Agenda Item No:

THE ROYAL WOLVERHAMPTON HOSPITALS NHS TRUST

Report to:	Trust Board
Date:	23 May 2011
Subject:	Quality & Safety Report
Report by:	Director of Nursing & Midwifery
Author:	Patient Safety Manager
Purpose of Report	To provide the Trust Board with information regarding performance and progress with Trust quality and safety.

Report

The report relates to Quarter 4 (1 January to 31 March 2011) 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.

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 4 (1 January to 31 March 2011)

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 Committee 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:

- Increase in serious incidents related to ward closures due to diarrhoea and notification of Grade 3 and 4 pressure ulcers
- Increase in C Difficile related to increased sensitivity of new test
- Poor compliance with completion of VTE risk assessments
- Decrease in complaints response times
- Increase in falls

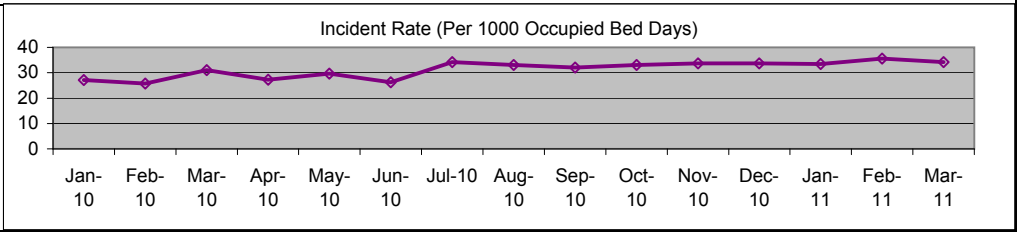
- No MRSA bacteraemias
- DRHABS 20% reduction against annual target
- 158 days since a central line infection in the ICCU
- Decrease in insulin errors

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.

	Jan-11	Feb-11	Mar-11
Div 1	240	213	286
Div2	465	431	469
Total	705	644	755
Per 1000obd	**33.4**	**35.6**	**34.2**



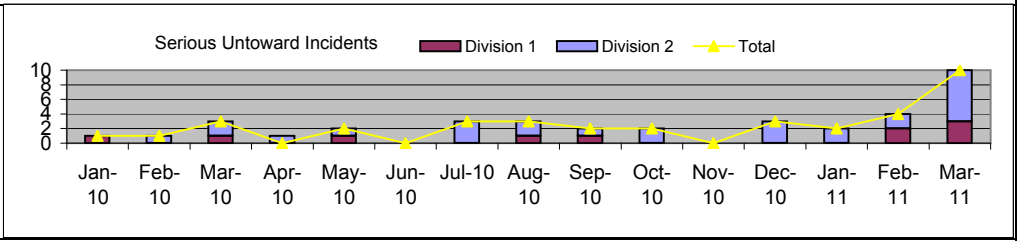
Analysis: The number of incidents reported during Q4 (Jan - Mar 11) has increased by 0.6% from the previous quarter. The majority of incidents are reported by nursing and midwifery staff and the largest category of incidents is patient falls (further information on patient falls in section 3.7).

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.

	Jan-11	Feb-11	Mar-11
Div 1	0	2	3
Div2	2	2	7
Corp	0	0	0
Total	2	4	10



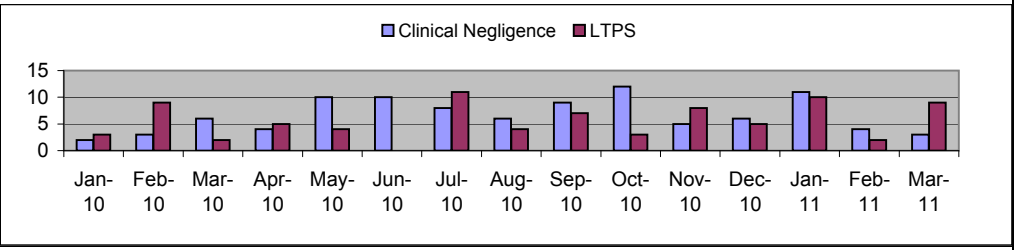
Analysis: SUI's reported in this period include incidents of diarrhoea affecting both staff and patients (D8), very small notebook lost that contained patient stickers and was lost within hospital grounds (Critical Care), alleged physical assault to a patient during surgery (Cardiac), Ward D20 closed due to diarrhoea & vomiting, Cardiology ward closed due to patients with diarrhoea and vomiting, delivery of a stillborn, throat pack not immediately removed post procedure (Critical care), Post partum haemorrhage > 1000mls, Stillbirth / Intra Uterine Death > 24 weeks, Ward D19 and D21 patients suspected of having Norovirus symptoms, patient found on floor fell on her way back from toilet deteriorated in evening urgent CT identified large subdural bleed, Grade 3 pressure ulcers (2 x Respiratory, 1 x Critical Care) and a Grade 4 Pressure Ulcer (MAU).

Actions: Diarrhoea affecting both staff and patients (D8) - daily meetings held with team, Infection Prevention & directorate, visiting hours restricted screens in place RCA commenced, visiting hours restricted, screens in place, Matron completed RCA. • Notebook lost - reported to head of department and searched extensively for book. • Physical Assault - Staff member excluded pending investigation and patient checked for any signs of physical injury (none noted). • Ward D20 closure - regular outbreak meetings being held. SHA and HPA informed. • Cardiology ward closure - outbreak meeting called all relevant actions implemented. IP advice followed regarding outbreak all measures to prevent spread of infection taken. • Delivery of Stillborn - This case was assigned CESDI 1 - sub-optimal care but different management would have made no difference to the outcome (in view of the length of second stage). • Throat pack - Action plan formulated which includes all staff receiving NPSA NRLS throat pack flow chart on their March payslip. • Post partum haemorrhage > 1000mls - case was felt to have been managed well. All measures were appropriately taken before the decision was made to proceed to a hysterectomy. • Stillbirth / Intra Uterine Death > 24 weeks - assigned as CESDI 1–sub-optimal care but different management would have made no difference to the outcome. • Ward D19 and D21 closure - Bays closed as directed. • Patient fall - patient assisted back to chair. Observations recorded GCS 15/15, doctor asked to review advised to observe patient, discussed with QE hospital not for intervention outcome described to family as critical unlikely to survive. Respiratory pressure ulcer 1 - RCA underway - Improved communication at handover required with regard to wound management. Need to use Thompson chart. • Respiratory pressure ulcer 2 - RCA underway, discussed with staff and reviewed paper work • Critical Care pressure ulcer - RCA completed - 2 bariatric beds purchased and staff trained in use. Need high specification of mattress for critically ill patients. • MAU Grade 4 pressure ulcer - RCA underway - Staff educated on pressure care and wound care bundle.

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.

	Jan-11	Feb-11	Mar-11
Clinical Negligence	11	4	3
LTPS	10	2	9
Total New	21	6	12



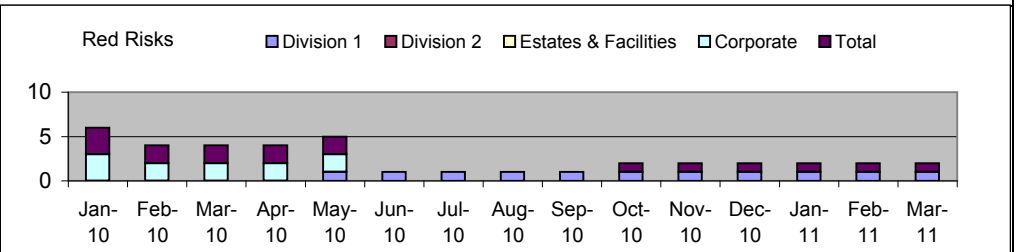
Analysis: Clinical negligence claims received during this period relate to treatment, diagnosis, nursing care, failure to refer, follow up appointments. LTPS claims relate to slip, trips and falls, needle stick, equipment injury, manual handling and other - e.g. buffer machine went out of control, chair collapsed, fell in a manhole

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.

	Jan-11	Feb-11	Mar-11
Div 1	1	1	1
Div2	0	0	0
Estates & Fac	0	0	0
Corporate	0	0	0
Total	1	1	1



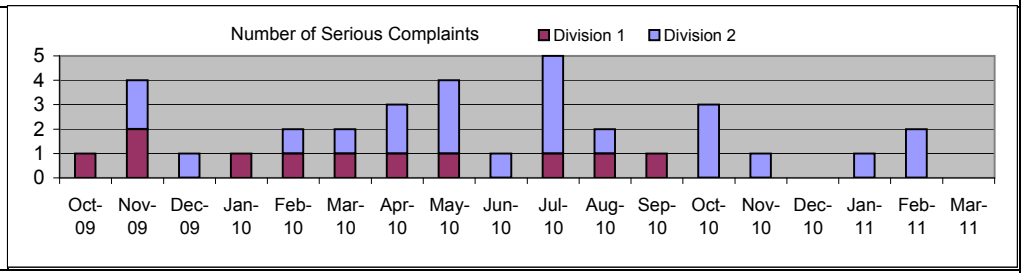
Analysis: There is one red risk within Division 1 - There is no routine reporting of plain x-ray films instead reporting of these films relies on the referring clinician evaluating the plain x-ray film. This risk is held at both Directorate and Divisional level.

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.

	Jan-11	Feb-11	Mar-11
Div 1	0	0	0
Div2	1	2	0
Total	1	2	0



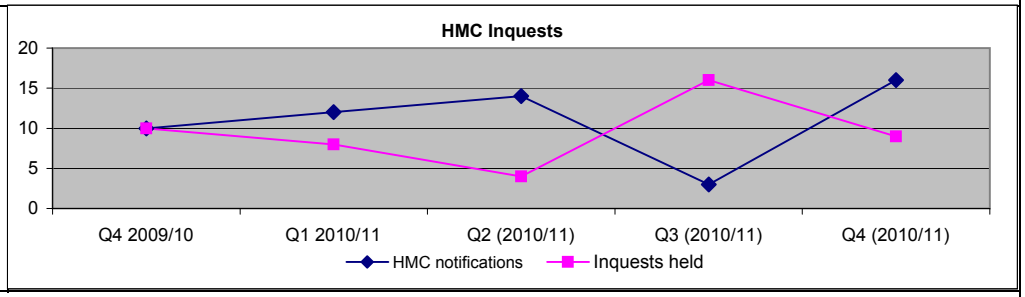
Analysis: Division 2 received one complaint graded amber in January 2011. The complaint relates to communication problems between teams and with the patient regarding the ongoing care of the patient's plaster cast. During February 2011 Division 2 had two complaints that were graded as amber. ▪ The first complaint concerned a patient who collapsed and died in a waiting area whilst awaiting an ECG ▪ The second complaint related to a patient who developed a pressure ulcer whilst an inpatient.

Actions: January 2011:An apology and response has been provided and the complaint has been discussed at the Directorate Clinical Governance Meeting. February 2011: First complaint - An apology and full response has been provided to the family and a meeting with the Chief Executive has been scheduled to discuss the families concerns. ▪ The second complaint highlighted issues with the documentation recorded in the patient's nursing notes the Charge Nurse will now address these with staff. An apology and response has been provided. The complaint has been shared with ward staff and at the Directorate Clinical Governance meeting. The importance of regularly checking pressure areas and what preventative measures can be put in place has also been reinforced with nursing staff.

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.

	2010/11			
	Q1	Q2	Q3	Q4
HMC notifications	12	14	3	16
Inquests held	8	4	16	9
HMC Recommendations	0	0	0	0
% Recommendations per FCE	0	0	0	0



Analysis: 9 inquests were held the verdicts of which are abbreviated as follows: died as a result of a haemorrhage, known infection complication, bronchopneumonia, effects of an intra pulmonary haemorrhage, natural causes, died following a fall and necessary surgery, cardiac arrest, open verdict and cardiac arrhythmia. 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.

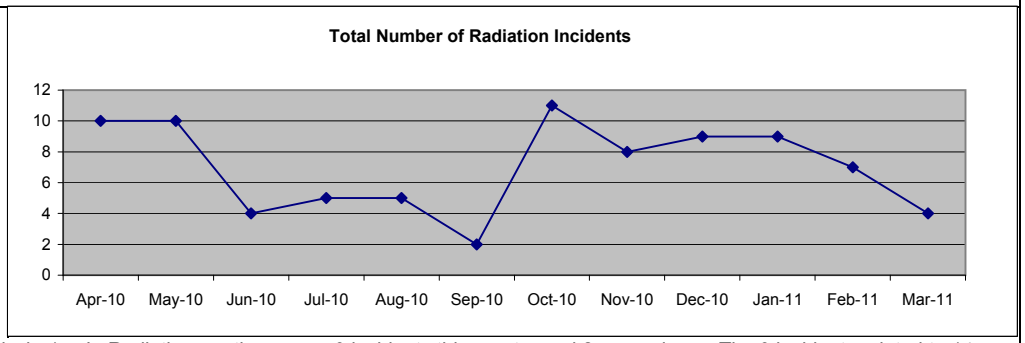
Actions: No further actions

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	Jan-11	Feb-11	Mar-11
Radiotherapy	5	6	0
Diagnostic Radiology	2	1	3
Nuclear Medicine	2	0	1
Laser/Non-ionising	0	0	0

Quarterly Rates			Q4 10/11
Radiotherapy Incident Rate per 1000 fractions			1.8
Diagnostic Radiology Incident Rate per 1000 procedures			0.1



Analysis: 1 Radiation Incident was reported externally to the CQC (Care Quality Commission). ▪ In Radiotherapy there were 9 incidents this quarter and 2 near misses. The 9 incidents related to 14 fractions of radiotherapy treatment. 7827 fractions of radiotherapy were delivered in total this quarter. Incident Rate: 1.8 incident fractions per 1000#. ▪ In Diagnostic Radiology 7 radiation incidents were reported on Datix. 1 of these incidents is reportable under IR(ME)R to the CQC. 2 reports submitted were regarding the same incident. 51500 radiological examinations were performed in Radiology this quarter and 6 separate radiation incidents occurred. Incident Rate: 0.1 incidents per 1000 procedures. ▪ Lasers - No incidents reported to the Trust Laser Safety Officer (TLSO) or found on Datix. It is the managers and LPSs responsibility to notify the TLSO of any incidents. There were also no MRI incidents reported this quarter. ▪ Nuclear Medicine Physics - 3 incidents involving radiation were reported to Datix. 2 incidents involved different aspects of the same patients care.

Actions: ▪ Radiotherapy - A number of the radiotherapy radiation incidents this quarter involved the use of a more accurate method of locating and treating the tumour bed for breast cancer patients. This method was discussed and confirmed by clinicians at the radiotherapy MDT meetings. There is a written procedure describing the technique. It was recommended by the group reviewing the incidents that further training be undertaken to reinforce this procedure and suggested that the methods of training for any amendments in practice should be reviewed for the future. ▪ Diagnostic Radiology - The incident to be externally reported involved the unintended exposure of a patient and member of staff. The incident has been reported to the Care Quality Commission and followed up as required. ▪ Two incidents this month involved patient identification. The Trust's RPA (Radiation Protection Advisor) is to contact the Clinical Director, Head of IT and Chief Operating Officer to discuss the issues. ▪ Nuclear Medicine - The nuclear medicine incident this month involved the failure of nursing staff to follow the procedure in the patient's notes in relation to a patient's radiation therapy treatment. To avoid a reoccurrence it is suggested that such therapies are carried out on one designated ward. The RPA is to contact the COO to discuss.

3) PREVENTING HARM, IMPROVING SAFETY MEASURES

Introduction:

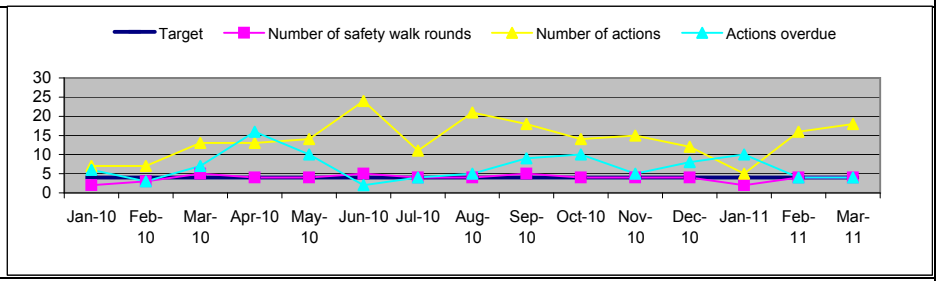
This section includes progress from the Preventing Harm, Improving Safety Group for the period Quarter 4 (January to March 2011). The overall aims of the Strategy for Preventing Harm, Improving Safety are to reduce our Hospital Standardised Mortality Ratio (HSMR) by 5 points per year over the next three 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 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.

	Jan-11	Feb-11	Mar-11
Number of Safety Walk Rounds	2	4	4
Actions Agreed	5	16	18
Cumulative actions overdue completion at the end of the quarter			18



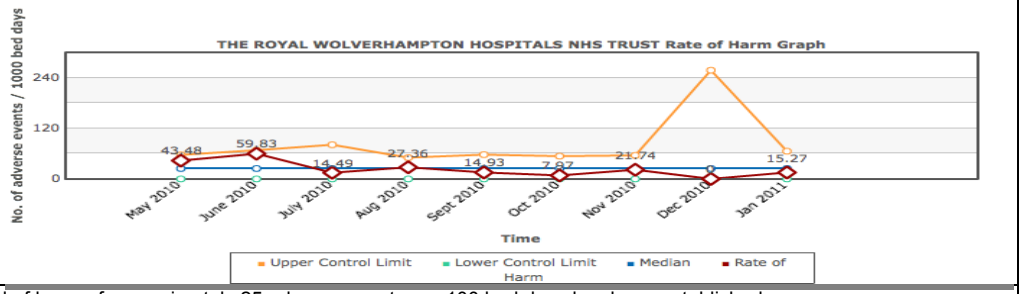
Analysis: Two walk rounds due to take place on the 12 January were cancelled due to interviews with Monitor.

Actions: Ten actions are overdue at the end of January, another four at the end of February and four at the end of March. The people responsible for actions have been contacted on more than one occasion therefore a summary of overdue actions will be sent to the Directorate management team to pursue.

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).

	Sep-10	Oct-10	Nov-10	Dec-10	Jan-11
Number of triggers	10	11	10	no data	2
Number of adverse events	3	2	5	no data	2

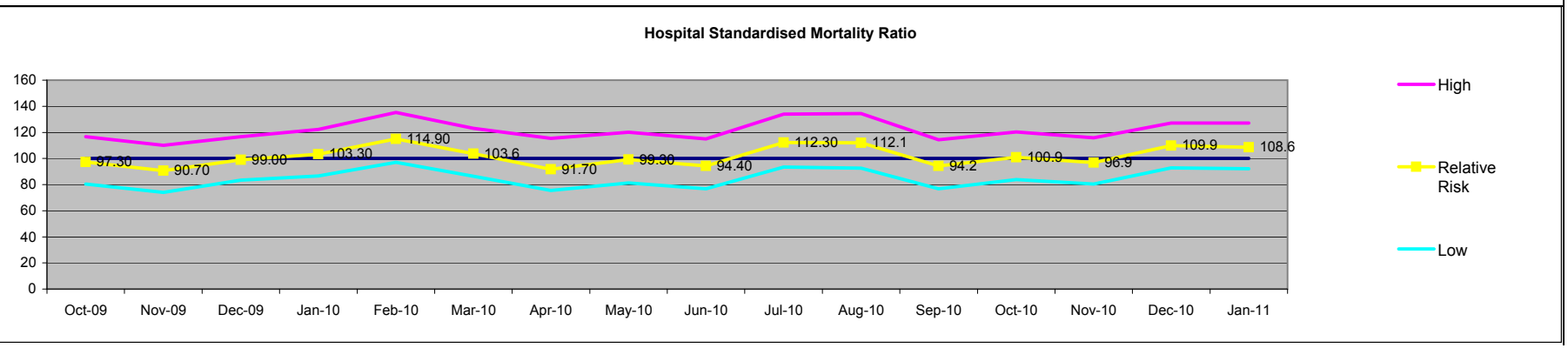


Analysis: Varying levels of harm with no specifically identifiable patterns. A median level of harm of approximately 25 adverse events per 100 bed days has been established.

Actions: Due to the lack of useful information gained from undertaking random case note reviews the GTT group in its current form will cease, and instead, more attention will be focussed on specific areas. In the first instance it is planned to focus on undertaking case note reviews of patients who have had a cardiac arrest.

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.

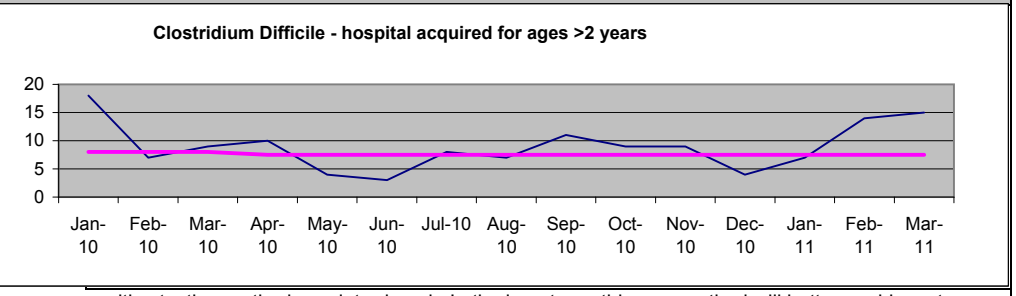


3.4 Healthcare Acquired Infections (HCAIs)

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	Cum Plan	Cum Actual	Cum Variance
	90	101	11

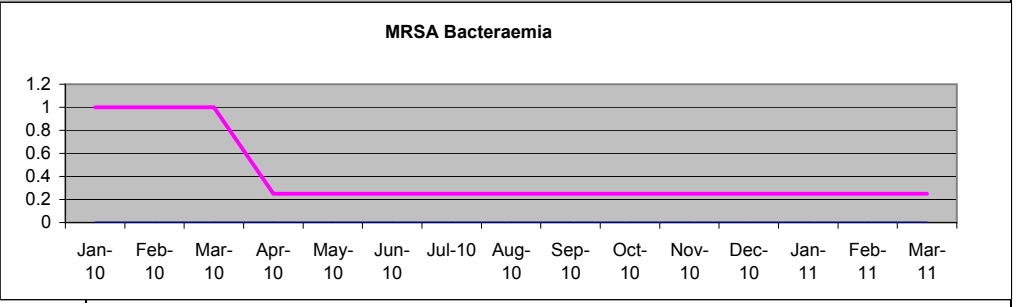


Analysis: Performance was within target up until the end of month 10. At this point a new, more sensitive testing method was introduced. In the long term, this new method will better enable us to identify those patients who have infection with *C. difficile* , manage them better and also take appropriate precautions to ensure proper decontaminated of the environment, thereby reducing the number of future cases.

Actions: *C. difficile* Action Plan updated to incorporate locally available high-level environmental decontamination using hydrogen peroxide vapour. Increased awareness of C. difficile through education. Antimicrobial prescribing guidelines are being reviewed in both secondary and primary care.

3.4.2 MRSA Bacteraemia

Number of MRSA	Cum Plan	Cum Actual	Cum Variance
	4	0	-4



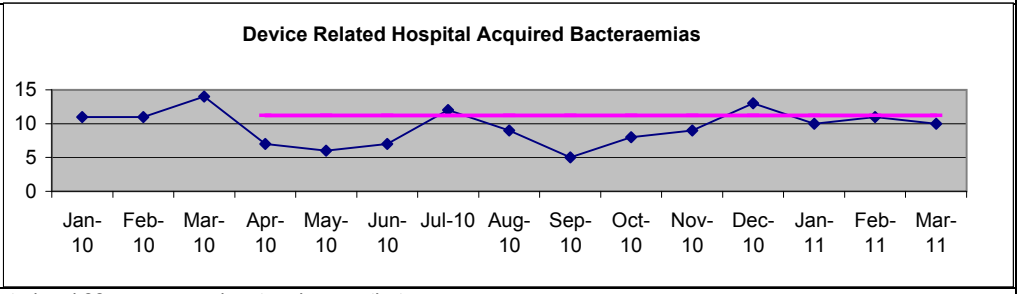
Analysis: A whole year with no MRSA bacteraemias.

Actions: Continue with current actions. Emphasis on hand hygiene, awareness by all staff of their role in preventing the spread of infection and MRSA screening of all admissions to RWHT plus various community screening programmes.

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.

	Jan-11	Feb-11	Mar-11
Target	11.2	11.2	11.2
DRHABS	10	11	10



Analysis: Target for the year was 134.4 and we had 105. Of these, 64 were line-associated and 22 were secondary to urinary catheters.

Actions: Continue ANTT training and device awareness campaign along with training and audit of devices and their management and databases to allow devices to be tracked. An e-learning package is being developed.

3.5 Critical Care Bundles

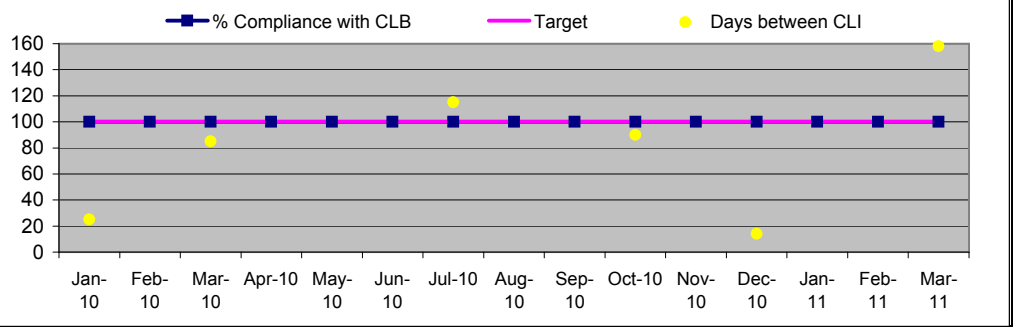
The aim of this initiative is to improve the care of patients receiving critical care through the reliable application of care bundles. Each care bundle has a number of components which together have been proven to significantly reduce ventilator acquired pneumonias and central line infections.

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.

	Jan-11	Feb-11	Mar-11
% Compliance with CLB	100	100	!00

Patient line days	approx 470	approx 470	480
Days between CLI			158
Cumulative CLI (since 01.07.09)			5



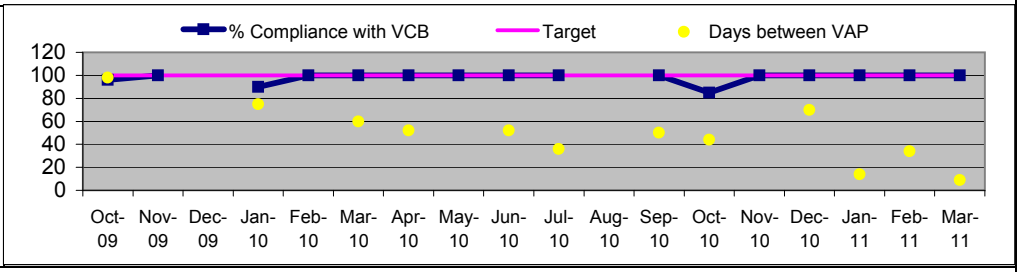
Analysis: CLI identified on 16/3/2011 after 158 days. Line tip potentially contaminated by heavy growth of Candida on numerous patient skin sites.

Actions: Importance of insertion site cleansing according to policy with alcoholic chlorhexidine reinforced with all staff.

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.

	Jan-11	Feb-11	Mar-11
% Compliance with VCB	100	100	100
Ventilated Days	444	370	357
Days between VAP	24/14	34	9
Cumulative VAP (since 01.07.09)			15



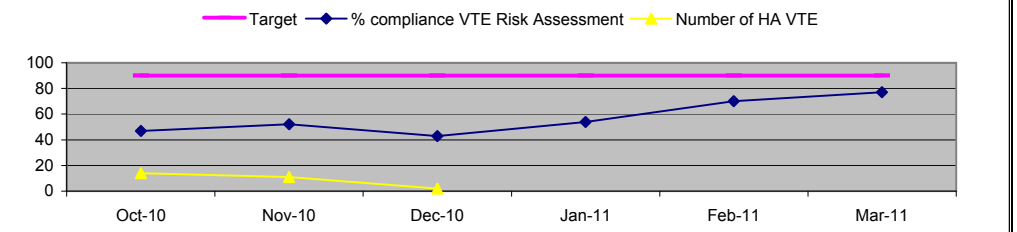
Analysis: 2 episodes relating to patient non compliance with care bundle due to agitation and inability to correctly position patient. 1 possibly relating to aspiration during unplanned self extubation.

Actions: Physios conducting audits into accuracy of documentation of head of bed elevation. Reiterating importance of thorough documentation surrounding procedures.

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.

	Jan-11	Feb-11	Mar-11
% adult patients with completed VTE risk assessment	53.90%	70%	77%
Number of patients with hospital acquired VTE	–	–	–



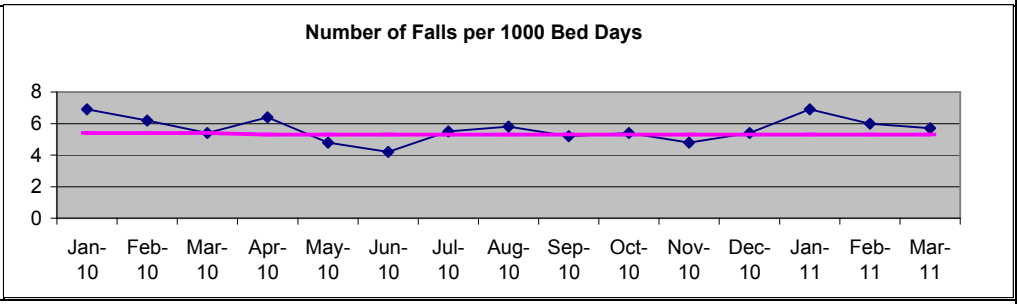
Analysis: The percentage of VTE risk assessments is based on a combination of low risk cohorts (defined by the Department of Health - e.g day case surgery under local anaesthesia, interventional radiology, renal dialysis), maternity VTE risk assessments recorded on Euroking and adult patients admitted and assessed on VitalPAC.

Actions: Changes in the Radiology reporting system, have reduced the notification of positive VTE; additional work is therefore being undertaken to identify the acquisition of VTE and to determine if this is community or hospital acquired . Case note reviews are still required to confirm VTE acquisition therefore the information will be included in the next report.
Actions to improve the compliance with VTE risk assessment include: junior doctor training, letters to clinical directors and junior doctors from the Medical Director, development of compliance reports by Consultant and by Ward for distribution, and VTE nurses targeting admission areas.

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	Jan-11	Feb-11	Mar-11
<5.3	6.9	6.0	5.7



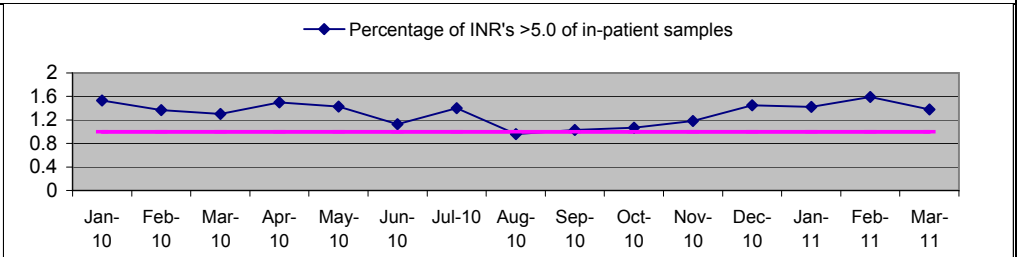
Analysis: As in 2010 a significant rise in inpatient falls in January with an improvement in subsequent months. This may reflect the increased number of frail elderly patients admitted over that period. The severe weather may have also contributed to patients admitted with multiple co morbidities.

Actions: Falls competencies completed across the Trust are currently 33%. A trial of new technology's nearing completion which may reduce the number of repeat fallers. Audit of all patients who have suffered significant harm planned to establish any trust wide themes not identified via RCA's. Policy updated and ratified. Rapid response in the event of a fall prompted by the NPSA has been addressed and will be circulated as laminated protocol for all areas detailing actions to be taken, with particular regard to head injuries and other significant injuries.

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.

	Jan-11	Feb-11	Mar-11
In-patient INRs tested	5559	4891	5417
Number of events (INR's >5.0)	79	78	75
% INRs >5.0 of inpatient samples	**1.42**	**1.59**	1.38



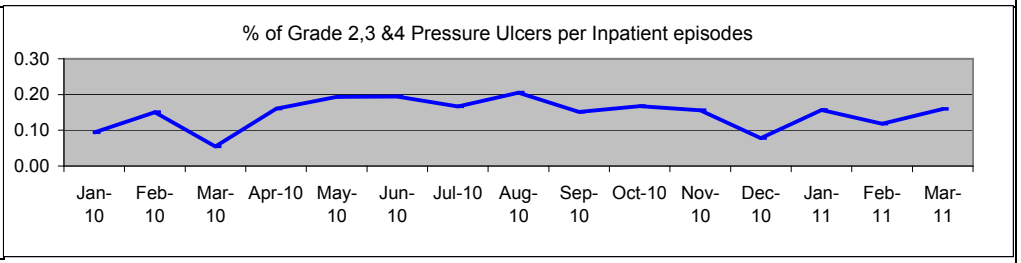
Analysis: The audit of INRs greater than 5 was completed in January and did not identify any cases that were avoidable. There are still some INRs greater than 8 that require case note review but to date there have been no concerns identified.

Actions: No further actions

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.

	Jan-11	Feb-11	Mar-11
Grade 2	20	11	15
Grade 3	0	3	5
Grade 4	0	0	1
Total	20	14	21
% Inpatient Episodes	0.16	0.12	0.16



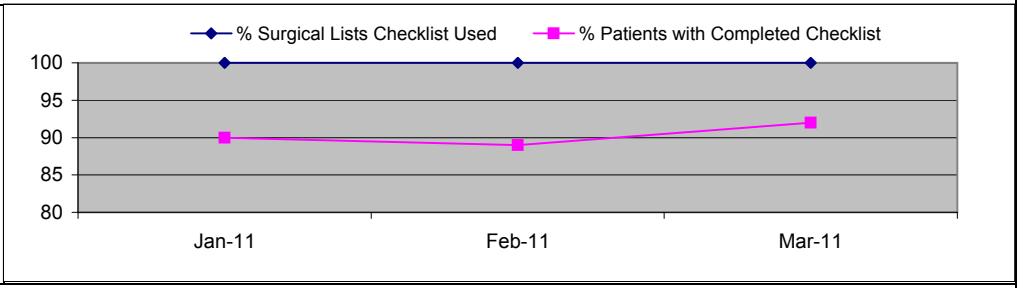
Analysis: Of the 9 grade 3/4 pressure ulcers,1 occurred in Division 1 in ICCU following the RCA it was clear that the patient had a highly complex medical condition with numerous co-morbidities and at times he was non-compliant with preventative interventions. In Division 2 the incidents occurred Care of the Elderly Directorate; Emergency services and General Medicine

Actions: For each incident an RCA has been undertaken and the multidisciplinary team invited to present the findings to both Head of Nursing for the Division and Lead Tissue Viability Nurse

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

	Jan-11	Feb-11	Mar-11
Percentage of Surgical Lists Checklist Used	100%	100%	100%
Percentage Patients with Completed Checklist	90%	89%	92%



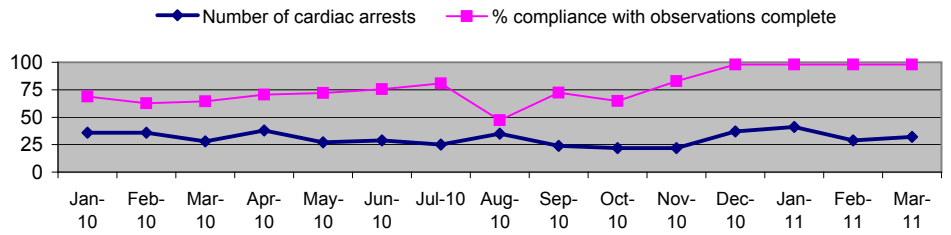
Analysis: In March 2011 additional audits were undertaken in Ophthalmology and Cardiac Theatres to identify team compliance with the WHO Checklist and the 4 elements of the Surgical Site Infection (SSI) Care Bundle. Each audit takes a considerable length of time as the auditor has to be based in the operating theatre for the duration of operating list (the auditor is part of the theatre team). **WEI** audited 6 operating lists and were 83.4% compliant with the check list and the care bundle (there was one operating list where the team did not undertake the WHO checklist). **Cardiac Theatres** audited 13 operating lists and the results are as follows: Team Brief 61.5%, Sign In 92.3%, Time Out 100%, Debrief 66%, overall compliance with the SSI Care Bundle was 92.3%. The detailed Quality Audit will continued to be targeted in specific specialities starting with Head & Neck. During Q4 the SSI care bundle had been added to the theatre peri-operative documentation and will be audited in May 2011.

Actions: TPOT leads for RWHT to meet with clinical leads for the WHO checklist in Cardiothoracic Surgery and Ophthalmology. For formulation of action plan, implement and re-audit May 2011.

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.

	Jan-11	Feb-11	Mar-11
Number cardiac arrests	41	29	32
% compliance observations completed	98.0	98.0	98.0



Analysis: The number of cardiac arrests has remained fairly constant over the last twelve months despite improvements in the completion of observations.

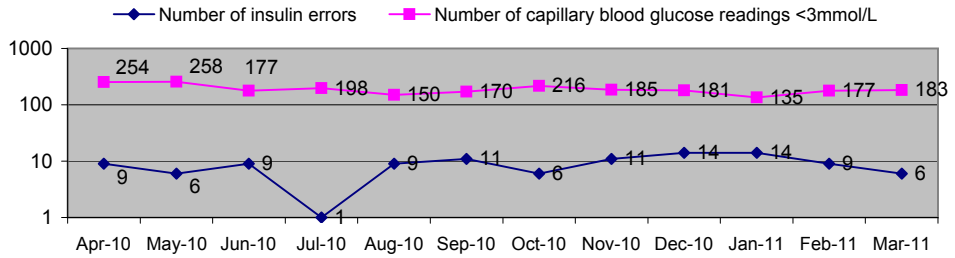
Actions: Now that VitalPAC has been rolled out the Deteriorating Patient Group is going to resume and establish further actions required to improve recognition and response to deterioration.

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.

	Jan-11	Feb-11	Mar-11
Number of insulin errors	14	9	6
Number of capillary blood glucose readings <3mmol/L*	135	177	183

*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: Incidents of documented low blood glucose have remained stable over quarter 4. Incidents involving insulin appear to have fallen during quarter 4. New diabetes charts were introduced to wards and departments at the end of January.

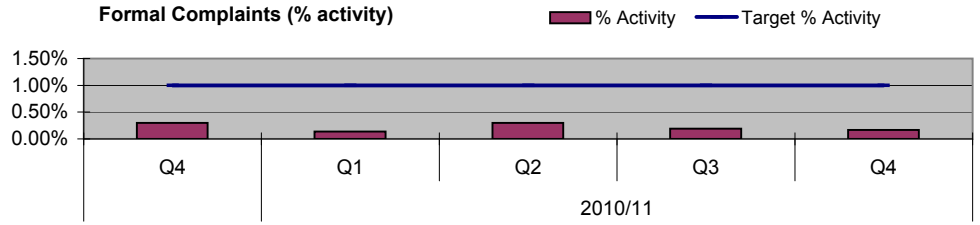
Actions: Pursue staff education with regard to insulin safety and Think Glucose which includes safety regarding hypo glycaemia. Training is now included on monthly KPI reports for compliance monitoring. Every insulin error will be taken through governance process at local level. Ward based diabetes education is also being rolled out. Forward planning for e-prescribing will also help prevent insulin errors.

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.

Q4 09/10	Q4 10/11	Target
0.30%	0.17%	1.00%



Analysis: 66 complaints received in Q4 for 10/11 which equates to 0.17% of the Trust's activity; this compares to 106 in the same quarter for 09/10.

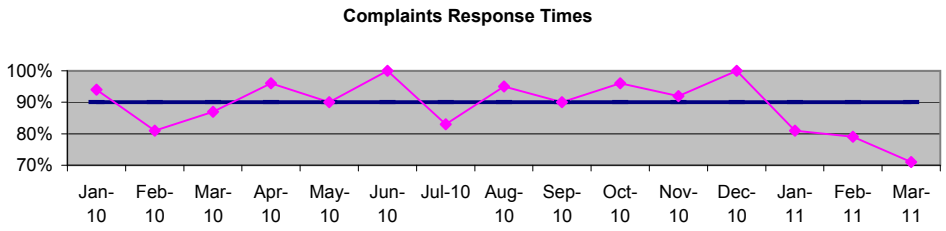
Actions:

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.

Jan-11	Feb-11	Mar-11	Target
81%	79%	71%	90%

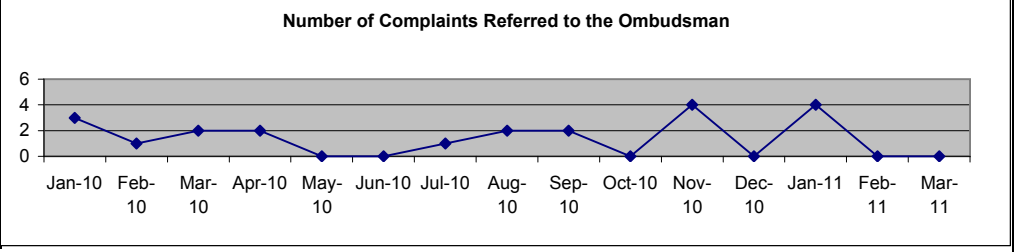


Analysis: Due to timescales for responding to complaints the March figure is only partially complete. The Trust has consistently failed to achieve its target for responding to complaints in this quarter. Complex investigations can take longer than 25 working days to complete, where this happens investigating officers should contact the complainant and gain consent to breach the deadline.

Action: The complaints team have established a weekly update report to all directorates detailing all complaints and progress towards meeting deadlines, to assist in improving compliance. The complaints policy is under revision and training for investigating officers will take place alongside the roll out of the revised policy, this issue will be highlighted during the training.

4.3	Ombudsman

	Q1	Q2	Q3	Q4
2009/10	9	7	7	6
2010/11	2	5	4	4



Analysis: In Q4 the PHSO closed 2 complaints, both were referred back for local resolution, the Trust has opted to use mediation in an attempt to resolve one of these referrals. No complaints were referred in February or March, with 4 complaints being referred to the PHSO in January 2010 . Of these 4 complaints 2 have been referred back to the Trust for local resolution as they were considered to be a premature referrals. 1 has been declined for investigation by the PHSO. All appropriate records and additional information have been provided to the PHSO regarding 1 complaint and we await their comments.

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

4.4	Vexatious Complaints

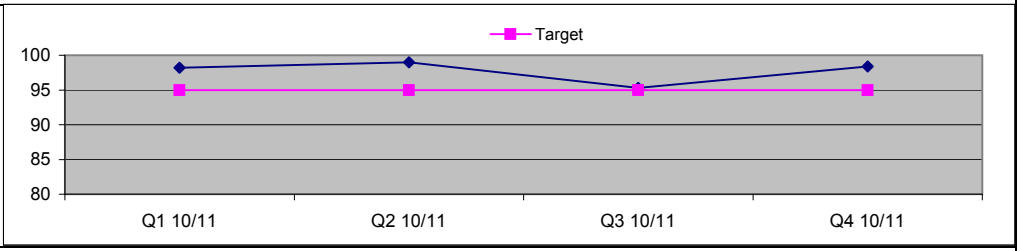
Details regarding vexatious complaints will be reported by exception.

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%.

	2010/11			
Target	Q1	Q2	Q3	Q4
95%	98.2	99	95.3	98.4



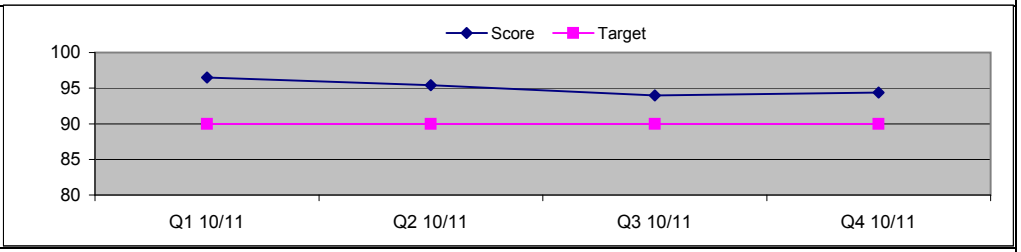
Analysis: There has been an improvement in quarter 4 in all areas, the main environmental issue is in Maternity and Endoscopy which have sinks units that are not compliant with the IP regulations. AHP and medics were observed not adhering to hand hygiene, and on some of the wards the hand gel dispensers the nozzles were clogged.

Actions: Both Maternity and Endoscopy have raised the sink unit non-compliance with the Estates Department and are awaiting resolution. The non-compliant staff we challenged during the observations, and the nozzles were cleaned following the audit

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%.

	2010/11			
Target	Q1	Q2	Q3	Q4
90%	96.5	95.4	94	94.4



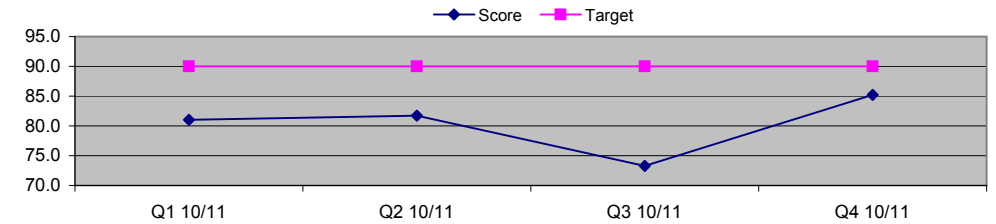
Analysis: There were 5 main areas of non-compliance, dusty air vents; dirty window blinds; non-laminated notices; low level dust and dirty floors.

Actions: There are numerous building projects on going across the Trust and this has resulted in low level dust and dirty floors, the Matron for these areas are working in partnership with hotel services to keep the impact of this building work to a minimum. The areas with dirty window blinds have agreed a cleaning or replacement programme to prevent a reoccurrence. The non-laminated notices were removed at the times of the audit

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%.

	2010/11			
Target	Q1	Q2	Q3	Q4
90%	81	81.7	73.3	85.2



Analysis: There has been an improvement this quarter particularly in relation to mental capacity and learning disabilities. The clinical nurse specialist for learning disabilities is now in post and has started training sessions and introduced a recognition flow chart which has distributed throughout the wards, she has also developed a website for resources and information. The learning disabilities liaison group has been relaunched.

Actions: The Essence of Care group are reviewing all the benchmarks and incorporating community representatives.

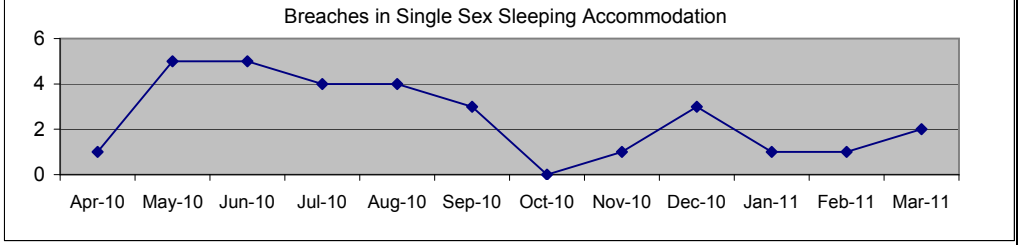
5.4 Single sex accommodation

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

	Jan-11	Feb-11	Mar-11
Target	0	0	0
Number of incidents	1	1	2

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)



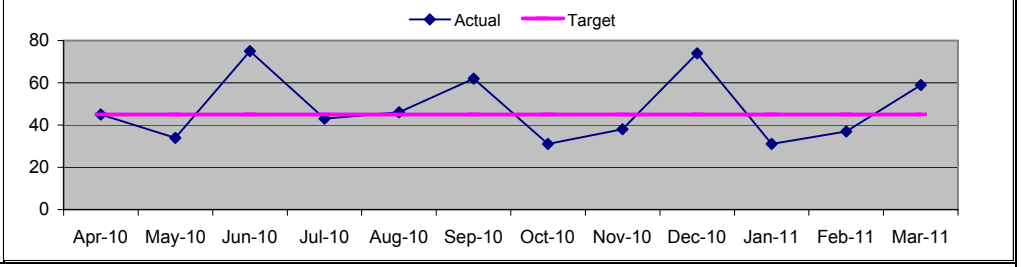
Analysis: In January and February there incidents which occurred on ICCU, following investigation both incidents were categorised as clinically justified, as both patients required high level care which could not be delivered anywhere else. In March there were 2 incidents, there was one on ICCU which following investigation is deemed clinically justified, the other occurred on D18 when a female patient was cared for in a side room which was within in a male bay.

Actions: The Matron for Gastroenterology is completing the investigation for the D18 incident and will produce an action plan to prevent a reoccurrence.

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	Jan-11	Feb-11	Mar-11
45	31	37	59



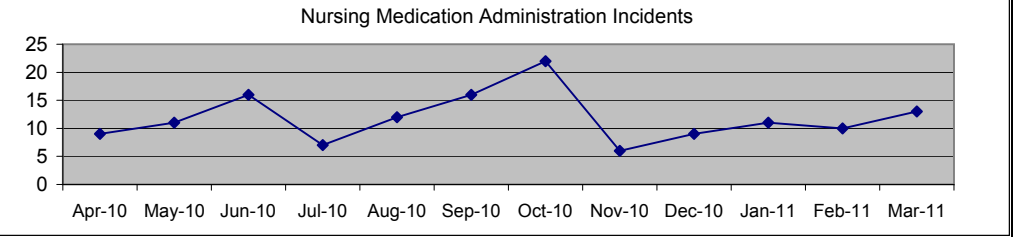
Analysis: The 31 incidents in January - 2 occurred in Division 1, 26 in Division 2 and 3 in Maternity, no serious harm occurred as a result. The 37 incidents in February - 1 occurred in Division 1, 32 in Division 2 and 4 in Maternity, no serious harm occurred as a result. In March there were 59 incidents, 54 of which occurred in Division 2 and they were predominately in Care of the Elderly Directorate, Trauma and Orthopaedic Directorate, and Renal Directorate. It was a mixture of short term and long term sickness and the inability to fill requests by the nurse bank

Actions:

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	Jan-11	Feb-11	Mar-11
Div 1	0	7	4	9
Div 2	0	4	6	4
Total	0	11	10	13



Analysis: The incidents were nurse drug administration errors and they occurred in several wards throughout the Trust, they were either: failure to document administration, wrong dose administration or administration of medication without allergy box completion.

Actions: Matron for the area has completed investigation and actioned the appropriate policy