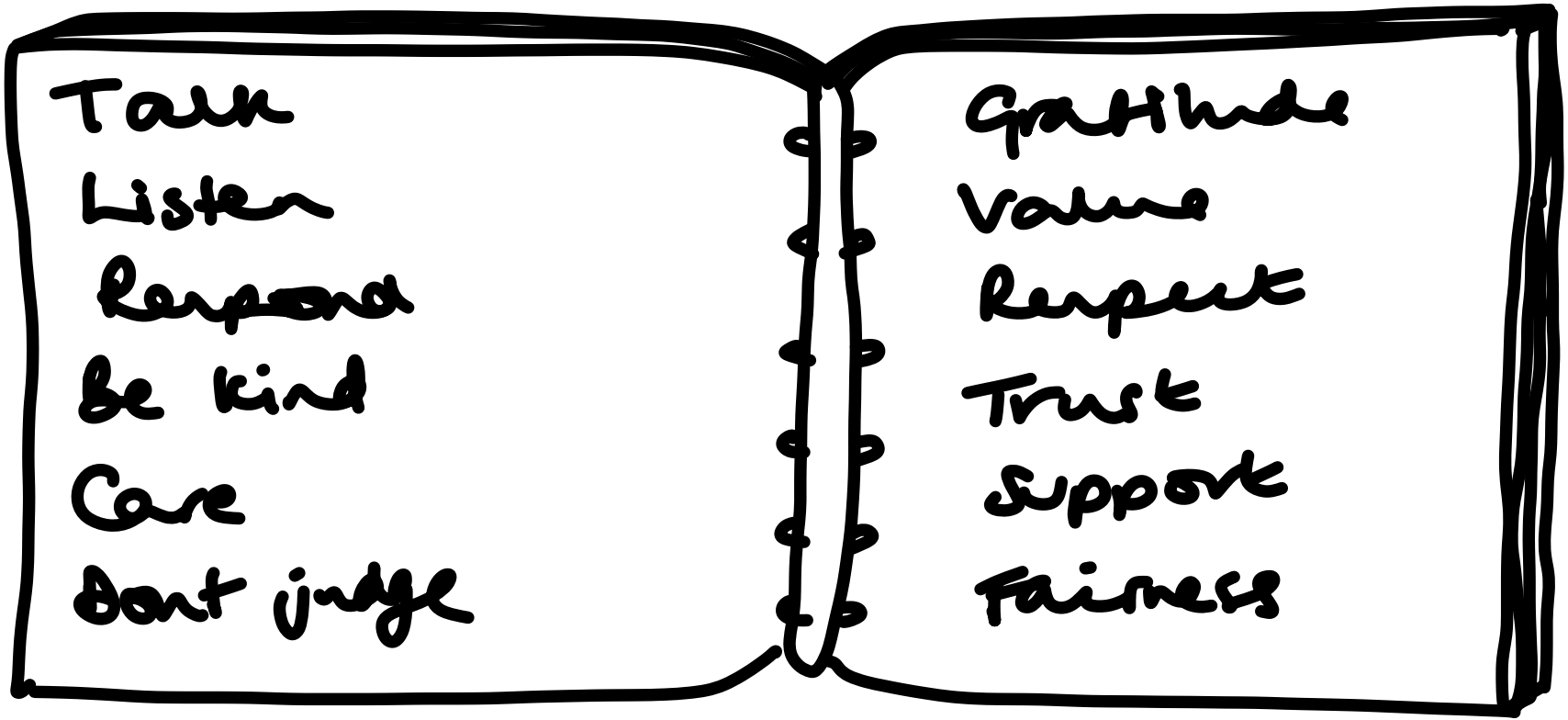
# Learning from excellence –

## highlights success in an environment where the prevailing approach to learning is to highlight failure

Dr Adrian Plunkett

learning from excellence


care
for the
people
that
care


Talk
Listen
Respond
Be kind
Care
Dont judge
Gratitude
Value
Respect
Trust
Support
Fairness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# Never forget how powerful it is to simply say ‘Thank you’


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# Thank you

www.signuptosafety.org.uk

www.suzettewoodward.org.uk

@suzettewoodward @signuptosafety


TheAHSNNetwork
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Supporting Change In Workplace Culture through Engagement
Sasha Wells
Maternity Improvement Advisor
NHS Improvement
Greater Manchester & Eastern Cheshire
Patient Safety Collaborative
Health Innovation Manchester
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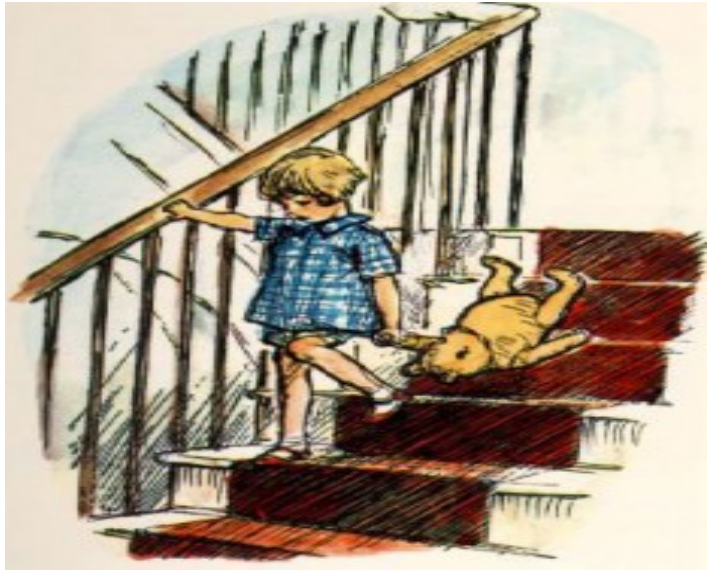
# What was the culture?

- Hierarchical
- Fear
- Covert Bullying
- Learnt behaviours
- Easier to Keep the Status Quo
- Unconscious Incompetence
- The Bay way



*Here is Edward Bear coming downstairs now, bump, bump, bump, on the back of his head, behind Christopher Robin. It is, as far as he knows, the only way of coming downstairs, but sometimes he feels that there really is another way…if only he could stop bumping for a moment and think of it!*
A. A. Milne

# How did it change?

- Leadership at all levels.
- Women's voice and views at the centre of everything. How and why?
- Active listening.
- Workshops.
- Professional integrity.
- Openness and Honesty.
- Do as you say, be consistent, do the right thing always.
- Staff engagement and involvement. Invest in teams compassionately.
- Ideas boxes.
- Walkarounds : Day and Night.
- Support. What is that
- Behavioural standards framework.
- FTSG.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Eastern Cheshire
Patient
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Health
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Manchester
European Union
European Regional
Development Fund

ImproveWell.

A digital solution focused on Quality Improvement (QI) which empowers frontline staff to drive change

AQuA
Advancing Quality Alliance

North West NHS organisation providing quality and safety improvement education and support at all levels of the health and care system.

AutumnCare

An innovative software company specialising in electronic care management systems for elderly care

SAFE STEPS
PREVENTING FALLS. IMPROVING LIVES

A secure digital risk assessment tool - built to NHS Digital standards - which provides a standardised and effective approach to falls risk management

Ambidect

Specialists in delivering learning and information where it's needed, when it's needed, and on any device.

BATHERTON HEALTHCARE

UK based distributor for a range of innovative healthcare products and the UK's exclusive distributor for 'Gloup' - the medication swallowing gel.

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# Nurturing a Safety Culture Across Our Healthcare System

Greater Manchester & Eastern Cheshire

**Patient Safety Collaborative**

Health Innovation Manchester

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February 2019


TheAHSNNetwork
NHS
Improvement
Culture Café
60 seconds
'Host Elevator Pitch
Challenge'
Greater Manchester &
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# Human Factors in the Healthcare Setting


## Peter Ledwith

Human Factors Programme Lead, AQuA (Advancing Quality Alliance)


Greater Manchester & Eastern Cheshire

Patient Safety Collaborative

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# Another Aviation "Expert"

# September 2nd 2006
# Nimrod XV230

# Drawing Parallels

- The merging of teams and organisations produced confusion and lack of standardisation
- The lack of an accountable officer
- Lack of understanding where and with who appropriate levels of risk should be held
- Inefficient and overly complicated error reporting systems
- Increasing levels of distraction
- Priorities moved towards business and targets, at the expense of functional values such as safety.

AQuA
Advancing Quality Alliance

NHS

# What are Human Factors and why are they important?

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# Human factors in healthcare

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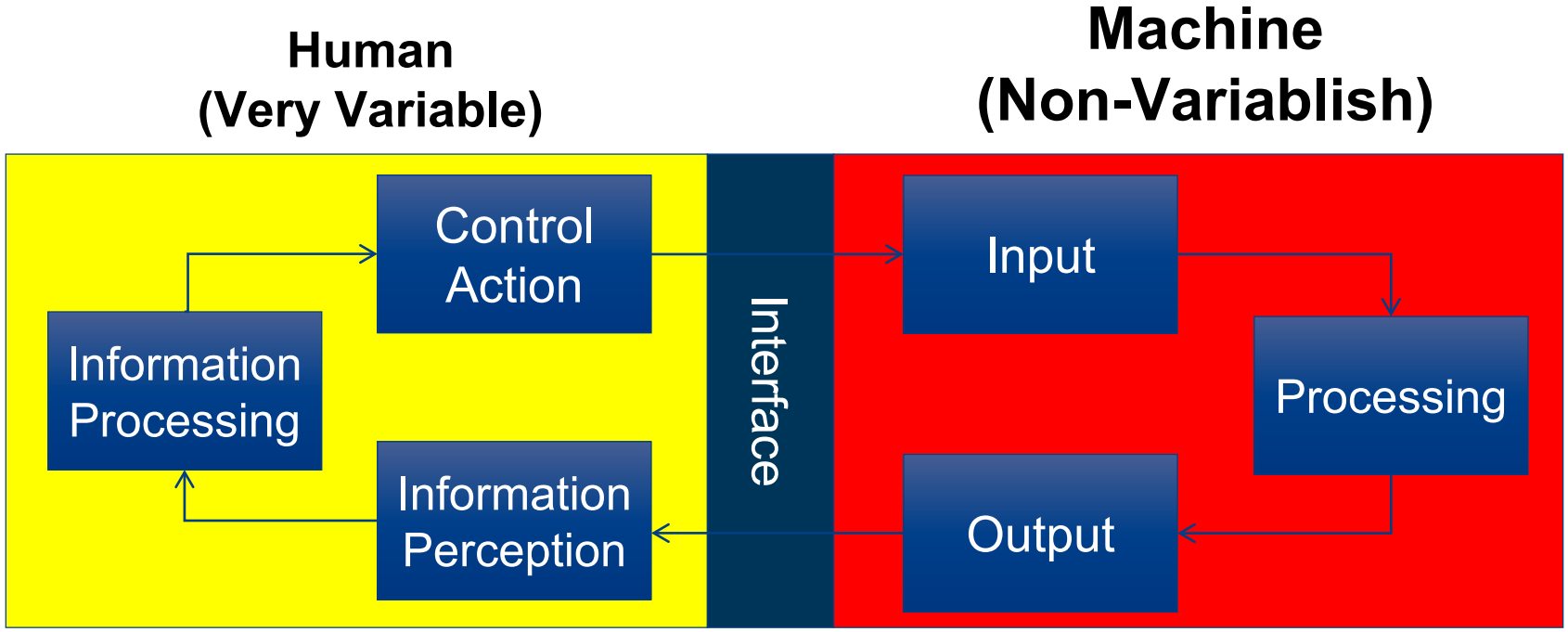
"enhancing clinical performance through understanding of teamwork, tasks, equipment, workspace, culture and organisation and their **effects on human behaviour and abilities** and application of that knowledge in clinical settings"

Dr Ken Catchpole

# An Industry Systems Model
## Does It Fit Healthcare?



# An Integrated Model for Human Factors


Charles Haddon-Cave QC
(2009)

# Exercise

AQuA
Advancing Quality Alliance

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# Error Causation

## "We Need to Write a Policy!!"

# Compliance

Now we need to complete the needle & swab count

OK – but how can we do the SIGN OUT if the surgeon has left ?

I am needed next door to start the anaesthetic for the next patient. SOMEONE ELSE can do Sign Out

I need ALL the boxes ticked

**GOAL CONFLICT**

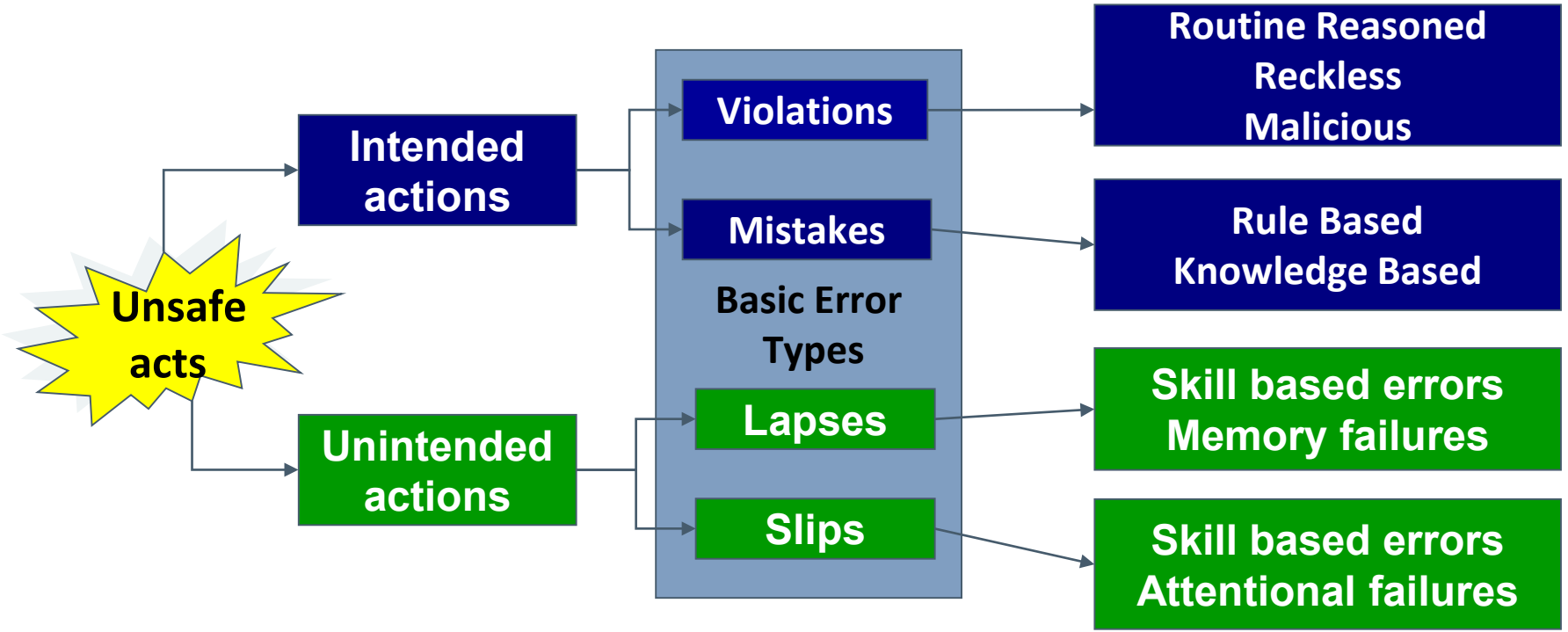
Need to check in with my pa to confirm tomorrow's schedule.. NO TIME for Sign Out


| Compliance | 100% | 100% | 60% |
|---|---|---|---|

# Causes of Failure

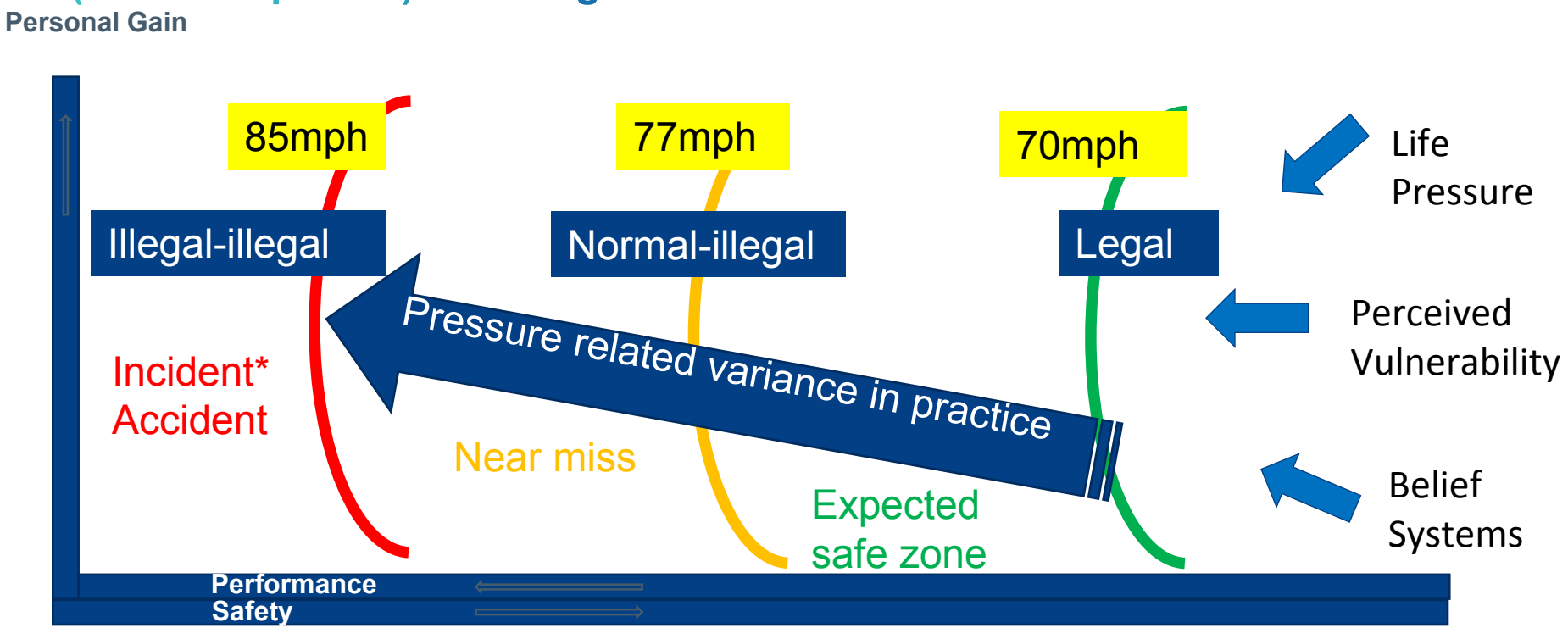
- Latent conditions
  - Organizational failures & systems design
  - Present in all systems for long periods of time
  - Increase likelihood of active failures
- Active Failures
  - Errors at the time of the event
  - Unsafe acts (errors and violations) committed at the “sharp end” of the system
  - Have direct and immediate impact on safety, with potentially harmful effects

# “Active Failures”



# Understanding Optimising violations

## Amalberti – Model of migration and transgression (Risk acceptance) – Driving version



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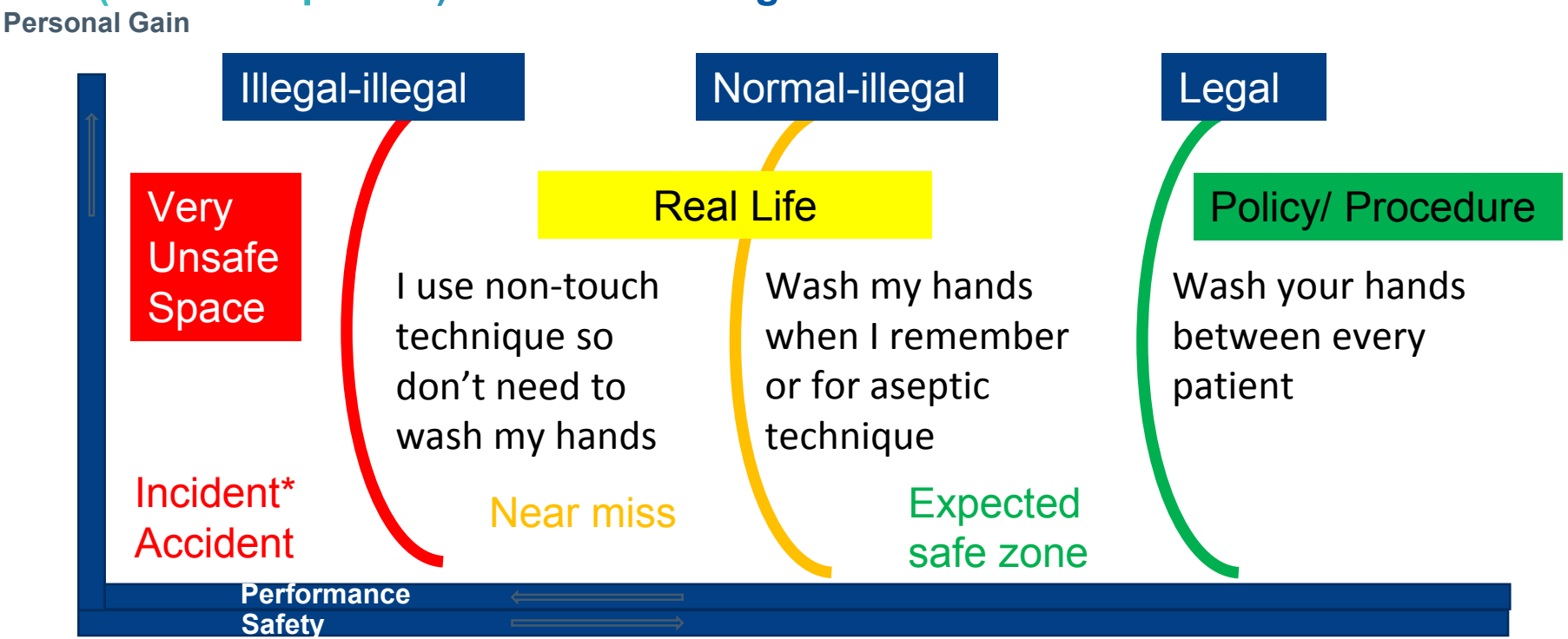
# Understanding Optimising violations

NHS Improvement

## Amalberti – Model of migration and transgression (Risk acceptance) – Hand washing



# Desktop Exercise

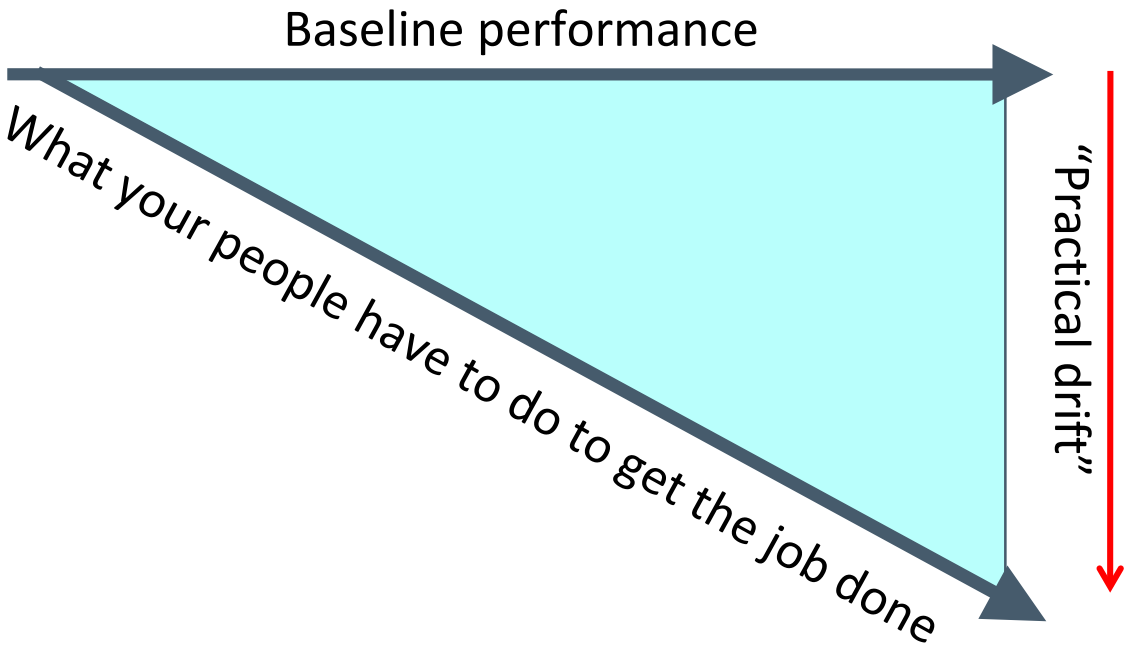
## (Consider and discuss policy violations in your work environments)

# Violations and Culture

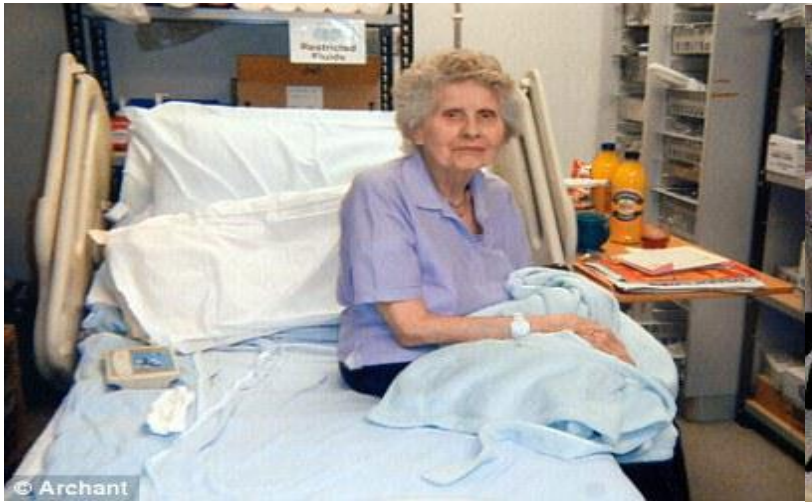
- Normalisation of deviance occurs in systems where there is variation and complexity
- Once normalised behaviours/transgressions migrate to extremely unsafe states

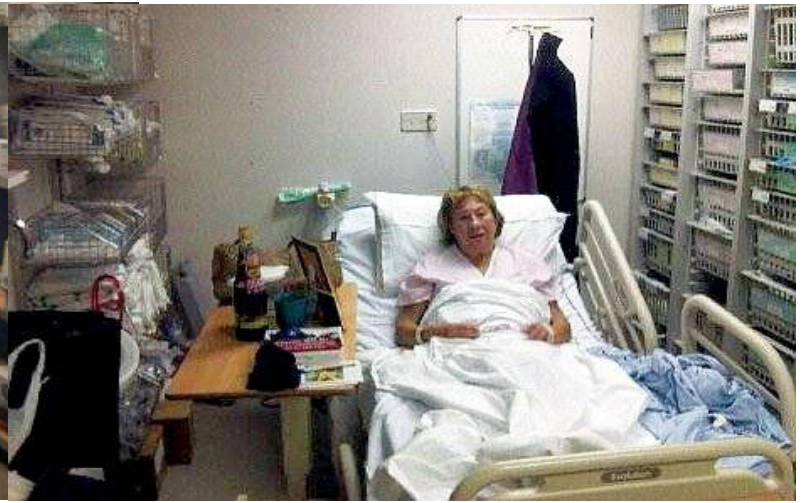
# Understanding what people have to do to get the job done





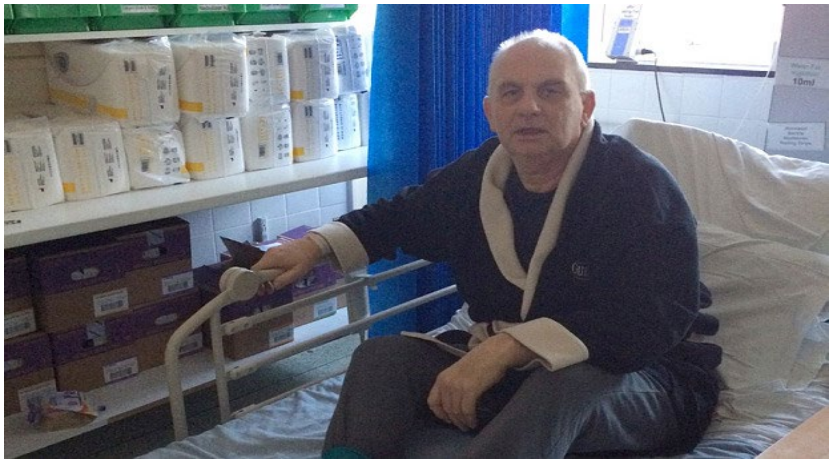
# How Does This Happen?

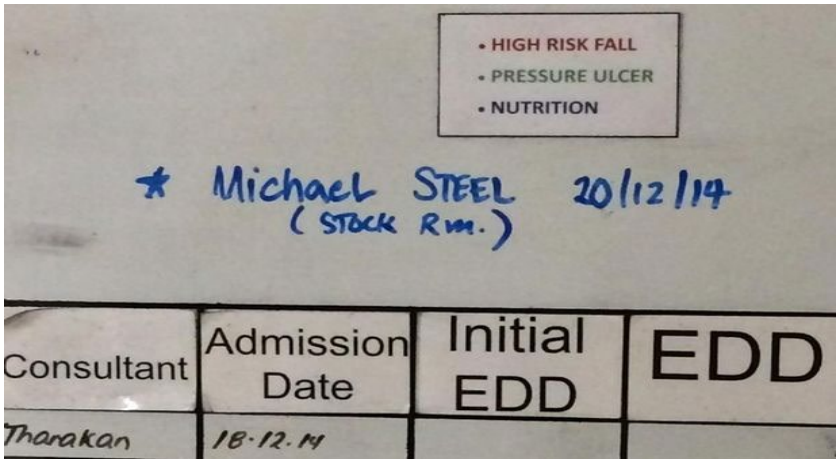


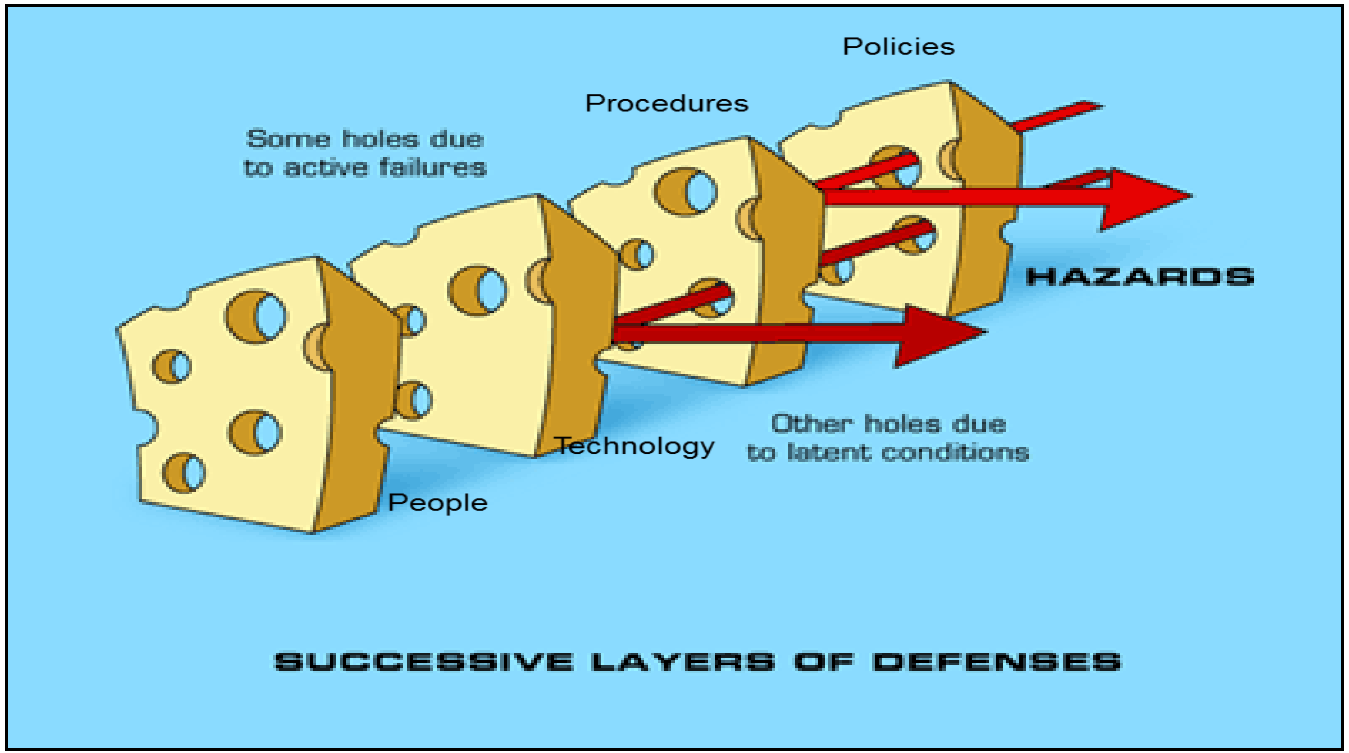
# Repeatedly!



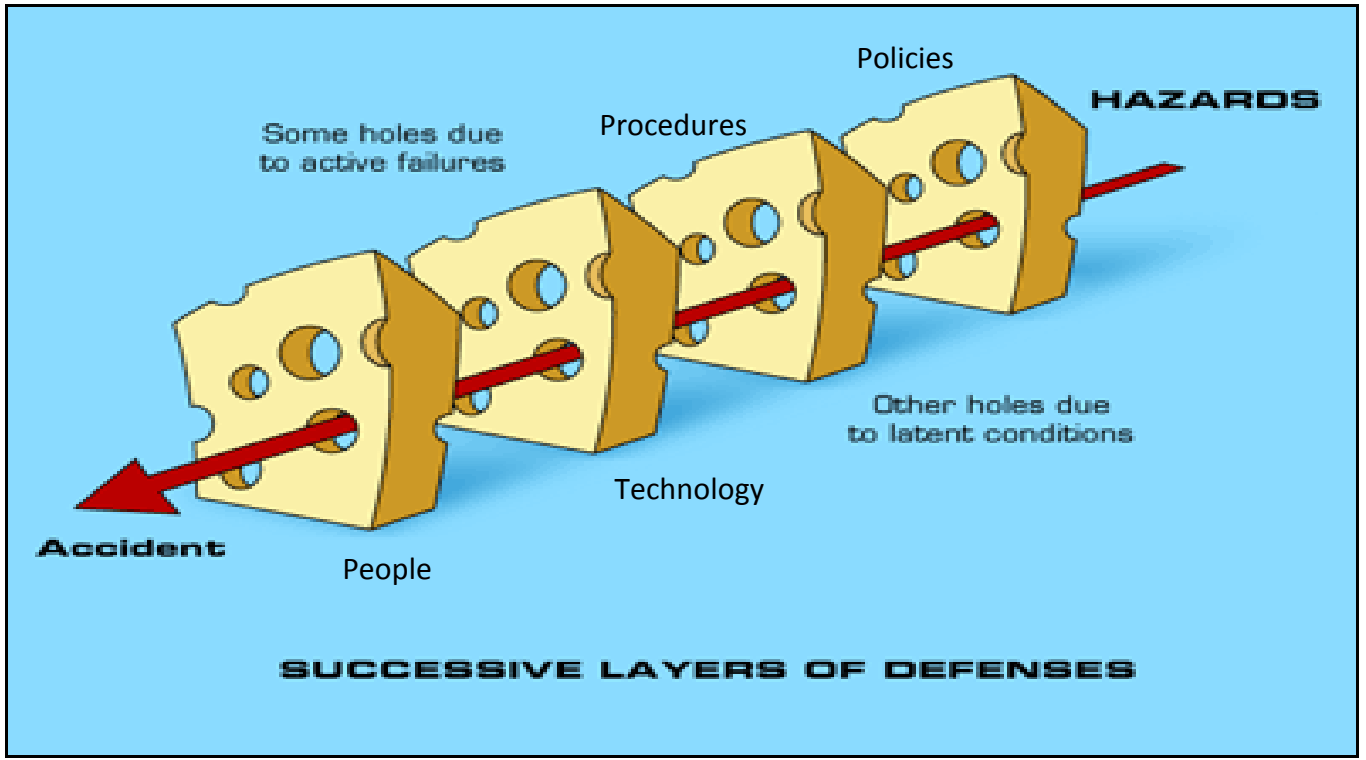



• HIGH RISK FALL
• PRESSURE ULCER
• NUTRITION
* Michael STEEL 20/12/14
(STOCK Rm.)
Consultant
Admission Date
Initial EDD
EDD
Tharakan
18.12.14

# Swiss Cheese Model of Error Causation



# Swiss Cheese Model of Error Causation



# What Motivates Intent?

# We would never do something that stupid!



# May that's a one off?

# ...and Tidy may not be Safer!



# Performance Influencing Factors (PIFs)

## Organisational

- Complex Systems
- Inadequate Education/Training
- Confusing Data
- Unavailable or Inaccurate Procedures
- Poor Access Equipment
- Lighting
- Noise

## Mental

- Memory
- Perception
- Concentration
- Stress
- Complacency
- Knowledge
- Attitude
- Awareness
- Motivation

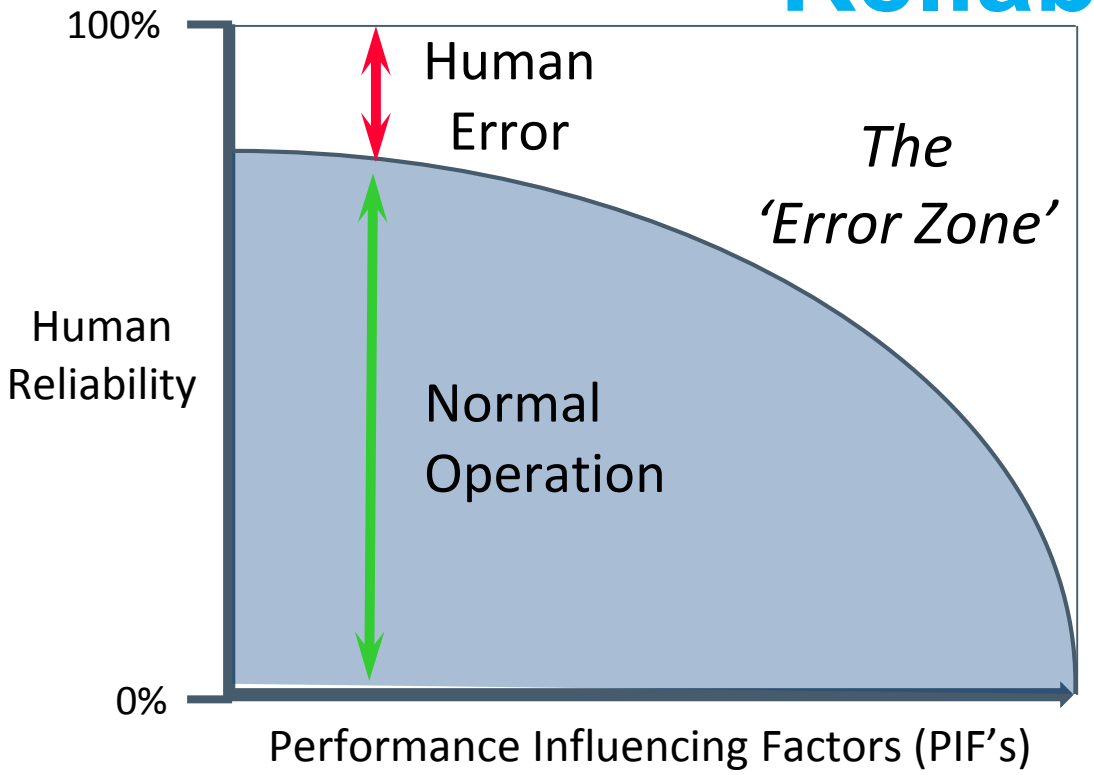
## Physical

- General Health
- Vision
- Substance Abuse
- Skills
- Size/Agility
- Hearing
- Medication

## Organisational

- Poor Ergonomics
- Communication
- Poor Teamwork
- Time Pressure
- Distraction
- Fatigue
- Excessive Workload
- Climatic Conditions
- Temperature

# The Human Reliability Curve



# Beliefs About Adverse Incidents

## Person Centered Approach

- Individuals who make errors are careless, at fault and reckless
- Blame and Punish
- Remove individual and improve quality/safety

## Systems Centered Approach

- Poor organisational design sets people up to fail
- Focus on the system rather than the individual
- Changing the system improves safety

# A Systems Approach

- Systems Approach:
  - Humans are fallible and mistakes are inevitable
  - The best of people can make the worst of mistakes
  - Errors are often shaped and provoked by upstream (system) factors
  - Change working conditions and system to prevent / reduce error
  - Importance of education and training (The human **cannot** be trained out of people)
  - Learn from errors and prevent future errors
  - Recognise patterns in errors and failures

# NHS Traditional Approach To Error Reduction

Add more boxes to be ticked irrespective of the frequency of the error type

=

Additional complexity and reduced compliance

and

**Increased risk.**

AQuA
Advancing Quality Alliance

NHS

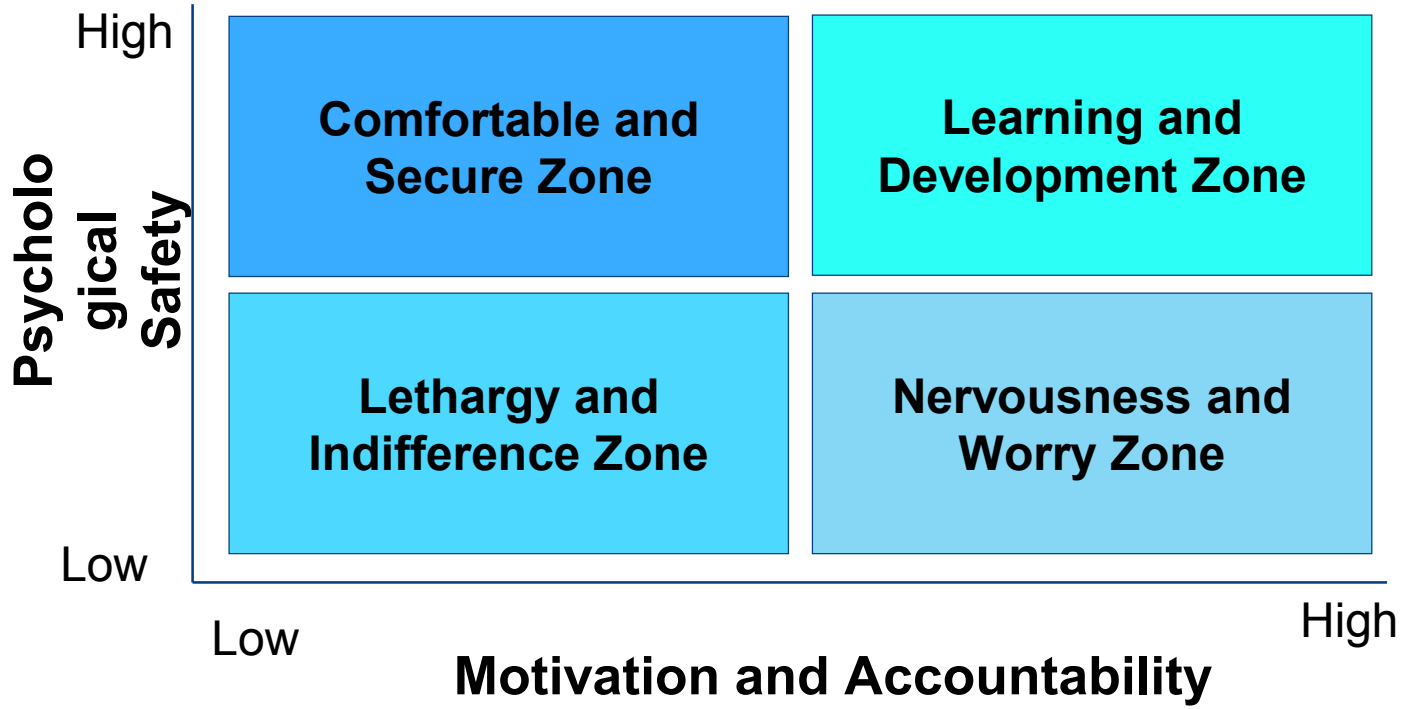
# Error Reporting

# CQC Requirement

The Care Quality Commission (CQC) assesses a trust's speaking up culture during inspections under Key Line of Enquiry 3 as part of the well-led question.

# Heinrich's Law
# The Error Iceberg

# Psychological Safety




'Reward' me and I will tell you what we have to do to get the job done
I will submit 2 reports a year

# Silence Kills


- 400 - 1200 more patients died between 2005 and 2008 than would be expected for this type of hospital.
- Terry Deighton / Julie Bailey raised concerns

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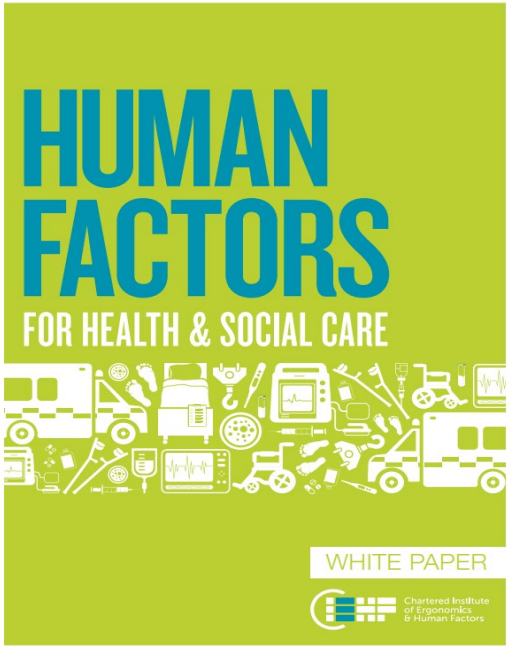
# The Three Ages of Reporting

NHS Improvement

# CIEHF October 2018 White Paper





**“Understanding human factors and ergonomics is a key element of building a better patient safety system”**


Peter.ledwith@srft.nhs.uk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NHS
Improvement
Expert Panel Q&A
Amanda Risino
Managing Director, Health Innovation Manchester
Greater Manchester & Eastern Cheshire
Patient Safety Collaborative
Health Innovation Manchester
European Union
European Regional Development Fund


NHS Improvement

## Delegates will receive a post-event email to include:

- Link to PSC event webpage and resources
- Survey Monkey Post-event Evaluation


## Don't Forget! Complete a question card if you have any questions or requests for assistance from:

PSC@healthinnovationmanchester.com