The Measurement and Monitoring of Safety Framework
Workshop 1

3rd April 2017
Leeds
Welcome and introduction

Debbie Clark
Improvement Academy
Housekeeping
Our # for the event

#howsafeisourcare

@Improve_Academy
‘A team of improvement scientists, patient safety experts and clinicians who are committed to working with frontline services, patients and the public to address to deliver real and lasting change.’

**Imagery:**
- **Improvement Academy**
  - Innovating for safe and effective care
- **Established May 2013**
- **Diagram**:
  - **Improvement Science**
    - Ensure evidence based solutions become routine practice
  - **Bring about lasting change**
  - **Co-create improvement** with frontline clinicians, patients and public
  - **Address professional and geographical isolation** through network learning
Improvement Academy
Innovating for safe and effective care
Measurement and Monitoring of Safety
Where we are now
Learning from phase 1

• **We Need to:**

  • Acknowledge complexity of the framework
  • Demystify the framework
  • Normalise the uncertainty
  • Interrogate the framework
  • Most activity was undertaken in areas where the framework would be accepted.
  • Recognise the framework can reduce learned helpfulness through supporting ownership and understanding of data and issues.
Overview of the plan

- Understanding safety
- Human Factors
- Quality Improvement
- Involving Interventions

Workshop 1

Workshop 2

Workshop 3

COACHING
<table>
<thead>
<tr>
<th>Organisation</th>
<th>Coach</th>
</tr>
</thead>
<tbody>
<tr>
<td>York Teaching Hospital NHS Foundation Trust</td>
<td>Jackie and Rachel</td>
</tr>
<tr>
<td>Calderdale and Huddersfield NHS Foundation Trust</td>
<td>Abimbola and Lynn</td>
</tr>
<tr>
<td>Leeds Teaching Hospitals NHS Trust</td>
<td>Rachel and Abimbola</td>
</tr>
<tr>
<td>South West Yorkshire Partnership NHS Foundation Trust</td>
<td>Debbie and Jackie</td>
</tr>
<tr>
<td>Yorkshire Ambulance Service</td>
<td>Rachel and Lynn</td>
</tr>
<tr>
<td>Springbank Health</td>
<td>Lynn and Jackie</td>
</tr>
<tr>
<td>Doncaster &amp; Bassetlaw NHS Foundation Trust</td>
<td>Debbie and Abimbola</td>
</tr>
<tr>
<td>Sheffield Teaching Hospitals NHS Foundation Trust</td>
<td>Rachel and Debbie</td>
</tr>
<tr>
<td>Sheffield Children’s Hospital</td>
<td>Lynn and Debbie</td>
</tr>
<tr>
<td>Hull and East Yorkshire Hospitals NHS Trust</td>
<td>Jackie and Abimbola</td>
</tr>
</tbody>
</table>

#howsafeisourcare
• Celebration and sharing event:

• 19th September.

• Studio, Leeds
Huddles?

About Safety Huddles

What are the Key Elements of a Patient Safety Huddle?

1. Non-judgemental environment
2. All ward staff are empowered to speak up
3. Flexibility on approach when starting huddles
4. Led by the most senior clinician, (nurse, or allied health professional)
5. All ward staff including non-clinical invited to attend
6. Happens at the same time/place (Mon-Fri minimum)
7. Are brief (5-15 minutes)
8. Ward staff agree on focus of harm for example: falls, pressure ulcers, 2222 calls
9. Would suggest one harm and build in further harms once huddles become more established
10. Review of days since last harm – keeps staff motivated

- Patients at highest risk
- Patient and carer concerns
What will this achieve?

• Measureable improvement in identified key areas of safety

• Improvement in team culture

• Evidence of organisational learning
<table>
<thead>
<tr>
<th>Time</th>
<th>Programme</th>
<th>Speakers</th>
</tr>
</thead>
<tbody>
<tr>
<td>10:30 – 11:20</td>
<td>What is safe care?</td>
<td>Debbie Clark</td>
</tr>
<tr>
<td>11:20 – 11:40</td>
<td>Refreshment break</td>
<td></td>
</tr>
<tr>
<td>11:40 – 12:15</td>
<td>Measuring and monitoring safe care</td>
<td>Debbie Clark</td>
</tr>
<tr>
<td>12:15 – 13:00</td>
<td>Lunch</td>
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<tr>
<td>13:00 – 14:30</td>
<td>Introduction to the framework</td>
<td>Jane O’Hara</td>
</tr>
<tr>
<td>14:30 – 14:50</td>
<td>Refreshment break</td>
<td></td>
</tr>
<tr>
<td>14:50 – 15:20</td>
<td>Culture and patient safety</td>
<td>Jane O’Hara</td>
</tr>
<tr>
<td>15:20 – 15:50</td>
<td>Being a team and working together</td>
<td>Abimbola Olusoga</td>
</tr>
<tr>
<td>15:50 – 16:00</td>
<td>Final Questions</td>
<td>Debbie Clark</td>
</tr>
<tr>
<td>16:00</td>
<td>Close</td>
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</tr>
</tbody>
</table>
What is safe care…. and how do we know?

Jane O’Hara
Debbie Clark
What do we mean by patient safety?

NHS England:

“Patient safety is about working to prevent errors in healthcare that can cause harm to patients. Harm in this context means injury, suffering, disability or death.”

Patient safety therefore is absence of harm.
Improving patient care

What does patient safety mean in your area?

Wrong body part op claims "rise"

Operations in which patients had the wrong body parts operated on have risen by a half in the last three years, claim figures show.

Last year, 40 patients in England had claims settled by the NHS Litigation Authority - up from 27 in 2003-4. The cost of settling the claims topped £3m. Among the mistakes were cases of the wrong leg and hips being operated on.

Campaigners said the errors were "unforgivable" and should never happen.
Beginning to recognise patient safety

The hazards of hospitalization*

E M Schimmel

The occurrence of hospital-induced complications on an \university medical service was documented in the prospective investigation of over 1000 patients. The reported episodes were the untoward consequences of acceptable medical care in diagnosis and therapy. During the 8-month study, 240 episodes occurred in 198 patients. In 105 patients, hospitalization was either prolonged by an adverse episode or the manifestations were not yet resolved at time of discharge. Thus, 20% of the patients admitted to the medical wards experienced one or more untoward episodes and 10% had a prolonged or unresolved episode. The severity of the 240 episodes was minor in 110, moderate in 82, and major in 48, of which 16 ended fatally. Patients encountering noxious episodes had a mean total hospitalization of 28.7 days compared with 11.4 days in other patients. The risk of having such episodes seemed directly related to the length of time spent in the hospital. The number and variety of these reactions emphasize the magnitude and scope of hazards to which the hospitalized patient is exposed. A judicious selection of diagnostic and therapeutic measures can be made only with knowledge of these potential hazards as well as the proposed benefits.

PLAN OF STUDY
This investigation was planned as a prospective study of the type and frequency of hospital complications occurring in the patients of a university medical service. The project was designed for performance during the author's tenure as chief resident on that service and was a joint effort of all the medical house officers. To allow new staff members to become accustomed to the service, the project was begun on August 1, 1960, rather than during July. It was concluded on March 31, 1961 after more than 1000 patients had been studied. The investigation included all patients admitted to the Yale University Medical Service of the Grace-New Haven Community Hospital. This service, comprising three wards with a capacity of 80 beds, cares for private patients of the full-time university staff and for service patients attended by the ward interns, residents, and staff physicians. The participating house officers sought and

Iatrogenic Illness on a General Medical Service University Hospital


Abstract
We found that 36 per cent of 815 consecutive patients on a general medical service of a university hospital had an iatrogenic illness. In 9 per cent of all persons admitted, the incident was considered major, in that it threatened life or produced considerable disability. In 2 per cent of the 815 patients, the iatrogenic illness was believed to contribute to the death of the patient. Exposure to drugs was a particularly important factor in determining which patients had complications. Given the increasing number and complexity of diagnostic procedures and therapeutic agents, monitoring of untoward events is essential, and attention should be paid to educational efforts to reduce the risks of iatrogenic illness. (N Engl J Med, 1981; 304:638-42.)
Improving patient care

Increasing awareness of patient safety

An organisation with a memory

Report of an expert group on learning from adverse events in the NHS chaired by the Chief Medical Officer
Is care safe?

1 in 10 of all medical admissions results in a harm event\textsuperscript{1,2}

50\% of events are thought to be preventable\textsuperscript{3}

1. US Institute of Medicine’s report (1999)
More understanding of patient safety?
Over to you….

1) On a scale of 1-5 (1=not safe, 5=extremely safe), how safe is the care provided by your healthcare organisation?

AND

2) How do you know?
How do we currently judge the safety of services?

- Mortality
- Adverse events
- Never events
- Complaints
- Hygiene ratings
Improving patient care
Improving patient care

Understanding the safety of care is difficult!

- Defining harm is hard
- Defining preventability is hard
- Rate of harm depends on how harm is ‘detected’
- Harm may ‘cross’ boundaries of care
- Measuring is really difficult
Understanding the safety of care is difficult!

• Defining harm is hard
  
  • Patients are generally (but not always) ill when receiving care, therefore difficult to decouple outcomes
  
  • Some treatment is harmful
  
  • Harm may not be immediately recognisable
  
  • Harm doesn’t always mean poor care
Understanding the safety of care is difficult!

- Defining preventability is hard
  - Preventability is often a subjective judgment
  - Who decides preventability?
Improving patient care

Understanding the safety of care is difficult!

• Rate of harm depends on how harm is ‘detected’
  • Case note review: 8% - 12% of admissions result in adverse events

BUT

• Sari et al (2007) – case note review of 1000 records
  • Only 5% of adverse events found case note review also reported in staff reporting system
Improving patient care

Understanding the safety of care is difficult!

• Harm may ‘cross’ boundaries of care

  • Is ‘harm’ in one care setting picked up in another?
    • e.g. diagnostic delay between primary and secondary care

  • Harm may not be harm until it is amplified across boundaries of care
    • e.g. two ‘correct’ prescriptions in different settings can have contraindications when together
Understanding the safety of care is difficult!

- Measuring is really difficult
  
  - events are uncommon (serious medication errors) or rare (wrong-site surgical procedure);
  
  - few have standardized definitions;
  
  - surveillance systems generally rely on self-reporting;
  
  - denominators (the populations at risk) are largely unknown;
  
  - the time period for exposure (patient day or device day) is unspecified.¹

¹ Pronovost et al (2006)
Are we progressing in our approach to patient safety?

*Taken from Vincent & Amalberti (2016) Safer Healthcare (Chapter 1):*

<table>
<thead>
<tr>
<th></th>
<th>Where we were (1995)</th>
<th>Where we are now (2015)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Foundations</td>
<td>Incident reporting, continuous improvement and development of best practice</td>
<td>Largely unchanged. More translation and use of industrial approaches to safety, increased attention to incident analysis, learning and feedback</td>
</tr>
<tr>
<td>Definition</td>
<td>Harm defined from a professional standpoint, rooted in a medico-legal and insurance perspective. Narrow vision of causality, direct association between technical care and harm</td>
<td>Patient safety still linked to a medico-legal perspective. Broader understanding of human error and organisational influences</td>
</tr>
<tr>
<td>Perimeter of inclusion</td>
<td>Dominant technical vision of care, improved clinical protocols as main priority for improving safety</td>
<td>Recognition of the importance of human factors and human sciences. Organisational factors and safety culture are additional priorities for safety</td>
</tr>
<tr>
<td>Measurement</td>
<td>Counting incidents and adverse events</td>
<td>Largely unchanged</td>
</tr>
</tbody>
</table>

Do we need to look at how we measure safety differently?
Coffee
How can we understand if care is safe?
Measuring and Monitoring

Debbie Clark
Measurement for patient safety

Why measure?

What do you measure?
What does measurement look like?

Past Harm?

<table>
<thead>
<tr>
<th>Were patients protected from harm?</th>
<th>Pressure ulcer</th>
<th>Fall (with harm)</th>
<th>Urine infection (in patients with catheters)</th>
<th>VTE (newly aspirated)</th>
<th>Harm Free composite</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient 1</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td>NO</td>
</tr>
<tr>
<td>Patient 2</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td>NO</td>
</tr>
<tr>
<td>Patient 3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>YES</td>
</tr>
<tr>
<td>Patient 4</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>YES</td>
</tr>
<tr>
<td>Patient 5</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>NO</td>
</tr>
</tbody>
</table>

NO 2/5 (40%) 1/5 (20%) 1/5 (20%) 0/5 (0%) 3/5 (60%)

YES 3/5 (60%) 4/5 (80%) 4/5 (80%) 5/5 (100%) 2/5 (40%)
What does measurement look like? More than past harm?

SAMPLE NURSING DASHBOARD

<table>
<thead>
<tr>
<th>Measure</th>
<th>Target sample</th>
<th>Jan</th>
<th>Feb</th>
<th>March</th>
<th>April</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall nursing care hours productivity</td>
<td>Needs</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurse skill mix percentage</td>
<td>65% RN</td>
<td>75</td>
<td>72</td>
<td>74</td>
<td>80</td>
</tr>
<tr>
<td>Nurse Turnover</td>
<td>&lt; 5%</td>
<td>8</td>
<td>12</td>
<td>7</td>
<td>11</td>
</tr>
<tr>
<td>Nurse vacancy</td>
<td>&lt; 3%</td>
<td>8</td>
<td>9</td>
<td>8</td>
<td>5</td>
</tr>
<tr>
<td>Overall patient satisfaction with nursing</td>
<td>100%</td>
<td>85</td>
<td>88</td>
<td>86</td>
<td>91</td>
</tr>
<tr>
<td>Adverse drug events</td>
<td>5 per 100 admissions</td>
<td>4</td>
<td>7</td>
<td>5</td>
<td>9</td>
</tr>
<tr>
<td>Patient falls (Falls per 1,000 patient days)</td>
<td>0</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Injury falls (Less than 1 per 1,000 patient days)</td>
<td>0</td>
<td>4</td>
<td>3</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>Hospital acquired pressure ulcer Stage 2+</td>
<td>0</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>Sentinel events</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>
Measurement for patient safety

Measures of all kinds need to be both valid and reliable.

Valid - whether the measure actually assesses what it is intended to measure.

The measurement of harm does not equate to the measurement of safety.

Reliable - A reflection of how well a measure provides consistent results in different circumstances.

Never take any measure at face value. We must always interrogate it to consider its meaning and what it truly reflects about the safety of care.
Why is measuring so important?

The measurement of harm remains a critical foundation of safety.

However, we need to look beyond the measurement of harm if we are to provide a more rounded approach to safety measurement and monitoring.

We need to devise more specific and more nuanced measures of harm that can be tracked over time and clearly demonstrate that healthcare is becoming safer.

No single measure will give us an holistic view of safety.

Vincent (2013)
Monitoring patient safety

'Safety monitoring is critical and does not receive sufficient recognition' (Vincent 2013)

What is safety monitoring?

How healthcare organisations continuously adapt, in the face of dynamic risks to patient safety, to maintain failure-free performance the majority of the time.

The appropriate set of indicators will vary depending on dynamic local conditions and contextual threats.
What does monitoring for patient safety look like?

Effective monitoring of system safety is delivered through designing systems that recognise the dynamic nature of the system and emerges through a balancing multiple factors at any single point in time.
Why is monitoring so important?

Having information and the capacity to monitor safety on an hourly or daily basis enables us to anticipate problems and be prepared. Integration of learning about safety can then be fed back into our systems to make improvements.

We can not always know what specific threats may effect patient safety in the future, but we can step back and monitor our ability to recognise and respond threats to safety.

Vincent (2013)
What should we measure - Leading and Lagging Indicators

Lagging safety indicators are:

Retrospective, and only capture information after the event.

These are the traditional safety metrics used to indicate progress toward compliance with safety rules.
What should we measure - Leading and Lagging Indicators

'Leading' safety indicator's are:

'a warning sign that can be used in monitoring a safety-critical process to detect when a safety-related assumption is broken or dangerously weak and that action is required to prevent an accident'

(Leveson 2015)

In healthcare leading indicators are still very rare

(Vincent, Burnett, Carthy, 2014)
A note of caution.....poor measurement can be dangerous.

- Gives the illusion of control
- Blind sight
- Can result in effort substitution
- Gaming

If you're not measuring, your not managing.

If you're measuring stupidly, your not managing.

If you're only measuring, your not managing.

Mary Dixon-Wood (2014)
Lunch and Networking
The measurement and monitoring framework: where it has come from and how it helps

Jane O'Hara
The measurement and monitoring framework: where has it come from?

Commissioned by the Health Foundation
Work carried out by Charles Vincent and colleagues
Published in 2014

Based on the principle that ‘What we currently measure is not how safe healthcare systems are now but how harmful they have been in the past’

Based on learning from the management of safety in other industries, literature and case studies/interviews in healthcare

Offers a different way of thinking rather than a set of rules for safety management
Measurement and monitoring of safety

Integration and Learning

Past harm

Reliability

Sensitivity to operations

Anticipation and preparedness

Integration and Learning

Anticipation and preparedness

Are we safe today?

Will care be safe in the future?
How does it help: 1. safety is so much more than past harm
A feeling of being safe (staff and patients)

A place where staff feel supported to do a good job, to be questioning and to continuously improve

Staff know what needs to happen consistently and they do it

A state of continuous monitoring and responding to local circumstances……. RESILIENCE

Senior Execs understand what support teams need to make care safer
1. respond to the actual
2. monitor the critical
3. anticipate the possible
4. learn from the factual
How does it help: 2. A structure for thinking about how safe you are

Has care been safe in the past?

Are our clinical processes and systems are reliable?

Is care safe today?

Will care be safe in the future?

Are we responding and improving?
How does it help: 3: Knowing where the gaps are
How does it help 4: Knowing when we measure too much, but do too little
Conclusion

- Focus on measures of past harm
- Does not tell us how safe we are today or will be in the future
- Takes a service, rather than a patient perspective
- Does not recognise when things go right
- Too many measures can lead to information overload and collection fatigue
NHS organisations should: ‘…routinely collect, analyse and respond to local measures that serve as early warning signals of quality and safety problems such as the voice of the patients and the staff, staffing levels, the reliability of critical processes and other quality metrics. These can be ‘smoke detectors’ as much as mortality rates are, and they can signal problems earlier than mortality rates do.’ (Berwick, 2013)
Useful references


Improving patient care
The Purpose of the MMSF

Rachel Smith
Patient Safety Project Manager
The 10 MMSF Commandments

1. The core of the framework is to help people think about safety differently.
2. It starts from the question “how safe is our care?”
3. It gives us an holistic view of safety.
4. The framework moves us from thinking about the absence of harm to the presence of safety.
5. Using the framework is not a one-off exercise, but part of ongoing business and everyone’s job.
The 10 MMSF Commandments

6. Using the framework is as much about the conversation about safety as the measures you use.
7. You need to use the right measures for you; it’s not about having more.
8. The framework is not the solution to all of your safety issues.
9. How you use the framework will depend on your circumstances, but it has to change the way you think.
10. There’s great potential and we’re learning and sharing.
Figure 2: The framework for measuring and monitoring safety – and useful prompts for using it in practice

- **Past harm**
  - Has patient care been safe in the past?

- **Integration and learning**
  - Are we responding and improving?

- **Reliability**
  - Are our clinical systems and processes reliable?

- **Anticipation and preparedness**
  - Will care be safe in the future?

- **Sensitivity to operations**
  - Is care safe today?

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**Integration and learning prompts**
- Use the analysis of incidents as a starting point to reveal the wider issues in the system
- Place more emphasis on learning, feedback and action than simply on data collection
- Integrate and tailor information to make it meaningful from the ward to the board

**Past harm prompts**
- Identify the different types of harm that can exist in your setting
- Use a range of safety measures, while understanding their strengths and limitations
- Ensure the measures are valid, reliable and specific

**Reliability prompts**
- Specify the level of reliability you would expect in areas of standardised practice
- Use local and national audits and initiatives to monitor reliability
- Understand what contributes to poor reliability

**Sensitivity prompts**
- Select an appropriate mix of formal and informal safety monitoring mechanisms
- Use this information to take timely action to avert safety issues
- Reflect on whether current structures and committees enable timely action to be taken

**Anticipation and preparedness prompts**
- Don’t wait for things to go wrong before trying to improve safety
- Explore new opportunities to develop systematic ways to anticipate future risks
- Use a variety of tools and techniques to build an understanding of the factors that give rise to safety issues
Group exercise

• Can you answer these questions?

• On post it notes write down what data are collected or what monitoring is undertaken in your organisation to answer each of the five questions (5 mins)

• Stick these on the large measurement and monitoring framework
Our Journey with MMS - BDCFT
What we did

• Mapped pathways
• Mapped measures
  • Analysed data
  • Identified triggers
• Explored use of patient safety tools
  • Adapted some tools
  • Adopted some tools
• Measured and monitored
  • Achieved results
## Quality and Safety Dashboard

<table>
<thead>
<tr>
<th>Measure</th>
<th>Safety measure Direct</th>
<th>Safety measure indirect</th>
<th>Impacts/ contributes on safety</th>
<th>Useful (Traffic Light System)</th>
<th>Past Harm</th>
<th>Reliability</th>
<th>Sensitivity to Operations</th>
<th>Anticipation and Preparedness</th>
<th>Integration and Learning</th>
</tr>
</thead>
<tbody>
<tr>
<td>Progress with Delivery of all Action Plans Arising from Clinical Audits Registered with the Clinical Audit Department</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>Y</td>
<td>N</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Clinical Policy Development</td>
<td>N</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>P</td>
<td>Y</td>
<td>N</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Percentage of staff with professional registration in date</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>N</td>
<td>Y</td>
<td>P</td>
<td>P</td>
<td>N</td>
</tr>
<tr>
<td>A Person Referred for Psychological Therapy Does not Wait Longer Than 13 Weeks From the Time at Which the Initial Referral is Received to the Time of the Assessment (<a href="#">Numerator and denominator not available</a>)</td>
<td>N</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>N/P?</td>
<td>Y</td>
<td>N</td>
<td>P</td>
<td>N</td>
</tr>
<tr>
<td>A person Who is Assessed as Requiring Psychological</td>
<td>N</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>N/P?</td>
<td>Y</td>
<td>N</td>
<td>P</td>
<td>N</td>
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<tr>
<td>Measure</td>
<td>Safety measure Direct</td>
<td>Safety measure indirect</td>
<td>Impacts/ contributes on safety</td>
<td>Useful (Traffic Light System)</td>
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<td>Reliability</td>
<td>Sensitivity to Operations</td>
<td>Anticipation and Preparedness</td>
<td>Integration and Learning</td>
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<tr>
<td>Friends and Family Tests</td>
<td>P</td>
<td>P</td>
<td>Y</td>
<td>A</td>
<td>P</td>
<td>Y</td>
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<td>P</td>
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<td>Y</td>
<td>Y</td>
<td>P</td>
</tr>
<tr>
<td>Dignity/Respect</td>
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<td>P</td>
<td>P</td>
<td>A</td>
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<td>P</td>
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<td>Y</td>
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<td>Safe</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>N</td>
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<td>Incident report</td>
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<td>Y</td>
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<td>Y</td>
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<td>CPA 12 month review</td>
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<td>Number of clients on CPA for 12 mnths</td>
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<td>Y</td>
<td>P</td>
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<td>N</td>
<td>Y</td>
<td>N</td>
<td>P</td>
<td>P</td>
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<td>Validated review within 12 months</td>
<td>P</td>
<td>Y</td>
<td>P</td>
<td>P</td>
<td>P</td>
<td>Y</td>
<td>N</td>
<td>Y/P</td>
<td>P</td>
</tr>
</tbody>
</table>
Pilot – Start small

- 2 acute adult mental health wards
- 1 Camhs service
- 1 project manager with admin support
- ANPs
- Ward Managers
- 1 clinical lead 1 day then 2 then 3 - 12 months
- +1 clinical lead 2 days - 3 months
- Engaged with managers, directors and experts
How we started with the teams

- Introduced the team to the framework
- Asked the team how safe they thought their care was
- Asked what made them less safe on a daily basis
- Completed a teamwork and safety climate survey

<table>
<thead>
<tr>
<th></th>
<th>Failing</th>
<th>Poor</th>
<th>Acceptable</th>
<th>Very Good</th>
<th>Excellent</th>
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</thead>
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<tr>
<td>A</td>
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<td>11.1%</td>
<td>22.2%</td>
<td>66.6%</td>
<td>0%</td>
</tr>
<tr>
<td>B</td>
<td>8.3%</td>
<td>8.3%</td>
<td>33.3%</td>
<td>50%</td>
<td>0%</td>
</tr>
</tbody>
</table>
A system model of accident causation

Some holes due to active failures

Other holes due to latent conditions

Successive layers of defences, barriers, & safeguards
Measures & Tools

- Top 3 Incidents
- Early warning triggers
- Physical health needs
- Days between incidents
- Teamwork & Safety climate surveys
- Statistical process charts (SPCs)
- Safety Huddles
- Contributory factor framework
- Improvement Academy
Teamwork and Safety Climate Surveys
Huddles give you...

- Platform
- Inclusivity
- Intelligence
- Choices
- Teamwork
Safety Huddles
Measurement & Monitoring Framework

Past Harm
Events in the last 24 hours discussed
Focus on top 3 incidents
Weekly early warning triggers,
Monthly summary report (visual)

Integration and Learning
A more integrated team
Staff work better and learning together
Opportunity to share and learn together daily
Focus on learning
Introduced safety conversations with patients
Patients’ morning meeting

Reliability
Daily safety huddles at 9:15
Staff rota/mix
Risk Assessments
Policies, Protocols, SOPs
Element of the RMS
Team work & Safety Climate Surveys

Anticipation and Preparedness
Situational & spatial awareness improved for team
Days between incidents measured daily
Mind set is on safety - issues & actions
Strengthened MDTs more resilience
Action plans for the day based on safety issues
Better management of physical health needs

Sensitivity to Operations
New ways of working
Freed up nursing time
Improved communications
Events in last 24 hours discussed
Patient, environment & staff issues discussed
What Measurement Changed

CAMHS

• Weekend Service (Tier 3.5)
• Audit of accurate effective referrals
• Feedback to the teams who do not work in the weekend service
What measurement changed

Acute Mental Health Ward (Female)

• Introduction of safety huddles
• Measuring incidents not reported (4 weeks)
• Real time event analysis  - incidents
Use Framework as the model

- Have ‘past harm’ data readily available
- Flush out weaker areas of reliability
- Be sensitive to staff and team needs working in collaboration
- Anticipate and prepare for the brick walls to measures
- Integrate staff with learning in other teams to support further learning and embedding
Tips for implementation

• Use the framework as a vehicle for communication and debate
• Highlight the good and the positive
• Identify gaps/weaknesses in each of the different dimensions
• Focus on the patient
• Focus on the service team
• Empower the team to take action and test (PDSA)
• Do not use the framework to make judgements
• Take time and give time to get it right
• Look at whole systems
A framework for the measurement and monitoring of safety

Has patient care been safe in the past?
Ways to monitor harm include:
- mortality statistics (including HSMR and SHMI)
- record review (including case note review and the Global Trigger Tool)
- staff reporting (including incident report and 'never events')
- routine databases.

Are we responding and improving?
Sources of information to learn from include:
- automated information management systems highlighting key data at a clinical unit level (e.g., medication errors and hand hygiene compliance rates)
- at a board level, using dashboards and reports with indicators, set alongside financial and access targets.

Safety measurement and monitoring

Integration and learning

Past harm

Reliability

Anticipation and preparedness

Sensitivity to operations

Is care safe today?
Ways to monitor sensitivity to operations include:
- safety walk-rounds
- using designated patient safety officers
- meetings, handovers and ward rounds
- day-to-day conversations
- staffing levels
- patient interviews to identify threats to safety.

Are our clinical systems and processes reliable?
Ways to monitor reliability include:
- percentage of all inpatient admissions screened for MRSA
- percentage compliance with all elements of the pressure ulcer care bundle.

Will care be safe in the future?
Possible approaches for achieving anticipation and preparedness include:
- risk registers
- safety culture analysis and safety climate analysis
- safety training rates
- sickness absence rates
- frequency of sharps injuries per month
- human reliability analysis (e.g., FMEA)
- safety cases.

Source: Vincent C, Burnett S, Carthey J.
The measurement and monitoring of safety. The Health Foundation, 2013
Measurement and Monitoring of Safety – exploration in an acute hospital in-patient setting

Dr RF Jeffrey
Bradford Teaching Hospitals NHS Foundation Trust
The measurement and monitoring of safety

Drawing together academic evidence and practical experience to produce a framework for safety measurement and monitoring

Spotlight
April 2013
A framework for the measurement and monitoring of safety

Past harm – ‘has patient care been safe in the past?’

We may gain insight into this from analysis of risk incidents, complaints and by case note review. This may also include surgical complications, mortality, infection rates.
Reliability – ‘are our clinical systems and processes reliable?"

This domain tests whether we do the right thing every time. It looks to standardisation of processes such as care bundles, hand washing, vital signs measurement, VTE risk assessment, prescribing and administration of drugs, equipment checking, WHO checklist etc. It also looks at administrative and organisational factors such as case notes availability, ordering stock and clinic bookings. Reliability is often measured by targeted audit.
Sensitivity to operations – is care safe today?
This tests resilience of the system, the ability to recover, being alert to perturbation and responding rapidly to get back on track. Consider the example of riding a bicycle; moment by moment adjustments are made taking account of the machine itself and the surrounding environment. Sensitivity is enhanced by a non-hierarchical structure and a strong safety culture. Relevant tools may include ward rounds, safety briefings and huddles, handovers and patient feedback. The key to this is timeliness.
Anticipation and preparedness – will care be safe in the future?
This is a forward looking domain which has been poorly addressed in the NHS thus far. It involves mapping new processes and innovations for hazards and designing them out at a planning stage. An active risk register is a key tool. Timescales for anticipation and preparedness vary. It may need to be slow and careful for some major development. However, when considering ‘sensitivity to operations- is care safe today?, this implicitly begs the question will care be safe today? highlighting the importance of day to day hazard identification and mitigation.
Board driven versus Localism
LAGGING INDICATOR
Allows learning from a look back at past harm or event

LEADING INDICATOR
Looks forward in anticipation of safety
Leading and lagging indicators

• Lagging
  – Risk incidents
  – Infection rates
  – Pressure ulcers
  – Falls
  – Surgical complications
  – Mortality review
  – Patient feedback
  – complaints

• Leading
  – MRSA screening
  – VTE assessment
  – MUST
  – Waterlow
  – Stock control
  – Nursing and medical rosters
  – Risk register
Ward interviews

- Patient aggression
- Staffing issues / lack of experience in agency staff
- Can’t always get a special.
- Waiting for pharmacy to dispense drugs, both for patients on wards and those awaiting discharge.
- Infection control – no en suite rooms. Samples not being sent off for testing as quick as they should be. Not enough side rooms.
- Bloods can be waiting a long time before being collected.
- All junior Drs working on-call at the same time, therefore all getting tired at the same time (roistering issues).
- Long time for notes to arrive – can be working on loose sheets of paper.
- Poor recording in notes of medication changes.
- Short staffing in Pharmacy.
- Errors in transcribing drugs, especially from charts to Evolve.
- Missing dosage info when antibiotics prescribed.
- Prioritising of patients when dispensing – discharge always comes first but they might not be most in need.
- Too many relatives visiting at same time.
- Old fashioned system of fax referrals. Can cause dangerous delays.
- Poor communication between docs and nurses – patients feel no one knows what’s going on.
- Patient visibility – geographical layout.
- Medicines management.
- NEWS escalation.
- No nurse on ward round (staffing).
- Information flows – often a lack of key information with slow arrival of case notes etc.
- Missed drug doses – linked to nursing shortage.
- Slips, trips and falls, especially due to patient demographic.
- Junior staff don’t always escalate early enough.
- Technical issues with Evolve.
- Management of diabetes – left to specialist team so ward staff have lack of knowledge.
- Lack of out of hours cover. Need more junior doctors.
- Rushed Evolve discharge summary.
- Poor handwriting and lack of detailed information in notes.
- Poor communication with handovers between wards. Patients can miss getting antibiotics.
- Inaccurate outliers list. Can result in patients not being seen.
- Easy for aggressive patients to get in and out of ward.
- Equipment left out, tripping hazard.
Reliability

- NEWS
- Handover
- Ward rounds
- Pharmacy prescription and administration
- Side room policy and practice
- EDD and Early discharge
- WHO checklist

SO MEASURE AND MONITOR!
Measurement and Monitoring

• A group of metrics will be captured and fed back from the centre.
• Some will be amenable to local audit or as a continuous QA indicator
• Integrated EPR will drive compliance and monitoring.
It has been 17 days since a pressure ulcer developed on this ward.
Integration and learning – are we responding and improving?

Key facets must be in place to embed integration and learning:

- A culture dedicated to patient safety, full engagement of the MDT where staff feel confident to challenge prevailing structures and processes.
- Key staff trained in QI and improvement methodology.
- A regular safety forum to discuss and synthesise learning.
- Regular, consistent measurement of locally derived leading and lagging safety metrics to produce a ‘balanced scorecard’.
  - Presentation of metrics in simple graphical format.
- Senior champions who act as role models.
- Mechanism of dissemination of safety issues to the whole team.
Q28: Please give your unit an overall grade on patient safety

- Failing
- Poor
- Acceptable (highest)
- Very Good
- Excellent
Ward Safety Meetings

- Ward measures
- PRASE report
- Safety culture survey
- Mortality review
- Weekly MDT learning sessions
- Clinical governance
Challenges

- Staff may not see the broader framework of safety.
- Knowledge and confidence to take an overarching perspective but also to appreciate the detail.
- Staffing rosters.
- Dedicated MDT time for safety.
1. Continue thinking about the measuring and monitoring information you have in your organisation as a team.

2. Map this information to domains of the framework in a way which makes sense to you.

3. Identify where you think you have effective measurement and monitoring of safety in relation to the framework and where you may need to do some more work.

4. Come back next time prepared to share your reflections with the group in a way you see fit.
Coffee
What is safety culture and why should we measure it?

Dr Jane O’Hara
University of Leeds / Bradford Institute for Health Research
What is safety culture?

- The notion of safety culture is not unique to healthcare
  - used extensively in the oil, gas and energy industries, the transport sector, aviation and military

“Our role is to help them create a positive and strong safety culture that will stand the test of time.”

© Jane K. O’Hara 2014
What is safety culture?

A global phenomenon and encompasses the norms, values, and basic assumptions of an entire organisation.¹

- Organisations with a positive safety culture have:
  - communication based on mutual trust
  - shared perceptions of the importance of safety
  - confidence in the effectiveness of preventive measures
  - support for the workforce.

¹ Taken from: Blegen MA, Pepper GA, Rosse J. ‘Safety Climate on Hospital Units: A New Measure.’ Advances in Patient Safety.
Why measure it? (i)

- Safety culture is seen as a *leading indicator* of patient safety

- Some evidence that safety climate can predict safety outcomes:
  - Readmissions (Hanson et al, 2010)
NHS culture at Mid Staffs that tolerated low standards and sold patients short

Francis report calls for openness and honesty to replace managerial cult

In answering the question of why hundreds of patients died needlessly at the Mid Staffordshire trust in the years between 2005 and 2009, Robert Francis QC, the specialising in the NHS and medical negligence who chaired the public inquiry, has identified a culprit: the NHS culture, which focused “on doing the system’s business - not that of the patients”.

A sharp legal brain, Francis has in four volumes and almost 2,000 pages cleverly weaved together the evidence from thousands of witnesses. He is a technocrat of rare ability who has also written a highly readable book.
Why measure it? (ii)

- Measuring safety climate helps to diagnose the underlying safety culture of an organisation or work unit.
- The prevailing culture influences safety behaviours and outcomes for both healthcare workers and patients.
- Safety climate questionnaires need to achieve as high a standard of measurement as possible so that healthcare managers can use the resulting data to design effective safety management systems and interventions.

*Measuring how good the safety culture is within an organisation helps to provide a starting point for change.*

How do we measure safety culture?

A *global phenomenon and encompasses the norms, values, and basic assumptions of an entire organisation*.¹

BUT to measure the abstract, we have to ask about something concrete and accessible…..

**Safety Climate:**

*Climate, on the other hand, is more specific and refers to the employees’ perceptions of particular aspects of the organisation’s culture.*¹

¹ Taken from: Blegen MA, Pepper GA, Rosse J. ‘Safety Climate on Hospital Units: A New Measure.’ Advances in Patient Safety.
Safety Culture:

broad term representing all aspects of an organisation’s values and actions related to safety

- Management Support
- Supervision
- Risk taking
- Safety policies & practices
- Trust and openness

Safety Climate
How do we measure safety climate?

<table>
<thead>
<tr>
<th>Factor:</th>
<th>Definition</th>
<th>Example Items</th>
</tr>
</thead>
</table>
| Job Satisfaction:       | Positivity about the work experience                                       | I like my job  
This hospital is a good place to work                                         |
| Teamwork Climate:       | Perceived quality of collaboration between personnel                       | Disagreements in this clinical area are appropriately resolved (i.e., what is best for the patient)  
Our doctors and nurses work together as a well coordinated team                |
| Safety Climate:         | Perceptions of a strong and proactive organizational commitment to safety  | I would feel safe being treated in this clinical area  
Medical errors are handled appropriately in this clinical area                  |
| Perceptions of Management: | Approval of managerial action                                                      | Hospital management supports my daily efforts in this clinical area  
Hospital management does not knowingly compromise the safety of patients    |
| Stress Recognition:     | Acknowledgement of how performance is influenced by stressors              | I am less effective at work when fatigued  
When my workload becomes excessive, my performance is impaired               |
| Working Conditions:     | Perceived quality of the work environment and logistical support (staffing, training, etc.) | Trainees in my discipline are adequately supervised  
This hospital deals constructively with problem personnel                      |
SECTION A: Your Work Area/Unit (continued)

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neither</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>6. We are actively doing things to improve patient safety</td>
<td>□ 1</td>
<td>□ 2</td>
<td>□ 3</td>
<td>□ 4</td>
<td>□ 5</td>
</tr>
<tr>
<td>7. We use more agency/temporary staff than is best for patient care</td>
<td>□ 1</td>
<td>□ 2</td>
<td>□ 3</td>
<td>□ 4</td>
<td>□ 5</td>
</tr>
<tr>
<td>8. Staff feel like their mistakes are held against them</td>
<td>□ 1</td>
<td>□ 2</td>
<td>□ 3</td>
<td>□ 4</td>
<td>□ 5</td>
</tr>
<tr>
<td>9. Mistakes have led to positive changes here</td>
<td>□ 1</td>
<td>□ 2</td>
<td>□ 3</td>
<td>□ 4</td>
<td>□ 5</td>
</tr>
<tr>
<td>10. It is just by chance that more serious mistakes don’t happen around here</td>
<td>□ 1</td>
<td>□ 2</td>
<td>□ 3</td>
<td>□ 4</td>
<td>□ 5</td>
</tr>
<tr>
<td>11. When one area in this unit gets really busy, others help out</td>
<td>□ 1</td>
<td>□ 2</td>
<td>□ 3</td>
<td>□ 4</td>
<td>□ 5</td>
</tr>
<tr>
<td>12. When an event is reported, it feels like the person is being written up, not the problem</td>
<td>□ 1</td>
<td>□ 2</td>
<td>□ 3</td>
<td>□ 4</td>
<td>□ 5</td>
</tr>
<tr>
<td>13. After we make changes to improve patient safety, we evaluate their effectiveness</td>
<td>□ 1</td>
<td>□ 2</td>
<td>□ 3</td>
<td>□ 4</td>
<td>□ 5</td>
</tr>
<tr>
<td>14. We work in “crisis mode” trying to do too much, too quickly</td>
<td>□ 1</td>
<td>□ 2</td>
<td>□ 3</td>
<td>□ 4</td>
<td>□ 5</td>
</tr>
<tr>
<td>15. Patient safety is never sacrificed to get more work done</td>
<td>□ 1</td>
<td>□ 2</td>
<td>□ 3</td>
<td>□ 4</td>
<td>□ 5</td>
</tr>
<tr>
<td>16. Staff worry that mistakes they make are kept in their personal file</td>
<td>□ 1</td>
<td>□ 2</td>
<td>□ 3</td>
<td>□ 4</td>
<td>□ 5</td>
</tr>
<tr>
<td>17. We have patient safety problems in this unit</td>
<td>□ 1</td>
<td>□ 2</td>
<td>□ 3</td>
<td>□ 4</td>
<td>□ 5</td>
</tr>
<tr>
<td>18. Our procedures and systems are good at preventing errors from happening</td>
<td>□ 1</td>
<td>□ 2</td>
<td>□ 3</td>
<td>□ 4</td>
<td>□ 5</td>
</tr>
</tbody>
</table>

SECTION B: Your Supervisor/Manager

Please indicate your agreement or disagreement with the following statements about your immediate supervisor/manager or person to whom you directly report.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neither</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. My supervisor/manager says a good word when he/she sees a job done according to established patient safety procedures</td>
<td>□ 1</td>
<td>□ 2</td>
<td>□ 3</td>
<td>□ 4</td>
<td>□ 5</td>
</tr>
<tr>
<td>2. My supervisor/manager seriously considers staff suggestions for improving patient safety</td>
<td>□ 1</td>
<td>□ 2</td>
<td>□ 3</td>
<td>□ 4</td>
<td>□ 5</td>
</tr>
<tr>
<td>3. Whenever pressure builds up, my supervisor/manager wants us to work faster, even if it means taking shortcuts</td>
<td>□ 1</td>
<td>□ 2</td>
<td>□ 3</td>
<td>□ 4</td>
<td>□ 5</td>
</tr>
<tr>
<td>4. My supervisor/manager overlooks patient safety problems that happen over and over</td>
<td>□ 1</td>
<td>□ 2</td>
<td>□ 3</td>
<td>□ 4</td>
<td>□ 5</td>
</tr>
</tbody>
</table>

Hospital Survey on Patient Safety

Agency for Healthcare Research & Quality (AHRQ)

https://www.ahrq.gov/professionals/systems/hospital/falpxtoolkit/falpxtk-tool1a.html
Variation in safety culture dimensions within and between US and Swiss Hospital Units: an exploratory study

ABSTRACT

Background The purpose of this study was to explore the variability in safety culture dimensions within and between clinical areas.

Conclusions The authors found differences in SAQ dimensions at the country, hospital and unit levels. The general emphases placed on teamwork and safety climate in quality and safety efforts appear to be highlighting dimensions that vary more at the unit than hospital level. They suggest that patient safety improvement interventions target unit level changes, and they support the emphasis being placed on teamwork and safety climate, as these vary significantly at the unit level across countries.
“Studies have found that managerial actions and unit level climate may be more important than overall organisational safety culture, so it is important to use tools that are sensitive to differences at individual, unit and organisational levels.”
Structures
Management Systems and Symbols
Organisational Behaviour and Norms

Easily Observable

Deep characteristics that lead to transformation and longer-term success

Underlying Beliefs and Values
Shared Purpose and Meaning
Measuring how good the safety culture is within an organisation helps to provide a **starting point for change**.
Addressing Teamwork & Safety Culture
Principles of Texas Survey:

Reliable
Valid
Different settings and countries

Define
Measure
Analyze
Feedback
Now What?

T1: Nurse input is well received in this clinical area

- Clin Support Worker: 95%
- Cons, Jr Doc & Reg: 100%
- Nurse: 45%
- Other: 67%
- Support Worker: 79%
- Combined: 70%
Some examples: before and after – Raising concerns

Q17: I am encouraged by my colleagues to report any patient safety concerns I may have

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<th>February 2016</th>
<th>November 2016</th>
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</thead>
<tbody>
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<td>Goal</td>
</tr>
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<td>Danger</td>
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<tr>
<td>Cons Jr Doc &amp; Reg</td>
<td>50%</td>
</tr>
<tr>
<td>Maternity Support Worker</td>
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<td>Midwife</td>
<td>86%</td>
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<td>Nurse</td>
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<tr>
<td>Other</td>
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</tr>
<tr>
<td>Overall</td>
<td>83%</td>
</tr>
<tr>
<td>Cons Jr Doc &amp; Reg</td>
<td>100%</td>
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<tr>
<td>Maternity Support Worker</td>
<td>100%</td>
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<tr>
<td>Midwife</td>
<td>71%</td>
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<tr>
<td>Nurse</td>
<td>100%</td>
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<tr>
<td>Other</td>
<td>100%</td>
</tr>
<tr>
<td>Overall</td>
<td>90%</td>
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</table>
Some examples: before and after – Speaking up

Q02: In this clinical area, it is difficult to speak up if I perceive a problem with patient care

<table>
<thead>
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<th></th>
<th>Agreeing</th>
<th>Goal</th>
<th>Danger</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cons Jr Doc &amp; Reg</td>
<td>50%</td>
<td></td>
<td></td>
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<tr>
<td>Maternity Support Worker</td>
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<td>Midwife</td>
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<tr>
<td>Nurse</td>
<td>17%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>26%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Overall</td>
<td>26%</td>
<td>50%</td>
<td>0%</td>
</tr>
</tbody>
</table>

February 2016

Q02: In this clinical area, it is difficult to speak up if I perceive a problem with patient care

<table>
<thead>
<tr>
<th></th>
<th>Agreeing</th>
<th>Goal</th>
<th>Danger</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cons Jr Doc &amp; Reg</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Maternity Support Worker</td>
<td>0%</td>
<td>0%</td>
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</tr>
<tr>
<td>Midwife</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Nurse</td>
<td>0%</td>
<td>0%</td>
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</tr>
<tr>
<td>Other</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Overall</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
</tbody>
</table>

November 2016
Example: Change in question scores – 1st and 2nd surveys

- The graph illustrates changes in responses to various questions between the 1st and 2nd surveys.
- Questions include:
  1. Nurse input is well received in this clinical area
  2. In this clinical area, it is difficult to speak up if I perceive a problem with patient care
  3. Decision-making in this clinical area utilises input from relevant personnel
  4. The doctors and nurses here work together as a well-coordinated team
  5. Disagreements in this clinical area are resolved appropriately
  6. I am frequently unable to express disagreement with the medical staff here
  7. It is easy for personnel here to ask questions when there is something that they do not understand
  8. I have the support I need from other personnel to care for patients
  9. I know the first and last names of all the personnel I worked with during my last shift
  10. Important issues are well communicated at shift changes
  11. Briefing personnel before the start of a shift (i.e. to plan for possible contingencies) is important
  12. Briefings are common in this clinical area
  13. I am satisfied with the quality of collaboration that I experience with medical staff in this area
  14. I am satisfied with the quality of collaboration that I experience with nurses in this clinical area
  15. The levels of staffing in this clinical area are sufficient to handle the number of patients
  16. I would feel safe being treated here as a patient
  17. I am encouraged by my colleagues to report any patient safety concerns I may have
  18. Personnel frequently disregard rules or guidelines (e.g., handwashing, treatment)
  19. The culture in this clinical area makes it easy to learn from the errors of others
  20. I receive appropriate feedback about my performance
  21. Medical errors are handled appropriately here
  22. I know the proper channels to direct questions regarding patient safety in this clinical area
  23. In this clinical area, it is difficult to discuss errors
  24. Hospital management does not knowingly compromise the safety of patients
  25. This institution is doing more for patient safety now, than it did one year ago
  26. Leadership is driving us to be a safety-centred institution
  27. My suggestions about safety would be acted upon if I expressed them to management

- The graph uses green bars to represent Second Response better than First, and red bars for First Response better than Second.
....and in relation to the MMSF
Culture Survey Logistics

Lead name

Number of surveys

Address

Deadline for completion - 21st April

IA analysis

Date for results to be shared with team - 8th May
Being a Team and Working together

Abimbola Olusoga
Clinical Leadership Fellow
Improvement Academy

#howsafeisourcare
Coaching Model

• Aim
  – Help frontline teams to assess current state and establish a rhythm of improvement processes
    • In the context of the team and organisation
    • Between workshop sessions
Coaching Model

• Role
  – Build relationships within the team that is continuously learning
  – Intervening in and moving to set aside ineffective and counter-productive habits
  – Build new skills, practices, habits and platforms for collaborating
<table>
<thead>
<tr>
<th>Organisation</th>
<th>Coach</th>
</tr>
</thead>
<tbody>
<tr>
<td>York Teaching Hospital NHS Foundation Trust</td>
<td>Jackie and Rachel</td>
</tr>
<tr>
<td>Calderdale and Huddersfield NHS Foundation Trust</td>
<td>Abimbola and Lynn</td>
</tr>
<tr>
<td>Leeds Teaching Hospitals NHS Trust</td>
<td>Rachel and Abimbola</td>
</tr>
<tr>
<td>South West Yorkshire Partnership NHS Foundation Trust</td>
<td>Debbie and Jackie</td>
</tr>
<tr>
<td>Yorkshire Ambulance Service</td>
<td>Rachel and Lynn</td>
</tr>
<tr>
<td>Springbank Health</td>
<td>Lynn and Jackie</td>
</tr>
<tr>
<td>Doncaster &amp; Bassetlaw NHS Foundation Trust</td>
<td>Debbie and Abimbola</td>
</tr>
<tr>
<td>Sheffield Teaching Hospitals NHS Foundation Trust</td>
<td>Rachel and Debbie</td>
</tr>
<tr>
<td>Sheffield Children’s Hospital</td>
<td>Lynn and Debbie</td>
</tr>
<tr>
<td>Hull and East Yorkshire Hospitals NHS Trust</td>
<td>Jackie and Abimbola</td>
</tr>
</tbody>
</table>

#howsafeisourcare
Resources – UK Improvement Alliance

• UKIA: howsafeisourcare
  – Monthly calls
    • Wednesdays, 1-2pm.
    • Sign up via Eventbrite.
    • Next call: Wednesday 12 April 2017 at 1pm
Questions?
Thank you for attending

Please complete the evaluation form in your pack, and return your badges before leaving.

---

**Name of Event**

**Date**

Please respond to each question by circling the appropriate response.

1. Please rate your overall satisfaction with this event
   - 1 = totally dissatisfied, 5 = completely satisfied
   - 2 = 1
   - 3 = 2
   - 4 = 3
   - 5 = 4

2. Do you have a better understanding of stroke prevention in AEP?
   - 1 = no, definitely not, 5 = you definitely
   - 2 = 1
   - 3 = 2
   - 4 = 3
   - 5 = 4

3. How relevant was this event to your service / practice?
   - 1 = not at all, 5 = highly relevant
   - 2 = 1
   - 3 = 2
   - 4 = 3
   - 5 = 4

4. Do you have a better understanding of areas in which your service / practice could improve?
   - 1 = no, not at all, 5 = you definitely
   - 2 = 1
   - 3 = 2
   - 4 = 3
   - 5 = 4

5. Do you have a better understanding of how the Improvement Academy can support you in these areas?
   - 1 = no, definitely not, 5 = you definitely
   - 2 = 1
   - 3 = 2
   - 4 = 3
   - 5 = 4

---

Please circle at least 3 words below that best represent your overall experience of today.

- Interesting
- Exciting
- Challenging
- Old hat
- Fascinating
- Entertaining
- Boring
- Confusing
- Difficult
- Basic
- Rushed
- Clear
- Realistic
- Practical
- Theoretical
- Too long
- Useful
- New
- Unfocused
- Waste of time
- Enjoyable
- Valuable
- Inspiring
- Fun
- Empowering
- Informative
- Over-ambitious
- Thought-provoking
- Exhausting
- Stimulating

---

Comments about the structure and the format of the event

Comments about the content of the event

---

About you: Role/Organization

Thank you for completing this evaluation form.

#howsafeisourcare
Contact Details

Debbie Clark - deborah.clark@yhahsn.nhs.uk
Rachel Smith - Rachel.Smith2@sth.nhs.uk
Abimbola Olusoga - Abimbola.Olusoga@yhahsn.nhs.uk
academy@yhahsn.nhs.uk
F: @ImprovementAcademy    T: @Improve_Academy
t: 01274 383966