NHS North West Patient Safety Catalyst Event

“Building New Research Collaborations for Patient Safety”

Wednesday 19th May 2010

The Lancaster House Hotel, Green Lane, Ellel, Lancaster LA1 4GJ

Event sponsored by NHS North West
Research & Development

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Event Summary:

NHS North West in collaboration with NHS academia and industry held a joint interactive workshop to facilitate collaborative working across organisations, with a view to developing innovative bids for R&D funding, including from sources not previously applied to by researchers in the North West. The event aimed:

- To promote a step change in North West Patient Safety research by creating a vibrant Patient Safety research community
- To improve links between NHS organisations and Universities to facilitate Patient Safety research and support changes in practice
- To improve links with Universities with expertise in Patient Safety research
- To speed up the process of taking research breakthroughs into NHS patient care and treatments
- To contribute to the North West's economic and wealth agenda through the attraction of additional R&D funding to the North West

Key note speakers were, Professor Charles Vincent and Dr Leigh Griffin.

Professor Charles Vincent is the Director of the Clinical Safety Research Unit based at Imperial College London, Director of the National Institute of Health Research Centre for Patient Safety & Service Quality at Imperial College Healthcare Trust and editor of Clinical Risk Management, author of Patient Safety (2005) and author of many papers on risk, safety and medical error. He is a Fellow of the Academy of Social Sciences and of the NHS Institute for Innovation & Improvement

Dr Leigh Griffin is formerly Chief Executive to three Primary Care Trusts and has recently moved from his role as Chief Executive of NHS Sefton to take on the challenge of establishing a Centre for the Transformation of Health and Well-Being for North West England (covering a population of c7M). This role encompasses the further development of an evidence base for health interventions and the promotion and enablement of cross-sectoral working. It also seeks to coordinate the actions of a wide range of improvement agencies, progress workforce redesign and strengthen relationships with Universities.

The main theme for discussion on the day was **supporting knowledge transfer in Patient Safety research** with the priority areas of knowledge translation, diagnoses, treatment and health service research. This event is part of the catalyst programme led by R&D NHS North West.

Methodology:

The event was conducted using a forum known as 'Open Space' which was facilitated by an external facilitator. The method is designed to enable people with mutual interests to meet and progress ideas for research proposals in a short period of time. Participants have control over what is discussed and can choose to participate in the various discussion forums generated on the day. At the conclusion of the discussion forums decisions are made about the outcomes and next steps to progress proposals. The event is an important part of the wider catalyst programme which promotes new collaborations and innovative bids for funding.

Summaries of the open space discussions, including the names of the participants are outlined below:

Topic	Group Convenor	Key points of discussion	Research Idea – key points	Next Steps	People in discussion	Interested people	Key people
Why does no one love a 'whistle-blower. How can we encourage it	Anne Garden	• Importance of culture:- - Top down v. bottom up (conflict between the two) - Leadership within culture • Issues around personal/ professional behaviour – patient safety • Imbalance between benefits of being a whistle-blower v costs off whistle-blowing • Knowing when to draw line – small issues – big issues 'salami principle'	• Look at other industries (air lines) – how do they do it? • Research around changing culture (policing system – learning system) (Normalising behaviours) • Making "patient the first priority" vital	Look at culture	Jackie Rigby Sarah O'Brien Susan Donaldson Alaric best Irene Swarbrick Helen Poole		Anne Garden to discuss with Dawn Goodwin
How can the Research Design Service help in patient safety research?	Tom Franshaw	• Discussed availability of support through RDS • Discussed funding options • More specific projects/relevance for funding applications	• Discussed generic research advice and availability of advisors	Raise profile of RDS via more local meetings/ roadshows			Tom Franshawe (via RDS central hub)
Emotional and cognitive factors and their influence on work performance	Konstantinos Arfanis	• Striking a balance between efficiency and "lateral" behaviour • Giving people "space to breathe" • Emotional displays as a	• Action research • Feedback (learning from experience) • Life stores • Observation • Role exchange	Raise the issue of communication and the importance of op-en and sagfe spaces for the		Mark Jackson Soo Downe	

and efficiency		weakness • Control vs personality • Status as a restraining factor on "lateral" behaviour • Feeling isolated vs requests for support are "frowned upon" or discarded • Communication	• Facilitate a way that enables people to reel safe to question practices, policies and seniority/status	"natural behaviour" to occur. Explore funding opportunities			
Human factors in theatre environments	Mark Jackson	• Planned intervention may not be effective (or cost effective) but research design may mask this • Need to prove efficiency gains as well as safety (QIPP) • "Pit Stop" approach erodes resilience. Need to identify and allocate responsibilities that can be shared	**Objective**: Improve safety culture and reduce complications in the OP, cath lab environment • Direct observation of practice backed up by cultural assessment and interviews with whole team • Avoid becoming a service improvement project by formally mapping paths and allocating with emphasis on which paths could be shared or not • Consider "exchange places" with another industry to promote cross-fertilisation	Send present bid to patient safety unit @ Morecambe Bay Provide feedback on bid Explore potential collaborations			Mark Jackson Andrew Smith Carol Wallace

Patient safety in mental health – how to improve collaborations between university/ research and primary care	Alison Beck	Discussion did not go ahead					
“Fresh pair of eyes”	Peter Dyer	• Lack of opportunity for patients and carers to report their observations • Shortfall – mechanisms in place for reporting complaints and incidents but not observations in a non-formal way	• How do we achieve a “fresh pair of eyes”	Training staff and patients + carer/relatives to be able to act as a ”fresh pair of eyes” + then cascade to other staff		Mark Jackson Andrew Smith Lloyd Gregory	
Reducing patient safety incidents for people with dementia admitted to acute medical care	Jacqueline Rigby	• Many patient safety incidents for people with dementia (pwd) • Many reports/enquiries – poor standards of care for vulnerable groups – but little action to ensure change happens • Research monies not forthcoming for these groups where people are vulnerable and do not have a ‘voice’ • Patient safety first – too focussed on tasks, not the individuals	• Care Pathways – would integration be successful for this group? • Reporting system for pwd not sensitive • Values and perception of staff delivering care/attitudes • Comparative study – does educating staff in dementia care make a difference – reducing harm/lower number	Have support from University of Aberdeen - doing MAC in patient safety (human factors approach)	Jacqueline Rigby Alison Beck Stuart Eglin Susan Donaldson		Jackie Rigby

			of incidents • Case study – on relatives who have experienced a pwd on an acute medical ward				
Patients, carers and the general public care about patient safety	David Britt	• Patient safety represents a key consideration for the patients and public • Research into this domain therefore may be more likely to attract support/interests from patients and public (often a key consideration for funding) • Discussed the links between quality accounts and PPI • Current future/practice ideas for improving PPI collaboration	• Important not to underestimate the importance/variety of input that can be made by PPI to research			Christine Birchall Wrightington Wigan & Leigh	
What is the iatrogenic risk of excessive focus on reducing adverse events to at or near zero?	Soo Downe	• Rules protocols should be developed dynamically at local level and subject to improvement and evaluation based on multiple measures of improvement • Issues of power, hierarchy may disrupt the potential of this process • How does this work when teams change/evolve	• Where does it work well for patients/staff in reporting incidents • What happens at the boundaries between systems? • What rationalisations are used as to why rules don't apply to them? – maternity care specific issues	Convene a group that might take this forward?	Maggie Mort Mary Fisher Grace Hopps Soo Downe		Mary Tilly Gill Gyte Dawn Goodwin

Identifying “at risk” /risky behaviours in staff/by staff	Andrew Smith	• Which staff groups/professions might be best to study? • Different people behave differently anyway • Individual or team behaviours + interviews? • Roile of individual personality in risk taking behaviour • Should the research try to link behaviours with consequences – good or bad?	• Should we relate behaviour to outcomes? • How could the outcomes be measured? (safe discharge home, longer term outcomes) • Who decides what is risky, and how? • How do you identify the risky behaviours – observe people first? • ‘Confidence’ vs ‘competence’ • Should respondents be asked to estimate severity of possible consequence? • Or should questions be a bout good/exemplary behaviour?	Comparisons between groups Could you produce a risk assessment tool for behaviour? Important to understand working culture and its effect on risk taking behaviour Where do you get your staffing list of risky behaviour? Complaints, incident reports?			Andrew Smith Prof A Tattersall, LJM Univ Helen Poole Carol Wallace
Electronic Surveillance of adherence to Hand Hygiene Protocol	Alaric Best	• How should it be used: - Discovery of HHP adherence - Training of HH - Ubiquitous use throughout hospitals	• Acceptability by staff • Levels of adherence HHP • Effects of kit on levels of HHP • Effects of kit on cross infection				Alaric Best Carol Wallace Andrew Smith Patient Safety Research Unit

			rates • Effects of different HHPs on infection rates				
How can we do gender mainstreaming in patient safety policy and practices?	Irene Swarbrick	• Gender not considered – same with class • All about "the system" – not the individuals • No appreciation of "axes of difference" • Difficult to address because "who has the research" and "who influenced the speakers" • No thought about can these policies apply equally and should they • One sizes fits all – or does it? • Mental health services – more likely to have severe harm/death	• Are there gender differences in patient safety policy implementation? - Responses to recording pt safety incidents - Avoiding pt safety incidents • Are pt safety protocols and policies sensitive to gender differences? • How would a pt safety policy look, that addressed gender and axel of difference? • Is pt safety gender blind –should it be? (thinking about mental health). If it is what is the effect?	Phase 1 Develop research questions Write proposal Phase 2 Seek funding Get funding			Irene Swarbrick Jacking Rigby
Workplace Cultures	Dawn Goodwin	• Measurement tools – values and constraints • Change – needs stability • 'deviance' • Challenges – questioning in a constructive way	• Compare/contrast 2 teams – which is subject to a 'human factors' cultural intervention • Explaining the role		Dawn Goodwin David Dalton Maggie Mort Alison Beck Donna		Mark Jackson Soo Downe

		• Hierarchy – purpose + effects – how to collapse it to favour the patient • 'feeling like you can't intervene'	of peer review amongst experts		Sidonio Mark Jackson		
Non- IT methods of reducing prescribing errors	Mary Tully	• Generalist v specialist roles – utilising the right workforce • Mentoring – specialist pharmacists - not policing! - others? • Do Drs who make lots of small errors also make lots of big ones?	• Action research – groups of pharmacists and doctors on psychosocial aspects of errors 'standing in each others shoes'	Discuss possible work on research study			Soo Downe
Lack of continuity of care – does it contribute to less safe care	Gill Gyte	• Patients need continuity of carer, so subtle, and sometimes not so subtle, changes can be identified – it is so easy and sometimes dangerous when signals are missed • Need information and continuity + accumulation of information about the patient and cultural continuity • Giving the information over again to different carers can focus the mind on the problems where really the aim is trying to move forward from the problem and focus differently	• Where can't provide continuity of carer, but could provide continuity of care? • How do we make important information readily available • Gather information on how often in patient 'error' was it contributed to by lack of continuity • Mapping the issues and patient journey to devise mechanisms • Reflecting back to engage the 'big	Control and managing events - patients need encouragement to contribute Cultural continuity and change should be investigated Patients needs encouragement to overcome the disempowering effects of discontinuity How do people feel about it? Wider range of views on diagnosis if more			Andrew Smith Patient Safety research Unit Mark Jackson Jane Sundell, Kings London Alaric Best Soo Downe

		• Content: age/condition/gender/privacy • Working time directive works against continuity	society' jargon words	practioners involved			
Potential for transferability of preventative safety management systems from the food industry to patient safety in healthcare	Carol Wallace	• Possible application of HACCP in wards where there is common condition • Potential problems due to complexity of healthcare pathways • Lessons from good examples in food industry e.g. low care/high care segregation • Minimum standards of care that patients should be able to expect • Role of the patient in teaching to increase motivation in staff	• Potential case study application of HACCP in theatres	Contact clinical leads and nursing leads for more detailed discussions			Research Design Service Sarah O'Brien Caroline Watkins
Behaviour – understanding responsibility – accountability ownership in actions	Mary Fisher-Morris	• Reactive culture • Complex situations • Internalisation of belief • People taking ownership –perception • Accountability • Leadership • Identification of roles • Personal responsibility despite resources	• Leadership ? top down example from seniors • Education – adoption of beliefs – internalisation • Accountability – personal and team • Fragmentation of care – ie documentation	Identify areas for study Training – leadership Medical education Evaluate % of risks involved in this group		Lloyd Gregory	

Next Steps:

NHS North West will contact discussion leads to ascertain if any assistance is required. The event summary and contact details will be circulated to participants to facilitate discussions to develop the proposals outlined. The event summary will be posted on NHS North West's R&D Team's website www.research.northwest.nhs.uk to promote the patient safety catalyst programme and encourage people not already involved but with an interest or experience in patient safety research to get involved.

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