NIHR | North West London Patient Safety Research Collaboration

NHS Imperial College Healthcare NHS Trust

Imperial College London

World Patient Safety Day 2023: Healthcare Professional Goody Bag resources

World Patient Safety Day 17 September

INSTITUTE OF GLOBAL HEALTH INNOVATION

Post-event links

We hope you enjoyed the event and found it useful. We'd really value your thoughts on what worked, where we can improve, and what you would like to see more of.

- Please let us know your feedback here
- And if you missed the event, or want to re-watch, you can access the recording of our World Patient Safety Day event here.

Things to read

'National State of Patient Safety 2022: What we know about avoidable harm in England' report [PDF]

- The report explores progress and identifies areas for improvement in patient safety nationally, based on analysis of publicly available data over the past 15 years. Produced by the Institute of Global Health Innovation and funded by the charity Patient Safety Watch.

Global Knowledge Sharing Platform for Patient Safety

- These patient safety resources and tools are submitted by health care ministries, facilities, stakeholders and the World Health Organization (WHO).

Framework for involving patients in patient safety

- The NHS Patient Safety Strategy (July 2019) recognises the importance of involving patients, their families and carers and other lay people in improving the safety of NHS care, as well as the role that patients and carers can have as partners in their own safety. This framework sets out how NHS organisations should involve patients in patient safety.

Children Unlimited

- Children Unlimited is an Australian network of researchers, clinicians, advocates and families with a shared vision: to improve the clinical care and quality of life of children, adolescents and young adults living with a chronic illness or disability. They have some great resources on building agency for young people to become health advocates and leaders.

Things to watch

Introducing the Patient Safety Incident Response Framework (PSIRF): A framework for learning

- The PSIRF sets out the NHS's approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety.

WPSD 2022 - Encouraging patient involvement in medication safety research

- For last year's WPSD, IGHI and NIHR NWL PSRC hosted a panel with Sara Garfield and public partners to discuss their experiences of facilitating and participating in medication safety research.

Introducing the Learn from Patient Safety Events (LFPSE) service

- The LFPSE service is a new national NHS service for the recording and analysis of patient safety events that occur in healthcare, supporting the NHS to improve learning from the 2.5 million+ patient safety events recorded each year.

A video round up of this year's event

- Watch this video summary of how this year's event was co-designed, promoted and a roundup of key takeaways.

Answers to event Q&A – Dr Michael Ramsay FRCA

How can restorative investigations allow us to better hear from patients and help clinicians involved recover from the trauma of being involved in incidents.

Communication and Optimal Resolution (CANDOR) is a process that a few hospitals have implemented. It helps hospitals improve their immediate response to harm and realize improvements in the monitoring and reporting of events by promoting candid, empathic communication and timely resolution for patients, caregivers and the organization. The process supports patients, families ***and caregivers***. It requires a paradigm shift away from the traditional response of organizations to harm events.

How can we support healthcare staff to be better listeners and truly engage with their patients in a meaningful way, when they are overstretched, stressed, burnt out and frightened of admitting they made a mistake? What are some of the practical ways to do so?

Hire enough staff to run the hospital. That is difficult but if you create a nursing school attached to the hospital it can provide a feeding line for staff. Create the Safety Culture and make sure all staff know that the ***patient*** is the most important person in the room and let the patient know it.

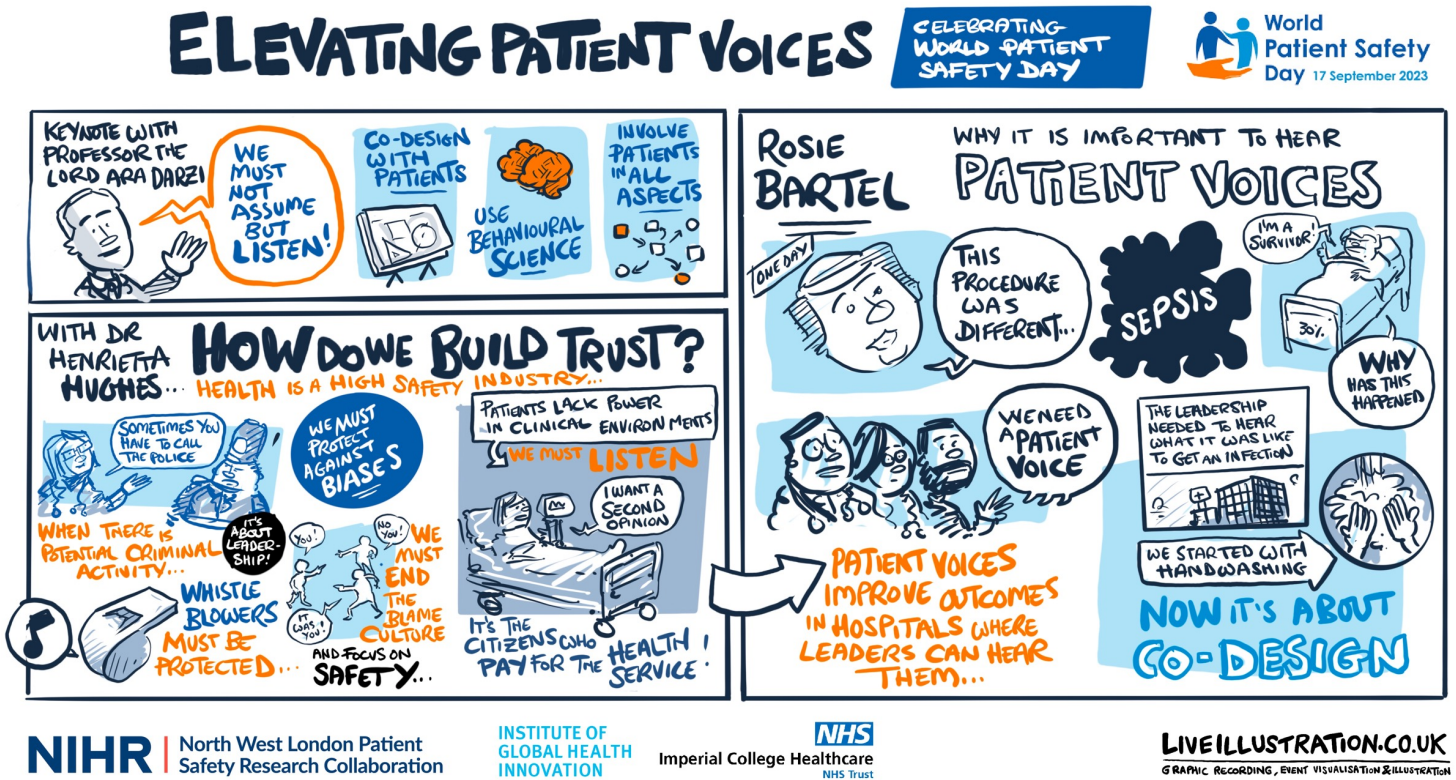
We talk about "hard-to-reach" patients. How do we access "hard-to-reach" clinicians and system leaders – those that are too overwhelmed and busy to engage in the discussion around patient safety?

This is a tough problem! The physician is often focused on being the best surgeon or clinician for a particular problem and expects the support for everything else including safety to be provided. The CEO of the hospital is so glad to have them on board as the referrals are bringing financial security to the hospital. The safety culture has to come from the top down and so the board of the hospital have to engage the clinician and provide support for safety. A firm but supportive approach can make changes.

I find professionals often appear to Listen but don't Hear what is being said by the patient – how can we ensure patients are truly being heard?

Try and make sure that the patient has a trusted family member or acquaintance with them – "a wingman" and engage them in the conversation as a check that you did understand what the patient's concerns are.

Live illustration – Keynote speeches



Live illustration – Panel Discussion