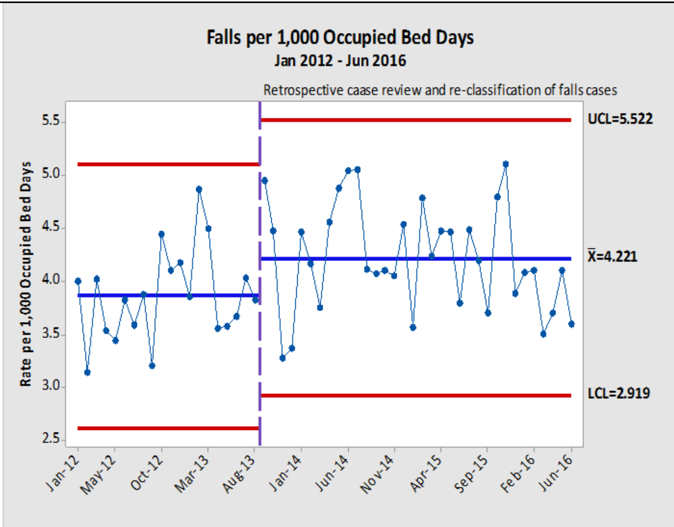
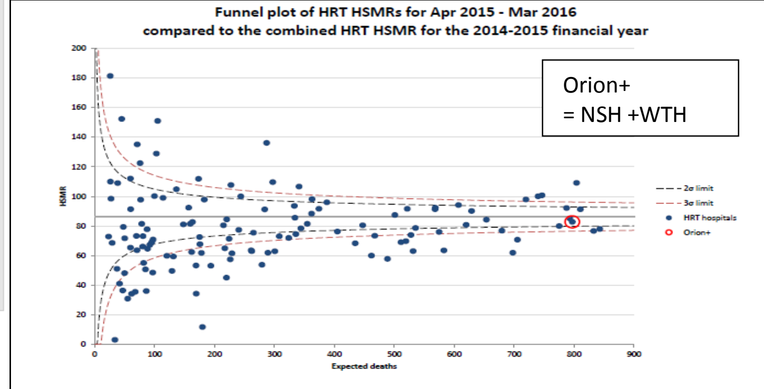
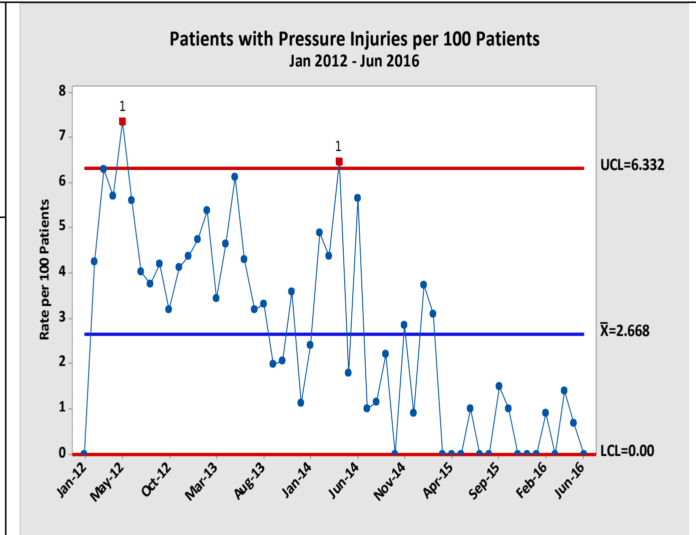
Waitemata DHB Quality Indicator Trends June 2016

"best care for everyone"

everyone matters | with compassion | better, best, brilliant | connected







Fall – Definition

A fall is defined as "inadvertently coming to rest on the ground, floor or other lower level, excluding intentional change of position to rest in furniture, wall or other objects". *(World Health Organisation, 2007: WHO global report on falls prevention in older age)*

Outcome data is based on the rate of falls with major harm (SAC 1& 2) or with harm (SAC 1-3) per 1,000 bed days

Comment

An increase in the rate of falls seen in Sep 2013 is attributed to better data capture with the implementation of systematic falls risk assessment and individualised care planning (Quality and Safety Marker) monitoring and reporting.

Hospital Standardised Mortality Ratio (HSMR)

The HSMR is expressed as a ratio and seeks to compare actual deaths occurring in hospital (or in hospital and following hospital admission), with a predicted number of deaths based on the types of patients admitted to the hospital

Comment

The graphs shows WDHB (Orion+) continuing to have the lowest HSMRs of the larger DHBs in NZ with an HSMR of 83 for the April 2015-Mar 2016, compared to all HRT hospitals (86) and NZ hospitals (100)

Pressure Injury – Definition

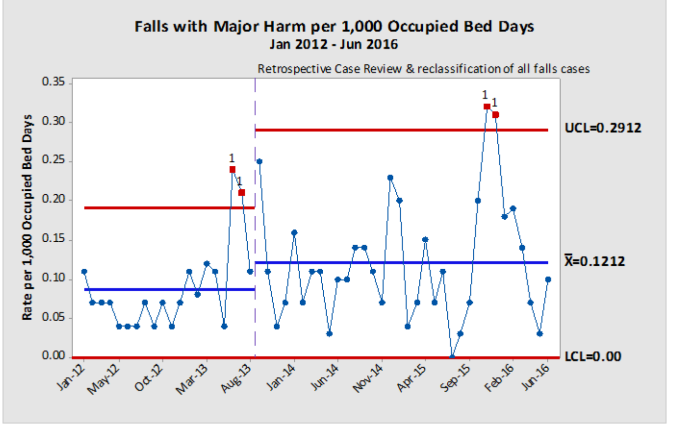
A pressure injury is "a localised injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction". (National Pressure Ulcer Advisory Panel, 2007)

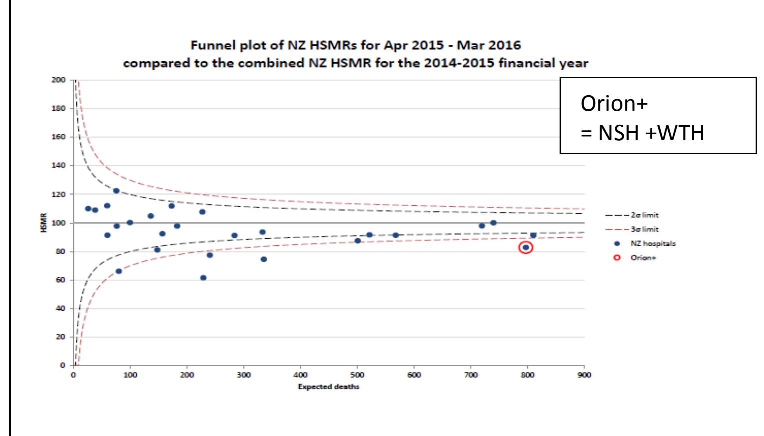
Outcome data is based on the rate of pressure injuries Grade 3 & 4 + ungradeables or total, per 100 patients

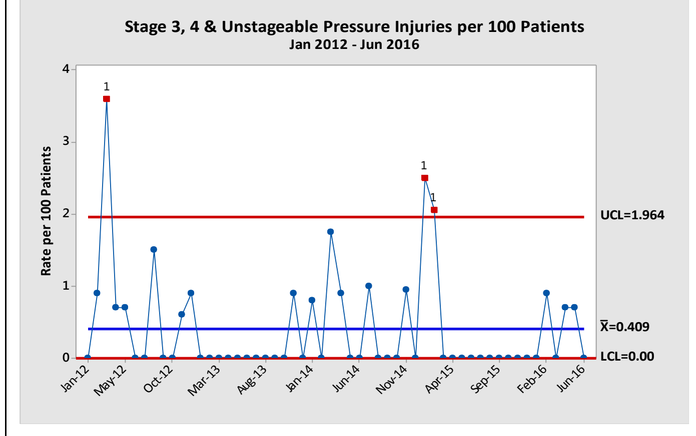
Comment

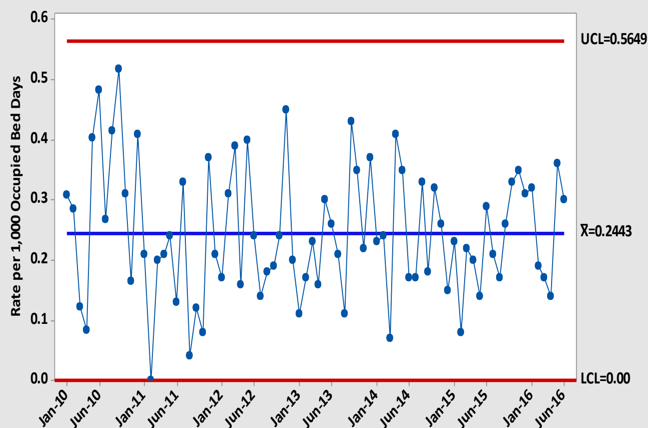
There was a decrease in the rate of pressure injuries over the past 12months following a FAST quality improvement programme and introduction of the Care Standards/Ward Accreditation Programme.

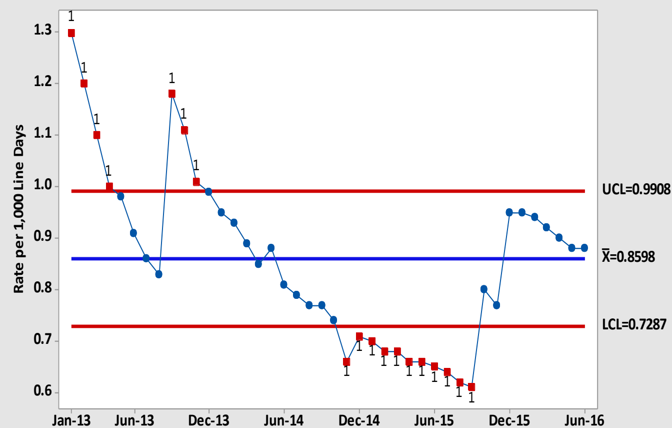
Four grade 3 and 4 pressure injuries were reported in 2015, an increase attributed to better data capture and reporting. There were zero Grade 3 and Grade 4 pressure injuries in the twelve months: Mar2015- Feb 2016; two injuries were reported in April and May 2016

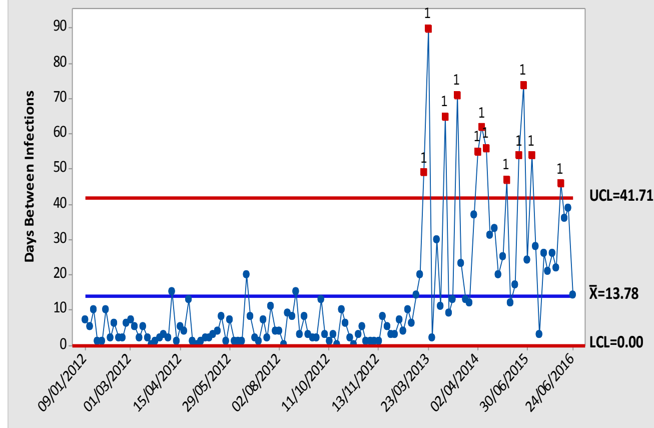












Hospital Acquired Blood Stream Infections (HABSI)

HABSI is defined as a bloodstream infection attributable to hospital where acute or rehabilitation care is provided, if the infection was not incubating on admission. Typically bacteraemia diagnosed after 48 hrs of admission, on readmission, related to a device, or within 30 days of a procedure (if no alternate source identified) is categorised as a HABSI. There is no recognised national benchmarking 'acceptable' rate or target for HABSI

Comment

There has been an increase in HABSIs from September through to December 2015. Overall HABSI rate remains stable and lower compared to 2013 and 2014 (0.24 for 2015).

June 2016 HABSI rate was 0.30

Source	June (n=9)
Post Procedure	2
IV Leur	2
CVL	1
Other	2
Unknown	2

Central Line Associated Bacteraemia (CLAB)

Patients with a central venous line are at risk of a blood stream infection **(CLAB).** Patients with a CLAB experience more complications, increased length of stay, and increased mortality; and each case costs approx. $20,000 - 54,000. CLAB infections are largely preventable using a standardised procedure for insertion and maintaining lines (insertion and maintenance bundles of care)

NSH's ICUs compliance with standard procedure and rates of CLAB are Health Quality and Safety Markers

Comment

Rate of CLAB/1,000 line days was 0.88 (June 2016) – the Target for this is **<1 per 1000 line days –** this increase is a reflection of the two ICU CLAB identified in September and November 2015.

236 "CLAB Free" days as at **30/06/2016**

One CLAB was identified in a **Renal** patient with end stage renal disease; investigation found 100% compliance with insertion and maintenance bundles. Due to patient's high risk the CLAB was deemed unpreventable.

The National target is >90% compliance for insertion and maintenance bundles use.

	Insertion Bundle	Maintenance Bundle
June 2016	100%	92%

Ward maintenance compliance rates and CLAB free days for other areas are reported in the Quality Report

Staph Aureus Blood Stream Infections

The rate of S.aureus **bacteraemia (SAB)** infections attributed to healthcare is the national outcome measure for hand hygiene compliance. The SAB rate is based on HHNZ's definition to maintain consistency in DHB reporting.

This is a 'days between' control chart and, therefore, the clustering of data points below the mean (X̄) represents events occurring close in time or an increased relative frequency of events.

Comment

The length of time between infections is increasing which may reflect improved compliance with to hand hygiene practices. There were **two** S.aureus infections; **one** related to an IV luer (not removed when patient developed fever) and one where the source was unable to be identified.

Waitemata DHB's SAB rate (quarterly rate of 0.03-0.06 per 1000 bed days) is consistently well below the national average (1.2-1.3 per 1000 bed days) with approximately one SAB per month**.** There was a total of **10** SAB identified in 2015 compared with **16** identified in 2014.