

Borders NHS Board



PROGRESS REPORT ON SCOTTISH PATIENT SAFETY PROGRAMME IMPLEMENTATION FOR NHS BORDERS

Aim

This report is designed to update members of the Borders NHS Board of the current status of the Scottish Patient Safety Programme within NHS Borders.

Background

The information contained within the report is based on the activities of the NHS Borders General Hospital Work streams with the National Patient Safety programme.

Summary

Situation: The patient safety programme activities are now ongoing in all medical wards, the two general surgical wards and are beginning in Orthopaedics. Paediatrics, Obstetrics/Gynaecology and Accident & Emergency will be coming on to the programme during the next 3 months.

Background: All of the pilot teams have implemented the processes within their individual change packages and almost all are measuring the impact of these changes. There have been improvements demonstrated in all of the clinical work streams. The Leadership work stream are supporting and engaging in patient safety even further as we now have an Executive Director attached to each Work Stream.

Assessment: There is an improved culture and awareness of Patient Safety within the Borders General Hospital. There are better outcomes for patients due to the clinical interventions focussing on reducing harm to patients in medical and surgical care. Staff are learning from:

- a) the use of the Model for Improvement methodology;
- b) the data derived from the changes they have implemented;
- c) developing a mind set of 'how can we do things better'

Staff have risen to the challenge of collaboration in working with the various other improvement initiatives that are ongoing. Also working with the lead for quality measures to ensure patient safety is part of the overall quality and performance scorecard.

Recommendation

The Board is asked to **note** the content of the report and continue to support the patient safety programme going forward in 2010.

Policy/Strategy Implications	This report is in line with the NHS Scottish Patient Safety Programme
Consultation	Not applicable
Consultation with Professional Committees	Not Applicable
Risk Assessment	Not Applicable
Compliance with Board Policy requirements on Equality and Diversity	Yes
Resource/Staffing Implications	None

Approved by

Name	Designation	Name	Designation
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Author(s)

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Introduction

The Borders General Hospital is the pilot site for NHS Borders for the Scottish Patient Safety Programme (SPSP) which has been running now since January 2008. The main focus of the programme is to improve healthcare and safety for patients. This is a change management programme; the changes are achieved through altering the way that care is delivered, rather than by introducing new interventions. It is founded on evidence based interventions which, if well embedded into the culture of the organisation, will make care safer. The premise is that by reliably introducing evidenced based changes to practice, patient safety in Scotland will be significantly improved.

1. Background

1.1 Patient safety emerged as a headline health service priority in 2008. The five year Scottish Patient Safety Programme commenced in January 2008. The aim is to eradicate all avoidable harm and avoidable deaths. The current estimate is that 1 in 10 patients admitted to acute care suffer some kind of adverse event. The programme uses a number of change and improvement tools and techniques to improve safety and is focused on 5 work streams. (See strategy map attached) All 15 Boards in Scotland are involved; the acute units in all Boards are the pilot sites for the introduction of the programme prior to spreading to other sectors of the health services.

1.2 The first phase has been organised through NQIS with the support of the Institute of Healthcare Improvement (IHI) who are acting as the technical experts. National Lead Co-ordinators were appointed to support the roll out of the Patient Safety programme. The programme work is very closely aligned to other improvement initiatives in particular with the avoidance of Healthcare Associated Infections.

1.3 The programme has an Executive Sponsor (Director of Nursing and Midwifery), who oversees the programme implementation supported by a strategic lead for patient safety and quality and a programme manager. The programme manager oversees the day to day management of the programme's activities together with the planning and organisation for spread across the acute unit. A Clinical practice facilitator has been identified to provide extra capacity on the programme. The team sponsors and team leaders focus on each of their respective change packages for their areas. Progress is measured through monitoring of Processes i.e. changes that are tested and implemented such as Hand Hygiene and Outcome Measures - the results of the changes i.e. reduction in infection rates, see graphs attached in appendix 2

1.4 The benefits to be gained are that Hospitals should be able to demonstrate a system of leadership which reflects safety as a strategic priority throughout its structure, where adverse events are reduced and staff are involved in and directly concerned with *improving* the quality of healthcare and measuring outcomes of care as part of their daily work. The patient benefits are that they are less likely to come to unintended harm as a result of the conscious efforts to improve care management and reduce risks to patients.

Patient safety in NHS Borders has been identified as the top strategic objective. A steering group meets monthly to oversee the implementation of the programme.

2. Implementation

2.1 Faculty Visit

NHS Borders was visited by the IHI/NQIS Faculty Team in March of this year. The final feedback report has not yet been received but the feedback on the day as well as the draft copy sent was very helpful and positive. An action plan, based on the recommendations made by Faculty has been drawn up and is the basis for our regular monthly feedback reports by the Team leaders to the Patient Safety Steering Group.

2.2 Overview of current status of Process and Outcome Measures for the Patient Safety Programme

All of five pilot teams are implementing the changes within their work stream change packages and most of these changes are also being measured. The programme activities have been spread to all medical wards, two surgical wards and the orthopaedic ward is in the early stages of implementing the general ward change package. Paediatrics is on line to commence the programme this summer; a National Event is scheduled for later this month. Obstetrics and Gynaecology are the next areas to adopt the programme and discussions are taking place with Accident & Emergency Department.

Pilot Team	Outcome Measures Total	Current Status	Process Measures Total	Current Status
Critical Care	9	100%	9	100%
General Ward	5	100%	10	90%
Leadership	0	0	2	100%
Medicines Management	0	0	3	100%
Perioperative	1	100%	7	90%
All Hospital	3	2	0	0

Institute of Healthcare Improvement Assessment Scale

2.0	Improvement noted (using run chart rules) in process and/or outcome measures for pilot populations in three or more work streams.	Jan 09
2.5	Improvement noted (using run chart rules) in process and/or outcome measures for pilot populations in all five work streams.	Apr 09
3.0	All key changes in all five work streams have been implemented in the pilot populations. Sustained improvement ¹ noted (using run chart rules) in related process and outcome measures in one to three pilot populations.	Jul 09
3.5	Sustained improvement (three months without sliding backwards) is noted in process and outcome measures for pilot populations in all five work streams. Spread (including testing, training, communication, etc.) of all key changes is underway beyond the pilot populations.	Jan 10

1. Sustained improvement is maintaining the new level of performance (with consideration for a little variation around the new level of improvement, i.e., +/- 5%) for 3 reporting periods (months) to be considered "sustained." If the improvement is

followed by a return to the previous level of performance, the site will still get credit for the improvement but not for sustaining the improvement. It takes 3 months at the new level of performance in order to be considered a sustained measure.

Due to the time it has taken to set up systems, test changes and implement them, we do not have sufficient data to apply run chart rules in the process and outcome measures in all five work streams therefore we have not yet reached the 3.5 level. It should be noted that across Scotland there are 9 Boards at 2.5 and only one Board at level 3.

2.3 NHS Borders Board Trajectory – Patient Safety Programme

5															
4.5															
4															Board trajectory
3.5															actual status to date
3															IHI trajectory
2.5															
2															
1.5															
1															
0.5															
	Jan -08	Apr -08	Jul- 08	Jan -09	Apr -09	Jul- 09	Jan -10	Jan -11	Jan -12	Dec -12					

3. Progress within work streams

3.1 Leadership

The main impact that leadership has on our safety culture is the message to staff that patient safety is the primary Corporate Objective. This statement is further supported by the Patient Safety Walkrounds which are placing a high focus on the national infection control standards

3.2 Critical Care

The intensive care unit has successfully implemented the care bundles (a collection of evidenced based interventions) to reduce central line infection and ventilator associated pneumonia for example there have been no Central Line Infections for over 545 patient days in the unit. The work of this team has been highlighted to other Boards by the Faculty and the team presented their work at the National Learning Event in Glasgow

3.3 Peri-operative Care

The work stream has introduced surgical safety briefings and pauses (checklists), which focus attention on crucial human factors within peri-operative practice. Close working with the theatre LEAN initiative has produced improved communications, better time management and generally a more efficient and effective working environment

3.4 Medicines Management

Work stream has improved the process for management of patient's drug history on admission and checking that any changes to drugs are fully documented and correct. Work is in progress on reviewing cases for adverse drug events.

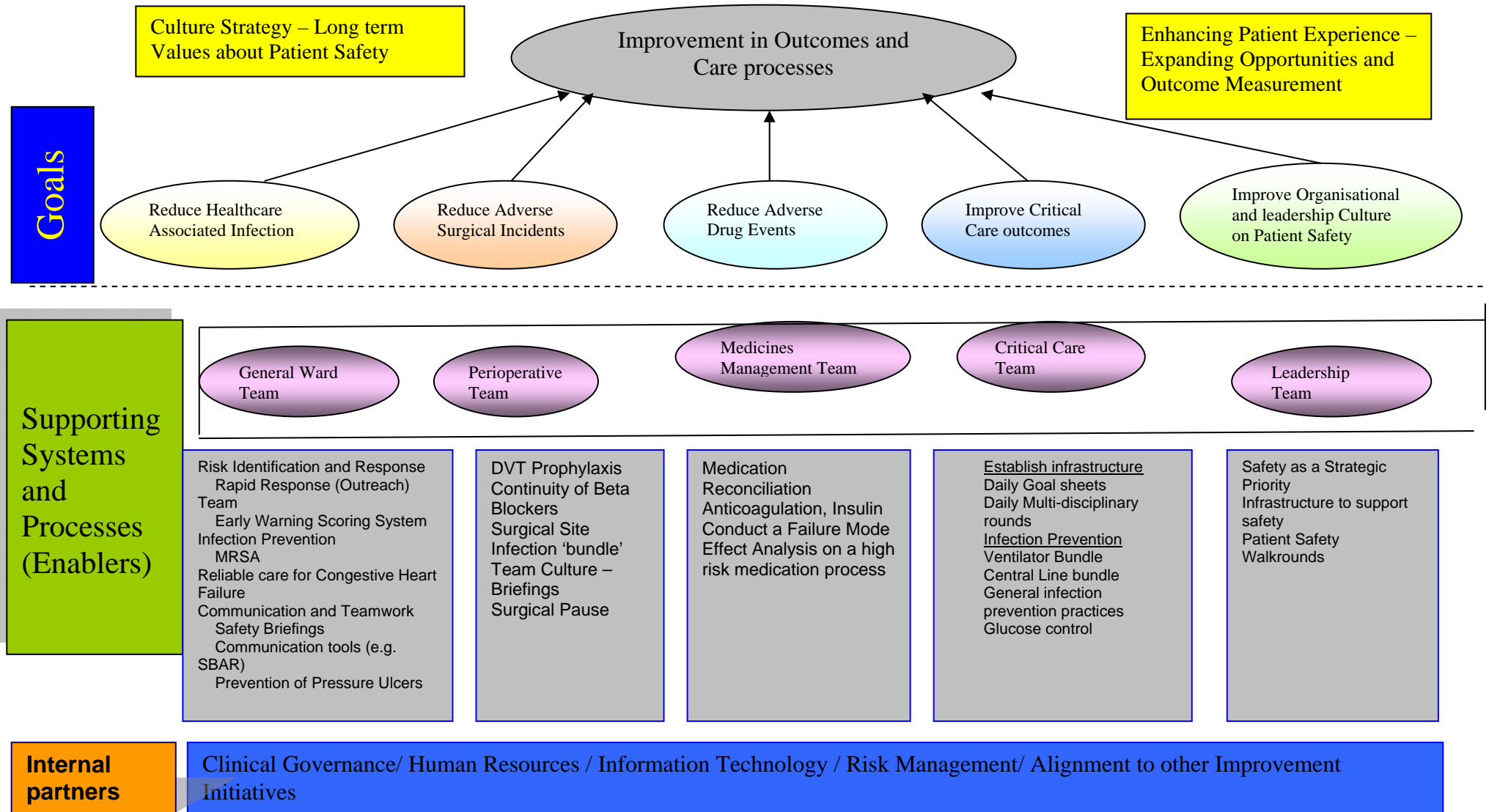
3.5 General Ward

Recognition of sick patient, introduction of Peripheral Vascular Catheter (PVC) Bundles to prevent infection, the use of the communication tool SBAR - *Situation Background, Assessment and Recommendation*, Safety Briefings, Adverse event case note reviews. These are all changes that have been implemented and are being measured. These activities support the improved outcomes for patients in fewer crash calls, improved communications particularly to the outreach team and the safety briefings which have been proven to reduce adverse events and near misses.

Following on from learning session 6, the staff found the team de-briefing sessions very helpful and have requested that we repeat this exercise locally. The team session is being planned for the summer. This will be for as many of the staff in the work streams who can attend to discuss their own activities, experiences, exchange ideas and generally help each other in maintaining the tempo and motivation.

PATIENT SAFETY PROGRAMME STRATEGY MAP

NHS Borders priority is to provide care to patients that is Safe, Timely, Effective, Efficient Equitable and is Patient and Family Centered



Related Process and Outcome Measures- Compliance with Hand Hygiene process and Infection rates in ITU

