How to improve the safety of patients treated in the NHS

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The NHS relies on a variety of different staff, medicines and equipment in order to provide health care. Coupled with the volume of patients being treated, this can make it difficult to maintain safety. A new report from the National Audit Office looks at what can be done to make the NHS a safer environment for patients.

A huge number of patients successfully access health care services in the UK – each day more than one million are treated by the NHS alone. However, it is estimated that 10 per cent of patients admitted to the NHS are harmed unintentionally (National Audit Office, 2005).

A recent survey from the Commonwealth Fund found that many developed countries, including the UK, urgently needed to tackle problems with patient safety, including the coordination of care during patient transition, lack of support for chronically ill patients and human error involving health care staff (Kermode-Scott, 2005).

The NHS relies on a variety of different staff, medicines and equipment in order to provide health care and this, coupled with the volume of patients being treated, means that eradicating accidents altogether is unrealistic. However, a new report from the National Audit Office looks at what can be done to make the NHS a safer environment.

The NAO surveyed 267 NHS acute, ambulance and mental health trusts, conducted a patient survey and reviewed safety practices in other industries and countries.

**Background**

In 2000 the chief medical officer’s report *An Organisation with a Memory* identified serious problems in the health service’s response to adverse incidents. It detailed specific areas in which the NHS was failing (Department of Health, 2000):

- The rising cost of adverse incidents;
- A “distressing” similarity in the type of incidents that were reoccurring;
- Inadequate reporting systems;
- A lack of research into incidents.

The report made 10 recommendations, including introducing mandatory reporting of adverse incidents, confidential reporting by staff, encouraging a culture of reporting and questioning in the NHS, and ensuring that lessons are learnt quickly.

In response to the chief medical officer’s findings, the DoH published *Building a Safer NHS for Patients* (2001), the main thrust of which was to establish a national, mandatory reporting system for adverse incidents and near misses. The report also brought into being the National Patient Safety Agency (NPSA), which was given the remit of collecting and analysing information, learning lessons from adverse incidents and producing solutions.

**A changing culture**

The NAO report found that some trusts had been more successful than others in creating a culture where reporting mistakes and learning from them is the norm. Encouragingly, most of the trusts had also succeeded in reducing the culture of blame. This was aided by the NPSA guidance *Seven Steps to Patient Safety* (2004) aimed at focusing on why an incident occurred rather than who was to blame.

The report notes that strong leadership and governance at board level is crucial but that this on
Incident reporting

The report states that unless trusts are able to identify the main risks to patient safety, then it will be much harder for them to target interventions with any degree of accuracy. Reporting systems should also be integrated, confidential and gather information on incident severity and risk.

Encouragingly, 78 per cent of trusts responded that attempts to foster a culture of open reporting meant the total number of incidents reported had been rising year on year. Despite this, trusts admitted that many incidents are not declared at all. The report states that on average 22 per cent of adverse incidents go unreported – mainly medication errors and those leading to serious harm. Near misses were also under-reported, mainly due to a lack of understanding about what they constituted.

Use of systems

Most of the trusts that responded to the survey did analyse incident reports in order to learn lessons about how accidents could be avoided. However, a number commented that monitoring these incidents put a lot of demands on senior staff, which meant a full examination was not always practical.

Over 50 per cent of trusts reported that they involved patients in the development of safety procedures and consulted them on preventing a recurrence of incidents. However, only six per cent of the patients surveyed stated that they had been consulted on how to prevent the same incident happening to someone else.

Other sources of learning from incidents were identified, including organised professional networks, for example those involving cancer and coronary heart disease. There are also examples of nurses setting up e-mail networks in order to share and disseminate information, such as the National Network for Learning Disability Nurses (www.mldn.org.uk/about.asp).

Overall, however, the report stresses that despite a plethora of local and national initiatives to prevent adverse incidents (including the DoH’s Safety Alert Broadcast System), most are underused.

Recommendations for nurses

The report recommends that patient safety should be an integral part of any nurse training programme, including the benefits of working in, and contributing to, an open and questioning environment. Individual nurses need to take responsibility for patient safety and be accountable for their actions. The report highlights that too often nurses feel that they have handed over responsibility for the incident as soon as they have filed an incident report.

Nurses also have a role to play in meeting another key recommendation – encouraging patients to take greater responsibility for their own safety. Nurses are often the first or most frequent contact with patients and as such are perfectly placed to use systems to prevent near misses.

This article has been double-blind peer-reviewed.

For related articles on this subject and links to relevant websites see www.nursingtimes.net

REFERENCES


BOX 1. THE MOST COMMON INCIDENTS

- Patient injury due to falls
- Medication errors
- Equipment-related incidents
- Errors in record documentation
- Communication failure

Its own is not enough to have a major impact. Bodies such as the RCN are placing a greater emphasis on individual staff taking more responsibility, and although few trusts provide incentives for staff directly to improve patient safety, the report found that 93 per cent of trusts involve staff in identifying solutions. It says there is much that trusts can do to help staff focus on patient safety, including detailed job descriptions, staff appraisals and 360 degree feedback exercises.

Although the report found trusts are more likely to be creating an atmosphere of openness and questioning, they often cite communication breakdown as a reason for incidents. Also, only 24 per cent of trusts routinely inform patients when they have been involved in an incident.

Surveys of nurses also continue to show that they believe a blame culture still exists in the NHS. For example, the RCN found that nurses still felt they were treated more harshly than doctors following a serious adverse incident (RCN, 2003).

Seventy-seven per cent of the trusts surveyed by the NAO said that the under-reporting of incidents by doctors was a problem but only 11 per cent cited this problem with nurses. This is partly due to doctors expecting nurses to report incidents.

The report concludes that trusts have more to do to create a fully open culture where staff feel comfortable communicating with patients about adverse incidents.

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