

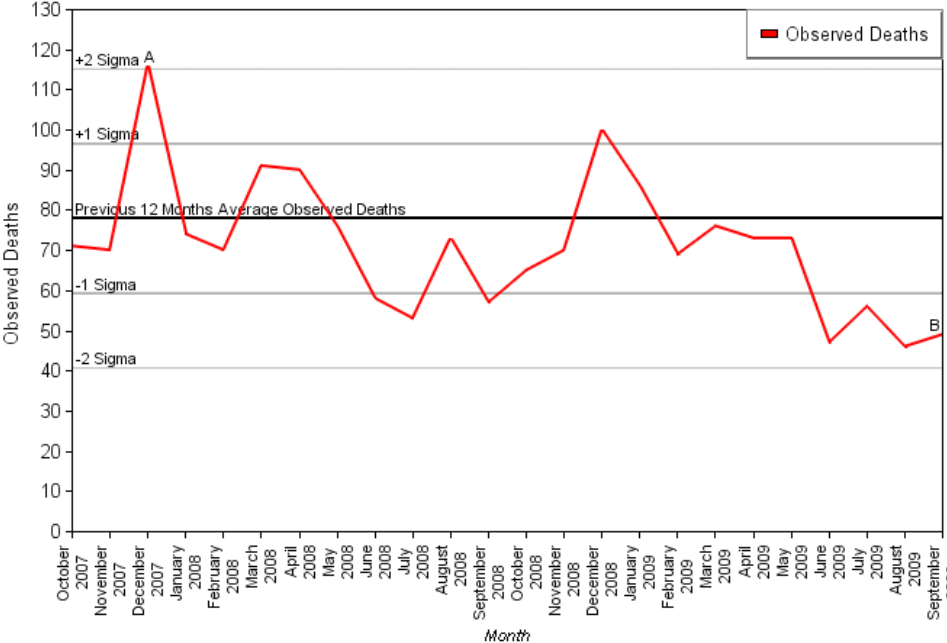


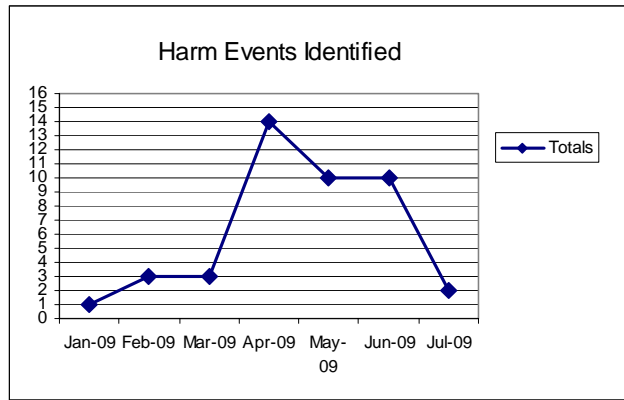
# Patient Safety Report

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

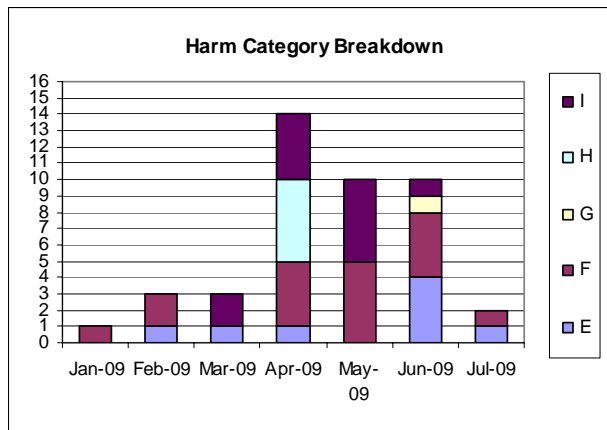
This 2 month time lag behind the date of the report is adopted to enable more meaningful information to be reported to the Board. This allows for upload of benchmarking data, review of cases by the clinical teams and for completion of the inputting and investigation within the time frames of the Trust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

<p><b>1. Mortality: Benchmarking Definitions</b></p>	<p>The benchmarking process includes an <b>Index value</b> 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><b>Key to Performance Spectrum</b>  <math>Spread = ((Trust\_Index - Peer\_Index) / Peer\_Stddev) * Thread\_Direction</math></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><b>1.1 Trust Risk Adjusted Mortality rate</b></p>	<table border="1" data-bbox="370 982 852 1066"> <thead> <tr> <th></th> <th>Trust</th> <th>Peer</th> </tr> </thead> <tbody> <tr> <td>Risk Adjusted Mortality 2008</td> <td>85</td> <td>89</td> </tr> </tbody> </table> 		Trust	Peer	Risk Adjusted Mortality 2008	85	89
	Trust	Peer					
Risk Adjusted Mortality 2008	85	89					
<p><b>1.2. Risk Adjusted Mortality Trends: Trust</b></p>	<p>Special Cause Flags          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><b>Mortality Trending</b></p> 						

**2.1 Patient Safety Strategy: Mortality Reduction \*TRUSTWIDE\***



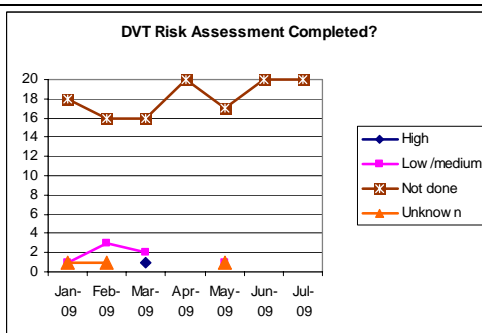
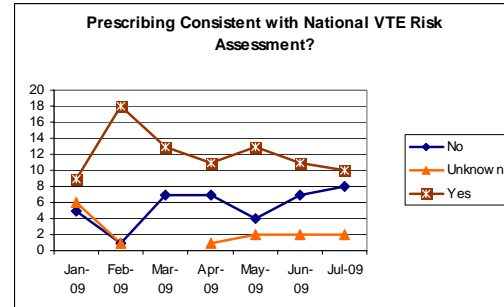
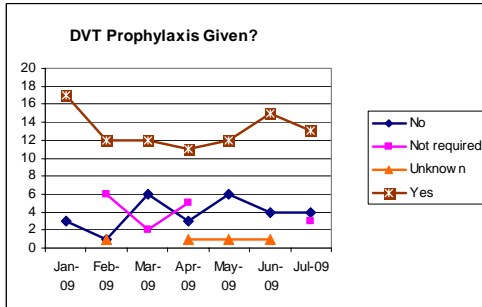
January 2009 - 1 patient \* February 2009 - 2 patients \* March 2009 - 2 patients \* April 2009 - 4 patients \* May 2009 - 6 patients \* June 2009 - 6 patients \* July 2009 - 2 Patients



**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

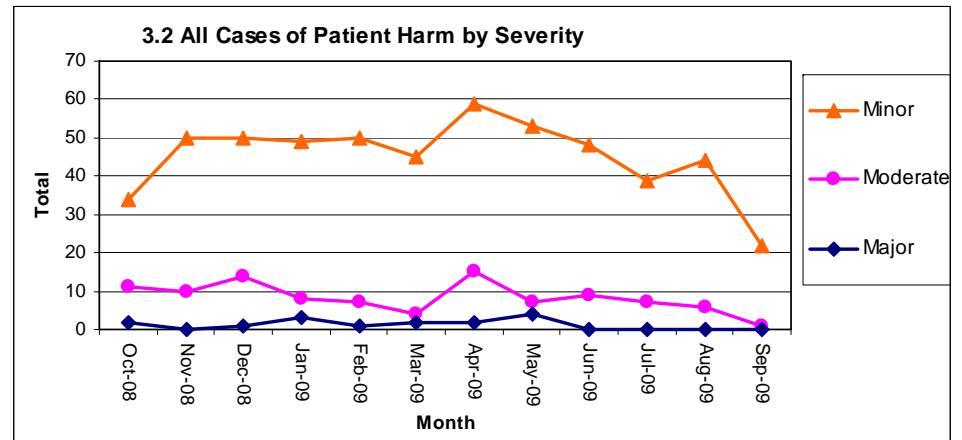
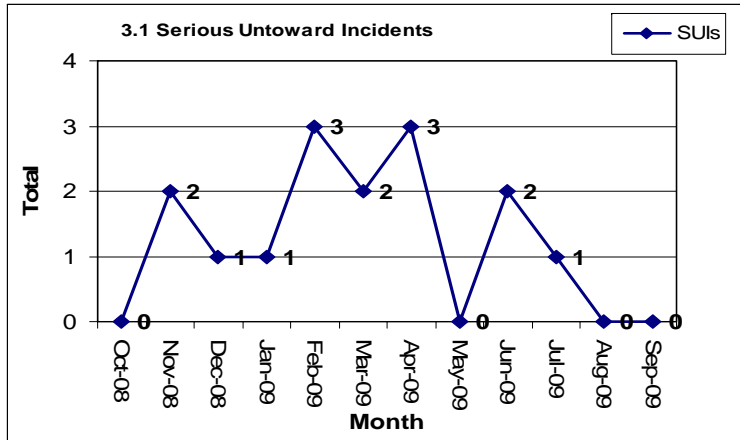
**July 2009 results**  
 E: Complication of procedure or treatment (1)  
 F: Wound infection (1)  
 (only current months results are shown)

**Deep Vein Thrombosis (DVT) risk**



**Notes:**  
**DVT Risk Assessments** are not being undertaken in every case. In fact the majority of the results show that there is little Risk Assessment completed around DVT, peaking in April when all 20 assessments show that no DVT Risk Assessment was made.

### 3.0 Incident reporting



**No harm (none)**

e.g. wrong dose of aspirin given, but no harm caused  
- requiring extra observation or minor treatment

**Low Harm (minor)**

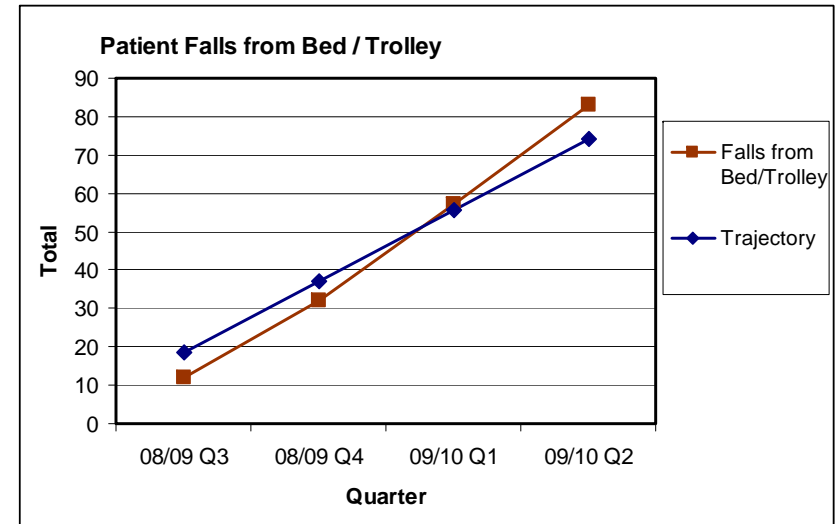
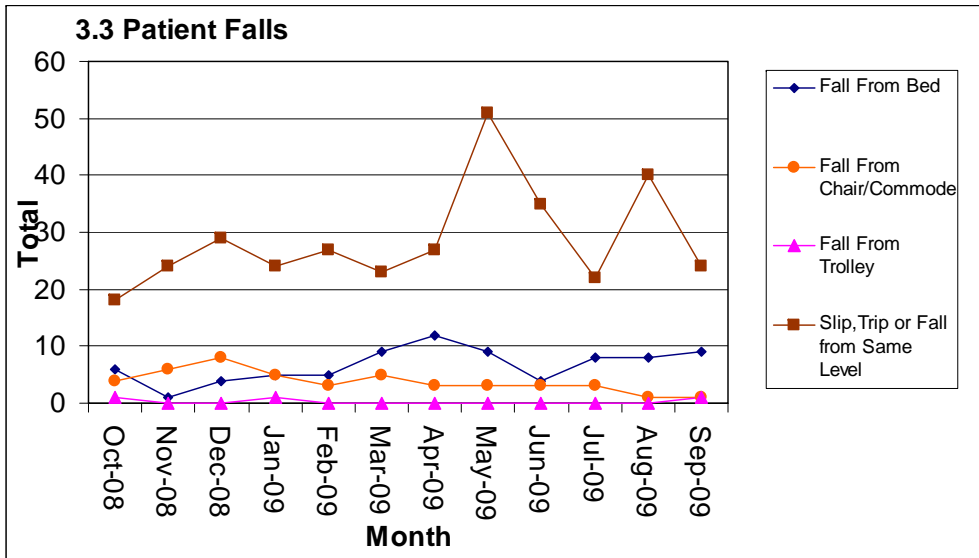
e.g. fell and grazed arm, dressing applied  
- causing significant but not permanent harm

**Moderate Harm (moderate)**

e.g. returned to theatre to drain wound site haematoma  
- causing permanent and significant harm

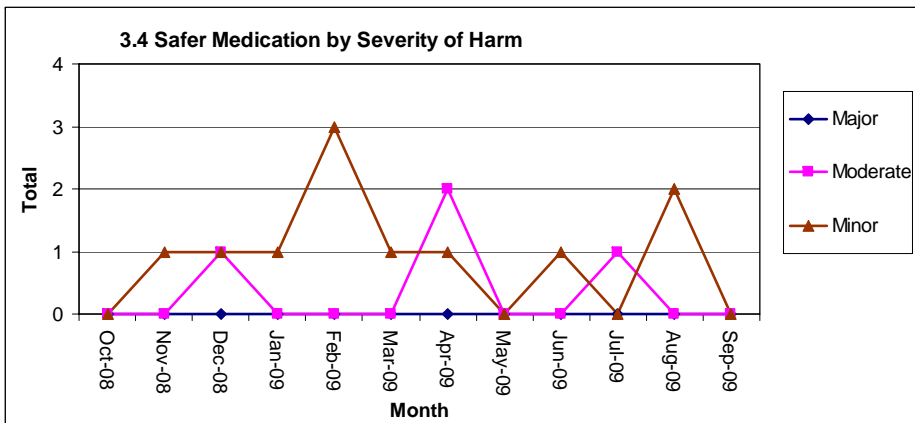
**Severe Harm (major)**

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



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.



## Pressure Ulcers (September 2009)

Information and data supplied by Melanie Barlow.

Bedford Hospital NHS Trust

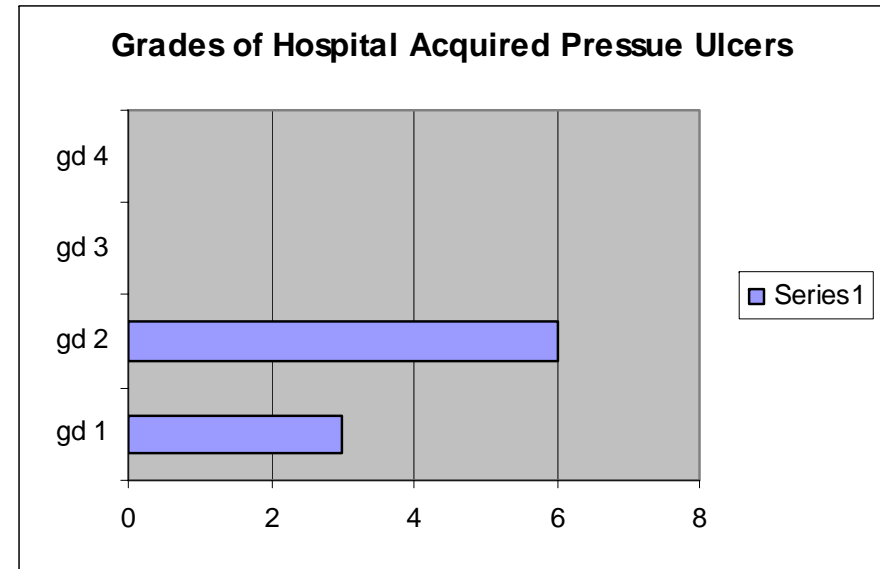
The overall incidence for **hospital acquired** pressure ulcers in September 2009 was 0.5%. This is a reduction of 0.18% on last month.

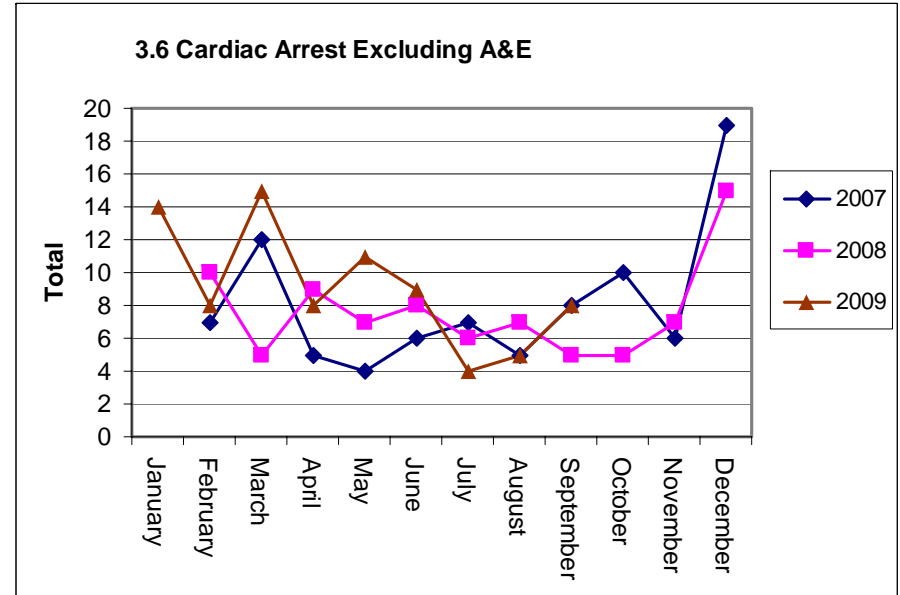
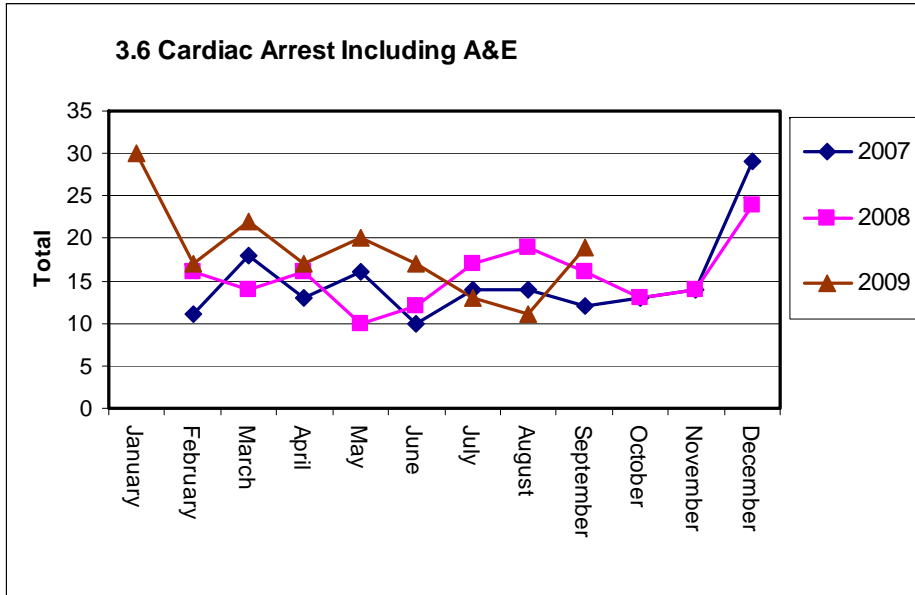
The wards that failed to complete and return data were: Godber, Howard, Richard Wells, Shuttleworth and Whitbread. Please note the ward admission figures for this month for these wards has been removed prior to any calculations being undertaken.

The incidence of **non-hospital acquired** pressure ulcers was 1.47%. It should be noted that 0.47% of these were grades 3 and 4. The cost of managing pressure ulcers is high in both physical / personal cost to the patient, as well as high financial costs. The total of all pressure ulcers being managed within the Trust in September 2009 was 1.9%.

### Grading of Hospital Acquired pressure ulcers:

Grade 1 3  
Grade 2 6  
Grade 3 0  
Grade 4 0





\* Cardiology charts based upon data supplied by Sue Collins

### 3.7 Invasive Devices (September 2009)

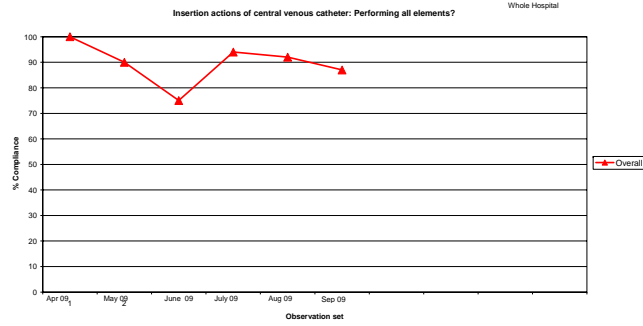
Information and data supplied by Alison Carter. High Impact Interventions 1, 2 and 6 September 2009.

- Compliance monitoring data from across the Trust shows steady improvement in the documentation of care given.
- The invasive devices audit currently underway aims support this monitoring with evidence of observed care.
- The insertion of Central venous catheter audit is now complete. A decision on how best to monitor CVC insertion needs to be made with relevant clinicians.

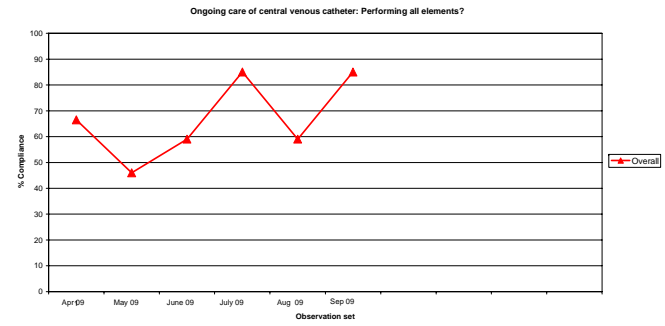
Training and development continues as below:

- New IV medication and Invasive Devices Study Day (Update ½ day commences in Jan 09)
- Invasive devices nurse input on venepuncture and cannulation study day.
- ANTT implementation by ward/ department.
- Planned additional teaching on central venous catheters.
- Continued work on policies and introduction of competencies related to these.
- Specific teaching for phlebotomists on infection prevention/ ANTT
- Recent teaching for FY1 and 2 Doctors from microbiology on specimen collection and specifically blood cultures to help reduce blood culture contamination rates.

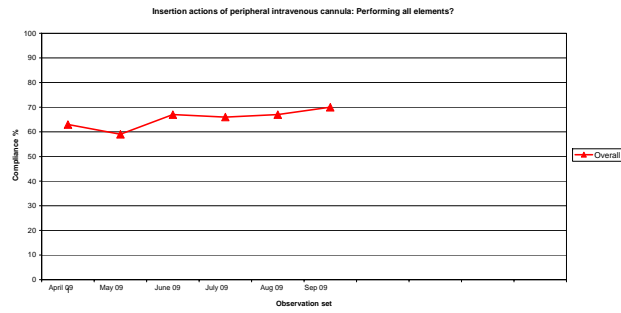
**Insertion actions of central venous catheter: Performing all elements?**



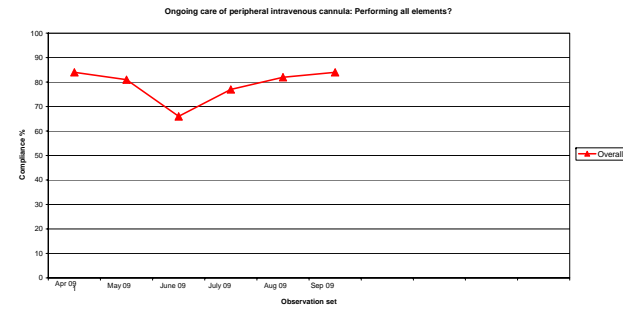
**Ongoing care of central venous catheter: Performing all elements?**



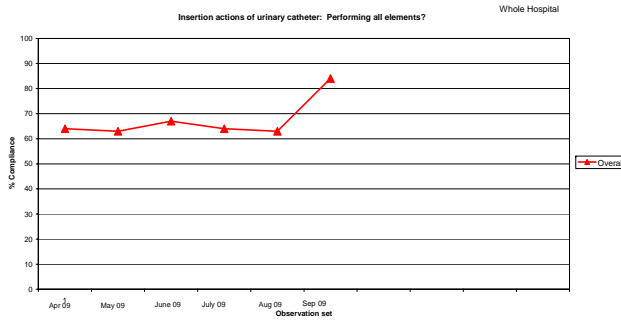
**Insertion actions of peripheral intravenous cannula: Performing all elements?**



**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?**

