Safety scorecard

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Introduction

Patient safety: '*The avoidance, prevention and amelioration of adverse outcomes or injuries stemming from the process of healthcare*.'[1]

A scorecard should look at a series of measures at a system/department level that are aligned with the strategic aims of the organisation. Measures need to be easy to understand and actionable at the point of service delivery. Measures of safety however, are hard to define and there are often multiple influences on the process of measurement. It is easier to measure non-safety/system failures which are measures to which one can react. Although these are informative, they may not reflect the current level of safety within a department. These retrospective indicators should be combined with 'leading indicators' which identify precursors, conditions or events or measures before an incident has occurred, but these are poorly developed in healthcare settings.[2] It is therefore difficult to design a scorecard which can show in a quantitative manner how safe an ED is at any point in time. Therefore it is also difficult to track improvement, and even more difficult to be assured that the data derived could be compared across departments.

Purpose

To describe ways in which safety can be assessed or described to allow departments to identify areas on which to focus improvement work, and demonstrate improvement over time.

NB This scorecard is not a validated tool.

References

1. Vincent C. Patient safety. 2nd ed. Chichester: John Wiley & Sons; 2010
2. Vincent C, Burnett S, Carthey J, The measuring and monitoring of safety. Health Foundation; April 2013

Objective	***Domain***	***Suggested areas to measure and Resources***
To demonstrate presence of error, harm or risk.	The Patient	***Areas to measure:*** • *Returns within 7 days (% requiring change of treatment or admission)* • *Did not wait (proportion of patients who did not wait for the completion of their treatment with qualitative analysis)* • *Observation of vital signs at appropriate frequency and with appropriate actions, use of early warning scores* • *Deaths:* *-within one week of discharge from the ED* *-within 24 hours of admission through the ED* • *Patient surveys*

	The Patient	***Resources*** *The CQC website provides the results of Accident and Emergency Departments experience surveys. Patient experience data acts as an A & E clinical quality indicator.* **Care Quality Commission, *Accident and Emergency 2012 experiences*** http://www.cqc.org.uk/public/reports-surveys-and-reviews/surveys/accident-and-emergency-2012 **Patient feedback (search for hospital and then A&E):** http://www.nhs.uk/Service-Search **Harm free care – NHS Safety Thermometer (how does the ED +/- CDU score?):** http://harmfreecare.org/make-it-happen/ ***Trigger Tools*** *have been developed in different healthcare settings to retrospectively detect adverse events and track their rate over time. The Global Trigger Tool is the most widely used, and has consistently shown that the number of clinical incidents that are reported is small in comparison to what is detected with the GTT. These tools would need modification for direct use in the ED.* **Global Trigger Tool** www.ihi.org/knowledge/Pages/Tools/IHIGlobalTriggerToolforMeasuringAEs.aspx This tool requires an IHI login. **Outpatient Adverse Event Trigger Tool** www.ihi.org/knowledge/Pages/Tools/OutpatientAdverseEventTriggerTool.aspx **Paediatric Trigger Tool** http://www.knowledge.scot.nhs.uk/media/CLT/ResourceUploads/1012616/Add%20-%20PTT%20form.pdf **Primary Care Trigger Tool** http://www.nes.scot.nhs.uk/media/6361/Primary%20Care%20Trigger%20Tool%20-%20Practical%20Guidance.pdf

	The Illness	***Areas to measure*** • *High risk conditions identified (from clinical incidents, M&M reviews, complaints, litigation)* ***Resources*** **Reliability of processes (following guidelines/pathways),** Nolan T, Resar R, Haraden C, Griffin FA. Improving the Reliability of Health Care. IHI Innovation Series white paper. Boston: Institute for Healthcare Improvement; 2004. (Available once registered with IHI www.IHI.org) **College of Emergency Medicine, *Consultant Sign Off*** http://secure.collemergencymed.ac.uk/Development/Consultant%20working/Consultant%20sign%20off/ ***Audits, local and national benchmarking*** **College of Emergency Medicine, *Audits*** http://secure.collemergencymed.ac.uk/Shop-Floor/Clinical%20Audit/Current%20Audits/default.asp **The Trauma Audit and Research Network** https://www.tarn.ac.uk/Content.aspx?ca=15
	The Staff	***Areas to measure*** • *Staff sickness absence rate* • *Proportion of staff having annual influenza vaccination and have documented immunity for measles, varicella and hepatitis B.* • *Proportion of all staffing hours covered by locums* • *Proportion of vacancies/unfilled clinical posts* • *Proportion of staff who have completed mandatory training* • *Proportion of staff (including bank/locum staff) that have had departmental induction* ***Resources*** ***Safe staffing levels*** **Emergency Medicine Operational Handbook, *The Way Ahead*,** College of Emergency Medicine, Version 2: December 2011 http://secure.collemergencymed.ac.uk/code/document.asp?ID=6235

	The Staff	*The RCN's new 'BEST' staffing tool addresses nursing levels based on patient dependency. You will need a RCN login to access this tool.* **Royal College of Nursing, *Baseline Emergency Staffing Tool (BEST)*** http://www.rcn.org.uk/development/communities/rcn_forum_communities/emergency_care/baseline_emergency_staffing_tool ***Staff burnout:*** **An investigation of factors supporting the psychological health of staff in a UK emergency department,** Philip J Yates, Elizabeth V Benson, Adrian Harris & Rachel Baron, *Emerg Med J, 2011* http://emj.bmj.com/content/early/2011/06/26/emj.2010.099630.abstract ***Staff training and engagement*** **National NHS Staff Survey Co-ordination Centre, *2012 Results*** http://www.nhsstaffsurveys.com/cms/ *Staff training – this can be found through Key Finding 6* *Staff engagement – this can be found through Key Findings 22, 24 and 25*
	The Work	***Areas to measure*** • *Time constrained – proportion of patients discharged between 220 and 240 minutes (a peak may indicate a rush to meet a target rather than safe and timely patient care).* • *Interruptions* ***Resources*** **"Do you really need to ask me that now?": a self-audit of interruptions to the 'shop floor' practice of a UK consultant emergency physician**, Jon Allard, Jonathan Wyatt, Alan Bleakley & Blair Graham, *Emerg Med J 2012;29:* http://emj.bmj.com/content/29/11/872.abstract **National NHS Staff Survey Co-ordination Centre, *2012 Results*** http://www.nhsstaffsurveys.com/cms/ *Roles and responsibilities, work intensity - these can found through Key Findings 1-5* *Staff satisfaction – this can be found through Key Findings 23-25*

	The Team	***Areas to measure*** • *Frequency of feedback from specialties or primary care about patient diagnosis or management* • *Frequency of multidisciplinary team training* ***Resources*** ***Handovers*** *This article addresses handovers of the ED*: **The ABC of Handover': impact on shift handover in the emergency department,** *Maisse Farhan, Ruth Brown, Charles Vincent & Maria Woloshynowych,* Emerg Med J: December 2011. http://emj.bmj.com/content/early/2011/12/28/emermed-2011-200201 These articles address handovers of patients to other specialties: **NHS Institute for Innovation and Improvement, *Situation Background Assessment Recommendation (SBAR)*** http://www.institute.nhs.uk/safer_care/safer_care/situation_background_assessment_recommendation.html **Royal College of Physicians, *Healthcare Record Standards*** http://www.rcplondon.ac.uk/projects/healthcare-record-standards **American College of Emergency Physicians, *Safer Sign Out Protocol*** https://webapps.acep.org/MasterSignIn/SignIn.aspx?redir=http://www.acep.org/content.aspx?id=88004 *To access this tool you will need an ACEP log in.* *An overview of the tool can be found here:* http://www.acep.org/uploadedFiles/ACEP/Membership/Sections_of_Membership/qips/homepage/Safer%20Sign%20Out%20Executive%20Summary.pdf ***Safety briefings*** **Scottish Patient Safety Programme, *Implementing Safety Briefings*** http://www.scottishpatientsafetyprogramme.scot.nhs.uk/docs/implementingsafetybriefings.pdf

	The Environment	***Areas to measure*** • *Number of incidents and complaints relating to the environment e.g. privacy within the department* • *Physical layout of the department* • *Crowding measures* • *Standard equipment within department and across the hospital* ***Resources*** ***Crowding measures*** **Emergency department crowding: prioritising quantified crowding measures using a Delphi study,** Kathleen Beniuk, Adrian A Boyle and John Clarkson, Emerg Med J: Dec 2011 http://emj.bmj.com/content/early/2011/12/20/emermed-2011-200646.abstract **Emergency Department Crowding: Time for Interventions and Policy Evaluations,** Adrian Boyle, Kathleen Beniuk, Ian Higginson and Paul Atkinson, Emerg Med Int. 2012; http://europepmc.org/articles/PMC3290817/reload=0;jsessionid=5RMCPtfvQECrPVBUfVTk.24 **Crowding in the Emergency Department**, College of Emergency Medicine, August 2012. http://secure.collemergencymed.ac.uk/code/document.asp?ID=6296 ***Physical layout*** **Design Council, *Reducing violence and aggression in A&E*** http://www.designcouncil.org.uk/our-work/challenges/health/ae/ **Health Building Note 15-01: Accident & emergency departments**, Department of Health, April 2013 https://www.gov.uk/government/publications/hospital-accident-and-emergency-departments-planning-and-design
	The Culture	***Areas to measure*** • *Exit interview/survey information as staff leave the department* ***Resources*** ***Safety culture surveys*** **Agency for Healthcare Research and Quality, *Hospital Survey on Patient Safety Culture*** www.ahrq.gov/professionals/quality-patient-safety/patientsafetyculture/hospital/resources/index.html

	The Culture	**Measuring patient safety climate: a review of surveys,** J B Colla, A C Bracken, L M Kinney, W B Weeks, Qual Saf Health Care 2005; 14 http://qualitysafety.bmj.com/content/14/5/364.full.pdf+html **Institute for Healthcare Improvement, *Checklist for Assessing Institutional Resilience*** http://www.ihi.org/knowledge/Pages/Tools/ChecklistForAssessingInstitutionalResilience.aspx An IHI login is required for this tool. **National NHS Staff Survey Co-ordination Centre, *2012 Results*** http://www.nhsstaffsurveys.com/cms/ *Safety culture: these can found through key findings 12 – 15*
	Data that may cover any/all of the domains	***Areas to measure*** • *Incidents and complaints: Use qualitatively (due to under reporting and reporting bias) not quantitatively. Evidence of learning and integration of this into everyday practice.* • *Number of Serious Untoward Incidents and Never Events* ***Resources*** ***Risk assessment of new services/processes*** **Scottish Patient Safety Programme, *Failure Modes & Effects Analysis (FMEA)*** http://www.scottishpatientsafetyprogramme.scot.nhs.uk/docs/FMEA.pdf **Institute for Health Improvement, *Failure Modes & Effects Analysis (FMEA)*** http://www.ihi.org/knowledge/Pages/Tools/FailureModesandEffectsAnalysisTool.aspx You will need a login to access this tool. **College of Emergency Medicine, *Prospective Hazard Analysis*** http://secure.collemergencymed.ac.uk/code/document.asp?ID=6181