"Learning Together from Patient Safety Incidents" Workshops

Whittington Health NHS

Background

Considerable time is spent on root cause analysis (RCA) investigations of patient safety incidents associated with harm. However, evidence shows that learning from actions for improvements determined by these investigations is not shared consistently and widely[1].

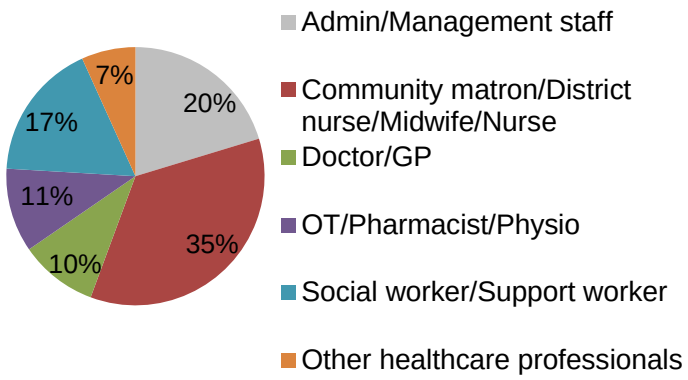
"Learning Together" workshops

We took individual patient stories from serious incident investigations and turned them into a series of eight inter-professional education afternoons. The workshops were divided into the:

- patient story
- working groups focusing on what went well, less well and lessons learnt
- interactive talk on patient safety and how to generate action plans

At the end of each workshop, attendees had a chance to make a personal patient safety pledge.

Attendees



Key words from personal pledges

Feedback & key learning points

Feedback collected immediately after each workshop suggested that attendees valued the opportunity to learn with and from each other. They reported increased confidence to discuss patient safety issues with their immediate colleagues and other teams.

A post-workshop survey was sent to all attendees three months after the events to demonstrate ongoing learning. Feedback collected so far suggests that most attendees:

- fulfilled their personal patient safety pledge and have taken more active role in promoting patient safety
- have been able to successfully apply some of the skills and knowledge gained at the workshops to change their way of working

References

1. A promise to learn – a commitment to act. National advisory group on the safety of patients in England. https:www.gov.uk/berwickreport

Authors: Dr Julie Andrews, Miss Jana Kristienova, Whittington Health NHS Trust

COMMUNITY EDUCATION PROVIDER NETWORK ISLINGTON

cepn community education provider network haringey