Patient safety: staff safety – hand in hand?

Health care is a high-risk, high-demand, high-stress industry, the intensity of which is impacted by perpetual change, through drives for innovation, improvement and technological advance.

Providing a service such as the NHS, i.e. perioperative staff working in fast-paced environments and experiencing high physical and cognitive demands in meeting the health needs of fragile, complex and compromised people, while caring is the primary focus of our work, we do so whilst juggling the demands of our employing organisations to deliver greater efficiencies and productivity.

The demands and pressures we encounter on a daily basis surface the frailties of being human, namely ‘error’, and, as an unintended consequence, harm of our patients.

Since Sir Liam Donaldson’s report, An Organisation with a Memory (DH 2000), a lot has and is being done to address the ‘safety culture’ of the NHS. Campaigns such as Patient Safety First and the complimentary efforts of the National Patient Safety Agency, NHS Institute for Innovation and Improvement and the Health Foundation have influenced recognition and acceptance that patient safety must be the priority of boards and that executive leaders play a crucial role in setting the cultural norms and management practice of the organisation and in developing safer systems, processes, equipment and controls.

While patients rightly focus our, it is increasingly recognised that to assure exemplary patient care organisations must make a fundamental shift to equate worker safety with patient safety, ensuring that a safety culture pervades the organisation, so that the safety of the workforce and the working environment are given equal priority.

Improving an organisation’s safety culture is integral to reducing risk and key to improving the overall business performance of the NHS, but of the organisation and challenges: not least because, it is easier to measure culture than to change it. The challenges encountered in bringing about improvement are brought into even sharper focus in the NHS, given the backdrop of reforms that demand new organisational structures, the fact that our workforce has to continually adapt to new working environments and the NHS has to deliver short term targets and shifting priorities both nationally and locally.

Reducing error and influencing behaviour to bring about the necessary culture shift, requires appreciation and embedding of human factors in the NHS. Human factors are defined by the Health and Safety Executive (2011) as comprising those environmental, organisational and job factors, which together with human and individual characteristics, influence our behaviour at work in a way that can affect the health and safety of our patients and peers. The Clinical Human Factors Group (2011), focusing specifically on human factors in health, describe our capacity to enhance clinical performance through an understanding of the effects of teamwork, tasks, equipment, workspace, culture, organization on human behavior and the abilities and application of that knowledge in clinical settings.

The relationship of patient and staff safety and the challenges we face in developing a safety culture in the NHS, are illustrated in the papers skilfully selected for this month’s journal.

Suzette Woodward shares views on the patient safety function of the new NHS Commissioning Board (England) reassuring us, that lessons learned from the safety ‘effort’ of the past ten years, will be used to design for improvement, going forward as current reforms bed down. While this article pays particular attention to England, it contains transferable messages for Scotland, Northern Ireland and Wales regarding the importance of leadership at all levels of the NHS, the role of boards in setting the tone and culture for safety improvement, and the traction that can be achieved through peer review, measurement and sharing best practice.

Strategies to tackle bullying and harassment in our operating theatres are examined by Jacqueline Randle, while Julie Quick explores how Inter-professional approaches to education and training can improve our team work and appreciation of the contribution of the discrete professions that make up our theatre teams. Sultan et al, focus on a discrete aspect of anaesthesia safety and the ‘harm’ that patients can experience through excess ‘cuff pressure’ when experiencing endotracheal intubation. As for me, I ponder some questions as to why surgical never events continue to occur.

‘Human factors’ runs as a connecting theme through all the articles, if you do not know much about them and how they impact on your practice, why not access two additional resources through the hyperlinks below? In doing so, think about the observations our writers share, how they might inform the improvement of your own practice and/or how they relate to changes that may be occurring in the organisations, where you are working at the moment.

Jane Reid
Non Executive Director
Dorset County Hospital NHS Foundation Trust

Jane is the former President of the Association for Perioperative Practice and current President of the International Federation of Perioperative Nurses (IFPN).

References

Clinical Human Factors Group 2011 Clinical Human Factors Group Available at: www.chfg.org/ [Accessed September 2011]


Resources
