University Hospitals Bristol NHS
NHS Foundation Trust

Summary Annual Report 2008/9

Patient Safety

Key National Standards and Requirements

- Core Healthcare Standards Safety and Patient Focus. 1a (incident reporting), 1b (acting upon safety notices and alerts), 2 (Child Protection), 4a (infection control), 4b (use of medical devices), 4c (reusable medical devices), 4d (medicines management), and 13b (consent).
- National Patient Safety Agency (NPSA) requirements:
    - Patient safety incidents and near miss incidents reported within the Trust are also reported to the National Patient Safety Agency National Reporting & Learning System. A 6 monthly Extranet report is produced comparing University Hospitals Bristol NHS Foundation Trust (UHBristol) with equivalent NHS Trusts across the country.
    - NPSA Alerts and Safe Practice Notices notified via the Central Alerting System (CAS) must be disseminated, risk assessed and implemented within timescales
    - NPSA Never Events applicable to UHBristol Trust are reported and investigated as Serious Untoward Incidents
- NHS Litigation Authority (NHSLA) standards and accreditation for Acute Trusts and Maternity Services
- Risks identified by specialist committees reporting into the Clinical Risk Assurance Committee which are also reported nationally e.g. Serious Hazards of Transfusion (SHOT)

Summary of 2008/09 Activity

Support and assurance structures

- Each Clinical Division has a patient safety structure headed by a Divisional Patient Safety Lead (Senior Doctor, Nurse or Technician). The Divisions of Surgery and Women & Children are supported by designated Patient Safety Managers/Advisors. The Divisions of Medicine, Specialised Services and Diagnostics and Therapy have Patient Safety Advisors who have a prime clinical role e.g. Consultant Medical Staff, Heads of Departments. These and other key staff have been trained in the use of Root Cause Analysis techniques and provided with relevant tools for use in incident investigation.
- The Corporate Patient Safety team comprises the Trust's Patient Safety Manager and four part time Patient Safety Managers, some of whom are dedicated to fixed term externally funded Patient Safety First project work, plus a part time administrator.
- The Patient Safety Forum meets bi-monthly and acts as a developmental forum for these patient safety leads and advisors. The focus is on the sharing of learning and best practice across clinical specialties. Topics during 2008/9 have included: Deteriorating Patients and early warning scoring schemes, Corporate Manslaughter Act, Identification of key patient safety training topics, and learning from incident investigations

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Safer Patient Initiative to Patient Safety First

The Trust completed it's involvement in the Healthcare Foundation 'Safer Patient Initiative' in conjunction with North Bristol NHS Trust. In 2009 the Trust joined the Patient Safety First Campaign which includes similar work-streams. Implementation of changes in practice will follow a small scale testing methodology (Plan Do Study Act cycle) to determine effectiveness and encourage front line staff involvement. There is a strong emphasis on monitoring or measuring to gauge the impact of the practice changes. This work is allied to the Productive Ward and Productive Theatre lean projects. The work-streams are:

- Leadership - involving 'walkrounds' of clinical wards and departments by a member of the Executive Team to identify safety hazards and solutions. Non Executive Directors now attend these, either with an Executive Director or alone.
- Peri-operative care – use of techniques and monitoring to maximise the recovery of patients from surgery including temperature regulation, use of prophylactic antibiotics and glucose regulation for relevant patients. Also improved communication between teams by use of pre-list and pre-case briefings and completion of the WHO Safer Surgery Checklist for all surgical cases.
- General ward – prime focus on prompt identification of deteriorating patients. To include safety briefings between clinical teams to identify potential hazards and the use of a structure communication model (SBAR-Situation, Background, Assessment and Recommendation). In addition new patient observation charts to include early warning triggers to identify changes in a patient's condition have been implemented.
- Medicines management – concentration on the safe use of high risk drugs for anti-coagulation therapy, opiates, injectable sedatives and insulin. The reconciliation of medication prescribed in hospital with the community or long term medications is allied to this to prevent patient harm.
- See Appendix 1 for further details of activity underway and progress to date

Incident reporting

- There were 9337 (5900 clinical and 4437 non-clinical) incidents reported throughout the Trust for 2008-2009. 72 clinical incidents were graded as catastrophic where a patient died or serious implications for Trust reputation were associated. Detailed incident investigation concluded that 2 should be classified as avoidable patient deaths. The Division of Women and Children's Services continues to report more incidents than other Divisions 37.4% of all incidents. The total number of clinical incidents for 2007-2008 was 5,984.
- Patient safety incident activity data is presented in a Statistical Process Chart format to track trends and peaks and troughs in activity. The consistent top categories are incidents related to prescribing/administration of medications and a range of incidents linked to staffing levels and workload pressures eg delays in access to surgery, closure of delivery suite. A positive development is the continued increase in near miss reporting – deemed an indicator of a positive safety culture.
- The introduction of an online process for reporting of incidents has been subject to extensive testing in departments and wards.

Safety notices and alerts

Safety Alert Bulletins (SABs) are disseminated within the Trust, for review, implementation and

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assurance of compliance to all relevant clinical staff and departments by the Trust Medical Equipment Management Organisation (MEMO). Safety alerts comprise those raised by the Medicines and Healthcare Products Regulatory Agency (MHRA) the Department of Health, including the Estates and Facilities Division and the National Patient Safety Agency (NPSA). In 2008/9 there were 9 NPSA alerts issued: 6 related to medications. UH Bristol Trust confirms compliance for 7 with projects underway for medicines reconciliation and patient wristbands using bar code technology.
The MHRA issued a total of 88 alerts in 2008 (calendar year), 42 alerts in 2009 (up to June 2009)

Medical devices
In addition to the MHRA alerts for 2008/9 the following activity is reported:

- 34 alerts received in 2008/9 from all agencies using the SABs now Central Alerting System (CAS)
- Self assessment process for medical staff for medical equipment training agreed logged on risk register until fully implemented as Risk 886.
- Point of Care Testing Committee established to report to Diagnostics and Therapies Division
- Introduction of changes to bed store still incomplete and potential for faulty beds to be reintroduced into use before repair.
- Funding and location for longstanding introduction of Equipment store still outstanding.

Medicines management
In addition to the medication related work streams of the patient safety projects and the NPSA alerts for 2008/9, the following activity is reported as ongoing:

- Progress in implementation of NPSA guidance final actions due by April 2009
- Recording of training provided to clinical staff on medications required for NPSA and NHSLA standards. Central recording via Electronic Staff Record preferred method. Currently only possible for induction training.
- Increased demand for audits for NPSA alerts and National Institute for Clinical Excellence (NICE) guidelines. Use of alternative methods of continuous sampling methodologies to be explored.
- Introduction of new Warfarin chart for inpatients December 2008
- Audit of prescribing and administration action plan for improvement includes recording of allergy, dose omissions, route and use of generic drug names

Hospital Transfusion Committee
During 2008/09 this committee has focussed on:

- MHRA Inspection January 2009 identified a number of key actions to ensure safe practice.
- Lack of compliance with MHRA blood tracking requirements has lead to blood product wastage.
- Training implementation continues to ensure compliance with NPSA Alert.

Radiation Protection Committee
Key areas of note for this committee in 2008/09 are:

- Updating the Radiation Protection Policy in line with Ionising Radiation Regulations on

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Document Management Service
- A clinical audit outcome showing that 3-4% of x-ray requests have incomplete or inaccurate patient or clinical details

Consent
Improvement in obtaining informed consent have been made as follows:
- Mental Capacity Act awareness training is incorporated into induction for new clinical staff and as update for existing staff
- Change in practice to reflect policy requirement for no delegation of consent unless subject to specific Clinical Risk Assurance Committee approval

Resuscitation Committee
During 2008/09 the Resuscitation Committee has:
- Ensured the replacement of Ambu bag valve masks on all resuscitation trolleys for safety
- 154 Junior medical staff received resuscitation training in August 2008 induction
- Audit of 'do not attempt resuscitation decisions' required Trustwide. 1 audit underway but needs to be extended
- Laryngoscopes with faulty handles replaced
- Intralipid to be stored in infusion cupboards rather than trolleys in wards/departments and treated as controlled drug for storage and checking
- Poor compliance with mandatory training has been identified and actions to improve.
- Do not attempt resuscitation and cardiac arrest audits are outstanding.
- Limited awareness of staff attending resuscitation training identified of use of early warning scores and SBAR communication tool.

Confidential Enquiries
These are a mixture of national audit and research projects aimed at investigating the contributions of deficiencies in care to serious adverse patient outcomes with the aim of identifying areas where clinical practice needs to be improved, and to make recommendations for changes that will improve outcomes for patients.

National Confidential Enquiry into Patient Outcome and Death (NCEPOD)-current enquiries which have been reviewed and updated on progress
- Trust response to published NCEPOD reports:
    - NCEPOD reports published 1989-2004: final checks on compliance with all a small number of outstanding recommendations noted on appropriate Risk Registers
    - NCEPOD reports for Sickle Cell Disease and Cardiac Surgery undergone gap analysis and indicate good levels of compliance with some actions for implementation
    - NCEPOD report for Trauma services. Compliance is lacking in some areas and service implementation implications presented to Trust Operational Group
    - Emergency Admissions (2008) 11 recommendations which are not met or partially met
    - Systemic Anti-Cancer therapy (2008) non compliance declared for recommendations relating to provision of palliative care and emergency admission of chemotherapy

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patients to BRI.
    - Severely Injured Patients (2007) implementation of outstanding actions is reviewed by Trust Operational Group
- Confidential Enquiry into Maternal and Child Health (CEMACH):
    - Bid for funding to provide pre-conception counselling and support service to at risk women including those receiving fertility treatment, mental health conditions or obese
    - Access of appropriate interpreting services identified and services currently under review
    - Compliance with NICE recommendations for Glucose Tolerance Testing dependant on PCT funding support
    - Capacity pressures impeding compliance with requirement for all women to receive first trimester ultrasound scans.
    - Mortality Surveillance (in utero death >24 weeks gestation and neonatal deaths up to 28 days) Yearly increase in stillbirth, perinatal and neonatal death rates noted at St Michael's Hospital. Coding of lethal/life threatening anomalies for CEMACH requirements leads to apparent raised mortality rate. Post mortem examination rate is lower than national average 33 - 38%
    - Also see Obstetrics & Gynaecology report below
- No update for Confidential Inquiry into Suicide and Homicide required for this report

Thrombosis and Anticoagulation Committee

During 2008/09 the focus has been, and continues to be, on venous thrombo-embolism (VTE) risk assessment. Feedback from a South West VTE Prevention Initiative peer review process has highlighted the need for increased compliance in carrying out these risk assessments to identify the correct preventative regime for patients.

- The Clinical Quality Indicator (CQUIN) target for quarters 3 and 4 of 2009/10 is for 95% of all adult patients to be risk assessed for VTE.
- Key areas of focus are developing metrics, performance management from the Trust Executive Group to Divisional Boards, engagement of senior clinicians and education and training.
- A VTE Prevention policy is currently out for consultation.

Risk Management Training Plan

- A Risk Management Training Plan encompassing Health and Safety and Patient Safety has been completed to ensure the Trust has a systematic and planned approach to providing training for key risk areas.
- A Risk Management Training Needs Analysis has been completed following consultation with key stakeholders which will be a guide for managers to clarify which staff require training and how often.
- A Risk Management Training Prospectus will guide all staff to training opportunities and methods of delivery.
- The Oracle Learning |Management System will enable managers to generate compliance reports to provide assurance to the Trust Board.

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Safeguarding Children Steering Group

Key areas of activity for this committee in 2008/09 are:

- Protection of Children Act (POCA) in addition to Criminal Records Bureau (CRB) prior to offers of appointment for relevant clinical staff. Prompt recruitment is being hampered by delays in checks. Particular impact on Women and Children Division. Risk assessment of each recruitment is required to determine if an offer can be made without relevant confirmation.
- Review of child protection training levels to improve attendance compliance
- Previously identified risk of numerous version of case notes in Women and Children Division still not fully reduced
- POCA (Prevention of Child Abuse) Checks Policy not defined for all Clinical Divisions
- Serious Case Review (South Glos) likely to be critical of aspects of Bristol Royal Children's Hospital (BRCH) practice re documentation

Record Keeping

- There has been patchy attendance at Assurance of Record Keeping Group (ARKG) from some Divisional representatives
- The group has identified overlap between Clinical Effectiveness Committee (CEC) and ARKG function for new clinical documents. It has been agreed that guidelines will be for approval by CEC and checklists for approval by ARKG.
- Serious untoward incident re administration of Heparin has identified poor gate-keeping of documents uploaded to Connect
- Poor use of name stamps by medical staff identified as part of monthly Global Trigger Tool case note reviews.
- Use of screen savers with best practice reminders for record keeping is an incomplete action from 2007/8 health records audit.

Obstetrics and Gynaecology Patient Safety Report

- Capacity risks associated with workload and staffing continue - reflected in incident activity.
- 9 incidents related to retention of swabs in Women's Services in last year. Changes in practice underway to reduce likelihood of repetition.
- Introduction of an elective caesarean section theatre list with the aim of improving patient outcomes
- Incident investigations have identified the difficulties in ensuring the Central Delivery Suite Co-ordinator remains supernumerary.
- Incident investigation of delayed diagnosis of endometrial adenocarcinoma identified communication failures inherent in current system of review of results. Actions are underway.
- Confidential Enquiry report "Saving Mothers Lives" (2007): incomplete implementation of action plan for the following due to lack of funding/service provision:
    - preconception counselling
    - interpretation services
    - perinatal psychiatric services
    - access to services for vulnerable women

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- diabetes antenatal clinic

Mental Health Steering Group

- Delays in staffing Psychiatric Consultant Liaison post for Elderly patients will impact on referrals.
- Lack of Service Level Agreements with Avon and Wiltshire Partnership Mental Health Trust (AWP) to be actioned by former Chief Nurse in new role in AWP.

Key Outcomes for 2008/09

Assurance to Trust Board and support to Clinical Divisions

- Successful completion of interim (informal) NHSLA level 2 Acute Standards assessment during 2008/9
- Instigation of regular compliance reports for NPSA Alerts to Clinical Risk Assurance Committee and Trust Governance and Risk Committee
- Quarterly review of Trustwide clinical risks via Clinical Risk Assurance Committee
- Implementation of interventions for Patient Safety First project and linkage to ongoing patient safety activity.
- Regular review and compliance assessment of Confidential Enquiries

Indicators of Effectiveness (extracts from Assurance Framework)

- NHS Litigation Authority accreditation – Level 1 general; Level 3 maternity

- Core Standard C1a - Patient safety incidents are reported to the National Reporting & Learning System via the Ulysses database. UH Bristol below average for all incident reporting in comparison with similar Trusts and above average for reporting of medication related incidents
- Core Standard C1b – Training programme underway to ensure clinical staff use correct process for prescribing, checking and administration of blood products in line with NPSA requirements

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2009/10 Plan and Priorities		
Priority	*Person responsible*	*Target date*
NHSLA Acute Risk Management Standards interim level 2 assessment in June 2010 with view to formal assessment in Oct 2010	Nicola Henderson	October 2010
NHSLA Maternity Risk Assessment Standards formal assessment at level 3 December 2010	Jackie Moxham Janet Pollard Bryony Strachan	December 2010
Introduce simple process for all clinical staff to use the Ulysses database to develop local and relevant reports for their teams	Andy Landon Simon Harrison-Boyle	March 2010
Dissemination of Patient Safety First work-streams across UHBristol	Nicola Henderson Catherine Hughes Angela Cherrington Cat McElvaney Valerie Clark	ongoing throughout 2009/10
Introduce on line incident reporting	Andy Landon Simon Harrison-Boyle Anne Reader	March 2010
Delegation of consent: monitor compliance with procedure specific permission from Clinical Risk Assurance Committee	Nicola Henderson	March 2010
Mental Capacity Act: include audit of the use of the capacity assessment pathway to ensure this is effective in health records audit 2009/10	Nicola Henderson	July 2010
Continue development work in use of Trust wide Risk Register	Patient Safety Team	ongoing
Support staff development in Clinical Divisions	Patient Safety Team	ongoing
Continue work of Thrombosis and Anticoagulation Committee with focus on patient risk assessment.	Sue Fyfe-Williams	ongoing
Continue the work of The Assurance of Record Keeping Group – to mitigate against the risks logged on the trust wide risk register and achievement of NHSLA level 2	Nicola Henderson	ongoing

Prepared by: Nicola Henderson – Trust Patient Safety Manager June 2009

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Patient Safety First Programme

Introduction: The aim of the Patient Safety First Campaign is "to make the safety of patients everyone's highest priority" with no avoidable deaths or no avoidable harm occurring. UH Bristol joined this national campaign in January 2009, following on from the Safer Patient Initiative work undertaken by the Trust during 2007/08.

Appendix 1

Programme Objectives

- To improve patient safety within the Trust by implementing the clinical interventions as recommended.
- To measure the impact for each clinical intervention and to use these measures to focus the work and continually improve.
- To produce a Quality Report by March 2010 that demonstrates improvements. .

Achievements to date

- Observations chart implemented across the Trust (March 2009)
- Communication Tool SBAR launched. (March 2009)
- Executive Walk rounds monthly with action reports generated (Jan 2009)
- System in place to record all necessary information for peri-operative care and regular feedback being given to theatres on the results. (April 09)
- E-learning packages in existence for a number of the interventions for eg. V.T.E assessment.

Key Performance

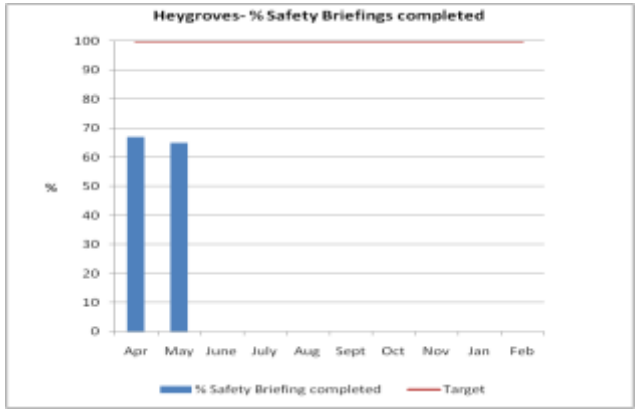

Table. 1 Key Aims & deliverables of the 5 Interventions

Intervention	Executive Lead/ Intervention Leads	Aim	Key Actions	Key Measures
Leadership for safety	Graham Rich Jonathan Sheffield & Catherine Hughes	To ensure leadership culture at board level which promotes quality and patient safety and provides an environment where continuous improvement in harm reduction becomes routine throughout the organisation.	•Assign an Executive Lead for each Intervention. •Continue with the Executive walk rounds and action plans. •Report measures for all interventions at appropriate Board meetings.	• No. of planned executive walk rounds vs actual •No. of action reports generated actual vs. planned .
Reducing Harm from deterioration	Pat Fields Trevor Brooks & Peter Murphy	Reduce in-hospital cardiac arrest and mortality rate through earlier recognition and treatment of the deteriorating patient.	•Continue to monitor use of Observation chart throughout the Trust •Continue with education and training. •Act on information captured via monitoring to ensure areas supported to increase use .	•% of observations charts with obs. recorded and % of what obs. recorded •% of charts with action reports if chart has trigger score
Reducing harm in peri-operative care	Jonathan Sheffield Clare Evans & Gerry Baber	Improve care for adult patients undergoing elective surgical procedures in the hospital setting	•Reduce surgical site infection by implementing a number of good practise methods e.g. maintaining normathermia •Improve teamwork and communication by introduction of WHO surgical checklist (by Feb 2010) and safety briefings. •Reduce Venous thrombosis embolism rates by ensuring all appropriate patients receive a VTE assessment.	•No. of Surgical site infection 30 days post-op. •% of list using the WHO safety checklist •% of theatre sessions started with a safety briefing. •% appropriate patients who have been VTE risk assessed.
Reducing harm in paediatric critical care	Alison Moon (tbc) Pam Cairns	Improve the care of paediatric patients receiving critical care through the reliable application of care bundles		•Reduction in infection rates
Reducing harm from high risk medicines	Irene Scott Steve Brown, Kevin Gibbs, Sarah Hepburn	To prevent harm from high risk medicines	•Implementation of warfarin chart a & protocol cross the Trust. •Implementation of NPSA heparin concentration guidance •Medicines Reconciliation.	•Anticoagulation adverse event rate •Adverse event rate associated with low molecular heparin •Insulin adverse event rate.