The Scottish Patient Safety Programme (SPSP)

Introduction
In September 2007 QIS announced that the Institute for Healthcare Improvement (IHI) were to be the technical partners for the Scottish Patient Safety Programme. The IHI are based in Boston in the USA and are world leaders in patient safety improvement work. Scotland is the first country in the world to adopt improvement work on a national scale.

The SPSP was commenced in October 2007 and this involved all Health Boards completing pre-work and submitting initial data to QIS in December 2007. Initially this programme will focus in acute hospital settings and has the main aims of:

- Reducing mortality by 15% in 3 years
- Reducing adverse events by 30% in 3 years

The five basic programme objectives are to:

- Reduce healthcare associated infections
- Reduce adverse surgical incidents
- Reduce adverse drug events
- Improve critical care outcomes
- Improve the organisation and leadership on safety

As the programme develops it will encompass other service areas, and involve community settings and Primary Care service areas. The national drive for excellence will involve the whole of NHSScotland within five years. Scotland is therefore at the forefront in patient safety having agreed to adopt a whole healthcare system approach.

There are key national Learning Sessions each year where the key staff taking forward the work within each Board will attend. This includes Chief Executives, Directors, Frontline Clinical staff and Clinical Governance Risk Management Unit staff. Action Sessions take place between the Learning Sessions in which each of the five workstreams will undertake a variety of work.

<table>
<thead>
<tr>
<th>Work Stream</th>
<th>Change Package Element</th>
</tr>
</thead>
<tbody>
<tr>
<td>Leadership</td>
<td>• Infrastructure to support safety</td>
</tr>
<tr>
<td></td>
<td>• Walkrounds</td>
</tr>
<tr>
<td></td>
<td>• Safety a strategic priority</td>
</tr>
<tr>
<td>Medicines Management</td>
<td>• Medicines reconciliation</td>
</tr>
<tr>
<td></td>
<td>• Reliable processes for Anticoagulation &amp; Insulin,</td>
</tr>
<tr>
<td></td>
<td>• Conduct an Failure Modes Effect Analysis (FMEA) on high risk medication process</td>
</tr>
</tbody>
</table>
| Critical Care | • Establish infrastructure  
|              |   - Daily goal sheets  
|              |   - Daily multi-disciplinary rounds  
|              | • Infection Prevention  
|              |   - Ventilator bundle  
|              |   - Central line bundle  
|              |   - General infection prevention practices  
|              |   - Glucose control (ITU then to HDU)  
|              |   - Hand Hygiene compliance  
| General Ward | • Risk Identification and Response  
|              |   - Rapid response (Outreach) teams  
|              |   - Early warning system  
|              | • Infection Prevention  
|              |   - MRSA/MSSA/C Dif  
|              |   - Peripheral Vascular Cannulae bundle  
|              |   - Hand Hygiene compliance  
|              | • Reliable care for Congestive heart failure  
|              | • Communication and Teamwork  
|              |   - Safety briefings  
|              |   - Communication tools (e.g. SBAR)  
|              |   - Prevention pressure ulcers  
| Perioperative | • DVT prophylaxis  
|              | • Antibiotic prophylaxis  
|              | • Continuity of Beta blockers  
|              | • Surgical site infection bundle  
|              | • Team culture – briefings  

The model for roll out of the programme involves slow steady growth, building success and enthusiasm, rather than a whole organisation immediate approach. To achieve this the model for improvement will be adopted. This is the small rapid cycle change process of Plan Do Study Act (PDSA).

Each of the pilot areas are carrying out PDSA cycles at present. They begin testing with one patient and once 95% reliability is achieved move to testing with 3 patients and repeat the process then move to 5 patients and repeat the process. Then spread to all patients in your sample area then monitor your reliability.
NHS Grampian Key Points.

- The Scottish Patient Safety Programme (SPSP) is being implemented as part of the revised Patient Safety Strategy and the pilot sites within Aberdeen Royal Infirmary (ARI) and Dr Gray’s (DGH) are becoming established in their improvement work. The first spread phase is on track with the second phase just being introduced. In addition formal groups have been set up within Children’s Services and in Aberdeenshire CHP to take this work forwards in a structured way.

- There is considerable involvement of frontline staff in all workstreams to support this work with excellent clinical leadership which combined with clear senior leadership support has resulted in progress. The Pilot sites are gathering their own data and information showing their improvements and this is being displayed within the Ward/Unit areas. Some examples of these have been shared across Scotland by the SPSP Faculty.

- Key changes are beginning to develop in the pilot sites as they have improved compliance around their process measures (e.g. Hand Hygiene, Cannula Care, Safety Briefings, SBAR) there are changes in outcomes e.g. two pilot areas exceeded the SPSP goal of 300 days without having a Staph. Aureus Bacteraemia infection.

- As part of this work a monthly report is submitted detailing barrier and breakthroughs, learning from tests of change, next steps as well as a detailed measurement set. This is assessed by the SPSP Faculty and NHSG is currently at the agreed score required for SPSP which demonstrates progress and improvement in all pilot workstreams.

- A public representative is a member of the Patient Safety Reference Group and has been involved in the development of materials to capture patient views on their care as part of the SPSP work with pilot sites. In addition they are now participating in the Patient Safety Walkrounds.
- Corporate Communications have developed posters/banners/leaflets for the SPSP teams and have updated the communication plan. Regular SPSP information is now being communicated via Upfront, NHS News etc. The team are also assisting the pilot sites to test a “How are we doing?” form to capture patient experience along with the Nurse Consultant for Patient Safety & Experience.
- SPSP and HAI teams are exploring ways to join up data collection with support from Health Intelligence and E-Health.
- Links have been made with the Universities re incorporating PDSA and the SPSP elements into the curriculum for Medical/Nursing/AHPs/Pharmacists.
- Board commitment to improving safety and quality by the appointment of a Medication Safety Officer, Nurse Consultant for Patient Safety & Experience and Patient Safety Co-ordinator. All these posts support the work of the SPSP.
- SPSP has developed links with Productive Ward/CQI/Senior Charge Nurse Review and is now part of the wider continuous service improvement work CSI work within NHSG to ensure consistent approaches.
- Agreement at the Board to take forward the development of a quality dashboard of measures. Initial thoughts are to focus on five key areas (In-patient mortality, adverse events, crash call rates, infection rates, patient experience).

For more information about the Scottish Patient Safety Alliance and the Scottish Patient Safety Programme visit [www.patientsafetyalliance.scot.nhs.uk](http://www.patientsafetyalliance.scot.nhs.uk)

**Jenny Ingram**
NHS Grampian SPSP Programme Manager, (01224) 552511, [Jenny.ingram@nhs.net](mailto:Jenny.ingram@nhs.net)
August 2009