Scottish Patient Safety Programme – Reducing Pressure Ulcers in Care Homes Improvement Programme (SPSP-RPUCH)

Induction Event
27-28 June 2016

Health and Social Care Partnerships
- Argyll and Bute and Highland
- Dumfries and Galloway
- East Dunbartonshire
- Perth and Kinross

B I N G O

- Stand up, move around and speak to people
- Complete your bingo card
- Shout BINGO! when you have completed your card

Shhh… there is a prize!

5 min

Aims of Induction Event

1. To network and develop as a Steering Group team
2. To agree overall programme aims and plan, and way of working together
3. To build QI capability
4. To plan the work for the following months

Ground rules

- Be present
- Participate
- Listen openly
- Ask if you don't understand
- Challenge if you disagree
- Respect the learning
- Vegas rule
- Hawaii

TEAM

T TOGETHER
E EVERYONE
A ACHIEVES
M MORE

Agenda – Day 1

Timings	Content
10.30	Welcome and Introductions to the SPSP-RPUCH
11.40	Coffee break
11.50	How we will work together
12.15	Why pressure ulcers matter and occur?
13.00	Lunch
13.45	Introduction to the Model for Improvement
15.30	Coffee break
15:45	Safety Culture in care homes
17.45	Close of session
20.00	Dinner

Hopes and fears

Introduction to SPSP-RPUCH

Scottish Patient Safety Programme

Assurance   Improvement   Evidence

- Acute Adult
- Mental Health
- Maternity, Paediatrics and Children
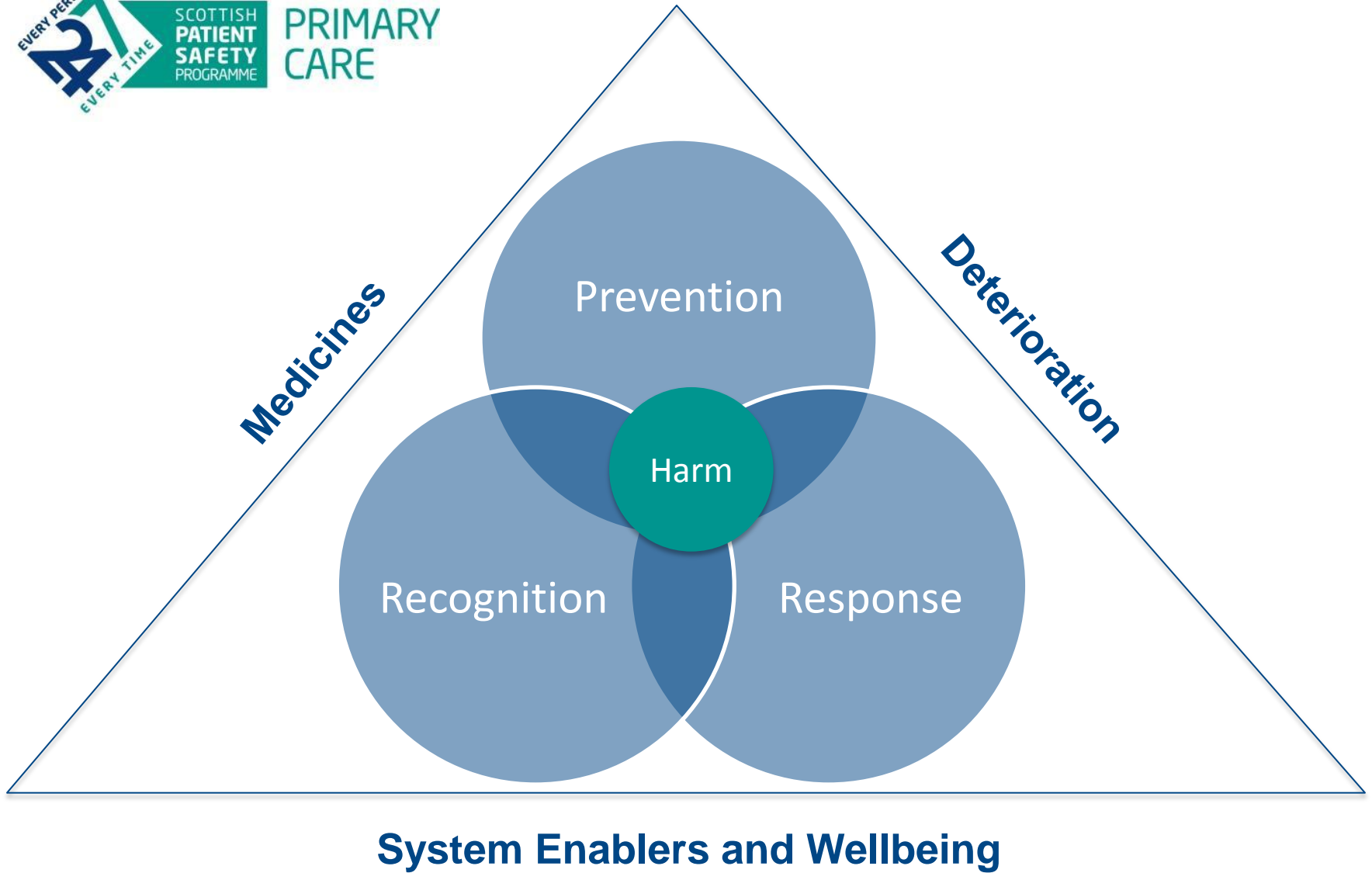- **Primary Care**

'The very first requirement in a hospital is that it should do the sick no harm.'

(Florence Nightingale)

Outcome 7.
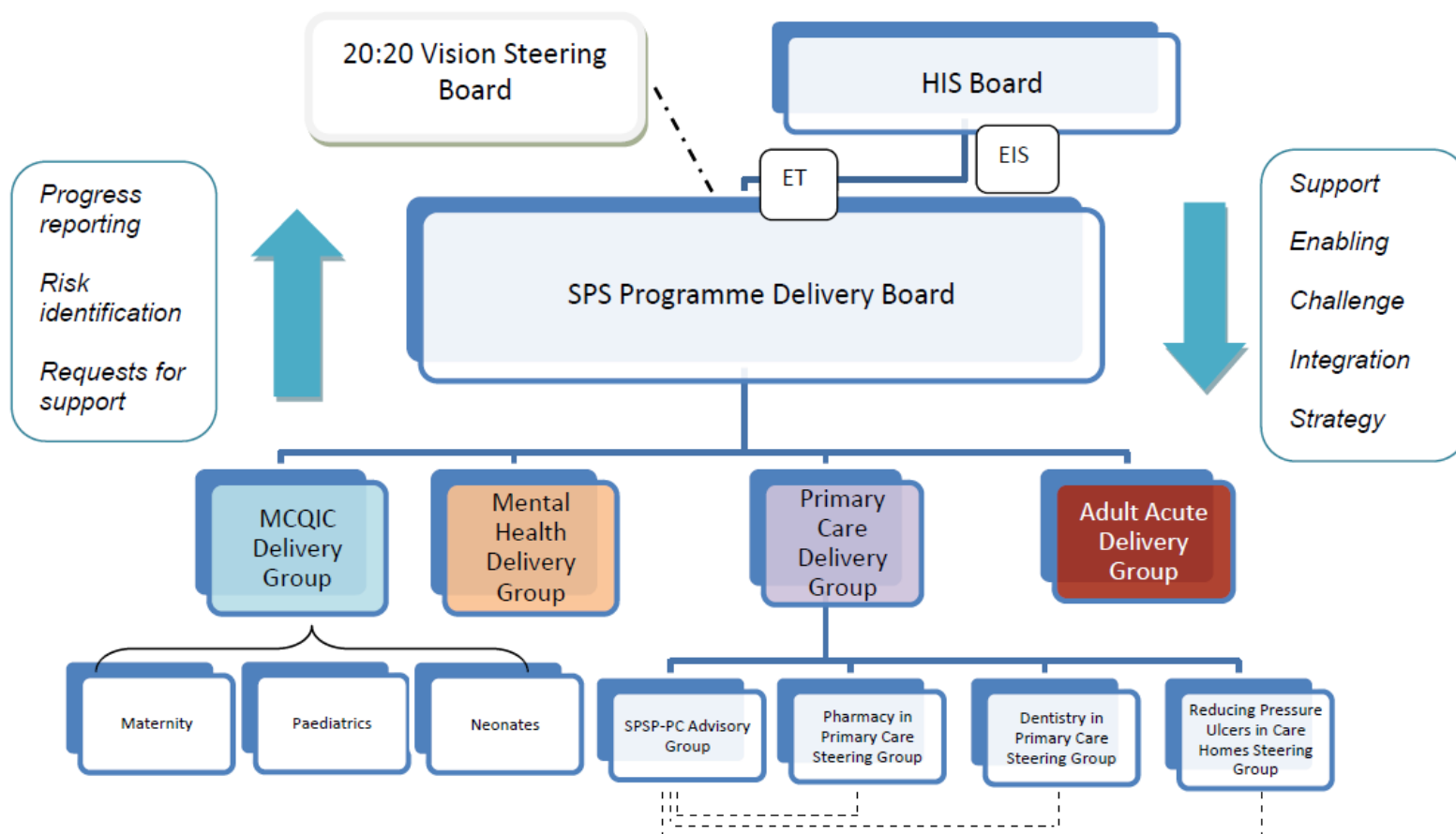# People using health and social care services are safe from harm

SPSP-PC Phased Approach

Stage 1	General Medical Services	Prototype and Testing 2010- 12 Launched March 2013
Stage 2	Pharmacy and Nursing	Proto-typing and testing from 2014
Stage 3	Dentistry and Optometry	Exploratory work late 2014

SPSP – PC Governance Structure

To reduce pressure ulcers by 50% in participating care homes by December 2017

Scottish Care

Membership organisation and representative body for independent providers of social care in Scotland

www.scottishcare.org

Margaret McKeith
National Lead
Partners for Integration

Scottish Care

What is the Independent sector?

- Individuals and organisations wholly or partially independent of the Public Sector.
- Care Homes, Care at Home, Housing Support and Day Care services
- Traditionally referred to the "Private Sector" and the "Voluntary Sector"
- Consists of single providers, small and medium sized groups, national providers, not for profit organisations, associations and charities

Scottish Care

Membership organisation and representative body for independent providers of social care in Scotland

www.scottishcare.org

PARTNERS FOR INTEGRATION

AIM – Ensure and support Independent sector involvement in the delivery of the agreed outcomes for Integration, and so play a lead role in service improvement at local and national levels.

Care Home and Care at Home Provision

- **32,888 Residents in Care Homes (2013)**
- 75% – Private Sector
- 14% – Voluntary Sector
- 11% – Local Authority / NHS

- **Care at Home** delivered to almost 63,00 people
- 814 services registered with Care Inspectorate
- Of these, 692 (85%) operated by Private and Voluntary sector organisations

Workforce

Total Social Care workforce of 199,670 in Scotland

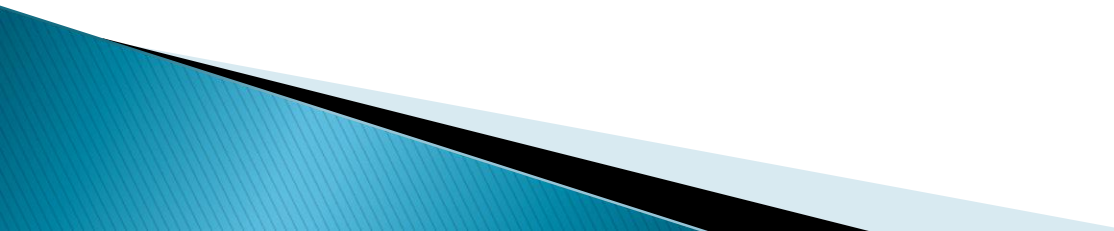Of these, 120,510 employed in Care Homes, care at Home or Housing Support Services (64%)

Of these, 97,800 are employed by the Private or Voluntary sectors.

Private sector is the largest employer – 41% of the workforce

Scottish Care

Models of Care

- Care Home (Nursing and Residential)
- Care at Home
- Housing Support
- Intermediate Care – Step Up, Step Down, Hospital at Home
- Respite Care
- Extra Care Housing
- End of Life Care
- Hospital at Home
- Care Villages

Challenges for Independent sector Providers

- Funding
- Recruitment and Retention
- Registration and Regulation
- Public image of sector
- Poor knowledge of range of services available
- Recognition of skills and expertise within the workforce
- Political environment
- Recognition of opportunities

Opportunities for Independent Sector

- Health and Social Care Integration
- Range of services available
- Entrepreneurial attitude
- Flexibility
- Innovation
- Drive for best value
- Opportunities for sharing good practice – local, national and international
- Commitment and attitude of workforce

Joyce O'Hare

Health Improvement Manager

OVERVIEW OF

CARE INSPECTORATE HEALTH IMPROVEMENT PRESSURE ULCERS

1. What improvement activity have you done in the past?

2. What improvement tools did you use?

How we will work together

What makes a successful collaborative?

We want to run a successful improvement collaborative

Our checklist:

- [ ] Involve the right people
- [ ] Pick the right problem
- [ ] Organise and adapt
- [ ] Provide the necessary resources

For more tips and evidence about what works, read *Improvement collaboratives in health care*: www.health.org.uk/collaboratives-scan

Project Milestones

2016 **2017**

Current state assessment

Safety Climate Cards

Safety Climate Cards

Induction Event

Learning session 1 – 1 day (x4)

Learning session 2 – ½ day (x4)

Learning session 3 – ½ day (x4)

May   June   July   Aug   Sep   Oct   Nov   Dec   Jan   Feb   Mar   Apr   May   June   July

◆ Reporting back (including data)

▲ Steering group meeting (evaluation team will provide updates in this meetings)

PRIMARY CARE

SCOTTISH PATIENT SAFETY PROGRAMME

scottishcare

care inspectorate

Reports - data

Reports - data

Reports - data

Reports - data

Away team

Away team

Away team

Away team

Data – Reports?

Data – Reports?

Data – Reports?

Data – Reports?

CH_1	CH_1	CH_1	CH_1
CH_2	CH_2	CH_2	CH_2
CH_3	CH_3	CH_3	CH_3
CH_4	CH_4	CH_4	CH_4
CH_5	CH_5	CH_5	CH_5

Argyll and Bute and Highland

Dumfries and Galloway

East Dunbartonshire

Perth and Kinross

Compact

1. What do you agree with?

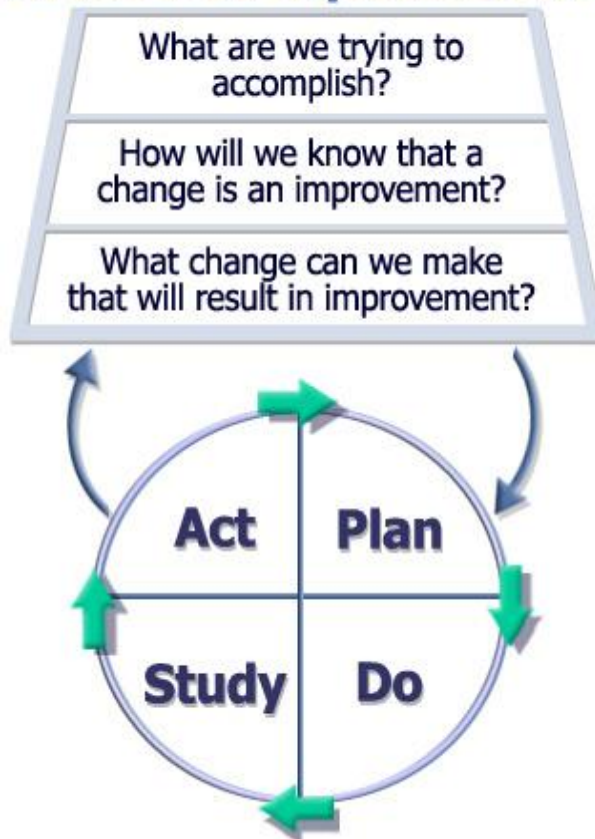2. What other information would you like to add?

3. What don't you agree with?

Introduction to the Model for Improvement
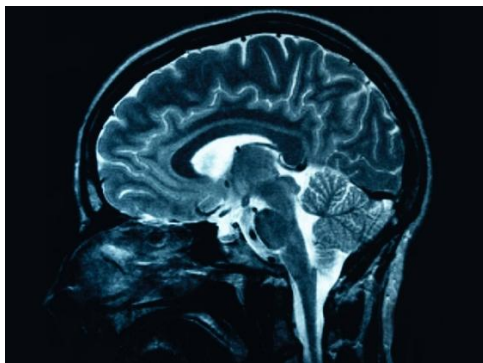
The Model for Improvement

Model for Improvement

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

Act | Plan
Study | Do

'This model is not magic, but it is probably the most useful single framework I have encountered in twenty years of my own work on quality improvement'
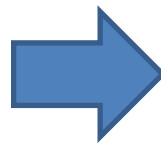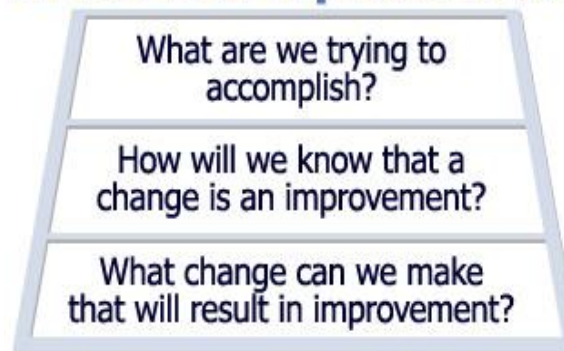
Dr Donald M. Berwick
Former Administrator of the Centres for Medicare & Medicaid Services
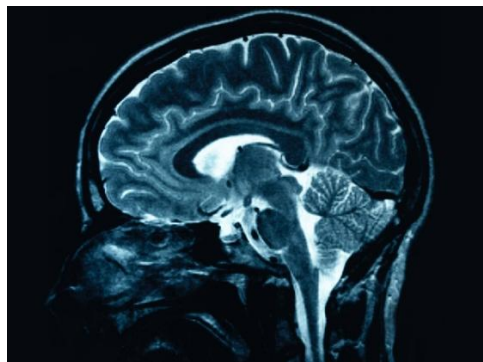*Professor of Paediatrics and Health Care Policy at the Harvard Medical School*

Scottish Patient Safety Programme — Primary Care

Model for Improvement

What are we trying to accomplish?

How will we know that a change is an improvement?

What change can we make that will result in improvement?
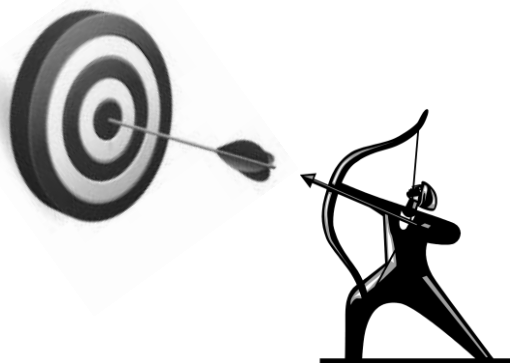
Act | Plan
Study | Do

PLANNING
part of the MfI

Model for Improvement

What are we trying to accomplish?

How will we know that a change is an improvement?

What change can we make that will result in improvement?

Act — Plan

Study — Do

Developing the team's Aim Statement

Aim Statements – how much by when?
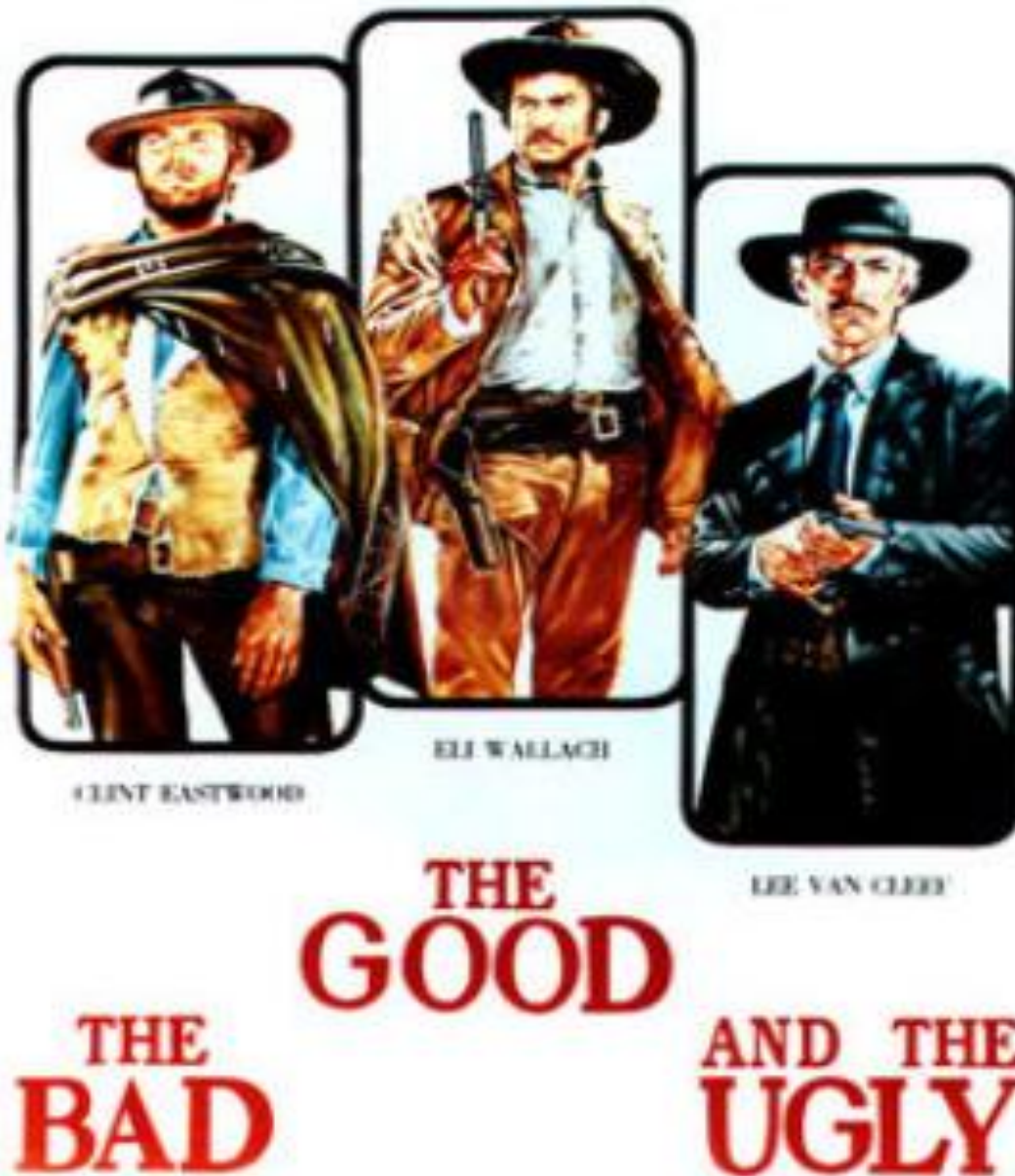
AIM Content

- Explicit over arching description
- Specific actions or focus
- Goals

AIM Characteristics

- Measurable (How good?)
- Time specific (By when?)
- Define participants and customers

Aim Statements You Make the Call!

Aim Statement	Good	Bad	Ugly
We aim to reduce harm and improve patient safety for all of our internal and external customers.			
By June of 2011 we will reduce the incidence of pressure ulcers in the critical care unit by 50%.			
Our outpatient testing and therapy patient satisfaction scores are in the bottom 10% of the national comparative database we use. As directed by senior management, we need to get the score above the 50th percentile by the end of the 2ndQ of 2011.			
We will reduce all types of hospital acquired infections.			
According to the consultant we hired to evaluate our home health services, we need to improve the effectiveness and reliability of home visit assessments and reduce rehospitalisation rates. The board agrees, so we will work on these issues this year.			
Our most recent data reveal that on the average we only reconcile the medications of 35% of our discharged inpatients. We intend to increase this average to 50% by 4/1/11 and to 75% by 8/31/11.			

Model for Improvement

What are we trying to accomplish?

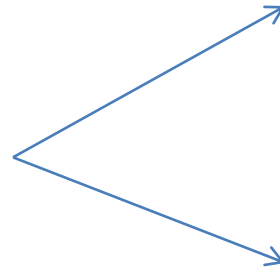How will we know that a change is an improvement?

What change can we make that will result in improvement?
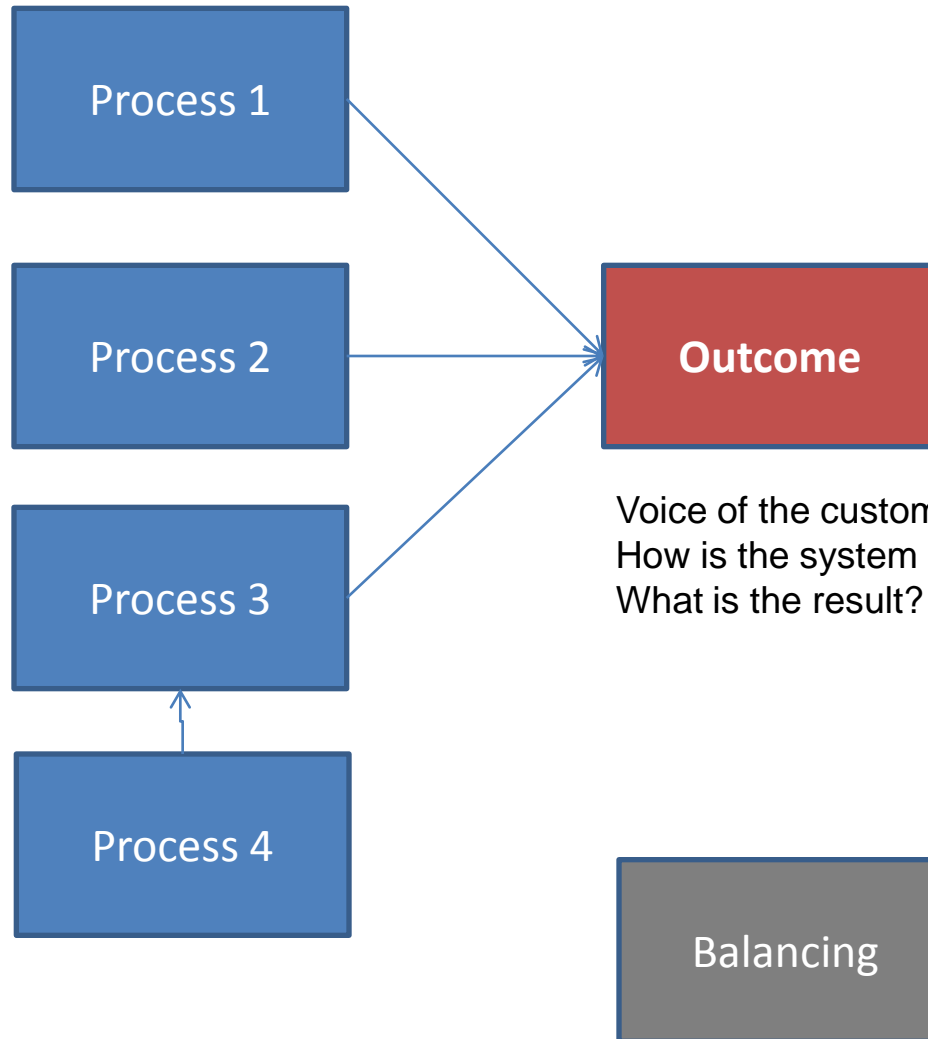
Change vs Improvement

> *"All improvement requires change but **not all change will result in an improvement"***

Langley et al, 2009 (The Improvement Guide)

Measures

Process 1

Process 2

Process 3

Process 4

Outcome

Balancing

Voice of the workings of the system. Are the parts/steps in the system performing as planned?

Voice of the customer or patient. How is the system performing? What is the result?

What happened to the system as we improved the outcome and process measures? (eg unanticipated consequences, other factors influencing outcome)

Measurement

- Clear definitions
- Common understanding
- Are we all measuring the same thing, in the same way?
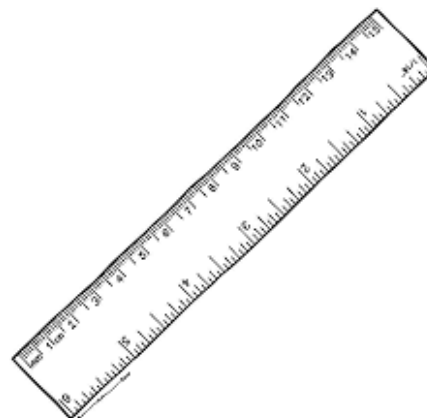
How big is your banana?

1. Create a step-by-step operational definition to capture the size of your banana accurately.

2. Measure your banana using this definition, write down the result but keep it secret!

3. Pass your definition and banana to the next table. They will then use your definition to measure the banana.

4. Compare results

Measure your banana using the tools

Changes / ideas sourced from:

- **evidence**

- **experience**

- **hunches**

Model for Improvement

What are we trying to accomplish?

How will we know that a change is an improvement?

What change can we make that will result in improvement?

Act | Plan

Study | Do

Driver Diagram

Outcome	1º driver	2º driver	Specific Change Ideas

Outcome — 1º driver — 2º driver — Specific Change Ideas

- Aim or Outcome
- 1º driver 1
- 1º driver 2
- 2º driver 1
- 2º driver 2
- 2º driver 3
- 2º driver 4
- 2º driver 5

Ideas:
1
2
3
4
5
6
7
8
9
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N

Driver Diagram
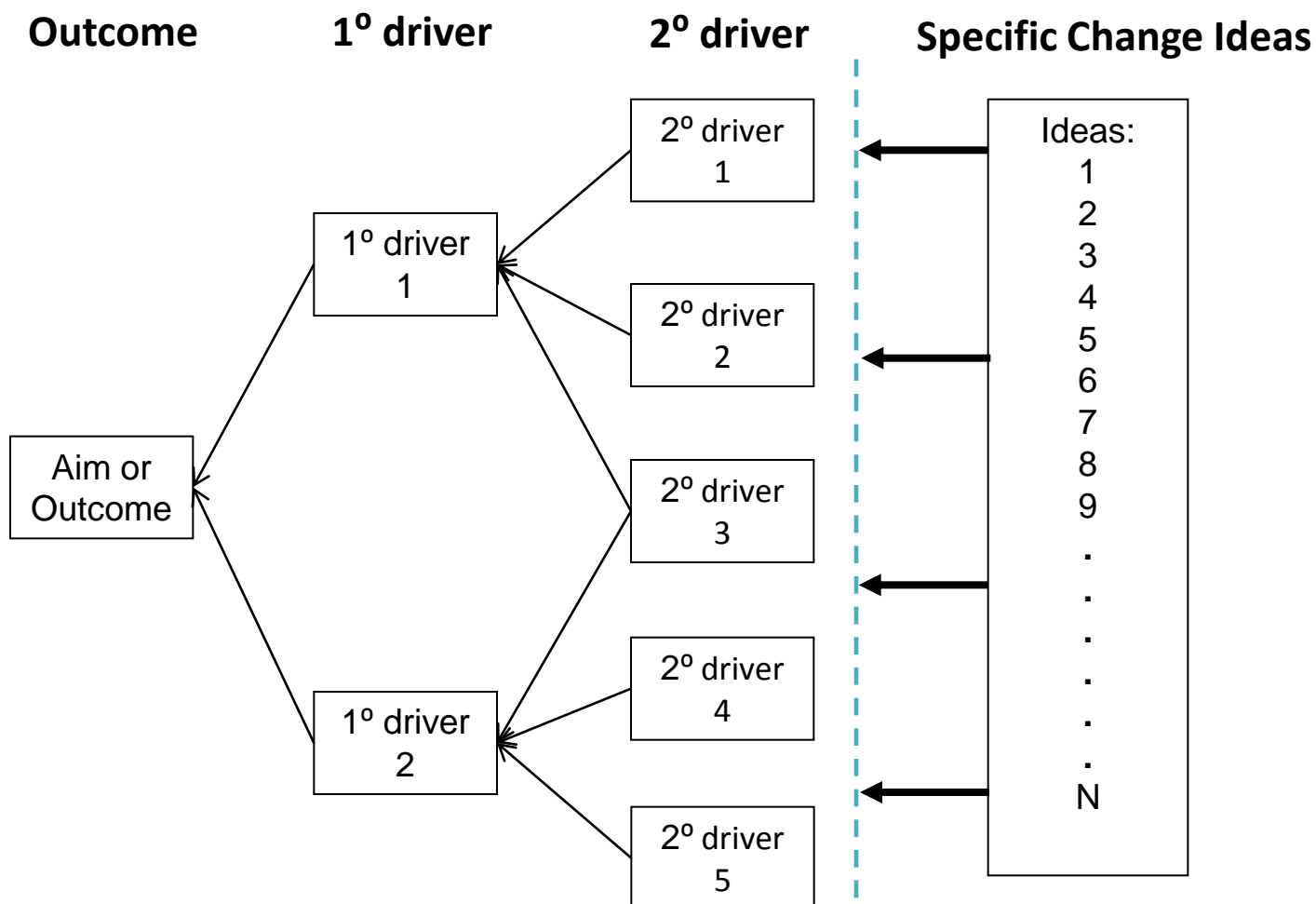
	Primary	Secondary	Change Ideas
Aim 95% of patient(s) have their medicines accurately reconciled in community pharmacy by July 2016	Person-centred Care	• Patient(s)/carer(s) understands how to take the right medicine(s) at the right time in the right way • Compliance support assessment • Patient(s)/carer(s) are actively involved in medicines reconciliation and involved in discussions regarding changes	Teach Back technique Compliance support tools (reminder charts, apps. medication administration reminder (MAR) chart) Patient(s)/carer(s) keeps patient(s)/carer(s) held list/record/passport Prompts for patient(s)/carer(s)s to take a medicines list to all appointments
	Leadership and Culture	• Enable a culture to support safety and improvement work • Promote clinical role of pharmacists within the healthcare team • Pharmacy Leadership to support medicines reconciliation	Participation in Safety Climate Survey Multidisciplinary quality improvement training Share learning from SEAs, etc Promote the clinical significance to patient(s)/carer(s) safety of having an accurate and current medicine list
	Team Work, Communication and Collaboration	• Counsel patient(s)/carer(s) on changes to their medicines • Clear interface communications • Discharge information is communicated to Community Pharmacy • Community Pharmacy has access to Immediate Discharge Letter (IDL) • GP practice communicates any GP changes through GP10 prescription to pharmacist • Pharmacist communicates any pharmacist changes to GP practice following medicines reconciliation • Fostering whole team participation within the pharmacy	Communication systems between GP, acute and community pharmacy IDL (or equivalent) sent to Community Pharmacy at discharge Two-way communication tool (including OTC)
	Safe, Effective and Reliable Care	• Community Pharmacy to check daily for IDL • Education and training for pharmacy teams, patients and carers • Error and Near-miss identifying, reviewing and reporting • New medicines intervention identified (talk to patient and record) • Patient(s)/carer(s) returns any discontinued medicines	Teach Back and NES LearnPro module Awareness of RPS near-miss support tools Record new medicine intervention (NMI) in PCR Invite patient(s)/carer(s) to bring any discontinued medicines to pharmacy.
	Systems and IT Infrastructure	• Effective IT available • Explore and optimise eHealth solutions to support medicines reconciliation • Standardise documentation and communication tools	Access to ECS and IDL information Communication tool between AA/GP/CP

Create a driver diagram with the cards provided
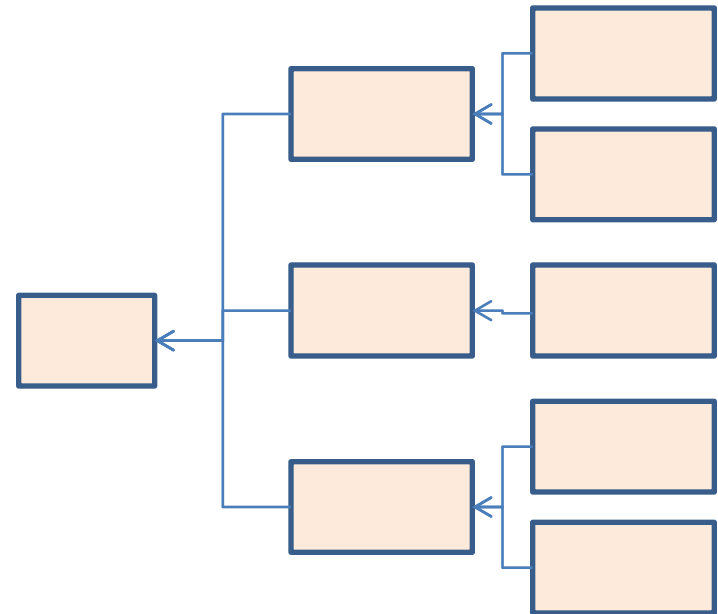
DOING
part of the MfI

PDSA cycles

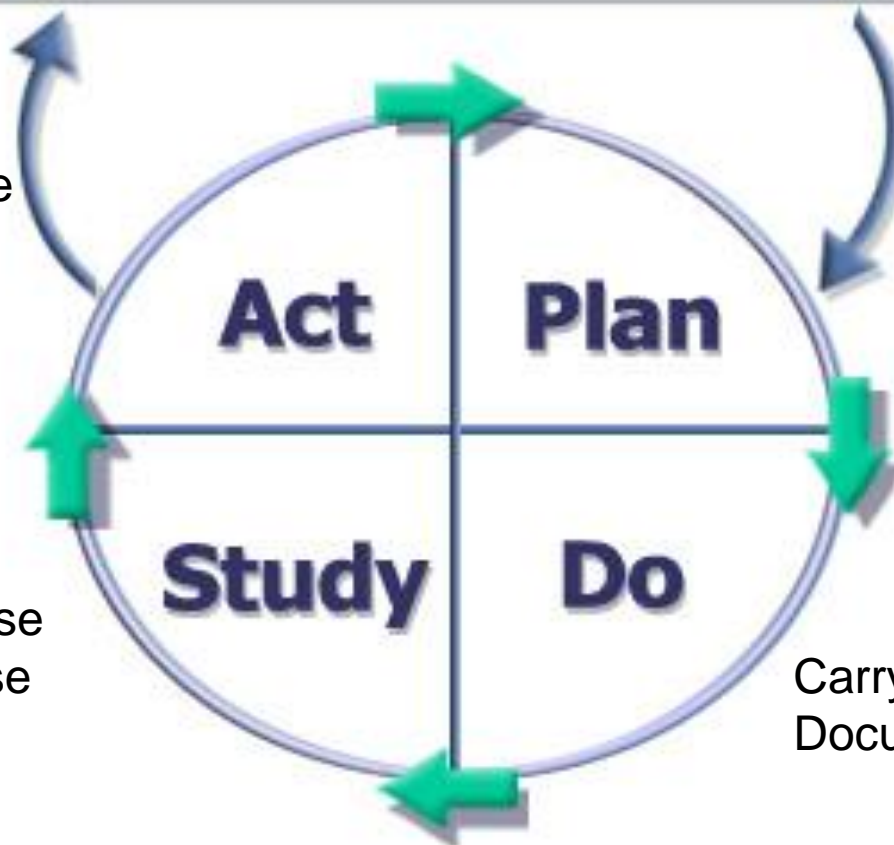- Please
- Do
- Something
- ANYTHING!!

What change can we make that will result in improvement?
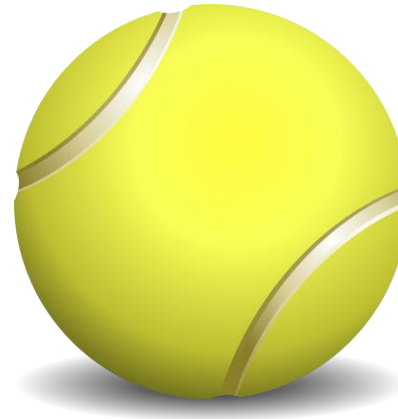
Act — What changes are to be made? Next cycle?

Plan — Aim & plan the cycle (who, what, when & how)

Study — Compare/analyse data, Summarise learning

Do — Carry out the plan Document problems

Tennis ball exercise

- Not just yet!

- Form yourselves into groups of 5, 6, 7 or 8

- Assign a time keeper

- Assign a number to each of the other people at your table, starting with the number 1 and continuing until you run out of people

Aim: to reduce the time taken for every person to touch the ball from X (your baseline)

- Test 1 will provide your baseline

  - following the sequence provided on the next slide note the time taken for every person to touch the ball

  - timekeeper to note how long the team takes to complete the process (in seconds)
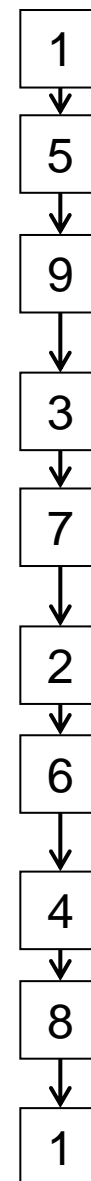
Exercise Sequence

•9 people

•8 people

•7 people

•6 people

•5 people

5 people: 1 → 3 → 5 → 2 → 4 → 1

6 people: 1 → 4 → 6 → 3 → 5 → 2 → 1

7 people: 1 → 4 → 7 → 3 → 6 → 2 → 5 → 1

8 people: 1 → 4 → 8 → 3 → 7 → 5 → 2 → 6 → 1

9 people: 1 → 5 → 9 → 3 → 7 → 2 → 6 → 4 → 8 → 1
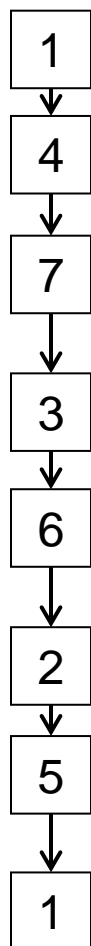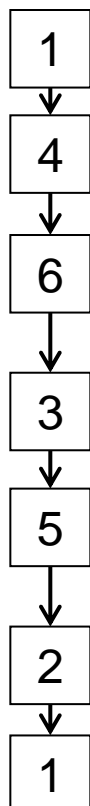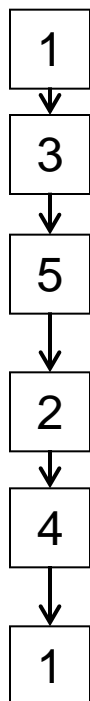
Tests 2, 3, 4 . . .

- Form a theory, come up with change ideas, use the MFI to test those ideas

- Rules:

  - The initial sequence as provided must be adhered to

  - You may only test <u>one</u> change idea at a time
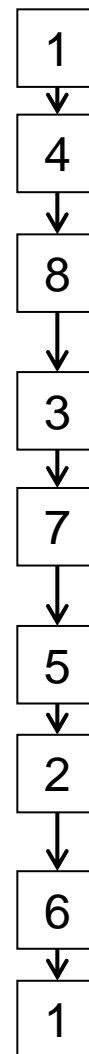
  - After each test stop and report your results

Sequence

•9 people

•8 people

•7 people

•6 people

•5 people

5 people:
1 → 3 → 5 → 2 → 4 → 1
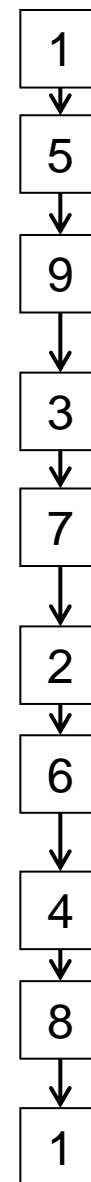
6 people:
1 → 4 → 6 → 3 → 5 → 2 → 1
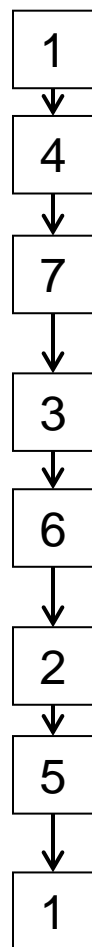
7 people:
1 → 4 → 7 → 3 → 6 → 2 → 5 → 1
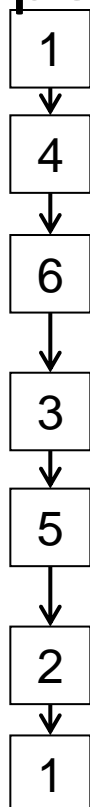
8 people:
1 → 4 → 8 → 3 → 7 → 5 → 2 → 6 → 1

9 people:
1 → 5 → 9 → 3 → 7 → 2 → 6 → 4 → 8 → 1
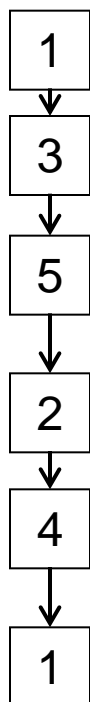
"*I did not fail one thousand times; I found one thousand ways how not to make a light bulb.*"

Thomas Edison
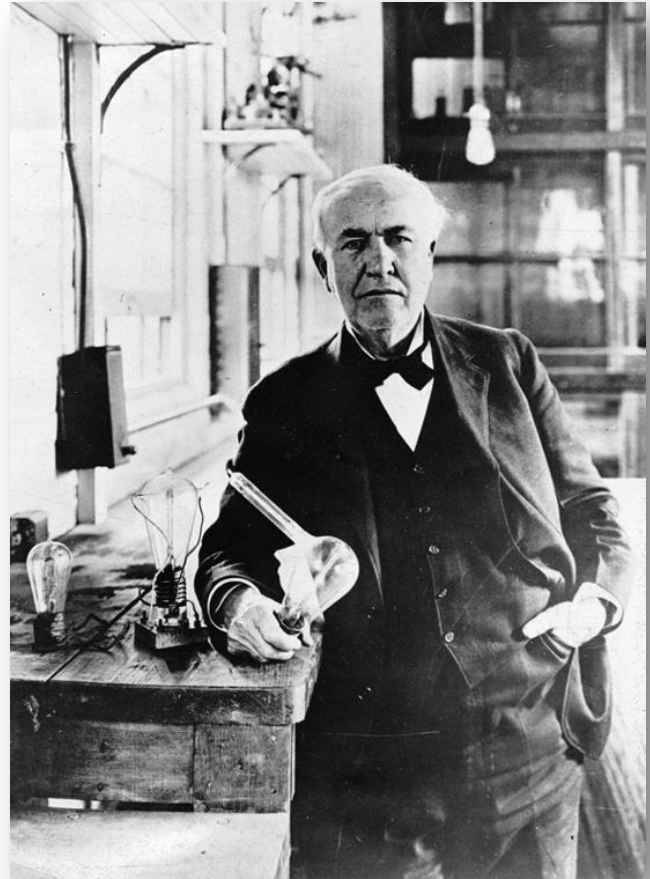
Exploring Safety Culture in Care Homes

Paul Bowie
Programme Director (Safety & Improvement)

paul.bowie@nes.scot.nhs.uk
Twitter: @pbnes

Quality Education for a Healthier Scotland

Workshop Content

- What does a strong safety culture look like

- Safety culture, just culture and accountability

- Why things go wrong and how to respond

- Review and validation of a safety culture tool

- Rollercoaster ride!

Small Group Work (1)

- What would a strong, positive safety culture look and feel like in your own team or organisation?

Common Safety Culture Domains

- Leadership
- Management/Supervision
- Team working
- Workload
- Safety Systems
- Communication
- Openness
- Handovers

- Staffing
- Organisational learning
- Stress recognition
- Work conditions
- Job satisfaction
- Managing risk
- etc

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"The idea of 'culture' is perhaps similar to that of 'intelligence' – everyone thinks they know what it is, but conceptual clarity is more elusive"

[Waterson, 2014]

"…it has the definitional precision of a cloud…"

[Reason, 2007]

Quality Education for a Healthier Scotland

Background – Safety Culture

- First used by the International Nuclear Safety Advisory Group (INSAG, 1986) to describe the sub-optimal conditions and decision processes at the Chernobyl nuclear power plant

- Term rapidly used worldwide to explain everything people could not explain or otherwise understand in the safety domain!!

- Safety culture **assessment or measurement** originated in high-risk industries (e.g. nuclear power, aviation and off-shore drilling) and is common in some acute hospitals, particularly in the USA.

Culture or Climate?

NHS Education for Scotland

Safety Culture (more deep rooted)

- ...refers to individual and group "*…values, attitudes, perceptions and patterns of behaviour that determine their commitment to workplace safety management*" **...*"the way things are done around here.*'**

Safety Climate (transient)

- Safety climate refers to the measurable 'surface' components of safety culture. It provides a 'snapshot' of culture at a given moment in time.

- The terms 'culture' and 'climate' are often used interchangeably.

Assessing Safety Climate/Culture

- Commonly, for safety climate to be assessed and improved **quantitatively** it must first be measured – typically using self-report questionnaires anonymously.

- Other approaches – **Qualitative**?

Influence of safety culture

- **Care teams with a positive culture** are **more likely to learn openly and effectively from failure** and **adapt** their working practices and **systems accordingly** to **reduce** future **risks**.

- The prevailing safety culture **also influences the priorities of individual clinicians, managers and staff** and **helps to sha**pe their discretionary attitudes, **behaviours and performance**.

- In many high-profile NHS failures a **poorly developed safety culture was implicated as a causal factor** e.g. Stafford hospital (high mortality rates from emergency admissions), Bristol Royal Infirmary (high infant surgical mortality rates) and the Vale of Leven hospital (deaths associated with *Clostridium difficile*).
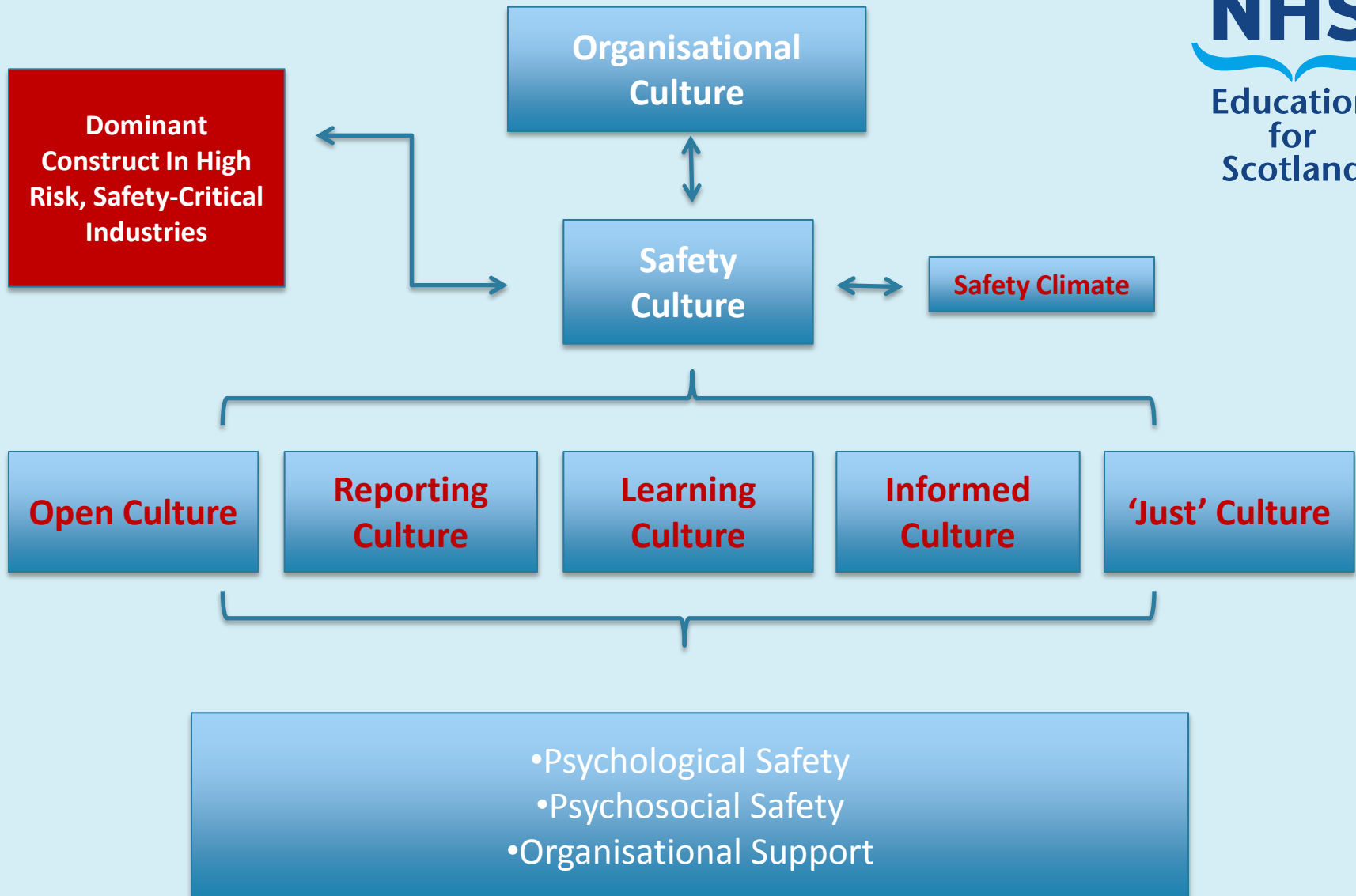
'Just Culture' in Your Organisation – Group Work

If we believe that lack of a 'Just Culture' in an organisation or team hurts justice and safety, and responses to incidents and accidents are seen as unjust then this can:

- *Impede learning from safety events,*
- *Promote fear rather than mindfulness in people who do safety-critical work,*
- *Make organisations more bureaucratic rather than more careful,*
- *And cultivate professional secrecy, evasion, and self-protection.*

A just culture is critical for the creation of a safety culture. Without reporting of and learning from failures and problems, without openness and information sharing, a safety culture cannot flourish. (Dekker, 2012)

If we could measure the presence of a 'Just Culture' on a scale where "1 = *A Non-Existent Just Culture*" and "10 = *A Highly Evolved Just Culture*", consider where you would place your own care team/organisation on this scale, justify your decision, then recommend what needs to be done to improve performance in this area, where necessary.

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What does Accountability mean in the context of a patient safety incident?

Think of this in terms of your individual professional response and also what the organisational response should be

Exploring Safety Culture

A Deeper Understanding of Safety Culture Requires a Deeper Understanding of…

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- Why thing go wrong – care homes as complex systems

- Workplace interactions and impacts on safety, performance and wellbeing

- 'Human error' theory

- Managing human biases – the blame game

- Performance variability, trade-offs,

- 'Just' Culture and Accountability

FIRST PRINCIPLES – Understanding and responding to why things go wrong

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UNDERSTANDING e.g.

- The 'Human Error' problem
- System complexity and interactions
- Goal conflicts
- Trade-offs
- Performance variability
- Organisational constraints
- Local rationality)
- Work as Imagined Vs Work as Done

RESPONDING e.g.

- We don't got to work to do a bad job
- Blame (self and colleagues)
- Human biases
- Emotional impacts on staff
- Professional Accountability
- Organisational Accountability
- Openness and transparency - Just culture

Safety Culture

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Benefits of Assessing Safety Culture

- Increases individual awareness of safety-related conditions and behaviours

- Enables the care team to 'diagnose' their prevailing safety culture/climate

- Identifies strengths and weaknesses in how work is really done around specific safety issues

- Facilitates action across the care system to build a stronger, more positive local safety culture and improve care delivery and personal wellbeing

- Participants can compare and evaluate progress over time

Health Foundation, 2009

The most rigorously tested/well-known tools:

- Safety Attitudes Questionnaire

- Patient Safety Culture in Healthcare Organisations

- Hospital Survey on Patient Safety Culture

- Safety Climate Survey

- Manchester Patient Safety Assessment Framework

- [GP-SafeQuest – NHS Scotland]

- [Nursing Home Questionnaires]

Testing a New Safety Culture Tool – Why?

- Mixed evidence on questionnaire measurement approaches

- Benefit is in teams learning together by assessing and improving local systems of care

- Adopting a Card game approach to discussion and analysis of Safety Culture developed by Eurocontrol

- Deeper understanding of how work is really done – closing the gap between <u>Work as Imagined</u> and <u>Work as Done</u>

- First stage – validation of the content by frontline experts (i.e. You) – **PAINFUL BUT NECESSARY**

Thank You!

Any Final Questions?

More Safety Culture Resources@

The Health Foundation
http://www.health.org.uk/

Health & Safety Executive
http://www.hse.gov.uk/

paul.bowie@nes.scot.nhs.uk

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