Greater Glasgow and Clyde NHS Board

Board Meeting

December 2013 **Board Paper No. 13/52**

Board Medical Director

Scottish Patient Safety Programme Update

1. Summary of Actions for Board Members

Members are asked to:

- Consider the outline of the Boards initial planning response to the ongoing priorities in the Acute Adult programme of SPSP, noting in particular the reframing of governance processes for individual elements.

2. Acute Adult Care Safety Programme:

We have previously advised the Board of a significant shift in the strategic approach to developing the Acute Adult Care programme within SPSP announced through the Chief Executive Letter CEL 19 (2013): Next Steps for Acute Adult Safety

The preceding report addressed one major change and our progress around implementation of the **PATIENT SAFETY ESSENTIALS.**

The next set of major improvement ambitions are articulated in the set of **POINT OF CARE PRIORITIES**, which are listed 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 report provides an update on work being led through the Acute Services Division to ensure initial evaluation of needs is completed and the subsequent development plans are put into action.

A number of key themes have emerged in the series of strategic discussions considering an effective model of programme management. There is a clear benefit to continue the designated corporate leadership model so there is appropriate oversight and support to service implementation. However we have in addition observed that many of the issues potentially affecting patients can arise in cross system pathways of care. Therefore we are indentifying organisational leads who will maintain operational oversight and leadership of each priority and will retain a specific responsibility to ensure cross system issues are suitably integrated into

improvement plans. There has also been further consideration of the role of local medical leads in developing engagement and supporting local testing. Building on the experience of other Boards we are looking to find models of protected time for medical leads and will test the value of this concept in the implementation work for deteriorating patient.

Although each priority has its rational for inclusion in the programme the local discussions have framed a specific need to prioritise work in relation to deteriorating patients. The national team in Healthcare Improvement Scotland have published a draft driver diagram to guide this work (See table one).

Table One POINT OF CARE PRIORITY – DETERIORATING PATIENTS

AIM	PRIMARY DRIVERS	SECONDARY DRIVERS
95% of people with physiological deterioration in acute care will have a structured response and plan A reduction of inappropriate interventions 50 % reduction in CPR attempts (with chest compressions and/or artificial respirations) in general ward setting by December 2015	Early Anticipation, collaborative planning and decision making.	• Anticipatory planning in Primary Care, • Patient and family at the centre of decisions & planning • Reliable access of primary care information on admission- eKIS • Assessment of functional capability and health trajectory and detection of limited reversibility when assessing patients • Reliable implementation of national DNACPR policy • Reliable provision of information to primary care on discharge- Ekis
	Scottish Structured Response Processes Reliably Implemented	• Reliable detection of the deteriorating patient using NEWS or local EWS • Screen for sepsis & initiate Sepsis Six if appropriate • Ensure competent responder • Ensure senior clinical involvement in care planning • Appropriate and timely referral to higher level of care/palliative care • Reliable communication across teams of at risk patients • Structured wards rounds in acute care- reliable review of treatment plan • Reliable ongoing patient and family communication • Provision of patient/family information • Use SBAR to communicate across MDT
	Infrastructure	• Local mortality & morbidity review • Involve resuscitation officers in education & improvement • Organisational priority: Executive Sponsorship, Clinical Leadership, Executive Lead for Palliative Care • Consider use of electronic track & trigger tools to actively measure and manage at risk patients across the sites. • Link with Older Persons & Person

		Centred improvement teams • Consider hospital rounding huddles to detect & predict deterioration

This builds on the existing successful work on patient observation, early warning scores and escalation of concerns that has been progressed in the first phase of the SPSP programme. However this driver diagram represents a significant expansion of requirements and does not include all the areas we think may be required to in the programme e.g. models of clinical support hospital at night provides. This has also increase the complexity in ensuring both the reliability of the clinically process and the coordination of inputs to ensure these are efficiently and effectively aligned to maximise the difference being made for patients and families. A further scoping session is planned for mid-December after which a more detailed plan will be developed.

The safer use of medicines is already a core part of the Scottish Patient Safety Programme in both Primary and Secondary Care with a number of high risk areas prioritised for attention. One of these areas is Medicines Reconciliation which is a recognised as a local priority area in SPSP implementation. Medicines reconciliation is the process undertaken by the healthcare team to ensure the medication record is as accurate as possible as a basis for prescribing. It is undertaken in partnership with the patient and carer to ensure we have a shared understanding of the list of medication currently being taken, and that this accords with the medication record held by other health professions who input to the patients care. This is a continuous process but especially vital in describing the reasons for any changes and supporting accurate timely communication as the patient moves across care settings. Accurate timely medicines reconciliation on admission to, and discharge from hospital is an integral part of clinical care and takes time to complete. SGHD/CMO (2013) 18 requires that the NHS Board demonstrates compliance in discharging their clinical governance responsibility around medicines reconciliation by ensuring the implementation and monitoring of guidance contained in the circular. NHS Boards are therefore required to

- Involve patients in medicines reconciliation both at steering group and in quality improvement work with clinical teams
- Establish multi-professional leads for medicines reconciliation supported by medical clinical champions in individual specialities
- Establish local mechanisms to coordinate medicines reconciliation quality improvement work which reports to the Area Drug and Therapeutics Committee.
- Undertake a gap analysis and develop local action plans to enable delivery of guidance set out in the circular. The action plans should include processes to
  - Ensure integration of medicines reconciliation with other key strategic policies e.g. 4 hour HEAT target, patient flow, Older People in Acute Care (OPAC), and Hospital Standardised Mortality Reviews (HSMR).
  - Develop and implement a medicines reconciliation policy setting out roles and responsibilities of key professions in medicines reconciliation which is widely understood by frontline staff.
  - Ensuring that medicines reconciliation is included as a core part of training including induction training.
  - Adopting the soon to be available NES Medicines Reconciliation e-learning module.
  - Implementing medicines reconciliation in acute receiving areas as a priority with spread to other clinical areas as testing is completed.
  - Develop and include electronic enablers to safer medicines reconciliation in eHealth strategies.
  - Including prompts for medicines reconciliation in paper and electronic prescribing systems.

A Medicines Reconciliation Oversight Group is being established with representation from patients, doctors, nurses and pharmacists to oversee medicines reconciliation quality improvement activity in the following key areas

- Medicines reconciliation an admission to hospital
- Medicines reconciliation on discharge from hospital
- Medicines reconciliation in General Practice

This will augment the existing improvement activity in Acute Services Division with a cross system focus and improve the overall governance of SPSP implementation.

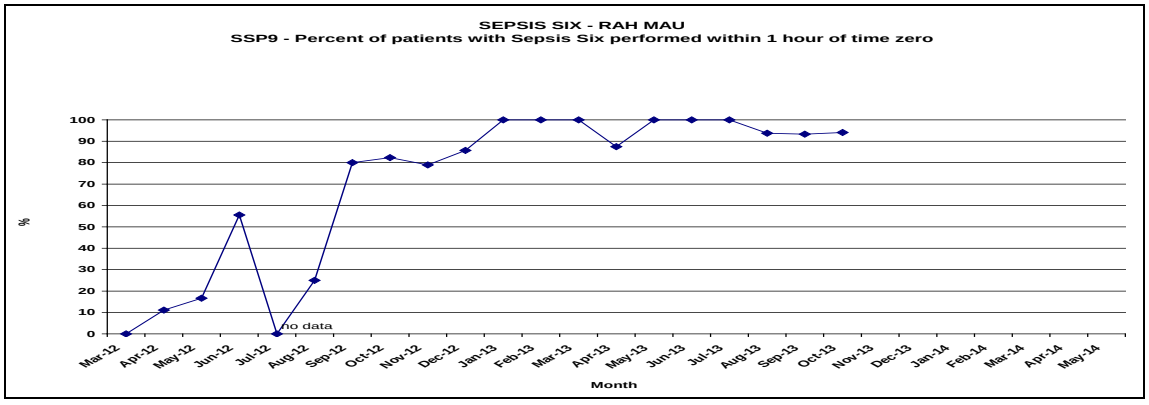
Sepsis has been an established element of SPSP and is now one of the Points of Care Priorities. It is referenced in the driver diagram for the deteriorating patient (see table one) and there is a question as to whether it should be managed as a distinct programme. However we have one notable progress point to build on. The Acute Clinical Governance Forum has a local improvement aim: to obtain process reliability for the Sepsis 6 Bundle in the NHS GG&C initial pilot population by December 2013.

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

The first objective of local testing is to create a reliable prototype, (prototype means that there is a clear designed work flow in place in a clinical team to ensure that the required evidence based care is provided to all patients who require it). This has now been achieved by the team at the RAH. Figure 1: SSP9a (Acute) Percent Compliance with Sepsis 6 within 1 hour of time zero: RAH Medical Assessment Unit.



As is consistent with the spread plan principles this reliable prototype process from the RAH is now being shared with other teams. For instance team at the Western Infirmary have adopted and adapted it to accelerate their own improvmetn plan and are now beginning to show a more reliable process.

Similarly the aim to develop more reliable risk assessment and appropriate thromboprophylaxis administration, looking at the assessment of patients and concurrent administration of interventions to prevent Venous Thromboembolism (VTE)E is part of the pre-existing programme. The local improvement plan is coordinated through the Board Thrombosis Committee, which is chaired by Dr Campbell Tait. The committee has taken on thelead role for VTE implementation, integrating SPSP methods into its pre-existing approach, with links to the Acute Services Clinical Governance Forum for monitoring and support needs. This arrangement will continue in our response to the point of care priorities. At this stage we are working with twenty seven clinical teams, with seventeen reaching the stage of testing and generating data to explore process reliability. Although none of the teams have yet reached reliability with all five elements for VTE we have a number of teams who can show reliability for each of the six elements (see table two).

Table 2: Description the six VTE Elements

Definition
Risk Assessment for VTE completed within 24 hours of admission
For those patients deemed at risk of VTE, is there a documented assessment of contra-indication to pharmacological or mechanical thromboprophylaxis?
For those patients deemed at risk of VTE, has correct pharmacological/mechanical thromboprophylaxis been prescribed and administered?
For those patients in hospital > 48 hours, is there a documented reassessment of VTE risk as per local policy (48 hours)?
Has patient been informed of VTE risk and treatment on admission?
SIGN Bundle (all or none)

The final set of points of care priorities (Heart failure, Pressure ulcers, Surgical site infections, Catheter associated urinary tract infections, Falls with harm) are newer aspects of SPSP but all fall within the scope of existing arrangements. It is the intention that responsibility and leadership for the SPSP requirements will be integrated into each dedicated arrangement, but recognising there may be an associated need for mentoring on the required improvement approaches. The confirmation of requirements is ongoing but includes indentifying the reporting links to ensure the Board can maintain oversight of the programme.

The Clinical Director of the Quality Unit in SGHD confirmed that Healthcare Improvement Scotland (HIS) are circulating a measurement plan intended to support Boards to review current levels of reliability and spread and perform actions to close any gaps. Our earlier involvement suggests this will require new forms of measurement which will result in further reorganisation of the implementation approach. There is an explicit expectation that Boards “demonstrate and report sustained and ongoing universal implementation” of SPSP, as well as reinforcing “NHS Boards of their responsibilities to have mechanisms in place to assure themselves that the self reported data by units is supported by quality assurance in the form of audit or similar management processes”. The measurement plan has just arrived with us and will require further review then translation into these new governance process for the programme implementation within the Board.

Appendix One
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