Introducing our e-Learning Module “Introduction to Patient Safety”

This e-learning resource was commissioned by the NES Patient Safety Multidisciplinary Group as one way to raise awareness of the fundamentals of patient safety and human factors amongst clinical training groups and it fits with existing training group curricula. However, undertaking the e-learning is also of value to all other NHSScotland staff and independent contractors.

The NES module was launched in August 2011. It has been published on learnPro NHS (for all NHS staff) and is accessible to students and non-NHS healthcare staff via learnPro Community. Independent contractors can access the module via the NES Portal.

Since then, over 4,000 users have enrolled on the module, and over 1,000 learners have already successfully passed the final assessment of the module.
Patient Safety e-Learning: Raising Awareness

**e-Learning Aims and Overview**

The module aims to introduce healthcare workers to a number of key patient safety concepts, suggests a number of practical ways in which anyone can contribute to patient safety, and provides practical examples of patient safety incidents.

Our target audience is NES postgraduate training grades and educational supervisors/tutors, but the module is relevant for other professional and staff groups.

Our e-learning was developed following a review of existing patient safety e-learning and other online learning resources, and it was piloted by learners and educational supervisors. Our e-learning continues to be developed with the ongoing capture of user feedback.

**Patient Safety e-Learning Module: Content and Structure**

The module’s content is in four sections; it takes about two hours to complete and includes an assessment and a glossary. A wide selection of “real-life” patient safety incidents from different professional settings is described and analysed so that learners can understand more about how and why these incidents occur and patients come to be unintentionally harmed.

- **Section 1: Patient safety fundamentals**
  This section describes the extent and cost of the patient safety problem. Important terms like ‘error’, ‘harm’ and ‘patient safety incident’ are defined. We also explain why a ‘systems approach’ and ‘just culture’ are important.

- **Section 2: Managing human error**
  All of us are vulnerable to err because of our human limitations. We describe how ‘adaptive mechanisms’ and additional factors can influence our behaviour in a positive or negative way, before considering two approaches to manage error. And we describe how the ‘three buckets’ model can be used to assess your error risk.

- **Section 3: How do we improve patient safety?**
  We answer this question by summarising the recent and on-going national patient safety improvement initiatives in the UK, and by suggesting a number of practical ways in which every healthcare worker can contribute to patient safety.

- **Section 4: Examples of patient safety incidents**
  We outline a large selection of ‘real life’ patient safety incidents which occurred across a range of health care settings in NHSScotland. We also highlight a small number and discuss the key learning points which arise. The incidents are grouped according to setting, specialty, profession and patient safety topic for convenience. This section does not form part of the assessment.

**Assessment**

There is a pre- and post-module assessment. Learners can review material after completion of the assessment.
Learner Feedback about our e-Learning

A link to a feedback questionnaire is included and feedback from just under 100 users has been analysed and shows:

- 91% of the respondents said that they would recommend the e-learning to a colleague.
- 84% of the respondents rated the quality of the content either ‘Excellent’ or ‘Good’ and the difficulty level of the material ‘About right’.
- Over 90% of the users said that the e-learning would have a positive impact on their day-to-day work.

When asked if they would be interested in additional training in this area (42% answered “Yes”) the most frequent request was for more practical examples and tools to use in a work setting, and not just e-learning modules.

Patient Safety e-Learning: Impact on Safer Patient Care

The following quotes from learners are about their perceptions on their practice of having accessed the Patient Safety e-Learning:

"I will certainly try and use some of the models discussed such as SBAR during routine day to day work. I am much more self-aware of the way errors might occur and I am hoping to contribute to the overall departmental management of patient safety by thinking of ways the department can improve in this area."

"Has raised awareness about errors and why they occur. Improved Knowledge base. Greater understanding of cause analysis. Exposed myths and identified knowledge skills gaps. Made me reflect on own practice and identify areas which require change."

"I will certainly be more aware of patient safety. I will attempt to use the models described in clinical practice. I will definitely consider different aspects in place in my day to day work to promote patient safety. I will endeavour to undertake regular Significant Event Analysis and encourage a just atmosphere."

"The increasing workload and pressures in this current climate have always raised questions regarding patient care. This course raises awareness that while it’s common for workers to take ‘short cuts’ or ‘help out’, it might not be the best solution and in fact would be counterproductive to the very people we aim to help. I am more confident in asking for appropriate allocation of time to complete tasks allowing for all procedures and protocols to be followed stringently."

"Spend more time analysing incidents and sharing experience with the wider team rather than those just involved with the incident."

"Error, harm and the Swiss cheese model!

In this model, the slices of cheese represent the various system defences between events and silent events and the holes represent holes and latent patient errors. The slices of cheese are not just one but can be seen to be a diagonal line with at least two two adjacent holes leading towards next patients."

"91% of the respondents said that they would recommend the e-learning to a colleague.

84% of the respondents rated the quality of the content either ‘Excellent’ or ‘Good’ and the difficulty level of the material ‘About right’.

Over 90% of the users said that the e-learning would have a positive impact on their day-to-day work.

When asked if they would be interested in additional training in this area (42% answered “Yes”) the most frequent request was for more practical examples and tools to use in a work setting, and not just e-learning modules.

Patient Safety e-Learning: Impact on Safer Patient Care

The following quotes from learners are about their perceptions on their practice of having accessed the Patient Safety e-Learning:

"I will certainly try and use some of the models discussed such as SBAR during routine day to day work. I am much more self-aware of the way errors might occur and I am hoping to contribute to the overall departmental management of patient safety by thinking of ways the department can improve in this area."

"Has raised awareness about errors and why they occur. Improved Knowledge base. Greater understanding of cause analysis. Exposed myths and identified knowledge skills gaps. Made me reflect on own practice and identify areas which require change."

"I will certainly be more aware of patient safety. I will attempt to use the models described in clinical practice. I will definitely consider different aspects in place in my day to day work to promote patient safety. I will endeavour to undertake regular Significant Event Analysis and encourage a just atmosphere."

"The increasing workload and pressures in this current climate have always raised questions regarding patient care. This course raises awareness that while it’s common for workers to take ‘short cuts’ or ‘help out’, it might not be the best solution and in fact would be counterproductive to the very people we aim to help. I am more confident in asking for appropriate allocation of time to complete tasks allowing for all procedures and protocols to be followed stringently."

"Spend more time analysing incidents and sharing experience with the wider team rather than those just involved with the incident."
Other Comments about our e-Learning:

“I would like more information regarding means to change culture to accept patient safety.

“My role is in education and training, so ensuring that trainees access and complete the modules will be on my agenda.

“Interesting to look at all the initiatives that are going on; despite being involved in patient care I was unaware of many of the initiatives with respect to patient safety.

“Very thought provoking.

“It makes me more aware of what potential harm I can bring to my patient in the daily tasks that I deemed ‘ROUTINE’.

“A good starter programme for any NHS employee - gives a brief overview of patient safety.

We have enhanced the human factors section of the e-learning and modified our feedback questionnaire, and we continue to capture other intelligence about patient safety learning needs.

Useful links
For a summary of other patient safety e-learning, a report of our pilot work to develop this e-learning and for links to other patient safety learning resources: http://www.nes.scot.nhs.uk/education-and-training/by-theme-initiative/patient-safety-and-clinical-skills.aspx

www.evidenceintopractice.scot.nhs.uk

For access to the e-learning module:
learnPro NHS: https://nhs.learnprouk.com
learnPro Community: https://community.learnprouk.com
NES Portal: https://www.portal.scot.nhs.uk

For further information contact:
Paul Bowie
paul.bowie@nes.scot.nhs.uk

Sabine Nolte
sabine.nolte@nes.scot.nhs.uk

Mark Johnston
mark.johnston@nes.scot.nhs.uk

Fiona Gailey
fiona.gailey@nes.scot.nhs.uk

Published by NES Patient Safety Multi-disciplinary Group, February 2013