

Patient Safety Report

The Patient Safety Report shows information up to the end of **November 2010**.

Key

↑	Improvement
→	No Change
↓	Deterioration

G	Green	No Concerns
A	Amber	Limited Concerns
R	Red	Significant Concerns

1. Mortality

Trustwide Mortality: Risk Adjusted Mortality 2008 figures will be used until April 2011 to correspond with our Quality Account 2010-11. HSMR (2009-2010): 99.7

G ↑

1.1 Mortality Overview

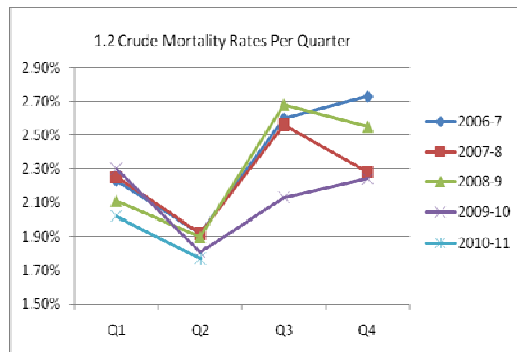
Note: Data obtained from CHKS

Trust Overview			
Filter	: None	Peer Group	: Bedford_Aug10
Time Period	: Sep 2010 to Nov 2010	Peer Group Period	: Sep 2010 to Nov 2010
Thread	Trust	Peer	Performance
Mortality	1.93%	1.69%	
Complication Rate - Attributed	0.8%	0.6%	
Complication Rate - Treated	1.7%	1.6%	
Risk Adjusted Mortality 2010	73	86	
Risk Adjusted Mortality	53	61	
Risk Adjusted Mortality 2008	63	73	
Readmissions	4.9%	5.4%	
Data Quality	92.5	84.4	
Misadventure Rate	0.04%	0.09%	

Risk Adjusted (2008) Directorate Drilldown

Directorate	Included Spells	Trust	Peer	Performance
Medicine	2,320	66	73	
Womens & Childrens	576	0	40	
Surgery	1,583	49	77	

1.2 Crude Mortality

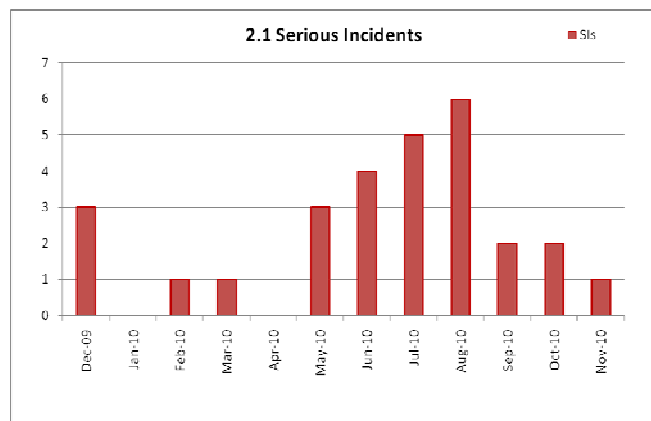
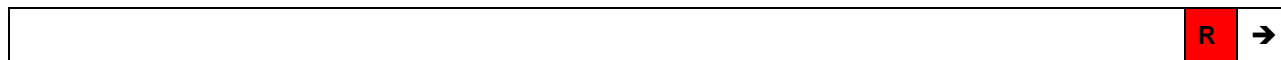


Crude Mortality data up to and including Q2. Q3 data available February 2011.

2. Incident Reporting Data

There were 207 patient incidents reported during November resulting in 32 patient harm events and 10 near misses/hazards. Of the patient harm events, the most frequently occurring (n16) were injuries to skin or tissue and were attributable to Pressure Ulcers, 3rd degree tears and falls. The one incident graded as Major was a 'failure to observe'. The investigation highlighted failures with fluid balance monitoring and documentation. This is being addressed by the Ward Manager and Patient Safety Manager.

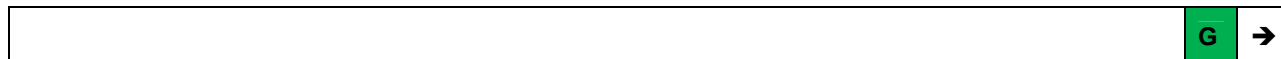
2.1 Serious Incidents (SI)



November 2010
1 Serious Incidents reported

Following a routine dose audit request by the Radiation Protection Advisor at Mount Vernon, the results of which were presented at the Radiation Protection Meeting on 22/11/2010, it became evident that 4 children under the age of 5 had received brain scans using CT protocols for adults from 14/04/2008 to 09/09/2008. As a result the audit was extended. On 30/11/2010 it became apparent that a further 5 children had also been scanned using adult protocols.

2.2 Never Events



The core list of Never Events is:

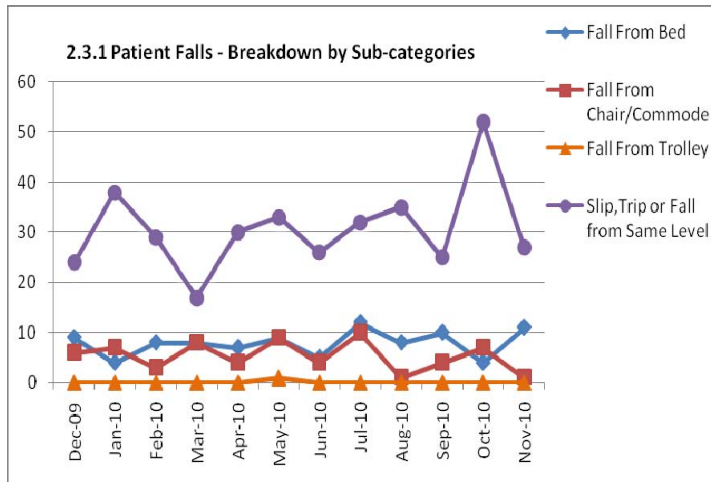
Results

	NPSA Never Events	09/10 Q4	10/11 Q1	10/11 Q2	10/11 Q3*
1	Wrong site surgery	0	0	0	0
2	Retained instrument post-operation	0	0	0	0
3	Wrong route administration of chemotherapy	0	0	0	0
4	Misplaced naso or orogastric tube not detected prior to use	0	0	0	0
5	Inpatient suicide using non-collapsible rails	0	0	0	0
6	Escape from within the secure perimeter of medium or high secure mental health services by patients who are transferred prisoners	0	0	0	0
7	In-hospital maternal death from post-partum haemorrhage after elective caesarean section	0	0	0	0
8	Intravenous administration of mis-selected concentrated potassium chloride	0	0	0	0

*So far this quarter

The NPSA have issued a further 14 recommended 'Never Events'. These are currently out for consultation. This committee will be updated with the final outcome once agreed.

2.3 Patient Falls



2.3.1 Patients Falls

Oct 2008 to Sept 2009

Number of falls 476

Mean rate per 1000 bed days 3.8

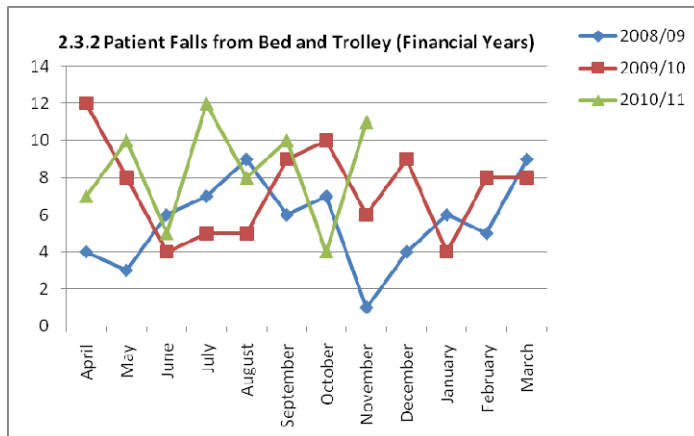
National mean rate per 1000 bed days 5.6

Oct 2009 to Sept 2010

Number of falls 504

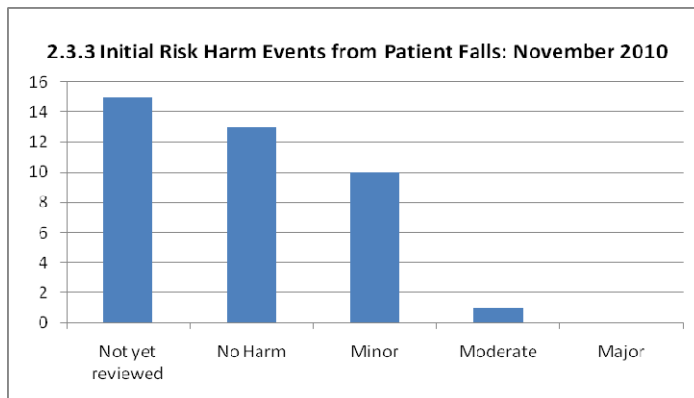
Mean rate per 1000 bed days 4

National mean rate per 1000 bed days 5.6



2.3.2 Patient Falls from Bed and Trolley

Reported falls from Bed = 11



2.3.3 Initial Risk Harm for Patient falls

Of the 39 reported falls in November

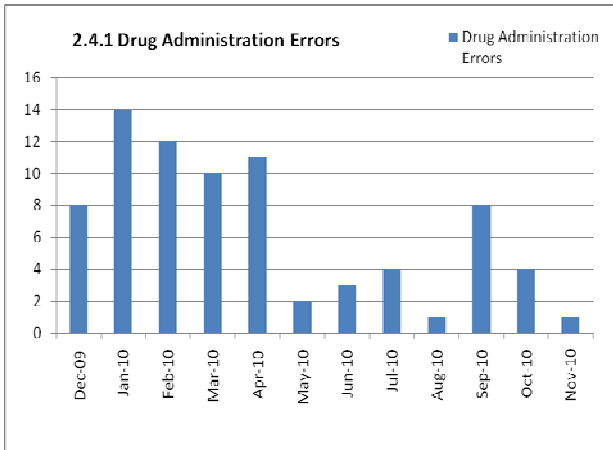
15 are still to be reviewed

13 resulted in **No harm** to the patient

10 Resulted in **Minor harm** to patient

1 caused **Moderate harm** when the patient re-dislocated her hip requiring MUA.

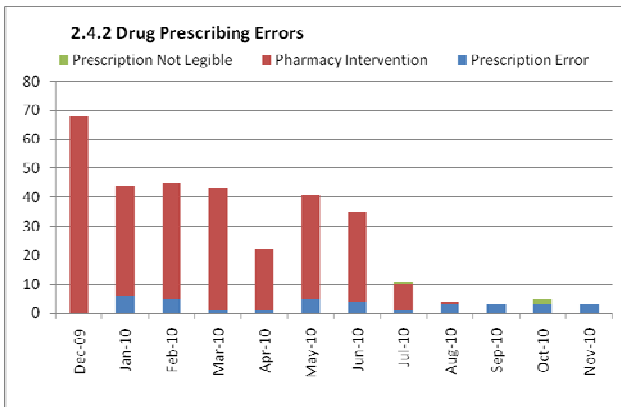
2.4 Safer Medication



2.4.1 Drug Administration*

*Incomplete data

Pharmacy interventions are under review. The Safer Medication Group has been asked to look at the process for reporting pharmacy interventions to ensure the data is appropriate and meaningful.

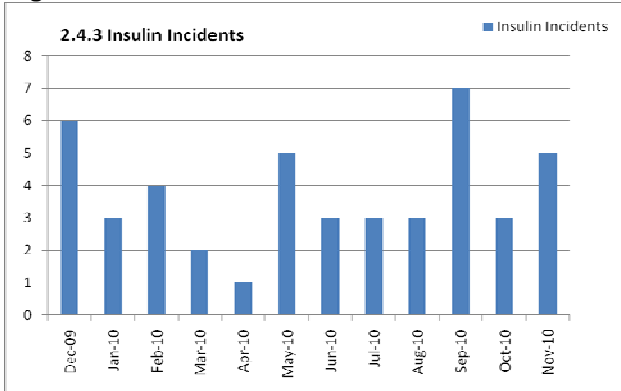


2.4.2 Drug Prescribing*

*Incomplete data

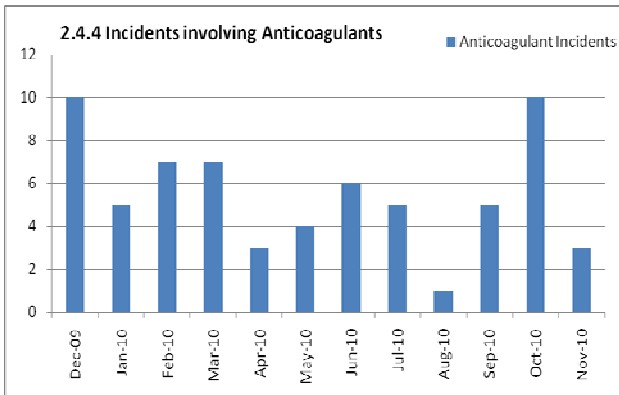
Pharmacy interventions are under review. The Safer Medication Group has been asked to look at the process for reporting pharmacy interventions to ensure the data is appropriate and meaningful.

High Risk Medicines



2.4.3 Insulin Incidents

There were **5** patient incidents involving insulin during November. All are reported as causing **no harm**.

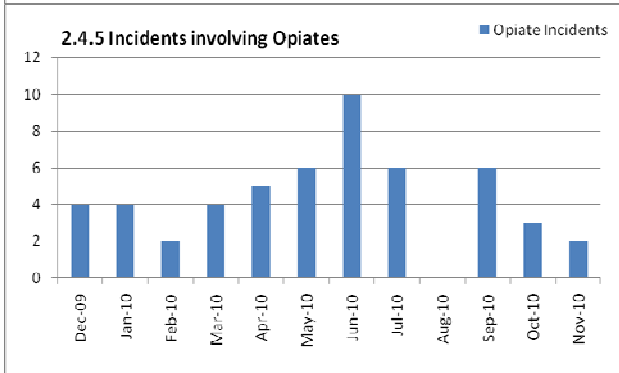


2.4.4 Anticoagulant Incidents

Anticoagulants searched are:

- Warfarin
- Tinzaparin
- Heparin
- Dabigatran
- Clexane

There were **3** reported incidents involving anticoagulation. **2** caused **no harm**, **1** is awaiting review.

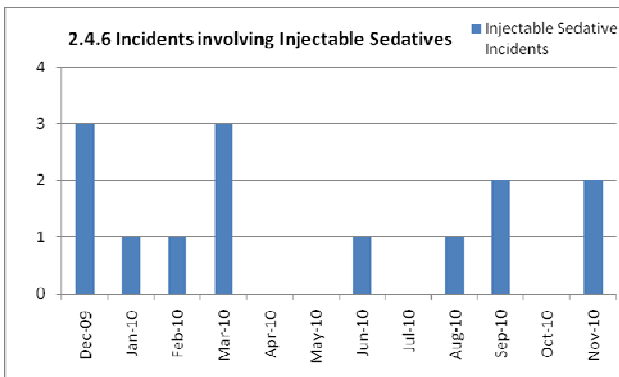


2.4.5 Opiate Incidents

Opiates searched are:

- Buprenorphine
- Diamorphine
- Fentanyl / Alfentanyl
- Meptazinol
- Methadone
- Morphine / Diamorphine
- Oromorph
- Oxycodone / Oxycontin
- Oxynorm
- Pethidine

There were **2** reported incidents involving opiates. **1** **no harm** and **1** overdose of morphine causing **minor harm**.



2.4.6 Incidents involving Injectable Sedatives

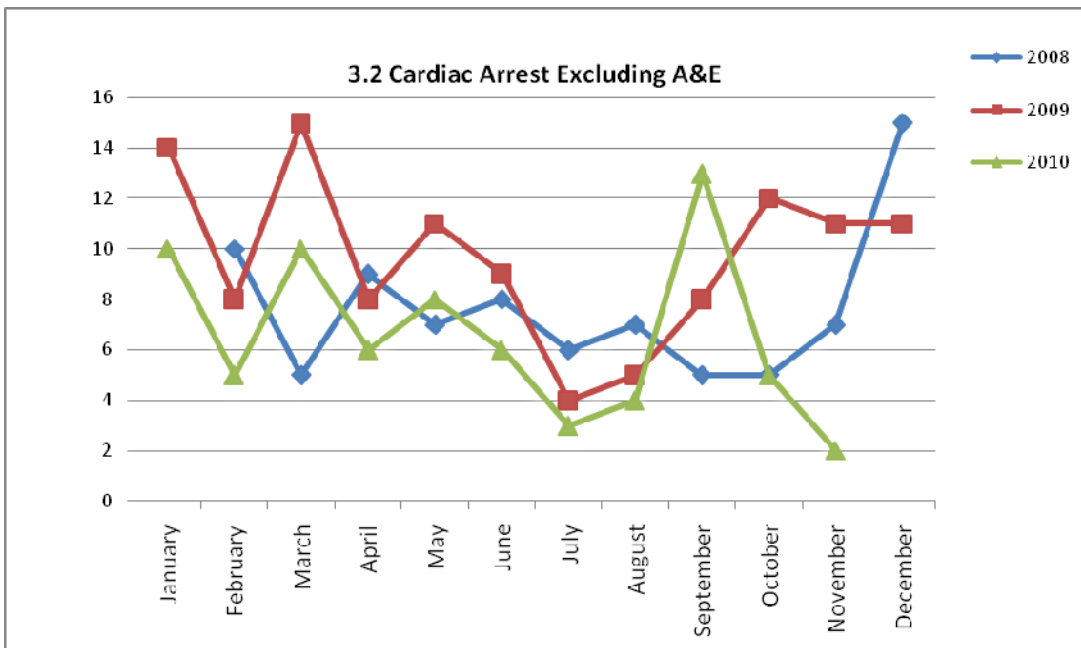
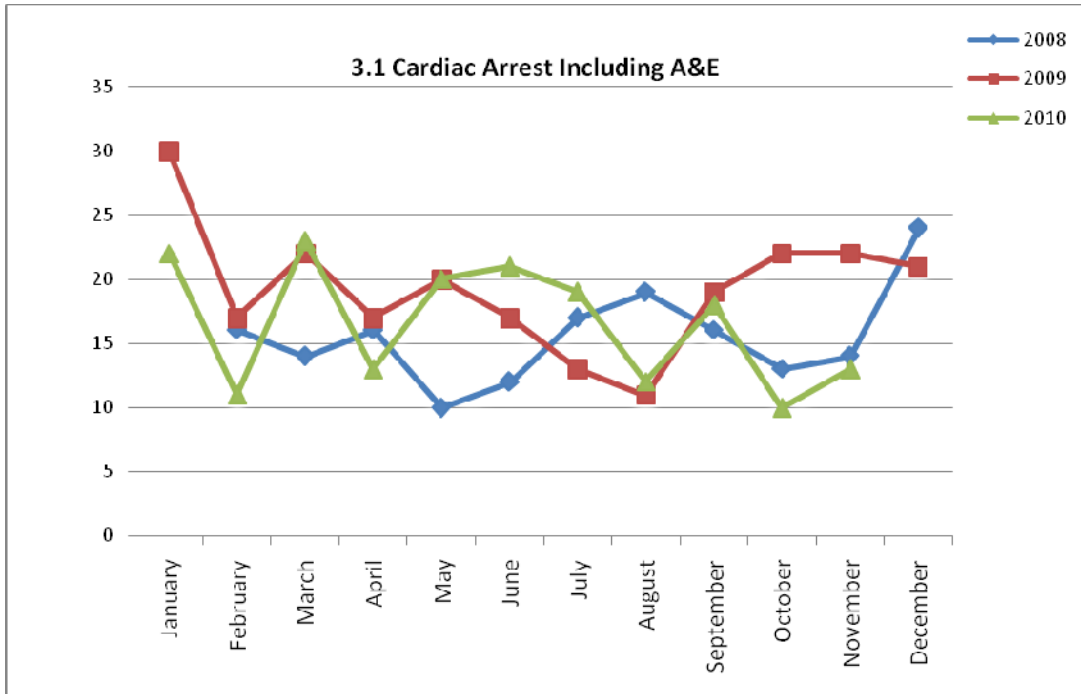
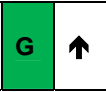
Injectable Sedatives searched are:

- Diazepam
- Lorazepam
- Midazolam
- Propofol

2 reported incidents involving Propofol. **1** related to an unlabelled syringe and was reported as a **near miss**. **1** involved a failure to follow guidelines but caused **no harm**.

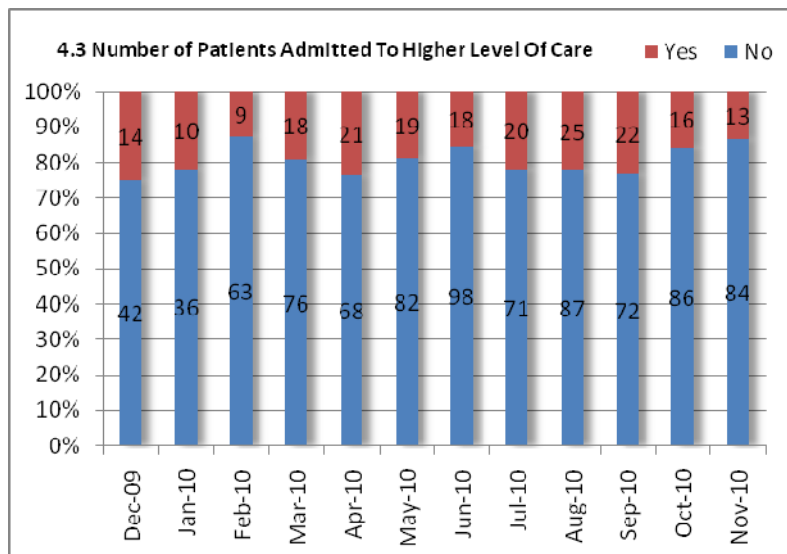
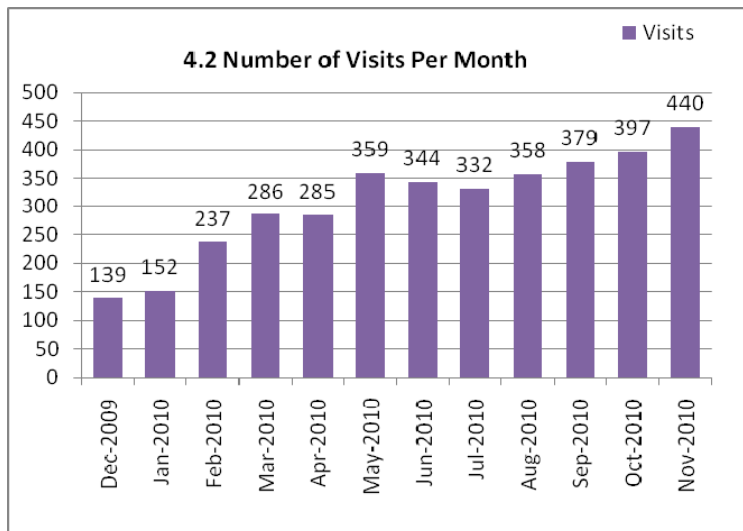
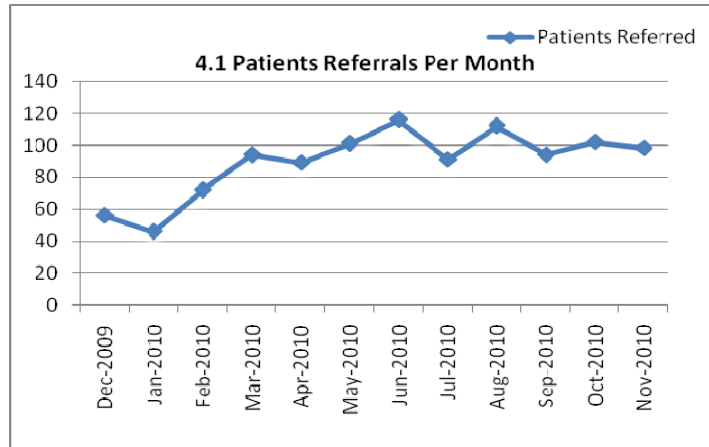
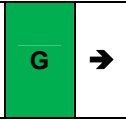
3. Cardiac Arrests

There were 2 cases of in patient cardiac arrests in November. This makes a total of 72 (January 2010 to November 2010) compared against the same period last year of 105 (January 2009 to November 2009).



4. Outreach/Patients at Risk (PAR)

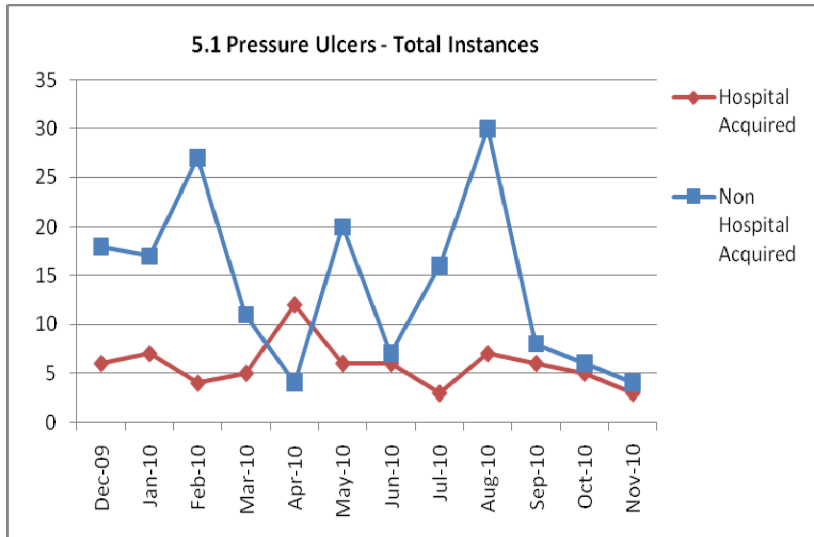
There were 97 patients referred to the Outreach Team during November 2010. 440 visits were made to these patients. 13 were admitted to a higher level of care, the remaining 84 were managed within the ward environment. The PAR service currently now operates 7 days per week from 08:00 to 20:00



5. Pressure Ulcers

November 2010: 3 Hospital Acquired (HA) pressure ulcers were reported in November, 2 of which were Grade 1. This information has been taken purely from DATIX figures and no additional information was available from Tissue Viability team.

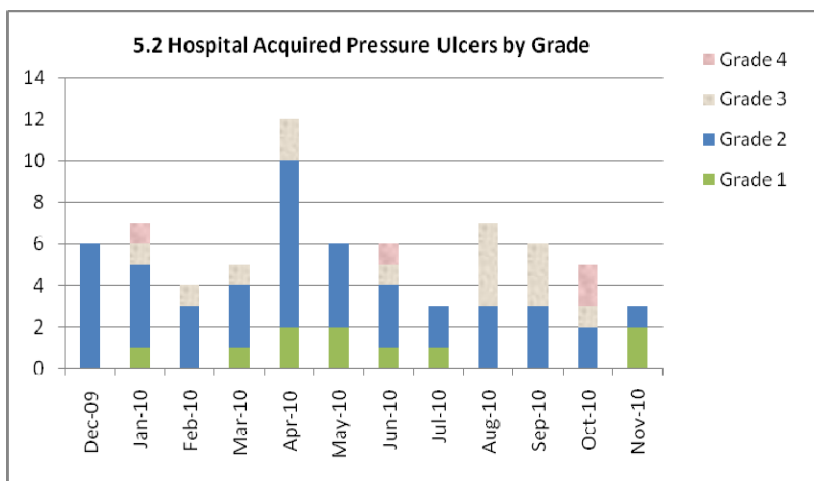
A ↑



November 2010

Hospital Acquired **3 cases**
Non Hospital Acquired **4 cases**

Reduced reporting. This month has seen a poor return of incident reports to the Tissue Viability team. Wards not returning data. This issue is being actioned by the Tissue Viability lead.



November 2010

Hospital Acquired
Grade 1 – 2 incidents
Grade 2 – 1 incident
Grade 3 – 0 incidents
Grade 4 – 0 incidents

Non Hospital Acquired
Grade 1 – 0 incidents
Grade 2 – 0 incidents
Grade 3 – 1 incident
Grade 4 – 3 incidents

Pressure Ulcer Classification (EPUAP*)

Grade 1:

Non-blanchable erythema of intact skin. Discolouration of the skin, warmth, oedema, induration or hardness May also be used as indicators, particularly on individuals with darker skin.

Grade 2:

Partial thickness skin loss involving epidermis, dermis or both. The ulcer is superficial and presents clinically as an abrasion or blister.

Grade 3:

Full thickness skin loss involving damage to or necrosis of subcutaneous tissue that may extend down to, but not through underlying fascia.

Grade 4:

Extensive destruction, tissue necrosis, or damage to muscle, bone, or supporting structures with or without full thickness skin loss.

*EPUAP - European Pressure Ulcer Advisory Panel

Note:

Clarification from the SHA and PCT has been obtained confirming that all grade 3 and 4 pressure ulcers must be reported as Serious Incidents and are subject to a full investigation. Whenever there is evidence or suspicion of neglect, these will also be reported as a safeguarding issue by the tissue viability team.

6. Patient Observations

The data for this project is collected from the **NPSA - Getting the basics right** chart checker. 4 wards are currently involved in this project. Revised observation charts are being introduced throughout the Trust. This should see an improvement in the results.

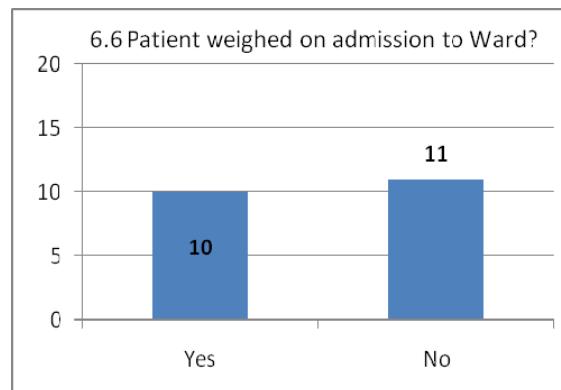
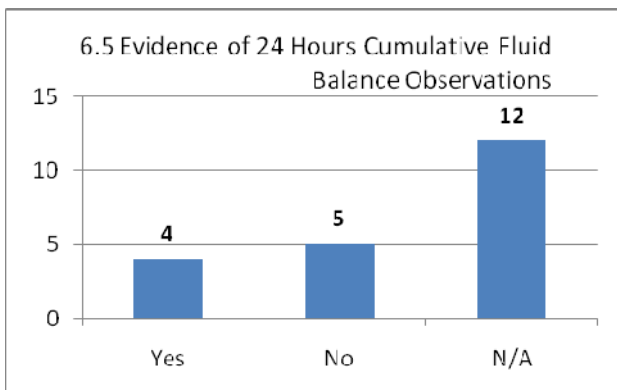
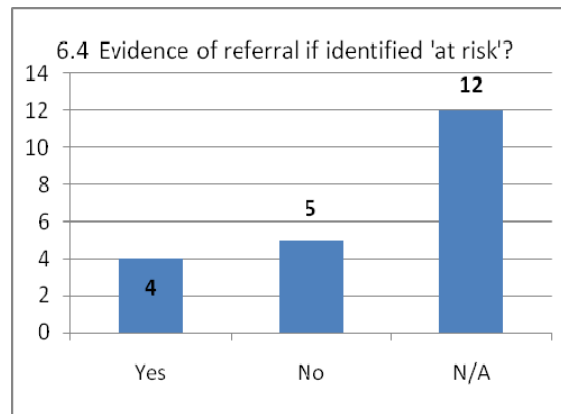
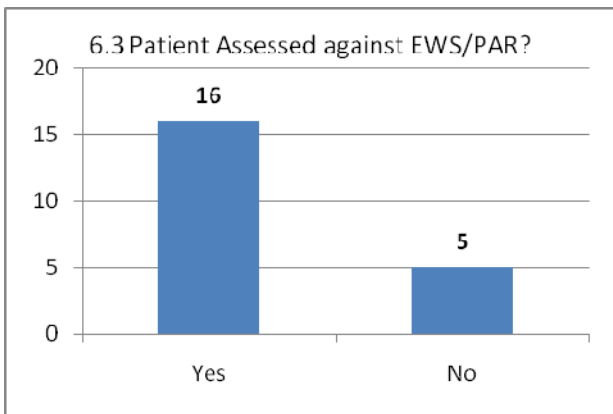
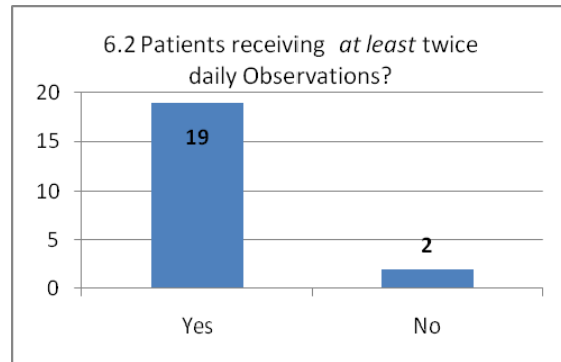
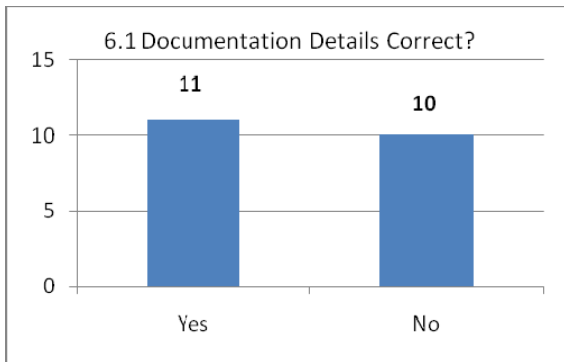
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Parameters measured:

- 6.1. All patient observation documentation provides details of ward, patient name, date of birth, hospital number, consultant and frequency of observations.
- 6.2. All patients receive *a minimum* of twice daily observations of temperature, pulse, blood pressure and respirations, level of consciousness & oxygen saturation in line with NICE CG50 (unless otherwise indicated).
- 6.3. The patients are assessed against an Early Warning Score (PAR score) in accordance with Trust policy.
- 6.4. There is evidence of documentation of referrals to medical staff for the patients assessed as being at risk.
- 6.5. 24 hr cumulative balances will be evident on all fluid balance observations.
- 6.6. The patient was weighed on admission to ward.

21 patients were measured in November (results only received from Richard Wells and Elizabeth wards for November – no returns from Shuttleworth or Reginald Hart Wards).



7. VTE Risk Assessment Compliance

Second data collection report on VTE risk assessment compliance. November compliance is 73.54% against a national target and agreed CQUIN of 90%.

A



<i>Ward</i>	<i>Qualified for assessment</i>	<i>Assessed</i>	<i>Percentage Assessed</i>
AAU (12 Hour Bay)	683	414	60.61
Acorn Suite - Maternity	18	18	100
Admissions Lounge	73	26	35.62
Assessment Elective	90	1	1.11
Biddenham Manor Hospital	62	6	9.68
Cardiac Cath Suite	131	104	79.39
Community Births	4	3	75
Coronary Care Unit	30	16	53.33
Day Unit - Cygnet Wing	14	14	100
Delivery Suite	286	256	89.51
Elizabeth	5	2	40
Endoscopy	504	499	99.01
Eye Theatre Reception	249	248	99.6
Folwell Ward - A&E	179	91	50.84
Godber	4	2	50
Harpur Ward	3	1	33.33
Howard	100	53	53
Intensive Care Unit	16	9	56.25
Minor Ops wards	101	98	97.03
Oral Day Ward	113	113	100
Orchard Gynaecology	133	122	91.73
Orchard Maternity	35	31	88.57
Pilgrim	4	2	50
Recovery ICU	2	1	50
Reginald Hart	63	46	73.02
Richard Wells	13	7	53.85
Russell	2	1	50
Shand	81	42	51.85
Shuttleworth	92	38	41.3
Tavistock Day Case Ward	408	317	77.7
Unknown Direct Theatre	2	1	50
Victoria (New)	13	8	61.54
Whitbread	24	11	45.83
Totals	3537	2601	73.54%