An Stiúrthóireacht um Ardchaighdeáin agus Sábháilteacht Othar
Oifig an Phríomhoifigigh Cliniciúil

National Quality and Patient Safety Directorate
Office of the Chief Clinical Officer

# The Role of Managers in Supporting Staff following Patient Safety Incidents

# Introduction

Welcome and thank you for taking the time to attend this important webinar.

Patient Safety incidents can have a detrimental impact on those involved, in particular the patient and their relatives and friends but also the staff who care for them. At the last webinar we covered the impact such events can have on staff and today we want to run through some points of consideration for managers who support staff through such events.

We know from the last webinar, where we referenced the INAES study, that an adverse event occurs in ~1 in every 8 acute hospital admissions. The research presented at the last webinar found that many healthcare professionals are likely to be involved in an adverse event at some point in their professional careers.

Being involved in an adverse event can be a stressful experience, especially after a very serious incident when someone has been seriously injured or there is loss of life, or where there is an associated investigation or legal process.

# Culture

## Ways Leadership can positively affect culture

- **Visionaries and strategic thinkers:** A boss tells you what to do, while a leader inspires you to want to do it. Leaders who lay out a vision that people buy into and a strategy that they understand will create a culture of engagement. People know where the organisation is headed, how it will get there and their role in helping achieve the vision.
- **Ethics that support values**: People look at what you do and not what you say. Values are words, ethics are actions. When leaders demonstrate values through their actions, they lead by example and create an ethical culture.
- **Empowerment:** Leaders who empower people to make decisions, give them the authority to act and carry responsibility will create leadership on all levels of the organisation.

Ways Leadership Affects Culture and Culture Affects Leadership | HR Exchange Network

# Culture


Patient safety and quality ecosystem and its constituent cultures vs. counter cultures.

Tan et al 2019

# The importance of culture

*"People make errors, which lead to accidents. Accidents lead to deaths. The standard solution is to blame the people involved. If we find out who made the errors and punish them, we solve the problem right? Wrong. The problem is seldom the fault of an individual; it is the fault of the system. Change the people without changing the system and the problems will continue."* - Don Norman, Apple Fellow

*"The single greatest impediment to error prevention in the medical industry is that we punish people for making mistakes"*

– Lucian Leape, Harvard School of Public health

*"It is through a Just Culture that we will begin to see, understand and mitigate the risks within the healthcare system"*

– David Marx, Outcome Engineering

# What is a Just Culture

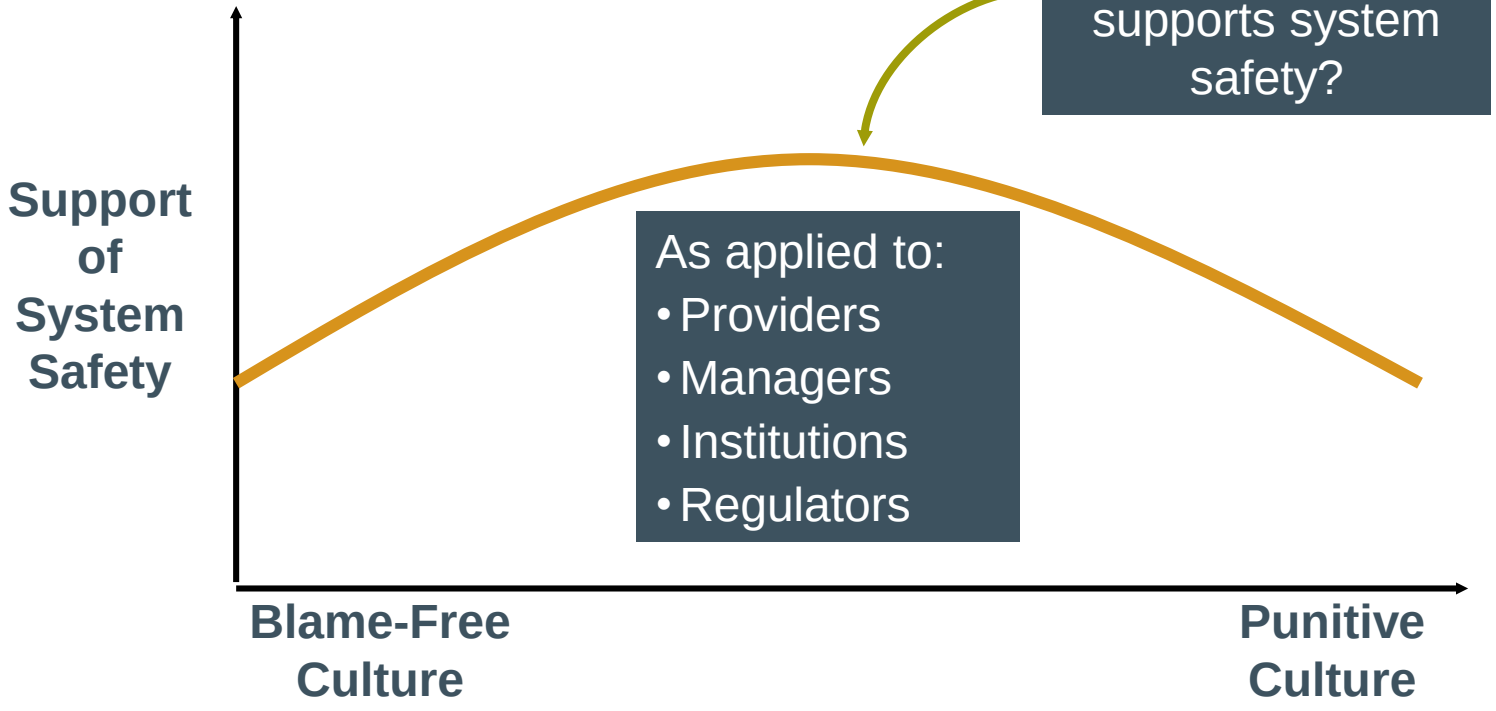
A values based supportive model of shared accountability (IMF 2020)

Proposes that:

- Individual Practitioners should not be held accountable for systems failings over which they have no control
- Does not absolve staff of the need to behave responsibly and with professionalism
- Does not tolerate conscious disregard of clear risks or professional misconduct
- Staff feel psychologically safe both to report errors and to ask for help when faced with an issue beyond their competence

# A "Just Culture" Answers

## The Problem Statement



# Just Culture

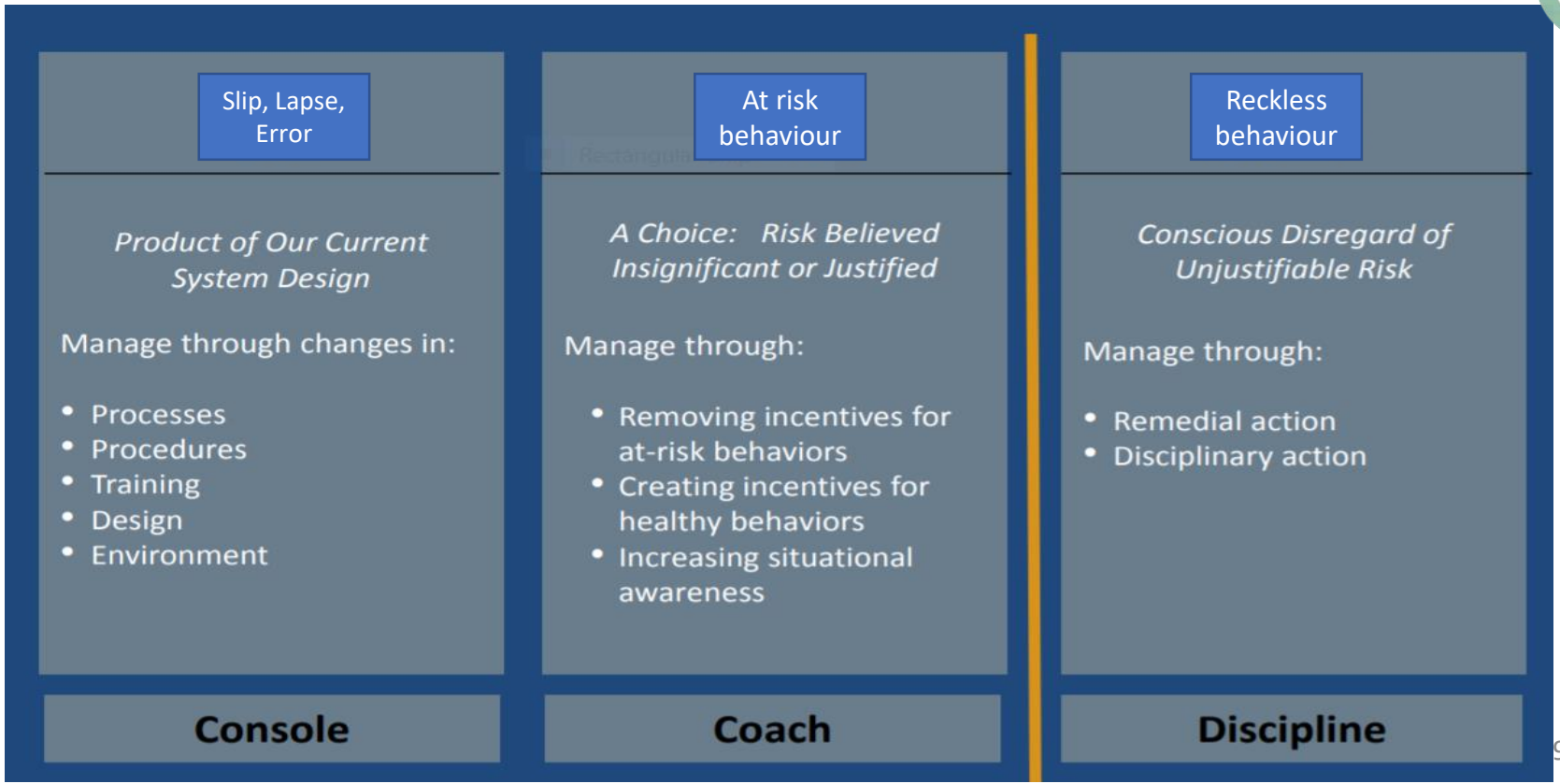
Ask what, not who, is responsible


[Annie's Story: How A System's Approach Can Change Safety Culture - Bing video]

Embraces those caught in faulty systems or processes

Reckless action = Accountability

# Just Culture



# Just Culture Guide HSE QPSIM website

| | | |
|---|---|---|
| **Start here – Q1. deliberate harm test** | | |
| **1a.** Was there any intention to cause harm? | Yes | **Recommendation:** Follow organisational guidance for appropriate management action. This could involve: contact relevant regulatory body, suspension of staff, referral to Gardai and disciplinary processes. Wider review is still needed to understand how and why service users were not protected from the actions of individuals. — End Here |
| **If No, go to next question – Q2. health test** | | |
| **2a.** Are there indications of substance abuse? | Yes | **Recommendation:** Follow HSE Policy and Procedure on the Management of Intoxicant Misuse. Wider review is still needed to understand if intoxicant abuse could have been recognised and addressed earlier. — End Here |
| **2b.** Are there indications of physical ill-health?<br>**2c.** Are there indications of mental ill-health? | Yes | **Recommendation:** Follow HSE policy for health issues affecting work e.g. Managing Attendance Policy and Rehabilitation of employees back to work after injury or illness policy, and the need to make a referral to occupational health. Wider review is still needed to understand if health issues could have been recognised and addressed earlier. — End Here |
| **If No to all go to the next question – Q3. foresight test** | | |
| **3a.** Are there agreed protocols/accepted practice in place that applies to the action/omission in question?<br>**3b.** Were the protocols/accepted practice workable and in routine use?<br>**3c.** Did the individual knowingly depart from these protocols? | If No to any | **Recommendation:** Action singling out the individual is unlikely to be appropriate; the patient safety incident review should indicate the wider actions needed to improve safety for future patients. These actions may include, but not be limited to, the individual — End Here |
| **If Yes to all go to the next question – Q4. substitution test** | | |
| **4a.** Are there indications that other individuals from the same peer group, with comparable experience and qualifications, would behave in the same way in similar circumstances?<br>**4b.** Was the individual missed out when relevant training was provided to their peer group?<br>**4c.** Did more senior members of the team fail to provide supervision that normally should be provided? | If Yes to any | **Recommendation:** Action singling out the individual is unlikely to be appropriate; the patient safety incident review should indicate the wider actions needed to improve safety for further patients. These actions may include, but not be limited to, the individual. — End Here |
| **If No to all go to the next question – Q5. mitigating circumstances** | | |
| **5a.** Were there any significant mitigating circumstances? | Yes | **Recommendation:** Action directed at the individual may not be appropriate; follow organisational guidance, which is likely to include senior HR advice on what degree of mitigation applies. The patient safety incident review should indicate the wider actions needed to improve safety for future service users. — End Here |
| **If No** | | |
| **Recommendation:** Follow organisational guidance for appropriate management action. This could involve individual training, performance management, competency assessments, changes to role or increased supervision, and may require relevant regulatory bodies to be contacted, staff suspension and disciplinary processes. The patient safety incident review should indicate the wider actions needed to improve safety for future patients. — End | | |

Extracted from the HSE Incident Management Framework (available at https://www.hse.ie/eng/about/who/nqpsd/qps-incident-management/ )

**Adapted from NHS Improvement (UK) with permission.**

# The six recognised stages associated with staff reaction in the aftermath of an adverse event

## Scott SD et al (2009)

**Chaos**

Error recognised

How/When

**Intrusive reflections**

Haunted re-enactments of event


**Restoring personal integrity**

Managing gossip

Fear


**Enduring the inquisition**

Realisation of seriousness

Who can I talk to?

**Obtaining emotional first aid**

Seeking personal and professional support


**Moving on**

- Dropping out (leaving profession)
- Surviving (coping)
- Thriving (learns from the event)

# The recognised staff response to patient safety incidents

Care should be taken to ensure that those staff who may be affected by an adverse event are identified as soon as possible and every effort made to provide appropriate practical and emotional support - both immediately post incident and in the longer term.

The following are examples of some of the symptoms which staff may experience in the aftermath of an incident.

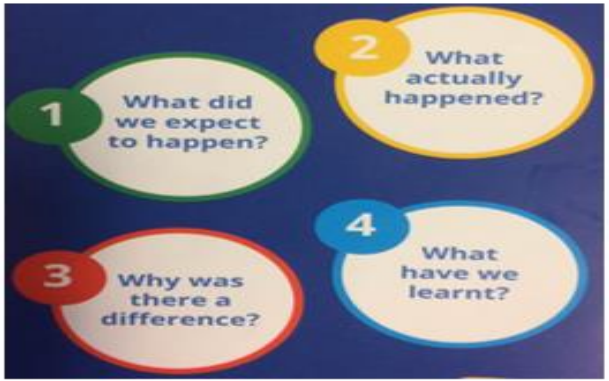
- Feelings of incompetence and isolation.
- Denial of responsibility – discounting of the importance of the event.
- Emotional distancing.
- Overwhelming guilt.
- Symptoms of post-traumatic stress
- An experience that is highly intense has the capacity to imbalance an individual at an emotional, cognitive and/or physical level.

# AAR and the immediate aftermath of an incident

## What is an After Action Review (AAR)?

AFTER ACTION REVIEW

- **A structured conversation for the purpose of learning**
- *AAR is most commonly used as a means of framing a structured facilitated discussion of an event that has occurred.*
- **4 Questions**
  - Expect?
  - Actual?
  - Why?
  - Learn?



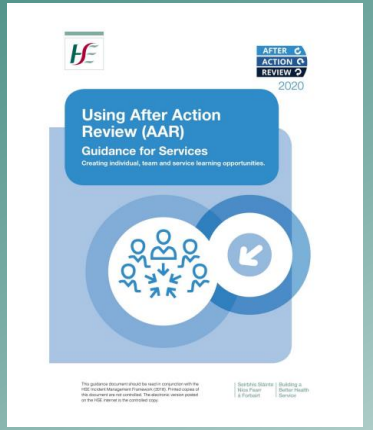

*HSE (2018) Using AAR – Guidance for Facilitators pg 2*

AFTER ACTION REVIEW

An Stiúrthóireacht um Ardchaighdeáin agus Sábháilteacht Othar
Oifig an Phríomhoifigigh Cliniciúil

National Quality and Patient Safety Directorate
Office of the Chief Clinical Officer

# AAR in the HSE




- People want to be involved in the process and view it positively as an opportunity to provide feedback and share experiences.
- It is inclusive with staff finding it a non-threatening process.
- AAR is efficient and responsive as a process which has a middle, beginning and end.
- It allows for timely explanation to service users
- AAR set timeframe i.e. over one session encourages participation and in particular facilitates clinical involvement.
- AARs are deemed as effective in identifying learnings
- AAR learnings are owned by staff, turning a negative experience into a positive experience
- AAR training, facilitation skills (managing the AAR group) and communication skills (reading a room/ensuring everybody has a voice) training are essential

RCSI

An Stiúrthóireacht um Ardchaighdeáin agus Sábháilteacht Othar
Oifig an Phríomhoifigigh Cliniciúil
National Quality and Patient Safety Directorate
Office of the Chief Clinical Officer

icaare

An Stiúrthóireacht um Ardchaighdeáin agus Sábháilteacht Othar
Oifig an Phríomhoifigigh Cliniciúil

National Quality and Patient Safety Directorate
Office of the Chief Clinical Officer


Opendisclosure.office@hse.ie
www.hse.ie/opendisclosure
@NationalQPS
#QIreland