Royal United Hospitals Bath
NHS Foundation Trust

Report to:	**Public Board of Directors**	**Agenda item:**	**7**
Date of Meeting:	**25 July 2018**		
Title of Report:	**Quality Report**		
Status:	**For discussion**		
Board Sponsor:	**Lisa Cheek, Acting Director of Nursing and Midwifery** **Bernie Marden, Medical Director**		
Author:	**Lisa Cheek, Acting 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 November 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:
  - Clostridium difficile
  - Acute Kidney Injury (AKI)
  - National Early Warning Score (NEWS)
  - Sepsis Inc. Anti-Microbial Resistance
- Exception reports:
  - Serious Incidents (SI) monthly summary and Overdue SI Report summary
  - Nursing Quality Indicators Exception report

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)

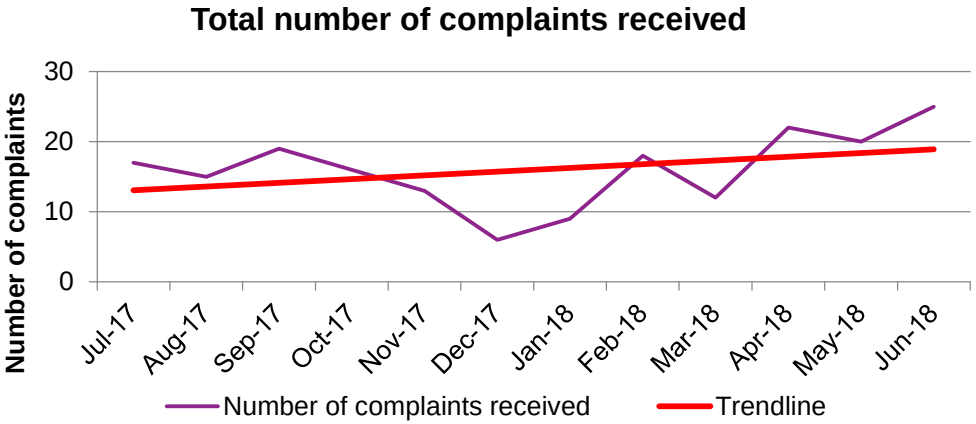
Delivery of the priorities is dependent on the continuation of the agreed resources for each project.

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

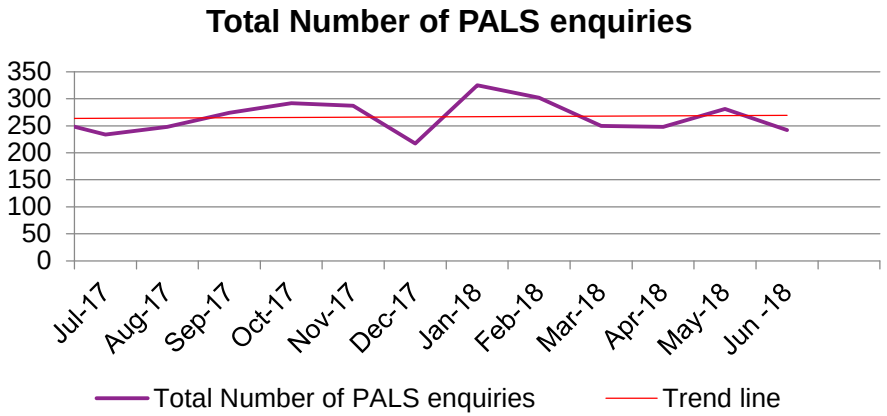


There were **25** formal complaints in June. **8** were for the Surgical Division; **15** for the Medical Division; **1** was for Women & Children and **1** for corporate services.

20 complaints cited Clinical Care and Concerns; **3** were poor communication, **1** was admission issues and **1** was Staff Attitude and Behaviour.

Complaint response rate by Division	**Division**			**Total**
	Surgery	W&C	Medicine	
Closed within 35 day target	2(33%)	0	4 (40%)	6 (37.5%)
Breached 35 Day target	4 (66%)	0	6 (60%)	10 (62.5%)
Total	6	0	10	16

Reasons for Breaches: **2** meetings scheduled outside target, **3** delays in responses for requested information, **2** further information requested by the Directors Office i.e. details regarding a procedure or explanation regarding a decision. **3** were delayed due to patients requests i.e. family member not available for meeting until a date outside of target, patient requesting a change from letter to meeting close to the response due date



There were **242 contacts** (including parking queries) **with PALS** in June 2018:

- 122 required resolution (50%)
- 95 requested information or advice (39%)
- 15 were compliments (6%)
- 10 provided feedback (5%)

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

Advice and Communication - there were **34** contacts relating to advice and communication. **16** of these were general communication enquiries; **9** related to telephones not being answered. There was no clear trend with the remaining contacts.

Appointments - there were **28** contacts. **8** of these were queries relating to new appointments, **5** relating to follow up appointments. There was no clear trend for the remaining contacts.

Clinical Care and Concerns – there were **14** contacts. **12** relating to clinical care, **1** relating to communication, **1** relating to quality of nursing care.

QUALITY REPORT

PART B – Patient Safety and Quality Improvement

Executive Sponsors

(1) Lisa Cheek, Acting Director of Nursing and Midwifery
(2) Bernie Marden, Medical Director
(3) Francesca Thompson, Chief Operating Officer

5
Patient Safety Priorities

Falls (1)
Clostridium difficile (1)
Acute Kidney Injury (AKI) (2)
National Early Warning Score (NEWS)(2)
Sepsis Inc. Anti- Microbial Resistance (2)

4
Executive sponsored projects:

Pressure Ulcers (1)
National Safety Standards for Invasive Procedures (NatSSIPs) (2)
Emergency Department Safety (3)
Improving Insulin Safety (3)

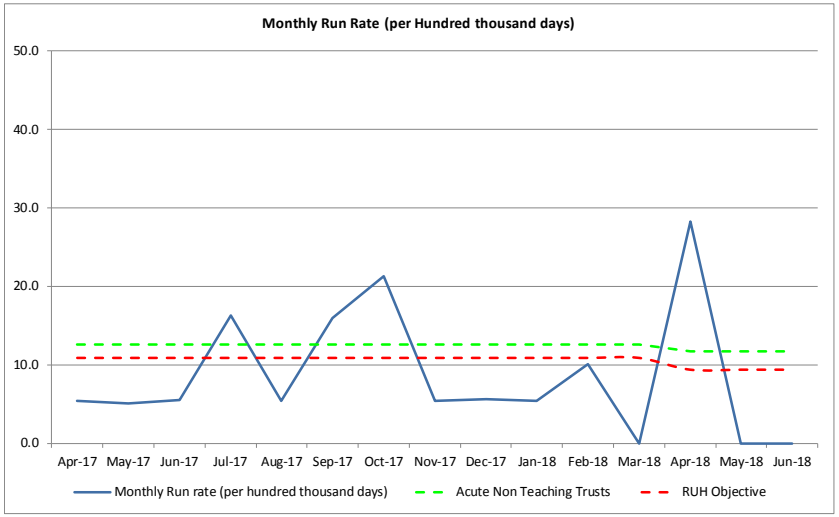
Patient Safety – Clostridium Difficile

Lisa Cheek

Background

The RUH target for 'Trust apportioned' *Clostridium difficile* in 2018/19 is 21 cases. At the end of Q1 there had been 5 cases, 3 of which have been submitted for appeal as there were no lapses of care identified.

Current Performance



All 5 cases occurred during April 2018; there were no Trust apportioned cases during May and June.
The 2 cases that have not been submitted for appeal were both on the same surgical ward. Lapses of care were identified including delay in isolation, lack of documentation on the stool charts, dirty commodes, low completion rates of the C diff Workbook and concerns regarding antimicrobial stewardship. The RCAs will be shared at the Surgical Governance meeting. Both isolates were sent for typing; the ribotypes were not the same.

NHSi Infection Prevention and Control Improvement Plan

An improvement plan was developed following the NHSi visit in January 2018, ongoing actions include:

Revision of the *Clostridium difficile* RCA template to include more background information and additional training compliance.

Implementation of a deep clean programme and 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

Investigate methods of enhanced cleaning: hydrogen peroxide vapour and ultra violet light. Visits to other sites planned.

Implementation of the Spring Clean Action Team involving Infection Prevention and Control, Estates and Quality Improvement staff.

90% of clinical staff to have received Infection Prevention and Control training in the last 2 years (currently at 86%)

Infection Prevention and Control Team under taking audits of equipment cleanliness which will be reported on the weekly HCAI report.

Patient Safety – Acute Kidney Injury (AKI)

Bernie Marden

Awareness and Training

- Training continues on core skills - see fig 1 for a breakdown by ward
- An application to make AKI/Sepsis training essential for role has been submitted so that it becomes part of induction requirements
- Work continues on AKI e-learning with the aim to be available by September
- A deteriorating patient campaign was held in April 2018 , which linked AKI to Sepsis and NEWS and the new fluid balance chart was launched

AKI Bundle compliance

- Trust wide data continues to be collected from 20 random patient notes per month (see run charts fig 2.0-2.4 on next page). This is difficult to get adequate sample size each month and an electronic method is being investigated.
- Focused work on inpatient acquired AKI within each speciality is commenced in Trauma and Orthopaedics, General Surgery, Maternity and Paediatrics.

Discharge Summary Information

- Trust wide data from the same patients as above is collated monthly (see run charts Fig 3.0 - 3.2), which is again difficult to sustain. The electronic alert in the discharge summary is still waiting for the Depart process to go live.

Improvement work

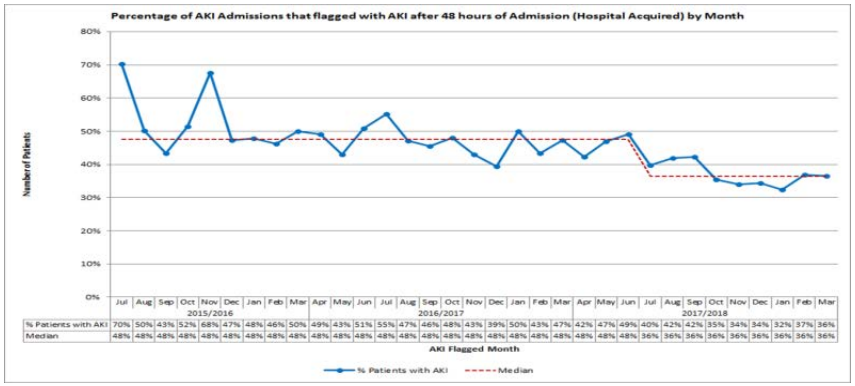
- Medication review: EPMA has been updated so that pharmacists patient list now includes AKI grade so that reviews can be prioritised.
- Fluid balance Chart : An amended fluid balance chart has been launched trust wide and work continues to embed and further improve the chart

Sharing and success

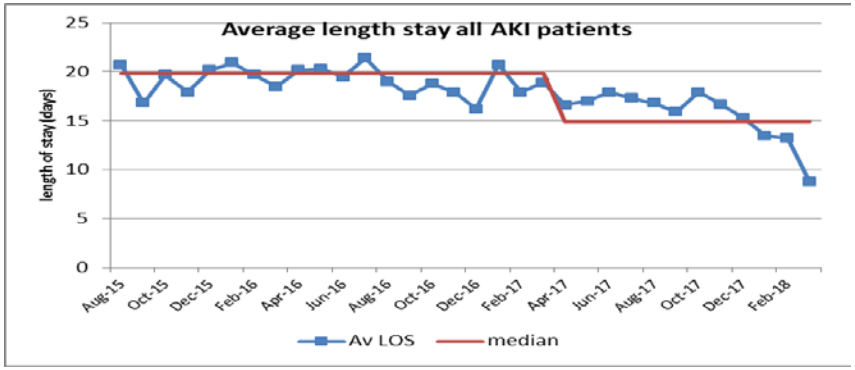
The work on AKI at the RUH was acknowledged regionally in June 2018, being selected from 48 projects across the South West to be presented at the AHSE Quality & Safety Conference in Taunton.

Outcome data

Since July 2017, following work on increasing awareness, implementing the amended hydration chart and contrast sticker, there has been a 25% reduction in the incidence AKI acquired during inpatient admission, with incidence decreasing from 48% to 36%



Length of stay for all patients with an AKI has also significantly decreased by a median of 5 days



Patient Safety – Acute Kidney Injury (AKI)

Bernie Marden

Fig 1. staff trained by inpatient ward or dept.

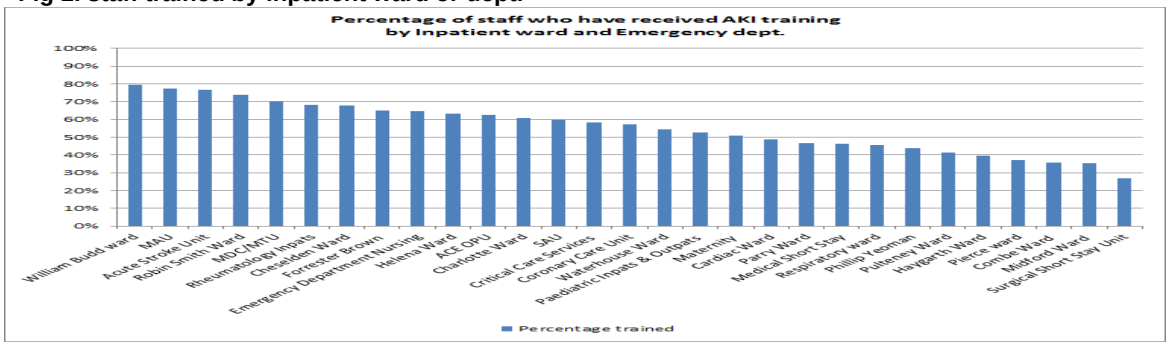
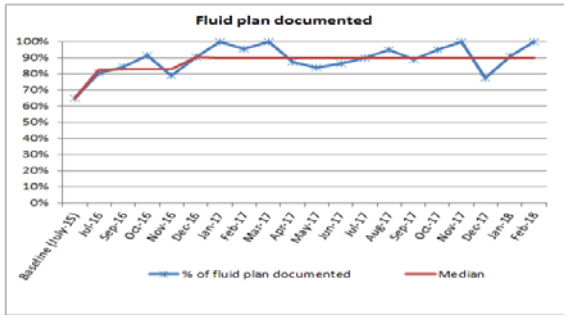
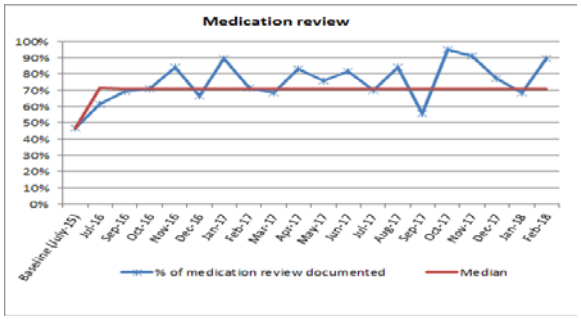
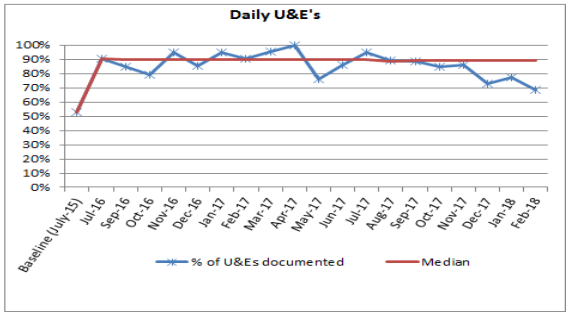


Fig 2.0-2.4 Bundle compliance audits based on 18—25 patients per month







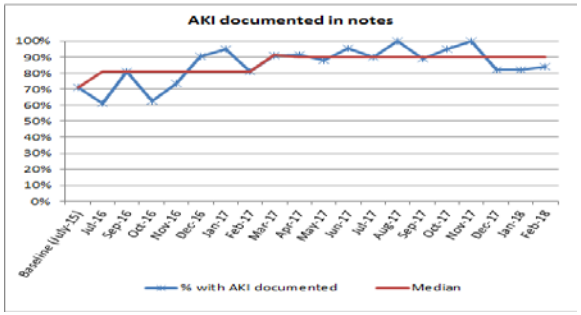
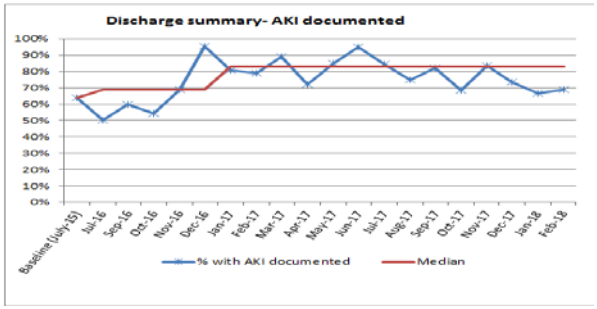
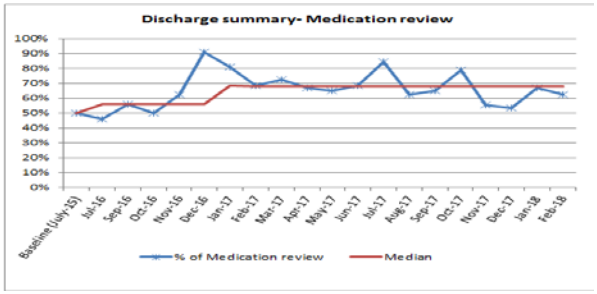
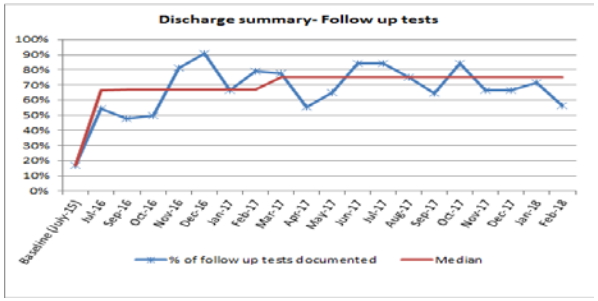


Fig 3.0- 3.2 Discharge summary compliance Audits based on 18—25 patients per month







Patient Safety – NEWS

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:

- A Deteriorating Patient campaign took place April 2018, as key part of this was tea trolley training to provide key messages around NEWS, Sepsis, fluid balance and escalation of the deteriorating patient. The training was delivered to 148 members of staff in 23 areas.

- Development of an eLearning package for NEWS has commenced during July and in August development of the storyboard and photoshoot is taking place with testing of the eLearning to take place in September. Aiming for launch by October.

- The development of a paper chart for NEWS 2 has commenced . NEWS 2 has some key changes: included in the NEWS 2 tool is a new parameter of assessment for new confusion and two scoring systems for oxygen saturation levels. Scale 1 is the usual scale for patients with normal oxygen saturation (the majority of patients) and scale 2 is a dedicated oxygen saturations scoring system for patients with hypercapnic respiratory failure whose desired oxygen saturations are set at a lower level (88 -92%) with the NEWS system adjusted accordingly. The aim is to have a draft of the NEWS2 chart for testing August 2018 with a programme of training and awareness and launch by October 2018.

- On 25 June a NEWS prevalence took place in all adult inpatient areas. The last NEWS was reviewed looking at the score of the last NEWS , accuracy of the score, whether it was a score of 5 or over and if it was over 5 whether it had been escalated.
- Results of the prevalence are as follows:
- There were 527 patients:
    - 98% had a NEWS recorded (7 N/A)
    - 93% had an accurate NEWS
    - 2.5% had a NEWS of 5 or more
    - 67% of NEWS that were 5 or above were escalated

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

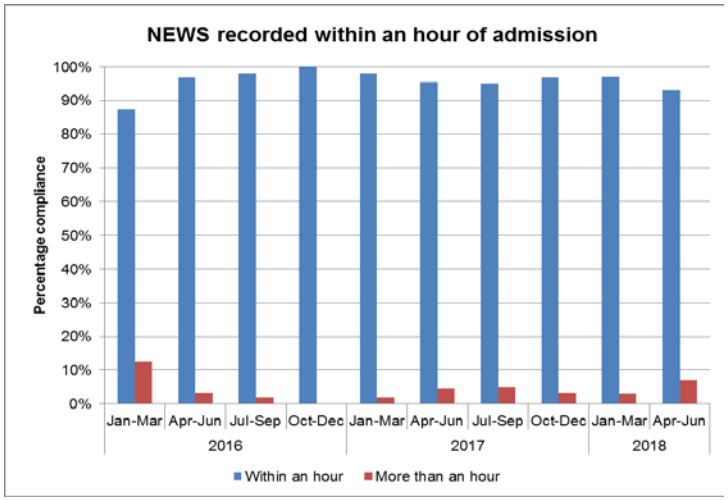


Figure 1

Patient Safety – NEWS

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.

Next steps:

- Areas where compliance is below 80% have been contacted to offer support and further training. Data is also shared on the Divisional scorecard
- The NEWS work stream will support and help drive the project for an electronic observation system timescales for which are currently being agreed .

NEWS accuracy	2018												
Ward	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
ACE OPU	86%	83%	95%	80%	81%	77%	85%	92%	96%	91%	98%	90%	81%
ASU	95%	95%	87%	93%	90%	88%	92%	93%	91%	98%	85%	96%	87%
Cardiac	90%	94%	84%	100%	94%	96%	96%	84%	81%	85%	88%	89%	96%
CCU	91%	96%	82%	94%	66%	89%	95%	97%	83%	89%	76%	97%	80%
Charlotte	100%	100%	96%	96%	92%	95%	92%	96%	100%	96%	96%	100%	96%
Cheselden	94%	100%	96%	100%	92%	100%	96%	100%	100%	96%	92%	96%	96%
Combe	94%	93%	87%	89%	85%	92%	83%	81%	83%	82%	96%	92%	89%
ED Obs	97%	81%	90%	95%	85%	100%	100%	100%	93%	88%	92%	96%	96%
Forrester Brown A	93%	92%	90%	82%	85%	90%	98%	81%	95%	72%	86%	92%	88%
Haygarth	92%	100%	94%	95%	88%	100%	100%	94%	94%	94%	98%	96%	90%
Helena	94%	98%	90%	96%	96%	100%	100%	96%	100%	95%	96%	100%	96%
MAU	96%	86%	90%	87%	84%	92%	91%	98%	90%	88%	96%	87%	96%
Midford	90%	92%	86%	90%	91%	71%	72%	96%	80%	88%	90%	94%	93%
MSSU	86%	91%	95%	94%	100%	77%	91%	100%	94%	95%	85%	86%	95%
Parry	90%	89%	85%	92%	94%	100%	100%	96%	96%	84%	96%	92%	100%
Philip Yeoman	81%	89%	88%	90%	76%	74%	94%	92%	82%	88%	91%	96%	89%
Pierce	83%	98%	94%	88%	81%	91%	83%	90%	96%	94%	82%	94%	88%
Pulteney (previously Wat	86%	88%	88%	96%	92%	100%	100%	94%	83%	92%	92%	95%	88%
Respiratory	96%	92%	88%	92%	96%	92%	92%	91%	90%	94%	86%	94%	86%
Robin Smith	91%	100%	92%	80%	94%	92%	83%	96%	100%	93%	98%	91%	90%
SAU	96%	92%	94%	94%	100%	100%	96%	100%	96%	100%	100%	100%	100%
SSSU	100%	100%	92%	89%	100%	84%	85%	91%	90%	96%	100%	96%	89%
Violet Prince	83%	97%	94%	92%	97%	100%	63%	90%	100%	98%	96%	83%	87%
Waterhouse	90%	92%	85%	94%	93%	98%	70%	90%	93%	88%	83%	94%	93%
William Budd	90%	90%	96%	84%	96%	94%	92%	88%	92%	90%	85%	81%	95%
Grand Total	**91%**	**93%**	**90%**	**91%**	**90%**	**91%**	**89%**	**92%**	**92%**	**91%**	**91%**	**93%**	**91%**

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

Table 1

Patient Safety – Sepsis inc AMR

Bernie Marden

CQUIN for Sepsis

- Targets for Sepsis Screening and Antibiotics are both 90% and trust wide.
- Q4 received partial payment for screening (79%) and full payment for antibiotics.(90% patients received antibiotics within 60 minutes of sepsis diagnosis)
- Targets continue to be 90% in 2018/19 which will be difficult to achieve but also recent changes to Q4 2018/19 now require screening to be performed using NEWS 2 or no payment will be received.

Sepsis on admission (see run charts fig 1)

- Median compliance with Sepsis screening on admission is 85% for adults and paediatric admissions, both showing improvements to over 90% in April and May
- Since implementation of First net in November, it has been difficult and time consuming to obtain the same sample as previously. In agreement with quality board, the team will obtain a sample of 20 per month, and concentrate on data from April onwards to get recent compliance It is however still difficult to identify the patients. Solutions have been identified to increase ease of identification – these require simple IT additions to first net and priority of data retrieval from BIU.
- Compliance with antibiotics in an hour from signs of sepsis for adults in April was 68% and 60% in May.
- Median time to receiving antibiotics in April and May was 55 minutes, but significant variation still exists, the range of times being 10 - 200 minutes.
- The medical lead for sepsis is continuing to test improvements. The main reasons identified for delay was time to medical review, as well as occasional delay in delivery following prescription. Many of these were related to exceptionally busy times in ED
- For Antibiotics timings in children there are only small numbers identified and current data is awaited. The commonest delay identified was difficulty in intravenous access, and, in consultation with Bristol Children's hospital, it has been agreed that, in this situation, an intramuscular dose can be administered while IV access is being obtained.

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

- Screening for inpatients remains from random note reviews trust wide and has been difficult to maintain due to manual recording of screening – median remains at 70% for adults. Electronic recording of observations is required to improve this

Management of Inpatients with sepsis

Inpatients with sepsis are identified from screening, outreach or sepsis nurse referrals and numbers range from 15-25 per month. In January and February less patients were identified due to capacity in the sepsis team and the exceptional acuity on the wards which required the sepsis team to support routine care. Due to small numbers the percentage with antibiotics in an hour decreased. Reasons for delay were difficulty with access or delayed screening and review, but once identified treatment was prompt.

- Median time to antibiotics for January to March was 40 minutes from signs of sepsis.
- Small numbers of paediatric inpatients are identified with sepsis , 5 being identified since January. All of whom received antibiotic within 60 minutes from signs.
- In maternity progress continues to be excellent : median of 85% mothers receiving antibiotics in 60 minutes from signs of sepsis

Awareness and training

- 2235 of staff have received the training.
- AKI/Sepsis training has been submitted for 'essential for role 'approval and will then be included in induction and appear on staff star records
- Sepsis e-learning development is in progress with a target date of August 2018
- Plans are in place to celebrate world sepsis day in September
- The team won best poster in the "Improvement in patient outcomes ' of the South West Quality Improvement conference in June for the work on improvement in inpatient sepsis screening and management .

Issues

- There have been significant improvements in inpatient management of sepsis but this is difficult to sustain and Implementation of electronic recording of observations is essential for further improvement
- The need to implement NEWS 2 for screening due to the new CQUIN requirement and national patient safety alert.
- If electronic observations are not implemented, a new paper chart for NEWS2 is needed with new nurse training. The concerns are that this will lead to a deterioration in accuracy of NEWS over a significant period of time while this is being embedded .

Patient Safety – Sepsis inc AMR

Bernie Marden

Fig 1.1 Emergency Adult sepsis screening
- 50 patients per month

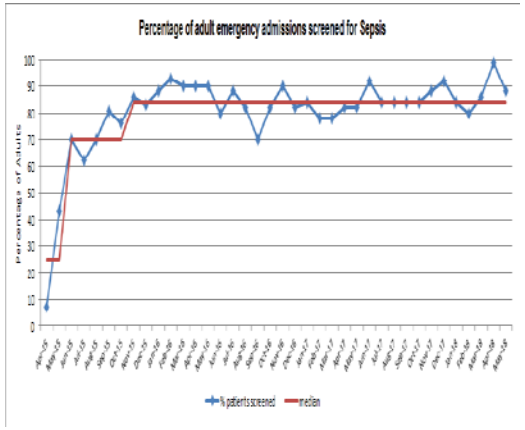


Fig 2.1. Inpatient adult screening-
between 80-100/month

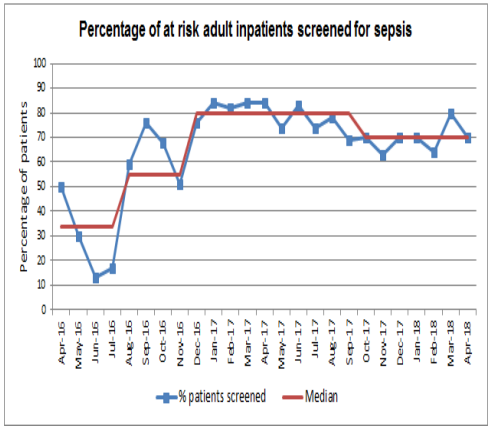
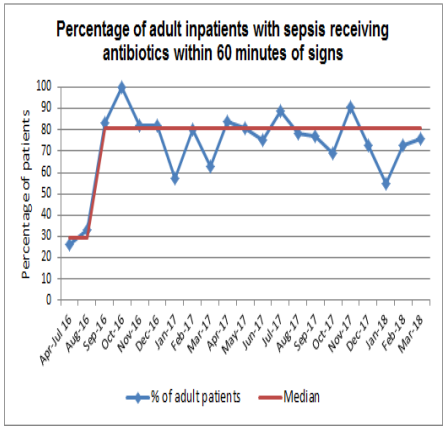


Fig 3.1: Inpatient Adult patients antibiotics in an hour



Since 2016 when work on introducing sepsis screening and NICE guidelines commenced , mortality rates from suspicion of sepsis codes has decreases as shown in figure 4 below

Fig 1.2 Emergency paeds sepsis screening
- 20 patients per month

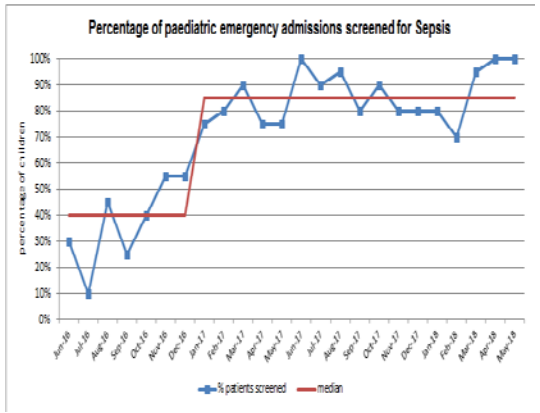


Fig 2.2: Inpatient paeds screening
– between 15-20/month

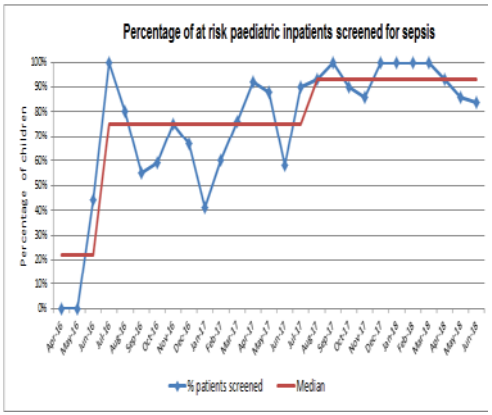


Fig 3.2: Maternity patients
- antibiotics in an hour

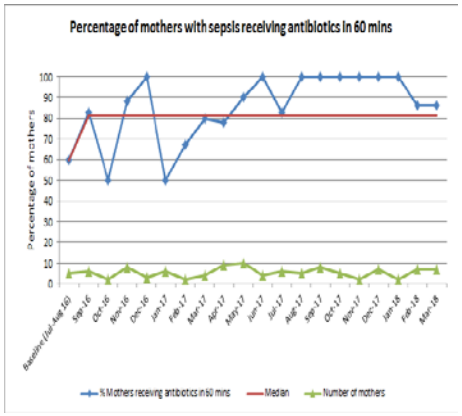
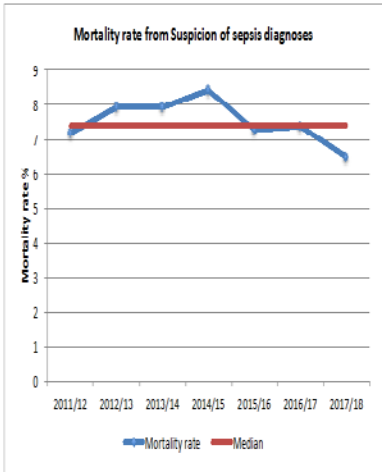


Fig 4. Mortality rates from 'Suspicion of sepsis infective codes



Serious Incidents (SI) Summary

Lisa Cheek

Current Performance

During June 2018 Two Serious Incidents were identified and reported to the CCG via STEIS. These comprised of a fall.

Serious Incidents Reported to STEIS April 2017 to May 2018													
May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18
4	3	3	7	0	5	6	6	10	5	0	3	13	2

Date of Incident	ID	Summary
09/06/2018	62634	Fall with fracture
27/06/2018	62775	Pressure ulcer

Overdue Serious Incident Report

Lisa Cheek

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

As of 11th July 2018, there are 32 Serious Incidents that remain open. Of these, 13 incident reports are overdue for submission to the Clinical Commissioning Group by the agreed due date. The Head of Risk and Assurance has been in contact with the investigators regarding submission dates and regular progress update meetings are in place with the CCG's.

Extraordinary OGC meetings have been arranged to review the outstanding serious incidents with an aim to have zero outstanding reports by September.

Delays 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 June OGC meeting, the status was reported as:

	June 17	July 17	Aug 17	Sept 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18	Apr 18	May 18	Jun 18
Outstanding Action Plans	17	21	22	15	19	19	30	23	28	32	25	19	14
Outstanding Actions	33	49	44	29	44	31	49	43	34	54	42	46	22

The Divisional leads have been pro-active in supporting staff to manage the action plans generated from SI investigations. Matrons meet on a weekly basis to review action plans and update progress accordingly. This support has demonstrated effective results by reducing the numbers of outstanding actions to 22 for the month of June. Risk Management team continues to provide support to assist in the completion and closure of actions and Serious Incident investigations.

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

Nursing Quality Indicators Exception Report Lisa Cheek

Areas of Focus
The Nursing Quality Indicators chart is attached as Appendix A.
Five areas have flagged this month as having nursing quality indicators of note.

Medical Assessment Unit (Acute Medicine)

This ward flagged in May 2018.
Quality matrices to note are:

- 1 Negative PALS contact
- Falls - no harm 3, minor harm 2
- HCA sickness 10.2%
- HCA appraisals 71.4%
- RN hours % night/day fill rate <85%

One PALS negative contact was received - the Matron for MAU has discussed this with the patient and their relatives and the issue was resolved.

All sickness is being rigorously managed in line with Trust policy. There are two members of staff who are currently on long term sick leave but there had been a 3% decrease in sickness compared to last month.

All achievable outstanding appraisals have a date for completion but this has been delayed due to senior nursing staff being on sick leave.

Vacancies are being actively recruited and MAU will be welcoming staff from the overseas recruitment with the first nurse starting in August. 3 new staff are due to start in the next 2 months. Staffing is reviewed twice daily by the MAU coordinator and Matron for MAU.

Midford ward (Older Peoples)

This ward last flagged 5 months ago in January 2018.
Quality matrices to note are:

- 2 Complaints
- Falls - no Harm 4, minor harm 2 and 1 moderate harm
- HCA sickness 6.3%
- RN sickness 6.9%
- RN hours % night/day fill rate <85%

Both complaints are under investigation.
Whilst every effort is made on Midford to prevent falls, providing consistent enhanced observation for patients at a high risk of falls can be challenging.

There were 3 staffing Datix reports this month.

Sickness is being closely managed in line with Trust Policy and with support from HR where required. Of note Midford staff appraisals are at 100%.

The vacancy level for RN is 12.55 wte. The Medical division have requested the closure of 5 beds to support the RN care hours in lieu of the vacancy and national issues with RN recruitment. Midford are proactively recruiting and have 2 RN expected to join the trust in August.

Nursing Quality Indicators Exception Report Lisa Cheek

William Budd ward (Oncology)
This ward last flagged 3 months ago in March 2018.

Quality matrices to note are:
- FFT response rate 24%
- 1 complaint received
- RN appraisals 78.60%
- HCA appraisals 71.4%
- RN hours 69.2% day and 78.2% night fill rate thus well below <85%

The poor response rate for completed FFT cards was mostly due to sickness of a few staff who usually support these being completed. The Senior Sister endeavours to monitor however this can be challenging. FFT cards have been placed in each bay to support easy access for patients and relatives. As from 16 July two Medical Nurse Practitioners will be in post and this will be shared responsibility between the MDT. 1 complaint was received but of note the ward has only had 2 complaints in 2 years.

There are a couple of appraisals not within date due to staff sickness. However for month of June it was noted that several staff have had their appraisals completed in recent months but these had not been communicated by appraiser to the appraisal email address or were not updated by HR.

Recruitment is being actively managed however challenged with the national shortage of nursing staff and on-going acuity and dependency of patients. Looking forward to overseas nurses arrival as further resignations have been received.

Cardiac ward (Acute medicine)
This ward last flagged 1 month ago in May 2018.

Quality matrices to note are:
- 1 Complaint
- HCA sickness 6.3%
- RN appraisals 63.6%
- HCA appraisals 71.4%
- RN hours % day and night fill rate <85%

Complaints are being proactively investigated and managed by the Senior Charge nurse and Matron.

Appraisals have been difficult to maintain due to short term sickness amongst the band 6's impacting on completion of appraisals. The Senior Charge nurse has a recovery plan in place to address the out of date appraisals in the next month.

The night and day fill RN fill rate is consistently lower ,this is partly to do with 4.12 wte vacancies and also due to staff then being moved from cardiac wards to support wards in greater need of RN's throughout the Trust.

There is some long term sickness with the HCA's which is being proactively managed via occupational health and human resources.

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Nursing Quality Indicators Exception Report Lisa Cheek

Critical Care services

This is the first time Critical care has flagged since reporting on the Nursing quality indicators.

The safer staffing data is based on funded establishment rather than acuity and dependency. The unit is piloting a self-sufficient staffing model which allows greater flexibility optimising the nursing resource to flex in response to varying demands.

All sickness is being rigorously managed in line with Trust policy with support from HR where required. Appraisal compliance in the HCA group is as a result of long term sickness.

Nursing Quality Indicators - Monthly Template June 2018

Ward Name	Report for May 2018 by ward/area triangulating FFT Percent Recommending; PALS; Complaints; Cdiff; Falls; Pressure Ulcers; HR, Staffing														
	Accreditation Status	FFT % Recomd:	FFT Response Rate %	Number of complaints received	Number of compliments received	Number of PALS contacts		Number of patients with Cdiff	Number of patients who fell				Number of Pressure Ulcers		
						Positive	Negative		No Harm	Minor Harm	Mod Harm	Major Harm	Cat: 2	Cat: 3	Cat: 4
SAU	Bronze	96	16%		1				0	2	0	0			
A&E	Foundation	96	8%	3	2	4			1	1	0	0			
MAU	Bronze	100	21%				1		3	2	0	0			
Charlotte	Bronze	99	37%						0	0	0	0			
Cheselden	Bronze	100	86%						0	0	0	0			
Pierce	Bronze	100	40%						0	0	0	0			
Parry	Foundation	98	44%						1	0	0	0			
Robin Smith	Foundation	100	35%						2	2	0	0			
Violet Prince (RNHRD)	Bronze	100	24%						0	0	0	0			
Medical Short Stay Unit	Foundation	96	16%						1	0	0	0			
Phillip Yeoman	Bronze	99	65%						0	1	0	0			
Forrester Brown	Bronze	96	37%						4	0	0	0			
Helena	Bronze	100	68%						1	0	1	0			
Surgical Short Stay Unit	Foundation	96	35%	2	2		1		1	0	0	0			
CCU	Bronze	100	55%						0	0	0	0			
Children's Ward	Bronze	96	6%						0	1	0	0			
Acute Stroke Unit	Foundation	95	70%						5	0	0	0			
Mary Ward	Bronze	99	33%						0	0	0	0			
Pulteney	Bronze	95	28%	1	1	1	2		0	0	0	0			
Respiratory	Bronze	94	58%			1	1		5	2	0	0			
ACE OPU	Bronze	97	57%			1			5	1	0	0			
Waterhouse	Bronze	100	67%	1					8	2	0	0			
NICU	Not assessed	100	5%												
Haygarth	Foundation	100	59%						2	2	0	0			
Combe	Foundation	95	55%						2	0	0	0			
Midford	Bronze	95	51%	2					4	1	1	0			
William Budd	Bronze	100	24%	1					3	0	0	0			
Cardiac	Foundation	98	44%	1					1	0	0	1			
Critical Care Services	Bronze	N/A	N/A						0	0	0	0			
		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				Avoidable harms any PUs		

APPENDIX A

Human Resources (1 month lag)				Nurse Staffing Datix Report	Safer Staffing % Fill rate				Care Hours Per Patient Day (CHPPD) overall	Number of times parameters outside of KPI metrics					
Sickness %		Appraisal %			Day		Night								
RN/RM	HCA	RN/RM	HCA		Reg Nurses/ Midwives	Care Staff	Reg Nurses/ Midwives	Care Staff		Jun 18 No:	May 18 No:	Apr 18 No:	Mar 18 No:	Feb 18 No:	Jan 18 No:
4.2	4.4	88.9	77.8		85.3%	112.3%	86.1%	124.7%	10.5	1	0	3	3	1	5
0.8	4.8	80.5	90.5							2	1	2	2	2	1
0.7	10.2	81.4	71.4		77.8%	142.6%	81.6%	149.0%	9.3	6	6	3	2	2	2
0.0	0.5	100.0	100.0		96.1%	90.9%	99.9%	101.6%	7.5	0	1	1	1	2	1
0.0	0.0	91.7	92.9	2	81.0%	101.9%	99.9%	100.0%	5.4	1	2	0	0	0	2
1.0	1.4	81.3	86.7	2	81.7%	139.3%	87.2%	179.0%	7.6	1	3	2	1	2	6
4.4	4.3	100.0	92.3		79.3%	98.2%	100.9%	111.8%	6.0	1	5	5	2	2	5
0.3	8.8	89.5	76.5		92.7%	125.2%	90.0%	127.1%	7.1	2	3	3	2	4	5
0.0	0.0	100.0	100.0		86.8%	70.2%	100.0%	80.6%	4.9	3	2	3	4	4	4
1.1	15.6	73.3	100.0		88.1%	113.7%	99.9%	134.7%	6.1	3	2	5	5	6	5
1.1	0.0	100.0	100.0		83.4%	73.5%	79.0%	85.2%	7.3	3	3	3	4	6	3
8.2	15.2	88.9	94.1	1	93.9%	100.8%	77.6%	137.5%	7.0	3	3	4	3	3	3
0.3	4.1	85.7	57.1	1	80.3%	130.4%	65.6%	154.9%	8.2	3	4	5	4	2	3
5.6	2.9	90.5	100.0	1	95.6%	144.1%	64.5%	183.9%	7.8	4	1	2	1	3	1
0.9	13.6	72.2	75.0		82.9%	100.9%	100.0%	100.0%	11.5	4	3	4	4	4	5
1.9	11.8	84.2	90.9		82.7%	79.4%	89.6%	132.0%	7.1	4	4	5	4	4	4
0.0	5.2	86.7	71.4	6	77.5%	87.4%	94.8%	131.6%	7.8	4	5	6	5	4	4
2.4	5.7	73.5	65.0	1	89.1%	88.3%	93.4%	91.4%	11.8	5	1	3	4	3	3
6.2	4.5	87.0	61.1	3	89.3%	108.4%	95.0%	125.5%	7.2	5	1	7	4	5	7
1.9	5.3	94.4	92.9	4	69.2%	141.7%	74.3%	119.1%	6.2	5	3	4	4	4	4
5.7	6.7	90.0	84.2	2	70.2%	103.1%	72.2%	116.7%	6.9	5	4	3	4	2	7
7.4	11.7	85.7	82.4		70.6%	103.0%	103.4%	103.4%	6.1	5	4	3	5	5	6
0.7	0.9	76.7	100.0		84.2%	59.1%	85.4%	50.0%	8.7	5	4	5	5	5	6
9.7	5.3	75.0	84.2		60.5%	109.8%	69.6%	179.2%	6.0	5	4	6	5	6	5
2.7	9.8	64.3	62.5	12	75.6%	114.5%	70.8%	203.5%	7.0	5	7	5	7	7	6
6.9	6.3	100.0	100.0	3	64.7%	139.5%	73.9%	213.4%	6.2	6	4	3	5	5	9
3.3	0.7	78.6	71.4	6	69.2%	95.0%	78.2%	116.6%	7.1	6	4	5	7	5	5
1.1	6.3	63.6	71.4	1	80.8%	114.2%	74.9%	194.0%	5.4	6	6	5	4	6	6
6.4	8.8	88.9	75.0		81.6%	80.1%	81.7%	12.9%	29.2	7	5	5	4	3	2
5% or more		80% or less			85% or less					More than 5 Amended metrics for Feb 2018					

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