Ashford and St. Peter's Hospitals NHS
NHS Foundation Trust

TRUST BOARD
26 May 2011

TITLE	**Quality Report**
EXECUTIVE SUMMARY	The Quality Report is presented for May 2011.
BOARD ASSURANCE (Risk) / IMPLICATIONS	The Quality Report provides assurance that Quality indicators are being monitored and assessed and that mitigating actions are being put in place as required. The Balanced Scorecard features no red ratings.
STAKEHOLDER / PATIENT IMPACT AND VIEWS	Patient views are included via the reporting mechanisms for quality. The clinical quality metrics indicate where poor care and poor experience is occurring. Stakeholder views have been sought as part of the Quality Account development process.
EQUALITY AND DIVERSITY ISSUES	All of our services give consideration to the equality on access taking into consideration disability, age and that all matters are dealt with in a fair and equitable way regardless of ethnicity or religion of patients.
LEGAL ISSUES	Poor quality for patients can lead to potential litigation. Poor quality care can lead to non compliance with essential standards of quality and safety. Compliance with these standards is a legal requirement of the Health Act (2009) and failure to do so could affect the Trust's registration and Monitor licence.
The Trust Board is asked to:	Review the paper; discuss the contents seeking additional assurance as necessary.
Submitted by:	Dr Mike Baxter, Medical Director & Suzanne Rankin, Chief Nurse
Date:	May 2011
Decision:	For Noting and Decision

Contents

1 Performance Monitoring

1.1 Quality and Safety Balanced Scorecard Indicator Definitions

1.2 Quality and Safety Balanced Scorecard and Commentary

1.3 Commentary on Quality with reference to the Trust's Balanced Scorecard

2. Clinical Effectiveness

2.1 Mortality and Morbidity

2.2 The National Diabetes Inpatient Audit

3. Safety update

3.1 National Patient Safety Alerts (NPSA)

3.2 Ensuring the Provision and Safety of General Paediatric Surgery

4. Patient Experience

4.1 Complaints/Ombudsman Reports

4.2 Ward Quality Indicators (WQI) Commentary

5 Appendices

Appendix 2 WQI explanations

Appendix 3 WQI scorecard

1 Quality Performance Monitoring

Table one: Quality Performance Dashboard

Ashford & St Peter's Hospitals NHS Trust
DRAFT BALANCED SCORECARD

Position as at: **30 Apr 2011**

1. To achieve the highest possible quality standards for our patients, exceeding their expectations, in terms of outcome, safety and experience.

	Patient Safety & Quality	Outturn 10/11	Annual Target 11/12	Annual Forecast 11/12	Apr Actual	Performance			YTD 11/12
						Feb	Mar	Apr	
1-01	Standardised mortality (Relative Risk)*	90.7*	82	88.8	85.7*	▼	▲	▲	85.7*
1-02	Crude mortality	1.60%	1.60%	1.72%	2.04%	▲	▼	▼	2.04%
1-03	MRSA (Hospital only)	5	4	3	0	◄►	◄►	◄►	0
1-04	C.Diff (Hospital only)	36	33	33	2	▲	▼	▲	2
1-05	Mortality from C.Diff (All cases)	10.3%	6%	9%	14.3%	▲	▲	▼	14.3%
1-06	Mortality from VTE	0.4%	0.35%	0.25%	0.0%	▲	▼	▲	0.0%
1-07	Mortality from Hip fractures	4.8%	4.6%	4.6%	6.0%	▲	▲	▼	6.0%
1-08	National Patient Survey>Avg responses	! New	>3	Annual measure					
1-09	Patient Satisfaction (NetPromoter Score)	77.3%	90%	82%	80.2%	▲	▲	▼	80.2%
1-10	Formal complaints	360	320	300	25	▲	▼	▲	25
1-11	SUIs	14	14	14	2	◄►	◄►	▼	2
1-12	Falls - resulting in significant injury (grade 3)	16	14	14	0	◄►	◄►	▲	0
1-13	Hip fractures treated within 36 hrs	93.0%	85%	90%	90.9%	▼	▼	▼	90.9%
1-14	Summated Adverse Report Index (SARI)	1,799	1,552	1788	149	▼	▼	▲	149
1-15	Average Bed Occupancy-actual beds	94%	94%	94%	90.3%	▲	▼	▼	90.3%
1-16	Average Bed Occupancy-planned beds	! New	To be reported next month						

*Source from Feb Dr Foster

1.1 Dashboard Definitions

The table is made up of 6 columns namely:

1. Description of Measure - self explanatory.

2. Targets - where possible a national or local strategic health authority target has been used, but where this is not available, we have used the 2010/11 year end total less 10% as the target. This sets us a goal of a 10% improvement on last year.

3. Forecast - the calculation is as follows:

    - For month 1 (April) we divide 201/12 Total by 2011/12 YTD at month 1 to give us the proportion of activity that has taken place as a guide to how much more activity will take place during the rest of 2011/12. This is then multiplied out by the YTD figure for 2011/12. To further account for recent up or downward trends we have divided the average monthly figure for 2011/12 by the most recent 12 months average and multiplied this by the first figure. If we are improving this will better forecast that improvement, conversely if we are getting worse the forecast will reflect this also.

    - The formula is this 1/(SUM(2011_12 up to m7)/SUM(2011_12 Total)) x 2011_12 YTD x (2011_12 Ave/Last 12 Months Ave)

4. Actual - this is the actual achievement for the month.

5. Monthly Trend Indicator - The arrows represent one of three states, improvement on the previous month, worse than the previous month, or the same. It must be noted that this does not necessarily mean that higher numbers are represented by an up arrow as higher numbers may be worse and thus will be represented by a down arrow.

6. Year to Date - The sum of the activity from the beginning of the financial year (April).

1.2 Commentary on Quality and Safety Balanced Scorecard

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1.01 and 1.02: The Trust's SMR has shown a reduction from last month's value of 94 and marks the second month of improvement. The crude mortality rate has risen to 2.04% which has increased over last month's value of 1.7%. This appears to be related to a decrease in the number of elective admissions in March which reduced the total activity of the Trust. This may have lead to an apparent increase in CMR. This is supported by looking at the absolute numbers of deaths in the Trust which at 117 which is similar to the Trust's usual monthly figure (90 -123). At this time there is no cause for concern but this result will continue to be monitored.

1.06: Mortality from VTE is now being monitored in place of VTE prophylaxis. This is an outcome metric for VTE intervention and the Trust has recorded a zero return for April.

1.07: The Dashboard now shows mortality as an outcome of fractured hip surgery as well as compliance with 36 hr operative rates. The Trust has seen a small increase in the mortality from hip fractures this month to 6%, which still remains below the national mean of 7%, but will be monitored closely.

1.14: The SARI now includes the new measures introduced on the new dashboard. This months figure is slightly higher than the predicted monthly return, and this has been extrapolated to a red rated forecast. However, it is paced on a limited data set and the Trust is focused on reducing the SARI score.

1.3 Commentary on Quality with reference to the Trust's Balanced Scorecard

The aim of this commentary is to draw the Boards attention to other quality measure reported within the Board papers. Please see the Trust's Balanced Scorecard presented within the Board document bundle.

3.01: There has been a small decrease in the number of emergency admissions in April.

3.10: There has been a 37% reduction in nursing home admissions (5.2% to 3.3%). However, **3.08 and 3.09**: indicate that there has been no demonstrable fall in elective or emergency readmission rates despite the operation of the Medical virtual ward.

4.09: The emergency length of stay has also increased from 4.9 to 5.3 days which represents an 8% increase. This is a function of the expanded bed base that the Trust is currently experiencing, which leads to operation inefficiency, and delayed discharges.

2. Clinical Effectiveness

2.1 Mortality and Morbidity

Table two: Crude Mortality rate by Directorate

	CMR FEB 2011	ABSOLUTE NUMBERS	DEC 2010	JAN 2011	FEB 2011
ALL	1.50%	91	▼	▲	▲
MEDICINE	4.47%	77	▼	▲	▲
SURGERY	0.65%	7	▼	▲	▲
ORTHO	0.42%	2	▼	▲	▲
PAEDIATRICS	0.00%	0	◄►	◄►	◄►

The February Crude Mortality Rates (CMR) demonstrate an improved performance in all Divisions over the January figures. This marks the second consecutive month of a global reduction in CMR
.
The total number of deaths in the Trust fell from 123 to 91 (27% fall). Characteristically, the majority were in acute medicine (77 deaths: 85% of total) but the CMR in medicine fell from 5.53% to 4.47%: an improvement of 20%.

Orthopaedics and Surgery also recorded improvements of 54% and 37% respectively in the Divisional CMRs.

Monthly mortality reviews have not identified any adverse trends or signals.

2.2 The National Diabetes Inpatient Audit

In November 2010, the Trust participated in The National Diabetes Inpatient Audit (NaDIA). This was a snapshot audit of inpatient diabetes care over the previous 7 days. Two data sources were used, bedside clinical data and patient experience questionnaires. The audit set out to answer the following questions:

1. Did diabetes management minimise the risks of avoidable complications?
2. Did harm result from the inpatient stay?
3. Was patient experience of the inpatient stay favorable?

1. Did diabetes management minimise the risks of avoidable complications?

Blood glucose was reported to be adequately controlled 81% of the time in patients on the Ashford site and 54% of time on SPH site. Ashford Hospital (AH) reported more visits by the Diabetes Team and greater Foot Reviews compared with the national average.

2. Did harm result from the inpatient stay?

Both Trust hospital sites had less diabetes prescription and medication errors and less severe hypoglycemia compared to the national data with AH having 0% occurrences.

3. Was patient experience of the inpatient stay favorable?

Around half the patients were "almost always satisfied with meal choices and meal times". National data reported that dissatisfaction with meals times and meal choices are associated with poorer outcomes. In addition, 15.9% of patients reported that they had to have food brought into hospital to meet their needs and those reporting poor meal timing or choice were more likely to have a severe hypoglycaemic episode.

The general dissatisfaction with food resonates with the National Inpatient Survey Report (2010) and both Divisional and Corporate Action Plans outline improvement plans.

The majority of patients felt staff were aware of their diabetes, but our patients were less likely to report that staff had enough knowledge about diabetes and the Trust had a poor score for team working.

4. The Way Forward

A multi-stakeholder action group will be bought together to implement an in-patient diabetes strategy plan. This work will be taken forward by the group currently in place to address the NPSA Safety Alert for Safer Use of Insulin though the implementation of an Adult Patient Passport to the Safer Use of Insulin.

3. Safety Update

3.1 NPSA Safety alerts

Overdue Alerts

Two alerts remain overdue as follows.

Deadline	Description	Status	Lead
05-Feb-07	Early identification of failure to act on radiological imaging reports	The Health Informatics team has developed software to ensure that all Radiological alerts are captured, reviewed and clinically signed-off. This software is currently in testing and is expected to be deployed across the Trust in June. An action plan is in place to ensure robust interim measures: Radiology Department has employed a clerical assistant and the new manual system is in place. Clinicians are signing to acknowledge they have received the report. The test order sheet and subsequent process must be embedded and reviewed to ensure it is working before closure of alert.	Mike Baxter Medical Director Jonathan Glover Consultant Radiologist
19-Sep-09	Risk to Patient Safety of not using the NHS Number as the National Identifier for all Patients	The Trust is still awaiting the release of version 4.3 from iSOFT to resolve this issue. iSOFT has confirmed that this version is currently in testing but no confirmed date has been provided for this version to become available on general release. Other Trusts with the same	Donna Jarrett Associate Director of Health Informatics

		CliniCom PAS are in the same position. In the meantime, and to mitigate the risk, the patients' hospital number and usual demographics are used in accordance with the patient identification policy.	

New Alerts

Date of Issue	Description	Deadline	Lead
30-March-11	The adult patient's passport to safer use of insulin.	31- Aug-12	Debbie Hindson Diabetes Specialist Nurse
STATUS			
An insulin action task and finish group chaired by the Deputy Chief Nurse is working towards introducing a hospital passport for diabetic patients. This will also become part of the admission and discharge process. The expected role out of this project is August 2011.			
Date of Issue	**Description**	**Deadline**	**Lead**
10-March -11	Reducing harm caused by misplaced nasogastric feeding tubes in adults, children and infants.	12- Sept-11	Dr Michael Parris Consultant Intensivist
STATUS			
All policies, protocols and documentation are being reviewed. New core care plans for nasogastric feeding incorporating a position check flow chart and covering the points raised in the alert have been compiled and are currently in draft form for launch in June 2011 during Nutrition Awareness Month. Competency assessment documents are being written to encompass theory and practice and will also be launched in Nutrition Awareness Month. The Training Tracker Programme for Doctors has been changed to include questions on checking the position of nasogastric tubes. Our fine-bore nasogastric tube supplier is currently improving their tube markings and we are also introducing a sticker into the pack which will be put into patient notes identifying batch number of tube, inserted by, date, length and pH on insertion.			

3.2 Ensuring the Provision and Safety of General Paediatric Surgery

A Healthcare Commission Report published in 2007, improving the Services for Children in Hospital, identified that many District General Hospitals (DGH) were seeing a decline in both planned and emergency paediatric surgery as the move to regionalise some specialities in tertiary centres took effect. The consequence can be that surgeons and anaesthetists do not complete a high enough number of paediatric episodes of care in order to sustain skills and competence.

Professional recommendations state[1] that surgeons with an expertise in adults can undertake common and minor planned surgery on children over the age of eight. However, surgeons working with younger children need specific training and need to ensure that they work with sufficient numbers of children to maintain their skills. It has been suggested that a surgeon working in the larger specialities should complete the equivalent of 100 cases each year. If a surgeon carrying out planned surgery on children works with fewer than 100 children a year, their trust should find out the age of the children and assure itself that the surgeon is operating within their abilities.

[1] Association of Paediatric Anaesthetists, the Association of Surgeons for Great Britain and Ireland, the British Association of Paediatric Surgeons, the Royal College of Paediatrics and Child Health, the Senate of Surgery for Great Britain and Ireland (2006)

There is evidence that giving anaesthetic to infants and children under the age of two carries an increased risk. Recommendations by the NCEPOD[2] in 1999 sought to reduce the number of anaesthetists working with infants. If an anaesthetist works infrequently with very young children, trusts should look carefully at whether the anaesthetist remains competent to do so, particularly if they work infrequently with children overall.

In order to respond the Trust has conducted a number of activities under the auspices of the Children and Young People Action Group which is chaired by the Chief Nurse and supported by the Divisional Director Women's Services and Paediatrics. In the first instance data has been collected to understand the level of paediatric work undertaken in the Trust.

- Between May 2010 and May 2011 approximately 1633 paediatric surgical episodes were undertaken by approximately 65 surgeons[3]. Individual numbers range from 1 to 457 for the period. It can concluded from the initial data that 17% of surgeons are doing 72% of the paediatric workload. This is indicative of the cohorting of paediatric cases to those surgeons with well maintained skills but is not conclusive evidence of best practice. Clear evidence of a paediatric focus existing within the specialities of maxillo-facial, ear, nose and throat, ophthalmology and orthopaedic surgery are evident and expected. Further data analysis has been requested that will enable a view of; number of cases per month per surgeon, cut by age (< 2years, 2-8years and >8years), procedure and whether the case was elective or an emergency.

- Between May 2009 and May 2010 approximately 1058 paediatric anaesthetic episodes were undertaken by approximately 100 anaesthetists. Individual numbers range from 1 to 240 for the period. It can concluded from the initial data that 10% of anaesthetists are doing 83% of the paediatric workload. This is indicative of the cohorting of paediatric cases to those anaesthetists with well maintained skills but is not conclusive evidence of best practice. Further data analysis has been requested that will enable a view of; number of cases per month per anaesthetist, cut by age (< 2years, 2-8years and >8years), procedure and whether the case was elective or an emergency.

The data analysis gives some assurance but a deeper understanding is required to be fully assured. In any event work is necessary to create a framework approach to the sustainment of General Paediatric Surgery and work is underway to achieve this including, the establishment of child only operating lists (already achieved by ophthalmology), the establishment of General Paediatric Surgery databases of activity by practitioner, procedure and age for surgeons and anaesthetists, completion of a self-assessment of the quality of children's services across the Trust using a recognised tool, the development of a General Paediatric Surgery Policy, review and selection of paediatric surgical and anaesthetic competency frameworks and the use of validation to authorise continued paediatric activity.

The current expert opinion[4] is that the most effective way to provide General Paediatric Surgery services in DGHs is through managed clinical networks of care. No such network currently exists within Northwest Surrey but a development of this kind will be scoped with the view that ASPH is well placed to be the lead provider of such a network.

An update on progress will be given in July.

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[2] National Confidential Enquiry into Perioperative Deaths (1999) *Extremes of Age: Report of the National Confidential Enquiry into Perioperative Deaths*

[3] Further data validation is required and therefore figures are indicative

[4] Association of Paediatric Anaesthetists, the Association of Surgeons for Great Britain and Ireland, the British Association of Paediatric Surgeons, the Royal College of Paediatrics and Child Health and the Senate of Surgery for Great Britain and Ireland, Children's Surgical Forum Royal College of Surgeons.

4. Patient Experience

4.1 Complaints/Ombudsman Reports

4.1.1 Complaints

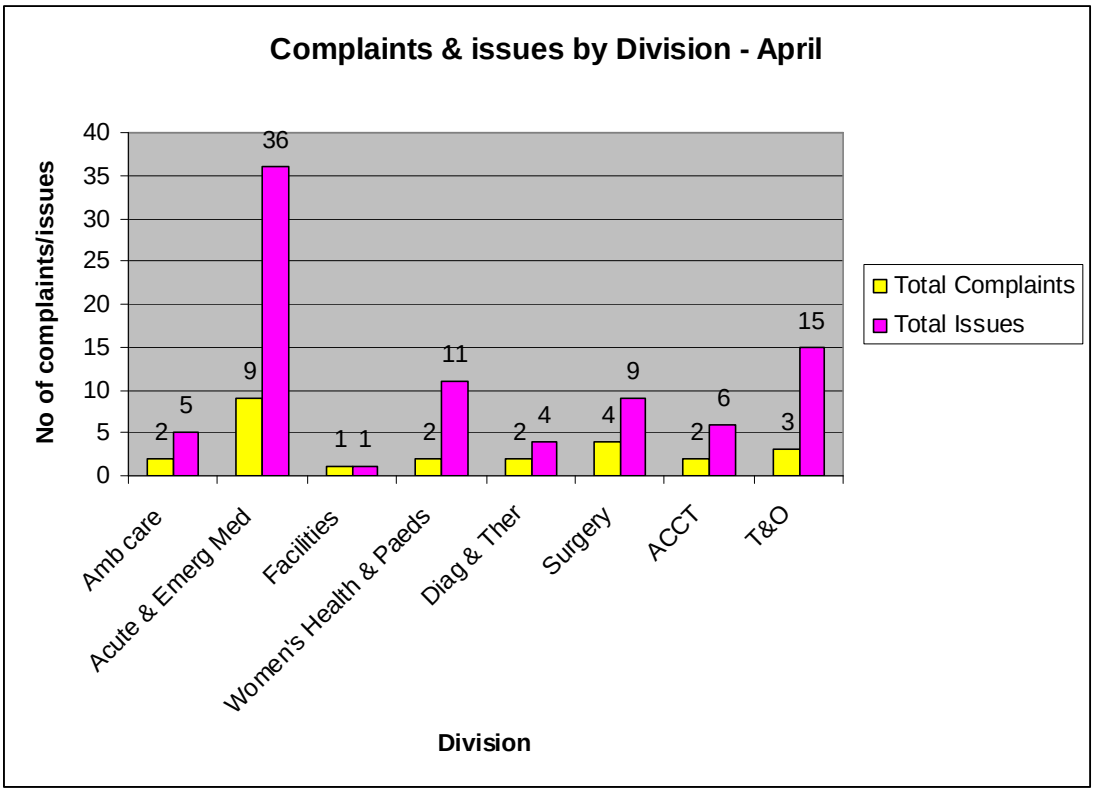
The Trust received 25 complaints in April compared with 38 in March. The Trust aims to reduce the number of formal complaints by 10% during 2011/12 with an overall target of 320 over the year. This equates to a monthly limit of no more than 27 complaints; hence the number received during April is in line with this limit.

By exception, the following issues were reported to the Complaints Monitoring Group meeting of 6 May:

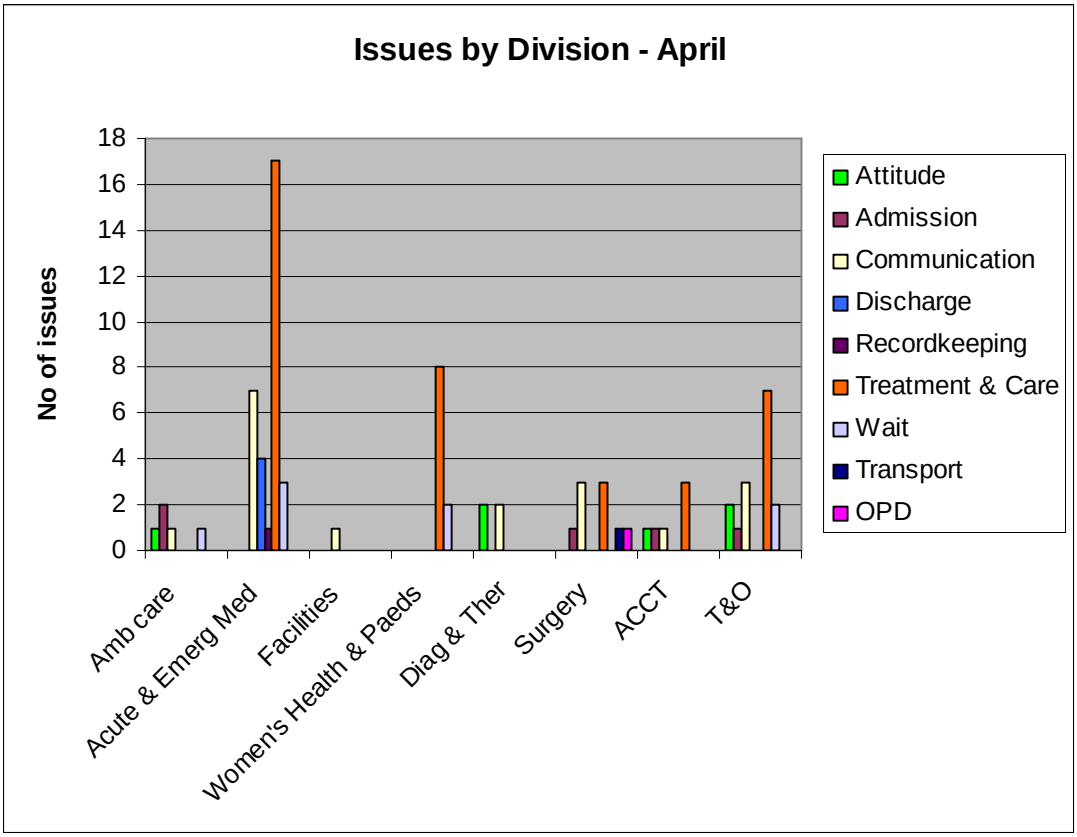
- The group noted a high number of complaints received in Acute & Emergency Medicine during quarter 4. The Divisional General Manager (DGM) advised this was related to increased activity levels where a high number of concerns related to the pathway and discharge of patients admitted as an emergency.
- The group noted a decline in performance against timescales for response and discussed actions necessary within divisions to improve this.
- The group reviewed the Corporate Risk: '*Lack of public confidence in the complaints process'* and agreed this should remain unchanged.

Graph one presents the total complaints and issues raised by Division in April. Graph two provides further detail on the types of issues raised.

Graph one: Complaints and Issues by Division



Graph two: Issues by Division



Across all divisions, 43% of issues related to Treatment and Care; essentially divided between concerns regarding medical treatment and decisions and the essentials of nursing care. The Best Care Programme focuses upon improving the essentials of nursing care including privacy and dignity and nursing documentation. Progress of this program will be monitored against national benchmarks. Concerns regarding medical treatment and decisions continue to be reviewed on an individual basis with trend analysis discussed at the Complaints Monitoring Group.

4.1.2 Ombudsman reviews

The Trust received no new referrals to the Ombudsman for review during April.

The Complaints Monitoring Group continues, on a quarterly basis, to monitor the action plan developed following the Ombudsman's review of a complaint upheld in July 2010 and featured in the Ombudsman's Report: Care and Compassion.

4.2 Ward Quality Indicators (WQI)

The review and subsequent narrative of the Ward Quality Indicators is provided by Divisional Heads of Nursing.

Scores for April have been very encouraging overall. However, we still have areas to improve upon. The introduction of the Best Care project and in particular the Essence of Care will have a rapid impact on the quality of care we give as well as the future of quality metrics and the way in which actions and root causes will be identified.

April has been very challenging for the Divisions with high demand on capacity and escalation beds open. As a result of staff redeployment to additional areas some audit processes have not been completed. Action to prevent this happening again has been identified.

For the month of April 2011, the WQI indicate that the main themes are:

Medicine and Emergency Services:

Falls- Maple ward still remains high, however the trend analysis indicate these are now decreasing. The Trust's Falls Group is developing a falls strategy and the Division have set a target of 15% reduction in falls for 2011-12. High impact interventions for nursing and midwifery and the development of Best Care programme will focus on addressing this as a first priority. The introduction of a Falls Nurse Specialist in early May is now focusing on the root causes of patients who fall and early identification of prevention strategies. Alert systems on IPL(In Patient List) will start to collate a falls database specifically matching the SHA's reporting requirements in line with the national agenda.

Medication errors- there have been a number of medication errors last month on a number of wards. A root cause investigation has taken place and actions plans are currently being developed. This month the division has seen a decrease from 17 incidents to 4.

Discharge checklists-CCU last month scored 31%. This month has seen an increase in compliance to 51%. The introduction of the new Single Assessment Document in June will highlight the importance of initiating the discharge process on admission.

As we progress within the new nursing structure one of the Matron's roles will be to monitor the quality of care given within the ward areas. These indicators will help the Matrons focus on rapid turnarounds of identified ward areas of concern. The Ward Manager will have accountability and ownership of all action plans.

Wards identified for further action, based on the above quality indicators are: CCU, Short Stay Unit (Ward Manager has been absent for the month and could be root cause of non submission and a decrease in quality). Examples of action noted are: discharge training, introduction of the new Single Assessment Process document and training and development of medication practices.

Trauma & Orthopaedics:

Falls- Juniper Ward had a total of 3 falls within the month. However the trend analysis indicates a decrease from 8 in the previous month. There has been a significant rise in the fall rate on Dickens Ward from 0 to 4 in month. This is due to transfer of elderly medical and fracture neck of femur patients from the SPH site. The introduction of the Falls Specialist Nurse along with the implementation of the High Impact interventions will support the ward with training programmes, identification of appropriate patients for transfer and falls prevention strategies.

Discharge Checklist-

Two wards have shown a significant improvement in compliance, Juniper Ward scored 87% an increase from 37% and Dickens Ward 95% an increase from 77%. However Elm Ward is showing a decrease to 14%. Discharge is seen as a high priority for the Division and is now being driven by the Clinical Director by setting EDDs (estimated discharge date) with the junior doctors every morning. With the introduction of the Single Assessment Process document and MDT discharge training that is planned for June, the above figures should improve further.

Pressure Ulcers- Both Juniper and Elm Wards have seen an increase from 2 to 4 cases of hospital acquired pressure ulcers for the month. This is unacceptable and the Matron along with the Ward Sisters and Clinical Practice Educator are carrying out root cause analysis and will address any training issues. This will be monitored by the Head of Nursing.

Surgery:

Peripheral Cannula- Kingfisher Ward scored 60% in month and this is being addressed by the Matron for surgery and the Head of Nursing for theatres to ensure that the documentation after insertion prior to anaesthesia induction is clearly documented. The Ward Sister will ensure that the

VIP score is documented for every shift and that cannulas are removed as quickly as possible. This will be monitored by the Matron who now has a more prominent clinical and quality focused role.

Discharge Checklist- There has not been a significant increase in completion this month across the Division and Heron Ward achieved the lowest score of 62%. This is attributed to having a lack of senior leadership for quite a considerable amount of time, due to the Ward Sister being on long term sick leave. This has now been addressed by the Matron and a plan to support the ward has been put into place.

VTE Assessment Compliance- Apart from Kingfisher Ward there is a declining trend for the other wards this month. This has been highlighted at both the medical and sisters Divisional meetings to raise awareness and education. Care Rounding and shift leader checks will monitor this going forward.

Maternity

Infection Control: The overall Matron's audit was 95%

Looking at all the results overall, the picture is quite good. The lower than usual score for urinary catheter after care on Joan Booker was due to 2 Midwifery Assistants not cleaning the tap before emptying and they have been reminded of this.

Complaints

One of the complaints was from June 2010

VTE:

VTE score is improving. This is a difficult are for Maternity as the women is in early labour, she will not have her assessment until after she delivers as it will change as she labours and we cannot give any prevention while she is in labour. If she then stops labouring and goes home, she sometimes misses the assessment for the time that she was in. We are working on ways to ensure we capture everyone.

Submitted by: Dr Mike Baxter, Medical Director & Suzanne Rankin, Chief Nurse

Date: 12th May 2011

Appendix 2 WQI definitions

Saving Lives is the compliance measurements that indicate the use of High Impact Interventions in key clinical procedures which aims to decrease the risk of infection

1 Hand Hygiene Compliance
Audits of members of staff cleaning/decontaminating their hands between procedures

2 Number of MRSA bacteraemia
MRSA isolated in a blood culture therefore present in the patient's blood stream

3 Number of C Diff cases (Hospital post 72 hours)
Clostridium Difficile toxin isolated from a patients stool specimen following episodes of diarrhoea.

4 Central Lines
Ensures the insertion and after care are undertaken in line with good practice to reduce catheter related bloodstream infections

5 Urinary Catheter
Ensures the insertion and after care are undertaken in line with good practice to reduce urinary catheter related infections

6 Peripheral Cannula care
Ensures peripheral cannula insertion and after care undertaken in line with good practice to reduce cannula infections

7 Cleanliness
Audit undertaken by facilities on a monthly basis related to cleaning standards

8 Matrons Environmental Audit
Matrons environmental audit undertaken weekly of the ward and department and the mean taken for the month

9 Blood Traceability
Numbers of labels returned against number of blood bags used.

10 Pressure Ulcer Prevention
2 areas are audited: Compliance with the monitoring return, and Actual Grade of Pressure Ulcer

11 Mixed Sex Wards
Number of patients that were in a mixed sex environment for more than 2 hours

12 Total number of falls

13 Number of falls resulting in significant injury,
Falls graded 3, 4 or 5 which indicates harm as reported via incident reporting

14 Complaints
Actual number of complaints registered to the clinical area in reporting month.

15 Medicine administration errors
Number of errors reported via incident reporting

16 Medication prescribing errors.
Number of errors reported via incident reporting