Improving Patient Safety: New horizons | New perspectives

Tuesday 15 October 2019

Philip Lewer, Chair

Calderdale and Huddersfield NHS Foundation Trust

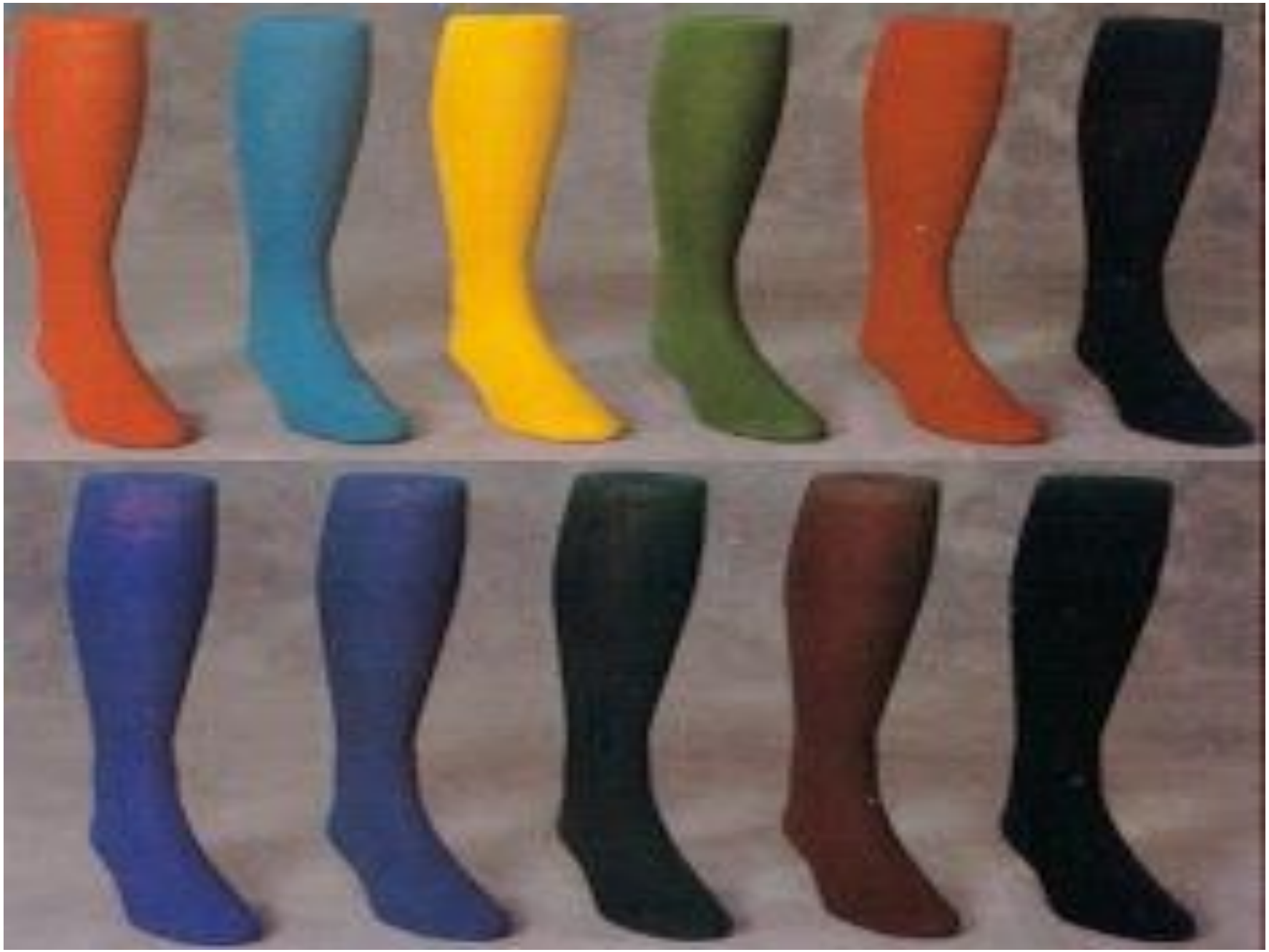
NHS
Calderdale and Huddersfield
NHS Foundation Trust

"I have a dream..."

Martin Luther King, Jr.

1929-1968


STEPHEN POND




User experience
Design

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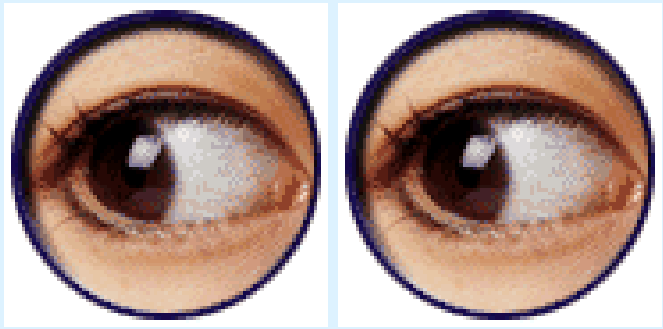
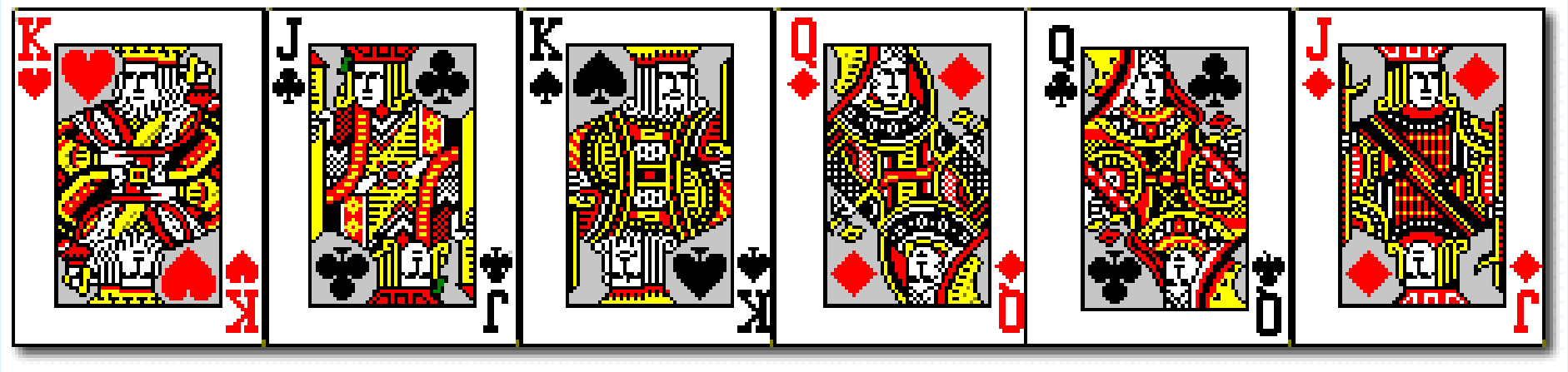
Look into my eyes



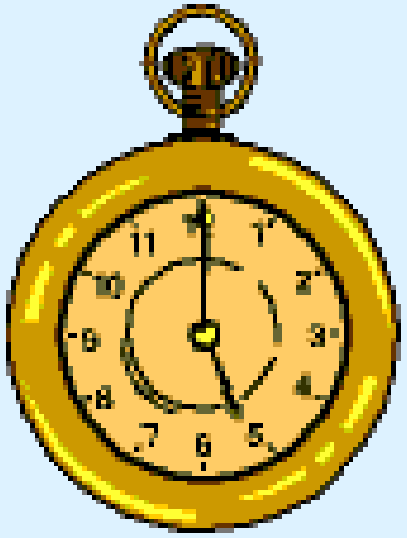
Select a card and concentrate on it.

After you have memorised your card, tell me!

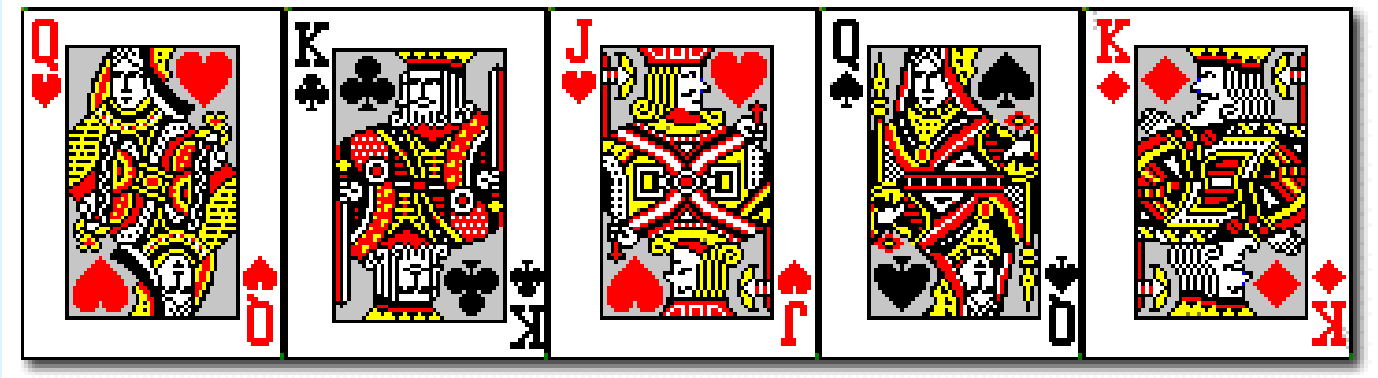


And now, whisper the name of your card out loud.

Please don't skip this part, it is very important.



I have selected your card and removed it from the pile.



Surprised?

We do not believe what we see. Rather, we see what we believe.

Joy, positivity, gratitude and wellbeing: lessons from the sign up to safety campaign

Suzette Woodward

Improving Patient Safety: New Horizons, New Perspectives

1

Create a balanced approach to safety

Safety as imagined

- Increased incident reports will indicate a good safety culture and system
- Root cause analysis will enable us to find and fix the problems
- We can reach zero harm or eradicate never events
- We know the level of harm and all we need to do is tell people to reduce it
- If we keep focusing on individual areas of harm we will be safer eventually

Safety as done

- Incident reports are data which will provide an indication of areas of concern or failure
- Root cause analysis is an outdated methodology for a complex adaptive system
- We will never reach zero
- We do not know the true level of harm
- Purely focusing on individual areas of harm is like rearranging the deckchairs on the titanic while the ship sinks

Relentless negativity

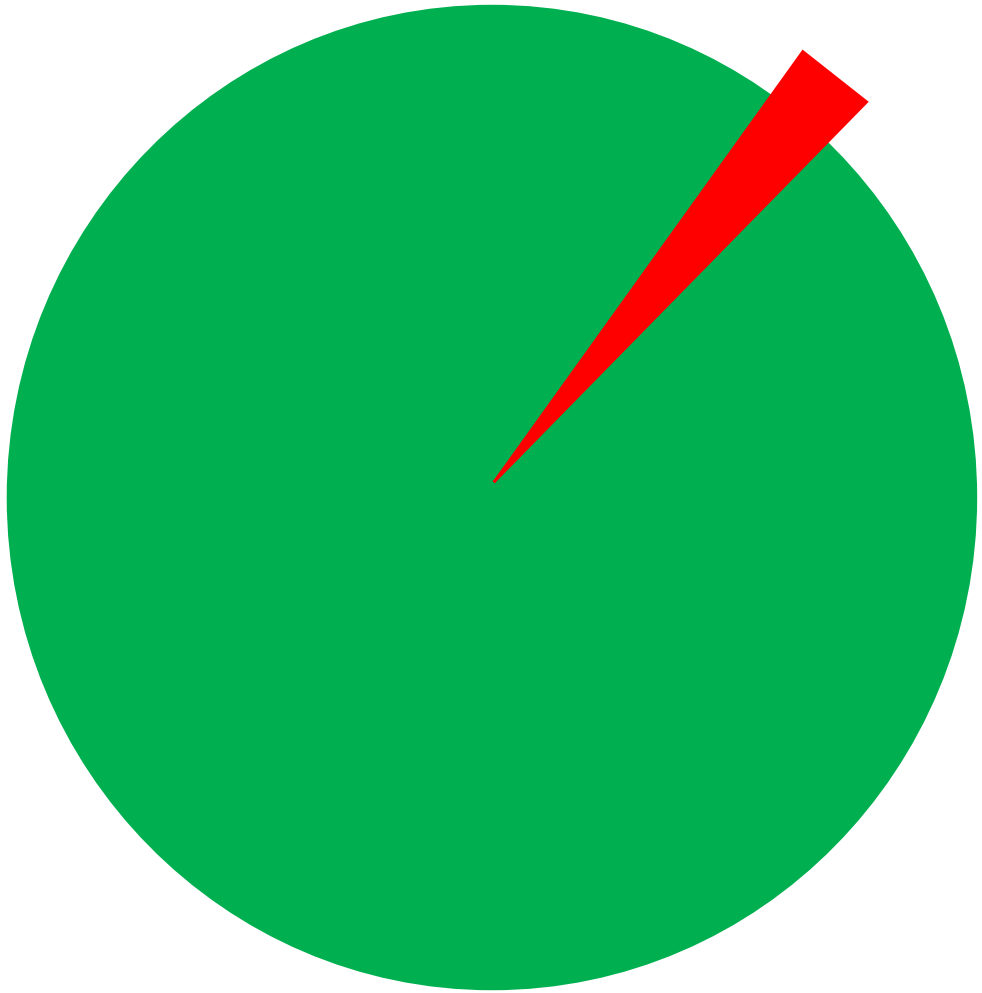
- Focus almost exclusively on failure
- Safety defined in terms of unsafety
- Treadmill of incidents, complaints and claims in and investigations and recommendations out
- All of our approaches and language bias us towards blame, individual sanction and fear

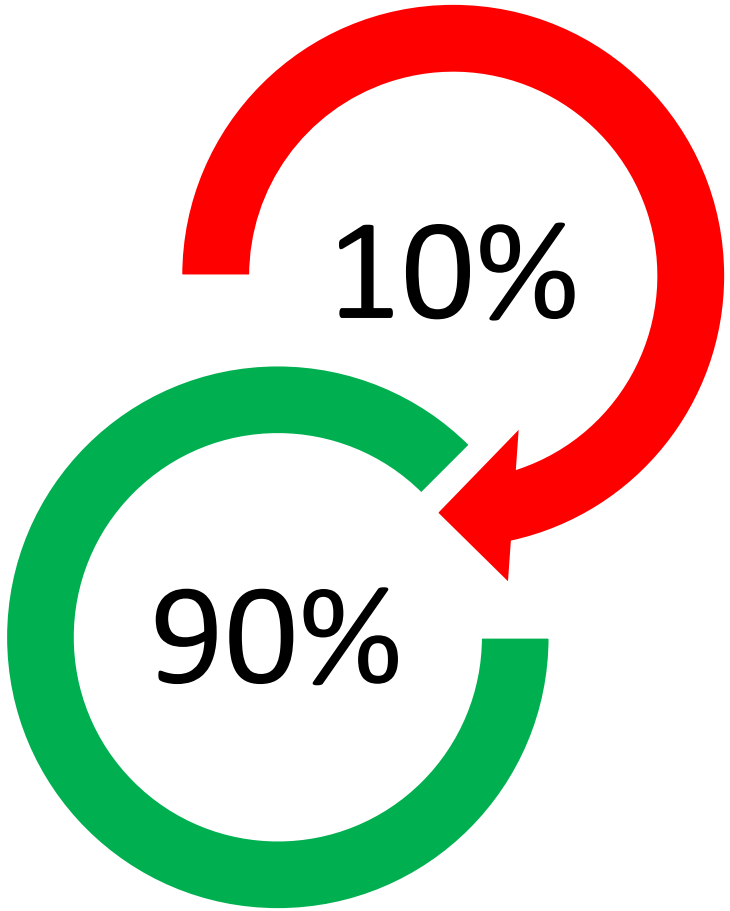
Safety Improvement

- Defined in terms of problems and failure and what is wrong
- Assumes everything needs ‘improving’
- Simplistic thinking – e.g. five whys – can lead you in the completely wrong path
- Does not often take into account a complex adaptive system
- The system is not linear or fixed – be careful what you aim to improve


Safety I

We need to look beyond that which goes wrong





Safety I

Safety II

Incidents
Never events
Significant and Serious incidents
Learning from deaths
Complaints
Claims

Normal day to day performance ‘how things just go’

Exceptional performance – ‘how things go really well’

What can we do with the resources we have available to us?

What if the solution was right in front of us?

The solution already exists

- Copes with the unexpected and emergent
- Innovative and adaptive
- Adjusts to the circumstances and conditions
- Creates order out of disorder

The ‘people’ are the solution – not the problem

The designers of the systems, equipment and buildings, procurers, time keepers, auditors, policy makers, politicians, commissioners, regulators, managers, accountants, administrators, doctors, nurses, academics, caterers, cleaners, porters, physios, occupational therapists, speech and language therapists, social workers, general practitioners, dentists, human resources, workforce planners, engineers, improvers, patient safety staff, complaints staff, claims staff, counsellors, researchers, analysts, microbiologists, radiologists, pharmacists …….

We all need to work together towards a shared purpose

• Work as imagined	• What we think people do
• Work as prescribed	• What we would like people to do
• Work as disclosed	• What people tell us they do
• Work as done	• What people actually do

Safety II

- Both Safety I and II
- Firstly try not to be judgemental – always seek to learn why a decision was made
- Study how people work everyday – how they adjust and adapt to make care safer
- Aim to replicate good practice or strengthen the system
- Learn about how things simply ‘go’ in order to understand why it failed in this instance

Focusing people on their shortcomings doesn’t enable learning; it impairs it

If we continue to spend our time identifying failure as we see it and giving people feedback about how to avoid it, we’ll languish in the business of adequacy


Safety II
Safety I

2

Urgently tackle the culture of incivility and blame

Right now we are mistreating our staff, we are ignoring their needs

People are leaving every single day

Even when we need the people the most we are rude to each other

We have to tackle the incivility and bullying

CIVILITY SAVES LIVES

civilitysaveslives.com

Christine Porath and Christine Pearson

The Price of Incivility
Harvard Business Review

A study of 800 managers who had been on the end of incivility

https://hbr.org/2013/01/the-price-of-incivility

Make or Break: Incivility in the workplace ESTH 2019

https://www.youtube.com/watch?v=S1EDatTYMkE

NHS
Epsom and St Helier University Hospitals
NHS Trust

Articulate and embed a just culture for all

- Who is hurt
- What do they need
- Whose obligation is it to meet their need

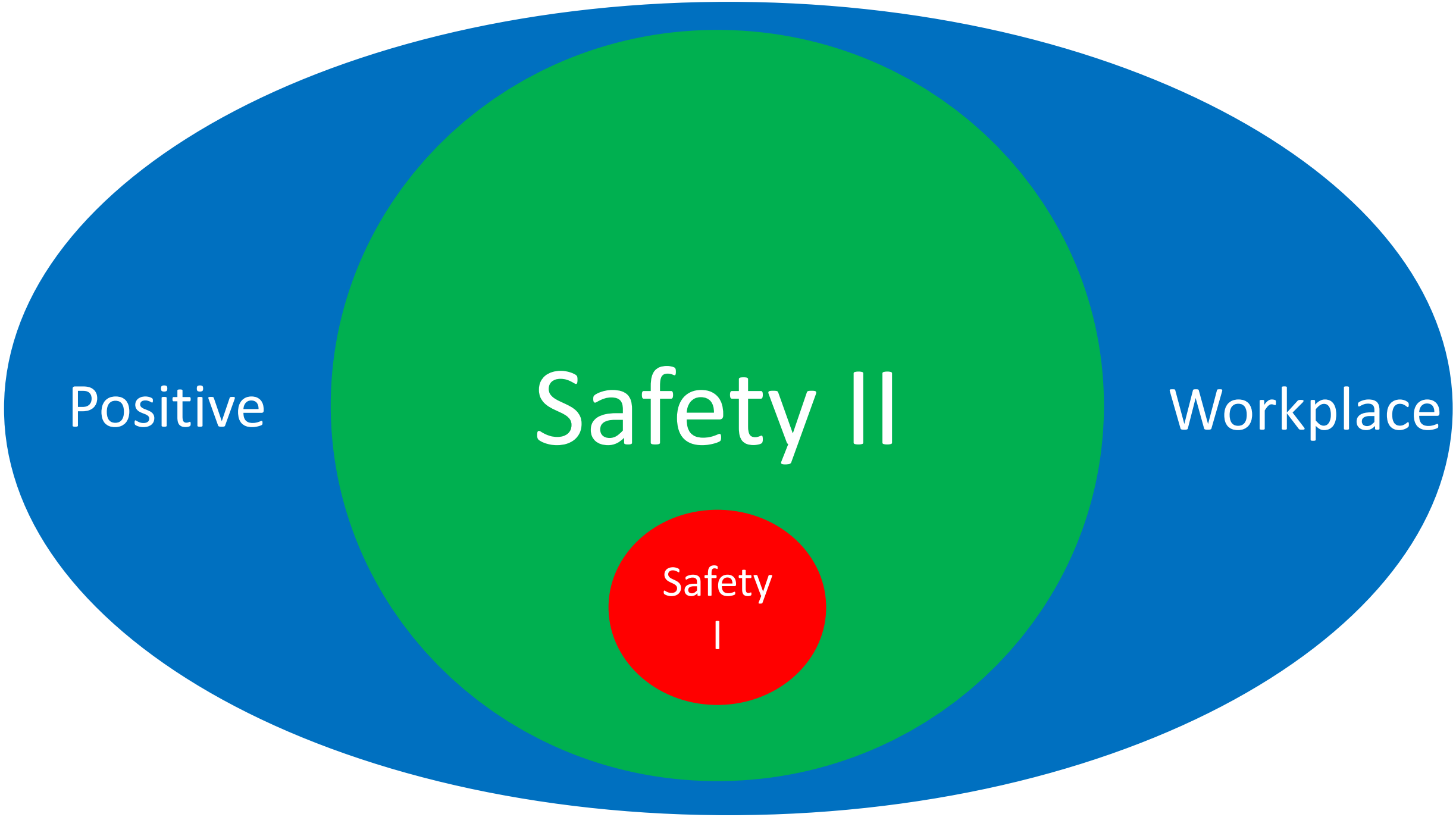
- Professor Sidney Dekker

The story of Mersey Care

Creating a restorative learning culture

30 min film via:

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


Positive
Safety II
Workplace
Safety
I

3

The most important of all


care
for the
people
that
care

SAFER CARE IS ONLY POSSIBLE IF WE CARE FOR THOSE WHO CARE FOR PATIENTS

Healthcare is incredibly complex.

We need to **LEARN** from everything we do, all the time – when things **GO RIGHT** and when they don't

Because healthcare's complicated, it's a **DIFFICULT WORK ENVIRONMENT**

Pressures, unhelpful cultures, stress, incivility and bullying, make it harder to **WORK SAFELY**

Patients are safer when those around them are **PHYSICALLY, PSYCHOLOGICALLY AND EMOTIONALLY WELL**

They need to be fed, supported, thanked, rewarded – even loved

Sign up to **SAFETY**

To help the **WHOLE SYSTEM** perform well, we need to help all **INDIVIDUALS** perform well

Kindness and civility needs to be encouraged and expected

People need the opportunity to connect and **FOSTER POSITIVE RELATIONSHIPS** that let them be heard

We each have a part to play in choosing the values and behaviour that guide our relationships, and we each have the power to **SUPPORT THE PEOPLE WE WORK WITH**

Positivity	Joy	Kindness
Empathy	Appreciation	Gratitude
Compassion	Psychological safety	Learning from excellence

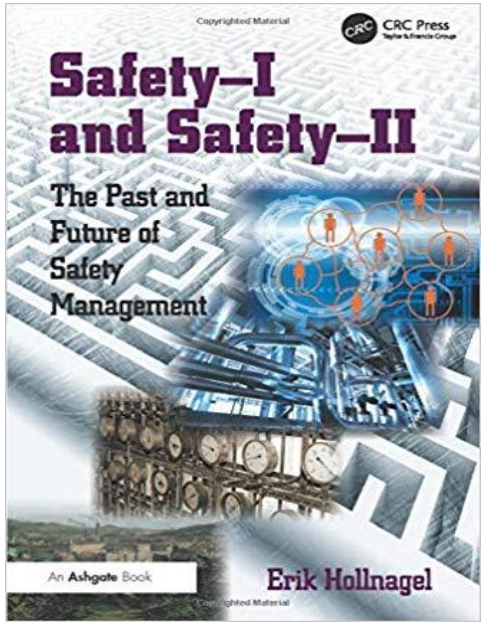
Health and wellbeing

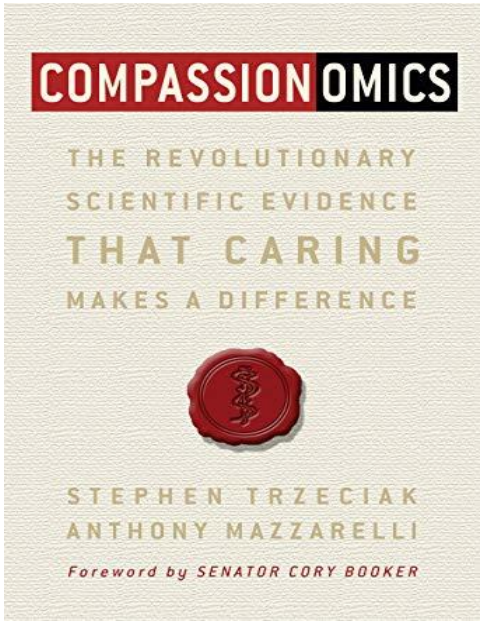
- Fatigue
- Hunger
- Memory loss
- Distractions
- Lack of joy
- Fear of speaking up
- Shame and grief

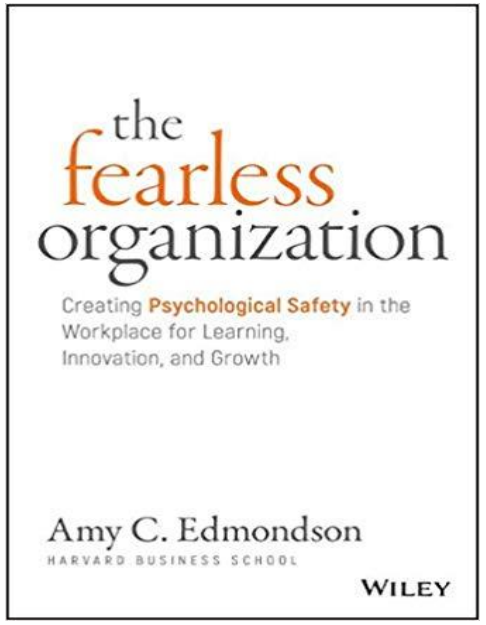
- Time and space to sleep
- Time to eat and drink
- Time and space to think
- Systems to reduce interruptions
- Joy at work
- Psychological safety
- Mental health support

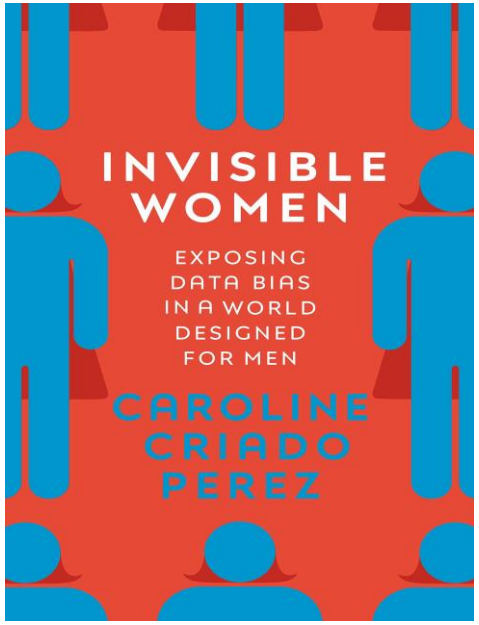
4

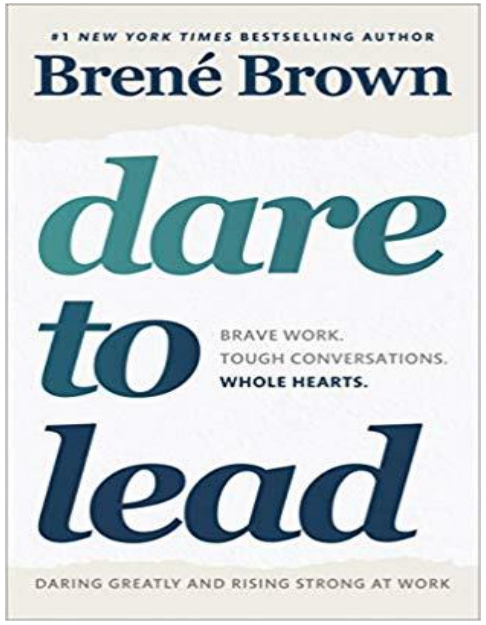
Turn to the evidence

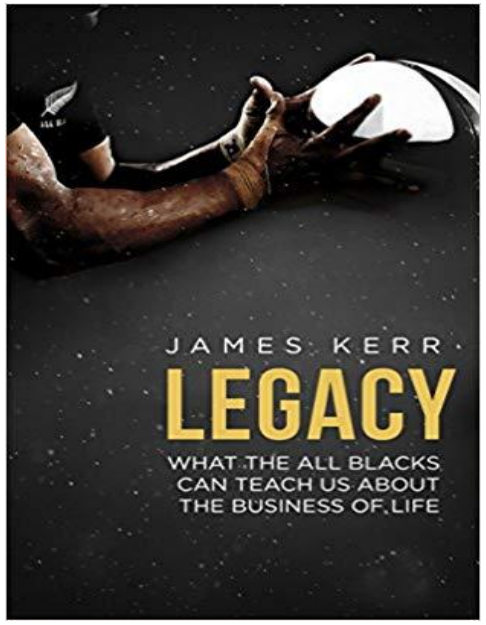

Safety–I and Safety–II
The Past and Future of Safety Management
Erik Hollnagel
An Ashgate Book

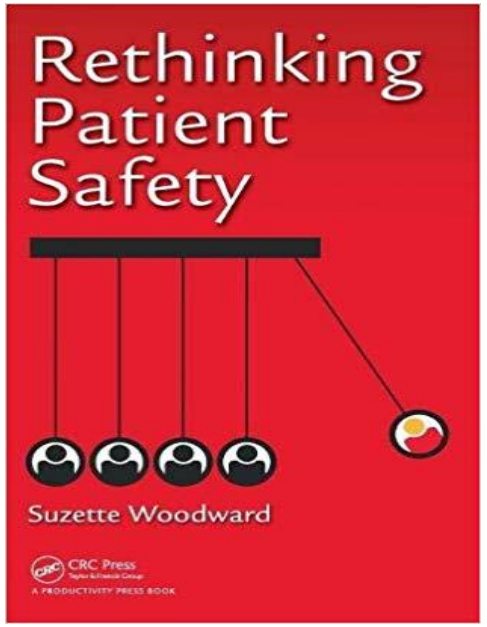

COMPASSIONOMICS
THE REVOLUTIONARY SCIENTIFIC EVIDENCE THAT CARING MAKES A DIFFERENCE
STEPHEN TRZECIAK
ANTHONY MAZZARELLI
Foreword by SENATOR CORY BOOKER

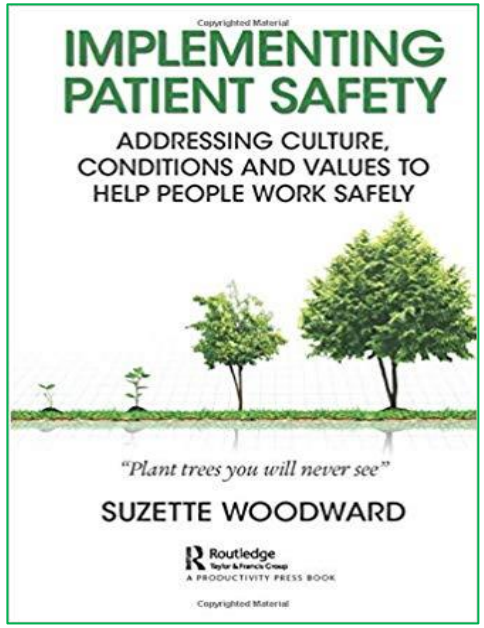

the fearless organization
Creating Psychological Safety in the Workplace for Learning, Innovation, and Growth
Amy C. Edmondson
HARVARD BUSINESS SCHOOL
WILEY


INVISIBLE WOMEN
EXPOSING DATA BIAS IN A WORLD DESIGNED FOR MEN
CAROLINE CRIADO PEREZ


#1 NEW YORK TIMES BESTSELLING AUTHOR
Brené Brown
dare to lead
BRAVE WORK. TOUGH CONVERSATIONS. WHOLE HEARTS.
DARING GREATLY AND RISING STRONG AT WORK


JAMES KERR
LEGACY
WHAT THE ALL BLACKS CAN TEACH US ABOUT THE BUSINESS OF LIFE


Rethinking Patient Safety
Suzette Woodward
CRC Press
A PRODUCTIVITY PRESS BOOK


IMPLEMENTING PATIENT SAFETY
ADDRESSING CULTURE, CONDITIONS AND VALUES TO HELP PEOPLE WORK SAFELY
"Plant trees you will never see"
SUZETTE WOODWARD
Routledge
A PRODUCTIVITY PRESS BOOK

Invisible Women - Caroline Criado Perez

- In a world designed for men by men
- This has the potential to impact significantly on safety
- We need to change that

Compassionomics - Trzeciak and Mazzarelli

- Provide opportunities for people to come together and talk
- Build compassionate conversations
- Build relationships within and across teams and professions
- Really listen
- Do so with humility, respect and kindness

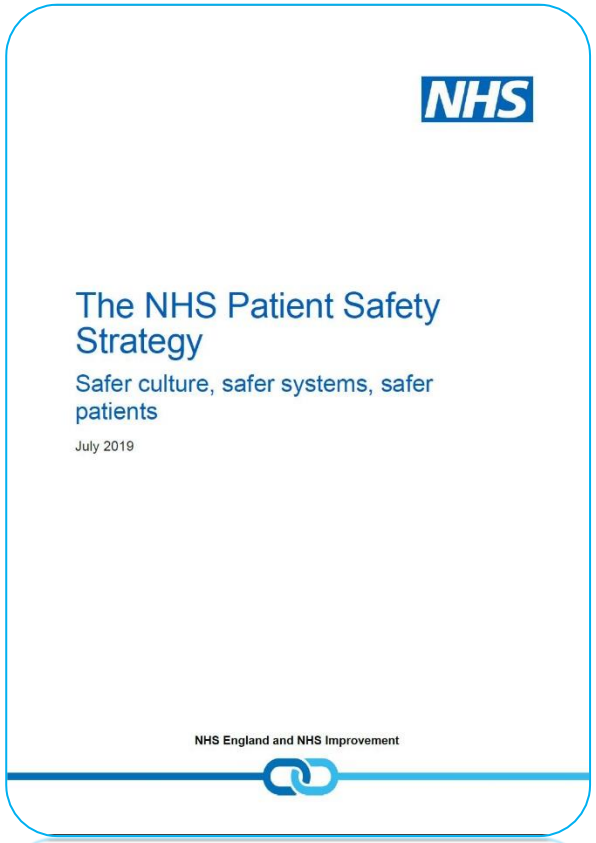
Recognition and appreciation

- When people are recognised for what they do they are 23% more effective

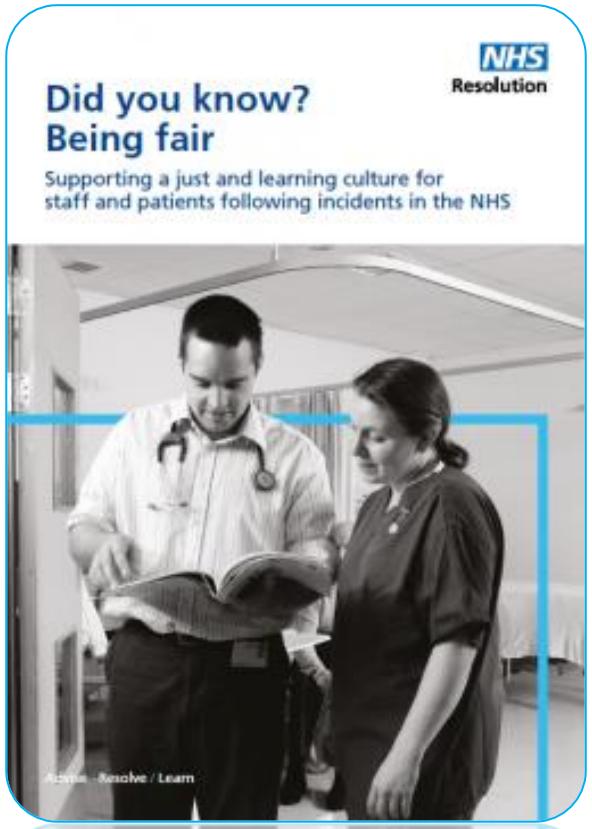
- When they are appreciated they are 43% more effective

Robbins M (2019) Why We Need Appreciation (Not Just Recognition) at Work via

https://greatergood.berkeley.edu/video/item/why_we_need_appreciation_not_just_recognition_at_work



https://engage.improvement.nhs.uk/policy-strategy-and-delivery-management/patient-safety-strategy/user_uploads/developing-a-patient-safety-strategy-for-the-nhs-14-dec-2018-v2.pdf



Chaffer, D., Kline, R. and Woodward, S.

https://resolution.nhs.uk/resources/being-fair/

5

Turn the evidence into practice

We can fix this

You can fix this

What we can do now

Change the language	Change the mindset
Patient Safety	Helping people work Safely
Human Error	Performance variability
Zero harm	Natural variation
It went wrong	Did not go as planned or as expected
Violations	Adjustments and adaptions

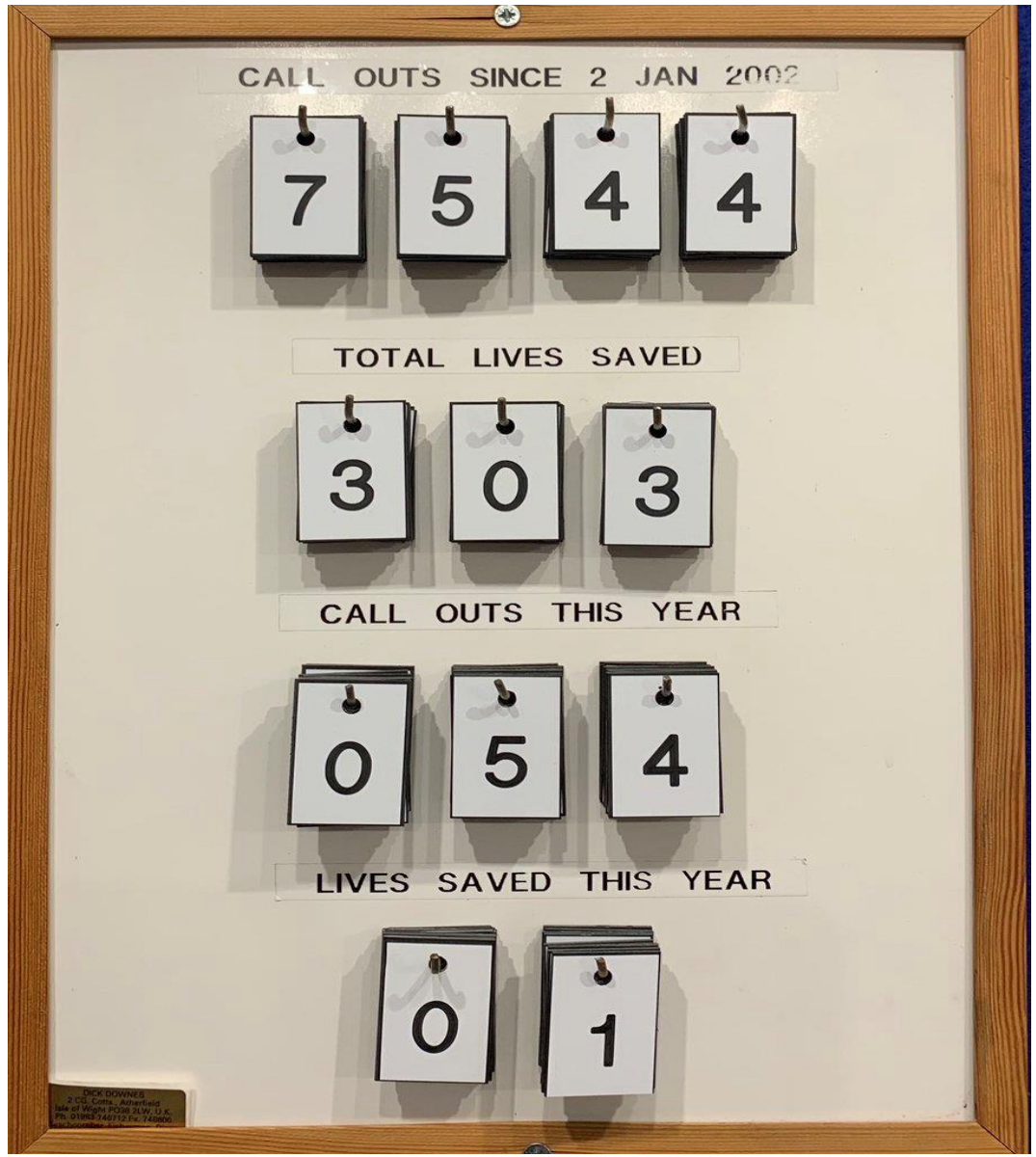

WHEN IT COMES TO BUILDING COMMUNITY:
FOCUS FIRST ON WHAT'S STRONG
NOT WHAT'S WRONG.

- Narrow the gap between work as imagined and work as done
- Find methods that study and analyse our everyday – exnovation, ethnography, daily conversations
- Redesign your current data collection systems – stop doing things that are not working or meaningless
- Change the language
- Build positive workplaces that are filled with joy
- Value, reward and recognise and say thank you

Whenever you see someone do something that you thought was lovely, stop for a minute and highlight it

By helping your team member recognize what excellence looks like you're offering them the chance to gain an insight; you're highlighting a pattern that is already there within them so that they can recognize it, anchor it, re-create it, and refine it

That is learning



RNLI Lifeboats

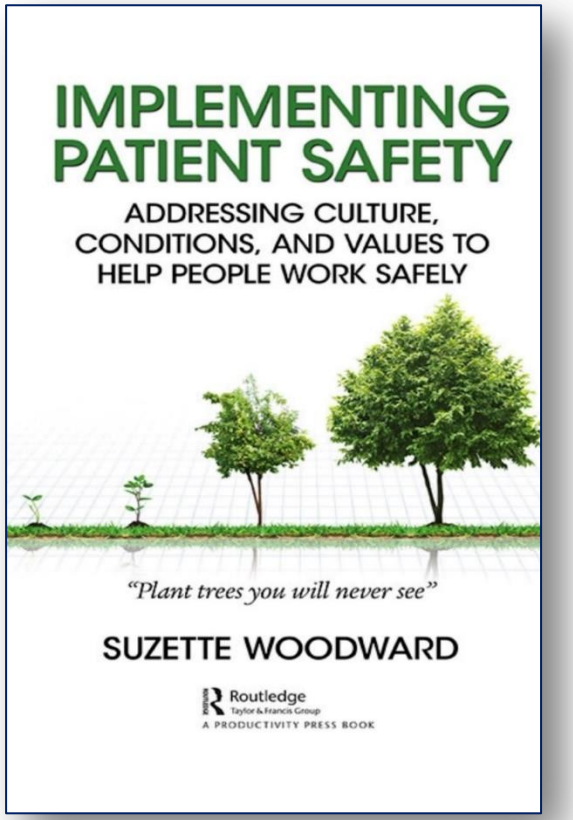
And finally…our time is limited

- Our greatest responsibility is to honour those who came before us and those who will come after
- Plant trees you will never see
- You actions today will echo beyond your time

Legacy – James Kerr

Never forget how powerful it is to simply say thank you

- Twitter @suzettewoodward



Making care safer by sharing ideas, decisions and power with patients and the public

Tessa Richards, Senior Editor /Patient Partnership BMJ

What shapes my views?

Work: General medicine and rheumatology, GP, BMJ editor, 5 years leading its innovative patient partnership strategy

Patient experience: Adrenal cancer, pernicious anaemia, hyperparathryroidism

Family: Carer for son with rheumatoid arthritis +parents with dementia, blindness, heart failure

WHO adopts patient safety as a global priority + 17 Sept 2019 as World Patient Safety Day

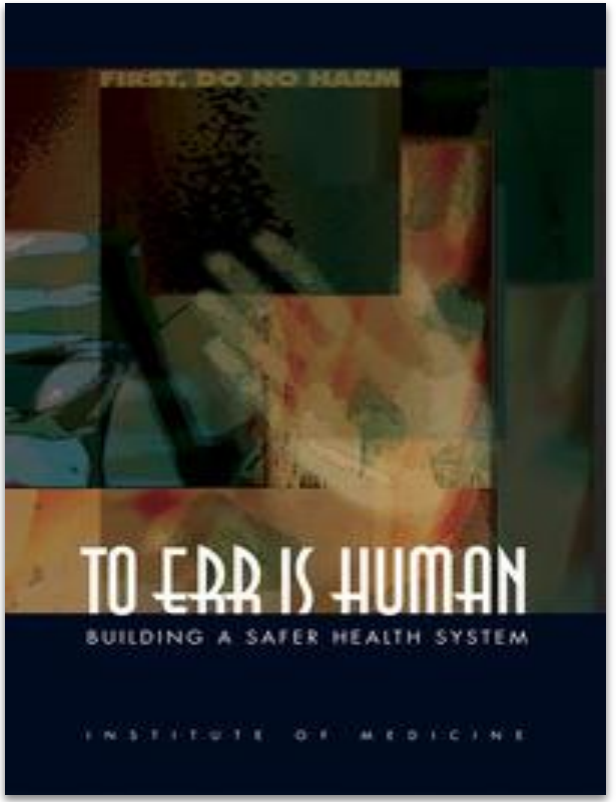
" Globally at least 5 patients die every minute because of unsafe care"

"Greater patient involvement can reduce the burden of harm by up to 15% and save billions "

1999 goal set by the IOM was to reduce preventable error and harm by 50% in 5 years...

- 12 % of patients harmed by healthcare
- Dealing with harm consumes 10-15% of health expenditure
- At least half of patient harm is preventable
- The young, old, vulnerable, and marginalised bear the highest burden
- Evidence from high income countries fails to capture true burden of unsafe care in low + middle income countries

IOM



Panagioti M. *BMJ* 2019;366:14185
https://www.who.int/news-room/fact-sheets/detail/patient-safety

- No clear consensus on the definition of preventable harm
- Adverse events don't capture "near misses" which are under-reported
- Over 80% of care delivered in primary care where research on preventable patient harm is sparse
- Patient harm usually results from the interplay of many failings across the system - not just a missed process of care
- *Patients perspectives essential for reliable detection of harm and near misses*

Papanicolas I. BMJ 2019;366:14611

Five reasons for optimism

Lancet Fontana G 2019 http://dx.doi.org/10.1016/ S0140-6736(19)32134-8

What will you do? or begin to do?

Symbolic action: ***patient safety as a human right ; co signed declaration with patient groups, NGOs and civil society***

Practical action: ***give health services enough resources to do their job safely + introduce mandatory staffing requirements***

Cultural change : ***promote a "just and open culture" which is fair to patients and families and protects staff from inappropriate blame or punishment***

Education interventions: ***put patient safety on curricla + develop role of patients as educators***

Increase patient + public involvement: ***encourage people to speak up about unsafe care + advance PPI in research***

Albert Wu J of Patient Safety and Risk Management (https://doi.org/10.1177/2516043519867525)

Unsafe staffing levels, burnout ,and "toxic" healthcare cultures matter

And fuel debate on who is the victim...

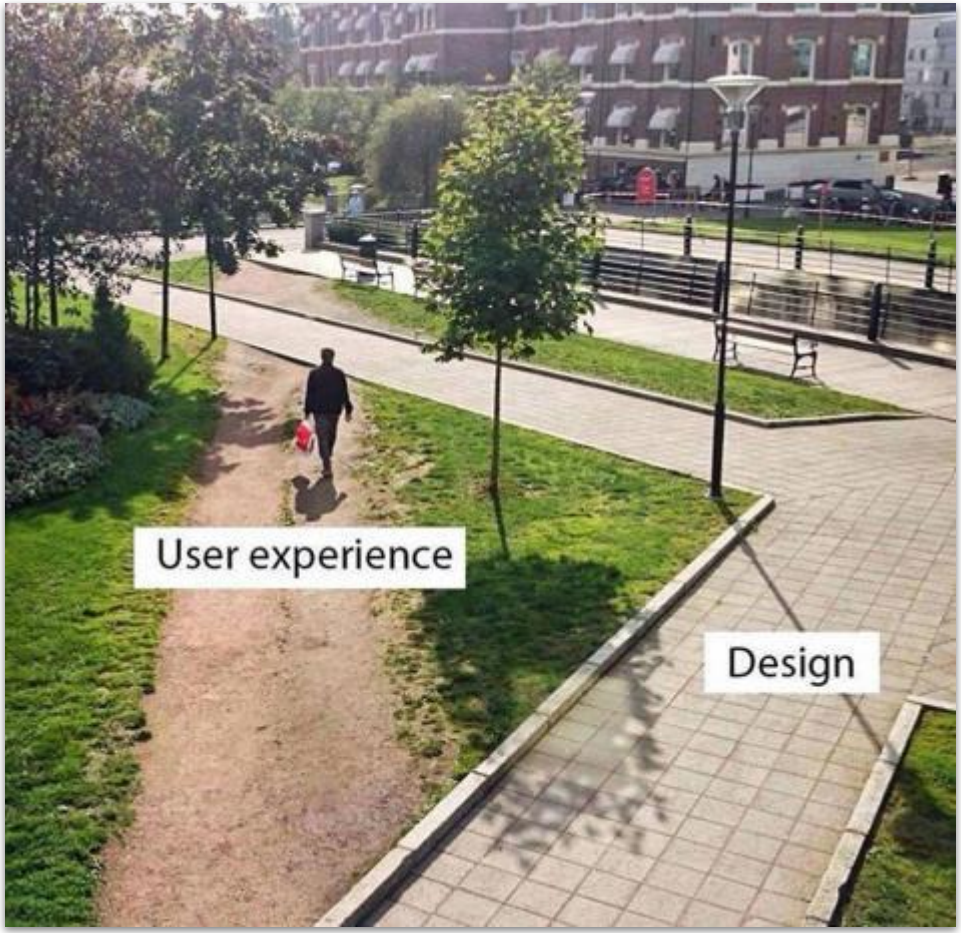
- *"Type "victim of medical error " into google and most of the results are about the second victim"*
- *"By referring to themselves as victims healthcare professionals they (and their institutions) promote the idea that patient harm is random"*
- *"We know who the real victims are"*

Clarkson M BMJ 2019;364:l1233

What the BMJ did on World Safety Day

"Unleash the power of patients to move the global patient safety programme out of the doldrums"

Helen Haskell, co chair of WHO Patients for Patient Safety *(BMJ 2019;366:l5565)*



Disease and doctor centric

Care fragmented, wasteful

Inefficient and too often harmful

Poor understanding of patients experience, priorities. preferences and resources
What outcomes and services they value

Patient and public involvement increasing but falls well short of partnership

Providers : *Patient advisory groups hospitals, primary care. Collection of patient experience data.*

Regulators: *EMA,FDA ,NICE, EU HTA agencies*

Academia: *Med.Education, Cochrane, Royal Colleges*

PPI in Conferences + medical journals

Research : *Funders requiring PPI*

(UK:NIHR, Netherlands:ZonMW, US:PCORI, Canada:SPOR Pharma)

PPI is an evolving science and art, not least in research

Feb 2019 RAND report

Better evidence needed to support it, embed it , and evaluate impact.

Best practice needs to defined and pursued *(https://sites.google.com/nihr.ac.uk/pi-standards/home)*

Priorities for research set jointly with patients and the public need to be taken up(*JLA PSP)*
http://www.twocanassociates.co.uk/wp-content/uploads/2019/09/More-Than-a-Top-10-Sep-19.pdf

More + better data on patient reported outcomes and quality of life (CPROR, ICHOM)

Increasing the role of patients and carers in identifying problems, harms, and preventing them

- **Improve reporting + use of feedback from patients CareOpinion.org.uk**
  https://blogs.bmj.com/bmj/2019/04/24/miles-sibley-evidence-based-practice-a-double-standard/

- **Use insights from those harmed by healthcare to identify "blind and hot spots"**
  https://www.milbank.org/wp-content/uploads/mq/volume-96/september-2018/GILLESPIE_et_al-2018-The_Milbank_Quarterly.pdf

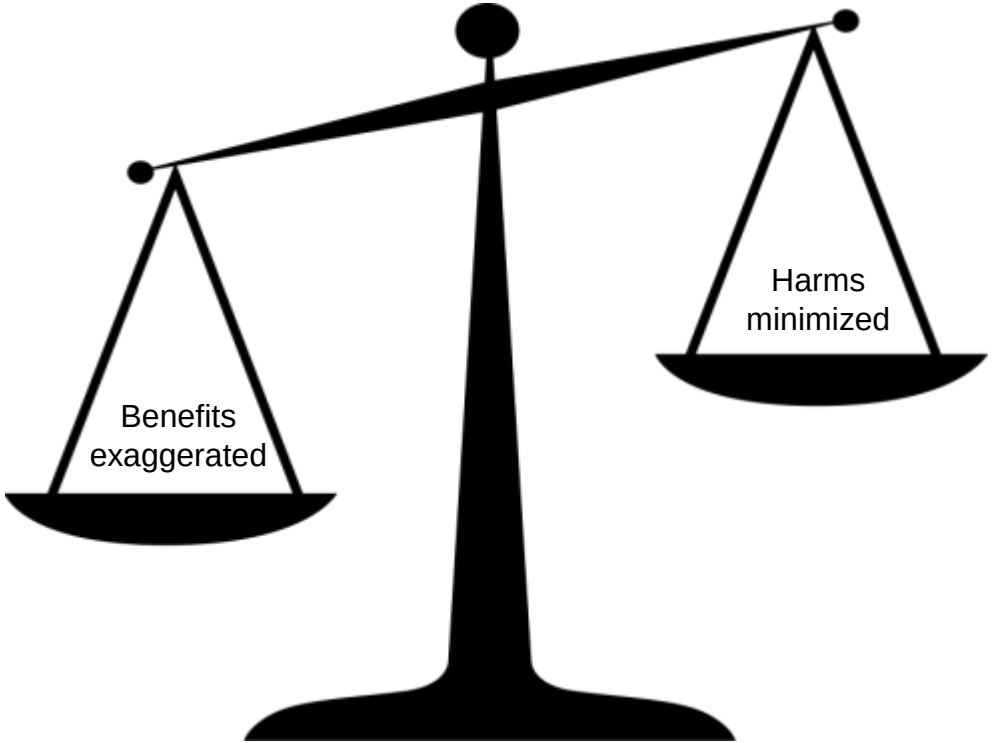
- **Work with "service users" to co design safer systems and environments**
  https://www.pointofcarefoundation.org.uk/our-work/

- **Patients voice included in analyses of "root causes" of error and harm**
  https://blogs.bmj.com/bmj/2017/08/14/sara-turle-and-andy-heeps-having-a-patient-in-the-room-has-changed-the-way-we-look-at-serious-incidents/

- **Make speaking up for safety "safe" for patients, carers as well as healthcare staff**
  https://blogs.bmj.com/bmj/2019/02/05/miles-sibley-the-language-used-to-describe-patient-feedback-has-a-detrimental-influence-on-safety-culture/

Recalibrate the balance between care and cure + and embed informed shared decision making

Health Information is often unbalanced



Journals role in promoting quality and safety in healthcare

Research*:* Patient alongside peer review of research
Mandatory #PPI statement

Education: Patients as contributors/authors/co authors of educational articles, editorials. WYPITS, Partnership in Practice series shares learning on "how to do it"

News & Views: Investigative journalism, campaigns, patient essays and perspectives/BMJ Opinion, H2H debates, podcasts, twitter chats.

Conferences + Awards: #Patients Included

Patient Editors, Patients on BMJs Editorial Board, International Patient/Public Advisory panel views integrated in editorial planning/commissioning meetings

Investigation exposes vaginal mesh “scandal” that has left thousands of women irreversibly harmed - what can we learn?

Implants approved on the flimsiest of evidence

Surgeons not adequately trained + patients not properly informed;

The "dash for mesh" fuelled by manufacturers stopped the development of alternatives

Mesh registries that would have identified complications sooner were not set up

NICE and the UK regulators let them off the hook (doi:10.1136/bmj.k4137, doi:10.1136/bmj.k4164).(doi:10.1136/bmj.k4231),

Unless mandatory national registries are established another mesh tragedy is inevitable.

Surgeons, researchers, and professional bodies are entangled with the device manufacturers.

"Patients who read their notes report understanding their care plans better,8 feeling more in control of their care,78 doing a better job taking their medications,9 improved communication with and trust in their clinicians,79 and improved patient safety.10"

https://www.bmj.com/content/367/bmj.l5725

1) As the advocate, I requested that the patient's loop recorder data be sent to me in addition to the #cardiology team. Dr said it wasn't necessary. "You won't know what to do with the data."

2) Determined, I called the manufacturer and was told "Sorry, you can't have the data. It wasn't designed for that. Don't worry." I was not only worried, I was furious.

3)There was 1 person in the office responsible for checking incoming data transmitted from implanted loop recorders . 1 person for god knows how many patients.

4) The #cardiology team missed 3 extensive #Afib episodes over the course of a few weeks.

5)The compliant, engaged patient had a stroke & ended up in the ER.

@GraceCordovano Enlightening Results

Patients and families have unique insight - and motivation to reduce harm

Justin A. Micalizzi died from an avoidable medical error at the age of 11

Learning from this devastating loss — and making a difference that will improve pediatric health care — has become a quest for Justin's family.

Justin's IHI/HOPE scholarships to health caregivers committed to improving patient safety. (awarded Oct 10 2019)

Thank you

https://www.bmj.com/campaign/patient-and-public-partnership

Tessa Richards,
trichards@bmj.com

Twitter:@tessajlrichards@BMJPatientEd,