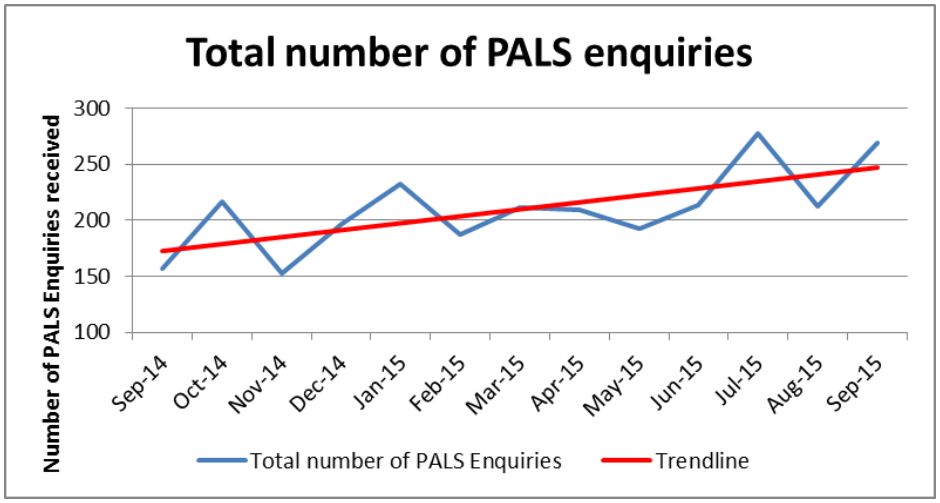
QUALITY REPORT

PART A – Patient Experience

Patient Advice and Liaison Service (PALS) Report



There were **269** contacts with the PALS service:

- 172 required resolution
- 13 provided feedback
- 73 requested information or advice
- 11 were compliments

Compliments received by PALS:
11 compliments were received by PALS. 9 were regarding caring and kind staff attitude and behaviour. Five related to the Medical Division (3 regarding Emergency Department staff), four related to the Surgical Division (2 regarding Audiology staff) and one to the Women and Children's Division.

The top three subjects requiring resolution were:

Communication and Information – 59 contacts (34%). Of these, 19 contacts were regarding difficulties in accessing outpatient services by telephone, of which 10 referred to access to the RNHRD rheumatology appointments office following the RNHRD transfer to the Millennium system on 1st September. Some training issues were identified with staff at the RNHRD site in the way that the Choose and Book facility was being managed. This meant that patients were calling in when it was not necessary as their referrals were being triaged and a date for an appointment was not available at this stage. This has now been resolved.

A shortage of staff in the central booking office at the RUH in September due to vacancies and long term sickness resulted in an increase in calls to the PALS service. A supervisor is now in post and the vacancy is being advertised.

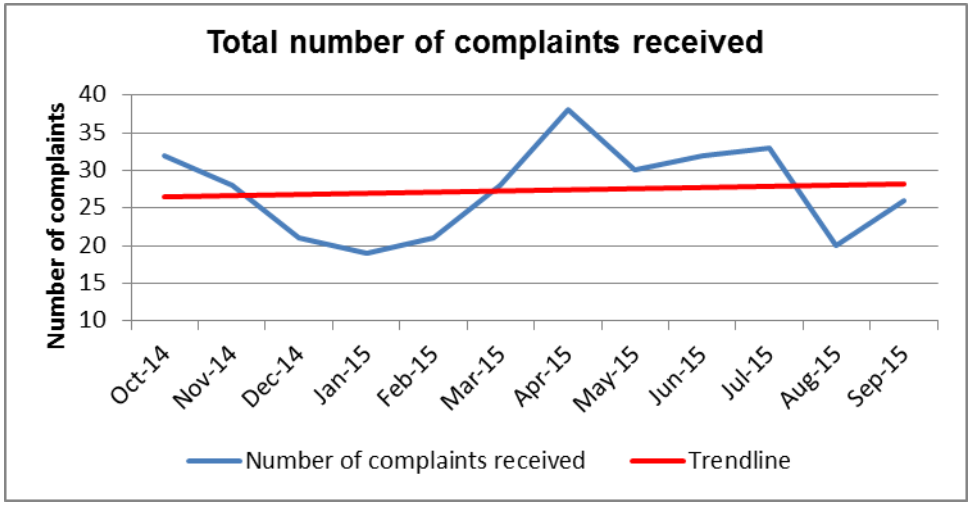
Appointments – 47 contacts (27%). All were queries regarding outpatient appointments, for example forgotten dates or requesting changes to appointment dates.

Clinical care and treatment – 29 contacts (17%). None of these were attributed to a particular hospital service.

A more detailed breakdown of PALS themes and trends will be provided in the Quarter 2 (July to September) report to the Board in November.

Complaints Report

Complaints



In August, **26** formal complaints were received. These were from the following areas:

- Outpatients: 11
- Ward areas: 4
- Birthing Centres: 4
- Emergency Department: 3
- Information Services: 2
- Radiology: 1
- Theatres: 1

The Medical Division had 12 complaints, the Surgical Division had 6, and the Women and Children's Division had 6 complaints in September. In addition there were two complaints categorised under Finance Directorate (information governance services).

Further analysis of the complaints relating to outpatients reflect the dissatisfaction of lengthy waiting times for appointments and waiting for test results. 2 formal complaints were received from patients who were not happy with the changes to the appointments system at the RNHRD and the outsourcing of clinic letters.

The 3 main reasons for complaints in September (accounting for 85% of complaints) were:

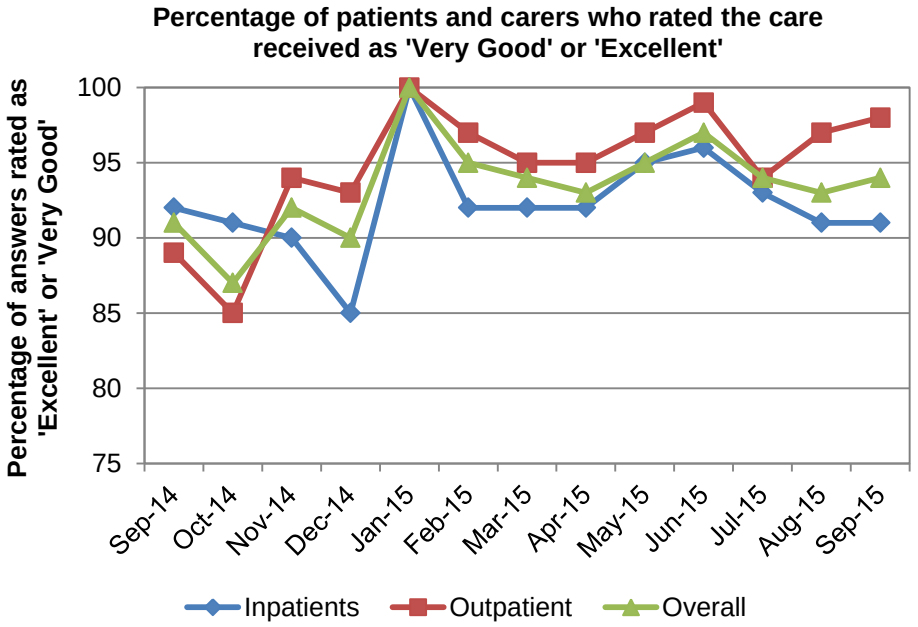
Quality concerns regarding medical care/ co-ordination of care: 14
(7 of these related to competence/knowledge of staff however these are across all 3 divisions)

Communication/ Information: 5
2 of these related to letters being sent to incorrect addresses and were reported as Information Governance breaches

Appointments: 3
2 of which related to length of time to wait for an outpatient appointment

Meridian Survey Results (Inpatient and Outpatient Surveys)

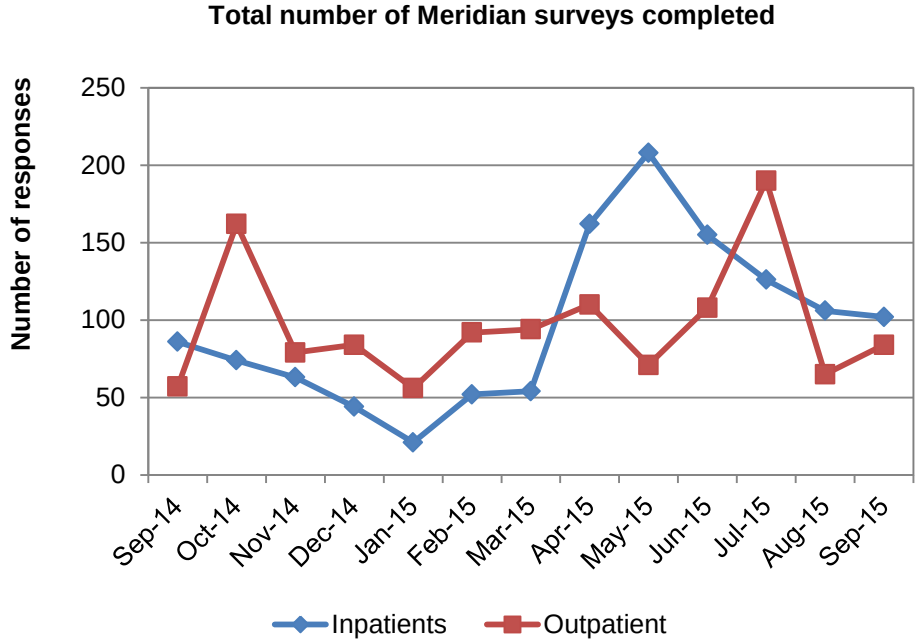
Current Performance



The overall percentage of patients that rated their care as 'Very Good' or 'Excellent' was 94% for September. Scores are broken down as follows:

- Outpatients: 98%
- Inpatients: 93%
- Inpatient Carer survey: 73%

The percentage displayed on the chart for inpatients, is a combined score for inpatient and inpatient carer surveys.



There has been a increase in the number of outpatient surveys (84) and a decrease in inpatient surveys (102) completed in September. The surveys are completed by the Matrons and volunteers whilst patients are at the hospital. In September, 6% were completed online.

The Patient Experience team continues to work with the Heads of Nursing and Matrons to ensure feedback surveys are undertaken, with targets agreed for Matrons of five surveys per week for each inpatient area.

October 2015 - Safer Staffing Monthly Report (September data)

Trust Overview

The average number of Registered Nurse (RN) hours at the RUH has been fairly consistent each month and reflects RN vacancies.
To adequately cover the wards additional HCA hours were provided or RNs were deployed from other wards to ensure appropriate availability of nurse staffing dependant on patient acuity/dependency.

September 2015	Day shift		Night shift	
	Ave fill rate RN/RM	Ave fill rate HCA	Ave fill rate RN/RM	Ave fill rate HCA
RUH	86.5%	100.1%	88.3%	108.0%
RNHRD V.Prince Ward	97.3%	115.8%	101.8%	116.7%
Chippenham Birthing Suite	100%	100%	100%	100%
Paulton Birthing Suite	100%	100%	100%	100%

The ward by ward staffing levels data are provided on Appendix D and where wards actual hours fill rate are outside of the parameters <90% (red) or >120% (blue) against their planned levels, explanations and remedial actions are provided. The overall number of individual ward's day and night shifts outside these parameters decreased this month to 54 from 62 last month with an decrease in 'red' shifts (<90% fill).

Waterhouse ward re-opened this month and RUH staff deployed for relocated beds in RNHRD came back to their respective wards which improved the overall Trust position.

Ward nurse staffing and patient experience

The staffing hours % fill rate have been incorporated on the FFT triangulation chart and mapped against quality matrices (Appendix A).
Two wards flagged this month, Acute Stroke Unit and the Medical Admissions Unit and the commentary on these wards is cited on the FFT Exception report overleaf with more detailed information provided.

Datix Nurse staffing reports

This month ward level Datix staffing reports are being collated on the Triangulation chart (Appendix A). The highest number of these reported in September was on the Acute Stroke Unit with 12 Datix reports submitted. The Head of Nursing has undertaken a detailed review of patient care on the unit (Oct 2015) and analysed patient quality and safety measures and has not found any areas of concern. The Head of Nursing will also be undertaking a detailed review of staffing levels on this ward following the Safer Nursing Care Tool review in August 2015.

Nursing Recruitment and Retention

RN vacancies on the wards have increased slightly this month and is approximately 100wte. However, newly qualified RNs are coming into post and this should reduce the vacancies next month. The Medical Division's Open Day for ED in September was successful and a further Open Day is planned. From November we will be recruiting 40 EU Registered Nurses (Spain and Italy) to commence in post Jan/Feb 2016, aiming to recruit 30 nurses to Medicine and 10 to Surgery.

A proposal for a cohort of 12 – 15 Trainee Assistant Practitioners to undertake a 2 year Diploma programme at the RUH has been developed. It is hoped that this initiative will attract some of our existing Band 3 HCAs and foster staff retainment, as well as provide staffing continuity where there are RN vacancies on wards which seem to be challenging to attract RNs.

Triangulation Chart – Exception Report (September data)

Areas of focus - The full Triangulation Report is shown in Appendix A.

Two wards have flagged this month

Medical Assessment Unit (MAU)
This ward has flagged for the first time this month with day and night staffing Registered Nurse (RN) fill rate <90%, predominately due to RN vacancies which have increased this month.
Quality matrices to note are:
- Friends and Family Test (FFT) net promoter score 50
- Formal complaint x 1 and 2 negative PALS comments
- Falls x 7 (6 negligible, 1 moderate harm)
- Appraisal rates RN 53.1% and HCA73.9%

Acute Stroke Unit (ASU)
This ward has flagged for the first time this month with day and night staffing Registered Nurse (RN) fill rate <90%, predominately due to RN vacancies. This ward has interim Senior Sister cover in place since the previous Senior Sister resigned in June 2015.
Their quality matrices are:
- Datix nurse staffing reports x 12 in month
- Negative PALS x 1
- Falls x 12 (9 negligible, 3 minor harm - 1 of whom fell twice)
- Clostridium difficile x 2 patients
- Appraisal rates RN 60.9% and HCA 70%

CQC flagged ASU to Trust following MP and constituent complaint regarding staffing levels and nursing care.

Note:
Respiratory Ward and Midford (OPU) Ward
Both these wards flagged last month, but have not flagged this month as their quality matrices have improved (FFT scores improved and patient quality matrices).

Quality matrices overall
There were 4 formal complaints received which significantly reduced from last month (8) and negative PALs comments are similar in number to last month (23).

Quality safety matrices of note are:
- Clostridium difficile x 6 cases (7 cases last month)
- Grade 2 Pressure Ulcer x 3 (1 last month)
- Falls have increased (117) with 3 moderate falls. (91 falls last month)
- Appraisal rates have reduced across the wards this month – this may reflect the summer holiday period.

A new measure for this month is recording the number of Datix nurse staffing reports to measure nurse staffing levels.
Acute Stroke Unit flagged the highest number of reports (12).

Actions being taken:
Medical Assessment Unit (MAU)
- The ED Matron and Senior Sister are proactively recruiting to the ward to cover vacancies. This includes specific recruitment events and EU recruitment.
- The Quality Improvement Facilitator for falls is working with the ward to review aspects of care with patients who are a high risk of falls.

Acute Stroke Unit (ASU)
- The Head of Nursing has undertaken a detailed review of the patient care on this ward and provided a written report to the Director of Nursing and Midwifery and CQC in response to the concerns raised. The review has provided assurance and did not corroborate the concerns raised by the CQC.
- The Head of Nursing and Matron will undertake a review of the staffing levels on this ward using the data following the Safer Nursing Care Tool review in August 2015

Responsive Review of Acute Stroke Unit (ASU)

Background:
In September 2015 the Care Quality Commission (CQC) received information from the Department of Health related to concerns that staffing levels had not been adhered to in the light of complexity of the patients' needs. It was reported that the concerns had been raised as incidents but there were no visible improvements seen or actions taken.

In response, the Head of Nursing (Medicine) completed a detailed investigation and written report which has been sent to the CQC.

Investigation
The Head of Nursing reviewed patient quality and safety matrices data for a six month period, (March – August 2015) and nurse leadership. The measures included:

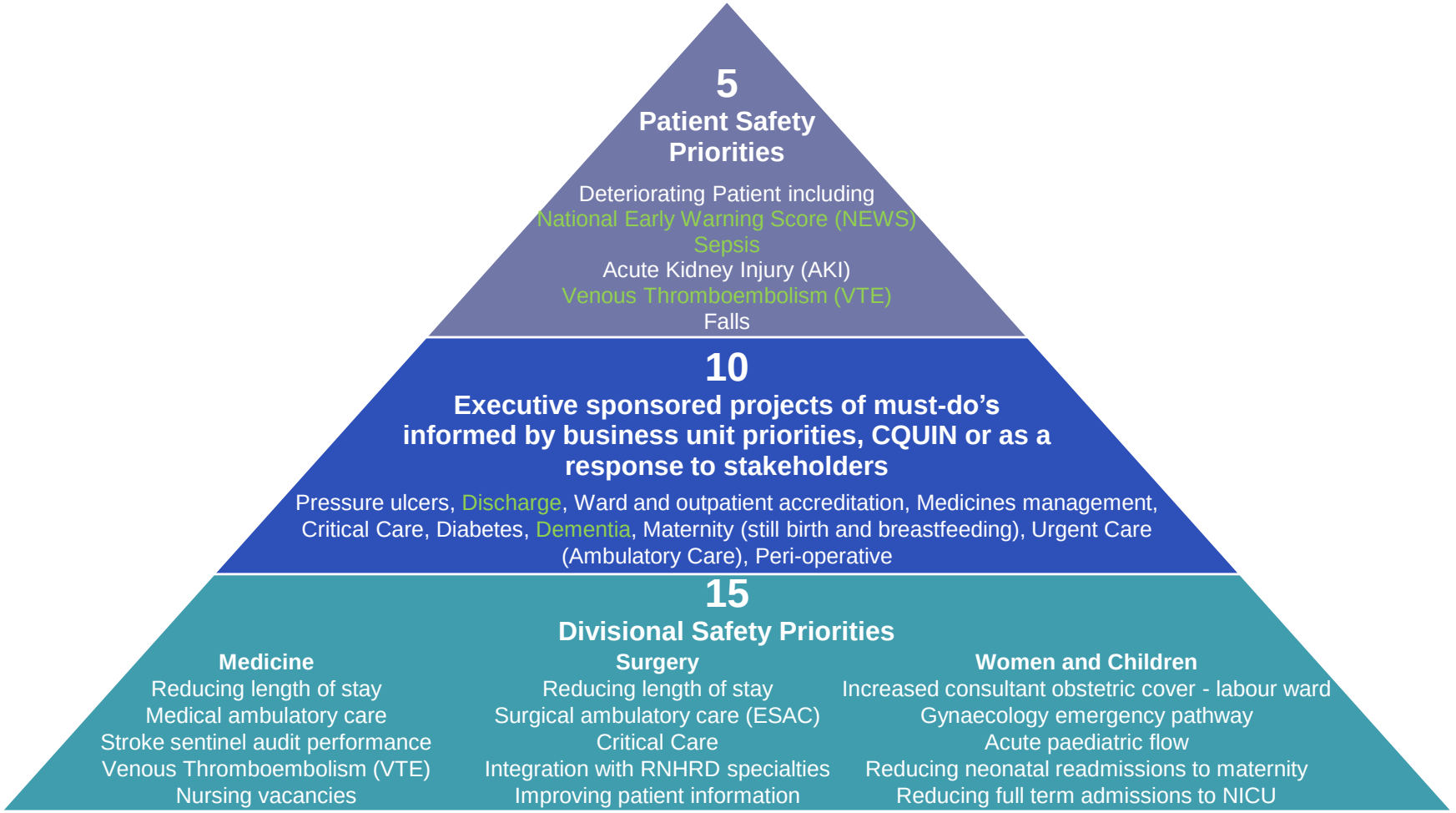
- Complaints/PALs/FFT comments
- Safer staffing data
- Datix reports
- Patient safety measures: Infection Control, Pressure Ulcers and Falls

Investigation findings
The investigation provided assurance about the quality of care being provided to patients:

- During this period there were no complaints received regarding lack of patient care and FFT feedback was extremely positive.
- The investigation did note that on occasions due to vacancies and sickness there were lower levels of staff than planned. However every effort had been taken to mitigate any risk and deploy staff from other areas, this included the Matron working clinically on the ward.
- Interim arrangements to cover the vacant Senior Sister post are in place, however the change of leadership since the previous post holder resigned has been positive for the ward team. The Senior Sister replacement post will be advertised this month.
- The Matron visits the ASU daily and senior nurses including Director of Nursing and Midwifery have undertaken unannounced visits out of hours. No concerns have been noted during these visits.

QUALITY REPORT

PART B – Patient Safety and Quality Improvement



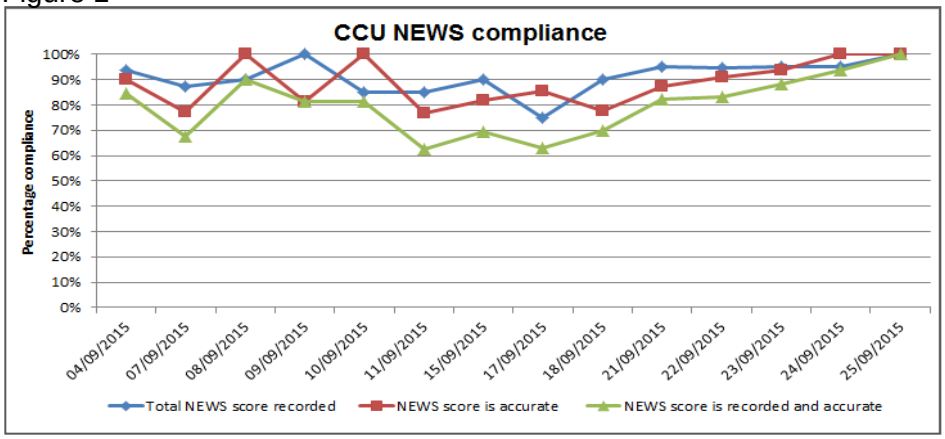
Patient Safety - National Early Warning Score (NEWS) work stream report

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.

- Driver diagram and process measures agreed
- Multidisciplinary team of 9 staff attended West of England Academic Health Science Early Warning Scores workshop in September; NEWS poster presented
- Implemented NEWS on RNHRD site in July
- Credit card size tool developed and funded by Innovation panel as training resource
- Training matrix defined and agreed for levels 1 to 3
- Human Factors and Simulation project to explore how nursing staff record and interpret vital signs and record a NEWS score has been completed in CCU. Measurement of effectiveness post staff simulation training is shown in Figure 1.

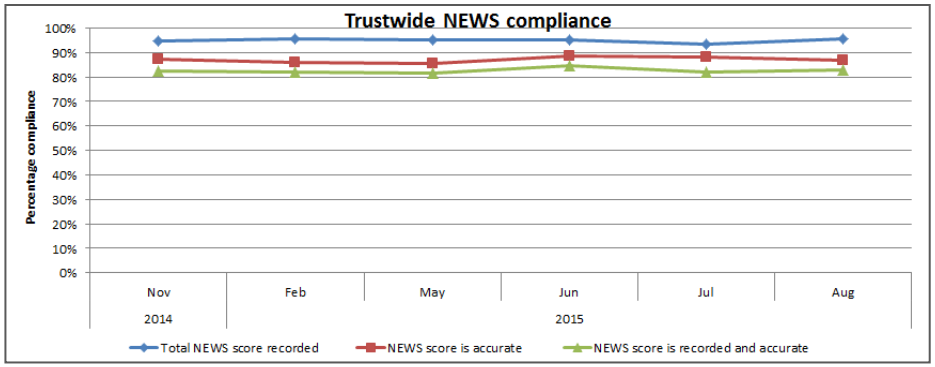
Figure 1



Current Trust wide Performance of NEWS

- Monthly audits continue; in each ward 10 patients charts are audited of 5 sets of observations. Reporting on measures:
  - NEWS score recorded
  - NEWS score accuracy
  - NEWS score recorded that is accurate
- Figure 2 shows trust wide compliance with the above measures

Figure 2 (based on 10 patient sample for each measure)



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

Table of Current Performance of NEWS score recorded

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

Table 1

Ward	Nov-2014	Feb-2015	May-2015	Jun-2015	Jul-2015	Aug-2015
ACE OPU	94%	98%	98%	100%	94%	100%
ASU	90%	93%	100%	94%	88%	98%
Cardiac	100%	98%	96%	96%	94%	98%
CCU	68%	91%	93%	80%	93%	77%
Charlotte	100%	98%	94%	94%	94%	90%
Cheselden	100%	98%	96%	No data	100%	98%
Combe	96%	94%	94%	88%	96%	98%
ED	82%	68%	95%	No data	97%	74%
ED Obs	100%	89%	69%	100%	43%	100%
Forrester Brown A	96%	100%	98%	98%	84%	98%
Forrester Brown B	98%	92%	84%	96%	94%	98%
Haygarth	96%	98%	98%	96%	96%	96%
Helena	98%	98%	94%	94%	88%	94%
MAU	91%	94%	92%	96%	98%	98%
Midford	96%	98%	94%	98%	98%	100%
MSSU	98%	97%	98%	98%	100%	96%
Parry	94%	100%	98%	90%	100%	100%
Philip Yeoman	100%	98%	94%	98%	90%	91%
Pulteney (previously Waterhouse)	84%	96%	98%	94%	100%	100%
Respiratory	100%	100%	98%	100%	98%	98%
Robin Smith	98%	94%	94%	98%	100%	98%
SAU	100%	98%	100%	100%	96%	100%
SSSU	84%	90%	98%	100%	89%	88%
Waterhouse (previously Pulteney)	94%	100%	92%	100%	96%	94%
William Budd	No data	92%	93%	100%	98%	100%
Grand Total	**95%**	**96%**	**95%**	**95%**	**93%**	**96%**

Next steps

NEWS Human factors and Simulation project next steps:

- Cascade training planned for three dates in October - nominations received from all wards for at least two members of staff to attend one of the sessions for training
- Cascade trainers will be given modified simulation training – involving scenarios with key training messages to deliver around NEWS charting and accuracy
- Cascade trainers will deliver training within ward setting
- Series of audits planned to measure effectiveness

Table of Current Performance of NEWS accuracy recorded

The percentage score shown in Table 2 is the percentage of observations performed where a NEWS score is accurate.

Table 2

Ward	Nov	Feb	May	Jun	Jul	Aug
ACE OPU	89%	95%	86%	80%	87%	90%
ASU	93%	85%	92%	91%	100%	98%
Cardiac	66%	73%	81%	96%	94%	76%
CCU	41%	69%	86%	82%	93%	74%
Charlotte	94%	68%	95%	94%	98%	82%
Cheselden	100%	79%	81%	No data	79%	92%
Combe	83%	70%	74%	93%	85%	82%
ED	68%	46%	84%	No data	87%	88%
ED Obs	100%	88%	78%	100%	100%	80%
Forrester Brown A	75%	98%	88%	86%	95%	80%
Forrester Brown B	90%	80%	82%	92%	89%	90%
Haygarth	94%	86%	82%	90%	81%	81%
Helena	100%	96%	74%	86%	93%	83%
MAU	100%	89%	93%	81%	78%	100%
Midford	69%	92%	85%	90%	96%	96%
MSSU	92%	92%	90%	92%	93%	79%
Parry	77%	100%	92%	82%	100%	100%
Philip Yeoman	96%	100%	94%	84%	96%	100%
Pulteney (previously Waterhouse)	79%	89%	90%	81%	76%	84%
Respiratory	92%	82%	63%	84%	82%	71%
Robin Smith	98%	89%	96%	94%	84%	86%
SAU	96%	87%	83%	96%	90%	88%
SSSU	86%	87%	94%	98%	93%	84%
Waterhouse (previously Pulteney)	93%	98%	82%	90%	78%	83%
William Budd	No data	89%	88%	88%	100%	96%
Grand Total	**87%**	**86%**	**86%**	**89%**	**89%**	**87%**

Next steps

- NEWS Workstream lead and Simulation project lead delivering workshop to West of England Academic Health Science Annual conference on the NEWS Simulation project on 15th October
- NEWS workstream lead developing standard template for NEWS project outline, measurement and reporting plan with QIPP team support
- Developing training resources and revised Internet page – to be launched October

Patient Safety – Sepsis work stream report

Current Performance

Identification of Sepsis and Delivery of sepsis 6 in an hour

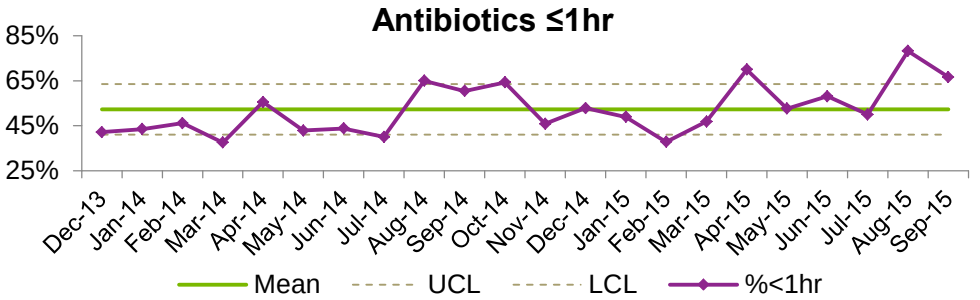
- Improved antibiotics in an hour in Emergency Department in August - 75% of patients with severe sepsis received antibiotics in an hour:
    - Presence of sepsis nurse has been an important factor in achieving this
    - On average between April – August 2015 61% of patients with severe sepsis have received antibiotics within an hour of admission and 80% within 2 hours
- Lactate measurement in an hour has been sustained: over 80% of patients for the last 4 months and 85% in August
- The number of patients identified with sepsis over the last few months has decreased reflecting a decrease in numbers of patient presenting with sepsis. This is now increasing again and in August 71 patients with sepsis were identified on alternate day data collection

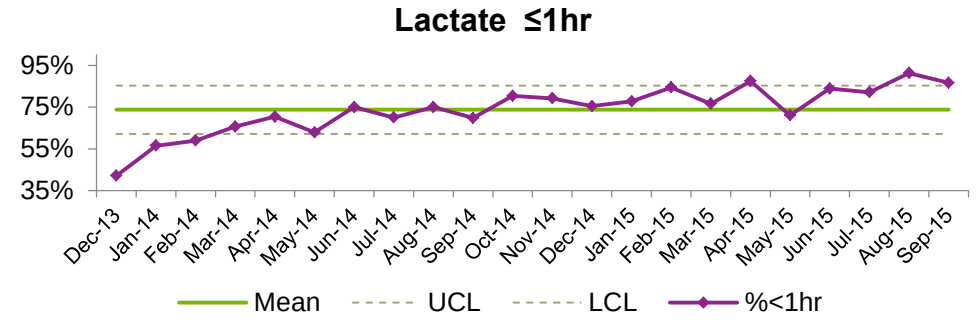
CQUIN

- National CQUIN for 2015/16 has been agreed which is in 2 parts:
- All patients admitted to the hospital at risk of sepsis must be screened. On track for Q2. 70% of at risk patients were screened in August 2015
- Percentage of patients with severe sepsis receiving antibiotics in an hour (see above)

Awareness and training

- World Sepsis Day promotion on 11th September – held successful workshops including demonstration of central venous access devices, paediatric and maternity sepsis and antibiotic stewardship
- Sepsis nurses are continuing the sepsis 6 training, developing ownership of this at ward level. Focused work planned on Haygarth led by senior nursing staff, as part of the spread to the wards
- F1s trained at their teaching session in August
- Formal subgroups of the Trust steering group have been set up to increase spread of work to the wards and Specialities such as Paediatrics, Maternity, Surgery and Medicine





Community and primary care awareness

- AHSN NEWS workshop in September focussed on sepsis and the regional group continues to test and plan roll out into the community

Next Steps

- Test out of hours assessment tool in one GP practice and the Urgent Care Centre at RUH
- Plans to promote awareness in staff and patients in these areas before spreading to others
- Educational session with GPs to be booked
- Focus on use of pre alert by paramedic crews and GPs
- Inclusion of Sepsis in the discharge summary to raise awareness in primary care
- Third sepsis master class planned for December, focusing on paediatric and maternity sepsis. National speakers have been booked and South West region invited

Patient Safety - Venous Thromboembolism (VTE) work stream report

Background

Between 1st July and 30th September, there were 3 Hospital Associated Thrombosis which is a 50% reduction compared to the previous quarter. The Root Cause Analysis (RCAs) identified the following themes:

- VTE Risk assessment not completed on admission, 24 hours later or when there is a change in patient condition
- Not following current hospital VTE protocol for the use of both chemical and mechanical prophylaxis
- Dalteparin not prescribed from admission
- Missed and omitted doses of Dalteparin

Some improvements made to address themes from the RCAs

- A 'clot stop' was introduced in the previous quarter as part of a new process to ensure VTE risk assessments are completed prior to elective surgery. 100% of patients now have a VTE risk assessment completed prior to surgery, and to ensure standards are maintained, this process has been audited on a weekly basis for the previous 2 months
- The new Intermittent Compression Devices (ICD) are now available Trust-wide; the mechanical device training programme has been rolled out and is on-going until all key ward staff have received training
- As part of the mechanical devices review, the Trust has changed its supplier of Anti-Embolic Stockings (AES) and a revised training programme is now under-way

Current Performance

The Safer Clinical Systems project ended in June, and as such, the audit methodology was reviewed. During July and August we performed concurrent audits of 5 drug charts in each of the 4 pilot areas of MSSU, SSSU, Philip Yeoman and Forrester Brown, as well as auditing the drug charts of 5 patients in ACE OPU, ASU, Charlotte Ward, Haygarth Ward, Respiratory Ward and Robin Smith. There remains some variation in the figures collected around patient weight, missed and omitted doses and the use of mechanical prophylaxis. However 92% and 96% of these patients received a VTE risk assessment on admission in July and August respectively.

Next steps

- Finalise review of VTE measurement plan as part of the Patient Safety work stream
- Extend the audit, taking a qualitative approach looking specifically at missed and omitted doses of Dalteparin
- Disseminate the VTE E-learning package to nurses and AHPs
- A VTE care plan has been designed and is currently being piloted on ASU and Philip Yeoman
- Continue with the training programme for mechanical prophylaxis, and maintain good teaching links with the company representatives
- Development of a Standardised Operation Note
- Monitor the actions remaining from the Safer Clinical Systems project via the Patient Safety Steering Group

Quality Account and CQUIN – Improving experience of discharge update

Work stream 1

: Safe and Proactive discharge

To standardise the discharge process across the Trust. For staff to be confident to facilitate a safe and proactive discharge

Update:

- 5 core ward standards for discharge have been developed. Presented at both Medical and Surgical sisters. Engagement with the wards has commenced
- 12 white board round principles developed, staff engagement in progress
- Ward round standards have been developed. These have been presented by the Lead Clinician for Medicine to his consultant colleagues and also discussed with the Lead Clinician for Surgery
- Change to discharge statue. Removal of "amber" being trialled on ACE and Forrester Brown
- Pilot use of live bed state and usage of bed board facility on Millennium
- KPI's for wards identified and being built into the Ward Dashboards

Work stream 2

Patient engagement and involvement **(CQUIN)**

To improve the patients experience and the effectiveness of discharge

Update:

- Two patient engagement events have taken place over the summer
- Patient passport has been developed
- Trial of patient passport has commenced on ASU, Helena, Waterhouse and Forrester Brown
- Discharge process audit continues on trial wards with patient feedback being collected. The table demonstrates the response of patients asked to rate their current experience of discharge from the RUH

Response	No. of patients
Excellent	6 (32%)
Very good	6 (32%)
Good	4 (21%)
Fair	1 (5%)
Poor	1 (5%)
Very poor	1 (5%)

Work stream 3

CHC Fast track and End of Life

To improve the patient and family experience of discharge to preferred place of care for patients at the end of life

Update:

- Staff knowledge and confidence questionnaire has been completed on William Budd and Midford wards
- CHC fast track audit completed and data base established for ongoing monitoring
- CHC fast track patient and carer leaflet in development
- CHC fast track flow chart and check list are currently being piloted by Midford and William Budd wards

Work stream 4

Integrated Discharge Team

Amalgamation of all discharge services

Update:

- Partnership engagement across BaNES, Wiltshire, Somerset and South Gloucestershire
- Multiagency, Multidisciplinary event held to define an integrated discharge team and decide referral processes into the team
- Redefine what constitutes a complex discharge
- A single referral form has been developed although not tested
- Discussions have commenced about colocation of the team on the RUH site

Next Steps

- Development of educational material and discharge information, work book, discharge app, web page development
- Application to the Innovation Panel for App development
- Review of pilot schemes
- Trolley dash week commencing 2nd November
- See it My Way about discharge 15th December
- Discharge celebration event planned in December

Quality Improvement (CQUIN) – Carers of People with Dementia

Background

By 2015 there will be 850,000 people with dementia in the UK*

- One in six people aged 80 and over have dementia*
- A quarter of patients in hospital at any one time have dementia
- 47% of people with dementia who go into hospital are physically less well when they leave than when they went in*
- 54% of people with dementia who go into hospital are mentally less well when they leave than when they went in*

The RUH have a multi-professional, multi-agency strategy group who are actively striving towards supporting the vision. The patient and carer experience work stream updates are included in this report.

*Source: Alzheimer's Society 2013

Carers Survey

A carers survey is undertaken monthly as a part of the CQUIN, with themes reviewed by the Strategy Group and shared with Senior Sisters and Charge Nurses.

- 41 of surveys were completed during Q1 and Q2
- The two themes for improvement have been consistent in both Q1 and Q2 :
  - *73% of carers questioned were satisfied with staff knowledge about dementia*
  - *72% were satisfied that staff spent time listening and acting upon individual*
- 96% of the carers who had contact with the Dementia Coordinators found their input helpful. Comments given were "Excellent - and invaluable at a difficult time" and "Very helpful"
- A dementia carers focus group was held in September, this was undertaken with Alzheimer's Support. Feedback from this event related to discharge, themes being long waits for medication and concerns about the interface between health and social care

Quality Improvement (CQUIN) - Carers of People with Dementia

The following table shows the full survey results for Q1 and Q2 combined:

Standard	Compliance
On admission, how satisfied were you with the RUH staff at recognising that your relative / friend has dementia?	80%
How satisfied were you with the dementia knowledge of the RUH staff who cared for your relative/ friend during their stay at the RUH?	73%
How satisfied have you been about the staff taking time to listen and act upon your relative / friends individual needs, likes and dislikes.	72%
How satisfied were you with the level of information you were given about the treatment of your relative/friend during their stay at the RUH?	78%
How satisfied have you been with the amount of involvement you have had in the care of your relative / friend whilst they have been at the RUH?	73%
Thinking overall, how satisfied have you been with the level of communication you have had with staff about the care of your relative / friend?	76%
How satisfied have you been with the degree of respect and dignity given to your relative / friend whilst they have been at the RUH?	85%
How satisfied are you with the discharge plan for your relative / friend?	74%
If you were contacted by a Dementia Coordinator, did you find their input helpful?	96%

John's Campaign

A national campaign for the right of people with dementia to be supported by their carers in hospital

Benefits:

- People with dementia are confused and often frightened by being out of their regular environment and a stay in hospital can be unnerving
- Involving a family carer from the moment of admission until the time of discharge has been a campaign for the right of people with dementia to be supported by their carers in hospital

RUH current situation

- Both Combe and Waterhouse dementia friendly wards are aware of and support the campaign
- Both wards actively encourage family carers to stay with patients who have dementia
- Both wards have facilities for family carers to stay with patients overnight if required – reclining comfy chairs can be positioned next to the bed

Next Steps:

- Currently in discussions with Designability about using the "Combe" clock to display welcome messages for carers
- Engagement with Patient and Carer Experience Team and ward staff to discuss a developing a Charter for Carers and/or passport
- Presentation at October Professional Nurses Forum

Quality Assurance Report – NHS Antenatal and Newborn Screening Programmes

On 16th June an external quality assurance (QA) review of the Royal United Hospitals Bath NHS Foundation Trust and Sirona Care and Health screening programme was undertaken. The commissioned screening programme has an eligible population of approximately 5000.

Purpose and approach to Quality Assurance
The aim of quality assurance in NHS Screening Programmes is to maintain minimum standards and promote continuous improvement in antenatal and newborn screening. This is to ensure that all eligible people have access to a consistent high quality service wherever they live.

QA visits are carried out by the Public Health England Screening Quality Assurance Service (SQAS).

The review considered data from the following sources
- Routine monitoring data collected by the NHS screening Programmes
- Data and reports from external organisations as appropriate
- Evidence submitted by the providers and commissioner
- Information shared with the screening quality assurance service as part of the visit process

The quality assurance review was of acute maternity services, including obstetric services, provided at the RUH and Midwife led units at Frome, Paulton, Trowbridge and Chippenham and included the sickle cell and thalassaemia laboratory and second trimester obstetric ultrasound service.

There are dedicated leads for the coordination of the local screening services supported by administrative staff.
Provision of antenatal and newborn screening programmes involves interdependencies with other providers**.**

Key findings of review
“The overall impression is of a committed team delivering a screening service to women and their families in BANES. Individual components of the screening programmes are going well and there is some notable practice”
Several areas of good practice were identified for shared learning:
- there is evidence of good working relations between NHS England and the provider organisations
- direct access for women to the midwifery service and early booking with the midwife
- screen positive results for infectious diseases and Down’s syndrome screening are communicated to the women by a specialist screening midwife. On-going care is actively tracked and monitored by the local team to ensure women are seen by specialist services within national timeframes
- regular review of 18-20+6 week scan images to identify areas for improvement and support quality in the screening programme
- training programme in preparation for implementation of the revised cardiac protocol for fetal anomaly screening ahead of national rollout
- the newborn hearing screening service has rigorous training and competency assessment for all staff
- timely recording of newborn blood spot results on the child health information system by 17 days of age

Screening Services - antenatal and newborn

Key recommendations

There were no immediate concerns identified but three high priority issues were identified which are required to be addressed within three months. These were:

- identification and tracking of eligible population along the whole screening pathway to include offer of test, results received and communicated to the parents of babies undergoing the newborn physical examination and referral to treatment services in line with national recommendations and timeframes (RUH)
- results for screen positive sickle cell and thalassaemia should be given by appropriately trained staff as per national recommendations (RUH)
- establish a process to cross reference the eligible population with GP practice lists so all movers in get offered appropriate newborn screening (Sirona Care and Health)

In addition, the report include 17 medium and 6 low risk recommendations which all providers involved in the screening programme are expected to be addressed within 6 and 12 months respectively.

Next Steps

A joint action plan has been developed and was submitted to the Quality Assurance team in September 2015.

The RUH elements of the action plan were approved by the Women & Children's Division and signed off by the Director of Nursing & Midwifery. Progress against the action plan will be monitored via the RUH Screening Committee, reporting to the W&C Divisional Governance Group.

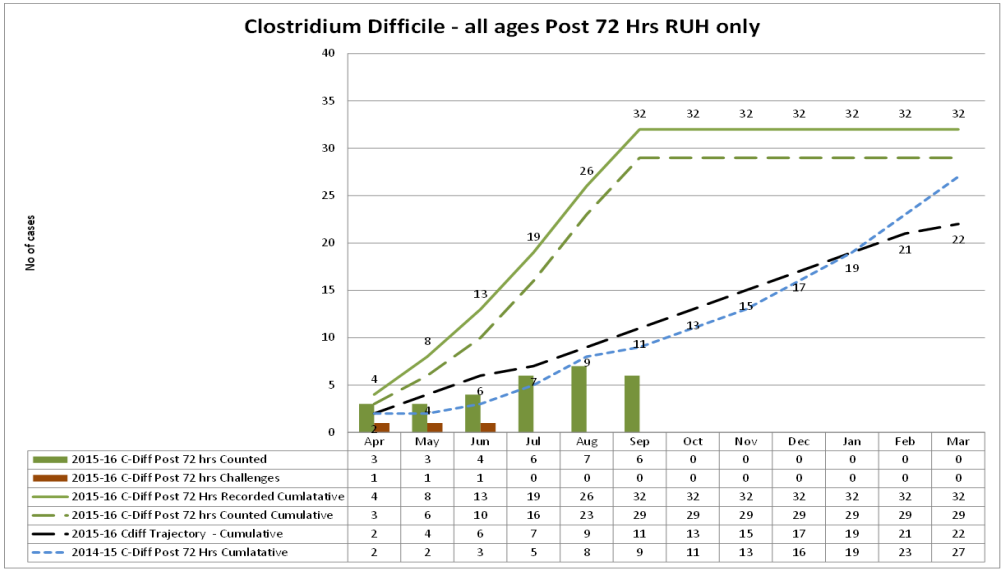
The action plan will also be overseen by the Antenatal & Newborn (ANNB) Screening Programme Board, which is a multi-agency group, chaired by Public Health England, in recognition of the various organisations involved in the screening programme.

Patient Safety - Clostridium difficile

Background

The RUH target for 'Trust apportioned' Clostridium difficile in 2015/16 is 22 cases. Clostridium difficile toxin positive stool samples taken 3 or more days after admission are 'Trust apportioned'.

Current Performance



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2015-16 C-Diff Post 72 hrs Counted	3	3	4	6	7	6	0	0	0	0	0	0
2015-16 C-Diff Post 72 hrs Challenges	1	1	1	0	0	0	0	0	0	0	0	0
2015-16 C-Diff Post 72 Hrs Recorded Cumlatative	4	8	13	19	26	32	32	32	32	32	32	32
2015-16 C-Diff Post 72 hrs Counted Cumulative	3	6	10	16	23	29	29	29	29	29	29	29
2015-16 Cdiff Trajectory - Cumulative	2	4	6	7	9	11	13	15	17	19	21	22
2014-15 C-Diff Post 72 Hrs Cumlatative	2	2	3	5	8	9	11	13	16	19	23	27

Actions

- Public Health England have accepted an invitation from the Trust to lead a peer review involving clinical experts and representatives from B&NES and Wiltshire CCG
- All the actions reported to Trust Board last month continue and are monitored through the C.Diff action meeting chaired by the Director of Nursing and Midwifery

Analysis of cases

Demographics and risk factors:

- Patients aged 44-96 years, average age 77
- Length of stay (LOS) 3 – 150 days, average LOS 30 days
- Ribotyping – no indication of cross infection
- Only one patient had not received antibiotics in preceding 3 months

Antibiotic Stewardship (from 26 RCAs)

- 4 (15%) indication for prescribing antibiotics not recorded on drug chart or in notes
- 4 (15%) antibiotics prescribed outside of Trust guidelines without consultation with Microbiologist
- 7 (27%) cases had no antibiotic review/stop dates recorded on the drug chart

Timeliness of stool sampling (from 26 RCAs)

- 13 (50%) delays in sending stool samples
- 11 (42%) cases may have been community acquired infections if sample taken within 72 hours of admission
- Delay in starting appropriate treatment as samples not taken in a timely fashion

Environment/equipment

- In 15 (58%) cases the cleaning score was below the target score for the area
- 12 (46%) wards had red or amber scores for commode cleanliness at the time that the samples were taken

Numbers and Cases appealed:

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Actual no cases	4	4	5	6	7	6						
CDI appeals (no lapse of care) upheld	1	1	1									
CDI appeals sought (awaiting CCG review)	1		2	1	1							

Serious Incident (SI) summary

Current Performance

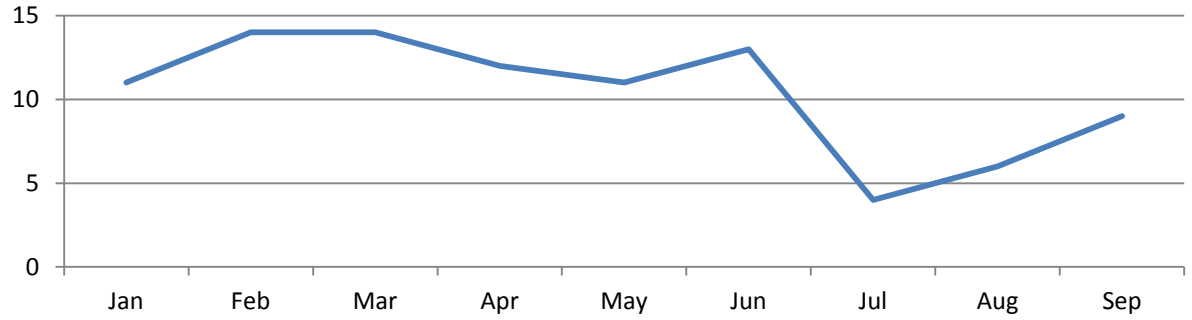
During September, five Serious Incidents were reported. All incidents are under investigation. The incidents have been discussed with the patient and/or their family and they are aware of the investigation, in line with the Duty of Candour framework.

Date of Incident	Datix ID	Summary
02.09.15	**35382**	Unwitnessed fall resulting in a fracture.
03.09.15	**35574**	Unwitnessed fall resulting in a fracture.
07.09.15	**35576**	MRSA positive blood culture.
15.09.15	**35921**	12 hour Emergency Department breach
21.09.15	**35985**	Patient fall resulting in a fracture.

Serious Incident reports approved by the September Operational Governance Committee (OGC)

Date of Incident	Datix ID	Summary	Learning/ Recommendations
05.01.15 (identified 19.03.15)	30432	Delayed diagnosis	There was a failure to thoroughly assess a patient with symptoms • Practitioner managed through HR and professional processes • To advise the team that early involvement of the Acute Oncology Service must be considered
17.06.14	21633	Pseudo –outbreak of Stenotrophomonas maltiphilia	This was investigated by Public Health England • Review traceability and systems and processes across the Trust for re-useable sterile equipment
26.06.15	33289	Unwitnessed patient fall resulting in a head injury	• Update all ward staff on the Falls Care Bundle and provision of ward based falls prevention and falls management training • Commencement of the Falls Care Bundle audit to measure compliance with the implementation of the Falls Care Bundle • Completion of the Post fall form; ensure clarity regarding the frequency of neurological observations post head injury
15.07.15	33857	Patient fall resulting in a fractured	• All 'hi-lo' beds to include floor mats as standard on delivery to a ward • All new low beds ordered by the Trust to have floor mats as standard • Re-state policy on transfer of patients with cognitive impairment out of hours unless there is a clear clinical need • Prompt transfer of patients to appropriate wards within an agreed timescale
25.06.15	33364	Patient identified as having a MRSA bacteraemia	• Review standards for prescribing/documentation of both skin wash and nasal decolonisation • Review of MRSA policy and MRSA care plan
15.07.15	33812	Patient fall resulting in a fracture	'Office' chairs should not be used in clinical areas except on an exception basis. If to be used, inertia wheels must be in place

Overdue Serious Incident Reports Summary



As of 6th October, there are 25 open Serious Incidents (SIs).

Of these, 9 are overdue, based on the previous target of completion of the investigation within 45 days; one of which is an HR investigation and these have an extended timeframe. From 1st September, the timescale for completion of the investigation has been agreed with the CCG as 60 days, as per the NHS England Serious Incident framework.

The investigation has been concluded for six of the open incidents and the reports will be submitted to the Operational Governance Committee for approval at the October meeting.

A target of no overdue SIs by October (with the exception of HR investigations) has been agreed. This will require a reduction in the number of overdue SIs by four per month and while this is supported by the post of Duty of Candour and Serious Incident Advisor, achieving this has proved difficult for the past two months, due to the competing commitments of the investigating managers. The Operational Governance Committee has agreed a revised process for reviewing the final reports and it is anticipated that this will assist in addressing this issue.

Trajectory	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct
Actual	11	14	14	12	11	13	4	6	9	
Target	-	-	-	-	-	-	12	8	4	0