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Implementation of a ventilator bundle as part of the “Safer Patients Initiative”: a qualitative case study

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The “Safer Patients Initiative” ventilator care bundle

- **Ventilator associated pneumonia (VAP)**
 - The most common form of hospital acquired pneumonia (Chaste & Fagon, 2002)
 - Significant cause of morbidity and mortality in the ICU, higher treatment costs (Westwell, 2008)
 - The ventilator care bundle can significantly reduce the risk of VAP (NICE 2008, IHI 2005)
 - elevation of the head of the bed
 - deep vein thrombosis (DVT) prophylaxis
 - gastric ulcer prophylaxis
 - daily sedation vacations
- **The “Safer Patients Initiative” (SPI)**
 - Patient safety improvement intervention in 24 NHS organisations (Health Foundation, IHI)
 - Aim: to improve the reliability of front line care processes (*critical care, general wards, perioperative care, medicines management*)
 - Methodology: PDSAs (Plan-Do-Study-Act cycles), incremental spread methodology, process measurement, SPC analysis, learning sessions, extranet, monthly evaluation, expert support
 - Goal for ventilator care bundle: 95% adherence to all 4 elements, every ventilated patient every day

Our study

- **Qualitative case study**
 - Setting: Intensive care units of 3 SPI sites
 - Sample: 9 senior executive leads, 4 SPI programme coordinators and 4 clinical operational leads in the critical care work stream (n=17)
 - Methods: Individual semi-structured interviews on perceptions of the implementation of the SPI ventilator bundle
- **Thematic analysis:** 3 overarching themes with relevant sub-dimensions
 - the power of measurement
 - *Overcoming previous assumptions about compliance*
 - *The process of defining outcomes*
 - feedback to experts and peers
 - *Feedback of compliance*
 - *Feedback of outcomes*
 - the methods used for improvement
 - *PDSAs, teaching sessions & daily goal sheets*

Key points

- Importance of **measurement and feedback** of compliance and outcomes
 - drive for learning and improvement
- **Feedback** of compliance and outcome data
 - discussions of good practice
- **SPI methodology** had an important impact on the buy-in of clinical staff
 - PDSA cycles: accelerate change
 - Teaching sessions: translate the language of the bundle into the operational language for staff at the bedside
 - Daily goal sheets: offer clarity about processes and the standards against which the staff were judged