

The aim of the trial was to find out what added benefit the PCCOT Nurse contributed to the PEWS system in the recognition and management of evolving critical illness thus enhancing patient safety. Other aims included improvement to the patient treatment pathway, to assess the types/range of skills the PCCOT Nurse needs and the level of activity of the PCCOT Nurse.

Utilising a service redesign model the project has moved through the following stages: **Problem Identification** Identifying issues surrounding 'failure to rescue' **Proposed initiative** PEWS and PCOTT . **Development of Tool** - PEWS, observation chart and escalation plan.

Pilot Stage The trial of PCOTT and new charts took place over 1 month.

Results: Total Number of patients 137. Average Number of PCCOT episodes per day 20 Time spent per episode 15 min - 6 hours Average PCCOT episodes per patient 5

Patients admitted to PICU/PHDU had higher PEWS score. Of 15 patients admitted to a higher level of care the transfers were controlled and timely. During the trial there were no cardiac arrests on the wards and only one 'collapse' needing ITU admission from a ward where PCOTT had not been involved.

Conclusion: Paediatric Critical Care Outreach supports the effectiveness of a PEWS System improving patient safety.

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PATIENT SAFETY: A CULTURAL MUST!

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Background and aims: Although patient safety has been a major topic in healthcare for more than a decade, the challenge remains to find effective and sustainable safety improvement programmes. A culture of safety is a key factor in the success of such programmes. We investigated the differences in patient safety culture on wards before the start of a safety program with wards where a safety program was implemented for several years.

Methods: A survey was undertaken amongst paediatricians and specialized nurses by means of the Hospital Survey on Patient Safety Culture

(HSOPSC) on wards without a safety program (group A) and on wards with a safety program (group B). The study took place at the Emma Children's Hospital, Amsterdam.

Results: In group A 252 surveys were provided with a response rate of 67% (64% nurses). In group B 153 surveys were provided with a response rate of 53% (80% nurses).

The HSOPSC consists of 40 questions, covering 11 dimensions. Results are presented in positive, neutral or negative ratings.

We found the following significant differences between groups (A vs. B) in positive ratings:

1. 'Feedback about and learning from error': 51% vs. 83%
2. 'Overall perceptions of safety': 48% vs. 59%
3. 'Frequency of event reporting': 38% vs. 59%
4. 'Hospital management support': 24% vs. 46%

Ratings in the other dimensions were unchanged.

Conclusion: Implementation of a patient safety programme improves some aspects in the culture on a ward, while other aspects demand more focused intervening.

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PATIENT SAFETY IN THE NICU

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Background: Patient safety is a spearhead of the University Medical Centre of Utrecht (UMCU), the Netherlands. It recognizes that human error is inevitable. Wherever possible, the system should be (re)designed in such a way that human error is discovered or intercepted before it leads to patient harm. Reporting incidents is part of the patient safety program running in our hospital. The Neonatal Intensive Care Unit (NICU) of the UMCU wanted to have more insight in the incident reports on their unit. By analysing the reports with NICU professionals, the chance of effective improvement on the department would be increased.

Aim: Increase of patient safety by incident analyses.