Portsmouth Hospitals NHS
NHS Trust

TRUST BOARD PART I - SEPTEMBER 2011

Agenda Item Number: 149/11
Enclosure Number: (7)

Subject:	**Patient Safety Quarter 1 2011/2012 Board Report**
Prepared by: **Sponsored by:** **Presented by:**	Fiona McNeight, Head of Governance and Patient Safety Julie Dawes, Director of Nursing Julie Dawes, Director of Nursing
Purpose of paper *Why is this paper going to the Trust Board?*	Discussion requested by Trust Board Regular Reporting For Information / Awareness
Key points for Trust Board members *Briefly summarise in bullet point format the main points and key issues that the Trust Board members should focus on including conclusions and proposals*	Data relates to quarter 1 2011/2012. • **SIRIs** (Contract) - 19 SIRIs, compared to 20 in Q4. - No never events. - Statistically significant reduction in SIRIs (excluding pressure ulcers) from August 2010 to March 2011. - Pressure Ulcers highest reported. • **Patient Safety Incidents** (Contract) - No statistically significant changes to report. • **Safety alerts** - 5 open alerts on DH website. • **VTE** (CQUIN and Quality Account) - Compliance 86.43% against target of 90% - actions being taken to address. • **Pressure Ulcers** (Contract) - 12 Hospital Acquired pressure ulcers against a trajectory of 15. • **Falls** (Contract and Quality Account) - Total of 9 red and amber incidents (8 amber, 1 red) reported, against a trajectory of 12. - Reduction on the rate of falls per 1000 bed days since January 2011. • **Patient moves** (Contract) - Quarterly monitoring commenced. • **Medical outliers** (Contract) - Quarterly monitoring commenced. • **Unplanned returns to theatres** (Contract) - Rate of 0.17 compared with 0.47 for Q1 2010/11. • **HCAI** (National Target and contract) - 1 MRSA bacteraemia against a trajectory of 1. - 30 C.Diff cases against a trajectory of 22 – actions being taken to address. - MSSA and E.Coli data collection commenced. • **Urinary catheterisation** (CQUIN) - Work underway to meet requirements of contract for quarter 2. • **Medication** (Contract and Quality Account) - 6 amber incidents reported compared to 4 amber and 1 red incidents in Q1 2010/11.

	- A theme arising from recent incidents related to missed doses. - 69% compliance with recorded allergy status. On target to achieve year end target of 71.5%. - 63% compliance with medicines reconciliation. Currently not on target to achieve year end target of 77%. Proposed restructure within Pharmacy expected to address. • **Nutrition** - Current screening compliance 75%. • **Wards on special measures** - C6 - CHOC • **Dr Foster Patient Safety Indicators** - No issues identified.
Options and decisions required *Clearly identify options that are to be considered and any decisions required*	Nil decisions required.
Next steps / future actions: *Clearly identify what will follow the Trust Board's discussion*	On-going monitoring of safety metrics and regular Board reporting.
Consideration of legal issues (including Equality Impact Assessment)?	Considered – none.
Consideration of Public and Patient Involvement and Communications Implications?	None.

1. Introduction

This Patient Safety Board report covers the Quarter 1 period (April 2011 – June 2011).

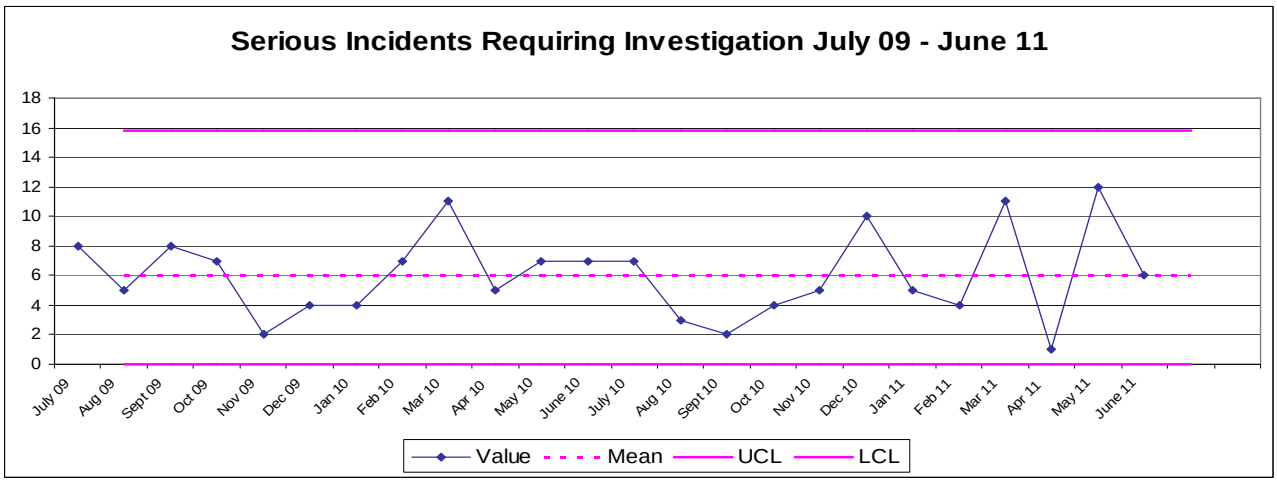
The report now makes reference to whether the indicator relates to a contractual requirement within the 2011/2012 Quality Contract (Contract), a Commissioning for Quality and Innovation (CQUIN) indicator, a national priority/target, or a priority identified within the 2010/2011 Quality Accounts (Quality Account).

2. Serious Incidents Requiring Investigations (Contract)

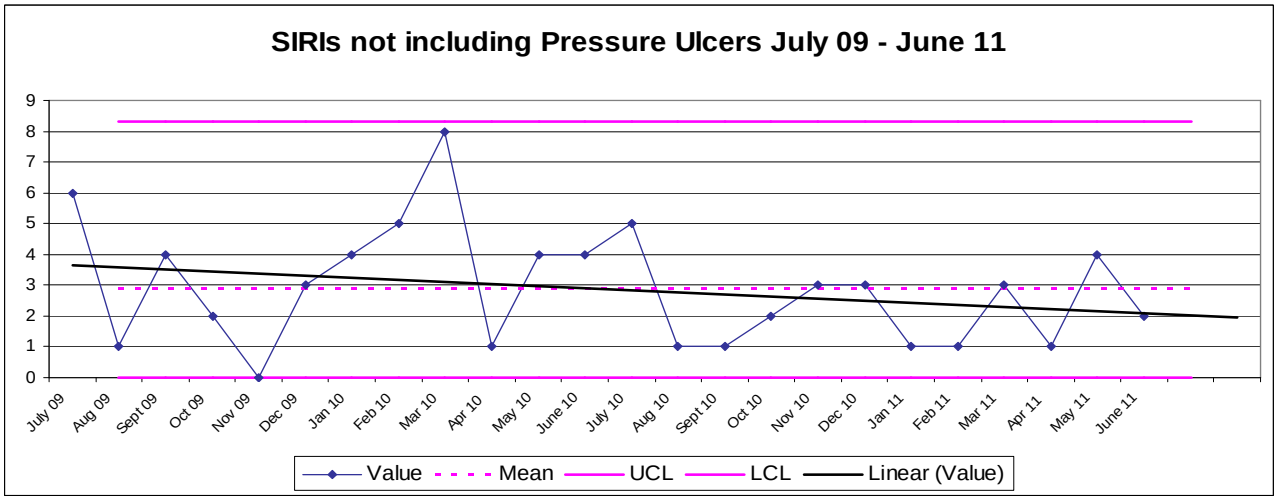
There were 19 Serious Incidents Requiring Investigations (SIRIs) reported in quarter 1 2011/2012 compared with 20 in quarter 4 2010/2011. Pressure ulcers remain the highest reported SIRI. However, it should be noted that there has been a reduction in the number of reported pressure ulcers: 12 being reported in quarter 1 compared to 15 in quarter 4 (16 reported in previous report, however, one SIRI has since been downgraded).

No other key themes have been identified within the reported SIRIs. However, it should be noted that incomplete documentation is a recurring factor in a large percentage of SIRIs. It is proposed to introduce a new documentation group to address this issue.

No 'Never Events' were reported in quarter 1.

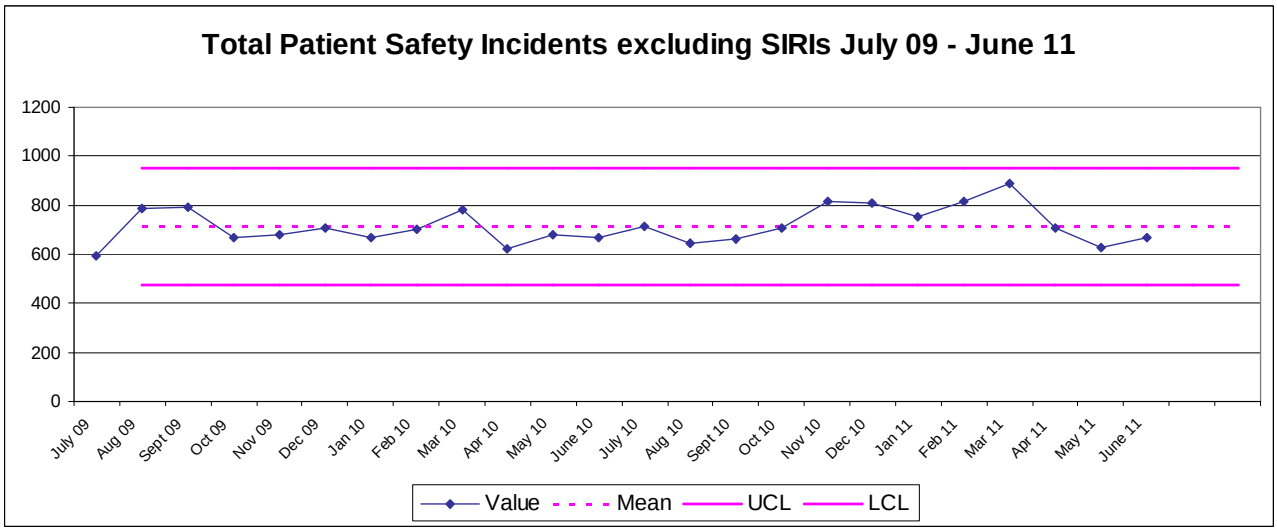


From August 2010 to March 2011 there were eight points below the mean, indicating a statistically significantly reduction in SIRIs (excluding pressure ulcers). As a result of this reduction the mean decreased to 2.875, reflected in the graph below and hence, some points are now above the mean.

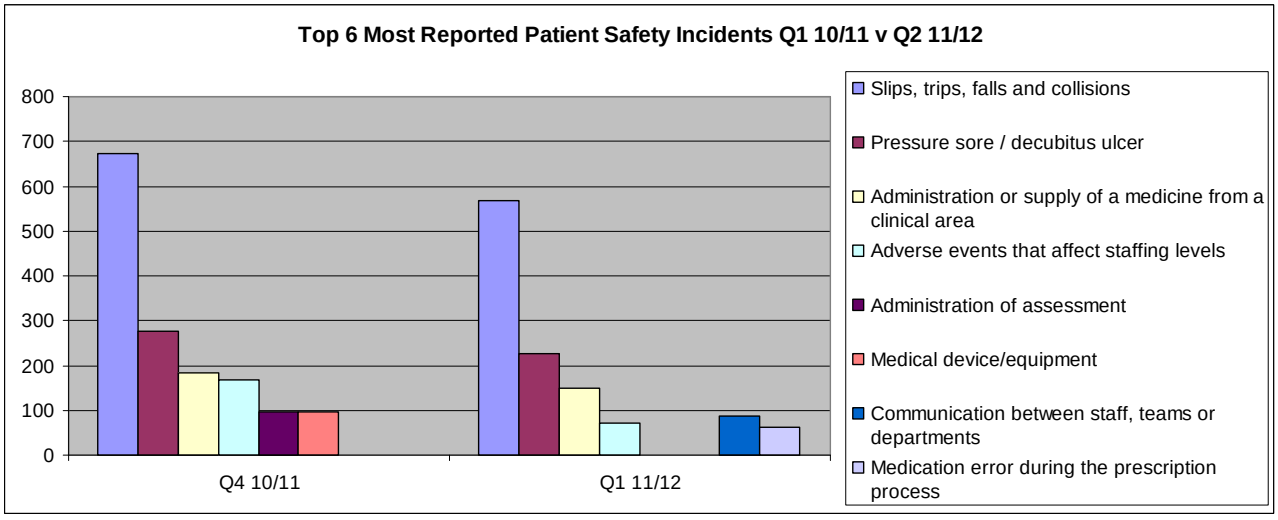


3. Patient Safety incidents (Contract)

As can be seen in the chart below, there are no statistically significant changes in the total number of patient safety incidents (excluding SIRIs).



Slips/trips/falls, pressure ulcers and administration or supply of a medicine from a clinical area remain the top 3 reported incidents. Medical device/equipment which emerged as a theme in quarter 4 was, as noted in the previous report, raised with the Head of Clinical Engineering for appropriate action. It can be seen that this issue no longer appears in the top 6 most reported patient safety incidents. However, medication error during the prescription process has emerged as a theme in quarter 1. An e-learning package has been introduced for junior doctors to undertake as part of their Trust induction. This forms part of the medicines management action plan supporting Care Quality Commission (CQC) compliance with outcome 9 (medicines management).



The Patient Safety Working Group continues to receive presentations on areas of high reporting with a falls management plan being presented in June and a pressure ulcer status report due to be presented in July 2011. Updates on action plans associated with areas of high reporting will continue to be received on a rolling basis apart from the medicines management action plan, which will be presented monthly.

4. Safety Alerts

As per Department of Health (DH) guidance, the Trust has implemented a new process whereby alerts can be closed, even if all actions have not been completed within the timeframe. If agreed by the Risk Assurance Committee (RAC) that the alert is transferred to

the Trust Risk Register and outstanding actions are therefore monitored, the alert is closed on the DH website. The lead responsible for managing the alert will provide RAC with a target date by which all actions will be completed. RAC will then monitor progress at its monthly meeting.

A total of 42 alerts were received by the Trust during quarter 1, of which 6 were applicable to the Trust. All have been closed on the DH website. However, there are 5 alerts which remain open on the DH website. The table below shows the current status with these alerts.

TITLE OF ALERT	DUE DATE
NPSA/2009/RRR 004: Preventing delay to follow up for patients with glaucoma	10 Dec 2009
NPSA/2010/RRR009: Reducing harm from omitted and delayed medicines in hospital	24 Feb 2011
NPSA/2010/RRR015: Prevention of over infusion of I/V fluid and medicines in neonates	28 Feb 2011
DH 2010 04: Theatre Operating Lamps	30 Nov 2010
DH 2010 03: Flexible Water Supply Hoses	30 Nov 2010

	To be presented to RAC in August 2011.		Awaiting receipt of action plans prior to discussion at RAC.

It is recognised that NPSA/2009/RRR004 has been open for an unacceptable length of time and the matter has been escalated to the Medical Director The overriding issue is one of capacity. However, a number of very positive initiatives have been introduced to improve the situation e.g. systems have been rebuilt to reduce the risk of glaucoma patients being lost to follow up; appointment of a new consultant in late 2010 and working with General Practitioners to try and reduce referrals, particularly for those patients with non-urgent, non-vision threatening problems. Whilst the Trust is confident that the situation has much improved, further monitoring and assurance is required prior to final closure of the alert.

The new process for the dissemination of alerts is now fully operational and is proving highly successful.

5. Venous Thrombo-embolism (CQUIN and Quality Account)

Risk Assessment

The Trust achieved 86.43% compliance with VTE Assessment upon admission for all adult in-patients in quarter 1 against a target of 90%, broken down as follows:

- April: 90.4%
- May: 87.75%
- June: 81.68%

The risk assessment figures for July have improved at 85.1%, however, this data is currently being validated and may be subject to change. It is anticipated that the validation process will not affect the compliance significantly.

The low compliance is attributable to the embedding of the new VitalPAC module.

Actions being taken to address compliance:

1. Performance against VTE assessment is discussed with every Clinical Service Centre (CSC) and Clinical Director with the expectation that compliance issues will be addressed.
2. Specific remedial actions are taken with ‘hot spot’ areas, in particular MSK.
3. Continued robust performance through CSC performance meetings.
4. Implementation of VTE/VitalPAC training at induction for all clinical staff, with particular focus at Junior Doctors induction.
5. Enforcing accountability with medical staff as the appropriate health care professionals to undertake the risk assessment. An email has been sent to all medical staff from the Medical Director.

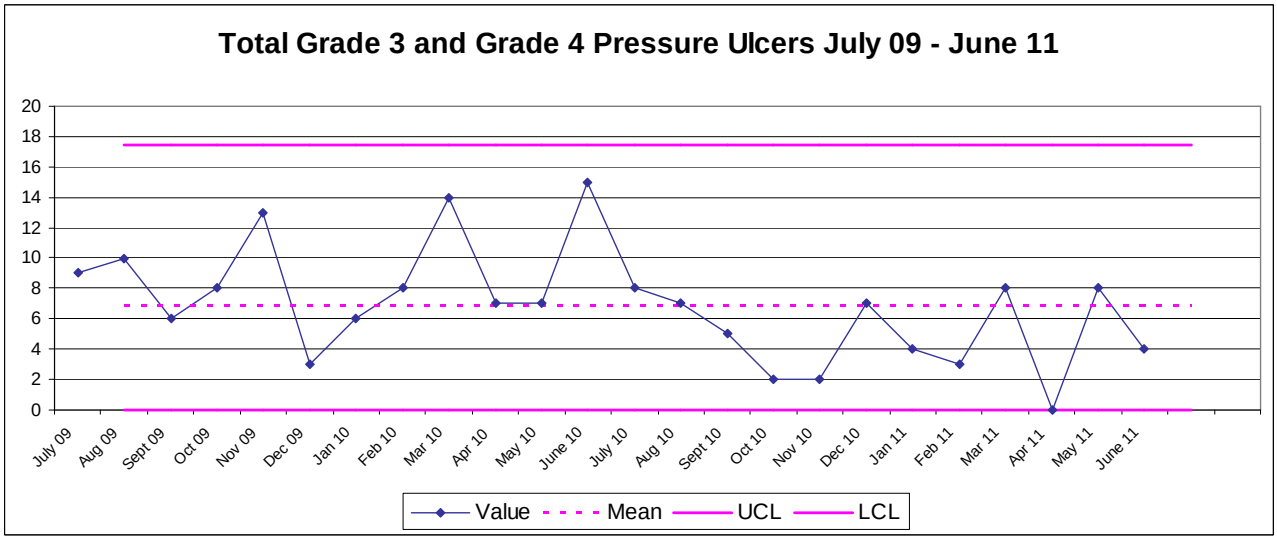
6. Enforcing accountability at CSC and consultant level for the risk assessments completed in clinical areas.
7. Review of resource to deliver training and support to clinical areas.
8. Moved to weekly monitoring of compliance from monthly.

Thrombo-prophylaxis
As per contractual requirements, this will be reported in quarter 2.

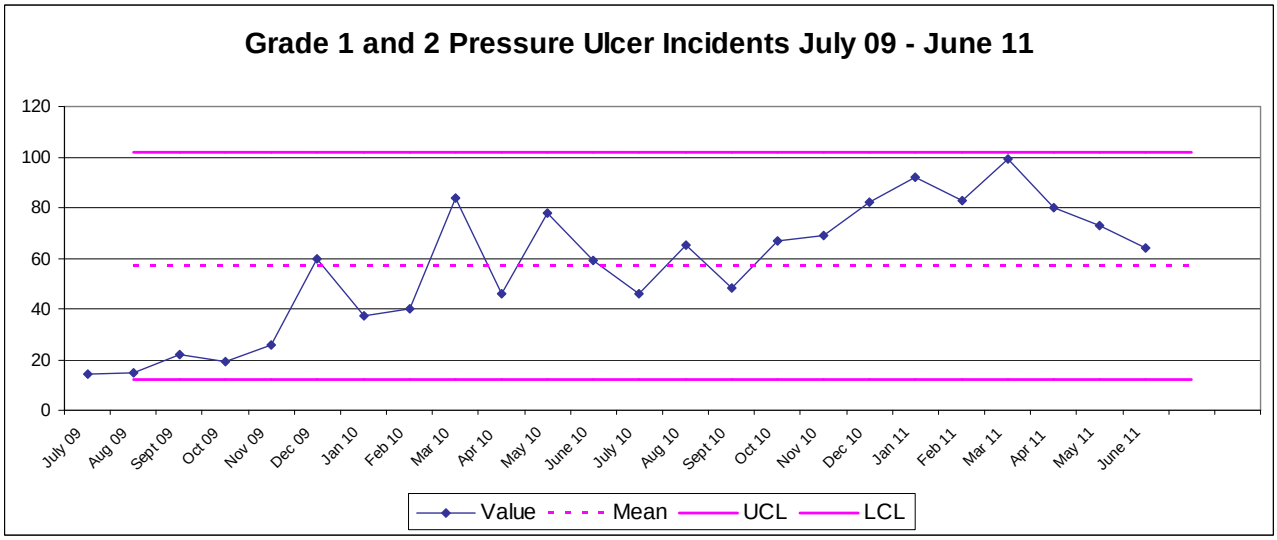
6. Pressure Ulcers (Contract)

The Trust is required to reduce the avoidable hospital grade 3 and 4 pressure ulcers by 25% against the 2010/2011 outturn.

As can be seen below, there has been a reduction in the number of reported pressure ulcers: 12 being reported in quarter 1 compared to 15 in quarter 4. This brings the total to twelve pressure ulcers (hospital acquired) against an upper trajectory of fifteen for quarter 1.



Since May 2011 there has been a reduction in reported grade 1 and 2 pressure ulcers, however, assumptions on the rationale for this can not yet be made.



TOTAL TRUST - PRESSURE ULCER INCIDENTS									
	Number of Pressure Ulcer Incidents		Number of Incidents by Severity 11/12					10/11	
Month	11/12	10/11	Near Miss	Green	Yellow	Amber	Red	Amber	Red
Apr-11	78	49	0	0	78	0	0	3	4
May-11	82	82	0	0	72	0	8	4	3
Jun-11	13	71	0	0	9	0	4	12	3
Q1 total	**173**	**202**	**0**	**0**	**159**	**0**	**12**	**19**	**10**

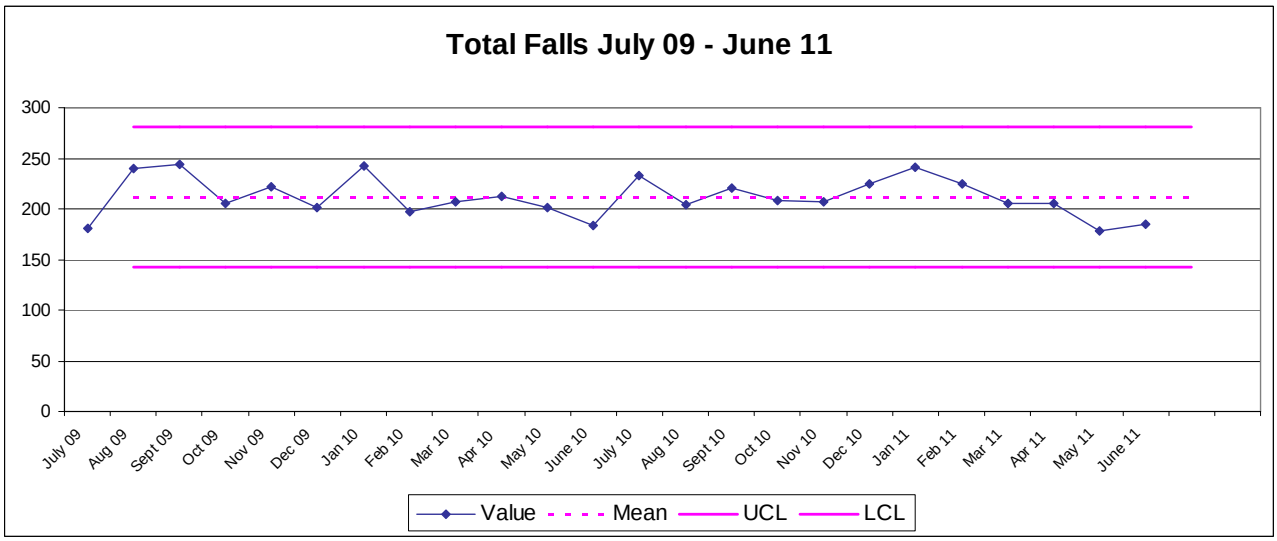
7. Falls (Contract and Quality Account)

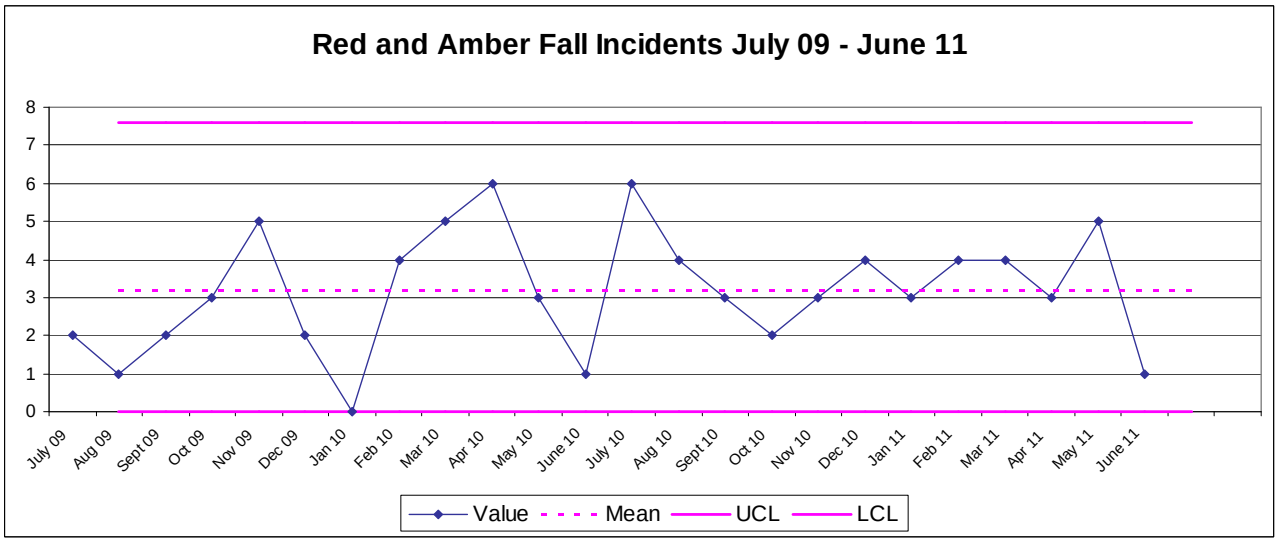
The Trust is required to deliver a 10% reduction in falls that result in moderate/severe harm, based on the 2010/2011 outturn.

The quarter 1 total is eight amber and one red incident. The trajectory for 2011/12 is 39 (combined red and amber incidents).The table below shows achievement against the monthly trajectory; the Trust is currently within trajectory.

	April		May		June	
	2010/11	2011/12	2010/11	2011/12	2010/11	2011/12
Amber	6	3	3	4	1	1
Red	0	0	0	1	0	0
Total	6	**3**	3	**5**	1	**1**
2011/12 Monthly Trajectory		**4**		**4**		**4**
Trajectory variance		**-1**		**+1**		**-3**

Total number of falls per month sees a modest reduction since 1st April in terms of overall reporting and number of injurious falls. A request for SHA wide benchmarking data has been made to enable a detailed comparison with other provider organisations.

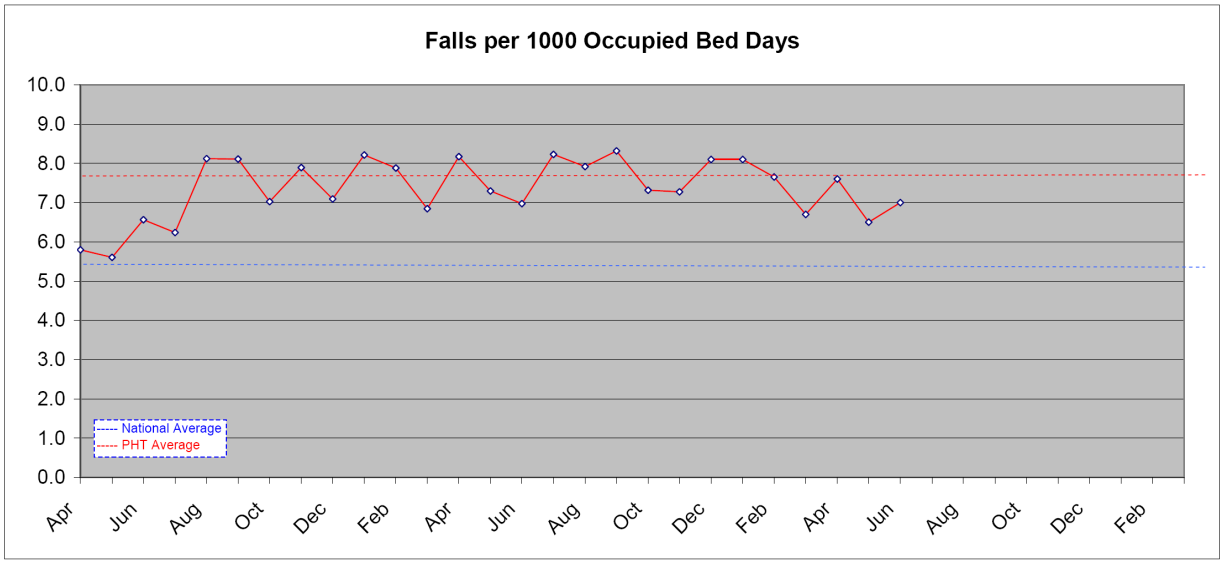




TOTAL TRUST - FALLS									
	Number of Falls		Number of Incidents by Severity					10/11	
Month	11/12	10/11	Near Miss	Green	Yellow	Amber	Red	Amber	Red
Apr-11	205	213	1	138	63	3	0	6	0
May-11	177	199	1	110	61	4	1	3	0
Jun-11	65	184	0	55	10	1	0	1	0
Q1 total	**447**	**596**	**2**	**303**	**134**	**8**	**1**	**10**	**0**

Falls per 1000 bed days

The graph below shows a reduction on the rate of falls by activity (per 1000 bed days) Trust-wide since January of this year.



8. Patient moves (Contract)

Although no targets have been set, the Trust is required to reduce the number of times patients are moved during their in-patient hospital stay. The measure is the quarterly number of patients moved two or more times by absolute numbers and per 1000 bed days. The numbers are compiled on a quarterly basis. The safety group are currently discussing an internally agreed target.

Patient Moves

	2010/2011[1]	2011/2012	
	Per 1000 bed days	Per 1000 bed days	Absolute numbers
Quarter 1	2.3	2.3	1,868
Quarter 2	2.4		
Quarter 3	1.2		
Quarter 4	1.7		

9. Medical Outliers (Contract)

Although no targets have been set, the Trust is required to monitor and report the number of medical outliers by month. It is importance to minimise the number of medical outliers as this leads to additional patient moves, higher risk (e.g. medical patients being looked after by non-medical nursing staff), reduced patient satisfaction and extended length of stay. This information is tracked by Medicine CSC.

Quarter 1 breakdown:

- April 2011: 1,037 occupied bed days were outside of the medical bed footprint.
- May 2011: 678 occupied bed days were outside of the medical bed footprint.
- June 2011: 1,200 occupied bed days were outside of the medical bed footprint.

Actions to date:

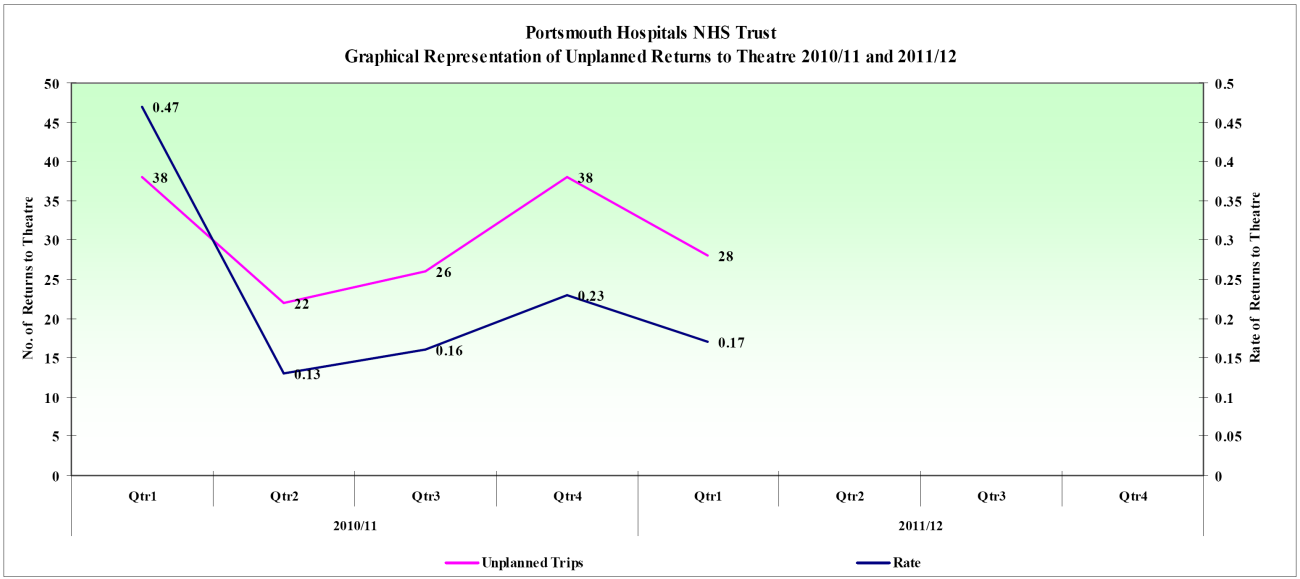
- Tracking system developed in September 2010 to ensure optimised patient safety.
- Medicine CSC monitor outliers on a daily basis to ensure medical teams have between 25 and 30 patients per consultant. Escalation process requires physician teams to increase once admission numbers exceed these levels.
- Outliers are identified on a daily basis by the physician and senior nurse on each ward, with assessment criteria.
- Bed rebalancing project and winter plan will increase medical bed capacity.

10. Unplanned returns to theatre (Contract)

The Trust is required to monitor the number of unplanned returns to theatre, identifying and acting upon significant trends. The measure is the numbers of patients with an unplanned return to theatre during the same inpatient admission against the number of procedures completed for that time period, per 100 cases. The numbers are compiled on a quarterly basis.

Unplanned returns to theatre		
	2010/2011	**2011/2012**
Quarter 1	0.47	0.17
Quarter 2	0.13	
Quarter 3	0.16	
Quarter 4	0.23	

[1] Previously required to report per 1000 bed days only.



11. HCAI (National Target and Contract)

MRSA

	MRSA >48hrs			C.difficile >72hrs		
	Cases	Target	Performance	Cases	Target	Performance
Q1	1	(1)	-	30	(22)	+8
Q2		(1)			(21)	
Q3		(1)			(19)	
Q4		(1)			(16)	

The Trust achieved its target of no more than one post 48 hour MRSA bacteraemia for quarter 1, with a single case occurring within MSK.

The Trust continues to screen all emergency admissions and relevant elective admissions for MRSA, as per DH guidelines. The DH no longer monitors this target although it still forms part of the Trust's quality contract. The measure reported reflects the total number of screens as a percentage of the total number of admissions. This crude measure will shortly be replaced by a more valid KPI that reports the total number of relevant admission screens over the total number of relevant admissions.

	All screens as % elective admissions	All screens as % all admissions
June 2011	236	111
May 2011	269	119
April 2011	281	115

Compliance legend
>100%
< 100%

C.Difficile

The Trust breached the C.Difficile trajectory for quarter 1 by 8 cases. A comprehensive action plan has been fully implemented and this has resulted in a significant reduction in the number of cases in July, with a halving of the trajectory deficit.

Factors that may have contributed to the breach in quarter 1 include:

1. A challenging trajectory for this year based on a 27% decrease on last year's output of 88 hospital attributable cases.
2. Analysis of the cases for quarter 1 does not show evidence of widespread patient to patient cross transmission. However, emergence of a prevalent Trust strain (Ribotype 015) supports the need for chlorine eradication of possible environmental spores.

3. Until June 2011 the microbiology laboratory was not testing diarrhoeal samples from the Emergency Department, Medical Assessment Unit and the Surgical Assessment Unit for presence of C.Difficile toxins. Therefore, many positive cases of C.Difficile could only be detected after 72 hours of admission thus making them attributable to the hospital trajectory irrespective of whether patients had been admitted with symptoms of C.Difficile or not.
4. The current toxin test used by the Trust misses about 20% of positives. The result of this is that patients are not isolated or treated and thus able to spread infection and contaminate the environment in an unchecked manner.
5. The Trust may be seeing the results of last year's flu/ winter pressures. The operational difficulties may have affected the priorities for isolation and cleaning.

The actions taken in response to sustained breaches in trajectory include:

1. The Infection Prevention Control Team (IPCT) nurses carry out a daily review of all known C.Difficile inpatients to ensure that there is optimal patient management including enforcement of all transmission precautions.
2. Actichlor plus (chlorine) cleaning has been extended Trust-wide (previously this has only occurred in isolation rooms).
3. The IPCT nurses conduct daily Adenosine Triphosphate (ATP) sampling of the immediate patient environment to ensure high standards of cleanliness.
4. Whenever possible the IPCT disinfect the bed spaces of C.Difficile patients (e.g. on discharge) with hydrogen peroxide vapour, after the terminal clean has been completed.
5. The Microbiology laboratory is now testing patients in the emergency corridor for C.Difficile to pick up cases in a more timely fashion.
6. A new 2 stage testing regimen has been agreed by the microbiology laboratory to facilitate improved detection of C.Difficile carriers and differentiate those who have active infection.
7. A Trust-wide education programme of drop in sessions and lectures has been implemented to update all staff in the prevention and management of C.Difficile with good attendance. C.Difficile has been discussed in senior nursing and medical forums, with articles in various Trust communications e.g. LINK.

An external review, conducted at the request of the IPCT through the Health Protection Agency (HPA) concluded that the Trust remains a well performing organisation in relation to C.Difficile and has a robust strategy to become a sustained low C.Difficile system. The Strategic Health Authority has also endorsed the comprehensive action plan to reduce C.Difficile.

MSSA and E.Coli

As required by the HPA and Quality contract, the Trust submits monthly data on MSSA and E.Coli bacteraemia (N.B. data collection for E.Coli was not required by the HPA before 1st June 2011).

	MSSA bacteraemia	
	< 48 hrs	> 48 hrs
Jun 2011	3	1
May 2011	8	3
Apr 2011	3	2

	Ecoli bacteraemia	
	< 48 hrs	> 48 hrs
Jun 2011	15	6
May 2011	15	5
Apr 2011	Not collected	

At present, there are no national or local targets attached to MSSA or E.Coli. National figures for MSSA bacteraemia attributable to acute Trusts for January-June 2011 show that the Trust continues to compare favourably with the majority of other organisations, in particular those with comparable renal services.

12. Appropriate Urinary Catheterisation (CQUIN)

Urinary tract infections (UTIs) are the second largest single group of healthcare-associated infection in the UK amounting to 19.7% of all hospital infections. Evidence suggests that 60%

of all UTI's are related to urinary catheter insertion. The estimated cost for each Catheter Associated Urinary Tract Infection (CAUTI) is in excess of £1000 per patient.

The CQUIN scheme includes an indicator aimed to reduce inappropriate urinary catheterisation. In quarters 1 and 2, the Trust is required to agree, with the Commissioners, a clinical definition of 'inappropriate' urinary catheterisation; develop an audit tool and undertake an initial audit. In quarter 4 the Trust is required to amend the tool and repeat the audit, this will develop a baseline for future years.

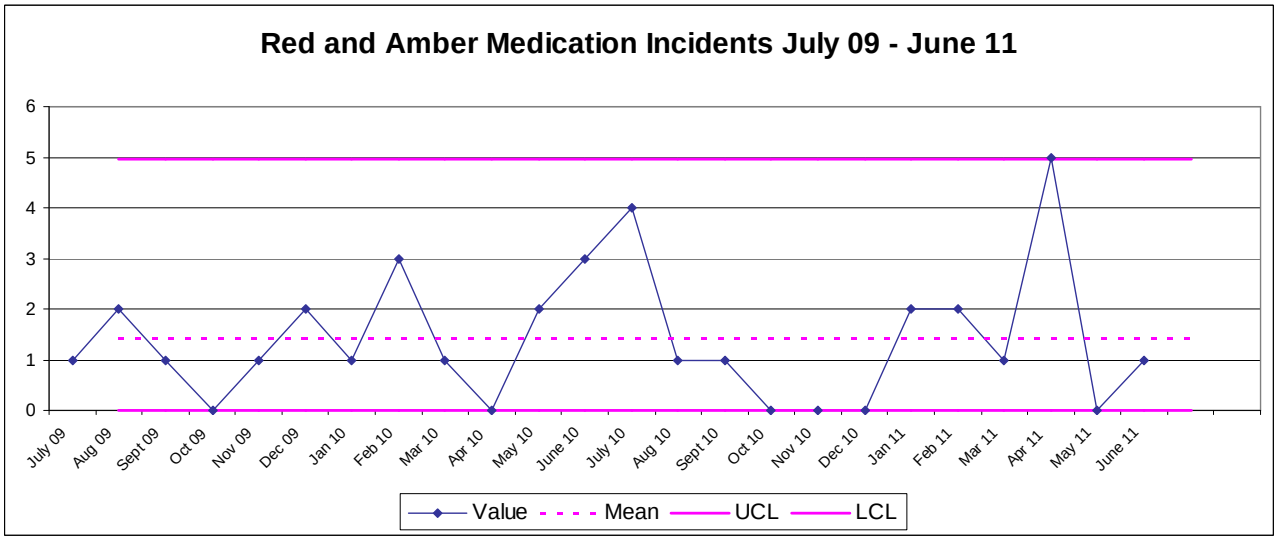
A work stream has been established to ensure the requirements are met, the work stream includes:

1. Drawing up a Trust Policy for Urinary Catheterisation.
2. An initial "demonstrate the problem" audit of patients on one floor on one day looking especially at reasons for catheterisation, documentation and review processes.
3. Development of an audit tool to allow on-going capture of data - VitalPAC if modified.
4. A closer look at the work undertaken in Birmingham and Winchester and Eastleigh which has produced interesting results.

13. Medication (Contract and Quality Account)

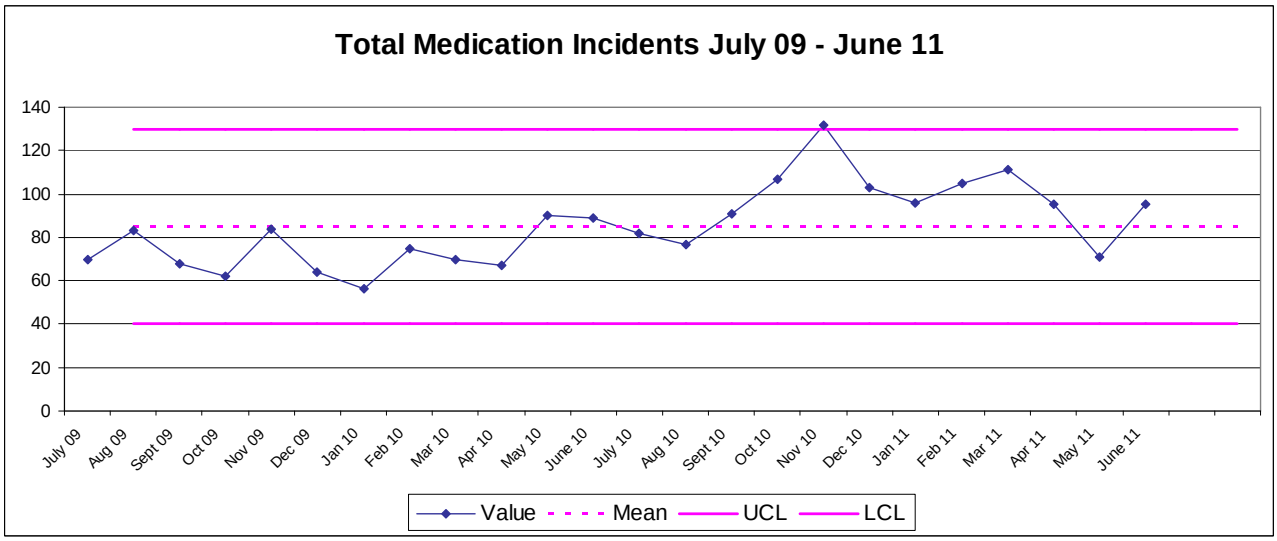
Although no targets have been set within the contract, the Trust is required to reduce the number of medication errors and severity of harm caused to patients.

With six amber medication incidents occurring in quarter 1 compared to four amber and one red in the same period last year, the Trust is not currently seeing a reduction in the total of red and amber incidents.



The increase noted for red and amber incidents in April / May 2011 is a reflection of higher than usual intensive reporting within the Clinical Support CSC.

Monthly reported numbers for medication errors appear to be stable.



MEDICATION ERRORS – QUARTER 1 2011/2012									
total medication errors			**medication incidents by severity 2011/12**					**2010/11**	
	11/12	**10/11**	**nr miss**	**green**	**yellow**	**amber**	**red**	**amber**	**red**
Apr	95	67	4	70	15	5	0	0	0
May	71	90	9	51	6	0	0	1	1
Jun	95	89	7	42	5	1	0	3	0
Q1 total	**261**	**246**	**20**	**163**	**26**	**6**	**0**	**4**	**1**

CONTROLLED DRUG ERRORS – QUARTER 1 2011/2012									
controlled drug incidents by severity 2011/12						**2010/11**		**total controlled drug incidents**	
	nr miss	**green**	**yellow**	**amber**	**red**	**amber**	**red**	**11/12**	**10/11**
Apr	0	4	5	0	0	0	0	9	5
May	2	5	0	0	0	0	0	7	8
Jun	0	5	0	0	0	0	0	5	5
Q1 total	**2**	**14**	**5**	**0**	**0**	**0**	**0**	**21**	**18**

Controlled drug incidents remain unchanged, however, security incidents regarding other medication have occurred and have been dealt with between the CSC, Accountable Officer and where necessary the police and the Fraud Investigation Office.

A large number of medication related incidents are due to missed doses and whilst a number do not have the drug(s) stated of those that do the top drugs implicated in 2010/11 are as follows:

- Enoxaparin (14%)
- Insulin (6%)
- Warfarin (5%)
- Morphine (4%)
- Paracetamol (3%)
- Heparin (3%)
- Tazocin (2%)
- Aspirin (2%)
- Co-amoxiclav (2%)

Actions have been highlighted through the Medication Safety Committee and the Patient Safety Working Group and individual CSCs are to be audited to highlight particular areas of concern.

Patient Safety Federation – No needless medication errors work stream

There is a contractual requirement to achieve a minimum of 98% of adult in-patients having an allergy status documented on their drug chart. The baseline compliance is 65% and the Trust

has agreed to achieve a minimum increase of 10% per annum until the minimum target threshold of 98% is achieved.

There is also a contractual requirement to achieve a minimum of 98% of adult in-patients having medicines reconciliation completed within 24 hours of admission. The baseline compliance is 70% and the Trust has agreed to achieve a minimum increase of 10% per annum until the minimum target threshold of 98% is achieved.

The table below demonstrates quarter 1 compliance.

Patient Safety Federation compliance			
Indicator	**Baseline**	**Quarter 1 compliance**	**Minimum target 2011/2012**
Allergy status	65%	69%	71.5%
Medicines reconciliation	70%	63%	77%

It is to be noted that collection rates for allergy and medicines reconciliation data have been low in quarter one; pharmacists have been contacted to ensure audit data is collected thereby ensuring the accuracy of the data analysed.

As can be seen the Trust is on target to achieve the allergy status indicator, however, there has been a reduction in compliance for medicines reconciliation in quarter 1 from the baseline.

To highlight the importance of completing allergy status documentation on the drug chart it is to be included in the new FY1 training being introduced in August and a scenario inserted into the simulation sessions. A poster is to be designed encouraging patients to be proactive in reporting their allergies and ensuring they are documented.

It is anticipated that the proposed restructure within Pharmacy will release more staff for ward based duties and hence positively impacting on medicines reconciliation.

An audit of the green bag system has been completed and results and analysis is awaiting from the Patient Safety Federation workstream.

The contract also requires the monitoring of INRs greater than 5, however, there is no target associated with this, given the numbers are so small. The table below shows the monthly INR data for quarter 1.

INR data					
Month	**Total no. of INRs**	**No. of INRs > 5**	**% INRs >5**	**No. of INRs > 8**	**% INRs >8**
Apr-11	8612	201	2.33	23	0.27
May-11	9076	245	2.70	26	0.29
Jun-11	9488	212	2.23	17	0.18

Warfarin guidelines are being reviewed and consideration is to be given to altering the loading regime in line with other trusts. Alongside this work the NPSA alert regarding Anticoagulant use is being reviewed and actions revisited.

14. Nutrition

MUST screening on admission

Throughout August, the Trust will be completing an audit of nutrition screening on admission and throughout hospital stay. Therefore, results are not available for publishing at this time.

Following the CQC report on nutrition spot audits of nutrition screening are to be undertaken by each CSC, this will commence in October 2011, following which the Trust will undertake a full Trust-wide audit twice yearly and spot audit 6 times a year.

Inclusion of nutrition screening onto Vitalpac is underway and it is anticipated to have this in place by year end.

Nutrition Education

Clinical Nutrition Nurses and Dietitians are developing a new e-learning package, alongside the tissue viability team, which will support clinical education of nutrition, screening and care planning.

Food service

Following the CQC report the Trust is assessing the demand and requirement of special aids for eating. A new 'patients' meal charter' has been produced to emphasise food service requirements and the clinical responsibility in delivering this.

Summary

Nutrition screening remains reported at 75%, however, this will be updated following a Trust-wide audit in August 2011. Following this, each CSC will undertake monthly nutrition screening snap shot audits to monitor compliance.

A new e-learning package on nutrition as well as electronic recording of nutrition screening should be in place by year end.

15. Wards on 'special measures'

C6 remain on special measures, but continue to make good progress in all aspects of performance. It is anticipated that they will be taken off special measures next month.

CHOC remain on special measures and are particularly receiving support in relation to their staffing and recruitment. A new sister has been appointed and it is anticipated that they will be taken off special measures next month.

16. Dr Foster Patient Safety Indicators

At the end of March 2011 Dr Foster launched Patient Safety Indicators. These are currently discussed at the Clinical Effectiveness Steering Group. Since introduction, no issues have been identified. The chart below shows the position between June 2010 to May 2011.

Jun 2010 to May 2011

Indicator		Observed	Expected	Observed rate/K	Expected rate/K
Deaths in low-risk diagnosis groups*		37	42.6	0.72	0.83
Decubitus Ulcer		49	44.3	11.32	10.23
Deaths after surgery		57	75.3	111.11	146.87
Infections associated with central line*		0	1.8	0.00	0.08
Post-operative hip fracture*		4	2.4	0.10	0.06
Post-op Haemorrhage or Haematoma		19	22.8	0.48	0.57
Post-operative physiologic and metabolic derangements*		3	3.4	0.09	0.10
Post-operative respiratory failure		21	18.3	0.68	0.59
Post-operative pulmonary embolism or deep vein thrombosis		61	72.7	1.52	1.82
Post-operative sepsis		2	9.3	1.28	5.92
Post-operative wound dehiscence*		2	2.1	1.22	1.30
Accidental puncture or laceration		53	91.8	0.55	0.96
Obstetric trauma - vaginal delivery with instrument*		48	44.3	82.76	76.39
Obstetric trauma - vaginal delivery without instrument*		96	131.9	26.07	35.80
Obstetric trauma - caesarean delivery*		1	5.1	0.67	3.45

Key

A red bar signifies an indicator for which the lower end of the 95% confidence interval is above the national average.

A green bar signifies an indicator for which the higher end of the 95% confidence interval is below the national average.

A blue bar signifies an indicator for which the relative risk equals the national average value within 95% confidence.

* For indicators marked with an asterisk expected values are derived from the national average crude rate and are not casemix adjusted.