The HSC Safety Forum has themed its work for quality and safety in healthcare under four main headings. Relevant papers and articles are listed below under these themes. In addition, a further section for general documents on patient safety-related areas has also been included.

Patient/client experience

Achieving an exceptional patient and family experience of inpatient hospital care (IHI)

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This IHI white paper presents a framework centred on five primary drivers of an exceptional experience of care that hospitals can use to design, test and implement changes, weaving them into the fabric of daily work to achieve outstanding results.

Achieving an exceptional patient and family experience of inpatient hospital care

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Advancing effective communication, cultural competence, and patient and family-centred care –
A roadmap for hospitals

This monograph was developed by The Joint Commission in the USA to inspire hospitals to integrate into their organisations concepts from the communication, cultural competence, and patient and family-centered care fields.

Advancing effective communication, cultural competence, and patient and family-centred care –
A roadmap for hospitals

‘Please ask’ website

‘Please ask’ is the National Patient Safety Agency’s website for patients. If you or someone close to you is going into hospital, you may have loads of questions. This website will help you become an informed patient and one that worries less. Documents available to download, including *Top ten tips for safer patients*

Processes

Respectful management of serious clinical adverse events (IHI)

This white paper introduces an overall approach and tools designed to support two processes: the proactive preparation of a plan for managing serious clinical adverse events, and the reactive emergency response of an organisation that has no such plan.

Respectful management of serious clinical adverse events

Global Trigger Tool for measuring adverse events (IHI) (Second edition)

This white paper provides comprehensive information on the development and methodology of the IHI Global Trigger Tool, with step-by-step instructions for this easy-to-use system of accurately identifying adverse events (harm) and measuring the rate of adverse events over time.

Global Trigger Tool for measuring adverse events

Sense and reliability

Some organisations can't afford to make any mistakes. What can we learn from them about dealing with the unexpected? A conversation with celebrated psychologist Karl E Weick (Harvard Business Review).

Sense and reliability

Outcomes

Can we save money by improving quality?

After years of unprecedented growth, the National Health Service (NHS) in the UK faces a major financial challenge. The cuts that providers will have to make to achieve savings will be dramatic. The UK is not alone – most health systems have been challenged to 'do more with less' to meet the immediate funding crisis, and also to meet the longer-term financial pressures resulting from changing demographics, new technologies and increased demand. Martin Marshall and John Øvretveit explore this challenging topic in their article published in BMJ, April 2011.

Can we save money by improving quality?

A multifaceted intervention for quality improvement in a network of intensive care units

Despite expensive life-sustaining technologies, mortality and complication rates in critically ill patients remain high. Such patients should therefore receive all evidence-based and cost-effective interventions that improve outcomes. This article sets out to determine the effectiveness of a multi-centre quality improvement programme to increase delivery of six evidence-based ICU practices.

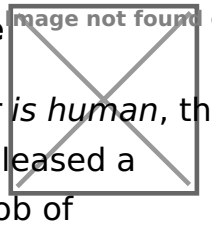
A multifaceted intervention for quality improvement in a network of intensive care units

Using care bundles to reduce in-hospital mortality: quantitative survey

This survey published in the BMJ in April 2010 explores the use of eight care bundles of treatment known to reduce in-hospital mortality.

Staff

Unmet needs: Teaching physicians to provide safe patient care



Ten years after the Institute of Medicine's landmark 1999 report *To err is human*, the Lucian Leape Institute at the National Patient Safety Foundation has released a white paper that finds US medical schools are not doing an adequate job of

facilitating student understanding of basic knowledge and the development of skills required for the provision of safe patient care.

Unmet needs: Teaching physicians to provide safe patient care

Seven steps to patient safety (NPSA)

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This document describes the steps that NHS organisations can take to improve safety. It provides a checklist to help plan activities and measure performance.

Seven steps to patient safety

Nurse staffing and inpatient hospital mortality

In this retrospective observational study, staffing of registered nurses (RNs) below target levels was associated with increased mortality, which reinforces the need to match staffing with patients' needs.

Nurse staffing and inpatient hospital mortality

Other documents of potential interest

Prevention of Venous Thromboembolism: A Key Patient Safety Priority

Prevention of venous thromboembolism (VTE) is an important part of our strategy to improve patient safety.

The Northern Ireland HSC Safety Forum established and facilitated a regional collaborative which developed a single VTE Risk Assessment Tool for N.Ireland

In a letter issued in July 2011, the CMO commended the use of this assessment tool across the region. This should ensure that every adult patient has a documented VTE risk assessment on admission to hospital which reflects guidance from the National Institute of Clinical Excellence (clinical guideline CG92).

It is hoped that this unified approach to VTE risk assessment will also improve and streamline the training of medical and nursing staff and reduce the need for re-training if they move their place of employment.

Safer Patients Initiative phase two Image not found or type unknown

Read the evaluation of the second phase of the Safer Patients Initiative, a complex large scale intervention and the first major improvement programme addressing patient safety in the UK.

Safer Patients Initiative phase two

Safer Patients Initiative phase one

Read the evaluation of the first phase of the Safer Patients Initiative, a complex large scale intervention and the first major improvement programme addressing patient safety in the UK.

Safer Patients Initiative phase one

Learning report – Safer Patients Initiative Image not found or type unknown

This learning report provides an overview of the Safer Patients Initiative (phases one and two) and its evaluation. The report highlights the impact of the programme, the key lessons to be learned and further issues for exploration.

Learning report - Safer Patients Initiative

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