Patient Safety Learning

SB 220 China Works
100 Black Prince Road
London SE1 75J

nfo@patientsafetylearning.org

www.patientsafetylearning.org

#### 4890811

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# A Blueprint for Action

### Shared learning for patient safety



#### In a patient-safe future:

- Learning for safety is easy
- Improvement is supported
- Investigations are consistently good

#### **Action:**

- Set and meet goals for learning and share insight
- Remove barriers so clinicians and patients can share learning
- Report on the effectiveness of investigations into unsafe care
- the hub, an online platform to share learning about patient safety

patient safety learning the hub

### Professionalising patient safety



#### In a patient-safe future:

- We have standards and accreditation for patient safety
- Behaviour, attitudes, skills and knowledge for all staff are underpinned by defined competencies
- We are safer by design: guidance, resources and toolkits are widely available and used
- We have enough staff with the correct skills to undertake critical tasks safely

#### Action:

- Build system-wide expertise in patient safety and human factors
- Initiate and support the development of standards, resources, competency framework and accreditation for patient safety

### Data and insight for patient safety



#### In a patient-safe future:

- We measure and manage healthcare to be safe, we don't just measure harm
- We report on patient safety performance
- We identify shortfalls in patient safety performance early and address them

#### Action:

- Develop practical models for measuring, reporting and assessing patient safety performance. These include both qualitative and quantitative data
- A panel of experts to identify critical data and insight for safety
- Patient safety designed into digital health initiatives as a core principle

### Leadership for patient safety



#### In a patient-safe future:

- Leaders address risks through the design of safer care
- Leaders challenge a blame culture through their behaviour and words
- Leaders adopt governance that specifies standards, actions and behaviours

#### Action:

- Set and deliver patient safety goals, outcomes and standards
- Convene leadership forum for the design and coordination of safe care
- Systems approach with human factors

### Patient engagement for patient safety



#### In a patient-safe future:

- Patients are engaged as valued partners in their healthcare
- Patients are part of the patient safety team
- Governance requires patient engagement including publishing safety goals, standards and performance
- After unsafe care, patients, families and staff are supported and cared for at every stage

#### Action:

- Organisations fund, recruit, train and support patients to become patient safety advocates
- 'Harmed patient care pathways' for patients, families and staff

## Culture for patient safety



#### In a patient-safe future:

- Our culture encourages and supports patient safety
- It is easy and safe for anyone to raise, discuss and resolve safety concerns
- Organisations demonstrate empathy, respect and rigour when addressing unsafe care

#### Action:

- Publish goals and programmes to eliminate blame and fear
- Measure culture transparently and report progress
- Share and celebrate innovation through the hub and Patient Safety Learning Awards

# **Patient Safety: A Blueprint for Action**



Specialist patient safety and human factors expertise



**Governance for patient safety** 



Improvements measured and reported



Patients contribute to investigations



Investigations undertaken by experienced and trained staff



Learning for safety is a priority



**Proactive redesign for safety** 



Patient safety embedded in decision-making



Staff and patients reporting unsafe care and near misses



Learning informs safety improvement



Blame culture behaviour not tolerated



Leadership for patient safety including patient engagement



Patient safety in integrated care

Minimal avoidable harm

Safety is a core purpose

Safe for staff



MINIMAL

Aiming to meet

statutory and

regulatory

requirements





22 222

Incidents recorded and reported



Patients informed of safety risks and consent to treatment



Patients and families engaged when things go wrong



### REACTIVE

Plans in place to meet statutory and regulatory requirements



Patients actively engaged in the safety of their care

**ACTIVE** 

Actively seeking

opportunities

to improve

patient safety



Safe staffing



**Patient advocates** 



Staff training on systems and human factors



**Safety culture assessment** 



Patient safety impact assessments



### **PROACTIVE**

Reducing harm, supporting staff, plans to deliver a patient-safe future





Standards and accreditation for patient safety



Competency framework for all staff



A demonstrable Just Culture



Safety performance information published



Patient safety impact assessments, business cases



Patients are members of the clinical team



Patient safety is a professional discipline with specialist staff

