SIGN UP TO SAFETY CAMPAIGN

Q3 REPORT (OCTOBER – DECEMBER 2016)

1.0 Participation in the campaign

Communications

It is now a year since we created the @FHPatientSafety Twitter account and we currently have 452 followers and regularly have our messages retweeted by the national Sign up to Safety Team.
Some of the wards at Wexham Park are currently trialling the Nudge Rewards app that sends 4-5 bite-sized pieces of information and allows staff to share ideas, feedback and complete quizzes. Staff who engage are awarded points and teams can compete for challenge trophies. Since the beginning of December Topic of the Week has been one of the bite-sized messages each week.

Staff engagement

Over the Christmas period we have been returning safety pledges to staff and asking them to reflect on their pledge, celebrate their personal and professional successes and learn from their experiences, even if they have not done exactly what they set out to do. We are also taking this opportunity to ask them to consider making a new pledge for 2017.

Public engagement

At the most recent constituency event we shared the new 'Top 10 Tips' banners, posters and leaflets. These were well received by the public who felt it was useful to them as patients, relatives and carers to know what more they could be doing to stay safe in hospital.

Topic of the Week

Since December Topic of the week is also now shared using the Nudge app. It is also included in corporate induction as one of the break time slides to increase awareness of the social learning opportunity. It has also been acknowledged that there are a lot of staff who do not feel confident using social media sites and a group of Frimley tweeters are now running face to face introductory sessions to help staff get started on Twitter.

2.0 Collaboration

We have now recorded the podcast which used the 3 way conversation model that Sign up to Safety have been promoting with Frimley Health being the 'story teller' talking about their experiences for the campaign so far, South West London and St George's Mental Health Trust (SWLStG) being the active listeners and Stranger Collective acting as facilitator and observer. The podcast has not yet been released by Sign up to Safety but we hope that it will be available in the New Year. Following the podcast SWLStG's have requested a visit to Frimley Health to see more of the work being done around handover and encouraging an open and just safety culture. We hope there will also be lots we can learn from SLWStG's as well.

We are currently in the process of arranging an event showcasing the Trusts work in safety improvement and will be inviting Professor Jane Reid, Regional Lead for Sign up to Safety to present an update on the national perspective.

The Lead Midwife for Sign up to Safety provided feedback on our continued experience with the Episcissors-60 to The NHS Innovation Accelerator Programme. In October the project was shared at The Royal College of Midwives conference via a poster display, attended by the lead Midwife.

3.0 Clinical handover

Summary of planned actions

- ✓ Review of existing processes related to handover, including transfer of care between specialists, movement between departments and shift change.
- ✓ Establish robust safety focused handover processes.
- ✓ Implement standardised safety handovers trust wide.
- ✓ Monitor handover practice to ensure sustainability and benefits to patient safety.
- ✓ Engage with patient and service users to understand their needs and expectations of safe handover.
- Final in-patient departments to adopt Safety SBAR handover by November 2016.
- 75% of in patients departments to include daily debrief at shift change by December 2016.
- Review implementation of hospital at night handover at Frimley Park and ensure key standards are reflected across Frimley Health.
- Align Trust transfer policy, including transfers from Emergency Department to wards, ward to ward transfers, transfers to critical care areas.

- Unified electronic solution for specialist referrals (using Safety SBAR format) including acceptable time limits and confirmation of transfer of care.

Update on Actions

To ensure that the Safety SBAR handover model is becoming embedding in all ward areas the Matrons, Senior Sisters and Senior Charge nurses for each area have performed spot observations of their wards and departments. The results of these are currently being reviewed but initial (un-ratified results) suggest that there has been great improvement in situational awareness of key safety concerns, patient engagement and discharge planning.

The wider impact of the Safety SBAR handover model, and in particular the introduction of a safety briefing has been highlight by one of the medical wards at Wexham Park where the staff have said that they feel the number of patient falls have reduced because of awareness and the safety handover (briefing). One staff member commented "everyone knows who is at risk at falling so they can care for them more appropriately".

Around 35% of wards are now regularly having end of shift debriefs. We are expecting this to increase over the next quarter as more staff attend the nurse in charge training where the concept of debrief, learning from everyday experiences and improving staff well-being are key topics in the handover session (1 hour). Ward leaders are taking an organic approach to introducing debriefs as bedside handover need to be starting and finishing on time before time can be set aside time for debriefs. The individual department cultures also need to be addressed so that debriefs are a safe place, where colleagues will listen and care for each other.

We spend 12 hours caring for patients, debrief is about spending 5 minutes caring for each other

In November the Safety SBAR handover model was presented as a poster at the Patient First conference in London, copies for the poster can be found on the Frimley health website https://www.fhft.nhs.uk/your-visit/keeping-you-safe/

Work continues on updating the hospital transfer policies to have a more robust and user friendly process which provides both safety for patients and staff and positive patient experience. A cross

site working group is planned for the end of January before the process is shared and tested by the members of the patient safety committee and deteriorating patient groups.

After reviewing the current hospital at night practices at both Wexham Park and Frimley Park it was agreed that Wexham's hospital at night meeting is part of 'business as usual'. Whereas further work is needed at Frimley Park to embedding the process, identifying what information should be shared and any actions taken at the nightly meetings. There was a noticeable improvement in engagement from the site and bed management teams but further work is required from a critical care perspective.

Next Steps

- Embed Safety briefings in remaining in-patients wards (15%) by April 2017
- Support ward leaders in developing meaningful end of shift debriefs for their departments
- Internal Transfer Policy agreed and published by April 2017
- Further work on engagement and by-in from ICU for Hospital at Night meeting at Frimley Park
- Develop a selection of Matrons and Senior Sisters to deliver handover training for preceptorship groups and Nurse in Charge master-classes as part of the long term sustainable solution to improve handover

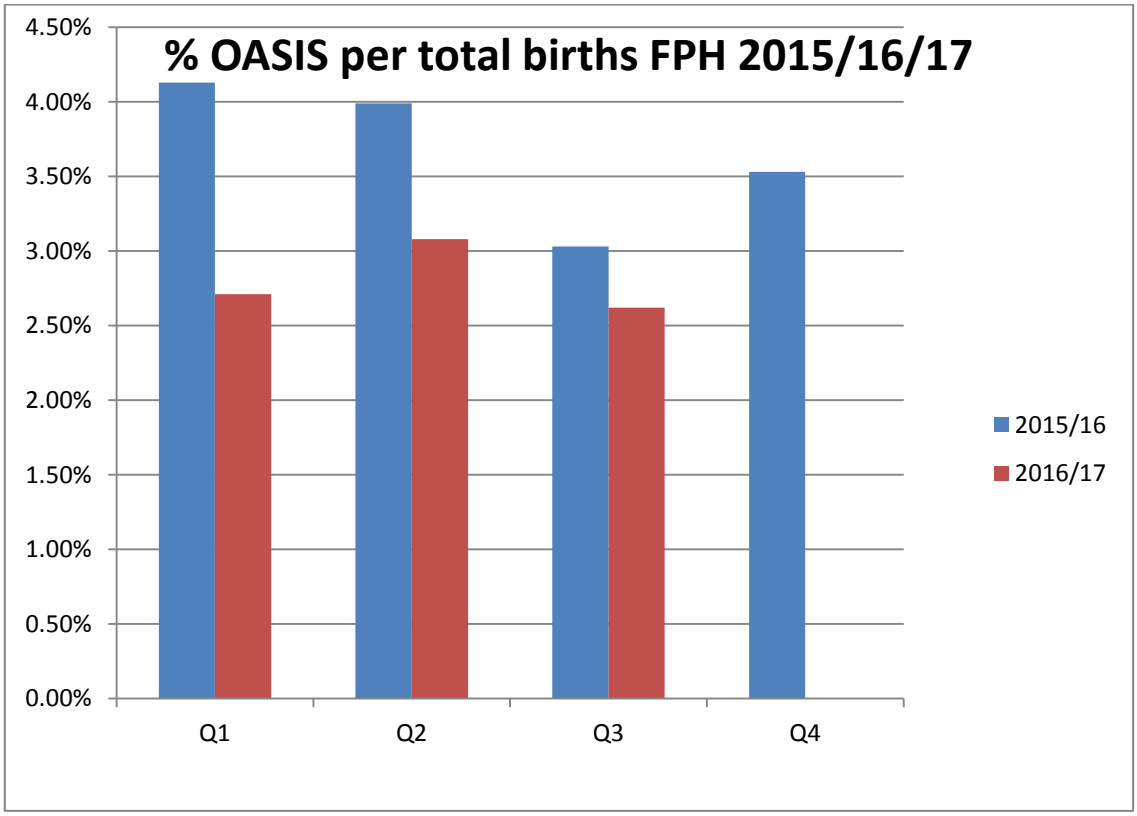
4.0 Management of the perineum during labour

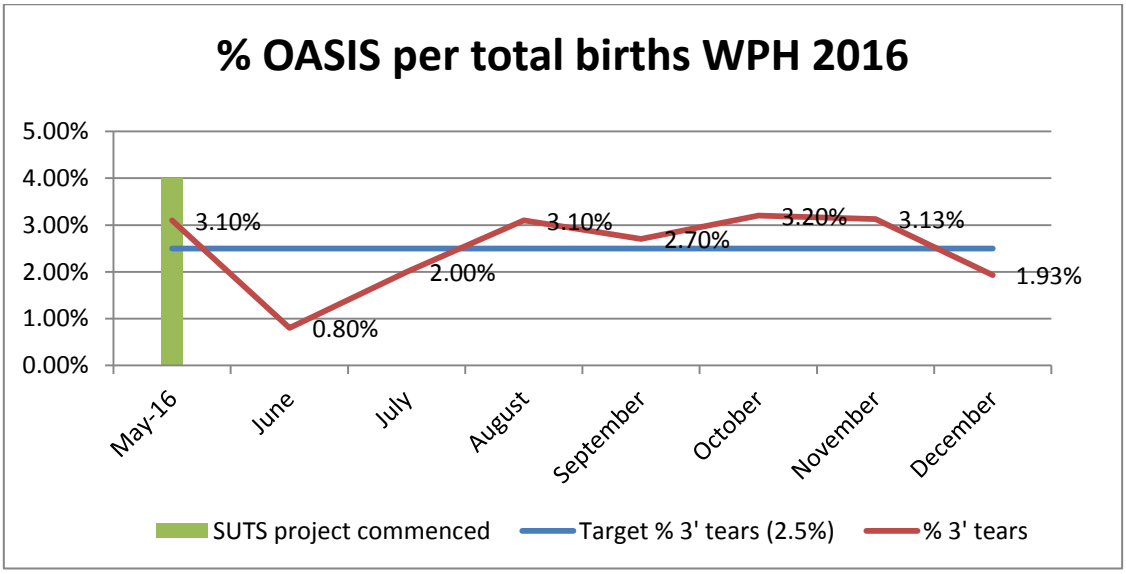
Summary of planned actions

- To improve care of the perineum at the time of childbirth with a focus on reducing the incidence of 3rd/4th degree tears.
- To train midwifery, medical and student staff in management of the perineum in 2nd stage of labour.
- To introduce specialist scissors for performing more accurate 60'episiotomy.
- To develop patient literature.
- To review/maintain associated guidelines.
- To review associated complaints and claims.
- To make national links and contacts.

Update on actions

- The rate of 3rd/4th degree tears for Q3 was 2.62% of total births at FPH site. This compares favourably with last year's Q3 (see below).





Figures for OASIS at WPH site should be viewed in the context of a higher LSCS rate than FPH site. Only monthly rate currently available.

- Teaching programme established at WPH site.
- Patient literature nearing completion for WPH site.
- Complaints and claims regularly reviewed and fed back to staff.
- Implementation of Episcissors for WPH site imminent
- Project aligned with pilot for national care bundle (FHFT lead midwife seconded to RCOG/RCM project).

Next steps

- Continue project at WPH.
- Embed use of Episcissors at WPH.
- Establish links with universities serving WPH to access student midwives
- Maintain impact of project at FPH site.
- Continue secondment to national project to ensure alignment.

5.0 Consent & Local Safety Standards for Invasive Procedures (LocSSIPs)

Summary of planned actions

- Review existing consent policy, documentation and procedures.
- Review existing consent process at specialty level.
- Understand current compliance with the consent policy within specialties, specifically focusing on:
  - quality and timing of process
  - documentation
  - WHO checklist compliance
  - use of patient information
- Identify high risk specialties/procedures.
- Work with patients to establish what they understand about the consent process – focusing on areas of particular interest and areas of concern.
- Ensure that:
  - patients are given sufficient time and knowledge to give informed consent
  - consent always considers patients' individualised comorbidities and the impact of risks and benefits are made clear

- Review current education and training for medical staff around the consent process.
- Implement Local Safety Standards for Invasive Procedures (LocSSIPs) based on NHS England's national guidance.

Update on actions

- Additional Band 7 project lead now in post since 12th December to drive consent programme.
- Continued review of existing policies and consent forms in order to align documentation across all sites is underway.
- All existing pre-populated consent forms are currently being reviewed. Pre-populated consent forms for specific orthopaedic procedures have been developed and are due to be implemented.
- Each consent project lead will focus on one of the identified high risk areas (Obs & Gynae, Orthopaedics and General Surgery) to ensure learning from Never Events, claims and serious incidents is disseminated within the specialty.
- Annual Trustwide Consent audit is currently underway across all sites. Notes for the identified specialties are being reviewed by a mix of senior nurses and medical staff.
- Full time Band 6 Sign up to Safety Facilitator appointed to support the campaign, particularly around consent programme with a key focus on patient information – starts Feb 2017.
- LocSSIP project lead now in post who will be based at Wexham Park to drive the LocSSIP programme across the organisation. They will support the procedural teams in developing and implementing LocSSIPs within each specialty and provide leadership around culture change and MDT training.

Next steps

- Trustwide Consent audit to be completed by end of January 2017. Results will be shared with the Quality Committee in February as a recommendation from a Never Event action plan. Recommendations to be shared with all specialties and actions implemented with specific target dates.
- Consent leads to collate learning from Never Events, claims and serious incidents to be presented at Clinical Governance meetings for high risk areas.
- Radiology and Theatres will be presenting their initial LocSSIPs at the next LocSSIP Group in February 2017.
- Work is currently underway to develop vascular access pathways (central lines, vas caths and mid lines) and the lumbar puncture LocSSIP for both adults and children. Discussions will take place with Haematology regarding the bone marrow LocSSIP.
- The aim is for Cardiology and Respiratory to have completed their LocSSIPs by the end of March.