Scottish Patient Safety Programme
Report by Pat Tyrrell, Lead Nurse

The CHP Committee is asked to:
• Note the contents of the report.

1. Situation

The Scottish Patient Safety Programme began at Lorn and Islands Hospital in Oban in December 2008. It is an evidence based programme designed to improve the safety and reliability of hospital care throughout Scotland. The programme has had high level of staff engagement throughout the hospital; baseline information has demonstrated areas for improvement and the change methodology has been very acceptable to staff.

2. Background

In March 2007, the Scottish Government launched the Scottish Patient Safety Alliance (SPSA). The Scottish Patient Safety Programme (SPSP) is the first major programme of work to be introduced by SPSA. SPSP is led by NHS Healthcare Improvement Scotland (NHS HIS) and has a technical partner, the Institute for Healthcare Improvement (IHI). SPSP’s National Co-ordinator Ros Gray works closely with Jason Leitch, the National Clinical Lead for Safety and Quality from the Scottish Government.

SPSP aims to systematically improve the safety and reliability of hospital care throughout Scotland. By building capacity and capability in the improvement methodology, they are developing a sustainable infrastructure for continuous quality improvement. Scotland was the first country to take this strategic, national approach to improving patient safety. Through SPSP the aim is to reduce adverse events by 30% and mortality by 15%. Improving everyday practice SPSP recognises the complexities involved in delivering modern healthcare and the need to standardise our approach to making care safer.

FIVE KEY WORKSTREAMS:

• Leadership
• Critical care
• General ward
• Medicines management
• Peri-operative.

SPSP believes that by reliably introducing evidence-based changes to practice, patient safety in Scotland will be significantly improved. The approach is an inclusive one, engaging NHS staff and public partners and facilitating each NHS board on a multidisciplinary level. Through national learning sessions, networking and capacity building events participants have learned about improvement methodology and how to implement specific programme interventions. SPSP arranged on-site support visits and facilitated the sharing of local findings and good practice among those leading safety improvements within their hospital or NHS board. They have hosted a series
of national, strategic integration meetings collaborating with partners aimed at aligning and integrating other national initiatives and programmes of work. SPSP vision is an NHS where SPSP methodologies are embedded into everyday practice.

The Scottish Patient Safety Programme recognises the complexities involved in delivering modern healthcare, and so it has been designed to standardise approaches to care. There is good research to show which interventions make a difference when it comes to protecting patient safety, and these will be implemented uniformly in acute hospitals across the country.

Over the next five years, steps will be taken to:

- Ensure early interventions for deteriorating patients
- Deliver evidence-based care to prevent deaths from heart attack
- Prevent adverse drug events
- Prevent central line infections
- Prevent surgical site infections
- Prevent ventilator associated pneumonia
- Prevent pressure ulcers
- Reduce staphylococcus aureus (MRSA plus MSSA) infection
- Prevent harm from high alert medications
- Reduce surgical complications
- Deliver evidence-based care for congestive heart failure
- Drive a change in the safety culture in NHS organisations

3. Assessment

The work in the Rural General Hospitals in Highland has demonstrated that not all elements of the work streams are relevant; because the throughput of patients has been lower than in the major centres where the programme originated, modification of some of the tools and data collection processes has had to take place.

The dashboard report included in Appendix One highlights the performance at Lorn and Islands Hospital in June 2011.

Current focus in the hospital is on the following areas:

- High INRs and Warfarin management.
- Medicines Reconciliation and education with new Junior Doctors
- Mortality review

Recent review of the work at Lorn and Islands Hospital was undertaken by the Scottish Faculty. The draft report of the visit is very positive and the final version is awaited. Some of the feedback included:

- Fantastic improvement work and creative structure of improvement workstreams managed consistently during extensive organisational change.
- Enthused and exited staff who shared their work with impressive and dramatic presentations in the morning.
As the approach and the learning from Lorn and Islands is rolled out across the Community Hospitals the main areas of focus are on the following three workstreams:

- Leadership
- General Ward
- Medicines Management

Work already underway in the Community Hospitals includes:

- Care bundles for PVC/CVC care
- Scottish Early Warning Scoring System
- Safety Briefings
- Daily Board Rounds

Further structure is required to embed the approach and the programme across Argyll and Bute. This will be an integral part of the Quality and Patient Safety framework and outcomes will be reported through the CHP clinical dashboard. NHS Highland Clinical Governance Committee is currently reviewing what performance indicators and measures will be contained within the dashboard.

Work is also progressing at national level to roll this programme out across all healthcare settings, including both mental health and primary care. It is anticipated that there be further support for local areas to learn and implement the improvement methodologies that have been instrumental in achieving the clinical engagement that has led to the success of this approach.