Towards safer surgery

Safety has always been of concern and a priority to those of us who work in the perioperative setting. However, attention on our surgical work and the relative safety of what we do for patients has intensified due to the World Health Organisation (WHO) Safe Surgery Saves Lives Programme (2007-2009), the National Patient Safety Agency (NPSA) Alert of 2009 requiring the NHS to embrace the WHO Surgical Safety Checklist and the championing of the Five Steps to Safer Surgery (NPSA 2010) by the national safety campaign Patient Safety First. The qualification of ‘Surgical Never Events’ introduced to the NHS in England from April 2009, following Lord Darzi’s proposal in High Quality Care for All (DH 2008) also generated considerable public and media attention.

Understanding surgical safety

Surgery was long ago identified as the source of a high proportion of preventable adverse events. A decade ago most of these would have been considered unavoidable or ascribed, generally incorrectly, as due to poor individual practice. Studies of process failures, communication, teamwork, interruptions and distractions have now identified multiple vulnerabilities in systems of surgical care (Healey et al 2006, Sevdalis et al 2009). We know that many surgical never events can be attributed to a failure to adhere to essential standards of swab, needle and instrument control, failure to engage in pre-list safety briefings, use of the WHO Surgical Safety Checklist and essential safeguards of read back techniques (DH 2012). Many groups are now moving beyond the undoubted gains of checklists to consider the wider surgical systems and the need for a more sophisticated understanding of surgical teamwork in both the operating theatre and the wider healthcare system. A certain level of error is inevitable because our surgical services are delivered by humans in very complex systems. However, there are many things that we can do to mitigate risk and ensure our environments and to make sure errors do not have consequences for patients.

The airline industry recognised the need for a systems approach some 30 years ago, following a series of accidents that could not be attributed to technical failures or deficiencies in technical skill. It was recognised that the industry had to alter its approach to human error, improve its safety culture and that certain behaviours were required on the flight deck to preserve safety. These related to decision making, situation awareness, communication, teamwork and leadership (Kanki et al 2010). These behaviours are equally essential to keeping patients safe (Flin & Mitchell 2008).

Safety culture as the foundation

The cultural context of surgery is also an important influence on healthcare teams. The Francis Report (2013) invited us all to pay attention to the predisposing conditions that can develop and erode the quality of care we provide patients. These include, but are not limited to, organisational violence (Morrison & Millikin 2001), cultural censorship (Hart & Hazelgrove 2001), consensual neglect (Weick 2002) and compassion fatigue (Sabò 2006); conditions that conspire and fail to safeguard patients in any environment, not least our operating theatres. The major finding of Francis was a tolerance of the unacceptable that simply became the ‘way we do things around here’ (Deal & Kennedy 1982).

The Francis Report (2013) focused minds on how deficits in care and essential standards can develop in organisations that lack a positive safety culture and where there are failings in the quality assurance, supervisory and regulatory peer challenge behaviours of staff. Mid Staffordshire was not an isolated case. Poor professional standards, including the perioperative setting, could have been found in other clinical settings in the NHS at that time - as they could be today. Our collective challenge concerns the scale of variation in the NHS in terms of patient safety, experience and clinical outcome, and the insidious acceptance of mediocrity and variation still to be found in some organisations. Thankfully so many of you work around these barriers and aspire to deliver to the very best of your potential and what is possible.

Building a just culture

If the NHS aspires to high reliability, then building and sustaining a safety culture is an essential part of that endeavour. In a safe culture; system leaders are sensitive to the unintended consequences of policy; staff at every level share responsibility for safety; teams act to preserve, enhance and communicate safety concerns; both teams and organisations take a prospective approach to risk and hazards; all clinicians strive to actively learn, adapt and modify behaviour that enhances both patient and worker safety (Agnew et al 2013).

Most critically, senior leaders, both clinicians and managers, need to respond with much more understanding to professionals who are involved in serious incidents and never events. There is a place for discipline and sanctions. However, a distinction must be made between intentional extreme violations (which are rare and unacceptable) and ‘borderline tolerated conditions of use’ (Amalberti et al 2006) which are pervasive, inevitable and often due largely to the pressures of clinical work when staff are stuck between a rock and a hard place as they juggle and balance competing pressures of demand and capacity in our health system (Vincent & Amalberti 2016).

From compliance to improvement

Improvement starts by examining current behaviour patterns and identifying what needs to change. This requires us to move beyond compliance, or what might be described as window dressing or ‘looking good’ type safety, to striving for something much deeper and almost visceral and palpable (Berwick 2015). High reliability organisations are ones that demonstrate maturity and a psychological sophistication that is sadly lacking in many of our operating theatres, much of our NHS leadership system and political economy.

There are three lessons from the developments in aviation that are relevant today as we strive to deliver safe care in a financially challenged system. The first is the need to fully analyse accidents to include an examination of ‘human factors issues’, especially workplace behaviours. Second is the importance of linking the findings from these analyses to ongoing training of the behaviours that constitute the non-technical skills in healthcare. Third, there is need to appreciate that humans will always be prone to fail in systems that have not been designed using ergonomics/human factors principles. Building an appreciation of human factors and ergonomics is an increasingly recognised priority in the perioperative setting, as is showcased by the contributors to this issue. Individuals in receipt of surgical care, either as a day case or inpatient, deserve a safe experience, free of avoidable harm. Whilst...
much is focused on our compliance with rules and regulation, for the sake of our patients, we need to pay greater attention to the frailties of the human condition, the toxicity of negative behaviours and the design of clinical systems, if we are to realise safer care. Safety in so many ways is dependent on individual personal commitment and what you choose to do, rather than what you are required to. We hope you enjoy this issue and are inspired by some of the illustrations and examples of what is possible.

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