TRUST BOARD IN PUBLIC	Date: 19 December 2013 Agenda Item: 2.3
REPORT TITLE:	**Joint Chief Nurse and Medical Director's Report**
EXECUTIVE SPONSOR:	**Fiona Allsop, Chief Nurse Dr Des Holden, Medical Director**
REPORT AUTHOR:	**Des Holden, Medical Director Sally Brittain, Deputy Chief Nurse**
REPORT DISCUSSED PREVIOUSLY: (name of sub-committee/group & date)	N/A

Purpose of the Report and Action Required:		(√)
An update of on-going work in relation to safe and quality patient care that sits out with the operational performance reports.	**Approval**	
	Discussion	√
	Information/Assurance	(√)

Summary: (Key Issues)

1. The recent trial of the MEWS and key areas for further development reported.
2. Update of PUD for November
3. The Trust performance in Q1 and Q2 for falls indicates;
   a. A reduction in the number of falls in Q2
   b. Good performance against the national falls rate per 1000 bed days
4. The Audit of the Falls Policy shows;
   a. Areas for improvement related to documentation and the purchase of additional equipment

Relationship to Trust Corporate Objectives & Assurance Framework:

Central to the delivery of safe and quality patient care.

Corporate Impact Assessment:	
Legal and regulatory implications	NONE identified currently
Financial implications	YES – but have been agreed via the relevant governance channels
Patient Experience/Engagement	YES – key and will require to be robustly demonstrated
Risk & Performance Management	YES – key and will require to be robustly demonstrated
NHS Constitution/Equality & Diversity/Communication	YES – key and will require to be robustly demonstrated

1. Early Warning Score Pilot

As reported in the November Board Report a pilot of the new Early Warning Score commenced on Copthorne and Charlwood on 4 December 2013. The results of this pilot are now available.

Background
Early warning scores were devised to assist in the early detection of deteriorating patients. The scores are based on the premise that there is a common physiological pathway for deterioration in acutely unwell patients. Accurate and timely observations and adherence to early warning scoring systems are crucial in identifying those patients at risk of deterioration.

NICE (2007) published national recommendations urging the use of early warning scoring systems. In 2012 the Royal College of Physicians published a National Early Warning Score (NEWS) tool. This has been adopted by Surrey and Sussex Healthcare Trust and in 2013 following response to recommendations from SI reports the Modified Early Warning Score (MEWS) tool was developed and a pilot commenced on Copthorne and Charlwood wards.

An audit of 10 sets of patient notes following this pilot demonstrated the following:

Patient identification:
100% of the charts had the patients name clearly identified and 90% had the ward area documented. Only 1 patient had their MRN number written on their chart.

Frequency of observations:
90% of patients had a set of vital signs recorded at the minimum recommendation of 12hrly (Nice 2007) and the frequency of observations were increased in 100% of cases in response to the detection of abnormal physiology.

Documentation:
99% of records had clearly completed documentation and a complete set of vital signs was recorded at every stage. In 9% of entries the respiratory rate was not included in the vital signs.

Staff are not recording the date every time vital signs are documented as is best practice, instead a date is being entered for the beginning of that day. Only 27% of entries have a corresponding date.

The MEWS was calculated in 95% of entries and of these 98% were correct.

Urine output was not recorded at every set of observations. 75% of those patients identified as requiring a urine output score had observations recorded regularly. 1 patient had not had a urine output score recorded.

Escalation:
There was no documented evidence in either the nursing or medical notes that escalation specifically related to an elevated MEWS score had taken place.

In the medical notes the medical staff continued to record vital signs and did not document MEWS as part of the ward round or review of the patient in response to escalation.

The ward round checklist sticker was present in one set of notes. This sticker indicates if the chart has been reviewed it not does not require the MEWS score to be recorded.

One patient had a review on two occasions by the MET team. In this case only the patient's observations were recorded not the MEWS score.

Summary:
Overall the quality, legibility and consistency of the documentation of vital signs were good. Verbal feedback from staff around the pilot chart suggests that improvements can be made to provide further clarity about documentation.

Escalation of a deteriorating patient is occurring; however work is needed with both the nursing and medical teams around the documentation and escalation of deteriorating patient using the MEWS as the trigger for response and review.

Recommendations:
1. An actual MEWS is requested on the ward round checklist which is comparable to the MEWS from the preceding day.
2. Re-launch of the SBAR (Situation, Background, Assessment & Recommendations) escalation tool - a communication tool to assist staff in clearly and concisely communicating concerns to the MDT which then forms part of the medical notes. Copies of this form are available to the meeting for review and to provide a greater understanding.

2. Pressure Ulcer Update

The Trust's hospital acquired pressure ulcers were reported in detail within the last Board Report however for assurance the incidence of pressure damage within the Trust remains low with no hospital acquired grade 3 or 4 pressure damage.

3. Falls Prevention Update

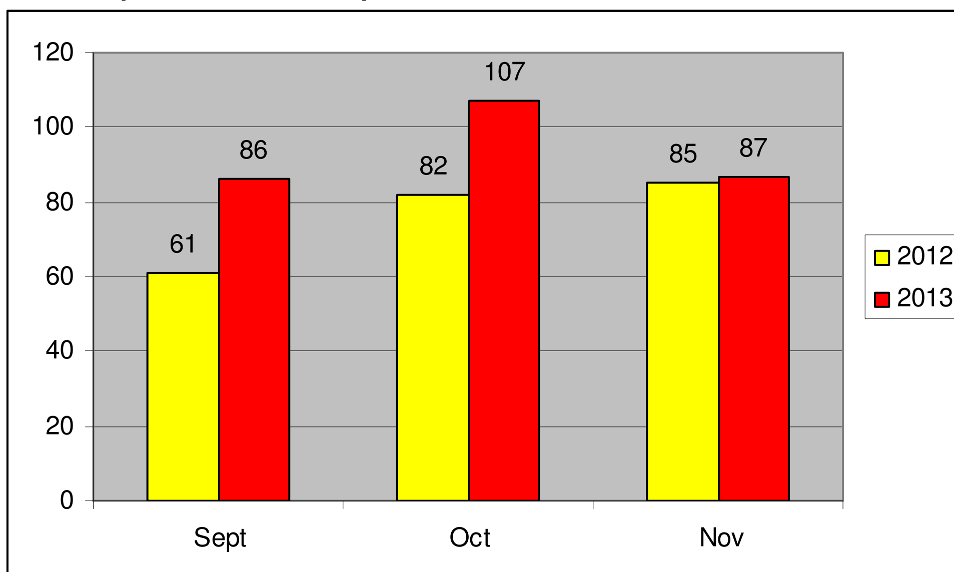
This report covers the period of 1 September 2013 to 30 October 2013 with comparison of previous data where appropriate.

Incident reporting
Analysis of the incidents of falls for this period is based on the information provided by the Datix reporting system.

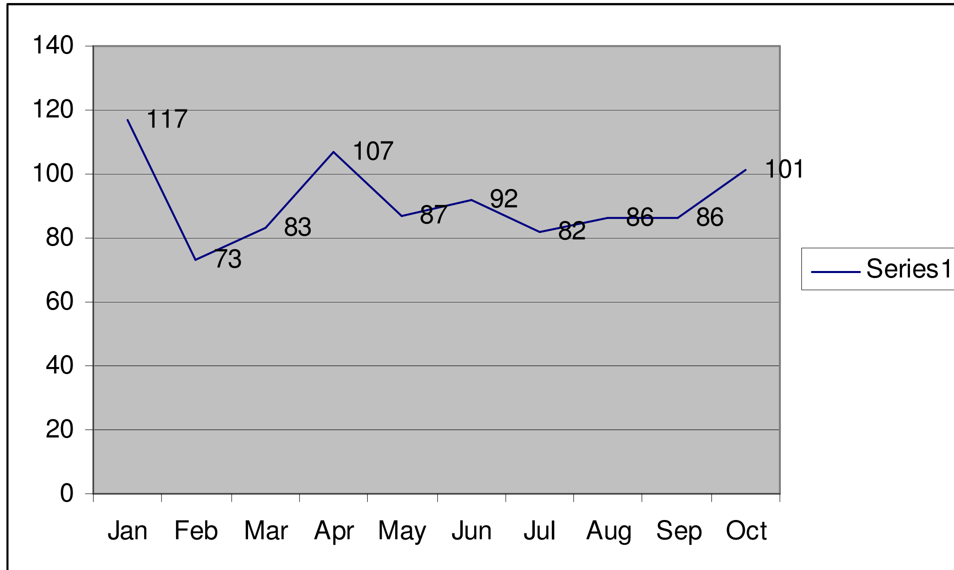
The reported number of falls was 86 in September, 107 in October and 87 in November.

The table below gives a comparison with the same period last year

Falls comparison with same period 2012



Falls Reported year to Date 2013

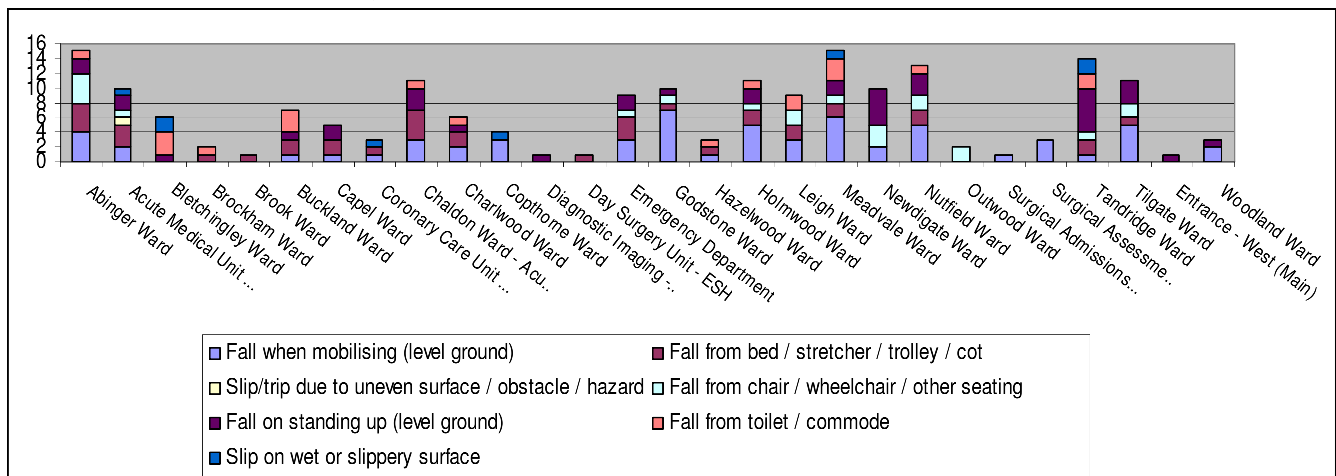


The number of falls per month is fairly static with an average of 100 falls reported in month. It should be noted that benchmarking against other Trusts indicates that an average of 80 falls against a 550 bed base is relatively low. Overall SaSH remains well below the national average for falls (120 per month).

The National Average Falls rate per 1000 bed days is 4.8.

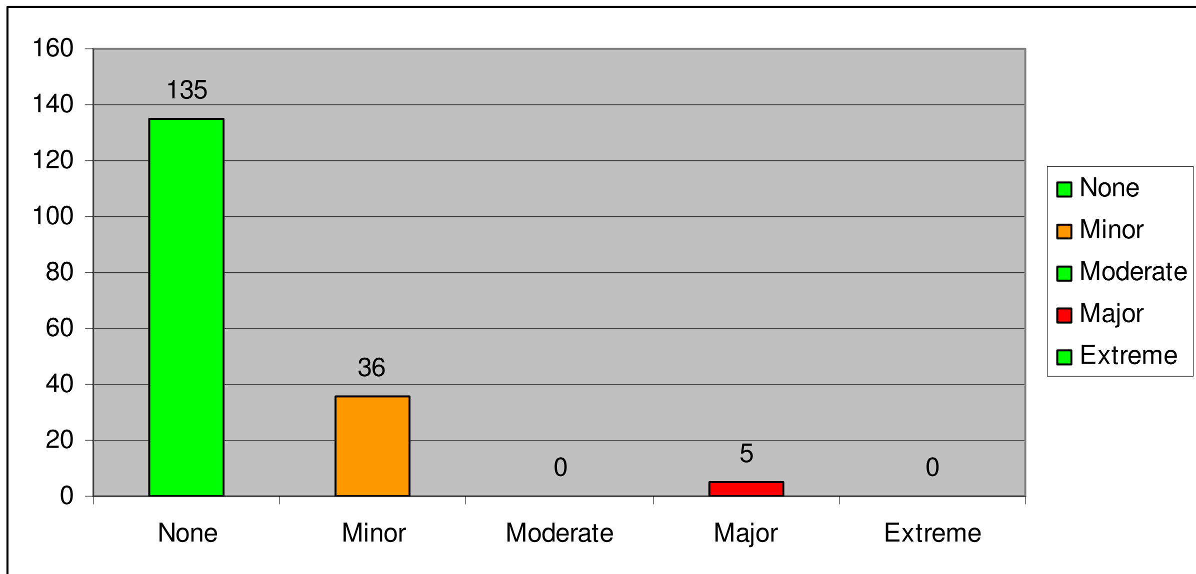
SaSH Falls rate per bed days in 2011-12 was 2.59 and 2012-13 was 2.41 which remains below the national average and demonstrates improvement.

Falls by department and fall type September 2013 – November 2013



Wards with high number of falls have been identified and FPL has reviewed September/October fall profile with Matrons of the areas and ward managers.

Fall by consequence (level of harm)



Serious Incident investigations

There are currently 6 SI's being investigated where patients experienced severe or significant harm.

Themes identified from SI's include:

1. Falls Pathway not being completed fully and not within the timeframe required by the policy.
2. Patients falling are complex often with pre-existing confusional states.
3. Application of the available falls prevention strategies needs to be improved

Actions that remain outstanding relate to:

1. The implementation of falls sensor monitors – business case has been completed for capital funding
2. The review of the falls pathway and roll out - this will be completed by 19th December
3. Doctors training - copies of the signed registers requested from PGMC,

Equipment Issues
Falls Sensors -A business case has been completed to purchase 60 sensors to alert staff that patients at risk of falling are becoming mobile and was presented to the Capital Bids Group on 18th November however it was not approved due to lack of funding and has been held over to await further discussion.
Crash mats - it was requested that a further 60 crash mats be added to bed contract variance, the Trust is awaiting confirmation of this.

4. Patient Falls Audit - Policy Compliance Audit
An audit program for patient falls has been registered with the Trust Audit program.
Two Audits have subsequently been undertaken.

A) The use of blue pillow slips.
The aim of this audit was to identify if the agreed identifier for patients at risk of falls was being used consistently and appropriately, and whether patients at risk of falls were being identified at handover.

The audit results identified: that the use of blue pillow slips was inconsistent and variable however it was reported that availability was an issue. In all but three wards patients at risk of falling were identified on the staff handover sheet, this was reported to the ward manager for action.

The audit was expanded to include the delivery of the blue pillow slips and this identified that the number of blue pillow slips available for the falls profile of the Trust is insufficient.

Recommendations
The delivery and stock of blue pillow cases be reviewed - it has been identified that the purchase of 2000 further pillow cases is needed. There is a cost implication for this; the Falls' group has been asked to consider an alternative for identifying patients at risk of falls

B. Compliance with the Inpatient Slips, Trips and Falls Policy.
The Purpose of the Audit was to determine whether:

1. Patient areas were compliant with key processes within the policy
2. Staff were aware the post fall protocol
3. Patient areas were compliant with training

Twenty one patient areas were audited over a three week period in October 2013. Maternity areas were not audited.

	Patient notes reviewed		Staff interviewed
Total for Trust	105	Total for Trust	102
Medical Division	60	Medical Division	62
Surgical Division	45	Surgical Division	40

The staff questioned included a range of grades and professions (nurse, HCA, Physio, OT, doctors)

The Audit Results:

The Trust is mainly compliant with key process for inpatient Falls Management. All patients have a falls pathway and that it updated either following a fall or within 7 days.

It is clear that there needs to improvement in the following areas
1. Recording of the patients fall, in the nursing and medical notes and the completion of the incident form.
2. The undertaking of post fall review by doctors.
3. Informing of the relatives of the patients fall
4. Awareness of the Falls Prevention Lead and role.

Recommendations:

1. Falls training continues to be included in all Falls Prevention training.
2. The post fall protocol be included in the Induction packs for new Doctors and awareness is raised through the clinical teams.
3. A system is developed for ensuring relatives are informed of the patients' fall, particular when it has occurred out of standard office hours.
4. Awareness of the falls prevention lead post and how to contact her should be improved following the roll out of the updated pathway as there is a prompt within the paperwork for referring patients as needed.
5. A memo be sent to the wards with the contact details for the Falls Prevention Lead

Further audits are planned; these will include the quality of the post fall review and documentation

Action Plan

Actions to achieve Recommendations	Priority	Level for action	Action Owner (Name)	Due Date	Monitoring arrangements	Evidence of completion
Inclusion of the post fall requirements to be included in the doctors induction pack	High	Strategic	FPL and Falls clinical lead	1 Feb 2014	Falls group	Email from PGEC conforming inclusion
Clinical Leads to raise requirements for post fall review with teams	High	Divisional	Clinical Leads	30 Dec 2013	Divisional management board	Confirmation from clinical leads with dates undertaken
Matrons ward managers to high light to ward teams importance of documentation	Moderate	Divisional	Matrons and ward manages	30 Dec 2013	Divisional management board	Confirmation from matrons/ward managers with dates undertaken
System for ensuring relatives are informed of patients fall and that this is accurate recording	High	Strategic	FPL/ Falls Group	30 Jan 2014	Falls group	Protocol ratified
Re Audit compliance 6 months	Mod	strategic	BCAS	30 July 2014		Audit results

Infection prevention

Since the last Trust Board we have hosted visits from the TDA infection control lead who reviewed all 22 CDiff cases we have reported this year, the RCA we have undertaken, and the actions we have recently introduced. She supported our processes and thought that we would see an impact in case numbers although she was unsure when this would be apparent. She confirmed that none of the actions we were taking was inconsistent with good practice or out of line with what other organisations she had been invited in to were doing. She encouraged us to open a dialogue with commissioners, siting many other trusts who have done this productively, to gain agreement where fines might be waived if care had been optimal and the patient still developed CDI.

Since that meeting we have changed the antibiotic formulary and prescribing guidance, purchased an app for smart phones which allows the guidance to be updated very easily and to be available on everyone's hand held device, and taken delivery of stocks of temocillin, an antibiotic associated with much lower rates of diarrhoea and CDI.

At time of writing, CDI numbers for this year remain 22.

Clinical cabinet

E hosted the second meeting of the local health economy clinical cabinet. This was well attended with medical and nursing leads for quality from CCGs and our clinical chiefs.
The main focus was on the stroke pathway and there was broad agreement that all parts of the pathway merited attention, including pre-hospital risk assessments, diagnosis of atrial fibrillation, and anticoagulation; care for the mildest and the most severe strokes whilst admitted, the use of metrics to describe performance and discharge to rehabilitation capacity in both Sussex and surrey.

The meeting will happen monthly and will have themes developed either through the CQPM and SPC, or by agreement within the cabinet itself.

KSS Clinical Senate

This group met two weeks ago and has decided that the first cross counties work it will lead on is advanced care planning for patients nearing end of life. There are many challenges in this area of health care provision including difficulties patients who have made plans experience when traversing primary/ community and secondary care boundaries.