Case Study: Emergency Department Collaborative

University Hospitals Bristol NHS Foundation Trust (UHB) was funded by the Health Foundation SHINE innovation programme in 2014 to introduce a Safety Checklist in the Emergency Department (ED). Since April 2016, the West of England Academic Health Science Network (WEAHSN) has worked to support all six Trusts across the West of England to introduce the ED Safety Checklist across their ED's.

The Checklist was piloted in UHB on November 2014 and achieved demonstrable success in improving patient safety during periods of crowding. This included the support and cooperation of South Western Ambulance Service NHS Foundation Trust who provided a National Early Warning Score (NEWS) via their Electronic Patient Care Record System and initiated the ED Safety Checklist if managing patients in queues waiting to transfer to ED.

Following the Institute of Healthcare Improvement model, an implementation toolkit was developed using the lessons learnt from the pilot site supporting Trusts introduce the ED Safety Checklist in their department. An inaugural West of England ED Collaborative meeting took place in May 2016 with a primary focus of implementing the ED Safety Checklist. These monthly meetings were an opportunity to regularly share learning and discuss issues.

Learning from implementation:

Benefits:

- Proven to be a useful tool in answering complaints and providing a safety net for staff
- Increased regular contact with patients and family leading to improved patient satisfaction
- Provides structure in times of overcrowding to allow effective timely treatment
- Faster transitions for some patients through ED
- An objective tool to communicate concern using a standardised language
- Better recording of pain management and reassessment
- Improved recognition of sepsis

Checklist:

- More successful when included in observation booklet/with original notes
- Clear guidance for escalation to doctors/other colleagues/services
- Edit the Checklist as necessary to be in line with latest hospital policies/guidance
- Standard of care and documentation is clearly set out
- Some of the Trusts are noting on the Checklist if the patient is being monitored in the queue/corridor by adding a 'Q' to the Checklist

Culture:

- The Checklist is a tool to support patient care and deterioration – it doesn't take away decision making or clinical judgement
- Continuous feedback to staff on progress and areas for improvement
- Identify a Checklist champion to drive implementation
- Feedback to champion with regards to staff members for additional training

Auditing:

- Data analyst role is key to the implementation of the Checklist and evidence its success by being able to monitor it regularly
- Checklists need to be at least 50% completed to be audited
- Staff are to initial when completed, along with time and 'n/a' if necessary
- Clear Key Performance Indicators (KPI) measured

Challenges:

- Cost of colour printing or photocopying of the Checklist
- Continued departmental pressures, as well as high use of agency staff and high staff turnover
- Initialling of the Checklist by staff (this was overcome by explaining the importance of the Checklist and its ability to support safe care)

For more information and resources to help support implementation, please go to www.weahsn.net/ED-Checklist