Exploring Healthcare Harm

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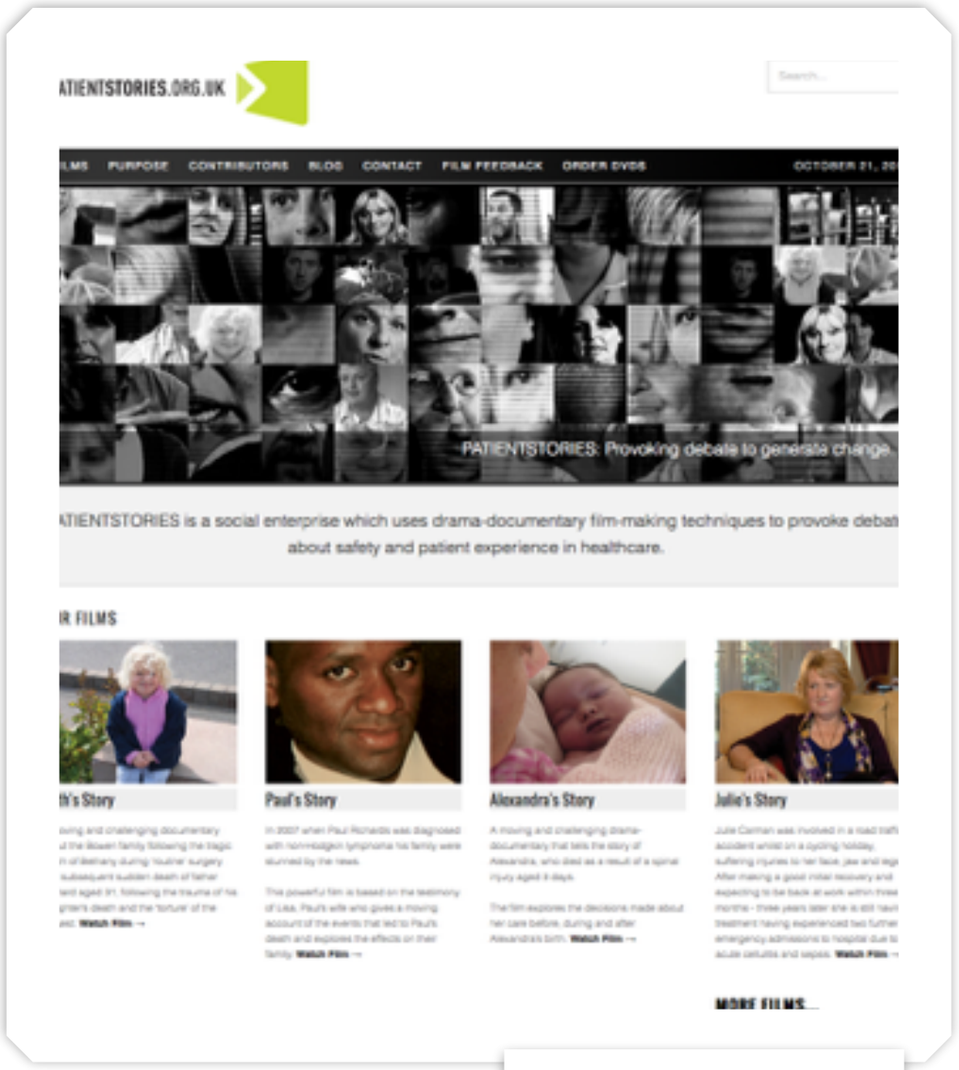
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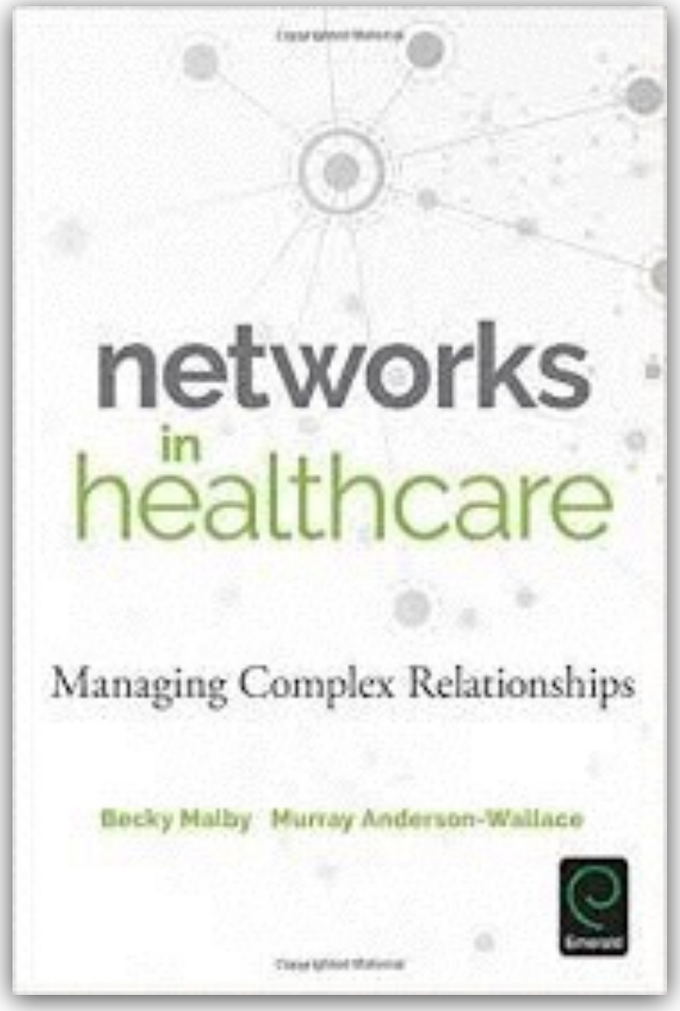
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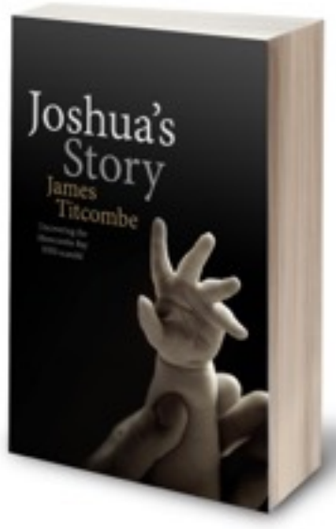
Joshua's
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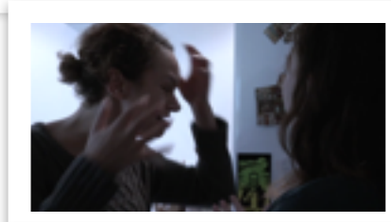

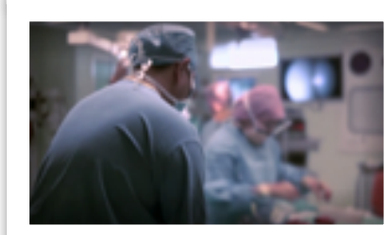


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Murray Anderson-Wallace

Murray Anderson-Wallace is an independent producer and specialist adviser in healthcare. He has a background in nursing, social psychology and organisational communications research

December 2013

Five obstacles that prevent people acting on their concerns

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

11 Dec 2013 6

May 2013

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

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

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

The death of baby Alexandra came after her parents repeatedly asked for a caesarean, only to feel ignored and mistreated

Murray Anderson-Wallace and **Roland Denning**
guardian.co.uk, Tuesday 28 May 2013 11.31 BST

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

24 October, 2014 | By James Titcombe, Murray Anderson-Wallace

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

When avoidable mistakes or failures lead to the most tragic consequences - the preventable death of a child or loved one - most would agree that learning lessons to prevent future recurrence must be the primary focus of any response.

'There's strong

However, there is very strong evidence to suggest that in

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OPINION

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

5 November, 2014

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

Although his parents repeatedly raised concerns about his condition, their calls for help went unheard. By the time action was finally taken, it was too late. Joshua's life could not be saved.

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

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How do we learn from patients' poor experiences?

4 April, 2013 | By Suzanne Shale, Murray Anderson-Wallace

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

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A culture of passive denial?

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ETHICAL INQUIRY, INDEPENDENT VOICE

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

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

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

Isabel Menzies Lyth (1960)

Isabel Menzies Lyth

Social Systems as a Defense Against Anxiety

An Empirical Study of the Nursing Service of a General Hospital*

Introduction

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

*A shortened version of the original—*Human Relations*, 13:95–121, 1960.

Sense-making in the odd moral world of healthcare

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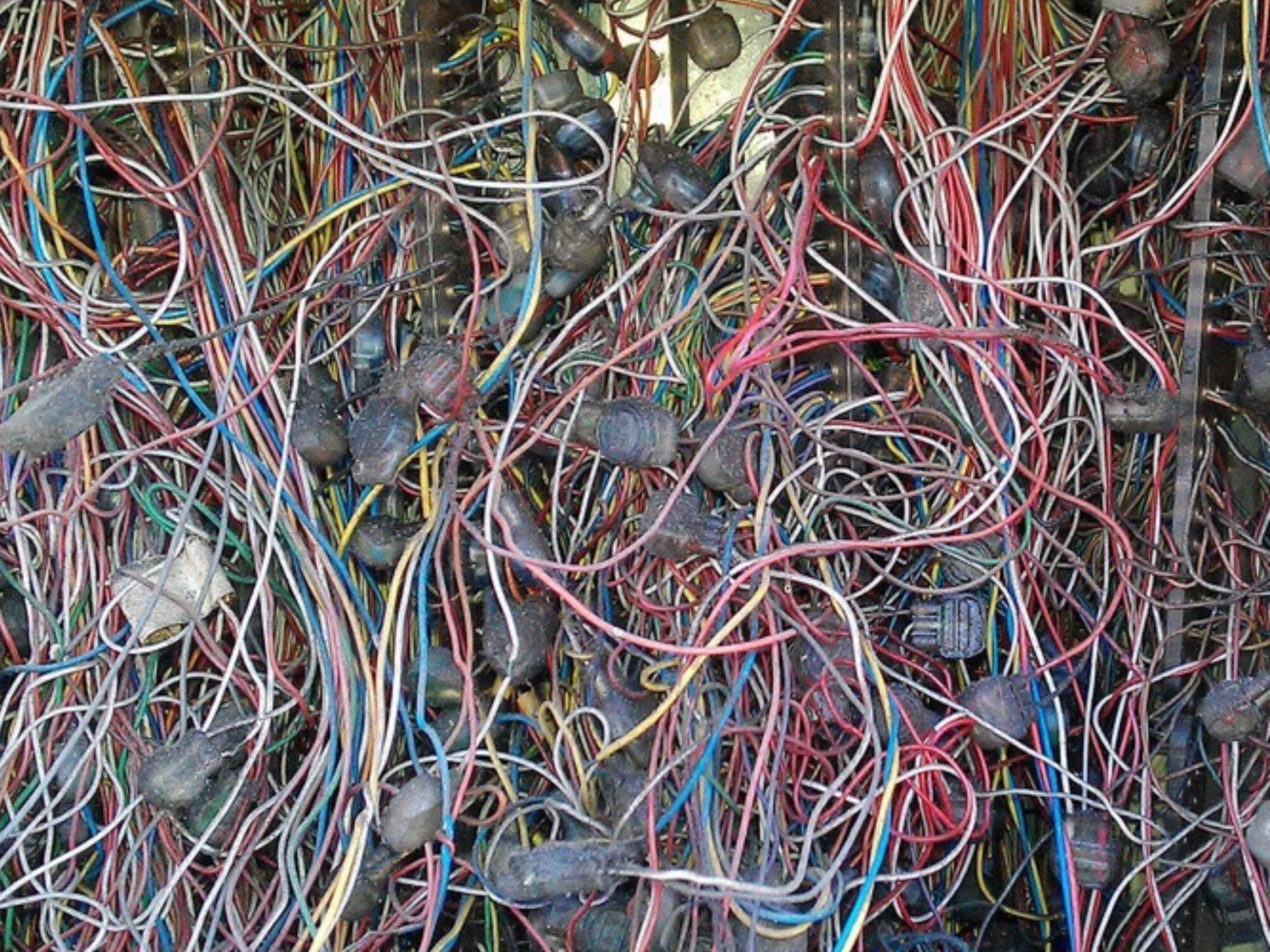
"In the hospital it is the good people, not the bad, who take knives and cut people open; here the good stick others with needles and push fingers into rectums and vaginas, tubes in to urethras, needles into the scalp of a baby; here the good, doing good, peel dead skin from a screaming burn victim's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

D. Chambliss *Beyond Caring* Chicago UP 1996



Violations in Healthcare

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

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

Perspectives

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

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

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

Improving the quality of response

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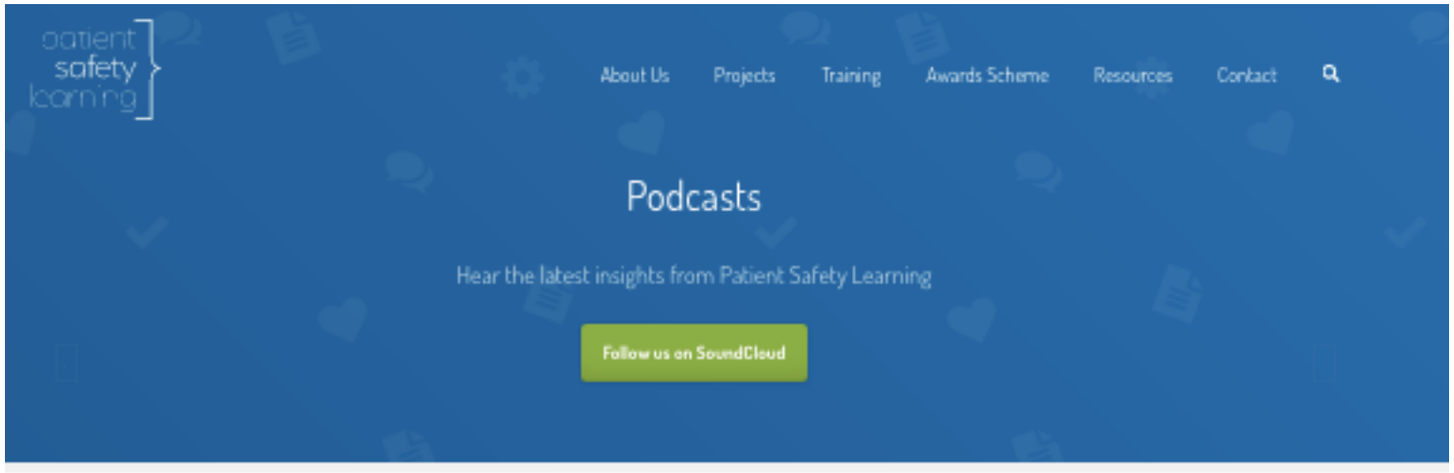
ETHICAL INQUIRY, INDEPENDENT VOICE

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

(Anderson-Wallace & Shale 2014)



https://www.patientsafetylearning.org/blog/test-blog-post