

# The PRASE (Patient Reporting and Action for a Safe Environment) project

Putting the patient at the heart of patient safety:  
Implementing a patient measure of safety in partnership  
with hospital volunteers

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## The project

The PRASE project, funded by the Health Foundation, is a collaborative quality improvement initiative involving three hospital trusts within the Yorkshire and Humber region. The project tests the implementation of the PRASE intervention and evaluates the impact and outcomes in terms of patient safety and improved quality of care.

## The challenge

Recent high profile reports in the UK have highlighted the importance of eliciting patient feedback to drive change in patient safety in hospital.

## Response

Research undertaken by the Yorkshire Quality & Safety Research Group has resulted in the development of a validated, evidence-based patient feedback tool called PRASE. This improvement project uses hospital volunteers, a novel approach in the NHS, to elicit patient feedback in a standardised way using electronic mobile devices. The tool uses questionnaire-based likert scales and free text narrative. The questions are linked to eight domains from the Yorkshire Contributory Factors Framework that have been identified by patients as being relevant to patient safety incidents. As part of the implementation project, PRASE software is being developed which will include an interactive reporting website and intuitive report template.

## PRASE process

Completion of a minimum of 20 questionnaires in each ward generates a feedback report. The report breaks down patient responses into eight patient safety domains and patient measures of safety scores, and also provides a description of patient-reported experiences. A multi-disciplinary action planning meeting is held on the ward to create an improvement plan with the support of a facilitator or coach. This action plan is owned by the ward and it is expected that this is triangulated with other safety performance metrics currently being collected on the ward.

Figure 1. PRASE process measures

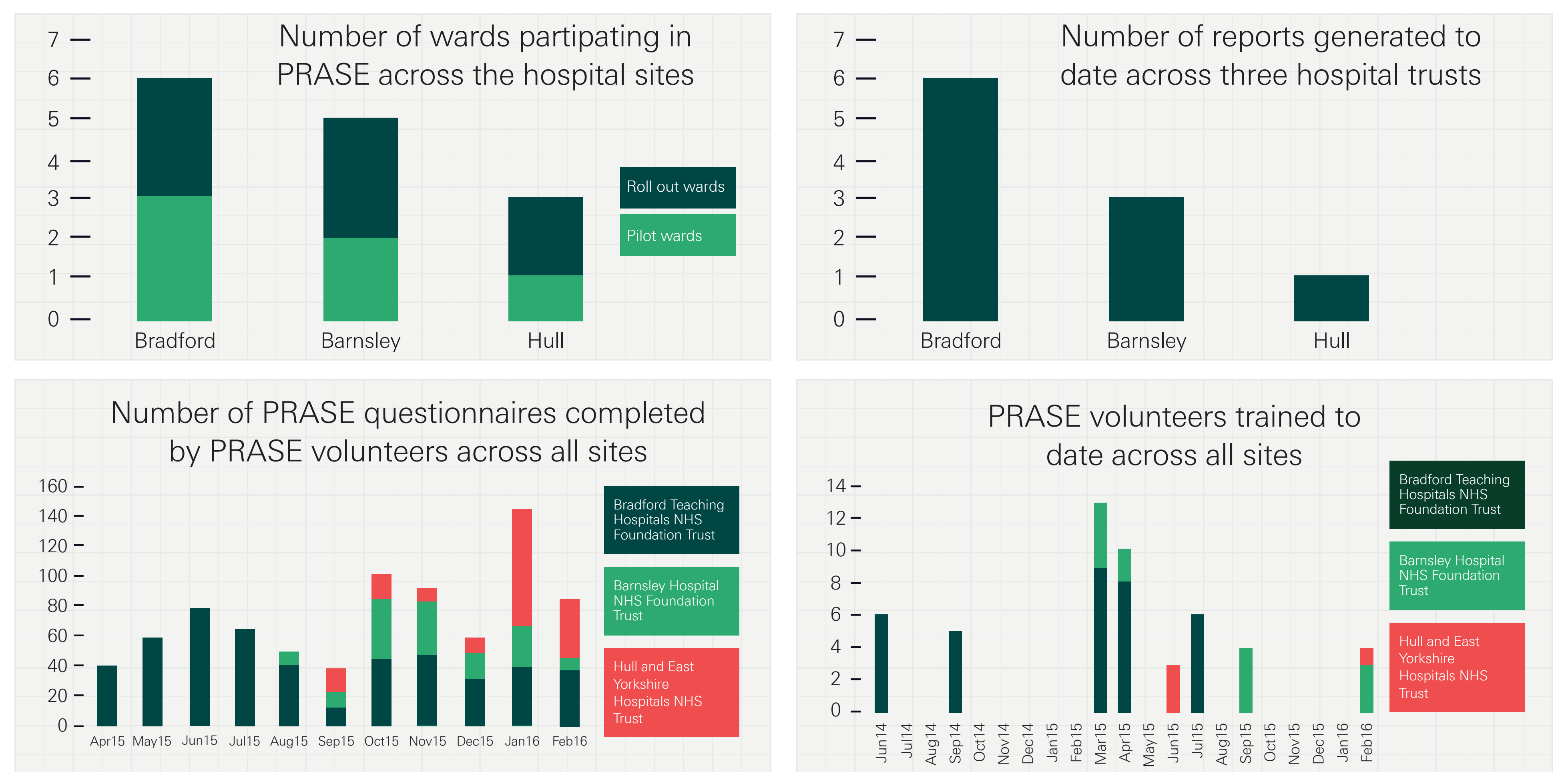


Figure 2. Patient safety domains



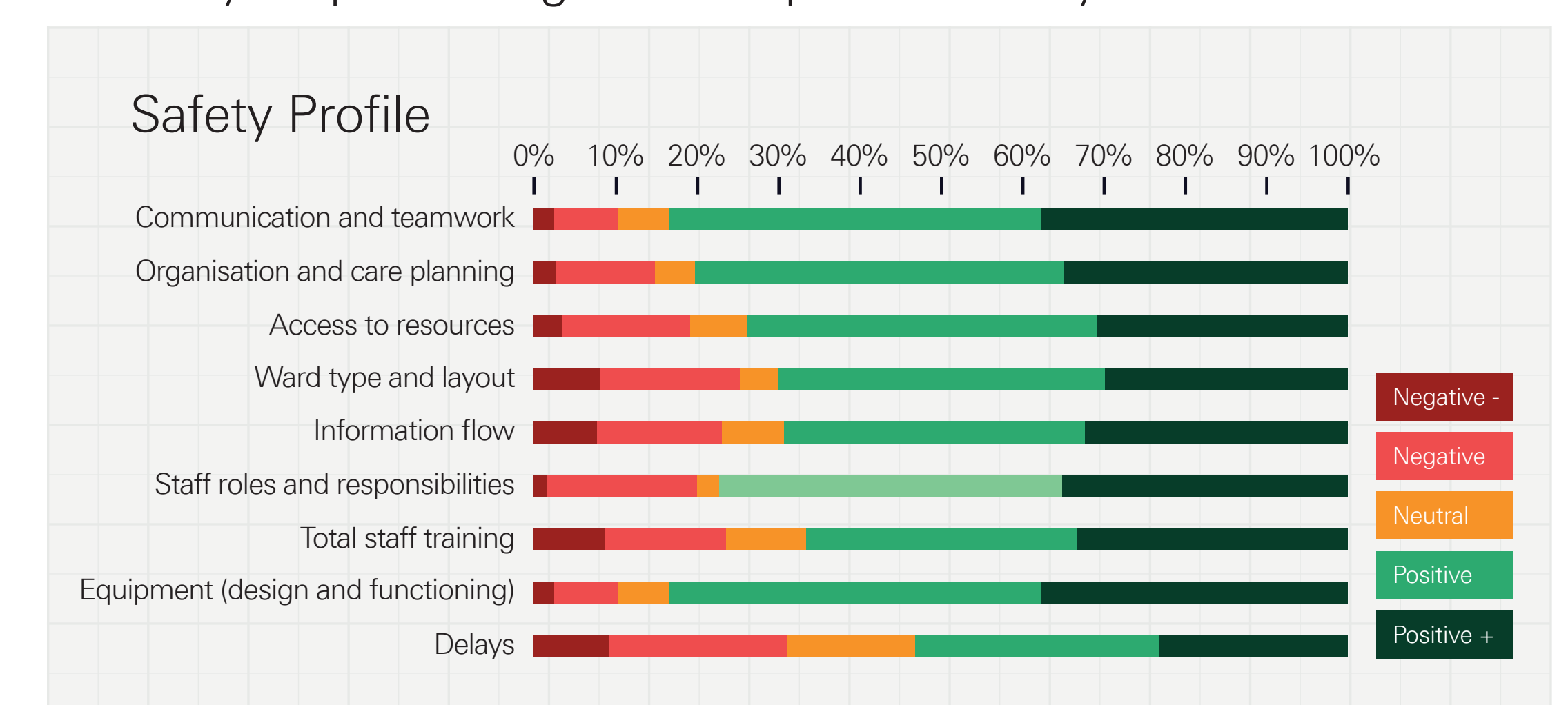
## Early findings

The ward multidisciplinary staff have found the feedback report visually attractive and appreciate the importance of gathering patient feedback. The success of the PRASE intervention will be contingent upon local ownership and willingness to engender change. The PRASE software solution will enable ward clinicians to compare reports over time and promote a culture of continual improvement.

## Challenges to date

These relate to capacity and capability of frontline staff in applying the PRASE process as part of routine quality improvement practice. The ability to demonstrate impact and improvement in quality outcomes will increase the face validity of PRASE and also drive future sustainability and spread.

Figure 3. Sample summary report presenting patient measures of safety responses against the patient safety domains



## References

- Bowers B (2011) Managing change by empowering staff. Nursing Times; 107: 32/33, early online publication. 18/6/15 <http://www.nursingtimes.net/nursing-practice/specialisms/management/managing-change-by-empowering-staff/5033731.article>
- Berwick D (2013) A promise to learn – a commitment to act: improving the safety of patients in England. London: Department of Health.
- Naylor, C., et al (2013) Volunteering in health and care - Securing a sustainable future. The Kings fund [http://www.kingsfund.org.uk/sites/files/kt/field/field\\_publication\\_file/volunteering-in-health-and-social-care-kingsfund-mar13.pdf](http://www.kingsfund.org.uk/sites/files/kt/field/field_publication_file/volunteering-in-health-and-social-care-kingsfund-mar13.pdf)
- Francis R (2013) Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry. London: The Stationery office.
- Giles, S., et al (2013). Developing a patient measure of safety (PMOS). BMJ Quality & Safety.
- Lawton, R., et al (2012). Development of an evidence-based framework of factors contributing to patient safety incidents in hospital settings: a systematic review. BMJ Quality and Safety ;21:5 369-380
- McEachan, et al on behalf of the Yorkshire Quality and Safety Research Group. Developing a reliable and valid measure of safety in hospitals (PMOS): a validation study. (2013) BMJ Quality and Safety.
- Pannick, S, Sevdalis, N, Athanasiou, T (2015) Beyond clinical engagement: a pragmatic model for quality improvement interventions, aligning clinical and managerial priorities BMJ Quality & Safety Online First, published on 8 December 2015.