

IN PRACTICE

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**TRANSFORMING PATIENT SAFETY:
SIMULATING SWARM HUDDLES TO SUPPORT A
NO-BLAME CULTURE**

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Introduction: The introduction of the Patient Safety Incident Response Framework (PSIRF) marked a shift in how patient safety incidents are reviewed. Although external training opportunities are available, staff feedback highlighted a need for more practical understanding of PSIRF and human factors. To address this, we developed a bespoke, financially sustainable course, enabling staff to engage interactively with the changes in PSIRF. A key focus was on preparing staff to carry out swarm huddles, as the new learning response with the most local ownership.

Methods: In collaboration with the patient safety team, the simulation team designed a full-day course combining lectures, workshops, and simulations to explore human factors and systems thinking (using the SEIPS tool [1]) before scaffolding this knowledge to carry out swarm huddles. We began with non-clinical examples such as “A Cup of Tea” developed by Epsom + St Helier [2], before progressing to analyse clinical scenarios using SEIPS. We created two videos of clinical scenarios: a deteriorating patient and a misplaced naso-gastric tube [3]. Participants then had the opportunity to conduct a swarm huddle with the involved characters, played by faculty members.

Success was evaluated through post-training surveys, qualitative feedback, and observed improvements in incident response.

Results: To date, 62 senior staff from diverse roles, including acute, community and non-clinical staff, have attended the training. 84% of attendees completed a post-course survey, leading to ongoing adaptations in course content.

Feedback included Likert scale assessments of confidence as well as qualitative comments. Attendees highlighted the cultural shift that the course contributed towards, commenting:

1. “Fostering an environment where staff feels safe to be a part of the learning process”
2. “More talking and bringing people together,”
3. “A focus on meaningful actions that genuinely demonstrate learning.”

A new swarm huddle template, developed during the course, is now used across the Trust. Staff, including those from the emergency department, have fed back successes of carrying out swarm huddles to learn from both events that have gone well and less well.

Discussion: While PSIRF focuses on patient safety, it also promotes a just culture centred on systems thinking and continuous improvement. This approach moves teams away from a blame culture and fosters unity across the Trust. Our program has garnered attention beyond our Trust, with positive feedback from organisations including North London Hospice and NHS England South-West, particularly regarding

the simulated videos. The course is being peer reviewed for quality assurance.

Ethics Statement: As the submitting author, I can confirm that all relevant ethical standards of research and dissemination have been met. Additionally, I can confirm that the necessary ethical approval has been obtained, where applicable

REFERENCES

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