

# Mapping Progress: An occasional series

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## The Challenge

Over the course of 2009, the National Patient Safety Agency recorded over one million incidents across healthcare settings in England where patient safety was compromised. Patient Safety Week (15th-21st November) offers a timely reminder of the need to prioritise the wellbeing of patients vulnerable to risk. The majority of incident types can be categorised under flaws in the delivery of care, from medication and clinical procedures to documentation and the transfer of patients. With prevention forming one of the four pillars of the QIPP agenda, implementing preventative measures impacts positively on two others – quality and productivity, by reducing harm and releasing resources.

In practical terms, it is easier and more cost-effective to establish prevention practice rather than problem management. Map of Medicine supports the targeting of key risk areas through specific evidence-based measures that can be easily implemented by healthcare professionals

### **The solution: making the best standard practice.**

Almost 9,000 of the cases in 2009 resulted in severe harm to the patient or death. Not all such incidents are preventable, but many are due to the combination of multiple underlying factors rather than a single unpredictable act. Addressing these factors individually removes the escalating circumstances that allow adverse events to occur.

One way of reinforcing simple but highly effective aspects of best practice is exemplified by care bundles. These are collections of practices that, when implemented together, produce improved patient outcomes. Map of Medicine's care bundles are peer reviewed and based on the NHS High Impact Interventions.

Each care bundle is linked to the appropriate procedural points in pathways, and aims to reduce healthcare-related infections by ensuring all care elements in the procedure are completed, from hand hygiene through to documentation.

Surgical interventions in particular pose a heightened level of risk. The World Health Organization (WHO) has taken steps to address this by creating a surgical safety checklist. This breaks operations down into three phases, associating specific safety checks with each phase in order to minimise the most common and preventable risks. The checklist has been adapted by the National Patient Safety Agency for use in England and Wales, and links to both checklists are incorporated in relevant Map of Medicine pathways.

Based on a pilot study that saw surgery-related complications drop by a third, WHO has estimated that implementing the surgical safety checklist will save half a million lives worldwide every year.

Another risk of hospitalisation is patients developing venous thromboembolism (VTE), a disease process that encompasses deep vein thrombosis and pulmonary embolism. A House of Commons Health Committee report has estimated that VTE contracted in hospital causes 25,000 deaths per year in England, despite the availability of simple prophylaxis. Part of the challenge in addressing such an ingrained problem is raising awareness of the extent of the issue. A VTE risk assessment pathway has been available on the Map of Medicine since 2008, but is now supplemented by content in other pathways. This new content, located at the point where a patient is admitted to hospital, prompts users to complete a VTE risk assessment, in line with 2010 guidance from the National Institute for Health and Clinical Excellence (NICE) and the Department of Health. The user is also directed to the full risk assessment pathway, enabling easy and timely access to up-to-date and authoritative guidance on risk reduction and prophylaxis.

Issues around medical documentation and the transfer of patients range from illegible records, to lack of continuity of care, to patients going missing. In order to combat this, formal discharge planning and effective, individualised transfer of care is essential. To support this, information on effective discharge has been added to selected Map of Medicine pathways. This information comprises a discharge summary checklist and a link to RCP Health Informatics Unit (HIU) Discharge Templates. The templates were developed with extensive clinical engagement and specialist consultation, resulting in a benchmark for the content structure of specific types of hospital communications. The checklist is a concise reminder for the discharging physician to ensure patient

discharge notes are accurately completed and effective discharge realised.

### In conclusion

In its White Paper, 'Equity and excellence: Liberating the NHS', the Department of Health emphasises that increasing the safety of patients is a priority. The main incentive for making improvements is self-evident, in reducing potentially devastating physical and emotional consequences for patients. However, against a harsh economic backdrop, financial implications for the healthcare provider involved can also be severe, with the risk of litigation and the cost of further treatment. In situations of potential clinical risk, one particular solution has been repeatedly proposed, and is reflected in Map of Medicine pathways: the checklist. As a basic, easily accessible resource, this serves as a simple reminder of the steps required to prioritise patient safety. Although isolated, unpredictable 'active failures' will, unfortunately, continue to occur, ingrained sub-standard practice can be addressed and improved through small changes embedded in everyday procedures. The Map of Medicine seeks to establish these procedural improvements as routine, enabling healthcare providers to offer the highest possible quality of care as standard.

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