Meeting Date	**02 December 2019**	**Agenda Item**	**3.1**
Report Title	Morriston Hospital Delivery Unit: Health & Safety Update Report		
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Report Sponsor	Deb Lewis, Unit Service Director, Morriston Hospital		
Presented by	Suzanne Holloway, Head of Quality & Safety, Morriston Hospital		
Freedom of Information	Open		
Purpose of the Report	To provide the Health Board's Health & Safety Committee with an update report on health & safety outcomes, challenges and risks at Morriston Hospital. Setting out improvement actions and mitigation for the remainder of 2019/2020.		
Key Issues	The report will cover the following key issues: • Falls/Accidents (Patients) • Healthcare Acquired Pressure Ulcers • Staff Incidents • Mandatory Training Performance • Unit based Health & Safety risks		
Specific Action Required ***(please choose one only)***	**Information**	**Discussion**	**Assurance**	**Approval**
	☐	☐	☒	☐
Recommendations	Members are asked to: • **Recognise** the governance structure at Morriston Hospital Service Delivery Unit to provide assurance in relation to health & safety requirements. • **Note** current outcomes, challenges and risks identified within this paper in respect of health & safety and the work undertaken in order to mitigate risk and improve safety.		

Morriston Hospital Delivery Unit
Health & Safety Report

1. INTRODUCTION

To provide the Health Board's Health & Safety Committee with an update report on health & safety outcomes, challenges and risks at Morriston Hosptial.

2. BACKGROUND

2.1 Health & Safety Business Assurance at Morriston Hospital

The Morriston Environment and Support Services Group is a sub-group of the Morriston Hospital Management Board and provides operational focus with regards to all site based health & safety issues, providing a formal quarterly exception report.

In establishing this group consideration has been given to the need to develop stronger operational relationships with both the Estates and the Facilities Departments (based at Morriston Hospital). This group aims to ensure that there are clear lines of communication and that joint decision-making and risk assessment are undertaken on a routine basis. This group includes key health and safety parameters such as the environment, water safety, security and cleaning.

This meeting is chaired by the Service Manager for Emergency Care and Hospital Operations and has been in place in this current format since February 2019. The Head of Quality & Safety at Morriston Hospital is the Unit's nominated member of the Health Board's Operational Health & Safety Group, which meets on a quarterly basis.

2.2 Health & Safety Improvement Notice Risk: HSE Visit – 17th September 2019

The purpose of the visit was to assess and assure the HSE in relation to action and learning from a series of improvement notices issued to the Health Board in November 2018.

Verbal feedback provided on the day was positive and there was a strong indication that all improvement notices applied to the Moriston Hospital Unit would be lifted.

Figure 3.1: Morriston Hosptial: Inpatient Falls Scorecard (as at Oct 2019)

	Target	2018/2019	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sep 19	Oct 19
*Inpatient Falls	**Reduce**	**1149**	104	86	80	84	82	95	104
*Serious Incident: Fractures reported to WG	**Reduce**	**15**	5	1	0	1	0	0	2
*Falls (Harm: Failings Identified) Reduction Profile: 10% in year	**77**	**86**	15	17	8	9	4	14	11
**Occupied Bed Days ('000)		**229.5**	20.5	20.9	20.3	20.8	20.3	20.1	20.4
Fall/1000 OBD	**6.63**	**5.01**	5.01	4.11	3.94	4.02	4.04	4.73	5.10
Significant Falls/1000 OBD (WG Reported)	**0.19**	**0.06**	0.24	0.05	0.00	0.05	0.00	0.00	0.10

Source Data:

* Datix Data Extract to show under of Patient Accident/Falls involving a witnessed/unwitnessed trip/fall or slip
** Data extracted from HB Ward Dashboard (Information Portal) – calculated using average number of beds available in month adjusted for midday bed occupancy

All cases where a patient sustains a fracture or significant injury as a result of an inpatient fall are reported to Welsh Government as a serious incident and a full investigation is undertaken. As an outcome of the investigation process an improvement plan is produced detailing all actions to prevent further incidents. These cases are presented at the Morriston Inpatient Falls Group to support shared learning from each event.

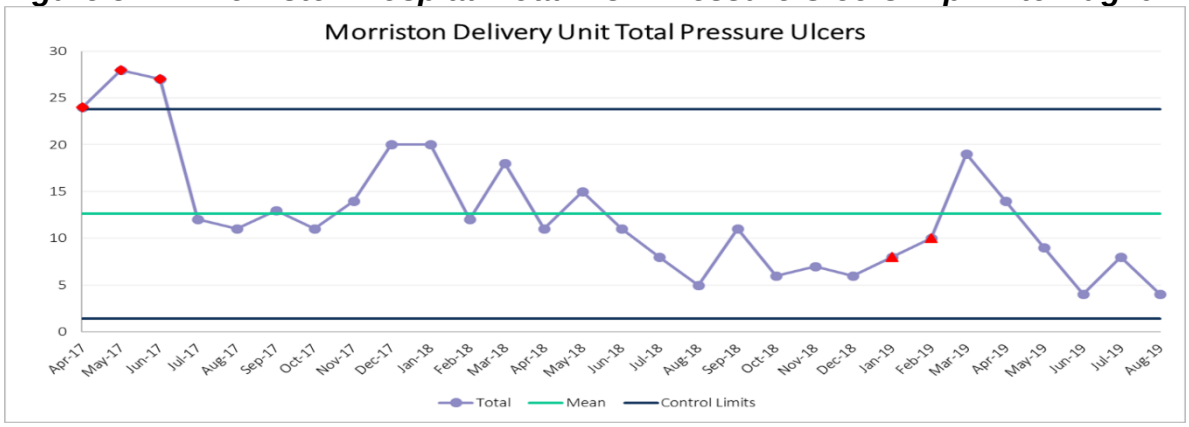
In undertaking investigation a contributory factor identified in a significant number of the cases was the implementation and application of Health Board Policy. As a result and in line with the preparation for the launch of the new Health Board Adult Inpatient Falls Prevention and Management Policy in September 2019 additional education and training has been rolled out onto wards to ensure that correct assessment documentation is being implemented and applied. To date over 1400 staff members at Morriston Hospital have received falls assessment training.

3.2 Healthcare Acquired Pressure Ulcers

All healthcare acquired (HCA) pressure ulcers attributed to Morriston Hospital are subject to scrutiny via the monthly Morriston Hospital Pressure Ulcer Scrutiny Panel. The panel is a sub-group of the Morriston Hospital Quality & Safety Group and is chaired by the Senior Matron for Surgical Services (Orthopaedics). The panel reviews all HCA pressure ulcer cases on a case by case basis which are deemed to have been healthcare acquired.

Figure 3.2. following demonstrates progress made at Morriston since April 2017 in the reduction of HCA pressure ulcers. Whilst it is acknowledged that March 2019 is an outlier relating to an in month increase in suspected deep tissue injury, the overall reduction profile month on month is evident.

Figure 3.2.1: Morriston Hospital Total HCA Pressure Ulcers: Apr17 to Aug19



Source: ABMU Pressure Ulcer Group

As part of the scrutiny process where any trends or themes emerge in relation to causation or admitting ward a “deep dive” audit is undertaken. The patient’s heel area continues to the prevalent site for health acquired pressure areas at Morriston Hospital along with challenges in ensuring that patients are checked and moved overnight in order to relieve pressure.

A Unit Pressure Ulcer Learning Event is being organised for the 28th January 2020 as an opportunity to share best practice and lessons learnt.

3.3 Staff Accidents

A Staff Incident desk top review has been undertaken at Morriston Hospital. The review’s scope included 3000+ reported Staff Incident during the period 1st January 2016 to 31st July 2019. The outcomes of the review were reported to the Unit ESS Group in September 2019 and the HB Operational H&S Group in November 2019, with the following key observations;

- There is a linear increasing trend of reported incidents over the period reviewed. Projection based on 2019 reporting up to July suggests that this projection will continue.
- Whist there is deviation in the volume of incidents reported by month The trend in reporting staff incidents does not appear to be influenced by seasonality
- Likewise when reviewing day of reporting – whist there is a clear decrease in the number of incidents reported at weekends it is likely that this is due to a reduction in the number of staff working at weekends. The true impact of this causation would need to be investigated further.

Gaps identified:

- Outside of V&A – Sharps Incidents appear to be on the increase on the Morriston site. ***Action: ESS has commissioned a T&F Group to relaunch the Safer Sharps agenda at Morriston in conjunction with corporate H&S.***

Unit RIDDOR Incidents: April to September 2019

- Renal Unit – staff member sustained lifting injury whilst transferring a patient ***Action: Head of Q&S request lessons learnt from HoN and Matron***
- Ward S – Staff sustained whiplash injury whilst trying to prevent a patient from falling ***Action: Head of Q&S request lessons learnt from HoN and Matron***
- Ward S – physical assault on a member of staff by an inpatient resulting in head injury. Patient involved deemed as lacking in capacity and placed on DOLS ***Action: Head of Q&S request lessons learnt from HoN and Matron***
- Hospital Grounds between ambulance liaison and CAB - Staff member (domestic staff) sustained fracture injury whilst transporting cleaning products

in a cage ***Action: request to Domestic Supervisor to share learning and any change in practice as a result of incident***

3.4 Mandatory Training Compliance

Table 3.5.1 below demonstrates Morriston Hospital Unit performance against key mandatory training indicators to support the health & safety agenda. Whilst is acknowledged that progress is slow there has been a sustained improvement over the last 12 months. Monitoring of compliance is embedded into the Morriston Hospital Business & Performance agenda which receives a monthly update on progress.

Table 3.5.1: Mandatory Training Compliance: September 2019

	Sept 2018	**Jun 2019**	**Sept 2019**
Fire Safety Training	68.0%	73.0%	74.4%
Health Safety and Welfare	64.6%	74.3%	77.0%
Moving and Handling (Level 1)	50.9%	64.9%	68.9%
Violence & Aggression	63.0%	72.3%	75.5%

Source: Electronic Staff Record

3.5 Health & Safety Risks and Outstanding Issues

The Unit Risk Register (Nov) has;
There are current 15 H&S risks on the Unit RR with only 3 showing over 16

- Risk to Emergency Dept staff as a result of patient behaviour (16)
- Risk to Patients within the Emergency Dept as a result of behaviour (16)
- Inpatient Falls Risk on medical wards (16)

The above risk scores are support by evidence based prevalence and all 3 have clear monitoring and improvement in place.

Gaps identified:

- Link Site Infrastructure Risks identified by Estates to Unit RR – ***Action***: ***established links with Asst. Director of Operations (Estates) in ensuring that site based infrastructure risks are clearly linked to Unit based service delivery/sustainability risks***

- Fire Planning – Morriston's current plan is out of date and needs revision in light of the Singleton incident – this coupled with a series of issues identified at ward/dept. level in relation to fire doors, wedges, training compliance etc. do add up to a risk at Morriston. ***Action: ECHO will be adding a risk on their RR but in response we are establishing a Fire Sub-Group of ESS to update our planning for fire, using the newly revamped Singleton document as a template.***

In addition to the formal risks reported on the risk register the following issues are have been identified:

Risk Updates

- **Compliance with the requirement of COSHH**
  Action: Added to the CSS RR (scored at 8)

- **Home Oxygen Therapy**
  Action: Agreement was reached that risk in relation to home oxygen (Medicine) can now be removed following the implementation of home assessment/support including Fire Service for acknowledged smokers

- **General Environment Ward Areas**
  Action: Environment refresh programme approved however service demands have impacted on the Unit's ability to progress in clinical areas due to a lack of decant facilities.

- **"Approved" Estates Staff**.
  Action: Estates action plan in place to address identified gaps.

- **Dedicated Support from Health & Safety Professionals**
  Action: In conjunction with Health Board's Assistant Director of Operations (H&S) development of quarterly Health & Safety site reviews. There are currently no health & safety professionals based on site at Morriston Hospital.

4 RECOMMENDATION

The Health & Safety Committee are asked to recognise the assurance structure at Morriston Hospital Service Delivery Unit in relation to health & safety requirements. In addition to note current outcomes, challenges and risks identified within this paper in respect of health & safety and the work undertaken in order to mitigate risk and improve safety.

Governance and Assurance		
Link to Enabling Objectives ***(please choose)***	**Supporting better health and wellbeing by actively promoting and empowering people to live well in resilient communities**	
	Partnerships for Improving Health and Wellbeing	☒
	Co-Production and Health Literacy	☐
	Digitally Enabled Health and Wellbeing	☒
	Deliver better care through excellent health and care services achieving the outcomes that matter most to people	
	Best Value Outcomes and High Quality Care	☒
	Partnerships for Care	☐
	Excellent Staff	☒
	Digitally Enabled Care	☐
	Outstanding Research, Innovation, Education and Learning	☐
Health and Care Standards		
(please choose)	Staying Healthy	☒
	Safe Care	☒
	Effective Care	☐
	Dignified Care	☒
	Timely Care	☒
	Individual Care	☒
	Staff and Resources	☐
Quality, Safety and Patient Experience		
Assurance in regards to both people who visit and use our hospital and the staff that work at the hospital are safe whilst on site.		
Financial Implications		
The above exception report does not require any additional financial resources.		
Legal Implications (including equality and diversity assessment)		
All legal consideration have been reviewed and noted within the report.		
Staffing Implications		
None identified.		
Long Term Implications (including the impact of the Well-being of Future Generations (Wales) Act 2015)		
The committee are asked to note the focus on prevention and co-production with patient and staff in achieving positive outcomes.		

Report History	None.
Appendices	None.