



PATIENT SAFETY 101

A PRACTICAL GUIDE

For Nurses Navigating The NHS and Beyond

Aderonke Opawande

PATIENT SAFETY 101

A Practical Guide to Patient Safety for Nurses in the NHS and Beyond First Edition

Copyright © 2026 Aderonke Opawande. All rights reserved.

No part of this publication may be reproduced, stored in a retrieval system, or transmitted in any form or by any means, electronic, mechanical, photocopying, recording or otherwise, without the prior written permission of the author, except in the case of brief quotations embodied in critical reviews and certain other non-commercial uses permitted by copyright law.

Medical Disclaimer

Although the author has made every effort to ensure that the information in this book was correct at press time, the author does not assume and hereby disclaims any liability to any party for any loss, damage, or disruption caused by errors or omissions, whether such errors or omissions result from negligence, accident, or any other cause. This handbook is intended as an educational resource and does not constitute clinical advice. Always refer to current NMC guidance, your employing organisation's policies, and current clinical guidelines in your practice.

First Edition: 2026

ISBN: 978-1-0676270-0-3

Published in the United Kingdom

For permissions, licensing enquiries, and CPD accreditation information,

Contact: soughtoutsafesystems@gmail.com

FOREWORD

Patient safety sits at the very heart of nursing practice. Every decision we make, every assessment we undertake, and every intervention we deliver carries with it a responsibility to ensure that the people entrusted to our care are safe. For nurses, patient safety is not an abstract concept, it is the daily expression of our professional values and our commitment to compassionate, high-quality care.

In recent years, the NHS has been strengthened by the contribution of internationally educated nurses who bring skill, dedication and diverse perspectives to our workforce. Their contribution has been invaluable. As a Chief Nursing Officer, I have seen first-hand the impact internationally educated nurses have when they are supported to thrive within the NHS. In our own organisation, we have welcomed more than 400 internationally educated nurses, and one of our greatest priorities has been to ensure that they do not simply work within our services, but that they truly belong within them.

Belonging matters because when nurses feel valued, supported and confident in their environment, patient safety is strengthened. Confidence in systems, understanding of clinical expectations and access to practical guidance are essential to helping nurses navigate complex healthcare settings. Resources such as Patient Safety 101 play an important role in supporting that journey.

This handbook provides a practical and accessible guide to some of the most important areas of patient safety in clinical practice, from safety culture and human factors to medication safety, deterioration, infection prevention and the growing role of technology in healthcare. Importantly, it translates these principles into guidance that is meaningful at the bedside, where patient safety is ultimately delivered.

I commend Aderonke for her commitment to supporting the nursing profession through this work. By focusing on practical safety principles and the realities nurses face in clinical settings, this handbook has the potential to be a valuable resource for nurses at different stages of their professional journey, particularly those navigating the NHS for the first time.

Patient safety is everyone's responsibility, but nurses stand at the centre of that mission. When we equip nurses with the knowledge, confidence and support they need, we strengthen not only our workforce but the safety of every patient we serve.

For that reason, I am pleased to support this important contribution to nursing practice.

Wellington Makala

Chief Nursing Officer

How to Use This Handbook

Each chapter follows a consistent structure designed around adult learning principles. You may read it cover to cover or navigate directly to the chapter most relevant to your current practice challenge.

- Learning Objectives map to Bloom's Taxonomy, use them to set your focus before reading.
- Patient Perspectives open each chapter, patient experience is the reason this work matters.
- UK Policy Boxes give you legal and regulatory context for the clinical practice in England.
- Clinical Alerts highlight high-risk information that requires immediate attention.
- Good Practice Spotlights offer evidence-based examples you can adapt immediately.
- Reflection Activities follow Kolb's Experiential Learning Cycle; they may be adapted to support NMC revalidation reflective accounts (standalone MCQs do not constitute CPD hours, but written reflections using the prompts do).

For Internationally Educated Nurses (IENs): Registration Pathway

Before receiving your NMC registration PIN, you must pass the NMC Computer-Based Test (CBT) and the Objective Structured Clinical Examination (OSCE). This handbook complements, but does not replace, your OSCE preparation. The clinical safety knowledge in every chapter directly supports OSCE stations on communication, escalation, medication safety, infection control, and documentation.

TABLE OF CONTENTS

Foreword	05
Preface	07
Acknowledgment	09
About the Author	10
How to Use This Handbook	13
A Note on UK-Wide Applicability	15
Introduction: The Promise of Safety	21
01. Foundation of Patient Safety	27
The Swiss Cheese Model: Why Systems Fail	31
Just Culture and Psychological Safety	32
Key Never Events: What Nurses Must Know	34
The NHS Patient Safety Strategy: A Framework for Practice	36
Key Messages: Chapter 1	40
02. Global Safety Cultures	45
Hofstede's Dimensions in the Clinical Context	48
Navigating Cultural Difference in Practice	49
Key Messages: Chapter 2	51

03. The Human Side of Error	56
Slips and Lapses	59
Mistakes	59
Violations	60
Second Victims: When Nurses Are Also Harmed	60
How Patient Safety Investigations Work	66
04. Communication Across Cultures	72
SBAR-C: The Culturally Enhanced Framework	75
Graduated Escalation: When SBAR Is Not Enough	77
Key Messages: Chapter 4	80
05. Medication Safety	85
The Five Rights, And Why That's Not Enough	89
Independent Double Verification: When, How, and Why It Matters	91
High-Risk Contexts: IENs and the UK Prescribing Landscape	92
Polypharmacy: A Growing Concern	93
When Things Go Wrong: Reporting and Learning	94
Common Documentation Errors and Legal Implications	98

06. Recognition and Response to Deterioration	104
Why Deterioration Goes Unrecognised	106
NEWS2: The National Early Warning Score	107
SBAR: A Shared Language for Safety	109
Escalation Pathways: Who to Call and When	111
Martha's Rule: The Patient and Family's Right to Safety	113
Falls Prevention: A Systematic Approach	114
VTE Prophylaxis: Every Admission, Every Day	115
The NHS Clinical Escalation Ladder	117
Sepsis 6: Time-Critical Nursing Actions	118
Night Shift Safety: Fatigue and Error	120
07. Infection Prevention & Control	128
Healthcare-Associated Infections: The Scale of the Problem	130
The Chain of Infection	131
WHO's Five Moments for Hand Hygiene	131
Personal Protective Equipment: Right Equipment, Right Situation	133
Aseptic Non-Touch Technique (ANTT)	134
Pressure Ulcer Prevention: The SSKIN Bundle	136
Key Messages: Chapter 7	138

08. Technology and Patient Safety	143
The Digital NHS: Context for Nurses	145
Electronic Patient Records and Safety Benefits	146
Electronic Prescribing and Medicines Administration (EPMA)	147
Data Protection in Clinical Practice: Your Responsibilities	150
Artificial Intelligence in Healthcare: Promise and Caution	151
Key Messages: Chapter 8	153
09. Becoming a Patient Safety Champion	159
Why You Are Already a Safety Leader	161
Psychological Safety: The Foundation of Safety Culture	162
Freedom to Speak Up: Using the Process	163
The NHS Patient Safety Strategy and PSIRF	165
Your Personal Patient Safety Development Plan	165
A Message to Internationally Educated Nurses	167
Safe Staffing: The Evidence Base and Your Role	168
Psychological Safety Toolkit: How to Speak Up Safely	173
Conclusion: Safety Is a Practice, Not a Destination	180
Patient Safety Checklist for Every Shift	181
Glossary of Key Terms	185

CHAPTER

01

Foundation of Patient Safety

Building a Culture Where Safety Thrives



TOP 10 PATIENT SAFETY RISKS FOR NEW NURSES

Based on NHS safety data and clinical education evidence

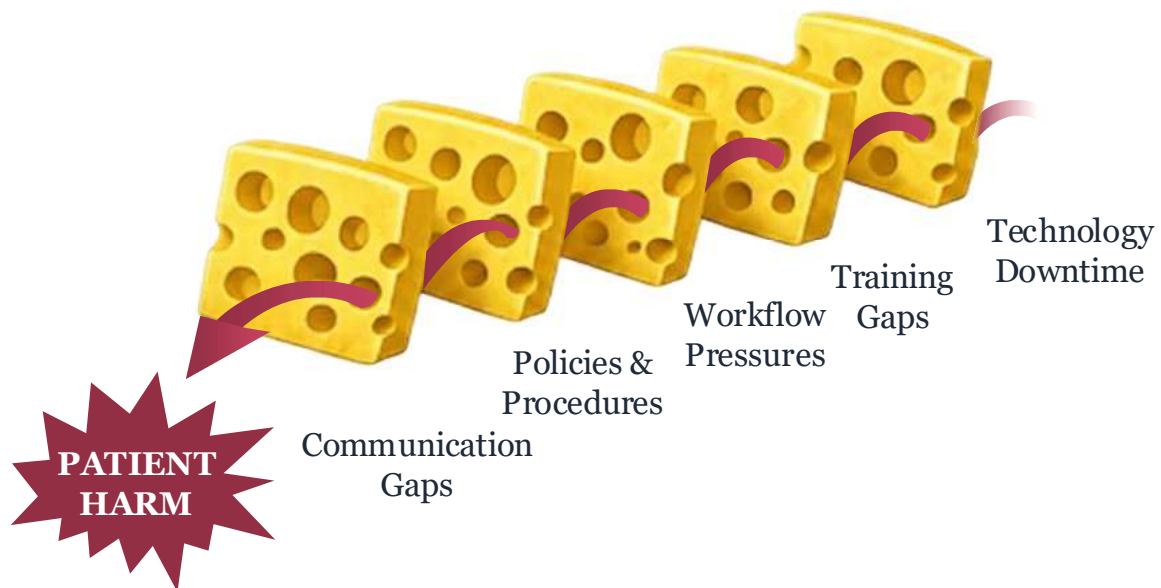
- 01 Medication interruptions:** Refuse/minimise interruptions during a drug round
- 02 Failure to escalate deterioration:** Act on NEWS2 triggers immediately, every time
- 03 Patient misidentification:** Check name, DOB, and NHS number before every intervention
- 04 Poor or delayed documentation:** Document as you go; contemporaneous records protect patients and you
- 05 Incomplete handover:** Use SBAR-C; never assume the oncoming nurse already knows
- 06 Cultural hierarchy barriers:** Silence in the face of a senior colleague is never safe; use graded assertiveness
- 07 Overconfidence after induction:** The first year is the highest-risk year; ask when unsure
- 08 Skipping double checks:** Independent verification exists because two trained nurses catch errors that one does not
- 09 Failure to question prescriptions:** You have a professional duty to question any prescription you do not understand
- 10 Fatigue during night shifts:** Error rates increase significantly after midnight; extra vigilance at night is non-negotiable

“Every system is perfectly designed to get the results it gets.”

W. Edwards Deming – Engineer & Management Theorist

THE SWISS CHEESE MODEL: WHY SYSTEMS FAIL

James Reason's Swiss Cheese Model, introduced in his landmark 2000 paper in the British Medical Journal, remains the most widely cited framework for understanding how serious harm occurs in complex systems.¹



The model holds that healthcare organisations have multiple defensive layers, protocols, training, supervision, equipment checks, incident reporting systems. Each layer has holes:

human errors, system gaps, resource failures. Most of the time, the holes do not align. Occasionally, when enough holes line up simultaneously, harm reaches the patient.

PRACTICE CHECKLIST: CHAPTER 1: SAFETY CULTURE ESSENTIALS



I know the name of my Freedom to Speak Up Guardian



I understand the difference between a just culture and a blame culture



I can explain James Reason's Swiss Cheese Model to a colleague



I know how to access my trust's incident reporting system (e.g. Datix)



I understand what PSIRF means for how incidents are investigated in my organisation



I have read or can locate my trust's Duty of Candour policy

KEY MESSAGES: CHAPTER 1

