

THE SHREWSBURY AND TELFORD HOSPITAL NHS TRUST

Trust Board 26th May 2011

Quality Report

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Corporate Objective	C1. Ensure that we learn from mistakes and embrace what works well C2. Design care around patient needs C3. Provide the right care, right time, right place, right professional C4. Deliver services that offer safe, evidence-based practice C5. Meet regulatory requirements and healthcare standards C6. Ensure our patients suffer no avoidable harm D7. Build service and redesign capacity and capability
Goal	Quality and Safety: We will always provide the right care for our patients and ensure that they suffer no harm Learning and Growth: We will develop our internal processes to sustain our ability to change and improve
Executive Summary	In national definitions of Quality, the three areas defined for Trusts are Patient safety, patient experience and clinical effectiveness and outcomes. The Board will, through the monthly Board performance report be able to track the performance on key areas of quality and safety. The Annual Quality Account process establishes a process by which the Board can approve an annual account of Quality with a high level view of performance and outcomes for Quality improvements. The Quality and Safety Committee however want to be able to reflect a Quarterly position on key issues that provide the wider Trust Board Directors with a position across the three elements of Quality. This report provides the first of these Quality reports.
Recommendations	The Trust Board are asked to NOTE the findings of this report.

Contribution to Inspection, Registration, Performance and Delivery

Risks and Assurance	
Contribution to Key Performance Indicators	
Compliance with Clinical and other Governance Requirements	

Impact Assessment

Quality	
Financial	
Workforce	
Legislation and Policy	
Equality and Diversity	
Communication and Marketing	

Engagement and Decision-Making Process

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Trust Board May 26th 2011

Quality Report

1.0 Introduction

In national definitions of Quality, the three areas defined nationally are Patient safety, patient experience and clinical effectiveness and outcomes.

The Quality and Safety Committee was established in order to provide a formal process for the Trust to focus on the detail of all three of these elements, to understand the trends and themes and to keep the Board briefed on any key areas of concern or trends and themes that need to be understood.

2.0 Purpose

The Board will, through the monthly Board performance report be able to track the performance on key areas of quality and safety with the Annual Quality Account process established which provides a high level view of performance and outcomes for Quality improvements. However, the Quality and Safety Committee want to be able to reflect a Quarterly position on key issues that provide the wider Board with a position of the three elements of Quality. This report provides the first of these Quality reports.

3.0 Patient Safety

3.1 Tissue Viability

Within the monthly Quality report to the Quality and Safety Committee, there has been significant focus on the improvements required on Tissue Viability and falls which are clear patient safety issues. To ensure that the improvement programme is clear and unequivocal, the Trust commissioned an internal review of all grade 3 & 4 pressure sores in the last year (33). The report commissioned by the Chief Nurse/Director of Quality and Safety required a case note review of each patient who had a pressure sore (Grade 3 or 4) with a review of the care prior to sustaining a pressure sore, the plan put in place to improve the care provided for that patient and to assess the confidence in care provision and the outcomes of the pressure sore on discharge. The report in Appendix 1 provides the full report and recommendations.

3.2 Ward Assurance process established to provide a baseline in care provided at ward level

This section provides an update on the findings and ongoing progress in providing the Board with assurances or identified gaps around the provision of patient care delivery within the Trust.

The Senior Nursing team commenced a process of review in January 2011 under the leadership of the Chief Nurse/Director of Quality and Safety. The initial process was identified to provide a baseline position about care delivery and has continued to date in order to review and audit a range of nursing practice in wards which has provided valuable data for patient care delivery. The team has identified trust wide nursing practice that needs improvement and development as well as highlighting specific wards where the confidence around the consistency of care delivery is not assured.

In response to trends around complaints, pressure ulcer acquisition, inpatient falls and serious concerns from patients and relatives a significant number of in depth reviews have taken place

from December 2010 onwards. Each in depth review takes between four and six hours to complete.

The in depth reviews have identified consistent themes across the wards where improvements and development s are required. Specifically:-

- The completion and accuracy of nursing documentation
- Bedside handovers require a Trust wide approach to ensure improved engagement of patients and to capture and discuss the care needs of patients in a systematic and consistent manner.

Feedback from patients and relatives on these reviews remains positive and there is evidence of accurate and appropriate care delivery.

There is a need to continue to monitor and report on a wide range of quality indicators so we can identify and recognise areas that require additional support, education and training to meet expected trust wide standards. These audits will continue over the following months to gain assurances and confidence that care delivery is sustainable and consistent across the organisation. The information will also be used to triangulate with other sources of feedback on care delivery and the Quality and safety Committee will progress this development.

4.0 Clinical Effectiveness – An Update on Mortality

4.1 Introduction

Mortality has been given a top priority for the Trust.

From now we will monitor our progress against this target through 2 key measures:

HSMR – A standard national measure gives a risk based on comparing actual deaths with expected deaths for 56 of the main diagnosis. It takes into account case mix and includes deaths in community hospitals if the Patient is directly transferred to them from SaTH.

Crude rate of Deaths – This is the total in-hospital deaths.

The baseline for our measures is the latest full year as reported in April 2011.

4.2 Current Status

The current status for April 2011 is:

Mortality Measure Month 1 April 2011	
Measure	SaTH
Baseline Crude rate of deaths	1782
Year to date Crude rate of deaths	151
Difference YTD from last year	-4
Baseline year HSMR (Re-based)	116.2
Year to Date HSMR (Re-based)	115.1
In Month HSMR (Re-based)	111.4

4.3 Ongoing and Future Actions

Outside of the LIPS programme, the focus of investigation and action at the moment is to reduce the HSMR at PRH and consolidate coding improvements consistently across both sites.

The actions are:

1. Understand if there are still differences between coding practices at the 2 hospitals. Patient notes from 50 deaths at RSH and 50 at PRH will be re-coded on the other site by 25th May. Any relevant differences can then be established.
2. A review of notes for a specific subset (Age 85+) of Patient deaths at PRH as well as general patients to understand any clinical learning.
3. An in depth review of our top 10 diagnosis codes within the HSMR basket against 6 peer Hospitals to identify significant differences.
4. To conduct a review of notes for Patients who died that week at PRH by a Consultant and Clinical Coder to ensure correct coding and derive any abnormal patterns in clinical care.

4.4 Dependencies

Any reduction in the crude rate of deaths will be dependant on the clinical initiatives delivered through the LIPS programme.

5.0 Patient Experience

5.1 Complaints

From February 2011 to the end of March 2011 the trust received 119 formal complaints over the three divisions and estates with the break down as follows:-

	Q3	Q4	Total
Admin/Clerical	11	15	26
Attitude	20	18	28
Breach of Confidentiality	0	3	3
Inadequate discharge	5	15	20
Inadequate Medical care	25	23	48
Inadequate nursing care	8	11	19
Inadequate support services	0	5	5
Lack of communication	23	21	44
Lack of medical care	18	11	29
Lack of nursing care	6	8	14
Patient accident	4	1	5
Unpleasant Environment	3	3	6

Waiting time for appointment	13	11	24
Other	10	7	17

The following are key areas for complaints:

- Inadequate/Lack Nursing care
- Inadequate/Lack Medical Care
- Inadequate discharges
- Communication/attitude
- Waiting time/appointment

There were a notable number of complaints in admission areas.

- MAU RSH X3
- MAU PRH X2
- A/E RSH X4
- A/E PRH X4
- SAU/WARD 12 X2

Other areas with 2 or more complaints were Ward 28, 27, 8, and Gynaecology.

Although there are still concerns about appointments in Quarters 3&4 there has been a reduction in the number of complaints following the introduction of a revised system in which appointment letters are only sent out 4 weeks before the appointments which has resulted in less correspondence about cancelled appointments.

Whilst the number of complaints has not increased this year in comparison to last year, the severity of the concerns has increased in the last two quarters, particularly with regards to the safety of the discharge.

In response to complaints the following actions have taken place to improve services:-

- Nurse led handovers have been improved by being undertaken at the bedside with the full involvement of the patient. "Comfort rounds" have also been introduced to ensure that those patients who are unable to articulate their needs have them met proactively.
- Regular comfort rounds have been introduced to ensure that staff are checking if patient's need to use the toilet
- Lighting at night on MAU being reviewed in order to try and reduce falls
- Appointment letters are now being sent out 4 weeks before appt time to reduce cancellations
- Customer care training was arranged for some staff who had concerns raised about their attitude
- New system for delivery of request cards for scans to improve services
- Oncology appointment letters now sent from Oncology and first class
- Child Protections sheets are no longer attached to the outside of a patient's file to improve confidentiality
- A training event has taken place for A&E doctors which included training on unusual findings of patients so that staff can improve on identification of seriously ill patients.

5.2 PALS

	Q3	Unresolved to formal complaint	Q4	Unresolved to formal complaint
RSH	252	21(8.3%	225	13(5.7%)
PRH	198	2 (1%)	206	10 (4.8 %)

The majority of PALS are resolved without going to a formal complaint.

The following areas are those that patients most frequently went to PALS to express concerns about in Q 3/4:-

- Appointments
- Admission transfer and discharge issue
- Communication
- Information
- Staff Attitude
- Waiting times

In Q4 there has been a notable increase in complaints in respect of valuable and property.

In response to PALS the following improvements have been made:-

- Facilities are increasing the signage for public telephones in the Trust
- Service Delivery Manager and pre-op nurses have improved the system of communication when patients are taking warfarin and the admission is cancelled and then re booked
- Visitor to the Trust witnessed the tug being driven in corridor and the tug was dirty, with blood stained tissues in the bottom of the cages. Cages will now be cleaned out regularly
- A patient's relative pointed out that the water in the side rooms on the wards isn't drinking water. Signs have now been put on the basins on the wards by Estates
- A property and valuables policy is currently being drafted to ensure staffs follow standard operating procedures.

5.3 CQC Annual Inpatient Survey

Results from the CQC Annual Inpatient Survey were published on Thursday 21st April. This is reported in full as a separate agenda item.

In summary, an initial review of the ratings identified that we score similar to other hospitals across England and that we have scored marginally higher on overall standards of care in our hospitals in 2010 compared to 2009. However the surveys have identified areas for development and opportunities to learn and improve on the standards of care we provide. Triangulating this to other sources of patient feedback is essential and will be a key action for the Quality and Safety Committee.

5.4 Monthly patient experience Surveys

In February we commenced monthly patient surveys in all our inpatient wards. The Clinical Nurse Specialists are supporting this piece of work by completing a face to face survey with 6 patients a month in each ward. The aim is that these real time audits will enable staff to continually reflect on patient feedback, provide us with greater opportunities to act quickly on

the results to change and improve practice speedily but also to recognise and acknowledge good practice.

The detailed results from the audits for February and March have just been released and require closer analysis for trends and themes but an initial over view has identified that there is positive patient feedback in the following areas:-

- Being treated with respect, dignity and privacy
- Cleanliness of the environment
- Observations of Hand Hygiene
- Patient being able to raise questions and being listened too about their care and treatment
- Care and management of pain.

Areas for further development and improvements are:-

- Greater information and discussion on medication needs side effects etc.
- Discharge planning and information
- Meeting and supporting religious and spiritual beliefs
- Disturbance of noise at nights.

5.5 National Cancer Patient Experience Survey

In 2010 the National Cancer Patient Experience Survey was designed with the aim to support the monitoring of progress on cancer care and to provide information that could be used to drive local quality improvements.

All adult patients (aged 16 and over) with a primary diagnosis of cancer, between 1st January 2010 and 31st March 2010 at SaTH were invited to participate in the survey.

769 patients from this Trust were sent a survey, 521 questionnaires were returned completed. This represents a response rate of 73%. Patients were invited across the full range of cancer (tumour) sites.

The Trust received two reports from the survey, published and unpublished. The Trust was identified as in the top 25% in the country by cancer patients.

In the published report the following key areas were notable:-

The Trust scored in the top 20% in the country for the following areas:-

- Good written and information on a range of issue including side effects, treatment details, support groups financial discharge arrangements and follow up
- Patients had understandable answers to important questions all or most of the time
- Patients given enough emotional support
- Staff did everything to control the side effects of chemotherapy and to control pain
- Patients did not have to wait any more than 30 minutes in the outpatient clinic
- Doctors had the right notes and other documentation with them
- Hospital and community staff always worked well together

Areas for improvement were:

- Making sure that patients are seen as soon as necessary (seeing your GP)
- Feeling they are given a choice of different types of treatment
- Making sure that our staff tells patients they can get free prescriptions
- Patients are always given enough privacy when discussing their condition or treatment

5.6 Taking Patient experience forward

Tracking our commitments to patients through our complaints responses is key to gaining confidence in our ongoing drive for improvements. To support an objective process of analysing patient experience feedback and holding the Trust to account for tracking improvements, the Quality and Safety Committee will be reviewing a proposed Terms of Reference for a Patient Experience Board.

The terms of reference would be that Board members would include patients, patient representatives, external partners & volunteers who want to support improvements in the patient experience. Staff would work with these partners to develop the proactive work required around real time patient feedback as well as other metrics and methods for gaining feedback.

This will then form an objective report process to Quality and Safety Committee.

May 2011

Appendix 1

Internal review into Tissue Viability systems and processes and Outcomes

1.0 Introduction

This paper provides an update on the Trust position in relation to Pressure ulcer acquisition. It provides information on the 33 hospital acquired grade 3/4 pressure ulcers acquired in the Trust in May 2010 – March 2011, specifically looking at what care and management the patient received once the ulcer had been identified. It gives an overview of the progress in relation to key actions taken regarding planning, delivery and effectiveness of care for patients with acquired ulcers both when in hospital and on discharge.

2.0 Background

The Trust reported 33 Grade 3/4 pressure ulcers in 2010 – 2011.

Table 1 provides a breakdown of the number of pressure sores grade 3 or 4 (2010/11 & 2011).

Ward area with grade 3 or 4 pressure sore	Month first recorded	Further pressure sores sustained	Total number of Pressure sores
Ward 8	July	October, December & January	4
Ward 14	June	August, November & January	4
Ward 24	July x2	November	3
Ward 9	January	March	2
Ward 16	July	February	2
Ward 7	May	June	2
Ward 26S	May	October	2
Telford ITU	October	November	2
Ward 28	April	April 2011	2
Apley ward	August	Nil to date	1
MAU (RSH)	September	Nil to date	1
Ward 21	September	Nil to date	1
Ward 10	November	Nil to date	1
Ward 22C	December	Nil to date	1
Ward 27	January	Nil to date	1
Ward 25	February	Nil to date	1
Ward 22SR	March	current	1
Ward 4	March	current	1
Ward 15	February	Nil to date	1

A Root Cause Analysis (RCA) undertaken on these ulcers identified a number of recurring contributing themes.

- Failure to undertake or adequately complete a Waterlow assessment on admission.
- Inadequate documentation of a preventative plan of care and delivery.
- Failure to regularly review and re-assess a patient condition, notably on transfer to other wards.
- A reliance on pressure relieving equipment with a failure to reposition and mobilise patients as often as necessary

- Failings to record or identify ulcers at grade 1/2 and take preventative action to prevent deterioration.
- Delays in referring patients to both the Tissue Viability Nurse and Dietician.

The Trust wide action plan focuses on the key recurring findings. Ward Managers and Matrons are accountable to ensure they implement the actions and recommendations.

A trust wide training, education and surveillance programme to support Tissue Viability Care delivery is being rolled out. Appendix A

3.0 Current position

In April 2011 the Trust reported a 1 Grade 3 ulcer in Ward 28 RSH.

The root cause was identified as a failure to comprehensively and regularly assess and document the patient's skin condition. The ulcer had been acquired on the patient heel. A pressure relieving mattress was in place, the ward had also used a trough to relieve pressure on the heel but poor positioning of the trough had contributed to the acquisition of the ulcer.

4.0 Follow –Up audit

A team of Senior Nurses reviewed the notes of all of the patients who had acquired Grade 3/4 ulcers within SATH from May 2010 to March 2011. Of the 33 sets of notes we were able to gain full access to 28 sets and we specifically explored the care in relation to the issues highlighted within the Trust wide action plan and the documentation of ulcer care when patients were transferred /discharged to another care setting or home.

It be highlighted that we found that nearly all of the patients reviewed had multiple co-morbidities and there were several instances where it was difficult to gain a full review of post-ulcer care delivery as the patient had either been transferred/ discharged from the hospital or had sadly died within a day or two of the identification of the ulcer.

4.1 Patient Assessments and Care Planning

The audit focused on 3 key assessments, the Waterlow assessments, wound assessments and Nutrition assessments. In most cases patients were found to have appropriate and regular assessments done following the acquisition of their ulcers. Planning of care in relation to assessments was not always done effectively, however, it was noted that the documentation of assessments and the planning of care showed a significant improvement following the introduction of the new documentation tool in November.

4.2 Patient Care

In most cases appropriate pressure relieving mattress equipment was utilised but there were still some gaps in the use of pressure relieving cushions being used for patents who sat out of bed.

In the latter part of the year there was evidence of the use of patient turning charts. However there remained variability in how well these charts were completed.

Documentation of wounds and wound care was evident and it was pleasing to note that for several patients their ulcers had either healed or were in the process of healing.

Patients had fluid and food charts in situ but many were inadequately completed and therefore we were not able to ascertain from this if patients nutrition/ hydration care needs were adequately addressed.

4.3 Input from Specialist Tissue Viability Nurse and Dietician

Review by the Tissue viability specialist Nurse was sporadic and some of this may have been due to lack of referral from ward areas but some may be due to the limited availability of the resource over the period in question.

There was very little documentation to support that when patients were highlighted as needing a dietetic review this actually occurring.

4.4 Patient Transfer/Discharge

There was evidence of some excellent discharge communication and information in respect of tissue viability, but whilst it is recognised that patients do have transfer/ discharge forms completed by nursing teams, these were not always photocopied and in evidence in the patients notes making it difficult to ascertain the levels of communication on all occasions.

In only 4 cases did we see that the patients' ulcers had been photographed and kept in their notes for future reference.

5.0 Conclusions and Recommendations

The review of documentation did identify that in the vast majority of cases there was evidence of appropriate care delivery and management following identification of the pressure ulcer. It is encouraging that patients appear to be having regular assessments and delivery of timely nursing care, there is evidence of pressure ulcers healing. There is still work to do regarding documentation of this care delivery and the referral to dietetic support services.

The audit also identifies a need for further ongoing and sustainable work to improve patient care planning and documentation on discharge to ensure that patients leaving our care are supported with their care needs. The use of photographic evidence needs to be strengthened to ensure we have visible documentation for future reference.

The Trust is increasing its specialist tissue viability nursing resource at the end of May and this will continue to provide the Nursing teams correct advice and support to both prevent and treat pressure ulcers.

Appendix 2

Ward Assurance Report

Since the 20th December the Senior Nursing team comprising of the Director of Quality and Safety/Chief Nurse, Head of Nursing Practice, Divisional Lead Nurses and Matrons have undertaken quality visits to all of the medical and surgical wards in the Trust.

The visits have reviewed and audited a range of nursing practices to identify any areas of concern and to seek assurances about the quality of care delivery and patient safety. The reviews have included the following key areas:

- Overall impressions of wards in terms of cleanliness, tidiness, attitude and receptiveness of staff.
- Overall appearance of patients including evidence of patients wearing identification wrists band, accessibility to drinks, call bells and hand gel.
- Review of 8/10 sets of nursing documentation looking at completion of risk assessments and evidence of documented care planning for Waterlow (Tissue Viability) , Falls Risk Assessment for the Elderly (FRASe), Bedrails and Nutrition.
- Completion of fluid balance charts.
- Legible prescription charts.
- Recording of patients vital signs on Vitalpac and care planning review and response where patient observations have triggered and early warning score (EWS).
- Talking to qualified and unqualified staff approached to gain assurances of care delivery and to ascertain their understanding for preventive actions for tissue viability and falls, meeting patient nutritional needs (including review of food charts/use of red tray system) and appropriate action in response to abnormal observations (Vitalpac).
- Talking to patients and relatives to enquire about perceptions of care delivery, helpfulness of staff, ability to talk to staff and the receiving of appropriate and timely information.
- Observation of nurse led patient handover between shifts.
- Review of ward checks for the cardiac arrest trolley, controlled drugs book, domestic cleaning list and housekeeper environmental check lists.
- Exploring staffing issues including the management of staff absence.
- Review of the department process for team meetings and escalation of communication and information.
- Review of the management of patient/relative complaints and the process in place for communicating information to teams.

Following each visit the Ward Manager and Matron have been sent a summary of the key findings outlining both good practice and areas for development and improvement.

3.0 Key Findings

The in depth reviews continue to reinforce the issues that were indentified from the preliminary visits and the areas requiring improvement are, in general, consistent across the wards.

The introduction of the new nursing documentation provided reviewers assurances that there has been a significant improvement in the completion of accurate patient risk assessments.

Completion of nursing assessment documentation is improving but accuracy of initial assessment and ongoing care planning needs to be strengthened. The current roll out of further education on the new nursing documentation will support this function.

There is evidence of appropriate care delivery but this is not always reflected in the documentation.

There is evidence of preventative actions being taken for patients at high risk of pressure ulcers and falls. Further work is required to ensure staff are more alerted and take greater preventive action for patients who are generating a medium rather than a high risk score.

Qualified and unqualified staff were able to describe the systems and processes to be followed following completion of risk assessments.

Health care assistants were aware of the need to escalate concerns about patients to registered staff. In some areas there is a need to gain greater assurances that the registered staff are checking care delivery and not relying entirely on the health care assistants' actions.

The majority of staff were aware of the "Red Tray" system and there was positive evidence of the use of food charts and patients being supported with eating. In some areas staff reported that in periods of high workload and in particularly in the evenings the availability of staff to feed patients could be challenging.

The accurate completion and appropriate use of fluid charts was an area for improvement in several areas and needs to be addressed Trust wide.

There is a weakness in ward handovers with evidence of limited involvement of the patient at the bedside. The delivery of handovers is not systematic in its approach and fails to fully discuss and identify the nursing needs of patients. Staff after handover did not appear to have the same consistent message about the needs of the patient. In the MAU the handover is very medically orientated.

Communication between the Registered Nurses (RN) and Health Care Assistants (HCA) needs development to ensure that HCA's are receiving clearer direction from the RN on care delivery needs. RN need to gain and give greater assurances that care delivery is timely and appropriate.

Discharge planning needs greater development both in terms of assessment on admission, EDD and ongoing review and action. Nursing staff, in general, confirmed that EDD is led by the nursing team with minimal involvement by the medical teams.

Completion of hemodynamic observations was by and large timely and complete.

On positive note the wards looked clean and generally tidy and patients well cared for with examples of excellent care delivery.

Staff were receptive and helpful and open to constructive feedback and suggestions for improvements.

Feedback from patient and relatives was positive and complementary about the nursing and medical teams. Some patients felt they could be better informed and engagement with patients at bedside handover would support this.

3.1 Identified areas for improvement

- A review on the accurate completion and use of fluid balance charts and the introduction of a trust wide fluid chart
- Ongoing education and training for completing nurse documentation
- Further work on documented evidence of preventative care planning
- Embedding preventative care delivery
- To look at strategies to support the feeding of patients to include protected mealtimes and flexible use of a range of staff
- To strategically review the care and management of the elderly dementia patients
- To review how we can improve on timely communication with patients and relatives

4.0 Next Steps

We need to continue to build up a picture of care delivery through robust monitoring of key quality indicators. The requirement for continued review and assessment is now being embraced by the Ward Managers and Matrons who are undertaking daily and weekly review of their areas. This ongoing scrutiny of practice will help to continue to detect areas for improvement, check on progress as well as identify areas of good practice.

Lynn Atkin (Lead Nurse Division 3)