Yorkshire & Humber HIEC

Turning best practice into common practice

Training and Action for Patient Safety (TAPS) Programme

What is TAPS?

Training and Action for Patient Safety (TAPS) is a new training programme to improve safety in the NHS, developed in Yorkshire and Humber by experts in the fields of patient safety and improvement science.

The TAPS programme takes place over a period of 20 weeks, and includes an on-line patient safety module and three workshops. Teams are supported to identify their own patient safety problem, to develop a solution, and to measure the impact of any intervention on practice and patient outcomes.

Who is involved?

An initial pilot was delivered in the Bradford health community across 11 multi-professional teams, with between 3 and 9 members, during 2010.

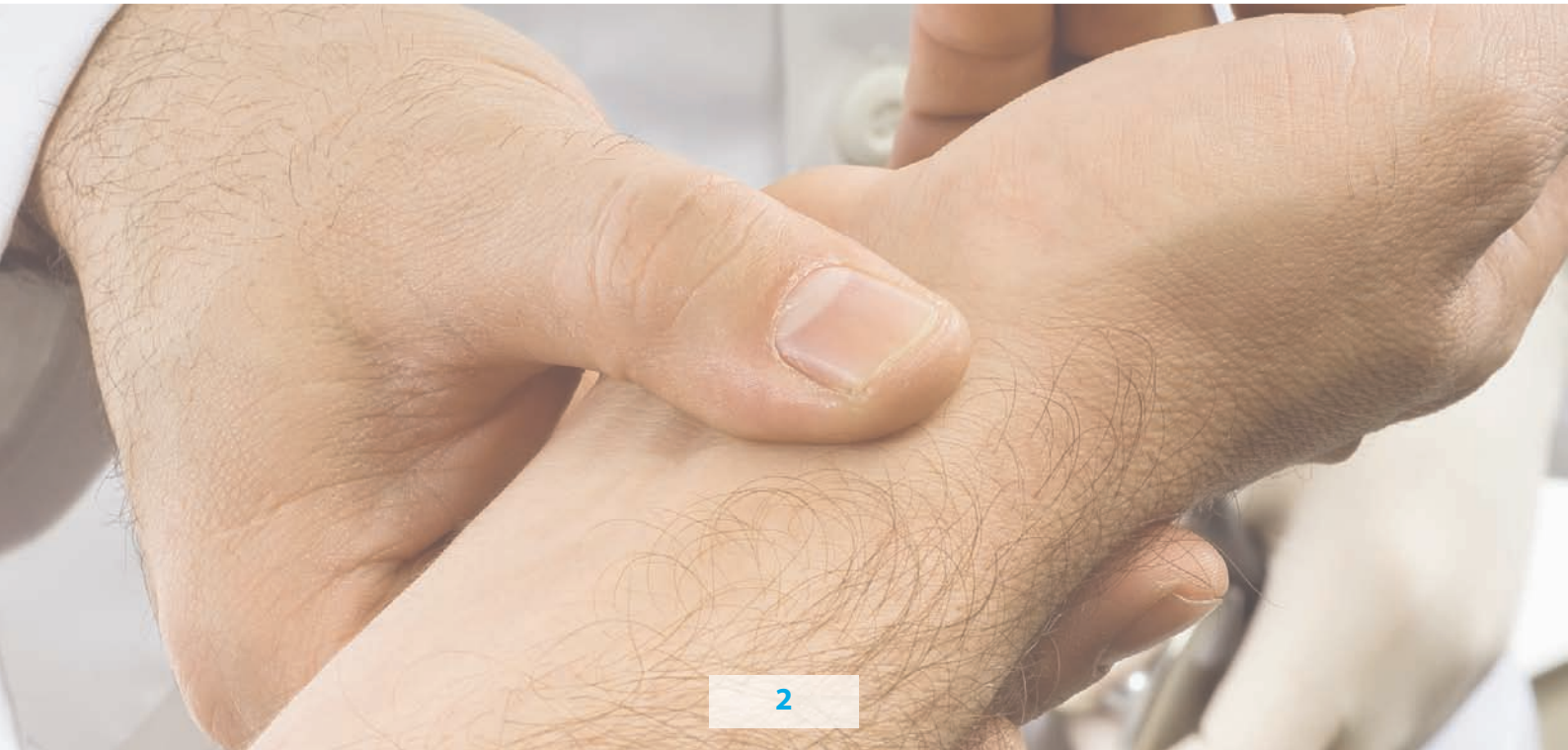
Since then more than 50 multi-professional teams have participated in 5 further TAPS programmes taking place in Doncaster, North-East Lincolnshire, and Sheffield, Leeds and York/Scarborough between August 2010 and December 2011. TAPS is currently being delivered in Hull.

TAPS is a truly multi-disciplinary programme which has involved: Junior doctors; GPs; Consultants; Nurses; Midwives; Matrons; Pharmacists; Clinical Educators; Managers - clinical and non-clinical; Patient Safety Leads; GP Registrars; Occupational Therapists; Clinical Audit Officers; Heads of IT; Heads of Quality; Medicines Safety Managers; Psychiatrists; Psychologists; Practice Managers; GP Trainers, across a variety of settings including Acute Hospitals, Mental Health, General Practice and Nursing Homes.

The benefits of TAPS

TAPS delivers benefits in a number of different ways. As well as the obvious impact on patient safety of the interventions delivered by the different teams, TAPS can also improve the relationships, communications, behaviours and, to some degree, the culture within organisations which can impact positively on other initiatives and issues. Individual participants can apply an increased patient safety awareness and improvement skills to different patient safety problems throughout their career. Reported benefits include:

- An improvement in knowledge following the programme including more general awareness of patient safety issues.
- The measure of safety culture demonstrated some immediate effects of the programme for communication openness, management support and organizational learning.
- In Bradford eight of the eleven teams demonstrated significant improvements in patient safety practices and/or outcomes and many reported that the programme had served to promote better multi-professional communication and teamwork. Interviews with participants two or three months after the end of the programme revealed a range of additional benefits of TAPS beyond the specific problem on which the team had focused.
- In Doncaster, North-East Lincolnshire, and Sheffield, evaluation of 10 of the 22 teams demonstrated quantifiable improvements in patient safety practices and/or outcomes. Three teams could describe improvements but did not have appropriate measures to demonstrate this, for one team the measures demonstrated that no improvement had taken place and for the additional 8 teams a longer period of support would have been required to deliver improvement in their identified patient safety issue.
- Helping participants to think about patient safety issues at a 'systems' or 'process' level, and the benefits of collaborative learning throughout the programme. At follow-up, participants reported that they were either making use of the learning from TAPS or had identified ways of doing this.
- Providing useful insight into others' perceptions of problems and solutions.



The impact of TAPS in Yorkshire and Humber

The two TAPS evaluation reports are available on the YH HIEC web-site and they set out in more detail the patient safety problems that NHS teams have used TAPs to address, how they did this and the outcomes. Across the teams who have been involved in TAPS to date the following impacts have been reported:

- Increased reporting of needle stick injuries and appropriate follow ups taking place.
- Improving handover for predictable deteriorating patients to avoid delays in management.
- Reduction in the number of patient falls at night.
- Improved time to register new patients between GP practice and nursing home.
- An increase from 14% to 90% of clinicians conforming to NICE guidelines for feverish illness in children.
- More rapid blood results leading to quicker treatment.
- Better communication between doctors and nurses on the ward.
- Better induction for junior doctors.
- Patients receive VTE prophylaxis at the correct dose throughout hospital stay.
- More reliable and accurate handover.
- Introduction of a transfer summary when patients are discharged.
- Implemented 72 hour review for incidents of violence and aggression.
- More reliable system for completing physical examination of new inpatients.
- More reliable risk assessment documentation for new referrals.
- Number of patients with recorded allergy status increased by 15%.
- Improvement in GP recording of 'red flag' symptoms for patients with back pain.
- Improved communication around prescription changes to dosette boxes.

Find out more

Details of the TAPS resources including the evaluations from completed programmes and the Introduction to Patient Safety on-line module are available at:

www.yhhiec.org.uk/themes/patient-safety/.

1. *VTE Risk Assessment & Prescribing, Doncaster & Bassetlaw Hospitals NHS Foundation Trust*

In Doncaster a team of 9 in the Medical Admissions Unit (MAU) used TAPS to increase the number of identifiable, completed VTE Risk Assessment forms for patients admitted via MAU. They did this by:

(1) Baseline ward audit on 20 patients.

(2) Introduction of Safety Cross.

(3) Introduction of current admission bookmark.

(4) Introduction of a poster for medical staff.

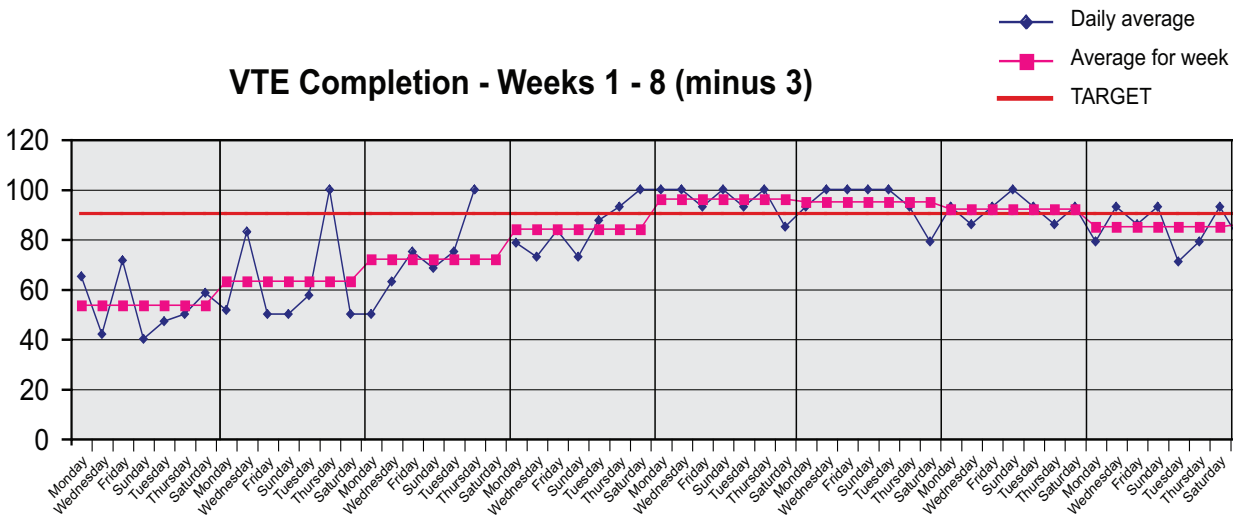
(5) Putting the VTE Risk Assessment in medical clerking pack.

(6) New improved poster with cost implications/how to complete.

(7) Email from Clinical Director to all non-consultant staff.

(8) Introduction of electronic pens for data capture/compliance.

The first seven weeks showed week on week improvement. A concerted effort was demonstrated by all staff concerned and by week seven the majority of the days they were achieving 100% compliance with the Risk Assessment. After week six 100% of patients received correct Thromboprophylaxis, however some patients still did not have a risk assessment completed (with the introduced electronic pen) and these have been taken into consideration when analysing their figures.



We are utilising PDSA cycles above anything else from the programme; we run with an idea and if it works we continue and build on it. If it doesn't work we come back to the drawing board. The success we had with the TAPS programme continues; we are maintaining 95-98% compliance with the risk assessment. We just do it now as it has become a part of the way we work.

What was most difficult in the TAPS programme was getting everyone together outside the TAPS off-site pre-determined sessions. It definitely needs one person to bring this together and take the role a step further than facilitative support.

Getting involved in TAPS has been fantastic for us – it has given us time to think not just do. We used the TAPS sessions to plan together so that when we came back into the organisation we could just get on and do it. We would often stay an hour after the set sessions to finish working plans through. It gave us the breathing space needed to work together to find solutions and if one idea didn't work we could come back to the drawing board.

As a group we have found TAPS to be really good and positive – we are still catching people in the corridors to share ideas and plan who to talk to about how to make them a reality. Even though our formal TAPS programme has ended the approach is being used daily.

Tracy P Evans-Phillips, IPOC Manager
Department of Clinical Audit and Effectiveness, Doncaster Royal Infirmary

2. *Rowan Ward, Sheffield Health and Social Care NHS Foundation Trust*

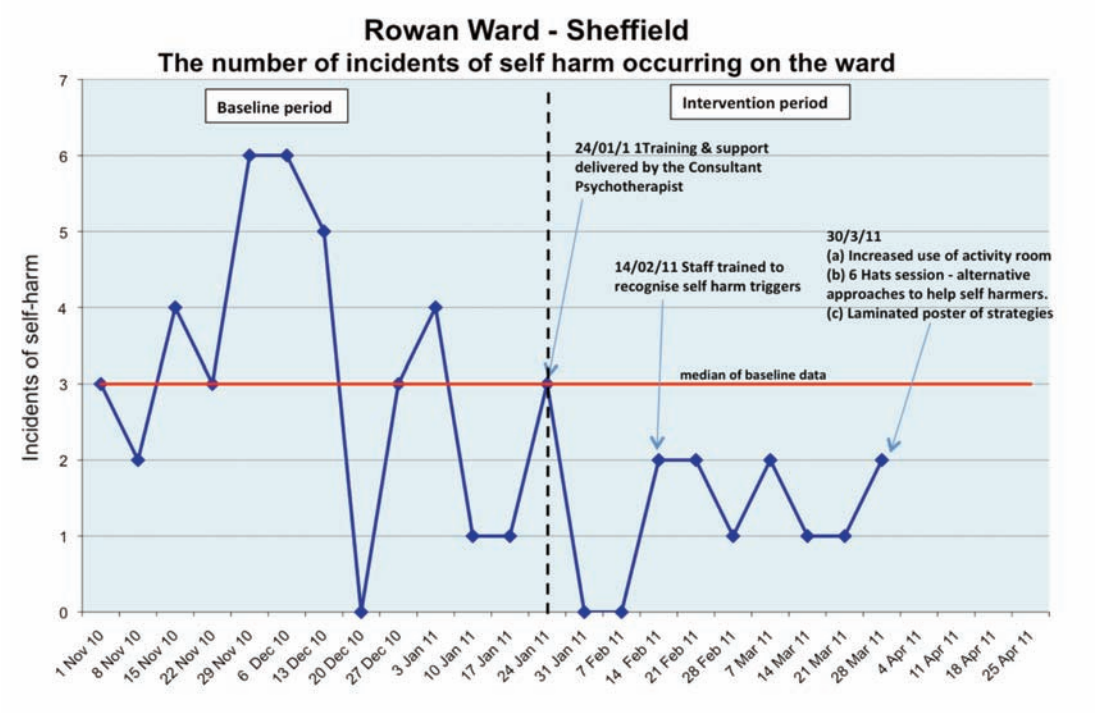
Staff in the Rowan Ward at Sheffield Health and Social Care NHS Foundation Trust used TAPS to reduce the incidence of self-harm on the Adult Mental Health Inpatient ward.

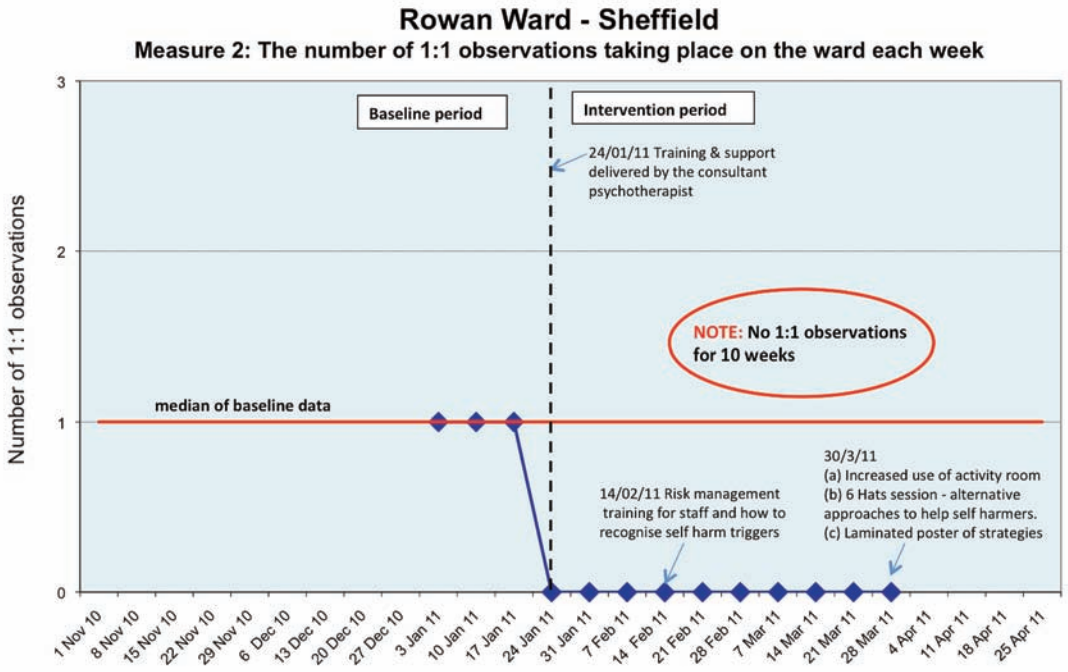
All of the ward staff attended risk assessment training, a consultant psychotherapist delivered sessions to staff on the ward on how to manage personality disorder patients and all the ward staff participated in a six thinking hats session on managing self- harm. As a result the following actions were identified:

1. Giving patients a choice / list of alternative coping strategies (ice, stress balls, elastic bands).
2. Maintaining a calm approach and understanding the risk and triggers for self -harm.
3. Patients having a 'collaborative care plan' that staff work through with patients.

The TAPS project coincided with the risk management training being given to staff on the wards. The variety of interventions used has had a positive impact on the incidence of self -harm and 1-1 observations.

The data that this team has collected is routine for them and will continue to be collected. The team is also considering analysing other data they routinely collect and generate run charts to see if this would be helpful. From the actions and interventions above the team intends to have more of a structured system in place in the future and especially in readiness for a CQC summer visit. As well as continuing to test out ideas with the original core TAPS team, the team is keen to bring in other additional staff.





TAPS is the best thing we've done for some time.

Self-harm was a problem we were having at the time and it was having a negative effect on patients and staff. A smaller team worked through the issue first using fishbone methodology and then we involved the wider team using De Bonos 6 hats to pull together ideas for interventions.

The multi-disciplinary approach and involvement of the whole team really made a difference. My experience is that teams are often too busy and reticent to engage but embraced the experience I think partly because the ideas were theirs e.g. posters introducing alternative coping strategies, the use of ice cubes, stress balls, elastic bands, going for walks etc.

We collect incident data for a range of incidents and following TAPS we noticed that incidents decreased more widely; on average 6-7 points. In the New Year when we have a little more time we're hoping to use a similar approach with a smaller then wider team to look at our approach to missing persons.

TAPS is the opposite of audit; it is short, not prescriptive or top down and engages the whole team not just 1 person. It improves practice and delivers quality and safety improvements in just 20 weeks. In audit around 1 in 10 projects are successful. Across the 8 TAPS projects in Sheffield I think only 1 failed to deliver. It has an obvious return and people enjoy it.

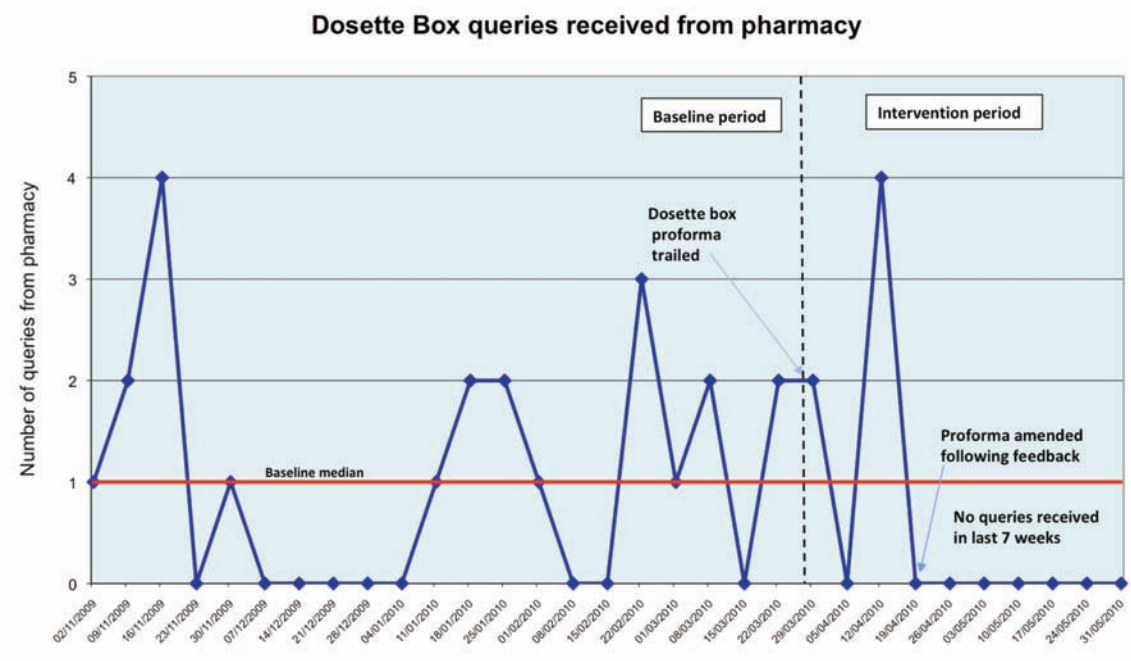
Jim Chapman, Clinical Audit Manager

3. *Improving the communication of changes to dosette boxes at Windhill Green Medical Practice, GP Training Practice, Bradford*

To improve the communication of changes to dosette box prescriptions (including those made by secondary care) between GP practice team and local pharmacy at Windhill Green Medical Practice, a method of communicating dosette box prescription changes was created, tested, adjusted and implemented. The innovation included both a formalised process and a supporting form.

The dosette box form is now in regular use and has been particularly useful in the management of vulnerable patients and recently discharged patients from hospital. It has allowed the safe and efficient transfer of information between the primary healthcare team members and allows an audit trail to be established.

This safer practice can easily be adopted by other GP practices and pharmacies – and is already being implemented (with minor adaptations) in two further Bradford GP practices.

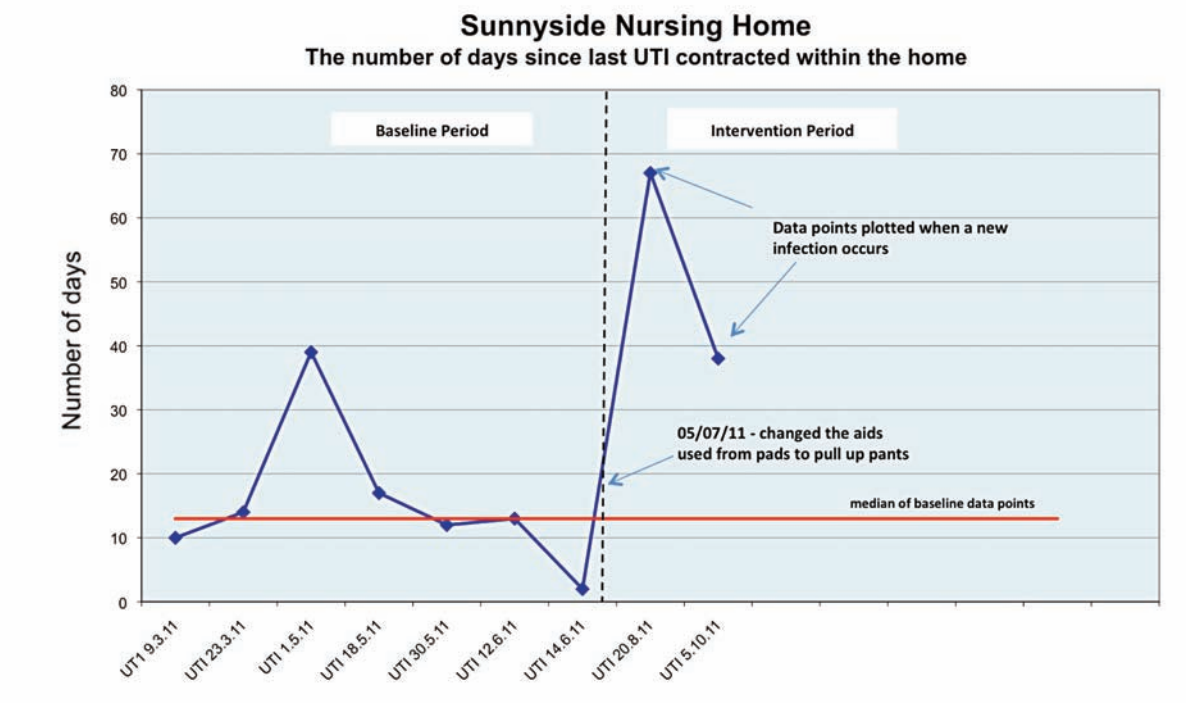


4. *Sunnyside Nursing Home, Leeds*

Sunnyside Nursing Home worked together to reduce the incidence of Urinary Tract Infections (UTIs), particularly amongst mobile residents to increase residents' well-being and reduce the risk of accidents.

Changes made included changing the aids used from pads to pull up pants and introducing specific incontinence reviews by GPs. The interventions are still having a positive impact and the team has learnt that:

- Compliance can be improved with a personally tailored programme even where capacity is reduced.
- Over attention to cleaning and changing was the most common risk factor due to embarrassment and ability. Reducing this over-activity had a major effect.
- Medication and hydration were other factors where more personalised assessment was helpful.



The key thing about TAPS for us was that it got the whole team to look at root causes. The manager and I had done this before but by having all the staff thinking laterally about the root causes there was greater ownership meaning staff were more engaged and therefore the solutions worked far better.

We have been surprised as none of us expected that the issue would be over attention, we assumed that it would be that patients were not cleaning properly but it was quite the opposite they were cleaning too much, causing irritation and infection. One key indicator for this was feedback from a member of the housekeeping staff who noticed that soap and wipes needed to be replenished more frequently in one of the bathrooms, this reinforces the importance of involving all staff in identifying root causes.

We have rolled out the approach to UTIs across all four of my nursing homes and the results (97% reduction in UTIs) have been consistent in all. I was surprised as it has been equally successful in one of our homes with Dementia patients who often have less capacity for caring for themselves than other patients.

We continue to use the approach as other issues arise – discussing root causes of problems at team meetings or if this is not possible talking outside meetings to individuals about an issue. We have learnt that a lot of the valuable knowledge around solutions comes from staff.

Julie Brown
Proprietor

5. *Acute medical floor – Leeds Teaching Hospitals NHS Foundation Trust*

The team on the acute medical floor at Leeds were looking to improve the safety of critically ill patients on the acute floor and efficiency of patient management, via formalised and standardised systems for identification, prioritisation and action of such patients. It was important as there had been IR2/SUI reports and complaint reports.

Interventions that worked well included:

- Modified Early Warning Scores (MEWS) on white boards achieved.
- Multi-professional education package to deliver training in MEWS & SBARR.
- Overall improvement seen in MEWS audit data.
- Weekly TAPS team meetings to maintain momentum.
- Growth of the team as enthusiasm and momentum spread.

The team has learnt that engendering a patient safety culture is a complex process - it is a slow, steady process than can fluctuate and that multi-disciplinary working is more successful than teams working in isolation. They are currently gaining management support for next patient safety project.

Every year as a doctor I complete an audit which is essentially a box ticking exercise. Audit doesn't change anything. So it's been great to be involved in TAPS working on quality improvements that yield results.

From a team perspective we are seeing real quality improvements and the value of a multi-disciplinary approach – learning from each other to engender a culture of patient safety. You can feel the change not just in the TAPS team but across all staff on the ward. I'm amazed at the success.

We now have the skills and quality improvement tools (from the TAPS programme) to apply the approach to other issues, the issue we will struggle with is the capacity/ resources to make it happen.

We have meetings set up with middle management to ensure that we can continue the existing work and early next year we have plans to use the TAPS approach to tackle our next priority. The enthusiasm of the team has been incredible so much so that we have managed to maintain momentum with replacement staff which puts us in a good position for tackling future issues.

Carla Cadiz, Acting Consultant

Yorkshire & Humber HIEC

Turning best practice into common practice

Report design by Medical Illustration, Bradford Teaching Hospitals NHS Foundation Trust. www.mibradford.co.uk. Tel: 01274 365652. *MID Ref: 12010312*