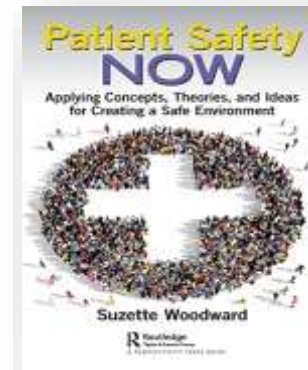
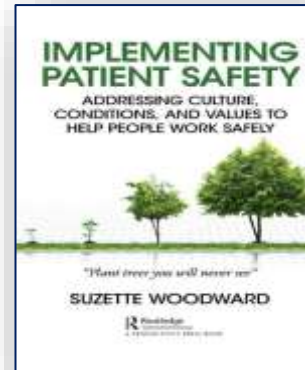


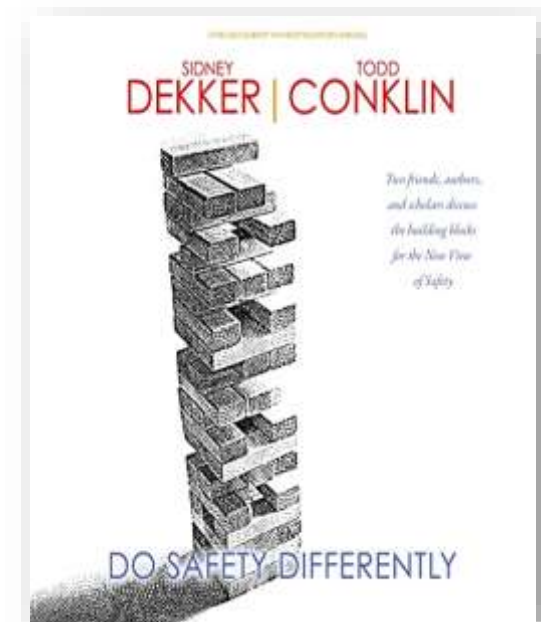
Patient safety, psychological safety and the doctors of tomorrow

Suzette Woodward



“Change happens through learning and when people are exposed to a new way of thinking.

The more individuals who are exposed to these new ideas the more there will be an increase in critical mass leading to impact”



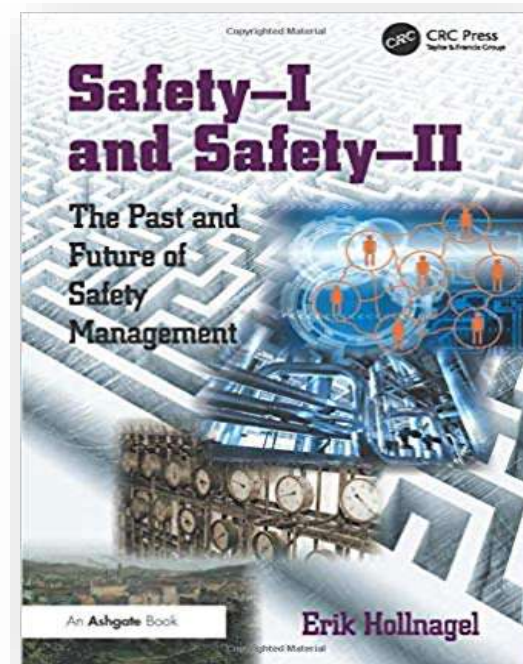
1. Look at safety differently

Safety I and safety II

There comes a point where we need to
stop just pulling people out of the river.
Some of us need to go upstream and
find out why they are falling in.

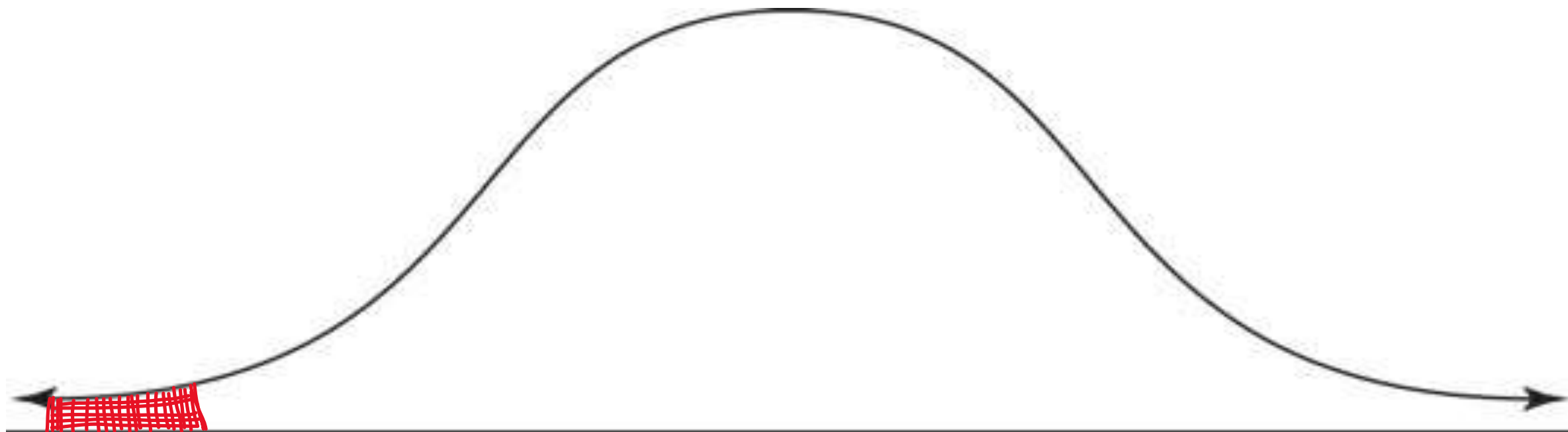
Desmond Tutu



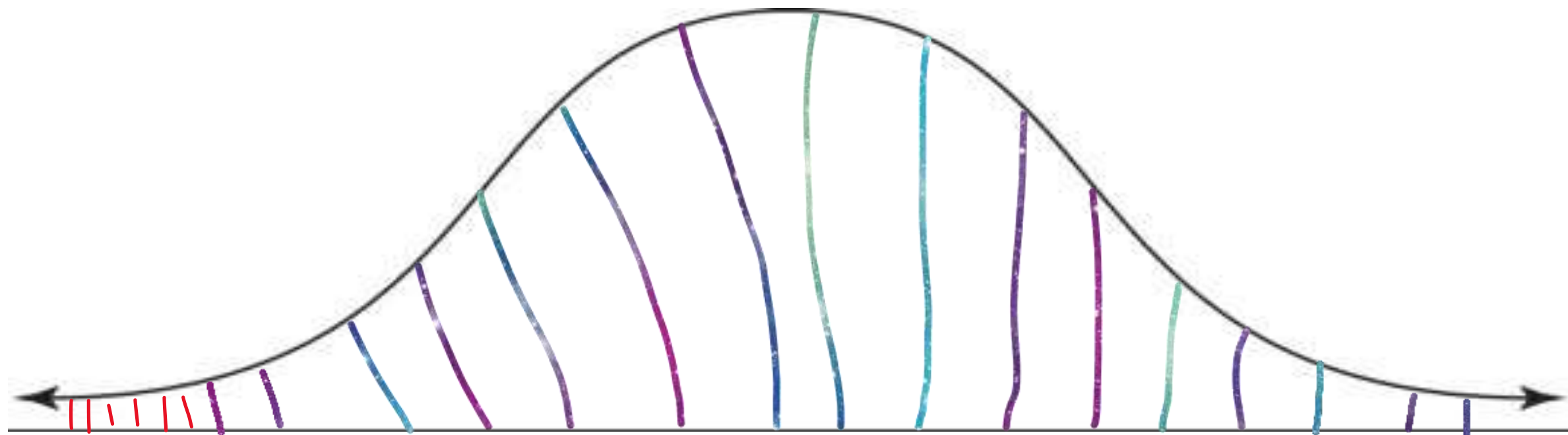


“You have to know the past to
understand the present”

Carl Sagan



What could go wrong almost
never does, but we don't pay
much attention to that



Safety-II is the study of both how things fail and how things work in order to improve what we do everyday

1. Look at safety differently

2. Understand the reality of people's
working lives

Work as done versus work as imagined.....

Safety as done versus safety as imagined.....

Healthcare is a complex adaptive system

A dynamic network of interactions with
people and processes acting in parallel
constantly reacting to other people and
processes

Three models of safety

Charles Vincent and Rene Amalberti.



Ultra safe systems

Risk is excluded as far as possible.
The model lends itself to regulation and supervision of the system to avoid exposing patients to unnecessary risk

process > people

An example would be delivering chemotherapy or radiotherapy.



High reliability systems

Risk is not sought out but is inherent in the job.

people = process

An example would be surgery, where there are both predictable processes and also clear inherent risk. The risk can often be mitigated for by skill, adaptability and control.

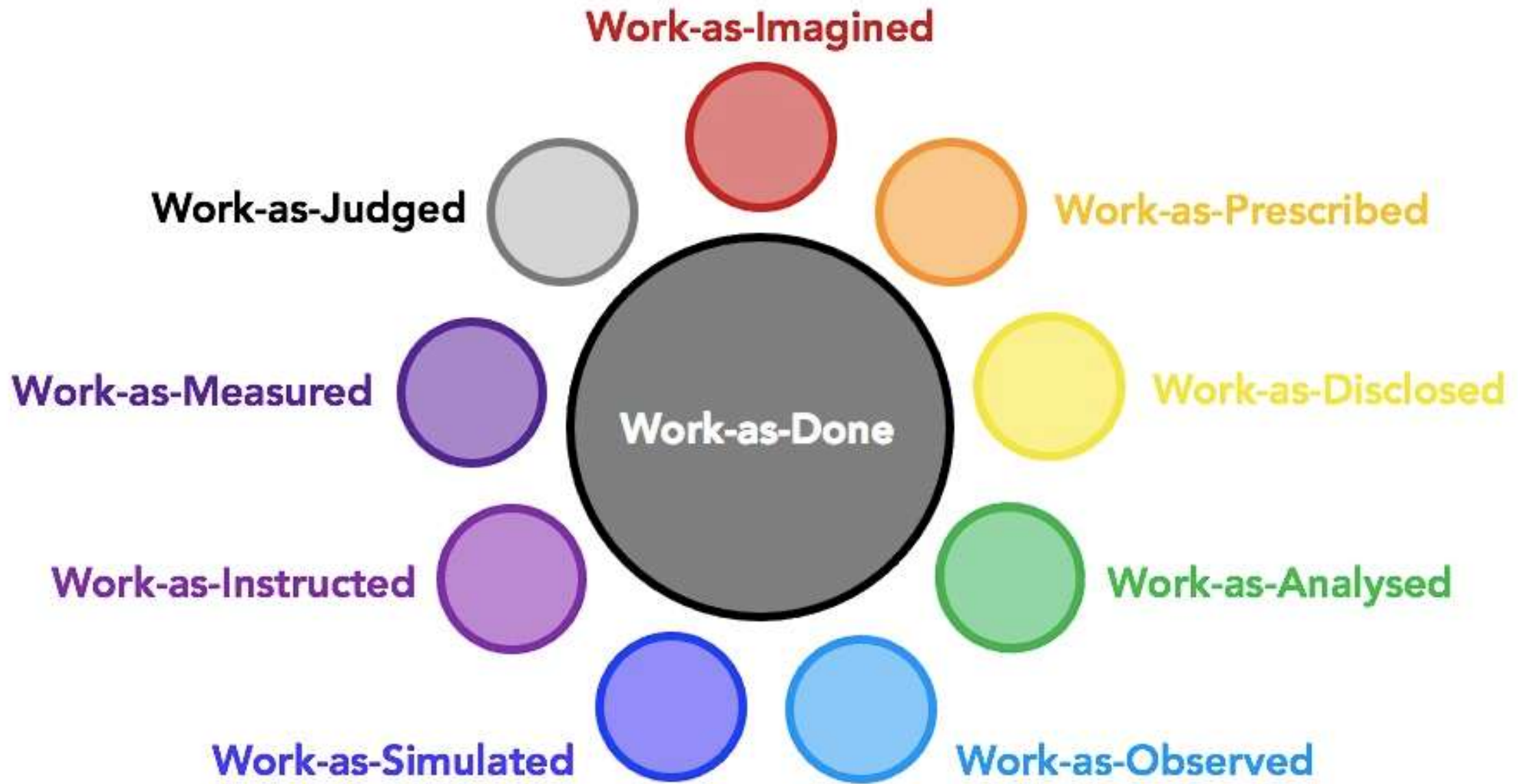


Ultra adaptive systems

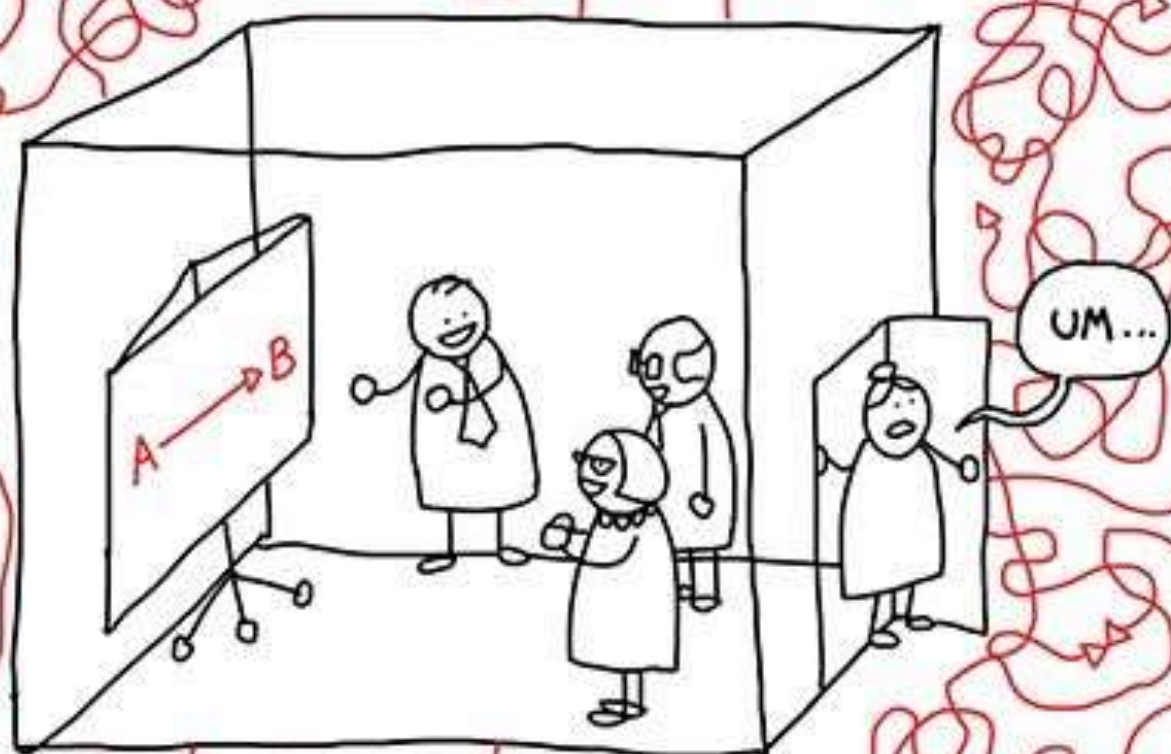
Risk is inherent in the system, and much of the skill is in people managing that risk moment to moment.

people > process

An example would be the emergency department, where staff have little control over what comes in and the situation changes from moment to moment.



humanisticsystems.com



LISTEN

Observe

- Video reflexivity can help illuminate context, culture, workarounds, social interactions, behaviours
- Study the mundane, the ordinary and unseen habits of work-as-done
- Examine what we don't see about what we do every day



1. Look at safety differently

2. Understand the reality of people's
working lives

3. Treat people with compassion

Restorative just culture.....

Quote from the Clapham Junction railway accident,
QC Anthony Hidden, 1989

"There is almost no human action or decision that cannot be made to look more flawed and less sensible in the misleading light of hindsight."

Five principles of human performance – adapted from Todd Conklin

1. Error is normal
2. Blame fixes nothing
3. Learning needs to be purposeful
4. How you respond matters
5. Context influences behaviour, systems drive outcomes

Fear

Blame

Shame

Burnout

Rudeness

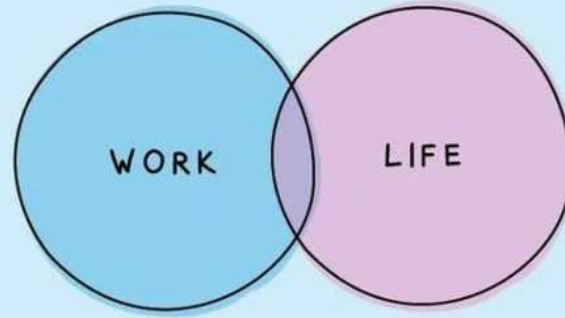
Fatigue

Incivility

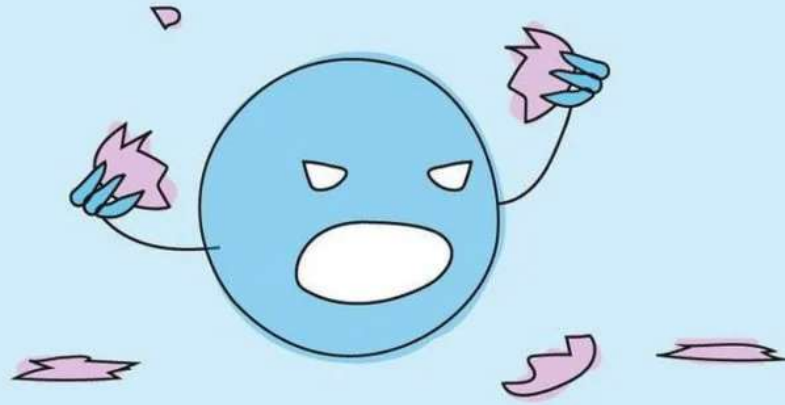
Hunger

Bullying

PRE - PANDEMIC



NOW

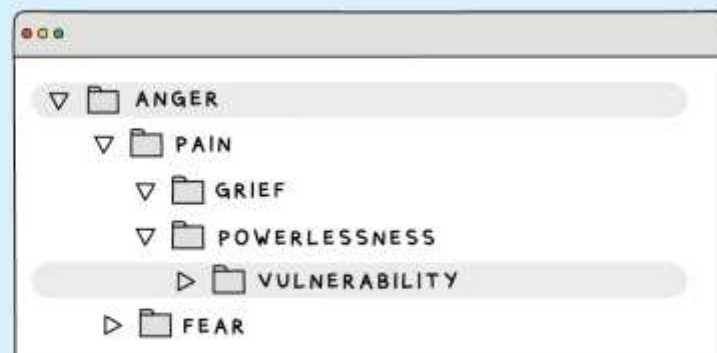


@LIZ AND MOLLIE

AT FIRST GLANCE



A CLOSER LOOK



Personalisation

It is absolutely all
my fault

Pervasiveness

It is going to ruin
every bit of my life

Permanence

I am going to feel
this bad forever

Restorative just culture



It costs nothing to be kind....



Meetings

Training
events

Handover

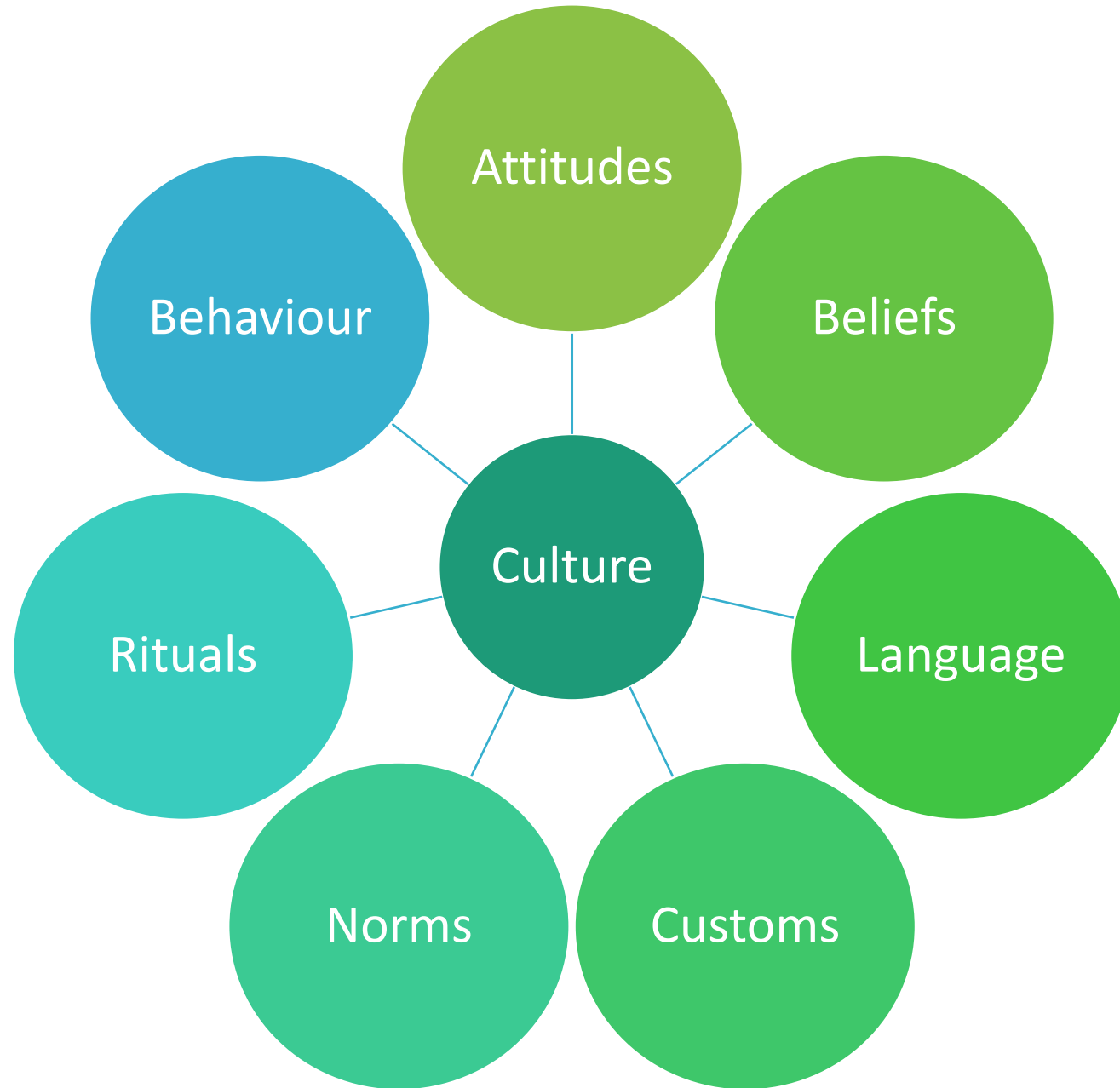
Briefing
and
debriefing

Huddles

Patient
Safety
Event
Reviews

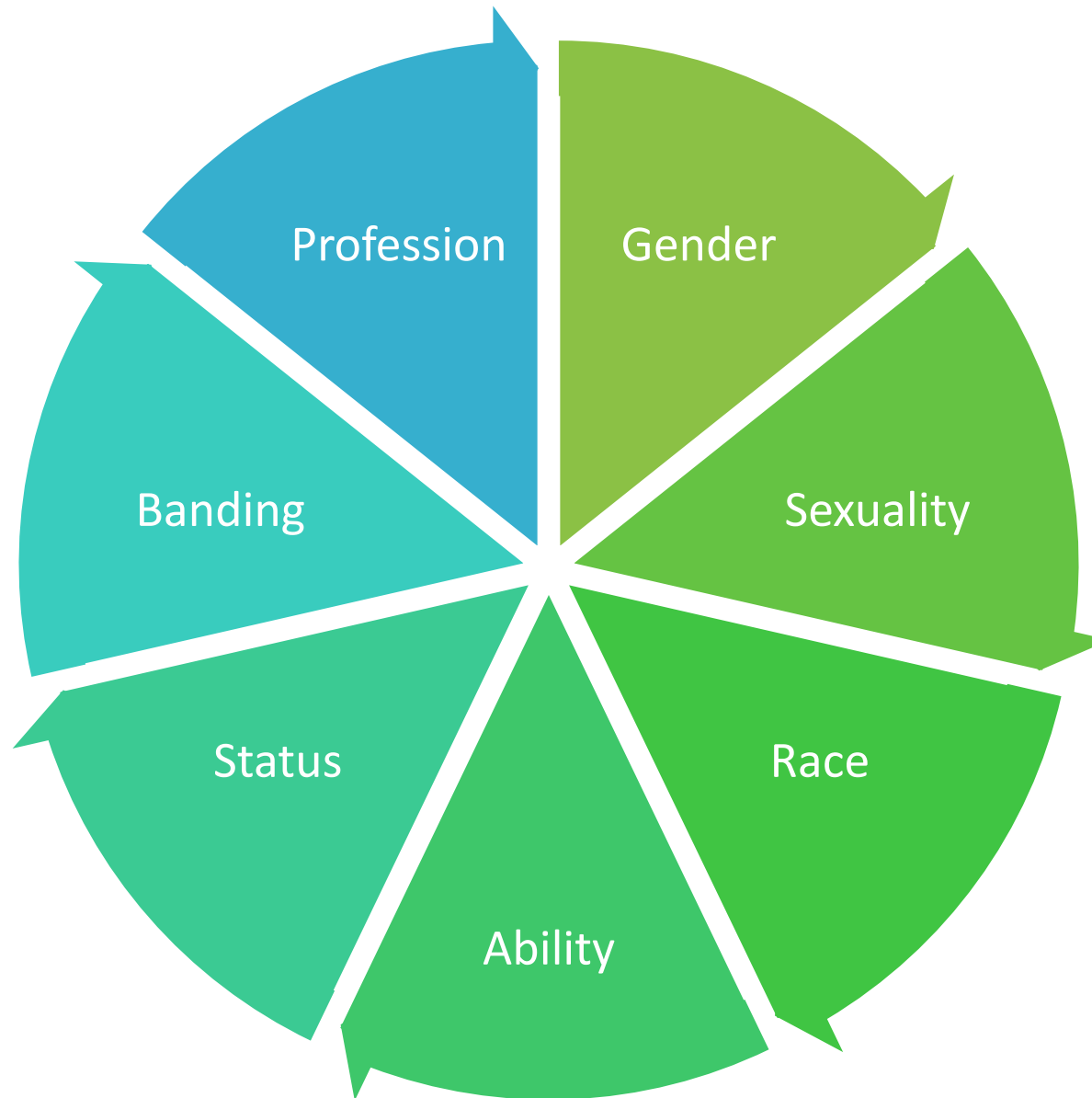
1. Look at safety differently
2. Understand the reality of people's working lives
3. Treat people with compassion
4. Build a culture where people feel accepted and respected

Psychological safety.....

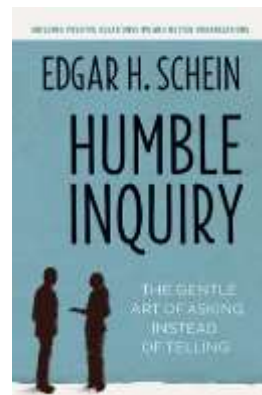


Diversity is having a seat
at the table, inclusion is
having a voice, and
belonging is having that
voice be heard.

@LIZ AND MOLLIE



“In most cultures, speaking up to a person of higher status is taboo. That’s why higher-ranking leaders must learn the art of humble inquiry and do the first step in creating a culture of openness. It is their duty as leaders”



Project Aristotle: 5yr study of 250 teams, 5 indicators of high performing teams

Psychological safety

Dependability

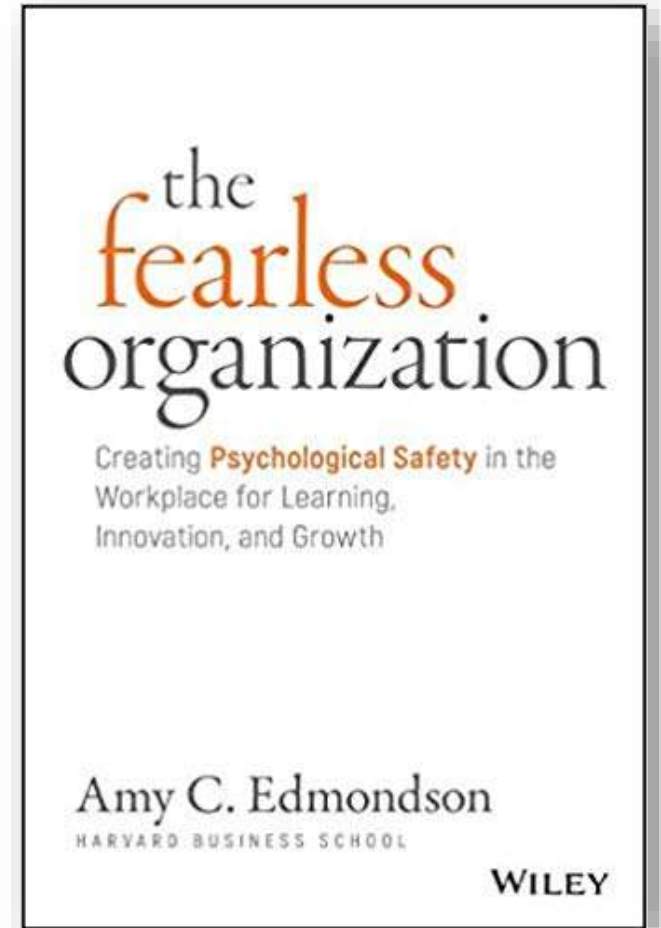
Structure and
clarity

Meaning of work

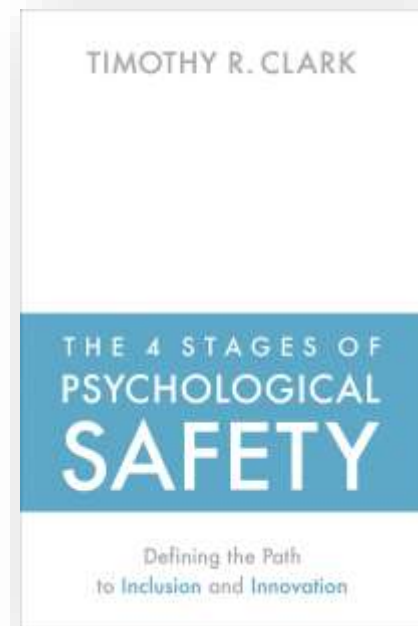
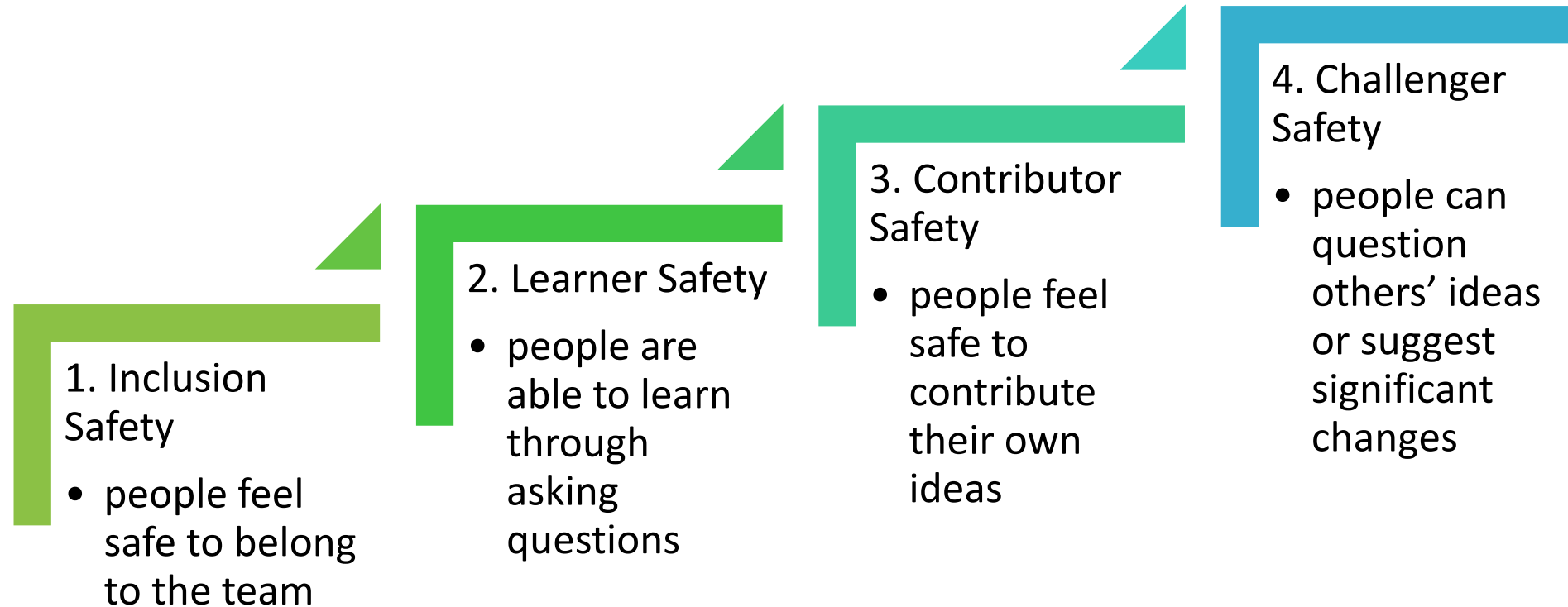
Impact of work

Psychological safety

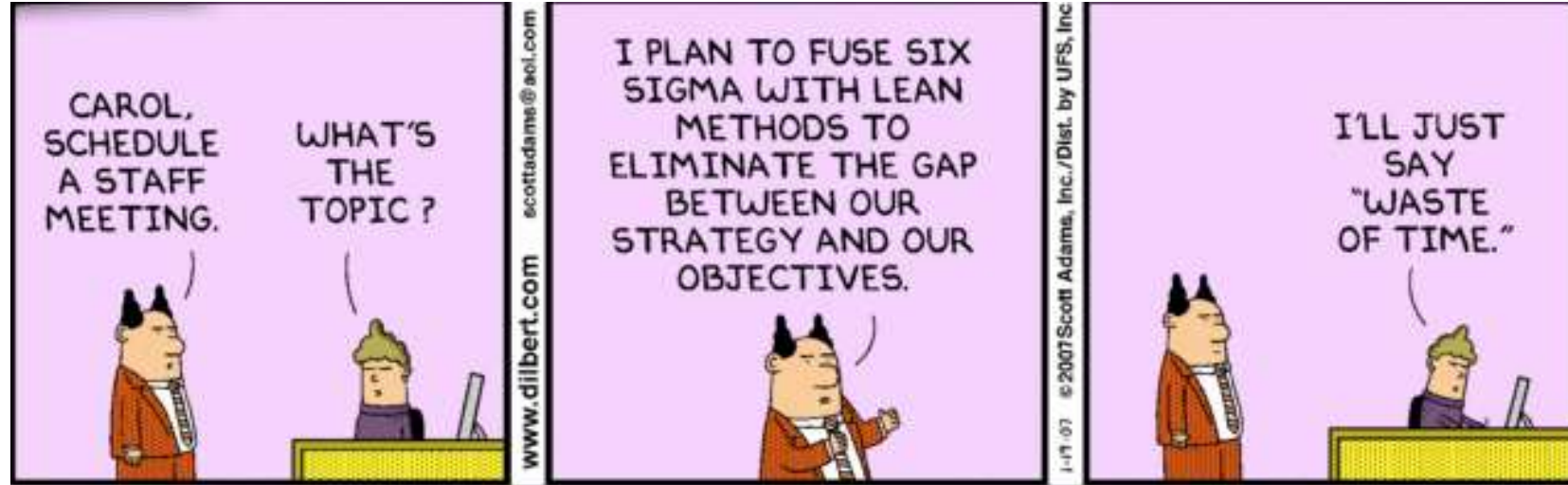
- A culture in which people feel accepted and respected
- Where they are able to challenge when they have concerns or questions
- Without any fear of repercussion



Four stages of psychological safety



1. Look at safety differently
2. Understand the reality of people's working lives
3. Treat people with compassion
4. Build a culture where people feel accepted and respected
5. Implementation

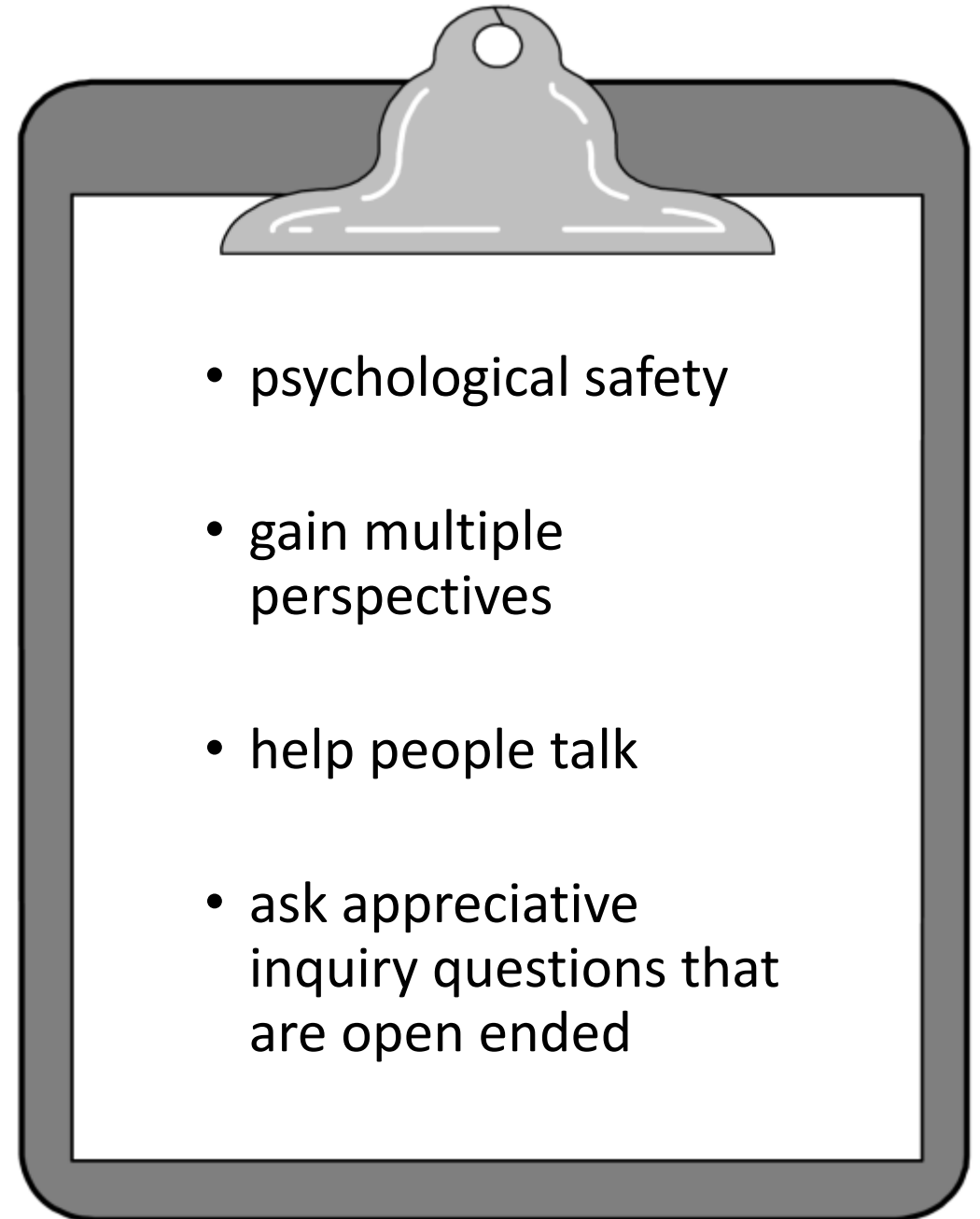


Plant trees you
may never see

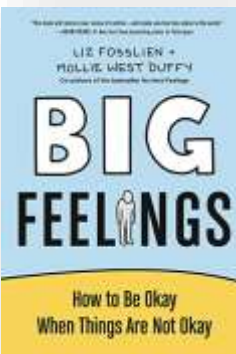
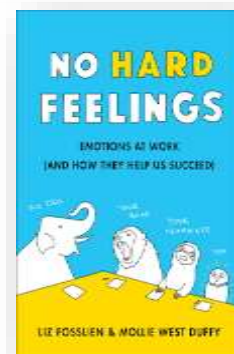
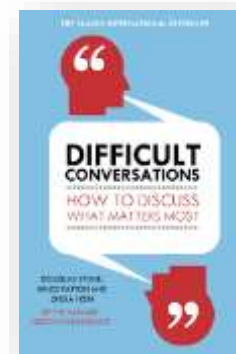
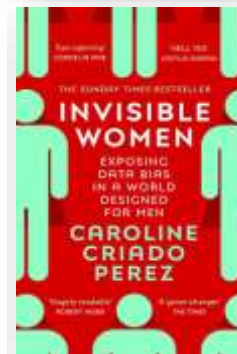
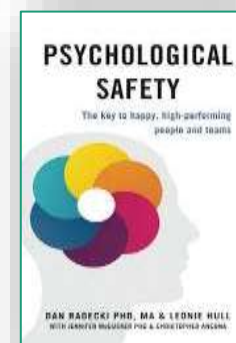
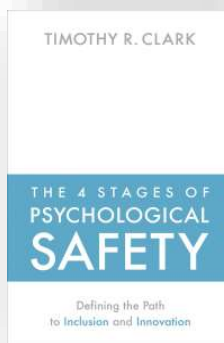
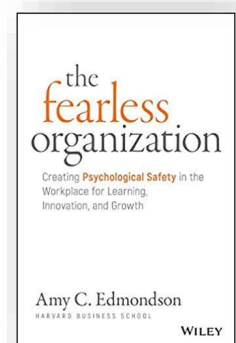
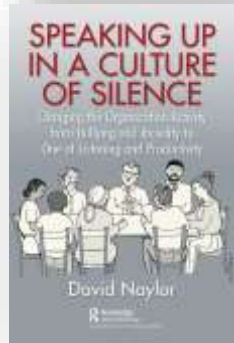
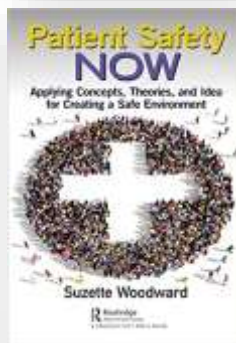
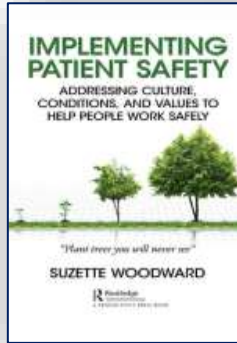
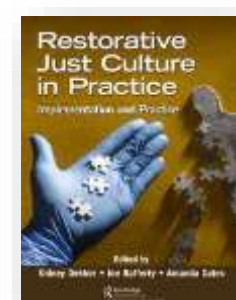
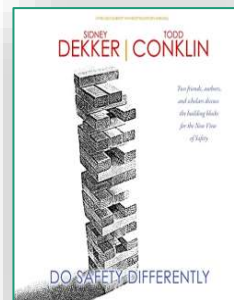
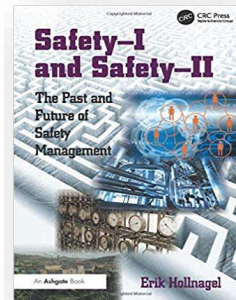
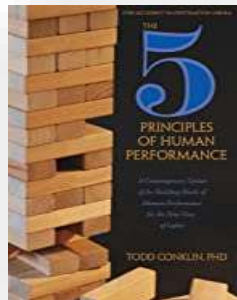
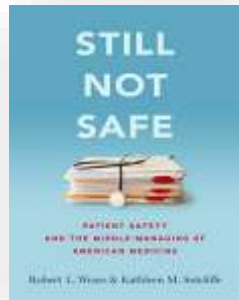


Ask the implementers

- Ask them about the realities of their work
- Listen to how this impacts on their daily work
- Explain 'why' not just 'what'
- Make it easy



The library



Toolkits

each baby counts + learn & support

A toolkit to promote psychological safety and clinical escalation

<https://www.rcog.org.uk/about-us/groups-and-societies/the-rcog-centre-for-quality-improvement-and-clinical-audit/each-baby-counts-learn-support/>



Supporting our staff: a toolkit to promote cultures of civility and respect

<https://www.socialpartnershipforum.org/sites/default/files/2021-10/NHSi-Civility-and-Respect-Toolkit-v9.pdf>

Videos

Make or Break: Incivility in the workplace ESTH 2019

<https://www.youtube.com/watch?v=S1EDatTYMkE>



Just Culture – The Movie
Mersey Care
Sidney Dekker

<https://safetydifferently.com/just-culture-the-movie/>



Healthcare is incredibly complex.
We need to **LEARN** from everything
we do, all the time – when things
GO RIGHT and when they don't



Because healthcare's
complicated, it's a
**DIFFICULT WORK
ENVIRONMENT**



Pressures, unhelpful cultures,
stress, incivility and bullying
make it harder to **WORK SAFELY**



Patients are safer when those around
them are **PHYSICALLY, PSYCHOLOGICALLY
AND EMOTIONALLY WELL**



They need to be fed, supported,
thanked, rewarded – even loved

Sign up to
SAFETY

SAFER CARE

IS ONLY POSSIBLE

IF

WE CARE FOR THOSE WHO CARE FOR PATIENTS



To help the
WHOLE SYSTEM
perform well,
we need to help
all **INDIVIDUALS**
perform well

Kindness and civility
needs to be encouraged
and expected

People need
the opportunity
to connect and
**FOSTER POSITIVE
RELATIONSHIPS**
that let them be
heard



We each have a part to play
in choosing the values and
behaviour that guide our
relationships, and we each
have the power to **SUPPORT
THE PEOPLE WE WORK WITH**

