The College of Emergency Medicine

The Safety Toolkit

Safer Care

December 2013

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Acknowledgements

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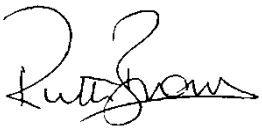
Introduction

Emergency Medicine is by its nature a high risk specialty – with the expectation that care will be delivered to large numbers of patients with undifferentiated problems and limited resources with which to operate. With the recent negative publicity regarding Emergency Medicine, a greater understanding of risk in general and the intense pressure to achieve quantitative targets on a background of efficiency programmes and increasing attendances, the absolute requirement to deliver high quality and safe care in Emergency Departments has never been greater. It is therefore crucial that the appropriate processes, culture and training are in place so that every Emergency Department in the United Kingdom can deliver the safest care in such an austere environment.

This safety tool kit aims to describe the structures, processes and skills required for a 'safe' department. The original concept was that it would enable any Emergency Physician, starting from scratch, to construct a safety framework that contained all the key elements necessary to support the delivery of high quality care whilst at the same time being vigilant to ongoing risks. We acknowledge that in reality the majority of Emergency Departments will already have well established structures for ensuring safe care but it is also probable that not all elements are as effective as they should be; so we hope this toolkit will provide something useful for all.

The recently published Berwick Report, A **promise to learn – a commitment to act** starts by stating there is a need to *place the quality of patient care, especially patient safety, above all other aims.* This toolkit, prepared by the Safer Care Committee, is a useful starting point in achieving this commitment. There are resources identified within each section to stimulate, provoke and challenge, as well as guide personal development. There are overlapping references and differing perspectives but the vision is of a resource for change and development.

Dr Sue Robinson FRCP FCEM
Safer Care Co-Chair



Dr Ruth Brown FRCS FCEM
Safer Care Co-Chair

How to use the safety toolkit

Ruth Brown

This toolkit is provided to Fellows as a comprehensive (but not exhaustive) resource for delivering safe care. We know many departments already have really good systems in place, whilst others are still developing them. It is also provided as a resource for senior trainees in thinking about their future role as a consultant.

We suggest you could use this resource in a number of different ways:

1. In your local departmental meetings - Ensuring that safety is considered in the meeting or by having specific safety meetings. We have included suggested agendas for such meetings in our toolkit section *Departmental Activity Resources.*

2. Working through the toolkit - You could take a section at a time, say over a year, and review the resources as a team, perhaps as a consultant CPD session or by asking an StR to present a summary. This embeds the content in everyone's psyche and lends an importance to it.

3. By discussing key topics with your managers and ensuring that all business plans and service developments are prepared using the toolkit as a resource for your document.

4. Modelling your in –house education using the resources or accessing your Trust quality and safety team to deliver the education with you – they can add a dimension to the clinical content by talking about real cases from a risk perspective.

5. One of the key chapters is *Supporting the Second Victim*. This is a relatively new concept and is particularly welcomed by staff. This might be the first section of the toolkit you review together as it will engage staff very early on.

Designing a risk register
Liz Saunders

Introduction
A risk register is part of the process of recording how you will manage the risks in your work area or organisation. Each risk that is identified should be recorded in a register that summarises:

- a description of the risk
- its cause and impact
- the existing controls for the risk
- an assessment of the consequences and likelihood of the risk happening with the existing controls
- the risk rating: low, medium, high or very high and the overall priority of the risk

Purpose
To enable ED leaders to develop a risk register and understand its purpose in maintaining patient safety.

Objective 1	***Action***	***Evidence and Resources***
Identifying risks for the register.	Identifying risk is important as risks have wide implications within the healthcare sector.	*The identification of risk, and use of a risk register, enables senior management of the organisation to prioritise individual risks and to structure efforts and resources into reducing risk and thereby improve quality and standards of care. Sources to identify risk include incident reporting, serious incidents, patient feedback and complaints. It is essential that frontline staff understand the role of the incident reporting system and the risk register.* *In many organisations, the risk register is populated by a risk manager to reflect complaints, litigations, inspection, reports and trends within incident reports within a service area or directorate.* *This guide for risk managers on how to populate a risk register has case studies and examples of how to identify risk within an organisation. It explains the purpose of assessing risk and how to integrate the risk register into the trust organisational structure.* **Making it Happen: A Guide for Risk Managers on How to Populate a Risk Register,** CASU and Risk Register working group of Keele University, 2002. http://www.dhsspsni.gov.uk/guidance_on_register.pdf *The Northern Irish Assembly, Department of Health, Social Service and Public Safety has a clinical governance section explaining the development of the risk register from how to populate the register to how to assess risk.* **The Department of Health, Social Services and Public Safety**, ***Risk Register Guidance*** http://www.dhsspsni.gov.uk/governance-risk

Objective 1	***Action***	***Evidence and Resources***
continued		*The Health Services Executive Ireland gives an overview of the risk register development process from department level to organisation level.* **Health Services Executive Ireland, *Developing and Populating a Risk Register Best Practice Guidance*** http://www.hse.ie/eng/about/Who/qualityandpatientsafety/resourcesintelligence/Quality_and_Patient_Safety_Documents/devrr.pdf
Objective 2	***Action***	***Evidence and Resources***
To be aware of the available resources for risk assessment.	Risk assessment is the process that supports organisations in understanding the range of risks they have, their ability to control these risks, the likelihood of occurrence and the potential impact of these risks.	***The National Reporting and Learning Service (NRLS) and NPSA (National Patient Safety Association)*** *have produced a range of resources to help managers and staff with risk assessment/management relating to patient safety, including:* *This risk management programme comprises an overview and specific guides for practice-based commissioning and commissioners of out-of-hours services. It describes the NRLS's risk assessment work programme and suggests tools and techniques that local NHS organisations can use in their risk management approach.* **Risk assessment overview programme**, National Patient Safety Agency, November 2006 http://www.nrls.npsa.nhs.uk/EasySiteWeb/getresource.axd?AssetID=60102&type=full&servicetype=Attachment *This document promotes vigilance in identifying risk and the ways in which risk can be minimised. It describes the difference between a hazard and a risk, and sets out the five steps to easy risk management. In addition it contains an example risk matrix and action required to reduce risks to an acceptable level.* **Healthcare risk assessment made easy,** National Patient Safety Agency, March 2007 http://www.nrls.npsa.nhs.uk/EasySiteWeb/getresource.axd?AssetID=60138&type=full&servicetype=Attachment *This risk matrix helps NHS risk managers implement an integrated system of risk assessment. The document includes guidance on consequence scoring, guidance on likelihood scoring, risk scoring and grading, relationship with incident scoring and a model matrix.* **A risk matrix for risk managers**, National Patient Safety Agency, January 2008. http://www.nrls.npsa.nhs.uk/EasySiteWeb/getresource.axd?AssetID=60149&type=full&servicetype=Attachment *On Friday 1 June 2012 the key functions and expertise for patient safety developed by the National Patient Safety Agency (NPSA) transferred to the NHS Commissioning Board Special Health Authority.* **The NHS Commissioning Board, *Patient Safety*** http://www.commissioningboard.nhs.uk/ourwork/patientsafety

Objective 2	Action	Evidence and Resources
continued		*NHS Scotland has a quality improvement tool on the risk register. This includes templates and methods of assessing risk.* **NHS Scotland Quality Improvement Hub, *Risk Register*** http://www.qihub.scot.nhs.uk/knowledge-centre/quality-improvement-tools/risk-register.aspx *This website contains interactive learning tools on risk management.* **Flying Start NHS, *Managing Risk*** http://www.flyingstart.scot.nhs.uk/learning-programmes/safe-practice/managing-risk.aspx *This document provides a template for the analysis of risk.* **The Australia / New Zealand Model** (AS/NZS 4360: 1999) www.dhsspsni.gov.uk/guidance_on_analysis.doc
Objective 3	***Action***	***Evidence and Resources***
To understand methods of risk management.	Once identified and assessed, risks need to be managed. Some risks can be managed others cannot and need mitigating.	*Organisations have risk management teams who collate and respond to the documentation of risk as identified by health care professionals at local level and integrate the highest risks (usually those with a score of 15 or more) into the trust or organisation's risk register.* *The NHS Litigation Authority regularly assesses NHS Trusts against its risk management standards. Trusts at Level 1 are assessed once every two years and those at Levels 2 and 3 at least once in any three year period. Trusts that fail an assessment are re-assessed within a year. Trusts at Level 1 in the risk management standards receive a 10% discount on their CNST and RPST contributions, with discounts of 20% and 30% given to those achieving Levels 2 and 3 respectively.* **NHS Litigation Authority, *Standards*** http://www.nhsla.com/Safety/Standards/Pages/Home.aspx *The CNST (Clinical Negligence Scheme for Trusts), administered by the NHS Litigation Authority, provides an indemnity to members and their employees in respect of clinical negligence claims. The Risk Pooling Schemes for Trusts (RPST) covers non-clinical risks. These schemes are funded by contributions paid by member trusts and contributions are calculated on an annual basis.* **NHS Litigation Authority, *Clinical Claims*** http://www.nhsla.com/Claims/Pages/Clinical.aspx *This document addresses risks in the healthcare sector and provides some good ideas on how to deal with them. It is an initiative by the health promotion bodies and the Health Services Advisory Committee.* **Risk assessment at work: Practical examples in the NHS,** NICE: 1997: http://www.nice.org.uk/niceMedia/documents/risk_assment_examples.pdf.

Objective 3	*Action*	*Evidence and Resources*
continued		*In this risk management standards document Figure 3.1 'Risk management process in detail' and the definitions are particularly useful.* **Australian and New Zealand Standards - Risk Management**, AS/NZS 4360:2004, http://www.mwds.com/AS4me_files/AS-NZS%204360-2004%20Risk%20Management.pdf
Objective 4	***Action***	***Evidence and Resources***
To appreciate the need to document and maintain the risk register.	The risks identified need to be documented and shared with the organisation so that action can be taken to mitigate the risk.	*Datix is a good example of an electronic "integrated risk reporting system" already used by many trusts in the UK for incident reporting. Now some trusts are developing the system further for managing their risk registers. However it is only as good as the information entered. It is a 'live system' and open for everyone (with access) to see. It is in constant flow, updating all the time, allowing new risks to be added when identified and old risks to be down -graded or even archived when changes have been implemented. It may be possible in the future that the risk registers will be uploaded to the NRLS as happens with the incident reporting.* **Datix** http://www.datix.co.uk *Prior to the development of systems like Datix the risk register was usually kept as a folder in the department and the risks reviewed at intervals - usually yearly. The below link is an example risk register from St Emlyn's Virtual Hospital.* **St Emlyn's Virtual Hospital** http://www.stemlyns.org.uk/download.php?dtType=media&fileID=547
Objective 5	***Action***	***Evidence and Resources***
To appreciate the teaching and learning required for good risk identification and assessment.	Frontline staff need to understand the role of the incident reporting system and the risk register in improving safety.	*The identification of risks for the register is only as good as the information available. Clearly if areas of risk exist which are not reported or recorded then the register will be less valid. Equally, the assigning of the priority order of risks may be subjective. These limitations can be reduced by high level of clinical ownership of the process.* *Many Trust held training programmes or workshops are offered by the Risk Management Team.* *There are many examples of NHS Trust guidance on risk assessment and management on the internet, for example:* **Royal Cornwall Hospitals NHS Trust, *Policy and Guidance for Risk Assessment and Risk Registers 2012*** http://www.rcht.nhs.uk/DocumentsLibrary/RoyalCornwallHospitalsTrust/Clinical/QualityAndSafety/RiskAssessmentPolicy.pdf

Objective 5	*Action*	*Evidence and Resources*
continued		**East Cheshire NHS Trust, *Risk Assessment and Risk Register Policy 2012*** http://www.eastcheshire.nhs.uk/About-The-Trust/policies/R/Risk%20assessment%20and%20risk%20register%201730.pdf ***Royal College of Physicians*** *and* ***NPSA*** *have produced a Teaching Module for FY1/FY2 on Risk assessment which includes:* Instructions: http://www.nrls.npsa.nhs.uk/EasySiteWeb/getresource.axd?AssetID=61911& Slides: http://www.nrls.npsa.nhs.uk/EasySiteWeb/getresource.axd?AssetID=61910&type=full&servicetype=Attachment *The Central Alerting System (CAS) is a web-based cascading system for issuing patient safety alerts, important public health messages and other safety critical information and guidance to the NHS and others, including independent providers of health and social care.* **NHS, *The Central Risk Alerting System*** https://www.cas.dh.gov.uk

Learning from practice

Ruth Brown and Emma Redfern

Introduction

Critical incident reporting is an important part of monitoring safety and learning from events. There are multiple tools available for reviewing adverse events and analysing causation before taking action.

Purpose

To provide resources that support active reflection on events, by complaint and adverse event analysis, mortality and morbidity meetings, case note review and prospective hazard analysis.

To provide templates and resources to allow a structured approach to safety.

Objective 1	*Action*	*Evidence and Resources*
To understand incident reporting and analysis.	It is important to understand the barriers and incentives to incident reporting as well as appreciate the strategies that can be used to increase the number of reports submitted.	***Barriers and overcoming them:*** **Creating an Infrastructure for Safety Event Reporting and Analysis in a Multicenter Pediatric Emergency Department Network** J Chamberlain Pediatr Emerg Care. 2013 Feb;29(2):125-30. http://www.ncbi.nlm.nih.gov/pubmed/23364372 **Can incident reporting improve safety? Healthcare practitioners' views of the effectiveness of incident reporting**. J Anderson Int J Qual Health Care. 2013 Apr;25(2):141-50. http://intqhc.oxfordjournals.org/content/early/2013/01/17/intqhc.mzs081.abstract **Interventions to increase clinical incident reporting in health care.** E Parmelli. Cochrane Database Syst Rev. 2012 Aug 15;8:CD005609. http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD005609/abstract **Critical incident reporting and learning**. Mahajan RP. Br J Anaesth. 2010 Jul;105(1):69-75. http://bja.oxfordjournals.org/content/105/5/698.1.full **Improving patient safety incident reporting systems by focusing upon feedback - lessons from English and Welsh Trusts.** L Wallace Health Serv Manage Res. 2009 Aug;22(3):129-35 http://www.ncbi.nlm.nih.gov/pubmed/19633181

Objective 1	*Action*	*Evidence and Resources*
continued		**Feedback from incident reporting: information and action to improve patient safety**. J Benn et al. Qual Saf Health Care. 2009 Feb;18(1):11-21 http://qualitysafety.bmj.com/content/18/1/11.abstract **Trends in healthcare incident reporting and relationship to safety and quality data in acute hospitals: results from the National Reporting and Learning System**. A Hutchinson. Qual Saf Health Care. 2009 Feb;18(1):5-10 http://www.ncbi.nlm.nih.gov/pubmed/19204125 **Development of an evidence-based framework of factors contributing to patient safety incidents in hospital settings: a systematic review**. Rebecca Lawton et al. BMJ Qual Saf 2012 21:369-380 http://qualitysafety.bmj.com/content/early/2012/03/14/bmjqs-2011-000443.full *A scoping study which identifies how the effective use of design could help to reduce medical accidents.* **Engineering Design Centre, *Design for Patient Safety*** http://www-edc.eng.cam.ac.uk
Objective 2	***Action***	***Evidence and Resources***
To understand the selection of processes for investigation and analysis of an event.	Incident analysis is more than just collecting information – appropriate reflection, analysis of events and team discussion of what the department was like at the time is crucial to understand why and what happened and therefore how the risk of recurrence can be reduced.	**NHS Patient Safety Resources, *Root cause analysis information and evaluation*** http://www.nrls.npsa.nhs.uk/resources/?entryid45=75602&q=0%c2%acroot+cause+analysis%c2%ac **Training health care professionals in root cause analysis: a cross-sectional study of post-training experiences, benefits and attitudes**. P Bowie et al BMC Health Serv Res. 2013 Feb 7;13:50 http://www.biomedcentral.com/1472-6963/13/50 **Experiences of health professionals who conducted root cause analyses after undergoing a safety improvement programme**. J Braithwaite Qual Saf Health Care. 2006 Dec;15(6):393-9. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2464895/ **Survey evaluation of the National Patient Safety Agency's Root Cause Analysis training programme in England and Wales: knowledge, beliefs and reported practices**. L Wallace Et al. Qual Saf Health Care. 2009 Aug;18(4):288-91 http://qualitysafety.bmj.com/content/18/4/288.abstract

Objective 2	*Action*	*Evidence and Resources*
continued		**Imperial College London, *The London Protocol*** http://www1.imperial.ac.uk/medicine/about/institutes/patientsafetyservicequality/cpssq_publications/resources_tools/the_london_protocol/ **Framework for analysing risk and safety in clinical medicine.** C Vincent et al. BMJ. 1998 Apr 11;316(7138):1154-7 http://www.bmj.com/content/316/7138/1154 **How to investigate and analyse clinical incidents: clinical risk unit and association of litigation and risk management protocol.** C Vincent et al . BMJ. 2000 Mar 18;320(7237):777-81. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1117773/ **Analysis of clinical incidents: a window on the system not a search for root causes**. Vincent CA. Qual Saf Health Care. 2004 Aug;13(4):242-3. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1743862/ **Beyond FMEA: The structured what-if technique (SWIFT)** AJ Card et al. American Society for Healthcare Risk Management 2012 vol 31, number 4, pp 23-29 http://onlinelibrary.wiley.com/doi/10.1002/jhrm.20101/pdf
Objective 3	***Action***	***Evidence and Resources***
To appreciate the utilisation of routine audit or M&M meetings to identify risk and reduce hazards.	These can be a useful way of monitoring the care of critically ill patients or sentinel conditions.	**Mortality and morbidity meetings: an untapped resource for improving the governance of patient safety?** Higginson J, Walters R, Fulop N. BMJ Qual Saf (2012). http://qualitysafety.bmj.com/content/21/7/576.full **The normalization of deviance in healthcare delivery. John Banja** Bus Horiz. 2010; 53(2): 139. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2821100/ **Medication safety: using incident data analysis and clinical focus groups to inform educational needs.** H Hesselgreaves . J Eval Clin Pract. 2013 Feb;19(1):30-8 http://www.ncbi.nlm.nih.gov/pubmed/22070161 **One model of healthcare provision lessons learnt through clinical governance.** V Webb J Forensic Leg Med. 2010 Oct;17(7):368-73 http://www.ncbi.nlm.nih.gov/pubmed/20851355

Objective 3	*Action*	*Evidence and Resources*
continued		**Prevention of medication errors: detection and audit.** Montesi G, Lechi A. Br J Clin Pharmacol. 2009 Jun;67(6):651-5 http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2723204/ **Morbidity and mortality conferences**: Their educational role and why we should be there. Epstein NE. Surg Neurol Int. 2012;3(Suppl 5):S377-88 http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3520073/
Objective 4	***Action***	***Evidence and Resources***
To understand how case note review can be used to identify errors or harm.	Routine small scale review of notes can demonstrate recurrent, and often hidden, errors or risks to safety.	***Evidence that errors are detectable by routine review*** **Preventable deaths due to problems in care in English acute hospitals: a retrospective case record review study**. H Hogan et al BMJ Qual Saf. 2012 Sep;21(9):737-45. http://qualitysafety.bmj.com/content/early/2012/07/06/bmjqs-2012-001159.full **To what extent are adverse events found in patient records reported by patients and healthcare professionals via complaints, claims and incident reports?** I Christiaaans-Dingelhoff et al. BMC Health Serv Res. 2011 Feb 28;11:49 http://www.biomedcentral.com/1472-6963/11/49
Objective 5	***Action***	***Evidence and Resources***
To understand the purpose of prospective hazard analysis in reducing risk.	Analysing and depicting complex systems highlighting weaknesses and vulnerable areas. A variety of techniques are available to predict failure before it happens.	***What happens when one part of a pathway fails*** *The Institute for Healthcare improvement has a tool for failure modes and effects. A tour of this tool can be found below:* **Institute for Healthcare improvement, *Failure Modes and Effects Analysis (FMEA) Tool*** http://www.ihi.org/knowledge/Pages/Tools/FailureModesandEffectsAnalysisTool.aspx http://app.ihi.org/Workspace/tools/fmea/ **Using Health Care Failure Mode and Effect Analysis -** The VA National Center for Patient Safety's Prospective Risk Analysis System, J Derosier et al. http://www.generalpurposehosting.com/updates/HFMEA_JQI.pdf **Using prospective hazard analysis to assess an active shooter emergency operations plan,** Alan J. Card, Heidi Harrison, James Ward and John Clarkson, Journal of Healthcare Risk Management (31,3) 2012 http://onlinelibrary.wiley.com/doi/10.1002/jhrm.20095/pdf

Objective 5	*Action*	*Evidence and Resources*
continued		***Use of FMEA in a pathway analysis*** **Using a multi-method, user centred, prospective hazard analysis to assess care quality and patient safety in a care pathway** J Dean et al http://www.biomedcentral.com/1472-6963/7/89 ***Example of best practice*** *This PhD is an example of best practice into a specific clinical question* **The evaluation of methods for the prospective patient safety hazard analysis of ward-based oxygen therapy**. M Durand http://dspace.lib.cranfield.ac.uk/handle/1826/4480
Objective 6	***Action***	***Evidence and Resource***
To utilise data from complaints to analyse risk to patient safety.	Complaints may give a different view of the department and the work therein – identifying situations where normal practice is not followed.	**Clinical complaints: a means of improving quality of care**. P Bark et al Qual Health Care. 1994 Sep;3(3):123-32. http://www.ncbi.nlm.nih.gov/pubmed/10139408 **A comprehensive overview of medical error in hospitals using incident-reporting systems, patient complaints and chart review of inpatient deaths.** J de Feijter PLoS One. 2012;7(2):e31125 http://www.plosone.org/article/info%3Adoi%2F10.1371%2Fjournal.pone.0031125 **Using Patient Complaints to Promote Patient Safety,** James W. Pichert, PhD, Gerald Hickson, MD, and Ilene Moore, Advances in Patient Safety Vol 2. http://www.ahrq.gov/professionals/quality-patient-safety/patient-safety-resources/resources/advances-in-patient-safety-2/vol2/Advances-Pichert_51.pdf ***This website provides guidance on how to improve complaints handling in the NHS.*** Parliamentary and Health Service Ombudsman, *Getting it right: our work in the new NHS* http://www.ombudsman.org.uk/listening-and-learning-2012/getting-it-right/getting-it-right-our-work-in-the-new-nhs **Learning from complaints about general practitioners - Clinical governance means handling complaints better - for both parties**, Richard Baker, BMJ. 1999 June 12; 318(7198): 1567–1568. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1115948/ **The role of the patient in clinical safety.** R Lawton and G Armitage. The Health Foundation 2012 http://www.health.org.uk/publications/the-role-of-the-patient-in-clinical-safety/

Safe leadership
Taj Hassan

Introduction
The expectations and need to deliver high quality safer care in hospitals and especially in Emergency Departments (EDs) has never been greater. Leadership qualities are required at every stage by every worker in an ED or affiliated to the ED in order for the culture of safety to be embedded into the very fabric of an organisation.

Purposes
This section provides a broad framework that will support all practitioners in developing an understanding of the leadership skills necessary when pursuing excellence in system design and improvement, human factors application and constant vigilance to minimise the risk of significant harm in an ED. It must be accepted that error is always liable to occur but showing leadership in order to minimise the likelihood of significant harm is vital.

Objective 1	*Action*	*Evidence and Resources*
To understand what constitutes a safety leader in the ED.	It is necessary to understand the leadership qualities and skills required of an individual in order to highlight problems with safety, encourage the development of an appropriate culture for safe practice and implement a successful change programme.	**Crossing the quality chasm – a new health system for the 21st century,** Institute of Medicine, 2001 http://www.iom.edu/Reports/2001/Crossing-the-Quality-Chasm-A-New-Health-System-for-the-21st-Century.aspx **Institute for Healthcare Improvement. Framework for Resident Education in Safety and Quality** http://www.ihi.org/offerings/ihiopenschool/resources/Pages/UniversityOfWashingtonResidentEducation.aspx **Transforming healthcare: A safety imperative.** Leape et al Qual Saf Health Care 2009;18:424–428. doi:10.1136/qshc.2009.036954 http://www.npsf.org/wp-content/uploads/2011/10/tranforming-healthcare.pdf **What is patient safety culture – a review of the literature.** Sammer et al Journal of Nursing Scholarship Volume 42, Issue 2, pages 156–165 http://onlinelibrary.wiley.com/doi/10.1111/j.1547-5069.2009.01330.x/abstract *This is a well recognised concept of looking at the 'task-individual-group.'* **Manage Train Learn, Adair's Three Circles**' http://www.managetrainlearn.com/page/adairs-three-circles *This programme breaks leadership up into 5 practices and 10 behaviours.* **Kouzes & Posner – The leadership challenge** http://www.leadershipchallenge.com/home.aspx

Objective 1	*Action*	*Evidence and Resources*
continued		**Scouller J.The three levels of leadership – how to develop your leadership presence, knowhow and skills.** http://www.three-levels-of-leadership.com/blog/tag/james-scouller/
Objective 2	***Action***	***Evidence and Resources***
To understand why systems need good leaders.	Systems need to have leaders at every level who are able to take responsibility for their role in the design and delivery of safer health care. In addition it is important to understand that some of the problems in healthcare, especially in Emergency Medicine, require different modelling and thinking in order to design safer solutions.	**Berwick review into patient safety** https://www.gov.uk/government/publications/berwick-review-into-patient-safety *Step 2 is 'lead and support your staff.'* **Seven steps to patient safety: full reference guide,** The National Patient Safety Agency (NPSA) http://www.nrls.npsa.nhs.uk/resources/?entryid45=59787&p=15 **Re-examining the components of transformational and transactional leadership using the Multifactor Leadership,** Avolio, Bass et al, JOOP 2010 http://onlinelibrary.wiley.com/doi/10.1348/096317999166789/full *This article provides a different way at looking at leadership situations and how to manage them. It includes 'The Cynefin framework' of how leaders can adopt a different framework to manage the complexity of the situation they face.* **A Leader's Framework for Decision Making,** Snowden & Boone Harvard Business Review: 2007 http://www.mpiweb.org/CMS/uploadedFiles/Article%20for%20Marketing%20-%20Mary%20Boone.pdf **Followership in the NHS,** Keith Grint & Clare Holt Kings Fund: 2011 http://www.kingsfund.org.uk/sites/files/kf/followership-in-nhs-commississon-on-leadership-Management-keith-grint-claire-holt-kings-fund-may-2011.pdf
Objective 3	***Action***	***Evidence and Resources***
To become a good safety leader.	To provide a set of resources that can support an Emergency Medicine trainee or Consultant to develop and enhance their skills in system design and human performance leadership resulting in safer care and constant quality improvement. It is important to appreciate that developing leadership	*The NHS leadership academy provides a number of resources to help doctors self-assess their own leadership skills and provides a framework for developing such skills.* **NHS Leadership Academy, *The leadership framework for doctors*** http://www.leadershipacademy.nhs.uk/support/the-leadership-framework-for-doctors/ *This acts as an example of team checklists* **WHO, *Surgical Safety Checklist*** http://www.who.int/patientsafety/safesurgery/tools_resources/SSSL_Checklist_finalJun08.pdf

Objective 3	*Action*	*Evidence and Resources*
continued	skillset in general and especially in the field of safety is a life journey. Building a broad knowledge base and skills are vital and then being able to apply them into safer care in your department may take time. Having a wider perspective, focusing on the basics and being able to think out of the box occasionally whilst having lots of patience is vital.	**The 'How to Guide' for Leadership for Safety,** Patient Safety First, 2008 http://www.patientsafetyfirst.nhs.uk/ashx/Asset.ashx?path=/How-to-guides-2008-09-19/Leadership%201.1_17Sept08.pdf **NHS Patient Safety Resources, *The Manchester Patient Safety Framework*** www.npsa.nhs.uk/patientsafety/improvingpatientsafety/humanfactors/mapsaf/ *The Safer Sign-Out system from the Emergency Medicine Patient Safety Foundation incorporates a checklist system for safer care that includes a team briefing as one of its steps.* **Safer Sign Out** http://safersignout.com **Stephen Covey – The 7 habits of highly effective people.** https://www.stephencovey.com/7habits/7habits.php
Objective 4	***Action***	***Evidence and Resources***
To understand what tools are available when things are not working.	Change is not always easy. Knowing what resources and tools can be used to help quantify where you or your organisation are in your journey to deliver safer care and how to maintain momentum is essential. The road to success is always littered with potholes. Whether you are trying to get staff to attend the Clinical Governance meetings or have been involved in a number of serious incidents that have led to harm, – be patient and persist in your efforts to do the right thing!	*The National Patient Safety Authority is a division of the NHS. It provides a wealth of materials based upon reports of patient safety incidents from healthcare staff across England and Wales. Clinicians and safety experts analyse these reports to identify common risks to patients and opportunities to improve patient safety.* **NHS Patient Safety** http://www.nrls.npsa.nhs.uk/ **Institute for Healthcare Improvement, *IHI Global Trigger Tool for Measuring Adverse Events*** www.ihi.org/IHI/Results/WhitePapers/IHIGlobalTriggerToolWhitePaper.htm *This article discusses applying the Global Trigger Tool to understand the issues.* **The Health Foundation, *Global Trigger Tools*** http://www.health.org.uk/public/cms/75/76/313/2601/global%20trigger%20tools.pdf?realName=InzqMF.pdf **Seven Leadership Leverage Points for Organisation- level Improvement in Health Care.** *Reinertsen J, Pugh M, Bisognano M*. IHI Innovation Series white paper. Cambridge, Massachusetts: Institute for Healthcare Improvement; 2005. http://www.ihi.org/knowledge/Pages/IHIWhitePapers/SevenLeadershipLeveragePointsWhitePaper.aspx

Objective 4	*Action*	*Evidence and Resources*
continued		**Behaviours that undermine a culture of safety.** Joint Commission, 2008 http://www.jointcommission.org/assets/1/18/SEA_40.PDF **Error reduction and performance improvement in the emergency department through formal teamwork training: evaluation results of the MedTeams Project**. Morey J, Simon R, Jay G et al. Health Serv Res 2002; 37(6): 1553-81. http://www.ncbi.nlm.nih.gov/pubmed/12546286 *Business world-speak but very easily extrapolated to healthcare.* **What to do when things go wrong,** Scott Berkun http://scottberkun.com/2012/what-to-do-when-things-go-wrong/ **Team Emotional Intelligence: what it can mean and how it can affect performance,** Hillary Elfenbein http://apps.olin.wustl.edu/faculty/elfenbeinh/TeamEI.pdf
Objective 5	***Action***	***Evidence and Resources***
To understand how to measure progress.	Measurement lies at the heart of good science. It is important to have the right systems and culture in place so that you and your team can measure progress and then be able to celebrate success as well as being able to maintain momentum!	**Celebrating safety success on World Day for Safety and Health at Work** http://www.reachsafety.com/index.php/reach-activity/posts/celebrating-safety-success-on-world-day-for-safety-and-health-at-work/ **Center for Innovation in Quality Patient Care, *Measuring the culture of safety*.** http://www.hopkinsmedicine.org/innovation_quality_patient_care/areas_expertise/improve_patient_safety/culture/measuring.html **The measurement and monitoring of patient safety.** Vincent C et al, The Health Foundation 2013 http://patientsafety.health.org.uk/sites/default/files/resources/the_measurement_and_monitoring_of_safety.pdf

Supporting the Second Victim
Sue Robinson

Introduction
Second victims are health care providers who are involved in an adverse patient event, or medical error and become victims because they are traumatised by the event[1]. Despite this term being first coined in 2000 by Professor Wu of John Hopkins[2] it is only in recent years that those responsible for training and managing doctors have actively established processes to support staff involved in critical incidents that cause harm to their patients.

Purpose
To enable the senior team within an ED to develop a framework that:
a) acknowledges the impact error can have on staff
b) enables staff involved in incidents to be effectively supported so that they can recover and return to work
c) acknowledges that occasionally a more formal intervention may be required and is able to facilitate this

References

1. Scott SD, Hirschinger LE, Cox KR, McCoig M, Brandt J, Hall L. The natural history of recovery for the healthcare provider 'second victim' after adverse patients events. Qual Safe Health Care.2009;18:325-330.
2. Medical Error: the second victim. The doctor who makes mistakes needs help too. BMJ.2000;320:726-727

Objective 1	*Action*	*Evidence and Resources*
To understand the concept of the second victim.	Caring for the member of staff involved in a medical error is often overlooked. It is important the whole team understand the impact a clinical error can have on staff and the wider health care system.	**The Second Victim Phenomenon: A Harsh Reality of Health Care professions.** May 2011 Perspective Scott SD. http://webmm.ahrq.gov/perspective.aspx?perspectiveID=102 **Medical error: Impact on and management by French General Practitioners in training. A study of 70 questionnaires and 10 semi structured interviews.** Venus E, Galam E, Aubert J et alBMJ Qual Saf 2012; 21:279-286. http://qualitysafety.bmj.com/content/early/2012/01/02/bmjqs-2011-000359.abstract **The Emotional Impact of Medical Errors on Practicing Physicians in the United States and Canada.**Watermann AD et al. Jt Comm J Qual Patient Saf. 2007;33:467-476 http://www.ncbi.nlm.nih.gov/pubmed/17724943 **Residents' Responses to Medical Error: Coping, Learning, and Change.** Engel K, Rosenthal M, Sutcliffe KM. Acad Med.2006;81:86-93 http://www.ncbi.nlm.nih.gov/pubmed/16377827

Objective 1	*Action*	*Evidence and Resources*
continued		**Association of Perceived Medical Errors with resident Distress and Empathy. A Prospective Longitudinal Study.** West CP, Huschka MM, Novotny PJ et al. JAMA.2006; 296:1071-1077 http://jama.jamanetwork.com/article.aspx?articleid=203249 *This dramatic 19-minute documentary film exposes the painful impact on clinicians when patient care goes wrong. Healing the Healer also includes eight short special features with a focus on providers and programs. The first half of the video offers a closer look at four providers who share their pain and personal insights for how doctors and nurses can be supported. The second half highlights four programs across the United States where institutions describe how clinicians are treated after an adverse event (n.b.. this video needs to be purchased.)* ***Healing the Healer* [DVD]** A CRICO Video production http://www.rmfstrategies.com/Products-and-Services/Risk-Education-Training-and-Products/Films-and-DVDs **'Healing the healer' trailer on YouTube** http://www.youtube.com/watch?v=JmB8PCEXVgk *A number of coping strategies are used by staff involved in critical incidents. These include:* **Coping with Medical Mistakes and Errors in Judgement.** Goldberg RM, Kuhn G, Andrew LB, Thomas HA. Annals of Emergency Medicine. 2002; 39:287-92 http://www.ncbi.nlm.nih.gov/pubmed/11867981 **Residents' Responses to Medical Error: Coping, Learning, and Change.** Engel K, Rosenthal M, Sutcliffe KM. Acad Med.2006;81:86-93 http://www.ncbi.nlm.nih.gov/pubmed/16377827 **The Natural History of recovery for the Healthcare provider 'Second Victim" after Adverse Patient Events.** Scott SD, Hirschinger LE, Cox KR. Qual Saf Health Care.2009;18:325-330 http://www.ncbi.nlm.nih.gov/pubmed/19812092

Objective 2	*Action*	*Evidence and Resources*
To develop a strategy for improving the care of the second victim.	It is crucial to understand what is meant by a just and safe culture so that this can be developed within the ED. Without this it is unlikely the appropriate support for the second victim will be developed.	*This document outlines expected good practice in building a safer culture and managing, reporting and learning from patient safety incidents. It sets out the seven steps that NHS organisations should take to improve patient safety.* National Patient Safety Agency, 2004. ***Seven Steps to patient safety: full reference guide.*** http://www.nrls.npsa.nhs.uk/resources/collections/seven-steps-to-patient-safety/?entryid45=59787 *This white paper introduces an overall approach and tools designed to support two processes: the proactive preparation of a plan for managing serious clinical adverse events, and the reactive emergency response of an organisation that has no such plan.* Institute for Healthcare Improvement, 2011. ***Respectful Management of Serious Clinical Adverse Events*** http://www.ihi.org/knowledge/Pages/IHIWhitePapers/RespectfulManagementSeriousClinicalAEsWhitePaper.aspx *The following two sites outline some of the tools available to assess the safety climate of an organisation and department. If undertaken they should be repeated over time to ensure improvement.* **Agency for Healthcare Research and Quality** http://www.ahrq.gov/professionals/quality-patient-safety/patientsafetyculture/index.html **Institute for Healthcare Improvement, Safety Climate Survey** http://w.primaris.org/sites/default/files/resources/Patient%20Safety/safety%20climate%20survey.pdf *This document aims to build awareness of the importance of human factors in making changes to improve patient safety.* Patient Safety First, 2010. ***Implementing Human Factors in Healthcare*** http://www.patientsafetyfirst.nhs.uk/ashx/Asset.ashx?path=/Intervention-support/Human%20Factors%20How-to%20Guide%20v1.2.pdf *The department should ensure there are opportunities to discuss incidents or error in a non-judgmental and structured manner such as Mortality and Morbidity meetings, action after review. The following resources are designed to support this.* **The UCH Education Centre**, ***Behavioural Programmes*** http://ucheducationcentre.org/behaviouralprogrammes.html **Mortality and morbidity meetings: an untapped resource for improving the governance of patient safety?** Higginson J, Walters R, Fulop N. BMJ Qual Saf (2012). http://qualitysafety.bmj.com/content/early/2012/05/02/bmjqs-2011-000603.full

Objective 2	*Action*	*Evidence and Resources*
continued	Open and honest communication with patients is crucial. Evidence suggests that being open when things go wrong can help staff to cope with the after effects of a patient safety incident.	*This framework is a best practice guide for all healthcare staff, including boards, clinicians and PALS. It explains the principles behind Being Open and outlines how to communicate with patients, their families and carers following harm.* **National Patient Safety Agency, 2009. *Being Open*** http://www.nrls.npsa.nhs.uk/resources/collections/being-open/?entryid45=83726 **National Patient Safety Agency, *Being Open*** www.nrls.npsa.nhs.uk/beingopen
	Consider what systems have been shown to work elsewhere and what elements need to be incorporated into a strategy to support the second victim.	*This paper outlines the core concepts of any support programme.* **Trust: The 5 Rights of the Second Victim.** Denham Cr. J Patient Saf 2007; 3:107-119 *http://hospitalrx.com/pdf/Denham_Trust_The-Five-Rights-of-2nd-Victim_JPS_2007June3%282%29pp107-119_LTR.pdf* *This describes the process followed to develop the second victim support programme highlighted below:* **How to Develop a Second Victim Support Program: A Toolkit for Health Care Organizations**. Pratt S, Kenney L, Scott SD, Wu AW. JtComm J Qual Patient Saf. 2012; 38:235-240 *http://psnet.ahrq.gov/resource.aspx?resourceID=24407* *This toolkit was developed to help healthcare organisations implement support programmes for clinicians.* **MITSS Clinician Support Toolkit for Healthcare Workers**, 2011. http://www.mitsstools.org/tool-kit-for-staff-support-for-healthcare-organizations.html *The following resources highlight systems for supporting the second victim:* **Caring for our Own: Deploying a System wide Second Victim Rapid Response Team.** Scott SD et al. JtComm J Qual Patient Saf 2010; 36(5): 233-240 http://www.psnet.ahrq.gov/public/Scott-JCJQPS-2010-ID-18023.pdf **Building a Clinician Support Program - Assessment Worksheet/Planner** http://www.mitsstools.org/uploads/3/7/7/6/3776466/building_a_second_victim_support_programdecember3.pdf **MITSS 'Disclosure and Apology: What's missing?' Advancing programs that support clinicians.** http://www.mitss.org/MITSS_WhatsMissing.pdf **Factors associated with disclosure of medical errors by house staff.** Kronman AC, Paasche-Orlow M, Orlander JD. BMJ Qual Saf 2012; 21:271-278. http://qualitysafety.bmj.com/content/21/4/271/suppl/DC1

Objective 2	*Action*	*Evidence and Resources*
continued		**Improving the patient, family and clinician experience after harmful events: 'the when things go wrong' curriculum.** Bell SK, Moorman DW, Delbanco T. Acad Med 2010; 85:1010-17 http://www.ncbi.nlm.nih.gov/pubmed/20505403 The following three websites highlight examples from a number of hospitals: **Brigham and Women's Hospital** http://www.mitsstools.org/uploads/3/7/7/6/3776466/peer_support_published.pdf **University of Missouri Health System** http://www.mitsstools.org/uploads/3/7/7/6/3776466/grand_rounds_9-1-10_second_victim.pdf **Brigham and Women's department of Professionalism and Peer Support** http://www.brighamandwomens.org/medical_professionals/career/cpps/PeerSupport.aspx
	There must be a fair and consistent approach towards staff involved in patient safety incidents. All staff should understand what to expect if they are involved in an error.	*The National Patient Safety Agency has developed the Incident Decision Tree to determine a fair and consistent course of action toward staff involved in patient safety incidents.* **National Patient Safety Agency, *Incident Decision Tree*.** http://www.nrls.npsa.nhs.uk/resources/?EntryId45=59900 *This paper details the evaluation of the above tool.* **The Incident Decision Tree: Guidelines for Action Following Patient Safety Incidents,** Sandra Meadows, Karen Baker, Jeremy Butler. Advances in Patient Safety: Vol. 4 http://www.ahrq.gov/downloads/pub/advances/vol4/Meadows.pdf *Staff should be aware of good practice in terms of governance e.g. root cause analysis, incident reporting.* **National Patient Safety Agency**, **Root Cause Analysis (RCA) investigation** http://www.nrls.npsa.nhs.uk/resources/collections/root-cause-analysis/
Objective 3	***Action***	***Evidence and Resources***
To optimise training in supporting the second victim	Disseminate guidance on how colleagues can support one another as they are likely to be the 'first responders' to second victims.	*The following resources can support training in the second victim:* *This tool is from the MITSS (Medically Induced Trauma Support Services)* MITSS Tools***, Supporting a Colleague*** http://www.mitsstools.org/how-to-support-a-colleague.html **Talking with Patients and Families about Medical Error: A Guide for Education and Practice** Robert D. Truog et al, The Johns Hopkins University Press. December 2010.

Education
Ruth Brown

Introduction
Awareness and contribution to maintaining safety is the responsibility of all staff. All staff need to have the technical knowledge and skills to provide safe care as well as the non-technical skills that contribute to minimising risk. Training for safer care is best carried out in multi-professional teams and in situ where possible to ensure validity and to promote team working.

All staff are expected to understand and know about the processes, tools and structures for promoting safety described elsewhere in the toolkit for instance incident investigation and reporting, learning from complaints and the risk register.

Purpose
To provide evidence and resources for teaching and learning about safety as well as material for faculty to use.

Objective 1	***Action***	***Evidence and Resources***
The curriculum for safety.	Understanding the behaviours required for delivery of safe care is fundamental to minimising harm to patients. The syllabus contains a list of behaviours whilst the curriculum may describe where and how they are developed.	*The College curriculum describes many behaviours that are crucial to safe care** **College of Emergency Medicine, *Emergency Medicine Curriculum*** http://www.collemergencymed.ac.uk/Training-Exams/Curriculum/default.asp **Patient safety – a curriculum for teaching patient safety in Emergency Medicine** K Cosby, P Croskerry, Acad Emerg Med 2003 Vol 10 69-78 http://onlinelibrary.wiley.com/doi/10.1197/aemj.10.1.69/pdf **Emergency Medicine Quality Improvement and Patient Safety** Curriculum J Kelly, et al Acad. Emerg. Med. 2010; 17:e110–e129 http://onlinelibrary.wiley.com/doi/10.1111/j.1553-2712.2010.00897.x/pdf *This article is a systematic review of studies of non-technical skills and patient safety. It is a useful reference list.* **Non-technical skills training to enhance patient safety: a systematic review.** M Gordon, D Darbyshire, P Baker. Medical Education Volume 46, Issue 11, pages 1042–1054, November 2012 http://onlinelibrary.wiley.com/doi/10.1111/j.1365-2923.2012.04343.x/pdf *A very easy to read volume on human factors and it's relation to patient safety is:* **Human Factors in the Healthcare Setting. A pocket Guide for Clinical Instructors. Advanced Life Support Group. Wiley-Blackwell**

Objective 1	*Action*	*Evidence and Resources*
continued		**Identifying Nontechnical Skills Associated With Safety in the Emergency Department: A Scoping Review of the Literature** L Flowerdew et al. Annals of Emergency Medicine Volume 59, Issue 5 , Pages 386-394, May 2012 http://www.annemergmed.com/article/S0196-0644%2811%2901806-3/abstract
Objective 2	***Action***	***Evidence and Resources***
Use of simulation to enhance safety teaching.	Descriptions of the use of simulation to recreate hazardous patient encounters and develop team skills in reducing risk.	*The College has a selection of resources for simulation including faculty training – which can be accessed above.* **College of Emergency Medicine, *Simulation course materials*** http://www.collemergencymed.ac.uk/Training-Exams/Training/Simulation%20Training/Simulation%20course%20materials/default.asp *This special issue of Quality and Safety in Health Care reviewed multiple aspects of simulation – with introductory commentary on psychology and application.* **Creating new realities in healthcare: the status of simulation-based training as a patient safety improvement strategy** Salas E, T Paige J, Rosen MA. BMJ Qual Saf 2013;22:449–452. http://qualitysafety.bmj.com/content/22/6/449.extract *A broad review of the use of simulation to train inpatient safety enhancing particularly the medical expert, communicator and collaborator skills.* **Training and simulation for patient safety,** R Aggarwal et al Qual Saf Health Care 2010;19(Suppl 2):i34ei43. doi:10.1136/qshc.2009.038562 http://qualitysafety.bmj.com/content/19/Suppl_2/i34.abstract *Use of simulation in a Paediatric Emergency Department to enhance safety focusing on attitudes and team work behaviours but recognising cultural and behavioural changes need repeated practice opportunities.* **Impact of multidisciplinary simulation-based training on patient safety in a paediatric emergency department**. M Patterson et al BMJ Quality & Safety *BMJ Qual Saf* 2013;22:383-393 doi:10.1136/bmjqs-2012-000951 http://www.ncbi.nlm.nih.gov/pubmed/23258388 *Further analysis of the simulation project* **In situ simulation: detection of safety threats and teamwork training in a high risk emergency department.** M Patterson et al BMJ Qual Saf. 2013 Jun;22(6):468-77. doi: 10.1136/bmjqs-2012-000942 http://www.ncbi.nlm.nih.gov/pubmed/23258390

Objective 2	*Action*	*Evidence and Resources*
continued		*This article discusses In situ simulation in a major teaching hospital.* **Unannounced in situ simulations: integrating training and clinical practice** S Walker et al. *BMJ Qual Saf* 2013;22:453-458 doi:10.1136/bmjqs-2012-000986 http://www.ncbi.nlm.nih.gov/pubmed/23211281 *Paediatric emergency medicine has developed in-situ simulation to good effect:* **Educational and Research Implications of Portable Human Patient Simulation in Acute Care Medicine** L Kobayashi et al. Acad Emerg Med. 2008; 15:1166–1174 http://onlinelibrary.wiley.com/doi/10.1111/j.1553-2712.2008.00179.x/pdf
Objective 3	***Action***	***Evidence and Resources***
To understand how the effectiveness of safety education can be improved and measured	Consolidation of learning is by reflection and building self-awareness.	*Evidence shows that experiential learning at undergraduate level can change behaviours regarding safety and error reduction.* **Teaching Medical Students About Medical Errors and Patient Safety: Evaluation of a Required Curriculum,** J Halback, L Sullivan. Acad Med. 2005; 80:600–606. http://journals.lww.com/academicmedicine/Fulltext/2005/06000/Teaching_Medical_Students_About_Medical_Errors_and.16.aspx *This article discusses how focused training develops safety skills in medical students.* **Development and evaluation of a 3-day patient safety curriculum to advance knowledge, self-efficacy and system thinking among medical students** H Aboumatar et al. BMJ Qual Saf 2012;21:416e422. doi:10.1136/bmjqs-2011-000463 http://qualitysafety.bmj.com/content/early/2012/03/14/bmjqs-2011-000463.abstract *Successful demonstration of simulation for acquisition of skills for medical registrar crisis resource management.* **Simulation to develop tomorrow's medical registrar** Shah, A., Carter, T., Kuwani, T. and Sharpe, R. (2013),. The Clinical Teacher, 10: 42–46. doi: 10.1111/j.1743-49 8X.2012.00598.x http://www.ncbi.nlm.nih.gov/pubmed/23294743 *Evaluation of what is needed to ensure quality improvement and safety training is effective.* **Quality improvement in medical education: current state and future directions**.B Wong et al Medical Education, 201246: 107–119. doi: 10.1111/j.1365-2923.2011.04154.x http://cores33webs.mede.uic.edu/ipse/edresources/documents/Publications/Teaching%20Patient%20Safety/Wong_Quality%20improvement%20in%20medical%20education.pdf *What works with surgical non technical skills*

Objective 3	*Action*	*Evidence and Resources*
continued		**Teaching non-technical skills in surgical residency: A systematic review of current approaches and outcomes**. N Dedy et al Surgery. 2013 Jun 15. pii: S0039-6060(13)00181-5. doi: 10.1016/
Objective 4	***Action***	***Evidence and Resources***
Faculty materials	Teachers of safety should have access to material which is suitable and relevant to the learner.	*The WHO have published resources suitable for both undergraduates and multi-professional learning.* **World Health Organisation, *Patient Safety Curriculum Guide*** http://www.who.int/patientsafety/education/curriculum/Curriculum_Tools/en/index.html *The Academy of Medical Royal Colleges have produced curriculum material specifically for postgraduate medical education although much is suitable for multi-professional EM teams.* **Academy of Medical Royal Colleges, *Safety Improvement*** http://www.institute.nhs.uk/safer_care/safer_care/patient_safety_and_improvement_guidance_for_postgraduate_medical_education.html *This document provides guidelines for faculty development for teaching non-technical skills.* **Training Faculty in Nontechnical Skill Assessment National Guidelines on Program Requirements 2013** Annals of Surgery Volume 258 (2) 370-375 http://www.ncbi.nlm.nih.gov/pubmed/23222032 *Key publications in the development of nontechnical skills are included here:* • **A universal model of diagnostic reasoning** P Croskerry 2009 Academic Medicine 84(8) 1022-1028 http://www.ncbi.nlm.nih.gov/pubmed/19638766 • **Critical thinking and reasoning in emergency medicine** P Croskerry 2009 Patient safety in Emergency Medicine (eds P Croskerry et al) Lippincott Williams and Wilkins p213-218 • **Beyond the organisational accident: the need for "error wisdom" on the front line** J Reason. Quality and safety in Health Care 13 (sup 2)ii28-ii33 http://qualitysafety.bmj.com/content/13/suppl_2/ii28.abstract • **Organisational safety: Organisations and safety in health care** R L Wears Qual Saf Health Care 2004;13:ii1 doi:10.1136/qshc.2004.012732 • **Safety at the sharp end – a guide to non technical skills**. R Flin, P O'Connor and M Crichton Ashgate Guildford *The National Patient Safety Agency (now part of NCB) has a range of resources for patient safety* http://www.nrls.npsa.nhs.uk/resources/patient-safety-topics/ *An overview of peer reviewed articles on a number of clinical and nontechnical skills related topics.* **Making Health Care Safer** A Critical Analysis of Patient Safety Practices *Evidence Reports/Technology Assessments, No. 43* Edited by K Shojania et al http://www.ncbi.nlm.nih.gov/books/NBK26966/

*the College is currently updating the safety aspects of the curriculum which will be published for 2014

Safety scorecard
Sally-Anne Wilson and Matthew Cooke

Introduction
Patient safety: '*The avoidance, prevention and amelioration of adverse outcomes or injuries stemming from the process of healthcare*.'[3]

A scorecard should look at a series of measures at a system/department level that are aligned with the strategic aims of the organisation. Measures need to be easy to understand and actionable at the point of service delivery. Measures of safety however, are hard to define and there are often multiple influences on the process of measurement. It is easier to measure non-safety/system failures which are measures to which one can react. Although these are informative, they may not reflect the current level of safety within a department. These retrospective indicators should be combined with 'leading indicators' which identify precursors, conditions or events or measures before an incident has occurred, but these are poorly developed in healthcare settings.[4] It is therefore difficult to design a scorecard which can show in a quantitative manner how safe an ED is at any point in time. Therefore it is also difficult to track improvement, and even more difficult to be assured that the data derived could be compared across departments.

Purpose
To describe ways in which safety can be assessed or described to allow departments to identify areas on which to focus improvement work, and demonstrate improvement over time.

NB This scorecard is not a validated tool.

References

3. Vincent C. Patient safety. 2nd ed. Chichester: John Wiley & Sons; 2010
4. Vincent C, Burnett S, Carthey J, The measuring and monitoring of safety. Health Foundation; April 2013

Objective	***Domain***	***Suggested areas to measure and Resources***
To demonstrate presence of error, harm or risk.	The Patient	***Areas to measure:*** • *Returns within 7 days (% requiring change of treatment or admission)* • *Did not wait (proportion of patients who did not wait for the completion of their treatment with qualitative analysis)* • *Observation of vital signs at appropriate frequency and with appropriate actions, use of early warning scores* • *Deaths:* *-within one week of discharge from the ED* *-within 24 hours of admission through the ED* • *Patient surveys*

	The Patient	***Resources*** *The CQC website provides the results of Accident and Emergency Departments experience surveys. Patient experience data acts as an A & E clinical quality indicator.* **Care Quality Commission, *Accident and Emergency 2012 experiences*** http://www.cqc.org.uk/public/reports-surveys-and-reviews/surveys/accident-and-emergency-2012 **Patient feedback (search for hospital and then A&E):** http://www.nhs.uk/Service-Search **Harm free care – NHS Safety Thermometer (how does the ED +/- CDU score?):** http://harmfreecare.org/make-it-happen/ ***Trigger Tools** have been developed in different healthcare settings to retrospectively detect adverse events and track their rate over time. The Global Trigger Tool is the most widely used, and has consistently shown that the number of clinical incidents that are reported is small in comparison to what is detected with the GTT. These tools would need modification for direct use in the ED.* **Global Trigger Tool** www.ihi.org/knowledge/Pages/Tools/IHIGlobalTriggerToolforMeasuringAEs.aspx This tool requires an IHI login. **Outpatient Adverse Event Trigger Tool** www.ihi.org/knowledge/Pages/Tools/OutpatientAdverseEventTriggerTool.aspx **Paediatric Trigger Tool** http://www.knowledge.scot.nhs.uk/media/CLT/ResourceUploads/1012616/Add%20-%20PTT%20form.pdf **Primary Care Trigger Tool** http://www.nes.scot.nhs.uk/media/6361/Primary%20Care%20Trigger%20Tool%20-%20Practical%20Guidance.pdf

	The Illness	***Areas to measure*** • *High risk conditions identified (from clinical incidents, M&M reviews, complaints, litigation)* ***Resources*** **Reliability of processes (following guidelines/pathways),** Nolan T, Resar R, Haraden C, Griffin FA. Improving the Reliability of Health Care. IHI Innovation Series white paper. Boston: Institute for Healthcare Improvement; 2004. (Available once registered with IHI www.IHI.org) **College of Emergency Medicine, *Consultant Sign Off*** http://secure.collemergencymed.ac.uk/Development/Consultant%20working/Consultant%20sign%20off/ ***Audits, local and national benchmarking*** **College of Emergency Medicine, *Audits*** http://secure.collemergencymed.ac.uk/Shop-Floor/Clinical%20Audit/Current%20Audits/default.asp **The Trauma Audit and Research Network** https://www.tarn.ac.uk/Content.aspx?ca=15
	The Staff	***Areas to measure*** • *Staff sickness absence rate* • *Proportion of staff having annual influenza vaccination and have documented immunity for measles, varicella and hepatitis B.* • *Proportion of all staffing hours covered by locums* • *Proportion of vacancies/unfilled clinical posts* • *Proportion of staff who have completed mandatory training* • *Proportion of staff (including bank/locum staff) that have had departmental induction* ***Resources*** ***Safe staffing levels*** **Emergency Medicine Operational Handbook, *The Way Ahead*,** College of Emergency Medicine, Version 2: December 2011 http://secure.collemergencymed.ac.uk/code/document.asp?ID=6235

	The Staff	*The RCN's new 'BEST' staffing tool addresses nursing levels based on patient dependency. You will need a RCN login to access this tool.* **Royal College of Nursing, *Baseline Emergency Staffing Tool (BEST)*** http://www.rcn.org.uk/development/communities/rcn_forum_communities/emergency_care/baseline_emergency_staffing_tool ***Staff burnout:*** **An investigation of factors supporting the psychological health of staff in a UK emergency department,** Philip J Yates, Elizabeth V Benson, Adrian Harris & Rachel Baron, *Emerg Med J, 2011* http://emj.bmj.com/content/early/2011/06/26/emj.2010.099630.abstract ***Staff training and engagement*** **National NHS Staff Survey Co-ordination Centre, *2012 Results*** http://www.nhsstaffsurveys.com/cms/ *Staff training – this can be found through Key Finding 6* *Staff engagement – this can be found through Key Findings 22, 24 and 25*
	The Work	***Areas to measure*** • *Time constrained – proportion of patients discharged between 220 and 240 minutes (a peak may indicate a rush to meet a target rather than safe and timely patient care).* • *Interruptions* ***Resources*** **"Do you really need to ask me that now?": a self-audit of interruptions to the 'shop floor' practice of a UK consultant emergency physician**, Jon Allard, Jonathan Wyatt, Alan Bleakley & Blair Graham, *Emerg Med J 2012;29:* http://emj.bmj.com/content/29/11/872.abstract **National NHS Staff Survey Co-ordination Centre, *2012 Results*** http://www.nhsstaffsurveys.com/cms/ *Roles and responsibilities, work intensity - these can found through Key Findings 1-5* *Staff satisfaction – this can be found through Key Findings 23-25*

	The Team	***Areas to measure*** • *Frequency of feedback from specialties or primary care about patient diagnosis or management* • *Frequency of multidisciplinary team training* ***Resources*** ***Handovers*** *This article addresses handovers of the ED*: **The ABC of Handover': impact on shift handover in the emergency department,** *Maisse Farhan, Ruth Brown, Charles Vincent & Maria Woloshynowych,* Emerg Med J: December 2011. http://emj.bmj.com/content/early/2011/12/28/emermed-2011-200201 These articles address handovers of patients to other specialties: **NHS Institute for Innovation and Improvement, *Situation Background Assessment Recommendation (SBAR)*** http://www.institute.nhs.uk/safer_care/safer_care/situation_background_assessment_recommendation.html **Royal College of Physicians, *Healthcare Record Standards*** http://www.rcplondon.ac.uk/projects/healthcare-record-standards **American College of Emergency Physicians, *Safer Sign Out Protocol*** https://webapps.acep.org/MasterSignIn/SignIn.aspx?redir=http://www.acep.org/content.aspx?id=88004 *To access this tool you will need an ACEP log in.* *An overview of the tool can be found here:* http://www.acep.org/uploadedFiles/ACEP/Membership/Sections_of_Membership/qips/homepage/Safer%20Sign%20Out%20Executive%20Summary.pdf ***Safety briefings*** **Scottish Patient Safety Programme, *Implementing Safety Briefings*** http://www.scottishpatientsafetyprogramme.scot.nhs.uk/docs/implementingsafetybriefings.pdf

	The Environment	***Areas to measure*** • *Number of incidents and complaints relating to the environment e.g. privacy within the department* • *Physical layout of the department* • *Crowding measures* • *Standard equipment within department and across the hospital* ***Resources*** ***Crowding measures*** **Emergency department crowding: prioritising quantified crowding measures using a Delphi study,** Kathleen Beniuk, Adrian A Boyle and John Clarkson, Emerg Med J: Dec 2011 http://emj.bmj.com/content/early/2011/12/20/emermed-2011-200646.abstract **Emergency Department Crowding: Time for Interventions and Policy Evaluations,** Adrian Boyle, Kathleen Beniuk, Ian Higginson and Paul Atkinson, Emerg Med Int. 2012; http://europepmc.org/articles/PMC3290817/reload=0;jsessionid=5RMCPtfvQECrPVBUfVTk.24 **Crowding in the Emergency Department**, College of Emergency Medicine, August 2012. http://secure.collemergencymed.ac.uk/code/document.asp?ID=6296 ***Physical layout*** **Design Council, *Reducing violence and aggression in A&E*** http://www.designcouncil.org.uk/our-work/challenges/health/ae/ **Health Building Note 15-01: Accident & emergency departments**, Department of Health, April 2013 https://www.gov.uk/government/publications/hospital-accident-and-emergency-departments-planning-and-design
	The Culture	***Areas to measure*** • *Exit interview/survey information as staff leave the department* ***Resources*** ***Safety culture surveys*** **Agency for Healthcare Research and Quality, *Hospital Survey on Patient Safety Culture*** www.ahrq.gov/professionals/quality-patient-safety/patientsafetyculture/hospital/resources/index.html

	The Culture	**Measuring patient safety climate: a review of surveys,** J B Colla, A C Bracken, L M Kinney, W B Weeks, Qual Saf Health Care 2005; 14 http://qualitysafety.bmj.com/content/14/5/364.full.pdf+html **Institute for Healthcare Improvement, *Checklist for Assessing Institutional Resilience*** http://www.ihi.org/knowledge/Pages/Tools/ChecklistForAssessingInstitutionalResilience.aspx An IHI login is required for this tool. **National NHS Staff Survey Co-ordination Centre, *2012 Results*** http://www.nhsstaffsurveys.com/cms/ *Safety culture: these can found through key findings 12 – 15*
	Data that may cover any/all of the domains	***Areas to measure*** • *Incidents and complaints: Use qualitatively (due to under reporting and reporting bias) not quantitatively. Evidence of learning and integration of this into everyday practice.* • *Number of Serious Untoward Incidents and Never Events* ***Resources*** ***Risk assessment of new services/processes*** **Scottish Patient Safety Programme, *Failure Modes & Effects Analysis (FMEA)*** http://www.scottishpatientsafetyprogramme.scot.nhs.uk/docs/FMEA.pdf **Institute for Health Improvement, *Failure Modes & Effects Analysis (FMEA)*** http://www.ihi.org/knowledge/Pages/Tools/FailureModesandEffectsAnalysisTool.aspx You will need a login to access this tool. **College of Emergency Medicine, *Prospective Hazard Analysis*** http://secure.collemergencymed.ac.uk/code/document.asp?ID=6181

Safety culture
Shammi Ramlakhan

Introduction

Safety Culture is the way patient safety is perceived, valued and prioritised in an organisation or department. It is indicative of the commitment to safety at all levels in an organisation or department and can be described as "how things are done around here," particularly when no external scrutiny is leveraged. An ED's Safety Culture is determined largely by a combination of Organisational (Trust or NHS) and Professional (speciality, nursing, allied professions) Cultures.

Purpose

To enable ED leaders to assess or diagnose the Patient Safety Culture within their departments and offer a framework for improving or changing this culture.

Objective 1	*Action*	*Evidence and Resources*
To understand what is meant by Safety Culture in the context of the ED.	It is crucial to understand what the features of a good safety culture are, so that this can be developed within the ED.	*The Agency for Healthcare Research and Quality briefly considers Safety Culture in healthcare settings.* **Agency for Healthcare Research, *Safety Culture*** http://psnet.ahrq.gov/primer.aspx?primerID=5 *This report from The Health Foundation also describes the idea of a Patient Safety Culture and goes on to consider the evidence that this improves outcomes.* **Does improving safety culture affect patient outcomes?** The Health Foundation, 2011 http://www.health.org.uk/publications/does-improving-safety-culture-affect-patient-outcomes/ *There are few papers that look specifically at ED safety culture. This questionnaire survey from the US lists Safety Culture specific questions as part of a larger survey on safety perceptions.* **The safety of emergency care systems: Results of a survey of clinicians in 65 US emergency departments**, Magid DJ, Sullivan AF, Cleary PD, Rao SR et al. (2009). Ann Emerg Med;53(6):715-23. http://www.ncbi.nlm.nih.gov/pubmed/19054592 This qualitative review of safety culture in the US hospital setting attempts to define what is safety culture and presents a conceptual framework of healthcare organisational safety culture. **What is patient safety culture – a review of the literature?** Sammer et al Journal of Nursing Scholarship Volume 42, Issue 2, pages 156–165 http://onlinelibrary.wiley.com/doi/10.1111/j.1547-5069.2009.01330.x/abstract

Objective 2	*Action*	*Evidence and Resources*
To establish the current safety culture within a department or organisation.	Safety culture influences safety outcomes and measuring a baseline identifies areas for improvement, identifies strengths and allows monitoring of changes/trends over time. Simply measuring or diagnosing safety culture can also raise staff awareness about patient safety. Measuring safety culture allows evaluation of the cultural impact of patient safety initiatives and interventions and facilitates internal and external benchmarking.	*Several tools for measuring safety culture have been used in a variety of healthcare settings. This report from the Healthcare Foundation considers the common tools and the contexts in which they are used. Only a few have been used in ED settings, however.* **Measuring safety culture,** The Health Foundation, 2011 http://www.health.org.uk/public/cms/75/76/313/2600/Measuring%20safety%20culture.pdf?realName=rclb4B.pdf *The NHS Institute for Innovation and Improvement has developed a slide set and facilitator guide for using the Manchester Patient Safety Framework tool for measuring safety culture. Although this is designed for primary care settings, many of the areas covered are relevant to EM and the set allows modifications.* **NHS Institute for Innovation and Improvement, *Safety Culture tools*** http://www.institute.nhs.uk/safer_care/primary_care_2/lips_primary_care_delegate_library.html The Institute for Healthcare Improvement and the Agency for Healthcare Research and Quality have developed tools for measuring safety climate in organisations. Some of the principles set out are relevant to emergency settings. **Institute for Healthcare Improvement, Safety Climate Survey** http://w.primaris.org/sites/default/files/resources/Patient%20Safety/safety%20climate%20survey.pdf **Agency for Healthcare Research and Quality** http://www.ahrq.gov/professionals/quality-patient-safety/patientsafetyculture/index.html **Agency for Healthcare Research and Quality, *Hospital Survey on Patient Safety Culture*** www.ahrq.gov/professionals/quality-patient-safety/patientsafetyculture/hospital/resources/index.html NHS Trusts completing the NHS Staff survey will already have some organisational measures of aspects of safety culture. Individual reports can be accessed from the **National NHS Staff Survey Co-ordination Centre, *2012 Results.*** *Key Findings 13-15 are primarily safety related.* http://www.nhsstaffsurveys.com/Page/1006/Latest-Results/2012-Results/

Objective 3	*Action*	*Evidence and Resources*
To enable senior clinical leaders to change or improve the safety culture.	In order to embed safety in the normal work of the ED, it is important to apply core patient safety attitudes and practice as the norm and to engage staff.	*This guide lists behaviours and activities which improve safety culture and also offers useful case studies on building a safety culture.* **Seven steps to patient safety: full reference guide,** National Patient Safety Agency, 2004. http://www.nrls.npsa.nhs.uk/resources/collections/seven-steps-to-patient-safety/?entryid45=59787 *This podcast from the NHS Institute for Innovation and Improvement is a short introduction to Safety Culture and basic steps to embed it in practice.* **NHS Institute for Innovation and Improvement, *Improving Quality and Safety Podcast*** http://www.institute.nhs.uk/safer_care/primary_care_2/improving_quality_and_safety_podcast.html *This article has some useful points about "teaching" safety culture. It lists the nine activities to improve safety in healthcare which have been adapted from the much more lengthy Institute of Medicine book.* **Teaching the Culture of Safety**, Jane Barnsteiner, Online J Issues Nurs. 2011;16(3) http://www.medscape.com/viewarticle/758853_4 **Crossing the quality chasm: A new health system for the 21st century,** Institute of Medicine (IOM). (2001) http://www.nap.edu/catalog.php?record_id=10027 *The Institute for Healthcare Improvement has an interesting interview transcript from Lucian Leape, where he talks about creating a culture of safety.* **Institute for Healthcare Improvement, Creating a Culture of Safety** http://www.ihi.org/knowledge/Pages/ImprovementStories/CreatingaCultureofSafety.aspx *Dominic Cooper's book, Improving Safety Culture, which is geared toward industry, has some useful ideas on the phases of safety culture improvement and tips which are relevant to healthcare.* **Improving Safety Culture**. A practical guide. Cooper, D. Chichester. (2001). http://www.behavioural-safety.com/articles/Improving_safety_culture_a_practical_guide.pdf Behaviour that is counterproductive and undermines the fostering of a culture of safety should be addressed. This sentinel event alert from the Joint Commission offers some guidance on managing disruptive behaviour and mitigating its effects on safety culture. **Behaviours that undermine a culture of safety.** Joint Commission, 2008 http://www.jointcommission.org/assets/1/18/SEA_40.PDF

Team working
Stephen Feltbower & Taj Hassan

Introduction
Excellence in team working lies at the very heart of a high performing ED. It is intrinsic to the smooth, effective strategic planning of a busy ED, management in the clinical area with a safety culture at its core and leads to the provision of efficient and effective care for our patients.

Purpose
This toolkit will provide some insight into the concept of teamwork, the role of the Emergency Medicine physician within various teams and some examples from around the world of specific training in teamwork.

Objective 1	*Action*	*Evidence and Resources*
To define the team, teamwork and individual roles within a team.	There are many different teams that operate within a healthcare organisation and specifically within an ED, from the management team, resuscitation room and other clinical areas through to the risk management and clinical governance group to name a few.	*A **team** is a group of individuals linked together by a common purpose.* http://en.wikipedia.org/wiki/Team *An overview of the science of 'teams' that can contribute to team effectiveness. This also describes how individual performance can be optimised.* **On Teams, Teamwork, and Team Performance: Discoveries and Developments,** Eduardo Salas, Nancy J. Cooke and Michael A. Rosen, *Human Factors: The Journal of the Human Factors and Ergonomics Society* 2008; 50; 540 http://hfs.sagepub.com/cgi/content/abstract/50/3/540 *This article describes the process model of how teams provide input, manage and create outputs. It also examines research evidence and makes recommendations on what teams are and how to maximise team effectiveness.* **Teams, the challenge of co-operative work.** Unsworth & West, 2013 http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2182831 *The Tuckman model for team development and behaviours helps explain the different stages that a team goes through when working together; individual members of a team may be at different stages at different times.* **The Tuckman Model** http://www.businessballs.com/tuckmanformingstormingnormingperforming.htm

Objective 1	*Action*	*Evidence and Resources*
continued		*This article is on team development and structure with specific reference to the resuscitation room.* **Resuscitation Team Organisation for Emergency Departments: A conceptual review and discussion.** Mellick L, Adams B. The Open Emergency Medicine Journal 2009; 2: 18-27. http://www.benthamscience.com/open/toemj/articles/V002/18TOEMJ.pdf *This systematic review identified non-technical skills associated with safety in the ED with teamwork featuring prominently.* **Identifying Nontechnical Skills Associated with safety in the emergency department: a scoping review of the literature.** Flowerdew L, Brown R, Vincent C, Woloshynowych M. Annals of Emergency Medicine 2012; 59(5): 386-94. http://www.ncbi.nlm.nih.gov/pubmed/22424651 **Innovation in top management teams**. West, Michael A.; Anderson, Neil R. Journal of Applied Psychology, Vol 81(6), Dec 1996, 680-693 http://psycnet.apa.org/index.cfm?fa=search.displayRecord&uid=1996-06918-005
Objective 2	***Action***	***Evidence and Resources***
To describe different practices that help get the best out of teams and optimise patient safety.	Teams require good leadership to function effectively. A variety of leadership styles may be needed for different situations. Some situations may even require a dynamic leadership style that can respond and adapt as a situation unfolds.	*Leaders come in different guises. "Transformational leadership" is often the most effective approach to use and yet there are many others too. Leadership is not "one size fits all" and there is a need to adapt style to fit a situation or a specific group. A good overview is provided here.* **Mind Tools, *Various leadership styles X10 - choosing the right style for the situation*.** http://www.mindtools.com/pages/article/newLDR_84.htm *John Adair is one of the doyens of leadership development. His three needs model is a well recognised concept of looking at the 'task-individual-group'.* **Manage Train Learn, *Adair's Three Circles*** http://www.managetrainlearn.com/page/adairs-three-circles *This breaks up leadership into 5 practices and 10 behaviours.* **Kouzes & Posner – The leadership challenge** http://www.leadershipchallenge.com/home.aspx **Leadership and team performance**, Gordy Curphy and Robert Hogan http://www.leadershipkeynote.net/articles/index_a7.htm

Objective 2	Action	Evidence and Resources
continued		*This article provides a different way of looking at leadership situations and how to manage them. It includes 'The Cynefin framework' of how leaders can adopt a different framework to manage the complexity of the situation they face.* **A Leader's Framework for Decision Making,** Snowden & Boone Harvard Business Review: 2007 http://www.mpiweb.org/CMS/uploadedFiles/Article%20for%20Marketing%20-%20Mary%20Boone.pdf *An excellent review article on the factors associated with high performance in health care such as the setting of objectives, teamwork and leadership supported by a variety of enablers and drivers.* **Factors supporting high performance in health care organisations**, National Institute of Clinical Case Studies Literature Review, 2003. http://www.nhmrc.gov.au/_files_nhmrc/file/nics/material_resources/Factors%20Supporting%20High%20Performance%20in%20Health%20Care%20Organisations.pdfv **The Effectiveness of Health Care Teams in the National Health Service**, Borrill et al. 1999 http://homepages.inf.ed.ac.uk/jeanc/DOH-final-report.pdf *This article discusses changing leadership style dynamically.* **Leadership Styles Vs Leadership Tactics,** James D. Boulgarides & William A. Cohen, Journal of Applied Management and Entrepreneurship (Spring 2001, Vol. 6, No. 1pp. 59-73). http://www.stuffofheroes.com/leadership_style_vs%20leadership%20tactics.htm *Step 2 is 'lead and support your staff.'* **Seven steps to patient safety: full reference guide,** The National Patient Safety Agency (NPSA), 2004. http://www.nrls.npsa.nhs.uk/resources/?entryid45=59787&p=15 **Re-examining the components of transformational and transactional leadership using the Multifactor Leadership**, Avolio, Bass et al, JOOP 2010 http://onlinelibrary.wiley.com/doi/10.1348/096317999166789/full
Objective 3	***Action***	***Evidence and Resources***
To understand how the use of checklists and training can improve the safety of teams.	The use of checklists has been cited as a way of making care safer and more accountable. They can provide a structure to improve communication between teamsand improve the non-technical skills of both the leader and other team members.	*The Safer Sign-Out system from the Emergency Medicine Patient Safety Foundation incorporates a checklist system for safer care that includes a team briefing as one of its steps.* **Safer Sign Out** http://safersignout.com/ *This acts as an example of team checklists.* **WHO, *Surgical Safety Checklist*** http://www.who.int/patientsafety/safesurgery/tools_resources/SSSL_Checklist_finalJun08.pdf

Objective 3	*Action*	*Evidence and Resources*
continued		*A Delphi study to define assertions and recommendations for checklist implantation.* **Implementation of checklists in health care; learning from high-reliability organisations,** Øyvind Thomassen et al, *Scandinavian Journal of Trauma, Resuscitation and Emergency Medicine* 2011, **19**:53 http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3205016/ *A research paper on the role of checklists to improve communication in the theatre environment.* **Getting teams to talk: development and pilot implementation of a checklist to promote inter-professional communication in the OR**. Lingard L, Espin S, Rubin B et al**.** Qual Saf Health Care 20005; 14: 340-6. http://www.ncbi.nlm.nih.gov/pubmed/16195567 **Systematic review of safety checklists for use by medical care teams in acute hospital settings - limited evidence of effectiveness**, Henry CH Ko, Tari J Turner and Monica A Finnigan, BMC Health Services Research 2011, 11:211 http://www.biomedcentral.com/1472-6963/11/211
	Regular training as a team is a useful way of maintaining skills and improving practice. Training can take a variety of forms, from web-based solutions to hi-fidelity simulation centres.	*The NHS leadership academy provides a number of resources to help doctors self-assess their own leadership skills and provides a framework for developing such skills.* **NHS Leadership Academy, *The leadership framework for doctors*** http://www.leadershipacademy.nhs.uk/support/the-leadership-framework-for-doctors/ **Error reduction and performance improvement in the emergency department through formal teamwork training: evaluation results of the MedTeams Project**. Morey J, Simon R, Jay G et al. Health Serv Res 2002; 37(6): 1553-81. http://www.ncbi.nlm.nih.gov/pubmed/12546286 **Teams under pressure in the emergency department: an interview study.** Flowerdew L, Brown R, Russ S, Vincent C, Woloshynowych M. Emerg Med Jrnl (2011). doi: 10.1136/emergmed-2011-200084. http://www.ncbi.nlm.nih.gov/pubmed/22186010 *This paper reported the use of online virtual ED tool for training trauma teams.* **Design, development and evaluation of an online virtual emergency department for training trauma teams.** Youngblood P, Harter PM, Srivastava S, Moffett S, Heinrichs WL, Dev P. Simulation in Healthcare 2008; 3: 146-53. http://www.ncbi.nlm.nih.gov/pubmed/19088658

Objective 3	Action	Evidence and Resources
Continued		*A video showing the role of team training in the ED.* **Team Training in the Emergency Department** http://www.dailymotion.com/gb/relevance/search/team+training+in+emergency+department/1#video=x6s2gr **BEST: Better & Systematic Trauma Care ETTER & SYSTEMATIC TRAUMA CARE** http://www.bestnet.no/best-stiftelsen/56-best-better-a-systematic-trauma-care *Norwegian trauma team training from the BEST (Better & Systematic Trauma care) Foundation* **Training multi-professional trauma teams**, Torben Wisborg, Guttorm Brattebø, Johannes Brattebø & Åse Brinchmann-Hanse, http://munin.uit.no/bitstream/handle/10037/2404/paper_1.pdf?sequence=4 *An evidence-based teamwork system to improve communication and teamwork skills among health care professionals.* **Agency for Healthcare Research and Quality, TeamSTEPPS** http://teamstepps.ahrq.gov/ *This course by the Scottish Clinical Simulation Centre is also run at other sites in the UK.* **Scottish Clinical Simulation Centre, Crisis Avoidance and Resource Management course at** http://www.scsc.scot.nhs.uk/courses/emergency-medicine/crisis-avoidance-and-resource-management-1 **London Trauma Courses** www.londontraumacourses.nhs.uk/
Objective 4	**Action**	**Evidence and Resources**
To understand what additional skills teams need to develop in order to be an effective team.	The emotional intelligence of a team is pivotal to ensuring the success of the team.	**Definition of emotional intelligence:** http://en.wikipedia.org/wiki/Emotional_intelligence **Creating successful teams with emotional intelligence,** Ross Jones, 2009 http://www.cgrowth.com/articles/hci_whitepaper.pdf **Team Emotional Intelligence: what it can mean and how it can affect performance,** Hillary Elfenbein http://apps.olin.wustl.edu/faculty/elfenbeinh/TeamEI.pdf **Does emotional intelligence affect successful teamwork?** Joe Luca & Pina Tarricone http://www.ascilite.org.au/conferences/melbourne01/pdf/papers/lucaj.pdf

Objective 4	*Action*	*Evidence and Resources*
continued		*This article may be business world-speak but easily extrapolated to healthcare.* **What to do when things go wrong,** Scott Berkun http://scottberkun.com/2012/what-to-do-when-things-go-wrong/ *An interesting study exploring the factors that make teamwork effective.* **Team behaviours in emergency care: a qualitative study using behaviours analysis of what makes team work**. Mazzocato P, Forsberg H, von Thiele Scwarz U. Scandinavian Journal of Trauma, Resuscitation and Emergency Medicine 2011; 19: 70. http://www.sjtrem.com/content/19/1/70
Objective 5	***Action***	***Evidence and Resources***
To understand how to measure the effectiveness of a team.	Teams and their leaders need to know how they are performing and how well they are doing. Success may be measured in terms of system process measures, mortality rates, complication rates, staff retention / recruitment or patient experience.	*An observational study attempting to find if simulation based teamwork training when added to an existing curriculum improved clinical performance.* **Simulation based teamwork training for emergency department staff: does it improve clinical team performance when added to an existing didactic teamwork curriculum?** Shapiro M, Morey J, Small S et al. Qual Saf Health Care 2004; 13: 417-21. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1743923/ *This article highlighted 8 evidence-based principles for effective team-training programmes.* **Does Team Training Work? Principles for Health Care.** Salas E, DiazGranados D, Weaver S, King H. Acad Emerg Med 2008; 15: 1002-9 http://www.ncbi.nlm.nih.gov/pubmed/18828828 *This qualitative study first identified key stressors for ED staff and then suggested interventions for improving how the ED team functions, related to leadership and teamwork training.* **Crew Resource Management: improving team work in high reliability industries**. Flin R, O'Connor P, Mearns K. Team Performance Management: An International Journal 2002; 8(3/4): 68-78. http://www.emeraldinsight.com/journals.htm?articleid=882855 **Measuring team factors thought to influence the success of quality improvement in primary care: a systematic review of instruments,** Sue E Brennan, Marije Bosch and Sally E Green, Implement Sci, 2013, http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3602018/ **Learning from adverse events: Fostering a just culture of safety in Canadian hospitals and health care institutions**: Canadian Medical Protective Association; 2009**.** http://www.cmpa-acpm.ca/cmpapd04/docs/submissions_papers/com_learning_from_adverse_events-e.cfm

Departmental activity resources
Sue Robinson and Ruth Brown

Introduction
In the busy and high-pressure environment of an ED it is difficult to create time and space to think about safety. The College has provided a number of resources that support a structured approach to safety (including the whole toolkit)

Purpose
To provide templates and resources to allow a structured approach to safety

Objective 1	***Action***	***Evidence and Resources***
To document safety activity in the department	Departmental safety meetings, agendas, minutes, TOR	**College of Emergency Medicine, *Clinical governance and patient safety groups*** http://www.collemergencymed.ac.uk/Shop-Floor/Safer Care/Safety in your ED/Clinical governance and patient safety groups
Objective 2	***Action***	***Evidence and Resources***
Clinical leadership for safety	The role of the safety lead	**College of Emergency Medicine, *Safety Leads*** http://www.collemergencymed.ac.uk/Shop-Floor/Safer Care/Safety in your ED/Safety Leads *Insights into leadership:* **National College for School Leadership, *Effective Leadership*** http://www.inclentrust.org/uploadedbyfck/file/2%20Research%20Methodology%20(Presentations_Monographs_Guidelines)/11/effective%20leadership.pdf *Self development for leaders:* **NHS Institute for Innovation & Improvement, *e-Learning The Productive Leader*** *http://www.institute.nhs.uk/index.php?option=com_joomcart&Itemid=194&main_page=document_product_info&products_id=946&Joomcartid=71dntdl3krluj0oansec8vuhh3*
Objective 3	***Action***	***Evidence and Resources***
Action plan tracking	Action plans have a habit of being inaction plans – some suggestions for making them happen	*Root cause analysis action planning tool from NPSA:* **NHS Patient Safety Resources, *Root Cause Analysis*** http://www.nrls.npsa.nhs.uk/resources/?entryid45=75425&q=0%c2%acaction+%c2%ac

Objective 4	Action	Evidence and Resources
continued		*PDSA tool* **NHS Institute for Innovation & Improvement, *Plan Do Study Act*** *http://www.institute.nhs.uk/quality_and_service_improvement_tools/quality_and_service_improvement_tools/plan_do_study_act.html* Action planning tool: **NHS Institute for Innovation & Improvement, *Action Planning Tool*** *http://www.institute.nhs.uk/quality_and_service_improvement_tools/quality_and_service_improvement_tools/action_planning.html*
Objective 4	***Action***	***Evidence and Resources***
Learning from Francis	Following the Francis report – the College has a range of resources for members including a checklist for directors to use to ensure quality is central to the delivery of care	**College of Emergency Medicine, *Francis Report*** http://www.collemergencymed.ac.uk/Shop-Floor/Safer Care/Safety in your ED/Francis Report
Objective 5	***Action***	***Evidence and Resources***
Integrating safety into departmental activity	Suggestions for integrating safety into the departmental work	*The College has developed a checklist of how you can ensure safety is considered at every turn.* **College of Emergency Medicine, *Integration of Safety Checklist*** https://secure.collemergencymed.ac.uk/code/document.asp?ID=7385

Integrating safety checklist

Ruth Brown and Sue Robinson

This checklist is designed to support Emergency Physicians in ensuring that safety is considered in every departmental activity.

Action	Why	Who
Departmental safety and quality meetings	• Focus on reducing risk, maximising quality and enhancing safety • Ensures required actions tracked until completed	• Multi-professional • Multi-speciality • All grades of staff
FY2/core training programme includes safety	• To ensure junior doctors are aware of the concepts of risk, safety and their role in improving safety	• All faculty • All trainees
Registrar training includes incident review, risk register review and quality improvement	• To ensure the next generation of Emergency Physicians are aware of their responsibilities and capable of establishing systems for safety • Requirement to ensure all aspects of curriculum are taught	• All faculty • All trainees
Multi-professional incident reviews and action planning	• To ensure the team work together on issues relating to risk and safety	• Multi-professional • Multi-speciality • All grades of staff
Quality and safety notice board	• Ensures awareness of current alerts, demonstrates improvements	• Senior team
System for rapidly disseminating safety information	• To ensure rapid delivery of key safety message to all staff • Need to be assured every member of staff informed	• Senior team
Safety alerts shared on board rounds and at handover	• Raises awareness, puts safety at the centre of activity	• Multi-professional • Multi-speciality • All grades of staff
Ensure system of induction into all matter related to safety e.g. knows how to report incident	• If all staff to participate in improving safety need to understand role and responsibilities	• Senior team • Team Leaders
Ensure every staff member reporting an incident receives individual email	• Ensure staff know incident reporting is valued	• Senior team • Department of Risk/Safety
Nursing education focuses on learning from incidents and principles of safety	• Nursing staff appreciate risk, safety and the importance of their input into mitigating risk	• Senior Nursing team
Pharmacy safety meeting	• To review medication lists, and drug storage, availability, prescribing and administration policies for the ED	• Senior team • ED pharmacist
Infection control meeting	• To ensure local performance against infection control and prevention policies are monitored	• All staff • Member of Trust IC&P team

Action	Why	Who
Review staff numbers against workload and align rotas with activity	• To ensure staffing optimised against workload	• Senior team
ICT user group	• To ensure technology supports safety and minimises risk	• Representation from all staff
Network meetings	• To review pathways and patient experience to enhance safety	• Multi-professional • Multi-speciality • Commissioners
Consultant sign off	• To ensure senior review of patients with known high risk conditions	• Senior team
Consultant job planning includes programmed activities designated for safety actions	• To ensure that a job plan allocates specific time for the completion of safety activities	• Senior team
Appraisal framework to include contribution to Quality Indicators and evidence of safety activity	• To ensure that staff are complying with safety Quality Indicators • To ensure that staff are conducting safety activities properly	• Senior team • All trainees

The College of Emergency Medicine
7-9 Bream's Buildings
London
EC4A 1DT
Tel: +44 (0)20 7404 1999
Fax: +44 (0)20 7067 1267
www.collemergencymed.ac.uk
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