Measuring harm and informing quality improvement in the Welsh NHS: the longitudinal Welsh national adverse events study

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Plain English summary

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Plain English summary

Studies conducted around the world report that 1 in 10 patients will have something happen to them during their stay in hospital that will harm them. We have assessed longitudinally, over 4 years, the percentage of Welsh patients who are injured or who have complications as a result of their treatment in order to assess where improvements can be made to health care and health-care processes. We confirm that 10% of patients experience this harm in Wales, a similar proportion to that reported in other countries, and around half of these events could be prevented if hospitals addressed their causes through improvement projects.

We compared different methods to measure the problems that commonly happen, such as infections, surgical complications and mistakes prescribing and administering medications. The Global Trigger Tool in this setting was inconsistent and overall under-reported these harm events, and the Harvard two-stage process was too cumbersome for routine use. We have developed a new tool, taking the best of both approaches, and a method by which individual hospitals can identify where patients are most at risk of being injured during the course of hospital care. Recognising this risk to patients offers the opportunity for hospitals to target problem areas to reduce the number of patients exposed to injuries or complications. If an approach of monitoring was continued across NHS Wales, Wales could become an international leader in patient safety. In the longer term, health-care safety measures that affect a small proportion of patients need to be placed in the context of the enormous benefits of health care to whole populations.

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