A tool to identify falling care quality

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- How a safety trigger tool was developed
- Advice on implementing this early warning system

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Issues raised in the Mid Staffordshire Foundation Trust inquiry led staff at NHS South West to develop a tool that could predict falling standards, so preventive action could be taken before failings in care occurred. This article describes how the Quality, Effectiveness and Safety Trigger Tool (QuESTT) was developed and implemented in practice.

After the publication of the Mid Staffordshire Foundation Trust inquiry findings (2010), we set out to ensure that such failures at ward level could not happen in hospitals in the South West. We wanted to find a simple, robust and accurate way of determining whether falling standards in individual wards could be predicted and action taken before they happened.

We developed a simple tool, based on peer review, that gives a voice to the intuitive feel that many nurses have when thinking about standards of care. While the Quality, Effectiveness and Safety Trigger Tool (QuESTT) is an early warning tool based on the principles of other early warning scoring systems, it can also pre-empt deteriorating standards.

The QuESTT informs ward leaders about how they are doing and provides robust and reliable information from ward to board, offering the trust board assurance of quality of care at individual clinical team level. Crucially, it is underpinned and validated by peer review. It is therefore not a performance management tool but one that aids understanding and enables action to be taken to remedy any precursors to underperformance at grassroots level.

Context The white paper Equity and Excellence: Liberating the NHS described plans for wide-ranging structural changes in the NHS (Department of Health, 2010). While the changes sought to put patients at the heart of care, deliver improved health outcomes and empower organisations and professionals to improve quality, the transition brings the potential for falling standards as attention is drawn elsewhere (National Quality Board, 2011). There is never a more pressing time to keep our eye on what is important – to routinely question standards of care and ensure systematic processes are in place to support organisations in keeping quality at the forefront.

At a time when several reports point to serious deficits in fundamental care, this creates a challenge. The Parliamentary and Health Service Ombudsman’s (2011) report adds weight to growing concerns. There is increasing evidence of the differences in standards of care both across and within hospitals (Mid Staffordshire Foundation Trust Inquiry, 2010).

Health secretary Andrew Lansley said the best hospitals monitored information about outcomes on a “ward-by-ward basis, enabling them to respond quickly to emerging conditions” (Santry, 2010).

However, while most hospitals now systematically collect and report on key nursing metrics and indicators to improve ward-to-board assurance, something is missing. Refuting or substantiating that “gut feeling” about falling standards within individual wards remains elusive; at trust board level, metrics are often aggregated to give an overall picture and individual ward or team performance may not be routinely considered.

Aims and preliminary work We wanted to find or develop a tool that offered a set of indicators that, when taken together, would show how well an area or ward was working. It needed to be designed for ward sisters/team leaders to use, who would be able to both assess the risk of deteriorating performance in their area, and benchmark themselves against others. Dame Jo Williams, Care Quality Commission chair, identified common factors in poor performance: lack of engagement of clinical staff; failure to learn from incidents; leadership that is not engaged in quality; and not listening to patient concerns (Williams, 2010). These, and other failings identified in the literature, gave us a broad range of themes that we knew were essential to our tool.

The next phase of the project involved finding out what was already being used across hospitals in the South West. We came across a number of examples of tools...
A trigger tool

The QuESTT is the end product of our work. It effectively identifies the potential for deteriorating standards of care delivered by a specific team in a ward or other setting.

While based on the principles of other early warning systems — that is, tools concerned with identifying and acting to prevent physiological deterioration of individual patients — QuESTT uses a different set of indicators and has another purpose.

The indicators, when grouped together, describe the most important conditions necessary for a well-functioning team. The tool prompts the ward sister/leader to make a judgement against key indicators then automatically scores them according to their importance. An overall score of more than 12 indicates that remedial action needs to be taken to prevent the quality of care deteriorating in that area.

How the tool works

The QuESTT is presented in two sections. Section 1 consists of 16 questions; if answered positively, each one automatically secures a score between 1 and 3 (the score for each positive answer depends on the weighting of 1, 2 or 3 applied by the tool). A total score is automatically generated as the tool is completed and will be anywhere between 0 and 36. A score of 12 or above is considered an early warning trigger. Section 2 makes up the trigger tool itself.

The questions are derived from themes that are important to a well-functioning clinical team and environment. For example, effective leadership is one element. The tool asks if there is an absence of line management (ward sister), or if the ward sister has been in place for less than six months.

Other themes and their related questions pick out the remaining elements of a well-functioning environment. They include attention to quality, staffing and staff development, patient safety, culture of multidisciplinary team working, engagement with patients and carers, evidence of acting on patients’ experience and operational demands.

Section 2 does not add to the trigger score, but helps to give an overall picture of the clinical area. Suggested key areas of enquiry are included within the tool but exactly what is included, and the method by which information is gathered, will vary between organisations.

Fig 2 outlines the process that should be followed when using the QuESTT. Optional additional steps are also shown to enhance the tool’s validity and effectiveness.

Within the hospitals using the tool in
Innovation

CASE STUDY 1. SOUTH DEVON HEALTHCARE FOUNDATION TRUST

Liz Childs, director of nursing and governance/deputy chief executive at South Devon Healthcare Foundation Trust says: “As a director of nursing, the responsibility for ensuring good standards of nursing care are delivered consistently across a large number of hospital wards is a significant challenge.

“Often the measures reported in an attempt to provide assurance are consistent with poor care delivery – that is, complaints, incidents, accidents and so on. They often trigger concern when numbers begin to rise – when in effect this is too late.

“Other measures of quality, such as patient surveys, are too often presented in ways that show a whole-organisation picture instead of a picture of an individual ward.

“One of the quotes from the Mid Staffs incidents that stuck in my mind was when the family of a patient who was moved from ward 6 to ward 7 noted: 'It was like going to another country.'

“Wards can and do vary in all of our hospitals and, in some cases, we can predict which wards might be brewing a problem – but could we measure this?

“The QuESTT tool allows exactly that. As well as informing each ward manager and unit matron, I now receive monthly information on each ward – identifying where the potential for poor care is most likely, and supporting me to ask questions as appropriate in terms of actions that need to be taken.

“An exception report forms part of my assurance to the trust board and helps non-executive as well as non-clinical executive colleagues to understand and more confidently challenge some of the complexities of ensuring good care.”

the South West, the QuESTT is completed in every clinical area every month. The ward sister or team leader is responsible for completing the questionnaire with team members; other members of the nursing team, or the wider multidisciplinary team, sign off the tool, which helps to foster team ownership.

Peer review underpins the whole concept. This process questions and validates the scores from section 1 of the QuESTT but also acts as a critical friend, eliciting further information where needed and challenging through feedback.

Peer review may be a formal process where the ward leader meets with a selected group of peers every month, or a less formal system where colleagues meet to review each other’s areas. It can be beneficial to involve staff from a range of disciplines, as well as other senior staff such as non-executive directors. The engagement of service users, patients and carers is crucial in developing an open, transparent and effective process.

Once peer review is complete, a report can go through divisional and corporate processes, finally reaching the trust board.

Implementing the tool

The trigger tool has been well received wherever it has been presented. Ward staff, nurse leaders and boards recognise a crucial gap in their assurance and welcome it. Nurses benefit from something that they can easily understand and from being able to see at a glance where they need to focus to improve care for patients, and improve their performance.

Acute hospitals across the South West are at varying stages of implementation and testing is taking place in community hospitals and mental health settings.

Case study 1 shows its benefits from the point of view of a director of nursing, while Case Study 2 shows how the tool was used to improve care in one ward. Advice for nurses on implementing QuESTT is given in Box 1.

Staff were supported through a programme focusing on person-centred care and managing complaints. Finally, the trust recognised significant operational pressures and removed medical outlier beds from what was a specialty area.

The head of governance at Yeovil has said that since then complaints have dropped from eight over three months to none over the same period and that scores have dropped from 22 to 3, taking the ward off the radar.

Case study 2. YEOVIL DISTRICT HOSPITAL FOUNDATION TRUST

In summer 2010, Ward X’s QuESTT scores were increasing month on month. They reached 22 out of a possible 36. The ward was receiving a lot of patient complaints and the new ward sister was struggling. An experienced matron was identified to oversee the ward and a period of mentorship and development followed.

CASE BOX 1. IMPLEMENTING THE QUESTT

- Share knowledge with a broad trust audience
- Gain commitment from ward leaders
- Learn about how and where QuESTT fits in your organisation
- Develop a project briefing paper
- Gain a mandate from the trust management board to act
- Enable ward leaders to be responsible for the process and minimise central administration
- Build evidence of QuESTT making a difference into trust reporting systems
- Share learning and engage other ward leaders through “discovery visits” and observation with peers

Conclusion

QuESTT offers a simple, effective tool that enables teams to know how they are doing. It provides a language by which individual clinical teams can communicate with other teams and the trust board. Any potential for falling standards can be pre-empted and acted on before they affect patients, and failings in care prevented.

The QuESTT tool can be obtained by contacting NHS South of England (West office). Email: go@southwest.nhs.uk or telephone Annette Cousins: 01823 361 226

References


Santry C (2010) Lansley gives PCTs more cash but defends their abolition. Health Service Journal; 5 October, p5. tinyurl.com/lans-pct-cash