Patient Safety Programme

Clinical Benchmarking for Hospice Care

Metrics, Categories and Definitions 2022/2023

- Bed Data
- Patient Falls
- Pressure Ulcers
- Medication Incidents

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Introduction

A patient safety incident is defined as any unintended or unexpected incident which could have or did lead to harm for one or more patients receiving care[1]. The National Reporting and Learning System (NRLS) states that a ''*patient safety incident'* is not a synonym for error'. The NLRS includes harm incidents that are not related to errors, for example, unexpected adverse reactions to mediation, and where there is potential for harm that staff identify and prevent before the error occurs[2]. Reflective of the NHS Patient Safety Strategy[3], safer care is nurtured on the foundations of a patient safety culture and a patient safety system.

This document lays out the metric definitions as agreed with the Patient Safety Network members enrolled in the patient safety programme. The Metric, Category and Definition are given for each area of monitoring. The programme enables clinical benchmarking within hospices across the UK by the regular collection of data relating to patient safety incidents within their in-patient units. These metrics are of particular significance due to the vulnerability of palliative patients and their increased risk of harm from patient safety incidents involving pressure ulcers, medication incidents and falls[4] .

Data submission

Data can be submitted monthly or quarterly, with reports distributed quarterly. Reports sent after the final quarter contain the data from all four quarters creating an annual report (April 2021 to March 2022), and contain historic data to facilitate analysis. Hospice UK welcome historic data entry, and hospices can alter any submission at any time.

Bed Data

The collection of the in-patient unit bed statistics allows for the membership data to be divided into comparable hospice in-patient unit sizes of small (up to 10 beds), medium (11 to 20 beds) and large (21 or more beds). Table 1 below sets out the parameters of bed data submission.

Table 1: Bed Data - metric, category and definition

Metric & Category	Definition
Number of beds	The total number of beds available on the in-patient unit. This includes all beds open for admission, both occupied and vacant. Where beds are closed to admission for a period of time, for example, a month or more, these should not be included in the submission.
Available bed days	Each open bed is counted as one per day, for example, where there are a total of 10 beds on the unit and 30 days in the month, the available bed days would be 300 (10 beds x 30 days).
Occupied bed days	The number of days each bed is allocated to a patient admitted to the unit. Where one patient is discharged from a bed and a new patient is admitted to the same bed on the same day, this counts as one occupied bed day. Any bed 'held' for a trial at home is recorded as an occupied bed.
Number of discharges	The total number of discharges from the in-patient unit over each month. If a patient has been admitted and discharged more than once in the month, each discharge is recorded. For example, one patient who is admitted twice and discharged twice will count as two discharges; this includes a 'failed' discharge where the patient is readmitted, which is different to a 'held' bed.
Number of deaths	The total number of deaths on the in-patient unit over each month. If a patient is admitted and discharged, then admitted again and dies during the admission, the discharge is recorded under No of Discharges and the death under No of Deaths.
Throughput	The throughput is auto-calculated when the bed data fields (as listed above) are completed on the submission form. Throughput is calculated as: *No of discharges* **+** *No of deaths* **÷** *No of beds* **=** *Throughput*

Patient Falls

Public Health England define a fall as unintentionally coming to rest on the ground, floor or other lower surface, and not as a result of a major intrinsic event, such as a stroke or overwhelming hazard[5]. There are over 400 risk factors related to falling, and the likelihood of falling increases with the higher number of risk factors[6]

The metrics used for recording patient falls are also the categories used to measure the level of harm as a result of the fall: No harm, Low harm, moderate harm, severe harm or death, and must be allocated within 48 hours of the incident happening.

All slips, trips and falls are to be included, i.e. a patient found on the floor, lowered themselves onto the floor, slipped from a chair, or rolled out of bed. Some patients may have more than one fall within the defined period. The data should reflect the number of falls, not the number of patients who have fallen. For example, a patient falls three times with two falls resulting in No Harm and one fall resulting in Low Harm. The submission should reflect all three falls and entered into the relevant categories, rather than as one patient in No harm and one patient in Low harm. Table 2 below sets out the parameters for submission of falls data.

Table 2: Falls - metric, category and definition

Metric & Category	Definition
No Harm	Any patient safety incident that ran to completion but no harm occurred ***How this might relate to your IPU*** Patient found on the floor with no signs of injuries and is able to explain why they are there. No additional observations taken other than routine nursing checks.
Low Harm	Harm requiring first-aid level treatment or extra observation only (e.g. bruises, grazes). Any patient safety incident that required extra observation or minor treatment and caused minimal harm, to one or more persons receiving care. ***How this might relate to your IPU*** A patient who has bruising and grazes and only requires first aid and/or additional observation.

Metric & Category	Definition
Moderate Harm*	Harm requiring hospital treatment or a prolonged length of stay but from which a full recovery is expected (e.g. fractured clavicle, laceration requiring suturing). Any patient safety incident that resulted in a moderate increase in treatment and which caused significant but not permanent harm, to one or more persons receiving care. ***How this might relate to your IPU*** A patient whose injuries resulting from the fall requires a visit to A&E for investigation. They may not need a hospital stay. This would also include patients where a decision is made not to transfer someone to A&E if very near end of life and further investigation may not change the management.
Severe Harm*	Harm causing permanent disability (e.g. brain injury, hip fractures where the patient is unlikely to regain their former level of independence). **Any patient safety incident that appears to have resulted in permanent harm to one or more persons receiving care.**
Death*	Where death is directly attributable to the fall
Duty of Candour applies to these categories of harm[7]	

Tissue Viability

A pressure ulcer is localised damage to the skin and/or underlying tissue, usually over a bony prominence (or related to a medical or other device) resulting from sustained pressure, including pressure associated with shear[8]. The damage can present as intact skin or an open ulcer and may be painful.

Each pressure ulcer is counted rather than each patient with a pressure ulcer as a patient can have more than one pressure ulcer. Include all pressure ulcers, including those that develop near the end of life due to skin failure, often referred to as Kennedy ulcers, as these are no longer to be recorded separately[9].

Table 3 sets out the European Pressure Ulcer Advisory Panel (EPUAP) classifications of pressure ulcers[10], as reference for the Category in submission of the pressure ulcer data. These categories are standard in England[11], Northern Ireland[12], Scotland[13] and Wales[14]. Table 4 sets out the parameters of the metric groups and their definitions, and Table 5 sets out the metric recording guide for pressure ulcers.

Table 3: EPUAP classification of tissue viability (pressure ulcers)

Category	Description
1 :non-blanchable erythema	Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have visible blanching; its colour may differ from the surrounding area. The area may be painful, firm, soft, warmer or cooler as compared to adjacent tissue. Category 1 may be difficult to detect in individuals with dark skin tones. May indicate "at risk" individuals (a heralding sign of risk).
2: partial thickness skin loss*	Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister. Presents as a shiny or dry shallow ulcer without slough or bruising, (bruising indicates suspected deep tissue injury). Category 2 should not be used to describe skin tears, tape burns, perineal dermatitis, maceration or excoriation.
3: Full thickness skin loss*	Full thickness tissue loss. Subcutaneous fat may be visible, but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunnelling. The depth of a Category 3 pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and Category 3 ulcers can be shallow. In contrast, areas of significant adiposity can develop extremely deep Category 3 pressure ulcers. Bone/ tendon is not visible or directly palpable.
4: Full thickness tissue loss*	Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often include undermining and tunnelling. The depth of a Category 4 pressure ulcer varies

Category	Description
	by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and these ulcers can be shallow. Category 4 ulcers can extend into muscle and/ or supporting structures (e.g., fascia, tendon or joint capsule) making osteomyelitis possible. Exposed bone/tendon is visible or directly palpable.
Unstageable: Depth unknown*	Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, grey, green or brown) and/or eschar (tan, brown or black) in the wound bed. Until enough slough and/or eschar is removed to expose the base of the wound, the true depth and therefore Category cannot be determined. Stable (dry, adherent, intact without erythema or fluctuance) eschar on the heels serves as 'the body's natural (biological) cover' and should not be removed.
Suspected Deep tissue injury: **Depth unknown***	Purple or maroon localized area of discoloured intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. Deep tissue injury may be difficult to detect in individuals with dark skin tones. Evolution may include a thin blister over a dark wound bed. The wound may further evolve and become covered by thin eschar. Evolution may be rapid exposing additional layers of tissue even with optimal treatment.
Duty of Candour applies to the categories where moderate harm (or above) is considered	

Moisture associated skin damage

Moisture associated skin damage (MASD) is defined as injury to the skin from urine, faeces or moisture [15]. Incontinence associated dermatitis, perineal dermatitis, diaper dermatitis and moisture lesions/ulcers all describe these types of skin damage caused by excessive moisture being in continuous contact with any intact skin of the buttocks, groins, inner thighs, perineum and natal cleft[16].

Skin damage determined to be as the result of incontinence and/or moisture alone should be recorded as a moisture associated skin lesion. Table 4 sets out the parameters of the metric

groups and their definitions, and Table 5 sets out the metric recording guide for moisture associated skin damage alongside pressure ulcers.

Table 4: Tissue Viability - metric group and definition (for reporting to Hospice UK Clinical Benchmarking Programme)

Metric group	Definition
Pressure Ulcer on admission 'POA/PUOA' (inherited)	The patient is admitted onto the unit with a pressure ulcer from any care setting, for example, from home, a care home, or hospital. For all categories of a pressure ulcer identified on admission (inherited), record the pressure ulcer category documented at the **initial assessment** and **only once**.
New pressure ulcer 'New PU' (acquired)	The patient develops a pressure ulcer whilst on the unit which was not present on admission, at the time of the initial skin integrity assessment. For all categories of a new (acquired) pressure ulcer, record the pressure ulcer category documented at the **initial assessment** and **only once**.
Moisture Associated Skin Damage (MASD)	Skin damage determined to be as the result of incontinence and/or moisture alone should be reported as moisture associated skin damage. A lesion that has been determined as a combined cause (such as incontinence, moisture and pressure) should be recorded as a pressure ulcer. If the patient has, for example, moisture damage and a pressure ulcer in different locations then these should be recorded separately under their relevant categories. Report each identified MASD site **only once**; count the number of moisture lesions and not the number of patients. MASD is **not** pressure damage, therefore, where a reported MASD site progresses to a pressure ulcer, it should be reported again as 'New PU' under the relevant pressure ulcer category documented at the **initial assessment** where the progression was first noted, and **only once**.

Metric group	Definition
Time of recording for MASDs & PUs	A pressure ulcer or moisture associated skin damage is recorded for Hospice UK data submission **only once over the episode of care**. This will be when the MASD or pressure ulcer is **identified and documented for the first time.** If a patient with any pressure ulcer or MASD is discharged from the hospice and subsequently readmitted with the same pressure ulcers or moisture lesions, these would be recorded and reported to Hospice UK under PUOA 'inherited' as this will be a new episode of care.

Table 5: Tissue Viability- metric recording guide

ON ADMISSION: Pressure ulcer and/or moisture associated skin damage	
Moisture Associated Skin Damage (MASD)	Total number of MASD **on admission**
PU Category 1	Total number Category 1 pressure ulcers **on admission**
PU Category 2*	*As above* but Category 2
PU Category 3*	*As above* but Category 3
PU Category 4*	*As above* but Category 4
PU Unstageable*	*As above* but Unstageable
PU Suspected Deep Tissue Injury*	*As above* but Deep Tissue Injury
Medical Device Associated*	Total number associated to medical devices **on admission**
Patients with PUOA	Total number of **patients** with a pressure ulcer on admission (1 or more)
NEW: Pressure ulcer and /or moisture associated skin damage	
Moisture Associated Skin Damage (MASD)	Total number of **New** MASD
New PU Category 1	Total number of **New** Category 1 pressure ulcers
New PU Category 2*	*As above* but Category 2

New PU Category 3*	*As above* but Category 3
New PU Category 4*	*As above* but Category 4
New PU Unstageable*	*As above* but Unstageable
New PU Suspected Deep Tissue Injury*	*As above* but Deep Tissue Injury
Medical Device Associated*	Total number **new** associated with a medical device
Patients with new PU	Total number of **patients** with a **new** pressure ulcer (1 or more)
Duty of Candour applies to the categories where moderate harm (or above) is considered	

Medication Incidents

Medication-related patient safety incidents are unexpected events involving errors in prescribing, dispensing, administration, and monitoring[17]. These incidents can be errors of commission, such as wrong dose or medication given, or errors of omission, such as omitting a medication dose or a failure to monitor[18]. There can also be unintended consequences of administration such as an adverse reaction to medication. Table 6 sets out the parameters for submission for medication incidents data.

Table 6: Medication incidents - metric, category and definition

Metric	Category	Definition
Level 0	**No harm: incident prevented** **(Near Miss)**	**Incident prevented** – the incident did not cause harm to the patient but was judged to have the potential to cause harm
Level 1	**No harm: incident not prevented**	**Incident occurred** – but ***no harm*** was caused to the patient; no additional monitoring or observation needed
Level 2	**Low harm**	Any incident that required extra observation or minor treatment (but there was no change in the clinical status)

Metric	Category	Definition
Level 3	**Moderate harm***	Any incident that resulted in a moderate increase in treatment/laboratory monitoring (change to the clinical status), and which caused significant but not permanent harm
Level 4	**Severe harm***	Any incident that appears to have resulted in long term or permanent harm
Level 5	**Death***	Any incident that has directly resulted in death
Duty of Candour applies to these categories of harm		

Examples of medication incidents

There has been much debate within the Patient Safety Network on the submissions of Level 0 and Level 1 medication incidents to the Hospice UK clinical benchmarking programme. Each hospice has their own clinical governance and quality assurance standards in place which includes their incident reporting standards and pathways. However, due to the number of different reporting systems and software across the sector, there has been increased variation in submissions of medication incident data.

The standard for submission of medication incident data has been agreed by the Medication Incidents sub-group, who represent the Patient Safety Network, clarifying that **only incidents that occur at the point of administration, or contact/integration with the patient should be included in the submission data to Hospice UK.** These should include prescribing, preparing, dispensing, administering, monitoring and providing advice on self (or carer) administration[19]. All hospices should continue with their own internal rigorous reporting processes. Table 7 offers examples of medication incidents related to the levels of harm 0-3. Levels 4 and 5 are considered to be self-explanatory.

Table 7: Examples of medication incidents for Levels 0 - 3

Metric & Category	Example
Level 0 **No harm: incident prevented** **(Near miss)**	• Wrong dose prescribed but noticed before dose given • Incorrect drug, dose, time, route or expired drug about to be given – noticed before administration • Medication about to be given to wrong patient - error noticed before administration • ID check prior to administration, patient details such as wrist band incorrect – medication not given • Patient prescribed medication they are allergic to – error identified before administration. • Medication labelled incorrectly, noticed just prior administration
Level 1 **No harm: incident not prevented**	• Incorrect drug, dose, time, route or expired drug given but no adverse effect on patient • Drug omitted but no adverse effect on patient • Analgesic patch applied without removal of existing (old) patch
Level 2 **Low harm**	• Incorrect drug, dose, time, route or expired drug given where additional observation was required to monitor affects • Any drug dose given too high and required observations and but no adverse effect on patient • Syringe driver fault resulting in either medication being administered to quickly or failing to administer at the correct rate or at all. Resulting in the need for extra observations or additional PRN medication • Drug omitted - additional observation and/or treatment needed; clinical status stable/unchanged
Level 3 **Moderate harm**	• Incorrect drug, dose, time, route or expired drug given where additional medications/treatment, tests and close monitoring required to monitor the change in clinical status of the patient • Any drug dose given too high and patient became opioid toxic requiring remedy • Drug omitted (for example: cardiac, epilepsy, Parkinson, analgesic medications) - additional medications/treatment, tests and close monitoring required to monitor the change in clinical status of the patient • Note: a change in clinical status may require a temporary admission to hospital for treatment

Contributors

Our thanks go to all the members of the National Patient Safety Programme Network. Thank you to those who have given their time and contributed to this document ensuring clarity of the definitions and reducing variation in data submissions, in turn creating a valued and comparable dataset for national clinical benchmarking across the hospice sector.

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