Stakeholders in Patient Safety

Who are they?
Where are we now?
How do we move forward?

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Who are the stakeholders?

Patients
Clinical Staff
Consultants
Managers
Commissioners
Patient Safety Leaders
Professional bodies
Who are the stakeholders?

- Patients
- Clinical Staff
- Consultants
- Managers
- Commissioners
- Patient Safety Leaders
- Professional bodies
Stakeholders

Universities
Regulatory bodies
Deaneries
Providers of HF training
DoH
Patient groups
Patients

Involved with decision making

Empowered to ask and contribute

Understanding of expectations

Informed

↑ outcomes
↓ LOS
↓ cost
↓ litigation
Clinical Staff

- Good teamwork
- Receptive
- Enthusiastic hierarchy flatteners!

No HF awareness nor formal training
Don’t talk to me about bl**dy timeouts, I’VE GOT A LIST TO DO.

I’m fed up with that idiot not telling me what’s going on

Human factors...hmmm. That’s everything to do with being human isn’t it?

I am not a ******* pilot!!
The state of play!
Surgery

Same kit
Same assistant and scrub nurse
Same theatre
Same anaesthetist
Same CD playing
Same implant
Same cement
Same sutures
Same dressing

“…… the challenge is to make every procedure the same as last one.”
The perfect operating list

Effortless
Never asking for anything
Quiet
Very fast but not rushed
Happy
Smooth
No glitches

Good outcomes
The average operating list

A struggle
Many items not immediately available
Noisy
Rushed but not very fast
Aggravating
Stop start
Blame

Sub-optimal outcomes
3.6 Generic guidance: examples of individual standards

> A surgeon must maintain the privacy, dignity and confidentiality of patients while working with all members of the surgical team, including undergraduates.

> A surgeon should contribute to the provision of a learning environment suitable for teaching, training and supervising students, trainees and others.

> A surgeon must only delegate duties and responsibilities that are appropriate to the level of competence of those with whom they are working and check that the delegated duty has been performed.

> If involved in teaching, a surgeon should ensure that they have the necessary skills and have taken part in training.

> A surgeon must be honest and open when assessing and appraising.

> A surgeon should be courteous when working with all members of the surgical team.
4.4 Communication

All surgeons must:

> listen to and respect the views of patients and their supporters;
> listen to and respect the views of other members of the team involved in the patient’s care;
> recognise and respect the varying needs of patients for information and explanation;
> insist that time is available for a detailed explanation of the clinical problem and the treatment options;
> encourage patients to discuss the proposed treatment with their supporter(s);
> fully inform the patient and their supporter of progress during treatment;
> explain any complications of treatment as they occur and explain the possible solutions; and
> act immediately when patients have suffered harm and apologise when appropriate.
5.1 Working together

Apart from in exceptional circumstances, surgeons must always make formal arrangements for cover. However, in such exceptional circumstances, surgeons must take responsibility for patients under the care of an absent colleague even if formal arrangements have not been made.

Ineffective team working must not be allowed to compromise patient care.

Surgeons must:

> work effectively and amicably with colleagues in multidisciplinary teams, attend multidisciplinary team meetings, share decision making, develop common management protocols where possible and discuss problems with colleagues;

> continue to participate in the care of, and decisions concerning, their patients when they are in the intensive care unit or the high-dependency unit;

> willingly and openly participate in regular appraisal of both themselves and trainee surgeons and other staff;

> always respond to calls for help from trainees and others in the operating theatre and elsewhere as a matter of priority;

> ensure there is a formal handover of continuing care of patients to another colleague at the commencement of leave; and

> ensure that, when acting as manager or director, their practice and appraisal processes are subject to the same scrutiny as others.

5.1.1 Further reading

*The Leadership and Management of Surgical Teams*, RCS, 2007

The Leadership and Management of Surgical Teams

THE ROYAL COLLEGE OF SURGEONS OF ENGLAND

June 2007

‘It should be the norm for surgical teams (the surgeon, anaesthetist, theatre nurses, operating department assistants) to have time together and with other teams, such as those in the ITU, to review and develop their performance as a team.’

Sir Ian Kennedy – Learning from Bristol 2000

Safety and Leadership for Interventional Procedures and Surgery (SLIPS)
We define medical professionalism as a set of values, behaviours, and relationships that underpin the trust the public has in doctors. We go on to describe what those values, behaviours, and relationships are, how they are changing, and why they matter. This is the core of our work. We have also identified six themes where our definition has further implications: leadership, teams, education, appraisal, careers, and research.

There is relatively little knowledge about how teams of health professionals operate in practice. What evidence there is suggests that teams are not even close to fulfilling their real potential. Ethnographic research in hospital settings, for example, shows that collaboration between professional groups is usually short-lived, unstructured, opportunistic, fragmented, and rushed.
The state of play

Recognition of failure
A sense that there is a better way
Increasing no. of resources
but
Little movement in culture of healthcare
No widespread change in training
No legislative drive to improve skills
Managers / PSMs

Little focus on HF
Unaware of link to quality
Consider it a luxury
Don’t understand business case for safety
Safety ≡ Risk management and Audit
Stakeholders requirements

To engender human factors thinking in the hearts and minds of all healthcare staff and stakeholders. From board to ward and beyond...

…… to improve patient safety by reducing the possibility and impact of errors.

CHFG aim & mission statement 2008
What do we need?

- Raise awareness
- Harmonise the message
- Demonstrate the potential
- Recognise we can learn from other industries
- Establish HF education at all levels of training
- Support the move to quality based commissioning
- Link successful HF training and practice with appraisal and revalidation
Questions

Managing different cultures
Physician professionalism and team function
Create a similar mindset for non-catastrophic events as catastrophic
Standardisation Vs prof. autonomy
Corporate attitudes
Dependence on p<0.05
Create a population of individuals trained to function in multiple teams
Getting patients involved