Greater Glasgow and Clyde NHS Board

Board Meeting

January 2013 **Board Paper No. 13/01**

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 ongoing progress achieved by NHS GG&C in implementing the Scottish Patient Safety Programme

2. Programme overview

The language relating to SPSP now suggests a family of improvement programmes within one overall national framework. This now extends to include

- Adult Acute Care (Core Programme)
- Paediatrics programme
- Venous ThromboEmbolism (VTE) collaborative
- Sepsis Collaborative
- Heart Failure bundle
- Maternal Care programme (to be launched in March 2013)

This report provides an update to the Board on the VTE collaborative and Sepsis collaborative. This anticipates a national team visit taking place to NHS GGG&C on the 25th March 2013 for both the Sepsis and VTE workstreams. (We note that the aim of this relating to the VTE workstream is to update on the multiple pilot site approach as this approach is unique in Scotland).

3. Update on VTE Collaborative

3.1 Aim of programme

This area of work is looking at the assessment of patients and concurrent administration of interventions to prevent VTE in patients being admitted for acute inpatient care. The challenging aim is as follows:

Reliable risk assessment and appropriate thromboprophylaxis administration

- 95% of all adult hospital admissions by December 2014

3.2 Summary of current position

NHSGGC now has 10 pilot wards identified in 6 hospitals active in developing processes around this care bundle. There has been spread into 5 other wards since the Autumn which includes three additional teams in Regional Directorate and the commencement of two teams in the Surgery &

Anaesthetics Directorate. Physicians have recommended the spread of the VTE collaborative to the medical receiving wards and this is now being progressed. The rationale for this is to support reliable risk assessment within 24hrs of admission.

3.3 Progress to highlight since last report

In pilot teams they are testing to identify what is the best process that ensures reliable clinical practice. A summary of testing development against each bundle measure is as follows

- **VTEP1 - Percent Compliance with assessment for patient and admission related risks within 24 hours of admission, VTEP2 - Percent compliance with assessment of contra-indication to pharmacological or mechanical thromboprophylaxis & VTEP3 - Percent compliance with correct pharmacological/mechanical thromboprophylaxis prescribed and administered**. Teams continue to test the VTE risk assessment tool (RAT). Both in terms of content, layout, structure as well as the work processes to ensure completion. Plan-Do-Study-Act (PDSA) tests of change include, completion of risk assessment tool included in safety brief, placement with the medicines reconciliation paperwork as a reminder prompt, included within the admission documentation, included in the new drug kardexes, at drug rounds, the nursing staff prompt the medical staff to complete any missing assessments, completion of RAT tick box to handover checklist for all medical wards, consultant support to drive completion at ward rounds, daily ward round sticker (includes tick box for VTE and kardex).

- **VTEP4 - Percent compliance with documented reassessment of VTE risk as per local policy (48 hours).** Teams continue to test using PDSA method around this process. The tests of change include consultants prompting at ward round every day; VTE Risk assessment completion added to safety brief, junior medical staff to review this section of drug Kardex everyday and ensure it is complete every 48 hours, nurse prompting medical staff during drug rounds.

- **VTEP5 - Percent compliance with patient/family informed of VTE risk and treatment within 24 hours of admission.** Teams continue to PDSA around this process with tests of change including patient information leaflet attached to the risk assessment tool, to prompt discussion with the patient, tool/leaflet placed prominently at each patient's bedside and patients are encouraged to ask questions, leaflets being ordered for placement in the information pack given to patients on admission, leaflets attached to risk assessment tool in drug Kardex, VTE information leaflet has been added to the patients nursing admission pack that is left on the bed of every patient at the start of their in patient stay.

4. Update on Sepsis

4.1 Aim of programme

To improve the recognition and timely management of Sepsis in acute hospitals in GGC. The desired outcome is a reduction in mortality from Sepsis of 10% in the pilot population by December 2014.

4.2 Summary of current position

Work continues recruiting pilot teams across the Acute Services Division and we note there is clinical enthusiasm within NHS GG&C for applying the Sepsis 6 rules set to improve care.

The new National Early Warning Score system has the sepsis six bundle (see below) written into the action reference tool and is being implemented all acute care hospitals by the end March 2013. As part of implementation nursing staff are receiving the supplementary education on the bundle to underpin effective use of the bundle.

Some tools and practices within the teams are being identified for common use e.g. the use of stickers in the patients notes to record the administration of the bundle elements shared. The seriousness of the condition is well acknowledged as a Medical Emergency, so some pilot areas are working on specific equipment for use with patients in Sepsis cases e.g. a trolley specified for Sepsis cases and containing all the equipment required to deliver the Sepsis 6 bundle appropriately within the optimum time.

The aim of the national faculty visit to NHS GG&C, on the 25th March 2013, is to explore how to plan to spread acute work across all receiving sites and also what the plans are around specialty sepsis work.

Sepsis Six provides key treatment for patients :

1. Give high flow oxygen
2. Take Blood Cultures
3. IntraVenous (IV) antibiotics within one hour
4. Start IV Fluid resuscitation
5. Check Lactate and Haemoglobin
6. Monitor urine output

Followed by Early Goal-Directed Therapy