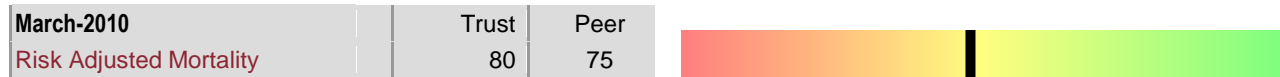


Patient Safety Report

The Patient Safety Report shows information up to the end of **March 2010**. The full report was submitted to the Patient Safety Committee on 3rd May 2010 who identified the key issues for reporting to the Board.

1. Mortality

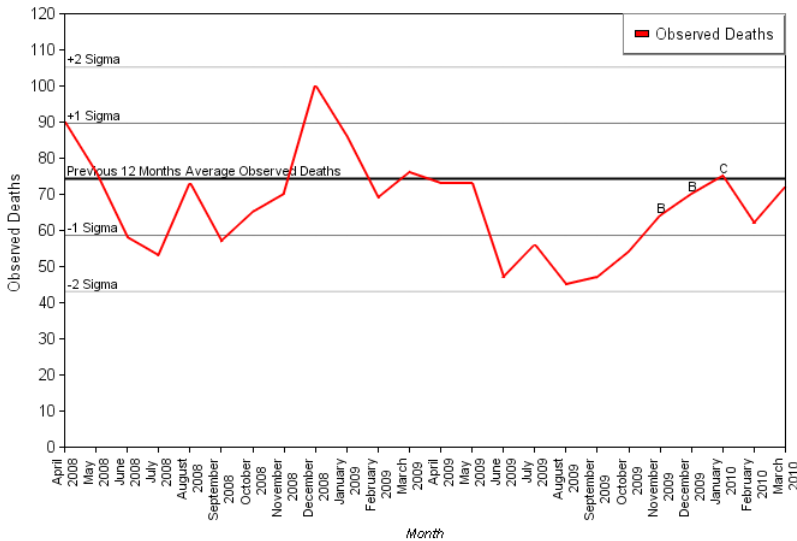
1.1 Risk Adjusted Mortality rate



HSMR (Dr Foster) : 101.87 Overall mortality rate for 1 year

1.2 Risk Adjusted Mortality Trends: Trustwide

Mortality Trending



Special Cause Flags

- A: Value beyond 2 sigma
- B: 8 consecutive values one side of the average.
- C: 6 consecutive values trend in one direction
- D: 4 of 5 beyond 1 sigma

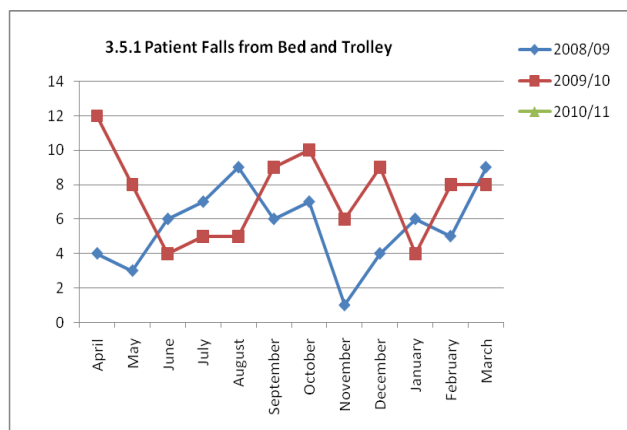
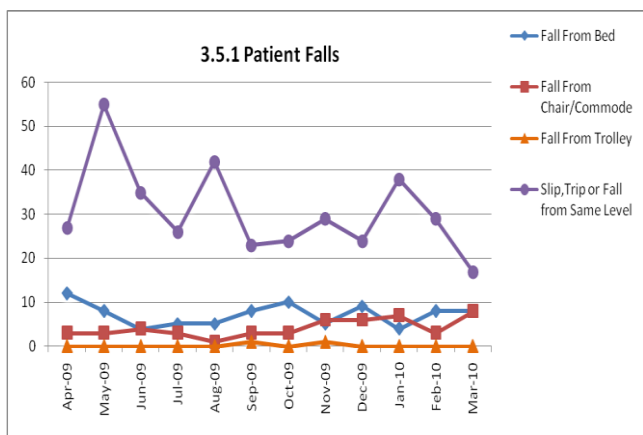
Review of mortality trends at specialty level shows a continued rise in the rates for Medicine and Care of the Elderly. Trends reversed in Cardiology and Respiratory Medicine in December. A case review of deaths is continuing

2. Incident Reporting	Patient incidents showed a slight rise in the past month but there was no events of major harm or red incidents this month	G
------------------------------	--	----------

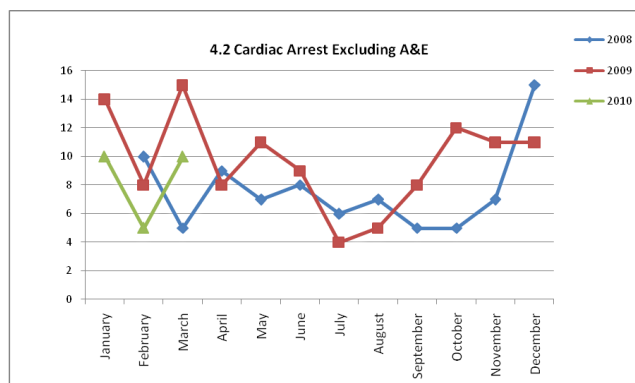
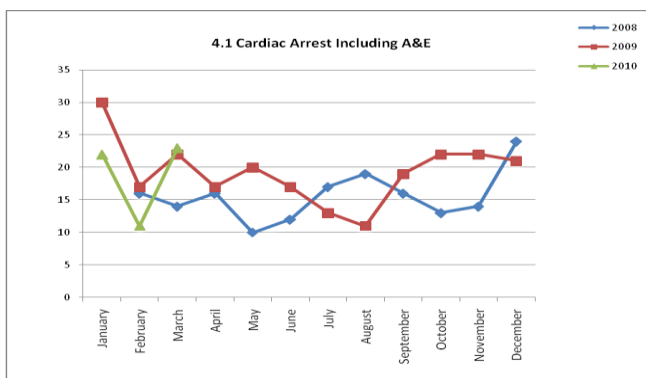
3.1 Serious Incidents (SI)	March 2010 – Nil Serious Incidents reported	G
-----------------------------------	---	----------

3.2 Never Events	March 2010 – Nil Never Events reported	G
-------------------------	--	----------

3.3 Patient Falls	Overall the number of falls has reduced. All have been investigated and there is no clear root cause as they are spread across both divisions	G
--------------------------	--	----------

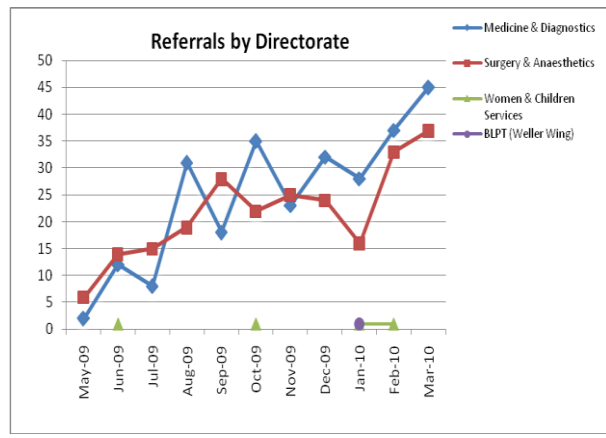
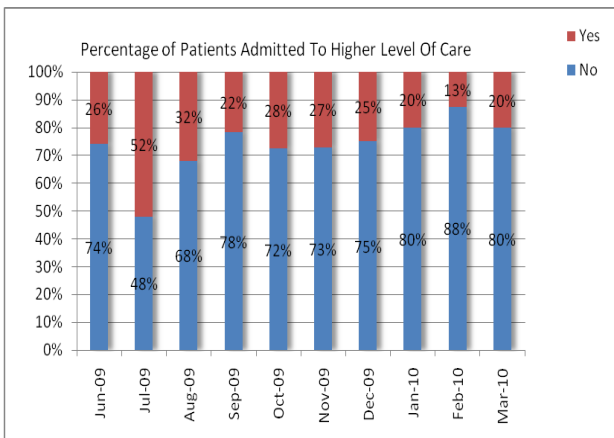
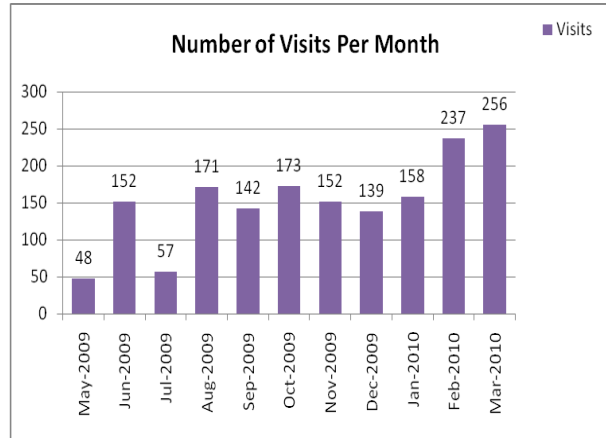
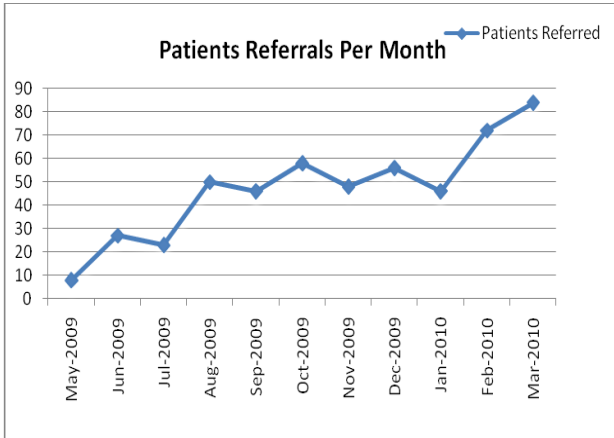


4. Cardiac Arrests	Disappointingly, the number of arrests rose back to the level experienced in January. No specific cause for concern	A
---------------------------	---	----------



5. Outreach / Patients At Risk (PAR) Data

During March 2010, there were 86 patient referrals to the Critical care Outreach Team. These 86 patients were visited 256 times. 20% of these patients (n=17) required admission to a higher level of care. The remaining 69 were either Critical Care follow ups or were managed within the ward area.



6. Pressure Ulcers

This month's report includes 1x Grade 3 Hospital- Acquired pressure ulcer. A root cause analysis will be undertaken to determine if it was "avoidable".

