South of England Collaborative
mental health quality and
patient safety improvement

Co-brand logo here

Introduction to Psychological Safety


Care Quality Commission
Opening the door to change
NHS safety culture and the need for transformation
DECEMBER 2018

Our Safety Contradiction

What healthcare culturally thinks about patient safety

vs

The experience of individual members of staff

Other Safety Critical Industries

- Talk of their work as high risk
- Immediately implement safety alerts effectively
- Understand team dynamics are central to how they work
- Safety protocols are followed without question
- Staff are expected to raise concerns as a matter of course
- No hesitation in stopping operations if safety is compromised
- Safety training isn't optional
- Errors accepted as inevitable

In Contrast

- Safety is the norm, things go wrong exceptionally
- Quick Fixes/ Technical solutions
- Overwhelming majority rooted in Human Factors based solutions

Human Factors

- Enhances clinical performance through the understanding of the effects of teamwork, tasks, equipment, workspace, culture and organization on human behaviours and abilities and the application of that knowledge in clinical settings

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 bodies, suspension of staff, and referral to police and disciplinary processes. Wider investigation is still needed to understand how and why patients were not protected from the actions of the individual. **END HERE**

No go to next question - **Q2. health test**

2a. **Are there indications of substance abuse?**

Yes → **Recommendation:** Follow organisational substance abuse at work guidance. Wider investigation is still needed to understand if substance abuse could have been recognised and addressed earlier **END HERE**

2b. **Are there indications of physical ill health?**

2c. **Are there indications of mental ill health?**

Yes → **Recommendation:** Follow organisational guidance for health issues affecting work, which is likely to include occupational health referral. Wider investigation is still needed to understand if health issues could have been recognised and addressed earlier. **END HERE**

If **No to all** go to next question - **Q3. foresight test**

3a. **Are there agreed protocols/accepted practice in place that apply to the action/omission in question?**

3b. **Were the protocols/accepted practice workable and in routine use?**

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 investigation 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 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?**

4b. **Was the individual missed out when relevant training was provided to their peer group?**

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 investigation 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 **No to all** go to 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 investigation should indicate the wider actions needed to improve safety for future patients. **END HERE**

If **No**

If **No to all** go to next question - **Q3. foresight test**

3a. Are there agreed protocols/accepted practice in place that apply to the action/omission in question?

3b. Were the protocols/accepted practice workable and in routine use?

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 investigation 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 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?

4b. Was the individual missed out when relevant training was provided to their peer group?

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 investigation 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

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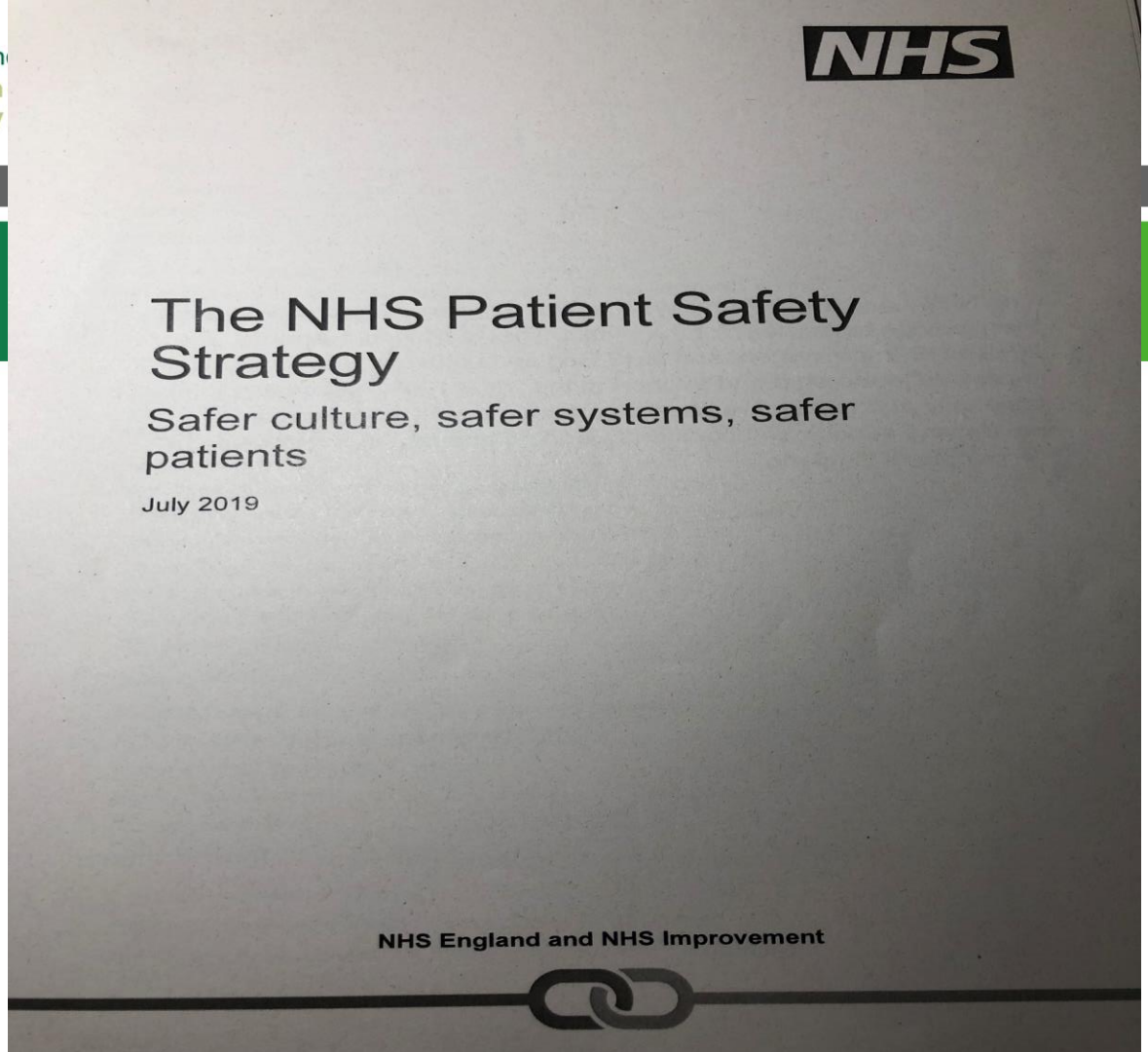


The Mental Health Safety Improvement Programme

Dr Helen Smith, National Clinical Director of the Mental Health Safety Improvement Programme (MHSIP), describes the work to address important safety challenges in the mental health sector.

Box 20: The Mental Health Safety Improvement Programme

In *The state of care in mental health services 2014-2017*, CQC identified safety as the biggest concern for mental health services. The MHSIP aims to provide both bespoke support to mental health trusts on their individual safety priorities as well as support around challenges that are common across many or all local systems.

The MHSIP works with the 54 NHS trusts providing mental health services in England, and closely with CQC centrally and with CQC and NHS Improvement teams regionally. The programme is delivered by a team of experts in mental health, some of whom have board-level and quality improvement professional experience and some lived experience of our services, either as a service user or as a carer of someone who has used services.

This programme has two main components.

1. The trust engagement programme

The MHSIP team meets every trust executive team after CQC reports on its inspection of the trust. Before this meeting the MHSIP team will have met the regional CQC and NHS teams to develop a shared understanding of each organisation's safety concerns. We work collectively to determine what a trust's priorities are and to devise an improvement plan accordingly. We aim to develop a safety improvement plan for each trust by April 2020.

Once complete we will move resources from the engagement programme to supporting the improvement collaborative programme.

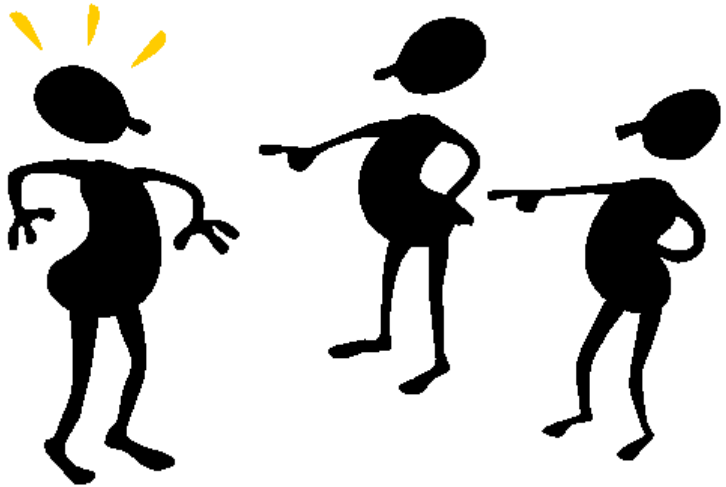
2. The improvement collaborative programme

This component concerns the complex safety problems in mental health. It uses quality improvement for testing, measuring and improving.

Patient Safety Strategy

- Patient Safety Culture
- Patient Safety Systems

Arch enemies of psychological safety



Concept of Psychological Safety

- “ a shared belief held by members of a team that the team is safe for interpersonal risk taking”
- ‘ describes a team climate characterized by interpersonal trust and mutual respect in which people feel comfortable to be themselves”
- Amy Edmondson

1st film

Discuss

- What did you see that confirmed what you already knew?
- What did you see that surprised you?
- How often do you think about these issues in your teams/organisations?

Assess your teams level of psychological safety

1. If you make a mistake on this team, it is often held against you?
2. Are members of this team able to bring up problems and tough issues?
3. Have people on this team sometimes rejected others for being different?
4. Is it safe to take a risk on this team?
5. Is it difficult to ask other members of this team for help?
6. Would no one on this team deliberately act in a way that undermines my efforts?
7. When working with members of this team are my unique skills and talents valued and utilized?

Discussion

- Think about these questions
- What going well within your team/organisation?
- What could be improved upon?

2nd film

Discussion

- What could you as a team an individual do differently tomorrow to improve the psychological safety in your team/organisation?

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