Every patient, every time

Patient Safety Strategy
Every patient, every time – Building a safer NHS for the people of Grampian

Patient safety in NHS Grampian is good by international standards. However, we believe that much more can be done to make the care we deliver even safer.

Research shows that 1 in 10 patients may experience an adverse event in hospital. Half of these adverse events are believed to be avoidable.

Improving patient experience and safety requires us all to work together in partnership – clinical staff, support staff, managers and, crucially, patients and their relatives and carers – patient safety is everyone’s business.

The main aims of this strategy are to:

• Reinforce NHS Grampian’s key clinical priority that the organisation integrates patient safety into the daily working routine.
• Create a safety culture in all areas and across all disciplines by maintaining the patient as the focus and raising staff awareness to recognise their contribution to improving patient safety.
• Implement evidence-based interventions that have been shown to reduce adverse events.

NHS Grampian fully embraces the work of the Scottish Patient Safety Alliance – NHS Scotland is the first health service in the world to adopt a national approach to improving patient safety – and will work enthusiastically to secure the benefits for the people of Grampian.

NHS Grampian is also active in the Scottish Patient Safety Research Network, which is at the forefront of research into patient safety.

Our approach to achieving these aims is set out in this document. Our strategy will be underpinned by policies, procedures, guidelines and improvement methods. These will be prioritised and developed by clinicians, drawing from the current good practice in NHS Grampian and beyond, to encourage best practice across the organisation. This strategy involves all members of staff working in all areas of the organisation.

Patient safety is a key priority for NHS Grampian - working in partnership with staff, patients and the public, together we will make it a reality.

David Cameron Chairman

Richard Carey Chief Executive

Elinor Smith Nurse Director

Roelf Dijkhuizen Medical Director
Context

Patient safety in Scotland and Grampian is good by international standards, but it could be better. The Scottish Patient Safety Alliance brings together the NHS, The Scottish Government, professional bodies, patient representatives, and the Institute of Healthcare Improvement, in a new drive to significantly reduce adverse events, through the Scottish Patient Safety Programme and the Patient Safety Research Network.

The Scottish Patient Safety Programme aims to
• Reduce mortality by 15% in three years.
• Reduce adverse events by 30% in three years.
• Reduce healthcare associated infections.
• Reduce adverse surgical incidents.
• Reduce adverse drug events.
• Improve critical care outcomes.
• Improve the organisational and leadership culture on safety.
NHS Grampian is participating enthusiastically in this initiative and good progress is being made.

The Scottish Patient Safety Research Network offers an excellent opportunity to build on joint working with Aberdeen University on initiatives such as Non-Technical Skills for Surgeons.

The national Patient Experience Programme “Better Together” was launched in February 2008 and locally we are taking this forward alongside our patient safety work. We want all our patients to have a safe and positive experience of healthcare.

Since June 2007, senior nurses across Grampian have been participating in “Back to the Floor” when they spend around a day per week in their clinical areas providing visible, accessible and credible nursing leadership, with a focus on patient safety and patient experience.
We have tested Patient Safety Walk Rounds, when senior executives visit clinical areas to discuss patient safety issues. This is welcomed by all and is an effective way of empowering staff to develop local improvements.

We have implemented a risk management information system (Datix) to capture incidents, complaints and claims so that we have sound data on which to build learning and improvements.

We are a pilot site for the Senior Charge Nurse Review/Quality Indicators Project. This is to ensure that ward sisters and charge nurses have leadership skills and authority to ensure that patients are cared for safely and effectively by the healthcare team.
NHS Grampian Patient Safety Objectives

Patient Safety objectives provide a framework for empowering staff to improve patient safety in NHS Grampian:

1. Patient Safety will become one of the main Leadership and Management priorities for NHS Grampian.
2. NHS Grampian will work to achieve the Scottish Patient Safety Programme nationally set targets by January 2011:
   • Reduce Adverse incidents by 30%
   • Reduce Mortality by 15%
3. Work with partners locally and nationally to deliver the Patient Safety agenda, in particular the University of Aberdeen and Robert Gordon University.

4. “Every patient, every time” will be the motto in NHS Grampian.

5. Integrate the Scottish Patient Safety Programme into the daily routine of all NHS Grampian staff by 2011.

6. Reduce inappropriate variation in our clinical practices by using evidence based practice as a means of reducing errors.

7. Create an environment of continuous improvement in all areas of healthcare.

8. Create an environment where we will share patient safety lessons.

9. Endeavour to create a truly patient-centred organisation.

10. Empower staff to develop solutions to improve patient safety.
Key Patient Safety Principles

1. Creating a Patient Safety Culture in NHS Grampian
   Patient safety incidents will occur, however diligent staff are. Incidents are more likely to be due to systems rather than individual error. NHS Grampian is committed to establishing a clear focus on patient safety throughout the organisation and to developing a culture of openness and fairness so staff are encouraged to report patient safety incidents and share lessons across the organisation. This will require strong and visible leadership at all levels.

2. Empowering staff to develop improvements
   NHS Grampian is committed to encouraging staff to develop their own solutions to situations which compromise patient safety. In order to achieve organisational learning, NHS Grampian will seek to ensure lessons in patient safety are learned and key solutions are identified and shared throughout the entire organisation.

3. Engaging with patients and the public
   NHS Grampian is committed to being receptive to engaging with patients and the public in the development and achievement of specific patient safety objectives. To ensure effective communication with non-English speaking patients, staff can call upon the services of 60 experienced interpreters. In addition, the “Language Line” telephone interpretation system is live in over 400 locations across NHS Grampian, with staff trained in its use in each location. There is a large range of NHS Grampian health care information already
translated into the main local ethnic community languages. NHS Grampian will also translate any piece of its health care information, into any other language, upon request.

There are a number of ways in which the needs of patients with communication difficulties are met. These range from the use of Signers, to the use of Portable Induction Loops, Deaf Blind Communicators or pictorial material.

Senior clinicians will ensure that information on risk is communicated to patients. This will enable patients to be active in their care, by becoming involved in the development of an environment where they and their carers feel appropriately informed, and supported, when incidents which threaten patient safety occur and are reassured that lessons have been learnt.
4. Working with Partners
NHS Grampian is committed to working with partners in patient safety, such as the University of Aberdeen, Robert Gordon University and the Scottish Patient Safety Alliance, in developing strategies to further improve patient safety through undergraduate and postgraduate programmes.

5. Applying Evidence-based Practice
NHS Grampian is committed to applying the best evidence to improve patient safety. Recent developments in the field of patient safety will be applied across the organisation to improve patient safety.

6. Learning from and sharing lessons
All events, or near misses, which result in harm, or which have a significant potential to harm, are on a risk management recorded system. This allows NHS Grampian to identify trends, learn lessons and allocate appropriate resource to ensure improvements are embedded through changes to systems, processes, and practices. Staff are encouraged to contribute to this reporting system. Support from senior clinicians is required to continue to develop patient safety incident reporting, assessment of trend analysis and investigation of incidents.
How will we achieve implementation of this strategy and demonstrate improvements?

We will use the Plan Do Study Act (PDSA) rapid cycle testing tool, risk assessments, learning from incident and near miss reporting and investigation, clinical audit, and promotion of safety as a Board priority. Services will then identify and implement local solutions to embed and effect change to practice, process and systems.

In addition, to achieve organisational learning and action, NHS Grampian will ensure that any lessons learned and the key solutions identified to prevent harm are shared.
Priorities for implementation:

**Model for Improvement**
Introduction and spread of the model for quality improvement will provide a framework for developing, testing and instigating change to ensure demonstrable improvement. The model has two parts of equal importance. The first asks staff to consider three questions that are essential for guiding improvement work:

1. What are we trying to accomplish?
2. How will we know that a change is an improvement?
3. What change can we make that will result in an improvement?

The second part of the framework is the Plan, Do, Study, Act (PDSA) cycles that assist the process of rapid cycle change. Reflection, that is, considering what worked well and what did not, is a major part of the cycle. This facilitates learning from experiences and uses this knowledge in the next tests of change, thus ensuring a continuous process of measurable and sustainable improvement.

**Leadership**
- Develop the infrastructure to support quality and safety improvement.
- Establish patient safety Executive Walk Rounds to demonstrate a system of leadership that reflects safety as a strategic priority and takes responsibility for spreading knowledge, expertise and improvement throughout the organisation and beyond.
• Adopt leadership roles that provide guidance and support, removing barriers and developing staff in all areas to improve patient safety practices.
• Create a culture that puts patient safety at the centre of everything the organisation does.
• Add the progress and results of the Scottish Patient Safety Programme to Operational Management Team and Board agendas.
Clinical Service

- Develop a quality improvement toolkit for clinical services to use.
- Pilot sites to begin using patient safety tools, such as safety briefings, structured communication, implementation of care bundles and PDSA rapid cycle change testing. Conclusions from these will then be spread to other areas.
- Support clinical areas to design tasks and processes to minimise dependency on short-term memory or attention span (e.g. promote the use of checklists).
- Develop mechanisms to simplify and standardise processes, protocols, equipment etc., across the organisation.
- Gathering of real-time data to measure progress unit-by-unit. Staff caring for patients will lead the process changes required to achieve demonstrable quality improvement.

Recording and Learning from Incidents

- Promote a fair and just reporting system that facilitates a team culture attuned to detecting and rectifying errors.
- Develop mechanisms to improve communication between services to reduce the duplication of effort (e.g. when revising/developing implementing guidelines).
- Pooling together of existing learning to share and develop templates with a focus on patient safety.
- Identify core patient safety competencies which staff require to develop appropriate learning opportunities.
- Develop template reports that allow services to share good or best practice via the Management to Governance structures. This will facilitate learning and changes to practice across the organisation.
NHS Grampian encourages all staff to become involved in making this strategy a reality to ensure that patient safety is embedded as part of the daily work routine. NHS Grampian will know that this strategy is being successfully implemented when the following are in place:

- An Action Plan to work towards local continued improvement in patient safety, as well as the achievement of external targets e.g. Scottish Patient Safety Programme, Quality Improvement Scotland (QIS) standards, and other key national work programmes.
- Evidence that services have implemented tools and techniques that have improved reliability and safety of systems and processes, which ultimately show sustainable improvements in patient care.

NHS Grampian has consulted with staff and members of the public in the writing of this Strategy.
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NHS Board and its Committees
- Leading
- Providing Assurance
- Performance Managing
- Linking

All Staff
- Awareness
- Reporting
- Implementing
- Improving

Clinical and Management Teams
- Monitoring and Actions
- Supporting
- Promoting Policy and Sharing Good Practice
- Reporting
References
1. Scottish Patient Safety Alliance
   http://www.patientsafetyalliance.scot.nhs.uk/
2. The Scottish Patient Safety Programme
   http://www.patientsafetyalliance.scot.nhs.uk/programme/
3. Institute for Healthcare Improvement
   http://www.ihi.org/ihi
4. NHS Quality Improvement Scotland
   http://www.nhshealthquality.org/nhsqis
5. National Patient Safety Agency
   http://www.npsa.nhs.uk/
6. Clinical Governance and Risk Management Unit NHS Grampian
   http://intranet.grampian.scot.nhs.uk/cgrmu
7. Scottish Patient Safety Research Network
   http://www.spsrn.ac.uk/
This publication is also available in large print and on computer disk. Other formats and languages can be supplied on request.

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