The Whittington Hospital NHS
NHS Trust

Draft

Patient Safety Strategy

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Ratified by:	Clinical Governance Committee
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Name of responsible committee	Hospital Management Committee, then Clinical Governance Committee
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Target Audience	All staff involved in delivering or planning patient care

Contents

1. Executive Summary

Patient safety lies at the heart of healthcare. The Whittington Hospital's aim is "to have no avoidable patient deaths and no avoidable harm to patients". In order to achieve this, patient safety must be embedded across all levels of the organisation from corporate to individual, and seen as everyone's day job.

It is also important to know how we are doing and set ourselves realistic but challenging targets that enable our performance to be monitored and demonstrate improvement. For this to happen key elements must be in place as follows: -

1.1 Clinical Elements

- Improving communication in clinical teams
- Reporting and learning from high level and serious untoward incidents, using the agreed standard NPSA tool
- Increasing patient involvement
- Following evidence based clinical guidelines and protocols
- Using clinical performance information

1.2 Organisational elements

- Setting, measuring and reporting of patient safety standards/metrics
- Use of resources
- Education and training
- Culture – being open

1.3 National patient safety initiatives

The trust is participating in a number of national patient safety initiatives, all of which have some type of quality indictors/metrics, many of which are similar or the same. Key, relevant indicators will be agreed, pulled together and included in the overall trust patient safety indictors. Current initiatives in which we are participating are: -

- Patient Safety First
- Energising for Excellence
- Productive Ward
- Essence of Care
- Think Glucose

1.4 Additional policies and strategies

As the Patient Safety Strategy is overarching, there are other key policies and strategies that deal with patient safety that feed into it, which provide more detailed information, as follows: -

- Risk Management Strategy
- Serious Untoward Incident Policy
- Infection Prevention and Control Annual Plan
- Clinical Audit and Effectiveness Strategy
- Root Cause Analysis Procedure
- Training and Education Strategy
- Whistle Blowing Policy

2. Definition

Patient safety is a broad term that encompasses the processes that protect patients from harm caused by clinical mismanagement. Ensuring patient safety requires the correct clinical and operational systems to be in place and working effectively together to minimise the risk of harm.

3. Aims of the strategy

Our overall aim is to have no avoidable patient deaths and no avoidable harm to patients.

The key elements of patient safety that must be in place to achieve the overall aim are described below.

4. Introduction

Over the past decade or so, mismanaged health care that kills or harms patients has increasingly drawn public and media attention as well as those involved in health care. No patient wants to attend a hospital with a reputation for poor patient safety, and staff rarely want to work in one.

The Whittington Hospital is committed to providing safe patient care, and our corporate objectives include several of its key elements, including: - consistently meeting agreed standards of clinical care, employing competent staff and developing an up to date programme of education.

We are also actively engaged in a number of national and local patient safety initiatives, including Patient Safety First.

Up until now, however, we have not pulled these together under one overarching umbrella of patient safety. This strategy therefore seeks to identify the key clinical and organisational elements that need to be in place to provide assurance that our hospital is as safe as it can be.

5. Governance arrangements

Statutory responsibility for patient safety ultimately rests with the Chief Executive. However, to ensure that it is implemented effectively, the CEO has delegated the responsibility jointly to the Medical Director and the Director of Nursing and Clinical Development, who in turn work with the other directors and the risk and clinical governance teams to translate the strategy into practice.

Board Assurance for patient safety is achieved via the Clinical Governance Committee, which is a sub-committee of the Audit Committee, and by ensuring that key risks and controls to achieving patient safety are reflected in the Trust's Assurance Framework and Risk Register.

Maintaining and improving patient safety depends on all service deliverers working together to this end. The risk and clinical governance teams, who have particular expertise in these key areas, are here to support, facilitate and train service deliverers

to do this. Success is, however, dependent upon ownership and delivery within the clinical directorates.

6. Key elements of patient safety

There are a number of key clinical and organisational elements that when in place will help to ensure safe patient care. We are also committed to continuing to deliver appropriate national patient safety initiatives.

6.1 Clinical elements

- **Improving communication in clinical teams**

Poor communication is one of the main causes of serious incidents as well as one of the top areas of patient complaint. Healthcare staff work in teams, so there must be:

  - Clear understanding of roles and responsibilities of team members
  - Clear and contemporaneous written communication in health care records and care plans
  - Clear and concise handover between all the multi-disciplinary team
  - Ability to work as an effective team member – may require team building support
  - An identified clinical team leader
  - Staff feeling able and knowing how to report any concerns about issues that could affect patient safety, including the practice of colleagues

- **Reporting and learning from high level and serious untoward incidents**

Successfully learning from, and then preventing future serious incidents relies on comprehensive and systematic reporting, investigation, analysis, action planning and implementation of lessons learnt.

It is important that such incidents are investigated, analysed and actions planned as a result using one tried and tested standardised system. It has been agreed that the Whittington Hospital will use root cause analysis (RCA) for this purpose, following the National Patient Safety Agency's RCA tool/template. NHS London has stipulated that the NPSA investigation template and reporting form is always followed. Training in the use of this must be provided for all appropriate staff, and support is available from the Risk Management Team.

Following a high level or serious untoward incident key actions must include targets for improving the safety in that particular area that are then monitored to ensure the necessary improvement is made and sustained.

- **Increasing patient involvement**

Patients can play a key role in ensuring that their care is safe, and is an under used strategy towards improving patient safety. The level of their involvement is dependent upon their condition, treatment and educational background, but many patients are able to understand their own medication regimes once explained to them and thus help avoid drug errors, monitor hand hygiene compliance of the staff caring for them, helping to prevent infection and look out for danger signals that could indicate a deterioration in their condition, allowing early intervention. Time taken to ensure the

patient understands their condition and treatment and knows how to communicate with the team about it is time well spent.

Improving ongoing mechanisms for obtaining and really using patient feedback to drive improvement is also vital to patient safety. This can be via patient surveys, but also as part of learning from complaints, legal cases and PALS, which often involve patient safety incidents.

- **Following evidence based clinical guidelines and protocols**

A key way to reduce human error is to reduce reliance on memory. Evidence based protocols, clinical guidelines and care pathways are successful tools to ensure safer patient care. The clinical guidelines approved for use at the Whittington are available on the intranet and are updated regularly.

- **Using clinical performance information**

Clinical staff need to see regular information on how they and their teams are performing, including benchmarking against other clinicians within the same speciality, so they can identify areas for improvement. The Whittington Hospital has a variety of methods for doing this, including the use of Dr Foster for consultants' performance, clinical audit programmes and the nursing and midwifery audits undertaken by the Visible Leadership Team.

6.2 Organisational elements

- **Setting, measuring and reporting of patient safety standards/metrics**

In order to ensure we are improving patient safety, there must be an agreed set of indicators /metrics that are regularly measured and the results used to inform a programme of improvement work. Currently acute trusts use a variety of such metrics and there is no universally agreed set. NHS London are taking part in a national initiative "Energising for Excellence" that seeks to address this, and will give trusts an agreed set of metrics that we must all follow. This will allow true benchmarking between trusts and will hopefully be available from spring/summer 2010.

In the meantime the Whittington Hospital must make it's own decision about what we should measure. The trust's performance dashboard already has a number of high-level clinical indicators/targets that should be continued. These include: -

- Adverse events
- Never events
- SMR mortality rate
- Avoidable mortalities
- Readmission rate
- HCAI, including MRSA bacteraemia cases and c. diff

As well as the above, we have agreed to participate in Patient Safety First and follow their recommendations, which are set out in Appendix A. As they are quite numerous, a smaller number of high priority recommendations will be selected to start with, and will include measurable targets, timescales and leads against each standard/metric. An action plan will be developed to steer this.

The trust is also required to meet quality standards set by our commissioners and will have to meet the new CQC registration requirements from April next year.

- **Use of resources**

In order to ensure that patient safety is embedded, clinical and operational leaders must reflect this in the planning and allocation of resources, both staff and money. Funding must be allocated to initiatives and equipment that help meet the agreed patient safety targets, and to ensure that relevant staff have the appropriate training and education.

- **Education and training**

In order to deliver safe care, staff must be trained and educated to do so, and then kept up to date. The trust is therefore committed to providing this though a variety of means, which are reflected in the Education and Development Strategy and action plan. This includes attendance at relevant courses, mandatory clinical skills training days and learning in the work place. Training must be supported by competencies, clinical supervision, appraisal and personal development plans.

- **Culture – being open**

Patient safety must be seen as everyone's core business and must be reflected at all levels of the organisation, from corporate objectives through to individual objectives.

Whilst aiming for no avoidable patient harm or deaths, health care is inherently risky. When something does go wrong, or there is a near miss, the trust will operate a "fair blame culture". This means not normally blaming individuals but analysing systems and processes to identify where changes need to be made and sharing lessons across and outside the trust.

This culture also includes being honest and open with patients and relatives. Further information on this is available in the Risk Management and SUI Strategies.

6.3 National patient safety initiatives

The trust will continue to actively participate in appropriate national initiatives, which will change over time, but are currently: -

- **Patient Safety First**

Patient Safety First is a national voluntary initiative, which the Whittington has agreed to participate in. Its cause is to "make the safety of patients' everyone's highest priority", and its aim is " no avoidable death and no avoidable harm". The key interventions and metrics it uses are set out in Appendix A.

- **Energising for Excellence**

This national quality initiative is currently being developed, and seeks to provide clinicians with a universal tool that enables care to be effectively measured so that findings are reliable, can be quickly acted upon, and are linked to workforce, including staffing numbers, skill-mix and competencies.

The vision is " Where all clinical care provided anywhere in the NHS is appropriately measured for its safety, effectiveness and patient experience; where we can increasingly measure the ultimate outcome of care, and where information on quality is acted upon rapidly and effectively to ensure continual improvement".

The initiative aims to pull together a number of other quality initiatives under one umbrella, including (but not exclusively): -
AUKUH nursing acuity tool
Essence of Care
Productive Ward
North West Region's Nursing Indicators
Patient Safety First

- **Productive Ward**

The Productive Ward Programme was developed by the NHS Institute of Innovation and Improvement and is based on tried and tested lean thinking techniques. The main aim is to free up the time that clinical staff traditionally spend carrying out non-direct patient care tasks, so they have more time to spend directly with patients, thus improving patient safety and the patient experience.

The programme provides the knowledge, tools and guidance necessary to think and work differently, as individuals and as teams. Although focussed on registered nurses and midwives it includes all members of the health care team, including those in supporting roles such as pharmacy, facilities and informatics. It includes a number of nationally used metrics.

- **Think Glucose**

Think Glucose is designed to support hospitals to improve the quality of care for patients who are admitted to acute care with a secondary, rather than primary diagnosis of diabetes. A toolkit has been developed that focuses on seven key areas that when addressed will enable high quality care to be achieved, with the added advantage of reducing length of stay. These are: - patient experience, early identification, assessment, care pathway, in-patient specialist team, staff education and commissioning and planning. We will be rolling out the programme to all in-patient wards.

- **Essence of Care**

Essence of care was developed some years ago to give clinical staff a toolkit for benchmarking the fundamentals of care, including: continence and bladder and bowel care, personal and oral hygiene, food and nutrition, pressure ulcers, privacy and dignity, record keeping, and principles of self care.

7. Additional policies and strategies

As this Patient Safety Strategy is overarching there are other policies and strategies that feed into it, which provide more detailed information, as follows: -

- Risk Management Strategy
- Serious Untoward Incident Policy
- Infection Prevention and Control Annual Plan
- Clinical Audit and Effectiveness Strategy

- Research and Development Strategy
- Root Cause Analysis Procedure
- Training and Education Strategy
- Whistle Blowing Policy

8. Monitoring

Compliance with this strategy will be monitored via the Clinical Governance Committee and the working groups that report to it.

Progress towards achieving the goal of having no avoidable patient deaths or harm will be monitored via the trust board dashboard reports and agreed clinical indicators.

9. Conclusion

This strategy is intended to be a high level document that supports and facilitates the trust's aim to have no avoidable patient deaths or patient harm. It brings together the key elements of work that need to happen in order to deliverer this aim into one strategy. It is underpinned by a number of other strategies, targets/ metrics and annual work plans against which progress is monitored and reported.

Appendix A

Patient Safety First Campaign Metrics

Intervention	Metric	Target	Current position against target	Lead	Time scale
1. Leadership	1.1 Hospital standardized mortality rate 1.2 Adverse incidents rate (obtained by use of Global Trigger Tool 1.3 Number of patient safety walkabouts per month 1.4 Number of patient safety walk around actions completed each month				
2. Reducing harm from deterioration	2.1 Number of cardiac arrest calls per month 2.2 Number of rapid response calls per month 2.3 Percentage of rapid response calls using communication tool 2.4 Percentage of patients who triggered that had an appropriate response				
3. Reducing harm in critical care	1.1 Ventilator care bundle compliance 1.2 Days between ventilator associated pneumonia (VAP) 1.3 Central line care bundle compliance 1.4 Days between central line infection (CLI) 1.5 VAP rate				

	1.6 Ventilator length of stay 1.7 CLI rate 1.8 Length of stay in ITU				
4. Reducing harm in peri-operative care	4.1 Surgical site infection rate 30 days post –operation 4.2 Percentage of surgical patients with antibiotics administered on time 4.3 Percentage of surgical patients with antibiotics discontinued on time 4.4 Percentage of surgical patients with normothermia 4.5 Percentage of known diabetic surgical patients with controlled glucose 4.6 Percentage of surgical patients with appropriate surgical site hair removal				
	4.7 Percentage of lists using the WHO Surgical Safety Checklist 4.8 Percentage compliance with the SSI care bundle 4.9 Days between surgical never events				

5. Reducing harm from high risk medicines	5.1 Percentage of warfarin doses administered according to protocol 5.2 Number of patients receiving warfarin with INR > 6 (or 5) 5.3 Percentage of patients receiving low molecular weight heparin outside protocol limits 5.4 Number of patients with no INR recorded on their warfarin prescription 5.5 Number of patients receiving flumazenil to counteract effects of midazolam 5.6 Number of patients who received opiates who received subsequent treatment with naloxone 5.7 Number of patients who received 25% / 50% glucose to correct insulin induced hypoglycaemia				

Appendix B – Equality Impact Assessment

To be completed and attached to any procedural/policy document when submitted to the appropriate committee for consideration and approval.

		Yes/No	Comments
1	Does the policy/guidance affect one group less or more favourably than another on the grounds of: -	No	The Patient Safety Strategy seeks to ensure that all patients receive safe care and the principles apply equally to all the listed groups of patients
	• Race	No	Interpretation will be required to ensure that the safety of patients who cannot speak English is not adversely affected
	• Ethnic origin	No	
	• Nationality	No	
	• Gender	No	
	• Culture	No	
	• Religion or belief	No	
	• Sexual orientation	No	
	• Age	No	
	• Disability – learning disability, physical disability, sensory impairment and mental health problems	No	Reasonable adjustments need to be put in place to ensure that care for this group of patients is as safe as for anyone else
2	Is there any evidence that some groups are affected differently?	No	
3	If you have identified any potential discrimination, are there any exceptions valid, legal and / or justifiable?	N/A	
4	Is the impact of the policy/guidance likely to be negative?	No	
5	If so, can the impact be avoided?	N/A	
6	What alternatives are there to achieving the aims of the policy/guidance without the negative impact?	N/A	
7	Can taking alternative action reduce the impact?	N/A	

If a potentially discriminatory impact has been identified, please refer it to the relevant manager, together with any suggestions as to possible actions that would avoid/reduce the impact.