

# ENGAGING STAFF FOR PATIENT SAFETY

*Primo at Lincoln*

United Lincolnshire Hospitals NHS Trust 

## Introduction

In 2010 a successful pilot study of a proactive approach to organisational learning (PRIMO) took place in Hereford. This work continues at Lincoln County Hospital.

## Objectives and Methods

Our overall aim is to improve patient safety by predicting and preventing problems and engaging staff to become actively involved and contribute towards an enhanced safety culture.

Led by junior doctors but including nursing and auxiliary staff, this work concentrated on the surgical admissions unit. Permanent Staff documented 'hassles' affecting patient safety and their work by using a series of narratives and questionnaires.

Qualitative analysis of narratives identified seven areas of concern, for example: Equipment and Computers, Staffing and Environment. Questionnaires were developed from the narratives with specific questions in each domain and distributed bimonthly.

As a result of the questionnaires we identified improvement actions. Working environment was identified as an area for further study: light bulbs didn't work and the process for replacement meant a regular

delay in replacing ward lights; the clinical notes were often not in the notes trolley. Feeding instructions were also identified as problematic. Simple interventions were developed. Baseline audit was undertaken. Other actions were identified and work is ongoing in these areas.

## Results and Outcomes

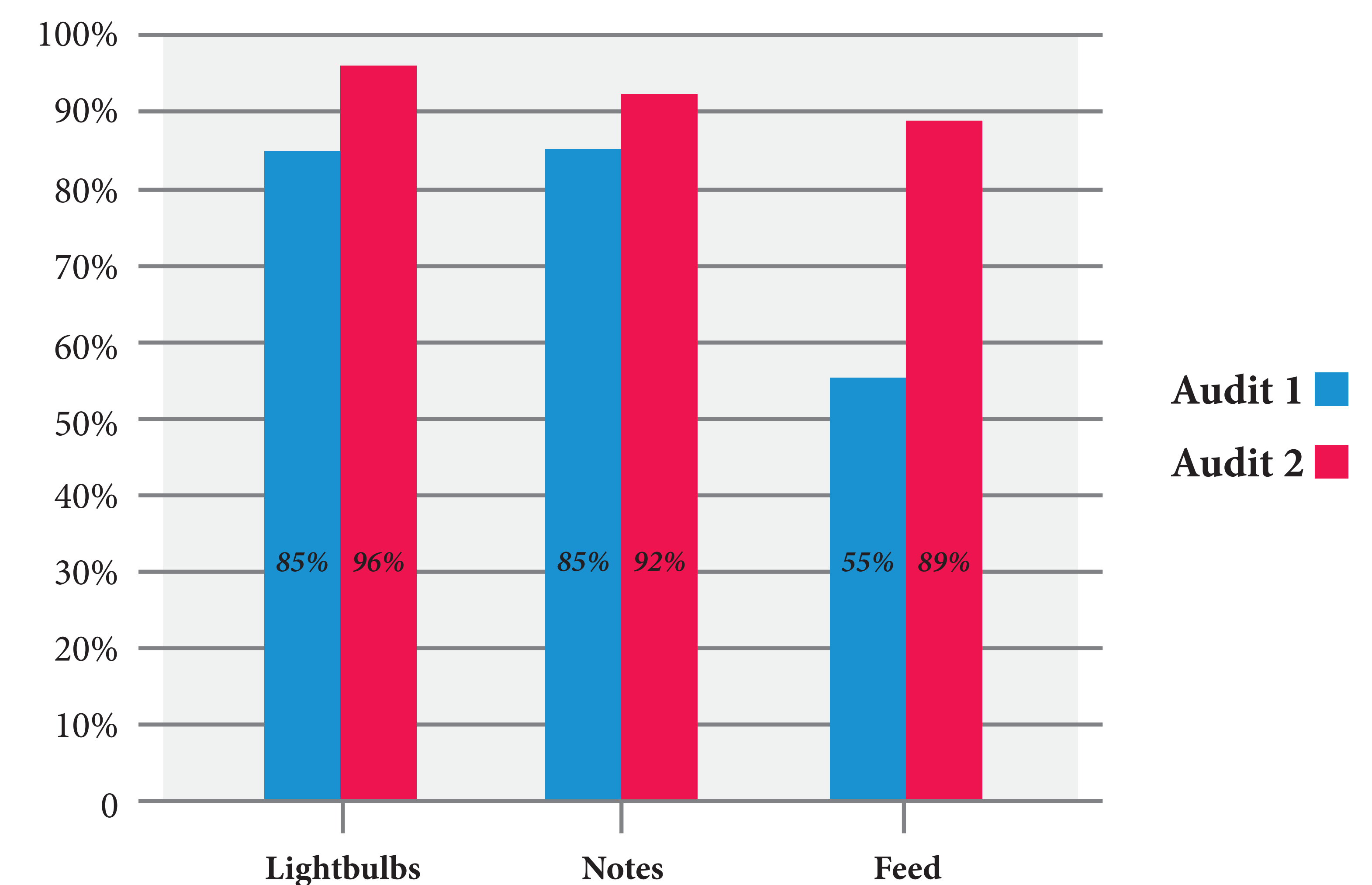
Faulty light bulbs were replaced. Numbers working improved from 86% to 96%.

Junior Doctors were given presentations at their regular weekly teaching on the importance of notes being returned to the trolley. Note placement improved from 85% to 92%.

Stickers were placed in the clerking proformas to highlight feeding regimes. Documented feeding instructions improved from 55% to 89%.

## Conclusions

These results suggest that by utilising staff feedback tools and with simple interventions patient safety and ward efficiency can be improved. This has led to better lines of communication between the multidisciplinary team that works in the busy environment of a surgical admissions unit. We feel it has also improved patient care.



## Summary and Discussion

This is a novel approach to patient safety and has shown continuous engagement of staff. It has illustrated problems and provided solutions. These changes have been brought about by simple and easy replicable interventions that any group of enthusiastic front line staff could perform. It has had short and long term benefits and work continues to reap rewards with longer term actions ongoing.

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