SPSP Mental Health Learning System Webinar

Safety Climate: What is it, why is it important and how do you improve it?

Thank you for joining: this event will begin at 13.00
In the meantime, please introduce yourself in the chat.

@SPSP_MH
#SPSPMH

Welcome and introduction

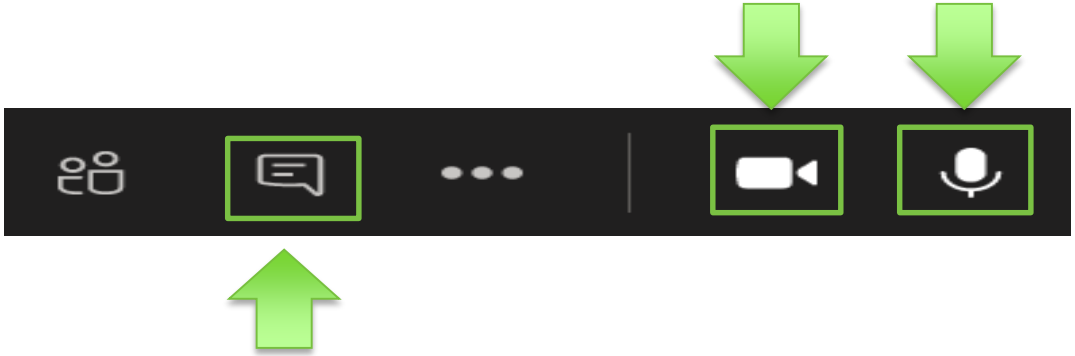
Dr Jane Cheeseman

National Clinical Lead

Healthcare Improvement Scotland

Housekeeping

During the meeting please have your microphone on mute and video turned off. This will avoid distraction and minimise the likelihood of slowing down the technology.



There will be opportunities for Q&A in the planned session. Please pop all questions in the chat box

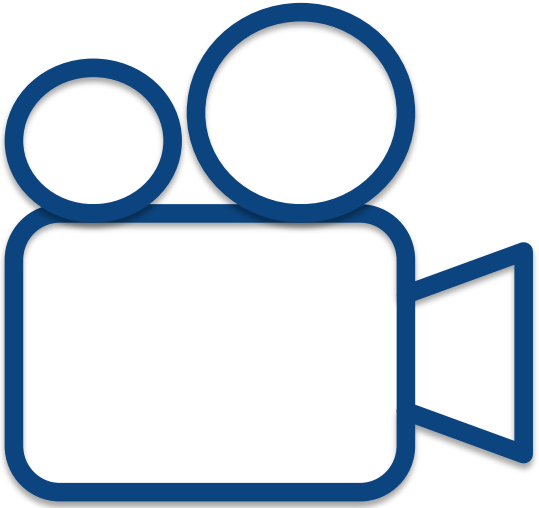
Some of this session will be recorded. REC

If you require any technical support please pop in the chat box or contact his.mhportfolio@nhs.scot.

Aims of the session

- Importance of safety climate
- How to measure and improve safety climate
- How Greater Glasgow MH Network have used the SPSPMH Patient Safety Climate Tool
- Launch of the new SPSPMH Safety Climate resources

The following section of the webinar will be recorded.



If you don't want to be included in the recording, please ensure your camera is off

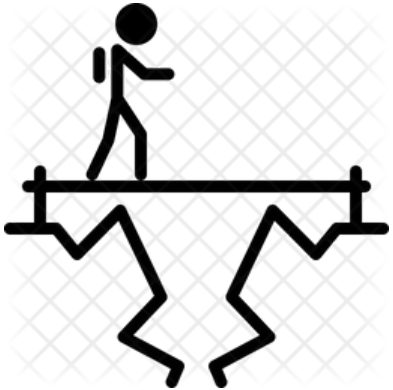
Safety Climate:
What it is, Why it is Important and How do you Improve it?

Paul Bowie

- Programme Director (Safety & Improvement)
- Twitter: @pbnes Email: paul.bowie@nhs.scot

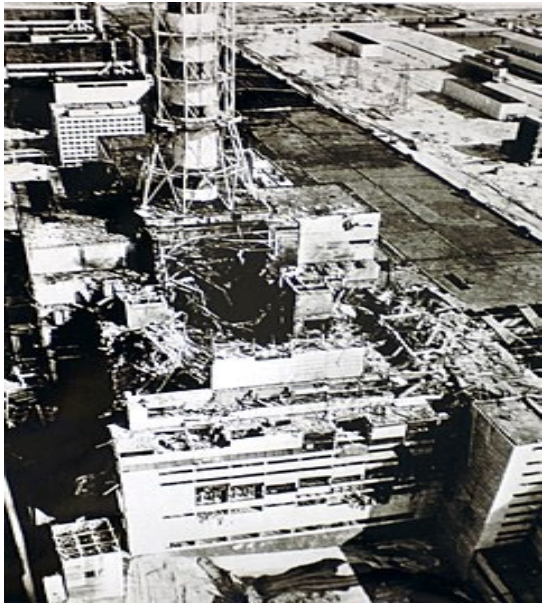
Session Purpose

- Rapid high level overview:
  - Safety Culture?
  - Culture or Climate?
  - Measurement
  - Practical Safety Culture Discussions
  - How to ‘Improve’?



Background – Safety Culture

- First used after Chernobyl nuclear power plant accident
- Explains everything people could not explain or otherwise understand in the safety domain!!
- Strong agreement
  - +ve – openness, transparency & commitment to learn
  - -ve – contributory factor in incidents and accidents
  - **To improve care performance and staff well-being - focus on the cultural context of work**



Culture or Climate?

- **Safety Culture (more deep rooted)**
  - ...refers to individual and group "*…values, attitudes, perceptions and patterns of behaviour that determine their commitment to workplace safety management*"
  - ***…"the way things are done around here"***

Safety Climate (transient)

  - The measurable 'surface' components of safety culture... a 'snapshot' of culture at a moment in time.

- **'Culture' and 'Climate'** used interchangeably.

Other Definitions

"…that assembly of characteristics and attitudes in organisations and individuals which establishes that as an overriding priority, patient safety issues receive the attention warranted by their significance"

"The safety culture of an organisation is the product of individual and group values, attitudes, competencies and patterns of behaviour that determine the commitment to, and the style and proficiency of, an organisation's safety…".

"What people at all levels in a team/organisation do and say when their commitment to safety is not being scrutinized"

Humorous Definitions

"The idea of 'culture' is perhaps similar to that of 'intelligence' – everyone thinks they know what it is, but conceptual clarity is more elusive"

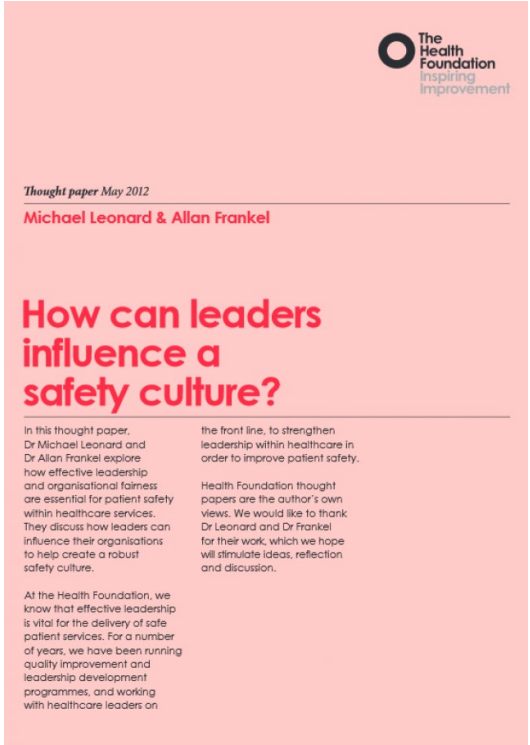
[Catchpole, 2014]

"…it has the definitional precision of a cloud…"

[Reason, 2007]

Influence of Safety Culture in Healthcare

- Leadership influence
- Positive culture - learn openly and effectively from system failure
- Influences the priorities of the workforce at all levels and helps to shape their discretionary attitudes, behaviours and performance.
- High-profile care failures, a sub-optimal safety culture was implicated
  - e.g. Stafford hospital (high mortality rates from emergency admissions),
  - Bristol Royal Infirmary (high infant surgical mortality rates); and
  - Vale of Leven hospital (deaths associated with *Clostridium difficile*).



Differences in +VE versus –VE Organisational Safety Cultures

Senior commitment

Mature, stable workforce

Good personnel selection, retention, promotion options

Thoroughly investigating all safety incidents and near misses

Regularly assessing safety culture and improving safety behaviours.

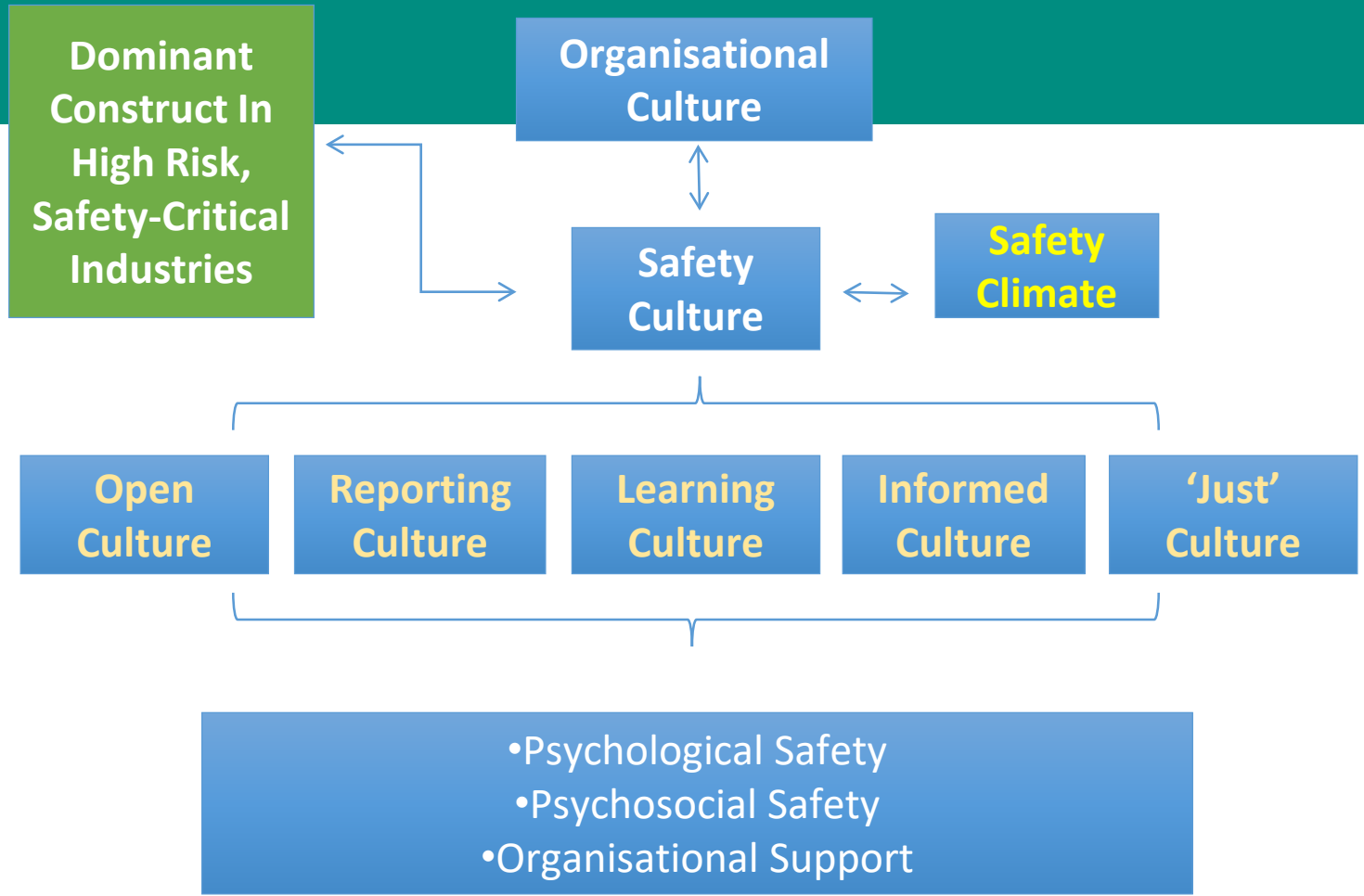
Accepting safety culture is a long-term strategy

Good induction and follow-up safety training

Ongoing schemes schemes reinforcing the importance of safety

Regular auditing of safety systems to provide feedback

Capturing attitudes towards incident reporting and analysis


Dominant Construct In High Risk, Safety-Critical Industries
Organisational Culture
Safety Culture
Safety Climate
Open Culture
Reporting Culture
Learning Culture
Informed Culture
'Just' Culture
•Psychological Safety
•Psychosocial Safety
•Organisational Support

Assessing Safety Culture / Climate

- Safety culture ‘measurement’ originated in high-risk industries
- Multiple ‘measurement’ surveys for healthcare
  - **Quantitatively**
    - typically using self-report questionnaires anonymously.
    - Assumption can link to care outcomes
  - **Qualitative:**
    - Manchester Patient Safety Framework (MaPSaF)
    - Safety Culture Discussion Cards

Common Safety Culture Domains

- Leadership
- Management/Supervision
- Team working
- Workload
- Safety Systems
- Communication
- Openness
- Handovers
- Staffing
- Organisational learning
- Stress recognition
- Work conditions
- Job satisfaction
- Managing risk
- etc

Perceived Benefits of Safety Climate Measurement

- Increases individual awareness of safety-related conditions and behaviours
- Enables the care team to ‘diagnose’ their prevailing safety climate
- Identifies relative strengths and weaknesses in comparison to other practices,
- Facilitates action to build a stronger, more positive local safety culture
- Participants can compare and evaluate progress over time (e.g. 18-24 months)
- **Holy Grail – link to outcomes**

Health Foundation, 2009

The most rigorously tested/well-known tools:

- Safety Attitudes Questionnaire
- Patient Safety Culture in Healthcare Organisations
- Hospital Survey on Patient Safety Culture
- Safety Climate Survey
- Manchester Patient Safety Assessment Framework
- [GP-SafeQuest – NES]

RESEARCH ARTICLE

Assessing safety climate in acute hospital settings: a systematic review of the adequacy of the psychometric properties of survey measurement tools

Gheed Alsalem[1,3*], Paul Bowie[2] and Jillian Morrison[1]

J Eval Clin Pract. 2012 Feb;18(1):135-42. doi: 10.1111/j.1365-2753.2010.01537.x. Epub 2010 Sep 22.

Measuring perceptions of safety climate in primary care: a cross-sectional study

Carl de Wet [1], Paul Johnson, Robert Mash, Alex McConnachie, Paul Bowie

ORIGINAL STUDIES

A Systematic Review of Measurement Tools for the Proactive Assessment of Patient Safety in General Practice

Lydon, Sinéad PhD*,†; Cupples, Margaret E. MD†,‡; Murphy, Andrew W. MD*,†; Hart, Nigel MD‡; O'Connor, Paul PhD*,†

Note of caution

Inadequate development

Acting on feedback

Link to outcomes?

Limited impact

So what?

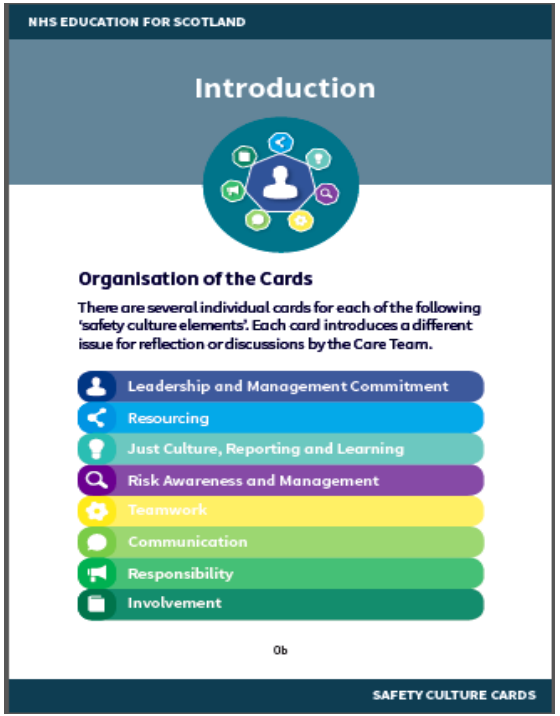
A Different/Complimentary Approach?
Safety Culture Discussion Cards

Purpose of Discussion Cards

- Get people talking!
- No answers, but raise questions!
- Build on what care teams already know and experience
- Encourage discussions to learn about and improve SC
- c80 Cards,
  - c10 guiding/explanatory,
  - 70 discussion cards,
  - 8 themes
- Aim to be straightforward and practical

Organisation of Cards

1. Leadership & Management Commitment
2. Resourcing
3. Just Culture, Reporting & Learning
4. Risk Awareness & Management
5. Teamwork
6. Communication
7. Responsibility
8. Involvement



Some Examples of Cards / Questions /Prompts

Avoid the Blame Game

When people report safety-related occurrences, are they blamed or treated in a just and fair manner?

How people are treated when they report safety related occurrences, including 'normal errors' is a test for the just culture of an organisation.

How can we encourage a just culture within the organisation, and the team?

Investigate to Improve

How well do we investigate safety occurrences?

A good safety investigation should describe and explain the occurrence and the factors that contributed to it, and present workable recommendations to reduce the chance that it will happen again.

What are the positives and negatives about how we investigate, and how could it be improved?

Some Examples of Cards / Questions /Prompts

Risk Awareness and Management

Taking Risks

Do you sometimes have to take risks that make you feel uncomfortable about safety?

It is hard to assess the level of risk involved in our own activities. But if we have to take risks that make us feel uncomfortable, it is time to stop and think.

How do you respond to risky activities?

Risk Awareness and Management

Blind Spots

Are you aware of care safety problems that are not being addressed sufficiently?

Sometimes problems seem so long-standing or difficult to resolve that they are ignored and become a 'blind spot'.

How can you help to make sure that safety problems are resolved rather than ignored?

How to Improve the Prevailing Safety Climate?

- Critical Importance of Leadership
  - Psychological safety and ‘speaking up’
  - Routine monitor / measure
  - Protected learning time
  - Team learning / Briefings / Huddles
  - Focus: understanding everyday work
  - Organisational fairness (restorative practice / ‘just’ culture)
  - Engaged leaders listen and act: patients and workforce

“Leaders are the keepers and guardians of these attitudinal norms and the learning system”.

Thank You!

paul.bowie@nhs.scot

500 Patient Safety Climate Tool Interviews

Gordon McInnes
Mental Health Network Greater Glasgow

500 Interviews

- Between November 2013 and February 2020 we facilitated 500 SPSP patient safety climate tool interviews across 14 wards in all the major hospital sites across the NHS GG&C area.
- These ranged from IPCU and AAU wards to rehabilitation wards.
- We are an independent lived-experience led organisation.

500 Interviews

What did we learn?

Across the three iterations of the Climate Tool:

The proximity and presence of staff to patients is hugely important.

Communication with patients is critical to engagement in care.

Patients exercise agency, even in highly controlled environments.

Relationships matter. Enormously.

Patients learn from their experiences of treatment.

500 Interviews

What benefits did this activity bring?

We provided feedback to support development of the climate tool.

We gave patients knowledge of the fact that the ward was part of the SPSP programme.

Facilitation allowed for an exploration of stated views to explore the entire context behind a statement.

We were aware of the ward level improvement activities and could to some degree explore these areas where they came up in the answers to the questions.

500 Interviews

Impact of the engagement activity

Built relationships with the ward environment and enabled them to become accustomed to patient engagement activities.

We could highlight where patient feedback was relevant to the ward level improvement activity.

Gave a credible source of patient feedback to support the programme.

MHNGG supported the leadership walk-rounds also and married the patient feedback into the wider SPSP programme.

Questions?

Launch of the Safety Climate Resources

Rachael Lee
Senior Project Officer, SPSP Mental Health

How did we get here?

Healthcare Improvement Scotland

SCOTTISH PATIENT SAFETY PROGRAMME

Workshop

- We Heard:
  - What works well
  - What needs improvement
  - What doesn't work

Consultation

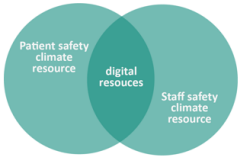
- 92% of respondents felt that new resources met their needs
- 86% of respondents likely to measure staff safety with new resources

Launch of Resources

- Updated guidance
- Updated questionnaires
- New resources

Updated Resources

What is included in this resource?



Patients

The Patient Safety Climate Resources for mental health are a set of questions designed by people with lived and living experience and given to people to assess different aspects of safety in a ward or unit.

An accessible version of the questionnaire has been developed for patients with communication difficulties.

Access the full patient safety climate resource here [link]

Staff

The Staff Safety Climate Resources provides information about the perceptions of front-line clinical staff about safety in their clinical area and leader's commitment to safety.

Access the full staff safety climate resource here [link]

Digital templates

Digital templates have been provided for both staff and Patient Safety Climate Resources. These can be used on any device, including tablet and mobile phone. The resource can be completed digitally, independently or with a help of a facilitator by clicking on the 'Duplicate it' button. The data entered into the digital resource provides real-time analysis.

Guidance Document

Updated staff questionnaire

Please answer the following items with respect to your specific area. Choose your responses using the scale below. Please also indicate ward/team name and indicate how many staff ticked/crossed each category.		1 Strongly disagree	2 Slightly disagree	3 Neither agree or disagree	4 Slightly agree	5 Strongly agree	X Not applicable
11	I would feel safe being treated as a patient by this team.						
12	Briefing staff before the start of a shift (for example to plan for possible contingencies) is important for patient safety (safety briefings).						
13	Safety briefings are common here.						
	Debriefs are common after safety incidents.						
14 I am satisfied with the availability of leadership in the following areas (please respond to all three):							
Medical							
Nursing							
Pharmacy							

Updated Patient Questionnaire

Please rate the following by placing a tick under the response that best fits with your experiences from strongly disagree to strongly agree		1 Strongly disagree	2 Slightly disagree	3 Neither agree or disagree	4 Slightly agree	5 Strongly agree	X Not applicable
Q6:	I feel the ward is a safe place for people to visit me. For example, my family, children, friends and carers.						
	Comments						
Q7:	I feel safe with the mix of patients on this ward.						
	Comments						
Q8:	I feel safe when there are difficult events on the ward that involve other people.						
	Comments						
Q9:	I feel confident that staff deal safely with difficult events on the ward.						
	Comments						
Q10:	If I witness difficult events on the ward, staff help me make sense of them.						
	Comments						
Q11:	If I become upset staff support me.						
	Comments						
Q12:	I feel able to express any concerns I have.						
	Comments						

New Resources

Group discussion resource

Organisation of the themes

There are several individual themes for each of the following 'safety' categories. Each theme introduces a different issue for reflection or discussions by a group of patients, carers or family members.

- Your personal safety
- Your relationship with staff
- The use of restrictive practices
- Your care and treatment

How to use

You can use these themes in any way that helps the group to think and talk about safety in the ward/unit or organisation. It is recommended that one person (staff or peer support, for example) acts as discussion facilitator – ideally someone independent of the ward or unit. You can use as many or as few themes and questions as you like.

Three possibilities are described in the following:

Option 1: Comparing views	**Option 2: Safety moments**	**Option 3: Focus on…**
Compare similar and different views between the group.	Discuss just one question for 15-30 minutes.	Discuss all of the questions in a particular safety theme.

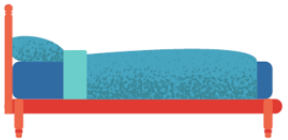
Accessible Version

2c. I feel safe in my room?

☑ yes

☒ no

? sometimes



Please tell us more about your answer?

2d. I feel safe in the dining room?

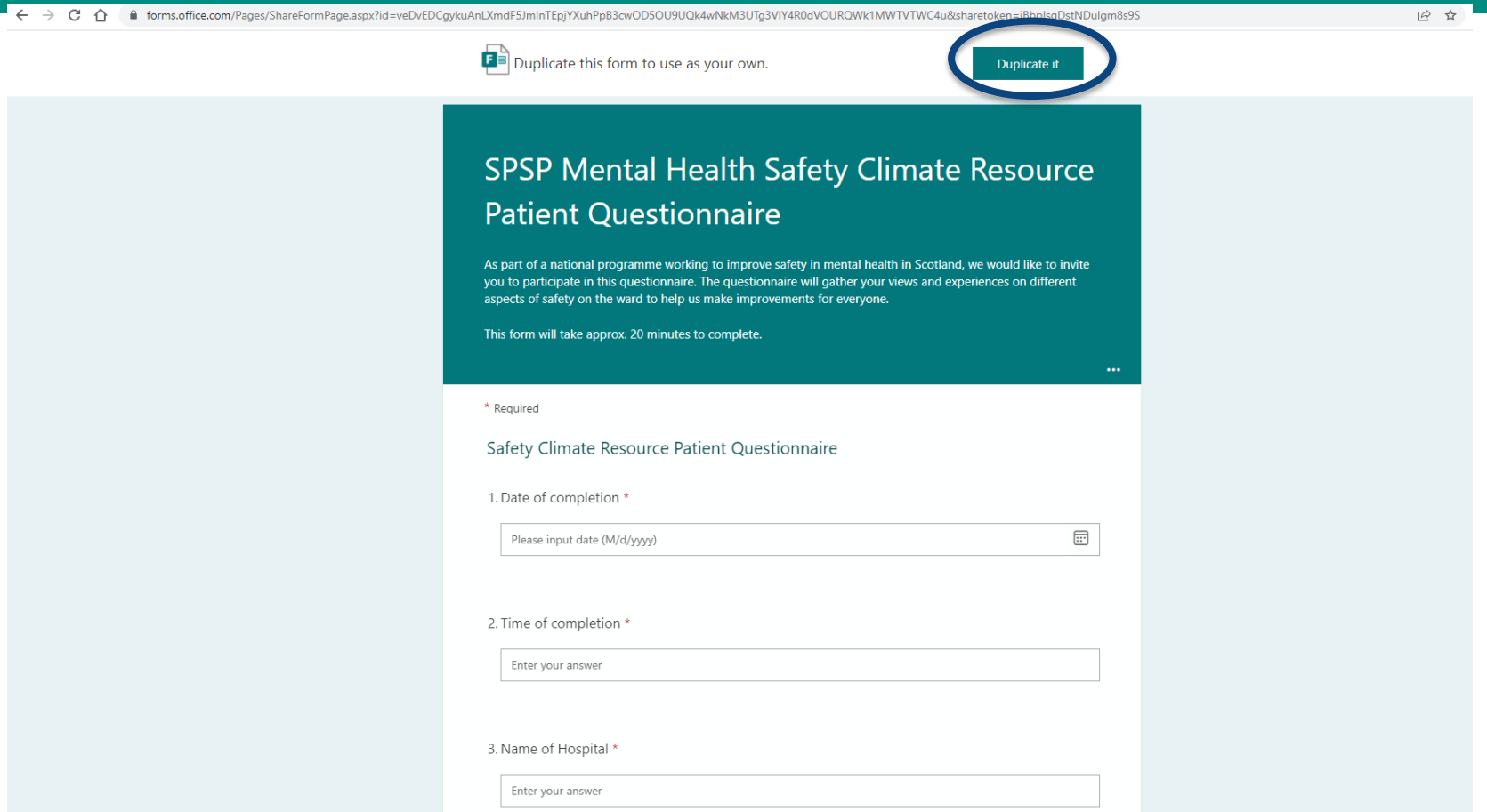
☑ yes

☒ no

? sometimes

Please tell us more about your answer?

Digital Resource

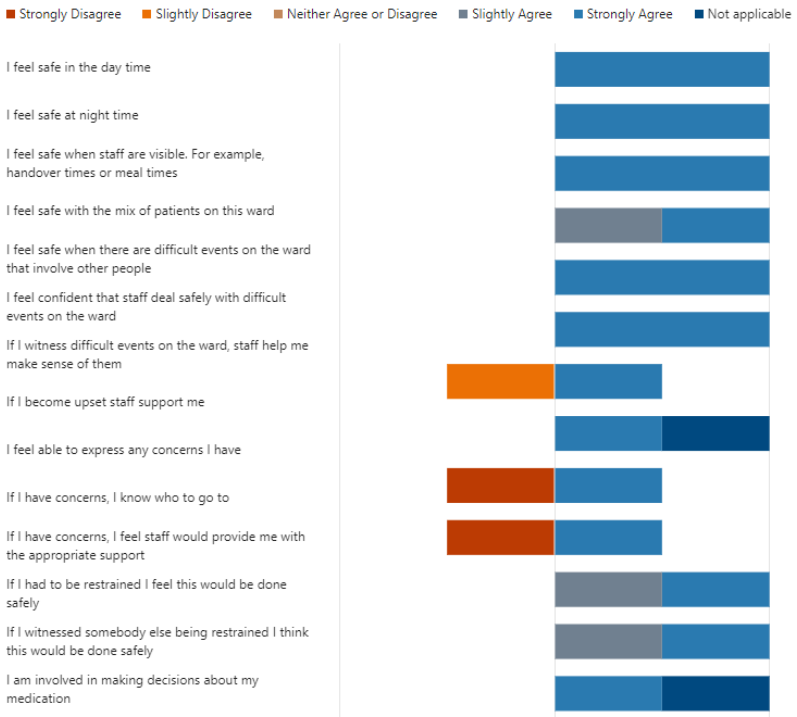


Digital Resource

Questions | Responses 2

7. Please rate the following questions by clicking the box under the response that best fits with your experiences

More Details



Questions?

Next steps

- Resources from today - available soon on our Learning System webpage
- Learning System Webinar 3: Essentials of safe care – date tbc

Feedback

Please take the time now to complete our evaluation form.

Keep in touch

His.mhportfolio@nhs.scot

@SPSP_MH

To find out more visit ihub.scot


THANK
You!