National Learning Event – 11th May 2012

Making Quality Everyday Business
Hywel Dda Health Board
Reducing Healthcare Associated Infections

Monthly Cannula & Catheter Audits March/April 2012
Methodology

Catheter
• Up to 5 Patients per ward audited for each Hospital

PVD
• Up to 10 Patients per ward audited for each Hospital

Wards Taken Part (37 in total)
• **Bronglais General Hospital:** Iorwerth, CMU, Meirig, Ceredig, Ystwyth, Rhiannon & Rheidol (7 wards)
• **Glangwili General Hospital:** Ceri, Gwenllian, CCU, Towy, CDU, Dewi, Steffan, Padarn (8 wards)
• **Prince Philip Hospital:** Ward 1, 3, 4, 5, 6 and 9, CDU, CCU (9 wards)
• **Withybush General Hospital:** A&E, ACDU, Medical Day, CSAI, Peads, ITU, CCU, Wards 1, 3, 4, 7, 10, 11, and 12 (14)
CAUTI

- No of patients Audited = 10 PPH
- No of patients Audited = 14 BGH
- No of patients Audited = 27 WGH
- No of patients Audited = 10 GGH
- Total = 61
Compliance Rate with Insertion and Maintenance Bundle Short Term Catheter

<table>
<thead>
<tr>
<th>Item</th>
<th>GGH</th>
<th>BGH</th>
<th>WGH</th>
<th>PPH</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care Bundle</td>
<td>96%</td>
<td>100%</td>
<td>89%</td>
<td>89%</td>
</tr>
<tr>
<td>Sticker Present</td>
<td>36%</td>
<td>10%</td>
<td>7%</td>
<td>10%</td>
</tr>
<tr>
<td>Catheter Still Needed</td>
<td>80%</td>
<td>80%</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td>Drainage bag in Correct Place</td>
<td>80%</td>
<td>80%</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td>Gloves &amp; HH</td>
<td>80%</td>
<td>80%</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td>Urethral Meatal Hygiene</td>
<td>85%</td>
<td>85%</td>
<td>85%</td>
<td>85%</td>
</tr>
<tr>
<td>Catheter Circuit in Tact</td>
<td>80%</td>
<td>80%</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td>Overnight link system discarded</td>
<td>37%</td>
<td>37%</td>
<td>37%</td>
<td>37%</td>
</tr>
<tr>
<td>Catheter drainage bag changed</td>
<td>70%</td>
<td>70%</td>
<td>70%</td>
<td>70%</td>
</tr>
</tbody>
</table>
Hywel Dda Compliance: Catheter
PVD

- No of patients Audited = 39 PPH
- No of patients Audited = 61 BGH
- No of patients Audited = 82 WGH
- No of patients Audited = 39 GGH
- Total = 221
Hywel Dda Compliance: PVD

GGH  BGH  WGH  PPH  Community  Health Board
Next Month

- Reinforcement of sticker usage. Appointments made with Senior Drs to assess how best to take this project forward.
- Extend PVD and CAUTI bundles to Community Hospitals
- Further HB audit to be completed in June 2012
- STOP Campaign to be launched across the Health Board.
- Begin to develop Exit strategy - Pilot one ward on each Acute site to complete an audit each month and place results on the Nursing Dashboard.
Situation

• To date - 12 clinical areas are using the Care Metrics Module to capture compliance data on the 4 RRAILS bundles across the Health Board

Continuing to work collaboratively to accelerate the implementation and spread of the mandatory interventions with the aim of reducing harm and mortality by acute deterioration and severe sepsis.
NEWS implemented on all Acute Hospital Sites

12 areas monitoring Compliance with the RRAILS bundle via the Care Metrics Module
Monitored via the County teams

Admission, Recognition & Response

NEWS Compliance Monitoring – snap shot audits
Undertaken by Ward Sisters supported by RRAILS leads

Community Hospitals – April/May 2012 - Initial meetings held to discuss action plans

Mental Health – April 2012 - Task & Finish group set up and first meeting held to formally agree action plans
Sepsis bundle - Emergency Departments and Admission Areas & Critical Care

Bundle Compliance monitoring
Monitored using the Care Metrics Module (CCM) by the County teams

Spread of Sepsis Bundle to all Clinical areas by April 2012

Sepsis Documentation – standardised across the HB To be launched May 2012

Pilot of ‘Sepsis Pack’
Piloted in one A & E department. Evaluation demonstrated that there was no benefit of having a Sepsis Pack within an A & E department.

SBAR pads approved for HB wide use – to be launched April 2012

Sepsis Management

Standardised training material agreed

Pilot of ‘Sepsis Pack’

To be launched April 2012

Monitored using the Care Metrics Module (CCM) by the County teams
Multidisciplinary team/human factors training - started in January 2012
Evaluation to be presented to HB Resuscitation Meeting in May 2012

Ensuring Competency

Additional Training, where appropriate

NEWS included in: induction training for Medical Staff

NEWS included in: Skills to care Training For HCSW

Rapid Response to Acute and Management of Critical Illness Module

NEWS/RRAILS included in: All ILS courses and simulation training

Collaboration between HB & College of Human and Health Sciences, Swansea University
### Background

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</thead>
<tbody>
<tr>
<td><strong>Rapid Response Groups in each county reporting to HB Resuscitation Committee</strong></td>
<td><strong>Transforming Care Programme used to facilitate the development of some of the work</strong></td>
<td><strong>1 ward capturing compliance data on the Admission, Recognition and Response Bundle (1000 lives + spread sheet)</strong></td>
<td><strong>Integration of RRAILS &amp; CCM/Dashboard – early adopters sites identified</strong></td>
<td><strong>3 areas capturing compliance data (CCM)</strong></td>
<td><strong>11 areas capturing data</strong></td>
<td><strong>12 areas capturing data (CCM)</strong></td>
<td></td>
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<tr>
<td><strong>Discussion on the introduction of NEWS</strong></td>
<td><strong>NEWS introduced to GGH &amp; PPH (Aug 2011)</strong></td>
<td><strong>NEWS introduced to WGH (Oct 2011)</strong></td>
<td><strong>NEWS introduced to BGH (Nov 2011)</strong></td>
<td><strong>NEWS spot audits undertaken</strong></td>
<td><strong>Initial discussions about NEWS in Community Hospitals &amp; in Mental Health</strong></td>
<td><strong>First meetings to discuss</strong></td>
<td></td>
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</tr>
<tr>
<td><strong>Sepsis Bundle already used in key areas within each county</strong></td>
<td><strong>Roll out plan for spread of Sepsis Bundle to all areas agreed</strong></td>
<td><strong>Training and Education commenced to support spread of Sepsis Six Bundle</strong></td>
<td><strong>Further work on Sepsis Screening tool, Antibiotic Guidance and 6hr management (sepsis six/ EGDT) protocol</strong></td>
<td><strong>Agreement to Standardise Sepsis Documentation for the HB &amp; Standardised SBAR documentation agreed</strong></td>
<td><strong>Finalise the standardise documentation</strong></td>
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Patient Safety Boards – Task and Finish Group

• Evaluated the variances of PSAG board design and application across the Health Board;
• Aligned the design of the board to the 1000 lives plus SBAR handover principles to ensure concise (‘3 second rule’), accurate and current multi-disciplinary patient information;
• Agreed a minimum data set for the mandatory information fields for PSAG boards in general in-patient areas (including RRAILS);
• Health Board PSAG practice guidelines have been developed which aim to define the principles for safe practice,

Integration of RRAILS & the Care Metrics Module

Roll out plans agreed for each county on using the CCM to collect the data on the RRAILS bundles

PDSA – RRAILS Bundles in A & E Departments

<table>
<thead>
<tr>
<th>Plan</th>
<th>‘What is it that we are trying to achieve’ - the earlier detection and treatment of sepsis and in order for this to happen a NEWS score would need to be calculated so that the screening tool can be applied.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Test the current RRAILS bundles in A &amp; E</td>
</tr>
<tr>
<td></td>
<td>• Use the CCM to collect the data</td>
</tr>
<tr>
<td>Do</td>
<td>Test the current RRAILS bundles in one A &amp; E department (March 2012)</td>
</tr>
<tr>
<td></td>
<td>• Integrate the measurement of compliance into normal A&amp;E activity</td>
</tr>
<tr>
<td>Study</td>
<td>Analyse the data &amp; get feedback from staff</td>
</tr>
<tr>
<td></td>
<td>• Look at the lessons learned</td>
</tr>
<tr>
<td></td>
<td>• Are the Current RRAILS bundles suitable for A &amp; E or do the Admission and Recognition bundles need to be adapted/amalgamated?</td>
</tr>
<tr>
<td>Act</td>
<td>Decide the way forward</td>
</tr>
<tr>
<td></td>
<td>• Can the current RRAILS bundles be introduced as they are to the A &amp; E departments (Spread to all A &amp; E departments) or is there further work required to adapt/amalgamate the Admission and Recognition bundles (further PSDA cycles)</td>
</tr>
</tbody>
</table>
Admission Bundle

Recognition Bundle

Response Bundle

Sepsis Bundle

Ward monitoring compliance with Sepsis Bundle since Oct 11 - No patients identified with sepsis in the 24 hour periods reviewed.
Admission Bundle

% Compliance - Admission Bundle (pilot Ward - Pembs)

Dec-11 Jan-12 Feb-12 Mar-12 Apr-12

Response Bundle -
Ward monitoring compliance with Response Bundle since Dec 11 - No patients identified at risk of deterioration identified in the 24 hour periods reviewed.

Recognition Bundle

% Compliance - Recognition Bundle (pilot Ward - Pembs)

Dec-11 Jan-12 Feb-12 Mar-12 Apr-12

Sepsis Bundle -
Ward monitoring compliance with Sepsis Bundle since Dec 11 - No patients identified with sepsis in the 24 hour periods reviewed.

Pilot of a New Data Gathering Tool
Data entered onto the 'Dashboard'
Patient refused to have BP recorded
Admission Bundle

Recognition Bundle

Response Bundle

Sepsis Bundle
Ward not capturing data on Sepsis Bundle – to start capturing data in April 2012
## Recommendations

<table>
<thead>
<tr>
<th>RRAILS - First meetings with the Community Hospitals</th>
<th>April/May 2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>RRAILS - First meeting of the Mental Health RRAILS Task &amp; Finish Group</td>
<td>April 2012</td>
</tr>
<tr>
<td>RRAILS - Feedback from the A &amp; E department on the RRAILS bundles</td>
<td>May 2012</td>
</tr>
<tr>
<td>RRAILS compliance - All the in-patients wards included in the County roll out plans to starting to collect data on the RRAILS indicators on the CCM</td>
<td>June 2012</td>
</tr>
<tr>
<td>Sepsis Bundle - Ensure that 70% of staff are trained within each ward areas prior to the introduction of the Sepsis bundle to all clinical areas</td>
<td>May 2012</td>
</tr>
<tr>
<td>Sepsis Bundle - Launch the HB Sepsis Documentation</td>
<td>May 2012</td>
</tr>
<tr>
<td>Patient Safety Boards - Agree the pilot areas for the new patient Safety Board format</td>
<td>April 2012</td>
</tr>
<tr>
<td>Communication - Launch the HB SBAR pads</td>
<td>May 2012</td>
</tr>
<tr>
<td>Ensuring Competency - Rapid Response to Acute, and Management of, Critical Illness University Module – County teams asked for nominations</td>
<td>April 2012</td>
</tr>
<tr>
<td>Ensuring Competency - Evaluation of the MDT human factors training to the HB Resuscitation Meeting</td>
<td>May 2012</td>
</tr>
</tbody>
</table>
Transforming Care
Hywel Dda Programme

2013 and beyond!
18 Month Programme

PROGRAMME DELIVERY

Implementation Phase:
- 5 centralised workshops
- Work based facilitation

Sustaining & Embedding Phase:
- additional 5 workshops over 14 months
- Ideally within county using informatics as appropriate & existing forums to connect to practice

Annual Celebration Event
- Shared learning & networking
Transforming Care & Cultural Change

18 Month Programme

Application Of Measures

Roles & Responsibilities

Sustaining & Embedding

Communication & Contracts

Sustainability
Transforming Care
a framework = Quality & Safety in Practice

Patient Care
- Pressure Damage prevention
- Nutrition
- RRAILS
- Reduced healthcare acquired infections
- Reduction of Falls
- Reduced complaints
Plan
An opportunity to:
• Reflect on progress
• Review the programme delivery & focus

Act
Roles and responsibilities for delivering and sustaining programme developed
Programme focus for delivering accountable, safe and sustainable Patient Centred Care is being developed

Do
Facilitation team establishing opportunities for communicating specific findings locally with teams and thematically across Health Board

Study
Individual teams are actively using the review to inform local action plans
Facilitation team applying the significance of outcome measures to existing programme
<table>
<thead>
<tr>
<th>KSF Core Dimensions</th>
<th>Clinical Practice Development Nurse</th>
<th>Clinical Practice Development Nurse (TC)</th>
<th>Senior Nurse for Practice</th>
<th>Associate Director of Nursing (Practice)</th>
<th>Board</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient</td>
<td>To transform the quality and safety of patient care</td>
<td>Explains the core principles &amp; disseminate the tools and techniques to the teams Ensures that all learning is captured and communicated Links with key stakeholders to optimise communication across the county</td>
<td>Dissemination of Information within the organisation and to Stakeholders. Facilitates discussions with stakeholders re: TC’s contribution to change</td>
<td>Dissemination of Information within the organisation and to Stakeholders. Facilitates discussions with stakeholders re: practice development team’s contribution to change including TC</td>
<td>Disseminates information within Organisation and to stakeholders</td>
</tr>
<tr>
<td>Communication</td>
<td></td>
<td>Facilitates the workshops and works with teams to ensure that agreed actions are implemented Supports teams to make effective use of the learning opportunities Contributes to share learning across the organisation and celebration of success Works with teams to improve systems and processes</td>
<td>Coordinates the workshops Contributes to setting the way forward for the HB Facilitates a mechanism for shared learning across the organisation and celebration of success</td>
<td>Supports the CPDN &amp; CPDN (TC) Works in collaboration with stakeholders to propose the way forward for the HB Supports the network for shared learning across the organisation and celebration of success</td>
<td>Provides a network across the Health Board to share learning and provide peer support, coaching and mentoring</td>
</tr>
<tr>
<td>Personal &amp; people Management</td>
<td></td>
<td></td>
<td></td>
<td>Work in collaboration to ensure that TC is aligned to local and national priorities and is being taken forward as a vehicle through which these can be delivered</td>
<td>Celebrates success</td>
</tr>
<tr>
<td>Health, Safety &amp; Security</td>
<td></td>
<td></td>
<td></td>
<td>Supports CPDN to collate “Knowing How We are Doing” data (across counties and organisation) Work in collaboration to monitor compliance with the TC objectives, with the focus being on outcomes.</td>
<td>Channels leadership attention to quality improvement and safety</td>
</tr>
<tr>
<td>Service Improvement</td>
<td></td>
<td></td>
<td></td>
<td>Contributes to ensuring that Transforming Care provides an overarching framework to support and facilitate teams to work together towards a quality focused culture</td>
<td>Aligns mean as strategy projects and leadership learning systems</td>
</tr>
<tr>
<td>Quality</td>
<td></td>
<td></td>
<td></td>
<td>Identifies and takes action when own or others' behaviour undermines equality and diversity.</td>
<td>Establishes, oversees and communicates systems aimed at improvement within the Organisation</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td></td>
<td></td>
<td></td>
<td>Identifies and takes action when own or others' behaviour undermines equality and diversity.</td>
<td>“Knowing How We are Doing” across the HB</td>
</tr>
</tbody>
</table>

Transforming Care - Roles and Responsibilities of Practice Team

Insert name of presentation on Master Slide
Flexible Facilitation in a Rural Health Board
Advantages
• Reduced travel for most
• Increased attendance
• Still offers networking opportunities
• Could use a smaller room

Disadvantages
• Reduced networking for participants
• VC operator /Facilitator skill!
• Increased planning for organisation and resources
• Duplication of resources in case of system failure
Potential savings (miles)

- PPH x 3 cars = 480
- GGH x 2 cars = 240
- WGH x 2 cars = 26
- Total = 988

- PPH x 3 cars = 120
- WGH x 1 car = 134
- Total = 254

- Total saving (miles) = 734
- 734 miles @ 42p per mile = £308
What helped?

- **Motivation**
  - Teams keen to participate
  - Facilitators wanting to ensure teams able to participate and achieve their objectives
  - Support from Strategic & Senior County Teams

- **Support**
  - Video-conference facilitator in Ceredigion
  - Training & Development Manager Informatics
  - Post-graduate centre at Bronglais
  - From practice team colleagues not at workshop

- **Programme**
  - Flexible to allow for break out and group work sessions locally

- **Novelty**
This programme is being rolled out to all 81 in-patient areas across the Health Board, aiming to complete this initial stage by Mid 2013.

Currently there are 41 wards at varying stages of implementation, with 11 wards in Pembrokeshire.

It is anticipated that all wards identified in the initial implementation plan will have completed the 16 week introductory programme by July 2013 and be working towards embedding and sustaining the principles into MDT practice.

11 wards have participated in either Transforming Care or Releasing Time to Care programmes within Pembrokeshire to date.

There are a further 9 wards and departments in Pembrokeshire who still need to be nominated onto the programme.
Situation

- In the County we currently have a Falls Pathway which was introduced in 2006. This integrated pathway which includes a comprehensive falls risk assessment is currently under review. The pathway does not include the detail included and required from the NPSA Rapid Response Report.
- The NPSA requires all inpatient areas to have an easily accessible protocol which includes the following information:
  - Checks by nursing staff for signs and symptoms of fracture or potential for spinal injury
  - Safe manual handling methods for patients with signs of fracture or potential for spinal injury
  - Frequency and duration of neuro observations for all patients where head injury has occurred or cannot be excluded e.g. unwitnessed falls based on NICE clinical guideline 56.
- To take the NPSA action forward a falls sub group was set up. The group includes representation from Nursing, Quality Improvement, Clinical Effectiveness and Manual Handling. A draft protocol has now been prepared. The template is based upon the evidenced based guidance included within the NPSA report and NICE guideline 56. This protocol will eventually form part of the Care Bundle for Falls which is currently in its development stage.
Background

- In the County a number of falls have resulted in head injuries and fractured neck of femur. There have been no spinal injuries as a result of a fall in the past 3 years, although there has been some cases where there has been a delay in diagnosis e.g. Fracture neck of femur. (Datix Data is available). In Carmarthenshire there have been two recent legal claims following an inpatient fall.
- The 1000 lives campaign has helped to focus high level attention on Falls prevention. A strategic Fall prevention and Bone Health group has been established to help support the development work across the County’s.
Assessment

- Prevention of falls is an important safety challenge. To determine the current position against the NPSA requirements and with current policy and documentation systems a baseline audit was undertaken by the Quality Improvement Manager. The audit included selected areas within PPH, GGH and the community hospitals.
- The audit found that practice differed across wards and speciality. Only one ward area was identified as having recorded neurological observations following an unwitnessed fall. A number of issues were raised regarding compliance with documentation standards, reporting of incidents and requesting medical review. Feedback has been provided to the areas where concern was raised about practice.
- The results of the audit have also been presented at the Acute Services Band 7 forum and good practice following a fall has been reiterated to all ward managers, this includes the reporting mechanisms and the completion of Datix reports.

Recommendation

It is recommended that the Post Fall Protocol is tabled at the Strategic Fall Prevention & Bone Health Group 20th January 2012 and the County Quality & Safety group March 29th 2012. If approved the information will be distributed to all adult inpatient areas within Carmarthenshire.
Implementation will be supported by education sessions for nursing teams. Manual Handling equipment has already been reviewed. To support implementation Safe Systems of work re- Manual handling guidance will also be supplied to each inpatient area.
Implementation of Recommendation
25th April 2012

- Post Fall Protocol presented at County Q & S on the 20th March - agreed for roll out to all adult inpatient areas in Carmarthenshire. This decision has been fed back to Strategic Falls Prevention & Bone Health group meeting which was held on the 20th April 2012.

Agreed Roll Out Plans

- Purchase outstanding equipment for A & E - confirm maintenance arrangements
- Establish Education and training requirements - Information on Essential Care After an Inpatient Fall will form part of the Manual Handling training for trainers.
- Update Datix reporting system to identify those who fall with Dementia and the requirements of the NPSA Rapid response
- Launch “Essential Care After an Inpatient Fall” at Nurse’s Day Events being held on May 14th 2012
- Pack to be prepared for all adult inpatient areas to include Essential care post falls protocol, recommended Neurological charts and Manual Handling Safe systems of work
- Compliance audit to be undertaken in July 2012 by Quality improvement Manager
- Storyboard Presentation to be prepared for NLIAH workshop in June 2012
- Sub group to be established to develop Care Bundle for Falls - confirm if work will have input from Ceredigion and Pembrokeshire. Meetings to commence end of May.
• Pembrokeshire FALLS Group is established and meets monthly
• Pembrokeshire is currently using the falls screening tool in:
  – A&E
  – Community Physio OT
  – District Nursing
  – Day Units
  – Acute Trauma Ward, Withybush General Hospital
• Work has commenced on in-hospital post falls guidelines in compliance with NPSA Falls Alert
• Database supported through NLIAH is currently being used in Day Hospital settings
• A draft information sheet to support the screening tool has been developed and will be finalised shortly
• FALLS exercise programmes are being run and are delivered in conjunction with Age Concern leaflets.
• A FALLS awareness CD Rom has been produced, one to be used for Patients / Clients, the other to support Professionals in delivery of appropriate messages.
• The Multi Agency Support Team (MAST) is operating with a District Nurse and Therapies input they provide a key link to A&E and ACDU in identifying patients who have sustained a fall and developing appropriate responses
Situation

• The reporting of pressure damage incidence throughout HDHB prior to implementation of change has been based on data generated from DATIX, which was the only agreed consistent method of recording pressure damage across the whole Health Board. It has been recognised that the data generated from DATIX does not always give reliable information due to under and over reporting and should be viewed with some caution.

• In order to compare practice and monitor change it will be necessary to increase the reliability of data used to report Pressure ulcer incidents. It is planned to generate more robust data by eliminating over reporting through duplication and inaccuracies in DATIX and then cross referencing between DATIX, the ward safety cross and nursing metric dashboard data.
Background

- The implementation of pressure damage prevention strategies, including the SKIN bundle has been in alignment with the 1000 lives plus work on ‘Improving Patient Safety’ and the Pressure Ulcer Work Stream which aims to eliminate the incidence of preventable pressure ulcers by 2015.

- The mandatory reporting requirements for pressure damage are
  - 1000 lives plus: compliance with SKIN bundle or appropriate technique
  - Transforming Care: number of incidence and number of days between each incidence
  - Fundamentals of Care Audit: Standard 12

- Since the end of 2010 there has been a roll out of an agreed implementation plan throughout the Health Board to the majority of wards and community hospitals (excluding paediatrics, maternity and mental health). The plan includes collecting information of pressure damage incidents on safety crosses and patients identified at high risk to have SKIN bundle documentation.
Assessment

- Pressure damage DATIX entries have been recorded on the upgraded DATIX template designed to facilitate the capture of more accurate information relating to each incident.
- Ward Safety Cross entries are collected monthly and a record kept of ‘days between’ each incident of pressure damage.
- Comparisons between the two data methods indicate that there are a lower number of ‘transferred in’ pressure damage reported on DATIX than on the ward safety crosses, which indicates presently DATIX data is not robust and accurate enough to use alone.
- Prior to November 2011 clinical areas in Carmarthenshire have started to collect hospital ‘acquired’ pressure damage data on the Nursing Dashboard. It has been hoped that the combining and comparing data collection from DATIX, nursing dashboard and the safety cross will help provide a more robust triangulated method of data collection
- Comparisons between data are detailed in the graph on the next slide.
Figure 1: Pressure Ulcers ‘transferred into hospital’ collected by DATIX and Safety Crosses

Figure 2: Comparisons between the three methods of hospital ‘acquired’ pressure damage data
Recommendations

• To continue to monitor DATIX entries to remove duplication and inaccuracies where possible to ensure accurate data for Tier 1 reporting
• To continue to combine and triangulate the three data collection methods monthly to achieve more robust and accurate pressure damage data for Tier 1 reporting
• Increased education & training will be maintained on pressure damage prevention for Ward, community and care home staff
• Possible introduction of a Health Board Pressure Damage Review Group.
• This group with membership from Senior nurse, Practice Development, Tissue Viability and relevant others would be able to review episodes of pressure damage and learn from the events, raising awareness of good practice and learning from missed opportunities
## Pressure Damage Pembrokeshire

### Recent Performance

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</thead>
<tbody>
<tr>
<td>Admitted with Pressure damage</td>
<td>34</td>
<td>27</td>
<td>31</td>
<td>23</td>
<td>19</td>
<td></td>
</tr>
<tr>
<td>Pressure Damage developed within hospital</td>
<td>16</td>
<td>13</td>
<td>7</td>
<td>13</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>50</td>
<td>40</td>
<td>38</td>
<td>36</td>
<td>24</td>
<td>50% reduction</td>
</tr>
</tbody>
</table>

50% reduction
Key Actions

- Recording of all pressure ulcers on DATIX will continue, however each entry relating to pressure damage will be monitored and cause of the pressure damage noted, and inaccuracies and duplication rejected.
- Details of all pressure damage transferred into and developing in hospital will be recorded on ward safety crosses with individual patient details captured so that trends can be established and action taken as required.
- Each clinical area will also record the information from the safety crosses onto the nursing metric dashboard.
- The aim will be to combine and triangulate the three data collection methods monthly to achieve more robust and accurate pressure damage data for Tier 1 reporting.
- Patients in hospital at risk of pressure damage will have intervention recorded on a SKIN bundle and a regular method of measuring and monitoring compliance with the SKIN bundle will be introduced using the Nursing Dashboard.
- Increased education & training will be maintained on pressure damage prevention for Ward, community and care home staff.
Situation
• The reviews into harm and quality of services continue with the Global Trigger Tool audits and the weekly mortality reviews.

Background
• Mortality reviews are undertaken weekly by 2 Consultants and the notes are also reviewed by Acute Nurse Manager and the Quality Improvement Manager. The feedback has to date been by selective case review at the Mortality Meetings.
• The GTT findings have been presented twice at Grand Rounds and the triggers and events with the adverse event rate are presented at the County Quality & Safety Committee for scrutiny.
• The data shows that lack of early warning score and 30 day readmissions continue to be the highest triggers for Bronglais with the 30 day readmission triggers actually converting to harm events.

• No change in data

Recommendations
The GTT lead will be discussing the triggers with the County Quality Leads.
The RAMI score for Withybush General Hospital moved above the target of 100 for September and October 2011. Some of these scores may be due to data quality, as Pembrokeshire's data quality % (according to CHKS is 91.2%). The RAMI is monitored at the County’s Quality & Safety Committee.

The increase in RAMI score in WGH needs to be scrutinised so that the county can understand why it is above 100. Decreased data quality within Pembrokeshire may be affecting the RAMI scores.

Continue monitoring the RAMI at the county Quality & Safety Committee.
A key target of the Health Board Quality and Safety Strategy is that the Health Board reduce its adverse event rate to below the base line of 27.33.

The above chart shows that from Nov 2010 to Oct 2011 Pembrokeshire has achieved an average adverse event rate of 26.32 per 1000 patient days which is a little lower than the set goal.
Within Ceredigion the Heart Failure Team is in the planning phase of developing a NICE Quality Standards driven service. A working group has been arranged for January 2012 with key personnel from Primary and Secondary care as well as patient representatives.

The group will consider the 13 NICE quality standards individually identify shortfalls and attempt to develop services and facilitate change.
Process Measures

% patients compliant with CHF care bundles

NICE Quality Standard 11

- People admitted to hospital because of heart failure receive input to their management plan from a multidisciplinary heart failure team.
- Over the past three years the service has made ongoing attempts to improve the outcomes for patients with an unscheduled hospitalization due to heart failure.
- Since June 2008 Heart Failure patients admitted to Bronglais Hospital are managed by the Cardiology team; there is now evidence demonstrated by the National Audit report 2009-2010 that patient mortality rates are better when patients are managed this way.
- As part of the Cardiology Annual audit program, patient outcomes in terms of in-hospital mortality on index (first ever Heart failure) admissions have been measured and compared to national levels (fig 1).
**Fig 1** Bronglais In-hospital mortality for Index unscheduled admissions due to heart failure

**Fig 2** demonstrates the % of patients seen by the cardiology team in Bronglais hospital. 2010 National audit data demonstrates only 46% of patients admitted with Heart failure are admitted under Cardiology.
Chronic Heart Failure Ceredigion

Assessment

- The outcomes of the Heart Failure re-audit identified improvements of all key components in the inpatient management of patients admitted with heart failure to Bronglais Hospital. However still only 20% of patients received education and a management plan pre discharge; for this serious life threatening condition. In order to improve this outcome two interventions have occurred during 2011

- In January 2011 Ceredigion was selected by the British Heart Foundation as a pilot site to fund a Cardiac Health Care Assistant. Part of her role is to ensure all patients with heart failure are identified and given education and appropriate monitoring post discharge. (Provided with the first blood form to take to the surgery for blood sampling).

- The nurses on CMU and Iorwerth have received two half day training sessions in April 2011 and are now aware of the core education needs and follow up monitoring required for patients discharged with a diagnosis of heart failure.

- Compliance for this intervention is being PDSA’d with the ward. The following chart demonstrates a gradual increase in patients receiving education and a management prior to hospital discharge.
NICE Heart Failure Quality Standard 12

- People admitted to hospital because of heart failure are discharged only when stable and receive a clinical assessment from a member of the multidisciplinary heart failure team within 2 weeks of discharge.
- Since the development of the HCA role the service has targeted patients discharged from hospital developing a system whereby the patient receives early follow up.
- The role of the HCA has been pivotal in identifying patients discharged with a diagnosis of heart failure.
- In September 2010 the service developed a waiting list due to capacity issues this waiting list resulted in many patients not being seen in a timely manor. In July 2011 the waiting list was abolished and a system was developed to access the HF team as soon as possible post discharge.
- In September 2011 there continued to be a delay in patients being seen post discharge due to the transfer of patient details to the HF office as a result of this the Team integrated their information system with the hospital system allowing transfer of patient information to occur electronically which has demonstrated some benefit.
- There has been gradual improvement since July 2011 However the 2 week post discharge follow up was not being achieved in all patients. As a result of this from the 1st of December patients were given their 1st outpatient appointment date and time prior to their hospital discharge. This has shown a significant improvement in the numbers of patients seen within 2 weeks.
Outcome Measures

Time to 1st appointment as a % of total discharges

% patients seen within 2 weeks of hospital discharge
Reducing Hospital Acquired Infections Pembrokeshire

• The County Infection Prevention and Control team implemented monthly hand hygiene compliance Audits and are a compulsory requirement for all wards / departments as part of the 1000 Lives+ initiatives and forms part of the Nursing Dashboard

• 100% reached in 5 out of the 14 areas monitored during April 2012 and 83% compliance overall for all areas monitored in April 2012 – variation in compliance between 50% to 100%. Withybush Hospital had an 86% average compliance over the last 6 months

• Continue to raise profile of hand hygiene decontamination with regular hand hygiene demonstrations at ward / department level by link nurses. To feed back to individual staff groups that do not have appropriate hand decontamination compliance and for managers to progress this non-compliance issue

• Continue to get those areas not currently taking part involved
European HAI Point Prevalence Study – November 2011

- Withybush Hospital had a low HAI rate as there were 9 HAIs identified out of 275 acute beds, which gave a HAI rate of 3.3%. Official feedback is awaited. This study is an annual event.
The implementation of the Butterfly Scheme has been a huge success story in Pembrokeshire.

The Butterfly project allows individuals whose memory is permanently affected by dementia to make this clear to hospital staff and provides a simple, practical strategy for meeting their needs.

It involves a solid picture of a butterfly being placed above the patient's bed. The patients receive more effective and appropriate care, reducing their stress levels and increasing their safety and well-being.

For individuals who do not have a definite diagnosis of dementia but have got some cognitive impairment then the outline of a butterfly will be placed above the bed area and either removed when confusion resolves or changed to a solid butterfly if diagnosis is obtained.
• The scheme has been rolled out on wards 7, 10, 11, CCU and South Pembs Hospital and will be rolled out to Tenby Cottage Hospital on the 2nd May. In addition staff have been to Bridgend and Bronglais hospitals to teach and update them on our progress.
• Following this staff will be disseminating information and supporting the Surgical Wards to commence the scheme.
• Verbal feedback from Relatives and Consultants has been very positive and it has been reported that there is a calmness to the ward.
• Journal of patient/relatives stories, including feedback from Relatives and Doctors.
The Acute Stroke Unit (8 beds) and the stroke rehabilitation ward (8 beds) are co-located on ward 11, WGH. The ward hosts a small gym, cognitive therapy room, and MDT room.

As well as a Consultant in the Care of the Elderly and members of the MDT, the service is supported by a 1 wte Stroke CNS (0.6 +0.4) and an Associate Specialist 9am -5pm, Mon – Friday.

24hr Thrombolysis commenced in WGH in Oct 11.
Intelligent Target report for March 12 (target 100%) - 13 patients

- Bundle 1 = 100%

- Bundle 2 = 75%
  Some problems with initial diagnosis and due to this, patients transferring to ACDU instead of directly to ASU

- Bundle 3 = 92%
  Links in to the above. Due to delay in diagnosis, patient (x1) not seen.

- Bundle 4 = 92%
  1 patient did not receive OT assessment in first 7 days. This was due to reduced OT provision during sickness.

- Thrombolysis
  Of the 13 patients only 1 was thrombolysed. 11 had exclusion criteria. 1 was a potential “missed“ thrombolysis due to delay in process in ED.
• HAT has been implemented. Engagement in audit will follow and provide an overall picture of rollout and assist early evaluation
• Pembrokeshire County is currently training nurses for the rollout of Thromboprophylaxis Risk Assessment
• This training plan is addressing the Pembrokeshire implementation of the 1000 Lives and NICE guidance for thromboprophylaxis risk assessment which is now HDHB wide.
Stories for Improvement

• Developing a systematic approach to using stories
• Pilot approach in Ceredigion spreading to Pembrokeshire and Carmarthenshire
• Wide range of people involved in story work – clinical and non-clinical e.g. audit and IT departments
• Working on improving the governance of story use including storage and access
• Not just about what we do it is about changing how we think
• Strong themes of communication and information coming through stories
• Importance of attitude, values and culture keep coming up in reflective debate on process