

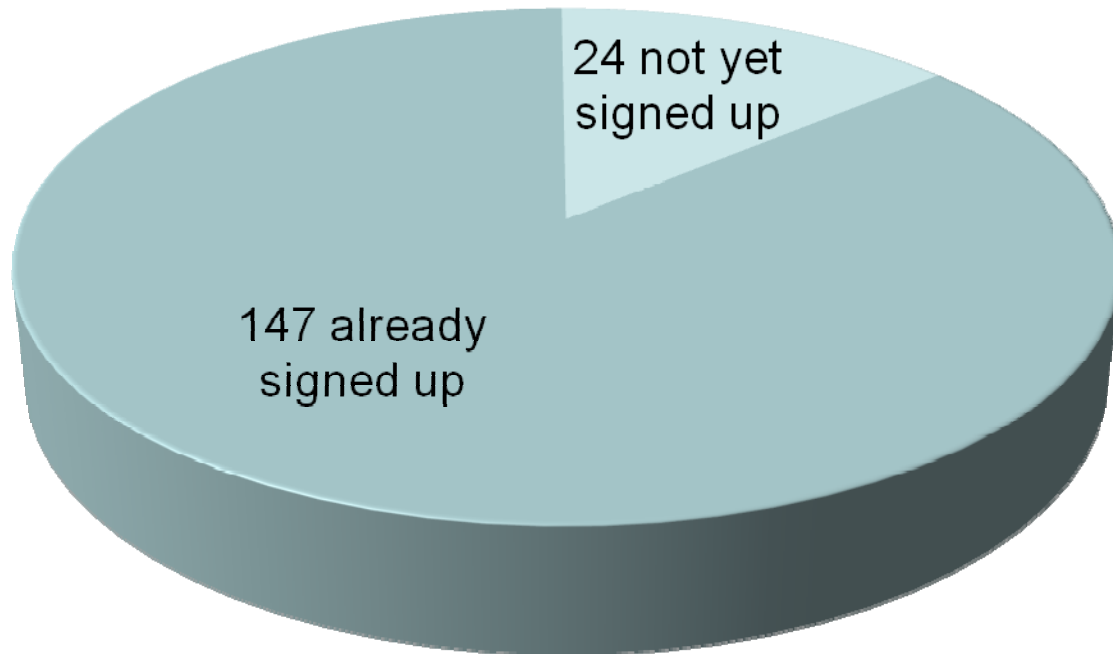
Patient Safety First Campaign

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Heart of England NHS Foundation Trust

85% of Acute Trusts Signed up



Background to safety

- Bristol – turning point
- 2000- “Organisation with a memory”
- 2001 - NPSA
- 2004 - Safety Alert Broadcast system (SABS)
- 2006 - Safety First – aim to place patient safety at top of agendas – patient safety campaign
- 2008 - High Quality Care for All – NHS next stage review

Adverse event

Unintended physical injury resulting from or contributed to by medical care that requires additional monitoring, treatment or hospitalisation, or that results in death.



What is the size of the problem

- 12 million admissions to NHS Acute Trusts in 2006/07.
- 10% patients experience an incident
- 50% preventable
- £2 billion/year

- 8.7% of admissions had at least one adverse event
- 31% of which were judged preventable.
- 15% of adverse events led to an impairment or disability that lasted > than 6 months.
- 10% contributed to patient death.
- - *Sari AB-A, Sheldon TA, Cracknell A. (2007) Extent, nature and consequences of adverse events: results of a retrospective casenote review in a large NHS hospital. Qual Saf Health Care 16:434-9*

The Campaign

Sponsors:

- NHS Institute for Innovation and Improvement
- Health Foundation
- National Patient Safety Agency

Core team

- Clinical staff and managers

Changing our views on patient safety

- It is the NHS what do you expect!
- Central line infections are inevitable
- Many complications or harm events previously considered unavoidable are avoidable.

The Campaign cause and aim

- To make the safety of patients everyone's highest priority.
- No avoidable death and no avoidable harm.

What makes this Campaign different?

- Seeks to change safety culture
- Supports staff to apply evidence-based interventions reliably for every patient, every time.
- Voluntary sign-up.
- ‘For the service by the service’ for patients
- Cause and aim applicable across whole NHS.

Campaign first wave interventions

- Leadership

4 clinical interventions for reducing harm from:

- Deterioration
- High risk medicines
- Perioperative care,
- Critical care

Leadership for safety

- Ensure leadership culture at board level which promotes quality and safety
- Provides an environment where continuous improvement in harm reduction becomes routine
- To be aware of HSMR and level of adverse harm events using Global Trigger Tool

Each Intervention has:

- Guidance on implementation of selection of tools, bundles or changes using Improvement Methodology
 - Small scale tests of change
 - Locally applicable
 - Clinical acceptance and ownership
- A selection of suggested measures to see if there is an improvement:
 - Outcome measure
 - Process measure – individual parts
 - Balancing measure – any consequences
- Examples
- Clinical Evidence

Future Interventions

- VTE
- Peripheral lines
- Falls
- Sepsis
- Human factors

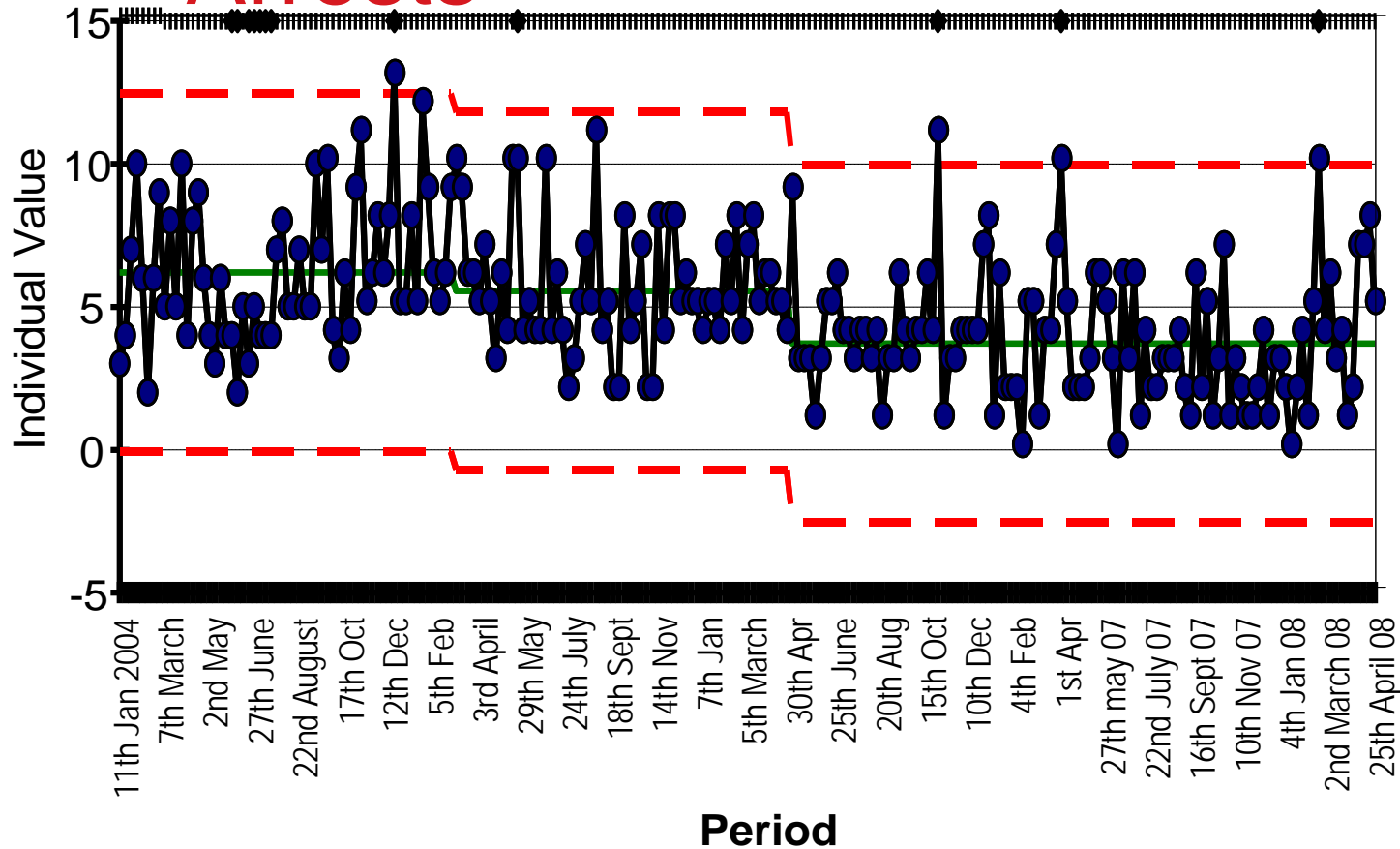
www.patientsafetyfirst.nhs.uk

Reducing harm from deterioration

Reduce in hospital cardiac arrest and mortality rate through early recognition and treatment of the deteriorating patient:

- Early warning systems
- Communication tool:
 - **S**ituation
 - **B**ackground
 - **A**ssessment
 - **R**ecommendation

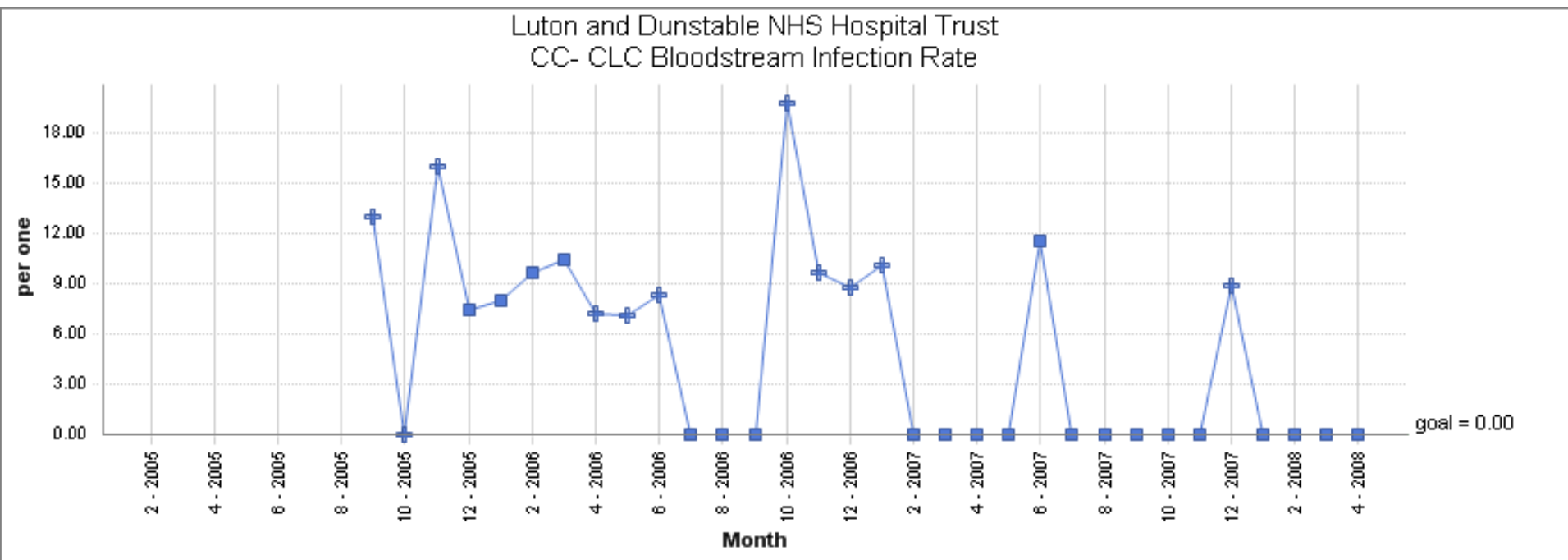
50% Reduction in Cardiac Arrests



Reducing harm in critical care

Reliable application of central line and ventilator care bundles

Elimination of Central Line Infections



Reducing harm in perioperative care

- WHO safer surgery checklist
- Prevention of surgical site infection

Reducing harm from high risk medicines

- Anticoagulants
- Injectable sedatives
- Opiates
- Insulin