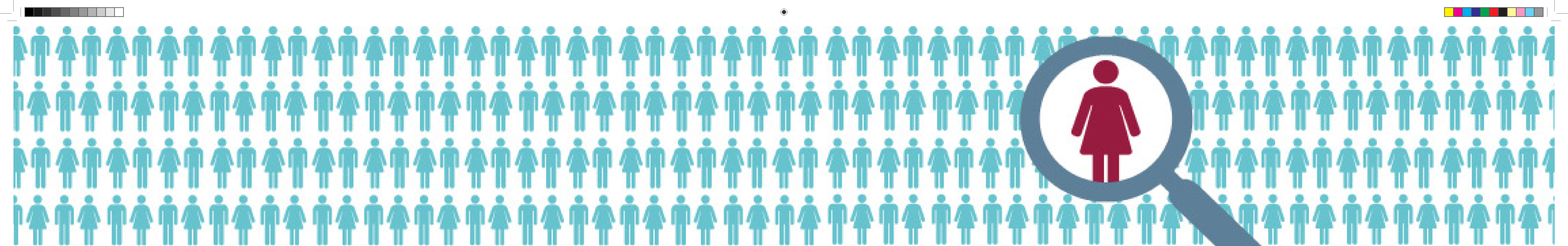


The Emergency Department Safety Checklist

Improving safety and reliability in overcrowded urgent care systems across the West of England

Following a successful pilot at University Hospitals Bristol NHS Foundation Trust (UHB), the West of England Academic Health Science Network (AHSN) supported the trusts across the West of England region to successfully introduce the ED Safety Checklist within their own EDs.

The objective of the project is:

- to standardise and improve the delivery of basic care in EDs
- to improve resilience in EDs during periods of crowding
- to improve the safety and clinical outcomes for patients accessing ED

The solution is:

- an ED Safety Checklist and implementation toolkit – a time based framework of tasks that is completed for every patient, other than those with minor complaints.

The issue

Overcrowding has an impact on the ability of staff in the ED to deliver safe care. Delays in recognition and treatment of severe illness are common, with associated poor outcomes. This is particularly problematic for patients suffering with strokes, heart attacks or sepsis. Staffing challenges in the ED workforce have resulted in a reliance on agency staff and non ED trained staff. As staff become overwhelmed by the tasks needed to complete while faced with constant interruptions, there is a risk of omissions in the delivery of basic care elements, which contributes to harm and difficulty in identifying the deteriorating patient in a crowd.

The intervention

The ED Safety Checklist has shown to improve standardisation and demonstrate improvements in patient safety and care. The ED Safety Checklist systemises the observations, tests and treatments required by patients in a time based sequence. This makes it clear what has been done and what needs to be done. The checklist serves as aide-mémoir for busy staff. Any doctor, nurse, bank or agency staff can join the department and provide the right care by providing this structure. The checklist results in improved outcome for patients and a reduction in system risk.

The checklist

The ED Safety Checklist includes:

Part 1 - provision of basic safe clinical care

- vital sign measurements
- calculation of National Early Warning Score (NEWS)
- pain scoring administration of drugs
- front loading investigations.

Part 2 - value added tasks

- referrals to drug and alcohol services, liaison psychiatry and occupational health
- commencement of pathways that demonstrate improved outcomes.

The methods

The ED Safety Checklist has been implemented in six Acute Trusts across the West of England region since December 2015:

- University Hospitals Bristol NHS Foundation Trust
- North Bristol NHS Trust
- Royal United Hospitals Bath NHS Foundation Trust
- Weston Area Health NHS Trust
- Gloucestershire Hospitals NHS Foundation Trust
- Great Western Hospitals NHS Foundation Trust
- South Western Ambulance Service NHS Foundation Trust, with the introduction of their Electronic Patient Clinical Record (ePCR).

The implementation was delivered using the IHI model for improvement, which allows each ED to benefit from the pilot learning and also encourages local adaption. Quality Improvement methodologies used include Plan, Do, Study, Act (PDSA) to test the ED Safety Checklist, measurement strategy with baseline and ongoing key performance metrics to measure the impact of the ED Safety Checklist.

To support the roll out across the West of England, an ED Safety Checklist toolkit was developed. The toolkit includes a project plan, educational/promotional material, data collection tools, role specifications and a generic dashboard.
The toolkit can be found here: www.weahsn.net/ed-checklist

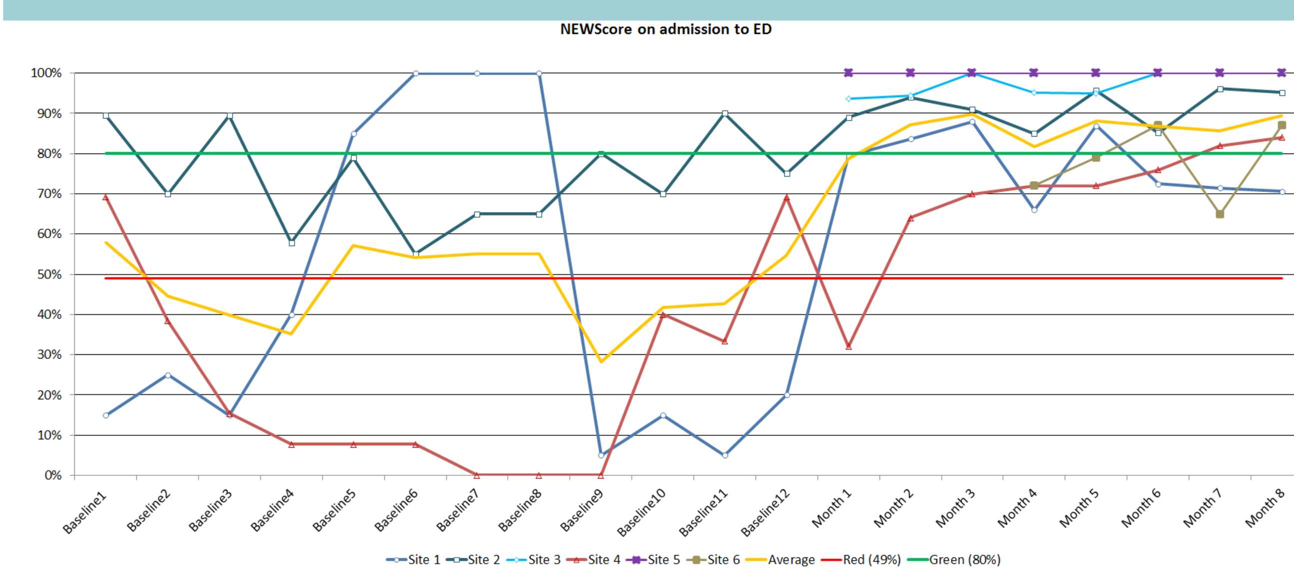
In addition to this the ED Collaborative was set up in August 2016 with a primary focus of implementing the ED Safety Checklist. It was an opportunity to regularly share learning and discuss issues. To support the implementation, the West of England AHSN hold regional learning set events twice yearly, for EDs to share and learn from each other's experience in using the intervention, as well as receiving updates on the latest guidance.

Staff culture was an important point to consider in the roll out of the ED Safety Checklist. The ED Safety Checklist was initially seen as over-prescriptive in tasks so there was reluctance to accept they were not already being performed well. By providing staff with demonstrable evidence and sharing patient stories they were able to understand the importance of the ED Safety Checklist and the link between the cumulative effect of several omissions in basic care through to unrecognised deterioration and harm, so that they might realise improvements in their own settings.

Equally important is the support from executive sponsors who have provided leadership, vision, peer support and enablement to increase the success of the implementation.

The results

- 555,000 patients receievd a NEWS score with the ambulance service's electronic patient clinical record (ePCR) 2016-2017).
- Over 75,000 patients received a NEWS score at Triage into ED (2016-2017)



- The ED Safety Checklist implementation is currently being evaluated by the National Institute for Health Research Collaboration for Leadership in Applied Health Research and Care West (CLAHRC West). The results will be published by the end of 2017.

"International evidence, highlighted in the 'Keogh Review' of Urgent and Emergency Care clearly demonstrates the risks that crowded EDs pose to patient safety and outcome. This intervention is designed to directly address these challenges, and has already been shown to be effective: it is entirely consistent with national policy in emergency care."

Professor Jonathan Benger,
National Clinical Director for Urgent Care, NHS England

Conclusion

The ED Safety Checklist standardises and improves the devliery of safer care in crowded emergency departments.

The principles are applicable across different emergency departments and a collaborative approach enables faster learning and quicker improvements.

The collaborative also supports implementation of the ED Safety Checklist by:

- creating a strong social network
- allowing for exchange of ideas and relevant discussions
- standardise measurements enables the teams to see progress and improvements over time and make comparisons
- allowing teams to adapt the ED Safety Checklist and then share the adaptations that work well.

Key contacts

Dr Emma Redfern, Consultant in Emergency Medicine, University Hospitals Bristol - emma.redfern@uhbristol.nhs.uk

Kevin Hunter, Patient Safety Programme Manager, West of England AHSN - kevin.hunter@weahsn.net

NHS
University Hospitals Bristol
NHS Foundation Trust

West of England Academic Health Science Network

@UHBristolNHS

@WEAHSN