SAFE CARE

NHS Greater Glasgow and Clyde (NHS GGC) is committed to providing safe high quality care that our staff and patients can be proud of. Over recent years the Scottish Patient Safety Programme has provided a shared platform through which our clinical services have collaborated and developed improvement in the safety of care. Over the next few years we wish to develop an NHSGGC Clinical Safety Programme, which will build on our experience and the support of the national programme, but allow us to integrate other useful developments such as our clinicians work in reviewing quality of care through morbidity and mortality meetings.

Scottish Patient Safety Programme

SPSP Adult Acute

SPSP Deteriorating Patient
Improving the management of deteriorating patients is a key safety priority for NHS Greater Glasgow and Clyde; and a set of development objectives has been established and agreed.

Progress
- Almost 20% of teams are actively involved and the Royal Alexandra Hospital has all its ward teams participating
- 4 teams have created a reliable team process to ensure frequency of observation is appropriate to the patients clinical need

Next steps
- Support the Acute Services Division sectors and directorates to ensure those wards reporting the greatest frequency of crash calls in each hospital are active in the programme (this will cover those locations reporting 60% of all crash calls)

SPSP Sepsis

Progress
- 12 teams are continuing to measuring and testing how to further improve the clinical process
- 3 teams have achieved sustained reliability and are now on reduce data collecting schedules

Next steps
- Ensure the emergency departments and admission/assessment wards are able to demonstrate a reliable clinical process for Sepsis six (estimated target of 20 wards)

Medicines Reconciliation (MR)

The Acute Services Division has declared this as a key safety priority and have been developing implementation plans to deliver the agreed objectives for 2016/17. Teams are being supported to review their current MR process, test improvement ideas and measure the outcomes.

Progress
• The primary focus to date has been improving medicines reconciliation (MR) on admission to Hospital. Current measures show between 50-60% of patients have MR documented within 24hrs of admission and 80-85% of patients have an accurate prescription chart within 24hrs of admission. In preparation for focusing on MR at discharge, GP practices across NHSGG&C collected data on Immediate Discharge Letters (IDLs) they received, and reported that an average 80% of IDLs, from across all acute hospitals, have sufficient information about medicines and changes made during the patient's stay.

Next steps
Work is ongoing to replace the MR eForm with an electronic medicines reconciliation application in clinical portal. This application will have an interface with ECS to facilitate MR on admission, but will have the added functionality of enabling the reconciled list created on admission to become the starting point for MR at discharge and production of the IDL. This will create a joined up reconciliation process from admission to discharge with reduced transcription. Development and clinical testing will take place during 2016.

Falls

Progress
• Testing in pilots has led to the review of the of Falls Policy and the creation of additional guidance and education for staff

Next steps
• The existing Cannard risk assessment tool will be withdrawn, and replaced by the SPSP risk assessment and interventional plan (which includes the interventions for bundles 1-3).
• Spread of the bundles 1-3 documentation will begin in South Sector, commencing May 2016, then Clyde and finally North Sector.
• All wards to be monitoring their own outcome data via the redeveloped Datix reporting process.

Tissue Viability

Progress
• Following a period of testing in pilot wards a new tool for Pressure Ulcer Daily Risk Assessment has been developed leading to the withdrawal of the preceding tool.
• Spread of the pressure ulcer risk assessment and interventional plan commenced in South Sector on 18th January 2016 and North Sector on 7th March. Clyde is to follow in early May.

Next steps
• To continue with roll out of PUDRA.
• As South Sector was first with the roll out an evaluation of the documentation usage and outcomes is planned for May. This will be carried out by the Tissue Viability Service.
• Discussions are underway to find an alternative electronic means of collecting process measures.

Catheter Associated Urinary Tract Infection (CAUTI)

Progress
• Roll-out of NHSGGC AUC Insertion and maintenance care plan
• CAUTI process and outcome data is being measured across 8 sites in NHS GGC to date: GGH, IRH, Vale of Leven, RAH, Stobhill, Lightburn, QEUH (SIU and INS) and the GRI.
• 87 wards in total are engaged in the CAUTI work stream with 74 submitting data for February 2016.

Next steps
• A large number of teams are now engaged in collecting quality improvement data for CAUTI but there is a need to improve the process and support in terms of data collection, analysis and reporting.

SPSP Mental Health

Progress
• During 2015/16 a scoring system was introduced across the fourteen wards to ascertain what level of support was required across the wards.
• Leadership and Culture: All 14 wards have had Safety Conversations carried out in 2015. The actions are discussed at the SPSP MH steering group on a regular basis. 30 actions have been identified from the 2015 SCs, of which 29 have been completed to date. All wards are participating in the staff and patient safety climate surveys.
• Risk Assessment: The risk assessment bundle has been updated in line with feedback from the 14 wards that were testing. The bundle has now been agreed and compliance has increased from 43% to 65%.
• Communication at Transition: A new bundle has been developed to check if patients are followed up within 7 days of discharge from hospital. Early results suggest that the definitions need more work. A video has been filmed for the wards to see an example of a Safety Huddle.
• Restraint: A bundle has now been developed for Restraint but will be tested in four of the fourteen wards. The bundle will ensure that a person centred care plan is in place and that should restraint occur that a debrief takes place.
• Safer Medicines: Safer Medicines included a sticker for wards to use in patients notes to highlight the use of ‘as required’ medication. All 14 wards are using these stickers and find them helpful. A bundle has now been developed to ensure that the ‘as required’ stickers are discussed at the multi disciplinary team meeting and changes to medications considered where necessary.

Next steps
• An new implementation plan for spread across Mental Health Services is in development
SPSP Primary Care (PC)

Medicines Reconciliation (PC)

Progress

- The medicines reconciliation care bundle forms part of the “safer medicines” workstream and was included as part of the LES. The report at 30/3/16 shows 93% compliance with primary care IDL care bundle. Since June 2014 this compliance has remained stable and is achieving 92-94% compliance.

Next steps

- There has been sustained compliance for a considerable time with positive impact on patient safety. Due to the changes in contracts no further funding is available to continue in its current LES format. While there is no fixed agreement on the next steps there may be scope for the prescribing support teams to continue to measure in practices selected for the investment fund with further potential to for GP clusters to adopt as their as their "QI" area.

DMARDs (PC)

Progress

- Through a care bundle approach 202 GP Practices across NHS GGC have been asked to report their prescribing and monitoring activity of DMARDS to reduce potential harm to patients. There has been steady progress with compliance with a recent test of change focussing on NE sector due to lower rates of uptake. Over the period December –March, NE sector has begun to show highest engagement rates of 70% compared to the Board average. The drop in engagement in March may reflect the perceived uncertainty with the continuation of DMARDS due to the changes in GP contacts. The graph below highlights engagement and attainment rates from May 2015 to March 2016.

Next steps
• The DMARDs work will continue for 16/17. There is a plan to add additional Practice Nurse Support with the continued support from the CGSU team. A Toolkit will also be developed to share the learning from DMARDs and act as a practical guide to continue the work going forward.

Results Handling (PC)

Progress
• In a review of Significant Event Analyses (SEA) in general practice in Scotland (2009) 20% of SEAs related to results handling systems. In November 2013 a new results handing bundle was developed by NHSGGC and NHS Grampian. This has now been adopted nationally by HIS and rolled out to all other boards. In NHSGGC during 2015/16, 9 GP Practices have been involved in the Results Handling work. There has been significant improvement in compliance since the original Nov 13 bundle, when compliance averaged at 60% across the participating practices. The chart below highlights compliance form July 2015 to Feb 2016.

Next Steps
• The introduction of the IT system Ordercoms has assisted with the significant improvement with compliance. There is confidence that this will be in place for all GP practices in NHS GGC. Given the positive results and the reliable IT system it has been agreed that the results handing workstream will not continue in 2016/17.

CAUTI/ MUST (PC)

Progress
• Both MUST and CAUTI bundles have been development and tested with positive findings. For MUST reports on compliance with bundle and nutritional status of patients who have had nutritional screening are carried out now and available via a dashboard on Community Nursing Information System.

Next steps
• Develop the IT system to record the use of MUST and CAUTI amongst District Nurses is proposed. This will allow better understanding of impact and assist with the overall spread and implementation of the tools for improved patient care.

Sepsis (PC)

Progress
• Piloting use of NEWS (National Early Warning Score) with 6 Out of Hours GPs to detect early identification of sepsis for all adults with suspected sepsis for hospital admission. Use of the NEWS tool has already shown that it helps GPs to record five physiological parameters consistently and reliably (Pulse, Blood Pressure, Respiratory Rate, Oxygen Saturations, Temperature) and assists with identification and diagnosis of Sepsis.

**Next steps**

• Use the case stories within learning sessions to provide a patient focused dimension to the progress. Plans to have future learning sessions and involve more GP's this year is underway. Developing Sepsis code and NEWS score for the Adastra IT system within Out of Hours Service.

**High Risk Medicines (PC)**

**Progress**

• Community Pharmacy High Risk Medicines aims reduce co-prescribing of high risk drug combinations (NSAIDs + other medications) by 90% by 30th June 2016. 9 CPs are undertaking the pilot work with monthly data collection. Prescribing data is indicating a general decline in prescribing of NSAIDs in high risk patient groups and now seeing co-prescribing of NSAIDS and gastro protection by GP's.

![Overall Compliance](image)

**Issues**

• Key successes have been made with bundle compliance. We are now receiving feedback on the “softer” elements of the programme with the pharmacy teams feeling more involved in clinical care, being part of the follow up and seeing their recommendations being implemented. Development for direct access to Clinical Portal is underway and will assist in a smoother transition between services.

**Next steps**

• The pilot has now received extended funding until September 2016. There is discussions nationally and locally on consideration for local spread. In Jan 2016 we recently embarked on another project which aims for 95% of Patient(s)/Carer(s) to have their medicines accurately reconciled in Community Pharmacy by July 2016. Key successes already has been formally involving the pharmacy teams in the discharge process which is having an advantage for reducing medicine waste as well as clinical advantages. Work is also underway to test the use of Medicines Sick Day rules cards.
**Asthma (PC)**

**Progress**
- Supporting 5 pilot GP practices submitting care bundle data monthly. 1 practice had staffing issues and provided inconsistent monthly submissions. Improvement has been seen around use of Asthma Management Plans, improving teamwork, communication and also reviewing asthma diagnosis to allowed practices to target non attendees.

**Next steps**
- As of 31/3/2016 2 practices have shown an interest in continuing with Asthma bundle. Broader discussion with SPSP Primary Care Steering group required to discuss next steps.

**Paediatric**

**Progress**
- The Paediatric Intensive Care Unit has sustained reliability in VAP and Central Line processes with a reduction in infections (outcome data) also evident.

**Next steps**
- The central line insertion work is spreading formally to theatres who are currently testing; the maintenance process has now spread to 8 wards.
- New priority areas have been announced by the national team with a focus on medication errors and deterioration. Units will be supported in the implementation of these measures as soon as the details are available (due April 2016). Units will carry on working towards completion for the outstanding measures.

**Neonates**

**Progress**
- PRM are measuring in seven areas. They are stepped down for one measure, demonstrating sustained reliability for two measures and capability with four measures.
- RAH are also measuring seven areas. They are stepped down in six measures and demonstrating sustained reliability in one measure. They are also engaged with an additional measure but are not yet submitting data.
- RHC are measuring in eight areas. Sustained reliability is demonstrated in three measures, reliability is demonstrated in a further three measures, one measure is deemed capable and is currently collecting and measuring data for one measure.

**Next steps**
- New priority areas have been announced by the national team regarding deteriorating patients, neonatal hypothermia and late onset infection. Units will be supported in the implementation of these measures as soon as the details are available (due April 2016). Units will carry on working towards completion for the outstanding measures.
**SPSP Venous Thromboembolism Prevention (VTE)**

NHS GGC have chosen to focus on VTE from the set provided in the LDP guidance

**Aim**
- To improve delivery of risk assessment and appropriate treatment to reduce harm and mortality from venous thromboembolism.

**Progress**
- 27 wards confirmed into the programme across the Acute Services Division (adult wards).
- A further 9 wards are in the process of recruiting to the improvement programme during April 16.
- We now have an increased confidence in the changes tried and tested in the 7 wards who have demonstrated sustained reliability, and are at present transitioning from the testing and measurement model of support to more of a spread and implementation approach.
- Sustained Reliable (9 or more data points currently with a median of ≥95%).
  - 7 wards with sustained reliability for the measure code VTEP1
  - 19 wards with sustained reliability for measure code VTEP3
  - 7 wards have demonstrated sustained reliability for all measures

**Next steps**
- An overall plan for spread needs still to be agreed and discussed with Executive Lead and Sectors/Directorates Senior Leads but the proposed plan is increase the aim to spread to the workstream to 50% of applicable wards by December 2016.