Essentials of Safe Care Supporting Implementation

Thank you for joining: this event will begin at 11:30

#SPSP247 #theEoSC

Welcome and introduction

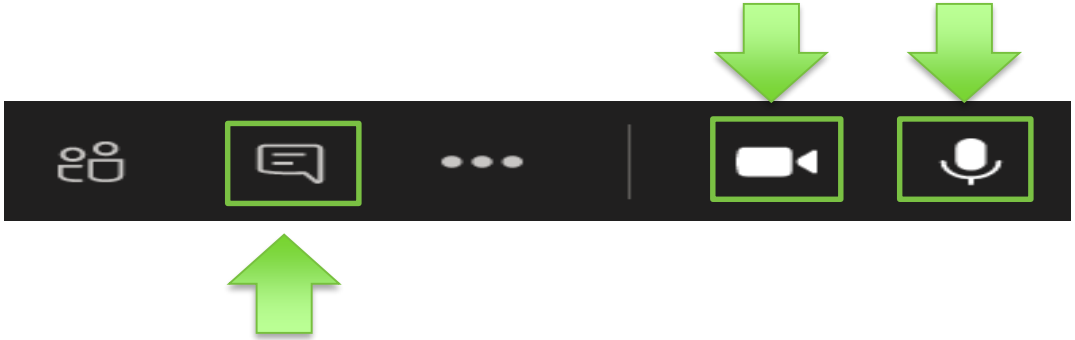
Ruth Glassborow

Director of Improvement

Healthcare Improvement Scotland

Housekeeping

During the meeting please have your microphone on mute and video turned off. This will avoid distraction and minimise the likelihood of slowing down the technology.



There will be opportunities for Q&A in the planned session. Please pop all questions in the chat box.

This session is being recorded. If you require any technical support please pop in the chat box or contact his.pspcontact@nhs.scot.

Agenda

Time	Agenda Item	Lead
11.30	Welcome and introductions	Ruth Glassborow, Healthcare Improvement Scotland
11:35	Update on the Essentials of Safe Care	Joanne Matthews, Healthcare Improvement Scotland
11:40	Using the Essentials of Safe Care to build an understanding of a system	Jennifer Green and Sheila Smith, The State Hospital
11:50	Q&A	Jennifer Green and Sheila Smith, The State Hospital
11:55	Why civility matters in a complex world	Chris Turner, Civility Saves Lives
12:40	Q&A	Chris Turner, Civility Saves Lives
12:55	Next steps	Joanne Matthews, Healthcare Improvement Scotland
13:00	Close	Ruth Glassborow, Healthcare Improvement Scotland

Aims of the session

- Share the progress and development of the Essentials of Safe Care over the last year.

- Explore how the Essentials of Safe Care can support the first steps of your safety improvement journey in understanding your system.

- Spotlight on the driver Leadership and Culture, learn about the importance of civility and the impact of behaviour in health and social care.

Introduction

Joanne Matthews

Head of Improvement Support and Safety

Healthcare Improvement Scotland

Essentials of Safe Care: Update

Joanne Matthews

Head of Improvement Support and Safety

Healthcare Improvement Scotland

SPSP

SPSP aims to improve the safety and reliability of care and reduce harm

Core Themes

- Essentials of Safe Care
- SPSP Programme improvement focus Maternity ,Neonatal, Paediatric ,Acute Care, Primary Care, Medicines and Mental Health
- SPSP Learning System

Where we have got to

A practical package of evidence based guidance and support that enables Scotland's health and social care system to deliver safe care for every person within every setting every time

Creating the conditions for care to be safe

Embedding within each of the SPSP Programmes and connecting beyond

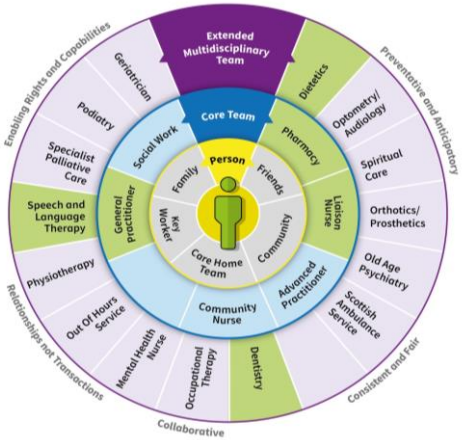
Developing the resources and tools within each of the primary drivers

All underpinned by the **SPSP Learning System**

Plans for this year

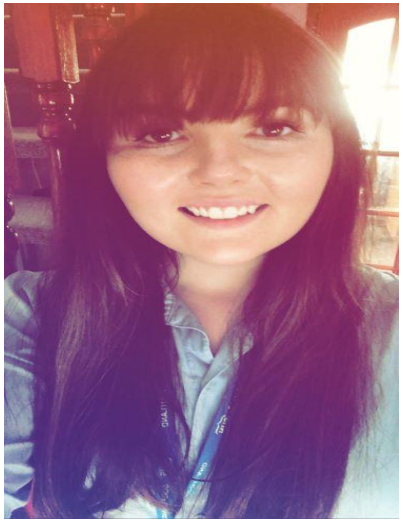
Ongoing development of resources

Programme design, implementation support, measurement



Healthcare Framework for Adults and Older People Living in Care Homes

Introduction



Jennifer Green
SPSP Project Manager
The State Hospital

Sheila Smith
Head of Clinical Quality
The State Hospital

Using the Essentials of Safe Care to build understanding of a system

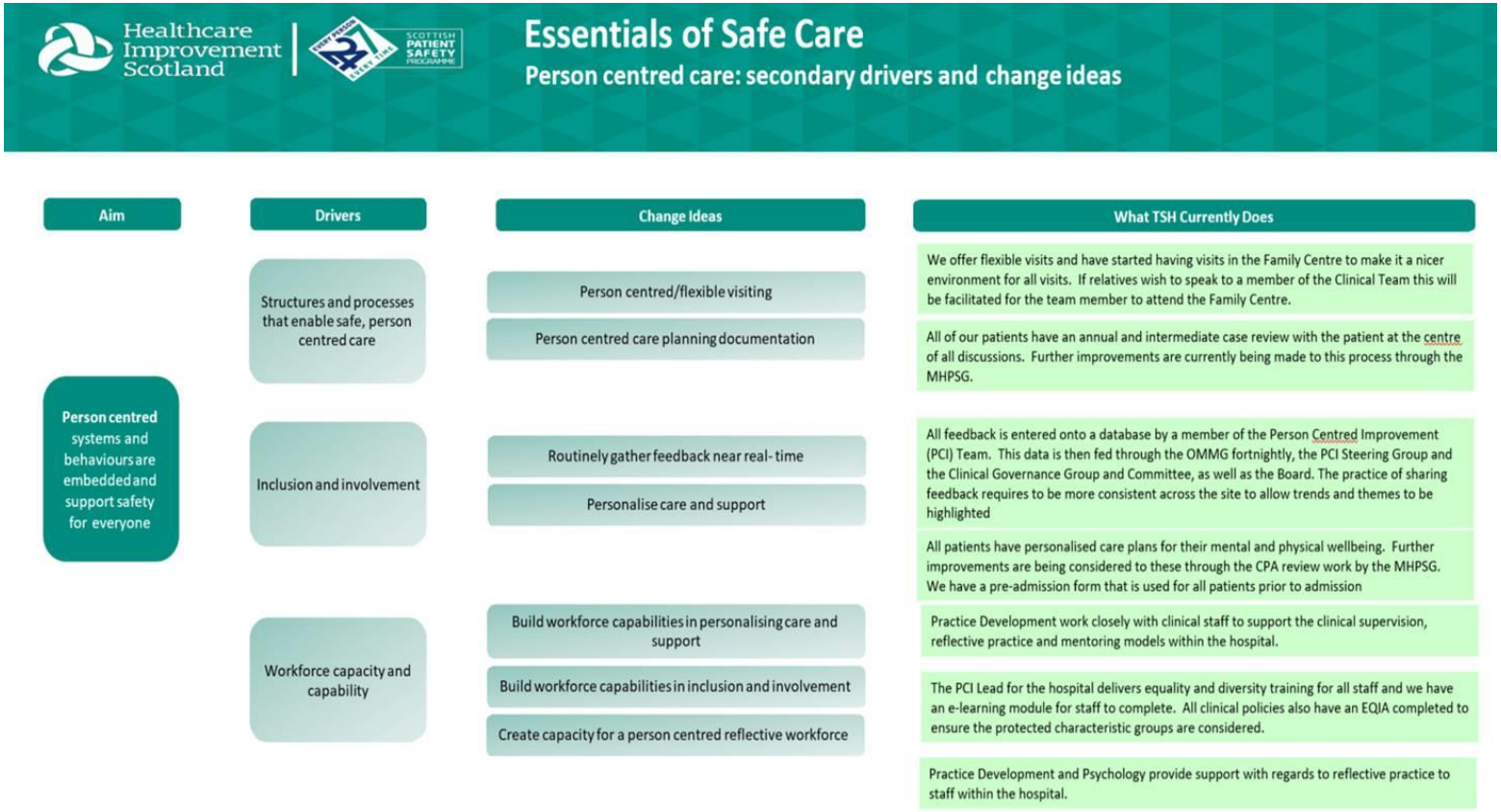
Jennifer Green
SPSP Project Manager
The State Hospital

Sheila Smith
Head of Clinical Quality
The State Hospital

The Patient Safety Group response

- Restarted the Patient Safety Group as this had been paused during the height of the pandemic.
- Considered all the driver diagrams inserting pieces of work we know are currently under way and where we had gaps.
- Patient Safety Group agreed that the change ideas would need some form of prioritisation.
- Agreed to adopt the Equality Outcomes prioritisation process.

What we started with



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Prioritisation process

For each change idea, we scored them by considering the following five indicators:

1. Scale
2. Impact
3. Improvement
4. Concern
5. Risk

The Prioritisation Tool

1. Scale	Maximum % of target stakeholders affected				
Rating	10% **1**	25% **2**	50% **3**	80% **4**	100% **5**
2. Impact	**Organisational culture of safe, consistent, person centred care**				
Rating	Prevents **1**	Limits **2**	Supports **3**	Promotes **4**	Achieves **5**
3. Improvement	**To stakeholder experience**				
Rating	None **1**	Nominal **2**	Minimal **3**	Significant **4**	Maximum **5**
4. Concern	**Significance of Issue**				
Rating	None **1**	Cause for Concern **2**	Concern **3**	Significant Concern **4**	Merits Urgent Action **5**
5. Risk	**Of potential negative impact(s) (if outcome not achieved)**				
Rating	Negligible **1**	Minor **2**	Moderate **3**	Major **4**	Extreme **5**

Aim	Drivers	Change Idea	Scale	Impact	Improvement	Concern	Risk	Total Score
Leadership to promote a culture of safety at all levels	Psychological safety	Compassionate leadership at all levels	5	4	4	3	3	19
		Collective leadership approach	5	5	4	3	3	20
		Structured 1:1 time	5	4	4	3	3	19
		Explore role and discipline of keyworker	5	3	4	2	1	15
		Visible, supportive leadership	5	4	4	3	3	19
	Staff wellbeing	iMatter - listening to the workforce and identifying improvements	5	3	4	4	3	19
		National health and wellbeing outcomes 1 (live longer)	2	4	4	4	3	17
		Celebrate success	5	3	3	1	1	13
	System for learning	System for identifying and spreading best practice	5	5	5	4	3	22
		Processes in place that support the appropriate use of evidence	5	4	4	1	2	16
Person centred systems and behaviours are embedded and support safety for everyone	Structures and processes that enable safe, person centred care	Person centred / flexible visiting (for visitors)	5	5	4	4	3	21
		Person centred care planning documentation	5	5	5	5	5	25
	Inclusion and involvement	Routinely gather feedback near real-time	5	4	4	2	2	17
		Individualised care and treatment	5	4	4	2	2	17
	Workforce capacity and capability	Build workforce capabilities in developing individualised care and treatment plans	3	3	4	2	2	14
		Build workforce capabilities in inclusion and involvement	3	4	4	2	3	16
		Create capacity for a person centred reflective workforce (clinical and non-clinical)	5	4	4	3	3	19
Safe consistent clincial and care processes across health and social settings	Reliable implementation of Standard Infection and Prevention Control Precautions (SICPS)	Staff education and awareness	5	5	4	2	4	20
		Access to evidence based guidance and policy	5	5	4	1	5	20
		Safety Leadership Walkarounds	5	2	2	1	3	13
		Access to resources	5	5	5	1	4	20
	Safe staffing (nursing)	Staff education and awareness	5	4	5	3	4	21
		Effective rostering	5	4	5	3	4	21
		Real-time staff risk assessment	3	5	4	2	4	18
		Mitigation	3	4	4	2	4	17
		Escalation	3	4	4	2	4	17
Safe communications across all stakeholder groups	Skills: appropriate language, format and content	Staff education and awareness	5	4	4	2	3	18
	Practice: use of standardised tools for communication	Executive Summary (CPA)	5	3	5	1	3	17
		Pre-admission assessment form	5	4	5	2	3	19
		Structured Communication (clinical SBAR)	5	4	4	2	2	17
	Critical Situations: management of communication in different situations	Weekend Safety Briefs	5	4	2	1	3	15
		Shift Handover	5	4	4	4	4	21

Where we are now

- Presented prioritisation findings to our Patient Safety Group in December 2021.
- Discussed and agreed on scoring.
- Identified if any change ideas were being taken forward by other groups in the hospital.
- Included the high priority change ideas into our work plan for the next 12-18 months.

Next steps

- Continue to monitor the change ideas progress taken forward by the Patient Safety Group.
- Receive updates from the service leads who are working on the additional areas of priority.
- Report to our governance groups surrounding our progress to date.

Questions?

Introduction

Chris Turner

Consultant in Emergency Medicine

University Hospitals of Coventry and Warwickshire

Co-founder of Civility Saves Lives

Why civility matters in a complex world

Chris Turner

Consultant in Emergency Medicine

University Hospitals of Coventry and Warwickshire

Co-founder of Civility Saves Lives

When we permit rudeness our patients die unnecessarily

CIVILITY SAVES LIVES

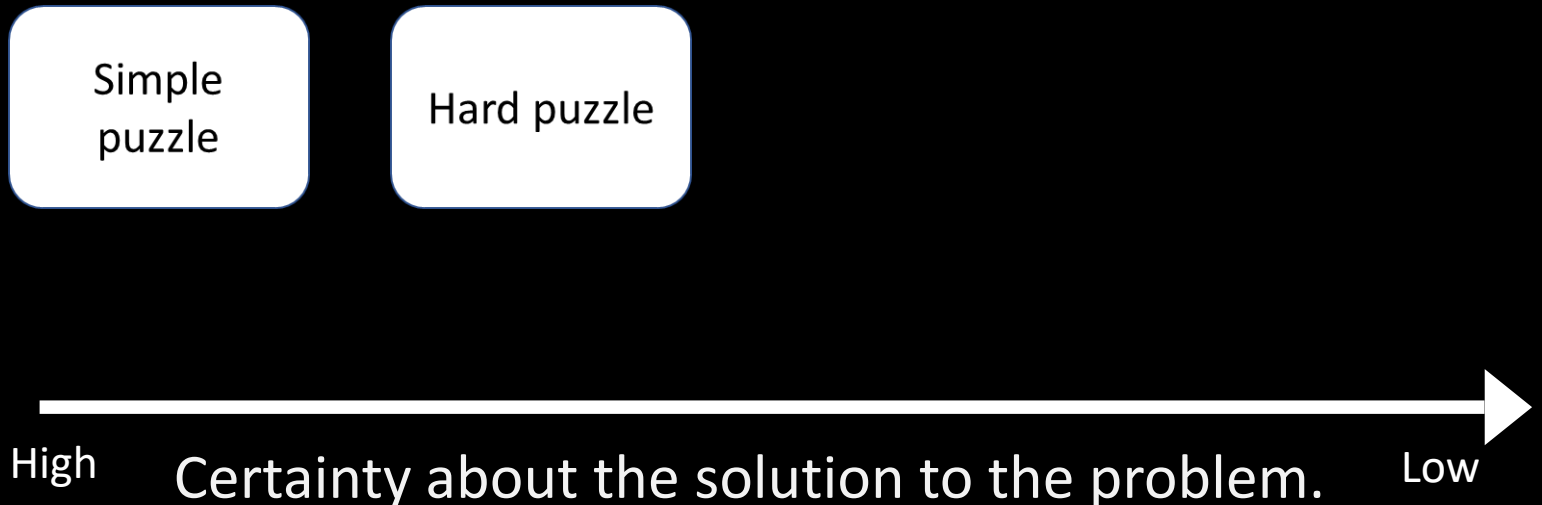
@civilitysaves

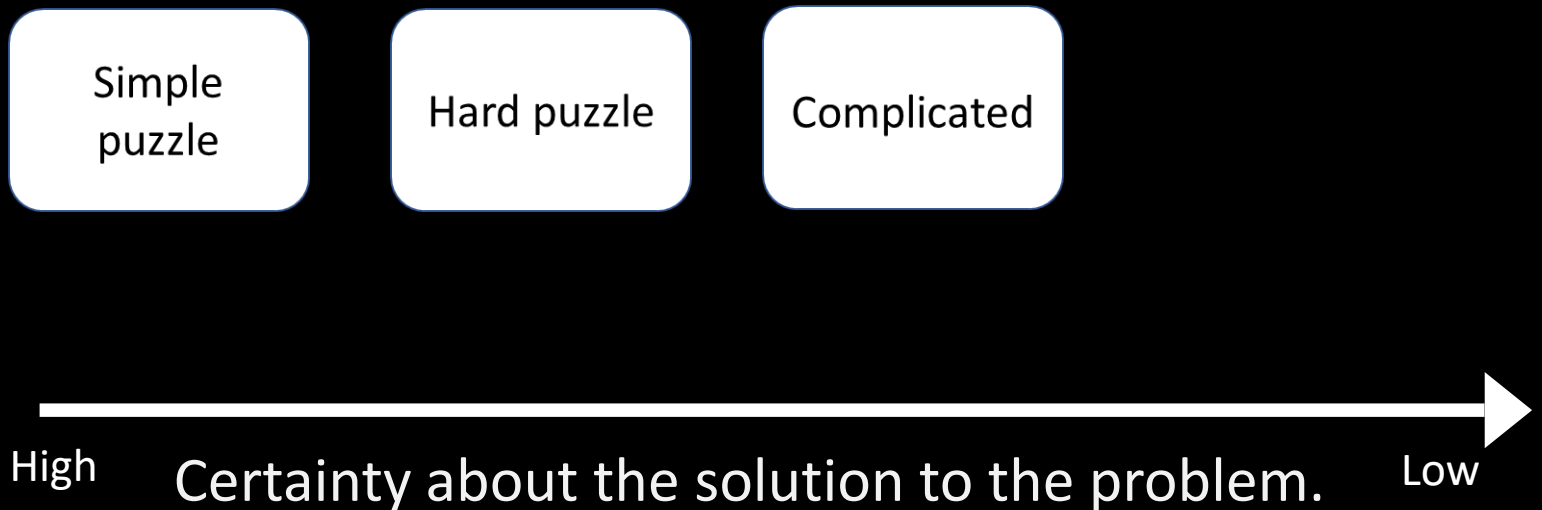

SURF LIFE

Complexity


High
Certainty about the solution to the problem.
Low


Simple puzzle
High
Certainty about the solution to the problem.
Low


Simple puzzle
Hard puzzle
High
Certainty about the solution to the problem.
Low


Simple puzzle
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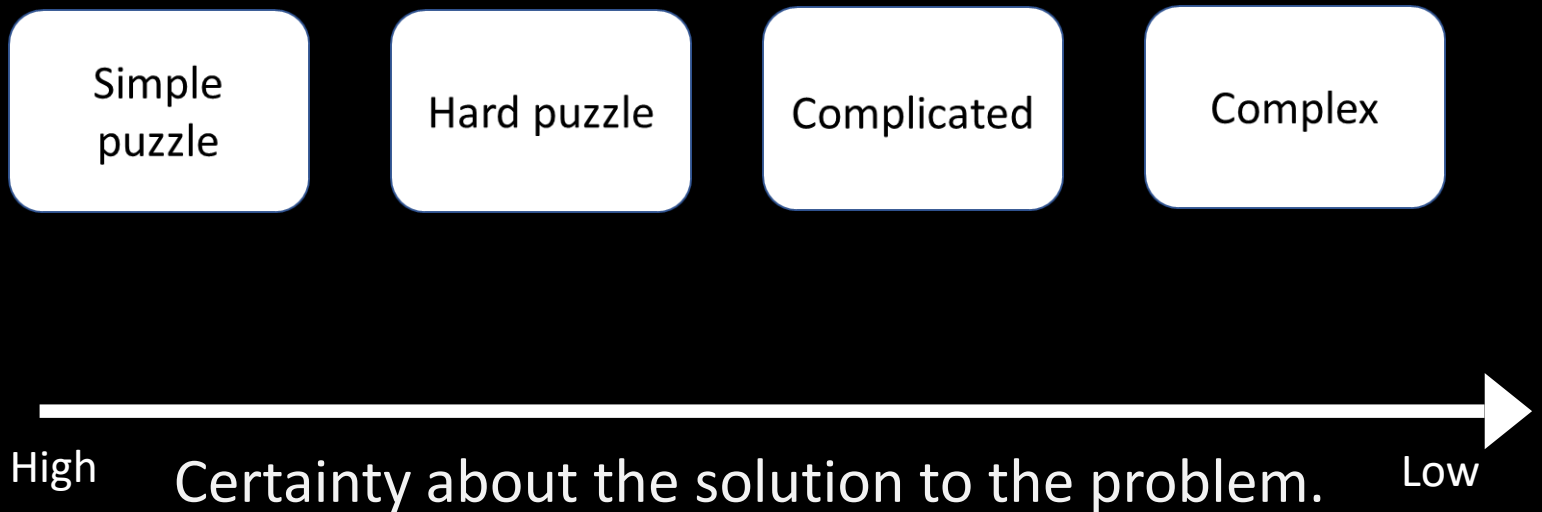
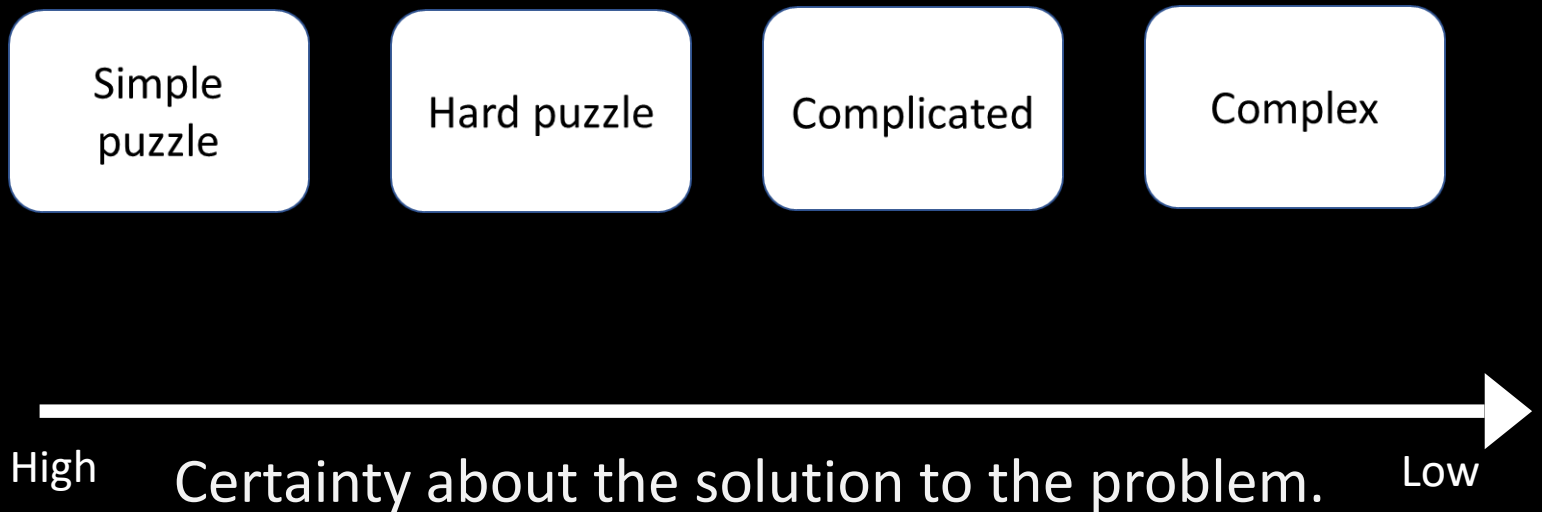
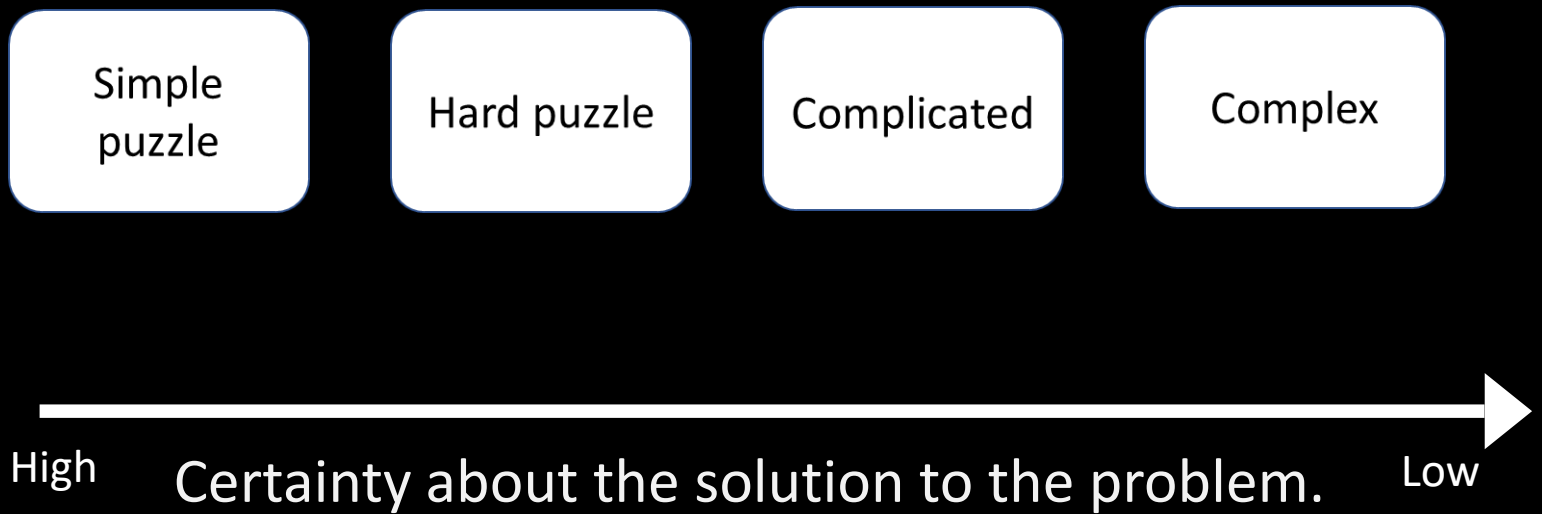
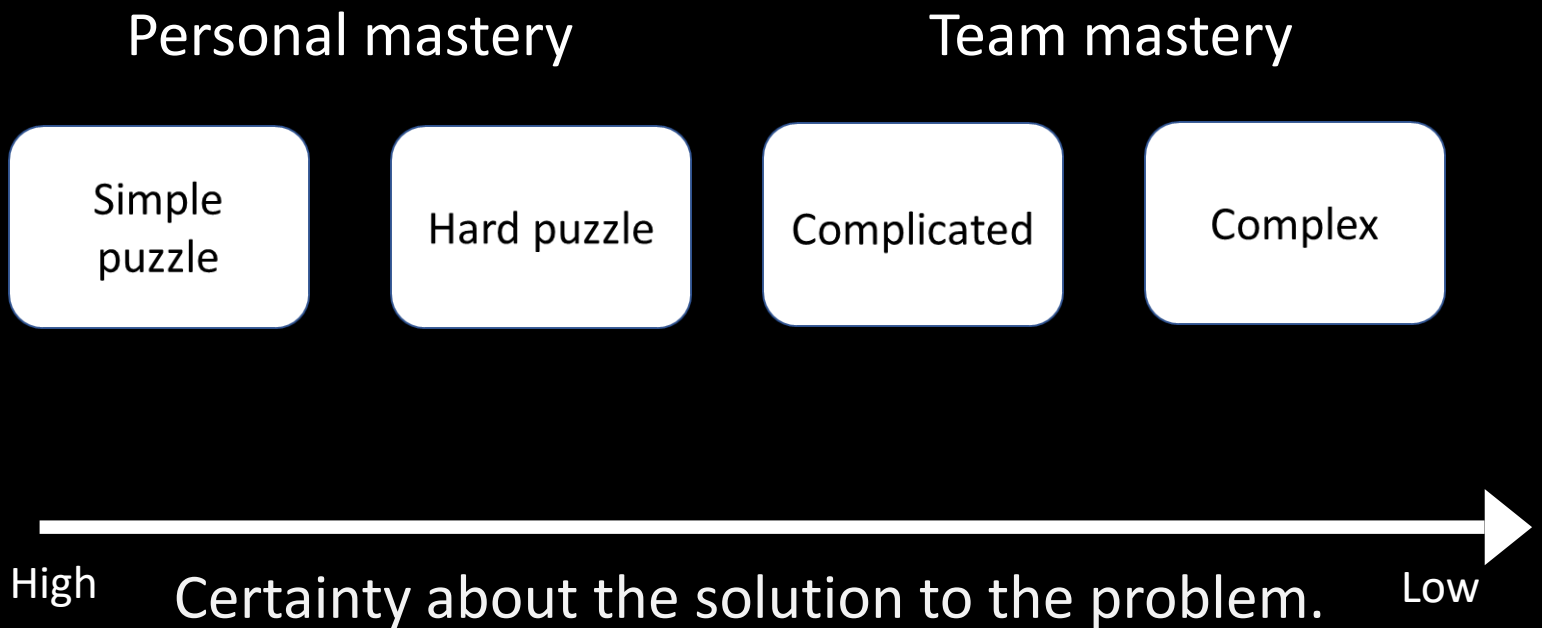

Simple puzzle
Hard puzzle
Complicated
Complex
High
Certainty about the solution to the problem.
Low

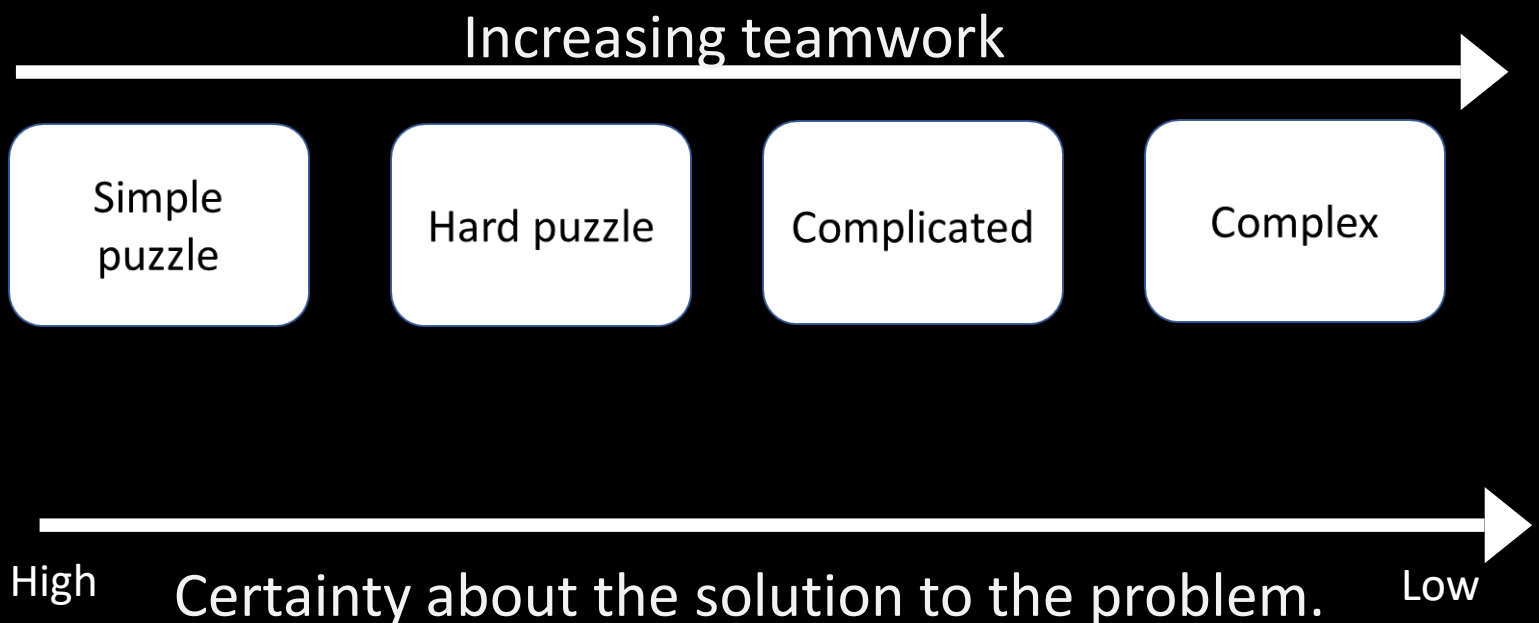
Where do we get results in healthcare?

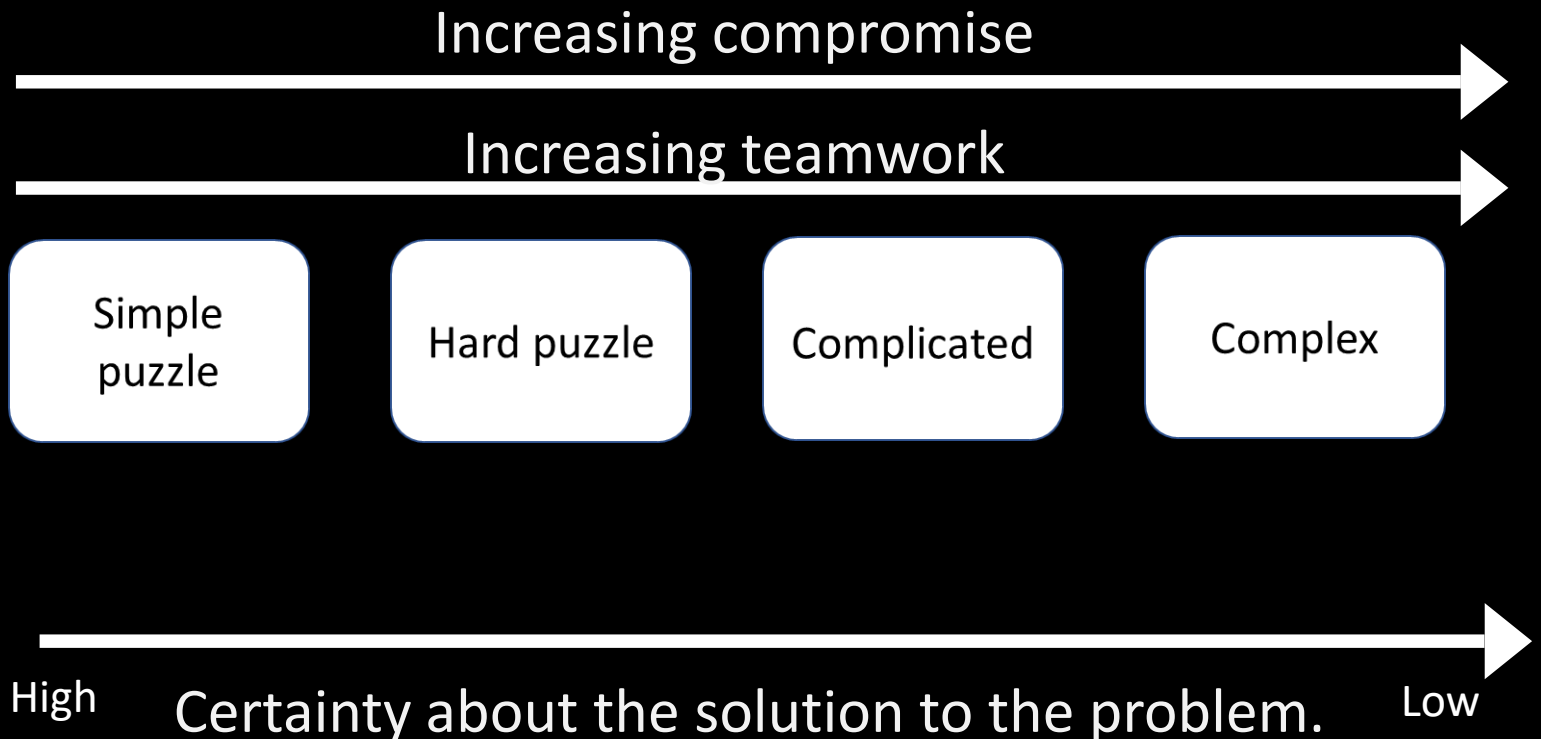

Simple puzzle
Hard puzzle
Complicated
Complex
High
Certainty about the solution to the problem.
Low

Personal mastery

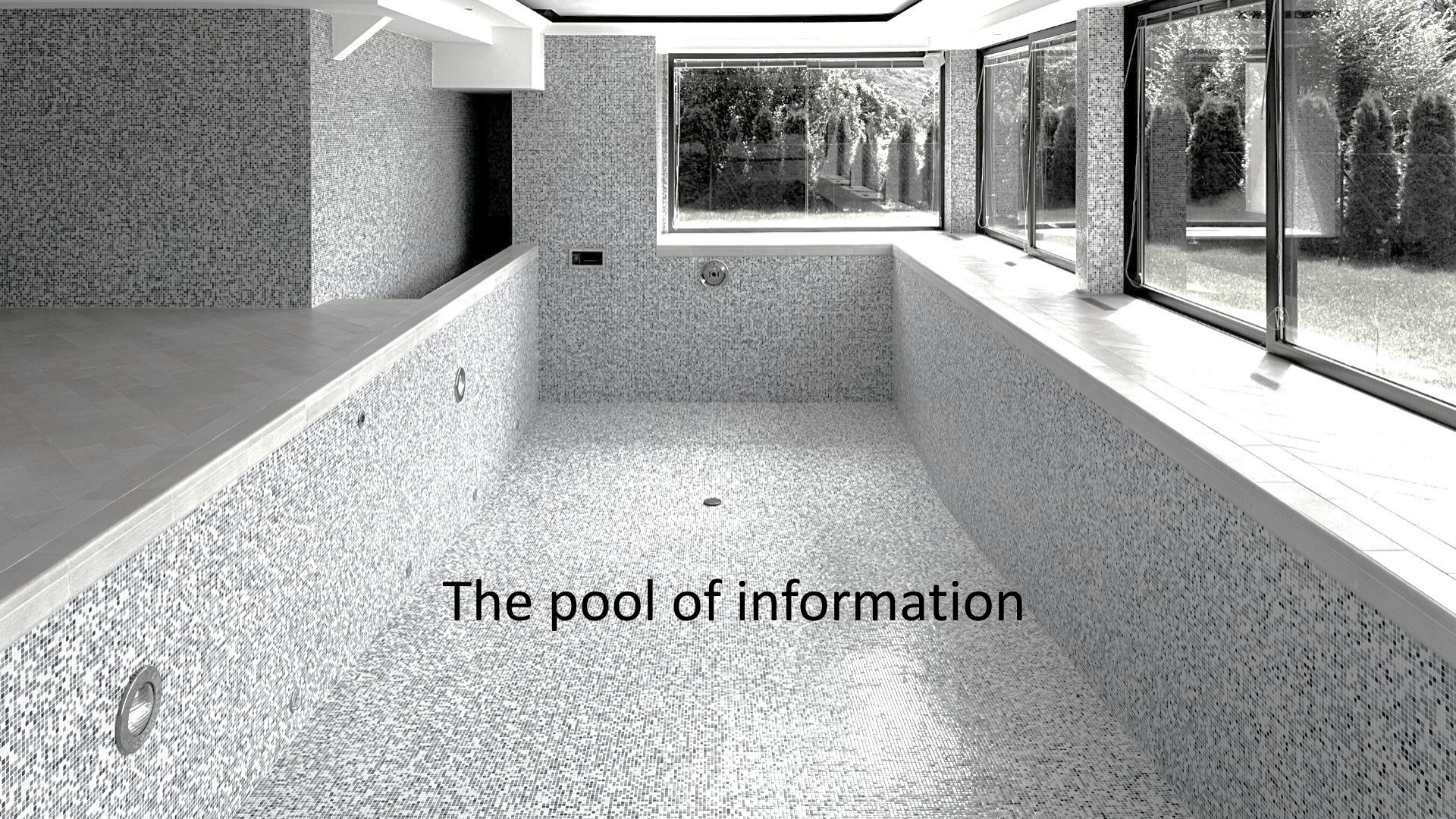



Personal mastery
Team mastery
Simple puzzle
Hard puzzle
Complicated
Complex
High
Certainty about the solution to the problem.
Low


Increasing teamwork
Simple puzzle
Hard puzzle
Complicated
Complex
High
Certainty about the solution to the problem.
Low


Increasing compromise
Increasing teamwork
Simple puzzle
Hard puzzle
Complicated
Complex
High
Certainty about the solution to the problem.
Low

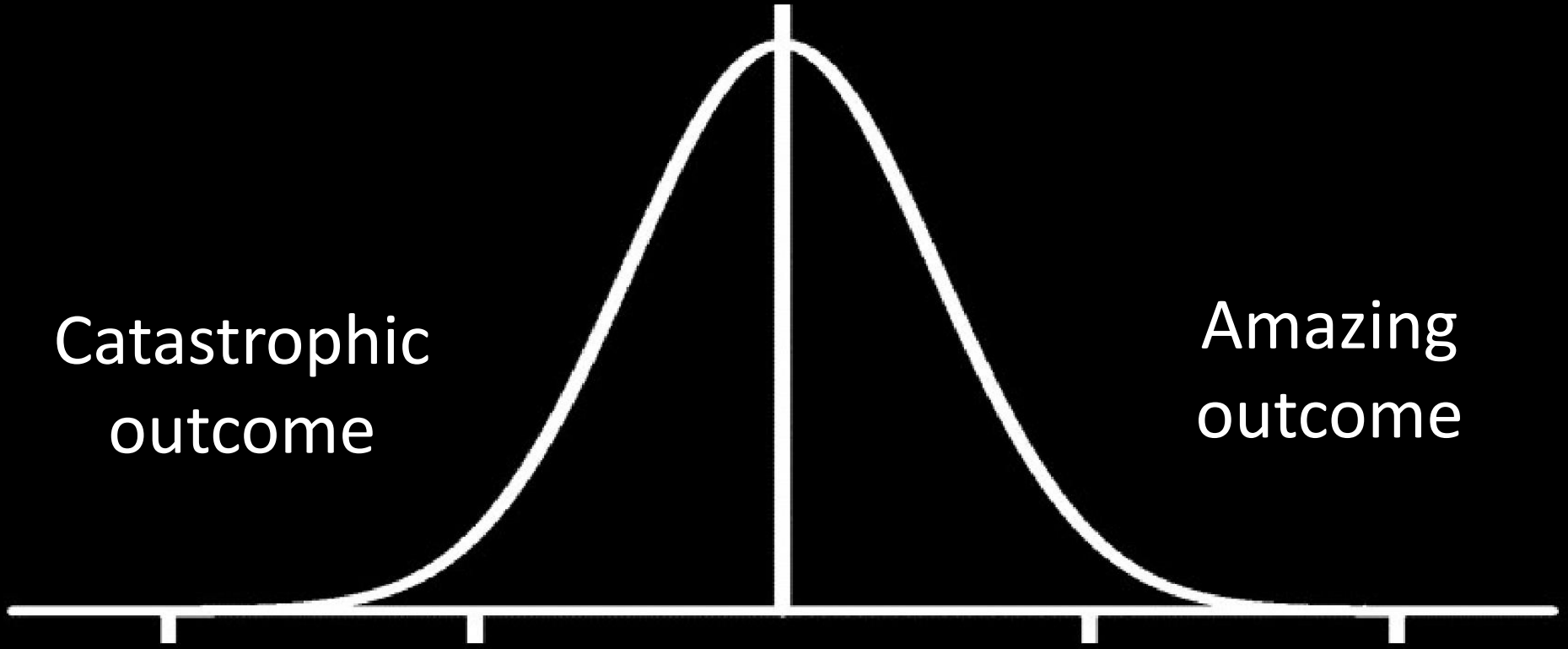
In complicated and complex situations information sharing positively predicts performance

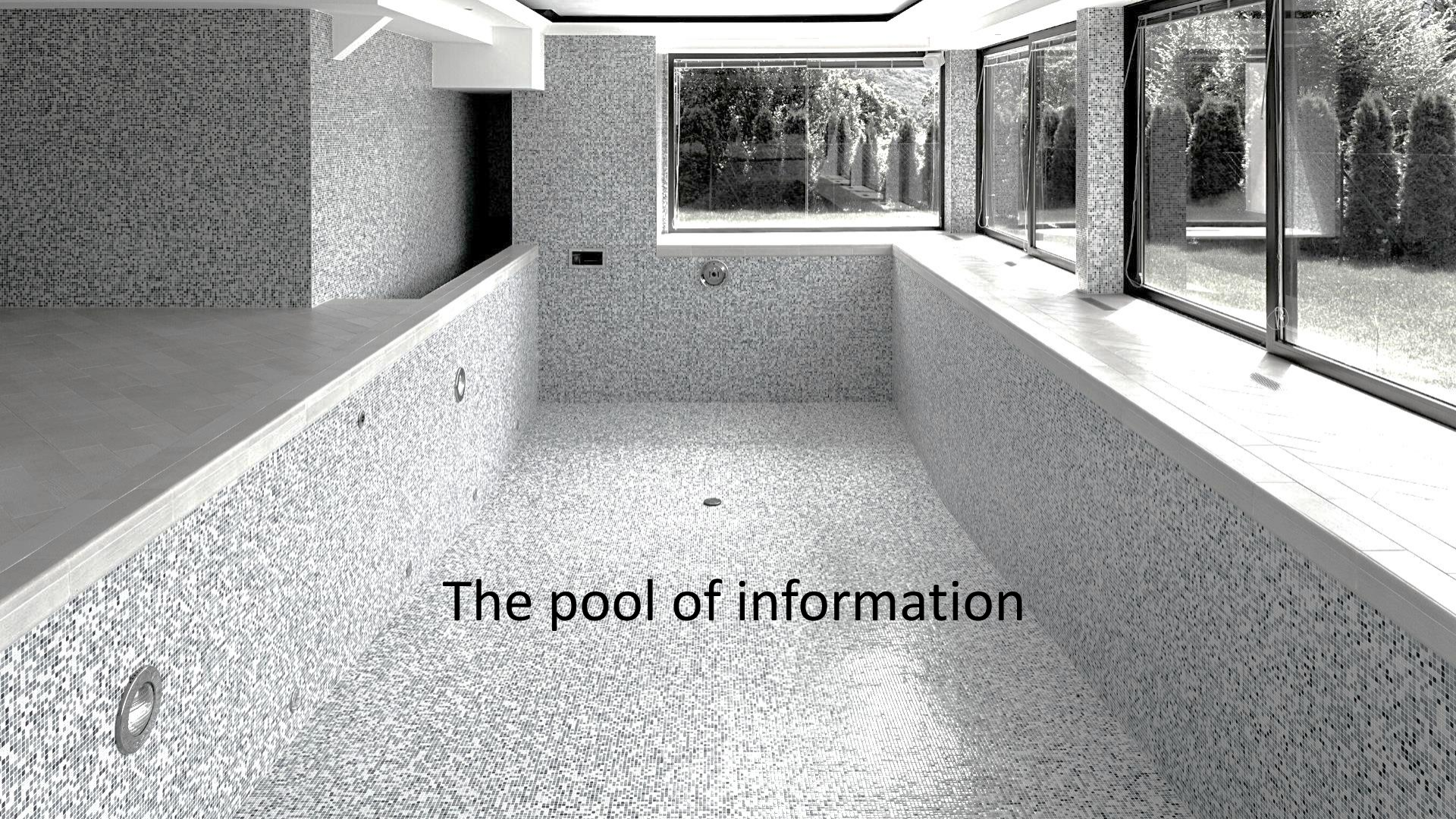

The pool of information

Teams


VERNON

Variation in outcomes for complicated/complex situations




The pool of information

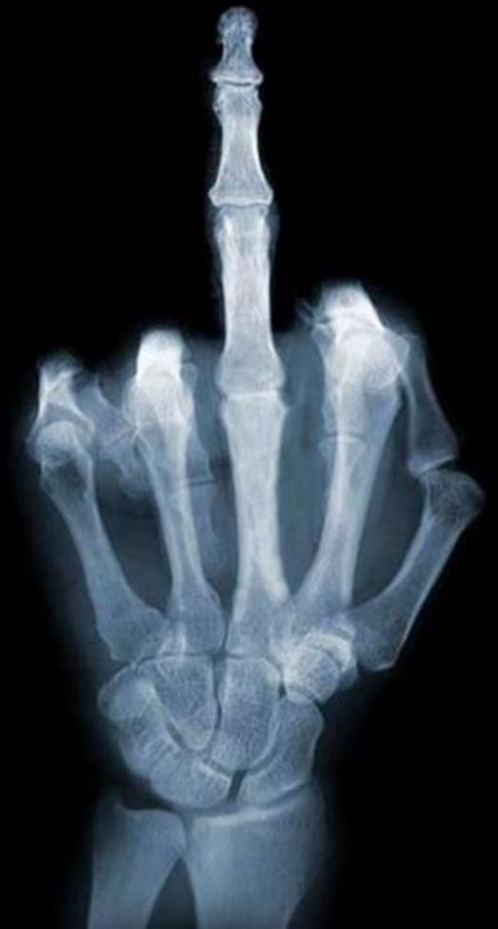
How we behave towards each other is the single greatest factor in how well competent teams perform.

Incivility

Have you seen rudeness at work?


How did it feel?

How did you respond to the rudeness?



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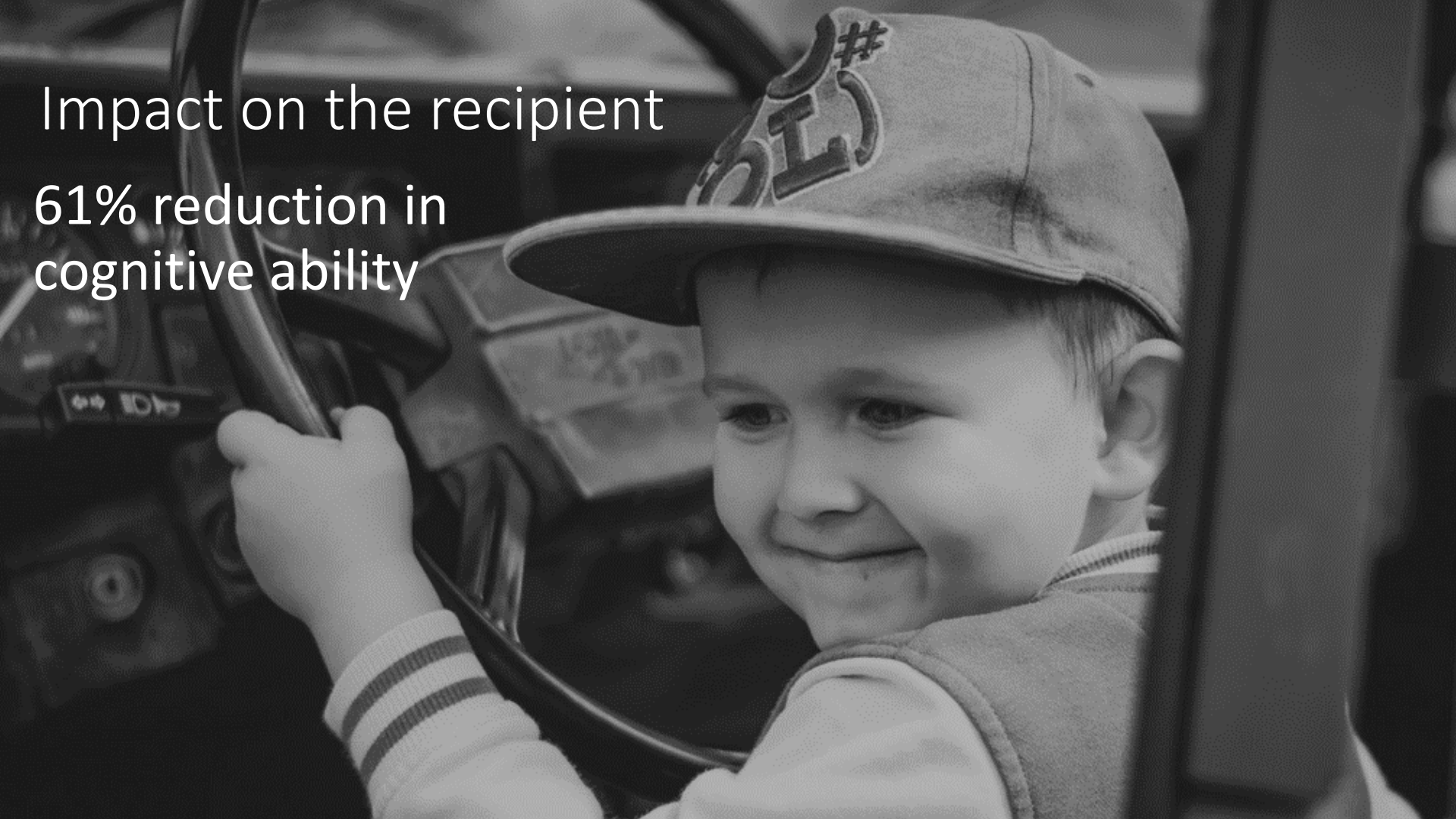

Impact on the recipient

61% reduction in cognitive ability

Impact on staff onlookers

20% decrease in performance.

50% reduction in willingness to help others.


My
mum


what a wonderful opportunity….

civility saves lives

CIVILITY SAVES LIVES

Questions?

Next steps/date for diary

SPSP MCQIC Safety Culture Webinar Series

24 March "Systems for Learning"
Key note speaker Michael Canavan, Quality Management System Portfolio Lead, Healthcare Improvement Scotland
Register for event

27 April "Psychological Safety"
Key note speaker Dr Suzette Woodward, patient safety expert
More info

SPSP National Event
Date tbc likely September / October 2022

Healthcare Improvement Scotland

SCOTTISH PATIENT SAFETY PROGRAMME

Keep in touch

his.pspcontact@nhs.scot

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To find out more visit https://ihub.scot/theeosc


THANK
You!