

Patient Safety Strategy 2014-2016



Introduction

The safe care of patients entrusted to York Teaching Hospital NHS Foundation Trust is our top priority and we are working tirelessly to ensure the continued improvement of patient care. Our ultimate objective is to be trusted to deliver safe, effective healthcare to our community-consistently.

We aim to be recognised as one of the safest hospitals nationally and internationally, delivering safe, evidence-based care, partly by acting and learning when we identify a need for improvement.

But this alone is not enough. Our patients and their families must receive their care with compassion and consideration and our resources have to be used wisely and to greatest effect.

The Trust recognises the value of working with patients and carers. We welcome patient partnership and strive to support patients to be more involved in their care. Additionally we seek to ensure that the patient voice is heard throughout the Trust including commissioning services and in our training programmes.

We are committed to the education, training and development of our staff. We want to ensure that our clinical staff are skilled and motivated and that our leaders can identify and develop patient safety behaviours and skills.

In adopting this strategy we will focus on enhancing our culture of transparency, in order to improve and provide support when things go wrong.

We recognise that our staff work in situations where risks are inherent and we will strive to maintain a working environment with safe and supportive systems of work, and an environment that also recognises responsibility and accountability. We will continue to encourage reporting of errors and incidents in order to learn from them however, we will not tolerate neglect or wilful misconduct.

How we are doing?

We have achieved tangible improvements in patient safety over recent years. Examples include a fall in mortality rates and better incident reporting.

Individuals, wards, departments and directorates have all made a contribution to improve patient safety. However, we know that our mortality rates are still higher than some of our peer organisations and that care is not always delivered in a consistent manner, 24 hours a day, seven days a week.

We must now take further action to reduce harm, diminish variation in practice and improve efficiency whilst always ensuring safe care.

The majority of our patients tell us that they would recommend our hospitals to their family and friends but there is variation between wards, departments and individuals.

When we get it wrong, the story our patients tell us is both powerful and moving and we promise to continue to learn from these stories.

We will continue to celebrate success and to promote and adopt best practice.



Patrick Crowley
Chief Executive



Dr. Alastair Turnbull
Medical Director

Patient Safety Strategy Implementation Plan

This Strategy has been developed following consultation with our staff. In addition, we have compared our systems and practices with other hospitals and considered national and international guidance on improving safety.

Our guiding principle is to provide safe, patient-centered care to a consistently high standard. To achieve this we will focus on six specific areas of work:

- Ensuring consistency of care, 24 hours a day, seven days a week
- Reduction of harm by early detection of the patient at risk of deteriorating
- Reducing mortality and improving mortality indicators
- Excellence in end of life care
- Infection prevention and control
- Action on areas of frequent harm.

Many of us focus on improvement for our patients, every day. This Strategy does not seek to exclude any of this work rather it helps us collectively to focus on those things we know can have the most impact, for the greatest number of our patients.

Clinical leaders continually review our systems of work to ensure that patients who are admitted to our hospitals do not experience undue delay in assessment, diagnostics, treatment or review by a senior clinician. We are working towards delivering a seven day service with no variation in timeliness or safety and quality of experience.

We are striving to improve the safety of those who are vulnerable to unexpected deterioration by enhanced training and the implementation of systems to support early recognition of the risk of deterioration. This is being supported by policies and clinical guidelines for initiation of early responses, interventions and, where necessary, escalation. This includes recent guidance around urgent and effective response to sepsis.

| NEWS SCORE | | Clinical Response |
|-------------|---|--|
| 3 LOW | Monitor Minimum 4 hourly 3-4 or Clinical Concern | <ul style="list-style-type: none"> ◆ Inform nurse in charge ◆ RN to re-check observations and ensure appropriate nursing interventions have been completed, using the ABCDE assessment. ◆ Consider commencing fluid balance monitoring. ◆ Nurse in charge to decide if escalation of care to F1/F2 or ST1/2 is required. |
| 5 MEDIUM | Monitor Minimum hourly 5-6 Or 3 in one parameter Or Urine output <30ml/hour for 2 consecutive hours Or Increasing oxygen demand to >60% | <ul style="list-style-type: none"> ◆ Inform nurse in charge ◆ RN to re-check observations and ensure appropriate nursing interventions have been completed, using the ABCDE assessment. ◆ Commence fluid balance monitoring. ◆ Initiate the deteriorating patient pathway and immediately contact F1/F2 or ST1/2 for review within 30 minutes. ◆ Inform critical care outreach. |
| 7 HIGH | Monitor every 15-30 mins 7 or more | <p>Do you need ZZZZ now?</p> <ul style="list-style-type: none"> ◆ Urgently inform the medical team (ST3) caring for the patient, and ensure appropriate nursing interventions have been completed, using the ABCDE assessment. ◆ Immediately inform critical care outreach. ◆ If Registrar (ST3) does not attend within 15 mins escalate to consultant |

We have developed and are refining systems for mortality review which will be consistently applied in all clinical areas including our community hospitals.

We will ensure that recognised strategies for reduction of mortality such as multidisciplinary ward rounds and *care bundles* are implemented - in all clinical areas. Many are currently in place and their implementation will be audited by review of compliance.

For our patients approaching the end of life and for their families and carers, our focus will be on the safety *and* experience of care. This includes patients who die suddenly or after a very brief illness. Our aim is to ensure that people approaching the end of life receive care which is aligned to their needs and preferences, is compassionate and delivered in accordance with agreed principles.

We have begun work on the implementation of electronic prescribing and medicines administration (EPMA), recognised to improve aspects of patient safety and helping to address one of our most frequent causes of avoidable harm. We will audit

compliance with administration of medicines focusing specifically on critical medicines and on antimicrobial stewardship.

We will use every opportunity to learn from incidents, complaints and litigation by reflecting on our practice and where necessary changing systems of work to ensure that patients are safe in our care and that repetition of avoidable harm is prevented.

The Serious Incident (SI) and Critical Incident (CI) procedures continue to evolve to ensure appropriate dissemination of change and learning, and work is now focusing on learning from litigation and complaints. We plan to use the recently developed Learning Hub as a resource for the delivery of learning objectives following Sis and clinical legal claims. In responding to incidents, complaints and litigation, we recognize the implication and responsibilities on our duty of condour.

We also take every opportunity to learn from national benchmarking including national audit publications such as National Confidential Enquiry into Patient Outcome and Death (NCEPOD) and inspections from our regulators. We have developed along with our local commissioners several patient safety initiatives which are being managed through the contracting for quality and innovations aspect of the contract.

The key aim of providing safe, patient centred care will be assisted by six driving principles:

- A culture of safety
- Partnering with other organizations
- Involving patients with safety
- Harnessing technology
- Costs and efficiency
- Developing our workforce.

A culture of safety

We encourage and require all our staff to report adverse events and unsafe conditions, to take action when it is needed and to seek assistance when concerned that the quality and safety of the care being delivered is threatened.

Our aim is to promote an open culture. Staff should be aware that that they are accountable for their actions however we want to develop and maintain an environment that feels safe, recognising that they will not be blamed for system faults in their work environment beyond their control.

We openly share safety information and focus on learning and improving from incidents, complaints and litigation. Whilst emphasising the importance of avoiding blame we will move towards a culture that will not tolerate non compliance with agreed procedures.

Patient Safety Walkrounds have provided valuable opportunities for senior leaders to discuss safety issues with frontline staff. As a commitment to developing our culture of safety we aim to undertake four walkrounds each month and to provide a monthly summary report to the Trust Board.

Fundamental to building on the successes of the Trusts current work on patient safety- as evidenced by a sequential fall in our mortality indicators- is placing it firmly and foremost on the agenda of all. At Trust Board, assurance of safe effective and compassionate care will continue to lead proceedings. The Boards subcommittees will develop, informed by an evolving Patient Safety and Quality Report and similar scrutiny will prevail at Executive Board but with a focus on actions required by Directorates. Use of Clinical Governance sessions will be reviewed to ensure consistency and individual clinicians will be expected to demonstrate their commitment to improvement. We will work with our Governors and seek their help with this strategy. Mindful of our growing and dispersed organization we will examine ways of better sharing learning, consistently throughout the Trust, for example by Joint Performance Improvement Meetings. More and more do we recognize the importance of designing safe systems that reduce harm arising from human factors and behaviors.

Partnering with other organisations

We aim to make good use of peer review to support analysis and to facilitate learning, both within and outside of formal systems. CHKS provides us with healthcare intelligence to support the delivery of safe and effective care.

We are one of 15 Foundation Trusts who are members of NHS QUEST; a network for Foundation Trusts who wish to focus relentlessly on improving quality and safety.

The Trust has also developed working relationships with other organisations such as Hull Hospital on the clinical pathway alliance, The Improvement Academy on mortality reviews, York University on patient incident reporting and the Global Sepsis Alliance.

Involving patients in safety

We want our patients to:

- Be involved as much as they want be in decisions about their care and treatment
- Let us know if anything of concern is noticed
- Be sure that we identify them correctly
- Ensure that they understand what we are planning to do before consenting to treatment
- Know what medicines they are taking and why
- Inform us of allergies
- To alert us to non compliance, for example with hand hygiene.

Harnessing the power of Information Technology

The Trust benefits from an integrated, effective and sophisticated Information Technology (IT) system. This has facilitated development of NEWS, escalation and result notification. It is fundamental in EPMA. Increasingly compliance can be measured electronically but most importantly clinicians will increasingly use smart systems, both to inform and document their work. It is essential that as such systems expand and develop they become even more accessible and user-friendly, thus ensuring consistent clinical engagement.

Costs and Efficiency

Cost improvement and safety improvement are not mutually exclusive, and there is ample international evidence for this. Length of patient stay in hospital will be reduced for example, by avoidance of harm and reduction of prescribing costs. Equally by tiered processes of assurance from Directorate to Executive level the Trust will examine proposed cost improvement programmes (CIPs) to ensure that at all times the CIP and patient safety programmes are aligned.

Developing our workforce

This strategy has referred to the essentiality of cultural factors but human factors are also key. Evidence indicates a clear link between the number of medical and nursing staff and safer patient outcomes. The Trust is committed to a process of continued review and of transparency and to a programme of focussed continuous professional development for staff. Professional capabilities and behaviours profoundly impact on the patients' experience.

The skills and competencies of our staff are key to the delivery of safe, cost effective, high quality care. It is essential that we have sufficient staff to care for the number and acuity of our patients. We recognise that, in particular, numbers of training grade and non Consultant grade medical staff are low by comparison with most UK hospitals. Constraints remain with regard to the number of training grade medical staff required nationally. The Trust is committed to delivering alternatives approaches and investing as required.

As indicated in our Nursing and Midwifery Strategy, We will ensure that our new staff have a robust induction programme with a period of meaningful perceptorship and that our current staff are able to participate in mandatory training.

We will aim to strengthen our clinical leaders through clear role definition, development and direction.

We will focus on the following six key areas of work.

1. Ensuring consistency of care, 24 hours a day, 7 days a week

The principle of 'equality of treatment or clinical outcome regardless of the day of the week' is a challenging yet intuitive concept. Evidence suggests that where there is inconsistent access to clinical services over a seven day period, patients suffer delays to their treatment and this contributes to less favourable outcomes.

We have begun to evaluate the requirement for developing our services for safer care. Seven day working does not necessarily mean operating all services 24 hours a day however, it will mean an extension to the working day or elements of a service becoming more accessible over the seven day period.

Reviews of serious untoward incidents and mortality reviews, observations of working practice and data collection, describe a system where patients can wait too long to be seen or treatment initiated and this can be a significant and contributing factor in failure to rescue some patients. We also know that ward rounds, where crucial decisions are made around patient management, can be variable and that adding structure, including checklists, to this will help prevent missed opportunities and reduce variation.

'Out of hours' there is still some inequity in workload, though recent changes have addressed many of these. Lack of clarity around some roles remains and is a focus for the 24/7 acute hospital 'out of hours' initiatives.

Nationally there is a shortage of junior doctors in training. This reduction in workforce will potentially have a significant impact to 'out of hours' where junior doctors have traditionally been the predominant medical workforce. As a result and in line with national work, we are committed to developing the Advanced Clinical Practitioner role and to ensuring a more consistent senior, (including consultant) presence. This process has begun, for example in obstetrics and anaesthetics. The planning implications of this are formidable and the Trust will be ever vigilant of the importance of learning arising across the organisation.

1.1 *Our aim is to:*

- Ensure that patients who are admitted to hospital for urgent treatment are assessed promptly
- Ensure excellence and consistency in ward round practices
- Ensure excellence and consistency in the use of safe systems including checklists
- Stream the 'out of hours' roles and methods of working.

1.2 *To achieve this we will:*

- Remodel pathways of care
- Improve staff capability and capacity to enhance the workforce 'out of hours'
- Improve communication and patient prioritisation

- Continue to develop advanced clinical practitioner roles
- Promote multidisciplinary ward and board rounds
- Further develop the ward round checklist
- Ensure patients have a daily senior medical review.

1.3 Outcomes:

- 80% of all acute medical, elderly medical and orthogeriatric patients will be reviewed by a consultant within 12 hours of admission, with a view to continuous improvement aligned with the Royal College of Physicians guidance – reported as per CQUIN
- 100% use of the Post-take Check List on Acute Assessment Units – reported as audit to Patient Safety Group
- Consistently achieve 100% compliance with the WHO surgical safety checklist – reported in Patient Safety and Quality Report
- Over 90% of patients admitted acutely with delirium or dementia aged 75 years or over will have a dementia specific assessment and where necessary be referred for advice or treatment on all our hospital sites – reported as per CQUIN.



2. Reducing Mortality and Improving Mortality Indicators

Mortality reviews

Learning all we can from critically examining care that patients receive before they die can teach us how to deliver safer care. This element of the strategy will continue to refine systems which ensure that a standardised approach will be taken to performing mortality reviews. Where trends can be identified, learning from reviews can be cascaded efficiently and improvements to patient safety occur where required.

Clinical coding

We know that our published mortality rates describe more deaths than expected in some areas. We know that this can be improved by making positive changes to the quality of our clinical documentation and clinical coding alongside delivering safer care. This will enable us to have increased confidence in our mortality data and to accurately reflect the care that is being delivered. Being able to compare ourselves externally enables us to strive to be the best and to learn from other high achieving organisations. Confidence in our coding processes enables us to use our data more effectively and fundamental to this is better documentation, recorded electronically, and close alignment between clinicians and coders. This contributes to better death certification as we move to introduction of the Medical Examiner role.

2.1 *Our aim is to:*

- Promote and develop the existing processes of mortality review for all patients who die in our hospitals
- Develop processes for dissemination of learning from mortality review
- Improve the depth of clinical coding.

2.2 *To achieve this we will:*

- Ensure that all in-patient deaths are reviewed by a consultant within four weeks of the death occurring
- Promote discussion of learning from mortality review at department governance meetings
- Provide a six monthly report of all deaths occurring in the Trust
- Monitor depth of coding via the mortality review process.

2.3 *Outcomes:*

- Summary Hospital-level Mortality Indicator (SHMI) of 95 on both acute hospital sites – reported quarterly in Patient Safety and Quality Report
- Overall Hospital Standardised Mortality Ratio (HSMR) of 100 or less – reported annually in Patient Safety and Quality Report.

3. Reducing harm from avoidable physiological deterioration

Problems surrounding the management of the deteriorating patient are often multi-factorial.

Outcome data shows that we are still performing slightly below average in terms of the number of cardiac arrests occurring in the Trust. Examining the care of patients who deteriorate has allowed us to understand the problem, including inaccurate early warning scores, failure to inform the senior nursing staff of deterioration, delay in senior medical review and failure of some patients being seen by a Consultant in the 24 hours prior to Critical Care admission.

The move to electronic observations has allowed improved compliance with early warning recognition and development of a robust escalation policy.

York Teaching Hospital **NHS**
NHS Foundation Trust

Have you heard the good NEWS?

National Early Warning Score (NEWS)

Standardising the assessment of acute-illness severity in the NHS

- Are you ready for the change?
- Chat to Critical care out reach as they walk the wards
- Nursing staff complete e learning

PAR Score will change to NEWS at the beginning of July

To improve the medical response, we have developed a deteriorating patient pathway to support the junior doctors in the initial assessment. The escalation policy is a graded response which ensures a structured and timely approach to the deteriorating patient.

By empowering all members of the team we will generate an open, receptive culture around the deteriorating patient.

We know we must further embed good practice to prevent patients developing pressure ulcers or falling while in our care and have ambitious plans for staff training, audit and support.

Patients miss doses of key medication more often than we would want and there is variation in our discharge processes around medication practice. Audit shows that our some of our highest reported adverse incidents relate to medicines. We will be developing a robust plan to support safer medicines management including but not exclusively a system for electronic prescribing and medicines administration (EPMA) which has significant committed investment.

3.1 *Our aim is to:*

- Increase knowledge of critical illness recognition and management
- Have a clear process for early detection of the deteriorating patient
- Establish robust escalation processes uniformly throughout the Trust
- Promote robust risk assessment and intervention for patients at risk of harm.

3.2 *To achieve this we will:*

- Provide training in acute illness recognition, management and escalation
- Audit use of the deteriorating patient pathway and policy
- Audit use of the sepsis management bundle of care
- Develop a patient observation policy
- Extend the use of safety briefings
- Increase Critical Care Outreach support at both acute sites.
- Critically review cardiac arrests regularly.
- Continue to promote better management of patients with diabetes
- Develop a medicines management plan which includes electronic prescribing.

3.3 *Outcomes:*

- Redesign and test the modified clinical pathway for patients with severe sepsis at both acute hospital sites – reported as per CQUIN
- Reduction of in-hospital cardiac arrests
- Introduce a modified version of the National Early Warning System (NEWS) in our community hospitals – reported in Community Dashboard.

4. Excellence in end of life care

Of the 500,000 people who die each year in the UK only 18% die at home, yet 60% wish to do so.

End of Life Care is an inclusive term for the care and management of patients identified as being in the last year of their life. Throughout this time, patients may come into contact with our services to varying degrees dependent on the acuity and

nature of their illness or disease. The Trust is committed to improving experiences throughout this time.

Although every individual may have a different idea about what would, for them, constitute 'a good death', for many this would involve:

- Being treated as an individual, with dignity and respect
- Being without pain and other symptoms
- Being in familiar surroundings
- Being in the company of close family and/or friends.

4.1 *Our aim is to:*

- Ensure appropriate inclusive and well documented Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decision making
- Ensure appropriate, agreed ceiling of care decision making
- Promote excellence in care planning at the end of life.

4.2 *To achieve this we will:*

- Develop the role of the Lead Nurse for End of Life Care
- Continue to audit DNACPR decision making and agreement on ceiling of care
- Continue roll out of AMBER^{*}/advance care planning
- Work with local commissioners to implement the AMBER/Advanced Care Planning booklet
- Link with mortality review processes and specifically DNACPR decision making
- Work with local commissioners to ensure that people at the end of their lives have care in their preferred place
- Facilitate compliance with definition of ceiling of care by using both the Ward Round Checklist and the Admissions Clerking proforma.

* AMBER is a systematic approach used in hospitals to manage the care of patients facing an uncertain recovery and who are at risk of dying in the next one to two months.

4.3 *Outcomes:*

- Patients will have appropriate, inclusive and well documented DNACPR decision making – Reported by Compliance Reviews to DNACPR Group
- Patients will have appropriate and agreed ceiling of care decision making, detailing treatment options as relevant to the patient including whether or not

to transfer to a higher level of care or the application of a DNACPR order – Reported to the Patient Safety Group.

5. Infection prevention and control

Hospital acquired infection remains a threat to the well being of our patients.

Levels of *Clostridium Difficile*, Methicillin-resistant *Staphylococcus aureus*, Methicillin-sensitive *Staphylococcus aureus* and *Escherichia coli* are collected weekly and Root Cause Analysis (RCA) undertaken by the treating clinician where appropriate.

The emergence of antimicrobial resistance, for example Carbapenamase-producing Enterobacteriaceae (CRE) is a key concern and we will continue to both develop a restrictive antimicrobial formulary and audit compliance with antimicrobial prevention guidelines including documentation of indication and course length.

Data on hand hygiene and bare below the elbows compliance are routinely collected and adherence to the Infection Prevention and Control (IPC) Policy will be universally required throughout the Trust.

The Director of Infection Prevention and Control (DIPC), Deputy DIPC and Hospital Infection Prevention and Control Committee will continue to monitor and report to the Trust Board of Directors data on IPC compliance, and continue to promote a culture amongst all staff of infection prevention awareness.

5.1 *Our aim is to: Reduce the Incidence of Healthcare Associated Infections.*

5.2 *To achieve this we will:*

- Ensure awareness of IPC measure via staff education, particularly hand hygiene and aseptic non touch technique.
- Improve the quality of antimicrobial prescribing.
- Ensure as far as possible, isolated of potentially infected patient.
- Improve own facilities to make effective isolation better and reduce care to care spread.
- Ensure compliance with National Guidance including DH, CRE Toolkit.

5.3 *Outcomes:*

- The indications and course length for prescribing an antimicrobial will be recorded in 100% of cases – Reported in the Patient Safety and Quality Report.

- Less than 60 cases of *Clostridium difficile*, MSSA 29 cases, MRSA 6 cases – Reported in the Patient Safety and Quality Report.
- Reports of antibiotic resistant organisms – Reported in the Patient Safety and Quality Report.

6. Areas of identified concern

This strategy has identified key foci for improvement, but analysis of harm events in the Trust identifies other recurrent themes around avoidable harm. These include morbidity and mortality from falls, and the development of pressure ulcers. Each of these will be the focus of specific actions for the Patient Safety team working with the Chief Nurse's Team. Each requires a multidisciplinary approach, identifying improvements made in other hospitals and rigorous incident reporting. Each will be subject to Root Cause Analysis via the Serious Incident process. Progress will be reported from Ward to Board.

6.1 *Our aim is to:*

- Ensure that clinical staff understand the risk to patients of falling in hospital
- Identify which patient are at higher risk of falling in hospital
- To reduce the incidence of patients falling in hospital
- To reduce the number of patients who experience severe harm following a fall in hospital
- To reduce the incidence of pressure ulcer development for patients in our care
- To promote early identification and treatment for patients with pressure ulcers.

6.2 *To achieve this we will:*

- Develop an Organisational Patient Falls Reduction Group
- Review our falls risk assessment
- Develop falls specific individual care plans
- Review and expand the pressure ulcer reduction plans
- Develop a Pressure Ulcer Steering Group.

6.3 *Outcomes:*

- Reduce the development of pressure ulcers (as measured by the Safety Thermometer audit) by 20% - Reported in the Patient Safety and Quality Report.
- Root Cause Analysis of all category 3 and 4 pressure ulcers – Reported as per CQUIN.
- Establish a standardised approach to assessment and interventions for patients at risk of falling in hospital – Reported as per CQUIN.
- Report all patient incidents of severe harm following a fall as Sis – Reported to Commissioners.

- Reduce the number of patients who fall in hospital and incur severe harm by 30% - reported in the Patient Safety and Quality Report.

Monitoring Progress

Progress with implementation of the Patient Safety Strategy will be reported monthly to the Executive Board and Trust Board. Progress with CQUIN will be monitored quarterly with local commissioners. Outcomes will be reported in the Patient Safety and Quality Report, The Director of Infection Prevention and Control Report and the Director of Nursing's Report and monitored by the Quality and Safety Committee.

The Trust Patient Safety Group will have responsibility for ensuring that the individual streams of work supporting the strategy implementation have adequate and appropriate support to achieve success and that they are progressing in accordance with their project plans.

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