Safety for all: patient and healthcare worker safety – two sides of the same coin

This editorial reviews the Safety for All campaign, which is calling for improvements in, and between, patient and healthcare worker safety to prevent safety incidents and deliver better outcomes for all.

Paul Grime[1,2]

Author details can be found at the end of this article

Correspondence to:
Paul Grime;
paul.grime@nhs.net

Introduction

The NHS and social care systems in the UK have been placed under serious strain from the ongoing effects of the COVID-19 pandemic. Acute and intensive care facilities struggled to manage the sharp rise in demand and hospitals were, and many still are, stretched to capacity (Scobie, 2021).

In 2020, the Safer Healthcare and Biosafety Network, an independent forum focused on improving healthcare worker and patient safety, launched a campaign called 'Safety for All' to improve practice in, and between, patient and healthcare worker safety to prevent safety incidents and deliver better outcomes for all (https://shbn.org.uk/safety-for-all/). The Safety for All white paper, *Patient and Healthcare Worker Safety – Two sides of the same coin* (Safer Healthcare Biosafety Network, 2021), sets out the symbiotic relationship between healthcare worker safety and patient safety.

The scale of the issue

Published in 2019, the NHS Patient Safety Strategy stated that around 11 000 lives a year are lost as a result of safety concerns, with older patients the most affected (NHS England and NHS Improvement, 2019). The unnecessary cost of human life, paired with the financial cost of at least £1 billion for extra treatment following patient safety incidents, highlights the scale of the problem we are facing. Healthcare workers also have some of the highest rates of occupational illness and injury, so it is vital that support for them is improved by ensuring safe staffing levels and support for workers following patient safety incidents.

Physical issues facing healthcare workers range from sharps injuries, slips, trips and falls, exposure to body fluids and hazardous substances, such as radiation or drugs which cause cancer, to violence. Associated psychological issues include burnout and stress from long working hours, work intensity and stigma in the wider community, as well as trauma from harassment or violence from patients, upset family members or the wider public. It is crucial that healthcare workers feel safe to speak up when experiencing any of the aforementioned issues or following a safety incident and that, when they do, their concerns are treated seriously. The Safety for All campaign argues that this support will help to create conditions of psychological safety and foster an environment of openness, benefiting the safety of healthcare workers in the long term and having a positive impact on patient safety.

Time for action

It is crucial that, in response to medical accidents or adverse events, patients affected receive the justice they deserve, but also that healthcare workers are not blamed or marginalised. A blame culture does not benefit workers or patients and allows systemic healthcare issues to be explained away as individual errors. The Just Culture Guide, produced by NHS England and Resolution, supports a conversation between managers about whether a staff member involved in a patient safety incident requires specific individual support or intervention to work safely (NHS England and NHS Improvement, 2018), but this must then lead to identification of the cause and implementation of a solution.

How to cite this article:
Grime P. Safety for all: patient and healthcare worker safety – two sides of the same coin. Br J Hosp Med. 2021. https://doi.org/10.12968/hmed.2021.0606

Staff must feel safe and encouraged when speaking up about systemic safety issues that have an impact on them. One method of achieving this is Schwartz rounds, which are group reflective practice forums that give staff from all disciplines an opportunity to reflect on the emotional and social aspects of working in healthcare (General Medical Council, 2019). Schwartz rounds have been running in numerous NHS trusts for years after first being trialled by the King's Fund in 2009.

All staff are obliged to respond to safety incidents, but the type of safety culture is shaped and maintained by the leadership in any organisation, and this is no different in healthcare. If workers of any grade or seniority are stigmatised or marginalised because they have reported something, the culture of safety will not be regarded as legitimate or valued, lessons learned will not be shared and safety will not be improved within the organisation. Failure to learn from different groups or workplaces means that an organisation is not able to improve and deliver safety for all.

Healthcare is a particularly complex system which relies heavily on human interventions, the performance and behaviour of which changes over time and cannot be completely understood by simply knowing about the individual components (Braithwaite, 2018). So, for safety improvements and effective behavioural change to occur, it is necessary to introduce controls which are evidence based and take into account the unique organisational culture in healthcare.

The government, agencies like NHS Improvement and regulators like the Care Quality Commission and the Health and Safety Executive need to encourage systemic and cultural change on safety for both patients and staff in health and social care. Leadership from chief executives and clinicians that is accountable, incentivised and committed to a stronger and mutually beneficial safety culture for both staff and patients will deliver better outcomes, and provide improved resources for staff.

Organisational health and safety standards, which need to be developed at the national level in patient safety and aligned with existing workplace health and safety standards in the NHS, can help with benchmarking and assessment and also promote safety accreditation of health and social care facilities. Applying a hierarchy of control approach to safety is a useful tool for improving safety interventions in healthcare for both staff and patients. Cultural change needs to be led from the top down, by politicians, senior executives and clinicians within the NHS and social care system.

Recommendations and actions

The key recommendations of the white paper and the campaign can be summarised as follows:

- Improved understanding of and advocacy for the mutual benefits to be accrued for patient safety by improving healthcare worker safety, and vice versa, as well as acknowledging the common risks, factors and interventions across patient and healthcare worker safety
- The application of shared learning and best practice for workplace and patient safety and, where appropriate, aligned or integrated synergistic solutions in safety systems, standards, governance and preventive measures
- Resources, leadership and staff committed to a stronger, reciprocal patient and workplace safety culture, with safety a priority for both, underpinned by better education and training
- Greater support for staff to encourage them to speak up following patient safety incidents, including a safety care pathway for both patients and staff, and to ingrain a just culture
- Improved risk management and reporting of safety incidents, learning and communication across patient and healthcare worker safety.

The Safety for All campaign is preparing a 'how to' manual to support staff after a serious safety incident to inform best practice and to ensure there is a safety care pathway for both staff and patients. It is also planning to prepare a culture change delivery toolkit and guidance on common workplace safety standards and compliance.

Conclusions

The size and complexity of the health and social care system makes implementing any long-term structural and behavioural change challenging. However, the scale of avoidable

Key points

- Patient safety and healthcare worker safety are synergistic, symbiotic and interrelated – they are two sides of the same coin.
- Change needs to be incremental and systemic, but to work effectively it must be both bottom up and top down.
- The campaign is calling for the systemic improvement of practice at the frontline level of safety systems, standards and governance, and preventive measures at the national political, legal or regulatory level.

cases of patient harm and deaths, and the impact of safety incidents on healthcare workers is so great, in terms of human as well as financial costs, that doing nothing is not an option.

The government must prioritise the improvement of both patient and healthcare worker safety, as the two have an interdependent and mutually beneficial relationship. Improved understanding and advocacy for the mutual benefits of patient safety by improving workplace safety, and vice versa, will reduce and prevent safety incidents for patients and staff and deliver better outcomes for all.

Author details

[1]Occupational Health Service, Guys and St Thomas' NHS Foundation Trust, London, UK

[2]Chairman, Safer Healthcare Biosafety Network, London, UK

References

Braithwaite J. Changing how we think about healthcare improvement. BMJ. 2018;361:k2014. https://doi.org/10.1136/bmj.k2014

General Medical Council. Schwartz rounds. 2019. https://www.gmc-uk.org/education/standards-guidance-and-curricula/guidance/reflective-practice/schwartz-rounds (accessed 19 November 2021)

NHS England and NHS Improvement. A just culture guide: supporting consistent, constructive and fair evaluation of the actions of staff involved in patient safety incidents. 2018. https://www.england.nhs.uk/wp-content/uploads/2021/02/NHS_0932_JC_Poster_A3.pdf (accessed 6 November 2021)

NHS England and NHS Improvement. The NHS patient safety strategy. 2019. https://www.england.nhs.uk/wp-content/uploads/2020/08/190708_Patient_Safety_Strategy_for_website_v4.pdf (accessed 7 November 2021)

Safer Healthcare Biosafety Network. Safety for All. 2021. https://shbn.org.uk/wp-content/uploads/2021/10/Safety-for-All-White-Paper-FINAL.pdf (accessed 25 November 2021)

Scobie S. What has been the impact of COVID-19 across the UK countries? 2021. https://www.nuffieldtrust.org.uk/news-item/what-has-been-the-impact-of-covid-19-across-the-uk-countries (accessed 19 November 2021)