Blackpool Teaching Hospitals

Sign Up To Safety

Implementation Plan

31st December 2014
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1. Introduction
Sign Up To Safety (SUTS) is a national campaign and unified programme for patient safety across the NHS in England. It is chaired by Sir David Dalton, with partnership from CQC, Monitor, NHS England / NHS IQ, DH, NHS LA, HEE and NTDA and Chairs of a variety of safety groups. Dr Suzette Woodward (CEO NHSLA) is Programme Director.

The aim of the programme is to reduce avoidable harm by half and save 6000 lives over the next 3 years, and to sustain the improvement over the following 3 years, whilst continuing the focus and drive on safety improvements.

The campaign is part of a wider Patient Safety Programme as detailed below.

As part of the campaign, the NHSLA has pledged to support those organisations who have patient safety improvement plans which demonstrate a reduction in their higher volume, higher value claims.

Trusts participating have made 5 key safety pledges and will be working with CCG’s, AHSN’s, Health Foundation, NHS England and regulatory bodies to develop and embed safety initiatives to improve patient outcome and experience.

Blackpool Teaching Hospitals NHS Foundation Trust (BTH) is committed to delivering consistently safe care and to taking action to reduce harm to patients in our care and protecting the most vulnerable.

2. BTH Safety Pledges
1. Put safety first. Commit to reduce avoidable harm in the NHS by half and make public our goals and plans developed locally.

Blackpool Teaching Hospitals NHS Foundation Trusts main strategic objective is to provide safe, high quality and patient centred care. We will deliver this through:

- Promote a ‘Be Safe-Together We Care’ Campaign to support and engage patients and their carers to be fully involved in ensuring their safety by:
  - Asking about their treatment
  - Listening to their concerns
  - Supporting them to have the courage to challenge practice and behaviours
  - Recognise their role in being safe
• Delivering our Strategic Quality Goals of:
  o Zero harms
  o Zero delays
  o Zero inappropriate admissions
  o All patients and carers involved in decisions about their care
  o Compliance with clinical pathways

• Improving our Staffing establishments:
  o We believe it is important to inform both staff and the public our staffing levels to give confidence that we recognise the link between safe patient care and ideal levels of staff who are skilled, motivated, compassionate and competent.
  o We already display, at ward level, staffing information and are working towards a robust method of recording staffing levels shift by shift on a daily basis.

2. **Continually learn.** Make our organisation more resilient to risks, by acting on the feedback from patients and by constantly measuring and monitoring how safe our services are.

Blackpool Teaching Hospitals NHS Foundation Trust aims to continually learn from our incidents, complaints, staff and patient satisfaction surveys and direct feedback.

  o We will publish a series of patient outcomes and staff and patient feedback on a monthly basis through our ‘Open and Honest Care’ project.
  o This information, along with lessons learned from incidents, will support clinical divisions to drive safety improvements.

3. **Honesty.** Be transparent with people about our progress to tackle patient safety issues and support staff to be candid with patients and their families if something goes wrong.

  o Blackpool Teaching Hospitals NHS Foundation Trusts will implement duty of candour to promote a culture of openness and transparency.
  o We will also review how we use data to provide board assurance through the development of an integrated board report, which will also give the general public access about our performance on a range of key activities.

4. **Collaborate.** Take a leading role in supporting local collaborative learning, so that improvements are made across all of the local services that patients use.

  o BTH are committed to continuing to work collaboratively with all key stakeholders to deliver our strategy of ‘together we care’ across our integrated services.
  o We will also continue to work with national and local partners and organisations to drive forward improvement through patient programmes.
5. **Support.** Help people understand why things go wrong and how to put them right. Give staff the time and support to improve and celebrate the progress.

   - Blackpool Teaching Hospitals NHS Foundation Trust will support our staff to have a can do attitude that will provide a positive staff and patient experience.
   - We will continue to roll out our patient revolution programme and talksafe initiative to support staff to challenge poor practice, support each other and celebrate success.
   - We will also continue to develop our staff through the talent management scheme and support them with access to effective coaching, mentoring and preceptorship to equip them to lead the safety agenda.
   - We will invest in training our staff in core features of human factors to organisationally embrace a safety culture.
   - We will also provide a robust staff wellbeing service to ensure staff are supported through their involvement in traumatic and stressful incidents, complaints or claims.

3. **Key Focus Areas**

   The Trust has identified that its key focus of safety will cover the following areas:
   - Falls
   - Pressure Ulcers.
   - Clinical Pathways
   - Care of the deteriorating patient

   The areas of focus have been identified due to each being noted as:
   - A risk that impacts on patient safety and experience
   - Directly or indirectly linked to litigation claims against the organisation
   - Supporting the delivery of the Trust Strategy, including the Vision and Quality Goals to provide integrated high quality, safe care (Appendix 1)
   - Supporting the delivery of the Trust values as outlined in the Trust Strategy
   - Supporting delivery of the Trust Compassionate Care Strategy 2013-16 (Appendix 2)
   - Supporting the delivery of the Trust’s pledges of SUTS
   - Supporting the delivery of CQC standards for providing care that is safe, effective, caring, responsive to people’s needs and well-led
   - Delivering the Trust’s action plans following the Keogh Review and CQC Inspection

   Work within these areas of focus is already on going within the Trust and links to the Trust’s Strategy and Quality goals, it is therefore anticipated that this work will continue and be built on as part of the SUSTS campaign via the following work streams:
   - Care of the Critically Ill Patient / Mortality reviews
   - Pressure Ulcer Prevention
   - Falls Prevention
   - Better Care Now – Clinical Pathways

   The work of the SUSTS campaign will be further complimented through the work of the remaining work streams associated with the Better Care Now project ‘reducing delays’ and ‘avoiding readmissions’ and the overall campaign will be underpinned and supported by the education of staff via the established Talk Safe Programme and liaison with the Health Professionals Education Centre and NW Deanery.
This document details how the SUTS campaign will be managed within the organisation and pulls on experiences and lessons learned from previous project implementation and staff engagement. In line with Keogh recommendations, it is not envisaged that this campaign generates additional work to that already identified within the Trust priorities, rather that it builds on existing and ongoing quality and safety work in line with the Trust Strategy and Quality Goals. The progress implementing the Safety Improvement Plan will be regularly reviewed and the Safety Improvement Plan will be updated accordingly. The Safety Improvement Plan will follow the 90 day cycle supported by NHS England’s Sign Up To Safety campaign. Appendix 3 outlines the proposed actions for the first 90 day cycle, Appendix 4 identifies the work stream reporting structure and the 2nd 90 day actions for the work streams.

4. Trust Board Engagement
The SUTS Campaign at BTH is supported by the Trust Board, and has identified The Director of Nursing, Marie Thompson and the Medical Director, Professor Mark O’Donnell as Executive sponsors. Trust Safety Leads have also been identified. The Board has committed to turn our implementation plan into reality to support our drive to improve patient safety. The executive sponsors and safety leads will lead the implementation and monitoring of the Safety Improvement Plan, supported by a Safety Improvement Project Group.

5. The Safety Improvement Project Group
The Safety Improvement Project Group will bring together and coordinate all aspects of the Safety Improvement Plan through active involvement and engagement of staff, patients and healthcare partners. Each area of focus will have a work stream, led by a senior member of staff within the Trust who will sit on the Project Group. They in turn will identify key stakeholders to form part of the work stream group to develop and support the work, initiatives and subsequent implementation within clinical areas.

Enclosed within this document in appendix 5, 6, 7 and 8, are driver diagrams and change packages that identify the drivers for the change we are aiming to achieve, the supporting rationale and measures. Each work stream will use these driver diagrams and change packages to develop localised action plans to meet individual clinical areas needs and support them through a process of staff and patient engagement and improvement in safety.

6. Patient engagement
The Patient Experience Team will be an integral part of the Project Group, seeking to involve patients and the wider public community in delivering the Improvement Plan. BTH proactively seeks to drive improvement through lessons by systematically reviewing care following investigations of incidents, claims, complaint and mortality reviews. Lessons learnt are shared by disseminating through the Divisional governance structures. Patient stories will be used in the programme to enhance learning across the organisation and keep the patient as the primary focus for all staff. It is envisaged that patient representation on all work streams will further support patient engagement and the patient voice in ongoing safety initiatives.
7. **Staff Education**
The Trust has implemented a Talk Safe programme in conjunction with the Learning and Development Department and Health Professional Education Team. This training focuses on enabling cultural and behavioural change through leadership and learning and individual and ‘community’ engagement to support the development and implementation of a safe culture, working and caring environment. Our staff are encouraged to challenge practice to make a difference and improve our safety culture through conversations based on a coaching approach.

Our overall Sign Up To Safety Campaign will be underpinned and supported by the Talk Safe Programme and the team delivering and facilitating this training will be represented on the Project Group.

8. **Communication Plan**
The Trust Communications Team will be engaged to help develop a communications strategy to support the Safety Improvement Plan, ensuring that staff, patients and the public are kept informed of our aims and the progress of implementing the Safety Improvement Plan. Details of our work will be provided on a dedicated page on the Trusts intranet, patients and public will be able to view this information on the internet site. The outcomes of our Safety Improvement Plan will be reviewed and details will be provided annually in the Trust’s Quality Account.

9. **Organisational and Staff Capability**
BTH is developing a network of Patient Safety Champions in clinical areas at every level throughout the organisation. This work will build on the existing ‘link nurse’ network, and align with staff education and competency needs to ensure the Patient Safety Champions have the necessary skills to drive improvement in quality and safety forward. Through collaborative working with the Learning & Development Department, the NW Deanery and the Health Professionals Education Centre, we will ensure staff patient safety knowledge skills are developed through training in keys aspects of patient safety such as the established Talk Safe Programme and Human Factors awareness. External educational needs will be met through collaboration with local universities, Academic Health Sciences Network and AqUA. We will also support the education and engagement of student nurses by supporting and encouraging them to undertake Student Quality Ambassador roles within our organisation and linking this to the established internal student nurse education programme.

9. **NHS LA application**
Blackpool Teaching Hospitals NHS Foundation Trust would like to be considered for the NHS LA incentive. The application can be found in Appendix 9.
## Appendix 1 – Trust Strategy

### Strategy for 2020 – Integrated care services that are safe, effective and caring

#### Blackpool Teaching Hospitals

#### Values
- People-centred - serving people is the focus of everything we do
- Excellence - continually striving to provide the best care possible
- Compassion - always demonstrating we care
- Positive - having a can do response whatever the situation

#### Quality goals
- All patients and carers involved in decisions about their care
- Zero inappropriate admissions
- Zero harms
- Zero delays
- Compliance with standard pathways

#### Strategic Objectives
- To provide an holistic model of care, with treatment undertaken in community settings wherever possible.
- To prevent unnecessary emergency admissions to hospital through delivery of new service models that provide enhanced support in community settings and integrated care for the most needy and frail patients.
- To provide safe, high quality and patient-centred care, using evidence-based pathways to deliver standardised approaches to care with positive outcomes.
- To be financially viable, managing services within available resources, allowing us to invest in our future.
- To support and develop a skilled, motivated and flexible workforce that is able to innovate in the development of our services.

<table>
<thead>
<tr>
<th>7-day services where required</th>
<th>Community-centred care</th>
<th>In-hospital care</th>
<th>Lancashire partnerships</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Urgent and emergency care</strong></td>
<td>Enhanced integration of community and acute services - attendance at A&amp;E and/or admission to an inpatient ward is only when necessary</td>
<td>Attendances at the acute hospital streamed into true ‘accident or emergency’ / minor injury / requires longer assessment</td>
<td>Major trauma to be treated at a specialist centre based at Lancashire Teaching Hospitals NHS Foundation Trust</td>
</tr>
<tr>
<td>Minimise the demand for true urgent and emergency care services by predicting demand and planning the care that is required.</td>
<td>Urgent Care Centres / Minor Injury Units in the North, Central and South of the region that will accept self-presentation and ambulance arrivals</td>
<td>Use of a Clinical Decision Unit to allow rapid assessment by experienced, multi-specialty clinicians</td>
<td>Partnership working for provision of stroke services.</td>
</tr>
<tr>
<td><strong>Frail elderly and long term conditions</strong></td>
<td>Enhanced Primary Care – patients managed by a GP-led multi-disciplinary team</td>
<td>Standardised care pathways across the treatment, recovery and rehabilitation stages.</td>
<td>Improved integration of health, social and voluntary sector providers to support care models such as End of Life and mental health</td>
</tr>
<tr>
<td>A holistic health and social care system providing coordinated care for the most needy and frail patients</td>
<td>Extensive services – elderly patients and/or those with multiple LTCs, managed by a generalist-led multi-disciplinary team</td>
<td>Elderly patients to be managed in a dedicated frail elderly unit, with a named clinician responsible for their care</td>
<td></td>
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<tr>
<td>Continuous, proactive management in place of reactive, episodic care</td>
<td>Step-up / down beds in the community</td>
<td>Centralised rehabilitation services</td>
<td></td>
</tr>
<tr>
<td><strong>Planned care</strong></td>
<td>Use of telehealth to enable remote monitoring and increase self care.</td>
<td>Efficient use of resources in operating theatres and diagnostic services.</td>
<td>Provision of tertiary care services.</td>
</tr>
<tr>
<td>Standardised care pathways across treatment, recovery and rehabilitation stages</td>
<td></td>
<td>Centralised rehabilitation services</td>
<td>Federation of services across providers in Lancashire, with decisions based on quality of care and cost effectiveness.</td>
</tr>
<tr>
<td><strong>Ambulatory care centres providing treatment regimes and minor surgical procedures</strong></td>
<td>Referral criteria for all procedures, with ‘readiness for surgery’ to be managed in primary / community care including ‘prehabilitation’ to support timely discharge from acute care</td>
<td></td>
<td>Partnership working for provision of vascular services.</td>
</tr>
<tr>
<td>‘One-stop’ outpatient services integrated with pre-admission</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Children and families</strong></td>
<td>Multi-disciplinary teams supporting child development and families with complex needs</td>
<td>Increased use of midwifery-led services for birthing</td>
<td>Partnership working with local authorities and the voluntary sector to support services such as safeguarding and school nursing</td>
</tr>
<tr>
<td>Full integration to provide holistic services around the patient with harmonised pathways across the region</td>
<td>Participation in the Head Start and Better Start Projects, supporting children, adolescents and families from deprived areas with physical and mental health and well-being.</td>
<td>Development of a complex pregnancy suite to support women with mental health issues and their families</td>
<td></td>
</tr>
</tbody>
</table>

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Our Values

People Centred
- Serving people is the focus of everything we do

Excellence
- Continually striving to provide the best care possible

Compassion
- Always demonstrating we care

Positive
- Having a can do response whatever the situation

The Trust Way
“Creating a Great and Safe Place to Work”
Appendix 2 – Trust Compassionate Care Strategy 2013-2016

Compassionate Care Strategy
2013 - 2016

Our Vision
Nurses, Midwives, Health Visitors and Therapists will provide high standards of care to our patients and families within a culture of compassionate and safe care.

Executive Summary
This three year strategy sets out a professional direction for Nurses, Midwifes, Health Visitors and Therapists and also reflects our local adoption of the Chief Nursing Officer, NHS England Strategy – ‘Our Culture of Compassionate Care’.

During 2013 colleagues have been involved in the development of the Compassionate Care Strategy through conversation and workshops and this has been important time to ensure that this strategy reflects our shared ambitions to develop and improve care for our patients.

“Despite the challenges the organisation and the wider NHS is experiencing I firmly believe that the collective energy, will and drive of our professions can make a real difference in influencing future care and service models for our patients. We have a great opportunity to lead to ensure that we realise our vision.”

Marie Thompson, Executive Director of Nursing and Quality

The Blackpool Context
Colleagues from Nursing and Therapies have reviewed the National Strategy ‘Compassionate Care’ and the findings of the Francis Public Inquiry Report (Feb 2013) to determine the strategic priorities for our professions.

Our Compassionate Care Strategy also links directly to the delivery of the Trusts Strategic Aims:

Zero Delays
Zero Inappropriate Admissions
100% Patients and Carers involved in decisions about their care
100% Compliance with Agreed Pathway
Zero Patient Harms
The delivery of compassionate and safe care is driven by a shared and ‘common’ set of values that all staff can identify with and ensure they role model in day to day practice.

**BTH Trust Values**

**Six C’s**

![Six C's Image]

- **People Centred**
  - Serving people is the focus of everything we do

- **Excellence**
  - Continually striving to provide the best care possible

- **Compassion**
  - Always demonstrating we care

- **Positive**
  - Having a can do response whatever the situation

**Our ‘Call to action’ – Compassionate and safe care**

**Patient Safety**

![Picture of Patient Safety]

- **Reducing Avoidable Harms to deliver Harm Free Care**

**Ambitions:**

Our Patients and their families will experience care from Nurses, Midwives and Therapists who are collectively focused on reducing harm from Pressure Ulcers, Patient Falls and VTE.

Whilst these areas of harm reduction will direct our improvement efforts they do not prevent us from working together on other aspects of patient safety.

**Patient Experience**

![Picture of Patient Experience]

- **Patients and carers are involved in decisions about their care**

**Ambitions:**

We will seek to better understand our patient and carers experience of care through a greater variety of patient feedback such as the Friends and Family Test, Local patient surveys, learning from patient complaints and through hearing our patient stories. Feedback from patients and carers is a powerful resource to help us reflect and look at how we can improve the care and service we provide.

As professionals we will provide strong patient advocacy through empowered practice.

We will also look at new ways working with our patients through the adoption of shared decision making and greater use of expert patient approaches and where possible based on best available evidence.
Clinical Quality

⇒ Patients and Carers receive high standards of care

Ambitions: We will continue to implement and develop care metrics that support real time data and feedback to focus our quality improvement priorities. As a transparent and open professional workforce we will publish our performance within all of our clinical environments.

Leadership

⇒ All staff are supported to develop their leadership potential

Ambitions: We will support our clinical staff to lead within the framework of the 6C’s and in congruence with our organisational leadership behaviours.

We will all strive to provide leadership that guides us to explore and develop new ways of working which in turn supports the Trust clinical direction to provide more care closer to the patient’s home.

Leaders will create an environment that supports Openness, transparency and candour.

Workforce and Education

⇒ Ensuring care is delivered in a safe environment with the appropriate level of staff resource including knowledge and skills

Ambitions: All of our clinical environments will have safe staffing levels and appropriate skill mix through the utilisation of available evidence and continuous review.

All staff will support their colleagues in providing a working environment that supports the development of their clinical career and also identifies the Trust as a great place to work for Nurses, Midwives, Health Visitors and Therapists’

We will provide education and training that supports the quality and safety of care delivery and also helps embed the 6C’s within our day to day business of caring for patients.

We will support new role development and also staff who are new in their post to develop their confidence and competence leading to a successful clinical career with our Trust.

To provide excellent learning environments and to support and develop our students as our future workforce.

To be open to and innovative in the development of new roles that will support the shift of care out of hospital into community and closer to our patient’s home.
Care

Care is our core business and that of our organisations and the care we deliver helps the individual person and improves the health of the whole community. Caring defines us and our work. People receiving care expect it to be right for them consistently throughout every stage of their life.

In consultation with our staff care was seen as integral and essential part of their role. The patient is always the focus and their best interest is always the rationale for whatever care is required. Care is delivered in the most appropriate way at the appropriate time with the patient’s and their loved one’s full knowledge and consent. Good care is open, considerate, and confident and embraces the full needs of the patient and their family.

During the consultation staff felt that the role of the leader in promoting a caring environment was essential and that they have the ability to develop the talent and support those individuals who can make a positive difference to organisational performance and drive improvements in patient care.

Commitment

A commitment to our patients and populations is a cornerstone of what we do. We need to build on our commitment to improve the care and experience of our patients. We need to take action to make this vision and strategy a reality for all and meet the health and social care challenges ahead.

Consultation with our staff recognised that hospital is not where most patients wanted to be, but wherever were cared for they wanted to receive the right care for them. As a team of nursing and Allied Health professionals we identified that every contact counted and in order to deliver high quality care we must measure outcomes to drive evidence based improvement. We can achieve this locally by ensuring clinical leaders support their teams. To plan and deliver individualised care to recognised best practice standards and share improvements across all healthcare settings.
Communication
Communication is central to successful caring relationships and to effective team working. Listening is as important as what we say and do. It is essential for ‘no decision about me without me’. Communication is the key to a good workplace with benefits for those in our care and alike.

During our consultation with staff in developing our strategy all staff recognised the importance of good communication. Staff are committed to continuously improving communication with patients and carers but also acknowledge that our communication with each other can be a challenge – we need to communicate better with each other through the use of available resources such as networking, use of technology and social media.

Compassion
Compassion is how care is given through relationships based on empathy, respect and dignity. It can also be described as intelligent kindness and is central to how people receive their care.

Across our organisation compassion means lots of things to all of us. Staff deliver services every day with dignity, respect and empathy, where this is not done we need to ensure we challenge our colleagues to ensure the care we all deliver to our patients is compassionate and meets their individual emotional needs.

Competence
Competence means all those in caring roles must have the ability to understand an individual’s health and social needs. It is also about having the expertise, clinical and technical knowledge to deliver effective care and treatments based on research and evidence.

When asked locally, staff in the organisation defined competence as ‘having the right person, with the right skills, in the right place, at the right time’. To ensure that the care we give is clearly documented and communicated effectively. In order for competence to flourish, we need confidence in what we are doing and in those around us. This can be achieved locally by ensuring clinical leaders support and develop staff within a changing health care environment. Most importantly we need our patients and public to have confidence in us, in our competence to deliver safe and high quality care.

Courage
Courage enables us to do the right thing for the people we care for, to speak up when we have concerns. It means we have the personal strength and vision to innovate and to embrace new ways of working.

Feedback from our clinical leaders within the organisation viewed courage as having two dimensions. Firstly a focus on speaking up and sometimes having to have difficult conversations. We need to challenge occurrences of poor care and advocate for those who cannot speak for themselves. We strive to develop a culture where whistle blowing is supported but we all need to be leaders who listen, are responsive and act appropriately to concerns raised. Our Talk Safe programme will help us on our journey to ensure patient safety but also to be courageous.
Compassionate Care Strategy 2013-2016

VISION - Nurses, Midwives, Health Visitors and Therapists will provide high standards of care to our patients and families within a culture of compassionate and safe care.

- Care
- Compassion
- Competence
- Courage
- Communication
- Commitment

Strategic Quality Goals 2020

Year 2 Actions

Patient Experience
- Friends & Families
- Test Expansion
- Shared Decision
- Making Expansion
- Awareness of Complaints Process
- Shadowing our Patients Journey

Patient Safety
- Achieve our Zero Harms Goals
- Pressure Ulcers
- Falls
- Medication Errors
- Improve Infection Prevention Standards
- MRSA Pathway Compliance
- CPE Policy Compliance
- Hand Hygiene Compliance
- Improve Safety
- Thermometer - Maternity Services

Clinical Quality
- Dementia Care Improvements
- Review & Expand Nursing Care Indicators
- Develop Therapy Care Indicators
- Improve Record Keeping

Leadership
- Role Model the 6C’s & Embed the Trust Values
- People Centered Compassion
- Positive Excellence
- Team Leader & Ward Leader Development

Workforce & Education
- Staffing Levels
- Reviews & Monitoring Patients Acuity
- Prepare for NMC Revalidation
- Pre-Registration Engagement
- Development of a Flexible Workforce
## Appendix 4 – Work stream Structure and 2nd 90 days actions for the work streams

<table>
<thead>
<tr>
<th>Workstream</th>
<th>Goal</th>
<th>What Action is required in the next 90 days?</th>
<th>Lead</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Falls</td>
<td>Reduce the number of falls resulting in harm by 20% by March 2017 from our 2015 baseline</td>
<td>Develop detail in Driver Diagrams Discuss at Falls steering group Explain process for use to ward / locality representatives to develop local plans for improvement Feedback to SUTS Board and link to communication strategy</td>
<td>Tracy Burrell &amp; Sue Jones</td>
</tr>
<tr>
<td>2A Failure to Rescue - Care of the deteriorating patient (General)</td>
<td>By March 2017 we will reduce avoidable harm caused by failure to rescue or failure to recognise the deteriorating patient 50% from our 2015 baseline of ‘Failure to Rescue’ 2222 calls</td>
<td>Develop detail in Driver Diagrams Discuss at Care of the Critically Ill Patient Committee Develop action plan for driving improvement Feedback to SUTS Board and link to communication strategy</td>
<td>Louise Kippax-Davis &amp; Dr Jason Cuppitt</td>
</tr>
<tr>
<td>2B Failure to Rescue - Care of the deteriorating patient (Maternity)</td>
<td>Ensure compliance with NICE intrapartum guidance and the sepsis pathway</td>
<td>Develop detail in Driver Diagrams Discuss at Maternal Sepsis and Abnormal CTG Group Develop action plan for driving improvement Feedback to SUTS Board and link to communication strategy</td>
<td>Louise Dowell</td>
</tr>
<tr>
<td>3 Pressure Ulcers</td>
<td>By March 2017 we will reduce avoidable harm caused by trust attributable pressure ulcers by</td>
<td>Develop detail in Driver Diagrams Discuss at Pressure Ulcer Steering Group Explain process for use to ward / locality representatives to develop local plans for improvement Feedback to SUTS Board and link to communication strategy</td>
<td>Tracy Burrell &amp; Sue Jones</td>
</tr>
<tr>
<td>4 Clinical Pathways</td>
<td>Improve mortality and prevent delays in treatment through AKI and Sepsis Clinical Pathways Compliance. Targets for 2015/16: Sepsis 40% AKI 50%</td>
<td>Review progress to date Agree at Mortality Board the next high mortality pathway Develop next pathway for launch after March Conduct baseline audit Re-invigorate existing pathways during winter hiatus Feedback to SUTS Board and link to communication strategy</td>
<td>Dr Nigel Randal &amp; Tracy Burrell</td>
</tr>
</tbody>
</table>
Appendix 5 – Falls Driver Diagram and Change Package

Reducing Falls
Driver Diagram & Change Package
V3.0

Author: Tracy Burrell, Assistant Director of Nursing, Quality & Safety
Background
Patient falls are one of the most common patient safety incidents reported. The majority of slips, trips and falls result in low or no harm to patients physically. However, any slip, trip or fall can result in the patient losing their confidence. There have been significant improvements within all areas of the Trust in reducing the numbers of falls over the last few years and a number of initiatives introduced during 2013/14 to promote the reduction in falls resulting in harm.
In line with the continuing improvement drive and to support the delivery of the Trust Strategic Framework, one of the Trust Quality Goals has been identified as reducing patient harms as a result of a fall. This driver diagram sets out how we aim to achieve this.

Purpose of the Change Package
This change package has been adapted from the 1000 lives campaign. It identifies and establishes recommended interventions which have been proven to collectively bring about improvements in falls prevention. The package illustrates what interventions wards and departments should consider in order to improve falls as part of a whole system of care.

Aim
Work to reduce patient harm due to falls and the associated risks, will be managed by the Falls Prevention Steering Group, which is multi-disciplinary and includes, CCG, Medical, neighbouring Trust, voluntary agency and LCC representation.
The aim of the work stream addressing Falls Prevention is to:
- Reduce the number of falls resulting in harm by 20% by March 2017 from our 2015 baseline

Key objectives
- Ensure safe admission and care planning for patients based on their identified risk factors
- Promote patient safety through effective implementation of intentional rounding
- Promote effective communication through collaborative working of the wider multidisciplinary team
- Learn lessons from Incident Reporting / RCA’s / and disseminate through Divisional Governance structures
- Promote the safe discharge and Rehabilitation of patients post fall through ensuring services required are identified and developed in line with health needs of the population
- Development of a Whole Health Economy falls pathway (including voluntary services / NWAS / LCC)
There are three distinct parts to this package; Driver Diagram, Change Concepts and Ideas and Measures.
The driver diagram describes the elements that need to be in place to achieve an improvement. It assists in focussing on the cause and effect relationships that can exist in complex situations, such as falls prevention.
The primary drivers are high level ideas that if implemented, will achieve the improvement aim. The best way of implementing primary drivers is to identify a series of actions (secondary drivers) which, when undertaken, will contribute to the primary drivers and in turn the aim.
A change concept is a general notion or an approach to improving an aspect of care. A change idea is an action which is expressed as a specific example of how a particular change concept can be applied in real life.

Also included in this package is a series of different measures; process, outcome and balancing measures. These measures are important as we need to know if the changes we are making are an improvement. In order to determine this we need to identify a defined process (such as compliance with elements of a care bundle) which is linked to an outcome (such as a reduction in the number of hospital falls). Both process and outcome which are linked are essential to evaluate the effectiveness of change.
Balancing measures are designed to identify the impact (positive or negative) of your improvement work and interventions on other parts of the care system.

**How to use this Change Package**
Using the rapid spread methodology Ward Managers are encouraged, with their teams, to review the change package to determine:

- What practices might already be in place in their area and decide if further work is needed.
- Identify and prioritise the changes the team will undertake, and determine what improvements these changes will lead to.
- What other changes may be required at a later date.
- Identify any barriers that may impede change and work with the Divisional Management Team to remove the barriers.
Outcome
Reduce the number of falls resulting in harm by 20% by March 2017 from our 2015 baseline

Driver Diagram
Primary Driver

Safe Patient Care

Leadership & Education

Compliance with NICE guidance

Secondary Driver

- Falls Steering Group Work Stream
- Safe admission and care planning for patients based on risk factors
- Effective implementation of intentional rounding
- Effective communication
- Incident Reporting / RCA’s / Disseminating lessons learned
- Safe discharge / Rehabilitation
- Whole Health Economy falls pathway (including voluntary services / NWAS / LCC)

- Improved Staff education
- Improved Patient and family/carer education
- Bespoke Leadership Programme

- Accurate GAP analysis
- Identification of best practice standards
- Implementation of Best Practice Guidance
<table>
<thead>
<tr>
<th>Primary Driver</th>
<th>Secondary Driver</th>
<th>Key Change Concept / Change Idea</th>
</tr>
</thead>
</table>
| Safe Patient Care | Falls Steering Group Work Stream  
Safe admission and care planning for patients based on risk factors  
Effective implementation of intentional rounding  
Effective communication  
Incident Reporting / RCA’s / Disseminating lessons learned  
Safe discharge / Rehabilitation  
Whole Health Economy falls pathway (including voluntary services / NWAS / LCC) | Assess falls risk within 6 hours of admission/transfer and re-assess daily / when change in condition  
Communicate risk status to patient and staff  
Utilise safety handovers / SBAR Approach / Safety Huddles.  
Engage with multidisciplinary team and develop a shared plan of care based on patient need.  
Monitor compliance with – SKIN Care Bundle, - SAS Tool  
Identify Ward level targets.  
Consider feasibility of visual communication processes to identify at risk patients.  
Develop monthly reporting process to identify patient harms, incorporating falls to focus areas for improvement.  
Promote Incident Reporting / RCA’s when a fall occurs to learn lessons and improve care  
Use of falls alarms as needed.  
Ensure mobility aids are within reach for patient.  
Ensure clinical and bed areas are de-cluttered to promote a safe environment.  
Ensure footwear of patient is appropriate and safe.  
Ensure home environment is safe from hazards.  
Ensure advice given is documented.  
Initiate and maintain correct use of equipment  
Utilise local and specialist nursing experience  
Work in partnership with patients, their family, voluntary and the multi-disciplinary team members to improve the quality of falls prevention care provided to patients  
Know how to refer the patient for falls rehabilitation  
Develop and implement process for post falls review  
Review patient communication in A&E department relating to potential fractures / orthopaedic follow up process  
Identify representation as stakeholder on work stream group |
| Leadership & Education | Improved Staff education  
Improved Patient and family/carer education  
Bespoke Leadership Programme | Ensure the skills, knowledge and competency of your team are up to date.  
Utilise formal and informal learning opportunities to educate your teams about falls prevention.  
Use patient stories to educate, motivate and inspire staff. (Hearts & Minds).  
Provide patients and relatives with information on the risks of falls on admission/transfer or when there is a change in their condition that puts them at risk.  
Educate patients and families how they can help to minimise falls risk whilst in hospital, at home, where relevant.  
Work with patients and families as co-partners in their care.  
Develop falls prevention workbook for staff  
Educate staff, patients on falls risk and prevention. |
<table>
<thead>
<tr>
<th>NICE Compliance</th>
<th>Identify staff leadership requirements within leadership programme</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Accurate GAP analysis</td>
</tr>
<tr>
<td></td>
<td>• Identify Best Practice Guidance</td>
</tr>
<tr>
<td></td>
<td>• Implement Best Practice Guidance</td>
</tr>
<tr>
<td></td>
<td>• Undertake GAP Analysis.</td>
</tr>
<tr>
<td></td>
<td>• Develop action plan to address gaps and implement – monitored by Falls Steering Group</td>
</tr>
<tr>
<td></td>
<td>• Consider Whole Health economy Pathway</td>
</tr>
<tr>
<td></td>
<td>• Collaborative working with CCG’s / LCC / NWAS / Voluntary Agencies</td>
</tr>
</tbody>
</table>
# Measurement Plan

<table>
<thead>
<tr>
<th>Measure Name</th>
<th>Compliance with signed and dated falls risk assessment on admission / transfer / first visit or when condition changes.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measure Type</td>
<td>Process (Percentage)</td>
</tr>
<tr>
<td>Measure description</td>
<td>% compliance with falls risk assessment / skin examination on admission / transfer or when condition changes.</td>
</tr>
<tr>
<td>Numerator</td>
<td>Number of patients who had a signed and dated falls risk assessment / 6 hours of admission / transfer.</td>
</tr>
<tr>
<td>Denominator</td>
<td>50% of all patients on each ward if patient numbers ≥20. (if patient numbers ≤20  use 10 patients as denominator, if patient numbers ≤10 use all patients as denominator) 10 patients per base</td>
</tr>
<tr>
<td>Sampling Plan</td>
<td>To collect this measure, randomly sample the correct number of patients according to the denominator o a monthly basis and identify from these records how many patients had a signed and dated falls risk assessment completed within 6 hours of admission / transfer.</td>
</tr>
<tr>
<td>Reporting Frequency</td>
<td>Monthly via Nursing Care Indicators</td>
</tr>
<tr>
<td>Numeric Goal</td>
<td>› 95% compliance with signed and dated falls risk assessment / on admission</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Measure Name</th>
<th>Compliance with all Falls Criteria (NCI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measure Type</td>
<td>Process (Percentage)</td>
</tr>
<tr>
<td>Measure description</td>
<td>This is a composite measure (all or nothing) requiring a simple yes/no outcome. If the individual patient did not have ALL the elements of the Falls Prevention NCI criteria completed/in place then they are considered non compliant with the indicator.</td>
</tr>
<tr>
<td>Numerator</td>
<td>Number of patients who had all five elements of the Falls Prevention NCI criteria completed.</td>
</tr>
<tr>
<td>Denominator</td>
<td>50% of all patients on each ward if patient numbers ≥20. (if patient numbers ≤20  use 10 patients as denominator, if patient numbers ≤10 use all patients as denominator) 10 patients per base</td>
</tr>
<tr>
<td>Reporting Frequency</td>
<td>Monthly via Nursing Care Indicators</td>
</tr>
<tr>
<td>Numeric Goal</td>
<td>› 95% compliance with all elements of the Falls Prevention NCI criteria.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Measure Name</th>
<th>Compliance with Skin and Safety Walk Around documentation (via NCI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measure Type</td>
<td>Process (Percentage)</td>
</tr>
<tr>
<td>Measure description</td>
<td>This is a composite measure (all or nothing) requiring a simple yes/no outcome. If the individual patient did not have ALL the elements of the Skin and Safety Walk Around documentation completed/in place then they are considered non compliant with the measure.</td>
</tr>
<tr>
<td>Numerator</td>
<td>Number of patients who had all ten elements of the Skin and Safety Walk Around documentation completed.</td>
</tr>
<tr>
<td>Denominator</td>
<td>50% of all patients on each ward if patient numbers ≥20. (if patient numbers ≤20  use 10 patients as denominator, if patient numbers ≤10 use all patients as denominator) 10 patients per base</td>
</tr>
<tr>
<td>Reporting Frequency</td>
<td>Monthly</td>
</tr>
<tr>
<td>Numeric Goal</td>
<td>› 95% compliance with all elements of the Skin and Safety Walk Around documentation.</td>
</tr>
<tr>
<td>Measure Name</td>
<td>Number of falls</td>
</tr>
<tr>
<td>----------------------------------</td>
<td>--------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Measure Type</td>
<td>Outcome – number of falls (count)</td>
</tr>
<tr>
<td>Measure description</td>
<td>A cumulative count of the number of In-patients falls by harm</td>
</tr>
<tr>
<td>Numerator</td>
<td>Number of In-patient falls (count)</td>
</tr>
<tr>
<td>Denominator</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Reporting Frequency</td>
<td>Monthly</td>
</tr>
<tr>
<td>Numeric Goal</td>
<td>To reduce the organisational incidence of falls resulting in harm by 20% by March 2017 from our 2015 baseline. Individual wards goals can be identified.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Measure Name</th>
<th>Days between falls. (this will be a new measure that requires implementing as part of the safety cross work)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measure Type</td>
<td>Outcome – days between falls (count)</td>
</tr>
<tr>
<td>Measure description</td>
<td>A cumulative count of the number of days that have gone by since a fall occurred on a ward / department was last reported (i.e. a new case is identified)</td>
</tr>
<tr>
<td>Numerator</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Denominator</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Sampling Plan</td>
<td>Record every occurrence of an individual falling (i.e. a new case is identified) and record accordingly on the Trust incident reporting system.</td>
</tr>
<tr>
<td>Reporting Frequency</td>
<td>Monthly</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Measure Name</th>
<th>Root Cause Analysis undertaken following a fall</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measure Type</td>
<td>Outcome – number of RCA carried out (count)</td>
</tr>
<tr>
<td>Measure description</td>
<td>Number of patients who had a Root Cause Analysis undertaken following a fall</td>
</tr>
<tr>
<td>Numerator</td>
<td>Total number of RCA’s undertaken per month</td>
</tr>
<tr>
<td>Denominator</td>
<td>Total number of falls.</td>
</tr>
<tr>
<td>Sampling Plan</td>
<td>Record every occurrence of an individual acquiring a fall on the Trust Incident Reporting System and complete the RCA if the system indicates the requirement</td>
</tr>
<tr>
<td>Reporting Frequency</td>
<td>Monthly</td>
</tr>
</tbody>
</table>
Balancing Measures

These are measures designed to identify the impact (positive or negative) of this work and interventions on other parts of the care system. In order to demonstrate cost savings, we will populate the productivity calculator below. To establish an organisational improvement we will gather baseline data for each measure and review progress on a quarterly basis.

<table>
<thead>
<tr>
<th>Cost (Productivity)</th>
<th>Reduction in the cost of litigation due to missed fractures or as a result of a patient experiencing a fall</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Complaints</td>
<td>Reduction in the number of complaints from service users relating to falls</td>
</tr>
<tr>
<td>Level of harm</td>
<td>Reduction in the level of harm to our patients</td>
</tr>
</tbody>
</table>
Appendix 6 – Pressure Ulcer Driver Diagram and Change Package

Pressure Ulcer Prevention
Driver Diagram & Change Package
V4.0

Author: Tracy Burrell, Assistant Director of Nursing, Quality & Safety
Background

Throughout 2009 the Trust had a reported 326 Hospital acquired pressure ulcers, with an estimated cost, using DoH calculation, of between £1.73million and £2.1million. We also know, from hospital numbers reported in the monthly point prevalence audit, that both hospital and non hospital acquired pressure ulcers have not always been reported via the incident reporting systems in place within the Trust. Besides creating significant difficulties for patients, carers and families, pressure ulcers also increase the length of time spent in hospital and therefore cost to the Trust.

With the publication of ‘High Impact Action for Nursing and Midwifery’ (October 2009), the Trust pledged to address the assessment, prevention, treatment and reporting of pressure ulcers within the Trust. The aim of the High Impact Action (HIA) – Your Skin Matters was ‘no avoidable pressure ulcer in NHS provided care’.

As a Trust we take the development of hospital acquired pressure ulcers seriously, and are working hard to reduce the incidence of these. The Trust is committed to reducing the prevalence of hospital acquired pressure ulcers and embedding cultural change through clinical ownership at ward level. Several initiatives have been undertaken over the last 4 years, from improved reporting, robust data analysis, staff education, set criteria within the nursing care indicators, meetings with the Director of Nursing of areas that develop stage 4 hospital acquired pressure ulcers and Assistant Director of Nursing for Stage 3 pressure ulcers. The purpose of these meetings has been to establish why these pressure ulcers occurred, and identify lessons learned in order to continuously improve patient safety.

Building on this work the Trust has identified as part of its 2020 Strategy that achieving eradication of all avoidable pressure ulcers is a quality goal.

The Trust is proud of the work already carried out with regards Pressure Ulcer Prevention, and has an incidence rate below national average, for prevalence of new pressure ulcers both acute, community and combined medians are below the national median. Pressure ulcers however, account for approximately 60% of our organisations harms to patients, we therefore recognise that there are still improvements to make in order to reduce patient harm further and improve their outcome.

The national median for old and new pressure ulcers is 4.655%. The improvements made to date have seen us in April 2014 attain prevalence median of 4.8% as an integrated organisation, we recognise however, that whilst the acute services have a prevalence median of 3.995%, the Adult & Long Term Conditions (formerly community services) have a median of 5.69%. Therefore the focus in the coming year must be on sustaining the current position from an acute setting and making improvements where possible, and focussing on implementing improvement processes into the community setting.

Aim

Work to reduce patient harm due to pressure ulcers will be managed by the Pressure Ulcer Link Nurse Group, and overseen by the Assistant Director of Nursing, Quality & Safety.

The aim of the work stream addressing Pressure Ulcer Prevention is to:

- Reduce the number of avoidable harm caused by trust attributable pressure ulcers by March 2017 from our April 2015 baseline by Stage 2 30%, Stage 3 50% and Stage 4 50%
Key objectives
- Ensure safe admission and care planning for patients based on their identified risk factors
- Promote patient safety through effective implementation of intentional rounding
- Promote effective communication through collaborative working of the wider multidisciplinary team
- Learn lessons from Incident Reporting / RCA’s / and disseminate through Divisional Governance structures
- Standardisation of best practice
- Support for ward managers and clinical teams to drive improvement
- Safe discharge / Transfer of care
- Improve staff education, skills and competency
- Improve patient / carer and family education

Purpose of the Change Package
This change package has been adapted from the 1000 lives campaign. It identifies and establishes recommended interventions which have been proven to collectively bring about improvements in pressure ulcer prevention. The package illustrates what interventions wards and departments should consider in order to improve pressure area care as part of a whole system of care.

There are three distinct parts to this package; Driver Diagram, Change Concepts and Ideas and Measures. The driver diagram describes the elements that need to be in place to achieve an improvement. It assists in focussing on the cause and effect relationships that can exist in complex situations, such as pressure ulcer prevention. The primary drivers are high level ideas that if implemented, will achieve the improvement aim. The best way of implementing primary drivers is to identify a series of actions (secondary drivers) which, when undertaken, will contribute to the primary drivers and in turn the aim. A change concept is a general notion or an approach to improving an aspect of care. A change idea is an action which is expressed as a specific example of how a particular change concept can be applied in real life.

Also included in this package is a series of different measures; process, outcome and balancing measures. These measures are important as we need to know if the changes we are making are an improvement. In order to determine this we need to identify a defined process (such as compliance with elements of a care bundle) which is linked to an outcome (such as a reduction in the number of hospital acquired pressure ulcers). Both process and outcome which are linked are essential to evaluate the effectiveness of change. Balancing measures are designed to identify the impact (positive or negative) of your improvement work and interventions on other parts of the care system.
How to use this Change Package
Using the rapid spread methodology Ward Managers/Team Leaders are encouraged, with their teams, to review the change package to determine:

- What practices might already be in place in their area and decide if further work is needed.
- Identify and prioritise the changes the team will undertake, and determine what improvements these changes will lead to.
- What other changes may be required at a later date.
- Identify any barriers that may impede change and work with the Divisional Management Team to remove the barriers.
- Collaborative working with the Corporate team to determine local performance to identify areas of focus for improvement drive.
By March 2017 we will reduce avoidable harm caused by trust attributable pressure ulcers by
  
  Stage 2  30%
  Stage 3  50%
  Stage 4  50%
  
  From our 2015 baseline

Driver Diagram

Outcome

Primary Driver

Secondary Driver

Safe Patient Care

Safe admission and care planning for patients based on risk factors
Effective implementation of intentional rounding
Effective communication
Incident Reporting / RCA’s / Disseminating lessons learned
Safe discharge / Transfer of care

Education

Improved staff education
Improved patient / carer and family education

Standardisation of top 5 best practice ideas on all wards

Standardisation of best practice
Support for ward managers to drive improvement
<table>
<thead>
<tr>
<th>Primary Driver</th>
<th>Secondary Driver</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safe Patient Care</td>
<td>• Safe admission and care planning for patients based on risk factors</td>
</tr>
<tr>
<td></td>
<td>• Effective implementation of intentional rounding</td>
</tr>
<tr>
<td></td>
<td>• Effective communication</td>
</tr>
<tr>
<td></td>
<td>• Incident Reporting / RCA’s / Disseminating lessons learned</td>
</tr>
<tr>
<td></td>
<td>• Safe discharge / Transfer of care</td>
</tr>
<tr>
<td>Key Change Concept / Change Idea</td>
<td>• Understand pressure ulcer risk factors</td>
</tr>
<tr>
<td></td>
<td>• Utilise Safety Handovers / Safety Huddles to communicate risk</td>
</tr>
<tr>
<td></td>
<td>• Inspect skin / pressure areas with a frequency dependant on risk and advice / clinical judgement dependant on individual’s needs to identify quickly pressure damage.</td>
</tr>
<tr>
<td></td>
<td>• Minimise pressure damage by ensuring manual handling equipment is available when turning patients assessed as at risk.</td>
</tr>
<tr>
<td></td>
<td>• Identify methods to manage the moisture of patients whose skin is exposed to increased moisture. (wound drainage, continence issues, leaks, discharge, excessive sweating).</td>
</tr>
<tr>
<td></td>
<td>• Ensure skin is kept clean and dry (note excessive dry skin presents an increased risk).</td>
</tr>
<tr>
<td></td>
<td>• Utilise patient and carer information leaflet.</td>
</tr>
<tr>
<td></td>
<td>• Engage with multidisciplinary team to support pressure ulcer prevention</td>
</tr>
<tr>
<td></td>
<td>• Set a clear local aim for reducing pressure ulcers.</td>
</tr>
<tr>
<td></td>
<td>• Assess tissue viability risk within 6 hours of admission / transfer and re-assess daily / when change in condition</td>
</tr>
<tr>
<td></td>
<td>• Develop monthly reporting process to identify patient harms, incorporating falls to focus areas for improvement.</td>
</tr>
<tr>
<td></td>
<td>• Promote Incident Reporting / RCA’s when a fall occurs to learn lessons and improve care</td>
</tr>
<tr>
<td></td>
<td>• Engage with staff to learn about the barriers to risk assessment being done within 6 hours from admission / transfer / first visit.</td>
</tr>
<tr>
<td></td>
<td>• Utilise safety handovers / SBAR Approach / Safety Huddles.</td>
</tr>
<tr>
<td></td>
<td>• Identify Ward and community base level targets.</td>
</tr>
<tr>
<td></td>
<td>• Develop RCA template corporately in collaboration with divisions</td>
</tr>
<tr>
<td></td>
<td>• Develop support process for areas with challenge to drive improvement</td>
</tr>
<tr>
<td></td>
<td>• Implementation of non-compliance, pressure ulcer prevention and safeguarding policies</td>
</tr>
<tr>
<td></td>
<td>• Monitor compliance with – SKIN Care Bundle, - SAS Tool</td>
</tr>
<tr>
<td></td>
<td>• Review the use of pressure relieving devices in line with the Trust guidelines.</td>
</tr>
<tr>
<td></td>
<td>• Arrange for staff to spend time shadowing the Tissue Viability Nurse Specialists.</td>
</tr>
<tr>
<td></td>
<td>• Re-enforce the use of the pressure ulcer staging tools.</td>
</tr>
<tr>
<td></td>
<td>• Make sure ward / department / Locality staff know about the tool to aid with pressure ulcer recognition and assist with their education / competency.</td>
</tr>
<tr>
<td></td>
<td>• Know how to contact the Tissue Viability Advisor if required. Ensure the skills, knowledge and competency of your team are up to date.</td>
</tr>
<tr>
<td></td>
<td>• Utilise local and specialist tissue viability nursing experience</td>
</tr>
<tr>
<td></td>
<td>• Initiate and maintain correct use of equipment</td>
</tr>
<tr>
<td></td>
<td>• Discuss risk as part of Board Round with medical staff</td>
</tr>
</tbody>
</table>
| Education | Improved staff education  
Improved patient / carer and family education | • Ensure the skills, knowledge and competency of your team are up to date.  
• Educate staff, patients on pressure ulcer contributory factors.  
• Ensure all new staff complete the pressure ulcer prevention workbook  
• Utilise formal and informal learning opportunities to educate your teams about pressure ulcer risk.  
• Use patient stories to educate, motivate and inspire staff. (Hearts & Minds).  
• Provide patients and relatives with information on the risks of pressure ulcers on admission/transfer or when there is a change in their condition that puts them at risk.  
• Educate patients, families and carers how they can help to minimize pressure ulcer risk whilst in hospital and at home, where relevant.  
• Work with patients and families as co-partners in their care.  
• Review and update Tissue Viability User Guide Folders for each ward / dept.  
• Review current patient information leaflet, including audio version. (arrange corporately)  
• Develop revised RCA template for all pressure ulcers stage 2, 3 and 4  
• Disseminate lessons learned from SUI’s / RCA’s  
• Develop pressure ulcer counter on intranet  
• Develop safety crosses to identify ‘days since’ a pressure ulcer harm |
| Standardisation of top 5 best practice ideas | Standardisation of best practice  
Support for ward managers to drive improvement | • Review best practice and areas of challenge  
• Engage ward managers at away afternoon  
• Identify and agree 5 best practice ideas to drive improvement and implement the same across the Trust  
• Develop ward manager pledge  
• Identify processes to remove barriers and work with divisional teams to achieve roll out of best practice |
# Measurement Plan

<table>
<thead>
<tr>
<th>Measure Name</th>
<th>Maintenance of incidence median below the national median split into acute, community and combined organisation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measure Type</td>
<td>Outcome – median of pressure ulcer prevalence</td>
</tr>
<tr>
<td>Measure description</td>
<td>Percentage or number of patients in our care who suffer a pressure ulcer stage 2, 3 or 4</td>
</tr>
<tr>
<td>Numerator</td>
<td>Median of Hospital acquired Pressure ulcers and Non-Hospital acquired pressure ulcers</td>
</tr>
<tr>
<td>Denominator</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Sampling Plan</td>
<td>Safety Thermometer</td>
</tr>
<tr>
<td>Reporting Frequency</td>
<td>Monthly</td>
</tr>
<tr>
<td>Numeric Goal</td>
<td>To maintain the organisational incidence median below the national median</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Measure Name</th>
<th>Compliance with signed and dated pressure ulcer risk assessment / skin examination within 6 hours of admission / transfer in the acute setting or on first visit in community setting.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measure Type</td>
<td>Process (Percentage)</td>
</tr>
<tr>
<td>Measure description</td>
<td>% compliance with pressure ulcer risk assessment / skin examination on admission / transfer</td>
</tr>
<tr>
<td>Numerator</td>
<td>Number of patients who had a signed and dated pressure ulcer risk assessment / skin examination within 6 hours of admission / transfer / first visit.</td>
</tr>
<tr>
<td>Denominator</td>
<td>50% of all patients on each ward if patient numbers ≥20. (if patient numbers ≤20 use 10 patients as denominator, if patient numbers ≤10 use all patients as denominator) 10 patients per community base – randomly selected</td>
</tr>
<tr>
<td>Reporting Frequency</td>
<td>Monthly via Nursing Care Indicators</td>
</tr>
<tr>
<td>Numeric Goal</td>
<td>95% compliance with signed and dated pressure ulcer risk assessment / skin examination within 6 hours of admission / transfer / first visit</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Measure Name</th>
<th>Compliance with all elements of the Tissue Viability Nursing Care Indicator (NCI) Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measure Type</td>
<td>Process (Percentage)</td>
</tr>
<tr>
<td>Measure description</td>
<td>This is a composite measure (all or nothing) requiring a simple yes/no outcome. If the individual patient did not have ALL the elements of the Tissue Viability NCI criteria completed/in place then they are considered non compliant with the indicator.</td>
</tr>
<tr>
<td>Numerator</td>
<td>Number of patients who had all five elements of the Tissue Viability NCI criteria completed.</td>
</tr>
<tr>
<td>Denominator</td>
<td>50% of all patients on each ward if patient numbers ≥20. (if patient numbers ≤20 use 10 patients as denominator, if patient numbers ≤10 use all patients as denominator) 10 community patients per base monthly – randomly selected</td>
</tr>
<tr>
<td>Reporting Frequency</td>
<td>Monthly via Nursing Care Indicators</td>
</tr>
<tr>
<td>Numeric Goal</td>
<td>95% compliance with all five elements of the Tissue Viability NCI criteria.</td>
</tr>
<tr>
<td>Measure Name</td>
<td>Number of Pressure Ulcers (Hospital and Non-Hospital acquired)</td>
</tr>
<tr>
<td>----------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------</td>
</tr>
<tr>
<td>Measure Type</td>
<td>Outcome – number of pressure ulcers (Spot prevalence)</td>
</tr>
<tr>
<td>Measure description</td>
<td>A count of the number of pressure ulcers on a ward / department as per the Safety Thermometer</td>
</tr>
<tr>
<td>Numerator</td>
<td>Number of Hospital acquired Pressure ulcers (count) and Non-Hospital acquired pressure ulcers (count)</td>
</tr>
<tr>
<td>Denominator</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Sampling Plan</td>
<td>Safety Thermometer</td>
</tr>
<tr>
<td>Reporting Frequency</td>
<td>Monthly</td>
</tr>
<tr>
<td>Numeric Goal</td>
<td>To reduce the organisational incidence of hospital acquired pressure ulcers by 30% from 2014/15 position by March 31st 2016.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Measure Name</th>
<th>Hospital Acquired Pressure Ulcer per 1000 Occupied Bed Days</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measure Type</td>
<td>Outcome – Rate</td>
</tr>
<tr>
<td>Measure description</td>
<td>The total number of pressure ulcers acquired on a ward / department per 1000 bed days</td>
</tr>
<tr>
<td>Numerator</td>
<td>Total number of Hospital acquired Pressure Ulcers developed on a ward / department per month</td>
</tr>
<tr>
<td>Denominator</td>
<td>Total number occupied bed days scaled to 1000 days</td>
</tr>
<tr>
<td>Reporting Frequency</td>
<td>Monthly via Open &amp; Honest Care Report</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Measure Name</th>
<th>Root Cause Analysis undertaken following development of a Stage 2, Stage 3 or Stage 4 Pressure Ulcer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measure Type</td>
<td>Outcome – number of RCA carried out (count)</td>
</tr>
<tr>
<td>Measure description</td>
<td>Number of patients who had a Root Cause Analysis undertaken following development of a Stage 2, Stage 3 or Stage 4 Pressure Ulcer</td>
</tr>
<tr>
<td>Numerator</td>
<td>Total number of RCA’s undertaken per month</td>
</tr>
<tr>
<td>Denominator</td>
<td>Total number of Stage 2, Stage 3 or Stage 4 Pressure Ulcer</td>
</tr>
<tr>
<td>Reporting Frequency</td>
<td>Monthly</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Measure Name</th>
<th>Number of Pressure Ulcers (Hospital and Non-Hospital acquired)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measure Type</td>
<td>Outcome – number of pressure ulcers (actual reported)</td>
</tr>
<tr>
<td>Measure description</td>
<td>A count of the number of pressure ulcers on a ward / department as per the Incident reporting system</td>
</tr>
<tr>
<td>Numerator</td>
<td>Number of Hospital acquired Pressure ulcers (count) and Non-Hospital acquired pressure ulcers (count)</td>
</tr>
<tr>
<td>Denominator</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Sampling Plan</td>
<td>Ulysses Incident Reporting System</td>
</tr>
<tr>
<td>Reporting Frequency</td>
<td>Monthly</td>
</tr>
<tr>
<td>Numeric Goal</td>
<td>To reduce the organisational incidence of hospital acquired pressure ulcers by 30% from 2014/15 position by March 31st 2016.</td>
</tr>
<tr>
<td>Measure Name</td>
<td>Compliance with Skin and Safety Walk Around documentation as per NCI</td>
</tr>
<tr>
<td>--------------------------------------</td>
<td>-----------------------------------------------------------------------</td>
</tr>
<tr>
<td>Measure Type</td>
<td>Process (Percentage)</td>
</tr>
<tr>
<td>Measure description</td>
<td>This is a composite measure (all or nothing) requiring a simple yes/no outcome. If the individual patient did not have ALL the elements of the Skin and Safety Walk Around documentation completed/in place then they are considered non compliant with the measure.</td>
</tr>
<tr>
<td>Numerator</td>
<td>Number of patients who had all ten elements of the Skin and Safety Walk Around documentation completed.</td>
</tr>
<tr>
<td>Denominator</td>
<td>50% of all patients on each ward if patient numbers ≥20. (If patient numbers ≤20 use 10 patients as denominator, if patient numbers ≤10 use all patients as denominator)</td>
</tr>
<tr>
<td>Reporting Frequency</td>
<td>Monthly</td>
</tr>
<tr>
<td>Numeric Goal</td>
<td>95% compliance with all ten elements of the Skin and Safety Walk Around documentation as per the monthly NCI</td>
</tr>
</tbody>
</table>
Balancing Measures

These are measures designed to identify the impact (positive or negative) of this work and interventions on other parts of the care system. In order to demonstrate cost savings, we will populate the productivity calculator below. To establish an organisational improvement we will gather baseline data for each measure and review progress on a quarterly basis.

<table>
<thead>
<tr>
<th>Cost (Productivity)</th>
<th>Reduction in the cost of managing pressure ulcers.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>The Department of Health Pressure Ulcer Productivity calculator located at the link below can be used to generate this information. <a href="http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_116669">http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_116669</a></td>
</tr>
<tr>
<td>Number of Complaints</td>
<td>Reduction in the number of complaints from service users relating to pressure ulcers.</td>
</tr>
<tr>
<td>Level of harm</td>
<td>Reduction in the level of harm to our patients</td>
</tr>
</tbody>
</table>
Clinical Pathways
Driver Diagram & Change Package
V4.0

Author: Tracy Burrell, Assistant Director of Nursing, Quality & Safety
Background
In recent years, monitoring deaths in hospital has become a standard part of assessing the performance of our hospitals and the quality of their care. Blackpool Teaching Hospitals was one of a number of Hospitals to have been identified as having had unusually high death rates in 2012-13, as judged by the summary hospital-level mortality indicator (SHMI). The SHMI, which captures and compares the number of patients who die while being treated as an inpatient, or within 30 days of their discharge from hospital, is one way of measuring if a hospital trust is seeing an average, higher or lower than average number of deaths among patients.
A higher than expected mortality rate shown by this indicator does not in itself tell us that a hospital is unsafe. It does however signal to Trusts that they should further investigate to identify the reasons for the higher than expected mortality rate and resolve any associated quality issues that may have contributed to this rate.
As a result of our SHMI, the trust was subject to a review led by Sir Bruce Keogh. The feedback from this review advised us to focus on mission critical areas of work to ensure that improvements are implemented quickly and effectively. In addition to the Keogh recommendations, the trust also recognised that it was slow to embed Advancing Quality (AQ) pathways and had invited AQuA to carry out a review of our services to identify how we may improve the quality of our care and subsequently our mortality rates.

The Trust’s response was to launch our Better Care Now project in August 2013 to focus on three work streams:
- Eliminating delays in care
- Improving patient pathways
- Delivering high quality care with the right professionals with the right skills

The project is overseen by Pat Oliver, Director of Operations, with each strand having a Senior lead. The work of the Better Care Now project also incorporates work identified in the Strategic Framework and consequently links our quality and safety initiatives under one umbrella.

Our mortality review initially identified our top 5 areas of mortality risk were Pneumonia, Sepsis, Stroke, Acute Myocardial Infarction and Acute Kidney Injury.

Ongoing review of our mortality rates allows us to identify further clinical pathways to develop to support improvements in patient care and outcome.

Aim
The development of clinical pathways in these areas will be overseen by Clinical Pathway work stream and aims to:
- Support a reduction in mortality
- Enhancing best practise standards
- Support a reduction in mortality

Key objectives
To efficiently manage the process of accurate and effective patient care through clinical pathways by:
- Introduction of evidence-based medicine and nursing care
- Standardised management
- Identification of key interventions
- Delivery of care within clinical guidelines
- Improved patient outcomes
- Reduced Length of Stay
- Providing real time audit feedback to Consultant and Nursing teams on performance.

**Measurements**
Details of the measurements that will be used for the ‘Management of Deteriorating Patient’ can be found at the end of this document. These will be flexible depending on the requirements of the work stream and in response to any local or national changes.

**Purpose of the Change Package**
This change package has been adapted from the 1000 lives campaign. It identifies and establishes recommended interventions which have been proven to collectively bring about improvements in pressure ulcer prevention. The package illustrates what interventions wards, departments and teams should consider in order to improve patient care through the delivery of clinical pathways as part of a whole system of care.

There are three distinct parts to this package: Driver Diagram, Change Concepts and Ideas and Measures. The driver diagram describes the elements that need to be in place to achieve an improvement. It assists in focussing on the cause and effect relationships that can exist in complex situations, such as pressure ulcer prevention. The primary drivers are high level ideas that if implemented, will achieve the improvement aim. The best way of implementing primary drivers is to identify a series of actions (secondary drivers) which, when undertaken, will contribute to the primary drivers and in turn the aim. A change concept is a general notion or an approach to improving an aspect of care. A change idea is an action which is expressed as a specific example of how a particular change concept can be applied in real life.

Also included in this package is a series of different measures; process, outcome and balancing measures. These measures are important as we need to know if the changes we are making are an improvement. In order to determine this we need to identify a defined process which is linked to an outcome. Both process and outcome which are linked are essential to evaluate the effectiveness of change. Balancing measures are designed to identify the impact (positive or negative) of your improvement work and interventions on other parts of the care system.

**How to use this Change Package**
Using the rapid spread methodology Ward Managers/Team Leaders are encouraged, with their teams, to review the change package to determine:
- What practices might already be in place in their area and decide if further work is needed.
- Identify and prioritise the changes the team will undertake, and determine what improvements these changes will lead to.
- What other changes may be required at a later date.
- Identify any barriers that may impede change and work with the Divisional Management Team to remove the barriers.
- Collaborative working with the Corporate team to determine local performance to identify areas of focus for improvement drive.
Improve mortality and prevent delays in treatment through AKI and Sepsis Clinical Pathways Compliance.

Targets for 2015/16:
- Sepsis 40%
- AKI 50%

Driver Diagram

Outcome

Primary Driver

- High Mortality Clinical Pathways Programme & Better Care Now Work Stream
- Improved clinical outcomes for patients
- Leadership & Education

Secondary Driver

- Effective and timely delivery of care for patients based on diagnosis and delivery of mission critical points of pathway
- Effective communication between team members
- Safe discharge / Transfer of care
- Compliance with AQ Standards
- CQUIN/ Quality framework requirement
- Communication of lessons learned
- Patient centred care
- Improved patient experience
- Board Assurance

- Standardisation of best practice
- Compliance with NICE
- Implementation of relevant NCEPOD recommendations
- Reduction in Length of Stay
- Reduction in SHMI, HSMR
- Reduction of Serious Untoward Incidents
- Compliance with key clinical audit standards
- Board Assurance

- Improved staff education
- Improved patient / carer and family education
- Bespoke Leadership Programme
<table>
<thead>
<tr>
<th>Primary Driver</th>
<th>Secondary Driver</th>
<th>Key Change Concept / Change Idea</th>
</tr>
</thead>
</table>
| **High Mortality**  | Effective and timely delivery of care for patients based on diagnosis and delivery of mission critical points of pathway | • Development and launch of new clinical pathways as identified and agreed at Mortality Board to incorporate AQ, NICE and NCEPOD standards as mission critical points  
• Baseline audit to establish current position in order to measure improvement  
• Develop audit proforma for each pathway for IT app to ensure real time feedback to clinicians  
• Communication strategy to launch and promote clinician engagement  
• Discuss pathway as part of Board Round to support effective team working  
• Utilise safety handovers / SBAR Approach / Safety Huddles.  
• Involve Medical Education Leads to engage junior medical staff |
| Pathways Programme & Better Care Now Work Stream | Effective communication between team members  
Safe discharge / Transfer of care  
Compliance with AQ Standards  
CQUIN / Quality framework requirement  
Communication of lessons learned  
Board Assurance | |
| **Improved clinical outcomes for patients** | Standardisation of best practice  
Compliance with NICE  
Implementation of relevant NCEPOD recommendations  
Reduction in Length of Stay  
Reduction in SHMI, HSMR  
Reduction of Serious Untoward Incidents  
Compliance with key clinical audit standards  
Board Assurance | • Engage with specialist team to support development of pathway  
• Engage with staff to learn about any barriers to pathway being implemented timely and escalate to Board  
• Develop real time feedback reporting process to support real time improvements in care for each pathway  
• Utilise safety handovers / SBAR Approach / Safety Huddles.  
• Discuss risk as part of Board Round with medical staff  
• Review untoward incidents relating to delayed treatment and disseminate lessons learned  
• Target areas of non-compliance to support improvements  
• Develop pathways incorporating NICE guidance / NCEPOD recommendations / AQ criteria / Royal College recommendations etc to ensure best practice standards identified within pathway  
• Develop process for identifying patient pathway on admission/ referral  
• Implement launch process to engage and inform staff |
| **Leadership & Education** | Improved staff education  
Improved patient / carer and family education  
Bespoke Leadership Programme | • Ensure the skills, knowledge and competency of your team are up to date.  
• Utilise formal and informal learning opportunities to educate your teams about the clinical pathways.  
• Use patient stories to educate, motivate and inspire staff. (Hearts & Minds).  
• Work with patients and families as co-partners in their care.  
• Disseminate lessons learned from SUI’s / RCA’s  
• Identify processes to remove barriers and work with divisional teams to achieve roll out of best practice  
• Ward walking prior to launch of new pathway  
• Grand Round launches  
• Identify staff for bespoke Leadership Programme  
• Work with the deanery to target junior doctors and trainees |
### Measurement Plan

<table>
<thead>
<tr>
<th>Measure Name</th>
<th>Compliance with mission critical points for all pathways composite</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measure Type</td>
<td>Process (Percentage)</td>
</tr>
<tr>
<td>Measure description</td>
<td>% compliance with all mission critical points of pathway</td>
</tr>
<tr>
<td>Numerator</td>
<td>Number of patients who were eligible for management of care under the pathway</td>
</tr>
<tr>
<td>Denominator</td>
<td>Number of patients who received all mission critical points of pathway within the time frame of the pathway criteria</td>
</tr>
<tr>
<td>Reporting Frequency</td>
<td>Monthly via Mortality Board Report</td>
</tr>
<tr>
<td>Numeric Goal</td>
<td>% compliance individual to each pathway and agreed with CCG. To be identified on report</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Measure Name</th>
<th>Compliance with overall mission critical points for all pathways</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measure Type</td>
<td>Process (Percentage)</td>
</tr>
<tr>
<td>Measure description</td>
<td>% compliance with overall all mission critical points of pathway</td>
</tr>
<tr>
<td>Numerator</td>
<td>Number of mission critical points each patient was eligible for management of care under the pathway</td>
</tr>
<tr>
<td>Denominator</td>
<td>Number of mission critical points delivered per patient</td>
</tr>
<tr>
<td>Reporting Frequency</td>
<td>Monthly</td>
</tr>
<tr>
<td>Numeric Goal</td>
<td>% compliance individual to each pathway and agreed with CCG. To be identified on report</td>
</tr>
</tbody>
</table>

### Balancing Measures

These are measures designed to identify the impact (positive or negative) of this work and interventions on other parts of the care system. In order to demonstrate cost savings, we will populate the productivity calculator below. To establish an organisational improvement we will gather baseline data for each measure and review progress on a quarterly basis.

<table>
<thead>
<tr>
<th>Cost (Productivity)</th>
<th>Reduction in the litigation costs associated with delayed diagnosis if related to a clinical pathway</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Complaints</td>
<td>Reduction in the number of complaints from service users relating to pressure ulcers.</td>
</tr>
<tr>
<td>Level of mortality</td>
<td>Improved SHMI</td>
</tr>
</tbody>
</table>

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Appendix 8 – Care of the Deteriorating Patient Driver Diagram and Change Package

Care Of The Deteriorating Patient
Driver Diagram & Change Package
V1.0

Author: Louise Kippax-Davis, Critical Care Outreach Lead
Background
Patients who are admitted to hospital believe that they are entering a place of safety, where they and their families and carers have a right to believe that they will receive the best possible care (NICE 50). Should their condition deteriorate, we should be able to provide prompt and effective treatment provided by staff with the right competencies. Staff on the ward areas should be provided with education and training to recognise the deteriorating and/or acutely ill patients and also be able to identify the needs of and care for patients transferred from critical care.
Recent publications have highlighted the importance of effective early management of this cohort of patients in ensuring better outcomes (NCEPOD 2007). This reinforces previous literature identifying the need to embed Track and Trigger systems based on aggregated scoring systems ie Early Warning Scoring (EWS) inextricably linked to a Graded Response Strategy (GRS).
The aging population and increasing complexity of medical and surgical intervention combined with shorter lengths of stay can pose increasing risks of patients becoming acutely unwell and may require admission to critical care.

Through the Critical Care Outreach service in collaboration with other key personnel, the Trust has developed a robust strategy for identifying the deteriorating patient and as part of the GRS, in July 2011 launched the unique ‘600 baton bleep’ carried 24/7 providing rapid access to support for the deteriorating patient.
Through annual audit, system analysis allows us to identify compliance failure and has also identified other areas for scrutiny, namely notes review of all 2222 cardiac arrest calls, these being the ultimate manifestation of ‘failure to rescue’ episodes.
We have been able to demonstrate a reduction in calls and low numbers of failure to rescue events.
Provision of education and training through R&A allows for reinforcement of lessons learned via RCA and audit trails.
This work is monitored via the Care of the Acutely Ill Patient Committee

Aim
The aim of the work stream addressing Care of the Deteriorating Patient is to:
• Improve patient outcomes and reduce the incidence of deterioration in the acutely ill through early identification and timely treatment. By March 2017 we will reduce avoidable harm caused by failure to rescue or failure to recognise the deteriorating patient by 50% from our 2015 baseline of ‘Failure to Rescue’ 2222 calls

• Reduce avoidable admissions to critical care associated with patient deterioration,. Although not identified as the measurement target for this campaign, we are aiming for a target of zero avoidable admissions by 2018 and a reduction of avoidable cardiac arrests to zero.

Key objectives
• To effectively manage the process of early identification of deterioration including:
• Accurate and reliable recording of EWS scores
• Timely recording of EWS scores
• Appropriate and early diagnosis of a patients deteriorating condition
• To implement a nurse led response to a deteriorating patient with appropriate clinician support.
• To ensure safety briefings on ward areas are implemented to aid the early identification of the deteriorating patient.
• To ensure that appropriately documented ‘ceilings of care’ are identified for all patients.
• To ensure appropriate DNA-CPR decisions have been made and accurately recorded.
• To ensure protocols and procedures support the early identification of a deteriorating patient and that hospital staff are appropriately trained in all aspects of timely recognition, escalation and care of these patients.

Measurements
Details of the measurements that will be used for the ‘Management of Deteriorating Patient’ can be found at the end of this document. These will be flexible depending on the requirements of the work stream and in response to any local or national changes.

Purpose of the Change Package
This change package has been adapted from the 1000 lives campaign. It identifies and establishes recommended interventions which have been proven to collectively bring about improvements in recognition and management of the deteriorating patient.
The package illustrates what interventions wards and departments should consider in order to improve their staff’s ability to recognise and escalate concern within this cohort of patients.

There are three distinct parts to this package; Driver Diagram, Change Concepts and Ideas and Measures.

The driver diagram describes the elements that need to be in place to achieve an improvement. It assists in focussing on the cause and effect relationships that can exist in complex situations.

The primary drivers are high level ideas that if implemented, will achieve the improvement aim. The best way of implementing primary drivers is to identify a series of actions (secondary drivers) which, when undertaken, will contribute to the primary drivers and in turn the aim.

A change concept is a general notion or an approach to improving an aspect of care. A change idea is an action which is expressed as a specific example of how a particular change concept can be applied in real life.

Also included in this package is a series of different measures; process, outcome and balancing measures. These measures are important as we need to know if the changes we are making are an improvement. In order to determine this we need to identify a defined process (such as compliance with elements of a care bundle) which is linked to an outcome (such as a reduction in the number of failure to rescue the deteriorating patient). Both process and outcome which are linked are essential to evaluate the effectiveness of change.

Balancing measures are designed to identify the impact (positive or negative) of your improvement work and interventions on other parts of the care system.

How to use this Change Package
Using the rapid spread methodology Ward Managers/Team Leaders are encouraged, with their teams, to review the change package to determine:
• What practices might already be in place in their area and decide if further work is needed.
• Identify and prioritise the changes the team will undertake, and determine what improvements these changes will lead to.
• What other changes may be required at a later date.
• Identify any barriers that may impede change and work with the Divisional Management Team to remove the barriers.
• Collaborative working with the Corporate team to determine local performance to identify areas of focus for improvement drive.

By March 2017 we will reduce avoidable harm caused by failure to rescue or failure to recognise the deteriorating patient 50% from our 2015 baseline of ‘Failure to Rescue’ 2222 calls.

In Maternity we will ensure compliance with NICE intrapartum guidance and the sepsis pathway.

**Driver Diagram**

**Outcome**

**Primary Driver**
- Corp/Proc /080 compliance
- Improved clinical outcomes for patients
- Obs/Guid/004 compliance
- Improved clinical outcomes for patients
- Early, reliable and timely identification of the deteriorating patient
- Compassionate care in preferred place of Care for patients at end of life

**Secondary Driver**
- Reduced number of ‘failure to rescue’ episodes and consequential organ harm
- Recognition of deviations from the normal with CTG interpretation
- Appropriate admissions to Critical care
- NICE CG 50 Annual Audit and action plan
- NCEPOD Recommendations ‘Adding Insult to Injury’
- 2222 cardiac arrest notes review
- Timely identification of high risk patients
- Improved patient experience
- Robust process for escalating concerns that a patient is deteriorating
- Patient centred care
- Appropriate and timely referral to palliative care

**Management and identification of patients with Sepsis or AKI**
- Safe Patient Care

**Effective Clinical Leadership**
- Staff Education and Training

**Compliance with Sepsis clinical pathways audit including maternity bundle**
- Compliance AKI clinical pathways audit
- Reduction in multi organ harms
- Timely and accurate observations based on patient need and risk
- Timely referral to Critical Care Outreach Team
- Reduced length of stay

**Recognise and Act, managing the deteriorating patient (R&A)**
- Improved R&A mandatory training for RNs
- ALERT training
- Post Critical Care Ward Patient study day
- Education supporting sepsis and AKI pathways embedded in the Recognise & Act and ALERT
- Bespoke Leadership programme
- Specialist maternity training
<table>
<thead>
<tr>
<th>Primary Driver</th>
<th>Secondary Driver</th>
<th>Key Change Concept / Change Idea</th>
</tr>
</thead>
<tbody>
<tr>
<td>Corp/Proc /080 compliance</td>
<td>Reduced number of ‘failure to rescue’ episodes and consequential organ harm</td>
<td>Monitor compliance with Corp/Proc /080 through annual audit (NICE CG50) NCIs and notes review 2222 cardiac arrests</td>
</tr>
<tr>
<td>Improved clinical outcomes for patients</td>
<td>Appropriate admissions to Critical care</td>
<td>Monitor readmission to critical care events and review from failure to rescue perspective</td>
</tr>
<tr>
<td>Early, reliable and timely identification of the deteriorating patient</td>
<td>NICE CG 50 Annual Audit and action plan</td>
<td>Identify common themes for the above cohort and amend education and training packages accordingly</td>
</tr>
<tr>
<td>Compassionate care in preferred place of Care for patients at end of life</td>
<td>NCEPQD Recommendations ‘Adding Insult to Injury’</td>
<td>Review GAP analysis and NCEPQD recommendations and subsequent action plans to drive improvements within recommendation framework</td>
</tr>
<tr>
<td>• 2222 cardiac arrest notes review</td>
<td>• Timely identification of high risk patients</td>
<td>Promote within your team the roll out of the new fluid balance record and it’s links to supporting identification of the deteriorating patient</td>
</tr>
<tr>
<td>• Improved patient experience</td>
<td>• Robust process for escalating concerns that a patient is deteriorating</td>
<td>• Communicate risk status of patients at safety huddles</td>
</tr>
<tr>
<td>• Patient centred care</td>
<td>• Monitor compliance with Corp/Proc /080 through annual audit (NICE CG50) NCIs and notes review 2222 cardiac arrests</td>
<td>• Promote Incident Reporting / RCA’s when an incident occurs to learn lessons and improve care</td>
</tr>
<tr>
<td>• Utilise local and specialist nursing experience</td>
<td></td>
<td>• Utilise local and specialist nursing experience</td>
</tr>
<tr>
<td>Management and identification of patients with Sepsis or AKI Safe Patient Care</td>
<td>Compliance with Sepsis clinical pathways audit</td>
<td>Identify any specific areas or groups where there is a failure to comply</td>
</tr>
<tr>
<td></td>
<td>Compliance AKI clinical pathways audit</td>
<td>Explore the mechanisms for failure to comply and address through education and training</td>
</tr>
<tr>
<td></td>
<td>Reduction in multi organ harms</td>
<td>Support the roll out of the clinical pathway for eligible patients</td>
</tr>
<tr>
<td></td>
<td>Timely and accurate observations based on patient need and risk</td>
<td>Discuss risk at Board Rounds/ Handover to improve communication and patient care</td>
</tr>
<tr>
<td></td>
<td>Timely referral to Critical Care Outreach Team</td>
<td>Utilise local and specialist nursing experience</td>
</tr>
<tr>
<td></td>
<td>Reduced length of stay</td>
<td></td>
</tr>
<tr>
<td>Effective Clinical Leadership Staff Education and Training</td>
<td>Recognise and Act, managing the deteriorating patient (R&amp;A)</td>
<td>Ensure the skills, knowledge and competency of your team are up to date.</td>
</tr>
<tr>
<td></td>
<td>Improved R&amp;A mandatory training for RNs</td>
<td>Utilise formal and informal learning opportunities to educate staff and reinforce the Trust strategies for identification and escalation of patients causing concern</td>
</tr>
<tr>
<td></td>
<td>ALERT training</td>
<td>Explore breaches in mandatory training attendance</td>
</tr>
<tr>
<td></td>
<td>Post Critical Care Ward Patient study day</td>
<td>Ongoing development of support mechanisms for patients post Critical Care</td>
</tr>
<tr>
<td></td>
<td>Education supporting sepsis and AKI pathways embedded in the Recognise &amp; Act and ALERT</td>
<td>Review of mechanisms to support failures to recognise Sepsis and AKI</td>
</tr>
<tr>
<td></td>
<td>Bespoke Leadership programme</td>
<td>Identify staff development needs for leadership programme</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Bespoke maternity training</td>
</tr>
</tbody>
</table>
## Measurement Plan

<table>
<thead>
<tr>
<th>Measure Name</th>
<th>Compliance with Sepsis clinical pathway</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Measure Type</strong></td>
<td>Process (Percentage)</td>
</tr>
<tr>
<td><strong>Measure description</strong></td>
<td>% compliance with all mission critical aspects of the clinical pathway</td>
</tr>
<tr>
<td>Numerator</td>
<td>Number of patients eligible for inclusion on the sepsis pathway</td>
</tr>
<tr>
<td>Denominator</td>
<td>Number of patients whose care reflected all mission critical points of the sepsis clinical pathway</td>
</tr>
<tr>
<td>Reporting Frequency</td>
<td>Monthly via Clinical Pathways report</td>
</tr>
<tr>
<td><strong>Numeric Goal</strong></td>
<td>40% compliance with delivery of all mission critical points as agreed with CCG’s</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Measure Name</th>
<th>Compliance with AKI clinical pathway</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Measure Type</strong></td>
<td>Process (Percentage)</td>
</tr>
<tr>
<td><strong>Measure description</strong></td>
<td>% compliance with all mission critical aspects of the clinical pathway</td>
</tr>
<tr>
<td>Numerator</td>
<td>Number of mission critical points each patient was eligible for management of care under the pathway</td>
</tr>
<tr>
<td>Denominator</td>
<td>Number of mission critical points delivered per patient</td>
</tr>
<tr>
<td>Reporting Frequency</td>
<td>Monthly</td>
</tr>
<tr>
<td><strong>Numeric Goal</strong></td>
<td>50% compliance with delivery of all mission critical points as agreed with CCG’s</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Measure Name</th>
<th>Compliance with NICE CG50</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Measure Type</strong></td>
<td>Process (Percentage)</td>
</tr>
<tr>
<td><strong>Measure description</strong></td>
<td>% compliance with NICE CG50 audit standards</td>
</tr>
<tr>
<td>Numerator</td>
<td>Number of eligible patients</td>
</tr>
<tr>
<td>Denominator</td>
<td>Number of eligible patients who met audit standards</td>
</tr>
<tr>
<td>Reporting Frequency</td>
<td>Annually</td>
</tr>
<tr>
<td><strong>Numeric Goal</strong></td>
<td>90% compliance with all NICE guidance audit standards</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Measure Name</th>
<th>Cardiac Arrest</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Measure Type</strong></td>
<td>Process (Case note review)</td>
</tr>
<tr>
<td><strong>Measure description</strong></td>
<td>Number of avoidable cardiac arrests</td>
</tr>
<tr>
<td>Numerator</td>
<td>Number of patients experiencing a cardiac arrest</td>
</tr>
<tr>
<td>Denominator</td>
<td>Number of patients whose cardiac arrest was avoidable</td>
</tr>
<tr>
<td>Reporting Frequency</td>
<td>Quarterly</td>
</tr>
</tbody>
</table>

Balancing Measures

These are measures designed to identify the impact (positive or negative) of this work and interventions on other parts of the care system. In order to demonstrate cost savings, we will populate the productivity calculator below. To establish an organisational improvement we will gather baseline data for each measure and review progress on a quarterly basis.

<table>
<thead>
<tr>
<th>Measure Name</th>
<th>Compliance with NICE CG190</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measure Type</td>
<td>Process (Percentage)</td>
</tr>
<tr>
<td>Measure description</td>
<td>% compliance with NICE CG190</td>
</tr>
<tr>
<td>Numerator</td>
<td>Number of eligible maternity patients</td>
</tr>
<tr>
<td>Denominator</td>
<td>Number of eligible maternity patients who met audit standards</td>
</tr>
<tr>
<td>Reporting Frequency</td>
<td>Annually</td>
</tr>
<tr>
<td>Numeric Goal</td>
<td>90% compliance with all NICE guidance audit standards</td>
</tr>
</tbody>
</table>

| Cost (Productivity)           | Reduction in litigation costs associated with failure to rescue / recognise deteriorating patient |
| Mortality (SHMI)              | Reduction in mortality associated with sepsis and AKI |