27th-28th June 2011, St Andrews, Scotland

Making health care safer: learning from social and organisational research

Visual display abstracts

Visual displays will be on show throughout the conference and you are encouraged to visit them at any time. There are handouts with each display that give further details and contact information.

We have asked the authors to stand by their displays for discussions and questions at these times:

Monday lunchtime: 12.45-14.00

Monday evening drinks reception: 18.45-19.30

The aim of the visual displays is slightly different from the traditional posters at conferences which aim to report research findings. We have asked the presenters to be creative and to use their displays to challenge us, to pose questions and to stimulate discussion. We hope you enjoy this new format!
## List of displays

<table>
<thead>
<tr>
<th>Title</th>
<th>First author/presenter</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 The Scottish Patient Safety Programme</td>
<td>Kirsteen Ellis</td>
</tr>
<tr>
<td>2 Moving and handling and patient safety</td>
<td>Jocelyn Cornish</td>
</tr>
<tr>
<td>3 NHS Fife's Journey to reduce Healthcare Associated Staph Aureus Bacteraemias</td>
<td>Annette McArthur</td>
</tr>
<tr>
<td>4 The Scottish Patient Safety Programme in NHS Fife</td>
<td>Heather Shearer</td>
</tr>
<tr>
<td>5 Scottish National Tissue Viability Programme</td>
<td>Lorraine Hill</td>
</tr>
<tr>
<td>6 Realistic Evaluation of the Safety Improvement in Primary Care (SIPC) Collaborative in NHS Scotland: Early contextual perspectives influencing sustainable quality improvement</td>
<td>Lyn Halley</td>
</tr>
<tr>
<td>7 How to design the complex – if it is complex</td>
<td>Eva-Maria Hempe</td>
</tr>
<tr>
<td>8 Safety Improvement in Primary Care</td>
<td>Claire Hosie</td>
</tr>
<tr>
<td>9 Improving Communication in a New Cardiothoracic Centre</td>
<td>Alison Hunter</td>
</tr>
<tr>
<td>10 Reducing delay and error by improving communication</td>
<td>Alison Hunter</td>
</tr>
<tr>
<td>11 The Hidden Nature of ‘Diagnostic Rescue’ Work</td>
<td>Nicola Mackintosh</td>
</tr>
<tr>
<td>12 Patient Safety and Healthcare Quality in Wales</td>
<td>Sharon Meyer</td>
</tr>
<tr>
<td>13 Evaluation of the SPLINTS system for scrub practitioners' non-technical skills</td>
<td>Lucy Mitchell</td>
</tr>
<tr>
<td>14 Increasing system resilience and patient safety through continued learning using a feedback mechanism – Junior Doctors Dashboard</td>
<td>Nothando Ngenwya</td>
</tr>
<tr>
<td>15 How do managers make health care safer?</td>
<td>Anam Parand</td>
</tr>
<tr>
<td>16 Prevention of Catheter Associated Urinary Tract Infections (CAUTI) using Improvement Science</td>
<td>Shirley Magee</td>
</tr>
<tr>
<td>17 Improving quality and safety in healthcare: a case study in dental primary care</td>
<td>Heather Cassie</td>
</tr>
<tr>
<td>18 Is Leadership Important in the Operating Room?</td>
<td>Sarah Henrickson Parker</td>
</tr>
<tr>
<td>19 The importance of preparing for doctors’ shift handovers</td>
<td>Michelle Raduma-Tomas</td>
</tr>
<tr>
<td>20 Patient safety climate and worker safety behaviours in Scottish acute hospitals</td>
<td>Cakil Sarac</td>
</tr>
</tbody>
</table>
21 The Buddhist Eightfold Path
Tracey Passway

22 Organised patient safety: learning from an experience in implementing a patient safety campaign in an acute general hospital in England
David Puga-Bolio

23 Inter-professional antagonism and the introduction of potentially unsafe practice in the interests of patient safety (health professionals’ responses to the NPSA Correct Site Surgery Alert)
Penny Rhodes

24 Consensus on Assessment and Outcome Measures: Implications for Safer Health Care
Pooria Sarrami

25 Micro-cultures in healthcare: perspectives from NHS managers in a large UK trust
Reema Sirriyeh

26 Safer Warfarin Management in NHS Fife
Paul Smith

27 How will it work? ‘Theory of change’ in patient safety programmes
Carolyn Tarrant

28 Cultural characteristics of a Middle Eastern multicultural healthcare institution and how it facilitates the mechanisms to enhance patient safety
Helena Tuite

29 Workforce ageing, a hot topic: what losing our older, experienced NHS staff could mean for patient safety
Jo Vallis
The Scottish Patient Safety Programme

Kirsteen Ellis, Stirling University and Senior Project Officer, Scottish Patient Safety Programme

The Scottish Patient Safety Programme (SPSP) was introduced to the Acute care areas across Scotland in January 2008 as a five year programme to introduce and establish Quality improvement within clinical areas, there were initially 5 work-streams – Critical care, General wards, Peri-operative, Medicines management and Leadership – with several other programmes and work-streams now being introduced to cover Paediatrics and Neonatal, Mental Health, Primary Care.

Personal experience and anecdotal evidence suggests that there are some clinical areas in which quality improvement methodology is more readily adopted than others – which leads us to ask why is this the case?

Question set

1. Thinking about Scottish Patient Safety Programme / quality improvement methodology implementation at local level, what have been the challenges you have experienced?
2. At local level how have you overcome challenges associated with implementing quality improvement methodology?
3. How much do you consider local / ward / unit culture contributes to challenges experienced in implementing quality improvement methodology / Scottish Patient Safety Programme? Do you perceive that this is the same across your Board?
4. Who or what is the most important influence which prevents implementation of quality methodology? Who or what is the most important influence which facilitates implementation of quality methodology?
5. Do you have successes relating to quality improvement methodology you would like to share? How do you share these successes locally?
6. Do you perceive the experience of implementing quality improvement methodology for a team to be the same as those experienced by individuals implementing quality improvement methodology?
7. What one thing would you change which you perceive would make SPSP / quality improvement methodology easier to implement – but you can’t say more money or staff!

For notes/comments
Moving and handling and patient safety

Jocelyn Cornish and Anne Jones, Florence Nightingale School of Nursing and Midwifery, King’s College London

- Why doesn’t moving and handling appear on the patient safety agenda when there are incidents of patient harm?
- Why do nurses risk causing patient injury by choosing not to use safe moving and handling techniques when moving patients?
- How does the institutional organisation of patient care affect safe moving and handling and why does poor practice persist despite current risk management policy?

Moving and Handling of patients is a fundamental component of nursing care. Patients who are unable to move independently require assistance ranging from verbal encouragement to the use of electric hoisting equipment. Decisions about the most appropriate interventions are made following individual risk assessment of patient need in accordance with national and local policy and professional guidelines (HSE 1992; NMC 2008). This enables the application of a safe system of work which maximises patients’ capabilities as well as preventing falls and other injuries. Previous studies that focus on moving and handling have indicated that patients are harmed because of poor practice, suggesting that moving and handling is an issue for patient safety (Cornish & Jones 2007, 2009). However, there is no discourse on the incidence of patient harm in the literature or the patient safety agenda; the majority of literature considers moving and handling from the perspective of the nurse’s well-being.

Research data shows that students are actively encouraged to participate in incorrect practice by people who might be viewed as their role models. It is important to investigate the reasons why staff flout these professional principles and specific legislation. It is clear that moving and handling comprises a complex interaction of interpersonal behaviours involving appraisal of the situation, risks, benefits and possibilities of achieving the aims of care. Against this backdrop it is important to recognise and understand the contribution of organisational and social influences to safer patient care.

For notes/comments
NHS Fife’s Journey to Reduce Healthcare Associated Staph Aureus Bacteraemias
Annette McArthur and Cathy Gilvear, NHS Fife (Presenter: Heather Shearer)

In January 2008, the Scottish Patient Safety Programme (SPSP) launched a national initiative to improve patient safety across Scotland based upon work undertaken by the Institute of Healthcare Improvement (IHI). The concept of care bundles was introduced at this time along with a series of tools and improvement methodologies.

As part of the programme, the Peripheral Vascular Catheter (PVC) bundle was introduced in an attempt to reduce the number of hospital acquired Staphylococcus Bacteraemias (SAB) developing. Despite the implementation of the bundle the expected reduction in SABs was not as successful as anticipated.

Leadership walk rounds undertaken by the HAI Lead identified a lack of conformity and understanding of HAI across the organisation and suggested that further work should be undertaken.

A multidisciplinary group met to examine the data and identify gaps in the processes around insertion devices. The group found a lack of standardised practice and poor documentation around PVC care and processes and an action plan to standardise practice was devised:

- Standardised practices around documentation
- Regular provision of educational sessions
- Awareness raising initiatives “Care for a Catheter”
- Rolling audit programme undertaken by Leadership based on performance in clinical areas.

Following the launch of the awareness raising sessions to standardise care a reduction in SABs was achieved. The Consultant Microbiologist in a bid to further improve the reduction in SABs developed a local Rapid Event Investigation (REI) tool adapted from Leeds Hospital.

Every SAB within the Operational Division is investigated at ward level by a Consultant Microbiologist and the wider multi-disciplinary team and an action plan developed to address any issues arising.

In a bid to consolidate the learning and taking cognisance of the improvement journey the HAI Lead decided to merge the C difficile and SAB steering groups to focus on HAI collectively. A combination of collaborative working and strong leadership has had a positive impact on the organisation’s mission to reduce SABs in NHS Fife.
The Scottish Patient Safety Programme in NHS Fife

Heather Shearer and Cathy Gilvear, NHS Fife (Presenter: Heather Shearer)

In January 2008, NHS Fife, along with all the other Health Boards in Scotland joined the “Scottish Patient Safety Programme” (SPSP) to improve the safety of hospital care across the country by implementing a series of proven measures and interventions to reduce the rate of “harm” endured by our patients. The implementation of this work was dependent on the application of a series of quality improvement initiatives undertaken by five workstreams:

- Critical Care
- General Ward
- Leadership
- Medicines Management
- Perioperative

Quality improvement initiatives have included:

- Medicine reconciliation
- Warfarin redesign initiatives
- Checkpoint Charlie (Theatres)
- Safety Briefings / surgical pause
- Central line bundles
- SSKIN bundles
- Peripheral Vascular Catheter bundles
- Urinary Catheter bundles
- Staphaureus reduction interventions

Although the programme initially focussed on the implementation of these initiatives within the Operational Division, the work has progressed more widely and each of the three CHPs within NHS Fife now participate in the programme.

Our patient safety work has had a positive impact on patient pathways and the learning within the operational division has been utilised to initiate quality improvement work in other areas.

Viewing safety improvement projects through the lens of an individual patient can highlight interactions between safety projects which may have implications for strategic decisions and priorities.
Scottish National Tissue Viability Programme

Lorraine Hill, NHS Fife (Presenter: Heather Shearer)

An integrated programme was set up by the Scottish Government in June 2008, hosted by NHS Quality Improvement Scotland (now Healthcare Improvement Scotland), to provide a coherent and co-ordinated national approach to tissue viability care throughout Scotland. The programme aims were to improve the overall quality of tissue viability care and reduce the number of preventable pressure ulcers in the first instance, through a Quality Improvement approach.

Four early adopter wards at Queen Margaret Hospital in Fife were initially involved in the testing of the SSKIN Care Bundle to reduce the incidence of pressure ulcers, although testing has since been extended to a further three wards. The SSKIN Bundle consists of five elements, and for the Bundle to work effectively all five elements must be completed when the patient is identified as being at risk of developing a pressure ulcer.

- S-Surface
- S- Skin inspection
- K- Keep moving
- I– Incontinence
- N- Nutrition

This bundle was originally developed in the USA and was brought to the UK by Annette Bartley (Improvement Consultant), which formed part of the 1000 lives campaign in Wales. Through a collaborative approach between Scotland and Wales, the SSKIN Care Bundle is being tested and adapted for use within an array of NHS settings as well as care home settings. In addition to this work, a new high level pressure ulcer risk assessment tool (PPURA) is being tested as a trigger for the SSKIN Care Bundle as part of an innovation work stream using the Institute of Health Care Improvement 90 day Research & Development Framework.

To ensure reliability it was vital that the process of evidence based care was visible to all, and this was achieved through the use of the SSKIN Care Bundle in conjunction with the Pressure Ulcer Safety Cross which is a simple method of recording the count of pressure ulcers which develop, or are transferred into a ward on a daily basis. Various measures are collected from the early adopter wards and feedback is given to ward staff on a weekly basis, and through real time learning sessions.

In the early stages of this work, some of the wards in the pilot study were recording that a new pressure ulcer was developing, on average, every 5-7 days. Whilst there is still much work to do with achieving and sustaining good compliance with various processes, two of the pilot wards surpassed their initial improvement aims in February 2011. One of the acute medical wards sustained 56 days without developing a new pressure ulcer and has continued to sustain improvement, and a second medical ward is presently sustaining more than 220 days without developing a new pressure ulcer, despite the fact that ward dependency had increased in January.

All documentation identified in this abstract was resourced and adapted from the Healthcare Improvement Scotland website www.tissueviabilityonline.com

Lorraine Hill
Practice Development Facilitator-Tissue Viability
NHS Fife
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Display 6

Realistic Evaluation of the Safety Improvement in Primary Care (SIPC) Collaborative in NHS Scotland: Early contextual perspectives influencing sustainable quality improvement

Lyn Halley, NHS Education for Scotland (NES)

Understanding various professional and organisational contexts is crucial in guiding the successful and relevant implementation of safety improvement programmes.

In May 2010, the 1st Wave of the Health Foundation funded Safety Improvement in Primary Care (SIPC) Collaborative was initiated involving 22 primary care teams based in NHS Forth Valley, NHS Lothian and NHS Tayside.

The SIPC Programme Aims
- To develop the safety and improvement skills, knowledge and expertise of up to 80 primary care teams.
- To identify and reduce avoidable harm and improve quality of care for patients with heart failure and those taking high medications.
- A realistic evaluation aims to explain what it is about the programme that works, for whom, in what contexts, and how.

From January to April 2011, multi-professional interviews with 17 Programme Steering Group and 25 General Practice team members identified early contextual findings conducive and non-conducive to the workings of SIPC:

Steering Group: Professional Contexts
- Conducive: Relationship building and collaboration between Programme Steering Group, NHS Boards and Primary Care Teams are key early successes.
- Non-conducive: Competing vested interests; strong personalities; challenging behaviour; over-inclusivity; and communication issues have, at times, hindered decision-making/progress.

General Practice: Organisational Contexts
- Conducive: Motivated, highly organised individuals with a genuine interest in the programme topics and Practices with an open culture, flat structure, strong team working and regular communication are factors driving successful participation in SIPC in addition to effective programme support/training and the allocation of protected time.
- Non-conducive: Time barriers, heavy workloads, lack of an open culture, ineffective and non-inclusive communication, hierarchical structures and lack of engagement of some GP’s are factors causing Practices to struggle to effectively participate. Inadequate resources and remuneration for Practices has potentially further hindered engagement.

Early Programme learning and contextual understanding of the implementation of safety improvement programmes is informing the next stages of the collaborative and also the wider patient safety agenda in primary care.
How to Design the Complex – if it is complex

Eva-Maria Hempe, Engineering Design Centre, Cambridge University

I looked at how to better design safe and suitable services for people with intellectual disabilities. Starting from Engineering Design, I looked into different branches of organizational research and found that a critical application of complexity science can give interesting insights.

I expected to be able to study existing design processes. Instead, when I began my field studies in a local service for people with intellectual disabilities I found myself faced with what I termed “organizational fuzziness”. Official and actual processes often only vaguely resembled each other and sometime there were no clear processes at all. The same was true for certain responsibilities and when asking what the goal or aim of the service was, only few members of staff could give me a clear answer.

Some scholars have argued that health care services are complex and thus a process focused view is not appropriate. I found that some of the fuzziness was indeed due to the high variability and complexity of the needs of the people whom the organization serves. However, in other areas and with the appropriate tools it would be possible to lift the fuzziness and create clear structures and processes. A second important insight was that complexity becomes manageable through simplification (for example through routines and standards). Standardized services will cater to the majority of cases acceptably well. Yet, they come at the cost of exclusion of those who do not fit the scheme.

The questions which I would like to stimulate are: how can we find out to which degree complexity is reducible, which means that processes become controllable, and where do we have to accept complexity? Where we have to accept complexity is important that the service has sufficient flexibility to adapt to it, I will present some ideas how this can be achieved.

For notes/comments
Safety Improvement in Primary Care

Claire Hosie, NHS Tayside

NHS Tayside are currently part of a collaborative to improve patient safety within Primary Care that involves 3 other Health Boards, NHS Quality Improvement Scotland (NHS QIS) and NHS Education Scotland with funding received from the Health Foundation (www.healthfoundation.org.uk). There are 4 workstreams to the collaborative that all 4 health boards are involved in:

- Care Bundles (Warfarin, DMARDs and LVSD)
- Trigger Tool
- Patient Involvement
- Patient Safety Climate Survey

Within Tayside there have been 8 general practices involved in the first year looking at improving the care for patients who are prescribed DMARDs, specifically those prescribed Methotrexate or Azathioprine. Care bundle data has been collected on a fortnightly basis. Improvements identified as a result of the care bundle include:

- Increasing the number of patients who have received the pneumococcal vaccination by updating processes to identify this group and contacting patients using a variety of engagement methods.
- Updating registers and protocols for patients prescribed Methotrexate & Azathioprine including a checklist for patients.
- Developing patient information for patients prescribed Methotrexate or Azathioprine.
- Encouraging patients who miss their monthly appointments to attend regular appointments for blood monitoring.

The 8 practices have also applied the trigger tool methodology to identify potential harm to patients. This approach involves the focused review of a random sample of patient records using a series of ‘triggers’ that alert reviewers to potential harm and previously undetected adverse events. Some areas of harm identified included:

- Allergic reactions to antibiotics due to contraindication with Methotrexate
- Non reporting of potential side effects such as sore throats, bruising.

Practices using the trigger tool have found the trigger tool to be one of the most exciting parts of the programme as it identifies issues the practice would otherwise miss. The trigger tool has allowed them to discuss and implement changes including awareness raising within their practices relating to the harm identified.

All participating practices from across the 4 health boards have attended national learning sets over the last year to share their learning, challenges and successes within their area. NHS Tayside have recruited a further 6 practices to participate in the programme for the coming year.
Improving Communication in a New Cardiothoracic Centre

Alison Hunter and Kenneth McKinlay, ICU, Golden Jubilee National Hospital

KEY ISSUES

Clear communication and reliable review of care plans is an essential element of high quality care, and there is good evidence that setting and regular review of Daily Goals for ICU patients can improve outcomes.

The West of Scotland Heart and Lung centre and was formed in March 2008 following the merger of 4 existing centres. Post merger, our combined unit had no clear process for setting, documenting and communicating plans of care for patients. The process for ongoing review of plans was unreliable, and communication within the multi-disciplinary team was variable. An initial attempt at implementing a process for Daily Goal setting was unsuccessful.

THE IMPROVEMENT PROJECT

We tested and implemented a process for setting Daily Goals. We carried out multiple tests of change around the format, content and timing of our Daily Goals. Learning from previous failure and with advice from the Scottish Patient Safety Programme Listserv, we simplified the process, requiring 2 goals only and designed a structured review as an integral part of the process. We used a simple paper form which is brightly coloured to act as a visual cue.

As with many improvements, the real challenge lay in engaging the users. To support this we held gallery style meetings to actively engage doctors and nurses in agreeing a shared baseline initially, and subsequently to review our data and identify barriers to progress.

OUTCOME

The most notable effect of our project is the improvement in communication between medical and nursing staff. Nurses are able to articulate the plan for their patient and can rely on structured and timely review of care plans.

We measured communication by asking nurses to accurately describe two goals of care for their patient. This improved from baseline of 60% to 90-100%. It is notable how closely our communication measure has tracked the reliability of daily goal setting.

Alison Hunter
Senior Charge Nurse

and

Kenneth McKinlay
Consultant Intensivist/Anaesthetist

ICU
Golden Jubilee National Hospital
Reducing delay and error by improving communication

Alison Hunter and Meghan Bateson, ICU 2, Golden Jubilee National Hospital

Key issues
This improvement project will be conducted in a 12 bed Cardiothoracic ICU in the West of Scotland. The patients are a heterogeneous mix from cardiothoracic surgery, interventional cardiology and acute heart failure. Within this ICU a key challenge in delivery of care is communication, particularly in reference to documentation.

An electronic patient record (EPR) is in place within the clinical area. While EPRs offer significant benefits in patient safety they also pose considerable challenges. The current free text format of the medical notes within the EPR has resulted in high variability of the content and quality. Furthermore, when utilising the EPR for clinical decision making, the lack of a common structure contributes to time wastage and communication errors.

The aim
Within the next 10 months the aim is to:

- Improve the quality and standardize the content of the medical note made on the morning ward round.
- Embed the Daily Goals sheet into the medical note to remove duplication of documentation
- Achieve a shared baseline for patient examination and care planning.

By December 2011 the medical note section of the Multi Disciplinary Team measure (Scottish Patient Safety Programme) will be greater than 90% reliable.

The improvement project
Methodology to fulfill aim:

- Gather existing examples of good practice in other centres around the UK.
- Undertake a Delphi process with an external panel of ‘experts’ – agree initial question with internal group
- Use the knowledge generated from the Delphi and external exemplars to build a ‘shared baseline’ of acceptable medical note structure and content.
- Design a proforma for the medical note based on the agreed shared baseline.
- Use the Model for Improvement to carry out small tests of change to test, implement and evolve the proforma.

Outcome
Outcome will be measured via:

- The existing Scottish Patient Safety Programme metric for multi-disciplinary rounds
- Designing a measure of communication and/or satisfaction
- Time taken for ward round
The Hidden Nature of ‘Diagnostic Rescue’ Work

Nicola Mackintosh, King’s Patient Safety and Service Quality Research Centre

Nicola Mackintosh: PhD student
Supervisors: Jane Sandall & Charlotte Humphrey

Abstract
‘In the beginning of the malady it is easy to cure but difficult to detect, but in the course of time, not having been either detected or treated in the beginning, it becomes easier to detect but difficult to cure’
(Machiavelli 1505)

The Key Issues
Policy discourse regarding ‘rescue of the acutely ill patient’ demarcates distinct stages to this process. These include monitoring, recognition of warning signs, interpretation and timely institution of appropriate clinical management once deterioration is identified. This categorisation presents too simplistic a picture of medical work and creates an illusion of transparency (Tsoukas, 1997). This doctoral study details how the majority of rescue work is distributed, collaborative and reflexive. Caring for acutely ill patients is underpinned by much hidden diagnostic work, i.e. the ‘intertwined practices of sense-making, assessment and action’ (Büscher, Goodwin, & Mesman, 2010 p.3). These diagnostic processes embody the nature and status of different types of rescue work and determine perceived notions of both the accuracy of interpretations and appropriateness of actions. This paper draws on findings from a 12 month ethnographic study of the management of complications in medicine in two UK NHS Trusts. Data will be presented from participant observations (>150 hours) and interviews (35) with health care assistants, nurses, doctors and managers.

Why these issues are important
This paper responds to calls for patient safety research to explore the ‘embodied, spatial, and interactive fabric of care’ (Iedema 2009). It shifts patient safety thinking away from a deficit model towards what Mesman terms ‘exnovation’, or the process of making existing team work strengths explicit (2008). This paper will facilitate debate regarding the importance of collaborative, mundane, ‘mind-the gap’ work in maintaining safety.

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Iedema, R. (2009) New approaches to researching patient safety. Social Science and Medicine, 69(12), 1701-1704
Patient Safety and Healthcare Quality in Wales
Sharon Meyer and Andrea Herepath, Department of Primary Care and Public Health, Cardiff School of Medicine, Cardiff University

Introduction
The Patient Safety and Healthcare Quality Registered Research Group fosters collaboration between the Universities of Bangor, Cardiff, Glamorgan, and Swansea, and is funded through a competitive process by the National Institute for Social Care and Health Research, Welsh Assembly Government.

Led by Cardiff University, and hosted in the Department of Primary Care and Public Health at the School of Medicine, this research group brings together a multi-disciplinary network of researchers to catalyse a programme of empirical research that seeks to enhance the evidence-base to inform future activity in Wales, the UK, and internationally.

In its start-up year, the Patient Safety and Healthcare Quality Registered Research Group has been awarded research grants from the National Institute for Health Research Health Services Research programme, the Service Delivery and Organisation programme, the Health Foundation, and the National Institute for Social Care and Health Research. To maintain this impetus, the research group is seeking to extend its network of collaborators across the UK.

The Patient Safety and Healthcare Quality Registered Research Group has two core themes in its emergent programme of research:

The epidemiology of harm—The research programme aims to describe the epidemiology of harm in Welsh hospitals. It therefore seeks to develop, and evaluate, the systematic assessment of error and harm collected from a wide range of sources (e.g. the Global Trigger Tool), so as to move towards the active surveillance of salient events.

Realist analysis and evaluation of patient safety and healthcare quality—A series of research programmes, each adopting variants of realist ontology, aim to examine the organisational context of patient safety and health care quality, and the role of the patient in the co-production of safer, high quality care.

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Evaluation of the SPLINTS system for scrub practitioners’ non-technical skills

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Background: The Scrub Practitioners’ List of Intraoperative Non-Technical Skills (SPLINTS) system is a prototype tool for training and assessing non-technical skills of the scrub practitioner in the operating theatre. The SPLINTS system contains 3 skill categories (situation awareness; communication and teamwork; task management). There are 3 behavioural elements underlying each skill category and the system also provides example behaviours (behavioural markers) for good and poor performance, to guide users of the system. This poster explains the prototype SPLINTS system and reports the psychometric properties and inter-rater reliability from an evaluation study.

Method: Experienced scrub practitioners (n=34) attended a single-day training/evaluation session. Participants received background training in human factors and non-technical skills in healthcare (4-hours). They were then trained to use the SPLINTS system (1 hour) before practising and using SPLINTS to rate the scrub practitioners’ non-technical skill performance in seven video-recorded simulated surgical scenarios (2 hours).

Results: Inter-rater agreement and accuracy of the SPLINTS system were assessed. Inter-rater agreement for skill categories (n=3) was acceptable ($r_{wg} > .70$). The underlying skill elements (n=9) were also reliably rated. Mean absolute deviation from reference ratings (by subject matter experts) indicated that participants were within one scale point in > 90% of ratings. Internal consistency of the system was good with a mean absolute difference $M < .2$ of a scale point (on a four point scale).

Conclusion: The SPLINTS system is a reliable tool for rating scrub practitioners’ non-technical skills in standardized, video scenarios. Usability of the SPLINTS system in the real operating theatre environment is currently being assessed.

For notes/comments
Increasing system resilience and patient safety through continued learning using a feedback mechanism – Junior Doctors Dashboard

Nothando B Ngenwya, Ugochi Nwulu and Jamie Coleman, University Hospitals Birmingham NHS Foundation Trust

Preventing human errors in healthcare has been a major priority of the patient safety agenda with information technology systems developed to reduce these errors. The identification of medication errors has historically had more of a “name, blame and shame” approach which has led to concealment rather than disclosure and learning. There is a need for change in this approach and this research proposes that informing junior doctors of their performance whilst using Clinical Decision Support Systems is one way of effecting a change in practice. University Hospitals Birmingham NHS Foundation trust has used an electronic Prescribing, Investigation and Communication System (PICS) with integrated Clinical Decision Support for over a decade. All prescriptions within the trust are made using PICS. There are currently over 23,000 prescriptions made in any one week period with 600 prescribers.

The workload of junior doctors has a high cognitive demand requiring precision and accuracy within their clinical role. CDSS have been implemented in many healthcare settings to aid clinicians in this cognitive work. What has emerged, however, is the occurrence of unintended consequences which can be caused by poor understanding of the role of the CDSS by clinicians. The Junior Doctors’ Dashboard is a tool that proposes a solution to this misperception by providing doctors with personal feedback on their use of PICS to prescribe medication within the trust. This feedback will empower them with knowledge of their skill level, compared to their cohort, which can motivate improvement in performance and the maintenance of their expertise. This feedback also aims to increase compliance with an important patient safety tool. Continued learning means the clinicians are more up to date with new developments within PICS consequently helping to increase its resilience and thus its ability to adapt to changing health care demands and priorities.
Managers in secondary care have a responsibility for the standard of service and patient care delivered. Whilst there has been much research supporting the positive impact of management on safety within industry, the role of management for safety within health care remains largely unexplored (Flin & Yule, 2004). In particular, the role that hospital managers play in patient safety requires attention in order for policy makers to develop well-informed decisions on what actions managers should be taking to make care safer.

Furthermore, health care management has been criticised for not learning from other disciplines, such as organisational behaviour and management studies (West, 2001). Whilst there are well-established academic pioneers in the field of management, such as Rosemary Stewart and Henry Mintzberg, who have offered both practical and theoretical recommendation for managers, theory-based recommendations have yet to permeate the boundaries of the hospital to improve processes, structures, strategies and styles of management.

The objective of this visual display is to present and debate findings from an ongoing PhD on the role of secondary care managers in patient safety and quality and include organisational psychology theoretical principles that explain them.

One study comprises of 38 semi-structured interviews with middle managers (e.g. general managers, service managers and service delivery managers) within two specialities (surgery and general medicine), conducted at a large teaching NHS Foundation Trust and a District General NHS Foundation Trust. The interviews were undertaken between December 2010 and February 2011. The researchers responsible for both interviewing and analysis had diverse backgrounds (Organisational Psychology and NHS management) to ensure multiple perspectives. Factors concerning managers and quality & safety included: daily responsibilities & routine; improvement activities; barriers & facilitators; targets & priorities; influence & change; knowledge & research translation; competencies; and impact.

For notes/comments
Prevention of Catheter Associated Urinary Tract Infections (CAUTI) using Improvement Science

Shirley Magee, Glenrothes and North East Fife Community Health Partnership (CHP)

With a desire to improve catheter care within the ward, a meeting between the Senior Charge Nurse and the Clinical Effectiveness Facilitator resulted in an improvement journey which would embrace the introduction of a new way of providing care within the ward by introducing the CAUTI prevention Bundles.

An opportunity arose for the Clinical Effectiveness Facilitator to participate in the Improvement Science in Action Course which was offered by the Institute for Healthcare Improvement and Sponsored by the Scottish Patient Safety Programme.

Utilising the Improvement Science methodology and ensuring collaborative working with clinical staff, Infection Control and the SPSP programme manager and SPSP fellow, Implementation of the Care Bundles are spreading across the organisation.

The CAUTI project resulted in the development of a Driver Diagram and the introduction of documentation to capture daily bundle care. Utilisation of the Model for Improvement ensures robust testing of the implementation of the bundles.

The project outcome is the successful implementation of the care bundles within our organisation ensuring a consistent, standardised approach to patient care. Measures include:

- Data collection of staff compliance with the bundles.
- Incident Crosses to record the incidence of Urinary Tract Infection within ward areas.

This project precedes the adaptation of the bundles for future use in the community setting which will involve multiprofessional planning to ensure that the best possible care can be given to patients in their own home. The development of Patient Self Care educational tools is fundamental to this process in order that the core principles of UTI prevention are captured and understood.

Another vital component to be considered is the quality of the content of the transfer and discharge documentation to ensure continuity care following transfer between wards within our hospitals and on discharge to the Community. In order to address this we will need to collaborate with our colleagues across all sectors to develop a tool that’s suits all circumstances.

There is also the potential for further spread within other Health Boards across NHS Scotland.
Improving quality and safety in healthcare: a case study in dental primary care

Heather Cassie, Dental Health Services and Research Unit, University of Dundee

CSO Doctoral Fellowship; Start Date 1st October 2010.  
(Supervisors: Professor Jan Clarkson, Dr Shaun Treweek, Professor Lorna McKee, Dr Craig Ramsay and Dr Linda Young)

Background:
Improving quality is fundamental for healthcare organisations. Whilst one means of ensuring high quality, effective care is the development of evidence-based guidance, a consistent finding is that translating this into practice is an unpredictable and haphazard process. Numerous studies have explored the impact of individual level behaviours; however, few have explored organisation/team level behaviours.

Aim:
To investigate which characteristics of primary healthcare organisations influence knowledge translation.

Objectives:
1. To explore the structure, culture and management of primary healthcare organisations.
2. To develop a self-report questionnaire-based instrument to measure structure, culture and management in general dental practices.
3. To determine which organisational characteristics are the most influential on knowledge translation.

Methods:
The study will comprise three phases:
1. a literature review exploring organisational change in primary healthcare organisations, focusing on knowledge translation; Critical Interpretative Synthesis will be used;
2. development and validation of a self-report questionnaire-based instrument to measure structure, culture and management in dental practices;
3. dental practice case studies, using mixed-methodology to collect data on the structure, culture and management of dental practices along with self-report compliance data to explore the relationship between organisational characteristics and guidance compliance.

Expected Findings:
It is anticipated that the study will identify the organisational characteristics that influence knowledge translation. The results will contribute to a framework for the translation of evidence and clinical guidance into routine clinical practice, ultimately improving effectiveness and quality of care for patients.

For notes/comments
Is Leadership Important in the Operating Room?

Sarah Henrickson Parker, Steven Yule, Rhona Flin, University of Aberdeen and Aileen McKinley, Aberdeen Royal Infirmary

Leadership is “...the process of facilitating individual and collective efforts to accomplish shared objectives”¹ and has been consistently identified as a key component for the successful functioning of teams.²⁻⁴ In industry, the quality of supervisory leadership has been related to decreased errors, reduced costs, improved safety⁵ and increased compliance with safety standards.⁶⁻¹⁰ Leadership can include functions such as defining the team’s mission, establishing expectations and goals, providing feedback, monitoring the team, and solving problems.¹¹ Traditional models of leadership may not be applicable to the operating room. For example, the surgeon is a technical expert, and may be the only member of the team with the ability to do the operation. Also, the team is interprofessional, ad-hoc and of limited duration, formed to accomplish a very specific task goal but the surgeon is not necessarily the team members’ supervisor.

Key issues to discuss:

1. Who is the leader in the operating room?
   - Within the OR, there is an entire team and three subteams: anaesthesia, surgical and nursing but it is not entirely clear if there are therefore three or more leaders at one time or how these various leaders interact. Also, who is the ultimate leader?

2. Should surgeons be responsible for team development, as in other industries?
   - When teams are ad-hoc, multidisciplinary, and formed for a short duration, who should be responsible for long-term development?

3. What is the relationship between responsibility for the patient and leadership?
   - This is an important legal and policy question: Surgeons are legally responsible for the patient even though they may not be doing the whole operation.

4. Are leadership behaviours for safety domain specific or general across all areas of the healthcare system?
   - This question has implications for training and certification for medical trainees, nursing trainees, and ancillary staff.

References:


For notes/comments
This PhD project found that the doctors’ shift handover process (in two acute medical units- AMU) consisted of a preparation phase (pre-handover), the handover meeting, and a post-handover phase. The pre-handover phase was found to be critical for effective and thorough handover, because it included the out-going doctors identifying sick patients and re-establishing a shared team understanding of patients to be discussed. The post-handover phase allowed doctors of the incoming shift to prioritise patient care based on the information communicated during the handover meeting. A Hierarchical Task Analysis constructed from interview and focus group data showed that there were key tasks that should be completed at each phase; observations found that some of these were omitted, especially during the pre-handover phase by out-going doctors due to inadequately updating supporting handover tools (e.g. patient lists/whiteboards). Findings also suggested that interruptions had a detrimental effect on the pre-handover phase, which was occasionally not resumed or even conducted due to staff interruptions. The location of where handovers were prepared and conducted (e.g. main corridors) may have played a major role in encouraging interruptions to the handover process. In light of these findings, it is worth considering:

- Handover quality improvement requires researchers to understand unit/ward cultures in order to develop and/or improve supporting tools for handover (preparation)\(^1\).
- Unit leaders need to recognise that preparation is not optional for good handover, but that it is a requirement.
- Minimising interruptions should be highly prioritised as studies in healthcare show that interruptions increase cognitive workload of clinicians and lead to medical errors\(^2\)\(^-\)\(^3\).

References
Patient safety climate and worker safety behaviours in Scottish acute hospitals

Cakil Sarac, Rhona Flin and Kathryn Mearns, Industrial Psychology Research Centre, University of Aberdeen

In 2007, the government Health Department launched a Scottish Patient Safety Alliance, a national initiative to improve patient safety, with the aim of reducing adverse events by 30% and hospital deaths by 15% in a four year period, along with clinical targets (http://www.patientsafetyalliance.scot.nhs.uk/programme). The ultimate objective was stated as, ‘to improve the organisational and leadership culture on safety’ (Quality Improvement Scotland, 2007). This paper presents the results from the first questionnaire study of safety climate in Scottish acute hospitals.

In order to identify possible areas of organizational culture and practices that could be targeted to improve patient safety across Scottish acute hospitals, a comprehensive safety survey was conducted of clinical staff (n = 1866) in six hospitals. This used the Scottish Hospital Safety Questionnaire with the Hospital Survey on Patient Safety Culture (HSOPSC) (Sorra & Nieva, 2004) as the main component of the instrument, along with several safety outcome measures (i.e. safety behaviours, self-reports of worker and patient injuries). The aims of the study were first, to obtain a measure of safety climate from a sample of NHS acute hospitals in Scotland and to test whether these climate scores were associated with worker safety behaviours and patient and worker injuries. Furthermore, safety climate scores were also examined based on the Scottish Patient Safety Programme (SPSP) involvement of the unit and the staff perceptions about the overall effect of the SPSP.

The results illustrated the areas of concern mainly at the organizational level variables, such as perceptions about the senior management and handovers across hospital units. The associations between the HSOPSC factors and the outcome variables were examined via regression analyses. The results revealed that the Staffing dimension had a significant influence on every outcome measure excluding the frequency of incident reporting, indicating that perceptions of the adequacy of staffing levels were associated with safety outcomes. When staff perceptions were examined in relation to the SPSP, significant differences were found between staff from units participating in the SPSP and those who are not. Moreover, participants who reported a positive effect of the SPSP, had more favourable perceptions about each aspect of the HSOPSC and higher rates of safety behaviours compared to the participants who reported a negative effect or no effect at all.

For notes/comments
The Buddhist Eightfold Path

Tracey Passway and Derek Tasker, NHS Tayside

Within the health setting patients and staff stories and patient and carers views have been seen as tools for positively influencing the care environment. Partnership working is a clear ambition within the Scotland Healthcare Quality Strategy 2010 within the key driver of Person Centredness.

Within NHS Tayside a number of tools and techniques are being used to measure the clinical effectiveness of care and treatment:

The question remains, do staff use this feedback to change or modify behaviour and how do we validate this?

We argue that safe, effective care exists where the culture is dynamic and built on trust and confidence. Using the questionnaires above will give insight into the process of care; the quality of care will be measured by the level of harm associated with adverse incidents, a reduction in the number of patients’ complaints and a reduction in staff sickness and these will be validated by the team vitality.

The Noble Eightfold Path is a Buddhist practice said to lead its practitioner toward self-awakening and liberation. It is a path which has been followed and practiced by all previous Buddhas and is taught to the Buddhist disciples so that they too can follow it. There are eight factors and these are sometimes divided into three basic divisions: wisdom, ethical conduct, concentration.

We believe aspects of this Buddhist practice can be applied to our work in this area. Wisdom can be defined as ‘the sense of direction with its conceptual understanding of reality’. The right view can also be demonstrated as the right perspective or right outlook. Improvement methodology encourages us to look through ‘the lens of profound knowledge’ and we as improvement leads and practitioners need to view care and treatment from the perspective of the patient.

Ethical conduct is centred upon the person and how we interact with people, how we view others. This builds upon treating patients, colleagues and others with dignity and respect and to an extent the care we give to our patients. Ethical conduct is balanced by each professions code of professional conduct. By following a philosophy of doing no intentional harm and acting in the patients best interest we are mindful of our actions, our own values and how we want others to see us.

Concentration can be defined as being safe and effective; ensuring that the outcome of our wisdom and conduct does not place patients at risk, impact negatively upon our colleagues and that we share similar values and visions. Thus we will reduce harm, complaints and staff sickness.
Organised patient safety: learning from an experience in implementing a patient safety campaign in an acute general hospital in England

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Our research looked into the factors affecting the implementation of a safety campaign in an acute general hospital in England, as part of a national initiative (the Patient Safety First campaign). We found that in this instance and as a result of a series of organizational factors, the programme has not been successful in greatly increasing awareness of patient safety issues in any systematic way, due in part to a lack of definition and support structures, resulting in delays and resistance to the process and generating an apparent lack of effectiveness and sustainability of organised patient safety efforts in the long term yet the hospital group continues to provide safe care for its patients according to measured standards. We discuss this paradox and conclude that improved patient safety at an organisational level is not always best served by organisation-wide programmes tackling specific conditions.

This information was used to construct a theoretical model of an ideal patient safety system, combining the views of various actors and stakeholders in the process with the ultimate objective of reaching an understanding of patient safety viewed as a purposeful system of its own rather than merely a property emerging from the greater healthcare system.

We propose that both external agencies in charge of patient safety programmes and organisational managerial structures as the owners and key actors of the improvement process should concentrate improvement efforts on creating the support structures that allow for strong safety systems to take shape, which does not seem possible unless the greater healthcare system aligns its strategic objectives and policies regarding safety at the same level as finance and productivity.
In March 2005 the NPSA issued a National Patient Safety Alert on Correct Site Surgery.

The alert specified marking of the correct site, how, when, where, by whom and with whom it should be done, and a series of 3 subsequent checks, each of which had to be documented and signed.

We looked at attitudes and practices prior to the issue of the alert and how they might have changed 12 months after it had been issued.

We found that:

- nurses and managers had different responses from surgeons – nurses and managers were more in favour and more compliant than surgeons
- surgeons’ attitudes and practices were aligned by speciality, those of nurses were not

Nurses and managers saw doctors’ resistance as an example of medical intransigence and cavalier disregard for ‘the rules’ rather than a matter of genuine clinical judgement.

The alert provided both the opportunity and means of exerting power over doctors by enforcing compliance with ‘the rules’, creating an ‘unholy alliance’ between nurses and managers.

In order to make doctors conform, nurses and managers collaborated unilaterally to introduce measures that would ensure compliance – refusing to release patients who had not been marked from the wards or admit them to theatre.

In so doing, and on the grounds of patient safety, they introduced a potentially unsafe practice which had not existed before – to prevent delays in theatre, a patient found not to have been marked might be marked in haste by a doctor who was not familiar with the case. And this did indeed happen during the course of the study.
Consensus on Assessment and Outcome Measures: Implications for Safer Health Care

Dr Pooria Sarrami¹, Dr Martin Batty¹,², Dr Sarah Pass¹, Dr Maria Moldavsky², Dr Michael Marriott², Dr Kapil Sayal¹,², Prof Chris Hollis¹,²

The use of outcome measures in routine clinical practice confers a number of potential benefits. These include the ability to monitor the effectiveness of services, clinicians and treatments (and service users’ opinions on their treatment), and the opportunity to evaluate and/or provide feedback to these groups/services [1]. Routine Outcome Measures (ROMs) are potential safety indicators, which offer the chance of enhancing the quality and safety of care, and the effective commissioning and management of services. However, the use of ROMs also raises a number of challenges, including tool choice and its implementation [2]. While ROMs have the potential to assist enhancing patient safety, it is important to explore how these may be put into practice within an organisation [3]. We present data from a study that aims to develop consensus in assessment and treatment outcomes in child and adolescent mental health (CATO). We present a snapshot of current knowledge, utilisation and attitudes towards the use of ROMs in child and adolescent mental health services (CAMHS) across three mental healthcare Trusts (Nottinghamshire, Derbyshire and Lincolnshire), identify the strengths and weakness of existing measures from the perspectives of a variety of stakeholders (clinicians, commissioners and service users/carers) and identify the barriers and drivers to the use of ROMs in clinical services.

References

Micro-cultures in healthcare: Perspectives from NHS managers in a large UK trust

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Abstract:
This display invites discussion on the issue of micro-cultures in health care organisations, their implications for the organisational safety culture, and how to address the challenges they pose to patient safety.

A descriptive, exploratory design was adopted, with interviews undertaken with 26 managers in a large NHS Trust as part of broader research assessing the impact of making a medical error on health professionals. Five higher order themes were identified from the data which included being management, structure and culture of healthcare, at the sharp end, a human system and micro-cultures. The latter category of micro-cultures is of particular relevance here. Micro-cultures refer to the variations in attitudes and behaviours between different sub-groups in health care. Consistent divisions were noted between professional groups, ranks, and specialities. Sub-cultures appeared to be driven in part by features of health care such as the diversity of professions, specialities working within one system, and their separate regulatory bodies and management structures. Differences were also noted dependent on patient group; for example, stronger patient-practitioner relationships develop in longer-term care environments such as renal care which can influence attitudes towards risk and safety. Divisions are further exacerbated by the maintenance of these distinctions through the structure and culture that is embodied in health care organisations.

Discussion points:

- What are the implications of micro-cultures for health care leaders in their bid to develop a stronger safety culture?
- How can variations in safety attitudes and practices between micro-cultures be addressed through organisational structures and processes?
- Can knowledge of the features of different micro-cultures be helpful for identifying areas in which stronger or weaker safety practices are generally adopted in health care?
- What are the potential implications of the Select Committee’s suggestion that more multi-disciplinary training should take place in health care for professional group divisions?
- In what ways can future research be used to contribute to our knowledge and understanding of micro-cultures in health care?
Safer Warfarin Management in NHS Fife

Paul Smith and Sandy Kopyto, NHS Fife

What were the goals?
To make warfarin therapy safer across NHS Fife and to reduce the number of hospital admissions for patients with raised INR due to inadequate warfarin management

How did we identify the problems?
We used the Failure Modes and Effects Analysis (FMEA) tool to identify the highest risk processes associated with new patient initiation to warfarin. A multi-disciplinary group including medical staff, nursing staff & pharmacists scored these using Risk Priority Numbers (RPN) and prioritised for action. The themes of the resultant highest scoring risks centred on poor communication, poor education for patients and clinicians and inadequate documentation.

What changes did we make?
The team identified that many of the highest rated risks could be addressed through the design of enhanced patient counselling and discharge processes and better prescribing guidance.

We also enhanced our warfarin discharge process to ensure that follow up INR checks would take place more consistently in the community

We are now developing a comprehensive anticoagulation protocol to include all the lessons learned including vital advice about co-prescribing of antibiotics and warfarin and a range of loading regimes.

How did we measure the success of these changes?
Lots of audits e.g. to verify the effectiveness of the discharge process and that follow up INR appointments are being made with GPs, monthly measurement of the number of patients admitted with INRs over 6 and a monthly case note review of all hospital inpatients using a Global Trigger Tool to identify any adverse drug events related to warfarin e.g. co-prescribing of antibiotics

We have already seen a reduction in the numbers of inpatients with INRs > 6.

What else did we learn?
Communication, education and documentation are crucial – if you can design robust and foolproof processes around these factors, they can provide building blocks for safer healthcare. And also that the FMEA lends itself well to identifying and prioritising risks in high alert medication processes.

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How will it work? ‘Theory of change’ in patient safety programmes

Carolyn Tarrant and Mary Dixon-Woods, Social Sciences Research Group, Department of Health Sciences, University of Leicester.

All patient safety programmes incorporate a theory of change – a theory that identifies plans and strategies for change and, importantly, provides a rationale for how and why those plans or strategies are likely to work. The theory of change may not necessarily be explicit. If strategic stakeholders in an organisation do not understand and share the programme theory of change, or do not accept it as legitimate, implementation of the programme may suffer.

A study involving telephone interviews with 60 strategic level hospital stakeholders, and 5 programme stakeholders, explored how they understood and responded to the first phase of the Health Foundation's Safer Patients Initiative. Overall the study found that stakeholders had a broadly shared understanding of, and commitment to, the theory of change. These strategic level individuals also anticipated contestations from front-line staff about the legitimacy of the initiative, likely local resistance to changes that would disrupt established norms, and risks related to resourcing and structuring issues. It was not clear that they had strategies to enable them to overcome these challenges.

Points for debate:

Can the theory of change always be specified in advance of a programme?
How important is it that a programme’s theory of change is understood (and accepted) - by programme leaders, by local stakeholders, and by front-line staff?
Does it matter if stakeholders have their own, local, theories of change?
What factors are likely to impact on the perceived legitimacy of a programme’s theory of change?
How can strategic stakeholders at the ‘blunt end’ get ‘sharp end’ staff to engage with the programme theory of change?
Cultural characteristics of a Middle Eastern multicultural healthcare institution and how it facilitates the mechanisms to enhance patient safety

Helena Tuite, University of Ulster

A movement to promote patient safety culture has grown over the past 12 years in the western world. 2004 witnessed the WHO launching the World Alliance for Patient Safety and it now includes representation from the Arabian Gulf States. Priorities for patient safety research (Bates, 2009) put identification, development and testing of locally effective and affordable solutions as the number one priority for research in the developing world in order to find the best solutions to resolve them (Dixon Woods, 2010). Reporting of medical errors is a key component of a patient safety culture. To identify local solutions to the global problem of gross underreporting of medical errors and near misses the culture of an organization needs to be understood. The uniqueness of the Middle Eastern healthcare institution and the richness of its cultural diversity with less than 8% of its healthcare providers from the indigenous workforce add complexity to medical error reporting. The study presented here adopts a combined ethnographic and discourse analytical methodology (influenced by the French philosopher Michel Foucault’s approach to governmentality and Schein’s (2004) organizational culture assessment model) to gain an understanding of a middle eastern health care culture and its relationship to error/near miss reporting. This presentation will share initial findings of this study which includes the use of intercultural language, the roles of external actors, medical error reporting processes, policy interpretation and contradiction between espoused values and those experienced in practice.

References:


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Workforce ageing, a hot topic: what losing our older, experienced NHS staff could mean for patient safety

Jo Vallis, Wendy Loretto, Marion Lacey, Lynn Walford, Tina Parkin, Fiona Gailey, Derek Phillips, William Reid, NHS Education for Scotland (NES)

Abstract:

Why? ‘Patient safety’ is the bedrock of our UK health policy, but there are real challenges to delivering it, not least because of the current financial climate. Our older, experienced employees are relatively expensive and could be more vulnerable to job losses. Also, some are leaving anyway, because of the current pension changes. But their indiscriminate loss from the service would be a crying shame, especially when considered against other important issues like workforce ageing and wider changes in health professional training and work ethic which can leave junior staff less prepared for practice and/or less willing or able to ‘go the extra mile’.

What? This paper explores these complex interlinked issues, through the eyes of older NHS employees themselves, and makes the case for better ‘age management’ to help them to develop their patient safety leadership skills and pass on their expertise to less experienced juniors.

How? We did 109 semi-structured telephone interviews with a wide range of older NHS employees (doctors, nurses, allied health professionals, healthcare scientists etc. aged 45+) in South East Scotland. Interviews explored factors affecting their retention and retirement, including their perceptions of health service changes.

What then? Interviewees said that changes in professional education and work ethic were contributing to slipping standards of care. They were particularly worried about the future safety of patient care unless older, experienced employees were kept on and enabled to pass on their knowledge and skills. Instead, they reported a general lack of management support, contributing to their de-motivation and early retirement plans. This suggests future skill gaps.

So what? We urgently need to value our older, experienced staff and find better ways of keeping them and helping them to pass on their knowledge and skill. The safety of future patient care (including my own!) depends on this.

For notes/comments