West Hertfordshire Hospitals NHS
NHS Trust

TRUST BOARD MEETING – November 2012

Title of the Paper:	Harm Free Care
Agenda item:	Part 1 Item 20/12
Author:	Maxine McVey, Interim Director of Nursing
Trust Objective:	1. Provide Safe Patient Care 2. Improve outcomes and quality of care 3. Improve the Patient Experience

Purpose

To provide the Trust Board with information and data

Risk Implications for the Trust *(including any clinical and financial consequences):*	**Mitigating Actions** *(Controls):*
Potential limited compliance with CQC Outcome 5 Meeting Nutritional Needs and SHA ambition on elimination of avoidable pressure ulcers.	Regular monitoring and corrective actions to achieve required level of compliance

Level of Assurance that can be given to the Trust Board from the report [significant, sufficient, limited, none]:

Sufficient with plans for improvement identified

Links to Board Assurance Framework, CQC Outcomes, Statutory Requirements (ie BAF risk reference, CQC outcomes linked to report)

CQC Outcome

Legal Implications:

Recommendation to the Trust Board:
To consider whether this report provides the assurance required.

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West Hertfordshire Harm Free Care Report

1. Introduction

This report provides a summary of the actions being taken in the Trust and our ambition to deliver Harm Free Care to 95% of our patients by December 2012.

This is monitored by the monthly safety thermometer audits which enables the percentage of patients within the Trust who received harm free care to be calculated. The data collected refers to a point prevalence audit and can be used alongside other local measures to evaluate our progress as a trust. This is a national tool that is one of the Trust CQUIN schedules.

2. Background

For the purpose of this report the term 'harm' will describe only a fraction of possible health care complications. It will be used to define the absence of four harms; pressure ulcers, harms from falls, catheter associated urinary tract infections (CAUTI's) and blood clots (Venous Thrombo Embolism).

The incidence of these are recognised globally as challenges to every health care system. However, patients classified as 'harm free' within the safety thermometer may be at risk of other harms.

Progress with implementation

Within our clinical strategy to deliver harm free care lies our commitment to improve our patients safety and experience whilst protecting them from harm. We aim to achieve this by ensuring the Trust's core value of putting patients first remains our primary focus whilst implementing a multidisciplinary approach to achieve harm free care.

Harm Free care is a journey which requires continual work and there are key primary and secondary drivers which will aid in delivering success (see appendix 1).

3. Measurement Tools

We measure harm using;

- Routine Data including the Nursing Quality Indicators and maternity dashboard to identify quality indicators such as number of complaints, hand hygiene compliance, nutrition.
- Adverse Events, incident reporting.
- Point prevalence audits through Monthly Safety Thermometer to determine 'how we are doing' in relation to the four harms
- Bench mark our practice and identifying themes and trends

Point prevalence audits promote a different mind set by prompting the multidisciplinary teams to think differently and measure harm from the patients perspective, by looking at the percentage of patients 'protected from harm'.

4. Strategies

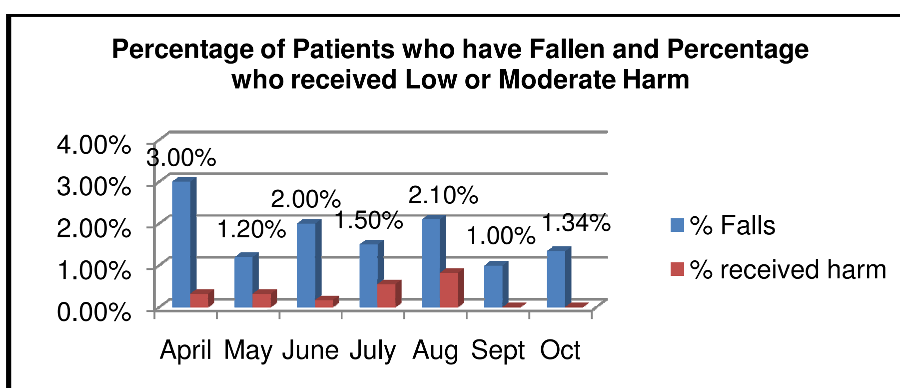
The strategies we have in place to achieve 'harm free' care;

- Work streams lead by the Matrons for each of the four key areas within 'Harm Free Care' reporting to a Multidisciplinary Harm Free Group.
- Standards of Care booklet providing expectations for staff in delivering the fundamentals of care
- Reduced nursing documentation by nine pages with the introduction of the 72 hour care record

- Incorporated ‘hourly rounding’ within the 72 hour care record
- Knowledge and expertise of the specialist nurses to provide education and training
- Utilise the Nursing and Midwifery Quality indicators to drive improvements in practice at every level from board to ward
- Reviewed the nutrition status of our patients by implementing the MUST (Malnutrition Universal Screening Tool)
- Launched ‘Place Mats’ in July to empower and prompt patient involvement in preventing pressure damage, eating well, managing pain and as a form of communication.

5.1 Our results
Obtained from the monthly Safety Thermometer audits completed by the Trust.

Falls
A fall is defined as an unplanned or unintentional descent to the floor, with injury regardless of the cause. Any fall that the patient has experienced within the previous 72 hours in a care setting is recorded within the safety thermometer.



- The new 72 hour care record was launched on 1st October incorporating hourly rounding.
- Multidisciplinary falls assessment tool is in place and used for patients identified ‘at risk’ or those have experienced a fall, aimed at reducing the incidence of falls.
- The Med line flexible ‘sure grip’ slippers are in place within ward areas. These were introduced to reduce incidence of slips, trips and falls due to poor compliance from wearing the previous foam slippers supplied across the Trust.

5.2 Pressure Ulcers
An old pressure ulcer is defined as a PU that was present when the patient came under our care, or developed within 72 hours of admission. A new is defined as a PU that developed 72 hours or more after admission. The patients worst ‘old’ and worst ‘new’ is recorded within the safety thermometer audit.

	May 12	June 12	July 12	Aug 12	Sept 12	Oct 12
Pressure Ulcers; percentage of patients with old and new PU’s	6.3%	6.1%	4.9%	7.8%	6.2%	5.5%
Percentage of patients with New PU	0.5%	0.6%	1.5%	2.0%	1.1%	0.5%

- SSKIN pressure ulcer care bundle for treatment is in place alongside the patient information leaflet.
- There has been no avoidable Grade 4 pressure ulcers reported since April 2012.
- Ongoing education is in place for nursing staff to distinguish between tissue damage caused by pressure on the skin and damage by moisture

We are part of NHS Midlands and East and collectively have shown more than a 35% reduction in the prevalence of pressure ulcers of any origin, category 2, 3 and 4 between April – September 2012.

This is the largest reduction in prevalence when comparing with NHS London, NHS North of England and NHS South of England**.**

The National percentage of patients documented as having a NEW pressure ulcer of any category (2, 3 or 4) between April – September 2012 is 1.5%. NHS Midlands and East's percentage reached 1.5% alongside NHS North of England and NHS South of England.

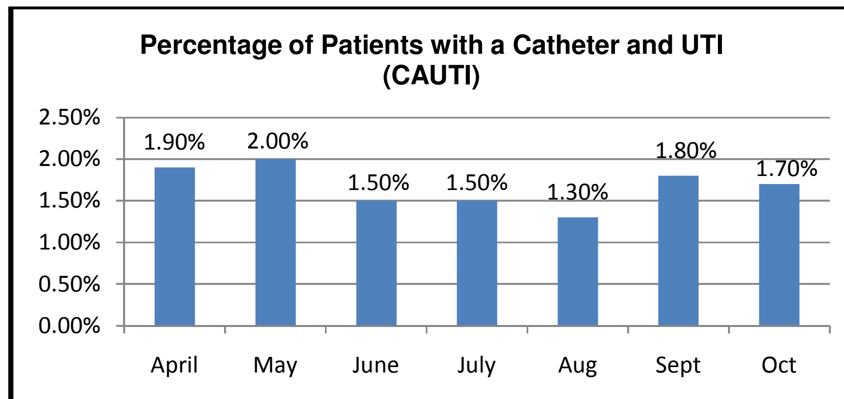
5.3 New VTE

A patient may be defined as having a new VTE if they are being treated for a deep vein thrombosis (DVT) or pulmonary embolism (PE).

	May 12	June 12	July 12	Aug 12	Sept 12	Oct 12
VTE; percentage of patients with documented VTE risk assessment	84%	86%	90%	79%	85%	83%

- Implementation of the new drug charts supports the need to regularly review whether appropriate prophylaxis is prescribed.
- Reduce the incidence of hospital acquired venous thrombo-embolism (VTE) by ensuring every patient has a VTE assessment on admission and is given appropriate prophylaxis if required

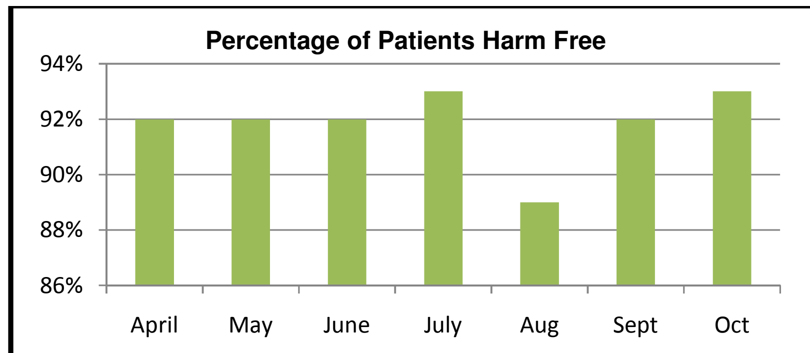
5.4 CAUTI's



- Ongoing auditing is in place to monitor the number of urinary catheters in ward areas, reasons for insertion and to challenge staff in ensuring timely removal.
- The catheter passports are being used to improve the ongoing care offered to patients with urinary catheters and support education and training on discharge.

The overall national percentage for patients with CAUTI's between April – September 2012 is 1.4%. NHS Midlands and East's percentage is 1.4% with NHS South of England at 1.7%.

5.5 Percentage of Patients 'HARM FREE'



	Pressure Ulcer	Fall (with harm)	Urine Infection (catheters)	VTE	Harm Free Care
Patient 1	no	yes	yes	yes	No
Patient 2	no	no	yes	yes	No
Patient 3	yes	yes	yes	yes	Yes
Patient 4	yes	yes	yes	yes	Yes
Patient 5	yes	yes	no	yes	No
					2/5

Currently 93% of our patients are like patients 3 and 4

= HARM FREE

National Information

SHA cluster	No harm	1 harm	2 harms	3 harms+	% harm free
NHS London	64,141	6,139	330	7	90.8%
NHS Midlands & East	377,037	38,004	1,970	42	90.4%
NHS North of England	216,504	19,406	965	41	91.4%
NHS South of England	136,913	13,254	18	20	91.2%
Total	794,595	76,803	3,283	110	90.8%

Please note that 875, 507 patients surveyed since January across England, This is the largest collection of safety data of this kind in any country of the world but has not been fully implemented across the whole of the NHS.

6.0 Recommendations

This report demonstrates an overall percentage of Harm Free Care to 93%. The target to be achieved is 95%.

The Board is asked to note the submission data and the initial work of the Harm Free Care group and the data produced from the safety thermometer and to support the following.

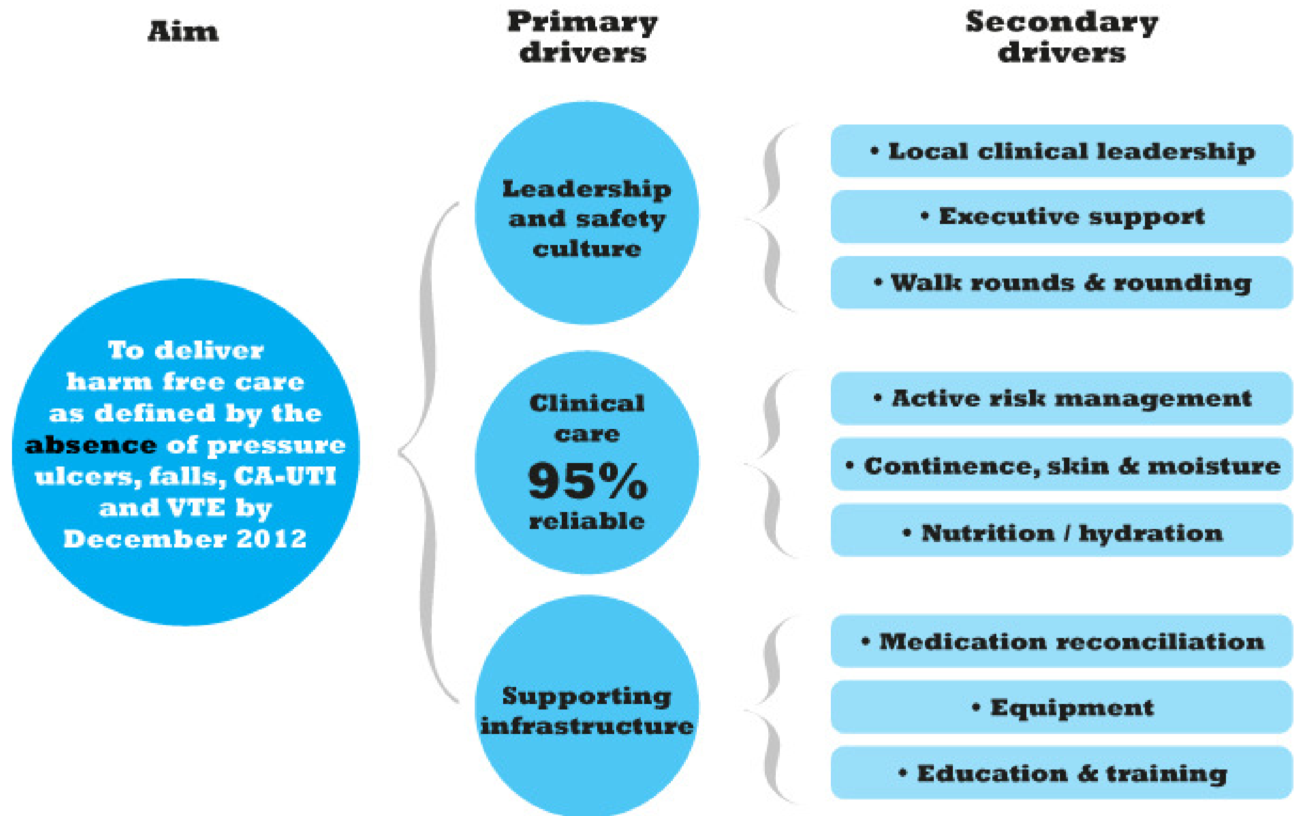
- Continue to spread the message and ensure harm free care remains a focus and 'topic of discussion'.
- Continue to measure harm from the patient's perspective and not from the health care perspective and refer to the percentage of patients who have been protected from harm.

The information presented in this report and more detailed analysis will be continued to be shared with the Nursing and Midwifery workforce and work streams to improve performance will be progressed via the Harm Free Care Group.

Maxine McVey
Interim Director of Nursing
November 2012

Appendix 1

To effectively deliver 'harm free' care to our patients there are key primary and secondary drivers which will aid in delivery of success.



The driver diagram should be read from right to left. The secondary drivers feed the overall aim. So by working through each of the drivers, you will accomplish our aim of delivering 'harm free' care to patients.