Royal United Hospitals Bath
NHS Foundation Trust

Report to:	**Public Board of Directors**	**Agenda item:**	**8**
Date of Meeting:	**31 January 2018**		
Title of Report:	**Quality Report**		
Status:	**For information**		
Board Sponsor:	**Helen Blanchard, Director of Nursing and Midwifery**		
Author:	**Jan Lynn, Lead Nurse, Workforce Development and Education & Lisa Cheek, Deputy Director of Nursing and Midwifery**		
Appendices	**Appendix A - Nursing Quality Indicators Chart (to follow)**		

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 December 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 – Patient Safety priorities:
  - Sepsis including AMR
  - AKI
  - NEWS
  - 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.)

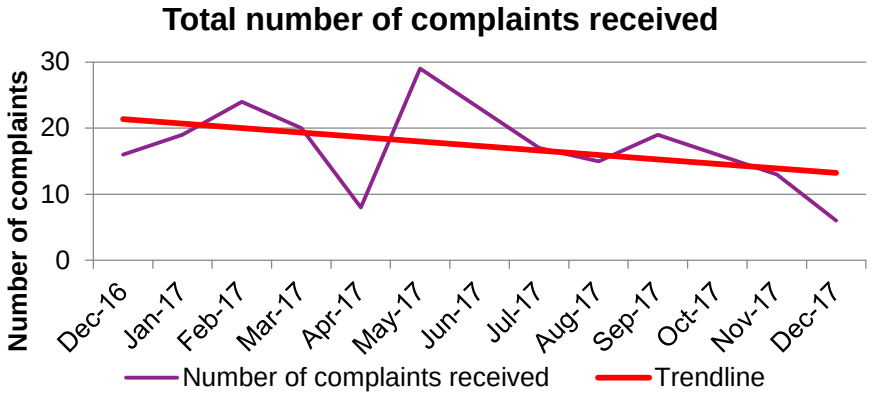
A failure to demonstrate sustained quality improvement could risk the Trust's registration with the Care Quality Commission (CQC) and the reputation of the Trust.

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

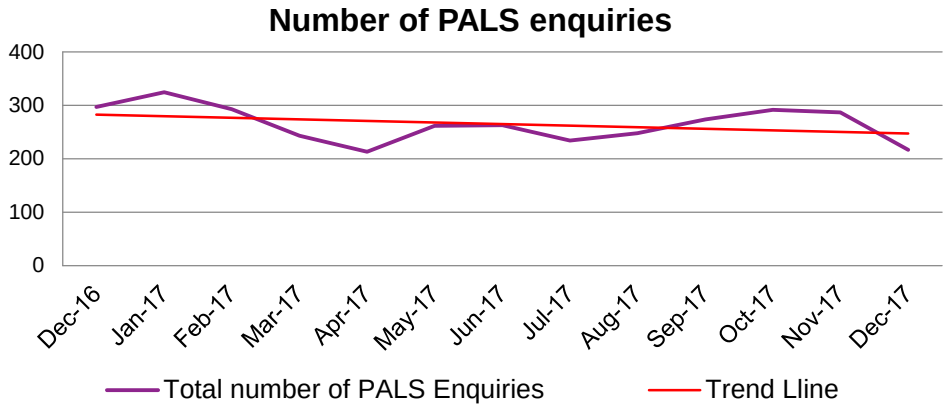
Complaints and Patient Advice and Liaison Report



There were **6 formal complaints** received in December. 4 were for Medicine Division; 1 for the Surgical Division and 1 for the Women and Children's Division. All of the complaints raised **Clinical Care and Concerns** as the main issue.

Complaint response rate by Division	Division			Total
	Surgery	W&C	Medicine	
Closed within 35 day target	5 (71%)	1 (100%)	11 (92%)	17 (82%)
Breached 35 Day target	2 (29%)	0 (100%)	1 (8%)	3 (18%)
Total	7	1	12	20

The performance against the 35 day working target improved in December. The 3 breaches were as a result of meetings arranged outside the timeframe.



There were **217 PALS contacts in December 2017**. This compares to 287 in November.

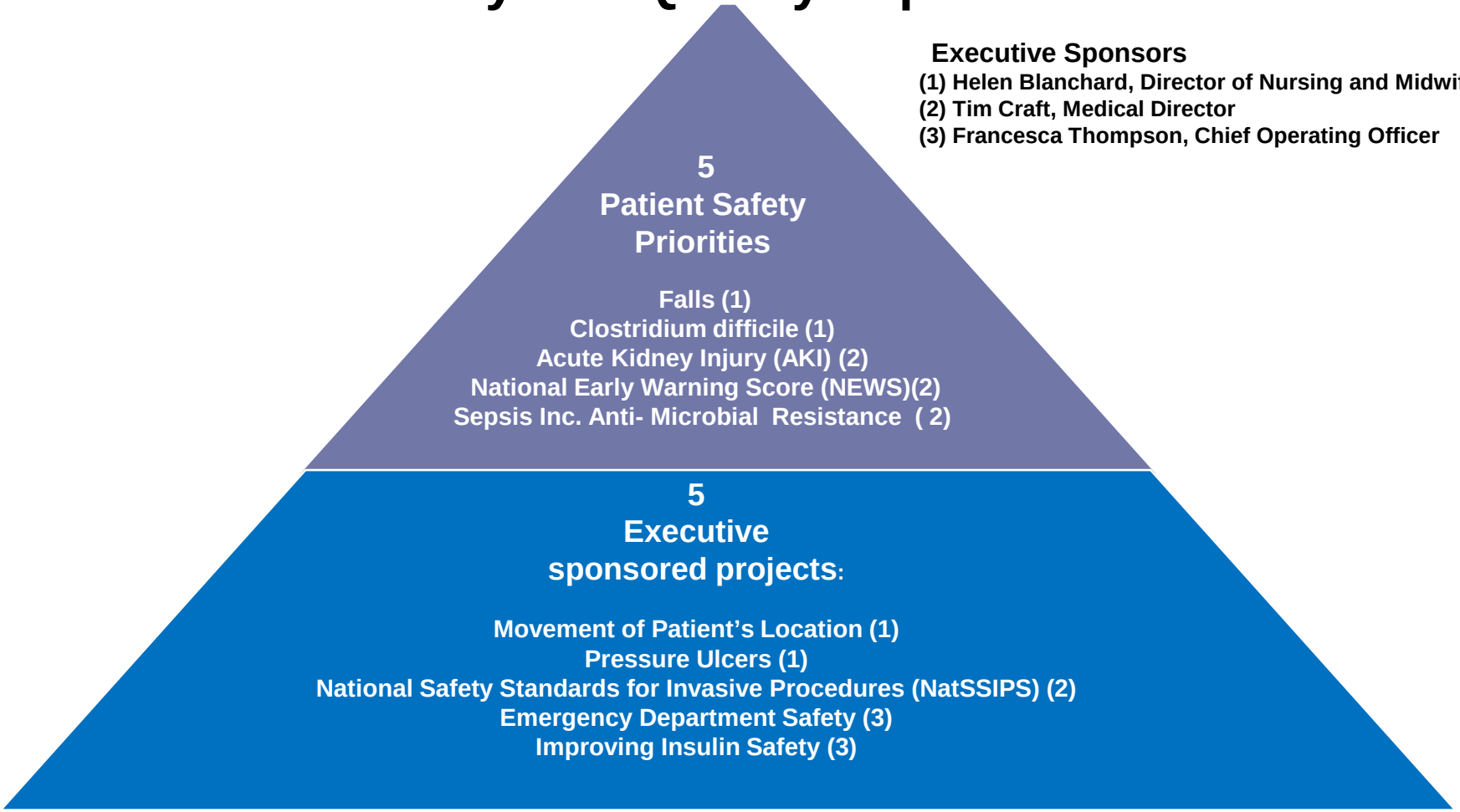
- 126 required resolution (58%)
- 63 requested information or advice (29%)
- 10 provided feedback (5%)
- 18 were compliments (8%)

The **top three subjects requiring resolution** were:
Appointments – there were **30** enquiries in relation to appointments; **11** required information about existing appointments, including making changes, **5** were about cancellations, **4** about waiting for new appointments and **3** about follow-up appointments.
Clinical care – **27** contacts related to clinical care concerns; **7** of them were general enquiries, **4** related to concerns about medical care and **1** about end of life care.
Communication and information – there were **24** contacts relating to communication and information; **11** required general information and advice, **3** were about discharge summaries and **3** about accuracy of record keeping.

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

Bernie Marden

CQUIN for Sepsis

- National CQUIN for 2017/18 and 2018/19 combines the previous Sepsis and Antimicrobial Stewardship CQUIN. (includes adult and paediatric direct admissions and inpatients)
- Targets for Sepsis Screening and Antibiotics are both 90% for the whole year.
- Overall Q2 data for screening was 79% which received a partial payment and for antibiotics ≤60 minutes from diagnosis was 90%.which achieved full payment

Patient's admitted with Sepsis

- Average compliance with Sepsis screening is 84% of adults and 85% of paediatric admissions. (See Fig 1.1 and 1.2).
- The NICE compliant sepsis screening tool is now embedded as mandatary field in emergency adult triage and assessment form on FirstNet, which should lead to an increased performance from December 2017.
- Delivery of antibiotics in an hour had decreased in the first half of 2017 , with an increase to 71% in July, further data is awaited.
- The decrease in performance in ED is being managed by the Matron for medicine and Divisional Lead resulting in more engagement and a sepsis champion has been identified. Review of processes is due to be performed in January
- Paediatric screening has improved over the year and there has been increased engagement with the use of the PEWS scoring and sepsis screening tool . There is still further work to do to ensure this occurs in 100% of at risk children.
- Antibiotics ≤60 minutes for children – small numbers identified only and the majority have received antibiotics in an hour, delays being due to intravenous access and transfer from ED to the ward which has been addressed.

Management of Inpatients with sepsis (see run chart fig 2 and 3)

Screening data for inpatients is from random note reviews trust wide. Antibiotic data is from patients identified with Sepsis through screening, as well as those identified from Outreach or Sepsis teams.(average 18-20 patients per month) This remains onerous.

- Screening for adults has been difficult to maintain above 80% due to the difficulties with data collection and manual recording of screening - on average 76% of adults are screened (see run chart)
- Screening for Paediatric inpatients has continued to improve and has been over 85% since July 2017, being 100% in December 2017(see run chart).

Management of Inpatients with sepsis (see run chart fig 2 and 3)

- Antibiotics treatment ≤60 minutes for adult inpatients with Sepsis has improved over the year with an average of 80% being delivered within 60 minutes of signs
- The small numbers of paediatric inpatients are identified with sepsis , 4 children being identified between August and December . All of these had antibiotic within 90 minutes from signs, any delays to delivery in 60 minutes were due to cannulation difficulties or to investigations required to confirm the diagnosis and were given within 15 minutes of diagnosis. All are reviewed by the paediatric lead and learning shared.
- In maternity progress continues to be excellent with 100% of mothers with sepsis receiving antibiotics in 60 minutes since Aug 2017. Screening processes are still dependant on stickers and data is difficult to collect as there are different notes for the various parts of a mothers care (antenatal, birth and postnatal), although solutions are being sought to embed the process into routine documentation.

Awareness and training

- 1780 (61%) of staff have received updated training since July 2016.
- The Sepsis team have identified the areas where training is under 50% of staff and have commenced focused training in these areas, focusing on 4 wards per month.
- Inclusion of sepsis training in Trust induction is being investigated
- A 'deteriorating patient' training package including AKI, Sepsis and NEWs is being developed, linking the NEWS , Sepsis and AKI work and a deteriorating patient campaign is planned for March 2018, to align the work and emphasis clear processes for further management. .
- E-learning training for the deteriorating patient is due to commence in January and planned to be available in July 2018.
- Sepsis champion half day planned for Feb 2018

Issues

- Data collection for the inpatient work remains burden and difficult to sustain
- Implementation of electronic recording of observations is essential for further improvement in screening and management
- Accurate date trust wide for all patients will also then be available

Patient Safety – Sepsis Work Stream Report

Bernie Marden

Fig 1.1 Emergency Adult sepsis screening - 50 patients per month

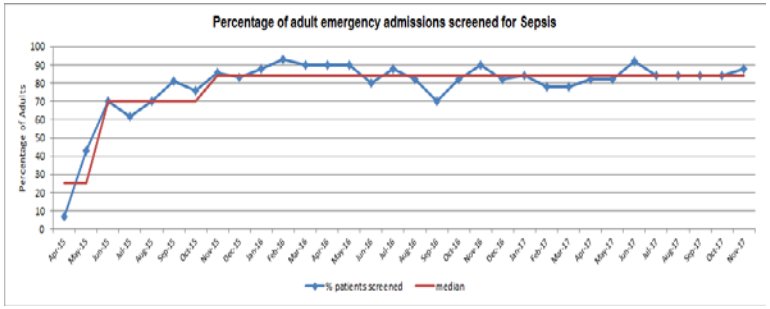


Fig 1.2 Emergency paeds sepsis screening - 20 patients per month

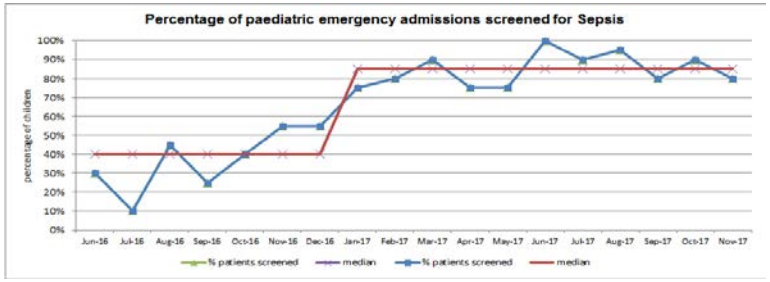


Fig 1.3 ED Antibiotics in an hour for adults
– between 20-30 patients/month

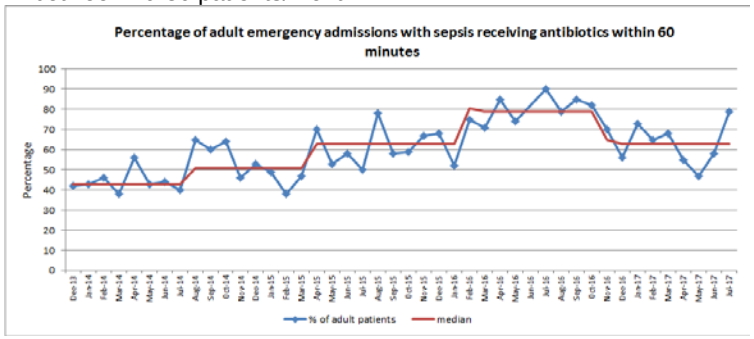


Fig 2.1. Inpatient adult screening- between 80-100/month

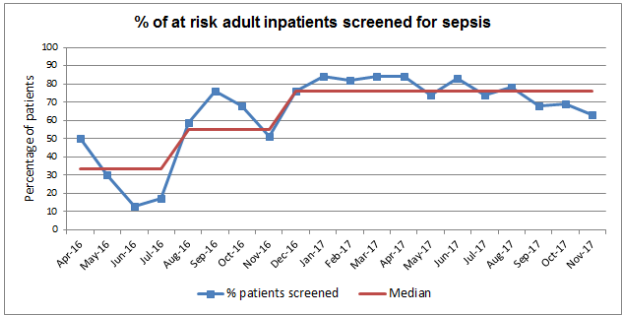


Fig 2.2: Inpatient paeds screening – between 15-20/month

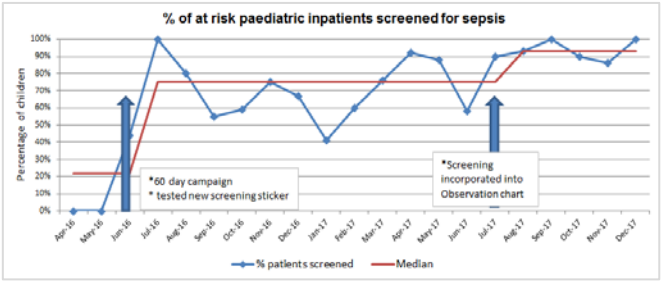


Fig: 2.3: Maternity patients Screened for Sepsis

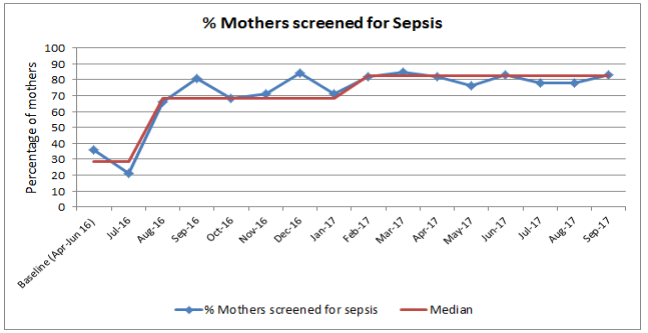


Fig 3.1: Inpatient Adult patients antibiotics in an hour

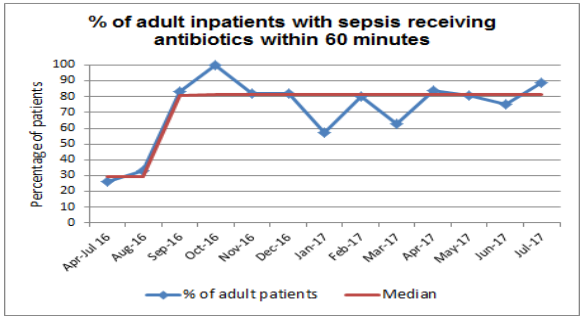
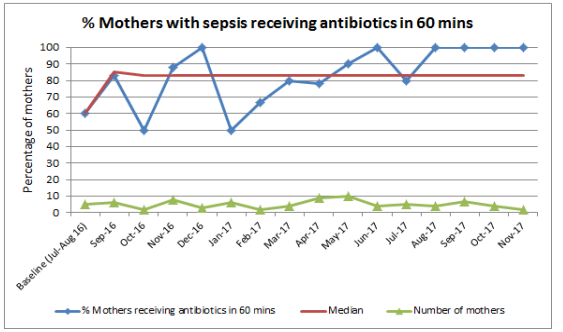


Fig 3.2: Maternity patients- antibiotics in an hour



Patient Safety – Acute Kidney Injury (AKI) Bernie Marden

Awareness and Training

- 1419 (44%) of staff have received the training.(see fig 1).
- The AKI work has been linked with the sepsis and NEWS work to develop a deteriorating patient training package and a deteriorating patient launch is planned for March 2018.
- The Sepsis team will be providing focused Sepsis and AKI training for the inpatient wards where training is under 50% of staff trained. They will focus on 4 wards per month and provide “on the ward” training and support.

AKI Bundle compliance

- Trust wide data continues to be collected from 20 random patient notes per month, and compliance shows sustained improvement since baseline data in July 2015 (see run charts Fig 2.0-2.4 on next page).
- Focused work on inpatient acquired AKI within each speciality will commence in January, starting with trauma and general surgery.

Discharge Summary Information

- Trust wide data from the same patients as above is collated monthly and shows improvement from baseline.(see run charts Fig 3.0 -3.2) which has been sustained.
- No further improvement was expected until the work on including the AKI alert automatically in to the discharge summary has gone live, which had been significantly delayed. This was due to go live witht eh Big 3 but has been delayed.
- It is expected that compliance with AKI information following implementation of this will increase significantly.

Improvement work

- Pharmacy
  - A new AKI champion has been identified who will increase training numbers in pharmacy and support improvement work with the pharmacists
- Fluid balance and hydration work:
  - The amended Hydration chart is fully embedded in all inpatient areas. Data on compliance is awaited from the documentation audits by the audit team
  - An amended fluid balance chart continues to be tested on SAU with an aim to roll out the amended chart during the deteriorating patient launch in March
- Awareness of patients at risk of AKI continues to be improve with the introduction of a sticker following IV contrast administration.
- We are linking with our regional contacts to develop a risk assessment tool.

Patient Information

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

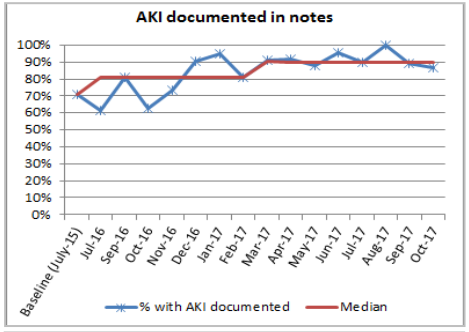
Next Steps

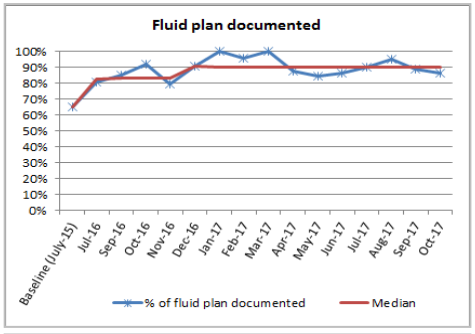
- Continue to increase training for AKI training in with less than 50% staff trained
- Work with the ward accreditation team to include AKI management as a measurement for sliver accreditation
- Develop “Deteriorating patient” ward champions
- Finalise fluid balance chart and spread to all areas .
- Develop risk assessment tool for AKI

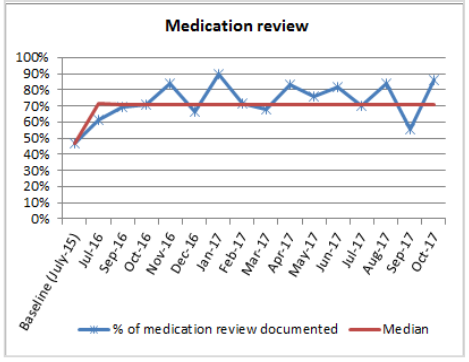
Patient Safety – Acute Kidney Injury (AKI)

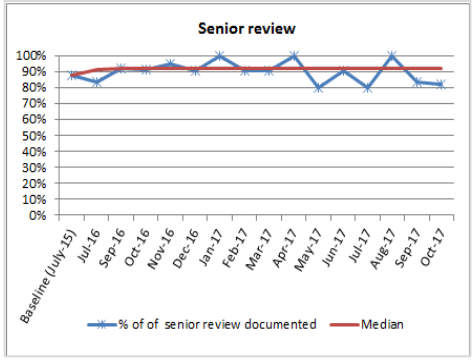
Bernie Marden

Fig 2.0-2.4 Bundle compliance audits based on 18—25 patients per month









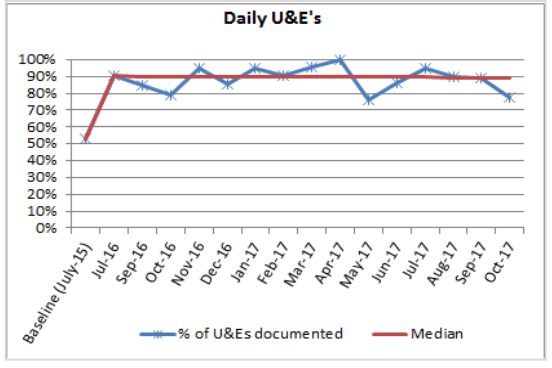
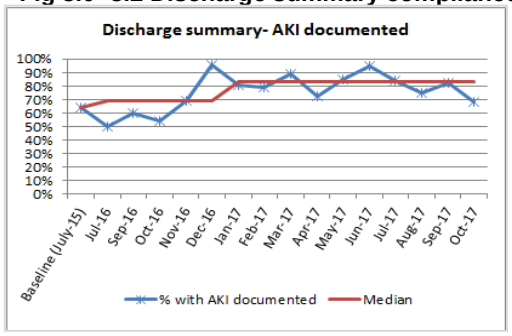
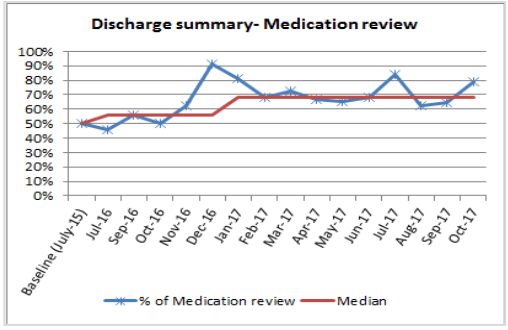


Fig 3.0- 3.2 Discharge summary compliance Audits based on 18—25 patients per month





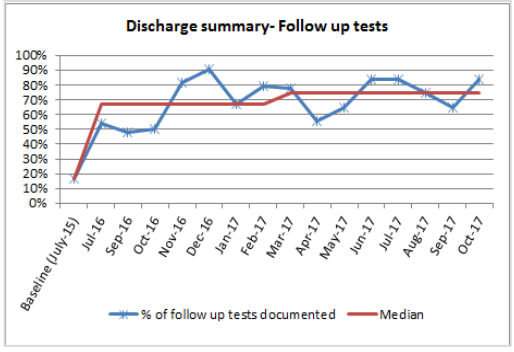
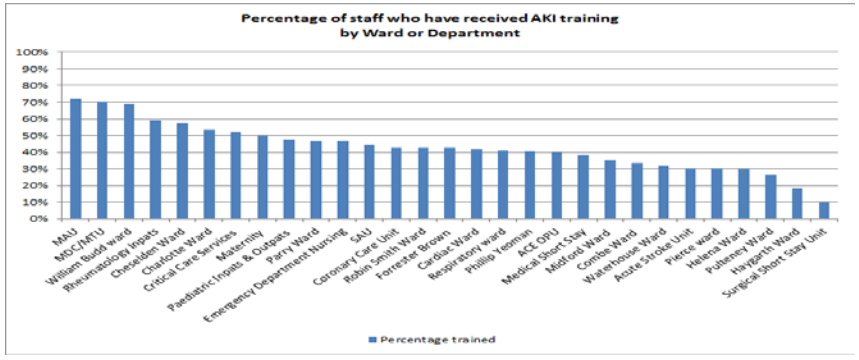


Fig 1. staff trained by inpatient ward or dept.



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

Bernie Marden

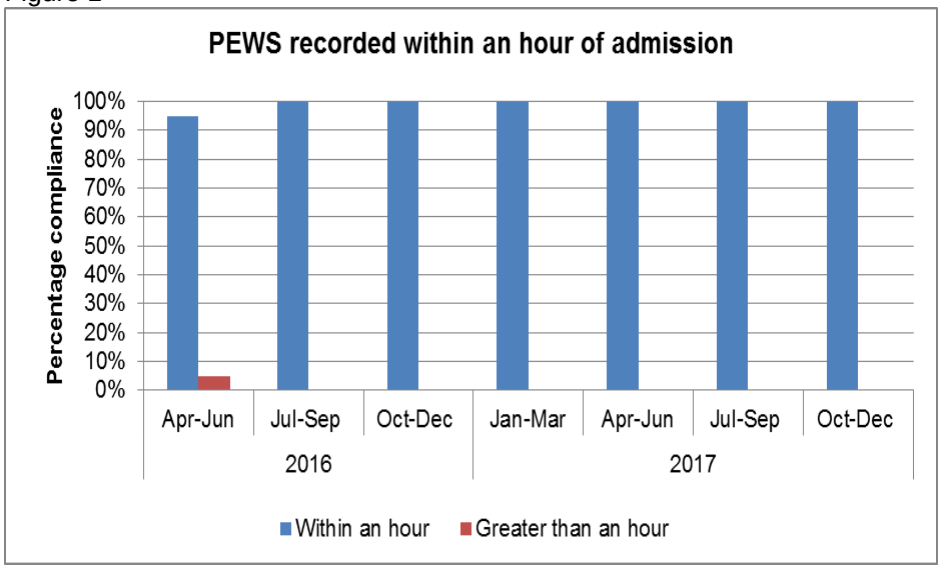
Work stream update

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:

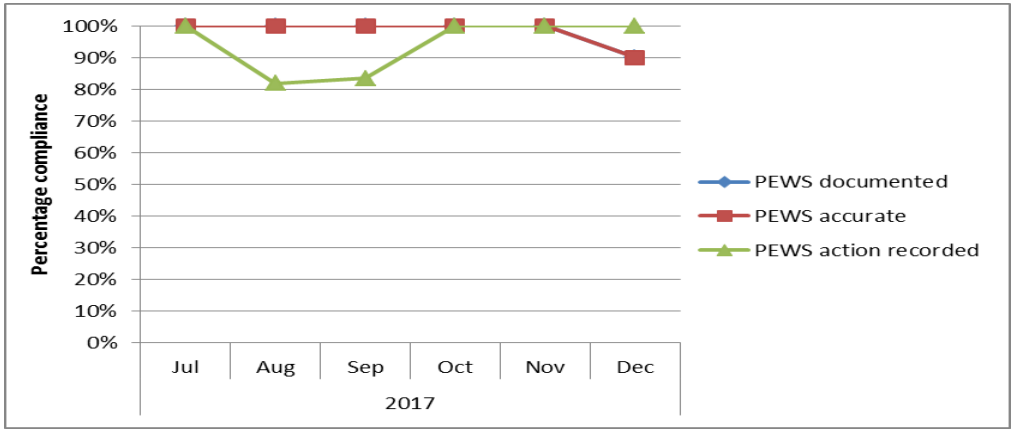
- Measurement of the recording and accuracy of Paediatric Early Warning Score (PEWS) and Maternity Early Warning Score (MEOWS) is now being routinely reported on.
- PEWS recorded on within an hour of admission data is shown in figure 1.Sustained at 100% since July 2016.

Figure 1



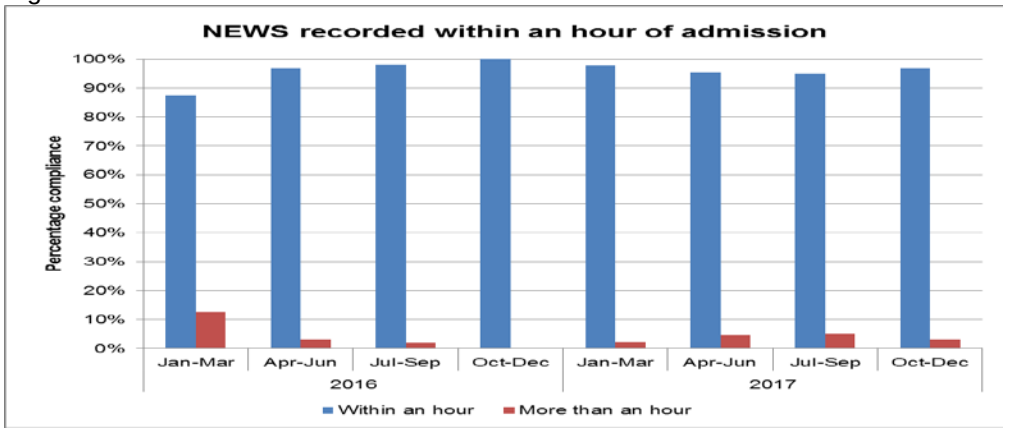
PEWS recorded, accuracy and acted upon is shown in figure 2

Figure 2 : n = 20 charts per month



NEWS recorded within 1 hour of admission data is collected. Figure 3 shows compliance in 50 patients per quarter in ED, direct admit to MAU,SAU or ASU.

Figure 3



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

Monthly audits continue to measure NEWS recorded and accuracy (Table 1).Data is reported as part of the Divisional scorecard .

NEWS recorded has been sustained trust wide at 98% since December 2016.

Table of current performance of NEWS accuracy

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

Ward	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
ACE OPU	98%	96%	85%	92%	90%	75%	86%	83%	95%	80%	81%	77%	85%
ASU	93%	91%	94%	91%	87%	95%	95%	95%	87%	93%	90%	88%	92%
Cardiac	88%	79%	90%	88%	98%	91%	90%	94%	84%	100%	94%	96%	96%
CCU	70%	64%	88%	100%	92%	89%	91%	96%	82%	94%	66%	89%	95%
Charlotte	91%	93%	82%	94%	96%	96%	100%	100%	96%	96%	92%	95%	92%
Cheselden	88%	92%	96%	84%	98%	96%	94%	100%	96%	100%	92%	100%	96%
Combe	84%	89%	92%	94%	96%	91%	94%	93%	87%	89%	85%	92%	83%
ED Obs	90%	88%	93%	96%	96%	86%	97%	81%	90%	95%	85%	100%	100%
Forrester Brown A	82%	93%	92%	90%	89%	85%	93%	92%	90%	82%	85%	90%	98%
Haygarth	90%	86%	94%	98%	94%	98%	92%	100%	94%	95%	88%	100%	100%
Helena	95%	98%	90%	94%	96%	98%	94%	98%	90%	96%	96%	100%	100%
MAU	76%	80%	94%	96%	76%	88%	96%	86%	90%	87%	84%	92%	91%
Midford	86%	78%	86%	88%	72%	96%	90%	92%	86%	90%	91%	71%	72%
MSSU	95%	85%	98%	92%	89%	100%	86%	91%	95%	94%	100%	77%	91%
Parry	85%	72%	90%	96%	98%	94%	90%	89%	85%	92%	94%	100%	100%
Philip Yeoman	88%	90%	85%	96%	93%	88%	81%	89%	88%	90%	76%	74%	94%
Pierce	88%	81%	89%	94%	86%	92%	83%	98%	94%	88%	81%	91%	83%
Pulteney	89%	87%	77%	82%	87%	93%	86%	88%	88%	96%	92%	100%	100%
Respiratory	94%	66%	84%	88%	79%	96%	96%	92%	88%	92%	96%	92%	92%
Robin Smith	94%	96%	81%	92%	96%	90%	91%	100%	92%	80%	94%	92%	83%
SAU	98%	93%	98%	96%	91%	100%	96%	92%	94%	94%	100%	100%	96%
SSSU	96%	82%	90%	96%	87%	88%	100%	100%	92%	89%	100%	84%	85%
Violet Prince	84%	75%	89%	87%	84%	82%	83%	97%	94%	92%	97%	100%	63%
Waterhouse	86%	87%	90%	94%	92%	96%	90%	92%	85%	94%	93%	98%	70%
William Budd	82%	96%	98%	98%	90%	80%	90%	90%	96%	84%	96%	94%	92%
Grand Total	**89%**	**86%**	**90%**	**92%**	**90%**	**92%**	**91%**	**93%**	**90%**	**91%**	**90%**	**91%**	**89%**

Table 1: n=10 charts each ward x 5 sets of observations

Next steps:

- Areas where compliance is below 80% have been contacted to offer support and further training.
- Revision of the NEWS Escalation sticker. Current format is not consistently used – a working group has been set up to redesign the format. Testing will commence February in MAU and SAU.
- Working collaboratively with lead nurse from Virgin care to adapt RUH NEWS chart for use in Paulton and St Martins inpatient wards.
- Jointly working with Sepsis and AKI work stream to develop combined training for Deteriorating Patient.
- Jointly working with Sepsis and AKI work stream to develop combined Cascade trainer / Champion role in all wards and departments for Deteriorating Patient.
- Working group developing Deteriorating Patient campaign – aimed for March 2018.
- Support and help drive the securement of an electronic observation system.

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

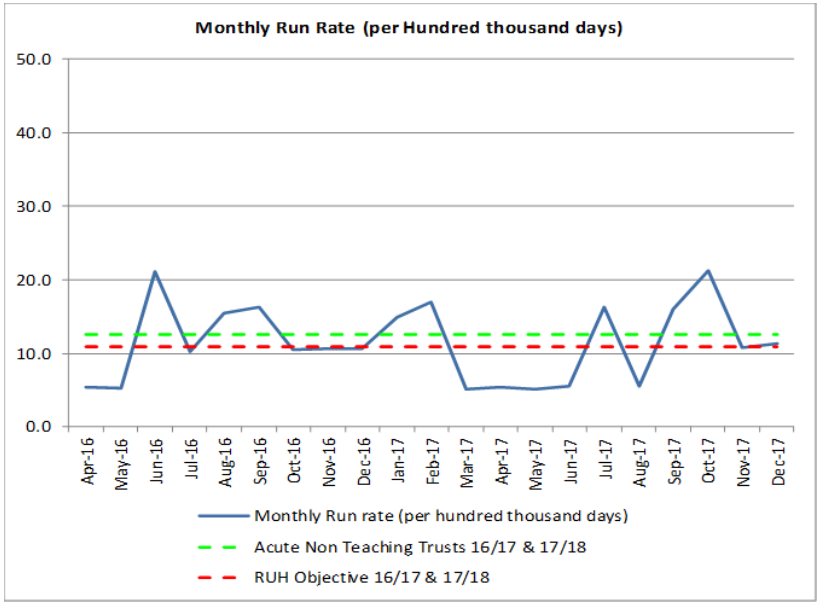
Patient Safety – Clostridium Difficile

Helen Blanchard

Background

The RUH target for 'Trust apportioned' *Clostridium difficile* in 2017/18 is 22 cases. *Clostridium difficile* toxin positive stool samples taken 3 or more days after admission are 'Trust apportioned'. At the end of Q3 there had been 27 cases, 9 of which had been successfully appealed.

Current Performance



Analysis of cases July - December 2017

21 cases, 18 RCAs received within 21 days

- 76% patients over 65 years of age
- Length of stay ranging from 4-76 days, average 19 days
- 4 (19%) patients were known to be *Clostridium difficile* colonised prior to infection
- Ribotyping has been carried out where there has been 2 or more cases on a ward: there is no evidence from the results of cross-infection.

There were cases where lapses of care have been identified these include:

- Stool sampling delays in 6 cases
- Stool charts not commenced from admission in 1 case
- Missing information on 4 stool charts
- Delays in isolation in 3 cases
- Dirty commodes at the time of the infection in 4 cases
- Concerns regarding antimicrobial stewardship in 11 cases

Actions

Improvement plan developed post NHSi visit, ongoing actions include:

- Seeking assurance on antibiotic guidelines from external review and from newly appointed Infection Control Consultant.
- Target pharmacist support to high risk clinical areas.
- Fully realise opportunity within EPMA for prescriber prompts and compliance monitoring.
- To consider increasing frequency of antimicrobial stewardship meetings from quarterly
- Revision of the Cleaning policy to reflect Estates commitment to cleaning air vents and radiators
- Investment in Band 1 support workers to support nursing staff with stock rotation and cleaning of equipment
- Feedback and actions from external review of the Microbiology Department
- 90% of clinical staff to have received Infection Prevention and Control training in the last 2 years (currently at 87.55%)

Serious Incidents (SI) Summary

Helen Blanchard

Current Performance

During December 2017, four Serious Incidents were reported.

Date of Incident	ID	Summary
5 Dec 2017	58885	Fall resulting in a fracture
27 Dec 2017	59459	Fall resulting in a fracture
1 Dec 2017	59127	Delayed communication of cancer diagnosis
5 Dec 2017	58867	Paediatric death

Overdue Serious Incident Report

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 10th January 2018, there are 24 Serious Incidents that remain open. Of these, seven incident reports are overdue for submission to the Clinical Commissioning Group by the agreed due date. It is intended that each of these reports is approved at the next OGC on 29th January 2018. The relevant CCGs are aware of the planned dates for submission.

Any delay in providing a final report is escalated to the relevant Divisional Management team, for the identification of 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 December OGC meeting, the status was reported as:

	Apr-17	May-17	June-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec - 17
Outstanding Action Plans	8	9	17	21	22	15	19	19	30
Outstanding Actions	15	13	33	49	44	29	44	31	49

The Risk Management team continues to provide reminders and support to assist in the completion and closure of actions and the Heads of Nursing and Divisional governance leads are notified of the responsible managers who require support to complete their actions .

The review of outstanding actions is now included in the Divisional Operational Performance review.

Nursing Quality Indicators Exception Report

Helen Blanchard

Areas of focus
The Nursing Quality Indicators chart is attached as Appendix A.
Six wards has flagged this month as having nursing quality indicators of note (below).

Midford Ward (Older Persons
This is the second consecutive month that this ward has flagged.

Quality matrices to note are:
- % FFT recommended 80%
- FFT response rate 22%
- One case of Hospital acquired Clostridium Difficile
- HCA sickness 12%
- RN appraisals 76.9%
- RN hours % day and night fill rate <90.0%

An interim Band 7 Senior Sister has been deployed from another medical ward to start on 22 January 2018 as there is a Senior Sister vacancy.
A Clinical Development Sister has been supporting the senior nursing team and will remain until the new Senior Sister has settled into post. The Matron is closely supporting the ward with regular staff meetings and working clinically when able.
RN appraisal completion has improved this month and there is a plan in place to continue to improve the percentage of completion.
RN sickness levels have greatly improved since last month and are now down to 2.7%, however HCA sickness has increased from 8.4% last month to 12% this month. Sickness is being closely managed by the Acting Sister and Matron as per Trust Policy.
Rolling Older Persons Unit adverts are out for RNs and HCAs and two HCAs have been appointed this month. Two ward Therapists (Band 5) will also commence on 22 January 2018.

Midford Ward (Older persons) cont:
A initial Root Cause Analysis (RCA) investigation has been undertaken regarding the case of Clostridium Difficile and appropriate actions will be taken.

The Matron is taking all the necessary actions as identified within the quality indicators Escalation Framework.

Medical Assessment Unit (MAU)
This ward has now flagged on 4 occasions within the previous 5 months.

Quality matrices to note are:
- FFT response rate 13%
- Six falls (4 no harm and 2 minor harm)
- RN sickness 5.6%
- RN appraisals 79.1%
- HCA appraisals 73.9%
- RN hours % day and night fill rate <90.0%

The Matron is supporting the Senior Sister to improve performance with FFT response rates as this has slipped again this month. An administration manager is now working with MAU reception staff to improve performance.

HCA sickness has improved since last month, however RN sickness has increased. Sickness is being proactively managed to Policy and with HR and Matron support where required.

The Senior Sister has been undertaking RN appraisals and there have been signs of a slight increase in the appraisal rates for the last 2 consecutive months. The Senior Sister will continue to undertake appraisals to improve this performance.

Nursing Quality Indicators Exception Report — Helen Blanchard

Combe ward (Older Persons)
This is the second time this ward flagged, the previous occasion being September 2017.

Quality matrices to note are:
- % FFT recommended 80%
- Six falls, all resulting in no harm
- RN sickness 12%
- HCA sickness 5.7%
- RN appraisals 62.5%
- HCA appraisals 71.4%
- RN hours % day and night fill rate <90.0%

The Senior Sister had an appraisal improvement trajectory in place however due to senior staff sickness appraisals have had to rebooked. The Matron will review the appraisal rates to date (data month lag) and provide more support where required.

Sickness is being closely managed as per Policy with support from HR and Occupational Health as required.

To address the shortfall of RN hours, additional HCA hours are provided to ensure there are sufficient staffing levels. The Charge Nurse also worked clinically as and when required.

The Matron is closely supporting the ward with regular staff meetings and working clinically when able. The Matron is also taking the actions as identified within the nursing quality indicators Escalation Framework.

Haygarth ward (Gastroenterology medical)
This is the first time this ward has flagged since February 2017.

Quality matrices to note are:
- % FFT response rate 32%
- One case of hospital acquired Clostridium Difficile
- Eight falls (6 no harm, 2 minor harm)
- HCA sickness 15.6%
- HCA % day fill rate < 90%
- RN hours % day and night fill rate <90.0%

Presently this ward has 6.0 wte Band 5 vacancies and the Senior Sister is proactively trying to recruit. This vacancy factor in conjunction with high HCA sickness has impacted on staffing levels. The Senior Sister has been supporting the ward by working clinically and other staff have been deployed from other wards to ensure safe staffing levels.

There have also been three members of staff on long term sickness, two of which have now returned to work on a phased return. HR and Occupational health have been supporting staff sickness which is being managed as per Trust Policy. The Matron has been supporting the Senior Sister with staff sickness meetings and is confident that this is being well managed.

Staff sickness also impacted on the FFT responses, however performance should improve next month as relevant staff are returning to work.

The Recruitment and Retention Nurse is actively working with the Senior Sister to attract new staff into post, meanwhile temporary staff are being deployed, for example Pool nurses.

Nursing Quality Indicators Exception Report

Helen Blanchard

William Budd ward (Oncology)

This is the first time this ward has flagged for six months since July 2017.
Quality matrices to note are:

- % FFT response rate 33%
- Five falls (3 no harm and 2 minor harm)
- RN sickness 9.1%
- HCA sickness 9.7%
- RN hours % day and night fill rate <90.0%

The Senior Sister is reviewing the process for collecting FFT responses and will put actions into place to improve the response rate.

There are staff with long term sicknesses which are being closely managed with support from HR and Occupational Health and via Trust Policy. The Matron is supporting the Senior Sister with this and all of these staff have management plans in place.

Recruitment is being managed proactively and includes recruitment campaigns to attract new staff. Where the RN fill hours are below planned the ward has increased HCA hours fill rates so that staffing numbers are sufficient.

The Matron has been reviewing the ward's staffing levels since a Peer review last year and the acting Director of Nursing and Midwifery and Head of Nursing are in the process of reviewing the ward's staffing levels.

Cardiac ward

This is the first time this ward has flagged since May 2017.

Quality matrices to note are:

- One nursing related complaint
- Seven falls (6 no harm, 1 minor harm)
- RN sickness 8.5%
- HCA sickness 12.9%
- RN hours % day and night fill rate <90.0%

The nursing related complaint is being managed by the Matron and is primarily around poor communication.

Staff sickness is being well managed and whilst there has been high long term sickness, these staff are now starting to returning to work. There are also four members of staff on maternity leave.

The Senior Sister has been supporting the ward by working clinically as required and additional HCA hours have been provided, particularly at night for those patients who need enhanced observation.

Nursing Quality Indicators Exception Report

Helen Blanchard

To note:
Waterhouse and Pulteney wards flagged last month but their quality indicators have improved this month. The wards will continue to be closely monitored and supported to maintain/improve performance as per the new nursing quality indicators Escalation Framework.

Other Quality Indicators of note:
Falls: the number of Falls is consistent again this month.

Clostridium Difficile: There were 2 cases this month. Initial RCA investigations are being undertaken and actions taken.

Nurse staffing: Nurse staffing remains a challenge with RN vacancies and high sickness in some areas this month. The Duty Matrons and Heads of Nursing review staffing on a daily and shift by shift basis as per Nurse Staffing escalation Policy to maintain safe staffing.
An International Recruitment Campaign is on track to recruit nurses from March 2018 and a Project group is in place to manage the campaign.

Emergency Department Safety

The Emergency Department (ED) has recently received assurance visits from the CCG with regard to current ED performance and the subsequent potential impact on patient safety.
These visits were centred around five themes, as below:

1. Managing capacity and demand
2. Preventing patient harm
3. Getting staffing right
4. Patient experience
5. Staff experience

A report has been received following the first visit on 1st January 2018 from the Director of Nursing BaNES CCG. Overall this report demonstrated assurance that the ED was well led and safety was being maintained. It was also noted that staff and patients gave positive feedback during the visit. Areas for improvement are noted below:

- Consider “fit to sit” in the majors area of ED and whether patients can be dressed in their own clothes once the initial clinical examination has been undertaken.

- To ensure that sufficient heating and blankets are provided for patients who are waiting outside of the cubicles.

- To improve the medical management of patients, in particular those patients who are waiting for discharge following review by the specialist inpatient teams.

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 % Recomd	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 Report	Safer Staffing % Fill rate				Number of times parameters outside of KPI metrics						
															Sickness %		Appraisal %			Day		Night								
					Positive	Negative		No Harm	Minor Harm	Mod Harm	Major Harm	Cat: 2	Cat: 3	Cat: 4	RN/RM	HCA	RN/RM	HCA		Reg Nurses/ Midwives	Care Staff	Reg Nurses/ Midwives	Care Staff	Dec 17 No:	Nov 17 No:	Oct 17 No:	Sep 17 No:	Aug 17 No:	Jul 17 No:	Total
Emergency Dept	A&E	99%	11%	2	6	10		1	3	0	0				0.0	3.0	85.7	76.2		N/A	N/A	N/A	N/A	2	3	3	4	1	2	15
	SAU	100%	15%					2	1	0	0				1.1	5.4	75.0	73.3		89.2%	119.9%	86.8%	119.7%	5	4	5	7	5	4	30
	MAU	89%	13%		1			3	1	0	0				5.6	2.1	79.1	73.9		82.6%	95.7%	84.7%	143.1%	6	6	2	7	6	4	31
Inpatient Wards	Charlotte	97%	38%		1	2		4	1	1	1				0.0	0.5	93.3	100.0	1	96.7%	98.6%	99.9%	125.8%	1	0	0	1	3	3	8
	Helena	100%	84%			1		5	2	0	0				0.0	8.6	88.2	100.0	1	102.1%	107.1%	91.4%	182.1%	2	0	1	2	3	5	13
	Forrester Brown	91%	26%					4	0	0	0				2.3	4.6	88.9	100.0	1	94.0%	106.4%	83.6%	112.1%	2	1	3	3	3	3	15
	Surgical Short Stay Unit	100%	17%			1		0	0	0	0				0.0	8.1	92.0	84.6	0	103.3%	156.6%	95.3%	188.0%	2	1	3	4	1	2	13
	Cheselden	100%	59%			1		1	1	0	0				4.6	7.1	100.0	100.0	0	110.9%	73.6%	99.9%	107.4%	2	3	2	1	1	1	10
	Critical Care Services	N/A	N/A					0	0	0	0				0.0	0.0	90.6	100.0	0	85.3%	142.1%	90.2%	51.6%	2	5	3	2	4	5	21
	Violet Prince (RNHRD)	96%	55%					1	1	0	0				0.0	20.3	92.9	85.7	0	89.8%	67.6%	100.0%	96.8%	3	2	3	2	2	2	14
	CCU	100%	38%			1		1	0	0	0				1.2	6.6	93.8	100.0	0	75.7%	65.6%	99.8%	94.8%	3	4	4	5	5	4	25
	Parry	93%	24%		1	1		4	0	0	0				0.5	0.7	100.0	100.0	0	82.1%	104.2%	71.9%	152.6%	3	4	5	4	4	5	25
	Respiratory	95%	37%					2	2	0	0				0.0	5.1	84.2	87.5	1	68.9%	144.3%	81.1%	118.1%	3	4	5	5	3	4	24
	Phillip Yeoman	96%	60%		1			0	0	0	0				1.5	2.6	92.9	92.3	1	84.2%	63.5%	71.4%	67.3%	4	3	4	3	6	7	27
	Medical Short Stay Unit	92%	17%			6		0	0	0	0				0.0	14.8	100.0	70.0	0	73.4%	105.7%	112.4%	181.3%	4	4	5	4	4	2	23
	Acute Stroke Unit	100%	15%			1		6	0	0	0				2.2	6.1	82.4	82.4	2	73.5%	91.5%	111.6%	91.1%	4	4	6	4	4	4	26
	Pulteney	98%	44%			1		2	0	0	0				2.6	11.4	72.7	65.0	6	79.5%	93.0%	91.7%	123.5%	4	6	3	5	3	7	28
	ACE OPU	100%	11%					3	4	0	0				1.7	4.4	80.0	64.7	1	71.6%	105.8%	92.5%	118.7%	5	2	4	4	5	3	23
	Children's Ward	98%	9%			1		0	0	0	0				0.4	0.0	79.5	90.0	6	84.0%	50.7%	89.4%	116.5%	5	2	4	5	4	4	24
	NICU	100%	8%					0	0	0	0				13.0	1.3	88.4	78.6	0	90.6%	92.5%	84.9%	87.1%	5	3	5	7	4	4	28
	Pierce	90%	39%					3	1	0	0	1			0.0	7.7	73.3	73.3	2	89.6%	127.4%	91.4%	175.8%	5	4	4	2	7	3	25
	Mary Ward	100%	26%	1				1	0	0	0				25.4	6.4	82.4	80.0	1	97.8%	78.4%	98.3%	94.6%	5	4	4	5	5	5	28
	Robin Smith	94%	24%					1	1	0	0				1.3	7.4	66.7	81.3	1	88.1%	102.3%	88.3%	115.3%	5	5	5	6	2	3	26
	Waterhouse	100%	52%			3		5	2	0	0				1.9	9.0	66.7	86.7	2	64.9%	104.6%	63.4%	117.8%	5	6	7	7	4	2	31
	William Budd	100%	33%			2		3	2	0	0				9.1	9.7	100.0	100.0	3	86.6%	147.4%	80.2%	165.1%	6	2	3	5	5	7	28
	Cardiac	98%	40%	1		1		6	1	0	0				8.5	12.9	86.4	84.6	0	85.7%	98.6%	77.3%	151.6%	6	4	3	2	3	4	22
	Haygarth	97%	32%		1	5	1	6	2	0	0				0.0	15.6	81.8	94.1	5	75.7%	87.6%	67.9%	128.3%	7	3	5	3	3	4	25
	Combe	80%	39%					6	0	0	0				12.0	5.7	62.5	71.4	4	78.2%	118.5%	75.1%	207.2%	8	4	5	6	5	4	32
	Midford	80%	22%			1	1	1	1	0	0				2.7	12.0	76.9	77.8	5	57.2%	113.9%	75.3%	134.1%	8	7	5	5	4	5	34
* FFT data taken from Maternity FFT touchpoint 2- Post natal Ward		80% or less	< 35% (< 15% ED, MAU & SAU)	Nursing / Midwifery related	Neg N/M related only		C. Diff (per patient)	5 Falls or more or a major harm				Harms any PUs			5% or more		80% or less			< 90%				More than 5						

A&E	ED Nursing
SAU	SAU
MAU	MAU

Acute Stroke Unit	Acute Stroke Unit
NICU	Newborn Intensive C U
Pulteney	Pulteney Ward
Medical Short Stay Unit	Med Short Stay
Cheselden	Cheselden Ward
Robin Smith	Robin Smith Ward
CCU	Coronary Care Unit
Helena	Helena Ward
Phillip Yeoman	P.Yeoman/Recovery
Surgical Short Stay Unit	Short Stay Surgical Ward
Children	Paediatric Inpats & Outpats (Pay Only)
ACE OPU	ACE OPU
Cardiac	Cardiology Ward
Parry	Parry Ward
Forrester Brown A	Forrester Brown
Haygarth	Haygarth Ward
Charlotte	Charlotte Ward
Waterhouse	Waterhouse Ward
Combe	Combe Ward (3)
Midford	Midford Ward (9)
Respiratory	Respiratory Unit
William Budd	W Budd Cancer Unit
ITU	Critical Care Unit
Mary Ward *	PAW Mary Ward
Violet Prince (RNHRD)	Rheumatology Inpats