## What Matters to You?

# Using Patient Safety Stories to Enhance Patient Safety and Patient Experiences



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### **About Patient Safety Stories**

Patient safety stories offer "a human side to patient safety work" in which the patient voice and staff experiences are central to understanding quality and levels of care. Stories offer practitioners the opportunity to reflect on experiences, build on exemplary practices and to improve the understanding of human factors in reducing harm and error. Using the power of emotive narrative, staff can disseminate patient safety experiences amongst peers, NHS Board leaders, and teams.

#### NES Patient Safety Multidisciplinary Group: 2013 Stakeholder Consultation

The consultation highlighted that patient safety champions (N=311) across several professions use patient safety stories in areas that include the sharing of learning, personal development planning, significant event analyses, and at clinical handover. Praise, positive outcomes, and the opportunity to contribute to ideas and solutions for action improvement in quality care are also shared.

How do staff disseminate patient safety stories and patient experiences?

- Talks and formal presentations
- Mortality and morbidity meetings
- Safety briefs
- Bulletins and reports

Our stakeholders (N=303) prefer the following formats for engaging with patient safety stories:



Note: respondents could choose as many as applied.

A number of stakeholders highlighted why they didn't engage with patient safety stories:

- Being new to the area
- The requirement of training
- Service pressures and time limitations
- Confidentiality and ethical issues
- Evidence based medicine versus anecdotes

#### Summary

Patient safety stories are an excellent way of reflecting on experiences, and they can be presented at team meetings, daily safety briefs and at continuing professional development (CPD) sessions.

Our stakeholders highlighted that they use patient safety stories to promote dialogue, disseminate experiences, discuss practices and lessons learned, and to implement positive changes for improvement.

From a learning perspective, some stakeholders also highlighted the increased utility of patient safety stories in contributing to safer patient care.

**Additional Information** 

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