

Safety-I and Safety-II – Sharing Outstanding Excellence (SOX)

Safety is a word that we all use frequently and we probably all believe we know what it means, and assume we're all talking about the same thing - but are we?

A simple definition is that safety is the absence of unwanted outcomes such as incidents or accidents¹. In day to day life what we generally mean by being safe, is that whatever it is that we are doing (driving a car, travelling on a plane for example) will be as expected (in the examples earlier this would mean not crashing the car or the aeroplane not falling from the sky). Safety therefore starts from the premise of there being an absence of something (error, accident) and, paradoxically, is measured by counting the number of times that it fails (number of car accidents, delays in flights, aeroplane crashes etc). This is referred to as Safety-1 and here our efforts to improve patient safety are almost entirely focused on identifying adverse incidents and errors, and implementing adaptations to avoid their recurrence². The evidence however, is that the benefits to this approach are limited^{3,4} and there is inadequate evidence that lessons are learned or effective changes implemented following incidents⁵. This approach (Safety-1) is stretched to or beyond breaking point – and the world has changed⁶.

Interestingly, we don't generally count the events when things went to plan (I can tell you exactly how many times I

have crashed my car but I have absolutely no idea of the number of times that I have driven my car without any incident).

If we therefore now turn our focus from what went wrong to what went right, we have what has been termed as Safety-II. This changes the definition of safety from 'avoiding that something goes wrong' to 'ensuring that everything goes right'⁷. This means that patient safety is managed by what we achieve (our successes), and similarly is measured by counting the number of times where things go right. In order to do this,

patient safety management cannot only be reactive, it must also be proactive. Adverse incidents only account for the minority of healthcare interactions and if we don't look at our successes we may be missing key learning opportunities.

One problem for us as humans, is that we have an innate negativity bias:

- We can't stop spotting errors. Take this sentence for example – "theirs nothing worse then a misplaced apostrophe's" (I bet you spotted the errors straightaway) or how about these sums:

$$1 + 1 = 2$$

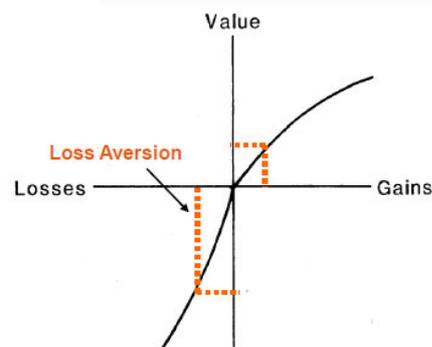
$$3 + 3 = 6$$

$$4 + 4 = 7$$

$$5 + 5 = 10$$

How many of you spotted that one of the sums was wrong? How many of you noted to yourself that three of the sums are right?

- We like to win but we hate to lose⁸ – this graph comes from the world of economics but has been shown to be true for many aspects of life; from lottery tickets to health choices⁹
- We are addicted to it (if you don't believe me just look at the most viewed pages on the BBC website or the front page of any newspaper...)



Life is different now

In the 1950s there were no computers in the work place (let alone in cars) and since this time traffic, for example, has increased threefold⁷ – compare the images below - taken roughly 70 years apart; they illustrate just how much life has changed.



Just as traffic has increased so have inventions and innovation; often with unintended consequences. Work today takes place in 'a socio-technical habitat'⁷(p113) which is increasingly complicated and another reason for re-thinking safety.

Today's emphasis on the rare



Never events; significant events, serious events - these are (thankfully) relatively rare. Focusing on rare cases of failure does not explain why human performance practically always goes right.

Focusing on rare never events/incidents in an effort to understand what is happening has been compared to us trying to understand shark behaviour by only looking at shark attacks. The latter is only a very small part of the picture.

Can we learn from positive events as well as we do from negative ones?

*"Negative emotions such as fear and anxiety can block learning, while positive feelings of attraction and interest may be essential for learning. To learn something that one is not interested in is extremely difficult"*¹⁰

- We can learn effectively through reflecting on failure (negative reinforcement) and success (positive reinforcement)¹¹
- Nurturing positivity is linked with improved resilience and ability to deal with adversity^{12,13}
- Happy caregivers = happy patients¹⁴

The evidence therefore is that we can, and, it is argued here, that we should!

Learning from Excellence

Learning from Excellence¹⁵ started at Birmingham Children's Hospital in April 2014. Their aim was to show appreciation to staff for their good work and importantly to learn from their excellent practice.

At Salisbury NHS Foundation Trust we used LfE as the basis for reporting excellence on the Spinal Unit. The initiative started in November 2016. A questionnaire was sent to all staff working on the Spinal Unit and 80 people responded.

The initiative is low-tech (a simple paper-based form with collecting box). Excellence reporters are asked:

- Who achieved excellence?
- What area do they work in?
- What did they do that was excellent?

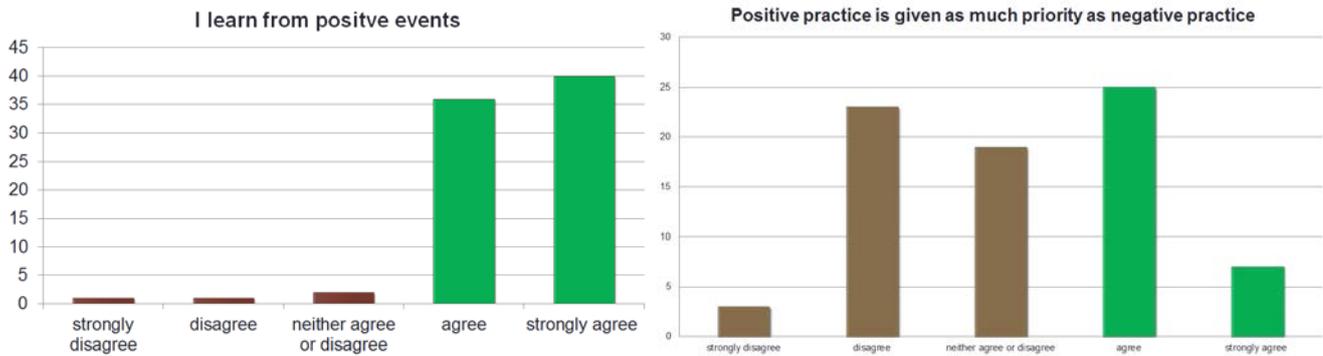
- To name one thing that we could do to develop excellence in this area.
- The reporter's name and the date of the excellence reporting is required.

Completed forms are put in a centrally-located post box and this is emptied every week.

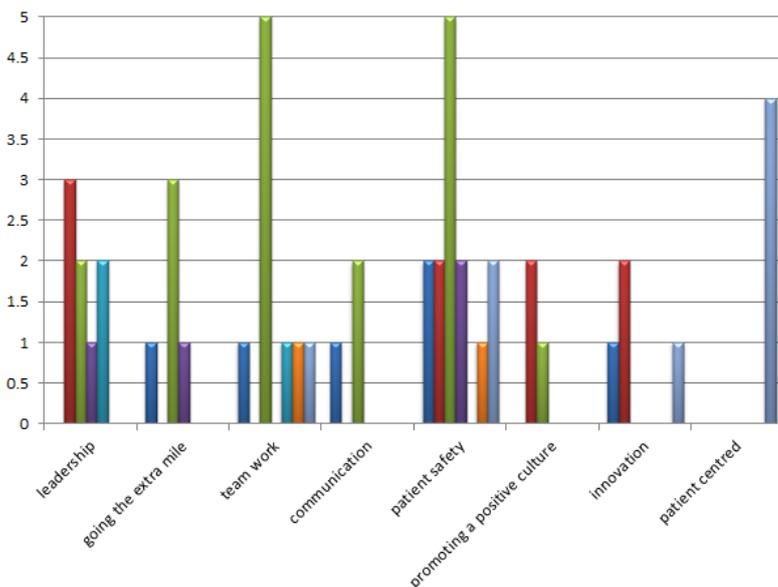
The nomination forms are typed up and feedback is given (via email) to the nominee, their line manager and the person who nominated them.

Results

The questionnaire we sent to staff before the initiative started showed that they overwhelmingly agreed that they could learn from positive events. It also showed that they did not believe that positive practice was given as much priority as negative practice.



The nominations are displayed for all to see on a board in the corridor (feedback from patients has been very positive).



The themes from the nominations can be seen on the graph here. We were very pleased to see the themes of patient safety and teamwork being the most reported; this reflects the literature around organisational culture and learning¹⁶.

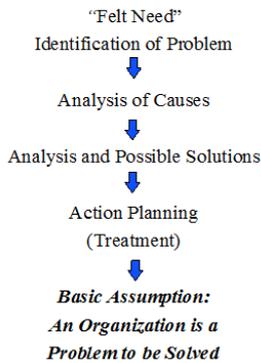
The initiative is currently being evaluated with a follow-up questionnaire being sent to staff and those who have nominated/been nominated. We plan to share our learning at a national meeting later this year.

Our next steps

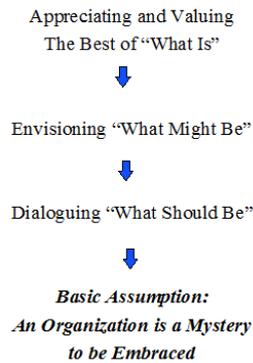
Appreciative Inquiry

Appreciative Inquiry (AI) has been defined as ‘the cooperative, co-evolutionary search for the best in people, their organizations and communities, and the world around them. It involves systematic discovery of what gives “life” to an organization or community when it is most effective, and most capable in economic, ecological, and human terms’ (p276)¹⁷.

Problem Solving



Appreciative Inquiry



AI is different from the way we usually solve problems (consider how we currently investigate incidents) and seems to fit well with the Safety-II approach since AI assumes that all organisations have rich and generally untapped positive stories to tell (Learning from Excellence nominations for example).

At the heart of AI is the *appreciative interview*, a conversation using questions that highlight peoples' experiences, explores individual and team values, facilitates a discussion around 'dreaming' about a point in time where everything just as they wished it to be and exploring how each person could contribute to this dream situation.

From Problem Solving to Appreciative Inquiry (p278)¹⁷

The AI conversation can be a quick and informal conversation with a friend or colleague, or a formal organisation-wide process involving all relevant stakeholders. Crucially the AI process bypasses 'the conversation about problems and moves people directly into solution mode' (p71)¹⁸. Answers to the questions posed and the stories that emerge can then be used generate agreed actions (and prioritise them if necessary) which can then be acted on and shared.

Conclusion

Safety I and Safety II offer complementary views of safety rather than two incompatible or conflicting approaches; just as traditional problem-solving approaches go hand in hand with an appreciative inquiry approach to learning.

Many of our existing practices can therefore continue to be used, although possibly with a different emphasis. With the Safety II mind-set, we can gather new insights, share experiences and talk about the every day. Methods such as Sharing Outstanding Excellence (SOX), Learning from Excellence, AI, Favourable Event Reporting Forms (FERF), storytelling, narratives and safety conversations are tools in our safety armamentarium that will help us going forward.

Next steps

- To spread excellence reporting. Our work was shared with the organisation at a Clinical Governance Core Session in July 2017 and immediately drew interest from two other areas who want to start reporting excellence.
- To begin to implement appreciative inquiry
- To explore an electronic means of capturing, sharing and analysing the excellence reports.

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