Agenda item: 8.2, Public
Date: 30 January 2013

Title: Q3 Ward to Board Report

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Presented by: Em Wilkinson-Brice, Chief Nurse and Executive Director of Service Delivery

Responsible Executive: Em Wilkinson-Brice, Chief Nurse and Executive Director of Service Delivery

Summary: Brief overview of issues addressed in the paper.

Actions required: For information

Status (*): Decision Approval Discussion Information

X

History: Previous Ward to Board (W2B) Drill Down Report was discussed in October 2012 Board of Directors Meeting.

Link to strategy/Assurance framework: Board Assurance Framework Strategic Risk 1C

Monitoring Information

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Please specify CQC standard numbers and tick ✓ other boxes as appropriate.
1. **PURPOSE**

1.1 To provide the Board with the quarterly drill down report into the Ward to Board (W2B) quality framework.

2. **BACKGROUND**

2.1 This report monitors performance at acute inpatient ward and divisional level and provides a RAG rated outcome indicator based on scores for each indicator against the set trajectory and target.

This report forms part of the Integrated Performance report for scrutiny by the Board. The monthly report is scrutinised by the Chief Nurse / Director of Service Delivery and it is currently monitored on a monthly basis by the Deputy Director of Nursing and Patient Care. A rolling action plan is developed and maintained by the Divisions in response to the monthly reports. The Deputy Director of Nursing and Patient Care holds the Lead Nurses to account for performance against the action plan.

This information is presented with the Clinical Quality Assessment Tool (CQAT) data and with information from incidents and complaints. Information is triangulated with complaint and incident data to provide an overall evaluation of performance.

2.2 The individual directorate aggregate scorecards are presented at the end of the narrative report.

2.2.1 **Medicine:**

This Division has successfully opened Ashburn and Yealm Wards this Quarter. This has contributed significantly to the Trust’s capacity plans. All the staff required for these new wards have been recruited and have undergone a comprehensive induction programme. The Division has seen a significant increase in unplanned activity. Norovirus has been very active in the local community and this has had a impact which has required several Wards to restrict admissions and movement of staff and patients around the hospital.

The Division has seen an improvement in the prevention of Pressure Ulcers culminating in December when there were no Pressure Ulcers of grade 2 or above.

The MUST Nutritional assessment and compliance audits of compliance with the triggers have shown a deterioration. This has been reviewed by the Lead Nurse for Medicine, who reports that the focus on this work is having a noticeable effect at patient level with far more patients receiving appropriate monitoring and suitable nutrition and supplements. A review of the timeliness of the initial assessment is being carried out. At the current time this assessment is often completed under pressure, and it is felt that there will be improved compliance and accuracy if this assessment is moved to later in the acute admission process. This is part of a wider review of the timing and documentation of all admission assessments which was commissioned by the Senior Nurses through the Care Matters meetings chaired by the Chief Nurse / Director of Service Delivery.

There has been a general deterioration in the Division’s Performance in Hand Hygiene Audits. Taw Ward has consistently failed to meet an acceptable level of hand hygiene for a number of months despite input from the Infection Control Team. There has been increased education and supervision in the area. A review of the last 6 months of data
does not indicate that this problem sits with any individual or professional group and is proving difficult to manage. A Senior Management meeting has reviewed all actions taken so far and to further understand this issue. The review has shown there has been no harm to patients that can be linked to this. The Division will continue to address the poor compliance by observing individual practice and using the Trust’s performance management process where indicated.

The Division has seen an increase in inpatient falls in the latter part of the Quarter. This is against a backdrop of improved falls assessment. The opening of Ashburn and Yealm has contributed to this increase. The number of falls in each area has increased marginally; none of these on their own represents a significant increase for any one ward, however in aggregation they show a peak. The Division will continue to monitor this situation closely.

The Division has seen a peak in sickness caused by staff suffering predominantly from Norovirus or colds. The Directorate continue with robust application of the Sickness Management Policy. This is reviewed through the monthly management review meeting.

The Ward to Board and CQAT results have been reviewed as part of Speciality and Directorate Governance Groups. Torridge Ward has a higher number of red triggers than would be expected, therefore the management team of Torridge has been requested to submit a review of their Ward to Board and CQAT supporting their action plan for review by the Divisional Governance Group.

2.2.2 Surgery:

Overall the Division continues to perform well, but there has been a slight general deterioration across all measures. In order to understand and address this before it becomes a problem the Lead Nurse for Surgery has called a meeting with Ward Matrons to reinforce minimum standards and to set trajectories for improvement where they are required.

Four Wards have been identified as contributing significantly to deterioration in compliance with the hand hygiene standards. The frequency of audits in these areas has been increased to weekly and the Infection Prevention and Control Team are actively engaged in monitoring and challenging practice in those areas. Early evidence from these audits is showing an improvement in compliance.

The Division reported poor compliance with the MUST Nutritional Risk Triggers in November. This has been investigated and it is largely due to the complexities caused by the necessary restrictions on diets that are often required in surgical specialties. This has resulted in the need to refine the audit process. This work has taken place through December and the resulting improvement in the data can be seen. The challenges in this audit process have not had an impact on patient care as the issue is purely one of audit design.

However some wards are showing a deteriorating compliance with the MUST initial nutritional assessment. Ward Matrons are proactively managing this. In order to understand whether there is another cause for this all missing data is currently being reviewed at an individual patient level.

There has been a reduction in the number of falls assessments being completed and an increase in the number of falls. There has not been an increase in harm to patients.
as a result of these falls. Ward Matrons are formally monitoring all patients on a daily basis to ensure assessments are complete. This is being performance managed formally through a weekly review with Senior Matrons

2.2.3 **Women’s Health – Wynard Ward:**

Wynard Ward continues to deliver good performance against all the indicators with the exception of VTE risk assessment. There is some confusion regarding the identification of patients for whom risk assessment is indicated. This is predominately focussed on discrepancies with the day case service. The Ward Matron is working to improve the understanding of this and adjustments are currently being made to the recording systems within the Day Case Unit on Wynard.

2.2.4 **Cancer Services:**

Cancer Services have continued to deliver excellent performance. They have delivered 97.2% harm free care.

2.2.5 **Paediatrics:**

The paediatric measures are showing excellent performance with 100% harm-free care and 100% compliance with the hand hygiene audit.

2.2.6 **Trauma and Orthopaedics:**

The Division has delivered an excellent set of results with the Safety Thermometer showing a complete absence of new harm and the delivery of 100% harm free care in December.

The only indicator causing concern within Trauma and Orthopaedics is sickness absence. This is largely as a result of seasonal illness.

4. **PROPOSALS**

4.1 The Infection Prevention and Control Team have developed a performance dashboard. A representation of this currently populated with sample data is attached at Appendix A for the Board’s information. It is proposed that the Board receives this dashboard as part of this report quarterly.

5. **FINANCIAL/OTHER IMPLICATIONS**

5.1 The reduction in Agency Nurse usage will reduce the cost pressures associated with temporary staffing.

The Trust is required to achieve 90% compliance with electronic VTE reporting during Quarter 3 and 4 in order to realise the associated CQUIN money

6. **RECOMMENDATIONS**
6.1 The Board is requested to note the Quarter 3 Ward to Board drill down report and to accept the proposal to include the Infection Prevention and Control Performance Dashboard in future reports.
A significant proportion of MRSA and other bacteraemias were associated with inappropriate care of peripheral cannulae and central intravenous devices. Considerable effort was given to making improvements in this area. Training and skill assessment has improved the ongoing care of all IV access devices with an associated reduction in infection rates.

This is a national HCAI performance indicator. The target for 2012-13 is to have no more than 2 MRSA hospital attributable bacteraemias. With such a low target a trajectory for each month or even each quarter is not possible therefore the target of 2 was allocated randomly to the months of April and July. The last hospital attributable bacteraemia was in September 2011.

This is a national HCAI performance indicator. The target for 2012-13 is to have no more than 67 hospital attributable cases. The trajectory agreed with the commissioners is slightly different to the trajectory set by monitor although the target is 67 for both. Current performance suggests that will be achieved. The reduction in August and September follows on from the annual deep clean of all ward areas.

The Trust agreed minimum standard for hand hygiene compliance with the WHO 5 moments for hand hygiene is currently set at 85%. In November and December 2012, there has been a slight reduction in compliance. Areas that fail to submit audit data are scored as 0% compliance - in December one ward area failed to submit data. There were low scores in 5 clinical areas which is being addressed within divisions.

This point prevalence data is collected as part of the Safety Thermometer work. Previous prevalence surveys undertaken by the Infection Control Team identified a higher proportion of patients with a catheter, 30%, and safety improvement work focused on reducing unnecessary catheterisation. Prevalence is now at less than 20%. The proportion of patients with a hospital acquired catheter associated urinary tract infection is low in comparison with other Quest hospitals.

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The reducing VAP care bundle was implemented in ITU as part of the SW patient safety work in 2010. The rate is low with just two cases identified, in August and October 2012 giving the rates identified above.
Continuous surveillance is undertaken for knee replacement surgery. The rate rose in 2010 with the RD&E became a high outlier against other participating centres and was above the benchmark for 4 successive quarters. Despite focused efforts by the knee team to address this, the quarterly rate has remained higher than the national benchmark in alternative quarters. However, the mean % rate for the last 4 quarters is 0.65 with the national benchmark at 0.6.

Continuous surveillance is undertaken for patients undergoing hip replacement. The rate of infection is consistently below the national benchmark.

Continuous surveillance has been undertaken for spinal surgery after a high rate was identified having completed a surveillance module in 2009. The rate is now consistently below the national benchmark.

Prudent antimicrobial prescribing optimises treatment of infection and minimises side effects such as the emergence & spread of resistant organisms and C.difficile associated diarrhea. CQUIN targets for drug chart documentation of indication and duration for antimicrobials were introduced in April 2012. Subsequently there has been a progressive improvement in prescribing documentation, although there is capacity to further raise and sustain standards.

CQUIN targets for in-patient antimicrobial prescribing compliance with Trust prescribing guidelines were introduced in October 2012. This has seen a considerable and sustained improvement in compliance across the acute Trust.

NB. The data used in this graph has not been validated, has been included in this draft as an example and is likely to be significantly lower once validated. Definition of bed days lost is: the sum of empty beds each day (to which patients cannot be admitted because the ward is closed to admissions) for the duration of a ward outbreak. For example a ward is closed to admissions for 3 days - if on day 1 there are 0 empty beds, day 2 there is 1 empty bed, day 3 there are 2 empty beds. Total bed days lost = 3 bed days.
Medicine
Cancer Services
Paediatrics

- Process - Absence of New Harm - Safety Thermometer
- Process - Hand Hygiene
- Outcome - Harm Free Care - Safety Thermometer
- Outcome - MRSA Isolates
- Outcome - Incidents & Complaints / Concerns