Exploring Healthcare Harm

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Five obstacles that prevent people acting on their concerns

Understanding what stops people speaking up and acting when concerns are raised is important, write Murray Anderson Wallace and Suzanne Shale.

Can health services learn from their mistakes over baby Alexandra's death?

Murray Anderson Wallace and Roland Denning: The death of baby Alexandra came after her parents repeatedly asked for a caesarean, only to feel ignored and misinformed.

The NHS shouldn't accept failure to learn from preventable errors

There is evidence that the NHS is not learning from preventable errors. While there are some patient safety initiatives actively supporting a cultural change, unless we listen to the experiences of families in a timely way, we won't learn, writes James Titcombe and Murray Anderson-Wallace.

'Proper support is needed for all if we are to learn from errors'

Joshua Titcombe would have been six years old today. He died on 5 November 2008 of an overwhelming infection; he was eight days old.

The grief of the Titcombe family turned to anger as they sensed the circumstances surrounding Joshua's death were being obscured. When Joshua's father, James - former project manager of the nuclear industry and now a patient safety advisor for the Care Quality Commission - received the news, he was shocked.

How do we learn from patients' poor experiences?

Far from sapping their time and energy, nurturing the healing relationship at the heart of medicine sustains clinicians' vitality, write Suzanne Shale, Murray Anderson-Wallace.
A culture of passive denial?

“In healthcare organisations, calm confidence is prized and the system has honed its ability to achieve it. Emerging issues, which exacerbate anxiety - like safety concerns, near misses and actual errors - are therefore often not welcome.

In this context there is a risk that people are too keen to be easily reassured and therefore close down difficult conversations and questions too early. This frustrates those who have concerns and speak up, while others become accustomed to deficiencies and dangerously accepting and passive”

Dame Elizabeth Buggins
Evidence to the Mid Staffordshire Public Inquiry led by Sir Robert Francis QC (2011)
Isabel Menzies Lyth

Social Systems as a Defense Against Anxiety
An Empirical Study of the Nursing Service of a General Hospital*

Introduction

This study was initiated by the nursing service of a general teaching hospital in London which sought help in planning the training of student nurses of whom there were 500 in the hospital. Trained nursing staff numbered 150. The student nurses spent all but six months of their three years of undergraduate training working full-time in wards and departments as “staff” while learning and practicing nursing skills. They carried out most of the actual nursing. The task with which the nursing service was struggling was effectively to reconcile two needs: for wards and departments to have adequate numbers of appropriate student nurses as staff; for student nurses, as students, to have the practical experience required for their training. Senior nurses feared the system was at the point of breakdown with serious consequences for student nurse training since patient care naturally tended to take priority whenever there was conflict. The study was carried out within a sociotherapeutic relationship the outcome of which, it was hoped, would be institutional change. The early part was devoted to an exploration of the nature of the problem and its impact on the people involved. While doing this “diagnostic” exploration we became aware of the high level of tension, distress and anxiety in the nursing service. How could nurses tolerate so much anxiety? We found much evidence that they could not. Withdrawal from duty was common. One-third did not complete their training; the majority of these left at their own request. Senior staff changed their jobs appreciably more frequently than workers at similar levels in other professions. Sickness rates were high, especially for minor illnesses requiring only a few days’ absence from duty.

Sense-making in the
don odd moral world of healthcare

“In the hospital it is the good people, not the bad, who take
knives and cut people open; here the good stick others
with needles and push fingers into rectums and
vaginas, tubes in to urethras, needles into the scalp of a
baby; here the good, doing good, peel dead skin from a
screaming burn victim’s body and tell strangers to take
off their clothes…The layperson’s horrible fantasies
here become the professional’s stock in trade.”

D. Chambliss Beyond Caring Chicago UP 1996
Violations in Healthcare

• Healthcare has fewer explicit rules relative to other high risk industries. Whilst there are many procedures and protocols, clinical judgment offers a great deal of flexibility

• Much information about safety come from incident reporting systems. Under-reporting and the lack of narrative makes violations hard to spot
Perspectives

• **Motivation & Attitude**
  – Based on a personal assessment of the local and contextual factors (Aizen 1991, Parker 1992)

• **Organisational and Cultural Approaches**
  – Vulnerable System Syndrome (Reason et al 2001)
  – 1\textsuperscript{st} and 2\textsuperscript{nd} order problem solving (Reason 2001, Tucker 2003)
  – Pathological cultures (Vaughan 1996)

• **Adaptability and Flexibility**
  – Violations are seen as an adaptive & intelligent response by frontline workers to complex work situations (Piaget, 1974; Vitgosky, 1978; de Terssac, 1992; Girin & Grosjean, 1996; Clot, 1997)
  – The law of requisite variety (Ashby 1956, Weik and Sutcliffe, 2001)
Improving the quality of response

1. Attentiveness to negative perceptions of care, and supportive action in response to complaints
2. Supportive disclosure to patients and their interested supporters
3. Support for clinicians, clinical teams and other affected staff
4. Transparent, impartial and authoritative inquiry
5. Implementation of actions approved and collaboratively developed with patients and supporters
6. Restorative approach to restitution
7. Institutional and individual accountability

(Anderson-Wallace & Shale 2014)
https://www.patientsafetylearning.org/blog/test-blog-post