TOWARDS SAFER RURAL PRACTICE

A framework for improving patient safety in European rural practice

(based on the Manchester Patient Safety Framework)

A joint Euripa / Equip initiative. Part of the Linneaus network.

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Introduction:

This Framework is a tool to help you understand the culture of your practice in relation to patient safety. It has been developed from the Manchester Patient Framework to make it more relevant and easier to use for rural primary care practices across Europe.

- **Why is it important to understand practice culture?** The culture of a practice and the degree to which it can learn from adverse incidents is very important for patient safety. A culture of safety will be one that supports and values the implementation of patient safety initiatives[1] and makes staff feel that it is safe to admit their mistakes. An important early step in improving patient safety is to change the traditional culture of blame to one of openness and learning from mistakes without fear or embarrassment.

- **Why was this Framework developed?** *Safety culture* is a new concept in primary care / family medicine and can be difficult to assess and change. Rural practice across Europe is diverse but is characterised by remoteness from centres of excellence, professional isolation, challenges in accessing education and training and requires a broader range of skills and knowledge. This Framework aims to stimulate discussion about the patient safety

[1] Taylor S, Dy S, Foy R, Hempel S, McDonald K, Øvretvei J, Pronovost P, Rubenstein L,
Wachter R, Shekelle P (2011): *What context features might be important determinants of the effectiveness of patient safety practice interventions?* BMJ Qual Saf 2011;20:611-617.

culture in any rural primary healthcare practice and, in doing so, will help that practice to reflect on its progress towards developing a mature safety culture.

- **This Framework is designed to be used by rural practices to:**
    - help your practice recognise that patient safety is a complex multidimensional concept;
    - stimulate reflection and discussion about the strengths and weaknesses of the patient safety culture in your practice;
    - highlight differences in perception between members of your team;
    - show how a practice with a more mature safety culture might look;
    - help you evaluate the impact of initiatives to improve the safety culture of your practice.

- **This Framework is not designed to be used:**
    - for performance management or assessment purposes;
    - to apportion blame when the results show that your practice's and/or team's safety culture is not sufficiently mature.

This framework needs to be flexibly applied. There is great diversity in healthcare provision in Europe, (eg. group practice / single-handed practice, state funded / insurance funded), as well as specific issues for rural primary care, such as professional isolation, that can make it difficult to carry out group / peer reflection activities. Therefore please be pragmatic when using this tool in your local context!

This Framework is a developmental tool and shouldn't be used too frequently; 18 months to 2 years is about right depending on your practice.

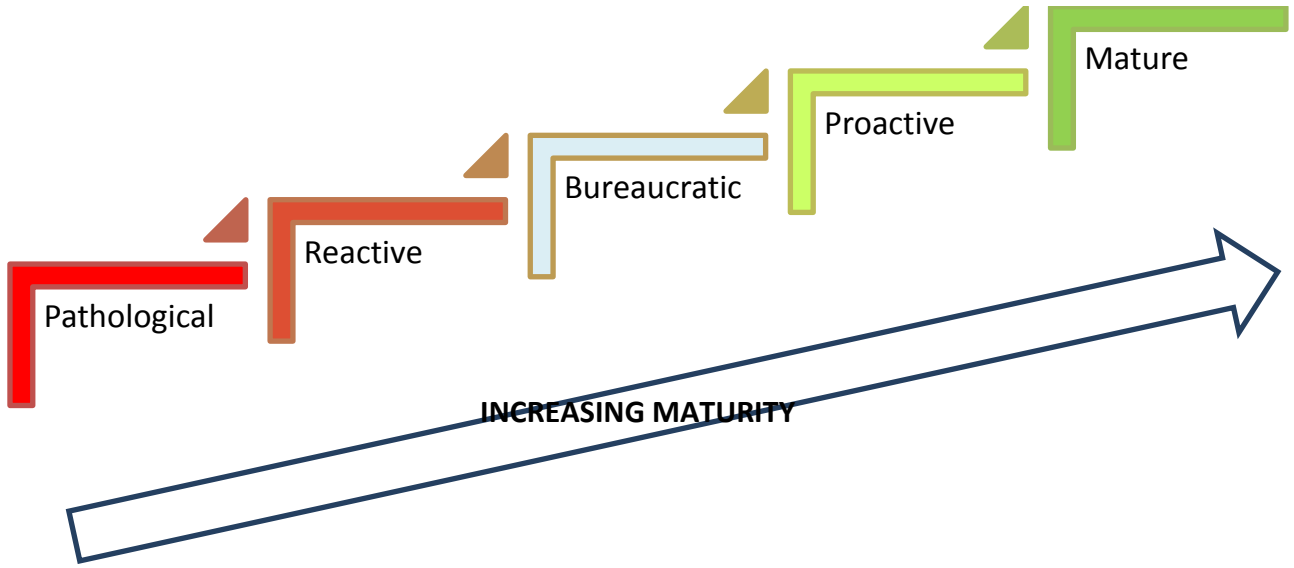
Since general practice / family medicine varies so much across Europe, 'practice' refers to the working environment in which you provide healthcare in your country, be it as part of a multidisciplinary team of several professionals, or as one individual practitioner. However while this Framework can be used by an individual practitioner, we feel that it is more valuable if there is a chance to discuss the issues in a group. It is perhaps therefore a useful first step to think about who might be part of your 'team' and to invite them to get involved in this process: Who else provides care for your patients? Even if they do not share the same premises as you, are there others who work with you to provide healthcare services in the community, such as nurses, pharmacists or midwives?

The Patient Safety Culture Framework

The MapSaF developed and defined nine dimensions of patient safety and for each of these dimensions describes what a practice would look like at five levels of safety culture. These are described below for rural practice:

- **The levels of patient safety culture:**

Level	Description
A - Pathological	Why do we need to waste our time on patient safety issues?
B - Reactive	We take patient safety seriously and do something when we have an incident.
C - Bureaucratic	We have systems in place to manage patient safety.
D - Proactive	We are always on the alert/thinking about patient safety issues that might emerge.
E - Mature	Managing patient safety is an integral part of everything we do.



The nine dimensions of safety culture:

Dimension	Description
1. Overall commitment to quality	How much is invested in developing the quality agenda? What is seen as the main purpose of your practice's policies and procedures? What attempts are made to look beyond your practice for collaboration and innovation?
2. Priority given to patient safety	How seriously is the issue of patient safety taken within your practice? Where does responsibility lie for patient safety issues?
3. Perceptions of the causes of patient safety incidents and their identification	Do you have a system for reporting and recording patient safety incidents? What sort of reporting systems are there? Are incidents viewed as an opportunity to blame or improve?
4. Investigating patient safety incidents*	Who investigates incidents and how are they investigated? What is the aim of the practice? Does the practice learn from the event?
5. Practice learning following a patient safety incident	What happens after an incident? What mechanisms are in place to learn from the incident? How are changes introduced and evaluated?
6. Communication about safety issues	What communication systems are in place? How good is the quality of your record keeping? How do you communicate with your team / colleagues about patient safety issues?
7. Personnel management and patient safety issues	How are safety issues managed in your practice? How are staff problems managed? What are the recruitment and selection procedures like? (You may not be responsible for all the human resource issues in your practice and if this is the case, how do you communicate any problems with those who are responsible?)
8. Staff education and training about patient safety issues	How, why and when are education and training programmes about patient safety developed? What do staff think of them? (You may not be responsible for staff training and therefore how do you communicate with those who are?)
9. Team working around patient safety issues	How and why are teams developed? How are teams managed? How much team working is there around patient safety issues?

*This term includes incidents that were prevented or which did not lead to harm.

- **How to use this " Patient Safety in Rural Practice Framework" :**

  The Framework is best used as a practice based self reflection and educational exercise and should be used by all appropriate members of your practice. *If you work entirely on your own, it may be helpful to form a learning group by joining up with neighbouring practices or professional groups such as pharmacists and nurses to carry out this learning exercise.*

  - For each of the nine aspects of safety culture, select the description (from the matrix at the end of this document) that you think best fits your practice and / or team. Do this individually and privately without discussion using the Evaluation Sheet below.
  - Place a tick on the evaluation sheet to indicate your choices. If you really can't decide between two of the descriptions, tick both. This will give you an indication of the current patient safety culture profile for your practice
  - Discuss your profiles with the rest of your team. You may notice that there are differences between staff groups. If this happens, discuss possible reasons. Address each dimension in turn and see if you can reach consensus.
  - Consider the overall picture of your practice and / or team. There will almost certainly be areas where your practice is doing well and areas where it is doing less well. Where things are going less well, consider the descriptions of more mature risk management cultures. Why is your practice not more like that? How can you move up to a higher level?

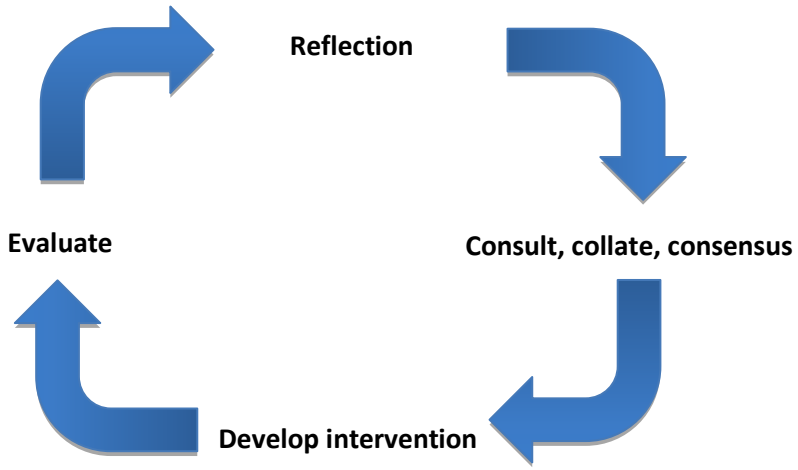
Evaluation sheet

All members of the practice should complete an Evaluation Sheet (see above) using the descriptions in the matrix.

Dimension of patient safety culture	**A**	**B**	**C**	**D**	**E**
1. Overall commitment to quality					
2. Priority given to patient safety					
3. Perceptions of the causes of PSIs and their identification					
4. Investigating patient safety incidents					
5. Practice learning following a patient safety incident					
6. Communication about safety issues					
7. Personnel management and safety issues					
8. Staff education and training about safety issues					
9. Team working around safety issues					

The Patient Safety Cycle

In order for a rural practice (of any size) to effectively address Patient Safety, which is described in the diagram below, the culture of the practice underpins its overall approach.



Dimensions of Patient Safety

- Overall commitment to quality
- Priority given to patient safety
- Perceptions of the causes of PSIs and their identification
- Investigating patient safety incidents
- Practice learning following a patient safety incident
- Communication about safety issues
- Personnel management and safety issues
- Staff education and training about safety issues
- Team working around safety issues

Levels of Safety Culture

A. Pathological
B. Reactive
C. Bureaucratic
D. Proactive
E. Mature

What we mean by these terms:

Patient safety incident (PSI): Any unintended or unexpected incident that could have or did lead to harm to one or more patients receiving healthcare.

Prevented patient safety incident (PPSI): Any patient safety incident that had the potential to cause harm but was prevented.

Root cause analysis (RCA): A technique for undertaking a systematic investigation that looks beyond individuals concerned and seeks to understand the underlying causes and environmental context in which the incident happened. It is designed to identify the sequence of events, working back from the incident.

Significant event audit: SEA enables primary care teams to learn from patient safety incidents and 'near misses', and to highlight and learn from both strengths and weaknesses in the care they provide.

Rural practice patient safety framework

	Pathological	Reactive	Bureaucratic	Proactive	Mature
01. Overall commitment to quality	**Quality is not valued** • There is little commitment to the general quality of care provided or recognition of its importance • Very little time or resources invested in quality assessment or improvement. If any auditing occurs, it lacks rigour and there is no action taken in response to the findings. • Existing protocols or policies are there to meet external requirements and are not used, reviewed or updated. • Maverick behaviour and poor quality of care is tolerated or ignored	**Quality improvements are a reaction to problems** • Quality framework developed in response to specific directives or an imminent inspection visit. • No real motivation or enthusiasm for the quality agenda • Auditing only occurs in response to specific incidents and national directives and does not reflect local need. • A minimum of policies and protocols exist and are unused. • Policy and protocol review and / or development occur in response to incidents or complaints.	**Quality improvements are driven by external agenda** • Defensive attitude towards the quality agenda. The practice is motivated by an external agenda and the potential rewards for being seen as quality focussed. • Frontline staff are not engaged in the process and they see it as a management activity. • Lots of auditing occurs but audit findings are only used if there is an incident. • Staff are overloaded with protocols and policies which are regularly reviewed but rarely implemented. • Patients may be involved in quality issues but only in a superficial way	**The quality agenda is at the forefront of service delivery.** • Quality is seen as everyone's responsibility in the practice • The practice aims to be recognised as one of the best and is keen to compare its performance against others. • Clinicians are actively involved in the auditing process. Audit results are used and lead to quality improvements. • Protocols and policies are developed and reviewed by staff and are used as the basis for care provision. • Patients and the public are formally involved in internal decision making to encourage a patient centred service.	**A quality culture is integral to all decision making at all levels.** • The practice is a centre of excellence continually assessing and comparing its performance against others. The practice designs and conducts its own audit programme which is outcome focussed • Staff are alert to potential patient safety risks. Patient safety is constantly on everyone's minds. • Patients are involved in quality in a routine meaningful way with on-going contribution and feedback.
02. Priority given to patient safety	**Low priority given to patient safety.** • The few risk management systems that are in place, such as strategies and committees are tokenistic and nothing is actually delivered. • This is a practice that believes that risks are worth taking and that if a patient safety incident occurs, insurance schemes can be used to bail them out	**Patient safety becomes a priority once an incident occurs.** • Little attention is paid to patient safety apart from meeting legal requirements. • Little evidence of any implementation of a risk management strategy. Safety is only discussed by the management in relation to specific incidents. • Action is aimed at self-protection and not patient protection. • Risks are taken to contain costs	**Patient safety has a fairly high priority but it is an imposed culture.** • There are numerous systems (including those integrating the patient perspective) in place to protect patient safety. However these systems are not widely communicated to staff or reviewed. • Responsibility for risk management and patient safety lies with a single individual who does not integrate it within the wider practice.	**Patient safety has a high priority and is promoted throughout the practice** • Patients, the public and other organisations are also involved in risk management systems and their review. • Actions taken are aimed at patient protection and not self-protection. • Risks to patients are identified and action is taken to manage them. • There are clear lines of accountability and while one individual takes the lead for patient safety in the practice it is a key part of all general management roles.	**Patient safety is integral to the work of the practice and its staff and is embedded in all activities.** • Responsibility for safety is seen as being part of everyone's role, including for cleaners and administrators, and this is reflected in individuals' terms of employment. • Staff are constantly assessing risk s and looking for potential improvements. • Patient involvement in and review of patient safety issues is well established.

				• There is reporting of patient safety incidents nationally, if there are schemes available.	
03. Perceptions of the causes of patient safety incidents and their identification	**Patient safety incidents are seen as 'bad luck' and outside the practice's control** • PSIs are seen as a result of staff errors or patient behaviour. • Ad hoc reporting systems are in place but the practice is largely ignorant unless serious incidents occur or solicitors' letters are received. • Incidents and complaints are ignored if possible. • There is a strong blame culture with individuals subjected to victimization and disciplinary action.	**Individuals are seen as the cause of the problem and solution is retraining and punitive action.** • There is an embryonic reporting system although staff are not encouraged to report incidents. • Minimum data on the incidents is collected but not analysed. • There is a blame culture so staff are reluctant to report incidents. • When incidents occur there is no attempt to support any of those involved including the patients and their relatives.	**The practice recognises that processes and systems contribute to incidents and not just individuals.** • The practice says that it has an open and fair culture but it not perceived in that way by staff. • A centralised anonymous reporting system is in place with a lot of emphasis on form completion. • Attempts are made to encourage staff and patients / carers to report all incidents although staff may be reluctant to report PPSIs. • The practice considers other sources of safety information alongside incident reports (eg. complaints and audits)	**It is accepted that incidents are a combination of individual and system faults.** • Reporting of PSIs, both locally and nationally (where possible) is encouraged and they are seen as learning opportunities. • Easy-to-use electronic reporting methods are used, where available, allowing trends to be analysed. • Staff, patients and relatives feel safe reporting patient safety incidents and are supported to do so. • The practice has an open fair and collaborative culture.	**Practice failures are noted although staff are also aware of their own professional accountability in relation to errors.** • It is second nature for staff to report PSIs as they have confidence in the investigation process and understand the value of reporting. • Integrated systems enable PSIs and PPSIs, complaints and litigation cases to be analysed together. • Staff, patients and relatives are actively involved and supported from the time of the incident through an open process. • The practice has a high level of openness and trust.
04. Investigating patient safety incidents	**Aim of investigation – avoid bad publicity.** • Incidents are superficially investigated with the aim of closing the issue and avoiding adverse publicity • Information gathered from the investigation is stored but little action is taken apart from disciplinary action and attempts to manage the media	**Aim of investigation – find someone to blame** • Investigations are instigated with the aim of damage limitation for the practice and apportioning individual blame. • Investigations are cursory and focus on a specific event and the actions of an individual. • Quick-fix solutions are proposed that deal with the specific incident but which may not be implemented once attention has moved away.	**Aim of investigation – document the problem** • Practice managers are involved in the investigation which is narrow and focusses on the individual and systems surrounding the incident. • There is a detailed procedure for the investigation process which involves the completion of multiple forms – the investigation is conducted for its own sake rather than examining root causes. • There is a concern to review procedures or change the dissemination of procedures. • Emphasis is placed on placating the patient / carer in a superficial way rather than informing, being open and supporting them.	**Aim of investigation – learning so as to avoid in future** • Staff involved in incidents are involved in their investigation which uses robust methods like root cause analysis and significant event audit to identify the contributory factors and system problems that led to the incident. • The investigation findings are disseminated widely. • Data from investigations are used to analyse trends, identify problem areas, and examine training implications. • It is a forward looking, open practice. • Patients are involved in the investigation process and their perceptions, experience and recommendations are sought.	**Aim of investigation – learning opportunity for development** • The practice conducts internal independent investigations using recognised techniques (e.g. RCA and SEA), which include the staff and patients involved in the incident. • Investigations are seen as learning opportunities and focus upon improvement rather than judgment and include patient recommendations. • The investigation process itself is systematically reviewed by all staff. • It is a learning practice as evidenced by a commitment to learn from incident investigations throughout all levels

05. Practice learning following a patient safety incident	**No learning** • It is not a learning practice as no attempts are made to learn from incidents unless imposed by external bodies. • The aim of the practice after an incident is to cover up the incident and protect itself: the practice considers that it has been successful when the media do not become aware of incidents. • No changes are instigated after an incident apart from those directed at the individuals concerned.	**Limited learning relating to specific incident** • Little, if any, practice learning occurs and what does take place relates to the amount of disruption that senior staff have experienced. • Any changes instigated in the aftermath of an incident are not sustainable as they are instant reactions to perceived individual errors and are devised and imposed by managers. Consequently, similar incidents tend to recur.	**Management imposed changes relating to specific incident** • Some systems are in place to enable practice learning to take place; this may include consideration of the patient perspective. • The lessons learnt are not disseminated throughout the practice. • This learning results in some enforced local changes that relate directly to the specific incident. • Management decide on the changes that need to be introduced and this lack of staff involvement leads to the changes not being integrated into working patterns.	**The practice has a learning culture** • There is management support for in-depth incident investigations using RCA and SEA. • Processes exist to share learning, such as reflection, sharing patient perceptions and SEA. Practice learning following incidents is used in forward planning. • Changes instigated address underlying causes (i.e. system failures). • Staff are actively involved in deciding what changes are needed and there is a real commitment to change throughout the practice. Hence changes are sustainable. • It is an open self confident practice	**The culture is one of continuous improvement.** • The practice learns from internal and external incidents and is committed to sharing this learning both within and outside the practice. • Patient safety incidents are discussed in open forums where all staff feel able to contribute. • Incidents are seen as a learning opportunity – they are inevitable but learning can occur to reduce the likelihood of reoccurrence. • Practice learning itself is evaluated. • Improvements in practice occur without the trigger of an incident • Patients play a key part in learning
06. Communication about safety issues	**Communication is poor and 'top-down'** • There are no mechanisms for staff to speak to managers about risk. • Events are kept in the practice and not talked about • Communication is negative, with a focus on blame. • Patients are only given information which the practice is legally bound to provide.	**Communication upwards is possible but only after something has gone wrong.** • Communication is unplanned and restricted to those involved in a specific incident. • Communication is very directive, with the management issuing instructions. This is a blame focussed practice • The patient is given the information the practice feels is appropriate and it is a one-way communication.	**There is a general communications strategy but unlinked to the patient safety agenda** • A risk communication system is in place, but no-one checks whether it is working. • Policies and procedures related to risk are in place, and lots of records about incidents are kept. There is formal communication between agencies and a large amount of written information is available. • Patient comments are obtained and documented but not effectively utilised. • There is information overload: little is actually done with the information recorded by staff and received by managers. • Information provided to	**The communication style is open and sharing** • The communications system and record keeping in general are both fully audited. There is communication between practices facilitating meaningful benchmarking with respect to areas of potential risk. • All levels of staff are involved and there are robust mechanisms for them to feedback to the practice. • Information about patient safety issues is shared with staff and patient groups; there are regular risk management briefing sessions where staff are encouraged to set the agenda.	**The management have an open door policy – communication is two-way.** • There is equality of communication about safety issues. They expect everyone to know about and learn from each other's experiences • It is a transparent practice and includes patient participation in risk management policy development. Innovative ideas are encouraged. • Electronic communication mechanisms are well-established and are the preferred mode within the practice. • This is a 'praising' practice

			patients is driven by fear of litigation.		
07. Personnel management and safety issues	**Staff are not valued as individuals** • Staff do not feel supported by management (or Human Resources where available) • There is no acknowledgement that personnel management is directly linked to any risk management agenda. • There is a rudimentary HR policy, no structured staff development programme or occupational health input. Recruitment and selection processes are basic. • Personnel take on a punitive role following an incident; the language used is negative and poor health and attendance records are seen as disciplinary matters.	**Staffing issues change in response to problems** • Job descriptions and staffing levels change only in response to problems, so there are good selection and retention policies in areas where the practice has been vulnerable in the past. • There is a very basic HR policy, but it is inflexible and developed in response to risk management problems that have already been experienced.	**HR policies are tools for controlling staff** • Recruitment and retention procedures are in place though they are distinct from risk management policies. • There is a lot of paperwork and the policies are made available for everyone to look at. Credentials are always checked. • The procedures for appraisal, incident investigation, staff development and occupational health are there, but inflexibly applied.	**Good systems of appraisal monitoring and review are seen as tools for supporting staff** • There is some commitment to matching individual skills and knowledge to specific posts. There are also visible, flexible support systems tailored to the needs of the individual. • Personnel management processes are reviewed following changes in risk management policy • There are attempts to understand why poor safety performance occurs and to tackle problems early.	**The practice is committed to its staff, and everyone has confidence in the personnel management procedures.** • Reflection and review about safety issues occur continuously and automatically • There is a policy for employing patients and their representatives. • Following a patient safety incident, a systems analysis is used to make decisions about the relative contribution of systems factors and the individual healthcare professional. This process informs decisions about staff suspensions and as such there is a consistent and fair approach to dealing with staff issues following incidents.
08. Staff education and training about safety issues	**Training has a low priority.** • Only training that is officially required is offered. • Training is seen by managers as irritating, time consuming and costly. • There are no checks made on the quality or relevance of any risk management training given.	**Training occurs in response to specific problems and high-risk areas** • Information about available risk management training is given to new staff in an induction pack. It is the responsibility of the individual to read and act upon this. • Education and training focus on maximising income and protecting the practice. • There is no dedicated training budget.	**Patient safety training is supported only if it benefits the practice.** • No thought is given to actively involving patients in training. • Everyone has their own basic Personal Development Plan but these are not given priority. • Training about safety issues is seen as the way to prevent mistakes. • There are a large number of courses on offer, but they are not always relevant to staff	**The practice values risk management and patient safety training and encourages staff to participate.** • There is an attempt to identify the risk management and patient safety training needs of the practice. Such training is well planned and resourced. • Education and training are tailored to the individual and are linked to other practice systems such as incident reporting. • Preliminary attempts to involve patients and the public in staff training are underway	**Education about safety issues is integral to the practice culture.** • The approach to training and education is flexible and seen as a way of supporting staff in fulfilling their potential. • Individuals are motivated to negotiate their own training programme. • Patients are involved in staff training to aid understanding of patient perceptions of risk and safety.
09. Team working around safety issues	**Individuals mainly work in isolation** • Where there are teams, they are ineffective in terms of risk management. • There are tensions between the	**No real commitment to team working** • There are teams but they have been told to work together and only take a superficial approach	**The team is put together to respond to government and external policies** • There is a risk management group within the practice. • There is little sharing of ideas of	**The team is collaborative and adaptable and actively contribute to the risk management agenda.** • Team structure is fluid with people taking up the role most	**Team membership is flexible, with different people making contributions when appropriate.** • The team is about shared understanding and vision about

	team members and a rigid hierarchical structure. They are more like a group of people brought together with a nominal leader and no direction.	to team working. • Teams get put together to respond to external demands. • There is a clear hierarchy within the practice. The team does work together but individuals are not actually committed to team work.	patient safety issues across the practice teams	appropriate for them at the time. • There is evaluation of how effective the team is and changes are made when necessary. • The team may involve those external to the practice.	safety issues rather than just being in the same building. • Everyone is equally valued and feels free to contribute to the patient safety agenda.