Managing risk in the short and longer term
A portfolio of strategies

NHS Providers
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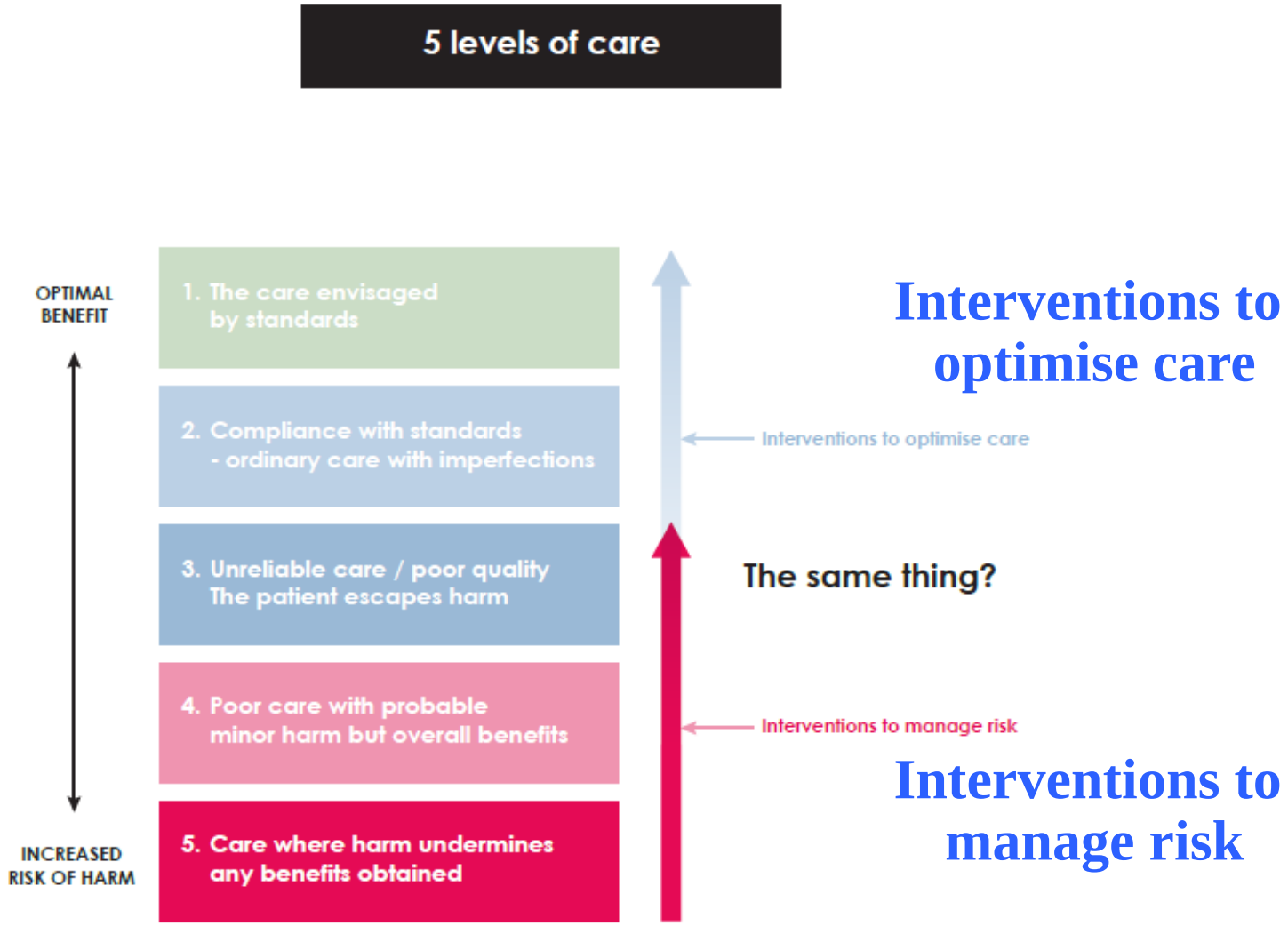
Overview

- The original vision: meeting the standards
- The varying levels of care
- Models of safety in different contexts
- A portfolio of interventions to build safer systems
- Complemented by adaptive strategies to manage short term pressures
- What does this mean for leaders?

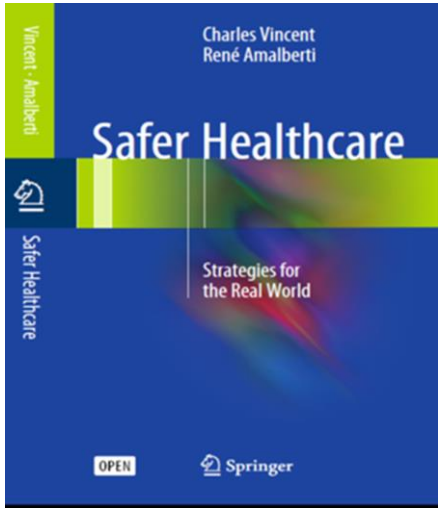

FIRST, DO NO HARM
TO ERR IS HUM
BUILDING A SAFER HEALTH S
INSTITUTE OF MEDI
INSTITUTE OF MEDICINE
CROSSING THE
QUALITY CHASM
A New Health System for the 21st Century
DH Department of Health
learning
ERROR
culture
standards
EVALUATE
management
protocols
LEARN
EVALUATE
active
near-miss
safer
organisation
CULTURE
hazard
accountability
An organisation with a memory
Report of an expert group on learning
from adverse events in the NHS
chaired by the Chief Medical Officer


5 levels of care
OPTIMAL BENEFIT
1. The care envisaged by standards
2. Compliance with standards - ordinary care with imperfections
3. Unreliable care / poor quality The patient escapes harm
4. Poor care with probable minor harm but overall benefits
5. Care where harm undermines any benefits obtained
INCREASED RISK OF HARM
Interventions to optimise care
Interventions to optimise care
The same thing?
Interventions to manage risk
Interventions to manage risk

Three models of safety

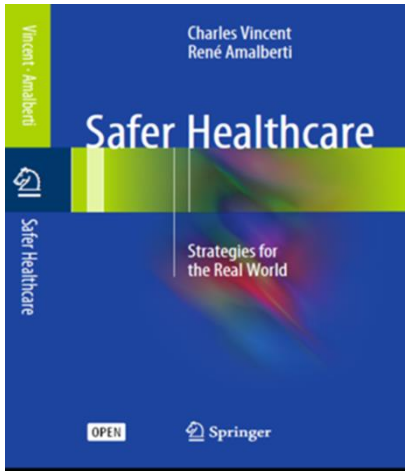
Our ambition and questions

- How are safety and quality achieved in different settings?
- A wider range of safety strategies and interventions?
- Can a framework of strategies and interventions be developed ?
  - Applicable across contexts? Hospital, home, primary care
  - Across levels? Patient, frontline, organisation, regulation and government?

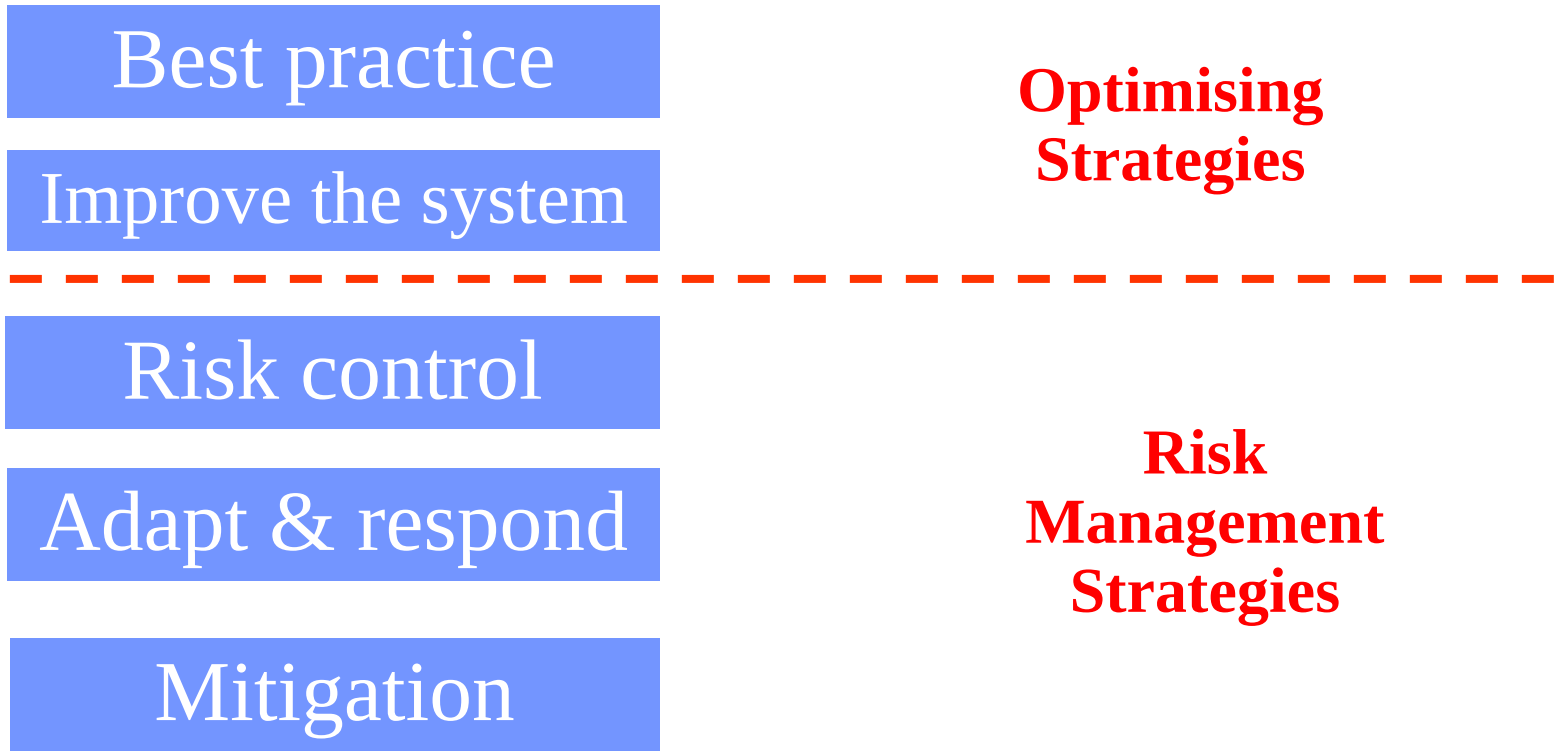


Safety Strategies and Interventions

Building for the longer term



Families of safety interventions



I Aspire to standards – safety as best practice

- Targeted at specific events
- Aim is to optimise reliability of basic procedures
- Quality improvement approach

Annals of Internal Medicine | SUPPLEMENT

The Top Patient Safety Strategies That Can Be Encouraged for Adoption Now

Table 2. **Patient Safety Strategies Ready for Adoption Now**

Strongly encouraged

- Preoperative checklists and anesthesia checklists to prevent operative and postoperative events
- Bundles that include checklists to prevent central line–associated bloodstream infections
- Interventions to reduce urinary catheter use, including catheter reminders, stop orders, or nurse-initiated removal protocols
- Bundles that include head-of-bed elevation, sedation vacations, oral care with chlorhexidine, and subglottic suctioning endotracheal tubes to prevent ventilator-associated pneumonia
- Hand hygiene
- The do-not-use list for hazardous abbreviations
- Multicomponent interventions to reduce pressure ulcers
- Barrier precautions to prevent health care–associated infections
- Use of real-time ultrasonography for central line placement
- Interventions to improve prophylaxis for venous thromboembolisms

Shekelle et al, 2013

II Safer systems – multiple avenues

Improved teamwork as an example

- Introduce tools such as whiteboards to facilitate team communication
- Define essential tasks and who is responsible for each task.
- Establish joint medical and nursing handovers.
- Use shared medical and nursing records.

Vincent et al, 1998; Carayon et al, 2006

Simplify the working environment

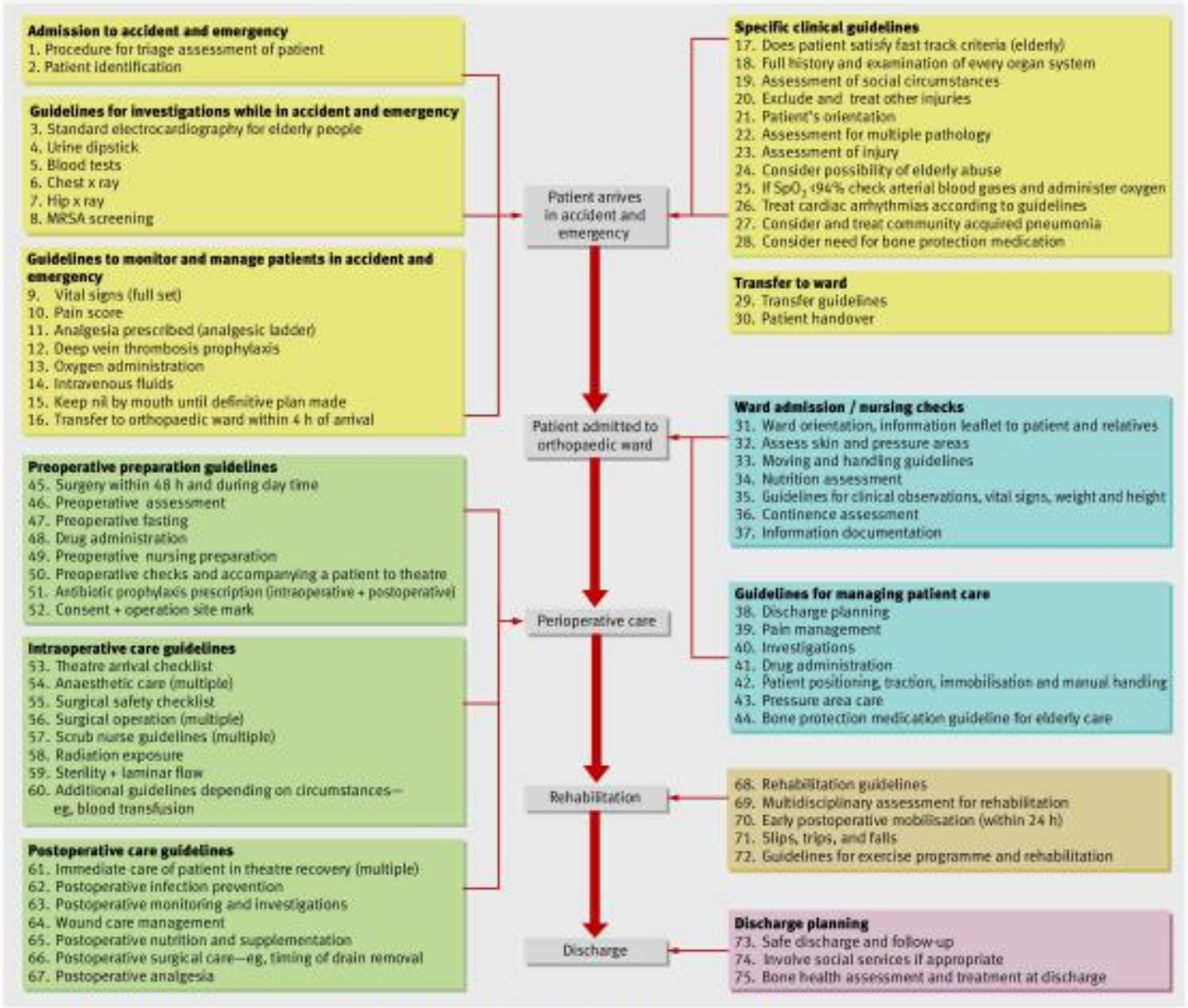


Fig 1 Typical patient journey for an elderly patient with fractured neck of femur

III Risk control

- Withdraw services
- Place restrictions on services
- Place restrictions on conditions of operation
- Place restrictions on individuals
- Prioritisation of activities

Risk control in medication

- Junior doctors are generally not permitted to prescribe certain drugs such as chemotherapy, oral methotrexate
- There are legal controls on the use of many drugs such as diamorphine and other opiates
- Nurses have to pass a test of competency to be permitted to administer intravenous medications

Risk control. Go/no-go

Use TIVA with propofol (BIS monitored)... I am well aware that a functioning oxygen monitor is present in the guidelines. To cancel would be the counsel of perfection, but this won't get the patient the treatment he needs.

Completely elective cases with faulty kit I would not proceed. There is a risk of awareness/hypoxia. Proceeding fails my stand up in court test. [Consultant; 10 yr of experience]

Go/no-go decision in anaesthesia: wide variation in risk tolerance amongst anaesthetists

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Clinical Practice

IV Monitoring, adaptation and response

- Building the capacity to detect and respond to problems in real time
- Resilient teamwork at the frontline
- Supportive interventions
  - Briefing and de-briefing
  - Team training for cross checking, monitoring
- Develop planned approaches to adaptation and recovery

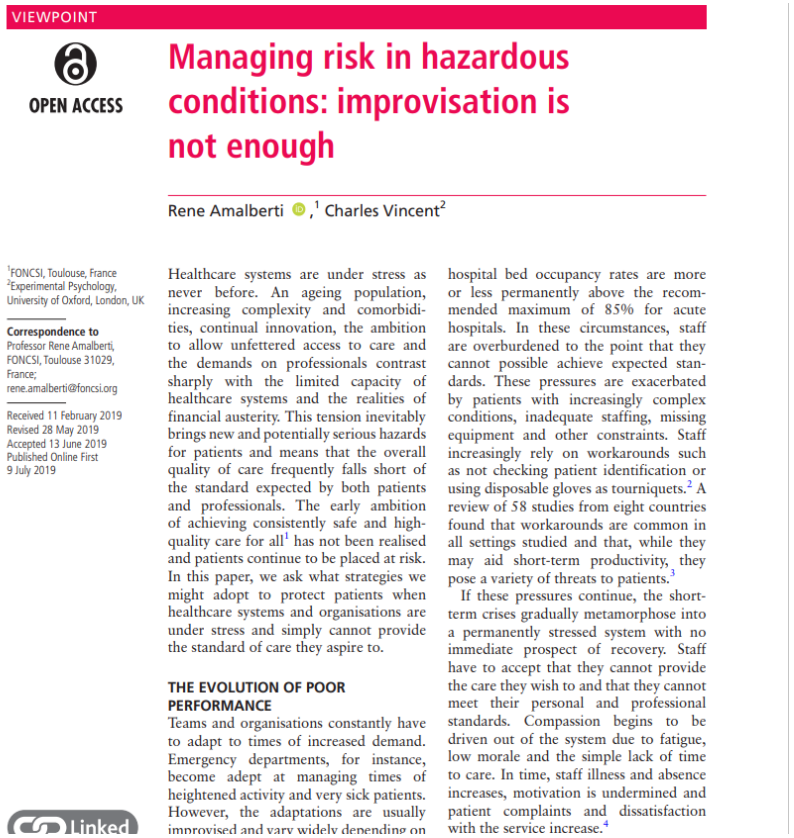
V Mitigation

- Support for patients, families and carers
- Support for staff
- Financial and legal planning
- Management of media
- Response to regulators

Adaptive strategies for the short term

Improvisation is not enough

- *“ The pressure on all healthcare systems is simply the daily reality for all clinicians and managers and for any patient or family member dealing with serious illness”*
- *“The first priority in developing practical strategies is to carry out primarily descriptive studies to identify common type of pressures and degraded conditions and their effect at the level of clinical team and the wider organisation”*



VIEWPOINT

OPEN ACCESS

Managing risk in hazardous conditions: improvisation is not enough

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Linked

Healthcare systems are under stress as never before. An ageing population, increasing complexity and comorbidities, continual innovation, the ambition to allow unfettered access to care and the demands on professionals contrast sharply with the limited capacity of healthcare systems and the realities of financial austerity. This tension inevitably brings new and potentially serious hazards for patients and means that the overall quality of care frequently falls short of the standard expected by both patients and professionals. The early ambition of achieving consistently safe and high-quality care for all[1] has not been realised and patients continue to be placed at risk. In this paper, we ask what strategies we might adopt to protect patients when healthcare systems and organisations are under stress and simply cannot provide the standard of care they aspire to.

THE EVOLUTION OF POOR PERFORMANCE

Teams and organisations constantly have to adapt to times of increased demand. Emergency departments, for instance, become adept at managing times of heightened activity and very sick patients. However, the adaptations are usually improvised and vary widely depending on hospital bed occupancy rates are more or less permanently above the recommended maximum of 85% for acute hospitals. In these circumstances, staff are overburdened to the point that they cannot possible achieve expected standards. These pressures are exacerbated by patients with increasingly complex conditions, inadequate staffing, missing equipment and other constraints. Staff increasingly rely on workarounds such as not checking patient identification or using disposable gloves as tourniquets.[2] A review of 58 studies from eight countries found that workarounds are common in all settings studied and that, while they may aid short-term productivity, they pose a variety of threats to patients.[3]

If these pressures continue, the short-term crises gradually metamorphose into a permanently stressed system with no immediate prospect of recovery. Staff have to accept that they cannot provide the care they wish to and that they cannot meet their personal and professional standards. Compassion begins to be driven out of the system due to fatigue, low morale and the simple lack of time to care. In time, staff illness and absence increases, motivation is undermined and patient complaints and dissatisfaction with the service increase.[4]

OPEN ACCESS

Health services under pressure: a scoping review and development of a taxonomy of adaptive strategies

Bethan Page [1,2] Dulcie Irving,[1] Rene Amalberti [3] Charles Vincent [1]

► Additional supplemental material is published online only. To view, please visit the journal online (http://dx.doi.org/10.1136/bmjqs-2023-016686).

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ABSTRACT

Objective The objective of this review was to develop a taxonomy of pressures experienced by health services and an accompanying taxonomy of strategies for adapting in response to these pressures. The taxonomies were developed from a review of observational studies directly assessing care delivered in a variety of clinical environments.

Design In the first phase, a scoping review of the relevant literature was conducted. In the second phase, pressures and strategies were systematically coded from the included papers, and categorised.

Data sources Electronic databases (MEDLINE, Embase, CINAHL, PsycInfo and Scopus) and reference lists from recent reviews of the resilient healthcare literature.

Eligibility criteria Studies were included from the resilient healthcare literature, which used descriptive methodologies to directly assess a clinical environment. The studies were required to contain strategies for managing under pressure.

Results 5402 potential articles were identified with 17 papers meeting the inclusion criteria. The principal source of pressure described in the studies was the demand for care exceeding capacity (ie, the resources available), which in turn led to difficult working conditions and problems with system functioning. Strategies for responding to pressures were categorised into anticipatory and on-the-day adaptations.

WHAT IS ALREADY KNOWN ON THIS TOPIC

⇒ Healthcare systems are operating under substantial pressures and often simply cannot provide the standard of care they aspire to within the available resources.

⇒ Organisations, managers and individual clinicians make constant adaptations in response to these pressures which are typically improvised, highly variable and not coordinated across clinical teams.

WHAT THIS STUDY ADDS

⇒ This paper presents an empirically developed taxonomy of pressures and strategies providing a menu of options that can be used by clinical leaders and teams, to help them adapt when healthcare systems and organisations are under stress and simply cannot provide the standard of care they aspire to.

Scoping Review: Pressures and Strategies

Staff skill-mix mismatch with demand

The intended increase in capacity was compromised by a skill mix problem.

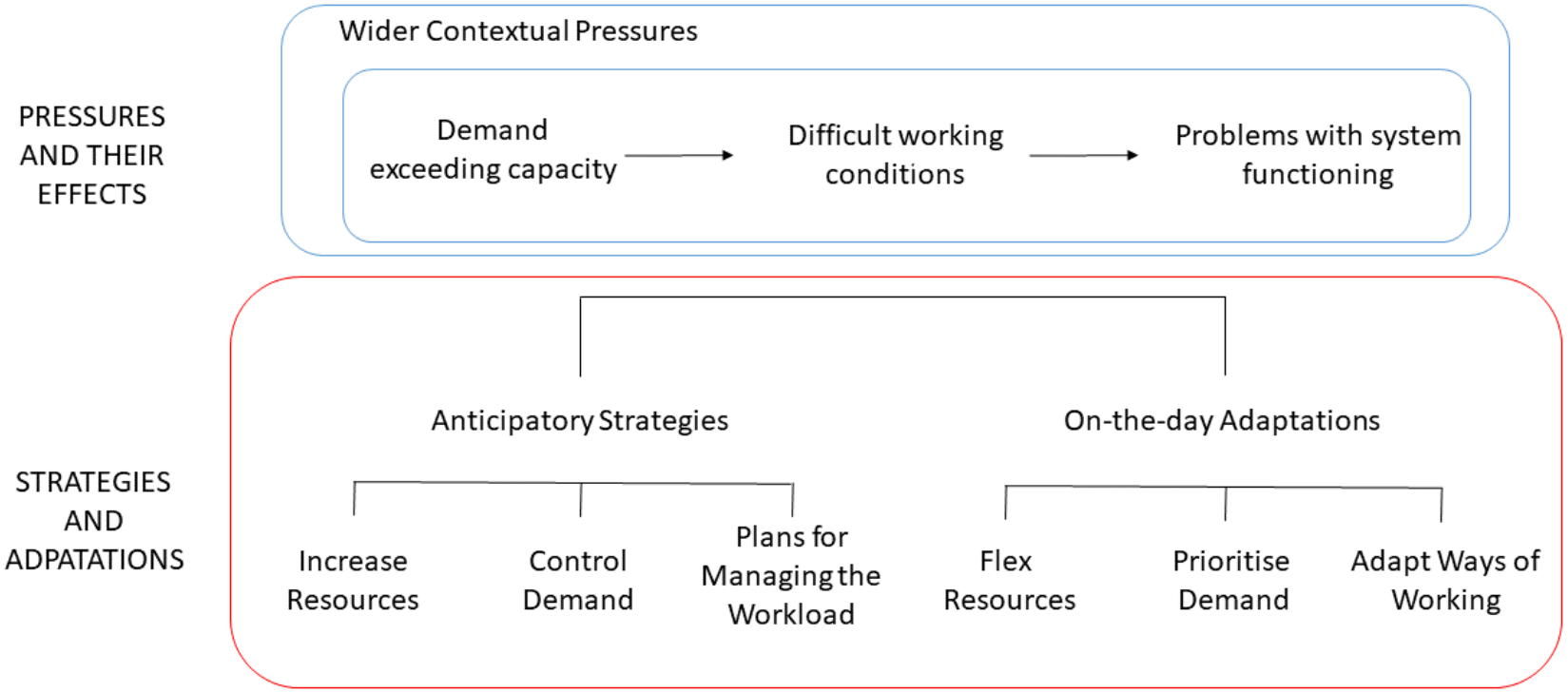
Improve skill-mix

Training staff in more general and acute functions allowed them to offer support in the high-demand wards (Gifford et al., 2022)

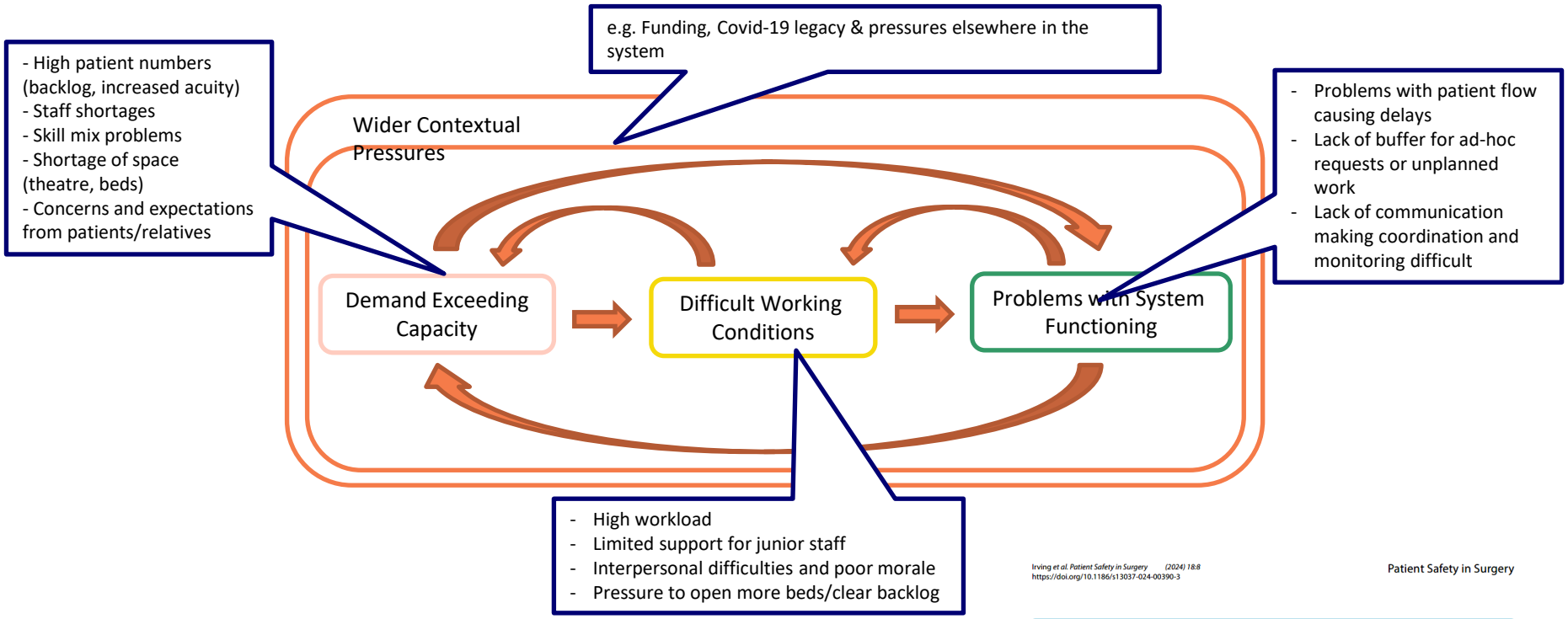
Flexing staff to address skill-mix

Mixed care teams with at least one experienced staff member to counterbalance and support the high number of junior staff (Saurin et al. 2022)

Conceptual Framework



Pressures in ICU and Surgery



Irving et al. Patient Safety in Surgery (2024) 18:8
https://doi.org/10.1186/s13037-024-00390-3

Patient Safety in Surgery

RESEARCH Open Access

Adaptive strategies used by surgical teams under pressure: an interview study among senior healthcare professionals in four major hospitals in the United Kingdom

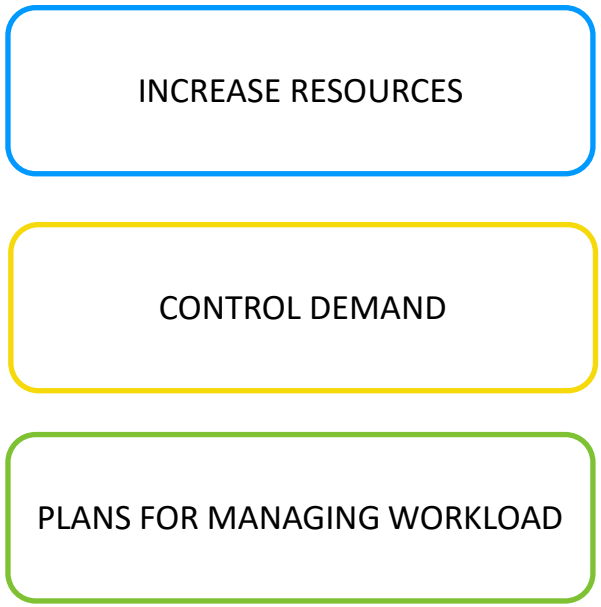
Dulcie Irving[1*], Bethan Page[1,2], Jane Carthey[3], Helen Higham[4], Shabnam Undre[5] and Charles Vincent[1]

Strategies in the ICU

Main objective when under pressure

"That's a really good question, because I could very easily say patient safety, but you can't… What's the main objective? We have to manage the risk to the best of our ability. That's the main objective, I think. I think the main objective on a day like that is risk management, and you can't walk around being risk averse, because obviously risk has gone up, hasn't it? So it's risk reduction, as much as you possibly can."

Anticipatory strategies (ICU)



Improve skill-mix

“Upscaling our HCA just to have more awareness of deteriorations in blood pressure and things like that to just help them along, to give them that reassurance. That they’ve got the confidence to say …his blood pressure’s changed by 20, you might want to have a look.”

Discharge patients home

"*The pressures of the wider hospital and the beds, we've discharged quite a few people home from critical care instead of to a ward, which was never heard of before*"

Adjust protocols

“There's a lot of mixed messages from the organisation, and outside of the organisation, that it’s a Christmas day service. And so we apply the staffing model and protocols that we would on a Christmas day service”

On-the-day adaptations (ICU)

FLEX RESOURCES

PRIORITISE DEMAND

ADAPT WAYS OF WORKING

Task-shifting

“fairly large education team who are pretty skilled. On the days when things are tight, they have to stop educating and start caring for patients.”

Temporarily stopping or delaying activities/types of care

“Tell people that actually it’s okay if you can’t, for example, turn that patient for four hours if you’ve had other things to do. Sometimes you can delay an antibiotic for an hour.”

More huddles/team communication

"It’s not just the daily huddle at the beginning. When the days are really busy, what I’ll do is I’ll recall to the office, and I’ll just say, can folks come to the office for a bit of a huddle? And then we’ll test and adjust."

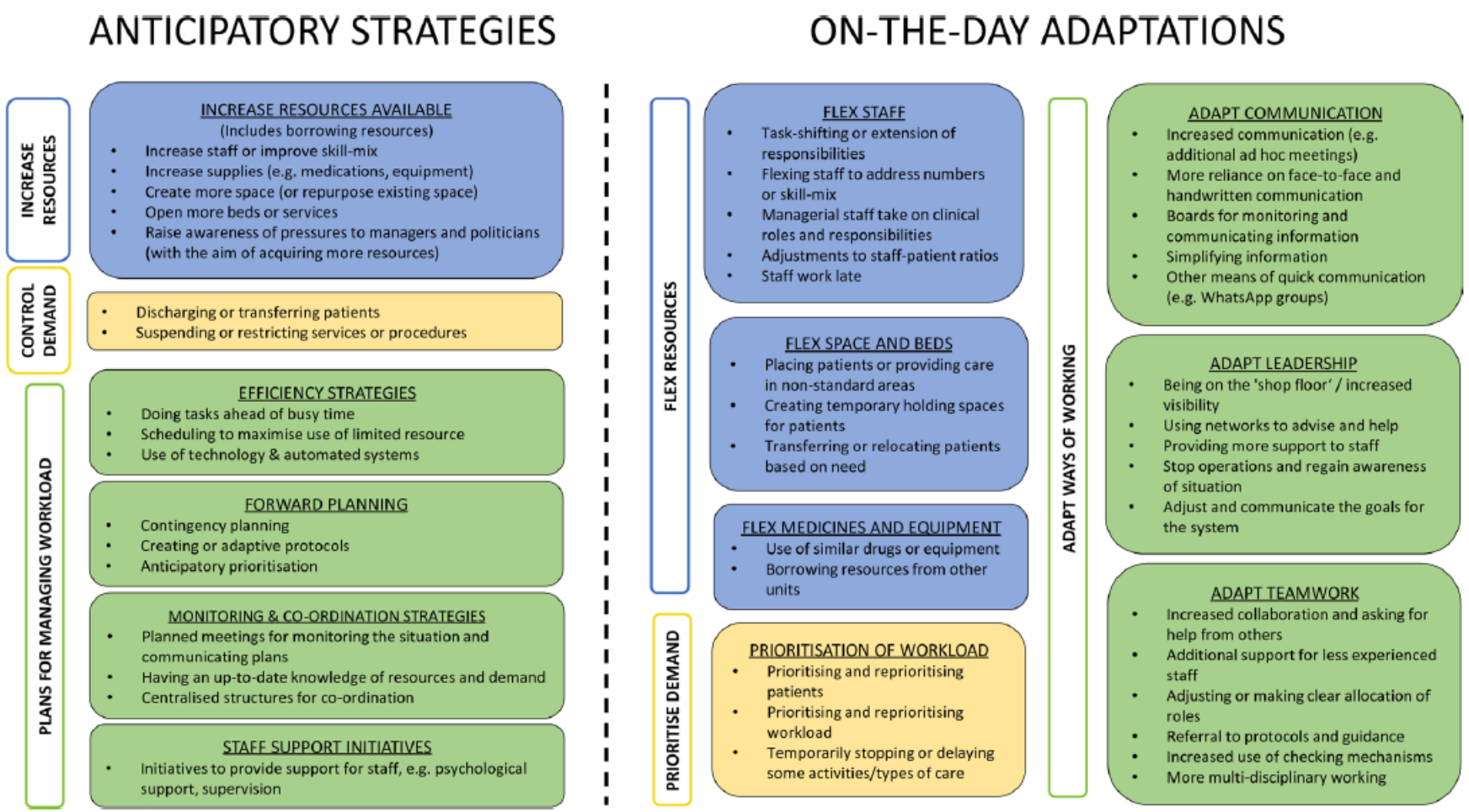


Figure 3 A taxonomy of strategies for adapting to pressures. The taxonomy includes two broad classes of adaptive strategies: anticipatory strategies to prepare for pressures and on-the-day adaptations to manage immediate pressures.

Examples of generic on the day adaptations

FLEX STAFF

- Task-shifting or extension of responsibilities
- Flexing staff to address numbers or skill-mix
- Managerial staff take on clinical roles and responsibilities
- Adjustments to staff-patient ratios
- Staff work late

FLEX SPACE AND BEDS

- Placing patients or providing care in non-standard areas
- Creating temporary holding spaces for patients
- Transferring or relocating patients based on need

What does this mean for leaders?

Implications for leaders: short term

- Acknowledge and communicate openly when standards cannot be met
- Allow and encourage adaptations that are explicit, shared and monitored
- Training programmes can be developed
- A coordinated approach to adaptation will be safer than ‘hidden’ individual and team adaptation
- Adaptations are not forever!

Implications for leaders: long term

- Think beyond quality improvement to a strategic approach to risk and quality
- Use a portfolio of strategies that can be customised to context and problem
- Maintain long-term programmes at times of pressure
- Shift to projects that aim to reduce burden on staff
- Simplification, standardisation and other system interventions will improve both safety and efficiency

Training in managing risk

- Total and SNCF training in values to maintain ‘safety first’ in adverse conditions
- Focus is on conflict and management of conflicts between safety and production pressures
  - Training in managing competing priorities at executive level
  - Middle managers as buffers between frontline and executive
  - Compensatory strategies at the frontline

TOTAL

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SNCF

A portfolio of strategies

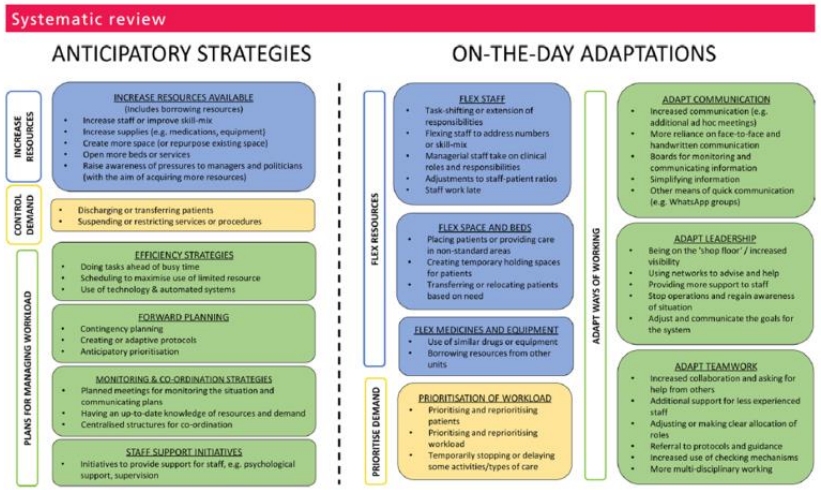

Figure 3 A taxonomy of strategies for adapting to pressures. The taxonomy includes two broad classes of adaptive strategies: anticipatory strategies to prepare for pressures and on-the-day adaptations to manage immediate pressures.

Families of safety interventions

- Best practice
- Improve the system

Optimising Strategies

- Risk control
- Adapt & respond
- Mitigation

Risk Management Strategies