Using patient and staff stories to improve risk management

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In recent years improving patient safety has emerged as a major challenge for health care institutions and clinicians. This article describes an initiative to reach a wide audience by sharing the lessons learnt from clinical incident investigations through the medium of patient and staff stories.

Root cause analysis (RCA) investigations into serious incidents have emerged as a dominant methodology for learning lessons when patients are harmed. Usually RCA reports are written in a dry and objective language. In this initiative we wanted to reach out to a wider audience by sharing the lessons learnt from clinical incident investigations using the medium of patient and staff stories. Patient safety is an emotive issue – the psychological harm that staff and patients involved in clinical incidents experience is well documented – so we wanted to find a voice that could tell these stories in a way to which staff can easily relate.

The literature
An increasing body of research shows that medical errors are a major cause of harm to patients. Estimates of how much harm is caused vary from study to study, largely as a result of inconsistent definitions, methodologies and the fact that the studies have been conducted in cultures with different health care delivery systems.

The US-based Harvard Medical Practice study (Brennan et al, 1991) found that 3.7 per cent of inpatient episodes led to harmful adverse events, while the figure reported in the Quality in Australian Health Care Study (Wilson et al, 1995) was 16.6 per cent. A UK-based pilot study showed the overall rate of adverse events to be 11.7 per cent when multiple adverse events were included (Vincent et al, 2001a). These figures from case note reviews can do no more than give an impression of the problem, because many errors are untraceable, and they tell us nothing about primary care. They confirm a substantial number of errors, of which it has been estimated as many as 70 per cent are preventable (Department of Health, 2000).

There has been a corresponding acknowledgement that error in a complex and at times high-risk health care system is ‘inevitable’ (DoH, 2001). In the UK, reducing error and learning from mistakes has become central to efforts to improve quality and safety in health care (DoH, 2001; 2006).

Investigating causes
Learning from an incident must necessarily begin with an understanding of the causes and contributory factors involved – including organisational cultural aspects such as attitudes to stress and teamwork (Sexton et al, 2000).

Patient safety teams in hospitals are responsible for investigating incidents, producing a written report of their findings and proposing an action plan to address the root causes and reduce the likelihood of recurrence. The investigative process involves interviews with individual staff members involved in the incident. Increasingly, this process is seen as fundamental not only to optimum memory retrieval (National Patient Safety Agency, 2001) but also to drawing meaning from an incident.

Skilled interviewers create conditions more traditionally seen as the domain of a therapeutic counsellor. As such, an undisturbed, relaxed environment away from the workplace is important, as is the asking of open questions, reflective listening and empathy, allowing staff members to tell their story without interruption or bias. Key themes and learning will naturally emerge from their narrative and reflection on events (Vincent, 2001b).

Increasingly patients and family are also being involved in investigations as their unique perspective and insights are recognised. Trusts will soon be required to have a clear policy concerning disclosure and the involvement of patients and families/carers following adverse clinical incidents. The General Medical Council (2001) already makes clear the ethical duty of disclosure following harm.

One approach to sharing the outcomes of RCA investigations is to produce patient safety stories. The power of stories to engage and ultimately change behaviour has been studied by researchers such as Bate (2004). In particular, Bate talks of the way in which personal stories – with their universal

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emotions and grounding in everyday life – have the ability to engage a wide range of health care workers, cutting across hierarchies.

The advantage of stories
Stories are devoid of jargon and the sterile pedagogy of action plans, which can alienate staff and distance them from the human impact. For example, a protocol dictating the washing of hands to prevent infection comes across as just another rule to be obeyed, whereas hearing how a patient felt on contracting MRSA has an enduring legacy because it affects the heart as well as the head (Box 1).

As author Philip Pullman observed, “Thou shalt not” is soon forgotten, but “Once upon a time” lasts forever. Bate argues that because of this binding up of emotion with reason, stories represent a unique way to spread and sustain messages. After all, storytelling is the natural medium through which we articulate and make sense of our experience. In our coffee breaks and at the end of each day we package events into stories so that others can share our experience.

Stories about clinical incidents ‘paint a picture of events’ so include ‘the accident-producing contexts’ (Beyea et al, 2004), which help practitioners to recognise warning signs and powerfully reinforce the importance of safe practice.

Stories have value for both the teller and receiver. Telling a story helps clarify one’s thinking. The act of recounting a story also helps the storyteller see patterns and connections more holistically. Receivers benefit from both the shared learning and from the opportunity to offer their own reflections. There are always multiple points of view that can be applied to a collection of events.

Mistakes are powerful learning opportunities for the individuals involved and they are unlikely to repeat the error. Stories, which have the power to emotionally connect, tend to be discreetly shared with close colleagues and friends along the way who can be trusted to provide support rather than blame, who understand the factors that contributed to the error and who are grateful for the free lesson. We are attempting to harness the potential of stories arising from human error by sharing them with staff across the organisation without stripping them of their personal and emotional content.

The stories that are generated are based on some minimum specifications (Zimmerman, 1998):

- They provide an early hook to the reader in the form of a provocative title or first sentence;
- The readers should be able to identify with the people or issue in the story;
- The story should contain explicit, honest reflection;
- The people in the story are comfortable sharing the reflections.

The last point is important. While most errors are probably due to poorly designed systems, often staff cannot avoid feeling guilt or shame. For this initiative to succeed, a prerequisite was to encourage staff to share their stories.

BOX 1. A PATIENT’S STORY

I knew something was wrong because I kept having blood and swabs taken but nothing was said. Then I was moved into a side room and still no explanation. I asked eventually. ‘It will be more peaceful to sleep,’ I was told. It didn’t sound like the truth but I said nothing.

I felt a terrible loneliness, abandonment. Almost a punishment or rejection – but I wasn’t sure what for. Why had I been separated off like this, treated like a leper? Why won’t anyone talk to me? Some days later I was told I had MRSA.

There was no consistency in how I was treated. Some staff were meticulous in their handwashing and use of gloves, others didn’t even wash their hands before touching me or when leaving the room.

I can’t really describe what it’s like to have MRSA – you just feel, well, so dirty, whatever you do you can’t feel clean. People are talking about how infectious you are and you feel you’re to blame somehow. You feel ashamed of yourself and your body.

It affects your confidence and self-esteem. I suppose it’s partly the stereotypes in your head – unclean, untouchable, unlovable.

At the same time I was trying to be rational – this is not my fault. I challenged staff on two occasions and on both occasions it was made very clear how unacceptable it was for me to do this. You can’t expect patients to challenge without a complete culture change, where it would be viewed as helpful rather than a personal attack.

I’ve heard MRSA called ‘hospital-acquired infection’ – but it’s not the bricks and mortar giving it to you is it? I remember one person touching my wound dressing without washing their hands and none of the staff with him said anything.

A few moments later his phone went off and a few of the staff tutted and he was really embarrassed and I thought, ‘My god, he can put me and other patients at risk and nothing is said but the phone goes off and he’s made to feel ashamed – if only it was the other way round!’ I think if people knew how it felt and how it affects you maybe they’d think again.

I know staff don’t set out to give a patient MRSA but I think they just don’t see that not washing their hands does exactly that.

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Learning from incidents

As part of the plan to capture these stories it was thought that interviews carried out during the investigation process would be the best way to identify potential stories. It was decided to use these opportunities to ask whether they would agree to share their (anonymised) experience – what happened and how it felt – for wider learning. If staff agreed, their story was written up as a short article, over which they had ultimate editorial control.

Contributory factors revealed during the investigation would be appended to set the incident in the proper context. We have also attempted to select incidents that relate to national findings on patient safety, such as infusion device errors, poor handover of patients between specialties and so on, rather than highlight one-off cases. As a rule, the focus for much of our investigations has been to find general causes rather than curious accidents.

The historian Edward Carr illustrates the difference between a general cause and an accident. Mr Robinson crosses a road near a blind bend to buy cigarettes and is killed by a drunk driver. A root cause analysis investigation might seek to identify the cause of his death. Carr suggests the significant causes are those that can be generalised. If Mr Robinson had not wanted cigarettes, he would not have been killed. So his desire for cigarettes was a cause of the accident. However, it was not the general cause, since in general a desire for cigarettes does not tend to lead to people being run over. In contrast, drunk driving and blind bends, the other contributing factors, can be generalised and therefore, in terms of possible lessons for others to learn, they may be considered significant.

While searching for staff stories, we were aware of the multiple points of view that can be applied to a clinical incident and the potential insights that patient stories would bring to this initiative. In our first series we included the reflections of two patients. The first was identified following a very detailed complaint regarding care and lack of sensitivity during a recent bereavement, the second involved a patient who had been in hospital for many months as a result of complications from surgery and MRSA (Box 1, p35).

Using the stories

The aim of sharing the patient’s story (Box 1) was to make the link between her personal experiences and some of the general lessons that can be learnt from her tale. The National Audit Office (2004) estimates that more than 5,000 people die each year as a result of health care-associated infections. Health Protection Agency (2004) figures show that MRSA increased by 3.6 per cent between April 2003 and March 2004 to 7,647 cases. The patient’s story also coincided with the trust’s participation in the first phase of the National Patient Safety Agency’s ‘cleanyourhands’ campaign. The story helps to bridge the gap, highlighting the human side of an increase in MRSA and reinforcing the importance of good hand hygiene.

When the project was conceived it was thought that the biggest hurdle would be finding staff willing to share their stories. For many professionals, involvement in a clinical incident can be traumatic and involve a lot of self-recrimination. To be open about both the error and its personal consequences seemed to be asking a lot.

Staff initially had concerns regarding anonymity and whether stories would be sufficiently set in context. However, once reassurance had been given on these points and it was made clear that nothing would be published without their agreement, staff were surprisingly supportive, many commenting that the most useful learning arises through informal narratives – conversations with their peers. All those asked agreed to share their story. The stories we have collected so far have been contributed by a wide variety of staff from a D-grade nurse to a consultant, and all involved personal error.

Patients offered a different challenge. At the initial meeting, care was taken to provide clarity regarding the project and the nature and scope of our involvement. Substantial benefits have accrued from collecting these stories. They have become an invaluable tool for the trust’s patient safety training.

One patient has become actively involved in patient safety by joining the trust’s Patient Safety Committee as its first patient representative, and she has been actively engaged in devising guidelines for this role. In addition, she has told her story, in person, in the Introduction to Patient Safety module run by the local university’s postgraduate medical school. She has also commented on the therapeutic effect of knowing that her experience has been acknowledged and can be used to facilitate change.

Another patient’s story concerning the loss of a newborn baby has been used by the specialty concerned during senior nurse away days to highlight the issues involved and their emotional impact. It has also been used on educational modules to ensure that patient experience remains central to teaching.

For professionals and those in the patient safety team involved with this initiative, it has reaffirmed the importance of Don Berwick’s adage that ‘conversation is the mainstay of safety’ and that sharing and reflecting on errors have an important role to play in developing a safety culture. Indeed, many staff, though not wanting their names printed, nevertheless passed round their edited articles among friends and colleagues. They wanted the issues that were highlighted to be discussed – in effect, telling their stories all over again.

References


