Royal United Hospitals Bath
NHS Foundation Trust

Report to:	**Public Board of Directors**	**Agenda item:**	**8**
Date of Meeting:	**31 October 2018**		
Title of Report:	**Quality Report**		
Status:	**For discussion**		
Board Sponsor:	**Lisa Cheek, Interim Director of Nursing and Midwifery Francesca Thompson, Chief Operating Officer 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 September 2018 data.

The Quality Report this month includes a quarterly update on the improvement priorities as highlighted in the 2018/19 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:
  - Sepsis including AMR
  - Acute Kidney Injury (AKI)
  - NEWS
  - Clostridium Difficile
- 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.	

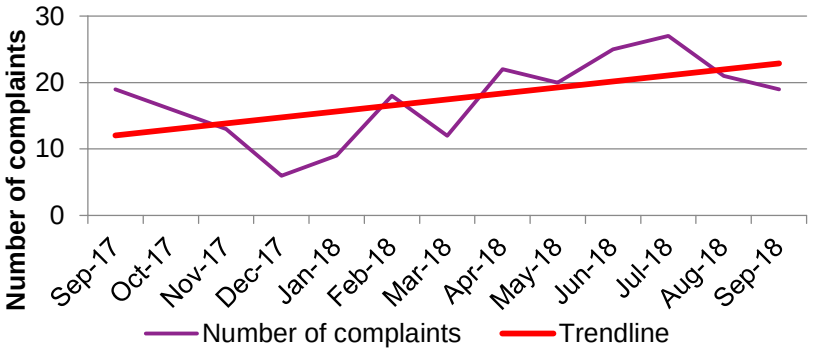
QUALITY REPORT

PART A – Patient Experience

Complaints Report

Lisa Cheek

Total number of complaints received



There were **19** formal complaints in September. **5** were for the Surgical Division; **13** for the Medical Division; **1** was for Women & Children. **9** complaints cited Clinical Care and Concerns; **3** related to appointments**, 6** Communication and Information**, 1** related to the discharge of a relative.

Complaint response rate by Division	**Division**			**Total**
	Surgery	W&C	Medicine	
Closed within 35 day target	2 (29%)	1 (33.3%)	4(29%)	7(29%)
Breached 35 Day target	5 (71%)	2 (66.6%)	10 (71%)	17 (71%)
Total	7	3	14	24

Of the complaints that breached the response dates:

- 3 were responded to within 40 days
- 4 were responded to within 45 days
- 3 were responded to within 53 days
- 7 currently have a response outstanding, these range from being 11 to 19 days over 35 day target (as at 15th October)

Reasons for the breach of response dates:

Surgery Division

- 3 due to meetings being arranged.
- Patient's notes had been transferred to Southmead and took time to recover
- Delayed by annual leave of staff involved and an extended review in the Director's Office

Medicine Division

- 2 due to meetings being arranged
- Delay in being able to access the patient's medical records
- Further information required for the response
- Meeting requested which changed to a written response at later date
- Complex complaint
- Ongoing safeguarding investigation

Women's and Children's Division

- Matron visited complainant in the home and sent follow up letter

A review of the current complaints process has started. The focus of the review is to streamline the process and reduce the number of breaches whilst maintaining the quality of the letters. Advise has been taken from the Chairman of the National NHS Complaint Managers Forum. The Regulations and the Complaints Toolkit from NHSE and Healthwatch advises that a member of staff contact the person making the complaint as soon as possible after the complaint is made and agree on a number of things with the person. One of these is agreeing when the response to the complaint should be sent out. The recommendation is that there should not be one fixed time for all complaints. The Regulations recommends that complaints are risk assessed. The toolkit is currently being reviewed.

Royal United Hospitals Bath
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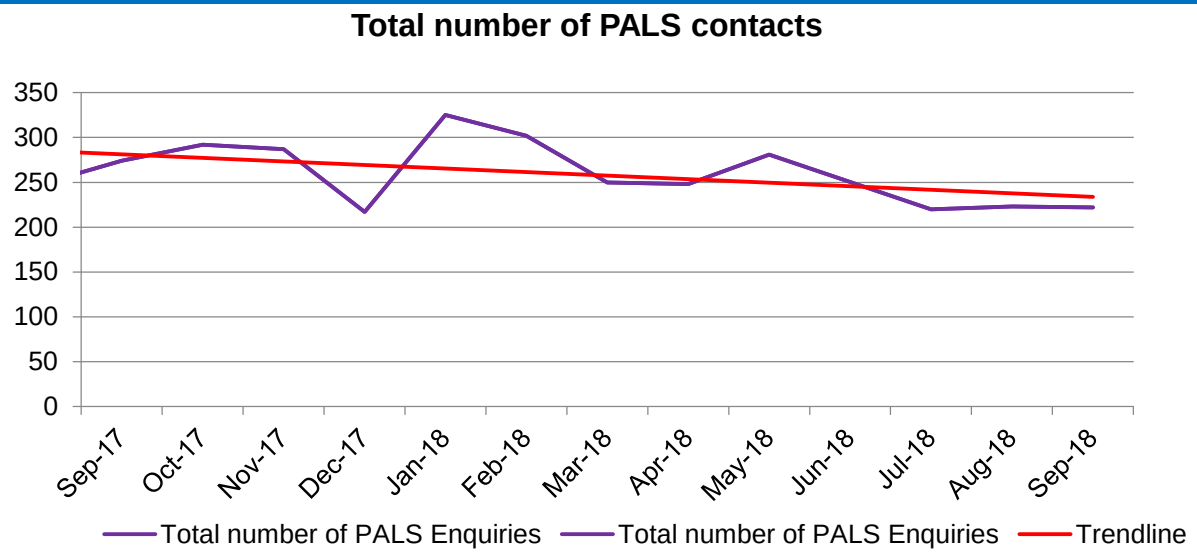
Patient Advice and Liaison Report

Lisa Cheek



There were **222 contacts with PALS** in September:

- 110 required resolution (50%)
- 89 requested information or advice (40%)
- 16 provided feedback (7%)
- 7 compliments (3%)

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

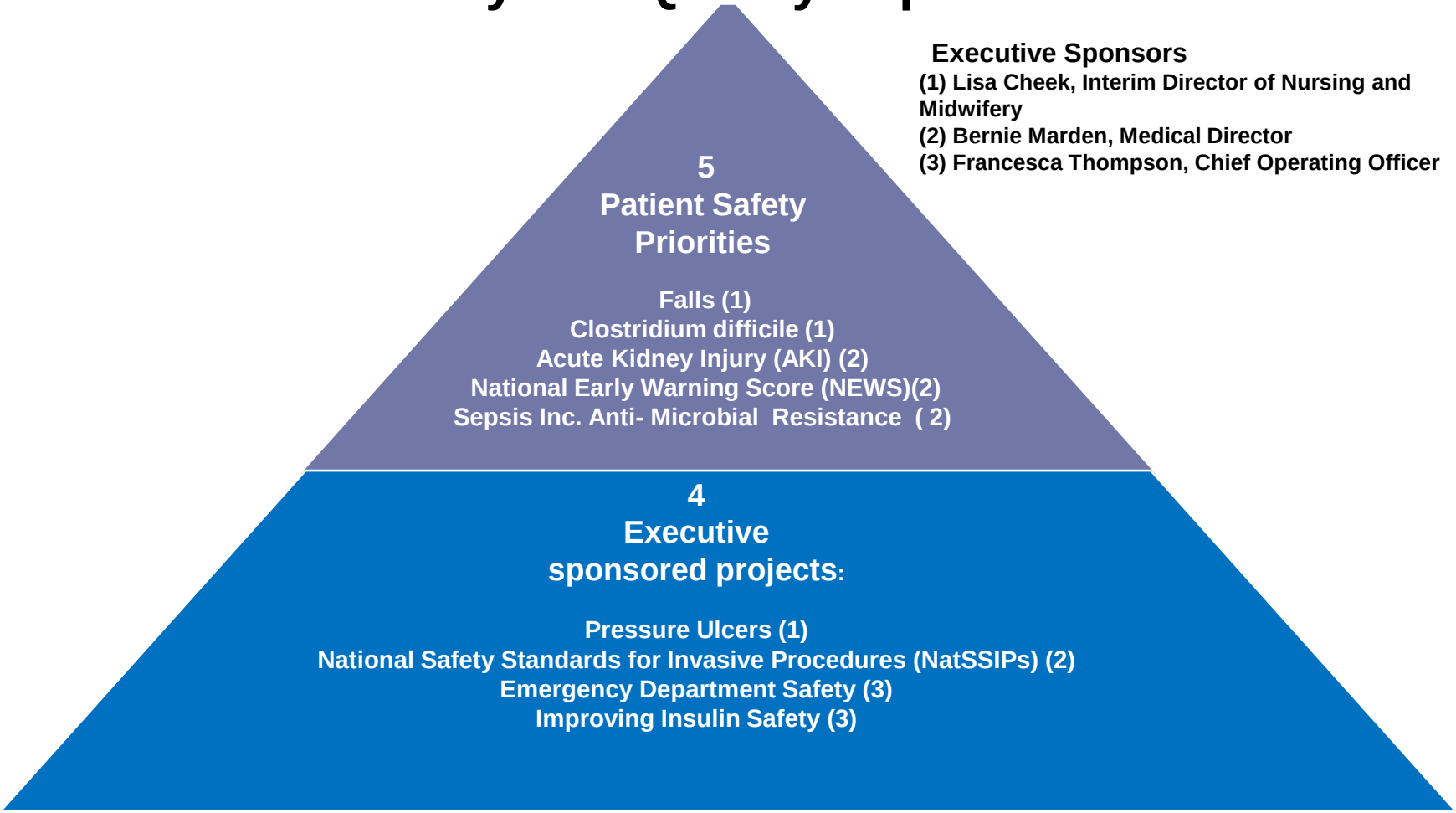
Clinical Care & Concerns - there were **26** contacts relating to clinical care & concerns. **9** of these were general enquiries; **4** concerned medication errors; 2 related to end of life concerns. There was no clear trend for the remaining concerns.

Appointments - there were **20** contacts. **6** of these were queries relating to the cancellation of an appointment; **3** related to appointment changes requested by the patient; **3** were enquiries relating to the length of time waiting for a follow up**.** There was no clear trend for the remaining concerns.

Communication & Information – there were **18** contacts. **6** were general enquiries; **4** relating to telephone issues; **3** concerning missing discharge summaries . There was no clear trend for the remaining concerns.

QUALITY REPORT

PART B – Patient Safety and Quality Improvement



Executive Sponsors

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

Patient Safety – Sepsis inc AMR

Bernie Marden

CQUIN for Sepsis

- Targets for Sepsis Screening and Antibiotics are both 90% trust wide for 2018/19. Q4 2018/19 also requires NEWS 2 to be used to be eligible for payment.
- Q1 received partial payment for screening (81%) and for antibiotics (87%) patients received antibiotics within 60 minutes of sepsis diagnosis just missing the target

Sepsis on admission (see run charts fig 1)

- Median compliance with Sepsis screening on admission is 85% for adults and paediatric admissions, with paediatrics reaching over 90% for Jun, Jul and Sep.
- Difficulties with identifying patients since First net implementation has now been partially resolved with a sample of 20 per month being obtained and compliance is now available from April 2018. Solutions are being further identified to increase ease of identification – these require some IT additions to first net and priority of data retrieval from BIU.
- Since April 71% patients have received antibiotics in an hour from signs of sepsis as shown in graph 1.3
- 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. There is also still delay in delivery of antibiotics due to transfer to ward and a multidisciplinary working group has been established to improve processes and standardisation of pathway.

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 is at 77% for adults. Electronic recording of observations is awaited to improve this.
- **NEWS2**
- The team have been working with the NEWS team to develop a new observation chart for NEWS 2 as well as improving the sepsis screening tool. This is due to go live at beginning of November, to be eligible for Q4 CQUIN.

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. Current compliance is median of 78% patients receiving antibiotics in an hour from signs and 87% in 90 minutes, with June and July , 100 % patients receiving antibiotics in 90 minutes (charts 3.1 and 3.2)
In maternity progress continues to be excellent with 100% receiving antibiotics in 90 minutes since December 2017 and 90% in an hour median of 85% (charts 3.3 and 3.4)

Awareness and training

- From September 2018 AKI/Sepsis training is included on Corporate Induction and continues to be delivered on Core Skills.
- AKI and Sepsis training has been approved to become essential for role and will appear on STAR record
- Sepsis e-learning development is in progress with a target date of Nov 2018
- World sepsis day was marked in September with various events across the Trust including simulation scenario training
- The team won best poster in the "Improvement in patient outcomes ' of the South West Quality Improvement conference in June 2018 for the work on improvement in inpatient sepsis screening and management .
- The inpatient sepsis and AKI work received national recognition and was shortlisted as a finalist for HSJ award 2018 in the patient safety category for Sepsis and AKI work. The team presented to the judges in October and results will be announced on 21st December.

Outcomes

In September 2018 a national 'Suspicion of sepsis 'dashboard has been produced to track outcomes from patients with 'all infections ' or 'suspicion of sepsis'(SOS). From this dashboard, between 2016/17 to 2017/18 there has been a **17% reduction in Mortality** rate,**12% reduction in average number ICU bed days** (average decrease 28 days per month) and **10% reduction in length of stay – 11,500 bed days** for these patients at the RUH. This is despite an increase in incidence SOS of 500/ year

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

Patient Safety – Sepsis inc AMR

Bernie Marden

Fig 1.1 Emergency Adult sepsis screening - 50 patients/ month

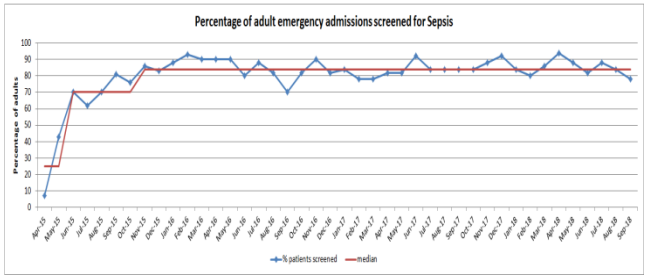


Fig 1.2 Emergency paeds sepsis screening – 20 patients/ month

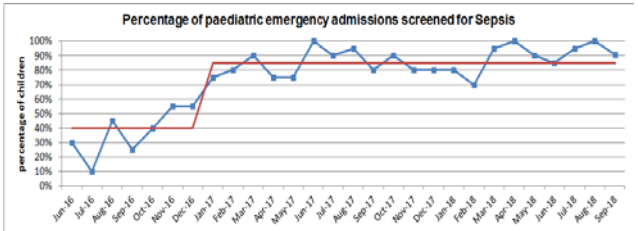


Fig 1.3 Emergency Adult Antibiotics in an hour from signs - 20 patients/ month

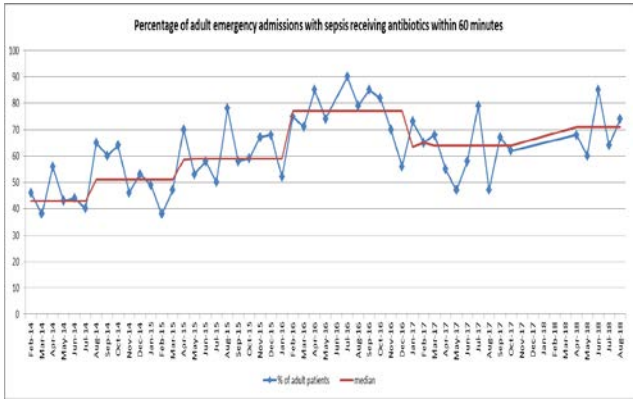


Fig 2.1. Inpatient adult screening-80-100/month

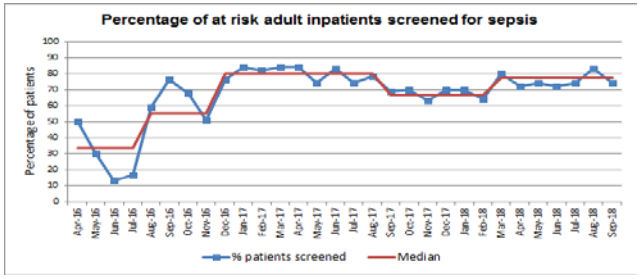


Fig 2.2: Inpatient paeds screening -15-20/month

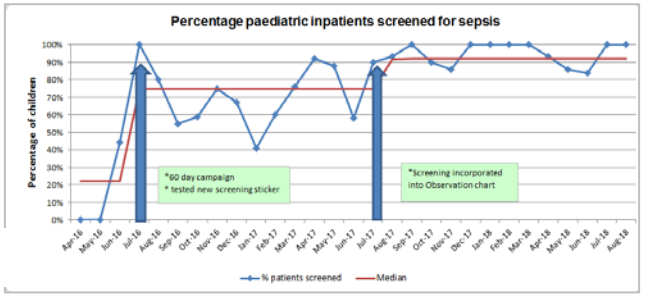


Fig 3.3: Maternity patients
- antibiotics in an 90 minutes

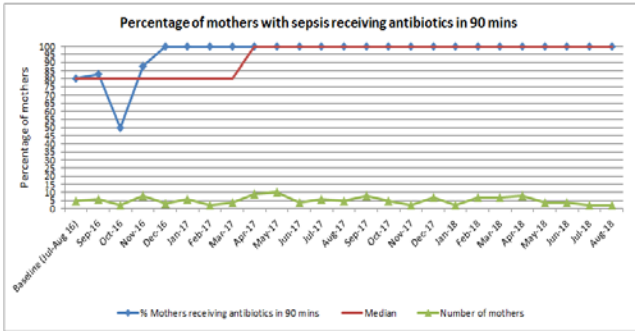


Fig 3.1: Inpatient Adult patients antibiotics in an hour

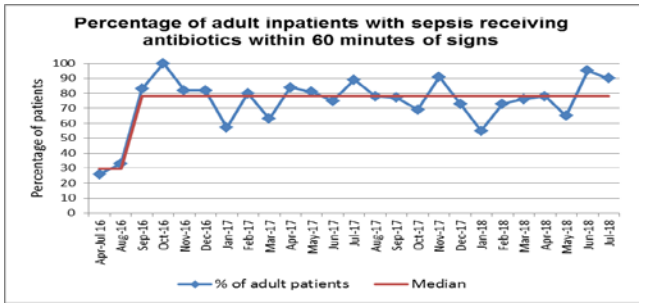


Fig 3.2: Inpatient Adult patients antibiotics in 90 minutes

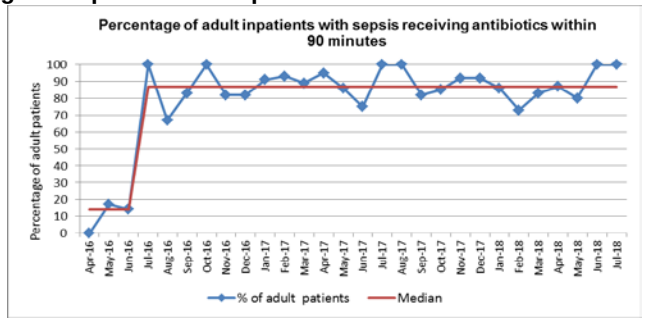
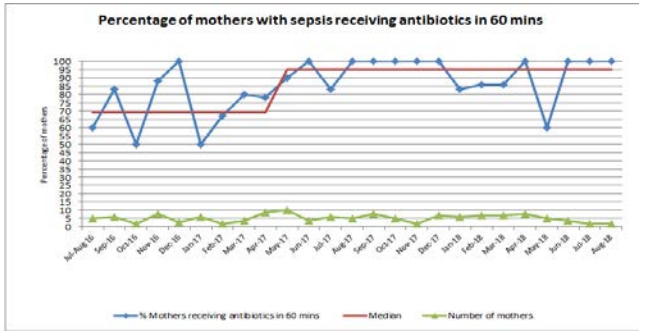


Fig 3.4: Maternity patients - antibiotics in an hour



Patient Safety – Acute Kidney Injury (AKI)

Bernie Marden

Awareness and Training

- From Sept AKI/Sepsis training is now included on Corporate induction and continues to be delivered on Core skills.
- AKI and Sepsis training has been approved to become essential for role has and will appear on STAR record
- AKI e-learning is being developed.
- Work continues to align AKI, Sepsis and NEWS work streams and deteriorating patient champions are being identified across all wards.

. **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).
- 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). 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 further improve the chart

Sharing our success

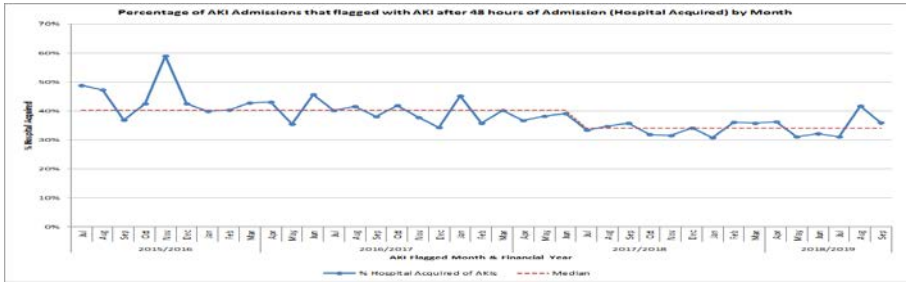
- National recognition.
- Shortlisted for HSJ award 2018 in the patient safety category for Sepsis and AKI work. Judging takes place in October, with winners announced in November.

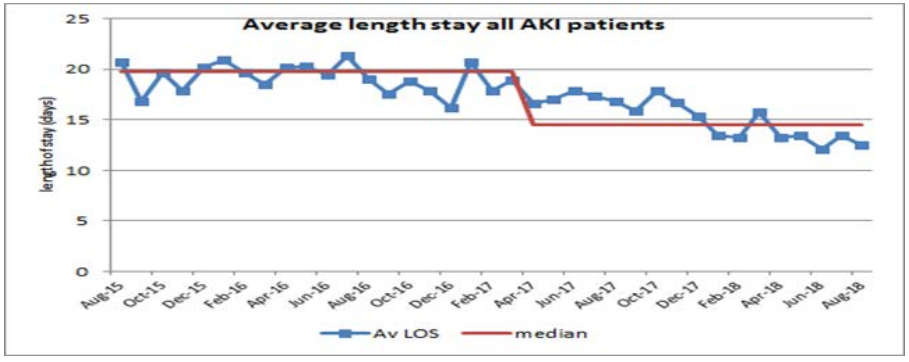
Sharing our success

- Regional recognition
- AKI work was acknowledged in June 2018 and was selected from 77 projects across the South West to be presented at the AHSE Quality & Safety Conference in Taunton

Outcome data

Following work on increasing awareness, implementing the amended hydration chart and contrast sticker, there has been a 20% reduction in the incidence AKI acquired during inpatient admission, and a decrease length of stay for all patients with an AKI by 6 days as shown below.

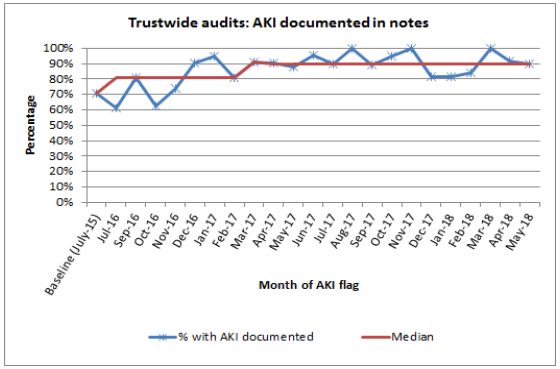


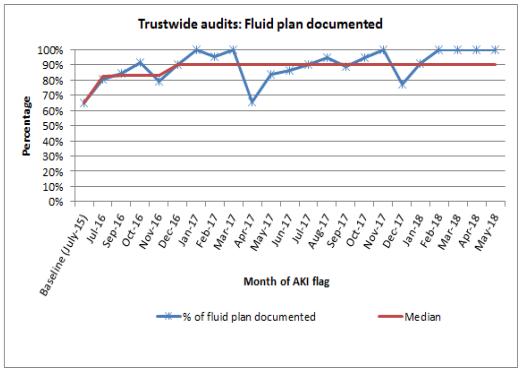


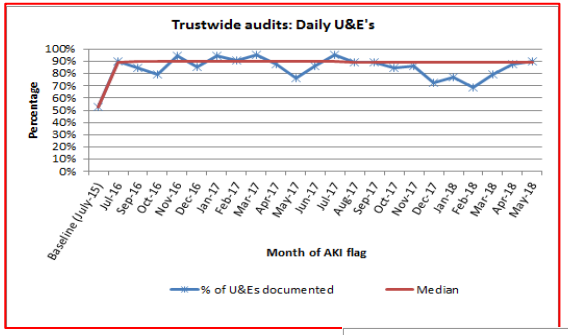
Patient Safety – Acute Kidney Injury (AKI)

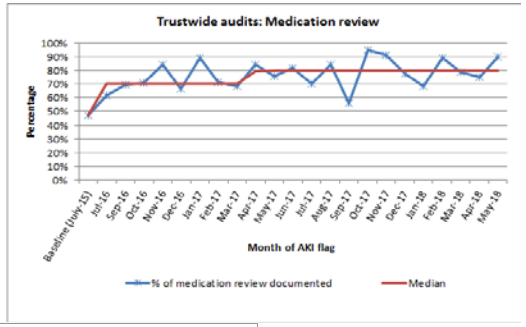
Bernie Marden

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









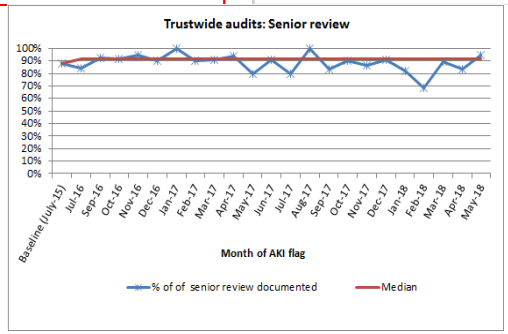
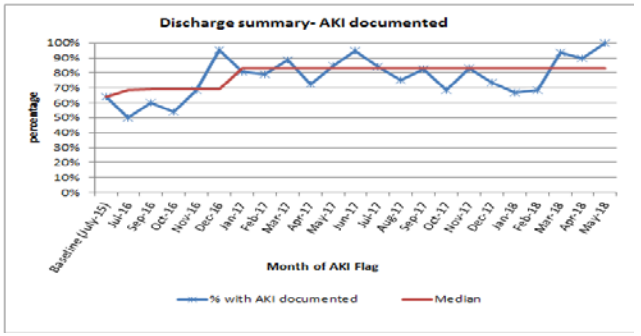
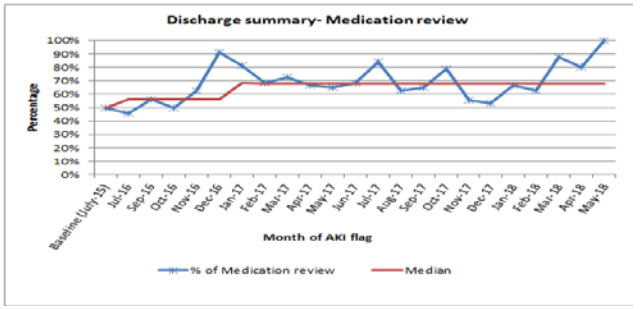
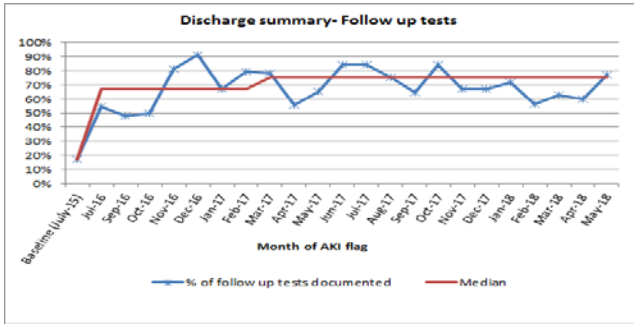


Fig 3.0- 3.2 Discharge summary compliance Audits based on 18—25 patients per month







Patient Safety – NEWS

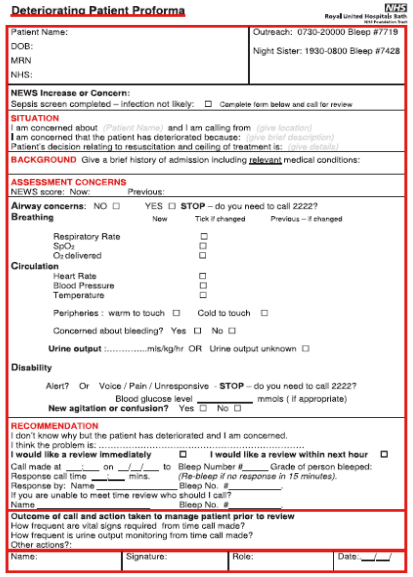
Bernie Marden

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 proforma has been developed as a prompt to aid nursing staff when escalating the deterioration of a patient, this also includes a section for completion by medical staff detailing their assessment and action plan post patient review. This proforma has been tested and will be launched on 7th November 2018



Deteriorating Patient Proforma

Patient Name:
DOB:
MRN
NHS:

Outreach: 0730-20000 Bleep #7719
Night Sister: 1930-0800 Bleep #7428

NEWS Increase or Concern:
Sepsis screen completed – infection not likely: ☐ Complete form below and call for review

SITUATION
I am concerned about *(Patient Name)* and I am calling from *(give location)*
I am concerned that the patient has deteriorated because: *(give brief description)*
Patient's decision relating to resuscitation and ceiling of treatment is: *(give details)*

BACKGROUND Give a brief history of admission including relevant medical conditions:

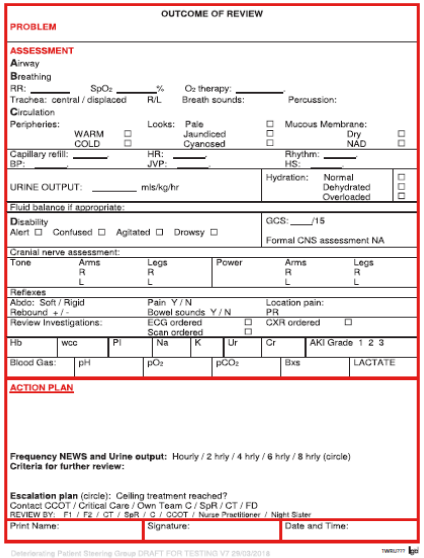
ASSESSMENT CONCERNS
NEWS score: Now: Previous:

Airway concerns: NO ☐ YES ☐ **STOP** – do you need to call 2222?
Breathing — New | Tick if changed | Previous – if changed
Respiratory Rate ☐
SpO_2 ☐
O_2 delivered ☐
Circulation
Heart Rate ☐
Blood Pressure ☐
Temperature ☐
Peripheries : warm to touch ☐ Cold to touch ☐
Concerned about bleeding? Yes ☐ No ☐
Urine output :.....mls/kg/hr OR Urine output unknown ☐
Disability
Alert? Or Voice / Pain / Unresponsive - **STOP** – do you need to call 2222?
Blood glucose level ____ mmols (If appropriate)
New agitation or confusion? Yes ☐ No ☐

RECOMMENDATION
I don't know why but the patient has deteriorated and I am concerned.
I think the problem is: .....
I would like a review immediately ☐ **I would like a review within next hour** ☐
Call made at ___:___ on __/__/___ to Bleep Number #_____ Grade of person bleeped:
Response call time ____/____ mins. *(Re-bleep if no response in 15 minutes).*
Response by: Name _____ Bleep No. #_____.
If you are unable to meet time review who should I call?
Name _____ Bleep No. #_____.

Outcome of call and action taken to manage patient prior to review
How frequent are vital signs required from time call made?
How frequent is urine output monitoring from time call made?
Other actions?:

Name: | Signature: | Role: | Date: __/__/__



OUTCOME OF REVIEW

PROBLEM

ASSESSMENT
Airway
Breathing
RR: ____ SpO_2 ____% O_2 therapy: ____
Trachea: central / displaced R/L Breath sounds: Percussion:
Circulation
Peripheries: Looks: Pale ☐ Mucous Membrane:
WARM ☐ Jaundiced ☐ Dry ☐
COLD ☐ Cyanosed ☐ NAD ☐
Capillary refill: ____ HR: ____ Rhythm: ____
BP: ____/____ JVP: ____ HS: ____
URINE OUTPUT: ____ mls/kg/hr Hydration: Normal ☐ Dehydrated ☐ Overloaded ☐
Fluid balance if appropriate:
Disability
Alert ☐ Confused ☐ Agitated ☐ Drowsy ☐ GCS: ___/15
Formal CNS assessment NA
Cranial nerve assessment:

Tone	Arms	Legs	Power	Arms	Legs
	R	R		R	R
	L	L		L	L

Reflexes
Abdo: Soft / Rigid Pain Y / N Location pain:
Rebound + / - Bowel sounds Y / N PR
Review Investigations: ECG ordered ☐ CXR ordered ☐
Scan ordered ☐

Hb	wcc	Pl	Na	K	Ur	Cr	AKI Grade 1 2 3

Blood Gas:	pH	pO_2	pCO_2	Bxs	LACTATE

ACTION PLAN

Frequency NEWS and Urine output: Hourly / 2 hrly / 4 hrly / 6 hrly / 8 hrly (circle)
Criteria for further review:

Escalation plan (circle): Ceiling treatment reached?
Contact CCOT / Critical Care / Own Team C / SpR / CT / FD
REVIEW BY: F1 / F2 / CT / SpR / Q / CCOT / Nurse Practitioner / Night Sister

Print Name: | Signature: | Date and Time:

Deteriorating Patient Steering Group DRAFT FOR TESTING V7 29/03/2018

- The NEWS 2 eLearning package has been developed and is currently being tested. Aiming to launch in November 2018 to coincide with the rollout of NEWS 2 across the Trust.

- 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. A paper chart for NEWS 2 has been developed and tested. Staff training commenced in October 2018 , this has been aimed at the Deteriorating Patient Link Nurse for them to cascade the key messages to the rest of their teams.

- The new NEWS 2 chart will be launched on the 7th November 2018. The team are planning a series of trolley dashes to support the clinical areas

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	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
ACE OPU	80%	81%	77%	85%	92%	96%	91%	98%	90%	81%	90%	81%	90%
ASU	93%	90%	88%	92%	93%	91%	98%	85%	96%	87%	98%	94%	83%
Cardiac	100%	94%	96%	96%	84%	81%	85%	88%	89%	96%	89%	90%	96%
CCU	94%	66%	89%	95%	97%	83%	89%	76%	97%	80%	52%	89%	97%
Charlotte	96%	92%	95%	92%	96%	100%	96%	96%	100%	96%	96%	95%	91%
Cheselden	100%	92%	100%	96%	100%	100%	96%	92%	96%	96%	100%	100%	100%
Combe	89%	85%	92%	83%	81%	83%	82%	96%	92%	89%	88%	92%	95%
ED Obs	95%	85%	100%	100%	100%	93%	88%	92%	96%	96%	100%	88%	90%
Forrester Brown A	82%	85%	90%	98%	81%	95%	72%	86%	92%	88%	83%	82%	83%
Haygarth	95%	88%	100%	100%	94%	94%	94%	98%	96%	90%	96%	100%	98%
Helena	96%	96%	100%	100%	96%	100%	95%	96%	100%	96%	100%	100%	100%
MAU	87%	84%	92%	91%	98%	90%	88%	96%	87%	96%	91%	98%	83%
Midford	90%	91%	71%	72%	96%	80%	88%	90%	94%	93%	94%	98%	100%
MSSU	94%	100%	77%	91%	100%	94%	95%	85%	86%	95%	92%	92%	88%
Parry	92%	94%	100%	100%	96%	96%	84%	96%	92%	100%	96%	100%	96%
Philip Yeoman	90%	76%	74%	94%	92%	82%	88%	91%	96%	89%	87%	94%	85%
Pierce	88%	81%	91%	83%	90%	96%	94%	82%	94%	88%	85%	89%	84%
Pulteney (previously Wat	96%	92%	100%	100%	94%	83%	92%	92%	95%	88%	92%	96%	88%
Respiratory	92%	96%	92%	92%	91%	90%	94%	86%	94%	86%	91%	94%	88%
Robin Smith	80%	94%	92%	83%	96%	100%	93%	98%	91%	90%	96%	100%	96%
SAU	94%	100%	100%	96%	100%	96%	100%	100%	100%	100%	100%	95%	100%
SSSU	89%	100%	84%	85%	91%	90%	96%	100%	96%	89%	100%	87%	98%
Violet Prince	92%	97%	100%	63%	90%	100%	98%	96%	83%	87%	93%	93%	95%
Waterhouse	94%	93%	98%	70%	90%	93%	88%	83%	94%	93%	89%	96%	95%
William Budd	84%	96%	94%	92%	88%	92%	90%	85%	81%	95%	90%	82%	98%
Grand Total	**91%**	**90%**	**91%**	**89%**	**92%**	**92%**	**91%**	**91%**	**93%**	**91%**	**91%**	**92%**	**93%**

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

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

Table 1

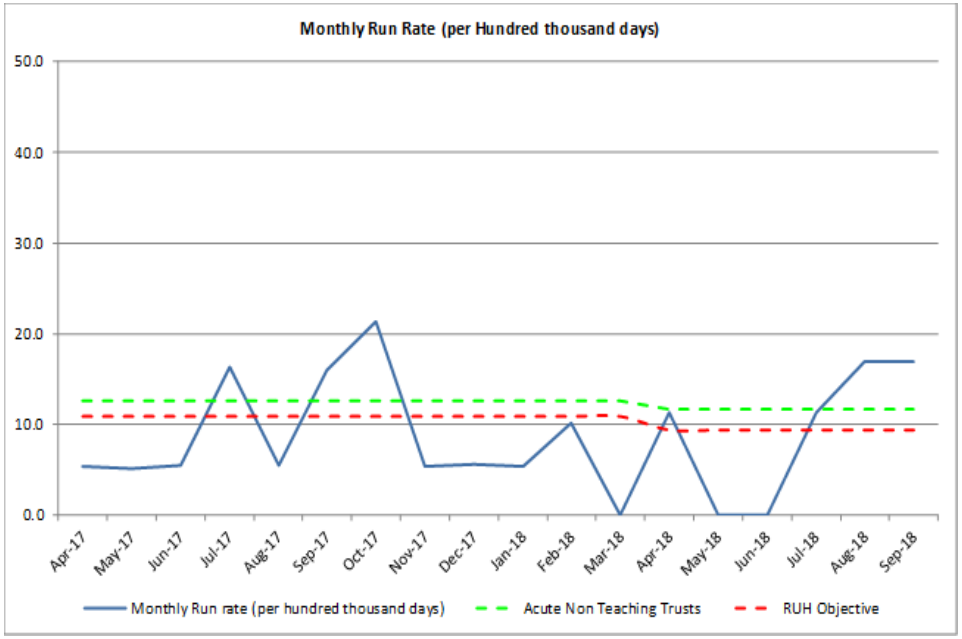
Patient Safety – Clostridium Difficile

Lisa Cheek

Background

The RUH target for 'Trust apportioned' *Clostridium difficile* in 2018/19 is 21 cases. Between April and September 2018 there has been a total of 13 Trust apportioned cases reported. Of these 3 cases are not counted against the trajectory as the CCGs have agreed that there were no lapses of care.

Current Performance



RCA's have been completed for the majority of the Trust apportioned cases with just one awaiting completion currently. Actions identified through the RCA's will be monitored by the divisional governance groups.

Ribotyping has been undertaken for all 10 cases that are counted against the trajectory. There are 3 wards that have had two or more cases however only two cases on Parry had the same ribotype (ie came from the same source). A meeting was held with ward staff and an investigation is being undertaken by the Infection Control Doctor.
Actions following the meeting include:

- A focus on hand hygiene compliance with regular audits
- Training session held for Parry staff with a focus on hand hygiene and Personal Protective Equipment (PPE) use
- Deep clean of the whole ward
- Microbiologists to be informed when inpatients are found to have *Clostridium difficile* colonisation; ribotyping will also be considered for these cases

There has been an increase in the number of Trust apportioned cases from July 2018 onwards.

Increased surveillance has been carried out on all wards that have new cases of *Clostridium difficile* infection. This includes audit of the environment and a cleaning audit, both of which are undertaken by Infection Prevention and Control team. New signage for side rooms has been introduced to provide a quick view of the precautions required and action cards have been issued to staff. Microbiology are also reviewing the antimicrobial prescribing policy.

A 'C less C diff' campaign has been planned for the week commencing 22nd October. This will include activities and educational sessions on the wards.

Serious Incidents (SI) Summary

Lisa Cheek

Current Performance

Five serious incidents were reported to STEIS in September and these remain under investigation.

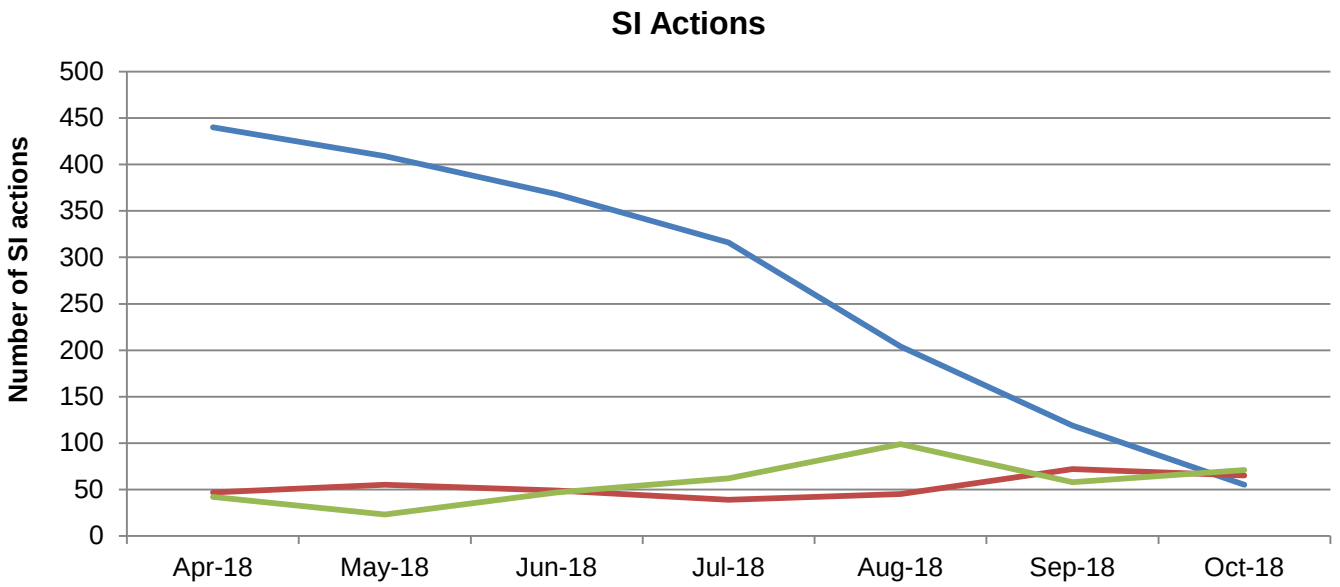
Serious Incidents Reported to STEIS July 2017 to September 2018												
Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	July-18	Aug-18	Sept- 18
0	5	6	6	10	5	0	3	13	2	5	8	5

Date of Incident	ID	Summary
10/09/2018	66207	Delay in treatment
01/08/2018	65242	Medication error
26/05/2018	63411	Transfer of deteriorating patient
12/01/2018	66537	Missed Diagnosis
19/09/2018	66482	Pressure ulcer

Overdue Serious Incident Report

Lisa Cheek

The drive to reduce the number of overdue SI reports continues this year and the result is the SI reports are being reviewed at OGC in a timely manner with the aim for the SI's to be ready for submission to the CCG within the required time.
Serious Falls Investigations are reviewed at the Falls steering group and a quarterly report will be presented at OGC going forward.
As of 12th October 2018, there are 24 Serious Incidents that are under investigation. Of these, one is awaiting final approval from the falls steering group chair. All other RCA's are on track and extensions have been granted or requested for those that may breach the original submission time. The following graph shows the number of open actions and those closed per month.



	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18
Number of open SI actions (still within due date at end of month)	440	409	368	316	204	119	55
Number of open SI actions (overdue at end of month)	47	55	49	39	45	72	65
Number of SI actions closed in month	42	23	47	62	99	58	71

Nursing Quality Indicators Exception Report — Lisa Cheek

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

Haygarth Ward
This is the second consecutive month that Haygarth has flagged. Haygarth currently do not have a band 7 Senior Sister/Charge Nurse.

Quality Matrices to note are:
- 1 Complaint via PALS
- 5 falls
- RGN Sickness 9.9%
- HCA Sickness 7%
- RGN % hours day and night < 85%

- The complaint has been managed and resolved by the Matron and the band 6 Junior Sister.
- The 5 patient falls is from a patient who repeatedly fell whilst undertaking a detoxing programme.
- The RGN and HCA sickness is being proactively managed in line with Trust policy. The Matron is overseeing this process.

Pulteney Ward
This ward last flagged in April 2018.

Quality Matrices to note are:
- 1 grade 3 pressure sore
- RGN sickness 8.2%
- HCA sickness is 5.2%
- RGN appraisal rate is 41.7%
- HCA appraisal rate is 25%
- RGN and HCA fill rate is <85%

- The grade 3 pressure ulcer is currently being investigated but at this stage is believed to have been unavoidable due to the co-morbidity of the patient who was end of life.
- There have been 3 RN's on long term sickness. One has left the Trust and the other 2 have returned to work on a phased return.
- 1 HCA has been on long term sickness and is now on phased return. All sickness has been managed in line with Trust policy. phased return
- The Matron is supporting the ward to improve appraisal rates. There are currently 5 RN's on maternity leave which will contribute to the appraisal rate.

Nursing Quality Indicators Exception Report Lisa Cheek

Combe (Older Peoples)
This ward has flagged for the third consecutive month.

Quality matrices to note are:
- 10 patient falls, no harm and 1 minor harm
- RN sickness is 7.2%
- HCA sickness is 8.2%
- RN appraisals 50%
- HCA appraisals 78.6%
- RN hours % night/day fill rate <85%

- There are two staff on maternity leave and a further two on long term sickness which impacts on the percentage completion rate for appraisals. The new band 6 has undertaken the appraisal training and is meeting with the matron weekly to go through the recovery trajectory.
- In addition there is short term sickness and the ward has a high vacancy factor. The Senior Sister is currently actively recruiting to these vacancies. Long term staffing indicates that Combe ward should be full staffed by February 2019. Staff are deployed where possible into enhanced bays for observation to minimise the risk of falls. HCA ‘s continue to be requested to help provide the enhanced observation.

ACE (Older Peoples)
This ward has flagged for the third consecutive month.

Quality matrices to note are:
- 1 patient contracted Clostridium difficile
- 4 falls with no harm 1 fall with minor harm
- HCA sickness 5.5%
- RN sickness 10.4%
- RN appraisals 55%
- RN hours % night/day fill rate <85%

- The Clostridium difficile case is currently under going investigation
- Additional HCA’s are requested to support enhanced observations
- Staff have recently returned from long term sickness and the short term sickness is being proactively managed in line with Trust policy.
- The appraisals are being managed with a recovery plan for the members of staff who are out of date, one of whom has recently completed their appraisal.
- All vacancies are being managed locally and divisional / trust wide. The matron is working with the senior sister to address these issues.

Nursing Quality Indicators Exception Report Lisa Cheek

Parry Ward

This is the first time this ward has flagged in the last 6 months.

Quality matrices to note are:
- FFT response rate is 26%
- 1 patient contracted clostridium difficile
- 6 patients fell no harm
- HCA sickness is 11.9%
- HCA appraisal is 76.9%
- RGN staff fill is 78.6%

- The Senior Sister and team are working to improve FFT response rates. This is being emphasised during safety briefings and whiteboard rounds.
- An RCA is underway for the clostridium difficile case and the senior sister is working closely with infection control.
- All outstanding appraisals are being actively managed and further appraisals have already been completed.
- Sickness is being managed in line with trust policy and is mainly due to long term sickness with one member of staff due to return in October.
- Parry ward have seen two new band 5 members of staff join the team.

Neonatal Intensive Care Unit
This ward has flagged for the third month consecutively.

Quality matrices to note are:
- FFT response rate 25%
- RN appraisal 67.5%
- HCA appraisal rate is 78.6%
- RN hours % night/day fill rate <85%

- The Senior Sister has allocated the FFT recovery plan as a project to a band 4 nurse. The senior sister continues to over see this improvement plan.

- There is a workforce appraisal plan in progress which is overseen by matron and new band 7. All outstanding appraisals are being actively managed by the senior sister.

- There are 3.0 WTE vacancies on NICU which are being actively recruited to, this is in addition to staff being on maternity leave. There are two full time care staff on maternity leave. Staff are relocated between Paediatrics and NICU dependant on workload requirement.

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Nursing Quality Indicators Exception Report Lisa Cheek

Midford Ward (Older Peoples)

This ward has flagged for the second consecutive month.

Quality matrices to note are:

- 1 complaint received
- 1 category 2 pressure ulcer
- 1 category 3 pressure ulcer
- 4 falls no harm 1 minor injury
- HCA sickness 6.8%
- RN sickness 5.35%
- RN hours % night/day fill rate <85%

- The complaint was regarding a very complex discharge plan. The Matron has been involved in answering this complaint with the consultant. The patient has now been successfully discharged.
- The category 3 pressure ulcer is being investigated as a serious incident. The patient has an underlying medical condition which is believed to make him very susceptible to pressure ulcers.
- On September 12th staff from Midford attended the Falls Collaborative and support is being given from the quality improvement nurses following this event. Requests are made for HCA's to work in the enhanced observation bays. The ward therapist is utilised to help with enhanced observations
- Sickness is being closely managed in line with Trust Policy and with support from HR where required.
- The vacancy level for RN remains high. The bed base is now 26 beds in lieu of the vacancy and national issues with RN recruitment. Midford are continuously proactively recruiting. The interviews for the Band 7 Senior Sister post on Midford is 9th November.

Nursing and Midwifery Accreditation Programme

Lisa Cheek

Background

The Ward and Outpatient Accreditation programme has been developed to recognise and incentivise high standards of care and reduce variation in practice at ward and department level. It also provides assurance that regulatory requirements including the Care Quality Commission (CQC) fundamental standards are being met and identify where improvements in practice are required. Wards and departments are scored against each of the performance indicators based on their levels of performance over the last 6 months on a sliding scale.

Ward Accreditation update

Table 1 summarises the accreditation level achieved by wards to date. At Bronze level the assessment is based on data routinely collected, observations of practice including quality of safety briefings, handover and whiteboard rounds, and interviews with patients and staff.

Progress

Acute Stroke Unit, Parry Ward and Surgical Short Stay achieved Bronze level in July 2018. NICU were assessed at Foundation level for the first time in July 2018 but have not achieved the required standards. This was due to improvements required for completion of pain assessments and the medicines storage audit. To date 23 of 31 wards have achieved Bronze Level. 7 wards remain at Foundation Level with a supportive programme and timeframe for re-assessment.

Next steps

The community birthing centres will be assessed for the first time at Foundation level from November. Indicators for Silver level are in development. These will build on Bronze level and include wards presenting a portfolio of evidence, including demonstration of improvements made following patient experience feedback and quality improvement projects, to a team of assessors. The framework for the Silver assessment will be tested on Helena Ward in November.

Table 1: Ward Accreditation	Dates of assessments and outcome					Current Level Achieved
	Sep-16	Jun-17	Oct-17	Mar-18	July 18	
Medicine Division						
ACE	X		✓			Bronze
Acute Stroke Unit	X		X		✓	Bronze
Cardiac	X					Foundation
Cheselden	✓					Bronze
Combe	X					Foundation
Coronary Care Unit	X		✓			Bronze
Emergency Department				X		Foundation
Emergency Department Obs				X		Foundation
Haygarth	X			X		Foundation
Helena	X		✓			Bronze
Medical Assessment Unit	X		✓			Bronze
Medical Short Stay	X		X			Foundation
Midford	✓					Bronze
Parry	X		X		✓	Bronze
Respiratory	X			✓		Bronze
Violet Prince				✓		Bronze
Waterhouse	✓					Bronze
William Budd	✓					Bronze
Surgery Division						
Critical Care Services	X			✓		Bronze
Forrester Brown	X			✓		Bronze
Philip Yeoman	X		✓			Bronze
Pierce				✓		Bronze
Pulteney	✓					Bronze
Robin Smith	X			X		Foundation
Surgical Admissions Unit	✓					Bronze
Surgical Short Stay	X			X	✓	Bronze
Women & Children Division						
Bath Birthing Centre (BBC)				✓		Bronze
Charlotte	✓					Bronze
Children's		✓				Bronze
Mary				✓		Bronze
NICU					X	None

Nursing and Midwifery Accreditation Programme

Lisa Cheek

Outpatient Accreditation update

Table 2 summarises progress for assessment of outpatients and the accreditation level achieved to date. At Bronze level the assessment is based on data routinely collected, observations of practice including quality of safety briefings, privacy and dignity and infection control and interviews with patients and staff.

Progress

Dermatology achieved Foundation level in September 2018. Cardiology and Rheumatology were also assessed for Foundation level in September but did not achieve the required standard.

All other Outpatient departments assessed between July and September 2018 were assessed at Bronze level. To date 17 outpatient areas have been assessed at Bronze Level, with 6 achieving Bronze.

Next steps

Staff from the Quality Improvement Centre have met with the department managers for areas not achieving Foundation or Bronze level to discuss the assessment findings and identify any further support needed to achieve the required standard.

Assessments at Bronze level are planned during October for ENT, Dermatology, Sexual Health and OPU and Neurology.

Table 2: Outpatient Department	Date of assessments and outcome						Current Level Achieved
	Mar-16	Oct-16	Aug-17	Jul-18	Aug-18	Sep-18	
Medicine Division							
Ambulatory Care	✓				X		Foundation
Cardiology	X	X	X			X	None
Chemotherapy Day Unit		✓				X	Foundation
Dermatology	X					✓	Foundation
Diabetes Clinic	✓			X			Foundation
Gastroenterology	X	X	✓		✓		Bronze
Medical Therapies Unit	✓				X		Foundation
Oncology Day Care		✓				X	Foundation
Oncology/Haematology	X	✓		X			Foundation
Respiratory	✓					X	Foundation
Rheumatology						X	None
Surgery Division							
Breast Unit	✓			✓			Bronze
ENT	X	✓					Foundation
Fracture Clinic	✓			X			Foundation
Ophthalmology	X	✓		✓			Bronze
Oral Surgery	X	✓				✓	Bronze
Pain Clinic	X	X	✓	✓			Bronze
Pre-Operative Assessment	✓						Foundation
Sexual Health	✓						Foundation
Urology	✓			✓			Bronze
Women & Children Division							
Gynaecology	✓			X			Foundation
Vascular Studies	✓					X	Foundation

Nursing Quality Indicators - Monthly Template September 2018

APPENDIX A

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			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			Sep 18 No:	Aug 18 No:	Jul 18 No:	Jun 18 No:	May 18 No:	Apr 18 No:
						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							
SAU	Bronze	94	10%						0	1	0	0				2.1	0.2	75.0	83.3	1	75.3%	102.2%	74.4%	110.2%	10.1	4	3	3	1	0	3
A&E	Foundation	98	3%	1	6		3		1	0	0	0				5.5	11.8	84.8	95.2							5	2	4	2	1	2
MAU	Bronze	85	8%		2		2		2	1	0	0				3.5	17.3	93.2	85.0		78.4%	123.6%	81.7%	129.3%	8.1	5	5	8	6	6	3
Cheselden	Bronze	95	83%						2	1	0	0				12.9	1.5	92.9	92.9		66.7%	119.3%	97.8%	99.6%	5.4	2	3	2	1	2	0
Acute Stroke Unit	Bronze	98	61%		1				8	1	0	0				2.9	4.2	84.6	100.0	4	60.9%	87.4%	85.4%	124.7%	7.3	2	4	4	4	5	6
Helena	Bronze	94	64%		1				4	0	0	0				6.1	6.5	100.0	93.3	1	86.0%	148.8%	84.3%	163.1%	9.8	3	1	3	3	4	5
Phillip Yeoman	Bronze	100	65%						0	0	0	0				3.8	0.7	90.9	100.0		96.9%	67.3%	68.2%	70.0%	6.3	3	3	3	3	3	3
CCU	Bronze	100	46%						2	0	0	0				2.0	9.4	87.5	50.0		73.6%	92.3%	98.3%	99.9%	10.4	3	3	3	4	3	4
Medical Short Stay Unit	Foundation	93	54%						0	0	0	0				6.2	0.5	57.1	77.8		70.9%	106.3%	98.3%	156.3%	5.8	4	2	5	3	2	5
Surgical Short Stay Unit	Bronze	97	60%	2	1		2		1	0	0	0				3.0	10.4	85.0	81.8		88.3%	96.6%	78.8%	163.3%	6.6	4	3	2	4	1	2
Violet Prince (RNHRD)	Bronze	96	62%						3	0	0	0				0.0	18.5	100.0	33.3		81.7%	70.8%	105.6%	93.3%	5.1	4	3	3	3	2	3
Robin Smith	Foundation	96	21%						1	0	0	0				5.2	6.1	90.9	94.1	2	95.4%	90.0%	79.5%	118.2%	6.2	4	4	1	2	3	3
Critical Care Services	Bronze	N/A	N/A						0	0	0	0				8.3	0.0	87.5	100.0		82.8%	86.0%	77.5%	60.0%	29.8	4	4	4	7	5	5
Respiratory	Bronze	90	58%	2					2	0	0	0				3.9	5.9	88.9	93.8	2	67.9%	130.7%	75.3%	120.0%	5.7	4	5	4	5	3	4
Forrester Brown	Bronze	90	37%				1		5	0	0	0				5.5	2.1	100.0	100.0	1	85.9%	104.1%	73.9%	137.4%	7.4	4	6	6	3	3	4
Charlotte	Bronze	100	22%		1				1	0	0	0				7.0	1.6	69.2	75.0	1	84.8%	85.4%	98.1%	95.1%	6.7	5	3	2	0	1	1
Mary Ward	Bronze	99	29%						0	0	0	0				2.9	5.0	79.3	33.3		105.4%	89.3%	91.3%	82.2%	10.0	5	3	4	5	1	3
Waterhouse	Bronze	100	42%	1	1				6	0	0	0				9.3	5.8	92.3	100.0	2	72.5%	91.2%	105.4%	102.5%	5.9	5	4	4	5	4	3
Children's Ward	Bronze	99	20%		2				0	1	0	0				3.4	1.4	70.7	90.0		82.0%	70.8%	78.3%	130.0%	6.7	5	5	3	4	4	5
Cardiac	Foundation	95	55%						5	1	0	0				3.8	10.9	75.0	93.3	6	76.2%	114.1%	75.0%	163.3%	5.0	5	6	6	6	6	5
Pierce	Bronze	92	16%	1	1		1		0	0	0	0	1			0.4	0.1	86.7	81.3		75.0%	136.5%	84.9%	183.3%	7.4	6	5	3	1	3	2
Parry	Bronze	97	26%					1	6	0	0	0				1.2	11.9	91.7	76.9		78.6%	92.0%	102.8%	98.5%	5.6	6	5	3	1	5	5
William Budd	Bronze	96	43%				1	1	1	0	0	0				0.5	0.0	66.7	71.4	3	66.7%	104.5%	72.3%	137.0%	7.2	6	5	4	6	4	5
Pulteney	Bronze	96	42%						2	1	0	0		1		8.2	5.2	41.7	25.0		80.0%	90.3%	75.4%	121.1%	6.4	7	5	5	5	1	7
Midford	Bronze	100	127%	1					3	1	0	0	1	1		5.3	6.8	80.0	86.7		55.3%	137.2%	66.2%	188.8%	7.1	7	6	4	6	4	3
NICU	Not assessed	100	25%		1				0	0	0	0				2.7	2.8	67.5	78.6		82.7%	33.1%	73.8%	43.3%	10.7	7	6	6	5	4	5
Haygarth	Foundation	96	31%				1		5	2	0	0				9.9	7.0	100.0	100.0	2	59.1%	103.8%	70.9%	193.0%	6.0	7	7	4	5	4	6
ACE OPU	Bronze	100	65%					1	4	1	0	0				10.4	5.5	55.0	94.1		68.2%	105.3%	58.1%	124.1%	6.6	7	8	6	5	4	3
Combe	Foundation	98	68%						10	1	0	0				7.2	8.2	50.0	78.6	10	60.2%	117.1%	69.5%	218.1%	6.7	7	8	6	5	7	5
		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			5% or more		80% or less			85% or less					More than 5 Amended metrics for Feb 2018 (falls and staffing levels)					

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