The Quality Unit
Professor Jason Leitch, Clinical Director

The Scottish Government

DELIVERING
A GAMES LEGACY FOR SCOTLAND

Dear Colleague

NEXT STEPS FOR ACUTE ADULT SAFETY – PATIENT SAFETY ESSENTIALS AND SAFETY PRIORITIES

1. This letter sets out a set of ten patient safety essentials to be implemented everywhere in NHSScotland. NHS Boards are expected to put in place arrangements to ensure that staff are supported to deliver these measures reliably and consistently to all patients who could benefit.

2. The patient safety essentials, which are described in more detail in Annex A, are:

- Hand Hygiene
- Leadership Walkrounds
- Communications: Surgical Brief and Pause
- Communications: General Ward Safety Brief
- Intensive Care Unit (ICU) Daily Goals
- Ventilator Associated Pneumonia Bundle
- Early Warning Scoring
- Central Venous Catheter Insertion Bundle
- Central Venous Catheter Maintenance Bundle
- Peripheral Venous Cannulla

3. The list includes a number of areas where good practice should be followed, such as hand hygiene and communication in the ward or theatre, as well as a number of evidence based 'bundles' of care which are collections of interventions and checks to improve both quality and safety of care.

4. Every item on the list is evidence based and has been developed, refined and tested over time in collaboration between the Scottish Government, Healthcare Improvement Scotland's Scottish Patient Safety Programme and clinicians across NHSScotland.

5. These measures are internationally recognised as fundamentally important for safe care. Each of them has been extensively tested and implemented at scale in Scotland across a wide range of clinical settings and situations as part of the Scottish Patient Safety Programme. Now proven, these measures will in future be a fundamental expectation of every person experiencing acute hospital care, wherever they are. Likewise, these measures will be a fundamental professional expectation for all clinical staff.

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Addresses

For action
Chairs
Chief Executives
Medical Directors
Nurse Directors

For information

Enquiries to:

Andy Longmate
St Andrew's House
Edinburgh
EH1 3DG

Tel: 0131-244 2852

Point of contact
andrew.longmate@scotland.gsi.gov.uk
owen.griffiths@scotland.gsi.gov.uk

http://www.scotland.gov.uk

6. The emphasis should now shift from testing and spread towards one of sustainable universal implementation which requires different approaches to ensuring and assuring the continued provision of these interventions as standard work in all clinical areas.

7. The ten patient essentials will be reflected within the continuing Scottish Patient Safety Programme, as one of the organisational priorities; these, together with the nine point of care interventions, form the 'nine plus two' safety priorities:

Organisational Priorities:

- Infrastructure for safety
- Strategic prioritisation of safety

Point of Care Priorities:

- Deteriorating patients
- Sepsis
- Heart failure
- Pressure ulcers
- Surgical site infections
- Venous thromboembolism
- Catheter associated urinary tract infections
- Falls with harm
- Safer medicines

8. The continuing safety priorities are based on sound evidence and require further rigorous testing, spread and reliable implementation using the quality improvement methodology familiar to those involved with the safety programme.

Implementation

9. The patient safety essentials listed as Annex A, are expected to be delivered with high levels of reliability. This level of implementation means embedding these interventions as standard work and standard operating procedure into normal, everyday practice. All Boards need to develop local mechanisms to assure themselves that these ten essentials of patient safety have been comprehensively spread and consistently implemented in all relevant clinical areas. Boards need to ensure robust mechanisms are in place to ensure sustainable and sustained maintenance of the 10 essentials.

10. The patient safety essentials should be monitored within operational delivery mechanisms and form an important strand of governance arrangements. However, Boards should also ensure that any recording or monitoring of these measures is proportionate and does not detract from the provision of high quality, compassionate patient care by generating an excessive data burden. A step down approach to process measurement may be appropriate depending on local context.

11. Boards may wish to consider all or some of the following mechanisms to provide assurance that the patient safety essentials are being reliably delivered:

- Direct observations on walk rounds
- Soft intelligence
- Wards visits and conversations with patients and staff
- Dashboards

- Continuation of local outcome measurement
- Sampling or snapshot reports

12. National reporting of the patient safety essentials will be through the Annual Review process. Additional information on the implementation of these measures will be provided through proportionate, periodic, scrutiny of delivery through external review, self-assessment and other accountability methods.

13. All staff should be working towards ensuring these essentials are met, but that if patient safety is endangered by failure to meet these standards or any other reason there are number of ways to raise their concerns, either locally or if necessary through the national confidential alert line

14. If you require any further information about this letter please contact Dr Andy Longmate, National lead for Patient Safety, on 0131 244 2852.

Yours sincerely

Jason Leitch
Clinical Director

PATIENT SAFETY ESSENTIALS (August 2013)

Hand Hygiene
Hand hygiene will be performed at all of the World Health Organisation '5 Moments' • Before touching a patient • Before clean/aseptic procedures • After bodily fluid exposure risk • After touching patient • After touching a patient's immediate surroundings Technique • Use of hand washing technique that assures thorough cleaning of skin surface
Rationale
Health care-associated infections, or infections acquired in health-care settings are the most frequent adverse event in health-care delivery worldwide. Good Hand hygiene is a simple and effective solution to both reduce and prevent the spread of most healthcare associated infections.
Evidence
Burden of endemic health-care-associated infection in developing countries: systematic review and meta-analysis Benedetta Allegranzi MD, Sepideh Bagheri Nejad MD, Christophe Combescure PhD, Wilco Graafmans PhD, Homa Attar PhD, Liam Donaldson MD ,Prof Didier Pittet MD *The Lancet* - 15 January 2011 (Vol. 377, Issue 9761, Pages 228-241) DOI: 10.1016/S0140-6736(10)61458-4

Leadership Walkrounds
Walkrounds should involve NHS board senior leaders engaging with frontline staff in clinical and non-clinical areas. The conversation should focus on: • Key patient safety concerns • What can we do together to improve • Teamwork and how do your local teams operate • Communication • How leadership can help At the end, agreement of key actions to be taken forward, by whom, and by when should be recorded. A minimum of four Walk Rounds per month is recommended depending on board size.
Rationale
Leadership walkrounds allow senior leaders to have a structured conversation about patient safety with frontline staff, and enquire as to the barriers to caring for patients as safely as possible. They increase awareness of safety issues among clinicians and establish a strong commitment by senior leadership to a culture that encourages patient safety.
Evidence
Patient Safety Leadership WalkRounds™ were developed by Allan Frankel, MD, Director of Patient Safety Partners Health Care System, Boston, Massachusetts, USA. Copyright © 2004 Institute for Healthcare Improvement

Communications: Surgical Brief and Pause
Surgical Briefing: a pre-operative list briefing will be held with all members of the surgical team. **Surgical Pause**: a pre-operative pause will take place before every surgery.
Rationale
Surgical Briefing: is an opportunity to ensure that the entire team understand the expectations for the list and for each procedure. **Surgical Pause:** is an opportunity to cover the surgical checklist and act as a final reminder of items that must be completed prior to commencement of the operation.
Evidence
WHO surgical safety checklist and implementation manual, World Alliance for Patient Safety, 2008

Communications: General Ward Safety Brief
A short, regular and multidisciplinary briefing where all ward staff gather together for 5 minutes to highlight any safety issues for the day for that shift e.g. identification of deteriorating patients and escalation mechanism, notification of faulty equipment and action taken.
Rationale
Safety Briefings are a simple, easy-to-use tool that front line staff can use to share information about potential safety problems and concerns on a daily basis. They help increase staff awareness of patient safety issues, create an environment in which staff share information without fear of reprisal, and integrate patient safety into daily work.
Evidence
Safety Briefing Tool - www.ihi.org/IHI/Topics/PatientSafety/SafetyGeneral/Tools/ This SBAR tool was developed by Kaiser Permanente.

Intensive Care Unit (ICU) Daily Goals
Establish Daily Goals Every patient in an ICU will have a set of daily goals agreed and documented in the case notes. • Establish appropriate, explicit daily goals for patients • Use daily goal sheet to document and communicate • Assess patients' progress in meeting daily goals
Rationale
Setting Daily goals allows better document and communication, supports evaluation of patient safety risks and focuses staff attention to early changes in patients' condition. Furthermore, it enhanced communication among team members and patients and their families.
Evidence
Improving communication in the ICU using daily goals Pronovost P, Berenholtz S, Dorman T, Lipsett PA, Simmonds T, Haraden C. Journal of Critical Care. 2003;18(2)71-75.

Ventilator Associated Pneumonia Bundle
An evidence based bundle of care to prevent ventilator associated pneumonia. Patients on mechanical ventilation will receive the following bundle every day. This will be measured on an all or none basis. • Sedation to be reviewed and, if appropriate, stopped each day • All patients will be assessed for weaning and extubation each day • Avoid supine position, aiming to have the patient at least 30-45º head up • Use chlorhexidine 6 hourly, as part of daily mouth care.
Rationale
Ventilator Associated Pneumonia (VAP) is a pneumonia infection acquired during mechanical ventilation; this evidence based bundle of care will be administered to all patients daily to prevent a VAP.
Evidence
HPS Literature Review: http://www.hps.scot.nhs.uk/haiic/ic/publicationsdetail.aspx?id=52941

Early Warning Scoring
Assess patient risk using Early Warning Scoring System based on physiological measurements undertaken when patients present to hospital: • Respiratory rate, oxygen saturations • Temperature, systolic blood pressure • Pulse rate, level of consciousness
Rationale
The EWS has been demonstrated to identify patients at risk from deterioration and patients who would potentially benefit from more intensive monitoring from nursing and medical staff. The EWS is used as part of a "track-and-trigger" system whereby an increasing score produces an escalated response varying from increasing the frequency of patient's observations (for a low score) up to urgent review by a Rapid Response or Medical Emergency Team. The response mechanisms are still being tested a key part of the SPSP acute programme and not yet ready to be included as an essential.
Evidence
Early Warning Systems: Scorecards That Save Lives, IHI, last modified 04/26/2011 Standardising the assessment of acute-illness severity in the NHS. London: Royal College of Physicians, 2012 www.rcplondon.ac.uk/national-early-warning-score

Central Venous Catheter Insertion Bundle
All central lines inserted should be performed under bundle conditions This will be measured on an all or none basis. • Ensure that surgical scrub is performed immediately before donning maximal sterile barrier precautions (e.g. gloves and gown))* • Ensure that maximal sterile barrier precautions are used; including headwear, mask, sterile gown and sterile gloves for healthcare workers • Ensure maximal sterile barrier precautions are used by applying a sterile body drape • Ensure that aseptic technique is maintained throughout insertion of CVCs • Ensure that 2% chlorhexidine in 70% isopropyl alcohol is used for skin preparation of the insertion site and allowed to dry, before CVC insertion • Ensure that the subclavian site is used if possible, or internal jugular vein (femoral site should be avoided whenever possible) • Ensure that a sterile, transparent, semi-permeable dressing is used to cover the catheter site
Rationale
A Central Venous Catheter (CVC) commonly known as a central line, is a plastic tubing or drip used to administer medicines or fluids into large veins of the body. An evidence based CVC insertion bundle to prevent central line associated blood steam infections will be used every time central lines are inserted.
Evidence
Central Line Insertion Bundle. HPS Literature review http://www.hps.scot.nhs.uk/haiic/ic/publicationsdetail.aspx?id=50994

Central Venous Catheter Maintenance Bundle
An evidence based bundle of care to prevent central line associated bloodstream infections. Patients with a central line insitu will receive the following bundle every day. This will be measured on an all or none basis. • Ensure that the need for the CVC insitu is reviewed and recorded today (on a daily basis) • Ensure that the CVC dressing is intact • Ensure that the CVC dressing has been changed in the last seven days • Ensure that 2% chlorhexidine gluconate in 70% isopropyl alcohol is used for cleaning the insertion site during dressing changes • Ensure that hand hygiene is performed immediately before accessing the line/site (WHO Moment 2) • Ensure that an antiseptic containing 70% isopropyl alcohol is used to clean the access hub prior to accessing – rub the access hub for at least 15 seconds ('scrub the hub')
Rationale
CVCs are a leading cause of device-related blood stream infections. An evidence based CVC maintenance bundle to prevent central line associated blood steam infections will be used every day on every patient.
Evidence
Scottish Intensive Care Society Audit Group http://www.sicsag.scot.nhs.uk/SICSQIG-report-2012-120209.pdf

Peripheral Venous Cannulla
Patients with a peripheral venous cannulla (PVC) insitu will receive the following bundle every day. This will be measured on an all or none basis. ***100% of PVCs:*** • *in situ* still being required. • In use have appropriate and intact dressings. • Procedures were performed after HCWs performed hand hygiene. ***0% PVCs***: • In situ have phlebitis or extravasation around the insertion site. • Have been *in situ* longer than 72 hours.
Rationale
Use of the evidence based care bundle for PVC will help in preventing infections when inserting and maintaining a PVC.
Evidence
Scottish Intensive Care Society Audit Group http://www.sicsag.scot.nhs.uk/SICSQIG-report-2012-120209.pdf