Scottish Patient Safety Programme

What is the “Scottish Patient Safety Programme”?

The Scottish Patient Safety Programme (SPSP) is a government-sponsored programme to improve the safety of patients in the Scottish healthcare system.

The objective of the ground-breaking Programme is to steadily improve the safety of hospital care right across the country. This will be achieved by using evidence-based tools and techniques to improve the reliability and safety of everyday health care systems and processes.

Why do we need it?

Patient safety in Scotland is good by international standards, however too many people experience care that could be safer. Research shows that 1 in 10 patients in Scotland may experience an adverse event (such as contracting an infection) in hospital. Half of these adverse events are believed to be avoidable. By implementing evidence-based interventions that become routine, patient safety can be significantly improved.

The Scottish Patient Safety Programme builds on impressive work that is already taking place in Scotland. A similar safety initiative in 3,000 American hospitals resulted in the prevention of more than 122,000 avoidable deaths.

The 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.

What are its aims?

The overall aims are a 30% reduction in adverse events and a 15% reduction in mortality over the five-year period of the Programme. Over the five-year period, steps will be taken to:

- Improve the organisation and leadership on safety
- Reduce healthcare associated infections
- Reduce adverse surgical incidents
- Reduce adverse drug events
- Improve critical care outcomes
- Ensure early interventions for deteriorating patients
How does it work?

Good people working hard will not be able to overcome the complexities of today’s systems of care to prevent errors. Those systems need to be redesigned to help people do the right thing. Redesign needs to be based on the best evidence, presented in a way that allows its widespread adoption.

For the SPSP, a number of Change Packages have been devised; for critical care, the general ward, to promote leadership, for medicines management and for perioperative care. Contained within these Packages are tools for improving care. For example, there are bundles that enable optimum management of peripheral vascular lines and central lines, preventing infection.

Bundles are a collection of fairly simple protocols known to have the most impact in improving a particular aspect of care. Using the Central Line bundle, one intensive care unit in Scotland has not had a central line infection for over 500 days. Previously infection of central lines was thought to be an inevitable risk of a stay in intensive care. The change has not been achieved easily, and not just by transplanting a tool devised in one area directly into another area. Evidence, an available tool and goodwill are all essential but are not enough on their own. Each practice area needs to find out for itself how to integrate changes into practice, and adapt the available tools as necessary. Some practice areas develop their own tools, and pass these on in turn, to help others develop. At the heart of making these changes is the Model for Improvement (MFI):

As the questions at the beginning of the model indicate, having a clear idea of what needs to be changed and how to measure that change are key elements of the MFI. Practitioners are often shocked by the poor results when they first measure whether a tool is being used consistently and/or as designed (the Early Warning Score chart is a prime example).

“Plan, Do, Study, Act” (PDSA) cycles are rapid tests of change, at first with small numbers, increasing as confidence grows. So a clinical area would try the Peripheral Vascular Catheter (PVC) bundle with one patient, one nurse, one shift, and escalate from there. The first PDSA cycle might show the available dressing did not enable date and time of insertion to be written on the dressing, so making removal within 72 hours difficult. This problem could be dealt with in the next PDSA cycle.

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Another essential part of the process is measuring what has happened – the gathering and displaying of data. Three kinds of measures are used; process measures (was the central line bundle done consistently?), outcome measures (have central line infections decreased?) and balancing measures (what else has an influence on events?). The data from these measures is displayed in run charts, simple graphs of change over time. These help show whether a change is an improvement or not.

What other new terms can I expect to encounter?

Adverse Event: This is when something happens to a patient which should not have. It might be getting a pressure sore, getting the wrong drug, falling, acquiring an infection in hospital, receiving insufficient nutrition, being under or over transfused, etc. Adverse events should be regarded as defects in the system, not as an inevitable consequence of care.

Bundles: A bundle is a structured way of improving processes of care and patient outcomes. It is a small straightforward set of practices (generally three to five) that, when performed collectively, reliably and continuously, have been proven to improve patient outcomes.

Control Chart: A more sophisticated version of a run chart.

Failure Modes and Effects Analysis (FMEA) is a way of analysing the potential flaws in a system. In medicines management, it is being used to avoid errors with medicines where the potential consequences are catastrophic (eg, giving an intravenous drug by the intrathecal route).

Global Trigger Tool: This is a tool for seeking out the true rate of adverse events in a hospital. Use of the tool suggests that the true rate of adverse events in an acute hospital is closer to 30% than 10%, most being minor, but all with the potential to be more serious. In Raigmore, the tool identified that SEWS charts were often not filled in correctly, sometimes with serious consequences. A massive staff re-training programme was implemented as a result.

Medicines Reconciliation: The aim of medicines reconciliation on hospital admission is to ensure that medicines prescribed on admission correspond to (are reconciled with) those that the patient was taking before admission. Also, ALL the drugs a patient is taking should be recorded, and action taken accordingly. This includes prescribed, over the counter and illegal drugs.

Safety WalkRounds™ are regular tours of clinical areas done by senior staff. On such WalkRounds, senior staff are likely to put the introduction of change “to the test” by asking junior staff questions about the changes. It is also an opportunity for junior staff to tell managers what is really going on!

SBAR stands for Situation, Background, Assessment and Recommendation. This is a tool which enables complex information to be reported simply and concisely. It has been used in emergency situations, for contacting medical staff by phone, for handover reports and to help meetings buzz along both quickly and productively. It is one method for enabling junior staff to speak truth to power.
**Statistical Process Control:** The method by which data is processed to show if an improvement has taken place. Simple rules allow interpretation of data in run and control charts.

**Surgical Pause** is a brief pause before surgery to enable safety checks to be made. It has been adapted from the pre-flight checks airline pilots make before taking off. It includes introductions by first name, to reduce inhibitions about speaking up if a junior person thinks an error is being made.

**Surgical Safety Checklist** is a perioperative checklist to ensure patient safety. The checklist is included in the Surgical Pause.

**Surgical Briefing** refers to a full theatre briefing at the start of the surgical day and also includes a debrief at the end of the operating list.

**Yellow Book:** This is an anti-coagulant therapy record booklet kept by patients on warfarin, in which their medication and clotting status is recorded.

**How can I find out more?**

As well as a local lead on patient safety (usually your Senior Charge Nurse) there are a number of other Health Board staff with specific responsibilities:

**Websites:**

Scottish Patient Safety Programme. Acknowledgement: Much of the text for this leaflet has been adapted from material on this site; [http://www.patientsafetyalliance.scot.nhs.uk/programme/](http://www.patientsafetyalliance.scot.nhs.uk/programme/)

Institute of Healthcare Improvement. The Institute is working with the SPSP – much of the methodology is derived from the Institute. There are two free on-line training programmes available from the IHI Open School, which take about 3-4 hours each. They can be done a few minutes at a time; [http://www.ihi.org/ihi](http://www.ihi.org/ihi)

Health Protection Scotland. Some of the bundles are available here, plus information on hand hygiene audit. [http://www.hps.scot.nhs.uk/haiic/ic/bundles.aspx](http://www.hps.scot.nhs.uk/haiic/ic/bundles.aspx)

NHS Institute of Innovation and Improvement. A great deal of material available here to download, including a zip file of the Improvement Leaders’ Guides; [http://www.institute.nhs.uk/](http://www.institute.nhs.uk/)

The Continuous Improvement Toolkit, NHS Scotland [http://member.goodpractice.net/ContinuousImprovementToolkit/Welcome.gp](http://member.goodpractice.net/ContinuousImprovementToolkit/Welcome.gp)