



# **Speaking Up: A Team Based Approach to Patient Safety**

J. Meek & L. Dodd  
K. Fenwick  
J. Fisher

**NHS**  
Northumbria Healthcare  
NHS Foundation Trust

 **Newcastle  
University**

# IPL & Patient Safety

‘Enables two or more professions to learn **with, from and about** each other to improve collaborative practice and quality of care <sup>(1)</sup>’



## Mid Staffs hospital scandal: key recommendations of the Francis report

Robert Francis QC urges changes including a duty of candour for every healthcare organisation and a single regulator



▲ The Francis report into the Mid Staffordshire NHS trust scandal. Photograph: © ian Garmy Images

## Gosport hospital deaths: Police launch new inquiry

34 April 2016



Gosport hospital deaths



Ian Sandford, whose mother died in Gosport Hospital, attended a meeting between police and residents

## Research Questions:

Can IPL encourage healthcare students to identify patient safety issues?



Can IPL encourage healthcare students to communicate concerns about patient safety?



## Method:

### The Students

84 undergraduate students

6 different healthcare backgrounds



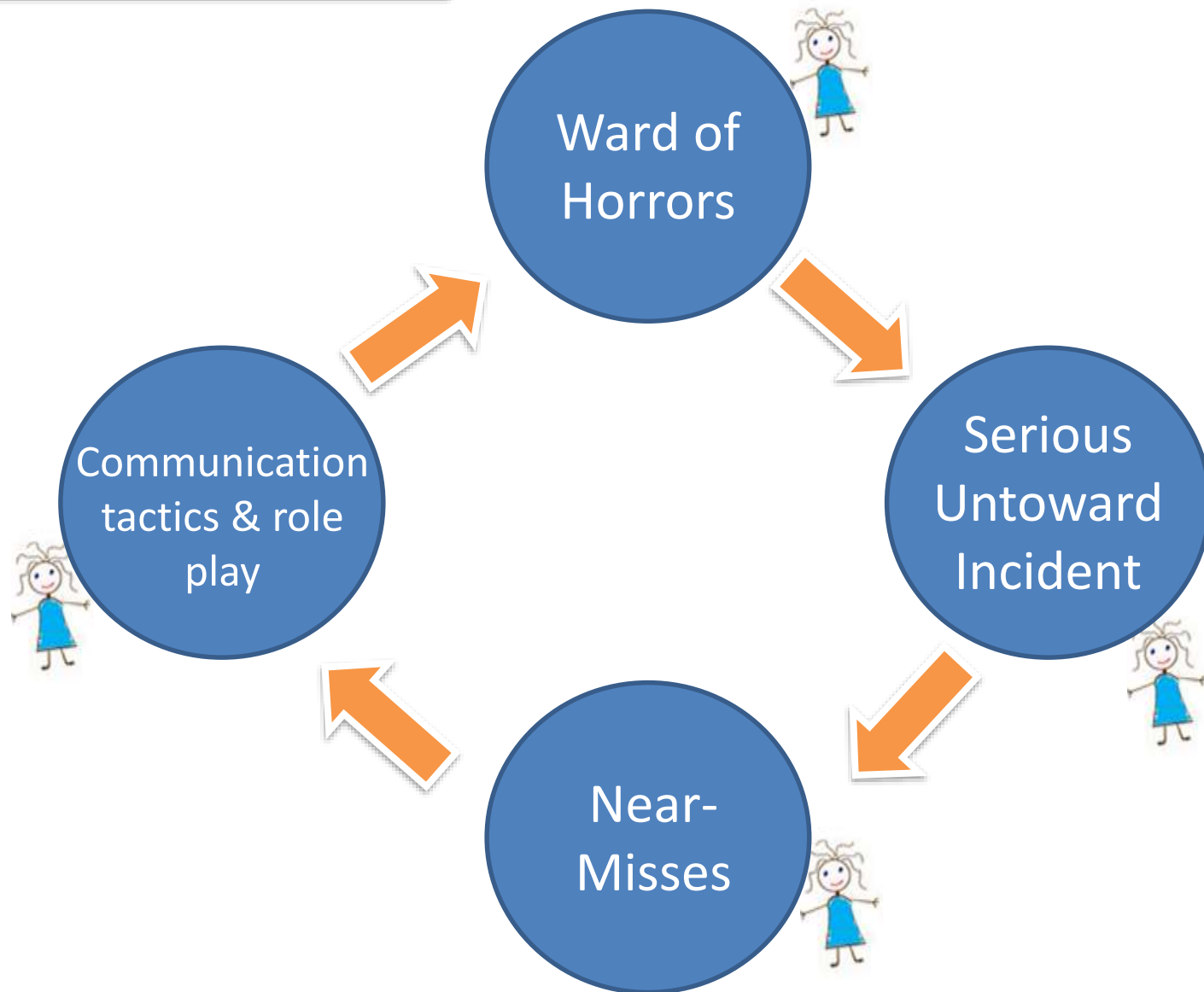
### The Faculty

Inter-professional faculty:

Nurses  
Pharmacists  
Doctors



## The Intervention:

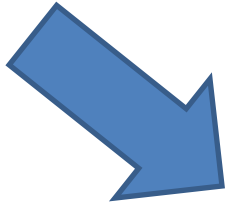
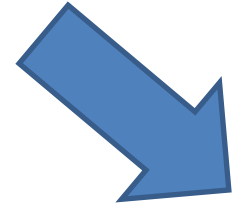
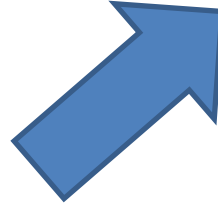




# Ward of Horrors:



# Serious Untoward Incident (SUI)<sup>(3)</sup>



# Near-Misses:



Stress

Incident details

Incident date (YYYY-MM-DD)

Date entered

Site

Business Unit

Speciality

Sub-speciality

Location (type)

change as required

Location (exact)

Description

Enter facts, not opinions. Do not enter any identifiable information (the job title or the ward/patient to define persons involved). Do not use abbreviations. Do not complete in BLOCK CAPITALS. If you put in the name of a ward please use the word Ward before the name.

Remedial action taken at the time of the incident or to prevent re-occurrence.

Free text rules apply, see above 'Description of incident' for details.

Type

Was this a medication incident?

Was any equipment involved in the incident?

Category

Detail

Adverse Event

Result

Severity

Distracted

Lack of Knowledge



*Improvement*

Poor  
Communication

The National Patient Safety  
Alerting System

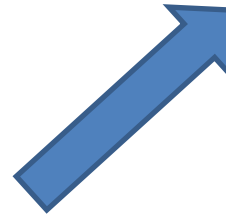


# Communication Tactics & Role Play (4):



CUSS approach

- Concern – "I'm concerned that..."
- Unsure – "I'm unsure that..."
- Safety – "It is not safe..."
- Stop – "Stop what you are doing..."



# Data Collection & Analysis <sup>(5)</sup>(6):

Data  
Collection

Analysis

## Quantitative

SAQ

RIPL

Wilcoxon  
Signed Rank  
Test

## Qualitative

Free text  
feedback

Inductive  
Approach

## Results:

Ward of  
Horrors

SUI

Near-  
Misses

*Working with other professionals was great for sharing knowledge and skills. The ward of horrors was especially useful for demonstrating how we are safer when combining all professionals' view point.'*

Appreciation  
of other  
disciplines

Positively  
identifying  
patient  
hazards

Learning from  
other  
perspectives



## Results:

### Role Play

Quantitative data revealed that 12 of the 14 questions within pre- & post-questionnaire statistically significant shift

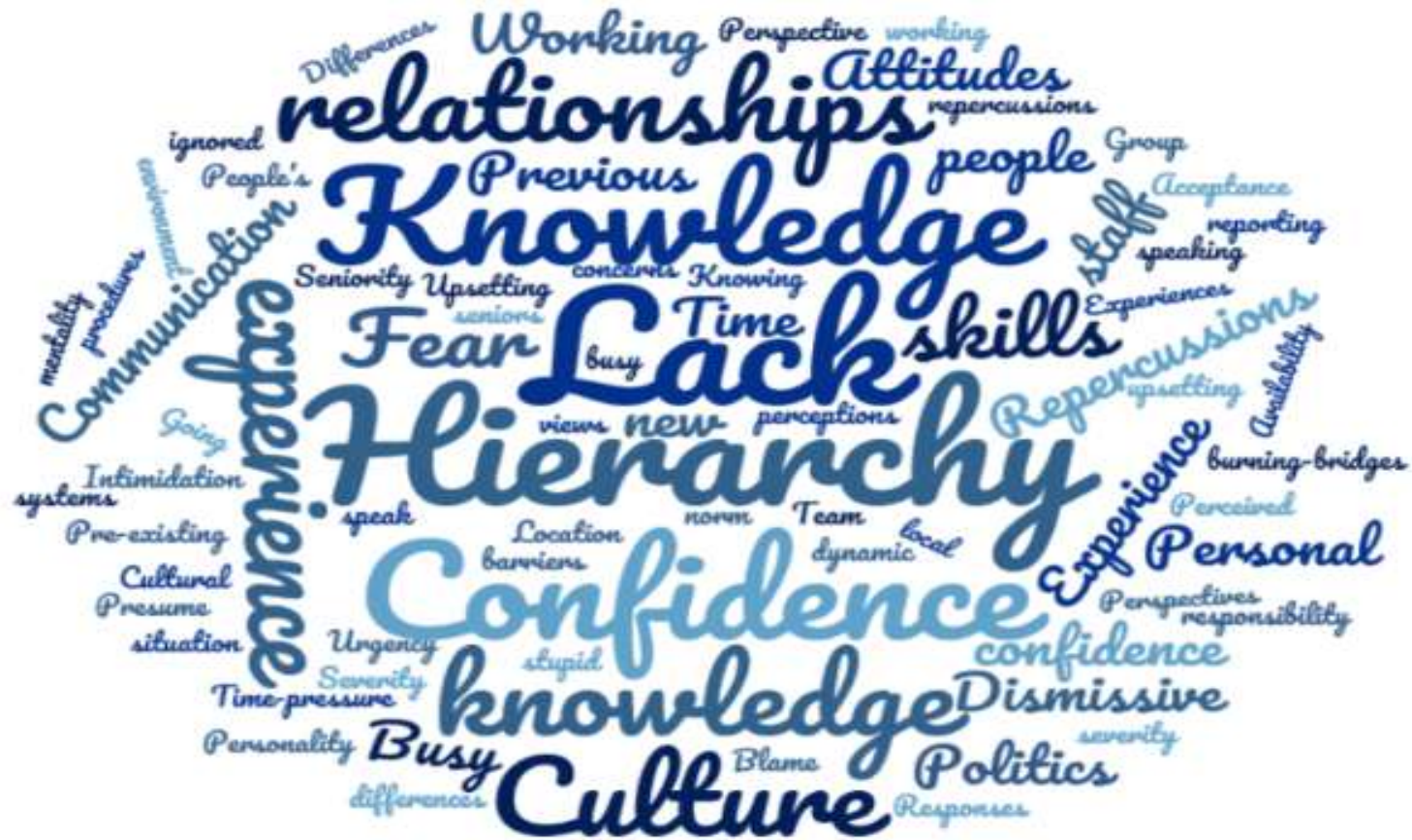
Communication skills should be learned with other health care students/professionals

I think it would be difficult to speak up if I perceived a problem with patient care during my clinical practice

I feel that my training has adequately prepared me for communicating with other health care professionals **in a challenging environment**



## Unexpected Findings:





# Reflections and Limitations:

## Barriers

- Hidden curriculum – making the implicit, explicit
- What cultures, behaviours are the trainees observing?

## Limitations

- Data collection
- MDT mix

## Thank you

- Dr Janis Meek and Dr Lorna Dodd
- Dr James Fisher
- Fiona Robinson (physiotherapy lead)
- Marie McKeown (Nursing placement lead)
- Chris Shepherd (Occupational therapy lead)
- Dr Jenny Yeo (Physician Associate lead)
- Kate Smith (Pharmacy placement lead)
- Sharon Hartley (IPL lead)

And all the fantastic facilitators in the education department!

## References

1. CAIPE (2002) Interprofessional education - a definition. [www.caipe.org](http://www.caipe.org) [Accessed on 11/6/19]
2. O'Daniel, M & Rosenstein, A. (2008) Chapter 33: Patient safety & quality: an evidence based handbook for nurses. Agency for healthcare research and quality.
3. Recognising Risk and Improving Patient Safety - Mildred's Story (2010) YouTube added by the University of Leicester. Available at <https://www.youtube.com/watch?v=BTpnPoSyuJg>. [Accessed 11/06/2019]
4. Nickson, C. (2019). Speaking Up. <https://litfl.com/speaking-up/>. [Accessed on 11/6/2019]
5. The Health Foundation (2011). <https://www.health.org.uk/sites/default/files/MeasuringSafetyCulture.pdf> [Accessed on 11/6/2019]
6. Yu, Jowsey & Henning (2018) Evaluation of a modified 16-item Readiness for Interprofessional Learning Scale (RIPLS): Exploratory and confirmatory factor analyses. Journal for interprofessional care. 32(5)584-591
7. Case, G. A. (2014) Performance and the Hidden Curriculum in Medicine. Performance research. Vol. 19, Pg 6-13
8. Darbyshire, P & Thompson, D. Gosport must be a tipping point: professional hierarchies in healthcare. BMJ.2018.363