| | | | |
|---|---|---|---|
| **Report to:** | **Public Board of Directors** | **Agenda item:** | **7** |
| **Date of Meeting:** | **26 July 2017** | | |
| **Title of Report:** | **Quality Report** | | |
| **Status:** | **For discussion** | | |
| **Board Sponsor:** | **Helen Blanchard, Director of Nursing and Midwifery<br>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 June 2017 data.

The Quality Report this month includes a quarterly update on the improvement priorities as highlighted in the 2017/18 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 – 5 Executive Sponsored Projects
  - Sepsis
  - AKI
  - NEWS
  - Falls
  - C Diff

- Exception reports:
  - Serious Incidents (SI) monthly summary and Overdue SI Report 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.)

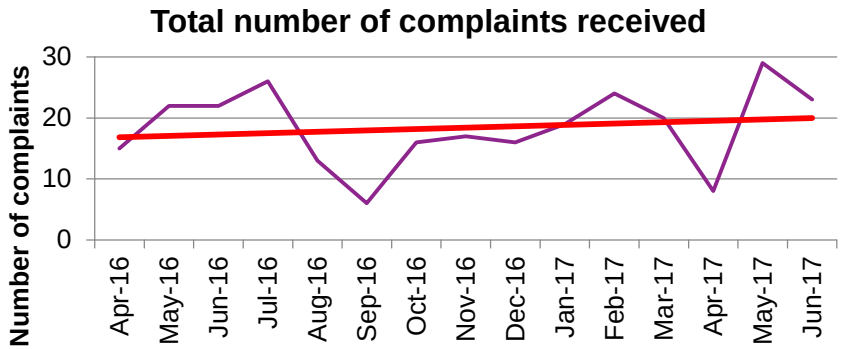
A failure to demonstrate sustained quality improvement could risk the Trust's registration with the Care Quality Commission (CQC) and the reputation of the Trust.

| 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

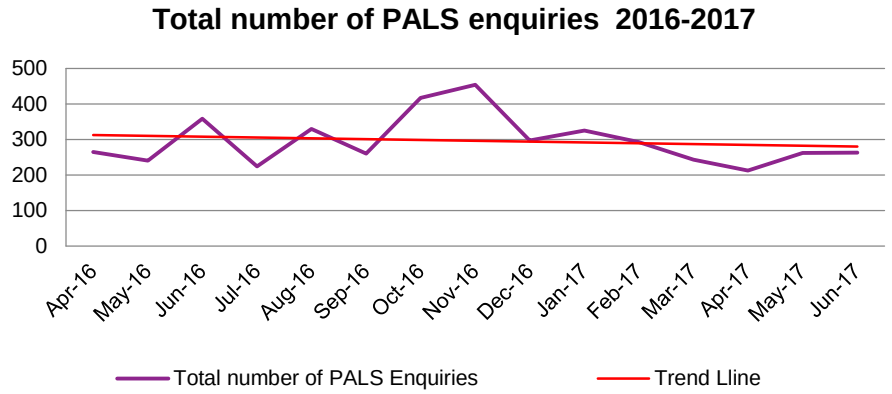
# Complaints and Patient Advice & Liaison (PALS) Report




There were **23 formal complaints** received in June. 10 were for Medicine Division; 10 for the Surgical Division and 3 for the Women and Children's Division.

- **Clinical care and concerns -** 22 of the complaints referred to clinical care and concerns. 10 (Surgery); 9 (Medicine); 3 (Women and Children).
- **Communication/information –** 1 complaint was related to communication and information in the Medicine Division.

| Complaint response rate | Division | | | Total |
|---|---|---|---|---|
| | Surgery | W&C | Medicine | |
| **Closed within 35 day target** | 2 (50%) | 2 (67%) | 13 (81%) | 17 (74%) |
| **Breached 35 Day target** | 2 (50%) | 1 (33%) | 3 (19%) | 6 (26%) |
| **Total** | 4 | 3 | 16 | 23 |




**PALS contacts** - **262** during May and **263** in June.

- 107 requested information or advice (41%)
- 132 required resolution (50%)
- 9 were compliments (3%)
- 15 provided feedback (6%)

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

**Clinical care and concerns – 16** contacts for resolution related to issues around clinical care and concerns. All **16** were general enquires spread fairly evenly across service areas.

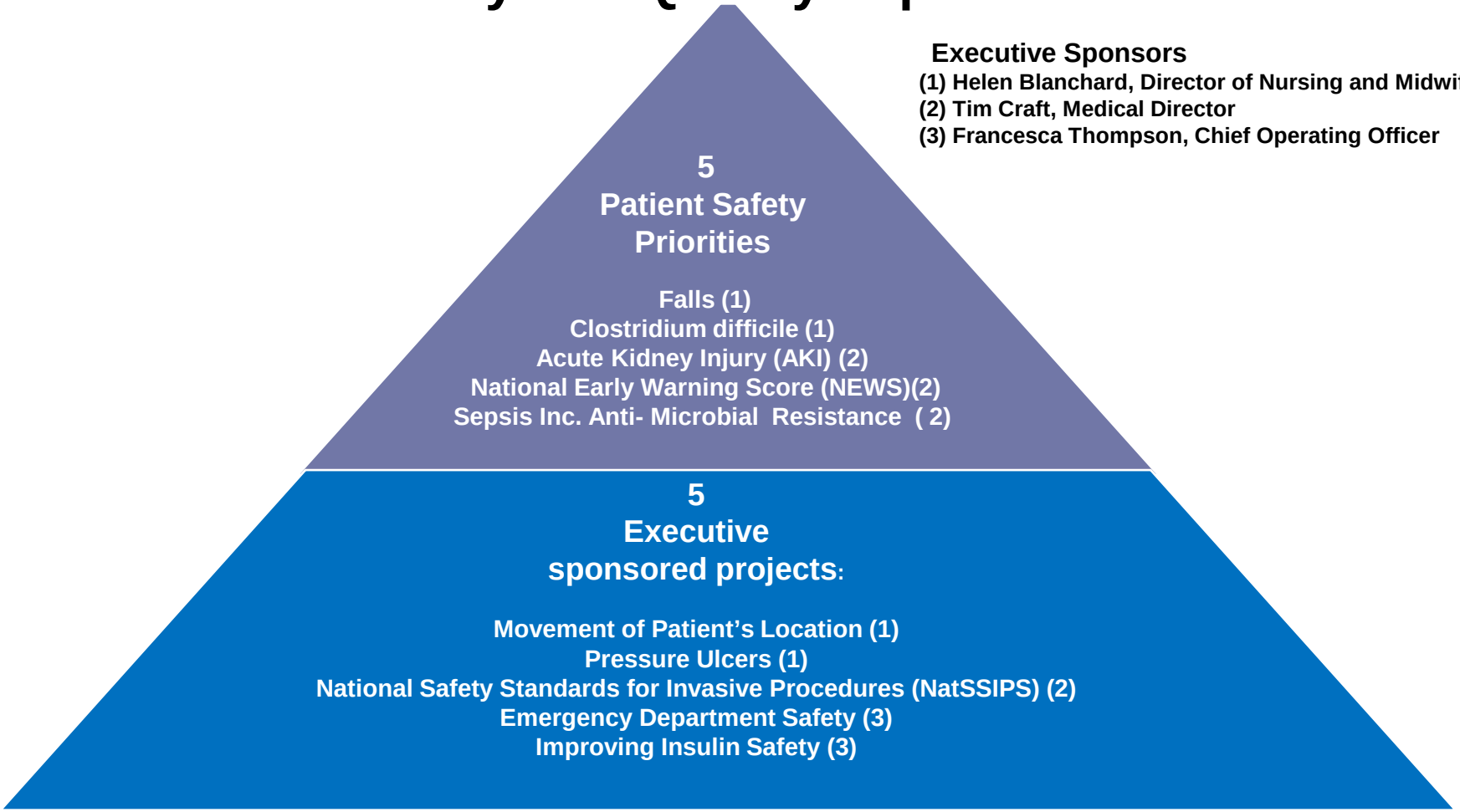
**Communication and information** – there were **39** contacts relating to communication and info, **30** required general information about a cross-section of services, **7** were in regards to poor or inappropriate information and **2** about overseas patients and funding.

**Appointments –** there were **29** enquiries in relation to appointments:- **16** required information on existing appointments, including changing. **2** related to surgery cancellations, **6** referred to the length of time for new appointments and **5** for follow-ups.

# 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**



# Patient Safety – Sepsis work stream report

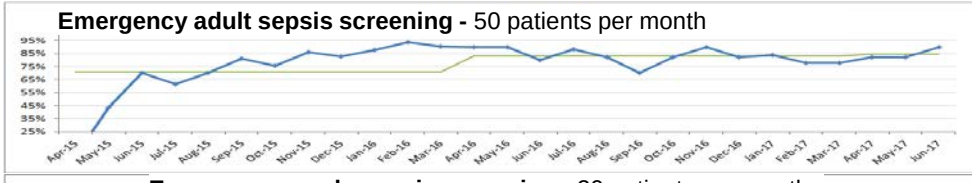
Tim Craft

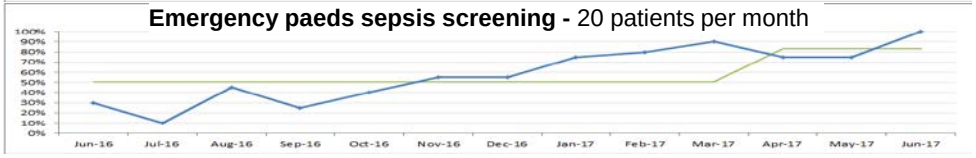
## New CQUIN for Sepsis

- The National CQUIN for 2017/18 and 2018/19 combines the previous Sepsis and Antimicrobial Stewardship CQUINs to encompass emergency admissions and inpatients, adults and paediatric and consists of 4 parts - screening, antibiotic treatment, antibiotic review and reduction in antibiotic consumption.
- Annual target for both Screening and Antibiotics at 90%. Antibiotics time starts from diagnosis, rather than onset of symptoms as previously used. The CQUIN data defined for antibiotic timings is now a small sample as opposed to previous 50% of our patients. Collecting compliance data as before to continue our improvement work so the figures may vary slightly from the CQUIN data.
- Q1 screening data currently 79% of all patients and overall 82% of patients received antibiotics in 60 minutes but final data to be confirmed. Although an improvement on Q4, neither screening or antibiotic expected to reach 90% target and so partial payment will be achieved.

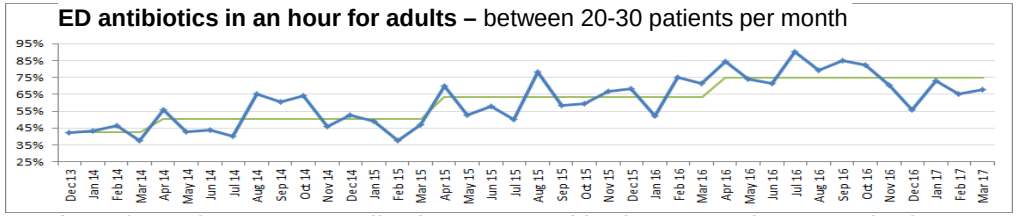
## Patient's directly admitted with Sepsis

- Average monthly adults screening for ED is 85% and was 90% in June
- Focus on improving recording of paediatric early warning scores in ED. Sepsis and paediatric sepsis screening has improved to 100% in June.



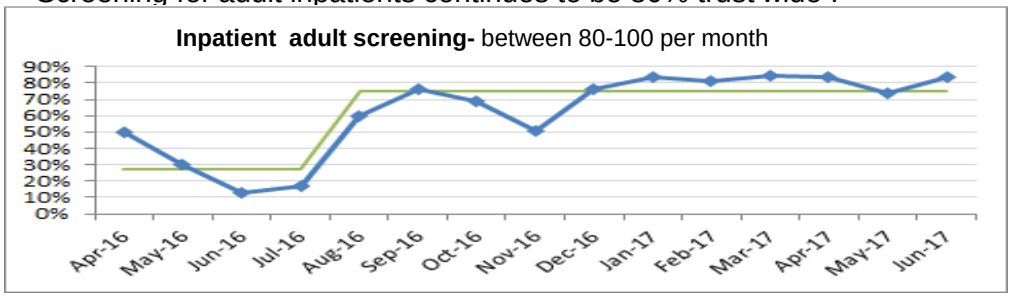

- ED antibiotic compliance within 60mins for adults from time of arrival is still being validated for Q1 but was 69% at Q4.



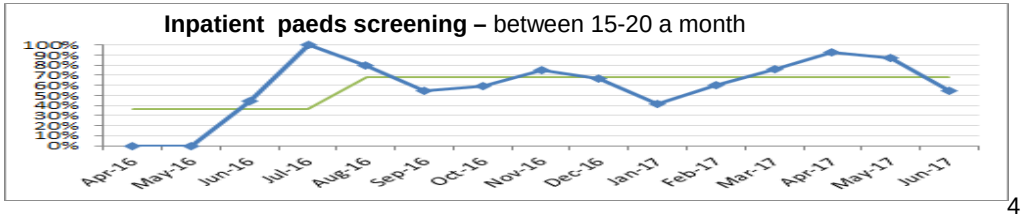

- There have been no paediatrics captured in the screening sample that met criteria for red flag sepsis in Q1. children admitted on PAU is awaited.

## Management of Inpatients with sepsis

- New observations charts with the sepsis screen incorporated were introduced Trust wide in April 2017.
- Screening for adult inpatients continues to be 80% trust wide .



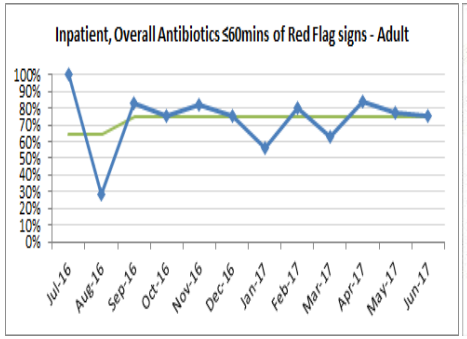

- Increased focus on inpatients paediatric sepsis screening and management saw improvement to 92% in Apr and 88% in May

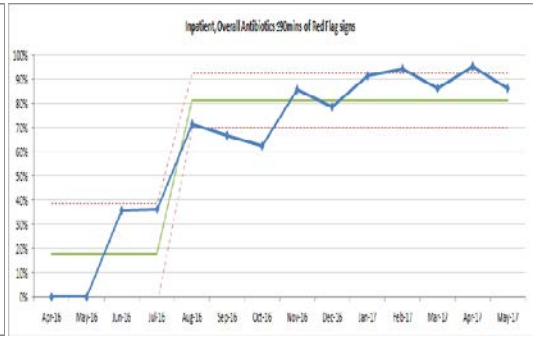


# Patient Safety Priorities – Sepsis

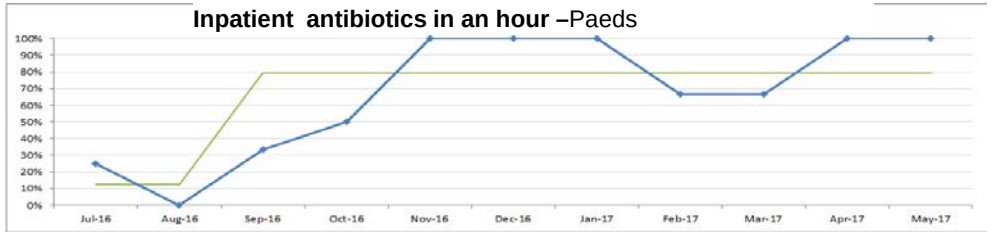
Tim Craft

- The data collection for inpatient screening compliance for both adults and children is very onerous and not sustainable . Over the last year significant improvement has been achieved to 80% but this is unlikely to improve further reliably without the implementation of electronic recording of vital signs. This will enable automatic screening when a patient triggers and will also enable easier identification of those with sepsis so antibiotics can be administered faster.
- Compliance with antibiotics within 60 minutes from time of signs in adult inpatients was 80% for April and May and awaiting final data for June. This is continuing improvement with 90% of adult inpatients receiving antibiotics in 90 minutes and June data is awaited.




- Paediatric antibiotic compliance has also improved and is 100% for Q1




## Awareness and training

- Sepsis Training continues across all wards, with one ward each month receiving focused training. The last few months Sepsis Nurse has focused on MAU. ED and Children's ward focus during July.
- Recruitment of a band 6 Sepsis Nurse to support training and spread trust wide has been advertised with planned interview in August
- Sepsis champions event in May 2017 well attended. 1400 staff trained trust wide since July 2016 and numbers are fed back to the divisions with the aim of achieving 90% by April 2018.
- Sepsis training now in weekly core skills and the resuscitation team have run several combined Sepsis/ AKI Utopia simulation sessions
- A team have been established to develop and deliver 'Deteriorating Patient training' , including Sepsis and AKI consisting of outreach, resuscitation, sepsis and AKI teams
- Patient information leaflets to be developed by the Sepsis Steering group.

## Next steps

- Develop deteriorating patient training, including an eLearning module
- Appoint Band 6 sepsis nurse to start in Autumn.

## Issues

- Establishing electronic recording of vital signs is required to achieve Sepsis CQUIN targets for the next 2 years.

# Patient Safety Priorities - Acute Kidney Injury (AKI)

Tim Craft

## Background

- AKI is a patient safety priority for 2017/2018

## Awareness and Training

- 1178 staff have been trained since November 2015. Roles shown on graphs and numbers reported to divisions with aim to increase percentages.
- AKI training is part of the weekly core skills. AKI sepsis Utopia simulation courses have been run and further sessions with resuscitation team are being developed.
- An e-learning package for ward staff is being developed regionally.
- Aim is to link AKI / sepsis champions in the future.
- Focus on areas with AKI incident to improve awareness.

## AKI Bundle compliance

- Due to vacant post in pathology data for April, May and June have been delayed. A new pathology lead is due to commence.
- Trust wide data on 20 patient per month, randomly selected shows sustained improvement since baseline data in July 2015.
- Compliance for AKI documentation, Fluid plan, U&Es and senior review have all reached over 90% for March.

## Discharge Summary Information

- Trust wide data from the same patients as above is collated monthly and shows improvement from baseline as shown in run charts, with each measure being 70-80% compliant
- To improve further the information needs to be a mandatory part of the discharge summary . Inclusion of the AKI alert into the discharge summary has been part of a wider discharge summary project, which has been completed. This was was due to go live in April 2017 but has been delayed due IT capacity issues.

## Improvement work

- Fluid balance and hydration work:
  - Amended Hydration chart launched in April 2017, well received and now embedded on the wards
  - An amended fluid balance chart is being tested
- The contrast sticker now reliably implemented meaning sticker placed in patient notes who had received IV contrast, leading to improved fluid management following contrast. Now being spread to cardiology
- Both were presented at the poster competition at the Bristol Patient Safety Conference in May 2017
- The implementation of e-prescribing will also support medication review for patients with an AKI

## AKI Incidences

- On average we have 206 patients with an AKI per month, 4.5% of total admissions. Reports on AKI per speciality and ward shared with the divisions.
- A 16% decrease in the incidence of inpatient acquired AKI has been demonstrated between June 2016 and March 2017. Median length of stay for all AKI patients between June and December 2016 also decreased by an average of 2.7 days/ month. New data is awaited to see continuation.

## Patient Information

- Patient Information leaflets have been developed and are available on the public website and staff intranet. These will be distributed across the hospital into public waiting areas.

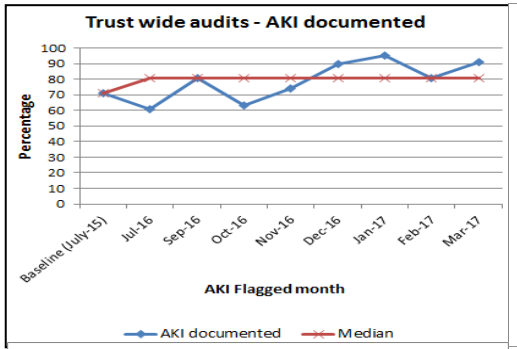
## Next Steps

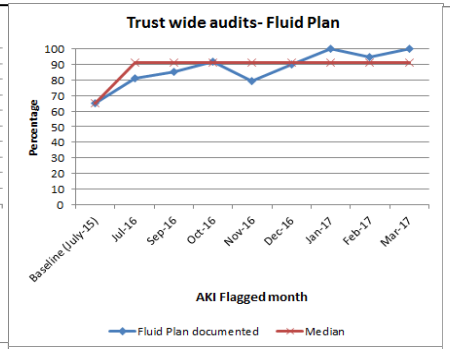
- Development of Deteriorating patient training , combining AKI, Sepsis and NEWS

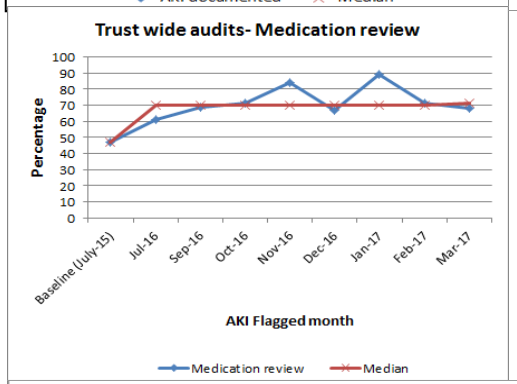
# Patient Safety - Acute Kidney Injury (AKI)

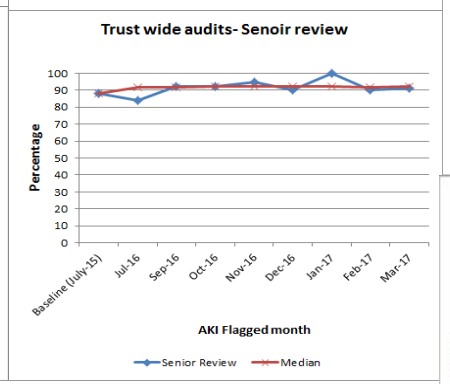
Tim Craft

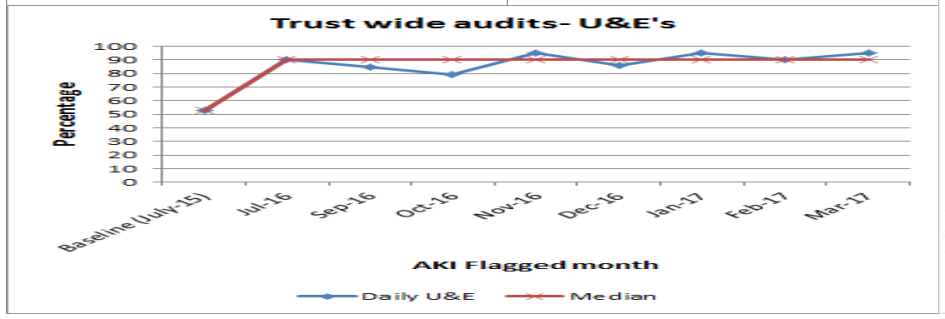
**Bundle compliance audits based on 20—25 patients per month**



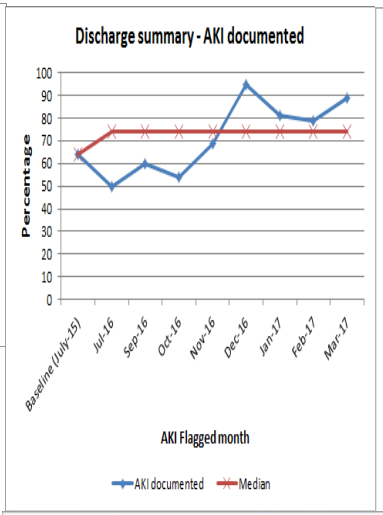



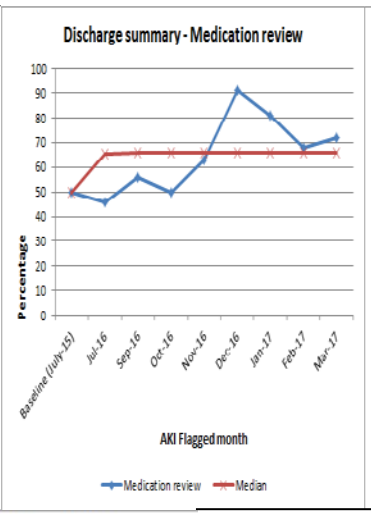



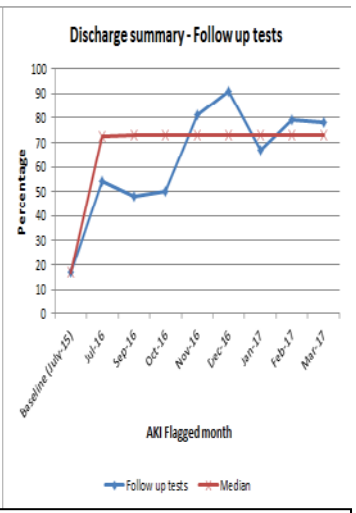



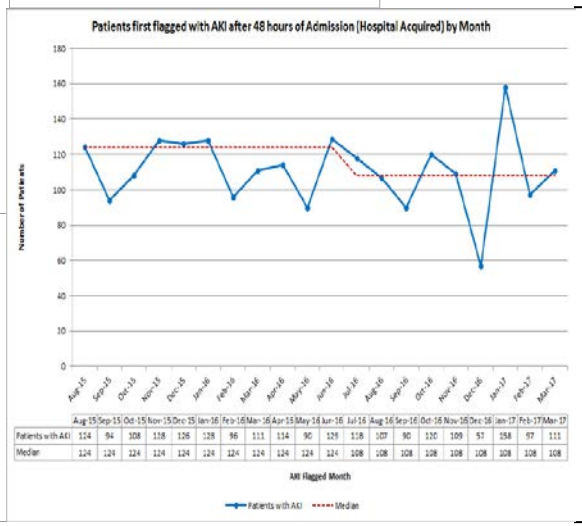



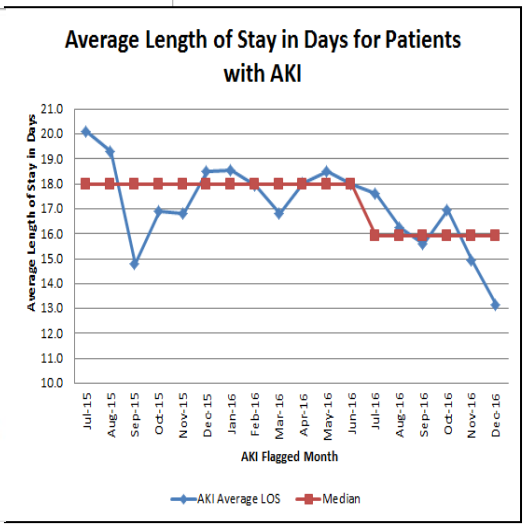

**Discharge summary compliance Audits based on 20—25 patients per month**




**AKI incidence and length of stay**

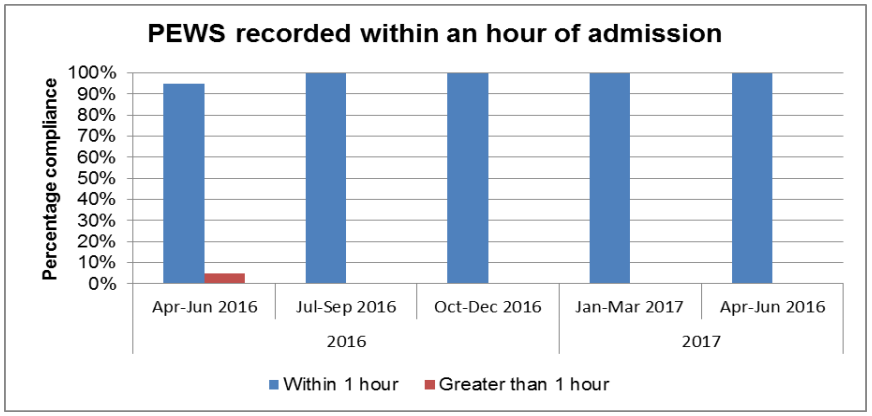
# Executive Sponsored Project - National Early Warning Score (NEWS) Tim Craft

**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:**

- On April 26th the revised NEWS chart was launched Trust wide alongside an Escalation sticker, designed to support the use of SBAR, to standardise clinical response to a raised NEWS.
- The NEWS group will support the monitoring and reporting of Paediatric Early Warning Score ( PEWS) and Maternity Early Obstetric Warning Score (MEOWS) from July 2017.Baseline data has been collected in June.
- PEWS recorded on admission data has been collected since April 2016. The data in figure 1 shows compliance in 20 patients per quarter in paediatrics.




- NEWS recorded within 1 hour of admission is collected. The data in Figure 2 shows compliance in 50 patients per quarter in ED, direct admit to MAU,SAU or ASU.

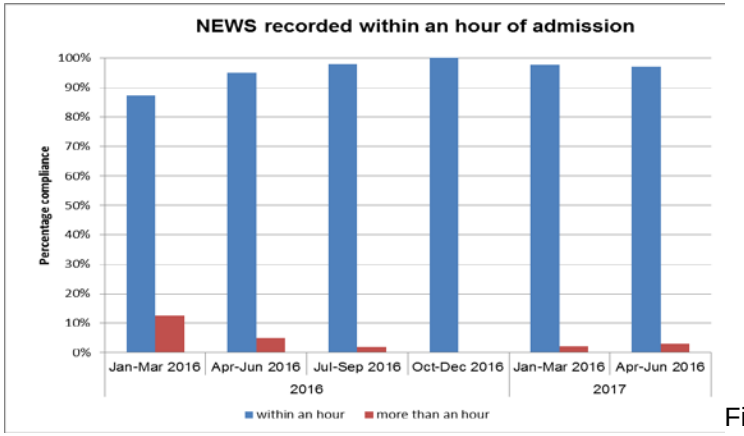
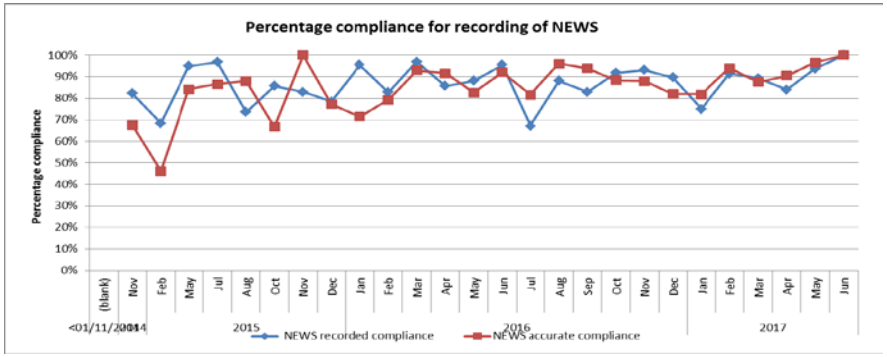



Figure 2

NEWS recording and accuracy continues to improve in Emergency Department and has been incorporated into the programme of ED Safety. Figure 3 below shows recording and accuracy of NEWS.



# Executive Sponsored Project - National Early Warning Score (NEWS) Tim Craft

Monthly audits continue to measure NEWS compliance and accuracy.
Senior Sisters/Charge Nurses are informed of ward performance and data is submitted to the ward dashboard.

**Table 1 - current performance of NEWS recorded**
The score is the percentage of observations performed where NEWS is recorded. It should be noted that compliance is consistently high for recording of NEWS with an average of 98% compliance for the last quarter.

**Table 2 - current performance of NEWS accuracy**
The score relates to the percentage of observations performed where NEWS is accurate.
In June 19 areas are over 90% for NEWS accuracy.

| NEWS recorded compliance | 2017 | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Ward | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun |
| ACE OPU | 100% | 95% | 100% | 100% | 100% | 98% | 98% | 96% | 94% | 98% |
| ASU | 100% | 94% | 98% | 98% | 92% | 98% | 98% | 91% | 100% | 93% |
| Cardiac | 92% | 100% | 100% | 92% | 98% | 96% | 100% | 100% | 98% | 98% |
| CCU | 98% | 97% | 83% | 98% | 97% | 98% | 100% | 96% | 94% | 94% |
| Charlotte | 96% | 98% | 87% | 100% | 100% | 100% | 100% | 100% | 100% | 100% |
| Cheselden | 98% | 98% | 100% | 98% | 98% | 98% | 98% | 98% | 100% | 100% |
| Combe | 94% | 98% | 94% | 100% | 100% | 100% | 98% | 100% | 96% | 98% |
| ED Obs | 93% | 95% | 93% | 100% | 94% | 90% | 96% | 92% | 100% | 97% |
| Forrester Brown A | 94% | 100% | 100% | 90% | 96% | 95% | 98% | 100% | 98% | 98% |
| Haygarth | 96% | 96% | 98% | 100% | 100% | 100% | 100% | 100% | 100% | 100% |
| Helena | 98% | 98% | 98% | 100% | 100% | 100% | 98% | 98% | 100% | 100% |
| MAU | 100% | 92% | 86% | 100% | 98% | 98% | 94% | 96% | 100% | 92% |
| Midford | 98% | 96% | 100% | 96% | 100% | 100% | 98% | 90% | 98% | 100% |
| MSSU | 100% | 100% | 96% | 100% | 100% | 91% | 93% | 94% | 93% | 100% |
| Parry | 100% | 98% | 96% | 100% | 100% | 100% | 98% | 100% | 98% | 98% |
| Philip Yeoman | 91% | 98% | 98% | 91% | 98% | 100% | 92% | 96% | 98% | 100% |
| Pierce | 98% | 89% | 98% | 100% | 96% | 98% | 100% | 100% | 98% | 94% |
| Pulteney (previously Waterhous | 96% | 100% | 90% | 98% | 96% | 98% | 100% | 94% | 100% | 100% |
| Respiratory | 100% | 100% | 100% | 100% | 100% | 96% | 96% | 98% | 100% | 100% |
| Robin Smith | 98% | 96% | 94% | 96% | 100% | 100% | 98% | 100% | 98% | 100% |
| SAU | 100% | 100% | 100% | 100% | 98% | 100% | 96% | 100% | 100% | 100% |
| SSSU | 100% | 98% | 98% | 98% | 98% | 100% | 98% | 98% | 98% | 97% |
| Violet Prince | 100% | 100% | 93% | 95% | 79% | 97% | 100% | 98% | 89% | 100% |
| Waterhouse (previously Pultene | 98% | 96% | 100% | 94% | 100% | 100% | 100% | 96% | 96% | 93% |
| William Budd | 98% | 98% | 96% | 100% | 98% | 98% | 100% | 96% | 92% | 98% |
| **Grand Total** | **98%** | **97%** | **96%** | **98%** | **98%** | **98%** | **98%** | **97%** | **98%** | **98%** |

| NEWS accuracy | 2016 | | | 2017 | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Ward | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun |
| ACE OPU | 94% | 93% | 96% | 98% | 96% | 85% | 92% | 90% | 75% | 86% |
| ASU | 90% | 80% | 86% | 93% | 91% | 94% | 91% | 87% | 95% | 95% |
| Cardiac | 89% | 92% | 90% | 88% | 79% | 90% | 88% | 98% | 91% | 90% |
| CCU | 82% | 93% | 96% | 70% | 64% | 88% | 100% | 92% | 89% | 91% |
| Charlotte | 83% | 93% | 100% | 91% | 93% | 82% | 94% | 96% | 96% | 100% |
| Cheselden | 88% | 84% | 92% | 88% | 92% | 96% | 84% | 98% | 96% | 94% |
| Combe | 79% | 77% | 87% | 84% | 89% | 92% | 94% | 96% | 91% | 94% |
| ED Obs | 75% | 94% | 96% | 90% | 88% | 93% | 96% | 96% | 86% | 97% |
| Forrester Brown A | 80% | 91% | 88% | 82% | 93% | 92% | 90% | 89% | 85% | 93% |
| Haygarth | 96% | 79% | 80% | 90% | 86% | 94% | 98% | 94% | 98% | 92% |
| Helena | 93% | 85% | 94% | 95% | 98% | 90% | 94% | 96% | 98% | 94% |
| MAU | 94% | 100% | 88% | 76% | 80% | 94% | 96% | 76% | 88% | 96% |
| Midford | 81% | 91% | 83% | 86% | 78% | 86% | 88% | 72% | 96% | 90% |
| MSSU | 96% | 91% | 89% | 95% | 85% | 98% | 92% | 89% | 100% | 86% |
| Parry | 88% | 84% | 83% | 85% | 72% | 90% | 96% | 98% | 94% | 90% |
| Philip Yeoman | 93% | 89% | 82% | 88% | 90% | 85% | 96% | 93% | 88% | 81% |
| Pierce | 80% | 80% | 90% | 88% | 81% | 89% | 94% | 86% | 92% | 83% |
| Pulteney (previously W | 89% | 100% | 91% | 89% | 87% | 77% | 82% | 87% | 93% | 86% |
| Respiratory | 96% | 88% | 84% | 94% | 66% | 84% | 88% | 79% | 96% | 96% |
| Robin Smith | 90% | 90% | 95% | 94% | 96% | 81% | 92% | 96% | 90% | 91% |
| SAU | 92% | 98% | 98% | 98% | 93% | 98% | 96% | 91% | 100% | 96% |
| SSSU | 93% | 96% | 94% | 96% | 82% | 90% | 96% | 87% | 88% | 100% |
| Violet Prince | 86% | 85% | 86% | 84% | 75% | 89% | 87% | 84% | 82% | 83% |
| Waterhouse (previous | 78% | 84% | 86% | 86% | 87% | 90% | 94% | 92% | 96% | 90% |
| William Budd | 94% | 94% | 92% | 82% | 96% | 98% | 98% | 90% | 80% | 90% |
| **Grand Total** | **88%** | **89%** | **89%** | **89%** | **86%** | **90%** | **92%** | **90%** | **92%** | **91%** |

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

Table 1

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

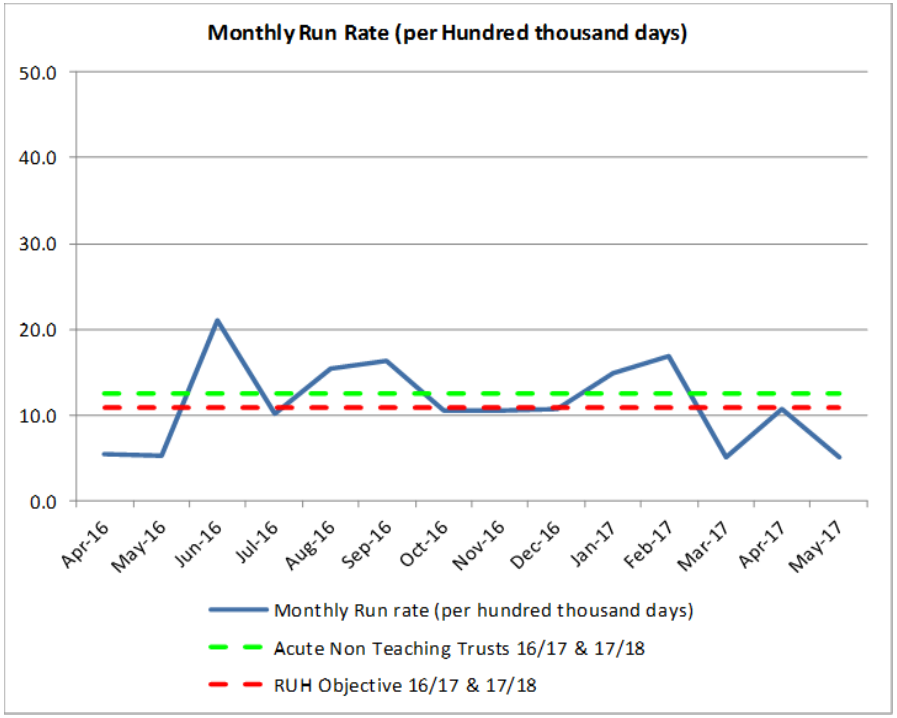
Table 2

# Patient Safety Priorities – C 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 January-June 2017**
15 cases, 11 RCAs received within 21 days
- 93% patients over 65 years of age
- Length of stay ranging from 4-94 days, average 21 days

One patient had a second episode of C diff infection during Q4 2016/17, first episode included in Q3 figures.
- Opportunities for improvement were identified in 8 cases:
  - Stool sampling delays in 6 cases
  - Stool charts not commenced from admission in 1 case
  - Missing information on 7 stool charts
  - Delays in isolation in 1 case
  - Dirty commodes at the time of the infection in 1 case
  - Concerns regarding antimicrobial stewardship in 5 cases

**Actions**
Improvement plan developed post NHSi visit, actions include:
- Implementation of a C diff 'swarm' for single cases of hospital attributed infection, this includes targeted training.
- Revision of stool chart.
- Review of the antimicrobial prescribing policy
- Introduction of C diff alert letters for patients and GPs
- Review of cleaning process and identification of responsibilities for cleaning
- Planned introduction of a new process for carrying out infection prevention and control audits.
- Improved attendance at C diff RCA meetings.
- Increase IPC training compliance to 90%.

# Serious Incident (SI) Summary

Helen Blanchard

**Current Performance**

During June 2017, four 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 |
|---|---|---|
| 15.06.17 | **54122** | Infection – not Trust attributable |
| 15.06.17 | **54141** | Fall resulting in a fracture |
| 16.06.17<br>notified 20.06.17 | **54175** | Fall resulting in a fracture |
| 25.06.17 | **54436** | Fall resulting in fractures |

# Overdue Serious Incident reports summary

Helen Blanchard

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

As of 10 July 2017, there are 14 Serious Incidents that remain open. Of these, three incident reports are overdue for submission to the Clinical Commissioning Group by the agreed due date. Of the 14 open incidents, an extension has been agreed by the CCG for two of these investigation reports and these reports are awaiting resubmission to the Operational Governance Committee, the third report is for submission.

The investigation has been completed for a further three of the 14 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 June OGC meeting, the status was:

| | Dec-16 | Jan-17 | Feb-17 | Mar-17 | Apr-17 | May-17 | Jun-17 |
|---|---|---|---|---|---|---|---|
| Outstanding action plans | 14 | 14 | 14 | 19 | 8 | 9 | 17 |
| Outstanding actions | 26 | 23 | 32 | 29 | 15 | 13 | 33 |

The Heads of Nursing and Divisional governance leads are notified of the responsible managers who require support to complete their actions.

# Nursing Quality Indicators - Exception Report

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 (see below).

**Pulteney Ward**
This is the third consecutive month this ward has flagged.
Quality matrices to note are:
- RN hours fill rate day and night shift <90%
- HCA hours fill rate day shift <90%
- Datix staffing reports x11
- HCA sickness 9.8%
- RN appraisals and HCA appraisals < 80%

The Senior sister is proactively recruiting nursing staff and 3.0wte RN's are due to start within August and September. An improvement action plan regarding ward environment and team management has been implemented by the Matron and Senior Sister and this includes completion of appraisals. Sickness continues to be managed robustly in line with trust policy,

**Parry Ward**
This is the third consecutive month this ward has flagged.
Quality matrices to note are:
- 5 falls (4 negligible harm,1 minor harm)
- RN sickness 7.8%
- HCA sickness 8.4%
- RN hours day and night shift fill rate <90%
- PALs x 1 negative contact nursing related
- FFT response rate <35%

The senior sister is proactively recruiting to RN vacancies and to manage the RN shortfall the skill mix has been adjusted with increased HCA hours both day and night to ensure sufficient staffing levels.

**Parry Ward continued:**
Staff sickness is being proactively managed and the HCA sickness has reduced from last month.
There is a plan in place to increase appraisal compliance.
FFT response rate has increased since last month since additional actions were put in place and it is anticipated that the response rate will increase again next month.

**William Budd Ward**
This is the first time this ward has flagged within the previous 12 months.
Quality matrices to note are:
- FFT response rate 25%
- 5 falls (all negligible)
- RN sickness 13.5%
- HCA sickness 10%
- HCA appraisal rate <80%
- RN % staffing fill rate during both day and night shifts < 90%

RN vacancies have increased from 1.66 wte to 3.66 wte during this month. Recruitment is being proactively managed with plans for dedicated advertisements to promoting Oncology nursing.
Long term sickness (1.6 wte RN and 1.0 wte HCA) is also being proactively managed with support of HR and Occupational Health.
Appraisals have been completed for all HCAs (except those on sick) and the Matron will support the senior sisters to ensure Appraisal compliance is maintained.
A Discharge Co-ordinator commenced in post at the end of June and it is anticipated there will be an improvement in FFT responses as they will coordinate these.

# Nursing Quality Indicators - Exception Report

Helen Blanchard

**Areas of focus continued:**

**Pierce Ward**

This is the first time this ward has flagged in 6 months, last flagged Dec: 2016.

Quality matrices to note are:

- FFT response rate 32%
- 7 falls (5 negligible, 2 minor)
- RN sickness 8.9%
- HCA sickness 5.7%
- RN % staffing fill rate day shift < 90%
- Datix staffing reports x 5

There are RN vacancies however the senior sister is actively recruiting and staff are starting in post during August and September. Staff sickness is being proactively managed within Trust policy. The ward is engaged with the Falls improvement programme and where required is placing patients in an enhanced observation bay. The senior sister has put actions into place with her staff to increase FFT response compliance.

**Surgical Admissions Unit**

This is the first time this ward has flagged since November 2016.

Quality matrices to note are:

- FFT response rate 8%
- 5 falls ( 2 negligible harm, 3 minor harm)
- RN sickness 7.8%
- HCA sickness 15.1%
- RN % staffing both day and night shifts fill rate <90%

**Surgical Admission Unit continued:**

The senior sister is proactively recruiting nurses and with new recruits in the pipeline, she expects to have less than 1.0wte vacancy by the end of September. The ward team are undertaking the falls improvement project and the location of patients assessed as high risk on the ward are being managed to ensure close observation.
The ward's Patient Support Assistant who hands out FFT cards to patients will now follow up patients and encourage them to complete them prior to discharge to improve response rates.
Sickness continues to be managed robustly in line with trust policy.

**Other quality matrices:**

- **Falls:**

The Falls Improvement programme has rolled out across the Trust with every ward engaged. Whilst it is too early to determine if the programme is making a difference, this month the number of overall falls were 95 this month compared 117 falls last month. The average number of falls per month are approximately . . . .
The number of patients who were repeat fallers are also down from 28 last month to 16 this month

- **C Difficle:**

There was one case reported and an initial Root Cause Analysis investigation is being undertaken. For Quarter 1 the Trust was within trajectory.

## Appendix A - Nursing Quality Indicators - Monthly Template

**APPENDIX A**

| Ward Group | Ward Name | Report for July 2017 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 | | | | Number of times parameters outside of KPI metrics | | | | | | |
| | | | | | | | | | | | | | | | 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 | Jun 17 No: | May 17 No: | Apr 17 No: | Mar 17 No: | Feb 17 No: | Jan 17 No: | Total |
| Emergency Department | A&E | 98 | 20% | | 2 | 5 | | | 1 | | | | | | 2.3 | 7.3 | 83.9 | 92.0 | | N/A | N/A | N/A | N/A | 2 | 1 | 1 | 2 | 2 | 1 | 9 |
| | MAU | 94 | 19% | | | 2 | | 2 | 1 | | | | | | 2.3 | 5.8 | 90.0 | 87.0 | | 78.5% | 98.7% | 80.4% | 134.9% | 3 | 4 | 3 | 5 | 6 | 3 | 24 |
| | SAU | 95 | 8% | | | | | 2 | 3 | | | | | | 7.8 | 15.1 | 89.5 | 92.9 | | 77.2% | 100.8% | 83.7% | 123.3% | 6 | 5 | 4 | 3 | 4 | 2 | 24 |
| Inpatient Wards | Robin Smith | 98 | 35% | 1 | | 2 | | 3 | | | | | | | 3.1 | 2.2 | 90.5 | 93.8 | 1 | 91.0% | 104.7% | 90.6% | 125.0% | 0 | 6 | 3 | 0 | 4 | 2 | 15 |
| | Cheselden | 94 | 97% | | | 2 | | 1 | | 1 | | | | | 0.0 | 2.1 | 87.5 | 91.7 | 2 | 102.7% | 81.7% | 96.5% | 115.0% | 1 | 0 | 1 | 0 | 1 | 0 | 3 |
| | Violet Prince (RNHRD) | 97 | 38% | | | | | 2 | | | | | | | 0.5 | 1.2 | 93.3 | 100.0 | | 121.2% | 89.8% | 100.0% | 93.3% | 1 | 2 | 4 | 1 | 2 | 3 | 13 |
| | Helena | 94 | 59% | | | 1 | | 1 | | | 1 | | | | 4.7 | 0.5 | 100.0 | 85.7 | | 90.0% | 116.1% | 67.8% | 154.9% | 2 | 1 | 2 | 2 | 2 | 0 | 9 |
| | Forrester Brown [A] | 91 | 41% | | | 2 | | 3 | 1 | | | | | | 4.9 | 6.0 | 94.4 | 100.0 | 4 | 82.8% | 99.1% | 87.5% | 106.6% | 3 | 4 | 2 | 1 | 2 | 1 | 13 |
| | Surgical Short Stay Unit | 99 | 81% | 1 | | 2 | | 1 | | | | | | | 6.5 | 7.3 | 87.5 | 75.0 | 1 | 133.6% | 164.3% | 123.3% | 186.7% | 3 | 4 | 3 | 1 | 2 | 2 | 15 |
| | Critical Care Services | N/A | N/A | | | | | | | | | | | | 1.9 | 2.2 | 94.7 | 100.0 | | 89.0% | 141.7% | 89.1% | 10.0% | 3 | 4 | 4 | 2 | 4 | 2 | 19 |
| | Charlotte | 100 | 31% | | | 1 | | 2 | 1 | 1 | | | | | 2.5 | 8.1 | 86.7 | 100.0 | 3 | 89.7% | 97.5% | 101.1% | 96.7% | 3 | 5 | 1 | 2 | 2 | 1 | 14 |
| | ACE OPU | 99 | 57% | | | | | 9 | 1 | | | | | | 1.1 | 2.5 | 77.3 | 87.5 | 2 | 69.3% | 94.3% | 95.5% | 106.5% | 3 | 5 | 3 | 3 | 3 | 5 | 22 |
| | NICU | 100 | 18% | | | | | | | | | | | | 6.8 | 4.4 | 81.8 | 92.9 | 2 | 90.5% | 86.5% | 73.4% | 195.9% | 4 | 3 | 3 | 2 | 1 | 3 | 16 |
| | Children's Ward | 100 | 24% | 1 | | | | | | | | | | | 0.6 | 1.2 | 92.1 | 91.7 | | 77.0% | 85.7% | 79.4% | 106.7% | 4 | 3 | 3 | 3 | 3 | 3 | 19 |
| | Midford | 100 | 87% | | | 1 | | 4 | 1 | | | | | | 7.3 | 0.8 | 100.0 | 94.7 | | 69.0% | 111.1% | 75.2% | 146.7% | 4 | 4 | 4 | 4 | 3 | 2 | 21 |
| | Haygarth | 97 | 48% | | 1 | | | 4 | 4 | | | | | | 4.5 | 9.6 | 82.4 | 81.3 | 1 | 76.1% | 96.5% | 76.6% | 111.7% | 4 | 4 | 5 | 4 | 7 | 8 | 32 |
| | Medical Short Stay Unit | 98 | 44% | 1 | | 2 | | 2 | 1 | | | | | | 2.6 | 16.7 | 100.0 | 87.5 | | 71.4% | 81.7% | 97.8% | 120.0% | 4 | 5 | 3 | 2 | 4 | 4 | 22 |
| | Respiratory | 94 | 47% | | | 1 | 1 | 4 | | | | | | | 1.9 | 2.2 | 94.7 | 100.0 | 2 | 46.8% | 139.2% | 71.3% | 138.1% | 4 | 5 | 4 | 6 | 6 | 8 | 33 |
| | Cardiac | 98 | 43% | | 1 | 2 | | 1 | 1 | | | | | | 4.1 | 1.8 | 73.1 | 84.6 | | 77.7% | 107.1% | 74.9% | 153.3% | 4 | 7 | 2 | 4 | 5 | 7 | 29 |
| | Mary Ward* | 100 | 28% | | | 1 | | | | | | | | | 5.5 | 14.7 | 100.0 | 81.8 | | 97.3% | 59.8% | 93.7% | 82.2% | 5 | 5 | 2 | 4 | 3 | 5 | 24 |
| | Waterhouse | 100 | 88% | 2 | | | | 4 | 1 | | | | | | 4.4 | 6.2 | 86.7 | 88.2 | 1 | 65.0% | 105.7% | 67.1% | 106.7% | 4 | 5 | 3 | 7 | 5 | 5 | 28 |
| | CCU | 100 | 62% | | | | | | | | | | | | 11.6 | 23.3 | 90.0 | 75.0 | 3 | 81.8% | 47.8% | 100.0% | 93.3% | 5 | 5 | 5 | 6 | 5 | 3 | 29 |
| | Combe | 95 | 86% | | | | | 3 | 2 | | 1 | | | | 11.5 | 0.5 | 80.0 | 81.3 | 7 | 91.6% | 166.7% | 71.1% | 183.3% | 5 | 5 | 8 | 5 | 6 | 5 | 34 |
| | Phillip Yeoman | 99 | 59% | | | 2 | | 2 | | | | | | | 13.9 | 10.1 | 86.7 | 100.0 | 1 | 106.4% | 71.6% | 87.9% | 101.9% | 5 | 6 | 4 | 4 | 3 | 3 | 25 |
| | Acute Stroke Unit | 94 | 56% | | | 1 | | 1 | | | | | | | 6.9 | 7.6 | 91.3 | 88.2 | | 76.8% | 86.2% | 82.2% | 105.3% | 5 | 6 | 6 | 4 | 3 | 4 | 28 |
| | Pierce [FB- B] | 100 | 32% | | | | | 5 | 2 | | | | | | 8.9 | 5.7 | 82.4 | 86.7 | 5 | 86.0% | 114.5% | 97.0% | 158.3% | 6 | 4 | 4 | 2 | 0 | 0 | 16 |
| | William Budd | 94 | 25% | 1 | | | | 5 | | | | | | | 10.0 | 13.5 | 64.7 | 100.0 | 4 | 84.6% | 102.4% | 79.8% | 126.2% | 7 | 4 | 4 | 4 | 3 | 4 | 26 |
| | Pulteney | 98 | 39% | | | 4 | | 1 | 3 | | | | | | 3.3 | 9.8 | 47.6 | 38.1 | 11 | 85.7% | 85.5% | 84.0% | 122.2% | 7 | 6 | 7 | 5 | 7 | 4 | 36 |
| | Parry | 87 | 33% | 1 | | 4 | | 4 | 1 | | | | | | 7.8 | 8.4 | 100.0 | 87.5 | | 82.9% | 127.5% | 67.4% | 175.0% | 7 | 7 | 6 | 3 | 5 | 2 | 30 |
| * FFT data taken from Maternity FFT touchpoint 2- Post natal 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 | | | | Harms any PUs | | | 5% or more | | 80% or less | | 5 or more | < 90% | | | | More than 5 | | | | | | |

Template updated 10 January 2017 V.3

* FFT Data Forrester Brown A&B

* Forrester Brown Ward (Prior to becoming 2 wards A&B)