

Agenda Item: 3.i

Report to:	Board of Directors	Date: 4 <sup>th</sup> October 2018
Report from:	Chief Nurse and Medical Director	
Principal Objective/ Strategy and Title:	<b>GOVERNANCE: COMBINED QUALITY REPORT Patient Safety, Effectiveness of Care, Patient Experience and DIPC</b>	
Board Assurance Framework Entries:	Unable to provide safe, high quality care BAF numbers: 742, 675, 1511 and 1878	
Regulatory Requirement:	CQC	
Equality Considerations:	None believed to apply	
Key Risks	Non-compliance resulting in poor outcomes for patients and financial penalties	
For:	Information	

1. Purpose/Background/Summary

The Medical Director and Director of Nursing would like to highlight the following in addition to the Papworth Integrated Performance Report (PIPR) to the Board:

2. Safety -Safer Staffing (BAF 742) August:

Day	Night		Night	
Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	
80.5%	96.4%	81.7%	108.6%	
Ward by ward percentage fill rate:	Day		Night	
Ward name	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)
CMU	82.7%	97.5%	99.9%	98.4%
HEMINGFORD & HDU	94.8%	92.4%	99.7%	118.9%
CF WARD	96.2%	125.1%	99.2%	-
HUGH FLEMING	77.6%	88.4%	72.3%	76.4%
MALLARD & PCU	75.8%	101.2%	85.2%	159.2%
RSSC	50.0%	88.0%	79.2%	101.9%
VARRIER JONES	75.7%	155.4%	97.8%	159.2%
CRITICAL CARE	103.8%	48.1%	102.0%	46.3%
DAY WARD	68.1%	71.3%	0.0%	-

**Exception report:**

CMU

Day shift for RN short against predicted need. Adjustments in patient case mix. Beds held during day for overnight stay from day ward.

Hugh Fleming

Five beds closed for 2 weeks in August. Predicted to 33 beds delivered to 29 through August.

Mallard

Flexing of beds utilised/cohorting of patients to enable best use of resource, beds held without affecting capacity.

Varrier Jones

Good team working and use of B4 PRPs to support RN vacancies.

CCA

RN to patient 1:1 care maintained. Care staff are not counted in this ratio.

Overall CHPPD has been maintained. High levels of care staff reflect enhanced 1:1 supervision and B4/PRPs counted in this line. CCA has supported ward areas with RNs. No notable impact on nurse sensitive indicators.

**3. DIPC (BAF 675):**

**Increased incidence of C-Difficile**

All cases involved in the increased incidence of C-Difficile have been through the scrutiny panel, and non were due to omissions in care at the hospital, and therefore none are sanctioned and effect our trajectory.

We have had 2 cases of C.difficile in September, one was pre 72 hours so does not require an RCA. The RCA is in progress for the first case and a scrutiny panel has been arranged.

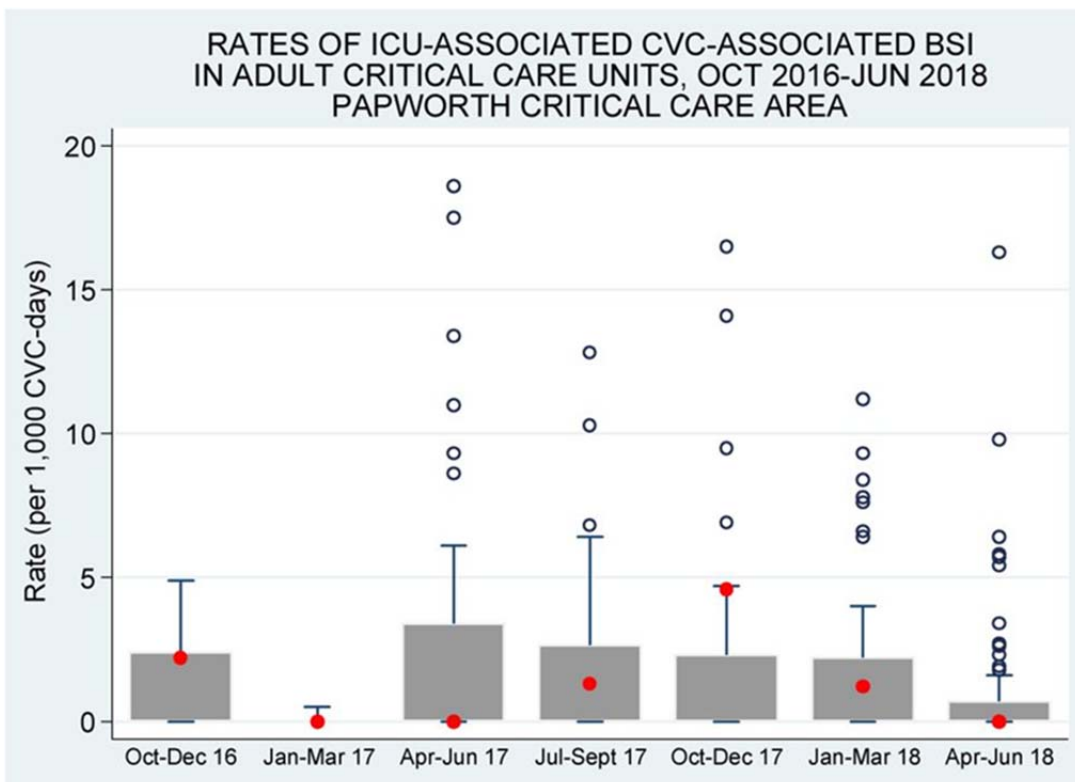
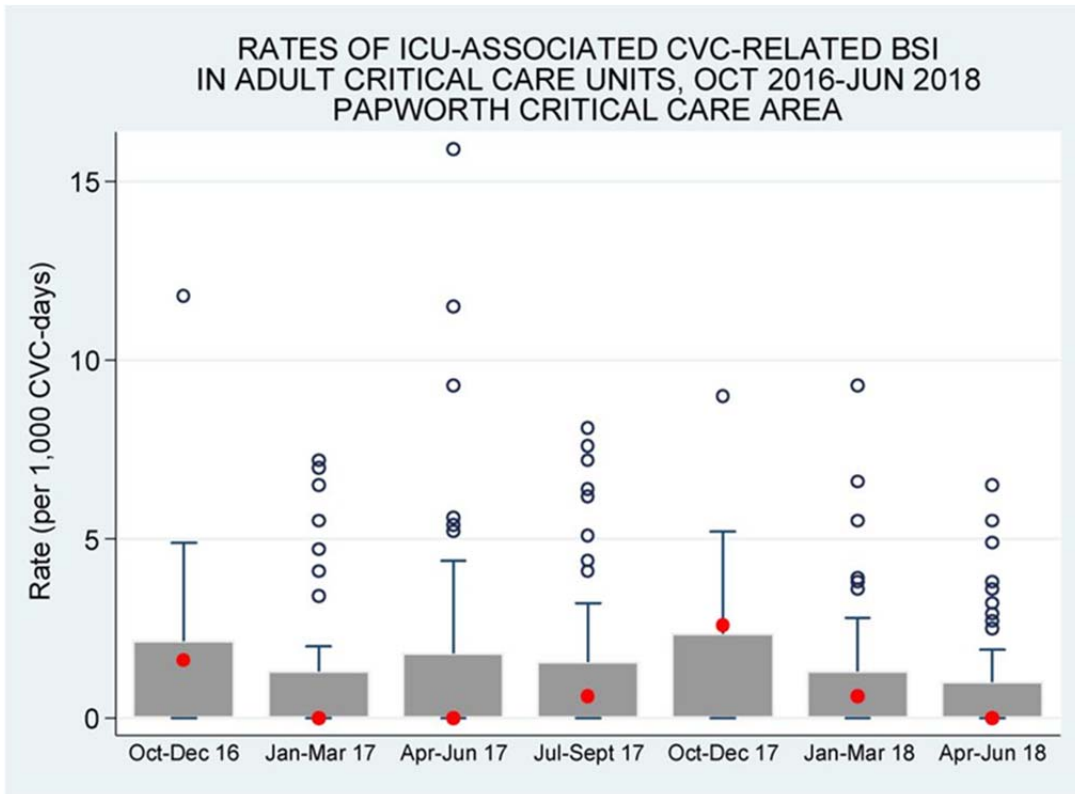
Ceiling trajectory figure for 2018-19 is 4 cases. We currently stand at 2.

**Rates of CVC-associated and CVC-related bloodstream infections in critical care.**

The hospital continues to participate in critical care bloodstream infections surveillance (ICCQIP). The recent report showed that CVC (Central venous Catheter)-related and CVC-associated infection rates were comparable with those in other adult critical care units since the beginning on 2018 year (red dots = Royal Papworth Hospital).

**Related** means a stronger association (direct relationship) because the same organism is cultured from both blood culture and the central venous catheter line tip.

**Associated** means an assumed relationship (indirect relationship) because we didn't culture the same organism from the central venous catheter line tip but clinical symptoms cannot be explained by other reasons apart from line infection.



**Bed closures for IPC issues:**

12 bed days lost for suspected CPE on Duchess Ward.

19 bed days lost due to suspected Norovirus and CPE on Mallard and CCA respectively.

#### 4. Inquests/Investigations:

##### Patient A

Patient in advanced heart failure admitted for a Cardiac Re-Synchronisation Therapy Pacemaker (CRTP). Following the procedure, the patient experienced a pneumothorax (known complication) which required a chest drain to be inserted. The patient went on to develop severe surgical emphysema and was admitted to Critical Care for airway management. Patient sadly died the same day. Investigation carried out which concluded the procedure was carried out appropriately and the complication recognised and treated immediately.

Narrative Conclusion – Died from a rare complication of surgical emphysema and iatrogenic pneumothorax caused by an elective cardiac re-synchronisation procedure.

Recommendations – The Trust has already met with the family to discuss the findings of the report and they had no concerns regarding the procedure and management of the complication.

Risk of death to be added to Patient Guide and Consent Form.

Inquests – The Trust currently has 33 inquests pending with 4 out of area.

#### 5. Quality Improvement (QI):

The In House Urgent Quality Improvement Project was launched successfully on the 18<sup>th</sup> September. The progress of the project will be reported through PIPR Responsive.

#### 6. PIPR Safety KPI review

The Q+R committee as requested by the Board, reviewed the Serious Incident(SI) key performance indicator (KPI). The Committee proposes that the SI KPI is moved to the monitoring section. It was decided that this should not be replaced by a different KPI at this stage, as the number of KPIs remains comparable with the other domains reported in PIPR. The committee supported the moderate and above incident rate as the indicator of safety incident reporting.

##### Deteriorating Patient

A ‘kick off’ meeting took place on 27 September 2018 with key stakeholders to introduce the general principles of quality improvement and methodologies were introduced. The team were facilitated in process mapping the deteriorating patient and to try and establish the overall aim of the project and the primary drivers. It was agreed a wider stakeholder group needs to be established with representation from all staff involved in the deteriorating patient journey. Data is currently being analysed to establish our baseline and balance measures at key points; this will ensure any PDSA (Plan, Study, Do, Act) cycle can demonstrate whether a change made an improvement.

##### Patient Falls

This was the first quality improvement project to be started and has progressed significantly with identifying sub projects and measuring outcomes via a series of PDSA cycles. It has been agreed that there needs to be a wider falls quality improvement team and a “kick off” meeting will happen at the beginning of November with the wider team.

##### Red to Green

This project has been implemented and a meeting is currently being arranged to understand if we can use quality improvement methodologies to demonstrate and improvement in the patient journey and experience.

**Recommendation:**

**The Board of Directors is requested to note the contents of this report and agree with the SI KPI change in PIPR.**