Meeting Date	**3rd December 2018**	**Agenda Item**	**2a.**
Report Title	Morriston Hospital Delivery Unit: Annual Health & Safety Update Report		
Report Author	Suzanne Holloway, Head of Quality & Safety, Morriston Hospital		
Report Sponsor	Rebecca Carlton, Unit Service Director, Morriston Hospital		
Presented by	Rebecca Carlton, Unit Service Director, Morriston Hospital Suzanne Holloway, Head of Quality & Safety, Morriston Hospital Alison Gallagher, Service Group Manager, Emergency Care and Hospital Operations, Morriston Hospital		
Freedom of Information	Open		
Purpose of the Report	To provide the ABMU Health Board's Health & Safety Committee with an annual update report on health & safety outcomes, challenges and risks at Morriston Hospital. Setting out improvement actions and mitigation for the remainder of 2018/2019.		
Key Issues	The report will cover the following key issues: • Falls/Accidents • Healthcare Acquired Pressure Ulcers • Sharp Incidents (resulting in harm) • Violence & Aggression Incidents • Mandatory Training Performance • Unit based Health & Safety risks		
Specific Action Required ***(please ✓one only)***	**Information**	**Discussion**	**Assurance**	**Approval**
			✓	
Recommendations	Members are asked to: • **NOTE** 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
ANNUAL HEALTH & SAFETY REPORT

1. INTRODUCTION

The purpose of this report is to provide the first Morriston Hospital Annual Health & Safety Report to the newly revised ABMU Health & Safety Committee; setting out key outcomes, challenges and risks.

2. BACKGROUND

2.1 Health & Safety Governance at Morriston Hospital

The Morriston Health & Safety Group is a sub-group of the Morriston Quality & Safety Group, which in turn is a reporting forum of the Morriston Hospital Management Board. This meeting is chaired by the Service Manager for Emergency Care and Hospital Operations. A Terms of Reference for the group has been in place since 2015 together with a Health & Safety Improvement Plan. A planned review of the terms of reference are under consideration at the October 2018 Quality & Safety Group, as part of its annual work programme.

As part of a recent review of governance arrangements at Morriston Hospital, consideration has been given to the need to develop stronger operational relationships with both the Estates and the Facilities Departments (based at Morriston Hospital) and the development of a dedicated Estates and Facilities Group. This group would ensure that there are clear lines of communication and that joint decision-making and risk assessment are undertaken on a routine basis. This group will include key health and safety parameters such as the environment, water safety, security and cleaning. Work in relation to this development is progressing as part of a wider actions from the review and will be concluded by the 31st December 2018.

The Head of Quality & Safety at Morriston Hospital has historically sat on the Health Board's Health & Safety Committee and is now a member of the Health Board's Operational Health & Safety Group, which meets on a bi-monthly basis.

3. HEALTH & SAFETY EXCEPTION REPORT

3.1 Falls/Accidents

Fall/Accident events are the most common reason for reporting an incident at Morriston Hospital. In the first 6 months of 2018/2019, a total of 3306 incidents were reported on the datix system attributed to Morriston Hospital Service Delivery Unit.

(Please note that incidents involving services such as estates, facilities, pharmacy and catering who are not managed by Morriston Hospital Service Delivery Unit will not be included in this total.)

Of the 3000+ incidents, 24% (781) relate to falls and accidents.

- 664 involved patients
- 112 involved staff members
- 5 involved visitors to the hospital

3.3.1 Inpatient Falls

The Morriston Hospital Inpatient Falls Group was established in June 2016 and is a sub-group of the Morriston Hospital Quality & Safety Group and provides an update

report on outcomes on a monthly basis. The group is chaired by the Head of Nursing for the Medicine at Morriston Hospital. Falls outcomes for Morriston Hospital as a whole and on a ward-by-ward basis are measured and monitored against the nationally accepted Royal College of Physicians standards on a monthly basis.

In 2017/18, a total of 1251 inpatient falls were report at Morriston Hospital. This equated to 5.47 inpatient falls per 1000 beddays against the national standard of 6.63. Included in this are a number of significant falls which resulted in fracture or significant injuries; at Morriston this meant 13 significant cases. In terms of national standard this equates to 0.06 significant falls per 1000 beddays (nationally accepted target 0.19)

Current performance for the period April to August 2018 whilst showing a small reduction in the overall incidence of inpatient falls (approximately 5%) indicates that fall rates are being sustained at 2017/2018 levels.

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 of this additional education and training has been rolled out onto wards to ensure that correct assessment documentation is being implemented and applied.

During 2017/18 and within the first half of 2018/19, there has been a cluster of inpatient falls on Ward D at Morriston Hospital. Ward D is an elderly care ward with a high prevalence of patients with a diagnosed dementia. A comprehensive improvement plan has been developed for the area which has been shared at the Health Board's Professional Nursing Forum. The ward has had an increased nursing establishment and significant work has been undertaken to ensure that patients are fully assessed at the start of their stay. Falls 'care plans' are initiated and equipment is provided to reduce the risk of falls.

3.1.2 Staff Accidents

At any point in time there are approximately 3,500 members of staff delivering services managed by the Morriston Hospital Delivery Unit.

Table 3.1.2: Staff Accidents by Theme for Apr18 to Sep18

Contact with Sharps	40
Lifting/Manual handling	24
Contact/Collision (not sharps)	21
Slip/Trip or Fall	19
Contact with Potentially Infectious Materials	6
Entrapment	2

Table 3.1.2 illustrates the causative themes of accidents reported by staff at Morriston Hospital in the first 6 months of 2018/2019. Based on the number of staff related incidents reported there is a rate of 0.53 incidents per 100 members of staff. There are currently no national or local comparators available for this rate.

Incidents related to contact with sharps will be reviewed later in this report under ***Section 3.3.***

The remaining 72 incidents have been reported across 46 different locations within Morriston Hospital, there is no correlation between staff incidents and a specific location.

A review of the manual handling incidents has identified that 50% (12) relate to the events involving equipment rather than patients, 25% (6) to events directly linked to lifting patients and 25% (6) to events involving patients but not in the action of lifting, e.g. stretching.

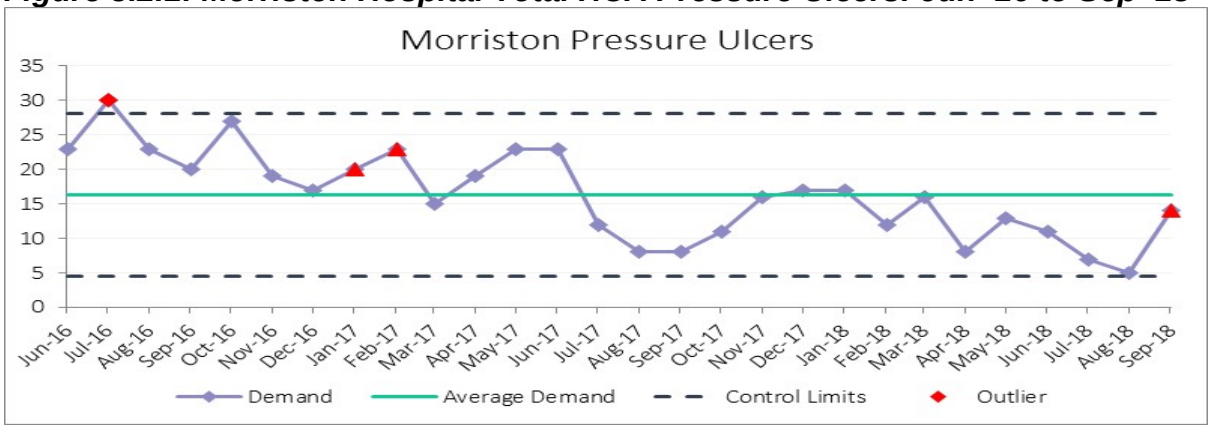
Performance at a Unit level in relation to manual handling mandatory training is currently 50%. Monitoring and focus on improving rates of compliance for mandatory training are being managed through the weekly Morriston Business & Performance Group. Further details is included later in this report under ***Section 3.5****.*

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 Unit Nurse Director. The panel reviews all HCA pressure ulcer cases on a case by case basis.

Figure 3.2.1 below demonstrates progress made at Morriston since June 2016 in the reduction of HCA pressure ulcers. Whilst it is acknowledged that September 2018 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: Jun '16 to Sep '18



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. Examples of audit and improvement work undertaken are shown below.

- Development of a Plaster Cast Improvement Plan – where the application of plaster devices has been identified as a causative factor in a HCA pressure ulcer.
- Introduction of proactive pressure area assessment and management in Theatres
- Introduction of skin care bundle into Cardiac Catheterisation Laboratory – reviewing availability of pressure relieving devices within the area.
- Pembroke Ward – documentation audit with an outcome of 100%
- Ward A – Ward Audit reviewing the recording of outcomes at point of care – positive improvement but some gaps identified with a plan to re-audit in November 2018

3.3 Sharps Incidents causing Harm

In the past 18 months (April 2017 to September 2018) there have been a total of 70 incidents reporting harm as a consequence of staff contact with medical sharps. However over this period there has been a visible and sustained reduction in the numbers reported, please see ***Figure 3.3.1*** below.

The highest prevalence by location has been within the Theatre environment (15 harm incidents over a 18mth period). The dominant theme within sharps injury is accidental “needle stick” whilst clinically treating a patient, in particular whilst suturing. Whilst the environment is a common factor within these incidents there is no correlation to individual medical staff either as individuals or within a specialty group.

Other minor themes relate to the changing of equipment such as connectors and the use of patient’s own insulin injectors, which are not subject to “safer sharps” devices, have been identified but are not significant.

Figure 3.3.1: Sharps Incidents reporting Harm Apr 2017 to Sep 2018

Source: Datix

Incident Locations

- Theatres – 15
- HDU/ITU - 8
- Emergency Dept – 5
- Renal Unit – 4

All other locations had 3 or less incidents reported.

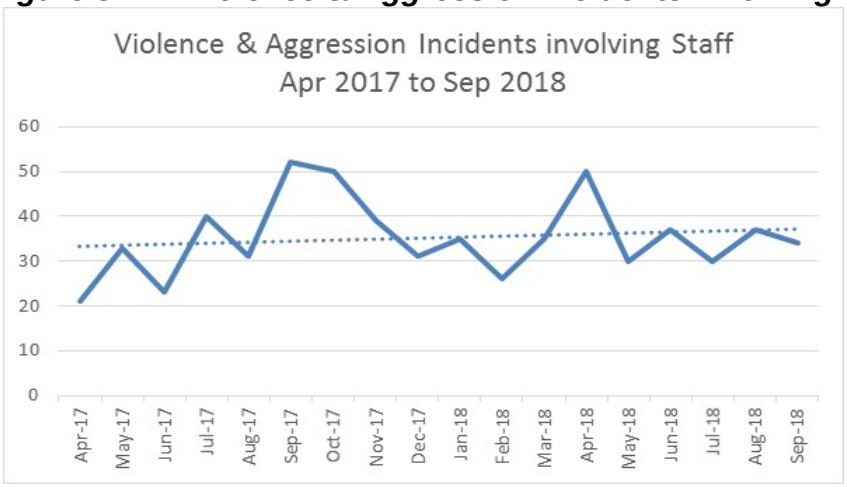
3.4 Violence & Aggression Incidents

In the past 18 months (April 2017 to September 2018) there have been a total of 632 incidents reporting adverse behaviour including violence and aggression towards staff

working at Morriston Hospital. Of the total, 592 incidents reported adverse behaviour by a patient or visitor towards staff, with the reminder of incidents occurring between staff members.

Figure 3.4.1, below illustrates the number of incident reporting involving staff by month over an 18 month period. The numbers have remained relatively stable over the period although it is acknowledged that there is a zero tolerance with regards to any adverse behaviour towards staff

Figure 3.4.1: Violence & Aggression Incidents involving Staff Apr17 to Sep18



Source: Datix

Incident Location
Emergency Dept
16% (101)

Ward J
10% (64)

Ward D
8% (52)

All other location have less than 4% of total

The largest volume of incidents occurred within the Emergency Department. The risk to staff within the department has been fully recognised within the Morriston Hospital Risk Register with a risk score of 16. Actions to mitigate the risks to staff are ongoing (see details in ***Section 3.6***) and outcomes and learning from a recent visit by the Healthcare Inspectorate Wales (HIW) to the Emergency Department at Princess of Wales Department, which made recommendations in relation to security risks within the Emergency Department. These have been shared with Morriston Hospital for inclusion in future improvement plans.

There are a significant number of incidents occurring in Ward D and Ward J. Whilst the acuity of the patients admitted to Ward D is directly related to the incidents reported for this area (confusion, diagnosed dementia) a “deep-dive” review in relation to causation on Ward J is being undertaken.

A high level review of all incidents reporting adverse behaviour between members of staff has been undertaken. All cases appear to be isolated and there is no pattern in relation to individuals or location involved.

3.5 Mandatory Training Compliance

Mandatory training compliance to June 2018 was reported from data collected via the Health Board’s care metrics. This provided only limited assurance as the data only relates to ward based staff (registered and non-registered). However, since June 2018 reported data has been sourced directly from the electronic staff record (ESR), which now includes all staff attributed to Morriston Hospital Service Delivery Unit.

Table 3.5.1 below demonstrates Morriston Hospital 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 3 months following the change in the base-data being monitored. 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 2018

	June 2018	**September 2018**
Fire Safety Training	63.7%	67.96%
Health Safety and Welfare	57.71%	64.64%
Moving and Handling (Level 1)	43.2%	50.93%
Violence & Aggression	56.8%	62.99%

Source: Electronic Staff Record

3.6 Health & Safety Risks and Outstanding Issues

There are currently 6 recorded Health & Safety risks on the Morriston Hospital Risk Register. The highest risk is currently scored at a 16 and reflects the increases in violence and aggression incidents reported within the Emergency Department at Morriston Hospital. ***Table 3.6.1*** below gives a brief summary of the 6 risks notified.

Table 3.6.1: Morriston Hospital Health & Safety Risks – Risk Register (Sep 2018)

Risk	**Location**	**Score**	**Actions**
Adverse behaviour towards staff	Emergency Dept	16 (reduced from 20)	• Increased police presence • V & A Training compliance • Security staff and CCTV. • Missing person Policy. • Staff vigilance. • Zero tolerance Policy. • Appropriate staffing levels. • Monthly police/mental health meetings and identify where necessary strategies and information sharing

Insufficient storage causing a fire hazard	Theatre Areas	15	Review of environment included within Theatre Improvement actions
Risks of Inpatient Trips/Falls/Slips	Ward D	12 (reduced from 15)	Inpatient Falls Improvement Plan in place.
Sharps Risk	Emergency Dept	9	Ensuring sharps bins are available in all clinical areas, and are replaced when full. Reminders to staff re sharp safety -"STOP" campaign. All needles changed to safer sharps needles.
Exposure to hazardous substances (decontamination)	Cardiothoracic	8	Universal protective equipment precautions and training of staff.
Prescribed Home Oxygen: Fire Risk	Patient's Home	8	Patient are given detailed instruction on:- Correct storage of equipment, ensuring fire breaks in situ and working fire alarms. Patients are educated on high risk of fire/explosions and burns whilst on oxygen. Written information is provided and patients are asked to sign an advice sheets.

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

- **General Environment Ward Areas**
  Action: Environment refresh programme approved. Work underway on Ward J and then moving to Ward C

- **"Approved" Estates Staff**.
  Action: Concerns raised by Pharmacy with the Estates Dept at Morriston Hospital in relation to the availability of estates staff to support medical gases and decontamination – pending a response

- **Maintenance of Safety Critical Systems**
  Action: Concerns in relation to changes in maintenance agreements for safety critical systems which resulted in a failure in fire alarms being operation over a weekend period. All fire systems now tested and operational.

- **Security and CCTV**
  Action: Outcomes and recommendations made following recent HIW visit to Emergency Department at Princess of Wales Hospital to be reviewed in order to ensure adoption across the Health Board. CCTV in Emergency Department currently not fully operational and security presence not available 24/7.

- **Dedicated Support from Health & Safety Professionals**
  Action: In conjunction with Health Board's Head of Quality & Safety development of quarterly Health & Safety site reviews. There are currently no health & safety professionals based on site at Morriston Hospital.

4 RECOMMENDATION

Members are asked to :

- **NOTE** the governance structure at Morriston Hospital Service Delivery Unit in providing assurance in relation to health & safety requirements; and
- **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.