Situational Awareness for Everyone - Paediatric Safety Huddles

Clare Peckham – Clinical Lead for Paediatrics RLI
HOW ....

• 3 wave project – we were in the 2\textsuperscript{nd} wave
• 28 centres
• Learning events and advice
• Develop and test tools
• Driver diagrams / run charts / extranet
• Used QI methodology
• Apply pt safety methodology
• Change the way we think
• Evaluate what we did
Our Journey with SAFE

• 2015 annual conference – Wave 1 presentation
• Sept 2015 – enrolled and started Wave 2
• Poster and oral presentation 2016 conference
• Award for best impact
• Video
• Jan 2017 Trust grand round
• June 2017 P Lachman visit to UHMBT MSC meeting
• Oct – Poster ISQUA 2017 London
• Nov – AcademyOfFabStuff@FabNHSStuff #BrilliantBayDay
• Special measures to good ( outstanding for care )
• SAFE logo – lessons learned bulletins monthly
Our Original Team

• Clinical lead
• CYP Matrons
• Clinical Leader Wd 32 (CYP ED nurse)
• Research nurse and parent rep
• Paediatric Trainee ST3, Dr Simon Nicol
• Support from CAN for CYP, Dr Paul Gibson, Chief Exec Nurse and Director of Governance
# Children’s Services

<table>
<thead>
<tr>
<th>Royal Lancaster Infirmary (RLI)</th>
<th>CW 20 inpts Inc 2 HDU PAU 5 beds CDCU 6 beds</th>
<th>NNU level2 10 cots Inc 2 NICU</th>
</tr>
</thead>
<tbody>
<tr>
<td>Furness General Hospital (FGH)</td>
<td>CW 14 inpts Inc 1 HDU PAU 5 beds CDCU 8 beds</td>
<td>SCBU level1 4 cots</td>
</tr>
</tbody>
</table>

@SAFE_QI

University Hospitals of Morecambe Bay NHS Foundation Trust

SAFE: Situation Awareness for Everyone
UHMBT SAFE Project Plan

• Improve safety climate
  – Embed MDT Huddles
  – Staff education
  – Reinforce SBAR handover
  – Maintain EWS (CPOTTS)
  – Encourage parent engagement
  – Encourage an “eyes wide open” approach
  – Encourage Cross Bay team working
  – (put Kirkup recommendations into practice)
What we were already doing ....

• IWGC monthly reports
• NHS Choices
• Friends and Family Tests
• You said we did ....
• Nurse only safety huddles
Parents, young people and Carers Please Help
We need you to help us improve safety, quality and patient experience.

Introducing; The Huddle

At least once a day doctors, nurses, support workers and play leaders will come together to discuss what’s happening on our unit.

You can contribute by sharing any concerns and worries you or your child may have so please speak with any doctors or nurse so that we are aware.

We want you to help us keep you SAFE.
Huddles (not cuddles!) – start with PRAISE

**PPPASS IT ACROSS BAY!**

“Team Bay Watch” MDT Safety Huddle Checklist

- Patients
- Parents
- PSI’s, PAU, Previous 24hrs, Potential Problems
- Acuity, Accident and Emergency
- Staffing
- Safeguarding
- Investigations, IT issues, IDS, Infection
- Technology trouble
- Across Bay (what’s happening across the Bay)
When Where Who

- Childrens Ward – ward office / clean utility
- 2pm (if possible)
- NNU – Ward Office – after NNU WR, Wd 17 and CDS visits – usually about 12.30
  EVERY DAY INCLUDING WEEKENDS
- Also without the docs at other times ie every shift
- Ad hoc extra huddles if needed
- Takes no longer than 5-10 mins
- Led by nurse or medic
Measures

• Qualitative
  – Patient/parent surveys
  – Staff surveys

• Quantitative
  – Patient safety incident reporting
  – Transfers to PICU
Patient Safety Incident Reporting

Graph showing the number of incidents reported over the specified periods, categorized by severity levels:
- 1 No Injuries
- 2 Low
- 3 Moderate
- 4 Severe
- 6 Near Miss

Source: University Hospitals of Morecambe Bay NHS Foundation Trust.
reasons

- Better understanding of purpose of PSI’s
- Less blame
- More openness and transparency
- Regard PSI’s / CIR’s in a positive manner
- Identify the learning on a regular basis
Days Between Transfers to PICU
September to March – 2013-14 vs. 2014-15 vs. 2015-16

Mean for Sept-Mar
2015-2016 38.50
2014-2015 16.00
2013-2014 11.50

University Hospitals of Morecambe Bay
NHS Foundation Trust
Reasons

• Pre-empt issues arising
• Early recognition
• More phone calls for advice
• Better team work
• MDT Communication /Staffing / Acuity = key issues
• Situational awareness
• ?? ?? Luck
Challenges in UHMB (RLI)

- Trust Geography AND #childrenmatter
- Implementing
  - Convincing colleagues – NOT more work
  - IS different to a ward round – Not a handover
  - Embedding practice – no excuses
  - Audit compliance
- Data Collection/Analysis
  - Seasonal variance and unpredictable acuity
  - Small data set and/or infrequent events
  - Measuring perception of safety
Advice

• Choose your team wisely – they need to convert others! Its all about a change in CULTURE – positive approach needed ( our nurses have been the main drivers , but also our juniors/ middle grades have now really embraced the approach )
• Use data that is easily/already available
• Seek out senior exec support
• Set realistic goals for expansion
• Its not rocket science
Summary

- Decrease in harmful patient safety incidents
- Healthy incident reporting culture
- Improved escalation to intensive care
- Feedback from all staff is unanimously extremely positive
- “It’s a great initiative and has improved morale, made staff feel safer, improved teamwork, we love our huddles, they really help, helps prevent us missing things “
- Need to maintain the process, and adapt as appropriate
- Extend to other site, and even to adult services?
- Need support with laminated cards / posters / funding etc?
- Convert to an LiA project
What next?

- Ensure firmly embedded – included in induction
- Change venue – wipe boards vs white boards
- Parents – “its OK to ask” – (pts too!) need more involvement
- Extend reliably to NNU at RLI and? Include SCBU at FGH as well as CDS
- embed at FGH CW and SCBU and collect new data
- Continue with safety climate survey and run charts on extranet
- ? Introduce night time tel huddle with consultant at home? 11pm
- Insist on an extraordinary huddle if needing to escalate/divert
- Spread to the rest of the hospital outside the division
- Druggles ........
6 questions to ask every day at every level

• **What did we do well?** So we can replicate
• **Past Harm** — has pt care been safe in the past?
• **Reliability** — are our clinical systems and processes reliable?
• **Sensitivity to operations** — is care safe today?
• **Anticipation and preparedness** — will care be safe in the future?
• **Integration and learning** — what have we learnt
This is just the start....

- Culture of Safety is Key......we have changed the way in which we speak and communicate ..... It feels like it is working

- Focus on situation awareness using the huddles as our tools
- Treating and healing is a given in what we do
- Lets make SAFETY the reason we do the work

- Focus on processes , the pt and the family etc.... Then safety culture just happens.....

- Make sure no child deteriorates or is in danger under our care when this shouldn’t have been the case......

- #safetyhuddleswork #whywouldn’tyou? #childrenmatter
Thank you
clare.peckham@mbht.nhs.uk

Watch video of our huddle
Its on U tube via the RCPCH website!