

## NHSI Consultation on Patient Safety – Response

### Q1. Principles

#### A. Do you agree with these aims and principles? Would you suggest any others?

IPEM, in general, agrees with the aims and principles as proposed. The statement *“We also need to empower NHS staff and patients to identify and then act on those areas where we can improve.”*

on page eight of the consultation is important as it is essential that staff feel that they have the resources and knowledge to act to improve patient safety.

Some concern was expressed over the second aim: *“give staff at all levels the skills and support they need..so they can be the infrastructure for safety improvement.”* Patient safety is everyone's concern; that is above reproach. However, staff are part of larger systems and it has been demonstrated that *“Most errors and inefficiencies in patient care arise not from the solitary actions of individuals but from conflicting, incomplete, or suboptimal systems of which they are a part and with which they interact.”*<sup>[1]</sup> The concern raised in this particular case is that this aim individualises the issue thereby reducing the focus on the production, testing and proliferation of effective new models and systems of work.

A suggested alternative or complementary aim might be *“produce, test and proliferate effective new models and systems of work that are demonstrably safer than current models.”*

#### B. What do you think is inhibiting the development of a just safety culture?

The reasons that the development of a just culture in the NHS appears to be inhibited are complex and extend much wider than the NHS into our general society as a whole. It has been demonstrated that safety culture is in itself a complex phenomenon that is not clearly understood by health leaders, making it difficult to operationalise.<sup>[2]</sup> Aligning operational objectives, staff competency, and fiscal and human resources across a spectra of organisations: DoH, to trust board rooms, primary care partnerships, to the front-line services is a complex challenge that required significant education & co-ordination. Safety culture extends beyond the organisational boundaries of the NHS. Casual observation suggests that the United Kingdom has a very strong and somewhat distorted blame culture, such that there is often a very visible and public need to apportion blame to an individual in every unfortunate circumstance; often before an investigation has even begun. In cases where there is demonstrable individual organisational negligence or malpractice, it would seem reasonable to hold the relevant individuals to account; however, in other cases, visible preventative action to limit recurrence would seem to be most appropriate. It would appear that the latter cases are not of particular public interest and so simply do not receive the same attention and go unnoticed. As a result of this, it might be reasonable to assume that individuals involved in a specific safety incident fear that they may well be blamed themselves therefore try to ensure that they themselves are not blamed, but someone else thus inhibiting the development of such a culture.

#### C. Are you aware of “A just culture guide”?

IPEM members who responded to the consultation appeared to have little knowledge of this document.

#### D. What could be done to help further a just culture?

A quote from the above guide states the following; “A *just culture* considers wider systemic issues where things go wrong, enabling professionals and those operating the system to learn without fear of retribution.” However, the guide’s focus is then reactionary e.g. “In a *just culture* investigators principally attempt to understand why failings occurred and how systems led to sub optimal behaviours.” Excellent multidisciplinary team practice has the potential to increase levels of openness. It is known that coordination, communication, and decision making between health-care team members and patients are aspects of care that could be improved by multidisciplinary team working. However, many practical barriers to the successful implementation of this care method e.g., professional and institutional resistance, and manpower and logistical difficulties remain. [3]. Nevertheless, as may be seen from response C, above, simply improving promotion of the just culture guide through trusts; supporting its application; demonstrably applying it consistently across the NHS and identifying areas of weakness in its application and rectifying them would promote a just culture.

#### **E. What more should be done to support openness and transparency?**

It is important that in addition to promoting a just culture, openness and transparency these things are seen to be put into action and demonstrably supported in individual organisations, otherwise they will be perceived to be ineffective and the old cultures will remain. In addition, the implementation of common standards and training (see below) across all professional groups, especially regarding MDT practice, as part of core curricula. It is especially the case that a proactive culture is developed so that when a concern about *potential* safety issues and risks to patient safety is raised that it is investigated effectively, and appropriate action taken to prevent incidents before they arise.

#### **F. How can we further support continuous safety improvement?**

It was felt by IPEM respondents that high quality training in relevant systems and process thinking is essential and, in particular, in developing a robust understanding of the concept of root cause. Reported experience suggested that actions taken as a result of safety incidents can often focus on operational “patches”, rather than addressing the root cause of an incident; sometimes the actions taken with the best of intentions can be a contributory factor to a subsequent incident. This is an area in which Medical Physicists and Clinical Engineers working in clinical environments have a unique skill set to contribute.

### **Q2. Insight**

#### **A. Do you agree with these proposals?**

Yes, IPEM members who responded to this consultation agreed with the proposals. It is important to learn from what goes right as well as what goes wrong, and an improved reporting system is long overdue; however, it is also important that any reporting system has the flexibility to reliably report safety incidents in *all* clinical environments. The data provided by such a system can be used to produce models and methods that could aid future learning and might be proliferated through Safety II and the Patient Safety Incident Management System, currently under development.

#### **B. Would you suggest anything different or is there anything you would add?**

There are a number of sectors within healthcare (radiotherapy) and outside healthcare (aviation / nuclear industry) that have very good safety records in complex, safety critical environments.

Consideration should be taken to reviewing the approaches and best practices of these areas with a view to translating them into the broader healthcare environment. Involvement of sectors with wide experience in this area is essential as expert co-ordination, root decisions, and answers to questions such as what data to gather and in what format, by whom, will ensure the project's success or ultimate failure.

### **Q3. Infrastructure**

#### **A. Do you agree with these proposals?**

IPEM members broadly agree with these proposals. First, a cross development of a shared and consistent patient safety curriculum for all current and future NHS staff was seen as a good idea; however, it would have to be adaptable, as new, proven, more effective models to ensure patient safety are developed. A possible model for this is the system adopted by the UK Resuscitation Council, which is an educational body that disseminates new best practice materials for all styles of learning at an appropriate level and also certifies instructors. The concept of a network senior safety specialists was seen as positive as they are drawn from existing NHS staff and with their experience of a clinical background, as was their appointment at a senior level in provider organisations. A patient safety support team to support improvement in individual organisations that are struggling is a good idea, but it is essential that all these roles have the authority to implement safety against competing pressures.

#### **B. Would you suggest anything different or would you add anything?**

Flexibility in the safety curriculum was seen to be important as it needs to impart the common safety information, but within the context of specific clinical environments so that those learning can relate it directly to their own work and experience. A second concern centred around the redeployment of existing staff and the importance of being able to backfill the positions.

#### **C. Which areas do you think that a national patient safety curriculum should cover?**

Areas might include a basic understanding of root cause; human factors; and how vulnerabilities can be introduced into safety critical systems but in the context of the clinical environment. Communication skills were also seen as key as it is known that a leading root cause of sentinel events in health-care. <sup>[4]</sup> and enhanced communication skills heighten competency and health-care professional wellbeing. These core aspects of communication should also be supplemented by a rolling programme of targeted on the available evidence base. Other aspects such as leadership skills are essential for the role and effective teamwork.

#### **D. How should training be delivered?**

A review of the experiences of the delivery of safety training to different professional groups in safety-critical industries might go some way to answering this question; however, whatever system is employed, it should be competency based.

#### **E. What skills and knowledge should patient safety specialists have?**

Root cause analysis and investigation, the importance of process, system safety and decision making applied at the appropriate level for a clinical environment and the understanding of how humans interact with such systems (for example automaticity, redundancy and unintended consequences) and how poor design and decisions can introduce weak points and vulnerabilities into safety-critical systems, have all been suggested as skills for patient safety specialists. The newly established field of Neuroleadership may

also be beneficial as it uses neuroscientific techniques to discover screening tools for good leaders, to improve leadership skills, and to identify unconscious factors affecting behaviour in hopes of improving management and practices. <sup>[5]</sup> Elements of neuroleadership, in particular, neuro linguistic programming techniques, have proven effective in health-care teaching strategies. <sup>[6]</sup>

In the consultation document it states on page 14:

*“These roles should not be filled by recruiting new staff, but rather by identifying existing staff who are already working in safety-related roles, be they nurses, doctors, pharmacists, managers or allied health professionals, and who can be supported to become these skilled specialists”.*

There is one group of staff, however, that is not included in the above statement, which already has a good understanding of process, systems and in many cases safety-critical systems, namely Healthcare Scientists and, in particular, Medical Physicists and Clinical Engineers. Those scientists and clinical engineers who have been working in safety critical areas such as radiotherapy or medical device design and manufacture, for example, have substantial and experience of safety in the clinical environment and this should be exploited to the full.

#### **F. How can patient/family/carers involvement in patient safety be increased and improved?**

One way might be to make it easier for patients to raise concerns and to have a standard system for logging complaints, particularly surrounding areas of which patients are most aware, but which have a large potential impact on patient safety: cleanliness and hygiene, mis-identification and broken equipment. The patient logging system could be used to gain further information by comparing it with the staff reporting system to see whether an incident was also reported by staff. Safety specialists should work with PALS teams to review complaints, to identify trends and areas of concern for further investigation. For example, understaffed areas might receive more complaints simply because they have insufficient resources; understaffing has been identified as a causal factor in many safety incidents.

#### **G. Where would patient involvement be most impactful?**

H. Patients play an essential part in managing (or mismanaging) their own health. They may be a source of expert information; e.g. their own medication regimes. <sup>[7]</sup> Patients may wish to be engaged concerning treatment making decisions – this may be particularly appropriate in patient with chronic conditions.

#### **I. Would a dedicated patient safety support team be helpful in addition to existing support mechanisms? If yes, how?**

Yes, as previous stated: Neuroleadership is a interdisciplinary field that use neuroscientific techniques to improve leadership skills, and to identify unconscious factors affecting behaviour in hopes of improving management and practices e.g. safety. A safety support team with equipped with such skills would be best equipped to engage root causes e.g. beliefs and introduce lasting change.

### **Q4. Initiatives**

#### **A. Do you agree with these proposals?**

The use of an evidence-based approach and the involvement of professional organisations seems an appropriate one for this work. It is important that all professional groups are involved in the work, especially the Medical Physics and Clinical Engineering workforce, many of whom have a unique and relevant skillset with respect to safety critical systems.

**B.**

**NA**

**C.**

Sustained engagement with safety scientists would best facilitate analysis of effective improvement approaches and delivery models. <sup>[8]</sup>

**D.**

As the process evolves, sustained engagement with safety scientists would be important.

**E.**

**F.** High level statistics may be used to determine reporting and incident levels; however, successes may be highly contextual. Engagement with safety scientists should be maintained for an objective, outside point of view that might inform measures of success.

NA

## References

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