Patient Safety Update - June 2017

Patient Safety Zone (Turas)

NHS Education for Scotland’s Patient Safety educational resources have moved to the digital platform Turas, all our materials can be found within the ‘Patient Safety Zone’ patientsafety.nes.nhs.scot Please note the QI Hub is no longer available.

If you have any questions, please do not hesitate to contact catrina.gordon@nes.scot.nhs.uk.

Enhanced Significant Event Analysis (eSEA) Tools

The enhanced significant event analysis eLearning module is a new learning resource designed to help with understanding and application of this systems-based method of analysis. It is now more widely recognised that enhanced significant event analysis, if carried out effectively, can be an important patient safety and educational activity. This short eLearning module, which can be accessed here, allows you to choose and work through a real-life enacted SEA most relevant to your own working environment hopefully making it seem more relevant to you. The newer tools available to support the enhanced SEA method also include an App on which you can work through and record your own SEA, building the relevant information in bite sizes by saving and downloading the information as you collect it. The enhanced SEA App can be downloaded to your mobile device of choice from think link.

More information on eSEA can be accessed on patientsafety.nes.nhs.scot.
Healthcare Associated Infections

NHS Education for Scotland is leading the way in demonstrating a national approach to infection prevention and control with the introduction of the Scottish Infection Prevention and Control Education Pathway (SIPCEP). The Pathway was launched at the NHSScotland Conference on 20th June 2017 and is now ready for use. The aim of the pathway is to enable all staff to contribute to a healthcare culture in which patient safety related to infection prevention and control is of the highest importance. The pathway offers the flexibility to create your own development journey suited to your specific needs and role and adopts a modular structure with short learning bites and a range of standalone resources that can be used in local training.

The pathway is available on learnPro NHS and community websites and is identified as NES: Scottish IPC Education Pathway - Foundation. To find out more about the pathway and how it will benefit you, your colleagues, your organisation and ultimately the people you provide care to, visit the NES website at www.nes-hai.info.

Knowledge Services

Knowledge Network: Spotlight on DynaMed Plus

Patient safety relies on access to the most up to date and trustworthy guidance and evidence to support clinical decisions. Point of care resources such as DynaMed Plus include guidelines, protocols and evidence summaries which often provide the quickest and easiest way to find answers.

Find answers to patient safety questions on DynaMed Plus, for example:

What measures can routinely be taken to ensure the safety of patients undergoing surgery?
Search in DMP: safety surgery
Related topic/section: Surgical Safety Checklist >> Overview >> includes a summary as well as measures to ensure safety in patients undergoing surgery
Watch a short video to see how

How can I determine risk for and prevention of pressure ulcers in patients?

Search in DMP: Pressure ulcer
Related topic/section: Prevention & Screening >> Risk Assessment

Health and care staff in Scotland can use their OpenAthens username for free access to DynaMed Plus via The Knowledge Network: www.knowledge.scot.nhs.uk/pointofcare
For training, support or enquiries please contact the Help Desk: knowledge@nes.scot.nhs.uk

Quality Improvement
Quality Improvement Zone - REGISTER NOW!

The QI Zone on NHS Education for Scotland's new digital platform Turas is now LIVE. In the QI Zone, you will find:

- information on the improvement journey and related quality improvement tools and topics
- a range of educational resources, including eLearning modules, guides and frameworks
- information on the different levels of experience in quality improvement and associated learning programmes

One of the key benefits is that if you choose to register for the QI Zone you will be able to create and update your own personal learning record, keeping details about all your training and development in one place.

Visit QIZone.nes.nhs.scot and click 'Register' which will direct you to a simple online registration form to gain full access to the QI Zone.
Research, Development & Evaluation

Scoping Review of Human Factors and Ergonomics in Primary Care

Much of the early research and focus in human factors/ergonomics (HF/E) in healthcare has been in the acute sector. This is partly because the early high profile interest has been from people in acute areas learning lessons from other safety-critical industries who operate in team-based, functionally and critically time bound areas. In trying to learn from other industries we have tended to ignore the fact that the vast majority of interactions between patients and the healthcare system, take place in the primary care setting. It is our aspiration that the world of HF/E is allowed to influence care delivery in places where the need for resilience, efficiency and delivering safety, despite human vulnerabilities, in both care-givers and patients is perhaps even more important.

In order to do this, we needed to understand what is already known or being done around HF/E in primary care. This important piece of work was undertaken by Paul Bowie and his team at NHS Education for Scotland supported and led by the CHFG, and it is with my sincere thanks to all involved that we now have our starting point.

- The executive briefing summary found here Scoping Review Executive Briefing Summary
- The full report can be found here Scoping Review Full Report

If you would like further information on any of the above, please contact Paul Watson (paul.watson@nes.scot.nhs.uk)

Patient Safety Workshops

Patient safety has been brought to the fore by the publication of a multitude of reports since the 1990’s, reports such as “To err is human” and more recently the enquiry into the failings at Mid Staffordshire NHS Trust should have resulted in a step change in how unintended harm is viewed. Unfortunately, the misunderstanding of terms such as human error and violation have perpetuated in some, the notion that bad things happen because bad people are the cause, and if we can only mitigate and root out these bad individuals then our healthcare system will be improved and patient safety will improve.

To improve patient safety, it is necessary to go back to first principles and examine our own attitudes to unintended harm. What is the cause or causes of it? Can we ever eliminate it? How do we treat our colleagues when they are involved in unintended harm? How would
we want to be treated if our everyday work resulted in unintended harm?

We are delighted to announce that we will be running the following workshops again from September 2017 – June 2018 in various locations throughout Scotland:

1. Why things go wrong and right in complex systems
2. How to respond when things go wrong in complex systems
3. Human Factors Taster session

Workshops will be available to book via portal week commencing 3rd July 2017.

For further information, please visit patientsafety.nes.nhs.scot or contact Catrina Gordon.