

World Patient Safety Day 2024







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The RCSEd would like to extend our gratitude to everyone who kindly contributed to our World Patient Safety Day (WPSD) 2024 Campaign.

Upholding patient safety and ensuring the highest standards of patient care are core values of the College and at the heart of all the work the College undertakes. Patient safety is embedded in the rigorous professional standards that run through all our educational, examination and audit activities. The College works hard to improve safety for patients, for surgeons, for teams, for organisations - for all.

The following includes added links to view all the content and features that were included in the promotion of The RCSEd WPSD 2024 communications.

Thank you for supporting our WPSD 2024 Campaign!

Surgeons' News

September Edition

World Patient Safety Day – and how does it affect you.

10 page feature on patient safety

CLICK HERE to view!





Blogs and Features.

WHO World Patient Safety Day 2024: Improving Diagnosis for Patient Safety' by Anna Paisley, Consultant General Surgeon, RCSEd Council Member and Patient Safety Group Chair. CLICK HERE to view.

'Diagnostic Safety in Surgery' by Anna Paisley, Consultant General Surgeon, RCSEd Council Member and Patient Safety Group Chair. CLICK
HERE to view.

'The Importance of Teamwork for Surgical Diagnostic Safety in Outpatients' by Andrew D Martindale MA BM BCh FRCSEd (Urol.) Consultant Urological Surgeon NHS Tayside, RSA East Scotland and Educational Tutor, RCSEd. CLICK HERE to view.

'The potential of AI to help reduce diagnostic errors' Afra Jiwa, PhD Student, Centre for Medical Informatics, Usher Institute, University of Edinburgh and Malcolm Cameron, Research Assistant, Centre for Medical Informatics, Usher Institute, University of Edinburgh. CLICK HERE to view.

'Virtual diagnostics' by Afra Jiwa, PhD Student, Centre for Medical Informatics, Usher Institute, University of Edinburgh and Malcolm Cameron, Research Assistant, Centre for Medical Informatics, Usher Institute, University of Edinburgh. CLICK HERE to view.

'Improving Diagnosis for Safety in Dentistry' by Claire Morgan. Deputy Chair for Patient Safety Group and Dental Council RCSEd Consultant in Restorative Dentistry, Patient Safety Specialist Barts Health Trust. CLICK HERE to view.



Blogs and Features.

Can my stool be tested for bowl cancer?' by Prateek Arora. MS, MRCS, DNB, DrNB Surgical Gastro, Senior Clinical Fellow, Colorectal and Peritoneal Oncology Unit, Christie NHS and CR Selvasekar MD. FRCSEd (Gen), MFSTEd, MA (Clin Ed), MBA (Health Executive). CLICK HERE to view.

'A View from the Bridge' by Chris McEwan. Lay Representative on RCSEd Patient Safety Committee. CLICK HERE to view.

'Diagnosing Acute Aortic Dissection – The Patient Perspective' by Gareth Owens, MSc.(Oxon), MBCS, CITP, Aortic Dissection Survivor, Chair, Aortic Dissection Awareness UK & Ireland. Global THINK AORTA Campaign Lead. CLICK HERE to view.

'Protecting your precious gift of life' by Dr Sumita Barua. Heart Transplant Fellow, Queen Elizabeth Hospital Birmingham UK and Mr Majid Mukadam FRCS(C-Th) MCh(CVTS) PGCE(UoB). Associate Specialist (Surgeon) – Cardiothoracic Transplantation. Queen Elizabeth Hospital Birmingham UK. CLICK HERE to view.

'NCEPOD: Prioritising Diagnostic Safety for Better Health Outcomes' by Martin Sinclair, NCEPOD Surgical Clinical Co-ordinator, on behalf of NCEPOD. CLICK HERE to view.

'A Novel Facial Cellulitis pathway; Improving the time to surgery for Facial Necrotising Fasciitis' by Mr Peter Steele, Consultant OMFS/ Head & neck Surgeon. CLICK HERE to view.



Blogs and Features.

'Diagnostic Safety in Otolaryngology-Head and Neck surgery' by Nashreen Oozeer, Head and Neck cancer Surgeon based at South Tyneside and Sunderland NHS trust, northeast of England. Deputy chair for the RCSEd Otolaryngology SSB. Lead for ENTUK Patient information project and the ENT UK co-lead for robotics. CLICK HERE to view.

'Improving Diagnostic Safety in Orthopaedics' by Professor Neil Ashwood. Consultant Trauma and Orthopaedic Surgeon. University Hospitals of Derby and Burton. CLICK HERE to view.

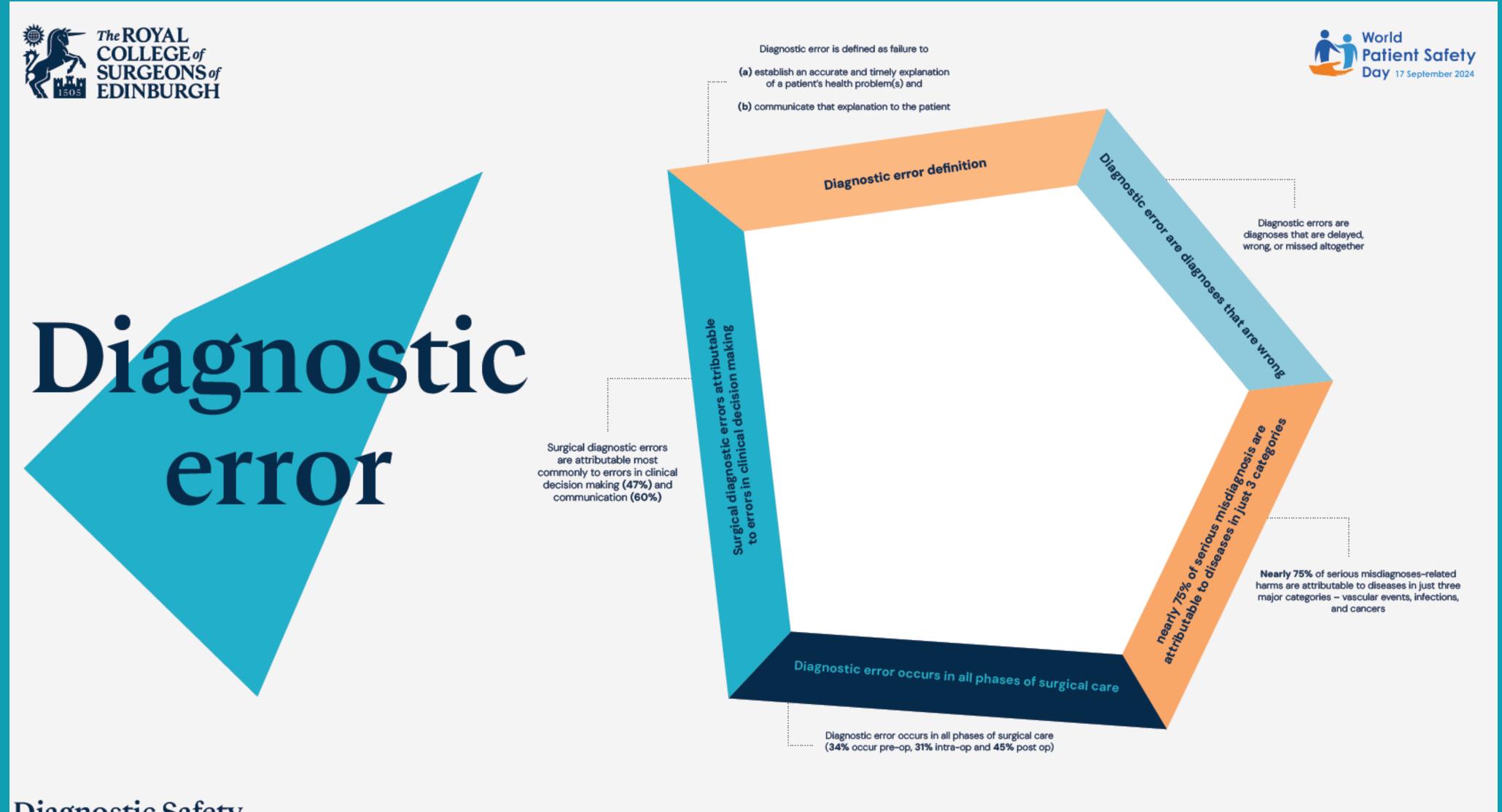
'Enhancing Diagnostic Safety in Surgery Through Non-Technical Skills' by Professor Steven Yule. Chair of Behavioural Sciences, University of Edinburgh Director, Surgical Sabermetrics Laboratory, Usher Institute, University of Edinburgh. Director of Non-Technical Skills Faculty, Royal College of Surgeons of Edinburgh and the Non-Technical Skills for Surgeons (NOTSS) Committee. CLICK HERE to view.

'Challenges in the diagnosis of twin silent killers: aortic aneurysm and acute aortic dissection' by R. Weerakkody, Consultant Vascular Surgeon and A.L. Tambyraja, Consultant Vascular Surgeon. CLICK HERE to view.

'Using audit to improve outcomes for patients with Upper Tract Urothelial Cancer' by Mr Alexander Laird PhD FRCSEd (Urol). Consultant

Urological Surgeon and Honorary Clinical Senior Lecturer. Department of Urology. The University of Edinburgh. CLICK HERE to view.

WPSD Infographic 1 — Diagnostic Error.



WPSD Infographic 2 – Scale of the Problem.





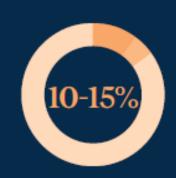




diagnostic errors accounts for **16%** of preventable harm that arises in healthcare globally



most people will experience at least one diagnostic error in their lifetime



10-15% of all diagnoses are erroneous



diagnostic errors account for 22% of paid malpractice claims in acute care



diagnostic errors remain the most common, most catastrophic, and most costly of serious medical errors in closed malpractice claims



over 50% of patients involved in surgical error experience at least moderate harm, and this is fatal in 1 in 7



misdiagnosis accounts for up to 80,000 deaths and 16,000 serious harms in US hospitals annually



8% of adverse events in medicine are related to harmful diagnostic errors



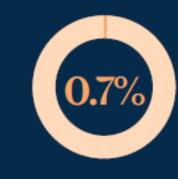
14% of adverse events in hospitalized patients are related to harmful diagnostic errors



diagnostic error occurs in 4% of primary care consultations



diagnostic error occurs in 5% of outpatient consultations



diagnostic error occurs in 0.7% of adult hospitalizations



diagnostic error occurs in **7%** of patients transferred to intensive care



diagnostic error occurs in 30% of Accident & Emergency patients

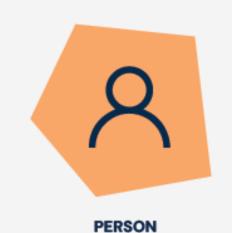


diagnostic error occurs in 6% of medical 7-day readmissions

WPSD Infographic 3 – Cause of the Problem.



Cause of the problem





Inadequate knowledge Inadequate skills Cognitive bias Tunnel vision Intrinsic bias



Extremes of age Health complexity Atypical presentation Rare condition Cultural differences



Challenging job demands
Time pressure
Distractions
High cognitive load
High stress



%=

TASKS

World

Patient Safety

Inadequate task performance
Poor information gathering
Poor information processing
Poor pattern recognition
Poor clinical reasoning
Poor handover
Poor investigation governance
Poor communication
Poor documentation



TECHNOLOGY AND TOOLS

Inadequate administrative procedures
Inadequate documentation tools
Inadequate access to information
systems
Inadequate use of technology to
highlight abnormal results
Inadequate systems to track diagnostic
information over time



ENVIRONMENT

Chaotic work environment Overcrowding Boarding Overbooking Interhospital transfer



ORGANIZATION

Poor work schedules
Lack of continuity of care
Inadequate staffing
Delays in outpatient review
Delays in investigations
Delays in actioning results
Lack of reliable measurement of
diagnostic safety
Lack of feedback on diagnostic performance
Inadequate targeting of high risk groups

Inadequate health education



PROCESS

Diagnostic process complex Inherent diagnostic uncertainty Not all symptoms are diagnosable Available information often incomplete Diagnostic errors hard to measure Diagnostic standards hard to define

Diagnostic Safety

WPSD Infographic 4 – Solutions.









PERSON



Regular training Involve patients Seek feedback on decisions Address personal biases Be an effective team player



Share all symptoms and medical history
Take an active role in care
Ask for information
Be clear what matters most to you



TASKS



Improve job demands Ensure sufficient time Reduce distractions Reduce stress



Improve task performance
Assess patients thoroughly
Be aware of red flags
Capture insights from wider team
Improve handover
Communicate effectively



TECHNOLOGY AND TOOLS

Improved Electronic Health Record Diagnostic Time Out Checklist Electronic Trigger Tools Closed loop system for results Safety netting systems Early Warning Scores Al & machine learning



ENVIRONMENT

Prevent overcrowding Reduce boarding Limit patient transfers Optimize patient flow Do not overbook clinics/lists

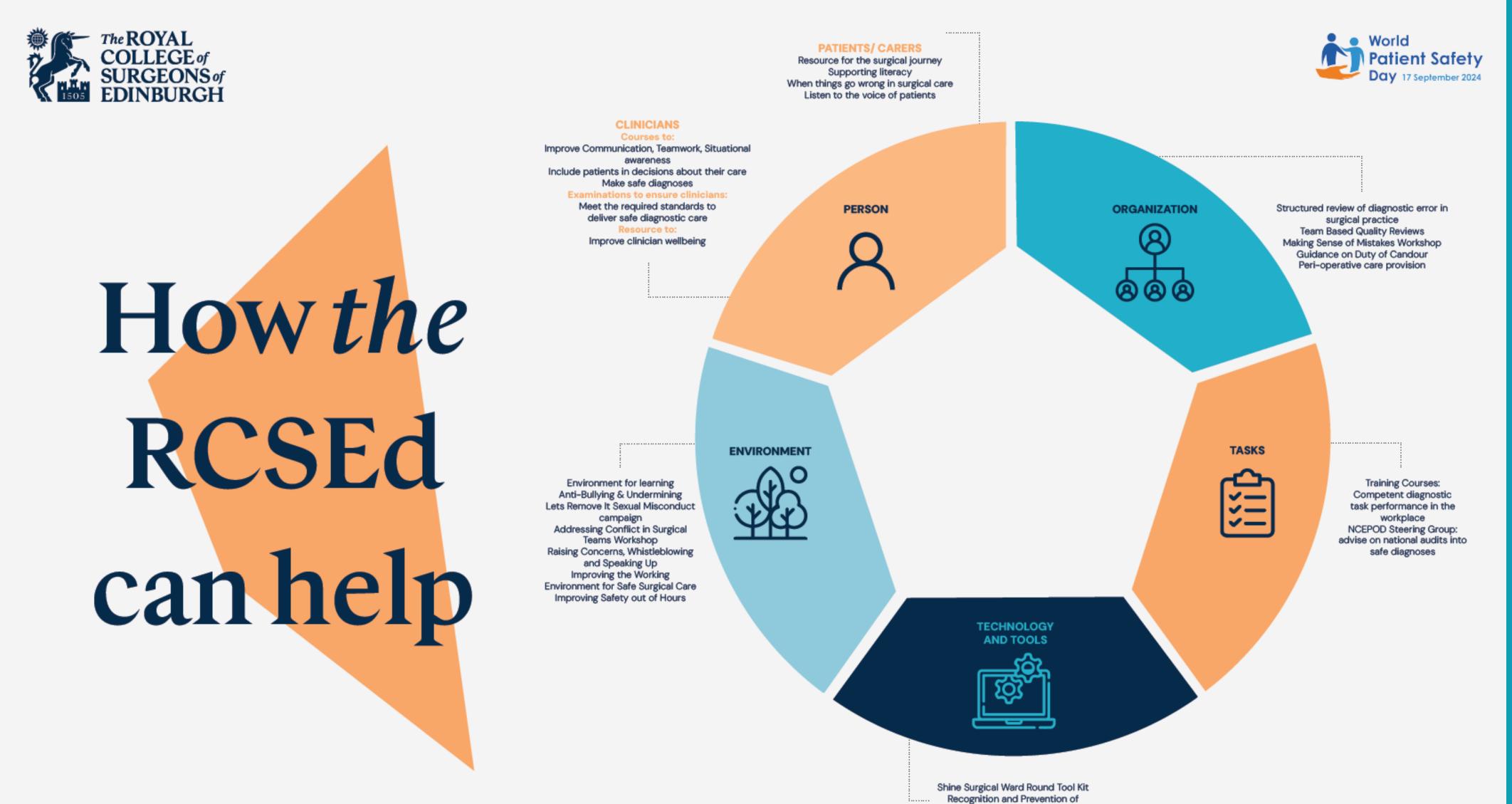


ORGANIZATION

Improve continuity of care
Ensure safe staffing levels
Improve teamwork
Develop pathways for common presentations
Target high risk groups
Ensure blame free culture focused on improvement
Champion diagnostic safety in policies
Train staff on diagnostic safety
Measure diagnostic safety
Provide diagnostic safety feedback
Promote patient education

Diagnostic Safety

WPSD Infographic 5 – How can RCSEd Help.



Injury and Deterioration

Diagnostic Safety

rcsed.ac.uk

Webinar.

Healthcare Safety & Quality in the US: Perspective from Time Leading a National Organisation 17th September 2024, 18:00 to 19:00 GMT.

Overview

This webinar will give an overview of the safety & quality scene in the US with a focus on accreditation and regulation of healthcare organisations.

Aims and Learning Objectives

By the end of this webinar, attendees should be able to:

- Understand the regulatory and accreditation world of healthcare in the US
 Have a glimpse at the patient safety challenges faced in the US
 Understand diagnostic errors and bias in healthcare

This will be available post-webinar for RCSEd Members to view at convenience on the RCSEd website, archived webinars section by **CLICKING HERE.** rcsed.ac.uk

Vignette 1. CLICK HERE to view.

World Patient Safety Day

Non-Technical Skills for Surgeons (NOTSS). Vignette 1 of 3.

Situation Awareness: Staying Ahead of Potential Issues.



Vignette 2. CLICK HERE to view.

World Patient Safety Day

Non-Technical Skills for Surgeons (NOTSS). Vignette 2 of 3.

Team Communication: The Key to Clarity and Precision.



Vignette 3. CLICK HERE to view.

World Patient Safety Day

Non-Technical Skills for Surgeons (NOTSS). Vignette 3 of 3.

Leadership in Surgery: A Case Study.



Thank You