An adaptation of the Manchester Patient Safety Framework (MaPSaF)

Increasing Maturity

Domain	A	B	C	D	E
1 Commitment to overall continuous improvement	No resources are invested in the identification of problems or areas of good practice. If any auditing occurs it lacks structure and there is no response to what is discovered. Whatever protocols or policies exist are there to meet statutory requirements and are not used, reviewed or updated. Poor quality care is tolerated or ignored. This attitude is evident at Board level and throughout individual healthcare teams.	A continuous improvement framework is developed in response to specific directives or an imminent 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 to any audit findings. The bare minimum of protocols and policies exist and these tend to be out-of-date and unused unless an incident occurs that triggers their review. Development of new protocols and policies occurs in response to incidents and complaints.	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 with organisational or ward needs. Staff are overloaded with protocols and policies (which are regularly reviewed and updated) that are rarely implemented. 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 for continuous improvement. It is recognised that continuous improvement is everyone's responsibility and that the whole ward / organisation, including patients and the public need to be involved. The aim is to be a centre of excellence and compare performance against that of others. Clinicians are involved in, and have ownership of, the auditing process which leads to continuous improvement. Protocols and policies are developed and reviewed by staff and are used as the basis for care and service provision. Patients and the public are formally involved in internal decisions – making it a patient centred service.	A culture of continuous improvement is embedded and is integral to decision making at all levels. The ward / organisation is a centre of excellence, continually assessing and comparing its performance against others both within and outside the health service. Teams design and conduct their own outcome focused audit programme, in collaboration with patients and the public. Staff are alert to potential safety risks. This means that over time the need for protocols and policies is reduced as evidence-based practice is second nature and patient safety is constantly on everyone's mind. Patients and the public are involved in a routine, meaningful way with ongoing contribution and feedback.
2 Priority given to safety	A low priority is given to safety. There are some risk management systems in place, such as strategies and committees, but nothing is actually delivered. The ward / organisation is unaware of their risks, believing that if a patient safety incident occurs, insurance schemes can be used to bail them out.	Safety becomes a priority once an incident occurs, but the rest of the time only lip service is paid to the issue apart from meeting legal requirements. There is little evidence of any implementation of a risk management strategy. Safety is only discussed by the Board in relation to specific incidents. Any measures that are taken are aimed at self-protection and not patient protection. In order to meet financial constraints or government set targets, risks are taken.	Safety has a fairly high priority and there are numerous systems (including those integrating the patient perspective) in place to protect it. However, these systems are not widely disseminated to staff or reviewed. They also tend to lack the flexibility to respond to unforeseen events and fail to capture the complexity of the issues involved. Responsibility for risk management is invested in a single individual who does not integrate it within the wider organisation. It is an imposed culture.	Safety is promoted and staff are actively involved in all safety issues and processes. Patients, the public and other organisations are also involved in risk management systems and their review. Measures taken are aimed at patient protection and not self-protection. Risks are proactively identified, using prospective risk assessments, and action is taken to manage them. There are clear accountability lines and while one individual takes the lead for patient safety in the organisation, it is a key part of all managers' roles.	Safety is the top priority, and responsibility for safety is seen as part of everyone's role including patients and the public. Staff constantly assess risks and look for potential improvements. Patient safety is a high profile issue and is embedded in the activities of all staff, from the Board/senior managers through to healthcare teams who have day-to-day contact with patients, including support staff. Patient involvement in, and review of, patient safety issues is well established.
3 Recording, evaluating and learning from incidents and best practice	Ad hoc incident reporting systems are in place but largely there is 'blissful ignorance' unless serious incidents occur or solicitors' letters are received. There is a high blame culture, with individuals subjected to victimisation and disciplinary action. Incidents and complaints are superficially investigated with the aim of 'closing the book'. Information from investigations is stored but little action is taken, apart from disciplinary action. There is little recognition of good safe practice. No attempts are made to learn from incidents unless imposed by external bodies such as public enquiries. Change is only directed at those individuals involved in an incident.	There is an embryonic incident reporting system, although staff are not encouraged to report incidents. Minimal data on the incidents is collected but not analysed. There is a blame culture, so staff are reluctant to report incidents. There is no attempt to support those involved. Investigations are cursory and focus on a specific event and the actions of an individual. Quick-fix solutions are proposed, but may not be instigated once the 'heat is off'. Little, if any, learning occurs. All learning is specific to the particular incident. Any changes instigated are not sustainable as they are knee-jerk reactions to perceived individual errors. Change is devised and imposed by senior managers. Similar incidents tend to recur.	A centralised anonymous reporting system is in place with emphasis on form completion. Staff and patients are encouraged to report incidents and near misses, although they do not feel safe or comfortable doing so. Other information is considered alongside incident reports (e.g. complaints and audits). Senior managers are involved in investigations, which focus on the individuals and systems surrounding the incident. Investigations involve multiple forms – they are conducted for their own sake and to placate patients rather than to examine root causes and support those involved. Some systems facilitate learning but it is not disseminated. Enforced local changes relating directly to specific incidents are made. Committees / managers decide on changes and a lack of staff involvement means they are not integrated. Patients and public are only involved to prove commitment to regulators.	Incident reporting is encouraged. Accessible, 'staff and patient friendly' reporting methods are used, allowing trends to be readily examined. Staff feel safe reporting incidents, including those that were prevented. Staff and patients are supported from the moment of reporting. The ward / organisation is open to inquiry and welcomes external involvement to gain an independent perspective. Staff are involved in investigations to identify root causes and issues. Patients are also involved. The aim is to learn from incidents and disseminate the findings widely. Data from incident reports are used to analyse trends, identify 'hot spots' and examine training implications. There is a learning culture and processes exist to share learning, e.g. reflection and sharing patient perceptions. Management support investigations and changes instigated address underlying causes. Staff are actively involved and there is a real commitment to sustainable change and learning from others' experience.	It is second nature for staff to report patient safety incidents (including those prevented or with no harm). They have confidence in the investigation process and understand its value. Patients are actively encouraged to report incidents. Robust systems exist to record best practice and compliments. Internal and external independent investigations are conducted that include the staff and patients involved. Investigations are learning opportunities and include patient recommendations. The ward / organisation learns from internal and external information, experience and best practice. It is committed to sharing this learning both within and outside the organisation. Patient safety incidents are discussed openly and staff are empowered to contribute. Improvements occur without the trigger of an incident. Patients play a key role in learning and they contribute to change.
4 Communication about safety issues	Communication in general is poor; it comes from the top down and staff are not able to speak to their managers about risk. Events are kept in-house and not talked about. The ward / organisation is essentially closed. What communication there is, is negative, with a focus on blame. Patients are only given information which must be legally provided and only after exerting a lot of pressure to give them access.	Communication in general is directive with managers issuing instructions. Staff are only able to speak to their managers after something has gone wrong. Communication is ad hoc and restricted to those involved in a specific incident. The patient is given the information the organisation feels is appropriate in a one-way communication.	There is a communication strategy. Policies and procedures are in place, and lots of records are kept. There is a lot of information collected from staff, patients and other organisations but it is not effectively utilised. This leads to an information overload meaning that little is actually done with the information received by staff. A risk communication system is in place, but no-one checks whether it is working.	The communications system and record keeping are fully audited. There is communication across organisations facilitating meaningful benchmarking. All levels of staff are involved, and there are robust mechanisms for them to feedback. Information is shared, there are regular briefing sessions where staff are encouraged to set the agenda. Effective communication regarding safety issues is made with patient and public involvement groups.	Everybody communicates safety issues and learns from the experiences of others (good and bad). It is a transparent ward / organisation and includes patient participation in risk management policy development. Innovative ideas are encouraged and staff are empowered to implement them. Good practice is communicated both externally and internally.
5 Team working	Individuals mainly work in isolation but where there are teams they are uni-disciplinary and dysfunctional. There are tensions between the team members and a rigid hierarchical structure. They are more like a collection of people brought together under the direction of a nominal leader. Information is not shared between team members. The team operates secretively.	People only work as a team following a negative event and to respond to external demands. Individuals are not actually committed to the team. There is a clear hierarchy corresponding to the hierarchy of the organisation as a whole. There are multidisciplinary teams, but they have been told to work together, and only pay lip service to the ideals of team working. Information is cascaded to team members following an incident. The team operates defensively and newcomers are not welcomed.	Multidisciplinary teams are put together to respond to government policies, but there is no way of measuring how effective they are. Teamwork is seen by lower grades of staff as paying lip service to the idea of empowerment. Teams are given lots of written information about how they should function. There are official mechanisms for the sharing of ideas or information within and across teams but these are not used effectively. Teams operate behind the scenes and generally within a single organisation.	Teams are multidisciplinary and time and resources are devoted to team development processes. Team structure is fluid, with people taking up the role most appropriate for them at the time. There is evaluation of how effective the team is and changes are made when necessary. Teams are collaborative and adaptable. Teams are open and may involve members external to the organisation.	Regular and evaluated team resource management training is offered to fully integrated multidisciplinary teams. Team membership is flexible with a horizontal structure. Different people make equally valued contributions when appropriate. Teams are about shared understanding and vision rather than geographical proximity. Team working is the accepted way. Teams are totally open, involving members from diverse organisations, locally, nationally and even internationally.