Healthcare Improvement Scotland

SCOTTISH PATIENT SAFETY PROGRAMME

Continuous Improvement to Embed the Essentials of Safe Care

SPSP Adults in Hospital Programme

Leading quality health and care for Scotland

NHS SCOTLAND

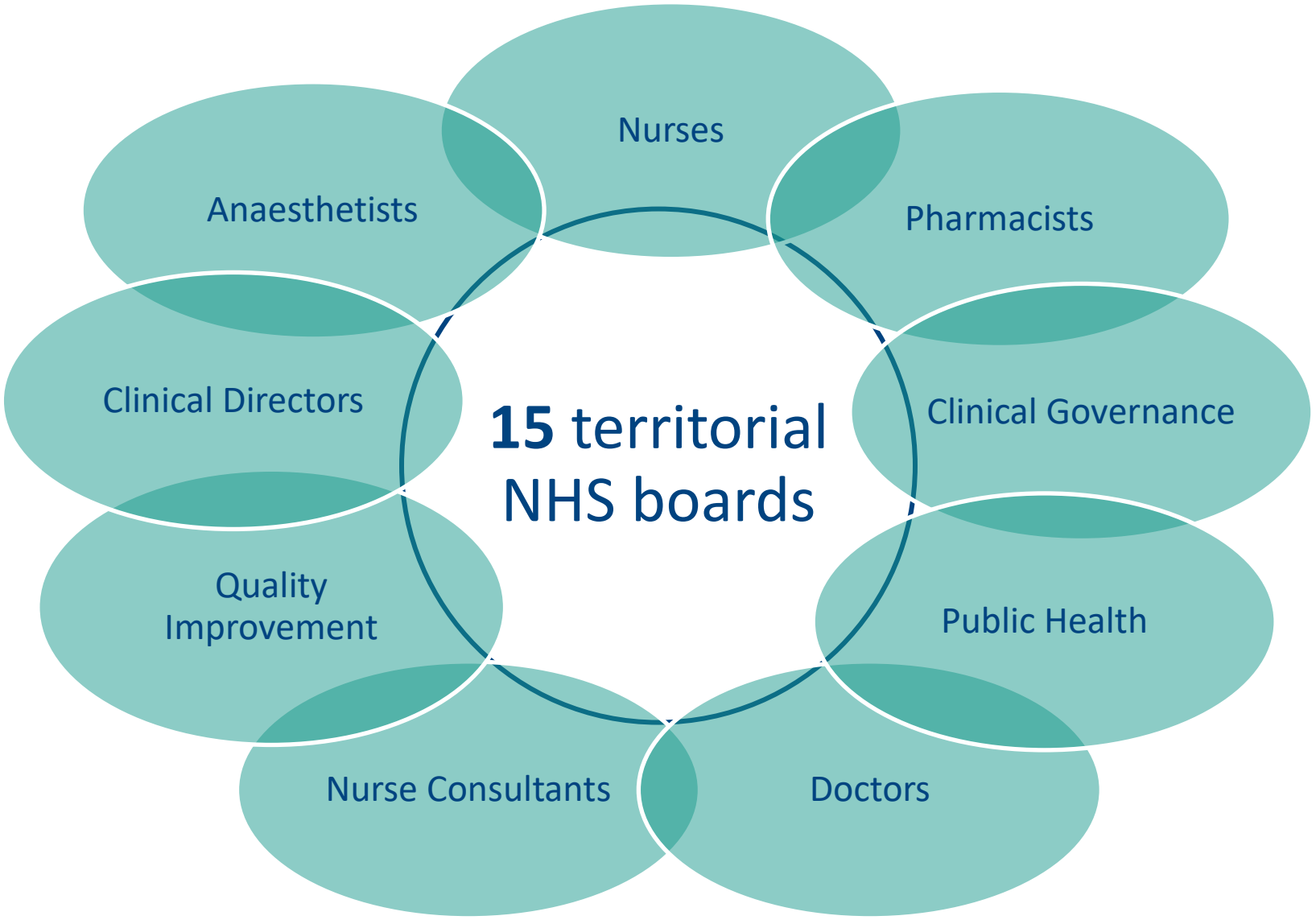
Welcome

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?

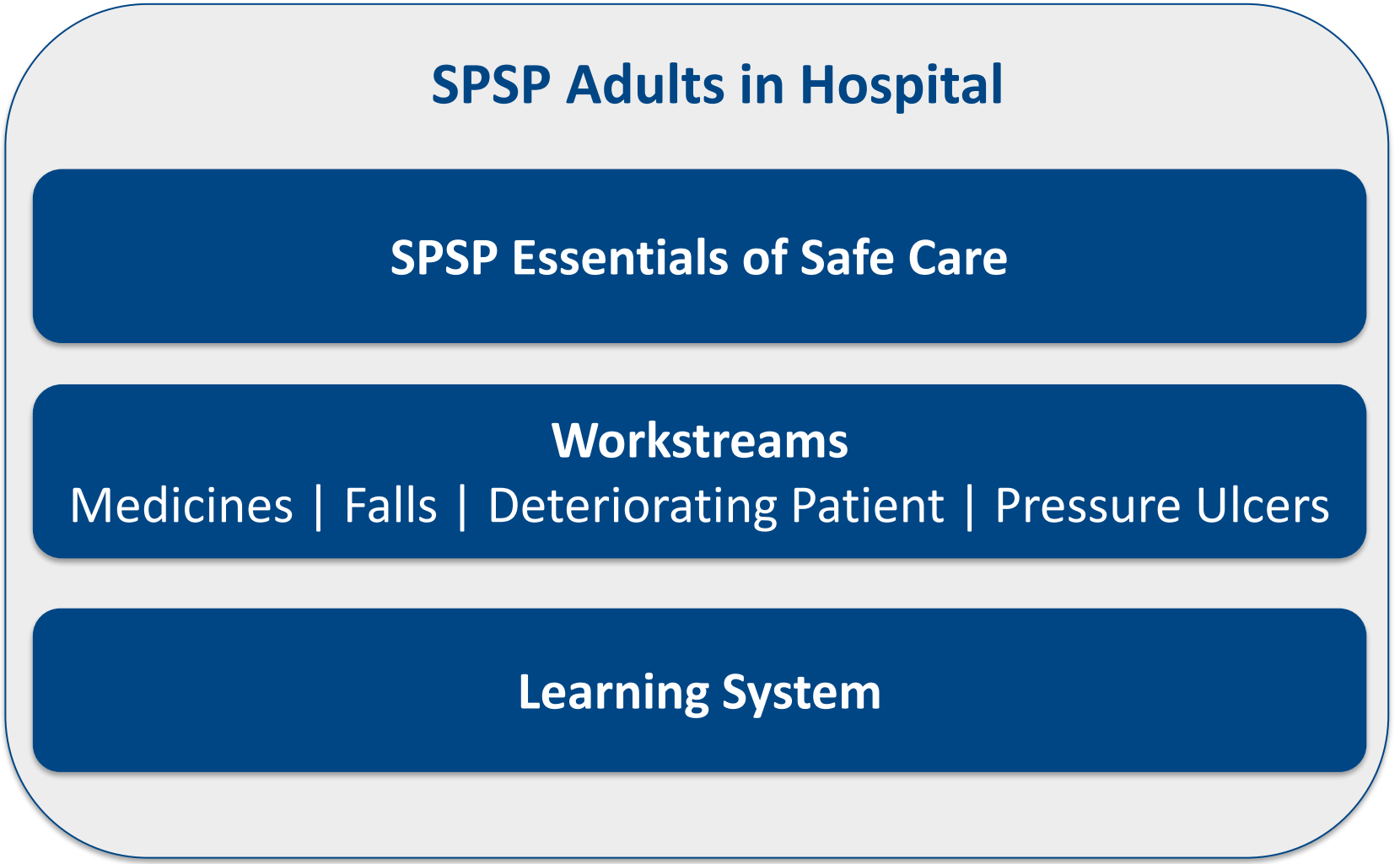


Agenda

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



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**

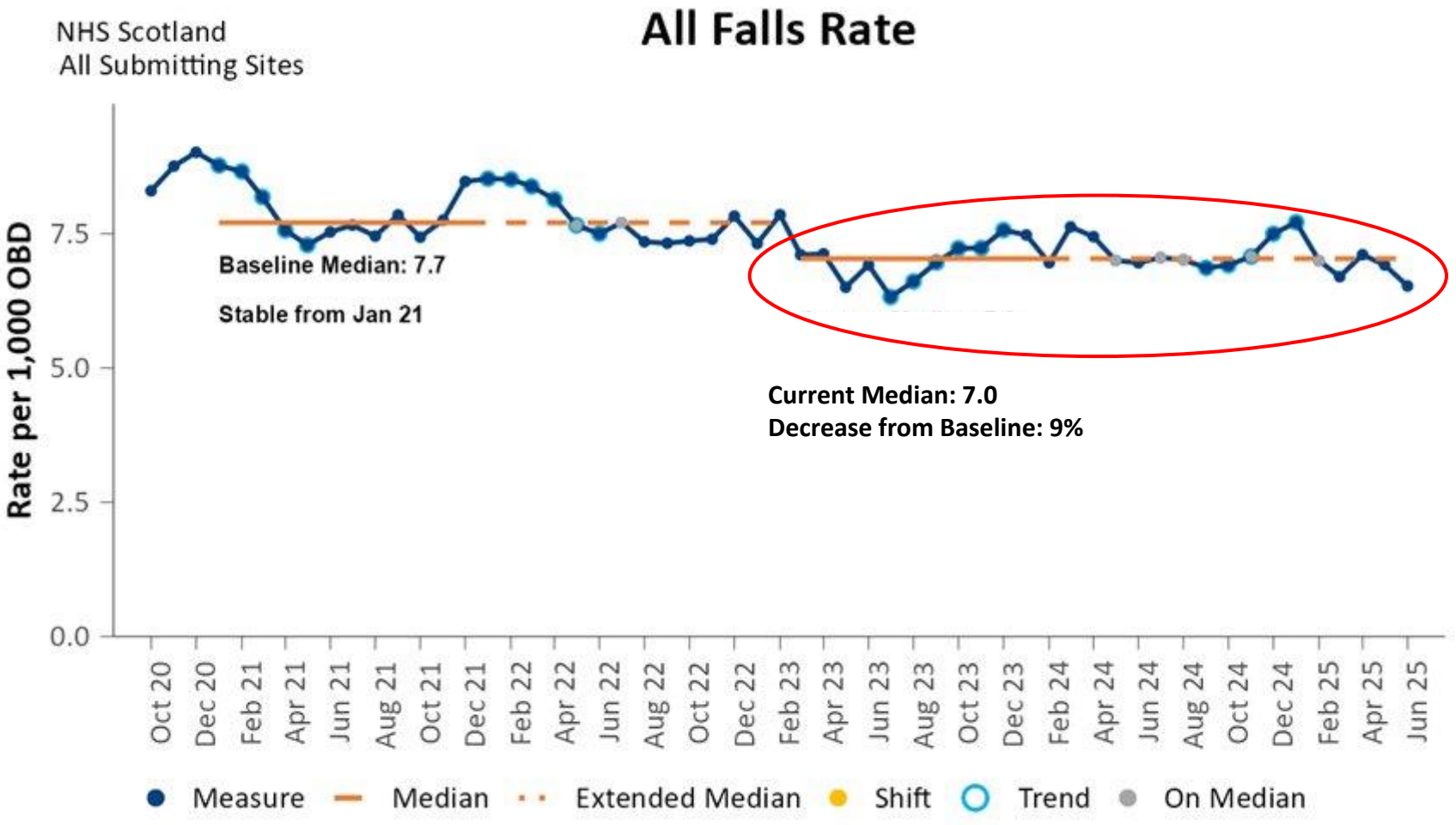
Essentials of Safe Care 2025

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	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
	Effective and inclusive communication	Communication tailored to individual needs and preferences People and teams feel safe and able to speak up Team communication and collaboration
	Leadership at all levels to support a culture of safety	Leadership is compassionate and inclusive Staff feel supported and valued Learning system for continuous improvement Everyone has the opportunity to learn and develop
	Safe clinical and care processes	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

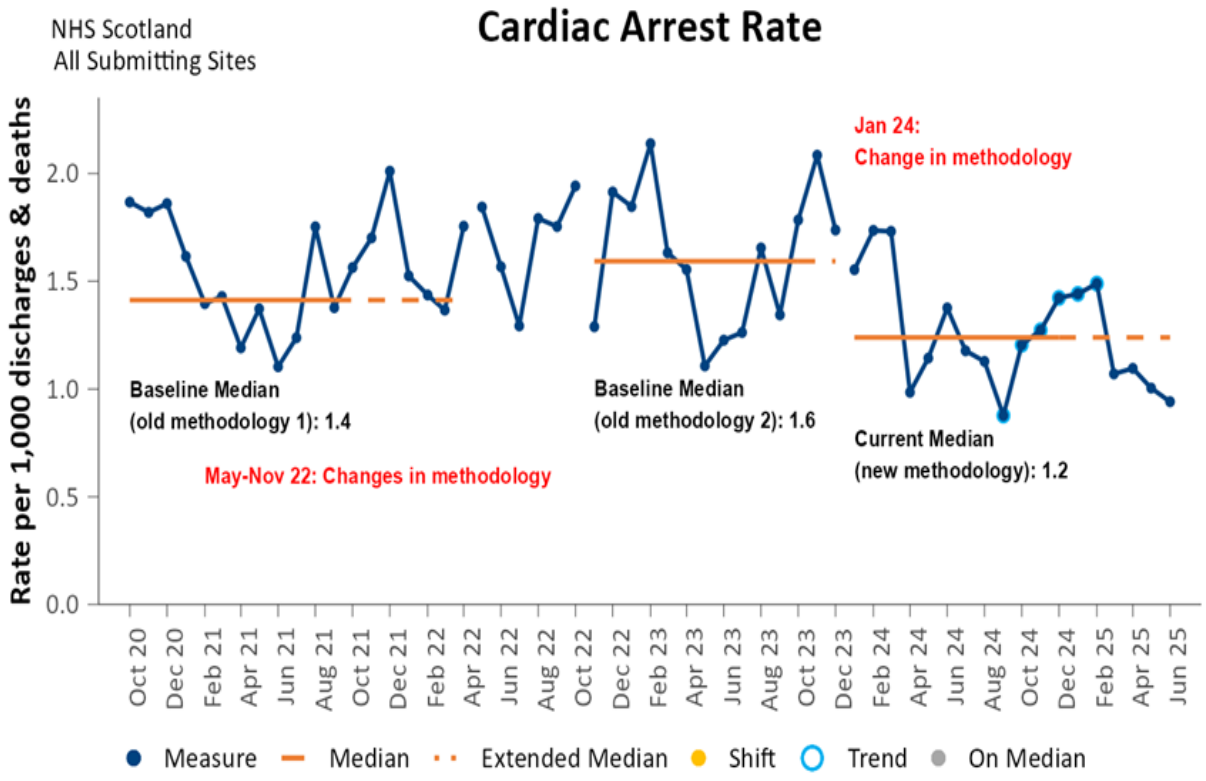
Data highlights – falls



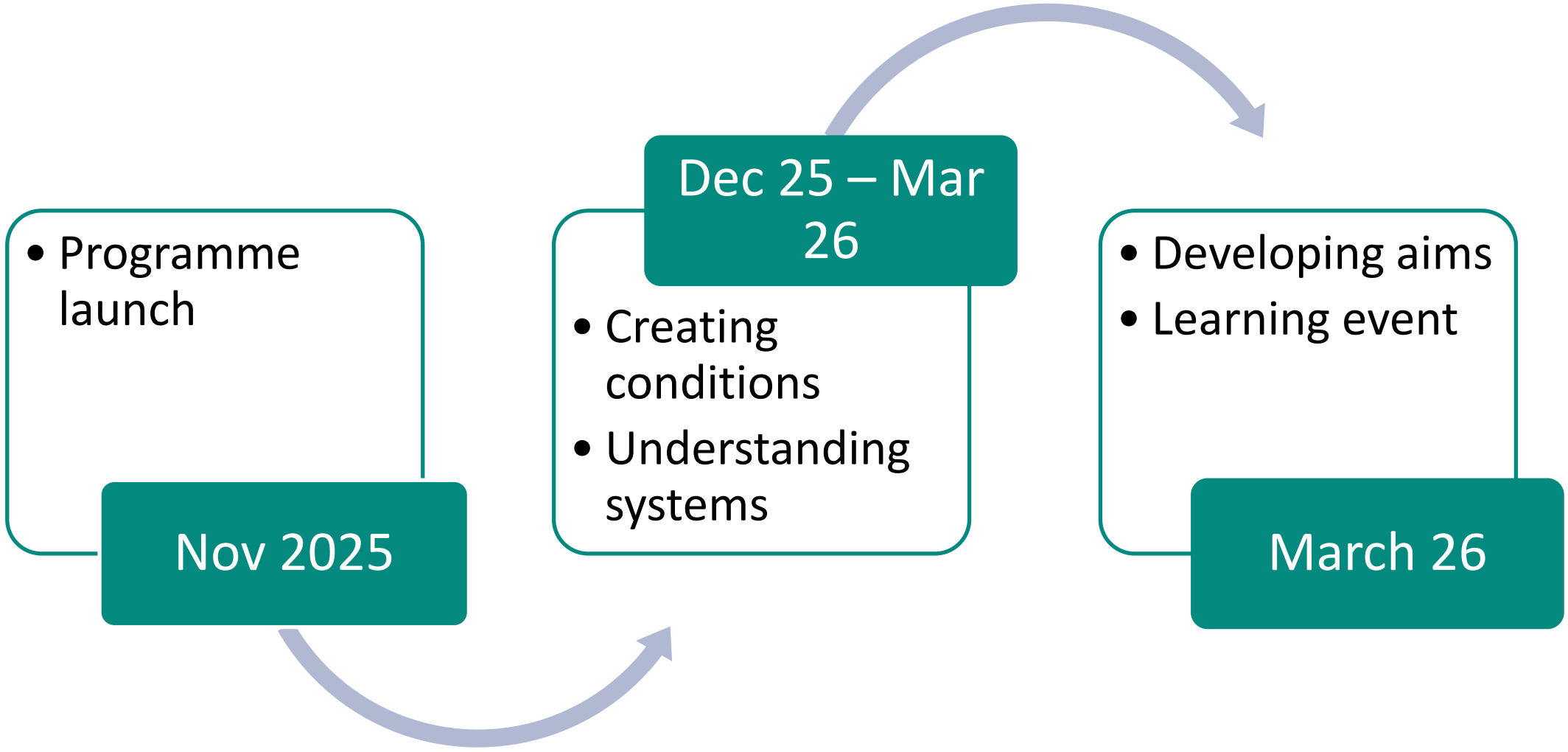
- Leadership to support a culture of safety
- Person centred approaches to care
- Multidisciplinary communication and approach
- Promoting safer mobility

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


• Programme launch
Nov 2025
Dec 25 – Mar 26
• Creating conditions
• Understanding systems
• Developing aims
• Learning event
March 26

Healthcare Improvement Scotland

Scottish Patient Safety Programme

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

NHS Lothian

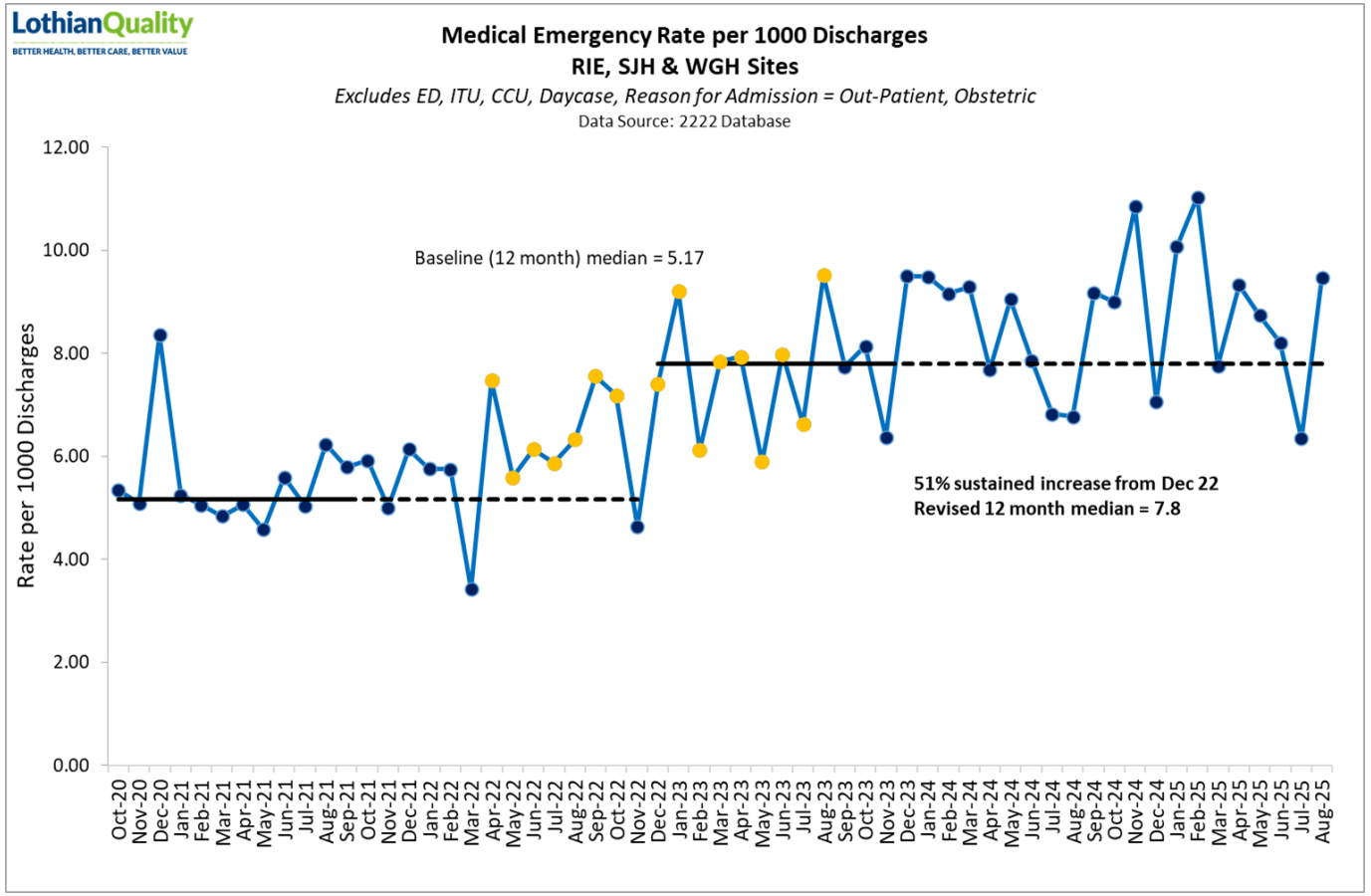
Dr Deepa Rangar
Geriatrician & Clinical Lead: Deteriorating patient programme

Jacqui Blackie
Quality Improvement Advisor

Emma Ford
Associate Quality Improvement Advisor

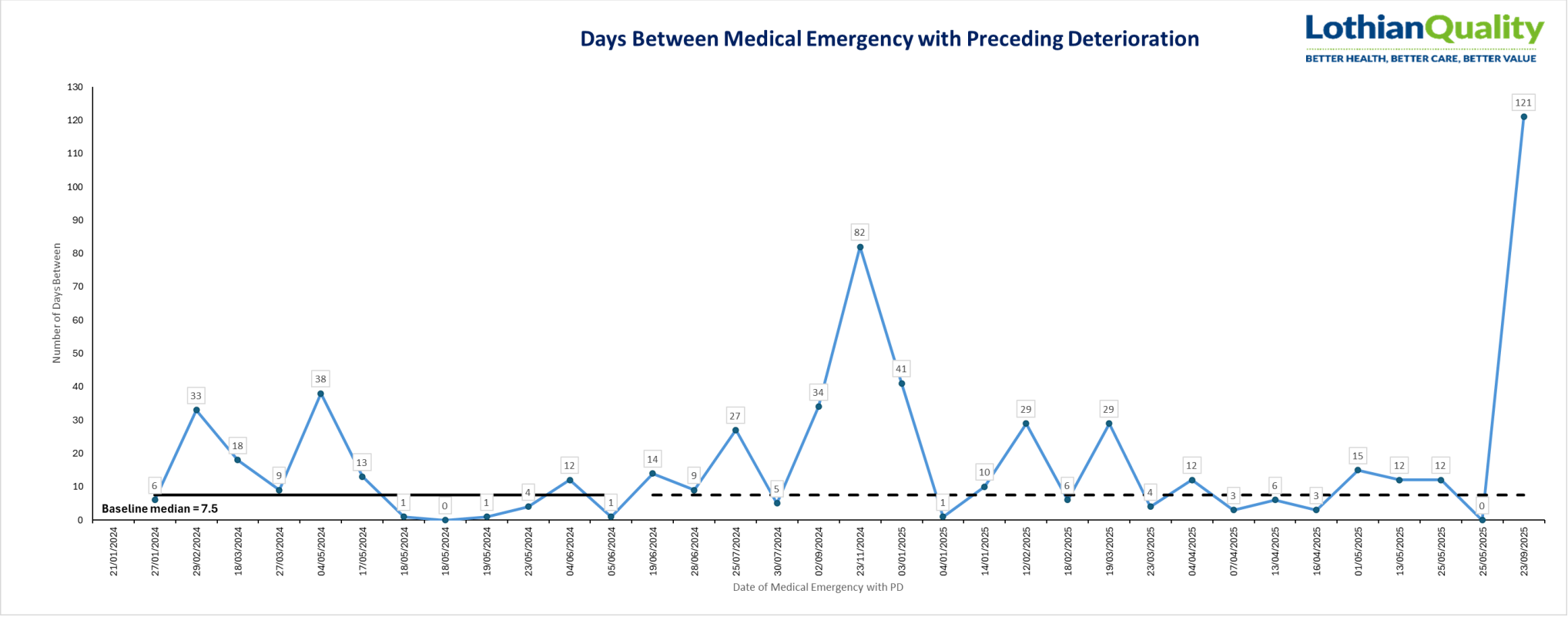
Background

- 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

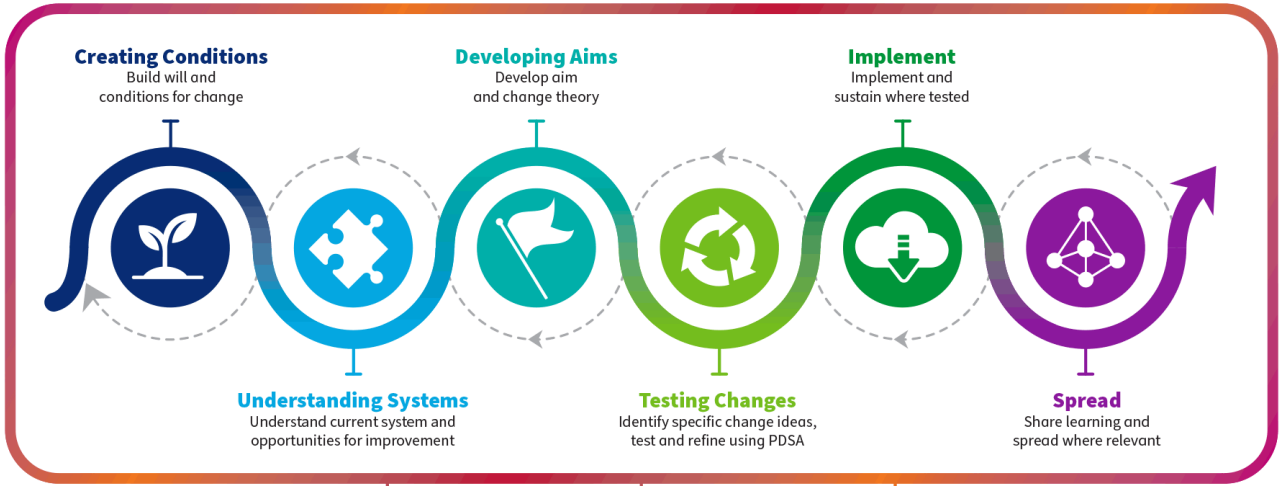
January to April

- Creating conditions
- Understanding systems
- Developing aims

May to present

- Testing changes
- Implement and sustain

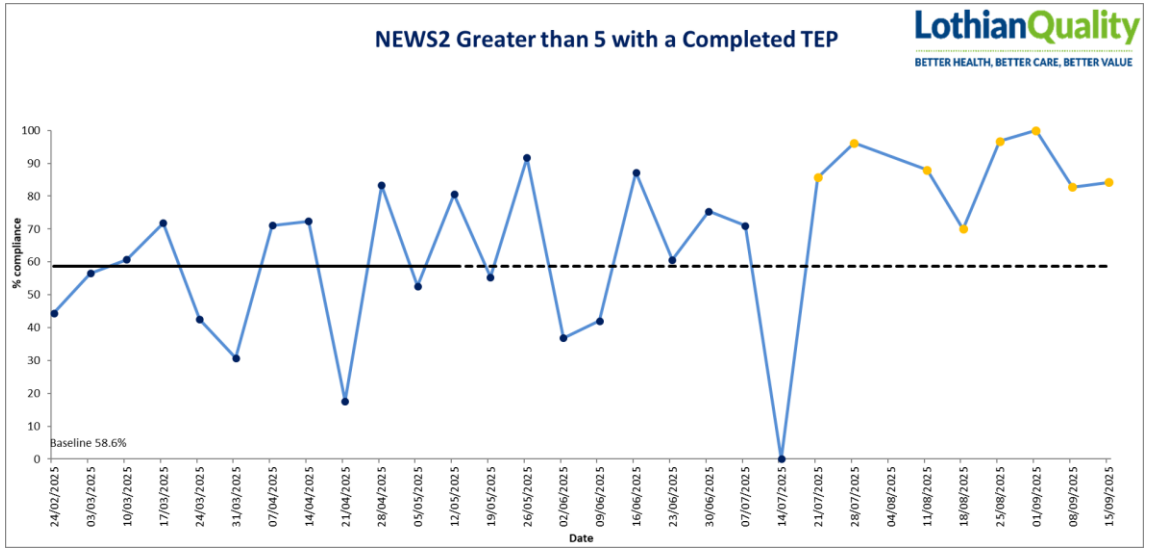
- Medical ward, highest number of calls for medical emergencies on the site.
- Screening of all calls from January 2024
- 61% of calls showed signs of preceding deterioration
- Developing an aim while ensuring confidence in staff to continue to call medical emergencies when needed.

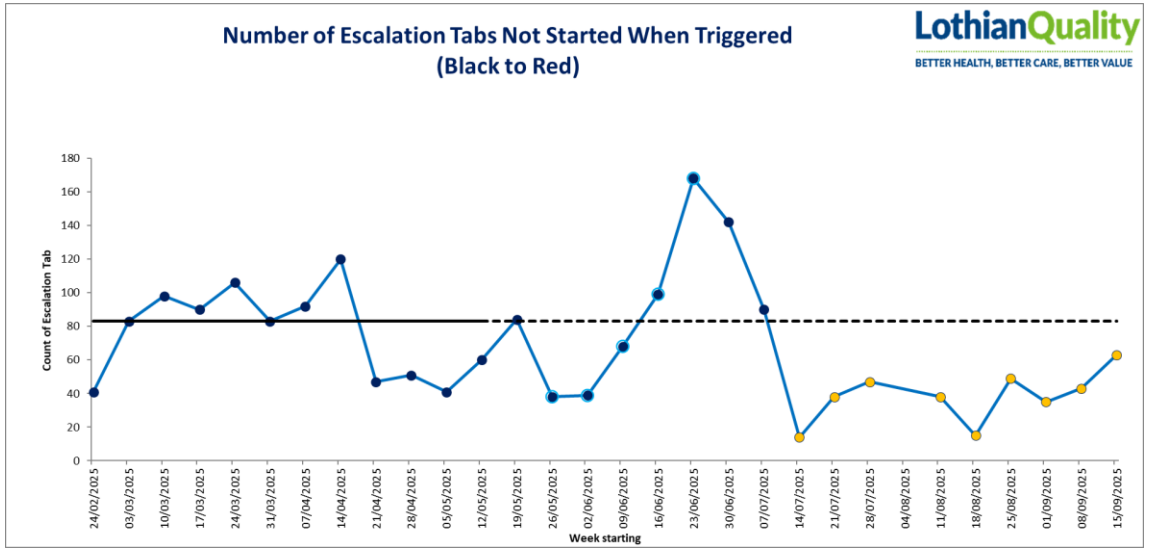


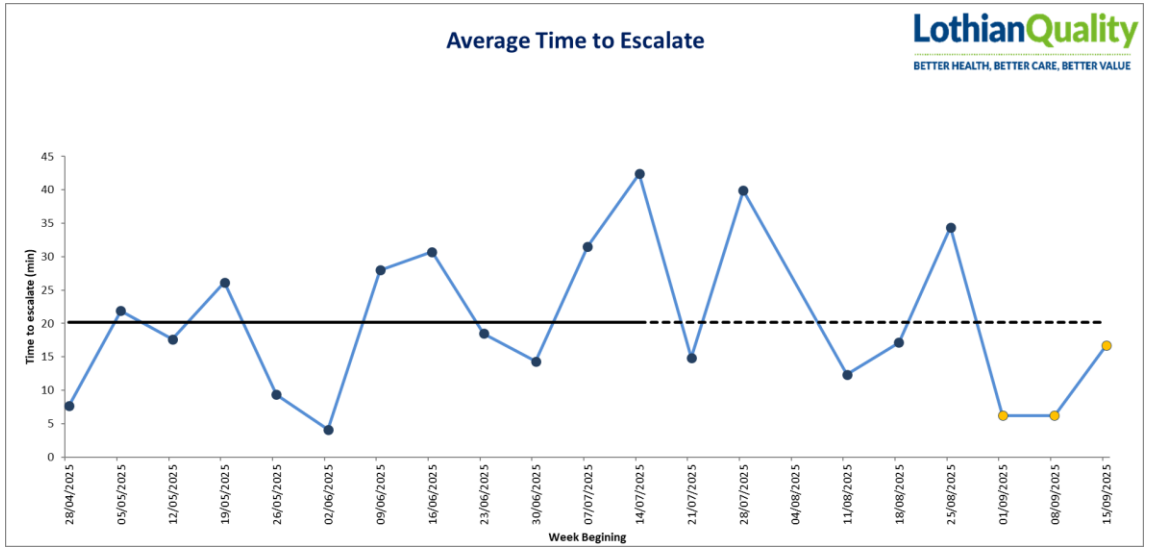
Improvement journey

Process measures

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







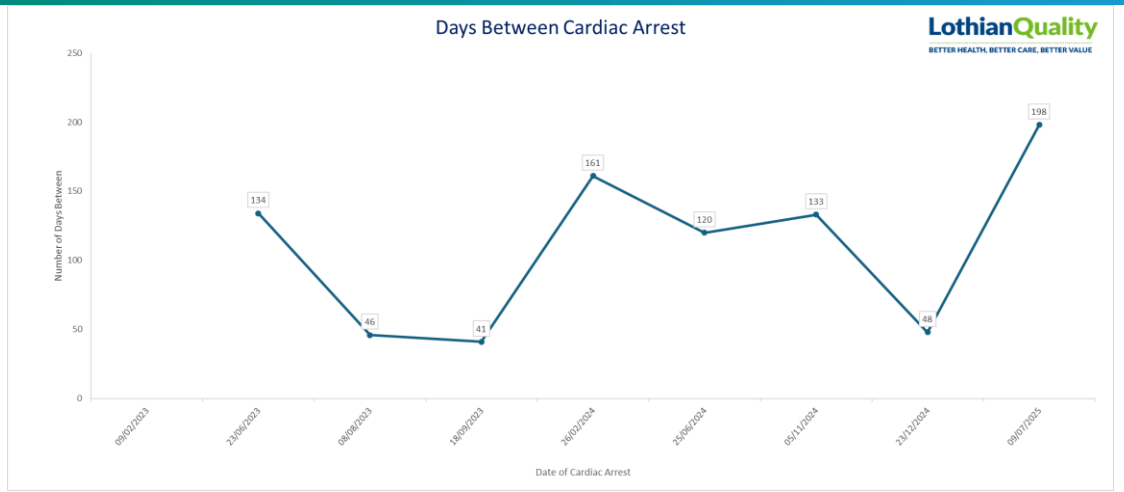
Results

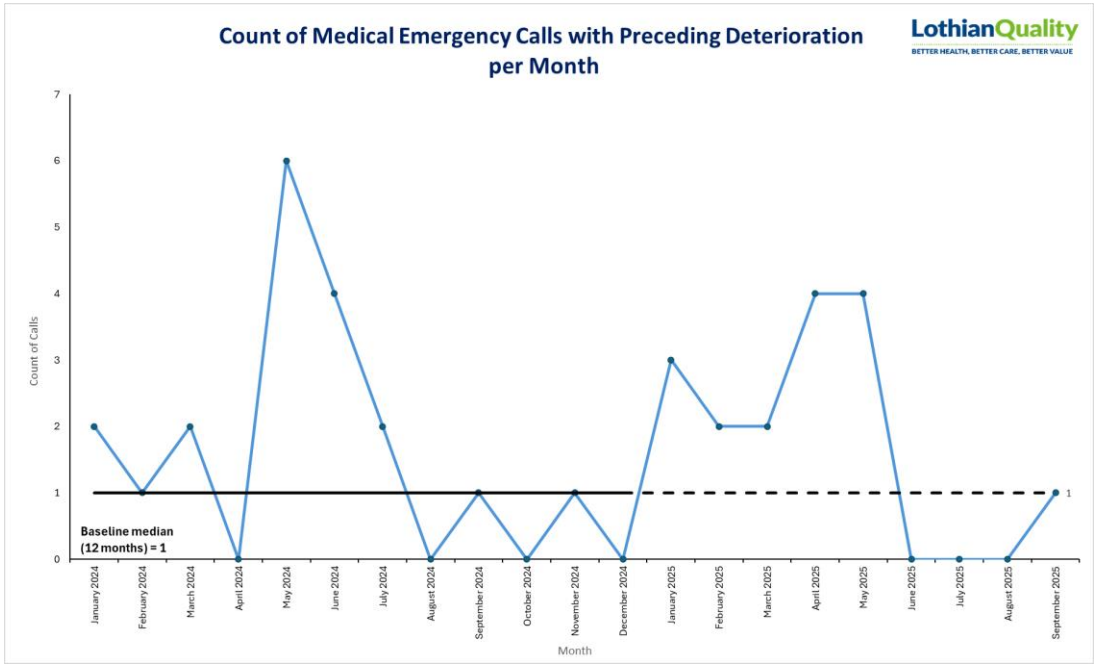
Outcome measures

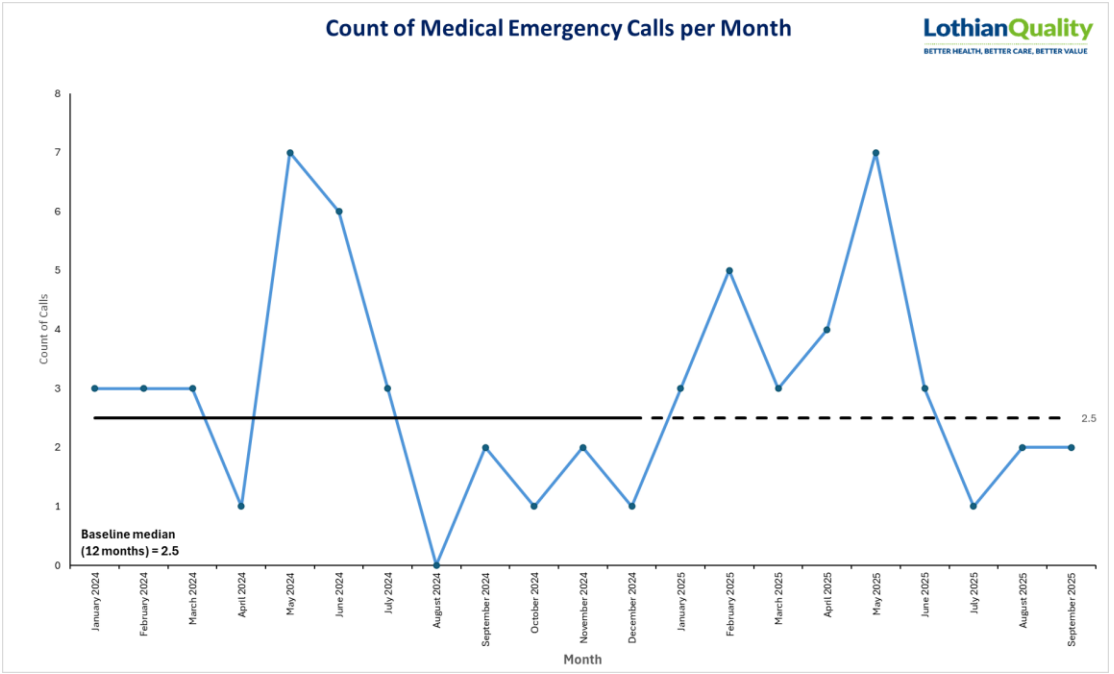
- Number of medical emergencies with preceding deterioration

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

- Leadership at all levels to support a culture of safety
- Safe clinical and care processes
- A people-led approach to the planning and delivery of safe care
- Effective and inclusive communication

Effective MDT working

- Clear roles and responsibilities
- Effective use of standardised communication processes
- Improving staff experience
- Safe transitions in care

Safe, effective and reliable processes

- Reliable scoring of NEWS2
- Reliable frequency of NEWS2
- Standardised process to documenting deterioration, escalation and response
- Reliable use of a structured response to deterioration (\depat)
- Reliable use of NEWS2 Escalation Policy
- Reliable use of NEWS overview board
- Action on patient, family and carer concern
- Action on clinical concern
- Reliable documentation of plan for review and reassessment

Person Centered Care

- Person centred care planning and goals of care documented
- Shared decision making
- Reliable conversations of what matters to you
- Reliable use of and review of treatment escalation plans (TEP)
- DNACPR conversations and documentation
- Reconciliation of KIS and previous ACP documentation on admission

Data Reliably Available and Shared

- Mechanism in place for shared learning across the system
- Reviewing 2222 calls for medical emergency
- Reliable programme for staff training and development
- System for learning to support continuous improvement

Healthcare Improvement Scotland

SCOTTISH PATIENT SAFETY PROGRAMME

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

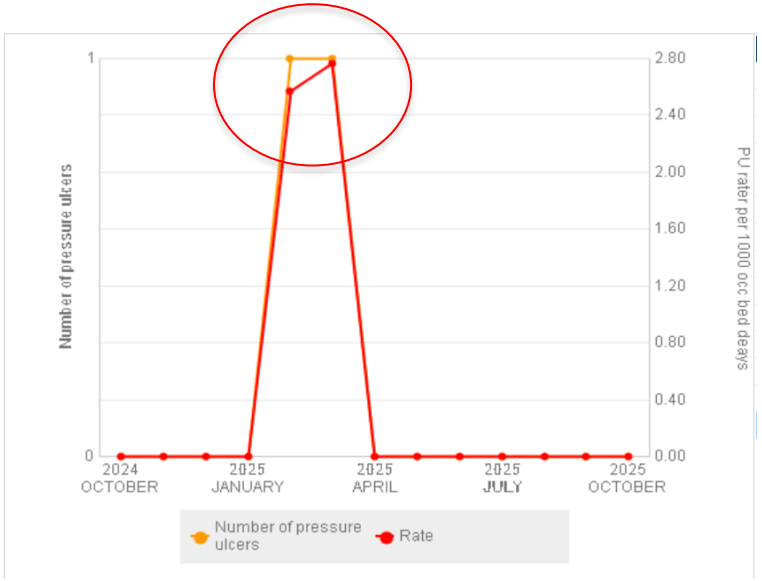
Heather Hodgson

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

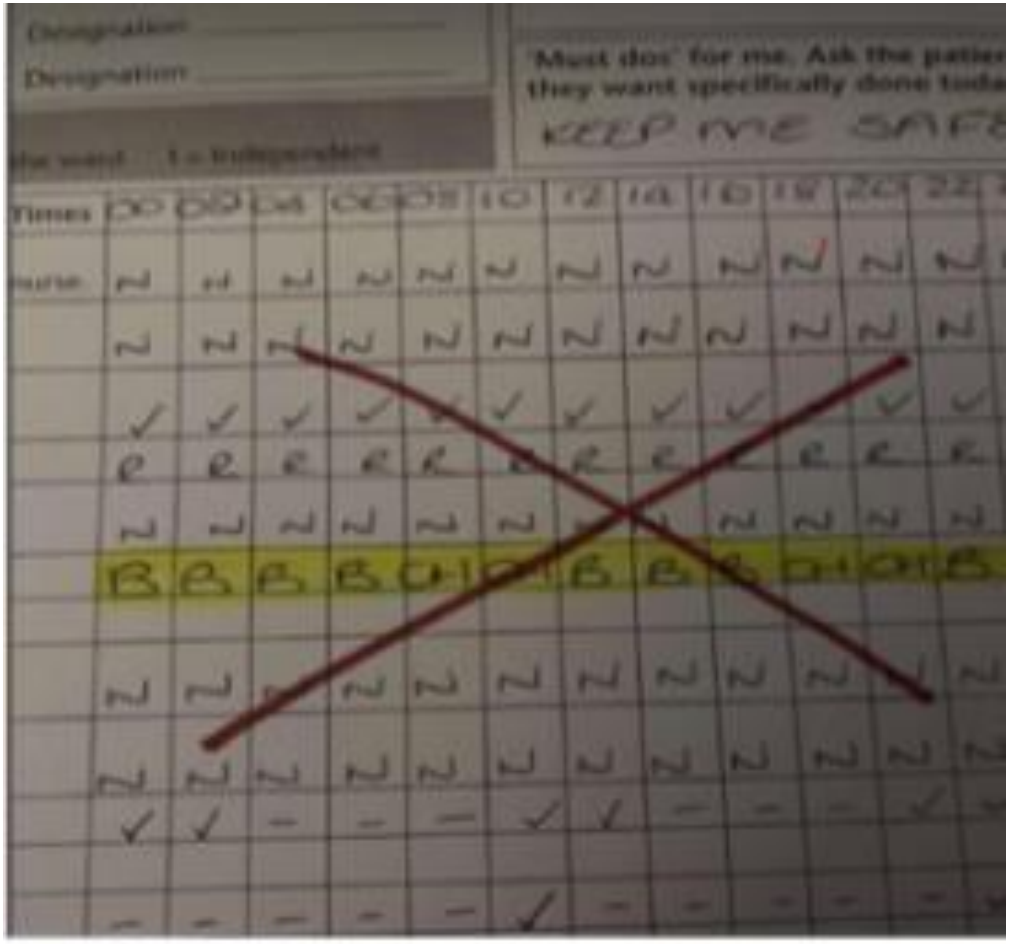
- Tissue Viability review conducted to determine causes

- 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



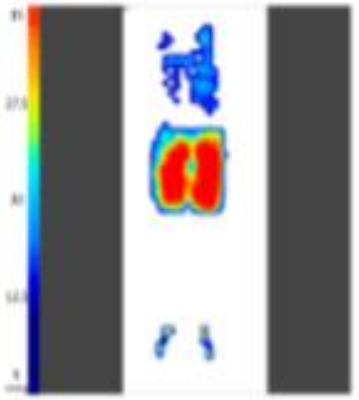
Aim

- 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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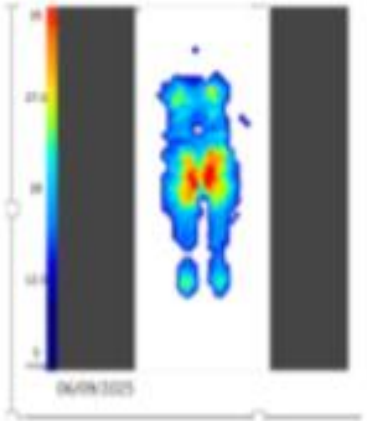

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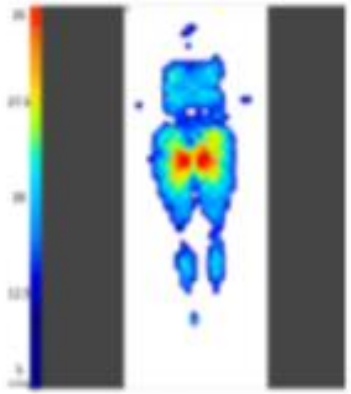

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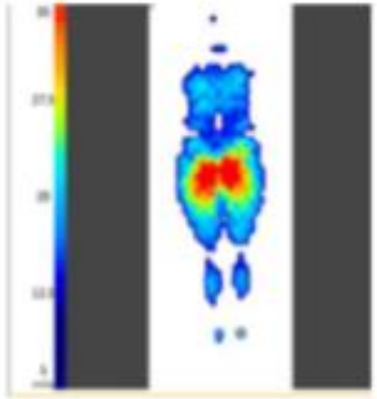

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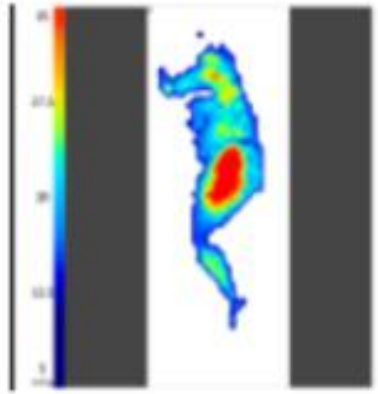

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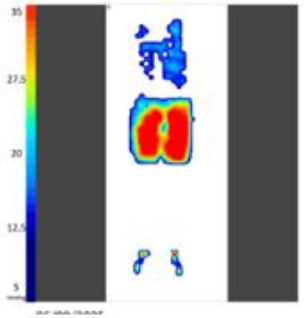

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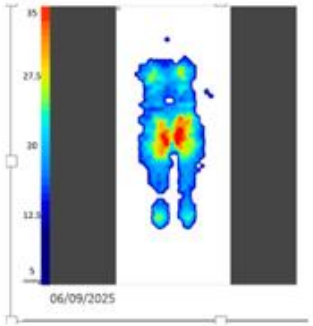

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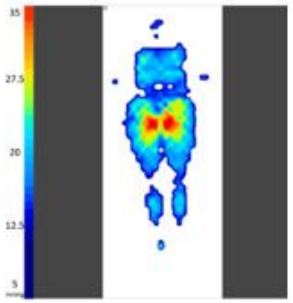

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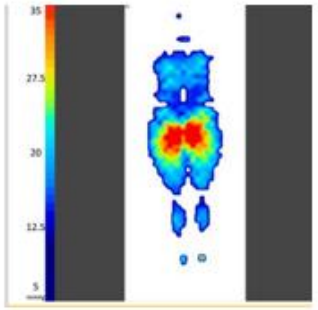

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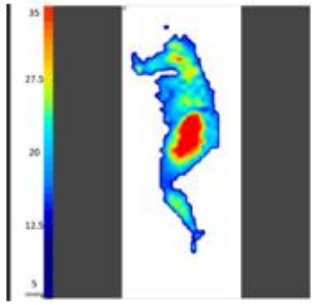

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A

B

C

D

E

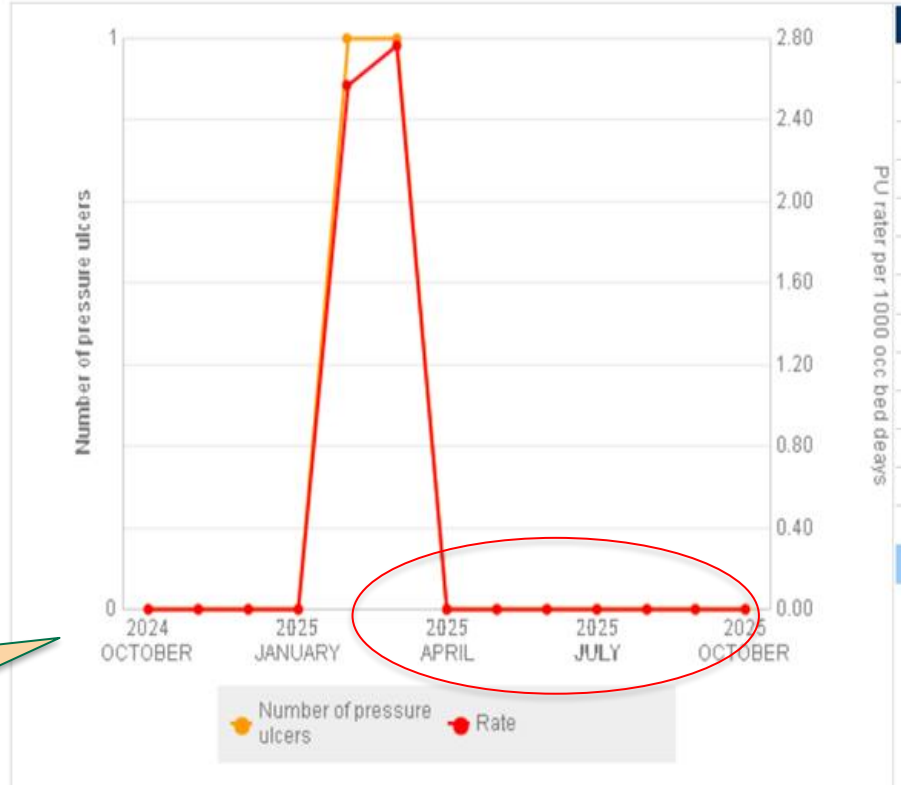
Results and Impact

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
2024	DECEMBER	0	0
2025	JANUARY	0	0
2025	FEBRUARY	1	2
2025	MARCH	1	2
2025	APRIL	0	0
2025	MAY	0	0
2025	JUNE	0	0
2025	JULY	0	0
2025	AUGUST	0	0.00
2025	SEPTEMBER	0	0.00
2025	OCTOBER	0	0.00
Total		**2**	**0.40**

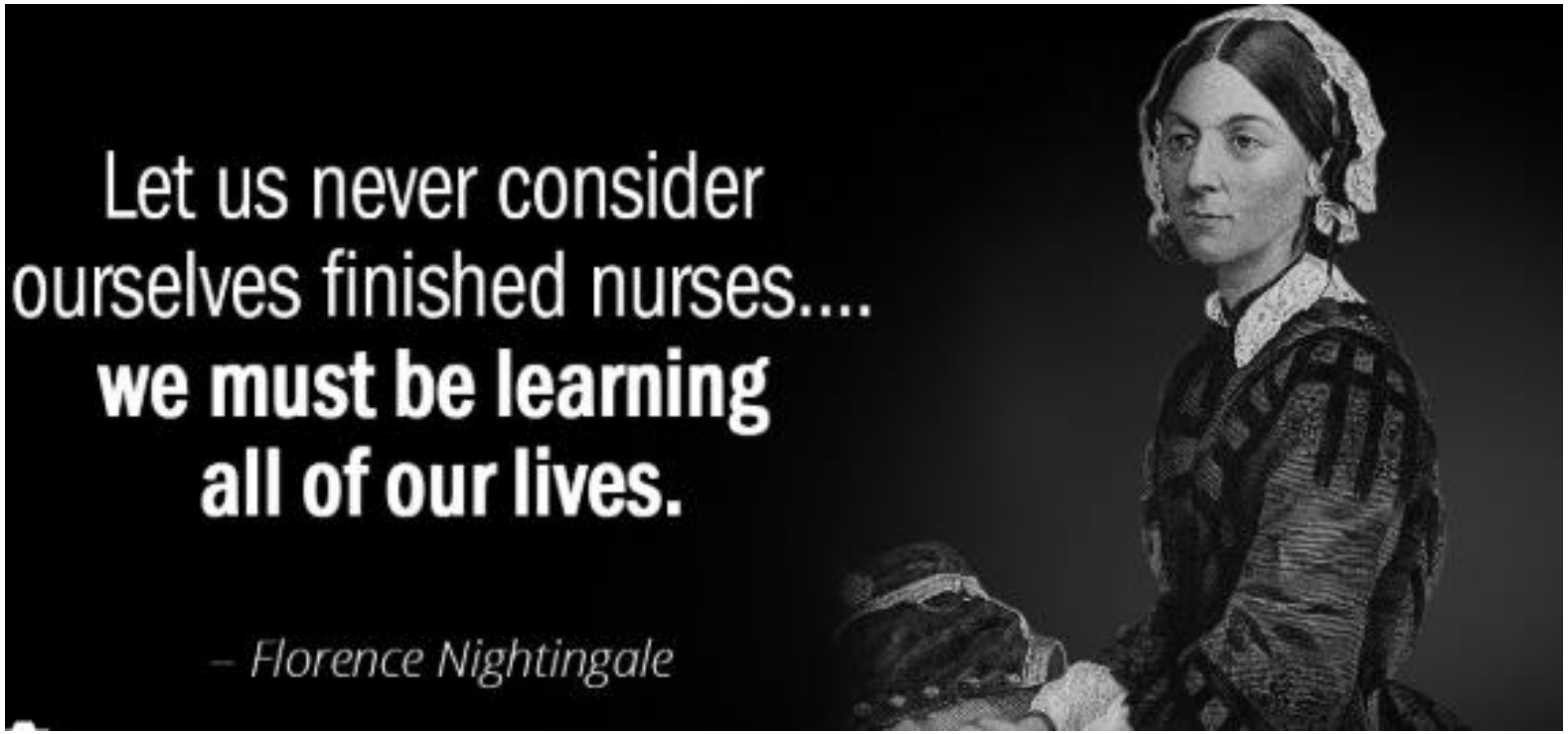
"Best pressure ulcer prevention presentation"

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

heather.hodgson@nhs.scot



Keep in touch

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Thank you