Patient Safety Programme

Clinical incident comparisons for Hospice Care (Adult services)

Metrics, Categories and Definitions 2024

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

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Updated 30.09.24 ('all falls' added in)

Updated 6.1.26 (branding and occupied bed day definition updated)

Updated 21.1.26 (falls definition updated)

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[i1]. The guidance for users on the Learn from Patient Safety Events (LFPSE) service maintains the principle that the degree of harm recording is related to the actual impact on a patient from the particular incident being reported (NHS England, 2023)[2]. Recording patient safety events, whether they result in harm or not, provides vital insight into what can go wrong in healthcare and can provide essential learning in the system.

A review of the patient safety programme offer from Hospice UK was undertaken in early 2024 with a group of colleagues from member hospices across the four nations. Part of this review was the ambition to streamline the data collection process and to ensure that clinical incident data management focused on quality improvement at hospice level rather than performance benchmarking. Benchmarking relies on accurate operational definitions and learning from the programme has highlighted variation across hospices, thus invalidating accurate comparisons. The ambition is to support hospices in their own improvement journey, whilst also collecting a streamlined cohort of data for aggregated analysis across the sector.

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. One aim of the programme is to benchmark reporting of falls, pressure ulcers and medication incidents from member hospices (adults) across the UK. The second aim it so facilitate participating hospices to benefit from receiving their own data presented as a rate over time for their own use. This will be undertaken by the regular collection of data relating to patient safety incidents within their in-patient units and submitting this information to Hospice UK on a monthly basis.

Where practical, it is good practice to discuss the level of harm with the patient affected and to consider the patient's perspective on the harm definitions as described in the LFPSE guidance.

Data submission

Data can be submitted monthly or quarterly, with the cumulative data returned quarterly in the form of a run chart to each individual hospice, along with aggregated data.

Bed Data

The collection of the in-patient unit bed statistics allows for the incident data to have a denominator, to create a rate as opposed to a number meaning that hospices are no longer required to be categorised as small, medium or large.

Table 1 below sets out the parameters of bed data submission.

Table 1: Bed Data - metric, category and definition (for submitting to the Hospice UK Patient Safety Programme)

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 is a total of ten 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	Defined as beds occupied at any point in a 24-hour period (midnight to midnight, irrespective of 1 hour or 23 hours / 1 patient or 2 patients, etc). 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.

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 Number of Discharges and the death under Number 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

NICE (2025b) defines a fall "as an event that causes a person to, unintentionally, rest on the ground or other lower level". There are over four hundred risk factors related to falling, and the likelihood of falling increases with the higher number of risk factors[4]. Clinical guidelines recommend a multifactorial approach to falls prevention and management.

All patient's 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. Categories of harm have been removed to reflect consensus of the short life working group and practice within hospices.

Table 2: Falls - metric, category and definition (for submitting to the Hospice UK Patient Safety Programme)

Metric	Category	Definition
All falls	**All Falls**	All patient slips, trips and falls that have been reported on the incident management system.

Metric	Category	Definition
Level 4	**Severe harm (physical or psychological)**	Any incident that appears to have resulted in long term or permanent harm.
Level 5	**Fatal**	Any incident that has directly resulted in death. (You should select this option if, at the time of reporting, the patient has died and the incident that you are recording may have contributed to the death).

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 damage[5]. 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.

Table 3 sets out the European Pressure Ulcer Advisory Panel (EPUAP) classifications of pressure ulcers[6], which are mirrored in the National Wound Care Strategy Programme recommendations (October 2023) as a reference for the category in submission of the pressure ulcer data. These categories are standard in England[7], Northern Ireland[8], Scotland[9] and Wales[10].

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

Category	Description
1: Non-blanchable erythema	**Not required to be submitted:** Non blanchable Erythema Intact skin - in lighter skin tones, this presents as non-blanchable redness of a localised area usually over a bony prominence. Darkly pigmented skin may not have visible blanching, but 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 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 or as a shiny or dry shallow ulcer without slough or bruising. This Category should not be used to describe skin tears, tape burns, perineal dermatitis, maceration, or excoriation.
3: Full thickness skin loss	Full thickness skin loss and full thickness tissue loss. Subcutaneous fat may be visible, but bone, tendon or muscle are not exposed. Slough or necrosis may be present. 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.

Category	Description
4: Full thickness tissue loss	Full loss thickness tissue loss with exposed bone, tendon, or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunnelling. The depth of a Category 4 pressure ulcer varies 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.
	The following are <u>not</u> required to be submitted to Hospice UK:
Unstageable: Depth unknown	Pressure ulcers where the skin is broken but the wound bed is not visible due to slough or necrosis (formally referred to as 'unstageable') should initially be recorded as Category 3 pressure ulcers but immediately re-categorised and re-recorded in the patient's records if debridement reveals category 4 pressure ulceration.
Suspected Deep tissue injury: **Depth unknown**	Deep tissue injuries (DTIs) should not be reported as pressure ulcers unless they result in broken skin or they fail to resolve and it is evident on palpation that there is deep tissue damage present, at which point, they should immediately be categorised and reported. However, the skin change must be recorded within the clinical record (for example by ticking the vulnerable skin option in the PURPOSE T tool) and appropriate preventative care delivered as soon as the damage is noted.

Category	Description
Moisture associated skin damage.	Moisture associated skin damage (MASD) is defined as injury to the skin from urine, faeces or moisture[11]. 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[12]. 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 pressure ulcers.

Table 4: Tissue Viability - metric group and definition (for submitting to the Hospice UK Patient Safety Programme)

Metric group	Definition
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**.
Time of recording for PUs	A pressure ulcer is recorded for Hospice UK data submission **only once over the episode of care**. This will be when the pressure ulcer is **identified and documented for the first time.**

Metric group	Definition
	If a patient with any pressure ulcer is discharged from the hospice and subsequently readmitted with the same pressure ulcers 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

NEW: Pressure ulcer	
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
Medical Device Associated	Total number **new PUs** associated with a medical device
On admission: Pressure ulcer	
PU Category 2 on admission	*As above* but Category 2
PU Category 3 on admission	*As above* but Category 3
PU Category 4 on admission	*As above* but Category 4
Medical Device Associated PU (**Cat 2 – 4**) on admission	Total number **PUs on admission,** associated with a medical device

Medication Incidents

Medication-related patient safety incidents are unexpected events involving errors in prescribing, dispensing, administration, and monitoring[13]. 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[14]. 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

(for submitting to the Hospice UK Patient Safety Data Programme)

Metric	Category	Definition
Level 4	**Severe harm (physical or psychological)**	Any incident that appears to have resulted in long term or permanent harm
Level 5	**Fatal**	Any incident that has directly resulted in death. (You should select this option if, at the time of reporting, the patient has died and the incident that you are recording may have contributed to the death).

Examples of medication incidents

There has been much debate within the Patient Safety Network on the categorisation of medication incidents 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 types of submissions of medication incident data.

As per previous editions, 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[15]. Harm levels are being removed from the data submission process due to complex

variation and thus in ability to benchmark, but all hospices should continue with their own internal rigorous reporting processes. Severe harm and death will continue to be submitted as these definitions are less variable.

Contributors

Our thanks go to all the members of the National Patient Safety Programme Network and Short Life Working Group. 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 comparisons across the hospice sector.

Appendix 1

Full definitions of harm gradings (taken from NHS England LFPSE Guidance):

Severe physical harm

Severe harm is when **at least one** of the following apply:

- permanent harm/permanent alteration of the physiology
- needed immediate life-saving clinical intervention
- is likely to have reduced the patient's life expectancy
- needed or is likely to need additional inpatient care of more than 2 weeks and/or more than 6 months of further treatment
- has, or is likely to have, exacerbated or hastened permanent or long term (greater than 6 months) disability, of their existing health conditions
- has limited or is likely to limit the patient's independence for 6 months or more.

Fatal (previously documented as 'Death' in NRLS)

You should select this option if, at the time of reporting, the patient has died and the incident that you are recording may have contributed to the death, including stillbirth or pregnancy loss. You will have the option later to estimate to what extent it is considered a patient safety incident contributed to the death.

Severe psychological harm

Severe psychological harm is when **at least one** of the following apply:

- distress that did or is likely to need a course of treatment that continues for more than six months
- distress that did or is likely to affect the patient's normal activities or ability to live independently for more than six months

distress that did or is likely to result in a new mental health diagnosis, or a significant deterioration in an existing mental health condition, and recovery is not expected within six months.

References

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[13] NICE (2016) Medicines optimisation quality standard 3: learning from medicines-related patient safety incidents Available at: https://www.nice.org.uk/guidance/qs120/chapter/quality-statement-3-learning-from-medicinesrelated-patient-safety-incidents#quality-statement-3-learning-from-medicinesrelated-patient-safety-incidents (Accessed 24.04.24)

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[15] Care Quality commission (2021) Reporting medicine related incidents Available at: Reporting medicine related incidents | Care Quality Commission (cqc.org.uk) (Accessed24.03.24) (Accessed 24.06.2024).