EASTERN PROMISE: WHAT THE UNITED KINGDOM MIGHT LEARN FROM HONG KONG ON PATIENT SAFETY

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Patient safety in the United Kingdom remains high on the Department of Health's agenda. There remains the drive to embrace a culture of learning and provide high quality care to patients.

Hong Kong reverted to Chinese sovereignty on 1 July 1997, after 156 years of being a part of the UK. In Hong Kong there has, for a number of years, been great success in having a culture of learning, which has led to high quality care.

Marking nearly 20 years since the handover, Ed Glasgow — a partner in Kennedys Healthcare Division — and Dr David Dai — a consultant geriatrician in Hong Kong — explore what the UK can learn from Hong Kong in the context of providing better care.

Kennedys

GOOD PRACTICE

In Hong Kong, it is sometimes said that: *"before the rain pours, prepare the shades against the downpour"*, and: *"when a risk threatens, turn this into an opportunity"*.

This article details the impressive steps Hong Kong has already taken towards improving patient safety.

In all public hospitals in Hong Kong, quality and safety units are in place which monitor risks and conduct root cause analysis after every incident. In the past six years, the patient relations teams have been working more closely with the risk management teams to manage complaints, with particular emphasis on the emotional aftermath.

Example: Adverse incident in Hong Kong

- A senior clinician overseeing the patient relations team, reviews the clinical notes and formulates a departmental view in consultation with the head of department.
- The staff involved are interviewed by the senior clinician. The patient's relatives are contacted and a meeting with them and the patient relations officer is offered on the same day or, at most, the next day after the incident.
- The patient relations officer and the senior clinician will acknowledge the emotional nature of the incident. The senior clinician will express regret and may make an apology if error is obvious. The patient and family members are encouraged to elaborate on their view of the incident. The senior clinician will explore the sequence of events and disclose what facts are known. Subsequent care plans are then discussed, whilst there is still an opportunity for improvement for the patient.
- Family members are reassured that responsibility is taken. The patient relations team will follow up with family members on matters of compensation if further investigations of the incident confirm error.
- At the same time, the head of department takes responsibility for counselling and supporting the staff.
- The risk management team is then engaged to conduct root cause analysis on the incident, to prevent further occurrence.
- The patient and family members are invited to return for a meeting following the investigation so that the findings can be explained by a senior clinician.

HONG KONG: GOOD PATIENT SAFETY

In Dr Dai's view this can be broken down into four categories. Namely:

- The patient
- The healthcare provider
- Ethos
- Leadership

THE PATIENT

Focusing on the individual patient is paramount.

Communication

A clear understanding of the patient's journey and attention to better communication at critical points on that journey will reduce risks of errors and misunderstanding. The patient journey often starts in the emergency department. Key points in the journey for clear communication include at the stages of admission, change of clinical condition and on discharge of the patient. Good communication remains at the heart of patient safety and all staff must receive training.

Categories of patient that warrant special attention are the young and elderly, plus those with complex medical conditions that require specialist treatment.

An elderly patient with pneumonia admitted to a medical ward, found following admission to have a hip fracture requiring surgical intervention — and later developing complications requiring intensive care — is a good example. Such a patient needs understanding and good communication between treating teams, as well as with the patient and family.

Complaints

When complaints arise, the patient relations team should help the clinical team meet family members. It must be appreciated that incidents without error can be perceived as negligence in the eyes of the

patient and family and such views must be taken seriously.

Mediation skills, often used in a legal setting, become relevant. Activities such as listening, handling emotions, reframing and summarising are important. As are observing non-verbal communication via gestures and by showing empathy. This will assist in restoring trust between the patient, family and the healthcare team.

THE HEALTHCARE PROVIDER

A consistent approach.

Analysis

The investigation should identify errors which may be human and/or systemic. Action plans must be realistic, implemented and audited to prevent further occurrence.

Monitoring

Incidents need to be compared so that any trends can be found, with measures taken to reduce such events.

ETHOS

Ethos underpins good patient safety.

Culture of safety

A culture of safety derives from clinical leadership. From the perspective of the clinicians — with regard to overall strategy — there must be crossover between departments, when caring for a patient.

For example, when a patient has surgery following a hip fracture the patient would first be admitted to the orthopaedic ward and then transferred to theatre. Thereafter, the patient may be admitted to the intensive care unit and following this to a surgical or medical ward.

Differences in culture between these areas of the same hospital then quality of care and safety will vary. Underlying flaws will exist.

Reporting

Hong Kong has an Adverse Incident Reporting System (AIRS). Clinicians are encouraged to report any event which they consider to be significant from a patient safety or public health perspective.

The AIRS is an electronic programme which allows access to all clinical staff to report any suspected incidents. The system is founded on a no fault finding principle and the aim is to reduce risks so as to achieve better and safer care.

Learning

In Hong Kong — as in the UK — there is continuous education in medicine. Training programmes within Hong Kong are designed to engage staff and to ensure that — at the grass roots level — medical schools are educating students on how clinicians should communicate.

Mediation courses are available and are a good option for learning conflict resolution. These courses are led by mid-level clinicians and are not time consuming.

Partnership

Partnership between clinicians and patients is important. Hospitals in Hong Kong strive to achieve patients, and their families, having a degree of ownership in the process with the clinicians.

The clinician should understand that the patient is his or her best partner in future care. Paying attention to the patient's experience contributes to the planning and refining of treatment.

Patient satisfaction surveys to understand patient and family perception of the healthcare system — and service provided — helps improvement and fills gaps in care.

Recognition that all those providing care should have an input is also important. A nurse or pharmacist may be the first healthcare professional to see changes in a patient. These observations may need to be escalated so as to engage further with the patient.

LEADERSHIP

Leadership — as a driver for ethos — is vital in any clinical setting.

Senior clinicians

The culture of individual hospitals in Hong Kong is driven by its leaders. This is central to patient safety. Within Hong Kong — approximately six years ago — there was a gradual change in culture led by clinical leaders.

Various clinical leaders brought about change by way of renewed openness and transparency. They were the front line senior clinicians.

Senior clinical leadership is important in bringing about and maintaining the right culture. Middle ranking clinical managers mentor junior staff in patient safety. Patient relations should engage with clinicians and communication skills training should be given equal importance as professional skills training.

The above is assisted by what is known in Hong Kong as *"open disclosure"*. This derives from the initial apology offered to the patient when care is not at the level that it should have been.

After an incident has occurred, an apology and disclosure go hand in hand. Helping the patient and family members understand what has happened as accurately as is known up to that moment in time, is a vital part of the process. As the patient and family are walked through the process perceptions may change. This — combined with the apology — and an acceptance of responsibility for an error, all help.

Finally, the clinical staff involved are also recognised as victims going through a professional process of guilt, fear and potentially isolation. Clinical staff should be looked after.

An acceptance of an apology may help relieve the burden on both sides.

Succession planning

Skill transfer and succession planning should be in place to ensure the culture is continued and developed.

Integrity

Trusting the integrity of healthcare professionals and their commitment to do good work remains at the heart of Hong Kong healthcare. A culture of complaint and blame will deter the professional interaction with the patient and system as a whole. Excellent communication skills and honesty are central to quality care. Good communication at all levels — between the clinician, patient, family, public and in hospital governance — are fundamental to achieving this.

THE FUTURE

What can the UK and Hong Kong learn?

- Small scale patient-centred approach

Via a forward-thinking approach (and a smaller scale set up in Hong Kong) catastrophic events where the safety of an entire hospital has been called into question has been avoided.

- Regulation

The Hospital Authority in Hong Kong — operating in the public sector — has led the way on ensuring that systems are in place for better patient safety in Hong Kong.

The Department of Health — in the private care setting in Hong Kong — is following suit. Guidance has been put in place by the Department of Health via individual hospitals and clinical groups. This is being continually reviewed and developed.

- Learning

What is essential from a clinician's perspective, is the correct interpretation of data collected. It must be in a form which has practical value. Information needs to assist all in understanding why something occurred.

If learning is to be achieved and the medical profession is to improve, then the data must make sense to clinicians. It does however take skill and investment if data is to be converted into a form useful to those who are able and want to implement change.

Learning must be shared between all medical staff. In particular, nursing staff should be engaged in the process. They are a valuable source of information.

- The long term

Direct and respected clinical leadership — together with good communication with patients — work on conflict resolution, openness and a willingness to apologise has been and will continue to improve safety in Hong Kong. The same elements are also being employed by the UK. Sharing learning and improving patient safety are common goals, whether care is being provided in Hong Kong or in the UK.

BUILDING A CARING FUTURE

What the UK is already doing

The work of Annie Laverty (Director of Patient Experience at Northumbria Healthcare NHS

Foundation Trust) and her colleagues has already shown the tangible benefits of a patient-centred real-time approach.

Across three general hospitals, a specialist emergency care hospital and seven community hospitals which make up this Trust, the focus has been on ensuring patients and families are part of team level improvement. Capturing and reporting the patient experience — in real time — has underpinned this, together with the support of the Executive Management Team.

In Northumbria, time has been invested in understanding what matters most. Factors such as consistency and coordination of care and shared involvement in decision making are regarded as paramount.

Other elements of the care package — such as the patient relationship with doctors and nurses — together with cleanliness and pain control are monitored. These have been found to be the elements that matter most to patients.

Seven hundred patients are being interviewed per month. Real time measurements are taken across eight sites on 40 wards. Scores are aggregated so that Trust-wide performance can be assessed — a granular understanding of the patient experience is also appreciated at a ward, site, specialty and individual consultant level.

This has yielded recognition for consistently good patient experience outside the Trust, for example by the King's Fund.

With leading performance in national survey data, Northumbria has been awarded an outstanding rating by the Care Quality Commission.

Transparency is recognised as the cornerstone of improvement, bringing with it a need to be open and honest about the current state of affairs and what is required for improvement.

If the whole purpose is to improve patient experience — mindful of the need to preserve precious resources — then surely early notice is key.

Capturing incidents, candour with patient and family and involvement in improvement are all elements used by both the UK and Hong Kong.

Support for staff is improving in the NHS, as is sharing learning for improvement.

Promoting patient safety and care by influencing the design and delivery of services via the above patient-centred approach, provides for a positive and exciting future for patient safety.

FURTHER INFORMATION

To find out more about our services and expertise, and key contacts, go to:
kennedyslaw.com/healthcare

KEY CONTACTS

Ed Glasgow
Partner
t +44 20 7667 9129
ed.glasgow@kennedyslaw.com

Dr David Dai
Consultant Geriatrician