



Improving Patient and Client Safety

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Role of HSC Safety Forum

- HSC Safety Forum constituted in June 2007 to support Trusts in implementing internationally recognised evidence-based interventions known to reduce mortality and harm
 - Assist organisations to deliver safe care within an open, learning culture
 - Build and develop quality improvement capacity in line with internationally recognised theory and practice
 - Work collaboratively with key stakeholders
 - Acting in an advisory capacity in relation to safety and quality improvement to the HSC Board (PMSI) and the Safety, Quality and Standards Directorate, DHSSPS
- The Forum is not an executive body and has no powers to direct HSC organisations, but rather exists to support and advise HSC bodies in achieving the highest standards of quality and safety




Improvement Methodology

- Build the *will* to improve, generate *ideas* about alternatives to the status quo and assist providers in making it real-*execution*
- Develop quality improvement capability
 - Principles of Reliability
 - The Improvement Model
 - IHI Collaborative Model for achieving Breakthrough Improvement
- The imperative of Leadership





The Model for Improvement

What are we trying to accomplish?



How will we know that a change is an improvement?

What changes can we make that will result in improvement?



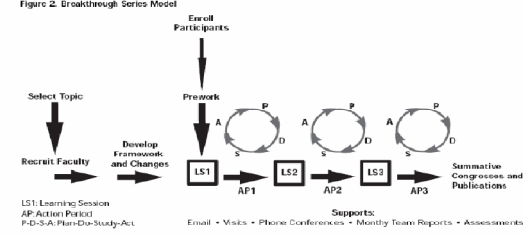
- Set aims that are measurable, time-specific, and apply to a defined population
- Establish measures to determine if a specific change leads to improvement and plot data over time
- Select changes most likely to result in improvement
- Test the changes

T. Nolan et al. www.ihl.org



The Breakthrough Series: IHI's Collaborative Model for Achieving Breakthrough Improvement

Figure 2: Breakthrough Series Model




LS1: Learning Session
AP: Action Plan
P: Plan-Do-Study-Act

Supports: Email • Visits • Phone Conferences • Monthly Team Reports • Assessments

How to Improve

- Form the Team (right people crucial)
- Set Aims (how much by when)
- Establish Measures (begin with baseline and plot over time)
- Select Changes
- Test Changes (1,3,5,all)
- Implement Changes (only after successful testing under a variety of conditions)
- Spread Changes (only after successful implementation in pilot unit)




Priorities for Action(PfA)2008/09/10

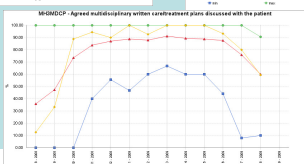
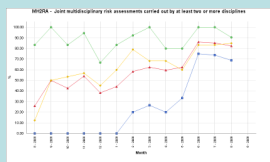
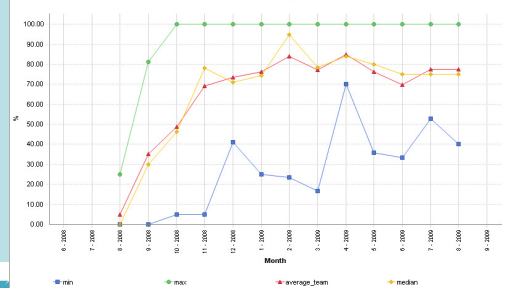
2008/09

- Reduce MRSA by 10% and C Diff by 20%
- Reducing VAP,CLI,SSI (ortho and C-Section)and Crash calls
- Mental Health inpatient risk assessment, multidisciplinary review and patient involvement

2009/10

- Trusts should ensure that satisfactory progress is made towards the achievement of Trust-specific targets for VAP, SSI, CLI, crash calls rate and mental health inpatient care
- By 30 June 2009, Trusts should submit to the Dept for approval and monitoring, QIP's to prevent venous thromboembolism (VTE) through risk assessment and adherence to local policies on VTE prophylaxis

SSI - Bundle Compliance



Other regional improvement work

- Regional Perinatal Collaborative (started 2008)
 - Focusing on EFM, induction/augmentation of labour, communication and team working
- Medication Safety at the Primary/Secondary Care Interface (Acute and Mental Health); 2009)
- VTE Collaborative (2009)
- WHO Surgical Safety Checklist (2009)
- Mental Health Medication Safety Initiative utilising IHI improvement methodology in 1 Trust since 2005 (South Eastern)
- TCAB/ Clinical Microsystems prototype work (2008/9)
- Previous work: CSCG Support Team-Regional Children's Service Collaborative –first use of IHI methodology in Social Care (2007/08)
- 2009/10
 - Involving Patients in Improving Patient Safety
 - Social Care Collaborative (??unallocated child care cases)
 - Stroke Collaborative
 - Work with Ambulance Trust
 - Building Improvement Capability