Greater Glasgow and Clyde NHS Board

Board Meeting

June 2014 **Board Paper No. 14/34**

Board Medical Director

Scottish Patient Safety Programme Update

1. Background

The Scottish Patient Safety Programme (SPSP) is one of the family of national improvement programmes, developed over recent years in relation to the national Healthcare Quality Strategy. These programmes draw on improvement methods advocated by the Institute for Healthcare Improvement. SPSP now contains a number of distinctly identified programmes as follows:

- Acute Adult Care
- Primary Care
- Mental Health
- MCQIC (incorporating Paediatrics, Maternal Care & Neonates)

2. Purpose of Paper

This is a high level overview report to update the Board on the Acute Adult Safety Programme consisting of the following sections:

- Safety Essentials summary
- Points of Care overview

This report is presented to Board for information and approval. In particular the Board is asked to:

- Note the update on safety essentials
- Note the summaries of each of the Points of Care work-streams, in terms of current activity, key areas of progress, or key issues to note.

3. Safety Essentials

3.1 Background

This section presents a summary of the current position with the 10 Scottish Patient Safety Programme elements identified as essential to patient safety. A significant shift in the

strategy approach to evolving the Acute Adult Care programme within SPSP was announced through the issue of Chief Executive Letter CEL 19 (2013). This included the announcement of PATIENT SAFETY ESSENTIALS, with the key message 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". The 10 Safety Essentials are deemed to be evidence based processes that have achieved a level of spread and reliability across acute hospitals in Scotland since the launch of SPSP in 2008.

Over recent months the Acute Services Division has been confirming that level of spread in the reliable care processes across its clinical teams is of sufficient magnitude to translate their oversight into what the CEL describes as routine "operational delivery mechanisms".

3.2 Current position

The following table provides a brief update on the ongoing plans for the transfer of reporting responsibilities around the ten patient safety essentials.

Table 1: Safety Essential overview

Safety Essential (spread %)	Comment
Hand Hygiene (98%)	Compliance monitored monthly. Measurement support currently sits with CGSU.
Early Warning Scores (92%)	Responsibility for reporting and support in transition from CGSU to service.
Safety Brief (94%)	Responsibility for reporting structure and frequency now sit with service.
Peripheral Venous Catheter (85%)	Responsibility for reporting and support in transition from CGSU to service.
Brief & Pause (98%)	Responsibility for reporting structure and frequency now sit with service.
Ventilator Associated Pneumonia (100%)	Responsibility for reporting structure and frequency now sit with service.
Central Venous Catheter Insertion (100%)	Responsibility for reporting structure and frequency now sit with service.
Central Venous Catheter Maintenance (100%)	Responsibility for reporting structure and frequency now sit with service.
Intensive Care Unit Daily Goals (100%)	Responsibility for reporting structure and frequency now sit with service.
Leadership Walk-rounds	Administrative and measurement support continues to sit with CGSU.

4. Review of Points of Care

4.1 Current Position

The next set of major improvement ambitions for SPSP are described in the CEL as Point of Care Priorities, and are listed as follows:

- Deteriorating patients
- Sepsis*
- Venous thromboembolism* (VTE)
- Heart failure*

- Safer medicines*
- Pressure ulcers
- Surgical site infections
- Catheter associated urinary tract infections (CAUTI)
- Falls with harm

This set is deemed safety critical for 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. Other points of care are acknowledged patient safety needs and the Board already has dedicated structures to reduce the frequency and consequence of infections, falls and pressure ulcers. We have clarified training and support needs in the quality improvement methodology for staff linked to those structures. In relation to deteriorating patient implementation governance has been re-designed and is now established.

In terms of current activity (see table 2) we can see that we have returned to small scale testing in a limited set of pilot teams for the newer programmes.

Table 2: Points of Care – overview of current spread

Bundle	Number of teams			
	Target Teams	Active Pilots*	Submitting Data	Reliability achieved
CAUTI	All NHSGGC in patient bed areas	10	0	0
Deteriorating Patient	TBC	6	0	0
Falls	6	2	0	0
Heart Failure	5 (within Cardiology)	5 (within Cardiology)	4	3
Pressure Ulcer	6	2	0	0
Safer Use of Medicines[1]	106	85	70	20
Sepsis	TBC	20	10	2
VTE	210	31	26	-

***** A pilot team is considered active once an initial meeting has taken place in which they agree to take part in the Programme.

[1] Excludes Women's & Children's Directorate as discussions are ongoing re total number of target teams.

4.2 Overview- key areas of progress or issues to note

Table 3 below contains a high level update from the Programme Managers on current activity, key areas of progress or key issues to note, for each of the Points of Care Work streams.

Table 3: Points of Care key updates

Bundle	Current position	Key areas of progress	Key issues to note
CAUTI	▪ Pilot Hospital site identified using point prevalence data. ▪ 10 Wards/dept piloting process measures and collecting outcome data locally. ▪ Remaining 5 Wards/depts at pilot site commencing pilot week beginning 09/06.	▪ Recruiting of pilot sites. ▪ Development of data collection tools e.g. CAUTI Safety Cross ▪ Staff engagement at pilot sites. ▪ Development of tool to collect data in wards/pilot sites (initially Excel Spreadsheet). ▪ Local QI education day developed with Clinical Governance team for infection control staff.	▪ Await board data collection system guidance for outcome and process measure collection.
Deteriorating Patient	▪ Builds on preceding SPSP focus on reliable use of Early Warning Scoring charts ▪ Steering Group, Clinical Lead and project plan in place ▪ Links to other key groups in place e.g. Resuscitation Committee	▪ Skill based refresher programme for nurses on early detection and escalation being design by practice development ▪ Initial pilot work at Inverclyde Royal Hospital is underway	▪ The outcome measure (rate of Cardio Pulmonary Resuscitation performed) remains problematic so needs redesigned
Falls	▪ Teams in early stages of testing		

Heart Failure	▪ The bundle is currently active within 4 Cardiology wards/areas in NHSGGC.	▪ 3 teams - GRI Ward 43/44, RAH Ward 8 and WIG F3/F4 continue to show sustained reliability in the bundle.	▪ Seeking clarification at a national level of the scope and applicability of the bundle ▪ Consideration of next steps for teams currently showing sustained reliability ▪ Consideration of potential spread of the bundle to non Cardiology areas, and the resource implications and mechanism for progressing this. Scoping work is underway to identify the number of heart failure patients who are not admitted to Cardiology, and potential wards/ areas for spread
Pressure Ulcer	▪ Teams in early stages of testing		
Safer Use of Medicines	▪ ECMS relatively stable and current focus on S&A and RSD who have implementation plans in place.	▪ Improved engagement of medical leadership & inclusion of MR in safety briefs in S&A, but await translation into improved performance ▪ Improvements noted in Plastics and neurosurgery ▪ Increase in use of Medicines Reconciliation eForm across Directorates from 1,270 Pts in March to 1,949 in May	▪ Access to eForms/ECS has been problematic in some areas - escalated to IT ▪ Work ongoing to agree a plan with W&C.

SEPSIS	▪ Measurement plans agreed to cover several sites and classed as one team in renal and ED/AMU areas ▪ Team recruitment difficult until data management issues resolved (TRAK? LANQIP?)	▪ Blood gas analyser now agreed and being installed within WOSCC to enable achievement of full bundle. ▪ ED services set up cross board collegiate working ▪ First cross board conference call in April attracted good audience	▪ Sepsis six care now written into therapeutics handbook as mainstream care, burden of data collection putting teams off measuring compliance ▪ Teams still working on local spreadsheets
VTE	▪ 31 wards confirmed into the programme ▪ Across 7 hospital sites & a range of specialties o medical receiving wards/units o respiratory/general medicine o spinal injuries o gynaecology o oncology o plastic surgery o orthopaedics o urology o obstetrics o general surgery o care of the elderly ▪ 25 teams submitted data for April 14	▪ NHSGGC Thrombosis Committee to lead, drive and monitor progress of the collaborative ▪ Local groups of nurses, doctors, pharmacists and improvement support are leading the testing of reliable designs for VTE prevention in 31 wards ▪ A VTE resource folder has been developed for all wards part of the VTE collaborative ▪ Implementation of a VTE Patient Information Leaflet ▪ Generic standardised VTE risk assessment tool for majority of specialties ▪ Standardised VTE prevention guideline for majority of specialties	▪ The national team have revised the Aim for VTE Prevention ▪ The new aim means we need to recruit an additional 75 teams by summer 2014. ▪ Discussion of recruitment of teams to spread to in underway with the Clinical Directorates ▪ **VTE Prevention Measurement Strategy** ▪ From April 14, a new measurement strategy for VTE is in place. The main changes are ▪ reduction in measures from 6 to 4, ▪ slightly different wording changes ▪ extension of the reassessment measure from 48 hours to 72 hours

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