



## RECORD

## Why?

- Recording patient safety incidents is vital to contribute to local and national patient safety improvement.
- It is important to understand common elements across the system that might require regional or national improvement.

## How?

- Engage with your local systems, which may be at practice, PCN, federation or ICB level.
- Learn from Patient Safety Events service (LFPSE) is available in England. NHSE requires that all practices register with LFPSE, but use of the system is not mandatory.

## RESPOND

## Why?

- To understand:
  - what happened
  - how it happened
  - which system factors came together to result in the incident.
- To examine processes and work conditions to support the design of safer care for patients.
- To take a whole system approach to support a culture of just learning.

## How?

- Create a safe space for curiosity to guide the generation of insight; make sure that individuals understand that there is a fair learning culture.
- Use a recognised systems-based approach that considers multiple interacting contributory factors.
- Capture the 'view from inside the tunnel' – seek to understand how the incident was perceived by those involved and why decisions made sense at the time.

## Act

## Why?

- To transform insight into effective and sustainable improvement.

## How?

- Use an integrated and collaborative approach for designing, implementing, and monitoring safety actions.
- Give staff ownership of the process; externally imposed actions can fail to engage staff and lack sustainability.

## MONITOR

## Why?

- Monitoring effectiveness of actions over time will test whether changes result in safer care.

## How?

- Continue to be curious – inquire about how things are working and monitor whether actions put in place remain effective and are sustainable.

## SHARE

## Why?

- Creates an opportunity to reduce duplication of effort.
- Enables change outside your organisation.
- Allows safety patterns and trends to be noticed as soon as possible.

## How?

- Create local networks where safety incidents and the response to them can be discussed in a confidential and no-blame fashion.
- Consider writing up particularly useful incidents as case reports or journal articles.