'Harmfree'care®

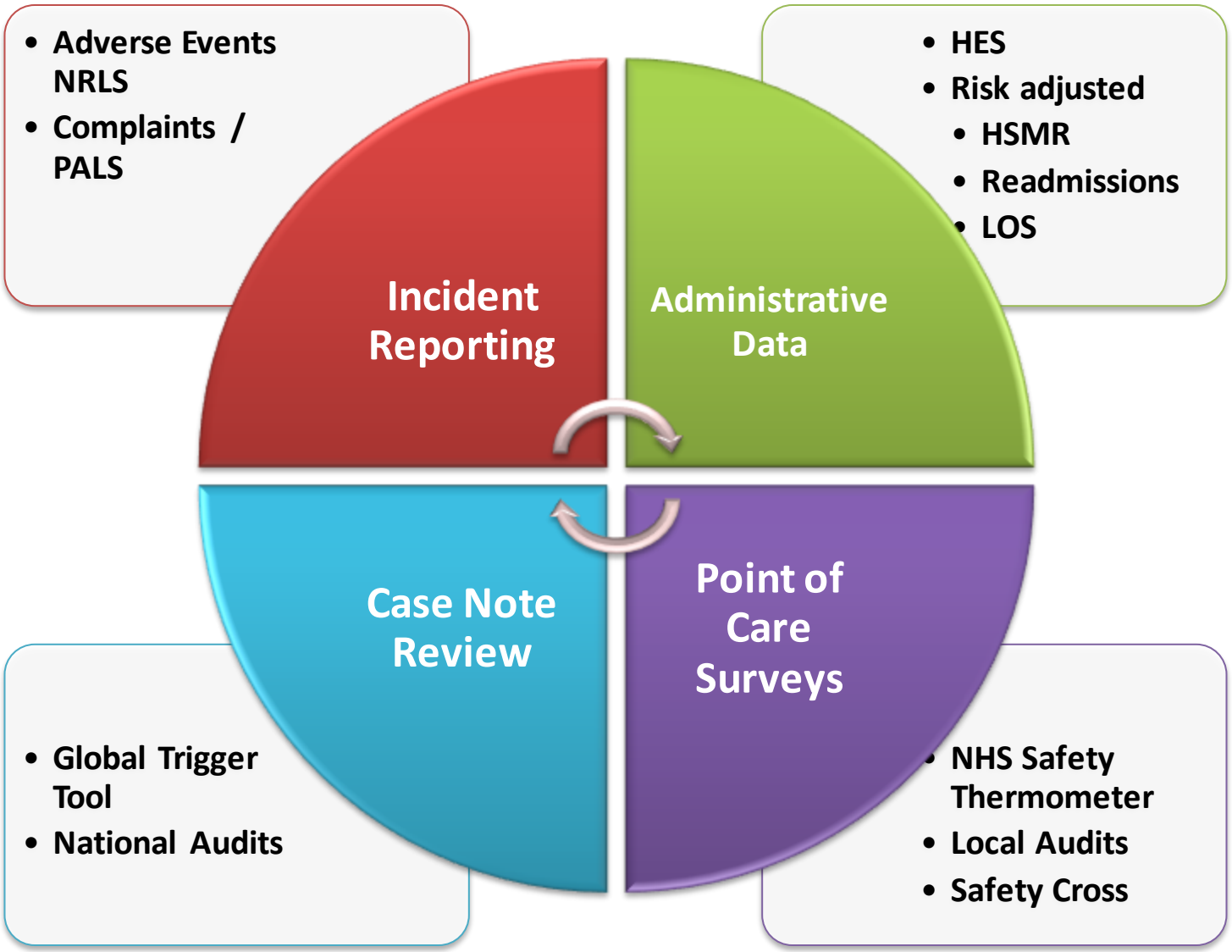
A new mindset in patient safety improvement

It's not just counting…it's caring!

Measuring harm and the NHS Safety Thermometer

hælo

Measurement is complex



Administrative Data

Advantages

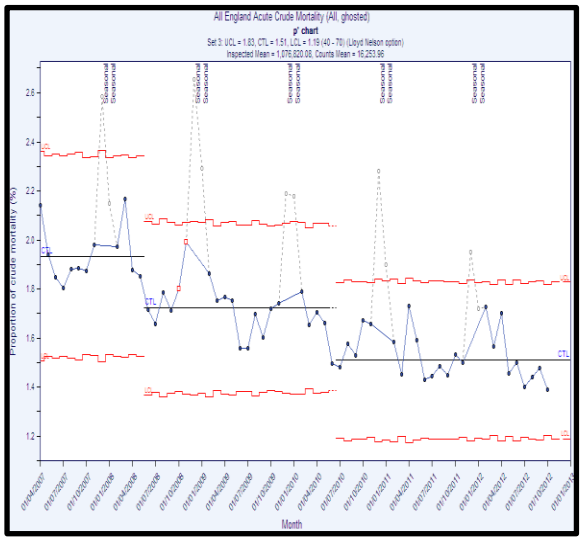
- Automated
- Code available for PU & falls

Challenges

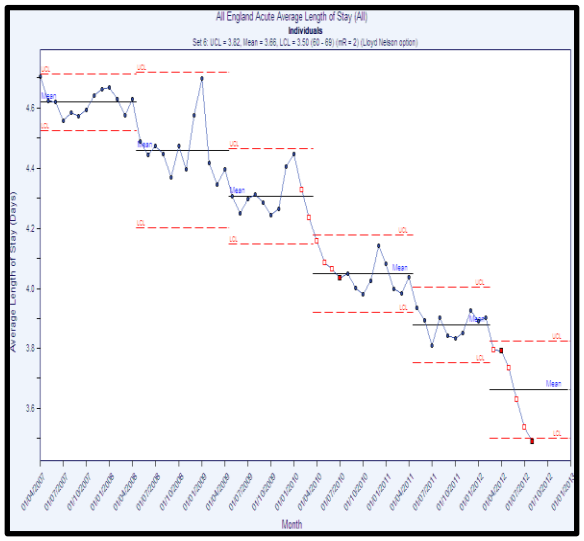
- Coding Variation
- Under report

Hospital Episode Statistics

Mortality (in hospital)

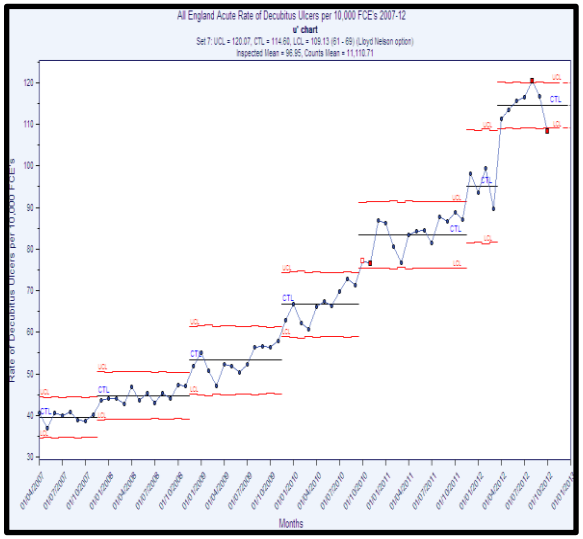


Length of in-patient stay

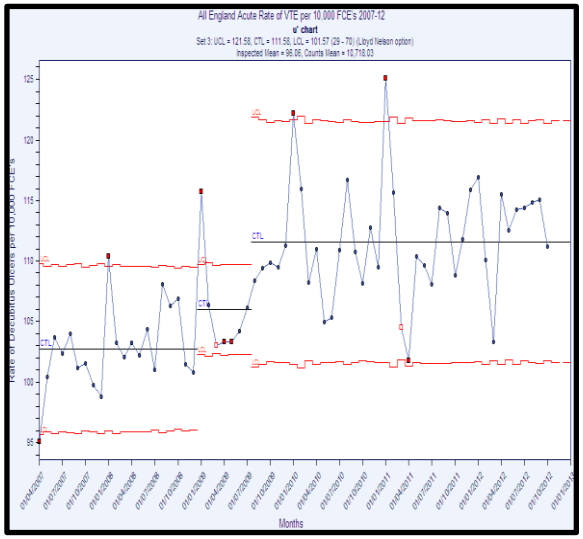


30 day Readmission

Decubitus ulcer



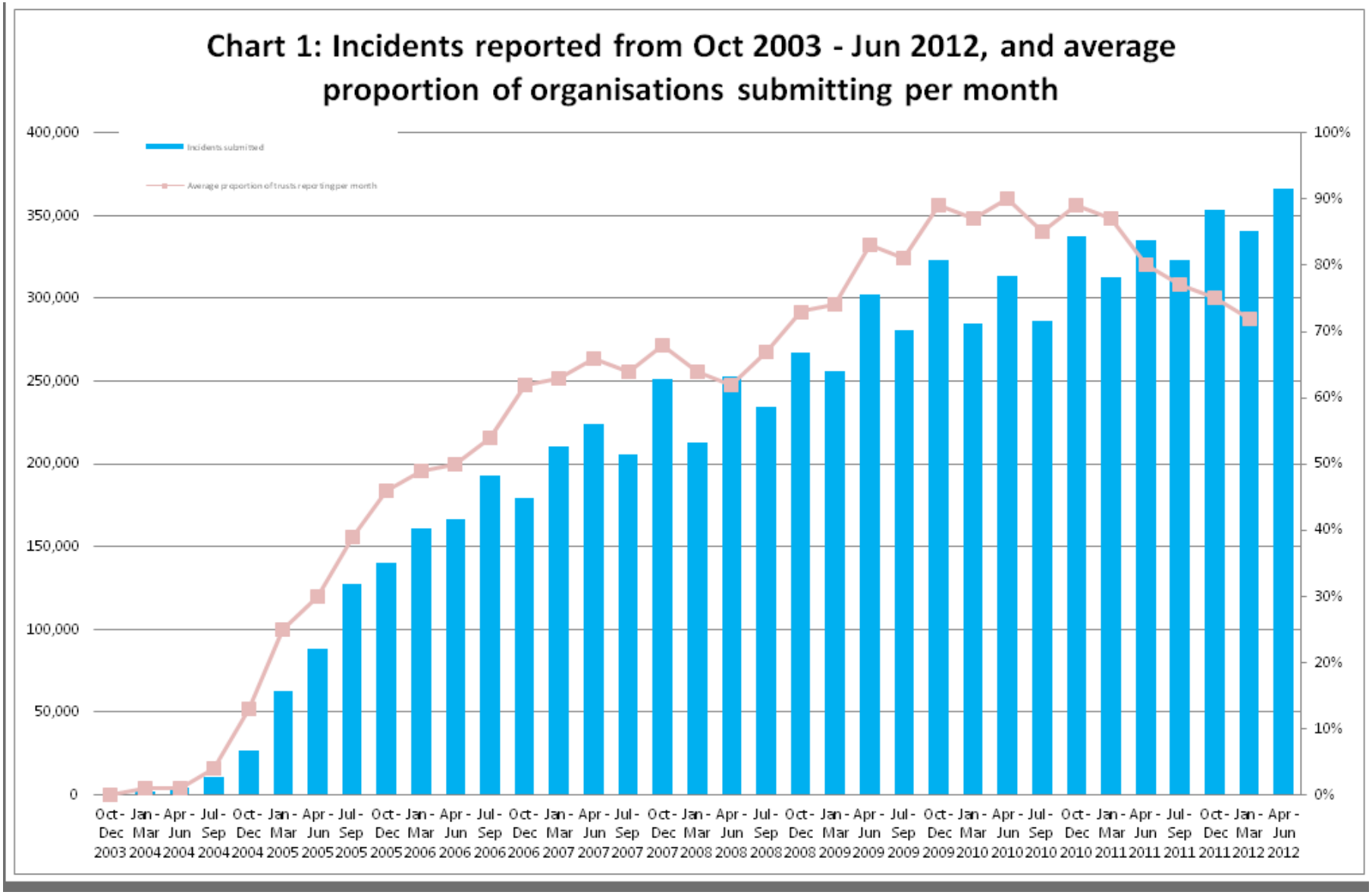
VTE



Unpacking sources of data

Incident Reporting

Advantages	Challenges
Known entity	Time Culture
PU & Falls	Staff Report



http://www.nrls.npsa.nhs.uk/

http://www.nrls.npsa.nhs.uk/resources/?EntryId45=135153

Point of care surveys

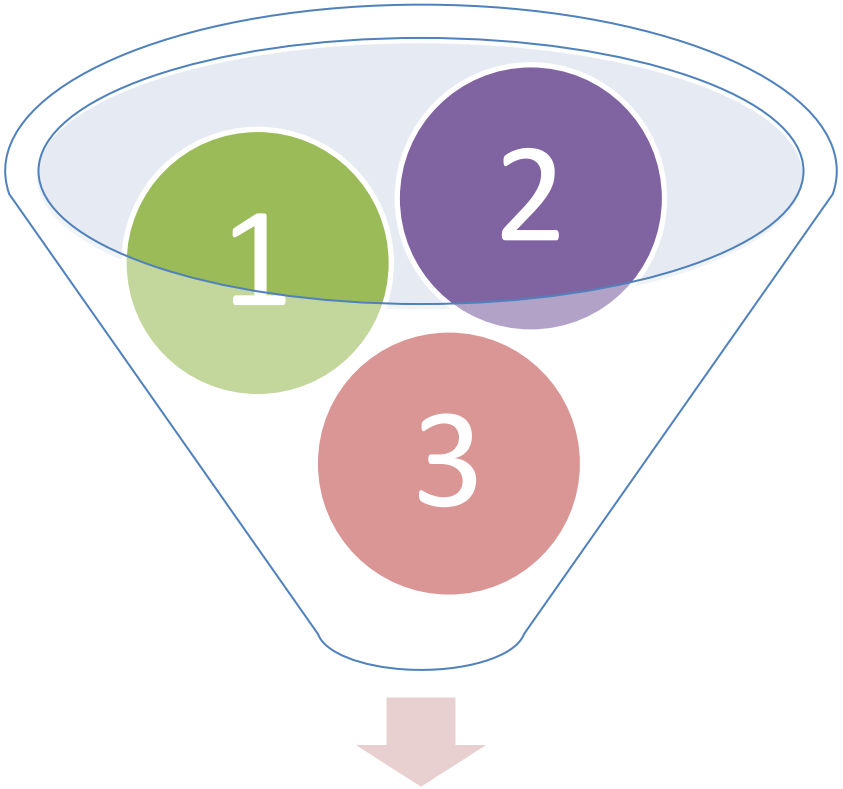
Advantages

- Composite Harm ‘free’
- Data & charts immediate

Challenges

- Sample Size
- Consistency of Use????

Maybe the solution lies with using multiple sources of data for a single issue?



'Harmfree'care®

A new mindset in patient safety improvement

What is the burden of harm?

- Pressure ulcers
- Falls
- Urinary infections (in patients with catheters)
- VTE

Are we improving?

Is the patient protected from all 4 harms?

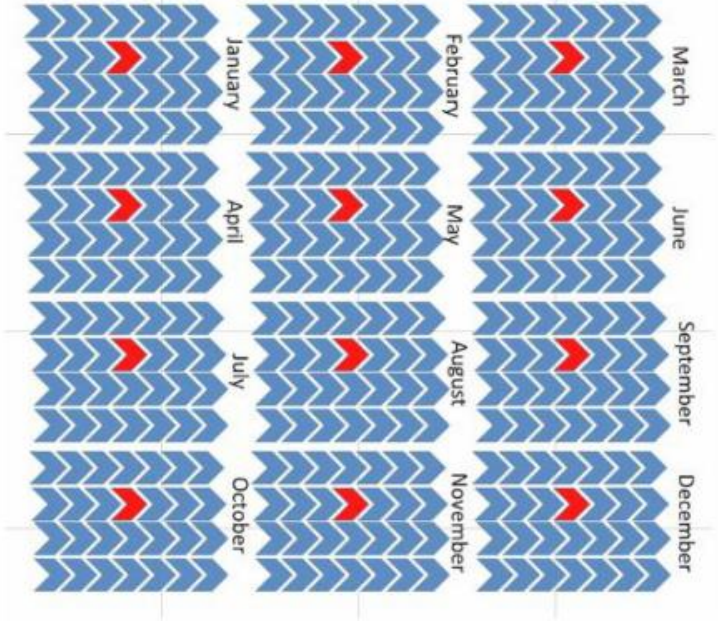
	Pressure Ulcer	Fall (with harm)	Urine Infection (catheters)	VTE	Harm Free Care
Patient 1	no	yes	yes	yes	No
Patient 2	no	no	yes	yes	No
Patient 3	yes	yes	yes	yes	Yes
Patient 4	yes	yes	yes	yes	Yes
Patient 5	yes	yes	no	yes	No
					2/5

Design Principles

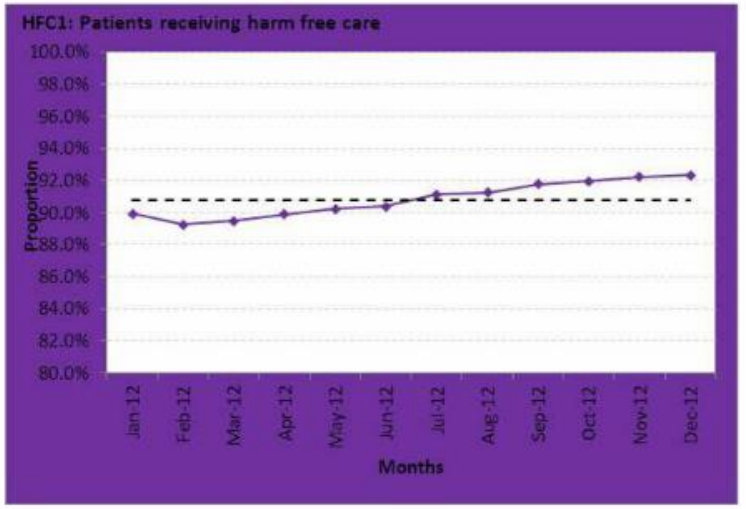
Design principles for the instrument were agreed as follows:
1. **Clinically valid** with clear operational definitions for harm outcomes (in this case, pressure ulcers, falls, catheter associated urinary tract infection and venous thromboembolism).
2. **Efficient** it should not take longer than 10 minutes per patient and must fit within the daily work flow of frontline clinicians.
3. **Equitable** and capable of being used wherever the patient is located (e.g. in a home, community or hospital setting).
4. **Timely** giving an immediate summary of results that can be used by teams in their improvement work.
5. **Patient focused** measuring the absence of all four outcomes in individual patients 'harm free' care as well as the individual harms.
6. **Focused on all harm** irrespective of perceived availability or attribution.
7. **Easy to aggregate** to show results at the ward, region or national levels.

Measurement for improvement

100% of appropriate patients surveyed on ONE day per month



Improvement over time



Process measures collected locally

The NHS Safety Thermometer measuring 'harmfreecare' at the point of care

Development

Iterative testing using PDSA

Gathering user feedback

Working with content and measurement experts

Partnership working

More than just a measurement tool...

Operational definitions

Patient focused

Integratin measurement into daily routines

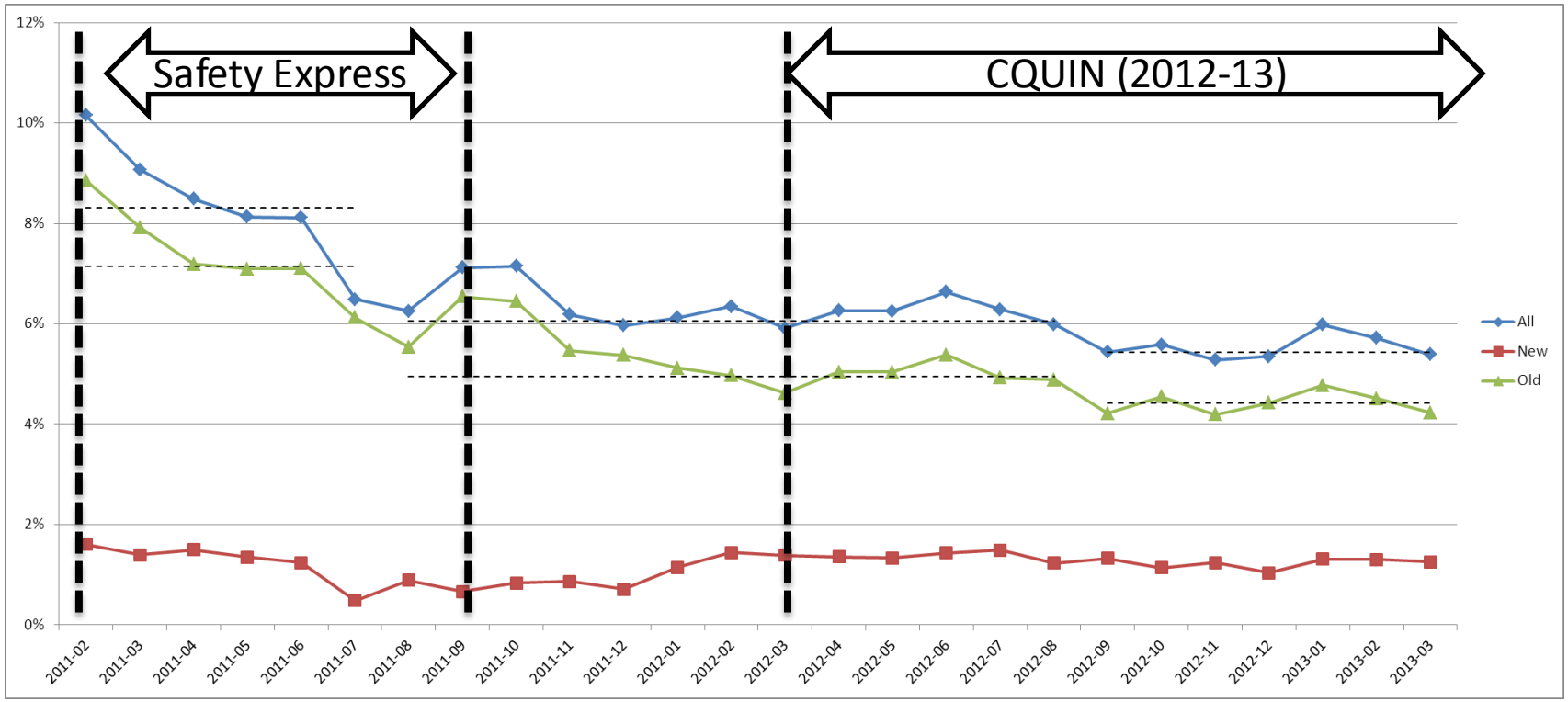
Immediate results - local, regional and national

Raising awareness of the four harms and changing mindsets

Social movement..a call to action for front line staff

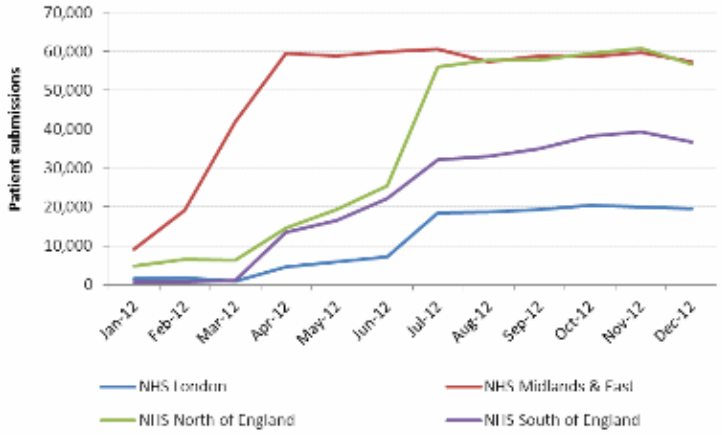
Its not just counting...it's caring

Pressure Ulcer Prevalence in Safety Express participants



The run chart shows the percentage of patients with a pressure ulcer at the commencement of safety express in January 2011 to be 8%, 7% and 1% for all pressure ulcers, new pressure ulcers and old pressure ulcers respectively. In July 2011, six months after the start of the collaborative, the median values were reset for all pressure ulcers and old pressure ulcers to 6% and 5% respectively because of signals of special cause variation (a run of 6 data points descending) but remained the same for new pressure ulcers. This change represents a 27% and 30% reduction in pressure ulcer prevalence in the two categories. The collaborative ended in October 2011 and progress was maintained. In March 2012 a national CQUIN scheme was introduced to incentivise organisations to review the data and six months later there was a second signal of special cause variation (a shift of 7 data points below the median line) which was maintained through to the year end and represented a further reduction of 10%. In total the medians improved by 35 and 38% respectively for all pressure ulcers and old pressure ulcers. No change was seen in new pressure ulcers.

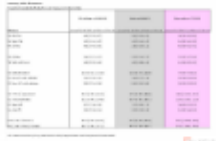
Scale up to a national data collection



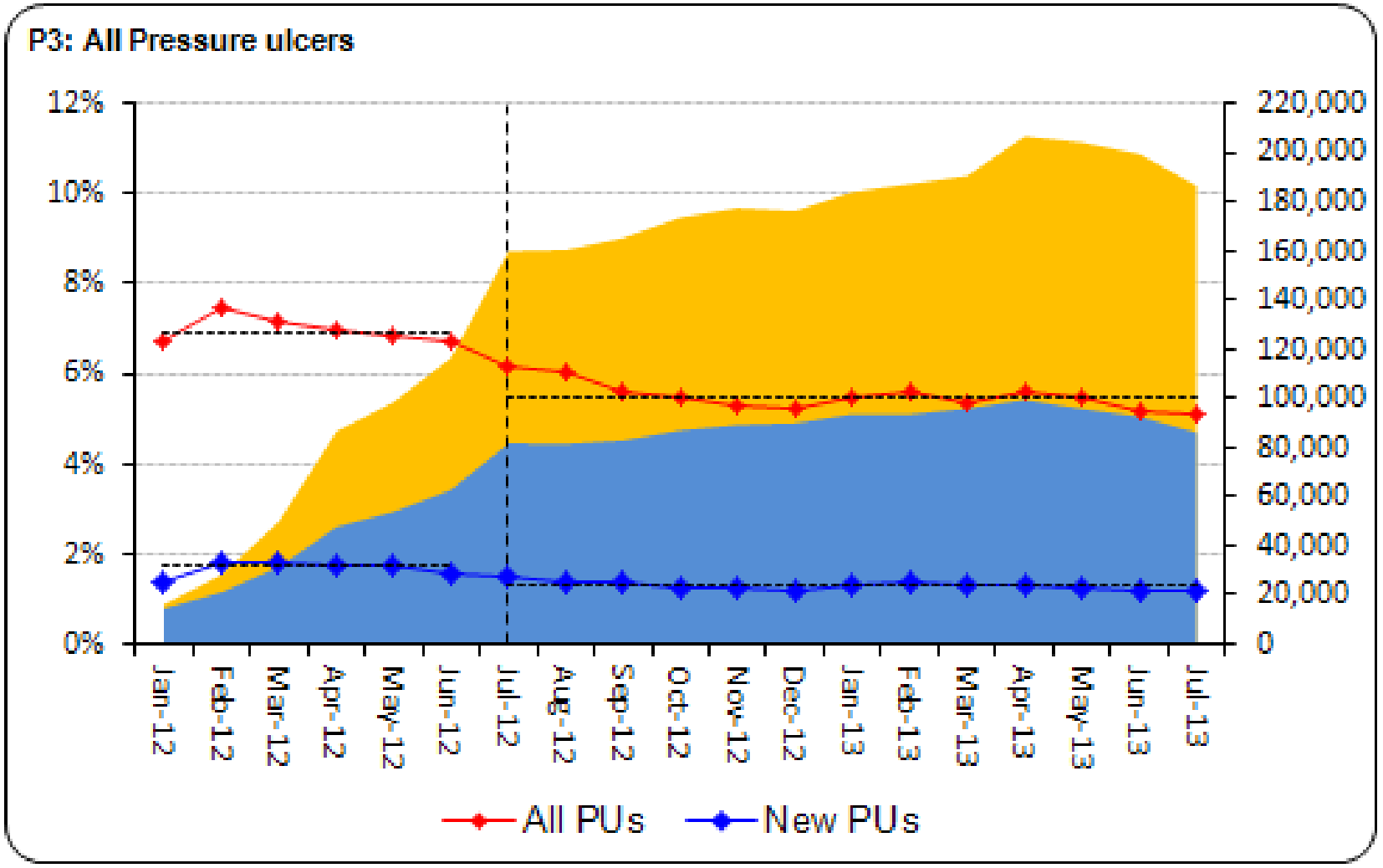
719 organisations

146 acute, 573 non-acute

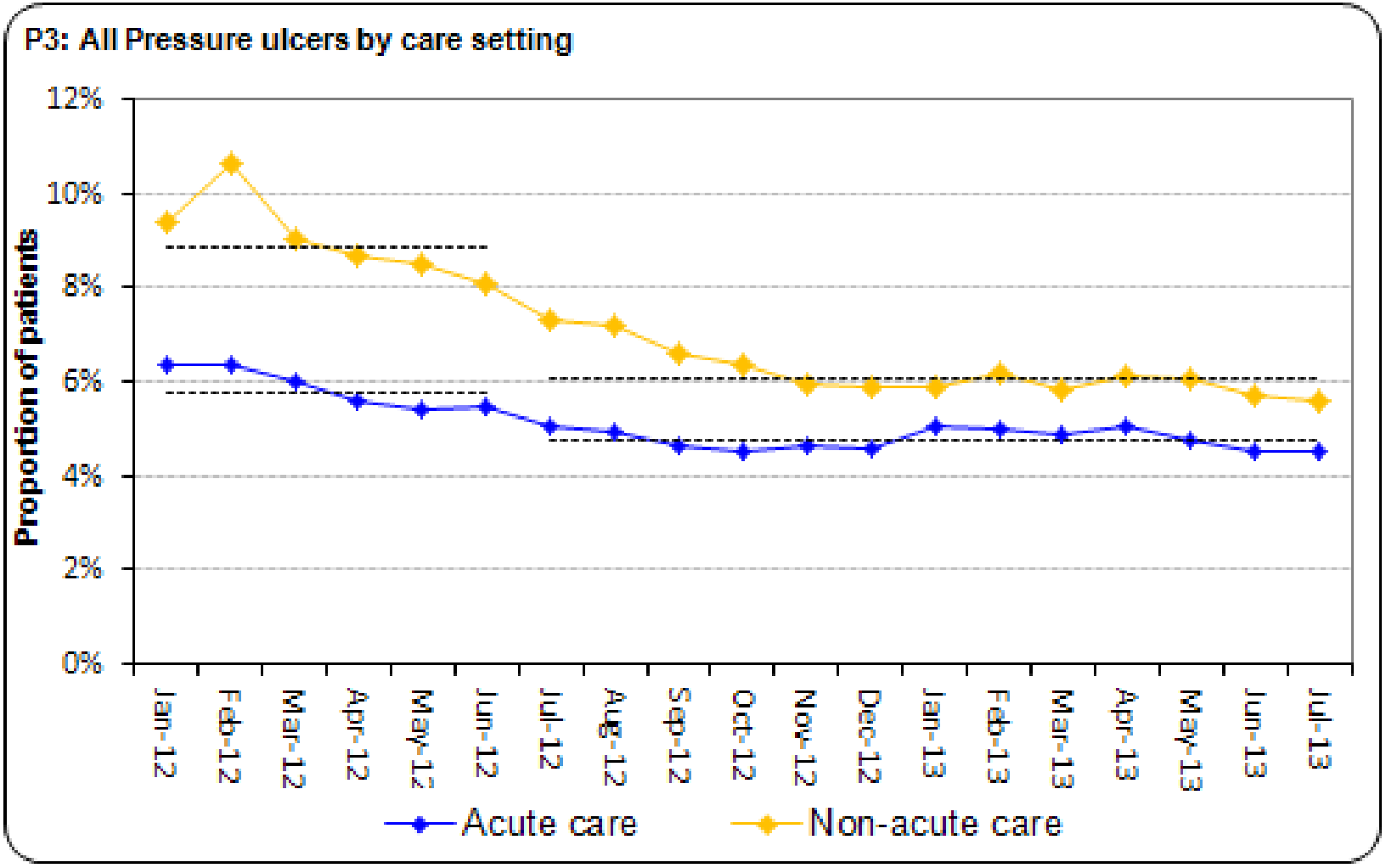
1,933,662 patients surveyed



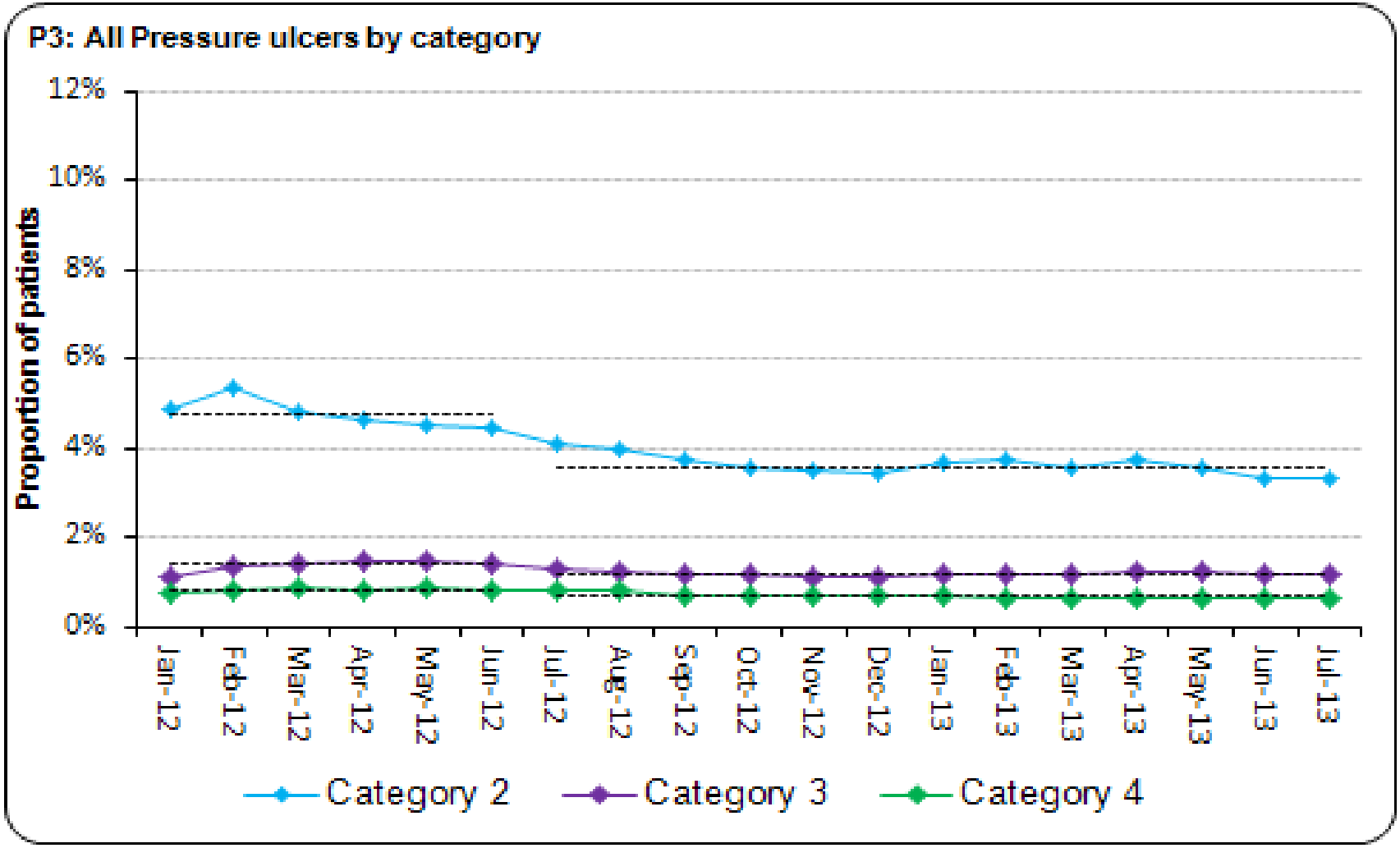
How many patients have a pressure ulcer?



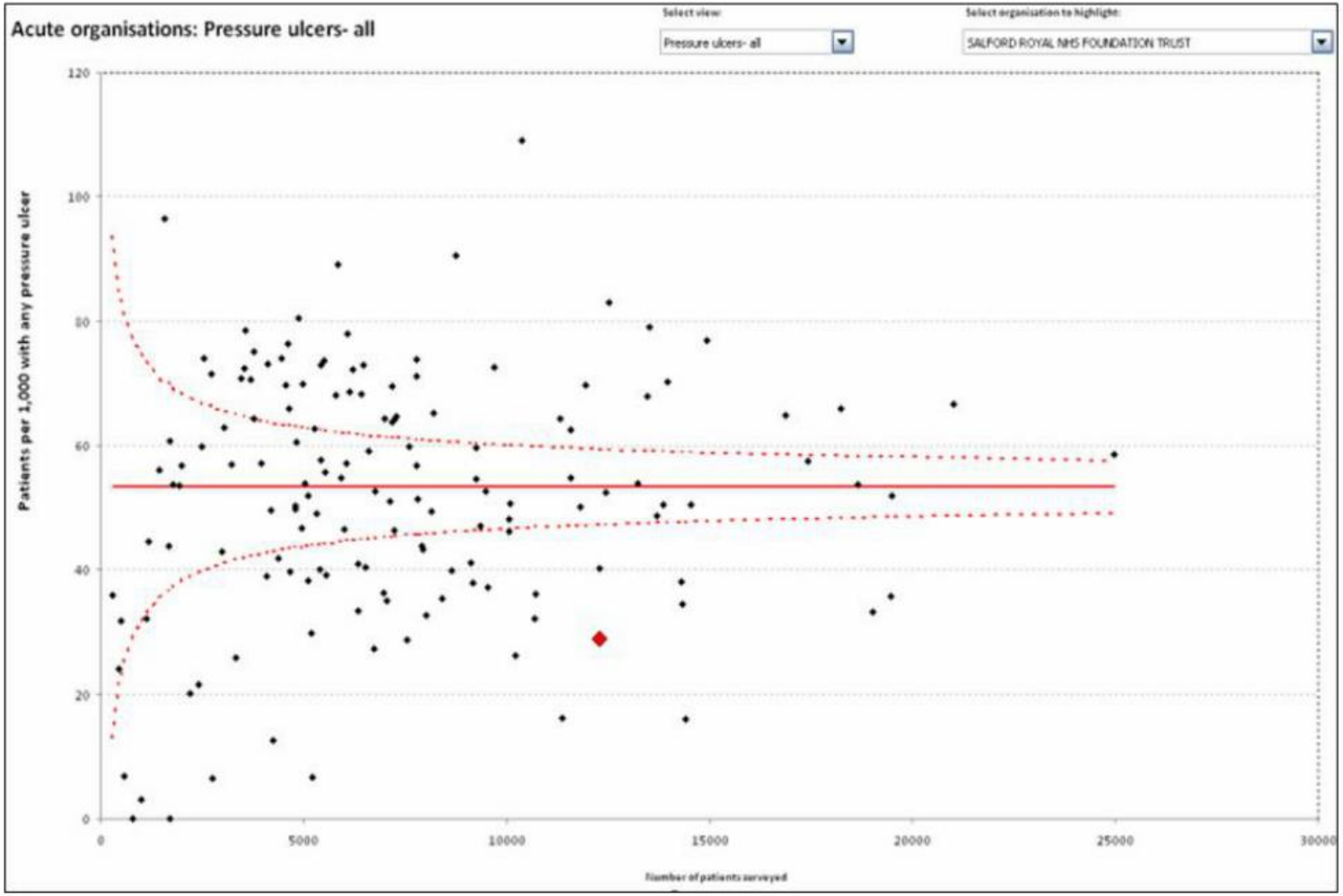
Is there a difference between settings?



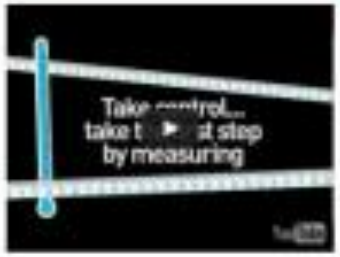
What category is most common?



How much variation is there nationally?



www.harmfreecare.org



Resources

www.harmfreecare.org

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Thank you

http://harmfreecare.org/harm-free-care/videos/

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