Northern Health & Social Care Trust

Patient Safety Quality Improvement Plan
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1.0 Background

The Northern Trust is committed in developing a corporate approach to patient safety. Currently Antrim and Causeway Hospitals have an agreement with the Institute of Healthcare Improvement (IHI) and the Health Foundation to deliver the Safer Patients Initiative by September 2008. This work has presented the Trust with an opportunity to develop, improve and support organisational change through the implementation of the Institute for Healthcare Improvement (IHI) improvement methodology, and as part of the work required to meet the PIA targets during 2007/08 which included Medicines Reconciliation, VAP and crash call rate. The patient safety quality improvement plan sets out how the Trust will deliver the PfA targets for 2008/09 under Ensuring Safer, Better Quality Services and mainstream patient safety improvement activities across the organisation.

2.0 Accountability Structure

The NHSCT Accountability structure for Patient Safety seeks to enable the Head of Governance and Patient Safety to discharge his/her responsibilities through Governance Management Board. Within the accountability structure, Directors remain accountable for implementing the Patient Safety Quality Improvement Plan and performance managing the improvements in their service areas. Directors are responsible to the Chief Executive for implementing the Patient Safety Quality Improvement Plan within their Directorate and ensuring objectives/targets are met.

2.1 Intervention teams

The Northern Trust intervention teams will be based on the methodology used through the Safer Patients Initiative and will focus on measuring and achieving 95% compliance with each element of the bundles in the segmented area and then plan to spread through to other areas during 2009/10.

A multi-disciplinary team has been established for each intervention and the membership consists of a number of clinical staff who have responsibility for ensuring that changes are tested and data is collected on a monthly basis. The team will be responsible for sharing best practice raising the profile of patient safety and spreading to other areas. The teams will be fully supported by the Governance Management Board, Trust Risk Governance and Patient Safety Group and led by the Trust Clinical and Social Care Governance Manager.
3.0 Accountability / Reporting Arrangements

TRUST BOARD

Governance Management Board

Trust Risk, Governance and Patient Safety Group

- Crash Calls
- Critical Care
- Maternity C-Sections
- Mental Health
- Medicines Management
3.1 Patient Safety - Governance Management Board

The purpose of the Governance Management Board (GMB) with regards to patient safety is to act as the strategic committee responsible for leading patient safety across the Trust. The committee meets on a monthly basis and comprises the following membership:

- Chief Executive (Chair)
- Medical Director (Patient Safety Lead)
- Director of Emergency, Primary Care & Older People (& Executive Director of Nursing)
- Director of Elective and Acute Reform
- Director of Children’s and Womens Services
- Director of Mental Health and Learning Disability
- Director of Human Resources
- Director of Finance
- Director of Strategic Planning and Performance Management
- Head of Governance & Patient Safety
- Trust Clinical and Social Care Governance Manager
- Trust Corporate Risk Manager

Frequency of meetings: Monthly

This Board will:

- Performance manage compliance against safety targets
- Approve patient safety quality improvement plan and monitor progress against the plan
- Provide leadership direction and advice to the teams
- Influence high level clinical and managerial support for this plan
- Promote and embed a patient/client safety culture across the organisation through the implementation of this plan
- Approve reports for Trust Board
- Ensure that an effective communication strategy is developed
3.2 Terms of reference for Trust Risk, Governance and Patient Safety Group

This group will report to Governance Management Board, and will meet on a bi-monthly basis and will be chaired by the Medical Director. The remit of this committee will be to ensure implementation of the patient safety quality improvement plan and methodologies across agreed wards/services.

Membership:

- Medical Director
- Head of Governance
- Trust Clinical and Social Care Governance Manager
- Corporate Risk Manager
- Representative from Finance Directorate
- Representative from Estates
- Representative from Medical/Dental/Pharmacy forum
- Representative from Nursing forum
- Representative from Social Work forum
- Representative from AHP forum
- Governance Leads from 4 service Directorates

Frequency of meetings: Bi-monthly

The main purpose of the group is to ensure that patient safety and risk management processes across the organisation are dynamic, that learning is shared and best practice is promulgated.

- To review data on incidents and extrapolate trends and areas of concern for the attention of GMB or individual directors
- To bring to the group’s attention, evidence of emerging cross directorate risks and any concerns regarding progress against existing risks
- Share learning from incident/completing investigation
- **Monitor Trust performance against the Patient Safety Quality Improvement Plan and report progress to Trust Board**
- **Provide direction and guidance on Patient Safety Strategy for the Trust**
- **To ensure linkages between incident analysis, patient safety outcomes and audit plans**
- To receive and review reports on the activity of advisory groups and collate into composite report for GMB bi-annually
- To review evidence of implementation of or action in response to Chief Officers letters, alerts, guidelines and circulars from Safety and Quality and Standards Unit
- To ensure that an audit programme is developed which reflects corporate priorities, and promotes continuous improvement in clinical and social care activity
- To receive and monitor progress against action plans developed in response to serious incidents both internal and external
4.0 System Level Aims and the Relationship with PfA Targets

The ‘high-level outcome measures’ of any patient safety work is to reduce deaths and unnecessary harm. The following graph illustrates the relationship between these ‘big dots’ and the PfA targets (including ongoing interventions and other areas of patient safety work within the Trust):

- **CORPORATE OBJECTIVE**
  
  TO PROVIDE SAFE, HIGH QUALITY CARE TO OUR PATIENTS/CLIENTS

- **PATIENT SAFETY PROGRAMME OBJECTIVE**
  
  REDUCE DEATHS & UNNECESSARY HARM

- **2008/2009 PRIORITY AREAS**

  **TRUSTWIDE**
  - Leadership Walkrounds
  - Reduction in MRSA
  - Reduction in C Difficile

  **MENTAL HEALTH**
  - Mental Health
  - Inpatient Risk Assessment
  - Inpatient Review
  - Discharge Planning

  **ANTRIM HOSPITAL**
  - VAP
  - Crash Calls (Use of PEWS)
  - SSI (C Section)
  - CLI
  - Safety Briefings
  - Use of SBAR
  - SPI Measures
  - Mortality rate
  - Adverse event rate

  **CAUSEWAY HOSPITAL**
  - VAP
  - Crash Calls (Use of PEWS)
  - SSI (C Section)
  - CLI
  - Safety Briefings
  - Use of SBAR
  - SPI Measures
  - Mortality rate
  - Adverse event rate

  **MID-ULSTER HOSPITAL**
  - Crash Calls (Use of PEWS)
  - Safety Briefings
  - Use of SBAR

  **WHITEABBEY HOSPITAL**
  - Crash Calls (Use of PEWS)
  - Safety Briefings
  - Use of SBAR
### 5.0 PfA Target 2008/2009 Interventions Per Site

<table>
<thead>
<tr>
<th>PfA Target</th>
<th>Aim</th>
<th>Measures/Definitions</th>
<th>Changes</th>
<th>Improvement Teams</th>
</tr>
</thead>
<tbody>
<tr>
<td>SSI Ortho</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
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</tbody>
</table>

**MATERNITY TEAMS - SSI – C-section (Antrim and Causeway Hospitals)**

A reduction rate will be set when baseline information is obtained from HISC and will be agreed by the intervention teams. Currently the Trust will focus on developing compliance with the four elements of the SSI bundle and on improving compliance with the completion and return of the SSI monitoring forms for HISC. The pilot population will initially be elective cases only and will then spread to all C-section patients by March 2009.

### 5.1 SSI C-Section

To reduce SSIs in all C-section patients by 20-30% by March 2010 against the HISC baseline data.

To introduce the SSI bundle and ensure 95% compliance with all elements of the bundle with all C-section patients by March 2010.

To improve compliance on completion and return of HISC forms.

- 95% compliance with Prophylactic Antibiotics
- 95% compliance with Hair removal
- 95% patients with peri-op normothermia
- 95% surgical patients with peri-op Glucose control
- 95% Compliance with carrying out Surgical Pause (Safety Briefing)

Overall bundle compliance Caesarean section SSI rate

Education & training

- Appropriate use of antibiotics
- Appropriate hair removal
- Peri-operative normothermia
- Peri-operative glucose control

**Responsible Director:**

Glenn Houston

**Assistant Director:**

Margaret Gordon

**Head of Midwifery:**

Mary Maxwell

**Antrim:**

- Dr Greg Furness, Cons Anaes
- Dr Frances Stewart, Cons Delivery Suite
- Sr Brigid Laverty, Labour Ward
- Caroline Keown, ACSM,
- Joanne O’Loughlin, Ward C1
- Heather McKillop, Ward C2
- Helen O’Neill, Community Midwife

**Causeway:**

- Dr B Marshall, Cons Obs
- Sharon Sherrard, ACSM
- K Graham, Ward Manager
- Therese McKay, Community Midwife

Martine McNally, Trust Clinical and Social Care Governance Manager
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<tr>
<td><strong>CRITICAL CARE TEAM - Central Line Infections (Antrim and Causeway Hospitals)</strong></td>
<td>The central line bundle in both Antrim and Causeway began in Intensive Care Units in March 2007, and a system for insertion monitoring and daily review is now in place and will be reported monthly.</td>
<td><strong>5.2.1 CLI</strong> Central Line Infection</td>
<td>To increase days between to 300 days or greater by March 2010. To further develop the Central Line bundle in ICU to ensure 95% compliance with each element of the bundle by March 2010.</td>
<td>95% compliance with - Optimal insertion site - Hand Hygiene - Maximal Barrier protection - Sterile technique (including chlorhexidine) - Daily line review</td>
</tr>
<tr>
<td><strong>- Ventilator Acquired Pneumonia (Antrim and Causeway Hospitals)</strong></td>
<td>ICU in both Antrim and Causeway have been working in this area since March 2007, and have introduced a daily review system for each patient to ensure that all change elements have been achieved. This is carried out and documented by nursing staff within the unit and appropriate action is taken if compliance is not achieved.</td>
<td><strong>5.2.2 VAP</strong> Ventilator Acquired Pneumonia</td>
<td>To achieve 300 days between VAPs. To further develop the prevention of VAP in ICU to ensure 95% compliance with each element of the ventilator bundle by March 2010.</td>
<td>95% compliance with - HOB elevation - GI Prophylaxis - DVT prophylaxis - Sedation break</td>
</tr>
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</table>
### Critical Care Team (contd) SPI Measures (Antrim and Causeway Hospitals)

The critical care teams both at Antrim and Causeway will continue to measure compliance with the critical care interventions for 2008/09. The plan will be to sustain improvement and achieve compliance with all the elements.

<table>
<thead>
<tr>
<th>PfA Target</th>
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<td><strong>Process</strong></td>
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<td><strong>Outcome</strong></td>
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| 5.2.3 Critical Care SPI Measures | Refer to SPI Measurement Plan | ALOS on mechanical ventilation | 80% of patients’ blood glucose within the range 3.5 – 8.5mmol | Responsible Director: Martin Sloan  
General Manager, Anaesthetics: Pauline McGaw  
Antrim: Dr Ronnie Bailie, Consultant Anaesthetist  
Sr Kay Johnston, ICU  
Sr Anne Scullion ICU  
Causeway: Dr Geoff Wright, Consultant Anaesthetist  
Sr Anne Christie, ICU  
Martine McNally, Trust Clinical and Social Care Governance Manager |
| Percent of ICU and HDU blood sugar results within range (3.5 – 8.5 mmol/L) | To maintain 80% of patients’ blood glucose within the range 3.5 – 8.5mmol | 95% compliance with hand hygiene | To reduce mortality in ICU |
| Percent of ICU mortality | To reduce mortality in ICU | 95% of patients have a MDR | |
| ALOS on mechanical Ventilation | To ensure 95% compliance with hand hygiene | 95% of patients have daily goals set | |
| Percent compliance with hand hygiene | | Reintubation rate | |
| Percent achievement of multi-disciplinary rounds | To ensure that 95% of patients have a MDR | ICU ALOS (balancing measure) | |
| Percent achievement of multi-disciplinary rounds and daily goals | To ensure that 95% of patients have daily goals set | | |
| Reintubation rate | | | |
| ICU ALOS (balancing measure) | | | |
### GENERAL WARDS TEAM - Crash Call

Definition of crash call is a cardio-respiratory arrest requiring resuscitation to sustain life. This is assessed in 3 ways: a log is received by switchboard indicating an arrest has occurred; then the resuscitation officers receive a message on their pager system; completed monitoring forms are audited by the resuscitation officer. As part of the Safer Patients Initiative project, both Antrim and Causeway have developed a robust system to monitor and measure crash call rate and as a consequence have reduced the crash call rate by at least 30% as at September 2008. The Northern Trust has developed a standardised approach to Physiological Early Warning Score (PEWS) and was issued in June 2008 across all areas. As part of the Safer Patients Initiative, safety briefings have been rolled out to all areas in Antrim and Causeway and the plan is to spread to Mid-Ulster and Whiteabbey Hospitals by March 2009. Also the SBAR (Situation, Background, Assessment, Recommendation) communication tool is used for nursing handover and emergency situations, both in Antrim and Causeway and the plan is to spread to Mid-Ulster and Whiteabbey by 2009/10.

#### 5.3 Crash Call Rate
(exclude Coronary Care, ICU and A&E)

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<td>Process</td>
<td>Outcome</td>
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<tr>
<td>Antrim &amp; Causeway: The aim is to sustain the reduction that has been achieved by September 2008</td>
<td>95% compliance with PEWS: - All vital signs recorded</td>
<td>Crash call rate per 1000 patient discharges</td>
<td>Further development of safety briefings to all ward areas during which ill patients are to be identified.</td>
<td>Responsible Director Peter Flanagan</td>
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<tr>
<td></td>
<td></td>
<td>- All scores totalled</td>
<td>95% compliance with ward safety briefings</td>
<td>Protocol for medical response to be reviewed and measurement system identified.</td>
</tr>
<tr>
<td>Mid-Ulster &amp; Whiteabbey: The aim is to maintain a low crash call rate by March 2010 within Mid-Ulster and Whiteabbey Hospitals.</td>
<td>- Evidence of action from score</td>
<td>95% staff using emergency SBAR briefing</td>
<td></td>
<td>Martine McNally, Trust Clinical and Social Care Governance Manager</td>
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<tr>
<td></td>
<td></td>
<td>- Frequency documented</td>
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<td>Changes</td>
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<td><strong>INFECTION CONTROL TEAM – Health Care Acquired Infections (HCAI)</strong></td>
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<td>The Northern Trust has a corporate infection reduction plan for both Clostridium difficile and MRSA.</td>
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| **5.4.1 Clostridium difficile** | To reduce the number of C Diff infections by 20% across the Trust against the 06/07 baseline by March 2009 | To measure the actual number of C Diff infections per month | % compliance with C Diff bundle | Responsible Director: Peter Flanagan, Medical Director  
Team: Mrs Shirley Johnston Taskforce Group  
Martine McNally, Trust Clinical and Social Care Governance Manager |
| | Monthly average should be 11 | To measure the days between C Diff infections | Monthly number of C Diff patients | | |
| | | 95% compliance with evidence of appropriate hand washing | | | |
| | | % patients with evidence of review of antibiotic treatment for C Diff infections and overall patient management | | | |
| **5.4.2 MRSA** | To reduce the number of Staph aureus bloodstream infections including MRSA by 10% across the Trust by March 2009 | To measure the actual number of MRSA infections per month | Monthly number of staph aureus bloodstream infections including MRSA. | Responsible Director: Peter Flanagan, Medical Director  
Team: Mrs Shirley Johnston Taskforce Group  
Martine McNally, Trust Clinical and Social Care Governance Manager |
| | Monthly average should be 8 | To measure the days between MRSA infections | | | |
| | | 95% compliance with hand hygiene | | | |
| | | % utilising the RCA tool for every bacteraemia within 24 hours and to be completed within 5 working days | | | |
| | | Flagging up on patient notes that patient has been identified that they have been infected | | | |
Mental Health

Multi-disciplinary weekly team review (MDWTR)

(6 acute admission units)

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5.5.1 Mental Health

Multi-disciplinary weekly team review (MDWTR)

(6 acute admission units)

To ensure that 95% of patients’ weekly multi-disciplinary review, in each acute admission unit, meets each element within the overall intervention by March 2010 (7 elements within this intervention).

**Exclusions:**
- Long stay patients 6 months+
- Patients admitted and discharged before MDT meeting
- Patients who leave against medical advice

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<td></td>
<td>1. 95% of patients receive weekly MD team reviews</td>
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<td>2. 95% reviews recorded in notes</td>
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<td>3. 95% clear evidence of a plan review</td>
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<td>4. 95% future management agreed</td>
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<td>5. 95% interventions identified been allocated to professional</td>
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<td>6. 95% target date been set for completion of intervention</td>
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<td>7. 95% evidence in notes that 2 or more disciplines conducted the review</td>
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<td>95% all 7 elements are evidenced in the selected sample (20 patient records)</td>
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**Changes**

Review of current documentation

Staff education

Development of data collection system to measure progress

**Improvement Teams**

**Responsible Director:** Oscar Donnelly

**Assistant Director:** Noelle Barton

**Head of Hospital Services:** Trevor Fleming

Denise Martin, Nursing Services Manager (System Leader)
Dr Gerry Lynch, Clinical Director
Dr Estelle McFarland
Ruth Hedley, Ward Manager (Day to day lead)
Rosie Mooney

Martine McNally, Trust Clinical and Social Care Governance Manager
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| **5.5.2 Mental Health**  
Joint Risk Assessment (RA) | To ensure that 95% of patients’ joint risk assessment, in each acute admission unit, meets each element within the overall intervention by March 2010 (5 elements within this intervention). | 1. 95% of patients have a joint risk assessment completed  
2. 95% that 2 or more disciplines conducted the RA  
3. 95% of RA completed using risk proforma  
4. 95% of RA actioned and communicated to other colleagues if appropriate  
5. 95% of RA reviewed during patient stay in hospital | 95% inpatients who had a MD risk assessment by 2 or more disciplines and reviewed as appropriate during the inpatient stay | Review of current documentation  
Staff education  
Development of data collection system to measure progress | Responsible Director: Oscar Donnelly  
Assistant Director: Noelle Barton  
Head of Hospital Services: Trevor Fleming  
Denise Martin, Nursing Services Manager (System Leader)  
Dr Gerry Lynch, Clinical Director  
Dr Estelle McFarland  
Ruth Hedley, Ward Manager (Day to day lead)  
Rosie Mooney  
Martine McNally, Trust Clinical and Social Care Governance Manager |
| **5.5.3 Mental Health**  
Treatment/Care Plan (TCP) | To ensure that 95% of patients', in each acute admission unit, are involved in their treatment/care plan by March 2010 (3 elements within this intervention). | 1. 95% of patients should have a treatment/care plan developed  
2. 95% evidence that TCP discussed with patient/carer during stay in hospital  
3. 95% evidence that TCP has been reviewed in discussion with patient/carer during stay in hospital | 95% inpatients who have a treatment/care plan agreed, developed and reviewed in discussion with the patient/carer during their stay in hospital through to discharge | Review of current documentation  
Staff education  
Development of data collection system to measure progress | Responsible Director: Oscar Donnelly  
Assistant Director: Noelle Barton  
Head of Hospital Services: Trevor Fleming  
Denise Martin, Nursing Services Manager (System Leader)  
Dr Gerry Lynch, Clinical Director  
Dr Estelle McFarland  
Ruth Hedley, Ward Manager (Day to day lead)  
Rosie Mooney  
Martine McNally, Trust Clinical and Social Care Governance Manager |
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<tr>
<td><strong>MEDICINES MANAGEMENT TEAM</strong></td>
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<tr>
<td>5.6 Medicines Reconciliation</td>
<td>To increase to 95% the rate of medication reconciliation in an agreed targeted patient group, within 24 hours of admission to hospital.</td>
<td>95% Targeted patients with complete medication reconciliation within 24 hours of admission to the hospital. Target patients are those as per original IMM project, with few exceptions. Medication reconciliation rate are determined as per Trust approach to Medication Reconciliation. In other words by clinical pharmacists at AAH, and by medical or clinical pharmacy staff at Causeway Hospital, using the definition of medication reconciliation as agreed by site.</td>
<td>Links with IMM outcomes - reduce length of stay - more accurate drug history - improved medication appropriateness - eliminate wastage of patients’ own drugs - reduce missed doses - discharge prescription accuracy - counselling Links with SPI outcome measure ie rate of Adverse Drug Events associated with anticoagulants</td>
<td>New medication reconciliation form Update of medication history/reconciliation process within clinical pharmacy SOPs New Trust warfarin administration and discharge form (in development under the remit of the Northern Area Anticoagulant Safety Group) Ongoing review of monthly INR results from labs in order to detect changes in trends with results, which reflect processes relating to anticoagulant management. Development of protocols and guidelines for the management of anticoagulant, both locally (heparin) and from regional working group as a sub0group of the Regional Anticoagulant Group for NPSA Alert 18.</td>
</tr>
<tr>
<td>5.6.1 Adverse Drug Events</td>
<td>To reduce harm from anticoagulants by 50%</td>
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## PERI-OPERATIVE TEAM (SPI measures)

The peri-op team both at Antrim and Causeway will continue to measure compliance with the peri-op interventions for 2008/09. The plan will be to spread this work to Mid-Ulster and Whiteabbey during 2009/10.

<table>
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<tbody>
<tr>
<td>Measured/Defined</td>
<td>Process</td>
<td>Outcome</td>
<td>Development of new proforma for ‘IPPAUSE’ (format of safety briefings/surgical pause)</td>
<td>Responsible Director – Martin Sloan</td>
</tr>
<tr>
<td>PfA Target</td>
<td>Aim</td>
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<td>Changes</td>
<td>Improvement Teams</td>
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<tr>
<td>PERI-OPERATIVE TEAM (SPI measures)</td>
<td>The aim is to reduce Surgical Site Infections against our baseline for 2007</td>
<td>95% eligible surgical patients receiving DVT prophylaxis</td>
<td>Number of surgical patients developing a Surgical Site Infection (SSI)</td>
<td>Responsible Director – Martin Sloan</td>
</tr>
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<td>Percent of surgical patients developing a Surgical Site Infection (SSI)</td>
<td>To ensure that 95% of surgical patients receive DVT Prophylaxis as appropriate</td>
<td>95% on-time prophylactic antibiotics administration</td>
<td>Development of new proforma for ‘IPPAUSE’ (format of safety briefings/surgical pause)</td>
<td>Responsible Director – Martin Sloan</td>
</tr>
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<td>Percent of eligible surgical patients receiving DVT prophylaxis</td>
<td>To ensure that 95% of surgical patients receive prophylactic antibiotics 0-60 minutes pre knife-to-skin as appropriate</td>
<td>95% known diabetic surgical patients with peri-operative glucose control</td>
<td>Responsible Director – Martin Sloan</td>
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<td>Percent on-time prophylactic antibiotics administration</td>
<td>To ensure that 95% of surgical patients’ blood glucose levels are maintained within range</td>
<td>95% surgical patients on maintenance beta blockade who were continued on beta blockade</td>
<td>Responsible Director – Martin Sloan</td>
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<td>Percent of known diabetic surgical patients with peri-operative glucose control</td>
<td>To ensure that 95% of appropriate surgical patients’ beta blockade is recommenced following surgery</td>
<td>95% eligible surgical patients with peri-operative normothermia</td>
<td>Responsible Director – Martin Sloan</td>
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<td>Percent of surgical patients on maintenance beta blockade who were continued on beta blockade</td>
<td>To ensure that 95% of surgical patients’ body temperatures are maintained as normothermic</td>
<td>95% inpatient surgical patients with appropriate hair removal</td>
<td>Responsible Director – Martin Sloan</td>
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<td>Percent of eligible surgical patients with peri-operative Normothermia</td>
<td>To ensure that 95% of surgical patients have their hair removed by clippers as close as possible to time of surgery</td>
<td>95% patients with Peri-operative briefings (surgical time out)</td>
<td>Responsible Director – Martin Sloan</td>
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<td>Percent of inpatient surgical patients with appropriate hair removal</td>
<td>To ensure that surgical pauses have been held for 95% of surgical cases</td>
<td></td>
<td>Responsible Director – Martin Sloan</td>
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</tr>
</tbody>
</table>

Responsible Director: Martin Sloan
General Manager: Geraldine McKay?
Antrim:
Dr Leyden
Pauline McGaw
Sr Rosie McCauley
Sr Heather Lowry
Causeway:
Mr Brown
Sr Irene McLaughlin
Mid-Ulster and Whiteabbey:
Martine McNally, Trust Clinical and Social Care Governance Manager