Ashford and St. Peter's Hospitals NHS
NHS Trust

Trust Board
29th April 2010

TITLE	**Quality Report**
EXECUTIVE SUMMARY	The Quality Report brings together the • Dash Board, with associated commentary and analysis • Ward Metrics, with associated commentary and analysis • Quality overview In the April report is the PICC (PALS Incidents Complaints and Claims) quarterly report which gives details on areas of concern in directorates and an overview of the corporate position. The dashboard indicates less than satisfactory performance on fractured neck of femur treatment with 48hours. MB will give further information at the Board on actions. This month the Matrons provide a report for their areas against the ward indicators. 5 safety alerts remain outstanding with action plans for completion through May to Sept 2010. Incident reporting remains within our variance, as does complaints and PALS. Discharge and discharge planning is a common theme through PALS incidents and complaints; there has been concerns raised around readmission in A&E and this has been audited and reviewed. MB has instigated a full review and discussion of the results. PALS are receiving concerns around lack of communication around discharge planning and this remains a significant area for complaints across all directorates. Falls have been steadily reducing and we can now demonstrate a step change, with our average falls dropping form 89 to 71 per month.
BOARD ASSURANCE (Risk) / IMPLICATIONS	Assurance is given to the Trust Board that the details within this Quality report are discussed and debated in detail within the Clinical Governance Committee, which reports by exception to the Integrated Governance Assurance Committee (IGAC).
STAKEHOLDER / PATIENT IMPACT AND VIEWS	Good Quality services are essential. The quality metrics are benchmarked by the Strategic Health Authority and nationally. Poor quality services can affect the level of confidence the patients and commissioners place on our services, and affect the organisations reputation.
EQUALITY AND DIVERSITY ISSUES	All of our services give consideration to equality on access taking consideration into 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 & Caroline Becher Chief Nurse
Date:	15th April 2010
Decision:	To Note

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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).

Line-by-line explanation of each Measure:

1-01 Summated Adverse Report Index (SARI)
This measure is a sum of all the patients who were subject to an adverse event during the month. An adverse event in this case excludes mortality as that is reported 2 months in arrears.

1-02 Standardised mortality (Relative Risk)
This measure is taken from Dr Foster for a limited set of diagnoses standardised across all NHS trusts so that mortality can be compared fairly with other trusts. The data is presented as a relative risk of mortality, a number below 100 means that the trust is better than the average for England, the lower the number the better performing the trust.

1-03 Non-elective mortality (Relative Risk)
The same as 1-02 but filtered for emergency admissions only.

1-04 Mortality 75+ (Relative Risk)
The same as 1-02 but filtered for patients 75 and over.

1-05 Hip fractures treated within 48hrs
The number of patients admitted for hip fractures that have been treated within 48 hours of admission. We specifically look for the time difference in hours between the admission date and the first procedure date.

1-06 Readmissions within 14 days
The percentage of acute patients who have been re-admitted to hospital to the same specialty within 14 days, where the admission method is an emergency admission. We exclude patients who died in hospital, under 16's, maternity, planned and cancer patients.

1-07 Pressure Ulcers/10,000 Bed Days
All patients with a diagnosis of 'L89X' in the first 3 diagnosis fields, criteria supplied by the SHA.

1-08 DVT during admission
All patients with a primary diagnosis of 'I80.1 or I80.2', criteria supplied by the SHA.

1-09 Falls – resulting in significant injury (grade 3+)
Data supplied from Datix by Quality department

1-10 SUIs
Serious Untoward Incidents - Data supplied from Datix by Quality department

1-11 Formal Complaints
Total complaints for the month - Data supplied from Datix by Complaints department

1.2 Balanced Scorecard

Balanced Scorecard

Quality Section

Table 1

Ashford & St Peter's Hospitals NHS Trust

BALANCED SCORECARD

Position as at: **31 Mar 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	Target	Forecast	Actual	Change			YTD
1-01	Summated Adverse Report Index (SARI)	2421	2699	175	▼	▲	▼	2699
1-02	Standardised mortality (Relative Risk)	<100	82.6	81.6	▲	▼	▼	82.6
1-03	Non-elective mortality (Relative Risk)	<100	82.1	82.0	▲	▼	▼	82.1
1-04	Mortality 75+ (Relative Risk)	<100	83.8	80.1	▲	▼	▼	83.8
1-05	Hip fractures treated within 48hrs	100%	83.6%	85.7%	▲	▲	▼	83.6%
1-06	Readmissions within 14 days	2.6%	2.9%	1.8%	▼	▲	▲	2.9%
1-07	Pressure Ulcers/10,000 Bed Days	16.5	11.7	10.1	▲	▼	▲	11.7
1-08	DVT during admission	72	88	5	▼	▲	▼	88
1-09	Falls - resulting in significant injury (grade 3)	29	32	2	▼	▲	▼	32
1-10	SUIs	12	16	0	▲	◄►	▲	16
1-11	Formal complaints	365	401	39	▲	▲	▲	401

1-01 Our SARI has taken an upward movement in month, this reflects the 48 hr hip fracture rate which has been discussed above.

1-02 The SMR rates have shown a non significant small increase in the in month figures. The overall trend for the trust is however down and the trust is double green rated. More specific data is reviewed in section 2.1.1 for pneumonia and heart failure.

1-05 There is a disappointing figure for hip fracture operations within 48 hrs. A more detailed update will be given verbally at the board. This target now needs much more active management to secure its delivery.

1-06 Readmission rates remain below target (which is good) at 14 days. More detailed analysis is provided by an internal audit reported in section 2.

1-10 &1-11 There has been a sustained improvement (decline) in SUI and complaints. This may be the early signs of improving patient experience.

1.3 WQI (Ward Quality Indicators) commentary

The WQI definitions can be found at Appendix 3

The WQI scorecard can be found at Appendix 4

1.3.1 Theatres and Day Surgery Ashford Matrons report

Environmental audit for theatres progressed from amber to green through relaunching a programme for damp dusting and the checking of all department fridge temperatures

1.3.2. Surgery- Falcon, SDU, Kingfisher and Heron wards- Matrons report

Pre and post cannula insertion care on Falcon and Heron, due to lack of VIP scoring and not changing cannula after 72 hours
Action put into place:

- Each ward now has a cannulation trolley. Spot check audits are being undertaken
- Education of staff on a daily basis to raise awareness

1.3.3 Orthopaedics –Elm, Juniper, Dickens, Rowley Bristow Unit

Compliance with Pressure Ulcer monitoring – Elm & Juniper are both down this month to 80%, it is not clear why, but both wards have been reminded of the practice and process. Compliance for Dickens ward is up to 100% from 50% following some on the ward education.

Falls – Elm ward has seen an increase in the number of falls this month. We are working on our management of High Falls Risk patients, and will be trialling a new Falls Care Plan.

Complaints – we have had the same overall number of complaints within the Unit as last month, however, there is one complaint for each area this month. Actions taken relate to each individual complaint.

Medicines administration – Juniper had one administration error, which is the same number as the previous month. However, the ward sisters will be following up on multiple medicines errors using the Capability policy where necessary.

Matrons' Environment Audits - Matrons' environment audits scores are up in 3 of the areas due to action taken as a result of auditing.

1.3.4 MAU and SAU Matrons report

Pressure ulcer audit for both MAU and SAU is Red. SAU failed to submit data for 1 week out of 4. Staff member Band 6 has now been given responsibility for submission of data every Sunday to Matron for MAU and administrative staff member.

2 complaints were received by MAU for the month of March as opposed to 5 for February. This is seen as a good result as the department is one of high pressure due to the complexity of cases and fast paced work environment.
There has been as increase to 100% from 80% for hand hygiene audits this month in SAU

1.3.5 Medicine

Peripheral Cannula care – 80% on May and Maple. May opened as escalation capacity with no cannulation trolley which has been effective elsewhere. Trolley is being acquired. On Maple ward the correct process for aftercare has been re-iterated.

Compliance with Pressure Ulcer Monitoring – MHDU and Maple omitted 1 return. All Wards now required to send returns electronically and copy Matron in to monitor and ensure compliance.

Falls – remain higher on Care of Elderly Wards. Trend shows slight increase but no current action, continue to monitor.

Complaints – May and Maple both had 1 but all other areas show zero or a decrease (Aspen down to 1). May and Kestrel has moved to a vacated ward and increased its capacity with reliance on bank staff. They have unfortunately received 1 complaint during this time.

Drug Administration and Prescription Errors - Prescribing errors are dealt with by pharmacist at the time with the Dr. Examples of errors are taken to the weekly Junior Doctors Forum. New group starting 19th April with a Consultant, Clinical Practitioner Educator, Clinical Governance Manager and Pharmacist to monitor and put in place actions to reduce the errors from both a nursing and medical perspective

The majority of scores show high scores have been maintained. Cleanliness score is very pleasing in view of the ward moves and work that is being carried out on May and Kestrel.

1.3.6 NICU/TCU

Prescribing error: Locum doctor prescribed incorrect doses for drugs. They were not administered. The locum agency contacted and doctor not to be used again.

Drug administration error: Incorrect concentration of IV dextrose being infused.
A concentration chart has been produced for reference.

1.3.7 Rehabilitation Wards, Ashford, Matrons report

Pressure sore compliance: wards to be reminded to use electronic audit tool for data collection. All wards to ensure that if they have an allocated staff member to do the audit that there is a deputy to cover for annual leave. The grade 2 hospital acquired pressure sore was acquired before transfer to Chaucer ward.

Falls: Rehabilitation brings a high risk of falls; this has been highlighted to ward staff. All the wards have had confused patients over recent weeks.

2 MORTALITY AND MORBIDITY

2.1 Dr Foster Summary report

The 2 red trends reported to the board last month are being reviewed.

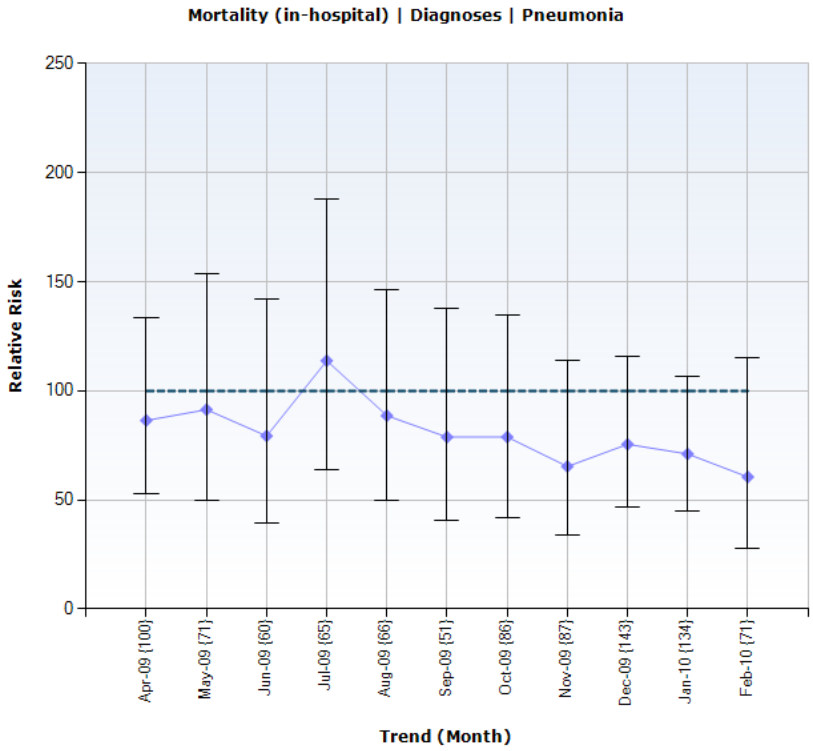
The investigation into non Hodgkins lymphoma has indicated that it only involves 8 cases which have been reviewed by Dr Laurie with no clinical concerns raised. This signal has subsequently been returned as blue and no longer causing concern. This will be watched and reported if concerns return.

The diagnostic category of “other” respiratory disorders is clearly eclectic and in many ways not helpful. We are currently working to understand the diagnostic codes involved and progress will reported back to the board.

In order to offer assurance to the board, that the trust has good performance outcomes for the treatment of patients with respiratory disease a more specific review of pneumonia outcome is presented in section 2.1.1

2.1.1 Pneumonia

Pneumonia is the commonest cause (HRG) of death in most acute hospitals, including ASPH and as such is a very important diagnostic category. Data below shows trends across 2009/2010 in figures and graphically and a benchmarked ranking for ASPH in the SEC.



Trend (Month)	Spells	Superspells	% of all	Deaths	%	Expected	%	RR	Low	High
All	936	934	100.0 %	165	17.7 %	207.5	22.2 %	79.5	67.9	92.6
Apr-09	100	100	10.7 %	20	20.0 %	23.1	23.1 %	86.5	52.8	133.6
May-09	71	71	7.6 %	14	19.7 %	15.3	21.6 %	91.4	50.0	153.4
Jun-09	60	60	6.4 %	11	18.3 %	13.9	23.1 %	79.3	39.6	142.0
Jul-09	65	65	7.0 %	15	23.1 %	13.2	20.3 %	113.9	63.7	187.8
Aug-09	66	66	7.1 %	15	22.7 %	16.9	25.6 %	88.6	49.6	146.2
Sep-09	51	51	5.5 %	12	23.5 %	15.2	29.8 %	78.8	40.7	137.7
Oct-09	86	86	9.2 %	13	15.1 %	16.5	19.2 %	78.9	42.0	134.9
Nov-09	87	87	9.3 %	12	13.8 %	18.4	21.1 %	65.4	33.7	114.2
Dec-09	143	143	15.3 %	21	14.7 %	27.8	19.4 %	75.5	46.7	115.5
Jan-10	135	134	14.3 %	23	17.2 %	32.4	24.1 %	71.1	45.1	106.7
Feb-10	72	71	7.6 %	9	12.7 %	14.9	20.9 %	60.5	27.6	114.9

Peer SHA analysis for the same data
Ashford and St. Peter's rank 5th in the SHA for relative risk of outcome of death from pneumonia

Peer (SHA)	Spells	Deaths	Expected	RR
Trust A	3	0	0.4	0.00
Trust B	592	92	130.4	70.6
Trust C	768	140	179.2	78.1
Trust D	1635	407	516.1	78.9
Ashford and St Peter's Hospitals NHS Trust	936	165	207.5	79.5
Trust E	852	167	208.7	80
Trust F	785	200	227.8	87.8
Trust G	1099	262	284.1	92.2
Trust H	947	206	220.8	93.3
Trust I	703	203	204.1	99.5
Trust J	536	123	120.4	102.1
Trust K	635	143	132.4	108

The data show that our current SMR is 60 and we are showing a month on month improvement in the HRG across the year. Furthermore we are ranked a close 3rd in the SEC sector for lowest mortality from pneumonia..

This data reflects our highly developed use of medical HDU function and use of non invasive ventilation in respiratory patients in HDU and on the medical wards
It is of interest that a lack of non invasive ventilation facilities was noted as one of the deficiencies at Mid Staffordshire which was thought to explain, at least in part their high acute medical SMR. This serves as another feature of our service which distinguishes us from mid staffs

Enhancing Quality programme includes pneumonia; this involves being able to produce a cumulative score for our achievement of key clinical indicators of best practice. This means teams can continue to improve practice where required and clearly identify improvements in clinical care as we continuously audit this pathway. We will report progress on this to the board.

Congestive Heart Failure Patients

The enhancing care program also involves heart failure; we have therefore looked at our SMR for this HRG in the Trust.

Ashford and St. Peter's have the lowest relative risk rate for congestive heart failure in comparison to our peers across the SEC.

Peer	Spells	Deaths	Expected	RR
Ashford and St Peter's Hospitals NHS Trust	316	36	56.7	63.4
Trust B	674	94	142.4	66
Trust C	344	44	63.5	69.3
Trust D	462	54	76.4	70.7
Trust E	198	25	34.3	73
Trust F	246	33	45.1	73.2
Trust G	213	29	35.4	82
Trust H	258	50	56.2	89
Trust I	245	44	49.1	89.6
Trust J	463	69	76.8	89.8
Trust K	617	107	117.9	90.8

This offers great assurance of the quality of our clinical outcomes in this area and also places us well to be leaders in the SEC in the enhancing quality program

2.2 Trust Mortality group

This goes live in April and will provide the Trust with direct information concerning crude mortality rates, identifying trends or patterns which require review. The results of these monthly reviews will form an important part of the quality report from May

2.3 SUI update

There were no SUIs in March 2010.

There were 8 SUI's closed by the PCT in March

Current SUI's open on STEISS system in progress and/or awaiting closure by PCT

SUI	Date of Incident	Date for RCA completion	Date RCA completed
Staff restricted practice	19/02/10	02/04/10	Not yet complete
Reported in detail in part 2 of this report			
Fetal compromise	22/01/10	15/04/10	Not yet complete
During the investigation process it was highlighted that there was a requirement to do a midwifery supervisory investigation alongside the current investigation. An officer from the Local Supervisory Authority has been asked to participate in this process.			
Fetal compromise	09/09/09	02/11/09	Complete
This case had been sent to the PCT for consideration and closure at their Patient Safety Sub Committee (PSSC) which met on the 21st March 2010. The committee rejected closure and has written to the Trust for further information. An updated action plan has been sent re the maternity case and will be considered by the PCT, PSSC on the 15th April 2010.			

Never Event	21/08/09	14/10/09	Complete
This case had been sent to the PCT for consideration and closure at their Patient Safety Sub Committee (PSSC) which met on the 21st March 2010. The committee rejected closure and has written to the Trust for further information. Further to this the National Patient Safety Agency had written to the Medical Director with a list of questions related to the wrong site surgery (never event). The Trust held an extraordinary SUI debrief meeting on the 7th April 2010 chaired by the Medical Director. The original action plan has been reviewed and amendments made with definitive dead lines assigned. The list of questions posed by the NPSA has been answered and sent back to them for consideration. The conclusions and actions presented to the board have not been altered.			

A new national framework for Reporting and Learning from Serious Incidents Requiring Investigation has been published by the NPSA. The Trust has contacted the PCT for clarity of how this will be introduced locally and is waiting for feedback following discussion at their Patient Safety Sub-Committee Meeting. An update will given in the May report.

3 Quality update

3.1 Safety alerts

There are 5 alerts currently over the deadline for closure

05-Feb-07	Early identification of failure to act on radiological imaging reports	There is an early alert pilot in place currently, prior to implementation of electronic software later in the year. This pilot will be reviewed in July at Clinical Governance Committee, and then closed if review is positive.
31-Mar-08	Actions that make anti-coagulation therapy safer	A number of policies are still being developed before this can be closed
09 June 09	Reducing risk of overdose with midazolam injection in adults	The sedation policy was received by the drugs and therapeutics committee and further amendments are required. These will be made and ratified at the committee on the 25th May when the alert will be closed
07-Sep-09	Reducing risk of harm from oral bowel cleansing solutions	Meeting planned for April to put forward proposed process to GP's. Process involves GP's completing checklist and taking certain bloods, which is followed by the issue of an FP10 to the patient, who is then able to pick up a prescription form their local pharmacy with full instructions. Anticipate closure of alert in May 2010
19-Sep-09	Risk to Patient Safety of not Using the NHS Number as the National Identifier for all Patients	Our planned solution is to use iSOFT (PAS) there is a new release (4.3) due in Sept 2010 that will enable us to validate the correct NHS number with the correct patient. This will enable us to move forward with this alert. Other Trusts are in a similar position in that they are having to wait for the IT software to be completed and implemented.

A list of the current status of safety alerts is attached as Appendix 1

3.2 Clinical Audit

During March an analysis of patients who re-attended the hospital soon after discharge was conducted to establish if there were any common trends. There has been some concern expressed about the number of readmissions that are being seen in the Trust particularly in patients initially admitted for medical conditions. This has to date been observations been made by individual observations but not supported by systematic review.

An audit was conducted, initiated by clinical colleagues, into the patterns of readmission over a month early in 2010.

We are all aware that modern practice is to try and minimise both admission and the duration of hospital admission. This takes 2 major courses: avoiding admission of patients who could be managed by alternative services in other health care settings, and by ensuring that there is efficient and effective management of the patients in-patient stay, with discharge being made at the earliest time, to prevent inappropriate protracted stay in hospital.

This requires the assessment of risk and probabilities for the patient made on the basis of clinical experience, an understanding of support available at home or in the community and the patients and families/carers confidence and ability to cope outside hospital.

Readmission rates are a useful metric to monitor the process of discharge. Clearly a high or rising level of readmissions would be worrying and require adequate investigation, explanation and if appropriate action.

The Trust statistics show a 14 day readmission rate of 4%. This is 3% for emergency surgery and 5% for emergency medicine. This is against the PCT target of 6% and compares favourably with other Trusts locally. This figure is reported on a monthly basis to the PCT and to Trust Board.

The recent internal audit was conducted by looking at notes of patients over the age of 65 who were readmitted to hospital within 48 hrs of discharge in the period 31/1209 to 8/2/2010.

This audit identified 52 patients that were readmitted, mean age was 83 and all were being discharged to a home environment. It is worth recording that during this period there were 3200 discharges giving a readmission rate fro the Trust of 1.6%.

Of the 52 patients 23% (12) were discharged immediately from A&E or MAU without being formally admitted and returned the same day. 27% (14) had been admitted for a period of 24 hrs, 12% (6) for 2 days, 25% for 3 to 7 days and 24% (13) for over a week.

37% of patients were discharges from MAU.

The discharge of the rest of the patients was uniform across the wards of the trust (4% each). The high representation of MAU would be expected as this is the area of acute medical assessment and the place where decision on admission and discharge in the acute setting are made.

It is of interest that the re-admission rate for patients following an initial review or a short stay (1 day or less) is 50% of the total. The other 50% of readmitted patients had been inpatients for a more protracted period and therefore were not being accessed for discharge in an acute phase of their conditions.

It could be argued that this represents 2 separate populations. The early discharges being patients in whom an assessment in the acute phase of their illness was being made. The second group being a population who were being reviewed as established in patients following more intensive investigation and treatment.

Data collected separately by myself from HES shows that there is no clustering of readmissions around any individual consultant physician and that 14 consultant physician names feature in this list of readmissions.

In this audit a further sub review was conducted on 25 sets of case notes. Unfortunately it is not clear what cohort of patients these 25 patients represent and in particular it does not indicate the duration of admission of these patients or the ward base from which they were discharged. The audit does not therefore identify if these patients were failures in acute assessment or during the more chronic phase of treatment and care. This is an important point which requires more clarification.

This sub audit does show that in this patient cohort (undefined) 50% of patients there had physiological or biochemical markers that may have predict that the patient was unfit for discharge. These included low BP, high respiratory rate, low haemoglobins or abnormal renal function.

Furthermore 56% of patients had not had OT or social assessment. This may be relevant as all but 1 patient were discharged to their own homes. It is difficult in a retrospective audit to be clear and confident that there is a cause and effect relationship between observations and outcome. Statistically we need to determine the sensitivity and specificity of the markers as predictors of readmission. This data is of great interest and clearly requires further review.

In summary

The data available shows that the trust has a readmission rate of 4% which benchmarks well with the PCT target and neighbouring Trusts. However this still represents a significant number of patients who are readmitted and this cannot be considered to be acceptable and is not what we would wish from a high quality service.

It is now our objective to reduce this figure and improve our service for our patients.

Although a large percentage of early readmissions come from patients admitted onto MAU, this may be expected from the function and role of this unit. There is no clustering of readmissions to any particular physician. We will put in place an on-going audit of this activity.

The observation that 50% of patients may have had indications that predicted discharge failure is an important observation but requires more work and clarification.

I have asked for a meeting with the audit office and those involved with this audit in order to devise an action plan and audit cycle

As of immediate effect I have reiterated to colleagues to observe their discharges very closely and stressed that the primary concern should always be to ensure appropriate, safe clinical care for their patients. Particular attention should be made to older patients being discharged to their home environment.

3.3 Enhancing Quality (EQ) Programme

The Enhancing Quality programme has appointed a programme lead for 6 months to set up the project. The initial start up days have been attended and almost all clinical leads have been contacted and have attended the clinical sessions that form part of the ‘best practice’ set up for the clinical pathways.

We are currently in the set up phase which will run from April till June and involves setting up best practice pathway measurement proformas, ensuring that data can be collated and ensuring we have systems in place for the go live date in July. There is opportunity to try out the data results system which will enable us to get an idea of our outcomes for the pathways. In July 2010 we will start measuring the pathways proper and these results will contribute to the final published results, providing an aggregate score for treatment here at ASPH.

4 Quality reports

This month is the PALS Incidents Complaint and Claims report

TRUST BOARD
29th April 2010

PICC report (PALS, Incidents, Complaints and Claims)

Quarter 3,Oct – Dec 2009

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6 Summary

1. INTRODUCTION

The PICC report demonstrates the Trust position with regard to PALS (Patient Advice Liaison Service), Incidents, Complaints and Claims. The report provides the Board with the information on current position over the last quarter, and any identified trends and actions taken.

The PICC report for Quarter 3 is presented in its new format for the third time. Changes to the format of the report have been made in order to improve the relevance of information provided to the Board, and are made in conjunction with changes that have been made to the Clinical Governance Committee and to IGAC (Integrated Governance Assurance Committee).

Each Directorate reports every six months to the Clinical Governance Committee where more detail is requested and discussed on these issues.

The IGAC will receive an exception report from Clinical Governance Committee and seek assurance on behalf of the Board that actions are taken where necessary.

The report to the Board is presented in line with the Risk Management Standards required by NHS LA (NHS Litigation Authority) and in line with best practice from the Integrated Governance Handbook (2006). As part of our Foundation Trust application the governance processes are under review and as we make the relevant changes to ensure our processes are effective this report will continue to be improved upon.

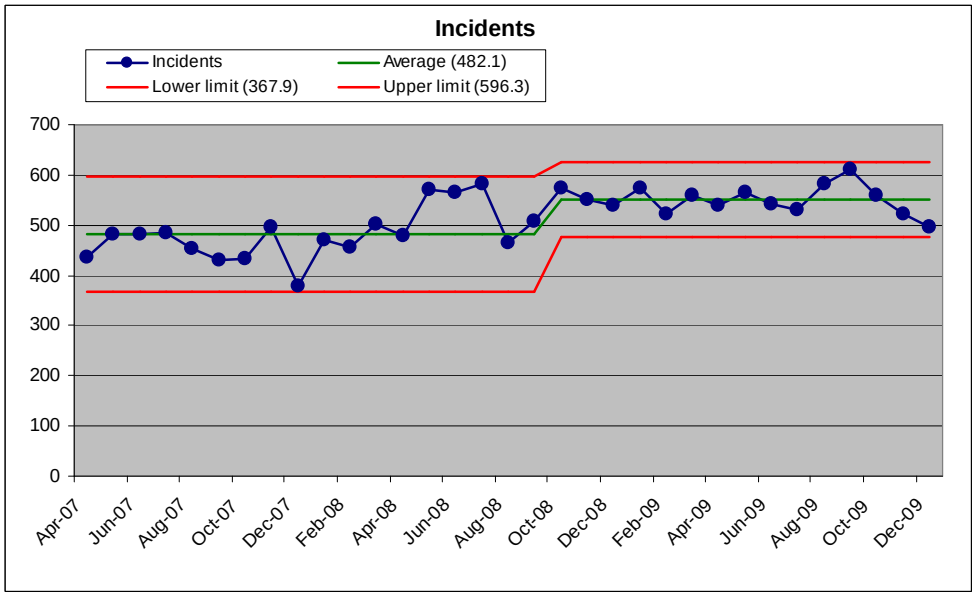
Reading SPC graphs

The SPC graphs (statistical process control) show the average over a period of time. To be relevant these graphs must have a number of points therefore the graphs demonstrate the trend over at least 18 months.
SPC is a better method of reviewing whether any change over time has occurred, rather than looking at one months figures against another as this will always vary, a decrease or increase in this case is not significant.

A step change in the average would be indicated by 7 points above or below the average, and this should be examined and changes made to processes.
A point outside the upper and lower limit variance line indicates an unusual cause that should be explained and actioned but does not necessarily require a change in process.

2. INCIDENTS

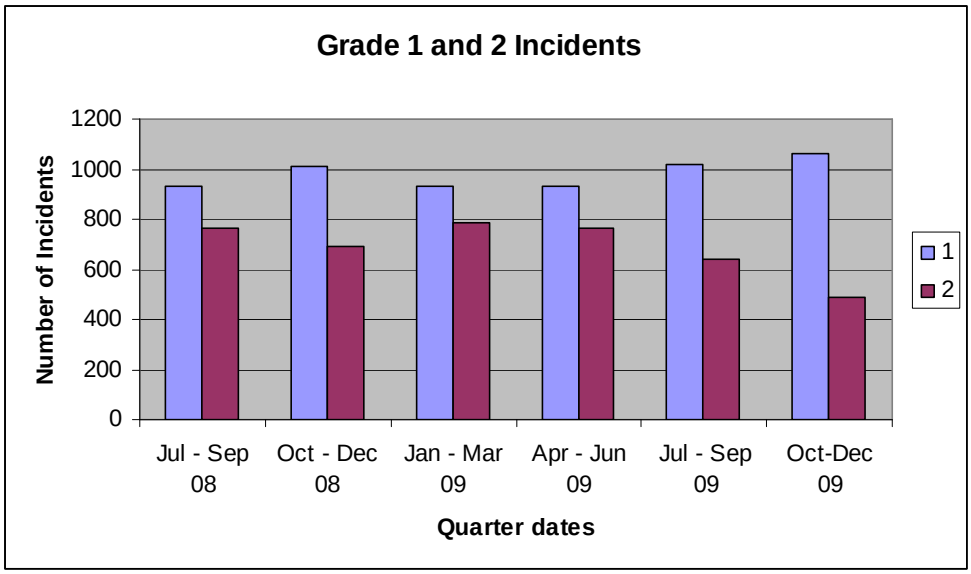
2.1 Total number of incidents by month

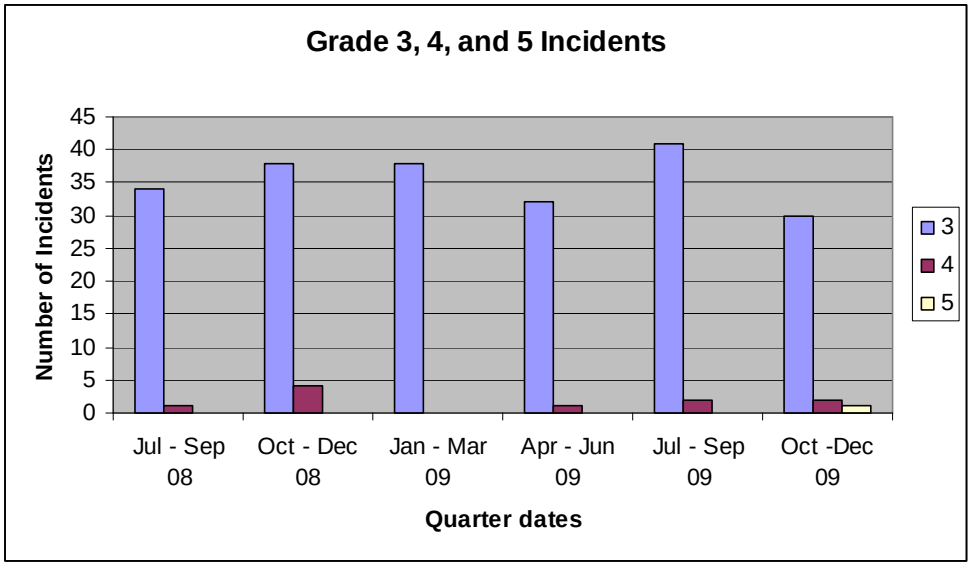


The number of incidents remains within variance with an average of 550 incidents reported per month. Benchmarked against other agencies ASPH is in the mid range of reporters.

2.2 Distribution of Incidents by grade

Grading of Incidents	
Negligible (minimal harm or injury)	1
Minor injury or illness	2
Moderate (moderate injury requiring professional intervention	3
Major (permanent or long term harm/damage)	4
Catastrophic (death caused by incident)	5



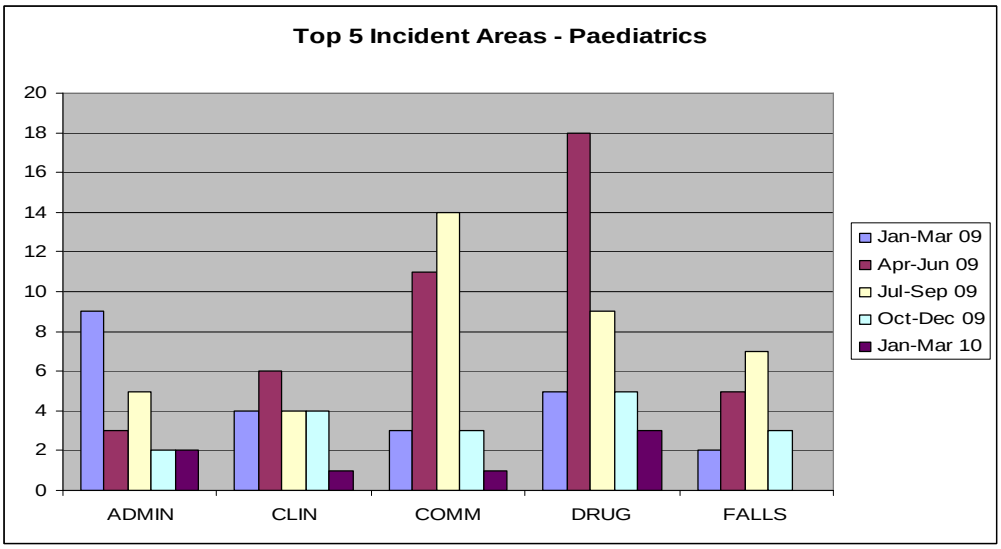


There were 30 recorded grade 3 incidents for this period compared with 41 for the previous quarter, 2 grade 4 incidents and 1 grade 5 event which was reported as an SUI to the PCT. A breakdown of incidents and lessons learned are covered in the Directorate Reports.

2.3 Top 5 incidents by Category and Directorate

2.3.1 Children's service

The top five categories of incidents remain unchanged for the last four quarters.



This report covers NICU, Paediatric A&E, Ash and Oak Wards and Paediatric Outpatients. There has been a decrease in all Top 5 incident areas except for admin, which has remained the same over the last two reporting quarters.

Admin
The majority of these incidents related to short staffing (72% on NICU and 83% on the wards). Recent recruitment drives have been successful; the wards are now fully staffed, NICU will have on-going skill mix and training issues until their remaining posts are filled. There is an additional risk, as identified in the Risk Register, of duplicate hospital numbers arising from the link between PAS and the Choose and Book system. We are currently working with the labour ward and the PAS Manager on improving these systems.

Clinical
Some issues arose on NICU with the storage of milk, timings and delays in feeds. A guideline for checking enteral feeds has been developed and is working well. There were no other trends identified in this category.

Communication
The importance of good communication and 'going the extra mile' in all areas of Paediatrics has been discussed at junior doctor departmental induction days and Educational Half Days. When a communication issue is highlighted line managers are encouraged to speak directly to the member of staff in question as soon as possible. This recently occurred with a junior doctor in the department who has now received further training and on-going tuition has been arranged with the Deanery. Communication is most challenging in Paediatric A&E due to the nature of their work.

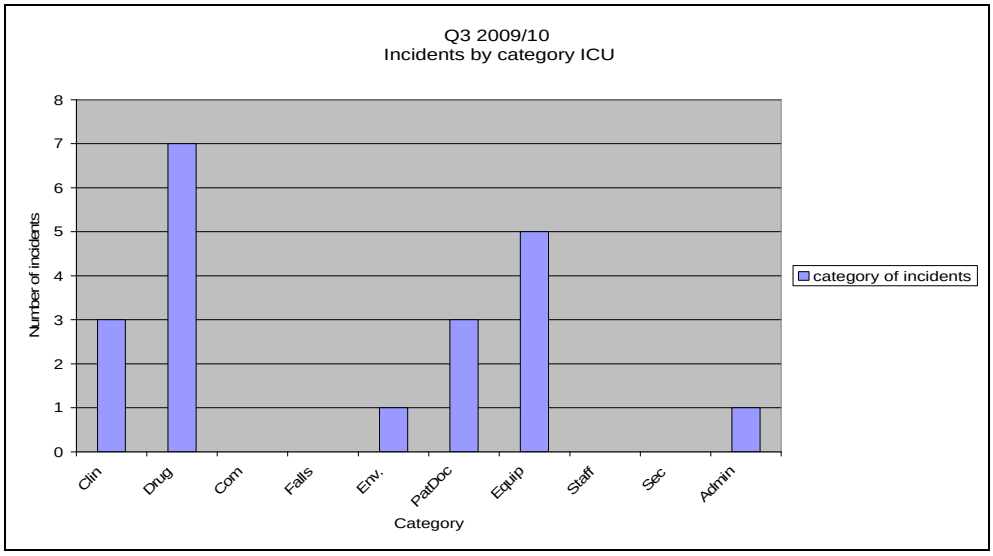
Drug errors
Several drug incidents concerned the non-availability/delivery of drugs from Pharmacy and the Paediatric Pharmacists are aware of these incidents. Others concerned incorrect drug chart entries and delays in administration, mainly occurring due to the pressures of short staffing. Further training has been undertaken with the junior doctors.

Falls
No falls were reporting in the last quarter. Previously, the majority of falls occurred when children fell off toys in the Ash Ward play room.

Learning from Grade 3, 4 & 5 Incidents

Children's Services had one Grade 3 incident which occurred on 31 May 2009 (incident event no. 99851). This was investigated by Helen Sibley, Directorate Manager for Children's Services, and an Incident Investigation Report was submitted on 22 September 2009. The incident involved concerns around child protection issues for a child brought into Paediatric A&E. The department are working closely with A&E to ensure all staff follow the same child protection procedures. Social Services have provided a temporary link social worker for any immediate communications and all staff in the Trust have undertaken a programme of Level 2 Child Protection training.

2.3.2 Critical Care

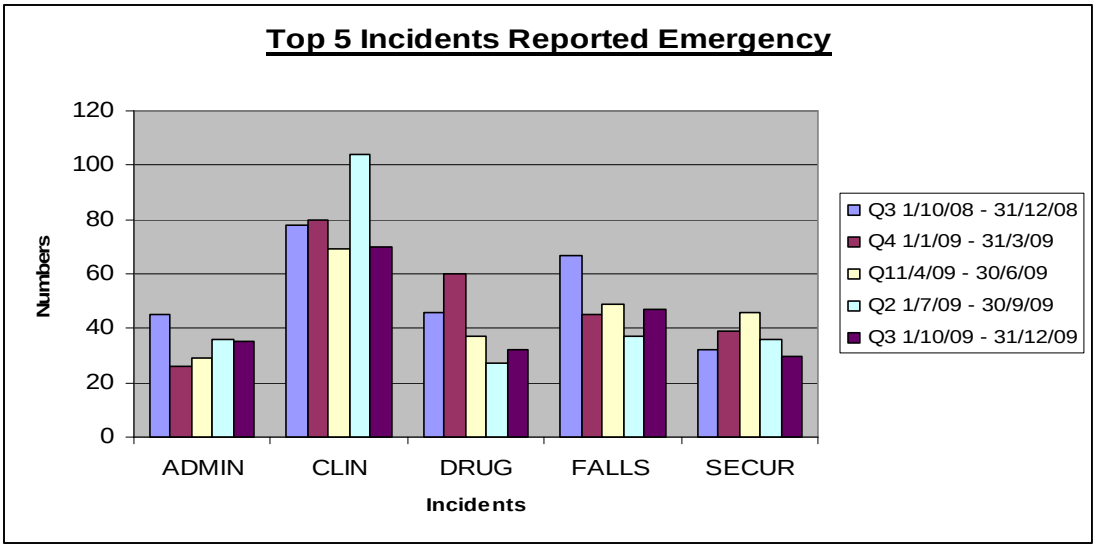


There were no grade 3 or 4 incidents reported in the Critical Care Directorate for this quarter.

Equipment
All of the equipment incidents relate to beds being transferred into ICU visibly dirty and contaminated. This has been reported to the lead for infection control and the deputy chief nurse and plans are now in place.

Drug errors
The drug errors include documentation, administration, omission and underdose. Education has been given within the department to address these issues as well discussion on an individual basis with staff involved.

2.3.3 Emergency Services



Falls

Falls have increased by approximately a quarter (up from 37 to 47) since quarter 2. A large proportion of these falls occurred in MAU and are fairly evenly distributed throughout the unit whereby a problem area for falls on MAU has been identified. The falls are most commonly reported during later evening and the night.

Staffing levels and skill mix on MAU remain a concern at present for nursing staff but an ongoing recruitment programme is currently in place to address this problem and a favourable outcome is anticipated as recruitment and retention improves. The discharge annexe is no longer in use for over night patients and this may account for some reduction in falls on MAU.

Administration

Incident rates have remained stable (from 36 to 35 reported incidents) since quarter 2. The common theme still appears to be concerns over staff shortages and poor skill mix both in MAU, SAU and A+E. As explained above, an ongoing recruitment campaign continues and the results are showing a steady improvement in terms of an increase in nursing numbers.

Another trend identified is the lack of or delay of psychiatric assessment in the A+E department. The Mental Health Trust has had limited resources, and access to psychiatric assessment, particularly out of hours, has been exceptionally difficult. The Mental Health Trust has detailed a plan to commence in quarter 1 2010/11 which increases the number of psychiatric liaison nurses available during hours, adds a new psychiatric liaison manager, and more clearly defines the role of out of hours psychiatric services. There is an on-going acknowledgement that there is a gap in care for people of working age who are ill but do not warrant a psychiatric admission.

Clinical

The reporting of clinical incidences has dropped by approximately one third (down from 104 to 70 reported incidents) for the Emergency Services as a whole.
Patients reported to have been admitted with pressure sores is the first most common incident. Body mapping and documentation have been identified as areas of practice that require input and monitoring in this field since this quarter and the results are yet to be yielded.

Unavailability of a CT scanning service due to equipment failure has also been highlighted as a problem for the emergency services. One occasion reported X2 CVA patients being brought to the A+E department by ambulance when the CT scanner was not in use.

Delay in assessing patients in MAU due to lack of medical staff. There continues to be severe pressures on the medical take team at certain peak hours. These have not decreased during quarter 4, but changes to the emergency pathway during 2010/11 are aimed at reducing the number of emergency medical admissions down to 2008/09 levels, and to increase the ambulatory care ability of the A&E department through the development of a Clinical Decision Unit.

Drugs

The overall reporting of drug errors for quarter 3 increased slightly (from 27 to 32 reported incidents) with the most common trend being incorrect prescribing by doctors. This issue has been addressed at the junior doctors' forum.

On 2 occasions patients were sent home with the wrong patients TTO's requiring transport to be sent out to the patients' homes to retrieve the drugs. This has been partially attributed to poor staffing levels and skill mix but has also been addressed at unit meetings on MAU.
There were also 2 incidences on MAU involving CD's. 1 related to incorrect entry into the CD register of the patients own drugs which was rectified once identified and the other related to the patients own drugs not being entered into the CD register at all throughout the patients stay. A training issue was identified and addressed with the individual concerned.

Security

A 17% drop for quarter 3 has been noted for security incidences (falling from 36 to 30 reported incidents). The most common incident reported was assaults/abusive and antisocial behaviour towards staff in both A+E and MAU.

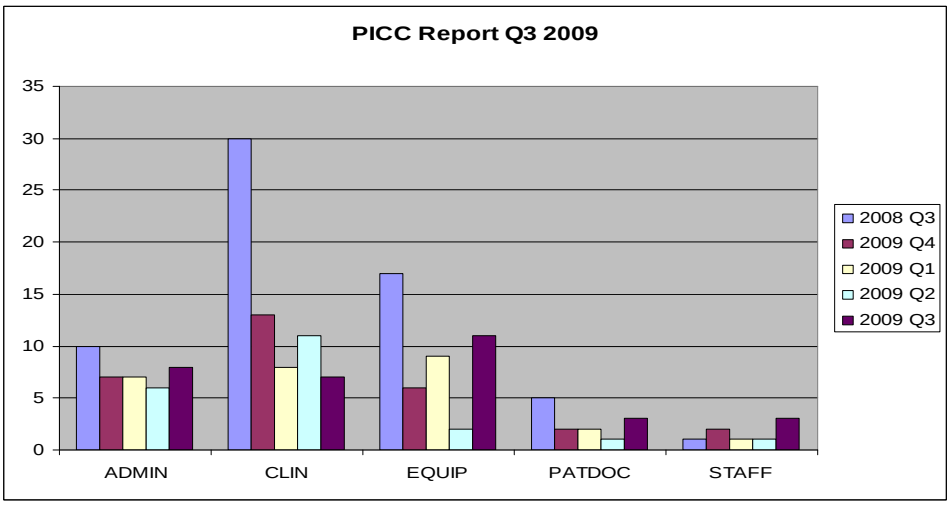
Learning Grade 3 -5 incidences

There were 4 grade 3 incidents for this quarter

- Transfer from Ashford to MAU without a PEG feed. Feedback given to Ashford.
- Missed fracture of right ankle. Continuing review of all x-rays within 24hours. Imaging now also providing 90% of reports within 24hours during weekdays.
- Dislocation of shoulder whilst assisting patient following a fall. Ensure staff up to date with correct moving and handling procedures.

A woman admitted to A+E with psychiatric needs. The incident report recalls that the psychiatric team would not review the patient without a mental health assessment form, which was delayed in being completed because the patient was intoxicated. Home Treatment Team finally reviewed patient at 10:30 the following day, however two assaults had occurred during the night**.**

Imaging and Endoscopy



Administration
A trend has been identified in Endoscopy whereby patients are being admitted for observations after their colonoscopy procedure - sometimes staying overnight. The figures are not unusually high with minimal change from previous quarters. This has always been documented on the incident forms and will continue to do so. There is no area of concern at the moment but this practise will continue to be monitored as usual.

Clinical
No trends have been identified in the clinical areas.

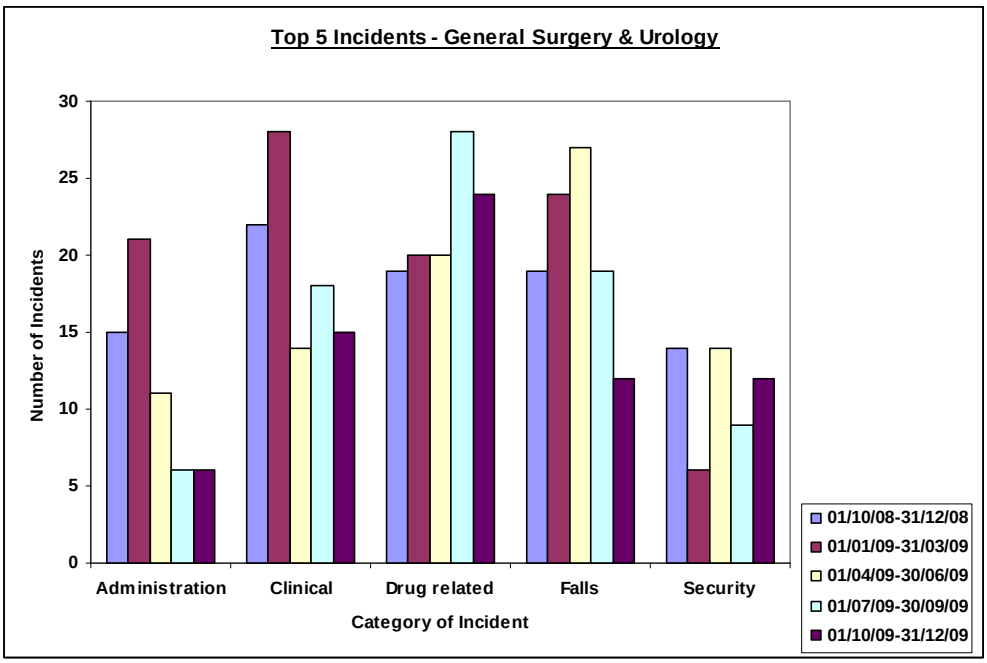
Equipment
The decontaminating ISIS G4 equipment continues to fail on a regular basis at both Endoscopy sites. The centralised decontamination unit is expected to be operational by mid-June with additional decontamination equipment.. With dedicated de-contamination staff and back-up equipment the impact of failing equipment won't have the same implications as presently.

Patient Documentation
On two occasions colonic biopsy specimens were requested in histology details on the form indicated suspected infective colitis, no DANGER OF INFECTION sticker were placed on the pot or form.
The Matron and Sister of Endoscopy reminded all staff of the policy and it's importance. All staff are aware of the correct policy and 'danger of infection' stickers are readily available in the unit.

Staff
On two occasions the radiology staffs were not informed about patients' infective status. According to our departmental policy these patients undergo their procedures at the end of the list to minimise cross infection. The referring doctors were immediately informed of the omission and it's implication and requested to ensure such information is available in future.
At the doctors induction the correct policy is highlighted to the new doctor's.

2.3.5 General Surgery and Urology

There were 80 incident forms completed for this reporting period which is a slight reduction when compared to quarter 2. The overall trend appears to be a reduction in the severity of the completed incident forms.



Drug related

There has been a small reduction in the number of reported drug related incidents when compared to quarter 2. There has been an increase from 13% to 21% for nursing administration errors. Identified nursing staff are still in receipt of one to one training with the clinical practice educator, in order to resolve training needs. There has been a reduction in the number of prescribing errors from 36% to 8%. Currently an interventions audit is being carried out by pharmacy which is focussing on prescribing errors as these incidents are felt to be under reported. Medical staff are still required to write a reflective account of the incident and discuss the incident with the clinical governance lead.

Clinical

There were no identified trends regarding clinical incidents. These incidents referred to patients admitted with pressure sores and safeguarding issues which were escalated within the Trust and were reported to social services. There were incidents relating to the inappropriate placement of level 2 patients within SHDU. An audit has been completed in order to obtain detailed information in order to resolve this issue. There have been issues regarding the length of time that central lines remain insitu. As a result the Infection Control Team are currently agreeing policies to resolve this issue.

Falls

There has been a slow reduction in the number of patients sustaining falls although the severity remains high. Two incidents in this category were reported as grade 3's. The majority of falls still occur when patients are independently mobilising. Falls risk assessments continue to be performed, "specials" booked appropriately for those identified "at risk" of falling and patients continue to be nursed in the appropriate location near the nursing station.

Security

The majority of these incidents related to the aggressive and verbally abusive behaviour of patients with an additional incident relating to the aggressive behaviour of relatives. One patient left the ward for a short period without informing nursing staff and there were 2 unrelated incidents involving the loss of money, security was informed.

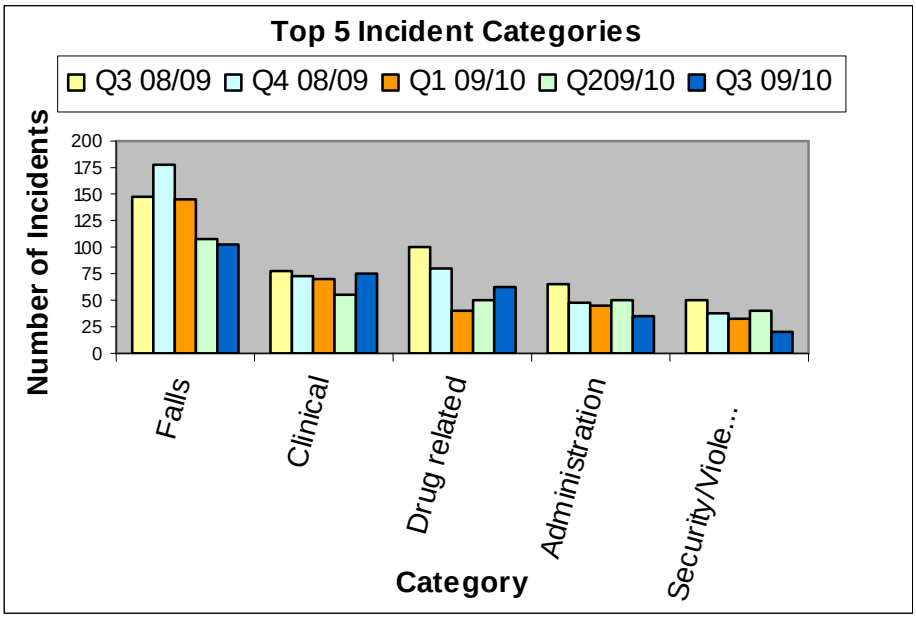
Administration

These incidents related to nursing staffing shortages, mixed bay issues and issues with N.H.S.P. nursing staff. The rolling programme for nursing recruitment is in progress and to date has been successful. This has resulted in the low staffing levels for SHDU, Heron and Kestrel being removed from the risk register with only Kingfisher remaining on the risk register as an identified risk. Capacity and mixed bay issues were highlighted whilst essential building work was being carried out to ensure that the surgical wards were compliant in providing single sex accommodation for patients. Issues regarding to NHSP nursing staff have been escalated to NHSP management and investigated on an individual basis by the NHSP manager.

Learning from grade 3, 4 & 5

There have been 2 grade 3 incidents during this reporting period. Both of these incidents involved patients that fell and sustained injuries that required medical intervention. In both cases all actions to mitigate the risk of the patient falling had been taken by nursing staff. Learning from these incidents focused on the timely manner of reporting these incidents and escalating to senior management and reporting to RIDDOR. Secondly, further education for nursing staff regarding the preoperative care of diabetic patients was identified as being required.

2.3.6 Medicine

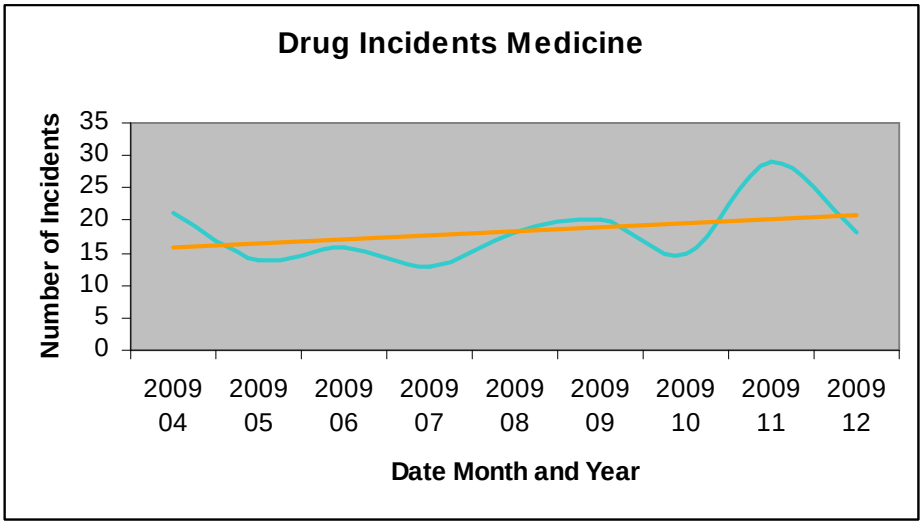


The top 5 incident categories remain unchanged.

Falls
Falls remain the highest category of incident with 102 incidents reported during quarter 3 showing a slight decrease from quarter 2.
The severity of injury sustained following patients who fell in hospital showed an improvement in quarter three with zero patients sustaining fractures in comparison to the 7 patients sustaining fractures in quarter 2.
The severity of incidents where patients fell in quarter 3 showed 98 patients sustained minimal harm or injury, and 8 patients sustained minor harm or injury.

Root cause analysis continues for all patients who fall in hospital with reports going back to ward areas detailing trends and specific locations of falls, times and issues to address.

Medication



Drug incidents remain in the top 5 categories with 63 incidents reported in quarter 3.

Medication has been a focus in medicine with a LEAN event taking place in January 2010 to map the take home medication process and the issues associated with delays in this process.

Prescription errors are the most frequent category of drug incident reported. These incidents are followed up with the individuals by the pharmacists and shared at junior doctor's forum as appropriate.
From the LEAN event, ward pharmacists are highlighting interventions made to the drug charts in an attempt to pick up trends in poor prescribing and address with appropriate teaching.

Top 5 Medication Incidents by sub-category

Prescription error	37
Prescribed drug not available/ordered in clinical area	22
Drug administration error	19
TTO Discharge Issue	15
Controlled Drug Issue	15

Following the pilot of a form on Maple ward for nursing staff to record where they put drugs away when they empty the pharmacy bags, this practice is in the process of being considered for all wards by pharmacy.

All the Medical Unit Sisters received training on controlled drugs at the medical unit sisters meeting in December 09 this was cascaded by the medical unit matrons who had attended the training form the Chief Pharmacist.

Clinical incidents

Top 5 Clinical Incident Subcategory

Pressure ulcer on admission	36
Treatment policy/procedure/method not followed	16
Unexplained patient injury	6
Skin tear	3
Blood product/transfusion issue	2

The highest number of clinical incidents reported related to patients having pressure ulcers noted on admission. Body maps are recorded and where necessary patients referred to wound nurse specialist. Social Services are contacted if the patient comes from a nursing home.

Treatment policy/procedure not followed, 9 of these incidents relate to issues in care highlighted from receiving area on patient transfer eg, lack of dates on cannula, 2 incidents relate to the swine flu policy. Remaining incidents refer to individual issues.
5 incidents coded unexplained patient injury refer to patients admitted with bruising.
Blood transfusion issue one incident records a discrepancy in date of birth recorded on the unit of blood and the patients A&E case notes. The second incident refers to misfiling of a blood transfusion record.

Learning from Grade 3, 4 and 5 incidents

Medicine has reported 5 incidents in quarter 3.

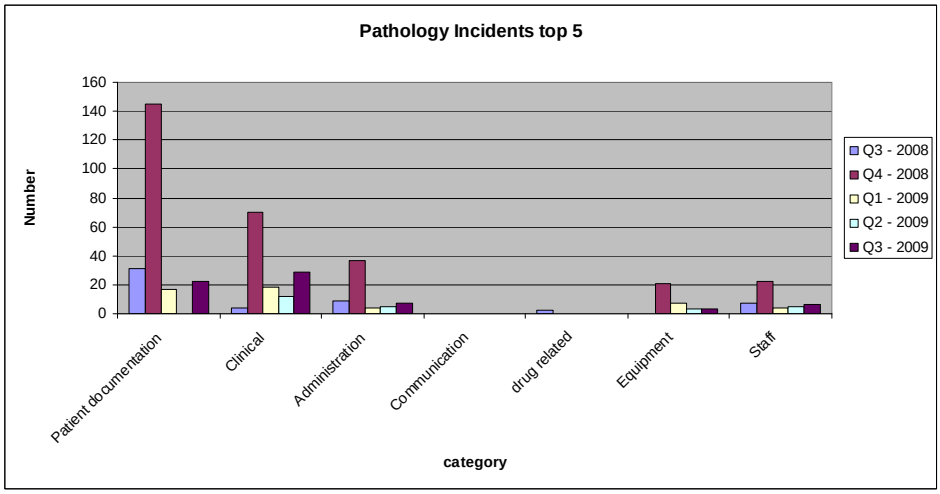
Pressure ulcer on admission	1
Missed diagnosis	2
Unexpected fracture	1
Unexpected patient deterioration	1

Incidents have been investigated and feedback from action plans given via the local clinical governance report to Directorate meeting, medical unit sisters meetings and junior doctor's forum.

The pressure ulcer on admission was a grade 3 sacral sore present on patients admission so although recorded as moderate injury requiring professional intervention was not a result of hospital admission.

Incident regarding unexpected deterioration concerned a patient who was transferred to Ashford for rehabilitation and whose condition rapidly deteriorated requiring transfer back to SPH. This case was also raised as a PALS concern with PALS and the incident investigator liaising to ensure the incident investigation report covered the PALS issues raised.

2.3.7 Pathology



Pathology reported 67 incidents in Quarter 3 2009, with no grade 3, 4 or 5 reported.

Documentation

Documentation errors where the department receive incomplete or incorrectly labelled samples and request forms remain in the top 5.

Equipment

Equipment failures related to blood transfusion problems and Biochemistry analyser failures. The blood Transfusion analyser problems have been reported to the MHRA and the company supplying the equipment.

Clinical errors and administration errors

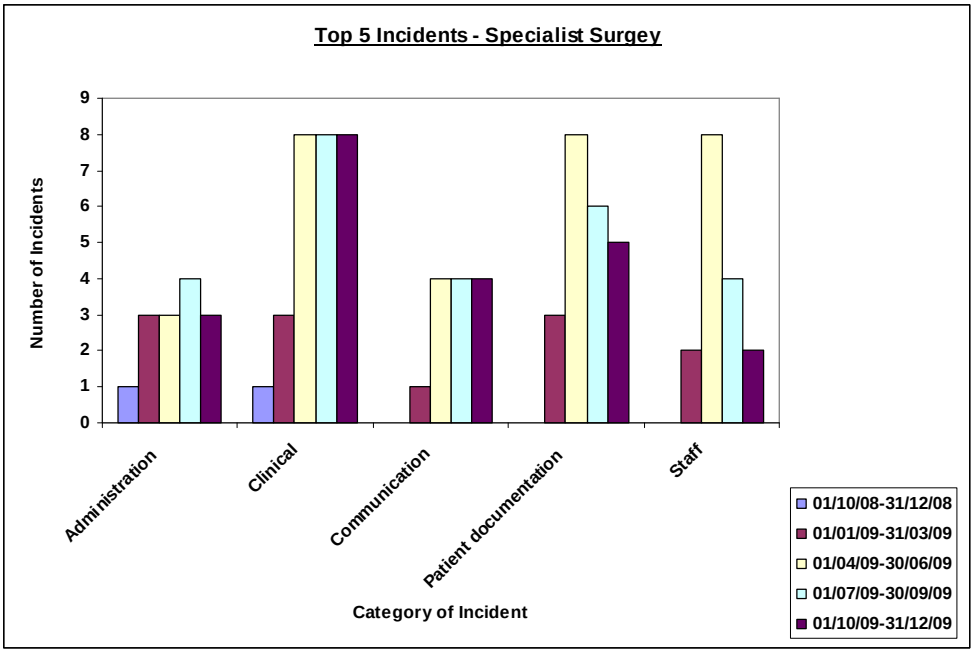
These incidents relate mainly to problems reported by the anticoagulation service around non referral or re referral of patient for anticoagulation therapy. All these incidents are copied to the directorate where they originated from.

Staff

These incidents are accidents relating to staff. They are all reported and discussed at the Pathology Health and Safety committee.

2.3.8 Specialist Surgery

There were 23 completed incident forms for this reporting period which represents a slight reduction when compared to quarter 2. The majority of these incidents were grade 1 incidents and there were no grade 3, 4 or 5 incidents reported during this period.



Clinical
There were no identifiable patterns to this category of incident. There was one incident relating to a patient being consented on the incorrect consent form; this issue was discussed at the Ophthalmology Directorate meeting. There has been an issue with inappropriate referrals to the Eye Clinic at Ashford. The West Middlesex Hospital is currently waiting for a response from the Primary Care Trust regarding the appropriate placement for their acutely unwell urgent ophthalmology patients. As an interim measure all medical staff who accept referrals have been made aware of this issue and have been advised to gain a detailed history to determine the appropriateness of accepting these referrals.

Patient documentation
These incidents refer to a lack of patient medical records for clinic appointments, lack of referral letters in notes and misfiled notes. All of these issues have been feedback to Medical Records.

Administration
These incidents related to delays in patients being seen by medical staff in the Ophthalmology Outpatient Department. There was 1 incident involving a patient being booked into the incorrect clinic therefore the patient had to return for another appointment.

Communication+
There were no identifiable trends for this category of incident. Communication issues occurred between patient and staff and between Trust staff members.

Staff
Both of these incidents relate to the internal fire doors of the Eye Clinic at the Heart of Hounslow. This risk is currently on the risk register. The doors are heavy and staff have been complaining of shoulder injury due to the frequent opening and closing of these doors. This problem has been assessed by Health & Safety, Fire and Occupational Health representatives. Currently this problem is in discussion with owners of the building to resolve the situation.

Learning from grade3, 4 & 5 incidents
There were no grade 3, 4 or 5 grade incidents during this reporting period.

2.3.9 Pharmacy

There were a total of 192 incidents for Q3

New in Top 5 is drug administration error. This type of incident was the second highest medicine-related incident in quarter 3
Several recurring themes can be identified: included therapeutic duplication of drugs, drug administration box left blank, drugs administered beyond the stop date, medicine policies not followed and errors relating to the use of the enoxaparin drug sheet and subsequent administration.
Lack of transfer of medicines between wards, particularly from Medical Admissions Unit (MAU) to wards has been a recurring theme. This has been raised on several occasions, and at Nurse Managers meetings in October 2009 as an area of concern. The unavailable drugs are frequently re-ordered from pharmacy and dispensed a second time..
These and similar incidents are taken up with the Sister on the ward and clinical governance managers for further action

The new drug chart is of longer duration, is more comprehensive and has more prescribing sections for both “when necessary” and regular medicines. The chart should go some way to help alleviate errors due to the current layout of the prescription form. . Education and training will be provided for staff which will endorse this as a practice.

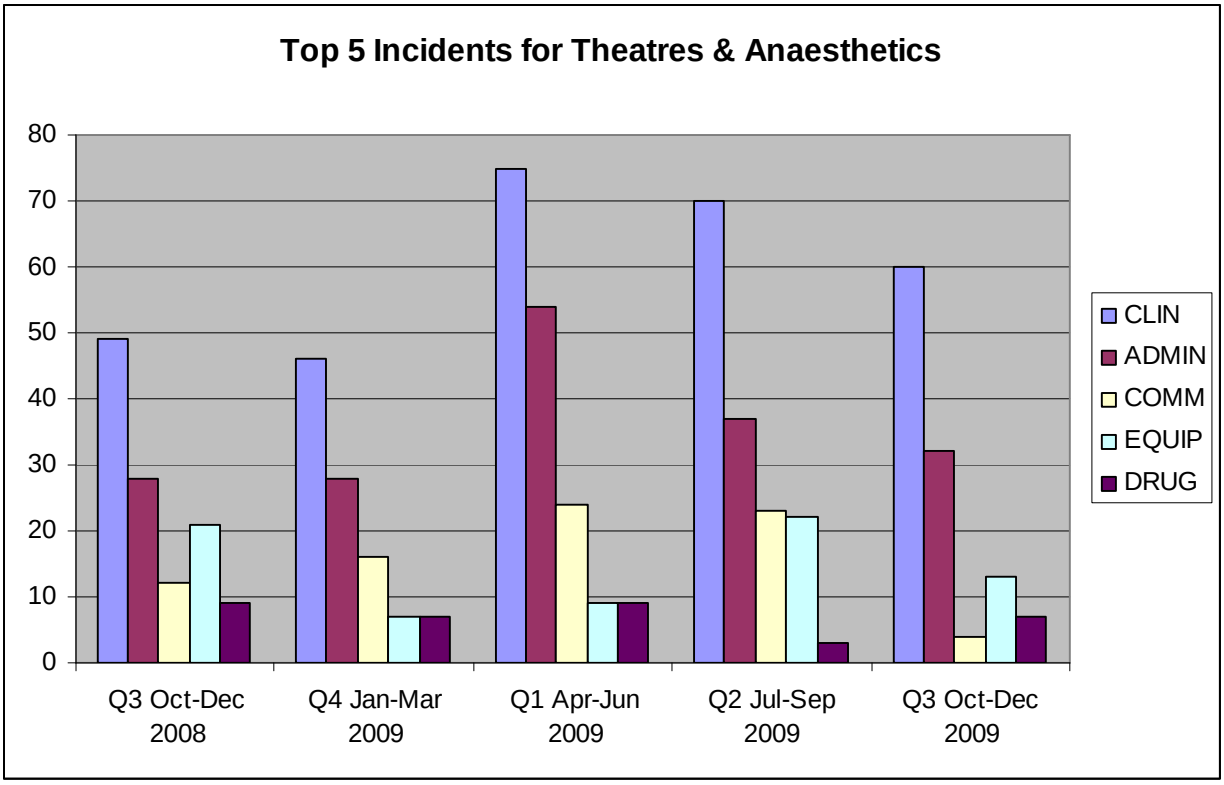
Other issues relating to drug errors have been raised at relevant forums including the Single Nurse Drug Administration study day, and at mandatory updates.

<u>Prescription Error</u>
This was has been the top incident for Q3
There is ongoing education and training, supporting changes in medical staff, teams and directorates. A Pharmacy Teaching Programme for F1s is run from September to July, addressing key prescribing problems (NPSA top categories) and issues found at local level. Additionally there is the facility of the evolving Training Tracker, where concerns may be raised from low scores on the Pharmacy modules.

Several incidents have occurred concerning the re writing of drug charts and the new adult drug chart which has an extra week’s duration should help alleviate this.
Incorrect drug histories are a common concern; Pharmacists and pharmacy Medicines Management Technicians record drug histories as part of their medicines management duties; the clinical interpretation and appropriateness of medicines is reviewed by the pharmacist. The Medicines Reconciliation Record [part of NICE-NPSA Patient Safety Guidance 1: Technical patient safety solutions for medicines reconciliation on admission of adults to hospital] will be introduced together with the new drug chart.

<u>Controlled Drug Issues</u>
This was the third highest medicine-related incident in Q3. A separate quarterly Controlled Drug] report is prepared for the Chief Pharmacist and Trust Accountable Officer covering incidents graded with this datix code, plus controlled drug discrepancies.

2.3.10 Theatres and Anaesthetics



Clinical

In the Quarter 3 (2008) 49 Clinical incidents were reported however in the same quarter following year can notice the rise in the clinical incidents reporting. This rise is noticeable within the subcategory of 'Treatment policy/procedure/method not followed' from 9 to 20 cases. Within this increase could no see a trend but most required training and retraining. Copies of the forms were sent to the Clinical Governance Managers for the other specialties and appropriate training has been planned or completed.

The Unplanned Return to Theatres remains exactly the same. These cases all go to the Theatre Incident Review Group and the cases will be discussed and followed up in order to establish the reasons for patient's return to the theatre.

Administration

In this category it is noticeable that 'Unexpected over night stay' has been doubled. Some patients had to stay in hospital because there were no one to care for them at home at least for 24 hours or some patients had come back from theatres and unexpectedly had to have drains in situ.

Other contributing factors are issues such as pain control, unexpected bleeding. Directorate is looking into better pain control for patients for day surgery.

Cancellation of Surgery remains the same however directorate is actively looking into the specific trends for the cancellation of surgery or delays in starting the list. This will help us towards correct patient selection as a day case and to be better equipped for the cases booked.

Communication

In this category the reporting has been decrease from 12 cases to only 4. This can contributed better communication between the staff in theatres and also with the other multidisciplinary teams. Each time that there is failure in communications the issue is raised with the team or individual and try to seek a better approach to communication.

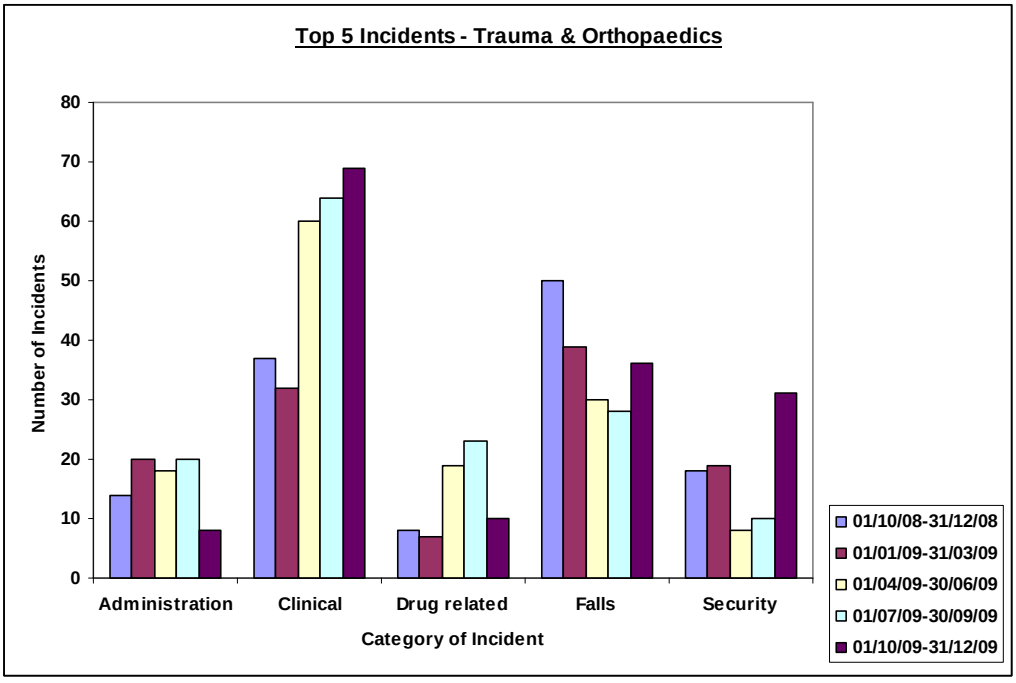
Equipment

The equipment related issues remain the same. In the Quarter three 2009 there were few incidents/concerns around the new Lateral Transfer Sheet. The increase in reporting can be contributed to the recent introduction of the lateral transfer sheets to the trust. Any Incident or concern that was raised has been discussed with minimal handling team and every effort was made to explore the issue by involving the company Representative in order to make the use of it safe.
Also staff continues to use the communication book and the board. This has been helpful in communicating the equipment issues.

Drugs
There has been a slight decrease in this category but no specific sub category can be identified.

2.3.11 Trauma and Orthopaedics

There were 174 completed incident forms for this reporting period.



Clinical
The delay in treatment for the fractured neck of femur patients accounts for 29% of the incident forms in this category. Patients developing skin tears and blisters accounts for 15% and a further 12 % account for the number of patients admitted to hospital with pressure sores. All patients admitted to hospital with pressure sores from nursing/residential homes are reported to social services. The number of patients developing blisters and skin tears now have their clexane dosage reviewed and in some cases reduced in an attempt to improve the occurrence of skin tears and bruising.

Falls
There has been an increase in the number of incidents for this category from 28 to 36 falls for this reporting period. Further analysis shows that 31% of patients were found on the floor, 17% fell whilst mobilising and 14% of patients fell whilst in the bathroom. Two of the grade 3 incidents during this reporting period were concerned with patients that had fallen and both required medical intervention.

Security
There has been an increased number of confused disorientated patients admitted to the wards and 33% of these incidents related to clinical physical assaults. Loss of property accounts for 16%and the Matron for Trauma & Orthopaedics sent a memo to all staff reminding of the importance of

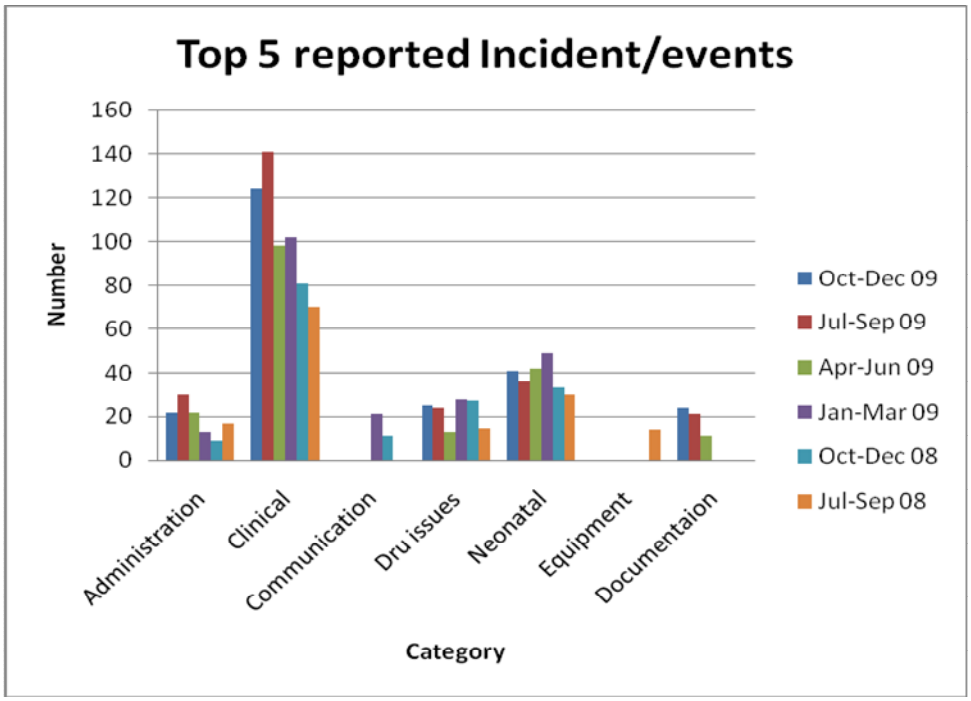
completing patient property lists. Miscellaneous security issues accounted for 16% and a further 13% accounted for non clinical physical assaults. Security has been informed of these incidents.

Drug related
There has been a dramatic reduction in the number of reported drug incidents falling from 24 to 10 reported drug related incidents during this reporting period. There is no obvious trend to the drug related incidents. These incidents include TTO & C/D issues, prescribing, dispensing, administration and omission issues.

Administration
These incidents relate to nursing staff shortages which accounts for 50% of these incidents. Mixed bay issues and capacity issues account for the remaining incidents.

Learning from grade 3, 4 & 5 incidents
There were 3 grade 3 incidents during this reporting period of which 2 incidents related to 2 patients that fell and required medical intervention. These patients had been in receipt of their falls risk assessments and "specialing" measures were in place for one of the patients. The other grade 3 incident has resulted in additional training regarding care of patients with cardiogenic shock for junior doctors through the post graduation centre. There is now increased training as regards the completion of DNR forms on mandatory training sessions for Consultants.

2.3.12 Women's Services



Gynae reported 4 incidents during this quarter, 1 featured a documentation issue the other 3 were clinical concerns.
Overall the reporting trend continues to increase in Women's Health services across the 6 quarters which is very positive. 282 incidents were reported in this quarter, compared with 197 in Quarter 3 2008/2009

Drugs
Breakdown of the types of drug incidents reported highlighted that drug omissions (Enoxaparin) and prescribing errors were the two main incidents related to drugs. The location for drug issues are mainly on the postnatal ward area and an action plan to address these issues has been formulated in a effort to reduce recurrence. Patient self administration will start soon and a new

Maternity risk assessment tool is currently being developed for all in patients in maternity. This will be implemented alongside full training which will include prescribing Enoxaparin.
Compliance with antibiotic guidelines has been variable. The antibiotic pharmacist presented at the junior doctors induction in December 2009 and will continue to do so at all future doctors' inductions in Women's Health

Documentation
This category has been in the top 5 for the last threes quarters. Ongoing audit suggests that postnatal record keeping is an area for action. The introduction of the new Maternity notes has occurred in October 2009 and an extensive training program was rolled out to all staff. The last two recordkeeping audits have shown improvement in all areas. Further spot checks on the postnatal ward are expected to improve records in this area.

Communication
The multidisciplinary team from labour ward attended the collaborative leadership and communication training offered in the South Coast region. The feedback from these study days has been extremely positive. Communication remains a mandatory update sessions on our local Bonus Day training

Neonatal
Neonatal issues this quarter are reduced. These range from feeding issues to admissions to NICU which are integral to the work in maternity services. Significant issues are discussed at the monthly perinatal mortality meeting. Admission of a number of cold babies to NICU was considered at the labour ward forum where it appeared that policies were followed for the management of the neonate at birth

Administration
These relate to staffing issues the numbers reported are reduced this quarter.

Learning from Grade 3 & 4 Incidents and SUIs
There were a total 7 grade 3 & 4 incidents and no grade 5 incidents with one categorised as an SUI during this period. Datix show more incidents reported due to double incident form generation regarding the same incident by different staff members.

An SUI was reported in Maternity Services in September investigation completed November2009. A number of recommendations were made which have been taken forward

- Adjust the trigger list for calling a consultant to make it explicit to all staff that consideration should be given to calling a consultant in periods of high labour ward activity
- Women who have epidurals in labour should ALL be risk assessed using the Waterlow score and their pressure areas actively managed throughout labour Include Waterlow scoring and pressure area care in the mandatory epidural lectures for midwives
- In collaboration with the obstetric anaesthetists, midwives to consider more active mobilisation in labour when mobile epidurals are in situ.
- Consider agreeing unit standard for lithotomy usage in the labour ward-e.g. maximum length of time
- Introduce hourly CTG checks for labouring women which should be made by two trained personnel.
- Ensure postnatal records are filed in a timely manner following a woman's discharge from maternity care

An incident involving administration of Anti D occurred. Following this incident the lab has changed report comment from 'Anti-D of probable prophylactic origin detected in patient's plasma' to 'Anti-D detected. This could be of prophylactic or immune origin. Please clarify whether patient has received prophylactic anti-D prior to this blood test, if not please contact Blood Bank on Ext 3036 and refer for consultant obstetrician review'. Midwives are required to check report before administering prophylactic anti-D.

An incident occurred where a patient suffered a post partum haemorrhage following elective caesarean section for previous caesarean section (CS) at maternal request.
Lessons learned

- Follow a clear care pathway for all women with previous CS with full documented discussion of risks and benefits of elective repeat CS vs. VBAC. (vaginal birth after caesarian section) The Clinical director is to agree previous CS care pathway with all obstetric consultants and ensure this is adopted by all. Community midwives to ensure all women with a previous CS are strongly advised to attend previous CS information session prior to consultant appointment at 34/40 to decide mode of birth in line with care pathway to be agreed
- Ensure all registrars are clear about the criteria for calling for senior (consultant) help in emergency situation Criteria for calling senior help to be emphasised at SpR training.
- Ensure all necessary emergency equipment (balloon catheter) available in theatre at all times.

Unexpected admission to NICU. Lessons learned:

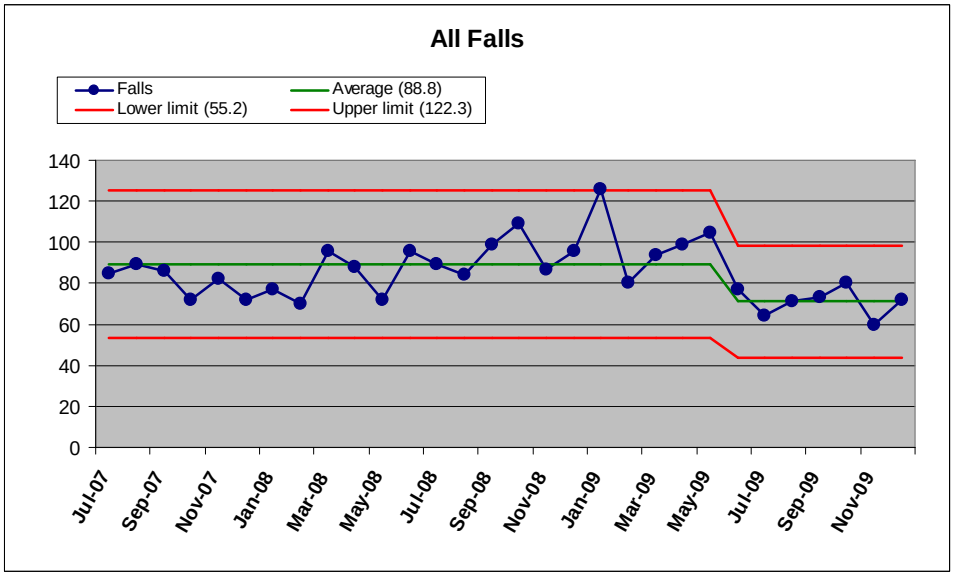
- Handover of care to be Registrar to Registrar during busy times: Remind staff to call for help in busy times. Registrar handover must happen face to face if unable to do so consider calling a consultant if delay in patient assessment is likely to be significant
- Do not admit PSROM with susPICCious CTG to Joan Booker ward
- Ongoing documentation training for all and assurance that all staff attend information governance training

A PPH case was reviewed which identified issues in relation to the code red proceedure for emergency blood requirements and poor documentation. Lessons learned:

- Porters to be part of skills drills training in Maternity in relation to PPH-Labour ward clinical specialist to invite for training
- CODE RED practice run to be run at least annually

2.4 Key action areas

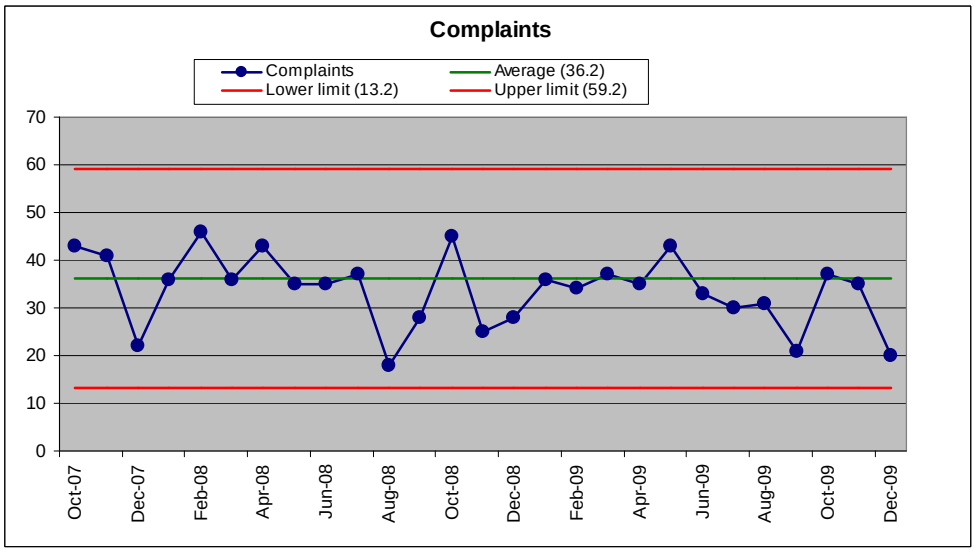
2.4.1 Falls



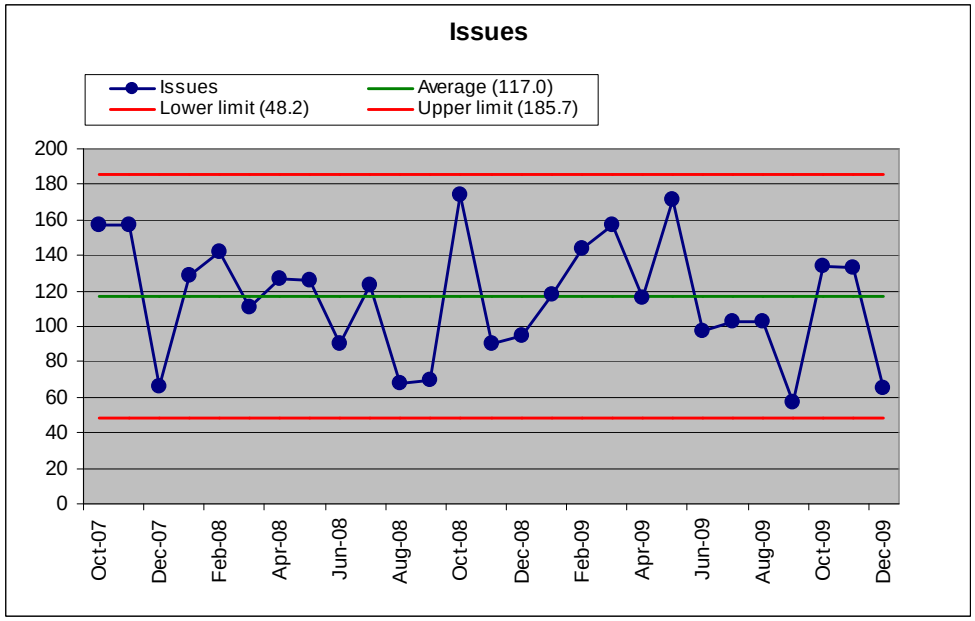
The data for falls in the trust indicates a statistically significant reduction. The average number of falls has dropped from 89 per month to 71. All areas have reduced falls this quarter with the exception of Trauma and Orthopaedics however all areas have increased awareness of falls prevention and the importance of risk assessment and actions

3 COMPLAINTS

3.1 Total number of Complaints

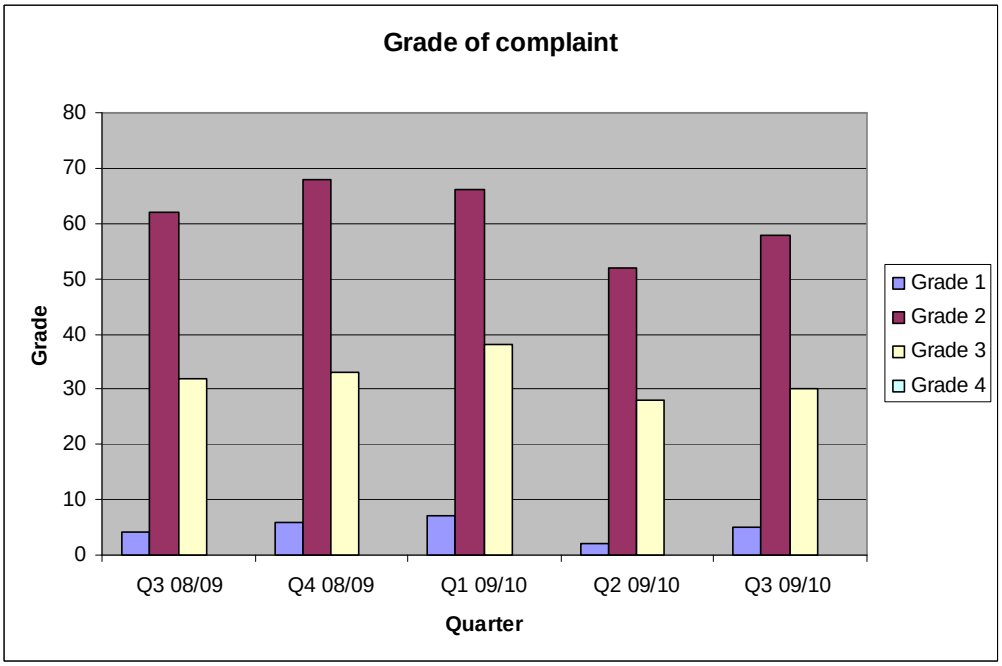


3.2 Total number of Issues



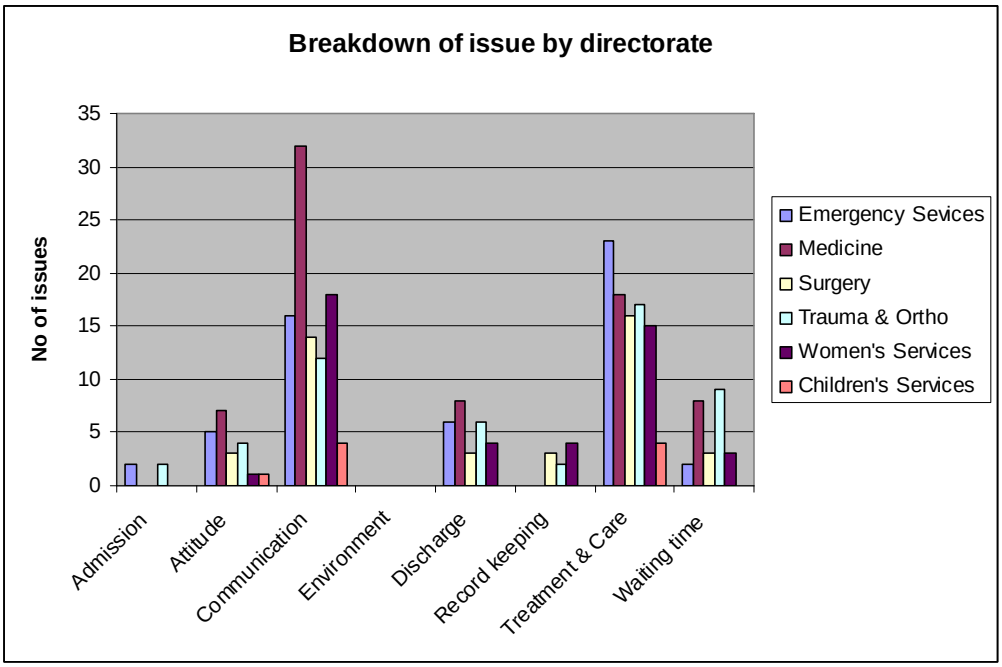
Each separate issue raised in a complaint is logged onto the DATIX database to provide further analysis of the type of concern raised and any emerging trends. There were 93 complaints in quarter 3 with 345 issues recorded.

3.3 Distribution of complaint by grade



All formal complaints to the Trust are graded from 1 – 4 according to the severity of failing/effect upon the patient. The number of grade 3 (more serious) complaints as a proportion of the overall complaints received has remained constant throughout the last 5 quarters. There have been no grade 4 complaints during the same period.

3.4 Distribution of issues across Directorate



This chart illustrates the type and number of issues raised within each directorate/ service area. The highest number of issues were recorded for Trauma & Orthopaedics (52), Medicine/General Medicine (37) followed by Emergency Care/ MAU (36). Previously Trauma & Orthopaedics was reported as part of surgery, this has now been separated to reflect the new structure.

3.5 Ombudsman Second Stage Reviews

3.5.1 Requests for second stage review by Ombudsman received during Q3

There were no notifications of cases having been referred to the Ombudsman for second stage review during Quarter three.

Two cases: 08/466 & 08/002 were closed without proceeding to full review and were referred back to the Trust for a local resolution meeting to be held. One case has undergone full review and the draft final report has been received which indicates the complaint has not been upheld however, the Trust awaits the final report in this case.

3.5.2 Summary of files currently under consideration by the Ombudsman at close of Quarter three:

Ref	Directorate	Request rec'd	Synopsis	Status
08/317& 09/101	Under assessment as to whether full review will take place detailed above			
08/004A	Medicine	Q1 09/10	Patient unhappy with cardiology care.	Under assessment as to whether full review will take place
07/346	Medicine	Q1 09/10	Concerns regarding discharge planning, and whether pt was medically fit for discharge.	Under assessment as to whether full review will take place
06/192	Surgery/ Endoscopy	Q4 2008/09	Complaint regarding clinical management of a pseudocyst in the pancreas.	Under full investigation – draft report received which indicate complaint was **not upheld** – Trust awaits final report.

Learning from complaints

General concerns around nursing practice on Orthopaedic ward

A detailed complaint was made directly to the Chief Nurse and Complaints Manager in which concerns around alleged poor nursing practice on Elm Ward were detailed. These included concerns around call bells being ignored, serious lack of care with regard to patients' hygiene needs, lack of empathy towards elderly patients and the uncoordinated discharge of the patient resulting in readmission soon afterwards.

Following this complaint the following actions were taken to investigate the serious allegations made:

- The Chief Nurse presented the case to the Executive Team shortly following receipt of the concerns.
- An internal investigation was carried out by a Consultant Nurse supported by the Complaints Manager. Final report and recommendations were made to the Chief Nurse
- As part of this investigation, the complaint was shared with the nursing team on the ward. 12 members of staff were interviewed including the Sister and Deputy Ward Sister.

- The Chief Nurse carried out a clinical shift on the ward to help achieve an understanding of the issues facing the ward staff
- Lessons learned were disseminated via the Chief Nurse's formal meetings with both matrons and Ward sisters.
- A skill mix review is underway to establish what changes may be necessary to the ward staffing in light of recent changes in acuity and dependency.

Specific learning - Children's Services

A complaint was made regarding the way in which the Trust had communicated with the foster parents of a new born baby regarding a diagnosis. Concern related to the mother of the baby not being made aware of the diagnosis. Social Services held joint parental responsibility for the child also.

In light of this complex and unusual case a review was undertaken of the channels of communication and what more could have been done to ensure correct communication with the mother. The case was presented at the department's Educational Half Day and discussed at the Clinical Governance meeting with a view to ensuring that all clinical staff are aware of the parental rights where there is joint responsibility and Social Service involvement and how to avoid a repeat of this rare occurrence.

Specific learning – Medicine

A number of complaints were received regarding the way in which patients' telephone calls to a particular department were being dealt with. Concerns included callers leaving messages and not receiving a call back, inadequate response to queries raised and inappropriate comments/attitude of secretarial staff.

The Trust acknowledged that there had been difficulty in supporting the secretarial staff in a department which had been understaffed. This had in turn resulted in a backlog of telephone messages at a time when a staff member was absent due to sickness and an unmanageable workload on their return.

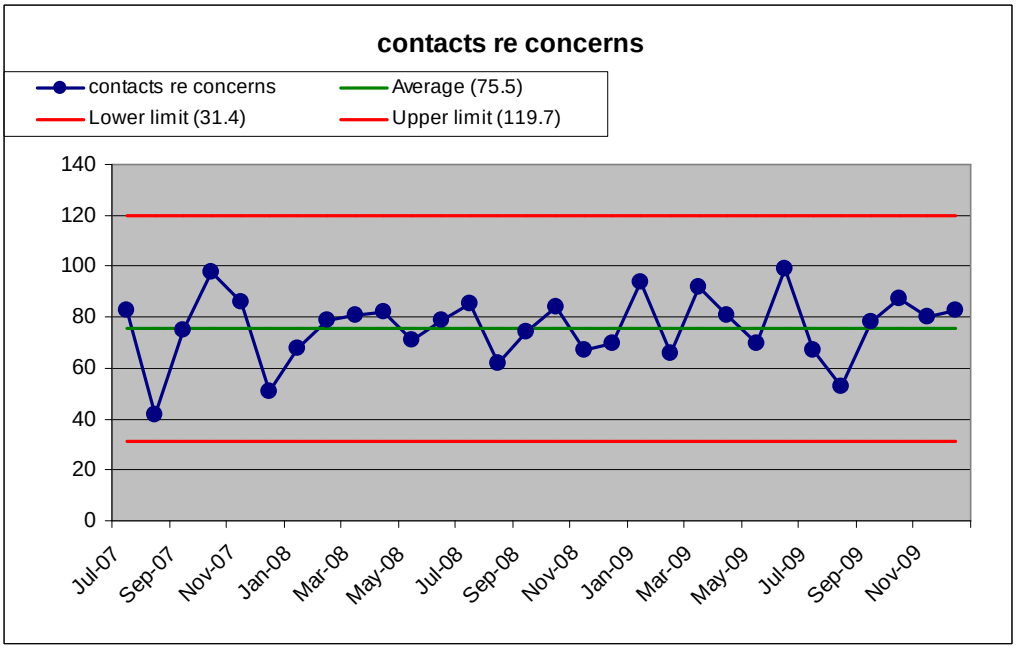
In response, additional staff have now been recruited to adequately cover the workload. The message system has been improved to ensure all messages are appropriately picked up and the particular staff member concerned has been provided with the support and training necessary to help manage future stressful and potentially confrontational situations.

4 PALS

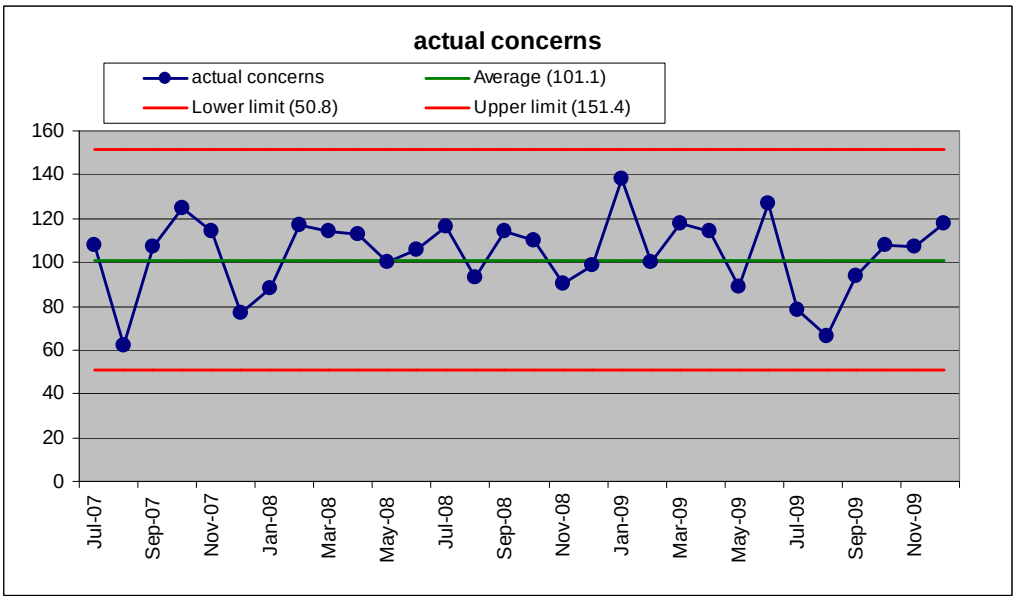
A total of 324 PALS contacts were received; 79% (250) of which were in relation to concerns, 10% were requests for support and 7% for advice and information. It is noted that this quarter PALS received the highest number of contacts since the service was established.

Of the cases where concerns were raised; 82% were resolved, 5% were referred to a more appropriate person, 3% were given information about the formal NHS complaints process and 2% were referred directly to the complaints process.

4.1 Contacts re concerns



4.2 Actual concerns



4.3 Top 5 Concerns Q2 2009/10

Table 2: Top 5 Concerns Q3 2009/10

Nature of Concern	Number of Concerns
1. Clinical decisions/treatment (Doctors)	39
2. Verbal Communication	24
3. Accuracy & completeness of communication	19
4. Timeliness of communication	17
5. Discharge – follow up arrangements/care	13

Qualitative summary of top five concerns

Clinical decisions & treatment (doctors)

As previously discussed this is a very broad category and concerns this quarter include;

- Clinical decisions around the need to perform surgery, or to cancel surgery or procedures.
- Decisions around medication.
- Some users were concerned that their conditions have not been resolved, or about a lack of diagnosis.

Where such concerns are raised, there are many good examples of cases where users are supported in resolving their concerns in a timely manner, with the clinicians concerned.

Verbal communication

Examples of concerns raised in the category this quarter include:

- Concerns around the communication style of staff, where users do not see this as poor attitude but as unhelpful, with the agreement of the user feedback was given to the staff concerned.
- Two users were concerned that they were unable to speak with staff about their relatives' care; PALS facilitated relevant contact and the concerns were resolved.

Timeliness of communication

Examples of concerns raised in the category this quarter include:

- A concern was raised that messages were left and not responded to. This was related to the lack of cover for a secretary during their annual leave and was highlighted to the relevant BUSM.
- A patient did not attend an appointment as they had not received the appointment letter in time.
- A concern was raised that information about delays in clinic was not shared with patients in a timely manner; this was feedback to the Business Manager.

Accuracy and completeness of communication

Examples of concerns raised in the category this quarter include:

- Inaccurate information about the 18 week pathway was given to a patient, this was resolved when the pathway was correctly explained.
- Four concerns were raised in relation to patients and relatives not being given a complete or accurate information in relation to care. Following PALS liaison, staff provided clear explanations and concerns resolved.
- A patient was sent a letter incorrectly inviting him to a clinic appointment.
- One patient's surgery was cancelled at short notice and their details had been entered on the wrong list.
- A discharge summary had an amalgamation of two patients' clinical details on it. This was corrected.

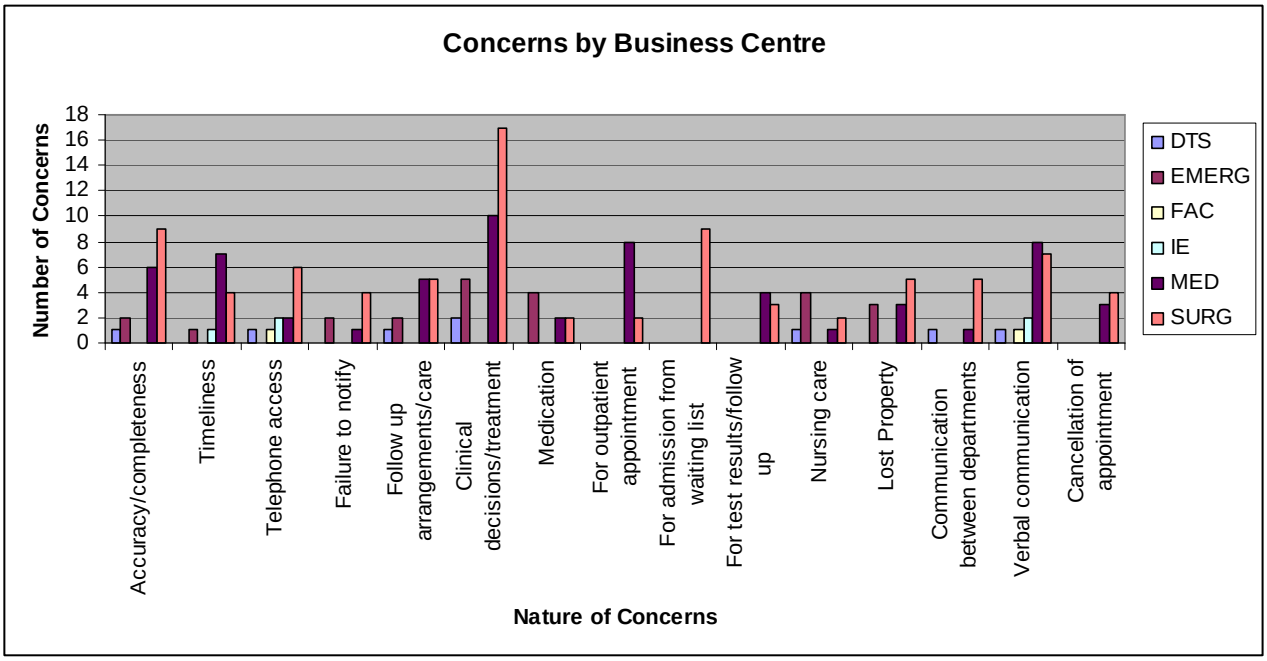
Discharge – follow up arrangements

- Primarily concerns this quarter are in relation to proposed plans for follow up care and have been quickly resolved following liaison with key staff and where necessary PALS support at Ward discharge meetings. It is worth noting that although there has been an increase regarding discharge arrangements on last quarter, PALS reported on an increase in

concerns regarding discharge in Q3 2008/09 and the number of concerns raised is equivalent.

- It is also worth noting that concerns around discharge last year focused on the actual arrangements on the day and there has been a decrease from 11 cases in Q3 2008/09 to 3 cases this quarter in relation to such concerns. However it is also worth noting that 3 concerns were raised where patients had been discharged with cannula in situ. These cases have been shared with the Matrons concerned and incident forms raised.

4.4 Concerns by Directorate



Graph 1 provides a comparison of the main PALS concerns across the top 5 Directorates. For further information please see below.

Positive outcomes:

- A concern was raised about a loose paving slab at the front of the Main Outpatients Reception, where a relative had tripped and fallen; tarmac has now been laid in this area.

- A relative was concerned that a patient had experienced a high level of pain for 3½ hours without analgesia in A&E, Matron has raised this at team meetings and is addressing the management of pain within the department and ensuring clear recording of pains scores.

- The mother of a young patient was concerned that following GP recommendation, she and her child spent a period in Paediatric A&E, they were then told there was no ENT cover at St Peter's and they should go to The Royal Surrey County Hospital (RSCH), where her child later required surgery. Following this a reminder to GPs will be sent to in the GP Newsletter, reminding them of the hub and spoke nature of the ENT service in the area and advising that if it is likely a patient will need an ENT procedure they should be directed in the first instance to the RSCH.

- A patient was concerned that she was told she would not need a separate appointment for an ultrasound scan, when attending a gynaecology clinic; however at her appointment she

was told no scan appointments were available. Following this more scan appointment slots have been provided to the clinic and an additional one stop clinic has been created to avoid recurrence.

4 Claims

4.1 Clinical Claims

Reported claims

At the end of Quarter three the Trust held 56 reported clinical claim files.[1] This compares with 69 files for the end of Quarter two. In addition to the reported files, the Trust 'holds' a number of files which are in the early stages of the claims process (mostly following disclosure of records). Under NHS Litigation Authority (NHSLA) reporting guidance, the Trust is not required to report these cases but is required to undertake early investigation and analysis. This report details reported cases which are defined as a claim. .

In percentage terms the claims profile of the Trust remains stable and reflects the nationally reported profile. The Surgical Directorate [2] has the highest number of claims accounting for 45% of the files held (nationally 41%). This is followed by the Maternity Services Directorate which accounts for 23% of the files held (nationally 23%). A five quarter summary of claims by Directorate and the national benchmarks can be seen at Tables one and two.

Within specialties, Obstetrics/ Ante natal obstetrics and has the highest number of claims accounting for 13 of the files held (23%). This is followed by Trauma and Orthopaedics accounting for 9 of the files held (16%) and Surgery accounting for 7 files (13%). A five quarter summary of claims by Specialty can be seen at Table three two.

Table one: Reported Claims by Directorate

	2008				2009					
	Q3		Q4		Q1		Q2		Q3	
Children Services	3	*4%*	4	*6%*	4	*6%*	4	*6%*	2	*4%*
Maternity	16	*19%*	14	*19%*	12	*17%*	12	*18%*	13	*23%*
Women's Services	6	*7%*	4	*6%*	5	*7%*	5	*7%*	4	*7%*
Emergency Care	11	*13%*	9	*12%*	8	*11%*	8	*12%*	6	*10%*
Medicine	3	*4%*	5	*7%*	6	*8%*	7	*9%*	3	*5%*
Surgery	41	*49%*	33	*45%*	33	*45%*	30	*44%*	25	*45%*
Theatres, Anaes & Criti Care	1	*1%*	2	*3%*	3	*4%*	2	*3%*	2	*4%*
Imaging & Endoscopy	1	*1%*	1	*1%*	1	*1%*	1	*1%*	1	*2%*
Pathology	2	*2%*	1	*1%*	1	*1%*	-	-	-	*0%*
TOTAL	**84**		**73**		**73**		**69**		**56**	

[1] Where cases have been reported to the NHS Litigation Authority (NHSLA) as a clinical negligence claim. These cases have either been assessed as high risk of a negligence claim following a serious incident or the Trust has received a Letter of Claim or been issued with proceedings. This figure includes cases reported under the CNST, ELS and cases being managed by the Strategic Health Authority.

[2] Defined as Surgery, Specialist Surgery and Trauma and Orthopaedics

Table two: National Benchmarks
Total number of reported CNST claims by Specialty as at 31 March 2009.

Specialty	Number	%
Surgery	20,161	41.3
Obstetrics & Gynaecology	10,568	22.6
Medicine	9,066	18.4
Accident & Emergency	5,746	11.8
Anaesthesia	1,239	2.4
Radiology	875	1.7
Pathology	823	1.6
Nursing	138	0.2
TOTAL	48,616	100

Reference: NHSLA Fact sheet three: Information on Claims

Table three: Reported Claims by Specialty

	Q3 2008	**Q4 2008**	**Q1 2009**	**Q2 2009**	**Q3 2009**
Accident & Emergency	11	9	8	8	6
Ante natal obstetrics	3	2	1	1	2
Anaesthetics		1	1		
Breast Surgery	2	1	1	1	
Cardiology	1	1	2	2	1
Children's Services	3	4	4	2	2
Colorectal	2	2	3	2	2
Gastroenterology	1				
General Medicine		1	1	1	1
General Surgery	12	9	11	10	7
Gynaecology	6	4	5	5	4
Haematology	1	2	2	2	1

Neurophysiology		1	1	1	
Obstetrics	13	12	11	11	11
Ophthalmology	4	3	3	3	3
Oral Surgery	1	1	1	1	1
Pathology	1				
Plastic Surgery	1	1	1	1	1
Phlebotomy	1	1	1		
Radiology/Imaging	1	1	1	1	1
Theatres	1	1	2	2	2
Trauma and Orthopaedics	16	14	12	11	9
Urology	3	2	1	1	1
Vascular Surgery					1
	84	**73**	**73**	**69**	**56**

4.1.2 New claims for the quarter

Within the last quarter the Trust has reported five new cases to the NHSLA. A summary can be seen at Table four.

Table four: New claims received by Directorate

Directorate **Claim ref** **Risk matrix grading[3]**	**Incident date**	**Previously reported as an Incident and progressed via PALS/ Complaints**
Emergency care		
SPH/1065 Green (Score 6)	6.5.09	Investigated as a complaint. Reported as an incident.
Surgery		
General Surgery		
SPH/985 Green (Score 6)	27.9.07	Investigated as a complaint

[3] Information presented denotes position on the risk grading matrix and associated score. (Consequence x likelihood of reoccurrence. .Maximum score 25)

Trauma & Orthopaedics		
SPH/1049 Green (Score 6)	23.10.07	Investigated as a complaint
SPH/989 Green (Score 4)	15.7.08	Reported as an incident
Maternity Services		
SPH/1053 Green (Score 4)	17.10.08	

4.1.3 Letters of Claim/ Proceedings

Five Letters of Claim have been received (one from a patient acting as a Litigant in Person).

4.1.4 Closed files

Eighteen files have been closed during the period. Of the closed cases, six cases were settled, five were withdrawn and seven closed by the NHSLA due to lack of progress.

Details of settled cases can be seen at Table five.

Table five: Settled Claims by Directorate

Directorate **Claim ref** **Risk matrix grading**	**Incident date**	**Claim date**	**Synopsis** **Risk Management**
A&E			
SPH/843 Yellow (10)	16.12.06	11.6.09	**Risk Management:** This case was reported and investigated as a grade 3 incident. The incident investigation identified failings in care including general monitoring, observation and ongoing assessment and a failure to follow admission protocols. Recommendations and actions were taken as a result. The death of this patient was subject to a Coroners Inquest. Verdict: Accident to which neglect contributed Following the outcome of the Coroners Inquest ,the Chief Executive wrote to the patients family and apologised for the Trusts failing in care
Surgical			
Trauma and Orthopaedics			

SPH/993 Green (Score 6)	22.4.05	31.10.08	**Risk Management:** This case was investigated as a complaint. The patient was dissatisfied with the Trusts response to her concerns and requested review by the then Healthcare Commission (HCC). Following review, the HCC were critical of the Trust and advised that the 'delay in establishing diagnosis fell below the expected standard'. The patient subsequently instructed solicitors. Following the HCC review this case was fully reviewed by the department and an action plan in response to HCC recommendations was put in place.
SPH/895 Green (Score 6)	24.8.06	16.11.07	**Risk Management:** The treating clinician has been asked to reflect on his management of this case and consider any possible learning as a result.
General Surgery			
SPH/875 Yellow (Score 9)	6.3.07	14.6.07	**Risk Management:** The Consultant Surgeon counselled junior doctors involved in this incident. They were reminded of the importance of undertaking X-ray should there be any query regarding the removal of a drain. It is notable that at the time this case was not reported as an incident. A request was made for this incident to be recorded retrospectively.
Medicine			
SPH/907 Green (Score 6)	27.2.07	14.11.07	**Risk Management:** This case was subject to a detailed incident investigation following which actions were detailed and undertaken. The case was also subject to a complaint investigation
Paediatrics			
SPH/1027 Green (Score 4)	24.11.08	3.3.09	**Risk Management:** This incident was reported as part of the Trust's Risk Management Procedures. As a result of this incident, the Caterer was instructed to remove any items from the menu that have known nut products in them.

5.2 Non Clinical Claims

5.2.1 New claims

There was one new non clinical claim for this Quarter.

Our Ref	Specialty	Synopsis	Status	Incident/Complaint
Cm/22/PL	Estates	Visitor claimed to have tripped over hospital sign blown into Tesco's car park	Liability denied	No record

The Trust has the following policy excess arrangements in place:

Employer liability	£10,000
Public liability	£3,000
Property expenses	£20,000

5.2.1 Ongoing Claims

Our Ref	Speciality	Synopsis	Status / Outcome	Incident/ Complaint
Cm/07/EL	Emergency Services	Nurse injured by patient in MAU	Liability admitted	Incident
Cm/10/EL	Medicine	Bank HCA slipped on wet floor	Liability denied	Incident
Cm/14/EL	Medicine	HCA slipped on wet floor	Liability denied	Incident
Cm/18/EL	Medicine	HCA suffered needlestick injury when syringe left on chair	Liability admitted	Incident

5.2.2 Closed Files

Our Ref	**Speciality**	**Synopsis**		**Incident/ Complaint**
Cm/15/PL	Estates	Tree fell in staff car park damaging six cars	Liability admitted	Incident

6 Summary of PICC

The Heads of services met to review the report and discuss whether there had been any common themes linked through incidents, claims, complaints and PALS. It was noted that there was one case in A&E that resulted in an incident, a complaint, and a claim.

Discharge and discharge planning is a common theme through PALS incidents and complaints; there has been concerns raised around readmission in A&E and this has been audited and reviewed and MB has instigated a full review and discussion of the results. PALS are receiving concerns around lack of communication around discharge planning and this remains a significant area for complaints across all directorates.

Incident reporting remains within our variance, as does complaints and PALS. It is recognised that a number of claims (as indicated in the report, albeit a number of years ago) and complaints were not reported as incidents at the time of the event. This needs to be addressed through training and further scrutiny when directorates report to the Clinical Governance Committee.

Falls have been steadily reducing and we can now demonstrate a step change, with our average falls dropping form 89 to 71 per month.

- End -

Submitted by: **Caroline Becher, Chief Nurse and Dr Mike Baxter, Medical Director**

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Edited by Sarah Johnston Head of Quality and Integrated Governance

Date: 20th April 2010

5 Appendices

Appendix 1

CENTRAL ALERTING SYSTEM SAFETY ALERTS STATUS REPORT MARCH 2010

Alerts not closed by deadline			
Ref	Title	Date Issued	Deadline
NPSA/2007/16	Early Identification of Failure to Act on Radiological Imaging Reports	05-Feb-07	28-Feb-08
NPSA/2007/18	Actions that can make Anticoagulent Therapy Safer	28-Mar-07	31-Mar-08
NPSA/2008/RRR011	Reducing Risk of Overdose with Midazolam Injection in Adults	09-Dec-08	09-Jun-09
NPSA/2009/RRR012	Reducing Risk of Harm from Oral Bowel Cleansing Solutions	19-Feb-09	07-Sep-09
NPSA/2009/SPN002	Risk to Patient Safety of not Using the NHS Number as the National Identifier for all Patients	24-Jun-09	18-Sep-09
Ongoing Alerts			
NPSA/2009/PSA003	Being Open: Communicating with Patients, their Families and Carers Following a Patient Safety Incident	19-Nov-09	23-Nov-10
NPSA/2009/PSA004A	Safer Spinal (Intrathecal), Epidural and Regional Devices - Part A	24-Nov-09	01-Apr-11
NPSA/2009/PSA004B	Safer Spinal (Intrathecal), Epidural and Regional Devices - Part B	24-Nov-09	01-Apr-13
NPSA/2009/PSA005	Safer Lithium Therapy	01-Dec-09	31-Dec-10
NPSA/2010/RRR008	Vaccine Cold Storage	21-Jan-10	21-Jul-10
NPSA/2010/PSA001	Safer Use of Intravenous Gentamicin for Neonates	09-Feb-10	09-Feb-11
NPSA/2010/RRR009	Reducing Harm from Omitted and Delayed Medicines in Hospital	24-Feb-10	24-Feb-11
Alerts Received in March (Open)			
MDA/2020/018	All models of mobile hoists, ceiling hoists and bathing lifts manufactured by Joerns Healthcare Ltd.	09-Mar-10	10-May-10
MDA/2020/019	All types of Oxford slings and standing harnesses manufactured by Joerns Healthcare	09-Mar-10	10-May-10
EFA/2010/01	Medical patient weighing scales	15-Mar-10	30-Jul-10

NPSA/2010/RRR010	Early detection of complications after gastrostomy	31-Mar-10	30-Sep-10
MDA/2010/025	Silicone gel filled breast implants	31-Mar-10	28-Apr-10
Alerts Closed in March			
MDA/2020/016	Pregnancy test for professional use. Clearview hCG Combo	08-Mar-10	06-Apr-10
MDA/2020/017	Peripheral cannula. Nexiva closed IV catheter system	08-Mar-20	22-Mar-10
DH (2010) 01	UK wide Estates and Facilities Alerts	09-Mar-10	06-Apr-10
MDA/2010/020	Hansen type coloured connectors on dialysis fluid lines.	10-Mar-2010.	24-Mar-10
MDA/2010/021	Anaesthetic gas scavenging systems	10-Mar-10	07-Apr-10
MDA/2010/022	Hoists and standing aids.	10-Mar-2010.	31-Mar-10
EFA/2010/02	Access hatches	16-Mar-10	03-Sep-10
MDA/2010/023	Intercranial stent: SILK artery reconstruction device	23-Mar-10	13-Apr-10
MDA/2010/024	Endotracheal (ET) tubes, adult and paediatric sizes.	23-Mar-10	20-Apr-10
EFA/2010/003	Anti-ligature rails.	30-Mar-10	30-Jul-10

Appendix 2 WQI definitions

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

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

6 Urinary Catheter
Ensures the insertion and after care are undertaken in line with good practice to reduce urinary catheter related 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 Pressure Ulcer Prevention
2 are audited: Compliance with the monitoring return, and Actual Grade of Pressure Ulcer

10 Falls
Total number of falls and number of falls resulting in significant injury i.e. graded 3, 4 or 5
Data supplied from Datix system via Quality department

11 Complaints
Actual number of complaints registered to the clinical area in reporting month. Data supplied from Datix system via Complaints department

12 Medication Errors
Number of errors reported via incident reporting. Data supplied from Datix system via Quality department

Ashford and St Peter's Ward Quality Scorecard - March 2010

N/S: No submission

		Hand Hygiene Compliance	Number of MRSA Bacteraemia	Number of C Diff Cases (Hospital post 72 hrs)	Saving Lives						Cleanliness	Matron Environment Audit	Pressure Ulcer Prevention	Mixed Sex Wards Compliance	Patient Falls		Complaints	Medication Errors	
					Central Lines Insertion	Central Lines After Care	Urinary Catheter Insertion	Urinary Catheter After Care	Peripheral Cannula	Peripheral Cannula After Care			Compliance with monitoring of Pressure Ulcer		Number of falls	Resulting in Injury		Administration	Prescribing
		>=90%	=0	=0	>=95%	>=95%	>=95%	>=95%	>=95%	>=95%	>=85%	>=90%	=100%	=0	=0	=0	=0	=0	=0
		89% - 80%			94% - 85%	94% - 85%	94% - 85%	94% - 85%	94% - 85%	94% - 85%	84% - 75%	89% - 80%	99% - 76%						
		<80%	>=1	>=1	<85%	<85%	<85%	<85%	<85%	<85%	<75%	<80%	<=75%	>=1	>=1	>=1	>=1	>=1	>=1
Medicine 1, 2, 3	ASPEN	100 %	0	0	N/A	N/A	100 %	100 %	100 %	90 %	90 %	100 %	100 %	0	0	0	1	1	2
	CCU	97 %	0	0	N/A	N/A	100 %	100 %	100 %	100 %	89 %	100 %	100 %	N/A	0	0	0	1	0
	BIRCH	100 %	0	0	N/A	N/A	100 %	100 %	100 %	100 %	86 %	100 %	100 %	6	4	0	1	0	1
	MHDU	100 %	0	0	100 %	100 %	100 %	100 %	100 %	100 %	88 %	100 %	80 %	N/A	0	0	0	0	0
	HOLLY	100 %	0	0	N/A	N/A	100 %	100 %	100 %	100 %	89 %	97 %	100 %	0	3	0	1	0	0
	CEDAR	91 %	0	0	N/A	100 %	100 %	100 %	80 %	100 %	89 %	94 %	80 %	0	7	0	0	2	2
	MAY	95 %	0	0	N/A	N/A	N/A	100 %	90 %	100 %	94 %	95 %	100 %	0	1	0	0	1	2
	MAPLE	97 %	0	0	N/A	N/A	100 %	100 %	100 %	80 %	N/A	95 %	100 %	0	0	0	1	3	2
	COLPOSCOPY	100 %	0	0	N/A	N/A	N/A	N/A	N/A	N/A	93 %	N/A	N/A	N/A	0	0	0	0	0
	ANGIO SUITE	N/A	0	0	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0	0	1	0	0
	RHEUMATOLOGY	N/A	0	0	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0	0	2	0	0
Ashford	CHAUCER	100 %	0	0	N/A	N/A	100 %	100 %	100 %	100 %	90 %	92 %	80 %	0	2	0	1	0	0
	WORDSWORTH	100 %	0	0	N/A	N/A	100 %	100 %	100 %	100 %	94 %	93 %	80 %	0	1	0	0	0	0
	FIELDING	100 %	0	0	N/A	N/A	100 %	100 %	100 %	100 %	91 %	92 %	80 %	0	3	0	0	0	0
	DICKENS	100 %	0	0	N/A	N/A	100 %	N/A	100 %	N/A	96 %	93 %	100 %	0	0	0	1	0	0
Orthopaedics	ELM	99 %	0	0	N/A	N/A	100 %	100 %	100 %	100 %	92 %	93 %	80 %	0	4	0	1	0	0
	JUNIPER	99 %	0	1	N/A	N/A	100 %	100 %	100 %	100 %	94 %	93 %	80 %	0	1	1	1	1	0
	ROWLEY BRISTOW	100 %	0	0	N/A	N/A	N/A	N/A	N/A	N/A	89 %	91 %	N/A	N/A	0	0	1	0	0
Surgery	KINGFISHER	98 %	0	0	N/A	100 %	100 %	100 %	100 %	100 %	98 %	92 %	100 %	0	0	0	4	0	0
	FALCON	94 %	0	0	N/A	N/A	100 %	100 %	75 %	67 %	87 %	91 %	60 %	0	0	0	0	0	0
	KESTREL	100 %	0	1	N/A	N/A	100 %	100 %	100 %	100 %	94 %	95 %	60 %	0	0	0	1	0	0
	SDU	96 %	0	0	N/A	90 %	100 %	100 %	90 %	80 %	98 %	97 %	60 %	0	0	0	0	0	0
	ADMISSIONS LOUNGE	100 %	0	0	N/A	N/A	N/A	N/A	100 %	N/A	N/A	N/A	N/A	N/A	0	0	0	0	0
	HERON	89 %	0	0	N/A	N/A	100 %	100 %	100 %	50 %	93 %	93 %	100 %	0	0	0	0	0	0
	MAXFACS CLINICS ASH	100 %	0	0	N/A	N/A	N/A	N/A	N/A	N/A	87 %	98 %	N/A	N/A	0	0	0	0	0
Emergency Services	MAU	100 %	0	1	N/A	N/A	100 %	100 %	100 %	100 %	96 %	N/A	0 %	0	0	0	2	1	0
	SAU	100 %	0	0	N/A	N/A	100 %	100 %	100 %	100 %	98 %	N/A	80 %	0	0	0	1	0	0
	A&E	88 %	0	1	N/A	N/A	N/A	N/A	100 %	N/A	90 %	N/A	N/A	N/A	0	0	8	0	1
Paediatrics	OAK	94 %	0	0	N/A	100 %	N/A	N/A	100 %	N/A	98 %	95 %	N/A	N/A	0	0	0	0	0
	ASH	85 %	0	0	N/A	100 %	N/A	N/A	80 %	N/A	97 %	93 %	N/A	N/A	0	0	0	0	0
	PAED A/E	93 %	0	0	N/A	N/A	N/A	N/A	100 %	N/A	N/A	93 %	N/A	N/A	0	0	1	0	0
	NICU	97 %	0	0	N/A	N/A	N/A	N/A	N/A	100 %	95 %	90 %	N/A	N/A	0	0	0	1	1
Theatres	THEATRES SPH	100 %	0	0	100 %	100 %	100 %	N/A	100 %	100 %	89 %	90 %	N/A	N/A	0	0	0	0	0
	THEATRES ASH	100 %	0	0	N/A	N/A	N/A	N/A	N/A	N/A	95 %	97 %	N/A	N/A	0	0	1	0	0
	DSU SPH	100 %	0	0	N/A	N/A	100 %	100 %	100 %	100 %	N/A	97 %	N/A	2	0	0	0	0	0
	DSU ASH	100 %	0	0	N/A	N/A	N/A	N/A	100 %	100 %	96 %	91 %	N/A	0	0	0	1	0	0
Imaging / Endoscopy	ENDO	98 %	0	0	N/A	N/A	N/A	N/A	100 %	N/A	92 %	90 %	N/A	N/A	0	0	0	0	0
	IMAGING ASH	100 %	0	0	N/A	N/A	N/A	N/A	N/A	N/A	N/A	94 %	N/A	N/A	0	0	0	0	0
	IMAGING SPH	100 %	0	0	N/A	N/A	N/A	N/A	N/A	N/A	85 %	96 %	N/A	N/A	0	0	0	0	0
Critical Care	ITU	100 %	0	0	100 %	100 %	100 %	100 %	100 %	100 %	89 %	97 %	100 %	N/A	0	0	0	0	0
Maternity	JOAN BOOKER	100 %	0	0	N/A	N/A	N/A	100 %	N/A	100 %	82 %	90 %	N/A	N/A	0	0	0	0	0
	LABOUR	94 %	0	0	N/A	N/A	100 %	N/A	90 %	100 %	N/A	91 %	N/A	N/A	0	0	0	0	0
	LABOUR THEATRES	N/A	0	0	N/A	N/A	N/A	N/A	N/A	N/A	91 %	95 %	N/A	N/A	0	0	0	0	0
	MATERNITY TRIAGE	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	1	N/A	N/A
Outpatients	OUTPATIENT ASH	97 %	0	0	N/A	N/A	N/A	N/A	N/A	N/A	96 %	96 %	N/A	N/A	0	0	0	0	0
	OUTPATIENT SPH	100 %	0	0	N/A	N/A	N/A	N/A	N/A	N/A	97 %	76 %	N/A	N/A	0	0	1	0	0
Ophthalmology	EYE CLINIC ASH	90 %	0	0	N/A	N/A	N/A	N/A	N/A	N/A	95 %	98 %	N/A	N/A	0	0	1	0	0
	EYE CLINIC SPH	90 %	0	0	N/A	N/A	N/A	N/A	N/A	N/A	87 %	96 %	N/A	N/A	0	0	1	0	0
	EYE WARD ASH	90 %	0	0	N/A	N/A	N/A	N/A	N/A	N/A	83 %	90 %	N/A	N/A	0	0	0	0	0