Whittington Health NHS

# QUALITY & SAFETY DASHBOARD

**Period: November 2011**

## Divisional Narrative: Integrated Care and Acute Medicine (ICAM)

| **Indicator: Grade 2/ 3/4 Pressure Ulcers** | This period | 3 grade 2, nil Grade 3 & 4 in Acute |
|---|---|---|
| | Last period | 2 grade 4 |

**Acute Hospital.**

There were 3 grade 2 pressure ulcers reported on datix for the JKU wards in November. There were no grade 3 or 4 pressure ulcer acquistions on the medical wards in November 2011.

There have previously been two grade 3 acquired pressure ulcers on the acute wards this year, one on Montuschi Ward and the other on Mercers ward. These have both been fully investigated, the report for Montuschi ward has been submitted to NHS London, and the report for Mercers ward is due for submission in January 2012.

Outcome of these investigation:

**Montuschi** – Hospital acquired grade 3 pressure sore.
Root Cause Analysis , patient assessed as high risk but no preventative plan implemented following this. All actions on the action plan following this investigation have been completed

**Mercers**- Grade 3 hospital acquired. Report currently being finalised.

**Community.**

Islington- 5 grade 2 pressure ulcers. 5 grade 3 to 4, one declared to NHS London as an SI, the others were reviewed by the PUSIP and considered not to require further investigation.

**Action plan.**

Montuschi-All actions on action plan completed.

Mercers- action plan being finalised, report to be submitted to NHS London January 2012.

Community- The Distirct Nursing Pressure Ulcer action plan across ICO is ongoing aimed at reducing pressure ulcer acquisition in the community

**Progress Update.**

Montuschi- action plan fully implemented.

Implementation of District Nurse Pressure Ulcer Action plan is ongoing- an update is being presented to the Divisional Board in January 2012 and will be presented as part of the Divisional presentation to the Quality Committee later this year.

| **Indicator: Falls in hospital** | This period | 13 |
|---|---|---|
| | Last period | 19 |

**Analysis of the Issues.**

Number of falls is decreasing

September 25
October 19
November 13

All of these falls reported on Datix are graded as low risk. However, a recent review of all falls as part of the Falls Group work has shown that there are a number of issues with the risk rating of falls. Whilst high risk incidents have been accurately risk rated, there are an number of low risk incidents where patients sustained injuries such as cuts and lacerations, a number of

these incidents also related to patients who had fallen on more than one occasion.

**Action plan**

Continue implementation of Trustwide Falls action plan across the Medical Division (copy of this enclosed)

**Progress Update**

Clear definition of a fall and education regarding the risk rating associated with these incidents will be addressed as part of the action plan which has been implemented to address the assessment, management and prevention of falls in the acute Trust.

| Indicator: **Patient Experience** | This period | |
|---|---|---|
| | Last period | |

Analysis of the issues

Limited numbers of responses in Medical OP clinics

Not all wards are collecting data but generally high Net Promoter Scores (especially Nightingale)

**Action plan**

**Wards:**
Use of PDA s in all ward areas discussed with ward managers. Ward clerks are to ensure that all patients who are going to be discharged are asked to complete the patient experience survey. HON to continue to monitor those wards were data collection via PDA is poor.

**Emergency Department:**
A replacement Kiosk has situated back in the Emergency Department (Nov 11) ED Manager J Nobes monitoring use and results expected in end of Dec
Semi structured interviews have taken place with a cohort of 50 admitted and non admitted patients - analysis being undertaken and will be ready in Jan 12

**OPD**
HON discussed with nurses in OPD about encouraging patients to complete feedback prior to leaving department

**Progress Update**

No patient survey data for OP clinics and ED.
Report of patient interviews undertaken in ED will be completed in January and action plan developed from any issues identified through this. Initial review of this data is positive.

| Indicator: Cleanliness | This period | |
|---|---|---|
| | Last period | |

Analysis of the issues

Hand hygiene scores have greatly improved in November – all wards are 100% excepted for Cavell Montuschi ward failed to meet the Ward cleanliness standards

**Action plan**

Hand Hygiene- Divisional Action plan has been developed and is being implemented throughout the Division. (copy included with this report). There is a separate action plan for the ED dept were compliance has been an issue.

Ongoing monitoring of ward cleanliness by Matrons and HON.

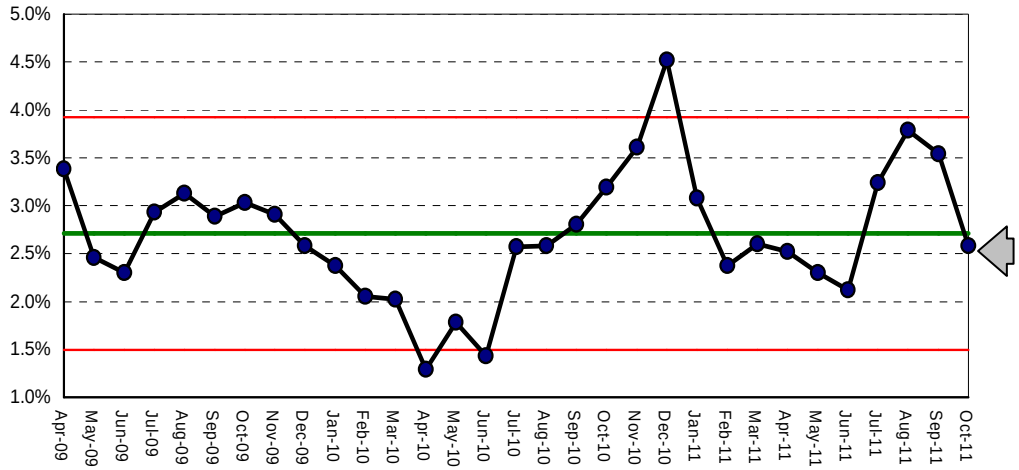
Emergency Department- Infection Control Action Plan developed and implemented. Update to be presented at next IP&C Committee on 15/12/2011). Hand hygiene Audits have continued daily throughout November 2011 in the Department and have significantly improved. Working with LAS to improve compliance from LAS staff.
An ED Quality Indicator Scorecard is being developed which will be available in Feb with data for January. This scorecard will follow a similar format to the Ward Quality Indicator Scorecards.

**Progress Update.**
Divisional IP&C action plan being worked through at present.

Indicator: Sickness Absence

| This period | |
|---|---|
| Last period | |

Analysis of the issues




Trust target is 2.5%

Action plan

*What has already been done*
Heads of service monitoring absence and sickness rates in division. Long term sickness being proactively managed. Sickness and absences will also be managed as part of quality impact of CIPS.
It is understand however that that there may be some inaccuracies with data as ESR does not accurately reflect new divisional structures.

*Responsibilities & timetable*
Head of service . Head of Nursing. Ongoing.

| Indicator: Mandatory Training | This period | |
|---|---|---|
| | Last period | |

Analysis of the issues

Percentage of staff having attended mandatory training in the last two years
Target = 95%

Actual: 68% (historic data n/a)

Action plan

*What has already been done*
Discussed at DMT with actions for Heads of service to have as standing item on team meeting agendas'
Learning sources cascaded and published with push on E learning.

*Proposed actions*
HR learning for L& D to have regular slot at DMT to provide feedback on update in division – commencing 13th Dec

*Responsibilities & timetable*
Heads of service , Head of Nursing.
*When will actions impact on the indicator (is there a time lag?)*
Expect to see impact over next months however as with sickness and absences data quality ( ESR) is questionable and may not reflect new structures.

Progress Update

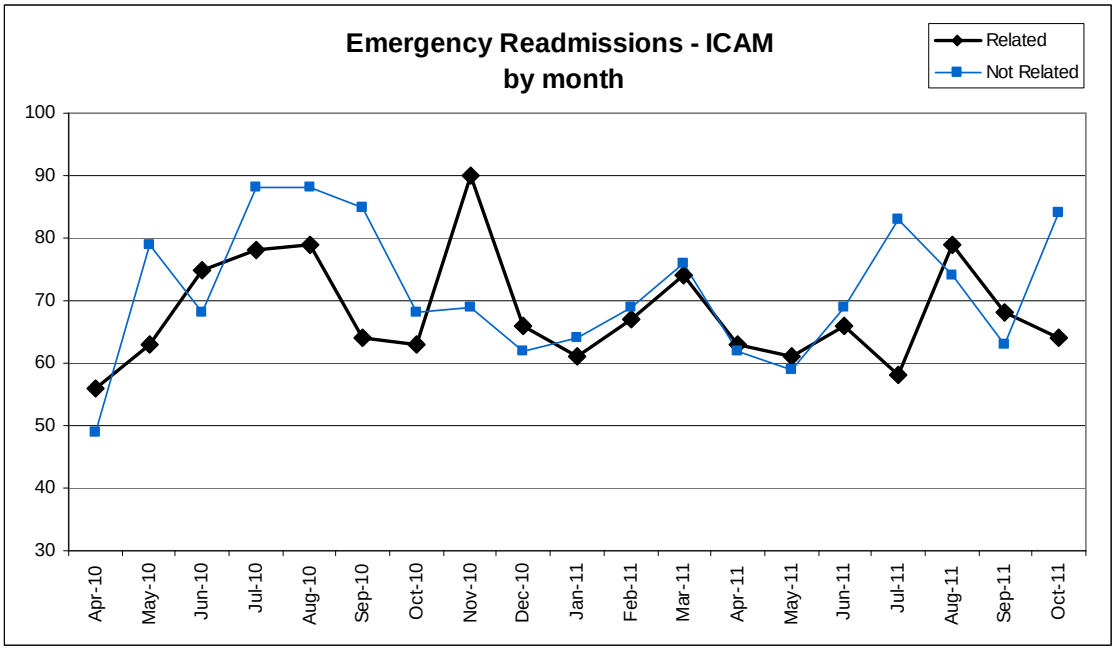
See above

| Indicator: Emergency Readmissions | This period | |
|---|---|---|
| | Last period | |

Analysis of the issues

Readmissions following an elective or day case discharge within 30 days are not meant to happen and there is a requirement to reduce the number of readmissions following an emergency discharge by 25%.

There has been no reduction in the rate of readmissions following an elective discharge or those following an emergency discharge. The chart below provides the monthly trend split by Related/ Un Related – defined as the HRG chapter (body system effectively) assigned to the original and the readmitting spell.




Action plan

*What has already been done*

**AECS project group set up with wider remit on readmissions following confirmation of 30 day readmission monies**

*Proposed actions*

1. AECS p athways scoped and agree.
2. Recruitment started for backfill for CM
3. Additional PAs agreed for NR – to commence at beginning of Jan
4. Winter pressure COPD plan presented to ICAM board. Agree live date –latest beginning of January ( delay in recruiting to locum COOP post ) however may be able to bring forward to this side of Xmas
5. Full AECs service to commence once locum in post.

*Responsibilities & timetable*

Clinical leads, Clarissa Murdoch , Natalie Richard. Operational Lead Paula Mattin

*When will actions impact on the indicator (is there a time lag?)*

From Q 1 2012./13

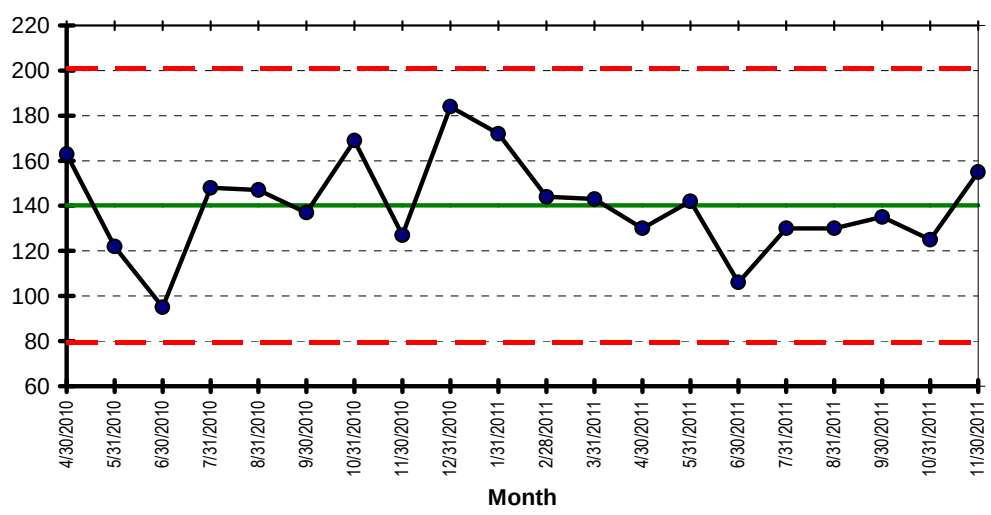
Progress Update

See above

| Indicator: Emergency Admission Rates for LTC | This period | |
|---|---|---|
| | Last period | |

Analysis of the issues

The definition of this indicator has changed to be consistent with the NHS Outcome Framework indicator Emergency admissions for chronic ambulatory care sensitive conditions. The full list is contained in the data dictionary but is not dissimilar to the previous indicator (includes asthma, diabetes, heart failure, COPD, bronchitis, angina, iron deficiency anaemia, hypertension, epilepsy)




Action plan

*What has already been done*
LTC projects agreed
Scoped services across acute and community
Work on transformation pathway with senior clinicians

*Proposed actions*
As per LTC projects plans

*Responsibilities & timetable*
Fiona Yung , Head of LTC
*When will actions impact on the indicator (is there a time lag?)*
12-18months

Progress Update