Sign up to Safety
National Campaign

Closing the implementation gap

Harnessing the commitment of NHS staff to make care safer

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National Campaign Director – Sign up to Safety

NHS Confederation 3 June

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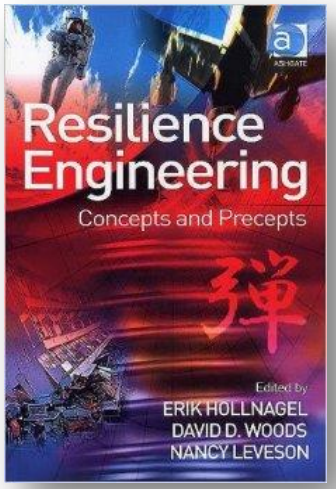
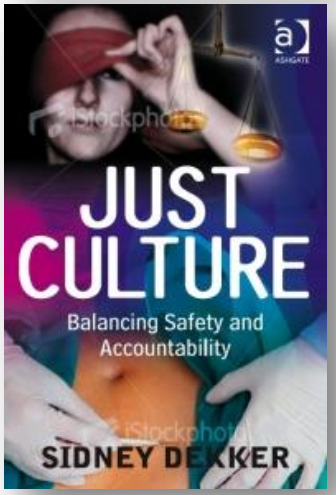
Creating a Safety Culture





Key References

Just Culture

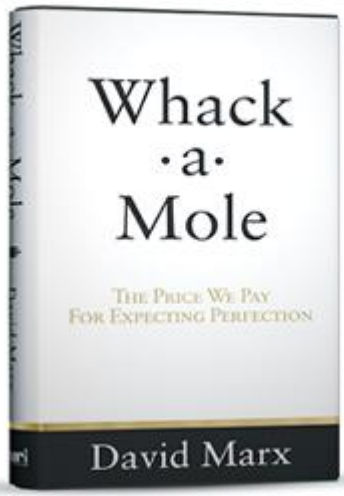
Just Culture

David Marx

Just Culture Community

Sidney Dekker

Just Culture



“The single greatest impediment to error prevention is that we punish people for making mistakes”

Dr Lucian Leape

12 October 1997

Things we should all agree on

- The best people can make the worst mistake
- Systems will never be perfect
- Humans will never be perfect

- Just where we all understand and respond appropriately to human error, risky behaviour and reckless behaviour
- Open where we acknowledge, say sorry and explain when things go wrong
- Fair where all staff are treated consistently
- Learning where we continually learn about what we could do differently to make care safer

“People make errors, which lead to accidents. Accidents lead to deaths. The standard solution is to blame the people involved. If we find out who made the errors and punish them, we solve the problem, right? Wrong. The problem is seldom the fault of an individual; it is the fault of the system. Change the people without changing the system and the problems will continue.”

Don Norman
Author, the Design of Everyday Things

Current culture

- Human error coupled with harm to a patient usually results in social condemnation and disciplinary action
- Disciplining employees in response to honest mistakes does little to improve the overall safety system
- Few people are willing to come forward and admit an error when they face the full force of the current punitive system

Learning from incidents and our natural bias

- Outcome
- Confirmation
- Hindsight

Outcome bias

- The outcome effect occurs when the same “behaviour produce[s] more ethical condemnation when it happen[s] to produce bad rather than good outcome, even if the outcome is determined by chance.”

For example

- If a nurse makes an error that causes no harm we consider the nurse to be lucky
- If another nurse makes the same error resulting in injury to a patient we consider the nurse to be blameworthy and disciplinary action may follow
  - the more severe the outcome, the more blameworthy the person becomes
- This is a flawed system based upon the notion that we can totally control our outcomes
- Interestingly outcome bias has influenced our legal system..
  - A drunk driver suffers far greater consequences for killing someone than merely damaging property, the drivers intent is the same, the outcome very different yet society has shaped the legal system around the severity of the crime
  - What is worrying here is that the reckless individual who does not injure someone sometimes receives less punitive sanction than the merely erring individual who caused injury

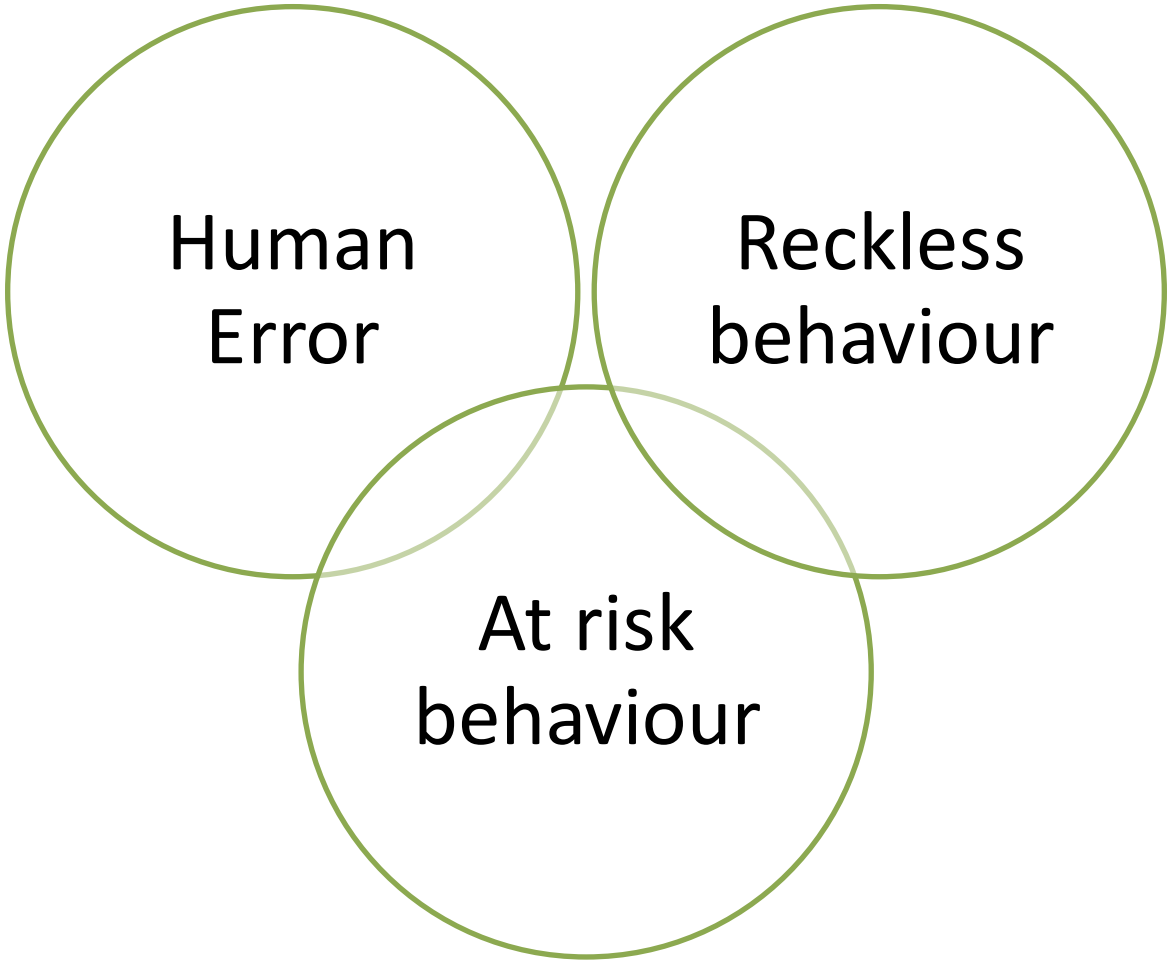
Confirmation bias

- Confirmation bias is the tendency to search for, interpret, or recall information in a way that confirms one's beliefs or hypotheses

Hindsight bias

- Hindsight bias
  - ‘why did you do it like that’ or ‘I would never have done that’ or ‘the knew-it-all-along effect’
  - Happens after an event has occurred
  - Sees the event as having been predictable, despite there having been little or no objective basis for predicting it
  - May cause memory distortion, where the recollection and reconstruction of content can lead to false theoretical outcomes

The big 3*



*These are not mutually exclusive and can over lap with each other in definition and they can all occur in the same mishap

The big 3

- Human error
  - inadvertent action; inadvertently doing other that what should have been done; slip, lapse, mistake
- At-risk behaviour
  - behavioural choice that increases risk where risk is not recognised or is mistakenly believed to be justified – includes violations and negligence
- Reckless behaviour
  - behavioural choice to consciously disregard a substantial and unjustifiable risk

Responses*

Human error	• Comfort, support, console
Risky behaviour	• Coach, teach, train
Reckless behaviour	• Punish, discipline, sanction

*for all – use design to create a system that helps prevent them happening

Human Error

- When an individual should have done something other than what they did and in the course of that action inadvertently caused or could have caused an undesirable outcome
  - Calling your child by the wrong name
  - Picking up the wrong keys
  - Forgetting your ID
  - Miscalculating a medication dose
  - Missing a turnoff from the motorway
  - Picking up strawberry yoghurt instead of raspberry
    - We make errors every day with generally minimal consequences
    - In healthcare we make similar types of errors with the potential for dire consequences
    - Terms include mistake, slip, lapse
    - We need to understand that individuals do not intend the error or its undesirable outcome even though the consequences are potentially life threatening

What about the person who makes repeated errors?

- The individual may be in a job, or performing a specific task that is very prone to error
- Drug labels and equipment layouts lacking in standardisation and good design will lead individuals to make repetitive errors
- A source may lie with the individual who is stressed, distracted, unfocused leading to an increased propensity to error
  - in fact those that have erred are more likely to do it again because of the stress caused by the first error
  - In these cases it may be appropriate to remove the individual from the current task however this must not be seen as a punishment

Blame free?

- This is not a blame free system in which any conduct can be reported with impunity
- There need be no loss of accountability – it is just different – the accountability requires an employee to raise their hand in the interests of safety
- Not reporting your error, preventing the system from learning is the greatest problem of all
- Some actions do warrant disciplinary or enforcement action
- So where do you draw the disciplinary line?

Risky behaviour

- At risk behaviour is usually where an employee had no reason to know that he or she was creating a risk - there should be no discipline
  - in fact our civil legal system does not allow for punitive sanction for individuals deemed negligent because of the lack of intent to cause harm; compensation is paid by the organisation not the individual

- If the employee knew and consciously disregarded the risk they were taking – this is reckless behaviour and intentional - they must be disciplined and may even be considered to have acted criminally

Violations

- Rules = procedures, policies, standard operating procedures, guidelines, standards – which require or prohibit a set of behaviours
- There are unintentional rule violations and intentional rule violations
- Unintentional – usually that the individual was not aware of the rule or did not understand it
- Intentional – when an individual chooses to knowingly violate a rule while performing a task – does not necessarily mean they were risk taking
  - they may be situational or circumstantial or patient centred

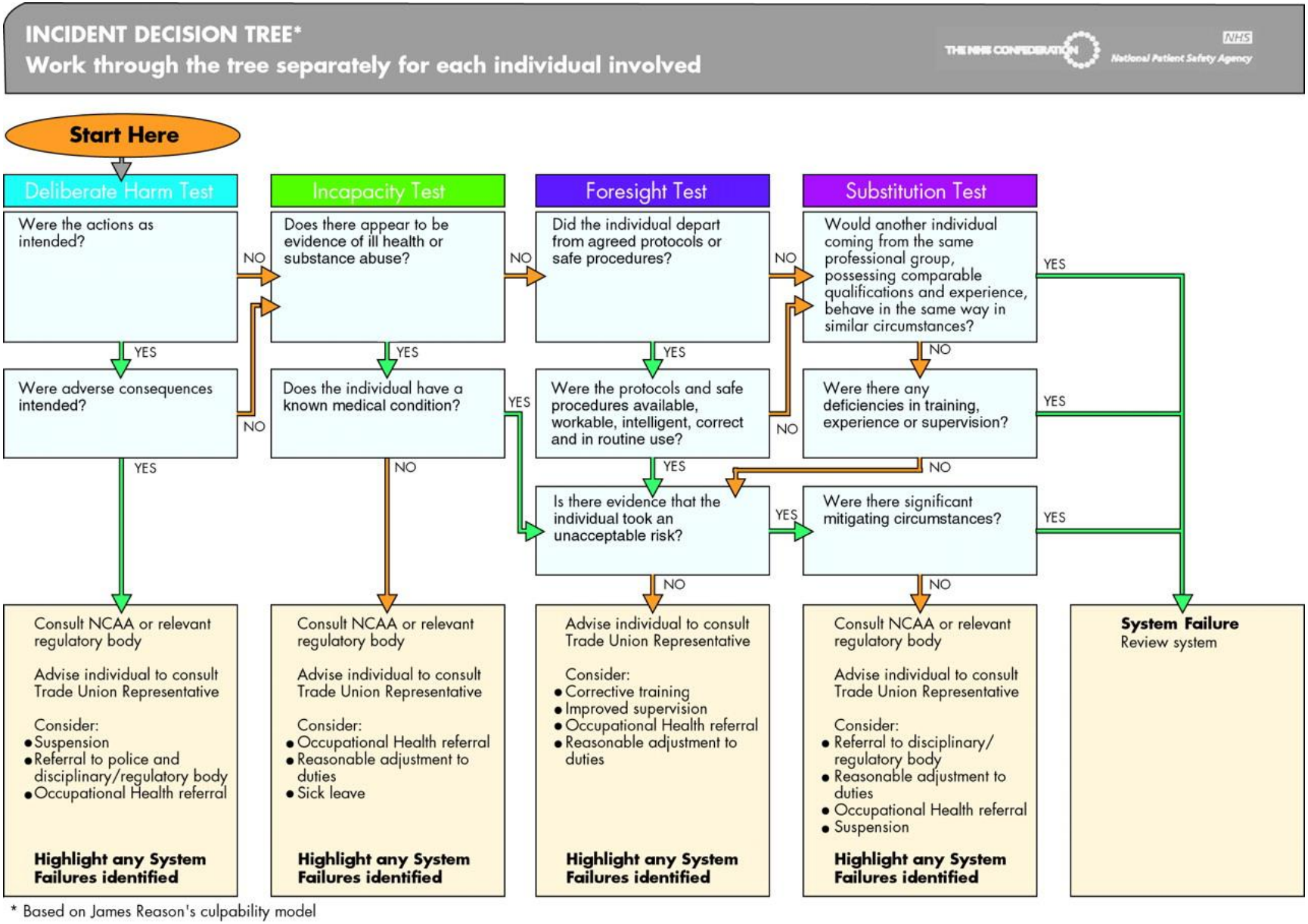
Recklessness

- A person acts recklessly if he/she consciously disregards a substantial risk and is aware of the consequences of their actions

- Recklessness is a crime – demonstrating in law greater intent than mere negligent conduct

- All reckless behaviour should be disciplined

www.npsa.nhs.uk



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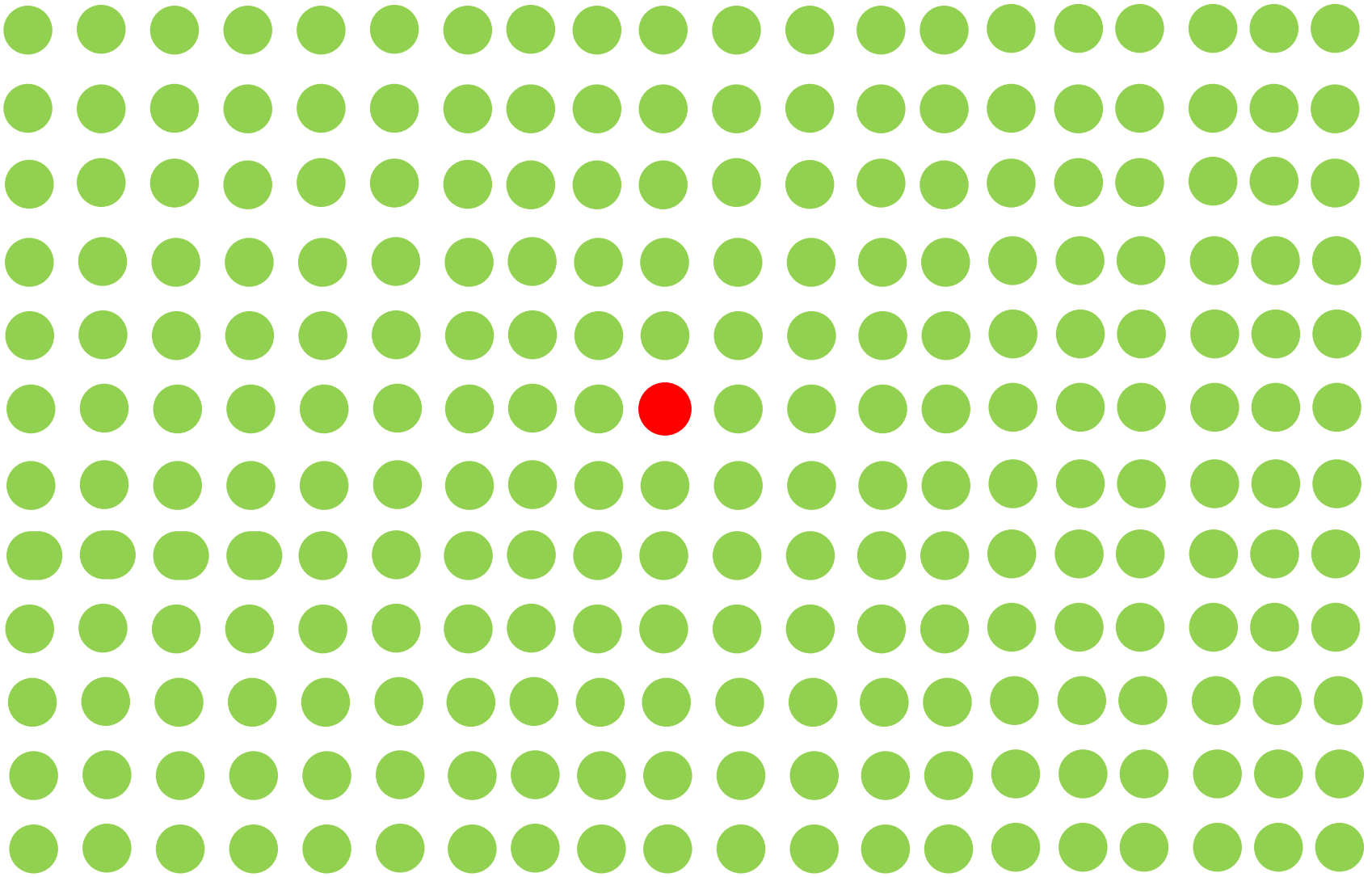
Sign up to Safety

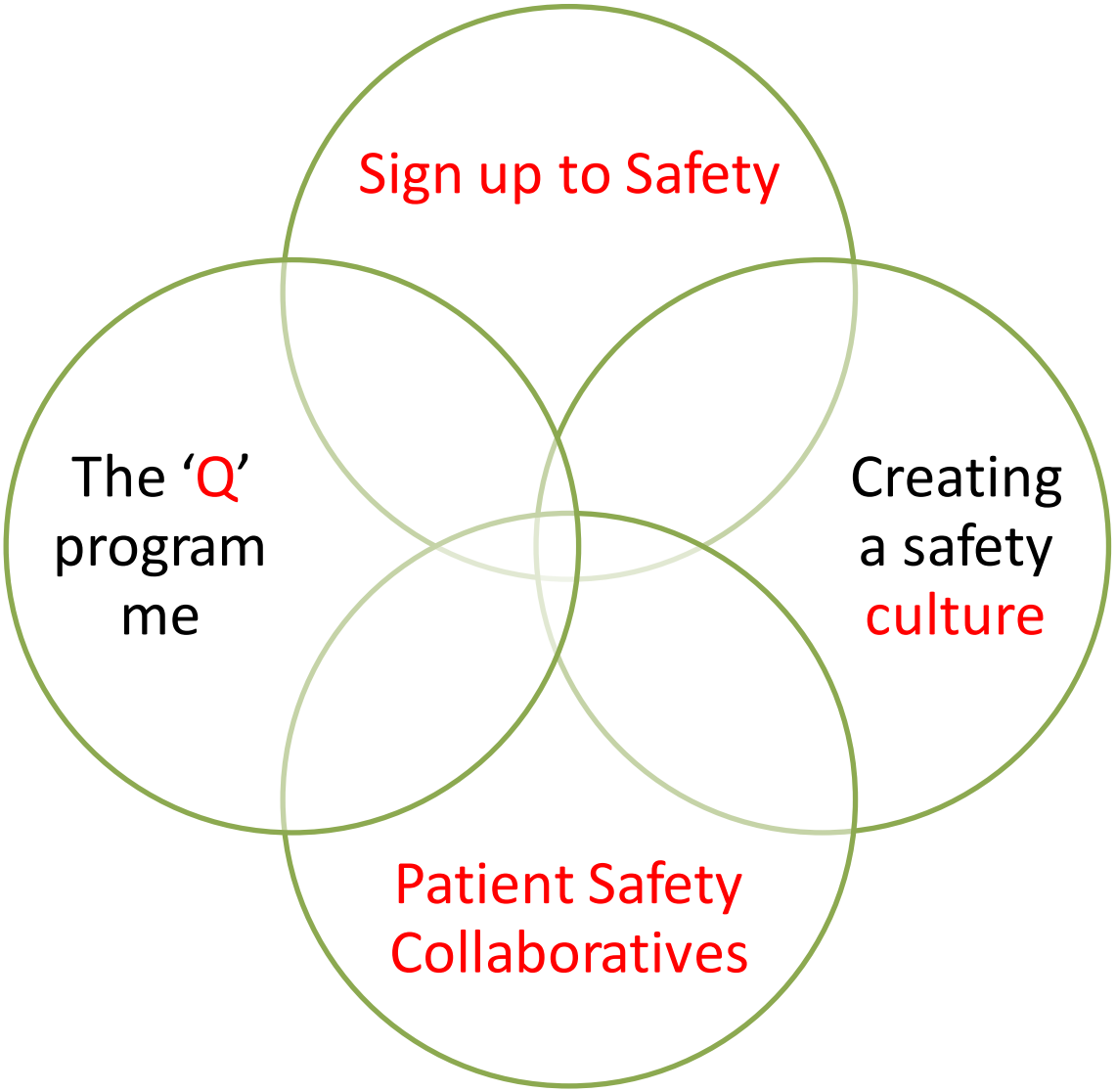
WHAT IS SIGN UP TO SAFETY?

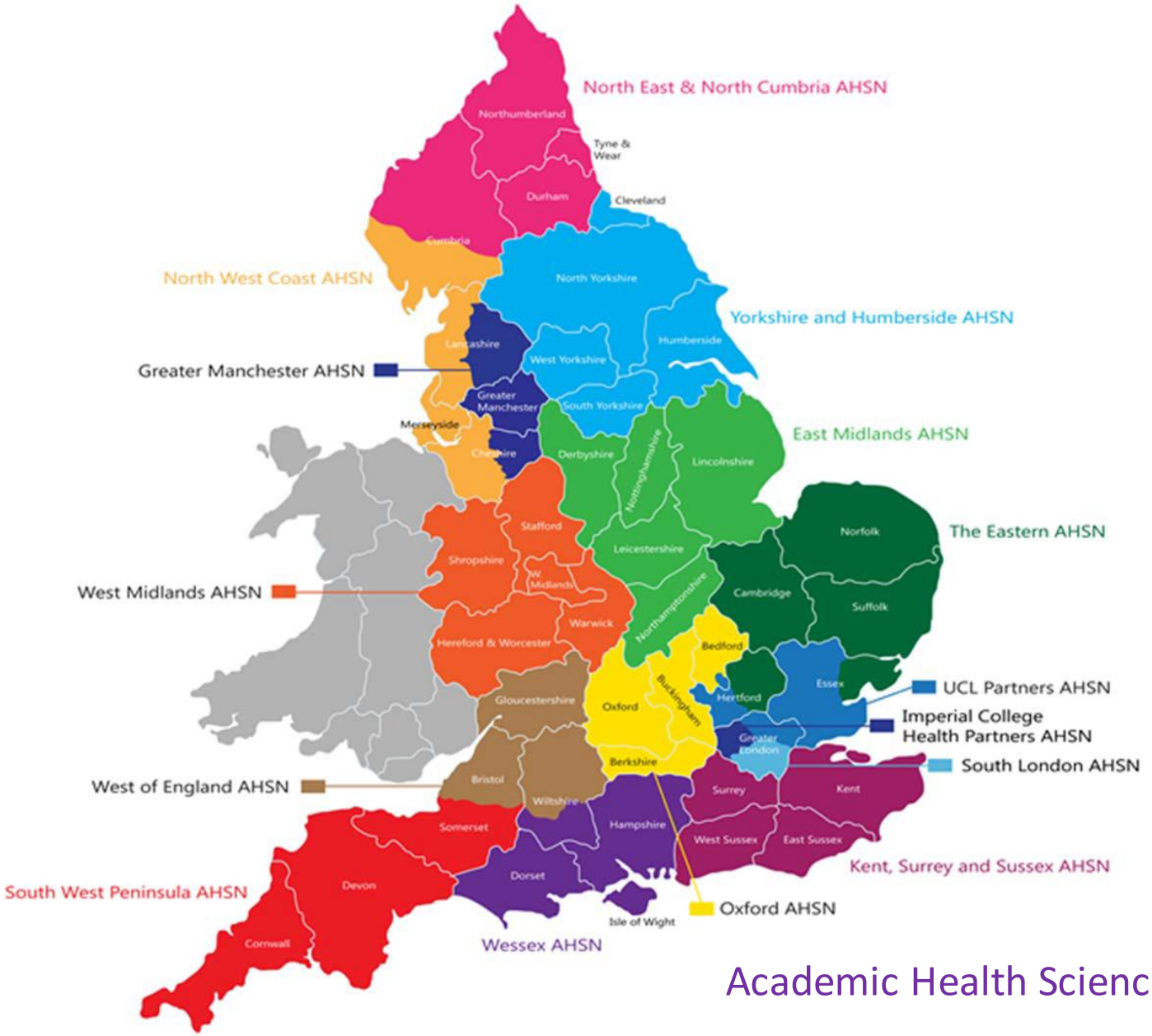
Sign up to Safety is helping to make the NHS the safest healthcare system in the world

Sign up to Safety Community



Integrated national programme





Academic Health Science Networks

A connected community working together
to improve health care quality across the UK

The Health Foundation

NHS England

The Health Foundation in partnership with NHS England – to increase the number of skilled individuals focusing on quality across the NHS in England

Sign up to SAFETY
LISTEN LEARN ACT

Our shared cause

Reducing avoidable harm by 50% and saving 6000 lives

Campaign objectives

Energise and mobilise organisations and individuals to make care safer

Capture knowledge about what works and how we all create the conditions for safety

A MOVEMENT FOR CHANGE

Launched on 24th June 2014, over three years we will bring together collective learning, to engage and connect individuals and organisations working on safety improvement to help people take action.

ORGANISATIONS WHO JOIN SIGN UP TO SAFETY COMMIT TO MAKE CARE SAFER BY:

1

Setting out the actions they will undertake in response to the five Sign up to Safety pledges and agree to publish this on their website for staff, patients and the public to see.

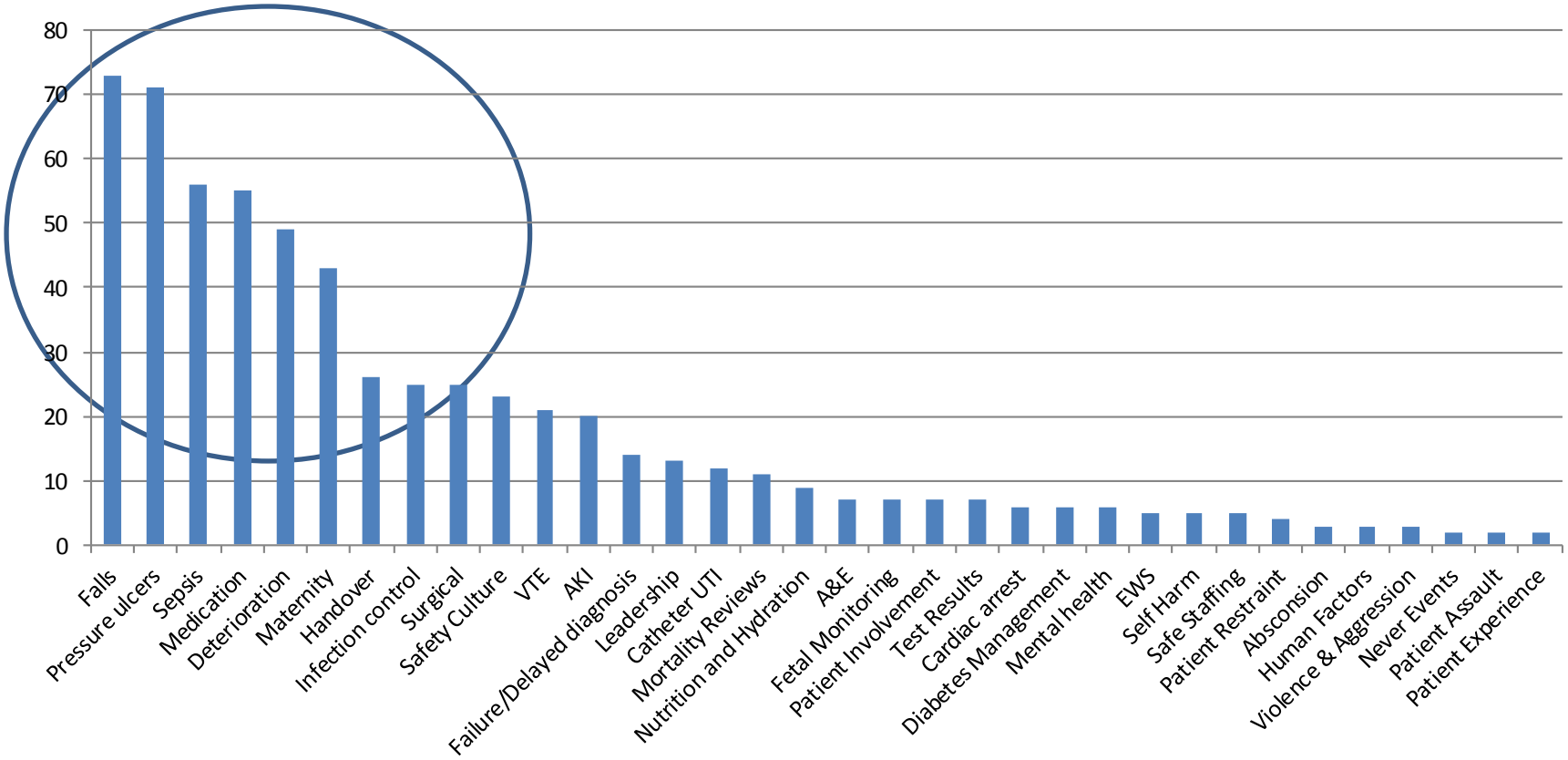
2

Committing to turn their pledges into a safety improvement plan (including a driver diagram) which will show how organisations intend to save lives and reduce harm for patients over the next 3 years.

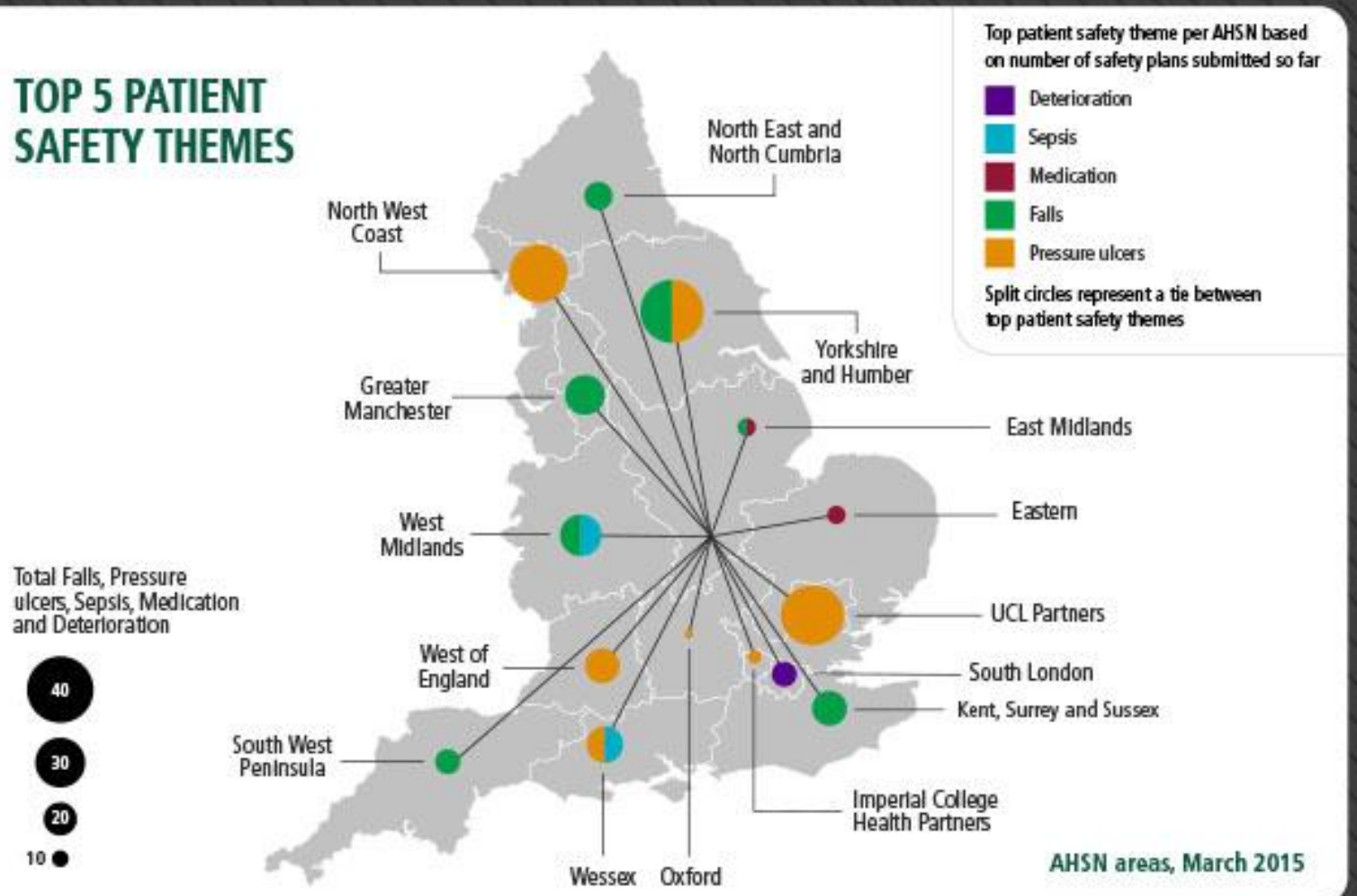
THE FIVE CAMPAIGN PLEDGES

- Put safety first
- Continually learn
- Be honest
- Collaborate
- Be Supportive

Safety Improvement Plan Themes



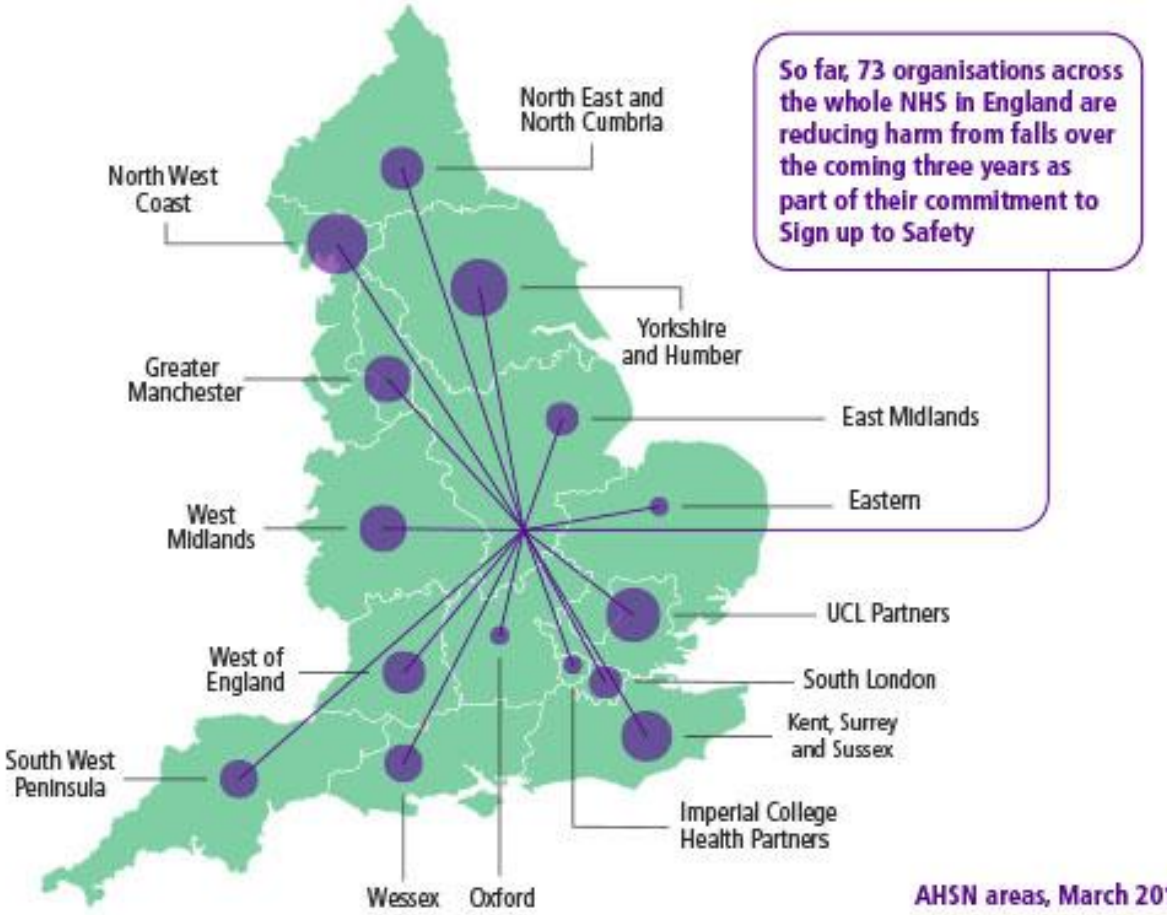
TOP 5 PATIENT SAFETY THEMES



Sign up to SAFETY

To date, over 130 Safety Improvement Plans have been developed by organisations signed up to the campaign. Each focuses on 3-5 areas of work and aims to reduce avoidable harm over three years. Each plan is developed and delivered locally, and remains owned by the organisation. Sign up to Safety helps by connecting this work on a national scale to enable learning for others to adapt. **Join the movement at www.signuptosafety.nhs.uk**

FALLS



So far, 73 organisations across the whole NHS in England are reducing harm from falls over the coming three years as part of their commitment to Sign up to Safety

Sign up to SAFETY

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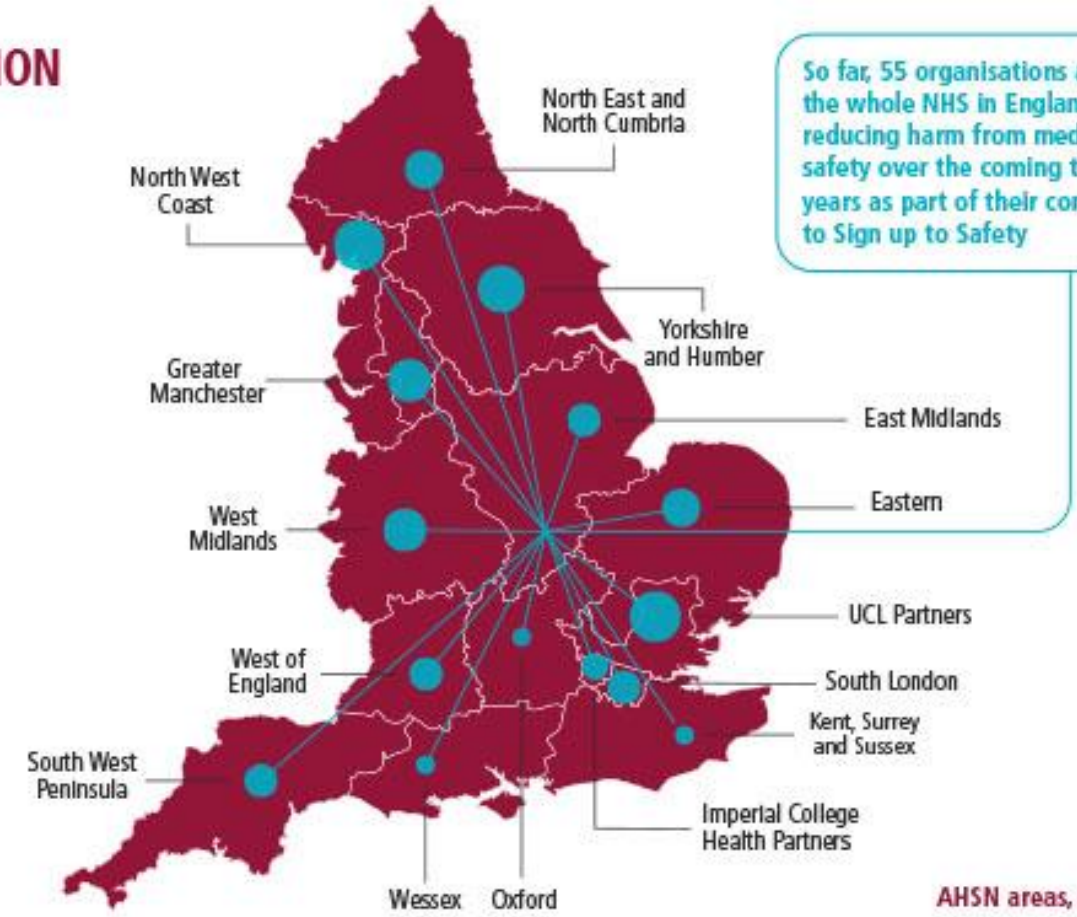
MEDICATION SAFETY



So far, 55 organisations across the whole NHS in England are reducing harm from medication safety over the coming three years as part of their commitment to Sign up to Safety

AHSN areas, March 2015

Sign up to SAFETY

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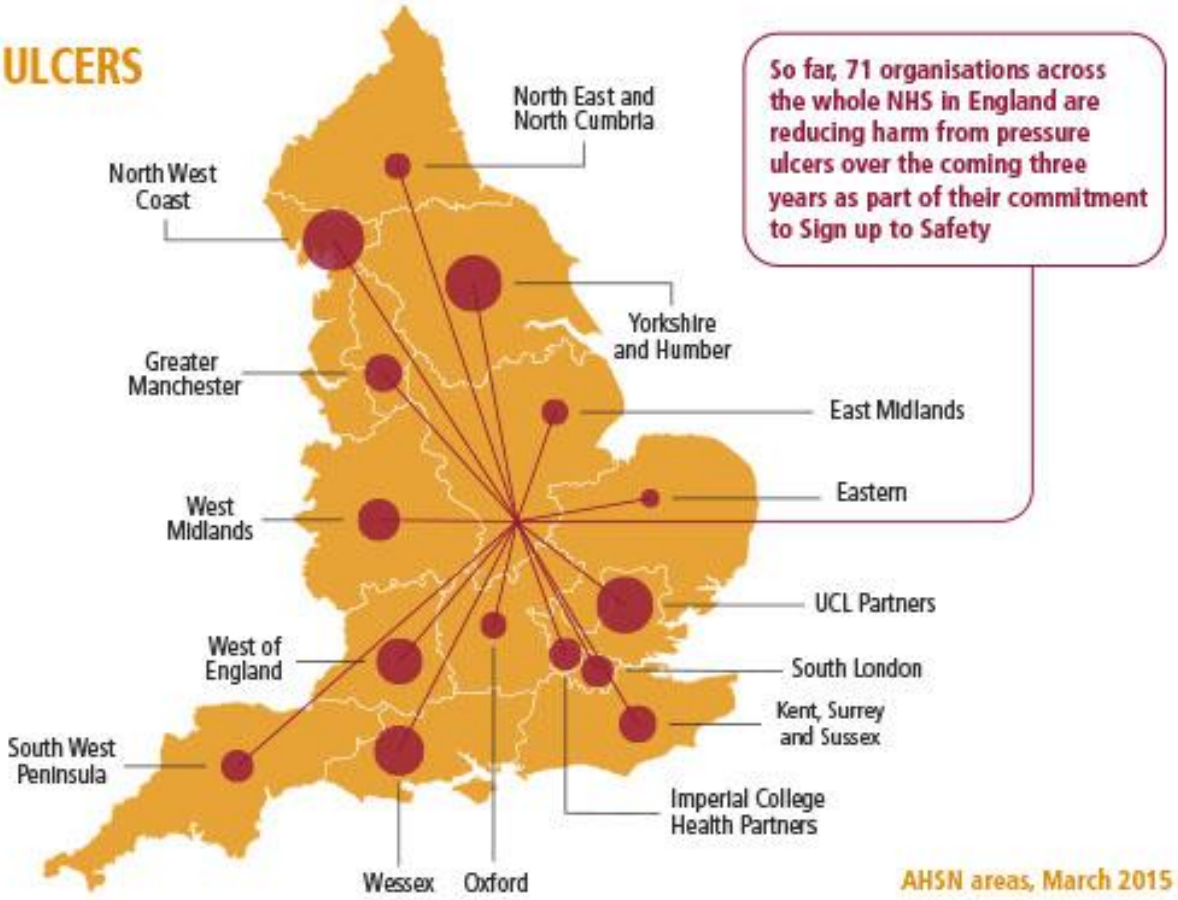
PRESSURE ULCERS



So far, 71 organisations across the whole NHS in England are reducing harm from pressure ulcers over the coming three years as part of their commitment to Sign up to Safety

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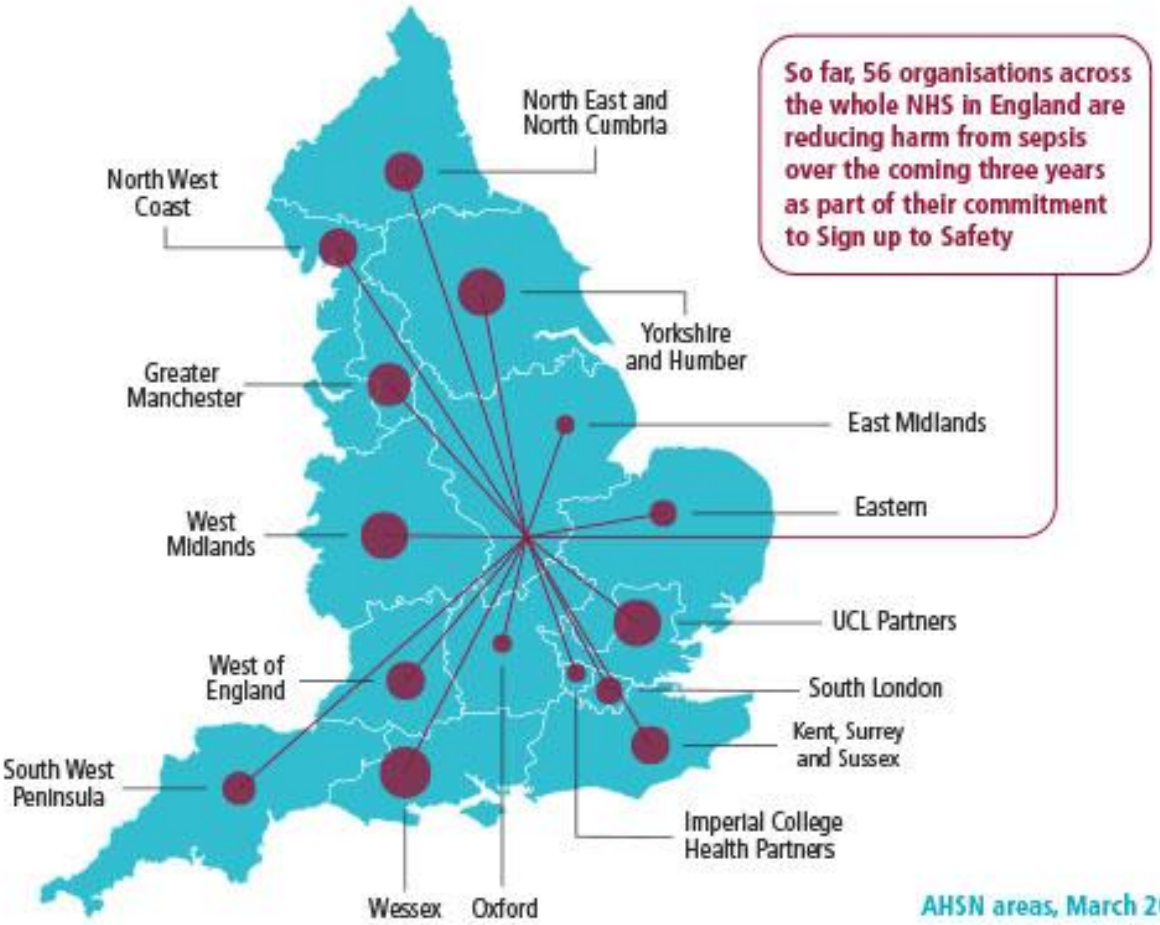
SEPSIS



So far, 56 organisations across the whole NHS in England are reducing harm from sepsis over the coming three years as part of their commitment to Sign up to Safety

Sign up to SAFETY

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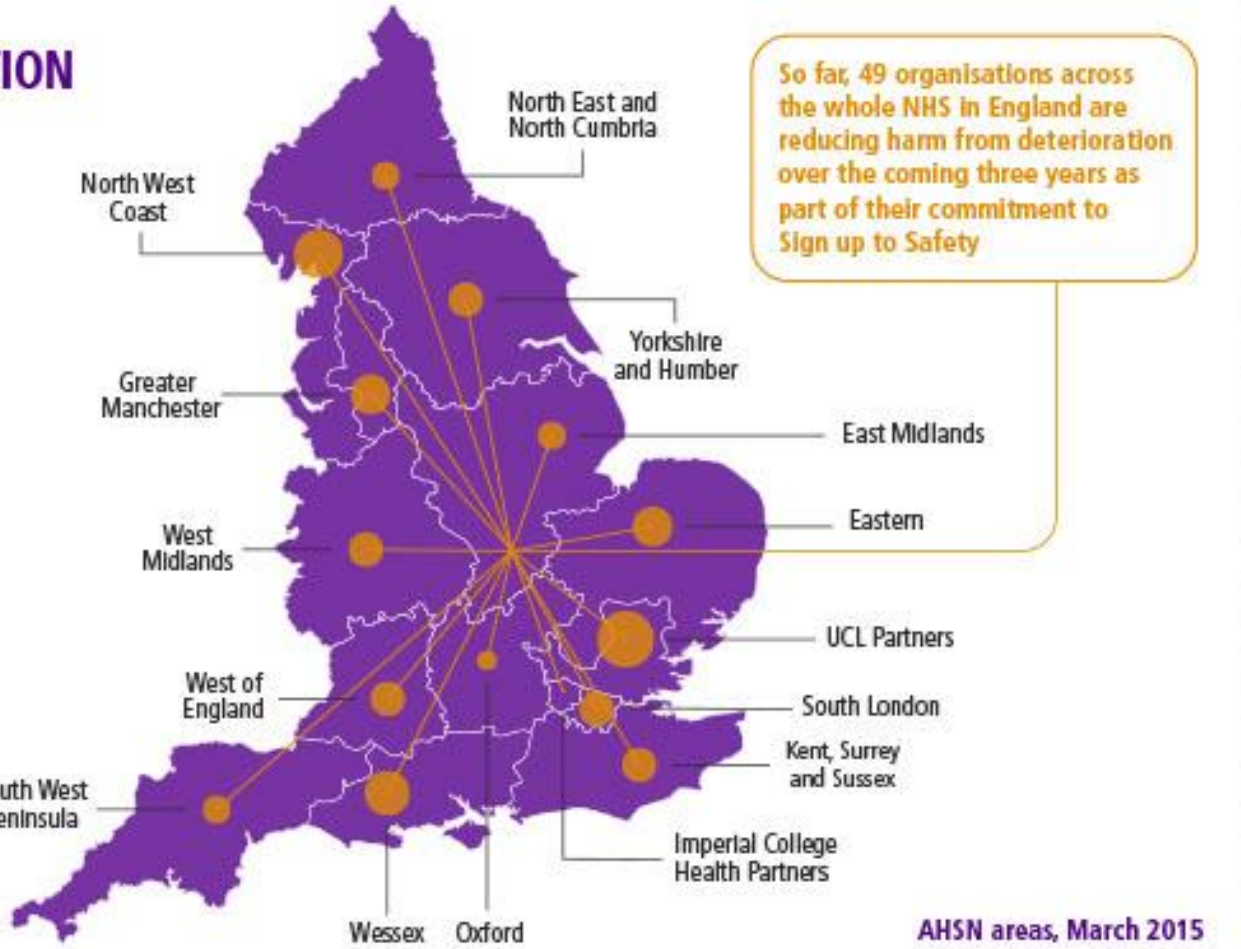
DETERIORATION



So far, 49 organisations across the whole NHS in England are reducing harm from deterioration over the coming three years as part of their commitment to Sign up to Safety

Sign up to SAFETY

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3

Implementation

Sign up to Safety aims to help organisations move beyond pockets of excellence:

The implementation challenge

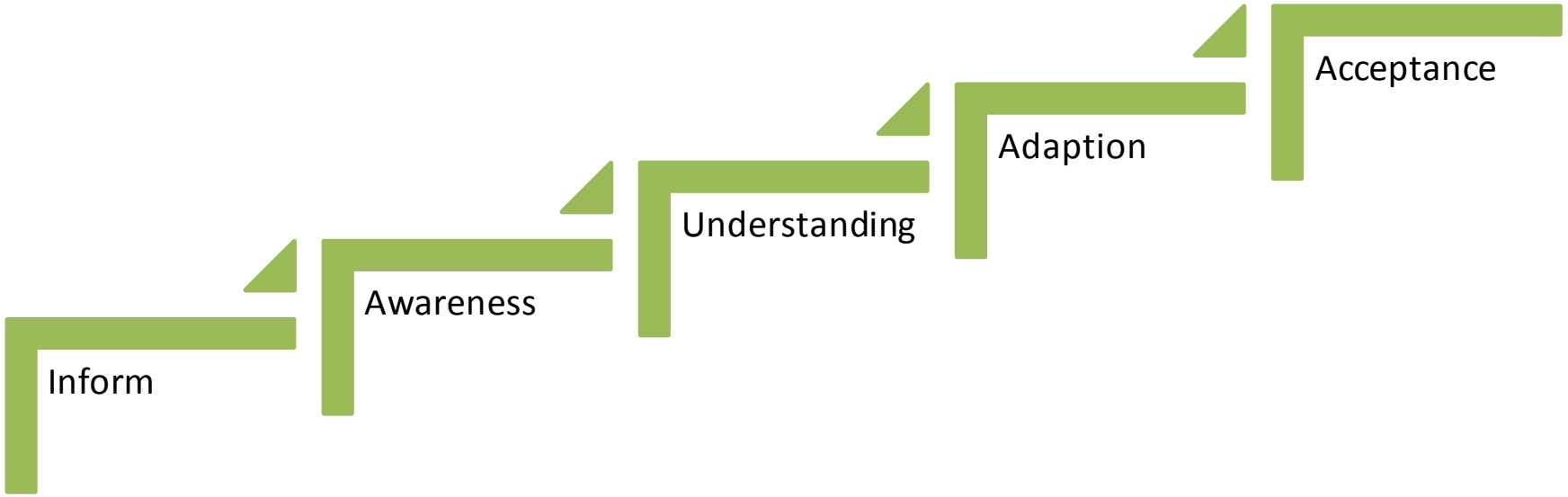
What is implementation?

- Implementation is shorthand for how innovations, interventions and guidance are communicated, disseminated, adopted, and spread

- The aim is obviously to do this effectively so that the new practice or change is sustained and embedded into everyday practice

- Implementation is a process not an event, it is complex and requires both expertise and concerted effort, it most definitely is not about simply telling people to ‘do it’

Process of implementation

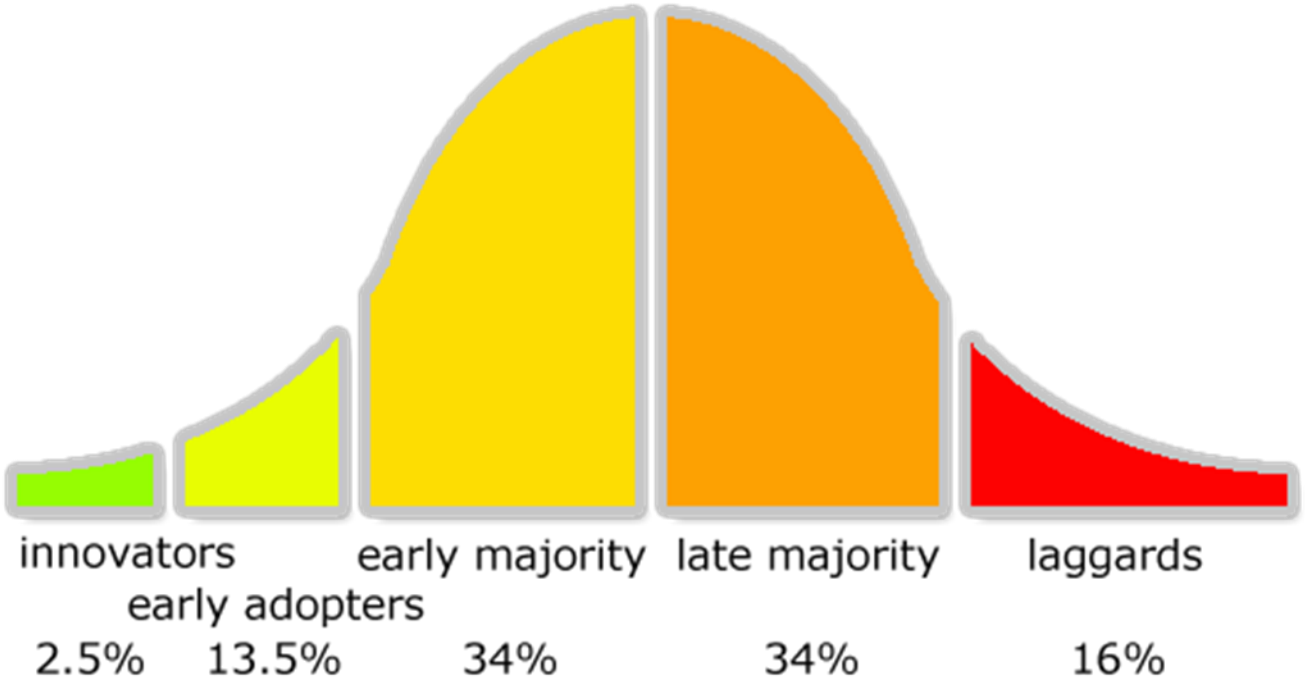


Different innovations spread and get adopted at different rates

- Some never spread at all – so you need to understand how to maximise success. A summary of the key attributes are:
  - Relative advantage – i.e. is it of benefit?
  - Relevance - i.e. is it relevant for the particular problem
  - Compatibility – i.e. is it compatible with existing practices and values
  - Reputation – i.e. the degree to which it adds to the person's social approval
  - Low complexity – i.e. is it simple to understand and simple to implement/spread
  - Risk – i.e. how risky is it to adopt
  - Observability – i.e. visible, can others see it working
  - Trialability – i.e. can it be tested or tried out first
  - Transferability – i.e. can it be transferred from one group to another

Regular and repeated use is generally accepted as adoption

- A critical mass of adopters is needed to convince the majority of other individuals



Implementation Plan

1. Create a checklist

Checklist

[adapted from The Health Foundation]

- By considering the following questions early on in your work, you will save time and energy in the long run

- What?
  - What ideas, approaches or behaviour change do you want others to adopt?
  - What are your ambitions for spreading the work more widely if it is successful?
  - What do you therefore need your plan and communications to achieve?

Checklist

[adapted from The Health Foundation]

- Who?
  - Who gains from the work, whose jobs will be affected and who will have to pay for it?
  - Who will you therefore need to influence to ensure the work is adopted and supported in the short term?
  - Who will you need to influence to ensure the work is sustained, funded and spread in the longer term?
  - Do your governance and advisory groups include the decision makers, champions and partners that will help you engage these people?

Checklist

[adapted from The Health Foundation]

- How?
  - How does the work align with other priorities?
  - How will you communicate the work at each stage, and how can you encourage those involved to communicate with each other?
  - How will you convince others?
  - What evidence/measures can you use (e.g. clinical outcomes, cost-effectiveness, patient experience)?
  - How will you resource your activity?
  - Many of the most effective approaches are not costly but do require time and knowledge
  - Do you have the skills and understanding within the team to analyse, to communicate, to lead your spread plan and to develop a business case and/or win future funding?
  - Who else can you ask to help?
  - How will you measure your success in spreading the work?
  - What are the measures that would show you have been successful?

Checklist

[adapted from The Health Foundation]

- When?
  - Do you have a phased plan?
  - Do you have an executive sponsor on board from the beginning?
  - Are you engaging representatives from the professional and patient groups and the organisations affected early enough?
  - What else is going on, both internally and externally?
  - Are there potential opportunities or clashes to be aware of?

2. Inform, communicate and raise awareness

Dissemination

How will your change and information be shared?

- Guides and documentation
- Social media
- Email, webinars and e-newsletters
- Events, conferences, meetings

Using opinion leaders

- High status
- Large number of followers
- Endorsement reduces uncertainty
- Creates authority and credibility
- Respect by virtue of higher knowledge
- Able to explain evidence to others
- Able to respond convincingly to challenges and debate
- Main state of influence early on in project
- Optimum when it is peer to peer

Language and messaging

- Positive
- Hopeful
- Clear
- Simple
- Understandable
- No acronyms
- No jargon

Telling the story

- Gather and share stories from staff to demonstrate how they are implementing their plans used to:
  - illustrate the impact of local activity
  - demonstrate how improvements have positively impacted on patient outcomes

- Seek individuals who have a story to tell and get them to be the voice of the change – real people, real stories

- Share across a range of communication channels and work well if captured on video or as podcasts which are easier than you think – see easy guide from Sign up to Safety

Effective communication

1. Don’t drown people in too much information; say one thing – in multiple ways – but don't communication multiple issues in one go

2. Talk about what you want to happen

3. Provide visual or physical evidence to show people the problem – if people can see or touch something they will notice more (visuals trump data)

Keep it simple

- Never presume that people remotely understand a single thing you are talking about – keep it simple
- If you know what you want people to do then you should tell them and provide simple instructions
- for example in a fire the objective is to get people to leave the building, not to understand why fire happens or provide a detailed theory as to why people need to leave the building

3. Build your plan around the success factors

90 day planning

Key to success

- Demonstrating that the change is better than status quo and relevant, with tangible benefits
  - i.e. the answer to the question 'Why should I bother?' or put it another way, 'there needs to be a need for the change'

- The change is easy to do
  - i.e. it doesn't need a 100 page manual or intense hours of training and there are lots of useful resources to help reduce the time it takes such as a set of templates or presentation slides already created for you to adapt

- The change is adapted to local conditions
  - i.e. something that works in another country, another organisation or even another team will not automatically work for you – you have to test it, adapt it, and test it again to get everything to feel it fits for them

- The change is liked by people you respect, often referred to as peer to peer influence or the use of opinion / role models
  - i.e. you will implement changes that are liked by people who do a similar job to you, and you think are sensible, possibly even charismatic, and you want to a) be like them and c) do what they do because if they like it, it must be good

Key to success

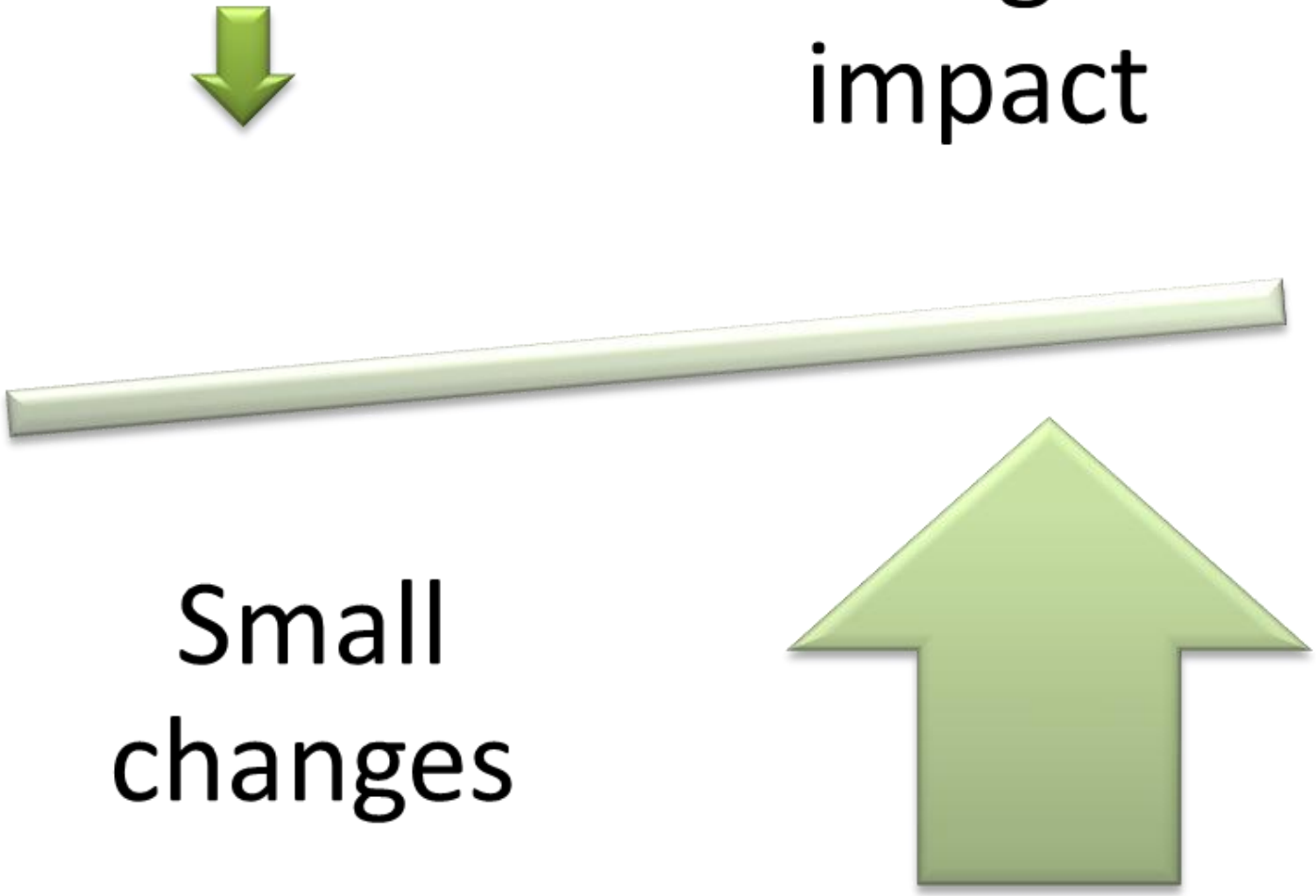
- The change matches your intrinsic motivators
  - i.e. presses the buttons that make you want to do things, like your beliefs, moral compass, ethics, desires, competitive streak, positive feedback, energising activities and so on
- Reward and recognition
  - i.e. people are recognised for their actions, thanked and valued for their contribution to safer care
- Measurement and visible results
  - i.e. I know obvious, but you cant tell how well you are doing, you cant offer recognition and make people feel good about what they have done, if you haven't measured it
- Even if the scope of your effort includes all patients in your hospital or system, the interventions you choose should be piloted on a small scale when possible. The bottom line is this:
  - Think BIG, but start small
  - Don't bite off more than you can chew initially, but testing and learning on a small scale can make even very large projects more manageable

Scope

- Determine the target population(s) for improved outcomes and clearly define the scope of your efforts

- Consider these questions:
  - Will you target one ward or a service?
  - Will you target one or more groups of staff?
  - How long will the testing phase last?
  - Will you focus on one or more aspects of the change?
  - Which patient population(s) will be targeted?

Big impact



Small changes

4. Address the hindering factors

It may not be working if..

- The new interventions do not adequately address the problem
- Old habits, disagreement with the change, ignorance or unwillingness to change
- The new interventions are too hard to use
- More familiar, well-known, or simpler routes of providing care are still available and easier to use

It may not be working if..

- Training in isolation
  - i.e. didactic training with no consideration of the success factors above
- Simple dissemination with no support
  - i.e. a guidance passively disseminated expecting people to notice
- Carrots or sticks in isolation
  - i.e. providing incentives or punishments without thinking about the success factors above
- Lack of awareness
  - i.e. no recognition of the problem
- The wrong solution
  - i.e. the change doesn't actually address particular problem that needs addressing
- Lack of or poor preparation

Challenges

- Competing priorities:
  - The huge number of articles, policy documents, guidance, interventions published daily – coming from all different directions including your own organisation, or seeing the wood for the trees – trying to figure out which are the ones to pay attention to and which are the ones to ignore

- Effort and perceived effort:
  - Increasingly as I attend meetings events or conferences the last line seems to be, 'the key problem with improving safety is implementation of the things we know work' with the assumption often that surely this must be easy. It isn't
  - If we do 'one thing' it is for the 'problem of implementation' to be owned by the guidance developers, solution designers and researchers and not those that are expected to do the implementation

- Controversy:
  - The need to improve on patient safety implies that healthcare delivery might not be as safe as believed
  - There are fears of senior management about threatened or damaged reputations (individually and organisationally)

- Resources:
  - The scarcity of financial and other resources available to the work – which should turn itself into an opportunity to work differently and do things differently and show what you can do with the minimum of funding

5. Measure and Evaluate

The principal question examination question is does the change lead to improved patient safety outcomes

- This is difficult to answer
  - It may not be possible to have a control group
  - It is difficult to quantify the independent contribution amongst the rest of the organisational' quality and safety programmes
  - This is no different from the problem that affects most national and safety improvement work
    - i.e. it is not possible to evaluate a single intervention

How will you know you are making a difference?

- Data collection, analysis, and presentation are essential to the success of any safety improvement plan
  - *People improve what they measure*

- For example
  - Outcome Measures
    - a. Length of stay
    - b. 30-Day rehospitalisation rates
    - c. Patient satisfaction
    - d. Completion rate of discharge summary within 48 hours
  - Process Measures
    - a. Patient or carer understanding of diagnosis, treatment, follow-up appointments, and warning signs or symptoms and response
    - b. Rate of implementing components of the discharge policy

Goals

- Start by creating broad goals that generally define the purpose of your program. For example:

- General aim 1: Substantially improve the discharge process for hospitalised patients
  - Is converted to Specific aim In six months, 90% of patients discharged from the hospital service will have a phone call with the follow-up clinician (outlining the post discharge issues) prior to discharge

- General aim 2: Decrease 30-day readmissions
  - Is modified to Specific aim By January 2017, the 30-day readmissions for patients discharged with a principal diagnosis of heart failure will decrease by 50%

- General aim 3: Improve patient satisfaction regarding the discharge process

- General aim 4: Increase the knowledge of nurses and doctors in optimising the discharge process

Despite the challenges, measurement and evaluation of all aspects of a change is crucial

- There is a need for both qualitative and quantitative metrics to highlight the impact of the change

- In particular:
  - Inputs
    - all background information, planning and research
  - Outputs
    - quantitative measure of the outputs
  - Uptakes
    - measure of participation, awareness, understanding and memory
  - Outcomes
    - measure of the extent to which the change alters or influences knowledge, beliefs and/or behaviours

Tips to take away with you…

- Integrate your current activity and focus on implementation of known safety solutions – this is not about inventing something new

- This is not about top down directives – this is about local ownership and local accountability – your change belongs to you

- Be prepared to share with anyone

Tips to take away with you…

- Take your time – to truly embed change it takes years – lets get this right
- Find out what works and don't be afraid to stop and change your approach
- 90 day cycles - implement, test, check, adapt, revise, implement – every 90 days
- Learn about how you are changing not just what – be interested in the success factors and not just the outcome

Enjoy!

And finally

Back to Sign up to Safety

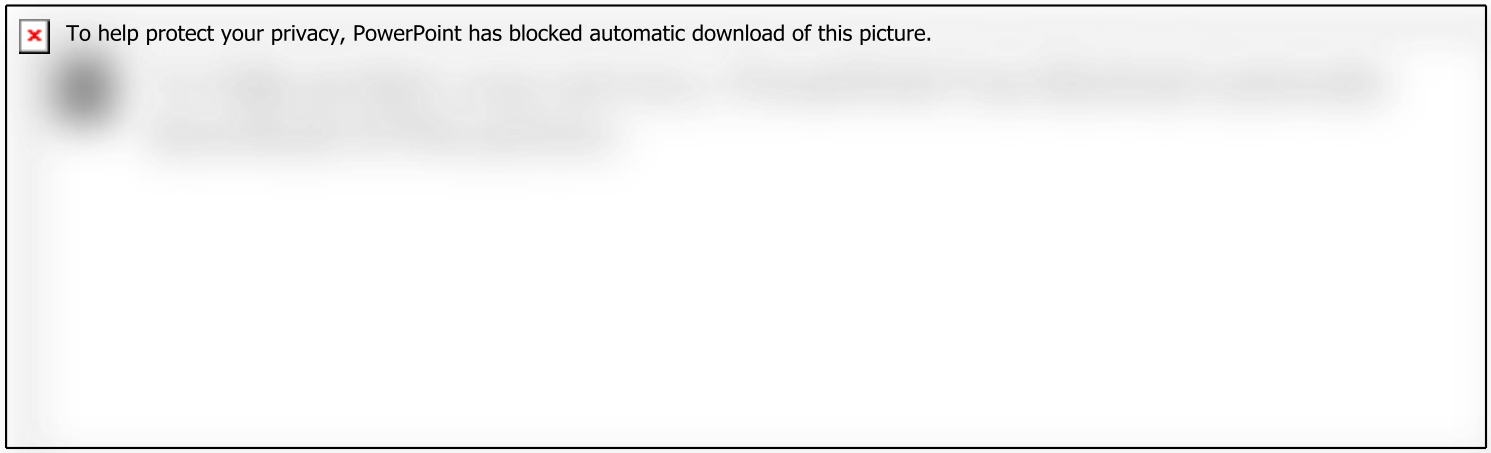
24 June - our first birthday

- The theme is 'Sign up to Safety + Me‘
- We want to use the anniversary to celebrate the great work that’s underway and highlight that Sign up to Safety is for everybody
- We want to encourage lots more people to sign up and make their own personal safety pledges
- It’s also a chance to find out what Sign up to Safety means to your team members and encourage them to get involved in your safety improvement work

You and your staff can register for all upcoming webinars at…

www.signuptosafety.nhs.uk/webinars

Subscribe to our e-newsletter



Three things you can do tomorrow

Number One

- Review your current disciplinary policy
  - Ensure it accounts for when incidents are investigated that there is an understanding of human factors and the just culture
  - Your key issue is to ensure that learning from the events outweigh the deterrent effect of punishment and your staff feel able to speak out, raise concerns and report incidents

Three things you can do tomorrow

Number Two

- Conduct a culture survey of your staff (may need to have an anonymous route)
- Ask them if mistakes are made that they feel safe to come forward so that the organisation can learn from the event
- Feedback the information on a unit by unit basis not for the whole organisation

Three things you can do tomorrow

Number Three

- Review your incident reporting system – if your incident reports are mainly about:
  - problems with processes and equipment – you have a low reporting culture – these are easy to do without backlash on individuals
  - individuals reporting on other individuals – you have a low reporting culture – it is easy to point the finger at others
  - individuals reporting their own mistakes – you have a good reporting culture – the individual will act against their own self interest and report so that others can learn
  - individuals reporting their own violations – you have an outstanding reporting culture – they understand that you understand that violations are not disciplinary actions and are to be learned from

How to get in touch

- @signuptosafety
- #signuptosafety
- #SU2S
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