Transcript: Patient Safety Spotlight Interview with Jordan Nicholls, Serious Incident, Quality Improvement and Governance Lead

My name's Jordan. I'm currently the SI, QI and governance lead for Milton Keynes Mental Health at Central Northwest London NHS Trust. That's quite a mouthful! Although pretty soon I'm going to be moving over to Great Ormond Street Hospital as a Safety Surveillance Manager so that's very exciting. What I do at the minute on a day-to-day basis is manage the serious incident process (the SI process), trying to make sure that we get the systematic learning from what's gone wrong and try and embed that into a good practice, but also at the same time trying to look at when things are going well and how we can put that into practice. Also looking at safety culture and safety climate trying to improve that where we can. We're trying to manage QI projects as well, all using governancy techniques, a lot of data and a lot of dashboards to try and work out where we're doing well and where we need to improve.

How did you first become interested in patient safety?
I started off doing a degree in drama and education at Central School and Speech and Drama, from there it was just at the time where a lot of arts funding was being dismantled and I wasn't quite sure what to do, so I found my way into a communications role with Bedfordshire Police and loved it, working in their press office. It was really high demand and I was using a lot of those kinds of skills that I've developed - communication, crisis management, all that sort of stuff. I really enjoyed it and from there I did communications for East Anglian Air Ambulance as well and then moved to the East of England Ambulance Service. While I was at EAAA it was quite a long commute and I listened to ‘Black Box Thinking’ by Matthew Syed. If you've not read it, the first chapter is about Martin Bromley and his wife Elaine - the tragic incident of Elaine going into surgery and sadly dying and all the work that Martin was doing around it. I still maintain that that was the drive into work that changed me and made me think, “I want to work on this. Whatever this is, it feels really important.” When I was at the ambulance service I got a really amazing opportunity to work in the patient safety team—I'd done a lot of work with them while I was a press officer and got seconded to the team and then worked there, and haven't left the industry. So quite a long-winded way of getting into it, but I don't think there's really a ‘typical’ way. And the point is as well, that I'm non-clinical; I don't have any sort of clinical background, I don't have any qualifications apart from an expired first aid certificate. I think that's really important to highlight, that roles like this are not just for doctors, nurses, paramedics, technicians, AHPs. You can work without any of those qualifications because it's about using a variety of skills and putting different lenses onto the challenging topics.

Which part of your role do you find the most fulfilling?
I think it's difficult to say with certainty for the majority of the work that I do, that what I've done has had a direct impact. There's not many things where it's very obvious; it's often a lot more subtle—it's training, it's education,it's conversations in the corridor that spark other people's work or thinking. There's obviously the odd occasion where you put in a new process and then someone comes back to you and says, “That process stopped X or it picked up Y” or whatever, but I think for me the thing that I like the most is when I'm giving some information or a training session, and then someone comes back and says, “Oh do you know what, I use that in a session with a patient,” or “we were coming across a situation

and I said we need to think about X and and that really helped." I think that's the biggest thing for me.

What patient safety challenges does the health system face at the moment?
Recruitment and retention: number one. There just aren't enough people to do the jobs, and that causes high demand on any and all services. I think that's the biggest issue. There's obviously cultural stuff; we know from all across the NHS that there are a variety of cultural challenges. There was the report that came out recently about how management processes and structures need to improve to help support organisations and I 100% agree, but it's difficult to quantify really. But for me the main thing that I see and have seen across my career and when I talk to others on the patient safety network, is just having enough people to do the tasks. I don't know what the solution is to that because that's not going to change overnight—that's going to be five to ten years worth of change.

At the minute I work with a mental health trust and it's interesting coming from a physical health setting of the ambulance service. The variety of challenges that you get with mental health patients; obviously they come into the service and then leave again but they might be with the service for a long period of time, they might be going through a course of therapy or they might be an inpatient for however long, but then there is only a certain amount of safety netting that that can be done once they once a patient leaves an inpatient setting. For example, they may have all the resources and options to come back if anything happens or if anything changes or they have concerns, but there is only so much that can be done. With physical health it's very much, "Okay if you have X condition, you need to look out for A, B, C, D and E." And if you start to deteriorate in that way you know to call for help, whereas in mental health it may not be as obvious or it might be quite individual what someone's deterioration looks like. So it's a bit more tricky to identify.

What do you think the next few years hold for patient safety?
What do the next few years hold for patient safety? A lot of change, an awful lot of change, with PSIRF and LFPSE - that's the patient safety response framework about how to investigate incidents and excellence, as well as learning from patient safety events, the monitoring tool to go with it. We're due those, or at least the full guidance information and the blessing to start using it almost any day now I think. So that will be a huge thing that's going to be quite a big shift in how we look at safety across the NHS, and then as I mentioned earlier we've got that management guidance—this is the thing that needs to change in NHS management report, and that's going to start changing as well. But then you've also got the patient safety syllabus as well, so the ability for almost any member of staff to educate themselves more on patient safety. I've talked to a lot of colleagues who say, "Oh I didn't realise that I was involved in patient safety." I'm like, "Well, you deal with patients!" It's about shifting that mindset and I think anyone who's done culture change or change management knows that it's difficult. I describe it to people as like physio—you've got to go through the uncomfortable bits to get to a better future, and I think there are going to be some difficult conversations, some challenges and some confusion and that's fine. In theory, if everything works out and lays out the way that we're roughly hoping for it to, then hopefully that means more innovation, more practice, more improvement.

If you could change one thing in the healthcare system right now to improve patient safety, what would it be?

I'm going to say the accessibility of resources, and I'm going to try and explain myself a bit. So what I mean by that is: in the managers network, we're talking a lot to people about things like the SEIPS model of systems engineering for patient safety and about understanding what's happened and why. We speak to some amazing people about work that's ongoing—research, QI programs and all that sort of stuff and it's amazing, but it's about what does the front line person on a night shift have access to, to think about patient safety? To do their own thing to improve patient safety from a human factors point of view? Whether that's checklists or mental models or things they can just quickly grab and say, "Oh, you know what it's it's three in the morning and I've been working seven hours and I've still got a few hours to go. I need to check myself and make sure that I'm all right." It's access to the resources that we're all calling out for, just to think about safety in their own world. That's not just for frontline people, but also things like finance and procurement which are the other go to examples, because they're the people who buy the stuff and fund the services. So if they were able to, when they're making a decision, have some information that says, "This is this is best practice for safety," or "These are some really good guidelines for making a safe purchase," I think that would really help.

Are there things that you do outside of your role which have made you think differently about patient safety?

One of the things I do outside of work is advanced driving and it's very, very boring to a lot of people! It's with a road safety charity and it allows people to go out and get more advanced training. It's the same style as police, fire, ambulance driving—it's thinking about how to be safer on the road and it's about improving your observations, your planning and generally just being a better driver. I love it—I love cars, I love driving, I love all that stuff!

The model of driving is something called IPSGA—it's a mental model that you go through and it stands for information, position, speed, gear and acceleration. I started doing this when I was 17 or 18 so I've been doing it for about 12 years or so now. The idea is that every time you're in a car and every time you do anything, you follow this model—so you look for all the information, you position the car, you get your speed right, get the gear right and then accelerate through the hazard, and I think I have taken that away a lot. I know there's a lot of acronyms for things in healthcare: you've got SBAR (situation background assessment recommendation) you've got ATMIST and METHANE in pre-hospital and emergency settings and all these different things, but this IPSGA setup does make me think a lot about what other theories and ideas we can give to people to support them in their everyday work—something that just takes the cognitive load off a little bit. Because I know that every time I come across something I need to go through this process. It's about observations and planning—the training is about looking miles ahead, not just 30 feet in front of you, not just in front of the bonnet. I think it's fair to say the NHS is quite bad at looking five or ten years ahead and spotting hazards, so one of the things that I've been taught to do is just call out hazards and I try to do that with my work as well. So if I see something that's potentially a problem or I think could be a problem I might just call it out in a meeting and say "Have we considered this?" Even if people say, "We have, and we've got mitigations for it," that's fine. I would rather say it and not need it than need it but not say it.