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The NHS Patient Safety Strategy 2020.
To High Reliability and Beyond?

31st May 2022

Dr David Newbold

Session Outline

1. Introduction

2. Patient Safety Timeline and past policies

3. Examples

4. Safety 1

5. CQC 2018

6. The NHS Patient Safety Strategy 2019/20

7. The National Patient Safety Syllabus 2021

8. Safety 2

9. High Reliability Slides

10. Discussion

NHS Patient Safety Timeline

https://warwick.ac.uk/fac/arts/history/chm/research/current/hazardoushospitals/patient-safety-timeline

NHS Patient Safety Timeline

Year	UK patient safety events	Other events
1948		Establishment of the NHS.
1952	Establishment of national Confidential Enquiry into Maternal Deaths	
1967	The campaigner Barbara Robb's *Sans Everything: A Case to Answer* draws attention to the care of the elderly on long-stay hospital wards in psychiatric hospitals. While several of her recommendations, such as a hospital inspectorate, were subsequently adopted by the government following the Ely Scandal, her allegations were dismissed, and Robb was discredited by the Minister of Health, Kenneth Robinson.	
1968	Ministry of Health report *Allegations Concerning the Care of Elderly Patients in Certain Hospitals* (Cmnd. 3687).	Creation of Department of Health and Social Security (DHSS).
1969	Ely Hospital report: *Report of the Committee of Inquiry into Allegations of Ill ~ Treatment of Patients and other irregularities at the Ely Hospital, Cardiff* (Cmnd. 3975).	
1970		Establishment of the Hospital Advisory Service to inspect hospitals and make recommendations. However, the Service is not empowered to investigate individual complaints, or intervene in matters of clinical judgement.
1973	Report of the Davies Committee into hospital complaints procedures (*Report of the Committee on Hospital Complaint Procedure*).	Establishment of the Health Service Commissioner (Ombudsman). Patient complaints can be referred to the Ombudsman, but it is not empowered to investigate clinical complaints, or the actions of GPs.
1974		NHS reorganisation: creation of Regional Health Authorities (RHAs), Area Health Authorities (AHAs), and district management teams

Establishment of Community Health Councils (CHCs), which act as the voice of patients in the NHS, but cannot deal with complaints arising from clinical procedures. |
| 1975 | Merrison Committee report into the regulation of the medical profession. | |
| 1976 | Hospital Advisory Service expanded to include community health services, becoming NHS Health Advisory Service. | |

Recent Examples & Reports

- Mid Staffordshire (2007)- *Francis Report (2013)*

- Morecombe Bay- Kirkup Report (2015)

- **CQC Report (2018)** ***Opening the Door to Change***

- Gosport War Memorial Hospital - *Independent Panel Report (2018)*

- Shrewsbury and Telford (2000-2019)- *Ockenden Review (2022)*
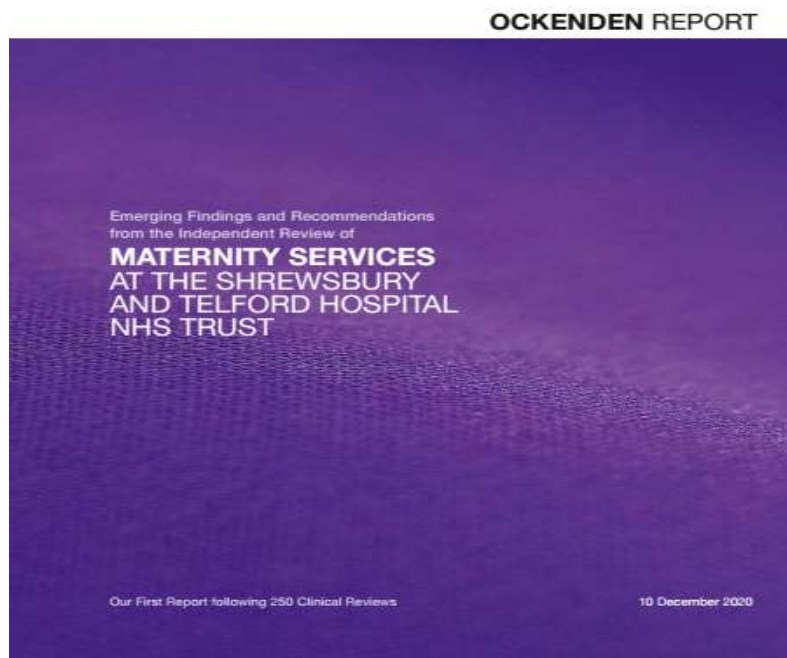
- *Nottingham, emerging case*

RECENT major failures in maternity care, for example, Furness Hospital Cumbria

The Report of the Morecambe Bay Investigation

Dr Bill Kirkup CBE

- 11 avoidable baby deaths
- 1 avoidable maternal death
- ….If clinical care was different
- Jan 2004 to June 2013
- Report published 2015

- *failures in the culture of care and the clinical management*
- *Escalation mechanisms*
- *Response to serious incidents*
- https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/408480/47487_MBI_Accessible_v0.1.pdf

…and The Royal Shrewsbury Hospital

OCKENDEN REPORT

Emerging Findings and Recommendations
from the Independent Review of
MATERNITY SERVICES
AT THE SHREWSBURY
AND TELFORD HOSPITAL
NHS TRUST

Our First Report following 250 Clinical Reviews   10 December 2020

https://www.gov.uk/government/publications/final-report-of-the-ockenden-review/ockenden-review-summary-of-findings-conclusions-and-essential-actions#immediate-and-essential-actions-to-improve-care-and-safety-in-maternity-services-across-england

- *Overconfidence in the ability to manage complex pregnancies and babies with foetal abnormalities*
- *Failure to follow national guidelines*
- *Lack of compassion by staff*
- *Difficult working relationships*
- *Medical staffing issues*
- *A culture of them and us, between obstetrics and midwifery*
- *Regular failure to escalate concerns to consultants*
- *Lack of action following escalation*
- *Fear to speak up/escalate shortcomings in care*
- *Frequent Changes of Senior Leadership*
- *The Trust Board did not have a full picture of what was occurring- unable to plan for corrective action*
- *Weak internal investigations*
- *external reviews gave false reassurance, families may not always have been listened to.*

The "Safety 1" Model of Patient Safety "Work As Imagined"

- Safety is defined as the number of incidents, accidents and risks, i.e. the LACK of safety
- The focus is on events where safety is absent, rather than where it is present
- **Traditional QI/process Improvement- reactive**
- **Hierarchical "Command" Structures and behaviour**
- Complexity in care delivery
- **A complex but linear accident model**
- **A Quasi legal investigation system- after harm has occurred**
- **Possibly a "blame culture"**

The possible consequences:
- Change does not happen
- **The same adverse event or never events still occur**
- **The organisation instinct is to suppress and closedown the issue**
- There are more "first victims"
  - *The patient and family*
- There are more "second victims"
  - *The staff involved*
- There are "third victims"
  - *the organisation*

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Safety Culture

- The term "safety culture" has been defined by various organizations.

- Generally, a safety culture is viewed as an organization's shared perceptions, beliefs, values, and attitudes that combine to create a commitment to safety and an effort to minimize harm (Weaver et al 2013).

- Weaver SJ, Lubomksi LH, Wilson RF, Pfoh ER, Martinez KA, Dy SM. Promoting a culture of safety as a patient safety strategy: a systematic review. Ann Intern Med 2013 Mar 5;158(5 Pt 2):369-74

- https://pubmed.ncbi.nlm.nih.gov/23460092/

- **In the simplest of terms, a safety culture is the combination of attitudes and behaviours toward patient safety that are conveyed when walking into a health facility.**

- A safety culture is not limited to healthcare. The concept is used in other high-risk industries, such as nuclear power and aviation,

- they seek to understand safety incidents to prevent future disasters.

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CQC Report 2018... A feeder to the National Patient Safety Strategy

https://www.cqc.org.uk/publications/themed-work/opening-door-change

Care Quality Commission

Opening the door to change

NHS safety culture and the need for transformation

DECEMBER 2018

- NHS Improvement and HEE ensures the entire NHS workforce understands patient safety and has skills, leadership, culture

- A clear vision on Patient Safety in the NHS and embedded safety culture at every level

- Leadership has training expertise and support to drive safety improvements

- Develop a framework to identify where clinical processes, equipment and governance can be standardised.

- Create a Standardised Patient Safety Alert System with clear and effective action points

- Review The Never Events Framework to focus on leadership and safety culture and explore the behavioural barriers to errors

- CQC to improve the way they assess and regulate safety

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The NHS Patient Safety Strategy 2019/2020
Three Main Areas of Action

NHS

The NHS Patient Safety Strategy

Safer culture, safer systems, safer patients

July 2019

1 INSIGHT

- *Better Measurement/Digital Support System*
- *Patient Safety Incident Response Framework*
- *The Healthcare Safety Investigation Branch*
- *National Patient Safety Alerts Committee*

https://www.england.nhs.uk/patient-safety/the-nhs-patient-safety-strategy/

NHS England and NHS Improvement

The NHS Patient Safety Strategy 2019/2020
Three Main Areas of Action

NHS

The NHS Patient Safety Strategy

Safer culture, safer systems, safer patients

July 2019

NHS England and NHS Improvement

2 INVOLVEMENT

- **Patient and Families as Partners**
- **Patient Safety Education and Training**
- **Patient Safety Specialists**
- **Safety 1 and Safety 2 Models**

The NHS Patient Safety Strategy 2019/2020
Three Main Areas of Action

NHS

The NHS Patient Safety Strategy

Safer culture, safer systems, safer patients

July 2019

NHS England and NHS Improvement

3 IMPROVEMENT

- **Continuous Improvement**
- **The National Patient Safety Improvement Programme**
- **The Maternity and Neonatal Patient Safety Improvement Programme**

The National Patient Safety Syllabus 2020
https://shbn.org.uk/wp-content/uploads/2021/05/National-patient-safety-syllabus-v2.pdf

Academy of
Medical Royal
Colleges

NHS

National patient safety syllabus 2.0

Training for every member of staff across the NHS

Making Safety Active:

- Preventing harm before it occurs
- Seeing risks and making them safe
- It's time to change what we do

Figure 1. Key Domains in the Patient safety syllabus

| Systems approach to patient safety | Learning from incidents | Human factors, human performance and safety management | Creating safe systems | Being sure about safety |

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The Safety 2 Model of Patient Safety "Work As Done"

- **Safety is defined by the number of things that go right**
- **The system is measured by the number of safe outcomes and the number of unsafe outcomes**
- Complexity in care delivery
- A complex but NON linear accident model, health care is a sociotechnical system
- More proactive with QI/process Improvement methods, eg FMEA
- Organisational Learning
- Flatter Hierarchies with power to challenge and escalate
  - *Fair and just culture*
  - *Reporting culture*
  - *Learning culture*

Safety 1 tools are still used, but the focus is also on:
  - *Anticipation of adverse events*
  - *resilient performance in the face of challenges*
  - *Containment of risks before major impact*

High Reliability /HRO (Weick and Sutcliffe 2007)

Anticipation:
  - *Preoccupation with Failure*
  - *Reluctance to Simplify*
  - *Sensitivity to Operations*

Containment:
  - *Commitment to Resilience*
  - *Deference to Expertise*

What is A High Reliability Organization?
See Dr DuPree, Joint Commission (?2022)

Five Characteristics of High Reliability Organizations

Anticipation - "Stay Out of Trouble"
- 1. Preoccupation with failure
- 2. Reluctance to simplify
- 3. Sensitivity to operations

Containment - "Get Out of Trouble"
- 4. Commitment to resilience
- 5. Deference to expertise

MANAGING THE UNEXPECTED
THIRD EDITION
Sustained Performance in a Complex World
KARL E. WEICK
KATHLEEN M. SUTCLIFFE
WILEY

33
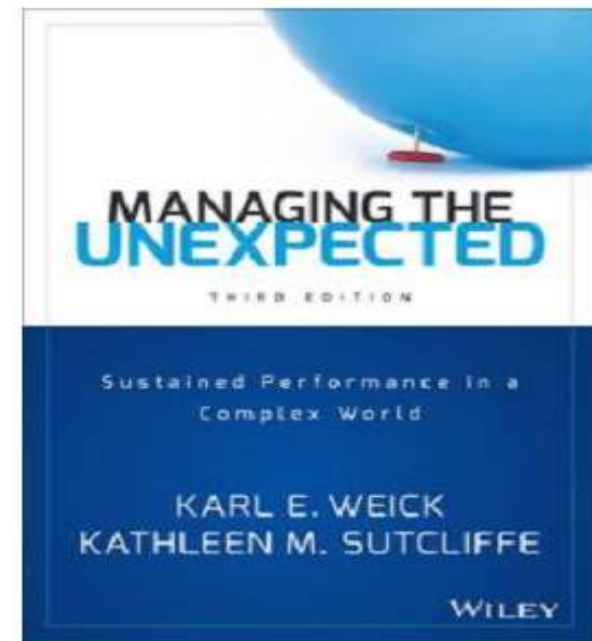
Three Pillars of the High Reliability Organization (VA, 2020)
https://www.hsrd.research.va.gov/publications/forum/summer20/default.cfm

FORUM — translating research into quality healthcare for Veterans

Summer 2020

VA | U.S. Department of Veterans Affairs
Veterans Health Administration
Health Services Research & Development Service

Commentary

VHA's Vision for a High Reliability Organization

Richard A. Stone, MD, Executive in Charge, and Steven L. Lieberman, MD, MBA, FACHE, Acting Deputy Under Secretary for Health, Veterans Health Administration, Washington, DC

The Veterans Health Administration (VHA) is undergoing a transformational modernization at a scale and scope not experienced since General Omar Bradley's leadership of the Veterans Administration in the 1940s. At the center of this modernization is a culture change that will be realized throughout VHA – our transformation to a high reliability organization (HRO).

An HRO is an organization that experiences fewer than anticipated accidents or events of harm despite operating in highly complex, high-risk environments where even small errors can lead to tragic results. HROs establish trust amongst leaders and staff by creating a Just Culture that balances individual accountability with systems thinking. HRO leaders empower all staff to lead continuous process improvements within their own workspace. Creating an environment where employees feel safe to report harm or near misses requires our leaders to focus on the why, not the who, when errors occur. Leaders must fairly distinguish between conduct deserving of discipline versus the much more common unintentional human error or drift from protocol that can lead to harm despite the best efforts and intentions of staff.

The work to become an HRO not only unleashes the incredible talent and commitment within our system to do great things, but it also supports our efforts to strengthen the trust of Veterans and the American people in VA.

VHA has been a leader in the patient safety movement for more than 20 years. We are committed to continuing to build on the great strides we have made with improving safety and quality of care. In February 2019, VHA launched an enterprise-wide HRO transformation effort and made a long-term commitment to pursuing a goal of Zero Harm. As Veterans Integrated Service Networks (VISNs) and VA Medical Centers (VAMCs) advance toward HRO maturity, leaders are applying an organization-wide commitment to Zero Harm by developing a strong safety culture featuring empowered, collaborative frontline teams supported by engaged leadership within a climate of trust and continuous improvement.

VHA's HRO Journey to Date

Our renewed focus on becoming an HRO over the last year builds on efforts led by VHA's National Center of Patient Safety (NCPS) starting in the 1990s. This transformation is being led by the VHA HRO Steering Committee (whose members include select VISN and Medical Center Directors, Chiefs of Staff, Nurses, Patient Safety Experts, and Quality Managers), as well as an HRO Leadership Coalition comprised of all VISN Directors and national leaders within VHA. We are building on our organization's existing safety and high reliability practices and developing an enterprise-wide strategy that was launched with 18 VAMCs in early 2019. This phased approach, with 18 "lead sites" in the first year, is expanding to include all VHA facilities. The foundational work

of becoming an HRO includes developing leadership commitment to the goal of Zero Harm, establishing a positive safety culture, and engaging and supporting all employees in a continuous process improvement culture.

VHA's 2020 HRO activities are focused on the following six areas.

1. **HRO Baseline Training** for all frontline staff, supervisors, and executive leaders to develop behaviors that foster a Just Culture, error prevention, and continuous improvement.

2. **Clinical Team Training (CTT)** on how to integrate team-based error prevention and management practices to improve patient safety and job satisfaction by facilitating clear and timely communication through collaborative teamwork in the clinical workplace.

3. Implementation of daily **continuous process improvement (CPI)** management systems and tracking of improvement efforts including expanded training in Lean methodologies.

4. **Site-specific assessments and planning** will help each facility continue to strengthen their safety culture and practices.

5. **HRO leadership coaching** provides facility leaders with opportunities to work with a coach to target site-specific HRO practices to help reach the next level in their journey to high reliability.

1

Figure 1. Pillars of HRO

THREE PILLARS OF HRO

Leadership Commitment — Safety and reliability is reflected in leadership's vision, decisions and actions.

Safety Culture — Throughout our organization, safety values and practices are used to prevent harm and learn from mistakes.

Continuous Process Improvement — Across the organization, teams use effective tools for continuous learning and improvement.

Change Management

"The result is an organization that celebrates transparency and contributions from every individual regardless of their position."[1]

1. Adapted from Chassin, Mark R. and Loeb, Jerod M. "High-Reliability Health Care: Getting There from Here," The Milbank Quarterly 2013; 91(3):459-90.

Six Activities to Create a High Reliability Organization (VA, 2020)

https://www.hsrd.research.va.gov/publications/forum/summer20/default.cfm

- 1. HRO Baseline Training
- 2. Clinical Team Training
- 3. Daily Continuous Process Improvement
- 4. Site-Specific Assessment & Planning
- 5. HRO Leadership Coaching
- 6. Experiential Learning

HRO Training Mousavi et al 2016

https://dr-jabarvand.com/wp-content/uploads/2017/12/Training-Courses-and-Staff-Knowledge-for-Implementation-of-High-Reliability-Organizations-Model-i.pdf

Training Courses and Staff Knowledge for Implementation of High Reliability Organizations Model in Farabi Eye Hospital, Tehran, Iran

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Received 2016 July 27; Revised 2016 September 27; Accepted 2016 October 25.

Abstract

Background: Hospitals as the most common health care centers should be changed into high reliability organizations to achieve the best performance and also improve patient safety. High reliability organizations can manage adverse events better, and create a safe environment for patients and staff. This requires accurate planning, training, and high responsibility and commitment hospitals leaders to implement this model.
Objectives: The current study aimed to determine the knowledge of Farabi eye hospital's managers and supervisors of the departments, and the success of this hospital to implement high reliability model before and after the training course.
Methods: Study was a semi-experimental research. Data were collected through a questionnaire and a checklist in two phases, before and after the training course of high reliability model; 80 clinical and non-clinical managers and supervisors of Farabi eye Hospital in Tehran, Iran, participated in the study by census method.
Results: After holding high reliability model training course, 52.2% of respondents expressed obtaining a keen knowledge of high reliability organizations model. Compared to knowledge of the managers and supervisors of the departments before the training course (18.8%), it was indicated that high reliability organizations model training course had a significant effect (P < 0.001) on the knowledge development. Also, the results of this research showed that implementation of high reliability organizations model after the training course increased (P < 0.001).
Conclusions: Although, successful implementation of high reliability organizations is based on knowledge of managers and supervisors, the effectiveness of this model is still in the maturity and readiness phase.

Keywords: High Reliability Organizations, Patient Safety, Farabi Eye Hospital

1. Background

Human life is measured by hospital scale. All people refer to hospitals from birth to death. However, medical errors, nosocomial infections and non-conventional methods of payment may change the view of clients toward hospital performance (1).

Human error is defined as a situation in which the planned sequence of physical or mental activities to achieve the desired result fails or the existence of an inappropriate program or unplanned action (2). In an effort to protect patients, patient safety regulation and the medical report of errors that harm patients and staff are presented by joint committee on accreditation of health care organizations (JCAHO) (3). However, a great number of medical errors occur in hospitals every year. The report of American medical institution, entitled "to err is human" reported that every year 44,000 to 98,000 of Americans encounter side effects of medical errors as one of the important causes of mortality in the United States (4, 5). In addition, about 70% of the reported medical errors are predictable, and at least 50% of them are not reported (6). In most cases, medical errors are not due to the mistakes of physicians and nurses; they originate from many different sources such as inefficient health systems, inadequate training and lack of safety regulation (7, 8).

Achieving high reliability as a main goal of hospitals needs maximum efforts of managers, and implementing effective and efficient management to achieve these goals (9, 10). Therefore, implementation of health care system with safe structure requires the application of a new paradigm named high reliability organizations (HROs),

- **Improved HRO knowledge (p>0.001)**

- **Increased HRO model Implementation (p>0.001)**

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Reducing Polypharmacy by adopting HRO principles (Bhattar et al 2019)
https://pubmed.ncbi.nlm.nih.gov/31892781/

Understanding Principles of High Reliability Organizations Through the Eyes of VIONE,

A Clinical Program to Improve Patient Safety by Deprescribing Potentially Inappropriate Medications and Reducing Polypharmacy

Saraswathy Battar, MD; Kimberly R. Watson Dickerson, PharmD, BCPS; Christopher Sedgwick, PharmD, BCPS; and Tim Cmelik, RPh, MBA

The assessment of polypharmacy and reduction of potentially inappropriate medications using VIONE has benefited about 60,000 veterans with more than 128,000 medications deprescribed, yielding more than $4 million in annualized cost avoidance.

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High reliability organizations (HROs) incorporate continuous process improvement through leadership commitment to create a safety culture that works toward creating a zero-harm environment.[1] The Veterans Health Administration (VHA) has set transformational goals for becoming an HRO. In this article, we describe VIONE, an expanding medication deprescribing clinical program, which exemplifies the translation of HRO principles into health care system models. Both VIONE and HRO are globally relevant.

Reducing medication errors and related adverse drug events are important for achieving zero harm. Preventable medical errors rank behind heart disease and cancer as the third leading cause of death in the US.[2] The simultaneous use of multiple medications can lead to dangerous drug interactions, adverse outcomes, and challenges with adherence. When a person is taking multiple medicines, known as polypharmacy, it is more likely that some are potentially inappropriate medications (PIM). Current literature highlights the prevalence and dangers of polypharmacy, which ranks among the top 10 common causes of death in the US, as well as suggestions to address preventable adverse outcomes from polypharmacy and PIM.[3-5]

Deprescribing of PIM frequently results in better disease management with improved health outcomes and quality of life.[4] Many health care settings lack standardized approaches or set expectations to proactively

deprescribe PIM. There has been insufficient emphasis on how to make decisions for deprescribing medications when therapeutic benefits are not clear and/or when the adverse effects may outweigh the therapeutic benefits.[5]

It is imperative to provide practice guidance for deprescribing nonessential medications along with systems-based infrastructure to enable integrated and effective assessments during opportune moments in the health care continuum. Multimodal approaches that include education, risk stratification, population health management interventions, research and resource allocation can help transform organizational culture in health care facilities toward HRO models of care, aiming at zero harm to patients.

The practical lessons learned from VIONE implementation science experiences on various scales and under diverse circumstances, cumulative wisdom from hindsight, foresight and critical insights gathered during nationwide spread of VIONE over the past 3 years continues to propel us toward the desirable direction and core concepts of an HRO.

The VIONE program facilitates practical, real-time interventions that could be tailored to various health care settings, organizational needs, and available resources. VIONE implements an electronic Computerized Patient Record System (CPRS) tool to enable planned cessation of nonessential medications that are potentially harmful, inappropriate, not indicated, or not necessary. The

TABLE 2 Cross Walk Between Core Pillars of High Reliability Organizations and VIONE

High Reliability Organization Pillars	VIONE
Leadership Commitment Safety and reliability is reflected in leadership's vision, decisions, and actions	• Decisions and actions to adopt a systems-based approach to improve safety and reliability of prescribing practices; and • Empowerment of staff to directly and proactively assess risk and reduce harm from polypharmacy.
Safety Culture Throughout the organization, safety values and practices are used to prevent harm and learn from mistakes	• Education about the risks of potentially inappropriate medications; and • Collective mind-set for identification and correction of medication errors without fear of retribution.
Continuous Process Improvement Across the organization, teams use effective tools for continuous learning and improvement	• Ongoing practice of continuous assessment of polypharmacy and planning for cessation of medications as appropriate; and • Ongoing refinement and the systemwide spread of program.
Demonstrate Safety and Reliability Outcomes	• Reduced adverse effects due to polypharmacy potentially inappropriate medications; and • Improved quality of care.

Reducing Polypharmacy by adopting HRO principles
(Bhattar et al 2019)
https://pubmed.ncbi.nlm.nih.gov/31892781/

TABLE 1 Cross Walk Between Key Principles of an HRO and the VIONE Program

High Reliability Organizations Principles	VIONE Implementation Principles
Sensitivity to operations	• Incorporates into the workflow with ease, whereby providers can document VIONE related interventions as they are making decisions regarding appropriate medication continuation/planned cessation of medications; • Considers EVERY medication within methodology; no medication is excluded from a review as any could lead to AEs; and • Focuses on deprescribing as a solution rather than blaming the original prescriber, accepting that overprescribing and polypharmacy is a known health system issue rarely related to a single HCP.
Reluctance to simplify	• Does not make sweeping assumptions about a single medication or medication class as inappropriate; it deals with each patient's clinical picture individually; • Incorporates shared decision making and captures, transmits, communicates relevant data in simple formats; • Training focuses on patient safety and quality of life, in addition to medication management.
Preoccupation with failure	• Staged to become a standard mind-set for polypharmacy, PIM deprescribing practice; every patient could (and should) be evaluated with the VIONE methodology as a standard to prevent any patient from having an AE; and • Going forward, the VIONE Risk Score is a malleable evolving stratification method to identify high-risk patients based on new risk factors identified by experts.
Deference to expertise	• Empowers HCPs at all levels in all specialties to focus on deprescribing in polypharmacy situations; and • Patient identification and review can be a team approach, deferring to either the intake nurse, clinical pharmacy specialist, or specialty prescriber depending on the expertise required for the medication.
Commitment to resilience	• Designed to address risk factors for poly pharmacy/PIM related AEs; patients who have historical polypharmacy related AEs (falls, emergency department visits, vulnerable patients, aged > 65 years, on > 15 medications, etc), have higher VIONE Risk Scores and thus warrant expedited review to prevent a similar AE in the future.

Abbreviations: AE, adverse event; HCP, health care provider; HRO, high reliability organization; PIM, potentially inappropriate medication.

Humber Teaching NHS Trust Patient Safety Strategy 2019-22

https://www.humber.nhs.uk/downloads/Learning%20From%20Deaths/Patient%20Safety%20Strategy%202019-2022.pdf

NHS
Humber Teaching
NHS Foundation Trust

Patient Safety Strategy 2019-22

Becoming a High Reliability Organisation

'Better today than yesterday, every day'

Our Patient Safety Priorities

Insight

1. To become a 'develop a positive and proactive safety culture
2. To reduce the number of Patient Safety Incidents resulting in harm

Involvement

3. To work with patients, carers and key partners to continuously improve patient safety
4. To ensure staff are equipped with the appropriate patient safety knowledge and skills to embed an organisational wide culture of learning from patient safety incidents

Improvement

5. To ensure a culture of continuous improvement
6. To work with the wider community to improve patient safety

Caring, Learning and Growing

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Humber Teaching NHS Trust Patient Safety Strategy 2019-22

https://www.humber.nhs.uk/downloads/Learning%20From%20Deaths/Patient%20Safety%20Strategy%202019-2022.pdf

Insight Priorities

Priority 1 To develop a positive and proactive safety culture	**Strategic Goal 1** Innovating quality and patient safety
Priority 2 To reduce the number of Patient Safety Incidents resulting in harm whilst maintaining high levels of reporting	**Strategic Goal 2** Enhancing prevention, wellbeing and recovery

Involvement Priorities

Priority 3 To work with patients, carers and key partners to continuously improve patient safety	**Strategic Goal 3** Fostering Integration, Partnership and Alliances
Priority 4 To ensure staff are equipped with the appropriate patient safety knowledge and skills to embed an organisational wide culture of learning from patient safety incidents	**Strategic Goal 4** Developing an effective and empowered workforce

Improvement Priorities

Priority 5 To ensure a culture of learning and continuous improvement	**Strategic Goal 5** Maximising an Efficient and Sustainable Organisation
Priority 6 To work with the wider community to improve patient safety	**Strategic Goal 6:** Promoting People, Communities and Social Values

Two Challenges That A HRO Might Overcome:

Closed Culture (CQC) May 2022

https://www.cqc.org.uk/guidance-providers/all-services/how-cqc-identifies-responds-closed-cultures

Normalization of Deviance (Banja 2010)

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2821100/

CareQuality Commission

How we find out if a service has a 'closed culture' and what we do about it

May 2021

1

The normalization of deviance in healthcare delivery

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Abstract

Many serious medical errors result from violations of recognized standards of practice. Over time, even egregious violations of standards of practice may become "normalized" in healthcare delivery systems. This article describes what leads to this normalization and explains why flagrant practice deviations can persist for years, despite the importance of the standards at issue. This article also provides recommendations to aid healthcare organizations in identifying and managing unsafe practice deviations before they become normalized and pose genuine risks to patient safety, quality care, and employee morale.

Keywords

Medical errors; Patient safety; Preventable harms; Deviations from standards of care; Normalization of deviance

1. Compliance failures and normalizing deviance

Over the last decade, hospital safety personnel have gradually become disabused of a long-standing but incorrect belief: that harm-causing medical errors, such as wrong-side surgeries or retained surgical instruments, result from a single individual doing something inexplicably stupid. Rather, contemporary research on mega disasters—for instance, Chernobyl, space shuttles Challenger and Columbia, Bhopal, and any number of patient care catastrophes—has consistently shown that major accidents require (1) multiple people (2) committing multiple, often seemingly innocuous, mistakes that (3) breach an organization's fail-safe mechanisms, defenses, or safety nets, resulting in (4) serious harm or frank disaster (Cook, 1998; Gerstein, 2008; Green, 2004; Perrow, 1999; Reason, 1999; Woolf, Kuzel, Dovey, & Phillips, 2004). In other words, mistakes such as failing to check or record a lab finding, ordering the wrong drug, or entering a lab finding in the wrong patient's chart are usually not enough to guarantee an occurrence of harm. The recipe for disaster additionally requires these errors, lapses, or mistakes *to go unattended, unappreciated, or unresolved for an extended period of time*. Harm-causing errors therefore result from "active errors" intermingling with "latent errors": laws or weaknesses in a system's defenses that allow the former to breach those defenses, reach patients, and cause harm (Reason, 1999).

Remarkably, the failure of health professionals to comply with standards, rules, or regulations is a fundamental cause of such breaches. Indeed, breaches of a system's defenses and rule

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Discussion Points?

- *Too Slow?*
- *Will it work?*
- *How will we know?*
- *Are we doing the right things?*
- *How does it Link to Quality Improvement?*
- *Training Requirements?*

Thank You!

Discussion, Q&A

Links to Sources

Patient Safety Timeline
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Kirkup Report

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https://www.gov.uk/government/publications/final-report-of-the-ockenden-review/ockenden-review-summary-of-findings-conclusions-and-essential-actions#immediate-and-essential-actions-to-improve-care-and-safety-in-maternity-services-across-england

Weaver et al 2013

https://pubmed.ncbi.nlm.nih.gov/23460092/

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NHS Patient Safety Strategy

https://www.england.nhs.uk/patient-safety/the-nhs-patient-safety-strategy/

National Patient Safety Syllabus

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DuPree High Relaibility

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