



Does an organization need a catastrophe to change?

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Chief Operating Officer
October 2007**



Ask

What **promises** are you prepared to make to patients and their families?



Our Aim

- No needless deaths
- No needless pain or suffering
- No helplessness in those served or serving
- No unwanted waiting

The Key Elements of Breakthrough Improvement



Will to do what it takes to change to a new system

Ideas on which to base the design of the new system

Execution of the ideas

Focus on the reduction of



- Waste
- Variation
- Harm

Harm vs Error



- Harm is the focus of discussion
- Looks at all unintended results
- Measurement with Trigger Tool is clear and direct
- Nothing is unpreventable

- Errors are the focus of discussion
- Tends to focus only on those outcomes felt to be related to error
- Measurement relies on self-reporting
- Many ADEs are seen as unpreventable

8 Steps to Achieving Patient Safety and High Reliability



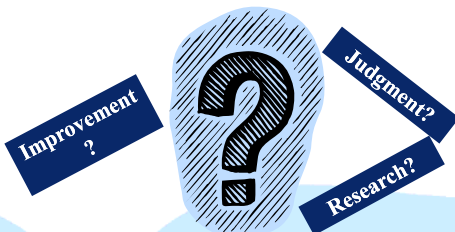
1. Address strategic priorities and infrastructure
2. Engage Key stakeholders
3. Communicate and Build awareness
4. Establish,oversee and communicate system level aims
5. Track and measure performance overtime,strengthen analysis
6. Support staff and patients through the impact of error
7. Align system wide activities and incentives
8. Redesign systems and improve reliability

Model for Improvement



- What are we trying to accomplish? (**AIM**)
- How will we know that a change is an improvement? (**MEASURES**)
- What change can we make that will result in improvement ? (**CHANGES**)
- **HOW GOOD BY WHEN?**

Why are we measuring?




The answer to this question will guide your entire quality measurement journey!

NHS
Tayside

Safer Patient's Initiative Goal

50% reduction in adverse events in 20 months

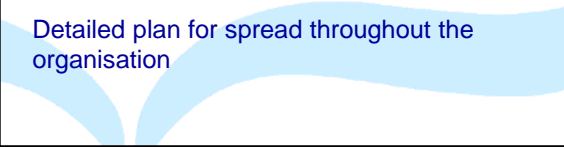


NHS
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Work Streams

- Leadership
- Medicines management
- Peri-operative care
- Intensive care
- General ward

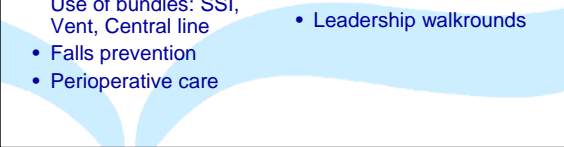
Detailed plan for spread throughout the organisation



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Key Actions
Safety at the top of the agenda

- Use of multiple rapid cycle tests then measurement of
- Rapid response team-early rescue
- Medication systems
- Infection Prevention-Use of bundles: SSI, Vent, Central line
- Falls prevention
- Perioperative care
- Hand Hygiene compliance
- Safety Huddles/Briefings
- SBAR
- Medicines reconciliation
- Trigger tool case note review
- Leadership walkrounds



The Results



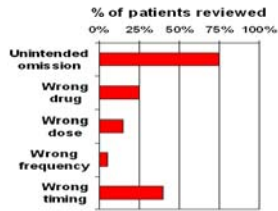
- 71% reduction in adverse events (case note review)
- 91% reduction in medication errors rates on admission
- 66% reduction of line infections in renal and ICU
- SSI bundle 95% compliance
- 50% reduction in VAP

Medicines Reconciliation, Ward 15

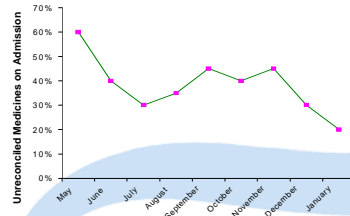
Acute Medical Admissions Ward



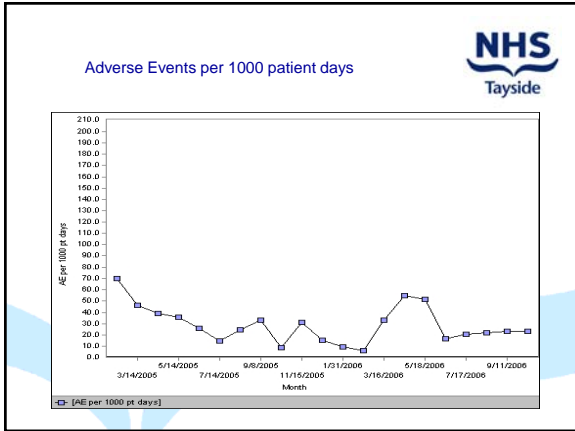
- 20 patients randomly selected from 216 admitted over 6 week days
- 36 admissions per day
- 81% seen by pharmacist
- 85% need intervention
- Mean per patient:
 - 3.6 interventions
 - 1.6 intervention type

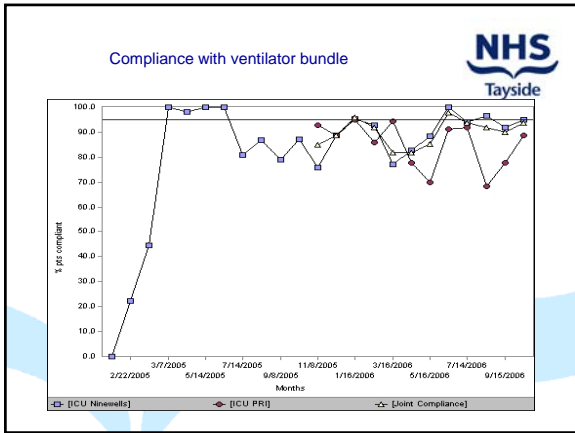


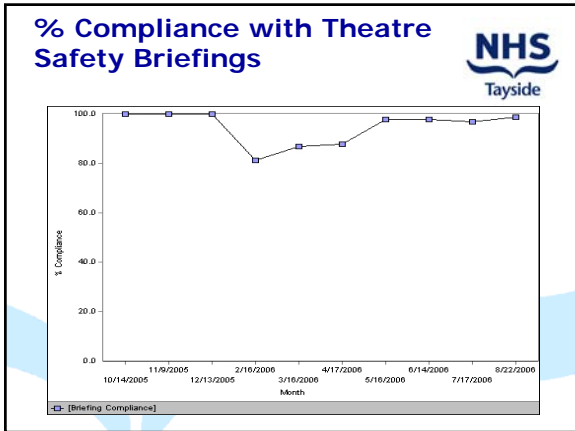
Impact of Standardised Medicines Reconciliation Sheet



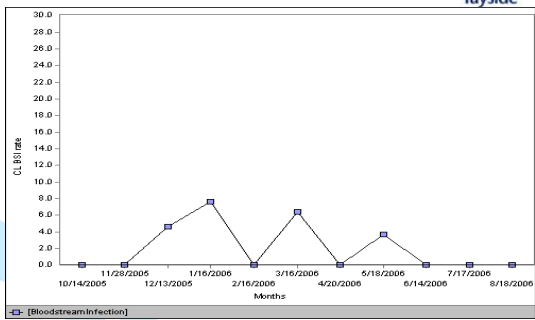
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CLC Bloodstream Infection Rate



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