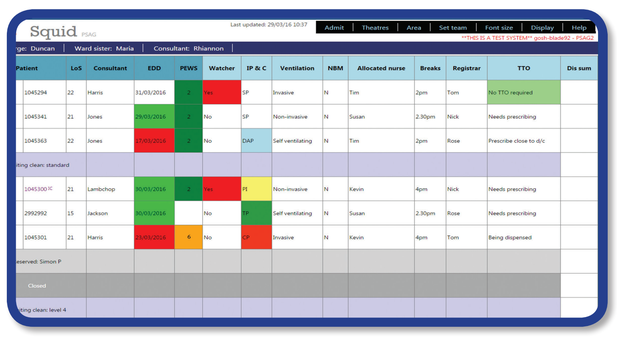
SITUATIONAL AWARENESS

In 2015, the Royal College of Paediatrics and Child Health (RCPCH) initiated a 2 year programme called SAFE (Situational Awareness for Everyone). The programme was implemented by a partnership including Great Ormond Street Hospital (GOSH), UCL Partners and the Anna Freud Centre. The aim of the programme was to increase Situational Awareness (SA) and the ability to recognise and manage a deteriorating patient.
At GOSH, we implemented three interventions as part of the SAFE programme; Safety Huddles, ePSAG (electronic Patient Status at a Glance) boards, and a new status called the 'Watcher'. The wider project was renamed the Situational Awareness Programme

WHAT DID WE DO?

ePSAG BOARDS

The ePSAG board replaces the previous patient whiteboard in each ward. These electronic whiteboard systems provide clinical staff, patients and their families with an overview of the patients on a ward. Information is pulled from clinical hospital systems and displayed to enable staff to access clear, accurate and real-time patient information. **This has improved communications across teams and reduced interruptions, thus releasing time to care.**



SAFETY HUDDLES

At GOSH, Safety Huddles are defined as a 5 minute daily huddle held at the ePSAG board at a specified time. They are attended by all nurses on the ward, the lead doctors and any other appropriate staff members to discuss all patients' PEWS, escalation plans, identify the sickest patient on the ward and identify any 'watchers'. **This has led to the better identification and escalation of deteriorating patients.**

'WATCHER' STATUS

The 'watcher' status is a tool used to validate clinical gut feeling and parental concern about a child. It is displayed on the ePSAG screen to increase visibility by the wider team, inform the Safety Huddle and is used to identify patients who the team may feel are still at risk of getting sicker. **The 'watcher' status is also a mandated field within our electronic clinical observation set, meaning its status is continually reveiwed.**

PEWS (PAEDIATRIC EARLY WARNING SYSTEM)

PEWS is a score based early warning system designed to identify potential deterioration in children. The introduction of PEWS completed on an electronic platform, means clinicians are able to access up-to-date patient scores at both a ward and Trust level, **providing a more accurate clinical picture and supporting clinical judgement.**

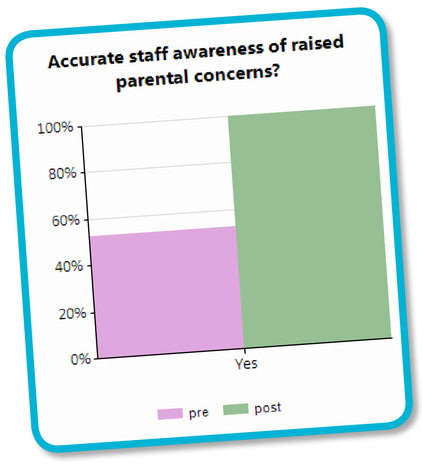
WHAT DID WE LEARN?

Throughout the SA programme we have consistently sought to measure the impact of the interventions at ward level. Given the nature of SA we chose a combination of qualitative and quantitative outcome and process measures.

What difference do you think safety huddles have made on your ward?
I feel the Safety huddles have made my ward more organised with better team work and awareness.
(Med Reg)

Do you feel that the safety culture on your ward has improved as a result of doing safety huddles?
Yes. Being up to date with all patients on the ward has definitely improved the safety culture as we are now all aware of each other's concerns/patients.
(Staff nurse)

> It would have just made us feel like members of staff at GOSH as we would know an escalation route that other medical people would use to highlight something that was wrong with their patient.
> *(Parent referring to the 'watcher' status)*



WHAT HAPPENS NEXT?

Following the successful implementation of Safety Huddles at GOSH and across the UK, we are continuing to collaborate with the RCPCH, as active participants in SAFE 2. This project involves partnering with other hospitals across the UK to spread the learning from the original SAFE programme and support them to achieve the benefits we have seen here at GOSH.