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)

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<thead>
<tr>
<th>Dimension of patient safety culture</th>
<th>A</th>
<th>B</th>
<th>C</th>
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<td>1. Commitment to overall continuous improvement</td>
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<td>10. Team working</td>
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T = Team  O = Organisation
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.

Why MaPSaF was developed

• 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 designed to be used to:

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.
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

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<tr>
<th>Level</th>
<th>Description</th>
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<td>A – Pathological</td>
<td>Why do we need to waste our time on patient safety issues?</td>
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<td>B – Reactive</td>
<td>We take patient safety seriously and do something when we have an incident.</td>
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<td>C – Bureaucratic</td>
<td>We have systems in place to manage patient safety.</td>
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<td>D – Proactive</td>
<td>We are always on the alert/thinking about patient safety issues that might emerge.</td>
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<td>E – Generative</td>
<td>Managing patient safety is an integral part of everything we do.</td>
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MaPSaF is based on Parker and Hudson’s (2001) application of Westrum’s (1992) stage model of organisational culture maturity.

### References

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

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<td>1. Commitment to overall continuous improvement</td>
<td>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?</td>
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<td>2. Priority given to safety</td>
<td>How seriously is the issue of patient safety taken within the organisation? Where does responsibility lie for patient safety issues?</td>
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<td>3. System errors and individual responsibility</td>
<td>What sort of reporting systems are there? How are reports of incidents received? How are incidents viewed—as an opportunity to blame or improve?</td>
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<td>4. Recording incidents and best practice</td>
<td>Who investigates incidents and how are they investigated? What is the aim of recording the incident?</td>
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<td>5. Evaluating incidents and best practice</td>
<td>How are any incidents evaluated? What recognition is there of safe practice? How is the resultant data used?</td>
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<tr>
<td>6. Learning and effecting change</td>
<td>What happens after an event? What mechanisms are in place to learn from the incident? How are changes introduced and evaluated?</td>
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<td>7. Communication about safety issues</td>
<td>What communication systems are in place? What are their features? What is the quality of record keeping to communicate about safety like?</td>
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<tr>
<td>8. Personnel management and safety issues</td>
<td>How are safety issues managed in the workplace? How are staff problems managed? What are the recruitment and selection procedures?</td>
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<td>9. Staff education and training</td>
<td>How, why and when are education and training programmes about patient safety developed? What do staff think of them?</td>
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<tr>
<td>10. Team working</td>
<td>How and why are teams developed? How are teams managed? How much team working is there around patient safety issues?</td>
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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
A continuous improvement framework is developed in response to specific directives or an inspection review process. Auditing only occurs in response to specific incidents and national directives and does not re-focussed on feedback. Little attempt is made to respond to the data collected.

The base minimum of protocols and policies exist but there are obvious gaps that need to be filled. An incident occurs that triggers their review.

Developments of new policies occur in response to incidents and complaints.

Frontline staff are not engaged in the improvement process and they see it as an management activity that is external to them.

Lots of auditing occurs but lacks an overall strategy linking with organisation or local needs. Staff are overload with protocols and policies (which are regularly reviewed and updated) and do not have sufficient time to participate in its development or contribute to its content.

Patients and the public may be involved in quality issues but this is lip service rather than true 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 can reduce the time and cost required to maintain a high level of safety and excellence by realizing that patient’s safety is a shared achievement. Staff are all motivated and safety risks are exploited. This means that there is the need for a strong culture of patient safety.

Safety is promoted throughout the organisation and staff are actively involved in safety and quality processes. Patients, the public and other organisations are also involved in risk management systems and their reviews. Models are taken 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 white-collar individual takes the look into both the safety policy in the organisation. It is a key part of all managers’ roles.

Evaluating incidents and best practice

The organisation is essentially closed. What information gathered from the investigation is stored ‘hiding any skeletons in the cupboard’.

Junior management has the aim of ‘closing the book’ and the problems and relates almost entirely to high risk areas and is unsatisfactory.

There is some commitment to matching individuals to posts. There are some localised systems in place to protect individuals. However, these systems are not widely known about or utilised. Some systems are in place to facilitate organisational learning, but they are not just individuals. The organisation says that it has an open culture but does not discuss this.

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 used to make decisions about the contribution of systems factors and the individual. The individual is the Incident Decision Tree. This process informs decisions about staff supervision and so there is a consistent and fair process.

The organisation is open to inquiry and welcomes external involvement in investigations in order to gain an independent perspective. The staff involved in the investigation are aware of the issues and causes and interface issues. The aim of investigations is to learn from incident and improve processes. Data from incident reports are used to analyse trends, identify ‘hot spots’ and develop initiatives to prevent future incidents.

The organisation has a learning culture and processes exist to share learning within the organisation and with other organisations. It is a forward-looking, open learning organisation and robust systems exist in order to record best practice and components.

There is a culture of continuous improvement embedded within the organisation and integrated 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. There is a strong culture of patient safety.

Innovative ideas are encouraged and staff are empowered to contribute. Risk management and everyone has confidence in the process. Improvements in practice occur without the trigger of an incident as the culture is aware of continuous. Patients play a key role in learning and contribute to subsequent change processes.

There are a few blame cultures with individuals subjected to victimisation and disciplinary action.

There is a strong blame culture with individuals subjected to victimisation and disciplinary action. An incident reporting system occurs in place but the organisation is a small affair and they do not report incidents. Minor changes are made and do not have enough investigation.

Communication in general is not present or is not used. What information gathered from the investigation is stored ‘hiding any skeletons in the cupboard’.

Teams are about shared understanding and vision rather than direct working. The public are involved in a routine, meaningful way with ongoing consultation with all staff.

Learning from best practice is shared across the organisation and this is done through multiple levels. It is a learning organisation and risk management systems exist in order to record best practice and components.

There is a clear hierarchy in every team, corresponding to the hierarchical levels of the organisation. There is a strong commitment to matching individuals to posts. It is the responsibility of the organisation to ensure they have access.

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