NHS Ayrshire & Arran

Meeting:	**Ayrshire and Arran NHS Board**
Meeting date:	**Tuesday 23 May 2023**
Title:	**Acute Services Quality Update**
Responsible Director:	**Joanne Edwards, Director of Acute Services**
Report Author:	**Stephanie Frearson, QI Lead Acute Services** **Nina McGinley, Lead Nurse Excellence in Care**

1. Purpose

This is presented to the Board for:

- Discussion

This paper relates to:

- NHS Board/Integration Joint Board Strategy or Direction

This aligns to the following NHS Scotland quality ambitions:

- Safe
- Effective
- Person Centred

2. Report summary

2.1 Situation

This paper outlines Scottish Patient Safety Programme (SPSP) progress in alignment with Excellence in Care (EiC) locally and describes to members the current status and plans going forward in relation to core measures including:

- Falls
- Falls with harm
- Cardiac Arrest
- Pressure Ulcers

2.2 Background

The SPSP is a longstanding national initiative that aims to support and improve the safety and reliability of health and social care and reduce harm, whenever care is delivered. EiC is a national approach which aims to ensure people have confidence they will receive a consistent standard of high-quality of care no matter where they receive treatment in NHS Scotland, providing consistent, robust processes and systems for measuring, assuring, and reporting on the quality of care and practice.

2.3 Assessment

As part of the SPSP Acute Adult Portfolio, all Boards have a requirement to report Falls, Falls with harm, Cardiac Arrest and Pressure Ulcer (PU) data nationally to Healthcare Improvement Scotland (HIS). Additionally, as part of the EiC programme, data for Falls and PUs is also submitted monthly to Public Health Scotland (PHS) via a data extract from Datix and the Patient Management System. Essentially this has resulted in two programmes requesting the submission of the same data from NHS Boards. Nationally, discussions between SPSP and EiC integrating both programmes continue and we await confirmation of proposed next steps.

Full details of all QI Activities and progress against these measures are included in **Appendix 1.**

2.3.1 Quality/patient care

SPSP Acute portfolio is a longstanding national safety initiative that aims to support and improve the safety and reliability of health and social care and reduce harm to patients whenever care is delivered.

EiC aims to deliver consistent and robust processes and systems for measuring, assuring and reporting on the quality of nursing and midwifery care and practice within nursing and midwifery in all hospitals and community services, from Emergency Department (ED) to mental health, and care of older people to children's services.

2.3.2 Workforce

Locally there is a requirement for staff to report adverse events such as Falls, Falls with Harm and PUs locally (via Datix). Additional data such as cardiac arrest is recorded by staff via the Quality Improvement (QI) Portal. Opportunities for learning and improvement will require ongoing collaborative engagement from staff across the organisation, e.g. QI Team, Leadership Teams and clinical staff.

2.3.3 Financial

It should be noted that reduced performance in relation to SPSP measures may have a financial impact, for example potential increased extended length of stay due to experiencing a fall with harm or PU. It was our intention to integrate, where possible, a Value Management Approach (VMA) to the delivery of SPSP as it has been demonstrated that use of such a model not only improves the quality and effectiveness of nursing care but has a positive impact on expenditure as well as patient outcomes. Ongoing clinical pressures and the onset of the COVID pandemic however led to the suspension of testing VMA. At a National level a VMA collaborative supported by HIS was launched and ran from November 2019 to October 2022, it is our understanding that there are no plans to extend this programme. Within NHSAA a decision has yet to be taken regarding resuming testing of this approach within acute services.

2.3.4 Risk assessment/management

Failure to comply with national improvement programmes may lead to patient harm, complaints, litigation and adverse publicity. The following risks are noted and will be added to the risk register:

- Additional COVID-19 outbreaks and/or staffing pressures will potentially affect our ability to progress SPSP as follows:
    - Increased pressure within clinical teams due to the re-prioritisation of resources to ensure continued delivery of high-quality patient care, resulting in lack of momentum and lack of capacity to support SPSP activity.
    - In addition, there are a number of current vacant posts within the Acute QI team. There has been difficultly in recruiting into these posts, particularly Band 6 Improvement Advisor posts. This will have an impact on the support that can be offered to clinical teams within Acute Care. Work is in progress to mitigate against these recruitment challenges through optimisation of financial resources across the QI budgets to remodel and refresh vacancies.

2.3.5 Equality and diversity, including health inequalities

An impact assessment has not been completed because the policies for this improvement work are derived from a national standard. Implementation of this work impacts positively on all patients and service users regardless of inequalities or protected characteristic.

2.3.6 Other impacts

- Best value
    - Vision and Leadership
    - Governance and accountability
- Compliance with Corporate Objectives
  Create compassionate partnerships between patients, their families and those delivering health and care services which respect individual needs and values; and result in the people using our services having a positive experience of care to get the outcome they expect.

  Protect and improve the health and wellbeing of the population and reduce inequalities, including through advocacy, prevention and anticipatory care.

2.3.7 Communication, involvement, engagement and consultation

This paper does not require stakeholder engagement

2.3.8 Route to the meeting

This paper was presented to the Healthcare Governance Committee at their meeting on 24 April 2023.

2.4 Recommendation

Board Members are asked to receive and discuss this report which provides an overview of performance and activity in terms of SPSP Acute Adult portfolio in alignment with the EiC programme within NHS Ayrshire & Arran.

3. List of appendices

The following appendix is included with this report:

- Appendix No 1, Acute Services Quality Update Scottish Patient Safety Programme/ Excellence in Care Update Falls, Pressure Ulcers and Cardiac Arrest April 2023

Appendix 1

Acute Services Quality Update
Scottish Patient Safety Programme/Excellence in Care Update April 2023
Falls, Pressure Ulcers and Cardiac Arrest

1. Introduction

The Scottish Patient Safety Programme (SPSP) is a longstanding national initiative that aims to support and improve the safety and reliability of health and social care and reduce harm, whenever care is delivered. As part of SPSP, all Scottish Health Boards were historically required to report Falls, Falls with Harm (FWH), Pressure Ulcers (PU) and Cardiac Arrest rates to Healthcare Improvement Scotland (HIS) SPSP/Acute Adult Portfolio quarterly. Following a pause during the COVID pandemic, data submission recommenced in November 2021 however PU data was no longer requested and/or submitted.

Commissioned by the Scottish Government in response to the Vale of Leven Hospital Inquiry, Excellence in Care (EiC) is Scotland's national approach to assuring and improving nursing and midwifery care. As part of the EiC programme in acute services, data for Falls, PU, Workforce Variance and Student Experience is currently submitted monthly to Public Health Scotland (PHS) via a data extract from Datix and the Patient Management System. There is ongoing work to improve process of submission of Food, Fluid and Nutrition data. Unlike the SPSP programme routine EiC submission to PHS has resumed since October 2020.

This has resulted in submission of similar data from NHS Boards to two different national programmes. At a local level and in an attempt to reduce data burden a request was made in 2022 to NHS Ayrshire & Arran Healthcare Governance Committee (HCG) to combine the reporting of EiC and the SPSP Acute Adult Portfolio. This would align both programmes and provide a more relevant, reliable and robust process of reporting.

This paper outlines SPSP progress in alignment with EiC locally and describes to members the current status and plans going forward in relation to core measures including:

- Falls
- Falls with harm
- Cardiac Arrest
- Pressure Ulcers

1.1 Understanding how our system is performing

The Acute Services Quality Improvement (QI) team alongside EiC colleagues have been working to improve our understanding of how Falls/FWH and PUs are being reported and how data is available to support learning and improvement. Recently, a minor discrepancy was noted with the median rate of Falls and PUs we report locally and nationally compared with the same measures that are reported via the EiC programme.

The Acute QI team are responsible for reporting quarterly data to SPSP. This is retrieved from all adult acute in-patient areas and provides collated data and contributes to a national (Scottish) median rate which NHS Boards use to benchmark and to detect signs of deterioration and/or improvement. In comparison EiC data refers to a national reference point (as opposed to median). The reference point takes into consideration all adult inpatient wards, mental health and maternity/women and children. This has resulted in differing median/reference points for certain measures such as Falls/FWH and PU and understandably caused some confusion around the understanding and interpretation of local data for staff. This discrepancy is not unique to NHSAA and has been reported nationally from other Boards who also submit data to both programmes.

To date 48%, totalling 16 NHS Boards have submitted their EIC data therefore the data does not provide a robust oversight for all Scottish NHS Boards. NHSAA have continued to submit data to both EiC and SPSP.

Work towards submitting data via a single system is underway nationally and assurance has been given that this problem will be rectified. At a local level both EiC and QI teams have been working collaboratively with Business Intelligence around this issue.

1.2 Data Surveillance

Falls/FWH/PU

Locally there is a requirement for staff to report adverse advents such as Falls, FWH and PUs locally (via Datix). A QI team monthly surveillance programme has been introduced with support from both the PU Improvement Nurse and the Falls Co-ordinator. A locally developed data dashboard which gives an 'at a glance' overview of performance (reportable harms) on both acute sites is accessed to enable complete data overview of SPSP reportable harms and identify areas who may require QI support. This identifies areas that have an increase in median rates of Falls/FWH and/or PUs. Clinical data over the last 2 years from both acute hospital in-patient areas is reviewed using improvement methodology and run-chart rules applied. Where the data demonstrates an increasing rate, clinical teams are contacted and offered an opportunity to discuss data, identify improvements and a supported QI action plan is implemented. Areas displaying decreased rates of harms are also identified to share the success and enable shared learning throughout the organisation. The dashboard is shared monthly with senior nursing staff including Chief Nurses, Interim Deputy Nurse Director and Associate Nurse Director (Acute Services). More recently conversations have taken place with General Managers and Clinical Nurse Managers (CNMs) to discuss how this data can be more widely shared.

This approach offers an opportunity to use data for improvement and work collaboratively alongside the Falls Co-ordinator, Tissue Viability (TV) and QI teams to reduce falls, falls with harm and PUs within the clinical areas.

Alternative Data/Median Calculation – Acquired Pressure Ulcers (APU)

Guidance was sought recently from the Health Improvement Scotland (HIS) data team regarding available options to interpret APU data 'more accurately'. The current application of run chart rules results in a median re-calculation only where there has been a minimum of 9 data points above/below the median within any 12-

month period. This has resulted in historical 'high' medians in areas with no recent APUs and a high proportion of wards with regular APUs recording a median of 0. Following discussion, it was suggested that 2 rules relevant to data with a median of 0 be considered - this specified:

- A baseline median of 0 should not be applied

- Where there is currently a median of 0 an alternative approach could be considered. (referred to as the 7/12 rule)

Application of the 7/12 rule would allow the median to be re-calculated when there are 7 data points above the median in any 12-month period (statistically similar to the 6 points above/below shift rule). It was suggested that this approach may be more reflective of the current system we are working within with regard to increased APU acquirement across both sites and can better direct QI initiatives.

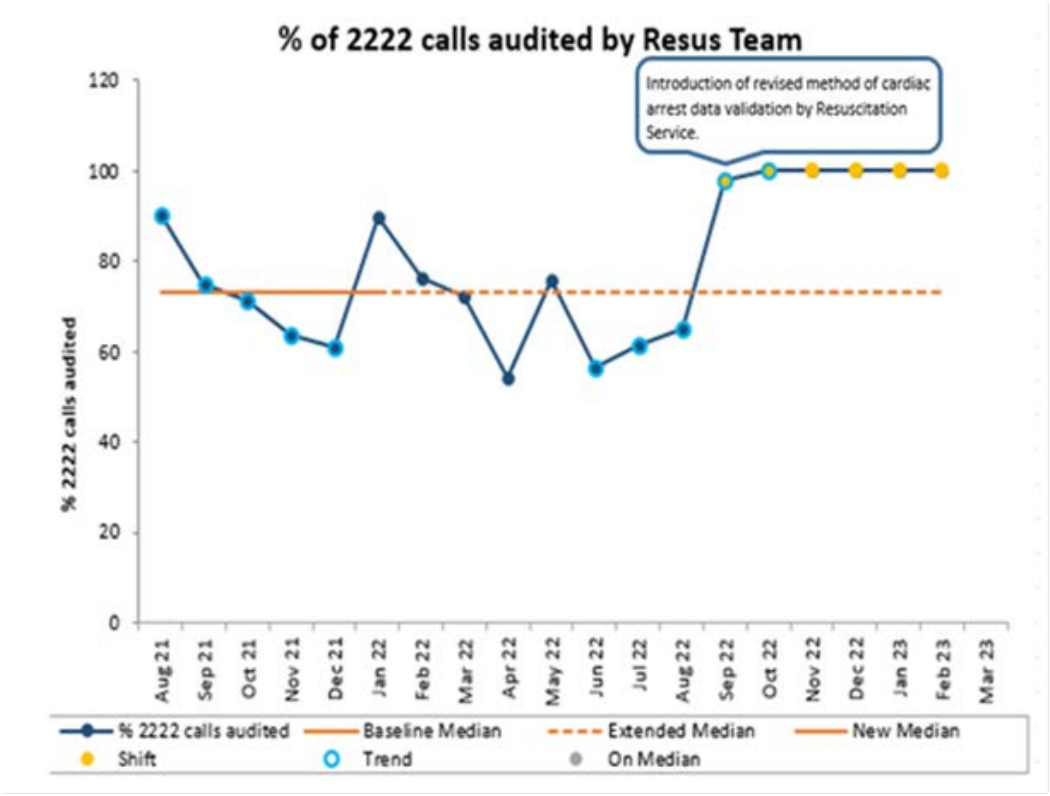
The following recommendations were tabled and approved by the Pressure Ulcer Improvement Group in February 2023:

- Apply the 7/12 rule as a test of change to PU data only as part of the PU collaborative
- Re-calculate by removing medians of 0 and implementing a new median once 7/12 points above 0 to allow more accurate reporting of median rates of APU.

<u>Cardiac Arrest</u>

Resuscitation Services collate and review cardiac arrest data. They have achieved, through improvement strategies, an increase in data reliability. Cardiac arrest audit returns since September 2022 have been 100% cross-site (See chart below). True cardiac arrests continue to be recorded via the clinical portal, with a breakdown of data sent to Chief Nurses, ANPs, CNMs, Associate Medical Directors and Senior Charge Nurses (SCN) from team response areas. As part of the SPSP Acute Adult Collaborative we have moved to DATIX reporting of all true cardiac arrest, this allows for timely escalation through the Adverse Event Review Group (AERG) if planning failures are evident and thought to have potentially affected patient outcome. The Resuscitation Team have designed and tested a review tool that is now used for all 2222 true cardiac arrests. There is opportunity through this new process to allow SCNs and Clinicians to be involved in reviewing and identifying learning from cardiac arrests in their area. Identified themes from this data include;

- Lack of treatment escalation planning
- Lack of end-of-life conversations and decision making
- Good early recognition of deterioration
- Early escalation



NEWS 2 has now been rolled out throughout the organisation with the exception of the Stroke Ward, who are working with the Resuscitation Team to test a bespoke chart. Current clinical pressures have resulted in a pause to the running of acute site 'mock' (simulated) 2222 drills, with a plan to revisit recommencing these next month.

1.3 Clinical Governance Reporting

Considerable progress has been made recently in terms of establishing an infrastructure in which the Acute QI team can report into current NHSAA governance structures. The QI Advisors regularly attend site-based Governance meetings to provide an update on current QI work underway within acute clinical areas. Both the EiC and QI Leads attend Acute Clinical Governance Group meetings and report by exception.

1.4 Collaborative Working

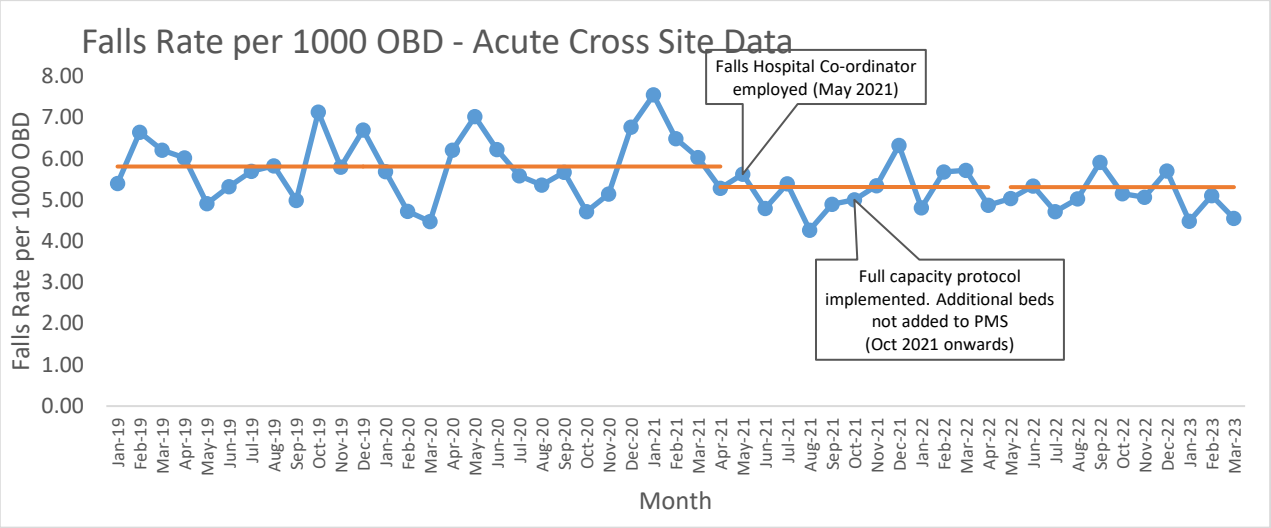
The Chief Nurse Assurance meetings provide an open platform to share site and National data and offer QI support around the SPSP/EiC agenda. These had initially resumed post-COVID via MS Teams, whilst these have been taking place in UHA, a number of scheduled meetings at UHC have had to be cancelled due to system pressures in order to prioritise with site safety. Future dates will be added to address this.

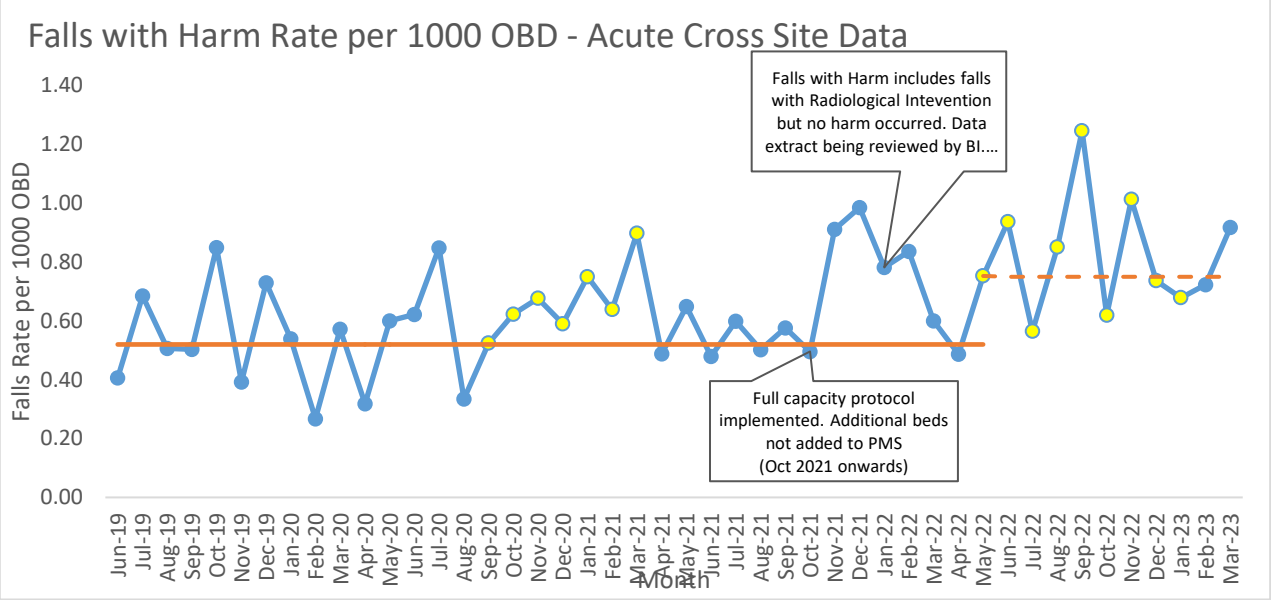
The QI support framework that was recently introduced and involved each CNM/SCN being allocated a 'named' QI advisor to support both local and national improvement projects within their allocated ward areas has had to be suspended, due to reduced capacity and unfilled vacancies within the Acute QI Team. As an interim measure, priority QI support will be given only to those requiring QI support as a result of an increase in avoidable harms.

2. Falls/Falls with Harm

On a monthly basis, the Acute Services QI team review falls data to highlight areas of good practice and identify areas which have a higher and/or increasing rate of falls. The median rate for all falls across NHS Scotland is currently **7.6** per 1000 OBDs. The Scottish level aggregated figures for **falls with harm** are not currently compiled due to variation in the local application of the definition for falls with harm.

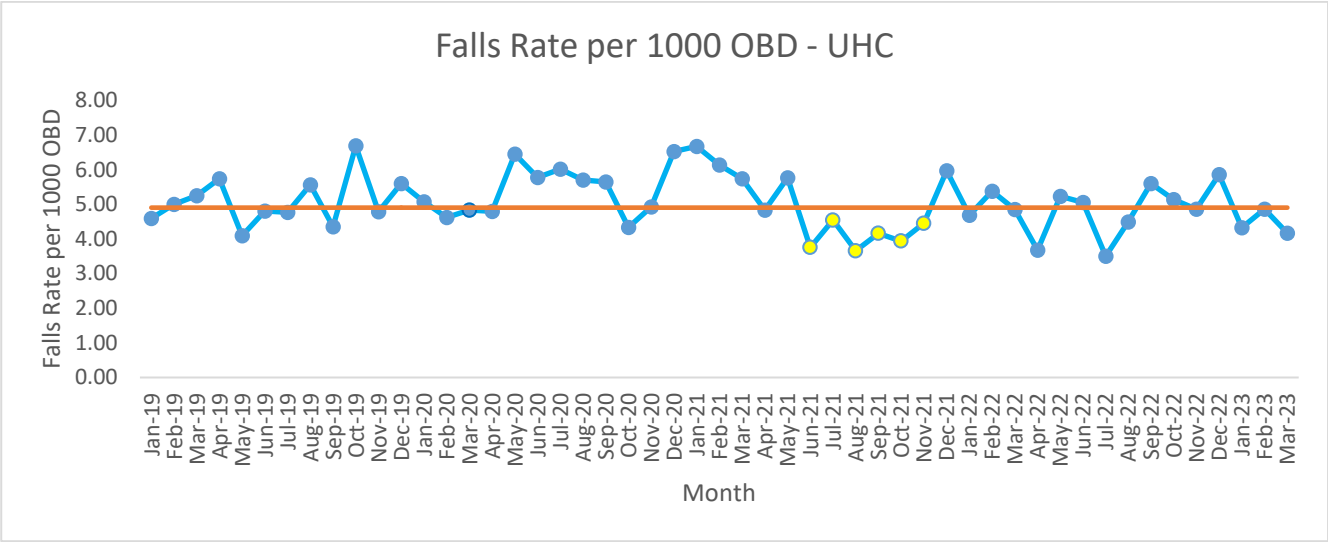
2.1 Falls Data Cross-site





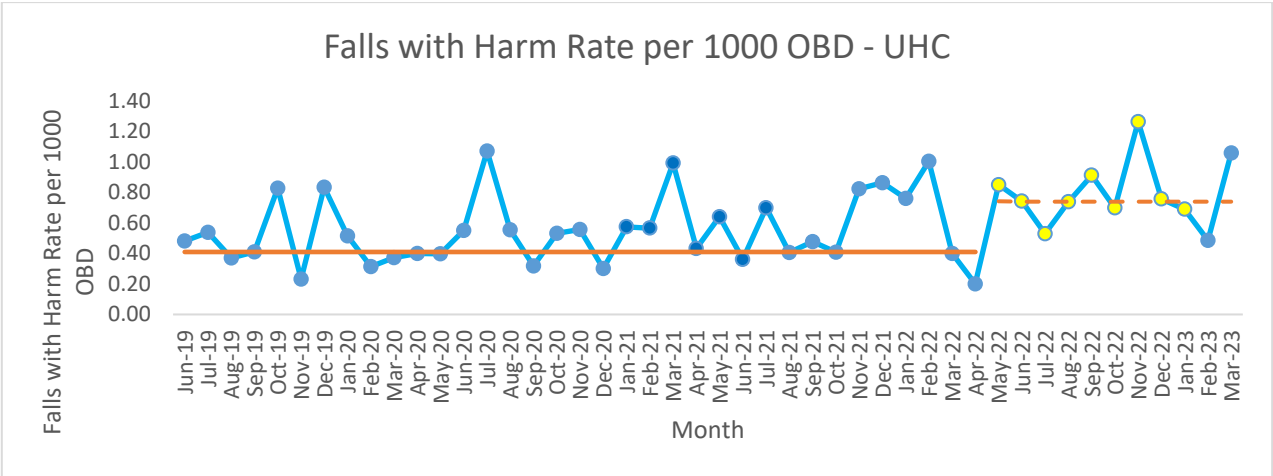
The charts above detail the cross-site data (University Hospital Crosshouse (UHC) / University Hospital Ayr (UHA) combined) for both Falls and FWH. The Falls data highlights a recent re-calculation of the median reducing the falls rate from 5.81 to 5.31 per 1000 OBDs. An increase in median however from 0.52 to 0.74 per 1000 OBDs is noted in the FWH data.

2.2 Falls UHC



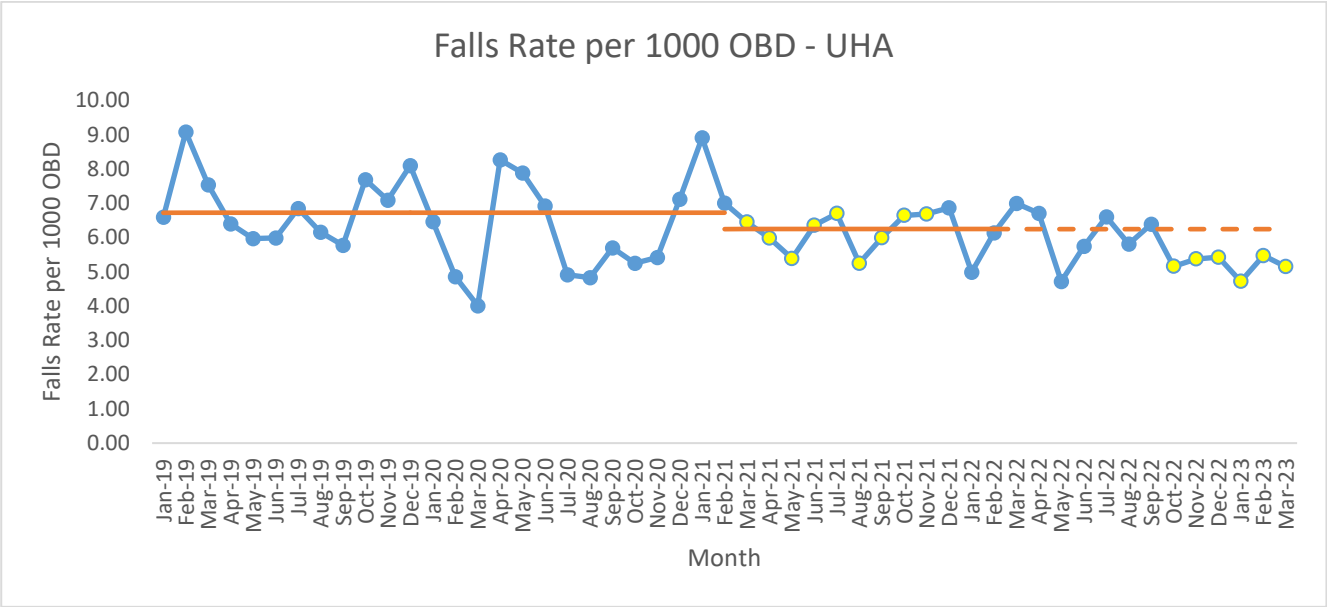
The chart above represents the rate of falls within UHC which is currently **4.91** per 1000 OBDs. A previous shift in data indicating signs of improvement was unfortunately un-sustained meaning the median has been unchanged since 2019. Despite the UHC falls rate being lower than the national median rate for all Scottish hospitals, improvement work continues to try and achieve a sustained 25% reduction in the rate of falls.

Falls with Harm Data UHC



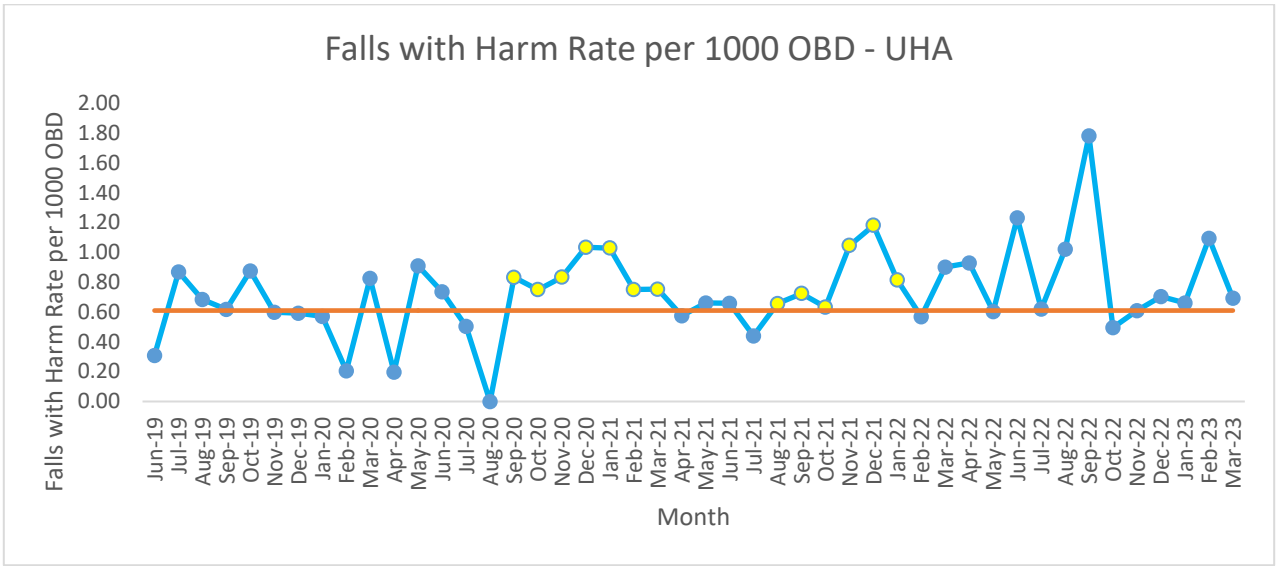
The chart above represents the rate of FWH within UHC. The current rate of falls with harm has recently increased to **0.74** per 1000 OBDs following a sustained increase (shift) in FWH rates.

2.3 Falls Data UHA



The chart above represents the rate of falls within UHA. Sustained improvement in falls data during 2021 has resulted in a reduction in the falls rate from **6.73** to **6.25** per 1000 OBDs. It is further noted that the last 6 data points are sitting below the current median, if this continues over the coming 4 months a further reduction in median rate will occur.

Falls with Harm Data UHA



The chart above represents the rate of falls with harm within UHA. The current rate of falls with harm in UHA is **0.61** per 1000 OBDs

2.4 Falls Improvement Group

Clinical teams and the Falls Co-ordinator (Acute) are invited to provide regular data updates to multi-disciplinary Falls Improvement Group that was established in December 2020. This is chaired by the Chief Nurse for Excellence in Care and

Professional Development and has pan-Ayrshire representation that includes both acute hospital sites, community hospitals and Health and Social Care colleagues.

The group's objectives are to:

- Be an action focused group
- Be data driven to inform improvement
- Report to Healthcare Governance
- Support ongoing improvement work and provide assurance

2.5 Falls Co-ordinator (Acute Services)

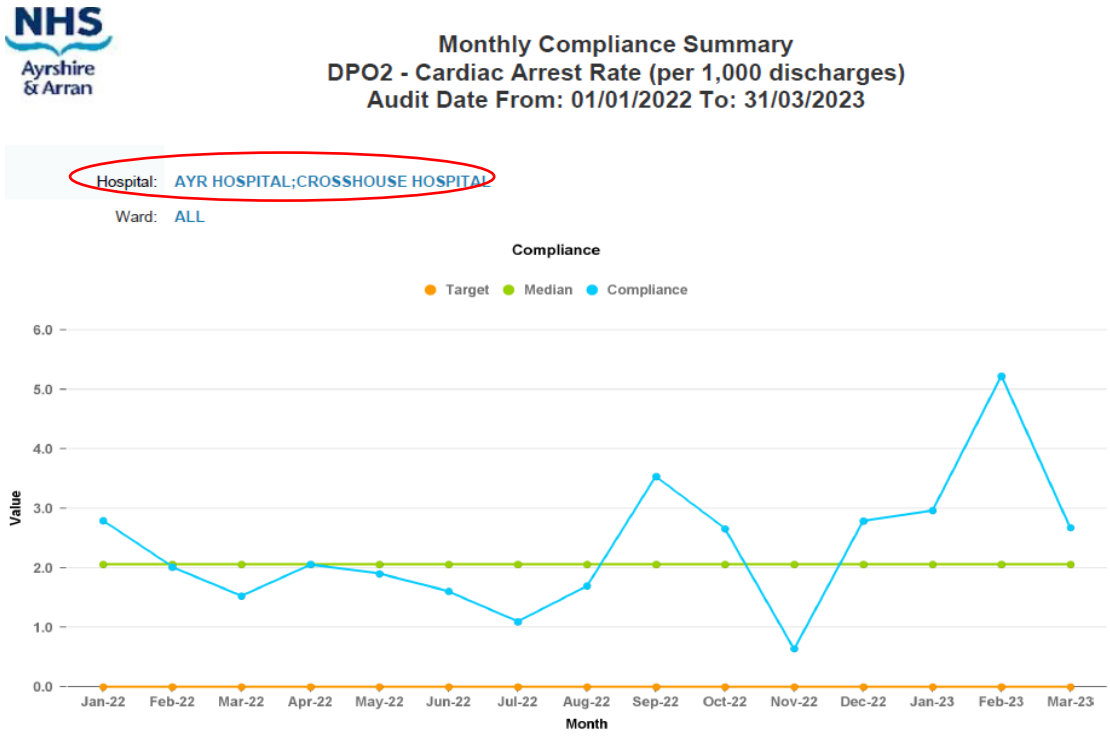
The Falls Co-ordinator (FC) for Acute Services. To date the priorities and work plan the FC team have been progressing have included:

- Education - Link Nurse /Champion programme /General Falls training
- Introduction of referrals via Trakcare
- Falls page development on Athena
- Post falls management (Nursing and Medical)
- Monthly identification of 10 wards for Falls/Harm (high risk areas)
- Falls Friday support
- SPSP Falls Collaborative
- Falls with Cons 4/5 harm /AERG support
- ED Nursing Documentation/risk assessment review

The Executive Nurse Director recently asked the Falls Co-ordinator (FC) to review all C5 harms that have occurred within the acute hospitals during 2022 to date and collate information, highlight any common themes and learning. A recent paper detailing this was tabled at HCG in Jan 2023.

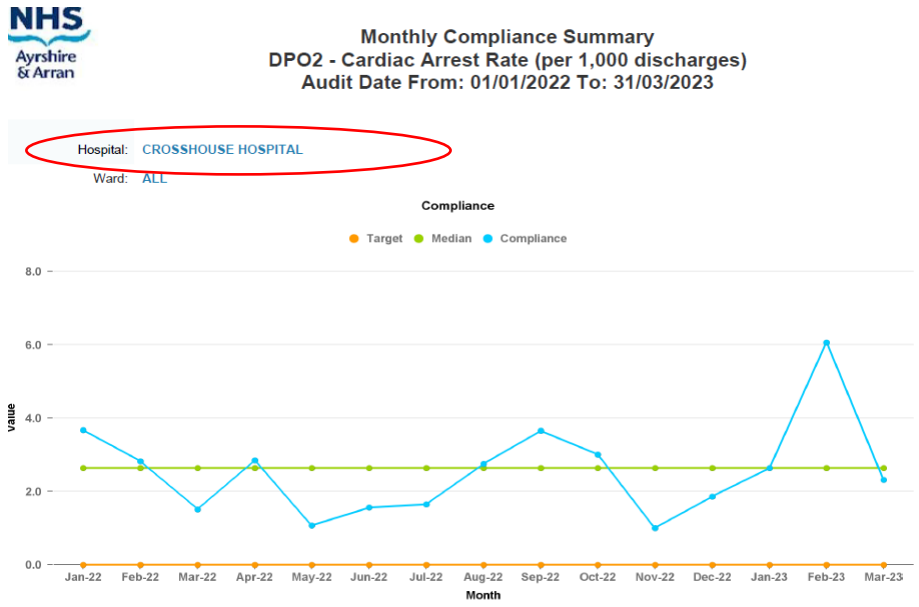
3. Cardiac Arrest

3.1 Cardiac Arrest Data – UHA & UHC



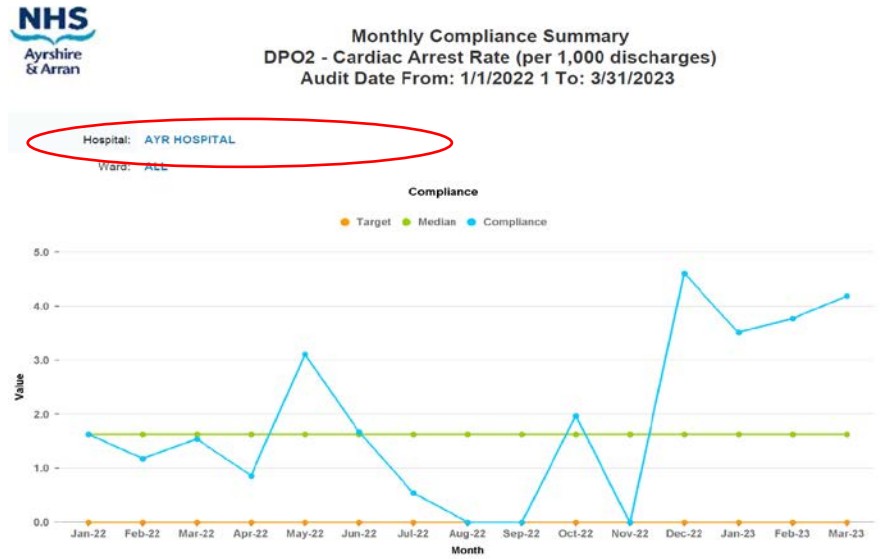
Across Acute (both sites), the data demonstrates that 6 out of the last 7 data points fall above the median. There is potential for this to be indicative of an early signal of deterioration. However, it should be noted that this could also be due to the impact of the work from the Resuscitation Team to provide more reliable collation of true cardiac arrest data. Compliance for this has been 100% for the past 6 months (see run chart page 8), which is a big improvement from previous compliance rates at times of around 60%. The Resuscitation Team will continue to collate, monitor this data closely, and review the true cardiac arrest events via Datix and use of a standardised 2222 review tool for learning and identification of actions for collaborative improvement.

3.2 Cardiac Arrest Data UHC



The current median for UHC for rate of true cardiac arrests per 1000 discharges plus deaths is 2.4, whilst the national median which was reset as of September 2021, sits at 1.4.

3.3 Cardiac Arrest Data UHA



The median for UHA for true cardiac arrest is currently 1.6, which is more in keeping with the national median of 1.4. There is recognition that the last 4 data points are well above the median.

Whilst we can offer assurance around the standardised and reliable review of all true cardiac arrests, further engagement with inter-professional colleagues to put themes and improvements into action is essential going forward. This has proven challenging due to ongoing system pressures.

4. SPSP Falls/Deteriorating Patient Collaborative

In September 2021, the SPSP Acute Adult Collaborative was launched by HIS. The programme uses a breakthrough series collaborative approach over a 2-year period and aims to bring together NHS Scotland Boards seeking improvement in the topic area of falls and deteriorating patient. Clinical areas from across both acute sites were recruited as part of NHSAA's commitment to the collaborative with a clear focus on reducing in-patient falls and early recognition and timely intervention for deteriorating patients. During phase 1 of the collaborative, several tests of change were initially identified and tested using improvement methodology and as a result the following have now been introduced to clinical practice across both acute hospital sites:

Falls

- Patient information leaflet
- Behaviour chart
- Post – Fall pro-forma
- Post- Fall Staff Debrief (pending)

Deteriorating patient

- NEWS 2
- Review of 2222 calls (pending)

This breakthrough series approach promotes the use of QI methodology therefore the QI team are working collaboratively with the Falls Co-ordinator and Resuscitation Team to support clinical staff on their QI journey. Moving forward into the next phase of the collaborative has involved the teams scoping out current practice then utilising a priority matrix tool to help identify areas of improvement and new tests of change.

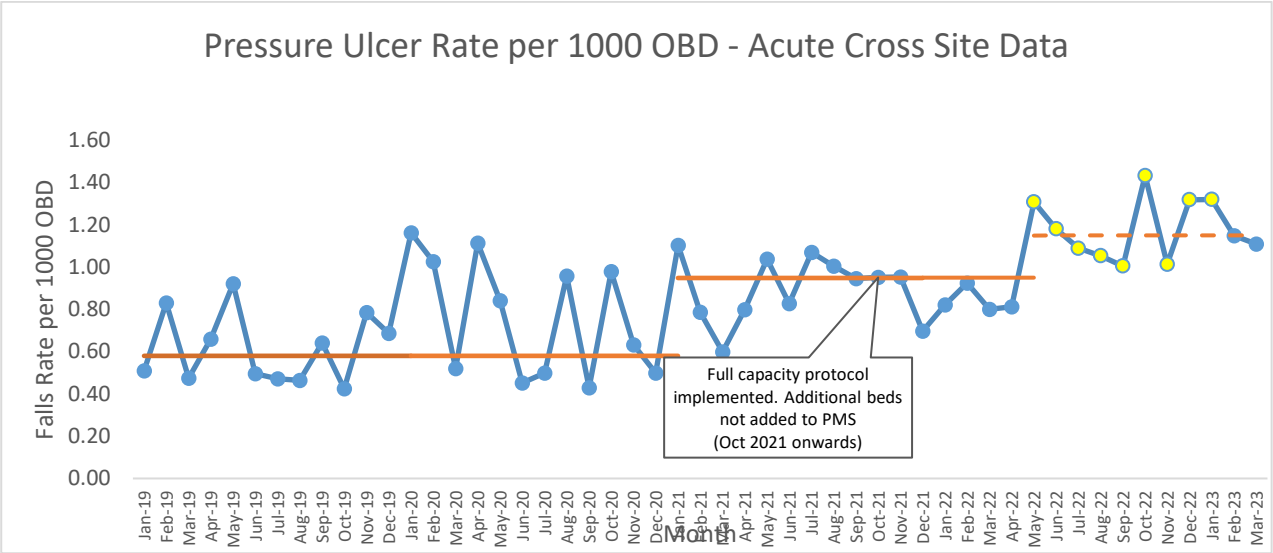
5. Pressure Ulcers (PUs)

Reducing the incidence of healthcare acquired PUs remains a key safety priority for health and social care organisations across Scotland. As there is no ask of NHS Boards to submit PU data to SPSP Acute Adult Programme there is no current Scottish SPSP median to benchmark against however it may be worth noting the last NHS Scotland PU median recorded in October 2019 pre pandemic was 0.42 per 1000 OBDs.

Excellence in Care programme have continued to extract and submit to PHS rate of Pressure Ulcers ≥ Grade 2, via the Datix reporting system. As previously highlighted PU data extraction continues to be submitted for PU rates for the EiC programme however unlike the Acute Adult Portfolio a median is not used, instead a national reference point statistically calculated by PHS is used as a reference on the national dashboard CAIR.

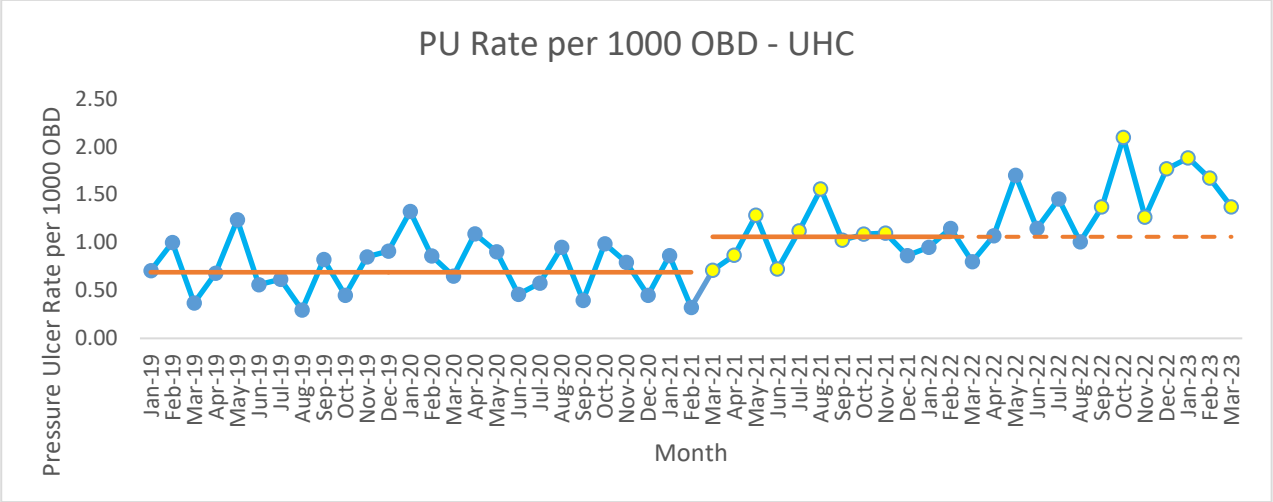
Utilising the Care Assurance and Improvement Resource (CAIR) dashboard, a national overview of PU is achieved. EiC data is reflective of locally collated data and a notable increase in acquired PUs has been highlighted.

5.1 Pressure Ulcer Data – Cross-site



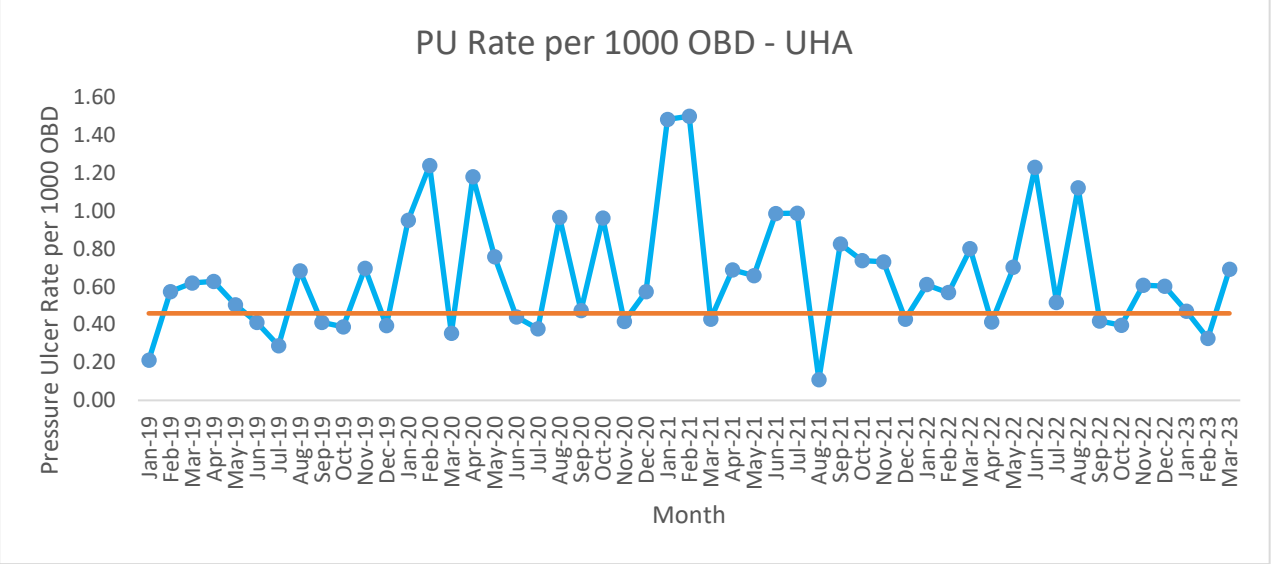
The chart above represents the rate of PUs in acute cross site data. A further increase in the median rate from 0.95-1.20 per 1000 OBDs is noted.

5.2 Pressure Ulcer Data – UHC



The chart above represents the rate of PUs within UHC. A recent increase in the PU median is demonstrated above within UHC site which is now recorded as **1.06** per 1000 OBDs. It is worth noting the 7 data points now currently sitting above the median line. Should this continue over a further 2 months a further median increase will be calculated.

5.3 Pressure Ulcer Data UHA



The chart above displays random variation of the PU data within UHA. The median rate of PUs within UHA is currently calculated at **0.46** per 1000 OBDs.

5.4 Pressure Ulcer Improvement Group

The Pressure Ulcer Improvement Group was formed in November 2020 and continues to meet on a regular basis to ensure a collaborative approach to identifying and supporting clinical teams with increased incidence of PUs across all of NHS Ayrshire and Arran. This is co-chaired by the Associate Nurse Director for Acute Services and East Ayrshire Health and Social Care Partnership (EAH&SCP) Community Nursing. As with the Falls Group there is representation from both acute and community hospitals and external partners. The aims of the group are:

- Use of data to inform improvement across acute, community hospitals and district nursing services
- Review PU standards, identify the gaps and look at how we can support
- Identify areas where there are frequent pressure ulcers and carry out improvement work
- Improve cross-site working having short-, medium- and long-term actions
- Identifying anything that has been successful in short term
- Observe the number of Support Adverse Event Reviews (SAER) across community and acute services

5.5 Pressure Ulcer Improvement Nurse

Funding received from the HIS Continuous Quality Improvement (CQI) allocation in 2021 enabled the development of a 2-year seconded post for a PU Improvement Nurse (PUIN) for Acute Services. Using the same model as the Falls Co-ordinator role the aim of the PUIN role to be based within the Acute QI team and use a collaborative approach employing QI methodology to identify and support change in areas with increasing incidence of acquired PUs. Unfortunately, due to delays in the recruitment process the post was not recruited into until March 2022. The following priorities and work plan were agreed and identified:

- Deliver bespoke PU education
- Develop PU Champion programme
- Monitor acute sites, collect data, investigate Grade 3 and above PUs
- Monthly identification of high-risk areas/wards (Grade 4/5)
- Lead on PU Collaborative initiatives
- Support Adverse Event Review Group process
- ED Nursing Documentation/risk assessment review
- Ensuring accuracy of DATIX information

To date we have 35 PU champions trained across both acute sites. In conjunction with the Tissue Viability (TV) Team education sessions have been developed and are currently being offered as part of the PU Collaborative. The PUIN has also undertaken a review of the process of all consequence 4/5 PU harms reported to the AERG. This resulted in the development and testing of a Consequence 4 or 5 harm pathway for pressure ulcers that has recently been introduced to the AERG.

5.6 Pressure Ulcer Collaborative

Data from both acute sites has been suggestive of an increase in reportable PUs. This is further supported by feedback from AERG who have noted an increase in category 4/5 PUs incidence requiring review.

As set out in a previous Board paper, a recent proposed action plan to provide a clear focus on driving improvements around prevention of PUs across both acute sites within NHSAA was approved by our Nurse Director and Acute Clinical Governance Group. One of the actions within the plan was to develop a local collaborative approach to support the reduction in the number of PUs and achieve a sustained improvement in PU prevention and management. The aims of the collaborative would be:

- To reduce newly acquired PUs across identified sites within acute in-patient wards within NHSAA
- To support using Quality Improvement methodology/approaches develop and improve knowledge and skills in PU prevention
- To develop a learning community and network locally which will hasten learning and share good practice
- To promote a culture of learning and continuous ongoing quality improvement

A soft launch of the PU Collaborative took place in November 22. This provided not only a platform to share with staff the aims, planned tests of change and anticipated outcomes of the collaborative but an opportunity for staff to feedback and contribute their own ideas and suggestions for change and improvement. The PU collaborative was officially launched in December 2022 with 2 wards from each acute site recruited as early adopters/test wards. Unfortunately, the ongoing clinical pressure resulted in a pause in the planned programme over December/January; however we have now resumed and are continuing to progress with the agreed improvement plan.

6. Summary

This report provides an overview of performance and activity in terms of SPSP Acute Adult portfolio within Acute Services NHSAA which is summarised below:

- The median rate for all falls across NHS Scotland is currently **7.6** per 1000 OBDs. For UHA this is **6.29** and in UHC **4.21** per 1000 OBDs.
- The median rate for all Falls has **decreased** from **5.81- 5.31** per 1000 OBDs on cross-site data.
- The median rate for FWH has **increased** from **0.52 to 0.74** per 1000 OBDs is noted on cross-site data
- There has been a **sustained reduction** in the falls rate from **6.73** to **6.25** per 1000 OBDs on the UHA site
- Some clinical areas in both acute hospitals have a higher rate of falls than the site median.
- There is no current Scottish median PU rate to benchmark against
- The current median for PUs for UHA is **0.46** and UHC median is **1.06** per 1000 OBDs
- A further increase in median PU rate from **0.95-1.20** per 1000 OBDs is noted in cross site data.
- Available data suggests there remains a higher median rate of PUs in UHC compared to UHA
- Some clinical areas in both acute hospitals have a higher rate of PUs than the site median.
- Some clinical areas within UHA are displaying lower PU rates than site median
- Alongside the Falls Co-ordinator and PUIN the QI team will continue to offer guidance and support to clinical areas.
- The median rate for Cardiac Arrest rates across NHS Scotland is currently **1.4** per 1000 discharges. For UHA this is **1.6** and in UHC **2.4** per 1000 discharges.