People at the Centre of Health and Care

Person-Centred Health and Care Collaborative

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OVERVIEW

Why are we all here? Josie's story

1. HUMAN FACTORS

-Define and explain systems approach

2. LEADERSHIP TED talk

-Psychological safety
- Collective leadership

3. CULTURE

-Normalised deviance
-Just culture

4. LEARNING Annie's story

Significant Event Analysis tool

Josie's Story

A person centred culture could change our system

http://vimeo.com/24841615

Over to you...

1. How might a culture that lived person centred values have been able to counter some of these problems?

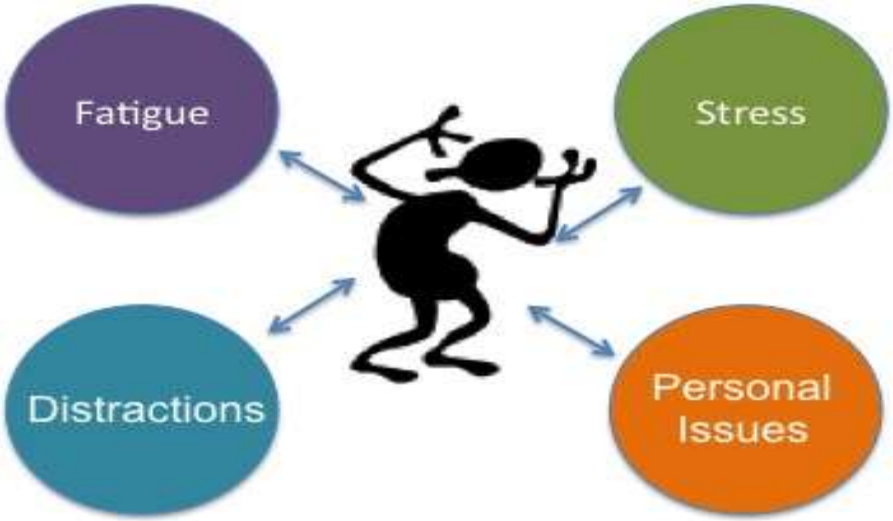
2. What can you do to make a difference to start to bridge that gap?

1. HUMAN FACTORS

Human Factors defined

The science of human factors (HF) seeks to understand how to optimise:

- the way individuals behave
- the teams work together
- the way equipment and settings are designed, and
- how organisations function.



Some key principles

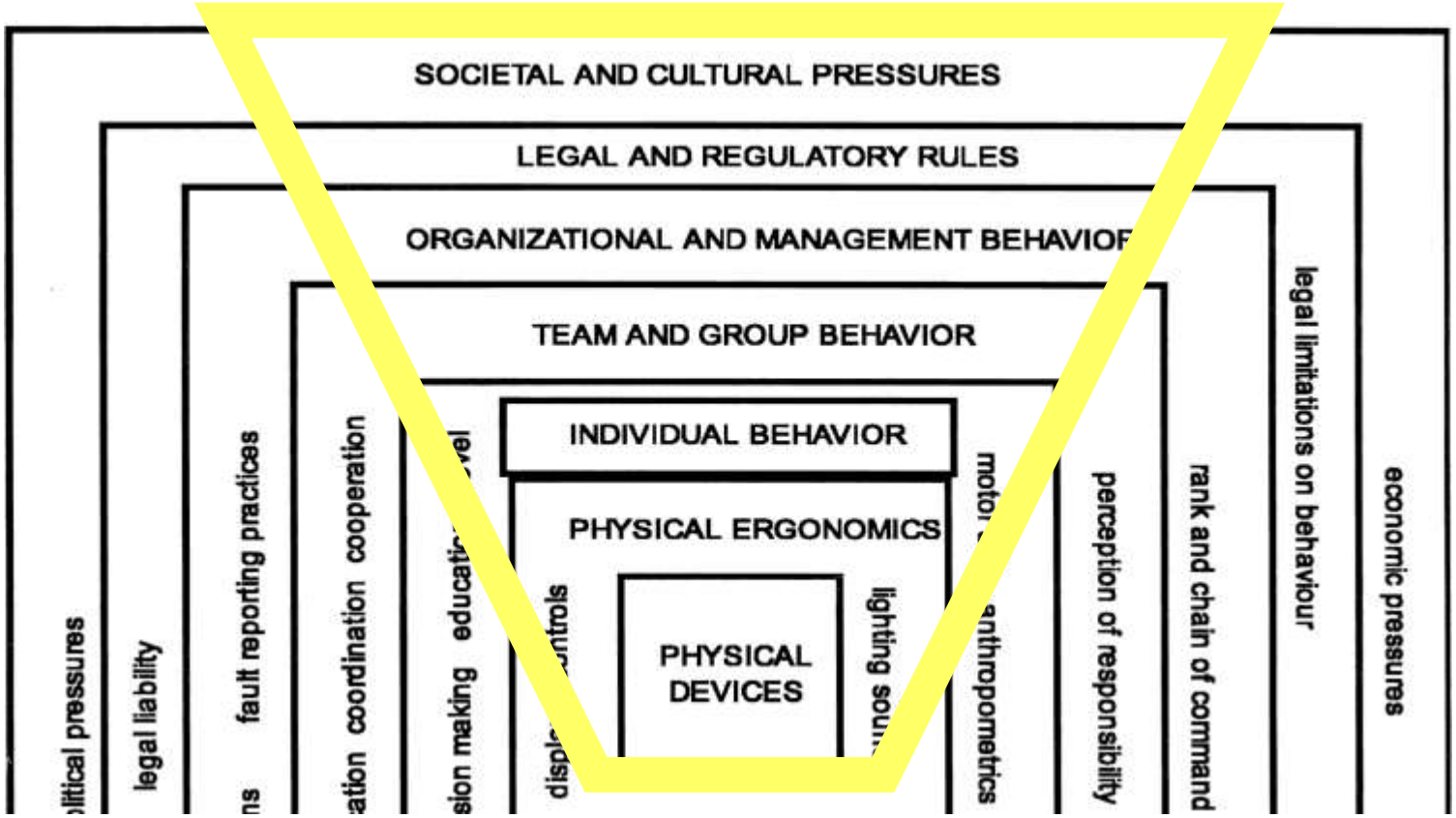
- Systems determine the success or failure of those individuals that work within them

- Leaders play a key role in understanding where risks lie and where change is needed

- Culture must allow for people to challenge the status quo and feel free to report errors

- Learning must happen at all levels and support new ways of working

The System

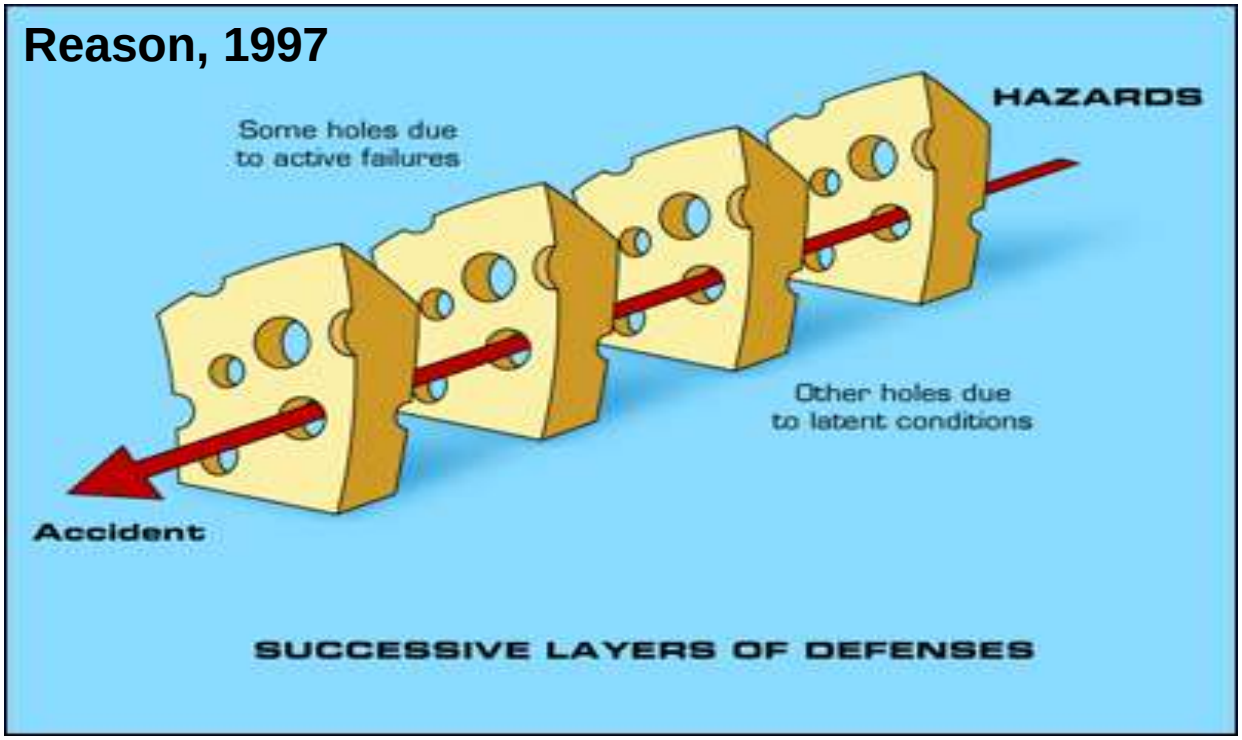


'The problem is seldom the fault of an individual; it is the fault of the system. Change the people without changing the system and the problem will continue.' (Don Norman, 1988).

Human Factors theory

The organisational accident model shows how defences within a system, or what we put in place to stop bad things happening, can fail.

When errors all line up, then there will be an accident. HF methods can help us learn about how we recover from error chains once they begin and how we can feed this knowledge back into the design of our processes



- **Active failures**
- **Latent conditions**

2. LEADERSHIP

Psychological safety

‘A shared belief that the team is safe for interpersonal risk taking’

(Edmondson, 1999)

Team members feel accepted and respected so that they:

-Ask questions
-Admit mistakes
-Raise issues
-Offer ideas

-Seek assistance
-Escalate problems
-Listen intently
-Open to others opinions

‘Psychological safety does not imply a cosy environment in which people are necessarily close friends, nor does it suggest an absence of pressure or problems. Rather, it describes a climate in which the focus can be on productive discussion that enables early prevention of problems and accomplishment of shared goals, because people are less likely to focus on self-protection ’ (Edmondson, 2003)

Collective leadership

'Everyone taking responsibility for the success of the organisation as a whole – not just for their own jobs or work area.' (Kings Fund Report, May 2014)

It requires high levels of dialogue, debate and discussion to achieve shared understanding about quality problems and solutions.

"When a leader makes the choice to put the safety and lives of the people inside the organisation first, to sacrifice their comforts and sacrifice the tangible results **so that the people remain and feel safe and feel they belong**, remarkable things happen!"

(Simon Sinek, 2014)

Why good leaders make you feel safe

A leader who “walks the walk” could change our system

http://www.youtube.com/watch?v=lmyZMtPVodo

Over to you...

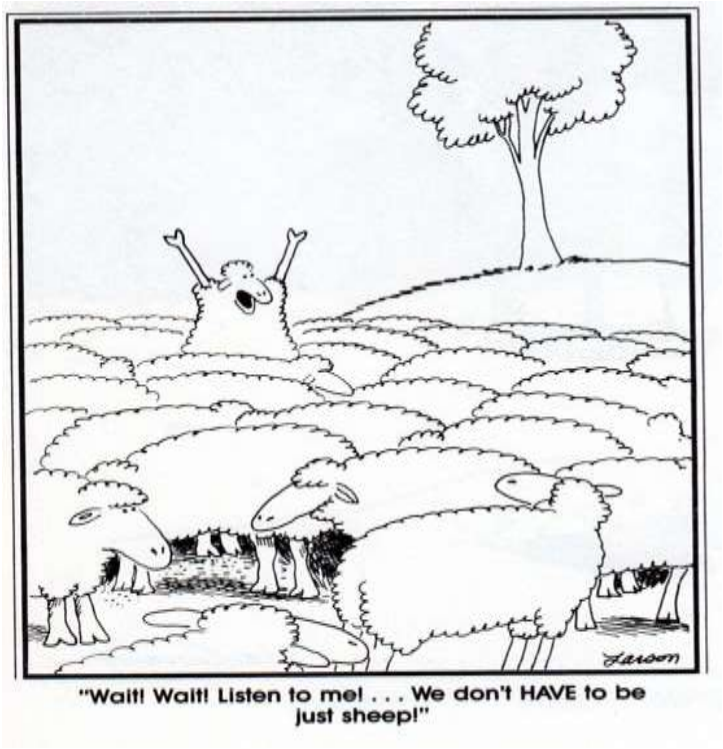
1. How psychologically safe do you feel at work?
   - What factors impact on this and make it better or worse

2. How can you change your own approach to others in order to ensure you are promoting openness and psychological safety?

3. CULTURE

Organisational Culture

- norms of behaviour – what people usually do
- “the way we do things around here”
- How we behave when no-one is watching



Changing culture

“To create new norms, you have to understand people’s existing norms and barriers to change. You have to understand what’s getting in their way”

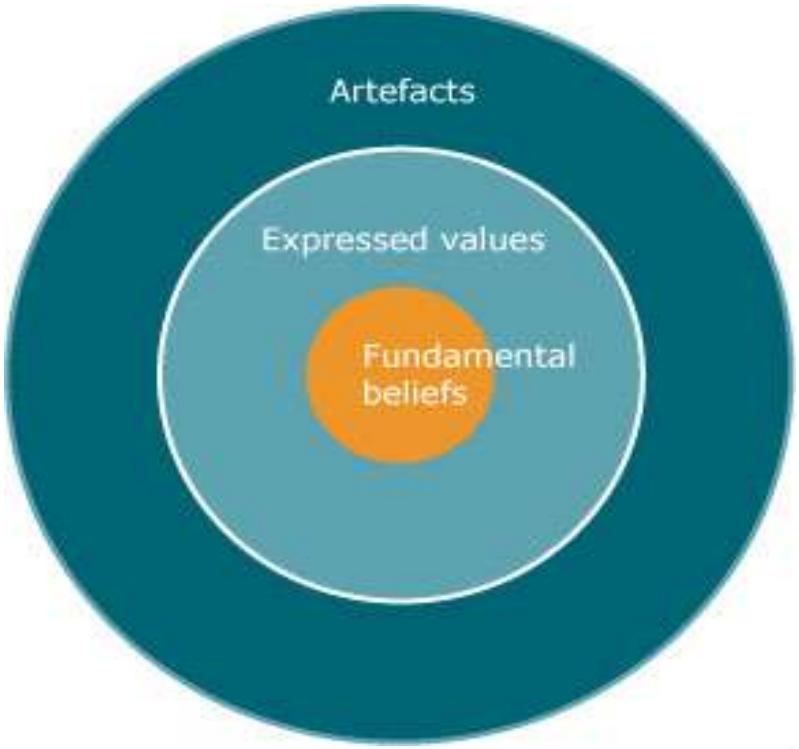
~Atul Gawande

Levels of culture

Artefacts – “the things we see”, e.g. the way people dress at work

Values – “the things we say”, e.g. what the strategies say about us

Beliefs – “the things we think and feel”, e.g. what really drives us



Schein, 1990

Normalised deviance

‘The gradual process through which unacceptable practice or standards become acceptable or normal’

(Hall, 2003)

“work around” becomes the norm because policy or protocols do not fit the work processes or tasks performed

(Banja, 2010)

‘...expecting strict adherence to safety standards before addressing the relevant systems issues would be a mistake’

(Wachter, 2009)

Just culture

'A just culture is meant to balance learning from incidents with accountability for their consequences. All the current proposals for just cultures argue for a clear line between acceptable and unacceptable behaviour.' (Dekker, 2008).

BEHAVIOUR	Chose it?	Saw the risk?	Duty?
Human Error	NO	NO	Console
At Risk Behaviour	YES	NO	Coach
Reckless Behaviour	YES	YES	Punish

'Most errors are innocent slips committed by competent and committed caregivers and are best dealt with by focusing on improving systems rather than people.' (Wachter, 2009).

Blame culture

Fear
Vulnerability
Shame
Competition
Silence
Obstruction
Power
Bullying
Lying
Denial
Risk averse
Insecure

"This organization has a blame culture. And that's all Jeremy's fault."

Person centred culture

Compassion and kindness, to enable well being

Flexible and empowering culture and system

People in relationship

Trust, respect and empathy

Equality, mutuality and individuality

4. LEARNING

Significant Event Analysis (SEA)

- Long history of incident analysis tools in safety critical industries and benefit of systematic approach

- *Things to be aware of*:
  - Cognitive biases
  - Group think
  - Emotional impacts, “second victim”
  - Witness memory degradation

The use of tools like SEA may aid a culture transformation from normalisation of deviance to **normalisation of incidents**, where *reporting, investigating and acting on incidents* takes into account the dynamic system and both active and latent conditions.

Three areas of focus (SEA tool)

PEOPLE	ACTIVITY	ENVIRONMENT
Individual e.g. skills, attitude **Team** e.g. roles, support **Patient** e.g. clinical, social **Others** e.g. other health and social services	**Complexity of work process or task** e.g. Clear, accessible, up to date procedures **Design** e.g. complexity, workload **Equipment** e.g. access, usability	**Work setting** e.g. staffing **Organisational** e.g. culture **Communication** e.g. formal/informal **Education and Training** e.g. supervision **Societal, Cultural and Regulatory Influences**

The team based process (SEA tool)

- Awareness
- Multidisciplinary team
- Information
- Meeting itself
- Documentation
- Express any concerns *BEFORE* and also conflicts of interest
- Use SEA tool as a group
  - **People, Activity, Environment**
- Reporting
- Dissemination

Annie's Story

Considering how a just culture could change our system

http://www.youtube.com/watch?v=zeldVu-3DpM

Over to you...

1. What are the factors that need to be in place to move us from the blame to learning?

2. Who needs to know more about human factors and the systems approach to make progress?

TAKE HOMES

- *Systems approach*
- *Psychological safety*
- *Collective leadership*
- *Normalised deviance*
- *Just Culture*
- *Incident Analysis*

- **The SEA tool**

www.nes.scot.nhs.uk

A quick guide to conducting a SEA

- **QI Hub web pages**

www.qihub.scot.nhs.uk

A range of current resources and references

- **Twitter...**

#humanfactors #systemsthinking #design @drjeffcott @markjohnston71 @martinbromiley @scotsimcentre @DrCJohn

CALL TO ACTION! ☺

What will you pledge to do differently when you go back to work as a result of today's session?