SPSP Mental Health Learning System Webinar

Safety Climate: What is it, why is it important and how do you improve it?

Thank you for joining: this event will begin at 13.00
In the meantime, please introduce yourself in the chat.

@SPSP_MH
#SPSPMH
Dr Jane Cheeseman
National Clinical Lead
Healthcare Improvement Scotland
Housekeeping

During the meeting please have your microphone on mute and video turned off. This will avoid distraction and minimise the likelihood of slowing down the technology.

There will be opportunities for Q&A in the planned session. Please pop all questions in the chat box.

Some of this session will be recorded.

If you require any technical support please pop in the chat box or contact his.mhportfolio@nhs.scot.
• Importance of safety climate
• How to measure and improve safety climate
• How Greater Glasgow MH Network have used the SPSPMH Patient Safety Climate Tool
• Launch of the new SPSPMH Safety Climate resources
The following section of the webinar will be recorded.

If you don’t want to be included in the recording, please ensure your camera is off.
Safety Climate: What it is, Why it is Important and How do you Improve it?

Paul Bowie
- Programme Director (Safety & Improvement)
- Twitter: @pbnes  Email: paul.bowie@nhs.scot
Session Purpose

• Rapid high level overview:
  – Safety Culture?
  – Culture or Climate?
  – Measurement
  – Practical Safety Culture Discussions
  – How to ‘Improve’?
Background – Safety Culture

• First used after Chernobyl nuclear power plant accident

• Explains everything people could not explain or otherwise understand in the safety domain!!

• Strong agreement
  – +ve – openness, transparency & commitment to learn
  – -ve – contributory factor in incidents and accidents

  – To improve care performance and staff well-being - focus on the cultural context of work
Culture or Climate?

- **Safety Culture** *(more deep rooted)*
  - ...refers to individual and group “...*values, attitudes, perceptions and patterns of behaviour that determine their commitment to workplace safety management*”
  - ...*"the way things are done around here”*

**Safety Climate** *(transient)*
- The measurable ‘surface’ components of safety culture... a ‘snapshot’ of culture at a moment in time.

- ‘Culture’ and ‘Climate’ used interchangeably.
“...that assembly of characteristics and attitudes in organisations and individuals which establishes that as an overriding priority, patient safety issues receive the attention warranted by their significance”

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

“What people at all levels in a team/organisation do and say when their commitment to safety is not being scrutinized”
Humorous Definitions

“The idea of ‘culture’ is perhaps similar to that of ‘intelligence’ – everyone thinks they know what it is, but conceptual clarity is more elusive”

[Catchpole, 2014]

“...it has the definitional precision of a cloud...”

[Reason, 2007]
Influence of Safety Culture in Healthcare

- Leadership influence
- Positive culture - learn openly and effectively from system failure
- Influences the priorities of the workforce at all levels and helps to shape their discretionary attitudes, behaviours and performance.
- High-profile care failures, a sub-optimal safety culture was implicated
  - e.g. Stafford hospital (high mortality rates from emergency admissions),
  - Bristol Royal Infirmary (high infant surgical mortality rates); and
  - Vale of Leven hospital (deaths associated with *Clostridium difficile*).
Differences in +VE versus –VE Organisational Safety Cultures

- Senior commitment
- Mature, stable workforce
- Good personnel selection, retention, promotion options
- Thoroughly investigating all safety incidents and near misses
- Accepting safety culture is a long-term strategy
- Regularly assessing safety culture and improving safety behaviours.
- Good induction and follow-up safety training
- Ongoing schemes schemes reinforcing the importance of safety
- Regular auditing of safety systems to provide feedback
- Capturing attitudes towards incident reporting and analysis
Organisational Culture

Safety Culture

Open Culture
Reporting Culture
Learning Culture
Informed Culture
‘Just’ Culture

• Psychological Safety
• Psychosocial Safety
• Organisational Support

Dominant Construct In High Risk, Safety-Critical Industries
Assessing Safety Culture / Climate

- Safety culture ‘measurement’ originated in high-risk industries
- Multiple ‘measurement’ surveys for healthcare
  - Quantitatively
    - typically using self-report questionnaires anonymously.
    - Assumption can link to care outcomes
  - Qualitative:
    - Manchester Patient Safety Framework (MaPSaF)
    - Safety Culture Discussion Cards
Common Safety Culture Domains

- Leadership
- Management/Supervision
- Team working
- Workload
- Safety Systems
- Communication
- Openness
- Handovers

- Staffing
- Organisational learning
- Stress recognition
- Work conditions
- Job satisfaction
- Managing risk
- etc
Perceived Benefits of Safety Climate Measurement

- Increases individual awareness of safety-related conditions and behaviours
- Enables the care team to ‘diagnose’ their prevailing safety climate
- Identifies relative strengths and weaknesses in comparison to other practices,
- Facilitates action to build a stronger, more positive local safety culture
- Participants can compare and evaluate progress over time (e.g. 18-24 months)

- Holy Grail – link to outcomes
The most rigorously tested/well-known tools:

- Safety Attitudes Questionnaire
- Patient Safety Culture in Healthcare Organisations
- Hospital Survey on Patient Safety Culture
- Safety Climate Survey
- Manchester Patient Safety Assessment Framework
- [GP-SafeQuest – NES]
Note of caution

Inadequate development

Acting on feedback

Link to outcomes?

Limited impact

So what?

Assessing safety climate in acute hospital settings: a systematic review of the adequacy of the psychometric properties of survey measurement tools

Gheed Alsalem1,3*, Paul Bowie2 and Jillian Morrison1

Measuring perceptions of safety climate in primary care: a cross-sectional study

Carl de Wet1, Paul Johnson, Robert Mash, Alex McConnachie, Paul Bowie

A Systematic Review of Measurement Tools for the Proactive Assessment of Patient Safety in General Practice

Lydon, Sinéad PhD†; Cupples, Margaret E. MD‡; Murphy, Andrew W. MD§; Hart, Nigel MD†; O’Connor, Paul PhD†;
A Different/Complimentary Approach?
Safety Culture Discussion Cards

NHS Education for Scotland

Introduction

What Is Safety Culture?
Safety culture can be described as our:

1. Values
   What is important
2. Behaviours
   The way we do things around here
3. Beliefs
   How things work

Safety culture has been shown to be a key predictor of safety performance in several industries. It is the difference between a safe organisation and an accident waiting to happen. Thinking and talking about our safety culture is essential for us to understand what we do well, and where we need to improve.

These cards are designed to help us to do this.
Purpose of Discussion Cards

• Get people talking!
• No answers, but raise questions!
• Build on what care teams already know and experience
• Encourage discussions to learn about and improve SC
• c80 Cards,
  – c10 guiding/explanatory,
  – 70 discussion cards,
  – 8 themes
• Aim to be straightforward and practical
Organisation of Cards

1. Leadership & Management Commitment
2. Resourcing
3. Just Culture, Reporting & Learning
4. Risk Awareness & Management
5. Teamwork
6. Communication
7. Responsibility
8. Involvement
Some Examples of Cards / Questions / Prompts

Just Culture, Reporting and Learning

Avoid the Blame Game
When people report safety-related occurrences, are they blamed or treated in a just and fair manner?

How people are treated when they report safety related occurrences, including ‘normal errors’ is a test for the just culture of an organisation.

How can we encourage a just culture within the organisation, and the team?

Investigate to Improve
How well do we investigate safety occurrences?

A good safety investigation should describe and explain the occurrence and the factors that contributed to it, and present workable recommendations to reduce the chance that it will happen again.

What are the positives and negatives about how we investigate, and how could it be improved?
Some Examples of Cards / Questions / Prompts

**Risk Awareness and Management**

**Taking Risks**
Do you sometimes have to take risks that make you feel uncomfortable about safety?

It is hard to assess the level of risk involved in our own activities. But if we have to take risks that make us feel uncomfortable, it is time to stop and think.

How do you respond to risky activities?

**Blind Spots**
Are you aware of care safety problems that are not being addressed sufficiently?

Sometimes problems seem so long-standing or difficult to resolve that they are ignored and become a ‘blind spot’.

How can you help to make sure that safety problems are resolved rather than ignored?
How to Improve the Prevailing Safety Climate?

• Critical Importance of Leadership
  – Psychological safety and ‘speaking up’
  – Routine monitor / measure
  – Protected learning time
  – Team learning / Briefings / Huddles
  – Focus: understanding everyday work
  – Organisational fairness (restorative practice / ‘just’ culture)
  – Engaged leaders listen and act: patients and workforce

“Leaders are the keepers and guardians of these attitudinal norms and the learning system”.
Thank You!

paul.bowie@nhs.scot
500 Patient Safety
Climate Tool Interviews

Gordon McInnes
Mental Health Network Greater Glasgow
Between November 2013 and February 2020 we facilitated 500 SPSP patient safety climate tool interviews across 14 wards in all the major hospital sites across the NHS GG&C area.

These ranged from IPCU and AAU wards to rehabilitation wards.

We are an independent lived-experience led organisation.
What did we learn?

Across the three iterations of the Climate Tool:

The proximity and presence of staff to patients is hugely important.

Communication with patients is critical to engagement in care.

Patients exercise agency, even in highly controlled environments.

Relationships matter. Enormously.

Patients learn from their experiences of treatment.
What benefits did this activity bring?

We provided feedback to support development of the climate tool.

We gave patients knowledge of the fact that the ward was part of the SPSP programme.

Facilitation allowed for an exploration of stated views to explore the entire context behind a statement.

We were aware of the ward level improvement activities and could to some degree explore these areas where they came up in the answers to the questions.
Impact of the engagement activity

Built relationships with the ward environment and enabled them to become accustomed to patient engagement activities.

We could highlight where patient feedback was relevant to the ward level improvement activity.

Gave a credible source of patient feedback to support the programme.

MHNGG supported the leadership walk-rounds also and married the patient feedback into the wider SPSP programme.
Questions?
Launch of the Safety Climate Resources

Rachael Lee
Senior Project Officer, SPSP Mental Health
How did we get here?

Workshop
- We Heard:
  - What works well
  - What needs improvement
  - What doesn’t work

Consultation
- 92% of respondents felt that new resources met their needs
- 86% of respondents likely to measure staff safety with new resources

Launch of Resources
- Updated guidance
- Updated questionnaires
- New resources
# Updated Resources

## What is included in this resource?

- **Updated Resources**
  - Guidance Document
  - Updated Patient Questionnaire
  - Updated staff questionnaire

## Patients

The Patient Safety Climate Resources aim to improve patient safety by providing tools for patients to assess different aspects of safety in their healthcare experience. An accessible version of the questionnaire is available for patients with communication difficulties. To access the full patient safety climate resource, visit: [link](#).

## Staff

The Staff Safety Climate Resources provide insights into the perceptions of frontline staff about safety in their clinical areas and leadership's commitment to safety. To access the full staff safety climate resource, visit: [link](#).

## Digital templates

Digital templates are provided for both staff and Patient Safety Climate Resources. These can be used on any device, including tablets and mobile phones. The resource can be completed digitally, independently or with assistance, by clicking the "Duplicate" button. The data entered into the digital resource provides real-time analysis.

## Updated Patient Questionnaire

### Please rate the following by placing a tick in the response that best fits with your experiences from 'strongly disagree' to 'strongly agree'.

<table>
<thead>
<tr>
<th>Response</th>
<th>1 Strongly disagree</th>
<th>2 Slightly disagree</th>
<th>3 Neither agree or disagree</th>
<th>4 Slightly agree</th>
<th>5 Strongly agree</th>
<th>X Not applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1: I feel the ward is a safe place for people to visit me. For example, my family, visitors, friends and carers.</td>
<td>Comments</td>
<td>Comments</td>
<td>Comments</td>
<td>Comments</td>
<td>Comments</td>
<td>Comments</td>
</tr>
<tr>
<td>Q2: I feel safe when there are difficult events on the ward that involve other people.</td>
<td>Comments</td>
<td>Comments</td>
<td>Comments</td>
<td>Comments</td>
<td>Comments</td>
<td>Comments</td>
</tr>
<tr>
<td>Q3: I feel confident that staff deal safely with difficult events on the ward.</td>
<td>Comments</td>
<td>Comments</td>
<td>Comments</td>
<td>Comments</td>
<td>Comments</td>
<td>Comments</td>
</tr>
<tr>
<td>Q4: If I witness difficult events on the ward, staff help me make sense of them.</td>
<td>Comments</td>
<td>Comments</td>
<td>Comments</td>
<td>Comments</td>
<td>Comments</td>
<td>Comments</td>
</tr>
<tr>
<td>Q5: If I become upset staff support me.</td>
<td>Comments</td>
<td>Comments</td>
<td>Comments</td>
<td>Comments</td>
<td>Comments</td>
<td>Comments</td>
</tr>
<tr>
<td>Q6: I feel able to express any concerns I have.</td>
<td>Comments</td>
<td>Comments</td>
<td>Comments</td>
<td>Comments</td>
<td>Comments</td>
<td>Comments</td>
</tr>
</tbody>
</table>
New Resources

Group discussion resource

Organisation of the themes

There are several individual themes for each of the following "safety" categories. Each theme introduces a different issue for reflection or discussion by a group of patients, carers or family members.

- Your personal safety
- Your relationship with staff
- The use of restrictive practices
- Your care and treatment

How to use

You can use these themes in any way that helps the group to think and talk about safety in the ward/unit or organisation. It is recommended that one person (staff or peer support, for example) acts as discussion facilitator – ideally someone independent of the ward or unit.

You can use as many or as few themes and questions as you like.

Three possibilities are described in the following:

<table>
<thead>
<tr>
<th>Option 1: Comparing views</th>
<th>Option 2: Safety moments</th>
<th>Option 3: Focus on...</th>
</tr>
</thead>
<tbody>
<tr>
<td>Compare similar and different views between the group.</td>
<td>Discuss just one question for 15-30 minutes.</td>
<td>Discuss all of the questions in a particular safety theme.</td>
</tr>
</tbody>
</table>

Accessible Version

2c. I feel safe in my room?

- yes
- no
- sometimes

Please tell us more about your answer?

2d. I feel safe in the dining room?

- yes
- no
- sometimes

Please tell us more about your answer?
SPSP Mental Health Safety Climate Resource Patient Questionnaire

As part of a national programme working to improve safety in mental health in Scotland, we would like to invite you to participate in this questionnaire. The questionnaire will gather your views and experiences on different aspects of safety on the ward to help us make improvements for everyone.

This form will take approx. 20 minutes to complete.

1. Date of completion *
   
   Please input date (M/d/yyyy)

2. Time of completion *
   
   Enter your answer

3. Name of Hospital *
   
   Enter your answer
### Digital Resource

7. Please rate the following questions by clicking the box under the response that best fits with your experiences.

<table>
<thead>
<tr>
<th>Question</th>
<th>Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>I feel safe in the day time</td>
<td></td>
</tr>
<tr>
<td>I feel safe at night time</td>
<td></td>
</tr>
<tr>
<td>I feel safe when staff are visible. For example, handover times or meal times</td>
<td></td>
</tr>
<tr>
<td>I feel safe with the mix of patients on this ward</td>
<td></td>
</tr>
<tr>
<td>I feel safe when there are difficult events on the ward that involve other people</td>
<td></td>
</tr>
<tr>
<td>I feel confident that staff deal safely with difficult events on the ward</td>
<td></td>
</tr>
<tr>
<td>If I witness difficult events on the ward, staff help me make sense of them</td>
<td></td>
</tr>
<tr>
<td>If I become upset, staff support me</td>
<td></td>
</tr>
<tr>
<td>I feel able to express any concerns I have</td>
<td></td>
</tr>
<tr>
<td>If I have concerns, I know who to go to</td>
<td></td>
</tr>
<tr>
<td>If I have concerns, I feel staff would provide me with the appropriate support</td>
<td></td>
</tr>
<tr>
<td>If I had to be restrained, I feel this would be done safely</td>
<td></td>
</tr>
<tr>
<td>If I witnessed somebody else being restrained, I think this would be done safely</td>
<td></td>
</tr>
<tr>
<td>I am involved in making decisions about my medication</td>
<td></td>
</tr>
</tbody>
</table>
Next steps

• Resources from today - available soon on our Learning System webpage
• Learning System Webinar 3: Essentials of safe care – date tbc
Please take the time now to complete our evaluation form.
Keep in touch

His.mhportfolio@nhs.scot

@SPSP_MH

To find out more visit ihub.scot
Thank you! 😊