NHS
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Safer Care

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The NHS Institute for Innovation and Improvement supports the NHS to transform healthcare for patients and the public by rapidly developing and spreading new ways of working, new technology and world class leadership.

The NHS Institute: the way we work

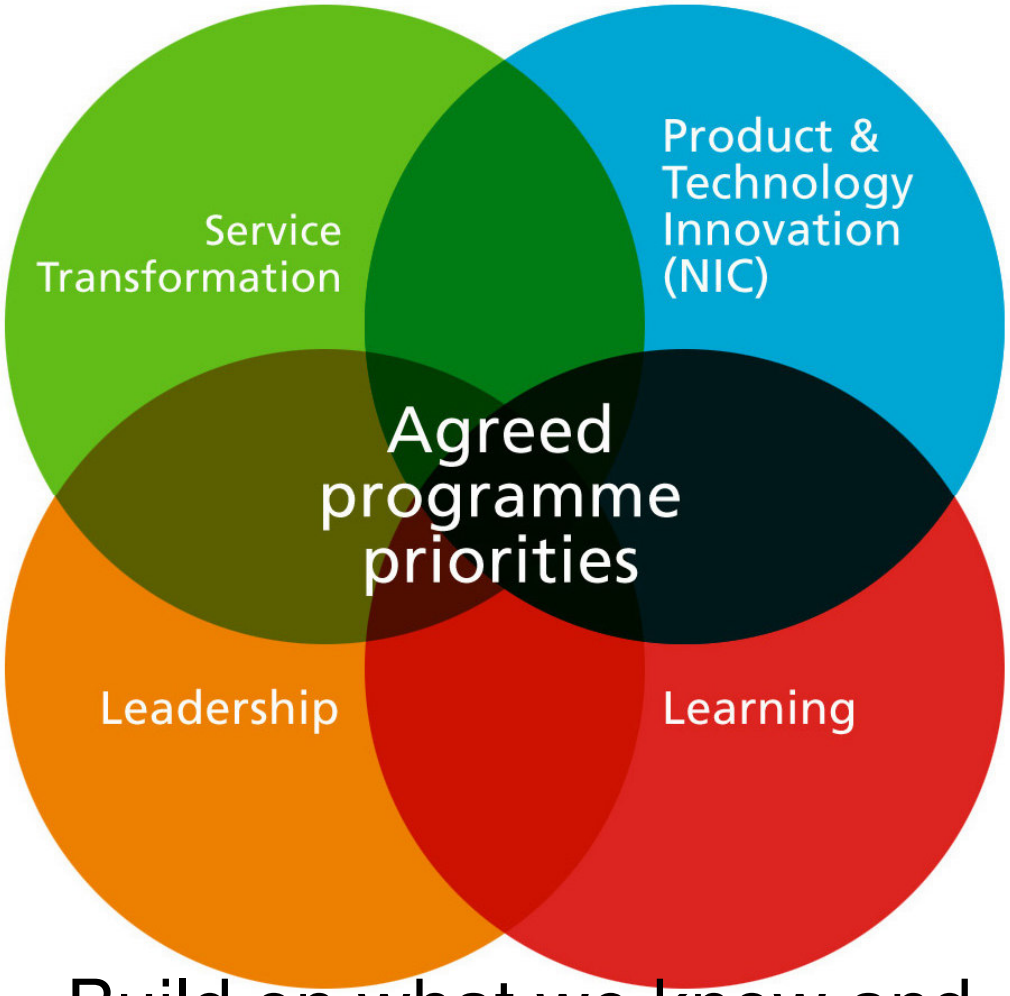
Working methodology

Clinical systems improvement

Productive series

Sustainability guide

Thinking differently



Local Innovation Hubs

Innovation fund

Graduate programmes

Board development

Clinical development programmes

Breaking through & Gateway

Improvement leaders guides

Learning modules

Involvement framework

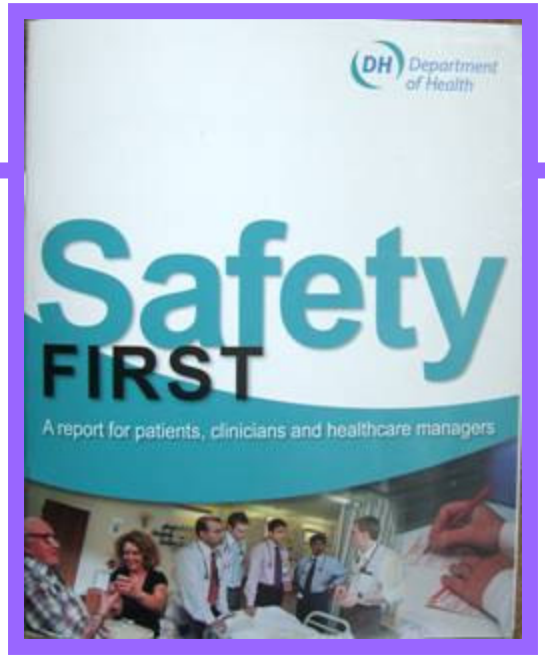
HR/OD/WFP network

Build on what we know and generate new knowledge

Our brief from the Department of Health

Education and Training

#11: NHS Institute to work with medical Royal Colleges and others to ensure that advances are made in ***education & training*** to support patient safety



Help lead NHS campaign

#3: The National Patient Safety Forum should oversee the design and implementation of a national patient safety campaign-focused initiative.

The objective of this initiative should be to engage, inform and motivate clinical staff and healthcare providers to address the challenge of providing safer healthcare.

Safety First (Dec. 2006) available on the DH website

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Building an NHS where every member of staff has the passion, confidence and skills to eliminate harm to patients

Safer Care: building an NHS where every member of staff has the passion, confidence and skills to eliminate harm to patients

Education and Training for technical competence

Training for new and current staff

- **Leading Improvement in Patient Safety course (LIPS)**
- Global Trigger Tool Training
- Joint events with Royal Colleges
- Clinical Systems Improvement training
- Safety in undergraduate courses

Creating a strong network

- **Safety improvement faculty**
- Junior doctors and safety

Expanding into Primary care

- Primary care Global Trigger Tool developed and training provided

Organisational competence

Developing senior leaders

- **Executive Quality and Safety Academy for senior leadership teams**
- Safety for Boards
- Safety Improvement for SHAs and NPSA

Roll out

- Leading Improvement in Patient Safety
- Global Trigger Tool training
- Increase role of faculty

Help lead NHS Campaign

Co-leading the campaign

- Helping shape and set up the campaign
- Supporting activities

Compelling communications

- Martin Bromiley DVD
- Patient and staff stories
- Experience Based Design work with MRSA patients

Key: Expected delivery to the NHS

Year 1

Years 2 and 3

	Individual	Organisation	Cross-Organisational
Will	Compelling communications Campaign Global Trigger Tool	Compelling communications EQSA Global Trigger Tool	**Campaign**
Understanding	**Campaign** **Global Trigger Tool** **Core Module** **Patient Safety Managers** **Primary Care scoping**	**EQSA** **Boards on Board** **Campaign** **Global Trigger Tool** **LIPS programme**	**Campaign,** **Primary Care** **LIPS programme**
Skills technical and behavioural	**Campaign,** **CSI modules** **Undergraduate modules** **Faculty development,** **Improvement Advisors development**	**Campaign** **LIPS programme**	**Campaign** **NPSA training** **undergraduate modules** **Faculty development** **Improvement Advisors**
Confidence, individual and organisational	**Campaign** **CSI modules**	**Campaign** **SHA training** **NPSA training**	**Campaign** **SHA training** **NPSA training**

How will we measure the impact of what we do?

Safer Care Programme level

- Number of participating organisations undertaking GTT and reporting
- CASIL measures
- Evaluation of Leading Improvement in Patient Safety

NHS organisational level

- HSMR
- Self-assessment framework (Chris Collison)
- Global Trigger Tool
- Process measures

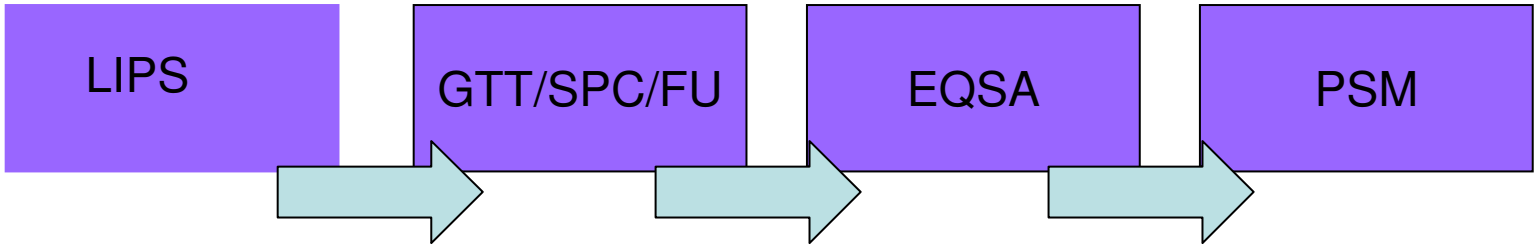
Co-development of a measurement framework is required

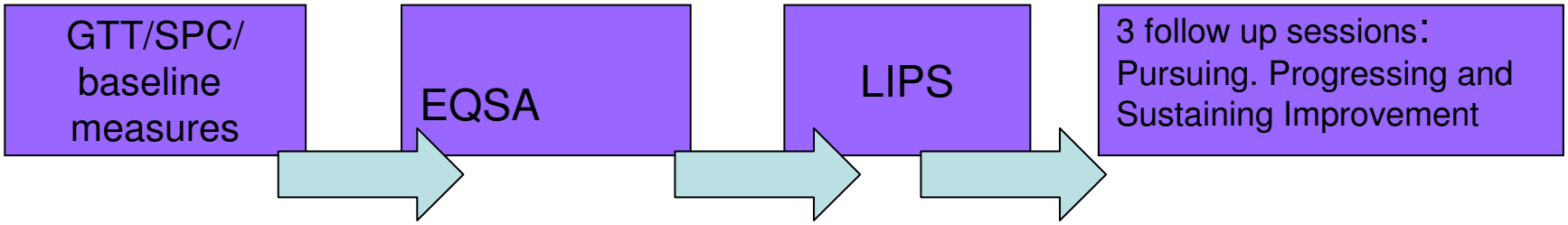
Safer Care Programme measures

From CASIL …..

2	**INDIVIDUALS IN ORGANISATIONS**
C	**Deliver LIPS and EQA 6 times**
A	**80% of campaign members and 25% of other Trusts are aware of available training**
S	**60 % of the organisations with trained staff can demonstrate an increased focus on safety**
I 1	**Measurable reduction in harm as measured by GTT or HSMR**
I 2	**60% Acute Trust with people trained can demonstrate improvement in at least one key safety measure**
L	**Learning capture, understand and reframe**

LIPS Components; Learning





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‘the LIPS programme has been instrumental in catapulting patient safety to the top of the organisation’s agenda’ - Doctor

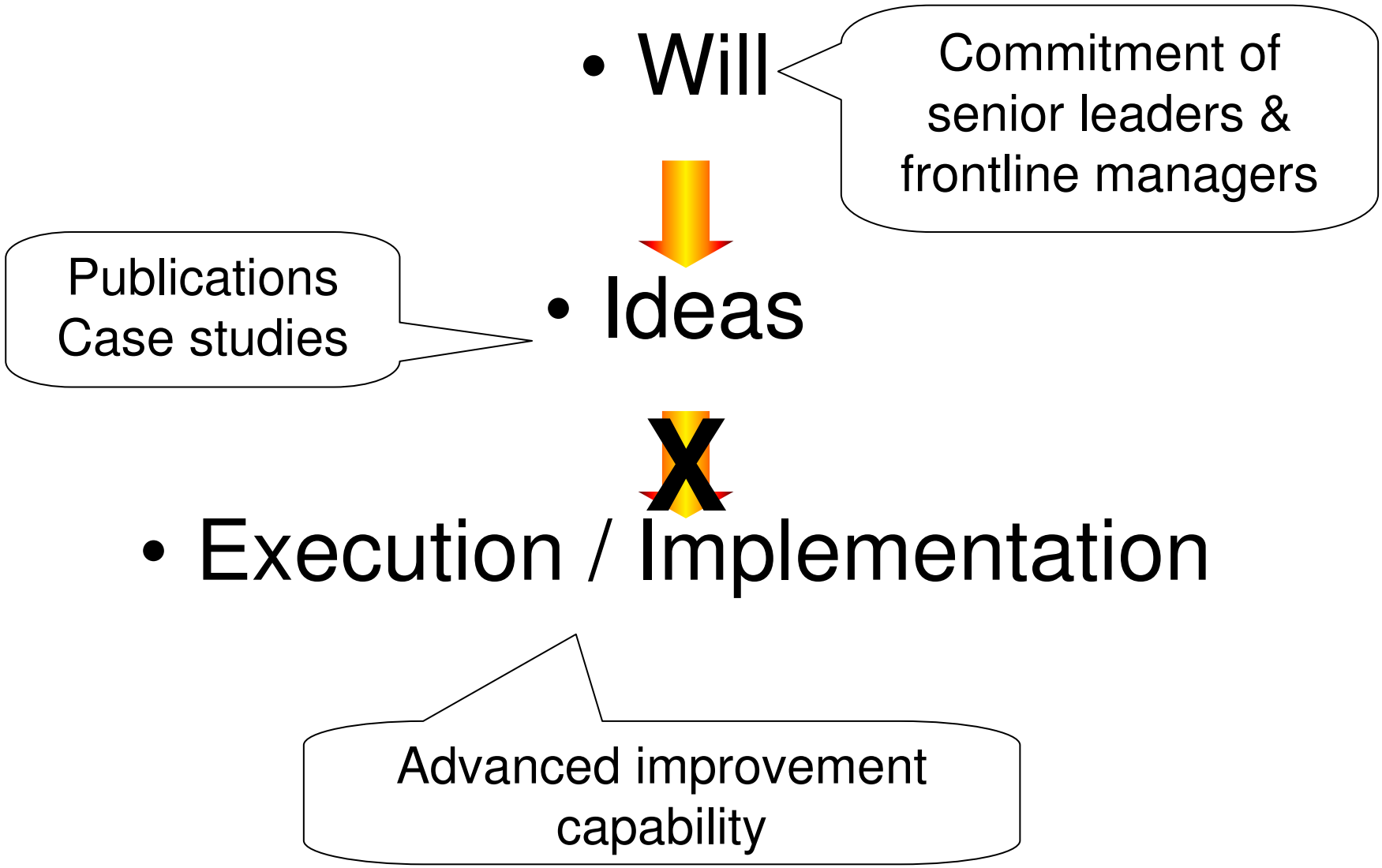
‘we have devoted an entire Trust Policy Group Meeting to patient safety and have 3 'trigger tool' audits up and running , so we have been busy and I think the level of awareness in our Trust has certainly been raised significantly- Medical Director’

“I think I really have learnt quite a lot. Some things I thought I knew it turns out maybe I didn’t know Them in the depth I need to know them. I leave the course stronger than when I arrived”

Some challenges

- **How do we develop a measurement framework that quantifiably demonstrates the impact of our products on organisations and their individuals ?**
- **How do we train the volume of staff required?**
  - **Out of 10,000 doctors how many do we need to influence?**
- **What do we need to do to develop our safety improvement faculty**?

What does an organisation need to do this?



Executive Quality and Safety Academy

Seven Leadership Leverage Points for Organisation-Level Improvement in Health Care
Set specific system-level aims and oversee their achievement at the highest level of governance
Build an executable strategy to achieve the aims
Channel leadership attention
Put patients and families on the team
Make the Director of Finance a quality champion
Engage doctors
Build improvement capability

J Reinertsen IHI

EQSA

"This was the most thought provoking programme I have ever experienced. It offers a new approach to the quality agenda which challenged our thinking"

Chris Burke CE Stockport

" Carrying out the EQA programme together gave our medical director, chief operating officer/nursing director and me a great opportunity to focus on moving the patient safety agenda forward. Since we completed the EQA we have radically restructured our governance, performance and service improvement arrangements…the EQA have us the momentum to make this radical change and without it I doubt we would have achieved a consensus on the way forward"

Sue James CE Walsall

Where are we as an organisation?

Is safety what the health care commission tells us?

Is safety very important work and competes with other priorities?

Is safety the right of every patient and a given in the hospital?

Do our systems help?

Systems to measure error are in place and reported to senior leadership

Error reporting is actively encouraged, some aggregation occurs. Improvement efforts centre around strong champions and root cause analysis

Systems to measure harm and errors are used to drive rates ever lower. Standardisation and reduction in variation are embraced. There is data transparency

Patient Safety as Strategy

Is safety improvement in the objectives of all staff?

Are we interested in hearing from patients on safety issues?

Are we clear about the barriers to improvement and have we the will to address them?

Patient Safety as Strategy

Be ambitious

Do we believe we can be the best and exceed safety goals and targets?

Is it clear that everybody is involved in the achievement of safe care?

Are all strategies aligned to safety improvement?

Improve Care

Is safety improvement in the objectives of all staff?

Are we interested in hearing from patients on safety issues?

Are we clear about the barriers to improvement and have we the will to address them?

Do we invest in the improvement skills of our staff?

Lead for Safety

Are organisational strategies aligned to patient safety? E.g. is safety embedded in audit, clinical governance plans, clinical management team agendas?

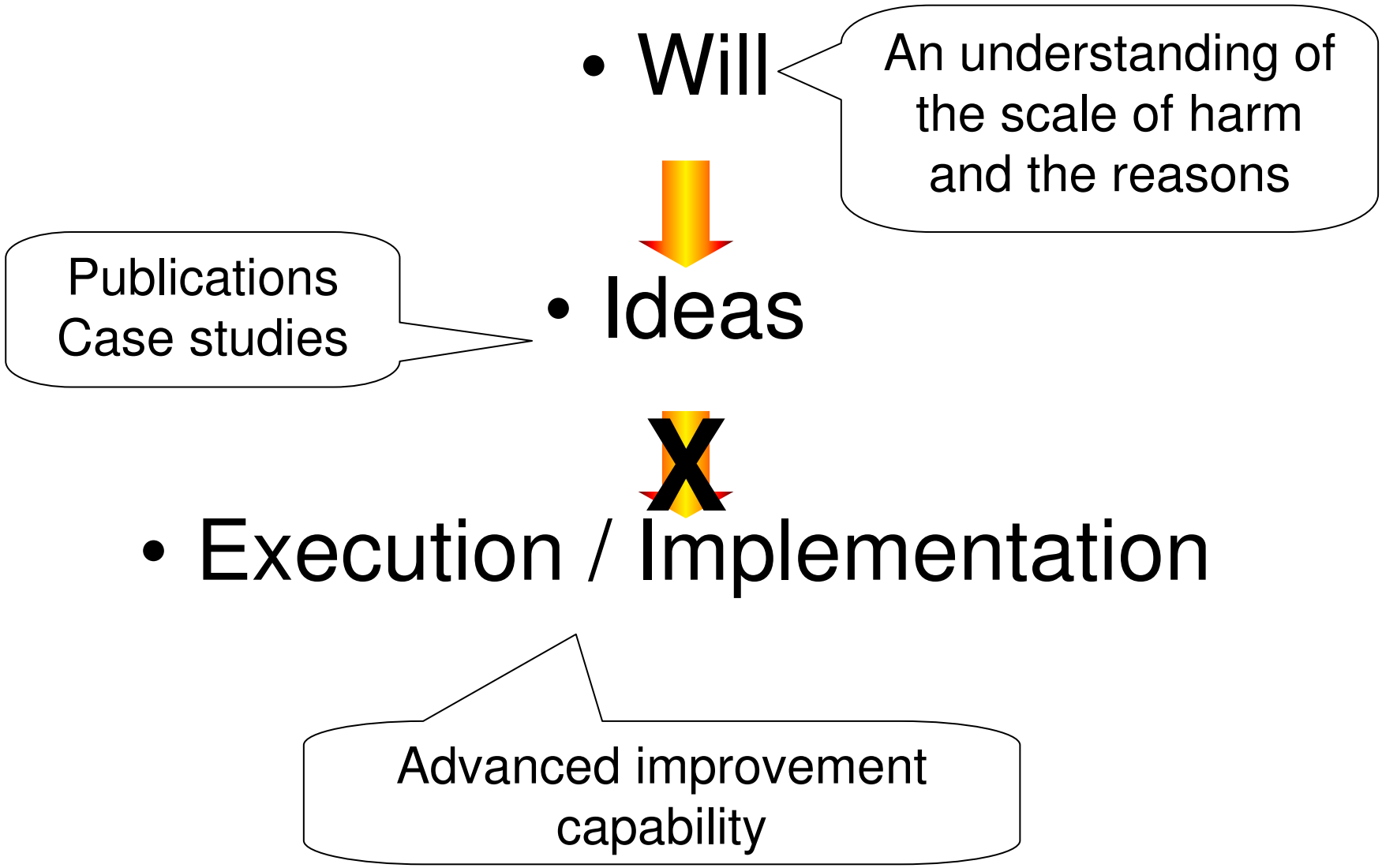
Is safety embedded in the performance of individuals and directorates?

Are the roles of project leads and clinicians leading safety work clear particularly in relation to accountability ?

Do clinicians have the time to lead and be involved in patient safety?

Is standardisation pushed where applicable?

What does an individual need to do this?



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Mortality Reviews

Institute for Healthcare Improvement (IHI)
www.ihi.org

The Mortality Diagnostic – 2x2 Matrix

Review (most recent)
50 consecutive deaths
Place them into a two by two matrix based on:
- Was the patient *admitted* for palliative care?
- Was the patient *admitted* to the ICU?

Focus your work initially on boxes that have at least 20% of your mortality.
Change ideas are linked to these boxes

SAFETY CHANGE STRATEGIES

	ICU admission Yes	ICU admission No
YES Comfort Care NO	ITU admission criteria 1	End of Life Plans Hospice/home care Palliative care team 2
	Care bundles Glucose control Multidisciplinary rounds 3	Observations EWS & SBAR CC outreach Teamwork Risk assessment Medication errors Infection 4

The Mortality Diagnostic; Failure to Recognise, Plan, Communicate

Analyse deaths in box 3 and 4 for evidence of failure to: recognise, communicate, plan.

This will help you understand the local environment.

The Mortality Diagnostic;
Failure to Recognise, Plan, Communicate

Analyse deaths in box 3 and 4 for evidence of adverse events using the Global Trigger Tool.

This will give some further direction to local problems.

Why Use Trigger Tools?

Traditional reporting of errors, incidents, or events does not reliably occur in the best of cultures in healthcare

Voluntary methods underestimate events and concentrate on what is interpreted as being preventable

Easily identifies events without complex technology

Can be integrated into a good sampling methodology

IHI Global Trigger Tool (UK)

General care module

G1 Lack of early warning score or early warning score requiring response

G2 Any patient fall

G3 Decubiti

G4 Readmission to hospital within 30 days

G5 Shock or cardiac arrest

G6 DVT/PE following admission evidenced by imaging +/or D dimmers

Surgical care module

S1 Return to theatre

S2 Change in planned procedure

S3 Removal/Injury or repair of organ

Intensive care module

I1 Readmission to ICU or HDU

I2 Unplanned transfer to ICU or HDU

Medication module

M1 Vitamin K

M2 Naloxone

M3 Flumazenil

M4 Glucagon or 50% glucose

Lab test modules

Haematology

L1 High INR (>5)

L2 Transfusion

L3 Abrupt drop in Hb or Hct (>25%)

Biochemistry

L4 Rising urea or creatinine (>2x baseline)

L5 L6Electrolyte abnormalitiesNa+ <120 or >160K+ <2.5 or >6.5

L7 Hypoglycaemia (<3mmol/l)

L8 Raised Troponin (>1.5 ng/ml)

Microbiology:

L9 MRSA bacteraemia

L10 C. Difficile

L11 VRE

L12 Wound infection

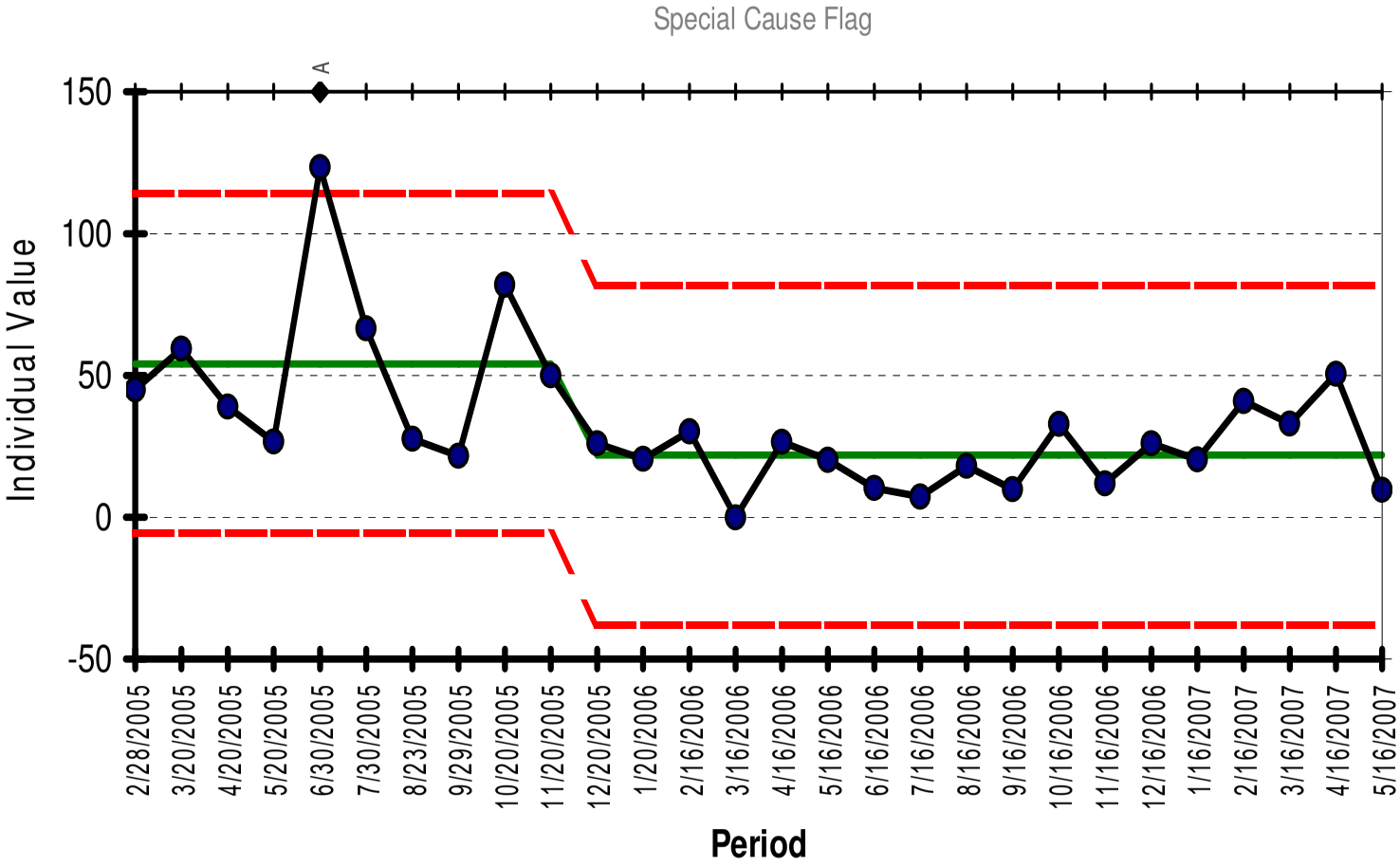
L13 Nosocomial pneumonia

L14 Positive blood culture

Category of Harm NCCMERP Index

E	Temporary harm, intervention required
F	Temporary harm, initial or prolonged hospitalization
G	Permanent patient harm
H	Life sustaining intervention required
I	Contributing to Death

Adverse events



What skills and knowledge do individuals need to have?

Model for Improvement
Measurement
Systems thinking
Reliability

Just culture
Human Factors
Violation and Migration
Teamwork and communication