

# Critical questions in patient safety

Patient Safety in Estonia:  
Linking Research, Education, Policy and Practice  
June 3<sup>rd</sup> 2022

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## For Debate

### Research into medical accidents: a case of negligence?

CA Vincent

Public awareness of medical accidents is growing, as the rapidly rising rate of litigation and the corresponding increase in defence costs suggest. In many accidents—for example, aviation, road and rail travel, industry—errors and accidents are the subject of extensive inquiry. Several accidents are routinely investigated and extraordinary measures taken to minimise the risk of their repeat. The risk of death under anaesthesia is comparable to the risk of accident on a commercial flight. Yet in anaesthesia, and medicine generally, accidents are seldom discussed publicly and few studies are conducted. Many doctors, of course, review their work in morbidity and mortality meetings. This does not usually promote systematic study, however, and the results are not usually communicated to the wider medical community. I suggest here that research into medical accidents has been greatly neglected but that accidents can and should be studied.

#### Accidents, errors, and negligence

A consistent finding in all accident research is that the main cause of accidents is human error, often compounded by organisational factors. From catastrophes such as the accidents at nuclear power plants at Chernobyl and Three Mile Island, to the result of unusual circumstances but of quite ordinary slips and lapses. Assuming some parallel with other areas, two points can be made about the study of medical accidents. Firstly, the main focus of investigation should be on the actions of those concerned, rather than on patient characteristics or technical faults. Secondly, the study of medical accidents should include errors and near misses (cases where an accident was narrowly avoided).

Error does not necessarily imply negligence. Some accidents involve negligence, but many do not. Researchers should in any case not assess negligence, for three reasons. Firstly, one medical error can be due to involve negligence, secondly, cooperation can be expected only if researchers treat information obtained as confidential, thirdly, the assessment of negligence is ultimately a matter for the courts. Finally, if any, should be assessed independently from cause and by people other than researchers.

emphasis is on packaging and the consequences of medication errors. The authors of the five papers discussing the actual errors are usually pharmacists or nurses."

occurrence

Official statistics are collected on many forms of accidents, but little is known about the overall incidence of medical accidents in the United Kingdom. The perspective societies have information on the annual rate of claims and complaints, but this is only a fraction of the total number of accidents, many of which will not involve negligence. The Harvard medical practice study will shortly provide detailed information on the occurrence of medical accidents and negligence in New York State. The only published information, however, comes from a study conducted in California in 1974. Three million hospital admissions led to 140,000 injuries, 21,000 being due to negligence. With four million hospital admissions a year in England alone, this might mean as many as 280,000 medical accidents in English hospitals, some 40,000 being due to negligence.

#### CONFIDENTIAL INQUIRIES

The confidential inquiries into deaths during child birth, anaesthesia, and surgery<sup>1</sup> did not specifically set out to study medical accidents (that would have been precluding the issue). Nevertheless, all have found that a high proportion of the deaths were avoidable, some associated with substandard care. For instance, the diligence of high risk abortion operations to register appears to have contributed to several deaths. The reasons for this can, however, only be guessed at. The diagnosis might have been due to staff shortage, overconfidence on the part of the registrar, inadequate supervision by the consultant, or a failure of communication between registrar and consultant. Only more detailed studies will reveal the causes of such accidents—and provide effective methods of prevention.

#### FROM MEDICAL RECORDS

When a case is brought against a doctor an expert opinion, based on an examination of the case notes, is sought by both defence and prosecution. These experts

Index Medicus classifies accidents under several headings. There are also sections on prevention and accident proneness.

Medical errors and accidents, however, do not even merit a classification.

Official statistics are collected on many forms of accidents, but little is known about the overall incidence of medical accidents in the United Kingdom.

Most audits stop short of identifying mistakes, or at least stop short of publishing the information.

Studies of medical errors are rare; studies of their causes are even rarer.

Vincent, 1989

## Patient safety – a very, very brief history

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- 30 years ago – the dark ages
- 25 years ago – risk management, incident reporting & analysis
- 20 years ago – epidemiology, the scale of harm
- 15 years ago – process change, teamwork, culture, organisational change
- 10 years ago – prioritisation of interventions, evaluation, strategy
- 5 years ago – new national programmes, increasing equivalence to quality improvement



Cutting error and harm  
by 50% within 5 years

But what are the priorities for Estonia?

What is the nature and extent of harm?

## Adverse events in British hospitals: preliminary retrospective record review

Charles Vincent, Graham Neale, Maria Woloshynowych

BMJ

**Results** 110 (10.8%) patients experienced an adverse event, with an overall rate of adverse events of 11.7% when multiple adverse events were included. About half of these events were judged preventable with ordinary standards of care. A third of adverse events led to moderate or greater disability or death.

**Conclusions** These results suggest that adverse events are a serious source of harm to patients and a large drain on NHS resources. Some are major events; others are frequent, minor events that go unnoticed in routine clinical care but together have massive economic consequences.

Vincent, Neale, Woloshynowych  
British Medical Journal 2001

## Research

BMJ

### Sensitivity of routine system for reporting patient safety incidents in an NHS hospital: retrospective patient case note review

Ali Baba-Alhari Sari, Trevor A Sheldon, Alison Cracknell, Alastair Turnbull

#### Abstract

**Objective** To evaluate the performance of a routine incident reporting system in identifying patient safety incidents.

**Design** Two stage retrospective review of patients' case notes and analysis of data submitted to the routine incident reporting system on the same patients.

**Setting** A large NHS hospital in England.

**Population** 1000 hospital admissions between January and May 2004: surgery (n=311), general medicine (n=231), elderly care (n=184), orthopaedics (n=131), oncology (n=61), and three other specialties (n=68).

**Main outcome measures** Proportions of admissions with at least one patient safety incident, proportion and type of patient safety incidents missed by routine incident reporting and case note review methods.

**Results** 324 patient safety incidents were identified in 230/1000 admissions (22.9%, 95% confidence interval 20.3% to 25.5%); 270 (83%) patient safety incidents were identified by case note review only, 21 (7%) by the routine reporting system only, and 33 (10%) by both methods. 110 admissions (10.9%; 9/1% to 12.8%) had at least one patient safety incident resulting in patient harm, all of which were detected by the case note review and six (5%) by the reporting system.

**Conclusions** The routine incident reporting system may be poor at identifying patient safety incidents, particularly those resulting in harm. Structured case note review may have a useful role in surveillance of routine incident reporting and associated quality improvement programmes.

about the cause, contributory factors, preventability, and impact of these incidents.<sup>1,2</sup> In this paper we evaluate the relative performance of a local routine incident reporting system that feeds into the national reporting and learning system, by comparing it with a well validated method of systematically reviewing case notes.<sup>3,4</sup>

#### Methods

We did the study in a large NHS hospital trust in England in 2006. We selected a stratified random sample of 1000 admissions (>24 hours' stay) between January and May 2004 from eight specialties: surgery; oncology; orthopaedics; general medicine; medicine for the elderly; oncology; eye, nose, and throat; and ophthalmology. All data extracted were anonymised and kept confidential. The study consisted of using structured data extraction tools to do a two stage retrospective case note review of the sample admissions and reviewing the patient safety incidents reported by the routine hospital reporting system for the same admissions.

#### Review of medical records

We used previously described methods to do the case note review.<sup>5,6</sup> First trained nurses screened patients' records by using 18 explicit criteria (box). We used case for (more) positive criterion as an indicator of a patient safety incident and scrutinised these medical records in stage two. One of the other nurses independently reviewed a 10% sample to assess inter-rater reliability. In addition, medical staff fully reviewed 10% of admissions for which no positive criteria were identified to identify false

But incident reporting only detects 5% of harmful events

# Why do things go wrong (and right)?

## How to investigate and analyse clinical incidents: Clinical Risk Unit and Association of Litigation and Risk Management protocol

Charles Vincent, Sally Taylor-Adams, E Jane Chapman, David Hewitt, Sue Prior, Pam Strang, Ann Tizzard

Why do things go wrong? Human error is routinely blamed for disasters in the air, on the railway, in complex surgery, and in health care generally. However, quick judgments and routine assignment of blame obscure a more complex truth. The identification of an adverse departure from good practice is usually only the first step of an investigator. Although a particular failure or violation may be the immediate cause of an incident, deeper analysis usually reveals a series of events and disparities from safe practice, each influenced by the working environment and the wider organisational context. This more complex picture is gaining acceptance in health care.<sup>1</sup> But it is seldom put into practice in the investigation of actual incidents.

The Clinical Risk Unit has developed a process of investigation and analysis of adverse events for use by researchers.<sup>2</sup> Two years ago a collaborative research group was formed between the unit and members of the Association of Litigation and Risk Management (ALARM). This group has adapted the research methods to produce a protocol for the investigation and

### Summary points

Analyses of clinical incidents should focus less on individuals and more on organisational factors.

Use of a formal protocol ensures a systematic, comprehensive, and efficient investigation.

The protocol reduces the chance of simplistic explanations and routine assignment of blame.

Experience with the protocol suggests that training is needed for it to be used effectively.

Analysis of incidents is a powerful method of learning about healthcare organisations.

Organisational analyses lead directly to strategies for enhancing patient safety.

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Website:  
www.cru.ac.uk  
Further copies of  
the investigation  
protocol are  
available at the  
CRU website:  
www.cru.ac.uk

BMJ VOLUME 340 | 13 MARCH 2010 | www.bmj.com

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## Summary points

Analyses of clinical incidents should focus less on individuals and more on organisational factors

Use of a formal protocol ensures a systematic, comprehensive, and efficient investigation

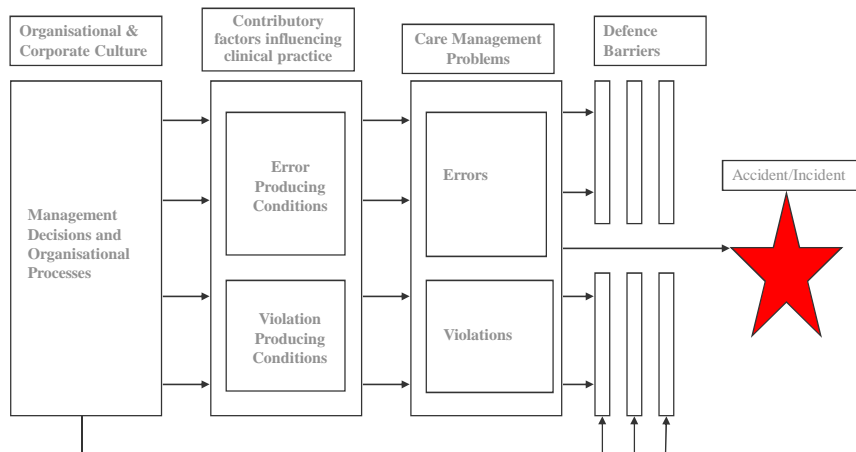
The protocol reduces the chance of simplistic explanations and routine assignment of blame

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Analysis of incidents is a powerful method of learning about healthcare organisations

Organisational analyses lead directly to strategies for enhancing patient safety

## Stages of development of organisational accident



Adapted from Reason, 1997

## The Process of Investigation: the 'moves'

The core of the process is to ask:

- What happened?
- How did it happen?
- Why did it happen?
- Get the story (the real story not the one in the notes)
- Identify the care delivery problems
- Consider the contributory factors
  - And what does this tell you about your system?
- Prioritisation and action

# Contributory factors: 7 levels of safety

- Patient
- Task
- Individual staff
- Team
- Working conditions
- Organisational
- Government and regulatory

Vincent, Adams, Stanhope 1998

# Incidents are a window on the system

Incident analysis

## Analysis of clinical incidents: a window on the system not a search for root causes

CA Vincent

It is time to pay more attention to incident analysis

Incident reporting lies at the heart of many initiatives to improve patient safety. The UK National Patient Safety Agency (NPSA) has actively been promoting national reporting and learning systems following international guidance and research across the healthcare health service (NHS). In the USA the Agency for Healthcare Research and Quality (AHRQ) made incident reporting the cornerstone of its first patient safety learning programme, involving 500 centres in the first year. More recently, an incident reporting system, The National Outcomes Reporting System for adverse events, is being developed to support a number of safety programmes—whether local or national—and an incident reporting system on the nature of safety problems and to provide indications of the extent of these problems and the likely solutions.

but why is there so little in the national line we have already, and where should attention be? The purpose is to achieve a safer healthcare system, then it is necessary to go further and reflect on what the incident reveals about the gaps and weaknesses in the healthcare system in which it occurred. The incident also acts as a 'window' on the multi-level system analysis incident analysis reports questioned in risk assessment methods for new cancer for an attempt to look at the future. In a sense, the particular nature of the incident is specific to one patient, to one case in the past. However, the weaknesses of the system revealed are still present and could lead to the next incident.

### PROSPECTIVE AND RETROSPECTIVE APPROACHES

Prospective analysis of systems are increasingly being employed in health care as the immediate response that is better to examine safety proactively and to prevent incidents before they happen. Incident analysis is usually seen as retrospective while techniques such as Failure Modes and Effects Analysis (FMEA) which examine a range of cases are seen as prospective. FMEA and related approaches are being studied in a variety of settings and conducted in the UK. However, adoption of FMEA, and other "proactive" health care systems, these prospective approaches with essentially constant incident



## First do no harm: practitioners' ability to 'diagnose' system weaknesses and improve safety is a critical initial step in improving care quality

Mike English,<sup>1,2</sup> Muthoni Ogila,<sup>2,3</sup> Jalemba Aluvaiya,<sup>2,3</sup> Edith Gicheha,<sup>2,4</sup> Grace Inimu,<sup>2,4,5</sup> Jacob Mckinnigt,<sup>1</sup> Charles A Vincent<sup>1</sup>

<sup>1</sup>Global Centre for Global Health Research, Nuffield Institute for Health, University of Oxford, Oxford, UK; <sup>2</sup>Health Services Research, University of Liverpool, Liverpool, UK; <sup>3</sup>Department of Health Services, University of Toronto, Toronto, Canada; <sup>4</sup>Department of Health Services, University of Colorado Denver, Denver, Colorado, USA; <sup>5</sup>Department of Health Services, University of California, San Francisco, San Francisco, California, USA

**ABSTRACT**  
Healthcare systems across the world and especially those in low-income settings (LICs) are under pressure and one of the first priorities must be to prevent any harm done while trying to deliver care. Health care workers, especially department leaders, need the diagnostic abilities to identify local safety hazards and design actions that benefit their patients. We draw on concepts from the safety sciences that are best well known than multidisciplinary improvement interventions in LICs. We use them to illustrate how to analyse the complex interactions between resources and tools, the organisation of tasks and the norms that they govern behaviours. Together with the strategic and collaborative of systems, all interact to influence care and outcomes. To employ these techniques leaders will need to focus on the local attainable standards of care, build trust and shift away from the blame culture that undermines improvement. Health system education should evaluate development of the technical and educational skills needed to perform these system diagnostic tasks. Some safety challenges need leadership from professional associations to provide support, resources, peer support and evaluation to sustain safety work.

### INTRODUCTION

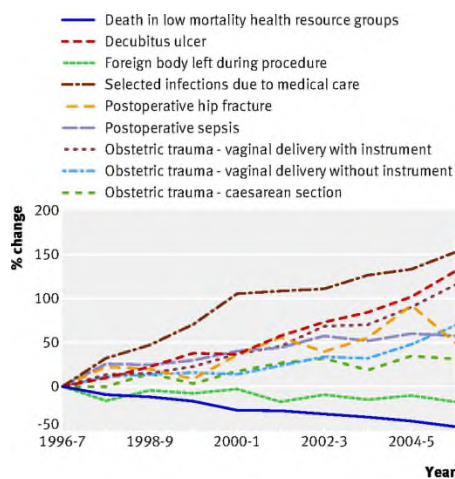
**What is already known on this topic?**  
• Harm resulting from unsafe care is common and results in significant adverse health and economic consequences in high-income countries.  
• Efforts to prevent or reduce harm often focus on identifying errors to that their specific causes can be addressed.  
• More recently, attention has been turned to considering how harms arise as a product of complex interactions in systems.

**What this study adds?**  
• Patient safety is much less well studied in low-income settings than in higher income settings.  
• We suggest how concepts being employed in an adverse patient safety during in higher income settings could be adapted by practitioners in low resource settings.  
• The ability to diagnose system weaknesses should become a core skill for those leading teams, wards, departments or facilities in low-resource settings.

## Are our services becoming safer?

### Is health care getting safer?

Despite numerous initiatives to improve patient safety, we have little idea whether they have worked. **Charles Vincent and colleagues** argue that we need to develop systematic measures



We do not know whether we are making progress or not

Vincent et al, BMJ 2008

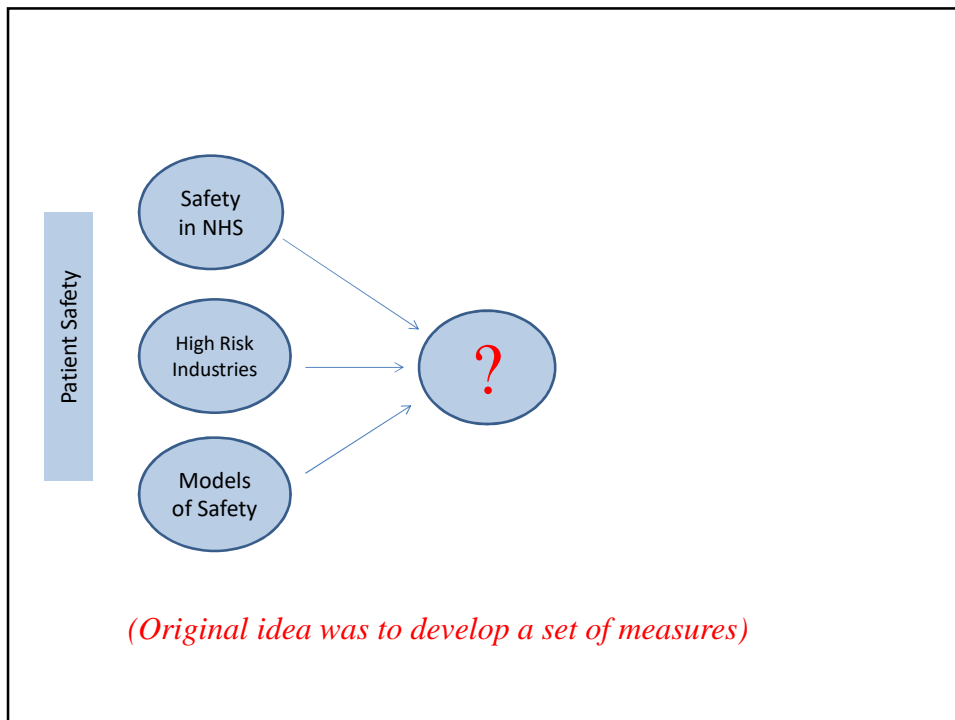


Just tell me - are we safe?



**Jane  
Carthey**

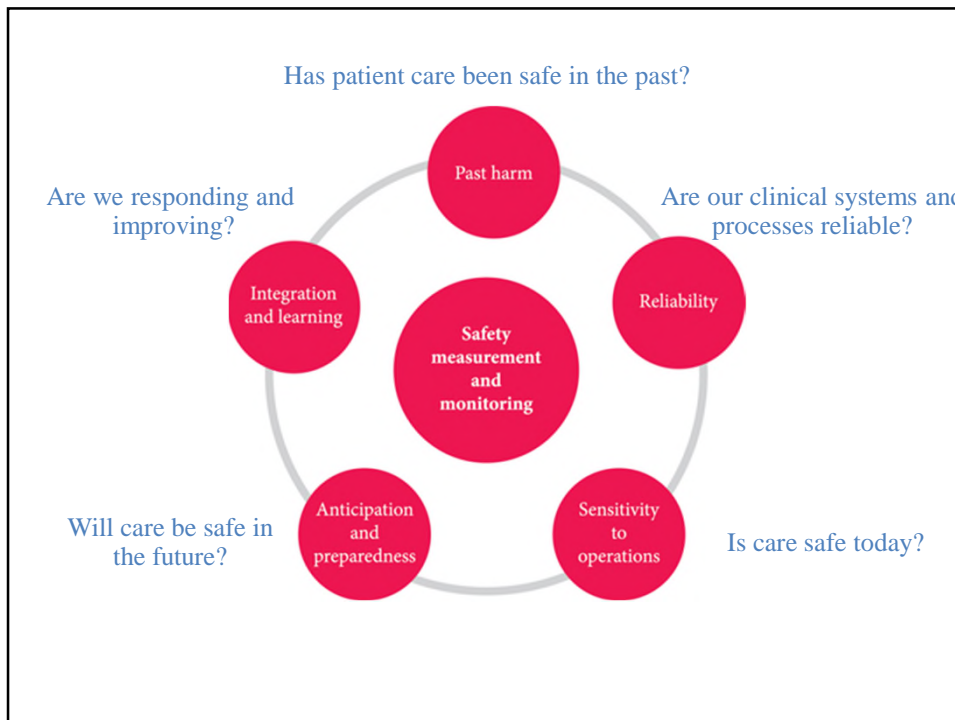
**Susan  
Burnett**



## The fundamental questions

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- Has patient care been safe in the past?
- Are our clinical systems and processes reliable?
- Is care safe today?
- Will care be safe in the future?
- Are we responding and improving?



## Adverse events in older people

- Errors, omissions
- Operative/procedural complications
- Hospital acquired infections
- Adverse drug events

← Adverse events affecting all age groups

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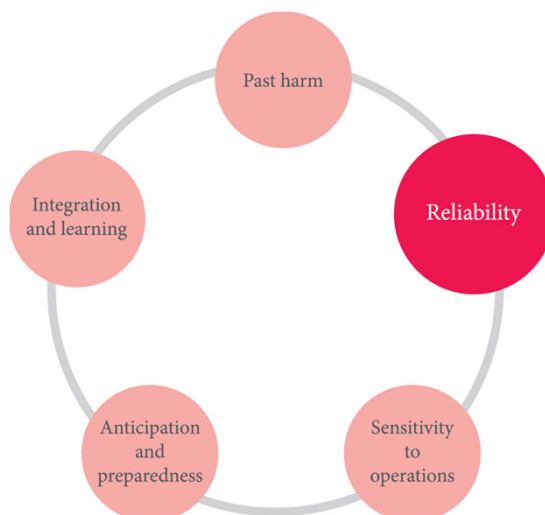
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- Falls
- Pressure sores
- Incontinence
- Functional  $\pm$  mobility decline
- Delirium
- Depression
- Nutritional decline
- Dehydration

The geriatric syndromes

Should be thought of as adverse events

- Preventable?
- Prolonged hospital stay
- Increased morbidity and mortality



## How reliable are clinical systems in the UK NHS? A study of seven NHS organisations

Susan Burnett,<sup>1</sup> Bryony Dean Franklin,<sup>2</sup> Krishna Moorthy,<sup>3</sup> Matthew W Cooke,<sup>4</sup> Charles Vincent<sup>5</sup>

- Clinical information available in hospital outpatient clinics
- Prescribing for hospital inpatient
- Equipment availability in the operating theatre
- Equipment available for inserting peripheral intravenous lines

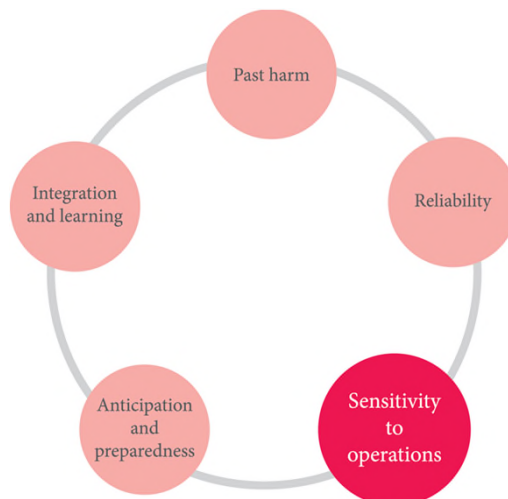
### Missing & faulty equipment



Site	Total operations studied	Number of operations with equipment problems	Percentage operations with one or more equipment problems
A	258	50	19%
D	67	25	37%
F	165	19	12%
<b>Total</b>	<b>490</b>	<b>94</b>	<b>19%</b>

*'We always need a colposcope with that list and time  
and time again it isn't there or it's broken or it isn't  
back or nobody knows where it is'*

Surgeon 3 Organisation A



## Sensitivity to operations

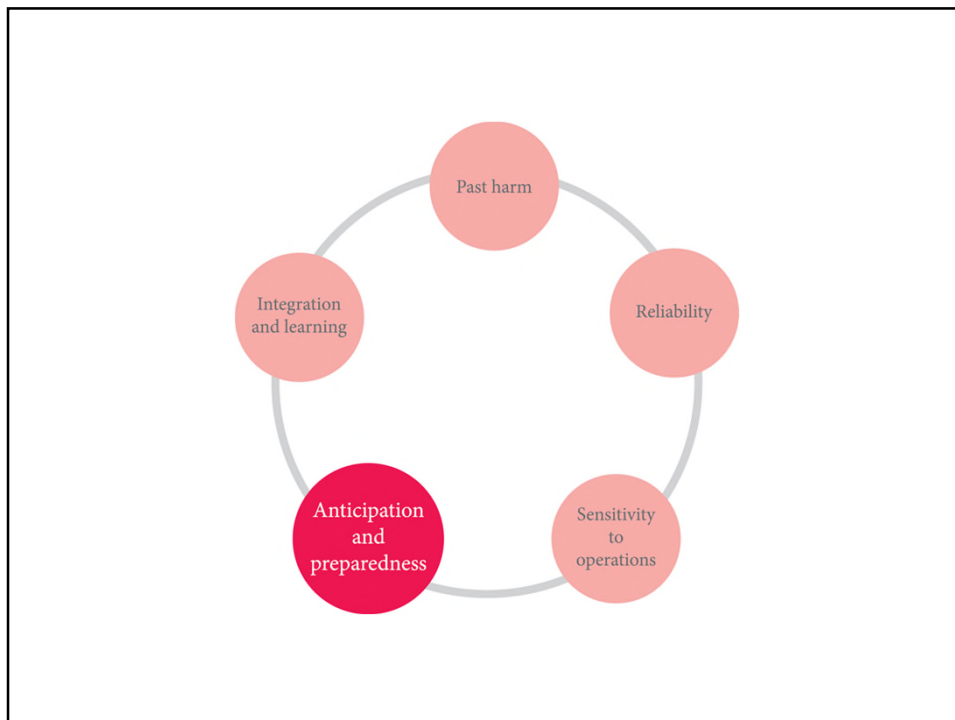
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- Clinicians monitor their patients, watching for subtle signs of deterioration or improvement,
- Leaders monitor their teams for signs of discord, fatigue or lapses in standards.
- Managers have to be alert to the impact of staff shortages, equipment breakdowns, sudden increases in patient flow and other problems.

## Soft intelligence

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- Safety walk-rounds
- Using designated patient safety officers
- Operational meetings, handovers and ward rounds
- Briefings and debriefings
- Day to day conversations
- And above all .... the patient voice
- .... *To which we can now add real time EHR derived data*



## Experts are constantly thinking ahead



- Pre-mission planning for
- fighter pilots often takes longer than the mission
- Each part of the route is analysed for possible threats, whether from hostile aircraft, personal factors, weather or technical breakdown.
- During the flight pilots devoted over 90% of available time to anticipation
- Typically they developed a 'tree' of events that might occur over the course of the flight.

Amalberti & Deblon, 1992



## Anticipation and Preparedness: Will care be safe in the future?

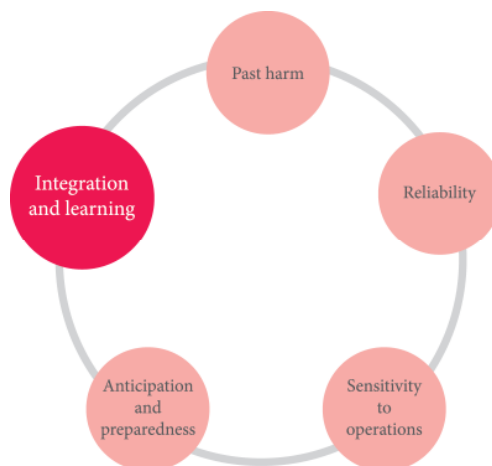
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- WHO Surgery Checklist
  - Risk assessments
    - (falls, pressure ulcers, self harm)
  - Risk registers
  - Safety culture assessments
  - Safety cases
- Bringing available information in the organisation to anticipate safety in the future



## Integration & learning. Are we responding and improving?

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## Berwick Report

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“Most Health care organisations at present have very little capacity to analyse, monitor, or learn from safety and quality information. This gap is costly and should be closed and that early warning signals can be valued and should be maintained and heeded” (Berwick, 2013, p26)

## Great Ormond St: team level

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- Number of days since the last serious incident (SI)
  - narrative, lessons learnt and recommendations
- Central venous line, MRSA (MSSA) infection rates
- Hand hygiene compliance rate
- WHO Surgical Safety Checklist compliance rate per clinical unit
- Common themes identified in executive walk-rounds
- Medication errors
- Top three risks from the clinical unit’s risk register.

# Response & Evolution



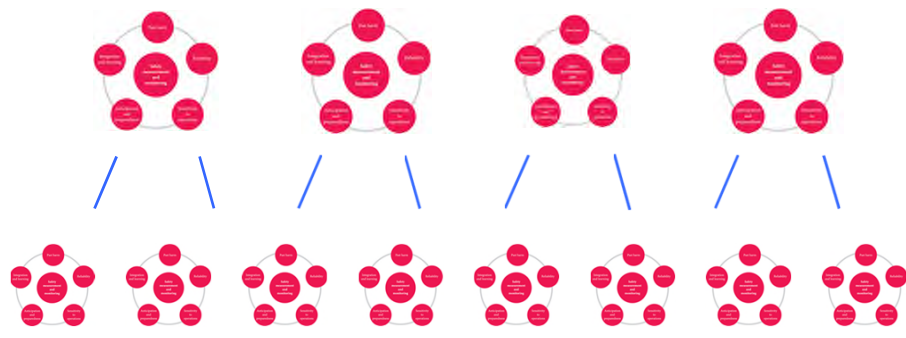
## Measurement and monitoring of safety: impact and challenges of putting a conceptual framework into practice


Elleanor Chalburn,<sup>1</sup> Carl Mazzeo,<sup>1</sup> Jana Carberg,<sup>2</sup> Charles Vincent<sup>1</sup>

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<sup>2</sup>York Learning Community, York, UK


**ABSTRACT**  
 Background: The measurement and monitoring of safety is a complex process, and it is important to consider the impact and challenges of putting a conceptual framework into practice. This paper discusses the impact and challenges of putting a conceptual framework into practice, and the need for a more holistic approach to safety measurement and monitoring.


have and reliability to assess standards of care and target programmes of improvement. They also need to return data to frontline and participants in the event, and be subject to ongoing review and management. The nature of safety has been discussed in the wider literature but, in particular at this time, there has been little consensus on the core dimensions of safety or what exactly should be measured and monitored.





**Healthcare Improvement Scotland**





**Shift to Safety**

Rewriting your thinking on measuring and monitoring of patient safety.

To improve your organization's patient safety, you need reliable, up-to-date qualitative and quantitative information to help guide your delivery of safe healthcare. The Measurement and Monitoring Safety Framework, created by Professor Charles Vincent and colleagues from the Health Foundation, consists of five dimensions that organizations, units, or individuals including leaders, providers, patients and families can use to understand, guide and improve patient safety. This new approach assesses and evaluates safety from "ward to board" by providing a comprehensive and accurate real-time view of patient safety. The Framework helps users move from "assurance" to "inquiry" by shifting away from a focus on past cases of harm towards current performance, future risks and organizational resiliency.


**The Measurement and Monitoring of Safety**

**RESOURCES**

Webcast Archive: **How can your Board use the Measuring and Monitoring for Safety Framework?**

Webcast Archive: **Implementing the Vincent Framework at the Frontline**

Webcast Archive: **Introduction of the Measuring and Monitoring of Safety (Vincent) Framework to Canada**



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**SHIFT to Safety**



National Action Plan for Increased Patient Safety in Swedish Health Care 2020-2024

**Act for safer healthcare**

Socialstyrelsen  
The Swedish Board of Health and Welfare

International Centre for Quality in Health Care, 2017, 2018, 2019  
Research Areas: Patient Safety, 193, 1433, 1811  
Keywords: Patient Safety

**A meta-review of methods of measuring and monitoring safety in primary care**

PAUL O'CONNOR<sup>1</sup>, LAURENCE ANAGON<sup>2</sup>, EMILY O'DONOVAN<sup>3</sup>, SARAH BYRNE<sup>4</sup>, and SINEAD LYDON<sup>5</sup>

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**Abstract**  
Background: There is much variability in the measurement and monitoring of patient safety across healthcare organisations. With no recognised standard approach, this study examines how the key components outlined in version 4.0 of the Measuring and Monitoring Safety (MMS) Framework can be adapted to closely approximate a healthcare safety surveillance system. The aim of this study is to use the MMS Framework to evaluate the Irish and other healthcare safety surveillance systems for hospital care.

**Methods:** This qualitative study consisted of two distinct phases. The first phase used document analysis to review national and international literature on measuring and monitoring safety in health care. The second phase consisted of semi-structured interviews with key stakeholders between May and August 2020 via a video conference call and focused on exploring the knowledge of those patient safety researchers and implementers in Ireland. The MMS Framework was used to support data analysis.

**Results:** These documents were included to compare and contrast 21 semi-structured interviews with stakeholders who key stakeholders working in the Irish health care system. A total of 51 unique methods of MMS were identified with one method of MMS addressing two dimensions of the MMS. Although 100% of MMS were completed with past data, 14.3% were completed with the ability of safety critical processes, 27.1% were completed with unit-level operations, 15.4% were completed with organisational and organisational, and 17.2% MMS were completed with population and health.

**Conclusions:** The document analysis and interviews show a combination of MMS in use in Irish health care. The inclusion of MMS often a useful framework to help healthcare organisations and implementers to think critically about MMS and how the data from different methods of MMS can be integrated in individual healthcare or health systems.

**Keywords:** Patient safety, Measurement, Monitoring, Hospital, Secondary care, Health care

# Measurement and Monitoring of Safety Framework e-guide

## Better Questions Safer Care

Analysing the Measurement and Monitoring of Safety Frameworks to Support Safety Improvement in Healthcare

AQUA hokid

### Using the MMSF Planning and timelines

Consider the best time and likely timescales for introducing the MMSF.

#### Planning and timing

Your Theory of Change will have a huge bearing on your approach. More implicit approaches, designed to influence and structure existing safety planning, require less initial coordination than an approach that involves training large numbers of frontline staff.

#### Timeline

Even though the testing of the MMSF was supported by The Health Foundation, the timelines for the approach to the MMSF were quite long. Those who contributed to this e-guide found reframing, planning and creating a Theory of Change took between two and six months. The majority found it was more than four months before any explicit action was taken.



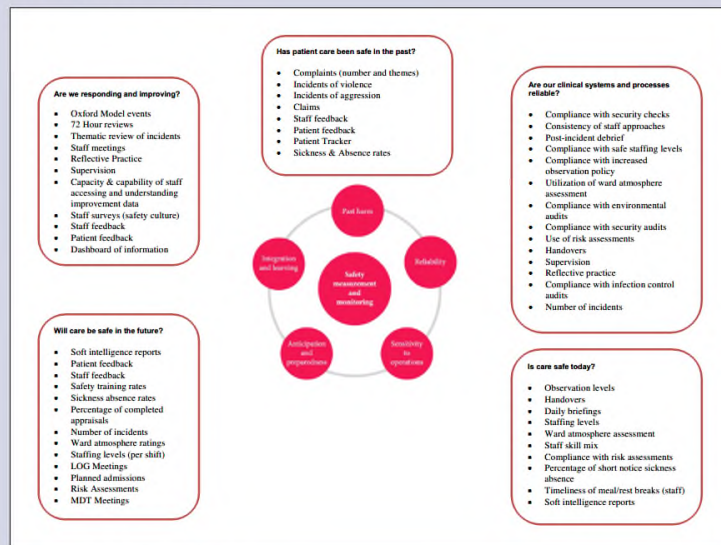
*We completely underestimated how much time it would take us to understand, apply and engage our brains and behaviours around what the MMSF can offer.*

Regional Improvement Body



### Considering the MMSF Mapping of existing work

Example of mapping current measurement and monitoring activity around the MMSF in a mental health setting (Source: Merseycare NHS Foundation Trust)

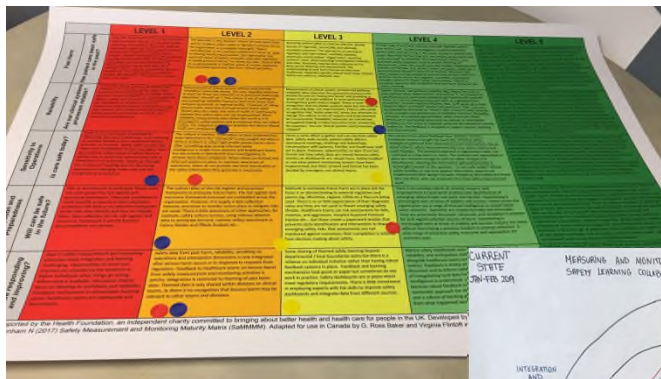


The Measurement and Monitoring of Safety Framework

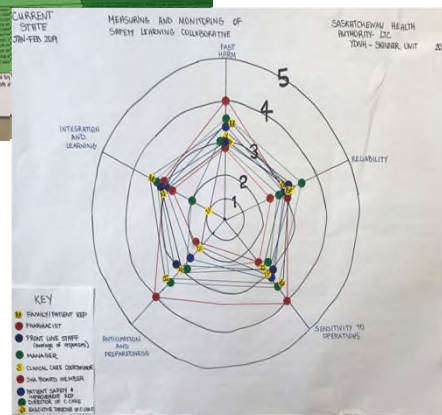
## Maturity Matrix

	Level 1	Level 2	Level 3	Level 4	Level 5
<b>Past Harm</b> Has patient care been safe in the past?	Very few mechanisms exist to learn from past harm and those that do are not used; under-reporting of incidents is the norm.	The approach is very reactive: lessons are only learnt from serious incidents when media or regulatory pressure forces the organisation to investigate thoroughly.	Improving patient safety is a tick-box exercise; activity focuses on regionally and nationally mandated measures.	A broad range of past harm measures are used. Specially-specific harm metrics exist. Incident investigation is used to proactively identify what could go wrong in the future, not just to identify root causes.	The cultural norm is that safety measurement should constantly evolve and complacency be avoided, even when safety performance is good.
<b>Reliability</b> Are our clinical systems and processes reliable?	Unreliable clinical systems, processes and pathways are accepted as the norm.	Measurement of clinical system, process and pathway reliability is externally driven: the only reliability measures in place are those set nationally or by commissioners.	Measurement of clinical system, process and pathway reliability takes place but the approach is bureaucratic.	System, process, and pathway reliability data shapes the focus of improvement work.	Unreliable systems, processes and pathways are viewed as unacceptable.
<b>Sensitivity to Operations</b> Is care safe today?	Little or no importance is attached to observing how care is delivered, or to listening to or seeking feedback from health care teams, patients or families.	The culture is reactive: information on how treatment has been delivered in the 'real world' is only sought out when a serious incident or high profile patient harm occurs.	There is some effort to gather and use real-time safety data.	The culture seeks feedback from patients, families and health care teams every day. Informal safety intelligence gathered from observations and conversations has an equal value to safety measurement data.	There is a system of early, pre-emptive identification of problems so that actions can be taken (today) before they cause harm to patients.
<b>Anticipation and Preparedness</b> Will care be safe in the future?	Little or no importance is attached to observing how care is delivered, or to listening to or seeking feedback from health care teams, patients or families.	The culture is reactive: information on how treatment has been delivered in the 'real world' is only sought out when a serious incident or high profile patient harm occurs.	There is some effort to gather and use real-time safety data.	The culture seeks feedback from patients, families and health care teams every day. Informal safety intelligence gathered from observations and conversations has an equal value to safety measurement data.	There is a system of early, pre-emptive identification of problems so that actions can be taken (today) before they cause harm to patients.
<b>Integration and Learning</b> Are we responding and improving?	Few or no measures to anticipate future harm are used except the risk register and assurance framework.	The culture relies on the risk register and assurance framework to anticipate future harm.	Methods to anticipate future harm are in place but the focus is on demonstrating to external regulators and commissioners they are being used.	There is an evolving culture of curiosity, enquiry and empowerment to lead which enables early identification of emerging safety threats and quick intervention.	A culture of curiosity, enquiry and empowerment to prevent safety threats is fully embedded within the organisation and throughout the whole health economy.

Carthey & Downham, 2017



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Source Jane Carthey





### The fundamental questions

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- ◆ Has patient care been safe in the past?
- ◆ Are our clinical systems and processes reliable?
- ◆ Is care safe today?
- ◆ Will care be safe in the future?
- ◆ Are we responding and improving?

