Patient Safety Education: What matters to you?

Report of the NES Patient Safety Educational Resources Stakeholder Consultation

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http://www.nes.scot.nhs.uk/initiatives/patient-safety
Patient Safety Education: What Matters to You?
NES Stakeholder Consultation Team

Dr Nancy El-Farargy: Research and Information Officer, leading on the analyses and report writing, including recommendations on behalf of the team.

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Derek Boyle: Senior Knowledge Manager, involved in the patient safety story section, and making links with other knowledge services resources.

Prof Philip Cachia: Chair, PSMG, Sponsor of this work, and with FG, including recommendations on relevant forums, and commissioning resources/developments in response to stakeholder priorities/challenges in support of patient safety.

Other PSMG members supported the survey development; and our consultation findings, learning briefs and recommendations feature on PSMG agendas.

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1. Executive Summary

Report of the NES Patient Safety Educational Resources Stakeholder Consultation

1.1 Introduction

The NHS Education for Scotland (NES) Patient Safety Multi-Disciplinary Group (PSMG) aims to champion patient safety by researching, developing and promoting a range of educational solutions for the workforce.

This report presents the views, perceptions and learning priorities of over 500 respondents involved in patient safety in Scotland. It offers key findings and suggested ways forward in building and promoting patient safety capacity and capability.

1.2 Patient Safety in Context

The World Health Organization (WHO) defines ‘patient safety’ as “the absence of preventable harm to a patient during the process of healthcare”2. International studies estimate that approximately 10% of all patients admitted to hospital suffer from some form of preventable harm3. Less is known about adverse events in primary care, however, it is estimated that 1-2% of consultations may involve adverse events4. In relation to other industries, healthcare levels of harm are higher than those found in air, road, and rail transport; and people in high risk occupations such as construction5.

The international drive towards excellence in healthcare continues to gain credence, with concerted action taking place nationally across Scotland and within NES.

Established in 2008, the NHS PSMG delivers a coordinated response to the overall objective of ensuring that NHSScotland staff have the knowledge, skills and behaviours to minimise harm to patients and to improve quality of care.

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5 Ditto.
1. Executive Summary

The following are central to meeting these objectives:

- Raise awareness of how NES contributes to the Scottish Patient Safety Programme (SPSP) and the wider patient safety agenda (e.g. by participating in SPSP learning networks and other opportunities to meet objectives).
- Identify, evaluate and revise existing NES and partnership educational resources to incorporate, as appropriate, key themes of the WHO patient safety multi-professional curriculum.
- Contribute to the development of pilot work with named leads (e.g. with SPSP and national patient safety leads).

The NES PSMG contributes to the SPSP, which seeks to reduce unintended harm to patients and improve healthcare outcomes across all settings. In addition, the PSMG aims to support the inclusion of the WHO multi-professional patient safety curriculum topics into existing curricula. These topics include: human factors; learning from error; understanding and managing clinical risk; infection prevention and control; and improving medication safety.

1.3 Consultation Aims

The consultation sought to identify respondents' views and perceptions on the current NES learning and development resources available to support patient safety; and to inform and explore ways forward for the further development and sharing of resources.

In particular, the following aims were central:

- Plan NES activities to support stakeholders, and to become better informed about their learning priorities and preferences.
- Align education and training resources for reducing harm with local service workforce development that is already available.
- Share NES and local developments to make care safer; such as training, and the dissemination and use of learning resources, across a spectrum of areas.
- Align educational activities to support patient safety, and to make links across the many topics relevant for making care safer for patients.

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1.4 Methodology

PSMG colleagues designed and distributed a ‘NES patient safety educational resources’ consultation between 24 May 2013 and 30 June 2013. With the aim of generating a mix of qualitative and quantitative viewpoints on supporting patient safety education in Scotland, the questionnaire consisted of the following six main components.

![Figure 1: Questionnaire components.](image)

A targeted audience of service educational, clinical and patient safety contacts were invited to participate; and included team leads responding on behalf of teams. Other forms of distribution involved links on NES social media and the corporate website; in which all interested stakeholders were invited to participate.

None of the questions were mandatory, and the vast amount of qualitative responses received were analysed into themes through content reduction. The quantitative responses were analysed separately and grouped as appropriate. In order to protect anonymity, respondents’ views and transcripts are not ascribed to named individuals.

1.5 Questionnaire Respondents

The questionnaire yielded 581 responses, and the majority consisted of:

- Those working in territorial health boards/the service.
- A main healthcare setting of acute and primary care.
- Those working as general medical practitioners, in medical specialties and in nursing & midwifery.
- Those describing themselves as in the middle or late stages of their career.
- Over 480 with a key role in developing colleagues’ capacity and capability in education and training.

Filtered profession specific data annexes (10 and 11) have been produced, which further informed key findings and onward recommendations.

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1.6 Key Findings

Emanating from the results of the questionnaire, the following key findings are presented.

1.6.1 Stakeholders’ engagement with patient safety stories

- Patient safety stories are disseminated at various meetings, presentations and at handover.
- Reasons for engaging with stories include lessons learned, changes made and next step suggestions for improvement. In addition, the use of narrative was viewed as being powerful in supporting learning and reflection.
- Some caveats/limitations on using patient safety stories in support of patient safety include being new to the area, the need for further education and training, the notion of the ‘evidence base’ versus ‘anecdotes’, and finally confidentiality/ethical issues.
- In addition, a non-consistent approach to creating, gathering, storing, accessing and using patient safety stories, is evident.
- Preferred formats for engagement include podcasts/videos and text.
- Various terminologies/phrases are used to denote the concept of ‘patient safety stories’.

1.6.2 Stakeholders’ relevancy ratings of a range of NES approaches to reducing harm

- In general, stakeholders perceived a range of NES approaches and resources for patient safety as relevant and useful for their work:
- However, it was evident that many were unaware of the resources and/or had not accessed them.
- Where applicable, the relevance of this selected cohort of resources was viewed influentially: (1) NES ‘Introduction to Patient Safety’ e-Learning modules; (2) NES website, patient safety and clinical skills section; (3) NES training to apply knowledge and evidence in frontline practice; and (4) NES patient safety face to face courses for staff.
- Stakeholders found the ‘Patient Safety Education Scenarios’ (a suite of resources that aim to raise awareness of how different NES educational interventions contribute to safer care) relevant. However, only 20% of respondents were aware of them.
- The most popular scenarios were ‘Patient Safety Short Courses’ and ‘Improving Significant Event Analyses using feedback from trained peer groups’.
- Overall, the Patient Safety Education Scenarios were viewed positively in terms of engaging colleagues, learning about patient safety, and in enhancing access to education for safer care.
1.6.3 Stakeholders’ views on patient safety topics for potential NES development of learning resources

- The WHO Curriculum Guide topics were presented in the context of training available and learning to date, and the vast majority of respondents viewed all topics as relevant.
- Stakeholders rated the following WHO topics as the most relevant: (1) Learning from errors to reduce harm; (2) Understanding and managing clinical risk; (3) Improving medication safety; (4) Being an effective team player.
- Respondents also highlighted their perceptions of relevance of other presented patient safety learning topics. The majority were viewed positively, with the highest ratings concentrating around communication, error management and human factors.
- With respect to practical patient safety tools\(^\text{12}\), respondents felt that learning about them would be relevant in the context of their team and/or healthcare setting.
- Profession specific data filters for practical patient safety tools, highlight subtle differences between the groups. Managers expressed preferences for Plan-Do-Study-Act (PDSA), and both Allied Health Professionals and Nursing & Midwifery staff expressed preferences for resources to support reflective learning. GPs and other medical specialties expressed preferences for Significant Event Analyses (SEAs).
- Taking the results together (and in no particular order), there are a number of overlapping themes emerging for the future development of educational resources: (1) medication and error management; (2) human factors; (3) critical and interpersonal communications; (4) learning and reflection; and (5) teamwork.

1.6.4 Stakeholders’ preferred learning approaches

- Respondents were invited to indicate their preferred learning approach, and the most popular approach indicated was ‘learning from error, involving team reflection’.
- The next three cited priorities were learning as part of day to day working (including through project work), as part of team learning in general, and attendance at conferences and workshops.
- Profession specific data filters for preferred learning approaches highlight differences between the groups.
  - General Practitioners: Learning from error, involving team reflection
  - Other Medical Specialties: Learning from error, involving team reflection
  - Nursing and Midwifery: Part of your job, including through project work
  - Management: Part of your job, including through project work
  - Allied Health Professionals: Part of team learning in general

\(^{12}\) These resources include Significant Event Analyses (SEAs), early warning scores, trigger tools and driver diagrams.
1. Executive Summary

1.6.5 Stakeholders’ perceived challenges and barriers

- Respondents were invited to reflect on their challenges and barriers in their development, application and learning in support of patient safety. Nine pertaining themes emerged:

1. **Time and workload**: The management of time and job pressures were the greatest challenges cited in developing and applying knowledge and skills to reduce harm. Competing priorities between clinical demands, administrative tasks, and other workloads, appeared to render ongoing learning and continuing professional development in support of patient safety, low on the priority list. In addition, it was highlighted that the development of error was a consequence of trying to meet targets, and by working in pressurised environments.

2. **Formal education and training**: Whilst the importance of formal education and training was highlighted, it was evident that releasing staff to attend these sessions sometimes proved challenging. Stakeholders commented that protected learning time was required; in addition to the need for reflection time to review and eventually implement learning. In addition, negative perceptions were directed towards the utility of e-Learning as a constructive form of learning. Finally, concerns were raised regarding a lack of education and training provision available to various professional staff groups.

3. **Staff resource**: Staffing pressures at the frontline were evident; which further impacted on formal education and training in support of patient safety.

4. **Organisational culture**: The need for proactive engagement was highlighted. In addition, in order to facilitate change, respondents felt that mindsets, hierarchical structures and embedded cultures/‘ways of doing things’ simply needed challenging.

5. **Knowledge and awareness**: Respondents felt that there were issues with availability, access to and actual awareness of patient safety resources. Citations relating to an inconsistent approach with too many developments taking place, heightened confusion in relation to accessing and making use of patient safety resources.

6. **Staff engagement, commitment and influence**: Influencing and engaging staff about patient safety issues were other concerns cited. It was noted that all staff members were required to engage in the work; noting that the provision of education and training for all staff groups was required. The upward management of staff was suggested as key to acknowledging and facilitating changes in practice.

7. **Management and leadership support**: Respondents felt that positive leadership, management, and acknowledgment of the patient safety agenda, were required to facilitate staff engagement and service improvement.

8. **Consistency of approach**: Perceptions relating to inconsistent and numerous initiatives taking place were highlighted; in which needs for coherent organisational and national approaches to patient safety were expressed.

9. **No challenges and barriers**: A number of respondents cited no challenges and barriers to developing and applying patient safety skills and knowledge. It was noted that the concept of patient safety was integral to the role they were playing; with some noting personal responsibilities for additional learning and development (i.e. out-with contracted hours).
1.7 Recommendations

In prioritising future NES patient safety developments, the results offer useful insights into the needs of the Scottish healthcare workforce.

Emanating from the results, the following 20 key recommendations have been formed.

Patient Safety Stories:
R1. Explore options to support NHSScotland staff in their recording and reflecting on patient safety stories.
R2. Review options for NHSScotland regarding the accessibility and confidentiality/ethics of patient safety stories held in teams.
R3. During NES training sessions, promote the use of quantitative data and narrative as a vehicle for reflection and ongoing improvement.
R4. Widely disseminate the ‘Making the Most of Patient Safety Stories’\textsuperscript{13} learning briefing to promote dialogue across the service, and to support the use of both quantitative data and narrative as a vehicle for change and improvement.
R5. Develop a collection of resources (e.g. case studies) that demonstrates how the use of narrative gives rise to change and positive improvement. These can be from patient and staff perspectives.

NES Approaches to Reducing Harm:
R6. Utilising a variety of communication channels, deliver a measured promotional campaign\textsuperscript{14} to enhance access to NES resources that support patient safety education and training.
R7. Promote the learning resource ‘Introduction to Patient Safety’\textsuperscript{15} e-Learning module as a component within corporate induction sessions.
R8. Continue impact assessment/evaluation of a selected cohort of resources and training endeavours.
R9. Build on the patient safety education created by NES to further the patient safety agenda of excellence in patient care.
R10. Continue to work with NES patient safety directorate nominees and other colleagues, to champion and embed patient safety education and training, within NES supported and service-wide educational developments, as appropriate.


\textsuperscript{14} A review and development of the communications strategy for patient safety is underway.

\textsuperscript{15} This is currently available on \url{https://nhs.learnprouk.com} [registration and login required]. Additional information is available at: \url{http://www.nes.scot.nhs.uk/education-and-training/by-theme-initiative/patient-safety-and-clinical-skills/introduction-to-patient-safety.aspx} [Accessed 09 March 2014].
1. Executive Summary

Exploring Patient Safety Topics:

R11. Continue to align NES patient safety educational resources with the WHO Curriculum patient safety topics\(^\text{16}\).

R12. Build on current delivery work and where there are gaps, actively develop resources (and where appropriate, deliver training sessions) on topics around human factors, communication, medication and error management, and interpersonal interactions.

R13. Provide further education and training in a range of practical patient safety tools, (e.g. SEA and learning from reflection).

Preferred Learning Approaches:

R14. Tailor and align learning, education and training opportunities by profession, as appropriate.

R15. Continue to provide inclusive education and training for the NHSScotland workforce, and offer alternative formats to users, as appropriate.

Challenges and Barriers:

R16. Deliver education and training which supports the translation of current policy drivers (e.g. Everyone Matters: 2020 Workforce Vision\(^\text{17}\)) into frontline action.

R17. Support the development of resources to engage all staff in on-the-job learning, reflection and work-based learning.

R18. Actively target all staff groups to attend – and benefit from – patient safety education and training.

R19. Develop and actively promote an accessible resource/platform for all work relating to patient safety\(^\text{18}\).

R20. Continue to engage with leaders locally and nationally to promote education and training in patient safety as a route towards service improvement and excellence.

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\(^{16}\) A NES-wide scoping exercise has mapped the WHO Curriculum topics with current NES educational resources (across various teams).


\(^{18}\) Note: the ‘Quality Improvement Hub’ (http://www.qihub.scot.nhs.uk/default.aspx) contains resources from collaborating NHSScotland Special Health Boards and the Scottish Government Health Directorates. Additionally, NES resources are available in the ‘Patient safety and clinical skills’ subsection of the NES website (http://www.nes.scot.nhs.uk/initiatives/patient-safety).
The NES PSMG is reviewing the recommendations and is gradually including targeted recommendations on various agendas.

At the outset, Table 1 distils these recommendations under four areas of influence.

<table>
<thead>
<tr>
<th>Area of Influence</th>
<th>NES Recommendations</th>
</tr>
</thead>
</table>
| NES Patient Safety Multi-Disciplinary Group | - Disseminate and promote the use of narrative/patient safety stories as a means to service improvement.  
- Members to champion NES patient safety resources at every applicable opportunity.  
- Continue to deliver and increase patient safety education and training to healthcare teams and supporting professionals.  
- Continue to evaluate the impact of a selected cohort of NES patient safety resources. |
| NHS Education for Scotland         | - Actively promote resources through corporate online media channels.  
- Continue to provide strategic leadership for patient safety education and training.  
- As appropriate, acknowledge differing learning needs and styles, and present education and training activities accordingly. |
| NHSScotland Boards                 | - Provide local patient safety education and training for all members of the healthcare team.  
- Continue to liaise with staff across NHSScotland in support of patient safety education and training. |
| Policy/national approach           | - Advocate strong leadership and promote the national approach given to making Scotland a world leader in healthcare.  
- Continue to work towards providing a coherent and systematic approach to patient safety.  
- Translate national policies and strategies into resources for frontline action. |

Table 1: Summary of recommendations.

The results highlight the critical importance of continuing education and training in patient safety. The need to continue to liaise and work with NHSScotland and partners is paramount to ensuring that effective improvement in all areas of service delivery is implemented, disseminated and sustained throughout.
2. Patient Safety in Context

This section of the report provides a contextual overview of the patient safety discipline and the main policy drivers behind the work.

2.1 Patient Safety

The WHO defines ‘patient safety’ as “the absence of preventable harm to a patient during the process of healthcare”\(^\text{19}\). International studies estimate that approximately 10\% of all patients admitted to hospital suffer from some form of preventable harm\(^\text{20}\). Less is known about adverse events in primary care, however, it is estimated that 1-2\% of consultations may involve adverse events\(^\text{21}\). In relation to other industries, healthcare levels of harm are higher than those found in air, road, and rail transport; and people in high risk occupations such as construction\(^\text{22}\).

Patient safety research has gained much international recognition over the past 10 years\(^\text{23,24}\) and has included areas like:

- Human factors\(^\text{25}\)
- Team communication and handover\(^\text{26}\)
- Organisational cultures\(^\text{27,28}\)
- Error management and analysis\(^\text{29}\)

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More recent commentary notes the requirement for, and indeed the criticality of, novel and more successful approaches to patient safety research, policy and practice\(^{30}\).

The international drive towards excellence in healthcare continues to gain credence, with concerted action taking place nationally across Scotland and within NES.

### 2.2 The Scottish Strategic Backdrop

The Scottish Government is committed to reducing mortality and adverse events in NHSScotland\(^{31}\) and since December 2009, Quarterly Hospital Standardised Mortality Ratios (HSMRs) are published for all Scottish hospitals participating in the SPSP\(^{32}\). There are national patient safety programmes and initiatives in other areas of Scottish healthcare, and include: acute adult care; maternity and child health; mental health; and primary care. In addition, there is an evolving set of national patient safety outcomes which are gradually being highlighted across a range of healthcare services.

Key policy drivers include the **Healthcare Quality Strategy for NHSScotland**\(^{33}\), the **2020 Vision**\(^{34}\), and the **Everyone Matters: 2020 Workforce Vision**\(^{35}\). Together, their implementation aim to deliver the highest quality healthcare services, promote healthier and longer lives at home, and to develop the NHSScotland workforce.

In supporting acute adult safety, **Chief Executive Letter (CEL) 19 (2013)**\(^{36}\) presents ‘ten patient safety essentials’, nine point of care priorities, and two organisational priorities that are to be implemented throughout acute adult safety NHSScotland.

The **NHS Education for Scotland strategic framework**\(^{37}\) outlines our core role towards excellence in education for Scotland future public services. Specifically, we provide "consistent evidence-based excellence in education for improved health and care"\(^{38}\) and "education for improving quality to enhance patient safety and people’s experience of safety"\(^{39}\).

Further information on the wider strategic backdrop surrounding the patient safety agenda can be found in Appendix A – Strategic Background and Key Policy Drivers, p. 66.

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\(^{38}\) Theme 1: An excellent workforce.

\(^{39}\) Theme 2: Improved Quality.
2.3 NHS Education for Scotland Patient Safety Multi-Disciplinary Group

Established in 2008, the NES PSMG delivers a coordinated response to the overall objective of ensuring that NHSScotland staff have the knowledge, skills and behaviours to minimise harm to patients and to improve quality of care.

The following are central to meeting these objectives\(^{40}\):

- Raise awareness of how NES contributes\(^{41}\) to the SPSP\(^{42}\) and the wider patient safety agenda (e.g. by participating in SPSP learning networks and other opportunities to meet objectives).
- Identify, evaluate and revise existing NES and partnership educational resources to incorporate, as appropriate, key themes of the WHO patient safety multi-professional curriculum.
- Contribute to the development of pilot work with named leads (e.g. with SPSP and national patient safety leads).

The PSMG aims to support the inclusion of the WHO multi-professional patient safety curriculum topics\(^{43}\) into existing curricula. These topics include: human factors; learning from error; understanding and managing clinical risk; infection prevention and control; and improving medication safety.

In collaboration, the PSMG developed a national partnership educational framework for patient safety\(^{44}\). This framework includes five primary drivers:

1. Patient safety leadership development, with safety a strategic priority.
2. NHSScotland as a learning organisation committed to staff development and improvement.
3. Embedding patient safety and improvement methods in curricula, and building a sustainable infrastructure.
4. Patients actively engaged and driving patient safety improvement.
5. Safety culture and quality improvement enhanced by relevant scoping, development and research.

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3. Stakeholder Consultation

3.1 Aims
The consultation sought to identify respondents’ views and perceptions on the current NES learning and development resources available to support patient safety, and to explore ways forward for the further development and sharing of resources. In particular, the following aims were central:

- Plan NES activities to support stakeholders, and to become better informed about their learning priorities and preferences.
- Align education and training resources for reducing harm with local service workforce development.
- Share NES and local developments to make care safer; such as training, and the dissemination and use of learning resources, across a spectrum of areas.
- Align educational activities to support patient safety, and to make links across the many topics relevant for making care safer for patients.

3.2 Methodology
PSMG colleagues\textsuperscript{45,46} designed and distributed an online ‘NES patient safety educational resources’ consultation (Appendix B – Distributed Questionnaire, p.69\textsuperscript{47}) between 24 May 2013 and 30 June 2013. Its intention was to generate a mix of qualitative and quantitative\textsuperscript{48} viewpoints on supporting patient safety education in Scotland.

Specifically, the questionnaire consisted of the following components:

1. Respondents’ Backgrounds
2. Patient Safety Stories
3. NES Approaches to Reducing Harm
4. Exploring Patient Safety Topics
5. Preferred Learning Approaches
6. Challenges and Barriers

Figure 2: Questionnaire components.

A targeted audience of service educational, clinical and patient safety contacts were invited to participate; and included team leads responding on behalf of their teams. In particular leads with a key role in the development of education and training for patient safety, and in championing the work were aimed at.


\textsuperscript{46} Questionnaire design contacts: Lead Dr Fiona Gailey (Fiona.Gailey@nes.scot.nhs.uk) and working group members: Sabine Nolte and Mark Johnston. The questionnaire was piloted by service colleagues (in Healthcare Associated Infections), with final review undertaken by the then members of the PSMG (May 2013).

\textsuperscript{47} A questionnaire map can be found in Appendix C – Questionnaire Map, p. 81.

Other forms of distribution involved links on NES social media and the corporate website; in which all interested stakeholders were invited to participate. Respondents included clinicians, educationalists, patient safety/quality improvement fellows, and other stakeholders interested in patient safety.

### 3.3 Data Analyses and Reporting

The qualitative responses were analysed into themes through content reduction, and the quantitative responses were analysed separately and grouped as appropriate. None of the questions were mandatory.

In order to protect anonymity, respondents’ views and transcripts are not ascribed to named individuals.

The initial raw data report emanating from the consultation is available. Other reports are being produced; in which the following are currently available:

- **Supplementary Data Annex 1**: Selected educational questions filtered and presented by profession.
- **Supplementary Data Annex 2**: Selected educational questions filtered by profession, and presented by question number.

In addition, learning briefings and other outputs are being produced; in which the following are currently available:

- **Making the most of patient safety stories**: A learning briefing outlining stakeholders’ perceptions on the use of narrative for improving patient safety and experiences.
- **What matters to you?** A poster outlining stakeholders’ perceptions on the use of narrative for promoting dialogue, disseminating experiences and in implementing improvements.

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49 Some grammar, spelling and colloquial language have been corrected.
52 Quotes are coded by question number and file location.
- **Driving Improvements in patient safety**\(^58\): A poster outlining stakeholders’ views and perceptions on various patient safety learning resources, preferred learning approaches and the use of narrative to drive service improvement.

### 3.4 Report Layout

The remainder of this report presents the results over seven main sections, and offers some suggested ways forward in building and promoting patient safety capacity and capability.

1. An overview of respondents’ backgrounds is presented, and covers organisational background, healthcare setting, professional group, and role in patient safety (p. 20).

2. The use of patient safety stories, preferred formats, modes for accessing them and reasons for non-engagement are presented. In addition, linked resources emanating from the results are introduced (p. 24).

3. A review of NES approaches and learning resources for reducing harm is offered. This includes an initial review of a suite of resources that aim to raise awareness of educational interventions for reducing harm (p. 31).

4. A range of patient safety topics and practical patient safety tools are explored for relevance (p. 37).

5. Respondents’ preferred learning approaches are reviewed (p. 45).

6. Challenges and barriers into developing and applying knowledge and skills for reducing harm are reviewed. In addition, respondents’ barriers to learning about patient safety are presented, (p. 47).

7. Concluding the report, discussions and recommendations are offered (p. 59).

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4. Respondents’ Backgrounds

From a range of NHS Boards and other organisations in Scotland, 581 participants responded to the consultation. Further information is available in the initial raw data report.

4.1 General Details

578 individuals indicated their organisation, in which NHS Greater Glasgow and Clyde was the largest represented (18.2%, Figure 3).

![Figure 3: Respondents' organisational backgrounds (N=578), (Q1: Which Scottish health board or health organisation do you work for?). Note: frequencies are presented.](image)

13 ‘other’ responses were obtained, and included organisations like charities/trusts (4), hospices (3), a university (1), Health Boards not added in Figure 3 (3), a professional body (1) and an “independent” (1).

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The majority of questionnaire respondents work in acute and primary care (Figure 4).

**Figure 4:** Main healthcare setting (N=576), (Q2: Please indicate your main healthcare setting). See Table 14, p. 82 for ‘other’ specified responses.

‘Other’ main healthcare settings include hospice/care homes, specialist health services and other miscellaneous settings (Table 14, p. 82).
In terms of main professional group, the majority of respondents were in general practice, other medical specialities and nursing & midwifery (Figure 5)

Some respondents were from other specialties, professions and various other non-clinical roles (Table 15, p. 83).

The majority of respondents identified themselves at mid career (53.8%), with late career and early career at 39.6% and 6.6% of the sample (N=573) respectively (Figure 6).

This result is as expected, as the consultation also targeted team leads to answer on behalf of their teams.
4. Respondents’ Backgrounds

4.2 Role in Patient Safety

The majority of respondents had a key role in the education or training of colleagues (83.7%, N=575, Q560). This perhaps reflects the cascading of the consultation to NES networks’ of educators, professional leads and key patient safety contacts in the service.

54.2% (N=579, Q6) noted that they championed patient safety in their team or healthcare setting. Of this cohort, respondents were engaged in the following patient safety roles (valid N=313, Figure 7 and Table 16, p. 84).

![Figure 7: Respondents’ patient safety roles (N=313), (Q7: Which of these roles apply to you?). Note: respondents could tick as many as applied. For ‘other’ roles indicated, see Table 16, p. 84.](image)

It can be seen that the majority of respondents are mentors/trainers/supervisors/coaches for clinical training groups and professional leads. The majority identified themselves within the offered groups; however a number suggested other roles (Table 16, p. 84). These included nurse consultants, patient safety coordinators, Board members/Directors and roles within training, learning and development.

4.3 Summary

Respondents’ Backgrounds

- It can be seen that the questionnaire has successfully targeted key stakeholders.
- A wide range of roles and responsibilities are noted in the stakeholder sample.
- The greatest responses were received from frontline services (GPs, other medical specialties, and nursing & midwifery), and these groups were the main target audiences.
- The majority of respondents identified themselves as within mid and late career.
- In addition, 83.7% of respondents had a key role in the education or training of colleagues.
- Over half of respondents highlighted that they had a key role in supporting the patient safety agenda within their workplace/team setting.

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Question 5: “Do you have a key role in education or training, developing capacity and capability in colleagues?”

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Patient Safety Education: What matters to you?  
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5. Patient Safety Stories

This section reports on the use of patient safety stories; preferred formats and their accessibility/availability. It also explores reasons for not engaging with patient safety stories.

Of those who identified themselves as having a key role in championing patient safety (Q6), 77.2% (N=311, Q8) used patient safety stories (from a patient or staff perspective) to engage staff in patient safety.

Emanating from the results of this section, a patient safety story briefing\textsuperscript{61} and a poster\textsuperscript{62} have been produced (see also section 5.5, Linked Patient Safety Resources, p. 30).

5.1 Use of Patient Safety Stories

Respondents outlined how they gathered stories, where they disseminated them, and preferred formats for engagement.

Reasons for engaging with stories, and outcomes and lessons learned were also part of the discourse, with the following themes emerging from the free form responses (Table 2).

<table>
<thead>
<tr>
<th>Theme</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Where stories are disseminated (includes: talks/formal presentations/learning sessions/meetings/mortality and morbidity meetings/safety briefs/bulletins/reports/safety briefs/at handover)</td>
<td>153</td>
</tr>
<tr>
<td>Reasons for engaging, including outcomes and lessons learned</td>
<td>136</td>
</tr>
<tr>
<td>How stories are gathered (includes: professional bodies/staff/case note reviews/patient feedback/patient opinion website/reports/media)</td>
<td>94</td>
</tr>
<tr>
<td>Changes made/future changes/suggested next steps/improvements</td>
<td>25</td>
</tr>
<tr>
<td>Patient story example</td>
<td>24</td>
</tr>
<tr>
<td>Miscellaneous</td>
<td>4</td>
</tr>
<tr>
<td>Use of trigger tools/other safety tools</td>
<td>2</td>
</tr>
</tbody>
</table>

Table 2: Respondents’ usage of patient safety stories to engage staff in patient safety (N=228), (Q9: How do you use patient safety stories to engage staff in patient safety? Please give examples). Note: frequency demonstrates instances of occurrence.

Many respondents highlighted how they gather stories during the course of their work and present them at various meetings, presentations and teaching endeavours.


5. Patient Safety Stories

Reasons for engaging with stories included areas like learning and development, reflection and improvement.

I predominantly use stories related to patient experience. I gather these stories whilst on my rounds or through complaints. I tend to present them at Ward/Directorate meetings and M&M [Mortality and Morbidity] style meetings. I want all members of the staff to reflect on the case and discuss how things could have been done better or what was done well that should be replicated. The vast majority of these stories centre on absent or poor communication.

Often the care received has been acceptable but the experience woeful. I do use this forum to present stories from Datix which concentrate more on safety than experience however I feel we need a more robust method of patient safety incident feedback to ensure ongoing learning and development. [Other Medical Specialty, 9:87]

Other reasons included areas like improvement, review of lessons learned, and the sharing of best practice examples.

Data on its own is often dry and the point is lost. Staff engage in the debate when hearing a story before or after the data is presented. A run chart showing rate of INRs >6 doesn’t come alive until the patient story behind the dot is revealed. [Pharmacy, 9:36]

Datix reporting of chemotherapy near misses, patient reported issues etc. All chemo related ones come to our group and we consider these and act on any serious or recurring themes to make change and share reasons for change and changes made with the rest of the department. [Other Medical Specialty, 9:38]

Helps if staff can relate to a real life story as they can conceptualise the problem and solutions better. In my experience staff wish to deliver the best care they can and they are willing to engage in improvements to practice if they can relate to the problem and how this is effecting individuals. [Nursing & Midwifery, 9:78]

Respondents also highlighted where changes were being made, and the need for vigilance.

Often use examples of near misses e.g. a patient who went through the entire preop assessment process, but is scheduled for an operation they don’t need by a secretarial error, yet is only detected on the morning of surgery by an astute registrar and consultant who checked the notes and notice the error. I called a Significant Event Analysis out of which came changed patient safety procedures and consent rules. It’s a good example to use to reinforce the need for vigilance in patient safety. [Other Medical Specialty, 9:114]

Staff engage when hearing the outcomes of patient safety stories and can relate to improvement and quality in their roles and how the small changes they adapt can influence positive outcomes. [Nursing & Midwifery, 9:157]

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63 Quotes are coded by question number and file location.
5.2 Non-Engagement

Reasons for staff not engaging in patient safety stories (N=60, Q10) included aspects of not being exposed to the concept, being new to the area, time pressures and the need to refer to ‘evidence based medicine’ (Table 3).

<table>
<thead>
<tr>
<th>Theme</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Being new to the area/unaware of what it is/confidence issues</td>
<td>29</td>
</tr>
<tr>
<td>Require training/lack of opportunity/not applicable (to person or setting)</td>
<td>12</td>
</tr>
<tr>
<td>Difficulties in accessing (literature or patients)/not getting information</td>
<td>6</td>
</tr>
<tr>
<td>Willing/considering to use them in the future</td>
<td>4</td>
</tr>
<tr>
<td>Service pressures/require time</td>
<td>3</td>
</tr>
<tr>
<td>Miscellaneous</td>
<td>3</td>
</tr>
<tr>
<td>Require real life examples</td>
<td>2</td>
</tr>
<tr>
<td>Require evidence base</td>
<td>2</td>
</tr>
<tr>
<td>Confidentiality/ethical issues</td>
<td>2</td>
</tr>
<tr>
<td>Need to create value</td>
<td>1</td>
</tr>
</tbody>
</table>

Table 3: Respondents’ reasons for not engaging in patient safety stories (N=60), (Q10: Why do you not use patient safety stories to engage staff in patient safety?). Note: frequency demonstrates instances of occurrence.

Illustrative quotes on why patient safety stories are not used are presented below.

Does not really fit in the format of a walk round. [Finance, 10:11]

Don’t have the confidence to use them. [Allied Health Professional, 10:13]

Not aware of specific educational resources in this regard. Relatively new to role. [Other Medical Specialty, 10:38]

Patient safety should be evidence based not anecdote based. [Physician, 10:48]

However, anticipated future uses of patient safety stories were highlighted.

Aware this is a useful method and will work to encompass these as we promote our work. [Management, 10:3]

It’s not something I had thought about doing, but will in future. [Admin & Clerical, 10:29]

In addition, it was evident that the concept of ‘patient safety stories’ was used under other pretexts.

Don’t know what patient safety stories are - but do use incident reviews. [Other Medical Specialty, 10:15]

We probably do but not in a formal way. We often have patient stories within clinical supervision settings and often these have a patient safety theme. Not sure if this counts? [Allied Health Professional, 10:59]
5.3 Preferred Formats

Preferred formats for engaging in patient safety stories (N=303) include podcast/video, text and simulation (Figure 8).

![Bar Chart](image)

**Figure 8:** Preferred formats for engaging in patient safety stories (N=303), (Q11: If you were to use patient safety stories, which format(s) would you prefer for these stories?). Note: respondents could tick as many as applied. See also Table 4, p. 28, for additional other formats; noting preferences for face to face and group discussions.

‘Other’ (N=66, i.e. 22% of 303 respondents) narrative related to dissemination formats, included: live interviews; team discussions; a mixture of formats; and other miscellaneous topics.

*As case studies or critical incidents, with inquiry questions to guide debate.* [Educationalist, 11Other:4]

*Good if a patient can present but I accept this is costly and it is often difficult to source patients and may not be good for them if they wish to move on.* [Admin & Clerical, 11Other:19]

*I tell the story, they listen in disbelief.* [Educationalist, 11Other:24]

*Limited access to IT and open plan offices restrict our use of modern media.* [Other Medical Specialty, 11Other:28]

*Still no idea what you are on about!* [Other Medical Specialty, 11Other:52]

*Would use a mix of presentation, video text and simulation depending on the audience.* [Nursing & Midwifery, 11Other:66]

Further categorised themes on preferred formats for using patient safety stories can be found in Table 4 (p. 28); and these themes include comics/story boards, anecdotal feedback, and case studies/scenarios.

The most common format cited from the ‘other’ free text responses, was direct communication/face to face discussion; suggesting an overall mixture of real-time and asynchronous means to reflecting and communicating patient safety stories.
### Table 4: Summary of respondents’ ‘other’ preferred formats in engaging in patient safety stories (N=66), (Q11: If you were to use patient safety stories, which format(s) would you prefer for these stories?). Note: frequency demonstrates instances of occurrence.

<table>
<thead>
<tr>
<th>Theme (frequency)</th>
<th>Representative Quotes</th>
</tr>
</thead>
</table>
| • Discussion/direct communication/face to face/verbal (29) | • Chat.  
• Direct discussion with students at clinic and operating sessions.  
• Face to face.  
• In person.  
• Live interviews.  
• Verbal discussion works well although difficult to capture all staff.  
• Simply tell the story on the shop floor. |
| • Group/team discussion/meetings/presentations (13) | • Can be narrated by presenter.  
• Group work – discussions.  
• Lectures, seminars and tutorials.  
• On the Intravenous Therapy study day.  
• PowerPoint to use in meeting and stimulate discussion. |
| • Written materials/comics/story boards (7) | • Story tree.  
• Written communication.  
• Comics. |
| • Don’t know/no idea/don’t use (5) | • Would be interested in other formats but don’t have the resource.  
• Not sure as staff resources make it difficult for staff to access and have time to read/listen to material.  
• No idea. |
| • Miscellaneous comments (4) | • Limited access to IT and open plan offices restrict our use of modern media.  
• Have access to all for different situations. |
| • Other/not identified (4) | • Other, please specify. |
| • Anecdote (2) | • Anecdote using own experience. |
| • Case studies/scenarios (2) | • As case studies or critical incidents, with inquiry questions to guide debate. |
| • Simulation (1) | • …simulation depending on the audience. |
| • Video (2) | • Video link so you could circulate on email. |
5.4 Accessing Patient Safety Stories

Of those with a role in championing patient safety (Q5), 82.7% (N=306, Q12) had accessible patient safety stories that they were willing to share.

45 respondents highlighted additional routes to accessing stories, and included named contacts, meeting minutes, and personal communication (Table 5, Q13).

<table>
<thead>
<tr>
<th>Theme (frequency)</th>
<th>Representative Quotes</th>
</tr>
</thead>
</table>
| Named lead/department (27) | - All stored in different ways contact with Clinical Improvement unit to facilitate.  
- By writing to clinicians or seeking minutes of mortality and morbidity meetings department by department.  
- Contacting governance and risk team, hold digital stories/consent for use.  
- Speak to the Nurse consultant for patient safety/patient experience or the Director of Corporate Communications.  
- Via comms team and PFPI [Patient Focus and Public Involvement]. |
| Personal contact/email/verbal (12) | - Email me.  
- If a particular topic needs a story to illustrate it, I could try to provide one.  
- If GP’s were willing to share these for national use then contact via me would be first port of call. |
| Create repository/online availability/require IT system (10) | - Create a repository and widely advertise its existence. Then encourage people to dump their stories there where they will be read, accessed and appropriately categorised for ease of use by others.  
- Other defence unions likely to have similar on their sites (MPS [Medical Protection Society] etc). |
| Provide written account (2) | - Best one I have had was a video made by a patient. I agreed with her that use would be limited to the presentation I made to the RHIC [Reducing Harm Improving Care] conference. A written account would not be a problem to furnish. |

Table 5: Summary of accessing local/linked patient safety stories (N=45), (Q13: Please provide information on how NES Knowledge Services could access these local/linked patient safety stories). Note: frequency demonstrates instances of occurrence.

The online infrastructure was also highlighted as a vehicle to sharing stories.

Knowledge network portal would be useful one for patient stories and each board could populate their stories. [Admin & Clerical, 13:21]

However, a number of respondents highlighted the need for further work in the area.

Speak with someone who is actively in ambulances and fully understand patient safety & human factors. SAS should have records of serious adverse incidents. [Paramedic, 13:28]

There are no facilities at present. I keep the scenarios on file. I have scenarios which I have made using video and written text. I use these to train VT trainers. [Educationalist, 13:29]

Overall, there are a variety of means to creating, gathering, storing, accessing and using patient safety stories – and the general consensus is that a more coherent approach to storing and accessing them would prove useful.
5.5 Linked Patient Safety Resources

This patient safety stories section of the stakeholder consultation formed the basis of a learning briefing and a poster presentation at the International Forum on Quality and Safety in Healthcare, Paris 2014.

- Learning briefing: Making the Most of Patient Safety Stories: Enhancing Patient Safety and Patient Experiences.\(^{64}\)

A NES developed section on patient safety stories\(^{66}\) is also available on the NHSScotland Quality Improvement Hub\(^{67}\).

5.6 Summary

<table>
<thead>
<tr>
<th>Patient Safety Stories</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient safety stories are used in areas that include team meetings, learning and CPD sessions, safety briefs, and formal presentations.</td>
</tr>
<tr>
<td>The preferred format for engaging with patient safety stories is through video/podcast.</td>
</tr>
<tr>
<td>There is a general consensus amongst questionnaire respondents that the use of narrative is powerful in supporting learning and reflection, and that it provides “a human side to patient safety work”</td>
</tr>
<tr>
<td>However, a number of respondents alluded to a lack of awareness of the use of patient safety stories and/or that they were new to the area.</td>
</tr>
<tr>
<td>In addition, a non-consistent approach to creating, gathering, storing, accessing and using patient safety stories, is evident.</td>
</tr>
<tr>
<td>Overall, patient safety stories appear to be a powerful vehicle in disseminating significant event analyses, positive outcomes, and praise and feedback – and patient and staff voices are crucial in this respect.</td>
</tr>
</tbody>
</table>

---


6. NES Approaches to Reducing Harm

This section reviews stakeholders’ views (including those on behalf of teams) on some of the NES organised approaches and learning resources currently available for reducing harm\textsuperscript{68}.

6.1 NES Approaches to Reducing Harm

Respondents were invited to rate the relevance of a range of NES patient safety learning, training and workforce development resources (Q14\textsuperscript{69}, Table 6).

<table>
<thead>
<tr>
<th>Resource Presented</th>
<th>Additional Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>NES web site, Patient Safety and Clinical Skills section</td>
<td>A collection of web pages\textsuperscript{70} containing a range of multi-disciplinary information and resources to support patient safety.</td>
</tr>
<tr>
<td>NES ‘Introduction to Patient Safety’ e-learning modules</td>
<td>An e-learning module\textsuperscript{71} introducing patient safety (available to all NHSScotland staff via ‘learnPro’).</td>
</tr>
<tr>
<td>NES review of other online patient safety e-learning</td>
<td>A (2010) report\textsuperscript{72} outlining national and international patient safety e-learning products.</td>
</tr>
<tr>
<td>NES Patient Safety face to face courses for staff</td>
<td>A number of patient safety face to face courses\textsuperscript{73} are delivered by NES.</td>
</tr>
<tr>
<td>NES patient safety workforce development research, on NES web site</td>
<td>A web page\textsuperscript{74} containing some of the key NES research themes in patient safety.</td>
</tr>
<tr>
<td>Improving safety in primary care example resources, on NES web site</td>
<td>A web page\textsuperscript{75} outlining safety and improvement in primary care.</td>
</tr>
<tr>
<td>NES Evidence into Practice web site, Patient Safety Section</td>
<td>The patient safety section\textsuperscript{76} of the Evidence into Practice website.</td>
</tr>
<tr>
<td>NES Community websites or Shared Spaces</td>
<td>A collection\textsuperscript{77} of community sites and shared spaces on the Knowledge Network.</td>
</tr>
<tr>
<td>NES training to apply knowledge and evidence in frontline practice, Knowledge into Action Strategy</td>
<td>Additional information can be found in the Knowledge Into Action strategy.</td>
</tr>
</tbody>
</table>

Table 6: Overview of NES patient safety learning, training and workforce development resources. Note: this additional information was not presented on the questionnaire.

\textsuperscript{68} This section of the questionnaire also offered NES the opportunity to raise awareness of these resources.

\textsuperscript{69} Q14: Please rate the relevance of the following learning resources for your team/your healthcare settings/area of work, in the context of other training available and workforce development to date.


\textsuperscript{72} \url{http://www.nes.scot.nhs.uk/media/6341/FINAL%20REPORT%20of%20online%20modules%20January%202010.pdf} [Accessed 09 March 2014].


\textsuperscript{76} \url{http://www.evidenceintopractice.scot.nhs.uk/patient-safety.aspx} [Accessed 09 March 2014].

\textsuperscript{77} \url{http://www.knowledge.scot.nhs.uk/home/communities.aspx} [Accessed 09 March 2014].


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6. NES Approaches to Reducing Harm

It can be seen (Figure 9) that respondents’ top four most highly relevant resources are: (1) the NES ‘Introduction to Patient Safety’ e-learning modules; (2) the Patient Safety and Clinical Skills section of the NES website; (3) NES training to apply knowledge and evidence in frontline practice; and (4) NES Patient Safety face-to-face courses for staff.

![Figure 9: Respondents' perceptions on the relevance of learning resources (N=568-578), (Q14: Please rate the relevance of the following learning resources for your team/your healthcare setting/area of work, in the context of other training available and workforce development to date).](image)

However, the majority of respondents (over 50% in all of the cited resources) were unaware of, and/or had not accessed the learning resources.

Nevertheless, the majority of those who accessed and/or were aware of the resources viewed them as relevant/highly relevant. Taking the valid respondents into account (relevant and highly relevant added, valid N=210-266), this corresponds to a range of 70-95% of respondents highlighting the relevance of the workforce learning resources.

This demonstrates respondents’ perceptions on the importance and utility of these resources – for their team, healthcare setting and area of work – in the context of other training available and workforce development to date (Q14).

With respect to raising awareness, it is suggested that a promotional campaign should take place, which builds upon existing PSMG/NES communications activity to date. This is perhaps in line with respondents’ comments received in relation to awareness raising and embedding of resources (see section 9, Challenges and Barriers, p. 47). Promotional campaigns (enhancing access to resources/embedding educational resources) could include the following:
6. NES Approaches to Reducing Harm

- Embedding resources in existing educational infrastructures, (e.g. including via NES linked trainers and supervisors)
- PSMG members further championing NES patient safety resources
- Distributing resource links via dedicated email contact lists
- Promotion via corporate NES social media platforms
- Use of the NES blogging infrastructure
- A dedicated resource/platform for patient safety resources, which cross-links with other currently available platforms that stakeholders access
- Further signposting of resources at events and conferences
- Any other appropriate outlets; and in particular environments where resources are embedded in practice

6.2 NES Patient Safety Education Scenarios

The ‘Patient Safety Education Scenarios’\(^79\) are a suite of resources that aim to raise awareness of how different NES educational interventions contribute to safer healthcare. They are available in a range of topics and roles, and rest upon the premise of narrative for service improvement\(^80\).

Respondents were invited to indicate their usage of a selected range of scenarios, and only 20.1% (116) of respondents (N=578, Q15) indicated that they were already aware of these resources. From this cohort, stakeholders identified which of the selected scenarios they used (valid N=84, Figure 10, Q16).

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**Figure 10:** Patient Safety Education Scenarios that have been used (N=84), (Q16: Please indicate which Patient Safety Education Scenarios you have used). Note: respondents could tick as many as applied.

---


The majority highlighted that the ‘Patient Safety Short Courses’ were the most used, followed by ‘Improving Significant Event Analyses using feedback from trained peer groups’. Other responses included scenarios based examples (12), comments in relation to non-usage (4), and other miscellaneous commentary (2).

The scenarios appear to be relevant and are practically used in areas that include team discussion, self-learning, induction and in CPD sessions (valid N=39, Table 7, Q17).

<table>
<thead>
<tr>
<th>Theme (frequency)</th>
<th>Representative Quotes</th>
</tr>
</thead>
<tbody>
<tr>
<td>• As part of role/day to day working/own team use (22)</td>
<td>• Have used to promote importance of non-clinical roles in patient safety.</td>
</tr>
<tr>
<td></td>
<td>• In my everyday role, which includes a large component of Risk Management and Health and Safety.</td>
</tr>
<tr>
<td></td>
<td>• To discuss with own team.</td>
</tr>
<tr>
<td>• Education/training/induction (15)</td>
<td>• Made the education and learning aware so it’s included on bulletins, link it to e-ksf so staff will access.</td>
</tr>
<tr>
<td></td>
<td>• At protected learning time in practice re warfarin testing.</td>
</tr>
<tr>
<td></td>
<td>• Asked for these to be included in Induction Packs for new starts to the organisation.</td>
</tr>
<tr>
<td>• None/aware but not used yet/intend to make use/early stages of dissemination (8)</td>
<td>• I have been made aware of them, but I am still to utilise them directly, I have heard examples of their use being reported.</td>
</tr>
<tr>
<td></td>
<td>• Just aware of them. Haven’t used them.</td>
</tr>
<tr>
<td></td>
<td>• There is potential to use patient safety scenarios at RN Induction as it is not currently included.</td>
</tr>
<tr>
<td>• Advertised to Boards/practice leaflets (2)</td>
<td>• Advertised to Boards and telling them about them so they can access to build local capacity.</td>
</tr>
<tr>
<td>• To stakeholders/partnership working (2)</td>
<td>• Made available to stakeholders.</td>
</tr>
<tr>
<td>• Useful/other positive responses (2)</td>
<td>• Very useful.</td>
</tr>
<tr>
<td>• Board level use (1)</td>
<td>• At Board level.</td>
</tr>
</tbody>
</table>

**Table 7:** Respondents’ usage of the Patient Safety Education Scenarios (valid N=39), (Q17: Please give an example of how you have made use of Patient Safety Education Scenarios). Note: frequency demonstrates instances of occurrence, and valid to those already aware of the scenarios.

In addition, the following comments further demonstrate specific usage in day to day working across induction, education and equality impact assessment.

*Domestic services learning resource as an aid to developing new staff into health environment. [Management, 17:9]*

*Providing guided study opportunities for medical students. [Educationalist, 17:28]*

*Used Age as Asset to inform development of Equality Impact Assessment. [Management, 17:39]*

Whilst further promotion of the scenarios may prove beneficial, this section provides some evidence on how stakeholders are using them in practice.
Respondents were also invited to rate the usefulness of the Patient Safety Education Scenarios for their team/healthcare setting/area of work. Respondents viewed the scenarios relatively positively for engaging colleagues, for use as learning resources, and for enhancing access to resources for safer care (Figure 11, p. 35).

**Figure 11:** Respondents’ perceived usefulness of the Patient Safety Education Scenarios for their team/healthcare setting/area of work (N=109-111), (Q18: Please rate the usefulness of patient safety educational scenarios for your team/your healthcare setting/area of work). This question was valid to those aware of the educational scenarios (Q15).

Overall, the data suggests that where the resources are known to stakeholders, they are viewed positively for practical day to day work.
6.3 Summary

NES Approaches to Reducing Harm

- There is a wide range of NES resources available to support patient safety and quality healthcare.
- From a selected list of patient safety learning resources, the e-Learning patient safety modules were rated as the most relevant.
- However, the majority of stakeholders (approximately 60%) were unaware of the availability of a variety of resources and/or had not accessed them.
- Nevertheless, where applicable, the relevance of this selected cohort of resources was viewed influentially: (1) NES ‘Introduction to Patient Safety\(^{81}\) e-Learning modules; (2) NES website, patient safety and clinical skills\(^{82}\) section; (3) NES training to apply knowledge and evidence in frontline practice; and (4) NES patient safety face to face courses\(^{83}\) for staff.
- In looking at the Patient Safety Education Scenarios, 20% of stakeholders were aware of them, in which usage included team discussion, induction, education and training, and as part of everyday work.
- The top three scenarios used were cited as the ‘Patient Safety Short Courses’\(^{84}\), ‘Improving Significant Event Analyses’\(^{85}\), and ‘Good Health Records Management’\(^{86}\).
- Overall, the Patient Safety Education Scenarios were viewed positively in terms of engaging colleagues, learning about patient safety, and in enhancing access to education for safer care.
- Suggested implications arising from these results include a measured and targeted promotional campaign of our educational resources to improve care and patient safety.

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7. Exploring Patient Safety Topics

Stakeholders were invited to review the relevance of a variety of learning resources, topics and tools to support the NES development of patient safety educational resources (Qs 19-22). Specifically, this included respondents’ perceptions on the relevance of resources for their team/healthcare setting/area of work in the context of other training and workforce development to date. These resources included:

- The WHO Patient Safety Curriculum
- Other suggested patient safety priority topics for potential NES development
- Learning about practical patient safety tools

These perspectives are discussed in more detail in the following sections.

7.1 WHO Patient Safety Curriculum Topics

Based on available scientific evidence, the WHO Patient Safety Curriculum offers a multi-professional patient safety education framework. It was developed internationally by a core team of multi-professional experts, and the 11 topics (Table 8) that make up the framework are referenced here for clarity.

<table>
<thead>
<tr>
<th>The WHO Patient Safety Curriculum</th>
<th>Additional Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. What is patient safety?</td>
<td>Describes the evidence of harm and suffering caused by adverse events.</td>
</tr>
<tr>
<td>2. Why applying human factors is important for patient safety</td>
<td>Outlines some ways of working, and why errors may occur.</td>
</tr>
<tr>
<td>3. Understanding systems and the effect of complexity on patient care</td>
<td>Demonstrates how patient care involves a system of multiple steps and relationships.</td>
</tr>
<tr>
<td>4. Being an effective team player</td>
<td>Highlights the importance of teamwork across every healthcare professional.</td>
</tr>
<tr>
<td>5. Learning from errors to prevent harm</td>
<td>Demonstrates how a blame culture does not work and that a systematic approach to identifying the cause of error is required to ensure its non-repetition.</td>
</tr>
<tr>
<td>6. Understanding and managing clinical risk</td>
<td>Demonstrates the importance of preventative measures in identifying and fixing potential problems.</td>
</tr>
<tr>
<td>7. Using quality-improvement methods to improve care</td>
<td>Introduces the principles of improvement theory, and the tools and processes that can be incorporated into practice.</td>
</tr>
<tr>
<td>8. Engaging with patients and carers</td>
<td>Demonstrates the importance of honest communication with a patient in the event of an adverse event.</td>
</tr>
<tr>
<td>9. Infection prevention and control</td>
<td>Describes the types and causes of infection, as well as preventative measures in minimising infections.</td>
</tr>
<tr>
<td>10. Patient safety and invasive procedures</td>
<td>Presents the higher risks of surgery and other invasive procedures.</td>
</tr>
<tr>
<td>11. Improving medication safety</td>
<td>Identifies some factors that lead to errors, and preventative measures to minimise these.</td>
</tr>
</tbody>
</table>

Table 8: Summary of the WHO Curriculum Guide topics in patient safety. Note: this narrative was not presented in the questionnaire.

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Respondents (N=571-576, Q19) were invited to indicate their views on the relevance of these 11 topics for their team/healthcare setting/area of work, in the context of other training available and workforce development to date (Figure 12).

The majority of stakeholders viewed all topics positively, and of particular note, learning from errors to reduce harm, was rated the highest. This was followed by ‘Understanding and managing clinical risk’, ‘Improving medication safety’, ‘Being an effective team player’, and ‘Why applying human factors is important for patient safety’ (scaled by ‘highly relevant’).

These results perhaps suggest that the development and alignment of NES patient safety educational resources with the WHO curricular topics would be received positively.
Supplementary data annexes 1\textsuperscript{88} and 2\textsuperscript{89} outline filtered profession\textsuperscript{90} specific details regarding the relevance of the WHO Patient Safety Curriculum Topics.

Whilst all of the selected profession specific groups expressed the relevance of all these topics, a closer look at the data reveals some differences.

\textbf{Figure 13:} Filtered by General Practitioners (N=135-136). Q19: Please rate the current relevance of the following topic areas based on the WHO Patient Safety Curricula for your team/healthcare setting/area of work, in the context of other training available and workforce development to date.

\textbf{Figure 14:} Filtered by Management (N=34-35). Q19: Please rate the current relevance of the following topic areas based on the WHO Patient Safety Curricula for your team/healthcare setting/area of work, in the context of other training available and workforce development to date.


\textsuperscript{90} General Medical Practitioners, Other Medical Specialties, Nursing & Midwifery, Management, and Allied Health Professionals.
For instance, all of these named groups, excepting that of management; felt that ‘Learning from errors to reduce harm’ (e.g. Figure 13, p. 39) was the most important WHO Topic. The management specific group (Figure 14, p. 39) felt that ‘Using quality improvement methods to improve care’ was the most relevant.

Although the cohort sizes are not similar, the results highlight some of the differing relevancy perceptions amongst the named profession specific groups. Implications arising suggest the need to appreciate and accommodate the differing learning needs across the health service workforce, as appropriate.

7.2 Other Patient Safety Learning Topics

Respondents (N=569-574, Q20) were also invited to indicate their views on the relevance of other selected topics91 (Figure 15, p. 41), in the context of other training available and workforce development to date.

The top four topics rated (at highly relevant) were:

1. Critical communication when a patient is deteriorating
2. Minimising medication errors, a whole system approach
3. Human factors in daily work in NHS
4. The management of high risk medicines such as warfarin and insulin

Over 40% of respondents also rated the management of sepsis, the management of challenging interactions and structured handover for safer care as highly relevant for their team/healthcare setting.

In taking relevant and highly relevant together, respondents rated ‘human factors’ as the most important topic.

As views were asked in the context of other training available and workforce development to date, the results perhaps reflect respondents’ availability and accessibility to local training and development opportunities, as well as potentially team learning needs.

The least relevant topics were related to facts and figures, and specific point of care patient safety priorities (e.g. the management of falls, catheter associated urinary tract infections, and pressure ulcers). This perhaps suggests that other learning, training and development resources may be more accessible in these areas.

Overall, these results suggest that stakeholders view topics around human factors, communication, medication management and interpersonal interactions as relevant learning topics. It should however be noted that almost all the learning topics were viewed relevantly (taking results for highly relevant and relevant together); with the lowest rating being 69%. This perhaps substantiates the need for NES to develop these types of resources for supporting patient safety.

91 The inclusion of these other topics stemmed from (1) liaison meetings with national and SPSP programme managers, (2) at Educating for Patient Safety sessions with service educators and team leads, and (3) from feedback on the patient safety e-Learning module (personal communication, FG).
Figure 15: Respondents’ relevance rating of other topics, in the context of other training available and workforce development to date (N=569-574), (Q20: Please rate the current relevance of the following topic areas for your team/your healthcare setting/area of work, in the context of other training available and workforce development to date).

<table>
<thead>
<tr>
<th>Topic</th>
<th>N=569-574</th>
</tr>
</thead>
<tbody>
<tr>
<td>Critical communication when a patient is deteriorating</td>
<td></td>
</tr>
<tr>
<td>Minimising medication errors, a whole system approach</td>
<td></td>
</tr>
<tr>
<td>Human Factors in daily work in NHS</td>
<td></td>
</tr>
<tr>
<td>The management of high risk medicines such as warfarin and insulin</td>
<td></td>
</tr>
<tr>
<td>The management of sepsis</td>
<td></td>
</tr>
<tr>
<td>Managing challenging interactions</td>
<td></td>
</tr>
<tr>
<td>Structured handovers for safer care</td>
<td></td>
</tr>
<tr>
<td>Finding out what educational resources are available, what can be used</td>
<td></td>
</tr>
<tr>
<td>Persuasion and influencing skills</td>
<td></td>
</tr>
<tr>
<td>Leadership for safety, what does it mean for me?</td>
<td></td>
</tr>
<tr>
<td>Explore what is currently going on with patient safety education for staff and...</td>
<td></td>
</tr>
<tr>
<td>VTE management for safer care</td>
<td></td>
</tr>
<tr>
<td>The management of falls</td>
<td></td>
</tr>
<tr>
<td>The management of catheter associated urinary tract infections</td>
<td></td>
</tr>
<tr>
<td>The management of pressure ulcers</td>
<td></td>
</tr>
<tr>
<td>Patient safety, facts, and figures, covering all healthcare settings</td>
<td></td>
</tr>
<tr>
<td>Not relevant</td>
<td></td>
</tr>
<tr>
<td>Relevant</td>
<td></td>
</tr>
<tr>
<td>Highly relevant</td>
<td></td>
</tr>
</tbody>
</table>
Profession specific filtered data is also available for this question (20):

- Supplementary Data Annex 1\(^ {92}\): organised by profession
- Supplementary Data Annex 2\(^ {93}\): organised by question (p. 7 for professions relating to question 20, i.e. other patient safety learning topics)

Although statistical analyses have not yet been undertaken, at the outset, relevancy preferences across the professions can be seen (data for highly relevant reported):

- General Practitioners: Minimising medication errors, a whole system approach
- Other Medical Specialties: Critical communication when a patient is deteriorating
- Nursing and Midwifery: Critical communication when a patient is deteriorating
- Management: Human Factors in daily work in NHS
- Allied Health Professionals: Managing challenging interactions

The data perhaps evidences the need for specific targeting of educational resources for the workforce.

7.3 Practical Patient Safety Tools

This section presents respondents’ relevancy ratings for learning about the use of various patient safety tools.

536-568 respondents (Figure 16, Q21, p. 43) indicated whether learning about various patient safety tools would be relevant for their team, healthcare setting or area of work (in the context of other training available and workforce development to date).

From the resources presented, it can be seen that the majority highlighted learning about ‘Significant Event Analyses’ to be the most highly relevant.

Over 30% of respondents highlighted that learning about driver diagrams was not relevant for their team/healthcare setting. This might perhaps reflect the learning already shared at SPSP events.

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Interestingly, reflective learning was cited as the second most relevant resource/process, further suggesting a priority for NES development of educational solutions to support this practice.

Taking data for both relevant and highly relevant together, it is reflective learning\(^{94}\) that is most highly rated\(^{95}\).

**Figure 16:** Respondents’ learning preferences of various practical patient safety tools (N=536-568), (Q21: Learning about the use of which of these patient safety tools from a practical perspective would you rate as relevant for your team/healthcare setting/area of work, in the context of other training available and workforce development to date).

Note: 144 respondents indicated ‘other’, across the relevance scale, and 33 respondents offered examples (see Table 17, p. 85).

Numerous other tools, processes and methods were suggested as potential learning resources (Table 17, p. 85); with themes involving communication, implementation, application and sustainability. In addition, some respondents highlighted their lack of awareness of some of the tools/resources/processes\(^{96}\).

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\(^{94}\) Reflection is thought to be an essential element of learning. It could involve documenting events of a day and reflecting upon learning and experiences, and whether to continue practices undertaken. For example, see McClure, P. (nd). Reflection on Practice. A resource commissioned by the Making Practice Based Learning Work project, an educational development project funded through FDTL Phase 4 Project Number 174/02 and produced by staff from the University of Ulster. Available online: [http://cw.routledge.com/textbooks/9780415537902/data/learning/8_Reflection%20in%20Practice.pdf](http://cw.routledge.com/textbooks/9780415537902/data/learning/8_Reflection%20in%20Practice.pdf) [Accessed 15 July 2014].

\(^{95}\) Note that over 80% of respondents have a key role in education or training; developing capacity and capability in colleagues.

Profession specific details are also available for practical patient safety tools (supplementary data annexes 1\textsuperscript{97} and 2\textsuperscript{98}), and once again, differences and similarities are evident across the groups.

For instance, the following tools/processes were cited as the most relevant for the following selected groups:

- General Practitioners: Significant Event Analyses
- Other Medical Specialties: Significant Event Analyses
- Nursing and Midwifery: Reflective Learning
- Management: Plan-Do-Study-Act
- Allied Health Professionals: Reflective Learning

### 7.4 Summary

Exploring Patient Safety Topics

- This section of the report presented stakeholders’ relevancy perceptions of a range of patient safety tools, processes, resources and learning topics. This provides evidence to substantiate the NES development of a variety of educational solutions to support the patient safety agenda across Scotland.
- The WHO Patient Safety Curriculum was rated highly by stakeholders, and could inform the NES development of additional resources. In addition, the Curriculum could also be embedded in other targeted educational infrastructures.
- Moreover, other patient safety learning topics cited as particularly relevant include medication and error management, human factors, and interpersonal communications. All of this further corroborates the notion that NES should develop further educational resources in these areas.
- The majority of respondents felt that learning about a range of patient safety tools (from a practical perspective) would be relevant to their team/healthcare setting/area of work. Of the presented options, the top two processes/tools cited as relevant were ‘Reflective learning’ and ‘Significant Event Analyses’.
- Taking the results together (and in no particular order), there are a number of overlapping themes emerging for the future development of educational resources: (1) medication and error management; (2) human factors; (3) critical and interpersonal communications; (4) learning and reflection; and (5) teamwork.
- Critical communication in particular was noted in the context of deteriorating patients.
- Overall, the data perhaps evidences the need to specifically target workforce educational resources.


8. Preferred Learning Approaches

A variety of education and training opportunities are available to the NHSScotland workforce, and this section of the report presents respondents’ views on their preferred approaches to learning.

8.1 Preferred Approaches to Learning

Respondents (N=557-567, Figure 17, Q23) were invited to indicate their top three preferred learning approaches that they found most effective.

There is a general preference for learning to be part and parcel of the working environment and for it to be embedded as part of team-working (e.g. learning from error, through team reflection). Implications arising suggest that learning and development resources, which encourage teamwork and reflection, should be embedded into day to day activities.

Conversely, scheduled web conferences/webinars for more in-depth/follow up for a specific priority topic, were cited as the least effective approach to learning. This appears to resonate with respondents views’ on the availability and utility of IT and e-Learning within the clinical environment (outlined in the next section of this report).
Other cited examples (Table 18, p. 86) included targeted CPD and discussion opportunities, written publications, and other miscellaneous learning approaches.

Supplementary data annexes 1 and 2 present these results by selected professional groups; and, at the outset, differences are evident.

For instance, the top two learning priorities for GPs are:
1. ‘Learning from error, involving team reflection’ and
2. ‘Part of team learning in general’.

By contrast, the top two learning priorities for management are:
1. ‘Part of your job, including through project work’ and
2. ‘Attendance at conferences and workshops’.

In addition, for Allied Health Professionals, the preferred learning approaches are:
1. ‘Part of team learning in general’ and
2. ‘Attendance at conferences and workshops’.

Examination of the data is underway, however, at the outset, these results indicate the need to appreciate and accommodate the differing learning preferences amongst different professional groups. Given these results, the education and training provision of the whole care team may require further consideration.

**8.2 Summary**

<table>
<thead>
<tr>
<th>Preferred Learning Approaches</th>
</tr>
</thead>
</table>
| • In general, the top cited learning priority was ‘learning from error, involving team reflection’.
• In addition, it is notable that learning as part of day to day working, through project work and as part of team learning in general, were all cited as the next top priorities.
• Whilst usually held out-with the immediate clinical environment, conferences and workshops were the next rated learning approaches.
• Overall, scheduled web conferences/webinars for more in-depth follow up, were the least preferred formats, and could perhaps reflect the facilities available within the clinical environment.
• Filtered profession specific details perhaps demonstrate the need to appreciate and deliver aligned learning. |

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This section examines respondents’ views on the challenges to developing and applying knowledge and skills to reduce harm. In addition, insights relating to perceived barriers to learning about patient safety are also presented. Raw data examples can be found in the data report.

### 9.1 Challenges to Developing Knowledge and Skills to Reduce Harm

Respondents were invited to indicate, in free form, their most concerning challenges relating to their development of knowledge and skills to reduce harm (Q25). 460 individuals responded to this question, generating a wealth of information. 29 themes have been identified, and a brief narrative is presented below; with the overall summary presented in Table 9, p. 49.

The majority of respondents (N=314) indicated that their perception of time was a major (limiting) factor in the development of knowledge and skills to reduce harm.

*Having the time to develop knowledge and skills is very difficult unless you are able to do it on-the-job. As a specialist nurse my workload is quite high as I work full time, have my own caseload of patients, currently one of the leads on a quality improvement project and trying to complete an MSc course. I wish I could devote more time to each individual task.*

[Nursing & Midwifery, 25:71]

*There is always a tremendous time pressure. Management have recently job planned and decreased my SPA (Supporting Professional Activities).* [Other Medical Specialty, 25:87]

In addition, the need for reflection time was emphasised.

*Too many emails and too much Admin to do. i.e. busy. No-one to take the heat/burden off my shoulders and allow me some true 'Blue Sky thinking' time.* [General Medical Practitioner, 25:114]

Some minor evidence of the utilisation of personal study time (N=2) was apparent; including how a few individuals take personal responsibility to reduce harm, by keeping themselves appraised of developments (N=2). One indicated that personal study was a potential avenue, but highlighted that he/she was also too busy in that respect. A proactive approach to learning about patient safety was suggested (N=1). These challenges shared may reflect organisational and/or team cultures.

Workloads and job pressures (N=68) made up the second largest cohort, and included areas like the need for dedicated training time, balancing learning versus clinical commitments, and the need for more/ongoing learning.
Putting time aside to devote to this topic is nigh impossible, yet this is the same for most CPD activity. This is mainly due to pressure of clinical work on surgeons who are under pressure to meet government targets, and ironically it’s in just these high pressure circumstances that errors are more likely to occur. [Other Medical Specialty, 25:39]

...Job pressures ensure that we frequently carry out the same practices over and over as it’s how ‘it’s always done’... [Nursing & Midwifery, 25:57]

Competing priorities, a plethora of daily work that leaves little time for developing knowledge and skills, managers/leaders in my organisation not prioritising my learning because I am not high-ranking and do not have a clinical job. [Admin & Clerical, 25:134]

Time, capacity and pressure constraints, targets and objectives not relating to reducing harm... [Paramedic, 25:158]

Reflections on the organisational culture (N=31) highlighted that mindsets, ideas, hierarchical structures and old behaviours, simply needed challenging. In addition, a ‘blame culture’ was suggested.

Poor communication and dissemination of up to date practices. Unwillingness from management to listen to proposals to change practices from staff. Lack of change culture. [Nursing & Midwifery, 25:254]

Present culture of focussing on negativity rather than proactive engagement and really trying to understand the importance of the human elements of safety. [Allied Health Professional, 25:256]

The need for knowledge, awareness and access to patient safety resources (N=30) was also highlighted.

Knowing where to find the information in the first place. [Other Medical Specialty, 25:192]

Working for a small independent organisation in partnership with the NHS, it is important to be well informed with regards to current patient safety issues and have access to suitable quality training resources. [Educationalist, 25:364]

Knowing what I don't know. These matters are not being brought to our attention in a practical and useful way. Currently, 'Patient Safety' just seems like yet another 'buzz phrase' when in actual fact it applies to real-life situations. [General Medical Practitioner, 25:390]

Specifically, 22 respondents highlighted that knowledge and access to information sources appeared problematic, and it was highlighted that the spreading and cascading of learning – including the coordination and data sharing between departments – would help support patient safety (N=16).

In addition, available human resources and staff issues were noted as challenges (N=18). Moreover, there appeared to be a real need to support staff engagement, commitment and influence (N=17); including that of non-clinical staff.

Trying to engage/raise awareness among clinical staff of the work which non-clinical staff do to help reduce harm. [Educationalist, 25:160]

Spreading and cascading learning (N=16) were cited as important; as well as the ethos of making it compulsory for all staff to engage in patient safety work.

Accepting the concept as no-negotiable and pivotal for all staff to engage. [Other Medical Specialty, 25:244]
9. Challenges and Barriers

Finally, the need for a coherent and consistent approach (N=9) to supporting the patient safety agenda is apparent.

There are too many ‘national programmes, initiatives etc etc’ clamouring for attention – some coherence and a stepwise approach would help. [Other Medical Specialty, 25:26]

Unclear recommendations - from multiple sources. [Other Medical Specialty, 25:122]

In summary, the following table brings together the themes emanating from respondents’ most concerning challenges relating to their development of knowledge and skills to reduce harm (Q25).

<table>
<thead>
<tr>
<th>Theme</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time</td>
<td>314</td>
</tr>
<tr>
<td>Job pressures/workload</td>
<td>68</td>
</tr>
<tr>
<td>Organisational cultures and behaviours</td>
<td>31</td>
</tr>
<tr>
<td>Access to and awareness of resources</td>
<td>30</td>
</tr>
<tr>
<td>Staff resources and issues</td>
<td>18</td>
</tr>
<tr>
<td>Availability of resources</td>
<td>17</td>
</tr>
<tr>
<td>Staff engagement, commitment and influence</td>
<td>17</td>
</tr>
<tr>
<td>Spreading and cascading learning</td>
<td>16</td>
</tr>
<tr>
<td>Management support</td>
<td>13</td>
</tr>
<tr>
<td>Communication and discussion</td>
<td>12</td>
</tr>
<tr>
<td>Education and training</td>
<td>10</td>
</tr>
<tr>
<td>Integral to day to day activities</td>
<td>10</td>
</tr>
<tr>
<td>Financial issues</td>
<td>9</td>
</tr>
<tr>
<td>Multiple initiatives</td>
<td>9</td>
</tr>
<tr>
<td>IT/eLearning Issues</td>
<td>8</td>
</tr>
<tr>
<td>Utilising the evidence base</td>
<td>7</td>
</tr>
<tr>
<td>Job issues</td>
<td>7</td>
</tr>
<tr>
<td>None/NA/Unsure</td>
<td>7</td>
</tr>
<tr>
<td>Issues related to non clinicians</td>
<td>6</td>
</tr>
<tr>
<td>Clinical priority/scope of task</td>
<td>6</td>
</tr>
<tr>
<td>Personal responsibilities</td>
<td>6</td>
</tr>
<tr>
<td>Location of courses and events</td>
<td>5</td>
</tr>
<tr>
<td>Relevance of materials</td>
<td>5</td>
</tr>
<tr>
<td>Management acknowledgement of harm/high risk areas</td>
<td>5</td>
</tr>
<tr>
<td>Teamwork</td>
<td>3</td>
</tr>
<tr>
<td>Feedback utility of current tools</td>
<td>1</td>
</tr>
<tr>
<td>Conflicts of interest</td>
<td>1</td>
</tr>
</tbody>
</table>

Table 9: Theme summary of respondents’ perceived challenges to developing knowledge and skills to reduce harm (N=460), (Q25: Please describe your biggest challenge to developing knowledge and skills to reduce harm). Note: frequency demonstrates instances of occurrence.
9.2 Challenges to Applying Knowledge and Skills to Reduce Harm

Respondents (N=429) were further invited to indicate their most concerning challenges in applying knowledge and skills to reduce harm (Table 10, Q26). The themes that emerged were similar to the responses to the previous section (challenges relating to developing knowledge and skills to reduce harm).

<table>
<thead>
<tr>
<th>Theme</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time</td>
<td>151</td>
</tr>
<tr>
<td>Organisational cultures and behaviours</td>
<td>67</td>
</tr>
<tr>
<td>Staff engagement, commitment and influence</td>
<td>54</td>
</tr>
<tr>
<td>Job pressures/workload</td>
<td>52</td>
</tr>
<tr>
<td>Staff resources and issues</td>
<td>29</td>
</tr>
<tr>
<td>None/NA/Unsure</td>
<td>20</td>
</tr>
<tr>
<td>Management support</td>
<td>18</td>
</tr>
<tr>
<td>Availability of resources</td>
<td>18</td>
</tr>
<tr>
<td>Teamwork</td>
<td>16</td>
</tr>
<tr>
<td>Implementation/consistency of implementation</td>
<td>14</td>
</tr>
<tr>
<td>Knowledge and awareness of issues and resources</td>
<td>13</td>
</tr>
<tr>
<td>Miscellaneous</td>
<td>10</td>
</tr>
<tr>
<td>Financial issues</td>
<td>9</td>
</tr>
<tr>
<td>Integral to day to day activities</td>
<td>9</td>
</tr>
<tr>
<td>Multiple initiatives</td>
<td>8</td>
</tr>
<tr>
<td>Spreading and cascading learning</td>
<td>8</td>
</tr>
<tr>
<td>Communication and discussion</td>
<td>8</td>
</tr>
<tr>
<td>Education and training</td>
<td>6</td>
</tr>
<tr>
<td>IT/eLearning Issues</td>
<td>6</td>
</tr>
<tr>
<td>Acknowledgement of harm/high risk areas</td>
<td>5</td>
</tr>
<tr>
<td>Evidence base</td>
<td>5</td>
</tr>
<tr>
<td>Job issues</td>
<td>5</td>
</tr>
<tr>
<td>Recall/remembering</td>
<td>5</td>
</tr>
<tr>
<td>Issues related to non clinicians</td>
<td>4</td>
</tr>
<tr>
<td>Waiting lists/targets</td>
<td>4</td>
</tr>
<tr>
<td>General help/support</td>
<td>4</td>
</tr>
<tr>
<td>Feedback utility of current tools</td>
<td>2</td>
</tr>
<tr>
<td>Decision making at operational level</td>
<td>2</td>
</tr>
<tr>
<td>Relevance of materials</td>
<td>1</td>
</tr>
<tr>
<td>Clinical priority/Scope of task</td>
<td>1</td>
</tr>
<tr>
<td>Personal responsibilities</td>
<td>1</td>
</tr>
<tr>
<td>Coaching/Mentoring</td>
<td>1</td>
</tr>
<tr>
<td>Situation Awareness</td>
<td>1</td>
</tr>
</tbody>
</table>

Table 10: Theme summary of respondents’ perceived challenges to applying knowledge and skills to reduce harm (N=429), (Q26: Please describe your biggest challenge to applying your knowledge and skills to reduce harm). Note: frequency demonstrates instances of occurrence.
Respondents’ perceptions of time (N=151) were once again cited as the greatest challenge to applying knowledge and skills to reduce harm.

*Pressure of time. Although these checks etc may only take a few seconds all the seconds add up, and add minutes onto activities, constituting a significant % of the time allocated. At the same time there is pressure not to keep people waiting, to keep clinics to time, to answer phones in less than 30 seconds and still give patients time to explore their concerns, teach students etc etc etc.* [Other Medical Specialty, 26:249]

Similar to the development of knowledge and skills to reduce harm, organisational cultures (N=67), staff engagement (N=54), and job pressures (N=52) were also cited as challenges.

*Cultural indifference - people are fed up hearing about this until it becomes either a personal issue, they are harmed as a patient or, they cause the harm themselves.* [Healthcare Scientist, 26:71]

*Culture needs to be embedded in practice, through open discussion, practice education, educational meetings, multidisciplinary exercises involving cases and reflection.* [General Medical Practitioner, 26:74]

*Do you really think that further additions of pointless single issue bureaucracy is going to do anything other than add to staff workload when the wards are full of temporary agency staff, when the junior doctors numbers are decreasing and the managers have a transient mentality that is target driven to their jobs. Ask the boards how many people have been treated at the weekends on waiting lists and then ask if any of the patient safety ideals apply then over the waiting time targets. Mid Staffs is always bubbling below the surface...* [Other Medical Specialty, 26:83]

A consistent approach to applying and implementing patient safety was also highlighted (N=14).

*Ensuring all staff adhere strictly to all SOPs around patient/people safety throughout their daily work and lives. Creating a work environment when any member of the team can be challenged for incorrect process which may cause harm without 'shooting the messenger'.* [Management, 26:100]

As expected, some respondents (N=20) noted that applying patient safety principles were integral to their day to day activities.

*I don’t accept that compromise on this is acceptable - I don’t recognise barriers to applying safety principles at all times.* [Other Medical Specialty, 26:139]

*I think I do this all the time using the knowledge I have from attendance at 3 day IHI course and working with colleagues in SPSP.* [Management, 26:145]

The need for management support however, was emphasised (N=18) as a facilitator to implementing patient safety principles.

*Time pressures, apathy of fellow staff, low priority given by managers to actual improvements and not just organisational paper based meaningless exercises and rituals which they seem to favour as part of being seen to be doing something and reducing legal risk to the organisation.* [Other Medical Specialty, 26:385]
Finally, teamwork (N=16) and the engagement of staff (N=54) were highlighted as important drivers in the application of knowledge and skills to reduce harm.

> Very seldom does the intervention of a single well intentioned and educated person make a difference to team outcomes without team engagement. Team engagement, however well educated and intentioned its members may be, frequently dwindles in the overstretched and ever changing clinical reality. [Consultant, 26:413]

### 9.3 Barriers to Learning about Patient Safety

Respondents (N=428) were invited to indicate, in free form (Table 11, Q27), their most concerning barriers to learning about patient safety.

Responses were largely similar to the previous two sections, and once again, perceptions relating to time were cited as the biggest barrier to learning about patient safety (N=268).

> At times I am collecting all this data then I don’t have the physical time to implement change and drive improvement. Very demoralising as you can see how bad the figures are and yet you don’t have the resource to do anything about it. [Nursing & Midwifery, 27:31]

> I’m all for learning about patient safety - my Hons research was specific to patient safety, communication & handover. It can however be hard to find time to seek out learning when working in a busy ward environment. [Nursing & Midwifery, 27:89]

> Multiple and sometimes irrelevant demands on time. [Nursing & Midwifery, 27:143]

In contrast to previous sections, more instances (N=55) indicate uncertainty, little or no barriers to learning about patient safety.

> Don’t see that I have one as it’s an integral part of my role and responsibilities. [Nurse, 27:59]

> I personally do not experience any barriers to learning about Patient Safety if I can access information locally, but the current financial climate is restrictive to attending courses out with my area. [Nursing & Midwifery, 27:85]

> None - very familiar with concepts. Trained in aviation medicine many years ago - concepts applied in other industries well established and many transferable to healthcare sector. [Other Medical Specialty, 27:178]

> None really, there are now better resources than ever for learning. [General Medical Practitioner, 27:180]

> None this is a key part of my job and I will take all the available opportunities to learn more. [Other Medical Specialty, 27:181]
However, job pressures and workloads were once again cited (N=40) as barriers to learning.

*Continued service pressures and fire-fighting. There is no practice education in our area. This is ridiculous. How are we supposed to respond properly as a team if there is no resource set aside? [Other Medical Specialty, 27:48]*

*Danns of acute care outstrip job planned activities. [Geriatric medicine, 27:52]*

*Sausage factory mentality and misapplication of Lean Theory to clinical consults. [Consultant medical, 27:211]*

Once again, knowledge, understanding, and the awareness and location of resources, were cited (N=25) as challenges.

*Accessing material and having time to trial it within the ward and reassessing how it works. [Nursing & Midwifery, 27:10]*

*Availability of a resource that gives an overview of what is available where - with links etc. [Pharmacy, 27:32]*

*Knowing where the information is available from and what’s applicable in our world of receiving lots of information [Healthcare Scientist, 27:101]*

*Lack of knowledge of available resources - didn't know NES had resources! [General Medical Practitioner, 27:116]*

In addition, the need for changing organisational cultures and behaviours was also highlighted (N=20).

*Belief that it can make a difference - challenging and changing current systems and behaviours. [Nursing & Midwifery, 27:38]*

*Impotence to alter working practices - no time or settled teams. [General Medical Practitioner, 27:91]*

*That I will continue to write about harms in National Journals even if my local NHS Board do not facilitate such openess. [Other Medical Specialty, 27:224]*

Respondents (N=19) noted that more work was required in relation to clinical buy-in, staff engagement, colleague commitment and issues related to task value.

*Making it everyone’s business and responsibility. [Management, 27:137]*

*Myself. [Allied Health Professional, 27:145]*

*Opposition from medical staff - it can be very frustrating trying to constantly convince them of it - why is it that everyone else gets it and they (not all) don’t. I mean this in the context to facilitating others to learn about patient safety. So I guess the biggest barrier is about that 'creating the will' - if folk don't get that, no effort will be made to learn, as much of it is done by one's own enthusiasm and belief in the need for it (as well as the growing swell of emphasis that has been placed on it in Scotland). [Nursing & Midwifery, 27:194]*
9. Challenges and Barriers

Time and commitment from those in the know. Pointless system of reporting near misses/events via Datix. So much so that we are now going back to our historical within department system: case presentation/honesty with each other: incident reporting system. Hopefully more supportive to those who have had an unfortunate experience. Most criticism as usual comes from those who are not involved at the coal face, live in some cloud cuckoo land divorced from reality but over which they have the ability to have a major influence but not the courage to make useful decisions. Need to make someone specific responsible for the change you want to see - too nebulous at the moment. [Other Medical Specialty, 27:340]

With respect to education and training, respondents (N=16) stressed the need to facilitate more education and training in the area.

Access to Primary or Secondary learning seminars. Ambulance service does not seem to be part of either. [Paramedic, 27:6]

Lack of resources given to patient safety development by my board. Access to further education opportunities is limited. [Educationalist, 27:117]

My limited involvement in face to face learning sessions. [Nursing & Midwifery, 27:144]

The service provides dangerously low levels of ongoing training. Most staff seek their own training at their own cost and in their own time, this can lead to inconsistent approach. [Paramedic, 27:232]

However, once again, there were perceptions that multiple resources were available for learning about patient safety (N=9).

Sorting out the best learning resource from the many offered, knowing where to start on such a huge topic. [Nursing & Midwifery, 27:220]

A small number of comments (N=5) outlined resistance to change, and more positive future endeavours for patient safety (N=2).

The constant challenging of evidence which is accurate and intuitive to avoid altering practice. [Emergency Medicine Consultant, 27:228]

Not enough time. Would love to start as an SPSP fellow. Line management have suggested completion of an MSc should take place in the first instance. [Nursing & Midwifery, 27:186]

Other cited themes included barriers related to the relevance of materials, IT/e-Learning issues, management support, and the need to spread and cascade learning (Table 11, p. 55).
### Table 11: Theme summary of respondents’ perceived barriers to learning about patient safety (N=428), (Q27: What is your biggest barrier to learning about patient safety?). Note: frequency demonstrates instances of occurrence.

<table>
<thead>
<tr>
<th>Theme</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time</td>
<td>268</td>
</tr>
<tr>
<td>None/NA/Unsure</td>
<td>55</td>
</tr>
<tr>
<td>Job pressures/workload</td>
<td>40</td>
</tr>
<tr>
<td>Knowledge and awareness of issues and resources</td>
<td>25</td>
</tr>
<tr>
<td>Organisational cultures and behaviours</td>
<td>20</td>
</tr>
<tr>
<td>Staff engagement, commitment and influence</td>
<td>19</td>
</tr>
<tr>
<td>Education and training</td>
<td>16</td>
</tr>
<tr>
<td>Availability of resources</td>
<td>15</td>
</tr>
<tr>
<td>Access and ease of access to resources</td>
<td>13</td>
</tr>
<tr>
<td>Relevance of materials</td>
<td>9</td>
</tr>
<tr>
<td>Multiple initiatives</td>
<td>9</td>
</tr>
<tr>
<td>Staff resources and issues</td>
<td>8</td>
</tr>
<tr>
<td>Management support</td>
<td>8</td>
</tr>
<tr>
<td>Financial issues</td>
<td>8</td>
</tr>
<tr>
<td>Communication and discussion</td>
<td>8</td>
</tr>
<tr>
<td>IT/eLearning Issues</td>
<td>7</td>
</tr>
<tr>
<td>Implementation/consistency of implementation</td>
<td>6</td>
</tr>
<tr>
<td>Miscellaneous</td>
<td>6</td>
</tr>
<tr>
<td>Teamwork</td>
<td>5</td>
</tr>
<tr>
<td>Job issues</td>
<td>5</td>
</tr>
<tr>
<td>Integral to day to day activities</td>
<td>4</td>
</tr>
<tr>
<td>Clinical priority/scope of task</td>
<td>4</td>
</tr>
<tr>
<td>Location of education and training</td>
<td>3</td>
</tr>
<tr>
<td>Feedback utility of current tools</td>
<td>3</td>
</tr>
<tr>
<td>Personal responsibilities</td>
<td>3</td>
</tr>
<tr>
<td>Spreading and cascading learning</td>
<td>2</td>
</tr>
<tr>
<td>Acknowledgement of harm/high risk areas</td>
<td>2</td>
</tr>
<tr>
<td>Evidence base</td>
<td>2</td>
</tr>
<tr>
<td>Positive comments</td>
<td>2</td>
</tr>
<tr>
<td>Story telling</td>
<td>2</td>
</tr>
<tr>
<td>Coaching/mentoring</td>
<td>1</td>
</tr>
</tbody>
</table>

Interestingly, from this last cohort of questions, this question focusing on the most concerning barriers to learning about patient safety yielded the most positive responses\(^{102}\).

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\(^{102}\) 55 instances of ‘none/NA_UNSURE’ were obtained in relation to perceived barriers to learning about patient safety.
9.4 Additional Comments

Finally, respondents (N=188) were also invited to provide additional comments (Q28103) to help NES plan the development of knowledge and skills to reduce harm. Whilst this section yielded the least responses from the last group of questions, the richer narrative provides additional insights to support the development of resources to reduce harm.

Representative comments are presented below, with overall emerging themes depicted in Table 19, p. 87.

Once again, responses (N=29) stress perceptions of time.

- There is clearly a lot of excellent information 'out there' to update knowledge and skills around patient safety. We need time to read it and put it into practice. Things are slowly improving but more understanding from middle management and buy in from clinical leaders would help. [Other Medical Specialty, 28:160]

- Time is precious and if more staff were able to understand and speak of patient safety and techniques for improvement then engaging with them would be easier. [Pharmacy, 28:170]

Narrative relating to support from management, awareness of resources, and suggestions relating to communication and discussion was evident.

- Allow staff time to think, meet and reflect rather than just work on a one size fits all production line. Deaf senior management sucking up to politicians and not listening to staff will only produce harm. Did you read the Francis Report? [Consultant medical, 28:14]

- I would like to have a patient safety forum at our practice/hospital/primary care team. It would be useful to have some ideas and resources to help set this up. [General Medical Practitioner, 28:73]

In addition, access to IT and e-Learning issues were evident, rendering them unconstructive (N=17).

- As clinical staff there are limited opportunities to access PC's which is private or quieter. Nursing staff have no protected study time. Ward capacities are at an all time high with staffing levels which are lower than I have seen before in my career. Staff are working longer hours which means that on days off they are catching up with the other elements of home and family life, self development becomes a very small priority. [Nursing & Midwifery, 28:18]

- In my department most education is done by e-learning. This is sometimes difficult to access due to lack of computer time/equipment. This does not engender a group/team approach to patient safety. It creates a feeling of individualisation and isolation. It also limits time and ability to discuss change initiatives with other members of the team. Identifying change leaders and creating a team/group approach to learning is important to attaining goals, Individuals need to feel they have ownership and involvement of initiatives and have a place within that team. These components are all addressed in face to face group approaches to learning about patient safety initiatives. [Nursing & Midwifery, 28:79]

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103 Q28: Please make any other comments you have to help us plan the development of knowledge and skills to reduce harm.
9. Challenges and Barriers

While e-learning is undoubtedly a valuable support tool, it does not, on its own, appear to produce an effective practitioner. You can rush through and pass an e-learning module but not absorb much of the information. Perhaps people drawn to a practically based profession learn best in actual practice. (personal opinion). [28:179]

In looking at additional education and training activities (N=24), there were suggestions relating to collaborative working with NHSScotland Boards, educational commitment and speciality specific packages.

I am amazed at the number of resources listed in the NES directory relating to patient safety. I think NES should organise meetings during clinical audit afternoons to highlight the resources, and then to follow up to ensure that all clinicians have access to education. You could argue that completion of certain key safety modules should be part of the revalidation process for all consultants and trainees (and I don’t exclude other healthcare workers from this group), but it might mean restructuring some of the courses to deliver this in a concise and available form. [Educationalist, 28:63]

Please focus more on medical staff and developing packages aimed specifically at them. [Management, 28:133]

There has to be some profession-specific approach here. I realise the vogue is everyone thrown in together but with VERY LIMITED time we have to recognise that quality of experience suffers when the opportunities are limited by the breadth of involvement. There are undoubtedly areas of valuable cross-over between professions and I would not want to diminish this - but it has become a PC mantra that all must be done this way - which is nonsense and counterproductive. As a surgeon I do not need to sit for an hour whilst the minutiae of nursing practice is dissected any more than a nurse needs to sit and listen to debates over the never ending question of choice of thromboprophylaxis. Ideally we would all have infinite time to learn from each other but this is simply not the case in the real world. [Other Medical Specialty, 28:159]

We need to develop an education/training contract for staff, i.e. this is educational commitment we will commit to you and this is the commitment we expect from the individual staff member. This would ensure near compulsory on going education for all NHS staff. We must invest in our staff if we are going reap the benefit. It isn’t rocket science! [Nursing & Midwifery, 28:177]

Would be good if NES could work with boards to help develop education package with boards and thus using NES tools and packages. Be good if NES worked with named lead in board to keep up dialogue, share developments etc. [Management, 28:187]

It was also highlighted that patient safety, as expected, should be integral to day to day working (N=24).

"Patient safety" should be integral to the ethos of the organisation - woven into every fibre - it's not enough to have a "department “or a "movement“ within the NHS with that name!! We run the risk of forming an ineffective cult. [Consultant Surgeon, 28:3]
9. Challenges and Barriers

For all above time constraint is the biggest challenge to developing knowledge, for the application of that knowledge and learning about patient safety. To deal with this patient safety should be integrated into the culture of organisational thinking, policy making and implementation of these policies. To a large extent this is taking place in my health board with integration of safety policy into day to day working. For example the Sepsis 6 bundle and how we react, medicines reconciliation project with spin off projects such as the polypharmacy project. There are other specialty specific projects. Safety needs to be absorbed into the working culture rather than tagged on and perceived as additional work....which is happening to a large extent ...but no room for complacency. [General Medical Practitioner, 28:55]

Overall, it can be seen that whilst this was an open question to explore the NES development of knowledge and skills to reduce harm (Q28), respondents offered similar responses (Table 19) to the previous three questions, (relating to challenges in developing knowledge and skills, and learning and applying them to reduce harm).

9.5 Summary

Challenges and Barriers

- This section looked into respondents’ views and perceptions of their main challenges and barriers in reducing harm: (1) the development of knowledge and skills; and (2) the application of knowledge and skills. Respondents were also invited to reflect on their greatest barrier to learning about patient safety.
- The main challenges and barriers cited for the development of knowledge and skills to reduce harm were perceptions relating to time, job pressures/workloads, and organisational cultures and behaviours. The greatest response was skewed towards respondents’ perceptions of time, and a number of illustrative quotes have been presented.
- In the application of knowledge and skills, it was noted that patient safety principles are always applied and non-negotiable. However, once again, there were also challenges and barriers relating to perceptions of time, organisational cultures, behaviours and job pressures/workloads. Yet again, respondent’s perceptions of time were the highest cited.
- It was also evident that staff engagement, commitment and influence were required to ensure the application of knowledge and skills to reduce harm. In addition, perceptions relating to organisational cultures and behaviours were highlighted.
- With respect to barriers to learning about patient safety, once again, perceptions relating to the management of time were highlighted.
- However, a greater proportion of respondents noted that there were no/little challenges to learning, but felt that more formal education and training were needed.
- Once again, other challenges cited included job pressures and workloads, the awareness and location of resources, the need for colleague engagement, and the need to change organisational cultures and behaviours.
- Access to the IT infrastructure was cited as challenging, rendering e-Learning unconstructive. Finally, there were perceptions relating to the value of the online infrastructure and whether any ‘real’ learning was taking place.
- Whilst patient safety was perceived to be integral to day to day working, it was nevertheless suggested that more work was required to embed this philosophy throughout organisations as a whole.
10. Discussion and Recommendations

10.1 Questionnaire Respondents

The questionnaire yielded 581 responses from across Scotland, and the majority consisted of:

- Those working in territorial health boards/the service.
- A main healthcare setting of acute and primary care.
- Those working as general medical practitioners, in medical specialties and in nursing & midwifery.
- Those describing themselves as in the middle or late stages of their career.
- Over 480 with a key role in developing colleagues’ capacity and capability in education and training.
- Over 300 respondents who championed patient safety in their team or healthcare setting.

234 individuals agreed that NES could contact them to obtain further highlighted patient safety learning resources (that they are willing to share with NES).

In summary, it can be seen that the questionnaire attracted key respondents. Whilst this is a relatively small self-selected cohort in comparison to the whole of NHSScotland and other healthcare partners, the sample count and the targeted responses received – including those from team leads – are nevertheless encouraging enough to reflect upon and to further draw some recommendations.
10.2 Patient Safety Stories

Stakeholders highlighted that patient safety stories were disseminated at various meetings, presentations, reports and at handover. A wide range of reasons for engaging with stories were highlighted, and a number presented outcomes, lessons learned, changes made and next step suggestions for improvement. Specifically, respondents emphasised that stories were helpful in learning, development, reflection and positive improvements. Some caveats included being new to the area, the need for further education and training in their use, the notion of the evidence base versus anecdotes, and finally, confidentiality/ethical issues.

Respondents also reflected on their preferred formats for using patient safety stories, and it was highlighted that podcast/videos and text based formats were the most popular. From the free text responses, real time discussion was emphasised as a preferred format\(^{104}\).

A learning briefing on ‘Making the Most of Patient Safety Stories\(^{105}\) has been developed from this section of the consultation. It includes a summary of how stakeholders gather stories, where they are disseminated, preferred formats, outcomes and lessons learned and suggested ways forward in furthering the patient safety agenda. Interim results\(^{106}\) have also been presented at the 19\(^{th}\) Annual IHI/BMJ International Forum on Quality & Safety in Healthcare\(^{107}\), Paris, 08-11 April 2014.

<table>
<thead>
<tr>
<th>Recommendations: Patient Safety Stories</th>
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</thead>
<tbody>
<tr>
<td>R1. Explore options to support NHSScotland staff in their recording and reflecting on patient safety stories.</td>
</tr>
<tr>
<td>R2. Review options for NHSScotland regarding the accessibility and confidentiality/ethics of patient safety stories held in teams.</td>
</tr>
<tr>
<td>R3. During NES training sessions, promote the use of quantitative data and narrative as a vehicle for reflection and ongoing improvement.</td>
</tr>
<tr>
<td>R4. Widely disseminate the ‘Making the Most of Patient Safety Stories’ learning briefing to promote dialogue across the service, and to support the use of both quantitative data and narrative as a vehicle for change and improvement.</td>
</tr>
<tr>
<td>R5. Develop a collection of resources (e.g. case studies) that demonstrates how the use of narrative gives rise to change and positive improvement. These can be from patient and staff perspectives.</td>
</tr>
</tbody>
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104 It is noteworthy to mention that the option ‘real time discussion’ was not available within the set question.


10.3 NES Approaches to Reducing Harm

The majority of stakeholders reported the relevance of a range of NES approaches and resources for supporting patient safety. These included the NES 'Introduction to Patient Safety'108 e-Learning modules; the NES patient safety and clinical skills109 website, NES training to apply knowledge and evidence in frontline practice, NES patient safety face to face courses110.

However, whilst the resources were viewed very positively, it was evident that the majority of questionnaire respondents were not aware of the resources and/or had not accessed them111.

Respondents were also invited to reflect on their use of the ‘Patient Safety Education Scenarios’112, a suite of resources that aim to raise awareness of how different educational interventions contribute to safer healthcare. A range of specific titles were highlighted, with the most notable being the ‘Patient Safety Short Courses’, followed by ‘Improving Significant Event Analyses using feedback from trained peer groups’. Whilst these were the most popular, once again, it was evident that the wider cohort was not aware of the resources. Nevertheless, the resources were cited as being relevant and practically used in areas like team discussion, self-learning, induction and at CPD sessions.

Recommendations: NES Approaches to Reducing Harm

R6. Utilising a variety of communication channels, deliver a measured promotional campaign113 to enhance access to NES resources that support patient safety education and training.

R7. Promote the learning resource ‘Introduction to Patient Safety’114 e-Learning module as a component within corporate induction sessions.

R8. Continue impact assessment/evaluation of a selected cohort of resources and training endeavours.

R9. Build on the patient safety education created by NES to further the patient safety agenda of excellence in patient care.

R10. Continue to work with NES patient safety directorate nominees and other colleagues, to champion and embed patient safety education and training, within NES supported and service-wide educational developments, as appropriate.

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111 These results could potentially act as baseline measures for future impact evaluations.


113 A review of the communications strategy for patient safety is underway (NE).

114 This is currently available on https://nhs.lea prv.uk [registration and login required].
10.4 Exploring Patient Safety Topics

The WHO Curriculum Guide Topics in patient safety were presented as benchmarks for respondents to reflect upon. The vast majority of respondents felt that all the topics were relevant; although minor differences were evident once filtered by profession (e.g. management).

Respondents also highlighted their perceptions of relevance of other presented patient safety topics\(^{115}\) (Figure 15, p. 41). The majority of topics were viewed positively, with the highest ratings concentrating around communication, error management and human factors. In addition, the majority of respondents also felt that learning about a variety of practical patient safety tools would be relevant in the context of their team and/or healthcare setting.

<table>
<thead>
<tr>
<th>Recommendations: Exploring Patient Safety Topics</th>
</tr>
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<tbody>
<tr>
<td>R11. Continue to align NES patient safety educational scenarios with the WHO Curriculum patient safety topics(^{116}).</td>
</tr>
<tr>
<td>R12. Build on current delivery work and where there are gaps, actively develop resources (and where appropriate, deliver training sessions) on topics around human factors, communication, medication and error management, and interpersonal interactions.</td>
</tr>
<tr>
<td>R13. Provide further education and training in a range of practical patient safety tools, (e.g. SEA and learning from reflection).</td>
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10.5 Preferred Learning Approaches

In terms of preferred learning approaches, respondents highlighted that learning from error (involving team reflection) was the most popular approach. Learning as part of day to day working and as ‘part of team learning in general’, were the next cited priorities. Profession specific details demonstrate different preferred approaches across the different groups. A suggested implication arising is that in order to elicit maximum benefit, learning approaches and opportunities should be tailored and aligned by profession where practical, and as appropriate. In addition, where practical, education and training opportunities can be delivered, as appropriate, in alternative formats to further meet inclusivity and variation in learning experiences.

<table>
<thead>
<tr>
<th>Recommendations: Preferred Learning Approaches</th>
</tr>
</thead>
<tbody>
<tr>
<td>R14. Tailor and align learning, education and training opportunities by profession, as appropriate.</td>
</tr>
<tr>
<td>R15. Continue to provide inclusive education and training for the NHSScotland workforce, and offer alternative formats to users, as appropriate.</td>
</tr>
</tbody>
</table>

\(^{115}\) Responses were in awareness of other available/accessibe education and training.

\(^{116}\) A NES-wide scoping exercise has mapped the WHO Curriculum topics with current NES educational resources (across various teams).
10.6 Challenges and Barriers

Respondents were invited to reflect on their challenges and barriers on their development and application of knowledge and skills to reduce harm, and perceived barriers to learning about patient safety. This section yielded rich qualitative narrative with many inter-relating themes emerging. Of particular note, perceptions relating to the following were the most pertaining:

1. **Time and workload**: The management of time and job pressures were the greatest challenges cited in developing and applying knowledge and skills to reduce harm. Competing priorities between clinical demands, administrative tasks, and other workloads, appeared to render ongoing learning and continuing professional development in patient safety low on the priority list. In addition, a number of respondents felt that the development of errors were a consequence of trying to meet targets, and by working in pressurised environments.

2. **Formal education and training**: Whilst the importance of formal education and training was highlighted, it was evident that releasing staff to attend these sessions sometimes proved challenging. Stakeholders commented that protected learning time was required; in addition to the need for reflection time to review and eventually implement learning. In addition, negative perceptions were directed towards the utility of e-Learning as a constructive form of learning. Finally, concerns were raised regarding a lack of education and training provision available to various professional staff groups.

3. **Staff resource**: Staffing pressures at the frontline were evident; which further impacted on formal education and training in support of patient safety.

4. **Organisational culture**: The need for proactive engagement was highlighted. In addition, in order to facilitate change, respondents felt that mindsets, hierarchical structures and embedded cultures/‘ways of doing things’ simply needed challenging.

5. **Knowledge and awareness**: Respondents felt that there were issues with availability, access to and actual awareness of patient safety resources. Citations relating to an inconsistent approach with too many developments taking place, heightened confusion in relation to accessing and making use of patient safety resources.

6. **Staff engagement, commitment and influence**: Influencing and engaging staff about patient safety issues were other concerns cited. It was noted that all staff members were required to engage in the work; noting that the provision of education and training for all staff groups was required. The upward management of staff was suggested as key to acknowledging and facilitating changes in practice.

7. **Management and leadership support**: Respondents felt that positive leadership, management, and acknowledgment of the patient safety agenda, were required to facilitate staff engagement and service improvement.

8. **Consistency of approach**: Perceptions relating to inconsistent and numerous initiatives taking place were highlighted; in which needs for coherent organisational and national approaches to patient safety were expressed.

9. **No challenges and barriers**: A number of respondents cited no challenges and barriers to developing and applying patient safety skills and knowledge. It was noted that the concept of patient safety was integral to the role they were playing; with some noting personal responsibilities for additional learning and development (i.e. out-with contracted hours).
In overcoming and alleviating the noted perceived challenges and barriers, it is perhaps worthy
to reflect upon the development of education and training resources to support the
implementation of current national policy drivers and strategies.

**Recommendations: Challenges and Barriers**

R16. Deliver education and training which supports the translation of current policy drivers
(e.g. *Everyone Matters: 2020 Workforce Vision*) into frontline action.

R17. Support the development of resources to engage all staff in on-the-job learning,
reflection and work-based learning.

R18. Actively target all staff groups to attend – and benefit from – patient safety education
and training.

R19. Develop and actively promote an accessible resource/platform for all work relating to
patient safety.

R20. Continue to engage with leaders locally and nationally to promote education and
training in patient safety as a route towards service improvement and excellence.

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10.7 Conclusion

In prioritising future NES patient safety developments, the results offer useful insights into the needs of the Scottish healthcare workforce.

The NES PSMG is reviewing the recommendations and is gradually including targeted recommendations on various agendas. At the outset, the following table distils these recommendations under four areas of influence.

<table>
<thead>
<tr>
<th>Area of Influence</th>
<th>NES Recommendations</th>
</tr>
</thead>
</table>
| NES Patient Safety Multi-Disciplinary Group | • Disseminate and promote the use of narrative/patient safety stories as a means to service improvement.  
• Members to champion NES patient safety resources at every applicable opportunity.  
• Continue to deliver and increase patient safety education and training to healthcare teams and supporting professionals.  
• Continue to evaluate the impact of a selected cohort of NES patient safety resources. |
| NHS Education for Scotland               | • Actively promote resources through corporate online media channels.  
• Continue to provide strategic leadership for patient safety education and training.  
• As appropriate, acknowledge differing learning needs and styles, and present education and training activities accordingly. |
| NHSScotland Boards                       | • Provide local patient safety education and training for all members of the healthcare team.  
• Continue to liaise with staff across NHSScotland in support of patient safety education and training. |
| Policy/national approach                 | • Advocate strong leadership and promote the national approach given to making Scotland a world leader in healthcare.  
• Continue to work towards providing a coherent and systematic approach to patient safety.  
• Translate national policies and strategies into resources for frontline action. |

Table 12: Summary of recommendations.

In progressing Scotland towards the ambition of a world class health service, it is also essential that the work continues to build momentum and to robustly evidence the impact of educational endeavours and other interventions.

In conclusion, this consultation report highlights the critical importance of continuing education and training in patient safety. The need to continue to liaise and work with NHSScotland and partners is paramount to ensuring that effective improvement in all areas of service delivery is implemented, disseminated and sustained throughout.
Appendix A – Strategic Background and Key Policy Drivers

Quality Education for a Healthier Scotland: A refreshed strategic framework for 2014-19

The NHS Education for Scotland strategic framework outlines our core role towards excellence in education for Scotland’s future public services. It aligns our work under five strategic themes, which are supported by nine key outcomes.

Themes:

2. Improved quality: Education for improving quality to enhance patient safety and people’s experience of services.
3. New models of care: Education for new models of care to support the ‘2020 Vision’.
4. Enhanced educational infrastructure: Innovative educational support infrastructure covering people, technology and content.
5. An improved organisation: Enhancing the capacity and capability of our staff to give their best and achieve their potential.

Outcomes:

1. A demonstrable impact of our work on healthcare services.
2. An excellent learning environment where there is better access to education for all healthcare staff.*
3. Flexible access to a broad range of quality improvement education in the workplace.*
4. Leadership and management development that enables positive change, values and behaviours.*
5. A key role in analysis, information and modelling for the NHSScotland workforce to strengthen workforce planning.*
6. A range of development opportunities for support workers and new and extended roles to support integration.*
7. Improved and consistent use of technology with measurable benefits for user satisfaction, accessibility and impact.
8. Consistently well developed educational support roles and networks to enable education across the workplace.
9. An effective organisation where staff are enabled to give their best and our values are evident in every day work.


* Indicates a 2020 Vision priority for NES.
NHS Education for Scotland Patient Safety Multi-Disciplinary Group Terms of Reference

Established in 2008, the NES Patient Safety Multi-Disciplinary Group (PSMG) delivers a coordinated response to the overall objective of ensuring that NHSScotland staff have the knowledge, skills and behaviours to minimise harm to patients and to improve quality of care\(^{120}\).

The following are central to meeting these objectives:

- Raise awareness of how NES contributes to the Scottish Patient Safety Programme\(^{121}\) (SPSP) and the wider patient safety agenda (e.g. by participating in SPSP learning networks and other opportunities to meet objectives).
- Identify, evaluate and revise existing NES and partnership educational resources to incorporate, as appropriate, key themes of the World Health Organization (WHO) patient safety multi-professional curriculum.
- Contribute to the development of pilot work with named leads (e.g. with SPSP and national patient safety leads).

The Healthcare Quality Strategy for NHSScotland

The Healthcare Quality Strategy for NHSScotland\(^{122}\) is a key policy driver for our work and we have developed leadership across our organisation to maximise a systematic, collaborative approach to developing and disseminating our contribution to the ‘Quality Ambitions’.

- Mutually beneficial partnerships between patients, their families and those delivering healthcare services which respect individual needs and values and which demonstrate compassion, continuity, clear communication and shared decision making.
- There will be no avoidable injury or harm to people from healthcare they receive, and an appropriate clean and safe environment will be provided for the delivery of healthcare services at all times.
- The most appropriate treatments, interventions, support and services will be provided at the right time to everyone who will benefit, and wasteful or harmful variation will be eradicated.


2020 Vision

The ‘2020 Vision’\textsuperscript{123} provides a strategic narrative to the Healthcare Quality Strategy for NHSScotland, and provides the context for taking forward its implementation.

- Our vision is that by 2020 everyone is able to live longer healthier lives at home, or in a homely setting.
- We will have a healthcare system where we have integrated health and social care, a focus on prevention, anticipation and supported self-management.
- When hospital treatment is required, and cannot be provided in a community setting, day case treatment will be the norm.
- Whatever the setting, care will be provided to the highest standards of quality and safety, with the person at the centre of all decisions.
- There will be a focus on ensuring that people get back to their home or community environment as soon as appropriate, with minimal risk of re-admission.

Everyone Matters: 2020 Workforce Vision

The Everyone Matters: 2020 Workforce Vision\textsuperscript{124} recognises the vital role of the workforce in NHSScotland, and commits to delivering a high quality healthcare service which is among the best in the world.

- We will respond to the needs of the people we care for, adapt to new, improved ways of working, and work seamlessly with colleagues and partner organisations. We will continue to modernise the way we work and embrace technology. We will do this in a way that lives up to our core values.
- Together, we will create a great place to work and deliver a high quality healthcare service which is among the best in the world.

Next Steps for Acute Adult Safety – Patient Safety Essentials and Safety Priorities

In supporting the Acute Adult Safety Programme of the SPSP, Chief Executive Letter 19 (2013)\textsuperscript{125} outlines ten ‘patient safety essentials’ that are to be implemented throughout NHSScotland. They are coupled with nine point of care of priorities and two organisational priorities (infrastructure for safety and strategic prioritisation of safety).


Appendix B – Distributed Questionnaire

NES Patient Safety Educational Resources - Stakeholder Prioritisation Consultation

The NHS Education for Scotland (NES) Patient Safety Multidisciplinary Group coordinates NES support of the Scottish Patient Safety Programme, and other national initiatives to make care safer, contributing to the international effort to reduce harm.

Our activities range from commissioning research, to designing and delivering training to support capacity building at local level, and educational tools and resources for patient safety.

We would be grateful if you could answer the following questions to help us to plan our activities to meet your needs, align with local service workforce development and educational initiatives supporting patient safety, and to share also some of your own developments to make care safer with colleagues elsewhere across Scotland.

All information will be collected and stored anonymously.

Section 1: About You

1) Which Scottish health board or health organisation do you work for?
   Select answer:  
   Other, please specify: 

2) Please indicate your main healthcare setting.
   Select answer:  
   Other, please specify: 

3) Please indicate your main professional group.
   Select answer:  
   Other Healthcare Professional, please specify: 

4) Please indicate which “stage” in your career you are at.
   Select answer:  

5) Do you have a key role in education or training, developing capacity and capability in colleagues?
   ○ Yes
   ○ No

6) Do you have a key role in championing patient safety in your team or healthcare setting?
   ○ Yes
   ○ No

Next >>
NES Patient Safety Educational Resources - Stakeholder Prioritisation Consultation

This box is shown in preview only.
The following criteria must be fulfilled for this question to be shown:
  • (  
  • If 'Do you have a key role in championing patient safety in your team or healthcare setting?' equals 'Yes'  
  • )

2. Patient Safety Roles
7) Which of these roles apply to you?
- SPSP programme manager, other SPSP lead
- Safety or Quality Fellow
- Mentor, trainer, supervisor, coach for clinical training group
- CPD lead
- Profession lead
- Organisational development or other management lead
- Clinical governance role
- Infection control role
- Improvement Advisor or other QA Lead
- Other, please name: 

This box is shown in preview only.
The following criteria must be fulfilled for this question to be shown:
  • (  
  • If 'Do you have a key role in championing patient safety in your team or healthcare setting?' equals 'Yes'  
  • )

8) Do you use patient safety stories to engage staff in patient safety? These stories can be from a patient or staff perspective.
- Yes
- No

<< Back    Next >>

16 % completed
NES Patient Safety Educational Resources - Stakeholder Prioritisation Consultation

This box is shown in preview only.
The following criteria must be fulfilled for this question to be shown:

• If 'Do you use patient safety stories to engage staff in patient safety? These stories can be from a patient or staff perspective.' equals 'Yes'

9) How do you use patient safety stories to engage staff in patient safety? Please give examples.

---

This box is shown in preview only.
The following criteria must be fulfilled for this question to be shown:

• If 'Do you use patient safety stories to engage staff in patient safety? These stories can be from a patient or staff perspective.' equals 'No'

10) Why do you not use patient safety stories to engage staff in patient safety?
NES Patient Safety Educational Resources - Stakeholder Prioritisation Consultation

This box is shown in preview only.
The following criteria must be fulfilled for this question to be shown:

- (If 'Do you have a key role in championing patient safety in your team or healthcare setting?' equals 'Yes')

11) If you were to use patient safety stories, which format(s) would you prefer for these stories?

- [ ] Podcast/Video
- [ ] Voice recording/audio file
- [ ] Text
- [ ] Simulation
- [ ] Other, please specify: ___________________________

This box is shown in preview only.
The following criteria must be fulfilled for this question to be shown:

- (If 'Do you have a key role in championing patient safety in your team or healthcare setting?' equals 'Yes')

12) Do you have local, accessible patient safety stories (including links to elsewhere) that you would be willing to share with NES Knowledge Services, to enhance access to these stories for others to learn about patient safety?

- [ ] Yes
- [ ] No

<< Back  Next >>

36 % completed
NES Patient Safety Educational Resources - Stakeholder Prioritisation Consultation

This box is shown in preview only.
The following criteria must be fulfilled for this question to be shown:

- (  
  - If you have local accessible patient safety stories (including links to elsewhere) that you would be willing to share with NES Knowledge Services, to enhance access to these stories for others to learn about patient safety? equals "Yes"
- )

13) Please provide information on how NES Knowledge Services could access these local/linked patient safety stories.
NES Patient Safety Educational Resources - Stakeholder Prioritisation Consultation

Section 3: NES Approaches to Reducing Harm

14) Please rate the relevance of the following learning resources for your team / your healthcare setting / area of work, in the context of other training available and workforce development to date.

<table>
<thead>
<tr>
<th>Resource</th>
<th>Don’t know/have not accessed</th>
<th>Not relevant</th>
<th>Relevant</th>
<th>Highly relevant</th>
</tr>
</thead>
<tbody>
<tr>
<td>NES website, Patient Safety and Clinical Skills section</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>NES ‘Introduction to Patient Safety’ e-learning modules</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>NES review of other online patient safety e-learning</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>NES Patient Safety face-to-face courses for staff</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>NES patient safety workforce development research on NES website</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Improving safety in primary care example resources on NES website</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>NES Evidence into Practice website, Patient Safety Section</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>NES Community websites or Shared Spaces</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>NES training to apply knowledge and evidence in frontline practice, Knowledge Into Action Strategy</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
</tbody>
</table>

Patient Safety Education Scenarios

15) Please indicate if you were already aware of the NES ‘Patient Safety Education Scenarios’.

- Yes
- No
NES Patient Safety Educational Resources - Stakeholder Prioritisation Consultation

16) Please indicate which Patient Safety Education Scenarios you have used.
- Patient Safety Short Courses
- Domestic Services Learning Resource Workbook
- Good Health Records Management
- Prevention and Management of Pressure Ulcers: An Online Educational Workbook
- Improving Significant Event Analysis using feedback from trained peer groups
- Stroke Training and Awareness Resources (STARS)
- Age as an Asset
- Clinical Assessment Skills for Pharmacists
- Paediatric Retrieval Training using the Mobile Clinical Skills Unit
- Other, Please specify

17) Please give an example of how you have made use of Patient Safety Education Scenarios.
This box is shown in preview only.
The following criteria must be fulfilled for this question to be shown:

- ( ) If Please indicate if you were already aware of the NES ‘Patient Safety Education Scenarios’, equate Yes

18) Please rate the usefulness of patient safety education scenarios for your team / your healthcare setting / area of work

<table>
<thead>
<tr>
<th>Don’t know/have not accessed this resource</th>
<th>Not useful</th>
<th>Useful</th>
<th>Highly useful</th>
</tr>
</thead>
<tbody>
<tr>
<td>To engage colleagues in patient safety in their role (including at Induction)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>As a stand alone learning resource for patient safety</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>To highlight the value of a given learning resource to patient safety</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>As a tool to enhance access to an educational resource contributing to safer care</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

Section 4: Patient Safety Topics for NES Development of Learning Resources

WHO Priority Topics

19) Please rate the current relevance of the following topic areas based on the WHO Patient Safety Curricula for your team / healthcare setting / area of work, in the context of other training available and workforce development to date.

<table>
<thead>
<tr>
<th>Not relevant</th>
<th>Relevant</th>
<th>Highly relevant</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is Patient Safety?</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Why applying human factors is important for patient safety</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Understanding systems and the effect of complexity on patient care</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Being an effective team player</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Learning from errors to reduce harm</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Understanding and managing clinical risk</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Using quality-improvement methods to improve care</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Engaging with patients and carers</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Infection prevention and control</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Patient safety and invasive procedures</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Improving medication safety</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>
### Other suggested topics for NES development of patient safety learning resources (from other needs assessment work and feedback)

20) Please rate the current relevance of the following topic areas for your team / your healthcare setting / area of work, in the context of other training available and workforce development to date.

<table>
<thead>
<tr>
<th>Topic</th>
<th>Not relevant</th>
<th>Relevant</th>
<th>Highly relevant</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient safety, facts, and figures, covering all healthcare settings</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Leadership for safety, what does it mean for me?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Human Factors in daily work in NHS</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Structured handovers for safer care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Critical communication when a patient is deteriorating</td>
<td></td>
<td></td>
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<tr>
<td>The management of high risk medicines such as warfarin and insulin</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Minimising medication errors, a whole system approach</td>
<td></td>
<td></td>
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<tr>
<td>The management of sepsis</td>
<td></td>
<td></td>
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<tr>
<td>The management of pressure ulcers</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>The management of catheter associated urinary tract infections</td>
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<td></td>
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<tr>
<td>VTE management for safer care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The management of falls</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Finding out what educational resources are available, what can be used</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Explore what is currently going on with patient safety education for staff and students and sharing the different ways this is being delivered</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Persuasion and influencing skills</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Managing challenging interactions</td>
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</tbody>
</table>

21) Learning about the use of which of the these patient safety tools from a practical perspective would you rate as relevant for your team / healthcare setting / area of work, in the context of other training available and workforce development to date?

<table>
<thead>
<tr>
<th>Tool</th>
<th>Not relevant</th>
<th>Relevant</th>
<th>Highly relevant</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plan-Do-Study-Act (PDSA)</td>
<td></td>
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<tr>
<td>Reflective learning</td>
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<tr>
<td>Early warning scores</td>
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<tr>
<td>Driver diagrams</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Significant Event Analysis (SEA)</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Trigger tools</td>
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<td></td>
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<tr>
<td>Assessment of safety climate or culture</td>
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<td></td>
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<tr>
<td>Other</td>
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<td></td>
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</tbody>
</table>

22) If Other, please specify.

[Input field for Other comments]

[Progress bar: 73% completed]
**NES Patient Safety Educational Resources - Stakeholder Prioritisation Consultation**

**Section 5: Learning Approach Preference**

23) For your own learning, which of these learning approaches are the three most effective ones for you?

<table>
<thead>
<tr>
<th>Priority</th>
<th>Learning Approach</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st</td>
<td></td>
</tr>
<tr>
<td>2nd</td>
<td></td>
</tr>
<tr>
<td>3rd</td>
<td></td>
</tr>
</tbody>
</table>

24) If Other, please specify and indicate your priority ranking.

---

82% completed
NES Patient Safety Educational Resources - Stakeholder Prioritisation Consultation

Section 6: Challenges and Barriers to Learning to Reduce Harm

25) Please describe your biggest challenge to developing knowledge and skills to reduce harm.

---

26) Please describe your biggest challenge to applying your knowledge and skills to reduce harm.

---

27) What is your biggest barrier to learning about patient safety?

---

28) Please make any other comments you have to help us plan the development of knowledge and skills to reduce harm.

---
NES Patient Safety Educational Resources - Stakeholder Prioritisation Consultation

If you agree to be contacted by us to follow up any offers from you about sharing patient safety learning resources highlighted by you, please provide your e-mail address below.

Data Protection: NES uses the personal data you provide for purposes associated with our responsibilities for health workforce development, including the administration of courses, monitoring and evaluating training programmes and circulating information relating to relevant development opportunities.

For more information see http://www.nes.scot.nhs.uk/privacy-and-data-protection. Personal data will be retained in line with our records retention policies.

Thank you again for your feedback.

29) Please provide your email address below:

[Input field]

[Buttons: Back, Send]

100% completed
### Appendix C – Questionnaire Map

For ease of reference, this table maps the questionnaire to the main sections of this report.

<table>
<thead>
<tr>
<th>Question Number</th>
<th>Report Section</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Respondents’ Backgrounds</td>
</tr>
<tr>
<td></td>
<td>Patient Safety Stories</td>
</tr>
<tr>
<td></td>
<td>NES Approaches to Reducing Harm</td>
</tr>
<tr>
<td></td>
<td>Exploring Patient Safety Topics</td>
</tr>
<tr>
<td></td>
<td>Preferred Learning Approaches</td>
</tr>
<tr>
<td></td>
<td>Challenges and Barriers</td>
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<tr>
<td></td>
<td>Contact Agreement</td>
</tr>
<tr>
<td>1</td>
<td>✓</td>
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<td>2</td>
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<td>✓</td>
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<td>5</td>
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<td>6</td>
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<td>28</td>
<td>✓</td>
</tr>
<tr>
<td>29</td>
<td>✓</td>
</tr>
</tbody>
</table>

**Table 13:** Questionnaire map.
Appendix D – Qualitative Response Summaries: ‘other’ responses

Question 2: Please indicate your main healthcare setting.

<table>
<thead>
<tr>
<th>Theme (frequency)</th>
<th>Representative Quotes</th>
</tr>
</thead>
</table>
| Specialist Health Services (43)                        | • Both acute and primary care, I am a consultant microbiologist with infection prevention and control responsibilities for the community.  
• Service across Adult acute, community hospital and community.  
• In and outpatient diagnostics. |
| Office/non-clinical (9)                                | • Staff development.  
• Corporate.  
• Education. |
| Hospice/care home/palliative care (7)                  | • Hospice day therapy unit.                                                          |
| Health Board (Special or Territorial) (6)              | • Across all of NHS Lothian.                                                          
• Whole board area.                                      |
| Miscellaneous (6)                                      | • CHP wide.  
• Telemedicine.  
• Health charity.  
• Improvement support.                                   |
| Patient Transport Service and Ambulance Service (2)    | • Patient transport service.                                                          
• Ambulance.                                             |

Table 14: Summary of respondents’ other responses for main healthcare setting (63/66 respondents specified other roles), (Q2: Please indicate your main healthcare setting). Note: frequency demonstrates instances of occurrence (i.e. more than one role may have been disclosed).
**Question 3: Please indicate your professional group.**

<table>
<thead>
<tr>
<th>Theme (frequency)</th>
<th>Representative Quotes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specific specialties (28)</td>
<td>• Emergency Medicine Consultant.</td>
</tr>
<tr>
<td></td>
<td>• Consultant Psychiatrist.</td>
</tr>
<tr>
<td></td>
<td>• Consultant surgeon.</td>
</tr>
<tr>
<td></td>
<td>• Consultant physician.</td>
</tr>
<tr>
<td></td>
<td>• Consultant Obstetrician.</td>
</tr>
<tr>
<td></td>
<td>• Anaesthesia.</td>
</tr>
<tr>
<td></td>
<td>• Diabetologist.</td>
</tr>
<tr>
<td></td>
<td>• Geriatric medicine.</td>
</tr>
<tr>
<td></td>
<td>• Anaesthetics/ICU.</td>
</tr>
<tr>
<td></td>
<td>• Gastroenterology.</td>
</tr>
<tr>
<td>Non-clinical (5)</td>
<td>• Research/knowledge management.</td>
</tr>
<tr>
<td></td>
<td>• Facilities management.</td>
</tr>
<tr>
<td></td>
<td>• Finance.</td>
</tr>
<tr>
<td>Ambulance/patient transport (3)</td>
<td>• Ambulance technician.</td>
</tr>
<tr>
<td></td>
<td>• Ambulance care assistant.</td>
</tr>
<tr>
<td>NMAHP (2)</td>
<td>• Nurse.</td>
</tr>
<tr>
<td>Dental advisor/dental (2)</td>
<td>• Senior Dental Advisor.</td>
</tr>
<tr>
<td>Care assistant (1)</td>
<td>• Care Assistant.</td>
</tr>
<tr>
<td>CHP (1)</td>
<td>• Community Health Partnership.</td>
</tr>
<tr>
<td>Educational Supervisor (1)</td>
<td>• Education Supervisor.</td>
</tr>
<tr>
<td>Healthcare science (1)</td>
<td>• Healthcare Science Associate.</td>
</tr>
<tr>
<td>Optometry (1)</td>
<td>• Optometry.</td>
</tr>
<tr>
<td>Palliative care (1)</td>
<td>• Palliative Care.</td>
</tr>
<tr>
<td>Public health (1)</td>
<td>• Public Health.</td>
</tr>
</tbody>
</table>

**Table 15:** Summary of respondents' other responses for main professional grouping (N=45), (Q3: Please indicate your professional group). Note: frequency demonstrates instances of occurrence.
Question 7: Which of these roles apply to you?

<table>
<thead>
<tr>
<th>Theme (frequency)</th>
<th>Representative Quotes</th>
</tr>
</thead>
</table>
| Nurse consultant/nurse (15) | • District nurse.  
  • Senior charge nurse.  
  • Lead nurse, with extensive clinical and educational input.  
  • Consultant midwife. |
| Patient safety coordinator lead/M&M Lead/Other clinical lead (11) | • Cancer therapeutics lead.  
  • Clinical lead for 2 specialties.  
  • Acute pain lead, Equipment Lead.  
  • Practice lead quality/safety. |
| Educational Supervisor/clinical supervisor (5) | • Clinical Educator.  
  • Educational/clinical supervisor.  
  • GP trainer. |
| Training/learning and development (5) | • Ongoing teaching in Human Factors/risk Mx/risk communication.  
  • Learning and Development. |
| Programme Manager/Service management/staff management (5) | • Programme manager for medicines strategy.  
  • Staff management. |
| CEO/Board Member/Director (4) | • Clinical Director.  
  • Board member – participate in patient safety rounds. |
| Consultant (3) | • Consultant and clinical lead.  
  • Generally promote this to team and students as a senior consultant/teaching surgeon. |
| Quality (3) | • ISIA [Improvement Science in Action].  
  • Quality Management Representative. |
| Risk management (3) | • Helping lead a speciality Risk Forum.  
  • Run gynae risk management. |
| Manual handling/administration (2) | • Manual Handling. |
| National clinical lead (2) | • HIS National Clinical Lead. |
| Audit (1) | • Clinical audit lead. |
| Clinical Lecturer (1) | • Senior Clinical Lecturer [identifier removed] University Dental School. |
| Infection/cleanliness champion (1) | • Cleanliness champion. |
| Pharmacy (1) | • Area Antimicrobial Pharmacist. |

Table 16: Summary of respondents’ other patient safety roles (N=59), (Q7: Which of these roles apply to you?). Note: frequency demonstrates instances of occurrence.
### Appendix D

**Question 22: If other, please specify**

<table>
<thead>
<tr>
<th>Theme (frequency)</th>
<th>Representative Quotes</th>
</tr>
</thead>
</table>
| • Other tools/resources/methods (12) | • How to design and use surveys & then collate, analyse and feedback.  
  • Lean/Six Sigma or other advanced improvement tools  
  • Process mapping.  
  • Tools and methods for measurement and testing. |
| • Communication/discussion/surveys/feedback/reflection/inclusion of staff (9) | • Communication of timely and relevant safety alerts to frontline staff.  
  • Facilitation skills.  
  • Patient safety as a whole-team issue – the inclusion of non-clinical staff in PS issues.  
  • Safety brief. |
| • Not sure what tools are/not understanding/not relevant (6) | • How can I answer this question when I don’t know what they all are?  
  • I don’t know what a driver diagram is.  
  • It is not that these are not relevant – just less relevant in general practice. |
| • Miscellaneous (5) | • Patient safety as it relates to Value for Money.  
  • Why no mental health specific areas? |
| • Implementation/change/appropriate use and application (3) | • I think the community my team serves is quite familiar with these tools – whether they are used properly of course, is another matter.  
  • Seeing changes in care actually implemented is essential following any review. |
| • Personal attributes (2) | • Recognition of staff as individuals. |

**Table 17:** ‘Other’ examples for learning about practical patient safety tools (N=33), (Q22: If other, please specify).  
Note: frequency demonstrates instances of occurrence.

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126 This question refers to the preceding one; Q21: Learning about the use of which of these patient safety tools from a practical perspective would you rate as relevant for your team/healthcare setting/area of work, in the context of other training available and workforce development to date?
Question 24: If other, please specify and indicate your priority ranking.

<table>
<thead>
<tr>
<th>Theme (frequency)</th>
<th>Representative Quotes</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Learning programmes taken/additional learning opportunities/targeted CPD (4)</td>
<td>• I really, really, really want some specific higher training such as SPSP Fellowship, Improvement Adviser, or similar with direct support and feedback from highly skilled professionals with Improvement Methodology or Process Engineering/Human factors skills. It appears increasingly impossible to obtain this training.</td>
</tr>
<tr>
<td></td>
<td>• Targeted CPD.</td>
</tr>
<tr>
<td></td>
<td>• Use of local “improvement” clinics.</td>
</tr>
<tr>
<td>• Discussion/group discussion (3)</td>
<td>• PBSGL style groups have been highly effective for practice change.</td>
</tr>
<tr>
<td></td>
<td>• Sharing experiences with staff and community team regularly through monthly meetings. Priority 1.</td>
</tr>
<tr>
<td>• Written materials/publications/sound bites (3)</td>
<td>• Concise publication as printed document.</td>
</tr>
<tr>
<td></td>
<td>• Ready access to “sound bites” of learning.</td>
</tr>
<tr>
<td>• Environment (1)</td>
<td>• Entirely dependent on the context and what is to be learnt.</td>
</tr>
<tr>
<td>• Miscellaneous (2)</td>
<td>• Understanding that patient safety should be a culture not a module.</td>
</tr>
<tr>
<td>• Time for study (1)</td>
<td>• Having time for study.</td>
</tr>
</tbody>
</table>

Table 18: ’Other’ priority learning approaches identified (N=14), (Q24: If other, please specify and indicate your priority ranking). Note: frequency demonstrates instances of occurrence.

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127 This question refers to the preceding one; Q23: For your own learning, which of these learning approaches are the three most effective ones for you?
Question 28: Please make any other comments you have to help us plan the development of knowledge and skills to reduce harm.

<table>
<thead>
<tr>
<th>Theme</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time</td>
<td>29</td>
</tr>
<tr>
<td>Education and training</td>
<td>24</td>
</tr>
<tr>
<td>Integral to day to day activities</td>
<td>24</td>
</tr>
<tr>
<td>Miscellaneous</td>
<td>19</td>
</tr>
<tr>
<td>IT/eLearning Issues</td>
<td>17</td>
</tr>
<tr>
<td>Job pressures/workload</td>
<td>13</td>
</tr>
<tr>
<td>Communication and discussion</td>
<td>11</td>
</tr>
<tr>
<td>Knowledge and awareness of issues and resources</td>
<td>10</td>
</tr>
<tr>
<td>Access and ease of access to resources</td>
<td>9</td>
</tr>
<tr>
<td>Staff resources and issues</td>
<td>8</td>
</tr>
<tr>
<td>Teamwork</td>
<td>8</td>
</tr>
<tr>
<td>None/NA</td>
<td>8</td>
</tr>
<tr>
<td>Organisational cultures and behaviours</td>
<td>7</td>
</tr>
<tr>
<td>Multiple initiatives</td>
<td>6</td>
</tr>
<tr>
<td>Management support</td>
<td>5</td>
</tr>
<tr>
<td>Relevance of materials</td>
<td>5</td>
</tr>
<tr>
<td>Feedback utility of current tools</td>
<td>5</td>
</tr>
<tr>
<td>Staff engagement, commitment and influence</td>
<td>5</td>
</tr>
<tr>
<td>Positive comments</td>
<td>5</td>
</tr>
<tr>
<td>Financial issues</td>
<td>3</td>
</tr>
<tr>
<td>Spreading and cascading learning</td>
<td>3</td>
</tr>
<tr>
<td>Clinical priority/scope of task</td>
<td>3</td>
</tr>
<tr>
<td>Evidence base</td>
<td>2</td>
</tr>
<tr>
<td>Job issues</td>
<td>2</td>
</tr>
<tr>
<td>Coaching/Mentoring</td>
<td>2</td>
</tr>
<tr>
<td>Implementation/consistency of implementation</td>
<td>2</td>
</tr>
<tr>
<td>Story telling</td>
<td>2</td>
</tr>
<tr>
<td>Location of education and training</td>
<td>1</td>
</tr>
<tr>
<td>Acknowledgement of harm/high risk areas</td>
<td>1</td>
</tr>
<tr>
<td>Personal responsibilities</td>
<td>1</td>
</tr>
<tr>
<td>Additional research work</td>
<td>1</td>
</tr>
</tbody>
</table>

Table 19: Theme summary of respondents’ additional comments relating to the development of knowledge and skills to reduce harm (N=188), (Q28: Please make any other comments you have to help us plan the development of knowledge and skills to reduce harm). Note: frequency demonstrates instances of occurrence.
Patient Safety Education: What matters to you?  
*Report of the NES Patient Safety Educational Resources Stakeholder Consultation*

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