

Quality improvement meets mortality

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#EHMA2020

The problem

- Princess Alexandra Hospital Trust: A district general hospital in Essex. UK with no integrated electronic patient record (EPR)
- Significantly high hospital standardised mortality ratio (HSMR) and summary hospital mortality indicator (SHMI)
- Negative Outliers in key diagnostic groups
 - Fractured Neck of Femur
 - Pneumonia
 - Intestinal obstruction without hernia
 - COPD
 - Septicaemia



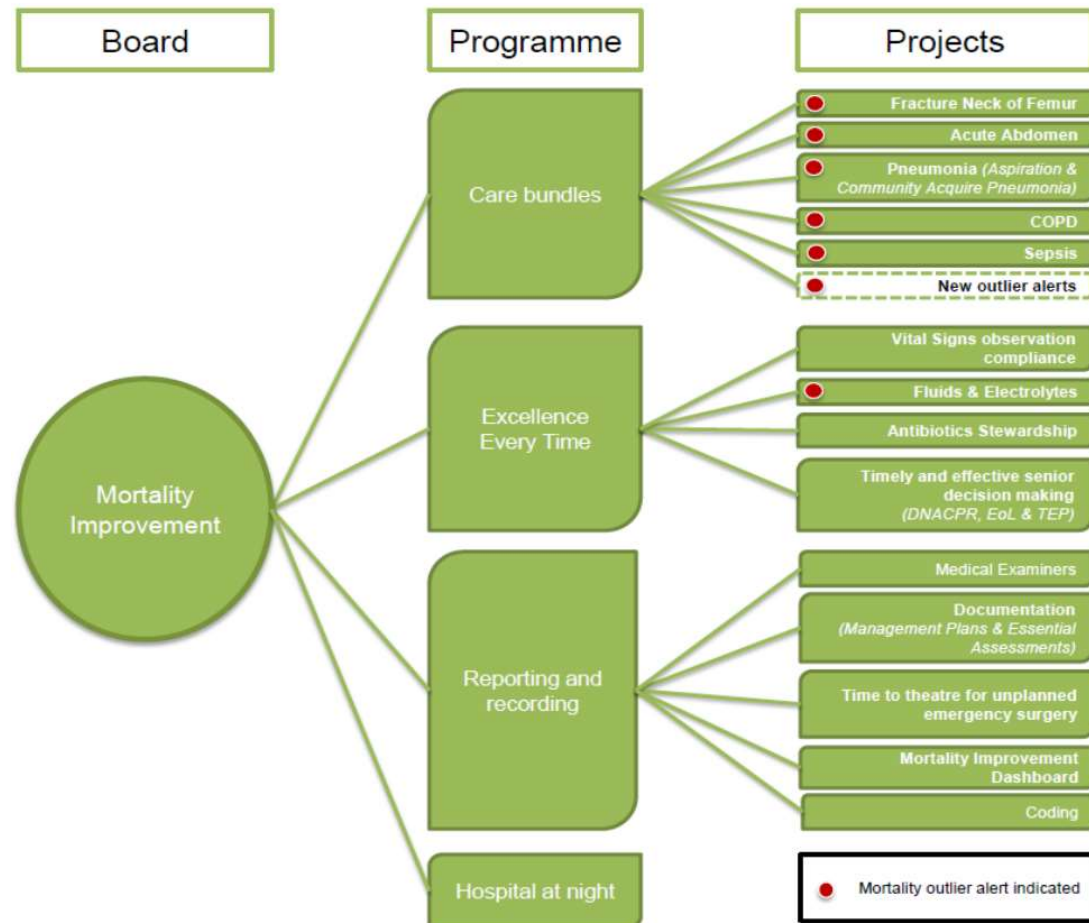
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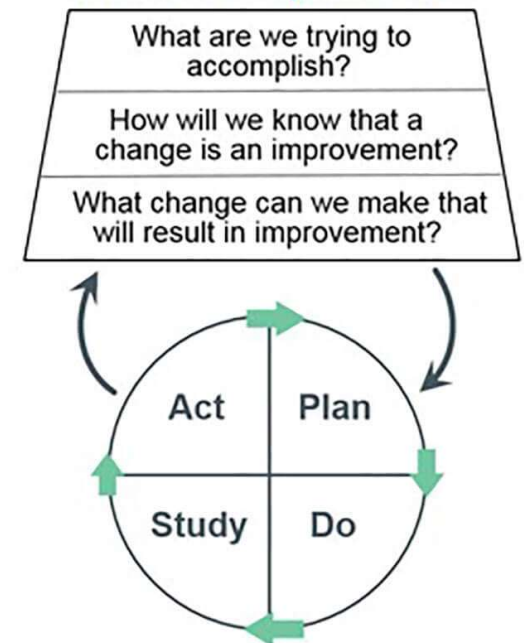
What were we trying to achieve?

- To achieve 'as expected' for mortality rates (HSMR) (SHMI) across all specialties, with no more than two outlier alerts over a 12 month rolling period by March 2021 and to be sustained.
- More importantly improved outcomes and experiences for our patients.
- The introduction of Mortality Improvement Board (MIB) in October 2018.

How did we plan to get there?



Model for Improvement








Key interventions – Care Bundles

- A care bundle is a set of interventions that must all be achieved within the timeframes. If adhered to they improve patient outcomes and reduce mortality
- Engagement from clinical leads is essential

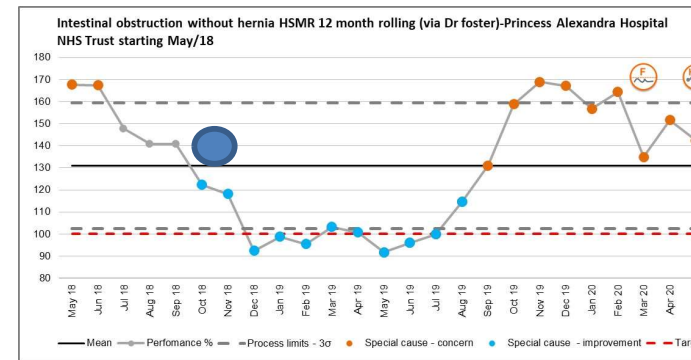
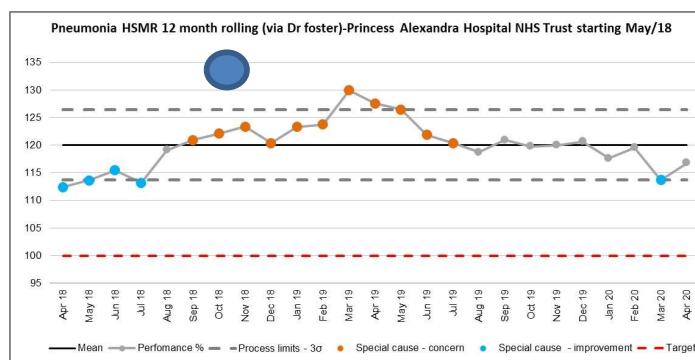
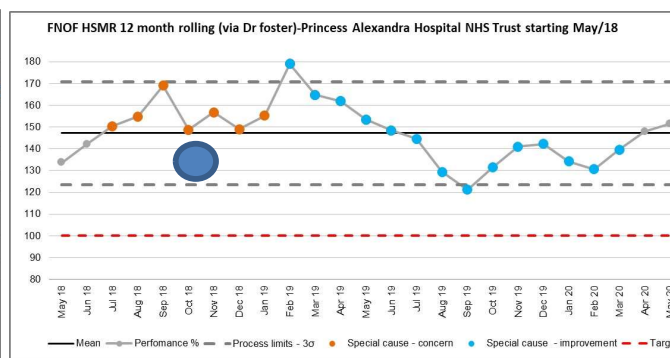
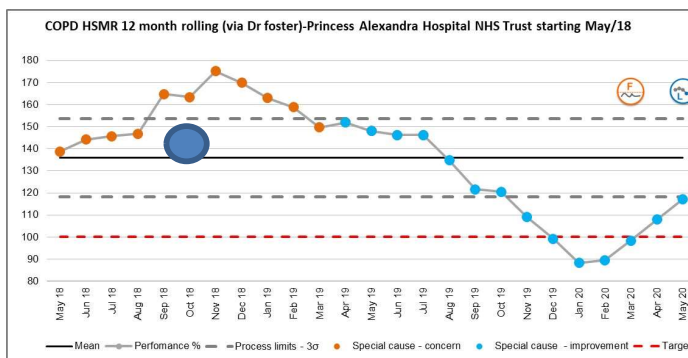
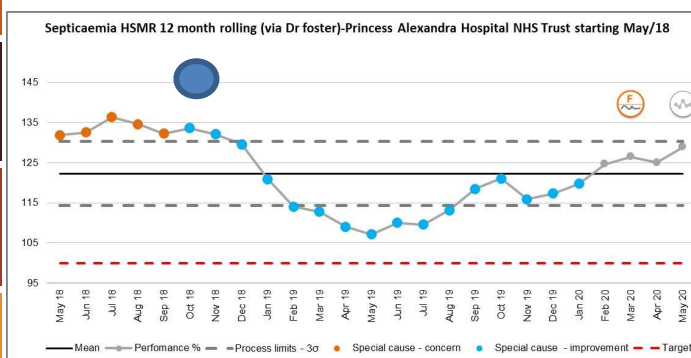


Picture taken pre COVID-19

PATIENT PRESENTS WITH SUSPECTED	Scan the QR code to access CARE BUNDLE AND PATHWAY	
Fractured Neck of Femur		
Acute Abdomen		
Chronic Obstructive Pulmonary Disease		
Pneumonia		
Sepsis		

Care Bundle mortality ratio (HSMR) results

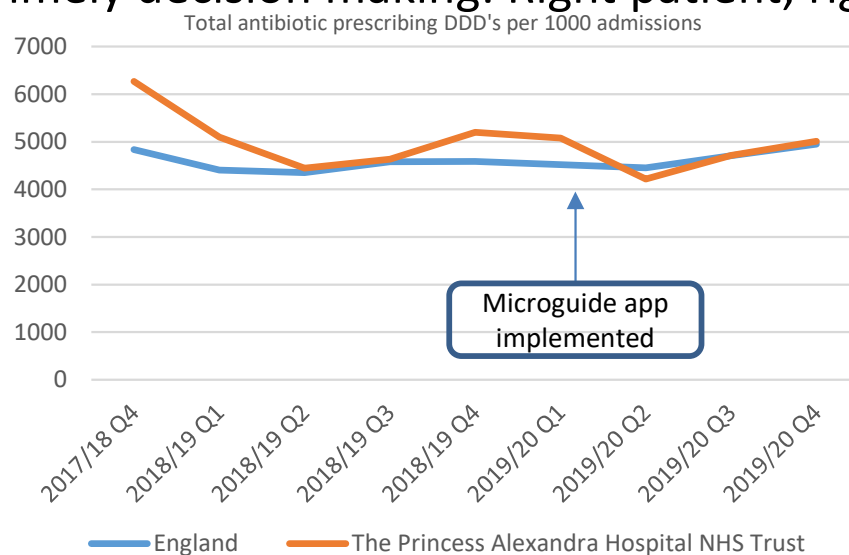
● Mortality improvement board introduced



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Excellence Every Time interventions & results

- Antibiotic stewardship: PAHT historically highest prescriber of antibiotics in the region
 - Implementation of micro guide app and antibiotic stewardship group
- Vital signs compliance, fluid balance management and AKI management
- Timely decision making: Right patient, right ward – first time



Hospital At Night

- Implementation of electronic hospital at night solution to support doctor handover.
- Structured approach to handover patients out of hours for all healthcare groups.
- Supported “task allocation” to automatically assign tasks.

H@N operational hours are Mon-Fri 5 pm - 8 am and 24/7 over the weekend/bank holidays. Only use this form for tasks to be completed during these hours

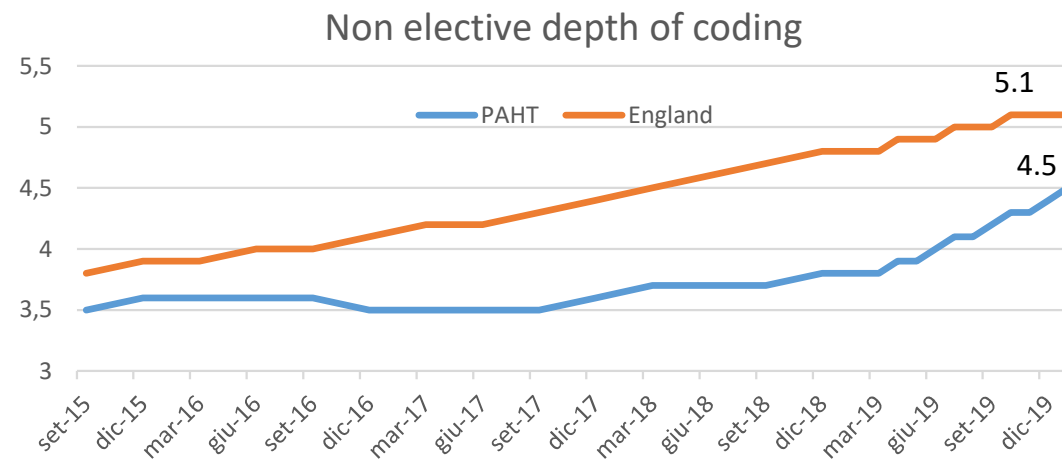
1 Nature of call:
Campus:
Ward:
Raised By:
Coordinator:
Time Required:

2 Patient Details
Lookup Patient: Hospital Number:
[Click here to enter details manually](#)
Name:
NHS No:
DOB:
Gender:
Ward:
Consultant:
Specialty:

3 Task Details
* Diagnosis:
* Reason for ECG:
* Rate:
Specify Other:
Notes:

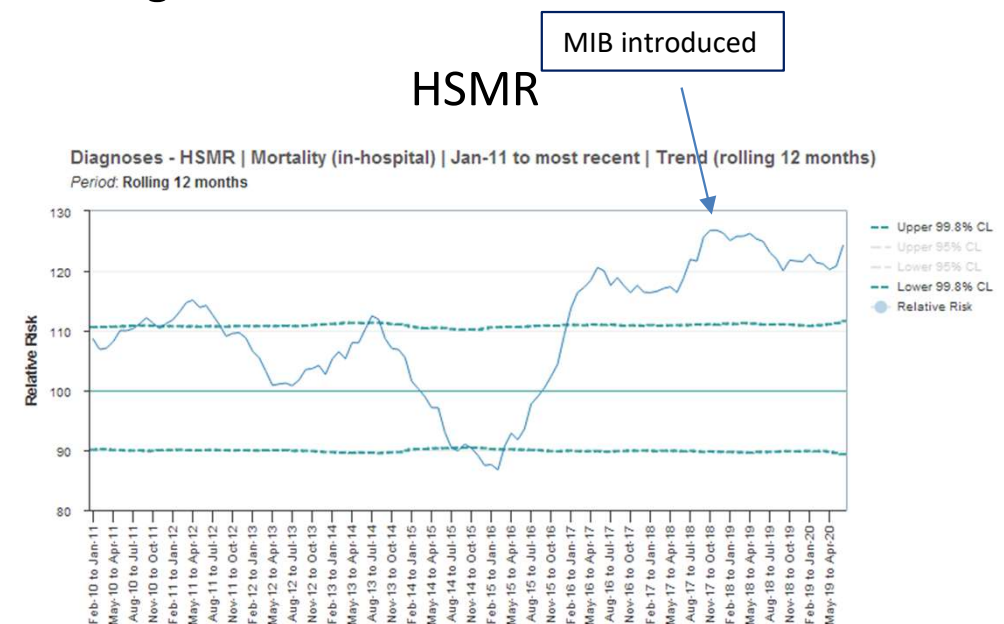
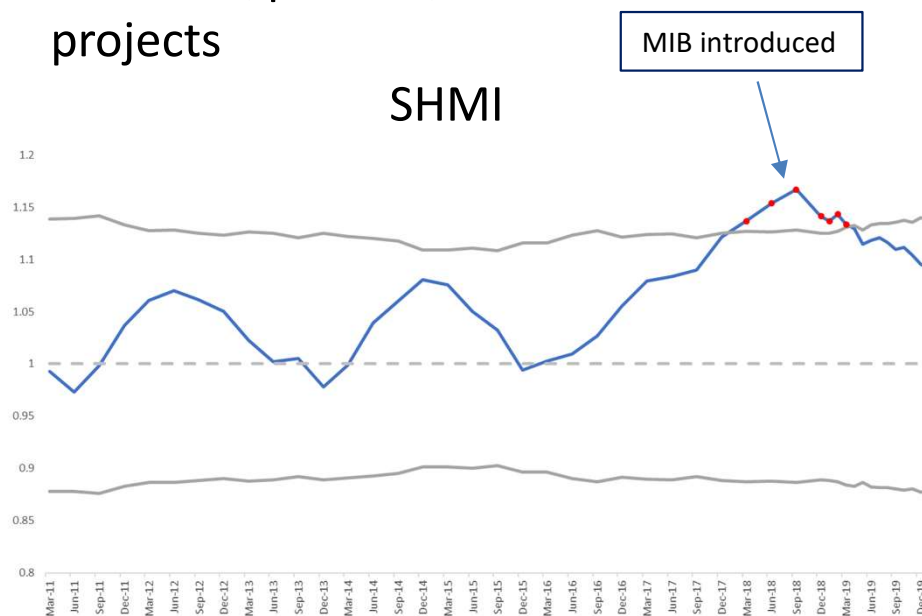
Reporting & Recording

- Clinician & coding educational sessions and notes review
- Robust learning from deaths process
 - Rapid implementation of medical examiners
- Speciality assessment tool implemented
 - Captured Charlson comorbidities



What are the results?

- To achieve 'as expected' for mortality rates (HSMR) (SHMI) across all specialties, with no more than two outlier alerts over a 12 month rolling period by March 2021 and to be sustained.
- Outcome/process/balance measures tracked throughout for individual projects



The future?

- A shift toward the learning from death process
- Continuous monitoring of 'live' mortality data to inform requirements
- Development of automated mortality improvement dashboard to enable a proactive approach to quality improvement.

What did we learn?

- The use of standardised Quality Improvement methodology is critical
- Engaged clinical leadership is vital in driving improvements
- Understand root causes before starting projects

Thank you and questions

- Nick Kroll- Graduate management trainee
- Ellie Hill – Graduate management trainee
- Robert Ayers – Deputy Director for quality improvement
- Miss Helen Pardoe – Consultant colorectal surgeon and chief clinical information officer (C.C.I.O)
- Lindsay Hanmore – Associate director of nursing for quality improvement



Please follow the Quality First team here:

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