Delivering Safer Care

Listen Learn Improve

12 MARCH 2014
BREAKOUT SESSION: OLYMPIC SUITE
FRONT LINE IMPROVEMENT

#safercare14
Getting it right for children and young people: a Paediatric Decision Unit as an alternative to acute admissions

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CRAIGAVON AREA HOSPITAL
PORTADOWN. CO ARMAGH. BT66 5QQ. N.IRELAND
Background

- Increasing numbers of children presenting to the ED
- Increasing paediatric inpatient admissions
- Increasing short stay admissions (Length of stay <24hours)
- Increasing strain on healthcare resources and risks to children
Aim

To reduce the number of ‘overnight stays’ for selected patients referred to a paediatric ward in a district general hospital
Project Design

- Measure acute admissions with length of stay <24 hours
- Obtain funding for a short stay observational facility
- List needs of primary care and ED
- Develop referral process protocol
- Develop list of common acute paediatric conditions
- Measure effects on inpatients
Service Changes

- Paediatric Decision Unit (PDU)
- List of paediatric conditions
- Paediatric advice line (PAL) mobile
- Telephone proforma
- Review meetings
- Networked with other short stay units
Multi-disciplinary Involvement

Core PDU Team

- ED
- GP
- Admin
- Ward nurses
- Patients
- Paediatric doctors
- Outside experts
Referral Process to PDU

ED Triage

ED/GP/OOH/MW/HV referrals

PAL phone

PDU Assessment

Direct Admission

ED Assessment

Routine OPA

Rapid OPA (< 3 days)
Difficulties encountered with change

- Unclear expectations
- Communication
- Adaptation of telephone proforma
- Technical phone issues
- Time of last referral
Monthly acute inpatient admissions to the paediatric ward

No of inpatients

Month

January
February
March
April
May
June
July
August
September
October
November
December

2011
2012
2013
Diagnoses presenting to PDU (Jan 2014)

- Resp URTI: 17%
- Resp LRTI: 32%
- G I: 20%
- CVS: 3%
- Abdo: 2%
- Hepatic: 10%
- Neuro: 7%
- MSK: 4%
- Haematological: 2%
- Skin: 3%

Legend:
- Resp URTI
- Resp LRTI
- G I
- CVS
- Abdo
- Hepatic
- Neuro
- MSK
- Haematological
- Skin
PDU patients Length of Stay for 2013

- <1 hr
- 1-<2 hrs
- 2-<4 hr
- 4-<6hr
- > 6hr
- Not documented

No of Patients

Length of Stay
Feedback

STAFF

- Improved ward structure
- Reduced disruptions
- Improve flow from ED
- Development of staff
- Reduced stress

PATIENT/FAMILY

- Quicker access to specialist
- Reduced family disruption
- Parental education
- 72 hour return option
Conclusions

The development of the Paediatric Decision Unit has resulted in:

- Decreased numbers of inpatient medical admissions
- Increased direct referrals from general practice
- Improved patient journey
- No increase in harm
- Improved ward structure
- Clinical and economic significance
Future Plans

- Secure funding for opening at weekends
- Increase number of beds in PDU
- Secondment of staff for advanced training
Improving the effectiveness of medicines reconciliation

Ciara Kirke
Drug Safety Coordinator
Tallaght Hospital, Dublin

Delivering Safer Care Conference
Belfast, 12th and 13th March, 2014
Goals and Aims

• Reduce preventable harm to patients by
  – Improving medicines reconciliation

• All patients receiving a clinical pharmacist medicines reconciliation review will have the recommended changes made to their prescription chart (or documented reason not to make the change) within 12 hours of the pharmacist’s recommendation in 75% of cases, by August 2012
Following discharge, error in 27% of drugs in transcribing discharge prescription to GMS prescription.

Duggan, IPU Review, Feb 2009

6.5% of admissions primarily due to adverse drug reaction

Pirmohammed et al, BMJ 2004

26% of admissions of over 65s due to drug-related harm

Hamilton et al, Arch Int Med 2011

On admission, 25% of pre-admission medication omitted/incorrect.

Clinical pharmacist medicines reconciliation for 30-60%.

In-house data

Approx one medication error per hospital in-patient per day

Institute of Medicine, Preventing Medication Errors

7-11% of new prescriptions- pharmacists identify potential intervention.

In-house data

50% of patients have errors on discharge prescription.

Grimes et al, BJCP 2011

Over 7,800 drug doses prescribed/administered per day

In-house data
At baseline

- Medicines reconciliation post-admission main clinical pharmacist activity
- Six Sigma project improved documentation

- 54% of recommended changes were made to the in-patient drug chart during admission
Model for Improvement

What are we trying to accomplish?

How will we know that a change is an improvement?

What change(s) can we make that will result in improvement?

Test changes

Act

Plan

Study

Do

Implement

Spread

Sustain

Gathering ideas for change & comments

- Existing data
  - Previous projects, research, data collected
- Process experts
  - Interns, SHOs, clinical pharmacists, nurses
- Stakeholders
  - Pharmacy managers, consultants, senior nurses, patients, me
- External
  - IHI, literature, RCPI participants and faculty
## Prioritising ideas for change

<table>
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<tr>
<th>Idea for Change</th>
<th>Impact</th>
<th>Work</th>
<th>Readiness for PDSA</th>
<th>Rating</th>
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<td>++</td>
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</table>

Figure 1: Ideas for Change, ranked by Impact (++++=likely to be highly effective), Work (+++=less work than currently for pharmacist/doctor), Readiness for testing (+++=ready)
Main PDSAs

1. Adding verbal communication: improved effectiveness from 46 to 75% and time to effect from 22 to 5 hours.
2. Larger test: Communicating verbally with the doctor.
3. For interventions documented in the notes initially which were not effective within 24 hours, verbal communication then.
Notes + verbal most effective...
... and quickest effect

![Chart showing mean time to effect (hours)]
THE EMERGENCE OF LANGUAGE

WE NEED TO TALK.

UH-OH.
Embed the changes

Reverting to usual practice?

Addressed psychology

Sustained improvement
Economics (2013)

• Net costs averted €153,588

• Additional 2,264 alterations made to chart
  – 9,055 discrepancies, additional 25% reached patient

• Additional 99.6 adverse drug events averted
  – 4.4% risk of an ADE per discrepancy (Boockvar et al, 2004)

• €156,983 costs averted
  – Attributable costs per adverse drug event €1,576 (Senst BL et al, 2001)

• Cost of intervention €3,395
  – 2 minutes per patient: 97 hours/year @ €35/hour
If all patients had been seen in 2013

• Would have saved €327,982, despite need to invest in staffing
  – 12,135 more med recs in 2013
  – 20 mins each
  – €35/hour
  – Costs incurred €141,575
  – Costs saved €469,557
Further work

Collaborative pharmaceutical care model

– decreased the prevalence of any medication error at discharge (adjusted OR 0.07; NNT 3)
– no PACT patient experienced a potentially severe error (NNT 20)
– improved the MAI score from preadmission to discharge in patients aged ≥65 years (Mann–Whitney U p<0.05; PACT median −1, IQR −3.75 to 0; standard care median +1, IQR −1 to +6)

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Endobronchial Ultrasound Guided Transbronchial Needle Aspiration for the Diagnosis of Lung and Mediastinal Lesions - A Case Series

Dr David McCracken
Dr Grace Loye
Outline

- Definition of EBUS-TBNA
- Role of EBUS
- Implementation of service
- Results from first unit in province
- Lessons learned and future developments
Definition and Role

- Endobronchial ultrasound guided transbronchial needle aspiration (EBUS-TBNA) is recommended by the National Institute for Health and Care Excellence (NICE) for the investigation of mediastinal, paratracheal and peribronchial lesions suspicious of malignancy.
Definition and Role

- Definitive staging requires tissue diagnosis
- It is less invasive than traditional mediastinoscopy and is widely used in the investigation of patients with suspected lung malignancy and mediastinal lymphadenopathy.
Aim

• Present the results of the first unit to offer EBUS-TBNA locally with particular reference to figures quoted by other referral centres across Europe
Implementation

- Implementation included adequate training of the endoscopist and day procedure staff, allowance of additional time during endoscopy lists and adequate investment in the service.
Results

- Thirty-seven patients underwent the procedure during the first 11 months, of which 24 were male.
- The mean age of the cohort was 63 (range 31-78) and each patient had traditional bronchoscopy in addition to EBUS.
- The mean time from CT scan to procedure was 34 days (range 2-84 days).
Results Continued

- Forty-one tissue samples were obtained and diagnostic sensitivity calculated as 82.4% and specificity 100%.
- One patient suffered a right sided pneumothorax requiring an inter-costal chest drain and recovered without complication.
Tissue Sampling

- The most common stations for tissue sampling were 7 (n=19), 10R (n=7), 4R (n=5), 11L and 11R (n=4 respectively) and 10L (n=2) as shown.
Anatomy of Lymph Node Stations
Tissue Results

- Pathological cells were found in 27 cases with primary lung tumours making up the bulk of the diagnoses.
Local Application and Sustainability

• A variety of pathology was identified using the technique with a similar diagnostic sensitivity and specificity as quoted by other referral centres in the UK and Europe.
Conclusion

- Thirty-seven EBUS-TBNA procedures have been carried out to date in the first unit to offer the service in Northern Ireland.
- Forty-one tissue samples were obtained and diagnostic sensitivity calculated as 82.4% and specificity 100%.
- Results were comparable to those quoted by other referral centres in the UK and Europe.
Thank You
References

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#safercare14
Waterford Regional Hospital
Reducing harm from falls.

- Gemma Poole (Clinical Placement Co Ordinator)
- Louise Brent (Arthroplasty nurse)
- Karen Power (Occupational Therapist)
- Breda Jones (Stroke CNS)
- Angela O’Neill (Care Assistant)
- Liz O’Shea (CNM2 Medical)
Waterford Regional Hospital

- Population of 500,000 - covers the counties Waterford, South Tipperary, Wexford, Carlow and Kilkenny.
- General Medical and Surgical services are provided for the Waterford City and County catchment population of 113,795.
- NCCP cancer centre

- Inpatient beds 401:
  - 45 Acute Psychiatry beds
  - 158 Medical beds
  - 114 Surgical beds
  - 36 Obstetric beds
  - 48 Paediatric beds
- Day Care beds: 103
Overview

- Falls Group in Waterford Regional Hospital
- Aim of the group
- Falls Collaborative
- Changes made in clinical practice
- Challenges & achievements
- Results - comparison data
- Movie madness – putting fun into the process
Falls Group

- Establishment of a falls awareness and prevention group in WRH in 2012

- Multidisciplinary
  - Nurse (all grades) – General Medical & Surgical, Care of the elderly, Stroke, Orthopaedic, Fracture liaison
  - Care Assistant
  - Occupational Therapy
  - Physiotherapy
  - Clinical Risk
  - Medical
  - Pharmacist
Aim of the Falls Group

- Reduce the likelihood of falls especially of falls with harm
- Develop and implement a falls policy to ensure consistent, safe and appropriate care of patients.
- Risk assessment and re-assessment of patients at risk of falling
- Clear identification of patients at risk of falling
- Communication of risk with multidisciplinary team
- Education of staff, patient and significant others
Six members of the falls group joined the Falls Collaborative facilitated by RCPI & NMBI in March 2013

Collaboration = labouring together
- Benchmark what was being done in other hospitals
- Knowing what you should do is not the same as HOW to do it

Collaboration changes the way we work by learning from others successes and mistakes

PDSA: Plan, do, study, act!!

Discover a JOY…………….Movie
Safety Crosses

- Idea came from Collaborative
- Visual tool to put falls on everybody's radar (immediate feedback)
- Green day = 0 falls
- Medical 1 commenced
- Working through all inpatient clinical areas in WRH
- Feedback
Sample: September-December 2013

September

October

November

December
Changes in clinical practice

- Falls are on the radar now - falls are being monitored
- Changes introduced one clinical area at a time - ward by ward
- All patients ≥ 65 must have a FRASE done on admission. Reassessment weekly (minimum)
- Pre-printed care plan to support care
- Safety Cross
- Newsletter monthly
- Information booklets
- Falls policy development and implementation (Algorithm)
Changes in clinical practice continued

- Visual prompt (We’ve been tangoed)

  - Orange is the colour identified with falls - what's it ORANGE about?
  - Identification of patient at risk of falling on the white board with orange colour
  - Orange square by the bedside
  - Information around the ward environment
  - Orange resource packs in the clinical areas
Falls resources
Challenges & Successes

Challenges

- Lack of resources such as
  - Staff time for training/implementation of changes
  - Equipment to prevent falls such as low-low beds, sensors
- Lack of belief/interest
- No dedicated position for falls management such as a falls prevention nurse/CNS
- No falls clinic in WRH
- Limited pharmacy input
- Limited Medical input

Successes

- Comprehensive falls policy
- Developed many online resources for the hospital such as: patient information booklet, relative information booklet, falls algorithm, falls stickers for patient notes, orange resource pack
- The safety cross has successfully been introduced on all acute wards - falls are on the agenda now!
- Monthly newsletters
- Finding motivated team members - start with the willing!
Safety Cross Results
October 2013-February 2014

* Note in January one patient fell repeatedly but no harm was sustained
In December the patient acuity was very high and in January there was a lot of staff sick leave not replaced which coincided with an increase in falls.
Safety cross results
August 2013- February 2014

* Note October one patient had several falls but no injuries sustained and February staffing levels were very low due to sick leave.
Results

- In the first six months of 2013 we had an 11% reduction in the number of falls overall. We have seen a staggering 73% reduction in our inpatient falls which resulted in a fracture compared to the same time period last year. We have also seen an over 50% reduction in bruising and other minor injuries.

- Some months there is an increase in falls the reason for this is investigated and acted on.

- Our motto is “even if you fall on your face you’re still moving forward”
The team.....
Making the Movie
Delivering Safer Care

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Giving the Silent Epidemic a Voice

Dr Eunan McCrudden (Highly Specialist Clinical Psychologist), Naomi Brown (Highly Specialist Occupational Therapist) & Lindsay Klimacka (Highly Specialist Speech & Language Therapist)
Overview

Where did we come from?

What does our service aim to do?

How have we aimed to do this?

How do we provide our service?

How close are we to our aims?

What do our outcomes look like?

What are our plans for the future?
Where did we come from?

- **RABIIG**
  - Regional review of brain injury services in NI
  - Pathways documents
    - child & adult services
  - Issues
    - Inequalities between adult & adult services
    - Perceived skills gap
    - Lack of information
    - Need for transition arrangements
What does our service aim to do?

To support existing services, to recognise and respond to the needs of children after an acquired brain injury.
How do we provide our service?

**Figure 1: Care Pathway – Moderate to Severe Acquired Brain Injury**

**Acute Care**
- Early recognition, triage, assessment and intervention, for example, in A&E Departments.
- Communication with family on severity of condition and arrangements.

**Transfer**
- Surgical/medically appropriate unit or ward for acute care and stabilisation.
- Commencement of care planning and intensive rehabilitation.

**Specialist Inpatient Care**
- Intensive Rehab RBHSC
- Specialist multidisciplinary assessment and care plan agreed with family/individual to include:
  - Rehabilitation goals
  - Discharge planning
  - Management of specific problems eg. tracheostomy
  - Liaison with community team
  - Follow-up arrangements
  - Named contacts
  - Support for families

**Community Care & Support**
- Planned discharge to home or other appropriate setting:
  - Community rehabilitation goals
  - Prevention of complications
  - Promotion of lifelong independence
  - Respite planning
  - Transition arrangements
  - Follow-up reviews, if appropriate
  - Clinical management in the community
  - Named contact details
  - Ongoing family support
  - Education services

Acute Services
Community Services (both child & adult)
Across programmes of care

Non-NHS Partners

Children’s Acquired Brain Injury Consultation Service, RBHSC
How have we aimed to do this?

- **Information:**
  - Production of information leaflets,
  - Improvement in utilisation of voluntary services.

- **Training:**
  - Pre- & post-qualification
  - Generic & difficulty specific
  - Foster shared developmental understanding

- **Consultation:**
  - Child specific advice & support across agencies/programmes of care
How close are we to our aims?

- Information:
  - Production of information leaflet: on-going
  - Formal networks established between professional & voluntary sector

- Training:
  - Local (team-specific)
  - Regional (Clinical Education Centre, CEC; social work training managers)
  - National (RCPCH)

- Consultation: 55 (53% HSC; 27% education)
## How close are we to our aims?

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Children’s Acquired Brain Injury Consultation Service, RBHSC
What do our outcomes look like?

“Informative input, made me think about children’s behavior in a different way, how accidents could have affected them.”

“Most Interesting, enlightening and definitely puts a whole new slant on case-history”

“Very well taught, great help, feel a lot more confident”

“All really interesting & such a useful resource to have available regionally”

“Include an educational specialist in the team”
What do our outcomes look like?

Consultation evaluations & Feedback

- “It’s an invaluable service! Thank you.”
- “Thanks for consultation and report, very helpful and appreciated”
- “Super to have this service to support and advise”

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What do our outcomes look like?

Case study of impact of service on programme delivery
Higher scores = improvement

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<th>Empathy &amp; Understanding</th>
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Mean Scores

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What do our outcomes look like?
What are our plans for the future?

- Develop specific trainings on common presentations
- Enhance partnership arrangements outside of HSC
- Seek “buy-in” from relevant agencies
- Further develop partnerships with academic institutions to develop evidence-based practice and share learning