King's College Hospital
NHS Foundation Trust

NSTEMI PATHWAY, PRUH

A Quality Improvement Project

THE QUESTIONS AND ANALYSIS…

As a referring centre how can we improve and what is in our gift to control?

Data Analysis

SERIOUS INCIDENT LEARNING/RCA

Non Stop NSTEMI Workshop

THE CHALLENGES

- -Delays in admissions to cardiology beds
- -Delays in referral via IHTL; patients not listed until admitted to cardiology bed
- -Inability to recover patients from cath lab interventions outside of cardiology wards
- -Errors with listing, generic login and only used by junior doctors
- -Fragmented communication
- -Transport booking errors/prep for procedure errors

RESTRUCTURING OF ROLES AND REPONSIBILITIES

ACS CNS to focus entirely on in-patient activity and flow

ACS nurse responsible for primarily managing IHTL

Patients to be listed on IHTL regardless of location

Proactive 'pull' of ACS patients

Location of patient not to prevent angiogram

Individual logins for IHTL and training

DAILY ACS SAFETY HUDDLE

10 minute huddle

ACS MDT Attendance

Discuss bed state, discharges admissions, transfers

Agree priorities for admission

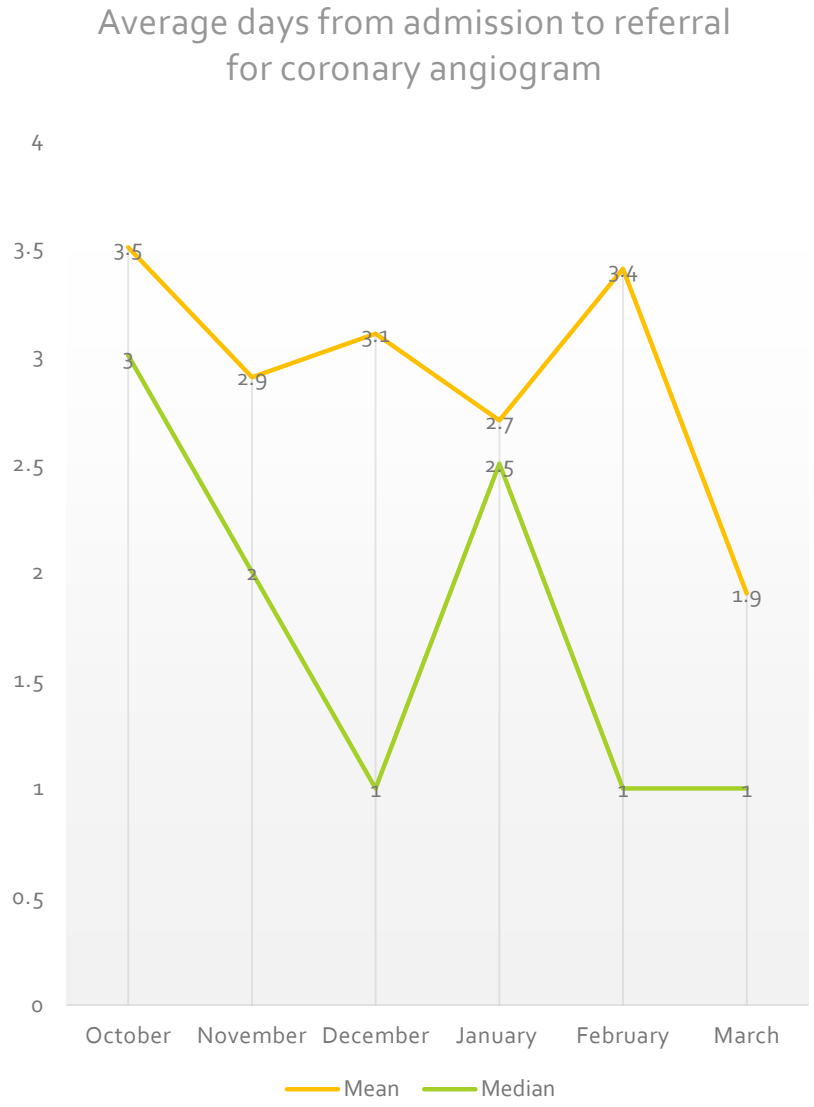
Sense check IHTL

Cath Lab planned activity

Medical 'take' list and proactive 'pull'

THE BENEFITS

- Improved Communication
- Reduction in time to referral via IHTL
- Less errors with transport bookings
- Correct patients prepared for procedures
- ACS nurse reports greater job satisfaction
- Developed better communication with cath lab managers at DH/GSTT
- A number of positive case studies



LEARNING/ONGOING CHALLENGES

- Lack of 7 day service
- Planning for absence of ACS nurse
- End of the day safety huddle needed to check transport bookings
- Removal of patient from list if angio done at PRUH with no need to proceed

CASE ONE

Patient A given slot for angiogram +/- at DH site. Overnight at PRUH developed pyrexia and WCC up.

Transport arrived to collect patient A during the morning safety huddle.

Able to identify as a group another patient that could use the spot (patient B), phoned DH who accepted change of patient.

Transport took patient B instead who received angioplasty and was discharged the following day.

CASE TWO

Via proactive ‘pull’ ACS nurse identified possible NSTEMI patient in ED from the medical take list.

Pt had not yet been referred to cardiology.

Pt discussed at safety huddle, reviewed in ED by ACS nurse.

Patient symptomatic of chest pain on review, rising troponin. ACS nurse arranged for urgent echo, agreed with consultant that patient required urgent angiogram.

Liaised with tertiary centre and patient transferred immediately for primary PCI.

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