Patient Safety Essentials

Study Guide

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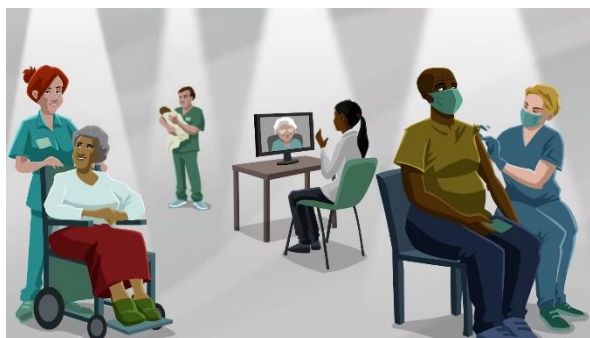
Those of us working in healthcare often experience very challenging circumstances. And we have a long history of proving ourselves to be remarkably adaptable in the way we care for patients. This includes our response to COVID-19. During the pandemic, we radically changed how we work. We kept patients safe while delivering essential care. We have all seen and done amazing things, every day, to help keep our patients safe. This is something that we can all rightly be proud of. But there is more we can do to make patient care even safer. Importantly, we need to think differently about what patient safety means and how we can make improvements.

When patients are harmed, it doesn't just affect them; it has an impact on their loved ones, our colleagues and, ultimately, our ability to care for our patients. Despite our best efforts over many years, too many patients are still suffering harm. There is a new Patient Safety Strategy that will help us deliver the changes that we need.

We already work hard to prevent safety incidents from happening. But to keep patients safer, thinking differently about patient safety means we need to be PROACTIVE. We need to identify and reduce RISK before harm occurs. To do this, we need to understand how the care SYSTEMS we work in can introduce risks to patient care.

There are already some limited proactive approaches in use in healthcare. These include the use of simulation to anticipate hazards in patient care or the user-testing of medical devices. But the management of system-based risks through proactive identification and mitigation is not yet widely or systematically applied, as it is in other safety-critical industries.

So, what can we do now?

By changing how we think about patient safety, we can:
- Deal with risks before they cause harm
- Create a positive patient safety culture
- Build safer systems of care
- Recognise everyone's role in patient safety
- Dealing with risks before they cause harm
- Staff always aim to provide safe care

The new, system-wide approach to training and education in patient safety is intended to make that easier for everyone. It will help us identify and address unsafe situations before harm occurs. Creating a positive patient safety culture.

Too often, patient safety incidents can result in an individual being blamed for making an error. But it is rarely as simple as that. In reality, even when we are highly motivated to do our best, a wide range of factors – usually outside our control – can affect our ability to perform our jobs.

Focussing on the impact the system has on our ability to deliver safe care will allow us to move away from this presumption of blame.

Building safer systems of care.

Once we understand how our systems of care affect patient safety, we can find ways to improve them. We can prevent risky situations from arising and make it easier to do the right thing. Recognising everyone's role in patient safety.

Finally, it is crucial that all staff, whatever our roles, should see safety not just as our responsibility, but as a key priority.

To summarise: We can now make healthcare even safer, by thinking differently about patient safety. This means:
- Dealing with risks before they can cause harm,
- Working to create a positive patient safety culture
- Building safer systems
- Recognising that patient safety is everyone's responsibility

The Patient Safety Strategy includes a syllabus and training programme for the whole NHS. There is patient safety education for every grade, every job, every profession.

This study guide is for every single person in the service. it's about:
- Working together in complex organisations
- Identifying and managing risks to patients
- Effective communications
- The importance of raising concerns

And it's a step towards creating a positive patient safety culture.

This guide introduces patient safety for all NHS and associated staff. It focuses on the essentials for creating patient safety. These include:
- listening to patients and raising concerns
- the systems approach to safety, where instead of focusing on the performance of individual members of staff, we try to improve the way we work
- avoiding inappropriate blame when things don't go well
- creating a just culture that prioritises safety and is open to learning about risk and safety
- Further sessions in this syllabus build on these essentials so that staff may become Patient Safety Practitioners or Advanced Practitioners or simply strengthen their approach to patient safety.

2. Essentials of patient safety for all

In looking after our patients in hospitals and the community, most things go well. Patients usually receive the care that they need. We are justly proud of this and of the many staff who work tirelessly to deliver care and improve our systems. In fact, it is the efforts of the people who deliver healthcare that make it as safe as it is.

Nevertheless, despite the efforts of healthcare staff, patients suffer harm every day in healthcare systems. Wrong medicines are given to patients, treatments may be omitted or delayed and patients in hospital beds develop pressure ulcers or are injured in a fall. Rarely, some patients die due to patient safety incidents whilst in our care.

Global studies have estimated that at least 1 in 20 patients are affected by preventable patient harm in medical care settings and that a high proportion of these, about 12%, cause permanent disability or even patient death. In the community, we know that similar incidents take place and overall, there may be many thousands of avoidable patient deaths every year.

We have made good progress over the past 15 to 20 years, when the NHS really started to focus on how things go wrong for patients. We have set up a national reporting and learning system to report patient safety incidents and share our understanding of patient safety.

Safety improvement initiatives have delivered real changes and certain types of risk have been effectively eliminated. We use past events to try to make it right where we can and yet things continue to go wrong.

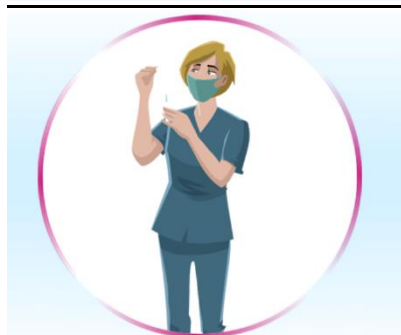It is clear that we need to do more.

The NHS Patient Safety Syllabus will provide training for all staff at all levels. It will provide training that can be used directly by all staff in the NHS and it will focus on 4 key areas.
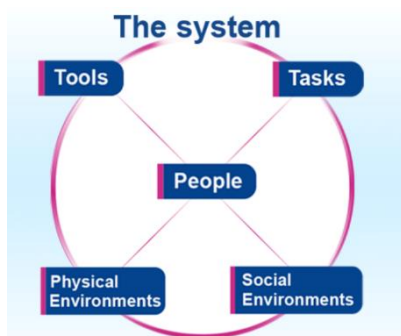
1. **Systems**

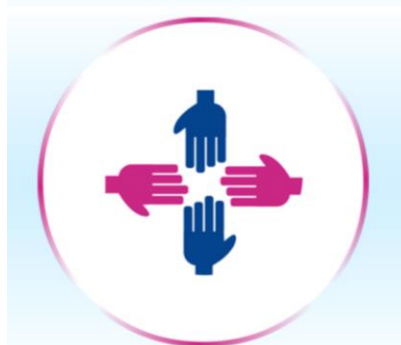   The complex way our various jobs fit together to provide what our patients need.

2. **Safety culture**

   The attitudes, beliefs and values that influence our work every day.

3. **Risk**

   How hazards can threaten the safety of our patients.

4. **Raising concerns**

   Supporting safety by listening to patients and observing how they get on in our complex organisations.

The NHS Patient Safety Syllabus.

Systems thinking is a way to understand how the individual elements in a greater whole influence each other and work together. You will learn about this approach and about the essential role of everyone in the team.

You will hear how we can best learn from past events and how we should understand the role of the individual members of staff when patients are harmed.

You will learn about how things go wrong for patients and how we can contribute to reducing harm by managing risk.

You will learn how to create safety proactively, using systematic tools and approaches.

Most importantly you will learn how every member of the NHS can support safety, how we can act to identify risk proactively, before a patient suffers harm. We can then go further and faster in anticipating and reducing patient harm.

3. Systems thinking

Everything exists in systems. Systems thinking is a way to understand how the individual elements in a greater whole influence each other and work together. We can begin to understand how this relates to healthcare by taking an example from real life which also forms the basis of a case study we will describe later in this session.

1 of 7 Baby's increased temperature

It begins with a family worried by their baby boy's increased temperature.

2 of 7 GP practice

The family's health is looked after by their GP practice.

3 of 7 Risk to health

When the GP identifies a serious risk to health, an ambulance may be called.

4 of 7 Hospital care

The hospital's care might include more specialist units.

5 of 7 Pharmacies

Medicines might be provided by pharmacies within the hospital or on the High Street.

6 of 7 Tests

Tests would be conducted and reviewed by other departments, including radiology and laboratories.

7 of 7 Additional care

Additional care in the community is provided by the GP practice, district nursing teams and health visitors.

HEALTH VISITOR

Everything exists in systems.

Systems thinking is a way to understand how the individual elements in a greater whole influence each other and work together, affecting the way we provide care for our patients.

Complex systems

Of course, in healthcare, these complicated systems are kept functioning by the people who work there.

The hard work of staff, who frequently go to great lengths to ensure proper care, is essential in making the systems work together, as well as anticipating problems and making sure that we can deal with unexpected or unusual issues when they arise.
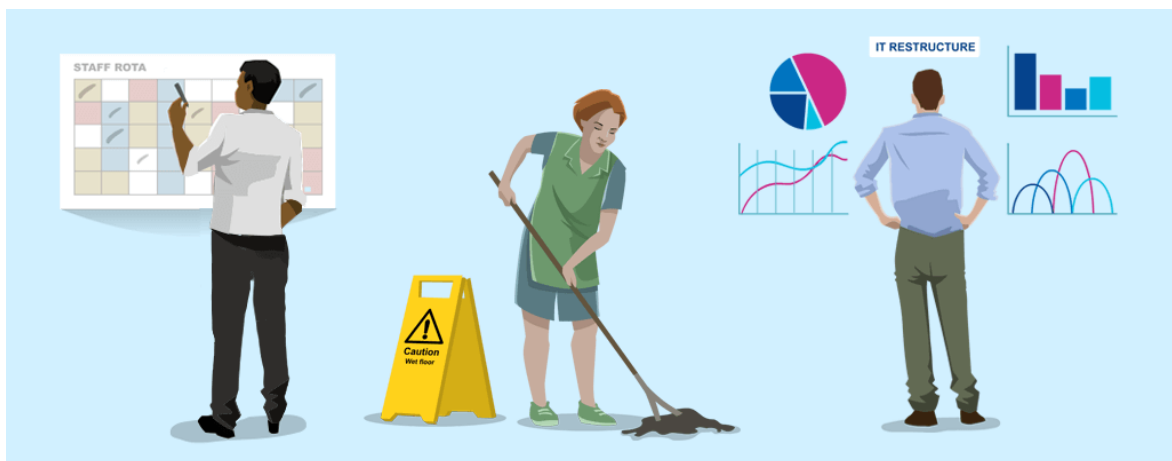
In the NHS, we rely on complex systems to deliver care to our patients. As we have shown, these systems might include diagnostics, medications, admission and discharge of our patients, the flow of information and communication, and the day-to-day care of our patients in the community and in hospitals.

Each of these is part of our overall system. Running through the system, making it work every day, are people, working correctly and resiliently, dealing with the unexpected, throughout thousands of staff and patient interactions every hour of every day.

4. A just culture

Safety in healthcare depends on systems and the people who work within them. As someone who works in healthcare, whether a carer, a mental health nurse in the community, a medical secretary, a porter, a doctor or a manager; you are part of our greater team, a team where patient safety is an essential objective.

Despite all our hard work making sure that things do go well, sometimes things go wrong.

Sometimes the complex systems that we are part of deliver outcomes that were not intended or desired.

It is natural to look for what went wrong, and everyone will have heard the words 'human error' used in this context. It is simple and natural to look for an individual, team or department to blame.

All too frequently it is usually the last person involved who gets the blame.

Yet we know that, when we examine carefully what has happened, we usually find that there were a number of interconnected reasons why things went wrong. These might include problems with equipment, workload, availability of information or distractions.

In other words, we find that there are many factors that contribute to why the system didn't deliver what was expected or hoped for, not the person who touched the patient last.

Case study

Let's look at a case study. This case is based on the real and very sad case of an 8-month-old baby boy who became poorly at home.

The baby developed a high temperature, was being sick and had a slight rash. The family doctor spoke with the baby's mother on the telephone but could not fit him in for a visit. Instead, he suggested that the baby was taken straight away to the local hospital, where there was a paediatric A&E Department.
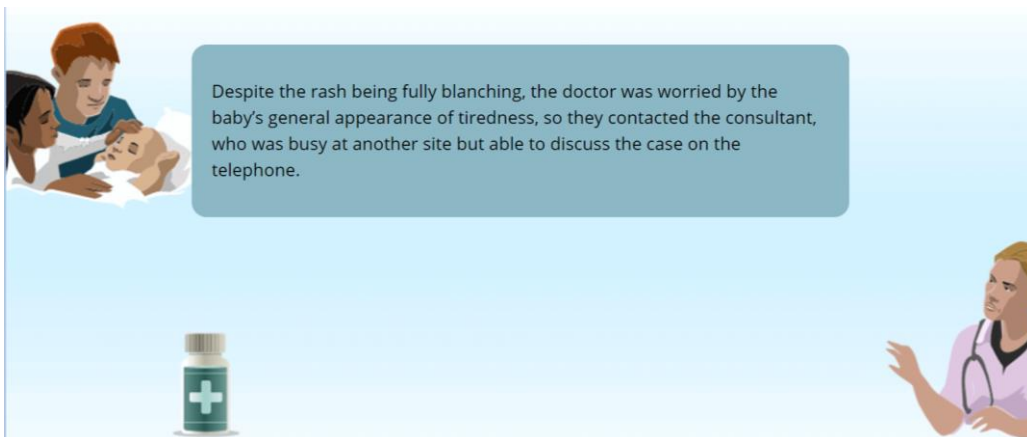

After a short wait, a triage nurse met with the family. The nurse did not examine the baby but did enter the baby's details on a computer-based triage system. After this, the nurse coded the baby as 'green', meaning that the baby should be seen within 2 hours.
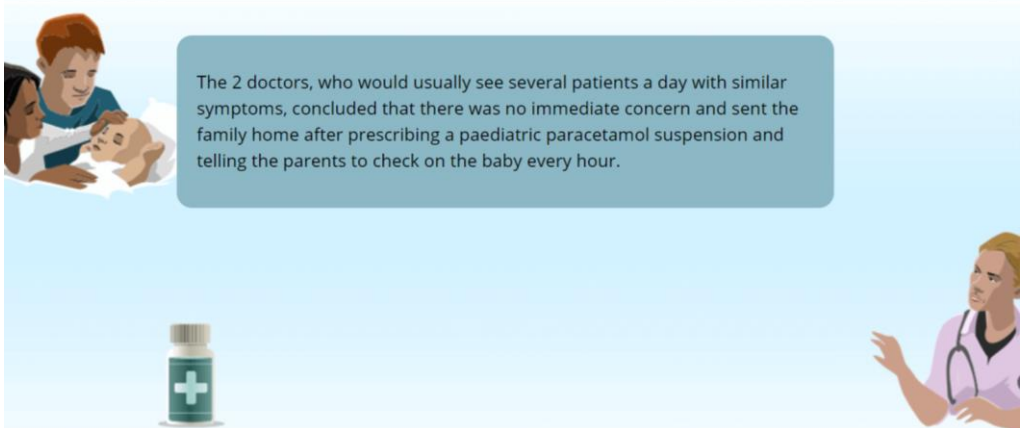

The baby was seen by a junior doctor after an hour. The doctor examined the baby boy and observed a faint rash which was fully blanching. This means that it disappeared when pressed on. A non-blanching rash is often a sign of bacterial meningitis and one of the key things to check.
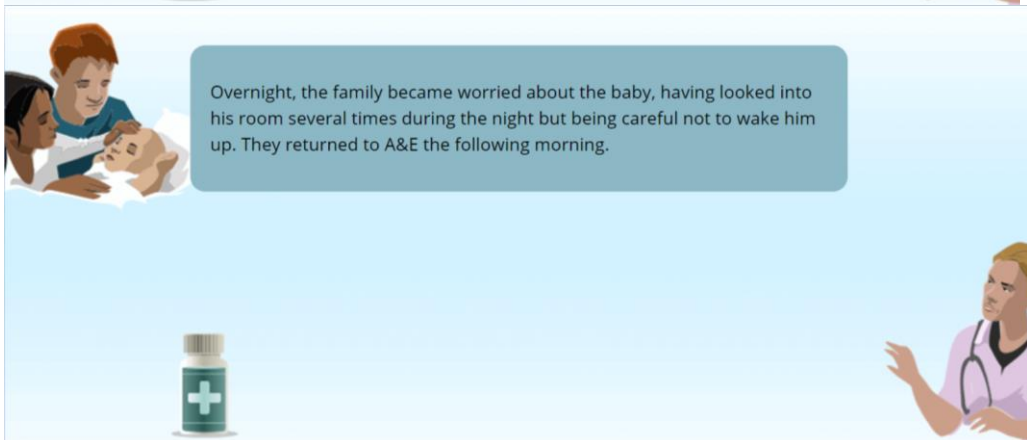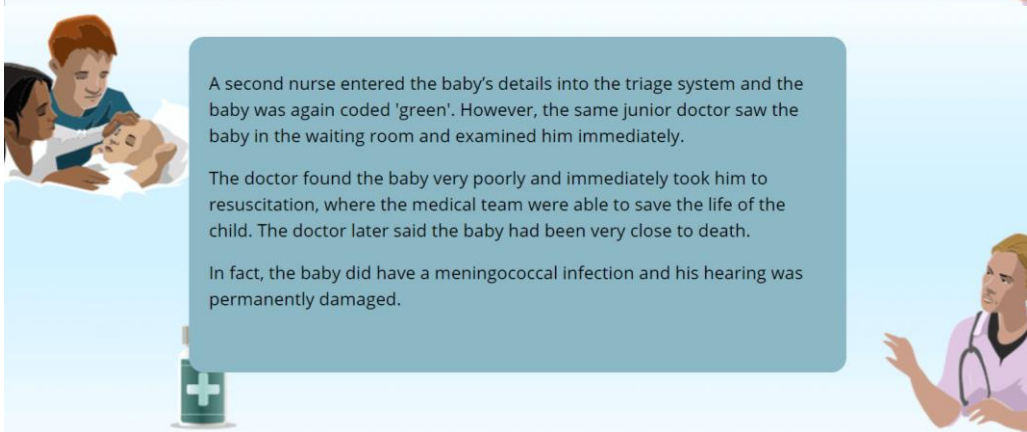
Despite the rash being fully blanching, the doctor was worried by the baby's general appearance of tiredness, so they contacted the consultant, who was busy at another site but able to discuss the case on the telephone.

The 2 doctors, who would usually see several patients a day with similar symptoms, concluded that there was no immediate concern and sent the family home after prescribing a paediatric paracetamol suspension and telling the parents to check on the baby every hour.

Overnight, the family became worried about the baby, having looked into his room several times during the night but being careful not to wake him up. They returned to A&E the following morning.

A second nurse entered the baby's details into the triage system and the baby was again coded 'green'. However, the same junior doctor saw the baby in the waiting room and examined him immediately.

The doctor found the baby very poorly and immediately took him to resuscitation, where the medical team were able to save the life of the child. The doctor later said the baby had been very close to death.

In fact, the baby did have a meningococcal infection and his hearing was permanently damaged.

In this case, many things could have gone better and prevented the permanent hearing loss and near death of the baby boy.

- Can you think of some ways this case could have been handled better?

- For example, we could highlight that:

- the triage system was not followed as expected and the lack of a direct examination of the baby was a key factor in the underestimation of the risk to the patient

- the triage system had been the subject of many complaints by the staff but nothing had changed so the staff had learned that raising concerns about it was futile

- the consultant was not available for direct examination of the baby

How to respond

Though it is tempting to look at the behaviour of individual members of staff, underlying factors were the systems in place at the time; a poor triage system that staff had become disengaged with, along with a busy period where no consultant was available in person.

In general, we could take 2 approaches here in response to the sad event.
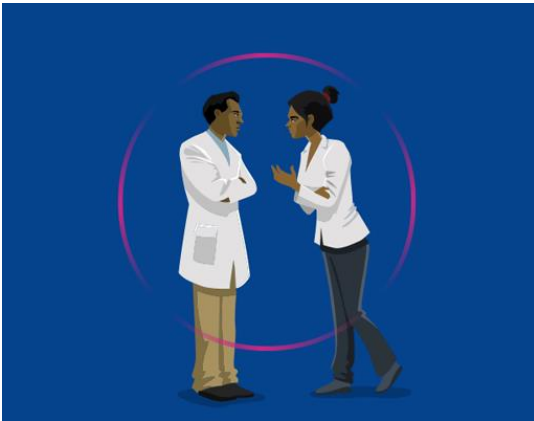
We could, for example, remind staff to follow policies, discipline and or retrain the nurses and doctors in the hope that they personally would be more vigilant in future. Then, if they happen to be on shift in similar circumstances, they may remember this event and the trouble they got into and consider acting differently.

They might leave the organisation given the guilt and shame they are probably feeling.

Either way, all the other staff that could be involved in similar situations in the future would carry on as before.

We could look at the systems and the working practices that apply to the entire department and change them for the better.

This is a graphical multiple choice question. Once you have selected an option, select the submit button below.

A. Of the 2 approaches, which do you think is the best way to respond to this sad event?

B. Of the 2 approaches, the systems approach (in short, fixing triage and consultant presence) was far more likely to create a safer department and support the safe care of all patients and the safe working practices of all staff.

Blame

We have seen in the case study how many different factors combined to allow the final, sad outcome. This is what is meant by the systems approach to safety and why when systems don't deliver the outcomes we want then it is unfair to assign blame to individual members of staff. It is better to look for how we can improve the systems, so that we can reduce the likelihood that it happens again.

Inappropriate blame

Inappropriate blame is very damaging. It is natural to blame a person; it's a simple explanation for when things go wrong and being simple it is satisfying. But it is rarely right. When a patient suffers a patient safety incident, the contributory factors of environment, equipment, the way people work together in the team and the way the whole organisation works with other organisations in the system are the factors that contribute to the incident. System factors, not individual members of staff are to blame.

Response to blame

The response of blaming our colleagues for problems with systems can be very damaging both to them and to ourselves. It creates a culture in which people are fearful and so they do not raise important issues about safety that involve themselves and their colleagues, for fear that they will be held responsible. That means we do not learn from our colleagues and important safety information is missed.

Blame suppresses learning

We need to avoid inappropriate blame and instead move to a just culture where the role that systems play in things going wrong is recognised. In a just culture people are not afraid of inappropriate blame and so feel safer in pointing out where things can be improved. This does not mean they are not accountable. Where people wilfully harm or neglect others then action must be taken but those situations are thankfully very unusual.

Risk

Let's turn now to risk. We are all aware that risks to patients are everywhere. It may be the risk of falling when a patient is unsteady on their feet or the risk of pressure ulcers developing when someone is immobile for a long period. It may be an unknown allergic reaction to a medication.

Staff in all professions, whether patient facing or not, will use their professional knowledge to identify risks to their patients and try to manage those risks. This includes clinicians, managers and administrative staff who all contribute to patient safety by creating and delivering systems and processes that seek to minimise risks to patients.

However, no one person can see the whole picture. That means that everyone caring for patients and service users must be aware of how things might go wrong. The risks might be in their immediate workspace but also in the larger system that delivers care to patients through our healthcare systems.

Of course, the patients themselves, their families, their carers, and representatives will recognise many factors that may be hidden from staff. Their involvement in safety and the management of risk is vital in forming a complete picture of risk and safe, compassionate care.

Identifying risks proactively

This component displays an image gallery with accompanying text. Use the next and back navigation controls to work through the narrative. Risk in our systems, risks created by the way we work, are often uncovered only after something has gone wrong for the patient. It is our duty to learn from these patient safety incidents and we frequently see in our rear-view mirror how risk to our patients was already present and how it contributed to an incident. However, it is clearly preferable to identify and mitigate risks to patients before a patient is harmed.

1 of 4 Identifying risks

The [NHS Patient Safety Syllabus](#) is focused on identifying risks proactively in addition to making better use of learning from previous investigations. In other words, identifying risks before harm has occurred.

Preventing harm requires an understanding of, and a focus on, risk. It is better to develop a full picture of hazards and their associated risks to patients and to monitor these than to have to ask why a harmful event occurred after the fact.

2 of 4 Managing risks

Other safety-critical industries have for many years focused on risk proactively and in this way have become safer and safer.

If we can identify risks upfront in our systems, then we have a good chance of managing them by designing them out or by changing our systems to avoid or minimise our risks.

3 of 4 Key to safety

This approach, where risks are identified proactively, is the key to being safe. The NHS Patient Safety Syllabus, in some of its further sessions, provides tools and techniques for staff to manage risk proactively and help reduce harm to patients.

4 of 4 Expand awareness

This is something that can be done by every single member of staff. If we are allowed to raise concerns without fear of rejection or inappropriate blame, then the NHS expands its awareness by encouraging risk awareness. Not only do we expand our awareness, we unlock the potential for everyone to improve how they and their colleagues do their jobs.

5. Raising concerns

Every member of staff has an opportunity to support safety by listening to patients and by observing how they are getting on in our complex organisations. Some of these observations may be that Mr Gibson isn't responding to treatment or that Mrs Patel has dropped one of her tablets or that Ms Jones' heels are giving her pain.

In our busy workplaces, many things can be missed just in the course of a normal day. When things get still busier, when the pressure is on, then more and more things are likely to be missed and actively raising concerns about patients becomes more and more valuable.

At an organisational level, many members of staff will recognise deficiencies in the way our systems interact or in how information is dealt with. There are many examples of systems where people were aware of risks or concerns, but these were not raised in a timely fashion, were not fully recognised or even ignored and that led to patient safety incidents.

In every case, raising concerns is a good thing and should be welcomed as such by everyone. Listening to patients, watching them on their journey and informing your colleagues, or your line manager, or one of the team caring for the patient is everyone's opportunity to create safety in our busy NHS or in other care settings.

If you are a member of staff to whom the concern is raised, remember our joint responsibility to look after patients and welcome the concern. We have a collective responsibility to manage risk proactively and to welcome the input of all members of staff.

Every organisation has a process for raising concerns, for example, through [Freedom To Speak Up Guardians](#) who provide independent support and advice to staff who want to raise concerns.

Make sure that you are aware of Freedom To Speak Up systems or whistle-blower systems, as they are sometimes called and use these responsibly and confidentially to help improve the way we work.

6. Summary and next steps

We have covered 4 main areas in this session:

1. the need for a systems approach

2. how a systems approach shows that inappropriate blame is damaging

3. the need to address future risk as well as past harm

4. the importance of raising concerns where necessary

We have also seen how systems failures can cause tragic events for patients and the critical importance of a patient-centred approach to care. All of these points and many more are explained more fully in further learning sessions of the NHS Patient Safety Syllabus.

Further information

If you want to develop your understanding and your ability to protect your patients or service users from further harm, then carry on to Level 2 - Access to practice. There are 2 short sessions.

Level 2 lays the foundations of 'safety science' in 4 key areas: human factors, risk, systems and safety culture. We have also collected some other resources, including key articles, videos and books on patient safety.

One thing we haven't covered in this session are the local safety priorities where you work. That's because these will be different depending on where you are. It's important to know what they are; your local organisation has been asked to provide the materials you need, either on paper or through your local Intranet.

If you want to know more or take a more active part in patient safety, please continue to Level 2 of this programme, Access to practice. This builds on the session you've just completed and will give you a strong basis in 'safety science':
  o systems thinking
  o risk
  o human factors
  o safety culture

This is the end of the module.
To complete the assessment please return to the pre-assessment system.

Content in this document is taken from the e-LFH module.