Report to:	**Public Board of Directors**	**Agenda item:**	**9**
Date of Meeting:	**26 October 2016**		

Title of Report:	**Quality Report**
Status:	**For discussion**
Board Sponsor:	**Helen Blanchard, Director of Nursing and Midwifery** **Tim Craft, Medical Director** **Francesca Thompson, Chief Operating Officer**
Author:	**Lisa Cheek Deputy Director of Nursing and Midwifery**
Appendices	**Appendix A - Nursing Quality Indicators Chart (Sept data)**

1. Executive Summary of the Report

This report provides an update on quality with a focus on patient experience and key patient safety and quality improvement priorities reviewing September 2016 data.

The Quality Report this month includes a quarterly update on the improvement priorities as highlighted in the 2016/17 Patient Safety and Quality Improvement Triangle. Other items will be reported on an exception basis.

This month the report focuses on:

- Part A - Patient Experience:
  - Complaints and PALS monthly activity data

- Part B - Quality Improvement Priorities:
  - Patient Safety – Sepsis
  - Patient Safety – Insulin Safety
  - Patient Safety – Unwarranted Movement of Patients
  - Patient Safety – AKI
  - Patient Safety – NEWS
  - Patient Safety – C Difficle

- Exception reports:
  - Serious Incidents monthly summary
  - Overdue serious incidents summary
  - Nursing Quality Indicators exception report

2. Recommendations (Note, Approve, Discuss)

To note progress to improve quality, patient safety and patient experience at the RUH.

3. Legal / Regulatory Implications

It is a legal requirement to comply with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3).

4.	Risk (Threats or opportunities, link to a risk on the Risk Register, Board Assurance Framework etc.)
A failure to demonstrate sustained quality improvement could risk the Trust's registration with the Care Quality Commission (CQC) and the reputation of the Trust.	

5.	Resources Implications (Financial / staffing)
Delivery of the priorities is dependent on the continuation of the agreed resources for each project.	

6.	Equality and Diversity
Ensures compliance with the Equality Delivery System (EDS).	

7.	References to previous reports
Monthly Quality Reports to Management Board and Board of Directors	

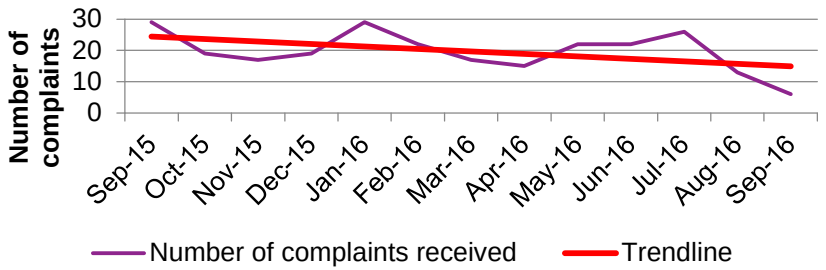
8.	Freedom of Information
Public.	

QUALITY REPORT

PART A – Patient Experience

Complaints and Patient Advice and Liaison Report

Total number of complaints received



There were **6 formal complaints** in September 2016:

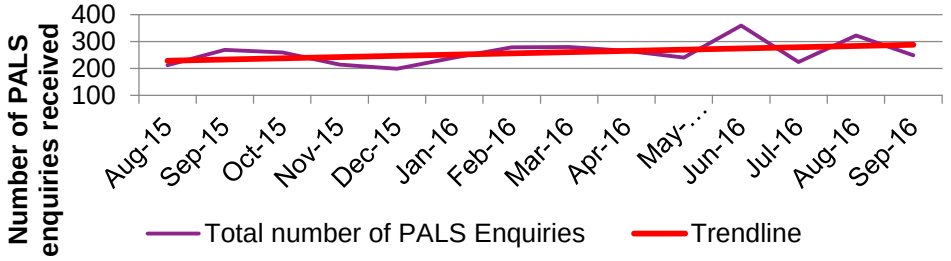
- 5 complaints were in the Medical Division
- 1 complaint was for Women and Children's Division
- There were no complaints for the Surgical Division

- **Clinical Care and treatment –** 5 of the complaints (83%) related to clinical care and treatment, 4 of these were in the Medical Division – RNHRD outpatients department, Respiratory Ward, Emergency Department and Cardiology. The complaint for the Women and Children's Division involved the Paediatric Outpatient Department.

- **Communication and information** – One complaint was received which related to a lack of explanation about the patient's clinical care at the RNHRD.

There has been a significant decrease in August and September in the number of formal complaints. The focus has been on resolving concerns about clinical care more immediately, either by frontline clinical staff or through our PALS service.

Total number of PALS enquiries



There were **249 contacts with the PALS** service this month, of which:

- 153 required resolution (61%)
- 61 requested information or advice (24%)
- 21 were compliments (9%)
- 14 provided feedback (6%)

The **top three subjects requiring resolution** were:

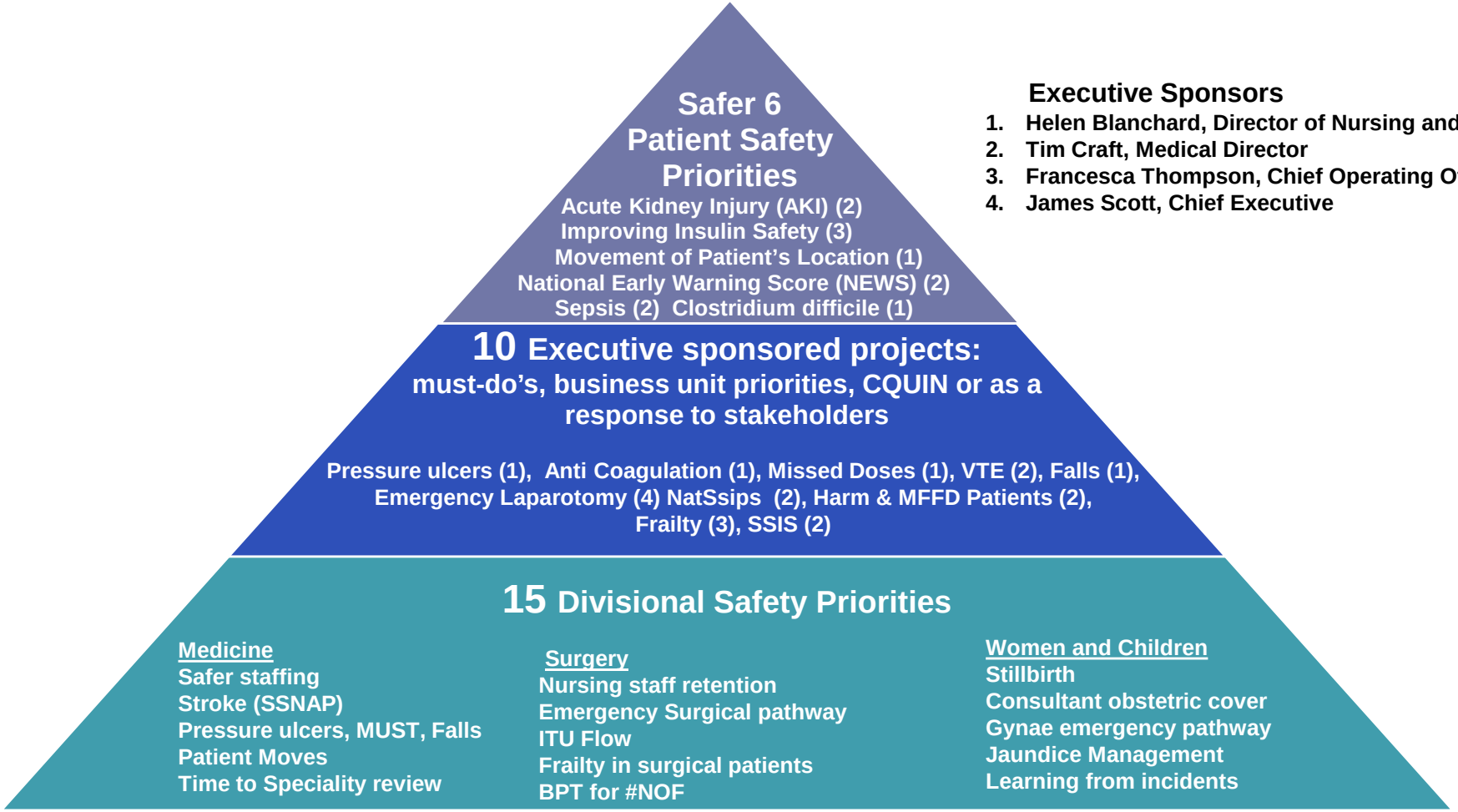
Clinical Care and Concerns – 55 contacts (22%) none were attributed to a particular hospital service. Of the 55 contacts, 29 (53%) were for Medical Division, 10 (18%) for Surgical Division, 4 (7%) for Women and Children's Division and 12 (22%) were general clinical enquiries.

Communication and Information- there were 32 contacts (13%) relating to communication, however there was no particular theme.

Appointments- there were 29 contacts (12%) regarding appointments. The main theme was that patient's had concerns about delays in outpatient follow up appointments and not having the information about the wait times for various specialties. Information available to patients on the Trust external website is being reviewed and will be updated.

QUALITY REPORT

PART B – Patient Safety and Quality Improvement



Executive Sponsors

1. Helen Blanchard, Director of Nursing and Midwifery
2. Tim Craft, Medical Director
3. Francesca Thompson, Chief Operating Officer
4. James Scott, Chief Executive

Patient Safety – Sepsis work stream report

Tim Craft

CQUIN for Sepsis in 2016/17

There are two parts of the CQUIN

3a Timely identification and treatment for sepsis for adult and paediatric patients directly admitted (which for RUH includes ED ,MAU, SAU, ESAC and Paediatric Admissions Unit).

3b Timely identification and treatment for sepsis in all acute inpatient settings, including paediatrics and maternity.

Both 3a and 3b are then broken down into the following

- % patients who met the criteria for sepsis screening and were screened.
- % patients who present with Severe Sepsis, Red Flag Sepsis or Septic Shock and were administered intravenous antibiotics within the appropriate timeframe and had an antibiotic review within three days.

For the inpatient part of the CQUIN the CCG have agreed to focusing on 5 pilot sites for the first 3 quarters but with data trust wide from quarter 4 with 90% targets, which will be exceptionally challenging. The pilot sites are Maternity, Robin Smith, Paediatric Ward, MSS and SAU (not direct admits)

Update on work plan

Delivery of Sepsis 6 for patients directly admitted withSepsis

Progress on delivery of sepsis 6 in an hour for all adult direct admissions is shown in the run charts and data is continued to be collected from all patients admitted on alternate days.

The average number of patients per month admitted severe sepsis on alternate days was 22 for the last 3 months (range 20-24 patients) including paediatrics

Compliance with all aspects of the sepsis 6 has been difficult due to the difficulties that the Emergency Department has experienced over this time with many periods of black escalation. However, following review of all the patients by ED consultant sepsis lead and MAU consultant to ensure all patients included met criteria for aggressive treatment, the percentage of patients receiving antibiotics in an hour and having antibiotic review was 83% for Q2

Awareness and training

- A new 60 day for sepsis 6 campaign was launched on 25th July and 600 staff have been trained to date across the trust in the campaign.
- 7 acute trusts in the West signed up the campaign and over 3000 staff have received training across the region.
- Sepsis training was received as part of Induction for the new F1s in July , and has been incorporated into core skills which occurs weekly
- .Combined Sepsis/ AKI simulation training took place in September and a new date has been booked for November

Management of inpatients with sepsis

A band 7 Sepsis nurse has been appointed and commences in November.

Targets for the Q2 Inpatient CQUIN have been achieved as follows:

Screening	Jul-16	Aug-16	Sep-16	Q2 Total	Target for Q2
No of Patients	44	74	54	172	
Percentage screened	34%	64%	70%	58%	34%

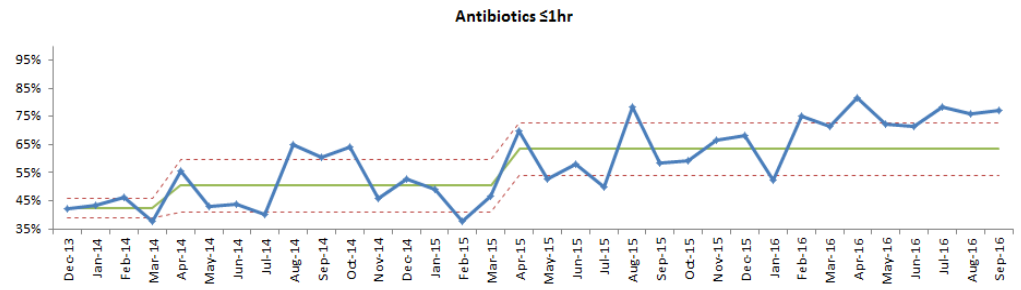
Antibiotic / Rv	Jul-16	Aug-16	Sep-16	Current Position	Target for Q2
No of Patients with Sepsis (red flags)	11	7	13	31	
% Antibiotics 90 mins and review within 3 days	36%	71%	62%	55%	22%

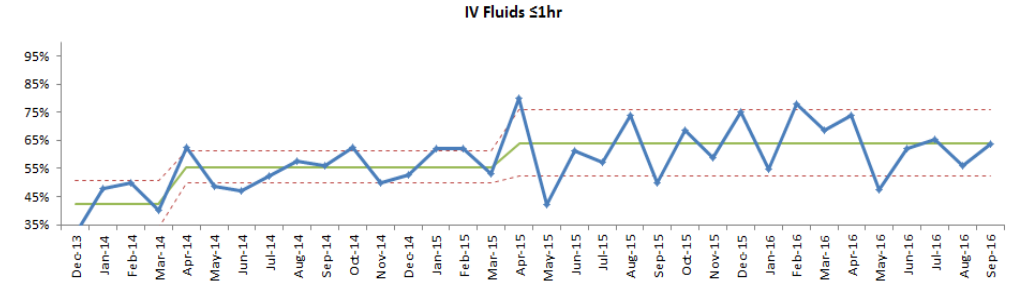
A screening tool and new proforma is being tested in our pilot areas and improvement work has been established, prior to rolling out trust wide.

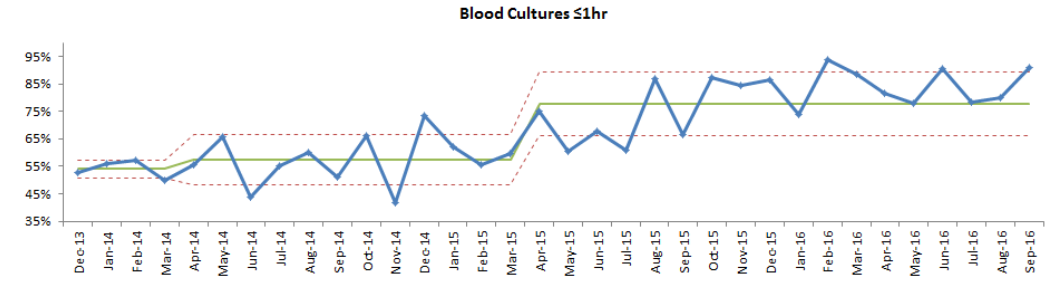
Next steps

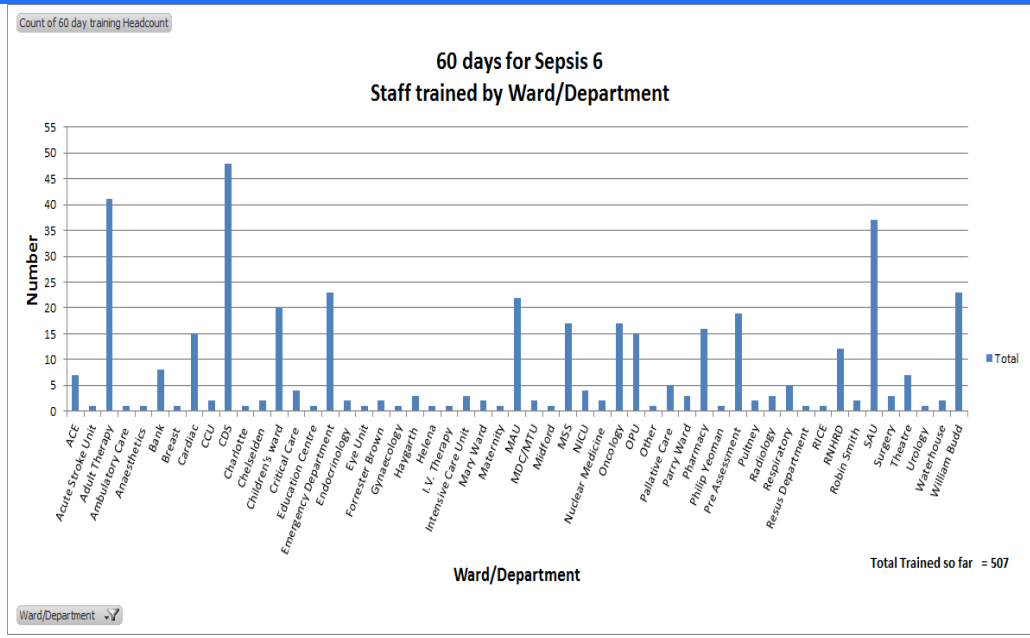
- Continue testing new screening sticker and proforma and roll out trust wide
- Continue sepsis training
- Continue sepsis data collection for inpatients and emergency admissions
- Deliver improvement trajectories as per CQUIN targets
- Implement antibiotic card for neutropenic sepsis patients, which is currently awaiting approval by Medicines Advisory group

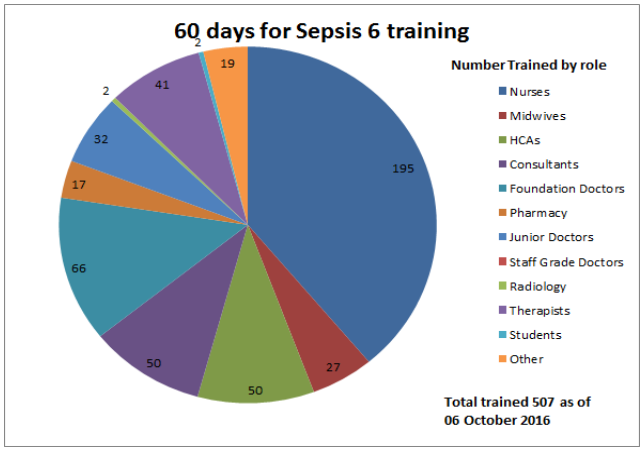
Patient Safety – Delivery of Sepsis 6 in adult patients directly admitted with sepsis and 60 days for Sepsis training figures











Patient Safety – Insulin Safety

Francesca Thompson

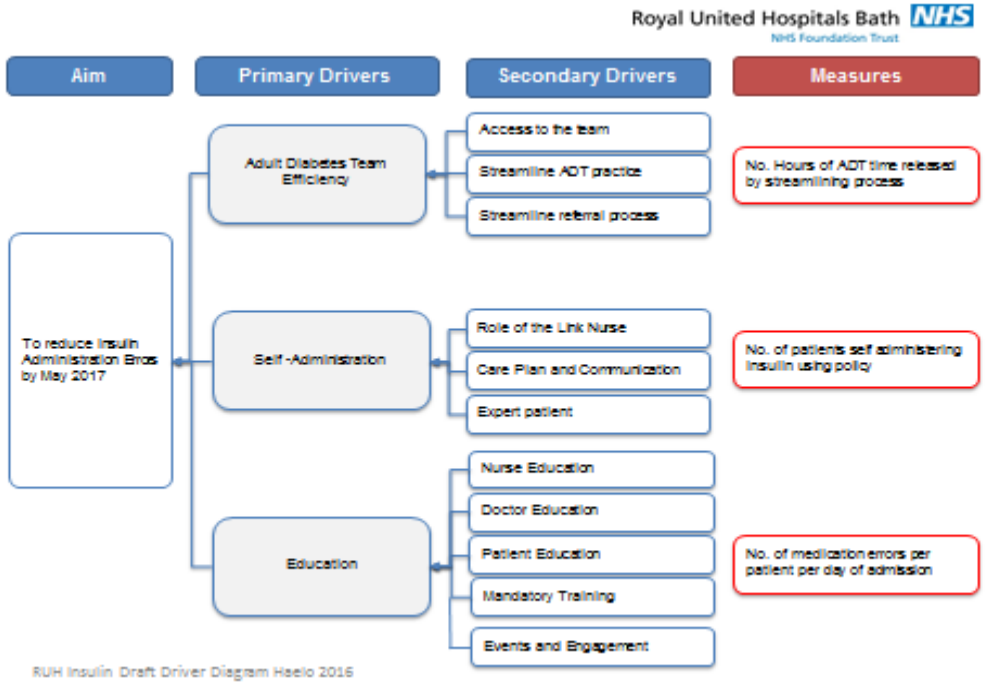
Background
Improving Insulin safety is one of the Safer Six Patient Safety priorities.
The AIM of the project is to reduce insulin administration errors to adult patients with diabetes by May 2017. This is a revised aim following initial testing to ensure that the project is achievable within the timescale.

Progress
Due to the complexity in insulin safety, the project team have undertaken a considerable amount of background work with patients and staff to find out why they think errors are occurring. The feedback from this work will enable appropriate interventions to be made.

Baseline Measures
The initial baseline measures were collected on two wards for 10 days (60 patients)
There were 6 patients on insulin during that period and 6 errors were identified.

Education
An e-learning package has been developed and tested and will be launched this month.

Driver Diagram for the Haelo Quality Systems project



Next Steps
Adopting more wards for continuous measurement. This poses a challenge in staff capacity and a meeting is planned to explore this in more depth with the Executive sponsor.

Patient Safety – Unwarranted Movement of Patients

Helen Blanchard

Aims of the project

The project aims to reduce the number of unwarranted patient moves and reduce inappropriate patient moves between 20.00- 02.00hrs

Background

A review of 44 randomly selected patients was undertaken focusing on the number of unwarranted patient moves and the number of inappropriate moves between 20.00hrs and 08.00hrs. The comparison of the time documented in the patients medical notes was made against the time recorded on Millennium (Patient Administration System) . This review was over a three month period from January to March 2016.

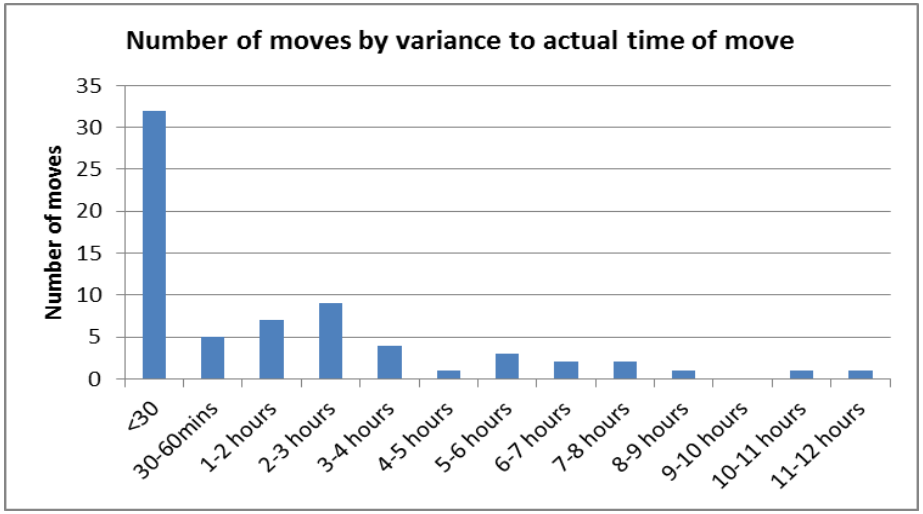
Results

The total number of ward moves for the 44 patients was 37 moves, this does not include the move from MAU/ SAU to the base ward or patients that were moved appropriately for their medical condition. In comparison to the previous notes review October to December 2015, there has been a reduction in moves from 90 to 37. In the previous review 11% of patients were moved more than four times during their stay; however in this review only 2% of patients were moved more than four times. The greatest number of transfers happened between 18.00 and 02.00hrs.

The time recorded on Millennium compared to the time documented in the patients' medical notes is detailed in **Figure 1**. 47% of patients were moved within a 30 minutes of the time documented in the medical records and the time recorded on millennium. 7% of patients were recorded as being moved on a different day, either on Millennium or in the medical records, and 11% of these patients wrongly recorded as moving after 20.00hrs.

Next Steps

- The project group to agree the final KPI's which will include the number of patient moves between 20.00-02.00, real time recording on millennium compared to documentation in the patients notes, and length of stay.
- Review all Datix reports linked to patient moves to determine themes.
- Gap analysis to be undertaken regarding training requirements of staff
- Full report to be presented at the discharge board.



Patient Safety - Acute Kidney Injury (AKI)

Tim Craft

Background

- AKI is a quality indicator for 2016/2017 – with focus on continuation of training programme, identification and management of AKI, compliance with the AKI care bundle and information in the discharge summary

Current Status

Awareness and Training

- *715* staff have been trained since November 2015 which equates to 35% of clinical staff (adult inpatient staff only)
- AKI training is now incorporated into the weekly core skills training and was covered in the August junior doctor induction.
- AKI/ Sepsis Simulation Utopia training has been developed and the first session occurred in September. Feedback was very positive and further sessions are planned.
- A bid has been submitted by the RUH simulation team in conjunction with the AKI team for funding to support simulation training on the wards for AKI.

AKI Bundle compliance

- Bundle compliance on cardiac and respiratory wards has remained within normal variation. Work on ownership of the work at ward level is progressing as well as focusing on other areas such as Maternity, Waterhouse and MAU

Discharge Summary Information

- Information in the discharge summary for cardiac and respiratory patients has remained constant and compliance trust wide from random note review for Q2 is similar (see charts) . Further improvement is not expected until the electronic solution is activated.
- This automatic electronic link of AKI alert to the discharge summary is part of the larger project on discharge summaries.

Fluid balance and hydration work

- The AKI steering group have linked with the Nutrition and Hydration group regarding increasing awareness of urine output in all patients, with good engagement.
- The link nurses were updated in September and an amended Hydration chart, aimed to increase early recognition AKI, is planned to be tested on Waterhouse ward in October

Links with Community

- The RUH AKI steering group has representation from the community AKI group and has links with the increased work in the community
- The AKI e alert has been switched on for GPs and community teams in September.
- RUH is hosting the next Regional AKI group meeting in October to share our learning with other trusts across the region

Patient Information

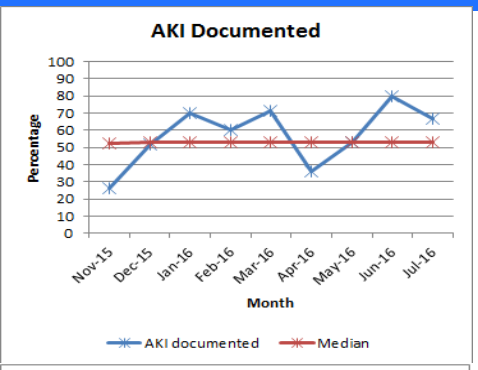
Patient Information leaflets have been developed and have been launched in October.

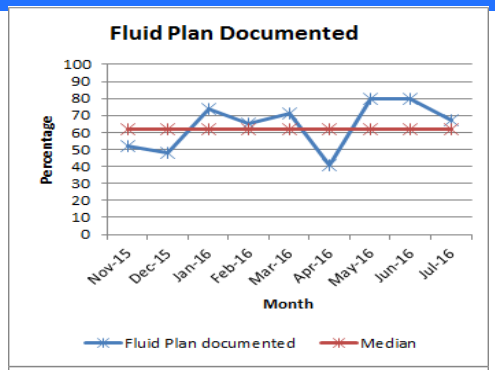
Next Steps

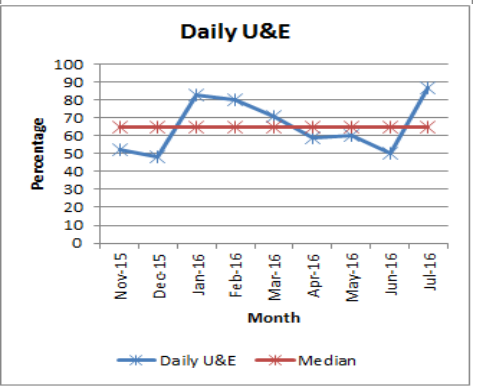
- Continue to increase training from AKI training in all areas
- Spread improvement work to all areas with ownership of bundle compliance and information in discharge summary with all specialities.
- Awaiting IT implementation of discharge summary link

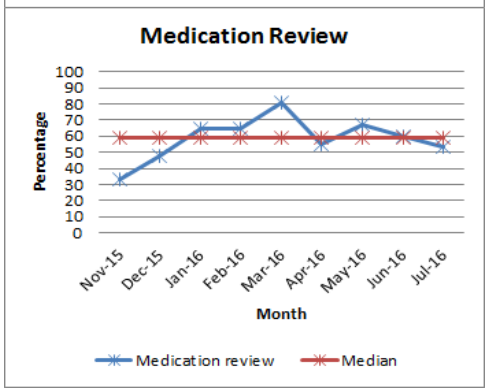
Patient Safety - Acute Kidney Injury (AKI)

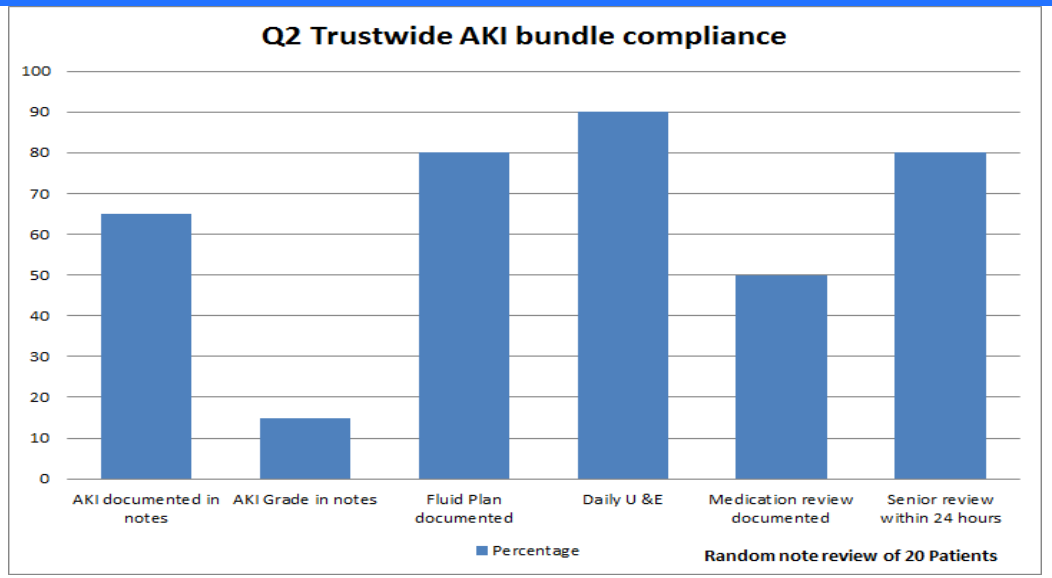
Tim Craft

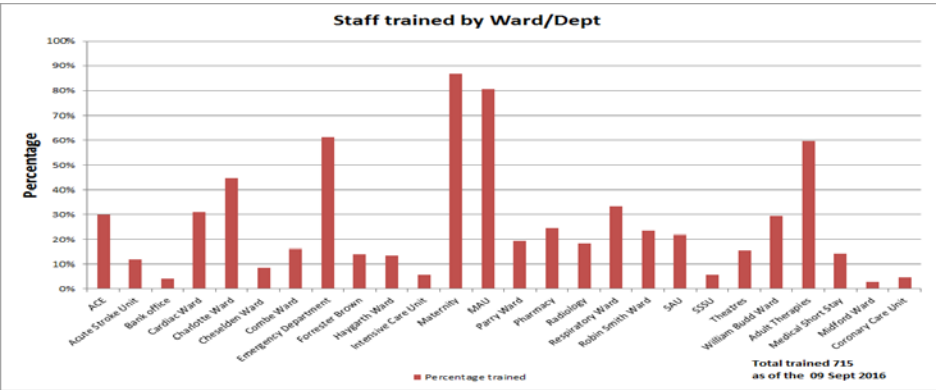


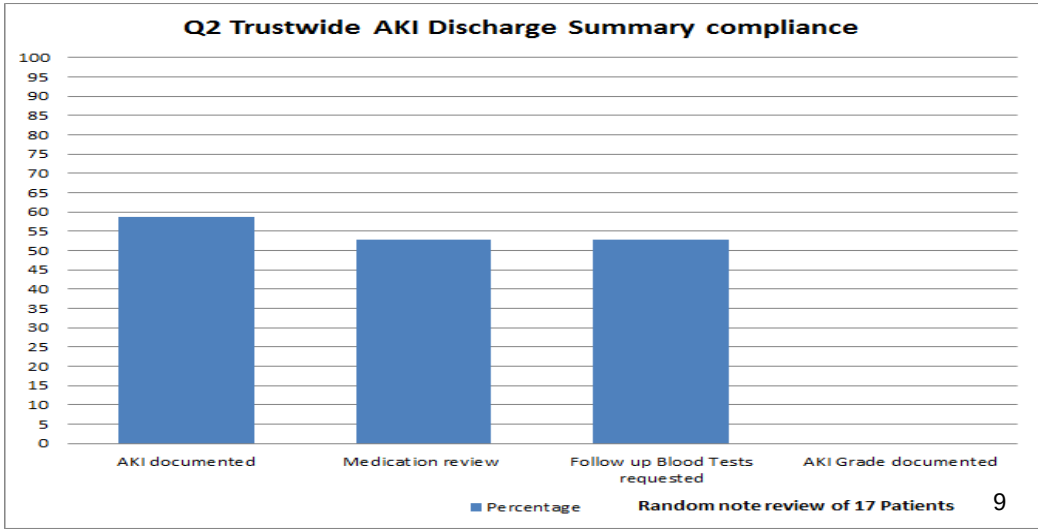












Patient Safety - National Early Warning Score (NEWS) work stream report

Tim Craft

Work stream update

The aim of the National Early Warning Score (NEWS) work stream is to ensure that NEWS is reliably and accurately used to monitor adult patients' vital signs, that care is appropriately and reliably escalated and that correct actions are taken to ensure optimal care for the patient.

Progress to work plan:

1.0 Documentation and Policy

- NEWS chart under revision and will include section for recording escalation and flowchart for management of Deteriorating patient
- Task and finish group decision in October on the option for an electronic system to record vital signs

2.0 Education and Training

- Total of 91 nursing and AHPs have been trained as cascade trainers which means 100% of wards have at least two Cascade trainers
- Total of 1082 nursing staff and AHPs have been trained at ward level by Cascade trainers (68% of the target group of Nursing and therapy staff)
- Meetings set up with Senior Sisters for 5 wards where under 50% of staff have received training to review and support training

Emergency Department:

- Focused Improvement work launched in ED 2nd May -Improvement team led by ED nurses supported by Consultant/ Clinical Governance lead and NEWS work stream
- Standard agreed for recording of NEWS in ED
- 7 Cascade trainers have trained 104 staff at level 2 to date, in total 94% of nursing staff
- Developed teaching sessions for doctors (includes prescribing of oxygen saturation ranges) and adjusting frequency
- Improvement measured by regular measurements (Figure 1)

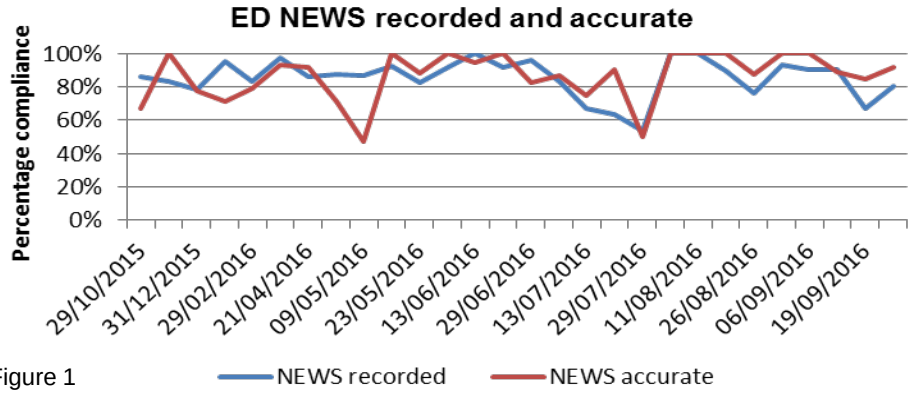


Figure 1

3.0 Measurement and communication of compliance

- In wards where cascade trainers have trained at least 75% of staff , additional audits are carried out to review the impact of the training on the completion of NEWS – example of MSSU (Figure 2)

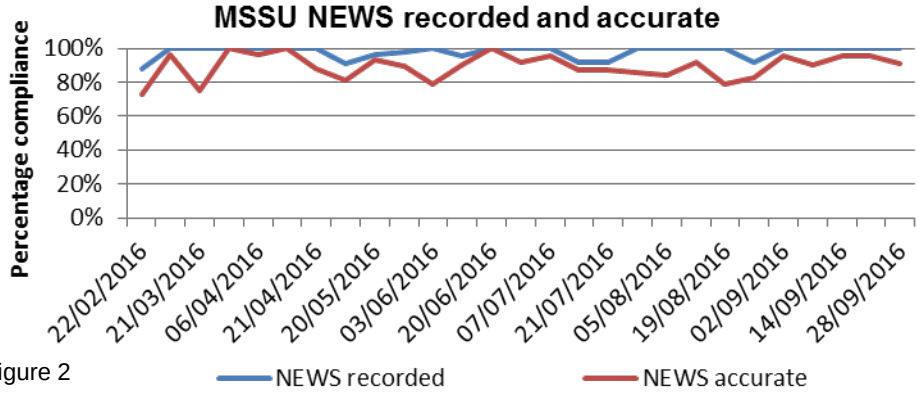


Figure 2

Patient Safety - National Early Warning Score (NEWS) work stream report

Tim Craft

Monthly audits continue to measure NEWS compliance and accuracy. Feedback of audit results via Senior Sister meetings for Medicine and Surgery and data submitted to dashboard (Tables 1 and 2)

Table of Current Performance of NEWS score recorded

The percentage score shown in Table 1 is the percentage of observations performed where a NEWS score is recorded.

It should be noted that compliance is consistently high for recording of NEWS with an average of 98% compliance for September.

Table of Current Performance of NEWS accuracy recorded

The percentage score shown in Table 2 is the percentage of observations performed where a NEWS score is accurate.

For September 12 areas are over 90% for NEWS accuracy.

NEWS recorded compliance	2016								
Ward	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
ACE OPU	100%	98%	100%	100%	100%	95%	100%	100%	100%
ASU	100%	98%	100%	94%	96%	96%	98%	100%	100%
Cardiac	94%	100%	96%	100%	98%	98%	94%	100%	92%
CCU	100%	87%	90%	97%	100%	93%	100%	88%	98%
Charlotte	90%	96%	100%	100%	100%	98%	94%	98%	96%
Cheselden	100%	100%	98%	98%	98%	98%	100%	100%	98%
Combe	100%	100%	100%	96%	96%	98%	100%	98%	94%
ED Obs	83%	100%	93%	92%	95%	97%	84%	96%	93%
Forrester Brown A	90%	100%	98%	91%	100%	100%	96%	96%	94%
Forrester Brown B	98%	94%	90%	100%	100%	100%	100%	96%	98%
Haygarth	98%	100%	96%	98%	100%	100%	98%	100%	96%
Helena	94%	98%	98%	100%	100%	100%	98%	98%	98%
MAU	96%	98%	100%	100%	100%	94%	96%	94%	100%
Midford	100%	100%	100%	98%	98%	100%	92%	100%	98%
MSSU	96%	96%	100%	100%	98%	97%	96%	100%	100%
Parry	96%	100%	98%	100%	100%	98%	100%	98%	100%
Philip Yeoman	98%	92%	98%	98%	92%	100%	98%	92%	91%
Pulteney (previously Waterhouse)	98%	90%	96%	94%	100%	96%	100%	100%	96%
Respiratory	100%	94%	100%	96%	98%	100%	98%	96%	100%
Robin Smith	96%	98%	98%	100%	94%	100%	100%	98%	98%
SAU	96%	100%	100%	98%	100%	100%	100%	100%	100%
SSSU	93%	98%	100%	94%	100%	96%	96%	86%	100%
Waterhouse (previously Pulteney)	94%	100%	100%	98%	96%	96%	98%	100%	98%
William Budd	94%	100%	96%	100%	98%	100%	92%	98%	98%
Violet Prince	94%	94%	94%	100%	94%	100%	100%	100%	100%
Grand Total	**96%**	**97%**	**98%**	**98%**	**98%**	**98%**	**97%**	**97%**	**98%**

Key: Adherence > 90% | Adherence 80% – 89% | Adherence < 80%

Table 1

NEWS accuracy	2016								
Ward	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
ACE OPU	90%	96%	94%	80%	98%	92%	92%	88%	94%
ASU	86%	98%	89%	89%	90%	88%	96%	82%	90%
Cardiac	81%	67%	76%	82%	88%	84%	89%	92%	89%
CCU	92%	80%	90%	93%	81%	75%	87%	83%	82%
Charlotte	77%	83%	81%	85%	92%	80%	77%	98%	83%
Cheselden	74%	90%	89%	91%	91%	88%	91%	96%	88%
Combe	83%	82%	76%	88%	71%	86%	93%	83%	79%
ED Obs	76%	95%	89%	89%	89%	77%	86%	83%	75%
Forrester Brown A	96%	90%	90%	71%	90%	91%	94%	74%	80%
Forrester Brown B	69%	84%	70%	85%	84%	87%	86%	94%	80%
Haygarth	96%	86%	88%	91%	88%	96%	92%	90%	96%
Helena	98%	94%	88%	88%	100%	93%	98%	96%	93%
MAU	78%	93%	90%	89%	81%	82%	89%	89%	94%
Midford	82%	80%	86%	100%	86%	93%	93%	87%	81%
MSSU	94%	85%	85%	82%	90%	94%	86%	88%	96%
Parry	90%	90%	80%	78%	85%	100%	98%	100%	88%
Philip Yeoman	91%	89%	98%	96%	81%	89%	92%	88%	93%
Pulteney (previously Waterhouse)	87%	78%	91%	82%	76%	79%	89%	84%	89%
Respiratory	83%	67%	86%	81%	77%	86%	91%	81%	96%
Robin Smith	89%	87%	80%	86%	91%	84%	86%	86%	90%
SAU	98%	98%	100%	92%	95%	96%	96%	98%	92%
SSSU	83%	88%	97%	86%	90%	93%	90%	88%	93%
Waterhouse (previously Pulteney)	89%	71%	83%	82%	85%	83%	84%	80%	78%
William Budd	80%	94%	87%	81%	67%	84%	80%	92%	94%
Violet Prince	94%	93%	100%	93%	91%	88%	83%	92%	86%
Grand Total	**86%**	**86%**	**87%**	**86%**	**86%**	**88%**	**90%**	**89%**	**88%**

Key: Adherence > 90% | Adherence 80% – 89% | Adherence < 80%

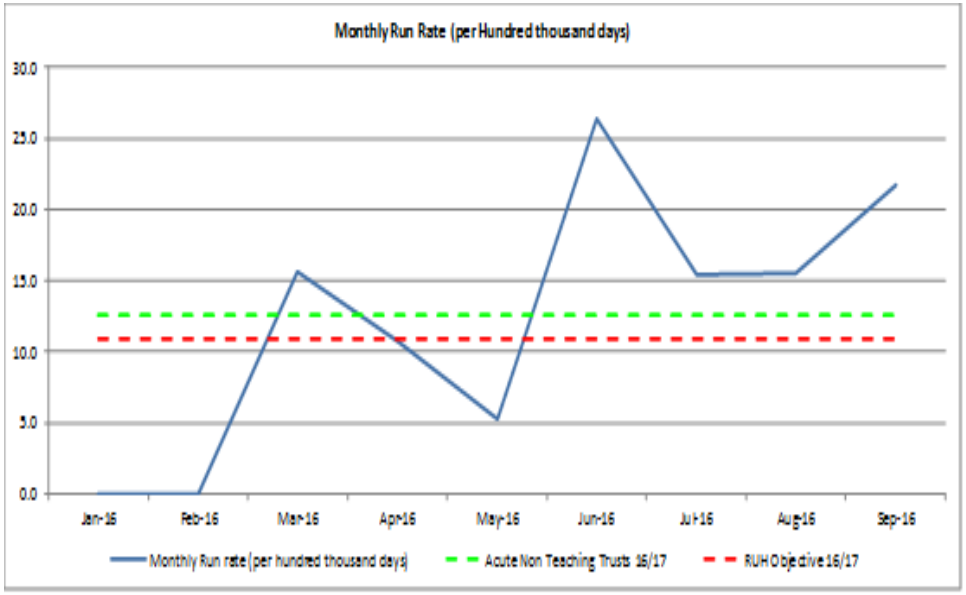
Table 2

Patient Safety - Clostridium difficile

Helen Blanchard

Background
The RUH target for 'Trust apportioned' *Clostridium difficile* in 2016/17 is 22 cases. *Clostridium difficile* toxin positive stool samples taken 3 or more days after admission are 'Trust apportioned'.

Current Performance



Analysis of cases April-September 2016
21 cases, 18 RCAs received

- 90% patients over 65 years of age
- Length of stay ranging from 4-82 days, average 23 days
- 10 cases where lapses of care have been identified these include:
  - Stool sampling delays in 4 cases
  - Stool charts not commenced from admission in 9 cases
  - Missing information on 4 stool charts
  - Delays in isolation in 4 cases
  - Dirty commodes at the time of the infection in 1 case
  - Concerns regarding antimicrobial stewardship in 1 case

Actions

- Infection Prevention and Control Team (IPCT) ran a 'C less C diff month' during September which included educational sessions and quizzes. This focused on timely stool sampling and documentation.
- C diff Collaborative launched during September with teams from 6 wards. Teams identified improvement strategies and will feedback on their projects in November 2016.
- 'Days between cases' graphs issued at the Collaborative; these will also be given to all other wards to display.
- Staff completing the C diff workbook: compliance is being reported to IPCT.
- New system for completing C diff RCAs has been launched to improve timeliness of completion and reporting of lessons learned.
- Disinfectant and sporicidal wipes will be launched across the Trust in October 2016 to improve the level of equipment cleaning. Training will be provided for staff.
- NHSi Infection Control Nurse invited to visit the Trust in November.

Serious Incident (SI) summary September 2016

Helen Blanchard

Current Performance

During September 2016 five Serious Incidents were reported and remain under investigation.

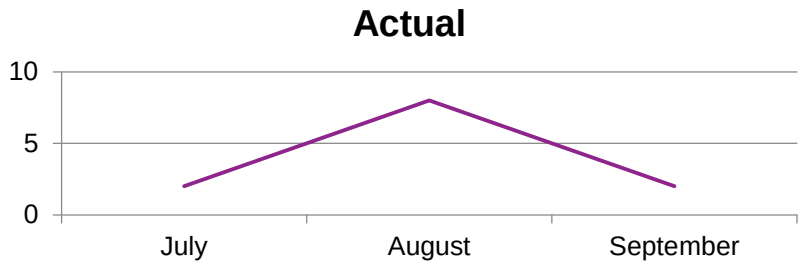
The incidents have been discussed with the patient and family. The family are aware of the investigations in line with the Duty of Candour framework.

Date of incident	Datix ID	Summary
02/09/2016	46098	Patient fall resulting in a fracture
04/09/2016	46122	Patient fall resulting in a fracture
05/09/2016	46133	Patient fall resulting in a fracture
15/09/2016	46435	MRSA bacteraemia diagnosed
19/09/2016	46520	Complications during surgery

Overdue Serious Incident reports summary September 2016

Helen Blanchard

Trajectory	July	August	September
Actual	2	8	1
Target	0	0	0



The drive to reduce the number of overdue SI reports will continue this year, working to a target of zero overdue reports.

As of 6 October 2016, there are 15 open Serious Incidents. Of these, 2 incidents (one with an authorised extension of time) are overdue for submission to the Clinical Commissioning Group but have been completed in draft and will be submitted to the October Operational Governance Committee. Any delay in providing a final report is escalated to the relevant Divisional Management team, for them to identify what further support can be provided to the investigator to assist them in completing the report.

The Operational Governance Committee monitors the progress against the action plans developed following the investigation; at the September OGC meeting the status was:

	July	August	September
Outstanding action plans	9	10	11
Outstanding actions	23	14	14

Nursing Quality Indicators - Exception Report (September data) Helen Blanchard

Areas of focus

The Nursing Quality Indicators chart is attached as Appendix A.
Five wards flagged this month as having nursing quality indicators of note (below). Two of these wards also flagged last month

Forrester Brown Ward A

Forrester Brown Unit flagged last month, however the unit reverted to 2 wards during mid August for a trial period with the aim that it will facilitate improvements with staffing and patient care as the wards become more manageable and each led by a Senior Sister. Unfortunately not all the individual ward data can be separated at this time e.g. appraisals and sickness and this needs to be noted when reviewing their matrices
The RN fill rates both day and night were <90% due to vacancies and sickness
Quality matrices to note are:

- HCA sickness 10.1%, RN sickness 6.8% (for both wards) slightly improved from last month
- RN Appraisal rate 75.7% (for both wards) slightly improved from last month
- 1 patient acquired C.Diff

The Matron is closely supporting the ward and proactively managing recruitment and staff sickness. A recruitment event was held in September with a disappointing response and 1 possible appointment. The Matron is considering different options regarding advertising e.g. social media.

Parry Ward

This ward has flagged for the second subsequent month.
The RN fill rate during the night shift was 74.4% overall, mainly due to RN vacancies which includes maternity leave. To cover the ward the HCA fill rate was over planned at 130% to ensure that staffing numbers were sufficient.

Parry Ward cont:

Quality matrices to note are:

- FFT response rate 31%
- 6 falls (5 negligible harm ,1 minor harm) (1 patient fell twice)
- HCA sickness 7.0%
- RN Appraisal rate 78.6% (3 RN's on maternity leave)

RNs have been recruited and will start in post over the next few months.
The Head of Nursing is currently reviewing this ward with the interim Matron to provide the support required

Robin Smith Ward

This is the first time this ward has flagged. The staffing levels during the day shift are <90% for both HCA and RNs and this is due to sickness and vacancies
Quality matrices to note are:

- FFT response rate 31%
- 5 falls (3 negligible harm 2 minor harm)
- RN sickness 5.2%
- RN Appraisal rate 78.9%

The Senior Sister has been on extended leave which is likely to have had an impact on the quality matrices. The Matron is closely supporting the Junior Sisters to put into place remedial actions to improve these matrices

Combe Ward

This ward last flagged in October 2015.
The staffing levels RN fill rate both day and night were <90% due to sickness, vacancies and staff being moved to other wards
Quality matrices to note are:

- 13 falls (11 negligible harm 2 minor harm) (3 patients fell 2/3 times)
- 20 Datix staffing reports
- RN sickness 9.8%
- RN Appraisal rate 80.0%

Nursing Quality Indicators - Exception Report (September data) Helen Blanchard

Other areas of focus:

Combe Ward cont:
Staff sickness and pressures on the Charge Nurse to work clinically have impacted on the staff quality matrices. A review of staffing Datix reports is currently underway by the matron to determine themes. The Quality Improvement (QI) Falls lead is working with this ward to trial future QI initiatives. The Matron is supporting the Senior Sister to manage sickness

Surgical Admissions Ward
This is the first time that this ward has flagged.
The staffing levels fill rate for both RNs and HCAs during the day were <90% due to sickness, vacancies and staff being moved to other wards. The Supervisory Charge Nurse worked clinically during the day to cover as required
Quality matrices to note are:

- RN sickness 5.0%
- HCA sickness 12.1%
- RN Appraisal rate 68.0%
- HCA appraisal rate 56.3%

Staff sickness and pressures on the Charge Nurse to work clinically have impacted on the staff quality matrices and the Matron is supporting the Senior Sister to address these matrices for future months and to recover the appraisal rate urgently.

To note:
The Acute Stroke Unit flagged for the previous 3 months although demonstrated signs of improvement each month. This month their quality matrices have improved again such that they do not flag this month.

Other areas of note:

Clostridium Difficile (C.Diff)
This month there were 4 cases of C.Diff (4 cases last month). The incidence of C.Diff continues to be a challenge and is being closely monitored by the Director of Nursing and Midwifery as the Trust's Director of Infection Prevention and Control (DIPC)

C.Difficile review (April – June 2016) 3 patients with C. Diff. who died. All these cases have been reviewed in detail and discussed at Sept IPCC meeting. The review identified that all 3 patients were very frail and elderly and had a history of being prescribed antibiotics for infections (community and Hospital). Delayed stool sampling and poor stool chart records were noted.
Actions and measures being taken

- Introduction of Sporicidal and Disinfection wipes to improve decontamination - Business Case approved for a 6 month trial period (commencing October 2016).
- A Quality Improvement Collaborative event Sept/Oct 2016.
- Importance of stool sampling discussed at Professional Nursing Forum.
- A collaborative event specific for medical staff.

Falls
The number of falls this month (117 falls) are similar to last month (118) and the number of patients who suffered multiple falls or major harms are also similar to last month.
Actions and measures being taken

- Every patient who has a serious Fall (moderate or major harm) has a root cause analysis (RCA) investigation undertaken
- The Falls group work plan 2016/17 has identified priority areas for improvement e.g. innovation, Medications, Training and Audit.
- A Quality Improvement workshop has taken place during September 2016.
- Learning is being drawn from other Trusts who are members of NHS Quest network.

Nursing Quality Indicators - Monthly Template

APPENDIX A

Ward Group	Ward Name	Report for September 2016 by ward/area triangulating FFT Percent Recommending; PALS; Complaints; Cdiff; Falls; Pressure Ulcers; HR, Staffing																				
		FFT % Recommending	FFT Response Rate %	Number of complaints received	Number of PALS contacts		Number of patients with CDiff	Number of patients who fell				Number of pressure ulcers			Human Resources				Nurse Staffing Datix Reports	Safer Staffing % Fill rate				
															Sickness %		Appraisal %			Day		Night		
					Positive	Negative		Negligible harm	Minor harm	Moderate harm	Major harm	Cat: 2	Cat: 3	Cat: 4	RN/RM	HCA	RN/RM	HCA		Registered Nurses/ Midwives	Care Staff	Registered Nurses/ Midwives	Care Staff	No:
Emergency Department	A&E	98	17%			4									4.5	3.7	92.8	88.9		N/A	N/A	N/A	N/A	0
	MAU	96	21%					9	1	1					1.3	7.3	94.9	87.5		83.1%	97.9%	90.4%	101.1%	1
	SAU	98	17%		1	2		2	2						5.0	12.1	68.0	56.3		87.1%	88.1%	93.6%	128.8%	6
Inpatient Wards	Cheselden	100	59%					3	2		1				0.5	3.1	87.5	88.9	1	97.8%	142.0%	99.9%	100.0%	1
	Surgical Short Stay Unit	97	47%			1		1							7.2	3.5	85.0	88.9		93.5%	132.4%	99.3%	203.2%	1
	ACE OPU	84	75%					7	1						2.3	4.2	91.3	82.4	1	78.9%	90.5%	102.2%	94.1%	2
	Charlotte	95	35%					1							0.4	24.1	86.7	70.0		102.7%	91.2%	103.3%	100.0%	2
	Helena	91	55%			1		1	1						2.6	4.7	93.8	100.0		78.9%	131.3%	68.5%	160.0%	2
	Pulteney	95	41%	1					1						1.4	1.0	82.6	90.5	1	87.0%	98.7%	107.4%	93.3%	2
	Violet Prince (RNHRD)	91	35%					5	1						0.0	1.2	86.7	75.0		98.6%	90.4%	96.6%	93.3%	2
	Cardiac	98	43%	1				5	3						1.4	2.2	85.0	90.0	1	82.2%	105.6%	79.1%	156.5%	3
	CCU	100	48%			1									0.7	0.0	78.9	100.0		88.3%	86.6%	101.7%	96.5%	3
	Mary Ward*	99	72%												5.5	10.7	82.8	86.7	2	100.9%	83.2%	92.8%	103.4%	3
	Medical Short Stay Unit	95	49%			1		1							4.1	30.4	100.0	85.7	1	79.4%	84.4%	96.5%	103.3%	3
	Midford	94	38%					2							2.1	1.9	91.7	80.0		76.5%	107.6%	80.8%	108.5%	3
	Phillip Yeoman	99	49%					1							12.2	2.7	93.8	78.6	1	93.8%	66.8%	97.6%	104.8%	3
	Children	99	24%			1									0.6	2.1	82.1	72.7	3	76.1%	149.6%	90.4%	51.7%	4
	Haygarth	96	62%		1	1	1	6			1				4.4	13.1	93.8	91.7		92.8%	81.2%	96.6%	100.0%	4
	William Budd	100	37%			2	1	5	2						0.5	0.0	89.5	85.7	1	92.5%	106.4%	88.6%	106.7%	4
	Acute Stroke Unit	100	47%			3		3	3						3.3	5.1	88.2	92.9	2	88.6%	75.0%	97.8%	98.6%	5
	ITU	N/A	N/A				1								4.4	18.3	93.5	66.7		96.2%	65.5%	94.1%	20.0%	5
	NICU	100	80%												5.4	3.4	74.4	91.7		63.5%	89.3%	103.2%	80.0%	5
	Respiratory	90	44%	1				5							3.1	8.5	84.2	70.6	4	77.8%	120.0%	84.5%	106.7%	5
	Waterhouse	100	13%			4		10							0.0	0.4	100.0	100.0		76.8%	98.5%	66.5%	104.4%	5
	Forrester Brown B	93*	47%*			3*		2							6.8*	10.1*	75.7*	96.3*	1	86.3%	106.0%	89.3%	145.0%	5
	Combe	100	93%					11	2						9.8	0.5	80.0	92.9	20	75.2%	104.2%	81.7%	148.3%	6
	Parry	96	31%			3		5	1						0.0	7.0	78.6	100.0	2	94.8%	87.3%	74.4%	130.0%	7
	Robin Smith	96	32%			3		3	2						5.2	2.5	78.9	92.9	2	87.9%	80.9%	98.7%	96.7%	7
	Forrester Brown A	93*	47%*			3*	1	1	1						6.8*	10.1*	75.7*	96.3*	1	82.8%	86.6%	84.0%	68.9%	8
* FFT data taken from Maternity FFT touchpoint 2 - Postnatal Ward		80% or less	< 35% (< 15% ED, MAU & SAU)	Nursing / Midwifery related		N/M related	C. Diff (per patient)	5 Falls or more or major harms				HA PUs			5% or more		80% or less		5 or more	< 90%				More than 5

*** Forrester Brown Ward (A&B) merged data unable to be split**

Template updated Sept 2016 V.2