Royal United Hospitals Bath
NHS Foundation Trust

Report to:	**Public Board of Directors**	**Agenda item:**	**7**
Date of Meeting:	**24 April 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 March 2019 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
  - Deteriorating Patient including sepsis AKI and NEWS
  - Clostridium difficile
- 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

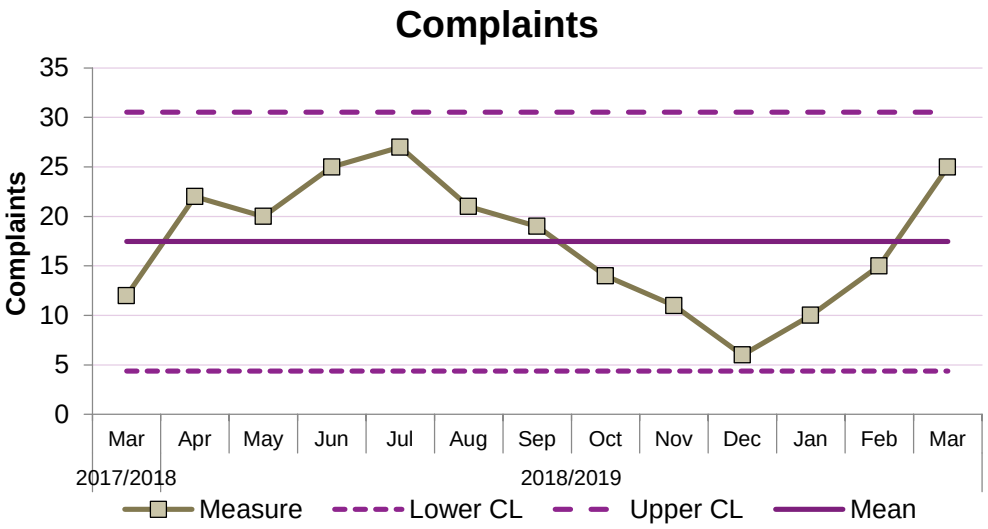
Ensures compliance with the Equality Delivery System (EDS).

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



Lower CL = lower confidence limits and **Upper CL** = upper confidence limits

Complaint response rate by Division	**Division**			**Total**
	Surgery	W&C	Medicine	
Closed within 35 day target	3 (100%)	0 (0%)	3 (50%)	6 (67%)
Breached 35 Day target	0 (0%)	0 (0%)	3 (50%)	3 (33%)
Total	**3**	**0**	**6**	**9**

There were **25** formal complaints in March. 13 were for the Surgical Division and 12 for the Medical Division. There were no complaints in the Women and Children's Division. The 25 complaints related to concerns in the following areas:

- Competence/knowledge of staff
- Staff attitude
- Quality and co-ordination of medical treatment
- Inappropriate care and treatment
- Inappropriate/inaccurate/incomplete correspondence
- Patient not kept informed/updated (on discharge/as an outpatient)
- Test results lost or mislaid
- Wait for Treatment/Tests/Appointments

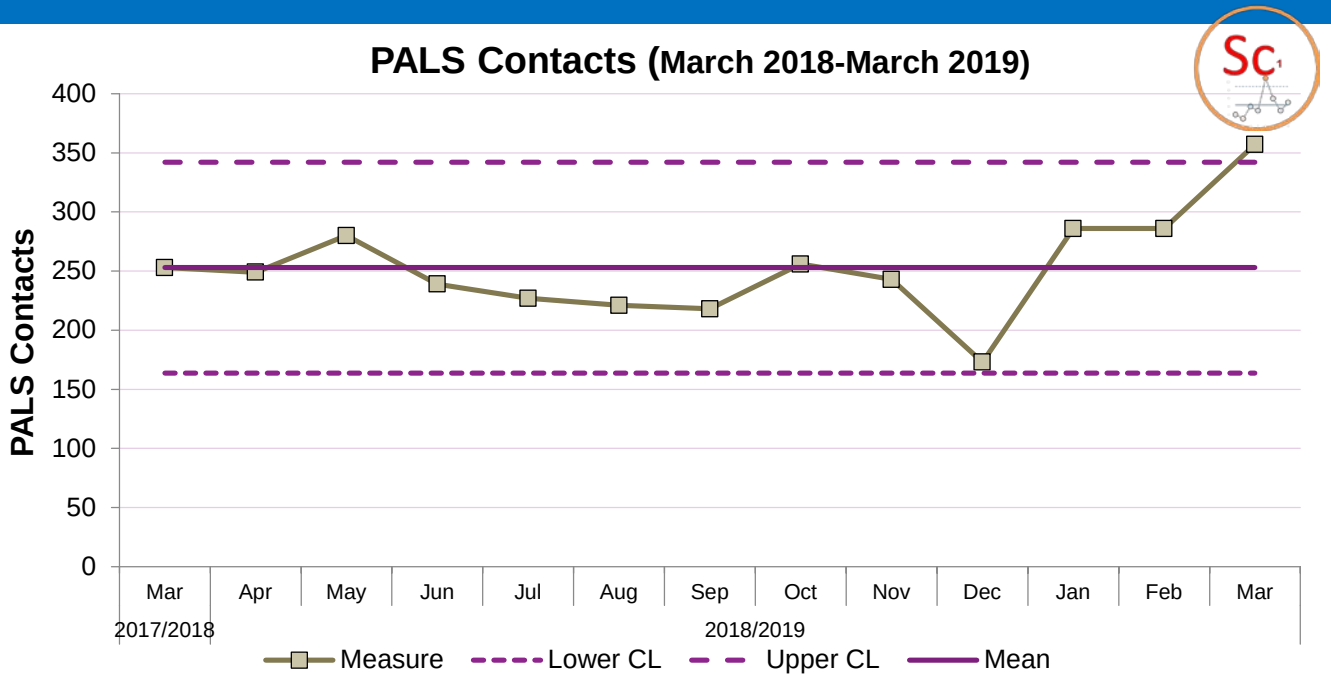
The numbers of complaints have increased since December 2018. The Surgical Division saw the most significant increase from 6 complaints in February to 13 complaints in March (117% increase). The increase was most notable in Orthopaedics (5) and General Surgery (5). The nature of the complaints varied for both departments. More detailed analysis of complaints in this quarter will be included in the Q4 report.

Reasons for breach of response dates and length of delay:

Medicine Division:

- A local resolution meeting slightly delayed due to staff sickness (5 workings days late)
- An external contributor to the complaint was delayed in submitting their response (8 working days late)
- One complaint is currently outstanding due to further drafting of the response required (currently 18 working dates late)

Patient Advice and Liaison Report



There were **337 contacts with PALS** in March 2019. This is a marked increased (33%) compared to the number of contacts in March 2018, and an increase (20%) from February 2019 and outside the upper confidence limit. This is as a result of the increase in telephone issues highlighted below.

- 202 required resolution (60%)
- 95 requested advice or information (28%)
- 16 provided feedback (5%)
- 24 were compliments (7%)

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

Appointments - **57** contacts - **21** of these related to appointment changes by patients; **11** concerned the length of time waiting for a new appointment; **10** concerned appointment information (date/time); **6** follow up appointment not given; **4** length of time taken for follow up appointment. There were no clear trends for the remaining **5** contacts.

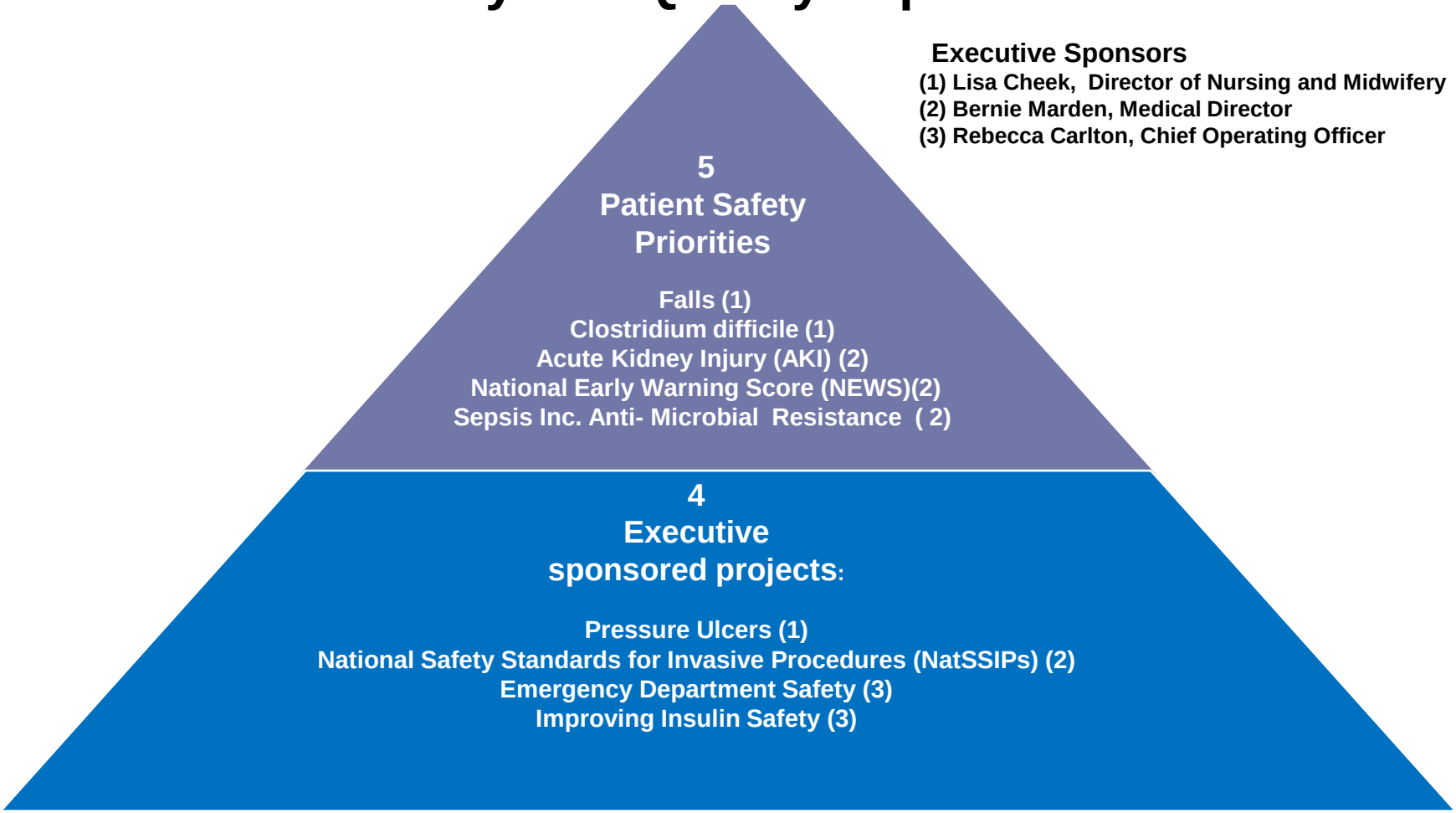
Clinical Care & Concerns - **36** contacts - **9** were general enquiries; **6** quality of nursing care; **3** quality/concerns regarding medical care; **3** concerned a wrong diagnosis. There were no clear trends for the remaining **15** contacts.

Communication and Information - **53** contacts. **22** related to telephone issues of which **16** cases were in the Appointment Centre (phones not working); **11** concerned telephone issues (phones not being answered this was across a number of departments); **10** were general enquiries/communication. There were no clear trends for the remaining **10** contacts. The quality of telephone calls has been an issue since late December. This is a result of a connection capacity issue with calls into the Netcall System, Appointment Centre, Fracture clinic and Audiology. Work was undertaken to resolve the call quality issues on 22nd March. This is being tested and PALS are monitoring the situation.

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) Rebecca Carlton, Chief Operating Officer



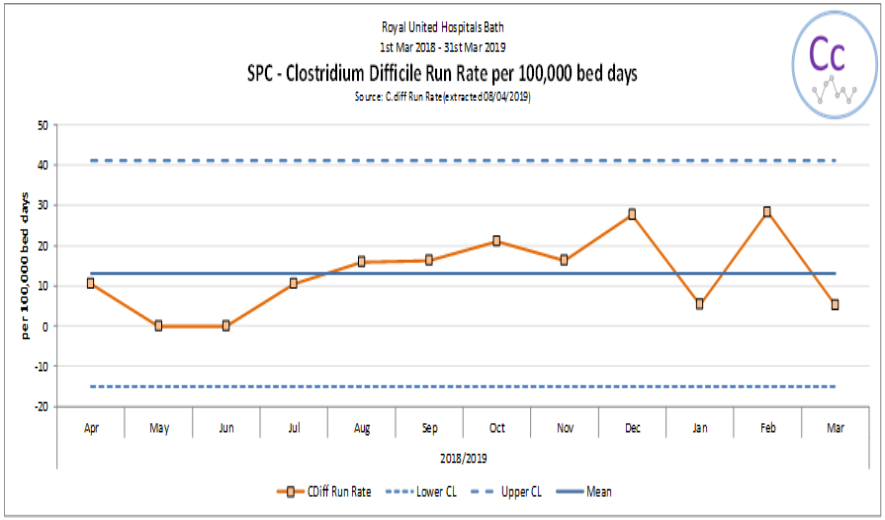
Patient Safety – Clostridium difficile

Lisa Cheek

Background

The RUH target for 'Trust apportioned' *Clostridium difficile* in 2018/19 was 21 cases. At the end of March 2019 there had been 32 cases in total, 5 of which will not be counted in the year end total as there were no lapses of care identified. Another 4 cases have been submitted to the CCG *Clostridium difficile* panels to be considered for removal from the trajectory. If these are agreed the Trust will have exceeded the target by 2 cases.

Current Performance



***Clostridium difficile* improvement plan**

A revised *Clostridium difficile* Improvement Plan has been developed in collaboration with the Heads of Nursing and Midwifery. The plan focuses on the themes from RCAs. These include:

- Timely investigation of all Trust attributed cases. One RCA remains outstanding currently.
- Regular specialist review of all patients with active *Clostridium difficile* including those who toxin positive and patients who are carriers on treatment. *Clostridium difficile* ward rounds take place weekly.
- Improving antibiotic stewardship including the roll out of the Antibiotic Review Kit (ARK). E-learning has been launched and can be completed by all grades of clinical staff.
- Prompt sampling of patients who have diarrhoea. Posters have been made to target admission areas so that samples are obtained on admission where possible.
- Increased support for nursing staff who are caring for patients with *Clostridium difficile.* Infection Prevention and Control (IPC) Team and matrons providing educational support and escalating isolation issues.
- Improve cleanliness of the environment and equipment. IPC Team and matrons attending cleaning audits where possible. Weekly equipment cleanliness audits are undertaken.
- Improve clinical staff knowledge regarding management of *Clostridium difficile* cases. IPC Team offering ward based teaching sessions on areas where training compliance is below 90%.

NHS Improvement visit

The visit has been rescheduled to take place on 2nd July 2019.

Patient Safety – Clostridium difficile

Lisa Cheek

Objectives for NHS Organisations 2019/2020

There are changes to the Clostridium difficile reporting algorithm which will be implemented from 1st April 2019. These are as follows:

- Cases will no longer be trust or community attributed. New terminology has been introduced and there will be four categories for case attribution: hospital onset healthcare associated, community onset healthcare associated, community onset indeterminate association and community onset community associated.
- The number of days to apportion hospital onset healthcare associated cases will change from three or more days (day 4 of admission onwards) to two or more days (day 3 onwards).
- Acute provider objectives have been set against two categories: hospital onset healthcare associated and community onset healthcare associated.
- Community onset healthcare associated are cases that occur within the community or within two days of admission when the patient has been an inpatient in the Trust in the previous four weeks.
- The Trust will complete RCAs for all hospital onset healthcare associated and community onset healthcare associated cases.
- The target for the Trust for 2019/20 is **59** cases.

Patient Safety – Deteriorating patient

Bernie Marden

Deteriorating patient overview:

The deteriorating patient is one of the key work streams for the organisation it is a Quality pillar of the Improving Together strategy and is a 'True North'.
A Deteriorating Patient Steering Group (DPSG) has been established to oversee reliable recognition and response to the 'deteriorating patient,' by supporting the work of the 'deteriorating patient working group,' which has recently been formed amalgamating the Sepsis, Acute Kidney Injury (AKI) and NEWS work. The group includes representation from critical care and will review processes for escalation to critical care. The DPSG will report to quality board and management board via the deteriorating patient quality report

Sepsis:

CQUIN for Sepsis

90% targets for Sepsis Screening and Antibiotics continue for 2018/19.
Q3 partial payment achieved for screening (73%) and full payment for antibiotics with (91%) patients received antibiotics within 60 minutes of sepsis diagnosis.
Q4 compliance is awaited. Sepsis CQUIN finishes in march 2019 but will form part of the CCG contract for 2019/20 with compliance targets remaining 90% trust-wide

Sepsis screening on admission

Median compliance with Sepsis screening on admission is 84% for adults, and processes have been reviewed over the last few months with signs of improvement, screening being >95% since January 2019 as shown.

Fig 1.0 Adult emergency admissions

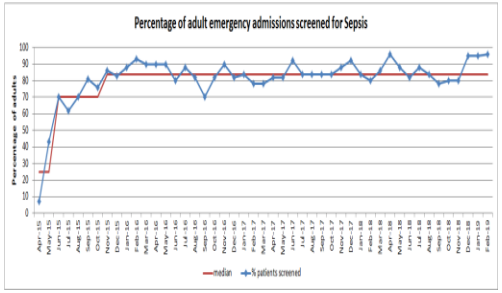
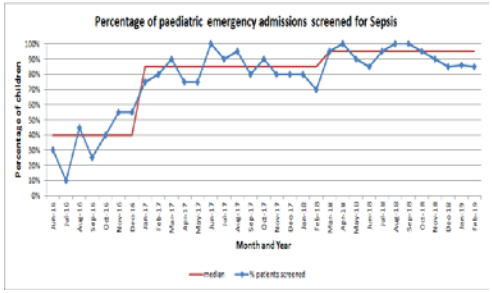


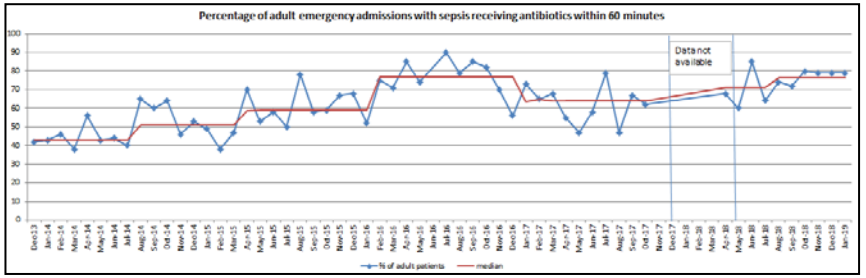
Fig 1.1 Paediatrics emergency admissions



Management of emergency admissions with sepsis

Delivery of antibiotics in an hour for emergency patients has improved since August 2018 with an average of 76.5% patients receiving antibiotics in an hour from signs.

Fig.1.2 Adult emergency admission with Sepsis receiving antibiotics ≤60 minutes



Inpatients with sepsis

Screening

Screening for inpatients remains from random note reviews trust wide and is difficult to maintain. There has been a decrease in November 2018 following the implementation of NEWS 2 and decrease in the sepsis nurse team. In response to this the sepsis nurses have delivered focused training on selected wards resulted in improved screening of 100% in those areas. The training is on going. A permanent band 7 sepsis nurse has now been appointed and the team will be back to 2 full time positions in May. Electronic recording of observations is currently in the planning phase and aimed to test on one ward in the following months. Paediatric screening has remained above 90%

Fig 2.0 Adult Inpatient

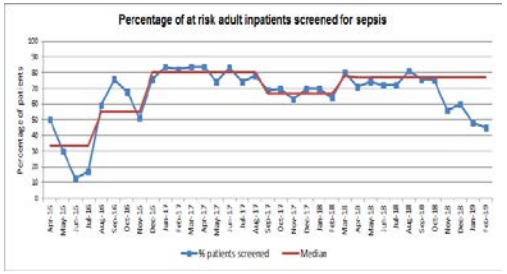
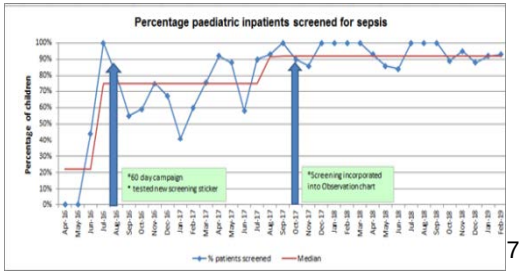


Fig 2.1Paediatrics inpatient



Patient Safety – Deteriorating patient

Bernie Marden

Management of Inpatients with Sepsis

Current compliance for adults is median of 78% patients receiving antibiotics in an hour from signs and 86% in 90 minutes. Data for Q4 is awaited

Fig 3.0 Adult inpatients with Sepsis

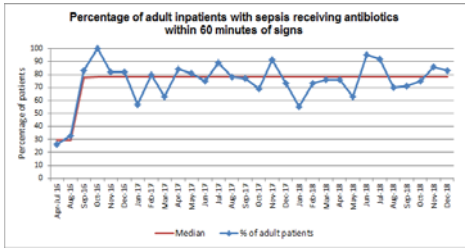
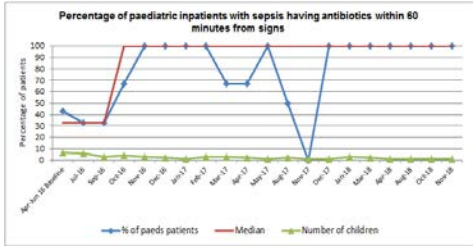


Fig 3.1 Paediatrics inpatients with Sepsis



Acute Kidney Injury:

AKI Bundle compliance

Trust wide data continues to be collected from 20 random patient notes per month (see run charts fig 4.0- 4.4).

Focused work on inpatient acquired AKI within each speciality has commenced in Trauma and Orthopaedics, General Surgery, Gastro, Maternity and Paediatrics. No Results awaited

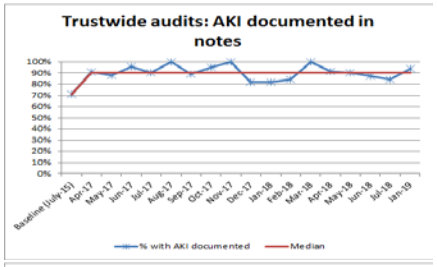
Discharge Summary Information

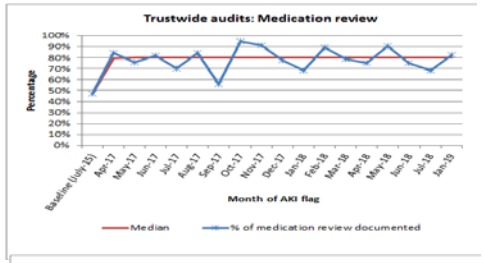
Trust wide data from the same patients as above is collated monthly (see run charts Fig 4.5-4.7). Information from the electronic alert in the discharge summary is still awaited.

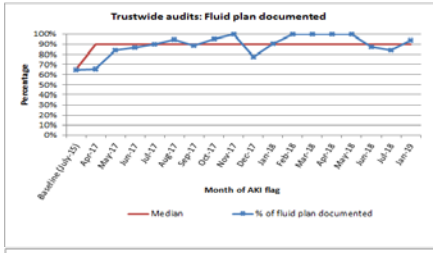
Improvement work

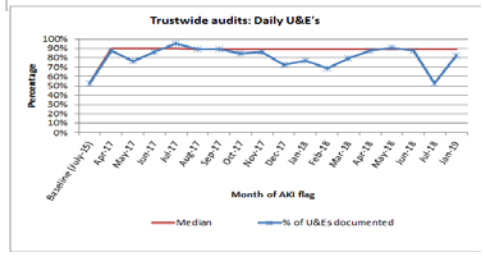
- Medication review: ePMA has been updated so that pharmacists patient list now includes AKI grade so that reviews can be prioritised.
- Fluid balance Chart: An amended fluid balance chart has been launched in March with a plan for electronic recording of urine output for 2019
- The sepsis nurses delivered tea trolley training to the wards on world kidney day to continue to raise awareness of the importance of accurate monitoring of urine output

Fig 4.0-4.4 AKI Bundle compliance









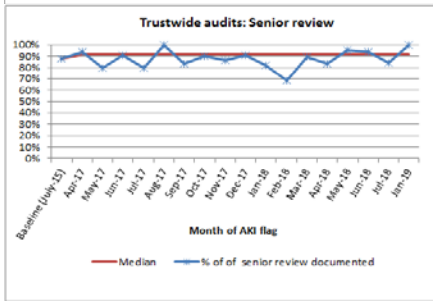
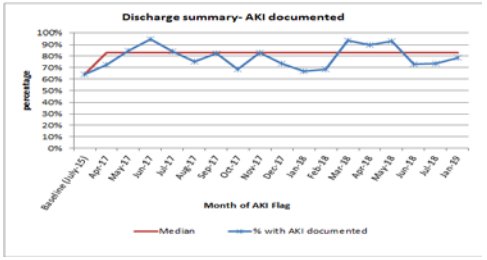
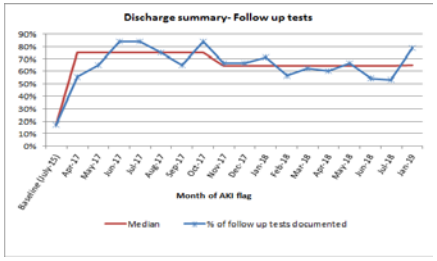
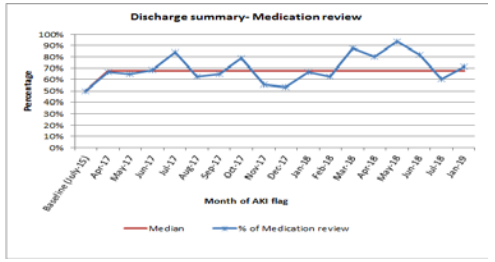


Fig 4.5-4.7 AKI Discharge Summary compliance







Patient Safety – Deteriorating patient

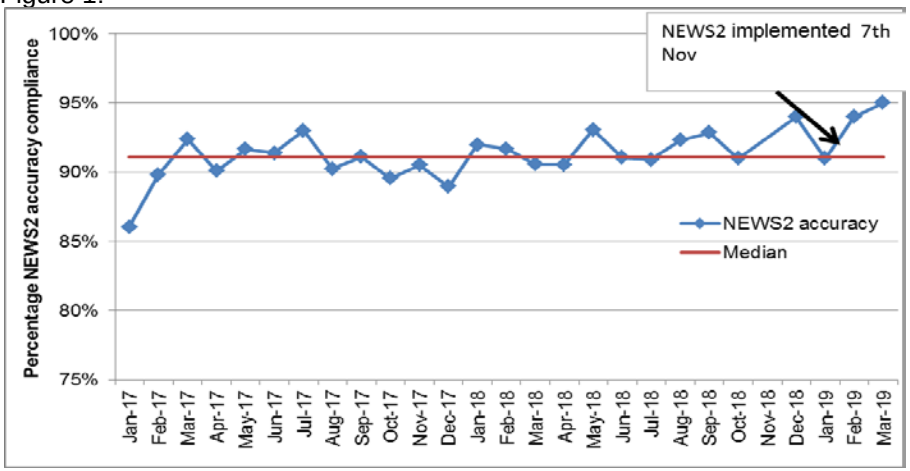
Bernie Marden

National Early Warning Score (NEWS)

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:

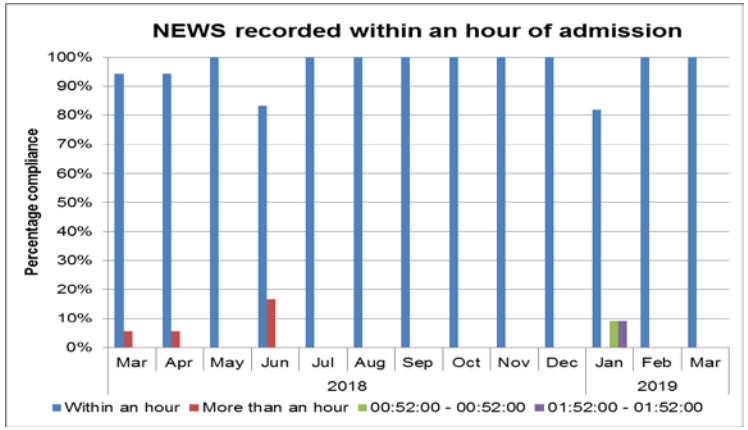


Work with Primary care and Community Hospitals

The sepsis lead continues to link with community teams to support the use of NEWS2 to prompt early identification of sepsis and deterioration. Plans are progressing with the CCGs to request NEWS score on referral from GPs.

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

Figure 2:



Progress to work plan and next steps:

- The NEWS 2 eLearning package is being finalised with a launch planned for May 2019.
- The NEWS work stream members are supporting the eObservations project and are part of the project board and mobilisation group.
- Current State review and design sessions are taking place with technical build and network configuration in progress.
- Agreement has been reached on the detail of configuration on the Welch Allen device which will be used to transmit observations into Millennium
- Test devices are now on site for demonstration and assessment
- The test ward will be Helena Ward date to be confirmed with a deployment plan for other wards under development

Deteriorating patient awareness and training

Deteriorating patient champions has been developed by combining NEWS cascade trainers and Sepsis / AKI champions. The champions have been identified on the majority of wards and a champions event is to be delivered in April, to formally launch the role, following which further NEWS UP What's Up campaigns will be spread across the trust.

Patient Safety – Deteriorating patient

Bernie Marden

Sepsis Kidney Injury Prevention (SKIP) team

The sepsis nurse team has been developed into a new preventative team, the SKIP team, to which a new permanent Band 7 lead nurse has been appointed. A permanent band 6 nurse post is being interviewed in April with plans for a further post in the future, to enable the service to run 7 days a week.

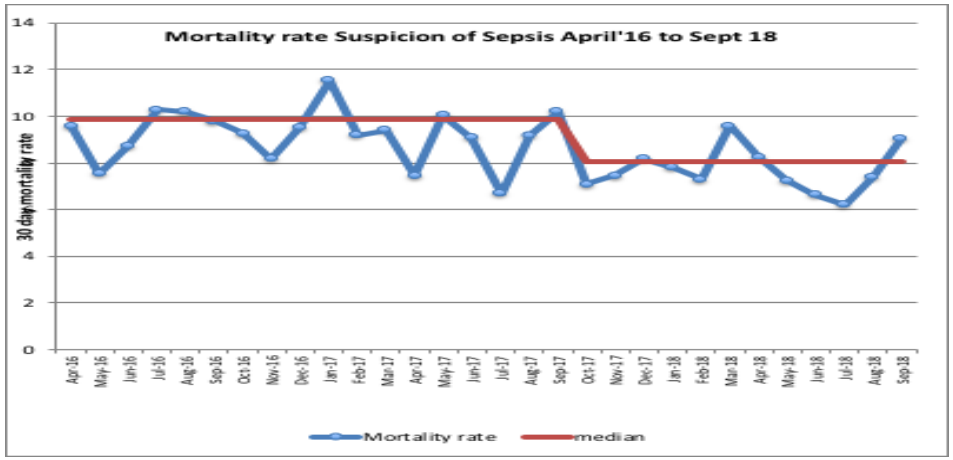
The team will focus on continuing to educate and support staff in all areas of the hospital to identify Sepsis and any decrease in kidney function early, aiming to improve outcomes further. They will work closely with the outreach team.

Outcomes

Sepsis

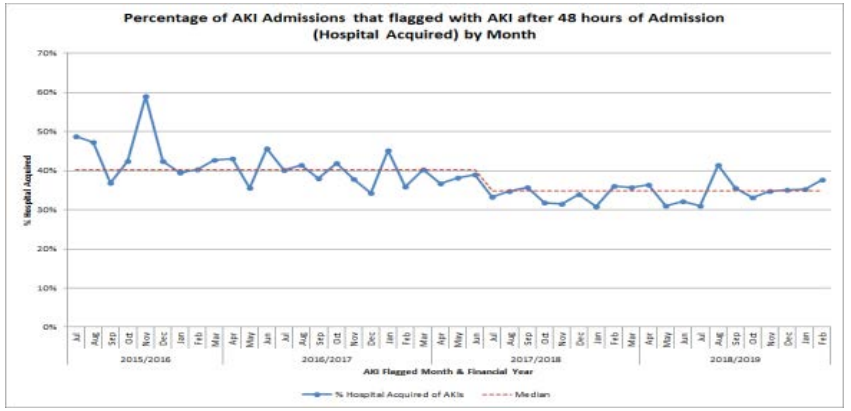
In 2018 a national 'Suspicion of sepsis' dashboard was been produced to track outcomes from patients with all infections termed 'suspicion of sepsis'(SOS).

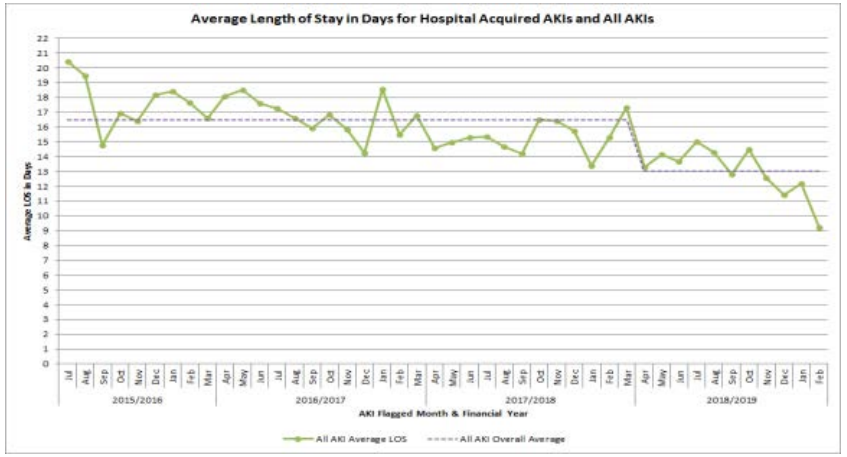
Mortality rate from SOS has shown an 18% decrease since October 2017 as well as decreased length of stay. This is despite an increase in incidence SOS of an average 500 patients per year. The SKIP tea will continue to monitor these outcomes.



AKI

Following the work on AKI, 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 as shown below.





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 provides assurance that regulatory requirements including the Care Quality Commission (CQC) fundamental standards are being met and identify where improvements in practice are required.

Ward Accreditation update

A total of 32 areas including 25 adult wards, Maternity ward (Mary), Bath Birthing Centre, NICU, Admissions suite, Children's ward, Critical Care Services and Emergency department are included in the Ward Accreditation programme. All areas have achieved Foundation level except NICU and Admission suite which were new to the programme towards the end of 2018.

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

Robin Smith and Combe achieved Bronze level in January 2019.Admission suite were assessed for the first time in February 2019 but have not achieved the required standards. Of the 32 clinical areas, 23 have achieved Bronze level with the remaining planned for reassessment in May - June 2019. 7 wards remain at Foundation Level with a supportive programme and timeframe for re-assessment.

Table 1 summarises the accreditation level achieved by wards to date.

Next steps

Silver level indicators have been developed building on Bronze level and with the addition of unannounced observations, Dementia and End of Life charter marks and a Portfolio of evidence that members of the MDT will present to a panel of assessors. The Portfolio is designed to showcase achievements and includes demonstration of improvements made following for example patient experience feedback and quality improvement projects. Helena ward is the first ward to undergo assessment which will be completed in April 2019.

Table 1: Ward Accreditation	Current Level Achieved	Date	Comments
Medicine Division			
ACE	Bronze	Oct -17	
Acute Stroke Unit	Bronze	Jul-18	
Cardiac	Foundation	Sept-16	Full reassessment at Bronze following change of leadership
Cheselden	Bronze	Sept-16	
Combe	Bronze	Jan-19	
Coronary Care Unit	Bronze	Oct-17	
Emergency Department	Foundation	May-18	For reassessment in Effective
Emergency Department Obs	Foundation	May-18	For reassessment in Effective and Well led
Haygarth	Foundation	Dec-18	For reassessment in Effective
Helena	Bronze	Oct-17	Undergoing Silver assessment
Medical Assessment Unit	Bronze	Oct-17	
Medical Short Stay	Foundation	Dec-18	For reassessment in Effective
Midford	Bronze	Sept-16	
Parry	Bronze	Jul-18	
Respiratory	Bronze	May-18	
Violet Prince	Bronze	May-18	
Waterhouse	Bronze	Sept-16	
William Budd	Bronze	Sept-16	
Surgery Division			
Admission Suite	None	Feb-18	For reassessment in Effective
Critical Care Services	Bronze	May-18	
Forrester Brown	Bronze	May-18	
Philip Yeoman	Bronze	Oct-17	
Pierce	Bronze	May-18	
Pulteney	Bronze	Sept-16	
Robin Smith	Bronze	Jan-19	
Surgical Admissions Unit	Bronze	Sep-16	
Surgical Short Stay	Bronze	Jul-18	
Women & Children Division			
Bath Birthing Centre	Bronze	May-18	
Charlotte	Bronze	Sep-16	
Children's	Bronze	Jun-17	
Mary	Bronze	May-18	
NICU	None	Jul-18	For reassessment in Effective and Well led

Nursing and Midwifery Accreditation Programme — Lisa Cheek

Outpatient Accreditation update

A total of 28 areas including 23 adult areas, Children's unit and 4 birthing centres are included in the Outpatient Accreditation programme. All areas have achieved Foundation level except the 4 Birthing centres which were new to the programme towards the end of 2018 and are now under assessment. 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

Ambulatory care, Dermatology, Medical Therapies Unit, Rheumatology, Fracture clinic, Pre-Operative assessment, Vascular Studies and Gynaecology achieved Bronze level in Jan 2019.Chemotherapy achieved in March 2019.Cardiology achieved Foundation level in April 2019 and Children's OPD were assessed in February 2019 but did not achieve the required standard.

Of the 28 outpatient areas, 16 have achieved Bronze level with the remaining undergoing reassessment by the end of May 2019.

Table 2 summarises progress for assessment of outpatients and the accreditation level achieved to date

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.

The development of Silver indicators for outpatient areas has commenced with the first area to be tested planned for July 2019.

Table 2: Outpatient Department	Current Level Achieved	Date	Comments
Medicine Division			
Ambulatory Care	Bronze	Jan-19	
Cardiology	Foundation	Apr-19	
Chemotherapy Day Unit	Bronze	Mar-19	
Dermatology	Bronze	Jan-19	
Diabetes Clinic	Foundation	Jul-18	For reassessment in Safe, Caring and Effective
Gastroenterology	Bronze	Aug-18	
Medical Therapies Unit	Bronze	Jan-19	
Oncology Day Care	Foundation	Oct-18	For reassessment in Effective
Oncology/Haematology	Foundation	Jul-18	For reassessment in Effective
OPU and Neurology	Foundation	Oct-18	For reassessment in Safe and Effective
Respiratory	Foundation	Oct-18	For reassessment in Effective
Rheumatology	Bronze	Jan-19	
Surgery Division			
ENT	Bronze	Oct-18	
Fracture Clinic	Bronze	Jan-19	
Ophthalmology	Bronze	Jul-18	
Oral Surgery	Bronze	Sep-18	
Pain Clinic	Bronze	Jul-18	
Pre-Operative Assessment	Bronze	Jan-19	
Urology	Bronze	Jul-18	
Vascular Studies	Bronze	Jan-19	
Women & Children Division			
Breast Unit	Bronze	Jul-18	
Children's OPD	Foundation	Feb-19	For reassessment in Safe and Effective
Gynaecology	Bronze	Jan-19	
Sexual Health	Foundation	Mar-16	For full assessment
Chippenham Birthing Centre	Under assessment		
Frome Birthing Centre	Under assessment		
Paulton Birthing Centre	Under assessment		
Trowbridge Birthing Centre	Under assessment		

Serious Incidents (SI) Summary

Lisa Cheek

Current Performance
Eight serious incidents were reported to STEIS in March 2019. All incidents continue to be under investigation.

Serious Incidents Reported to STEIS												
Mar-18	Apr-18	May-18	Jun-18	July-18	Aug-18	Sept - 18	Oct - 18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
0	3	13	2	5	8	5	5	4	6	4	8	7

Date of Incident	ID	Summary
27/10/2018	**67529**	Slip/Trip/Fall
24/02/2019	**70874**	Slip/Trip/Fall
24/02/2019	**70876**	Slip/Trip/Fall
06/03/2019	**71180**	Diagnosis/Failed or Delayed
07/03/2019	**71188**	Slip/Trip/Fall (awaiting downgrade)
24/03/2019	**71735**	Obstetric emergency
23/03/2019	**67529**	Slip/Trip/Fall

Overdue Serious Incident Report

Lisa Cheek

The risk team continue the drive to maintain compliance with submitting Serious Incidents to the Clinical Commissioning Groups. As of 1/04/2019, there were 20 Serious Incidents that were open and under investigation of which 2 were overdue due to awaiting amendments following the Operational Clinical Governance Committee meeting. One fall RCA remains open on STEIS pending a downgrade request and 4 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. As of 15/04/2019 there were 12 open Serious Incident investigations with a total of 25 actions overdue for closure. 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.

	Mar 18	Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19
Outstanding Action Plans	**32**	**25**	**19**	**14**	**21**	**29**	**32**	**26**	**24**	**18**	**8**	**9**	**12**
Outstanding Actions	**54**	**42**	**46**	**22**	**30**	**54**	**54**	**66**	**43**	**38**	**17**	**17**	**25**

Nursing Quality Indicators Exception Report Lisa Cheek

Children's Ward
This ward has flagged for the 4th consecutive month

Quality Matrices to note are:
- FFT response rate 26%
- HCA sickness rate 8.5%
- RN appraisal rate 74.3%
- HCA appraisal rate 60%
- RN staffing day fill rate 81.0%
- HCA day staff fill 82.4%
- RN staffing night fill rate 84.3%

The team on the Children's ward have made improvements on FFT response rate since last month. This continues to remain a team priority. Alongside this is the top and pants Children's feedback initiative that is being collated by a band 6 Sister. The HCA sickness figure is attributed to one member of staff on long term sickness. All sickness continues to be managed in line with the Trust supporting attendance policy. There is an action plan in place for the recovery of appraisals by the new band 7 Senior Sister which will be over seen and supported by the Matron. The new Senior Sister has had Trust Induction and a 2 week local induction including visiting NICU, working with the Matron, 1:1 with the band 6 Sisters and visiting various key departments within the RUH. The Children's unit continues to have a vacancy factor of 8.65 band 5 plus 1.92 on maternity leave. Two band 5 posts have been converted temporarily into band 6 development posts for one year fixed term contracts. These have been filled with one internal and one external candidate. There are two RN's returning from maternity leave reducing their contractual hours, which forms part of the vacancy factor. There is 0.8 WTE Healthcare Assistant on maternity leave. All vacant posts are out to advert and interviews are planned in April. Two RN's already recruited will start in August 2019 and a further two in January 2020.

NICU
This ward has flagged for the second consecutive month.

Quality Matrices to note are:
- RN appraisal rate 79.1%
- HCA appraisal rate 78.6%
- RN staffing day fill rate 78.7%
- HCA staffing day fill rate 47.8%
- RN staffing night fill rate 68.1%
- HCA staffing night fill rate 41.9%

The appraisal rate for both RN's and HCA's has been part of an action plan and trajectory to reach over 85%. This has now been achieved and should be reflected positively in next months indicators. The staff fill rate appears low. However, across the South West there is a reduction in the cot occupancy and therefore the need for RN 's over the previous months is lower than historically required and subsequently budgeted for. NICU are reviewing the daily acuity closely to ensure they maintain British Association of Perinatal Medicine (BAPM) standards and ensure the delivery of safe and high quality care. The staff are working flexibly to cover the shifts wherever possible across NICU with a similar system to Critical Care Unit. NICU continue to support the shortfall in Children's Ward if required.

Nursing Quality Indicators Exception Report

Lisa Cheek

ACE

This is the second consecutive month this ward has flagged.

Quality Matrices to note are:

- 8 falls, 4 no harm, 3 minor harm, 1 moderate harm
- RN sickness rate 7.7%
- HCA sickness 5.8%
- HCA appraisal rate 75%
- RN staffing day fill rate 68.7%
- RN staffing night fill rate 72.2%

ACE had 4 falls with no harm , one of these was a repeat fall. The fall with moderate harm was an independent lady who lost her balance in the bathroom. She was later found to have a small fracture to her ankle. This is being investigated following the 72 hour rapid incident review meeting. All falls have been put on datix and are currently being investigated. On admission to ACE ward all patients are assessed for their level of enhanced observations. If a patient falls, as part of the post fall process they are reassessed to determine what level of enhanced observation is then required. This may involve a change in location within the ward environment to allow better observation or 1:1 nursing.
RN sickness has improved since last month. 1 RN has returned from long term sick .1 RN remains on long term sick. All sickness is managed in line with the Trust supporting attendance policy. The HCA appraisal rate has improved since last month from 64.7%. There is an action plan in place to ensure all appraisals are undertaken in a timely manner. The RN day and night fill for staffing is below target. There are 2 WTE band 5 nurse vacancies on ACE, which are out to advert. ACE have two overseas nurses who are currently employed as a band 4 until registered with the NMC when they will become band 5. One band 6 nurse returned to ACE in April following a secondment to Pierce ward. All staff shortages continue to be put out for fill by bank staff or agency staff if not filled.

Midford

This ward last flagged in December 2018

Quality Matrices to note are:

- 10 falls, 9 no harm, 1 minor harm
- RN sickness rate 5.0
- HCA sickness rate 6.2%
- HCA appraisal rate 58.3%
- RN staffing day fill rate 68.9%
- RN staffing night fill rate 73.1%

Midford ward has seen a high number of falls this month. One patient has had repeated falls. The patient has not sustained any harm and several actions have been taken to try and prevent further falls; a high low bed, appropriate location on the ward for enhanced observation, and 1:1 nursing where possible. This month Midford Ward are currently undertaking a focus on falls action plan. The learning from this action plan has been an emphasis on detailed risk assessments, improved safety briefing at handovers and enhanced observations .
Midford ward has 1 nurse and 1 HCA on long term sick. In addition there have been episodes of short term sickness within the team. All staff sickness is monitored and managed in line with the Trust supporting attendance policy and where required support has been given from Human Resources. The lower HCA appraisal rate has already been acknowledged by the new band 7 Senior Sister who commenced her role in January 2019. The outstanding HCA appraisals have either been undertaken or have dates for the month of April. This is with the exception of those with long term sickness. This should reflect positively in next months data. Midford ward has 8.64 WTE band 5 vacancies. The Senior Sister has recruited into one of these vacancies with the nurse due to start in the summer. There is one nurse due to arrive from overseas.
Recruitment is ongoing and dynamic with rolling adverts for RN positions. The RN and HCA staff fill is regularly monitored by the Senior Sister and the Matron. Any short full is put out to bank staff and then agency if required. If no fill is obtained the duty matron manages the staffing across the division to minimise any risks.

Nursing Quality Indicators Exception Report Lisa Cheek

Critical Care Services

Quality Matrices to note are:

- RN sickness rate 8.4%
- HCA appraisal rate 66.7%
- RN staffing day fill rate 77.7%
- RN staffing night fill rate 7.9%
- Care/HCA staff fill rate 12.9%
- Grade 2 pressure ulcer X 1

There has been a rise in RN sickness this month, 5.7% short term sickness and 2.6% long term sickness. Critical Care does have robust sickness management systems including monthly HR meetings to review sickness. The critical care education team is undergoing re-modelling of their role with the new matron in order to support staff as there is some sickness in new starters with stress/anxiety .
Critical care have 4 HCA's in total. Three HCA appraisals are in date. The 4th HCA had their appraisal completed in March and should be reflected in next months data. Critical care operate a self-sufficient staffing model (SSSM). March saw a decrease in the patient acuity/dependency, therefore SSSM has been activated most days/nights. Overall SSSM has seen the agency usage decrease dramatically, a trend not seen in other critical care units in the network.

Vacancy factor for critical care is 10.8 WTE. This includes 6.1 WTE band 5's, 0.4 WTE band 6 and 0.97 WTE band 7. There are also 3.7 WTE band 3 HCA's and 0.6 WTE band 2 HCA's. Recruitment is ongoing with rolling advertisements. 4 nurses with the Critical Care course have been interviewed and offered positions. There are a further 4 nurses due to be interviewed next month. The band 7 post will be re-advertised in May.

The grade 2 pressure ulcer has been subject to a root cause analysis. (RCA). As a result of the RCA there have been changes in practice in relation to initial patient risk assessments and subsequent documentation of the risk assessments. Patient hand over has improved and includes highlighting if a patient is high risk of developing pressure ulcers. Furthermore, equipment has been moved within critical care services to ensure all bed spaces have easier access to Kerrapro, a protective agent used to reduce risk of device related pressure ulcers.

Nursing Quality Indicators - Monthly Template April 2019

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								
						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		Mar19 No:	Feb 19 No:	Jan 19 No:	Dec 18 No:	Nov 18 No:	Oct 18 No:
SAU	Bronze	100	14%	1					0	0	0	0				2.0	3.0	85.0	68.8	1	82.7%	109.4%	89.6%	119.6%	11.6	3	6	5	6	5	5
A&E	Foundation	94	4%	1	4	6	2		4	0	0	0				4.5	2.5	75.6	73.9							4	5	3	3	4	5
MAU	Bronze	96	25%	1	1	1			4	0	0	0				4.2	10.5	80.9	80.0		81.1%	152.8%	81.7%	138.3%	10.9	5	7	8	5	5	7
Charlotte	Bronze	98	58%			2			2	1	1	0				9.3	1.9	100.0	88.9		101.6%	96.5%	99.8%	99.9%	7.6	1	0	2	3	1	5
Robin Smith	Bronze	97	51%		1	1			1	1	0	0				1.2	4.7	89.5	88.2		90.7%	112.8%	84.3%	162.9%	7.0	1	5	3	3	3	3
Violet Prince (RNHRD)	Bronze	100	69%						0	0	0	0				0.0	2.8	100.0	100.0		87.5%	54.5%	100.0%	64.5%	4.6	2	1	3	7	4	3
Cheselden	Bronze	100	75%						4	0	0	0				15.5	0.2	100.0	100.0		62.8%	115.1%	100.0%	100.0%	5.6	2	2	2	2	1	2
Phillip Yeoman	Bronze	100	54%						2	0	0	0				2.8	0.8	66.7	100.0		70.4%	93.9%	97.2%	92.7%	7.6	2	2	2	5	3	3
Surgical Short Stay Unit	Bronze	98	117%	1					0	0	0	0				4.1	4.8	90.9	100.0		92.4%	92.2%	66.6%	196.8%	6.5	2	3	5	6	7	5
Acute Stroke Unit	Bronze	96	71%		1				7	1	1	0				0.7	11.9	81.8	94.1	2	74.1%	94.8%	91.7%	134.2%	8.3	3	3	3	2	2	2
Waterhouse	Bronze	100	72%						8	1	0	0				1.1	12.3	100.0	80.0	3	87.1%	113.5%	104.6%	118.7%	7.4	3	4	2	3	4	3
Helena	Bronze	94	55%		1	1			2	0	0	0				9.5	1.5	85.7	85.7		75.8%	165.1%	66.7%	166.1%	9.1	3	4	3	3	4	2
Forrester Brown	Bronze	98	44%						5	1	0	0				7.7	1.5	100.0	94.1		88.2%	105.7%	81.4%	135.5%	8.0	3	5	3	5	3	1
Haygarth	Foundation	92	41%						3	1	0	0	2			4.8	11.3	91.7	88.2	1	68.0%	104.4%	71.5%	188.4%	6.4	4	4	3	5	4	3
CCU	Bronze	100	55%		1				0	1	0	0				2.3	44.7	100.0	66.7		85.0%	84.0%	100.0%	106.5%	11.7	4	6	1	1	2	2
Pierce	Bronze	95	43%	1	1	1			0	0	0	0				7.6	12.3	93.8	81.3		86.8%	154.1%	78.1%	193.5%	8.2	4	6	5	6	7	6
Combe	Bronze	94	83%						5	0	0	0				3.8	6.8	76.9	84.6		71.5%	109.1%	71.0%	197.4%	7.1	5	4	5	4	4	5
Pulteney	Bronze	96	44%		1	1			2	0	0	0				11.4	15.1	56.5	28.6		82.7%	94.2%	91.9%	111.8%	6.7	5	5	3	4	4	6
Mary Ward	Bronze	100	28%			1	1		0	1	0	0				4.8	16.7	86.1	90.5	2	103.8%	74.4%	95.0%	83.9%	16.7	5	5	5	3	4	5
Parry	Bronze	96	40%	1		1			4	1	0	0				6.7	5.0	83.3	80.0		89.9%	96.3%	117.1%	111.9%	6.3	5	5	5	4	4	5
Medical Short Stay Unit	Foundation	100	43%		1	1	1		1	1	0	0				8.4	5.3	91.7	57.1	1	75.1%	98.4%	103.7%	135.5%	5.8	5	6	5	3	6	3
William Budd	Bronze	98	58%					1	3	0	0	0				16.4	10.1	100.0	100.0		63.0%	104.4%	75.6%	112.1%	7.3	5	6	6	4	1	5
Cardiac	Foundation	95	49%		2				4	1	0	0				4.5	13.7	85.2	76.9		80.0%	121.8%	76.6%	135.7%	5.7	5	6	6	7	4	6
Respiratory	Bronze	92	74%						2	0	0	0				4.4	6.2	75.0	78.6	1	74.2%	111.0%	78.8%	108.9%	5.8	5	8	4	4	7	4
Critical Care Services	Bronze	N/A	N/A						0	0	0	0	1			9.0	3.1	94.3	66.7		77.7%	89.5%	79.8%	12.9%	28.9	6	3	2	5	5	5
Midford	Bronze	100	79%						9	1	0	0				5.0	6.2	88.9	58.3	2	68.9%	113.4%	73.1%	177.2%	5.9	6	5	5	7	3	4
NICU	Not assessed	100	68%						0	0	0	0				2.0	1.6	79.1	78.6		78.7%	47.8%	68.1%	41.9%	10.6	6	6	4	4	4	6
ACE OPU	Bronze	95	57%		1				4	3	1	0				7.7	5.8	84.2	75.0		68.7%	92.8%	72.2%	106.9%	6.8	6	6	4	4	5	5
Children's Ward	Bronze	99	26%						0	0	0	0				0.6	8.5	74.3	60.0	1	81.0%	82.4%	84.3%	148.0%	7.1	7	6	7	6	5	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