Agenda Item: 3iii

Report to:	**Board of Directors**	**Date: 5 September 2019**
Report from:	**Chief Nurse and Medical Director**	
Principal Objective/ Strategy and Title:	**GOVERNANCE: COMBINED QUALITY REPORT Patient Safety, Effectiveness of Care, Patient Experience and DIPC**	
Board Assurance Framework Entries:	**Unable to provide safe, high quality care BAF numbers: 742, 675, 1511 and 1878**	
Regulatory Requirement:	**CQC**	
Equality Considerations:	**None believed to apply**	
Key Risks	**Non-compliance resulting in poor outcomes for patients and financial penalties**	
For:	**Information**	

1. Purpose/Background/Summary

The Medical Director and Chief Nurse would like to highlight the following in addition to the Papworth Integrated Performance Report (PIPR) to the Board:

2. Quality and Risk Committee Exception report and Escalation August 2019

In addition to the Chair's report, the Chief Nurse and Medical Director would like to escalate the following to the Board:

- **Patient Safety Alert:** The Board is to note that the Trust will not adhere to a recent Patient Safety Alert regarding fans. Although the new Hospital had been designed to provide better air flow, some patients, due to their health conditions, liked to feel the flow of air. Staff would use their clinical judgement and liaise with the Infection Control Team where necessary.
- **Learning from Gosport:** The Gosport Report June 2017 concerned the inappropriate use of opioids at the end of life. Q&R were informed how the Trust continued to monitor the use of opoids.

3. DIPC Report (BAF 675)

- The DIPC would like the Board to note the increased number of *C.difficile* positive results was noted in June and July 2019:

  26/06 – toxin negative
  28/06 – toxin negative
  21/07 – toxin negative
  24/07 – toxin negative
  24/07 – toxin positive

  The epidemiological analysis of these cases could not find a link between them and the cases were considered sporadic. However, in view of increased incidence of the total *C.difficile* positive results, a meeting was held on 30/07 to discuss cleaning practices in the hospital in order to improve them as a measure of precaution. This is at a time when the north of Cambridgeshire is experiencing a considerable increase in cases.

  Toxin positive results, 3 cases have been recorded so far this year (May, July and August) against the trajectory of 11. They have been discussed at the scrutiny meetings with the CCG

representative. As there were no lapses in care or treatment, none of them were sanctioned. Therefore, the incidence of toxin positive results can be regarded as usual so far.

- There were no bed closures for IPC issues in August 2019

4. Inquests/Investigations:

Patient A
Patient admitted for bilateral lung transplant. Transferred post operatively to the Critical Care Unit for on-going care. During early post-operative period the patient had a sudden cardiac arrest, resuscitation commenced and patient returned to theatre. During resuscitation it was identified that the patient was difficult to hand ventilate which resolved when the ventilator tubing with nebulizer was removed. On closer inspection the Critical Care staff identified that a one way (valved) T-piece had been used in error to administer nebulised medication immediately prior to the patient's cardiac arrest. This device is not designed to be utilised in this setting and concerns were raised that this may have caused the patient's deterioration.

Medical cause of death:
1a Hypoxic-ischaemic brain injury
1b Post operative cardiac arrest
1c Double lung transplant for hypersensitivity pneumonitis

Coroner's Conclusion:
Patient died from a cardiac arrest and consequent brain damage caused because a one way (valved) T piece connector (rather than a two way non-valved T-piece connector) was used in a nebuliser system that sits in a ventilator circuit.

This case has been reported and investigated as a Serious Incident.

The Trust currently has 31 Coroner's investigations/inquests pending with 5 out of area.

Recommendation:

The Board of Directors is requested to note the contents of this report.