

Introduction

Seven steps to patient safety for primary care



A message from the Joint Chief Executive

Background and introduction

A message from the Joint Chief Executive

Every day more than a million people are treated safely and successfully within NHS-funded primary care. Advances in technology and knowledge have made this possible but they have also created an immensely complicated healthcare system. In this environment patient safety is obviously of the highest importance and taking this concept forward might seem daunting. This is especially so in primary care, given the diversity and complexity of the sector and the huge change agenda that you all face.

This complexity brings its own set of risks, and things will and do go wrong, no matter how dedicated and professional staff are. The effect of this is widespread. There can be devastating emotional and physical consequences for patients and their families. For the staff involved too, incidents can be shattering, while members of clinical and practice teams can become demoralised and disaffected. Safety incidents also incur costs through litigation and extra treatment.

In November 2003, the National Patient Safety Agency (NPSA) launched *Seven steps to patient safety*, a guide to good practice intended to offer NHS organisations practical guidance and support on improving patient safety. This was followed in early 2004 with a full reference guide detailing more of the latest thinking and evidence on patient safety.

Although the guide was aimed at staff within all healthcare settings, feedback from primary care organisations and teams told us that they wanted their own version of the guide, to acknowledge and address the different challenges that the primary care sector faces. The NPSA is committed to ensuring that the products and advice we develop for healthcare staff and organisations are effective and useful. We also place great importance on the vital role and contribution that those working in primary care can make in driving forward the patient safety agenda and have responded by developing this separate version of *Seven steps to patient safety* specifically for the sector. We hope that you will find it useful in tackling the patient safety issues that you deal with on a daily basis.

Patient safety concerns everyone in the NHS, whether you work in a clinical or a non-clinical role, as an independent contractor, or for a primary care organisation.

At the NPSA we believe that tackling patient safety collectively and in a systematic way can have a positive impact on the quality and efficiency of all NHS-funded care. The NPSA recognises that improving patient safety depends not only on our work nationally but also on the vital work that is taking place at a local level. We have benefited greatly from the passion and steadfast work of numerous individuals, staff, patients and the public, across all sectors and levels of the NHS.

Since the NPSA was 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 improve the safety of the patients in their care. In particular we would like to acknowledge the organisations that have worked with us to develop and test our National Reporting and Learning System, along with our patient safety solutions. Our thanks and gratitude goes to all these organisations for their time, dedication and enthusiasm for patient safety.

Safety in healthcare is a relatively young field internationally and it will be some time before we can understand its full potential. We still have a long way to go but we are already seeing evidence that by working together we can make healthcare safer. We hope that this version of *Seven steps to patient safety* will help all of you involved in primary care to make patient safety a reality.

Sue Osborn and Susan Williams

Joint Chief Executive

Background and introduction

Your guide to patient safety in primary care

Huge numbers of people are treated and cared for in NHS-funded primary care each day. For example, almost one million people visit their family doctor; 1.5 million prescriptions are dispensed; and district nurses make 100,000 visits. Amongst all this complex activity, the potential for risk to patients is high; things sometimes go wrong and patients are harmed as a result. When patients move between the primary and secondary care sectors, the potential for patient safety problems increases further.

Seven steps to patient safety for primary care is a best practice guide that describes the seven key areas of activity that primary care organisations and teams can work through to safeguard the patients they care for.

The seven steps to patient safety

Step 1 Build a safety culture

Create a culture that is open and fair

Step 2 Lead and support your staff

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

Step 3 Integrate your risk management activity

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

Step 4 Promote reporting

Ensure your staff can easily report incidents locally and nationally

Step 5 Involve and communicate with patients and the public

Develop ways to communicate openly with and listen to patients

Step 6 Learn and share safety lessons

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

Step 7 Implement solutions to prevent harm

Embed lessons through changes to practice, processes or systems

Seven steps to patient safety for primary care is your guide to patient safety. It is most relevant to staff responsible for clinical governance and risk management, but it also applies to all those who are responsible for providing care for patients in the primary care setting. This guide is equally applicable to managed staff and independent contractor staff with differing accountabilities.

These Steps are founded on a thorough review of literature from across the world, reflecting current thinking and best practice, and on experience of what works in patient safety. The guide is divided into individual Steps which can be downloaded separately and used to develop your strategies, policies and action plans, as well as for presentations to your staff.

The tools and solutions described in these Steps have been developed in conjunction with patient safety experts together with NHS staff and organisations. We have made every effort to pilot each NPSA initiative first. While this may have slowed our progress we felt that it was crucial before any national roll-out across the NHS. We have tried not to be too prescriptive – there are national solutions for universal processes and procedures, but local problems require solutions tailored to the unique local environment. We hope this guide helps you identify the gains you can make within your own organisation, practice or team.

The Steps described are not exclusively one process after another. Rather, they are part of a continuing process and offer primary care organisations, staff and teams a framework on which to work towards improving patient safety. They will help you develop a culture where staff and patients are treated openly and fairly, where patient safety is a central feature of your policies and systems and is at the forefront of everyone's mind and is everyone's business. The NPSA believes that the patient experience should be at the heart of any drive to make patient care safer and that better communication between staff and patients is a key part of that effort. With this in mind, we have ensured that the principles of involving and communicating with patients are an important component of each Step.

Some organisations are already well advanced along the route to patient safety, but many are just starting to think about how best to address the patient safety problems they face. We have therefore tried to provide practical hints and techniques, examples of local best practice and tool kits for the management and promotion of patient safety. These provide a checklist to help you plan your activities and measure your performance.

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 you meet your current clinical governance standards or contractual obligations, risk management accreditations and the national standards for safety.¹ We encourage all staff who provide care in the NHS to use this guide as a patient safety manual and as a framework to develop your plans for improving patient safety over the next three to five years. There are many examples of initiatives around the world that have successfully demonstrated that patient safety can be improved. None, however, have been translated to an entire healthcare system. The NHS is uniquely placed to pioneer improvements in patient safety across a single system and *Seven steps to patient safety for primary care* provides a framework for primary care organisations, staff and teams to achieve this.

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Terminology

For ease of reference, throughout these Steps:

Primary care organisation(s) will be used as a collective term to describe primary care trusts (England) and local health boards (Wales).

Practice(s) will be used to include all the different types of practices; general medical practices, general dental practices, and their staff (e.g. practice nurses, practice managers, dental nurses, hygienists, receptionists), optometrists and opticians, pharmacy practices, and so on.

¹ Department of Health (2004). *National Standards, Local Action Health and Social Care Standards and Planning Framework 2005/06–2007/08*. Available at: www.dh.gov.uk/publications

Teams and staff applies to teams who are directly managed working in community settings, e.g. community children's nurses, community learning disability nurses, nursery nurses, district nurses, health visitors, community psychiatric nurses and community midwives (the latter employed by an acute trust). The term also includes 'lone' professionals working across community settings (e.g. clinics, patients' homes, respite care, day care, residential homes, nursing homes) such as specialist nurses (e.g. continence, tissue viability) as well as allied health professionals (e.g. chiropodists, podiatrists, physiotherapists, audiologists, speech and language therapists, occupational therapists, dieticians).

Leaders applies to the chief executive of a primary care trust or local health board; their board, fellow directors and senior staff; clinical and managerial leads within each practice (pharmacy leads, general medical leads, general dental leads, optometry leads, practice managers); lead nurses; and leaders of each allied health profession.

Patient safety – our national challenge

The Department of Health publication, *An organisation with a memory*, mobilised the patient safety movement in the NHS. The report reviewed the growing body of international evidence on patient safety. It drew attention to the scale and pattern of potentially avoidable patient safety incidents^a and the devastating consequences these can have on patients, their families and the healthcare staff involved. The report also acknowledged that, as in many other countries, there has been little systematic learning from patient safety incidents and service failure in the NHS. *An organisation with a memory* proposed solutions based on developing a culture of openness, reporting and safety consciousness within NHS organisations, and identified four key areas that need to be addressed if the NHS is to successfully modernise its approach to learning from failure:

1 Unified mechanisms for reporting and analysis when things go wrong

The NPSA aims to collect information on patient safety incidents, collate local data (from staff and patients), review existing evidence (e.g. epidemiological, research and development), trigger original research and development and feed back data and information

a Patient safety incident: any unintended or unexpected incident that could have or did lead to harm for one or more patients receiving NHS-funded healthcare. The term 'patient safety incident' will be used to describe 'adverse events' or 'clinical errors', and 'near misses'. **Step 4** describes this in more detail.

on patient safety to NHS organisations and patients. This is described further in **Step 4**.

2 A more open culture in which incidents or service failures can be reported and discussed

The NPSA aims to focus on changing the culture in healthcare to improve safety for patients. This is through raising awareness, providing clear guidance, providing support through a network of patient safety managers, and developing the tools and techniques described in **Steps 1 and 2**. **Step 5** describes the involvement and communication with patients and their families to ensure we are more open and inclusive.

3 Systems and monitoring processes to ensure that where lessons are identified, the necessary changes are put into practice

Step 7 promotes the importance of translating lessons from incidents into practical long-term solutions for change and ensuring these are embedded into the culture and routine practice of primary care trusts, local health boards, practices and teams. We offer guidance on how to incorporate lessons and changes into processes and systems and provide examples of approaches and solutions being developed by the NPSA.

4 A much wider appreciation of the value of the systems approach in preventing, analysing and learning from patient safety incidents

Step 6 explains how to use chronological investigation techniques – significant event audit (SEA) and root cause analysis (RCA) – to find out what went wrong in a patient safety incident, how and why. We suggest how primary care organisations, practices and teams can learn safety lessons through SEA/RCA and what the NPSA can do to help.

Online resources for patient safety

To access all versions of *Seven steps to patient safety*:

www.npsa.nhs.uk

Your local NPSA patient safety manager can also help with support and advice: **www.npsa.nhs.uk**

More information about safety briefings, safety culture assessments and other tools: **www.saferhealthcare.org.uk**

The NPSA developed the Incident Decision Tree for acute care to support fair decision-making, and is now adapting the tool for primary care:

www.npsa.nhs.uk/health/resources/incident_decision_tree

The NPSA's *Being open* policy encourages healthcare staff and organisations to be more honest and open with patients when things go wrong. Training tools and resources to support local policies are now available. For more information visit the *Being open* academy: **www.msnpsa.nhs.uk/boa**

Visit **www.npsa.nhs.uk/npsa/newsletter** to subscribe to our newsletter for updates on our work.

Your patient safety manager can update you about plans for training in root cause analysis in your area. The NPSA has also developed a web-based learning package about root cause analysis techniques:

www.npsa.nhs.uk/health/resources/root_cause_analysis

The latest solutions and advice from the NPSA:

www.npsa.nhs.uk/advice

Other useful websites:

Healthcare Commission, England:

www.healthcarecommission.org.uk

Department of Health, Safety Alert Broadcast System, England:

www.info.doh.gov.uk/sar/cmopatie.nsf

NHS Modernisation Agency, England: **www.modern.nhs.uk**

Healthcare Inspectorate Wales: **www.hiw.wales.gov.uk**

Institute of Quality Assurance, US: **www.iqa.org**

Institute of Medicine, US: **www.iom.edu**

Joint Commission on Accreditation of Healthcare Organisations, US:

www.jcaho.org

National Patient Safety Foundation, US: **www.npsf.org**

National Center for Patient Safety, US: **www.patientsafety.gov**

The Leap Frog Group for Patient Safety, US:

www.leapfroggroup.org

International Society for Quality in Healthcare, Australia:

www.isqua.org.au

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 for primary care

We have set out the seven steps that primary care organisations in the NHS 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 and risk management targets.

Further copies

If you would like to order printed copies of *Seven steps to patient safety for primary care*, please call the NHS response line on 08701 555455. Individual sections are available online at:

www.npsa.nhs.uk/sevensteps

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