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# The pre-eminence of patient safety in health care governance

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<http://dx.doi.org/10.1108/IJHG-12-2016-0054>

<b>Title</b>	The pre-eminence of patient safety in health care governance
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<b>Type</b>	Article
<b>URL</b>	This version is available at: <a href="http://usir.salford.ac.uk/41123/">http://usir.salford.ac.uk/41123/</a>
<b>Published Date</b>	2017

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Journal:	<i>International Journal of Health Governance</i>
Manuscript ID	ijhg-12-2016-0054
Manuscript Type:	Clinical Governance Reviews
Keywords:	Clinical audit, Clinical governance, Culture, Health care quality, Patient safety

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Manuscripts

Health Governance

IJHG 22.1

### **The pre-eminence of patient safety in health care governance**

In the field of health care, the first decades of the 21<sup>st</sup> century will be remembered as the time period when patient safety became a central pillar of healthcare governance. This era was ushered in by the Institute of Medicine (IOM) report "*To err is human: building a safer health system*" (Kohn, Corrigan & Donaldson 1999) which focused on the human cost of medical error. The report offered a clear and succinct definition of medical error as either the failure to complete a planned action, or as a planning failure where the action planned was unable to achieve the intended outcome. The authors concluded that medical error is divided into four major categories: diagnostic, treatment, preventative, other (Kohn, Corrigan & Donaldson 1999). The category 'other' included anything that could not be filed under the first three categories such as systems failure or communication breakdown.

The importance of communication failure as a major contributor to medical error, and thus an environment in which patients are unsafe, was illustrated in a study that commenced in the same year that the IOM report was published (Sutcliffe, Lewton and Rosenthal 2004). The researchers interviewed a sample of twenty-six medical residents about incidents in which they had personally been involved and asked them to reflect on the underlying causes. In seventy cases of medical error, residents identified communication as a major cause. An important finding was that communication failure stems from hierarchical relationships, ambiguity about roles and responsibilities, and issues around conflict and power. In essence, communication error cannot be attributed entirely to the players directly involved, but is embedded in the institutional culture of the hospital (Sutcliffe, Lewton & Rosenthal 2004).

Ten years later, communication failure continued to be a major cause of medical error, leading to a shortfall in patient safety. A dangerous trigger point for communication error causing harm to patients was identified as the 'hand off', or period of time when the care of a patient is transferred from one health care practitioner to another (Starmer, Spector, Srivastava et al 2014). In a prospective study published by the prestigious New England Journal of Medicine, the authors introduced a package, the I-Pass Handoff Bundle, (Starmer, Spector, Srivastava et al 2014) which included a mnemonic to use during medical handover, protocols for staff training and suggestions for faculty development. When researchers evaluated changes using pre and post intervention statistics, preventable errors at six out of the nine research sites decreased by 30%. This improvement reflects not only an acquired skill, but also a cultural shift within the institutions themselves.

Ferlie and Shortell (2001) recognised the necessity of transforming institutional culture in order to improve patient safety in both the UK and the USA. Institutional culture is sometimes intangible, they note, but always complex and a fundamental factor when altering operational norms. A culture that supports innovation and inter-professional dialogue can act as a powerful catalyst for

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3 change. Conversely, a closed, rigidly hierarchical culture can build barriers. A  
4 major source of conflict is often between the clinical culture and the managerial  
5 culture of an institution (Ferlie and Shortell 2001). A substantial change in this  
6 relationship occurred in 1999 in the UK as NHS Trusts became legally  
7 responsible for patient safety as part of the emerging clinical governance agenda  
8 (Flynn 2002). This was reinforced by the introduction of the National Patient  
9 Safety Agenda (NPSA) in 2001, with the stated goal of reducing harm to patients  
10 (Emslie, Knox and Pickstone 2002). While acknowledging that in a large  
11 organisation such as the NHS, mistakes will occur, the NPSA sought to change the  
12 institutional culture of the NHS from a blame culture to a learning culture in  
13 which mistakes can be acknowledged, analysed, reflected upon and learned from  
14 (Emslie, Knox and Pickstone 2002). Since this time, clinical governance has  
15 become the keystone of quality enhancement and evaluation within the NHS. In  
16 essence everything that contributes to an improvement in health care shelters  
17 under the clinical governance umbrella (Brennan and Flynn 2013). This includes  
18 audit, research, national standards, evidence-based practice, incident reporting,  
19 continuing professional development and risk management (Braithwaite and  
20 Travaglia (2008).

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25 This issue of IJHG presents a variety of articles illustrating how the overarching  
26 aim of good healthcare governance, to alter the culture of care in order to  
27 improve patient safety, is played out in different settings. From the new national  
28 health workforce regulation in Australia (Pacey, Smith-Merry, Gillespie and Short  
29 2017), through the introduction of a clinical governance framework in a medical  
30 combat unit (Currie, Mateer, Weston et al 2017) and an initiative to make  
31 hospital wards safer for patients with dementia (Eastham and Cox 2017) to a  
32 regional-based collaboration to increase patient safety (Veit 2017), all the  
33 articles have a common theme of improving patient safety through changes in  
34 the existing health care culture. Finally, Wood, Shaw, Sivananthan et al (2017)  
35 continue this theme with a review of a restraint technique used in psychiatric  
36 facilities, while Berland (2017) explores the use of the Johari Window to  
37 illustrate the interaction and divergence of patient and provider perspectives in  
38 health care encounters. Understanding and valuing the patient perspective is  
39 another example of how changing a healthcare culture from a “doctor knows  
40 best” model to one where the views and concerns of patients contribute to a  
41 collaborative approach to care, improves both patient safety and satisfaction.  
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45 **Pacey et al (2017)** illustrate the changing culture of Australian healthcare  
46 regulation as it moved, in 2010, from a patchwork of territorial, state or  
47 commonwealth regulations to a unified system embodied in a national  
48 framework for health legislation. This has contributed to patient safety by  
49 ensuring that standards are the same throughout Australia. Prior to 2010 state  
50 regulation of health professionals meant that in some professions, licensure was  
51 recognized in some states but not in others. This prohibited easy movement of  
52 health care workers, required to meet the demands of changing demographics,  
53 particularly the challenges associated with a rapidly ageing population. Pacey et  
54 al (2017) point out that although a national framework for health care regulation  
55 has many benefits, this may, in some cases, challenge the ability of states to  
56 regulate health care in response to the specific needs of their own populations.  
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3 This is somewhat compensated by the establishment of 137 local hospital  
4 networks (LHNs) which consist of small groups of public hospitals. LHNs have a  
5 responsibility for service delivery, outcomes, and budget management; they are  
6 therefore able to respond to local needs (Schweppenstedde, Hinrichs, Ogbu et al  
7 2014). The overall consensus is, nevertheless, that the regulatory framework  
8 should, in the long term, demonstrate benefits in terms of patient safety on a  
9 national level. However, as this is still an evolving project, comprehensive audit  
10 data sets may not yet be available. For example, Australian National Safety and  
11 Quality Health Service (NSQHS) standards published in 2011 by the Australian  
12 Commission on Safety and Quality in Health Care (ACSQHC) were only adopted  
13 nationally in 2013. These standards cover ten essential areas of health care  
14 relating to patient safety with a view toward establishing procedures for dealing  
15 with adverse incidents (Schweppenstedde, Hinrichs, Ogbu et al 2014).  
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19 Another example of the changing culture of health care is presented by **Currie,**  
20 **Mateer, Weston et al (2017)**. The authors report on the development of a  
21 clinical governance framework designed to improve patient safety within  
22 Australian deployed military units. One challenge identified is the cultural  
23 dissonance between the military tradition of obedience and the joint  
24 responsibility of health practitioners at all levels which provides checks and  
25 balances within a clinical governance framework.  
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28 This however can be viewed as a learning opportunity, which is not entirely one-  
29 sided. A great deal of knowledge in acute medicine and surgery, particularly in  
30 trauma care, is derived from experiences and innovations in caring for soldiers  
31 wounded in combat. A clinical governance framework affords the opportunity to  
32 provide education about best practice standards, using knowledge gained in the  
33 field. An example is the standardisation of resuscitation procedures for patients  
34 requiring massive blood transfusions. Following the adoption of an evidence-  
35 based guideline across all military units, the percentage of soldiers surviving  
36 following massive haemorrhage increased by over 10%.  
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39 While improving soldiers' ability to survive injuries sustained in battle is a  
40 noteworthy goal, it is important to realise that for some people, the activities of  
41 daily living are paramount to a continuous battle. This is especially true for  
42 patients with dementia. Confusion can be exacerbated for people with dementia  
43 by unfamiliar surroundings, thus environment has been increasingly recognised  
44 during the past decade as a therapeutic resource in the care of people with  
45 Alzheimers and other forms of dementia (Day, Carreon and Stump 2000).  
46 **Eastham and Cox (2017)** report on a literature review and a pilot study of  
47 patient engagement in the activities of daily living (Holland 2008) while living  
48 with a diagnosis of dementia. The authors describe the features of a dementia  
49 friendly environment, as endorsed by the Kings Fund, as "familiarity, legibility,  
50 wayfinding, orientation and daily activity engagement". The Kings Fund  
51 developed an assessment tool together with a number of NHS trusts. The  
52 enhancing the healing environment (EHE) tool contains seven criteria, which are  
53 scored independently to assess whether a ward can be considered 'dementia  
54 friendly' (Kings Fund 2014). Eastham and Cox used the criteria from the Kings  
55 Fund to design a ward environment and then assessed patient engagement and  
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3 interactions with staff. They found that simple geometric shapes, warm  
4 contrasting colours and a bright environment were beneficial for dementia  
5 patients. The authors acknowledged the limitations of the study due to a small  
6 sample size and the acute hospital setting. However, the setting may not have  
7 been the limitation that the researchers assumed it to be. In an earlier review of  
8 the literature, Day, Carreon and Stump (2000) found that a home-like setting  
9 within a clinical facility was not necessarily more beneficial for dementia  
10 patients, in terms of patient safety and engagement, than a more traditional ward  
11 environment. This is undoubtedly an important area of both research and  
12 governance in view of increasing lifespans, resulting in a rising number of people  
13 diagnosed with dementia.  
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17 **Veit (2017)** reports on a more strategic approach to increasing patient safety by  
18 reducing disparities in health care in Washington State. Established in the early  
19 years of the 21<sup>st</sup> century, the Washington Patient Safety Coalition (WPSC) was  
20 formed when the Washington state Department of Health (DOH) and the Health  
21 Care Authority (HCA) approached the Foundation for Health Care Quality  
22 (FHCQ) to create a working group for the purpose of addressing safety issues.  
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25 The WPSC's role is to create a safe space where members can discuss and debate  
26 patient safety issues. In addition, the WPSC acts as an education hub where  
27 resources can be shared, educational campaigns are planned, and an annual  
28 conference is organised.  
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31 The WPSC is led by a steering committee comprised of a rotating membership of  
32 15, made up of representatives from the thirty-eight organisations represented.  
33 A second tier of governance is the advisory committee, which is made up of one  
34 representative from each organisation. While members of the advisory  
35 committee can attend steering committee meetings, only steering committee  
36 members have a vote when deciding WPSC business.  
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39 The WPSC takes an active role in matters of patient safety by providing links to  
40 external information sources, hosting monthly webinars, holding an annual  
41 conference, and creating campaigns about specific safety issues. A recent  
42 campaign addressed medication safety. In addition, the WPSC works closely with  
43 other agencies such as the Washington Health Alliance and the Governor's  
44 Interagency Council to reduce health disparity and improve patient safety in the  
45 state of Washington.  
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48 **Wood, Shaw and Sivananthan et al's (2017)** article returns us to a specific  
49 issue with great importance to patient safety: the use of restraint with  
50 psychiatric patients. There can be no greater aim in the field of patient safety  
51 than preventing unnecessary death. Restraining a vulnerable individual in a face-  
52 down position (prone restraint) can lead to severe trauma, or even death by  
53 impairing a patient's airway or reducing circulation. Wood, Shaw and  
54 Sivananthan et al (2017) report on an audit of prone restraint, a controversial  
55 technique, which some mental health charities and organisations say should be  
56 banned. Some NHS trusts such as Cheshire and Wirral Partnerships NHS  
57 Foundation Trust (CWP), have already discontinued authorisation of prone  
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3 restraint. Nevertheless, in the this trust, its use has actually increased since 2013  
4 to 284 instances per 100,000 bed days and in over 40% of all incidents involving  
5 restraint, prone restraint was used. Data from the audit demonstrated that in  
6 93% of all incidents ending in the use of prone restraint, staff attempted to calm  
7 the patient by using non-restrictive techniques before employing the  
8 controversial restraining method. Findings from the audit indicated that patients  
9 subjected to this type of restraint had most commonly been diagnosed with  
10 paranoid schizophrenia or unstable personality disorder. Questions asked during  
11 the data collection phase included information about who was restrained (age,  
12 gender and diagnosis), why the restraint occurred, where it happened and how  
13 long it lasted. The audit showed that only 40% of prone restraining incidents  
14 were followed up by a staff debriefing session, and where these did occur, they  
15 were undocumented. Patient reviews took place in over half of the incidents but  
16 where these occurred, patient care plans were not updated.  
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20 This audit demonstrated that even in NHS trusts where the commitment to  
21 discontinue dangerous practices exists, prone restraint was still being used at  
22 the time of this audit with inadequate follow-up or documentation. The good  
23 news is that the audit process enabled staff to see what was happening and  
24 review their own actions, and those of their colleagues. At the time of writing this  
25 article, the authors report that the most recent audit results show that CWP now  
26 has reduced the use of prone restraint to less than the national average number  
27 on adult acute wards, psychiatric intensive care units and high dependency in-  
28 patient services. Information from patients on the use of this technique would  
29 have provided additional insights, which might be used to reduce even further,  
30 or even eliminate prone restraint entirely.  
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34 The final article reviewed focuses on just such patient perspectives through the  
35 use of the Johari Window. Psychologists Harrington (Harry) Ingham and Joseph  
36 Luff developed the Johari Window in 1955 (Armstrong 2006). While the name  
37 sounds exotic to Anglophones, it is simply a combination of the names of its  
38 creators (Joe & Harry). Designed as a tool to promote self-understanding and  
39 interpersonal communication, its descriptors includes 'soft' attributes such as  
40 helpfulness, sympathy and kindness. **Berland (2017)** reports on the use of the  
41 Johari Window to explore patient and provider perspectives. This tool was  
42 selected because of the way it presents a visual representation of information.  
43 The window is divided into four quadrants. One quadrant represents knowledge  
44 that the patient alone has, while its corresponding window contains knowledge  
45 known only to the care provider. The third window represents information  
46 shared by both the patient and the provider, while the final window depicts  
47 information known to neither of them.  
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51 While Berland (2017) acknowledges that there has been no formal evaluation of  
52 using this tool in health care planning, it has been used more widely in other  
53 fields where it has evaluated well (Armstrong 2006). It may, however, be  
54 particularly useful in health care where knowledge tends to be unevenly  
55 distributed among the various players. For instance, a surgeon may have a  
56 precise understanding of his or her surgical procedure: knowledge, which is not  
57 held by the patient. However the surgeon may have little understanding of what  
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3 it feels to be a patient who is fearful of dying on the operating table. In fact, this  
4 information may be hidden to the patient's conscious mind but manifest itself as  
5 anxiety or depression prior to surgery.  
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8 While Canadian hospitals often use 'scorecards' or 'dashboards' to summarise  
9 clinical quality indicators (CQI), these are often missing the patient perspective.  
10 When patient data is collected it is often superficial and does not capture  
11 patients' true views or deepest feelings about their hospital in-patient  
12 experience (Berland 2017). An example is patients who rate their hospital stay  
13 highly on discharge surveys, yet can talk to researchers about specific problems  
14 such as poor discharge planning.  
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17 Another benefit of the Johari Window is that it can accommodate both qualitative  
18 and quantitative data. This provides a more comprehensive picture of what  
19 works and what doesn't in health care and can aid in improvement planning  
20 (Berland 2017).  
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23 Patient safety continues to occupy the minds of both patients and of health care  
24 providers. The latter seek to enhance governance strategies to stimulate  
25 continual improvement in patient safety and satisfaction. The former consider  
26 whether they or their loved ones will be safe when entering a health care facility.  
27 Questions about infection control, surgical risk, being treated with dignity and  
28 respect, risk management and medication errors are asked on both sides of the  
29 surgical table or hospital bed. These are questions that must continue to be  
30 asked, and solutions found, to ensure patients remain safe and health  
31 practitioners can do their jobs with the assurance that they will be able to fulfill  
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