Patient Safety AWARDS

WINNERS' SUPPLEMENT

Patient Safety AWARDS 2010

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NT136

Foreword

It hardly needs saying that healthcare professionals and providers take patient safety seriously. However, it is all too easy to lose sight of this crucial issue in the plethora of priorities facing professionals and organisations.

There is now a general acceptance that we cannot take for granted that processes and procedures will not compromise patient safety. If we are to ensure healthcare is as safe as it can be, patient safety must be a specific consideration in all aspects of provision, from decisions taken by board members to individual interventions by frontline staff.

Professionals and providers have taken on this challenge and come up with a plethora of initiatives that protect patients from unnecessary harm. The Patient Safety Awards have been set up to celebrate the commitment and creativity shown by individuals and organisations, and to disseminate best practice throughout the UK and beyond.

The standard and number of entries in this first year of the awards demonstrates that healthcare professionals are equal to this challenge. Entrants submitted hundreds of examples of outstanding initiatives that have transformed patient care and outcomes. They have reduced morbidity, improved patients' experiences of healthcare, increased patients' quality of life and, undoubtedly, saved lives.

In these harsh economic times, it is worth pointing out that our entrants have saved considerable amounts of money – both in reducing patients' need for treatment and in avoiding compensation and litigation arising from safety related incidents

The individuals and teams involved in all the shortlisted entries are examples of the best in healthcare and demonstrate that patient safety truly is at the heart of what you do. I am delighted to have this opportunity to offer you all my sincere congratulations.

Alastair McLellan
Group editor
Health Service Journal* and *Nursing Times

The Health Foundation

If you want people to follow your example, give them an example worth following

High quality board leadership creates a culture in which improvements in patient safety can be made. Great boards engage with frontline staff and provide the leadership and vision to help staff improve safety. They set an example worth following.

We are proud sponsors of the 'board leadership' category of the Patient Safety Awards.

Visit **www.health.org.uk** for examples of good practice in patient safety.

Patient Safety First offers a practical leadership intervention visit

www.patientsafetyfirst.nhs.uk

BOARD LEADERSHIP

FINALISTS

Highly commended: First Do No Harm, board of directors, Leeds Partnerships FT

Leeds Partnerships Foundation Trust committed itself to a programme to make all services safer and more reliable. This is led by the board of directors, supported by the board of governors, the chief executive and the chairman. It includes: communications with all staff; promoting safe systems and a culture of safety; gauging progress; significant financial investment; and dissemination of this work, which has influenced mental healthcare nationally.

Highly commended: Executive Safety WalkRounds, Jayne Downey and Maxine Power, Salford Royal FT

The Executive Safety WalkRounds bring the executive team together with clinical and non-clinical staff at all levels. They break new ground in that patient safety issues are discussed with not only clinical staff but also non-clinical staff who are only one step away from the patient. Feedback shows that all staff feel comfortable discussing safety issues and that 94 per cent believe that the walkrounds are a good or excellent way to encourage a safer environment.

Reducing Mortality Through Teamwork, Sue Smith, North Tees and Hartlepool FT

The trust set an ambitious goal to reduce mortality by 15 per cent in one year, signing up to national safety programmes. Patient safety and care quality was moved to the top of the trust board agenda. The board of directors and clinical staff champion improvements that are clinically led. The board receives quarterly reports in which clinical teams describe progress. Board members have a high level of assurance that clinicians are engaged and leading patient safety changes at the point of care.

Improving the Quality Board Report, Laurel Simmons, Stockport FT

The board has implemented a reporting format – annotated run charts – to provide better measurement, narrative updates and alignment across the trust. This format allows the board to better answer the questions: "How good are we?" and "Are we getting better?" The charts, shared with all staff and commissioners, give a clear picture of performance and use narrative to provide the board with a greater depth of information. Results are attributed to clinical leads. The system has required few additional resources.

> **The framework leads to improvements including greater patient satisfaction and fewer serious incidents**

JUDGES

- Jo Bibby, The Health Foundation
- Gerry Marr, Ninewells Hospital and Medical School, Dundee
- Andrea Sutcliffe, Appointments Commission

JOINT WINNERS

Board Leadership, Ann Farrar and colleagues, Northumbria Healthcare FT

The board made safety and quality a priority following failures at Stoke Mandeville and Northwick Park hospitals. Ambitious strategic priorities and goals were agreed and included in the annual plan. Safety and quality became the first items on the board agenda, and monthly reports are made on strategic priorities. Variances in safety and quality are presented by the clinical head of service, with action plans. Safety and quality measures encourage a culture of measurement of both national and local priorities.

Board Leadership – Ward and Department Assurance Framework, Phao Hewitson and Colleagues, Walsall Hospitals Trust

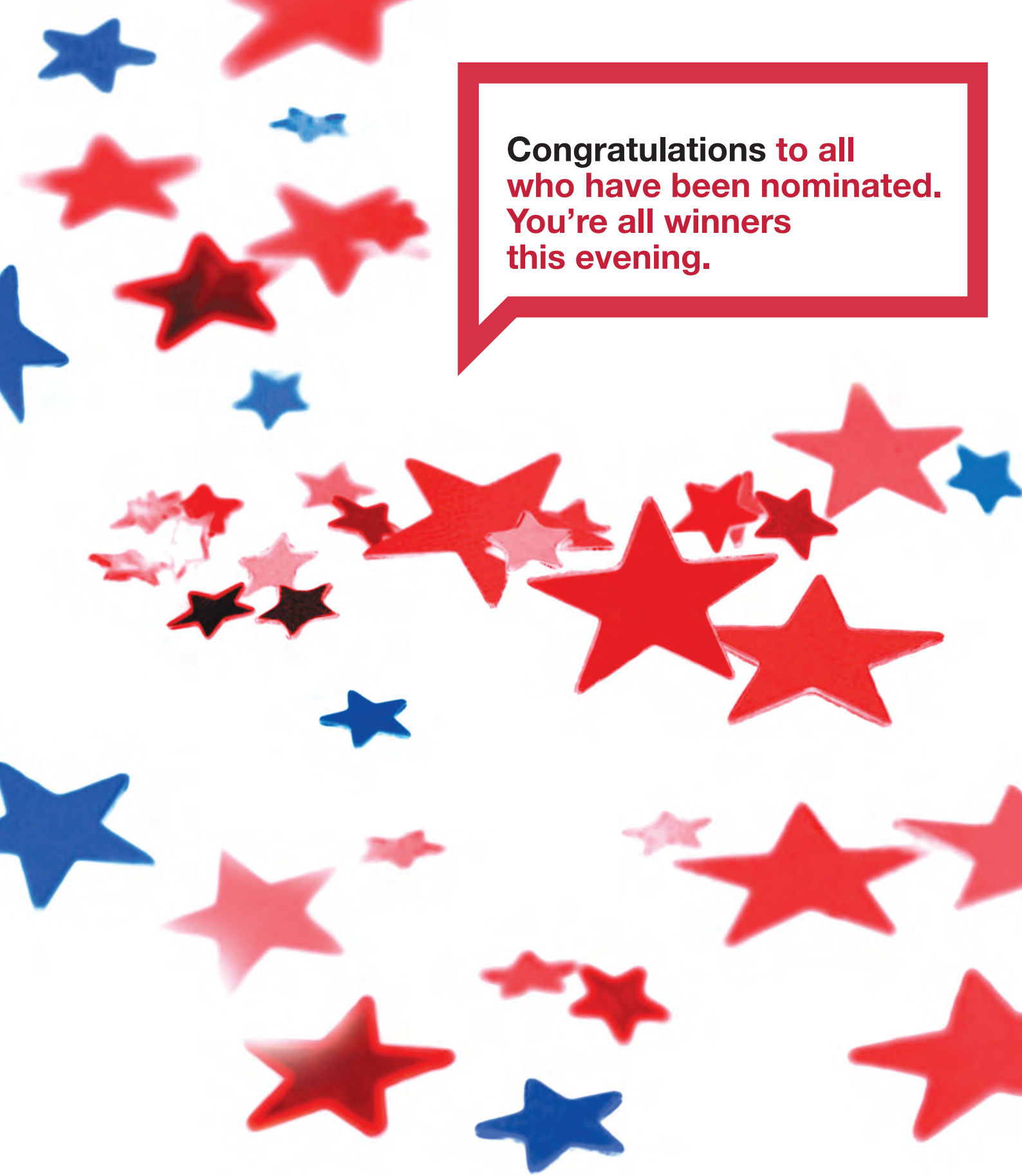
Walsall Manor Hospital has developed an innovative framework to provide board assurance about the safety, efficiency and effectiveness of care provided to patients at ward and department level.

Having identified patient safety as a main priority within our quality strategy for 2007-10, we joined the Patient Safety First campaign. During implementation of the campaign's leadership intervention, we decided that the performance measures used at ward level required a more formal approach if they were to provide assurance both at board level and locally.

To fulfil this, we developed a ward and department assurance framework focusing on a wide range of quality, safety and performance measures.

The framework is designed to provide board assurance and to promote local responsibility so that there is shared ownership of both process and results.

We have evidence that using the framework leads to demonstrable improvements including increased patient satisfaction and fewer serious incidents.



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Royal College of Nursing

CHANGING THE SAFETY CULTURE

FINALISTS

Highly commended: Reducing HSMR, Chris Chandler, Wrightington, Wigan and Leigh FT

The trust has cut its hospital standardised mortality rate from 124 to 82 in two years. This involved changing the culture from one that normalised the abnormal to one that aspires to zero tolerance of all harm events. The formula for changing culture involves accepting that problems exist, visible leadership, determination from the top, and improvement methodology including reporting to those who can make a difference. This formula has also been used for infection control, fractured neck of femur and stroke.

Antimicrobial Stewardship Programme, Caroline Bradley, County Durham and Darlington FT

A framework was set up to ensure prudent use of antimicrobials. Senior doctors believed that there was little relationship between antibiotic prescribing and healthcare associated infections or resistance. Research shows that prudent prescribing affect these, so doctors were engaged at all levels and supported to adopt restrictive prescribing.

Results include a reduction of broad spectrum antibiotic use by 40 per cent and overall antibiotic use by 14 per cent. HCAI rates have decreased significantly.

Transforming Care on Your Ward, Caroline Joyce, Great Ormond Street Hospital for Children

Transforming Care on Your Ward is a trust wide project to engage ward staff in achieving strategic goals of no waste, no waits and zero harm. Teams are given the tools and training to help them drive improvement, and data shows how their changes have made an improvement. With a focus on safety, teams choose what they want to work on, learning from others in the trust, nationally and internationally.

Peripheral Line Training Project, Olga Zolle and colleagues, NHS Education South Central

This project aimed to improve attitudes to curb device related MRSA and MSSA infections. It involved eight trusts, focusing on sharing best practice and training to instigate a culture change. It raised awareness about the aseptic technique and the importance of standardised equipment. Shared resources included guidelines and competencies, a competency certificate, a poster and training video. As more people were trained, the rate of MSSA infections decreased.

Salisbury Handover System, Debbie Dupont, Salisbury FT

This project aimed to improve handover, primarily for hospital at night, making it safe, efficient and effective. This has been achieved by using an innovative in-house IT handover system that supports verbal handover. This has resulted in a culture change. Virtually all ward staff use it and share handover information 24/7. With support from Skills for Health, the system is now available to the NHS.

> **Patients said they wanted services that were safe, clean and personal, so we adopted these words**

JUDGES

- Anneliese Dodds, King's Patient Safety and Service Quality Research Centre
- Kate Jones, NHS Institute for Innovation and Improvement
- Stephen Ramsden, Patient Safety First

WINNER

Quality Improvement - Strategy

Maxine Power and Paul Hughes, Salford Royal FT

Salford Royal Foundation Trust has an excellent safety record, but we want to be the safest hospital in the NHS.

We asked patients what they wanted from their hospital, and they told us they wanted services that are safe, clean and personal to their needs. Accordingly, we adopted these words for our organising principle.

Our aim is to save 1,000 lives between 2008 and 2011 by reducing our mortality rate to one of the lowest in the NHS, and to prevent 10,000 harmful events that patients would otherwise have experienced. The trust's quality improvement strategy complements initiatives at strategic health authority and national level to improve the quality of patient care.

The quality improvement strategy is managed through a series of projects that we believe will have a significant impact on unintentional harm and mortality.

A concurrent educational programme will ensure that knowledge of quality improvement techniques is embedded across the organisation.

The UK's premier patient safety event

Tuesday 25th – Wednesday 26th May 2010

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Patient Safety Congress 2010

Working together to champion innovation and embed change

"This is the annual conference worth attending when time and money are so precious"

Acting Director, Clinical Governance
University Hospitals of Leicester

Why should you attend Patient Safety Congress 2010?

- Agenda driven by Department of Health, The Health Foundation, National Patient Safety Agency and NHS Institute for Innovation and Improvement
- **90** national and international leaders share their commitment and experience
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Pledge your one thing to really make a difference to patient safety

change one thing Patient Safety Congress 2010

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Head of Safer Care
NHS Institute for Innovation and Improvement

Dr Suzette Woodward
Director of Implementation
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GP, Broadcaster & Journalist

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Dr Bruce Warner
Head of Primary Care Ambulance and Specialist Programmes, National Reporting and Learning Service, **National Patient Safety Agency**

Plus:

- **Sharon Beamish,** Chief Executive **George Eliot Hospital**
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- **Jill Pellett,** Associate Director of Patient Safety, **South Central**
- **James Rooney,** Deputy Director of Care and Patient Safety Lead **Devon Partnership NHS Trust**
- **Mary Monnington,** Director of Nursing and Patient Safety, **NHS Somerset**
- **Tim Evans,** Chief Executive **Bolton Council**
- **David Tranfield,** Management Consultant and Emeritus Professor of Management **Cranfield School of Management**
- **Martin McShane,** Director of Strategic Planning and Health Outcomes **NHS Lincolnshire**
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- **Glen Burley,** Chief Executive, **South Warwickshire General Hospital NHS Trust**

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The Patient Safety Congress is founded on a unique partnership, ensuring the highest quality speakers, information and format. Thank you once again to the event partners:

DH Department of Health · The Health Foundation · NHS Institute for Innovation and Improvement · NHS National Patient Safety Agency

COMMUNICATION

FINALISTS

Highly commended: *Sunshine* magazine, Jay Shingler, Air Products Healthcare

After listening to patients to understand their requirements, *Sunshine* magazine was developed. As the first magazine dedicated to oxygen patients and their unique needs, *Sunshine* breaks new ground to educate and reinforce important and potentially life-saving safety messages to the 52,000 oxygen patients that Air Products Healthcare serves in the UK.

Sunshine is written by staff who work with patients and has been spontaneously praised by patients and clinicians.

Highly commended: Acutely Ill Patient in Hospital Project, Caroline Spencer, Guy's and St Thomas' FT

After implementing NICE guidance on acutely ill patients, the trust sustained 97 per cent adherence to observation standards on all wards. In acute medicine, cardiac arrests fell from 0.8 to 0.2 per 1,000 bed days and crude mortality fell from 43 to 32 per month. Communication was vital and involved: training at all levels; a website; walkabouts; roadshows; rapid cycle reviews; a global trigger tool; feedback to and from wards; and performance reports.

Map of Medicine, Nat Billington and colleagues

Map of Medicine is a web based visual representation of evidence based, practice informed care pathways for common conditions. The pathways bring together disparate information into a single source of best practice.

The map is freely available to all NHS staff and patients in England and Wales. Its flexibility allows extensive local input. Benefits include more consistent care, better referrals, more efficient use of resources and reduced waiting times.

Patient Identification Campaign, Andrew Jackson, Harrogate and District FT

The campaign spread the message of the importance of positive patient identification. These included: screensavers on all PCs, showing "five steps to safe patient identification"; a patient poster explaining why we have to ask their names frequently – and that it's OK to challenge us if we don't; a system to identify patients who do not routinely wear wrist bands (for example in psychiatry); and patient ID posters in waiting areas. Debate is encouraged, and staff come up with innovations. The campaign makes good use of existing IT and invites patients to be active in their own safety.

NHS Number Programme, Elizabeth Simons and colleagues, University Hospitals of Leicester Trust

NHS numbers are put on patient electronic records, printed patient identification wristbands, case note labels, referrals, appointment letters and order forms. An action group ensured policies, data quality and IT systems complied with national standards. The aim was to make NHS numbers more visible in clinical use and to raise awareness of its use in improving safety. An action plan was drawn up, systems were audited, and data quality and clinical policies and procedures reviewed. The campaign targets both staff and patients.

> **Mortality rates have fallen considerably and infection rates are among the lowest in the country for MRSA**

JUDGES

- Murray Anderson-Wallace, NHS Institute for Innovation and Improvement
- Angela Brown, NHS North West
- Daniel Crosariol, Department of Health
- Jane Cummings, NHS North West

WINNER

Putting Patient Safety First

Caroline Hastie, Blackpool, Fylde and Wyre Hospitals FT

Patient safety is a main priority of the trust. The Putting Patient Safety First communication campaign aims to ensure that patient safety is led from the top of the organisation through board to ward engagement, and that it is embedded throughout the trust. It also aims to ensure that all staff are aware of their roles and responsibilities and the real difference they make to patient safety and quality of care.

This was done through initiatives including daily patient safety walkabouts by the executive team. More than 200 issues have been raised through these walkabouts and are discussed at the weekly executive meetings. Action plans are formed and feedback given.

Patient stories are regularly used as training tools. Patients are filmed and their experiences are shared with staff and action plans formed.

Mortality rates have fallen considerably and infection rates have been cut to among the lowest in the country for MRSA.

BT is proud to support the Patient Safety Awards 2010

Having worked with the NHS for over 60 years, BT is now one of its leading suppliers, providing healthcare professionals with the technology to support the delivery of better patient care.

Now BT's wide ranging safety products and services are helping the NHS manage clinical risks in health ICT.

Find out more about BT's work with the NHS at www.btplc.com/health/

INFORMATION MANAGEMENT

FINALISTS

Highly commended: Stroke Oracle, Eddie Hilton, East Cheshire Trust

The Stroke Oracle database holds information on all stroke patients. It was developed at the request of and with the continual involvement of clinical staff who individually input information. It is the first multidisciplinary designed IT system in the trust, merging existing patient information with that entered into Oracle, which had been held on paper. Data is reported in real time and can be accessed, analysed and reported on at the click of a button, so safety and quality issues can be identified and addressed immediately.

Ward Real Time Metrics, Sue Speak, Airedale Trust

This project was set up to ensure that all wards could collect measures required for Productive Ward. It started by trialling measures for falls, pressure ulcers, MRSA and *Clostridium difficile* on one ward. It now covers all wards and includes medication errors, patient survey results by ward and staff sickness levels. It is linked with daily safety briefings and adverse events forms and risk meetings. Data is collected daily by ward staff. Matrons and directors of nursing use it to review specific areas or the whole trust.

Vital Aspects of Clinical Safety, Amanda Pacey, Royal National Hospital for Rheumatic Diseases

Vital Aspects of Clinical Safety is an audit tool that allows the quality of nursing services to be measured objectively in a quantitative manner. Working at every level, VACS scrutinises systems to promote patient safety. Its findings can be communicated to patients, clinicians, managers and commissioners. The criteria on which VACS is based include the standards that nurses use in everyday practice, making it a real time and practical process.

Quality Dashboard, Elaine Inglesby and Peter Murphy, Salford Royal FT

The Quality Dashboard allows the board of directors to monitor the hospital system as a whole. Its metrics include mortality, readmissions, length of stay, harm, patient and staff satisfaction and ventilator associated pneumonia. It breaks new ground in that it displays measures using statistical process control charts. It has allowed us to monitor the interplay between metrics and compare the trust against top performing regional and national organisations.

Improving Inpatient Safety, Donna Swinden and colleagues, Tees, Esk and Wear Valleys FT

A team including 12 staff and one service user applied lean principles to an inpatient ward. Admission was streamlined and a standardised admission pack produced. Photographs of patients were stored, with consent, to help trace missing patients. A template standardised ward review and recording and flow charts for policies developed. Environmental improvements were made and reception hours increased, and engagement time with patients was protected.

> **An efficient and patient focused administrative structure is fundamental to safe care for prisoners**

JUDGES

- Frank Burns, former head of NHS IT
- Martin Ellis, BT
- Pat O'Connor, the Scottish Government

WINNER

Offender Healthcare

Rachel Tones and colleagues, County Durham and Darlington Community Health Services

Prison healthcare has been subject to criticism in the past for many shortcomings. Following the publication of Her Majesty's Chief Inspector of Prisons Sir David Ramsbottom's paper *Patient or Prisoner*, work began to integrate Prison Healthcare – a branch of the Home Office – with the NHS. This work was completed in 2006 with the transfer of all prison healthcare commissioning responsibility to the NHS.

The healthcare administration team in HMP Durham see the provision of an efficient, proactive and patient focused administrative structure as being fundamental to the provision of safe healthcare for prisoners.

Equally, the systems that we provide aid clinicians in the provision of safe healthcare and empower prisoners to maximise their ownership of the process.

The HMP Durham team believe that the more the patient/prisoner knows and understands about this healthcare, the safer the process will be and the better the outcomes.

The RSM's new Patient Safety Section is delighted to sponsor the Education and Training in Patient Safety Award

The Royal Society of Medicine

If you are involved in any aspect of patient safety then the RSM can support you through our educational meetings and resources, opportunities to network and membership of the Society.

Thursday 25th February 2010

Patient Safety Section Inaugural Meeting at the RSM

Speakers include:

Dame Deidre Hine, *Past President of the RSM,*

Dame Joan Higgins, *NHSLA*

Bertie Leigh, *Chair NCEPOD and Senior Partner Hempsons*

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Please mention Patient Safety Awards to receive 14 months membership for price of 12.

EDUCATION AND TRAINING

FINALISTS

Highly commended: Sepsis Symposiums, Matthew Inada-Kim, Winchester and Eastleigh Healthcare Trust

Multidisciplinary sepsis simulation symposiums, for staff and students, use real patient scenarios to cover recognition, assessment, management and process, and involve theory, brainstorming, clinical skills, handover, crew resource management and situational awareness.

Delays in antibiotic administration have been reduced by five hours. The training is patient centred, cost effective and sustainable, with audit built in. Attendance is high, and service disruption minimal. Feedback has been very positive.

Simulation Training for New Foundation Doctors, Jon Hanson, Newcastle upon Tyne Hospitals FT

New foundation doctors lack experience, which may result in medical errors. We redesigned our shadowing programme to include a simulation based course. The use of simulation, with debriefing covering clinical and human factors and one to one teaching of practical tasks, allowed this course to be delivered in a learner centred and non-threatening way. Confidence in managing acutely ill patients and performance of common tasks have improved.

Safe and Enjoyable Eating and Drinking for People with Learning Disabilities, Felicity Court and colleagues, Nottinghamshire Healthcare Trust

Speech and language therapists working in learning disabilities developed Safe and Enjoyable Eating and Drinking workshops for social care and health staff. Staff are better able to identify risks, and timely referrals to the dysphagia service have doubled. Highly accessible resources are now standard, including guidelines, personalised place mats and leaflets on dysphagia and learning disabilities. This flexible approach has improved patient safety and enjoyment at mealtimes.

Interprofessional Shared Learning, Marian Traynor and colleagues, Queen's University Belfast

This was one of the first projects in the UK to adopt an interprofessional approach using high fidelity simulation technology to enhance student learning. The main focus was how nursing and medical students work together to deliver safer patient care. Clinical case scenarios allow them to share learning, particularly around common core skills around patient safety and team work.

Saving Londoners' Lives, Gillian Schiller

This project aims to increase the number of people in the capital with emergency life support skills. Schoolteachers are given free instructor training in these skills from St John Ambulance London, so they can deliver the British Heart Foundation's Heartstart UK programme to pupils. The BHF supplies schools with equipment. Teachers are supported by London medical students, who are trained by the London Ambulance Service Trust.

> This has led to better care at the scene of the injury, improved outcomes and faster rehabilitation

JUDGES

- Margaret Dangoor, Royal Society of Medicine
- Simone Jordan, NHS Institute for Innovation and Improvement

WINNER

Making Burns Safer

Margaret Gately, University Hospitals Birmingham FT

This joint project, by the University Hospitals Birmingham Foundation Trust and the West Midlands Fire Service, has seen firefighters visiting Selly Oak Hospital to see at first hand how burns patients are treated once they reach hospital. As a result of the project, the fire service has changed the way it treats burns patients at the scene of an incident.

Before the visits, in the rush to rescue victims and begin resuscitation, patients were often placed straight on to the ground. Since the importance of keeping burns clean has been impressed on the firefighters during their hospital visits, patients are now transported on clean sheets to avoid contaminating the burns.

That change in practice has influenced new national guidelines for trauma care being developed by the Chief Fire Officers' Association. The close collaboration between West Midlands Fire Service and the trust has made possible an annual West Midlands Fire Service trauma conference, which attracts international delegates.

The benefits to both organisations have been tremendous, as both have learnt a huge amount about the different phases of burns treatment. This has led to better patient care at the scene of the injury, improved outcomes and faster rehabilitation.

MHRA

Medicines and Healthcare products Regulatory Agency

Proud sponsors of the Improving Medicines Safety in Healthcare Organisations Award

The Medicines and Healthcare products Regulatory Agency (MHRA) would like to congratulate all winners and nominees who have demonstrated their commitment to improving patient safety in the 2010 Patient Safety Awards.

The MHRA is the government agency which works to enhance and safeguard the health of the public by ensuring that medicines and medical devices work, and are acceptably safe.

It is important that all nurses tell us about any problems with a medicine or medical device, so that we can help you to keep your patients safe.

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Patient Safety AWARDS 2010 SPONSOR

BETTER SAFETY IN MEDICINES

FINALISTS

Highly commended: Reducing NSAID Related Harm, Anne Fittock and colleagues, NHS East Lancashire PCT

The medicines management team implemented a cross sector strategy to reduce NSAID prescribing. This included: formulary review with acute providers; GP incentives; pharmacist-led reviews; and patient information.

Prescribing of NSAIDs across the whole PCT fell by 20 per cent in one year. Patient harm was reduced and hospital admission due to serious gastrointestinal complications fell.

This project was also shortlisted for the Primary Care award.

Anticoagulation Safety Improvement, Barbara Clark and colleagues, Guy's & St Thomas' FT

This project aimed to minimise human error, increase reliability and explore new ways of laboratory practice and prescription writing. Interventions covered education, prescription times, outpatient referral and standardised handover. Clinical guidance encompassed the whole process.

There has been a reduction in high inpatient INRs, as well as improvements in thromboprophylaxis adherence rates to >90 per cent and in the reliability of outpatient referral.

Cancer Oral Chemotherapy Diary, Catherine Oakley and Jo Johnson, Guy's & St Thomas FT and St George's Healthcare

Patients may not be adequately supported to self medicate oral chemotherapy correctly, or report life threatening symptoms promptly. This simple, effective tool facilitates early reporting of drug errors and symptoms. Patients value the symptom traffic light system that guides them on when to call the hospital. It enhances patients' ability to self care, which in turn, leads to increased self efficacy.

Improving Medication Safety in Children, Suzanne Khalid and colleagues, University Hospitals of Leicester Trust

Following an increase in incidents of medication overdose in children at the trust, a multiprofessional project was undertaken. This identified contributory factors and changed systems, with a shift in organisational culture.

The project team made 51 recommendations. Medication risks have been reduced through: frank multidisciplinary discussion; critically evaluating accepted practice and making changes; and challenging organisational culture.

More Than Just a Raffle Ticket, Janet E Thomas and colleagues, Wrexham Maelor Hospital

A docket is attached to all outpatient prescriptions at the hospital pharmacy and completed by a trained receptionist after questioning the patient. Incorporating a double check for allergies and potential drug interactions, the docket serves as a valuable safety net. It prevents avoidable drug related harm, consultations and/or admissions, and encourages concordance. It is being piloted in community pharmacies.

> **The trust has the second highest level of reports for a mental health trust, with reporting done by all staff**

JUDGES

- Dr June Raine, Medicines and Healthcare products Regulatory Agency
- Martin Stephens, Department of Health

WINNER

Improving Medication Safety Using Pharmacist Interventions

Petra Brown and colleagues, Manchester Mental Health and Social Care Trust

Although mental health is the third highest reporter of medication incidents – 9 per cent in 2007 – under-reporting remains, particularly in community settings.

Within Manchester Mental Health and Social Care trust, medicines incidents were predominantly reported by inpatient nursing staff, and levels of reporting were low. Interventions made by pharmacists were not routinely captured on the trust's web based incident reporting system.

Using an amended pharmacy intervention form, all interventions made were reported and analysed alongside medication errors. These were reviewed and reclassified by the chief pharmacist.

Medication incident reporting increased dramatically. The trust now has the second highest level of reports for a mental health trust, with reports coming from all staff groups in all areas.

Learning from incidents has been established through incident scrutiny meetings, mandatory training, e-learning and newsletters.

Changes to systems include a new medicines card, nurse competency assessment, reviewed medical training and the appointment of a lead nurse for medicines management.

Environmental Hygiene Solutions

In association with SANYO Virus Washer would like to congratulate the winner of the Infection Control & Hygiene category at the

Patient Safety Awards 2010

The South Western Ambulance Service NHS Trust
- The Cleaner Care Initiative -

This successfully demonstrated that by implementing a network of improvement strategies at all levels across the organisation that attitude change is achievable in a short period of time.

We would also like to thank all finalists in this category for their commitment and inspirational approach to tackling Infection Control within the modern NHS.

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INFECTION CONTROL

FINALISTS

Highly commended: 6 Designs for Infection Control, Sally Halls, Grace Davey and colleagues, Royal College of Art Helen Hamlyn Centre

A specialist design team from the Helen Hamlyn Centre visited hospitals, talking to staff and spending time on wards to discover areas where design could improve infection control. Their research led them to focus on six everyday items in the bedspace. Working with clinical specialists, patients and frontline staff, they redesigned these items to make them easier and quicker to clean. The concepts received positive feedback from NHS staff, and are now being developed for manufacture in the near future.

ANTT Mats, Stephanie McCarthy, Derby Hospitals FT

Aseptic Non Touch Technique (ANTT) mats, designed with company Medifilm, adhere to preparation surfaces in clinical rooms. They have built-in silver ion antimicrobial protection, inhibit bacterial growth, minimise the risk of cross contamination and are easily cleaned and disinfected.

The idea for designating a permanent area where staff prepare IV drugs/injections and for procedures requiring aseptic technique came about as part of the Productive Ward programme. This establishes a "stop" moment for staff, so helps to reduce the risk of drug preparation errors.

VitalPAC Screening and Surveillance, Lorraine Albon and colleagues, Portsmouth Hospitals Trust

As a result of high numbers of MRSA bacteraemias in medical patients, a series of actions were adopted, including a seek and destroy approach to the management of patients admitted as an emergency.

This project added functionality to VitalPAC, software that has helped us standardise MRSA admission screening and enhance management. Results and treatment plans are given in real time at the point of care. Now, 98.3 per cent of patients are screened. MRSA bacteraemia has dropped by 78 per cent (105 to 23 cases) over five years. MRSA carriage has fallen from 5.3 per cent of patient screens to 2.5 per cent.

This project was also shortlisted for the Technology award.

Prevention and Management of Hospital Acquired Infections, Diane Wake and colleagues, Royal Liverpool and Broadgreen University Hospitals Trust

The trust's approach to excessive infection rates included: learning from reciprocal visits with Johns Hopkins Hospital in the US; implementing national guidelines at every level; an isolation ward; cooperation between the infection prevention and control team, the infectious disease unit team and clinical pharmacists; and close liaison with community teams. Sustained improved patient safety and business continuity has resulted from: containment of flu outbreaks and better staff immunisation; hugely reduced incidence of *Clostridium difficile*; reduced bloodstream MRSA; and containment of norovirus and other infections.

> **The programme challenged cultures and practices, with new guidelines, systems, education and equipment**

JUDGES

- Neil Ellwood, Environmental Hygiene Solutions
- Katherine Wilson, National Patient Safety Agency

WINNER

Cleaner Care: Transforming Pre Hospital Infection Prevention and Control

Adrian South, South Western Ambulance Service Trust

The cleaner care programme was launched because infection prevention and control standards varied. The ambulance environment presents a range of challenges, with 2,500 staff and 3,500 volunteers operating across 82 sites, within the largest geographical area of any NHS trust in England.

The project aimed to improve patient safety by embedding a culture committed to the principles of infection prevention and control. The programme successfully challenged accepted cultures and practices, implementing new guidelines, systems, education and equipment. A focus on returning to the basics saw the introduction of six commitments of cleaner care.

A deep cleaning programme was established to ensure that all vehicles were regularly cleaned. Audit processes were developed to ensure that all vehicles and premises were maintained to the high standards. The overall outcome of the project has been the transformation of infection prevention and control across the trust, with a significant shift in organisational culture.

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SAFE CLINICAL PRACTICE

FINALISTS

Highly commended: Surviving Sepsis, Leonie Lowe, Colchester Hospital University FT

A education programme was rolled out throughout the trust. This was a modified version of the six hour resuscitation care bundle, which incorporated four physiological identification parameters and three treatment initiatives. It was intended to enable early and easy recognition of the septic patient and promote swift treatment.

An audit looked at adherence to the care bundle to see if improvements had been made. It examined whether total compliance with the care bundle improved patient outcomes. Adaptations and improved educational programmes encourage further compliance and acceptance.

Reducing Patient Falls, Shirley Brady, Aintree University Hospital FT

A falls prevention collaborative was established to deliver an ambitious target of reducing patient falls by 30 per cent across a clinical business unit. Quarter one saw a 41 per cent reduction in falls; quarter two saw a 36 per cent reduction.

The project was designed to re-energise and refocus the approach to falls prevention through new tools. Local champions demonstrating strong visible leadership at point of care ensured engagement from frontline staff, based on a genuine desire to improve patient safety.

Working with Johns Hopkins Hospital in the US assisted the trust in developing a patient safety culture.

Reducing Avoidable Mortality Through the Use of Targeted Care Bundles, Elizabeth Robb, North West London Hospital Trust

The trust, one of the largest in London, is one of the top trusts in the country regarding patient mortality. This is largely thanks to the development of care bundles for the treatment of conditions that are known to be lethal, such as stroke, heart failure, pneumonia and chronic obstructive pulmonary disease. The care bundles are checklists of the best clinical evidence and outline action staff should take.

The trust significantly exceeded its target of saving 110 lives: within one year, its mortality rate had dropped to a level that equated to 255 actual lives saved.

Data published this year by NHS Choices put the trust's overall death rate as 71.9 – the lowest in the country.

The Falls Collaborative, Patricia Bain, the Rotherham FT

The trust decided to develop a whole system, high impact, evidence based improvement programme to reduce falls. The board of directors fully supported the programme. The hospital started a falls collaborative based on three wards to run for six months. This pilot involved a number of planned evidence based interventions, and others that came about as a consequence of planning and evaluation.

There has been a reduction of 30 per cent for all falls and of 50 per cent for falls from a height.

The falls collaborative has been so successful that it will be rolled out across the trust.

> We have seen 560 days pass since a pressure ulcer – equivalent to more than 11,000 bed days saved

JUDGES

- Sally Brown, Department of Health
- Maggie Nicol, School of Community and Health Sciences, City University London
- Janice Stevens, Department of Health

WINNER

Pressure Ulcers – Zero Tolerance

Hamish Laing, Abertawe Bro Morgannwg University Health Board

Pressure ulcers are painful and can be life threatening. Treating them is estimated to cost the NHS £2.4bn every year. One in 10 patients admitted to an acute hospital develop or already have a pressure ulcer, yet the majority of these wounds can be avoided.

By using improvement methodology to introduce a SKIN – Surface, Keep moving, Incontinence, Nutrition – bundle of care, adopting an effective communication tool, ensuring 100 per cent compliance with existing risk assessment tools and managing these appropriately, pressure ulcer incidence can be reduced significantly and, in most areas, eradicated permanently.

Through this methodology, we have introduced processes that have achieved sustainable culture change. On our pilot ward – Anglesey Ward – we have seen 560 days pass since the last pressure ulcer incident. This is equivalent to more than 11,000 patient bed days saved.

Spread has been effective across our hospital sites. Several wards have now reported more than 150 days since a pressure ulcer. Our aim is to make our entire organisation pressure ulcer free.

CRITICAL AND INTENSIVE CARE

FINALISTS

Highly commended: Time Critical Transfer System, Patrick Stewart, Western Health and Social Care Trust

We have to undertake time critical transfers of critically ill adults and children. We audited practice from a standpoint of time, then discovered there was an average of one serious equipment related incident per trip. We organised a patient gurney with equipment bolted on in a "ready to go" fashion, AC inverters and teamwork training for staff.

Transfer times shortened and there was a dramatic reduction in equipment related incidents. Our team can now access the 999 system to reduce ambulance delays.

Safer Patient Initiative – Adult Intensive Care, Richard Innes and colleagues, Musgrove Park Hospital

We took part in a programme to improve safety and quality of care in adult intensive care. There has been a year on year reduction in mortality, near elimination of MRSA acquisition and catheter related infections, and a reduction in ventilator associated pneumonia. New ways of communicating include bedside whiteboards. Our approach embedded evidence based practice into care in a sustainable fashion. Senior management support and small tested changes were crucial.

MRSA Prevention in Critical Care, Mary Burt and colleagues, Northampton General Hospital Trust

A protocol was implemented for all patients in ICU. This consisted of the use of antimicrobial body wash and nasal decolonisation ointment for five days, followed by two days without treatment then full MRSA screening before preventative treatment. This has cut MRSA colonisation.

This simple, cost effective measure to improve the safety of critically ill patients has also promoted close working between the critical care and the infection prevention staff.

Reducing MRSA Colonisations in ICU, Murad Ghrew and colleagues, Salford Royal FT

ICU staff started a project in May 2009 to reduce the number of patients colonised with MRSA in ICU by 70 per cent by 31 January 2010. Other objectives cover: patient screening; staff hand hygiene; and treatment of MRSA infection. A full report documenting achievements against target, including return on investment, will be presented to the board.

Central Venous Catheter Management in Critical Care, Critical care team, York Hospitals FT

Concentrating on reducing central line infection rates, this project focuses on the development of a care plan and audit tool that became the foundation of a trust wide database.

The care plan and audit tool have proved to be an effective measure of compliance with care bundles, and have brought about changes to systems through effective data generation. This approach was ultimately responsible for the reduction of central line infection rates.

> The approach included a colour coded observation chart, with intervals recording slight changes

JUDGES

- Kate Beaumont, National Patient Safety Agency
- Cheryl Crocker, NHS Institute for Innovation and Improvement
- Keith Young, Department of Health

WINNER

Reducing Cardiac Arrests

Kaye Sheppard and Julian Sonksen, the Dudley Group of Hospitals FT

Our aim was to improve the early recognition and care of acutely ill patients at risk of deterioration and cardiac arrest. To achieve this, the Dudley Group of Hospitals set up a multidisciplinary group with the remit to design and implement an effective early warning recognition and intervention programme.

The project took an approach that included a new colour coded observation chart, with minimum charting intervals recording the slightest changes and clear triggers for action by ward staff. Such actions include referral to the new 24/7 critical care outreach team or, if needed, a call and immediate response from the medical emergency team.

The above approach, combined with other initiatives to improve patient safety in the intensive care unit, have helped us achieve our target of reduced cardiac arrests and so we can now move on to tackling other safety issues affecting these patients.

MATERNITY

FINALISTS
Highly commended: three projects by Lyndsay Durkin and colleagues, the Royal Wolverhampton Hospitals Trust

'Pin Girl' Interactive Training Poster
This simple, inexpensive poster is a valuable learning tool about postpartum haemorrhage that is suitable for the training room and the clinical area.

Each session encourages staff to engage in a lively activity. Treatment is addressed and discussed throughout, to encourage interaction. The poster gives an overview of causes and care, as well the roles and responsibilities of each team member. Designed by a midwife, it has been evaluated positively by staff of all grades.

Intrapartum Faculty – Emergency Study

The faculty of midwives, obstetricians and maternity support workers strive to present this mandatory training day as interesting, informative, interactive and enjoyable.

The day includes lectures, scenarios and role play. It highlights learning from national recommendations, adverse outcomes and birth experience feedback. The aim is to raise staff awareness, improve outcomes and look at how and why changes in our unit are being managed.

Waterbirth Training DVD

This training DVD supports staff at all levels in providing safe care for women during labour and birth in water. Acted out in real time by maternity staff, it shows emergency situations from recognition to care. It can be used in a training room, clinical area or a woman's home.

Observing the safe management of emergencies has given staff the confidence to offer labour and birth in water. The ability to pause it allows the audience to reflect.

CHAPS Safe Handover, Dawn Elson and colleagues, Brighton and Sussex University Hospitals Trust

CHAPS was developed to provide a consistent approach to communication at handover. It involves: Clinical picture; History; Assessment; Plan; and Sharing of information.

Within the first year of CHAPS, the unit had no serious clinical incidents compared with 12 in the previous year. Handovers are more concise and more professional. CHAPS has focused attention on the clinical importance of handover and the dissemination of information within the team.

HICSS Maternity Risk Assessment, Linda Campbell and colleagues, Southampton University Hospitals Trust

The Hospital Integrated Clinical Support Systems Programme (HICSS) maternity risk assessment enables comprehensive data capture of antenatal and end of pregnancy activity. It triggers "per incident" reports when specific risk events occur and reports for service management, planning, risk management and clinical governance.

Midwifery and other staff are informed and continually challenged to address areas of practice where risk may occur.

> **A modified obstetric early warning system improves the recognition of vital sign deterioration**

JUDGES
- Susanne Cox, The King's Fund
- Hamid Rushwan, International Federation of Gynaecology and Obstetrics

WINNER
Obstetric ALERT
Sharon O'Brien, Cardiff and Vale University Local Health Board

Early warning signs of impending maternal collapse often go unrecognised, according to the latest report from the Confidential Enquiry into Maternal and Child Health. It says that a lack of clinical knowledge and skills among healthcare professionals is one of the leading causes of potentially avoidable mortality. The CEMACH report also states that, in a number of cases, there are readily identifiable factors associated with the care that the women received that may have contributed to their death.

To improve early recognition of impending maternal collapse within Cardiff and Vale University Local Health Board, the resuscitation service adapted the acute life threatening events recognition and treatment (ALERT) course to make it more applicable to obstetrics. The project was undertaken in conjunction with obstetric anaesthetics consultants and midwifery lecturers, with permission from Portsmouth Hospitals Trust.

A modified obstetric early warning system chart was introduced concurrently to improve the recognition of vital sign deterioration.

MENTAL HEALTH

FINALISTS

Highly commended: Fire and Mental Health Liaison, David Marsden and colleagues, Manchester Mental Health and Social Care Trust

Over 30 per cent of people who were injured or died in fires since 2000 in Manchester were known to mental health services. The trust worked with the city's fire service to reduce risks. An occupational therapist assessed interactions between a person's abilities, occupations and physical/social environment in partnership with the fire service. Service users have benefited from this person centred approach.

Highly commended: RIOTT, Naomi Lonergan, Tees, Esk and Wear Valleys FT

The Randomised Injectable Opiate Treatment Trial is the first in the UK to compare injectable opiate treatment with optimised oral methadone for severely entrenched heroin users. RIOTT targeted users who, despite treatment, still injected illicit heroin. It examined the effectiveness and cost effectiveness of treatment with injectable opiates for users who did not respond to conventional methadone. RIOTT reduced the use of illicit heroin and self reported crime in all users, especially the injectable diamorphine group.

It's Better in Bedfordshire, Carrie Catlin and colleagues, Bedfordshire and Luton Mental Health and Social Care Partnership Trust

An interim senior management team empowered staff and managers to work innovatively to raise standards, which resulted in major improvements in patient safety.

A combination of changes to buildings – including separating women and men – and cultural shifts led to a considerably safer service, with fewer serious untoward or violent incidents. The principles are being rolled out across the trust and the region as examples of excellence.

Falls Initiative, Jane Blakey, Tees, Esk and Wear Valleys FT

Falls account for the highest number of incidents per year in mental health services for older people. The falls assessment team developed an evidence based, assessment led service to prevent falls in these patients. This has involved setting up a multidisciplinary assessment team, the use of falling star stickers to highlight patients at risk, environment assessment and a slips and trips mapping tool.

Improving Inpatient Safety, Donna Swinden and colleagues, Tees, Esk and Wear Valleys FT

A team including 12 staff and one service user took part in intensive week of training, planning and lean principles. As a result, admission was streamlined and a standardised admission pack was produced. Patients were photographed, with consent, to help trace missing patients. A template standardised ward review and recording and flow charts for policies developed. Environmental improvements were made and reception hours increased. Visiting times were amended to protect engagement time with patients.

> It identified a hit list of topics with the potential for risks and planned to avoid or reduce harm

JUDGES

- Kathryn Hill, Mental Health Foundation
- Ian McPherson, Mental Health Development Unit
- Sian Wicks, Mental Health Strategies

WINNER

Year of Patient Safety

Gina White, Leeds Partnerships FT

A programme board was set up to make organisational and service decisions to deliver the recommendations within the *First Do No Harm – the Challenge of Safe, Reliable and Effective Services* paper endorsed by the trust board.

The Year of Patient Safety was a service improvement project, set up by the programme board, to deliver operational improvements in patient safety. It was to do this by identifying a hit list of topics that had the potential for risks and plan to avoid or reduce the likelihood of harm.

The hit list included: clinical risk training; medicines management; adherence to appropriately assigned and managed observation levels; reducing unauthorised absence from inpatient units; slips, trips and falls; minimising healthcare associated infections; and minimising and managing the physical side effects of drug treatment.

The trust wants to be the safest provider of mental health and learning disabilities services in the country by 2012. This programme has been the foundation to achieving that ambition.

PRIMARY CARE

FINALISTS

Clinical Governance Committee, Ravi Gupta, DMC Healthcare

DMC Healthcare, which runs 14 surgeries, has set up a strong clinical governance system. This consists of local and central meetings with clear lines of accountability, backed by information management systems designed in house. Information from the clinical governance meetings is disseminated to all staff via meetings and a quarterly clinical governance newsletter. The system covers all pillars of clinical governance, and is designed to evolve as DMC Healthcare expands, using a hub and spoke model.

Dysphagia Awareness Training, Andrea Stroud, Dorset Adult Speech and Language Therapy Team

The adult speech and language therapy team operates an evidence based dysphagia package to train other disciplines to feel confident in assisting dysphagic patients with food and drink. It has 12 competencies through practical application and reflective study and is linked to the Knowledge and Skills Framework and the interprofessional dysphagia framework. It is run in three acute and 12 community hospitals.

Out of Hours Pathway Initiative, Bruce Websdale, Primecare

Primecare improved the safety and experience of patients by applying lean thinking to the out of hours pathway.

We began by auditing the outcomes of out of hours clinical assessments by individual clinician. From this, we were able to provide near real time feedback to each triaging clinician on the appropriateness of their assessments.

Close monitoring of the outcomes of clinical assessments has improved consistency. Primecare has embedded this project across our out of hours services.

Falls Matron Role, Lynn Sutcliffe, NHS Blackpool

The falls matron role unites community matron and clinical falls specialist roles. Holistic falls risk assessment is provided in patients' homes, along with case management and support. The falls matron role incorporates education, expert assessment, and practice and service development. The service has made significant savings in terms of preventing unplanned admissions and attendance at accident and emergency – and is very popular with patients.

Reducing NSAID Related Patient Harm, Anne Fittock and colleagues, NHS East Lancashire PCT

The medicines management team implemented a strategy to reduce the prescribing of NSAIDs. This included: multiprofessional workshops; negotiation with acute providers to review formulary; audit and incentives for GPs; pharmacist-led clinical reviews to gain patient feedback; patient information leaflets; and using feedback. Prescribing of NSAIDs across the PCT fell by 20 per cent over one year, and hospital admissions due to serious gastrointestinal complications were reduced. This project was also shortlisted for the Medicines Safety award.

More than 600 patients were screened by GPs and nurses, and 100 per cent of melanomas diagnosed

JUDGES

- Ruth Kennedy, Improvement Foundation
- Alison Tongue, NHS Institute for Innovation and Improvement

WINNER

TELEderm

Iain Mack, Scansol

Scansol is registered by the Care Quality Commission as an acute hospital for the screening, diagnosis and treatment of skin cancer. Our mission is to increase the quality and availability of skin cancer screening in primary care.

More than 10,400 people in the UK are diagnosed with melanoma annually, resulting in 2,042 deaths. Survival is dependent on early diagnosis.

GPs face significant challenges with skin cancer screening – only one in six has had any formal training in dermatology and research indicates that one in three melanomas are initially misdiagnosed in primary care.

Scansol developed TELEDerm – a pioneering telemedicine service – to assist GPs in skin cancer screening.

TELEDerm was piloted by a primary care trust in 2008-09. More than 600 patients were screened by GPs and nurses, and 100 per cent of melanomas were diagnosed.

GPs found the service "exceptional" and patients rated it "good" to "excellent". As a result, TELEDerm was commissioned by the NHS in September last year.

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SURGICAL CARE

FINALISTS

Highly commended: Surgical Safety Briefings, Tom Hollins, Airedale Trust

The clinical environment may have a level of complexity beyond the limitations of individual human performance. Increased teamworking and fail safe systems are necessary.

Airedale Trust introduced surgical safety briefings. These are a simple tool to help multidisciplinary teams share potential safety problems and concerns. They increase staff awareness, encourage more open communication and, over time, help to create a culture of safety and reduce errors.

WHO Surgical Safety Checklist, Debora Pilkington, Royal Bolton Hospital FT

Implementing the checklist involved communication with clinical staff, patients, governors and the press, using real incidents from the hospital as well as international evidence that backs the checklist. Avoided incidents were recorded, along with the use of the checklist, to ensure the project maintained momentum. Audit results were fed back to staff. Gradual implementation was changed to an every patient approach with far better results.

WHO Surgical Safety Checklist, Ajit Abraham and colleagues, Barts and The London Trust

Barts and the London trust implemented its own version of the WHO Surgical Safety Checklist from 2008. Use of the checklist is embedded in the trust's safety culture rather than being seen as an imposition. This was achieved by developing it through staff communication and education, as well as through systematic change. The checklist has been tailored to meet the needs of other areas including interventional radiology and cardiology.

Safer Theatre Teams, Sylvia Lour and colleagues, King's College Hospital FT

King's used the WHO checklist as a starting point to engage surgical teams in all theatres to reduce preventable errors in a way that would be collectively designed, owned and acted on for long term results. Six months after the checklist launch, compliance was a steady 96-97.5 per cent, with a noticeable impact on adverse incidents and near misses. Factors that helped our success were engaging all staff, focusing on care not just efficiencies and considering sustainability at every stage.

Perioperative Safety Workstream, Shakil Abbas and colleagues, Salisbury FT

The WHO checklist has been used in all theatres since June last year. The project was led by a consultant anaesthetist and the clinical lead for theatres and underpinned by awareness raising, including a staff training DVD. Sustainability is tested through weekly audits with rapid feedback to staff, which inform small cycles of change to improve compliance, teamwork and safety. The team are implementing list prebriefs and debriefs using the same small cycle of change and rapid feedback methodology. The aim is to achieve a reliable process in all specialties and theatres.

> **Leadership and teamwork resulted in achieving 100 per cent deep vein thrombosis prophylaxis**

JUDGES

- Jane Reid, Association for Perioiperative Practice
- Suzette Woodward, Patient Safety First

WINNER

Perioperative Care Bundles

Thomas Daniel, NHS Fife

The Scottish Patient Safety Programme has spread to all health boards in Scotland. It evolved from work by the World Health Organization, the National Patient Safety Agency and the Independent Healthcare Association that could save lives or reduce harm. The perioperative team at NHS Fife progressed in all aspects of the programme to reach the target well in advance of the implementation date.

The principles were well disseminated to all areas of care and all professionals. Clear leadership and teamwork, along with executive support, enhanced the work. This resulted in achieving 100 per cent deep vein thrombosis prophylaxis to all eligible surgical patients, 95 per cent in administering antibiotic prophylaxis on time, and 100 per cent compliance with continuation of beta-blockers, monitoring of temperature to maintain normothermia and monitoring of glucose levels.

Our great achievement in the past year has been the introduction of Surgical Safety Checklist in all the theatres. The trust aims to introduce this into all of its interventional procedural areas this year.

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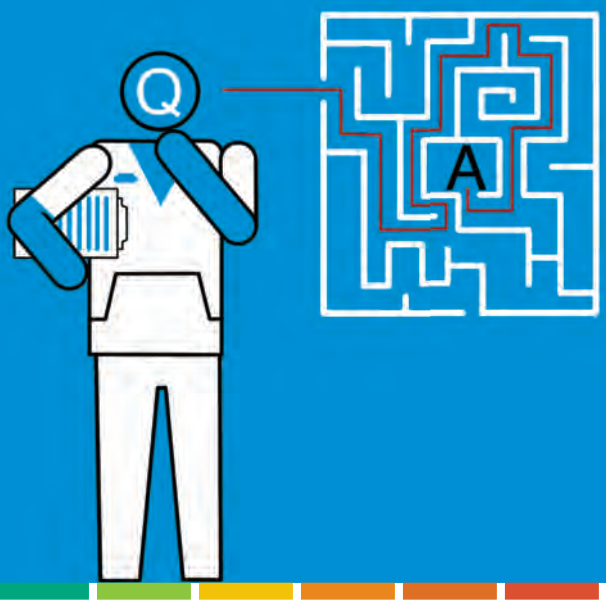

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TECHNOLOGY

FINALISTS

Highly commended: Proactive Care System, Tariq Muhammad and colleagues, Pharmacy Plus

The Proactive Care System, which is used in care homes, is the first system to prompt staff when drugs are due. Its unique barcode validation process prevents incorrect administration. PCS manages stock control, provides accountability and reports on every aspect of practice including near misses. It can significantly cut drug errors and 92 per cent of staff would not return to paper based systems.

Paeds ED, Haidar Samiei and colleagues, iED Applications

The Paeds ED decision aid is an iPhone application that calculates drugs and fluid dosages for paediatric emergencies. It contains an age to weight converter and a drug formulary list, consistent with UK and US national formularies. Once the user enters a patient's age or weight, the application constructs a formulary list for that patient in key conditions. The application has been downloaded in 30 countries over three months. Further testing and validation is in progress.

Electronic Blood Transfusion System, Mike Murphy and colleagues, Oxford Radcliffe Hospitals

Our approach to reduce transfusion error was to re-engineer procedures using barcode patient identification, bedside handheld computers and electronically controlled blood fridges. This has simplified procedures and improved practice.

Now implemented in the acute hospitals in Oxfordshire, the project has improved care and cut costs. Our group wrote a national specification for the process for the National Patient Safety Agency, which is being implemented in the UK and internationally. The system has the potential to be used in other procedures such as drug administration.

VitalPAC Screening and Surveillance, Dr Lorraine Albon and colleagues, Portsmouth Hospitals Trust

Action to cut MRSA bacteraemias included adding functionality to VitalPAC software that captures vital signs and calculates risk scores. This has helped standardise the approach to MRSA screening and management. Results and treatment plans are available in real time. MRSA bacteraemia has dropped by 78 per cent over five years, and MRSA carriage from 5.3 per cent to 2.5 per cent.

This project was also shortlisted for the Infection Control award.

eQuest, David Cable and colleagues, Southampton University Hospitals Trust

Initialled reports had been considered proof that results had been reviewed and acted upon. However, by the time reports had been received, results often no longer applied; recipients were often unfamiliar with the detailed diagnosis, and illegible signatures meant that clinicians could not be traced.

Based upon clinicians' designs, the eQuest electronic requesting and results system resolved these and many more issues while complementing routine clinical practice.

> Decision support regarding escalation of care is given directly to bedside staff via the handheld computers

JUDGES

- Juliet Beal, NHS London
- Jean Challiner, Clinical Solutions
- Krishna Moorthy, Imperial College London
- Jane Sandall, King's Patient Safety and Service Quality Research Centre, King's College London School of Medicine

WINNER

Hospital Wide Physiological Surveillance

Gary Smith and colleagues, Portsmouth Hospitals Trust

Numerous reports, including those from the National Patient Safety Agency and the National Confidential Enquiry into Patient Outcome and Death, have identified a failure to recognise or respond to deterioration in hospital patients as a major safety issue.

The National Institute for Health and Clinical Excellence has produced guidance for managing acutely ill patients in hospital. We took the NICE standards and designed a wireless, handheld computer based system, which permits staff to record patients' vital signs electronically at the bedside on general wards.

The system automatically calculates patients' early warning scores, and transmits raw and derived data wirelessly to the hospital computer system, creating an accurate, legible, electronic vital signs chart.

Decision support regarding escalation of care is provided directly to bedside staff via the handheld computers. The system gives staff elsewhere in the hospital instantaneous, reliable access to the charts and data via the intranet.