

## Strategy for Preventing Harm & Improving Safety

April 2009 – 2011



*Our aim:*

*“No avoidable death  
and no avoidable harm”.*

“Preventing harm and improving patient safety is our highest priority. This campaign is another positive step in our journey to improve patient safety and, whilst it may be challenging, I have every confidence we will achieve our goals.”

David Loughton, Chief Executive

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## **1 Introduction**

The Royal Wolverhampton Hospitals NHS Trust is committed to improving patient safety making the provision of safer care is our highest priority. The Trust has already made significant progress in reducing hospital acquired infections and improving patient outcomes and will continue to build on this success by our commitment to this patient safety campaign.

This campaign for preventing harm and improving patient safety is an integral part of the Trust's risk management processes and is closely aligned to the Trust's ten strategic goals. Our vision is to be a first class hospital providing top quality care in every way. The specific strategic goals are:

Goal 1: to provide our patients and staff with a safe environment

Goal 4: to progressively improve the image and perception of the Trust

Goal 5: to be in the NHS top quartile of benchmarks and measures of efficiency & productivity

Goal 10: to consolidate our position as a leading healthcare provider

The achievement of our goals will require the engagement and dedication of clinicians and managers at all levels and builds on the Trust's success and national recognition for its work on infection prevention.

## **2 What are we trying to achieve?**

Our overall aim is to have no avoidable deaths and no avoidable harm. This document describes how we will achieve this.

We will reduce our hospital standardised mortality rate (HSMR) to 85 by March 2011 and we will deliver a programme of improvement projects that will enable staff to make changes to provide safe and effective care to every patient, every time.

We will focus on a range of projects that make up the campaign framework and that have been proven to have a significant impact on the reduction of mortality and reduction in the number of events resulting in avoidable harm.

We will also undertake a cultural assessment of our patient safety culture using the Manchester Patient Safety Framework (MaPSaF) and develop a plan of action with the aim of developing a generative patient safety culture where managing patient safety is an integral part of everything that we do.

Our key goals for the campaign are:

- HSMR of 85 by March 2011
- 50% reduction in adverse event triggers by March 2010

We also want to achieve:

- patient and staff satisfaction scores in the top 20% of NHS
- reduction in infection rates
- reduction in the average length of stay
- reduction in readmission rates

### 3 Responsibilities

Responsibility for preventing harm and improving patient safety is that of every member of staff at The Royal Wolverhampton Hospitals NHS Trust. In addition individual responsibilities include:

- The Chief Executive who will chair the Preventing Harm, Improving Safety Group and will provide leadership support to the Campaign.
- The Director of Nursing and Midwifery who is the executive lead for the Campaign, will be the deputy chair of the Preventing Harm, Improving Safety Group and is responsible for the implementation of the Leadership for Safety work stream.
- The Director of Governance who is the chair of the Mortality Review Meeting will provide professional clinical advice to the Group on the implementation of the clinical projects and outcomes of the Mortality Review Meetings.
- The Medical Director who will provide a medical overview in relation to patient safety and issues relating to professional practice.
- The Patient Safety Manager who is responsible for ensuring that this strategy is implemented, and will lead the implementation of the campaign framework.
- The Project Leads who are responsible for implementing their project in the clinical areas and will ensure that progress reports are provided to the Preventing Harm, Improving Safety Group.
- The Divisional Representatives who will support the implementation of the strategy across their division and are responsible for ensuring that operational issues identified by the Preventing Harm, Improving Safety Group are acted upon in their Division.

### 4 Hospital standardised mortality rate

The hospital standardised mortality rate (HSMR) compares an organisation's actual number of deaths with the predicted number of deaths. The predicted number of deaths takes into account factors such as the patients' age, sex, diagnosis, type of admission (emergency or planned) and length of stay. This standardisation of the ratio allows comparison between different hospitals and their case mix.

If a Trust has an HSMR of 100, this means that the number of patients who died is as would be expected taking into account the factors above. A HSMR above 100 means more patients died than would be expected and below 100 means fewer patients than expected died.

In April 2009 The Royal Wolverhampton Hospitals NHS Trust HSMR data produced by Dr Foster was 95\* (\*includes data up to end of February 2009). UK hospitals in the top decile of performance have achieved an HSMR of 75. Table 1 demonstrates the Trust's HSMR for the last three years and Table 2 shows a planned reduction in the HSMR over the next four years.

Table 1 HSMR produced by Dr Foster 2005/06 to 2007/08

	<b>Actual Deaths</b>	<b>Predicted Deaths</b>	<b>HSMR</b>	<b>Lives saved</b>
2005/06	1629	1490.5	109.3	-139
2006/07	1484	1443.1	102.8	- 41
2007/08	1359	1398.1	97.2	39

## 5 Saving lives

In 2000 the Institute of Medicine published its report 'To Err Is Human' in which it concluded that about 10% of hospital deaths were due to preventable adverse care events. The report identified iatrogenic harm (a symptom or illness brought on unintentionally by an act or omission) as the third most common cause of death in the developed world.

We aim to reduce avoidable deaths and our HSMR by 5 points each year over the next four years, which would equate to a reduction of around 340 deaths.

Table 2: Planned reduction in HSMR from a baseline of 95 (2009) with a 5 point reduction year on year over the next four years

	<b>HSMR</b>
2010	90
2011	85
2012	80
2013	75

## 6 Measuring, monitoring and preventing harm

### Measuring harm

Harm can be defined as any 'unintended injury resulting from or contributed to by clinical care (including the absence of indicated treatment or best practice) that requires additional monitoring, treatment or extended stay in hospital'.

It is our duty to ensure that patients are safe in our care and that events that may cause harm such as hospital acquired infections, medication errors, falls and surgical infections are addressed swiftly and effectively and lessons are learned to avoid reoccurrence.

The Trust has an incident reporting procedure and actively promotes incident reporting. Incident reporting procedures are voluntary reporting systems, which are likely to identify approximately 10 % of adverse events, 90% of which cause no harm. We will measure harm by using the Institute for Healthcare Improvement's Global Trigger Tool (GTT), which uses a structured approach to identify 'triggers' and establish if those triggers have caused unintentional harm.

We will establish our baseline adverse event trigger rate and harm events using the GTT to determine the number of harm events per 1000 bed days with the aim of reducing our adverse event triggers by 50% by March 2010.

Our existing Mortality Review Team will continue to use the Dr Foster Real Time Monitoring (RTM) tool, 3x2 matrix and Global Trigger Tool to review deaths.

Each of the key projects within the campaign framework will include specific improvement measures which will be achieved by using the PDSA (Plan, Do, Study, Act) methodology to improve processes and patient outcomes.

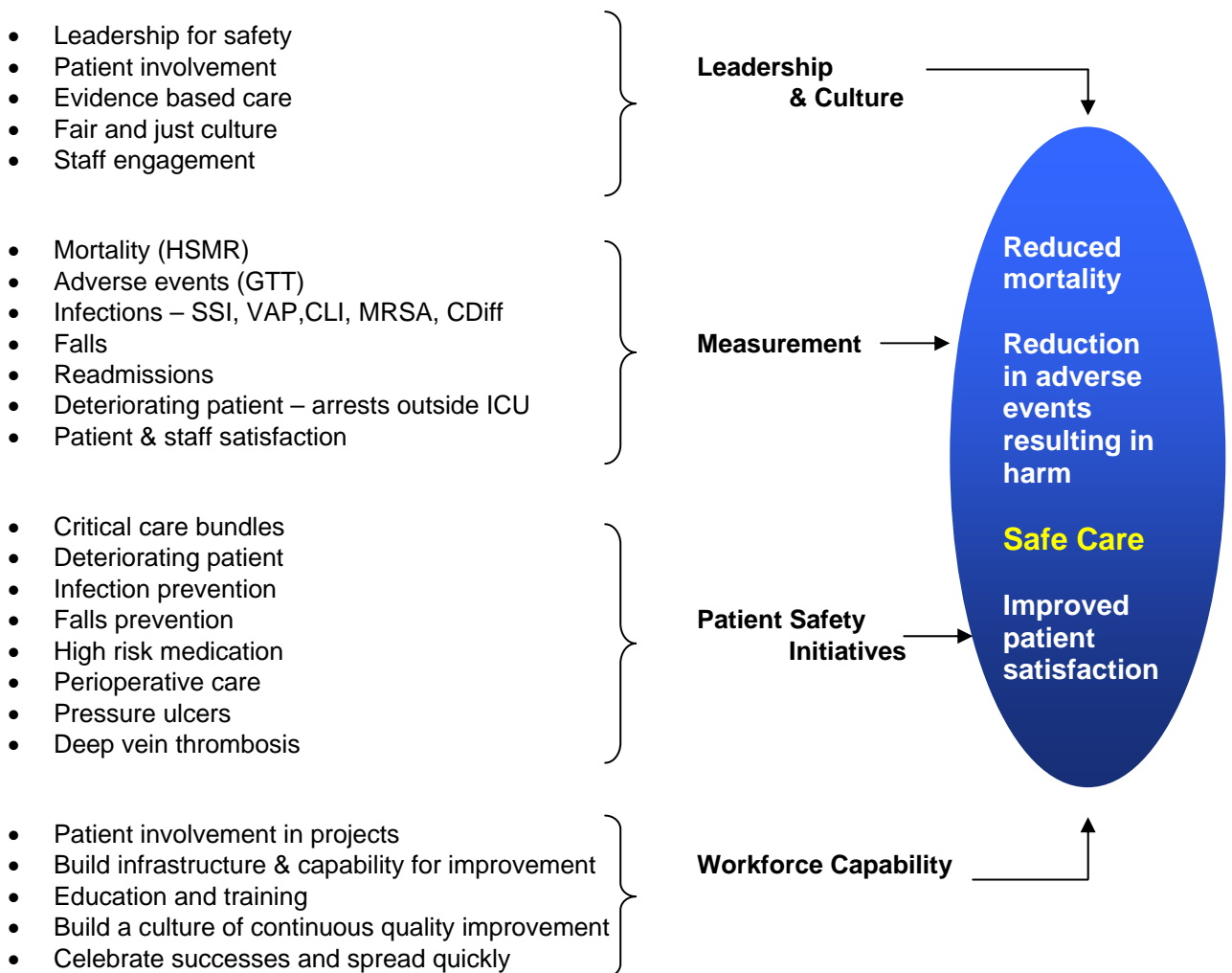
**Monitoring and preventing harm**

Progress will be monitored at a number of levels:

- Corporate - each quarter the Trust Board reviews data on a number of corporate indicators including the HSMR, readmission rates, length of stay and hospital acquired infections. In addition data on the trigger rate and harm event rate will be included.
- Project - each project will include work strands with key milestones and specific improvement measures which will be monitored by clinical area and across the project. Preventing Harm, Improving Safety Group will monitor progress across all the projects and report to the Quality & Safety Committee.
- Safety Initiatives - existing and new safety initiatives which do not fall within the key projects will continue to be encouraged and measures for improvement reported via the Preventing Harm, Improving Safety Group.

**7 Drivers for change**

Improvements in patient safety will come from a combined workforce, led by the Board of Directors that makes improving patient safety its highest priority. The diagram below demonstrates how the drivers for change are interconnected and how they will help us to achieve the campaign goals.

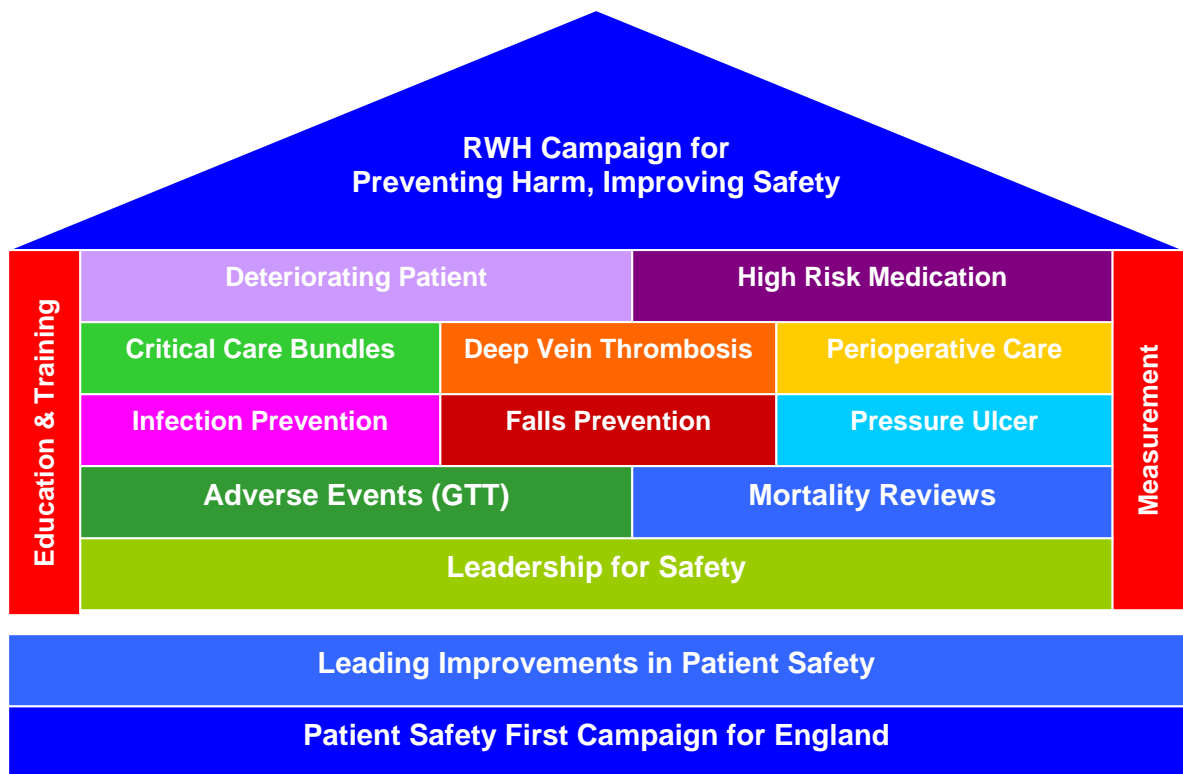


**8 Campaign framework**

The Trust has joined the Patient Safety First Campaign for England which was launched in 2008 by three partner organisations (National Patient Safety Agency, Health Foundation and NHS Institute for Innovation and Improvement). Our campaign framework includes the five key interventions of the Patient Safety First Campaign; in addition the Trust has a number of safety initiatives already underway and priorities to address.

Our campaign framework includes existing safety initiatives, the Patient Safety First interventions and Trust priorities. The diagram below depicts the campaign:

**The Royal Wolverhampton Hospitals NHS Trust  
 Campaign Framework for Preventing Harm, Improving Safety**



We will harness the support of the Patient Safety First Campaign for England and work with improvement experts to select, test and implement changes in the clinical areas so that systems are redesigned from the bottom up using small tests of change (PDSA cycle).

Each project / work stream will have a project plan that includes leadership support, patient involvement, clear aim(s), a focus on measurement, agreed time frame and clinical engagement. There will be a period of planning and preparation, project group meeting, project initiation & implementation, learning sessions and spread events. Table 3 details the timeline for our patient safety campaign.

**The Royal Wolverhampton Hospitals NHS Trust**  
*Preventing harm, improving safety – our highest priority*

**1 Preparation** – During preparation a project lead will be identified who will work with the Patient Safety Manager to identify other members of the team and organise the project meeting. Information will be gathered and a best practice framework developed by a small team. A project initiation document will be drafted.

**2 Project Group Meeting** – The Project Group will consist of enthusiastic members with expert knowledge and skills to facilitate improvement. They will convene and agree the project plan and timeframe.

**3 Project Initiation & Implementation** – This includes a detailed description of the aims, measures, changes and timescales. It will be presented to the Preventing Harm, Improving Safety Group and used to monitor the implementation of the project / work stream.

**4 Learning Sessions** – These sessions are opportunities for instruction in the theory and practice of improvement and best practice. They will be used by participants to share their methods, learning and results and for support and encouragement for making further changes.

**5 Spread Event** – This event will be discussed and presented by the project team and is an opportunity for teams not involved in the project to learn about the changes tested.

**Table 3: Preventing Harm, Improving Safety Timeline April 2009 to March 2011**

Phase 1	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M
Leadership for safety		P	M																					
Deteriorating patient		P	M			L	S			L	S			L	S			L	S			L	S	
Critical care bundles		P	M			L	S			L	S			L	S			L	S			L	S	
High risk medicines		P	M			L	S			L	S			L	S			L	S			L	S	
Perioperative care		P	M			L	S			L	S			L	S			L	S			L	S	
Deep Vein Thrombosis		P	M			L	S			L	S			L	S			L	S			L	S	
Pressure ulcers		P	M			L	S			L	S			L	S			L	S			L	S	
Infection prevention	S																							
Falls prevention			S																					

Project not started

Project planning

Project in progress

P = preparation

M = project meeting

I = project initiation & implementation

L = learning session

S = spread event

## **9 Marketing and communications**

To be successful in achieving our goals it is essential that staff, patients and visitors are fully engaged and involved in the campaign and in ensuring that preventing harm, improving safety is our highest priority. We will also engage the wider health and social care community and enlist their support both verbally and in the practices they adopt that impact on patient safety.

To start this process we will introduce the Strategy for Preventing Harm, Improving Safety to staff via the Trust News in June 2009, we will then invite staff to attend the launch of the campaign via the Trust Bulletin. The launch of the campaign will take place on the 15 July 2009 and will include invitations to the public and media to raise awareness amongst patients and the public. For patients, public and staff unable to attend the launch we will make information available at The Event and on the Trust website.

Regular safety briefings via the Intranet and Trust Website will keep staff, patients & the public informed of the progress as projects are rolled out and implemented. In addition we will provide LINKs with information for their newsletter and meet with the Patient & Public Engagement Steering Group. We will provide the Membership with information about our Campaign and invite patients who have experience of our hospital and to become involved in specific work streams.

## **10 Training and development**

Building staff knowledge and capability are essential for sustaining improvements in patient safety. The campaign for Preventing Harm, Improving Safety will be underpinned by a programme of education and training determined by both an overall and individual project specific training needs analysis and taking into consideration existing training opportunities.

**Project Plan – Leadership for Safety**

Leadership for Safety													
<b>Lead</b>	Cheryl Etches, Director of Nursing & Midwifery												
<b>Goal</b>	To ensure a leadership culture at Board level which promotes quality and patient safety and provides an environment where continuous improvement in harm reduction becomes routine throughout the organisation.												
<b>Action(s)</b>	<ol style="list-style-type: none"> <li>1 Develop explicit strategic priorities and goals</li> <li>2 Provide demonstrable leadership</li> <li>3 Ensure executive accountability</li> <li>4 Establish and monitor explicit system level measures</li> <li>5 Monitor progress and drive execution of plans</li> <li>6 Build patient safety and improvement knowledge and capability</li> </ol>												
<b>Measurement(s)</b>	<ul style="list-style-type: none"> <li>• Number of safety walkabouts per month</li> </ul>												
<b>Timeframe</b>	<b>2009/10</b>	<b>A</b>	<b>M</b> P	<b>J</b> M, I	<b>J</b>	<b>A</b>	<b>S</b>	<b>O</b>	<b>N</b>	<b>D</b>	<b>J</b>	<b>F</b>	<b>M</b>
	<b>2010/11</b>	<b>A</b>	<b>M</b>	<b>J</b>	<b>J</b>	<b>A</b>	<b>S</b>	<b>O</b>	<b>N</b>	<b>D</b>	<b>J</b>	<b>F</b>	<b>M</b>
	P = preparation                      M = project meeting              I = project initiation & implementation L = learning session                      S = spread event												
<b>Update</b>													

**Project Plan – Reducing harm from deterioration**

Reducing harm from deterioration													
<b>Lead</b>	Dr Sue J Smith, Consultant Anaesthetist – Critical Care												
<b>Goal</b>	To reduce in-hospital cardiac arrest and mortality rate through earlier recognition and treatment of the deteriorating patient.												
<b>Action(s)</b>	1 Review of physiological track and trigger system (MEWS) documentation 2 Physiological observations recorded for all adult patients 3 Physiological observations recorded and acted upon by staff who have been trained to undertake these procedures and understand their clinical relevance 4 Review of graded response strategy 5 Implementation of communication tool (SBAR)												
<b>Measurement(s)</b>	<ul style="list-style-type: none"> <li>• Number of calls to the critical care outreach team</li> <li>• Number of cardiac arrest or crash calls</li> </ul>												
<b>Timeframe</b>	<b>2009/10</b>	A	M P	J M I	J	A	S L	O S	N	D	J L	F S	M
	<b>2010/11</b>	A	M L	J S	J	A	S L	O S	N	D	J L	F S	M
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<b>Update</b>													

**Project Plan – Reducing harm in critical care  
 (Central line and ventilator care bundles)**

Reducing harm in critical care													
<b>Lead</b>	Dr Simon Hester, Consultant Critical Care												
<b>Goal</b>	To improve the care of patients receiving critical care through the reliable application of care bundles.												
<b>Action(s)</b>	1. Ventilator care bundle implemented with exception of contraindications  2. Central line care bundle implemented in all patients with central line in situ (not just critical care unit)												
<b>Measurement(s)</b>	<ul style="list-style-type: none"> <li>• % Compliance with ventilator care bundle</li> <li>• Days between ventilator associated pneumonia (VAP)</li> <li>• % Compliance with central line bundle</li> <li>• Days between central line infection (CLI)</li> </ul>												
<b>Timeframe</b>	<b>2009/10</b>	<b>A</b>	<b>M</b>	<b>J</b>	<b>J</b>	<b>A</b>	<b>S</b>	<b>O</b>	<b>N</b>	<b>D</b>	<b>J</b>	<b>F</b>	<b>M</b>
			P	M	I		L	S			L	S	
	<b>2010/11</b>	<b>A</b>	<b>M</b>	<b>J</b>	<b>J</b>	<b>A</b>	<b>S</b>	<b>O</b>	<b>N</b>	<b>D</b>	<b>J</b>	<b>F</b>	<b>M</b>
			L	S		L	S				L	S	
	P = preparation                      M = project meeting                      I = project initiation & implementation  L = learning session                      S = spread event												
<b>Update</b>													

**Project Plan – Reducing harm in perioperative care**  
**(Implementing WHO surgical safety checklist and preventing surgical site infection)**

Reducing harm in perioperative care													
<b>Lead</b>	Mr Andy Garnham, Consultant Surgeon												
<b>Goal</b>	To improve care for adult patients undergoing elective surgical procedures in the hospital setting												
<b>Action(s)</b>	<p>1 Implementation of the World Health Organisation Surgical Safety Checklist in following areas: Heart &amp; Lung Theatres, Nucleus Theatres, Obstetric Theatre, Beynon Centre, Endoscopy, Interventional Radiology, Cath Labs.</p> <p>2 Reduce surgical site infections by:</p> <ul style="list-style-type: none"> <li>○ appropriate use of antibiotics</li> <li>○ use recommended hair removal methods</li> <li>○ maintenance of glycaemic control for known diabetic surgical patients</li> <li>○ maintenance of post-operative normothermia for surgical patients</li> </ul>												
<b>Measurement(s)</b>	<ul style="list-style-type: none"> <li>● Percentage compliance with using the Surgical Safety Checklist</li> <li>● Percentage of patients receiving antibiotics on time</li> <li>● Percentage of patients with hair removal by the recommended method</li> <li>● Percentage of known diabetic elective surgical patients with controlled serum glucose (5-10mmol/l) on the day of surgery</li> <li>● Percentage of patients whose first post operative temperature was &gt;36C</li> </ul>												
<b>Timeframe</b>	<b>2009/10</b>	<b>A</b>	<b>M</b>	<b>J</b>	<b>J</b>	<b>A</b>	<b>S</b>	<b>O</b>	<b>N</b>	<b>D</b>	<b>J</b>	<b>F</b>	<b>M</b>
			P	M	I		L	S			L	S	
	<b>2010/11</b>	<b>A</b>	<b>M</b>	<b>J</b>	<b>J</b>	<b>A</b>	<b>S</b>	<b>O</b>	<b>N</b>	<b>D</b>	<b>J</b>	<b>F</b>	<b>M</b>
			L	S		L	S				L	S	
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<b>Update</b>													

**Project Plan – Reducing harm from high-risk medicines**  
**(Includes anticoagulants, opiates, injectable sedatives)**

Reducing harm from high risk medicines													
<b>Lead</b>	Professor Ray Fitzpatrick, Director of Pharmacy												
<b>Goal</b>	To prevent harm from high-risk medicines (including: anticoagulants, opiates, injectable sedatives)												
<b>Action(s)</b>	<ol style="list-style-type: none"> <li>1. Work with the VTE committee &amp; lead clinician to review identify, and review incidents related to anticoagulants</li> <li>2. Monitor and review implementation of NPSA/2007/018 (Anticoagulants)</li> <li>3. Undertake pharmacist intervention and monitoring of prescriptions</li> <li>4. Monitor and review implementation of NPSA/2008/RRR05 (Dosing Errors with Opioid Medicines)</li> <li>5. Monitor and review implementation of NPSA/2008/RRR011 (Midazolam overdose)</li> </ol>												
<b>Measurement(s)</b>	<ul style="list-style-type: none"> <li>• % inpatient warfarin doses administered according to protocol</li> <li>• Number of patients receiving warfarin with INR &gt; 6</li> <li>• Number of patients receiving warfarin with INR &gt; 5</li> <li>• Number of patients receiving warfarin with INR &gt; 8</li> <li>• Number of patients receiving flumazenil to counteract effects of midazolam</li> <li>• Number of patients receiving naloxone to counteract effects of opiates (excluding self harm)</li> </ul>												
<b>Timeframe</b>	<b>2009/10</b>	A	M P	J M I	J	A	S L	O S	N	D	J L	F S	M
	<b>2010/11</b>	A	M L	J S	J	A	S L	O S	N	D	J L	F S	M
	P = preparation                      M = project meeting              I = project initiation & implementation L = learning session                      S = spread event												
<b>Update</b>													

**Project Plan – Reducing harm from deep vein thrombosis**

Reducing harm from deep vein thrombosis													
<b>Lead</b>	Dr Rhys Lodwick, Consultant Emergency Medicine												
<b>Goal</b>	To reduce occurrence of deep vein thrombosis following admission to hospital												
<b>Action(s)</b>	1. Establish reporting of positive DVT & PE by Radiology 2. Review use of DVT assessment tool 3. Review of hospital acquired DVT 4. Review of thrombo prophylaxis												
<b>Measurement(s)</b>	<ul style="list-style-type: none"> <li>• Incidence of DVT and Pulmonary Embolism following admission to hospital</li> <li>• Incidence of DVT and Pulmonary Embolism within 4 weeks of discharge</li> </ul>												
<b>Timeframe</b>	<b>2009/10</b>	<b>A</b>	<b>M</b>	<b>J</b>	<b>J</b>	<b>A</b>	<b>S</b>	<b>O</b>	<b>N</b>	<b>D</b>	<b>J</b>	<b>F</b>	<b>M</b>
			P	M I			L	S			L	S	
	<b>2010/11</b>	<b>A</b>	<b>M</b>	<b>J</b>	<b>J</b>	<b>A</b>	<b>S</b>	<b>O</b>	<b>N</b>	<b>D</b>	<b>J</b>	<b>F</b>	<b>M</b>
			L	S			L	S			L	S	
	P = preparation                      M = project meeting                      I = project initiation & implementation L = learning session                      S = spread event												
<b>Update</b>													

**Project Plan – Reducing harm from pressure ulcers**

Reducing harm from pressure ulcers													
<b>Lead</b>	Gill Hiskett, Tissue Viability Nurse												
<b>Goal</b>	To prevent the development of pressure ulcers following admission to hospital												
<b>Action(s)</b>	1. To develop a Strategy for the prevention and management of pressure ulcers 2. To develop a strategic working group to provide ongoing review and monitoring of the implementation of the strategy 3. Implement and review implement Root Cause Analysis process 4. Undertake clinical practice ‘Benchmarking’ audit against local and national policy 5. Establish annual ‘prevalence’ audit of pressure ulcers												
<b>Measurement(s)</b>	<ul style="list-style-type: none"> <li>Number of Grade 2, 3 and 4 pressure damage</li> </ul>												
<b>Timeframe</b>	<b>2009/10</b>	<b>A</b>	<b>M</b>	<b>J</b>	<b>J</b>	<b>A</b>	<b>S</b>	<b>O</b>	<b>N</b>	<b>D</b>	<b>J</b>	<b>F</b>	<b>M</b>
			P	M	I		L	S			L	S	
	<b>2010/11</b>	<b>A</b>	<b>M</b>	<b>J</b>	<b>J</b>	<b>A</b>	<b>S</b>	<b>O</b>	<b>N</b>	<b>D</b>	<b>J</b>	<b>F</b>	<b>M</b>
			L	S		L	S				L	S	
	P = preparation                      M = project meeting                      I = project initiation & implementation L = learning session                      S = spread event												
<b>Update</b>													

**Existing Workstream – Infection Prevention**

Infection prevention	
<b>Lead</b>	Dr Mike Cooper, Consultant Microbiologist
<b>Goal</b>	To prevent hospital acquired infections MRSA and C Difficile
<b>Action(s)</b>	<ol style="list-style-type: none"> <li>1. Implementation and review of Infection Prevention Strategy, Policies and Guidance</li> <li>2. Compliance with Code of Practice</li> </ol>
<b>Measurement(s)</b>	<ul style="list-style-type: none"> <li>• Number of MRSA bacteraemias</li> <li>• Number of MRSA acquisitions</li> <li>• Number of C Diff cases</li> </ul>
<b>Update</b>	

**Existing Workstream – Falls Prevention**

Falls prevention	
<b>Lead</b>	Hilary Walker, Deputy Director of Nursing & Midwifery
<b>Goal(s)</b>	To reduce the number of patient falls.
<b>Action(s)</b>	<ol style="list-style-type: none"> <li>3. Falls Prevention Working Group leads the implementation of the prevention and management strategy</li> <li>4. Embed and monitor the falls care bundle</li> <li>5. Review reported incidents of patient falls including root cause analysis where required</li> <li>6. Deliver falls education and training programme</li> <li>7. Test environmental innovations and new technologies/equipment</li> <li>8. Monitor the provision of falls prevention information for patients and carers</li> <li>9. Develop and review of policies and guidance to support the falls prevention strategy</li> <li>10. Develop of falls prevention service</li> <li>11. Explore the patient experience of falls</li> <li>12. Agree local targets for falls prevention</li> <li>13. Develop an audit programme</li> </ol>
<b>Measurement(s)</b>	<ul style="list-style-type: none"> <li>• Number of patient falls per thousand bed days</li> </ul>
<b>Update</b>	