What is Patient Safety?...

It depends who you ask...

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Methodology and methods

Units of Analysis Within the Case

- Senior ED nurses
- ED Registered Nurses
- Senior ED Doctors (Group 1)
- Senior ED Doctors (Group 2)
- ICU Nurses
- ICU Doctors
- Organisational Leads

ED → Sharp end
ICU → Blunt end
Participants

Focus groups (n=6)

• Senior doctors (n=31/55%)
• Senior nurses (n=18/32%)
• Nurses (n=7/12.5%).

Interviews (n=3)

• Senior executives (n=2)
• Middle Manager (n=1)
“The power or ability to provide safe patient care”
Anticipation and vigilance

“We can anticipate there are going to be problems”

(OM3)

“There’s a difference between efficient and effective care to speed. Speedy care is not what we are about”

(SEDRN1)

“very few things present like we’ve been taught they present in a text book.”

(EDSRR10)
Vigilant and anticipatory approaches to risk

**Sharp End**
- EWS
- Re-triage
- Near misses
- Simulation
- Debriefing
- Breaking rules

**Blunt End**
- Bed occupancy and patent acuity systems
- Measurement and metrics
- Incident reporting systems
- System and process
- Risk register
“Patients want to have confidence that you have staff, and they’re well trained and equipped to do the job.”

“We can’t just work in isolation”

“If the ducks don’t line up, then something will fall out of the sky.”
Firefighting: ‘Work as done’

“It’s not about winging it, it’s about relying on your intuition and a bit of gut feeling about how far we can stretch, and what wouldn’t be ideal if you were planning forward, but at that point in time is possibly your only solution”.

(ICUSRN2)
“Patient safety is on a continuum”

“The tipping point”
“We don’t actually learn from our mistakes, and that really worries me because we make the same mistakes all the time ….hand on the heart I can’t say this is not going to happen again.”

(EDSDR10)
Study Implications
Thesis access:
goo.gl/zcs1Ue

HOW HEALTHCARE PROFESSIONALS IN
ACUTE CARE ENVIRONMENTS DESCRIBE
PATIENT SAFETY: A CASE STUDY

by

JOANNA WALILING

A thesis submitted to the Victoria University of Wellington
in fulfillment of the requirements for the degree of
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“The rise in the number of events reported reflects the culture change taking place in health care, with greater emphasis on learning from systems failings.”

(HQSC Chair Professor Alan Merry 2015)
Healthcare professionals embrace patient safety

“(Patient safety is) about having the same message, the same understanding, the same brand, the same focus on what’s important”

(ICUSMO2)
What is patient safety?

“The reduction of risk of unnecessary harm associated with healthcare to an acceptable minimum.”

World Health Organisation (2009)
What is safety culture?

“The product of individual and group values, attitude, competencies and patterns of behaviour that determine the commitment to, and the style and proficiency of, an organisation’s health and safety programmes.”

(Advisory Committee in the Safety of Nuclear Institutions 1993)
Can you measure culture?

Culture is not a homogeneous whole. Conflicting subcultures with different history, language and behaviours may influence “the product of individual and group values, attitude, competencies and patterns of behaviour…”

(Keesing, 1987)

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<thead>
<tr>
<th>Component (Shein 2000)</th>
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<td>Espoused beliefs and values</td>
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What do we know?
CRITICAL INCIDENT TECHNIQUE

“A procedure for gathering certain important facts concerning behaviour in defined situations.”

(Flanagan, 1954 p. 355).
(Keesing,

CASE STUDY

“An empirical inquiry that investigates a contemporary phenomenon in depth and within its real-life context, especially when the boundaries between phenomenon and context is not clearly evident
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ED ➔ Sharp end

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"We can anticipate there are going to be problems"  
(OM3)

"There's a difference between efficient and effective care to speed. Speedy care is not what we are about"  
(SEDRN1)

"The inherent risk with pathways and guidelines is that the first step is recognition. If you don’t recognise something you’re never going to start the pathway. Now does that mean it’s unsafe if you don’t recognise it? well that’s open to debate because very few things present like we’ve been taught they present in a text book."

(EDSDR10)
Study implications – how to get from WAI – WAD need picture

**Work-as-Imagined** - a shared understanding of how work takes place

**Work-as-Done** - clinical work accomplished by those who are in direct contact with patients

While WAD always will differ from WAI, it is important to purposefully reconcile the two.  
(Hollnagel 2014)