Royal College of Nursing

Health Education England Request for evidence – Commission on Education and Training for Patient Safety

Is your organisation active in patient safety improvement and training for healthcare staff and if so what are your priorities?

Patient safety is identified in the NMC Code (Nursing and Midwifery Council 2015) and the RCN Principles of Nursing Practice (RCN 2010) as an essential part of nursing care. Principle C states: "Nurses and nursing staff manage risk, are vigilant about risk, and help to keep everyone safe in the places they receive health care" (RCN 2010).

Patient safety is the prevention of avoidable errors and adverse effects to patients associated with health care. Staff practise patient safety when they apply safety science methods towards the goal of developing reliable systems of care. So patient safety is both a characteristic of a healthcare system and a way of improving the quality of care.

We believe that much more can be done to reduce preventable harm in health care. We are focusing our efforts in the following three key areas:

Growing safety conscious organisational cultures: organisational cultures can foster a proactive approach to patient safety. However we see attitudes and behaviours that discourage staff from learning from preventable incidents. This increases the likelihood of these incidents recurring. We can change attitudes by working with people to demonstrate how change can be made and sustained.

Designing for reliability: we can increase reliability when there is: agreement about the way of doing things; standardisation of elements of practice; and a commitment to implement best practice. Reliability changes our view of the world. It raises the importance of vigilance and sensitises us to the patient perspective.

Human factors as standard in education and training: the human factors approach to safer healthcare should be a part of the core curricula for all health professionals. Training needs to be co-ordinated along interprofessional lines.

The RCN has supported the movement towards human factors education and was a co-signatory to the report that resulted in the Concordat (National Quality Board 2013). We have developed an area of our website that sets out the human factors approach to patient safety (RCN 2012a) which is updated to showcase its application to key areas of work.

The RCN is playing an active role in the Academy of Medical Royal Colleges ongoing project on quality improvement education including preparing a paper on interprofessional education (IPE) and examples of good practice in quality and safety improvement (Academy of Medical Royal Colleges 2015).

The RCN is a supporter of the Q initiative and five RCN members, including our lead for infection control, Rose Gallagher, are in the first cohort (Health Foundation 2015).

We have developed online learning, “Making sense of patient safety” (RCN 2012b) and embedded the concepts of human factors in our learning for healthcare support workers, “First Steps” (RCN 2012c). We produce a fortnightly Quality and Safety bulletin that curates material on quality and safety improvement.

Royal College of Nursing

The RCN is a member of the Safe Staffing Education and Training Working Group, established by Health Education England to develop a national education and training package for nurses, midwives and care staff in relation to ensuring safe staffing. Nurse and midwives do not receive any specific education or training on safe staffing with most practitioners learning this '*on the job*'. The development of the education and training package will ensure there is a consistent approach for nurses and midwives to develop an understanding of the key principles; methods; tools and guidance available to support decisions in relation to ensuring safe and effective staffing, across all practice settings.

What do you think about current safety education and training of healthcare staff?

It is no longer acceptable that learning about safety remains implicit in curricula (Tella et al 2013). The curricula must be explicit about the extent of exposure to preventable harms and the importance of safety practices in mitigating their effects (Pearson et al 2009). Furthermore a uniprofessional approach to education in quality improvement science (QIS) and human factors and ergonomics (HFE) education is not meaningful in the context of health and social care. Proposals for the alignment of training and educational opportunities for QIS and HFE have been described (Hignett et al 2015). A "vertical integrated thread" of IPE teaching and learning related to QIS and HFE in all curricula (Pearson et al 2009) is required.

What are the main barriers for healthcare staff in ensuring safe care and what can be done to overcome these barriers?

While it will be important to introduce key patient safety concepts in undergraduate curricula it will not be sufficient in and of itself to make an impact on current practice. Learning is, still, predominantly conceived and organised as a separate activity, disconnected from the flow of daily work. Current work-based learning models emphasise the value that is released through exploiting learning opportunities beyond the course and curriculum mindset.

Work-based learning extends beyond learning events to embrace learning as a process, close to, if not part of the daily workflow. The Academy of Medical Royal Colleges project is mapping examples of work-based learning that share common characteristics: they foster reflection on work practices, not exclusively on the acquisition of technical skills; they view learning as arising from the working environment and centre on live projects and challenges; they can also approach learning as a shared and collective activity where problems and solutions are developed (Raelin 2008).

The RCN believes that a strategy to improve the health and wellbeing of nursing staff and create healthier working environments is central to improving patient outcomes. There is a growing body of evidence linking working conditions, management support and staff engagement with patient outcomes. The Boorman review into health and wellbeing in the NHS demonstrated the relationship between staff health and well-being and key dimensions of service quality, including patient safety (NHS Health and Wellbeing, 2009). Furthermore, work led by Aiken (2012) in the RN4CAST study reported that improvements in hospital working environments may be a cost-effective means to improving safety and quality in hospital care. The RCN will be launching its own Healthy Workplace campaign later this year to support organisations in making improvements to working conditions for nursing staff.

Royal College of Nursing

What are the main challenges to replicating and scaling-up best practice to improve patient safety?

Not all recommended practices are easily scalable or transferable. For example checklists require careful attention to the local context, workflow design and teamworking (Shojania and Catchpole 2015). In addition there are several factors that continue to inhibit safety improvement education:

Weak knowledge base relating to IPE applied to safety

Despite the focus on IPE within the UK and beyond evidence of the effectiveness of IPE approaches has been slow to emerge. This is attributable, in part, to the instruments used to evaluate educational interventions and the need to include a wider range of evaluative methodologies. A series of systematic reviews (Reeves et al 2015) have gradually built a clearer picture of the dispersed evidence. Most recently ways of strengthening the knowledge base have been put forward (IOM 2015).

Enduring misperceptions about safety incidents

Misperceptions about patient safety stubbornly persist and these influence the context in which patient safety programmes are introduced. Many organisations remain unconvinced that systems could be safer until a serious event occurs. Some organisations remain unconvinced even after a serious event. It is difficult to develop a learning organisation when the prevailing culture is toxic (Hudson 2003).

Patient safety is frequently defined by the absence of harm not by the things that people are encouraged to do. This fuels the belief that people are the faulty components in health system and that suspending/replacing/retraining them fixes the problem. A significant proportion of cases before the NMC are deemed “no case to answer” - nearly 50% in 2013/14 (RCN 2015). It is likely that a system based approach to safety, using tested approaches grounded in an understanding of human factors and ergonomics would reduce the number of cases of this type (RCN 2012a).

Communications about patient safety

We do not do well in discussing patient safety concepts and issues with staff or the public. We fail to close the gap between theory and practice. This can be compounded by using examples outside healthcare or assuming a level of knowledge not shared by our audiences.

What are the main patient safety priorities for education and training in the future?

- A curriculum that makes explicit the role of human factors and ergonomics (HFE) approaches to providing safer healthcare systems.
- Innovative pedagogies that share common features (Cooke et al 2011):
    - Quality improvement as an integral part of all clinical encounters
    - Health profession students and their clinical teachers as co-learners working together, along with patients and their families to improve patient outcomes and systems of care
    - Improvement work envisioned as the interdependent collaboration of a set of professionals with different backgrounds and perspectives skilfully optimising their work processes for the benefit of patients

- Assessment in health professions education focused on, not just individual performance, but also how the care team's patients fared and how the systems of care were improved.

- Interprofessional education as the dominant teaching and learning practice. A uniprofessional approach to education in quality improvement science (QIS) and HFE is not meaningful in the context of health and social care.
- Recognition of the importance of workplace learning, where the majority of learning opportunities occur. Learning is most effective when it becomes part of the workflow.
- Focus on a healthcare version of the human factors "dirty dozen"[1] (Civil Aviation Authority 2002). This would expose more staff to human factors issues and the practises that can be applied by staff to mitigate their effects.
- Align the learning from findings of the newly formed Independent Patient Safety Investigation Service (IPSIS) with formal and informal learning opportunities within the health care system.

References

NMC (2015) The Code. Professional standards of practice and behaviour for nurses and midwives.

RCN (2010) Principles of nursing practice. http://tinyurl.com/p6tp5da

National Quality Board (2013) Human factors in healthcare. http://tinyurl.com/olqpeqs

RCN (2012a) Patient safety and human factors. http://tinyurl.com/ccb8b34

Academy of Medical Royal Colleges (2015) Quality improvement - Training for better outcomes.

http://tinyurl.com/qjbuy7j

Health Foundation (2015) http://tinyurl.com/oz3qu2n

RCN (2012b) Making sense of patient safety. http://tinyurl.com/pj9ubwj

RCN (2012c) First steps. http://rcnhca.org.uk/

Tella S et al (2013) What do nursing students learn about safety? An integrative literature review. J Nurs Educ 53(1): 7-13.

Pearson P et al (2009) Patient safety in health care professional curricula: examining the learning experience. Project report. Patient Safety Education Study Group. http://tinyurl.com/onymrb5

Hignett S et al (2015) Human factors and ergonomics and quality improvement science: integrating approaches for safety in healthcare. BMJ Qual Saf doi:10.1136/bmjqs-2014-003623

Raelin JA (2008). Work-based learning: bridging knowledge and action in the workplace. Prentice Hall.

NHS Health and Wellbeing (2009) London: DoH (Chair Dr S Boorman). www.nhshealthandwellbeing.org

Aiken L et al (2012) Patient safety, satisfaction, and quality of hospital care: cross sectional surveys of nurses and patients in 12 countries in Europe and the United States BMJ 2012;344:e1717 Available at http://www.bmj.com/content/344/bmj.e1717 (accessed 2 September 2015)

Shojania K, Catchpole K (2015) 'The problem with…': a new series on problematic improvements and problematic problems in healthcare quality and patient safety. BMJ Qual Saf 2015;24:246–249 http://tinyurl.com/odrfnhq

[1] The "dirty dozen" are: lack of communication; distraction; lack of resources; stress; complacency; lack of teamwork; pressure; lack of awareness; lack of knowledge; fatigue; lack of assertiveness; norms.

Royal College of Nursing

Reeves S et al (2015). Synthesis of Interprofessional Education (IPE) reviews. Institute of Medicine. Measuring the impacts of interprofessional education on collaborative practice and learning outcomes. Appendix B. National Academy of Sciences. http://tinyurl.com/kxhafgx

Hudson P (2003) Applying the lessons of high risk industries to health care. Qual Saf Health Care 2003;12(Suppl 1):i7–i12 http://tinyurl.com/lr99bky

RCN (2015) Submission to PASC NHS complaints and clinical failure inquiry. http://tinyurl.com/ohge2og

Cooke M et al (2011). Mainstreaming quality and safety education for health profession students. BMJ Qual Saf 20 (Supp 1) 179-82. http://tinyurl.com/p484qyd

Civil Aviation Authority (2002) An Introduction to Aircraft Maintenance Engineering Human Factors for JAR 66 p20-21. http://tinyurl.com/oaev73o