Manchester Patient Safety Framework (MaPSaF)

Acute
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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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:

- 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.
Increasing Maturity

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

<table>
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<tr>
<th>Level</th>
<th>Description</th>
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<tr>
<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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References

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

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<tr>
<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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<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
Commitment to overall and continuous improvement

No resources are invested in the identification of problems or areas of good practice. Any warnings given are lost in translation and there is no response to what is discovered. Whatever problems or solutions emerge are then merged into the organisation’s statutory requirements and are not used, reviewed or updated.

Quality care is taken or ignored. This attitude is carried into the organisation throughout the healthcare teams.

A continuous improvement framework is developed in response to specific directives or an intensive 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.

The base minimum of protocols and policies exist and are similarly inflexible. In the event of an incident that triggers their review.

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 within the organisation or to local needs. Staff are overloaded with protocols and policies (which are regularly reviewed and updated) but are not told what to do and why. They are not involved in the development process.

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 involvement begins with the recognition of excellence and compare their performance against others of that category. Clinicians are involved in, and have contributed to, the development of strategies which leads to continuous improvement.

Increasing maturity

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 healthcare sector.

Staff and patients are treated fairly and are seen to be doing their job, so why would they need more training?

Safety is the top priority in the organisation, and responsibility for safety is multi-disciplinary at all levels from the Board to the patient.

There is a high blame culture, with individuals seen as learning opportunities. Accessible, ‘staff and patient friendly’ reporting methods are used, allowing trends to be readily examined.

The organisation is open to learn from incidents throughout all levels – from the Board down to the patient.

It is accepted that incidents are a combination of individual and system failures. The organisation has an open, fair and collaborative culture.

No attempts are made to learn from incidents unless those that were prevented. Staff, patients and/or their carers are supported from the moment of reporting.

The organisation is keen to listen and welcome external involvement in investigations in order to gain an independent perspective. The staff involved in investigations are identified to the organisation and stakeholders in order to gain a full understanding of the causes and interfaces involved. The aim of investigations is to learn from incidents and inform policy and procedures.

The organisation has a learning culture and processes exist to share learning from incidents. They are not a systems analysis process for in-depth incident investigations, but investigations initiated under emergency powers. The organisation is involved in the process and there is a real commitment to undertake as a learning tool. They are an opportunity to learn from others’ experiences.

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