

Improving Patient Safety within NHS Tayside

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Abstract

Publications such as An Organisation with a Memory (DOH, 2000), Doing Less Harm (DOH, 2001) and Building a Safer NHS (DOH, 2001) demonstrate that error prevention in healthcare is a National priority and provide structure and direction for the development of local adverse event systems focused on learning.

Evidence suggests that approximately 10% of all patients admitted to hospital may encounter an adverse event as a result of their healthcare experience. NHS Tayside evidence indicates that at 14.2% we sit above the national figure. With a survey on patient safety conducted by YouGov having key findings that illustrate that 72% of healthcare leaders think that “there are some good things in our healthcare system, but fundamental changes are needed to make it work better”, within NHS Tayside we recognise that change to latent conditions require all staff to be involved in improving patient safety. A multidisciplinary Adverse Incident Management (AIM) group has developed a reporting system that emphasises learning and change rather than blame. Although this has brought with it many new initiatives including developing and circulating risk alerts, developing and circulating quarterly newsletters and developing a catalogue of digital images of live patient safety problems, we recognise that there is still much more to be done to enhance patient safety, including the development of trigger tools to promote a more proactive approach at the proximal, intermediate and distal levels within the organisation.

The aim of this research is to evaluate the implementation process of a formalised adverse event system, attempt to identify the ways in which this has influenced service delivery and make recommendations on how NHS Tayside could further reduce their error rate, increase learning and further improve patient safety. This will be achieved by undertaking a literature review on theories of human and organisational behaviour, measuring errors at the proximal, intermediate and distal areas of the organisation and identifying triggers for prevention.

Keywords: Adverse event, patient safety, learning, error.