# Building a Just Culture in Healthcare:

## *a HSE Dialogue*

### Croke Park Conference Centre, Dublin

### 23rd May 2023

| Time | Content |
|---|---|
| 8.45 – 9.30 | Registration and Tea/Coffee on arrival |
| 9.30 – 9.45 | **Opening: Dr Colm Henry, Chief Clinical Officer, HSE** |
| | Session 1, The Need for Just Culture. *Chair: Dr Orla Healy, National Clinical Director of Quality and Patient Safety in the HSE* |
| 09.45 – 10.20 | **Introduction**: Dr Orla Healy<br>**Multi-perspectives:** ***We need Just Culture in Irish Healthcare services because: Including:***<br>• Ms Joan Johnston, GM, COPD Support Ireland and Patient Partner<br>• Mr Gerry Clerkin, Head of Service Quality and Service Improvement, HSE<br>• Dr Suzanne Crowe, President, Irish Medical Council<br>• Ms Deirdre Naughton. Dir. Midwifery, Portiuncula University Hospital |
| 10.20 – 10.45 | **Introduction**: Dr John Fitzsimons, Paediatric Consultant at CHI, Temple St and Clinical Director for Quality Improvement, QPSD HSE<br>**Shame and Vulnerability,** Dr Barry Lyons, Consultant in the Dept. of Anaesthesia and Critical Care Medicine at Children's Health Ireland, Crumlin |
| 10.45 – 11.00 | **Trust and Confidence in the HSE,** Roisin Guiry, Campaigns Director, HSE Communications |
| 11.00 – 11.30 | Tea/Coffee |
| | Session 2, Keynote presentation. *Chair: Ms Lorraine Schwanberg, Assistant National Director, QPS Incident Management in the HSE* |
| 11.30 – 13.00 | **Keynote: Restorative Just Culture in Practice: The Challenges, The Learning and the Impact,** Amanda Oates, Executive Director of Workforce and Joe Rafferty CBE, Chief Executive, Mersey Care NHS Foundation Trust |
| 13.00 – 14.00 | Lunch |
| | Session 3: Current Research, initiatives and moving forward. *Chair: Dr John Fitzsimons, Consultant at CHI, Temple St and Clinical Director for QI, QPSD HSE* |
| 14.00 – 14.50 | **Building a Safe & Just Culture: Lessons from other sectors,**<br>Professor Sam Cromie Director of the Centre for Innovative Human Systems in Trinity College Dublin & Professor Marie Ward, Human Factors researcher at St James's Hospital and Adjunct Assistant Professor at the Centre for Innovative Human Systems |
| 14:50 – 15:00 | **We are not starting from scratch: current work in HSE to support a Just Culture,** Ms Lorraine Schwanberg, and Dr Samantha Hughes, QPS Incident Management Team |
| 15.00 – 15.10 | **Mr. Bernard Gloster, CEO HSE** |
| 15.10 – 16:00 | **Interactive Dialogue: How do we implement Just Culture and what needs to happen next? Panel discussion with Amanda Oates, Joe Rafferty and HSE representatives and partners.** Facilitated by Dr John Fitzsimons |
| 16.00 – 16:30 | • Poster Awards<br>• Closing remarks: Actions for attendees when they return to workplace and close, Dr Orla Healy, National Clinical Director of Quality and Patient Safety, HSE |

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## Speaker Biographies

### Mr Bernard Gloster

**Chief Executive Officer, HSE**

Bernard Gloster took up the post of Chief Executive Officer of the HSE in March 2023. He has worked in health and social services for over 34 years, and re-joined the HSE from the state Child and Family Agency, Tusla where he served as Chief Executive Officer from September 2019. Prior to that, he held several senior management positions within the HSE including Chief Officer of HSE Mid-West Community Healthcare, and he worked in and managed in both community and acute hospital operations. He is a social care worker by profession, holds an MBA from Oxford Brookes University and an MSc in Management Practice from UCC.

### Dr Colm Henry

**Chief Clinical Officer, HSE**

Dr Colm Henry has been Chief Clinical Officer in the HSE since April 2018. He previously was the National Clinical Advisor and Group Lead for Acute Hospitals from 2014 – 2018, National Lead for the Clinical Director Programme from 2012 to 2014 and Clinical Director of the Mercy University Hospital Cork from 2009 to 2012. Following medical qualification, he underwent training initially in Ireland and completed higher specialty training in Scotland. He returned to

Ireland following his appointment to the Mercy University Hospital as Consultant Geriatrician in 2002.

As the HSE's first Chief Clinical Officer, he is responsible for aligning clinical expertise and leadership across the healthcare system from service and policy design to planning and implementation. A core function of the post is the design and implementation of clinical models of care to respond to and meet the challenges of healthcare in the 21st century. His office also is responsible for setting quality and patient safety standards across the health system and ensuring these are met. He is accountable for a number of key national services such as the National Cancer Control Programme and National Screening Service as well as Public Health reform. Dr Henry has lead the clinical response within the HSE to the COVID19 Pandemic since the first case emerged in February 2020 provided clinical leadership to the HSE Vaccine programme and its rollout to the Irish population.

## Amanda Oates

**Executive Director of Workforce**
**Mersey Care NHS Foundation Trust**

Amanda is one of the pioneering NHS Directors of Human Resources and Organisational Development in the North West. Her extensive experience includes Director level posts in a number of NHS trusts and she has operated at the most senior board levels since 2008.Since joining Mersey Care NHS FT she has transformed the way that the trust delivers its workforce function, and has received external endorsement from the highest levels in her profession most recently leading her team to win the Organisational Development Team of the year in 2019, Workforce Well Being in 2018, PPMH Awards, Best Learning and Development in September 2018 CIPD and in June 2018, the Trust won the National SPF Award for Partnership working for the implementation of the Just & Learning Culture at the HPMA Awards. Amanda also won the HPMA Human Resources Director of the year for 2018 and in 2020 were Highly Commended in the HSJ value awards. In 2020 the trust won the Public category in the Business Culture Awards 2020 for their civility and respect campaign.

Alongside, Joe Rafferty (Chief Executive of Mersey Care) and Sidney Dekker (Professor and Director of the Safety Science Innovation Labs at Griffith University in Brisbane) Amanda was the co-author of a book published on 16 June 2022 titled "Restorative Just Culture in Practice, Implementation and Practice" to guide organisations on the implementation and evaluation of restorative just culture. Amanda's passion for getting the best from everyone permeates everything she does for her colleagues going way beyond the normal expectations of her role.

## Joe Rafferty CBE

## Chief Executive

### Mersey Care NHS Foundation Trust

Joe Rafferty was appointed Chief Executive of Mersey Care NHS Foundation Trust in September 2012. During his tenure, he has led a significant expansion of the organisation, almost trebling it in size. This has been accompanied by significant modernisation of the estate and digital infrastructure. The trust is now one of the largest specialised integrated care providers in the NHS and includes inpatient and community mental health, community physical health, and learning disability and addictions services.

Whilst at Mersey Care, he has led the organisation embedding the concept of '*Pursuing Perfect Care'* using a series of audacious zero-based goals, such as zero suicides in care, zero restrictive practice, zero pressure ulcers and zero medication errors. Most notably, the trust has become internationally recognised for its work on 'Restorative Just Practice' to support learning in its pursuit of perfect care.
Awarded a Ph.D. in molecular genetics at Queen's University Belfast in 1987, he spent the next twelve years researching drug resistance in cancer and published over fifty peer review articles on this and related areas, before a career change.

Before joining Mersey Care, he held several Senior NHS Leadership roles including Regional Director (NHSNW) of Strategy and Commissioning and Chief Executive of a Primary Care Trust where he developed an interest in safety and quality improvement, including establishing the influential Advancing Quality programme. He is a founder member of the Zero Suicide Alliance UK and was named a Commander of the Order of the British Empire (CBE) in the New Year's Honours List 2020 for his work on suicide prevention. He was made an Honorary Professor at the University of Liverpool Institute for Population Health Sciences in March 2021

## Dr Orla Healy, MD, MPH FRCP FFPHM (I)

### National Clinical Director of Quality and Patient Safety in the HSE

A graduate of UCC in 1994, Orla worked in hospital medicine for five years before embarking in a career in Public Health Medicine. In May 2016, she moved to work in the South/South West Hospital Group where she occupied a range of senior management roles including Director of Quality, Governance and Patient Safety, Director of Strategy, Planning and Population Health and Chief Operations Officer. In 2018, she was made Adjunct Clinical Professor in the School of Public Health UCC.

Since taking up post as National Clinical Director of Quality and Patient Safety in the HSE in April 2021, Orla has reconfigured the Corporate Quality and Patient Safety Directorate. The

goal of NQPSD is to work in partnership with HSE operations, patient representatives and other internal & external partners to improve patient safety and the quality of care.

Orla leads the following teams:

- Patient Safety Programme
- QPS Improvement
- QPS Intelligence
- QPS Incident Management
- QPS Education
- QPS Connect
- NCCA

## Lorraine Schwanberg

### RGN RSCN LL.M

**Assistant National Director, QPS Incident Management in the HSE**

Lorraine leads out on the Incident Management arm of the National Quality and Patient Safety Directorate (NQPSD) in the HSE. Lorraine and her teams remit includes incident management, open disclosure and the National Incident Management System (HSE). They collaborate extensively with many partners on all things related to quality and patient safety to help drive and support improvement. Lorraine has worked in leadership roles in incident management, quality, risk and patient safety for many years, predominantly in the NHS. Most recently at King's College Hospital NHS Trust and Guy's and St Thomas Hospital NHS Trust. Lorraine also enjoyed a career as a paediatric and general nurse in Ireland where she developed an interest in patient safety which remains her passion.

## Dr Samantha Hughes

### QPS Incident Management Team

Dr Samantha Hughes graduated with a PhD in Biotechnology from DCU in 2000 and commenced working in the area of Clinical Audit in the Midland Health Board in 2001. Since then, Samantha has worked in all aspects of quality and patient safety both in acute and community services and has worked at national level in the area of Incident Management since 2014. Samantha was the project lead for the development HSE Patient Safety Strategy (2019 – 2024). She currently works in the National Quality and Patient Safety Directorate as a member of the QPS Incident Management Team, mainly focussing on incident management and review related training and support and policy/guideline development aspects of the team, and she is the Project Lead for HSE Just Culture implementation project.

## Dr John Fitzsimons

**Paediatric Consultant at Children's University Hospital, Temple St and Clinical Director for Quality Improvement, QPSD HSE**

Dr John Fitzsimons is a Consultant Paediatrician with Children's Health Ireland at Temple Street and Clinical Director for Quality Improvement (QI) with the HSE's National Quality & Patient Safety Directorate. He is course director of the HSE sponsored RCPI *Quality Improvement and Leadership* post-graduate certificate program which has been running since 2011 and trained over 750 participants. He has contributed to national improvement projects including *Irish Paediatric Early Warning System* (PEWS), *Situation Awareness for Everyone* (SAFE), Quality and Safety Walkrounds, Pressure Ulcer and VTE collaboratives and the HSE Patient Safety Strategy 2019-2014. He is an editor of the Oxford Handbook of Patient Safety published in 2022.

## Dr Barry Lyons

**Consultant in the Dept. of Anaesthesia and Critical Care Medicine at Children's Health Ireland, Crumlin**

Dr Barry Lyons is a consultant in the Dept. of Anaesthesia and Critical Care Medicine at Children's Health Ireland, Crumlin, where he is Chair of the Ethics Committee. He is also Associate Professor of Medical Law & Ethics at TCD. His research interests relate to the role of negative emotions in medicine, and the interface between law, regulation and medicine. He is a researcher on the Welcome Trust funded Shame and Medicine Project (https://shameandmedicine.org).

## Roisin Guiry

**Campaigns Director in the Communications Division of the HSE**

Roisin Guiry is a Campaigns Director in the Communications Division of the HSE. Roisin has over 15 years of experience working on health information, education and behaviour change campaigns and programmes across public health topics including mental health, sexual health, alcohol, child health and screening promotion. She has an interest in culture change having worked on the development of Values in Action; a staff led culture change movement in the HSE and currently on creating dementia inclusive communities across Ireland. Roisin's love for research insights and evaluation is strong and evident with her currently leading a research programme to understand trust in the HSE and the development of an approach to measure trust – the HSE Trust Index.

## Professor Marie Ward

**Human Factors researcher at St James's Hospital**

**Adjunct Assistant Professor at the Centre for Innovative Human System in Trinity College Dublin**

Prof Marie Ward, PhD Psychology Human Factors, is an embedded Human Factors researcher at St James's Hospital Dublin since 2021 – where she is engaged in a programme of health systems research and improvement with the Quality and Safety Improvement Directorate. Marie is an Adjunct Assistant Professor at TCD's multidisciplinary Centre for Innovative Human Systems which engages in Human Factors research and consultancy with all industries to improve human wellbeing and system performance. Marie is a lecturer on the Masters in Managing Risk and System Change (TCD); Masters in Human Factors in Patient Safety (RCSI); a committee member of the Irish Human Factors and Ergonomics Society; a member of the Chartered Institute of Ergonomics and Human Factors (UK) special interest group on AI in healthcare. Marie was awarded the International Ergonomics Association Liberty Mutual Medal in 2012 for her outstanding research in aviation safety. Her work has been widely published and she is a peer reviewer for a number of journals.

Her research interests include how to enable patient and staff safety and wellbeing from a systems perspective and co-designing new systems from a socio-technical perspective.

## Professor Sam Cromie

**Director of the Centre for Innovative Human System in Trinity College Dublin**

Prof Sam Cromie is Director of the Centre for Innovative Human System in Trinity College Dublin. He leads a team of highly experienced and dedicated researchers, to apply human factors and systems science to the real challenges faced by diverse sectors and to produce solutions that put people front and centre. A key focus of his recent research is on the cognitive and social processes of culpability decision making in adverse events.

He has 28 years' experience of action research in healthcare, aviation, pharmaceutical, process, manufacturing and maritime sectors and has worked with great organisations such as Aer Lingus, HSE, The Coombe Women and Infants University Hospital, University Hospital Waterford, Irish Rail, Rolls Royce, Airbus, British Airways, SAS, Cathay Pacific, EASA, Pfizer, BP & Statoil.

He has served on the JAA Maintenance Human Factors Subcommittee, working groups of the European Aviation Maintenance Training Committee and as an advisor to the HSE National Incident Management Team and Quality and Patient Safety Directorate. He also runs a training and consultancy business, delivering tailored human factors and safety management solutions to industry to keep his implementation focus sharp.

## Dr Suzanne Crowe

**President, Irish Medical Council**

Dr Suzanne Crowe was first elected to the Medical Council in 2018 and re-elected in 2023. Dr Crowe was elected as President of the Medical Council in 2021.
Dr Crowe graduated in Medicine from Trinity College Dublin, followed by Specialist training in Anaesthesia and Intensive Care Medicine with the College of Anaesthesiologists. After a Fellowship in Paediatric Intensive Care Medicine in the Royal Children's Hospital Melbourne she took up a Consultant post in Anaesthesia with a Special Interest in Paediatrics in Tallaght Hospital, Dublin.

In 2014, Dr Crowe moved to Children's Health Ireland Crumlin Hospital as a Paediatric Intensivist. She is a Senior Lecturer in Paediatrics in Trinity College Dublin and has an interest in bereavement studies and medical ethics. She is Associate Clinical Professor in UCD School of Medicine in the division of Women and Children's Health. Dr Crowe is a board trustee for three charities, the Down Syndrome Centre, Cheshire Ireland and LGBT Ireland.

## Joan Johnston

**General Manager, COPD Support Ireland**

**Patient Partner**

Joan is currently the General Manager of COPD Support Ireland, a patient support and advocacy organisation providing weekly peer support and exercise classes across 35+ locations in Ireland for those living with this chronic lung disease. She has just taken up the role of Vice Chair of the Board of IPPOSI (Irish Platform for Patient Organisations, Science and Industry) and chair's their working group on Patient Partnerships. Prior to joining COPD Support Ireland in 2020 Joan worked as a Respiratory Physiotherapist across a variety of public and private hospital settings.

Joan is mum to Ella (7yrs) & Leo (5yrs) and, following the diagnosis of Leo with Angelman Syndrome in 2018, she has undertaken a variety of Advocacy and Patient Partnership roles including Parent Ambassador for the Jack and Jill Children's Foundation, patient representative on the HIQA led Children's Reference Group (CRG) for Overarching National Standards for the Care and Support of Children using Health and Social Care Services, patient partner on the National Quality and Patient Safety Directorate Management Team and, in early 2023, was appointed as a patient partner to the HSE Board Planning and Performance Committee. Joan is passionate about the value patient partnerships can add when utilised throughout healthcare organisational structures - from high level planning and policy to local implementation and delivery.

## Deirdre Naughton,

**Director of Midwifery, Portiuncula University Hospital**

Deirdre Naughton is Director of Midwifery in Portiuncula University Hospital since July 2019. Deirdre gained invaluable experience working in practice development, clinical skills, as a clinical placement coordinator and most importantly, as a midwife throughout her career. She is an adjunct lecturer in the now University of Galway, has recently completed the Advanced Diploma in Medical law and is a regulator in the PPC in NMBI.

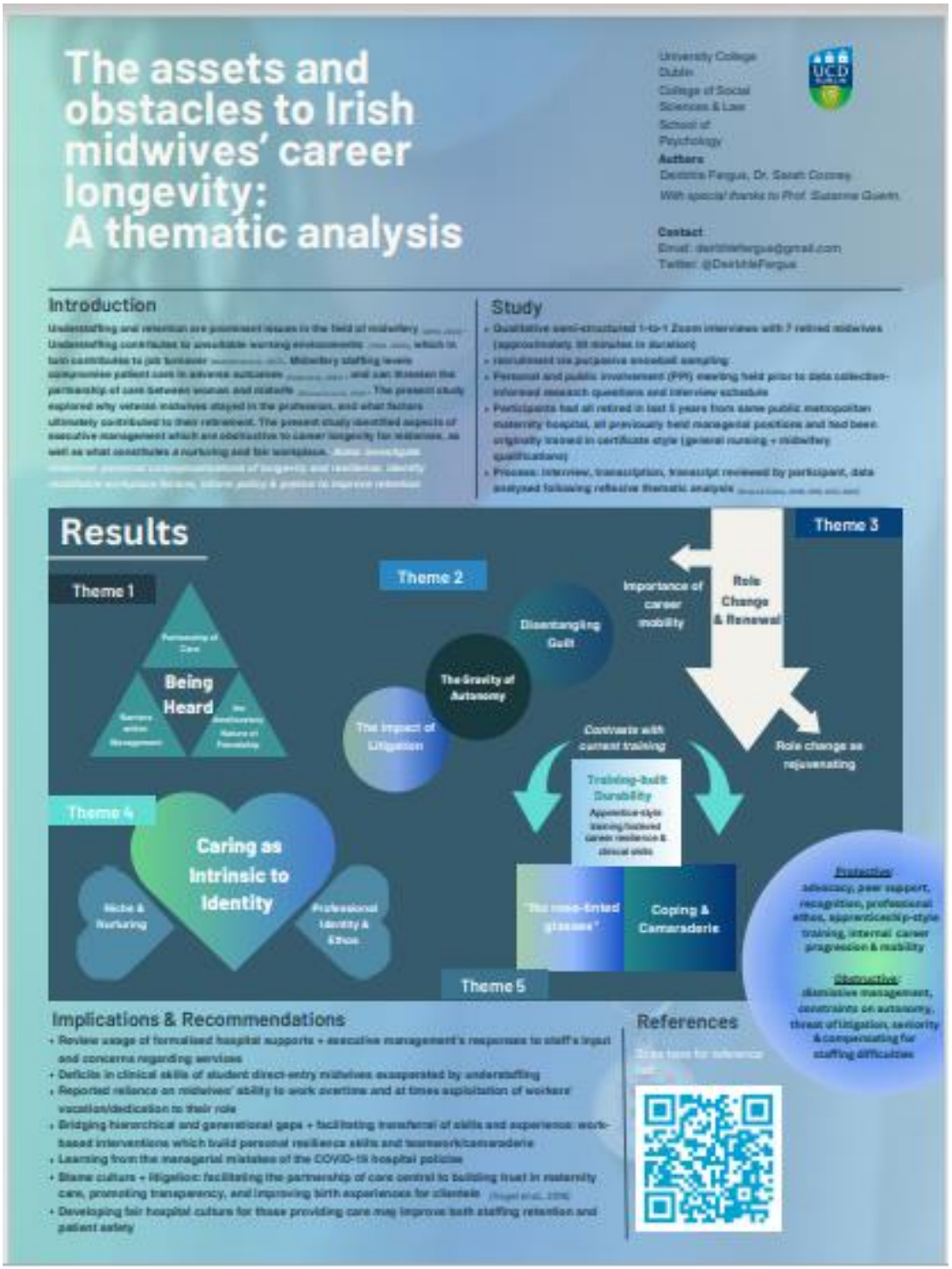
## Gerry Clerkin

**Head of Service Quality and Service improvement, HSE**

Gerry has worked in healthcare for over 40 years, and since April 2021 he is the Head of Service, Quality, Safety and Service Improvement for Community Healthcare, Cavan, Donegal, Leitrim Monaghan, Sligo. He is also an adjunct Lecturer in Trinity College, Dublin providing lectures on Quality and Safety on a Master's programme in Health Policy. A former Nurse for 20 years, Gerry professionally qualified in Psychiatric and General Nursing and holds an Honours Degree in Nurse Management and a Master's Degree in Healthcare Leadership and Quality. For the past twenty years, Gerry has worked in the area of Quality and Safety at both local and national level in both acute and community services and also nationally within the National Screening Services. Over the past 20 years of operating in a Quality and Safety function, Gerry has experienced a shift from seeing a "Blame Culture" with poor reporting and not raising concerns, to a "No Blame Culture" with no accountability, to a "Just Culture" where we need to build its principles into the practice and processes of daily work. This will help build an open, transparent and non-punitive approach and build public confidence in our Health Service.

# Poster Finalists

## Deirbhle Fergus



# Noreen Kennedy

## A Success story on our journey towards a just and fair culture in St. John's Hospital Limerick

Noreen Kennedy, Quality & Patient Safety Manager

## Aim

**To highlight the successful implementation of a just and fair culture in St. John's Hospital by focusing on the systems approach within the Incident Management Framework 2020.**

## Introduction

**The introduction of HSE Incident Management Framework 2020** (IMF) allowed for staff and service user engagement in the process of management, review and learning following patient safety incidents. This process promoted a culture of open, transparent and multi-disciplinary team involvement in the incident management process.


## Approach

The Quality Risk & Patient Safety Team (QPRS) used the IMF 2020 to help **focus staff on a systems approach to incident review and the learning following a patient safety incident.** Consistent with the values of the hospital a collaborative approach on a team by team basis was used by the QRPS Team to train staff in incident management.

Staff Engagement

inspire workplaces

## Feedback from Participants

| | |
|---|---|
| Patient | • "I don't want this to happen to anyone else" |
| Clinical Nurse Manager & Staff Nurse | • *"I had never seen Open Disclosure done step by step before'*<br>• *"There was no blame, no finger pointing. The IMF debrief helped me understand it was a system approach. I was so stressed, QRPS team kept checking in, this gave me comfort. The outcome was presented to all involved"* |
| Consultant | • *"Experts, objective, the review happened within a good timeframe and allowed for 100% learning, fair appraisal for those involved.* |

## Actions

- ❑ IMF induction training for all staff
- ❑ Consistent and experienced investigation team
- ❑ *Focus on a* **Systems Approach in the IMF** *and not on the person involved- Yorkshire Contributory Factors Framework*

- ❑ Early debriefing to all involved in the incident about the IMF process and their role
- ❑ Staff wellbeing supports offered
- ❑ Service user input encouraged and open communication
- ❑ Regular updates of review progress to staff and service users
- ❑ Presentation of review, findings and recommendations to the teams involved
- ❑ Learning notices developed and shared
- ❑ Strong leadership supported implementation

## Results

- Positive reporting, 30% increase in incident reporting since 2020
- Positive feedback from staff in relation to collaborative management of incidents
- Improved partnership between and within teams and QPRS department
- Positive shared learning post review

## Key Learning

Our success has magnified the evidence that Just Culture plays a critical role in improving patient safety.

Working towards commitment 2 of the Patient Safety Strategy "we are working to embed culture of learning and improvement that is just, fair and open".

## Acknowledgements

The St. John's Hospital QRPS Team: Elma Herbert, Maria Liston, Liz O' Riordan
The Staff of St.Johns Hosptial, Limerick
The HSE National Quality & Patient Safety Directorate

Ellen Liston, Dr Enda O'Connor and Dr Marie E. Ward

# Exploring Safety Culture, Just Culture in a Large Irish Teaching Hospital

Ellen Liston[1], Dr Enda O'Connor[2], Dr Marie E. Ward[2]
[1]Physiotherapy Department, St James's Hospital [2]Department of Critical Care & Anaesthetics, St James's Hospital
[2]QSID, St James's Hospital

## INTRODUCTION

Safety Culture (SC), a core part of organisational culture, has become a key priority for safety improvement and critical evaluations across healthcare industries, despite variations in definition (O'Donovan et al., 2019). Core components of all SC definitions involve prioritising safety, ensuring standards and reliability, flexibility and resilience, learning culture, team working, a supportive reporting culture and just culture (Wang and Sun, 2014).

Studies have identified positive links between positive SC and improved patient outcomes. The pandemic has further demonstrated the importance of positive SC to ensure safe, effective, and more resilient health systems. Currently there is no evidence on MDT safety culture and its relationship to adverse incident occurrence and reporting within an Intensive Care Unit in Ireland.

## AIM

The aim of the study is to triangulate data on SC from three sources in an Intensive Care Unit (ICU) in a large teaching hospital in Ireland.

**Research Questions:**

- What is the SC of an ICU Multidisciplinary team (MDT) in a busy Irish teaching hospital?
- What issues, if any, are currently impacting the SC?
- Which domains of SC feature most prominently in the findings (i.e. prioritising safety, ensuring standards and reliability, flexibility and resilience, learning culture, team working, a supportive reporting culture and just culture)?

## METHODS

A pragmatic mixed methods approach was used triangulating data from three sources:


- The study was completed in a 26 bed ICU in a large Dublin teaching hospital. All clinical staff (medical, nursing and Health and Social Care Professionals) who worked in the ICU were invited to participate, 216 staff in total.
- Ethical approval was granted by the Hospital Ethics committee (Project ID: 0622)
- Responses were calculated referencing AHRQ guidance document (AHRQ, 2021). Descriptive statistics were used to calculate the average percentage of positive responses. Demographic data were analysed using descriptive statistics, referencing characteristics of respondents, specifically profession and experience. Qualitative data from the open ended questions of the questionnaire was analysed using content analysis

**Ellen Liston** | Senior Physiotherapist
Email | ellenliston02@gmail.com

## RESULTS

There was a 47% response rate with 101/216 surveys completed, all clinical groups represented.


Figure 1. Study HSOPSC composite data compared to AHRQ database as per AHRQ, 2021

| Table 1. | AE data | GTT |
|---|---|---|
| ICU admissions | 123 | 123 |
| Charts reviewed | - | 10 |
| Triggers | - | 43 |
| No. of events | 11 | 16 |
| Near miss | 1 | 0 |
| Temp harm | 3 | 15 |
| Harm | 7 | 1 |
| Medication related | 2 | 6 |

Table 1. Adverse event data and data collected using GTT for February 2022. No AEs identified on GTT correlated with those reported.

## DISCUSSION & CONCLUSION

Survey data demonstrates an overall positive safety culture with 4 out of the 10 composites scoring well above the international benchmark as displayed in Figure 1. The low reporting was corroborated in the GTT and AE data. Key areas for improvement are currently being redesigned with the MDT and quality and safety staff.

# Beth Farren and Paula Cussen Murphy

## *'This is not about shame and blame; this is about changing the game'*- Experience of organisational support and feedback succeeding an adverse event.

Ospidéil OL
UL Hospitals
Working together, caring for you

Ms. Beth Farren (Patient Safety Strategy Manager, QPS, ULHG)
Ms. Paula Cussen Murphy (Director of Quality and Patient Safety, ULHG)

### Background

It can be argued that there are multiple factors that are inhibiting the recognition and promotion of a 'just culture'. One of these factors is appropriate leadership. If care givers who are directly involved in an adverse event are not supported appropriately, the forming of 'second victims' occurs (Ajri-Khameslou et al 2017). This is a narrative of personal suffering, which typically includes anxiety, negative emotional symptoms, and a loss of confidence in professional skills and performance (Mira et al, 2015). Thus, leading to more errors and an unwillingness to be upfront about patient safety concerns. It is imperative that we give a voice to those who have been directly impacted as a 'second victim,' expose leadership and management weaknesses in relation to adverse events and generate innovative quality improvement initiatives to develop not only a patient safety culture, but a just culture.

### Aims & Objectives

ULHG has recognised through feedback from incident review teams that the response to healthcare workers immediately after an adverse event is unsatisfactory. To improve the communication, support and leadership offered to staff members from management, it was proposed that semi-structured interviews would be undertaken. Here, staff members would have the opportunity to share their personal experiences in relation to how they were supported in the direct aftermath and the proceeding weeks after the occurrence of an AE. The objective of this project is to extract relevant themes from lived experience to initiate the successful implementation of a quality improvement plan. The intention being to develop support structures for second victims of AEs by improving the leadership skills of clinical managers and endorsing a restorative, just and safe clinical culture.

### Methodology

Focus groups were created with healthcare workers who had been involved directly in an adverse event. These interviews included a selection of pre-determined, open- ended questions used with the intention to prompt the participants to divulge as much of their lived experience as possible and create a discussion with peers. Qualitative data was analysed using the Braun & Clarke thematic analysis framework. This allowed the investigator to identify and extract patterns or themes from the participant's experiences.


### Results

| THEME | SUBTHEME | EXAMPLE |
|---|---|---|
| Blame Culture | *Strong Personalities* | "Certain personalities make it harder for people to report, instead of getting support, some managers will just reprimand you." |
| | *Omissions of Guilt* | "The culture is very negative, reporting incidents is seen as admitting guilt and covering your back rather than what is right for the patient." |
| | *Fear of Repercussions* | "I felt horrendous. I burst into tears, because I feared the repercussions of my own actions, even though I knew I had done everything to the best of my abilities." |
| Inconsistency in Support | *Person Dependent* | "The medical reg was extremely supportive and provided great reassurance, however, the consultant demanded to know who was responsible and even came across as being aggressive in his tone." |
| | *Lack of Knowledge* | "Management didn't seem to have any experience with external reviews and many of my questions remained unanswered." |
| | *Colleague Support* | "...friends and staff nurses' really helped to support me during this time." |
| Limited Feedback | *No Closure* | "...I walked around in fear in relation to this event because nobody gave me any feedback or closure." |
| | *No Learning* | "We need a culture that stops blame because learning is not happening. How do we know systems have been put in place to prevent this incident from happening again?" |

### Discussion, Learnings and the Future

- Inconsistency in support from management was the most prominent feature throughout the data.
- Participants felt they received both positive and negative experiences in relation to the intervention of clinical managers after an AE.
- There is a lack of standardisation, consistency and guidance for leaders on the actions required in the immediate aftermath of an adverse event to support staff.

This information is now being used to help create a bespoke support programme for frontline workers affected by adverse events. This QIP project will be delineated in the format of the acronym 'RISC' ( Regroup & Debrief, Information, Support, Conclusions and Closure). Each letter representing a step in the appropriate management of staff members both immediately after an AE and the time proceeding, up until the resolution of the incident. In conclusion, the elimination of a retributive culture and the introduction of consistency is invaluable for creating a just culture. This is not about shame and blame, this is about changing the game.

### References & Acknowledgements

Ajri-Khameslou, M., Abbaszadeh, A. and Borhani, F. (2017) 'Emergency nurses as second victims of error', Advanced Emergency Nursing Journal, 39(1), pp. 68–76.

Mira, J.J. et al. (2015) 'Interventions in health organisations to reduce the impact of adverse events in second and third victims', BMC Health Services Research, 15(1). doi:10.1186/s12913-015-0994-x.

**Thankyou to all the staff members who shared their authentic experiences during this project to help improve our services.**

Margaret McCabe-Rees, Deirdre Mullally, Kamille Hamilton, Jennifer Ffrench and Siobhan Doyle

# Implementing a Just and Fair Culture for Patient Safety

McCabe-Rees Margaret[1], Mullally Deirdre[2], Hamilton Kamille[1], Ffrench Jennifer[1], Doyle Siobhan[3]

1. Quality, Safety & Risk Departments, Wexford General Hospital
2. Complaints Officer, Wexford General Hospital
3. Operational & Deputy General Manager, Wexford General Hospital

## Introduction

The Patient Safety Strategy Commitment 2 states:
'We will work to embed a culture of learning and improvement that is compassionate, just fair and open'.[1]

In an ideal just culture, staff feel psychologically safe to report errors, have confidence to speak up when things go wrong and can access support, if required, when involved in an incident.

The HSE Incident Management Framework defines just culture as 'a values based supportive model of shared accountability. Individuals should not be held accountable for system failings over which they have no control.'[2]

There are continuously increasing demands on healthcare staff time in Wexford General Hospital. Just culture permeates into everyday life. Honesty, curiosity and energy are necessary to continue driving improvement and patient safety.

## Aims and Objectives

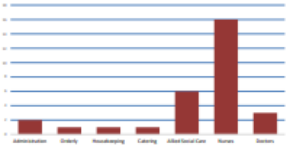
The aim of this review was to assess if staff feel they are actively supported by a fair just culture when it comes to incident management. A fair & just culture anonymous survey was distributed to healthcare staff working in various disciplines.

## Methods

A Plan, Do, Study, Act method was enacted. A survey was compiled of relevant indicators including

- fear of blame in reporting,
- knowledge of incident reporting,
- awareness of the ASSISTME tool and
- confidence in open disclosure practice[3].

The questionnaire was structured to provide qualitative and quantitative data, with five closed-ended questions assessed using a yes/no scale.



## Results and Feedback

**Do you think Wexford General Hospital promotes just culture?**

Comments:
'acknowledgement'


**Have you self-reported an error ?**

Comments:
'preferred extra support'


**Did you fear blame, punishment or judgement when reporting?**

Comments:
'always fearful of blame'
'unclear reporting pathway'


**Do you feel you have the confidence and skills to practice open disclosure?**

Comments:
'lack of confidence'
'need more training'


**Do you have an awareness of the Assist Me Tool?**

Comments:
'Never heard of it'


## Conclusion

The feedback identified measurable results and highlighted areas to implement evidence based quality improvement programmes. This includes openly appreciating staff potential by engagement and listening to foster positive, interpersonal relationships between all disciplines and grades. We have implemented an annual 'Exemplary Colleague Award' nominated anonymously by hospital staff. We continue to build engagement tools and staff connections with the Values In Action Programme. An essential element of our movement is to continuously implement education sessions focusing on line management behaviour, support services and skills of communicating in a non-threatening, non-personal way through Open Disclosure training, the National Healthcare Communication Programme, After Action Reviews and Incident Management. Proactively our 'think tank' is brainstorming outside the box idea's to reach all staff in the most efficient and effective manner: *feedback pathways *peer support *snapshot QPS sessions *catchphrases *fun incentives *promoting value *thank you

## References

1. HSE Patient Safety Strategy 2019-2024 https://www.hse.ie/eng/about/who/nqpsd/patient-safety-strategy-2019-2024.pdf
2. HSE Incident Management Framework 2020 https://www.hse.ie/eng/about/who/npqsd/qps-incident-management/incident-management/hse-2020-incident-management-framework-guidance.pdf
3. HSE Open Disclosure 2019 https://www.hse.ie/eng/about/who/qid/other-quality-improvement-programmes/opendisclosure/national-open-disclosure-policy-and-guidelines.html

Emer Gunning, Annmarie Hanley, Joanne Mannion, Rita Murphy, Fiona Rigney and Elaine Roseingrave

# A Just Culture in Patient Safety Incidents: Exploring the Experience of Staff & the Staff Liaison Person

Emer Gunning, Annmarie Hanley, Joanne Mannion, Rita Murphy, Fiona Rigney, Elaine Roseingrave.
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## Background

The goal of all healthcare staff is to provide the best care possible. When an adverse event happens, staff may also be affected, both personally and professionally, which can impact their wellbeing, health and performance.

Staff empowerment and engagement is one of the core commitments of the HSE Patient Safety Strategy (2019-2024)[1]. The Strategy recognises the importance of support an psychological safety for staff affected by patient safety incidents.

## Problem

When an incident review is underway, the role of **the Staff Liaison Person** is to keep staff informed of the progress of the incident review and to arrange relevant supports as required[2]. Fair and supportive treatment of staff is a core element of a Just Culture[3] . In practice, the locally available resources are not collated and readily available (e.g. digitally available) to assist the novice Staff Liaison Person in providing practical support to staff involved in a serious patient safety incident.


## Do

As a quality improvement project, the Mid-West Community Healthcare Quality & Safety Team will co- design a resource pack for Staff Liaison Persons. We will apply the Model for Improvement[4] 'Plan, Do, Study, Act' cycle.


The HSE Change Guide[5] will also be followed in order to deliver safer, better healthcare. This guide prioritises engagement of stakeholders which will be achieved through a co-design approach that explores the staff experience, and opportunity for regular feedback.

Relevant stakeholders include:

- Staff previously involved in adverse events
- Previous Staff Liaison Persons
- Human Resources
- Health and Wellbeing
- The National Quality and Patient Safety Division.

Regular, open communication and dignity and respect will be a key component of this approach.

## Study

Information gathered will be analysed using qualitative and quantitative methods, and will allow us to learn:

- The level and quality of support extended to staff.
- The understanding of staff regarding the accessibility and content of the support available.
- The experience of staff involved in patient safety incidents.

This analysis aims to yield insights into current effective practice, and also areas that require improvement regarding staff support following patient safety incidents.

## Act

We aim to have all information gathered within a three month period. We will engage in learning in action throughout by doing small tests of change and refining the change as appropriate.


Our aim is that our output will consist of a resource pack to assist the Staff Liaison Persons to provide practical assistance to staff affected by serious incidents. The resource pack should be:

- Available on the Staff App
- Relevant to all areas of the HSE
- Easily accessible
- Adapted for localised resources

1. Health Service Executive, 2019. Patient Safety Strategy 2019 – 2024, Dublin, Ireland: HSE.
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3. National Quality and Safety Directorate, 2022. Just Culture Guide, Dublin, Ireland: HSE.
4. National Centre for Clinical Audit, National Quality and Patient Safety Directorate, 2023. Clinical Audit: A Practical Guide, Dublin, Ireland: HSE.
5. Health Service Executive, Human Resources Division, Organisation Development and Design, 2018. People's Needs Defining Change – Health Services Change Guide, Kells, Co Meath, Ireland: HSE

# Dr Anna V. Chatzi

## The requirement for a definition of patient safety that is specific to the nursing discipline

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### AIM

To enhance nurse practitioners' understanding and engagement with patient safety by clarifying aspects of patient safety within everyday nursing practice

### BACKGROUND

- Nurses have a proportionate size and significant role within healthcare population
- Need for clarification of patient safety in nursing terms
- Research emerging nursing areas with safety issues and their relevant nursing interventions

### METHODOLOGY

A recent publication, that followed the umbrella review (review of systematic reviews or meta-analyses) (Rossiter et al., 2020) was selected. This paper reviewed systematically 16 systematic reviews that investigated the impact of person-centred care on patient safety between 2000 and 2019.

The **themes** that arose were:

- Investigation of **areas of nursing practice** that patient safety issues arise.
- Identification of **nursing processes** around patients/areas of care that need to be **mapped** against **safety-related outcomes**.
- Nursing processes must be **examined** for any or all indications of patients' characteristics reports, quality care metrics, other safety outcomes

### THE THREE THEMES LEAD TO THE CREATION OF 3 AXES

**AXIS 1**. What is harm for patients,

**AXIS 2**. How this harm can be eliminated or reduced and

**AXIS 3**. Which are the areas of nursing practice that are identified to provide opportunity for patient harm.

### PATIENT SAFETY DEFINITION

- Patients' unscheduled primary care visits,
- Hospitalisation, Emergency Room (ER) visits,
- Neuro-psychiatric symptoms (NPS),
- Patients' injuries, deterioration and mortality from unknown and known reasons *(Rossiter et al., 2020)*

AXIS 1

**Patient safety is the state in which harm to patients from nursing practice is eliminated or reduced so far as reasonably practicable through a continuing process of adverse effects' identification**

AXIS 2

**Nursing research** exploring and indicating innovative **nursing processes** to eliminate or reduce specified harm

AXIS 3

**Nursing research** investigating and identifying problematic safety-related **nursing practice** areas:

- *adherence with outpatient follow-up appointments and readmissions,*
- *patients' education, intervention, communication and resource support on acute illnesses and conditions,*
- *patients' infection rate (clinically acquired and clinically deteriorated),*
- *patients' falls and related injuries,*
- *pressure ulcers,*
- *Ventilator- Assisted Pneumonia (VAP),*
- *benzodiazepine, z-drugs and anti-psychotic medications management,*
- *medication errors (Rossiter et al., 2020)*

### HOW THE DEFINITION WILL HELP NURSES

- **Knowledge**, by giving nurses the **exact areas of care** they need to focus on
- **Self-awareness**, will enhance nurses' understanding of **risks** and will enable them to **evaluate** their own **performance** and be able to **predict outcomes** after own actions
- **Assertiveness**, will be **confident** and **empowered** to actively work on the **rectification** of the recognised **unsafe** clinical practise. This attribute will enable nurses to **oppose** imposed **pressure** and **avoid conforming** to norms that **contradict** with safe clinical processes

**Scan for open access paper**

Chatzi, A.V. & Malliarou, M. (2023). The need for a nursing specific patient safety definition, a viewpoint paper, International Journal of Health Governance, Vol. ahead-of-print No. ahead-of-print. https://doi.org/10.1108/IJHG-12-2022-0110

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# Clara Meehan and Cathal Kilcline

HSE Mental Health Services

Cúram Sláinte Phobail, Iarthar ag freastal ar Ghaillimh, Maigheo agus Ros Comáin | Community Healthcare West serving Galway, Mayo and Roscommon

## Consultation with individuals who avail of our services and those who support them

Clara Meehan, HSCP Lead, Galway/Roscommon Mental Health Services
Cathal Kilcline, Service User Representative, Galway/Roscommon Mental Health Services

### BACKGROUND

- The Roscommon Report (HSE, 2017) was an external review commissioned by the HSE. It set out 27 recommendations for service improvement/ development. This report highlighted the need for greater consultation with service users & family members as part of ensuring the continuity of care/ safe and effective care (p.29).
- The process of co-production was utilised in developing a framework for engagement with service users and family members. Co-production at an organisational level involves equal and active participation of service providers, individuals who avail of our services and their supporters in the planning, delivery and evaluation of the Mental Health Services (HSE, 2018). Empowering and enabling service users/family members to have their say also helps to create a positive safety culture (NHS, 2022).

### METHODOLOGY

- Co-produced questionnaires were developed in line with the Quality Framework in Mental Health (2006) to gain feedback from service users and family members on their experience of the service and identify areas of service improvement/development.
- A mixed method design was utilised in gathering the data e.g. paper format, interview in person/via phone or WebEx or electronic version distributed via email.
- The questionnaires requested feedback on services attended, information provision, access to therapeutic services and supports, waiting times, therapeutic relationships and family involvement/support.
- The PDSA (Plan, Do, Study, Act) cycle was used to enhance the tool and our approach for engaging with each individual team within the service.

### RESULTS & OUTCOMES

- 134 Service users and family members/carers engaged in the questionnaire from the acute unit, CMHT & training centres. The data gathered was uploaded onto Survey Monkey for data analysis. Eight key themes have been identified from the data and highlighted the need for:
  - Greater family engagement & support
  - More therapies & supports
  - Improved information on accessing the Mental Health Service.
  - A new acute inpatient unit with additional bed capacity.
  - A new crisis pathway/service.
  - Development of an electronic service user passport.
  - Embedding of the qualities required by health care professionals working in Mental Health.
  - Sharing of service user feedback regarding their experience of the training centres.

**KEY OUTCOMES**

1. Inclusion of the themes in the development of the local three-year strategy for the MHS in CHO2.
2. Development of a workplan to address the key themes in line with Sharing the Vision (2020) and the Patient Safety Strategy 2019-2024.
3. Enhanced collaboration between service users, family members and service providers.

### REFERENCES


- Health Service Executive (2017). Roscommon Mental Health Services: A report of a service review commissioned by the Health Service Executive.
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- National Health Service (2022) Safety culture: learning from best practice.
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Ms Suzanne Earls, Dr Conor White, Dr Nigel Salter

# Impact of Treatment Escalation Plans on Shared Decision Making

Ms Suzanne Earls, Dr Conor White, Dr Nigel Salter

## Background:

- One of the implications of the recently enacted Assisted Decision Making – (Capacity )Act has includes a statuary provision for the making and recognition of Advanced Care Directives.

- The International Liaison Committee for Resuscitation (ILCOR) and the European Convention for Human Rights have recommend that individuals with advanced illness/ multiple co-morbidities should be provided an opportunity to discuss emergency care and treatment plans with their Healthcare Providers.

- There have been a variety of such Emergency Treatment Escalation Plans developed internationally. In Ireland, most centres have focused on limitation of therapy in the form of DNA-CPR orders.


- Such strategies are akin to a STOP sign for treatment. A Treatment Escalation Plan offers an opportunity to ensure communication for ongoing treatment strategies that align with patient or service user's wishes as well as staff expectations and reducing harm, distress and enabling autonomy. In spite of recognition of need for such strategies in the National Consent Policy and the Slaintecare Report, there is no standardised national strategy currently in place in Ireland.


## Methods

- A systematic review was conducted to compare the impact of Treatment Escalation Plans vs DNA-CPR forms on shared decision making in adult patients with acute hospital presentations.

- The primary outcome assessed was impact on patient autonomy and shared decision making. Other outcomes assessed included impact on use of non-beneficial treatments including CPR, impact on harm and complaints. A search was conducted using relevant using PUBMED and CINAHL databases.

## Results

**The Bottom Line:**

- TEPs were observed to result in less harm to patients, their families and carers, especially with regard to commencement of non-beneficial interventions (including CPR) in patients aged 65 years and above with multiple co-morbidities vs DNA-CPR as well as in the absence of escalation planning.

-Stand-alone DNA-CPR forms were associated with more harm, indecision and complaints than TEPs.

## Discussion

- Outcomes for the Deteriorating Patient journey incorporate more decisions than mortality and unexpected cardiac arrest, but also consideration of other interventions, including ICU admission.

- TEPs incorporate shared decision making strategies considering all such outcomes.

- There are clear benefits from international literature of TEPs as a communication tool in shared decision making for patient deterioration.

- There is no standardised system for Treatment Escalation Planning in Ireland.

***When death is inevitable, the way that we die is important***

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