ITEM: 09/039

DOC: 3

Meeting:	Trust Board
Date:	18 March 2009

Title:	**Improving Safety for Patients at the Whittington Hospital**

Executive Summary:	This paper describes the actions we should take as a trust in order to address the issues affecting patient safety in a more systematic and pro-active way. If we decide to do this, it will require an increased amount of time commitment to and focus on patient safety by the Medical Director, the Risk Management Team, other executive team members and some consultants. The realisable benefits should be measurable using patient safety metrics and there should be associated reductions in costs of providing care since fewer adverse events and complications of treatment should occur. For Trust Board it will involve an affirmation that patient safety is our first priority and this will need to be reflected in the attention we pay to this in the future.

Action:	For discussion and decision regarding implementation

Report from:	Celia Ingham Clark, Medical Director

Sponsor:	David Sloman, Chief Executive

Financial Validation Lead: Director of Finance	Name of finance officer Resourcing yet to be agreed

Compliance with statute, directions, policy, guidance Lead: All directors	**Reference:** Will contribute to compliance with NPSA and DH guidance and to SLA quality indicators

Compliance with Healthcare Commission Core/Developmental Standards Lead: Director of Nursing & Clinical Development	**Reference:** Will contribute to future Care Quality Commission standards

Compliance with Auditors' Local Evaluation standards (ALE) Lead: Director of Finance	**Reference:** n/a

Evidence for self-certification under the Monitor compliance regime Lead: All directors	**Compliance framework reference:** n/a

Improving Safety for Patients at the Whittington Hospital

1. Background

We like to think our hospital is safe. We have a good reputation for teaching and training. Our hospital's standardised mortality rate has been low for several years. Nevertheless, a lot of our ongoing work on patient safety is reactive, not proactive. With a more systematic approach, it should be possible to improve safety for patients at the Whittington Hospital NHS Trust.

2. Where do we want to be

We should adopt the aims of the Institute for Healthcare Improvement to achieve -

- no needless deaths
- no needless pain and suffering
- no helplessness in those served or serving
- no unwanted waiting
- no waste
- no one is left out.

When this programme ran in the USA, 100,000 patients' lives were saved.

3.1 How do we get there

I propose that we work actively with the Patient Safety First Campaign and use their methodology. This has been shown to work in the USA and in early adopter hospitals in the UK. It is supported by the National Patient Safety Agency and the NHS Institute for Improvement. It involves a series of interventions, starting with Trust Board.

3.2 Leadership intervention (see "How To" guide in appendix)

This requires:-

a. a public statement to staff
b. safety walk rounds by executive team members
c. a leadership culture in the Board
d. setting specific goals to improve patient safety that are aspirational, inspirational and measurable.

3.3 Systematic measurement

Until now, we have collated patient safety information in the Trust from incident reports completed by individual members of staff and from patients' complaints and ad hoc audits of clinical outcomes. Our incident reporting rate is low and this is more pronounced in national benchmarking because our current database is not fit for the purpose and is due to be replaced this year including the option of electronic reporting. In future, we plan the following:-

a. Initial audit of 50 consecutive inpatient deaths.

b. Continuing review of deaths within specialities with a focus on unexpected deaths. This system is already in place for General Surgery, Rheumatology, Paediatrics and Maternity and is currently being rolled out to the other specialities. This should be done within speciality audit meetings.

c. Use of the Global Trigger Tool as a sampling audit to seek out adverse events. This involves an initial sample of 50 medical records, then 20 per month selected at random. The review is likely to need approximately 8 hours per month and must involve a Consultant with two trained assistants. It is proposed to rotate the Consultants involved by speciality in order to spread knowledge and understanding. The assistants to be trained will need to come from the Risk Management Team.

d. Hospital standardised mortality rate will continue to be measured, but is a fairly insensitive tool.

e. Systematic review of reported high-risk incidents, using root cause analysis techniques and looking for patterns.

f. Systematic review of complaints looking for patterns.

g. Systematic review of national benchmark comparators of performance, such as Dr Foster RTM by speciality and by individual Consultant. Outlying performance will need more detailed analysis and an improvement plan.

3.4 Clinical safety interventions recommended by the Patient Safety First Campaign (see appendix)

a. *Reducing harm due to deteriorating patients in acute care*.

Sarah Gillis is leading a group addressing this issue. Their success will be measured by use of the Global Trigger Tool.

b. Critical care bundles to reduce the risk of central line infection and ventilator acquired pneumonia.

Chris Hargreaves and the ITU Team have already implemented these. However, we need a reliable means of continuous audit to ensure compliance.

c. **Perioperative care**

The surgical safety checklist is already being rolled out in the Trust by Ahmed Chekairi and Jennifer Johnson. Its effectiveness will be measured by the Global Trigger Tool and by high-risk incident reports. Surgical site infections should be measured more systematically and with root cause analysis if infection occurs after a “clean” operation. There is a national database with which we can measure our performance on this.

d. **Reducing harm** from high-risk medications, such as insulin, warfarin, morphine and midazolam. The new drug chart and electronic prescribing will help with these. Monitoring will be via the Global Trigger Tool and reported incidents. Helen Taylor and Bridget Coleman in Pharmacy are keen to help.

e. **Recording "never events"**

The NPSA recently described a group of events that should never happen in hospitals. The ones that apply to us are as follows:

a) *Wrong site surgery*

This should be prevented by use of the surgical safety checklist.

b) *Retained instruments after surgery*

This should be prevented by the mandatory instrument counts that occur.

c) Misplaced nasogastric tube not detected before use

A lot of work has already been done on this at the Whittington Hospital and we have clear clinical guidelines reinforced by the Clinical Nutrition Team.

d) *In-hospital death of a mother due to post-partum bleeding after Caesarean section.*

This is very rare, but clearly catastrophic. The risk can be significantly mitigated by having access to interventional radiology. We have this during working hours but not usually out of hours. This needs to be addressed.

e) IV administration of concentrated Potassium Chloride

Pharmacy tell me that this drug preparation is no longer stocked in general clinical areas and is only available in ITU**.**

4.1 Management

It is proposed that the risk management committee is re-invented as the Patient Safety Committee reporting to the Clinical Governance Committee, new terms of reference and membership will be required to fulfil the new role**.**

4.2 Links with others:-

Links have been established and will be maintained with -

a. The PCT

Proposed quality indicators from Islington PCT for the year ahead that reflects patient safety include:-

-MRSA bacteremia rate
-number of SUIs
-number of patient safety incidents
-implementation of the global trigger tool
-implementation of the safe surgery checklist
-surgical site infection rate
-unplanned admissions after day surgery
-reduction in prevalence of pressure ulcers of grade 2 severity or above.

b. The SHA via Juliet Beale, Programme Director for Patient Safety and Quality.

c. The National Patient Safety First Campaign (note David Dalton in North West region is starting a new organisation called Quest, for Trusts wanting to be in the top quartile for patient safety).

5. Recommendations

The Trust Board is asked to agree to support the implementation of the patient safety measures detailed above.

Celia Ingham Clark M.Chir, FRCS
Medical Director