Sharing learning from incidents through creative, eye-catching design

October 2017

<table>
<thead>
<tr>
<th>Trust name</th>
<th>University Hospitals Bristol NHS Foundation Trust</th>
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<tbody>
<tr>
<td>Provider type</td>
<td>Teaching hospital</td>
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<tr>
<td>Site (if applicable)</td>
<td>Trust-wide</td>
</tr>
<tr>
<td>Core service</td>
<td>Surgery</td>
</tr>
<tr>
<td>CQC rating (SAFE)</td>
<td>Good</td>
</tr>
<tr>
<td>CQC rating (Overall)</td>
<td>Outstanding</td>
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Background

University Hospitals Bristol NHS Foundation Trust comprises eight hospitals and is one of the largest NHS trusts in the country. It is an acute teaching trust and became a foundation trust in June 2008. The trust has 899 beds and employs 7,745 full-time equivalent staff.

The trust provides services to three distinct populations: acute and emergency services to the local population of around 450,000 in south and central Bristol; specialist regional services across the region from Cornwall to Gloucestershire; and specialist services across the whole south west, South Wales and beyond.

In 2012, following a thematic review of incidents by the patient safety committee, they identified several recurrent themes, happening in different areas of the organisation. Although the investigations demonstrated clear learning at local level, they felt that, as a team, they could do more to ensure that learning was shared more broadly across the organisation.

However, they were also aware of the challenges any initiative to share information would face. First, if information was shared too frequently, staff might soon become desensitised to it. Second, anything that looked like guidelines would be unlikely to draw further attention from a busy workforce. Third, for an incident learning to be shared, there had to be a reasonable suspicion that a similar event could happen elsewhere in the organisation.

1 Chaired by the associate medical director for patients safety, with representation from the various clinical divisions and safety leads
The solution

Each month, following thematic review of incidents, they would choose the theme where they felt it was most critical to share learning across the organisation.

Working with a staff member who had a passion for design, they began devising patient safety posters, outlining the learning from this incident. They deliberately avoided using a standard format which would remind staff of national guidance; instead, opting for a more informal, eye catching design.

Where appropriate, the poster would include a reference or link to where staff could find more detailed guidance on what mitigating actions they could take to prevent recurrence in their clinical areas.

Initially they shared designs with clinical leads, whose responsibility was to cascade them in their teams, print them out and paste them in areas frequented by clinical staff but not patients, such as common rooms, changing rooms and toilets.

Over time, as they received informal feedback from staff across the organisation, they refined the process by:

- broadening the email distribution, bypassing clinical leads who were at times slow to disseminate, and reaching out directly to approximately 4000 staff each month
- pasting the poster in the body of the email, so that staff would be able to instantly judge whether it was relevant to them
- cutting down the word count, with fewer than 50 words being the magic amount for people to read it.

To avoid information overload or desensitisation, they ensured that no more than one poster per month was circulated. On very rare occasions, they would send a second ‘urgent response’ email in the middle of the month, if a serious incident occurred and they wanted everyone in the trust to be aware of it. This has only happened once or twice since the initiative was launched.

Feedback from staff has been highly positive and soon people from across the organisation started to engage in this process, suggesting incidents that had occurred in their clinical area, which they felt were worth sharing across the organisation. The scheme has become so popular that the team already have a list of themes/topics for the safety posters to cover the next six months, based on recommendations from across the organisation.

On occasions, they have also adapted national patient safety alerts into the eye-catching poster format, to ensure that they are noticed by staff.

Posters from previous campaigns remain available on the trust intranet for all staff members.
Enablers and challenges

Creative thinking and a focus on safety have been key drivers behind this project. The team haven’t experienced any difficulties in rolling it out and feedback has been overwhelmingly positive.

Impact

The impact of the scheme is difficult to evaluate formally, given that the information campaign complements and does not replace local initiatives and that incidents only rarely occur. However, they have noted that after issuing a poster campaign on a specific topic, they don’t detect any recurrent incidents in that particular area during the following months. Examples include:

- insulin prescribing (using circle instead of dot)
- following NICE guidelines on computerised tomography (CT) scans following head injury (these had not always been followed for inpatients).

Next steps and sustainability

A similar approach has since been adopted by the Royal College of Emergency Medicine, when sharing learning from incidents across departments nationwide.

Want to know more?

Have a look at the examples of posters published alongside this.

For more information, contact Dr Emma Redfern, Associate Medical Director of patient safety at Bristol University Hospitals: Emma.Redfern@UHBristol.nhs.uk

To see the other case studies in this series: visit the NHS Improvement website at: Improving quality and safety in healthcare.