

## Greater Glasgow and Clyde NHS Board

Board Meeting

December 2016

Board Paper No. 16/81

### 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 paper provides an update on the

- the recent national SPSP conference
- the programme of work for Tissue Viability – Acute Adult Care SPSP

The SPSP approach aims to develop clinical processes through iterative testing so they are capable of operating with higher levels of reliability. The paper describes a brief outline of progress and considers challenges for integration of SPSP within the broader programme of work.

The Board of NHS GG&C is asked to:

- note the SPSP update and the progress in improving quality of care in the Tissue Viability programme

#### 3. SPSP Programme Approach

##### National Safety Conference

The National SPSP conference took place on 29th November 2016. The event brought together all of the SPSP programmes within a set of shared aims:

- To celebrate success that teams have achieved in reducing harm services across Scotland,
- To share practical approaches to prevent deterioration and improve outcomes,
- To network with delegates to learn from their experiences of an integrated approach to prevention, recognition and response to deterioration.

NHS GG&C was well represented at the conference event. 73 staff attended and a healthy number were involved in providing presentations or facilitating workshops. The Board's local SPSP achievements were also referenced a number of times by the national speakers during the course of the day. One prominent piece was a video clip of a nurse from East Dunbartonshire Health and Social Care Partnership (HSCP) describing their participation in the Scottish Patient Safety Programme (SPSP) – Reducing Pressure Ulcers in Care Homes Improvement Programme. This is an exciting new collaborative between five local care homes, East Dunbartonshire HSCP Teams, NHS GGC Clinical Governance Support Unit, NHS GGC Tissue Viability Service and Scottish Care (who represent the largest independent health and social care sector in Scotland). The programme aims to reduce pressure ulcers in care homes and will run from May 2016 until December 2017.

#### **4. Update on SPSP for Tissue Viability Acute Adult Programme**

##### **Background**

Tissue viability is a clinical specialty that seeks to ensure high quality of prevention and care for patients at risk of skin and soft tissue wounds including acute surgical wounds, pressure ulcers and all forms of leg ulceration. Pressure ulcers are an injury that occurs when the skin and underlying tissue breaks down as a result of various forms of pressure (sometimes known as 'bedsores' or 'pressure sores').

Pressure ulcer care forms part of the Scottish Patient Safety Programme and is organised around a national aim of “zero pressure ulcers or 300 days between hospital acquired pressure ulcers (grade 2-4) per ward or department by the end of December 2017”.

The governance sits within the broader role the Tissue Viability Steering Group and is reported to the Acute Services Division Clinical Governance Forum as part of its oversight role to Acute Adult SPSP.

##### **Key Points for update**

The Tissue Viability Specialist team has used the opportunity of SPSP implementation to contribute to the development of a revised risk assessment document, Pressure Ulcer Daily Risk Assessment (PUDRA). This new tool encompasses all of the best practices advocated by the SPSP care bundle. PUDRA has been rolled out to all acute wards.

The Tissue Viability Specialist team have instituted processes to enhance the quality assurance of grading hospital acquired pressure ulcers and for screening out wounds previously reported as pressure ulcers that were not. This is achieved through all hospital acquired damage being peer reviewed prior to being reported via the incident reporting module in Datix. The structure of reporting via Datix has also been enhanced.

Through this work Tissue Viability specialists have observed:

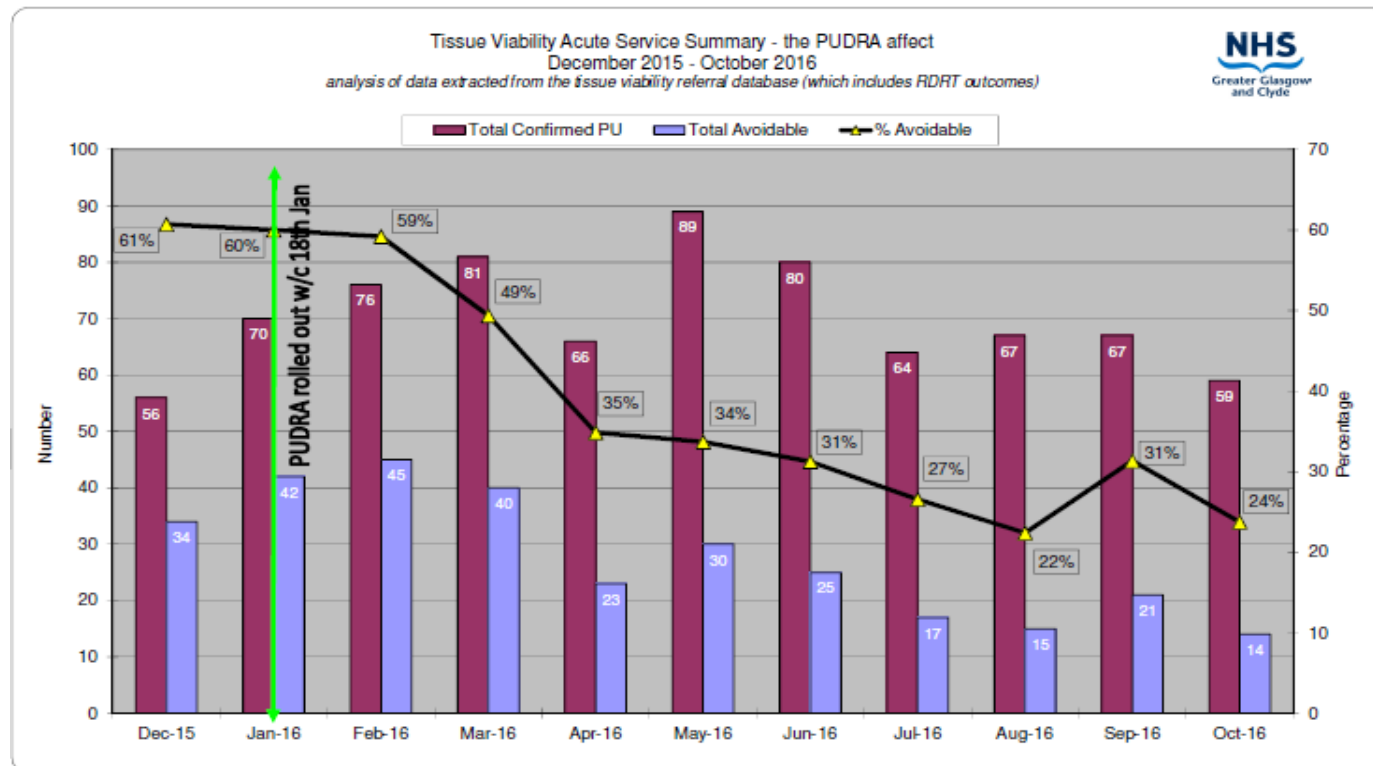
- the focus and priority in preventing pressure damage remains high
- the accuracy of reporting has improved
- there is more confidence in reported outcomes
- improvements can be demonstrated such as a reduction in Grades 3 and 4 pressure ulcers
- spread has been to every ward in every hospital and not restricted to the cohort of SPSP test wards
- education has therefore spread wider and faster than concentrating solely on test wards
- there is evidence that more than half of all wards have not reported acquired pressure damage over the last 3 months.

The cohort of teams declared as part of SPSP implementation remains small and does not reflect the broader activities involved in reducing the incidence of pressure acquired pressure ulcers. This is in part the result of limitations in providing support to ensure data collection for process measurement is not an excessive burden on the clinical team. It also reflects the decreasing sense of value in applying SPSP

methods in wards where it has been some time since patients have experienced acquired pressure damage.

## Impact

The following chart shows the impact of the implementation of PUDRA and the other supporting activities. All pressure ulcers reported were peer reviewed to establish whether indeed it was a pressure ulcer, to establish and agree the grade, and whether the ulcer was avoidable or unavoidable (If there are no identified defects in the application of current policy and clinical guidance the presumed unavoidable). This suggests a significant improvement is being observed with only fourteen patients reported as experiencing a potentially avoidable pressure ulcer in October.



## External Review

Healthcare Improvement Scotland is currently conducting a case review of learning around SPSP Tissue Viability. The following points were raised during the review meeting with NHS GG&C:

- The initial work to achieve pressure ulcer prevention and management within GGC was further advanced than the national programme. The Board is a valued source of advice and guidance to other parts of NHS Scotland.
- GGC is confident that the data being reported is amongst the most accurate being reported nationally, and is an accurate reflection of acquired pressure damage.
- It is now clear the SPSP for pressure ulcers has not been the singular driver for change and improvement within GGC. It has been challenging to try to create a 'fit' with the aims of the programme.
- In line with GG&C CAS measurement plan we should increasingly focus on outcome measurement with process measurement and improvement only deployed when outcomes need further improvement as a result of poor reliability in the clinical processes of care.

- The improvement methods in SPSP are however being used in creative ways. For instance on completion of a review of pressure damage teams complete an action plan, and use then PDSA cycles to improve and change practice. Any learning is then picked up by tissue viability nurses, shared at their team meetings and disseminated within their own hospitals and sectors.

### **Next Steps**

As it is increasingly recognised that there is mixture of improvement activities contributing to the observed improvements in quality the Tissue Viability Steering Group will be asked to endorse a NHS GG&C Improvement Programme, which selectively deploys SPSP to areas where the improvement methods match the nature of issue to be improved. This will include the proposal that GGC will only collect process measures (SPSP Measurement plan) from wards who have not achieved a continuous period of 90 days with no avoidable hospital acquired pressure ulcers. When teams achieve this outcome the process monitoring would stop. National reporting requirements will be modified to focus on outcome data. The future programme design should also seek to ensure that any opportunities for further prevention are maximised.

**Appendix One**  
**Scottish Patient Safety Programme: Glossary of Terms**

<b>SPSP</b>	Scottish Patient Safety Programme
<b>SPSP-MH</b>	Scottish Patient Safety Programme – Mental Health
<b>SPSP – PC</b>	Scottish Patient Safety Programme – Primary Care
<b>SPSPP</b>	Scottish Patient Safety Paediatric Programme
<b>CVC</b>	Central Venous Catheter
<b>CAUTI</b>	Catheter Associated Urinary Tract Infection
<b>DMARDs</b>	Disease Modifying Anti Rheumatic Drugs
<b>EWS</b>	Early Warning Scoring
<b>HAI</b>	Healthcare Associated Infection
<b>HDU</b>	High Dependency Unit
<b>HIS</b>	Healthcare Improvement Scotland
<b>HSMR</b>	Hospital Standardised Mortality Ratio
<b>IHI</b>	Institute for Healthcare Improvement
<b>ITU</b>	Intensive Care Unit
<b>ISD</b>	Information Services Division
<b>LES</b>	Local Enhanced Service
<b>LVSD</b>	Left Ventricular Systolic Dysfunction (heart failure)
<b>MCQIC</b>	Maternal Quality Care Improvement Collaborative
<b>MDT</b>	Multi Disciplinary Team
<b>NEWS</b>	National Early Warning Scoring
<b>PDSA</b>	Plan, Do, Study, Act (small scale, rapid, reflective tests used to try out ideas for improvement)
<b>PVC</b>	Peripheral Venous Cannula
<b>QOF</b>	Quality Outcomes Framework

<b>SBAR</b>	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.
<b>SMR</b>	Standardised Mortality Ratio
<b>SSI</b>	Surgical Site Infection
<b>SUM</b>	Safer Use of Medicines
<b>Surgical Briefing</b>	A pre-operative list briefing designed to ensure entire team understand expectations for the list and each procedure.
<b>Surgical Pause</b>	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.
<b>Trigger Tool</b>	A case note audit process designed to find examples where the care plan has not progressed as expected
<b>VAP</b>	Ventilator Associated Pneumonia
<b>VTE</b>	Venous Thromboembolism