



Healthcare
Improvement
Scotland



Continuous Improvement to Embed the Essentials of Safe Care

SPSP Adults in Hospital Programme

Leading quality health and care for Scotland



Welcome

Lara Mitchell

Strategic National Clinical Lead Frailty and Acute Care
Healthcare Improvement Scotland

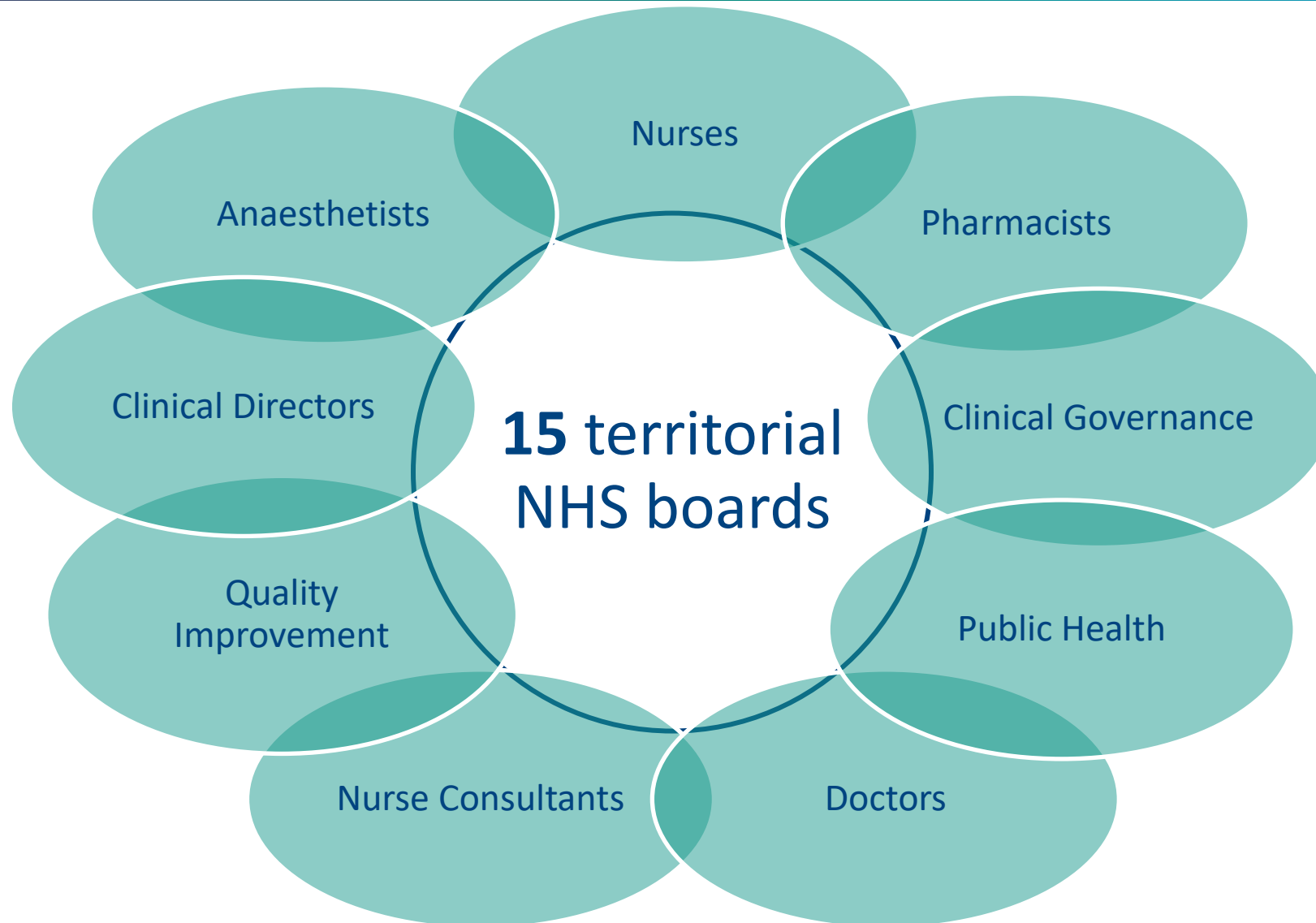


Aims of the breakout

- Hear from teams on how they are applying the EoSC in practice.
- Explore creating conditions and understanding systems for SPSP adults in hospital.
- Opportunity for group discussion and networking with colleagues across Scotland.



Who's here, online and in the room?



Agenda

Time	Title	Lead
1.35pm–1.50pm	Welcome, introductions and scene setting	Lara Mitchell, Strategic National Clinical Lead (Acute), Healthcare Improvement Scotland
1.50pm–2pm	Reducing medical emergencies with preceding deterioration: A new focus for the deteriorating patient	Deepa Rangar, Consultant Geriatrician and Clinical Lead, NHS Lothian Jacqui Blackie, Improvement Advisor, NHS Lothian Emma Ford, Associate Improvement Advisor, NHS Lothian
2pm–2.10pm	Q&A with the deteriorating patient speakers	Lorna Lennox, Improvement Advisor, Healthcare Improvement Scotland
2.10pm–2.20pm	Repositioning to reperfuse: Learning about ‘Essentials of Care’ from adverse event review	Heather Hodgson, Lead Nurse Tissue Viability, NHS Greater Glasgow and Clyde
2.20pm–2.30pm	Q&A with the pressure ulcers speaker	Susi Paden, Improvement Advisor, Healthcare Improvement Scotland
2.30pm–2.35pm	Summary and close speaker session	Lara Mitchell, National Clinical Lead Frailty and Acute Care Healthcare Improvement Scotland
2.35pm–2.50pm	Comfort break	All in person delegates
2.50pm–3.30pm	Table-top discussions- All in person delegates	Jennifer Baillie, Senior Improvement Advisor- Paediatrics, Perinatal and Acute Care
3.30pm–3.35pm	Closing remarks	Lara Mitchell, National Clinical Lead Frailty and Acute Care Healthcare Improvement Scotland

SPSP Adults in Hospital



**SPSP Adults in Hospital aims
to improve outcomes and
reduce harm for adults in
hospital across Scotland**

SPSP Adults in Hospital

SPSP Essentials of Safe Care

Workstreams

Medicines | Falls | Deteriorating Patient | Pressure Ulcers

Learning System

Key changes

Our Vision

**The delivery of safe care, improving outcomes for every person,
every time across health and care**

New Focus

People Led , Inequalities, Clinical and Care Governance, Digital

Change at each level

**Change Ideas developed at practitioner, service and organisational
level**

Readiness for change

**Readiness for change assessment aligned to the Scottish Approach
to Change**

Essentials of Safe Care 2025



EoSC



Readiness
Tool

Our vision is

Delivered through ...

Which requires...

**The delivery of
safe care,
improving
outcomes for
every person,
every time across
health and care**

A people-led approach
to the planning and
delivery of safe care

Effective and inclusive
communication

Leadership at all levels
to support a
culture of safety

Safe clinical and care
processes

People and professionals are equal partners in shared decision making

Care and support is shaped to meet the needs of people

People, families, carers and staff are systematically listened to, and concerns
are acted upon

Communication tailored to individual needs and preferences

People and teams feel safe and able to speak up

Team communication and collaboration

Leadership is compassionate and inclusive

Staff feel supported and valued

Learning system for continuous improvement

Everyone has the opportunity to learn and develop

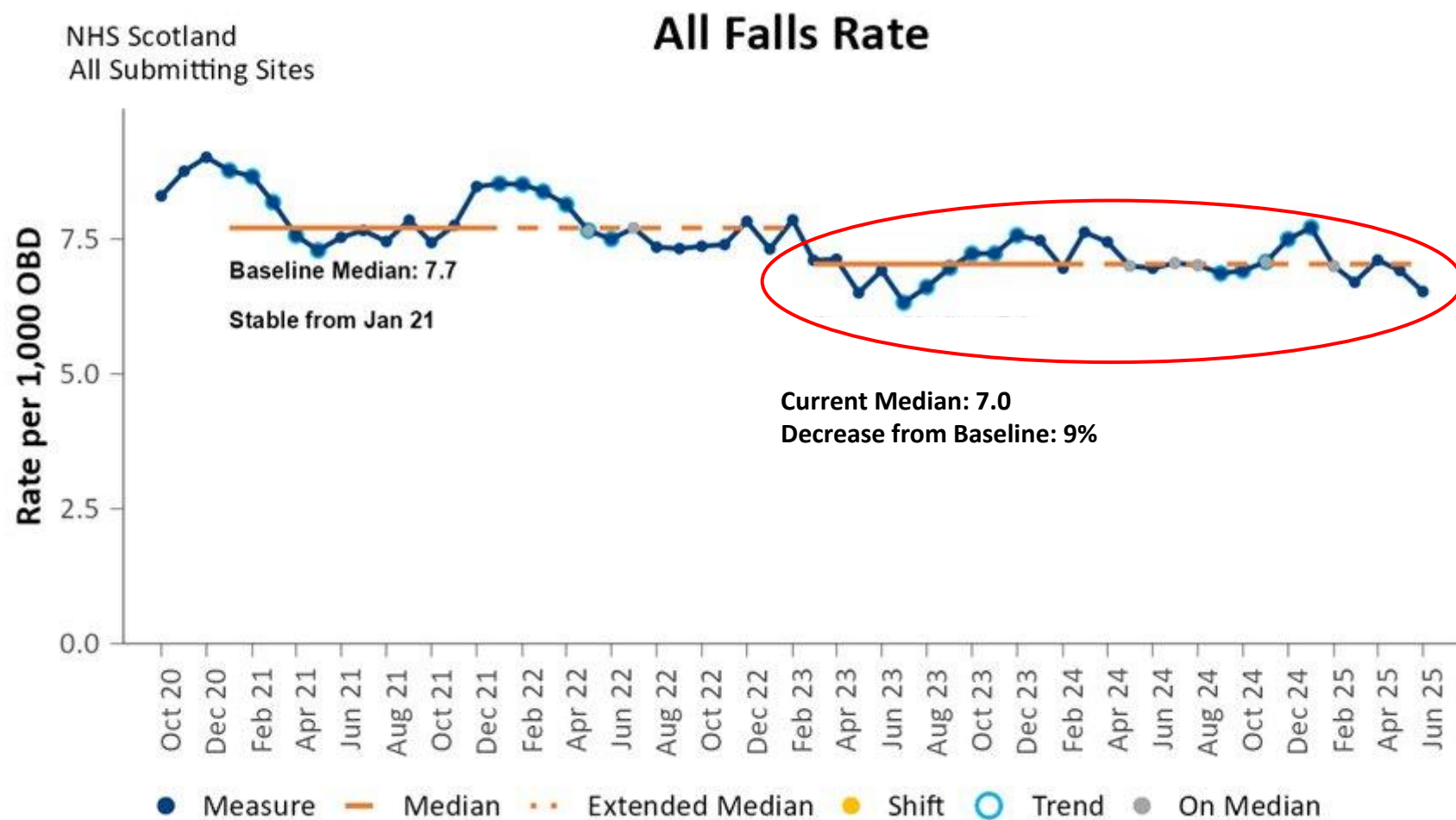
Safe staffing and skill mix

Care is up to date and evidence based

Clinical and care governance structures support safety

Information systems that work together

Data highlights – falls



Leadership to support a culture of safety

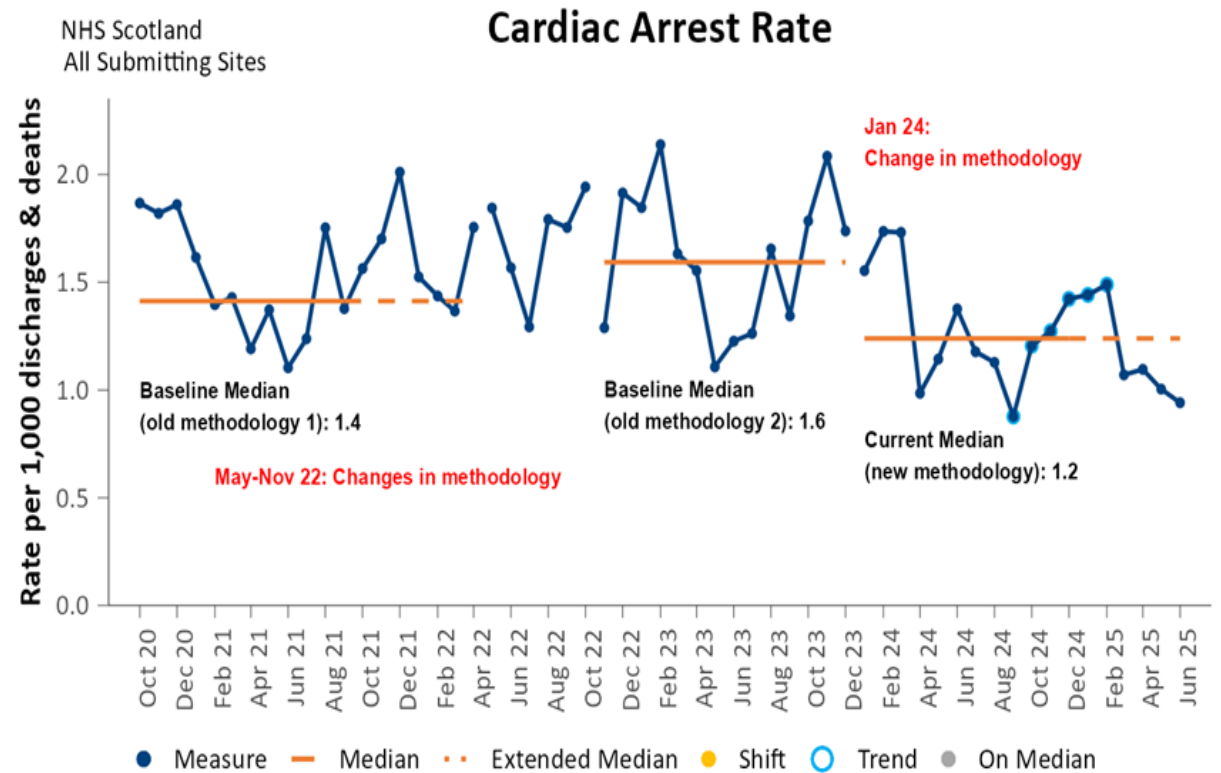
Person centred approaches to care

Multidisciplinary communication and approach

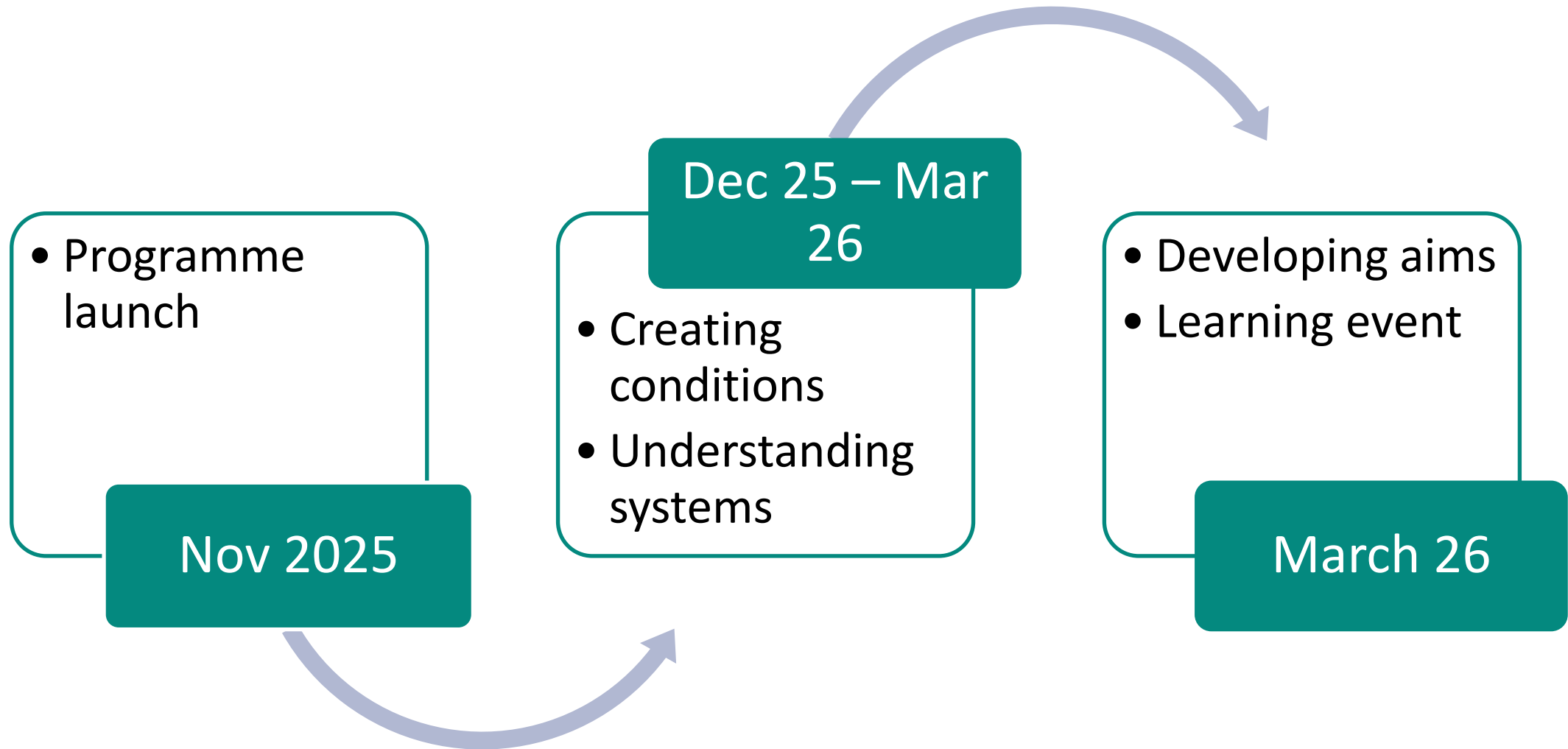
Promoting safer mobility

Data highlights - Deteriorating Patient

- Focus on understanding the emergent system, and local cardiac arrest data collection.
- Reliability of data collection improved in six of seven boards
- Five hospitals sustained a reduction in cardiac arrest rates (by between 20% and 52%) and two demonstrated an increase.



Next steps



Reducing medical emergencies with preceding deterioration: A new focus for the deteriorating patient.

NHS Lothian

Dr Deepa Rangar

Geriatrician & Clinical
Lead: Deteriorating
patient programme



Jacqui Blackie

Quality Improvement
Advisor



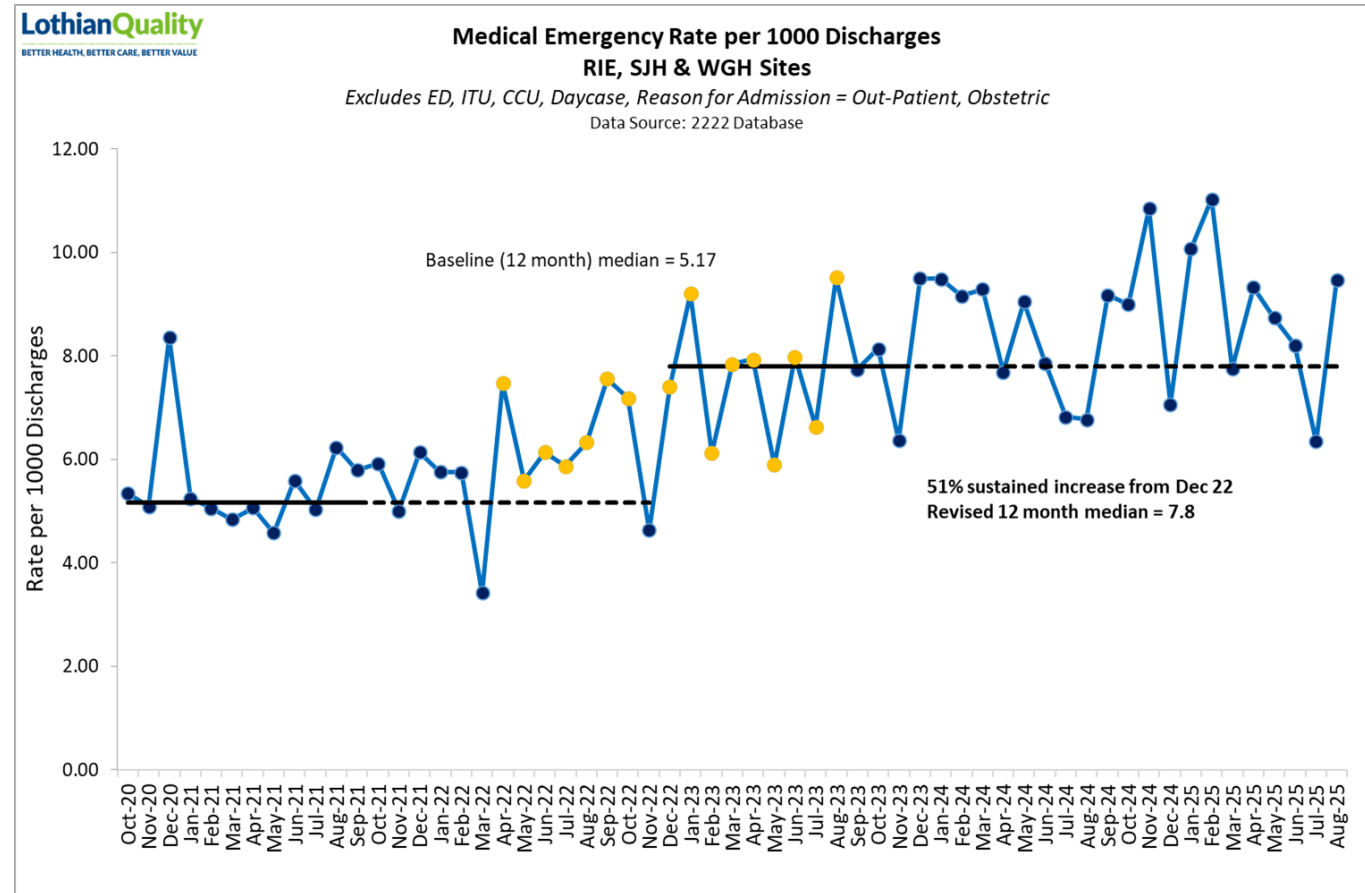
Emma Ford

Associate Quality
Improvement Advisor



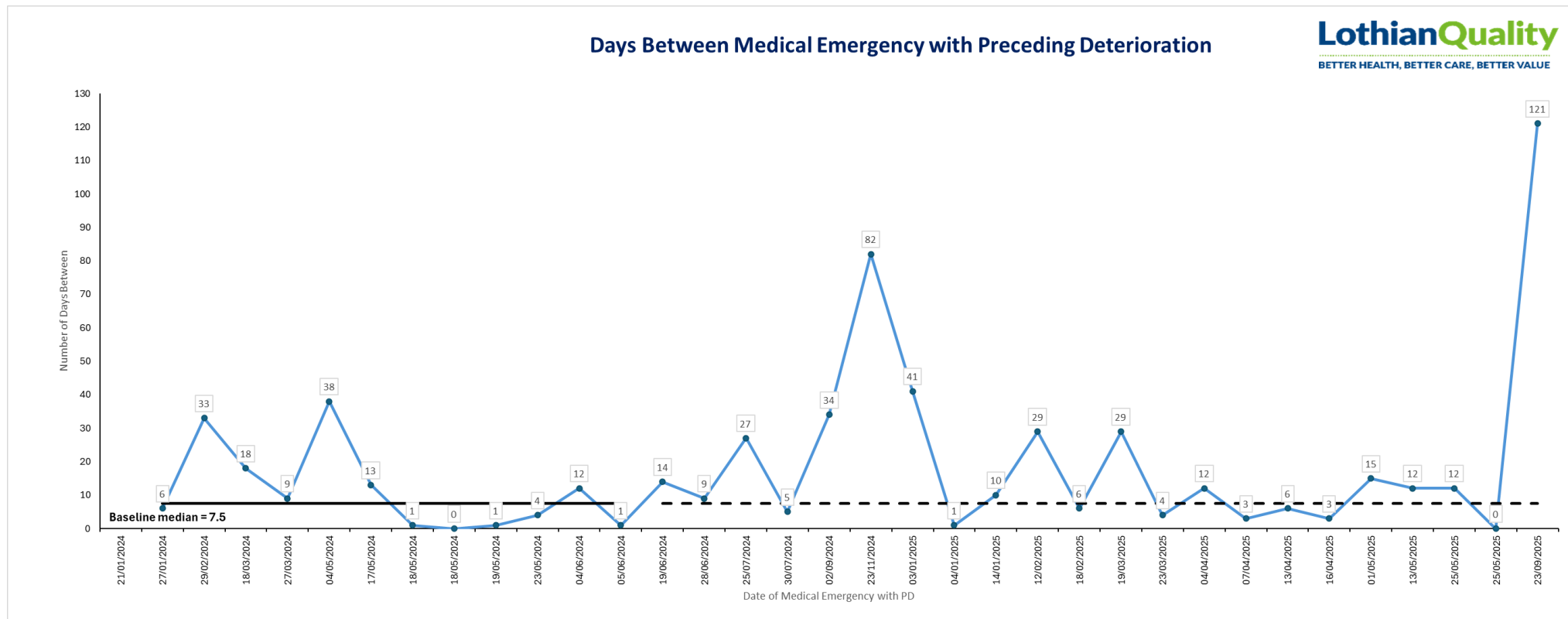
Background

- Since October 2020 our Cardiac Arrest rate has remained unchanged at rate of 0.8 per 1000 discharges
- Since December 2022 Medical Emergency rate had a sustained increase of 51%
- Learning from the cardiac arrest reviews and medical emergency reviews have identified common themes for improvements



Aim

- The aim of the Medical Emergency Improvement Programme is to reduce the number of 2222 medical emergency calls that are preceded by signs of clinical deterioration.
- For the purposes of this programme, preceding deterioration is defined as either a NEWS2 score greater than 7 or documented clinical concern within the 24 hours prior to the emergency call.



Improvement journey

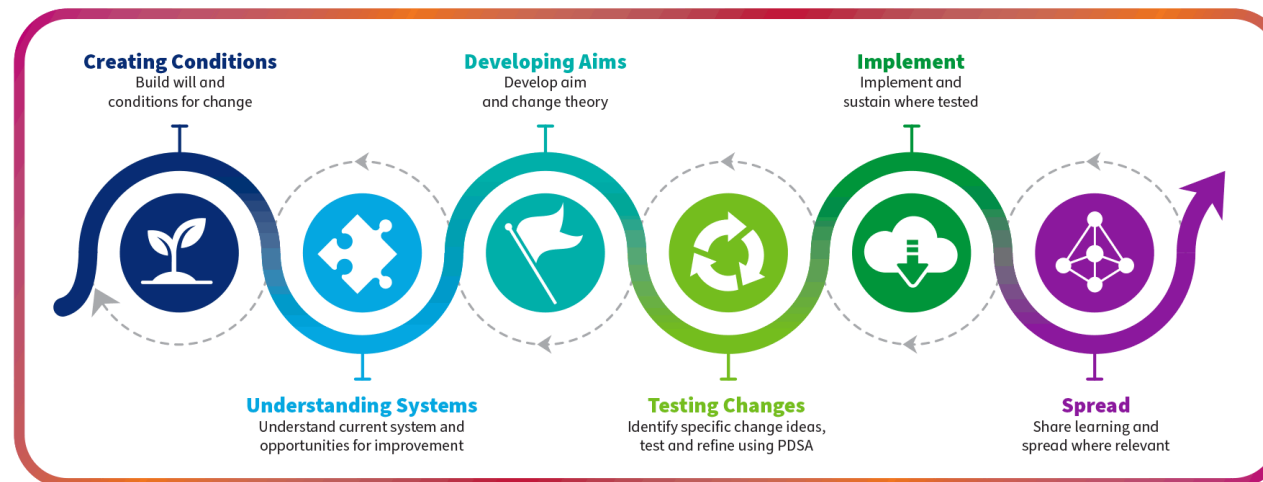
January to April

- Creating conditions
- Understanding systems
- Developing aims

May to present

- Testing changes
- Implement and sustain

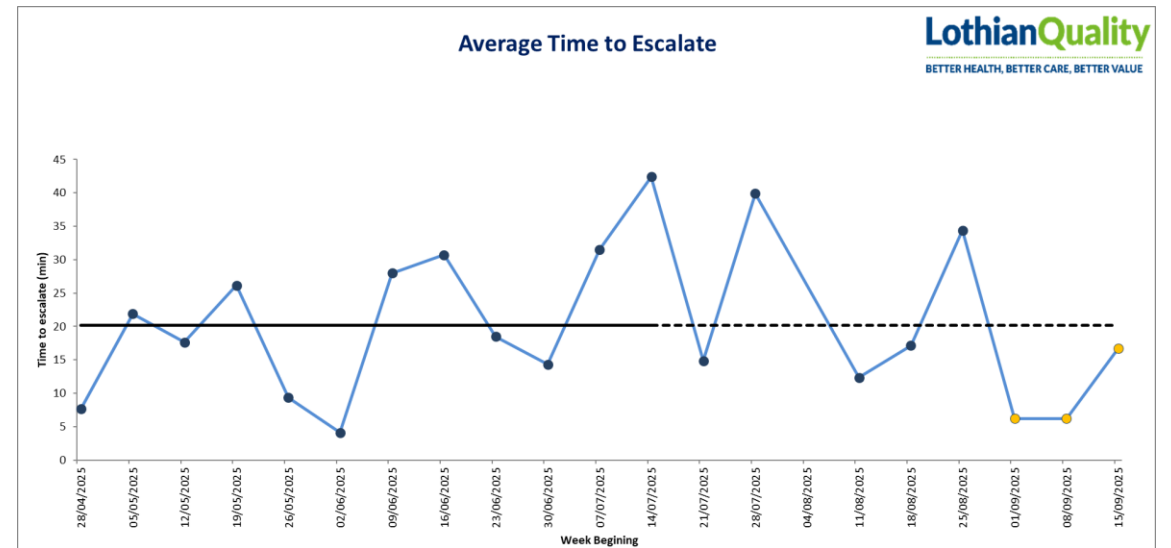
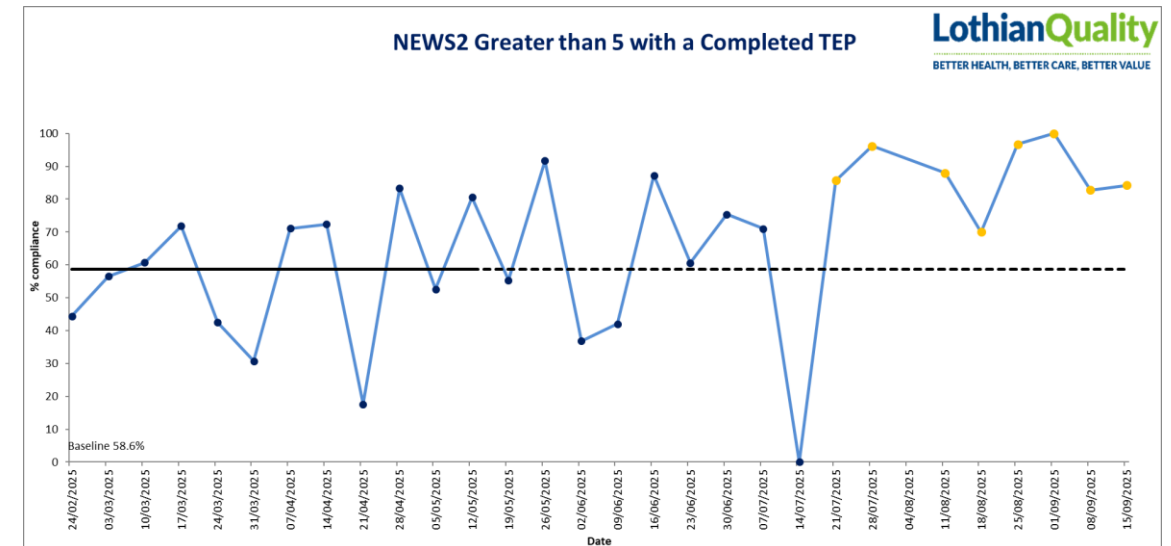
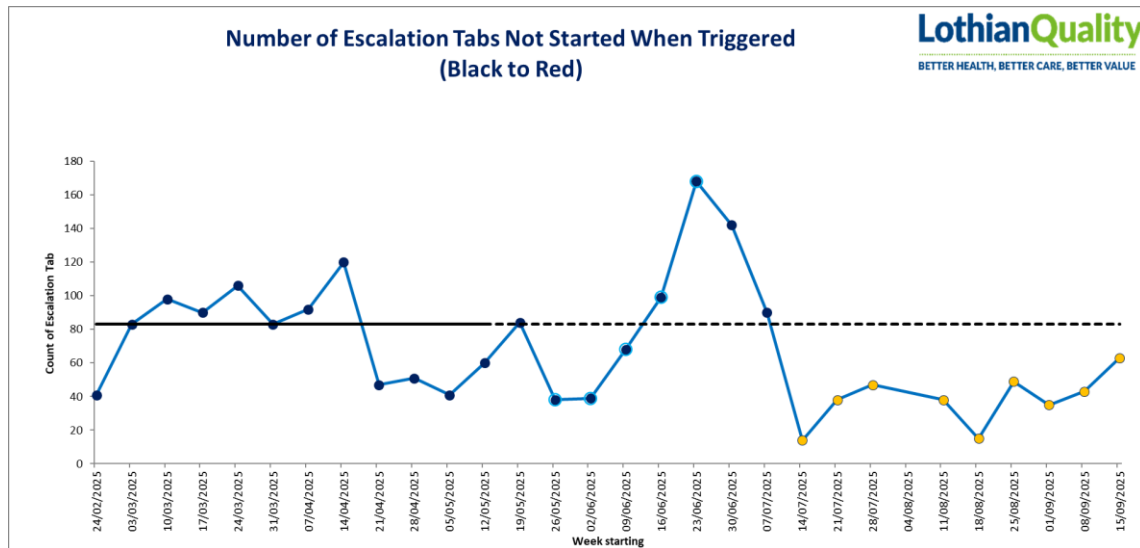
- Medical ward, highest number of calls for medical emergencies on the site.
- Screening of all calls from January 2024
- 61% of calls showed signs of preceding deterioration
- Developing an aim while ensuring confidence in staff to continue to call medical emergencies when needed.



Improvement journey

Process measures

- Reliable frequency of NEWS2
- Reliable use of escalation Tab in Trakcare
- Patients with a NEWS2 ≥ 5 have a TEP



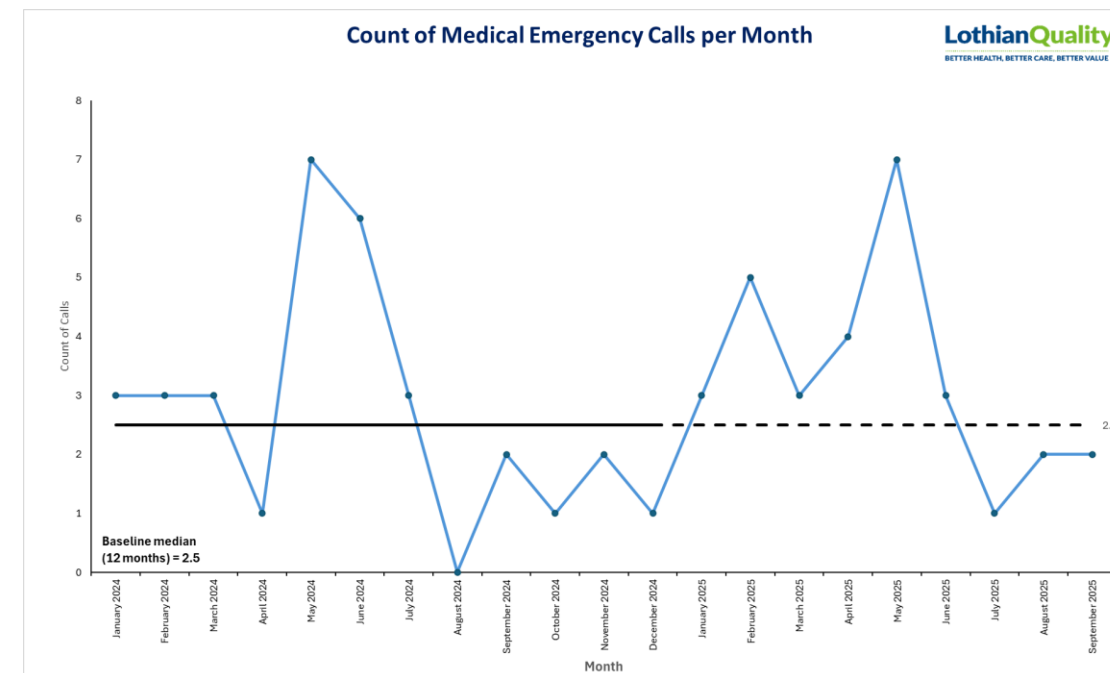
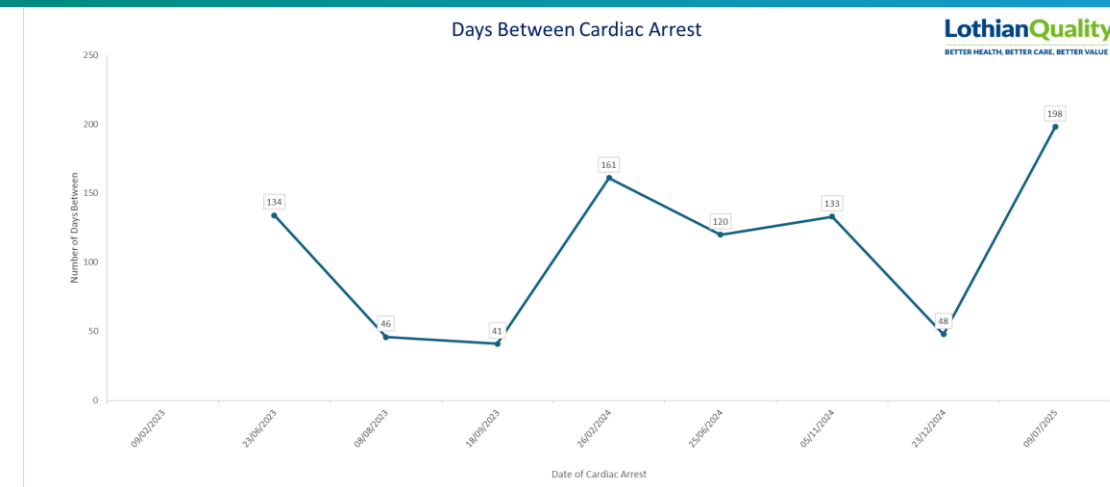
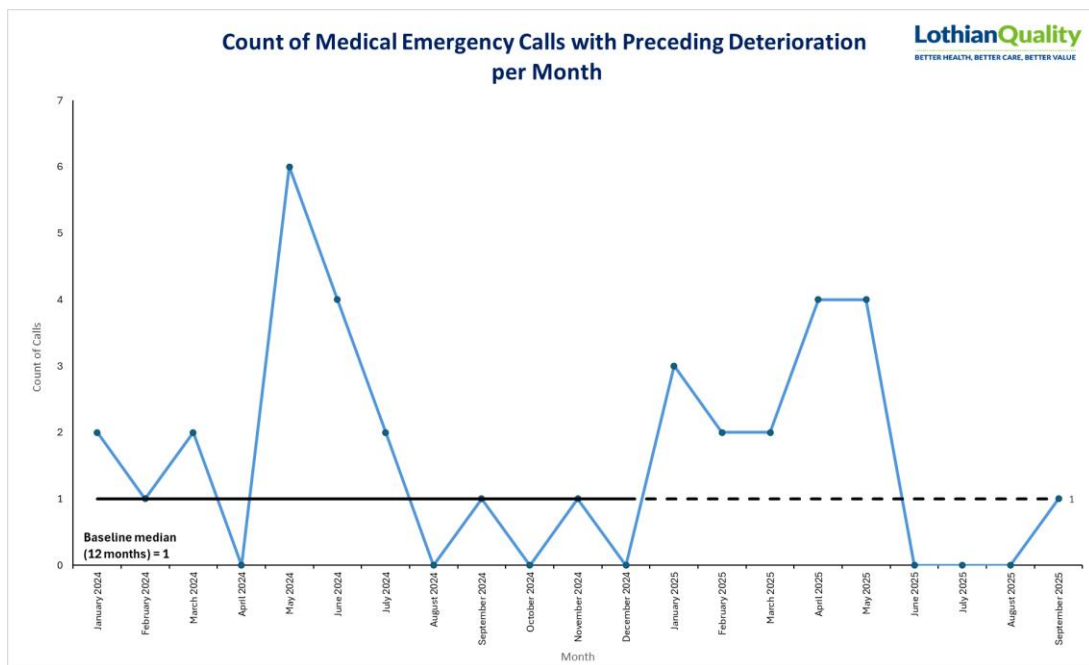
Results

Outcome measures

- Number of medical emergencies with preceding deterioration

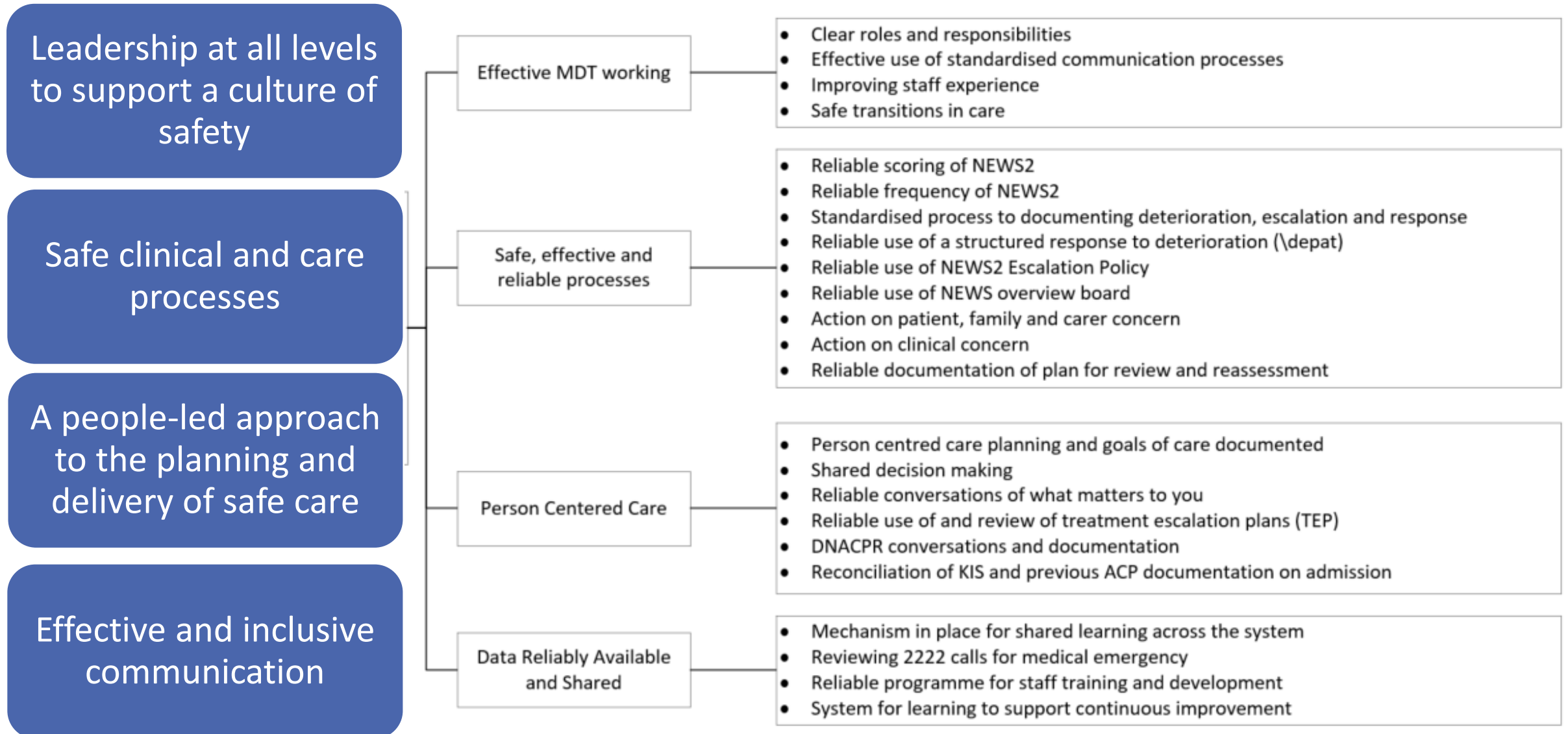
Balancing measures

- Number of overall medical emergencies
- Number of cardiac arrests



Links with Essentials of Safe Care

To enable the delivery of Safe Care for every person within every system every time



Repositioning to reperfuse: Learning about **‘Essentials of Care’** from adverse event review

Heather Hodgson

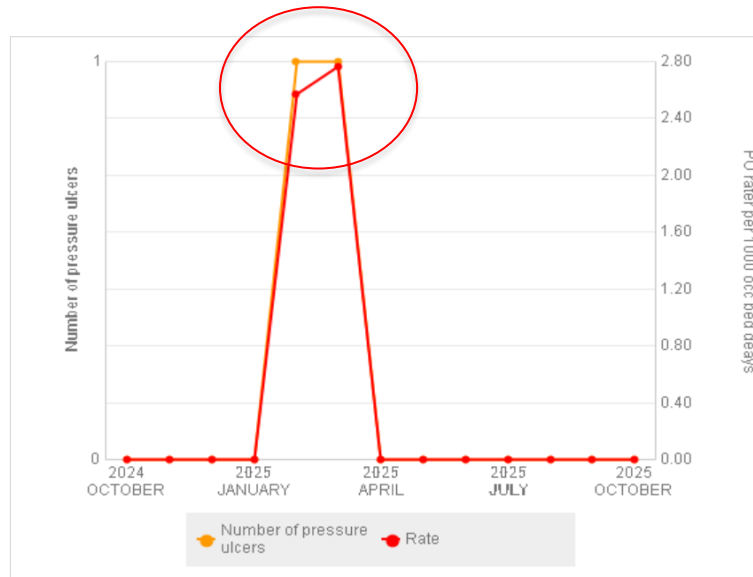
Lead Nurse: Tissue Viability

NHS Greater Glasgow & Clyde



Background

During April and May 2025, 2 patients developed healthcare acquired pressure damage in one clinical area. This was an unusual event for the clinical area.



Staff were really upset by the occurrence of pressure damage and struggled to understand why pressure damage occurred as the patients had received 2 hourly care interventions with no gaps in care.



Review process

- Tissue Viability review conducted to determine causes
- Full patient journey reviewed
 - Assessment
 - Person-centred care planning
 - Implementation
 - Evaluation

Key findings

What did the review tell us?

- Documentation showed repositioning occurred regularly – but not necessarily allowing reperfusion
- Staff equated movement with prevention, missing the pressure-relief principle

Designation: _____
Designation: _____
the ward: 1 - Independent

Must do's for me. Ask the patient they want specifically done today
KEEP ME SAFE

Times	00	02	04	06	08	10	12	14	16	18	20	22
1	2	2	2	2	2	2	2	2	2	2	2	2
2	2	2	2	2	2	2	2	2	2	2	2	2
3	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
4	P	P	P	P	P	P	P	P	P	P	P	P
5	2	2	2	2	2	2	2	2	2	2	2	2
6	B	B	B	B	B	B	B	B	B	B	B	B
7	2	2	2	2	2	2	2	2	2	2	2	2
8	2	2	2	2	2	2	2	2	2	2	2	2
9	✓	✓	-	-	-	✓	✓	-	-	-	✓	✓
10	-	-	-	-	-	✓	-	-	-	-	-	-

Aim

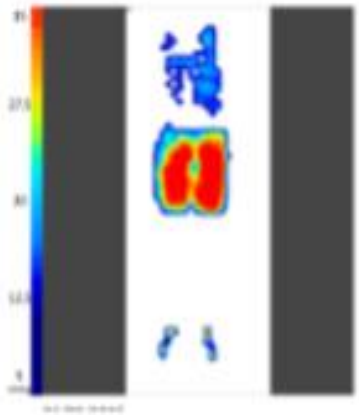
- Support nurses to understand the link between repositioning and reperfusion
- Dispel the myth that all movement = effective pressure relief
- Develop educational tools for practical bedside learning

- Collaborated with local and national teams
- Tested pressure mapping in various positions to visualise pressure distribution
- Created visuals linking body positions with real pressure data

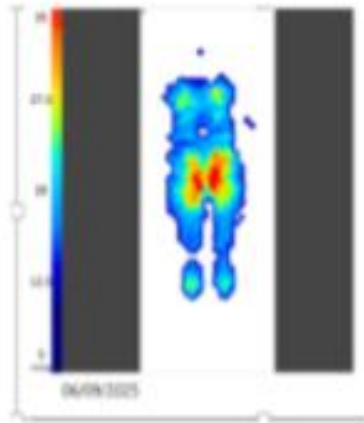


Improvement journey

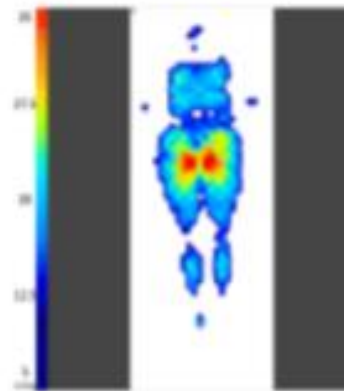
We placed Morven the SCN into lots of different positions and measured the pressure under her.



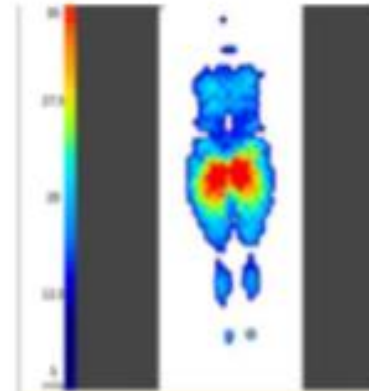
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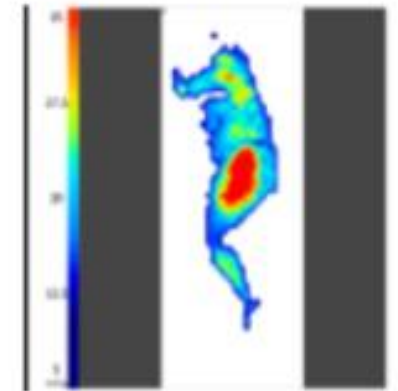
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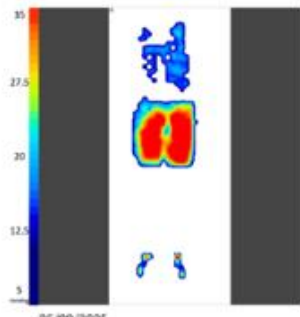
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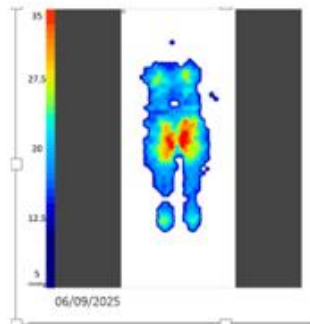
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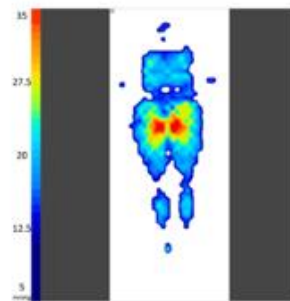
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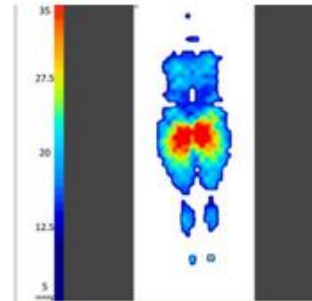
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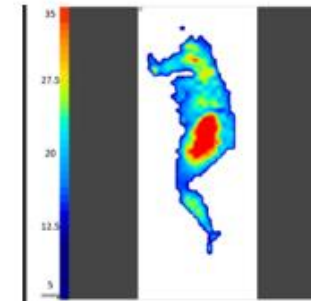
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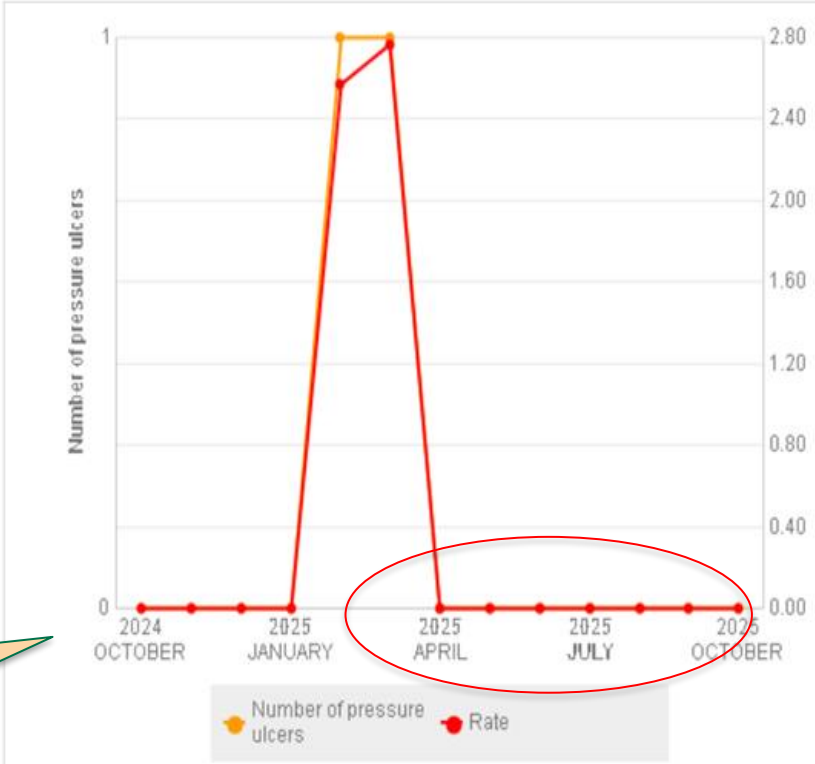
Results and Impact

Our work has been shared locally and nationally

“Eye-opening”

“It hit home”

“I see what you mean now”



Year	Month	Number	Rate
2024	OCTOBER	0	0.00
2024	NOVEMBER	0	0.00
2024	DECEMBER	0	0.00
2025	JANUARY	0	0.00
2025	FEBRUARY	1	2.80
2025	MARCH	1	2.80
2025	APRIL	0	0.00
2025	MAY	0	0.00
2025	JUNE	0	0.00
2025	JULY	0	0.00
2025	AUGUST	0	0.00
2025	SEPTEMBER	0	0.00
2025	OCTOBER	0	0.00
Total		2	0.40

“Best pressure ulcer prevention presentation”

Linking to Essentials of Safe Care

A people-led approach to the planning and delivery of safe care

- Involve all staff in the review of adverse events - Due process followed to encourage transparent investigation of healthcare acquired pressure damage
- Board wide sharing of healthcare acquired pressure damage for each clinical area.
- Shared learning gleaned from review of healthcare acquired pressure damage.

Effective and inclusive communication

- Safe, effective reliable process to investigate health care acquired pressure damage
- Board wide sharing of healthcare acquired pressure damage for each clinical area.
- Shared learning gleaned from review of healthcare acquired pressure damage.

Leadership at all levels to support a culture of safety

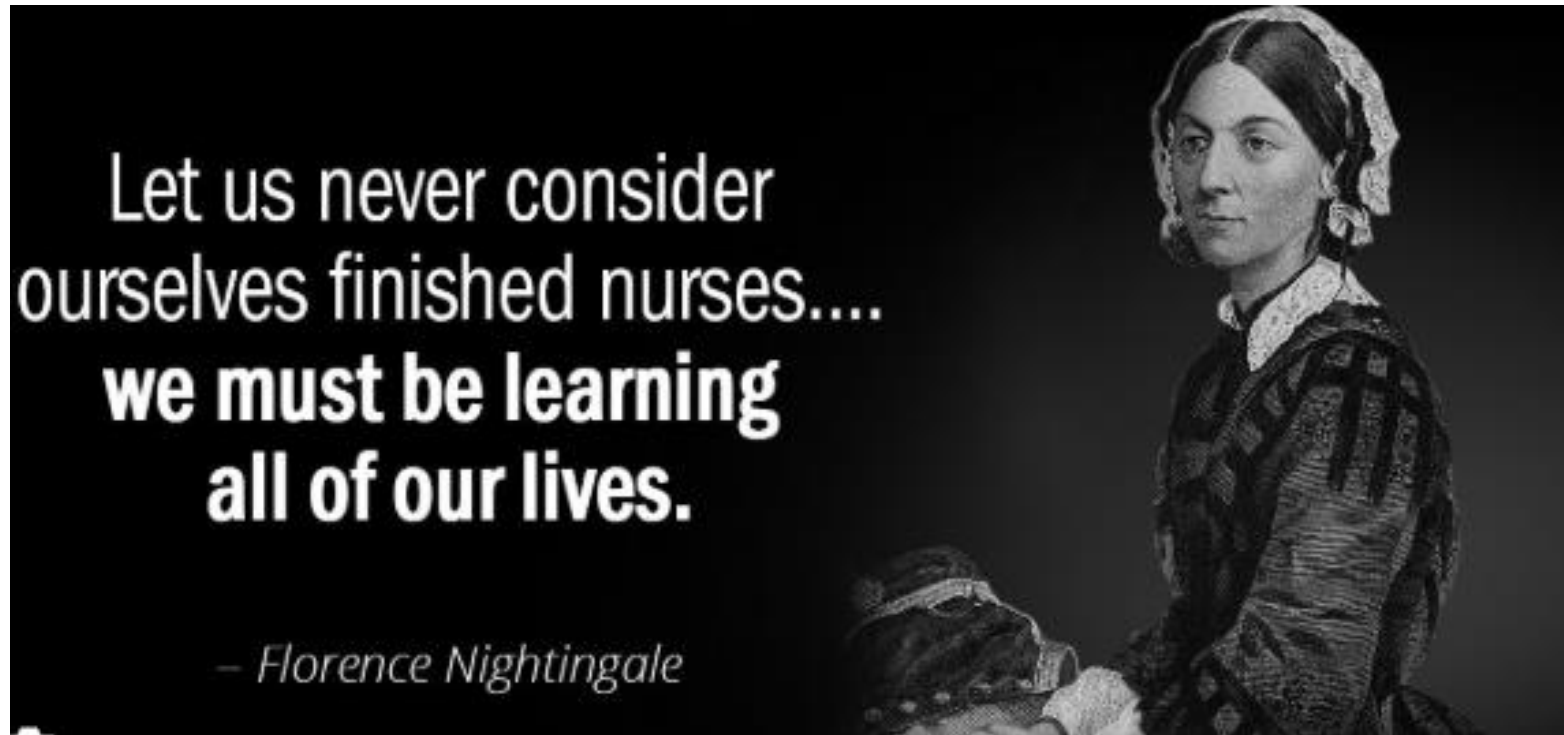
- Up to date PU prevention and management policy, learning together culture, fostering learning opportunities.

Safe clinical and care processes

- Reliable data available and shared
- Specialist review of data and completion of Datix triangulation of data to ensure data on Datix, PU database and CAIR dashboard matches, issue of monthly PU reports Board wide

Thank you

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Keep in touch

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Thank you

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