Report to:	**Public Board of Directors**	**Agenda item:**	**7**
Date of Meeting:	**22 February 2017**		

Title of Report:	**Quality Report**
Status:	**For discussion**
Board Sponsor:	**Helen Blanchard, Director of Nursing and Midwifery** **Tim Craft, Medical Director**
Author:	**Lisa Cheek Deputy Director of Nursing and Midwifery**
Appendices	**Appendix A - Nursing Quality Indicators Chart**

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 January 2017 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: Executive 10
  - Anti-Coagulation
  - Missed Doses
  - Falls
  - Pressure Ulcers
- Exception reports:
  - Serious Incidents (SI) monthly summary
  - Overdue Serious Incident Reports 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.)

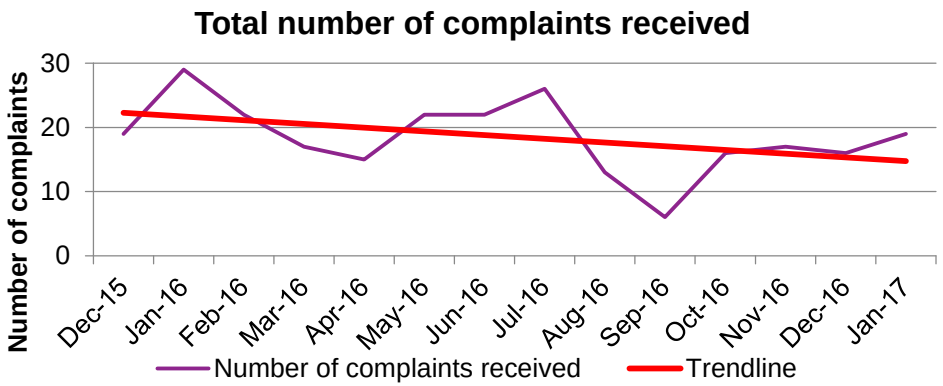
A failure to demonstrate sustained quality improvement could risk the Trust's registration with the Care Quality Commission (CQC) and the reputation of the Trust.

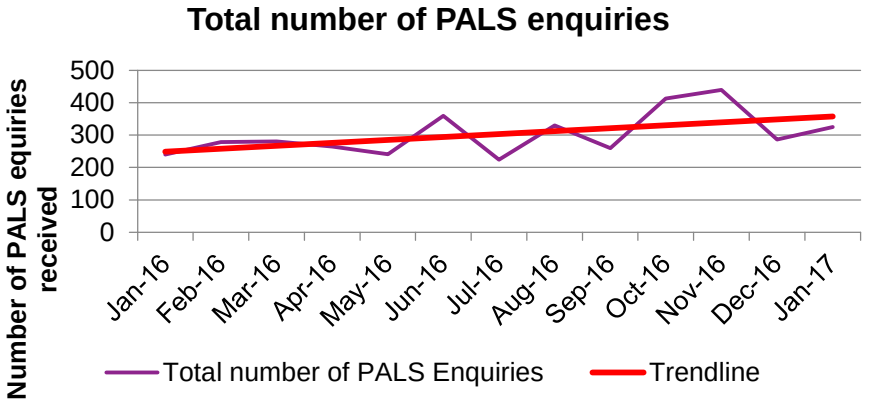
5.	Resources Implications (Financial / staffing)
Delivery of the priorities is dependent on the continuation of the agreed resources for each project.	
6.	**Equality and Diversity**
Ensures compliance with the Equality Delivery System (EDS).	
7.	**References to previous reports**
Monthly Quality Reports 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





There were **19 formal complaints** in January 2017:

- 8 complaints were for the Medical Division
- 7 complaints were for the Surgical Division
- 3 complaints were for the Women's & Children's Division
- 1 complaint was for Estates and Facilities

Clinical Care and Concerns– 12 complaints raised were with regards to clinical care and concerns. 5 for the Medical and Surgical Divisions, with 2 relating to the Women & Children's Division.

Communication and Information– 3 complaints raised were with regards to communication and information. 2 were for the Medical Division and 1 for the Women & Children's Division.

Staff Attitude and Behaviour – 2 complaints raised were with regards to staff attitude and behaviour, related to the Medical Division.

Appointments – 1 complaint raised related to appointments, had concerns surrounding the cancelation of the patient's procedure and delay in waiting times.

Premises/Environment/Parking – 1 complaint raised related to car parking, multiple parking fine notices received were appealed with ParkingEye but had been rejected.

There were **325 contacts with the PALS** service in January 2017:

- 129 required resolution (40%)
- 160 requested information or advice (50%)
- 18 were compliments (5%)
- 18 provided feedback (5%)

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

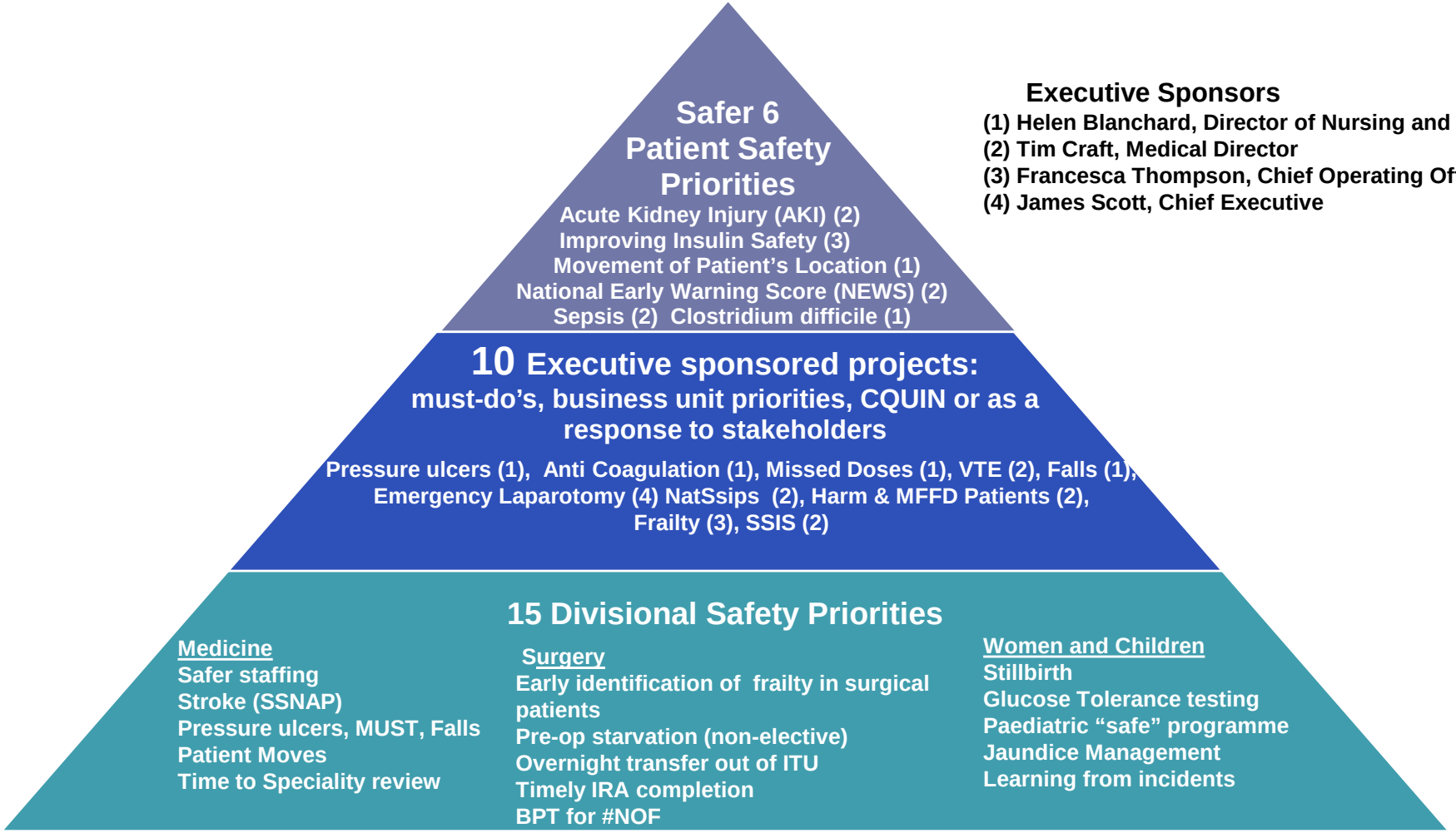
Communication and Information: there were 44 contacts with requests for communication and information regarding services provided by the Trust. There are no trends or themes in relation to these contacts.

Premises/Environment/Parking- 37 contacts related to premises/environment/parking. 33 of those related to car parking concerns – mainly client's receiving car parking notices and enquiries about registering their blue badge and 4 contacts related to maintenance and premises concerns.

Appointments – 22 clients contacted the service regarding appointment information and waiting times.

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 – Executive 10 – Anticoagulation

Helen Blanchard

Background

There are two workstreams looking at improving anticoagulation safety as part of the NHS Quest project :

The aim of Workstream A is to

- Have the correct anti-coagulation treatment in new admissions to RUH prescribed and administered at the correct time within 24 hours of admission by July 2017.

The aim of Workstream B is to

- Have 85% outpatients on warfarin within therapeutic range for more than 65% of the time. The patient group will have been on warfarin for more than 6 weeks under the outreach warfarin service.

Progress Workstream A

The revised tool was used to collect data on MAU on two separate days in December. Of the 19 patients reviewed, the doses and choice of medication prescribed were appropriate. The issues that require improvement are the documentation of indications and whether counselling had taken place.

On review it emerged that the data collection is complex, requires a high level of expertise and appears to be occurring too early in the pathway to get meaningful data .

The new anti-coagulant project pharmacist has been appointed.

Workstream B

Interventions

New protocols and guidelines for patients with INR greater than 8 have been written and shared with GPs. In addition a PGD for the supply of vitamin K for patients in the community setting is in place.

The specialist nurses from the RUH will administer this in the community, preventing any unnecessary admissions.

Workstream B continued

The team within Pathology run the warfarin anti-coagulation clinics for a number of patients in GP practices using a computerised program called DAWN.

The team at the RUH do not always know if a patient has been prescribed other medications that would interact with the warfarin, therefore they have now been trained how to access the GP medication records.

They will review patients more closely taking into account any interacting medicines and advise dose adjustments accordingly.

Next Steps Workstream A / B

A Trust wide snapshot audit will take place on the last Friday in February to get a broader view of prescribing issues and provide insight into the required interventions.

Once the new anti-coagulant pharmacist starts, all in-patients coming into ambulatory care prescribed new anticoagulants will be referred to the pharmacist who will collect data in real time.

The anti-coagulant pharmacist will also be tasked with prioritising improvement in counselling. Reported DATIX incidents continue to be reviewed.

Data on the use of Beriplex (to stop bleeding) will continue to be collected.

The driver diagram for both projects will be reviewed.

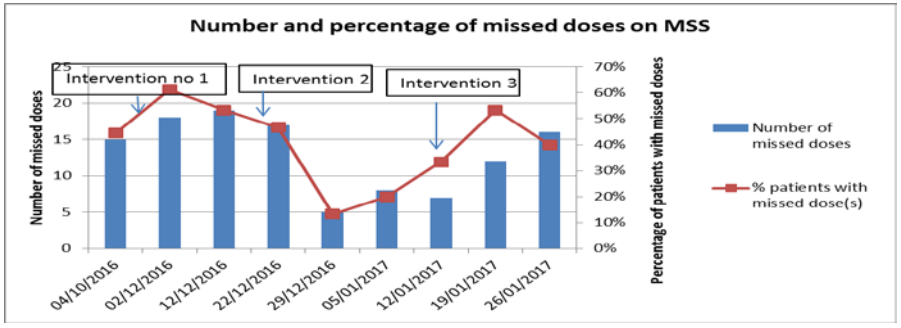
Patient Safety – Executive 10 – Missed Doses

Helen Blanchard

Background

A missed dose is defined as any dose of medication that is not given within 2 hours of the time indicated on the Medicine Administration Record (MAR). Whilst only a small percentage of missed doses may be classed as significant, it is important to recognise the significance and potential for harm. The overall aim of the project is to reduce the total number of missed by 50% by April 2017. The test ward for interventions has been MSS, with baseline data collected from five other wards.

Measures have been collected weekly on 15 MAR's on MSS for omissions codes 2 (patient refused), 4 (drug unavailable) and 10 (other); the total number of missed doses irrespective of omission code; the total number of prescribed medicines; and the name of the omitted medicines.

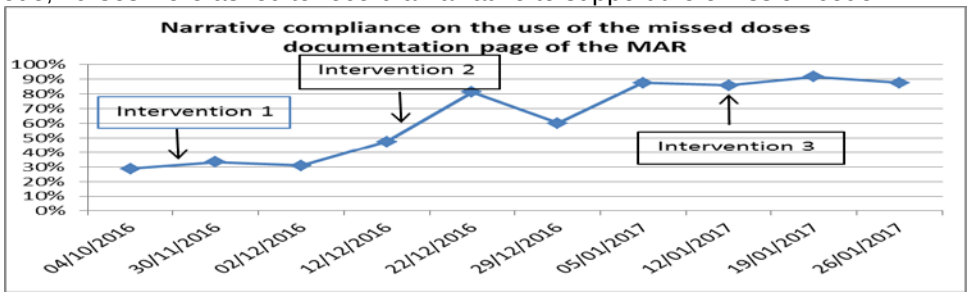


In addition, it was noted whether the omission code was listed on the documentation page of the MAR and if a narrative supported the omission code.

Within the scope, all medications that have been prescribed has been collected. Analysis shows that the most common omission code is 2, of which the most frequently missed medicine is Paracetamol. When Paracetamol is removed from the data collection, the most common omission code is 4. The next step is to review whether the scope of data collection is correct.

Intervention 1 (November 2016)

The education of staff in the use of the documentation page of the MAR so that it forms a communication tool between healthcare professionals. In addition to the omission code, nurses were asked to record a narrative to support the omission code.



This was communicated to ward staff via the safety brief, and posters distributed to the ward. The results were fed back to the ward weekly.

Intervention 2 (December 2016)

The medicines ward stock list has been reviewed and updated to ensure that all medicines required are available as part of the ward stock.

Intervention 3 (January 2017)

Targeted teaching sessions to ward nurses to explaining the importance of using the documentation page of the MAR, and to use this information to challenge whether medicines can be changed to 'as required' rather than regularly prescribed.

Additional wards data collection

Baseline data collection has been collected on Respiratory, Haygarth, Combe, Pulteney and Short Stay Surgery. The most common omission code was 2, with paracetamol being the most common omitted medication. There were no missed doses for omission code 4.

Next steps:

To review the scope of the medications included within the data collection and to identify an appropriate data collection method or tool to support the programme of spread to other wards within the next month.

Patient Safety – Executive 10 – Falls

Helen Blanchard

Background

Reduction in falls is one of the Trust's safety priorities.

Figure 1 shows the current performance of the total number of inpatient falls. Figure 2 shows the cumulative number of inpatient falls compared to 2015/16 with the 10% reduction trajectory

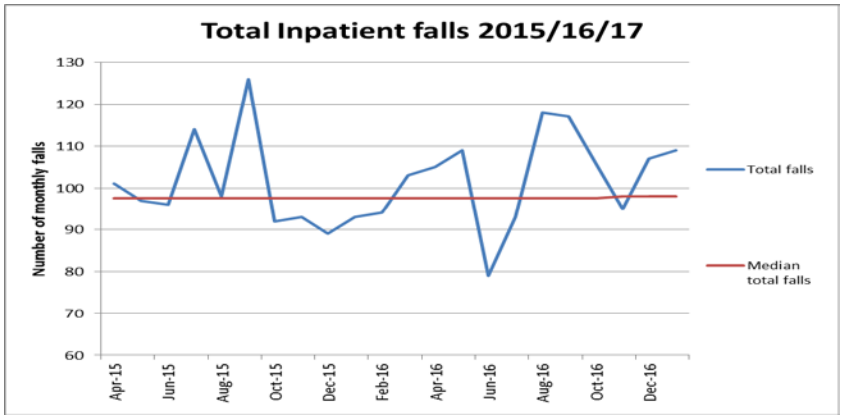


Figure 1

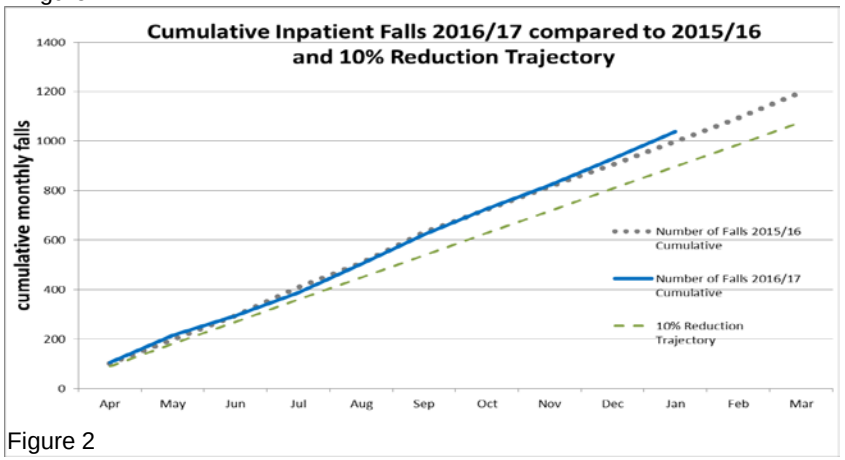


Figure 2

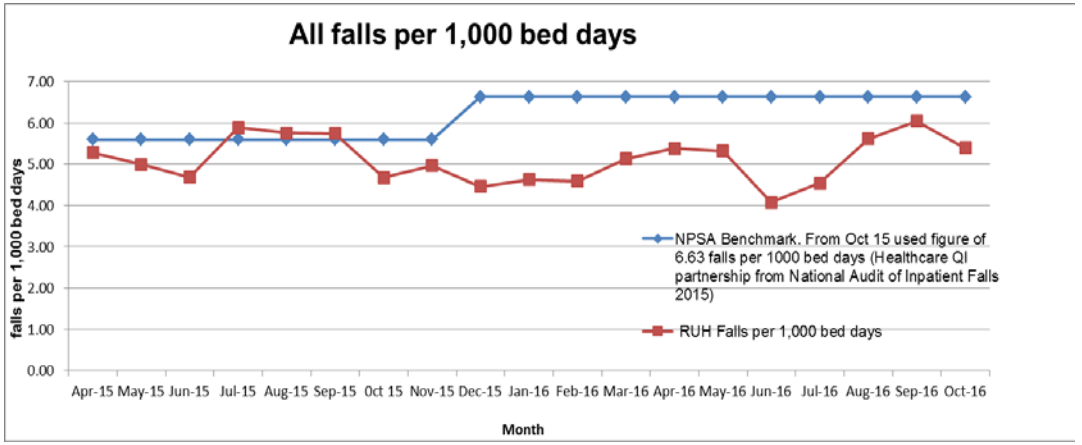


Figure 3

Figures 3 and 4 shows comparison with national data

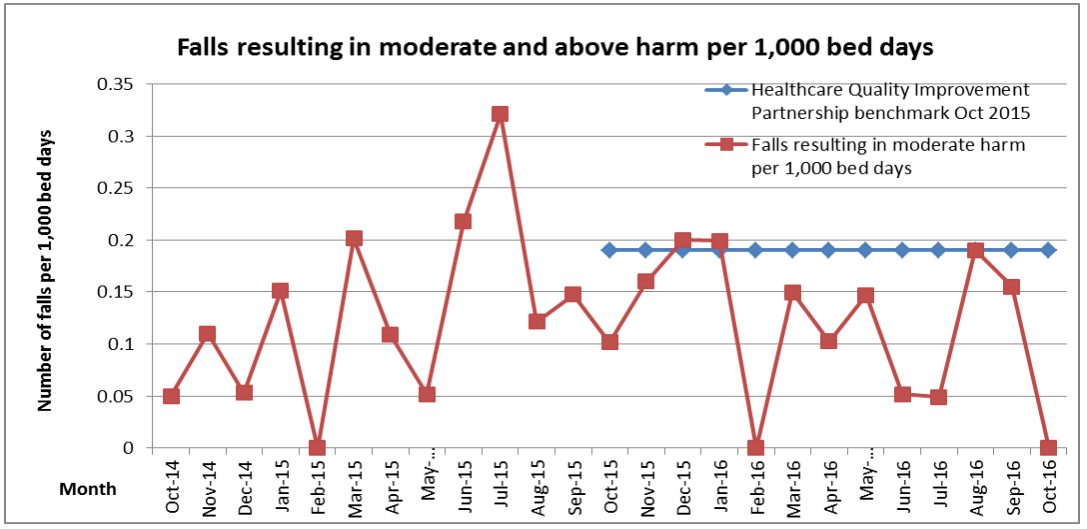


Figure 4

Patient Safety – Executive 10 – Falls

Helen Blanchard

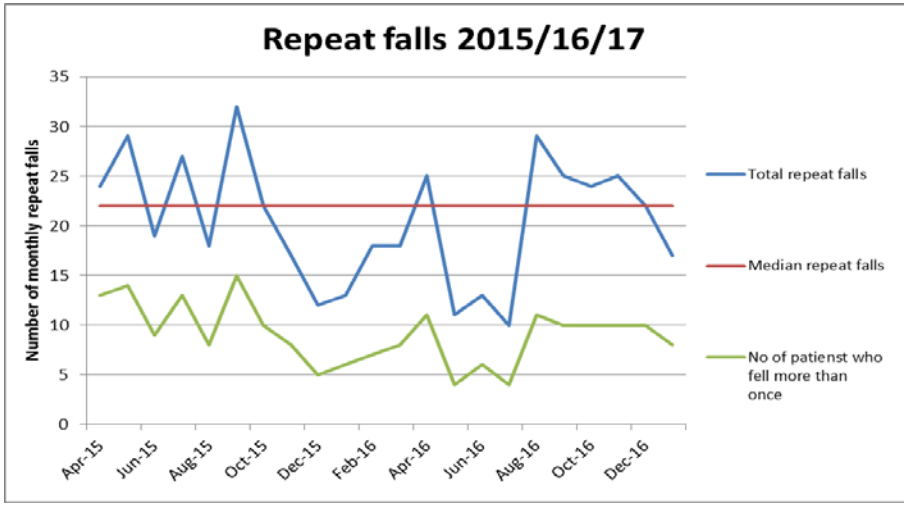


Figure 5

Figure 5 shows the number of repeat falls and the number of patients who have fallen more than once.

Workplan

The Falls work plan for 2016/17 is themed into 4 main areas:

1.0 Falls bundle and Interventions

The following interventions are being tested in a clinical area:

- SWARM – a rapid post falls review of each fall where all members of the MDT immediately review the fall, is being tested on ASU and Waterhouse. Initial feedback from staff is that the additional information collected on the SWARM form is useful when completing investigations. On Waterhouse, the SWARM form will be used for falls reported as Minor Harm and above.
- Enhanced care – an MDT approach to supervision of patients with safety risks including falls risk, ensuring that a member of staff has visibility at all times of patients within a bay. This was tested on Midford ward, to identify the times of the day when this could not be achieved. The most common reason this could not be achieved was due to staff assisting in other areas of the ward; and escorting patients to the toilet (no direct toilet access from the bay). The time of the day when it was most achievable was in the morning between 08:00 and 12:00.
- Bathroom environment improvements project on Haygarth to improve the visibility of the toilet and its surrounding aids through the replacement of white toilet seats and grab rails with contrasting blue ones as they need replacing.
- The investigation into the provision of a serious falls retrieval team to support wards particularly in the use of the falls retrieval kit, specialist equipment to raise the patient off the floor when a serious injury is suspected.
- The review of Morse as a risk prediction tool in light of NICE guidance which recommends a multifactorial assessment.

2.0 Medication factors

- A yellow sticker has been tested on ACE ward for all patients on the ward irrespective of their falls risk. The Medical lead has undertaken teaching sessions with junior doctors to emphasise the significance of the sticker. Robin Smith and SAU wards have had a baseline audit to establish what medication reviews are currently undertaken before introducing the sticker to these wards.

3.0 Training and Education

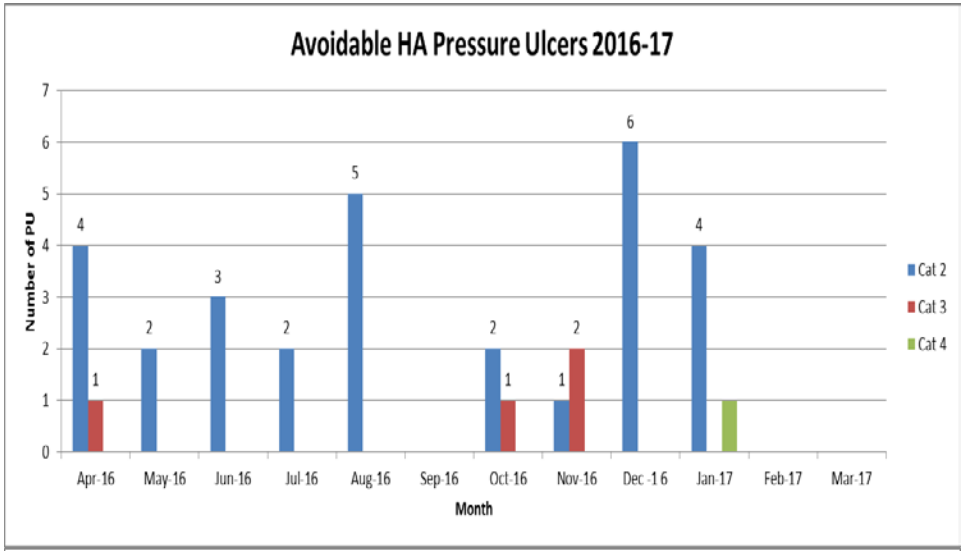
- Work is underway to develop a falls training package for all staff

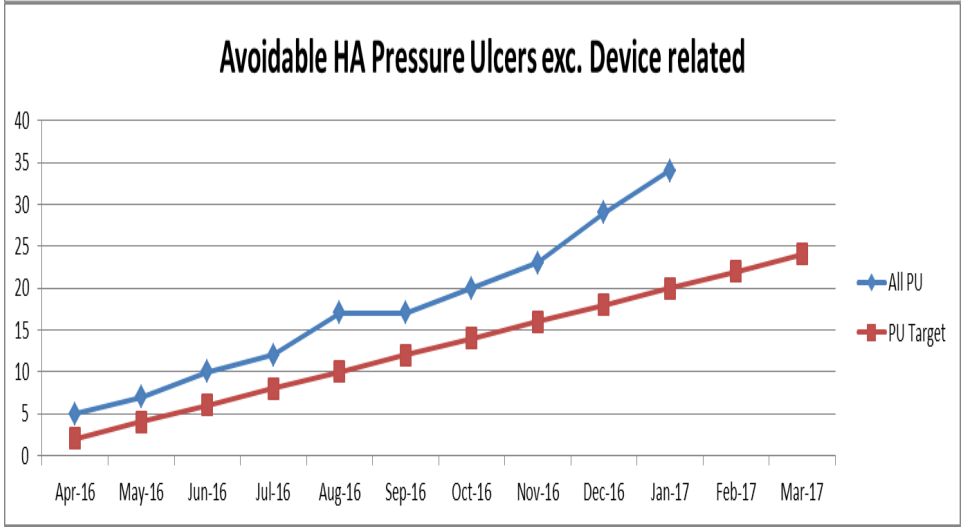
4.0 Audit and Assurance

- The Clinical Audit team have developed an audit tool to measure compliance with the falls bundle.

Patient Safety – Executive 10 – Pressure Ulcers

Helen Blanchard





Category 2 Pressure Ulcers performance October 2016 – January 2017

- The Trust at 14 Pressure Ulcers is over the internally set improvement trajectory which aimed for less than 2 category 2 avoidable pressure ulcers per month.
- October reported two category 2 pressure ulcers
- November reported one category 2 pressure ulcer and two device related pressure ulcers
- December reported six category 2 pressure ulcers
- January reported four category 2 pressure ulcers

Category 3 & 4 Pressure Ulcers performance

- October reported one category 3 pressure ulcer
- November reported two category 3 pressure ulcers
- January reported the first category 4 pressure ulcer in 4 years.

Key issues identified:

The Pressure Ulcer prevention pathway was not followed.

Next Steps:

An extraordinary meeting was held with the Director of Nursing to identify immediate actions for improvement:

- Heads of Nursing are to explore a central store for Repose foot protectors and storage of pre-inflated air mattresses on beds ready for immediate use.
- Heads of Nursing to monitor and improve the number of staff completing the mandatory e-learning package to 90% by 1st March 2017.
- The Heads of Nursing are reviewing the accountability process.
- TVN following pressure damage on the wards targeted training focusing on the Pressure Ulcer prevention pathway
- Prevention training initiated for student nurses on induction to the Trust
- Band 4 assistant practitioners additional training in the pathway, with an emphasis on accurate skin assessment
- All patients who are high risk or with existing pressure damage are to be highlighted at all safety briefings
- Package designed for Link Nurses to deliver SKIN bundle training to all staff, launch February 2017

Serious Incident (SI) Summary

Helen Blanchard

Current Performance

During January 2017, six Serious Incidents were reported and these remain under investigation.

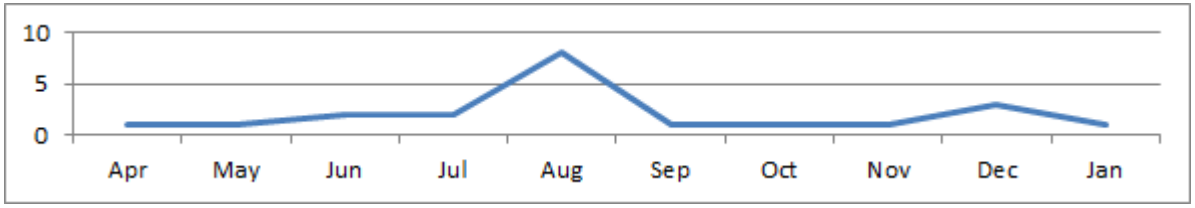
Each incident was discussed with the patient and their family and they are aware of the investigation, in line with the Duty of Candour framework.

Date of incident	Datix ID	Summary
01.01.17	**49676**	Patient fall resulting in a subdural hematoma
06.01.17	**49727**	Patient fall resulting in a fracture
10.01.17	**49810**	Patient fall resulting in a fracture
11.01.17	**49868**	Category 3 hospital acquired pressure ulcer
11.01.17	**49890**	An infection recorded as the primary cause of death.
26.01.17	**50279**	Fall resulting in a fracture

Overdue Serious Incident reports summary

Helen Blanchard

Current Performance



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

As of 03 February 2017, there are 17 Serious Incidents that remain open. Of these, one incident report is overdue for submission to the Clinical Commissioning Group by the agreed extension date. The investigation has been completed for a further five of the 17 incidents and these investigation reports are in draft. 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 enable them to completing the investigation and draft the report.

The Operational Governance Committee monitors the progress against the action plans developed following the investigation and at the January OGC meeting, the status was:

	April	May	June	July	August	September	October	November	December	January
Outstanding action plans	11	8	5	9	10	11	15	10	14	14
Outstanding actions	20	10	18	23	14	14	18	18	26	23

Nursing Quality Indicators - Exception Report

Helen Blanchard

Areas of focus

The Nursing Quality Indicators chart is attached as Appendix A.
Three wards flagged this month as having nursing quality indicators of note (below). Two of these wards, Haygarth and Respiratory, flagged for the last three months.

Haygarth Ward

Haygarth ward has flagged for the last 3 consecutive months.
The RN staffing levels (day and night) are < 90% fill rate due to HCA sickness, vacancies and maternity.

Quality matrices to note are:

- 1 complaint
- 4 falls (2 negligible harm, 1 minor harm, 1 major harm)
- 2 category 2 pressure ulcers
- 1 category 4 pressure ulcer
- HCA sickness 5.7%
- RN appraisal 66.7%
- RN % day fill rate <90%
- RN % night fill rate <90%

Due to concerns over a number of harm events and the ward flagging on the nursing quality indicators chart a review of the ward by a Nursing Intensive Support Team has been undertaken in December and the report is due for completion this month.

Staff sickness is high due to HCA short term sickness which is being proactively managed by senior nursing team.

Vacancies are being proactively managed. Senior Sister actively participated in Open Day. Mitigation to improve nursing fill rate complemented by HCAs.

Haygarth Ward continued:

Investigations into the pressure ulcers have been commissioned and are underway.
Nursing Intensive Support Team report and recommendations is due for completion this month . The improvement plan will be developed with the Senior Sister and Matron. This will be monitored by the Divisional Head of Nursing.

Respiratory Ward

This ward has flagged for the last 4 consecutive months and the Head of Nursing and matron are supporting the improvement and management programme.
Management plan commenced week beginning 9.1.17. Performance objectives set with specific reference to quality indicator(i.e. appraisal rate. FFT compliance).

Quality matrices to note are:

- FFT < 30%
- 1 negative PALS complaint
- 1 fall (negligible harm)
- RN sickness 13.7%
- HCA sickness 10.6%
- RN appraisals 78.9%
- HCA appraisals 78.6%
- 1 Nurse staffing Datix report
- RN day staffing <90%
- RN night staffing < 90%

Nursing Quality Indicators - Exception Report

Helen Blanchard

Area of focus continued:

Respiratory continued
Staff sickness remains consistently high both short and long term. Plans to address this within the performance management plan and some focused work with the nursing team around areas of concern.

Recruitment actions being undertaken include attendance at all recruitment events.

Cardiac Ward
This ward has flagged due to the number of falls and pressure damage.
Quality matrices to note are:

- FFT < 3%
- 1 negative PALS complaint
- 8 falls (7 negligible harm, 1 minor harm)
- 2 category 2 pressure ulcers
- RN appraisals 75%
- HCA appraisals 66.7%
- RN day staffing <90%
- RN night staffing < 90%

Cardiac Ward is currently undergoing a change of leadership. Start date for new senior charge nurse is 8.3.2017.

Period of hand over commenced with matron support and the incoming leader is attending planning sessions to address concerns and formulate a plan with areas of focus including reducing harm events, appraisal and staff recruitment.

Cardiac Ward continued

Falls action plan to include a full month's focus on actions to reduce occurrence. This includes root cause analysis of reasons behind the falls in Jan and the possible reason for the high level.

Junior sister has taken the lead for tissue viability and pressure damage and a teaching and awareness programme is being rolled out with assistance of TVNs.

Overall quality indicator to note:
Pressure Ulcers
There were 6 hospital acquired category 2 pressure ulcers this month and 1 category 4 pressure ulcer which is of concern.

The Heads of Nursing have presented to the Trust Board in January 2017 an improvement plan to support improvement with managing pressure damage prevention and this includes:

- Nursing intensive support into areas
- Targeted intensive training for high risk wards
- Addressing the accessibility of equipment
- An accountability structure where lapses in care have been identified.