THE SCOTTISH PATIENT SAFETY PROGRAMME (SPSP)
NHS FIFE UPDATE REPORT

1 PURPOSE OF THE REPORT
The purpose of this report is to update the Board of the ongoing activity underway across NHS Fife to implement the Scottish Patient Safety Programme (SPSP). This report covers December 2014 and January 2015 and provides a brief overview of the programme.

2 SITUATION
There are currently four national strands of the Scottish Patient Safety Programme in operation within NHS Fife; in addition the three CHPs have implemented appropriate elements of the Acute Adult Programme locally.

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The specific aims and objectives of each of the strands are outlined below.

3 BACKGROUND

3.1 Acute Adult Aims:

Reduce HSMR by 20% by December 2015.

95% of people in acute adult health care free from the three harms of the Scottish Patient Safety Indicator (SPSI 3)

- Cardiac Arrest
- Pressure Ulcers
- Falls

(The Catheter Associated Urinary Tract Infection outcome measure (CAUTI) was withdrawn from the “SPSI 4” in September 2014 until consensus around an outcome definition is agreed.)
To implement the ten essentials and nine priorities outlined in CEL 19.

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3.2 **McQIC Aims (Maternity Aims)**

Increase the percentage of women satisfied with their experience of maternity care to > 95% by 2015,

Reduce the incidence of avoidable harm in women and babies by 30% by 2015 by:

- reducing stillbirths and neonatal mortality by 15%
- reducing severe post-partum haemorrhage (PPH) by 30%
- reducing the incidence of non-medically indicated elective deliveries prior to 39 weeks gestation by 30%
- offering all women carbon monoxide (CO) monitoring at the booking for antenatal care appointment
- referring 90% of women who have raised CO levels or who are smokers to smoking cessation services
- providing a tailored package of antenatal care to all women who continue to smoke during pregnancy

3.3 **McQIC Aims (Paediatric)**

Reduce avoidable harm by 30% by December 2015 by focusing on:

- Serious safety events
- Ventilator assisted pneumonia
- Central venous catheter blood stream infection
- Unplanned admission to intensive care
- Medicines harm, and
- Child protection harm

3.4 **McQIC Aims (Neonatal):**

Reduce avoidable harm in neonatal services by December 2015 by focusing on:

- harm from mechanical ventilation
- harm from invasive lines
- high risk medicines
- harm from transitions of care
3.5 Primary Care Aims

Reduce the number of events which could cause avoidable harm from healthcare delivered in any primary care setting by focusing on:

- **Safety Culture**: improving patient safety through the use of trigger tools (structured case note reviews) and safety climate surveys
- **Safer Medicines**: including the prescribing and monitoring of high risk medications, such as warfarin and disease-modifying anti-rheumatic drugs (DMARDs), and developing reliable systems for medication reconciliation in the community.
- **Safety across the Interface** by focusing on developing reliable systems for handling written and electronic communication and implementing measures to ensure reliable care for patients.

3.6 Mental Health Aims

Reduce harm experienced by people receiving care from mental health services in Scotland by September 2016 by focusing on:

- Risk assessment and safety planning
- Restraint and seclusion
- Safer medicines management
- Communication at transitions
- Leadership and culture

4 ASSESSMENT

4.1 HSMR

*Chart 1* demonstrates NHS Fife’s HSMR in comparison to NHS Scotland.
The HSMR rate in NHS Fife at the time of the most recent report is 0.78. A reduction of 22% has been achieved since Dec 2007.

A regression line from Dec 2007 to June 2008 is used to smooth out seasonal variations in HSMR and to monitor long term change. The end of the baseline year is denoted by the vertical red line.

4.2 SPSI

Cardiac Arrests/Deteriorating Patient
We have not yet seen a significant drop in the number of cardiac arrests within NHS Fife. Testing of the Scottish Structured Response and Review did not go ahead as expected but testing is due to commence in one ward during February.

The Patientrack electronic system which automates the collation of patient observations and alerts Doctors of deterioration in a patient’s condition is being rolled out across the Acute Division. The system uses the National Early Warning Score (NEWS) system to highlight patients at risk of deteriorating. The system is now operational in thirteen wards to varying degrees. Four wards have adopted the system in its entirety, eight wards are running a partial system and one ward is currently being trained to use the system.

The system provides an automated forcing function to ensure that physiological observations are recorded in a timely fashion, that the observation score is calculated accurately and that an alert is sent to a Doctor if the NEWS score is triggered. Training has been delivered in the Medical Assessment Unit in preparation for implementation.

When the EWS score is triggered (using Patientrack or the paper version) the patient should be screened for sepsis and delirium.

The Sepsis six bundle has been implemented in four clinical areas:

- Accident and Emergency
- Medical Admissions Unit
- Surgical Admissions Unit
- Haematology Unit.
Chart 3 demonstrates an increase in the number of patients that have screened positively for sepsis within the Accident and Emergency Department and commenced on the Sepsis Six care pathway.

The Sepsis Six Pathway comprises of six interventions that are applied to improve the patient’s outcome if sepsis is suspected or present. Sepsis Six trolleys are situated within the department to facilitate rapid delivery of the elements contained in the pathway.

Since the sepsis six work began, 1219 patients have screened positively and received the elements of the sepsis care pathway.

**Pressure Ulcers**

During December a review of patients with a pressure ulcer recorded on the datix system was undertaken since a rise in the number of pressure ulcers had been highlighted. The findings of the review highlighted issues around multiple recording of pressure ulcers on the datix system and lack of a standardised approach around pressure ulcer care and subsequent guidance.

A short term working group with key stakeholders was convened to address this issue and to develop a plan to implement a Fife-wide approach to pressure ulcer improvement activity.

**Falls**

Following the call to action for falls during 2014 a number of improvement activities are underway across NHS Fife.

These include:

- Comfort rounds for all patients tiered to their needs
- Falls Risk Patient information leaflets / posters
• Provision of appropriate footwear if required
• Frailty screening tool incorporated into paperwork
• Robust frailty screening process to ensure that all patients have a frailty screen carried out
• New falls pathway reviewed – standardised across Fife (as appropriate – e.g. escalation process)
• Patient centred falls care plan
• Removed documentation from the wards
• Amalgamated 3 bundles into 1 measurement tool
• Currently developing post falls bundle
• Launch of falls prevention elearning module

CAUTI
The CAUTI maintenance bundles have been widely implemented across NHS Fife. In Glenrothes and North East Fife CHP, the team have provided some focussed improvement work around CAUTIs:

• From October 2014 all suspected CAUTIs now have a Rapid Event Investigation completed by the Infection Control Nurse
• The CAUTI Management Bundle was implemented in October 2014
• 3 month Urinary Catheter Audit Report January 2015
• The team found that the appropriate prescribing management for first line treatment was good but that the duration of treatment was inconsistent with the SAPG decision aid.

The team found that the most common reason for urinary catheterisation on admission to acute hospitals was for the management of acute urinary retention. Appropriate prescribing in the management of confirmed CAUTIs – good first line treatment however length of treatment is inconsistent with SAPG Decision aid.

Work is underway in the Acute Division to evaluate the bundle implementation and support staff with implementing the insertion bundle.

A short term NHS Fife working group is being convened to share the learning and to ensure that a NHS Fife approach is to improvement around CAUTI.

4.3 Ten Essentials Update

A Quality Assurance Framework has been developed to capture the implementation and spread of the ten essentials within NHS Fife. The framework has been developed to ensure that each clinical area defines the improvement processes that should be implemented and also provides prompts for staff to consider how they might validate sustained improvement and action lack of improvement.

The tool encourages the Senior Charge Nurses to consider how the wider team engage with the improvement interventions; the processes link to key indicator outcomes that improve patient care and the actions that should be taken going forward to either sustain improvement or improve process compliance.

A Clinical Dashboard is currently being developed to provide improvement and performance data that can be widely accessed by clinical staff at ward level and also by senior management.

The system will extract data from the LANQIP system which has recently been upgraded.

The project team is aiming to eventually migrate all of the input data for SPSP and CQI from the various systems currently in place, topic by topic. The Project Team are meeting every two weeks to progress the work at pace.
Hand Hygiene: Implemented widely throughout NHS Fife. Hand hygiene is the first SPSP measure that will be migrated onto LANQIP along with SAB and cdifficile output data. The measure has already been tested by the Project Team and will be tested by three wards before wider rollout.

Leadership Walkrounds: Embedded in the organisation.

Surgical Brief and Pause: Embedded in the organisation

General Ward Safety Brief: Widely implemented

ICU Daily Goals: Implemented in ICU

Ventilator Associated Pneumonia Bundles: Embedded in ICU: The team had achieved 296 days without a VAP but during October there has been two incidents that are awaiting a review to confirm that the suspected VAPs have been correctly diagnosed

Early Warning Scoring: Widely implemented. We are linking with the Patientrack Team to request compliance with the EWS measures. Due to the forcing functions of the system, one of the measures will always reach 100% compliance.

Central Venous Catheter Insertion Bundle: Embedded within Critical Care areas

Central Venous Maintenance Bundle: Embedded within Critical Care areas. The last central line infection in ICU occurred in July 2012

Peripheral Venous Cannula Bundle: Widely implemented.

4.4 Directorate / CHP Update

Emergency Care Directorate:

The Directorate identified some areas with gaps in their compliance data and as a result of this the actions to be taken forward are:

- All areas that reach sustained improvement will have a validation process applied
- All wards will complete Quality Assurance Framework document
- Falls bundle will be rolled out across ECD
- Falls and pressure ulcer outcome data will be displayed in ward areas.
- Safety cross for falls and pressure ulcers will be displayed in all areas
- Safety briefs / ward huddles are used to highlight patients at high risk of falling.
- Improvement data will be discussed as a standing agenda item at all CNM /HON 1:1 meetings and action plans implemented to address any gaps in data or areas of concern
- Pressure cluster review process continues to be used for collective learning from grade3 /4 pressure ulcers

Planned Care Directorate:

A number of wards have reached sustained improvement. The Directorate plan to carry out peer reviews to validate that they are assured of this position.
The Directorate reported 325 falls between 1/12/2013 and 31/1/2015. A review will be carried out across three wards to understand the reasons for the falls in each of the areas. The wards that will be reviewed will be areas reporting the lowest, middle range and highest reporting areas to determine if there are any evident themes and/or trends that can be addressed and to ensure that the learning is shared in the other clinical areas.

A random sample of patient falls will be audited by reviewing the notes and using the post falls bundle to evaluate whether all of the processes were in place prior to the patient falling.

The team are planning to print falls outcome data as charts and display in each of the wards to ensure that progress is evident.

Patients at a high risk of falling are currently highlighted on the safety brief to ensure that there is a heightened awareness of patients at risk to ensure that processes are in place to reduce their risks.

The falls bundles are in place in each of the wards.

**Ambulatory Care:**

The Directorate have completed a gap analysis to determine the number of areas that should be implementing SPSP improvement processes. The team identified eleven areas that could in whole or part implement some of the ten essential measures.

The team had been collecting hand hygiene data and some areas had implemented safety briefs but this had not been peer reviewed. A plan is being put into place to ensure that the compliance is validated using the Assurance Framework.

The team has been reviewing the measures and plan to adapt some of the tools so that they are fit for purpose for the teams to use.

The directorate plan to increase the data collection over all areas and produce an implementation plan

**G&NEF CHP:**

The team has implemented the falls pathway documentation in their in-patient hospitals. The team reported that the number of falls has reduced.

Following the first meeting of the Short Life Tissue Viability Working Group, the CHP are planning to test a new system with the risk team to reduce the duplication of pressure ulcers that are currently recorded. The results of testing will be shared with the other CHPs and the Acute Division.

The Team are in the process of rolling out the Fife Early Warning system in their community hospitals

**K&LM CHP:**

Since 2009 there have been a number of services within the CHP who have been implementing and reporting on a number of Adult SPSP measures:

- Older People Inpatient Wards
- Rehabilitation Inpatient Ward
- Hospital @ Home
- Community Nursing
- Mental Health Service
- Heart Disease MCN

The team has populated the assurance framework to ensure that the relevant improvement processes
are implemented in all of the appropriate areas. The mental health measures will be available for the next report.

The heart failure service is managed by K&LM CHP and an update will be available for the next report.

**D&WF CHP:**

The team are in the process of completing a gap analysis to determine the number of areas that should be implementing SPSP improvement processes.

The team has reflected that the introduction of the SAER process for pressure ulcers of grades 3 and 4 has helped the community and hospital at home staff to understand the importance of accurate reporting on Datix. The improved documentation provides a clearer understanding of how concerns and issues are escalated and provided some very rich learning. Feedback from the staff participating in the exercises has been very positive.

Actions from the SAERs are now on the Reducing Harm Action plan which in turn will ensure that wider learning is shared within the organisation.

4.5. **McQIC Maternity**

The Maternity Unit has been participating in the MCQIC programme since its launch in March 2013.

A Combined MCQIC and Early Years Collaborative (EYC) group has been established to oversee the delivery of the key aims and outcomes of MCQIC and Workstream 1 of the EYC.

The improvement work is focused around four primary drivers. Person Centred Care, Leadership and Culture, Teamwork, Communication and Collaboration and Safe and Effective Care.

The team recommendations include:

- Working towards key measure MP03 (providing a tailored package of care for women with CO levels ≥ 4 testing commenced January 2015 Antenatal Clinic (Victoria Hospital)
- Undertake the Safety Culture Survey – testing of the survey question in paper and electronic format now planned
- Implementing the PPH Prevention Bundle – change ideas for testing have been identified
- Testing VTE risk assessment on admission to the antenatal ward
- Demonstrate improvement with MP11 (Significant Adverse Event Debrief)
- Spread outwith the pilot sites

The Maternity Unit is also participating in two national studies aimed at reducing the number of stillbirths:

**Growth Assessment Protocol (GAP) with the Perinatal Institute** aimed at detecting fetal growth problems

**AFFIRM** – Edinburgh University, awareness of fetal movements and management of women who present with fetal movements.

The team has recently developed an action plan aimed at reducing the number of surgical site infections following caesarean sections.

Other improvement initiatives include:

- Communication & collaboration on transition between services - testing on how to improving
transition of care between Community Midwife and Health Visitor

- Income Maximization - Increasing midwives knowledge of Money Matters services and referrals to service
- Promoting attachment – extending skin to skin time following birth to beyond one hour, encouraging skin to skin in the postnatal ward and ongoing as part of daily routine
- Smoking Cessation – ongoing support for women postnatally from Smoking Cessation services.

**Challenges**

Undertaking the Safety Culture Survey within the whole unit

**McQIC Neonatal**

The team have embedded the key elements of the Neonatal strand. The team plan to start implementing the “Intubation Pause”, the “Warm Bundle” and ensuring the a consultation with parents by an experienced clinician in the Neonatal team is carried out within 24 hours of admission.

The “Warm Bundle” is applied to newborn infants with the aim of reducing hypothermia which is an important cause of morbidity and mortality for these babies.

**McQIC Paediatric**

The team has embedded a number of improvement measures and reduced compliance reporting to six monthly. The team are planning to audit compliance to validate their position.

The team are collecting sepsis 6 data but not yet reporting on the paediatric tool. This will be taken forward by the HDU team.

A naso gastric bundle was developed in house by the team. Data collection has started and the team plan to start reporting using a measurement tool.

The team recently developed a “Prescribing Corner” which was introduced with an aim to reduce prescribing errors and introduced the “Improvement Tree” where parents leave feedback in the shape of leaves on a tree, these are then entered into a “you said, we did” book that shares improvements.

4.6 **PRIMARY CARE**

The key pieces of work being taken forward in the Primary Care strand include:

- Medicines Reconciliation (the requirement of the LES are that ten Immediate Discharge Documents will be reviewed to determine application of the medicines bundle)
- Patient Involvement
- Warfarin
- Trigger tool reviews
- Patient Safety Survey

5 **Capacity / Events**

The fifth McQIC Learning Session took place on 5th February 2015.

The first Acute Adult South East Regional Event is taking place on 17th February. 28 delegates are
GOVERNANCE ARRANGEMENTS
The reporting process is currently being reviewed

RECOMMENDATIONS
The Board is asked to:
- Note the overview of progress for each work stream.
- Advise on aspects of the report that they found valuable and if they would value continuing reports in this format.

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Executive Sponsor for SPSP
11th February 2015

Mrs CATHY GILVEAR
Patient Safety Programme Manager