

## Patient Safety Annual Report

April 2009 – 2010



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# Patient Safety Annual Report 2009/10

## 1.0 Introduction

Patient safety is a national and a local priority. Providing safe and effective care is a fundamental principle of healthcare provision and is included in the Trust's strategic goals. In July 2009 the Trust Board approved the strategy for Preventing Harm & Improving Safety (April 2009 – 2011). This annual report provides an update on patient safety activities and progress against the strategy.

## 2.0 Description of Patient Safety Arrangements

The Trust has well established governance arrangements to manage risks and ensure patients are safe. To complement these arrangements the Board agreed to introduce the role of Patient Safety Manager to drive safety improvement initiatives across the organisation.

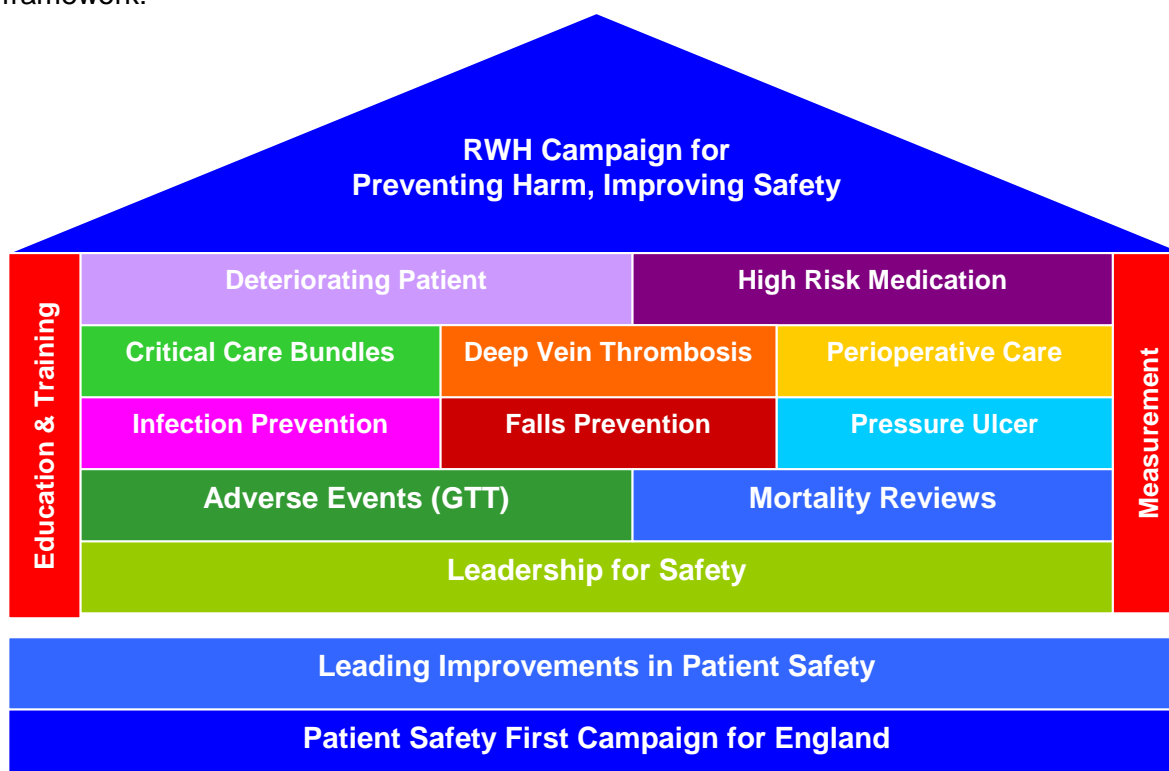
### 2.1 Responsibility for Patient Safety

The role of Patient Safety Manager is a new post for the Trust was introduced in April 2009. The Patient Safety Manager is responsible for the co-ordination of patient safety improvement activities and is accountable to the Director of Nursing and Midwifery.

### 2.2 Preventing Harm Improving Safety Campaign

The Preventing Harm Improving Safety Campaign was launched in July 2009. The overall aim of the campaign is to have no avoidable deaths and no avoidable harm. This is measured by a reduction in the Hospital Standardised Mortality Ratio (HSMR) of 5 points each year and a 50% reduction in adverse event triggers using the Global Trigger Tool by March 2010.

To achieve our aim we commenced a range of initiatives that have been proven to have an impact on the reduction of mortality and reduction in the number of events resulting in avoidable harm; each initiative is led by a medical or nursing clinician. The diagram below depicts the campaign framework:



## **2.3 Preventing Harm Improving Safety Group**

The Preventing Harm Improving Safety Group meets on a monthly basis and is chaired by the Chief Executive. The constitution and terms of reference of the Group can be found in Appendix 1.

The purpose of the Group is to:

- determine the strategic direction of the Preventing Harm, Improving Safety Campaign
- monitor progress of the improvement projects within the campaign framework
- monitor rates of harm identified through use of the Global Trigger Tool
- receive reports in relation to the outcome of mortality reviews
- review national guidance on patient safety initiatives
- make recommendations for action
- report progress and exceptions to the Quality and Safety Committee on a quarterly basis

Core members of the group include the Director of Nursing & Midwifery (Deputy Chair), Non Executive Director, Patient Safety Manager, Clinical Leads, Division Representatives, Patient Representative, and PCT Representative.

During 2009/10 meetings were held on the 21 May, 16 June, 24 July, 21 August, 25 September, 16 October, 20 November 2009 and 5 February 2010.

## **3.0 Reports to Trust Board**

The Trust Board are fully informed and involved; reports on patient safety issues, such as infection prevention and serious incidents, are provided on a regular basis. The Quality & Safety Report is submitted to Trust Board on a quarterly basis and includes information on incidents, risks, inquests, litigation, complaints and other quality initiatives such as single sex accommodation, environmental standards, hand hygiene practice, nursing staffing levels and essence of care standards. The report also includes details on the progress with each of the preventing harm improving safety initiatives.

The Trust Board members lead the weekly Leadership Safety Walk Rounds (see section 4.1) and have participated in an exercise to assess the Trust's safety culture using the Manchester Patient Safety Framework (MaPSaF).

## **4.0 Patient Safety Initiatives**

The following patient safety initiatives were identified following staff engagement and as a result of information from incidents, risks and complaints. Each initiative is led by a medical or nursing clinician and involves a multidisciplinary team and, in some groups, patients and carers.

### **4.1 Leadership for Safety**

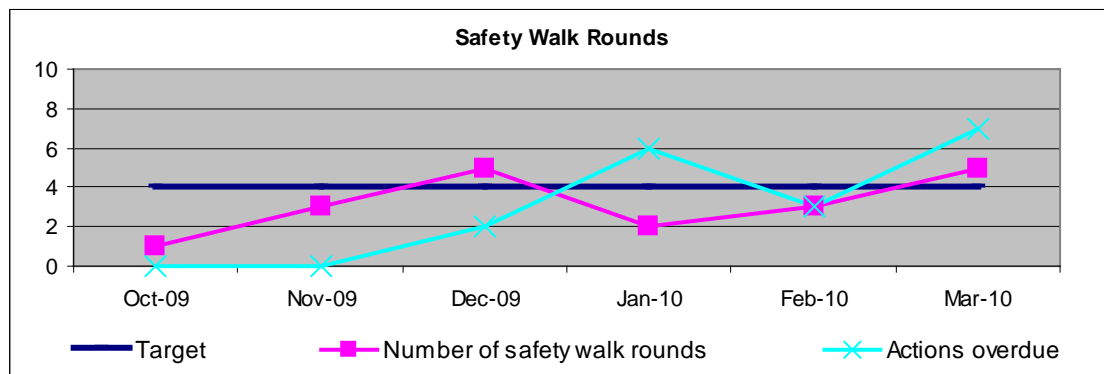
The aim of this initiative is to ensure a leadership culture at Board level which promotes quality and safety.

Leadership Safety Walk Rounds commenced in October 2009 and are led by an Executive Director. Walk Rounds were suspended for three weeks during the Noro virus outbreak otherwise they have been undertaken on a weekly basis. Following each Walk Round areas for action are agreed. Actions have included improvements to communication, equipment, and the environment.

The Walk Round process was reviewed after six months and changes implemented to provide the visiting team with information on incidents and complaints and introduced a poster to enable

contribution from the wider ward/department team. A system to monitor actions agreed at the Walk Rounds was also changed to ensure actions are monitored and completed as agreed. The Directorate management team now include the Walk Round report in their Governance meetings and regular updates are requested each month. Graph 1 demonstrates the number of Walk Rounds completed.

Graph 1 Leadership Safety Walk Rounds (October 2009 to March 2010)



Next steps 2010/11:

- Trust wide patient safety culture survey by July 2010
- Deliver patient safety awareness sessions for staff during September to November 2010
- Development of Directorate patient safety scorecard by March 2011

#### 4.2 Mortality Reviews

The Mortality Review Group meet on a monthly basis to review a sample of case notes of patients that have died whilst in our care. The purpose of the case note reviews is to identify if there are any lessons that can be learnt to prevent future reoccurrence.

Findings from the reviews include recommendations that end of life care planning is improved; improve recognition of the deteriorating patient, and review of anticoagulation policy and practice.

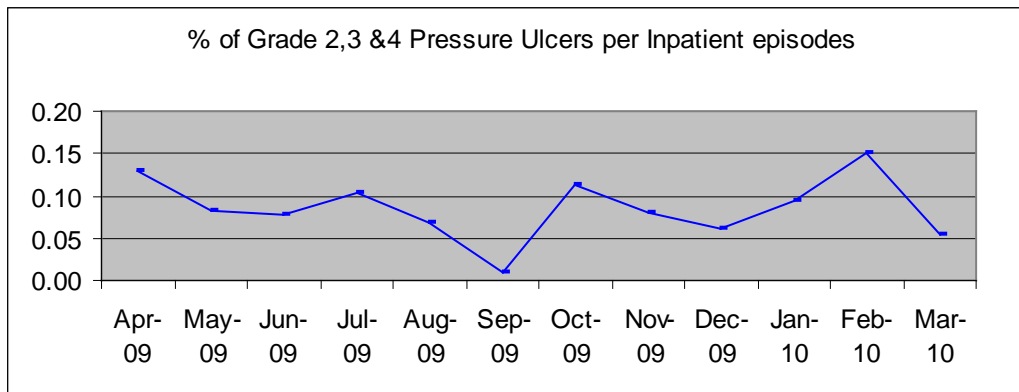
Next steps 2010/11:

A mortality policy has been devised to introduce a systemised approach for investigating mortality throughout the Trust during 2010/11. The review group is refocusing its efforts around 4 key areas: 1) Pulmonary embolism, 2) in hospital cardiac arrests, 3) mortality at weekends and 4) the processes for mortality review at the Directorate level.

#### 4.3 Prevention of Pressure Ulcers

Pressure ulcers represent largely avoidable episodes of harm to patients. This initiative paused due to difficulties recruiting a tissue viability specialist. A team was established in March 2010 and actions to reduce hospital acquired pressure ulcers have been agreed. During this time staff were encouraged to report and investigate incidents of pressure ulcers so that actions could be taken to prevent reoccurrence. The graph below represents the percentage of pressure ulcers per number of inpatient episodes.

Graph 2 Percentage of Pressure Ulcers per Inpatient Episode (April 2009 – March 2010)



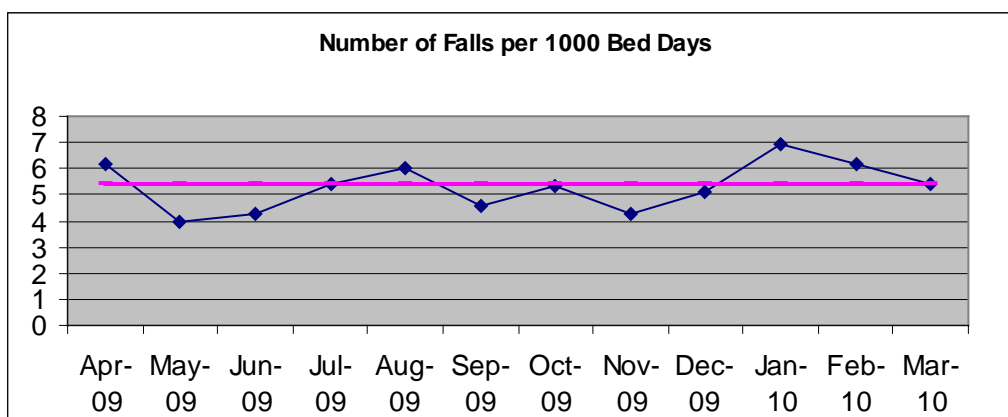
Next steps 2010/11:

- Improve and enhance detection, reporting and management of pressure ulcers
- Develop and implement pressure ulcer prevention and management policy by July 2010
- Implement care bundle for prevention and management of pressure ulcers by July 2010

#### 4.4 Falls Prevention

The reasons for patient falls are varied however the Trust is committed to reducing inpatient falls and has implemented a falls prevention strategy. This includes the use of falls risk assessment, the use of specialist equipment and staff and patient education and awareness. During January and February 2010 the number of falls increased significantly and has been attributed to the outbreak of C Difficile where patients had to be isolated and visitors restricted to prevent the spread of infection. This prevented us reaching our reduction target for the year. Further actions to reduce falls include basing nursing staff within the bays on the wards to improve patient monitoring, the development of falls competencies for staff, an audit tool and an electronic ward accreditation tool. Graph 3 shows the number of falls per 1000 bed days.

Graph 3: Number of Falls per 1000 Bed Days (April 2009 to March 2010)



Next steps 2010/11:

- Implementation of falls competencies for staff by May 2010
- Introduce additional equipment to prevent falls e.g. high low beds, movement sensors
- Review falls documentation by October 2010
- Review investigation and management of patients who have fallen more than once by October 2010

## 4.5 Infection Prevention

A detailed annual report on Infection Prevention can be found on the Trust website. The report details the achievements against infection prevention targets, in particular MRSA bacteraemias, which are unprecedented with no MRSA bacteraemia since June 2009. There is however no room for complacency and the Trust continues to target a reduction in other infections.

Unfortunately we experienced a significant outbreak of Norovirus during January and February 2010 however aggressive management reduced the length of the outbreak. The current infection prevention strategies continue with additional focus on the prevention of MRSA acquisition, MSSA, C Difficile and device related infections.

### Next steps 2010/11:

- Develop policy and practice to prevent infections related to medical devices such as urinary catheters and central lines
- Continue existing infection prevention strategies
- Review surgical site infection surveillance for the Trust

## 4.6 Perioperative Care

The surgical safety checklist provides the so called 'pre-flight checks' which aim to prevent adverse events in theatres, prevent surgical site infections and improve team work and communication. The World Health Organisation checklist was amended (as advised) and implemented in all theatres by the end of March 2010.

Our checklist incorporates each of the four components of the care bundle identified to prevent surgical site infections (antibiotics 60 minutes prior to incision, appropriate hair removal, maintenance of normothermia and maintenance of blood glucose in diabetic patients). Challenges include the engagement by all of the theatre team and the volume of data produced. Further developments include incorporating the recording requirements of the checklist into the perioperative care pathway.

### Next steps 2010/11:

- Review perioperative care document to incorporate all elements of the care bundle by September 2010
- Undertake observation and case note audits by October 2010
- Participate in National Patient Safety Agency (NPSA) initiative to share good practice and improve use of surgical safety checklist

## 4.7 Prevention of Venous Thromboembolism (VTE)

The NICE guidance for the prevention of VTE was released in January 2010. The clinical group responsible for this initiative reviewed the guidance and also reviewed Trust data on patients with confirmed diagnosis of VTE in the previous year. Clinical coding was not available to differentiate between patients who were admitted with a VTE and those which were hospital acquired VTE however this has now being addressed. The national VTE risk assessment has been amended to include additional factors for risk of bleeding and clotting. Future developments include electronic VTE risk assessment and monitoring of treatment to prevent patients from developing VTE.

Next steps 2010/11:

- Implement electronic VTE risk assessment for all adult patients admitted as an inpatient or day case by December 2010
- Develop policy and guidance for the prevention of VTE
- Develop and deliver training and education for medical and nursing staff
- Develop and implement investigation process for hospital acquired VTE

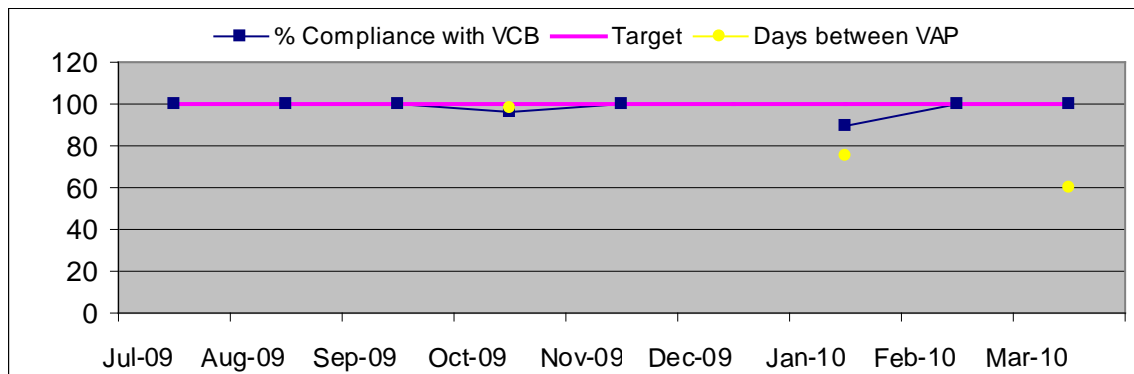
#### 4.8 Critical Care Bundles

The critical care bundles include actions to prevent central line infections (CLI) and ventilator acquired pneumonia (VAP). Care bundles include a small number of components of care that, if applied rigorously, will help to prevent either CLI or VAP.

The Trust joined the Matching Michigan (MM) national initiative which aims to prevent central line infections in intensive care units. Feedback from the first three months of MM suggests that the Trust ICCU has a lower rate of central line infections compared nationally. The last central line MRSA bacteraemia was on the 28 October 2008 and compliance with the care bundle is 100 percent.

The definition of a VAP has proved difficult. The clinical team review all cases of suspected VAP at regular meetings with the aim of identifying improvements to avoid reoccurrence. The number of VAP has increased as the team improve the process. This can be demonstrated in the graph below by the decreasing number of days between VAP. The team continue to monitor and reinforce the reliable application of each element of the care bundle in order to reduce VAP.

Graph 4: Compliance with the Ventilator Care Bundle and Days between VAP (July 2009 to March 2010)



Next steps 2010/11:

- Launch critical care patient safety group to raise awareness and improve knowledge around VAP and CLI by July 2010
- Develop database to record, monitor and improve practice with central lines by December 2010
- Continue to participate in Matching Michigan project and further develop improvements in practice to prevent CLI

## 4.9 High Risk Medicines

High risk medicines include: anticoagulants, insulin, opiates and injectable sedatives with each having a pharmacist lead. Individual groups were established, each led by a pharmacist. Activities included:

- Identification of International Normalised Ratio (INR) results greater than 5 followed by a review of cases with an INR greater than 8. The INR measures the blood coagulation (clotting) and is monitored closely in patients who are taking medication to prevent or treat thrombosis (blood clots). To date this has not identified any adverse events therefore an audit of all INRs greater than 5 is planned.
- An audit of insulin stored in ward fridges revealed 149 items which could not be used. As a result ward stock levels of insulin are being reviewed.
- A review of opiate stocks held by wards/departments and provision of support information for prescribers
- Development of a conscious sedation policy and education package to address patient safety issues related to injectable sedatives.

### Next steps 2010/11:

- Audit of INR results greater than 5 during one month by October 2010
- Introduce educational package on conscious sedation and competency assessment
- Review and continue to monitor opiate management

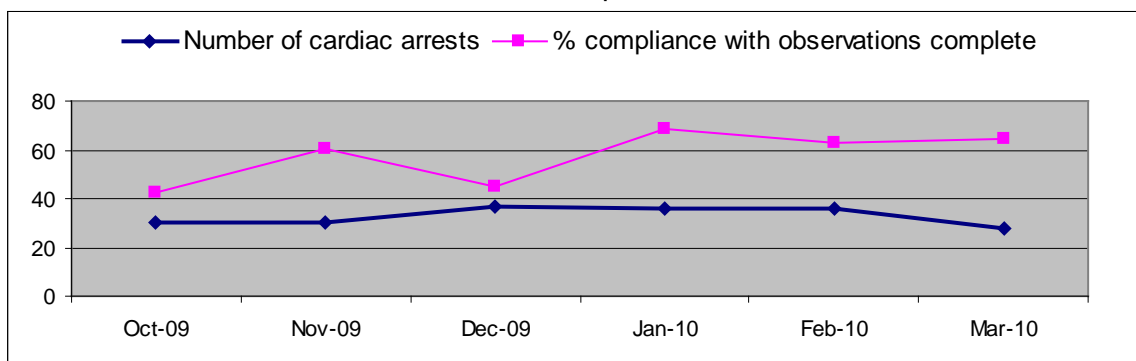
## 4. 10 Deteriorating Patient

The aim of this initiative is to reduce in-hospital cardiac arrest and mortality rate through earlier recognition and treatment of patients who are deteriorating.

The focus has been on the development of a business case for an electronic solution, which is seen as key to preventing harm from unrecognised deterioration. In addition, we have also reviewed how patients' physiological observations are taken, recorded and acted upon by staff and provided opportunities for further training to ensure that staff are fully trained to undertake these procedures. The graph below shows the number of cardiac arrests and overall compliance with all aspects of patient observations.

In conjunction with this a training package has been developed and is being delivered on a communication tool called SBARD (situation, background, assessment, response, decision) to improve communication about the deteriorating patient.

Graph 5: Number of cardiac arrests per month and compliance with all aspects of the observation chart completed



Next steps 2010/11:

- Implement VitalPAC in adult medical and surgical wards by December 2010
- Undertake physiological observation competencies (nursing staff) by October 2010
- Implement training in SBARD (Situation, Background, Assessment, Recommendation, Decision) communication tool by December 2010

#### **4.11 Think Glucose**

Think Glucose is a NHS Institute initiative that was due to commence in September 2009 and aims to reduce variation and improve the quality of care for diabetic patients who are admitted for reasons other than diabetes. Progress was initially slow however the team has recently extended its membership, identified leads and recommenced its efforts in the following areas: data quality & coding, length of stay, insulin errors, patient satisfaction, hypoglycaemia and education & training.

Next steps 2010/11:

- Ensure all patients with diabetes admitted to hospital are identified and appropriately referred to the Diabetes Outreach Team
- Review insulin errors and deliver education and training for clinical staff
- Reduce incidents and improve management of hypoglycaemia (low blood sugar) in diabetic patients

#### **5. Training and Development**

Training and development of staff is to each of the safety initiatives. The Education and Training subgroup of the Preventing Harm Improving Safety Group has worked with the clinical leads to develop education and training for doctors and nurses including e-learning modules and face to face training.

The Patient Safety Manager has completed the Patient Safety Leaders course provided by the NHS Institute for Innovation and Improvement and subsequently has been invited to present the application of the model for improvement to other Trusts participated in the Leading Improvements in Patient Safety course and Patient Safety Leaders course.

#### **6. Patient Safety Events**

The Preventing Harm Improving Safety Campaign was formally launched in July 2009. Patients, carers, Trust staff and PCT staff were invited to a series of presentations by the clinical leads. A range of products depicting the staff code for patient safety and the campaign framework were available to raise awareness of the Trust's campaign to prevent harm.

Patient Safety First week took place in September 2009 and during this week the clinical leads took part in sessions to raise awareness of their work and progress to date.

#### **7. Safety Culture Assessment**

In order to assess the Trust's safety culture and determine what actions can be taken to improve it three sessions were undertaken using the Manchester Patient Safety Framework (MaPSaF). The Framework facilitates a discussion about ten dimensions of patient safety and aims to seek agreement on the level of maturity for each dimension. This exercise was undertaken with the Trust Board and with each of the two clinical divisions.

A Trust wide survey of all staff was planned during 2010 however this was postponed while the organisation transferred over to the use of NHS mail. This survey was subsequently undertaken in

June/July 2010 and the results of the MaPSaF and staff survey will be combined to develop an action plan.

## **8. Summary of Achievements 2009/10**

Our achievement against our overall aim to reduce mortality was met as measured by the Hospital Standardised Mortality Ratio (HSMR) for 2009/10. This was provided by Dr Foster and showed a reduction in our annual trend (prior to the rebasing by Dr Foster) in line with our strategy. A reduction in adverse event triggers cannot be demonstrated as insufficient numbers of case note reviews using the Global Trigger Tool have been completed at this stage. In order to establish a baseline and to observe the effect of patient safety initiatives on the number of adverse event triggers the number of staff undertaking the case note reviews has been increased and we are continuing with the use of the Global Trigger Tool.

Key achievements include:

- Development of quarterly report to inform the Board
- Implementation of Leadership Safety Walk Rounds
- No MRSA bacteraemia since June 2009
- Implementation of the surgical safety checklist
- Foundation of multidisciplinary group to agree definition and attribution of ventilator acquired pneumonia and central line infections in order to learn lessons and prevent these infections
- Access to patient safety education and training on the Trust Intranet
- Development of a business case to implement Vital PAC, an electronic solution to improve the recognition and response to deteriorating patients.

## **9. Priorities for 2010/11**

During 2010/11 we will continue to implement our strategy to prevent harm and improve patient safety. Our key priorities for 2010/11 are:

- Prevention of unrecognised deterioration
- Prevention of hospital acquired VTE
- Prevention of hospital acquired pressure ulcers
- Prevention of device related bacteraemias

Further planned actions include:

- Patient safety awareness sessions for staff
- 30 day focus events on patient safety priorities
- Patient safety culture survey of all staff
- Patient safety conference

## Preventing Harm Improving Safety Group – Constitution and Terms of Reference

### Constitution

The Trust Management Team has resolved to establish a group to oversee the implementation of the Trust's campaign for preventing harm and improving safety to be known as the **Preventing Harm, Improving Safety Group**

### Core Membership

- **Chairman of the Committee** will be the **Chief Executive**
- **Director of Nursing and Midwifery** is the executive lead for the Preventing Harm, Improving Safety Campaign and will be the deputy chair of this Group
- **Director of Governance** and chair of the **Mortality Review Meeting** will provide professional clinical advice to the Group on the implementation of the clinical projects and outcomes of the Mortality Review Meetings
- **Medical Director** will provide a medical overview in relation to patient safety and issues relating to professional practice
- **Patient Safety Manager** will act as Secretary to the Group, ensuring that the strategy for Preventing Harm, Improving Safety is implemented, and will lead the implementation of the campaign framework
- **Project Leads** are responsible for implementing their project in the clinical areas and will ensure that progress reports are provided to the Group for consideration and action
- **Divisional Representatives** will support the implementation of the strategy across their division
- **Head of Education & Training** will provide advice and support regarding any training and development issues raised by the Group members
- **Patient Representative(s)** will support the Preventing Harm, Improving Safety Campaign and provide advice and feedback from a patient's perspective
- **Non Executive Director** will provide advice and support in relation to the implementation of the strategy

**PCT Representative** will provide advice and support in relation to the Primary Care Trust and the implementation of The Royal Wolverhampton Hospitals NHS Trust's strategy for Preventing Harm, Improving Safety

**Quorum** - A quorum will consist of a minimum of four core members to include one project lead and one divisional representative.

**Deputies** - If unable to attend a meeting the member will ensure that an appropriate deputy attends on their behalf. The deputy should be fully informed, have the authority to make decisions on behalf of the member and will fully brief the member following the meeting.

## **Frequency**

The Group shall meet monthly prior to the Quality & Safety Committee meetings to ensure all progress reports are timely so that effective management action can be taken.

## **Authority**

- The Preventing Harm, Improving Safety Group is authorised by the Quality & Safety Committee to review all documents relating to its terms of reference and that its reports inform the Trust's managerial decision making processes.
- It is authorised to seek any information it requires from any employee in pursuit of its Terms of Reference and all employees are directed to co-operate with any request made by the committee.
- The Preventing Harm, Improving Safety Group shall transact its business in an open manner and in conformity with the principles and values of public service.

## **Duties**

The Preventing Harm, Improving Safety Group will:

- determine the strategic direction of the Preventing Harm, Improving Safety Campaign
- monitor progress of the improvement projects within the campaign framework
- monitor rates of harm identified through use of the Global Trigger Tool
- receive reports in relation to the outcome of mortality reviews
- review national guidance on patient safety initiatives
- make recommendations for action
- report progress and exceptions to the Quality and Safety Committee on a quarterly basis