Royal United Hospitals Bath
NHS Foundation Trust

Report to:	Public Board of Directors	Agenda item:	7
Date of Meeting:	30 January 2019		
Title of Report:	Quality Report		
Status:	For discussion		
Board Sponsor:	Lisa Cheek, Director of Nursing and Midwifery Bernie Marden, Medical Director		
Author:	Lisa Cheek, 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 December 2018 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)
  - NEWS
  - Sepsis including AMR
- 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.)

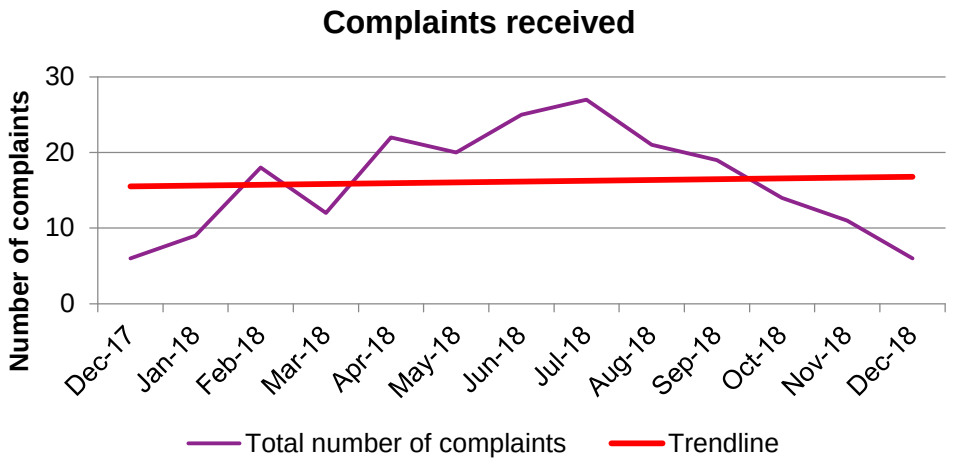
A failure to demonstrate sustained quality improvement could risk the Trust's registration with the Care Quality Commission (CQC) and the reputation of the Trust.

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 Report



There were **6** formal complaints in December. **4** were for the **Surgical Division** and **2** for the **Medical Division.** There has been a marked reduction in the numbers of complaints since July 2018.

The 6 complaints received highlighted the following concerns:

- Delays in treatment
- Attitude and behaviour of staff
- Communication with family
- Clinical concerns - including missed diagnoses and outcome from surgery

Complaint response rate by Division	Division			Total
	Surgery	W&C	Medicine	
Closed within 35 day target	0 (0%)	No responses due	1 (33.3%)	1 (17%)
Breached 35 Day target	3 (100%)	-	2 (66.6%)	5 (83%)
Total	3	N/A	3	6

Reasons for the breach of response dates:

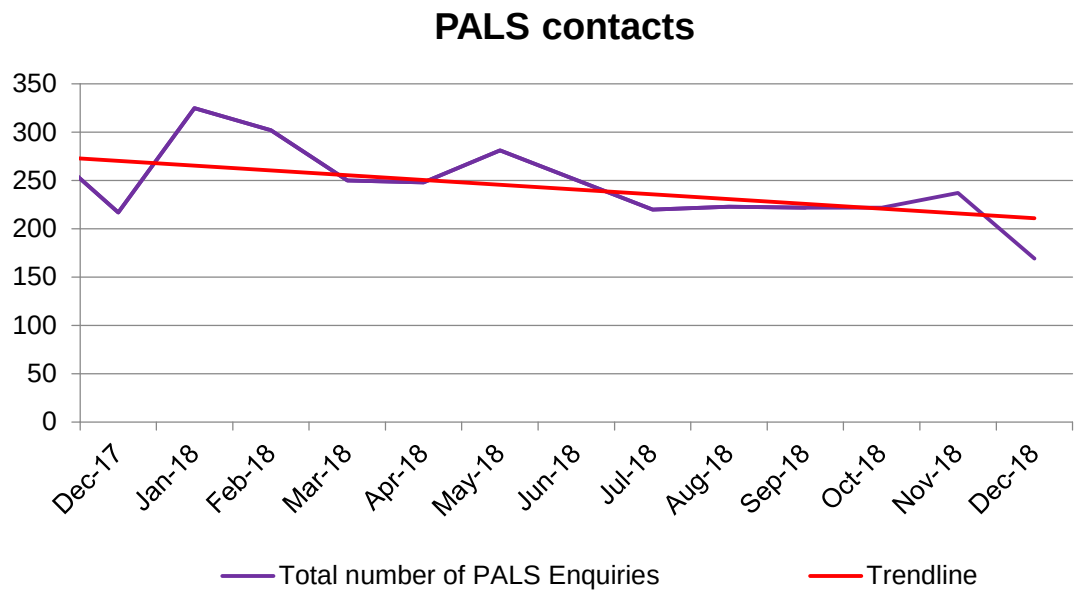
The **Surgical Division** currently have 2 responses outstanding that were due for a response in December:

- One is 10 days overdue – waiting for clinical information
- Delays in being able to agree a suitable meeting date. Now scheduled for end of January.
- One complaint that has now been responded to in December was 12 days late as a result of a complaint meeting that needed to be arranged with a number of specialities.

The **Medicine Division** had 1 complaint that was one day over target. This relates to more information needed.

Overview:
In November the Trust responded to 78% of complaints within 35 working days. In December there were less complaint responses due, however only 1 in 6 were responded to within the required timeframe. Work is being undertaken with the Divisions to explore the barriers to timely responses to complainants.

Patient Advice and Liaison Report



There were **169 contacts with PALS** in December. This is a marked decrease compared to the number of contacts in December 2017 and a 29% decrease from November 2018.

- 109 required resolution (65%)
- 43 requested advice or information (25%)
- 8 provided feedback (5%)
- 9 were compliments (5%)

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

Appointments - there were **31** contacts regarding appointments. **10** of these related to the length of time waiting for new appointment; **6** related to the length of time for a follow up appointment; **6** concerned appointment information – for example date and time. There were no clear trends for the remaining concerns.

Clinical Care & Concerns - there were **18** contacts. **16** were general enquiries about clinical care; **1** related to quality/concerns regarding medical care; the remaining **1** related to the care of a patient who felt the clinician was inconsiderate.

Communication and Information - there were **17** contacts. **6** were general enquiries/communication; **4** related to telephone issues (phone not being answered); **2** related to test results not being acted upon. There were no clear trend for the remaining contacts.

QUALITY REPORT

PART B – Patient Safety and Quality Improvement

Executive Sponsors
(1) Lisa Cheek, 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:

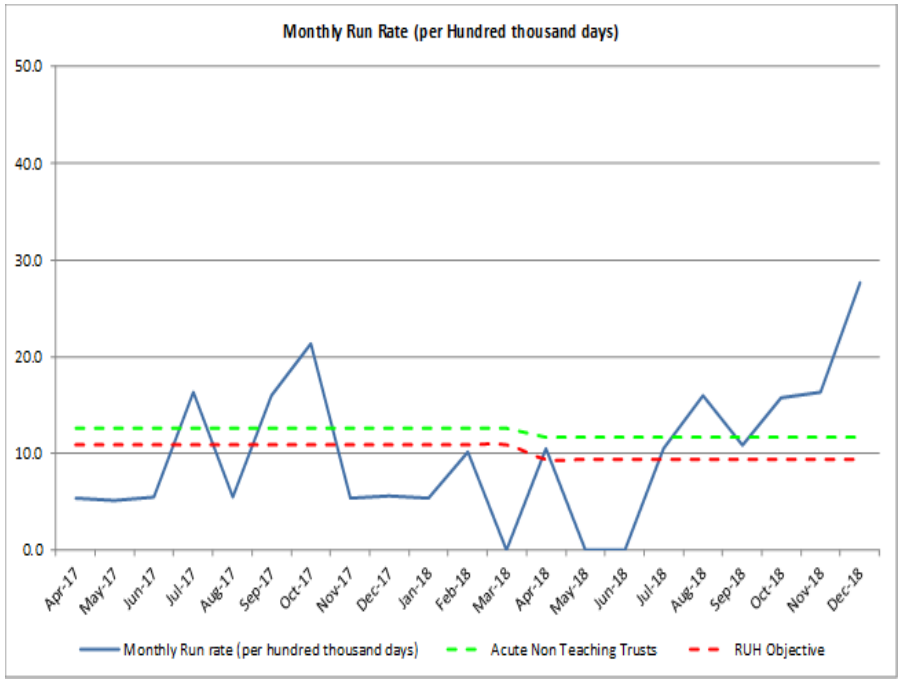
Pressure Ulcers (1)
National Safety Standards for Invasive Procedures (NatSSIPs) (2)
Emergency Department Safety (3)
Improving Insulin Safety (3)

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 Q3 there had been 25 cases in total, 5 of which will not be counted in the year end total as there were no lapses of care identified.

Current Performance



17 of the 25 RCAs have been received and lapses in care identified in 12 cases as follows:

- Delay in sampling
- Delay in isolation
- Incomplete documentation on stool chart
- Antibiotic prescribing not in line with Trust policy
- Duration of antibiotic course too long
- Delay in reviewing and responding to microbiological results
- Dirty commodes identified in the same week
- Poor hand hygiene audit results
- Low cleaning audit score
- IPC training below 90%
- Compliance with C diff workbook completion below 90%

Patient Safety – Clostridium difficile

Lisa Cheek

Actions to improve *Clostridium difficile* performance

- *Clostridium difficile* swarm immediately after each case: audits on hand hygiene, PPE usage, cleanliness and environment, focused training with ward staff. Commenced with immediate effect.
- Medical Director to attend the ward with the Infection Prevention and Control Team to review case, on the same day as the result is reported where possible. Commenced with immediate effect.
- Weekly *Clostridium difficile* ward round with microbiologist, antimicrobial pharmacist and Infection Prevention and Control Nurse: management of patient reviewed and treated adjusted when required, liaison with clinicians looking after the patient. Ongoing action.
- Matrons and Infection Prevention and Control Nurses in attendance at cleaning audits; issues raised during audit are escalated. Commenced November 2018.
- Revision/re-focus of the Cleaning Action Plan by 31 January 2019.
- Matrons to lead the 2019 Spring Clean/Declutter campaign with infection control team support. Plan to be put in place by 31 March 2019.
- Infection Prevention and Control Team undertaking equipment cleanliness audits with immediate feedback to staff. Ongoing action.
- Antibiotic Review Kit implementation from 10 January 2019
- Antimicrobial ward rounds on high risk areas. Ongoing action.
- Sharing of learning from RCAs across the Trust via Matrons and Sisters meetings. Ongoing action.
- Trial of revised diarrhoea pathway in ED and admission areas; to be rolled out to other areas if successful. Action by 31 January 2019.
- Stool sampling reminder poster delivered to all adult inpatient areas and discussed with staff. Acton completed.
- Duty matron to be informed of new cases at weekends. Ongoing action.
- Matrons to follow up cases within their area to support staff with management and isolation. Commenced with immediate effect.
- *Clostridium difficile* to be the main emphasis of the Infection Prevention and Control Link Practitioner study day in May 2019.

Patient Safety – Acute Kidney Injury (AKI)

Bernie Marden

Awareness and Training

- AKI/Sepsis training is included on Corporate induction as well as Core skills.
- Training has been approved as 'essential for role' and will be recorded on STAR records with an AKI e-learning in development.
- The AKI, Sepsis and NEWS work streams are now combined forming the 'Deteriorating Patient Working Group' 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 has commenced in Trauma and Orthopaedics, General Surgery, Maternity and Paediatrics. Results awaited

Discharge Summary Information

- Trust wide data from the same patients as above is collated monthly (see run charts Fig 3.0 - 3.2). Information from the electronic alert in the discharge summary is still awaited.

Improvement work

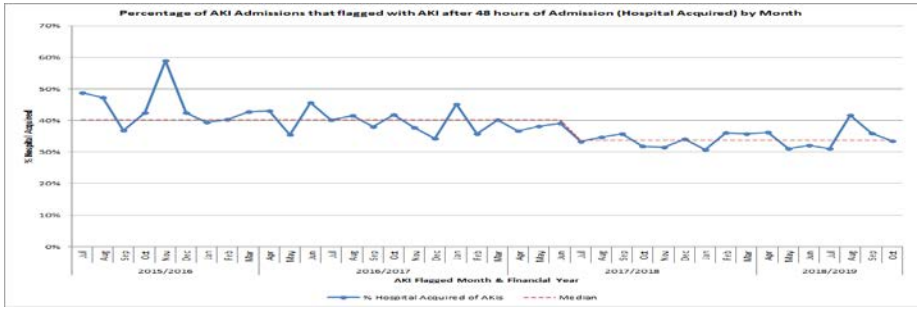
- Medication review: ePMA has been updated so that pharmacists patient list now includes AKI grade so that reviews can be prioritised.
- Fluid balance Chart : Work continues on the amended fluid balance chart with a plan for electronic recording of urine output for 2019

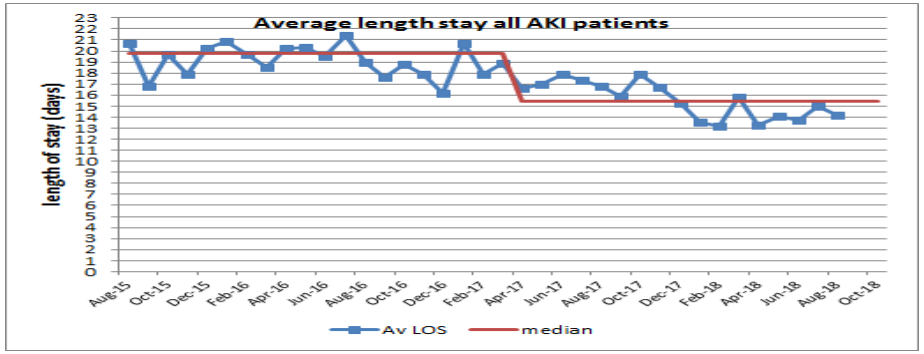
Sharing our success

- The sepsis and AKI work has achieved regional and national success in 2018, with AKI work selected from 77 projects across the South West to be presented at the AHSE Quality & Safety Conference in Taunton and the combined work was Shortlisted as finalists for HSJ award 2018 in the patient safety category.

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.

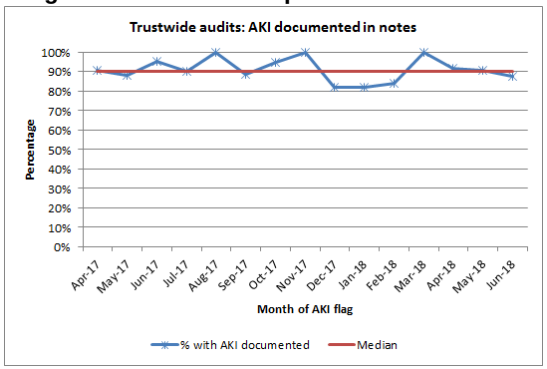


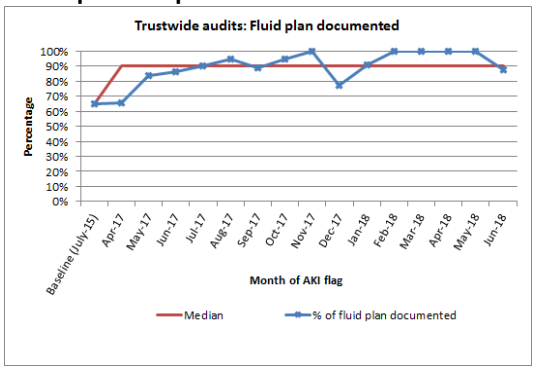


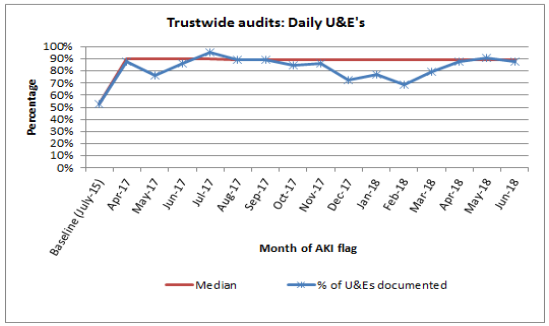
Patient Safety – Acute Kidney Injury (AKI)

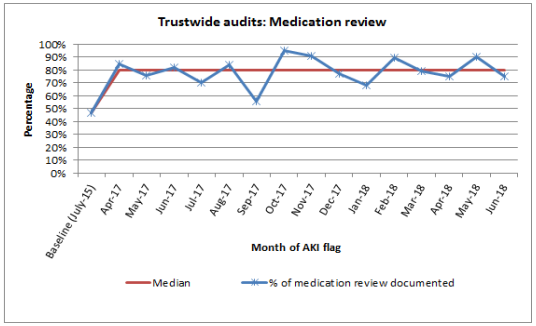
Bernie Marden

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









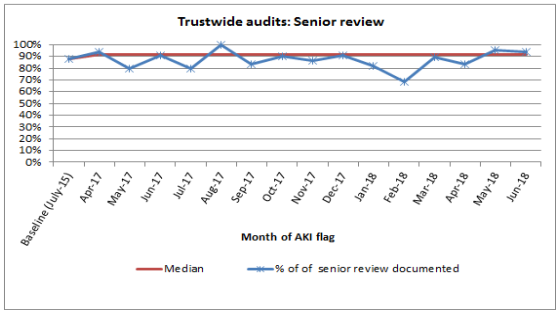
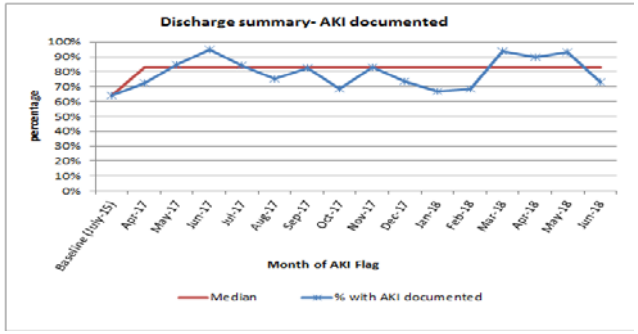
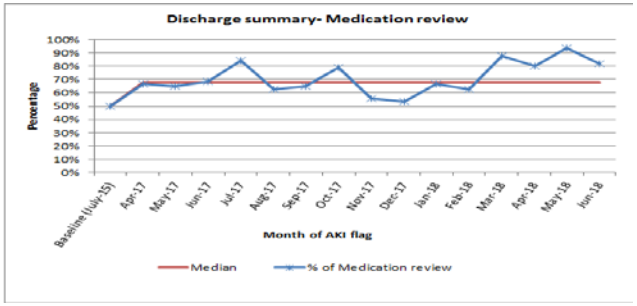
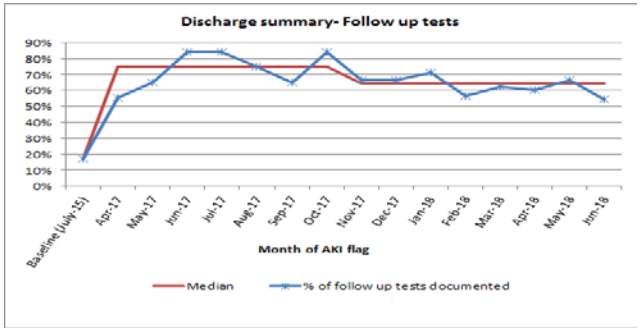


Fig 3.0- 3.2 Discharge summary compliance Audits based on 18—25 patients per month







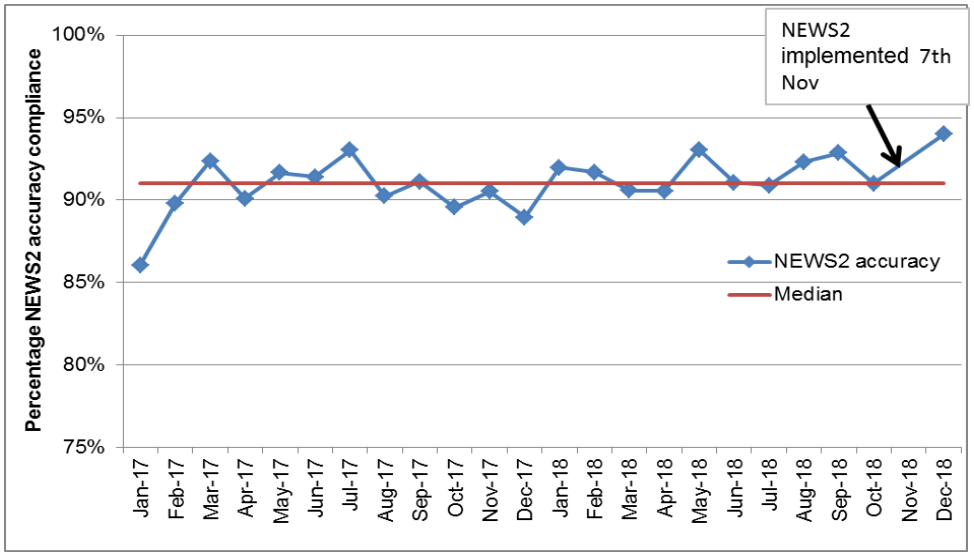
Patient Safety - National Early Warning Score (NEWS) workstream report Bernie Marden

Work stream update

The aim of the National Early Warning Score (NEWS) work stream is to ensure that NEWS2 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.

Monthly audits to measure NEWS recorded shown sustained results trust wide at 98% since December 2016. Accuracy of NEWS trust wide is shown in Figure 1.Data is shared and reported as part of the Divisional scorecard and ward dashboard.

Figure 1:



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

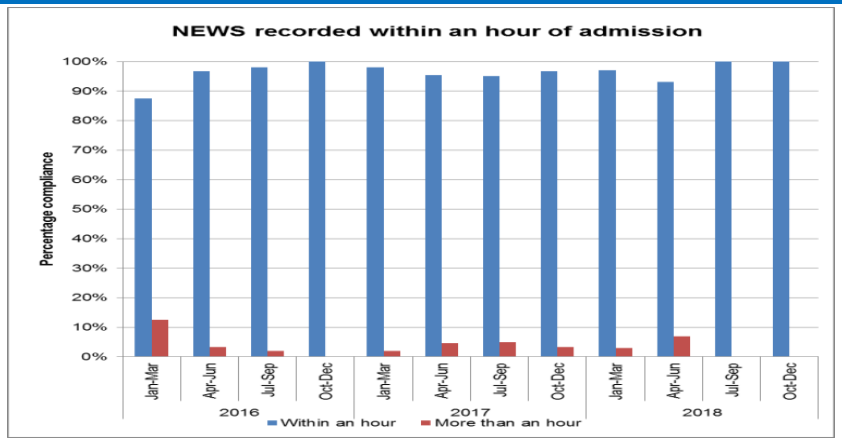


Figure 2

Progress to work plan:

- The Deteriorating Patient proforma was launched trust wide 7th November 2018.An audit of notes of all patients who had a 2222 emergency call in December is being undertaken 22nd January to measure compliance of use.
- In conjunction with the launch of NEWS2 chart in November 2018 the NEWS 2 eLearning package has been developed and is currently being tested. A launch of the eLearning is planned for February 2019.

Next steps:

- The NEWS work stream will support and help drive the project for an electronic observation system.
- The eObservations project board has been established with fortnightly meets scheduled, in addition a weekly Mobilisation team has been established.
- Devices to support the implementation are being sourced and the test ward will be Helena in March and second ward Philip Yeoman in April

Patient Safety – Sepsis inc AMR

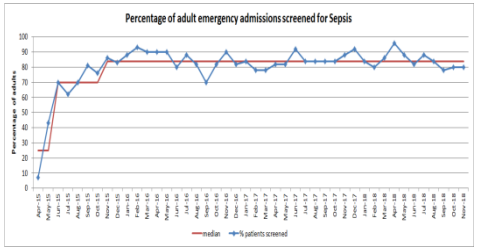
Bernie Marden

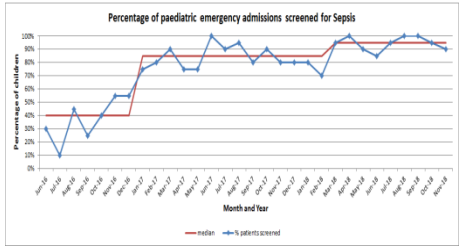
CQUIN for Sepsis

Targets for Sepsis Screening and Antibiotics are both 90% trust wide for 2018/19. Quarter 4 2018/19 also requires NEWS 2 to be used to be eligible for payment. Quarter 2 partial payment achieved for screening (82%) and full payment for antibiotics with 93% patients received antibiotics within 60 minutes of sepsis diagnosis.

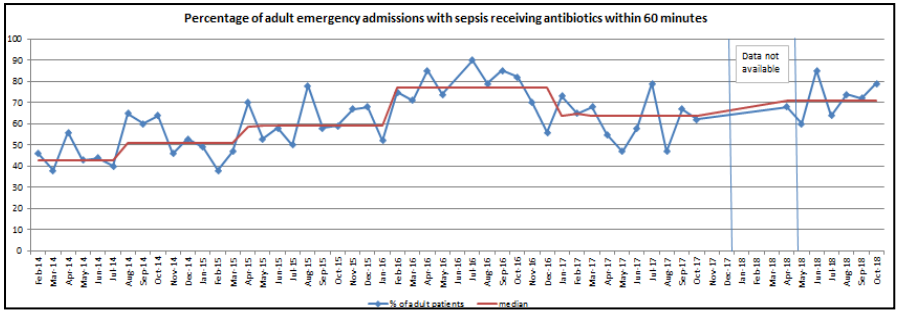
Sepsis on Admission

Median compliance with Sepsis screening on admission is 84% for adults. This has not shown further improvement over 2018 and processes are being reviewed to look for areas of improvement. Paediatric screening has improved and is 95%





Since April a sample of 20 patients identified with sepsis each month is obtained to gather antibiotic compliance data and on average 71% of patients have received antibiotics in an hour from signs of sepsis and was 79% in October 2018



The main reasons identified for delay for adult patients is time to medical review, as well as occasional delay in delivery following prescription. Many of these were related to exceptionally busy times in ED. Only small numbers of children are identified with sepsis and current data is awaited.

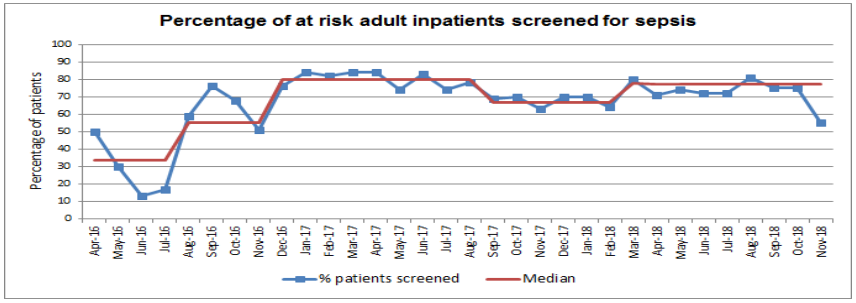
Inpatients with Sepsis

Screening:

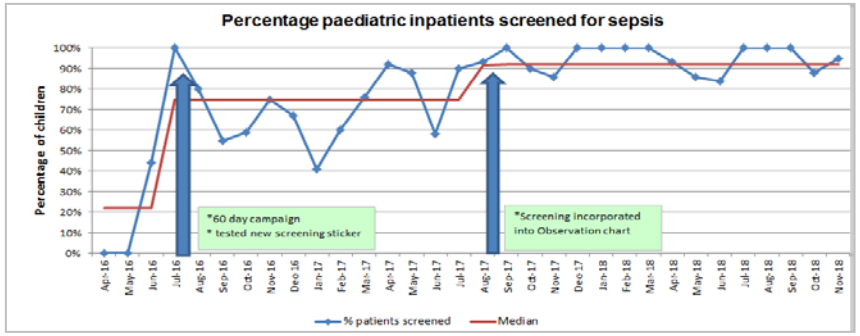
Screening for inpatients remains from random note reviews trust wide and is difficult to maintain due to manual recording of screening – median is 77% for adults since April 2018. Electronic recording of observations is awaited to improve this and is planned to be implemented in 2019.

Of concern, compliance in November dropped to 55%, probably attributable to the launch of NEWS2, as well as to the loss of the band 6 sepsis nurse.

Data collection is a concern going forward due to depletion of the sepsis team. A temporary team has been appointed and is in place until end March. A business case for a permanent team aimed at early detection of the deteriorating patient is being developed that will be present from 8am – 6pm 7 days a week.



Paediatric screening remains > 90%

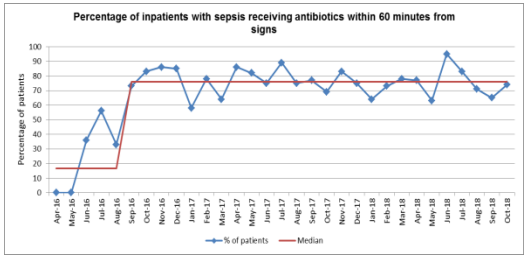


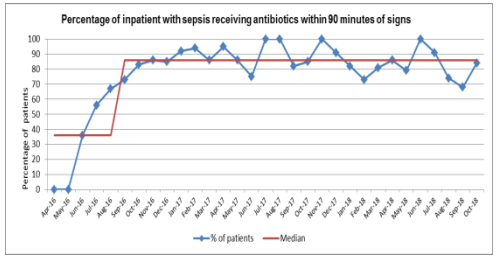
Patient Safety – Sepsis inc AMR

Bernie Marden

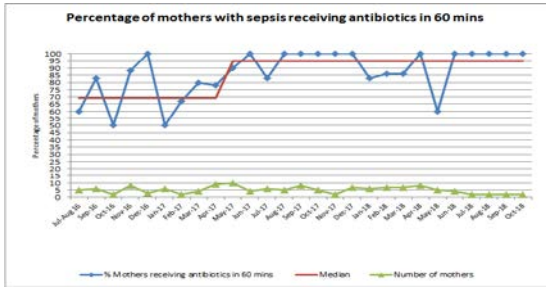
Management of Inpatients with Sepsis

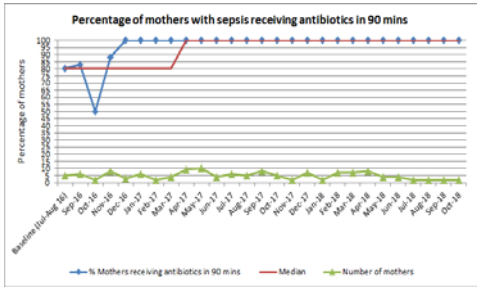
Inpatients with sepsis are identified from screening, outreach or sepsis nurse referrals and on average 20 patients are identified. In November and December with the decrease in sepsis nurse service, fewer patients were identified.
Current compliance is median of 76% patients receiving antibiotics in an hour from signs and 86% in 90 minutes. Some data is still awaited for October .





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%





Awareness and Training

From September 2018 AKI/Sepsis training is included on Corporate induction and continues to be delivered on Core skills. Both have been approved as 'essential for role' and will appear on STAR record, with e-learning in development.
The sepsis and AKI working groups have now merged with the NEWS working group to form the 'deteriorating patient working group' and Deteriorating Patient champions are being developed in each area.

National Recognition

The inpatient sepsis and AKI work received national recognition and was shortlisted as a finalist for HSJ award 2018 in the patient safety category.

Work with Primary Care and Community Hospitals

The sepsis lead has continued to drive use of NEWS in the community to prompt early identification of sepsis. Plans have been developed with the CCGs to request NEWS score on referral from GPs which will be implemented in 2019

Outcomes

In September 2018 a national 'Suspicion of sepsis 'dashboard has been produced to track outcomes from patients with 'all infections termed 'suspicion of sepsis'(SOS). From this dashboard, between 2016/17 to 2017/18 RUH has demonstrated significant improved outcomes for patients with SOS diagnoses:

- 17% reduction in Mortality rate,
- 12% reduction in average number ICU bed days (average decrease 28 days per month)
- 10% reduction in length of stay

Total of 11,500 bed days
This is despite an increase in incidence SOS of an average 500 patients per year.
The sepsis team will continue to monitor these outcomes.

Issues

The sepsis nursing team has decreased over the last 2 months and has a temporary team in place until the end of March. There have been significant improvements in inpatient management of sepsis but this is difficult to sustain and a permanent Sepsis / deteriorating patient team is required as well as implementation of electronic recording of observations to sustain these and improve further.

Serious Incidents (SI) Summary

Lisa Cheek

Current Performance

Six serious incidents were reported to STEIS in December 2018. All incidents continue to be under investigation.

Serious Incidents Reported to STEIS July 2017 to August 2018												
Dec 17	Jan 18	Feb 18	Mar 18	Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18
6	10	5	0	3	13	2	5	8	5	5	4	6

Date of Incident	ID	Summary
20/11/2018	**68249**	Fall with fracture
21/11/2018	**68252**	Fall with fracture
02/12/2018	**68599**	Wrong site surgery
08/12/2018	**68770**	Fall with fracture
10/12/2018	**68848**	Intrauterine death
11/12/2018	**68858**	Unexpected return to theatre

Overdue Serious Incident Report

Lisa Cheek

The risk team continue the drive to maintain compliance with submitting serious incidents to the CCG. The Trust compliance has improved and serious incident reports are prioritised for review at Operational Clinical Governance Committee with extra-ordinary meetings currently in place to enable serious incidents to be presented for Trust sign off in a timely manner. As of 2nd January 2019, there are 19 serious incidents that are open and under investigation of which 2 are overdue: one awaiting feedback following Operational Clinical Governance Committee Meeting and one was a late submission for falls, an extension request is submitted to the CCG pending the next falls group in January. One RCA remains open pending a downgrade request and four have extensions agreed by the CCG. All overdue RCA's are tracked by the Risk Team and escalated to Divisional or Trust leads accordingly when in breach of the submission dates.

Actions outstanding continue to fluctuate. The Heads of Nursing and Patient Safety Leads for each Clinical Division are advised weekly of the overdue actions that relate to their Divisions and are requested to update the risk team on progress of closure.

	Dec 17	Jan 18	Feb 18	Mar 18	Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18
Outstanding Action Plans	30	23	28	32	25	19	14	21	29	32	26	24	18
Outstanding Actions	49	43	34	54	42	46	22	30	54	54	66	43	38

Nursing Quality Indicators Exception Report Lisa Cheek

Surgical Admissions Unit
This ward has not flagged since September 2017.

Quality Matrices to Note are:
- 1 Negative PALS complaint
- RN Sickness 9.4%
- RN Appraisal 61.9%
- HCA Appraisal 50%
- RN Day staffing 74.6%
- RN Night Staffing 81.3%

The PALS issue was regarding a patient understanding the rationale of getting dressed after surgery. This was resolved following explanation by Ward Sister and the case was closed.
The RN sickness comprises of 2 long term sickness staff who have since returned to work in January and some short term self limiting illnesses. These are being managed in line with Trust sickness policy.
There is an ongoing plan across the surgical division regarding improving the rate of appraisals. The Senior Sisters will be offered support to improve appraisal rates during the month of January and February.
RN staffing is lower this month due to the higher sickness rate, there are no recruitment concerns for Surgical Admissions Unit.

Children's Ward
This is the first time Children's ward has flagged.

Quality Matrices to note are:
- FFT 11%
- 1 negative PALS contact
- HCA sickness is 7.6%
- RN appraisal rate 77.1%
- RN day fill 80.3%
- RN Night fill 84.9%

The Matron is aware of the low FFT response rate. She has contacted the Patient Experience Team to ask for their support in exploring more successful ways of obtaining this data.
The negative PALS contact has been overseen by the matron. The patient has been contacted and an apology given. The nurse involved has been asked to reflect on the issue raised.
All sickness is managed as per Trust policy.
Following recent successful recruitment the ward has reduced its WTE RN staffing vacancies to 7.17 WTE. The senior sister band 7 post is vacant, interviews on 13th February, 2019, there is an experienced band 6 paediatric nurse acting up in the interim senior sister position.
There are 4 WTE RN's on maternity leave. These issues will contribute to the lower appraisal rate and RN staff fill. The ward continues to actively recruit with rolling adverts out for band 5. Interviews scheduled for 17th and 21st January 2019.

Nursing Quality Indicators Exception Report Lisa Cheek

Surgical Short Stay Unit
This ward has flagged for the 2nd consecutive month

Quality Matrices to note are:
- FFT 34%
- HCA sickness is 17.6 %
- TN appraisal 76.2%
- RN day staffing fill 69.5%
- HCA day staffing fill 73.6%
- RN staffing fill 53.8%

The Matron and Senior Sister have reiterated the importance of FFT to the team stressing that it must become less receptionist dependant and more team dependant. This ward has seen a higher than usual level of short term sickness in December. All staff are monitored and managed in line with the supporting attendance policy.
With regards to day and night staffing fill, Surgical Short Stay Unit have supported other wards with their staffing during December. This is closely monitored by the matron to ensure safety is maintained.

Pierce Ward
This ward has flagged for the fourth consecutive month. Matron and Head of Nursing for Surgery are aware. Head of Nursing is meeting with the Matron to ascertain specific support required.

Quality Matrices to note are:
- FFT 20%
- 1 patient with clostridium difficile
- 5 patients fell with no harm
- HCA sickness is at 14.5%
- RN fill rate for days is 69.2%
- RN fill rate for night is 80.4%

In January the Senior Sister has implemented a system that involves the nurse in charge distributing the FFT cards and offering assistance should the patients require it. A new FFT poster is being displayed outside of each bay for staff, patients and relatives to see and an FFT reminder is included in the ward safety briefing.
The clostridium difficile root cause analysis meeting is taking place on 15th January 2019 , results yet to be confirmed. However in the interim period staff have been reminded regarding timely sampling of specimens and the importance of completing clostridium difficile workbooks. The Matron will monitor completion rates.
Pierce ward staff have attended recent falls prevention training on Forrester Brown ward. In addition the therapists on Pierce ward are doing enhanced falls risk training with the staff.
HCA sickness is long term with 2 members of staff. One is due to return beginning of March, this is being managed within the Trust's sickness policy.
The RN fill rate is being monitored by the Matron and risk assessed for each shift to see if further staff are required.

Nursing Quality Indicators Exception Report Lisa Cheek

Midford Ward
This ward last flagged in September 2018.
Quality Matrices to note are:
- 1 clostridium difficile case
- 9 falls no harm
- RN sickness 7.7%
- HCA Sickness 7.8%
- Rn Appraisal 80%
- RN Staffing day Fill 69.2%
- RN staffing night fill 83.1%

The clostridium difficile root cause analysis has shown that there were missed opportunities from the admission period. The Matrons from these areas are collaborating to further educate staff from these areas regarding the importance of sampling. Infection control are also involved in this collaboration.
During the month of December Midford had two patients that had repeated falls. These patients were nursed in the enhanced observation bay to minimise this risk.
RN sickness and HCA sickness is being managed under hospital policy. There are currently 10.6 WTE RN vacancies. The ward had one overseas nurse started in December 2018 and a second overseas nurse commencing week commencing 21st January 2019.
The substantive senior sister started 14th January 2019. The Matron will work with the Senior Sister to improve appraisal rates.
RN staffing fill is less than 85% across the 24 hour period. To help mitigate against this there has been increased HCA fill and one to one/enhanced HCA nursing. The Matron is working with the recruitment team targeting return to acute care initiatives.

Violet Prince Ward
This is the first time Violet Prince ward has flagged in the Nurse Quality Indicators.
Quality Matrices to note are:
- FFT response 7%
- Fall with major harm 1
- HCA sickness is 31.4%
- Appraisal rate HCA is 75%
- RN Staffing day fill rate 79.9%
- HCA staffing day fill rate 56.5%
- HCA staffing night fill rate 80.6%

The FFT response rate this month is unusually low for Violet Prince. Previously Violet Prince have been achieving scores over 60% (27% in Nov). The matron has asked the senior sister to drill down further to ascertain where the problem may have occurred this month and to report back.
There has been 1 fall with major harm. The RCA is currently being undertaken.
HCA sickness is being monitored and managed within Trust policy.
The reduction in safer staffing fill across day and night is proactively assessed on a day to day basis. Any shortage of staff is highlighted to duty medical matron at the RUH. The risk is assessed and staff deployed to Violet Prince as required.
There are 3.5 WTE RN band 5 vacancies and 1 WTE band 2 vacancy.

Nursing Quality Indicators Exception Report Lisa Cheek

Cardiac Ward
This ward last flagged in October 2018.
Quality Matrices to note are:

- FFT response lies at 28%
- 6 No harm falls
- 7.2% HCA Sickness
- 75% Appraisals RNs and 66.7% HCAs
- RN fill 72.9% day and 75.6% Night

The cardiac Band 7 has resigned and the post is out for recruitment. There is a plan to fill this post with the band 6's from the ward in the interim. Cardiac ward have a newly appointed substantive matron who commenced in her role in Dec 2018.

The FFT focus has been delegated to the ward clerks and discharge coordinators as part of their ongoing development. This will be monitored by the newly appointed matron and current senior charge nurse.
The focus on reducing fall remains as a high priority for cardiac ward. They have been working with the falls prevention team and this work continues. They have had one falls simulation exercise which 15 staff attended and a further one is planned for February.
There is 1 HCA on long term sickness and all staff are being managed in line with Trust policy. Appraisal rates have dropped this month. An action plan has been developed to significantly improve the appraisal rates during the month of January. Cardiac ward have recruited to their vacancies and are awaiting the start date for the new recruits. One RN commenced 7th January 2019 and one will be commencing on 1st February 2019, at this point the Cardiac ward will be fully staffed with RN's.

Nursing Quality Indicators - Monthly Template January 2019

APPENDIX A

Report for May 2018 by ward/area triangulating FFT Percent Recommending; PALS; Complaints; Cdiff; Falls; Pressure Ulcers; HR, Staffing

Ward Name	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								
						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 18 No:	Nov 18 No:	Oct 18 No:	Sep 18 No:	Aug 18 No:	Jul 18 No:
A&E	Foundation	98	2%	2			1		1	0	0	0				2.7	8.9	84.2	82.6							3	4	5	5	2	4
MAU	Bronze	100	7%				1		2	1	0	0				3.9	17.9	88.9	85.0		78.9%	162.3%	84.8%	132.3%	11.5	5	5	7	5	5	8
SAU	Bronze	98	18%		1		1		1	0	0	0				9.4	2.1	61.9	50.0		74.6%	107.0%	81.3%	129.0%	12.8	6	5	5	4	3	3
CCU	Bronze	100	46%						0	0	0	0				1.0	0.0	94.7	50.0		89.1%	121.2%	100.0%	99.1%	12.4	1	2	2	3	3	3
Cheselden	Bronze	98	98%						0	0	0	0				6.4	1.2	92.9	100.0		72.6%	104.0%	99.7%	101.6%	5.9	2	1	2	2	3	2
Acute Stroke Unit	Bronze	97	43%						4	1	0	0				3.3	0.9	83.3	90.9	5	70.7%	91.4%	89.9%	113.3%	7.4	2	2	2	2	4	4
Charlotte	Bronze	99	61%				1		1	0	0	0				1.4	5.9	100.0	81.8		109.3%	89.2%	98.4%	83.5%	8.3	3	1	5	5	3	2
Robin Smith	Foundation	97	25%		1				2	1	0	0				0.0	3.1	100.0	94.1		83.0%	112.0%	82.7%	148.6%	7.3	3	3	3	4	4	1
Helena	Bronze	100	56%						3	0	0	0				2.9	12.5	100.0	92.9		70.0%	138.6%	66.8%	136.3%	8.1	3	4	2	3	1	3
Waterhouse	Bronze	97	84%		1				7	1	0	0				5.4	3.6	92.3	100.0	2	68.3%	103.9%	101.9%	127.0%	6.5	3	4	3	5	4	4
Mary Ward	Bronze	98	27%						0	0	0	0				6.3	9.7	85.0	81.8		100.7%	85.3%	94.3%	85.5%	12.7	3	4	5	5	3	4
Medical Short Stay Unit	Foundation	98	41%						1	0	0	0				13.5	2.1	84.6	88.9		64.1%	115.3%	94.8%	124.3%	6.2	3	6	3	4	2	5
William Budd	Bronze	100	28%					1	1	1	0	0				1.7	1.8	90.9	85.7		55.0%	95.5%	66.4%	126.2%	8.1	4	1	5	6	5	4
Parry	Bronze	100	26%						6	0	0	0				3.1	14.6	90.9	84.6		79.0%	107.0%	98.3%	115.1%	6.2	4	4	5	6	5	3
Combe	Foundation	95	52%						9	0	0	0				5.7	1.3	83.3	100.0	2	67.5%	113.9%	67.4%	208.7%	6.9	4	4	5	7	8	6
Pulteney	Bronze	97	48%						2	0	0	0				0.3	6.1	44.0	25.0		75.2%	108.2%	88.9%	124.5%	7.5	4	4	6	7	5	5
NICU	Not assessed	100	62%						0	0	0	0				2.0	2.5	85.7	100.0		75.3%	37.1%	70.4%	46.8%	10.3	4	4	6	7	6	6
ACE OPU	Bronze	97	46%						4	0	0	0				10.5	5.0	85.0	88.2		59.9%	105.5%	68.2%	126.0%	7.2	4	5	5	7	8	6
Respiratory	Bronze	97	61%					1	1	0	0	0				11.2	4.2	94.7	94.1		75.3%	122.4%	78.4%	107.0%	5.8	4	7	4	4	5	4
Forrester Brown	Bronze	92	31%						2	0	0	0				10.4	10.4	100.0	94.4	4	85.0%	99.4%	84.1%	119.7%	7.1	5	3	1	4	6	6
Phillip Yeoman	Bronze	94	58%						1	0	0	0				2.1	5.8	66.7	90.9		90.5%	57.5%	66.1%	84.1%	7.7	5	3	3	3	3	3
Haygarth	Foundation	94	34%					1	4	0	0	0				3.6	1.3	80.0	100.0	1	68.9%	102.0%	66.6%	187.2%	6.6	5	4	3	7	7	4
Critical Care Services	Bronze	N/A	N/A						1	0	0	0				7.9	0.8	87.3	66.7		75.1%	98.8%	82.1%	16.1%	30.1	5	5	5	4	4	4
Children's Ward	Bronze	96	11%				1		0	0	0	0				4.6	7.6	77.1	90.0	4	80.3%	100.0%	84.9%	159.9%	7.0	6	5	5	5	5	3
Surgical Short Stay Unit	Bronze	98	34%						0	0	0	0				3.8	17.6	76.2	84.6		69.5%	73.6%	53.8%	138.7%	7.2	6	7	5	4	3	2
Pierce	Bronze	100	20%					1	5	1	0	0				4.5	14.5	81.3	78.6		69.6%	135.9%	80.4%	167.9%	7.5	6	7	6	6	5	3
Midford	Bronze	100	59%					1	9	3	0	0				7.7	7.8	80.0	100.0	3	69.2%	135.0%	83.1%	201.2%	6.5	7	3	4	7	6	4
Violet Prince (RNHRD)	Bronze	67	7%						0	0	0	1				0.9	31.4	100.0	75.0		79.9%	56.5%	98.8%	80.6%	5.3	7	4	3	4	3	3
Cardiac	Foundation	97	28%						6	1	0	0				3.2	7.2	75.0	66.7		72.9%	131.3%	75.6%	163.7%	5.3	7	4	6	5	6	6
		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