Safer Patients Initiative

Background

The Safer Patient Initiative is funded for twenty months by the Health Foundation, and is delivered by The Institute for Healthcare Improvement (IHI). The projects began in February 2007 and will complete in December 2008. Antrim Area and Causeway Hospitals are working as a ‘couplet’ for the duration of the Initiative to seek to enhance their patient safety cultures and enhance the patients’ experience of care. Work is led by five Pilot Teams in key areas that have a significant impact on patient safety. These include Critical Care, Medicines Management, Peri-operative Care, General Wards and Leadership, however the initiative will be spread to the entire hospital.

How it works

SPI is a structured process for both identifying patient safety and quality issues within an organisation and for addressing them. It is an initiative that seeks to enhance the culture of an organisation by focusing on improving quality and value within processes. This can be achieved through engaging and empowering staff to design and make improvements.

There are two key inter-related tools within the SPI process:

Small-scale tests of change

Teams use ‘small-scale tests of change’ to analyse current processes and practices and to seek to identify practical solutions and improvements. It is then hoped to spread those

Consistent programme of measurement

The second element of the initiative involves the measurement of a range of key ‘outcomes’ or ‘processes’. Ultimately the measurement programme is in place to identify the success of the Initiative against the aims that have been set by IHI, and the improvements that have been made in respect of key issues like infection rates and mortality.

The Measurement Programme

IHI have set specific aims to be achieved by all participating Trusts within the two years of the Initiative. These aims include:

- Mortality - 15% reduction;
- Adverse Events - 30% reduction;
- MRSA Bloodstream Infection - 50% reduction;
- Crash Calls - 30% reduction; and
- Medicines Reconciliation to ensure each patient has an accurate medication history listed.

To help address these and the other SPI aims, IHI have set forty-two specific measures for the Initiative that have been spread across the five areas and will spread throughout both hospitals.

Leadership Walkround is another core component within the Safer Patients Initiative.

Exemplar patient safety organisations are those that are able to:

- achieve a dramatic 50% reduction in adverse events
- demonstrate a system of leadership that reflects safety as a strategic priority throughout the organisational structure and takes responsibility for spreading improvement throughout the organisation and beyond
- adopt leadership roles that provide guidance and support, removing barriers and developing people to improve patient safety practices
- conduct thorough and ongoing assessments of organisational safety and act on those assessments
- establish a measurement system that reflects current safety performance
- create a culture that puts patient safety at the centre of everything they do
- demonstrate competence and capability in improvement methodologies
- spread knowledge and expertise

The aims of the walkrounds

1. Increase the awareness of safety issues among all clinicians
2. Make safety a priority for senior leaders by spending a dedicated time promoting a safety culture
3. Educate staff about patient safety concepts such as incident reporting
4. Obtain and act on information gathered that identifies areas for improvement.
Who is involved?
Staff and members of the Senior Management Team will visit each area accompanied by the SPI lead and a scribe to record key issues discussed.

Where does the walkround take place?
Walkrounds will be held on all wards and departments within Antrim Area and Causeway Hospitals. The Senior Management Team and staff can meet and hold the discussions in any area that suits the ward or department. This may be in the patient areas or in a quiet room within the main clinical area.

What happens at the walkround?
A member of the walkround team will explain and introduce the process including the rules for confidentiality, anonymity, and patient safety disclosures. Members of the walkround team will then ask a series of structured questions. All staff participating are encouraged to respond and have their responses recorded.

What we will discuss together:
- Your key patient safety concerns
- What can we do together to improve?
- Teamwork - how do your local teams operate?
- Communication
- How can leadership help?
- Incident reporting

At the end of the process we will agree at least 3 key actions to be taken forward to make the area safer for patients.

What will happen to the information we gather?
We will respond to the local team within 72 hours, highlighting the main areas discussed and actions to be undertaken.

For further information contact

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