Wessex Academic Health Science Network

Patient Safety Collaborative

Sepsis and Transfers of Care Breakthrough Series Collaborative (2015/16)

In 2015/16 the Wessex Patient Safety Collaborative (PSC) facilitated a collaborative project across Wessex to support staff and organisations to improve patient safety in two local healthcare priorities: Sepsis and Transfers of Care.

1. Summary

Collaboratives, using the Institute for Healthcare Improvement's Breakthrough Series (BTS) methodology, have helped many organisations, including health care, social services, education and public health make profound and lasting changes throughout their organisations. [Institute for Healthcare Improvement 2017]

The BTS approach encourages improvement teams to form and then connect, learn and share with wider colleagues in the region, whilst exploring how to apply Quality Improvement tools and techniques to the chosen topic. Tools include the Model for Improvement which is based on using small tests of change, supported by senior staff within the organisation.

Over 200 delegates in 22 teams from 13 healthcare organisations attended four learning events; the 200 "away" team members represented a much larger number of staff in the "home" teams back in their own organisations.

Our evaluation of the process demonstrated that individuals grew in skills, knowledge and confidence and teams enjoyed a positive learning experience. This has led to operational and cultural changes across the organisations taking part, with many examples of safer patient care and improved engagement with patient and carer representatives. There are also early indications of improved clinical outcomes around sepsis identification and management.

"Collection of data has allowed us to monitor shifts and trends in practice, identify where there is improvement and highlight where we need to focus our efforts. In addition to collaboration and sharing, the key to any successful patient safety initiatives is to ensure executive involvement and have strong clinical ownership. The Wessex collaborative has helped us continue to foster our culture of innovation, learning, safety and quality care."

Salisbury Sepsis Team

2. Examples of BTS sepsis work

- Improved the screening of patients for Sepsis in ED majors from just under 30% to 100%.
- Improved the 1hr delivery of antibiotics to red flag sepsis patients in Emergency Admitting areas from 26% to 67%.
- Improved pre printed screening stickers on revised NEWS charts and clerking proforma.
- Introduced an e-screening tool in ED with most antibiotics delivered within the 1 hour target.
- Implemented a screening tool for patients with a Modified Early Warning Score of over 3 in ED, ASU and AMU.
- Introduced a paediatric sepsis screening tool for children admitted to the Paediatric Assessment Unit.
- Achieved better MDT Sepsis management with engagement from microbiology, paediatrics and maternity teams.
- Implemented an electronic Screening prompt in ED, empowering nurse screening and supporting discussions with medical staff regarding concerns about the patient's condition.

"*The team found the journey to be very interesting, in particular the time available to share others' experiences, successes and challenges. We particularly valued the sessions at the learning events where we could see the progress made by other teams and how they arrived at that point. Sharing ideas and processes as well as being able to share our own progress with others facing similar challenges has been extremely useful. The opportunity to network and share concepts so as not to 'reinvent the wheel' is something that is more widely applicable to each of our practice as a whole and can also be used to achieve direct benefit to patients, carers and their families."*

The Wessex Paediatric Critical Care Network

3. Examples of BTS transfers work

- Replaced taped handovers (implicated in 2 serious incidents) with bedside handovers, safety briefings and patient information boards. Following the change there were no serious incidents and there was positive feedback from staff about the quality of the documentation and communications and also from patients about improvements in the quality of handovers.
- Improved post discharge care from a Community Hospital and Older People Mental Health Unit with daily follow ups to check patients were managing their medication and that planned care and equipment had arrived. Patients reported that knowing they were going to get a phone call increased their confidence when leaving hospital.
- Introduced new handover documentation leading to faster triage by the Tissue Viability Service.
- Created a questionnaire based on 'my usual life' regarding social circumstances and usual care needs. The questionnaire is completed by the patient with their relatives/carers and has improved staff knowledge about patients' usual care needs and social circumstances. Patients' relatives have also provided positive feedback as they feel they don't have to keep repeating themselves.
- Introduced a forum to enable acute and community hospitals across Dorset to collectively review the discharge/transfers of patients to learn what has gone well and what needs to be improved.

"Working with the collaborative and forming new networks with our colleagues across Wessex was good fun and learning what others were doing was interesting, enlightening and allowed us to reflect on our own practice. The learning events were invaluable as the protected time they gave us allowed us to spend precious time together as a team to learn and share experiences. As a team a small 'light bulb moment' has progressed into something that can, and does, improve the patient journey and communications between staff, their patients and the NOK/carer. I think we were all surprised in how a small idea (implemented slowly and carefully) could make such a difference to the patients' care."

Salisbury Transfers of Care Team

4. Engaging with Patients and Carers

This Collaborative project was designed to include patient/carer participation at all levels (co-design and co-production). As such patient/carer representatives participated as members of the PSC Steering Group and the BTS Faculty.

Over the period of the Collaborative members developed a toolkit to assist teams engaging patients in Quality Improvement and Patient Safety initiatives. The ARISE (Aims – Recruit – Integrate – Support – Evaluate) toolkit is now used to help teams engage effectively with patients in Wessex BTS Collaboratives and has subsequently attracted interest from NHSE (Patient Safety), CLAHRC (NW London), Portsmouth University and members of the Better Local Care (Southern Hampshire) Vanguard.

"We were able to engage with a patient who developed severe sepsis and had a very lengthy process of recovery within ICU and wards across two trusts. She recently presented for us at our Patient Safety Conference 'Sepsis – the Patients Perspective', which staff found very powerful and learned a lot from it."

University Hospital Southampton Sepsis Team

"The team developed a patient story based on a particular patient who had experienced a delayed discharge. His journey was mapped on a daily basis and used with the ward to identify where opportunities to progress his discharge had been missed. This engagement proved fundamental to changing attitudes in the ward and really ensured their commitment to change."

Royal Bournemouth & Christchurch Hospital Transfers of Care Team

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"The team invited the daughter of a patient to join them. She had made a complaint regarding the care of her father in which communication was noted as a key factor. The team invited her to join the group recognising the value of her experience around how patients and their families should be involved in decision-making. Her contribution to the review of discharge planning was considered invaluable."

Salisbury Transfers of Care Team

5. Sustainability and Spread

The Wessex Sepsis and Transfers of Care Networks

On the completion of the Collaborative two pan-Wessex Networks were launched in May 2016 to sustain and spread progress and to continue the peer support that staff had found so valuable during the BTS. The purpose of the Wessex Sepsis Network and Wessex Transfers Network is to connect staff across all sectors, to enable the sharing of process/outcome data, knowledge, projects, progress, resources and learning; to "shamelessly steal" and learn from each other for a region wide reduction in avoidable deaths and poor outcomes.

The Networks are designed to be self-sustaining and rely on active participation of members who drive the focus and the work. The Sepsis Network has been very successful and members are currently working on the design of a Wessex Screening tool.

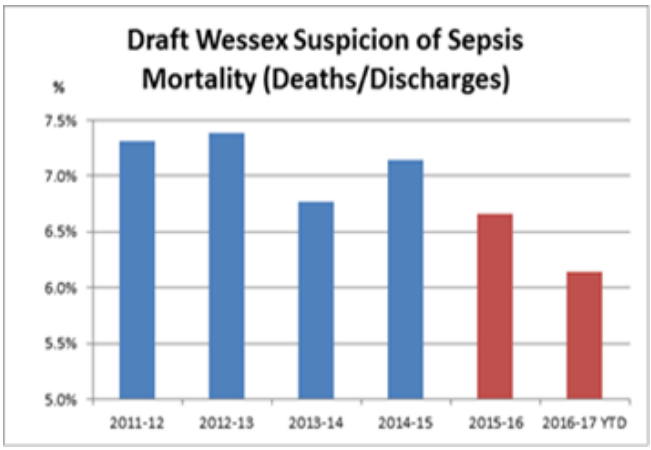
"I have greatly valued the support of the collaborative during the past year and in particular the perspective and support I have received. This project, like so many others, has been beset by challenges and at times it has been difficult to make progress in the light of competing priorities and pressures within the hospital. The process of discussing and reflecting on the project with the collaborative has been a great personal support for me. I have enjoyed sharing our journey, including its ups and downs with the members of the collaborative and have been hugely motivated by the support I have been given and the positive reaction for the work we have done in our organisation."

Royal Bournemouth & Christchurch Hospital Sepsis Team

The Wessex Community of Safety and Improvement Practice (CSIP)

CSIP is a Wessex-wide network that offers the opportunity to connect individuals, teams and projects across health and care in the areas of innovation, quality improvement and patient safety. CSIP joins up individuals and smaller Wessex communities such as BTS participants and Network members. All BTS participants were invited to join CSIP so that they could all stay connected, share their successes and learn from each other in order to speed up the adoption of good practices that make a difference to our patients. CSIP members have access to regional events, an annual conference and the LIFE platform which supports QI projects.

6. Regional Outcomes



Making causal links between small changes in operational practice and clinical outcomes is difficult. The PSC work coincided with the start of the sepsis CQUIN and many Trusts were already working to improve sepsis and transfer pathways.

However, alongside the positive qualitative evaluation of the BTS, follow-up clinical data from Wessex Organisations provides early indications that mortality trends may be starting to reduce.

This improvement will be for many reasons but initiatives such as the 16/17 BTS are undoubtedly equipping and empowering staff to play their part in improving health outcomes for our patients.

7. Case Studies

Two examples of Quality Improvement projects undertaken by BTS teams are provided on the next page to illustrate the large scale benefits that can arise through the design, testing and implementation of "small changes". Teams engaging with the BTS have the opportunity to take part in telephone and web based conference calls, seminars and world café presentations and produce posters, such as these, for their own use as well as at regional and national conferences.

Hampshire Hospitals NHS
NHS Foundation Trust

Sepsis Team

Wessex Academic Health Science Network

Our Journey with the Wessex Patient Safety Collaborative

OVERALL AIM:

To increase the number of patients who survive following an admission with sepsis

2015/16 AIM: To achieve 90% compliance with a) screening for sepsis and b) administration of antibiotics within an hour for patients attending ED majors (using the sepsis protocol) by March 2016, based on audit of randomised selection of 50 patients per month (25 per site). (National CQUIN)

What we did

PDSA 1 April 2015 designed a sticker to use in ED and used proforma V1

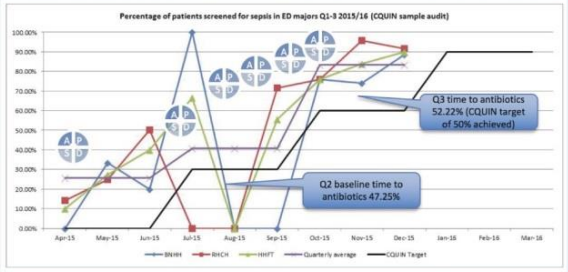
PDSA 2 July 2015 revised sticker template and added clarity over patient fall and mental health patients to proforma V2

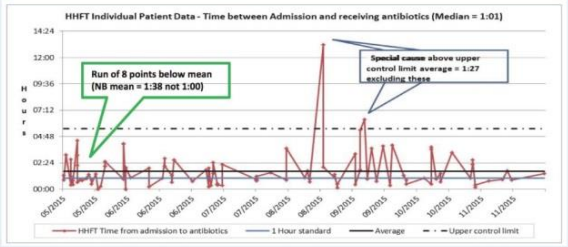
PDSA 3 August 2015 added when alternative diagnosis likely to proforma V3

PDSA 4 September 2015 held 2 sepsis awareness days

PDSA 5 October 2015 Revised sampling methodology as per NHSE guidance and used A40/A41 patients

PDSA 6 October 2015 If not 50 patients per month with A40/A41 then added in sample of 147 likely sepsis diagnosis codes





Sustainability

- Screening sticker now pre printed on revised NEWS charts and escalation stickers and clerking proforma
- Sepsis Group good MDT involvement including microbiology, paediatrics and maternity. Reports to Board via Reducing Harm from Deterioration Group

Next Steps

- Roll out paediatric tool to ED and revise maternity pathways and documentation to address all patient groups
- Patient Group Directions (PGDs), sepsis boxes, availability of antibiotics and awareness campaign for wards to improve timeliness to antibiotics
- Patient information leaflets to improve patient awareness

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Southern Health NHS
NHS Foundation Trust

Transfers of care:

Wessex Academic Health Science Network

Our Journey with the Wessex Patient Safety Collaborative

Where we started from:

We had two serious patient incidents (one fall and one pressure ulcer) as well as incidents of missed communication on the ward. The investigation showed, amongst other things, that nurse handover did not consistently flag patients at risk of harm.

At that time the late shift prepared a taped handover message, and night staff prepared a Handover sheet, to pass on information to the day shifts about patients. Verbal handovers were only brief, involving nursing staff only, so other MDT staff received no verbal handover.

Our improvement aim
To avoid harm coming to our patients by having clear handovers between shifts

Our success criteria
Ford ward is a safe place to be
- No serious incidents
- Patients feel involved in care

What changes did we think would result in improvement?
Handover information is updated at each shift, and given at bedside
Handovers to include a safety briefing that covers the most important risks to patients
To involve the patient in handover

What did we do?

We found out how handover is done in other places e.g. visited other wards and attended Patient Safety Collaborative.

Decided alternatives to taped handover.

Safety briefing content drafted, invited feedback from staff.

Introduced safety briefing at each shift handover, alongside bedside handover.

Using new whiteboard installed opposite nurses station.

Updated information in light of experience and feedback.

Where have we got to?

Handover is now through

- Patient board on wall, for 'at a glance' view, updated by night shift, and as required during day.
- Handover sheets updated by each shift for all staff
- No taped handover
- Bedside handover
- Safety briefing template in increasing use .....

'Safety briefing' covers:

- Planned discharge
- Admissions
- Infection
- Dementia / DOLS
- Pressure areas
- Risk of falls
- Nutrition
- Track & Trigger

The ward is on the way to being a safer ward- How do we know?

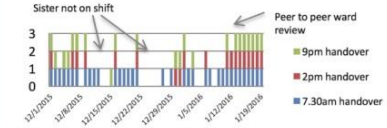
A review of two patients with unavoidable pressure ulcers showed good documentation and communication systems.

Physiotherapists feedback – more relevant handover, better use of time.

Patients comments about bedside handover.

No serious incidents.

Safety briefings at shift handover



Our next steps:

- To adjust day time arrangements for updates to Patient Board
- Discuss with staff why Safety Briefing is used at every shift handover, and feeding back consequences
- Discuss with staff how Bedside Handover is done at every shift handover
- To continually improve, be confident and competent in patient safety on the ward

What we have learned about quality improvement

"Trust involvement in Patient Safety Collaborative meant that I did not feel alone, picked up ideas and enthusiasm from others, had help with launching ideas on ward, to prioritise."

"I was reminded that you can start small and progress"

"It hasn't always gone well, but picked it up again and encouraged everyone to keep going"

"I discovered that a QI approach is effective in finding solutions that work for staff, rather than the big bang 'one size fits all' approach. I now encourage local action – for individual or team to experiment 'you don't need permission'. "

"That we need to include everyone on the ward"

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