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

TRUST BOARD
27th January 2011

TITLE	**Quality Report**
EXECUTIVE SUMMARY	The Quality Report is presented for the month of December 2010. The Quality dashboard indicates one red rated indicator – VTE assessment, this is now being recorded for all of the Trust's clinical activity, all data being registered and collected automatically. The Trust performance at 85.8% (for the whole Trust) is one of the highest rates in the country. Focussed improvement is ongoing in surgery and assessment areas. Data is now being provided for the National Bowel Cancer Audit Programme (NBOCAP). The Trust has been 1 of only 2 Trusts not to submit to this Audit programme. The Enhancing Quality programme has produced the first quarter results demonstrating compliance with best practice pathways. The Quality and Risk Profile demonstrates no change in the 16 essential standards but improvement in risk ratings for 2 of the 5 sections under which the 16 standards sit – these are Involvement and Information, and Personalised Care, Treatment and Support. This improvement relates to our improved maternity survey which is now part of the data set.
BOARD ASSURANCE (Risk) / IMPLICATIONS	The Quality Report provides assurance that Quality indicators are being monitored and assessed and that actions are being put in place when required.
STAKEHOLDER / PATIENT IMPACT AND VIEWS	None sought
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	None identified
The Trust Board is asked to:	Review the paper and discuss the contents
Submitted by:	Dr Mike Baxter, Medical Director & Suzanne Rankin, Chief Nurse
Date:	20th January 2011
Decision:	For Noting

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1 Quality Performance Monitoring

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 2008/09 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 7 (Oct) we divide 2008/09 Total by 2008/09 YTD at month 7 to give us the proportion of activity that historically took place as a guide to how much more activity will take place during the rest of 2009/10. This is then multiplied out by the YTD figure for 2009/10. To further account for recent up or downward trends we have divided the average monthly figure for 2008/09 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(2008_09 up to m7)/SUM(2008_09 Total)) x 2009_10 YTD x (2008_09 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).

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1.2 Commentary on Quality and Safety Balanced Scorecard

Ashford & St Peter's Hospitals NHS Trust

BALANCED SCORECARD

Position as at: **31 Dec 2010**

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

	Patient Safety & Quality	Annual Target	Forecast	Actual	Change			YTD
1-01	Standardised mortality (Relative Risk)*	82	82	86.6**	▼	▲	▲	87**
1-02	Crude mortality	2.6%	2.0%	2.3%	▲	▼	▼	1.6%
1-03	MRSA (Hospital only)	5	5	0	◄►	◄►	◄►	5
1-04	C.Diff	67	39	3	▲	▼	◄►	30
1-05	Patient Satisfaction (Your Feedback)	90%	80%	76.0%	▲	▼	▼	76.8%
1-06	Formal complaints	361	333	17	◄►	▼	▲	250
1-07	SUIs	14	15	0	▼	◄►	▲	12
1-08	Falls - resulting in significant injury (grade 3)	29	17	1	▼	▲	◄►	13
1-09	Hip fractures treated within 36 hrs	85%****	85.0%	90.9%	▼	▲	▼	88.6%
1-10	Readmissions within 14 days	3.7%	3.5%	3.0%	▼	▲	▲	3.2%
1-11	VTE Assessment	90%	90%	85.8%	▲	▼	▲	80.5%
1-12	Summated Adverse Report Index (SARI)	1924	1738	97	▼	▲	▲	1304

* Source data from Dr Foster ** Actual = Oct 2010 YTD =Apr-Oct 2010/11

*** Actual = Oct 2010/11 YTD =Apr-Oct 2010/11 ****Q3 = 85%

1.01 The Trust's SMR has shown a small improvement from the previous report (88).

1.02 The CMR for December has shown an increase from 1.7% to 2.3%. This reflects the very large spike in emergency activity related to the cold spell and an increase in those patients suffering from flu. The patients seen at this time have had increased acuity, with a substantial increase in critical care activity related to severe pneumonia and flu related illness. This has been experienced nationwide with nationwide directives being issued on the use of critical care.

1.03 There have been no cases of MRSA in the Trust. This marks 168 days since the Trust had its last MRSA case. Latest information suggests that next year the Trust's MRSA target will be 4 or less cases.

1.04 There have been 3 cases of hospital acquired C.Difficile. These 3 cases have been on the same ward (Maple) but the RCA has not suggested a causal link. Practices on the ward have been reviewed by the Infection Control Team and will continue to be monitored.

1.05 Patient experience is discussed in detail elsewhere in the report.

1.06 F Formal complaints have show an improvement from 32 recorded in the last report to a figure of 17 for December. The Trust is on track to record an overall reduction in formal complaints of 18%.

1.07 There were no SUIs registered in December. This reduces the YTD rag rating to amber from red in the previous month.

1.08 There was 1 fall resulting in grade 3 injury in January, this was on MAU.

1.09 The fractured neck of femur operation rates are 90.9% which is delivering on the Trust's Q4 (and the national) target of 85%. This is the second consecutive month the Trust has performed above 90% (last month was 93.5%) and gives assurance that the delivery of this target is now robust.

1.10 Readmission within 14 days, which is within target, will next month be replaced by the readmission rate at 28 days. This will be a new national metric and continues to be a focus of review in the Trust and nationally. At this time, we have not seen any significant change in the rate of 28 day readmissions. The Operating Framework states that there will be a financial sanction for readmission following an elective procedure and that the Trust should be able to demonstrate strategies to reduce elective to emergency readmissions by 25%. An action plan and option appraisal is being discussed at the NWS transformation board and an application for re enablement funding has been made. The Board will be updated when a decision has been made.

1.11 VTE assessment is now being recorded for all of the Trust's clinical activity, all data being registered and collected automatically. The Trust performance at 85.8% (for the whole Trust) is one of the highest rates in the country. We are now collecting data on mortality related to VTE events so that we can track the impact of full compliance on the rates of these complications.

1.12 The SARI shows a second consecutive month of improvement, with a reduction from 127 to 97 events this month. The Trust is on target to reduce the number of adverse events by 200 this year.

1.3 Triangulated data dashboard

The triangulated data dashboard is presented in draft. The Board should note that the data used is populated from previously established reports and is not validated. The process for ensuring accurate data will be established for the February Board. The parameters for targets are under review and will be presented to the Board in February for agreement.

The aim of the dashboard is to present an overview of the ward areas using outcome data. This will assist in quickly identifying an area in need of support and enable the Trust to address this.

1.4 NHS Outcomes Framework

The DoH has recently published guidelines for the new Outcomes Framework, which stipulates data to be collected, and published, for all trusts in the country. This data will be used to "benchmark" and compare the quality of clinical services and will be used as a monitor of quality performance but will also be available to commissioners and patients to assist their decision making.

The document describes one framework divided into 5 domains. From the 5 domains are drawn 10 over arching objectives. There are 31 areas described "for improvement" which are the subject to 51 separate metrics.

The 5 domains are collected under the Darzi headings outcome, safety and experience: 3 relate to outcome (reduction in mortality, improvement in chronic disease and improvements in acute care) one domain under safety and one under patient experience.

Mirroring our, and others experience, the metrics for outcome and safety are clear and easily defined. Those surrounding the patient experience are more difficult and are "to be announced".

The proposal is that the Trust will collect the data as described in the 5 domains. This data will be held in a data warehouse so that it can be drawn down automatically at anytime.

This data will feed 3 divisional dashboards representing outcome, safety and experience which will be populated by a subset of the original data which specifically addresses issues and concerns relevant to the divisions.

These 3 divisional dashboards will then "inform" a single Trust quality dashboard (divided into outcome, safety and experience) which supplies relevant information about the Trust's quality performance and cross references with the Trust's clinical quality strategy, whose construct directly mirrors the national framework.

This proposed structure will allow us to collect the national data set and then automatically draw on subsets of this information in dashboard reports throughout the organisation to monitor and report on the quality of care. The first draft of this report will be brought to the March Board.

2. Clinical Effectiveness

2.1 Crude Mortality Rate

CRUDE MORTALITY RATE BY DIVISION/SPECIALITY

	CMR OCT 2010	ABSOLUTE NUMBERS	AUG 2010	SEPT 2010	OCT 2010
ALL	1.55%	103	▼	▲	▼
MEDICINE	3.55%	68	▼	▼	▲
SURGERY	1.57%	21	▼	▲	▼
ORTHO	0.52%	3	▲	▲	▼
PAEDIATRICS	0.46%	3	▼	▲	▼

The mortality table has been modified to show the 3 month trends. Up arrows indicate a reduction in mortality, down arrows an increase. It is clear that there are no trends currently causing concern.

The data shows that the number of deaths in October was identical to the figure reported in September.

There had been an improvement in medicines mortality from 4.43% to 3.55%. There has been one death which appears to be related to a hospital acquired C.Diff infection. First review suggests this was in an elderly patient with co-morbidity who was appropriately treated with antibiotics which increased his risk of C.Diff. This will, however, be reported as an SUI, further investigated and a report will be presented to the Board.

Surgery has shown an increase in mortality (1.57% to 1.05%) the trend analysis does not show this to be a consistent pattern. The coding suggests that 3 of the patients were classified as elective procedures. This will be reviewed further and an update provided verbally.

Orthopaedics and paediatrics showed a small but insignificant increase in mortality rates this month but the numbers of patients involved in these divisions is very small (3 in each)

All divisions are holding Mortality and Morbidity reports which are reported at the CGC.

This analysis is supported by a comparison with other local acute trusts which shows ASPH medicine to have the lowest mortality locally while it is comparable in all other specialities.

2.2 National Bowel Cancer Audit Programme (NBOCAP)

ASPH was previously one of the only two Trusts in the country not to submit NBOCAP data. This was because our IT systems could not provide all the data items and a dedicated resource for data capture and input would be necessary and the Trust opted not to do this. An interim solution has been to undertake retrospective audit and the Information department have developed a database to enable submission of data. Further work is underway to provide an IT solution.

All eligible patients (~200 patients) from August 2009-10 have been entered into NBOCAP. This is an important for the Trust as it enables us to understand our clinical effectiveness alongside other Trusts. The Cancer network and PCT have been keen for the Trust to be part of this audit programme.

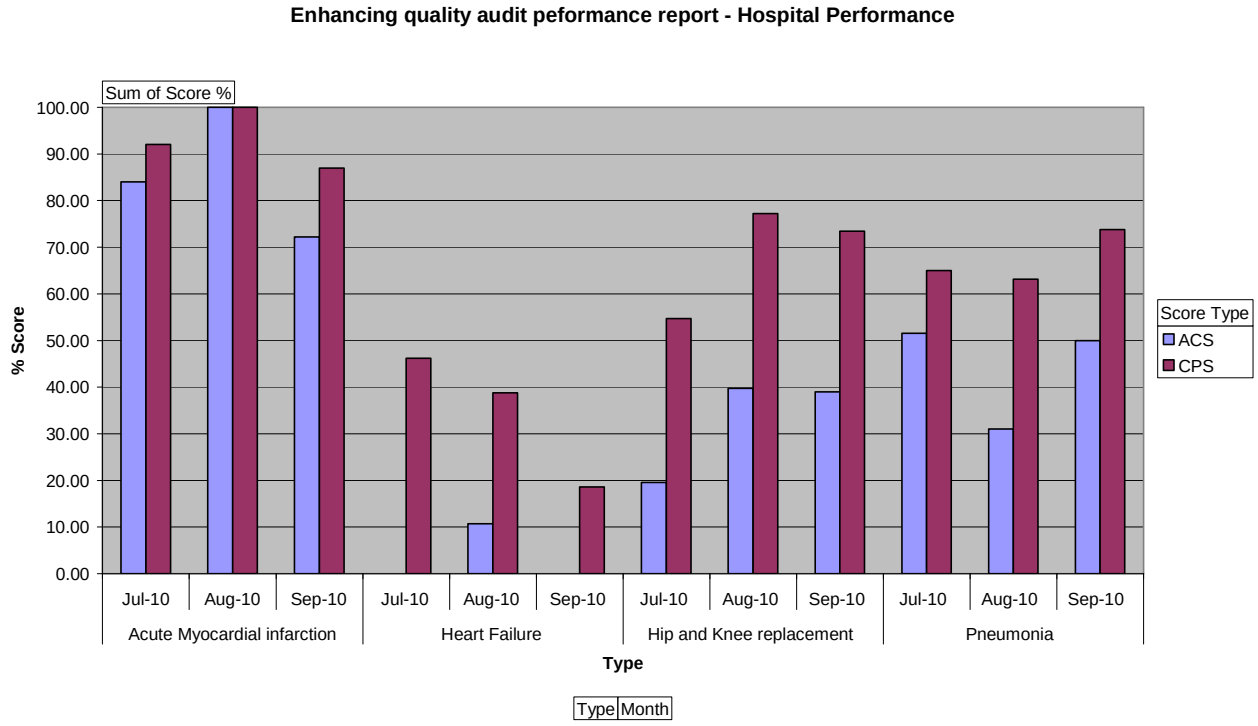
2.3 Enhancing Quality Programme

The Enhancing Quality programme has received baseline results from the first quarter audits. The results are provide for the four pathways; Acute Myocardial Infarction (AMI), Heart Failure, Hip and Knee Replacement, and Pneumonia.

The results are presented using a Composite Process Score (CPS) and an Appropriate Care Score (ACS)

The **Composite Process Score (CPS):** for each pathway there are a number of clinical interventions that are seen as important to a patient's care and outcome. The CPS simply adds up all the interventions that have occurred for all the patients within the pathway, and provides a percentage score. The CPS therefore gives the Trust an indication of whether the right interventions needed for the patient are being delivered.

The **Appropriate Care Score (ACS)**: for each pathway there are a number of clinical interventions that, when given together, provide the best outcome for the patient. The ACS calculates the number of patients that have received **all** of the clinical interventions, for each pathway. The ACS therefore gives the Trust an indication of whether patients within the pathway are receiving the best care possible. Where a pathway can show 100% in their ACS (as in Acute Myocardial Infarction) this demonstrates that all patients in this group have received the best care and therefore have the best opportunity for a good outcome.



The results were reviewed by the Clinical Leads group and it is noted that the four pathways each require a different focus for improvement. The pathways all have clinical interventions that have been agreed by SEC clinicians and are anticipated to give best outcomes for patients. We would aim to have 100% compliance with our ACS as this should ensure optimum outcomes for patients. For pathways such as AMI there are clear interventions already in place whilst heart failure is a pathway with more complexities and in need of further focus, not just in acute intervention but within our management process and across primary care boundaries.

Action plans are in place and the Clinical Leads group will monitor progress. The programme continues to be supported by events and learning opportunities to deliver improvements.

3. Safety Update

3.1 NPSA Safety alerts

Overdue Alerts
Two alerts remaining overdue as follows.

Deadline	Description	Lead	Status
05-Feb-07	Early identification of failure to act on radiological imaging reports	Jonathan Glover	Work is ongoing to move towards an IT solution using the Communicator software. Following a recent SUI the team are currently running an audit looking at code 5 reporting. This will lead to some recommendations which will be considered as improvements to our current process.
19-Sep-09	Risk to Patient Safety of not Using the NHS Number as the National Identifier for all Patients	Donna Jarrett	The iSOFT (PAS) new release (4.3) is planned for Jan 2011. This will enable us to move forward with this alert. Other Trusts that use the same PAS software are in a similar position in that they have to wait for the IT software to be completed and implemented.

New Alerts

Date of Issue	Description	Deadline	Lead	Status
16 December 2010	Safer ambulatory syringe drivers	16 December 2011	Karen Cook	On target

Alerts due for completion in next month

Date of Issue	Description	Deadline	Lead	
30 July 2010	Reducing treatment dose errors with low molecular weight heparins	26 January 2011	Lisa Jackson	

Status
There are a number of items outstanding and this alert is likely to be closed after the deadline. There are three outstanding actions that the team are actively working to progress. Divisions need to confirm that appropriate weighing scales are available and new ones ordered if required
The A&E Integrated Care Pathway is being updated to include a section for recording renal function (and any necessary dosage adjustments as a result) and weight. The team are also awaiting posters from the manufacturers of enoxaparin to support staff in calculating doses correctly.

4. Patient Experience

4.1 Your feedback

Net Promoter Score
The Net Promoter Score is identified in the triangulated data report.

Net Promoter Score Definition: Patients are asked 'Would you recommend the Trust to family and friends?' Response can be: Yes, definitely / Yes, probably and No. The net promoter score is calculated by subtracting the percentage of 'No' responses from the percentage of 'Yes' responses.

A new version of "Your Feedback" has been launched in January and will enable a more accurate calculation of the net promoter score; patients are asked to provide a score between 0 and 10. NPS is calculated by subtracting the percentage of 'detractors'', 0-6, from the percentage of 'promoters'', 9-10 scores.

There are a number of red rated areas. This may be due to the pressures wards faced during December, e.g. high volume of patients going though A&E and emergency flow areas, medical outliers on surgical ward areas and a number of escalation areas open within which staff are caring for patients. The results will be fed back to the ward areas.

'Your Feedback, Outpatients' was launched on 10 January and is running as a one month pilot in three specialties at both hospital sites: Gastroenterology, Ophthalmology and Respiratory medicine. The first reports will be available mid February.

4.2 Complaints/Ombudsman reports

There were 17 complaints received in December and the divisions with highest complaints were Medicine and Emergency Care (7) and Surgery (4).

Examples of the most common issues raised in December are given below

Communication – failure to notify (7 issues)
Family of an elderly patient raised several concerns regarding inadequate communication. Family was concerned around the lack of information from the nursing staff and the difficulty in trying to speak with a doctor. No discharge summary was sent to the patient's GP and there was no communication around the follow up treatment and management of his lung cancer.

Communication – accuracy/completeness (6 issues)
Patient's mother raises concerns relating to the lack of communication regarding her son's care and considers that she was provided with conflicting and inaccurate information from two different consultants. As a result she was unclear and concerned around the reason for protracted assessments and investigations.

Clinical decisions/treatment – medical (6 issues)
Patient was admitted with bleeding from a scalp haematoma and was admitted overnight for observation, including a CT scan and blood testing. The patient was discharged but was re-admitted with arterial bleeding from the scalp haematoma and as such considers their initial examination and assessment was inadequate.

Clinical competence – medical (4 issues)
Patient sustained a deep gash to the heel of their right hand, which was stitched before being discharged with antibiotics. When stitches were removed, the patient was subsequently found to have damaged the ulnar nerve, which the patient alleged had not previously been detected. The patient underwent an urgent operation and although is recovering, is unable to write, drive or carry out their job effectively.

All complaints are investigated by the Divisions and actions put in place to improve situations that have resulted in a complaint.

The Trust received no notifications of complaints having been referred to the Ombudsman for review during December.

4.3 Quality Risk Profile (QRP) November

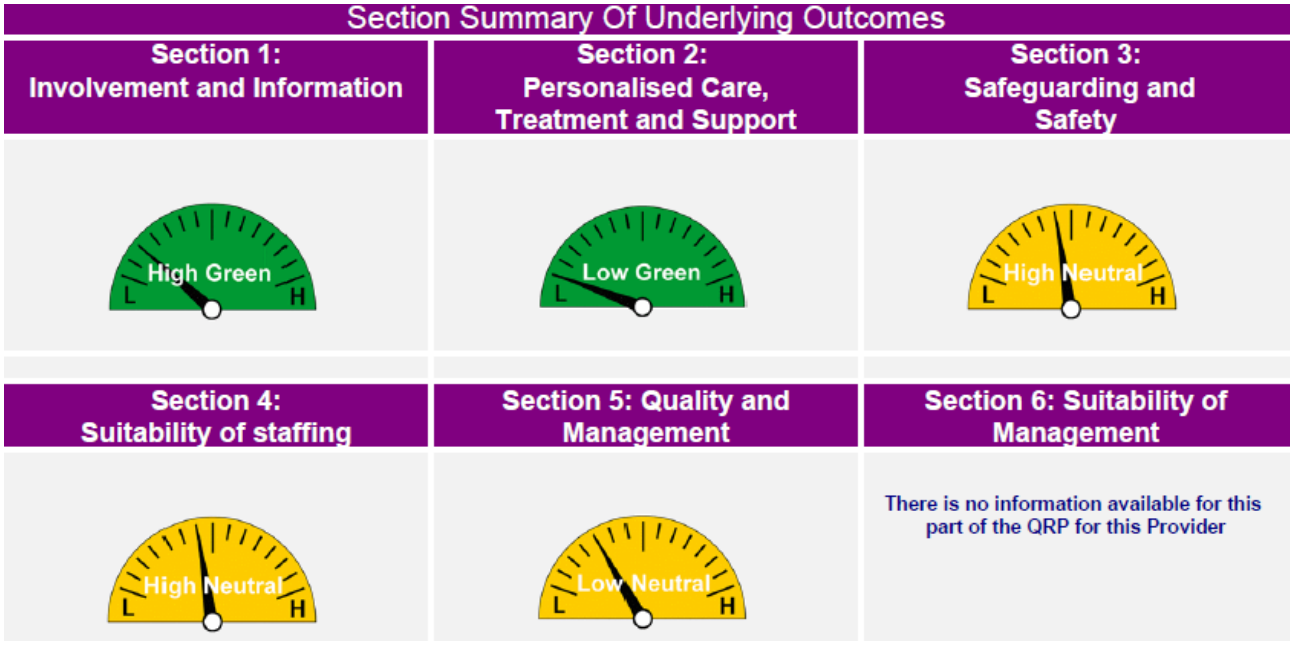
Current risk ratings

The results of the Maternity Survey highlighted in December Quality report has resulted in an additional data source being added to the profile – we are rated amber for this item which is as expected and we note the significant improvement from the previous survey in maternity services.

Recommendations from the Picker report on our maternity services and the CQC maternity survey have been incorporated into one action plan which was received by the Board in December. Actions relate to improvement in community services and labour services, both of which are being taken forward from now until April 2011.

Section improvements
The 16 Essential Standards for Quality and Safety are grouped under 5 sections. Risk ratings are provided for each section as well as the individual standards.

For Section 1 Involvement and Information our risk rating has improved from mid amber to high green.
For Section 2 Personalised care, Treatment and Support has also improved from mid amber to low green. Other sections remain the same



Risk ratings for Essential Standards of Quality and Safety
There is no change in the risk ratings for the 16 essential standards. For each essential standard data items are provided which are also rag rated. Red data items in the main relate to Outpatient Survey and are the same items noted in previous reports.

Outcome	Rating from QRP Oct 2010 (sept data)	Rating from QRP Nov 2010 (Oct data)	Rating from QRP Dec 2010 (Nov data)
Respecting and involving users	Low Amber	Low Amber	Mid amber
Consent	No information	No information	No information
Care of welfare of users	Very low Green	Very Low Green	Very Low Green
Nutrition	Very low Green	Very Low green	Very Low Green
Co-operating with other providers	No risk rating	Mid amber	Mid amber
Safeguarding	No risk rating	No risk rating	No risk rating
Cleanliness and infection control	Green	Low amber	Low amber
Management of medicines	Mid Amber	Mid amber	Mid amber
Safety and suitability of premises	Green	Very low green	Very low green
Safety and suitability of equipment	No information	No information	No information
Requirements relating to workers	No risk rating	No risk rating	No risk rating
Staffing	Amber	Mid amber	Mid amber
Supporting staff	Amber	Mid amber	Mid amber
Assessing and monitoring quality	Amber	Mid amber	Mid amber
Complaints	No risk rating	No risk rating	No risk rating
Records	Green	Mid amber	Mid amber

4.4 Ward Quality Indicators

In the month of December, the WQI indicate that:

- Complaints for the wards have reduced from 21 in November to 12 in December
- Prescribing medication errors have reduced but administration errors have demonstrated a slight increase
- Falls have increased from 41 in November to 80 in December. This level of increase is currently being investigated by the Heads of Nursing.
- MUST assessment completion rates have shown some improvement and action is in place through the Nutrition Steering Group to improve these rates and to ensure compliance and accuracy of assessment process in order to ensure those patients at risk receive appropriate early intervention
- Blood traceability is noticeably deteriorating this month across the Trust. The Deputy Chief Nurse will be investigating this indicator and ensuring actions are taken
- VTE compliance continues to demonstrate some improvement particularly in surgery due to action undertaken for the last two months. Assessment areas continue to receive focused support to improve compliance.
- There has been partial submission of WQI data from Fielding and Dickens Wards on Ashford site due to increased workload associated with escalation and operational pressures. This is not considered acceptable and the reasons for partial submission will be fully explored by the Chief Nurse and the Deputy Chief Nurse with the senior nursing team responsible for the site.

Actions have been undertaken to identify trends and patterns in graph format for each ward and this is now in draft development and will be brought to the next Board meeting in February.

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

Date: 20th January 2011

Appendix 1

INITIAL DRAFT FOR DISCUSSION

First draft of potential triangulation of Quality data:PLEASE NOTE amber perameters are for demonstration purposes and no amber ratings have been agreed by executive team.	**Data Sources**	
	NPS	Your Feedaback
	Complaints	Monthly complaints data, Customer Affairs
	PALS	Monthly PALS data, Customer Affairs
	CMR	Dr Foster, Information Department
	Incidents	Datix database Quality department
	HR data	Monthly performance data, HR

	Net Promoter score 'patient feedback' target 90% (>80% amber) NOTE Q3 data - not monthly	**Complaints any complaint red rated**	**PALS 4 (1 a week) = amber > 4 = red**	**CMR**	**Incidents grade 1+2**	**Incidents grade 3,4,5**	**Turnover target <13% (13-15 amber)**	**Sickness as a%hours available target <3.5% (3.5-5.5 amber) OCT DATA**	**Appraisal 95% (>85% amber)**	**Net Promoter score - 'staff feedback'**
Acute Medicine and Emergency care	**AVE = 66%**			**14%**						
ASPEN	80%		4	25%		0	17.0	6.3	72.7	
CCU			0	2%		0	16.5	0.4	83.3	
BIRCH	80%		3	10%		0	14.8	1.9	100	
MHDU			1	32%		0	5.5	1.9	90.5	
HOLLY	67%		5	44%		0	21.5	3.8	85.3	
CEDAR	79%	1	3	19%		0	5.9	2.4	91.4	
MAY	68%	1	4	22%		0	18.7	2.7	92.3	
MAPLE	67%	1	6	43%		0	20.0	2.9	100	
MAU	54%		17	5%		1	11.5	1.1	79.1	
A&E		2	6	0%		0				
CHAUCER	100%		1	14%		0	17.9	4.1	62.5	
WORDSWORTH	26%		1	20%		0	11.1	11.8	83.3	
KESTREL		1	3	4%		0	0.00		100	
FIELDING	55%		2	5%		0	5.0	3		
T&O	**AVE = 67%**			**2%**						
DICKENS	86%			0%		0	0.00	11.12	100	
ELM	51%		2	9%		0	5.40	6.68	96.4	
JUNIPER	56%			5%		0	8.40	1.1	73.7	
Surgery	**AVE = 71%**			**3%**						
KINGFISHER	64%	2	5	3%		0	21.40	5.3	80.6	
FALCON	77%			7%		0	16.90	1.1	88.9	
HERON	65%		2	3%		0	23.30	7.8	91.7	
SAU	77%	2		0%		0	8.10	14.6	71.4	
Anaesthetics, critical care and Theatres				**0%**						
THEATRES				0%		0				
DSU			4	0%		1				
Critical care				0%		0				
Diagnostics and therapeutics				0%						
ENDO				0%			3.60	2.7	80.8	
X-ray			3	0%						
Women's				0%						
JOAN BOOKER				0%		0				
LABOUR WARDS				0%		0				
PAEDS				1%						
ASH/OAK				0%		0	7.20	4.17	80.4	
PAED A/E			2	0%		0	23.30	6.09	94.1	
NICU				6%		0	8.10	8.66	87.9	

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