PATIENT SAFETY PROCESSES LEARNING

RECORD

Why?	How?
• 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.	• 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, but not mandatory in primary care.

RESPOND

Why?	How?

• 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.
	• 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?	How?
• To transform insight into effective and sustainable improvement.	• 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?	How?
• Monitoring effectiveness of actions over time will test whether changes result in safer care.	• Continue to be curious – inquire about how things are working and monitor whether actions put in place remain effective and are sustainable.

SHARE

Why?	How?
• 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.	• 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.