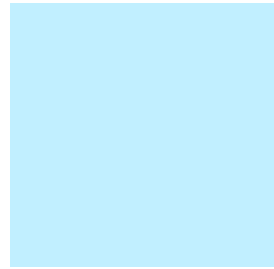
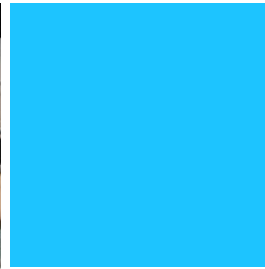
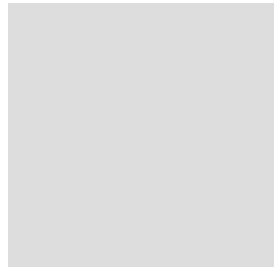


Gold Coast Health Service District  
**Clinical Governance Unit**



# **PACER: PATIENT AND CARER EXECUTIVE ROUNDING**

**Service:**  
**Date:**

**Gold Coast University Hospital**  
**23 October 2015**



**Queensland  
Government**



# Executive Rounding:

- Executive Rounding is promoted by several internationally respected organisations set up to improve patient safety and clinical care quality, including the IHI (Institute for Healthcare Improvement, Boston USA) & the UK's NPSA (National Patient Safety Agency)
- Executive Rounding aligns with our Hospital and Health Service Strategic Plan 2014 – 2017, of providing world class services, engaging our consumers and valuing and empowering our staff.





# PACER Program:

- The Patient Safety Executive Rounding Project involves members of the Executive team participating in a formal visit to clinical service areas within the Directorate of Specialty and Procedural Services (SaPS), to ask patients and staff 5 safety and quality based questions.
- The concept is intended to
  - ✓ Promote a culture of safety and quality
  - ✓ Provide leadership & staff awareness of patient safety & quality
  - ✓ Enable rapid identification of any active safety or risk issues
  - ✓ Provide acknowledgment and sharing of areas of excellence
  - ✓ Provide the vehicle for staff, patient and Executive engagement





# PACER Trial:

- 5 Clinical Units participated in the trial from across our diverse Directorate - 2 Surgical, 2 ICU and 1 Paediatric Unit
- At least one representative from the professional bodies of Medical, Allied health and Nursing were interviewed, along with 3 patients/Carers
- Staff were approached and individually interviewed, although some discussions were held opportunistically as group sessions.
- 10 Patients or carers participated in discussions around their care or the care of their loved ones.





## PACER Trial Outcomes:

- A total of 29 safety and quality issues were raised, with between 3 to 7 issues raised across each unit.
- At least one person or area of excellence was identified in each clinical area with certificates of excellence awarded to the nominated person or activity.
- Each issue raised was risk assessed - 62% of issues were risk rated as medium; 59% of identified issues were closed within 30 days
- Issues ranged from completion of contemporaneous notes into eMR; to equipment storage and workforce flexibility.





## PACER Trial Outcomes:

- All staff involved were offered the opportunity to evaluate their experience through a staff questionnaire
  - 100% were aware of the planned PACER visit and its purpose
  - 100% felt able to discuss their safety and quality concerns with the Executive team
  - 100% felt able to discuss and identify Quality Improvement Activities within their Unit
  - 73% found talking with the Executive team helpful
  - 73% identified that they gained information on safety and quality issues from participating in the PACER trial





# Areas Of Excellence:

- Patient and staff showed commitment and enthusiasm for the process of Executive Rounding
- The results of the survey indicated a number of areas of clinical excellence within each unit surveyed
- Patient overall impressions of care rated highly at Excellent – 60%, and the remaining 40% rated at Very Good
- 100% of patients were able to nominate staff, or individual members of staff, as requiring specific recognition; 70% of patients did not identify any concerns / issues during their stay





# Where to now:

- The program has been implemented across the Directorate as one of many patient experience and Executive rounding opportunities that informs service delivery and decision-making
- Outcomes and progress from Executive rounding are reported monthly through the Directorate Safety and Quality Meeting
- The program has been extended to incorporate additional informal Executive Visits; an Executive Practical and an Executive Patient Journey







# Patient Safety Scrum:

- Introduction and embedding of Divisional Safety Scrum into patient flow meeting
- Current bed flow meeting reviews
  - Bed numbers
  - Planning for discharge / transfer
  - Staffing
  - Theatre and ICU projected admissions
  - Patient concerns
  - Takes approximately 15 minutes





# Patient Safety Scrum:

- Additional Safety Scrum information:
  - ✓ Information on confirmed SAC 1 incidents in the preceding 24 hours
  - ✓ Code Blue / MET call Report
  - ✓ Patient safety notices
  - ✓ Clinical Incident themes on which to focus
  - ✓ Safety Message
- Feedback / Escalation
  - ✓ Nursing Director, Safety and Quality Manager
  - ✓ Nursing Director reports back to the GM / CD / SD on any emerging issues
  - ✓ NUM' s report to frontline clinical staff





# Safety Scrum Evaluation:

At the end of each meeting

- ✓ Attending staff evaluate how safe they perceive their clinical unit to be using a “safety thermometer” tool
- ✓ Contribute to an overall Evaluation of the Division
- ✓ Divisional evaluation or Individual Units evaluating themselves on the lower end of the safety scale – initiate an action of - further one to one discussion / planning / and escalation of issues to SaPS Executive.
- ✓ Database records Unit / Divisional self evaluations compares it to the number of incidents during that 24 hour period for the Division

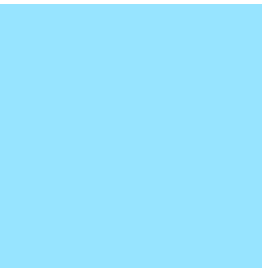




**Teamwork is the ability to work together toward a common vision. The ability to direct individual accomplishments toward organisational objectives. It is the fuel that allows common people to attain uncommon results.**

**Andrew Carnegie**





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