covered. There are five workshops in total during the session and all teams undertake them. A team is then chosen to feed back their thoughts on the patient safety issues raised by the scenario; follow up discussions are supported by the facilitator.

To encourage incident reporting and analysis, several issues that could be identified as adverse events for patients are explored, such as a misfiled blood result and a failed communication between nurse and doctor. The latter is demonstrated with a DVD of two conversations between the nurse and doctor. The first is a rushed exchange between the two, which results in a limited handover of critical patient information, while the second references the SBAR (situation, background, assessment, recommendation) structured communication tool, which is being introduced across the trust. The DVD forms part of a scenario that all groups watch.

The workshops start and the facilitators (usually two) move between groups, helping them to work through the patient safety issues highlighted by the information provided (see Box 1 for an example). One group then feeds back on the patient safety issues identified by the scenario, supported by a facilitator. A different group is selected for each scenario to ensure all staff have the opportunity to contribute to the session.

The trainers facilitate discussion on issues and policies to make sure the groups address the patient safety issues and ideas for improvements in practice. The findings are written on a flipchart to ensure all areas are covered; any issues that have not been identified can be dealt with and any gaps in knowledge filled. Box 2 is an example of a flipchart for workshop 1.

At the end of each workshop one particular issue is reviewed in detail, although all mandatory topics are covered. The session uses activities based on the information available at a given point in the patient’s journey, referring to current policies and guidelines. Participants use mock notes for fictitious patients to identify potential safety issues, such as misfiled results and poor documentation. It is hoped that involving local experts in developing paperwork for the scenarios — such as Great Western Ambulance Service Trust, children’s A&E practitioners, pain nurse specialists and theatre practitioners — ensures the programme is realistic for staff.

From an educational perspective, the session is structured to ensure that all types of learners can benefit from participation. This is done by blending learning methods (Honey and Mumford, 1992), such as workshop activities, referencing trust policies, formal and informal discussions, the internet and DVD resources.

At the end of each session every participant is given a copy of the monthly patient safety newsletter. This details updated policy and patient safety information and participants are asked to disseminate it to their colleagues and departments.

EVALUATION

We evaluated both the old and new sessions using staff surveys from the evaluation forms. The evaluations given here are based on all sessions in the first year of the new course.

The results were organised into quantitative and qualitative sections and Figs 1, 2 and 3 show some of the relevant data, comparing views on the old programme with those on the new one. The data shows a significant difference in relevance and staff confidence in practical application between the two programmes, despite the information being inherently the same.

Qualitative results

The first issue of note was that participants in the new programme were far more likely to fill in free text sections of the evaluation surveys than those in the old one. For example, there were no general comments in evaluations of the old format and 35 in the new one (all of which were positive). This trend was mirrored for all questions, for example: “I thought the format was very appropriate and made what could have been dry/boring much more interesting and informative.”

Participants were able to identify more relevant issues covered in the new programme (nine) than in the previous one (four). There was a similar finding when looking at most useful learning, where participants identified 11 separate issues in the new programme versus five in the old one, with several identifying more than one aspect of learning.

When discussing expectations that were not met, 25% of respondents on the old programme felt the sessions needed to be in greater depth. Only 12% commented on this aspect of the new programme and they either gave individual positive suggestions to improve it or raised issues that were not in the session’s remit. For example, one participant commented: “It would be useful to use scenarios for specific NICU [neonatal intensive care unit] issues – use on our own