

Seven steps to patient safety

An overview guide for NHS staff

Second print *April 2004*



This is the second printing of *Seven steps to patient safety – an overview guide for NHS staff* and is complemented by the more detailed examination of patient safety, contained in *Seven steps to patient safety – the full reference guide*. Both documents are available in electronic format from www.npsa.nhs.uk/sevensteps

Seven steps to patient safety

Step 1 Build a safety culture

Step 2 Lead and support your staff

Step 3 Integrate your risk management activity

Step 4 Promote reporting

Step 5 Involve and communicate with patients and the public

Step 6 Learn and share safety lessons

Step 7 Implement solutions to prevent harm

Creating a common language for patient safety

Patient safety: the process by which an organisation makes patient care safer. This should involve: risk assessment; the identification and management of patient-related risks; the reporting and analysis of incidents; and the capacity to learn from and follow-up on incidents and implement solutions to minimise the risk of them recurring.

Patient safety incident: any unintended or unexpected incident which could have or did lead to harm for one or more patients receiving NHS funded healthcare. *This is also referred to as an adverse event/incident or clinical error, and includes near misses.*

Clinical governance: a framework through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish.

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Find out more about patient safety

This is an overview of the NPSA's detailed guide to good practice which covers building a safer culture and managing, reporting and learning from patient safety incidents. This overview and its detailed counterpart, *Seven steps to patient safety – the full reference guide*, are available in full at www.npsa.nhs.uk/sevensteps

If you would like to receive future updates on the NPSA's work, and patient safety news and events, you can subscribe to the NPSA NewsLine via our website:

www.npsa.nhs.uk/newsletter/newsline.asp

Introduction

Every day more than a million people are treated safely and successfully in the NHS, but the evidence tells us that in complex healthcare systems things will and do go wrong, no matter how dedicated and professional the staff. And when things go wrong, patients are at risk of harm.

The effects of harming a patient are widespread. There can be devastating emotional and physical consequences for patients and their families. For the staff involved too, incidents can be distressing, while members of their clinical teams can become demoralised and disaffected. Safety incidents also incur costs through litigation and extra treatment.

Patient safety concerns everyone in the NHS, whether you work in a clinical or a non-clinical role. At the National Patient Safety Agency (NPSA) we believe that tackling patient safety in the NHS collectively and in a systematic way can have a positive impact on the quality of care and efficiency of NHS organisations.

But we need your help to make this happen.

Your guide to patient safety

This summary guide has been produced to provide you with an overview of patient safety and to update you on the tools the NPSA is developing to support you.

Improving patient safety depends not only on our work nationally, but also on the vital work that is taking place at a local level. Since we were established in 2001, we have encountered a high level of commitment to patient safety from a diverse range of NHS and non-NHS staff

The NPSA was set up in July 2001 following recommendations from the Chief Medical Officer in his report on patient safety, *An organisation with a memory*¹ and its follow-up *Building a safer NHS for patients*². Its role is to improve the safety of patients by promoting a culture of reporting and learning from patient safety incidents. By incidents we mean times when things go wrong in the NHS that did or could have harmed a patient. The National Reporting and Learning System (NRLS) on patient safety incidents is central to our strategy. Data collected through the system will help us to:

- identify trends and patterns of avoidable incidents and underlying causes;
- develop models of good practice and solutions at a national level;
- improve working practices in NHS organisations locally through feedback and training; and to
- support ongoing education and learning.

Improving patient safety depends not only on our work nationally, but also on the vital work that is taking place at a local level. Since we were established in 2001, we have encountered a high level of commitment to patient safety from a diverse range of NHS and non-NHS staff. Hundreds of organisations are already working with us to drive forward the patient safety agenda.

We hope this guide helps you identify the gains you can make within your own organisation, department or team

We hope this guide helps you identify the gains you can make within your own organisation, department or team. To assist you locally we have appointed a network of 32 patient safety managers across England and Wales. See page 22 for more on what the manager in your area can offer you.

Safety in healthcare is a relatively young field internationally and it will be some time before we understand its full potential. We still have a long way to go. However, we are already seeing evidence that by working together we can all make healthcare safer.

Sue Osborn and Susan Williams

Joint Chief Executive

Patient safety - our starting point

The NPSA aims to help the NHS to save lives and avoid unintentional harm to patients by promoting patient safety at all levels of the health care system.

The publication of *An organisation with a memory* and *Building a safer NHS for patients* highlighted international research which exposed the need to learn more from things that go wrong, and mobilised the patient safety movement in the NHS. In the US, studies have found that between 44,000 and 98,000 incidents are estimated to contribute to patient deaths. This is viewed by many commentators as underestimating the extent of the problem.

On the best available data in England, extrapolating from a small study in two acute care trusts, it is estimated that around 10% of patients (900,000 using admission rates for 2002/3) admitted to NHS hospitals have experienced a patient safety incident, and that up to half of these incidents could have been prevented. This study also estimated that 72,000 of these incidents may contribute to the death of patients³. Studies in Australia, New Zealand and Denmark have suggested similar findings. Although most of the research to date has focused on incident rates in acute care, many of the underlying contributory factors also apply to other healthcare settings.

Studies have also shown that **the best way of reducing error rates is to target the underlying systems failures, rather than take action against individual members of staff**. It is vital that we confront two myths that still persist in healthcare, as identified by Dr Lucian Leape⁴ from the Harvard School of Public Health:

- **the perfection myth:** if people try hard enough, they will not make any errors;
- **the punishment myth:** if we punish people when they make errors, they will make fewer of them.

At the NPSA, we recognise that healthcare will always involve risks, but that these risks can be reduced by analysing and tackling the root causes of patient safety incidents. We are working with NHS staff and organisations to promote an open and fair culture, and to encourage staff to inform their local organisations and the NPSA when things have gone wrong. In this way, we can build a better picture of the patient safety issues that need to be addressed.

At a local level healthcare staff can use this information to help avoid future risks. Nationally, the NPSA can identify underlying trends that require an NHS-wide response. In short, we believe it is no longer enough to rely on the best efforts of NHS staff to provide high quality, safe care; we must improve the systems they operate in and support them in their work.

The clinical governance agenda has provided the NHS with a greater focus on patient safety than ever before. It has helped NHS organisations develop clearer lines of accountability, strengthen their risk management functions, and improve their methods of assessing clinical quality. The Healthcare Commission (CHAI) will continue this drive for radical improvements in the quality and efficiency of our healthcare.

Within the clinical governance framework, two key NPSA initiatives are designed to drive the **patient safety agenda** forward:

- 1 The implementation in 2004 of the NPSA's **National Reporting and Learning System** (NRLS) across NHS organisations in England and Wales. This is the most ambitious patient safety incident data collection system in the world. National reporting will directly inform the development of our patient safety solutions and future research, and help the UK remain at the forefront of patient safety learning.
- 2 The provision of specialist training on **Root Cause Analysis** to staff in NHS organisations once reporting nationally. This technique is used to investigate incidents in a thorough and rigorous way, and the training supports local learning and promotes a consistent approach to managing incidents across the service. As importantly it supports a strengthening of reflective practice.

Seven steps to patient safety

What can you do?

It is vital that NHS staff can assess the progress they make towards delivering safer care. We have set out the seven steps that NHS organisations should take to improve patient safety.

Following these steps will help ensure that the care you provide is as safe as possible, and that when things do go wrong the right action is taken

The steps provide a simple checklist to help you plan your activity and measure your performance in patient safety. Following these steps will help ensure that the care you provide is as safe as possible, and that when things do go wrong the right action is taken. They will also help your organisation meet its current clinical governance, risk management and controls assurance targets.

1 Build a safety culture

Create a culture that is open and fair

2 Lead and support your staff

Establish a clear and strong focus on patient safety throughout your organisation

3 Integrate your risk management activity

Develop systems and processes to manage your risks and identify and assess things that could go wrong

4 Promote reporting

Ensure your staff can easily report incidents locally and nationally

5 Involve and communicate with patients and the public

Develop ways to communicate openly with and listen to patients

6 Learn and share safety lessons

Encourage staff to use root cause analysis to learn how and why incidents happen

7 Implement solutions to prevent harm

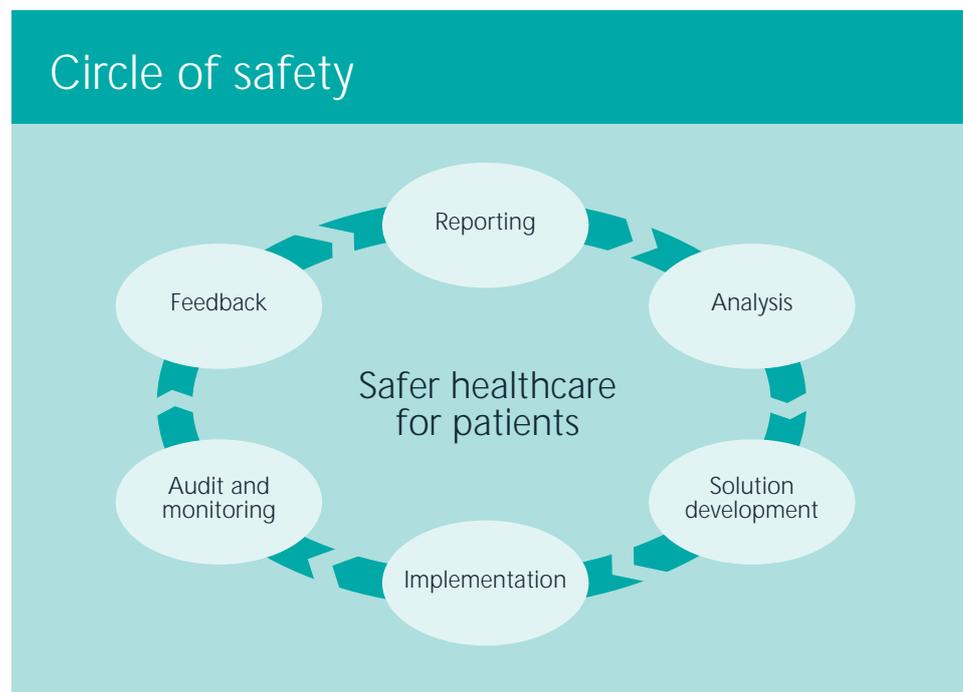
Embed lessons through changes to practice, processes or systems

For any system as complex as the NHS to achieve all of the above requires a significant shift in culture and a high level of commitment across the service over many years. We recognise that some NHS organisations are further down this path than others, and that you may need to prioritise the steps you take next.

Over the following pages we summarise some of the evidence for the steps and provide a checklist of key action points for NHS organisations,

teams and staff. At the end of each section we highlight the tools available to help you achieve real improvements to patient safety at a local level.

If after reading this you would like to learn more, the NPSA has also produced *Seven steps to patient safety – the full reference guide* which examines patient safety in more detail. The full reference guide is available at www.npsa.nhs.uk/sevensteps



Step 1

Build a safety culture

'Every effort should be made to create in the NHS an open and non-punitive environment in which it is safe to report...'

Learning from Bristol (Department of Health 2002)⁵

Create a culture that is open and fair

In its response to the Kennedy Report into children's heart surgery at Bristol Royal Infirmary, the Government said that without a culture of safety and openness in the NHS, incidents and concerns were routinely overlooked.

All too often in the past the immediate response to an incident in the NHS has been to identify and blame the individual members of staff involved. Staff may have been suspended while the root (underlying) causes of the incident were ignored. This promotes an unwillingness among staff to report incidents.

Research into safety in healthcare and other industries has shown that the best people sometimes make the worst mistakes, and that errors fall into recurrent patterns regardless of the people involved⁶. If NHS staff understand these principles they are more likely to report incidents. Staff dealing with incident reports are also more likely to respond in a systematic and fair way.

Patients, NHS staff and organisations have a lot to gain from the promotion of an open and fair culture.

Action points

For your organisation:

- ensure your policies state what staff should do following an incident, how it should be investigated, and what support should be given to patients, families and staff;
- ensure your policies describe individual roles and accountability for when things go wrong;
- assess your organisation's reporting and learning culture using a safety assessment survey (see 'Resources from the NPSA' on page 10).

For your team:

- ensure your colleagues feel able to talk about their concerns and report when things go wrong;
- demonstrate to your team the measures your organisation takes to ensure reports are dealt with fairly and that the appropriate learning and action takes place.

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Resources from the NPSA

Safety culture survey

The NPSA has reviewed safety culture surveys currently available, and will be developing a tailor-made survey for the NHS. This will enable organisations to undertake a baseline assessment against which they can measure progress over time. In the meantime, NHS organisations can use the Safety Climate Survey, available from www.qualityhealthcare.org

Incident Decision Tree

The Incident Decision Tree is an electronic, web-based interactive tool designed for NHS managers dealing with staff who have been involved in a patient safety incident. Based on a model developed by Professor James Reason for the aviation industry, it prompts the user with a series of questions to help them take a systematic, transparent and fair approach to decision-making. For more information, visit www.npsa.nhs.uk/idt

Visit www.npsa.nhs.uk/newsletter/newsline.asp to subscribe to our newsletter for updates on this work.

If after reading this you would like to learn more about **Step 1**, the NPSA has also produced *Seven steps to patient safety – the full reference guide* which examines patient safety in more detail. The full reference guide is available at www.npsa.nhs.uk/sevensteps

Step 2

Lead and support your staff

Establish a clear and strong focus on patient safety throughout your organisation

Patient safety affects everyone in the NHS. Building a safer culture depends on strong leadership and an organisation's ability to listen to all members of the healthcare team.

At the NPSA we are working to ensure that patient safety is a key element in training programmes for board level staff, NHS management and clinical staff, and in undergraduate and postgraduate courses. We will be providing training and induction tools to help you.

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Action points

For your organisation:

- ensure there is an executive board member with responsibility for patient safety;
- identify patient safety champions in each directorate, division or department;
- put patient safety high on the agenda of board or management team meetings;
- build patient safety into the training programmes for all your staff and ensure this training is accessible and measure its effectiveness.

For your team:

- nominate your own champion or lead for patient safety;
- explain the relevance and importance of patient safety to your team, and the benefits it brings;
- promote an ethos where all individuals within your team are respected and feel able to challenge when they think something may be going wrong.

Resources from the NPSA

Patient safety induction video

This 20 minute film provides a practical introduction to patient safety, and its relevance to NHS staff. Hosted by Channel 4's Krishnan Guru-Murthy, the film explores the reasons why patient safety incidents happen, what we can learn from them and how to minimise the risk of them happening again. To request a copy for your organisation please call the Department of Health response line on 08701 555 455, quoting reference PSIV2003.

Safety checklist for patient safety leads and champions

The NPSA has developed the safety checklist for patient safety leads and champions in the form of a self assessment tool. It can be used by all patient safety leads and champions to give individual or groups of leaders a range of choices to consider, periodically revisit and use to trigger action.

The safety checklist is available from the NPSA's detailed guide, *Seven steps to patient safety – the full reference guide* (see step 2), available from www.npsa.nhs.uk/sevensteps

Also in development:

Patient safety e-learning programme

An interactive web-based e-learning tool for NHS staff who want to learn more about patient safety. The tool can be adapted for different users, depending on their area of interest, healthcare setting and professional role.

Visit www.npsa.nhs.uk/newsletter/newsline.asp to subscribe to our newsletter for updates on this work.

If after reading this you would like to learn more about **Step 2**, the NPSA has also produced *Seven steps to patient safety – the full reference guide* which examines patient safety in more detail. The full reference guide is available at www.npsa.nhs.uk/sevensteps

Step 3

Integrate your risk management activity

Develop systems and processes to manage your risks and identify and assess things that could go wrong

Patient safety is a key component of risk management

Local risk management systems are designed to help NHS organisations manage incidents effectively and reduce the chances of them happening again. Patient safety is a key component of risk management, and should be integrated with staff safety, complaints management, litigation and claims handling, and financial and environmental risk. Local risk management systems should also be supported by an organisational risk management strategy, a programme of proactive risk assessments and the compilation of an organisation-wide risk register.

Action points

For your organisation:

- review your structures and processes for managing clinical and non-clinical risk, and ensure these are integrated with patient and staff safety, complaints and clinical negligence, and financial and environmental risk;
- develop performance indicators for your risk management system which can be monitored by your board;
- use the information generated by your incident reporting system and organisation-wide risk assessments to proactively improve patient care.

For your team:

- set up local forums to discuss risk management and patient safety issues and provide feedback to the relevant management groups;
- assess the risk to individual patients in advance of treatment;
- have a regular process for assessing your risks, for defining the acceptability of each risk and its likelihood, and take appropriate actions to minimise them;
- ensure these risk assessments are fed into the organisation-wide risk assessment process and risk register.

If after reading this you would like to learn more about **Step 3**, the NPSA has also produced *Seven steps to patient safety – the full reference guide* which examines patient safety in more detail. The full reference guide is available at www.npsa.nhs.uk/sevensteps

Step 4

Promote reporting

‘Reporting systems are vital in providing a core of sound, representative information on which to base analysis and recommendations.’

An organisation with a memory (Department of Health, 2000)

An organisation with a memory has firmly established the need for better reporting systems across the health service and demonstrated the impact of such systems on safety in other industries.

The NPSA was created to co-ordinate nationwide efforts to report and, more importantly, learn from patient safety incidents in England and Wales. As part of this work we have developed a National Reporting and Learning System (NRLS) that will provide a clearer picture of the patient safety issues that need to be prioritised across the service. We are also committed to supporting patient safety incident reporting locally, and to promoting best practice in local reporting and risk management.

Ensure your staff can easily report incidents locally and nationally

All NHS organisations should have developed, or be developing, a centralised system for collecting data on patient safety incidents. This will enable them to analyse the type, frequency and severity of the incidents, and to use this information to improve systems and clinical care. For such systems to be effective, organisations need to develop a policy to encourage and support staff to report patient safety incidents.

There are three types of incidents that should be reported:

- incidents that have occurred;
- incidents that have been prevented (also known as near misses);
- incidents that might happen.

Information from all these incidents and from risk assessments can flag up problem areas and lead to preventative strategies to protect patients.

In addition to local reporting, NHS organisations will participate in national reporting, with the implementation of NRLS across England and Wales in 2004. The system has been developed with the help of 39 English and Welsh NHS organisations, and reflects a range of healthcare settings. We worked with these organisations to develop:

- a system that interfaces with all the commercial local risk management systems in use in the majority of NHS organisations;
- a NPSA dataset - a standard national framework used to gather patient safety incident information and ensure optimum learning. The dataset can be adapted to enable both local data collection and analysis and

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The information provided to the NPSA will be analysed to identify patterns and key underlying contributory factors

- national data collection, and is tailored to each healthcare setting;
- consistent terminology and definitions so that NHS staff know what to report;
- an electronic reporting form (eForm) for organisations without a commercial local risk management system, or for those staff who only wish to report independently of their organisation. Nonetheless we will always encourage NHS staff to share their reports with their local organisation so that learning takes place at both a local and national level.

The information provided to the NPSA will be analysed to identify patterns and key underlying contributory factors. The names of the individuals involved, either staff or patients, will not be retained. Importantly, this data will be cross-referenced with a number of other information sources before we establish patient safety priorities and develop practical national solutions.

Once organisations are reporting nationally, they will also benefit from dedicated specialist Root Cause Analysis (RCA) training from the NPSA to support their own incident analysis locally (see pages 18-19).

Action points

For your organisation:

- complete a local implementation plan (see below) which describes how and when your organisation will begin reporting nationally to the NPSA.

For your team:

- encourage your colleagues to actively report patient safety incidents that happen and those that have been prevented from happening but that carry important lessons.

Resources from the NPSA

Get connected – how to sign up to the NRLS

We have developed comprehensive instructions to joining the NRLS, covering the options open to each NHS organisation. They include a readiness checklist to help risk management and clinical governance staff prepare their local implementation plan for national reporting. This is available at

www.npsa.nhs.uk/static/connecting.asp

If after reading this you would like to learn more about **Step 4**, the NPSA has also produced *Seven steps to patient safety – the full reference guide* which examines patient safety in more detail. The full reference guide is available at **www.npsa.nhs.uk/sevensteps**

Step 5

Involve and communicate with patients and the public

‘The active role of patients in their care should be recognised and encouraged. Patients have a key role to play in helping to reach an accurate diagnosis, in deciding about appropriate treatment, in choosing an experienced and safe provider, in ensuring that treatment is appropriately administered, monitored and adhered to, and in identifying adverse events and taking appropriate action.’

Charles Vincent and Angela Coulter (2002)⁷

Research studies have shown that patients accept something has gone wrong when they are told about it promptly, fully and compassionately⁸. Patients expect honesty from their healthcare teams⁹ and this open approach minimises the trauma they feel. Patients who do not feel that there has been an apology or an explanation are, understandably, more likely to make a formal complaint and to seek compensation⁸.

Develop ways to communicate openly with and listen to patients

At the NPSA we have found that we can gather valuable insights into why things go wrong by involving patients in the analysis of patient safety issues, like medication errors. In the same way, patients can also play a role in reducing the chance of harm. Patients are more often than not experts in their own condition and have a less fragmented perspective on the care they receive than NHS staff. These things help build a detailed picture of why an error happened.

To involve patients actively organisations need to:

- acknowledge and apologise for failings in the care they deliver, and reassure patients and their families that the right lessons have been learnt from patient safety incidents;
- have appropriate systems in place to support patients, their carers, families and staff who have been involved in incidents; and
- have policies that commit the organisation to being open about those incidents that involve permanent harm or death.

Patients are more often than not experts in their own condition and have a less fragmented perspective on the care they receive than NHS staff. These things help build a detailed picture of why an error happened

Action points

For your organisation:

- develop a local policy covering open communication about incidents with patients and their families;
- ensure patients and their families are informed when things have gone wrong and they have been harmed as a result;
- provide your staff with the support, training and encouragement they need to be open with patients and their families.

For your team:

- ensure your team respects and supports the active involvement of patients and their families when something has gone wrong;
- prioritise the need to tell patients and their families when incidents occur, and to provide them with clear, accurate and timely information;
- make sure patients and their families receive an immediate apology where it is due, and are dealt with in a respectful and sympathetic way.

Resources from the NPSA

In development:

Being open

We are developing guidance and training to help NHS staff facing the difficult task of talking to patients and their relatives following a serious patient safety incident. This will be available from summer 2004.

Visit www.npsa.nhs.uk/newsletter/newslines.asp to subscribe to our newsletter for updates on this work.

If after reading this you would like to learn more about **Step 5**, the NPSA has also produced *Seven steps to patient safety – the full reference guide* which examines patient safety in more detail. The full reference guide is available at www.npsa.nhs.uk/sevensteps

Step 6

Learn and share safety lessons

‘When a patient safety incident occurs, the important issue is not who is to blame for the incident but how and why did it occur. One of the most important things to ask is what is this telling us about the system in which we work?’

Charles Vincent (2002)¹⁰

Encourage staff to use root cause analysis to learn how and why incidents happen

To learn everything they can from patient safety incidents, NHS organisations should be applying Root Cause Analysis (RCA) or Significant Event Audit (SEA) techniques.

RCA and SEA are techniques to review a patient safety incident to find out what happened, how and why. They pinpoint areas for change, and prompt recommendations for sustainable solutions that reduce the chances of the incident happening again.

Action points

For your organisation:

- ensure relevant staff are trained to undertake appropriate incident investigations that will identify the underlying causes;
- develop a local policy which describes the criteria for when your organisation should undertake a Root Cause Analysis (RCA) or Significant Event Audit (SEA). These criteria should include all incidents that have led to permanent harm or death.

For your team:

- share lessons from the analysis of patient safety incidents within your team;
- identify which other departments might be affected in future, and share your learning more widely.

Resources from the NPSA

Root Cause Analysis training

We are providing specialist RCA training for selected staff in every NHS organisation in England and Wales that begins participating in national reporting. It is expected that up to 5000 NHS staff will receive this training.

Root Cause Analysis tool

We have developed a web-based e-learning training package on RCA. The package provides NHS staff with guidance on how to analyse incidents, and an interactive tool to help them develop confidence in performing RCA. Our online resource centre contains downloadable documents covering a range of RCA tools, a glossary, key references and links. This is available from www.npsa.nhs.uk/rca

If after reading this you would like to learn more about **Step 6**, the NPSA has also produced *Seven steps to patient safety – the full reference guide* which examines patient safety in more detail. The full reference guide is available at www.npsa.nhs.uk/sevensteps

Step 7

Implement solutions to prevent harm

‘One of the serious deficits in the NHS of the past has been an inability to recognise that the causes of failures in standards of care in one local NHS organisation may be the way in which risk can be reduced for hundreds of future patients elsewhere.’

Building a safer NHS for patients (Department of Health, 2001)

The NPSA aims to build on local learning and follow-up by analysing the underlying contributory factors and developing solutions at a national level.

Embed lessons through changes to practice, processes or systems

An organisation with a memory made the important distinction between ‘passive learning (where lessons are identified and not put into practice) and active learning (where those lessons are embedded into an organisation’s culture and practices)’.

To be effective, the local analysis of patient safety incidents should lead to a local action plan to ensure that lessons are applied throughout the organisation

To be effective, the local analysis of patient safety incidents should lead to a local action plan to ensure that lessons are applied throughout the organisation. The impact of these action plans should then be measured over time, as part of a core clinical governance activity review programme. Communicating the results of these action plans to staff will also help to boost confidence in the incident reporting process.

One of the NPSA’s primary aims is to develop sustainable national solutions that address key patient safety issues. Over time the National Reporting and Learning System (NRLS) will provide national data on reported incident types and factors that contributed to them. This information, together with other research, will inform our solutions work.

Where we establish that wider change is needed, for example in equipment re-design or with current national systems and processes, we will work with the Department of Health, other NHS agencies and manufacturers to highlight the appropriate evidence to ensure safer healthcare for all.

Action points

For your organisation:

- use the information generated from incident reporting systems, risk assessments, and incident investigation, audit and analysis to identify

local solutions. This could include re-designing systems and processes, and adapting staff training or clinical practice;

- assess the risks for any changes you plan to make;
- measure the impact of your changes;
- draw on solutions developed externally. These could be solutions developed at a national level by the NPSA or best practice identified elsewhere in the NHS;
- provide staff with feedback on any actions taken as a result of reported incidents.

For your team:

- involve your team in developing ways to make patient care better and safer;
- review changes made with your team to ensure they are sustained;
- ensure your team receives feedback on any follow-up to reported incidents.

Resources from the NPSA

Patient safety solutions

We have a wide range of patient safety solutions development projects underway. Once fully developed and tested, practical solutions will be shared with the service for implementation locally.

We will also issue alerts with advice where we identify serious patient safety issues. These have included alerts on preventing accidental overdose of intravenous potassium and standardising crash call numbers to 2222.

Examples of our major projects as of spring 2004 include:

- the launch of a toolkit developed from a pilot with six acute NHS trusts and the NHS Purchasing and Supply Agency (PASA) to test measures to reduce the errors associated with the use of infusion devices (www.pasa.nhs.uk/infusiondevices);
- a package of practical solutions to reduce errors associated with the use of the drug oral methotrexate. The package includes a patient treatment diary and a project to adapt default settings in IT systems in GP surgeries and community pharmacies;
- an integrated campaign to boost hand hygiene, piloted in six acute NHS trusts.

Visit www.npsa.nhs.uk/newsletter/newslines.asp to subscribe to our newsletter for updates on this work.

If after reading this you would like to learn more about **Step 7**, the NPSA has also produced *Seven steps to patient safety – the full reference guide* which examines patient safety in more detail. The full reference guide is available at www.npsa.nhs.uk/sevensteps

A patient safety manager will be located within each Strategic Health Authority area in England and NHS region in Wales

The local face of patient safety

A patient safety manager in your area

To support staff across the service working to improve patient safety, the NPSA has established a network of 32 patient safety managers. A patient safety manager will be located within each Strategic Health Authority area in England and NHS region in Wales.

Patient safety managers will:

- provide expertise, support and co-ordination to help develop and introduce the National Reporting and Learning System (NRLS);
- support and advise NHS staff on patient safety issues, with an emphasis on developing an open and fair culture and training in patient safety;
- support NHS risk managers in the identification, management, investigation and reporting of patient safety incidents and risks;
- bring patient safety concerns and solution ideas to the attention of the NPSA and help develop solutions;
- provide leadership and advice on patient safety to NHS organisations in their area.

Visit www.npsa.nhs.uk/static/contacts.asp to contact the patient safety manager near you.

Looking to the future

How do you measure your success in patient safety?

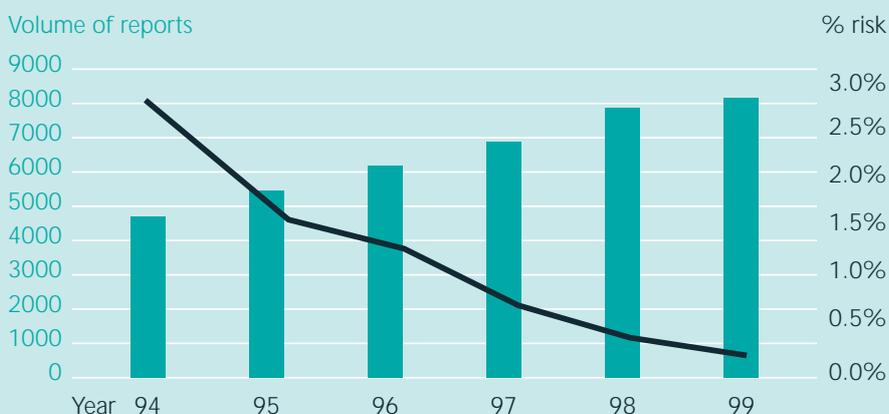
The experience from other sectors, such as the aviation industry, shows clearly that as reporting levels rise the number of serious incidents begins to decline

There is no single way to measure patient safety. Paradoxically, an increase in reporting of patient safety incidents is a sign that you have implemented an open and fair culture where staff learn from things that go wrong. The experience from other sectors, such as the aviation industry, shows clearly that as reporting levels rise the number of serious incidents begins to decline.

By following the seven steps to patient safety, you can make a significant impact on the quality of the care you provide. We look forward to working with you in achieving safer care for all.

Air safety reports

Volume of reports and risk
British Airways data 1994 -1999



Key ■ Total number of reports ■ High and medium risk events (as a percentage of the total number of events)

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The National Patient Safety Agency

We recognise that healthcare will always involve risks. But that these risks can be reduced by analysing and tackling the root causes of patient safety incidents. We are working with NHS staff and organisations to promote an open and fair culture, and to encourage staff to inform their local organisations and the NPSA when things have gone wrong. In this way, we can build a better picture of the patient safety issues that need to be addressed.

Seven steps to patient safety

We have set out the seven steps that NHS organisations should take to improve patient safety.

The steps provide a simple checklist to help you plan your activity and measure your performance in patient safety. Following these steps will help ensure that the care you provide is as safe as possible, and that when things do go wrong the right action is taken. They will also help your organisation meet its current clinical governance, risk management and controls assurance targets.

Further copies

If you would like to order more copies of *Seven Steps to Patient Safety* please call the NHS response line on 08701 555455

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