**Agenda Item No: xx**

**THE ROYAL WOLVERHAMPTON HOSPITALS NHS TRUST**

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| **Report to:** | Trust Board |
| **Date:** | 14 February 2011 |
| **Subject:** | Quality & Safety Report |
| **Report by:** | Director of Nursing & Midwifery |
| **Author:** | Patient Safety Manager |
| **Purpose of Report** | To provide the Board with information regarding performance and progress with Trust quality and safety. |

**Report**

The report relates to Quarter 3 (1 October to 31 December 2010) and includes progress of the Trust's campaign to prevent harm and improve patient safety in addition to an organisational overview of incidents, complaints, inquests, claims and risks. It also provides information on issues that fall outside of the campaign but contribute to the quality and safety agenda. During Quarter 4 the framework will be reviewed and amended in conjunction with the performance report for 2011/2012

**Review Committee Approval**

**Recommendation(s)**

The Board is asked to note the content of the report

**Contents**

## 1) EXECUTIVE SUMMARY

This report on Quality and Safety includes progress on the Campaign for Preventing Harm, Improving Safety. The report refers to the period Quarter 3 2010/11 (1 October to 31 December 2010)

Section 2 provides an overview of organisational quality and safety.

Section 3 details progress with the Campaign Preventing Harm, Improving Safety.

Section 4 reports on the patient experience. The Board is reminded that the second stage for formal complaints has now moved from the Healthcare Commission (now the Care Quality Commission) to the Ombudsman.

Section 5 includes performance on areas that impact on patient safety and quality.

**The areas to note regarding progress are as follows:**

- DRHABS above target for the month of December 2010 (section 3.4.3)
- Compliance with the completion of VTE risk assessment is poor (section 3.6)

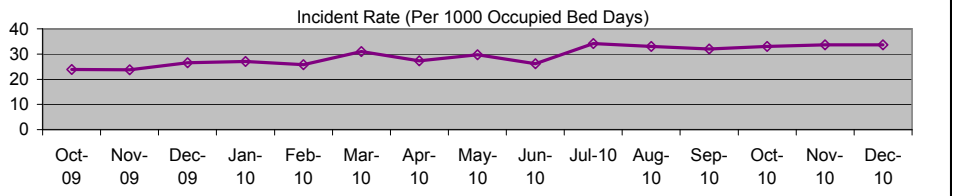
- Incident reporting continues to increase (section 2.1)
- Pressure ulcers have decreased with no grade 3 or 4 hospital acquired pressure ulcers reported (section 3.9)
- No MRSA bacteraemias (section 3.4.2)
- VitalPAC was rolled out to medical and surgical wards
- Complaint response times were achieved throughout the quarter (section 4.2.1)

## 2) TRUST SAFETY & QUALITY OVERVIEW

### 2.1 Incident Rate

Key to providing high quality care is having good systems in place for staff to report when patients have, or could have been harmed. Organisations with good levels of reporting are able to set safety priorities and direct investment, anticipate problems and reduce costly claims, identify problems and take actions. High reporting of incidents is a mark of high reliability organisations and therefore incident reporting is to be encouraged. It is essential that staff receive feedback, there is a focus on learning, frontline staff are engaged, incident reporting is easy, reporting systems focus on improving safety rather than blaming individuals and appropriate action is taken.

| | Oct-10 | Nov-10 | Dec-10 |
|---|---|---|---|
| Div 1 | 290 | 286 | 275 |
| Div2 | 401 | 412 | 417 |
| Total | 691 | 698 | 692 |
| | | | |
| Per 1000obd | **33** | **33.7** | **33.7** |



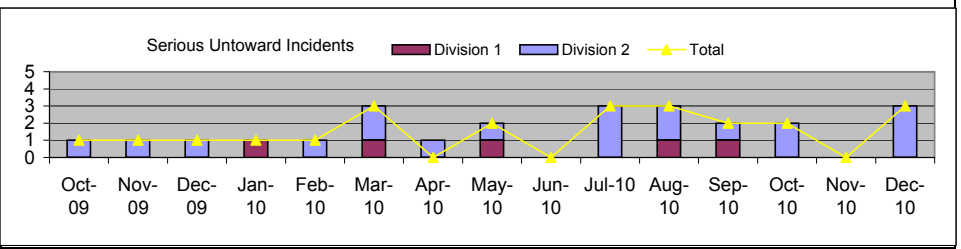

**Analysis:** The number of incidents reported during Q3 (Oct - Dec 10) has increased by 6% from the previous quarter. The majority of incidents are reported by nursing and midwifery staff and the largest category of incidents is patient falls (further information on patient falls in section 3.7).

**Actions:** The reporting of incidents continues to be encouraged and the use of online reporting of incidents via DatixWeb is extending. All directorates are working to achieve a sustained reduction in patient falls.

### 2.2 Serious untoward incidents (SUIs)

Serious untoward incidents (SUIs) are reported as they occur to the Trust's management team for urgent action by the Divisions and reported externally to the National Patient Safety Agency and Strategic Health Authority.

| | Oct-10 | Nov-10 | Dec-10 |
|---|---|---|---|
| Div 1 | 0 | 0 | 0 |
| Div2 | 2 | 0 | 3 |
| Corp | 0 | 0 | 0 |
| Total | 2 | 0 | 3 |



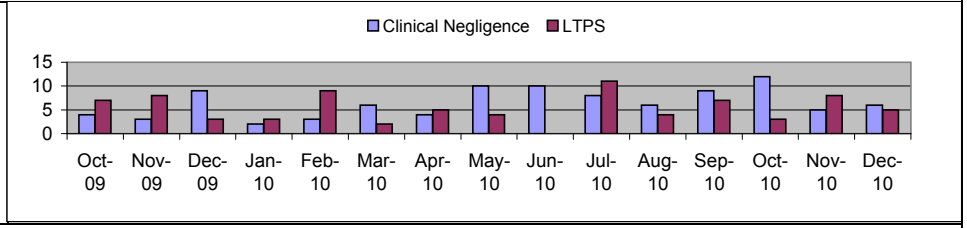

**Analysis:** SUI's reported in this period include ▪ a patient C Diff positive (deceased 1a), ▪ patient not screened for Hep C, ▪ stillbirth > 24 weeks, ▪ increased C Diff activity on ward and ▪ H1N1 identified in several samples - declared as an outbreak within the Trust.

**Actions:** ▪ C Diff - RCA completed and being presented at Januarys divisional governance meeting. ▪ Hep C patient - last round of testing to be completed by 17th January waiting for results to complete RCA. ▪ Stillbirth - RCA ongoing. ▪ CDiff activity - Individual RCA's completed and awaiting collective review. Isolation of suspected cases and contacts. ▪ H1N1 - Outbreak meeting called, regular actions implemented following daily meetings.

## 2.3 New Litigation

The numbers of new clinical negligence claims and liabilities to third party (LTPS) claims received during the quarter are detailed below. A detailed report is provided in the confidential section of the Trust Board every 6 months.

| | Oct-10 | Nov-10 | Dec-10 |
|---|---|---|---|
| Clinical Negligence | 12 | 5 | 6 |
| LTPS | 3 | 8 | 5 |
| Total New | 15 | 13 | 11 |



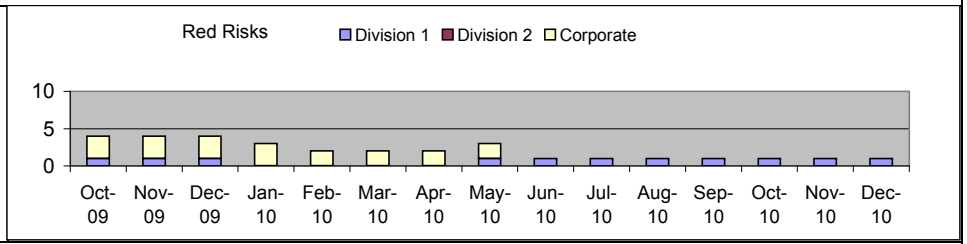

**Analysis:** Clinical negligence claims received during the period relate to treatment, diagnosis and obstetrics. LTPS claims relate to needle stick, slip, trips and falls, equipment, injury, assault and other

**Actions:** The divisions receive details of all new claims to enable any investigations necessary with a view to preventing a recurrence and an aid to the risk management process

## 2.4 Red Risks (Operational)

The numbers of new and existing red risks for the quarter are detailed below. A detailed report is provided to the Trust Management Team on a monthly basis.

| | Oct-10 | Nov-10 | Dec-10 |
|---|---|---|---|
| Div 1 | 1 | 1 | 1 |
| Div2 | 0 | 0 | 0 |
| Estates & Fac | 0 | 0 | 0 |
| Corporate | 0 | 0 | 0 |
| Total | 1 | 1 | 1 |



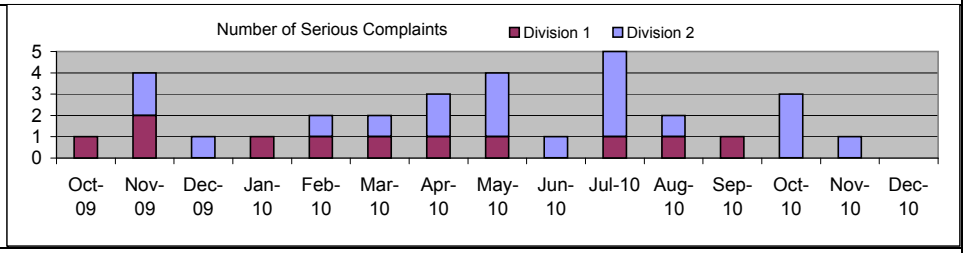

**Analysis:** There is one red risk within Division 1 - There is no routine reporting of plain x-ray films instead reporting of these films relies on the referring clinician evaluating the plain x-ray film.

**Actions:** Radiology DM to liaise with Divisional Medical Directors to identify roll out plan of protocol regarding responsibility of referrers.

## 2.5 Serious Complaints

A serious complaint includes complaints graded amber and red on the Trust's risk matrix. These complaints are reported and monitored by the Quality & Safety Committee on a quarterly basis and the Trust Board receives a summary report of red/amber complaints on a quarterly basis.

| | Oct-10 | Nov-10 | Dec-10 |
|---|---|---|---|
| Div 1 | 0 | 0 | 0 |
| Div2 | 3 | 1 | 0 |
| Total | 3 | 1 | 0 |




**Analysis:** During October 2010 Division 2 had three complaints that were graded as amber. ▪ The first complaint concerned a patient who was found by his wife lying on the bed without covers or clothing; he was lying in blood and urine, and appeared to be in pain. There were 5 other patients in the bay. ▪ The second complaint related to a patient who became ill in early 2007 with flu like symptoms which developed into a persistent cough and chest pain. An x-ray was requested but the patient was referred back to the GP. An x-ray carried out in Oct 2008 which revealed a growth which turned out to be leiomyosarcoma. ▪ The third complaint concerns a patient who was told that she had shadows on her lung which were detected following an x-ray. The patient has had numerous tests undertaken but without any diagnosis as yet, and is therefore unhappy with the amount of procedures performed without diagnosis.

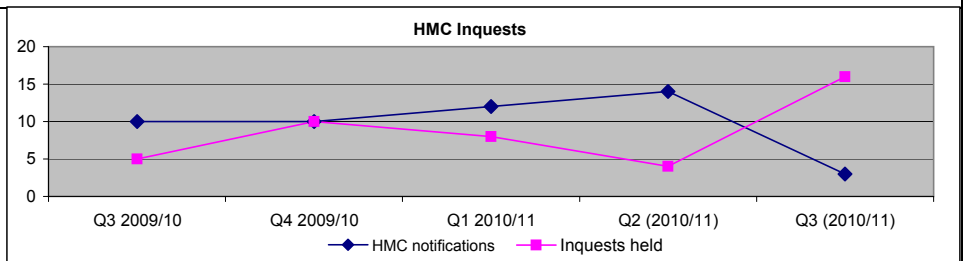
In November 2010 Division 2 had one complaint graded as amber. This complaint related to the attitude and decision making process of a consultant. The complainant wanted to know how the consultant can make such decisions without challenge even when confronted and questioned about his decision to discontinue monitoring the patient and her unborn child

**Actions:** October 2010: ▪ Apologies made to the family and patient for the unacceptable and undignified condition the patient was left in and for any distress caused. A formal letter is to be held on the staff members personal file with the reassurance given to the family that disciplinary action will follow if such an incident recurs. All nursing staff on EAU reminded about the need to follow the hospital policy for administering medication to patients, also that disciplinary action will be taken if it is not adhered to. ▪ The second complaint - letter sent to complainant advising that a firm of solicitors representing the deceased patient's family had already contacted the Trust, therefore no further action to be taken. ▪ November 2010: midwifery staff advised that they should challenge any doctor that they feel is making a wrong decision. It was also acknowledged that this can be difficult, but that the midwife can express their concerns to the senior midwife on duty.

## 2.6 Inquests

The purpose of the inquest is to determine how, when and where the deceased died. Her Majesty's Coroner (HMC) may give a narrative verdict or one of a number of standard verdicts. HMC may also make recommendations on the provision of care/treatment or service provided or, issue a Coroner's Rule 43 which allows him to report the findings to an individual or body who may have the power to prevent a similar death occurring in the future.

| | 2009/10 | 2010/11 | | |
|---|---|---|---|---|
| | Q4 | Q1 | Q2 | Q3 |
| HMC notifications | 10 | 12 | 14 | 3 |
| Inquests held | 10 | 8 | 4 | 16 |
| HMC Recommendations | 0 | 0 | 0 | 0 |
| % Recommendations per | 0 | 0 | 0 | 0 |




**Analysis:** 16 inquests were held and an abbreviation of the Coroner's verdicts is detailed as follows: pulmonary embolism, multi-organ failure, bronchopneumonia, pericarditis, septicaemia, natural causes x 4, naturally occurring morbidity, chemotherapy toxicity, myocardial infarction, cerebral haemorrhage, open verdict, cardiac arrest, renal hepatic and cardiac failure. It should be noted that this information is only part of the full verdict (except in cases of natural causes and open verdict) and care should be taken when considering this information.

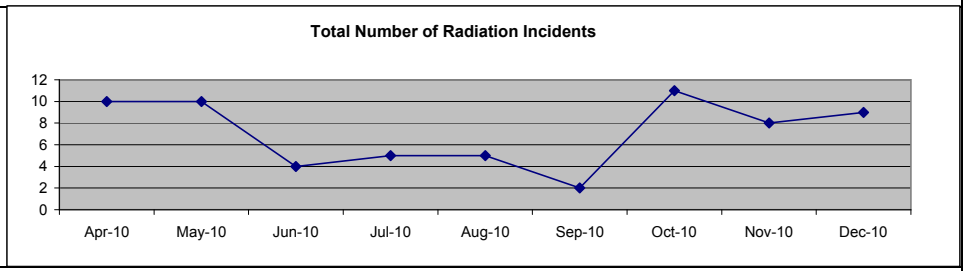
The Staffordshire Coroner issued a Coroners Rule 43 against the Trust following the conclusion of an inquest at which the Trust was not represented. The coroner's verdict was natural causes. At the hearing members of deceased's family raised issues regarding the minibus used transport the patient between New Cross Hospital and Cannock Chase Hospital being cold and on arrival he was chilled.

**Actions:** An investigation was undertaken by the Divisional Manager for Division 1 the outcome of which was that there were no problems or defects with the heating system on the vehicle or the saloon heater. There were also no problems recalled or logged by the crew about the journey. A response was sent by the CEO to the Coroner within the time frame set under Coroners Rule 43.

## 2.7 Radiation Incidents

All incidents involving radiation are reported on the Datix system following the Trusts Policies: HS05 Ionising Radiation Safety Policy and HS06 Laser Safety Policy. There is a legal requirement that incidents involving a greater than intended exposure or exposure of the incorrect patient are reported to the Care Quality Commission under the Ionising Radiation (Medical Exposures) Regulations 2000 and those involving equipment are reportable to the HSE under the Ionising Radiation Regulations 1999. The term 'greater than intended' is defined in HS05. All radiation incidents are reported to and discussed at the Trusts Radiation Safety Committee.

| Radiation Incidents | Oct-10 | Nov-10 | Dec-10 |
|---|---|---|---|
| Radiotherapy | 5 | 3 | 2 |
| Diagnostic Radiology | 6 | 5 | 7 |
| Nuclear Medicine | 0 | 0 | 0 |
| Laser/Non-ionising | 0 | 0 | 0 |




**Analysis:** ▪ Radiotherapy: There were 10 radiotherapy incidents, including 2 near misses. Review by the Radiation Safety Committee sub-group found that three of these incidents were due to procedures not being followed in full and the others due to human error. There was no harm to patients and none of the incidents were reportable under IR(ME)R to the Care Quality Commission. The incidents relate to 10 separate fractions of radiotherapy treatment. 7397 fractions of radiotherapy were delivered this quarter.

▪ Diagnostic Radiology: During this period 18 radiation incidents were reported on Datix. 1 of these incidents was reportable under IR(ME)R to the CQC as the patient received an additional exposure that was not required. It is thought that the incident arose from a patient referral letter being filed into the incorrect patient notes. During this period 51, 373 radiological examinations were performed in Radiology.

▪ Nuclear Medicine Physics: Although there were no incidents this quarter involving ionising radiation there were 2 incidents involving the production of the radiopharmaceuticals. The first involved a needle stick incident that required the recall of radiopharmaceuticals and a delay in multiple nuclear medicine procedures at multiple sites. This was reported to the MHRA. The second resulted in a delay to radiopharmaceutical production due to loss of pressure to the clean room.

**Actions:** ▪ Radiotherapy: A number of incidents this quarter involved Portal Imaging, it was agreed that a multidisciplinary meeting would be held within the department to discuss these issues.

▪ Diagnostic Radiology: Of the incidents reported this quarter a number were due to equipment issues which have now been resolved or are being dealt with. There were also a number of incidents involving the incorrect xray request forms, either incomplete information or incorrect patient details, one of which was reported externally to the CQC. In the next month a new electronic method of requesting radiological examinations is to be introduced, where it is hoped some of these issues will be addressed. The incidents with patient ID and the introduction of a new electronic request system also highlight that the Trusts Patient Identification Policy OP52 may need changing and that this would also need reviewing in light of the new patient tagging system due to be introduced into the Heart and Lung Centre within the next few months.

## 3) PREVENTING HARM, IMPROVING SAFETY MEASURES

**Introduction:**

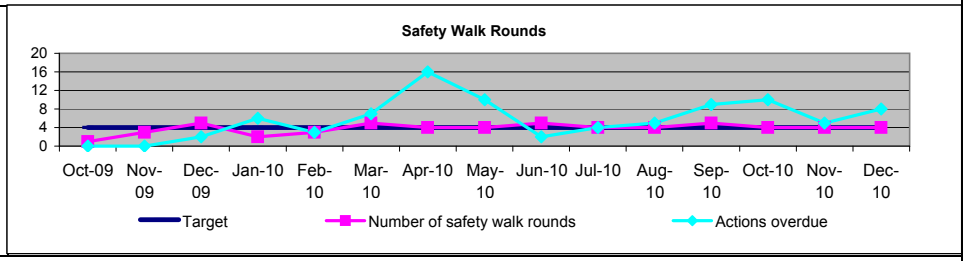
This section includes progress from the Preventing Harm, Improving Safety Group for the period Quarter 3 (October to December 2010). The overall aims of the Strategy for Preventing Harm, Improving Safety are to reduce our Hospital Standardised Mortality Ratio (HSMR) by 5 points per year over the next three years. In addition we aim to reduce the adverse event triggers by 50% (identified by undertaking monthly case note reviews using the Global Trigger Tool).

There are now eleven initiatives that will contribute towards achieving our aims: Leadership for Safety, Pressure Ulcers, Falls Prevention, Infection Prevention, Perioperative Care, Venous Thromboembolism, Critical Care Bundles, High Risk Medication, Deteriorating Patient, Think Glucose and Device Related Infections.
It is important to note that the monthly data provides internal measures for improvement rather than targets for achievement or for the purpose of benchmarking.

### 3.1 Leadership for Safety

The goal of this initiative is 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 through a learning and action orientated approach. We have undertaken safety culture assessment with the Trust Board members and each of the Divisional senior teams using the Manchester Patient Safety Framework. A patient safety culture survey of all staff was undertaken during June/July 2010; the findings will be reported next quarter. The measures refer to the safety walk rounds with the aim of undertaking four safety walk rounds per calendar month.

| | Oct-10 | Nov-10 | Dec-10 |
|---|---|---|---|
| Number of Safety Walk Rounds | 4 | 4 | 4 |
| Actions Agreed | 14 | 15 | 12 |
| Cumulative actions overdue completion at the end of the quarter | | | 18 |



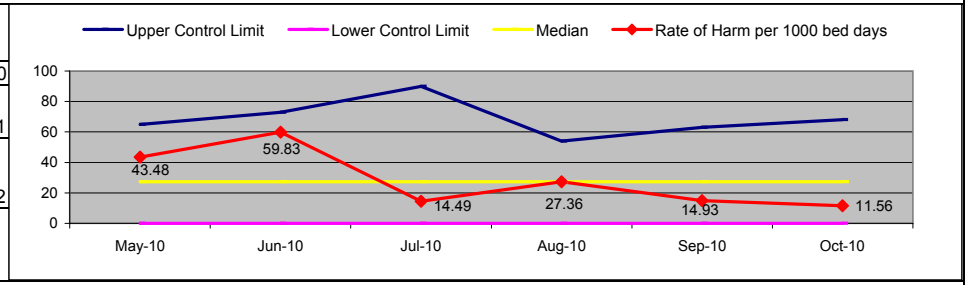

**Analysis:** Five safety walk rounds were planned for December 2010 however one was cancelled due to the executive being required off site at short notice. Overdue actions are related to a number of reasons e.g. staff having left the organisation, long term sickness or awaiting action by another party in order to complete the action.

**Actions:** Outstanding actions are being pursued, requesting regular updates and providing reminders when actions are about to become due.

## 3.2 Triggers and Harm Rate (Global Trigger Tool)

Traditional efforts to detect adverse events (AE is defined as 'any physical harm to the patient') have focused on voluntary reporting and tracking of errors. Research has established that only 10-20% of errors are reported and, of those 90-95% cause no harm to patients. The Global Trigger Tool (GTT) is an effective way of detecting harm to patients by completing a manual case note review of 20 case notes per month. Pre defined triggers are used to identify adverse events and assign a category of harm (scale Category E - contributed to temporary harm to Category I - contributed to patient's death). Over time a measure of the overall level of harm for the organisation can be established. The monthly measure will be displayed as a rate of harm per 1000 bed days (*number of adverse events/total number of days patients harmed were inpatients*1000).

| | May-10 | Jun-10 | Jul-10 | Aug-10 | Sep-10 | Oct-10 |
|---|---|---|---|---|---|---|
| Number of triggers | 30 | 12 | 3 | 12 | 10 | 11 |
| Number of adverse events | 9 | 7 | 1 | 9 | 3 | 2 |



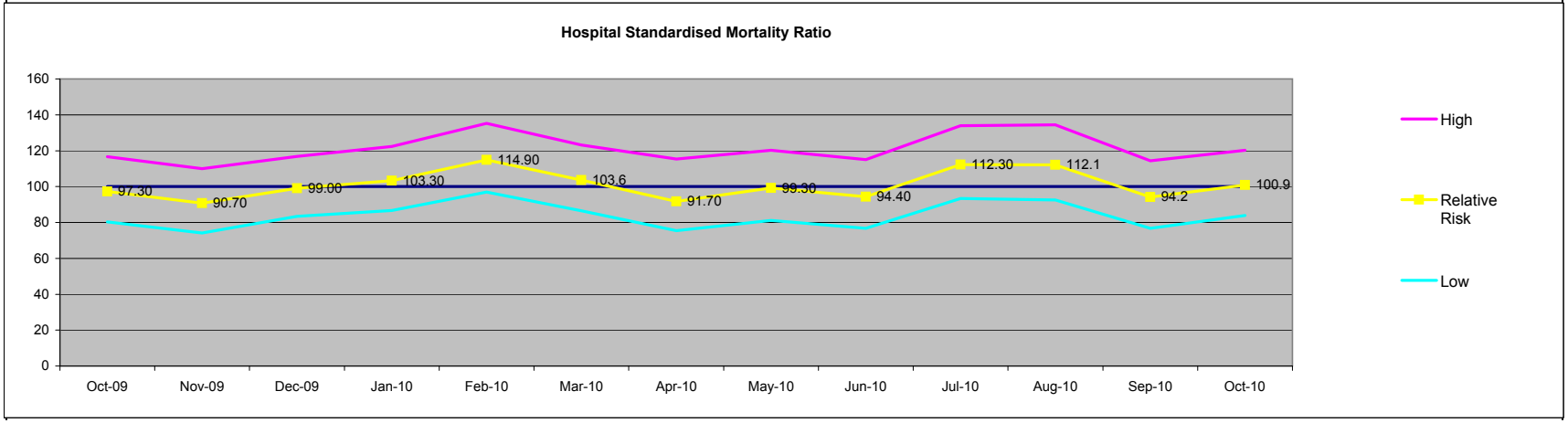

**Analysis:** Fortnightly case note reviews continue using the Global Trigger Tool. The data is based on the review of 86 case notes belonging to patients who were discharged during the months of May to October 2010.

- The approximate rate of harm over the last two month period is 13.5 events per 1000 bed days. This compares to about 36 for the previous quarter, which is considered to be fluctuation rather than real change.
- The most frequent triggers occur in the General Care and the Lab modules (as before)
- Less than half of the triggers convert to actual adverse events where patients are harmed (as before)
- Of the five identified adverse events, four contributed to or resulted in (only) temporary harm to the patients
- One adverse event contributed to or resulted in permanent patient harm
- No adverse event contributed to the patients death nor required Intensive care

**Actions:** The purpose of the GTT group is to establish a rate of harm, not to investigate harm. Where an adverse event is considered to have contributed to permanent patient harm or death the lead clinician of the GTT group has started to write to the consultant responsible for the patient's episode of care during which the adverse event took place so that further review can be undertaken, where necessary, and lessons learned.

## 3.3 Mortality

The Hospital Standardised Mortality Rate (HSMR) is an important indicator of the care provided. Figures shown are the monthly average and are the latest data available by Dr Foster.

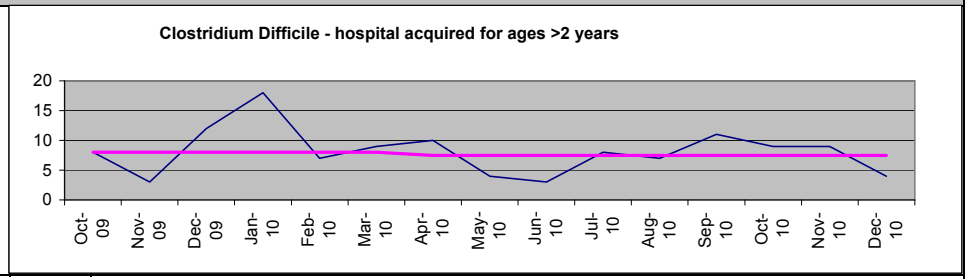


## 3.4 Healthcare Acquired Infections (HCAIs)

*Clostridium difficile* (C Diff) and Methicillin Resistant Staphylococcus aureus (MRSA) are an important indicator of infection prevention and control. The target for 20010/11, using the RWHT internal definition of attribution of cases, is less than 7.5 C Diff cases per month (< 90 per year) (2009-10 target was <8 per month) and less than 1 MRSA bacteraemia per quarter (< 4 per year attributable to RWHT).

### 3.4.1 Clostridium Difficile - hospital acquired for ages >2 years

| Number of C Diff Cases | Cum Plan | Cum Actual | Cum Variance |
|---|---|---|---|
| | 68 | 65 | -3 |

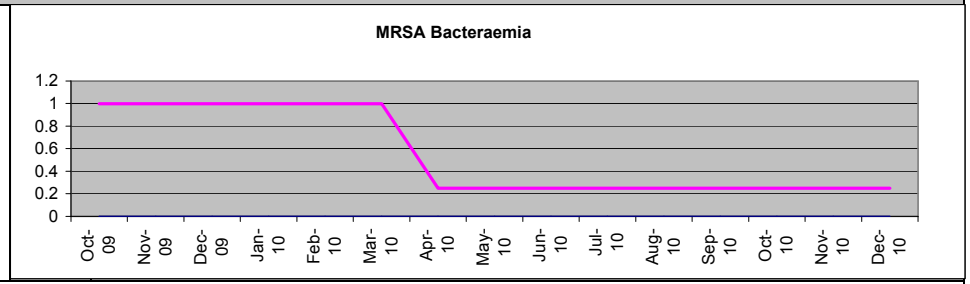



**Analysis:** 22 cases in the quarter using the Trust's internal definition of attribution, which takes into account recent discharge from the Trust. This is just within the target of 21.5 cases per quarter this year. Against the external Trust target there were 17 cases in the quarter; the target for this period was 26 and the stretch target 19.

**Actions:** A *C. difficile* Action Plan is in place. A key component of this is the routine use of high-level environmental disinfection using hydrogen peroxide vapour. This service has been started at the beginning of January 2011.

### 3.4.2 MRSA Bacteraemia

| Number of MRSA Cases | Cum Plan | Cum Actual | Cum Variance |
|---|---|---|---|
| | 3 | 0 | -3 |
| | | | |



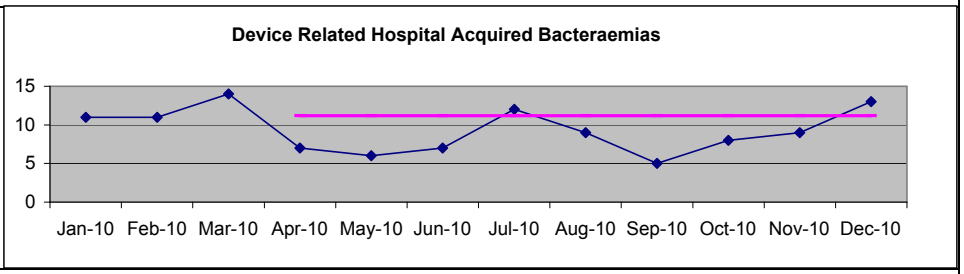

**Analysis:** No RWHT-attributable cases for 17 consecutive months.

**Actions:** Infection prevention education and audits, MRSA screening and other actions developed over the past four years to continue.

## 3.4.3 Device Related Hospitals Acquired Infections

The aim of this initiative is to reduce device related hospital acquired bacteraemias by 10% from June 2010 by June 2011. The current internal target is 11.2 per month.

| | Oct-10 | Nov-10 | Dec-10 |
|---|---|---|---|
| Target | 11.2 | 11.2 | 11.2 |
| DRHABS | 8 | 9 | 13 |




**Analysis:** During the quarter there were a total of 20 central line bacteraemias, 7 bacteraemias associated with urinary catheters and 3 with other devices such as biliary/nephrostomy stents. These occurred mainly in the renal and oncology specialties.

**Actions:** The various policies regarding central lines have now been standardised and are awaiting approval at the end of January 2011. The neonatal unit will be joining the ICCU in the Matching Michigan project, which aims to reduce central line infections. The central line database has been developed and is to be loaded onto the clinical web portal so that ICCU can start using it.
Urinary catheters - equipment is being standardised, a urinary catheter database is under development and there will be an education drive during the planned focus month on devices (March 2011).

## 3.5 Critical Care Bundles

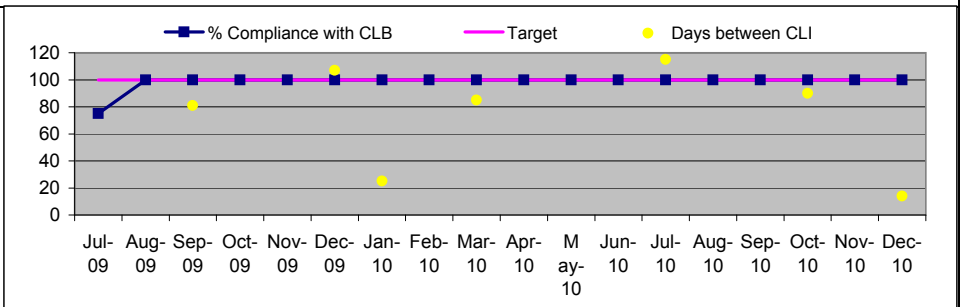
The aim of this initiative is to improve the care of patients receiving critical care through the reliable application of care bundles. Each care bundle has a number of components which together have been proven to significantly reduce ventilator acquired pneumonias and central line infections.

## 3.5.1 Central Line Infections (Integrated Critical Care Unit)

Bloodstream infections associated with central venous catheter insertion are a major cause of morbidity. The central line bundle includes five components which, when applied together consistently, can reduce the occurrence of central line infections: hand hygiene, maximal barrier precautions, chlorhexidine 2% skin antisepsis, optimal catheter site and daily review of line with prompt removal of unnecessary lines.

| | Oct-10 | Nov-10 | Dec-10 |
|---|---|---|---|
| % Compliance with CLB | 100 | 100 | 100 |

| | | | |
|---|---|---|---|
| Patient line days | 441 | 409 | 465 |
| Days between CLI | 90 | | 14 |
| Cumulative CLI (since 01.07.09) | | | 8 |
| Matching Michigan Rate per 1000 line days(cumulative from 1st December 2009) | | | Not available |



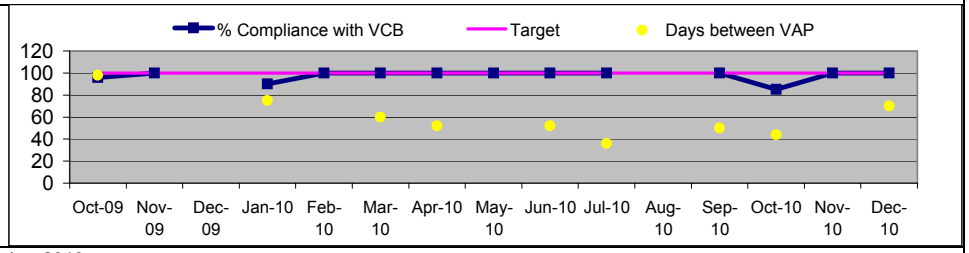

**Analysis:** There were 3 central line infections during the quarter - 6 October 2010 was a catheter suspected blood stream infection as there was an infected CVC tip. In December there were 2 suspected central line infections however the VAP group have yet to meet to confirm this diagnosis.

**Actions:** VAP group due to meet at the end of January 2011. Actions include increased focus on catheter insertion site inspections.

## 3.5.2 Ventilator Acquired Pneumonias

Respiratory infections are the fourth largest contributor to hospital acquired infection in the UK. Ventilator acquired pneumonia (VAP) is a significant cause of morbidity and mortality in critically ill and postoperative patients receiving mechanical ventilation. The ventilator care bundle consists of four main components which, when applied together consistently, can prevent VAPs: elevation of the head of the bed to between 30 - 45 degrees, daily sedative interruption, peptic ulcer prophylaxis, and venous thromboembolism (VTE) prophylaxis (unless contraindicated). A fifth component has been added to include chlorhexidine oral care.

| | Oct-10 | Nov-10 | Dec-10 |
|---|---|---|---|
| % Compliance with VCB | 85 | 100 | 100 |
| Ventilated Days | 434 | 405 | 435 |
| Days between VAP | 44 | | 70* |
| Cumulative VAP (since 01.07.09) | 9 | 9 | 9 |



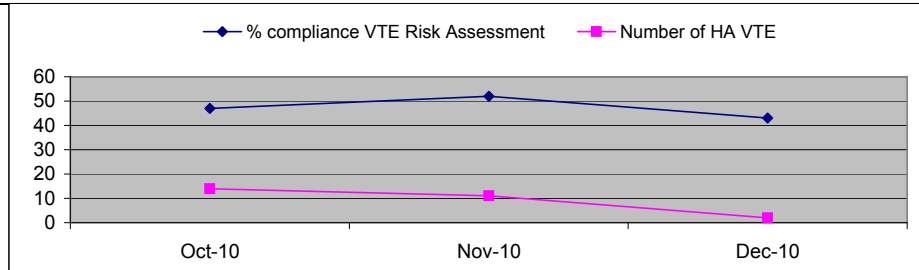

**Analysis:** *denotes ongoing after the end of the quarter as the last VAP was the 26 October 2010.

**Actions:** The reduction in the compliance with the care bundle was related to inadequate head of bed elevation - this has since improved. There appears to be a link with the VAPs and leaking around the tracheostomy tube cuff therefore there has been a focus on adequate cuff inflation and prompt changing of tracheostomy tubes where indicated.

## 3.6 Venous Thrombo Embolism

Venous thromboembolism (VTE) is one of the commonest causes of avoidable death in hospitals. There is a national VTE risk assessment and prevention pathway, which has been developed by the Department of Health following NICE Guidance released in January 2010. Compliance with VTE risk assessment is a CQUIN requirement, set at 90%. This is one of 7 key NICE standards for VTE prevention that the Trust is aiming to reach.

| | Oct-10 | Nov-10 | Dec-10 |
|---|---|---|---|
| % adult patients with completed VTE risk assessment | 47% (8 inpatient areas audited | 52% (10 inpatient areas audited | 43% (5 inpatient areas audited |
| Number of patients with hospital acquired VTE | 14 | 11 | 2 |



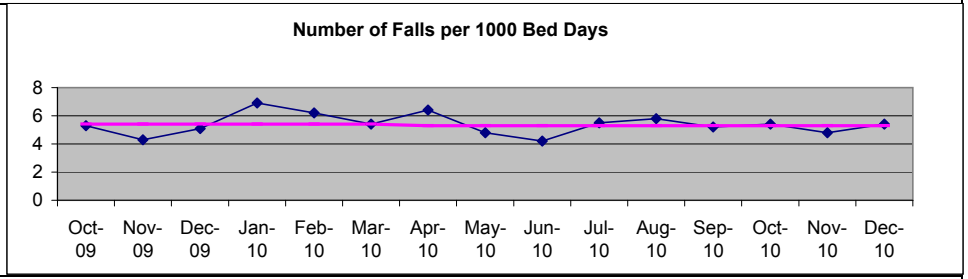

**Analysis:** The audit data relates to targeted audits of inpatient areas with compliance of the paper risk assessment tool by the VTE nurses. From January 2010 collection of Trust wide data has commenced using VitalPAC. The VTE team is collating data on the number of hospital acquired and Community acquired VTE.

**Actions:** Electronic risk assessment via Vital PAC has been rolled out to all inpatient areas and its implementation has been supported by the VTE nurses and VitalPAC team. Electronic capture of Maternity data is being captured by the Euroking system. Following the embedding of the electronic capture process the VTE team will publish monthly compliance league tables. The governance process regarding hospital acquired VTE has been formalised and cascaded to the directorate teams with the responsibility of the performance of RCA's for all identified hospital acquired VTE being placed with the Consultant.

## 3.7 Patient Falls

The proportion of reported patient falls in hospital represents avoidable episodes of harm to patients. Monitoring this aspect of clinical care will act as a proxy measure of patient safety. Measurements are at a rate of falls per 1000 Occupied Bed Days.

| Target | Oct-10 | Nov-10 | Dec-10 |
|---|---|---|---|
| <5.3 | 5.4 | 4.8 | 5.4 |



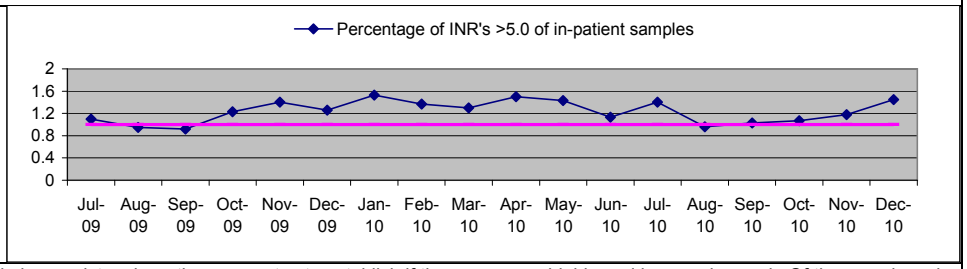

**Analysis:** During November 2010 a falls awareness initiative took place, which appears to have some impact across both Divisions but not consistently across all areas. Significant improvement were seen on D7 (now D22), D8 and ESS. Falls competencies were rolled out to all nursing staff during this time and continue to be assessed. The Falls Prevention Policy has been updated and is currently going through the approval process.

**Actions:** Falls education continues to be provided at nurse induction and a further monthly focus will be rescheduled after it was postponed in November.

## 3.8 High Risk Medicines

High risk medicines include anticoagulants, injectable sedatives, opiates and insulin and are more likely to cause significant harm to patients than other medicines. The Institute for Safe Medication Practices reports that incident rates with this group of medicines may not necessarily be higher than with other medicines, but when incidents occur the impact on the patient can be serious. The aim of this initiative is to prevent harm from these high risk medicines and will involve working with other initiatives such as DVT and Think Glucose. Initially the High Risk Medicines Group are focusing on Warfarin and have started collecting data on the percentage of INRs above 5 (where the risk of bleeding is raised) in order to establish a baseline for improvement.

| | Oct-10 | Nov-10 | Dec-10 |
|---|---|---|---|
| In-patient INRs tested | 5500 | 5592 | 5100 |
| Number of events (INR's >5.0) | 59 | 66 | 74 |
| % INRs >5.0 of inpatient samples | 1.07 | 1.18 | 1.45 |



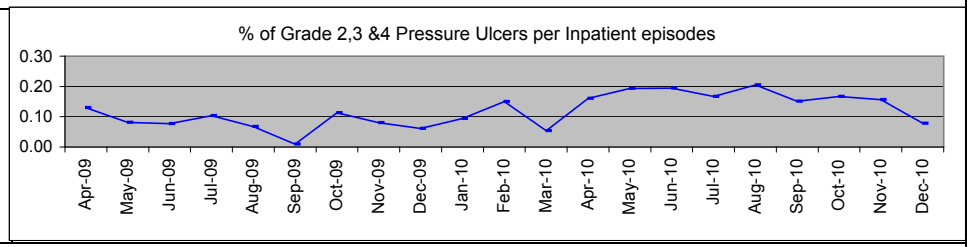

**Analysis:** During the quarter there were 12 patients with an INR greater than 8. The lead pharmacist reviews the case notes to establish if these were avoidable and lessons learned. Of those reviewed so far none have been deemed avoidable. An audit on all INRs greater than 5 was completed by a junior doctor for one month ending mid December. None of the INRs greater than 5 were considered avoidable as patients had multiple illnesses or were admitted with high INRs which were being treated appropriately. Doses were appropriately adjusted and omitted.

**Actions:** Continue review of INRs greater than 8.

## 3.9 Pressure Ulcers

Pressure Ulcers are commonly encountered and represent largely avoidable episodes of harm to patients. All hospital acquired pressure ulcers are reported and the number of pressure ulcers by grades 2,3 & 4 are represented below as a percentage of inpatient episodes.

| | Oct-10 | Nov-10 | Dec-10 |
|---|---|---|---|
| Grade 2 | 21 | 20 | 10 |
| Grade 3 | 0 | 0 | 0 |
| Grade 4 | 0 | 0 | 0 |
| Total | 21 | 20 | 10 |
| % Inpatient Episodes | 0.17 | 0.16 | 0.08 |



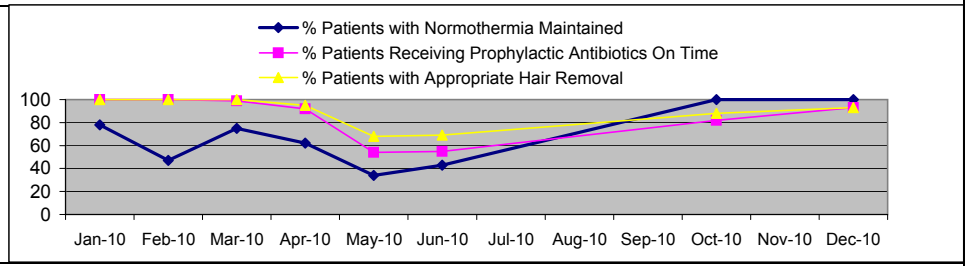

**Analysis:** The Number of grade 2 ulcers has decreased from last quarter. No grade 3 or 4 ulcers were reported

**Actions:** Weekly monitoring of reports continues. Figure show that reporting has improved and incidence is starting to reduce. A further documentation audit will be done in Q4

## 3.10 Perioperative Care

The aim of this work stream is to improve care for adult patients undergoing elective surgical procedures in the hospital setting. There are two main elements: introduction of the surgical safety checklist and the reduction of surgical site infections. Measures include: Percentage of patients receiving antibiotics on time, Percentage of patients with hair removal by the recommended method, Percentage of known diabetic elective surgical patients with controlled serum glucose (5-10mmol/l) on the day of surgery and Percentage of patients whose first post operative temperature was >36C

| | Oct-10 | Dec-10 |
|---|---|---|
| Percentage Patients with Normothermia Maintained | 100% | 100% |
| Percentage Patients Receiving Prophylactic Antibiotics On Time | 82.40% | 93% |
| Percentage Patients with Appropriate Hair Removal | 88.30% | 92.90% |



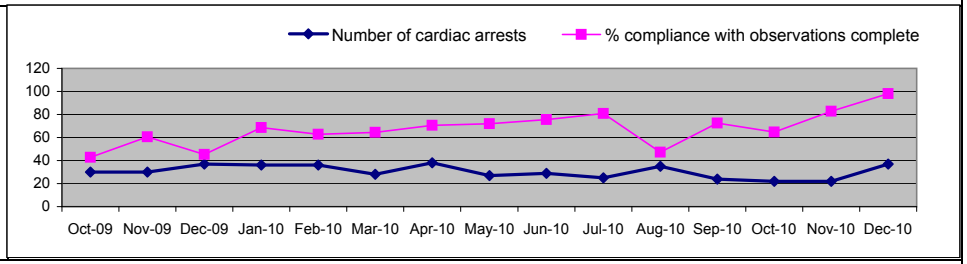

**Analysis:** The surgical safety checklist is now being used in all theatres. The checklist is no longer used as a record instead the key elements have been incorporated in the perioperative care document and the checklist is used as a prompt to confirm the responses to each stage of the process e.g. sign in, time out and sign out.

**Actions:** Observational audits have been completed and continue. The regional event was postponed due to inclement weather and will be rescheduled - the aim of the event is to increase clinician involvement in the surgical safety checklist both locally and across the region.

## 3.11 Recognition of the Deteriorating Patient

The aim is to reduce in-hospital cardiac arrest and mortality rate through earlier recognition and treatment of the deteriorating patient. This involves a review of how physiological observations are recorded and acted upon by staff, ensuring that staff are trained to undertake these procedures and understand their clinical relevance. In conjunction with this is the review of the use of the Modified Early Warning Score system and communication of the deteriorating acutely ill adult patient. Measures include: Percentage of patient observation charts fully completed as indicated, Number of calls to the critical care outreach team, and Number of cardiac arrest or crash calls.

| | Oct-10 | Nov-10 | Dec-10 |
|---|---|---|---|
| Number cardiac arrests | 22 | 22 | 37 |
| % compliance observations completed | 64.6 | 82.9 | *98.0 |




**Analysis:** The percentage of compliance with observations completed has been reported by the wards based on a review of 5 observation charts per week. During the quarter VitalPAC has been rolled out to medical and surgical wards therefore the data for *December has been retrieved from the VitalPAC Performance module. The data is based on completion of a full set of standard observations, which is used to calculate the early warning score. Reasons for incomplete observations are required by VitalPAC and these include: unrecordable due to lack of equipment, patient condition, or patient refused.

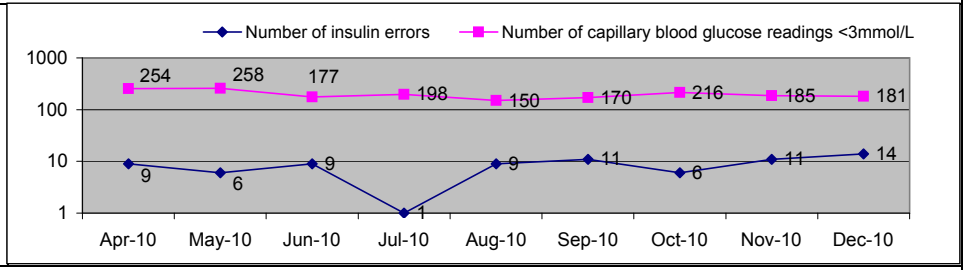
**Actions:** The Critical Care Outreach Team are using VitalPAC to contact wards and review patients whose early warning score is increasing or giving cause for concern. Ward sisters, Matrons and Heads of Nursing are due to receive training on the use of VitalPAC Performance during February 2011 so that they can review the data and target areas for improvement as required.

## 3.12 Think Glucose

Diabetes is a major clinical and economic issue for acute trusts. Think Glucose has been developed by the NHS Institute for Innovation & Improvement to provide a package of tried and tested products, learning and support to improve awareness and remove obstacles to the treatment of patients with diabetes as a secondary diagnosis. It aims to reduce insulin drug errors, prevent inappropriate referrals to specialist diabetes teams and reduce length of stay in diabetic patients admitted for reasons other than their diabetes.

| | Oct-10 | Nov-10 | Dec-10 |
|---|---|---|---|
| Number of insulin errors | 6 | 11 | 14 |
| Number of capillary blood glucose readings <3mmol/L* | 216 | 185 | 181 |

*Data collected on number of blood glucose recordings from finger prick samples on COBAS IT less than 3 mmol/l excluding repeat low BG within 30 minutes of the first (considered same hypo) and neonates.




**Analysis:** Reporting of incidents continue to be encouraged and are reviewed by the clinical lead for Think Glucose.

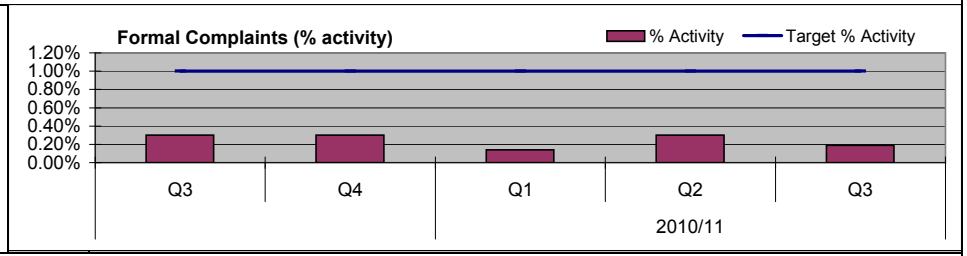
**Actions:** A diabetes e-learning package and safe use of insulin package have been developed and is available on the Intranet. Ward based training is being conducted by the diabetes outreach team nurses. Best start training has also commenced. An information resource including guidelines, protocols, procedures and clinical information is now available in one place on the intranet under TG logo. A new diabetes monitoring chart has also been distributed.

## 4) PATIENT EXPERIENCE

### 4.1 Formal complaints

The following numbers are based on the number of formal complaints received during the quarter. There is no national target in relation to the number of complaints received as the Trust welcomes all feedback as this helps us to continually improve the services we provide. However there is an expectation that the number of complaints received is less than 1% of the activity for the Trust. The percentage of complaints based on the number of inpatient spells is shown in the graph below.

| Q3 09/10 | Q3 10/11 | Target |
|---|---|---|
| 0.30% | 0.19% | 1.00% |




**Analysis:** 64 complaints received in Q3 for 10/11 which equates to 0.19% of the Trust's activity; this compares to 105 in the same quarter for 09/10.

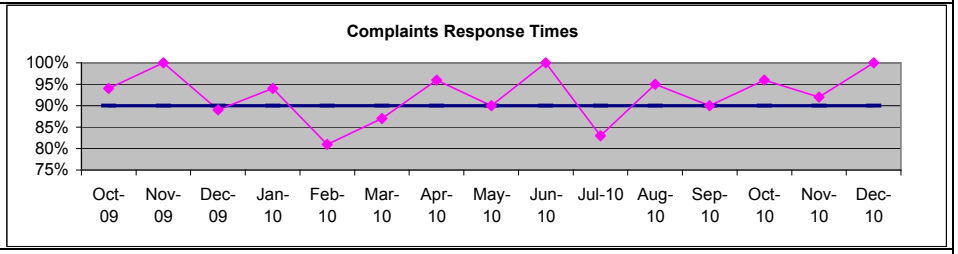
**Action:**

### 4.2 Management of Complaints

### 4.2.1 Complaints resolved within 25 days

The Trust aims to provide first class responses to greater than 90% of all complaints within 25 working days.

| Oct-10 | Nov-10 | Dec-10 | Target |
|---|---|---|---|
| 96% | 92% | 100% | 90% |

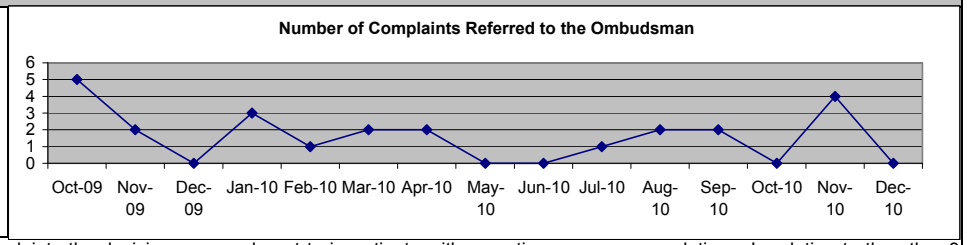



**Analysis:** Due to timescales for responding to complaints the December figure is only partially complete. The Trust has consistently achieved its target for responding to complaints in this quarter.

**Action:**

| 4.3 | **Ombudsman** |
|---|---|

| | Q1 | Q2 | Q3 | |
|---|---|---|---|---|
| 2009/10 | 9 | 7 | 7 | |
| 2010/11 | 2 | 5 | 4 | |




**Analysis:** In Q3 the PHSO closed 4 complaints. With regard to one of the closed complaints the decision was made not to investigate with no actions or recommendations. In relation to the other 3 complaints the PHSO considered these to be premature referrals and have referred the complaints back to the Trust for local resolution. No complaints were referred in October or December, with 4 complaints being referred to the PHSO in November 2010 . Of these 4 complaints 1 has been referred back to the Trust for local resolution as it was considered to be a premature referral. With regards to the remaining 3 complaints the appropriate records and additional information have been provided to the PHSO and we await their comments.

**Actions:** Trust to respond to additional concerns raised by complainants within the usual timescales.

| 4.4 | **Vexatious Complaints** |
|---|---|

Details regarding vexatious complaints will be reported by exception.

**Analysis:** The rolling 12 months indicates no vexatious complainants

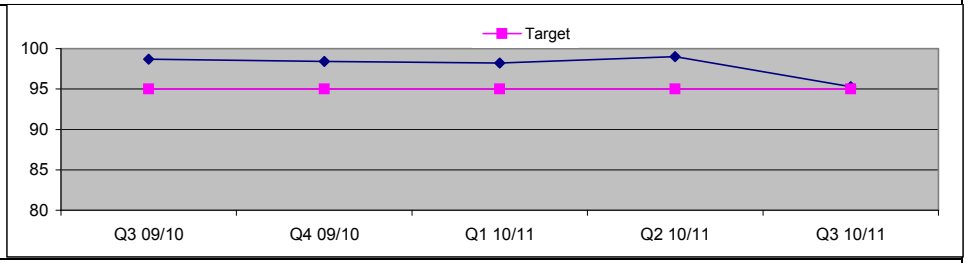
**Actions:** No actions to report

## 5) PATIENT SAFETY AND QUALITY

### 5.1 Hand Hygiene Practice

Consistent hand hygiene is key to high quality infection prevention practice. Quarterly audits measure compliance with hand hygiene standards. The Trust has set a target of 95%.

| | 2009/10 | 2010/11 | | |
|---|---|---|---|---|
| Target | Q4 | Q1 | Q2 | Q3 |
| 95% | 98.4 | 98.2 | 99 | 95.3 |



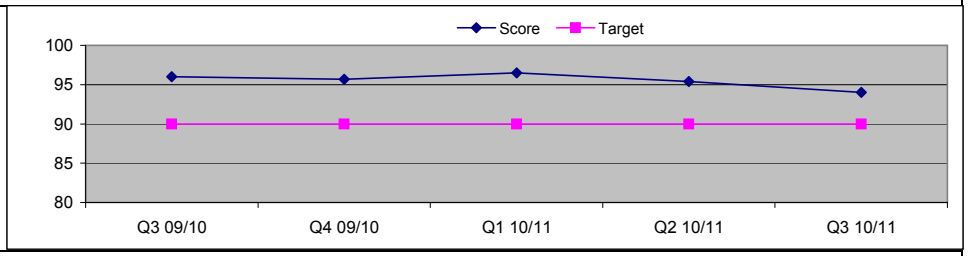

**Analysis:** There were 4 main areas of non compliance. Some sinks, especially in outpatient settings are not HBN 95 compliant; alcohol gel at entrance to some wards were empty at time of audit; medical staff were not always bare below elbow and were wearing jewellery; and the fourth non compliance was that hand cream was not always available.

**Action:** As areas are planned to be refurbished all non compliant sinks will be replaced. Wards where alcohol gel was empty, action taken to correct at time of audit. Medical staff continue to be challenged by Senior Nurses to ensure compliance with bare below the elbow. Hand cream has been ordered by those wards where it was missing.

### 5.2 Environmental standards

Cleanliness and tidiness of the environment is an important quality marker and valued highly by patients and the public. Quarterly audits measure compliance with stringent environmental standards. The Trust has set a target of 90%.

| | 2009/10 | 2010/11 | | |
|---|---|---|---|---|
| Target | Q4 | Q1 | Q2 | Q3 |
| 90% | 95.7 | 96.5 | 95.4 | 94 |



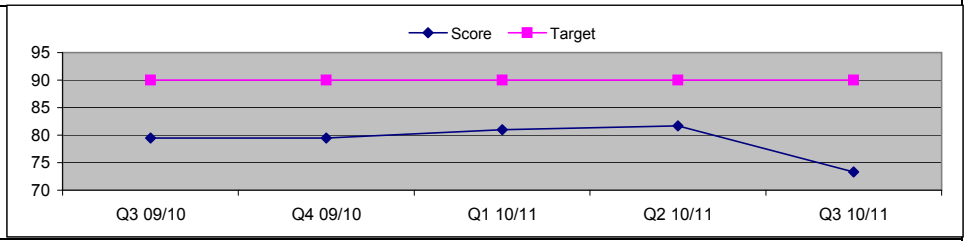

**Analysis:** There were three main areas non compliance, one particular area was in Nucleus theatres, this was caused by theatre work which was ongoing. High and low surface dust and some shelves were dusty in five areas. Cleanliness of window blinds in three areas.

**Action**: Theatre maintenance work in process, future work is planned. Cleaning schedules revised to address cleanliness of blinds. Areas of high and low dust were addressed at time of audit with hotel services supervisors.

**5.3 Essence of Care standards**

Essence of Care audits are conducted quarterly to measure compliance against a small number of key standards embracing privacy & dignity, communication, nutrition, personal hygiene, mental health and continence. The Trust has set a target of 90%.

| | 2009/10 | 2010/11 | | |
|---|---|---|---|---|
| Target | Q4 | Q1 | Q2 | Q3 |
| 90% | 79.5 | 81 | 81.7 | 73.3 |




**Analysis:** Two main areas of non compliance were lack of staff trained in relation to the Mental Capacity Act and learning disabilities.

**Action:** Learning Disabilities Specialist Nurse commenced on the 10th January 2011, she will review training opportunities and look to establish multi media training. Availability and uptake of mental disability training is being evaluated.

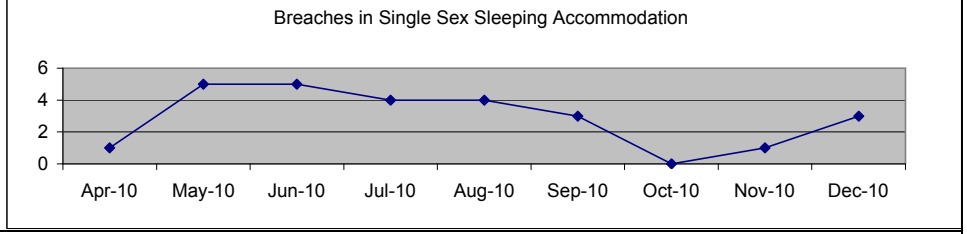
**5.4 Single sex accommodation**

Patients want care delivered in single sex accommodation. The vast majority of our clinical areas have declared themselves compliant against Department of Health standards for single sex accommodation. A small number of areas are not currently compliant, these include: Deanesly Ward, EAU, Renal Unit and Endoscopy all of which are waiting for building work. Additionally, it is known that ICCU, while making every attempt to segregate men and women, will be unable to achieve this consistently for clinical reasons. The measure below includes the number of incidents in those areas that have declared themselves compliant. We will measure incidents of mixed sex sleeping accommodation and incidents where patients have had to walk past members of the opposite sex to access toilets and washing facilities.

Single Sex Sleeping Accommodation

| | Oct-10 | Nov-10 | Dec-10 |
|---|---|---|---|
| Target | 0 | 0 | 0 |
| Number of incidents | 0 | 1 | 3 |

Definition of Single sex incident: A patient located in a bay with patients of the opposite sex is defined as one incident (e.g in a six bedded bay, 1 incident not 6 incidents)



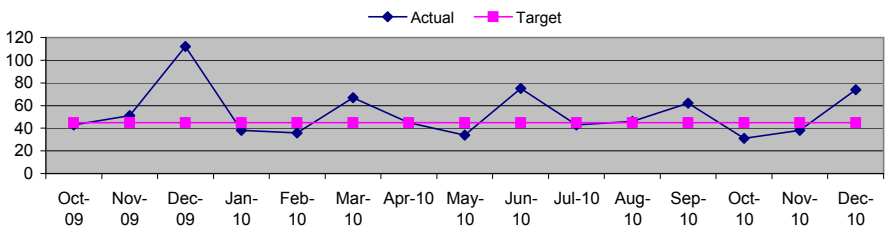

**Analysis**: All incidents in the Quarter occurred in the ICCU and all were clinically justified based on the needs of the patient.

**Action:** Ongoing monitoring by matrons of all areas.

**5.5 Nursing & Midwifery staffing levels**

Nursing staffing levels impact on the safety and quality of patient care. The wards and departments within the Trust have agreed normal staffing levels. Deviations from normal staffing levels that impact on the safety or quality of patient care are reported as incidents. The target is 45 incidents per month based on an average number of 50 incidents per month in 08/09.

| Target | Oct-10 | Nov-10 | Dec-10 |
|---|---|---|---|
| 45 | 31 | 38 | 74 |



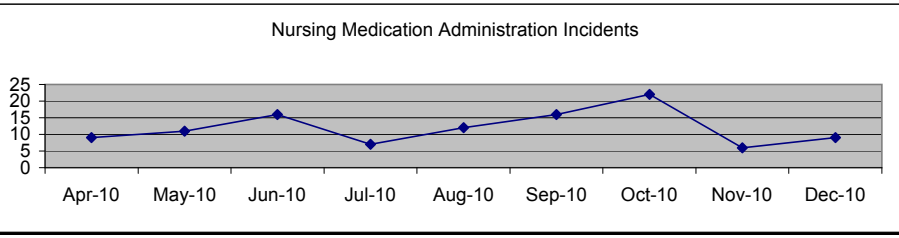

**Analysis:** October of the 31 incidents reported 20 were in Division 2, 5 maternity and 6 in Division 1 . November 20 were in Division 2 , 5 in Maternity and 13 in Division 1. December 57 were in Division 2, 1 in maternity and 16 in Division 1. In December the winter wards and additional capacity opened in surgery accounts for the increase in staffing incidents. No patient harm occurred as a result of this deficit.

**Action:** All incidents were investigated by the matron of the area and immediate action taken based on risk assessment.

**5.6 Medication administration incidents**

Medication incidents cover a wide range of events involving the prescription, administration and provision of medicines to take home. These incidents have the potential to harm patients and therefore all reported incidents are investigated. The indicator set for medication incidents is concentrating on nursing administration errors resulting in low, moderate & high levels of harm or causing death.

| | Target | Oct-10 | Nov-10 | Dec-10 |
|---|---|---|---|---|
| Div 1 | 0 | 13 | 4 | 7 |
| Div 2 | 0 | 9 | 2 | 2 |
| Total | 0 | 22 | 6 | 9 |




**Analysis:** These incidents were a mixture of incorrect dose allergy box, non completion and no signature on treatment sheet.

**Actions:** All incidents were investigated and action taken in accordance with Trust policies.