Safety Checklist

Questions Everyone Should Ask About Safety
These questions have been developed as a guide to support you to think about the questions you should be asking, and the answers you should expect when discussing safety within your organisation. You should think about the questions and what they mean to you within the context in which your services are delivered (for example clinical or non-clinical, patient facing or national support) and adapt them to meet your needs.

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Q1: Does everyone understand their role and responsibility in improving safety?

Why is it important?

Safety is an essential component of high quality health care. We need to make sure that our healthcare system is safe for our staff and our patients. Ensuring that patients and staff are kept safe within all healthcare settings (including urgent, primary, community and hospital care) is central to ensuring improvements in the quality of patient care. Safety is everyone's responsibility and everyone needs to understand what it means for them. Leadership and strategic support to improve safety should exist at all levels within our organisations.

What does ‘good’ look like?

• Our strategy includes a clear vision and purpose for the future that puts the quality of care and the safety of people at its heart.
• We have a clear plan for safety that is appropriately resourced and sets specific, measurable and challenging goals for improving the safety of patient care, service delivery and reducing harm each year. We make a public commitment to this.
• We are clear that everyone from Board members through to front-line staff, service users and their families are responsible for safety, are involved, empowered and have a part to play.
• We support leaders at all levels to undertake safety walkrounds to provide support for safety work and unlock barriers to improvement.
• Safety, effectiveness and a good experience are part of our quality agenda and are discussed at every Board meeting.

At least 25% of our Board agenda is about the quality and safety of the care we deliver. Our Board knows what actions to take if there are concerns about the safety of the care.
Q2: 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?

• Our 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.
• Our Board take responsibility for system failures 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, their families and carers about their experiences and opportunities to improve safety.
• Understanding the follow-up actions and response to safety walkrounds helps to create an open and fair culture and supports the principles of a learning organisation.
Q3: Are we actively encouraging reporting of adverse events?

Why is it important?

Organisations that report more adverse events usually have a better 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 (near misses) 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 feedback themes and lessons learned across the organisation and nationally.
• We understand that effective, honest communication and team working supports situational awareness across teams and the organisation, and allows all team members to have a voice, be listened to and responded to.
Q4: How is learning from adverse event reviews fed into local improvement programmes, including the Scottish Patient Safety Programme? (Are our systems and processes reliable; are we responding and improving?)

Why is it important?

The response system is always more important than the reporting system. A robust methodology should be in place to ensure adverse events are thoroughly reviewed so that all contributing factors are identified and any recommendations and improvements are implemented successfully. Providing feedback will enhance reporting, learning and improving. There must be clear, rapid and useful feedback on lessons learned and actions taken.

What does ‘good’ look like?

- Our staff are trained in review methodologies such as cause charts, fishbone diagrams and five whys, and understand how human factors (people, activity and environment factors) can combine to cause an adverse event.
- Lessons learned are implemented, where relevant, throughout the organisation and not just the specific location where the adverse event occurred. Improvements are planned and carefully monitored.
- Our Board members and staff across the organisation receive regular feedback showing results of reviews and improvements.
- Our Board members ask what has happened with the results of previous reviews.
- Staffing problems that have an impact on patient care are identified and rectified.
- We thank staff for their contributions.
- The system is focused on learning and makes extensive use of improvement methodology to test and implement the necessary changes.
- Near misses are reviewed regularly to promote learning and system improvements.
- The local infrastructure that supports safety should link with those managing adverse events in order that learning and improvement activity are aligned and coordinated.
Q5: Do we get the right information? (Has care been safe in the past, is it safe today and will it be safe in the future?)

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 events from becoming more major and serious adverse events. 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?

- We have an integrated approach to governance and draw from all sources including:
  - reported adverse event themes;
  - significant adverse event reviews;
  - clinical risks;
  - Scottish Patient Safety Programme datasets;
  - complaints;
  - claims;
  - patient experience;
  - staff experience;
  - prescribing data;
  - unexpected deaths;
  - Hospital Standardised Mortality Ratios; and
  - triggers highlighted from case note reviews.
• Our NHS Board scrutinises these data effectively to assure ourselves that our organisation learns from them, takes action and monitors the impact.
• An infrastructure exists to support data collection and reporting, and systems are in place to effectively and efficiently capture, assure, analyse and report data.
• We use patient and staff stories to put a ‘human face’ on the numbers and actively seek accounts of patient and staff experience wherever possible.
• Our NHS Board is kept informed of serious and ongoing issues and recognises the links between staffing, quality outcomes and patient safety.
• We maintain a state of intelligent wariness even in the absence of poor outcomes.
• We have an atmosphere of constant vigilance to avoid the pitfall of ‘it could not happen here’.
Q6: Are we always open when things go wrong?

Why is it important?

Communicating effectively with staff, patients, families and their carers is a vital part of dealing with errors or problems in the delivery of care. Saying sorry, providing an explanation and keeping them informed will help people 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 adverse event and to help them communicate well.

What does ‘good’ look like?

• Our staff understand our policy on Being Open.
• We say sorry when things go wrong.
• Those who may need to be involved in talking with patients, their family and carers when things have gone wrong are confident, appropriately trained and fully supported in this process.
• We actively involve patients, their families and carers in learning from adverse events.
• Staff involved in adverse events have access to counselling support.