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Bridge over troubled water: An introduction

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learning from excellence





Patient safety within safety science

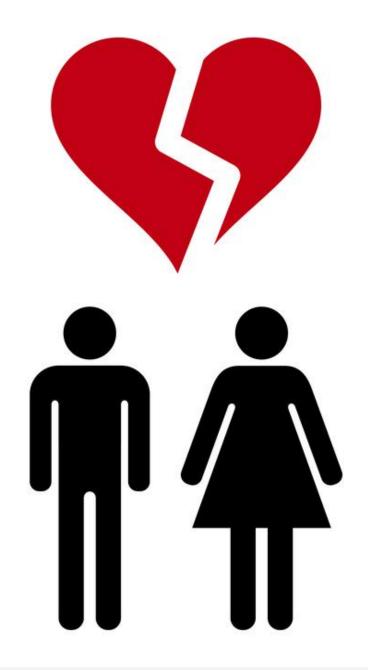


Safety science has a long history

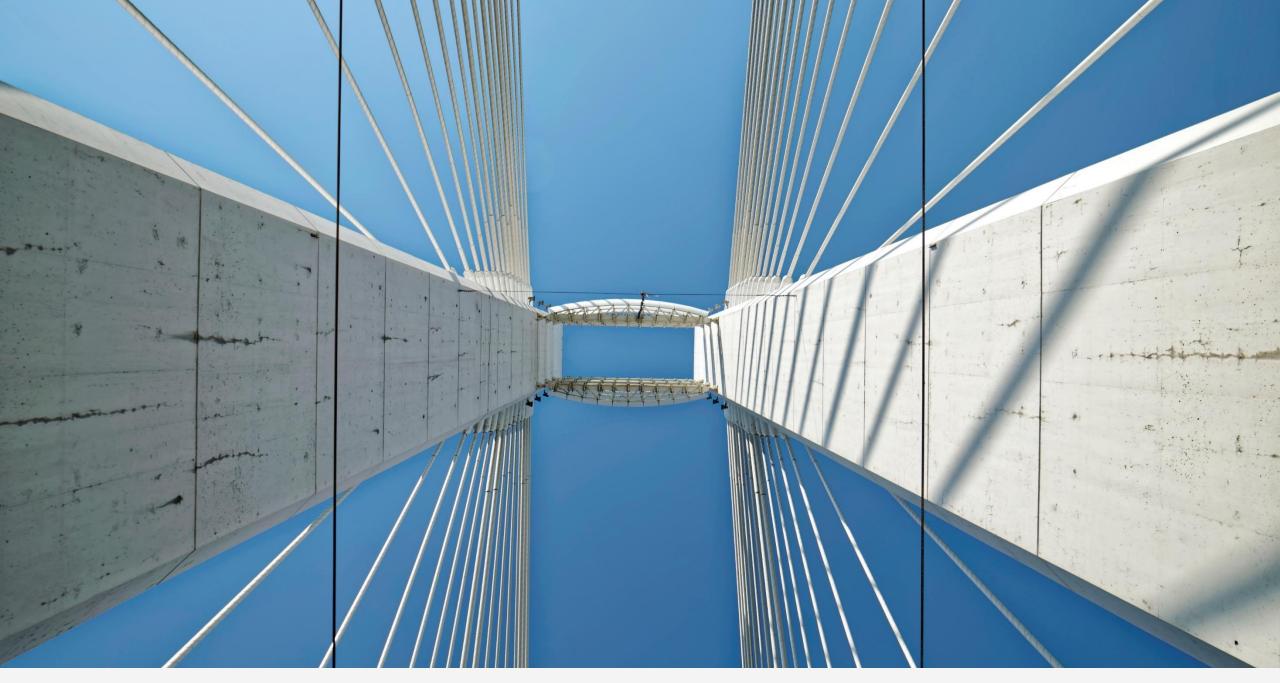








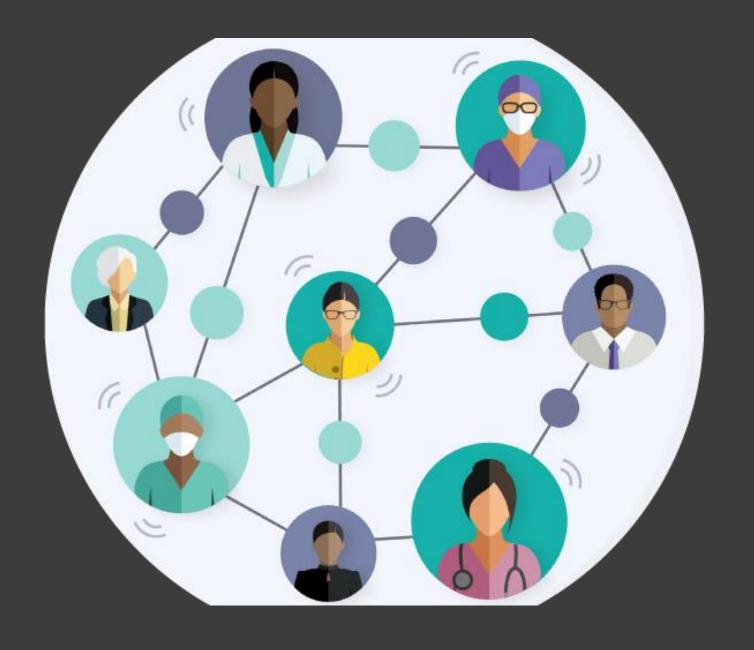




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Whose work contributes to safety?

Healthcare staff
Managers
Suppliers
Policy makers
Regulators
Patients, families and carers







Axel RosBackground

Debbie Clark
Workarounds in
practice

Siri Wiig Collective learning Catherine
Calderwood
Where do we go from here?

Rebecca Lawton
Summary and close





Bridge over troubled water Part 1, some theory

Safety I & II
Resilience
Work-as-done
Workarounds

Axel Ros

Chief medical officer/Associate professor

Region Jönköping County/Jönköping University



Workaround (according to Wikipedia)

- A workaround is a bypass of a recognized problem or limitation in a system or policy.
- A workaround is typically a temporary fix that implies that a genuine solution to the problem is needed. But workarounds are frequently as creative as true solutions, involving outside the box thinking in their creation.
- Typically they are considered **brittle** in that they will not respond well to further pressure from a system beyond the original design. Placing pressure on a workaround may result in later system failures.
- Workarounds can also be a useful source of ideas for improvement of products or services.



A warm-up

- Who do we have in the room? health care practitioners, patient safety practitioners, managers, patients, politicians, policy makers, researchers...?
- Present yourself to a neighbour and briefly disclose a workaround you have recently done (at work or off-work)
 - what happened?
 - did it go well?
 - how did you feel?



Healthcare is a complex adaptive system

- ➤ It's a big system!
- ➤ It is complex
- ➤ Variability needed to manage variability
- **≻** Adaptations
- **≻** Intractable



Complexity – safety

- Modern healthcare systems are complex
- Complexity relates to variability changes, disturbancies, challenges and opportunities
- Safety in healthcare has to address the complexity
- Complexity has implications to how we understand safety



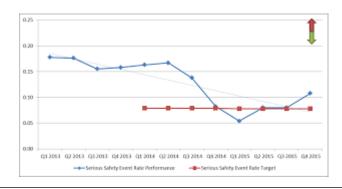
What does it mean to be safe?





When we think about safety, we usually think about accidents – about (low probability) events with adverse outcomes.

A system is safe if as little as possible goes wrong.



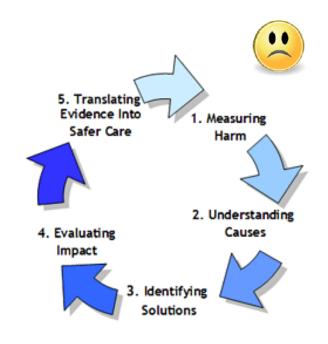


Safety – the traditional way to see it When nothing goes wrong

Safety is a condition where the number of adverse outcomes (accidents / incidents / near misses) is as low as possible.

Safety is defined by its opposite – by the lack of safety (accidents, incidents, risks).

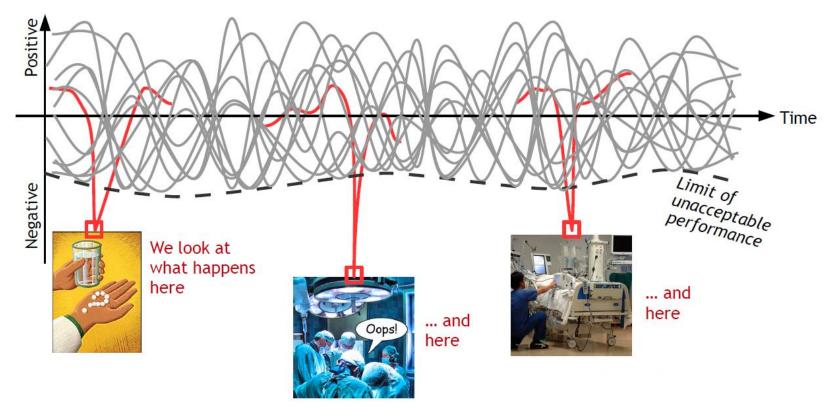
The premise for safety is the need to understand why accidents happen.





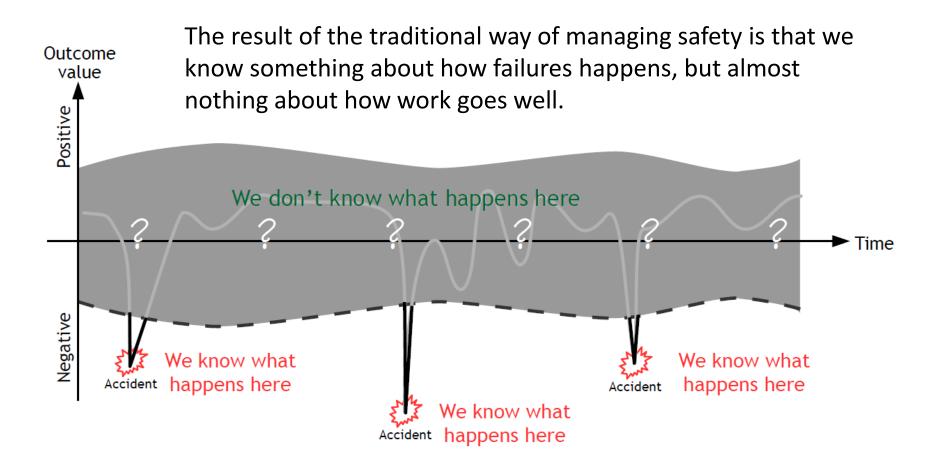


Managing safety by snapshots





Managing safety by snapshots





In a complex world everyday work must be flexible to cope with the variability



People adjust what they do to match the situation. These adjustments are inevitable and necessary.





Resources may be limited and uncertain (time, manpower, materials, information, etc.).



Because of resource limitations, performance adjustments will always be approximate.



Performance variability is the reason why everyday work is safe and effective.





Performance variability is the reason why things sometimes go wrong.





Safety – another way to see it When everything goes right

Safety is a condition where the number of successful outcomes (meaning everyday work) is as high as possible.

It is the ability to succeed under varying conditions.

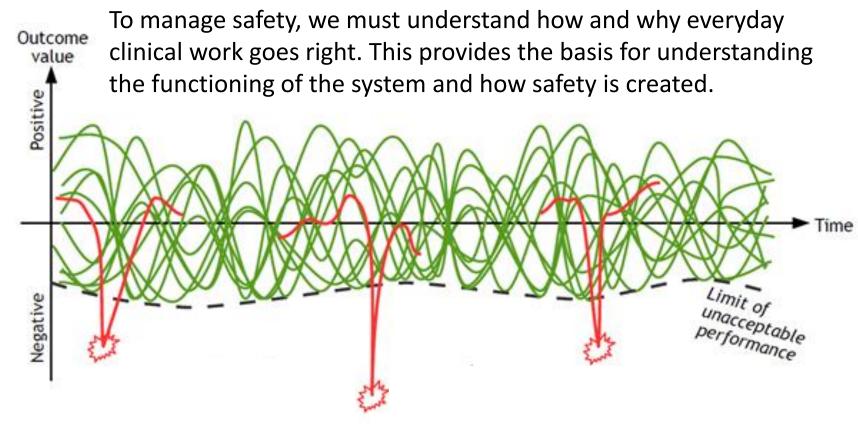
Safety concerns should be directed at everyday events, at that which happens when "nothing" happens, when work just goes as it should.





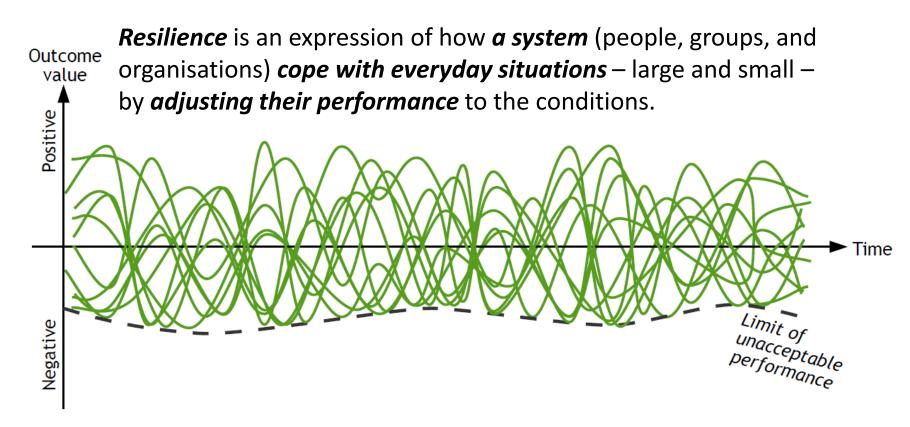


Managing safety differently

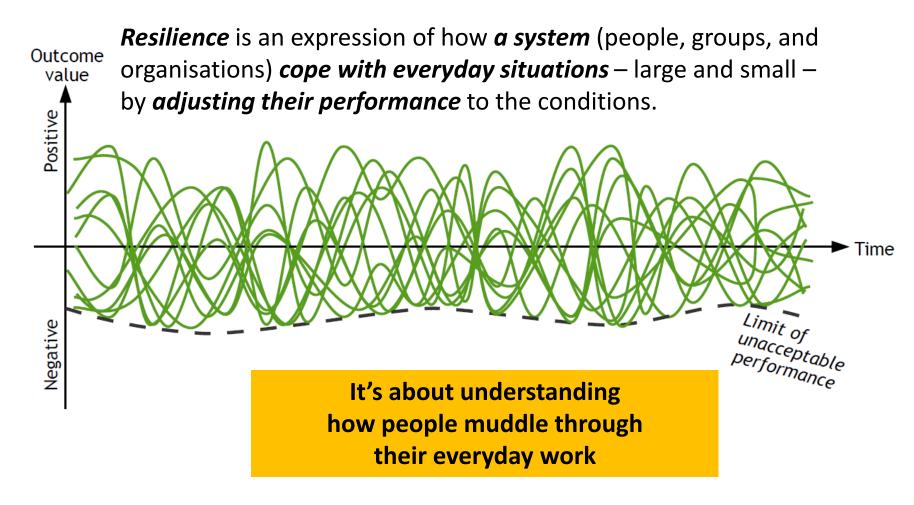




The focus of resilience



The focus of resilience





Definitions

Resilience

A resilient system can adjust its functioning prior to, during, or following events (changes, disturbances, and opportunities), and thereby sustain required operations under both expected and unexpected conditions. (Hollnagel 2015)

Resilient healthcare

A healthcare system's capacity to adapt to challenges and changes at different system levels, to maintain high-quality care. (Wiig et al 2020)

Resilient performance is a (an intrinsic) system property.

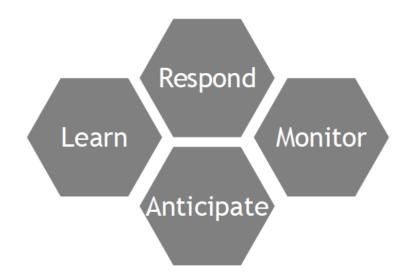


Resilient performance

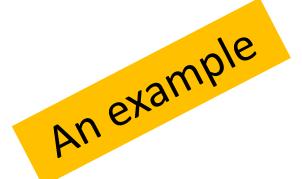
Resilience is created, it is something that is done

Resilient performance requires that an organisation has the ability to

- respond to that what happens,
- monitor what is happening,
- anticipate what might happen,
- **learn** from everything.







Resilient performance in the containment of an outbreak of ESBL-producing Klebsiella in a neonatal intensive care unit



The setting

- County hospital Ryhov, Jönköping, Sweden
- Neonatal intensive care unit (NICU)
- ESBL-producing Klebsiella outbreak June 2015
- 5 infected children, no invasive disease
- Outbreak group leading the work with outbreak containment



The ability to Respond

- Evident both in the outbreak group and the NICU staff
- Both in activities according to routines and in activities that were adaptations to the events and situation

NICU staff responses and actions according to decisions from the outbreak group.

We did what we were told to do, sometimes even more

Sometimes decisions were unclear, or difficult to adhere to

But we managed anyway



The ability to **Monitor**

- Monitoring is a part of the work in the outbreak group
- Monitoring was not an integrated part of the staff work

According to standard routines
 Eco-cultures, environment cultures to detect infections



The ability to **Anticipate**

- To evaluate future events, to be prepared
- To be informed of relevant important matters and reflect over anticipated events increases the abilities to deal with the outbreak

If these cultures turn out positive we will...

➤ Important part of work in the outbreak group



The ability to Learn

- Learning that had an impact on work during the outbreak
- Learning that facilitates situational awareness
- A need to learn more was expressed

> There can not be to little information

After a while we took up an afternoon meeting, besides the morning one

➤ Where is the risk?

It's the parents that are careful and thorough; it's us that mixes things up









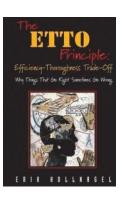
Trade-offs and Workarounds

natural and necessary in complexity



ETTO -

Efficiency Thouroughness Trade-off (Erik Hollnagel)



Efficiency – time to perform relates to being fast and efficient



Thouroughness – time to think, reflect, plan relates to safety and accuracy

We do trade-offs all the time.

To save time, energy, money.....

Full efficiency and full thoroughness at the same time is impossible.



ETTO –

Efficiency Thouroughness Trade-off



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ETTO / workarounds

ETTO – shortcuts and workarounds – to save time, energy, money.....

If you assume that A "always" is true in situation B, you do not have to check every time – or do you?

You only check what is important. But how can you know? And when?

Exemples

- "This is not really important"
- "This normally is OK, so we don't have to check"
- "This looks like X, so it has to be X"
- "We have to finish in time"



ETTO / workarounds

ETTO – shortcuts and workarounds – to save time, energy, money.....

If you assume that A "always" is true in situation B, you do not have to check every time – or do you?

You only check what is important. But how can you know? And when?

Carelesness, or only human?
Regardless, you probably have
to accept that this is the way it is

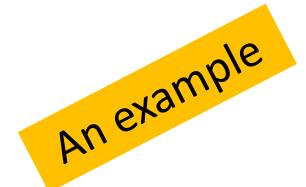
Exemples

- "This is not really important"
- "This normally is OK, so we don't have to check"
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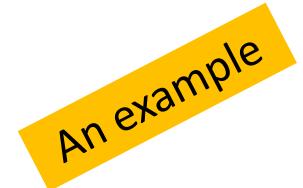




A blood transfusion case

- A busy Saturday at the OR ward
- Two surgeries at adjacent rooms
- Both patients in need of blood transfusion
 in OR 10 Sven Svensson, a male born 1947, personal ID 471112-2476
 in OR 11 Stina Svensson, a female born 1947, personal ID 471103-2464
- Nurse anesthetist in OR10 recieve a blood bag for her patient, assumes it is right since she has never got the wrong bag before, is in a hurry, reads name and ID (in hindsight too) fast, and misses that she has Stina Svensson's blood bag in her hands.





A blood transfusion case

- A busy Saturday at the OR ward
- Two surgeries at adjecent rooms
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 in OR 10 Sven Svensson, a male born 1947, personal ID 471112-5076
 in OR 11 Stina Svensson, a female born 1947, personal ID 471103-2464
- Nurse anesthetist in ORIO recieves a blood bag for her patient, assumes it is right since she has never got the wrong bag before, is in a hurry, reads name and ID (too) fast,

 Efficiency before thoroughness

and misses that she has Stina Svensson's blood bag in her hands





More examples?

Do you have any own examples of ETTO that you want to share?



Muddling through

and

Work-as-imagined vs. Work-as-done





Work-as-done

How the work is actually done, when the ideal meets the reality

- complexity
- adaptations
- trade-offs
- workarounds
- resources



Work-as-imagined There is a gap! Work-as-done

Work-as-imagined To reconcile Work-as-done

- This is reality
- Important to recognize and understand the gap
- Don't blame learn!
- Often to understand (and fix)
 preconditions for work



Any own examples?

Do you have any own examples of WAI vs WAD that you want to share?



A brief recap

Safety I & II
Resilience
Workarounds / ETTO
Work-as-done vs. Work-as-imagined



The Resilient Health Care Society www.rhcs.se







JÖNKÖPING UNIVERSITY



Bridge over troubled waters – Part 2. Do safety standard workarounds support resilience?





THIS Institute PhD Fellow

Supervisors: Professor Jane O'Hara, Professor Rebecca Lawton, Associate Professor Laura Sheard. Study funded by a The Healthcare Improvement Studies (THIS) Institute fellowship award.



Through taking part in this session you will...

- Have an insight into safety standard workarounds performed in different healthcare contexts.
- Explore what workarounds are achieving, for who, considering the circumstances when using a workaround might be more beneficial than following a standard.
- Gain an understanding of perspectives from different levels of the healthcare system on if and when workarounds contribute to resilient performance.
- Have an insight into if and how studying workarounds can be used to support future improvement efforts.

Defining safety standard workarounds.



'An adaptation, improvisation or change, to an existing work rule designed to promote safety, in order to overcome, or lessen the impact of obstacles that are perceived as preventing that work system or its actors from achieving a desired goal.'

(Based on Alter, 2014).

Multiple case study (Flyvbjerg, 2006; Stake, 1995).







Ultra adaptive







Elective Surgery



Emergency Department

How is the practice of IV medication administration enacted by registered nurses in different healthcare settings within an acute hospital in England?



Multiple case study findings.

A single task may be associated with multiple safety standard workarounds.

Some safety standard workarounds are common across all settings, others are not.

Some safety standard workarounds may be beneficial to patient safety in certain circumstances, others are not.

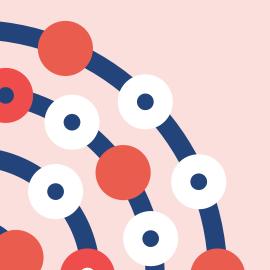








Tabletop discussions



Exemplar safety standard workarounds.



- 1. Who is the workaround helping?
- 2. When is the workaround helping?
- 3. Can the workaround be regarded as safe in some circumstances?

Highly reliable site – Double check omission.





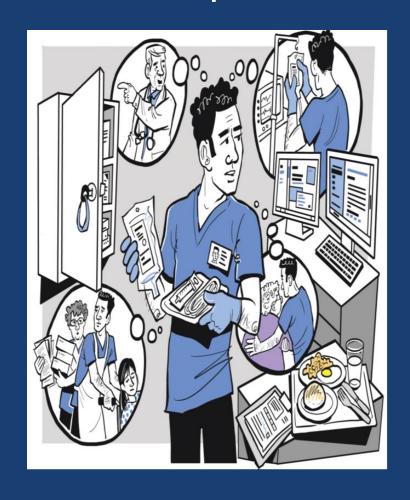


Ultra Safe site – Prescription adaptation.



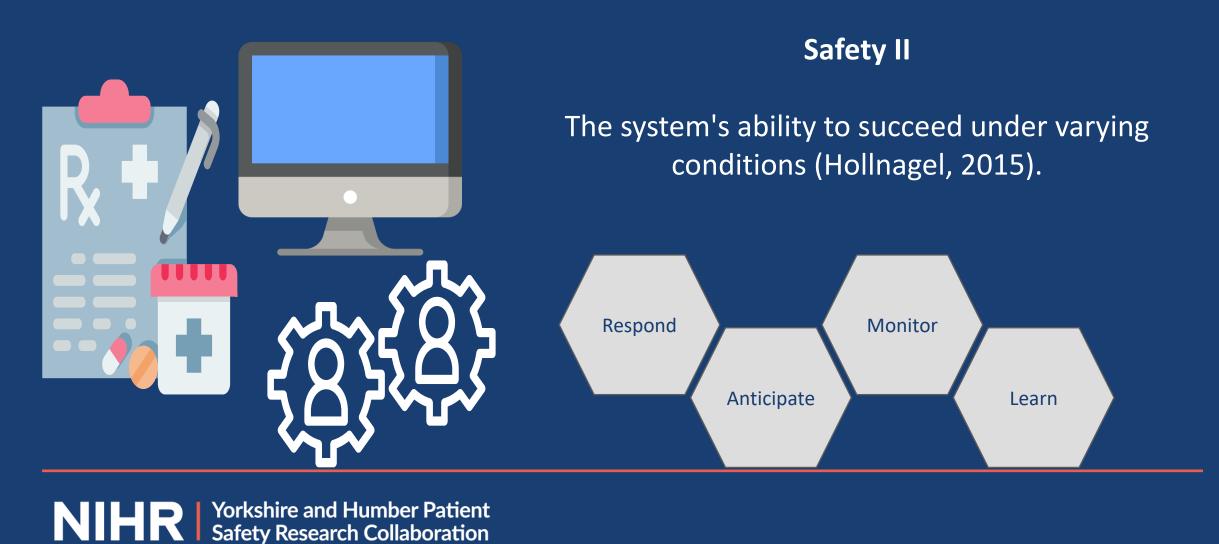


Ultra adaptive site – ePrescription system.





Are workarounds beneficial for safety in some circumstances? Do they support system resilience?



Online focus groups study (Daniels, 2019).





Workarounds are perceived to help...

- Patient(s)
- Nurse/ Team
- Organisation

You could make it safer, but you'd need to know what's really going on in the first place. P16 I think morally you want to do what's best for the patient in that moment. P12.

I think sometimes it's nerves you're worried and stressed yourself, thinking that patients gonna react. So I wanna be ultra prepared to be able to deal with it quickly. P2.

I have seen single person checks that have been done perfectly, absolutely spot on and considered safe. I've seen two person checks that have been shambolic and not actually achieve anything. P23.

Workarounds are useful when....

- Adherence to policy perceived to result in less effective care
- Working in challenging conditions
- Balancing risks

I understand that standards are required, but sometimes it's absolutely impossible.

And then when we don't follow those standards, people are reprimanded and that doesn't drive a good culture.

P16.

What's kind of what's morally right and what's policy right. P13.

It's about balancing risk. I would advise the nurses, doctors, AHPs, use your clinical knowledge and do what you think is right and the best thing for that patient at that time. P24.

Are workarounds safe in some circumstances?

- Culture
- Dynamic risk assessments
- Safe adaptation

It was a good outcome (using the workaround) because the alternative would have beenprobably terrible. P2.

I think you need to have a culture, again, I'm talking about culture, where it gives the nursing staff confidence to make those decisions.

P22.

Given the balance of risk, we have to say yes, it's safer for the patient if we deviate. P17.

That's not what the standards say, no, but you've got the patient in front of you and you're using your eyes and your ears and your clinical knowledge, and that takes precedent over the policy. P24.



How can workarounds be used to improve care?





Thank you for taking part.







SIRI WIIG

Center director, Professor of Quality and Safety in Healthcare Systems, University of Stavanger, Norway Honorary Professor, Australian Institute of Health Innovation, Macquarie University, Australia Honorary Professor, University of Wollongong, Australia

Adjunct Professor, Western Norway University of Applied Sciences, Norway

Testing the digital Resilience in Healthcare learning tool to translate safety II thinking and adaptive capacity into practice

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Cecilie Haraldseid-Driftland, Hilda Bø Lyng, Veslemøy Guise, Birte Fagerdal, Heidi Dombestein, Hilde Valen Wæhle, Eline Ree, Lene Schibevaag, Sina Øyri, Janet Anderson, Carl Macrae, Jeffrey Braithwaite, Karina Aase





Why resilience and adaptive capacity are crucial



RAPID CHANGES & INNOVATION



COMPLEXITY



EMERGING RISKS



PANDEMICS



RETHINKING CURRENT APPROACHES



The Resilience in Healthcare program (2018-2024)

BMJ Open Resilience in Healthcare (RiH): a longitudinal research programme protocol

Karina Aase 0 .1 Veslemøy Guise 0 .1 Stephen Billett. Stephen Johan Mikal Sollid, 1,3 Ove Nja, 4 Olav Røise 0, 1,5 Tanja Manser, 6 Janet E Anderson, 1,7 Siri Wiig1

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of what constitutes high quality in healthcare. Yet, much of this research has been conducted on individual elements and their specific challenges. Hence, goals other than understanding the complex of factors and elements that comprises quality in healthcare have been privileged. This lack of progress has led to the conclusion that existing approaches to research are not able to address the inheren complexity of healthcare systems as characterised by a significant degree of performance variability within and across system levels, and what makes them resilient. A shift is, therefore, necessary in such approaches. Resilience in Healthcare (RiH) adopts an approach comprising a comprehensive research programme that models the capacity of healthcare systems and stakeholders to adapt to changes, variations and/or disruptions: that is, resilience. As such, RiH offers a fresh approach capable of capturing and illuminating the complexity of healthcare and how high-quality care can be understood and advanced.

Introduction Over the past three decades, extensive

research has been undertaken to understand the elements

Methods and analysis Methodologically, to illuminate what constitutes quality in healthcare, it is necessary to go beyond single-site, case-based studies. Instead, there is a need to engage in multi-site, cross-national studies and engage in long-term multidisciplinary collaboration between national and international researchers interacting with multiple healthcare stakeholders. By adopting such processes, multiple partners and a multidisciplinary orientation, the 5-year RiH research programme aims to confront these challenges and accelerate current understandings about and approaches to researching healthcare quality.

The RiH research programme adopts a longitudinal collaborative interactive design to capture and illuminate resilience as part of healthcare quality in different healthcare settings in Norway and in five other countries It combines a meta-analysis of detailed empirical research in Norway with cross-country comparison from Australia Japan, Netherlands, Switzerland and the LIK. Through establishing an RiH framework, the programme will identify processes with outcomes that aim to capture how high-quality healthcare provisions are achieved. A collaborative learning framework centred on engagement aims to systematically translate research findings into practice through co-construction processes with partners

Strengths and limitations of this study

- Moving beyond the individual case study approach and taking a longitudinal multilevel, cross-case an proach to explore the complexities of resilient ca-
- The 5-year longitudinal research programme offer ing an integration of resilience theory, collaborative learning as well as patient and stakeholder involve ment (PSI) is enacted through a multidisciplinary
- healthcare settings in one country, with crosscountry comparison of resilient capacities in six of er countries as a basis for meta-analysis.
- A potential limitation is that the programme duration of 5 years may not be sufficient to demonstrate how lient capacities can improve healthcare quality

Ethics and dissemination The RiH research programme is approved by the Norwegian Centre for Research Data (No. 864334). The empirical projects selected for inclusion in this longitudinal research programme have been approved by the Norwegian Centre for Research Data or the Regional Committees for Medical and Health Research Ethics. The RiH research programme has an embedded publication and dissemination strategy focusing on the progressive sharing of scientific knowledge, information and results, and on engaging with the public, including relevant patient and stakeholder representatives The findings will be disseminated through scientific articles. PhD dissertations, presentations at national and international conferences, and through social media, newsletters and the popular media

Resilience in healthcare

Resilience in healthcare (RiH) is central to what constitutes quality in healthcare provi sion. Defined by the proactive capacity tha organisations, units, teams and individual enact to adapt to changes and potential chal lenges in everyday practices, rather than to



The primary objective: to reform the understanding of quality in healthcare by the development, implementation, and test of a theoretical and practical RiH framework

> BMJ Open Developing a collaborative learning framework for resilience in healthcare: a study protocol

> > Cecilie Haraldseid-Driftland 0, 1 Karina Aase 0, 1 Siri Wiig 0, 1 Stephen Billett

continuously through everyday work in the healthcare ystems as professionals engaging in clinical work, and iteracting with other coworkers, patients and stakeholi

meaning occa adaptations in respond to needs. Method and analysis. The study applies a mixed methods design in a two-phased approach to explore and develop the relationship between collaborative learning and resilience. *hase One is exploratory using literature review, meta--antificials independent and fire propers and dis-

care system that allow it to maintain the delivery of high-quality care during and after activities

events that challenge, change or disrupt its activities, 'ranging from high impact situation such as dealing with a pandemic, to everyday in practice requirements and develop

BMJ Open Multilevel influences on resilient healthcare in six countries: an international comparative study protocol

Janet E Anderson, ^{1,8} Karina Aase , ⁹ Roland Bal, ⁹ Mathilde Bourrier, ⁴ Jeffrey Braithwaite , ⁹ Kazue Nakajima, ⁶ Siri Wiig, ⁹ Vesterney Guise , ⁹

BMJ Open Patient and stakeholder involvement in resilient healthcare: an interactive research study protocol

Vesiernøy Guise 🥯 ,1 Karina Aase 🥹 ,1 Mary Chambers,2 Carolyn Canfield,3

ortificate to resilience across all levels of the healthcar determine and distances that your story dipplies as determine design in a low-plane of proposal to explane and conceptuation patient and obtainables revolutioned in realizer freethname. Story phase 1 is explanable and will use anything phase 1 is explanable market and will use anything the control prospe. Shory press 2 will use a participative design agreement of develop, that and revolutile a conceptual model for patient

ABSTRACT Introduction in FreeBocare (Bill) is understood as the capacity of the healthcare septions to adapt to challenges and changes of different applies invests, to materials reply—applied care. Adaptive capacity in textucine in the scowedge, solids and experiences of the people in the applies, and adaptive, and adaptive, and adaptive, and adaptive.

uncertainties and highly dynamic condition

Resilience in healthcare (Bill) is funds, underwood as a dynamic set of internal (Resilience in healthcare (EEE) in funda-mental or understanding qualite in brach complete and the electronical and extractalled quality in brach complete and electronical and contract and contract and the electronic and t

Resilient healthcare principles

- Complex system requires to anticipate problems, adapt, and prioritise competing demands
- 2. Procedures are not always helpful they cannot anticipate all interactions
- 3. Adapting safely to pressures keeps the system functioning -> improvement efforts should focus on strengthening this capacity



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Defining adaptive capacity in healthcare: A new framework for researching resilient performance

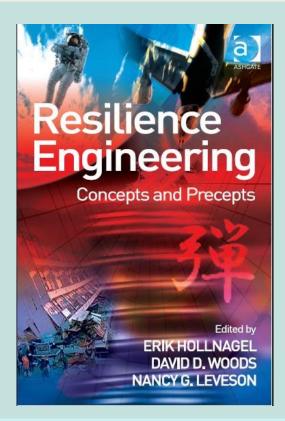


J.E. Anderson a,*, A.J. Ross b, C. Macrae c, S. Wiig d

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Resilience and adaptive capacity



Wiig et al. BMC Health Services Research (2020) 20:330 https://doi.org/10.1186/s12913-020-05224-3

BMC Health Services Research

DEBATE

Open Access

Defining the boundaries and operational concepts of resilience in the resilience in healthcare research program



Siri Wiig¹, Karina Aase¹, Stephen Billett², Carolyn Canfield³, Olav Røise^{1,45}, Ove Njå⁶, Veslemøy Guise¹, Cecilie Haraldseid-Driftland¹, Eline Ree^{1*}, Janet E. Anderson^{1,7}, Carl Macrae^{1,8} and on behalf of the RiH-team

Abstract

Background: Understanding the resilience of healthcare is critically important. A resilient healthcare system might be expected to consistently deliver high quality care, withstand disruptive events and continually adapt, learn and improve. However, there are many different theories, models and definitions of resilience and most are contested and debated in the literature. Clear and unambiguous conceptual definitions are important for both theoretical and practical considerations of any phenomenon, and resilience is no exception. A large international research programme on Resilience in Healthcare (BiT) is seeking to address these issues in a 5-year study across Norway, England, the Netherlands, Australia, Japan, and Switzerland (2018–2023). The aims of this debate paper are: 1) to identify and select core operational concepts of resilience from the literature in order to consider their contributions, implications, and boundaries for researching resilience in healthcare, and 2) to propose a working definition of healthcare resilience that underprise the international RH research programme.

Main text: To fulfil these aims, first an overview of three core perspectives or metaphors that underpin theories of resilience are introduced from ecology, engineering and psychology. Second, we present a brief overview of key definitions and approaches to resilience applicable in healthcare. We position our research program with collaborative learning and user involvement as vital prerequisite pillars in our conceptualisation and operationalisation of resilience for maintaining quality of healthcare services. Third, our analysis addresses four core questions that studies of resilience in healthcare need to consider when defining and operationalising resilience. These are: resilience for what', to what', of what', and 'through what? Finally, we present our operational definition of resilience.

Conclusion: The RiH research program is exploring resilience as a multi-level phenomenon and considers adaptive capacity to change as a foundation for high qualify care. We, therefore, define healthcare resilience as: the capacity to adapt to challenges and changes at different system levels, to maintain high quality care. This working definition of resilience is intended to be comprehensible and applicable regardless of the level of analysis or type of system component under investication.

Keywords: Resilience, Healthcare, Adaptive capacity, Change, System perspective, Multi-level approach, Conceptualization

Resilience:

 Resilience is defined as the capacity to adapt to challenges and changes at different system levels, to maintain high quality care

(Wiig et al 2020)

 Capacity to adapt to changes is fundamental for quality of care



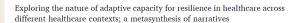




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Hilda Bø Lyng ^{a, *}, Carl Macrae ^{a,b}, Veslemøy Guise ^a, Cecilie Haraldseid-Driftland ^a, Birte Fagerdal ^a, Lene Schibevaag ^a, Janne Gro Alsvik ^a, Siri Wiig ^a

Capacities for Resilient Healthcare

RESEARCH

Balancing adaptation and innovation for resilience in healthcare – a metasynthesis of narratives

Hilda Bø Lyng¹*, Carl Macrae¹², Veslemøy Guise¹, Cecilie Haraldseid-Driftland¹, Birte Fagerdal¹, Lene Janne Gro Alsvik¹ and Siri Wiig¹

RESEARCH

Open Acces

Capacities for resilience in healthcare; a qualitative study across different healthcare contexts

Hilda Bø Lyng^{1*}, Carl Macrae^{1,2}, Veslemøy Guise¹, Cecilie Haraldseid-Driftland¹, Birte Fagerdal¹, Lene Schibevaag¹ and Siri Wilg¹









resilient healthcare: an interaresearch study protocol

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ABSTRACT

Introduction Resilience in healthcare (RiH) is understood as the capacity of the healthcare system to adapt to challenges and changes at different system levels, to maintain high-quality care. Adaptive capacity is founded in the knowledge, skills and experiences of the people in the system, including patients, family or next of kin, healthcare providers, managers and regulators. In order to learn from and support useful adaptations, research is needed to better understand adaptive capacity and the nature and context of adaptations. This includes research on the actors involved in creating resilient healthcare, and how and in what circumstances different groups of patients and other key healthcare stakeholders enact adaptations that contribute to resilience across all levels of the healthcare

Methods and analysis This 5-year study applies an interactive design in a two-phased approach to explore and conceptualise patient and stakeholder involvement in resilient healthcare. Study phase 1 is exploratory

Strengths and limitations of this study

- This study will contribute to a limited yet growin body of knowledge of patient and stakeholder involvement (PSI) in resilience in healthcare (RiH).
- This study will translate system-wide concepts of resilience into practice by developing and testing a conceptual model for PSI in RiH.
- This study adopts a participatory approach to the development and test of a conceptual model for PSI in RiH, involving stakeholders from a variety of healthcare contexts across all levels of the healthcare contexts.
- This study features a broad approach to healthcare stakeholders which include patients and family carers, as well as providers, managers and regulators of healthcare services.
- ➤ The 5-year project period may restrict opportunities for documenting long-term outcomes of the imple-

Understanding patient and stakeholders' role in resilience

BMC Health Services Research

RESEARCH

Open Access

Identifying, categorizing, and mapping actors involved in resilience in healthcare: a qualitative stakeholder analysis



Veslemøy Guise^{1*}, Mary Chambers², Hilda Bø Lyng¹, Cecilie Haraldseid-Driftland¹, Lene Schibevaag¹, Birte Fagerdal¹, Heidi Dombestein¹, Eline Ree¹ and Siri Wiiq¹



Understanding collaborative learning in resilience



RESEARCH ARTICLE

Open Access

The role of collaborative learning in resilience in healthcare—a thematic qualitative meta-synthesis of resilience narratives



Cecilie Haraldseid-Driftland^{1*}, Stephen Billett², Veslemøy Guise¹, Lene Schibevaag¹, Janne Gro Alsvik¹, Birte Fagerdal¹, Hilda Bø Lyng¹ and Siri Wiig¹





Understanding resilience in teams and role of leaders



RESEARCH

Open Access

Exploring the role of leaders in enabling adaptive capacity in hospital teams – a multiple case study

Birte Fagerdal^{1,24}, Hilda Bø Lyng¹, Veslemøy Guise¹, Janet E. Anderson³, Petter Lave Thornam⁴ and Siri Wiig¹



rih.uis.no/







Test the <u>Resilience in Healthcare</u> – A digital learning tool for practice



Resilience in Healthcare

Welcome to the Resilience in Healthcare reflection tool - learning from what goes well





Select one of the elements below. We recommend that you start with mapping.



Mapping

Here, you are asked to score your team/unit on three statements for each of the 10 different resilience capacities, in order to map your current status of own team/units' resilience capacity.

Go to mapping



Scenario

Here, you will get an overview of all the learning scenarios. You can use these to consider one or more resilience capacities in depth.

Go to scenarios



Resilience reflection list

Here, you will find a simple overview of how you can reflect on the team/unit's capacity for resilience by reflecting on situations in everyday life.

Go to resilience reflection list







Mapping

Aim:

Awareness of areas of own team/units' capacity for resilience













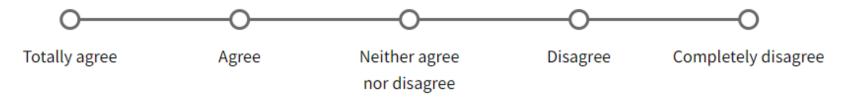




Mapping

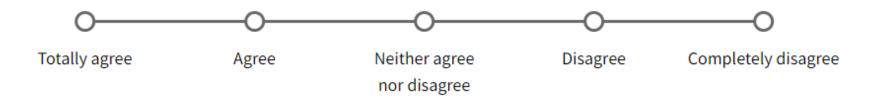
Question 1:

We are good at collecting information from various sources and using it to anticipate and prevent adverse situations from arising.



Question 2:

We are keen to have an open discussion about risk across different professions, in order to shed light on a situation from different points of view and find out how to handle various situations. (For example, discussion between a doctor and nurse about a patient's assessment and why it has been assessed in that particular way.)



Question 3:

We use clear and precise language with objective information (such as BP/pulse/other measurements) to communicate potential hazards well across professions.



Test in groups 1

- 1. Open the tool
- 2. Select one or two capacities (leadership or risk awareness)
- Discuss in groups the statements and try to respond
- 4. Reflect on how you could use this in your organisation or unit



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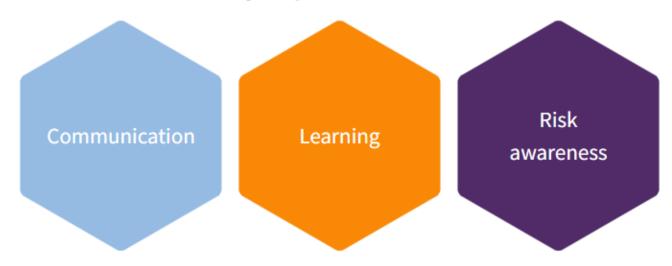




Result

These are the three capacities that you excel at. Click on 'See scenario' to get suggestions for the scenarios you can work on further to become aware of what you are good at and why. You will now continue working on the indicators that you perform well on.

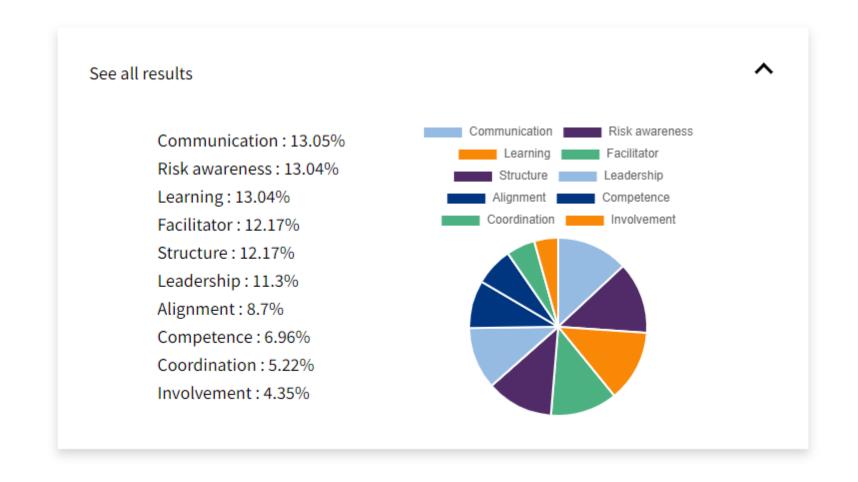
Here you perform the best:













Scenario

Aim:

Understand what your team does that provides positive outcomes





Scenario



Structure 1

Access to resources and task management

Lack of resources in the department and ambiguities around the distribution of tasks

See scenario



Structure 2

Newly employed staff

Newly employed staff who has challenges settling in

See scenario



Structure 3

Medication administration

Busy work day, challenges with medication administration

See scenario



Learning 1

Simulation at the workplace

Facilitating learning situations at work



Learning 2

Training and skill development

Example of how the management facilitates skills development at the



Learning 3

Patient admission

Newly admitted patient



Test in groups 2

- 1. Go to the scenario part
- 2. Select leadership
- 3. See scenario: Leadership 1
- Discuss in groups the questions for reflection
- 5. Reflect on how you could use this in your organisation or unit



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RiH (uis.no)



Questions for reflection

- 1. How does management ensure professional development among staff, even when there is a shortage of resources?
- 2. What measures are taken to increase staff commitment and motivation in their work?





Resilience reflection list

Here you will find three questions that could help you perform a resilience reflection. The questions are a tool that can be used in everyday work, for example after completing a task, before or after a handover, or any another occasion where you come together and talk to your co-workers. The resilience reflection list consists of 3 simple questions to help you reflect on what went well and why. One of the questions asks you to discuss how the different capacities of resilience contributed to the success of the situation. This is to help you to describe and justify why things went well, so that you can better understand what it is that contributes to better outcomes - and in turn learn from this and transfer it to other situations.

Resilience reflection

- What went well and why?
- 2. How did the different capacities of resilience contribute?
 - 3. What did you learn and how can it be applied further?

Download the resilience reflection list





Here you will find concrete tips on how to strengthen resilience



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Resilience in Healthcare

Resilince reflection tool:

- 1. What went well and why?
- 2. How did the different resilience capacities contribute?
- 3. What did you learn and how can his be **applied** to other areas?

Here you will find concrete tips on how to strengthen resilience



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Professor Catherine Calderwood

Professor of Health Futures, University of Strathclyde, Glasgow

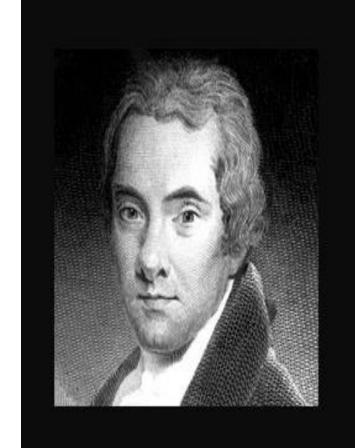
Consultant Obstetrician NHS Lothian, Edinburgh

Former Chief Medical Officer for Scotland









You may choose to look the other way but you can never say again that you did not know.

~ William Wilberforce





NHS maternity scandal: police investigate 600 further cases

Report condemns staff failures that may have led to 201 baby deaths

Andrew Gregory

Police are examining 600 cases linked to the biggest maternity scandal in into baby deaths condemned health staff for blaming mothers while ignor-

The independent inquiry into incidents of cerebral palsy. maternity practices at Shrews-

uncovered hundreds of cases in which years after her daughter Kate died in health officials had failed to undertake serious incident investigations, while deaths were dismissed or not the families. investigated appropriately.

Instead, grieving families were denied access to reviews of their care and mothers were blamed when their babies died or suffered horrific

A total of 201 babies and nine NHS history after a damning report survived if the NHS trust had pro-

vided better care, the inquiry found. ing their own catastrophic blunders. suffered severe brain injuries and 65 suffered so gravely, I am sorry."

2009, said the numbers did "not tell the whole story" of the impact on

Sajid Javid, the health secretary, issued a Commons apology yesterday, telling MPs: "We entrust the NHS with our care, often when we're at our DCS Damian Barratt most vulnerable. In return we expect the highest standards.

mothers could have or would have met, we must act firmly and the fail-active police investigation, Operation ures of care and compassion set out Lincoln, which is looking at around in this report have absolutely no place 600 cases," he said. There were 29 cases where babies in the NHS. To the families that have

Rhiannon Davies, one of the NHS staffresponsible for the "serious" "very much active" and added: "We bury and Telford hospital NHS trust mothers who fought for justice for and repeated failures" would be will be fully reviewing the findings

The families live with unimaginable trauma and grief

West Mercia police

"When those standards are not held to account. "There is also an

Detective Chief Superintendent Damian Barratt, of West Mercia Javid offered reassurances that police, said the investigation was

of the report and feeding appropriate elements into our investigation.

"We do not underestimate the impact the report's findings and our ongoing investigation has on the families involved, who have suffered unimaginable trauma and grief that they still live with today."

A combination of an obsession with "natural births" over caesarean sections coupled with a shocking lack of staff, training and oversight of maternity wards resulted in a toxic culture in which mothers and babies died needlessly for 20 years while "repeated failures" were ignored

Julie Rowlings, whose daughter Olivia died



The lights are off. But Ukraine's rail lifeline brings hope

Shaun Walker

shuttered and lights dimmed. a darkened train pulls into a station platform, also unlit. As the train comes to a halt, attendants toss boxes of humanitarian aid to station workers on the platform.

Huddles of passengers, who arrived at the station hours earlier so as not to be on the streets during curfew hours, search in the inky blackness for the right carriage, before the train is on its way again with a gnashing of wheels and a long hiss of steam.

This scene has played out at stations across Ukraine repeatedly over the last month, as Ukrainian Railways has been engaged in on of the most impressive



▲ Evacuees on the train for the two-day journey from Kryvyi Rih in eastern Ukraine to Chop, close to the western border with Slovakia PHOTOGRAPH: HELLE KRING:

Labour giant Frank Field has quit because the party he's given his life to is mired in anti-Semitism. What are his fellow MPs waiting for?

COMMENT SEE PAGE 16



FRIDAY, AUGUST 31, 2018

www.dailymail.co.uk



MORE than 60 babies and mothers are feared to have died or suffered devastating

harm at a maternity unit.

An investigation began last January into 23 suspicious incidents at the Shrewsbury and Telford hospital trust.

But the Mull can reveal that this number has almost trebled to at least 63.

The vast majority of the cases involve the deaths of babies and mothers during child-

REVEALED: Probe finds 60 babies

and mothers have died or suffered

serious harm at ONE hospital trustthree times more than first thought



Why Bruce Willis quitting acting ■

Deborah Ross

Childbirth 'is not safe for women in England'

Mothers and bubies died avoidably in NHS scandal

Health Correspondent

Mismes in England are not sale in children's until the recommendations of a report on the NTO's worst maker and scandal are expleniented in full, its

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Abote Streem, a Tary MP, told the Commons probable that the had had Sand head, the health wanters, said





Putin faces revolt over blunders in Ukraine

Larks Srpen Celercy Editor

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Prevident Patts Gern a general mobility suscensificative like presental surf in Ukraine in his salisant let his him shout the cumpaging fadhem, a his howest Plenning, the develor of GC1002, will sestion have the famous leade has "annual-de mispagings" the capabilities of his welders, the results of the Ukrainian people and the drampful of the Wirel's requires to his session.

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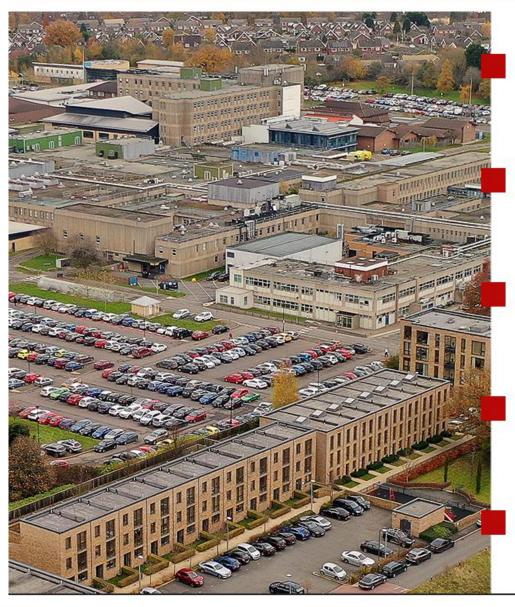


£10/4

Posh & David home as thief prowls upstairs

106

The Ockenden report findings



Examined almost 1,600 cases spanning 20 years

201 deaths where concerns over care found

131 stillbirths and **70 neonatal deaths** affected

Also **29 cases** where babies suffered severe **brain injuries**

And 65 incidents of cerebral palsy





Scandal of the 'Musketeer' midwives: Five staff who triggered baby deaths scandal at NHS hospital to finally face justice after being allowed to keep working there for seven years

The problems within the Trust fell into five problem areas, which resulted in the service being described as seriously dysfunctional. These were:

- 1.Clinical competence of a proportion of staff fell significantly below the standard required for a safe, effective service
- 2. Working relationships between different groups of staff were extremely poor
- 3. Midwifery care in the unit became strongly influenced by a small number of dominant individuals
- 4. Advice to mothers that it was appropriate to consider delivery at FGH was significantly compromised by a failure to assess the risks properly 5. A grossly deficient response from unit clinicians to serious incidents with repeated failure to investigate properly and learn lessons

Issues identified in numerous reports

Standards and guidelines

Communication

Extension of roles beyond training

Tolerance of exception

Unacceptable becomes acceptable

Lack of care and compassion

My challenge to you

Can you see anything of what I have discussed in your organisation?

What is the culture – what do you feel?

How will you describe what you do to your family and friends?

"Do not wait for leaders; do it alone, person to person"

~Mother Teresa

