Blackpool Paediatrics Patient Safety Initiative

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Introduction

Over the last decade there has been an increasing awareness within the NHS about the impact a positive or negative safety culture within organisations can have on patient outcomes and experience. Up to now, we have had no formal understanding of how our culture in Paediatrics impacts our patients, and the ways in which we could reduce harm through improvements to our workplace.

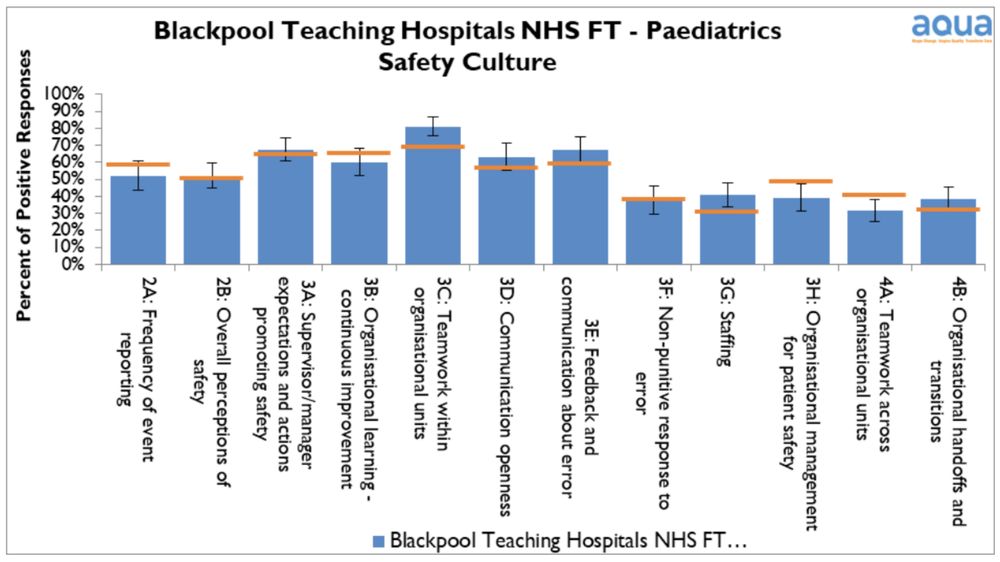
After a safety culture survey conducted by Advancing Quality Alliance to assess our strengths and weaknesses, we sought to build on national work by the Royal College of Paediatrics and Child Health as well as theories on patient safety described by the Health Foundation (Vincent 2013) in order to improve the reliability of our systems and ensure we have greater sensitivity to operations, i.e. that we are collectively aware of issues that may impact the safety of our patients.

Aspirational goal

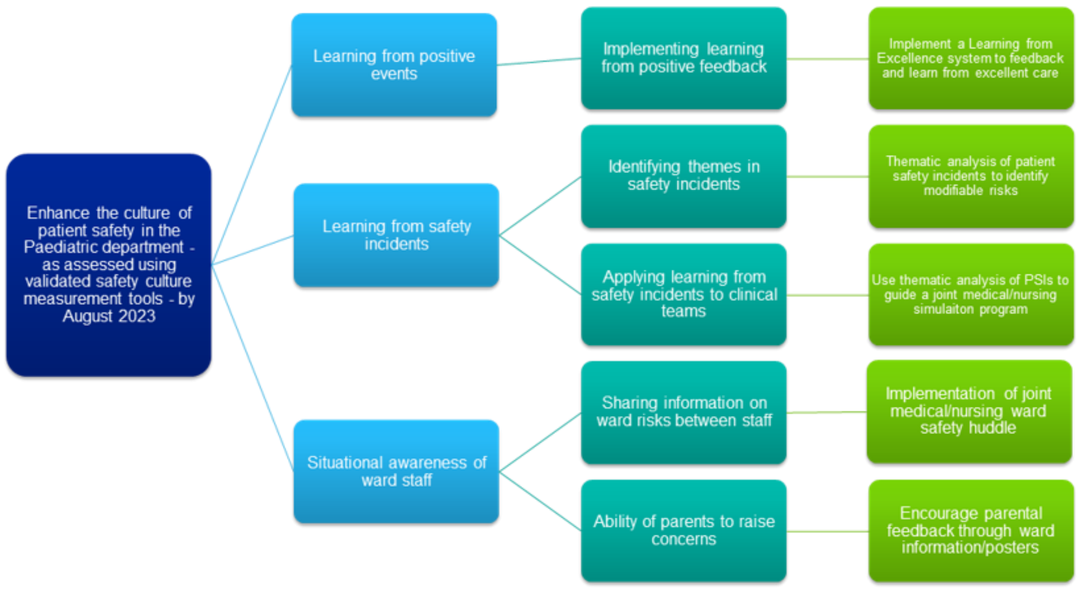
"Enhance the culture of patient safety in the Paediatric department, as assessed using validated safety culture measurement tools."

Initial assessment

Agency for Healthcare Research and Quality (AHRQ) Safety Culture Survey – Orange bars indicate peer trust performance



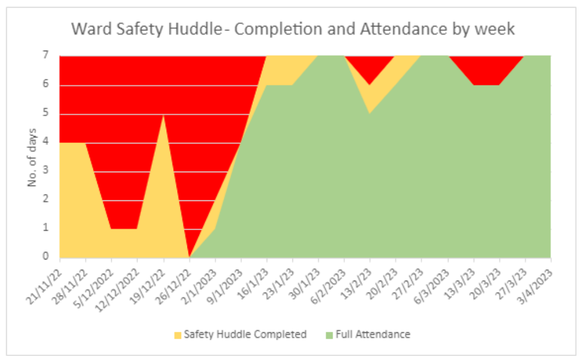
Driver Diagram



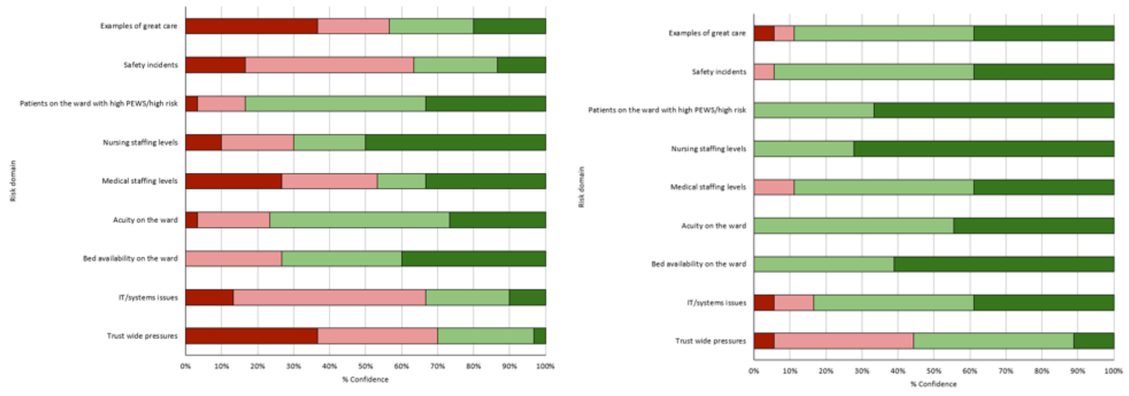
Change ideas

learning from excellence

Results



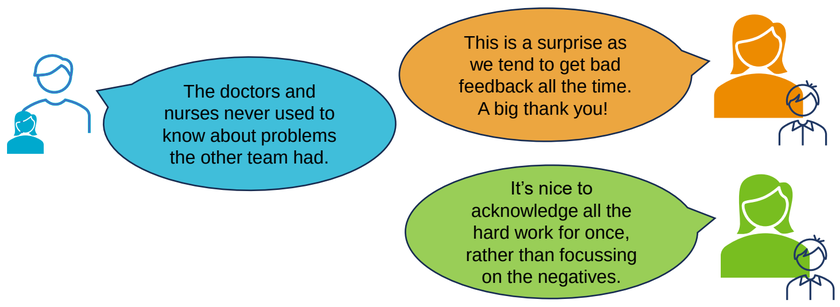
Staff survey - % of staff indicating knowledge of daily risks relating to each risk domain



September 2022 May 2023

Bimonthly surveys have shown significantly improved staff situational awareness of risks on the ward, allowing planning and reallocation of resources to minimise risks to patient safety.

Feedback



Sustainability and Spread

- Explore themes arising from safety huddle
- Safety Huddle to Neonatal Unit
- Learning from Excellence to Emergency Department and Maternity

Repeat sustainability assessment has shown improvements in the resilience of the programme, with improvements in the infrastructure and buy in from clinical leaders, as well as resilience to changes in personnel. Next steps include the evolution of the safety huddle to address key risks, and the spread of both programmes to other clinical areas.

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