Personal Experience of Using the NHS Safety Thermometer

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Our Trust

North East London NHS Foundation Trust provides mental health and community services in north east London and community services in south west Essex. Our community services in north east London include:

- two community hospitals
- approximately 30 community clinics
- broad demographic mix of patients

Where we started

We joined the Safety Express pilot, in December 2010, working with the acute trust.

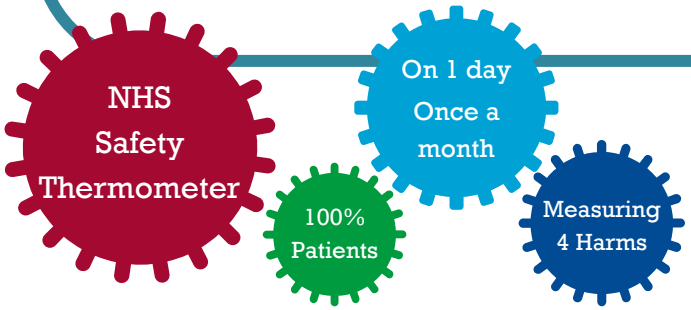
From the community trust we initially recruited both community hospitals and three district nursing teams, with support from the Director of Nursing. Following that, clinical community teams voluntarily signed up to join the pilot through word of mouth and networking, which also brought in new members. We also had one private dementia care home brought on board via the district nurses.

Our first aims of project 'Safety Express'

- For every registered nurse to be able to state the four harms
- For each registered nurse to know about the improvement work on their ward / in their team being done to prevent the four harms

Engaging with District Nursing Teams

To engage with the District Nursing teams, we went back to why the four harms are important and how they relate to District Nursing practice. When we explored these in detail, we were able to make clear links to their practice, in particular for VTE. Through examining this harm we saw how relevant it is to District Nursing. For example, where a patient is receiving post fracture care, the importance of the District Nurse's contribution to prevention of VTE, not just now, but in say, 9 months' time.



Linking Frameworks

We placed the Safety Express work and NHS Safety Thermometer within the E4E framework, appealing to the leadership skills of our nurses and the 'call to action' message. We wanted to highlight this as something that nurses can really make a difference with.

NHS Safety Thermometer

Benefits to Patient Experience

Anything that opens a dialogue between the Nurse and patient outside of what the patient is being treated for is a bonus. Although the District Nurses are already completing a holistic assessment, focusing on these four harms contributes to a safer care environment for that patient.

TOP TIP

It is important to make sure your staff are familiar and confident with the NHS Safety Thermometer tool and the questions to need to be asked be asked about the four harms. To ensure this, it may be helpful to provide training for staff.

Co-ordinating the Data Collection

Collecting the data for the NHS Safety Thermometer is challenging, especially for the District Nursing teams. **However, it is not unachievable**. To gather data on all patients on a particular day, staff go out with a hard copy of the NHS Safety Thermometer and bring it back to a central place for an admin or team leader to input to the excel tool. **The tool itself is very quick**; it takes virtually no time to input the data. What takes a little more time is using the tool at the patient's bedside in the patient's home.

Reporting Back at Team Level

It was really helpful to be able to provide individual graphs of data for the teams. The information really becomes theirs then; not about the whole organisation but about them and their team. So six months in, they could see their improvement path, their graphs and that was a really big thing, a big help to them.

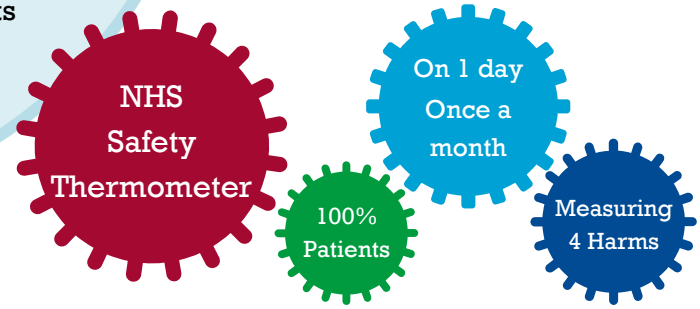
Increased Awareness of Harms and Improvement

After 6 months of collecting data for a baseline position, our SHA provided us with a dashboard of our data[1], which proved very positive against the national picture. We found this dashboard to be an excellent way to engage more senior management, because it shows the organisation as a whole.
Using the NHS Safety Thermometer has raised staff awareness of the harms, leading to an increased and more co-ordinated number of improvement projects across various aspects of care.

[1] This dashboard and data are now published by the NHS Information Centre

Engaging with a Private Care Home

A district nursing team got a private care home on board through visits to residents. The care home do their own type of monitoring but nothing like the NHS Safety Thermometer.
In this case, their results were excellent. Nevertheless, the graphs were very visual and great to share with staff and the care home owners alike.



Improvement Work

Linking Other Work

We had started a lot of patient safety work prior to joining Safety Express, but it's been really nice to be able to pull it all together, under one framework and show the difference that has been made. We started a huge pressure ulcer programme awareness before Safety Express and we're only now starting to see the benefits and impact of that. But a big change is how we can present the difference that this has made – being able to present the improvement work as one, not separate strands, which is often what happens with this type of programme.

Safety Crosses

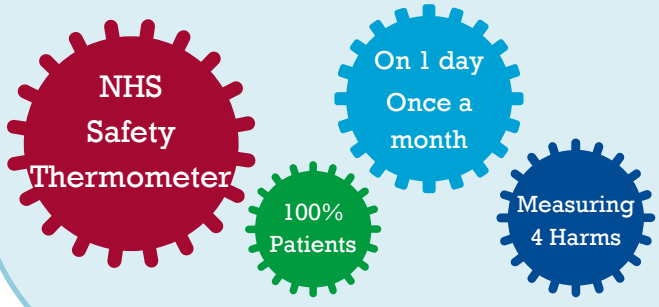
We've linked the Safety Express work in with the Productive Ward 'Safety Crosses' tool. For example, with pressure ulcers, we mark green for absent days, and red when we have an incident. At handover we investigate with a route cause analysis and have added on a twenty minute slot to talk about how it happened. This has led to changes in practice and we have invested in some new equipment especially for heals.

Visible leadership programme

Our senior nursing team have increased their presence on the wards. At every visit there are structured discussions with patients and staff, talking about the four harms, hoping to capture their experiences and what it was like for them. Patients are assured, whilst quality, dignity and respect are being promoted.

The senior team also ask key questions about the four harms to staff at every opportunity, and seek to gain their feedback. The staff clearly liked the 'Energise for Excellence' (E4E) framework, e-learning and face to face teaching. As the visible leadership programme has become more familiar, staff have stated more clearly and confidently what is in place to protect patients from harm, and the process to follow should an event occur.

In addition, every two weeks senior nurses go to the wards and do different audits, for example, medicines management, equipment, linking to CQC audits.



The Matrons can see how providing a high level of service particularly cascading the red tray/ jug system from one hospital to the other, can and has impacted positively on care provision. We also completed an audit of bed rails and found that they didn't reach the NPSA standard, so we were able to remove those and address the issue.

Improvement Work

Training Needs

We recognised that health care support workers had little/ no catheter training, so we put on a course in catheter care, based on a RCN skills requirement and Royal Marsden guidance. We also reviewed and updated related documentation, for example, a transfer document which included the date and insertion of catheter, as we recognised this was an aspect we fell down on when patients transferred across different boundaries.

When we reviewed the Community hospitals completion of the VTE risk assessment, we noticed a big difference between sites, especially again, with transfer risk assessments from acute sites. So we realised and acknowledged a need to improve and introduced VTE assessment training.

Engaging the District Nursing Teams

Having an open dialogue with the District Nursing teams about what the implications were for the four harms was really useful. There were concerns over knowing if a patient had fallen with the last 72 hours, but we highlighted how talking with the patient could open up a new pathway of care if the need is identified, in a proactive manner. Falls is an areas that we still have a lot of work to do but this was a great start.

Developing New Tools

When the District Nurses started to really examine pressure ulcer incidence, they found many risks and indicators of pressure ulcers already existing. From this, the Nurses decided that they wanted to look at ways address that issue and support patients to contact their DN team before the pressure ulcer developed. They have developed and piloted, in line with NICE guidance, a 'Body Checklist'. This is a picture based resource which highlights the areas to look out for pressure marks on the body if the tissue gets damaged or a patient is not very well. And then importantly, it says how the local District Nursing Team can be contacted if any pressure risk is identified. Because the tool is not a great long leaflet but quick and to the point to prompt action, it can be used by carers, care agencies, relatives, and the patient themselves. It's excellent that this development has come from the teams themselves; we're on the second version now.

From May 2012 we will be taking individual patients and follow their path across the whole health economy to see if there is anything we can identify and in particular, we can do to reduce the risk. We are going to investigate on one ward, all patients arriving with a pressure ulcers, identify what we could have done differently and then test actions with PDSA cycles towards improvement.

Focus Moving Forward

Up to now, we have put a of time and resources into pressure ulcer campaigns. This now needs monitoring with measurement for improvement. The NHS Safety Thermometer tool shows new harms, and we are seeing these as being falls, so our improvement focus will shift to this. We also want to look at developing training programmes with assessment tests, and utilising Essence of Care benchmarking within the 'harm free' care mind-set.