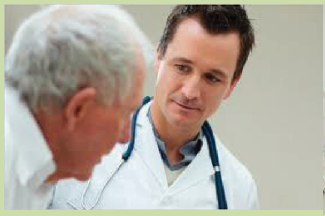
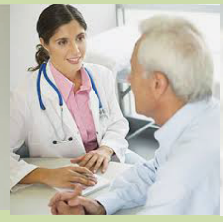


YQSR
Yorkshire Quality and Safety Research Group

An evidence-based Patient Measure of Safety (PMOS)

The Patient Measure of Safety (PMOS) taps patient perceptions about those aspects of care that are known to contribute to problems with safety. Developed by the Yorkshire Quality and Safety Research group as part of an NIHR programme grant, with support from AvMA, the PMOS asks patients to answer questions about communication and teamwork, organisation and care planning, equipment and physical environment, to name a few. This measure has been developed from a thorough review of the factors contributing to patient safety incidents in hospitals and extensive interviews with patients.

It has proved to be a reliable and valid tool, showing strong correlations with staff perceptions of safety and safety outcomes on wards. The PMOS has now been completed by more than two thousand patients in the Yorkshire and Humber including children and the elderly, male and female, short stay and long stay patients and those from different ethnic groups. Over 85% of patients we approached were happy to provide feedback in this way.

When captured at a ward level the feedback of results of the PMOS can be used by wards/units to proactively manage risks to patient safety. In our most recent work we have found that healthcare staff find this feedback useful and are able to develop improvement plans based on the information they receive. PMOS can also be used to identify strengths and share learning about good practice. See the example of feedback to staff below.

Feedback report 1

We are currently investigating whether volunteers can collect this information on behalf of wards with the aim of enhancing the uptake of this tool across the NHS. We are also exploring whether we can enhance the learning of nurses and doctors about the patient perspective on patient safety by encouraging them to collect this feedback during their undergraduate training. For further information about any of these projects please contact XXXX at XXXX.

Patients as teachers: patient safety training from victims of error

Educational interventions on patient safety training for NHS staff concentrates on 'health-professional lens' rather than a 'patient lens' with limited emphasis on the impact of safety lapses on the patient and their families, and little or no involvement of patients in the design or delivery of the training. Patient narratives are now widely employed as part of medical training; these allow patients to share their own health-related stories and experiences with professionals to facilitate clinical knowledge and skills. Patient safety is a particularly appropriate area for narrative-based teaching as it allows patients to share their own real lived experiences of lapses in safety resulting in harm to themselves and/or their relatives. These real stories, when brought to the classroom, allow the exploration of factors that may have caused the error, increase awareness of the personal impact of such errors on the patient and their families and facilitate a wider discussion of safety issues around and beyond the patient-specific error. We undertook a randomised controlled trial of the use of patient narratives in patient safety training by developing an intervention based on patients as teachers training junior doctors about patient safety. We found it was feasible, acceptable and had a significant impact on the emotional engagement of staff, with improved understanding of: risk management and governance; learning about error; communication; processes related to patient safety and the role of education. For further information contact XXXX at XXXX.

A patient designed incident reporting tool (PIRT)

Staff incident reporting in the National Health Service (NHS) harbours numerous weaknesses especially in relation to organisational learning. It is clear from earlier work that patients have the potential to comment on their care but so far, NHS patients have not been given the opportunity to directly and systematically report any immediate safety concerns to their care providers. We have worked with patients and staff to co-design a bespoke Patient Incident Reporting Tool (PIRT). Over a developmental phase of three years, we established patients' preferred means of sharing 'safety concerns' – through a guided conversation at their bedside - and also established a method for providing feedback about such concerns to hospital staff. We have collected 648 reports of safety concerns from patients, through three rounds of piloting across 26 wards, as well as collecting comments on patients' positive experiences of care. The PIRT is now being further tested alongside PMOS in a multi-centre trial. Patients have the chance to provide feedback on organisational safety and if appropriate, submit a 'safety concern' using PIRT. The information will be collectively analysed and presented back to participating wards, which they will use as a platform for action planning on the basis of the patient perspective.

For further information contact XXXX at XXXX.

ThinkSAFE: patients and staff working together to prevent avoidable harm

Patients, and their families, are willing to help reduce their risk of experiencing avoidable harm from the care they receive, but are concerned that this might compromise their relationships with healthcare staff. Staff can see benefits of a patient role in improving safety, but can also feel scrutinised and challenged by "activated"

patients. These perceived difficulties are confounded by reports from both patients and staff that opportunities for important patient-staff interaction are greatly limited by a lack of time, heavy staff workloads and competing priorities for staff.

"ThinkSAFE" is an approach, developed in partnership with patients, their relatives and healthcare staff, that aims to support patients and staff together in reducing risk of harm. Further underpinned by current evidence and behavioural science, ThinkSAFE comprises four components. Three of these – a pre-admission educational video, a patient-held "healthcare logbook" incorporating practical tools to facilitate information sharing, and a staff educational session – address issues of knowledge and understanding of patient safety, and promote patient and staff behaviour change by targeting influential beliefs and encouraging staff to actively seek patient engagement. A final component – "Talk time" – is a dedicated session seen as essential to facilitate the patient-staff interaction and make best use of the other components.

Pilot studies have shown the value of ThinkSAFE, and demonstrated that it can have real impact, including reduction in medication errors. ThinkSAFE is currently being further refined and its implementation tested across acute hospitals in the north-east, before being made available for wider implementation.
For further information contact XXXX at XXXX.

A patient designed incident reporting tool (PIRT)

Staff incident reporting in the National Health Service (NHS) harbours numerous weaknesses especially in relation to organisational learning whether in secondary or primary care. It is clear from earlier work that patients have the potential to comment on their care but so far, NHS patients have not been given the opportunity to directly and systematically report any immediate safety concerns to their care providers. The Yorkshire Quality and Safety Research Group, in consultation with AVMA, have worked with patients and staff to co-design a bespoke Patient Incident Reporting Tool (PIRT). During a three year development phase, we established patients' preferred means of sharing 'safety concerns' – through a guided conversation at their bedside - and also established a method for providing feedback about such concerns to hospital staff. We then incorporated the PIRT with the PMOS tool (above) in a combined patient safety intervention that was tested in a randomised, controlled trial in three acute NHS hospitals. A total of 2,400 patients were recruited from 33 wards over three two week periods between 2012 and 2014; having completed PMOS, they were asked to report any patient safety concerns using the PIRT. We collected over 1000 reports of safety concerns from patients, as well as collecting comments on patients' positive experiences of care. The information gained from PIRT alongside PMOS has allowed NHS staff to gain patient feedback on the safety of their care at the time of their hospital stay which many staff have used in action plans to improve organisational systems and provide a unique perspective on healthcare quality.

For further information contact XXXX at XXXX.