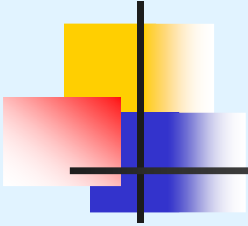


Stakeholders in Patient Safety

Who are they?

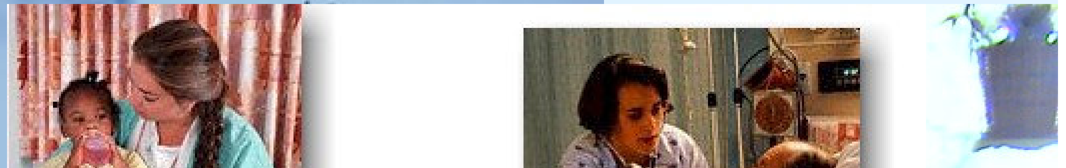
Where are we now?

How do we move forward?

Mark Emerton
Consultant Orthopaedic Surgeon
Safer Care Programme
NHS Institute for Innovation and Improvement

Who are the stakeholders ?

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



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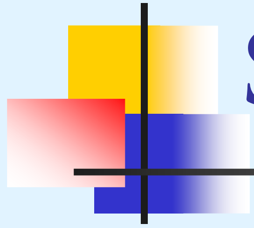


Stakeholders

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

Patients

Involved with decision making

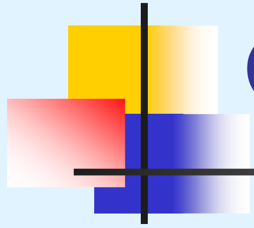
Empowered to ask and contribute

Understanding of expectations

Informed

↑ **outcomes** ↓ **LOS**

↓ **cost** ↓ **litigation**



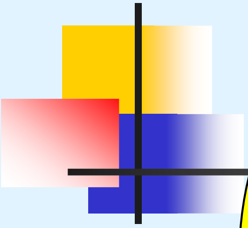
Clinical Staff

Good teamwork

Receptive

Enthusiastic hierarchy flatteners!

No HF awareness nor formal training



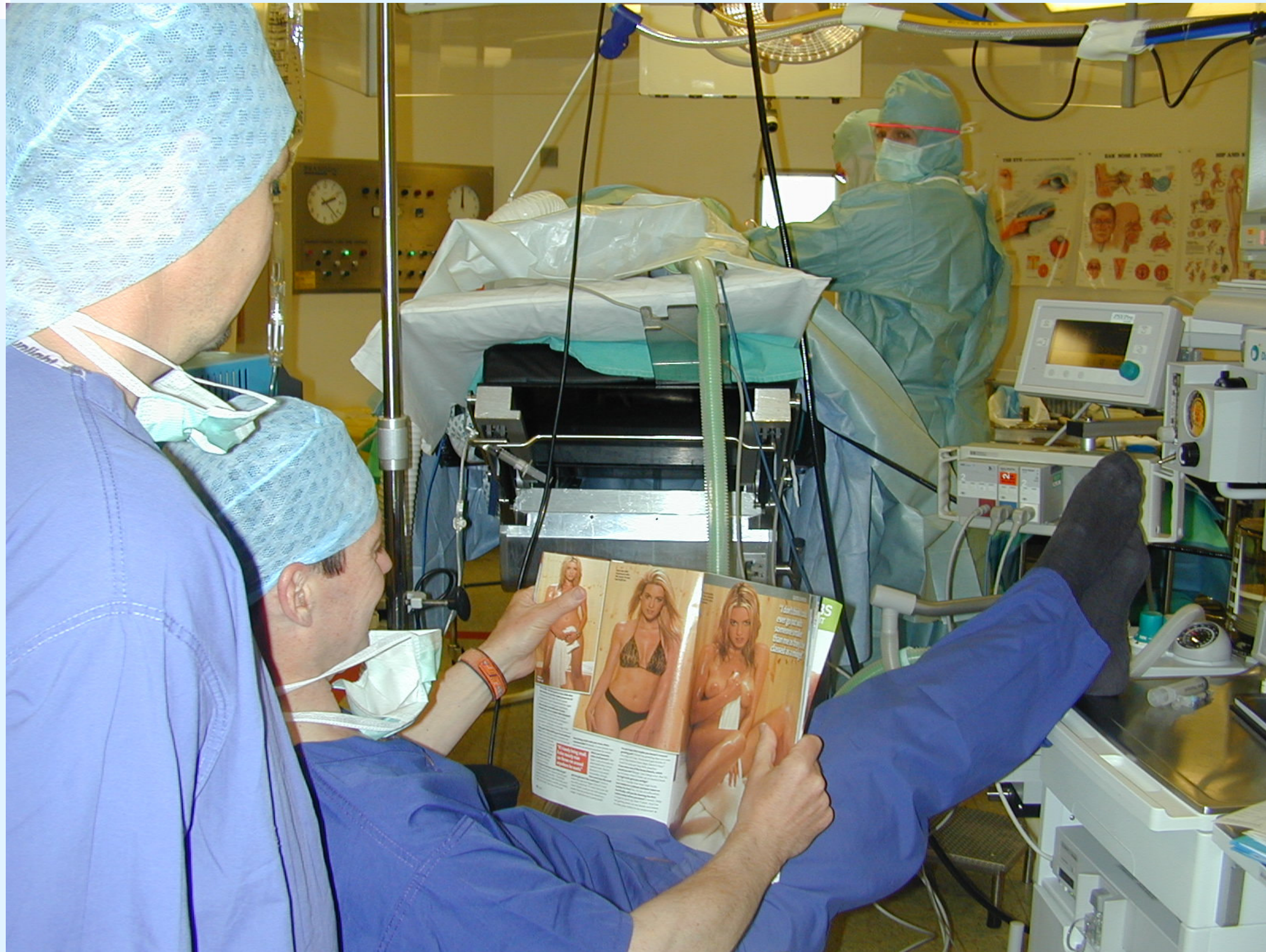
I'm fed up with that idiot not telling me what's going on

Don't talk to me about bl**dy timeouts,
I'VE GOT A LIST TO DO.

I am not a ******* pilot!!

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

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

<u>Good outcomes</u>

The average operating list

A struggle

Many items not immediately available

Noisy

Rushed but not very fast

Aggravating

Stop start

Blame

<u>Sub-optimal outcomes</u>

The Professional Bodies

Good Surgical Practice

February 2008
Review date: 2010

The Royal College of Surgeons of England

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.

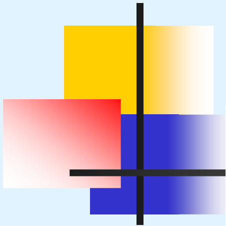
Endorsement of the
WHO World Alliance for Patient Safety
Second Global Patient Safety Challenge:

SAFE
SURGERY
SAVES LIVES

with Dr Atul Gawande

28 February 2008, 4.00pm – 5.15pm
National Patient Safety Agency
4-8 Maple Street, London W1T 5HD

RSVP to Stephanie McNair, 020 7927 9360
stephanie.mcnair@npsa.nhs.uk



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;

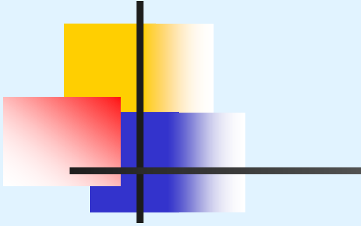
> insist that time is available for a detailed explanation of the clinical problem and the treatment options;

> 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
Management of Healthcare: the Role of Doctors, paragraphs 19–21, GMC, 1999

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.’[1]

Sir Ian Kennedy – *Learning from Bristol*, 2000

The Royal College of Surgeons of England

Safety and Leadership for Interventional Procedures and Surgery (SLIPS)

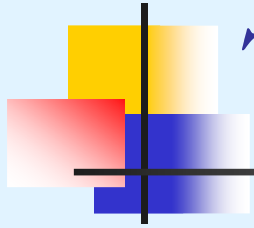
Doctors in society

Medical professionalism in a changing world

Report of a Working Party, December 2005

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.45



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

- 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

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