

A Soft Systems Methodology approach to analysing the implementation of patient safety actions

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Introduction

Implementing patient safety initiatives in health care organisations represents a major challenge for all those involved, but especially to those individuals in charge of leading such programmes, who might be faced with challenges unique to their particular site such as resistance to cultural and practice change from certain groups, cynicism towards proposed improvement measures, varying degrees of support from managers, diluted patient safety objectives, and especially the clash between strategy makers and frontline practitioners regarding the way in which proposed actions are implemented.

It is in this scenario that elements and techniques from management science can be used to structure an approach towards strategy deployment (closing the loop) and assist those involved in implementing patient safety actions to acknowledge other perspectives by taking a look at different aspects of the system in order to detect potential critical issues in the implementation of patient safety actions. One of such techniques is the Soft Systems Methodology.

The Soft Systems Methodology

Soft Systems Methodology (SSM) is a systematic approach which seeks to “articulate a social learning process by structuring discussion of a problem situation”, based on models of concepts of purposeful activity, built on explicit worldviews, in order to enable actions to improve to be taken. (Checkland and Poulter, 2006)

As a method designed to look at the *system*, SSM proposes looking at the following elements within the system from the different perspectives: roles in the process, social norms and values, political relations, CATWOE analysis (Clients, Actors, Transformation Process, Worldview, Owners, Environmental constraints), 3 E’s (Efficacy, Efficiency and Effectiveness) definition and measures, and coming up with a and explicit *root definition* that states the ultimate goal of the process.

SSM techniques are currently being used as a framework to analyse the implementation of the Patient Safety First campaign in an acute trust in the north west of England, looking for ways to narrow the gap between patient safety strategy designers and front-line practitioners during the implementation process.

The ultimate goal is to bring about improvement in the way in which patient safety actions are being implemented.

Examples of SSM tools used to analyse the implementation of patient safety initiatives

CATWOE Analysis of the implementation of a patient safety campaign from two individual’s perspectives

	Frontline Staff	Administrative Staff
C	Patients	Trust Board, SHA
A	Clinical (frontline) staff	Clinical Staff and Managers
T	Implementing evidence-based safety practices throughout the Trust is the solution	Satisfying upcoming national standards
W	Actions designed to abate patient safety incidents do not take into account the views of front-line practitioners and that’s why they don’t work	The Trust needs to comply with National Standards
O	Trust’s Board of Directors	Trust’s Board of Directors
E	No special budget, no extra time allocated, no extra staff appointed, limited resources	Financial issues, achieving Foundation status is top priority, all other initiatives come in second available

A root definition of a patient safety system(What, How and Why) from a patient safety campaign leader’s perspective.

“A system to reduce or eliminate adverse incidents associated with clinical care occurring in the Trust by

- implementing practices that minimise or eliminate the chance of an adverse event in a sustainable manner,
 - setting up measurement systems in order to ensure that goals in improving patient safety are being reached and
 - designing and putting into practice administrative and operational systems that support these goals
- in order to improve patient safety for all users of the service.”

A work in progress

While SSM produces a model with the intent to understand and clarify a problematic situation by incorporating different perspectives (worldviews), the desired outcomes and the proposed activities through which these will be reached, it is the *iterative process* of searching for information and disseminating that information among all those involved that produces the result: an explicit understanding which would pave the way towards an *accommodation of ideas* regarding actions to be taken towards improvement.

References

Checkland, P. and Poulter, J. (2006) **Learning from Action: a short definitive account of Soft Systems Methodology and its use for Practitioners, Teachers and Students.** John Wiley and Sons.