Agenda Item No.1

NHS
The Queen Elizabeth Hospital King's Lynn
NHS Foundation Trust

REPORT TO THE TRUST BOARD (IN PUBLIC)

RESPONSIBLE DIRECTOR:	REPORT FOR:		IMPACT ON BUSINESS:		
Emma Hardwick Chief Nurse	Decision		High	Med	Low
	Discussion	√	√		
	Information				
LEAD MANAGER:	**REPORT TYPE:**		**BAF REFERENCES & RAG:**		
Valerie Newton Deputy Chief Nurse	Strategic				
	Operational	√			
	Governance		**RELATED WORK: (PREVIOUS PAPERS TO COMMITTEE)**		
PEER ASSIST:	**PEER REVIEW:**				
CQC Domain: (safe, caring, effective, responsive, well-led)					

Meeting Date: 29th May 2018

Report Title: Quality Exception Report

PURPOSE:					
To provide supplementary information supporting the Integrated Performance Report					
SUMMARY:					
To update and advise the Trust Board on: • Pressure ulcers • Infection control • Ward level clinical indicators					
RISK ASSESSMENT (CROSS-REFERENCE WITH RISK REGISTER WHERE APPROPRIATE):					
Strategic / External	**Operational/ Organisational**	**Financial**	**Clinical**	**Legal/ Regulatory**	**Reputational / Patient Experience**
√	√	√	√	√	√
RECOMMENDATION/S:					
The Trust Board is requested to note this report.					

QUALITY EXCEPTION REPORT

1 PRESSURE ULCERS

1.1 In all the areas where there had been avoidable pressure ulcers development, the TVN team have discussed the reasons behind the pressure ulcer development with the ward manager and ward team so that the lessons can be learnt and implemented within the relevant area.

1.2 Each ward manager is involved in the investigation into the pressure ulcer development and has developed an action plan to prevent a reoccurrence of the harm caused on future patients and has responsibility to ensure that this learning is implemented. Going forward the CNO will oversee a prompt table top review with Ward manager and matron for any avoidable pressure ulcers with the follow up of actions via Harm Free care group and the monthly CNO ward performance meetings.

2 INFECTION CONTROL

2.1 Due to the ongoing infection control issues and the potential impact of the 1.00 wte vacancy in the IPC nursing team the Trust is now triggering Red for IPC by NHSI. The are no additional reporting measures associated with this and the continued support from the NHSI Lead Nurse for IPC is valued.

2.2 The CNO has requested a Peer review with a terms of reference to cover all areas of concern, this is being led by NHSI and is scheduled for June 12th 2018. An IPC awareness programme of several sessions led by the CEO with a film of a patient storey regarding IPC has commenced in May 2018.

2.3 Master classes for Matrons led by NHSi have taken place and Matrons are undertaking Perfect Ward audits and using a checklist devised following the class to ensure wards and areas are meeting standards, these are monitored weekly by the CNO via the Senior Nurses meeting.

2.4 The IP&C team are continuing supportive measurers on W Raynham, ITU and Oxborough Wards, and providing support and education to staff in these areas.

2.5 Support is being received from CCG colleagues while the IP&C Team has reduced staff, helping with auditing and completion of RCAs .

2.6 A Gap analysis of cleaning services at the Trust has been received during May and provides details for recommended cleaning frequencies, standards and training levels for staff. A plan with clear timescales is in place and being led by the Domestic Manager. This includes a programme to deliver British Institute of Cleaning Science (BICSc) accredited training to all Domestic and Housekeeping staff. This will be commenced in June with a target completion date of 30th September 2018. The Associate Chief Nurse's are working closely with the Domestic teams to ensure a coordinated approach between the Domestic and Housekeeping teams. The current Trust wide review of Housekeeping will be presented on June 8th 2018 to the Quality Matters Group and will provide the recommendations for providing a standardised approach to the delivery of Housekeeping across the inpatient ward areas.

3 WARD LEVEL CLINICAL INDICATORS

3.1 A review of the clinical indicators for April shows that completion of fluid balance charts in clinical areas is inconsistent with completion varying from 48% to 98%

3.2 Four clinical areas ; Marham, MAU, Terrington and Windsor have a nil return this is due to the audit department not receiving the audit forms within timeframe.

3.3 In order to provide assurance in relation to hydration of patients in the Trust a Deep Dive of Hydration of patients is being presented to the Quality and Patient Safety Committee in June. Data collection for May will be personally overseen by the Associate Chief Nurse in each division to ensure there is compliance of returns in all areas

3.4 In the longer term Fluid Balance and Hydration will be included as part of the "Perfect Ward" programme.

3.5 It should be noted that the re score of Waterlow (skin assessment) and falls assessment are not undertaken in SAU, MAU and Terrington as patients are not in these areas a week after admission and therefore a nil return is expected from these 3 areas as a matter of course.

3.6 The oversight of other areas of a non-return in care rounds, bedrail assessments, Waterlow and MUST assessments continue via the ACN and via the CNO during the ward performance meetings with matrons and ward managers.

3.7 While there has been an increase in the compliance with documentation of the Frequency of observations there are still areas of concern.

23 May 2018
Emma Hardwick
Chief Nurse