WORKING TOGETHER TO ENHANCE PATIENT SAFETY

Professor Kim Manley CBE

Professor, Practice development, research and innovation and Co-Director, England Centre for Practice Development

Joint Clinical Chair. Associate Director, Transformational research and practice development.

East Kent Hospitals University NHS Foundation Trust

ACKNOWLEDGEMENTS OF THE ENGLAND CENTRE FOR PRACTICE DEVELOPMENT TEAM

Carrie Jackson ; Christine McKenzie (RCN); Ann Martin; Toni Wright

WHAT WILL I COVER?

- Background to the Academic Health Science Network (AHSN) Patient Safety Collaborative Initiative – links to safety, quality and learning
- Why safety culture is important and what we mean by it
- The Safety Culture, Quality Improvement Realistic Evaluation (SCQIRE) project methodology and methods
- Insights into the work so far!
- No surprises!! Culture of working together is dependent on leadership, collaboration, inclusion, participation teamwork, shared purpose and agreed ways of working

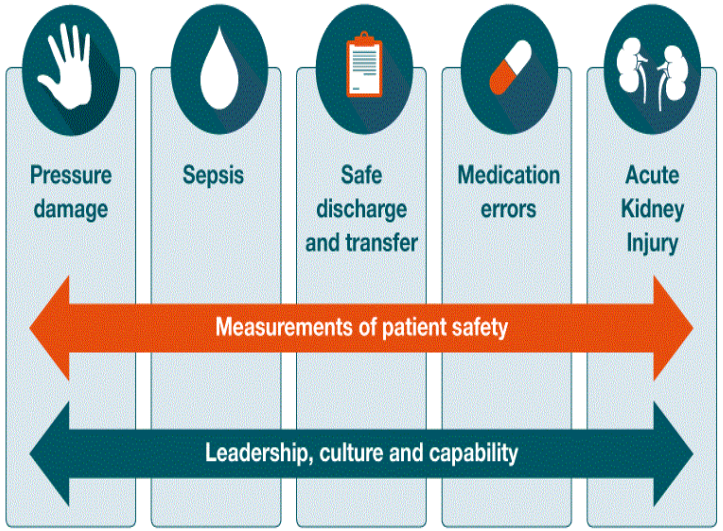
BACKGROUND

- Kent Surrey Sussex (KSS) Patient Safety Collaborative one of 15 nationally
- Set up October 2014
- Putting patients, carers and staff at the heart of quality improvements in patient safety
- Work alongside NHSE Sign up to Safety initiative:

''*to become, more than ever before, a system devoted to continual learning and improvement of patient care, top to bottom and end to end.*'' A promise to learn- a commitment to act (2014)

PRIORITY WORKSTREAMS IN KSS

- Pressure damage
- Sepsis
- Safe transfer and discharge
- Medication errors
- Acute Kidney Injury



❖ 2 cross cutting themes that lay foundation for patient safety
- Measurement of patient safety
- Leadership, culture and capability

Kent Surrey Sussex Academic Health Science Network

Patient Safety Collaborative

A model to develop safety culture, improvement capability and leadership in Kent Surrey and Sussex

A proposal to acute Trusts
October 2015

- Initiative designed to explore and improve safety culture with front line teams & develop capability for improvement
- Drawing on Health Foundation, Yorks and Humber Improvement Academy, NHS Leadership Academy and NHS improvement tools
- Action learning for participants to share experiences
- An independent evaluation partner – US!!! Particularly wanted a qualitative approach

SAFETY CULTURE DEFINED

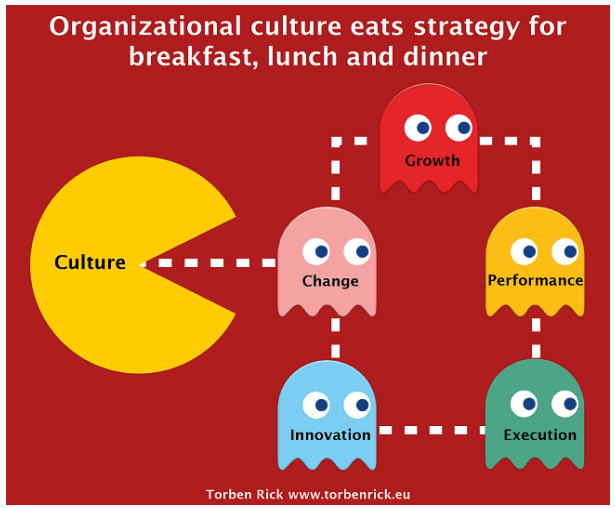
" *Safety culture is more than just a subset of organisational culture. It is made up of the different sub-cultures that exist within healthcare organisations at the frontline, management and executive level or layer*" *(Health Foundation 2013)*

Focus on the reciprocal relationship between **culture and outcomes** (Health Foundation 2011)

WHAT DO WE KNOW ABOUT WORKPLACE CULTURE?

"A robust safety culture is the combination of attitudes and behaviours that best manages the inevitable dangers when humans, who are inherently fallible, work in extraordinarily complex environments. The combination epitomised by healthcare is a lethal brew."

(Leonard & Frankel 2012)



Workplace Culture: Why is it important?

"In all studies of culture in health care, dominant hierarchical cultures, characterised by a preoccupation with target setting, rules, regulations and status hierarchies ***never*** *predict good performance. Instead,* ***they potentially inhibit a positive climate for safety due to fear of negative outcomes and blame for reporting safety-related problems****". (West 2015 for Kings Fund)*

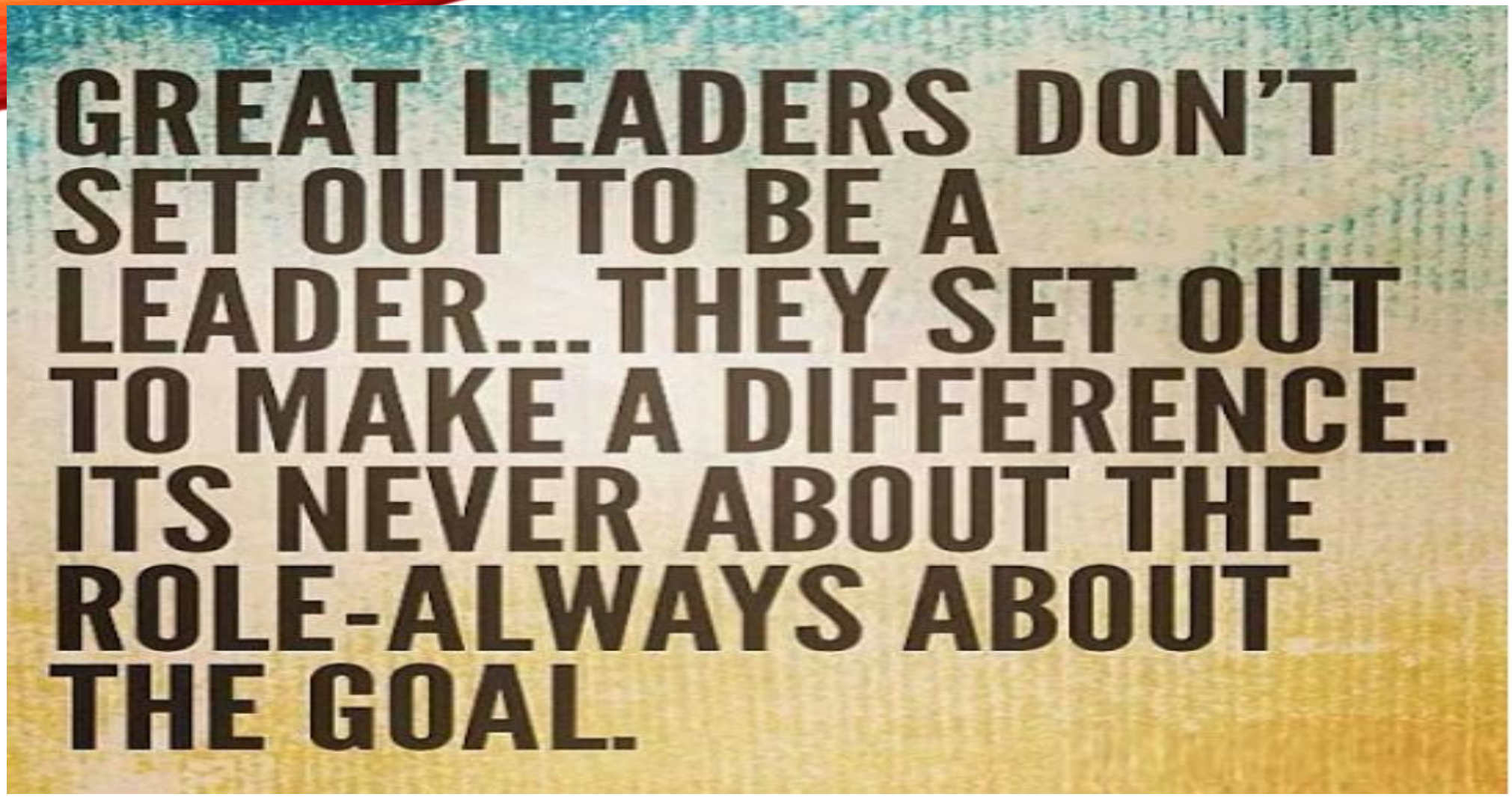
ESSENTIAL INGREDIENTS FOR SUCCESSFUL SAFETY CULTURE (LEONARD AND FRANKEL 2012)

- **Distributed leadership**
- Focus on **nurturing appropriate behaviours** and attitudes and engendering confidence in front line staff **to speak up without fear**
- **Organisational fairness**, care givers know they are accountable for being capable, conscientious and engaging in unsafe behaviour but not accountable for system failures
- An **active learning system** where engaged leaders **hear patient and front line care givers concerns** regarding factors that interfere with person centered safe and effective care

WHAT WOULD WE SEE OR NOTICE ABOUT A WORKPLACE?

- Staff have positive perceptions of team work and leadership
- Staff feel comfortable discussing errors
- Leaders and front line staff take shared responsibility for delivering safer care
- There is lack of complacency and a constant concern about safety

(The Health Foundation 2015)


GREAT LEADERS DON'T
SET OUT TO BE A
LEADER....THEY SET OUT
TO MAKE A DIFFERENCE.
ITS NEVER ABOUT THE
ROLE-ALWAYS ABOUT
THE GOAL.

SHARED PURPOSE – SHARED VALUES – SHARED UNDERSTANDING

Purpose defines the ultimate 'why' of the practice and/or service, it is positioned above all other strategic statements and expresses our identity and the reason we exist (Finney 2013).

'*Shared purpose results when a group of individuals aligns their belief systems or values with a common challenge, vision or goal.* ' (Finney 2013:5)

IMPACT ON QUALITY

Cultures that provide high-quality care are characterised by shared values translated into agreed ways of working that embrace care, compassion and support, and are developed through leadership recognised as a collective endeavour rather than command and control (West et al., 2014; Stodd, 2016).

Effective workplace culture handout

EFFECTIVE[1] WORKPLACE CULTURE[2]
Concept Analysis

Manley, K., Sanders, K., Cardiff, S., Garbarino, L. and Davren, M. (v6 7/7/06)

Enabling factors

INDIVIDUAL:

- transformational leadership
- skilled facilitation
- role clarification.

ORGANISATIONAL:

- flattened and transparent management
- organisational readiness
- human resource management support.

Essential attributes

1. Specific values promoted in the workplace, namely:
   - person-centredness
   - lifelong learning
   - support and challenge
   - leadership development
   - involvement and participation by stakeholders
   - evidence-use and development
   - positive attitude to change
   - open communication
   - teamwork
   - safety (holistic).
2. All the above values are realised in practice, there is a shared vision and mission and individual and collective responsibility.
3. Adaptability, innovation and creativity maintain workplace effectiveness.
4. Appropriate change is driven by the needs of patients/users/communities
5. Formal systems exist to continuously enable and evaluate learning, performance and shared governance[3].

Consequences

- Continuous evidence that:
  - ➢ Patients', users' and communities' needs are met in a person-centred way.
  - ➢ Staff are empowered and committed.
  - ➢ Standards and goals are met (individual, team and organisational effectiveness).
  - ➢ Knowledge/evidence is developed, used and shared.
- Human flourishing for all.
- Positive influence on other idiocultures.

1. Effective = achieving the outcomes of person-centredness and evidenced-based care (performance).
2. Workplace culture = the most immediate culture experienced and/or perceived by staff, patients, users and other key stakeholders. This is the culture that impacts directly on the delivery of care. It both influences and is influenced by the organisational and corporate culture as well as other idiocultures. Idioculture is used to imply that there are different cultures that exert an influence on each other rather than one organisational/corporate culture with sub-cultures within a hierarchical arrangement.
3. Shared governance encompasses achieving stakeholder participation in using evidence from a variety of sources (e.g. audit, feedback, reflective practice, research) for decision making.

Kouzes and Posner – Transformational Leadership

Model the Way	• Clarify Values • Set the Example
Inspire a Shared Vision	• Envision the Future • Enlist Others
Challenge the Process	• Search for Opportunities • Experiment and Take Risks
Enable Others to Act	• Foster Collaboration • Strengthen Others
Encourage the Heart	• Recognize Contributions • Celebrate the Value and Victories

CORE VALUES

- Being person centred
- Safe and effective care
  - lifelong learning
  - evidence-use and development
  - positive attitude to change
  - safety (holistic)
- Working with others
  - collaboration, involvement and participation with stakeholders
  - high support and high challenge
  - open communication
  - teamwork
  - leadership development

(Manley, Sanders, Cardiff, Webster 2011)

INTRODUCING THE RESEARCH EVALUATION – SAFETY CULTURE, QUALITY IMPROVEMENT, REALISTIC EVALUATION (SQIRE)

STUDY AIM

- To evaluate the impact of the Patient Safety Collaborative model (KSSAHSN) on safety culture, improvement capability and leadership across four acute NHS Trusts in Kent Surrey & Sussex

- **Multi-site Evaluation**

WHY IS THIS IMPORTANT?

- Patient safety top government priority
- Less workforce, drive for greater efficiencies
- Focus on understanding how to enable bottom up change and innovation
- What essential ingredients are required to promote workplace cultures that foster successful sustainable innovation?
- Blending culture, leadership, facilitation, learning, development, inquiry, innovation and quality improvement for first time

METHODOLOGY

1. Realistic Evaluation (Pawson and Tilley 2004)
2. Drawing on critical ethnography
3. Descriptive case study design (Yin 2003)

Enables the strategies that are influential within and across the four different case study sites to be identified and linked with specific outcomes. Also involves literature analysis.

Canterbury Christ Church University

DESIGN: REALISTIC EVALUATION

- 'What works for whom, why and in what context?'
- Specifically at the frontline, what strategies:
  - contribute to developing a safety culture
  - develop quality improvement and leadership capacity

- Underpinning assumptions:
  - ✓Collaborative, inclusive and participative
  - ✓Focus on learning
  - ✓Different ways of getting to the same outcome
  - ✓Facilitation of learning, development and improvement is a key skill set required by trust facilitation teams

PARTICIPANTS

- **Site 1** working with three teams
  - Antenatal and post-natal ward
  - Respiratory ward
  - Clinical decision unit/urgent care
- **Site 2** working with one team
  - Ward previously experiencing a high fall rate
- **Site 3** working with two teams
  - Midwifery Delivery Suite
  - ED
- **Site 4** working with four teams:
  - Frailty ward and safe discharge
  - Renal ward and sepsis
  - A &E and patient transfer to wards
  - Ambulatory Care - discharge

GENERATION OF THEORY

- Various data sources used to generate theories which are then tested and refined.
  - documents
  - literature
  - documentary analysis
  - interviews with stakeholders
  - Front line practitioners, facilitators,
  - AHSN patient safety programme team
  - formal programme theory -patterns of **Context-Mechanism-Outcome**

METHODS

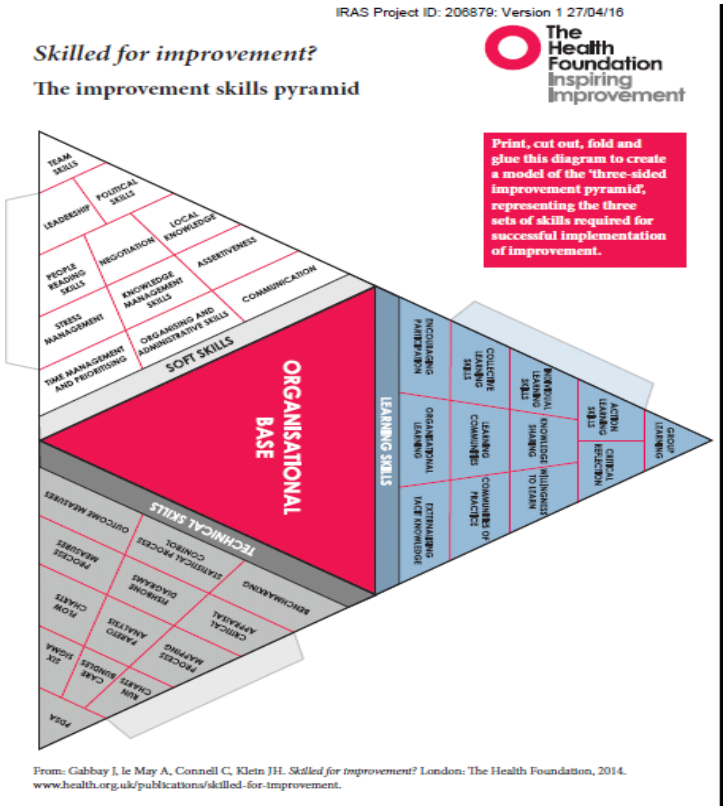
- Literature review
  - Safety culture, QI and leadership
  - Patient Safety
- Synthesized into concept analysis framework
  - ✓ Enablers
  - ✓ Attributes
  - ✓ Consequences
- At individual, team and organisational levels

METHODS- RICH PICTURE OF CONTEXT

- Timed measurement points across 12 months- pre and post intervention of safety project
- Self-assessment (Jackson et al, 2015);
- Qualitative 360 degree feedback (Garbett & Manley, 2007)
- Critical observation of frontline practice (RCN, 2007; Austin & Hickey, 2007);
- Stakeholder evaluation (Claims, Concerns, Issues) (Guba & Lincoln, 1989)
- Emotional touch points (Bate & Robert, 2007; Dewar and Mackay 2009) using QI Pyramid (Gabbay et al, 2014),
- Texas safety culture survey tool (Sexton et al , 2006).
- *Mapping degree of change using Normalisation Process Survey (May et al 2016)*

Canterbury Christ Church University

USING HEALTH FOUNDATION QI PYRAMID WITH EMOTIONAL TOUCHPOINTS



- Getting to the heart of what really matters to people
- Working with positive and negative emotions
- Looking at the knowledge and skills required by facilitators working with front line teams

Literature Concept analysis framework:Team

TEAM ENABLING FACTORS	TEAM ACTIVITIES & BEHAVIOURS	TEAM CONSEQUENCES
SHARED VISION & VALUES & AUTHENTIC LEADERSHIP TSCE6: Shared vision, values, common objectives competences, behaviours OSCE2: Strong organisational culture, shared values, beliefs and goals OSCE3: Compelling shared vision and modelled by leaders creating the right conditions TSCE5: Authentic leadership by example, motivated managers **VALUES: PARTICIPATION & ENGAGAMENT WITH PATIENTS & STAFF** OE1.Value patient participation, engagement & person centredness OE2.Value, clinical and practical expertise & staff autonomy & involvement in safety & quality improvement OE3.Value stakeholder involvement in safety campaigns, detection and design TE6.Know-how & know why of engaging staff	OA1. Sharing & communicating information with patients & families, staff OA2.Encouraging & engaging patients to participate in care as equal partners OA3. Staff involved/engaged in identifying concerns, determining & implementing interventions OA4. Involving/engaging patients, service users and providers in care & safety systems, quality improvement, drawing on their expertise TA3. Engaging & involving staff to create ownership for safe practice TA17. Students participating in systematic QI	**STAFF ENGAMENT, MORALE, SATISFACTION** TSCC9: Staff & patient empowerment OC2. Improvement in staff outcomes & morale TC4. High level staff engagement TC5. Improved staff morale IC4. Job satisfaction & staff motivated in patient safety & QI TSCC10: Improved staff engagement TSCC11: Improved staff morale & satisfaction

CMO'S EXPLAINED

- Key to realistic evaluation is the local development, testing and refinement of relationships between contexts (C), mechanisms (M) used (i.e. the strategies) and outcomes (O) termed the MCO relationships.

EXAMPLE INDIVIDUAL CMO'S (LITERATURE)

CONTEXT	MECHANISMS	OUTCOMES
ISCE1 - Personal characteristics, ISCE2 – Personal values and beliefs	TA1 - Compassionate presence; engaging patients and families, TA2 - Interactions between patients, providers & environment, ISCA9 - Communicating effectively without discrimination, ISCA8 - Truly Listening to others , ISCA10 - Committed engagement and building relationships with others	IA1 - Establish & maintain caring, responsive, trusting, therapeutic relationships based on communication, ISCA1 - Collaboration across whole systems to promote learning, ISCC4 - Staff speaking up, ISCC1 - Increased ownership & accountability for own practice

Action hypothesis:

Contexts where individuals possess specific personal characteristics and values and beliefs who use compassionate presence and committed engagement with patient and families through truly listening, communicating without discrimination and building relationships with others will enable: the establishment and maintenance of caring responsive trusting therapeutic relations; collaboration across the system to promote learning; staff to speak up; and increased accountability for own practice

EXAMPLE -INDIVIDUAL CMO'S (LITERATURE)

CONTEXT	MECHANISMS	OUTCOMES
ISCE2 - Personal values and beliefs	ISCA3 - Reflecting and recognising own assumptions developing awareness about own interventions, ISCA7 - Participating in practice based learning and showing readiness to change	TC1 - Actions based on learning ISCC9 - Continuous learning & creative problem solving, ISCC4 - Staff speaking up. ISCC1 - Increased ownership & accountability for own practice, ISCC2 - Increased safety awareness, ISCC3 - Improved compliance, TSCC8 - Behaviour change to safety behaviours & attitudes, IC5 - Behaviour change ISCA1 - Advocacy for patients as individuals , IA1 - Establish & maintain caring, responsive, trusting, therapeutic relationships based on communication

ACTION HYPOTHESIS:

Contexts where individuals possess specific values and beliefs who reflect and recognise own assumptions to develop awareness of own interventions, participate in practice based learning and show a readiness to change are associated with **increased accountability for own practice; continuous learning and creative problem solving; behaviour change based on learning, the establishment of caring responsive therapeutic relationships, and advocacy for patients**.

WHAT ARE THE SPECIFIC INDIVIDUAL VALUES & BELIEFS?

ISCE1. Personal characteristics

- Person-centred, compassionate and caring
- Authentic, open, honest and trusting with integrity
- Supportive, valuing and empathetic
- Motivated , showing perseverance, resilience and adaptability (IE1. Are *respectful,* & resilient)
- (IE2. Are active and adaptive to the work system)
- Creativity, passion with drive and self-efficacy
- Enthusiastic and optimistic
- Vision and systems thinking

ISCE2 Personal values and beliefs

- Respectful and ethical
- (IE1. Are respectful, & *resilient*)
- Accountable, responsible and taking pride in one's work
- Self and safety aware and reflective
- A commitment to safety, quality, learning and a blame free approach to incident reporting
- IE3. Show positive commitment to adopting & implementing safe, ethical practice
- Courage to speak up assertively

Examples- Team CMOs

CONTEXT	MECHANISM	OUTCOMES	ACTION HYPOTHESIS
OE1 - Value patient participation, engagement & person centredness	OA1 - Sharing & communicating information with patients & families, staff, OA2 - Encouraging & engaging patients to participate in care as equal partners	TSCC9 - Staff & patient empowerment	**Team contexts that value patient participation, engagement and person centredness** and use approaches **that share and communicate information with patients, families and staff, and encourage and engage patients in care as equal partners achieve staff and patient empowerment.**
TE6 - Know-how & know why of engaging staff	OA3 - Staff involved/engaged in identifying concerns, determining & implementing interventions, TA3 - Engaging & involving staff to create ownership for safe practice	IC4 – Job satisfaction & staff motivated in patient safety & QI, TSCC10 - Improved staff engagement	**Teams who possess the know how and know why of engaging staff** will use approaches **that involve and engage staff in identifying concerns, determining and implementing interventions; and creating ownership for safe practice** will **achieve continued improved staff engagement, job satisfaction and staff motivated in patient safety and quality improvement.**

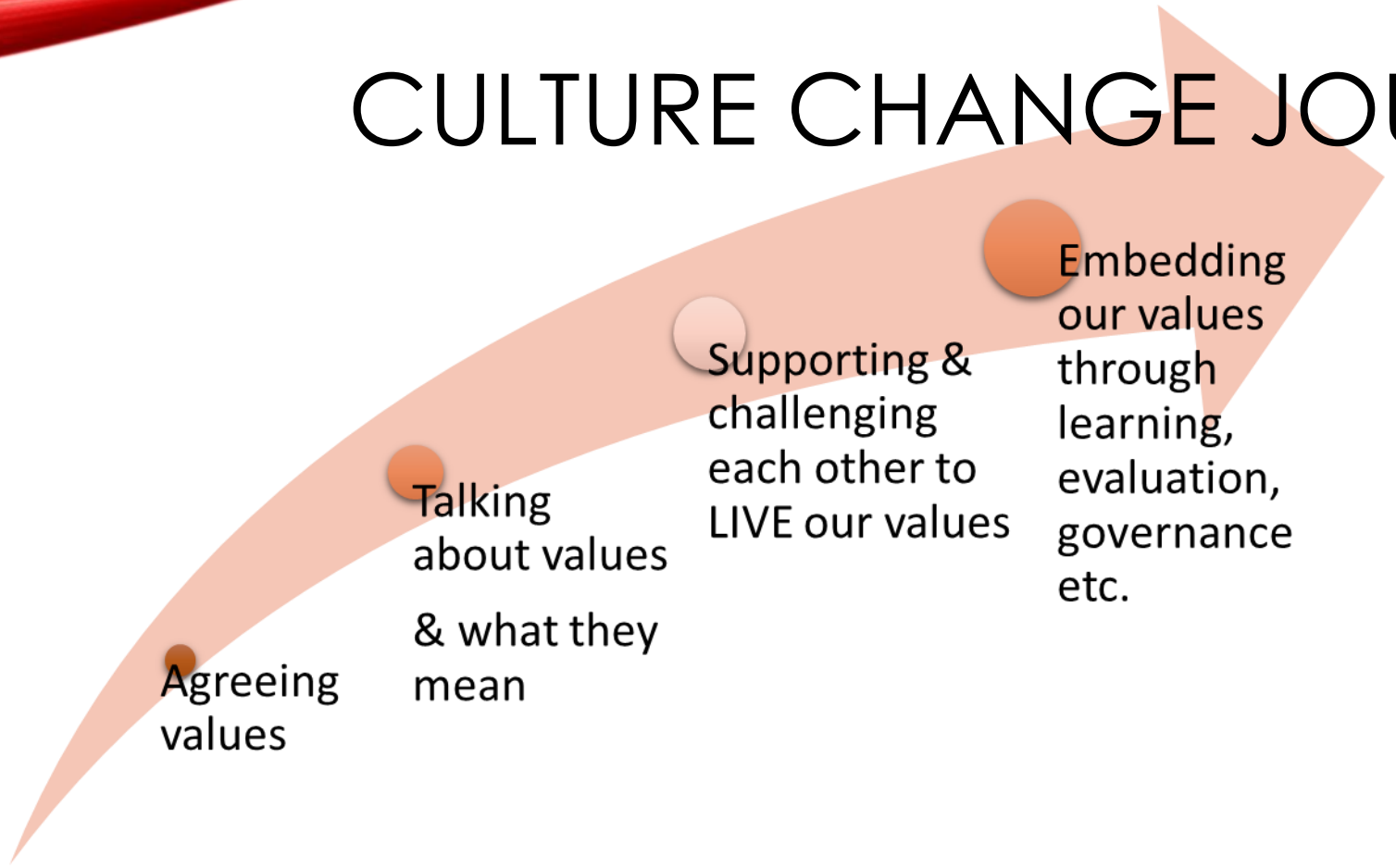
Examples- Team CMOs

CONTEXT	MECHANISM	OUTCOMES	ACTION HYPOTHESIS
OE1 - Value patient participation, engagement & person centredness	OA1 - Sharing & communicating information with patients & families, staff, OA2 - Encouraging & engaging patients to participate in care as equal partners	TSCC9 - Staff & patient empowerment	**Team contexts that value patient participation, engagement and person centredness** and use approaches **that share and communicate information with patients, families and staff, and encourage and engage patients in care as equal partners achieve staff and patient empowerment.**
TE6 - Know-how & know why of engaging staff	OA3 - Staff involved/engaged in identifying concerns, determining & implementing interventions, TA3 - Engaging & involving staff to create ownership for safe practice	IC4 – Job satisfaction & staff motivated in patient safety & QI, TSCC10 - Improved staff engagement	**Teams who possess the know how and know why of engaging staff** will use approaches **that involve and engage staff in identifying concerns, determining and implementing interventions; and creating ownership for safe practice** will **achieve continued improved staff engagement, job satisfaction and staff motivated in patient safety and quality improvement.**

Examples- Organisational Hypotheses arising from CMOs

ACTION HYPOTHESIS
ORGANISATIONAL READINESS Organisations characterised by organisational readiness reflected in non-hierarchical, inclusive bottom up driven learning organisations, adaptive capacity with shared and supportive, inclusive and involved senior leadership/ management committed to safety, quality and improvement through: genuine interest and presence of leaders; collaboration, teamwork and horizontal accountability; addressing organisational barriers; implementing organisational systems that provide incentives, recognise and celebrate; report, monitor and respond to harms; respond compassionately and simply to complaints; staff training and education; and educating patients about harm. The outcomes include shared accountability/responsibility by all staff; Improved leadership communication, organisational learning, reduced organisational stress; improved resilience and positive impact from targeted interventions
WHOLE SYSTEMS APPROACH Organisational contexts characterised by a whole systems approach, highly reliable integrated systems and safety nets to prevent harm and errors that focuses on collaboration for learning, problem solving and systems thinking rather than individual competence will achieve organisational learning, community partnerships, transformation of cultures, reduced risks, errors and harm

CULTURE CHANGE JOURNEY



Manley 2014

KEY INSIGHTS ARISING FROM THE CASE STUDY SITES

- ✓ The power of observations of practice – seeing the world through different eyes and working together
- ✓ Clinical leadership (with/without management roles) modelling values, enabling learning creating a positive team culture
- ✓ Skilled facilitation in drawing on the workplace as the main resource for learning, development and improvement
- ✓ Skills in engaging staff and stake holders – collaboration, inclusion and participation

360 degree feedback to manager/facilitator at one site

"You have very clear standards for the delivery of care and I have never known you to compromise these standards. This sends a clear message to staff, encourages and inspires similar standards."

"You have a welcoming and enthusiastic personality that makes you easy to approach, ask questions and suggest solutions. This makes it easy for staff to report adverse incidents and support further learning and enhances safety."

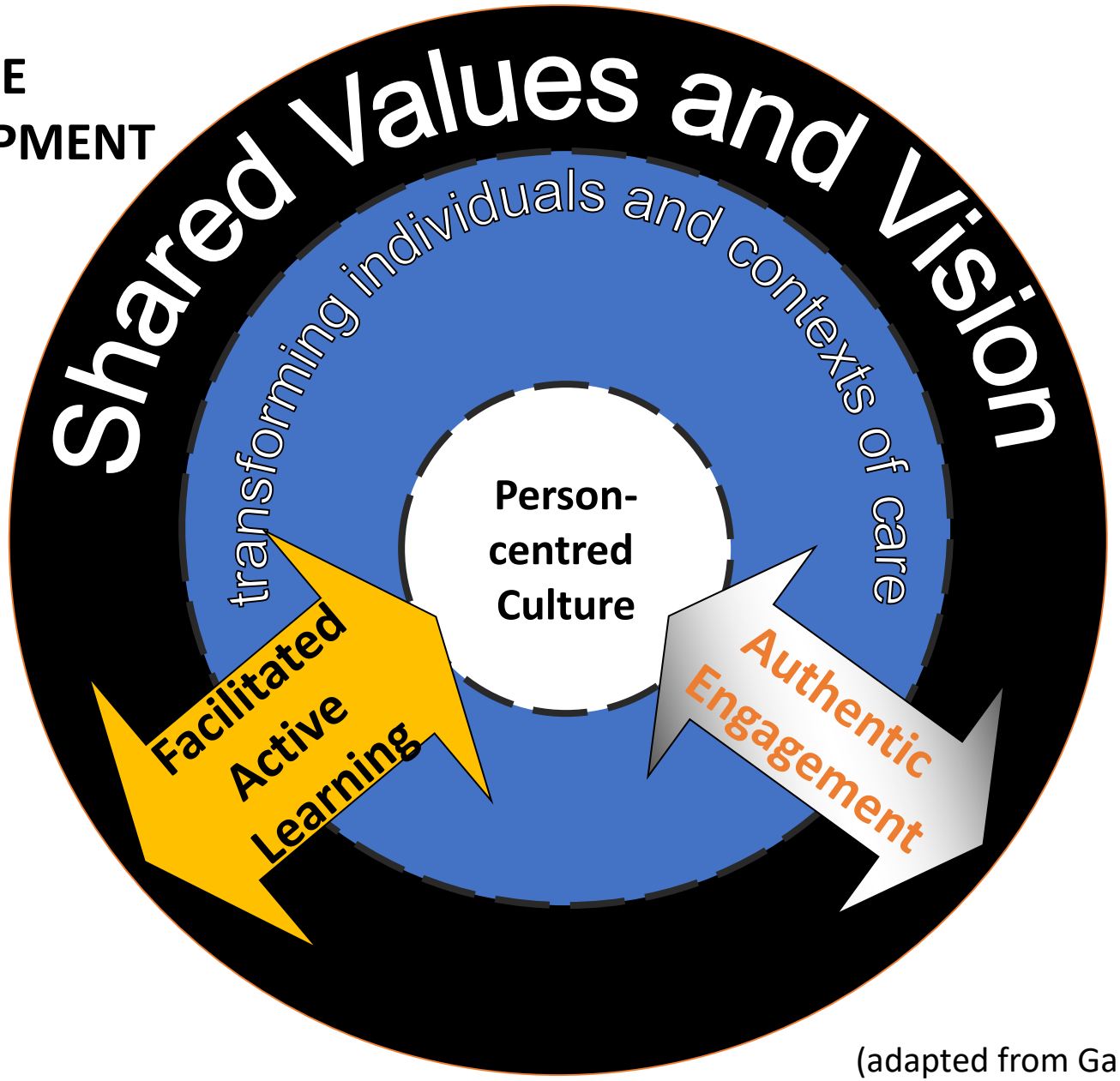
"You always make the time to listen and explain; this is a great trait in a manager and has been a great support."

"Positive support and leadership to staff and listen to concerns"

"Always seeks to develop service and involves teams in actions"

"You involve staff in discussion and decision making about changes"

PRACTICE DEVELOPMENT



(adapted from Garbett & McCormack, 2002)

THE PROCESSES THAT ARE INFLUENTIAL!!

‘Engagement appears to be higher in healthcare organisations where leaders create a positive climate to ensure that staff feel involved and have the emotional capacity to care for others.’

Dawson et al., 2011

THANK YOU FOR LISTENING

Twitter:
@EC4PD @kimmanley8, @ECPDCarolyn;

Website:
www.canterbury.ac.uk/ecpd

Email:
Kim.manley@nhs.net kim.manley1@canterbury.ac.uk
carolyn.Jackson@canterbury.ac.uk

Facebook:
www.facebook.com/groups/ecpd1


QUESTIONS