



Feidhmeannacht na Seirbhíse Sláinte  
Health Service Executive

# Hospital Patient Safety Indicator Report

Children's Health Ireland (CHI) at Crumlin

Reporting Month:

Aug-24

## Purpose & Context

The aim of the Hospital Patient Safety Indicator Report (HPSIR) is to assure the public that the indicators selected and published for this report are monitored by senior management of both the hospital and hospital group as a key component of clinical governance.

There are a number of considerations which should be noted for context:

- The HPSIR collates indicators from a range of data repositories
- While all data in the HPSIR is collated and verified in good faith, data from the original source may be updated and not reflected in the HPSIR due to time lags.
- Therefore, the data repositories, and not the HPSIR, should be considered the accurate source of data.
- The HPSIR cannot, and should not, be used to compare performance of hospitals or hospital groups. Different hospitals specialise in treating patients with different and sometimes much more complex care needs, making comparisons between hospitals ineffective.
- Like all indicators, the data should be interpreted with caution as there is natural variation between months which is influenced by case complexity
- While all hospitals collect a large range of data on an ongoing basis, these metrics have been selected on the basis that they are robust, relevant and underpinned by standardised definitions.
- The HPSIR should not be considered, nor is aimed to be, a comprehensive overview of patient safety in a hospital or hospital group

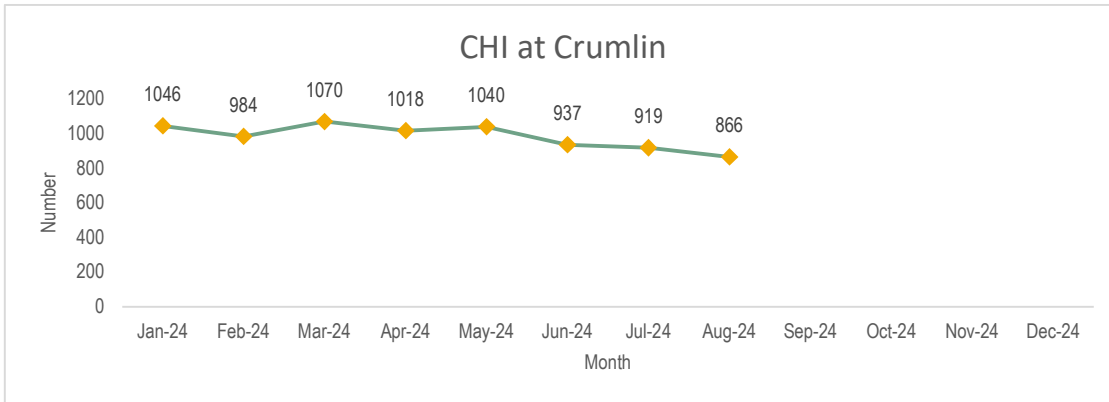
The completion and publication of the HPSIR is, in itself, a performance indicator for each hospital.

## 1 .Number of inpatient discharges

### What does this mean for me?

This data refers to the number of in-patients, excluding day cases, who were discharged from a publicly funded acute hospital. This indicator is used to assess quality of care, costs and efficiency, and is also used for health planning purposes.

**Expected Activity:** National (2018): 633,786



### Data Caveats:

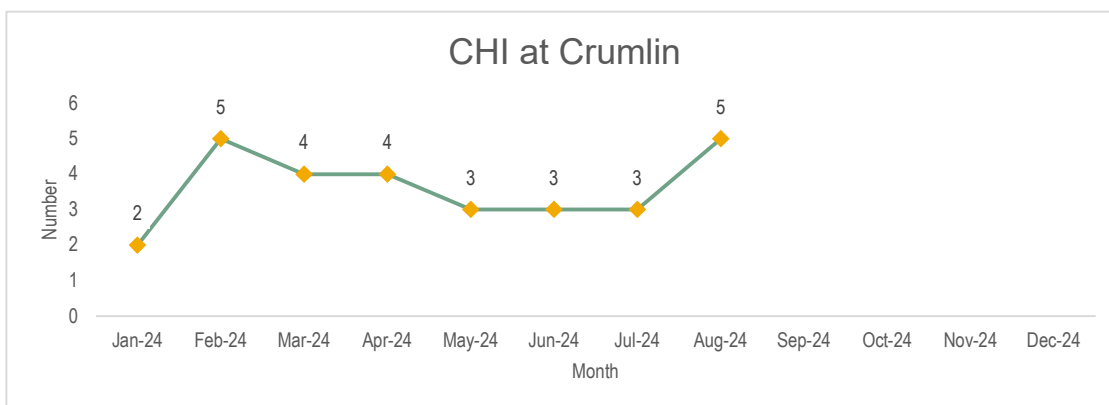
Nil

## 2. Number of beds subject to delayed transfers of care

### What does this mean for me?

Delayed Transfer of Care: A patient who remains in hospital after a senior doctor (consultant or registrar) has documented in the healthcare record that the patient care can be transferred. This indicator is used to assess quality of care, costs and efficiency, and is also used for health planning purposes.

**Target:** There is no hospital-level target associated with this indicator



### Data Caveats:

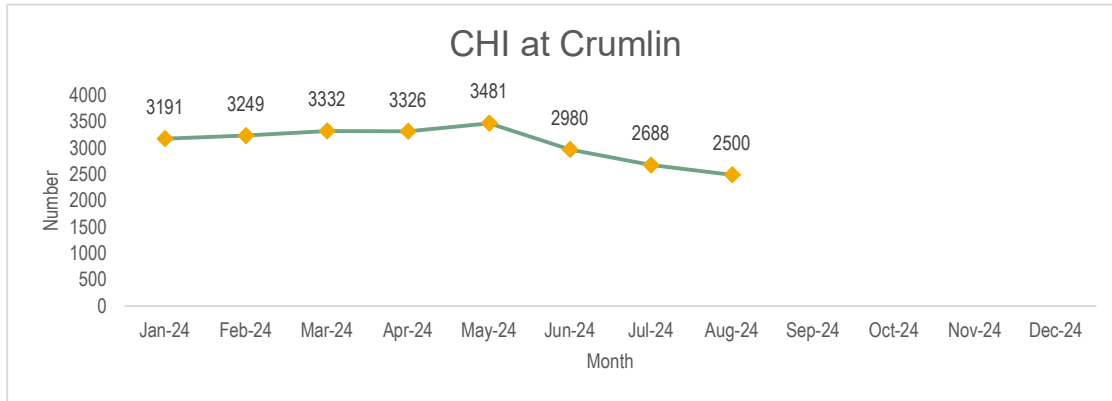
Nil

### 3. Number of new ED attendances

#### What does this mean for me?

Total number of new patients who present themselves to hospital Emergency Department (ED). It is an important measure for clinical audit/governance and planning of services and to measure the unplanned attendances to each hospital to measure demand on the entire service.

**Expected Activity:** National (2018): 1,178,977



#### Data Caveats:

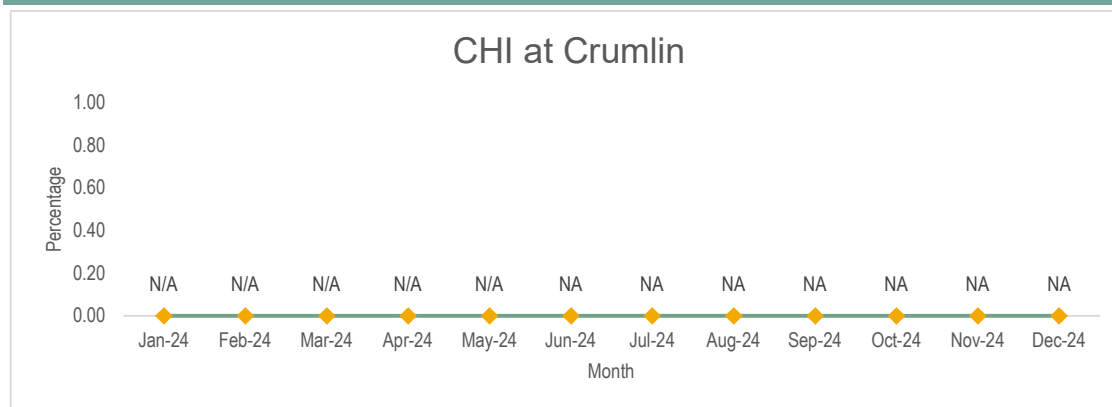
Nil

### 4. Percentage of all attendees aged 75 years and over at ED who are discharged or admitted within nine hours of registration

#### What does this mean for me?

Prolonged durations of stay in EDs are associated with poorer patient outcomes. The risk of patient mortality (death) increases after 9 hours total time spent in the ED. Patients waiting more than 9 hours should be cared for in a more appropriate care setting than an ED.

**Target:** 85%



#### Data Caveats:

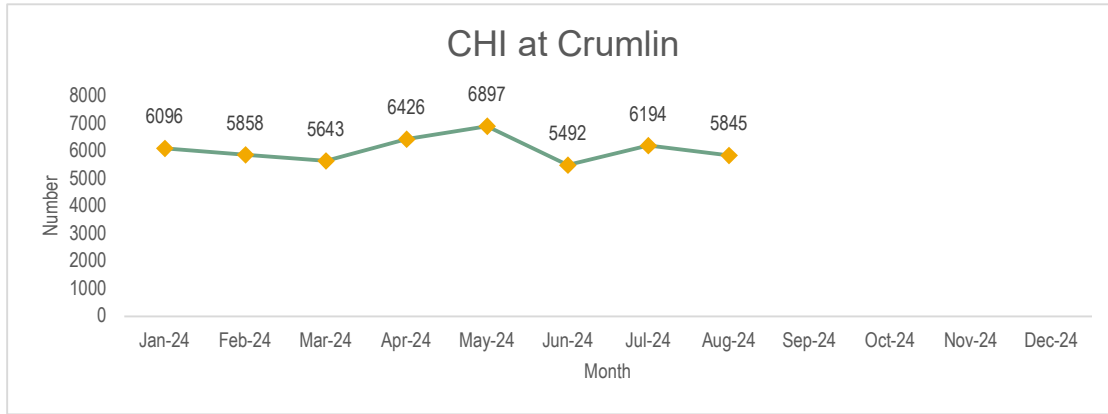
Not applicable to paediatrics.

## 5. Number of new and return outpatient attendances

### What does this mean for me?

This data includes both new and return attendances. New attendance: first new attendance at a consultant led outpatient clinic. Return Attendance: attendance by a patient who has been treated as an outpatient at least once previously, or as an inpatient or day case. This indicator is used to assess quality of care, costs and efficiency, and is also used for health planning purposes.

**Expected Activity:** National (2018): 3,337,967



### Data Caveats:

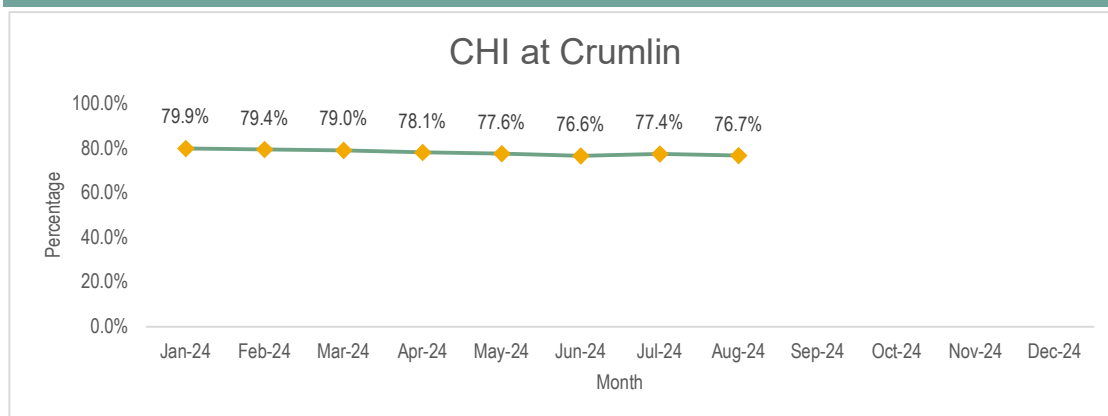
Nil

## 6. Percentage of people waiting <15 months for first access to OPD services

### What does this mean for me?

The % of people waiting less than 15 months to be seen in outpatient services. This indicator is used to assess quality of care, costs and efficiency, and is also used for health planning purposes.

**Target: 90%**



### Data Caveats:

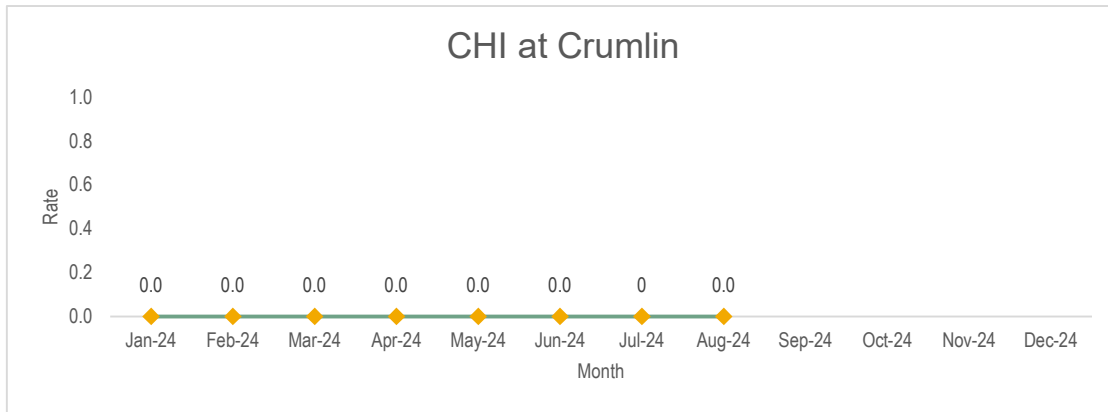
Nil

### 7. Rate of new cases of hospital-acquired Staphylococcus aureus bloodstream infection

**What does this mean for me?**

Staphylococcus aureus is a common cause of hospital-acquired bloodstream infection. The aim of monitoring this indicator is to ensure that rates are within acceptable levels. It is not always possible to have no hospital-acquired Staphylococcus aureus bloodstream infections.

**Target:** <0.8/10,000 bed days



**Data Caveats:**

NA

### 8. Rate of new cases of hospital-associated Clostridium difficile

**What does this mean for me?**

Clostridium difficile is a common cause of hospital-associated infection. This indicator measures the new cases of laboratory confirmed C. difficile infection per month per 10,000 bed days associated diarrhoea in acute hospitals. The aim of monitoring this indicator is to ensure that rates are within acceptable levels. It is not always possible to have no hospital-associated clostridium difficile infections.

**Target:** <2/10,000 bed days



**Data Caveats:**

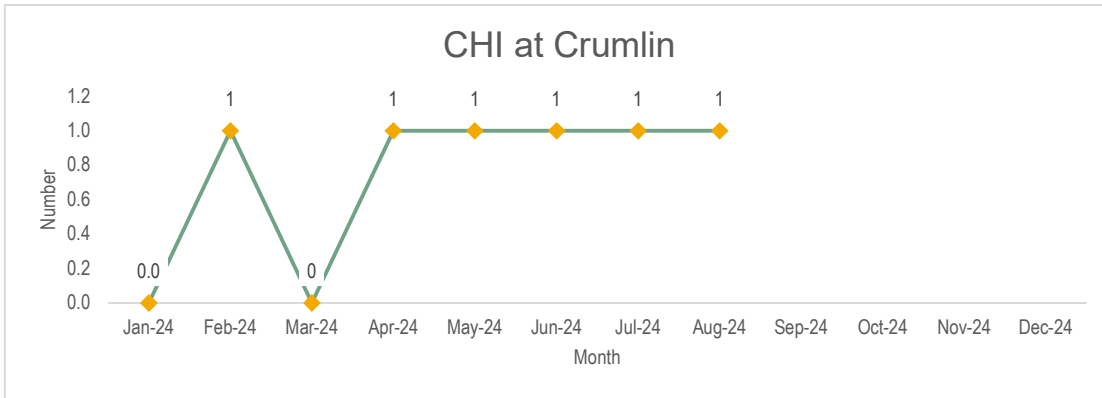
Incident form raised; additional training and education recommended.

### 9. Number of new cases of CPE

#### What does this mean for me?

CPE (Carbapenemase Producing Enterobacterales) reported in swabs/faeces or other samples by acute hospitals, is a relatively new bacteria that is mainly spread through acute hospitals. For most people, CPE live harmlessly in the bowel but can cause very serious infection in some patients. Tracking of the number of new cases of CPE is key to accurate assessment of the situation in Ireland.

**Target:** There is no target associated with this indicator



#### Data Caveats:

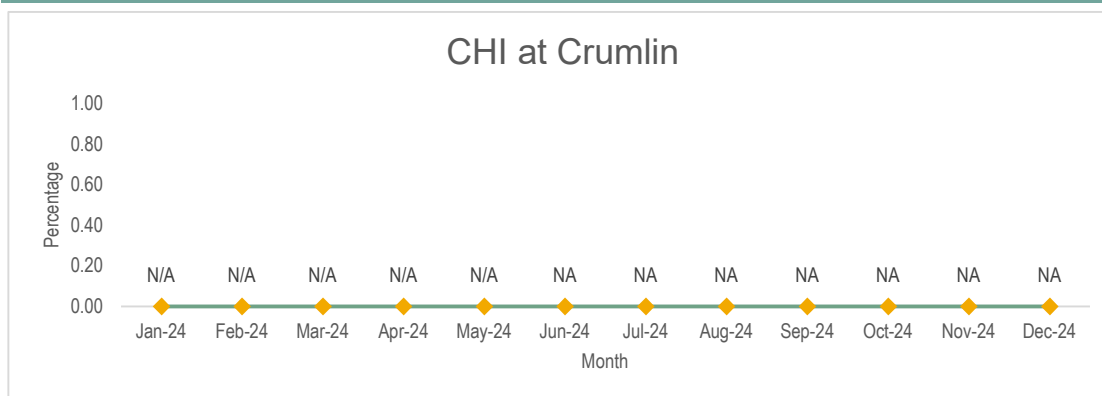
Nil

### 10. If the patient is identified as at risk of falling, nursing interventions are in place to minimise the risk of falling

#### What does this mean for me?

If you are admitted to hospital a nurse will check if you are at risk of a fall. In order to reduce an identified risk, the nurse will offer support in a way that suits you. This will be documented in your nursing plan of care.

**Target:** 90%



#### Data Caveats:

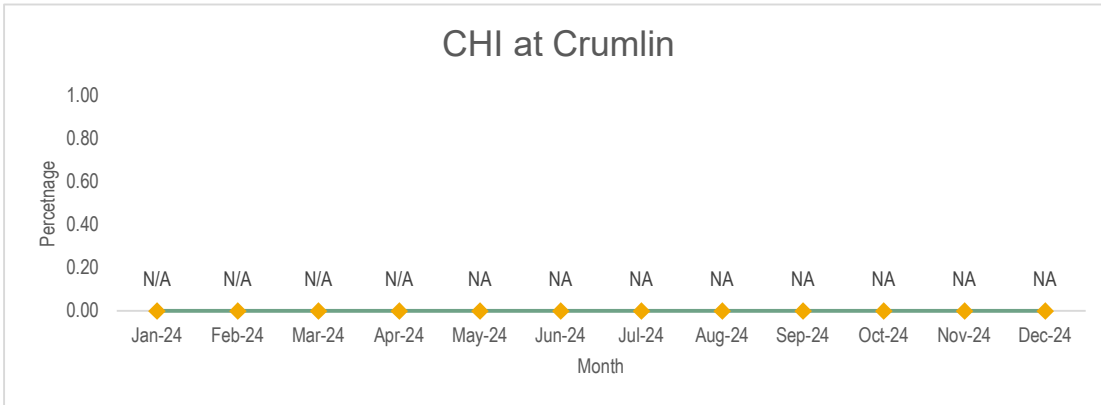
Not applicable to paediatrics.

**11. If a patient is identified as at risk (of pressure ulcer), daily skin inspections have been recorded, as per the National Wound Management Guidelines?**

**What does this mean for me?**

If you are admitted to hospital a nurse will check if you are at risk of developing a pressure ulcer. In order to reduce the risk, if present, the nurse will assess your skin at least once daily and document, date/time and sign in your nursing records.

**Target: 90%**



**Data Caveats:**

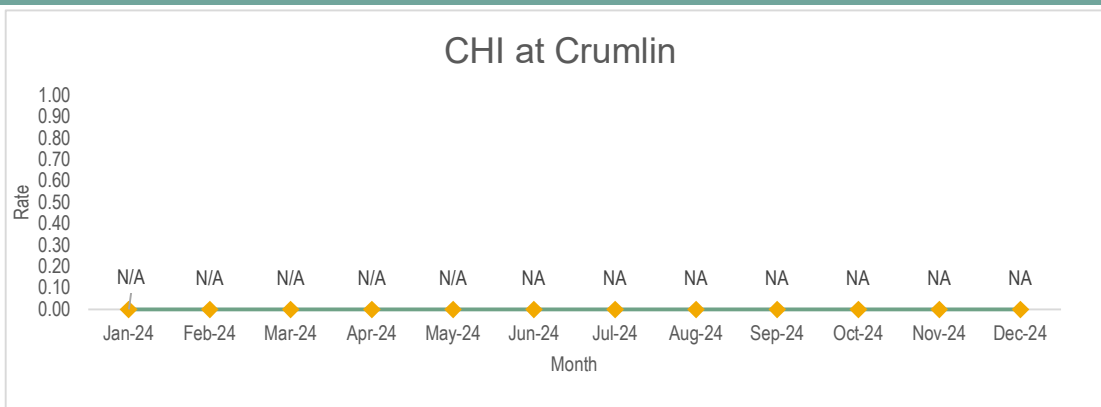
Not applicable to paediatrics.

**12. Rate of venous thromboembolism (VTE, blood clots) associated with hospitalisation**

**What does this mean for me?**

Hospital associated venous thromboembolism (VTE, blood clots) is common cause of harm to patients, and up to 70% may be preventable. Assessing patients' risk of VTE and bleeding and choosing the appropriate VTE prevention for them early in their hospital admission reduces their risk of developing a blood clot.

**Target: There is no target associated with this indicator**



**Data Caveats:**

Not applicable to paediatrics.

### 13. Percentage of hip fracture surgery carried out within 48 hours of initial assessment

**What does this mean for me?**

It is recognised that minimising the time between admission to hospital and performance of surgery for patients with a hip fracture results in better outcomes for patients. Though not all patients who experience a hip fracture will be suitable for immediate surgery (for example, because of other medical conditions which may need to be stabilised prior to surgery).

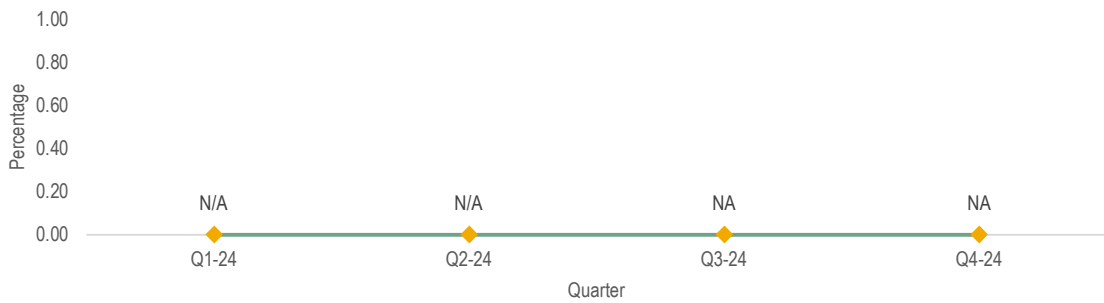
**Target: 85%**

**What does**

Intradepartm  
consultant p  
authorisatio

**Target: 3%**

#### CHI at Crumlin



**Data Caveats:**

Not applicable to paediatrics.

**Data Caveat**

Not applicat

### 14. Number of colonoscopies where the terminal ileum / caecum / anastomosis has been reached expressed as a % of total colonoscopies

**What does this mean for me?**

Intubation of the caecum indicates the completeness of a colonoscopy. As the caecum is the final part of the colon, reaching (or intubating) it shows that the scope has passed through the entire colon and got to the end.

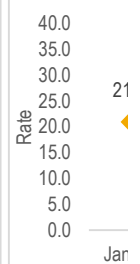
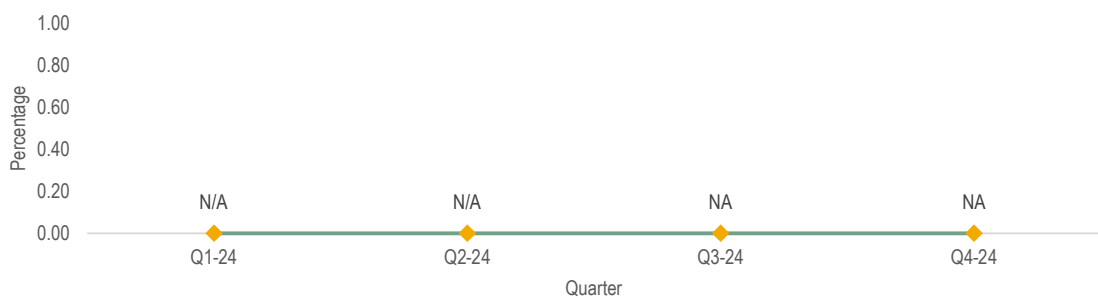
**Target: 90%**

**What does**

An incident  
Higher repo

**Expected A**  
14.80 per 10

#### CHI at Crumlin



**Data Caveats:**

Not applicable to paediatrics.

**Data Caveat**

An increase



### 15. Percentage of intradepartmental consultations completed (Histology P01-P04)

**What does this mean for me?**

An Intradepartmental Consultation (IDC) occurs when a consultant pathologist seeks a second opinion from another pathologist within their department or within their regional hospital network on a particular case prior to the final report.

**What does this mean for me?**

This indicator... A high standard... the actual number... into consideration... the actual data... there should...

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**Expected Accuracy**

Oct 2021 to
Jan 2022 to
Apr 2022 to
Jul 2022 to

Notes:  
... to paediatrics.

If there is both... statistical out...

### 16. Rate of clinical incidents as reported to NIMS per 1000 Bed Days

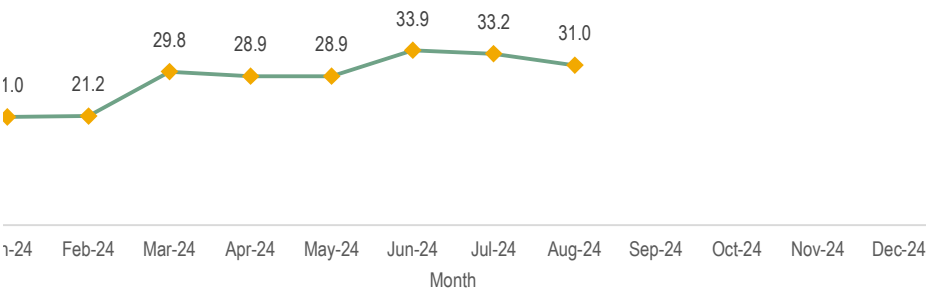
**What does this mean for me?**

A clinical incident is an event or circumstance which could have, or did lead to unintended and/or unnecessary harm (IMF 2018). Reporting rates reflect a positive safety culture.

**Activity:** The rate of clinical incidents reported to NIMS per 1000 bed days from July 2016 to June 2018 was 31.0 per 1000 bed days (Range: 5.80 to 48.0 per 1000 bed days)

**Data Caveats:**  
- Interpreting... assure patient... which are o...  
- A statistical... limits are br... that have st... uploads/gen...  
- Continued... and learnt fr...  
- An unexpect... may indicate...

#### CHI at Crumlin



Notes:  
... in the rate of person-related incidents seen in that month.

**17. Has there been a mortality statistical outlier?**

**What does this mean for me?**  
 This assures patients that mortality data is being monitored in hospitals. A standardised mortality ratio (SMR) and breached CuSum control limit alerts the hospital to review its data. An SMR is a ratio of the number of patients who die in hospital versus the number expected to die, when factors known to impact mortality are taken into account. A CuSum is a control chart which is a statistical tool for detecting small sequential changes in the difference between actual deaths and the expected deaths in hospital over time. It does not necessarily mean that there are more patients dying than expected.  
**Activity:** Continual monitoring of mortality by hospitals.

The objective of this patient safety indicator is to ensure that the HPSI patient profile

Date Periods			Has there been a mortality statistical outlier?
1 Sep 2022	AND	Jan 2022 to Dec 2022	0
1 Dec 2022	AND	Apr 2021 to Mar 2022	0
1 Mar 2023	AND	Jul 2022 to Jun 2023	
1 Jun 2023	AND	Oct 2022 to Sep 2023	

The Hospital (2024) has the highest mortality rate in the hospital at

If a hospital has a high SMR (red) and breached CuSUM limit (red) in two consecutive data periods, for the same diagnosis, this is a mortality statistical outlier and thus 'Yes' is recorded for this indicator.

**Notes:**  
 Monitoring mortality data is very complex. This indicator does not aim to inform viewers of mortality figures. It aims to inform patients and members of the public that hospitals are monitoring and responding to usual and unusual signals outside of the national expected range of mortality for a particular condition. A mortality statistical outlier in NAHM is defined where a combination of the standardised mortality ratio (SMR) is high and control limit breached (CuSum) for the same condition in two consecutive reporting periods. NOCA engages with hospitals to address mortality statistical outliers in line with its monitoring and escalation policy [http://s3-eu-west-1.amazonaws.com/noca-general/NOCA-GEN-POL014\\_-\\_NOCA\\_-\\_Monitoring\\_Escalation\\_Policy\\_v2.1.pdf](http://s3-eu-west-1.amazonaws.com/noca-general/NOCA-GEN-POL014_-_NOCA_-_Monitoring_Escalation_Policy_v2.1.pdf). The continual monitoring of NAHM mortality data is necessary to ensure that high or above average signals are acted upon promptly. A statistically high or low SMR or CuSum signal may not always be related to the quality of care in a hospital, but it does indicate to a hospital that there is a need to review their data quality or the processing of the data.

Hospital  
 Hospital Group  
 Hospital Group  
 Chief Executive  
 Director  
 Hospital Group  
 Director of

## Clinical Governance

One of the key objectives in publishing the HPSIR is to provide public assurance, by communicating to patients, staff and wider public in an open and transparent manner, that important safety indicators are being monitored by hospital management on a continual basis. The HPSIR is not intended to be used for comparative purposes as the clinical activity, profile and complexity of each hospital can differ significantly.

The Hospital Patient Safety Indicator Report for (CHI at Crumlin) for the month of (August) has been discussed at a hospital management meeting by senior management of the hospital and the hospital group, as a core element of clinical governance between the hospital and the hospital group.

	Name	Date	Signature
CEO/GM	Prof Sean Walsh	22/10/2024	<i>Sean Walsh</i>
Hospital Group CEO	Ms. Fiona Murphy	25/10/2024	<i>Fiona Murphy</i>
Hospital Group Clinical Director	Delete as required	Delete as required	Delete as required
Hospital Group Chief of Nursing	Delete as required	Delete as required	Delete as required