Report to:	**Trust Board**	**Agenda item:**	**6**
Date of Meeting:	**9 November 2011**		

Title of Report:	**Patient Safety & Quality Report August 2011**
Status:	**Standing Item**
Board Sponsor:	**Francesca Thompson, Director of Nursing**
Author:	**Jo Miller, Assistant Director of Nursing, Patient Safety** **Sharon Manhi, Head of Quality Improvement**
Appendices	**None**

1. Purpose of Report (Including link to objectives)

The RUH is committed to improving the quality of care for patients and this report gives an update on progress in September 2011.

As a member of the NHS South Quality and Patient Safety improvement programme the patient safety culture is widely embedded in the Trust and forms a key part of the Quality Improvement work.

2. Summary of Key Issues for Discussion

Summary of progress against NHS South Quality and Patient Safety improvement programme. The Patient Safety programme is aligned to the RUH Strategic direction of putting patient care and safety at the forefront of business.

This report includes a focus on:

- Leadership workstream
- Dementia improvement plan and peer review

3. Recommendations (Note, Approve, Discuss etc)

To update and inform the Board on progress to improve quality and patient safety at the RUH.

4. Care Quality Commission Outcomes (which apply)

Outcome 4: Care & Welfare of people who use services.
Outcome 5: Meeting Nutritional Needs
Outcome 8: Cleanliness and Infection Control
Outcome 9: Management of medicines
Outcome 11: Safety availability and suitability of equipment

5. Legal / Regulatory Implications (NHSLA / Value for Money Conclusion etc)

Care Quality Commission (CQC) Registration 2011/12

6.	NHS Constitution
This report demonstrates compliance with the following principle; 3. The NHS aspires to the highest standards of excellence and professionalism	

7.	Risk (Threats or opportunities link to risk on register etc)
Risk 178 Mismanagement of anticoagulants Risk 188 Hygiene Code. Risk 133 Medication errors.	

8.	Resources Implications (Financial / staffing)
None identified.	

9.	Equality and Diversity
None identified.	

10.	Communication
Patient safety campaign: " Safety Matters" RUH Quality Improvement Strategy will play a key role in both internal and external communications.	

11.	References to previous reports
Routine monthly quality and patient safety reports.	

12.	Freedom of Information
Public. .	

Patient safety and quality report

1. Introduction

This is the monthly patient safety and quality report for Trust Board with an emphasis upon delivery of the Quality Improvement Strategy 2010 -2014 and the NHS South Quality and Patient Safety Improvement programme, in particular our work on the Leadership workstream.

2. Patient Safety work overview

2.1 The Trust continues to provide a progress report on each of the 5 workstreams - Leadership, General Ward, Critical Care, Perioperative and Medicines Management. This progress is uploaded on a monthly basis through the Institute of Healthcare Improvement (IHI) extranet.

2.2 Following the successful application to participate in the Health Foundation Safer clinical Systems programme, the project manager and the registered nurse have been appointed. The programme consists of 4 steps; step 1 concentrates on the pathway definition and context. Within this stage we host 2 site visits, the first on 2nd November when the Programme Director, site facilitator, and Project Manager from the Health foundation will meet the implementation team and the Medical Director.

During the second visit on 7th December, a training need analysis will be undertaken with the implementation team and other stakeholders. A condensed format of the Manchester Patient Safety Culture tool will be undertaken facilitated by the Assistant Director of Nursing Patient Safety and a facilitator from the Health foundation. Further safety culture work will be undertaken during this initial step focusing on 100 members of staff involved in the specific pathway.

A stakeholder's event for the non elective pathway is planned for 3rd November. Further events for the elective pathway and the community are in the process of being planned for November / December.

2.3 A team from Paediatrics have been completing monthly Paediatrics Global Trigger Tool analysis and as a result of this a piece of work on vital signs is about to commence on the paediatric ward.

A further piece of work which has been happening on the paediatric ward is around MRSA swabbing of admissions in their assessment area. Prior to commencement of this work compliance of MRSA swabbing was 20%, since the improvement work the compliance is currently 90%. Further work continues with plans to spread to other areas of the Childrens ward.

2.4 As part of the patient safety work we are required to review 20 random sets of notes of patients discharged in the previous month. The focus of this review is based on the use of the Global Trigger Tool (GTT). The GTT is a structured, validated case note review tool used internationally to assist in measuring the rate of harm across an organisation. In September there were 29 harm events per 1000 bed days. The 3 harm events recorded in September contributed or resulted in harm to the patients and required initial or prolonged length of stay.

Figure 1 details the number of harm events per 1000 bed days. It is expected that each Trust will have an average of 20-30 harm events per 1000 bed days (Institute of Healthcare Improvement). The SHA have confirmed this monthly variation in adverse events has been similar to many of the Trusts participating in the NHS South Quality and Patient Safety Improvement programme.

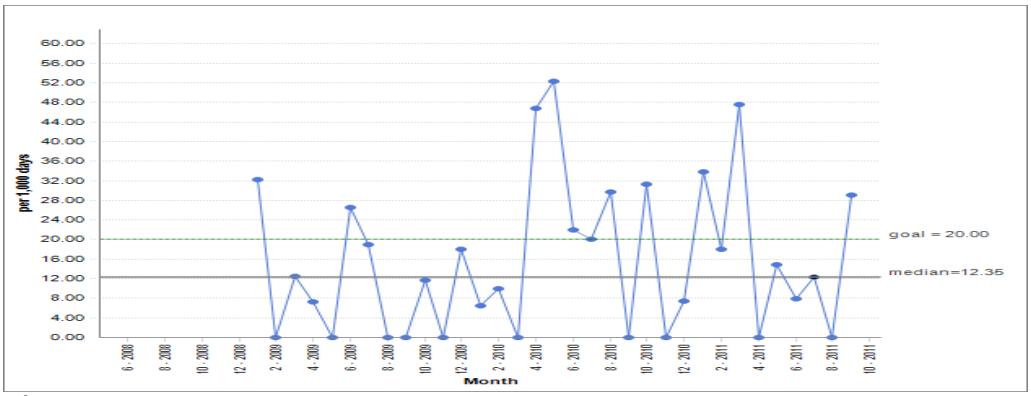

Figure 1

2.5 Following the recent changes within the PCT's a discussion has been initiated by the Director Infection Prevention Control (DIPC) RUH and the DIPC for the PCT cluster regarding the loss of momentum in infection control within the health community. Recently it has become apparent that there is less cohesive working across the community. There is fragmentation and loss of rigor with the community wide winter plan, decolonisation of MRSA patients, and the shared learning around RCA's which was previously well developed. As a result there will be a planned meeting between local Nurse Executives in order to explore what actions should be taken.

2.6 Compliance with the WHO Safer Surgery checklist from the random notes review in September showed between 80-90% compliance for all 3 elements. The Executive Lead (Director of Estates) for the peri-operative workstream is fully engaged in this leadership role seeking improvement.

3. Leadership Workstream

3.1 The aim of this workstream is to provide the leadership systems to support the 'improvement of patient safety and quality outcomes in the Trust'.

3.2 The executive patient safety visits remain an integral part of the leadership workstream. Each Executive is assigned a number of clinical areas including; wards, outpatients, laboratories, operating theatres, pharmacy, and the emergency department. Each January the Executive's areas are changed; this allows the Executives to build relations with staff in a number of different areas.

3.2.1 These visits have continued to gain momentum since commencing in January 2009. To date 100% of all identified areas have had an Executive patient safety visit, this includes areas which have recently been added. Figure 2 shows the number of cumulative visits which have taken place during the previous 3 years.

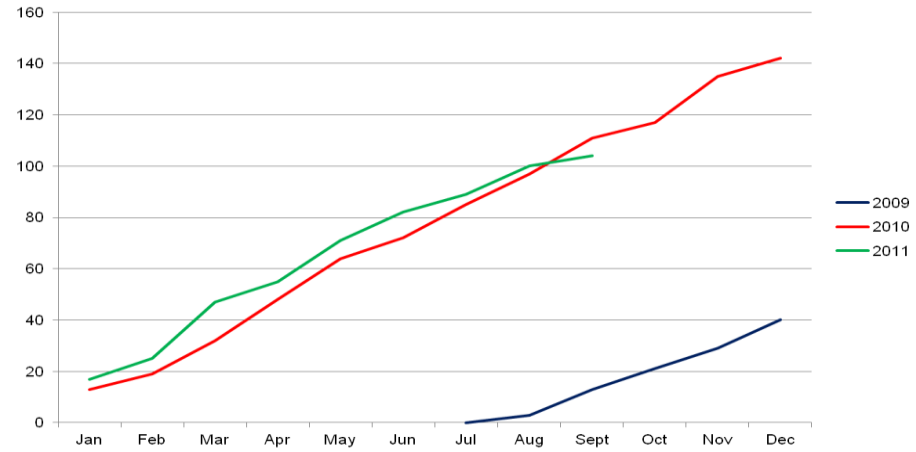

Figure 2

3.2.2 During these visits notes are taken and all actions agreed by the Executive and the ward / department team. These actions are then monitored for completion. Figure 3 below details the number of cumulative completed actions for the last 3 years.

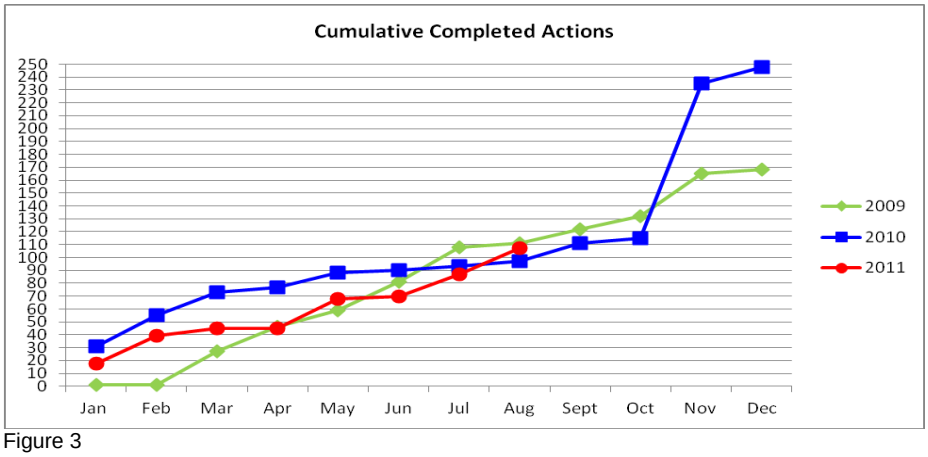

Figure 3

NB – please note that the spike in November represents an administrative 'catch-up' on completed actions.

4.0 Dementia Peer Review preliminary feedback

4.1 The Dementia Peer Review took place on 13th October. A formal report will be submitted to the Strategic Health Authority from the peer review team. This will be signed off by the SHA and available to the RUH and the public in December 2011.

4.2.1 Feedback from the peer review team on the day noted the following areas of good/excellent practice:

- High level of enthusiasm from staff at all levels with a good sense of taking improvements in Dementia care forward
- Excellent clinical leadership at all levels
- Dementia Charter Mark was an example of exemplary practice
- Dementia befriending scheme noted as a good idea
- The team were pleased to observe protected mealtimes in place
- Superb interaction between medical students and patients at the mealtime observation
- Good use of the Malnutrition Universal Screening Tool (MUST) with good automatic referral to Dietician
- Availability of specialist cups and plates to help patients with eating and drinking
- Food looked appetising
- Information for carers displayed in all ward areas visited
- Emergency Department and Medical Assessment Unit – very good practice observed at first point of contact for Dementia patients. Good use of red tray system and 'forget me not' flowers to identify Dementia patients
- The importance of Millennium was recognised and seen as a useful tool for senior nurses to audit the completion of patient assessments identifying patients with Dementia
- Good use of library resources with up to date information for all staff
- Dementia champions in place

4.2.2 The Peer Review team noted that there were a number of areas where the Trust had identified the need for improvement. These are:

- Training of all staff, clinical and non-clinical, and the mechanisms in place for ensuring this is sustained
- Consider increasing the number of staff at mealtimes and the inclusion of carers and volunteers
- The availability of a Mental Health Liaison Service – this was identified as a challenge but recognised that plans are in place to discuss this with Commissioners when agreeing the business plan for 2012/13
- End of Life Care requires specific training however, the Trust is working in close collaboration with Dorothy House Hospice who have funded specific training and provided backfill to our palliative care team

allowing the Trust to establish a new role of an End of Life Care Facilitator

- Discharge liaison with Wiltshire has been a challenge but it is anticipated that this may improve with the new cluster arrangements

4.2.3 The Qulturum hosted a café event for the peer review team who felt that this was a fantastic way to showcase our work and gave the team the opportunity to meet other staff.

5.0 Staff engagement with the Qulturum and the Quality Improvement agenda

5.1 It is important that staff at all levels in the organisation are familiar with the Trust's quality improvement strategy and the purpose behind the Qulturum. A number of key groups involved with quality improvement hold meetings in the Qulturum and external stakeholders; GP's and commissioners recognise that the establishment of the Qulturum will support the ongoing improvements to patient care.

5.2 A group development session will be held with Qulturum staff on 31st October. The Head of Leadership and Management Development will facilitate this. The session will consider how the team engage with staff in the organisation and what needs to be done to increase staff awareness and ensure all staff can contribute to quality improvements.

5.3 A website is being developed that will allow staff to interact with the work that is being undertaken and celebrate successes. This will be an opportunity to increase staff awareness and for staff to learn from areas of best practice.

6.0 Summary

The Qulturum continues to support the patient safety and quality agenda and the establishment of the cluster arrangements has allowed for a greater depth of understanding of key areas that require improvement. Working with all levels of staff in the organisation and using already recognised networks will enable the process of quality improvement to spread. However, it is important that we recognise the need to make savings while ensuring that quality is not compromised.