Patient Safety Starts with ME

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**Case for change**
- Quality Systems Assessment & Staff survey results demonstrated a poor understanding of the link between quality systems and direct patient outcomes
- Patient stories demonstrated a gap in patient assessment and subsequent patient outcomes

**Goal**

**Objectives**
- Staff to make the connection between quality, evidence based care and patient outcomes
- 25% more units believing there is a positive safety culture within their unit by April 2014
- 15% more units believing senior management show patient safety is a top priority by April 2014

**Method**

**Diagnostics**
Patient stories and staff surveys were collected across the Hastings Macleay Clinical Network
Identified issues were brainstormed with the project team and prioritised:
- Communication
- IMS
- Feedback
- Teamwork
- Accountability
- Equipment

**Solutions**
The project team included representatives from each site and discipline. Strong engagement of both sponsors, steering committee & senior staff was vital to the project success.
Staff in-services of the project and solutions were conducted

**Solutions trialled:**
- Patient Safety Board
- Innovation Board

**Results to date**
The project team implemented two final solutions, a Patient Safety Board and a Staff Innovation Board.
The solutions targeted the project identified issues.
A pilot of the Patient Safety Board commenced in Oct 2013

**Patient Safety Board KPIs**
Falls per 1000 bed days: Oct 2013 5.24 Feb 2014: 2.88

**Pre and post staff survey results:**
Pre: 30% of Ward 1C staff strongly agreed/agreed there was a strong positive patient safety culture in their unit
Post: 90% of Ward 1C staff strongly agreed/agreed there was a strong positive patient safety culture in their unit

A pilot of the staff innovation board commenced Nov 2013

**Sustainability**
Following completion of the project pilots the Patient Safety Board and Innovation Boards will be rolled out throughout the Hastings Macleay Clinical Network.
A brief to rollout the Patient Safety Boards district wide has been developed and submitted to the district Senior Execute Team.
Solutions are transferrable to any health care facility/unit/department setting.
There is potential for use of the Patient Safety Board state wide as interest has been expressed by the CEC during the pilot launch.
Solutions will be monitored with results written up and shared with health professionals via innovation websites such as ARCHI

**Conclusion**
The project has demonstrated
- Staff empowerment
- Provided Feedback mechanisms
- Improved Communication
- Closes IMS feedback loop
- Engages unit staff as a team
- Unit becomes accountable for KPIs

Ongoing evaluation will continue

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**2013 QSA results:**
Although the QSA survey was undertaken early in the project journey results have already shown a 22% improvement in HMCN patient safety culture.