Viewpoint: Integrating safety concepts in health and social care

Abstract

Purpose

Keeping individuals safe from harm and exploitation is a clearly articulated goal within both the health and social care sectors. Two key concepts associated with achieving this common aim are safety and safeguarding. The purpose of this paper is to critically appraise the differences in safety terminology used in health and social care, including opportunities and challenges for greater integration of safety systems across health and social care in England.

Approach

This paper presents the authors' viewpoint based on personal, professional and research experience.

Findings

In healthcare, safety is usually conceptualised as the management of error, with risk considered on a universal level. In social care, the safeguarding process balances choice and control with individualised approaches to keeping adults safe, but lacks the established reporting pathways to capture safety incidents. Efforts to safely integrate health and social care services are currently constrained by a lack of shared understanding of the concepts of safety and safeguarding without further consideration of how these approaches to keeping people safe can be better aligned. As such, there is a need for a single, unified discourse of patient safety that cuts across the patient safety and safeguarding concepts and their associated frameworks in health and social care settings.

Value

A single unified concept of safety in health and social care could coincide with an integrated approach to the delivery of health and social care, improving the care of patients transitioning between services.

Viewpoint: Integrating safety concepts in health and social care

Keeping individuals safe from harm and exploitation is a clearly articulated goal within both the health and social care sectors. Two key concepts associated with achieving this common aim are 'safety' and 'safeguarding', with each addressed through distinct frameworks and regulatory systems that differ by country (Schweppenstedde *et al.*, 2014). At their most fundamental level, whether in health or social care, these safety concepts appear to have the same objective of improving the safety of people who interact with and use services. However, the way that they are approached in terms of how safety is defined, how threats to safety are identified, and how safety is promoted or assured differ between health care and social care. This is particularly challenging when boundaries between health and social care are blurred, such as care at home, as the two different approaches to safety may operate independently of one-another, hindering their potential for producing beneficial outcomes.

In this paper the differences in safety terminology used in health and social care are critically appraised, including opportunities and challenges for the greater integration of safety systems across health and social care in England. In particular, the differences in safety terminology are explored in the context of potential challenges and solutions to the conceptual differences between safety and safeguarding, including the recommendation for a unified approach to safety in health and social care.

Safety in Healthcare

An Organisation with a Memory (Department of Health, 2000b) and *To Err is Human* (Kohn, Corrigan, & Donaldson, 2000) were seminal publications in the healthcare patient safety movement, expanding awareness of patient safety and the levels of harm that exist within healthcare systems internationally. The new approach to patient safety promoted by these and subsequent reports has been informed by concepts and theories found within social psychology, critical sociology, and human factors, which show that human error is enabled or conditioned by factors located in the work environment or organisation. As a result patient safety, defined by Runciman *et al.* (2009) as 'the reduction of risk of unnecessary harm associated with healthcare to an acceptable minimum' (p.19), has focused on identifying adverse events and associated active and latent factors with the aim of fixing the systems in which they occur. For this approach to be successful, there is a requirement to accurately identify

patient safety incidents so that their systemic causes can be identified and safety improvements introduced (Reason, 2000a). In turn this requires a just culture, which promotes awareness of risk and openness to individual and organisational learning, while at the same time ensuring that individuals are accountable where safety violations occur.

There are numerous approaches to identifying incidents, each providing a unique lens on the number of patients harmed or potentially harmed within healthcare. Medical record reviews are perceived to be one of the most rigorous methods, identifying that around 10% of patients are harmed by their healthcare with half being preventable (Department of Health, 2000b). Other approaches can contribute to a wider understanding of levels of harm through staff reporting of safety incidents via locally or nationally based systems, such as the National Reporting and Learning System in the UK, and broader indicators of safety such as global trigger tools and early warning tools. This has led to a measure and manage orthodoxy with growing use of tools to identify, measure and control risks (Waring *et al.*, 2016a). The developing field of patient involvement provides an additional lens, with studies theorising patients' perspectives of safety can lead to the identification and reporting of safety concerns (Scott, Dawson, & Jones, 2012); in particular, where it has been demonstrated that incidents are not easily captured via medical record review (Weissman *et al.*, 2008).

The established approach to creating safe care, sometimes referred to as Safety-I, is largely concerned with the absence of safety or experience of harm, and is concerned with how these harms can be measured and managed. Safety-I is associated with retrospective learning systems and error management. Although not often explicit, this can be interpreted as encouraging a narrative of vulnerability that is applied universally to all patients.

Safety-I assumes tasks can be clearly specified and that care can conform reliably to standard procedures, reducing variation in practice in an attempt to eliminate errors caused by human factors. However, there is growing recognition that the delivery of healthcare, particularly in the community but also in all care settings, cannot be carried out with such predictability and precision. In recent years an alternative, more flexible and prospective approach to safety management proposed by Hollnagel, Braithwaite, and Wears (2013), commonly referred to as Safety-II, has been advocated. Safety-II aims

to build resilience to variation and risk, rather than adherence to prescribed and specified actions. In recognition of the paradox of measuring safety by its absence first identified by Reason (2000b), Safety-II emphasises proactive approaches to safety by focusing upon what makes patients safe in an attempt to learn from success rather than failure. It also recognises that flexible systems and agency amongst healthcare staff can create the conditions for safe care that would not otherwise be available when strictly following Safety-I approaches. Whilst this begins to shift the narrative away from universal vulnerability and risk, differences in the ways in which safety is conceptualised and operationalised are still apparent between health and social care settings.

Safety in Social Care

No Secrets (Department of Health, 2000a), published at a similar time to *An Organisation with a Memory* (Department of Health, 2000b), outlined the need to protect vulnerable adults from institutional abuse. This includes instances of poor care resulting from neglect or poor professional practice, which may range from isolated through to pervasive incidents, demonstrating that harm can result from the lack of appropriate and responsive organisational systems and processes. The approach taken in social care focuses governance of safety on professional and individual risk, such as expectations on social workers to appropriately identify people at risk and arrange appropriate interventions, which fundamentally differs to the systems approach of safety (organisationally-driven risk management) in healthcare. In social care, more emphasis is placed on an individual's ability to respond to risk and links risk assessments more explicitly with the legal requirements of the Mental Health Act 2007 (Department of Health, 2007), meaning that the individual's responsibility often falls under the umbrella of safeguarding rather than safety. Safeguarding covers a range of activities that aim to uphold the right of individuals who are at risk of abuse or neglect to be safe and free from harm when in receipt of care services. Common types of abuse include physical, sexual, psychological, financial or material, and discriminatory, any of which can be perpetrated as a result of deliberate intent, negligence or ignorance.

The Care Act 2014 (Ahmed, Burt, & Roland, 2014) also places emphasis on vulnerable adults (or 'adults at risk'), in particular those who are unable to protect themselves against abuse or neglect. It also reiterates the social care governance system in which safety exists, by giving local councils with

social service responsibilities (CASSRs) the lead role in hosting multi-agency Safeguarding Adults Boards (SABs) and by requiring providers of social care to provide information and advice about raising concerns when the safety of an 'adult at risk' is compromised. Safety is deemed to be compromised where abuse or neglect is known or suspected by the SAB to result in death, or if the SAB knows or suspects serious abuse or neglect for adults still alive. By defining the compromise of safety (thus unsafe care) at this high level rather than all types of harm or potential harm, the possibility of learning from near-misses or cases of lower harm is diminished.

This is not to say that safety is not measured on a universal level in social care, as demonstrated by studies on the prevalence of safety issues. For example, a review of medications in care homes by Barber *et al.* (2009) identified that two-thirds of residents were exposed to one or more medication errors. However, this is an example of research as opposed to routine practice on a scale large enough to identify trends. Likewise, a specific concept of safeguarding does exist in healthcare and is not unique to the social care setting, but where the emphasis of each system is placed produces prominent differences in approaches to the management of safety and risk.

Comparing safety in health and social care

The difference in the narratives of risk and vulnerability is one of the main departure points in the understanding and governance of safety in health and social care (see Figure for a comparison). There are also many grey areas in between, where the assessment of risk varies from location to location and not necessarily distinguished by a single, distinct health or social care boundary, such as care at home. The different approaches suggest that the systems approach prominent in healthcare is not aligned with the safeguarding approach adopted in social care. This means that when, or if, both approaches operate in tandem, their potential for producing beneficial outcomes could be hindered. Where the focus is mainly on the individual, the opportunity to learn from systematically capturing or anticipating error can be missed. As such, there is a need for a unified approach to safety in health and social care, which we refer to as 'care safety'. For care safety to be put into effect, and for health and social care services to efficiently learn and share responsibility for the safety of service users, patients or clients, it is first necessary to recognise where gaps in the delivery of integrated health and social care exist.

<Insert figure around here. Figure legend: Comparison of approaches to safety in health and social care and their implications>

Bridging the gaps in the delivery of safe, integrated health and social care

Health and social care in England has changed rapidly in the recent past, with greater emphasis being placed on integration of care services. Attempts to achieve both horizontal and vertical integration have focused on reducing unnecessary gaps and duplication between services, in particular by designing and delivering services around patient needs rather than strict observation of organisational boundaries. The Better Care Fund (Bennett & Humphries, 2014) is the latest strategy in England to incentivise NHS services and local government to work together by pooling budgets.

The need for financial organisational alignment was identified by the Barker Commission (Barker, 2014), which identified a lack of alignment between health and social care organisations and commissioning. The NHS England (2014) Five Year Forward View, which sets out how health and social care services can adapt to funding constraints, also states that barriers between National Health Services (NHS) and social care services will be broken down. Both of these reports reflect a move towards greater integration of care that is widely anticipated to improve the quality of care that patients receive as care becomes centred around the patient. Aligning with these calls for increased integration, the CQC has recently established a clinical governance framework for both the health and social care sectors and, within England, applying the same national standards for safety to health and social care settings; an effort limited by the different approaches taken to provide safe care.

Despite these attempts to provide greater integration between services a number of factors have increased rather than decreased organisational boundaries including increased specialisation of care, technological advances and changes to where care is delivered (Reid, Haggerty, & McKendry, 2002). As such, providing integrated care within an increasingly complex environment is becoming more difficult to negotiate, as demonstrated by Lewis *et al.* (2015) in case studies on identifying child mistreatment as a safeguarding function within healthcare. Other examples include the challenge of safe discharge from healthcare (secondary care) to social care (Waring, Bishop, & Marshall, 2016b),

and of involving patients in the reporting of safety experiences following discharge (De Brún *et al.*, 2016). Thus, attempts to keep people safe within this increasingly complex context which lacks a shared understanding and approach to safety, and the lack of integration between health and social care services more generally, may create a situation where any knowledge and learning about the factors that could prevent or lead to preventable harm may fail to be captured, as illustrated in Box 1.

In order to address the differences that exist between health and social care services, there are two areas that require further understanding. The first is a lack of understanding about safety from the patient's or client's perspective, including the types and meaning of harm in both health and social care and, in particular, when patients or clients cross care boundaries. The second is how safety is constructed at an organisational level when care crosses boundaries, which encompasses the cultures and governance frameworks in health and social care. This can be structured in terms of macro, meso and micro levels, and includes how safety is portrayed, understood and created within health and social care policy, across organisational boundaries, and amongst individuals working within and across the health and social care systems.

Patient illustration 1: Discharge from hospital to care home (medication)

An 85 year old individual with moderate disability was admitted to hospital with atrial fibrillation (abnormal heart rhythm) and is prescribed an anti-coagulant (Warfarin) to reduce risk of stroke. The patient is ready to be discharged back to their care home, and no specific safeguarding risks have been identified. Due to an error at the point of discharge, the patient is dispensed an incorrect dosage that is not identified during the discharge process or subsequent administration by staff upon arrival at the care home. The patient subsequently experiences a severe acute ischaemic stroke, leaving the patient with permanent and severe physical disability, which significantly reduces their quality of life. The adverse event is not reported, meaning that neither the discharging hospital nor the nursing home were able to learn from the incident.

Patient illustration 2: Admission to hospital (pressure ulcer)

A 60 year old individual is admitted to hospital from a care home for a routine operation with a superficial (grade 2) pressure ulcer (PU), which is only identified during admission. The hospital is

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required to report the PU within their own safety reporting systems, and the PU is attributed to the ward that the patient is admitted to. During discharge, the patient's care home is made aware of the PU, and a risk assessment takes place at the care home. Procedures are adapted for this individual patient now that they are deemed vulnerable or a person at risk, within a safeguarding framework. No organisational learning takes place as the number and types of safety incidents relating to PUs are not recorded and analysed systematically. Whilst this individual patient's risk of a PU has reduced, overall risk of PUs for other patients does not change.

Patient illustration 3: Care at home (catheter care)

A 75 year old individual has a urinary catheter in situ. Repeated infections occur and after a serious infection the individual is admitted to hospital to deal with both infection and the resultant confused state caused by the infection. The infection is treated and the confusion resolves. A series of infections in hospital wards or in care homes would be captured using infection control audit tools. While the occurrence of a confused state may trigger a safeguarding alert the previous infections and this infection are not likely to be part of any alerts to managers of home care staff and would not be considered a safeguarding issue. The pattern is repeated both in this individual and across the population of people cared for by the home care agency but due to a lack of a reporting system to capture incidence of catheter related infection the pattern of infections goes undetected and fails to highlight the fact that the home care workers from this particular agency have not received adequate training in changing or managing urinary catheters.

Box 1: Hypothetical case illustrations of the differences in approaches to safety in health and social care sectors.

Conclusion

In healthcare, safety is usually conceptualised as the management of error, with risk considered on a universal level, and an increasing acknowledgement of the importance of variability and agency amongst healthcare staff to produce safe care. In social care, the safeguarding process balances choice, control and agency with individualised approaches to keeping adults safe, but lacks the established reporting pathways to capture events such as medication errors, equipment failures and

other events such as falls or infection. Efforts to safely integrate health and social care services are currently constrained by a lack of shared understanding of the concepts of safety and safeguarding without further consideration of how these approaches to keeping people safe can be better aligned. We propose a common discourse of care safety that cuts across the patient safety and safeguarding concepts and their associated frameworks. A number of steps are required in order for a common discourse of care safety to be adopted in health and social care (Box 2).

As organisations and service provision become more integrated, it is essential that:

- A common concept of care safety should be recognised and developed that traverses and looks to bridge the gap between the current concepts of safety and safeguarding across the health and social care sectors

- Governance frameworks, in particular those related to safety, require a single concept that is able to span both health and social care if these services are to be integrated.

- Differences between safety and safeguarding exist for genuine reasons and these should be accounted for in the new concept of safety

- Opportunities for improved organisational learning are exploited by adopting a systems approach to safety across all care sectors and settings.

Box 2: Summary of recommendations for integrating a unified approach to safety in health and social care

This single concept of care safety has the potential to foster collaboration and mutual learning between care sectors where care tasks may be undertaken by both health and social care employees. By developing a shared understanding of safety and safeguarding, with the support of governance structures, there will be a better understanding of safety on both individual and organisational levels. For example governance structures that link safety in health and social care sectors could facilitate quality improvement initiatives to further improve communication relating to

transitions in patients' care; often cited as one of the greatest challenges to patient safety and results in excessive hospital readmissions, as demonstrated by Witherington, Pirzada, and Avery (2008).

Care safety would also offer a common and shared understanding that focuses on harm to the individual but also draws upon the best elements from across health and social care sectors, where one is systems focused but largely retrospective and the other is prospective but individualised. These recommendations could facilitate the move towards an integrated approach to safety that can coincide with an integrated approach to the delivery of health and social care. This shared approach would need to respond to differences in how care is organised and provided in different organisational contexts whilst maintaining the principles of openness with a just culture.

References

Ahmed, F., Burt, J., & Roland, M. (2014). Measuring Patient Experience: Concepts and Methods. *The Patient - Patient-Centered Outcomes Research, 7*(3), 235-241. doi: 10.1007/s40271-014-0060-5

Barber, N. D., Alldred, D. P., Raynor, D. K., Dickinson, R., Garfield, S., Jesson, B., . . . Zermansky, A. G. (2009). Care homes' use of medicines study: prevalence, causes and potential harm of medication errors in care homes for older people. *Quality and Safety in Health Care, 18*(5), 341-346. doi: 10.1136/qshc.2009.034231

Barker, K. (2014). *A new settlement for health and social care.* London: The King's Fund.

Bennett, L., & Humphries, R. (2014). *Making best use of the Better Care Fund: Spending to save?* London: The King's Fund.

De Brún, A., Heavey, E., Waring, J., Dawson, P., & Scott, J. (2016). PReSaFe: A model of barriers and facilitators to patients providing feedback on experiences of safety. *Health Expectations.* doi: 10.1111/hex.12516

Department of Health. (2000a). *No secrets: Guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse.* London: Department of Health.

Department of Health. (2000b). *An organisation with a memory: Report of an expert group on learning from adverse events in the NHS.* London: Department of Health.

Department of Health. (2007). *Mental Health Act.* London: HMSO.

Hollnagel, E., Braithwaite, J., & Wears, R. L. (2013). *Resilient Health Care.* Farnham, UK: Ashgate.

Kohn, L. T., Corrigan, J. M., & Donaldson, M. S. (2000). *To err is human: building a safer health system.* Washington, DC: National Academies Press.

Lewis, J., Greenstock, J., Caldwell, K., & Anderson, B. (2015). Working together to identify child maltreatment: social work and acute healthcare. *Journal of Integrated Care, 23*(5), 302-312. doi: doi:10.1108/JICA-08-2015-0032

NHS England. (2014). *Five Year Forward View.*

Reason, J. (2000a). Human error: models and management. *BMJ, 320*(7237), 768-770. doi: 10.1136/bmj.320.7237.768

Reason, J. (2000b). Safety paradoxes and safety culture. *Injury Control and Safety Promotion, 7*(1), 3-14.

Reid, R., Haggerty, J., & McKendry, R. (2002). *Defusing the confusion: Concepts and measures of continuity in healthcare.* Ottawa: Canadian Health Services Research Foundation.

Runciman, W. B., Hibbert, P., Thomson, R., Van Der Schaaf, T., Sherman, H., & Lewalle, P. (2009). Towards an international classification for patient safety: key concepts and terms. *International Journal for Quality in Health Care, 21*(1), 18-26. doi: 10.1093/intqhc/mzn057

Schweppenstedde, D., Hinrichs, S., Ogbu, U. C., Schneider, E. C., Kringos, D. S., Klazinga, N. S., . . . Nolte, E. (2014). *Regulating quality and safety of health and social care: International experiences* Retrieved from http://www.rand.org/pubs/research_reports/RR561.html

Scott, J., Dawson, P., & Jones, D. (2012). Do older patients' perceptions of safety highlight barriers that could make their care safer during organisational care transfers? *BMJ Quality & Safety, 21*, 112-117. doi: 10.1136/bmjqs-2011-000300

Waring, J., Allen, D., Braithwaite, J., & Sandall, J. (2016a). Healthcare quality and safety: a review of policy, practice and research. *Sociology of Health & Illness, 38*(2), 198-215. doi: 10.1111/1467-9566.12391

Waring, J., Bishop, S., & Marshall, F. (2016b). A qualitative study of professional and carer perceptions of the threats to safe hospital discharge for stroke and hip fracture patients in the English National Health Service. *BMC Health Services Research, 16*(1), 1-14. doi: 10.1186/s12913-016-1568-2

Weissman, J. S., Schneider, E. C., Weingart, S. N., Epstein, A. M., David-Kasdan, J., Feibelmann, S., . . . Gatsonis, C. (2008). Comparing patient-reported hospital adverse events with medical record review: Do patients know something that hospitals do not? *Annals of Internal Medicine, 149*(2), 100-108.

Witherington, E. M. A., Pirzada, O. M., & Avery, A. J. (2008). Communication gaps and readmissions to hospital for patients aged 75 years and older: observational study. *Quality and Safety in Health Care, 17*(1), 71-75. doi: 10.1136/qshc.2006.020842

	Health care	**Social care**
Predominant approach to safety	Identifying and learning from active failures and latent conditions to foster local and organisational change. Harm is understood on a systemic level, with harm originating from system failures.	Risk management is applied to individuals with an emphasis on professional assessment of risk and vulnerability. Harm is understood as a serious event occurring to an individual, with risk of harm originating from the client themselves, their setting or from individual professional neglect and abuse.
Responsibility for safety	Responsibility for safety is held primarily with the system or professional.	Responsibility for safety is shared between clients and professionals.
Effects	Emphasis is placed on a 'just' culture and organisational learning.	Emphasis is placed on discipline and the legal consequences of harm.
Implications of having different approaches to safety	Barriers to working across health and social care boundaries are reinforced due to differences in governance arrangements for safety Limited ability for health and social care services to learn from each other or to learn together about safety incidents Safety agendas will remain parallel, unconnected fields resulting in a lack of shared understanding of safety and harm.	