

Looking after our people to look after our patients

A Patient Safety and Health and Safety collaborative





**Staff Culture
of Safety**



**Patient
Safety**



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Journey of change

- H&S - not just Estates & Facilities
- Commitment, engagement and vision
 - Health & Safety Policy
- Health & Safety Group, key stakeholders
 - IPC
 - Occ. Health
 - Hospital SLT Clinic leads
 - Patient Safety
 - HR – workforce

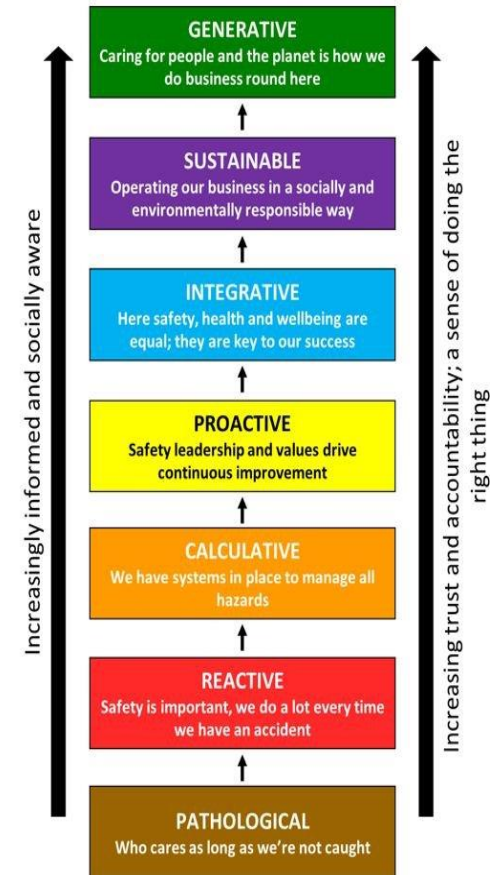


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Journey of change

- Health and Safety Management framework
 - NHS workplace health and safety standards
 - Aspiration for 45001
- Data analysis
 - Learning
 - Continual improvement
- Education and awareness
- SLT accountability
- Measuring and celebrating success
- Assurance



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Case study



Key Lines of Enquiry

- What is the variation in both staff physical movement and time, when undertaking clinical tasks within the new Hospital ward environment comparative to the current ward environment?
- Assessment of the new ward layout in reducing physical movement between task components and over all task completion.
- Assessment of the patient environment with a particular focus on:
 - Falls prevention
 - Suicide prevention
 - Tissue/skin damage
 - Infection prevention control measures
- Assessment of the physical environment against the existing model of staffing and care to ascertain the ability of current models to support a model of enhanced quality and safety within the new hospital environments.

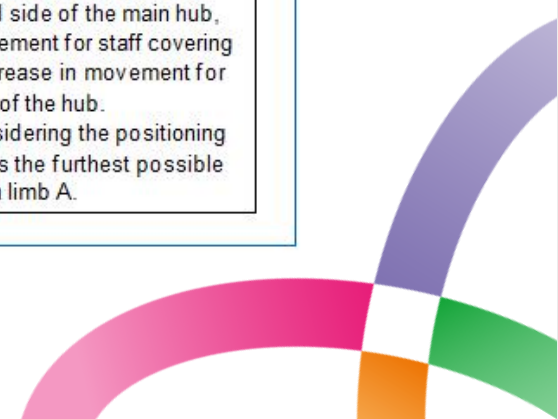
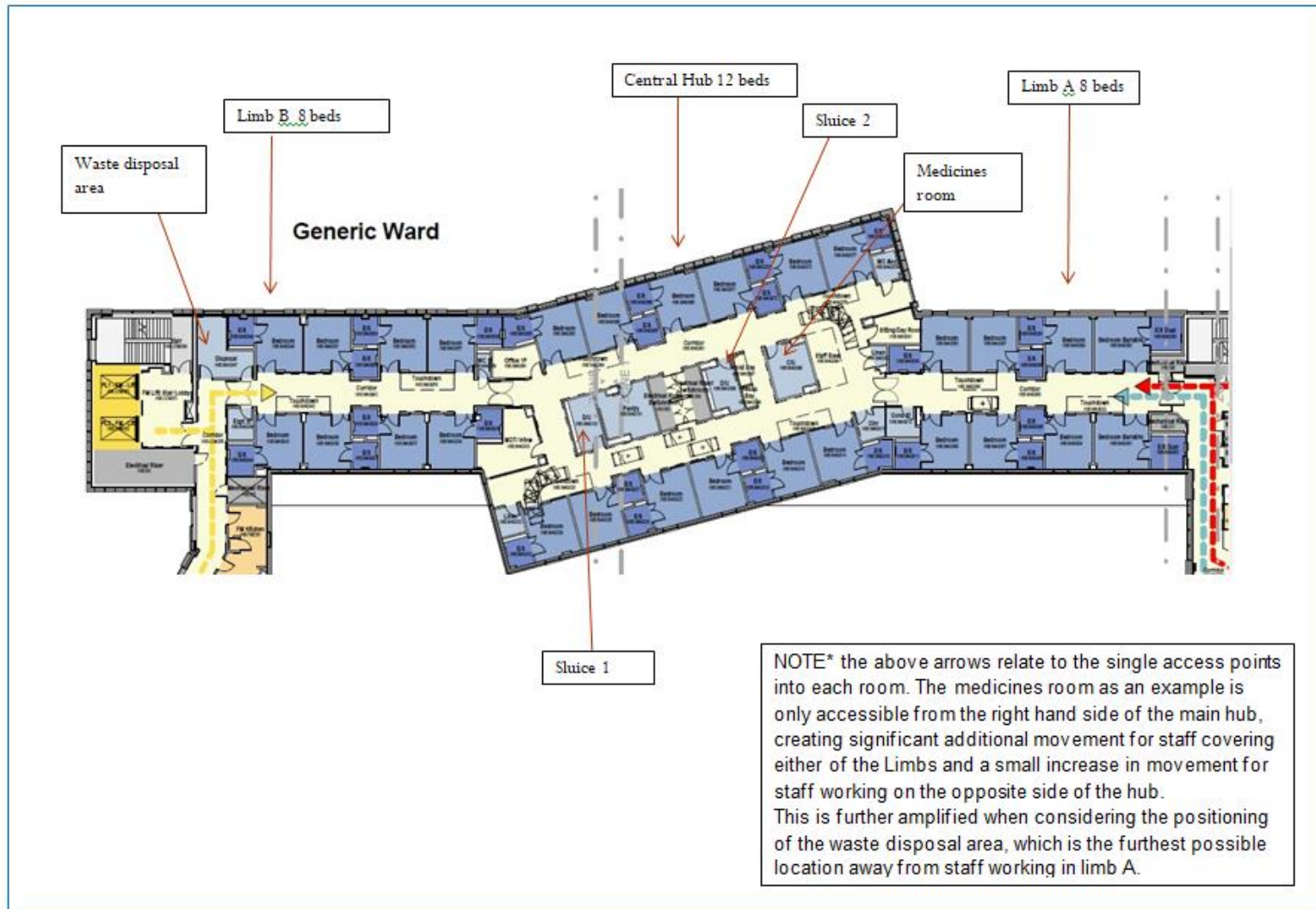


Findings

Test subject	Time variation	Distance variation	Steps taken variation (without trolley)	Steps taken variation (with Trolley)
DM	132% ↑	81% ↑	81%↑	81%↑
PN	129% ↑	97%↑	99%↑	99%↑

- A significant increase in both time and physical movement when undertaking tasks within the new Royal, compared to the current hospital ward environment can be seen.
- This increase is amplified by the additional movement required to access storage and /or waste disposal areas.

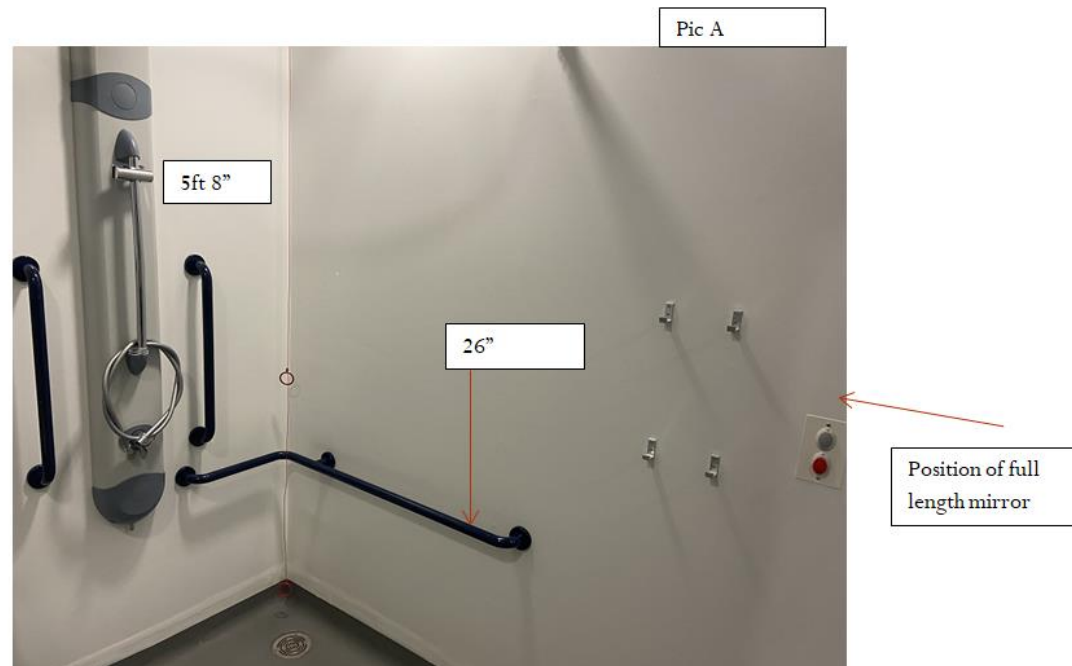




Environmental Challenges

General En-suite design

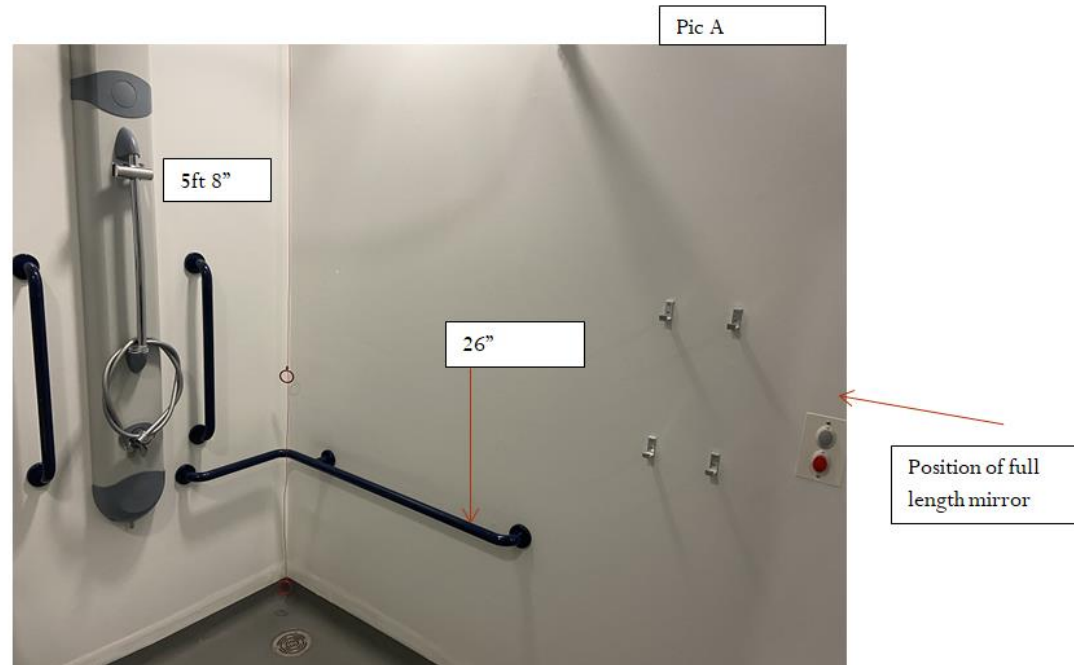
- Designed to accommodate the wheel chair user as a base design principle.
- Whilst this is to be commended, it is not without risk to non-wheelchair using patients as detailed below.



Environmental Challenges

Shower height.

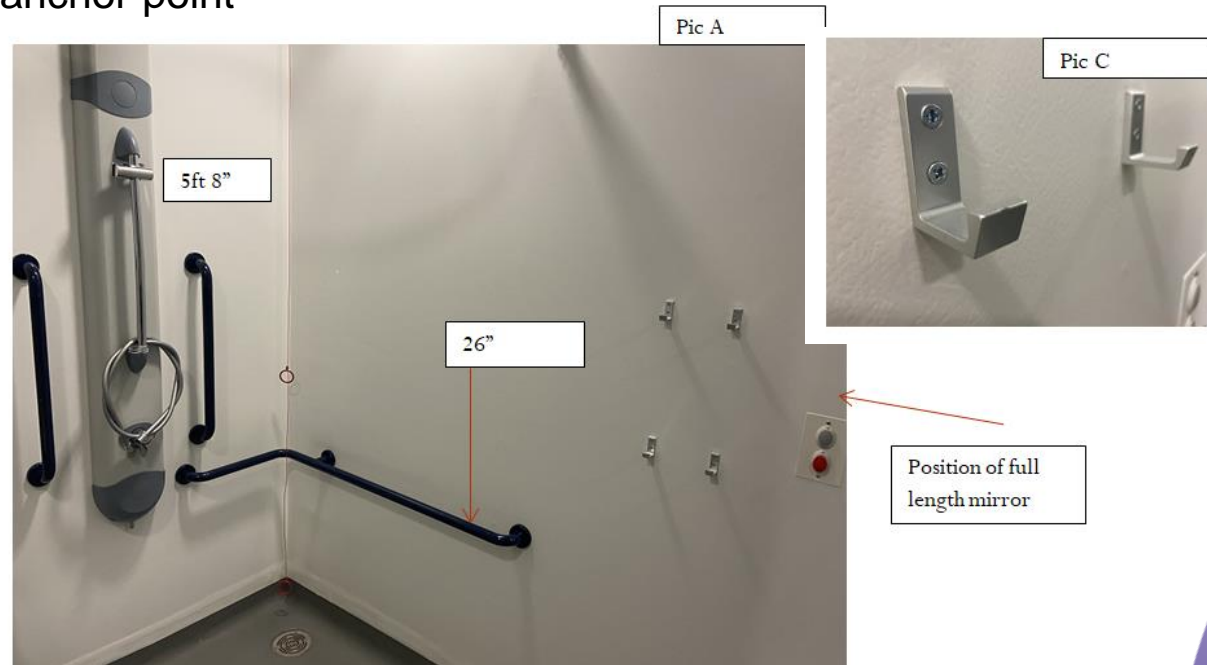
- Maximum extended height of 5ft 8", providing a maximum user height of 5ft 6"-7" to stand upright and utilise the shower effectively
- Patients taller than 5ft 7" required to adopt an unnatural or stooped position increasing the risk of falling for patients with existing balance and mobility issues



Environmental Challenges

Hooks

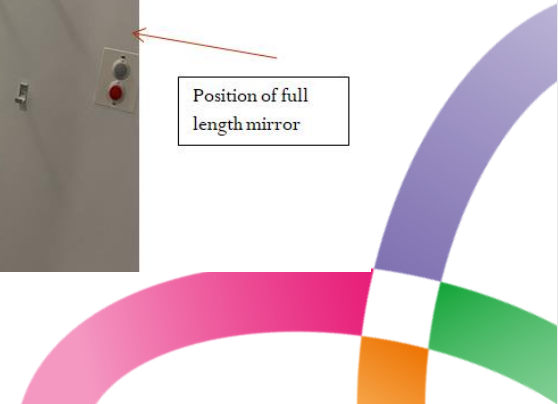
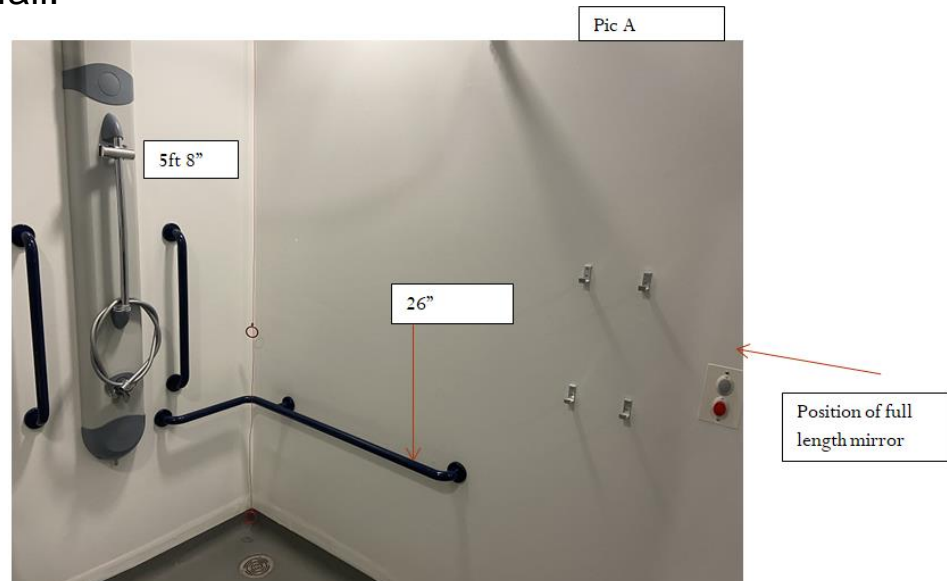
- Each room and en-suite has a selection (up to seven per room) of metal hooks with relatively sharp edges to the point that injury is highly likely should a patient with delicate skin either brush past or fall against.
- The hooks range in height from 3ft to 5ft 8", a metal hook placed at a height of 5ft 8" is sufficient to form an anchor point



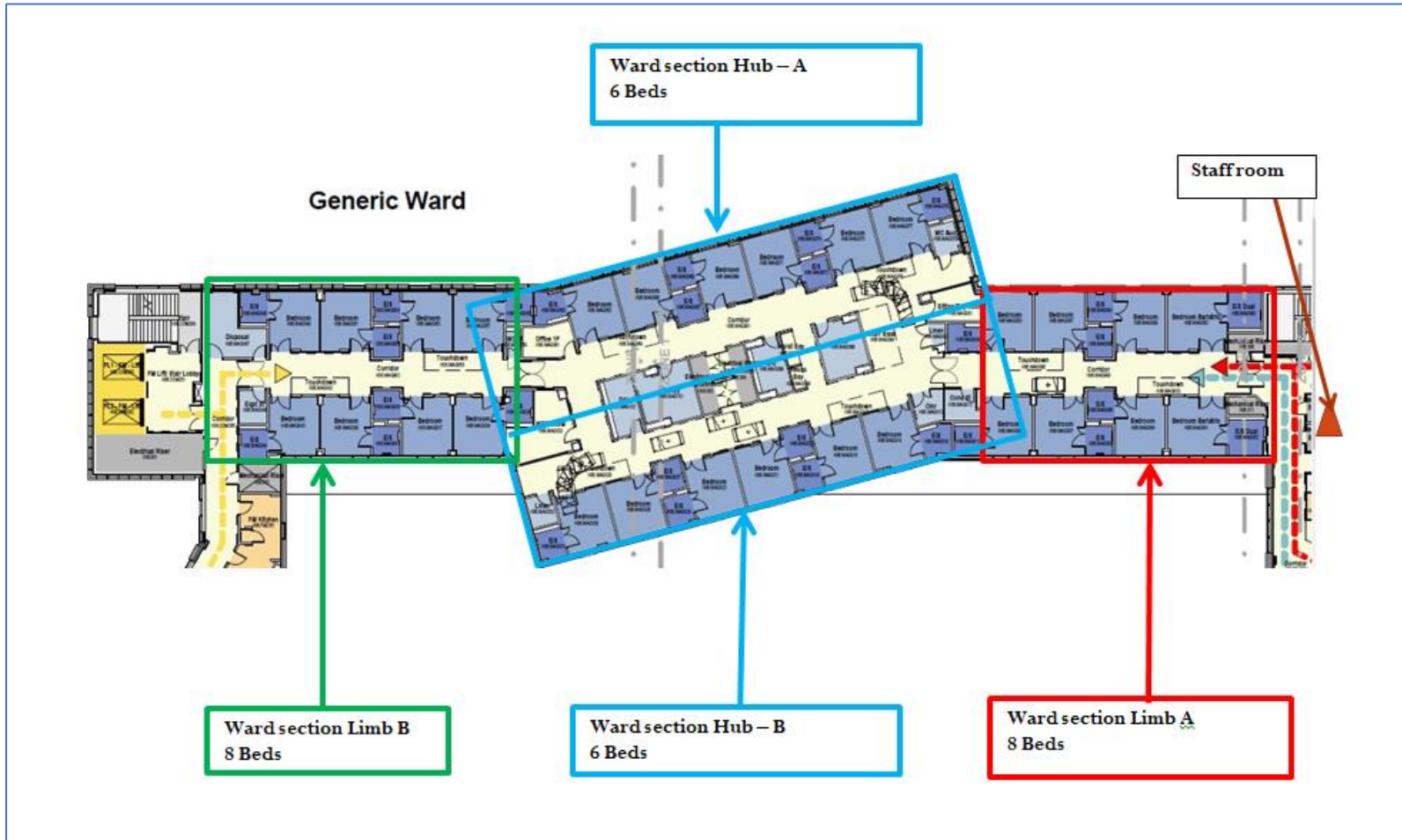
Environmental Challenges

En-suite grab rails

- A number of the available grab rails are situated at a height of 26" to accommodate wheel chair users.
- no visual design cues to differentiate between wheel chair user and non-wheel chair user - lower height grab rails will be used by standing patients in an attempt to maintain balance.
- One of the grab rails in each room has been attached to the door, a moving and often unstable object, this combined with the height of 26" creates a significant risk of overbalancing and a subsequent fall.



Proposed Compartmentalization Model



Proposed Care Delivery Model

- Each ward compartmentalised into four distinct care delivery areas.
- The anticipated approach:
 - LIMB A - 1 x registered Nurse + HCA 1
 - LIMB B - 1 x registered Nurse + HCA 1
 - HUB A - 1 x registered Nurse + HCA 1
 - HUB B - 1 x registered Nurse + HCA 1
 - Main ward desk = 1 Registered Nurse co-ordinator/Operational/non direct care support + 1 additional HCA
- Total = 5 registered nurses and five HCA's (Patient ratio = 1:7 ratio)
- Staff room is located outside of the main ward areas and outside of audible and RF signal range - staffing model must compensate for a reduction in staff surveillance and response during break times.
- Current 12 hrs shift length will be at the maximum of a proportion of our workforce's physical capacity – resulting model will need to consider the impact of an increase in physical movement (Mean 94% ↑)
- MDT - consideration should be given to ward based therapy, pharmacy and medical teams to further support effective care delivery, this should increase both the effectiveness of visibility and a shared team based efficiency,



Culture in the Sector

- Challenging the wider NHS culture
 - Sleep-deprivation
- Crown immunity was removed in 1991
- Better regulation

Sleep-deprived medical staff 'pose same danger on roads as drunk drivers'

British anaesthetist pleads for doctors and nurses to be allowed naps and limited night shifts, as in other critical workplaces



📷 A paramedic at Blackpool Victoria Hospital takes a breather during a long shift. Photograph: Lynsey Addario/Getty Images

About half of all hospital doctors and nurses have had accidents or experienced near misses while driving home after a night shift.

Future challenges

- Health care doesn't currently appear to receive the same level of regulation aligned to the protection of health care staff that is afforded to other High risk/High reliability industries.
- If its not acceptable to drive after 9hrs, why is it acceptable to perform surgery, anaesthetise, administer complex medications
- To keep our patients safe, we must first ensure the safety and optimised performance of our staff.

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