Put safety first

*Commit to reduce avoidable harm in the NHS by half and saving lives through a **systematic approach** to safety.*

*Make **public** your locally developed goals, plans and progress.*

*Instil a **preoccupation with failure** so that systems are designed to prevent human error and avoidable harm.*

Sign up to Safety

Creating the conditions for; a safety culture, a just culture, a learning culture and locally led, self directed safety improvement; and building a safer care movement to reduce avoidable harm by half and save 6000 lives.

Bringing to life the five values and behaviours [our pledges]

- put safety first
- continually learn
- be honest
- collaborate
- be supportive

Helping all in the NHS (in England) address five cross cutting system and human factors

- Communication failures
- Availability and design of the right equipment
- Individual factors; well-being, experience, stress, attitudes and relationships
- Observation failures
- Information failures

Aligning and encouraging the use of five different theories and methods

- Improvement science
- Implementation Science
- Movement methods
- Campaign methods
- Evidence based guidance, standards, targets and incentives

Not assuming we know what works - exploring and questioning current thinking – to do things differently

Sign up to SAFETY
LISTEN LEARN ACT

2015

Strategy on a page

Mission: To create the conditions for a safer NHS to support locally led, self directed safety improvement

Vision: To build a safer NHS in England to reduce avoidable harm by half and save 6000 lives

1
Put Safety First
Objectives:
1 Continue to build membership
2 Drive a reduction in avoidable harm through a systematic approach to safety
3 Foster locally led, self directed safety plans
4 Promote and lead actions that engage staff, patients and the public
5 Explore and question current safety thinking in order to potentially do things differently in the future

2
Continually learn
Objectives:
1 Learn about the challenges of making care safer
2 Promote a continuous learning culture and share frontline experiences
3 Curate existing relevant safety resources and provide links
4 Explore different methods for getting beneath the surface of safety starting with the implementation gap
5 Use learning to change our approach

3
Be honest
Objectives
1 Promote the principles of being open and candour
2 Work with others to support staff to being honest with colleagues and patients
3 Be honest about progress in terms of safety improvement
4 Explore different ways of demonstrating the difference made
5 Never assume we know the answers and work with a healthy cynicism to our work

4
Collaborate
Objectives
1 Actively collaborate with strategic partners
2 Influence others to ensure a sustained approach to safety across the system
3 Help 'wire together' the different components of the national patient safety strategy
4 Provide linkages for the frontline and the patient safety collaboratives
5 Join forces with the NHS LA for evaluation of financial incentives scheme

5
Be supportive
Objectives
1 Nurture and role model the just culture
2 Ensure organisations respond appropriately
3. Foster a way of working where we are kind to each other and help people bring joy and pride to their work.
4 Promote a systems approach where we address the cross cutting system and human factors*
5 Ensure we listen and learn from our members and act

*Holistic approach to address five system and human factors related to; communication, design of equipment, individuals, observation and information

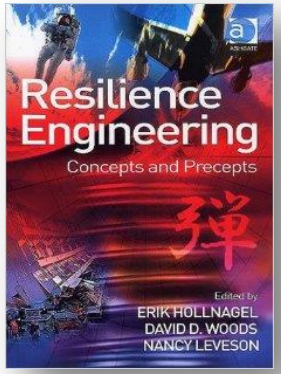
Guiding theories

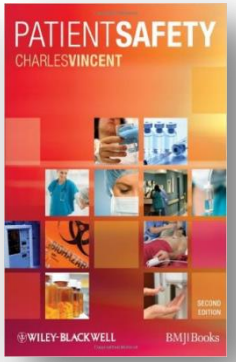
- Improvement science
- Implementation science
- Social movements
- Campaigning methods
- Evidence based practice; guidance, standards, targets and incentives

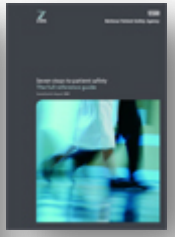

1. Make **public** your goals, plans and progress on your website and throughout your organisation
Making public goals, plans and progress on your website, and engaging with your frontline staff demonstrates that you are taking safety seriously and being open and transparent
2. Discuss progress with safety improvement plans at each board meeting
Discussing progress with your safety improvement plans at each board meeting demonstrates that the leaders of the organisation are taking safety seriously
3. Use **proactive tools** to measure risk and the potential for harm and consider how these can be designed out with changes to the environment, equipment, processes, pathways or tasks
Encouraging the use of **proactive tools** to measure risk and the potential for harm will help to prevent environment, equipment, process, pathway or task error and incidents from occurring
4. Design all patient areas with safety in mind
Designing all patient areas with safety in mind will prevent avoidable harm and error
5. Ensure your organisation has a **procurement policy** which reduces variation and buys with safety in mind
Ensuring all organisations have a **procurement policy** which reduces variation and buys with safety in mind will prevent avoidable harm and error
6. Foster a good **safety culture** by having processes (not just incident reporting) for hearing from your staff when things go wrong or when things could have gone wrong, feedback to those staff
Fostering a good **safety culture** and having processes (not just incident reporting) for hearing from your staff as well as providing feedback to those staff, will ensure you learn about when things go wrong or when things could have gone wrong quickly so that you can prevent error and incidents from happening or prevent the minor incidents from becoming serious
7. Build the **just culture** principles into your human resource policies and procedures
Building the **just culture** principles into your human resource policies and procedures will ensure that your staff feel able to speak out and are supported when they do but remain accountable for their actions

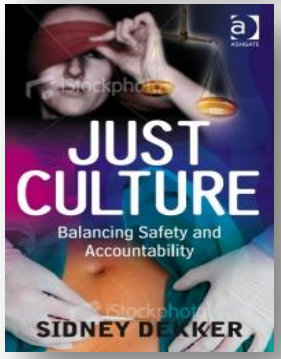
Key References

Macrae C. BMJ Quality and Safety
The problem with….incident reporting
Published Online First: doi:10.1136/bmjqs-2015-004732









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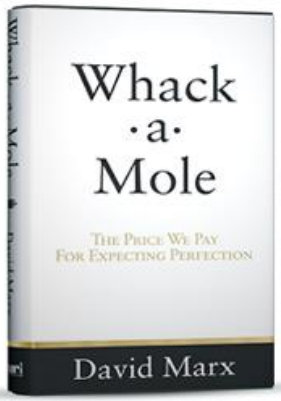
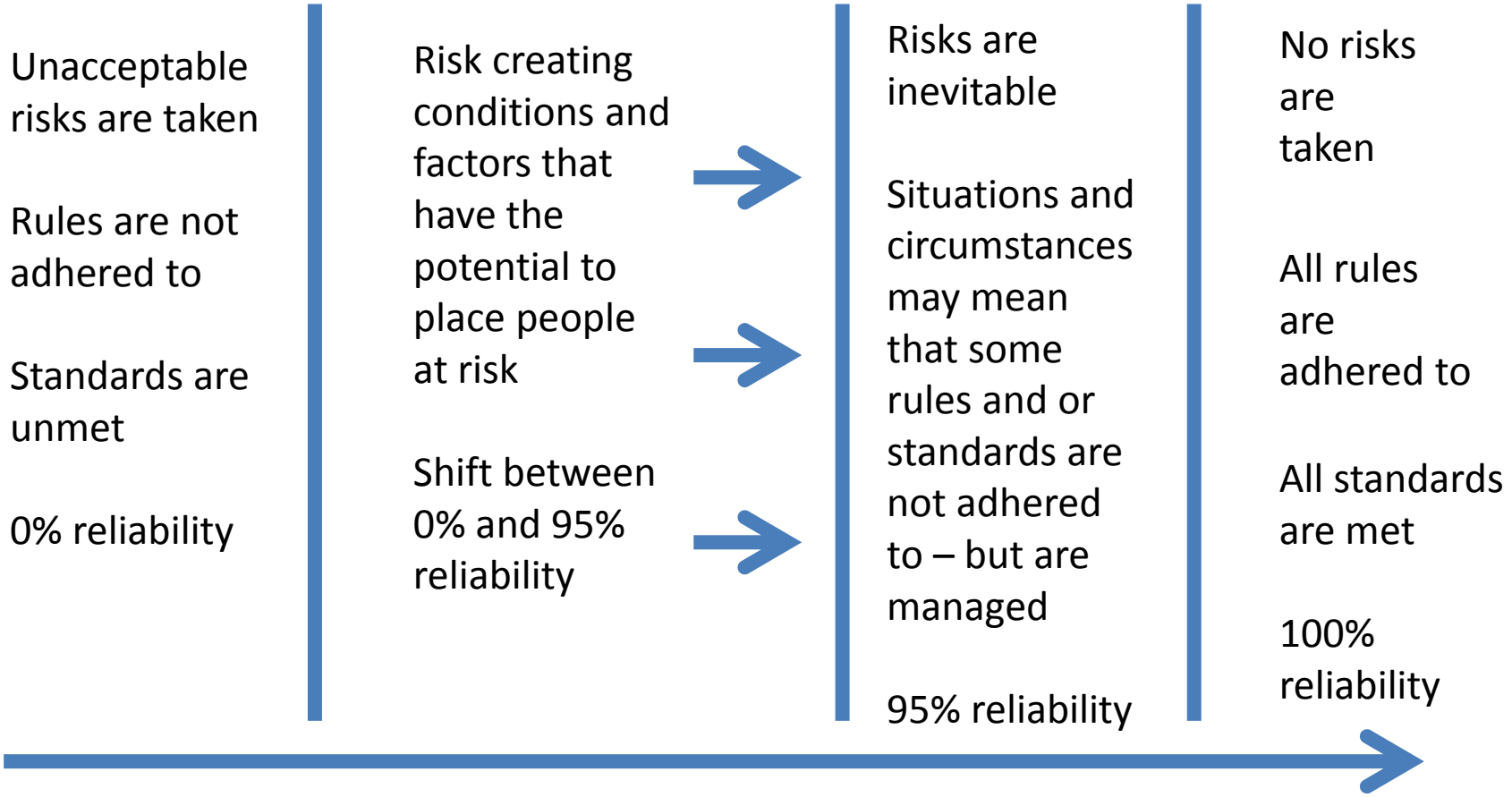


Put safety first

Creating a resilient organisation

Safety System



Resilience

- A resilient organisation is one that continually revises its approach to work in an effort to prevent or minimise failure
- Constantly aware of the potential for failure
- The ability to make decisions and direct (the limited) resources to minimise the risk of harm, knowing the system is compromised because it includes sometimes faulty equipment, imperfect processes, and fallible human beings

Factors that help

- Human factors design to reduce the rate of error
- Barriers to prevent failure
- Recovery to capture failures before they become critical
- Limit the effects of failure

Organisational issues that help safety

- Information
- Equipment/Tools
- Design/Configuration
- Job/Task
- Qualifications/Skills
- Perception of Risk
- Individual Factors
- Environment/Facilities
- Organizational Environment
- Supervision
- Communication

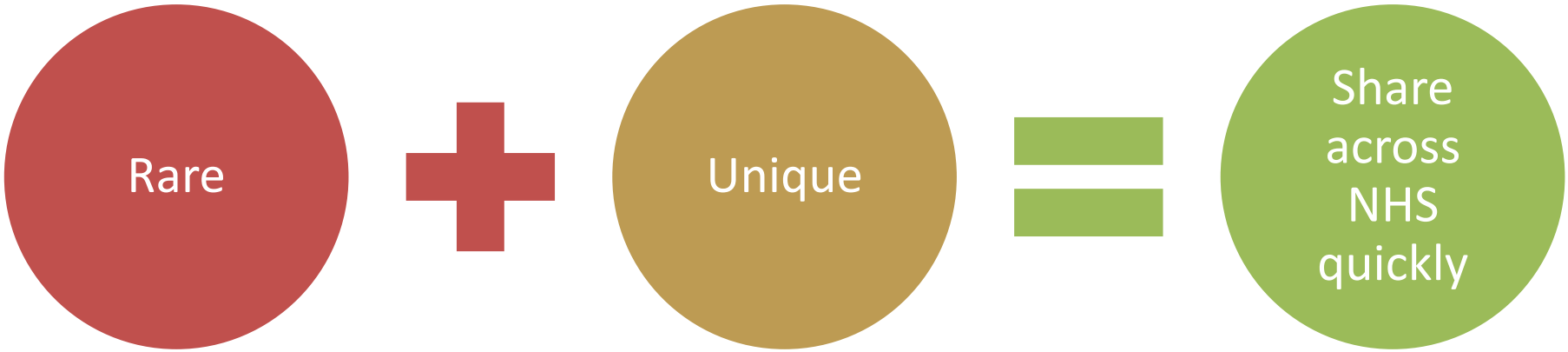
Put safety first

How we need to review our understanding of human error and learning from when things go wrong

- Incident reporting systems have become one of the most widespread safety improvement strategies in healthcare, both within individual organisations and across entire healthcare systems

- However… fundamental aspects of incident reporting systems are misunderstood, misapplied or entirely missed in healthcare

Incident reporting is the most mistranslated intervention from aviation



- ‘Report it all’ as a criteria means we have filing cabinets full of incident reports and the results of past investigations

- Most of this paperwork has only historic value

- An army of personnel is required to examine incident reports for trends or to produce useful analyses

- Incident reports are not a measure of safety
- Numbers or rates of reported incidents are a blunt measure of safety performance
- These systems detect only a tiny fraction of what actually goes wrong

- Increased reporting does not mean a better safety culture
- They are biased towards the easy to report actually hiding the needle in the haystack
- Repeated reports of the same type of event suggest a strong culture of reporting but a poor culture of learning

- Decreased reporting of the same types of incidents does not always mean learning

- Reduced reports of a particular type might simply indicate that people became accustomed to something happening, grew tired of reporting or stopped noticing the problem in question

- When reports decline, incident data on their own cannot distinguish between a reassuring improvement in safety or a concerning organisational blind spot

- Incident reports and investigations are biased, often inaccurate and usually entirely wrong

- Incident reports begin with one person's partial view of a complex clinical and organisational situation

- Reporters and investigators are biased by outcome, context, hindsight

- Many incident reporting systems involve staff reporting incidents to their superiors
- Reporting directly to a line manager potentially influences what is disclosed
- Reporting to your boss can introduce a damaging filter that prevents bad news being passed up a hierarchy

Ownership and engagement

- Incident reporting remains a relatively passive process of submitting reports on one hand and issuing feedback on the other—a process of information transfer rather than participative improvement

- Staff perceive incident reporting as simply a way of logging problems and waiting for fixes, removing any responsibility for local improvement

- Conversely, staff can simply fix a problem themselves and never report it, removing the opportunity for broader learning and sharing of insights

Feedback

- Feeding back information to staff is critically important to demonstrate the value of reporting and inform staff of actions taken and lessons learnt

- An incident report represents someone speaking up, stating that an issue concerns them and that they have an interest in its improvement

- Rather than simply collecting and feeding back information incident reporting systems should provide spaces that encourage open conversation, participative investigation and collective improvement of safety

Root cause analysis

- Poor recall
- Months to find out the answer
- Outcome, hindsight and confirmative bias
- Superficial recommendations
- Erosion of practice over time

The truth?

- We now know that in any one event there are multiple truths and facts
- That for one person there is their version of the truth, the facts, the event and for another there is a different version of the same incident
- We all know when telling stories about our own lives that we sometimes miss things out or elaborate a fact to make a point
- This natural behaviour distorts the truth very early on
- So to see incident reports as telling the exact truth is wrong

HR policies and culture that takes into account our 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

Proactive learning

- Incidents are not just things that need to be fixed but opportunities to improve our understanding of system and behaviour risk
- Improving patient safety depends upon a culture where we learn from our mistakes – whether they be near misses or incidents that result in actual harm
- It is through the lessons of our everyday errors that we can design our environment to be less error prone and more error tolerant
- We have to create a culture in which employees are willing to come forward in the interests of safety
- To promote a culture in which learning is paramount organisations must re-evaluate how the disciplinary system fits into this equation

Duties

- Professional duty
- Organisational values
- NHS constitution
- Duty of candour

Managerial duty

- Investigating the source of errors and at-risk behaviours
- Turning events into an understanding of risk leading to
  - Designing safe systems
  - Facilitating safe choices
- Understanding the right response for the particular behaviour
  - Consoling
  - Coaching
  - Punishing

Individual duty

- Look for the risks around me
- Report errors, hazards and incidents
- Help design safe systems
- Make safe choices e.g.
  - Following procedure
  - Making choices that align with organisational values
  - Never signing for something that was not done

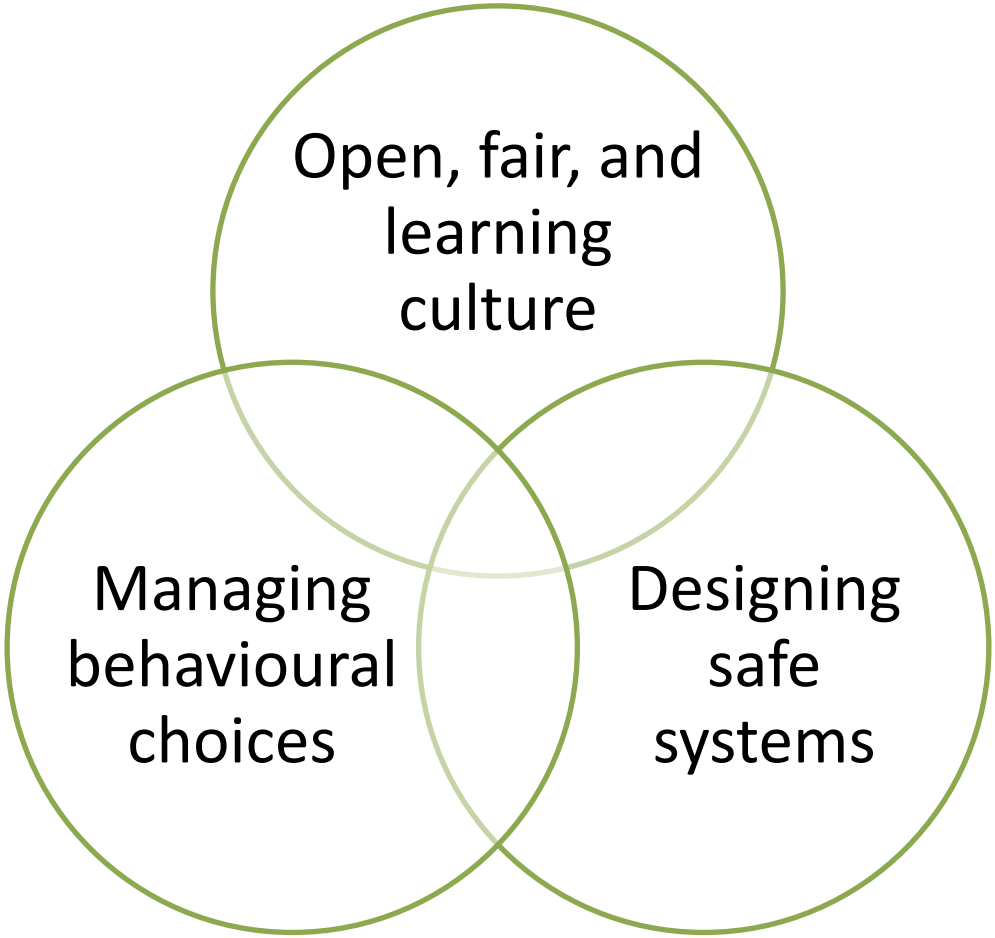
Put safety first

Creating the just culture

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

What is a just culture?



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

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

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

Are all intentional violations bad?

- There will always be circumstances where the rule does not fit the situation
- If a healthcare provider felt it was necessary to violate a policy to save a patient
  - e.g. a cardiac arrest in the car park may mean that some infection control rules are not followed
- We should judge individuals based on whether they knew the risks they were taking increased the potential for harm

Rule based disciplinary action

- Most high risk industries have rules, policies and procedures
  - e.g. checking of arm bands for ID of a patient
- The two questions to be asked are:
  - Did an individual violate a rule?
  - Did an individual intentionally violate a rule?
- Unfortunately a lot of organisations punish whether it was intentional or not

Normalising behaviour

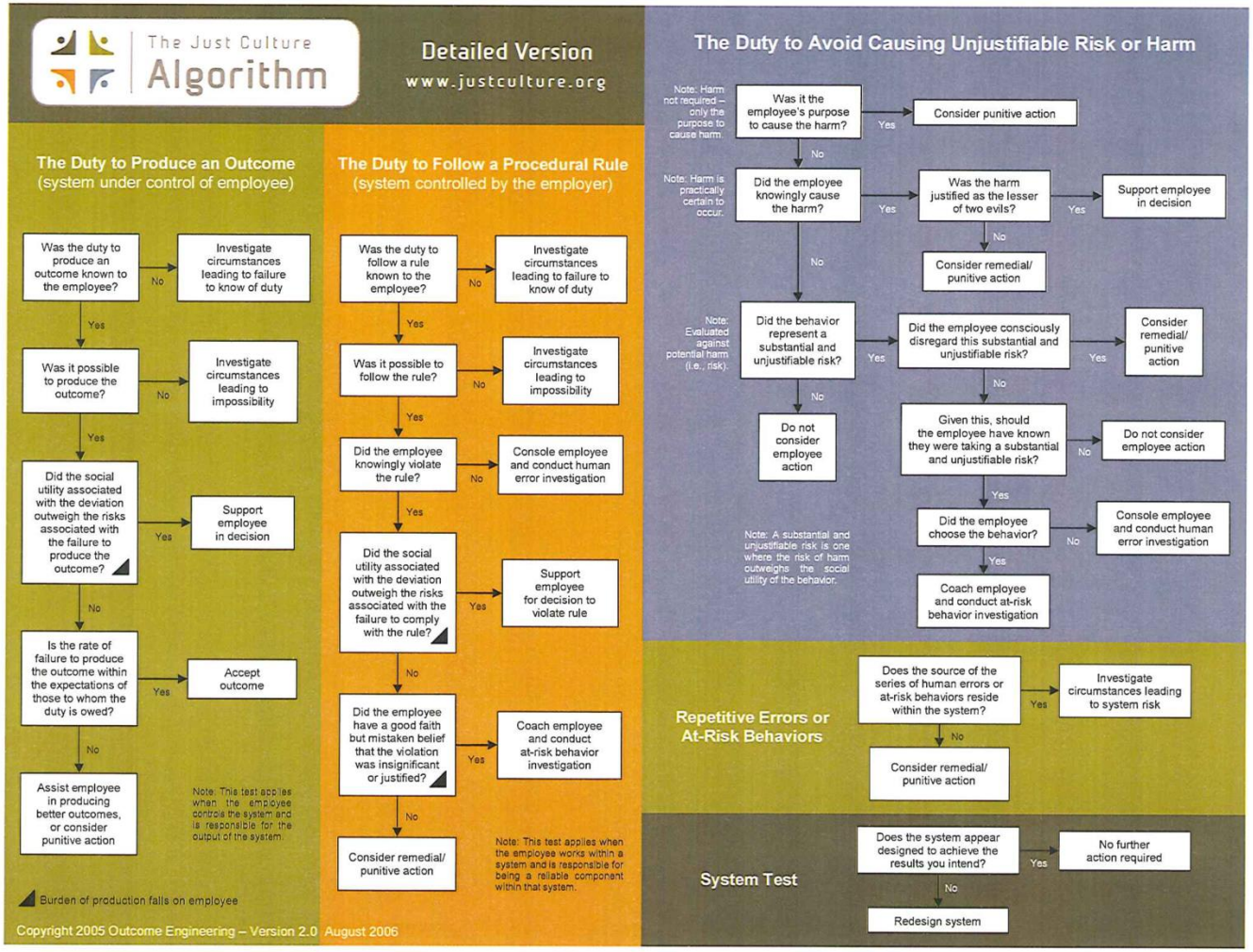
- Intentional violations of rules and procedures occur everyday – this is called normalising behaviour

- This is behaviour developed over time, often without the workforce's knowledge

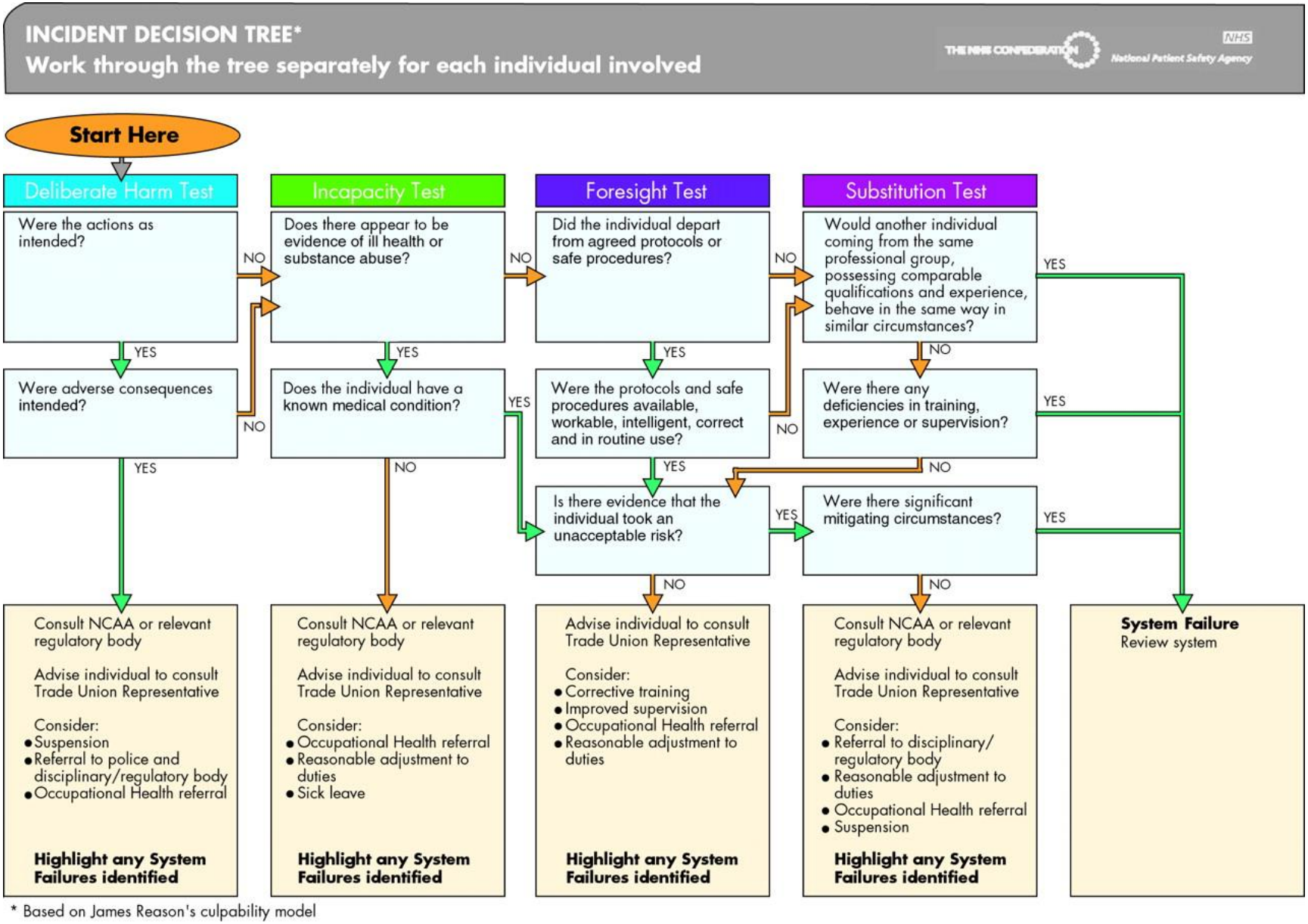
- Much can be learned by understanding why certain violations become the norm

Tools to help

https://www.justculture.org/



www.npsa.nhs.uk



Put safety first

Design out error where you can

“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

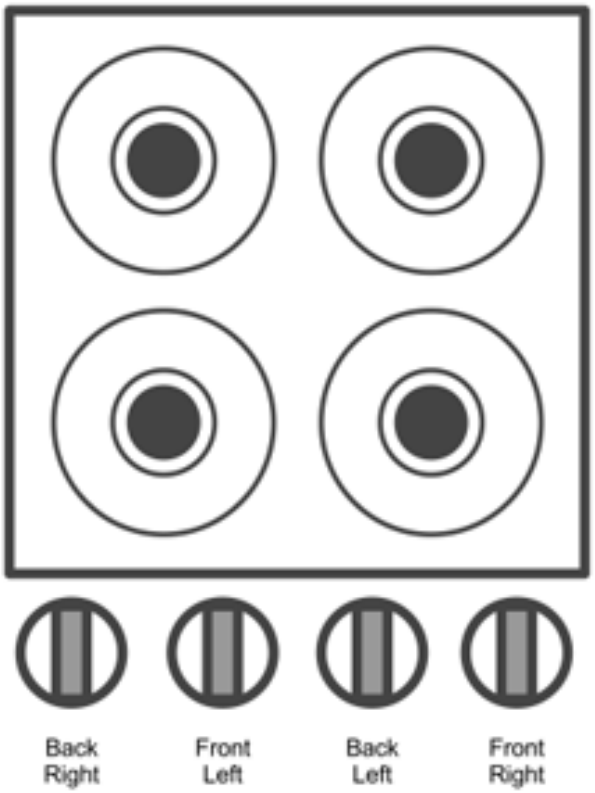
Designing out error

- Prevent user error from occurring – by encouraging simple-to-use and intuitive device operation
- Anaesthesia machines, for example, may have knobs of different shapes and colours to control the flow of oxygen and nitrous oxide gases being delivered
- This provides tactile as well as visual feedback, which helps prevent errors in selecting the wrong control knob

Design mindset

- Expect to administer ten times the dose
- Expect to operate on the wrong leg
- Expect to ….

- A preoccupation with failure rather than counting where we have failed



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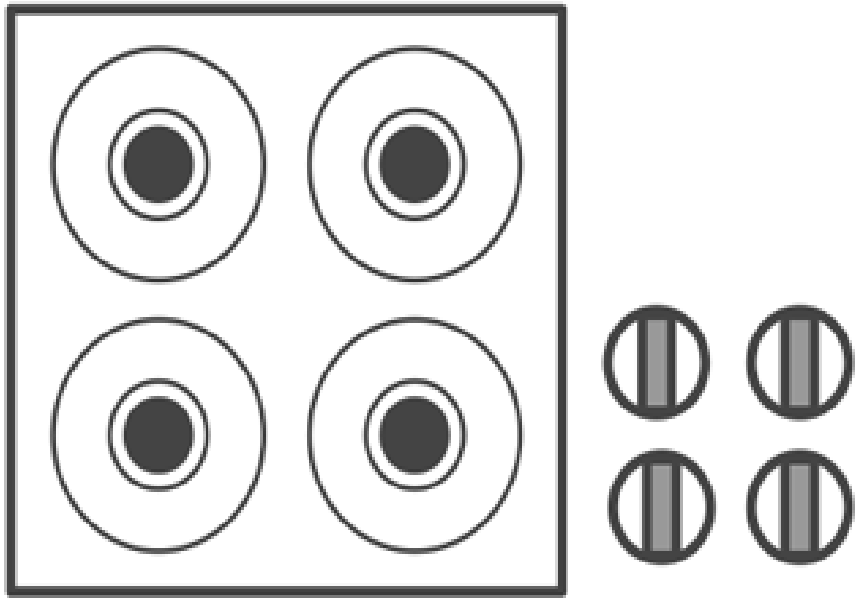

B


PRESCRIPTION ONLY MEDICINE
KEEP OUT OF REACH OF CHILDREN
cefTAZIDIME
Sandoz®
2g
ceftazidime powder for injection 2g
CAREFUL!
CHECK
FOR MEDICINES WITH SIMILAR NAMES
1 vial
I.V.
Each vial contains 2g ceftazidime (as ceftazidime pentahydrate).
AUST R 90916
SANDOZ
PRESCRIPTION ONLY MEDICINE
KEEP OUT OF REACH OF CHILDREN
cefEPIME
Sandoz®
2g
cefepime powder for injection 2g
CAREFUL!
CHECK
FOR MEDICINES WITH SIMILAR NAMES
1 vial
I.M. / I.V.
Each vial contains 2.0g cefepime (as hydrochloride)
AUST R 171734
SANDOZ

Visual clues

Design to address the multiple contributory factors

- When an elderly person fails to take a prescribed medicine, for example, is this due to a single cause such as poor communication in the pharmacy?

- Or is it the result of a complex chain of interrelated factors:
  - An unreadable leaflet or a medicine bottle
  - Poor vision or mental confusion
  - Problems reading
  - English is a second language
  - Problems understanding medication packaging

- The underlying causes of errors must be clearly understood before effective design solutions to these problems can be offered

Design to address the causal factors

- Every day in the NHS there are many interactions within and between:
  - different teams
  - the environments they work in
  - the care they deliver
  - the equipment they use and
  - the information they need to keep track of patients and their treatments

- So when mistakes do occur, the causes – in all but the most obvious of cases – are likely to be just as complex, originating in the culture, physical, technological and psychosocial factors

Do we help ourselves?

- Actual work practices can challenge good design
- Staff remove ampoules from their original packaging and repack them in more convenient mixed batches
- Patients remove tablets from their original packaging and place them all into single pots
- In doing so the most obvious visual clues of identification have been removed increasing the chance of a mistake

Hedonic Adaptation

- When people become accustomed to a positive or negative stimulus.. Emotional effects of that stimulus are attenuated over time
- We become desensitised or bored of the same thing

Purchasing for safety

- NHS purchasing decisions must take into account the needs of users and the ease of use of products or equipment (by healthcare practitioners) not just price

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

Share

- There are a lot of great resources you all use; it would be lovely if you were to share these with your fellow campaign members. We'd like to know what you think. What are the challenges and opportunities these actions present and which are you tackling already? We would like to share your experiences with the community, shine a light on your success and what you're learning along the way in order to help others make progress too.
  - Ask yourself:
    - What has your organisation/your area of work/your team done to put safety first?
    - Do you have a story to tell?
    - What actions are you undertaking to bring this pledge to life that you can share for others to use?
    - Even if you don't think you have done much or you have only just started we are interested in how you are thinking about this pledge.
- So if you have ideas, links, favourite websites, favourite documents then please send HERE: signuptosafety@nhsla.com.

Questions

- Does your Board understand patient safety?
- Does your Board make decisions that make it easier for frontline staff to make care safer?
- What about primary care?
- What about isolated staff?

Put safety first

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*Make **public** your locally developed goals, plans and progress.*

*Instil a **preoccupation with failure** so that systems are designed to prevent human error and avoidable harm.*