“Patient safety is freedom from healthcare associated, preventable harm. A simple explanation is that ‘when things go right, nothing bad happens.’”

Established in 2008, the NES Patient Safety Multi-Disciplinary Group (PSMG), delivers a coordinated approach to the overall objective of ensuring that NHSScotland staff have the knowledge, skills and behaviours to minimise harm to patients and to improve the quality of care. The group contributes to the Scottish Patient Safety Programme (SPSP), further supporting the international effort to make care safer.

This briefing on using patient safety stories stems from the results of our Patient Safety Educational Resources Stakeholder Consultation. Participants who indicated that they had a role in championing patient safety (311/581) were asked whether they used patient safety stories to engage staff in patient safety (from a patient or staff perspective). Respondents were also asked to provide examples of using patient stories in the course of their work.

In summary, stakeholders told us:
- How patient safety stories are gathered
- Where stories are disseminated
- Preferred formats for dissemination
- Reasons for engaging with patient safety stories
- Outcomes and lessons learned
- Suggested ways forward in furthering the patient safety agenda
- Patient safety examples

This resource can be used during educational and training activities to:
- Promote dialogue in using patient safety stories
- Effectively disseminate patient safety stories
- Understand the benefits in discussing practices and lessons learned

Two Examples from our Consultation

“An 88 year old patient with chronic ill health, including dementia, was in a ward for 2 weeks undergoing investigations. His wife was too frail to visit. Nobody phoned her for the 2 weeks, but when they eventually did, they established that the patient would never have wanted admission and she just wanted him home. He got home that day and died 3 days later. He need not have spent his last 2 weeks of life in an acute bed undergoing endoscopies and CTs, and all that was required was one phone call.”

“We had a patient who died with a cerebral haemorrhage on warfarin who had not had their INR checked. Since then we have established a register and continual audit of patients on warfarin. We have had no significant events since starting this system and it has also reduced our anxiety about using warfarin – and as a result patients are started on warfarin when indicated in primary care. This is not known to happen nationally.”
Patient Safety Stories: What did you tell us?

Using the power of emotive narrative, staff can disseminate patient safety experiences amongst peers, NHS Board leaders, and teams.

Patient safety stories offer “a human side to patient safety work” in which the patient voice is central to understanding quality and levels of care.

They offer practitioners with the opportunity to reflect on experiences, build on exemplary practices and to improve the understanding of human factors in reducing harm and error.

In addition, stories have been reported as being powerful vehicles in disseminating event analyses, positive outcomes and praise & feedback.

For staff, they offer the opportunity to contribute to ideas and solutions for action improvement in quality of care.

Gathering Patient Safety Stories: Your comments

There are a number of ways in which accounts of care, staff experiences and safety events can be gathered:

- Directly discussing quality of care with patients and staff
- Reading letters received from patients – these may involve complaints or praise
- Feedback from ‘touchpoints’
- Patient feedback questionnaires
- Gathering stories whilst ‘on rounds’
- Collecting patient experiences as part of clinical governance reviews
- From the ‘Patient Opinion’ website: https://www.patientopinion.org.uk

Disseminating Stories: Some of your suggestions

Patient safety experiences can be presented at team meetings, daily safety briefs and CPD sessions.

Applications include the sharing of learning and significant event analyses, personal development planning, and sharing of experiences during handover between clinical teams.

Other ways of disseminating patient safety stories include:
- Podcast and videos
- Written texts
- Voice recordings
Lessons Learned: Some of your outcomes

- Practitioners can address issues that have arisen
- Practitioners can reflect after particularly challenging or rewarding situations
- Staff can use stories to identify how to change practice
- Future errors can be avoided through the dissemination of a “hard hitting story”
- Learning from adverse incidents can be cascaded to other practitioners
- “Potential confusions” and “near miss reporting” can be illustrated

Ways Forward in Improvement: Some of your proposals

- Embedding questionnaires to collate feedback and share with staff
- Methods for patient safety incident feedback reporting to ensure ongoing learning and development
- Develop metrics and plans to embed and follow up on improvements

Additional Reading


The above resource offers guidance on the recording of patient safety stories, and in particular advice in relation to obtaining consent from patients and carers, and in disseminating stories.


The above link contains a growing collection of patient safety stories. Further information from Derek Boyle, Derek.Boyle@nes.scot.nhs.uk.

For Further Information Contact

Dr Nancy El-Farargy Nancy.El-Farargy@nes.scot.nhs.uk
Dr Fiona Gailey Fiona.Gailey@nes.scot.nhs.uk
Dr Sabine Nolte Sabine.Nolte@nes.scot.nhs.uk
Mark Johnston Mark.Johnston@nes.scot.nhs.uk

Making the Most of Patient Safety Stories: Enhancing Patient Safety and Patient Experiences

NES Patient Safety Multi-Disciplinary Group
http://www.nes.scot.nhs.uk/initiatives/patient-safety


