Quality and Safety Assurance Report

QSEC Meeting December 2021

Situation

The purpose of this report is to provide the Quality, Safety and Experience Committee (QSEC) with an overview of quality and safety across the Health Board.

The Health Board uses a number of assurance processes and quality improvement strategies to ensure high quality care is delivered to patients.

This report provides information on improvement work linked to themes within patient safety incident reporting, externally reported patient safety incidents, mortality review, and external inspections, for example Healthcare Inspectorate Wales (HIW).

Incident Reporting – 1st April to 31st October 2021

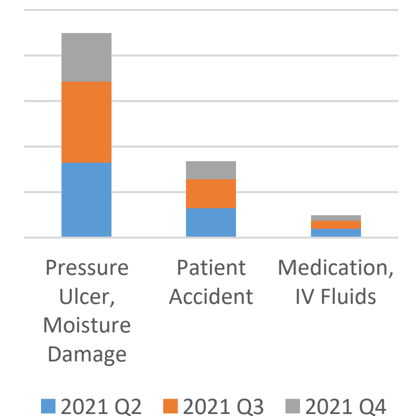
500
450
400
350
300
250
200
150
100
50
0

Apr 2021 May 2021 Jun 2021 Jul 2021 Aug 2021 Sep 2021 Oct 2021

None
Low
Moderate
Severe
Death

In September and October 2021, 2,681 incidents were reported of which 2,269 were patient safety related. These figures are consistent with previous months.

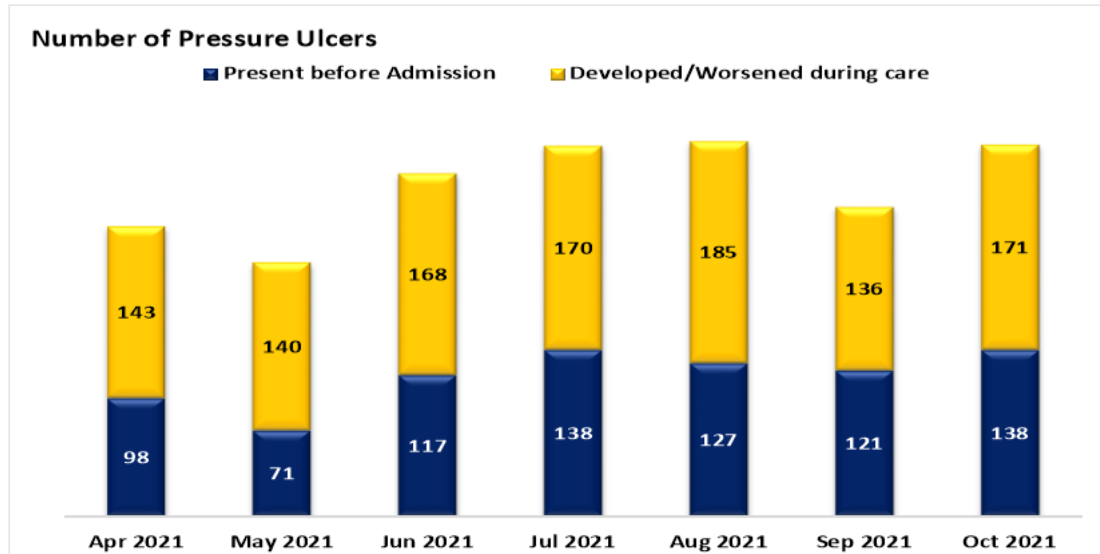
Top 3 Patient Safety Incidents



The introduction of DatixCymru in April 2021 has altered the way in which severity of harm is reported. The new system allows the opportunity for the reporter to grade the harm to the person affected (which cannot be changed) and then on closure following investigation the actual harm to the person affected is recorded by the investigator.

There were 9017 Patient Safety Incidents reported on the new system between 1st April and 31st October 2021. Of the 9017, 4722 have been closed and 2103 have had the severity amended. 1481 incidents were downgraded whilst 622 were upgraded.

Pressure ulcer



The Quality Assurance Information and System Team continue to support the services with accurate and up to date data to enable them to undertake regular monthly review/scrutiny meetings, where the pressure ulcers acquired in a hospital setting are captured on the Health Board's Datix Cymru System and are discussed in detail. Following the review at the pressure ulcer scrutiny meeting, the figures in the graph may alter.

As part of our Enabling Quality Improvement in Practice (EQIiP) programme, improvement work has commenced to ensure that there is timeliness and consistency of investigation and approval of pressure ulcer incidents. This will help ensure that reported data is accurate and learning is captured and shared.

Improvement work

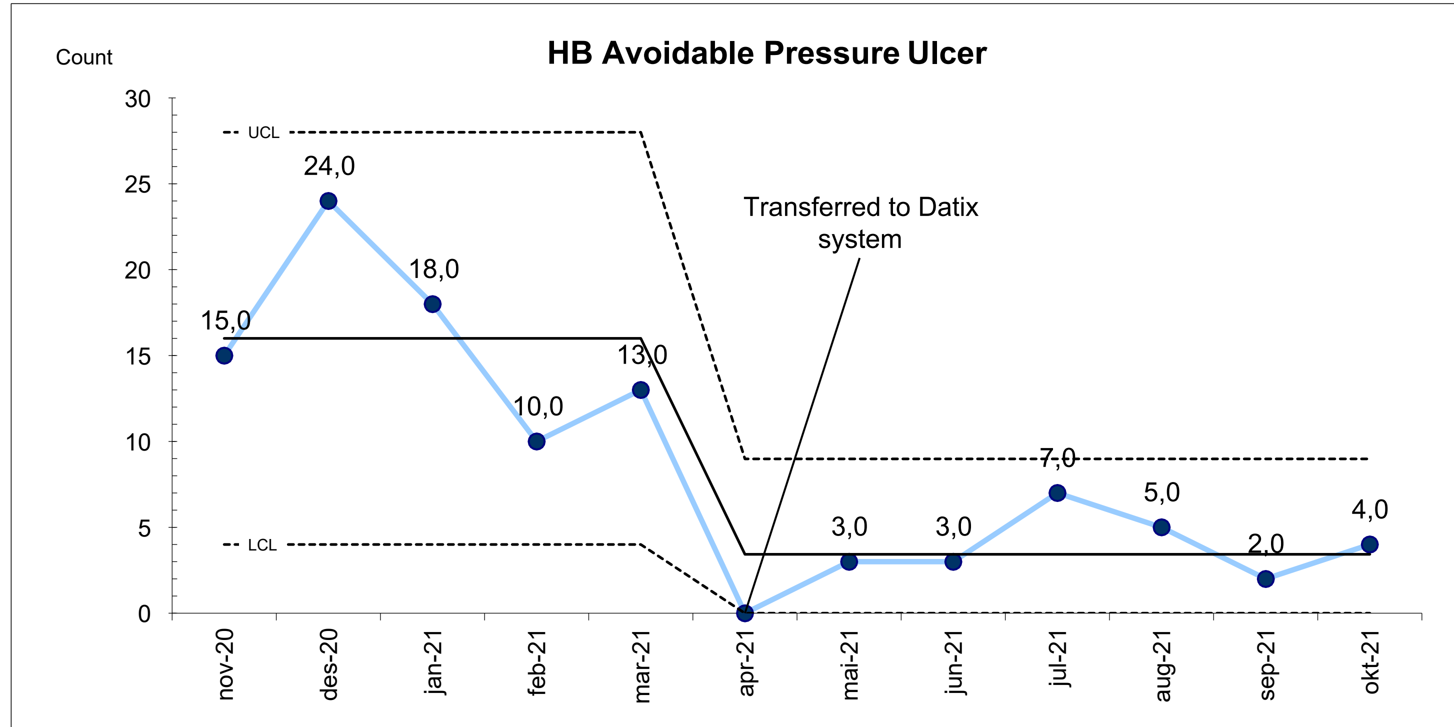
Actions Complete

- Appointed Lead PPDN to support the improvement work
- Developed improvement plan
- Standardised agenda, action plans and ToR for scrutiny meetings
- Investigation and scrutiny preparation training for Ward Managers

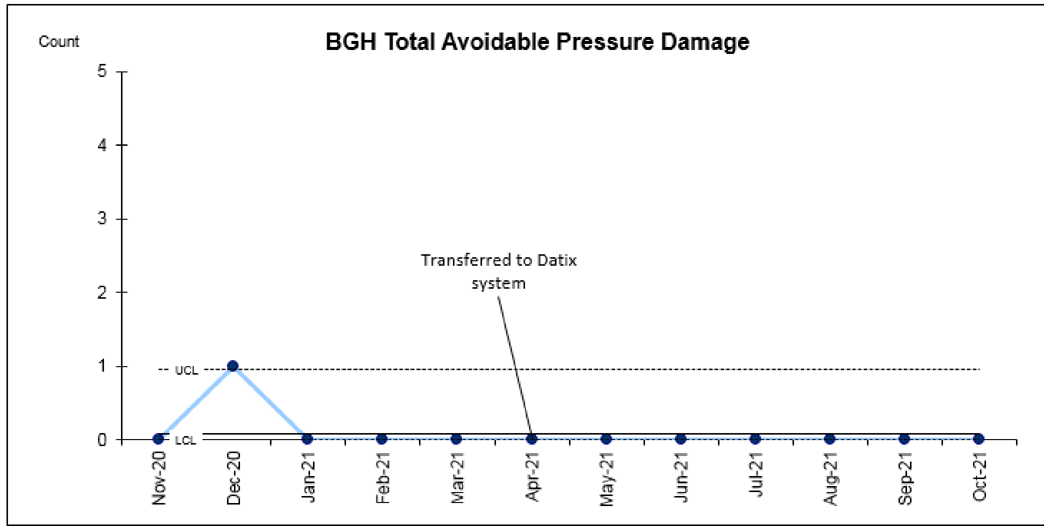
Next steps

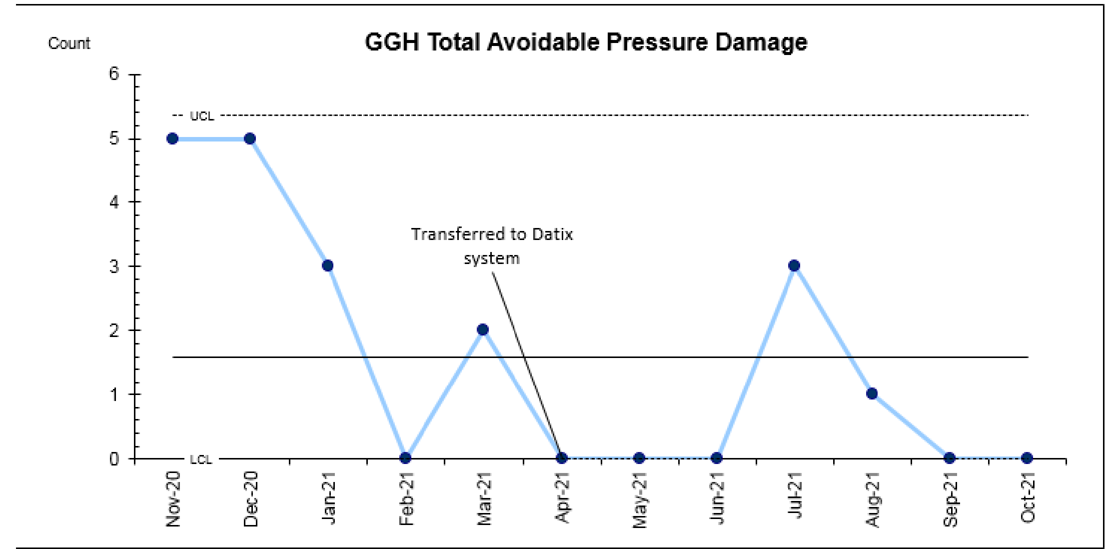
- All learning outcomes to be effectively communicated to clinical teams
- Highlight issues, good practice, successes in local assurance meetings and wider service
- Complete the process to clear historical data within the system
- Establish process to investigate incidents of pressure ulcer present on admission to acute service where patient not known to community services (EQIiP project)
- Improve quality of Datix completion

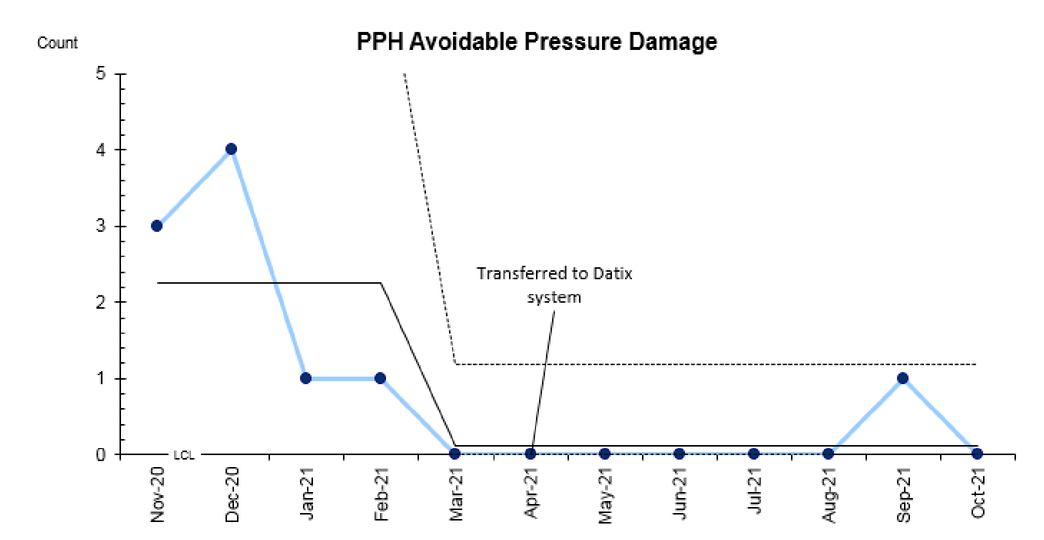
HB Avoidable Pressure Ulcer

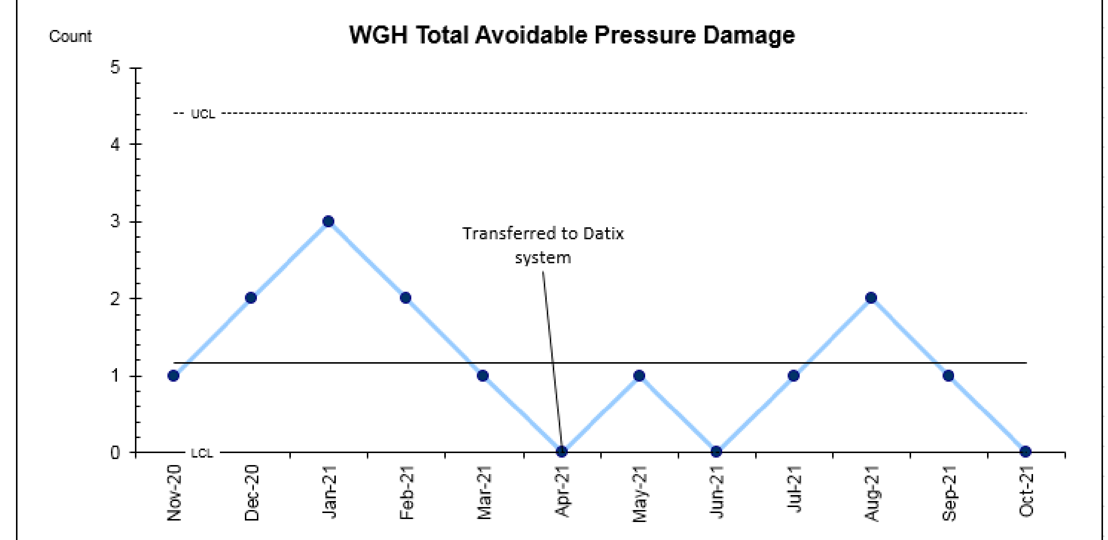


Please note, transfer to the new RLDatix system in April 2021 with many incident outcomes remaining unrecorded and still needing to be assigned following investigation/scrutiny, this may help explain the dip in the data from this date.









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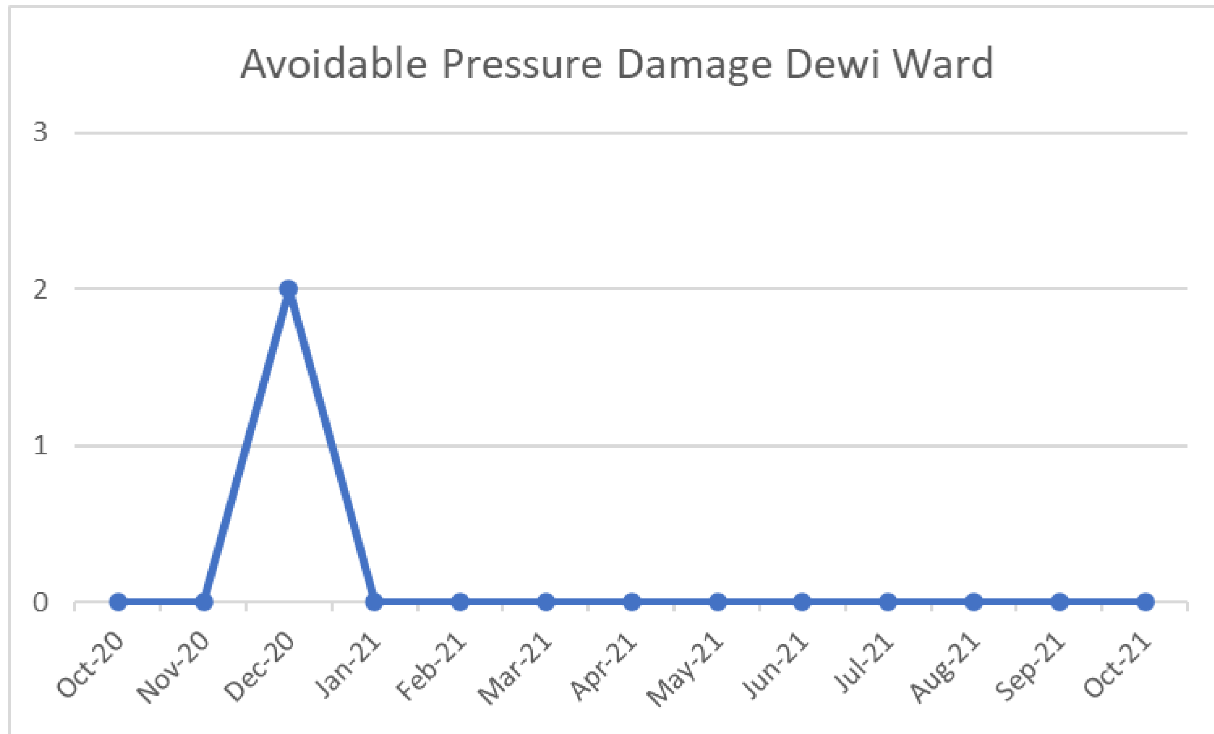
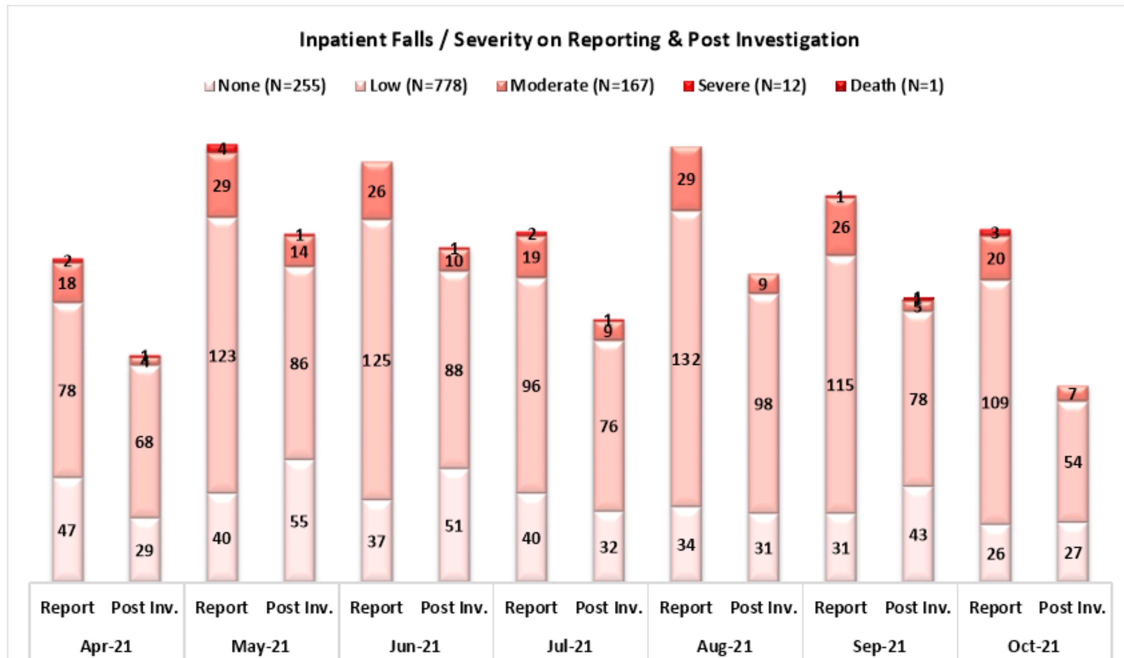
Dewi Ward, Glangwili Hospital



Dewi Ward in GGH has had no avoidable pressure ulcer since December 2020

- They have introduced Pressure Ulcer Champions
- There has been an improvement in evidencing care following documentation and accountability sessions
- They have created Pressure Ulcer Awareness Notice Boards
- Pressure Ulcer Prevention is everyones' responsibility and a role for all MDT members
- Patient information leaflets are available

Inpatient falls

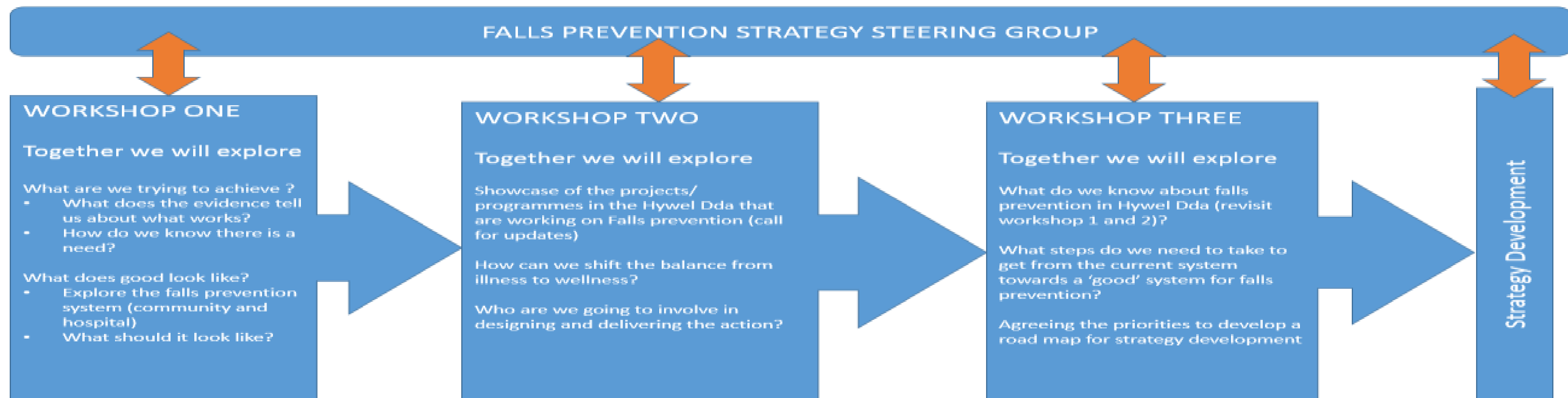


Health Board Falls Strategy

The Quality Improvement Team have been tasked with producing a collaborative falls framework in conjunction with key stakeholders with the following aims:

- to promote falls prevention
- to reduce the number of avoidable falls in the community and in our hospitals
- to work collaboratively with relevant third sector and social care services
- to ensure an equitable three county approach to community fall intervention
- to develop a seamless transition for patients between hospital and home

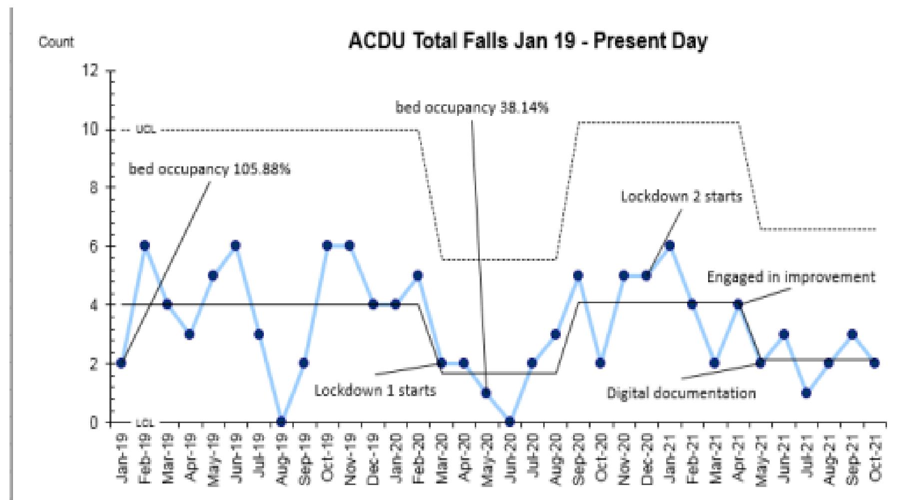
A falls strategy group has been established which has now met on two occasions. Workshops are being delivered by Public Health Wales using the Wellbeing Lens (see image below)



Falls Improvement (Focus on 2 Areas)

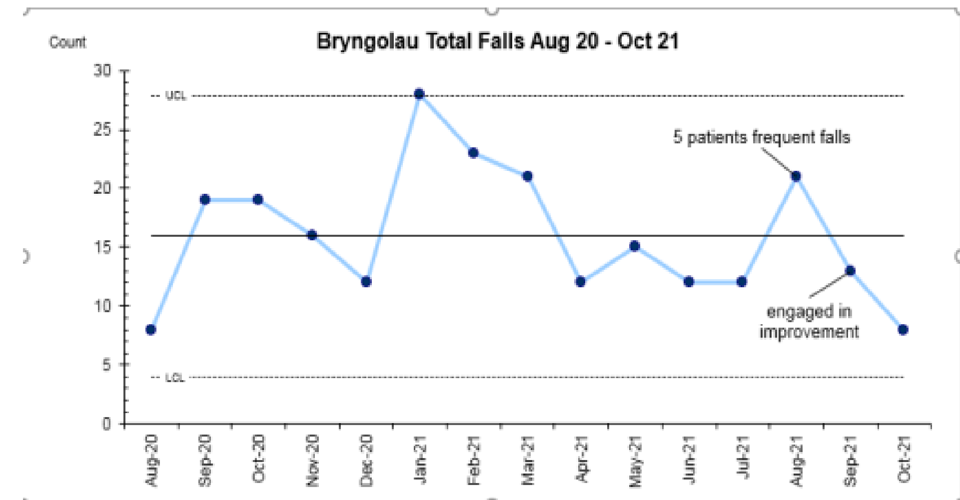
ACDU (Adult Clinical Decisions Unit) in WGH

The Quality Improvement Team engaged in falls improvement with ACDU in WGH back in April 2021. A series of away days were organised for the team which covered wellbeing, Health Board values and teaching/improvement sessions in relation to falls. As a result, falls champions have been identified who are working on different initiatives in order to reduce patient falls including review of bed rails documentation and looking at equipment availability.

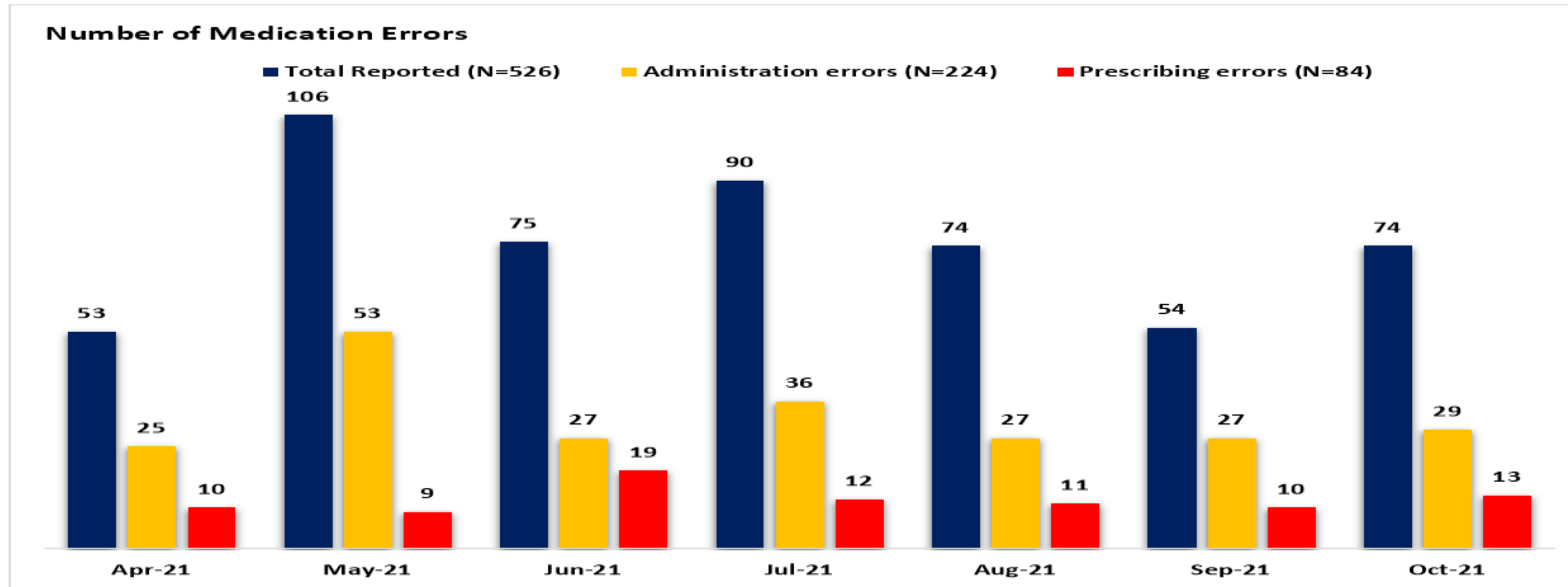


Bryngolau

The Quality Improvement Team engaged in falls improvement with Bryngolau ward in PPH, September 21. Bryngolau report the highest number of falls for an inpatient area within the Health Board. A number of staff participated in Falls Brief Intervention Training and falls champions have been identified focusing areas including sleep, vision and equipment provision. Early results show an initial reduction for 2 consecutive months and work continues with the staff who have been fully engaged and committed to making sustained improvements.



Medication errors

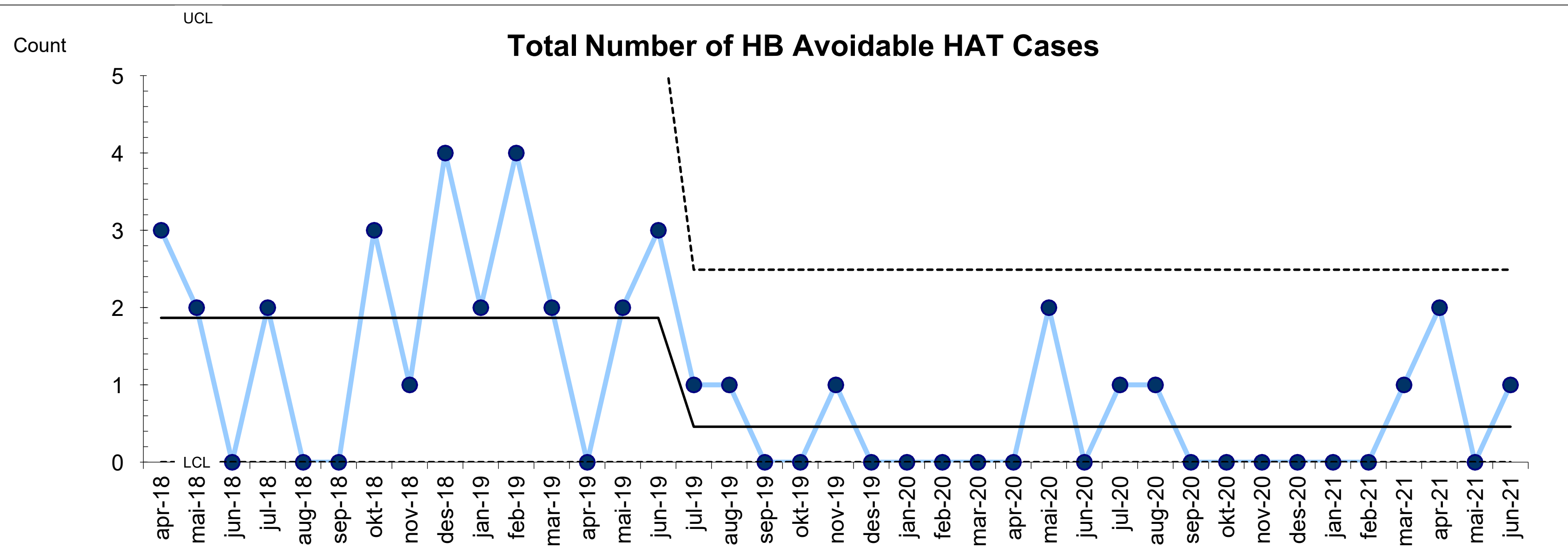


Improvement work

Number of focused areas aiming to improve medicines management. These include working with Welsh Ambulance Services NHS Trust to encourage patients to bring their own medicines into hospital alongside ensuring that patients medicines accompany them when they are transferred to different wards and community hospitals.

Work has also been undertaken to develop a programme to support medical staff when they have any prescribing errors. The programme identifies relevant individual e-learning packages that supports additional learning for the doctors. Once the learning has been completed; the certificate of learning is uploaded to the incident record on DatixCymru prior to closure of the incident record.

Hospital Acquired Thrombosis



Actions complete

- Identify a clinical lead for HAT
- Temporary adoption of the all Wales Thrombo-prophylaxis policy during pandemic period
- Set up an Improvement task & finish group
- Develop an improvement plan
- Secure funding and employ a QIST member who is dedicated to the HAT improvement agenda
- Ensure robust reporting and review processes in place across all acute site for compliance with Welsh Government HAT Tier 1 target
- Review outcomes from HAT case reviews for Tier I target and take appropriate action to share and respond to lesson learnt
- All learning outcomes from HAT reviews are effectively communicated to clinical teams and are acted on

Next steps

- Amend and localise the All Wales TP Policy for HDHUB including an EQIA
- Following the requirement from Welsh Government that Tier 1 reporting is no longer required, establish an approved reporting process for HDUHB
- HAT QIST practitioner is now in post, depending on current nurse staffing levels and release. They will support:
    - Develop appropriate training and awareness raising mechanisms for all clinical staff on the prevention of HAT
    - Monitor compliance with the TP risk assessment across the acute sites using QI methodology and data collection
    - Develop robust and consistent approach to Redress process for all preventable HAT cases across all Acute Sites.
    - Full implementation and compliance with all Wales thrombo-prophylaxis policy when approved
    - Highlight issues/good practice/success in local Governance meetings
    - Review newly published NICE Quality Standard 201 – work with the Clinical effectiveness team on a gap analysis and improvement plan to achieve this.

Acute Kidney Injury (AKI)

Background

- In 2019 serious incident highlighted inconsistency in recognition and treatment of patients with an AKI in Surgical/Trauma and Orthopaedics at Withybush Hospital
- In March 2019 an AKI working group was set up. This group would be responsible for AKI improvements within Withybush Hospital.
- The aim of the group is to improve the recognition and treatment of patients who are at risk of, or develop an AKI.
- The outcome measures are the amount of AKI alerts across the Surgical and Trauma and Orthopaedic wards.
- Collaborative working across the site has been to key to effective change

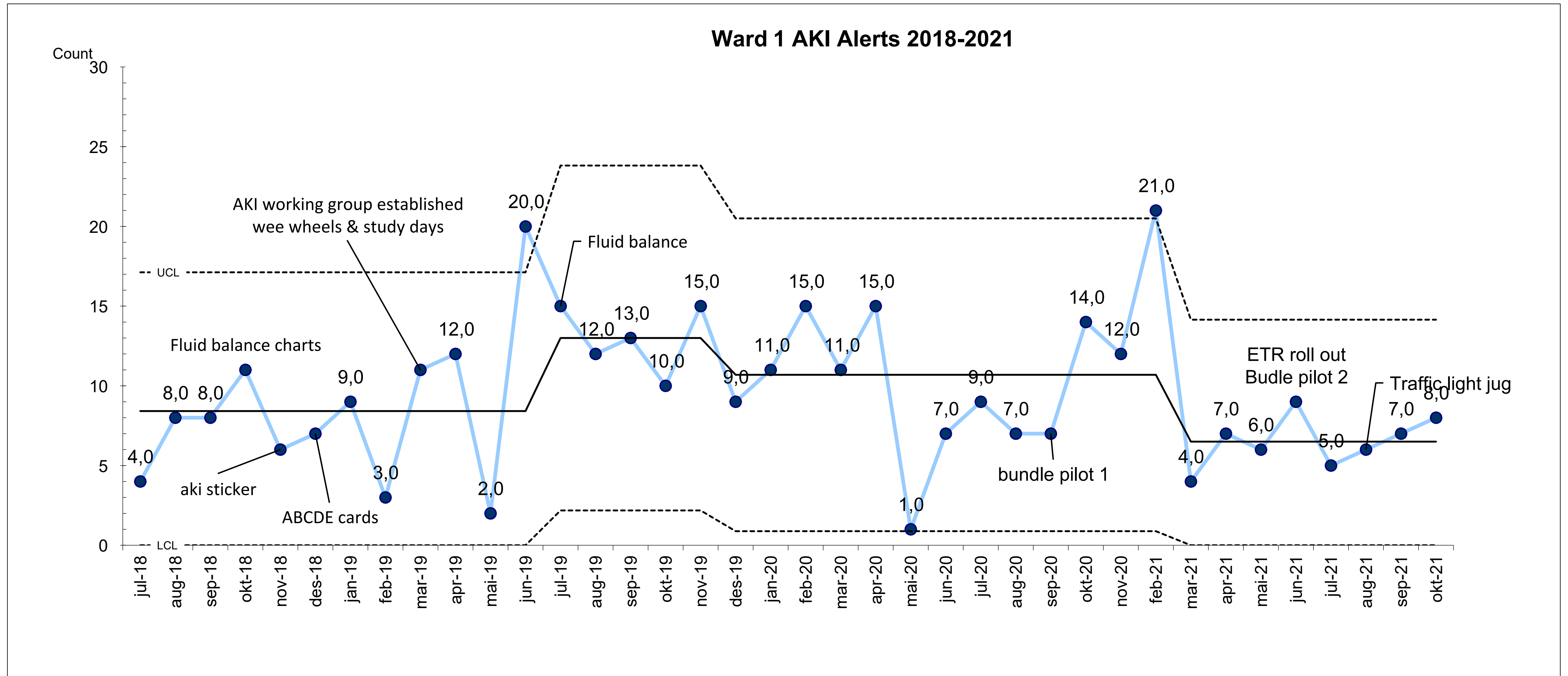
Improvements to date

- Fluid balance chart training to Nurses and HCSW throughout the hospital
- Spot checks and audit of fluid balance charts
- AKI training delivered to Nurses and HCSW in T&O and Surgical areas
- AKI training now incorporated into annual ILS training
- All elective T&O patients have BP recorded on NEWS charts at pre-assessment as well as same day admit to give 2x baseline Blood Pressure's
- Fluid balance charts for T&O now commenced in recovery
- Start times of fluid balance charts changed from 06:00hrs to 01:00hrs
- AKI alerts received earlier, now 18:00hrs
- Introduction of electronic test requests for quicker turn around of blood samples
- Wee Wheels obtained from improvement Cymru distributed to wards
- AKI ABCDE cards developed and given to Nurses
- Development and pilot of an AKI bundle on ACDU, T&O and Surgical wards

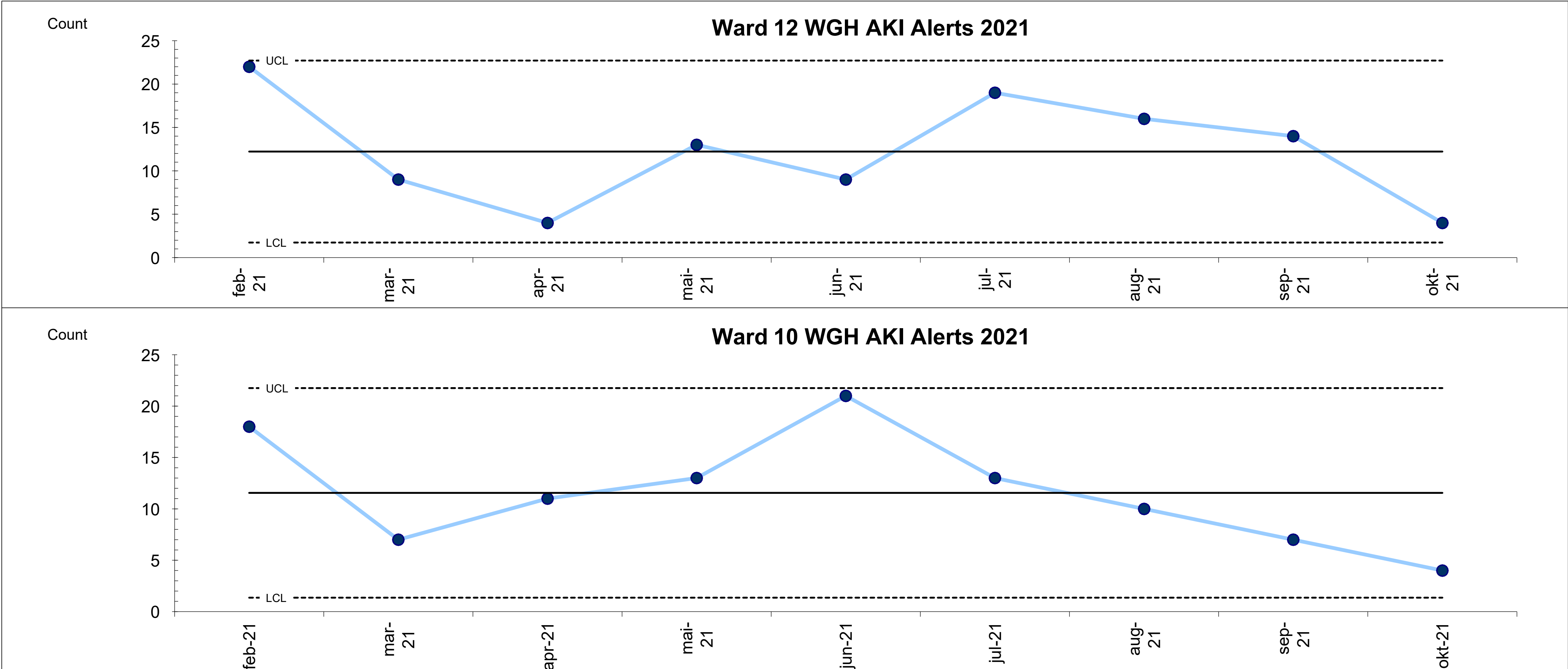
Next Steps

Feedback from pilot audits indicate that an SBAR to HB Rails is required with a recommendation for the monitoring of AKI. Data would be fed back at governance meetings. Development of an RCA tool, similar to HAT process would allow for investigation when numbers increase.

Data: Ward1 Withybush Hospital



AKI alert monitoring at Withybush Hospital



Reportable incidents

	Q2 2020	Q3 2020	Q4 2020
Absconded patient*	1	2	0
Pressure Damage*	2	2	1
Retained Foreign Object	1	0	0
Patient Fall (serious harm)	3	8	3
Unexpected Death **	4	7	5
Neonatal/Perinatal Care	0	0	0
Wrong site surgery/procedure	1	0	0
Under 18 Admission*	0	10	0
Other	1	0	2
Total	**13**	**29**	**11**

*not reportable - temporary change in SI reporting during first wave, requirement to report re-introduced. However, reporting requirements have recently change in view of second wave pressures

	Q1 2021	Q2 2021	Q3 2021	Q4 2021
Infection Control	0	1	0	
Self Harm	0	1	1	
Serious Harm	0	2	1	

*not reportable - temporary change in SI reporting during first wave, requirement to report re-introduced. However, reporting requirements have recently change in view of second wave pressures

Patient Safety Incidents

Between 1st September and 31st October 2021, **2** reportable incidents were reported to the Delivery Unit.

Risk and Mitigations

Scrutiny of all incidents reported undertaken by the Quality Assurance Information System Team on a daily basis.

Report of themes and trends in reporting provided to Head of Quality and Governance, Assistant Director of Nursing and Associate Medical Director.

Improvement and Learning Action Plans are developed and implemented within Directorates in response to the findings of the investigations.

The learning from serious incidents is shared at Directorate Quality and Safety meetings.

Mortality Update

- A **Clinical Lead for Mortality** has been appointed, with responsibility for supporting the development and delivery of effective processes and learning from mortality review, in line with the **All Wales Learning from Mortality Review Model Framework**; and developing wider mortality accountability, scrutiny of all available mortality metrics and working with Clinical Directors and Clinical Leads to increase ownership and prioritisation of mortality across the Health Board.
- The Health Board is in the process of ratifying the **All Wales Learning from Mortality Review Framework** and continues to contribute to national discussions regarding the implementation of the Framework and ongoing development as it becomes embedded across Wales.
- Considerable engagement has taken place with Clinical/Hospital Directors, Nursing, Therapies, Pharmacy, operational and corporate teams to develop **local processes** which align with the **All Wales Framework**. This enables the key principles of the Framework to be achieved whilst also allowing for local variations.
- Local processes include the development of a **Multidisciplinary Panel** and discussions are ongoing with regards to membership. Preparations are underway for the first Multidisciplinary Panel to take place.
- Engagement is ongoing with other Health Board’s in order to maximise opportunities to share learning and build from others’ experiences.
- The **Medical Examiner Service** will be fully established across all four acute hospital sites by the end of November. All deaths will be reviewed by the **Medical Examiner Service** from December onwards.

HIW Quality Checks/Inspections: Summary 17 September – 15 November 2021

New Quality Checks/Inspections

Area of Review	Recommendations	Update
Ty Bryn Learning Disability and Specialist Autism Service, Hafan Derwen	9 Immediate Recommendations	The Quality Check was held on 1st November 2021, with an immediate assurance plan issued containing 9 recommendations on matters relating to the physical environment and governance. The Health Board have responded to the recommendations raised, and are awaiting receipt of the draft report and following improvement plan.
Tregaron Community Hospital	29	An on-site inspection was undertaken on 7th and 8th September 2021, whereby 29 recommendations raised on matters including patient experience, delivery of safe and effective care and quality of management and leadership. HIW have accepted the responses provided by the Health Board to the recommendations raised, with the final report awaiting publication on the HIW website. The recommendations raised will be tracked via the Audit and Inspection Tracker, with expected completion by September 2022.

Update on previous Quality Checks/Inspections

Area of Review	Recommendations	Update
Glangwili General Hospital – Towy Ward	2	The Quality Check was held in November 2020, with recommendations raised relating to action plans for falls and pressure and tissue damage, and staff training compliance. Confirmation has been received from the service, and sent on to HIW that all recommendations have now been actioned and the report is now considered closed.
Glangwili General Hospital – Morlais Ward	3	The Quality Check was held in March 2021, with the final report published in May 2021. Three recommendations were raised relating to the completion of a Cleaning4Credits audit, staff training compliance and data regarding restraint incidents, with a view that all recommendations will be completed by March 2022.
Tenby Surgery (UHB Managed Practice)	9 Immediate Recommendations 2 Recommendations from main report	The Quality Check was held in June 2021, with 9 recommendations raised on an immediate improvement plan, and a further 2 from the main report. Confirmation has been received from the service, and sent on to HIW that all recommendations have now been actioned and the report is now considered closed.
Llandovery Hospital	N/A	The Quality Check was scheduled for June 2021, but was postponed by HIW. The Health Board are currently awaiting a revised date for this inspection.
St Caradog Ward, Withybush General Hospital	2	The Quality Check was held in August 2021, with 2 recommendations raised relating to addressing issues identified within the fire safety reports and point of ligature risk assessments, and to produce an action plan to address issues raised within the IPC audit. A progress update has been submitted to HIW in November 2021 detailing the partial completion of the recommendations raised. Recommendations are expected to be actioned in full by June 2022.

HIW Quality Checks: Additional Information

National Reviews

The Health Board have been invited to partake in the National Review of Patient Flow in relation to the Stroke Pathway, the aim of which is to assess the impact that patient flow challenges may have on the quality and safety of patients awaiting assessment, receiving treatment, through to discharge from hospital services. Nominated contacts have been identified to partake in an initial stakeholder meeting scheduled for December 2021.

Services of Concern: New HIW Process

The Health Board received a proposal document from HIW in July 2021, outlining their intention to implement a Service of Concern process, and supporting process guidance. Previously, HIW followed an internal escalation process when an issue of concern came to their attention. The new proposal is to formally use a Service of Concern designation when HIW identifies significant singular service failures, or cumulative or systemic concerns regarding a service or setting.

It is intended that a Service of Concern designation will increase transparency around how HIW discharges its role and ensure that focused and rapid action can be taken by a range of stakeholders, including health boards, to ensure that safe and effective care is being provided. The Health Board provided its responses to the consultation in September 2021, and the process is now in force as of 15th November 2021. Further information can be found via the following link: Service of Concern Process for NHS Bodies in Wales (www.hiw.org.uk)

Risks and Mitigations

- All correspondence received by third parties in relation to their activity is logged on receipt by the Assurance and Risk team.
- Process in place for co-ordinating and quality checking responses to HIW requests by the required deadlines.
- Recommendations from HIW immediate assurance plans and final reports are logged on the central tracker and progress is requested from services by the Assurance and Risk team on a bi-monthly basis.
- Central tracker reported to every Audit and Risk Assurance Committee (ARAC) meeting.
- HIW activity will form part of the new quality governance arrangements within Directorates going forward.

Recommendation

The Quality, Safety and Experience Committee is requested to take assurance from the Quality and Safety Assurance Report that processes are in place to review and monitor:

- patient safety highlighted through incident reporting
- patient experience highlighted through external inspections

The Committee is asked to take assurance on the improvement work outlined in the report.