Borders NHS Board

SCOTTISH PATIENT SAFETY PROGRAMME (SPSP) REPORT – JULY 2011

Aim

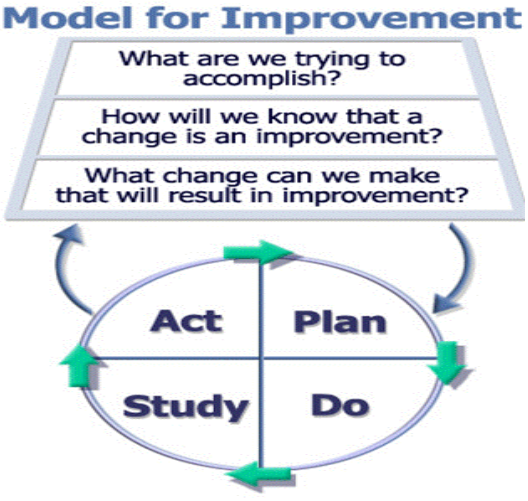
The aim of this report is to update the Board on progress with the implementation of the SPSP, taking forward the standardisation of improvement methodology, using evidence based interventions and measuring the improvement levels throughout the project. The Board are reminded of the programme goals which are to:

- Reduce Healthcare Associated Infection
- Reduce Adverse Surgical Events
- Reduce Adverse Drug Events
- Improve Critical Care Outcomes
- Improve Organisational and leadership Culture on Patient Safety

NHS Borders was visited by the Health Improvement Faculty Team on the 9th June 2011. The purpose of this visit was to support the Board in the implementation of the Programme, provide guidance and discuss any challenges that we face. The visiting team was also very keen to learn about our successes and to offer us suggestions to further our improvement work. During the course of the visit, the team met with members from each of the work stream teams as well as visiting the clinical areas, talking to the frontline staff and viewing our patient safety boards within the clinical areas. Feedback following the visit was very positive and we have since received the draft report which has been circulated to all staff who were involved for comment. The final report will be published in due course.

The Faculty agreed that we could de-escalate some of the measures in the Critical Care Team and the Peri-operative Team as they were considered to be sustained. These measures will now be reviewed on a quarterly basis. This will allow the teams to turn their focus onto other aspects of patient safety that they wanted to work on using the same methodology which will be to create new Driver Diagrams and begin testing the new processes. This is an excellent example of the application of the Model for Improvement whereby the staff have made changes, demonstrated improvement and now wish to address the third section of the model which is to make more changes. See diagram 1

Diagram 1



An action plan has been compiled based on the recommendations in the draft report which will be monitored by the Patient Safety Steering Group.

As indicated in the previous report, the main focus now needs to be on the spread and sustainability of the successes which have been made. It is acknowledged that this phase is the most difficult. According to the Institute of Healthcare Improvement (IHI), delivering on this kind of project, there has to be success in three areas: the need to generate the w*ill* to pursue the changes despite the difficulties and competing demands on staff, time and resources; *ideas* that will help to transform the service; and finally, the need to *execute* those ideas effectively to achieve the improvement required. IHI suggest that from their experience, '*Execution'* is the weak link.

There is also increased attention being paid to the high level goal of the programme which is to examine the Mortality Rates of each Board. Although NHS Borders has a consistently low hospital mortality rate, the faculty team were encouraging us to complete a review of 50 in hospital deaths, and to review the trend of increased deaths over the winter months. A Driver Diagram of how this review of mortality could be implemented has been drawn up and will be taken to the Patient Steering Group for agreement. See diagram 2

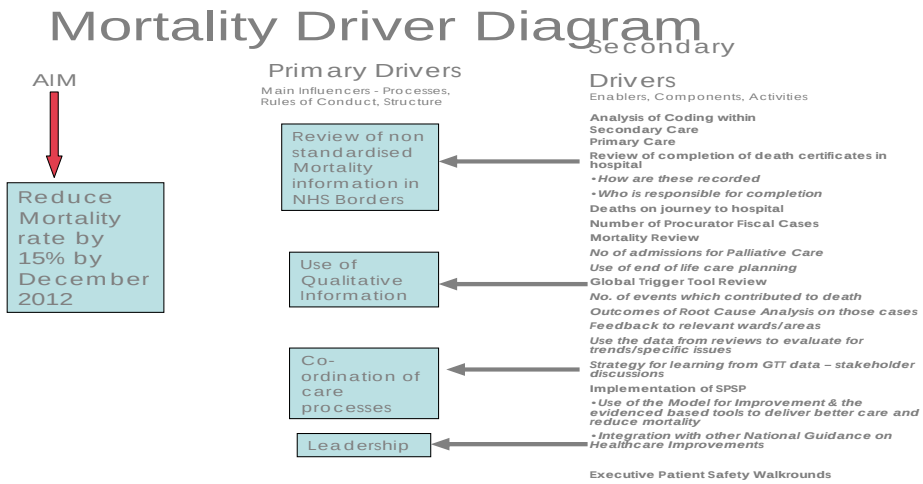


Diagram 2

Paediatric Patient Safety Programme

The Paediatric team has been in collaboration with NHS Lothian to learn the techniques of using the Global Trigger Tool to run their monthly case note reviews. The Faculty Team were very impressed with the work that the Paediatric team had already set up. The main challenge currently is setting up the systems to collect the data for measurement.

Safety in Primary Care 2nd phase (SIPC2)

The project has recruited 5 GP practices. A local dedicated core team has been set up. High and low level mapping sessions involving primary and secondary care colleagues have been conducted exploring the 'sample journey'. Presently the work is on prioritising the measures according to the actions and opportunities identified. The next stage will be to address the creation of a 'bundle' to:

- ensure safe management of both 'normal' and 'abnormal' blood results;

- reconciliation of blood tests leaving the practice and the results being acted upon;
- universal best practice management processes for safe handling of blood borne virus's; and,
- urgent results which originate in primary care.

The next step is a national two day workshop at the end of September to which all recruited practices are invited to.

Scottish Patient Safety in Mental Health Programme (SPSMHP)

The finalised version of the programme has not yet been published. However, there is work ongoing on the commencement of medication reconciliation within mental health. The staff are testing the process using the PDSA model.

Recommendation

The Board is asked to **note** the continuing steady progress of this programme and it impact on safer patient care.

Policy/Strategy Implications	This report is in line with the Scottish Patient Safety Programme (SPSP) objectives
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 identified

Approved by

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