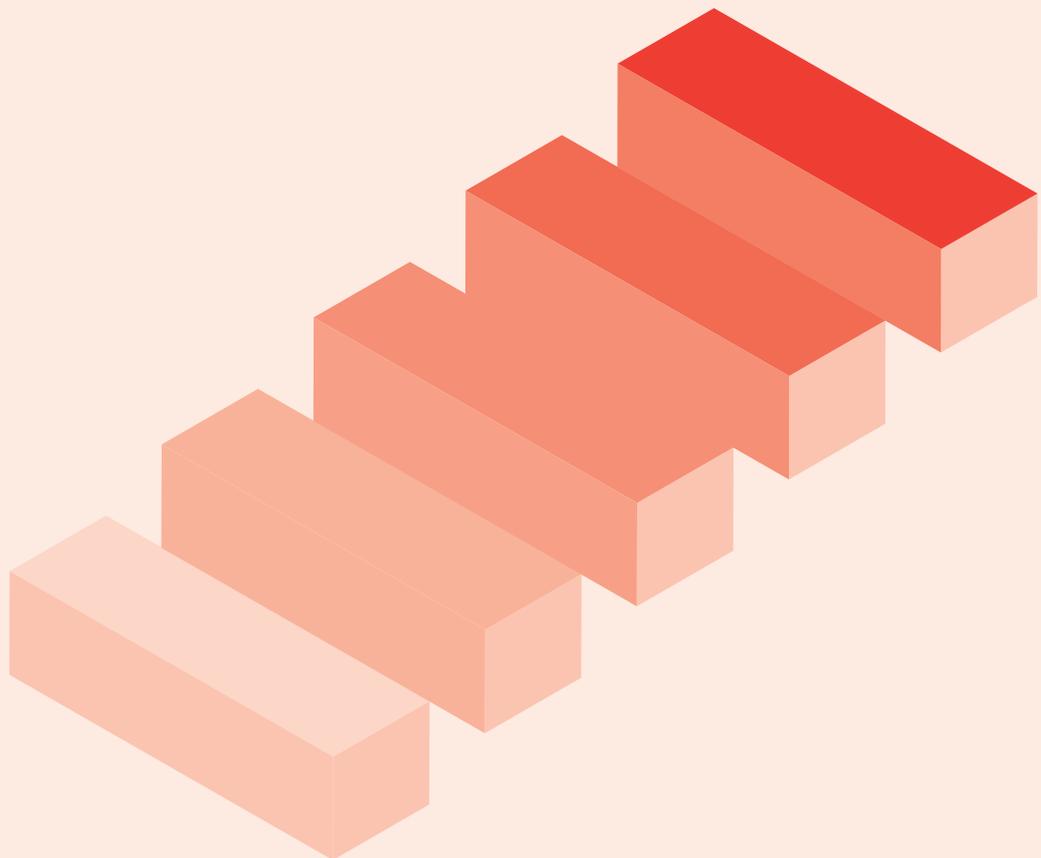


Manchester Patient Safety Framework (MaPSaF)

Acute



How to use MaPSaF

MaPSaF is best used as a team based self-reflection and educational exercise:

- it should be used by all appropriate members of your team;
- for each of the ten aspects of safety culture, select the description that you think best fits your organisation and/or team.
Do this individually and privately, without discussion;
- use a T (team) or O (organisation) on the evaluation sheet to indicate your choices. If you really can't decide between two of the descriptions, tick both. This will give you an indication of the current patient safety culture profile for your organisation;
- discuss your profiles with the rest of your team. You may notice that there are differences between staff groups. If this happens, discuss possible reasons. Address each dimension in turn and see if you can reach consensus;
- consider the overall picture of your organisation and/or team. You will almost certainly notice that the emerging profile is not uniform – that there will be areas where your organisation is doing well and less well. Where things are going less well, consider the descriptions of more mature risk management cultures. Why is your organisation not more like that? How can you move forward to a higher level?

What we mean by these terms

Patient safety incident (PSI):

Any unintended or unexpected incident that could have or did lead to harm to one or more patients receiving NHS-funded healthcare.

Prevented patient safety incident (PPSI):

Any patient safety incident that had the potential to cause harm but was prevented, resulting in no harm to patients receiving NHS-funded healthcare.

Root cause analysis (RCA):

A technique for undertaking a systematic investigation that looks beyond the individuals concerned and seeks to understand the underlying causes and environmental context in which the incident happened. Retrospective and multidisciplinary in its approach, it is designed to identify the sequence of events, working back from the incident.

Evaluation sheet (sample)

Dimension of patient safety culture	A	B	C	D	E
1. Commitment to overall continuous improvement					
2. Priority given to safety					
3. System errors and individual responsibility					
4. Recording incidents and best practice					
5. Evaluating incidents and best practice					
6. Learning and effecting change					
7. Communication about safety issues					
8. Personnel management and safety issues					
9. Staff education and training					
10. Team working					

T = Team O = Organisation

Manchester Patient Safety Framework (MaPSaF) – Acute

MaPSaF was originally developed by Dianne Parker, Sue Kirk, Tanya Claridge, Aneez Esmail and Martin Marshall in a collaborative project supported by the National Primary Care Research and Development Centre, University of Manchester. The original idea came from research funded by Shell International.

Why MaPSaF was developed

The safety of both patients and staff in a healthcare organisation is influenced by the extent to which safety is perceived to be important across the organisation. This 'safety culture' is a new concept in the health sector and can be a difficult one to assess and change. This framework has been produced to help make the concept of safety culture more accessible. It was originally designed for use by general practices and primary care organisations and has now been adapted for use in other sectors of healthcare provision to help these organisations understand their level of development with respect to the value that they place on patient safety. It uses ten dimensions of patient safety and for each of these describes what an organisation would look like at five levels of safety culture. The framework is based on an idea used successfully in non-health sectors. The content is derived from in-depth interviews and focus groups with a range of healthcare professionals and managers.

MaPSaF is designed to be used to:

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

MaPSaF is NOT designed to be used:

- for performance management or assessment purposes;
- to apportion blame when the results show that an organisation's and/or team's safety culture is not sufficiently mature.

MaPSaF and the National Patient Safety Agency (NPSA)

The NPSA has endorsed MaPSaF to help healthcare organisations reflect on their progress in developing a safety culture. The NPSA is not a regulator or a reviewer and the framework has not been developed for this purpose. Rather, it aims to stimulate discussion about the patient safety culture in any given healthcare organisation and, in doing so, will help that organisation reflect on its progress towards developing a mature safety culture.

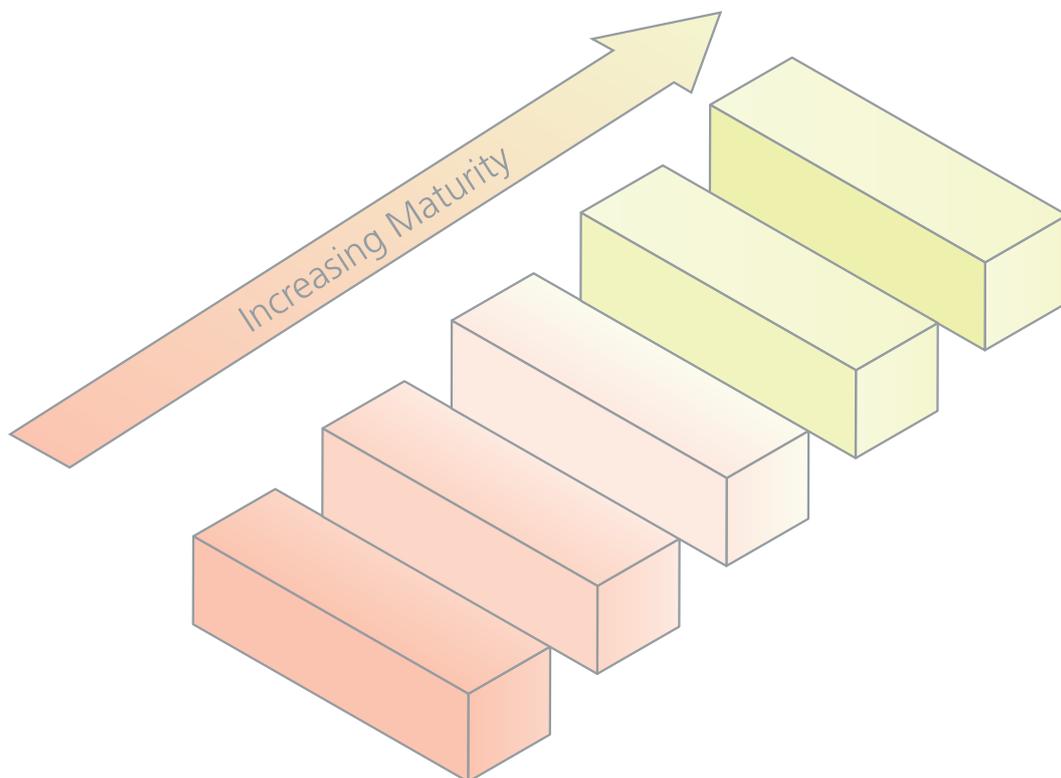
MaPSaF describes in words some of the key elements of an open and fair culture, previously described in the document, *Seven steps to patient safety*. MaPSaF can be used by boards, clinical governance teams, management teams, healthcare teams and others who would like to pause and reflect on their safety culture and risk management processes.

Public and patient involvement

It might seem that patient and public involvement in a maturing patient safety culture should be included as a eleventh dimension. However, the development of processes to ensure meaningful participation should be seen as being integral to all ten dimensions identified and this is how they have been integrated into the MaPSaF matrix.

The levels of patient safety culture explained

Level	Description
A – Pathological	Why do we need to waste our time on patient safety issues?
B – Reactive	We take patient safety seriously and do something when we have an incident.
C – Bureaucratic	We have systems in place to manage patient safety.
D – Proactive	We are always on the alert/thinking about patient safety issues that might emerge.
E – Generative	Managing patient safety is an integral part of everything we do.



MaPSaF is based on Parker and Hudson's (2001) application of Westrum's (1992) stage model of organisational culture maturity

References

Parker, D and Hudson, P (2001) *Understanding your culture*, Shell International Exploration and Production.
Westrum, R (1992) *Cultures with Requisite Imagination* in Wise, J, Hopkin, D and Stager, P (eds.), *Verification and validation of complex systems: human factors issues* (pp 401–416), Berlin: Springer-Verlag.

How the dimensions were developed

The dimensions are themes that emerged 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 with senior managers and clinical specialists from acute organisations with experience of patient safety issues. These groups refined and generalised the dimensions developed for the original MaPSaF for use with teams working in acute care in the NHS.

Defining the dimensions

Dimension	Description
1. Commitment to overall continuous improvement	How much is invested in developing the quality agenda? What is seen as the main purpose of policies and procedures? What attempts are made to look beyond the organisation for collaboration and innovation?
2. Priority given to safety	How seriously is the issue of patient safety taken within the organisation? Where does responsibility lie for patient safety issues?
3. System errors and individual responsibility	What sort of reporting systems are there? How are reports of incidents received? How are incidents viewed – as an opportunity to blame or improve?
4. Recording incidents and best practice	Who investigates incidents and how are they investigated? What is the aim of recording the incident?
5. Evaluating incidents and best practice	How are any incidents evaluated? What recognition is there of safe practice? How is the resultant data used?
6. Learning and effecting change	What happens after an event? What mechanisms are in place to learn from the incident? How are changes introduced and evaluated?
7. Communication about safety issues	What communication systems are in place? What are their features? What is the quality of record keeping to communicate about safety like?
8. Personnel management and safety issues	How are safety issues managed in the workplace? How are staff problems managed? What are the recruitment and selection procedures?
9. Staff education and training	How, why and when are education and training programmes about patient safety developed? What do staff think of them?
10. Team working	How and why are teams developed? How are teams managed? How much team working is there around patient safety issues?

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.

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For further information about the National Patient Safety Agency visit:
www.npsa.nhs.uk

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Manchester Patient Safety Framework (MaPSaF) – Acute

Increasing maturity 

	A	B	C	D	E
01. Commitment to overall continuous improvement	No resources are invested in the identification of problems or areas of good practice. If any auditing occurs it lacks structure and there is no response to what is discovered. Whatever protocols or policies exist are there to meet the organisation's statutory requirements and are not used, reviewed or updated. Poor quality care is tolerated or ignored. This attitude is evident at Board level and throughout the organisation in the healthcare teams.	A continuous improvement framework is developed in response to specific directives or an imminent inspection visit. Auditing only occurs in response to specific incidents and national directives and does not reflect local needs. Little attempt is made to respond to any audit findings. The bare minimum of protocols and policies exist and these tend to be out-of-date and unused unless an incident occurs that triggers their review. Development of new protocols and policies occurs in response to incidents and complaints.	Frontline staff are not engaged in the improvement process and they see it as a management activity that is externally driven. Lots of auditing occurs but lacks an overall strategy linking with organisational or local needs. Staff are overloaded with protocols and policies (which are regularly reviewed and updated) that are rarely implemented. Patients and the public may be involved in quality issues but this is lip service rather than real engagement.	There is a genuine desire and enthusiasm throughout the organisation for continuous improvement. It is recognised that continuous improvement is everyone's responsibility and that the whole organisation, including patients and the public, need to be involved. Such organisations aim to be centres of excellence and compare their performance against that of others. Clinicians are involved in, and have ownership of, the auditing process which leads to continuous improvement. Protocols and policies are developed and reviewed by staff and are used as the basis for care and service provision. Patients and the public are formally involved in internal decisions – making it a patient-centred service.	A culture of continuous improvement is embedded within the organisation and is integral to decision making at all levels. The organisation is a centre of excellence, continually assessing and comparing its performance against others both within and outside the health service. Teams design and conduct their own outcome focused audit programme, in collaboration with patients and the public. Staff are alert to potential safety risks. This means that over time the need for protocols and policies is reduced as evidence-based practice is second nature and patient safety is constantly on everyone's mind. Patients and the public are involved in a routine, meaningful way with ongoing contribution and feedback.
02. Priority given to safety	A low priority is given to safety. There are some risk management systems in place, such as strategies and committees, but nothing is actually delivered. This is an organisation unaware of their risks, believing that if a patient safety incident occurs, insurance schemes can be used to bail them out.	Safety becomes a priority once an incident occurs, but the rest of the time only lip service is paid to the issue apart from meeting legal requirements. There is little evidence of any implementation of a risk management strategy. Safety is only discussed by the Board in relation to specific incidents. Any measures that are taken are aimed at self-protection and not patient protection. In order to meet financial constraints or government set targets, risks are taken.	Safety has a fairly high priority and there are numerous systems (including those integrating the patient perspective) in place to protect it. However, these systems are not widely disseminated to staff or reviewed. They also tend to lack the flexibility to respond to unforeseen events and fail to capture the complexity of the issues involved. Responsibility for risk management is invested in a single individual who does not integrate it within the wider organisation. It is an imposed culture.	Safety is promoted throughout the organisation and staff are actively involved in all safety issues and processes. Patients, the public and other organisations are also involved in risk management systems and their review. Measures taken are aimed at patient protection and not self-protection. Risks are proactively identified, using prospective risk assessments, and action is taken to manage them. There are clear accountability lines and while one individual takes the lead for patient safety in the organisation, it is a key part of all managers' roles.	Safety is the top priority in the organisation, and responsibility for safety is seen as being part of everyone's role including patients and the public. Staff constantly assess risks and look for potential improvements. Patient safety is a high profile issue throughout the organisation and is embedded in the activities of all staff, from the Board/senior managers through to healthcare teams who have day-to-day contact with patients, including support staff. Patient involvement in, and review of, patient safety issues is well established.
03. System errors and individual responsibility	Incidents are seen as 'bad luck' and outside the organisation's control, occurring as a result of staff errors or patient behaviour. There is a strong blame culture with individuals subjected to victimisation and disciplinary action.	The organisation sees itself as a victim of circumstances. Individuals are seen as the cause and the solution is retraining and punitive action. When incidents occur there is no attempt to support those involved, including the patients and their relatives.	There is a recognition that systems contribute to incidents and not just individuals. The organisation says that it has an open and fair culture but it is not perceived in that way by staff. Being open/open disclosure protocols have been written to ensure that staff and patients/carers receive support following an incident do exist, but they are not widely known about or used.	It is accepted that incidents are a combination of individual and system faults. The organisation has an open, fair and collaborative culture. Following a patient safety incident, a systems analysis is carried out and used to make decisions about the relative contribution of systems factors and the individual, e.g. the Incident Decision Tree. This process informs decisions about staff suspensions and so there is a consistent and fair approach to dealing with staff issues following incidents. The organisation is also open and honest with patients and/or their carers when a patient safety incident occurs that led to severe harm or death, but does not discuss all types of incidents.	Organisational and system failures are noted and staff are also fully aware of their own personal accountability in relation to errors and of their empowerment to report them. Integrated systems enable patient safety incidents, complaints and litigation cases to be analysed together. Staff, patients and relatives are actively involved and supported from the time of the incident. The organisation has a high level of openness and trust. The organisation is also open and honest with patients and/or their carers about all types of patient safety incidents, irrespective of the level of harm caused.
04. Recording incidents and best practice	Ad hoc incident reporting systems are in place but the organisation is largely in 'blissful ignorance' unless serious incidents occur or solicitors' letters are received. There is a high blame culture, with individuals subjected to victimisation and disciplinary action. No learning can occur.	There is an embryonic incident reporting system, although staff are not encouraged to report incidents. Minimal data on the incidents is collected but not analysed. There is a blame culture, so staff are reluctant to report incidents. When incidents occur, there is no attempt to support any of those involved.	A centralised anonymous reporting system is in place with a lot of emphasis on form completion. Attempts are made to encourage staff and patients to report incidents (including those that were prevented or led to no harm) though staff do not feel safe and patients do not feel comfortable reporting them. The organisation considers other sources of safety information alongside incident reports (e.g. complaints and audits).	Reporting of patient safety incidents at both a local and national level (e.g. the National Reporting and Learning System) is encouraged and they are seen as learning opportunities. Accessible, 'staff and patient friendly' reporting methods are used, allowing trends to be readily examined. Staff feel safe reporting all types of patient safety incidents, including those that were prevented. Staff, patients and/or their carers are supported from the moment of reporting.	It is second nature for staff to report patient safety incidents (including those that led to no harm or were prevented) as they have confidence in the investigation process and understand the value of reporting to both local systems and nationally (e.g. the National Reporting and Learning System). Patients are actively encouraged to report incidents. It is a learning organisation and robust systems exist in order to record best practice and compliments.
05. Evaluating incidents and best practice	Incidents and complaints are 'swept under the carpet' if possible. Incidents are superficially investigated by a junior manager with the aim of 'closing the book' and 'hiding any skeletons in the cupboard'. Information gathered from the investigation is stored but little action is taken apart from disciplinary action ('public executions') and attempts to manage the media. In this organisation there is little recognition of good safe practice.	Investigations are instigated with the aim of damage limitation for the organisation and apportioning individual blame. Investigations are cursory and focus on a specific event and the actions of an individual. Quick-fix solutions are proposed that deal with the specific incident, but may not be instigated once the 'heat is off'. Some investigations are not completed.	Senior managers are involved in the investigation, which is narrow and focuses on the individuals and systems surrounding the incident. There is a detailed procedure for the investigation process, which involves the completion of multiple forms – the investigation is conducted for its own sake and to placate patients/carers rather than examine root causes and support those involved. Staff are motivated to review procedures or how the procedures are implemented, but learning is variable.	The organisation is open to inquiry and welcomes external involvement in investigations in order to gain an independent perspective. The staff involved in incidents are involved in their investigation to identify root causes and interface issues. The aim of investigations is to learn from incidents and disseminate the findings widely. Data from incident reports are used to analyse trends, identify 'hot spots' and examine training implications. It is a forward-looking, open organisation. Patients are involved in the investigation process and their perceptions, experience and recommendations sought.	The organisation conducts both internal and external independent incident investigations that include the staff and patients involved. Incident investigations are seen as learning opportunities and focus upon improvement and include patient recommendations. The incident analysis process is systematically and regularly reviewed following consultation with all staff. Learning from best practice is shared across the organisation and nationally. It is a learning organisation as evidenced by a commitment to learn from incidents throughout all levels – from the Board/senior managers through to healthcare teams and support staff.
06. Learning and effecting change	No attempts are made to learn from incidents unless imposed by external bodies such as public enquiries. The aim after an incident is to 'paper over the cracks' and protect itself – the organisation considers that it has been successful when the media do not become aware of incidents. No changes are instigated after an incident apart from those directed at the individuals concerned.	Little, if any, organisational learning occurs and what does take place relates to the amount of disruption that senior staff have experienced. All learning is specific to the particular incident. Any changes instigated in the aftermath of an incident are not sustainable as they are knee-jerk reactions to perceived individual errors and are devised and imposed by senior managers. Consequently, similar incidents tend to recur.	Some systems are in place to facilitate organisational learning and this may include consideration of the patient perspective. The lessons learned are not disseminated throughout the organisation. Some enforced local changes relating directly to the specific incident are made. Committees and managers decide on any changes to be introduced, but lack of staff involvement leads to them not being integrated into working patterns. Patients are only involved so the organisation can prove to regulators that they have some commitment to patient and public involvement.	The organisation has a learning culture and processes exist to share learning, such as reflection and sharing patient perceptions. There is Board/senior management support for in-depth incident investigations, and changes instigated address underlying causes (e.g. systems factors). Staff are actively involved in the process and there is a real commitment to sustainable change throughout the organisation. The organisation 'scans the horizon' for learning opportunities and is keen to learn from others' experiences. Organisational learning following incidents is used in forward planning. It is an open, self-confident organisation.	It is a learning organisation. The organisation learns from internal and external information and experience and is committed to sharing this learning both within and outside the organisation. Patient safety incidents (including those that led to no harm or were prevented) are discussed in open forums where all staff are empowered to contribute. Both individual and organisational learning is evaluated. Improvements in practice occur without the trigger of an incident as the culture is one of continuous improvement. Patients play a key role in learning and contribute to subsequent change processes.
07. Communication about safety issues	Communication in general is poor; it comes from the top down and staff are not able to speak to their managers about risk. Events are kept in-house and not talked about. The organisation is essentially closed. What communication there is, is negative, with a focus on blame. Patients are only given information which must be legally provided and only after exerting a lot of pressure on the organisation to give them access.	Communication in general is directive with managers issuing instructions. Staff are only able to speak to their managers after something has gone wrong. Communication is ad hoc and restricted to those involved in a specific incident. The patient is given the information the organisation feels is appropriate in a one-way communication.	There is a communication strategy. Policies and procedures are in place, and lots of records are kept. There is a lot of information collected from staff, patients and other organisations but it is not effectively utilised. This leads to an information overload meaning that little is actually done with the information received by staff. A risk communication system is in place, but no-one checks whether it is working.	The communications system and record keeping are fully audited. There is communication across organisations facilitating meaningful benchmarking. All levels of staff are involved, and there are robust mechanisms for them to feedback to the organisation. Information is shared, there are regular briefing sessions where staff are encouraged to set the agenda. Effective communication regarding safety issues is made with patient and public involvement groups.	Everybody communicates safety issues and learns from the experiences of others (good and bad). It is a transparent organisation and includes patient participation in risk management policy development. Innovative ideas are encouraged and staff are empowered to implement them. This is an organisation that communicates good practice both externally and internally.
08. Personnel management and safety issues	Staff are seen just as bodies to fill posts. Recruitment and selection processes are rudimentary. The language used is negative and poor health and attendance records are seen as disciplinary matters. Staff feel unsupported and see Personnel as 'them' and not 'us'. There is a rudimentary staff policy, no structured HR development programme and no links with occupational health.	Job descriptions and staffing levels change only in response to problems, so there are good selection and retention policies in areas where the organisation has been vulnerable in the past. The atmosphere is of blame and punishment. Staff support is available, but is minimal and tokenistic. There is a very basic HR policy, but it is inflexible and developed in response to problems that have already been experienced.	Recruitment and retention procedures are in place and credentials are always checked. The language used to manage staff is generally formal and neutral and guided by policies and procedures. Mechanisms for staff support are governed by a lot of paperwork and policies. The procedures on appraisal, staff development and occupational health are there but are inflexibly applied, and so do not always achieve what they were designed for. These procedures are seen as a tool for management to control staff.	There is some commitment to matching individuals to posts. There are attempts to understand why poor performance occurs, and visible, flexible support systems exist tailored to the needs of the individual. Personnel management processes are reviewed and changes are made when necessary. There is genuine concern about staff health, and good systems of appraisal, monitoring and review. Patient/carer input on safety and staffing issues is actively sought. There is demonstrable evidence of proactive measures taken in some areas (for example by using the NPSA's Incident Decision Tree following an incident).	Job specifications are designed to identify competencies using a Knowledge and Skills Framework. Reflection and review (both positive and negative) occur continuously and automatically. The organisation is committed to its staff, and everyone has confidence in the personnel management procedures that include mentorship and supervision. Patients and the public have meaningful involvement in the development and implementation of any policies related to safety and staffing issues. Personnel management is not a separate entity but an integral part of the organisation. Following a patient safety incident, a systems analysis is used (for example by using the NPSA's Incident Decision Tree) to make decisions about the relative contribution of systems factors and the individual healthcare professional. This process informs decisions about staff suspensions and as such there is a consistent and fair approach to dealing with staff issues following incidents.
09. Staff education and training	Training has a low priority. The only training offered is that required by government. Staff education is seen by management as irritating, time consuming and costly. There are consequently no checks made on the quality or relevance of any education or training given with regards to career development of staff. Staff are seen as already trained to do their job, so why would they need more training?	Training occurs where there have been specific problems and relates almost entirely to high risk areas where obvious gaps are filled. It is the responsibility of the individual to read, act upon and fund their own educational needs. Education and training focus on maximising income and covering the organisation's back rather than the career development of the staff. There is no dedicated training budget and staff appraisals occur on an ad hoc basis.	The training programme reflects organisational needs so training is supported only if it benefits the organisation. No thought is given to actively involving patients in training. Basic Personal Development Plans are in place so everyone has their own file. However these are not very effective as they are not properly resourced or given priority. There are a large number of courses on offer, however not all of these are relevant to the career development of the staff expected to make use of them. Training is seen as the way to prevent mistakes and appraisals are focused around this.	There is an attempt to identify the training needs of the organisation, and of individuals, and to match them up. Educational opportunities are well planned and resourced and are available from and for all relevant agencies. Training and education are seen as integral to the career development of individuals and are linked directly to other organisational systems, such as incident reporting. Appraisals are staff centred and are built around the needs of the individual. Preliminary attempts to involve patients and the public in staff training are underway and the organisation is starting to learn lessons from their experiences.	Individuals are empowered and motivated to undertake their own training needs analysis and negotiate their own training programme. Learning is a daily occurrence and does not happen solely in a classroom environment. Education is seen as being integral to the organisational culture. The approach to training and education is flexible and seen as a way of supporting staff in fulfilling their potential. Appraisals are initiated and managed by the staff themselves. Patients are involved in staff training to aid understanding of patient perceptions of risk and safety.
10. Team working	Individuals mainly work in isolation but where there are teams they are uni-disciplinary and dysfunctional. There are tensions between the team members and a rigid hierarchical structure. They are more like a collection of people brought together under the direction of a nominal leader. Information is not shared between team members. The team operates secretly.	People only work as a team following a negative event and to respond to external demands. Individuals are not actually committed to the team. There is a clear hierarchy in every team, corresponding to the hierarchy of the organisation as a whole. There are multidisciplinary teams, but they have been told to work together, and only pay lip service to the ideals of team working. Information is cascaded to team members following an incident. The team operates defensively and newcomers are not welcomed.	Multidisciplinary teams are put together to respond to government policies, but there is no way of measuring how effective they are. Teamwork is seen by lower grades of staff as paying lip service to the idea of empowerment. Teams are given lots of written information about how they should function. There are official mechanisms for the sharing of ideas or information within and across teams but these are not used effectively. Teams operate behind the scenes and generally within a single organisation.	Teams are multidisciplinary and time and resources are devoted to team development processes. Team structure is fluid, with people taking up the role most appropriate for them at the time. There is evaluation of how effective the team is and changes are made when necessary. Teams are collaborative and adaptable. Teams are open and may involve members external to the organisation.	Regular and evaluated team resource management training is offered to fully integrated multidisciplinary teams. Team membership is flexible with a horizontal structure. Different people make equally valued contributions when appropriate. Teams are about shared understanding and vision rather than geographical proximity. Team working is the accepted way in the organisation. Teams are totally open, involving members from diverse organisations, locally, nationally and even internationally.