NHS
Greater Glasgow and Clyde

Greater Glasgow and Clyde NHS Board

Board Meeting
August 2013 **Board Paper No. 13/42**

Board Medical Director
Head of Clinical Governance

Scottish Patient Safety Programme Update

1. Summary of Actions for Board Members

Members are asked to:
- Review and comment on the recently advise changes to the structure of the Acute Adult Care safety programme within SPSP and to note current progress achieved by the Acute Services Division in implementing the Scottish Patient Safety Programme

2. Acute Adult Care Safety Programme

A significant shift in the strategy approach to evolving the Acute Adult Care programme within SPSP was announced through the issues of a Chief Executive Letter CEL 19 (2013) {see appendix one}

The first major change is the announcement of **PATIENT SAFETY ESSENTIALS.**

The key message is that our emphasis around the patient safety essentials should now "shift from testing and spread towards one of sustainable universal implementation which requires different approaches to ensuring and assuring the continued provision of these interventions as standard work in all clinical areas".

Before the transition to any new form of governance for the patient safety essentials it is important to recognise the current position regarding levels of spread across acute services. This is outlined in section 2a.

2.a. Current Position Overview on Patient Safety Essentials

Table 1 below provides an overview of the current position with each of the clinical team Patient Safety Essentials.

Points to note:

- To demonstrate a reliable process in an element a team must show compliance of 90-100% for 6 consecutive measurement points at some point during their improvement work.
- The 'Demonstrated' column describes the number of teams to have achieved the specified level of reliability.
- The data is gathered by clinical teams as part of their ongoing improvement work. It is thereafter collected and aggregated so the position across the Acute Services Division can be ascertained.

Table 1: Reliability achieved by measure

Measure	Target Teams	Demonstrated a reliable process by August 2013	%
Hand Hygiene	209	197	**94%**
Early Warning Score	170	151	**89%**
Safety Brief	209	165	**79%**
Peripheral Vascular Catheters	149	108	**72%**
Surgical Brief & Pause	55	52	**95%**
Ventilator Associated Pneumonia (in ITU)	7	7	**100%**
Central Venous Catheter Insertion (in ITU)	7	7	**100%**
Central Venous Catheter Maintenance (in ITU)	7	7	**100%**
Daily Goal Setting (in ITU)	7	7	**100%**

We can see that the spread has already passed 90% in six of the nine elements with spread for Early Warning Score just about to pass the benchmark level. In both of the other two elements (Safety Briefs and Peripheral Vascular Catheters) the supporting team have identified measurement problems that have created a lag in reporting. The expectation is that that the practice in clinical teams is established but not reflected in our aggregated reports. As these measurement issues are being resolved an increasing number of teams will achieve the required reliability over the next few months until all elements are above. More detailed data and descriptions of these elements are included in Appendix One.

In general the position is we are reaching the point where the improvement work is concluded and there is opportunity to think about different approaches to assuring maintenance of required process reliability – to ensure are "monitored within operational delivery mechanisms". The Acute Services Division (ASD) has already reviewed options for this to become a specified general management responsibility. We are expecting the publication of a new national measurement plan, which is described as simplifying the data burden on clinical teams. However the SPSP support team will work with the ASD Directorate Management Teams to ensure that any local measurement processes are consistent with national requirements. The proposal has been agreed in principle but stills needs endorsement by the Board Clinical Governance Forum

Table 2: Number of Leadership Walkrounds to have taken place and actions completed within current reporting period (Mar 2008 – July 2013)

Measure	Number of Walkrounds	Actions	Actions Completed	%
Leadership Walkrounds	360	1044	806	77%

The patient safety leadership walkrounds are an ongoing and routine activity supported by senior leads in the Acute Services Division and by Non-Executive Directors. We except there to be contributed provision of the walkrounds and that they would remain a feature of the regular reporting framework so that we are assured they are being sustained.

2.b. Point of Care Priorities

The next set of major improvement ambitions are articulated in the set of Point of Care Priorities, which are as follows:

- Deteriorating patients*
- Sepsis*
- Venous thromboembolism*
- Heart failure*
- Safer medicines*
- Pressure ulcers
- Surgical site infections
- Catheter associated urinary tract infections
- Falls with harm

This set is deemed safety critical patients but known to require further rigorous testing, spread and reliable implementation using the quality improvement methodology familiar to those involved with the safety programme. Four of the nine *point of care* priorities (those marked with *) are already a focus of work within the programme, with the Acute Services Division recognising this is an opportunity to re-invigorate the current approach and priorities. The remaining areas are acknowledged patient safety needs and the Board already has dedicated structures to reduce the frequency and consequence of infections, falls and pressure ulcers. There is already support from staff trained in the quality improvement methodology familiar to those involved with the safety programme being linked to those structures, however this needs to be revaluated in light of the CEL. The Medical Director, through the Board Clinical Governance Forum, is leading the work to ensure this evaluation is completed and the subsequent development plans are put into action.

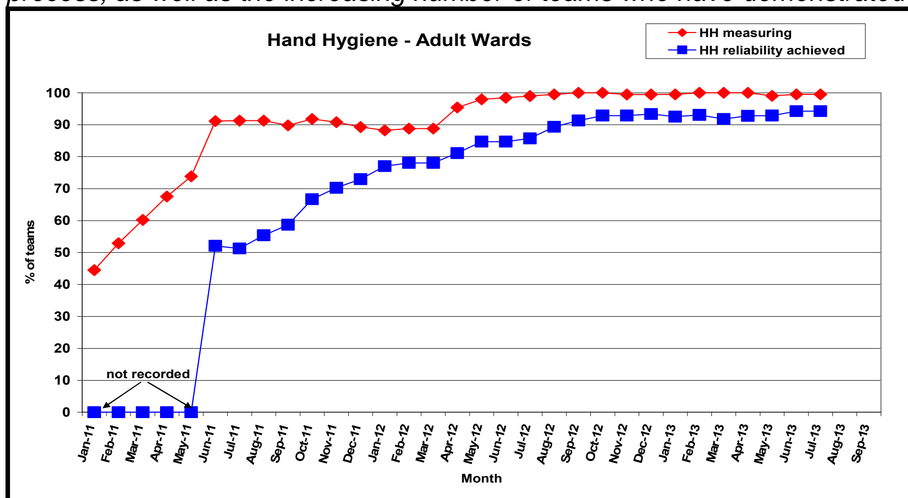
Hand Hygiene

Summary of Requirements and chart on spread

Hands will be washed at all of the World Health Organisation '5 Moments'

- Before touching a patient
- Before clean/aseptic procedures
- After bodily fluid exposure risk
- After touching patient
- After touching a patient's immediate surroundings.

The graph below charts the increasing number of teams engaged in measuring their Hand Hygiene process, as well as the increasing number of teams who have demonstrated reliability.



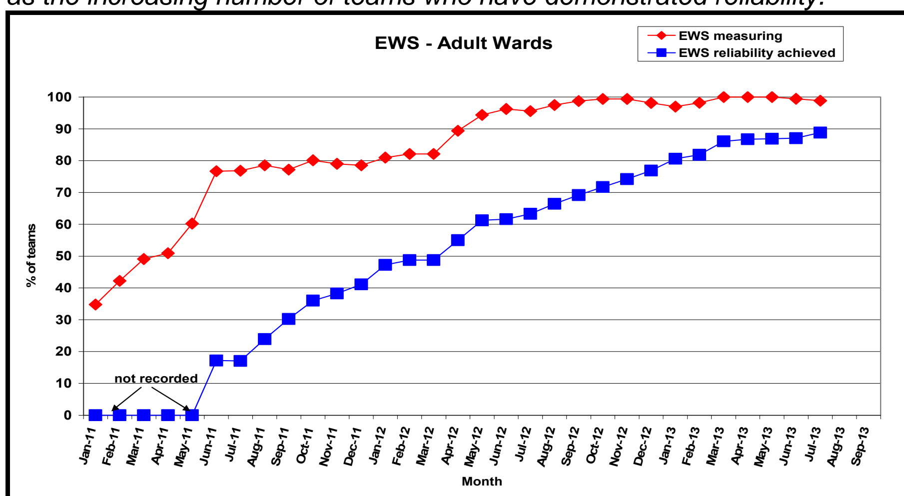
Measure	Target Teams	Demonstrated a reliable process by August 2013	%
Hand Hygiene	209	197	**94%**

EWS

Summary

The Early Warning Scoring is a simple series of observations used by nursing and medical staff to determine the degree of illness of a patient, identify patients who may need closer monitoring or more intensive levels of treatment.

The graph below charts the increasing number of teams engaged in measuring their EWS process, as well as the increasing number of teams who have demonstrated reliability.



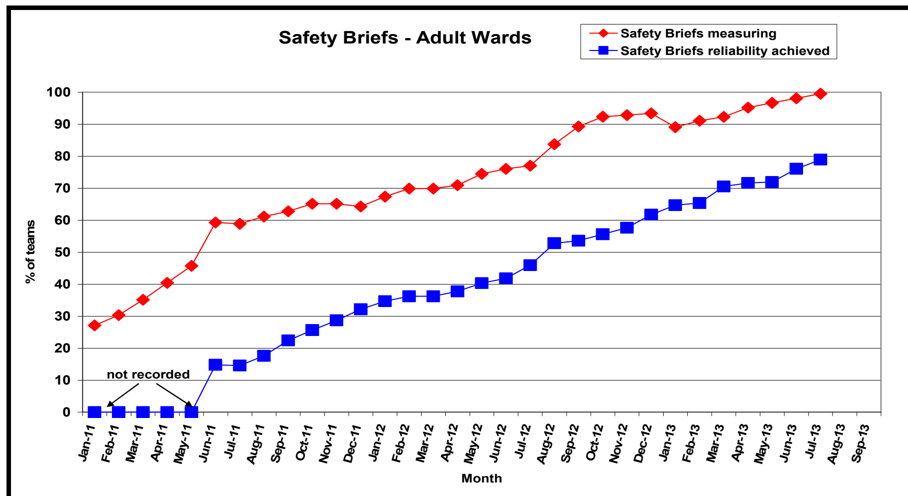
Measure	Target Teams	Demonstrated a reliable process by August 2013	%
EWS	170	151	**89%**

Safety Brief

Summary

On every ward, every day a short team briefing will take place when ward staff will gather together to highlight any patient or equipment safety issues for the day or shift.

The graph below charts the increasing number of teams engaged in measuring their Safety Brief process, as well as the increasing number of teams who have demonstrated reliability.



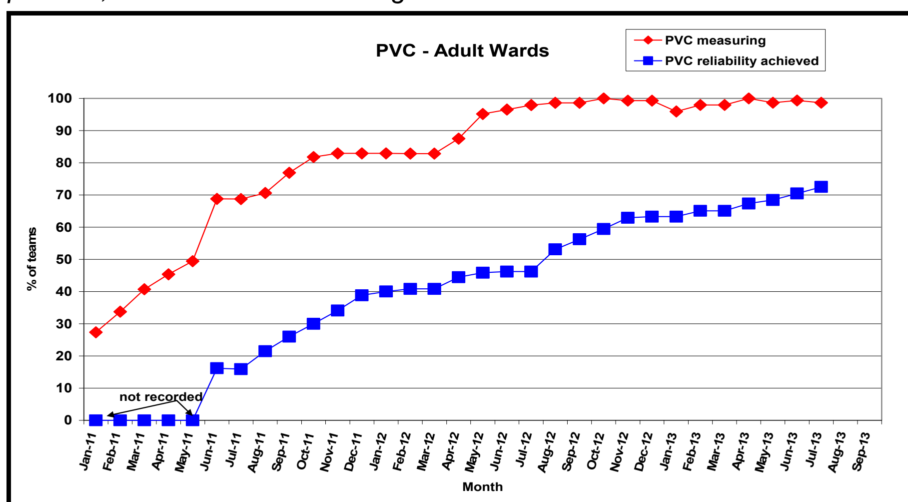
Measure	Target Teams	Demonstrated a reliable process by August 2013	%
Safety Brief	209	165	**79%**

PVC Maintenance

Summary

Reduce Healthcare Associated Infections through the demonstration of reliable systems for Peripheral Venous Cannula (PVC) care across all relevant acute service division wards.

The graph below charts the increasing number of teams engaged in measuring their PVC Maintenance process, as well as the increasing number of teams who have demonstrated reliability.



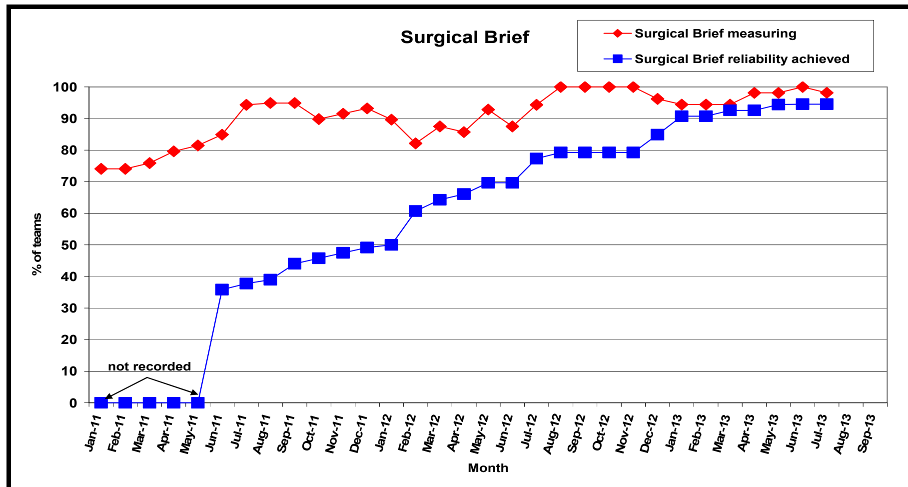
Measure	Target Teams	Demonstrated a reliable process by August 2013	%
PVC	149	108	**72%**

Surgical Brief and Pause

Summary

Surgical Briefing: a pre-operative list briefing will be held including all members of the surgical team. This aims to ensure that the entire team understand the expectations for the list and for each procedure.
Surgical Pause: a pre-operative pause will take place before every surgery. This is an opportunity to cover the surgical checklist and act as a final reminder of items that must be completed prior to commencement of the operation.

The graph below charts the increasing number of teams engaged in measuring their Surgical Brief and Pause process, as well as the increasing number of teams who have demonstrated reliability.



Measure	Target Teams	Demonstrated a reliable process by August 2013	%
Brief & Pause	55	52	**95%**

VAP Bundle

Summary

Ventilator Associated Pneumonia (VAP) is a pneumonia infection acquired during mechanical ventilation; this evidence based bundle of care will be administered to all patients daily to prevent VAP.

The table below shows the number of teams to have demonstrated a reliable process with the VAP bundle by July 2013, compared to June 2012

	VAP Bundle	
Team	**June 2012**	**July 2013**
WIG-ITU	x	√
GRI-ITU	√	√
IRH-ITU	√	√
RAH-ITU	√	√
SGH-ITU Neuro	√	√
SGH-SITU	√	√
VIC-ITU	√	√

CVC Insertion

Summary

An evidence based CVC insertion bundle to prevent central line associated blood steam infections will be used every time central lines are inserted.

The table below shows the number of teams to have demonstrated a reliable process with the CVC Insertion bundle by July 2013, compared to June 2012

	CVC Insertion Bundle	
Team	**June 2012**	**July 2013**
WIG-ITU	x	√
GRI-ITU	√	√
IRH-ITU	x	√
RAH-ITU	√	√
SGH-ITU Neuro	x	√
SGH-SITU	x	√
VIC-ITU	√	√

CVC Maintenance

Summary

An evidence based CVC maintenance bundle to prevent central line associated blood steam infections will be used every day on every patient.

The table below shows the number of teams to have demonstrated a reliable process with the CVC Maintenance bundle by July 2013, compared to June 2012

	CVC Maintenance Bundle	
Team	**June 2012**	**July 2013**
WIG-ITU	√	√
GRI-ITU	x	√
IRH-ITU	x	√
RAH-ITU	x	√
SGH-ITU Neuro	√	√
SGH-SITU	x	√
VIC-ITU	√	√

ICU Daily Goals

Summary

Every patient in an Intensive Care Unit will have a set of daily goals agreed and documented in the case notes. This supports communications between teams, plans patient care and supports the delivery of good practice care bundles and interventions.

The table below shows the number of teams to have demonstrated a reliable process with the implementation of Daily Goals by July 2013, compared to June 2012

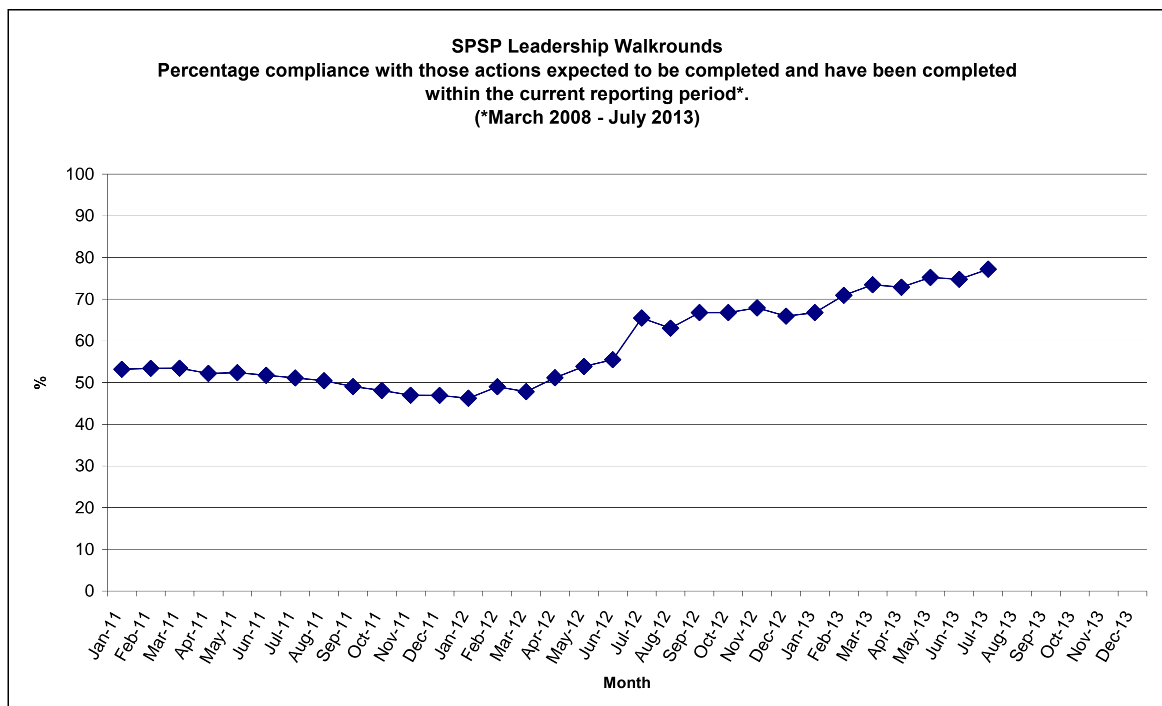
	ICU Daily Goals	
Team	June 2012	July 2013
WIG-ITU	x	√
GRI-ITU	x	√
IRH-ITU	√	√
RAH-ITU	√	√
SGH-ITU Neuro	x	√
SGH-SITU	√	√
VIC-ITU	√	√

Leadership Walkrounds

Summary

Leadership Walkrounds are designed to strengthen the opportunity for senior leaders to obtain learning and oversight of the safety issues, and work closely with patients and front line carers to further create and support the capability for learning and therefore improvement at scale within Scottish Hospitals.

The graph below charts the increasing number actions completed within the current reporting period (Mar 2008 – July 2013)



Measure	Number of Walkrounds	Actions	Actions Completed	%
Leadership Walkrounds	360	1044	806	77%

APPENDIX TWO CEL 19

The Quality Unit
Professor Jason Leitch, Clinical Director

CEL 19 (2013)

02 September 2013

Addresses

For action
Chairs
Chief Executives
Medical Directors
Nurse Directors

For information

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Dear Colleague

NEXT STEPS FOR ACUTE ADULT SAFETY – PATIENT SAFETY ESSENTIALS AND SAFETY PRIORITIES

1. This letter sets out a set of ten patient safety essentials to be implemented everywhere in NHSScotland. NHS Boards are expected to put in place arrangements to ensure that staff are supported to deliver these measures reliably and consistently to all patients who could benefit.

2. The patient safety essentials, which are described in more detail in Annex A, are:
- Hand Hygiene
- Leadership Walkrounds
- Communications: Surgical Brief and Pause
- Communications: General Ward Safety Brief
- Intensive Care Unit (ICU) Daily Goals
- Ventilator Associated Pneumonia Bundle
- Early Warning Scoring
- Central Venous Catheter Insertion Bundle
- Central Venous Catheter Maintenance Bundle
- Peripheral Venous Cannulla

3. The list includes a number of areas where good practice should be followed, such as hand hygiene and communication in the ward or theatre, as well as a number of evidence based 'bundles' of care which are collections of interventions and checks to improve both quality and safety of care.

4. Every item on the list is evidence based and has been developed, refined and tested over time in collaboration between the Scottish Government, Healthcare Improvement Scotland's Scottish Patient Safety Programme and clinicians across NHSScotland.

5. These measures are internationally recognised as fundamentally important for safe care. Each of them has been extensively tested and implemented at scale in Scotland across a wide range of clinical settings and situations as part of the Scottish Patient Safety Programme. Now proven, these measures will in future be a fundamental expectation of every person experiencing acute hospital care, wherever they are. Likewise, these measures will be a fundamental professional expectation for all clinical staff.

6. The emphasis should now shift from testing and spread towards one of sustainable universal implementation which requires different approaches to ensuring and assuring the continued provision of these interventions as standard work in all clinical areas.

7. The ten patient essentials will be reflected within the continuing Scottish Patient Safety Programme, as one of the organisational priorities; these, together with the nine point of care interventions, form the 'nine plus two' safety priorities:

Organisational Priorities:

- Infrastructure for safety
- Strategic prioritisation of safety

Point of Care Priorities:

- Deteriorating patients
- Sepsis
- Heart failure
- Pressure ulcers
- Surgical site infections
- Venous thromboembolism
- Catheter associated urinary tract infections
- Falls with harm
- Safer medicines

8. The continuing safety priorities are based on sound evidence and require further rigorous testing, spread and reliable implementation using the quality improvement methodology familiar to those involved with the safety programme.

Implementation

9. The patient safety essentials listed as Annex A, are expected to be delivered with high levels of reliability. This level of implementation means embedding these interventions as standard work and standard operating procedure into normal, everyday practice. All Boards need to develop local mechanisms to assure themselves that these ten essentials of patient safety have been comprehensively spread and consistently implemented in all relevant clinical areas. Boards need to ensure robust mechanisms are in place to ensure sustainable and sustained maintenance of the 10 essentials.

10. The patient safety essentials should be monitored within operational delivery mechanisms and form an important strand of governance arrangements. However, Boards should also ensure that any recording or monitoring of these measures is proportionate and does not detract from the provision of high quality, compassionate patient care by generating an excessive data burden. A step down approach to process measurement may be appropriate depending on local context.

11. Boards may wish to consider all or some of the following mechanisms to provide assurance that the patient safety essentials are being reliably delivered:

- Direct observations on walk rounds
- Soft intelligence
- Wards visits and conversations with patients and staff
- Dashboards

- Continuation of local outcome measurement
- Sampling or snapshot reports

12. National reporting of the patient safety essentials will be through the Annual Review process. Additional information on the implementation of these measures will be provided through proportionate, periodic, scrutiny of delivery through external review, self-assessment and other accountability methods.

13. All staff should be working towards ensuring these essentials are met, but that if patient safety is endangered by failure to meet these standards or any other reason there are number of ways to raise their concerns, either locally or if necessary through the national confidential alert line

14. If you require any further information about this letter please contact Dr Andy Longmate, National lead for Patient Safety, on 0131 244 2852.

Yours sincerely

Jason Leitch
Clinical Director

Scottish Patient Safety Programme: Glossary of Terms

SPSP Scottish Patient Safety Programme

SPSP-MH Scottish Patient Safety Programme – Mental Health

SPSP – PC Scottish Patient Safety Programme – Primary Care

SPSPP Scottish Patient Safety Paediatric Programme

CVC Central Venous Catheter

CAUTI Catheter Associated Urinary Tract Infection

DMARDs Disease Modifying Anti Rheumatic Drugs

EWS Early Warning Scoring

HAI Healthcare Associated Infection

HDU High Dependency Unit

HIS Healthcare Improvement Scotland

HSMR Hospital Standardised Mortality Ratio

IHI Institute for Healthcare Improvement

ITU	Intensive Care Unit
ISD	Information Services Division
LES	Local Enhanced Service
LVSD	Left Ventricular Systolic Dysfunction (heart failure)
MCQIC	Maternal Quality Care Improvement Collaborative
MDT	Multi Disciplinary Team
NEWS	National Early Warning Scoring
PDSA	Plan, Do, Study, Act (small scale, rapid, reflective tests used to try out ideas for improvement)
PVC	Peripheral Venous Cannula
QOF	Quality Outcomes Framework
SBAR	Situation, Background, Assessment, Recommendation (a structured method for communicating critical information that requires immediate attention and action; can also be used effectively to enhance handovers between shifts or between staff in the same or different clinical areas.
SMR	Standardised Mortality Ratio
SSI	Surgical Site Infection
SUM	Safer Use of Medicines
Surgical Briefing	A pre-operative list briefing designed to ensure entire team understand expectations for the list and each procedure.
Surgical Pause	A pre-operative pause as an opportunity to cover surgical checklist and act as final reminder of items that must be completed prior to commencement of the operation.
Trigger Tool	A case note audit process designed to find examples where the care plan has not progressed as expected
VAP	Ventilator Associated Pneumonia
VTE	Venous Thromboembolism