



Organisational and social perspectives on patient safety: contributions, critiques and future directions

Naomi Fulop, King's College London

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Outline

- Why make a contribution, and how?
- Drawing on two studies from a programme of work on governance and safety illustrate:
 - importance of studying at patient safety at macro, meso and micro levels and relationship between these
 - Dualism of 'professionalism' and 'managerialism' not helpful and dynamics more complex
- Challenges of translation/mobilisation
- Future directions



Contributions....why and how?

- Why make a contribution?
 - 'moral purpose' (Vincent, 2009)
 - But can be critical – this can contribute
- More important question – how?
- Broad range of ways social science can contribute
- emphasis on developing interventions to improve patient safety e.g. surgical checklist
- Less understanding of social science contribution to our understanding of 'why' and 'how' of what works (Benn et al, 2009)



Contributions.....why and how?

- 'Why' and 'how' not just of interventions, but also for social and organisational **context** for patient safety
- e.g. McDonald et al (2006)
- case study of hospital operating theatre questioning value of establishing 'safety culture'
 - Following written rules at odds with social rules



Governance of patient safety

- Programme of research on governance of patient safety
- Macro, meso, and micro levels of governance
- Governance/regulation literature usually focused at macro level (political sci)
- Clinical micro-systems research (e.g. Batalden et al 2007) neglected influence of macro (and meso) systems

Organisational governance

- *The systems, processes, cultures and behaviours by which an organisation ensures it is providing safe, high quality care*
 - Fulop, N, Chamberlain, J, Baeza, J, Humphrey, C, Magnusson, C & Rothstein, H (2008)
- <http://www.kingspssq.org.uk/programmes/organisational-governance/organisational-working-paper/>

Organisational governance components	Meso & Micro (organisational context)	Macro (external context)
Systems & Processes	Governance structures – key committees, membership and terms of references, flow of information. Internal reporting.	External partners and community, SHAs, media
Tools of control	Root cause analysis , internal audits, surveillance, performance measurement (how organisations lead & control their functions)	Regulation, standard setting, NICE guidelines etc.
Cultures & behaviours	Attitudes, power, professional relationships, cultures of safety/cultures of learning, accountability & leadership	

Diagrammatic elements: Vertical double-headed arrows connect the Meso & Micro context cells between Systems & Processes and Tools of control, and between Tools of control and Cultures & behaviours. Horizontal double-headed arrows connect the Macro context cell to the Systems & Processes cell, and to the Cultures & behaviours cell.



Governance and patient safety

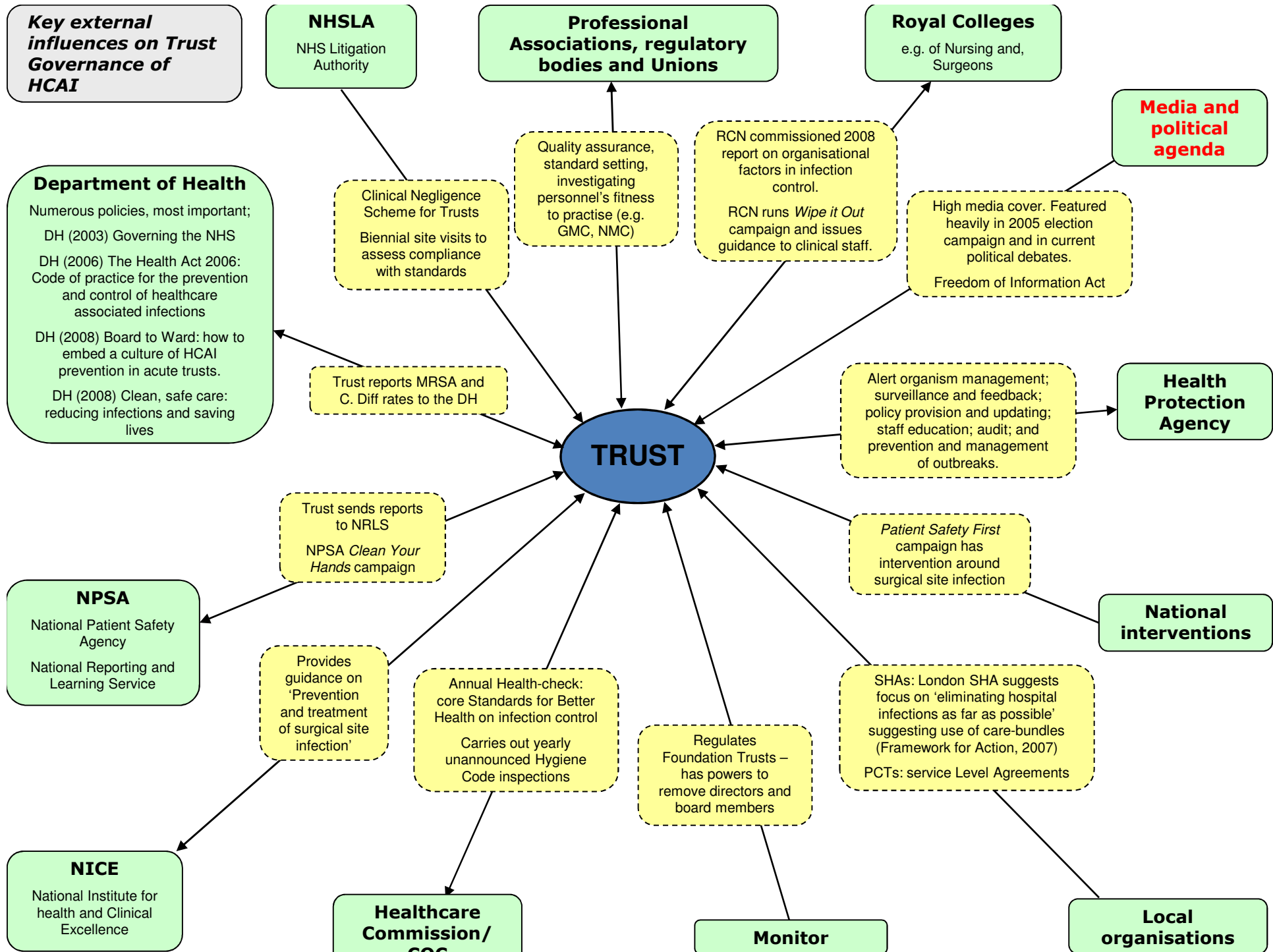
- Dynamic interactions between 'levels' – need to understand these if going to improve pt safety
- Relationship between macro (external) governance regimes and meso (internal)
 - Comparison of medication safety and HCAI
- Meso/micro relationships – studies of formal and informal governance systems
 - Formal and informal governance of medication safety
 - Accountabilities in HCAI
- Illustrate the roles of professionals and their relationships with managerial imperatives in relation to patient safety are more complex than is sometimes acknowledged

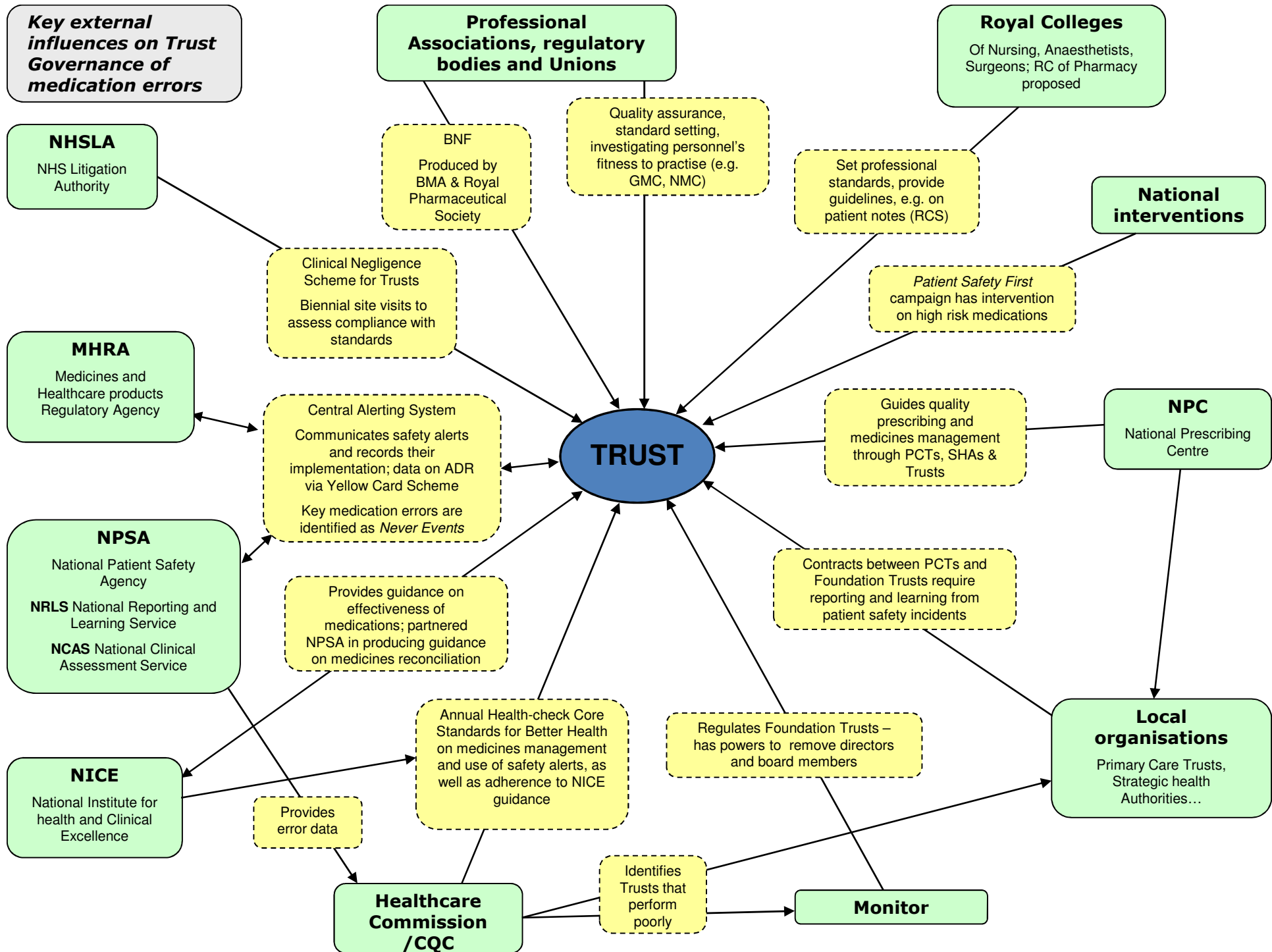


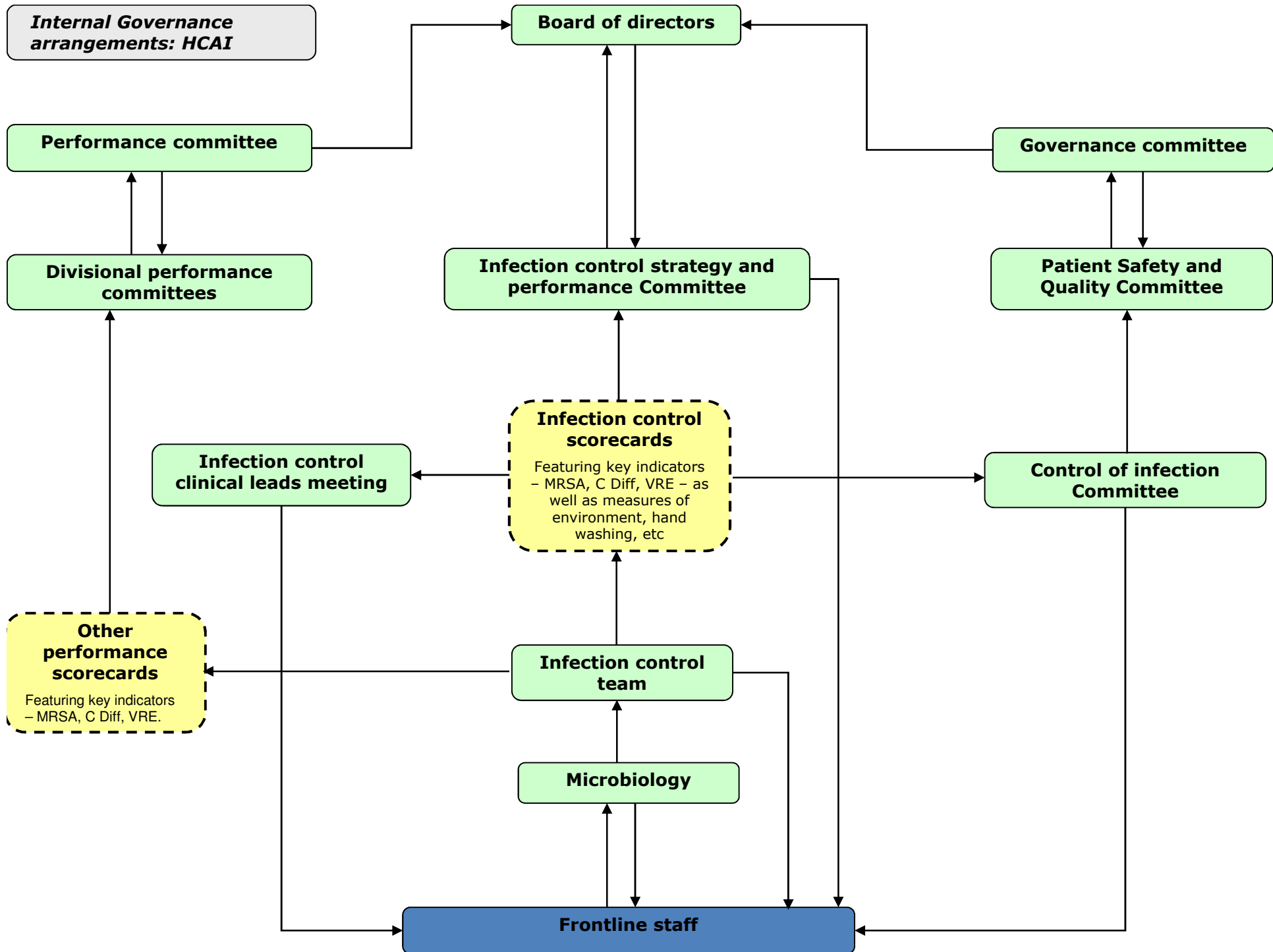
1. Relationship between macro (external) governance regimes and meso (internal)

- Mapping of *external* requirements & formal *internal* governance systems
- Adapted mapping framework used outside healthcare (Hood et al, 2001)
- Data for framework from interviews with key informants and documentary analysis

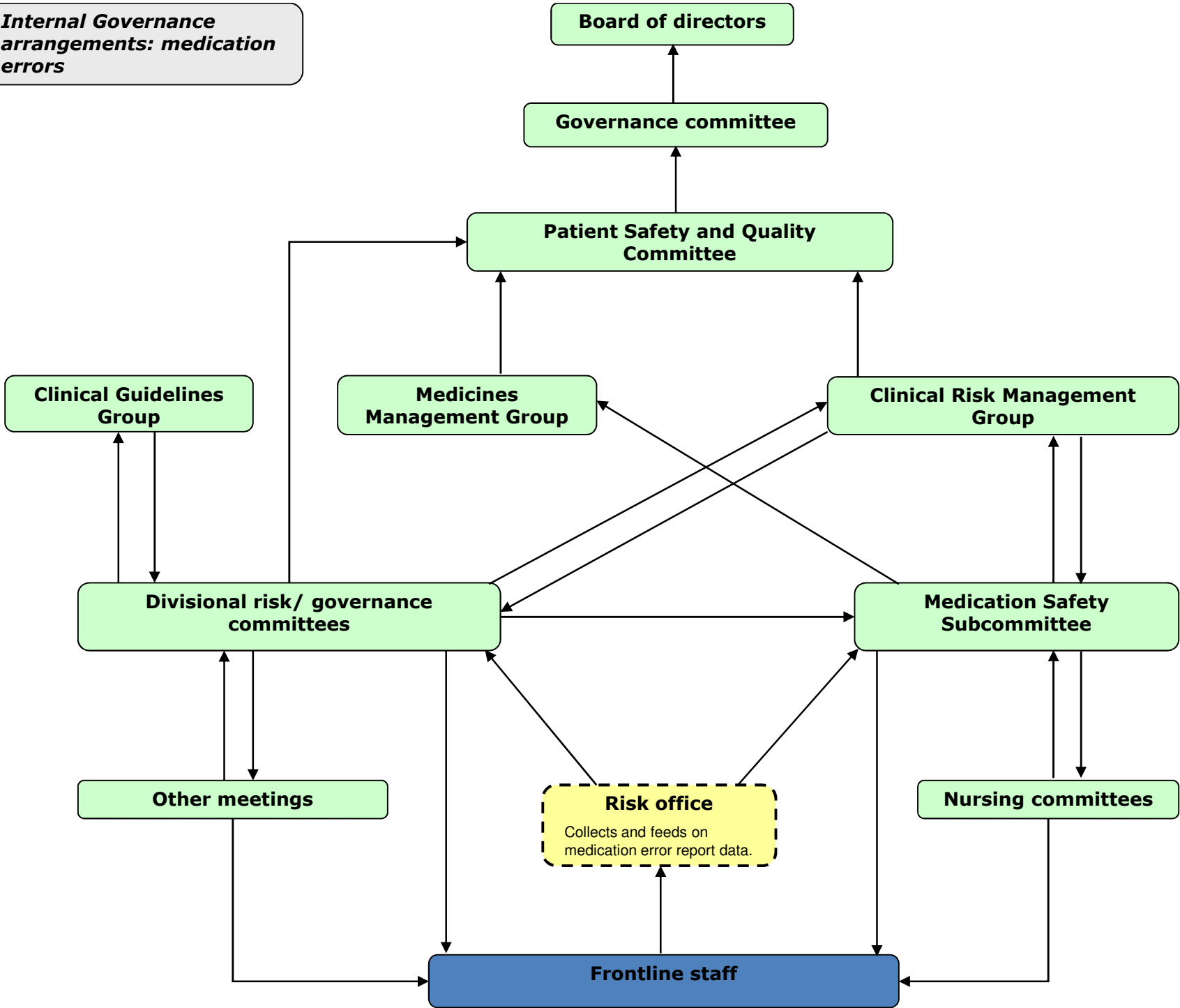
Ramsay, Fulop & Magnusson, 2010







Internal Governance arrangements: medication errors





Understanding relationship between formal external and internal governance regimes

- External differences
 - HCAs key national target in annual health check cf. medication errors focus on processes
 - HCAs included in numerous policies, guidance cf. medication errors
- Relationship between external and internal regimes – v important
- Internal differences
 - role of data and performance measurement (esp. scorecard)
 - more centralised, higher level approach to HCAs cf. med errors
 - roles and relationships of various sub-cttees and groups appear less clear, 'messier' for med errors cf. HCAs.



2. Relationships between meso and micro levels (and macro)

- Formal and informal governance of medication safety
 - Piloting of medication safety scorecard at ward level – 2 wards, 1 control over 3 month period (in Trust 1, about to repeat in Trust 2)
 - In-depth interviews with range of staff (36 in 2 Trusts)
 - Observations of meetings
 - Feedback of medication safety scorecard data (Trust 1)

(Turner, Ramsay, Fulop, 2011)

- Accountability systems for HCAI
 - Interviews (28) with staff at board/senior management level, middle management, and front line health care professionals
 - Observations of key meetings, documentary analysis

(Magnusson et al, 2011)



Findings from medication safety scorecard (Trust 1)

Baseline data from 3 wards over 3 month period:

- over 5% patients did not have their allergy status documented on their drug chart
- over 20% patients had ID bands that did not match allergy status, or no ID band at all
- on average, over 40% of patients experienced at least one drug omission in the 24 hours prior to data collection
- almost 1/4 patients had one or more unlabelled drug in their POD lockers; and 1 in 20 had one or more drug labelled for another person



Response to these findings

- On average, 40% pts had one drug omission in previous 24 hours
- 'It's probably mostly paracetamol' [Senior Clinician, Trust 2]
- Feedback to Medication Safety Cttee in Trust 1 – results not viewed as unusual or surprising
- Group of executive directors, Trust 1 – no reaction
- This level of error has become 'normalised' (Vaughan, 2005; Waring et al, 2007)



Response to these findings

- Contrast with another pt safety issue – HCAI
- Senior executive at same meeting talking about HCAI: *'we will have a target of zero MRSA bacteraemias'*
- Why are some errors 'normalised' and others not?
- Relationship with external regimes very important (and in turn these influenced by public concerns and the media)





3. Dualism of professionalism and managerialism

- Important to explore interplay between 'formal' governance systems and 'informal' cultures of safety practised by professional communities
- Literature seems to suggest
 - Dualism between 'managerialism' and 'professionalism' – inherent tension between external management systems and professionals own internal systems of learning and improvement (e.g. Currie et al, 2009; Waring, 2009)
 - Therefore 'give greater role for patient safety to the professionals'



Attitudes to medication safety vary across professional communities

- By clinical specialty:
 - For general surgeons, medication safety less important relative to other clinical skills (apprenticeship for junior doctors linked to mastery of surgical tools)
 - For renal specialists, use of medicines a critical aspect of care with transplant patients having complex drugs needs
- By occupational role:
 - Pharmacists – strong culture of medication safety based on its primacy in academic training and hospital socialisation
 - Doctors – not core to training; time pressures mean other tasks can take precedence
 - Nurses – not core to training, but attending to safety protocols more aligned with model of professional practice



Attitudes to external governance systems

Confirming previous research, reporting rates varied by professional group. Doctors questioned its value, *“I don't know that the act of filling in the form has directly enhanced my education or thinking about the process”* (Hospital A, doctor discussion group).

Nurses were more likely to report to avoid blame, *“they are very ingrained in there about the whole liability thing”* (Hospital A, pharmacist).

BUT

Clinicians were not necessarily opposed to external governance. Low reporting among doctors may not be due as much to cultural barriers within the profession than to perceived weaknesses in the reporting system: *“if you don't get feedback you say, well, what's the point in me doing it?”* (Hospital B, consultant, general medicine).



Persistence of professional boundaries

- Pharmacists were attached to ward teams – they attended ward rounds, gave advice, checked doses, drafted clinical guidelines and reviewed safety incidents. However, this reinforced the division of responsibility between professions for medication safety. Some doctors had come to rely on pharmacists when making prescriptions:

*“I don't actually think it gets very much priority at all. That's the problem in my eyes. Like I think because they [doctors] see ward pharmacists as their safety net a lot of the time and very good nurses will also pick up any like errors in like medication or odd doses”
(Hospital A, pharmacist)*

This shows how the hospitals have tried to influence everyday practice by bringing pharmacists onto the frontline, but equally how professional boundaries can persist unless challenged.



Persistence of professional boundaries: learning about medication safety

Managers used professional communities to influence practice. Senior nursing staff attended a weekly review of errors to generate professional debate about good practice, but other professions not included in this meeting.

Similar processes existed for junior doctors:

“they have what’s called action learning groups which are groups of their peers mentored by a consultant to cover aspects of care... the themes are broad so we haven’t got medicine safety yet in that, but there are other groups forming spontaneously on the back of the medicine safety visibility” (Hospital B, consultant).

Discussions of safety often took place **within** professions, reinforcing existing boundaries.



Accountabilities for patient safety: HCAI

(Magnusson et al, 2011)

- Performance accounts – driving blame or learning? e.g. **Root Cause Analysis (RCAs)**
- *'Because some you read you think they haven't got this at all have they that what is causing this, they haven't got to the cause. But then it's not the case of telling them off, you go back and say right what is it you didn't get about that because I can see clearly it's this and actually working through with them so that the next time. So they've got the learning, right okay get the learning.'*
[senior executive]



Driving blame or learning?

- To then be told that they were screening incorrectly, was described as a 'slap in the face':

'Unfortunately a lot of the root cause analysis, although it's not meant to be a kind of blame culture, sometimes it's very much seen like that, but actually you might gather all this evidence to say oh we did everything, we screened the patient, we screened them umpteen times, you know, but it still might come back well actually you didn't screen them properly and there was a problem, and I think sometimes that gets filtered down.' (Middle Management, Int 26, p13)



So what? (1)

- Professional communities have different attitudes towards medication safety and perceptions of formal governance processes
- In particular, professional boundaries matter for how safety issues are understood and governed within hospitals
- On the one hand, a return to profession-based solutions that rely on a natural order emerging from social relations appear inadequate for tackling safety



So what (2)

- On the other hand, there can be tensions between professional contexts for learning and governance processes which require performance accountability
- And multidisciplinary forms of working are not likely to emerge naturally, but depend on local leadership e.g. ward managers brokering interactions among professions



Translating/mobilising patient safety research

- Sensitivities of doing patient safety research – not acknowledged much
- Assumptions that can and should do collaborative research (e.g. Iedema, 2009)
- e.g. Co-creation of 'interventions' to improve patient safety
- Underlying assumption of NIHR national PSSQs
- Partnerships for patient safety research.....

Research Partnerships: the good, the bad, and the ugly





Research Partnerships: the good, the bad, and the ugly

- Should not ignore political and institutional context
- E.g. Use of 'never events' in NHS – if reported, don't receive £ for that case, and potential fines
- Professional self-interest.....



Future directions – but first, some reflections on where we've come from.....



Social science and health care: a changing narrative (1)

- 1960's-70's: social science critique of medicine and doctors e.g. Illich's (1975) concept of *iatrogenesis*, RD Laing's *anti-psychiatry*, feminist critiques of obstetrics (e.g. Oakley)
- Following the rise of managerialism in health care (e.g. Griffiths reforms in the 80's UK) - culminating in Bristol Inquiry
- Dualism of 'professionalism' and 'managerialism'



Social science and health care: a changing narrative (2)

- Social science critique of managerialism and attempts to control health care professionals, e.g. to improve patient safety, through external means because they ignore professional agency (e.g. Yeung and Dixon-Woods, 2010) and professionally based learning systems
- Narrative swung back to privilege professionally based approaches to patient safety
- Perhaps swung too far the other way.....?



Future directions

- Move beyond dualism of 'professionalism' and 'managerialism' – how can bring together 'formal' governance processes **with** 'informal', professional ones?
- Question the calls for more collaborative research – what is the nature of the collaboration?



Future directions (2)

- International comparisons
- Learning from top performing **and** 'developing' health care organisations (cf. Bate et al, 2008; Curry et al, 2011) e.g. QUASER
- Role of context
 - which contextual factors related to safety and quality?
 - which are modifiable?
 - impact of contextual factors at different levels?
 - when different contextual factors more or less impt?



THANK YOU!

<http://www.kingspssq.org.uk/>

naomi.fulop@kcl.ac.uk