The Royal Wolverhampton NHS Trust	

Trust Board Report

Meeting Date:	25 March 2013
Title:	Patient Safety Initiative: Annual Report
Executive Summary:	The report details an annual review of patient safety activity led by the Preventing Harm Improving Safety Committee in the last 12 months.
Action Requested:	For assurance
Report of:	Ms Cheryl Etches, Chief Nursing Officer
Author: **Contact Details:**	Ms Charlotte Hall, Deputy Chief Nurse Tel 01902 695968 Email charlotte.hall6@nhs.net
Resource Implications:	None
Public or Private: (with reasons if private)	Public Session
References: (eg from/to other committees)	Quality & Safety Committee Care Quality Commission NPSA
Appendices/ **References/** **Background Reading**	CQC Standards
NHS Constitution: (How it impacts on any decision-making)	In determining this matter, the Board should have regard to the Core principles contained in the Constitution of: - Equality of treatment and access to services - High standards of excellence and professionalism - Service user preferences - Cross community working - Best Value - Accountability through local influence and scrutiny

Background Details

1. Introduction

In 2009 the Royal Wolverhampton NHS Trust (RWT) embarked on programme of safety improvements to eliminate preventable harm, improve patient outcomes and reduce error in order to improve the overall safety for patients. A series of work streams designed to improve patient safety were led by senior clinicians, facilitated by the patient safety manager and provided with senior managerial support from the Chief Executive who chaired a monthly committee reporting quarterly to the Quality & Safety Committee, this committee continues and is called the Preventing Harm Improving Safety Committee (PHISC). This report builds on the priorities outlines in the 2010 Patient Safety Report.

The Trust has established governance arrangements to manage risk and ensure patients remain safe. The patient safety manager post was introduced in April 2009 but has since moved into the central governance department to continue to support the clinical divisions in preventing harm and improving safety through business as usual. Two of the original work streams now have their own committee structure and report directly to the Quality and Safety Committee on a quarterly basis namely the Infection Prevention Committee and the VTE Thrombosis Committee. Since 2009 other safety priorities have overtaken the agenda, for instance a higher than average number of never events reported in 2010/11 which necessitated a complete review of how the Trust manages the Safer Surgical Checklist.

This report provides an annual report on the patient safety initiatives undertaken at RWT to January 2013. In the last 6 months the reporting period has been changed to provide the most up to date data which is presented monthly through the Quality and Safety Report to the Quality and Safety Committee through to Trust Board.

2. Patient Safety initiatives at RWT

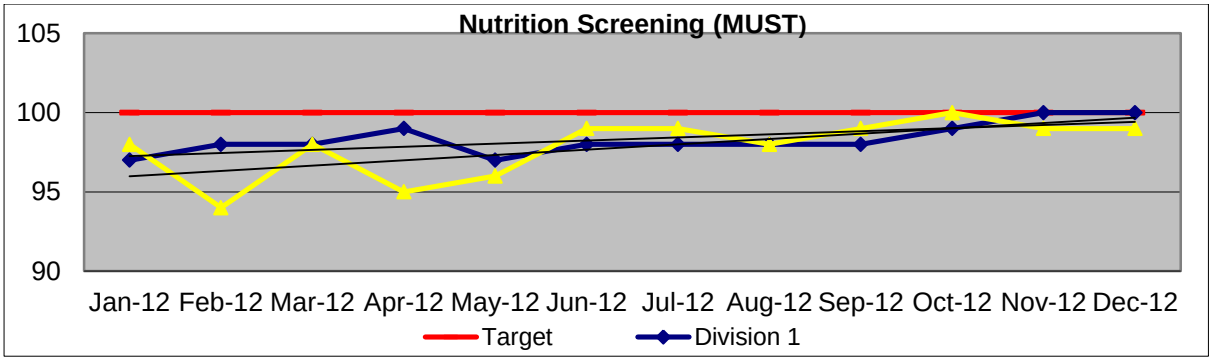
The safety priorities identified in the previous report published in 2011 include:

- Nutrition
- Pressure Ulcer reduction
- Falls reduction
- Infection Prevention: Device related hospital acquired bacteraemia
- Clinical Handover
- Venous Thrombo Embolism
- Deteriorating patient

In addition, in 2012 the Trust responded to increasing concerns around the number of never events reported by undertaking a review of how the organisation manages the risks of never events. The organisation successfully piloted the use of the Safety Thermometer in advance of the rest of the country and we now have 12 months of data with which to triangulate our own data on harms.

3. Nutrition

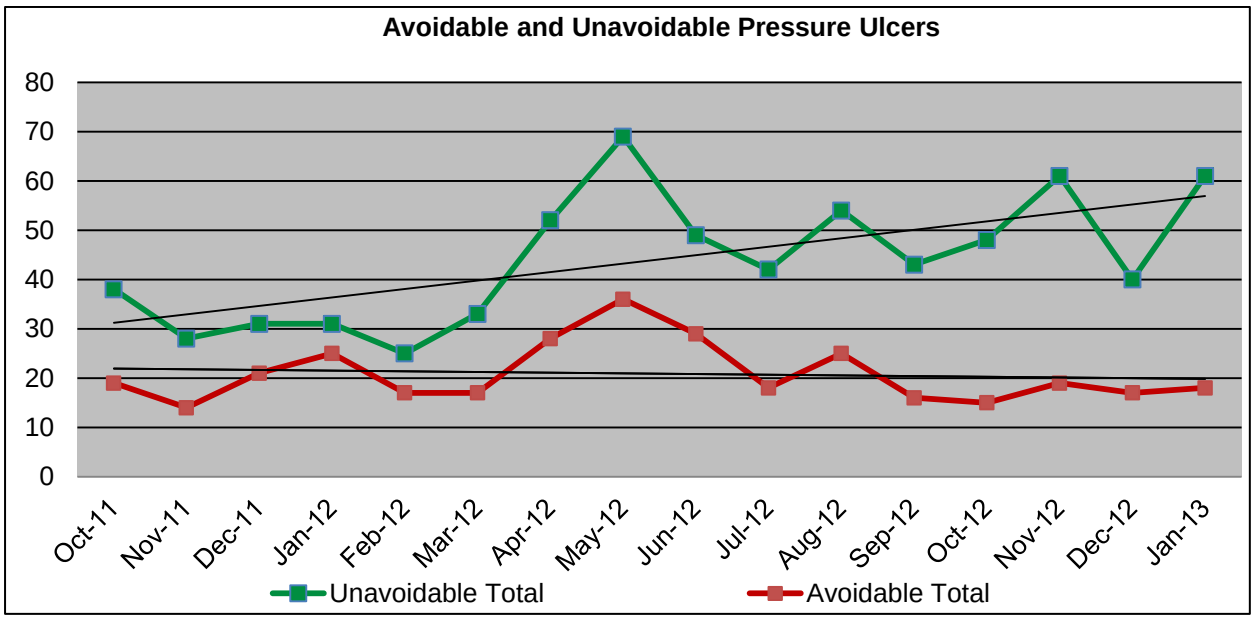
The Trust reports that 99% of patients have their nutritional risk assessment (MUST) complete within 6 hours of being admitted to a ward. In addition the Trust continues to promote the ‘Food First’ campaign and is currently trialling a range of snacks and homemade soup made available to every patient on the ward. The Protected Mealtime policy has been reviewed and meal times altered to reduce the hours between supper and breakfast and also helped with junior doctors being off the ward during teaching hour. Work with LINKs has identified improvements in nutrition and our volunteers continue to assist patients at mealtimes. Our next steps will be to assess the positive impact the interventions have had and consider adopted outcomes used in the Dementia ward where patient outcomes are measured by weight gain.



4. Pressure Ulcer reduction: Prevention of avoidable pressure ulcers

The Trust is successfully reducing the number of avoidable pressure ulcers and this has been achieved with active management by the Tissue Viability team and matrons. This has included additional non-recurrent funding from the commissioners to increase the capacity of the Tissue Viability team to train staff, survey pressure ulcer prevalence and incidence and advise staff on best practice in wound care. Specific resource has been put into a designated tissue viability nurse in the emergency department and acute medical unit, the development of a chronic wound project to identify and target community nursing practice and to promote best practice in managing chronic wounds for practice nurses.

The organisation has participated in the Strategic Health Authority's 'Ambition 1', to achieve zero avoidable pressure ulcers by December 2012. The Trust achieved 75% in this time scale and a number of wards are over 10 months without an avoidable pressure ulcer. The chief nursing officer runs a weekly accountability meeting where all grade three and four pressure ulcers are presented by the relevant ward sister and matron to determine avoidability and lessons learned. This has helped change behaviour and achieve a cultural shift in how our staff managing skin integrity and increasing compliance with all interventions that impact on patient comfort and safety including comfort rounds and good nutrition to name a few. There is a Trust wide Formulary which provides best practice guidance on dressings to use and a member of the tissue viability team is now working with the nursing homes in the city to educate and advice on tissue viability for their patients. The aim of all these initiatives is to reduce the burden of pressure ulcers across the health economy and improve the safety and quality of care to the patients of Wolverhampton.



5. The reduction of falls and prevention of serious harm caused by falls

The Trust has set ambitious targets for all wards in order to try to reduce the rate of patient falls per 1000 bed days and also to reduce the number of falls that cause harm; typically those that result in patients suffering fractures or cerebral bleeds. The number of falls per 1000 bed days at West Park has shown a decline over 12 months however this is not as pronounced at New Cross. An analysis of the data and work done by the Falls Steering Group has demonstrated no one single intervention is key however the following results have been noted.

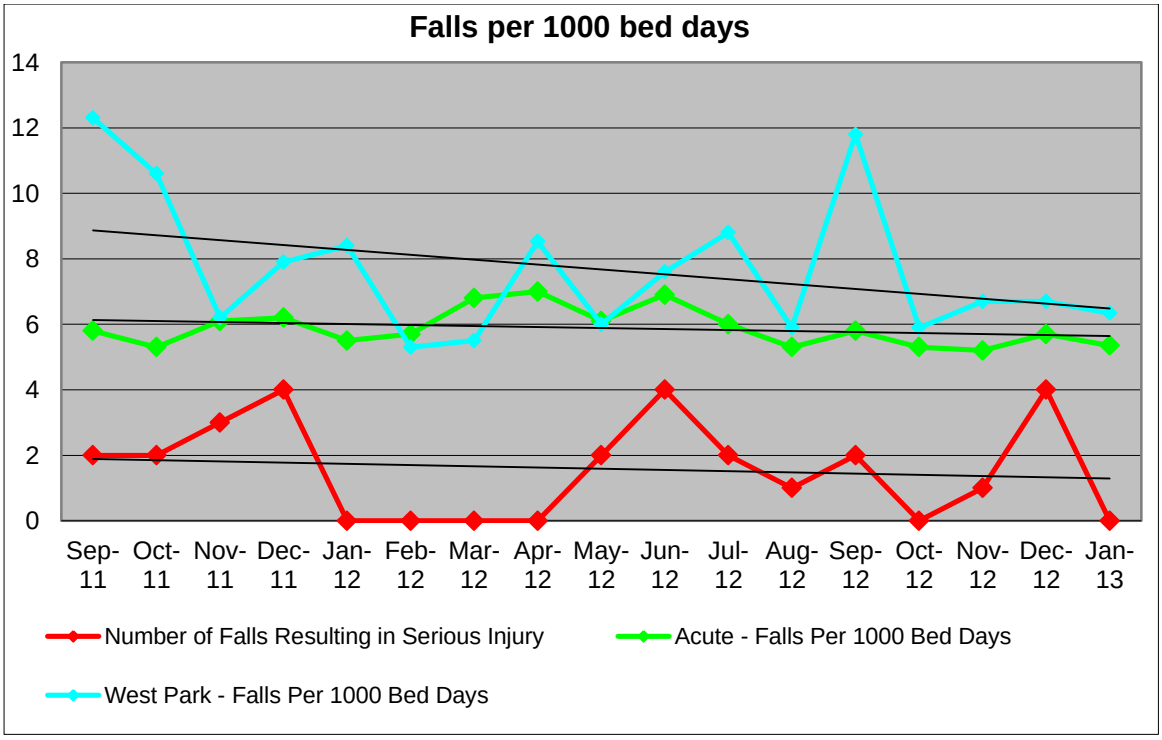
The number of patients who receive a risk assessment for falls on admission has increased to 95% within 6 hours of admission to hospital; work is on-going to ensure the care bundle is completed by all disciplines.

The Trust provides 7 day therapy assessment so access to walking aids is available and assessment by medical staff has supported the identification of 'culprit' drugs that can make some patients more likely to fall.

The move to bay nursing means patient are far more observable and this has demonstrated higher confidence levels from the patients in our tracker results and a reduction in so called 'unwitnessed' falls which is a positive sign in our plan to reduce overall numbers of falls. However this is very difficult to sustain during the night when staffing reduces to 3 nurses and particularly during outbreaks of Norovirus/ *C.Diff* where invariably two nurses will be required to help a patient thus leaving other patients vulnerable to falling should they require assistance. The night is frequently when patients become confused and the ward is naturally dark to promote sleep.

In the last 12 months the Trust has strengthened the policy for care of patients post fall where they may have sustained a head injury, written and distributed a bed rails policy, implemented a falls care bundle and linked with the community falls prevention team which is now managed by the therapy lead thus linking more with the acute sector. However our own analysis of falls and those that have caused harm in particular is that our patients require a standard set of first line interventions; slippers or shoes (many come in without) walking aids and confidence to mobilise. The latter is reliant on increasing balance and gait of patients who are likely to fall and is best improved with plenty of walking practice and exercises that support balance and fundamental manoeuvres such as getting out of the chair safely, reaching the toilet and opening doors.

This has been highlighted to the commissioners and is part of an improvement programme they are keen to support which would involve the Trust linking with the local authority exercise and safety programme run for patients who have been discharged from hospital.



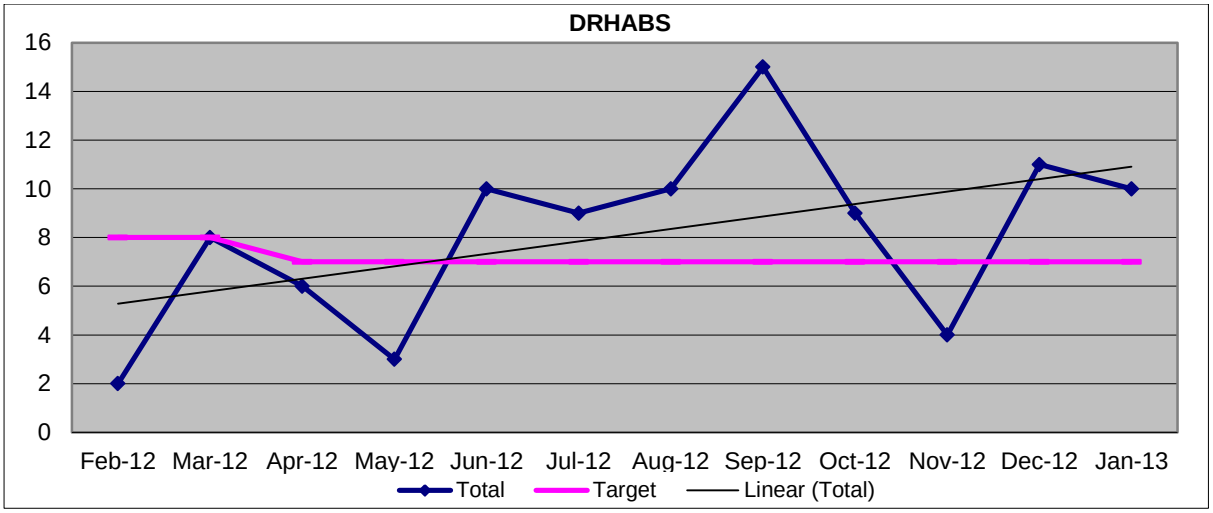
6. Clinical Handover

The clinical handover is the transfer of professional responsibility and accountability for some or all aspects of care for a patient, or group of patients, to another person or professional group on a temporary or permanent basis (NPSA 2005).

This work stream has recently been taken over by one of the AMU medical consultants and has resulted in a standardised handover that now takes place every evening using a proforma which is led by a senior clinician. The junior doctors have welcomed the order and rigour this brings where they can raise issues and have recently requested the same format takes place in the morning following 'on take' including at the weekends. This is appropriate and evidence from other Trusts has demonstrated a reduction in errors. The clinical lead for handover is auditing outcomes now that the practice is established. This work stream is also linking in with data available from Vitalpac which can alert the doctor automatically to a deteriorating patient.

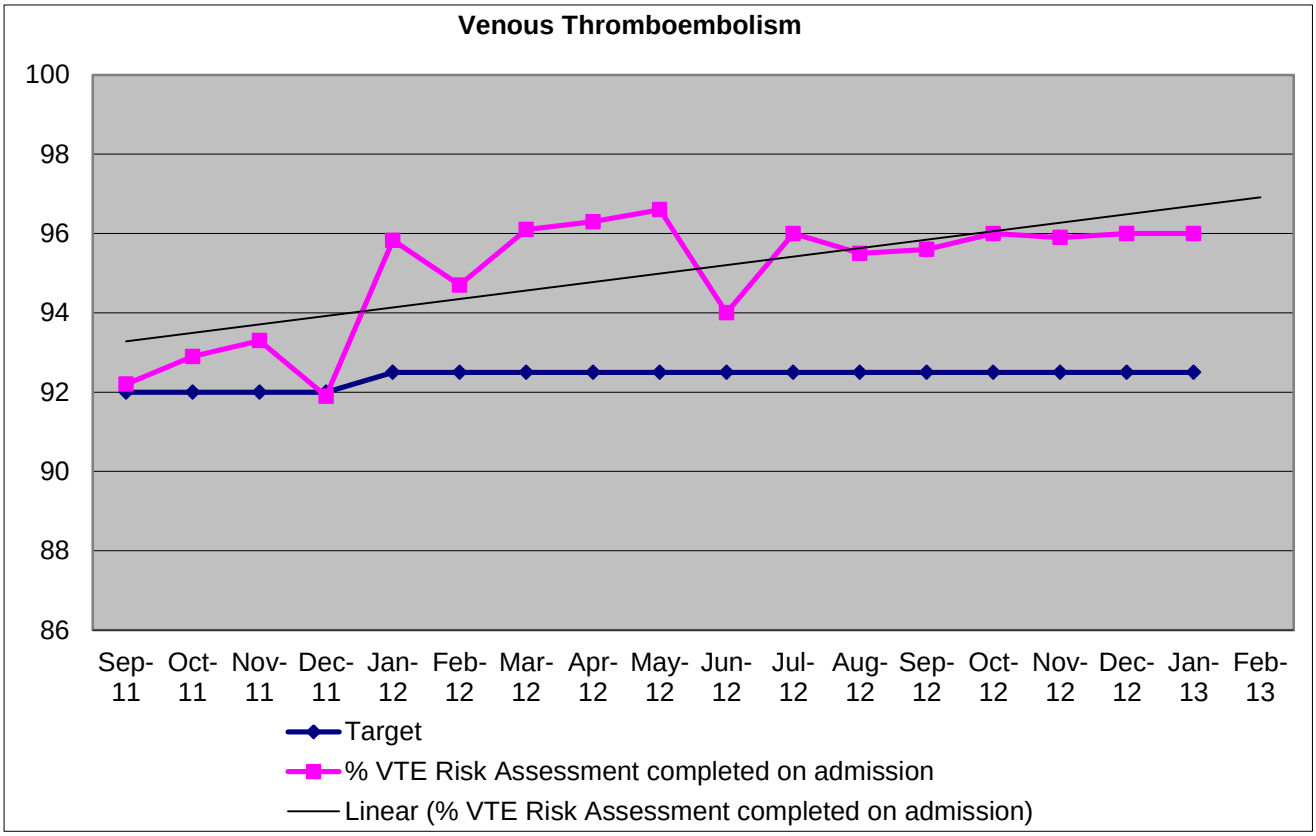
7. Device related hospital acquired bacteraemia (DRHABs)

The purpose of monitoring DRHABs is to reduce the risks of bacteraemia caused by invasive devices ie. urinary catheters, peripherally inserted central catheter lines (PICC) and routine blood sampling. All blood tests should be taken by the trained phlebotomists and the Trust is piloting a PICC line insertion service which is nurse led since August 2012. The reasons for urinary catheterisation are being monitored and the policy has been strengthened. The challenge is to reduce the use of urinary catheters and intravenous devices and to only use them as absolutely necessary. Results so far have been mixed however the use of the catheter care bundle is being reinforced through the team and data collection is in place which will determine effectiveness.



8. Venous Thrombo Embolism (VTE)

Every patient must have a VTE risk assessment completed on admission and at 24 hours post admission. The national target is 90% of patients. The Trust has regularly achieved in excess of this however the assessment at 24 hours has been challenging to achieve. This is being addressed by scoping the use of Vitalpac to alert staff to reassess each patient at 24 hours. Each patient who is confirmed as having suffered an embolism then has a root cause analysis completed in order to learn from this.



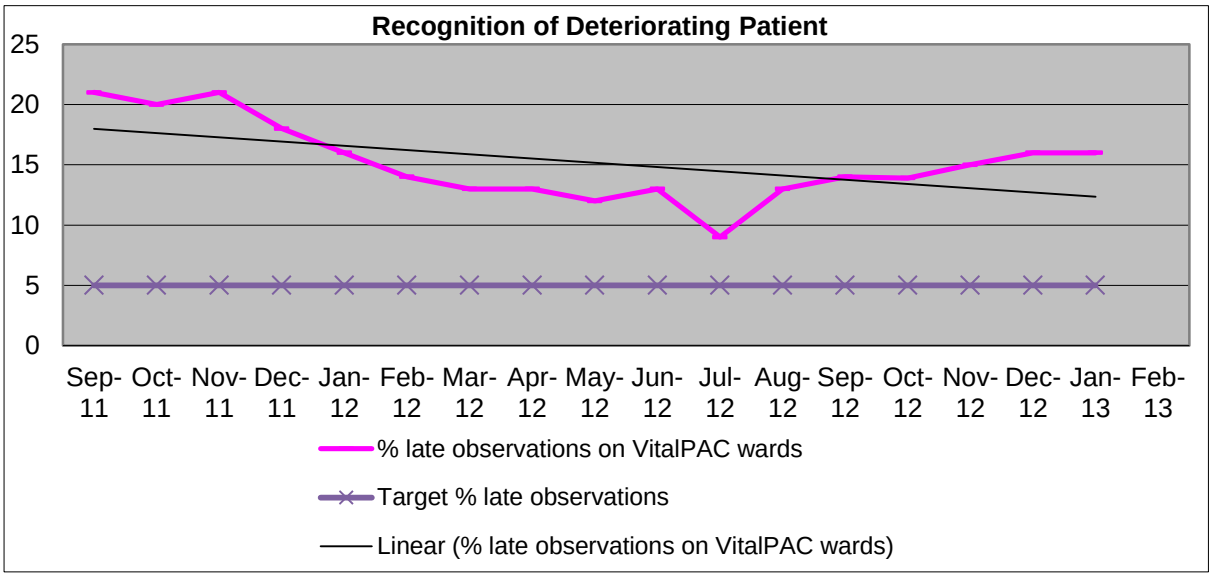
9. Deteriorating patient

The Trust introduced an electronic system called Vitalpac in 2009, the system enables nurses to capture the patient's vital signs electronically at the bedside.

The system analyses vital signs together with other data and provides risk scores and assessment tools which reduce clinical risk. This alerts the nurse to escalate to the clinician using the patient's early warning score which, with appropriate intervention, precludes physiological deterioration invariably leading to cardiac arrest/death. The effectiveness of this system has relied on a cultural change of behaviour in staff who are now expected to time and take patient observations according to physiological need; Vitalpac will alert the nurse to do this and this is a fundamental change in behaviour whereby ward routine would dictate when observations were routinely taken on a ward.

Over two years, the number of late observations has reduced from an average of 40% across the Trust to less than 5% in a number of areas with a range this month of between 20% and 2%. This indicates that the required behavioural changes had not been embedded when the system was first introduced, however this has now changed. The physiological deterioration of patients has impacted on mortality and 'failure to rescue' which is a national nursing metric. Wards are expected to achieve no more than 5% late observations and this is monitored weekly with a league table sent out to all wards and managers.

The Vitalpac system provides considerable data and moving forward it is our intention to ensure maximum use of data provided by the system is used to influence patient safety and drive deterioration of patients further. An example of data that will shortly become available is pain assessment, nutritional assessment, blood observations, canulla and catheter device inspection and changes in stool consistency which can indicate infection outbreaks which has successfully been used in Portsmouth to provide advance warning of diarrhoea outbreaks.



10. Reduction of the risk of never events

The department of health increased the number of never events in 2012/13. A series of never events prompted the Trust to review the use of the WHO Surgical Safety Checklist and introduce additional external training from the Association of Perioperative Practice. This has been very well evaluated by all levels of staff. There have been three never events, two occurred in year and one in March 2012 but was reported in April 2012. In addition the Trust took the unprecedented step to introduce surgical safety checklists into areas outside the operating theatre where invasive investigations take place. This prompts staff to consider the range of never events and safety of patients and also to consider safer practice to ensure policies and practice are followed. This is monitored monthly via the Quality and Safety Committee.

The CQC and commissioners have commented on the success of the safety culture particularly in the operating theatre and have just provided a report registering the Trust with no concerns or conditions.

11. Next steps

The PHIS Committee continues to meet monthly in order to support patient safety initiatives and provide management support. The monitoring of patient safety now rests with divisions as business as usual reported to the Quality and Safety Committee.

A Quality and Safety strategy is being devised which will incorporate the work streams discussed

Further work is anticipated in embedding escalation of patient concern using SBAR (Situation, Background, Assessment, Recommendation, Decision)

Continue to reduce never events and identify interventions that support the reduction of never events

Consider the use of VitalDoctor which enables medical staff to be automatically alerted to deteriorating patients supporting clinical handover and patient safety

Manage patient care through the use of care bundles in managing specific conditions ie. managing sepsis consistently

Maximise the data available from Vitalpac to report on patient outcomes