NHS
Education for Scotland

Overview of Patient Safety – National and International

August 09

Introduction

Patient safety relates to the prevention of avoidable harm to patients. For example, this is achieved through identifying adverse incidents, analysing their cause, and then improving the system that enabled the incident to happen. Various studies have suggested that international rates of avoidable harm are in the region of 10%. Examples of 'avoidable harm' include: healthcare acquired infections, wrong site surgery, ventilator associated pneumonia and drug errors. A National Audit Office report, published in November 2005, estimated that patient safety incidents cost the NHS in the UK an estimated £2 billion a year in extra bed days alone. That suggests costs in Scotland of £200 million per year.

International Overview

World Health Organisation (WHO)

In 2004, WHO launched its patient safety programme to underline the importance of patient safety as a global health-care issue. The aim of the programme is to coordinate, disseminate and accelerate improvement in patient safety worldwide. The key action areas of this work are shown in Table 1.

Table 1 – WHO Patient Safety Action Aims

1) Cleaner care
2) Safer surgery
3) Tackling antimicrobial resistance
4) Patient involvement
5) Research
6) Developing international patient safety classifications
7) Reporting & learning
8) Finding solutions & sharing good practice
9) Harnessing new technologies
10) Knowledge management
11) Eliminating central line-associated infection
12) Education for safer care
13) International award for excellence in patient safety to act as a driver for improvement

European Union Network for Patient Safety (EuNET PaS)
This network was launched in 2008 and aims to encourage EU stakeholders to work together to improve patient safety. The five key topic areas are:

- promoting a culture of patient safety
- structuring education and training in patient safety (through exchange of experience and knowledge and working with higher education to promote integration of patient safety education in under- and post-graduate curricula)
- proposal of core European curricula for patient safety in higher education
- implement reporting and learning systems which will provide member states with a database of solutions to related issues
- pilot implementation of medication safety by identifying good practice, translating this into tools and then testing those tools

Individual Nations
There is a range of patient safety work being undertaken by individual countries, including: Canada, Finland, Denmark and Sweden.

Patient Safety in the UK

National Patient Safety Agency (NPSA)
The NHS NPSA leads and contributes to improved, safe patient care (in England & Wales) by informing, supporting and influencing organisations and people working in the health sector. The National Reporting & Learning Service arm of the NPSA aims to improve patient care in the NHS with rapid responses to incidents and the collaborative development of actions that can be implemented locally. Some of their current campaigns include: 'clean your hands' (England & Wales); 'Patient Safety Campaign' (England); '1000 Lives Campaign' (Wales) and WHO Surgical Safety Checklist.

Health Foundation
The Health Foundation is a charitable foundation working to improve the quality of healthcare across the UK and beyond. It's *'Safer Patients Initiative'* (2004 – 08) was set up to find practical ways of making acute hospitals safer for patients. The initiative ran in various sites across the UK, including 3 Scottish sites, and has influenced the national safety initiatives across the UK, spreading the approach across the UK health services.

The Health Foundation also provides funding for experienced clinical staff to attend the *Institute for Healthcare Improvement's* (IHI) Quality Improvement Fellowship, which is an area of work that NES is also involved in.

Scottish Patient Safety Programme (SPSP)
The SPSP is coordinated by *NHS Quality Improvement Scotland* and aims to minimise adverse events in the NHS in Scotland by improving safety processes. The SPSP builds on the work that has already taken place through the *Safer Patients Initiative* (see above), which involved NHS

Tayside, NHS Ayrshire & Arran and NHS Dumfries & Galloway. In the United States, a similar safety initiative in 3000 hospitals resulted in frontline teams preventing more than 122, 000 avoidable deaths. This initiative was led by IHI, who are now working in partnership with the programme.
At local level, NHS Boards are working to reliably implement interventions in pilot sites, prior to spreading the work to other areas. Each NHS Board has a designated Programme Manager, who is responsible for coordination and who can be contacted for more information about how to become involved locally. A networking culture is being developed for the sharing of good practice. This includes a series of learning sessions and networking events. More information can be found at: www.patientsafetyalliance.scot.nhs.uk

The programme's key aims for acute hospitals are as follows:

- ensure early interventions for deteriorating patients
- deliver evidence-based care to prevent deaths from heart attacks
- prevent adverse drug events
- prevent central line infections
- prevent surgical site infections
- prevent ventilator associated pneumonia
- prevent pressure ulcers
- reduce *Staphlococcus aureus* (MRSA and MSSA) infections
- 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

SPSP – Progress so far & Examples of Success

Since the start of the SPSP in January 2008, there have been many successes across NHS Boards in Scotland. Some examples of the progress so far is outlined below.

- Four national learning sessions have been held – attended by around 2000 frontline staff, executive and leadership teams
- All 14 territorial NHS boards and the Golden Jubilee National Hospital have been testing and implementing changes from the five SPSP workstreams, and an increasing number of NHS boards are beginning to see statistically significant improvement in their measures using run chart rules.
- Examples of significant improvements were highlighted in the following measures: critical care teams with significant time since last central line infection; 603 Leadership Walkrounds have been completed; reduced ventilator associated pneumonia rates; reduced *Staphlococcus aureus* bacteraemia rates and *Clostridium difficile* associated infections.

For more information on any of the work mentioned above, please see the NES document: Scoping Research of Patient Safety strategies & policies from other countries & organisations – July 2009.

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