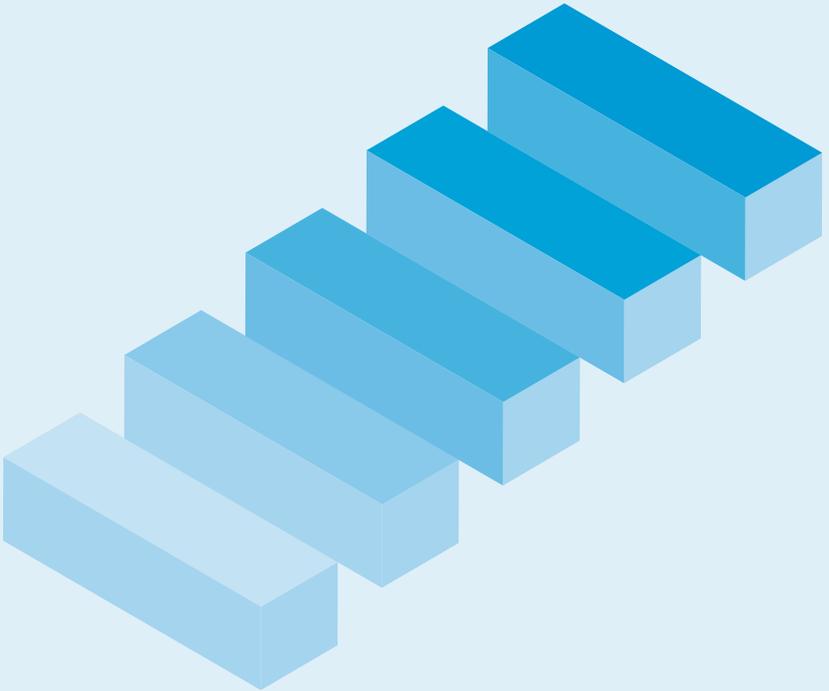


Manchester Patient Safety Framework (MaPSaF) Facilitator guidance



1.0 Introduction

This guidance document has been developed for healthcare staff who would like to facilitate a workshop to explore the safety culture of their team and/or organisation using the Manchester Patient Safety Framework (MaPSaF). It provides information on the background and development of MaPSaF and advice on how to organise and lead a workshop using this framework.

1.1 What is the Manchester Patient Safety Framework?

MaPSaF is a tool that has been developed to help healthcare teams and organisations reflect on their progress in developing a mature safety culture. MaPSaF makes the concept of a 'safety culture' more accessible. Originally designed for use by general practices and primary care trusts (PCTs), MaPSaF has now been adapted for use in other healthcare settings, including acute, ambulance and mental health. It can help healthcare staff explore their level of development with respect to the maturity of the safety culture of the healthcare organisation in which they work.

MaPSaF uses critical dimensions of patient safety and, for each of these, offers a description of what an organisation would look like at five levels of safety culture maturity. By safety critical dimensions we mean key areas where attitudes, values and behaviour around patient safety are likely to be reflected in the organisation's working practices. For example, how patient safety incidents are investigated and what staff education and training about risk management takes place.

The framework is based on an idea used successfully in non-health sectors and originated in the oil and gas industry by Shell International. It is based on an idea proposed by Robert Westrum, a US sociologist. This idea distinguishes between different types of organisations based on how they handle information. Further detail about this theory is presented in Section 2.2.2.

The content of MaPSaF has been developed from in-depth interviews and focus groups with a range of healthcare professionals and managers. The safety critical dimensions were identified following:

- a literature review about patient safety in primary care and the NHS in general;
- feedback from opinion leaders and interviewees;
- consideration of the dimensions in terms of their comprehensiveness and appropriateness for primary care;
- focus group discussions of senior managers and clinical specialists from acute, ambulance and mental health trusts with experience of patient safety issues to refine and adapt the dimensions developed for the original MaPSaF, for use in other types of NHS organisation.

1.2 MaPSaF and the National Patient Safety Agency

The National Patient Safety Agency (NPSA) has endorsed MaPSaF to help healthcare organisations reflect on their progress in developing a patient safety culture. The NPSA is not a regulatory body and the framework has not been developed for performance management. Rather, the aim of the framework is to stimulate discussion about patient safety culture in a healthcare organisation and, in doing so, help that organisation consider its progress towards developing a mature patient safety culture. This is a key step towards improving the safety culture in your organisation.

MaPSaF describes some of the key elements of an open and fair culture, previously described in the document *Seven steps to patient safety* (NPSA, 2003; www.npsa.nhs.uk/sevensteps).

2.0 Getting started with MaPSaF

2.1 Identifying an appropriate facilitator

The first step in getting started with the framework is to identify an appropriate facilitator. Careful consideration needs to be given to both the professional expertise and personal characteristics of the person chosen to facilitate the MaPSaF workshop. Feedback from focus groups used to develop acute, ambulance and mental health versions of MaPSaF has shown that it is easy to understand the tool's concepts. Therefore, using external professional facilitators is not necessary or recommended. The NPSA recommends that workshops are led by someone from within each healthcare organisation, wherever possible.

Who should facilitate a MaPSaF workshop?

MaPSaF workshops should be facilitated by someone with knowledge of the risk management processes in your organisation. This could be a risk manager, clinical governance lead or other healthcare professional who has a lead role in taking the patient safety agenda forward in their organisation.

In terms of personal characteristics, a facilitator should feel confident and enthusiastic about MaPSaF. They also need to be knowledgeable about the tool's development and have set aside time to read through this guidance document and the standard presentation for facilitating a workshop, which is part of your organisation's MaPSaF toolkit provided by the NPSA and the University of Manchester.

2.2 How do I organise a workshop?

In order to be able to carry out a MaPSaF workshop you will need to go through the following steps:

2.2.1 Understanding the theory behind MaPSaF

The NPSA and the University of Manchester have prepared a standard presentation and speaker notes which describe the theoretical basis and development of MaPSaF. It is important to learn the notes and read the relevant background research papers provided in your MaPSaF toolkit, prior to embarking on a workshop. This will make you feel confident about the literature and the framework; both key elements in being a successful facilitator.

2.2.2 The patient safety culture framework explained

MaPSaF is based on Westrum's typology of organisational communication (1992), which described how different types of organisations process information. This typology was expanded upon by Parker and Hudson (2001) to describe five levels of increasingly mature organisational safety culture, as follows:

- A Pathological:** organisations with a prevailing attitude of 'why waste our time on safety' and, as such, there is little or no investment in improving safety.
- B Reactive:** organisations that only think about safety after an incident has occurred.
- C Bureaucratic:** organisations that are very paper-based and safety involves ticking boxes to prove to auditors and assessors that they are focused on safety.
- D Proactive:** organisations that place a high value on improving safety, actively invest in continuous safety improvements and reward staff who raise safety-related issues.
- E Generative:** the nirvana of all safety organisations in which safety is an integral part of everything that they do. In a generative organisation, safety is truly in the hearts and minds of everyone, from senior managers to frontline staff.

MaPSaF enables you to identify at which level of safety culture your healthcare organisation is now, where it could be, and facilitates a structured discussion on how to improve.

2.2.3 Understanding when and how often it is appropriate to use MaPSaF, and what it should be used for

It is important to understand when and how often MaPSaF should be used, and what it should be used for. This section answers questions you may have about these issues.

When should I use MaPSaF?

MaPSaF can be used to educate healthcare staff about the safety culture in their organisation and/or team. It is not specifically designed to be applied after a problem with the culture has been identified, although this is one of its potential uses. Rather, the scope of the framework is broader, as it aims to promote consideration about patient safety culture amongst healthcare teams. MaPSaF can be used by boards, clinical governance teams, management teams, healthcare teams and others who would like to consider patient safety culture and risk management processes in their organisation and/or team.

What can I use MaPSaF for?

There are many ways in which MaPSaF could potentially be used; some of these are listed below:

- to facilitate reflection on the patient safety culture of your healthcare organisation and/or team;
- to help your team recognise that patient safety is a complex, multidimensional concept;
- to stimulate discussion about the strengths and weaknesses of the patient safety culture in your team and/or organisation;
- to reveal any differences in perception between staff groups;
- to help understand how an organisation and/or team with a more mature safety culture might look;
- to help you to evaluate any specific intervention needed to change the patient safety culture of your organisation and/or team.

When should MaPSaF not be used?

MaPSaF should not be used:

- for performance management and assessment purposes;
- to apportion blame if the results show up problems with the safety culture of an organisation and/or team.

The NPSA does not endorse using MaPSaF for performance management purposes. We feel that its uniqueness is as a tool for self-reflection and educating healthcare staff about what a safety culture looks and feels like.

How often should MaPSaF be used?

The NPSA recommends that MaPSaF is used at least once a year with each healthcare team or department. This will allow sufficient time to develop and implement plans to improve safety culture in response to the findings from earlier workshops. By re-applying/re-using MaPSaF at regular intervals, it is possible to chart your progress in developing a mature safety culture.

Please note that MaPSaF is not designed to be used too frequently. For example, it should not be used at monthly intervals as this is too frequent to identify changes in the safety culture. A significant time period needs to elapse before re-using the framework with an individual healthcare team. Over-use of the framework may lead to staff becoming disenfranchised and disillusioned; cultural development takes time to achieve and does not happen overnight.

3.0 How to carry out a MaPSaF workshop

It is important that the right people attend the workshop and, in order to achieve this, it is essential to give sufficient notice of when and where the workshop will take place. You will also have to explain the purpose of the workshop in order to persuade staff to attend. Reassurance should be given that the purpose of the workshop is not performance management; you will need to explain that MaPSaF has been developed as a self-reflection exercise. You will also need to advise people that carrying out a complete workshop of this type takes approximately two and a half hours and so you need to ensure that you book sufficient time with them. However, MaPSaF does not have to be used in its entirety; you may decide that time constraints or organisational priorities mean that you only want to consider a selection of the critical dimensions of patient safety culture.

You will need the following in order to be able to run the workshop:

- a room large enough for 10-12 people;
- flip charts;
- laptop and LCD projector (this is optional; the information in the presentation is available as handouts if necessary);
- paper and pens;
- MaPSaF evaluation sheets for each workshop participant to fill out individually;
- Standard introductory MaPSaF presentation.

MaPSaF is best used as a team based self-reflection and educational exercise and these are the steps you should go through in order to run the workshop properly:

Step 1: Explain the purpose and objectives of the session

- Introduce yourself and the purpose of the workshop and thank everyone for attending.
- Give a brief overview of the session, explaining the process you will go through. Emphasise that the workshop will be interactive to maximise its learning potential.

Step 2: Explain the background behind MaPSaF

- Deliver the standard MaPSaF presentation (as provided by the NPSA and the University of Manchester). Allow some time for questions if necessary.

Steps 1 and 2 should take no longer than 15 minutes.

Step 3: Individual evaluations

- Give each participant a copy of the MaPSaF evaluation sheet. Allow them sufficient time to read through the framework (or the selection of dimensions you have chosen). Whilst they are reading through the framework, ask participants to start thinking about how the descriptions fit with their own team and/or organisation.
- Ask each participant to complete the evaluation sheet individually (without conferring with other team members). Advise participants that for each of the nine (or 10) aspects of patient safety culture, they should select the description that they think best describes their team and/or organisation.
- Encourage them to annotate their evaluation sheet with a 'T' to indicate the safety culture level of their team, or an 'O' to indicate the safety culture level of the organisation, or both. This part of the exercise should be done individually, without discussion.
- If they cannot decide between two of the descriptions, they should annotate both, indicating that they believe that the culture for that dimension is between two levels. Explain that there are no right or wrong answers and that the framework is designed to explore perceptions of safety culture and to facilitate discussion between healthcare staff about these perceptions.

This step should take approximately 30 minutes.

Step 4: Comparisons of individual evaluations

- Ask participants to work in pairs. They should be encouraged to share their perceptions of the team and/or organisational patient safety culture level for each of the safety critical dimensions considered. They should discuss why they think they are at that level of safety culture and try to reach a consensus. They should record reasons for their choices and provide supporting information for their perceptions for later discussion.

This step should take approximately 25 minutes.

Step 5: Facilitate an open discussion of the evaluation findings

- After Step 4 has been completed, you will need to facilitate an open discussion about each patient safety dimension, during which workshop participants discuss their perceptions with the rest of the team. Use the reasons given in Step 4 to stimulate the discussion – put them on the flipchart /overhead projector/ PowerPoint slide and get the group to see whether they agree on the level for that dimension.

What if no one wants to discuss their perceptions openly?

The exercise that is done in pairs (Step 4) is designed to get staff warmed up for a more open discussion with the larger group. Facilitators should circulate during the pair-work exercise and consider which pair is likely to feel comfortable about opening the broader discussion with the whole group.

However, if one pair is reticent and does not want to go first, do not force them to. Ask the most senior member of the team to open up the discussion. Think about the mix of professions in the group, and also the levels of seniority of the members.

At this stage there will probably be differences between staff groups. If this happens, discuss possible reasons. Address each dimension in turn and see if you can reach a consensus, or identify reasons for the differences in the perceptions of the groups. Is it because there is poor communication between/within groups/job levels/functions? Is it because the groups operate in different work environments?

How should I respond if there is strong disagreement between team members?

It is important to reiterate that there are no right or wrong answers when using MaPSaF and, that by identifying differences in perceptions between staff, a healthcare organisation and/or team can learn lessons about safety culture. MaPSaF is not a test; it is a stimulus for discussion, so don't feel defensive if people don't share the same views on their organisation's cultural maturity.

This step should take no longer than 30 minutes.

Also, don't take it as a reflection of your work within the organisation if you are the lead for patient safety.

Step 6: Develop an action plan

- After all patient safety dimensions have been discussed, ask the participants to consider the emerging profile of the team or department. You will almost certainly notice that it is not uniform and there are areas where your organisation is doing well and areas where it is doing less well. Where things are going less well, ask participants to consider the descriptions of a more mature patient safety culture. Pose the following three questions to the group:
 - Where are you now?
 - Where would you like to be (in terms of the levels of safety culture)?
 - How are you going to get to where you want to be?
- Use this discussion to develop an action plan to move your organisation or team's cultural maturity to the right of the matrix. Encourage the group to set itself milestones to achieve specific objectives and decide when it will reconvene to check if there has been a positive shift in culture. It may be very useful to define specific actions and identify who will be responsible for carrying them out.

Appendix 1 lists some of the NPSA products and publications that may help you develop a more mature safety culture.

Step 7: Record the findings

- Record the findings of applying MaPSaF in the facilitator's folder provided by the NPSA. It is essential to keep a record of where the workshop participants thought they were on each risk dimension and to compare these results with subsequent workshop findings.

Appendix 1:

NPSA products and publications that can help improve your safety culture

Areas identified for improvement	NPSA products and publications
Staff engagement and/or ownership/priority given to patient safety	<p><i>Seven steps to patient safety</i> www.npsa.nhs.uk/sevensteps</p> <p>Introduction to patient safety e-learning www.npsa.nhs.uk/health/resources/ipsel</p> <p><i>Medical error</i> www.saferhealthcare.org.uk/IHI/Products/Publications/MedicalError</p> <p><i>Engaging clinicians</i> www.npsa.nhs.uk/site/media/documents/1342_EngagingClin.pdf</p>
Reporting patient safety incidents	<p>National Reporting and Learning System www.npsa.nhs.uk/health/reporting</p> <p>Patient Safety Observatory report www.npsa.nhs.uk/site/media/documents/1280_PSO_Report.pdf</p> <p><i>Engaging clinicians</i> www.npsa.nhs.uk/site/media/documents/1342_EngagingClin.pdf</p>
Investigating patient safety incidents and learning from them	<p>Root cause analysis e-learning toolkit and training www.npsa.nhs.uk/health/resources/root_cause_analysis</p>
Communicating about patient safety incidents with patients and carers	<p><i>Being open</i> policy, e-learning and one day training workshops www.npsa.nhs.uk/health/resources/beingopen</p>
Supporting staff involved in a patient safety incident	<p>Incident Decision Tree www.msnpa.nhs.uk/idt2/(kht2ahft1belwmja2tlgre45)/index.aspx</p> <p><i>Being open</i> policy, e-learning and one day training workshops www.npsa.nhs.uk/health/resources/beingopen</p>
Teamwork and team communication	<p>Team Climate Assessment Measure To be launched in 2006</p> <p><i>Safe handover: safe patients</i> www.npsa.nhs.uk/site/media/documents/1037_Handover.pdf</p>

The Manchester Patient Safety Framework (MaPSaF) research team, based at the University of Manchester, includes psychologists, healthcare researchers and healthcare professionals from both primary and acute care settings.

The development of MaPSaF is one part of an ongoing programme of patient safety research that draws on both our expertise working on safety issues in a range of high risk industries, and our extensive research and practical experience in healthcare in the NHS.

For further information about this project or the work of the MaPSaF team contact:

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