



Quality & Safety

A column by Maureen Flynn

THE SAFETY CROSS SYSTEM: SIMPLE AND EFFECTIVE



OUR fourth Quality and Safety column introduces the 'safety cross system' – an effective, engaging patient safety method.

Productive ward

The safety cross is one of the methodologies from the 'Productive ward: Releasing time to care initiative' – a ward-based quality improvement programme to empower nurses, midwives and multidisciplinary teams to streamline how they manage work. This achieves lasting improvements, predominantly in the extra time available to give to patients, which positively impacts the care delivered.

There are three foundation and eight process modules. Key to the project is the ability of frontline staff to affect changes that are required to improve patient experiences. It is currently being introduced nationally across Ireland in multiple pilot sites (in 27 hospitals).

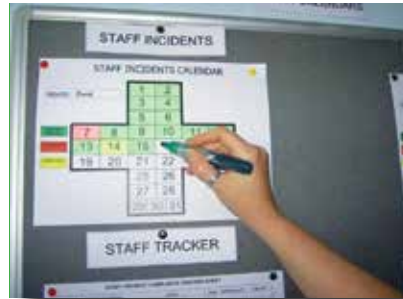
Knowing how we are doing

Know-How-We-are-Doing (KHWD) is one of the foundation modules that introduces measurement systems that are timely, accurate and useful to ward staff. The measures help to understand and benchmark the ward's performance and subsequently, how to make decisions on what to do to improve patient safety and performance.

One such system is the safety cross, which involves the entire ward team working together to choose the safety measures relevant to the ward, such as monitoring falls, infection rates and medication incidents.

The safety cross

The safety cross is a simple data collection tool. It is basically a one-month colour-coded calendar that notes daily safety measure incidents (see image above). Each number on the cross represents the day and date for that month to enable staff to differentiate safety incidents – coloured in red, from incident-free days



– coloured in green. This means the team can focus on timely solutions that are within their sphere of influence.

Monthly data is plotted and displayed for patients, staff and visitors to view. Regular multidisciplinary team meetings review the data trends and discuss and agree on solutions for improvement.

Supports for the productive ward

The initiative commenced in January 2011 and it is envisaged that the culture of patient safety and improvement will be sustained long after each ward completes the 11 productive ward modules (around two years). Each site is supported with implementation in their organisation through a local steering group and a regional 'area co-ordinator', who supports the project.

Experience of using the safety cross

Monthly safety cross data reports have been collected from each productive ward and collated and trended nationally. Improvements have occurred in almost all of the key patient safety areas in most pilot sites using the safety cross method.

Many of the patient safety improvements have been reported nationally through the national clinical programmes forum and have highlighted:

- The value of using a patient safety measure that engages the whole ward team
- That simple visual tools engage (see image)
- Encouraging team participation in data collection, discussions and providing solutions, increases the chances of success

- An exact definition of the measure is essential for local and national reporting
- Internal and external project-support maintains momentum.

Challenges to safety cross introduction

- Choosing meaningful and measurable patient-safety metrics
- Multidisciplinary team agreement with the patient safety improvement metric
- Developing a culture of 'it is everyone's job to collect the daily data'
- Holding regular team reviews of data and working with process improvements tools
- Moving onto new measures once sustained improvement has been achieved.

Opportunity to get involved

The productive ward provides a means to put the spotlight on safety and provide more time for you to focus on direct patient care. You can reflect on your area of practice and identify possible uses of a safety cross. At your next team, ward, unit or department meeting, why not suggest using a safety cross to collect data and monitor if any clustering or common trends can be identified in patient falls, pressure ulcers or medication incidents?

Maureen Flynn is the director of nursing (national lead for quality and safety governance development) at the Office of the Nursing and Midwifery Services Director, Quality and Patient Safety Directorate, HSE

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For further information, contact:

National lead productive ward: Releasing Time to Care: Mark White, Interim Director NMPD HSE-SE, mark.white@hse.ie

Area co-ordinator HSE-NE: Dolores Donegan, NMPD, Kells, dolores.donegan@hse.ie

Area co-ordinator HSE-DNE: Michelle Waldorn, NMPD Swords, michelle.donegan@hse.ie

Area co-ordinator HSE-DML: Raphael McMullin, NMPD Palmerstown, raphael.mcmullin@hse.ie

Area co-ordinator HSE-Midlands: Mary Manning, NMPD Tullamore, mary.manning@hse.ie

Area co-ordinator HSE-South: Miriam Bell, NMPD Kilkenny, miriam.bell@hse.ie

Area co-ordinator HSE-West: Gillian Conway, NMPD Limerick, gillian.conway@hse.ie

Area co-ordinator HSE-NW: Liz Breslin, NMPD Ballyshannon, liz.breslin@hse.ie



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Health Service Executive

Quality and Patient Safety Directorate

About the HSE Quality and Safety Directorate: The Quality and Patient Safety (QPS) Directorate of the Health Service Executive (HSE) was established in January 2011, on the appointment of the National Director, Dr Philip Crowley. The role of the QPS Directorate is to provide leadership and be a driving force by supporting the statutory and voluntary services of the HSE in providing high quality and safe services to patients their families and members of the public.

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