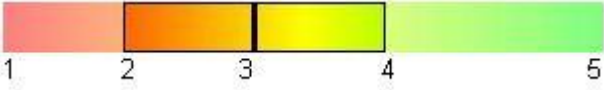

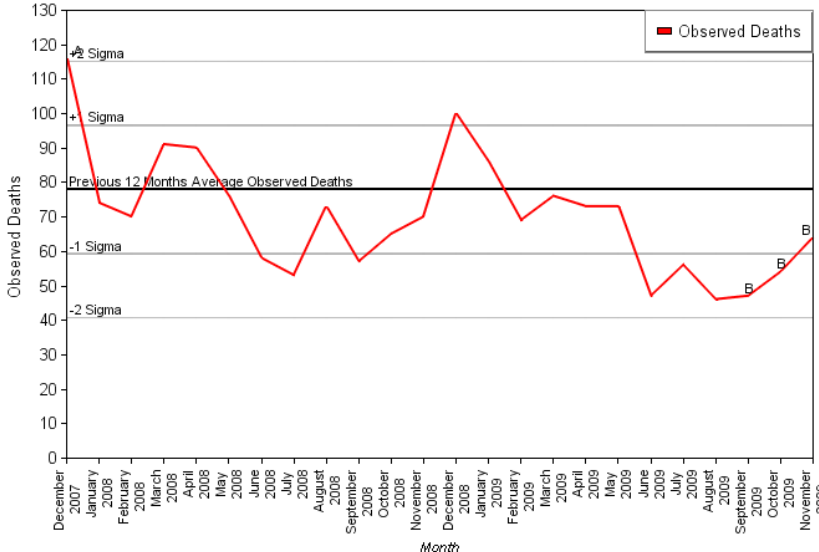


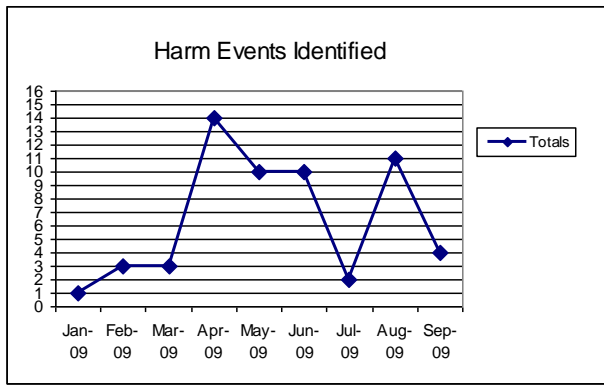
Patient Safety Report

The Patient Safety Report shows information up to the end of **November 2009**.

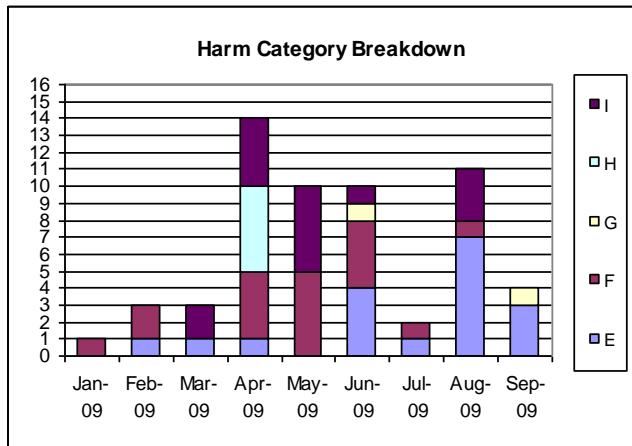
This 2 month time lag behind the date of the report is adopted to enable more meaningful information to be reported to the Board. This allows for upload of benchmarking data, review of cases by the clinical teams and for completion of the inputting and investigation within the time frames of the Trust Incident reporting policy.

<p>1. Mortality: Benchmarking Definitions</p>	<p>The benchmarking process includes an Index value by combining Trust and Peer group figures to derive Index values for Indicators. The Index value is calculated around 100. An Index value of 100 means that the Trust has exactly the same rate as the Peer group for the indicators given the age/sex mix of the patients treated. An Index value of 80 means that the Trust has a rate of 80% of that of the Peer having taken into account the age/sex mix of patients. An Index value of 120 means that the Trust has a rate 20% higher than the Peer after age / sex adjustment</p> <p>Key to Performance Spectrum Spread = $((\text{Trust_Index} - \text{Peer_Index}) / \text{Peer_Stddev}) * \text{Thread_Direction}$</p>  <p>3 = Trust_Index (from above) 2 = (3) – Trust Lower Confidence Interval (see below) 4 = (3) + Trust Upper Confidence Interval (see below) 1 = Peer_Index – (3 * Peer_Stddev) 5 = Peer_Index + (3 * Peer_Stddev)</p> <p><i>Risk adjusted Mortality : In order to compare like with like the data is adjusted or standardised to take into account the age and sex of patient populations and other elements of casemix such as co-morbidity.</i></p>						
<p>1.1 Trust Risk Adjusted Mortality rate</p>	<table border="1" data-bbox="319 1120 845 1220"> <thead> <tr> <th></th> <th>Trust</th> <th>Peer</th> </tr> </thead> <tbody> <tr> <td>Risk Adjusted Mortality 2008</td> <td>84</td> <td>88</td> </tr> </tbody> </table> 		Trust	Peer	Risk Adjusted Mortality 2008	84	88
	Trust	Peer					
Risk Adjusted Mortality 2008	84	88					
<p>HSMR</p>	<p>(source: Dr Foster website) 101.87</p>						
<p>1.2. Risk Adjusted Mortality Trends: Trust</p>	<p>Special Cause Flags</p> <p>A: Value beyond 2 sigma B: 8 consecutive values one side of the average C: 6 consecutive values trended in one direction D: 4 of 5 beyond 1 sigma</p> <p>Mortality Trending</p> 						

2.1 Patient Safety Strategy: Mortality Reduction *TRUSTWIDE*



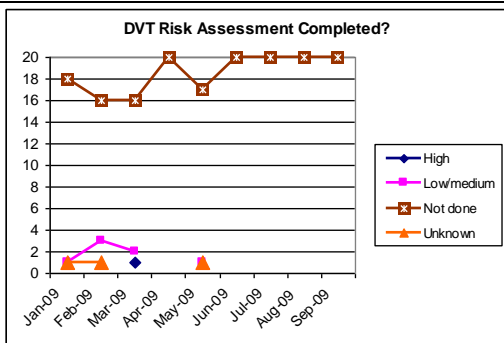
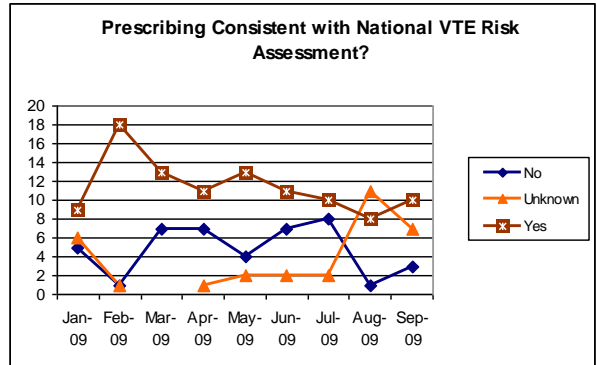
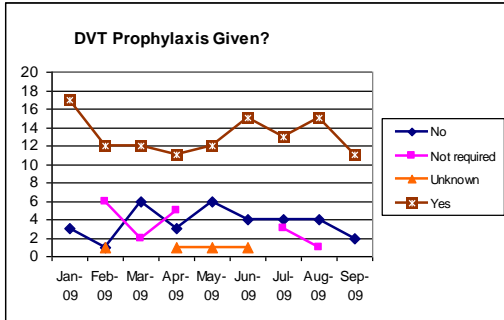
January 2009 - 1 patient * February 2009 - 2 patients * March 2009 - 2 patients * April 2009 - 4 patients * May 2009 - 6 patients * June 2009 - 6 patients * July 2009 - 2 patients * August 2009 - 7 patients * September 2009 - 3 patients



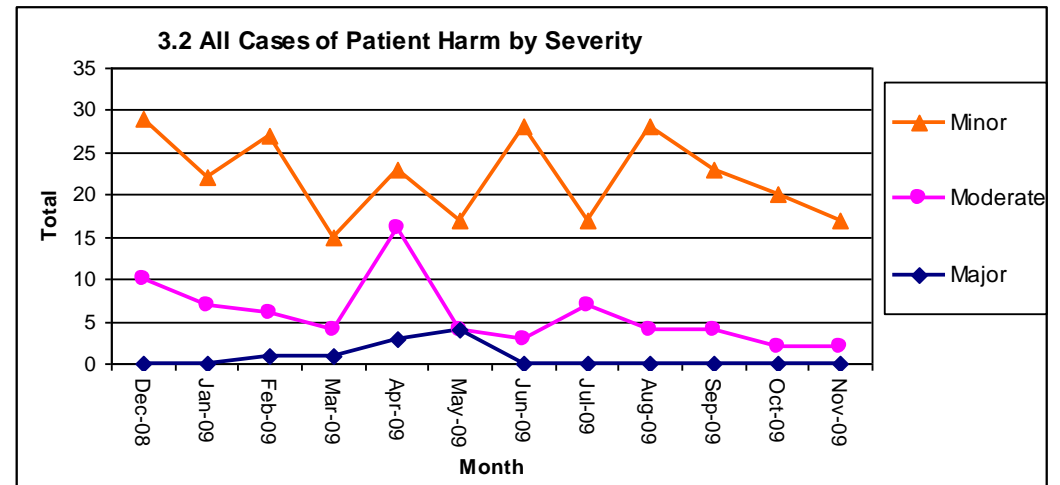
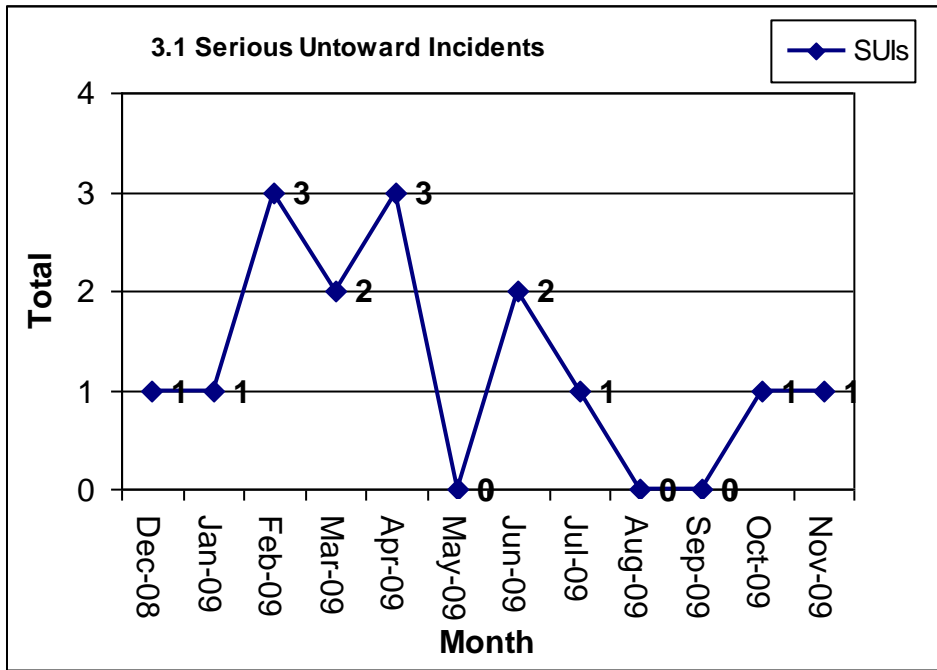
Key:
Category E: Contributed to or resulted in temporary harm to patient and required intervention
Category F: Contributed to or resulted in temporary harm to patient and required initial or prolonged hospitalisation
Category G: Contributed to or resulted in permanent patient harm
Category H: Required intervention to sustain life
Category I: Contributed to patient's death

September 2009 results
E Transfusion
E Electrolyte abnormalities Na 120 or 160 K 25 or 65
E Positive blood culture
G Patient Fall

2.1 Deep Vein Thrombosis (DVT) risk



Notes:
DVT Risk Assessments are not being undertaken. New NICE guidance released November 2009. Audit planned.



All Clinical Incidents including incidents Awaiting Final Approval as well as Finally Approved

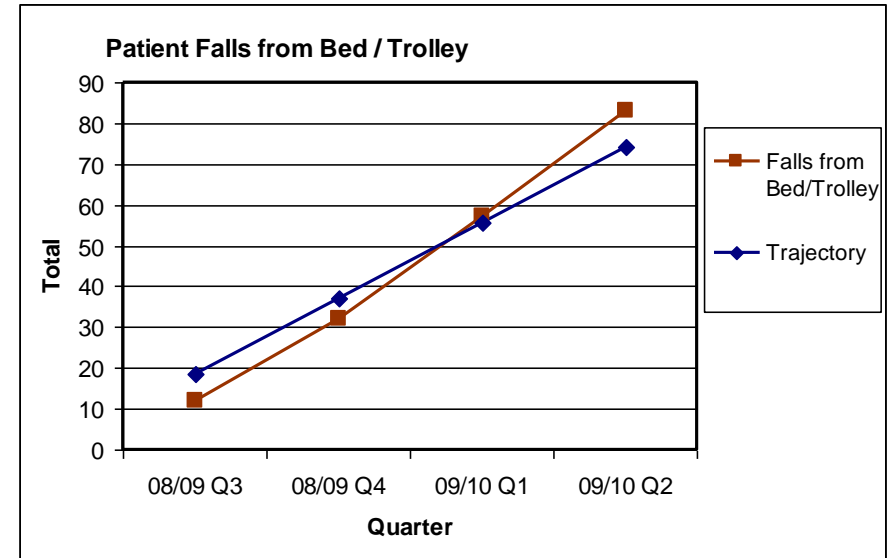
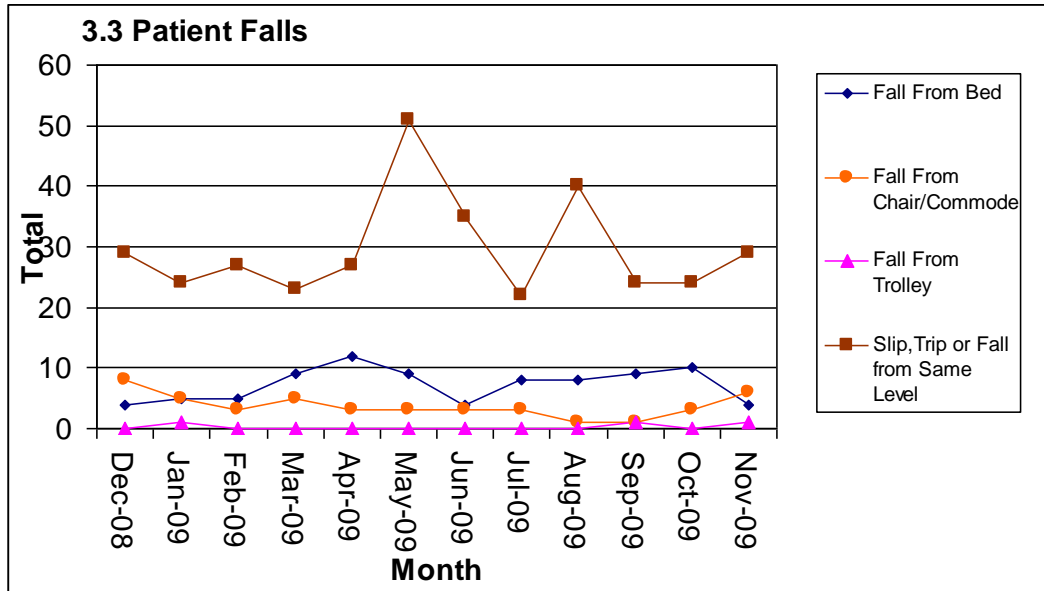
November 2009 - 1 Serious Untoward Incident reported to PCT
 Details:
 Norovirus outbreak on Whitbread Ward

No harm (none) e.g. wrong dose of aspirin given, but no harm caused
 - requiring extra observation or minor treatment

Low Harm (minor) e.g. fell and grazed arm, dressing applied
 - causing significant but not permanent harm

Moderate Harm (moderate) e.g. returned to theatre to drain wound site haematoma
 - causing permanent and significant harm

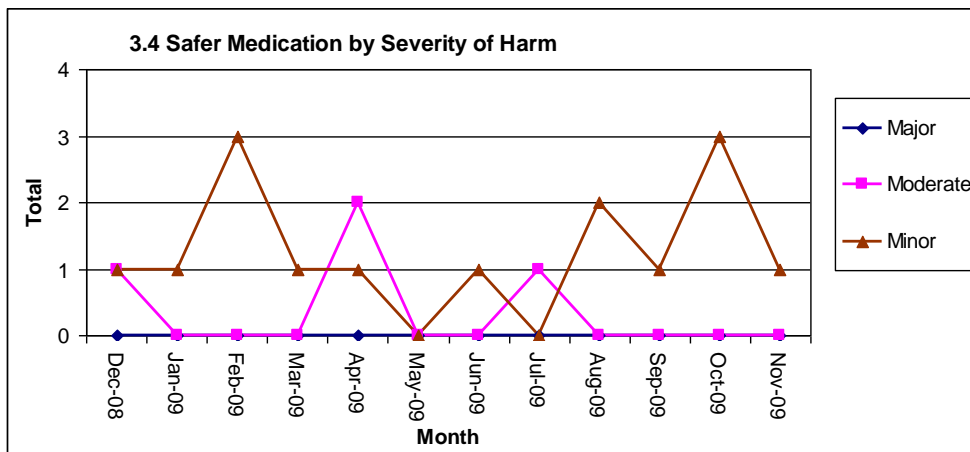
Severe Harm (major) e.g. cardiac arrest after allergic reaction, anoxic brain damage- directly attributable to the patient safety incident Or Death-where death is directly attributable to a patient safety incident e.g. paracetamol levels not checked in overdose patient, fatal liver failure



NB. Cumulative

The above graphs contain data from DATIX. DATIX is a 'live' software system, where managers access the reports to investigate them as pressure of work allows. There may be times when the incidents are not investigated in a timely manner (and according to the Trust Incident and Accident Reporting Policy) and therefore have not been approved and moved across to the DATIX main database from which the figures for these graphs are sourced.

3.3 Patients Falls - Peaks in May, June and August 2009 due to one patient. This patient has now left the Trust and should be reflected in future figures.



Safer Medication by Severity of Harm

All Drug Related Incidents involving patients - including incidents Awaiting Final Approval as well as Finally Approved.

Pressure Ulcers (November 2009)

Information and data supplied by Melanie Barlow.

Bedford Hospital NHS Trust

The overall incidence for hospital acquired pressure ulcers for November 2009 was 0.41%. Accurate recording from participating wards may have affected this data.

The 6 wards who failed to return data sheets were:
CCU; Godber; Pilgrim; Howard; Shand and Shuttleworth

The incidence of non-hospital acquired pressure ulcers was 2.67%. The cost of dealing with pressure ulcers is high in both personal / physical cost to the patient, as well as high financial costs. In addition to monitoring and managing pressure care within the Trust, the TVN will be monitoring the severity of non-hospital acquired pressure ulcers, and monitoring the patient's area of admission. The total for all pressure ulcers being managed / treated with Bedford Hospital NHS Trust in November was 3.1%.

Grading of hospital acquired pressure ulcers:

Grade 1 0
Grade 2 0
Grade 3 4
Grade 4 1

The one grade 4 hospital acquired pressure ulcer occurred on Elizabeth, but was transferred from Russell. The TVN will be reviewing why this occurred.

Location of HA pressure ulcers

Heels 3
Sacrum 2
Knee 0
Achilles 0

Due not only to the pain, suffering and limitations experienced by the patient with a pressure ulcer, but also reviewing the financial implications of pressure ulcers a chart of the grades of pressure ulcers Bedford Hospital NHS Trust is dealing with from the community has been attached.

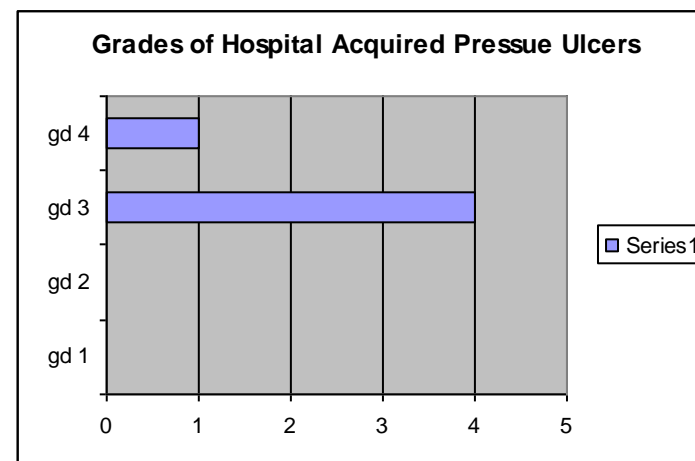
Here are just a few of the financial implications:

Equipment: pressure relieving mattresses; profiling bed frames and dressings

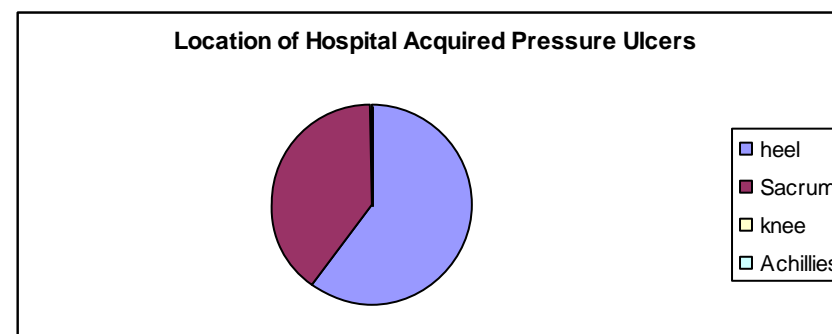
Nursing time: Regular repositioning of patients, time spent undertaking dressings; managing pain effectively; Time with patient and relatives offering advice and help in how and why equipment works etc.

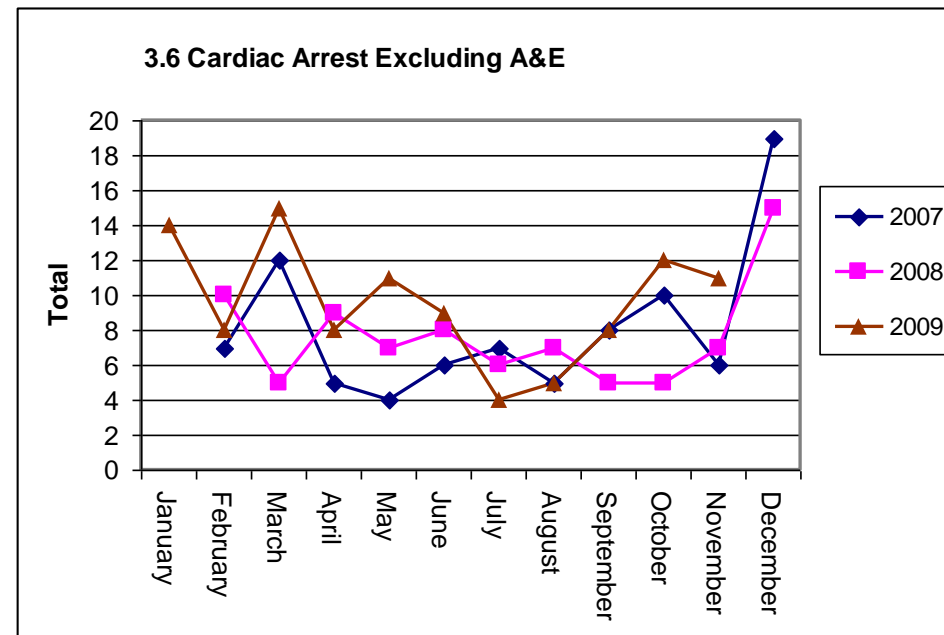
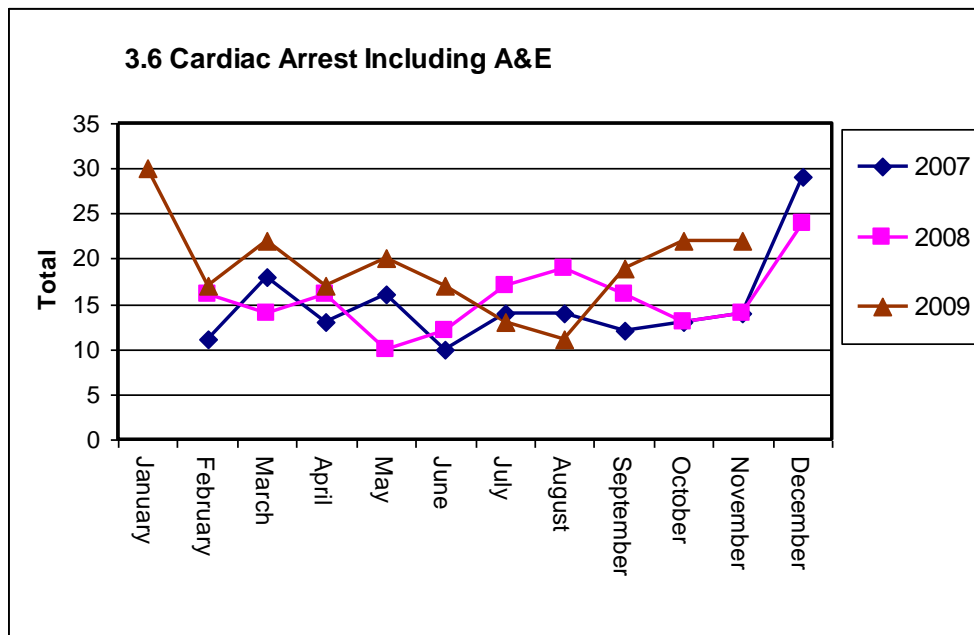
Nutrition: Extra dietetic input for all patients with pressure ulcers.

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Action: For TVN to ensure pressure care prevention strategies are undertaken and adhered to. Also to re-iterate grading score to ensure pressure ulcer grading is correct. For all staff to be aware of difference between a leg ulcer and a pressure ulcer.





- Cardiology charts based upon data supplied by Sue Collins

4. Invasive Devices November 2009

The high impact interventions from Saving Lives (DoH 2007) include a tool to monitor compliance at the point of patient care with care bundles for invasive devices. This is not an audit but a tool to help individual ward areas to recognise good practice and pick up on areas of the care bundle that need improving.

Monitoring the compliance with documentation is the most practical way to use this tool at present as the SHA and PCT require monthly key performance indicators and request these percentages for this.

The compliance monitoring figures alone do not fully represent practice. They indicate areas for development, training and assessment. This is ongoing and incorporated in the Invasive Devices Group action plan.

'Insertion' compliance has not improved for several months; the following new actions are being undertaken:

Compliance with insertion care bundle is subjective for HII 1 – CVC due to documentation. Anaesthetists aim to standardise this using a sticker.

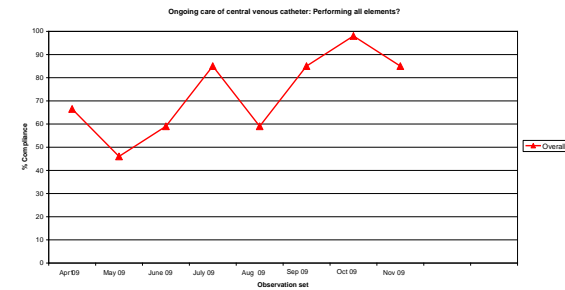
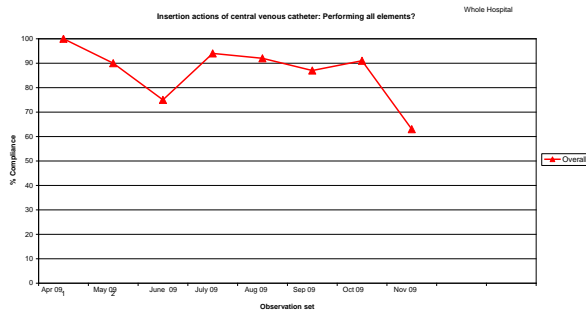
Compliance with insertion care bundles for HII 2 and 6 seems slightly lower than it has been.

- A survey of one day A and E admissions to the wards showed that **none** of the patients followed up had the insertion of peripheral line documented in A and E.
A similar survey needs to be conducted in Theatres to assess documentation of devices inserted in theatre. This will be done in the New Year when the new theatre manager is in post.

Invasive Devices November 2009

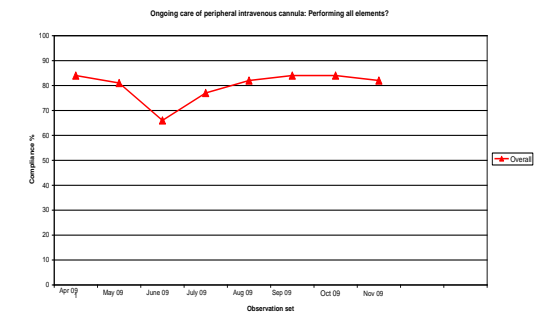
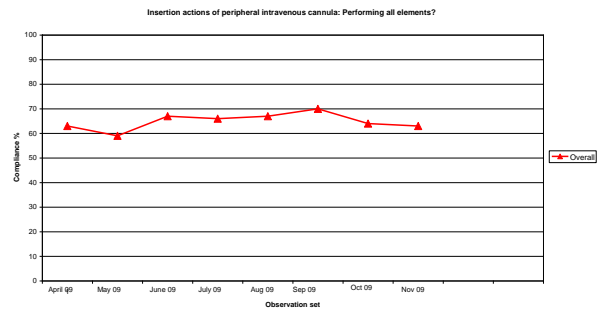
Insertion actions of central venous catheter: Performing all elements?

Ongoing care of central venous catheter: Performing all elements?

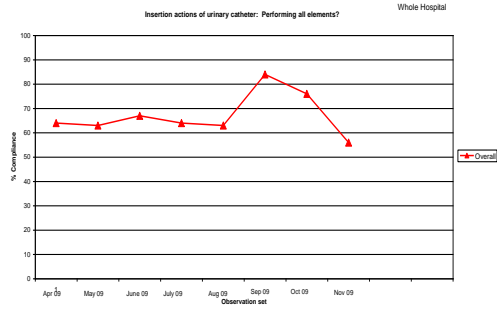


Insertion actions of peripheral intravenous cannula: Performing all elements?

Ongoing care of peripheral intravenous cannula? Performing all elements?



Insertion actions of urinary catheter: Performing all elements?



Ongoing care of urinary catheter: Performing all elements?

