

# fact sheet

JUNE 2009

## Questions are the answer!

### Seven questions every board member should ask about patient safety

#### Question 1. Does everyone understand the importance of patient safety?

**Why is it important?** A clear and explicit view of patient safety is the foundation for setting goals and standards. Patient safety is everyone's responsibility and everyone needs to understand what it means for them.

**What does 'good' look like?** Patient safety is a top organisational priority. Our board has a clear strategy for patient safety that sets specific, measurable and challenging goals for improving the safety of patient care and reducing patient harm each year. We make a public commitment to this. We have named executive and non-executive board members responsible for patient safety and we are clear that everyone from board members through to front-line staff are involved and have a part to play. Safety, effectiveness, and a good experience are part of our quality agenda and are discussed at every board meeting. At least 25 per cent of our board agenda is about the quality and safety of the care we deliver.

#### Question 2. Do we really have an open and fair culture?

**Why is it important?** Staff are less likely to report errors or raise safety concerns if they are punished or blamed. Most errors are as a consequence of weaknesses in the system which then affect the performance of the individuals within that system. A culture of blame can drive reporting underground and prevent us from learning what makes things safer.

**What does 'good' look like?** The chair and chief executive make a clear, public commitment to staff that the organisation fully supports an open and fair culture. When things go wrong, staff feel able to be open, they are

treated fairly and we identify the failures in the system and improve them, rather than seeking to blame specific individuals at the 'sharp end'. Regular board safety walkrounds provide an opportunity to talk to front-line staff, patients and their families about their experiences and opportunities to improve safety.

#### Question 3. Are we actively encouraging reporting of incidents?

**Why is it important?** Organisations that report more incidents usually have a better and more effective safety culture. We can't learn and improve if we don't know what the problems are. It is important to know what happened and why it happened. We also want to know about the things that nearly happened as well as those that did.

**What does 'good' look like?** We understand that high reporting indicates an open and fair culture. We encourage staff to report things that go wrong. We make it easy to do so and we ensure we feed back themes and lessons learned. Our board uses national comparative data from the National Reporting Learning System (NRLS) reports to see where we feature in terms of numbers reported and levels of harm reported.

#### Question 4. Do we get the right information?

**Why is it important?** Learning from all sources of data together provides an organisation with a true reflection of where things are going wrong and what is needed to prevent minor incidents from becoming more major and serious incidents. A resilient system is one that expects the unexpected. It anticipates mistakes and risks and creates barriers so that their effect is either lessened or even prevented.

**What does 'good' look like?** Our organisation draws from all sources including: reported incident themes and rates; clinical risks; complaints; claims; patient liaison issues; serious untoward incidents; prescribing data; unexpected deaths; hospital standardised mortality ratios; and triggers highlighted from case note reviews. Our board scrutinises these data effectively to assure ourselves that our organisation learns from them, takes action and monitors the action. Our board uses patient and staff stories to put a 'human face' on the numbers and actively seeks accounts of patient experience wherever possible. Our board is kept informed of serious and ongoing issues and recognises the links between staffing and quality outcomes and patient safety. We maintain a state of intelligent wariness even in the absence of poor outcomes. We have an atmosphere of chronic unease to avoid the pitfall of 'it could not happen here'.

#### **Question 5. Are we always open when things go wrong?**

**Why is it important?** Communicating effectively with patients and their carers is a vital part of dealing with errors or problems in their treatment. Saying sorry, providing an explanation and keeping them informed will help patients and their families to cope when things have gone wrong. This can lessen the trauma suffered by patients and potentially reduce complaints. It is also vital to provide staff with support to cope with the incident and to help them communicate well.

**What does 'good' look like?** Our staff understand our organisation's policy on being open. Those who may need to be involved in talking with patients and their family and carers when things have gone wrong are confident, appropriately trained and fully supported in this process. We actively involve patients and their families in learning from patient safety incidents. There is access to counselling support for staff involved in patient safety incidents.

#### **Question 6. Do we learn from patient safety incidents?**

**Why is it important?** The response system is always more important than the reporting system. A robust methodology should be in place to ensure incidents are thoroughly investigated so that all contributing factors and root causes are identified and any recommendations are implemented successfully. Providing feedback will enhance reporting and learning.

There must be clear, rapid, and useful feedback on lessons learned and actions taken.

**What does 'good' look like?** Our staff are trained in investigation techniques such as root cause analysis or significant event audit. Lessons learned are implemented, where relevant, throughout the organisation and not just where the incident occurred. Implementation is planned and carefully monitored. Our board members and staff across the organisation receive regular reports showing results of investigations and implementation plans. Our board members ask what has happened with the results of previous investigations. Staffing problems that have an impact on patient care are identified and rectified. We thank staff for their contributions.

#### **Question 7. Are we actively implementing national guidance and safety alerts?**

**Why is it important?** A resilient organisation strives to continuously improve safety practices rather than being content to keep one step ahead of regulatory sanctions. It is vital to learn lessons from outside the organisation as well as from local information.

**What does 'good' look like?** Our organisation has an efficient and effective response to all national guidance and alerts. There is robust monitoring of implementation of those relevant, and the actions required quickly become embedded in the organisation. A proactive stance means that our board strives to seek out and remove potential problems. Our board receives regular updates on the implementation of national safety information. Our organisation is committed to and is implementing the changes supported by national initiatives, including Patient Safety First (England), 1000 Lives Campaign (Wales), the Scottish Patient Safety Programme and Patient Safety Initiative in Northern Ireland, as appropriate to our organisation.

Go to [www.npsa.nhs.uk/nrls](http://www.npsa.nhs.uk/nrls) for references, tools and guidance to support each of these seven essential questions.

#### **Links**

[www.patientsafetyfirst.nhs.uk](http://www.patientsafetyfirst.nhs.uk)

[www.patientsafetyalliance.scot.nhs.uk/programme](http://www.patientsafetyalliance.scot.nhs.uk/programme)

[www.wales.nhs.uk/sites3/home.cfm?orgid=781](http://www.wales.nhs.uk/sites3/home.cfm?orgid=781)

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## References

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*Safe in the knowledge.* The Healthcare Commission, 2008

Safer Practice Notice 10. NPSA, 2005

*Act on reporting.* NPSA and NHS Confederation briefing issue 161, June 2008

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## Contributions

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Robina Shah MBE DL JP, Chair, Stockport NHS Foundation Trust

Andy Willis, non-executive director, Taunton and Somerset NHS FoundationTrust and Associate, King's Fund