West Hertfordshire Hospitals NHS
NHS Trust

TRUST BOARD MEETING – 31 March 2011

Title of the Paper:	**Measuring Quality- Nursing & Midwifery Quality Indicators**
Agenda item:	**39/11**
Author:	**Natalie Forrest, Director of Nursing**
Trust Objective:	Provide safe patient care Improve outcomes and quality of care Improve the patient experience

Purpose

To provide the Trust Board with information and data on key quality indicators within in patient services.

Risk Implications for the Trust(*including any clinical and financial consequences):*	**Mitigating Actions** *(Controls):*

Level of Assurance that can be given to the Trust Board from the report [significant, sufficient, limited, none]:

Sufficient with plans for improvement identified

Links to Key Line of Enquiry (KLOE 1 - 5)

Legal Implications:

None

Recommendation to the Trust Board:

For information and noting.

West Hertfordshire Hospitals NHS
NHS Trust

Agenda 39/11

Nursing Quality Indicators Report

1. Introduction

This report sets out the performance of the Trust against the agreed Nursing Quality Indicators for the period October 2010 – February 2011.

2. Background

Quality indicators facilitate an understanding of a system and how it can be improved, through accurate measurement and monitoring of performance against agreed standards or benchmarks. They provide a mechanism whereby care providers can be accountable for the quality of their nursing services. The key purpose is to turn valid data into actionable information, which will have a positive impact on quality care provision.

In 2010 the Nursing and Midwifery Senior Management Team agreed the following quality indicators as significant to the quality of care provision within the Trust; consideration has been made of the Trust Patient safety goals, the CQUIN targets, the Chief Nursing Officers High Impact Actions for Nurses and Midwives and the Trust Quality Account.

In order to use these indicators as measures for improvement, targets were set across all divisions providing in patient services.

Quality Indicator	Data Definition	Measure definition
Slips ,Trips & Falls	Reduction in number of falls sustained by people over 65 years of age, resulting in harm.	Physical injury occurs by age band per thousand bed days
Commode audit	Zero tolerance to any unclean commode	Clean commodes
Hand hygiene audit (Nurses)	Zero tolerance to non compliance	95-100% compliance
Pressure ulcers	All patients with a newly developed pressure ulcer following admission to WHHT	50% reduction in Grade 1&2 pressure ulcers Zero tolerance to grade 3&4 Pressure ulcers
Medication errors	Reduction in number of medication incidents	Reduction in number of medication incidents which is resulted in harm

Failure to rescue	Cardiac/respiratory arrest (Excluding ITU, A&E & CCU)	Reduction in number of cardiac/ respiratory arrests
Nutrition	All patients have a nutritional screening assessment recorded on admission or within 24hrs of admission	100% Compliance

Monthly Data collection of the agreed quality indicators commenced October 2010, with the exception of Nutrition which commenced in January 2011.

3. Quality Indicators

Monthly data collection October 2010 – February 2011

Quality Indicator	Oct-10	Nov-10	Dec-10	Jan-11	Feb-11	R.A.G Ratings
Slips Trips & Falls	47	76	57	15	16	R: any increase A :no change G: any decrease
Commode Audit	95%	83%	85%	90%	96.6%	R:<95% A:95%-99.9% G:100%
Hand Hygiene (Nurses)	99.5%	98%	99%	99.5%	98.6%	R:< 90% A:90%-94.9% G:95%-100%
Pressure Ulcers Grades 1&2	29	26	22	39	26	R: > 20 A: 15.1-20 G: 15
Pressure Ulcers Grade 3&4	0	3	4	4	0	R:>1.0 A: 1.0 G: 0
Medication errors	36	29	26	26	22	R: any increase A: no change G:any decrease
Failure to rescue	20	34	29	34	14	R: any increase A: no change G:any decrease
Nutrition				72%	77%	R:< 95% A:95%-99.9% G:100%

The RAG rating system has been used to identify compliance.

Target Reached	
Working towards Target	
Target not reached	

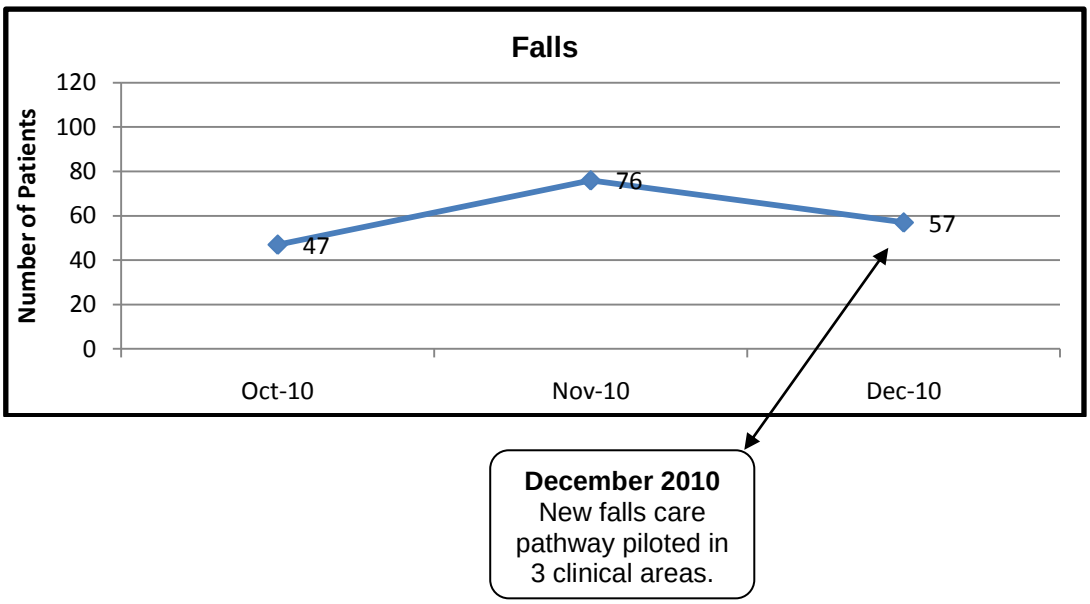
3.1Slips,Trips & Falls

A patient fall is defined as an unplanned / unintentional descent to the floor with injury, regardless of the cause.

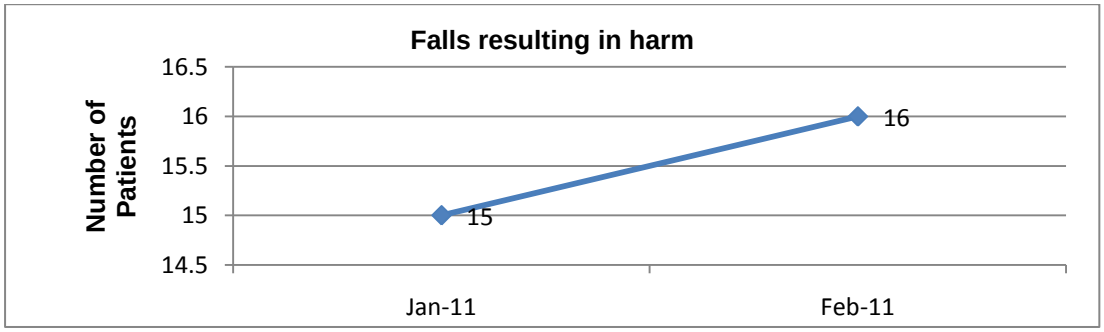
The rationale behind the falls indicator is to capture all those patients over the age of 65 years sustaining injury after falling, to investigate if there are any common denominators for these falls and to take action with the aim to reduce the number of these incidents across the Trust.

The data on falls is gathered from the Datix incident reporting system and collated by the divisional risk leads.

The first 3 months below shows the total number of all falls across the Trust.



The data from January 2011, as detailed below, reflects only the number of falls that have resulted in harm.



The Datix system does not currently have the option to specify the age of the patient so it was not possible to differentiate the age of the patients but enquiry has taken place to see if this will be possible for future reports.

Plan for improvement

- The national institute for clinical excellence (NICE) recommends that the older people who present with a medical condition because of a fall or at risk of falling should receive a multidisciplinary falls assessment.

- A new multidisciplinary falls care pathway was trialed in December 2010 on 3 wards that have a high number of patients over 65 years. The care pathway uses a scoring system, the Morse falls scale, and this indicates the level of risk of that patient falling. For patients identified as high risk a multidisciplinary assessment is then completed and a plan of care agreed.

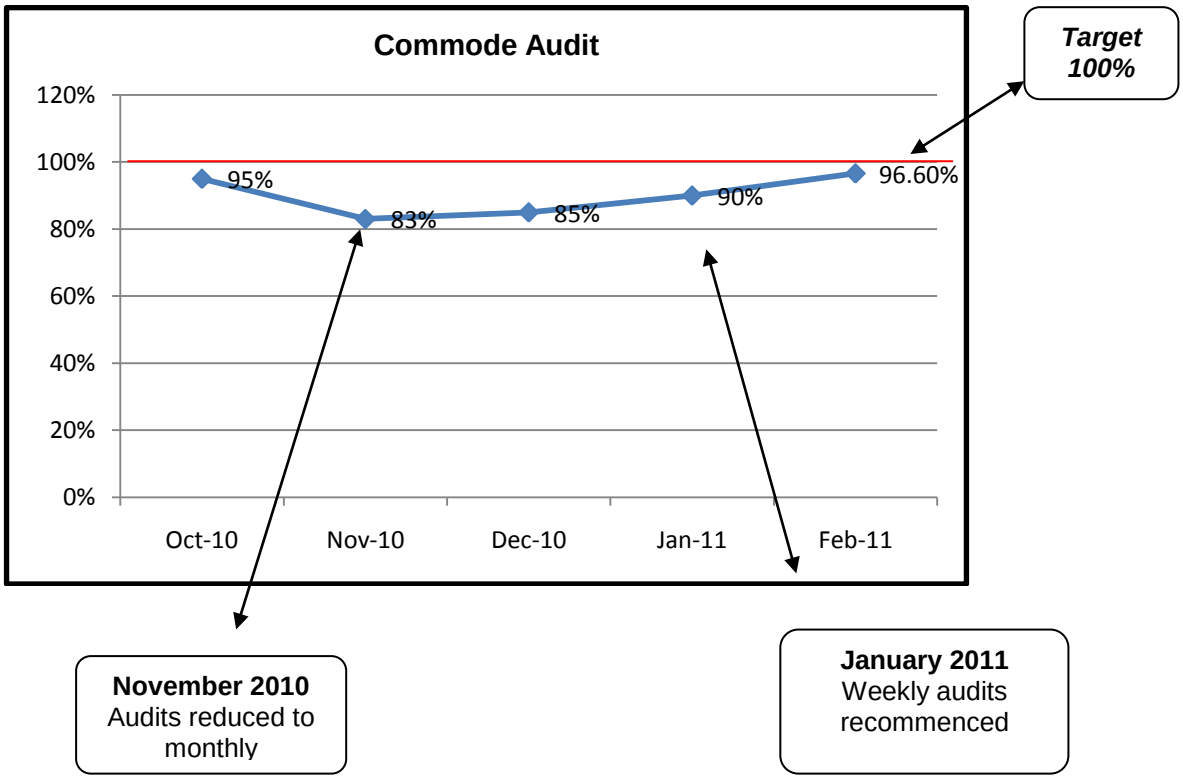
3.2 Commode Audit

All commodes must be left in a clean condition ready for use after each patient use.

A member of the Infection control team carries out a commode audit weekly to check for non-compliance.

The results in October showed good compliance towards this target and it was agreed to reduce the audit to monthly in those areas with 100% compliance.

Unfortunately as the frequency of audits reduced the level of non-compliance increased.



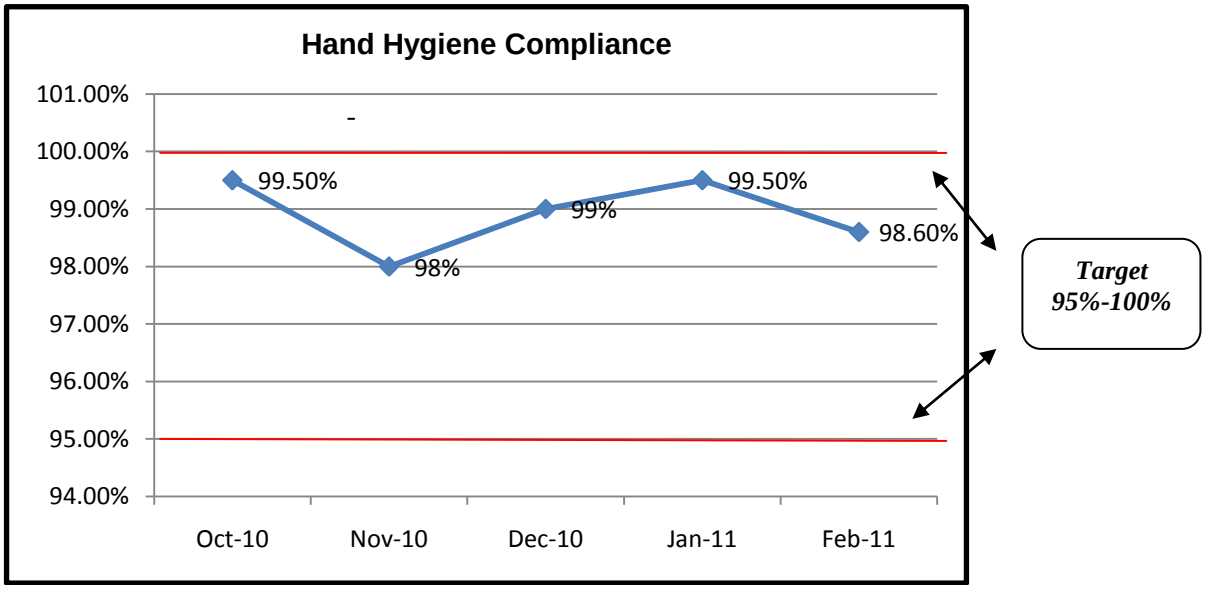
Actions for improvement

- Weekly commode audits reintroduced to all areas
- Zero tolerance to any failure to achieve 100% clean commodes
- Infection control team carry out random ‘clean commode’ checks daily and give feed back to the staff to increase compliance
- Cleaning charts are displayed on the wall where the commodes are cleaned and stored, as reminders of how to clean commodes correctly.

3.3 Hand Hygiene Audit

As part of the Cleanyourhands campaign audits for hand hygiene compliance are carried out weekly by the ward staff. This involves a member of staff observing nursing staff cleaning / washing their hands prior to patient contact or on entering the clinical areas. The percentage of compliance is then calculated.

Target is set for 100% compliance



Actions for improvement

- To continue auditing hand hygiene compliance weekly

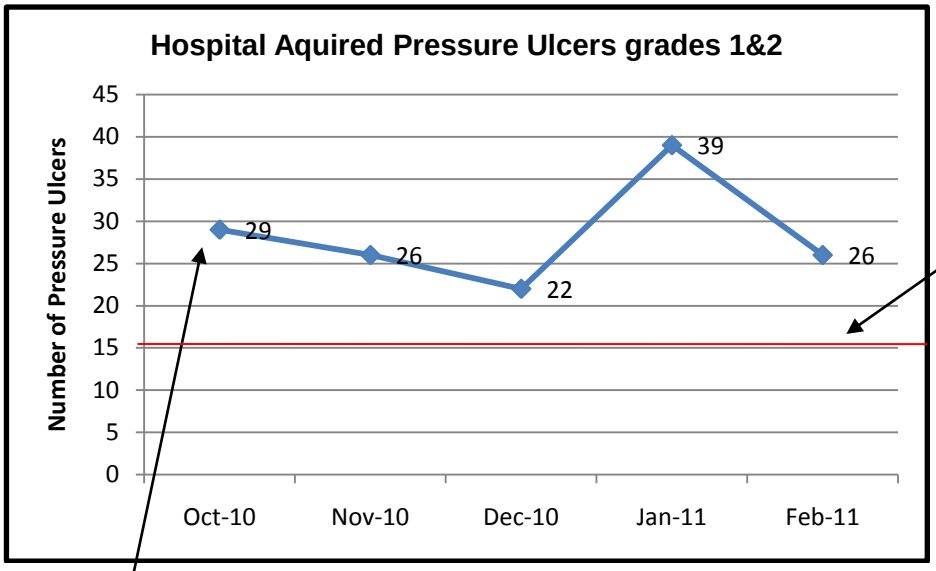
3.4 Hospital Acquired Pressure Ulcers

The Tissue Viability Team monitors the incidence of hospital acquired pressure ulcers on a weekly basis, in order to identify any trends in pressure damage and to assess the effectiveness of treatments plans. The data relates to the number of pressure ulcers that have developed.

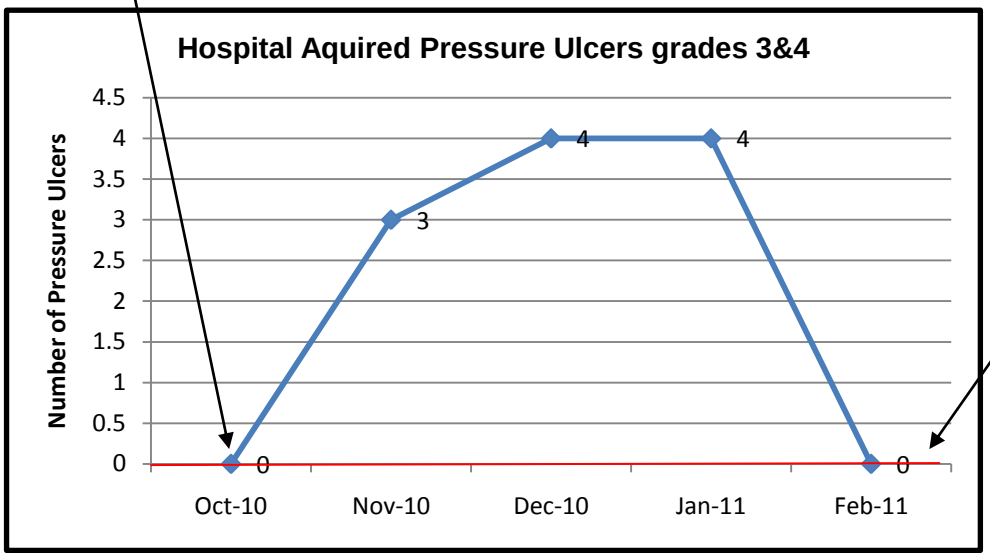
A target has been set to reduce the incidence of Grade 1 and 2 pressure ulcers by 50% and a standard of zero tolerance towards hospital acquired Grade 3 and 4 pressure ulcers.

Between October and December 2010 the data shows a decrease in the number of Trust acquired Grade 1&2.pressure ulcers.

Unfortunately there are no monthly figures for ‘hospital acquired pressure ulcers’ for 2009 to do a comparison over the same time period as monthly data has only been documented from April 2010.



October 2010
Pressure Ulcer Summit



Actions for improvement

- A pressure ulcer summit was held in October 2010. This summit was well attended by many professionals across the Trust keen to discuss and develop systems that will assist in reducing the risk of a patient developing a pressure ulcer whilst in hospital.

- Matrons have to demonstrate a reduction in pressure ulcers developments within the Trust as part of the High Impact Actions.

- Matrons in Medicine & Surgery attend monthly quality indicators meetings where they discuss the pressure ulcers acquired within their own divisions.

- All hospital acquired pressure ulcers of grades 3 &4 are entered into Datix and reported as Serious Incidents. A Root Cause Analysis (RCA) investigation is completed and action plans developed.

- The Medical directorate use safety crosses on all wards to monitor the incidence of pressure ulcers acquired in each area daily.

- The Tissue Viability Team and the Equipment Library staff work together to monitor appropriate usage of the pressure relieving equipment available.

- Cardboard clocks by patient's bedsides are being trialled as a reminder to nursing staff to reposition the patient, to reduce the incidence of pressure ulcer development.

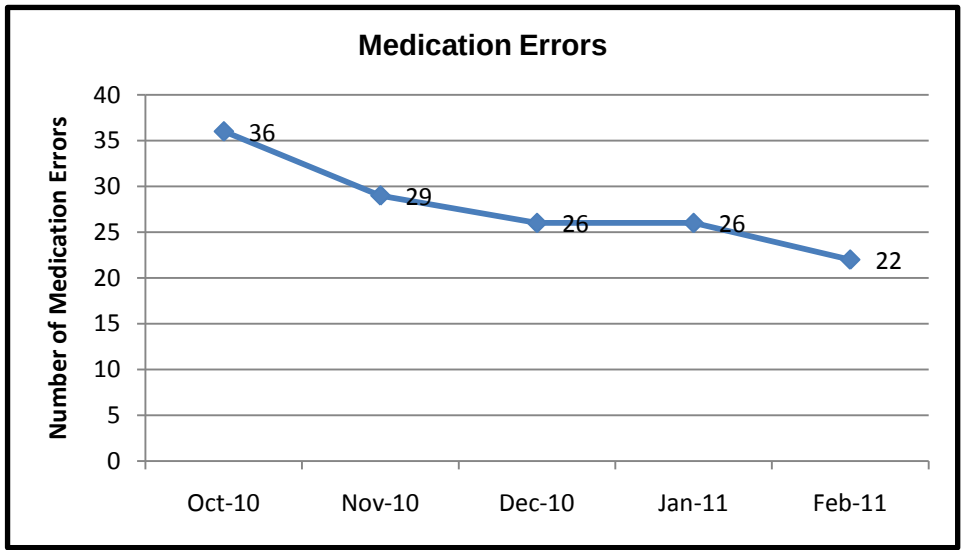
- Tissue Viability service have launched a web access referral system on wherts-tr.tissueviability@nhs.net

- Moisture lesions are being commonly misidentified as Grade 2 pressure damage so the Tissue Viability team are training staff by giving 15 minute teaching sessions, by the patients bedside, to aid correct identification of pressure ulcers.

3.5 Medication Errors

The medication errors data is obtained from Datix and collated by the divisional risk leads. The National Patient Safety Agency (NPSA) is informed when an incident occurs that relates to patient safety, this includes medication.

Since October there has been a reduction in the number of drug incidents reported via Datix.



Actions for improvement

- Encourage staff to continue to report medication errors on Datix

- Pharmacy audit of omitted medicines leading to the development of action plans to reduce the incidence of medication not given to patients

- Educate and training staff in correct method of administration and documentation of medication given.

- Part of the Releasing Time to Care, productive ward module looking at safe and reliable medicine administration and compliance towards the medication policies.

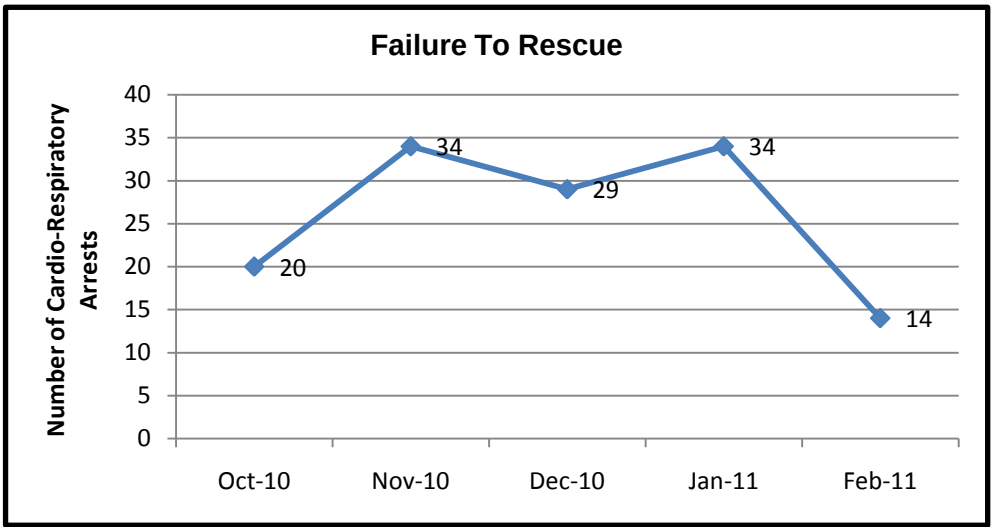
3.6 Failure to Rescue

This indicator refers to the 'deteriorating' patient. Clinical deterioration can occur at any time during a patient's illness, failure to recognise this deterioration and acting appropriately may result in cardio-respiratory arrest.

Nurses in this Trust use an early warning observation chart called a Modified Early Warning Score or MEWS. This gives values to certain observations and the resulting score then prompts the nurse to take appropriate steps when caring for a deteriorating patient, ensure the correct treatment is given & referrals made to appropriate experts in time to reduce the number of cardio- respiratory arrests.

The Critical Care Outreach Team support the ward areas by providing an Outreach service; the outreach nurse will assess any ward patient that has triggered a high MEWS score and give advice to ward teams.
An outreach nurse assesses every patient discharged to the ward from Intensive Therapy Unit (ITU) to prevent re-admission to ITU.

The data collected is the number of cardio-respiratory arrests that have occurred within ward areas.



Actions for improvement

- New MEWS charts are being trialled. These MEWS observation charts have flow diagrams that give prescriptive instructions of what actions to take with any MEWS score, designed to empower the nurse to take the correct course of action.

3.7 Nutrition

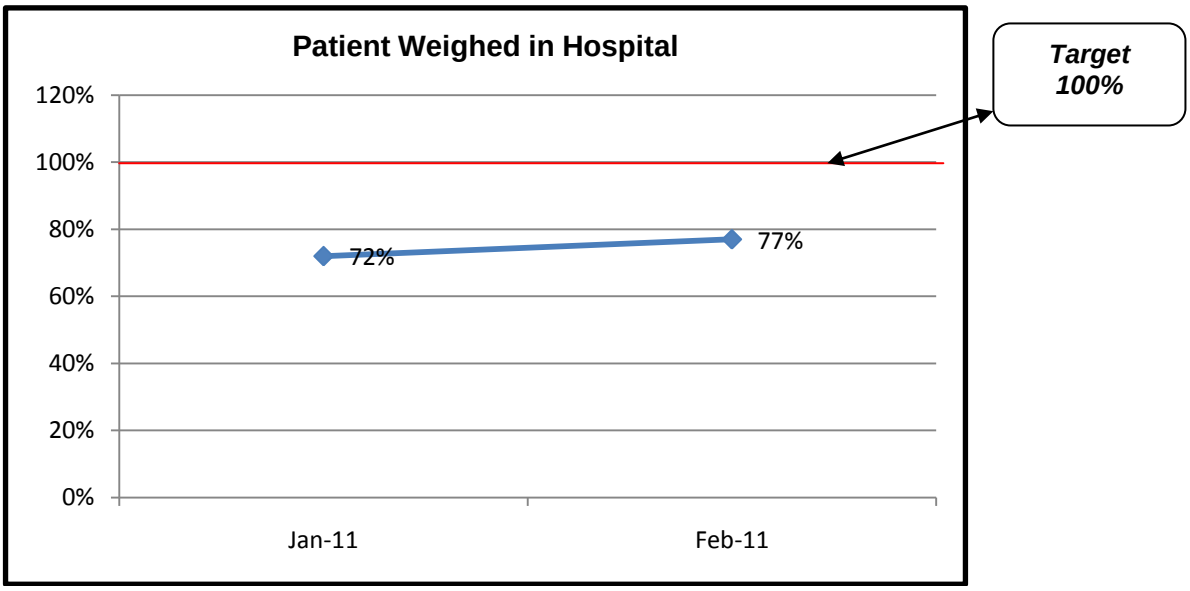
Nutritional screening aims to identify patients at risk of malnutrition and prompts the action to make a referral to the dietician or nutritional support team for further nutritional assessment. The Trust has a commitment to ensure that patients do not suffer malnutrition and the CEQUIN target to ensure that all patients are weighed

The Trust appointed a Nutritional Specialist Nurse in September 2010. As part of her role she has been reviewing the nutritional screening assessments carried out across the Trust, to identify what nutritional screening is taking place, how and when nutritional screening reassessments are being carried out and to see if patients are being weighed whilst in hospital in accordance with NICE guidance.

Initial findings showed that patient's nutritional status was recorded on admission but regular re-assessments and the weighing of patients varied from ward to ward.

The nutritional audit, commenced in January 2011, sets out to improve the compliance of patients being weighed on admission or within the first 24hrs of admission to hospital.

The housekeeper on the ward randomly selects 10 patients per month and checks how many of these 10 patients have a weight recorded in the nursing documentation.



Actions for improvement

- A multidisciplinary nutrition steering group has been set up to report to the board on nutritional issues.
- Monthly audit the documentation of patients' weights.
- Educate nursing staff around the importance of nutritional screening.
- The current nutritional screening tool is being reviewed and the Malnutrition Universal Screening Tool (MUST) for adults will be trialled in April/May. This tool promotes a multidisciplinary approach and responsibility towards combating malnutrition of patients.
- Launch the nutrition module of the Releasing Time to Care (RTTC) project. This will look at all aspects of nutrition including organisation of meal times.

4. Conclusion

This first report demonstrates that whilst there are some pockets of good practice there is much room for improvement across the Trust. These results provide staff with a baseline from which to work from and will be used to measure improvements going forward.

5. Action

The Board is asked to receive this report on a quarterly basis in future to allow sufficient time for staff to implement the agreed actions for improvement and demonstrate an increase in the quality of care.

Natalie Forrest
Director of Nursing
March 2011