PATIENT SAFETY AWARDS 2020

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PROJECT SHOWCASE

PATIENT SAFETY TEAM OF THE YEAR

WINNER

ROYAL UNITED HOSPITALS BATH FT

THE SEPSIS AND KIDNEY INJURY PREVENTION (SKIP) TEAM IMPROVING OUTCOMES FOR PATIENTS

Sepsis and Acute Kidney injury are common causes of in-hospital patient deterioration associated with high morbidity and mortality. The team aimed to identify deterioration as early as possible, increasing prompt management and decision-making, improving outcomes by decreasing mortality, length of stay and preventing their occurrence. Sepsis and AKI can occur anywhere in any speciality, so it was essential to establish a specialist team to support and drive improvements. Innovative awareness campaigns, '60 days for Sepsis 6' and 'UR'INE Trouble', were used to train a critical mass of staff rapidly.

JUDGES COMMENTS

This winning project is an amazing and inspiring piece of work which clearly demonstrates the desire to improve outcomes for patients. There were impressive results, showing improvements in safety across a range of indicators, and great methods of engaging staff. The judges felt that this displayed fantastic learning that should be rolled out nationally.

PATIENT SAFETY TEAM OF THE YEAR

HIGHLY COMMENDED

Nursing & Midwifery Council
The Public Support Service Team

The PSS was created to ensure that patients, family members and users of services are at the heart of our fitness to practise process. The service was co-produced by the Public Support Steering Group made up of patients, relatives, external healthcare stakeholders and our own staff. As an organisation, we set out for the PSS to play a significant part in helping us to ensure that our process is person-centred and that we can meet the needs of patients, families and the public. This was a huge challenge, involving the need to make significant cultural change: from the way we approached our fitness to practise process, how our processes work and the way we engaged with people; to thinking about the impact on people of each single aspect of our work.

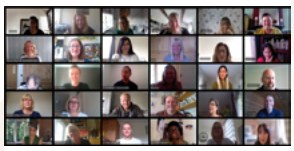
JUDGES COMMENTS

This project was vital work which is truly patient centred, a valuable initiative which enables patients to share their experiences. The real strength of this project is that the NMC are demonstrating learning and are now listening to and engaging with those who were previously treated like evidence rather than people with feelings. Well done to all those involved.

FINALISTS

Portsmouth Hospitals University Trust and Wessex AHSN
Time to ACT Project Team

In September 2016 a multi-disciplinary working team was formed to undertake a quality improvement initiative linked to deteriorating patients. The first initiative chosen was to develop and implement a Deteriorating Patient pro forma across all adult in-patient wards. Improvement targets for this initiative included the number of patients with a new NEWS score of 5 or more that had an increased frequency of vital signs recording and were escalated and seen in a timely manner. It also included the grade of responder and time to patient review as measured against the organisations escalation protocol. A final measure was the presence of documentation of actions post clinical review including treatment escalation plan, consultant discussion and documentation of communication.



PRIMIS at the University of Nottingham and the AHSN Network
The PINCER Team

A replication model for the scale and spread of PINCER, a pharmacist-led IT-based intervention to reduce medication errors in general practice, was developed by PRIMIS and researchers at the University of Nottingham, for national rollout in partnership with the AHSN Network. PINCER involves searching general practice clinical systems using computerised prescribing safety indicators to identify patients at risk from their medications. Pharmacists, specifically trained in PINCER, then review the outputs and work with practices on an ongoing basis to reduce both current and future patient risk, using a range of quality improvement tools. The vision is to make primary care prescribing even safer for patients by implementing PINCER in at least 60% of general practices in England by 2023.

PATIENT SAFETY TEAM OF THE YEAR

FINALISTS

Royal Devon and Exeter FT
The Chest Trauma MDT

The Chest Trauma MDT was formed to improve the safety and outcomes of patients who sustain chest traumas. Together the team improved the detection and recognition of chest trauma patients through trust wide education and exposure. They also developed the Care Pathway to suit the changing needs of the Trust, and improved knowledge and Nursing skills on the ward level to create Chest Trauma Trained Nurses to manage these vulnerable patients. By providing the Nursing Team with education and training support they are now a settled and empowered workforce resulting in the lowest staff turnover for 2 years. This then benefits the safety of these patients by having continuity of specialist care and compassionate, enthusiastic care providers.

South Tyneside and Sunderland FT and Sunderland CCG
Older Person Care Home Team: Digital NEWS Project

Sunderland CCG has invested in digital technology to improve the monitoring of residents' health in the 49 nursing and residential care homes operating across Sunderland, using the National Early Warning Score tool. The system encourages proactive monitoring, enabling health professionals to identify deteriorating patients quickly then guide them to an appropriate escalation route required. They are also able to communicate observations across organisations robustly, resulting in improved quality of care, outcomes and better response times. The training is designed to upskill and develop the workforce regardless of ability, by encouraging proactive monitoring and linking with specialist nurses.

Southend University Hospital FT
Acute kidney Injury Policy and Specialist Nurse

The team developed a simple, consistent and sustainable approach to an electronic Acute kidney Injury (AKI) alert. The overarching ambition of the project was to reduce deterioration in AKI by 20% over two years and also reduction in length of stay and mortality. An "AKI clinical nurse specialist," was appointed from initial data. The role included engaging frontline staff and driving organisational change towards improved AKI management for improved patient safety. They showed a reduction in length of stay, from 14 days to 10 days; and 30-day mortality from 30% to 20%, amounting to cost savings of 1.19 million/year.

West London Trust
Taking Safety Huddles the Extra Mile: Windrush Ward

West London NHS Trust (WLT) in partnership with Imperial Collage Health Partners took a QI approach to testing and evaluating safety huddles in mental health inpatient settings. The project aimed to test the introduction of multi-disciplinary safety huddles into daily ward practice and measure impact on locally identified harms, teamwork, communication and safety culture. In February 2019 Windrush ward had been locally identified as a 'struggling ward'. In the past 12 months Windrush Team have used the opportunity of the Safety Huddles project and QI approach to proactively review and develop a safe ward culture. Windrush Ward has transformed to a safer more enjoyable place to work and be cared for, through testing new ways of work, demonstrating excellent leadership and team commitment to learning.

Thank you to our partners

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BD

Key Partner

General Medical Council

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