Minutes of Derby Medical Society, Tuesday 29th January 2019

Derby Medical School Lecture Theatre

'Fairness, kindness and calling it: Exploring the notion of a just culture'

Apologies

Tony Henry

David Cole

Shehla Imtiaz-Umer

Speaker

Dr Suzette Woodward: National Clinical Director, Sign up to Safety Team

Introduction

The meeting was opened by Miss Hewitt, everyone was welcomed, and good luck was wished to all students sitting exams in the near future. Members from the resus team and Lauren Priestman were also welcomed as guests.

The meeting's speaker was introduced by Miss Hewitt. Dr Woodward was asked to present after Miss Hewitt attended a 'Learning through Excellence' event. This led to the implementation of the 'Greatex' – the antidote to the 'Datex', to improve culture within medicine. This was found to really help departmental morale and working relationships.

Dr Woodward's background is in Paediatric nursing and for the last 25 years she has specialised in patient safety. She has an MSE, a doctorate and has written a book – 'Rethinking patient safety', with a second one 'Implementing patient safety', out in 3 months. Bound to be a best seller!

Presentation

'Fairness, kindness and calling it: Exploring the notion of a just culture'

Patient safety has only really been prominent in healthcare for the last 25 years or so, it is therefore quite a new science. In the beginning other high-risk enterprises, such as Aviation, were studied – from this, incident reporting and teamwork training were picked out as things which improved safety in that field and could therefore be used within healthcare systems.

However, our patients are not aeroplanes and hospitals are not airports. Engineering and Aviation fields are able to work well to safety standards and guidelines, whereas healthcare at times has to go outside these boundaries and rules, in order to make care safer.

Main aims of talk today:

1. How do we integrate 'Safety 1' and 'Safety 2'
2. The need to urgently tackle blame culture
3. Care for the very people who care for our patients

'Safety 1'

- First principle - capturing and investigating everything that goes wrong, often known as adverse events/incident, due to unplanned or unexpected things. These can include errors and lapses, such as operating on the wrong body part.
- Second principle – assumption that we will know the absolute truth surrounding incident
- Third principle – assumption that all incidents are fixable.

However, in healthcare we sometimes do not always know what went wrong following incident investigations, we may never find the answer to the root cause of the problem.

Genuine root causes are due to decisions made at political levels, such as staffing levels or education. However, we often pin the cause on smaller factors such as poor handover or poor note documentation and miss the actual genuine root cause.

Problems with 'Safety 1' include the fact that it is highly reactive and has an element of superficiality. It can also result in aiming for quantity of safety reporting, as opposed to quality.

'Safety 1' is tackled with analytical approach, rather than delving deeper. It causes us to separate problems, such as the incidence of sepsis or pressure ulcers.

Dr Woodward was recently watching a webinar that claimed incident reporting is unhelpful as all they do is perpetuate blame culture. For example, the most common incident report is 'Falls'. Do we really need more recording of falls, is it making any difference?

In 1999 Charles Vincent and his team, including Dr Woodward, conducted a research study, trying to replicate the New York study into patient safety. It was a case note study, which was highly subjective. Researchers studied the case notes 5000 records and estimated that 10% patients were harmed by the care as opposed to the underlying condition. Literature often quotes this figure, despite bias and flaws in study.

Dr Woodward posed the question that even if the 10% figure is true, then it is worth remembering that 90% of times things go right. In healthcare we are often obsessed with the 'never events' and the times when things have gone wrong. We therefore miss all the good day-to-day performance of what we do. What we do in healthcare is we adjust and adapt to correct order in a system which is fundamentally under pressure.

'Safety 2'

Erik Hollnagel explains that people adjust to conditions they work in, meaning that performance variability is inevitable and necessary. This should be studied and celebrated. This is the basis of 'Safety 2'. We should aim to understand the everyday, replicate and optimise it. This being said it is not always about improving everything, there is a middle ground of things which are going well and therefore do not need to change. Sometimes in healthcare we only focus on improvement or failures.

Dr Woodward then outlined the different forms of 'work':

'Work as done' – intuitive, everyday work

'Work as imagined' – what policy makers imagine work is like, for example workers in surgical theatre must use a standardised surgical checklist, however it may not actually match that particular theatre. This can result in people being forced to work in a certain way in aim to fix a problem.

'Work as disclosed' – rarely open to inspectors/CQC etc. This is a group of workers who do not fully comply with the rules, usually because they know they are not fit for purpose, but do not openly disclose this. Therefore, are we getting the whole truth during investigations. Sometimes people have different viewpoints of same event and sometimes there are sometimes multiple truths.

Therefore, Dr Woodward suggests that we should study all forms of work, things that go well and things that go wrong. We can then use this to decide what needs improving and how. She also suggested that we need to change the language surrounding patient safety.

For example:

Human error – Performance variability

Zero harm – Natural variation

One possible way to monitor for variation and change is to record 'Golden Days'. These are good day in which the team communicated and performed well. This allows us to note how many good days there are, in order to make it easier to compare with days which have not gone as well.

Another idea is a 'Gratitude journal'. This involves writing down 5 things a day you have really loved, thus allowing us to realise that we do more good things than bad things, this is good for morale.

Another good to think about it comes from the 'New Hypothesis', adapted from Adrian Plunkett - people make countless adjustments during their day, most lead to success, some lead to failure. This is just work. We must take the blame out of failure.

2. Tackling the blame culture

Despite all the good that we as healthcare providers do, we tend to define people by a single mistake for their career. A perfect example of this is the Dr Bawa-Garba case. We are all aware that there were many problems with that day, such as problems with IT and lack of induction. Dr Bawa-Garba was a thoughtful doctor who made bad decisions. She was found guilty of gross negligence manslaughter, appealed GMC removal from register, won and the suspension has been overturned. Dr Woodward does not think this was truly a case of gross negligence manslaughter. It was a heavily scrutinised case. She outlined all the confounding variables surrounding the course and asked us to consider how many of us would survive the microscopic scrutiny of our case managements.

Treating error as a crime means we will always be losers. It is also easy to humiliate people enough for them to define themselves with the error.

We all agree there is nothing wrong with barriers to prevent mistakes. But there is a difference between a genuine mistake and intentional acts. Only a tiny fraction of healthcare workers are guilty of intentional acts.

An alternative to the blame culture is the 'Restorative Just Culture'. Sidney Dekker wrote about this, saying that people are not the problem, they are usually the solution. When something goes wrong ask – who was hurt, what do they need? Whose obligation is it to meet the need? Sometimes people not even involved need support as it can have wide reaching effects.

For further information on this area Dr Woodward recommended watching - The story of Mersey Care – a 20 minute film, found at: sidneydekker.com/just-culture/. It outlines the true story of a HR manager reading about 'Restorative Just Culture' and changing the culture of blaming staff in the institute.

3. Care for the people who care for patients

Dr Woodward discussed a quote by Carl Horsley regarding patient safety - 'It is not just about safety. It is about everything.'

We know there are difficulties facing staff – fatigue, hunger, small messes, low staffing levels etc. These things have been eroded by targets and initiatives. This is outlined well in the bestseller 'This is going to hurt' by Adam Kay, in which he touches upon shame, grief and struggles.

We can improve patient safety by looking after staff – sorting out breaks, dedicating time for people to talk to each other, providing places for people to rest and by encouraging fun in the workplace.

Very importantly, we must stop being rude to each other. At times there is a culture of minor incivility throughout NHS. Low grade casual rudeness impacts staff and effects onlookers.

Dr Woodward once spoke with student nurses and found they often struggled with incivility. Common examples included being sneered at for not knowing answers or by people not learning their names on placement.

So, what is the antidote for incivility? Dr Woodward argues it is kindness. Kindness erodes rudeness. People pass on kindness, it is a strength.

Other methods include targeted praise, personal feedback and empowerment of staff. People perpetuate meaningful feedback, resulting in positive reinforcement. This is a good way to reduce negative incidents.

Also, ultimately, never forget how powerful it is to simply say 'Thank You'.

Discussion was opened to the floor and Dr Woodward took questions

Taker Home Message and Key learning points

Last meeting Dr Suzette Woodward, the National Clinical Director of the Sign up to Safety Team, drew upon 25 years of experience to give a presentation on Patient Safety.

1. When as a profession we first started to investigate how to improve patient safety, people often turned to the Aviation and Engineering industry to see if safeguards and guidelines they follow to make their work safe, could be used to improve safety in healthcare. There were some improvements but it is now more widely accepted that actually in healthcare we

at times have to go outside the boundaries of rules and regulations, in order to make care safer. In healthcare there are also times when we never find the answers to what went wrong.

2. We urgently need to tackle the blame culture within the NHS. Incident reporting has not seemed to make a huge difference in patient safety, as it is a superficial way of assessing a problem. Instead of focusing on errors, we should accept a natural variation in the different ways we work, promote good practice, study and celebrate working differences and ultimately adopt a 'Restorative Just Culture'. This model is all about people being the solution and not the problem.
3. Lastly, one of the best ways to effectively care for patients is to care for the care-givers. Healthcare professionals are often faced with stressful situations and fun, safe working conditions have been eroded by targets and the need to fulfil initiatives. Allowing staff to have breaks and spaces to communication with each other is good for morale and departmental team-working, ultimately benefitting patients. Also, never forget that basic civility and a simple 'Thank You' can often go a long way.

Full members - 18

Guest members - 4

Doctors in training - 1

Medical students - 20

Total Attendance - 43