Accidents will happen...

I AM SURE WE HAVE ALL HEARD the saying 'better to be safe than sorry'. Perhaps your mother or grandmother have said it. There are very few days that pass where I don't have my mother's sage safety advice ringing in my head: "Always wear clean underwear in case you get knocked over!"

So, WHY am I talking about this? I think these maternal figures are trying to teach us that to be prepared is a good thing whilst, I am convinced, making sure the offspring in question knows how to cross a road safely, or ensuring safety measures are in place in whatever endeavour they are being sent off on.

There is a parallel professionally that through our quality management systems we ensure as much as is reasonably possible that we operate safely and protect our patients and ourselves from harm. Yet, however hard we try, accidents will happen. By definition an accident is something that happens unexpectedly and unintentionally without apparent or deliberate cause. So it is very difficult to plan for. No one starts their day trying to bring harm to another.

The Bolam principle, in brief, says that as a rule, a health professional is not negligent (failure of care through act or omission) if they act in accordance with a practice accepted at the time as proper by a responsible body of opinion. In other words, you listened to all the safety advice and looked both ways before you crossed the road.

WHY is this important? How do you prove that you took all reasonable measures to protect your patients/colleagues, that this was an accident that could not have been foreseen? Your quality management system comes into its own at this point, you should be able to show risk assessments, protocols/procedures and guidelines which demonstrated what you did was as safe as it could have possibly been, with informed consent from patients as necessary to outline any risks that are known. In other words, you made sure you had 'clean underwear' on.

Like underwear there is a time limit on its use! Therefore, can your quality management system show regular audit, updates and improvements? Like learning to cross the road safely, can you get into the habit of checking your policies, procedures and guidelines so that they can protect you and your patients?

Whatever route you take to assurance, whether it be ISAS or your own, it is always better to be safe than sorry.

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WHY Fronts: PDSA

Chris Woodgate, ISAS Officer

A NEW TECHNIQUE, a dispensary for sick animals or an audit tool? No prizes for guessing which one I will choose.

Through the winter you may feel like a 'workhorse' who has been 'flogged almost to death', dealing with the influx of requests caused by winter pressures. Our profession does not have the luxury of sanctuary away from the crowd. We are an essential mainstay of the operational services within any healthcare organisation and so our services are never 'off duty'.

WHY am I bringing this up when you have better things to do and other battles to fight? Well...audit can help you. WHAT/HOW you cry or turn the page to something less boring. Audit will allow you to build an evidence base to prove you need something, or provide you evidence that a new technique is better/safer for patients and/or more efficient, maybe like the following examples;

- More radiographers/radiologists
- Better equipment
- Improved skill mix
- Time for research and innovation.

P.D.S.A or Plan, Do, Study, Act is an audit tool (other audit tools are available) which will help you build a case of need, prove a theory and demonstrate a better way of working. How does it work? An easy guide can be found here http://bit.ly/2jvUZ1s, it is not rocket science (otherwise I couldn't use it). If you want to show your manager or trust board that you have something worth looking at, it is a relatively easy way to provide the evidence. Accreditation is built on continuous audit process, helping you refine and build on the service you have, which allows accredited services to be transformational. Even if accreditation and ISAS may seem a distant goal for your service, it would be positive to start embedding the principles of regular audit and start to be transformational.

Why not give it a go? Rather than remain stuck under the pressures you have, prove there is a better way, a development need, a research project which will make a positive difference. Managers love people who come to them with solutions rather than problems, and even better if they have evidence to back it up; so WHY not, you may be surprised at what you can achieve. If you don't have the bright ideas, then who will? And if someone else does, will they know the service as well as you do?

Remember it is easier to do than it is to be done to! This is your service, your patients, your hard work and in the end your taxes that pay to keep services running; WHY not make your service the best it can be.

In other words fortuna audaces iuvat – fortune favours (aids) the bold; or as Darth Vader would say "the force is strong with this one", proving that the dark side can acknowledge a good idea when it sees one!

WHY Fronts: The times they are a-changin'

Chris Woodgate, ISAS Officer

LIFE IS A PROCESS OF CHANGE and if you read the lyrics/poetry written by Bob Dylan to the above, I think he outlines the challenges (in the issues he visualised) in an interesting and evocative way.

How we deal with challenges and change has also been expressed through an experiment with bees & flies – I know, who thinks of this stuff!

It is described in this article (http://bit.ly/2mhEJBr), and it really caught my attention.

In short, bees and flies are placed in a jar with a bright light shining through the base of the jar. The bees' knowledge of light (their intelligence/knowledge) is their undoing in this experiment as they persist in trying to get out through the solid glass bottom of the jar, whereas the flies, careless of logic and through trial and error find the opening to freedom. It is by pursuing every imaginable alternative that the flies escape while the bees perish because they believe the light is the only way out because, after all, generations of bees were successful following the light.

The hypothesis is that we are educated to think reproductively like the bees in the experiment. Whenever we are confronted with a problem, we fixate on something in our past that has worked before and we apply it to the problem. If it does not work, we conclude it's not possible to solve. The flies resemble productive thinkers as they fly hither and thither exploring every possibility and, through trial and error, find the way to safety. The lesson to us is to always approach a problem on its own terms and to consider all alternatives including the least obvious ones, which often are solutions brought by those who are new/fresh to the issues i.e.' the beginners'.

So what does change have to do with accreditation? One of the key aspects of accreditation is that it can be transformational; through regular audit process the need for change is often identified. Even the fact that accreditation causes you to look at how you do 'things' may shed a spotlight on areas of practice which you want to change.

Change management can be difficult as Bob Dylan so eloquently puts it; but there are models which are helpful and some of those can be found here: http://bit.ly/2micKS4

- Kurt Lewin: Unfreeze –Change – Refreeze model
- ADKAR® : Awareness, Desire, Knowledge, Ability, Reinforcement
- Kotter: 8 – Step model of Change
- Stephen Covey: 7 Habits Model
- Kubler-Ross: Stages of change

Times really are "a-changin'" we just need to look in the press, social media and our own services to see how the NHS is changing (or not) to meet the needs of the present.

Accreditation can help you 'find your way out of the jar' because where the external spotlight is shining on your service may not be where the change is needed, as the fly wisely puts it in the film 'A Bugs Life' – "Don't look at the light!"

Use all the tools you have to find the answer, don't be blinded by the problem and don't forget to ask those of your teams who are not steeped in past way of doing things. Ask yourself 'am I afraid to abandon an old belief system, learn a new skill, or tackle a new project?' Do you think when you're finished learning you are finished? Is it that only real limitations are those we place on ourselves by refusing to learn or to change? Only you can answer those questions.

WHY Fronts:
Freedom to Breathe

SOLZHENTSYN wrote this poem as a result of the imprisonment within the Russian Gulag system and when asked why he thought the Gulag's came into existence he said, "We didn't love freedom enough".

As the pressure of increasing demands on imaging services becomes relentless and you feel that you 'don't have time to think never mind freedom to breath' how can you ensure you don't lose the person who is the patient at the centre of it all? Are you assured your patients are at the centre of all you do, is your quality of service to them safe, effective and efficient? Do you value the quality of your service enough?

The Health Care Professions Council (HCPC), Standards of Conduct, Performance and Ethics has 'promote and protect the interests of service users and carers' as number one on their list. The SCoR likewise put 'Relationships with Patients and Carers' at the top of their Code of Professional Conduct. If, as professionals, we are to meet this obligation (I would suggest) we need to make time to do so, that we give ourselves the 'freedom to breathe'. But how do you do that? How do you personally assure yourself that the service you, and others around you, give is that which your professional and registrant body requires?

Well Martin Luther King said, "All labour that uplifts humanity has dignity and importance and should be undertaken with painstaking excellence." That is quite a tall order 'painstaking excellence', but if Martin Luther King could 'have a dream' why not us?

So how do you as an assistant practitioner, radiographer, or team lead make that difference, when you don't make the final decisions and those that do seem a long way from where you are day after day?

Last month I looked at change and you and I may be willing to change, but, how do you convince others it is a good idea? Do you have to be the 'boss' to make sure change happens or is it possible that as an assistant practitioner, radiographer, team lead, you can influence changes that affect everyone? If you could, what would you want to change, what in your day to day work would you do to improve patient care and/or your colleagues working life to make that 'dream' a reality?

In change management there are lots of scholarly articles about how to, with whom, when to, with models that demonstrate how difficult it might be and how you know when you are succeeding. One thing that is recurrent in most change models is the role of leadership and its importance in influencing change.

Robin S. Sharma states, 'leadership is not about a title or a designation. It's about impact, influence and inspiration. Impact involves getting results, influence is about spreading the passion you have for your work, and you have to inspire team-mates.' If this is true then you can make a difference, you can promote the 'dream' where quality of service and care of the patient outweighs all other demands. You don't have to do this on your own; you can gather other likeminded members of your team to be examples of what it is you 'dream' of and gather more around you as your enthusiasm spreads. Have a look at the new ISAS standard, there is now a whole section on leadership and management, are there any ideas in there you can use? Remember if we don't 'love' quality of care for our patients then we may lose it. Have the 'freedom to breath' and make a difference. Today, can you be THAT person!

WHY Fronts: Inspiration

(Asking the question WHY to promote quality service provision)

Chris Woodgate, ISAS Officer

OVER THE PAST COUPLE OF MONTHS I have outlined (very briefly) how and WHY you can make a difference to the Quality Management (QM) in your services. But what happens when you just don't know how or you don't have any idea what to do or where to start?

Jack London (writer/novelist) once said, "You can't wait for inspiration. You have to go after it with a club," he advised. "And if you don't get it you will nonetheless get something that looks remarkably like it."

In a very helpful article/blog; T Bram has outlined seven points to help us find that elusive starting point, idea, audit, change that is needed to improve how we work together for patients.

1. Go out looking for inspiration:
Find out what other services are doing with their QM have they any helpful tips or hints. If you are working towards accreditation or thinking about it, WHY not have a chat with those that have already been though the process; they can be found on the SCoR ISAS webpage or the UKAS ISAS webpage.

2. Look outside your area of expertise:
Can you get any help from colleagues in Pathology who have their own QM process or Breast Screening colleagues who have been involved with QM for a long time? Just because they don't 'do' what you 'do' doesn't mean they can't spark some ideas in you by what they are involved in.

3. Try another format:
Writing standard operating procedures, policies and protocols can eventually 'suck the life' out of you; been there on that one! So how about writing them your own way first to keep it 'alive' for you, once you have the ideas on paper it is easier to transfer it to your organisations way of presenting them.

4. Get an outsider's take:
Be careful what you write; what makes sense to you may mean nothing to someone who doesn't understand your modality. One of the key things a UKAS assessor will look for is that your documents are unambiguous, if they were to follow them line by line would they get the end result you are expecting? WHY not ask a colleague from another modality/discipline to have a look and make sure they make sense. You may find their input really helpful.

5. Look back at what has worked:
When you do your policy etc. review look out for ideas that come to mind or that have developed through the timeframe of that policy. It may be that only a small change is needed, if you had a dynamic change last time is it really needed again? When you review WHY not think about how you could use the inspiration from last time on some of your other projects?

6. Borrow an idea:
Document sharing, is it a bad thing? Are there colleagues in other Trusts who will be willing to share what they have written? If you work in a service where you think you have some good policies etc. would you be willing to share on the SCoR ISAS webpage; anonymised of course? If you are let me know and we can pull together a repository of useful information for others to use; please email ISAS@sor.org and I will develop this for our members.

7. Brute force your way through:
Sometimes it isn't easy, sometimes you just have to grit your teeth sit down and put pen to paper or finger to keyboard. Sometimes it is just 'boring' but if you never have the lows how do you recognise the highs? If you are sat in the shadow of an audit that is to be completed or a policy deadline remember the "the shadow proves the sunshine" (Switchfoot Lyrics 2005); it will be worth it as you will have helped contribute to a safer, quality service for your patients.

As Jack London said if you don't get inspiration but you work at it "you will nonetheless get something that looks remarkably like it." WHY not think about it?

http://www.sor.org/imagine-services-accreditation-scheme

WHY Fronts: Quality Assurance

(Asking the question WHY to promote quality service provision)

Chris Woodgate, ISAS Officer

SOUNDS LIKE A REALLY BORING SUBJECT, especially if you have just spent 3 years achieving your degree, 1-2 years obtaining a qualification in advanced practice, worked your way through from assistant to accredited assistant practitioner or other clinical achievement which makes a difference to the care you give your patients.

But is Quality Assurance so different from all those other wonderful achievements? How do you know that the degree programme or course you attended was 'good enough'? How do you know that your new exciting area of practice remains up to date and evidence based?

How do you know that the new piece of equipment that has just been installed is fit for purpose and safe for you and patients to use? How do you find out if the new technique that has been developed is safe and effective? How can you be sure that the efficiencies that are made in your service by your managers is based on evidence and not just cost cutting?

Big questions – but important all the same; so where do you get the answers? The answers to all the above should be found in your quality assurance programme which is managed by a quality management system.

They are the basis on which the SCoR and the RCR built the Imaging Standards (these and other relevant information can be found at the web address at the bottom of the article). As professionals we should be looking to meet the highest standards wherever possible, otherwise all your study, hard work and dedication could be undermined as we are often reminded by salutary 'tales' from the HCPC disciplinary committee.

So what is the difference between quality assurance and quality management:-

1. QUALITY ASSURANCE

You may have thought of this in terms of making sure a product, like a tin of beans, is made/manufactured safely, consistently, accurately and fit for purpose. How then do you transfer this to the clinical setting?

a. Safe – everything you do needs to be safe for the patient and the staff performing any task.,

b. Consistent – it should be the same for every patient – in the BBC 'fly on the wall' documentary over the winter period a senior nurse was quoted as saying "it doesn't matter if they come from Buck House or the park bench, they are all treated the same" is that true of everything you do?

c. Accurate – are you sure that you are doing the right test, with the right equipment, at the right time, for the right patient?

d. Fit for purpose – is everything you do evidence based, can you demonstrate that it is best practice, that it is efficient and effective, using the best 'tools' to obtain the required result.

2. QUALITY MANAGEMENT

'A management system providing the means of establishing policy and objectives and the means to achieve those objectives'. In other words a repository where all your evidence, audit, policy/protocol/procedures are kept to demonstrate that as a service you are quality assured.

I don't know about you, but that still sounds a bit boring to me! How then is it relevant, interesting, productive, or helpful?

To me if I came into work everyday and did the same job without question – that is boring. You and I did not train to be automatons but to be professionals who challenge, innovate, move our profession forward, combating resistance with evidence gained through research and audit of our practice and others.

I don't know about you but I am really proud to be a radiographer, I am proud of my profession and any opportunity I get I want to demonstrate that our profession is forward thinking and innovative.

So dust off that all important question WHY. Be assured that in all you do there is a standard with an evidence base to back you up and if the evidence base is missing or out of date then WHY don't you research, audit, publish and demonstrate that as professionals we are a force to be reckoned with?

http://www.sor.org/imagine-services-accreditation-scheme

WHY Fronts

(Asking the question WHY to promote quality service provision)

How do you create change when you're not in charge?

WHO IS IN CHARGE? Is it your line manager, their line manager, the Radiology Manager the Chief Executive, NHS England, the Department of Health or A. N. Other (e.g. evil Galactic Empire, yes I like Star Wars)?

Do you need to know who is in charge to create change that benefits your patients and service? Going back to the 'evil Empire' I would say, "The only thing necessary for the triumph of evil is for good men to do nothing" (Edmund Burke), so perhaps doing nothing and leaving it to others is not a good option? When you look around you on the first hour of your shift/working day do you see inequality, unsafe practice, waste, a better way to do something? If so can you be bothered to do something about it and do you need to know who to complain to get them to change it?

Change is, at its core, a people process. So how do you create change when you are not in charge. A few ideas are outlined below;

- Challenge the existing beliefs and assumptions you and others have. Why do you do something the way you do; is it 'custom and practice' or is it evidenced based. Is it comfortable or challenging? Questioning why something is done the way it is allows you an understanding of how you may be limiting your possibilities without knowing it.
- How can you influence others; when you are working day to day your example of questioning process (in a positive way) and behaving in a dynamic way is the best influence ever, it will get you noticed!
- Do your homework/research; e.g. use the Imaging standard to measure your practice against, look for new techniques and challenges in professional journals. If you have the evidence it is easier to convince others that they should have a look at what you are suggesting.
- Try and find a sponsor; find a colleague who has a wider sphere of influence than you, who may have tried to do or succeeded in change in the past. Ask them why they think they did/didn't succeed. Ask them to check out your idea; they probably want to do that anyway before they stick their neck out for you. Ask someone you trust and respect and be prepared to share the 'glory'.
- Do you know who your audience is? If so make sure you articulate your ideas in way they will understand. After many years in the NHS I have learned that we speak 'radiographer', nurses speak in 'nurse', doctors speak in 'doctor' etc. You may need a translator to get your ideas across disciplines, for example audit to one group of professionals may not have the same meaning to another group of professionals. If you want to get them on side what is the 'win' for them, what is the agenda they are working too that would fit with yours?
- Empathy and diplomacy may be needed; you don't want to leave a trail of broken dreams in your wake. Others may have tried and failed, others may have a different agenda and others may have a vested interest in the status quo. Sometimes it is good to listen to the history of a process before destroying it.

The challenge - working with your colleagues and others to find opportunities to create change in the areas that you can influence. Testing your beliefs and assumptions, work together to identify what is within your span of control and your sphere of influence and what isn't. Create little victories that can build upon each other over time, and don't be afraid of failure that just lets you know one way it won't work, keep trying till you find the way it will work.

The best motivator of all, have some fun doing it! Why not give it a go after all you could save us all from...

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