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Have health and social care lost the ability to care? Key lessons from the Francis Inquiry

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Common response to tragic events is to establish an independent inquiry and vow that such things should never be allowed to happen again – BUT:

- Are there common themes from previous scandals?
- What happens when/why do things go wrong?
- How can leaders support staff to deliver high quality, dignified care?

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1. Mental health hospital scandals (1960s/70s)

- Isolation (geographical but also lack of visits by medical staff)
- Closed, institutional settings and a tendency to suppress complaints
- A corruption of care - focusing on the maintenance of order and routine rather than on providing care
- Failures of leadership
- Staff shortages and inadequate training

1. Key themes from CHI (2003)

- The isolated nature of services
- Institutional environments
- Low staffing levels and high use of bank and agency staff
- Closed cultures
- Poor clinical leadership and supervision

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1. Common themes from inquiries

- Isolation, especially professional
- Inadequate leadership
- System and process failure/lack of checks and balances
- Poor communication – internal and external
  - not seeing the full picture
- Disempowerment of staff and service users
  - cultural norms, learned helplessness

2. What causes bad things to happen? (SCIE)

- A *person approach* (blames individuals for their mistakes and inattention - can lead to a blame culture in which it is difficult to admit and learn from mistakes, and can prevent us from focusing on the underlying conditions that led to the error in the first place)
- A *system approach* (sees errors and poor practice as the result of the conditions under which people work and the way that the overall system is organised)

2. Latent conditions v active failures (James Reason)

"Latent conditions – as the term suggests – may lie dormant within the system for many years before they combine with active failures and local triggers to create an accident opportunity. Unlike active failures, whose specific forms are often hard to foresee, latent conditions can be identified and remedied before an adverse event occurs. Understanding this leads to proactive and reactive risk management."

2. Latent conditions cont.

“To use another analogy: active failures are like mosquitoes. They can be swatted one by one, but they still keep coming. The best remedies are to create more effective defences and to drain the swamps in which they breed. The swamps, in this case, are the ever present latent conditions.”

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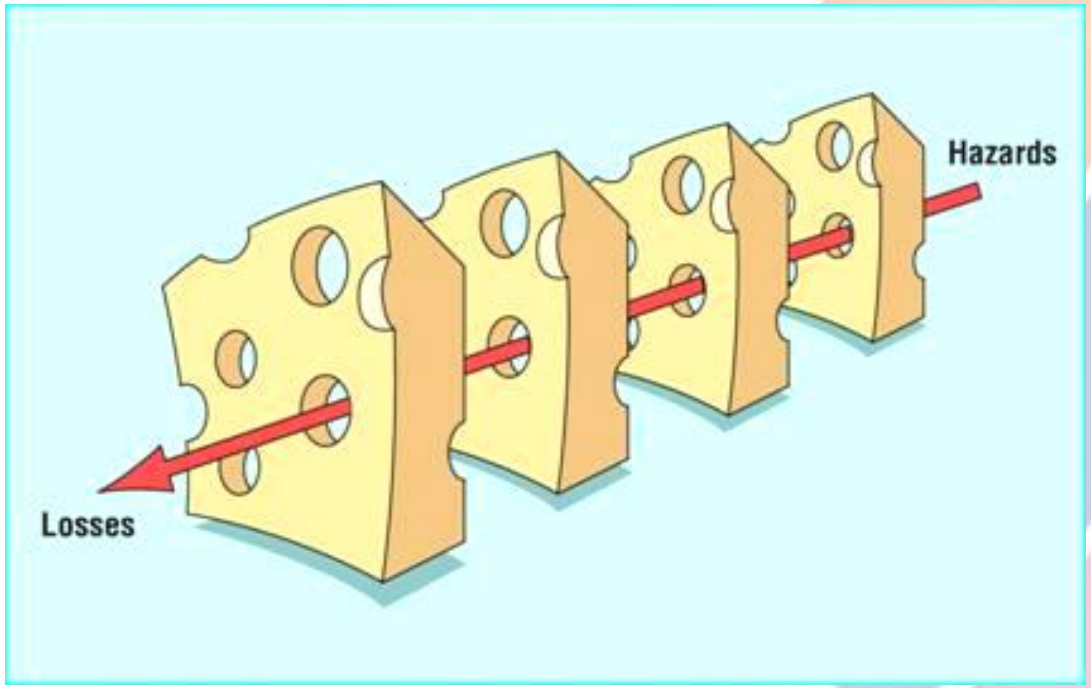
2. Why do things go wrong? (James Reason)



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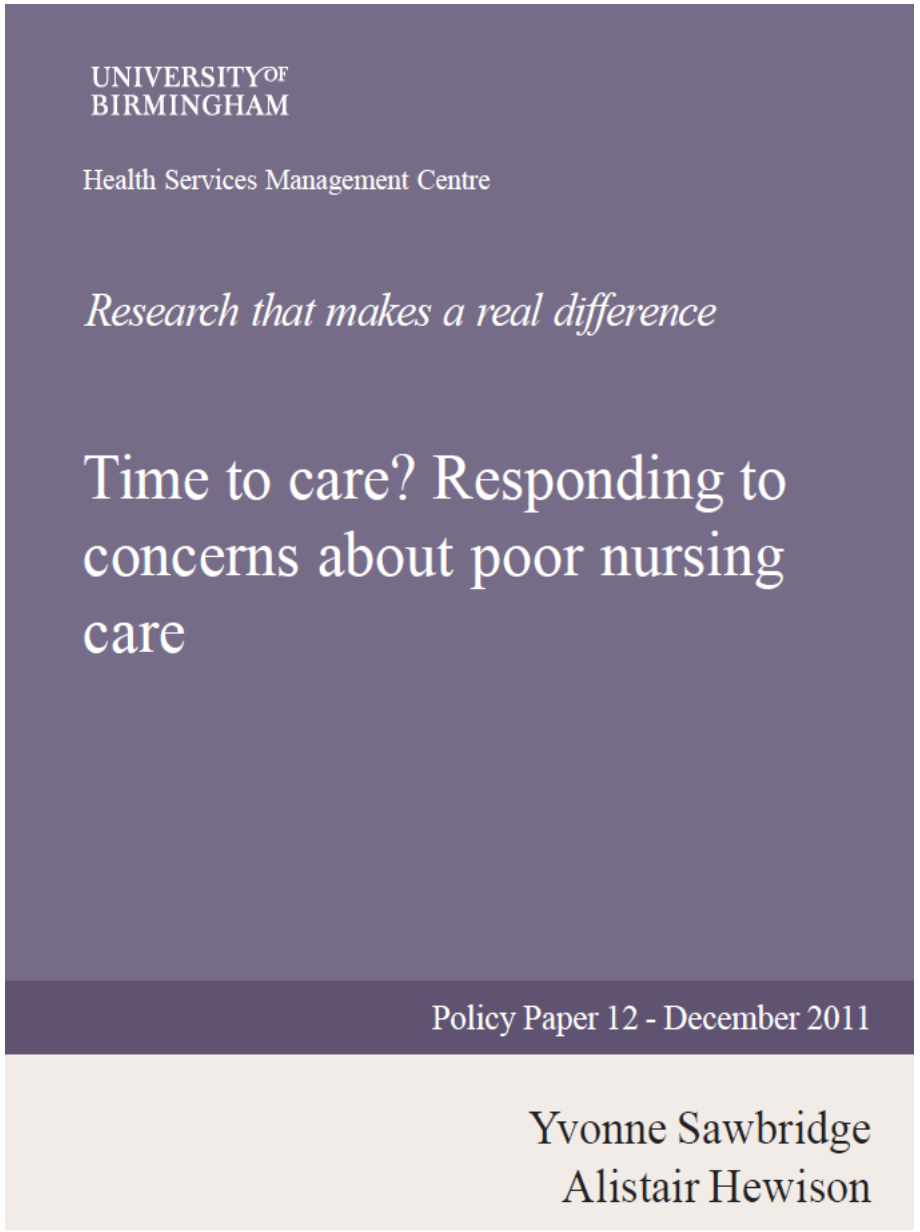

- Key stakeholders
- Literature search
- Nursing think tank
- 3 main themes:

- Environment of care
- Education and development ("too posh to wash?")
- Emotional labour of nursing

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3. Coping with caregiving...

I am in charge tonight with five nurses and 30 patients. Two of my nurses are floats who have never been on the floor; one will be an hour late, so I will have to cover her patients. Our ...patients have diagnoses... Kidney failure, stroke, diabetes, cancer, sickle-cell disease, hepatitis, AIDs, pneumonia and Alzheimer's disease.

The average age of our patients is 79. We have five ..post-operative patients and one going to surgery in two hours. As I come out of report one of our stable patients who transferred from Coronary Care Unit yesterday, is having chest pain. There is a Dr on the phone waiting to give admission orders and the anaesthetist for our pre-operative patient wants the old chart, ***now.*** *Down the hall an elderly confused patient has just crawled over the side rails and fallen. Two ..post-op patients are vomiting as a side effect of the anaesthesia..their families are very tense and need reassuring. One of the patients I am covering for has just pulled out his IV; another wants something for pain; another needed the bed pan and I got there too late. The lab has called with a critical low haemoglobin level on the patient who pulled out his IV; he'll be getting a few units of blood ..*

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3. Different perspective...

"Staff don't need more blame and condemnation; they need active, sustained supervision and support. In the high-volume, high-pressure, complex environment of modern health care it is very difficult to remain sensitive and caring towards every single patient all of the time. We ask ourselves how it is possible that anyone, let alone a nurse, could ignore a dying man's request for water? What we should also ask is whether it is humanly possible for anyone to look after very sick, very frail, possibly incontinent, possibly confused patients without excellent induction, training, supervision and support."

(Jocelyn Cornwell, Kings Fund 17th Feb 2011)

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Key questions

- Do some of the lessons from previous inquiries apply to you?
- What latent conditions exist within your organisation?
- How do you support the emotional labour of care?

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