# Open and Honest Care in your local hospitals

The *Open and Honest Care: Driving Improvement* programme aims to support organisations to become more transparent and consistent in publishing safety, experience and improvement data; with the overall aim of improving care, practice and culture.

Report for:

## East Lancashire Hospitals NHS Trust

November 2016

# Open and Honest Care at East Lancashire Hospitals NHS Trust : November 2016

This report is based on information from November 2016. The information is presented in three key categories: safety, experience and improvement. This report will also signpost you towards additional information about East Lancashire Hospitals NHS Trust's performance.

## 1. SAFETY

### NHS Safety thermometer

On one day each month we check to see how many of our patients suffered certain types of harm whilst in our care. We call this the safety thermometer. The safety thermometer looks at four harms: pressure ulcers, falls, blood clots and urine infections for those patients who have a urinary catheter in place. This helps us to understand where we need to make improvements. The score below shows the percentage of patients who did not experience any harms.

99.0% **of patients did not experience any of the four harms whilst an in patient in our hospital**

99.6% **of patients did not experience any of the four harms whilst we were providing their care in the community setting**

Overall 99.2% **of patients did not experience any of the four harms in this trust.**

For more information, including a breakdown by category, please visit:
http://www.safetythermometer.nhs.uk/

### Health care associated infections (HCAIs)

HCAIs are infections acquired as a result of healthcare interventions. Clostridium difficile (C.difficile) and methicillin-resistant staphylococcus aureus (MRSA) bacteremia are the most common. C.difficile is a type of bacterial infection that can affect the digestive system, causing diarrhoea, fever and painful abdominal cramps - and sometimes more serious complications. The bacteria does not normally affect healthy people, but because some antibiotics remove the 'good bacteria' in the gut that protect against C.difficile, people on these antibiotics are at greater risk.

The MRSA bacteria is often carried on the skin and inside the nose and throat. It is a particular problem in hospitals because if it gets into a break in the skin it can cause serious infections and blood poisoning. It is also more difficult to treat than other bacterial infections as it is resistant to a number of widely-used antibiotics.

We have a zero tolerance policy to infections and are working towards eradicating them; part of this process is to set improvement targets. If the number of actual cases is greater than the target then we have not improved enough. The table below shows the number of infections we have had this month, plus the improvement target and results for the year to date.

| Patients in hospital setting | **C.difficile** | **MRSA** |
|---|---|---|
| **This month** | 4 | 0 |
| **Trust Improvement target (year to date)** | 19 | 0 |
| **Actual to date** | 25 | 0 |

For more information please visit:
www.website.com

## Pressure ulcers

Pressure ulcers are localised injuries to the skin and/or underlying tissue as a result of pressure. They are sometimes known as bedsores. They can be classified into four categories, with one being the least severe and four being the most severe. **The pressure ulcers reported include all avoidable pressure ulcers that were obtained at any time during a hospital admission that were not present on initial assessment.**

This month 3 Category 2 - Category 4 validated pressure ulcers were acquired during Acute hospital stay and 1 in the community.

| Severity | Number of Pressure Ulcers in our Acute Hospital setting | Number of pressure ulcers in our Community setting |
|---|---|---|
| Category 2 | 2 | 1 |
| Category 3 | 1 | 0 |
| Category 4 | 0 | 0 |

In the hospital setting, so we know if we are improving even if the number of patients we are caring for goes up or down, we calculate an average called 'rate per 1,000 occupied bed days'. This allows us to compare our improvement over time, but cannot be used to compare us with other hospitals, as their staff may report pressure ulcers in different ways, and their patients may be more or less vulnerable to developing pressure ulcers than our patients. For example, other hospitals may have younger or older patient populations, who are more or less mobile, or are undergoing treatment for different illnesses.

| | | |
|---|---|---|
| Rate per 1,000 bed days: | 0.10 | Hospital Setting |

The pressure ulcer numbers include all pressure ulcers that occured from hours after admission to this Trust

In the community setting we also calculate an average called 'rate per 10,000 CCG population'. This allows us to compare our improvement over time, but cannot be used to compare us with other community services as staff may report pressure ulcers in different ways, and patients may be more or less vulnerable to developing pressure ulcers than our patients. For example, our community may have younger or older patient populations, who are more or less mobile, or are undergoing treatment for different illnesses.

| | | |
|---|---|---|
| Rate per 10,000 Population: | 0.02 | Community |

## Falls

This measure includes all falls in the hospital that resulted in injury, categorised as moderate, severe or death, regardless of cause. **This includes avoidable and unavoidable falls sustained at any time during the hospital admission.** Falls within the community setting are not included in this report.

This month we reported 2 fall(s) that caused at least 'moderate' harm.

| Severity | Number of falls |
|---|---|
| Moderate | 2 |
| Severe | 0 |
| Death | 0 |

So we can know if we are improving even if the number of patients we are caring for goes up or down, we also calculate an average called 'rate per 1,000 occupied bed days'. This allows us to compare our improvement over time, but cannot be used to compare us with other hospitals, as their staff may report falls in different ways, and their patients may be more or less vulnerable to falling than our patients. For example, other hospitals may have younger or older patient populations, who are more or less mobile, or are undergoing treatment for different illnesses.

| | |
|---|---|
| Rate per 1,000 bed days: | 0.07 |

# 2. EXPERIENCE

To measure patient and staff experience we ask a number of questions.The idea is simple: if you like using a certain product or doing business with a particular company you like to share this experience with others.

The answers given are used to give a score which is the percentage of patients who responded that they would recommend our service to their friends and family.


## Staff experience

Between July - September 2016 we asked 1766 staff in the Trust the following questions:

| | % recommended |
|---|---|
| I would recommend this ward/unit as a place to work | 73 |
| I would recommend the standard of care on this ward/unit to a friend or relative if they needed treatment | 80 |

## Patient experience

### The Friends and Family Test

The Friends and Family Test requires all patients, after discharge from hospital, to be asked: *How likely are you to recommend our ward to friends and family if they needed similar care or treatment? We ask this question to patients who have been an in-patient and/or attended Acccident & Emergency (A&E). Both scores (if applicable) are below;*

| | | |
|---|---|---|
| **In-patient** FFT % recommended * | 98.00% | This is based on 2077 patients asked |
| **A&E** FFT % recommended* | 76.00% | This is based on 1350 patients asked |

We also asked 551 patients the following questions about their care in the hospital:

| | Score | Score |
|---|---|---|
| Were you involved as much as you wanted to be in the decisions about your care and treatment? | 97 | |
| If you were concerned or anxious about anything while you were in hospital, did you find a member of staff to talk to? | 94 | |
| Were you given enough privacy when discussing your condition or treatment? | 98 | |
| During your stay were you treated with compassion by hospital staff? | 99 | |
| Did you always have access to the call bell when you needed it? | 97 | |
| Did you get the care you felt you required when you needed it most? | 97 | |
| How likely are you to recommend our ward/unit to friends and family if they needed similar care or treatment? | 98 | |

We also asked 251 patients the following questions about their care in the community setting:

| | |
|---|---|
| Were the staff repectful of your home and belongings? | 98 |
| Did the health professional you saw listen fully to what you had to say? | 98 |
| Did you agree your plan of care together? | 96 |
| Were you/your carer or family member involved decisions about your care and treatment as much as you wanted them to be? | 96 |
| Did you feel supported during the visit? | 99 |
| Do you feel staff treated you with kindness and empathy? | 99 |
| How likely are you to recommend this service to friends and family if they needed similar care or treatment? | 100 |

## A patient's story

At East Lancashire Hospitals Trust it is important for us to hear stories not only from a patients pespective but also from the patient's carer and/or relatives. The following story is from a husband and wife , with the sections in italics being the patient's wife.

I am 65 years of age and run my own business employing 6 people. In March 2016 I was admitted to hospital with a severe chest infection. I was discharged home on 9 May 2016.

I am usually in good health but on the Wednesday afternoon at around 3.30pm, I didn't feel too good, I felt a bit uncomfortable, so decided to go home early. I came home and don't remember much from then on but we went to the hospital.

*My husband woke me up at about 4.00 am and asked me to take him to hospital as he was experiencing excruciating stomach pains. We went up to the hospital on the Thursday morning and were seen, a number of tests were carried, but they couldn't find anything particularly. However, they were looking at his abdomen, not at his chest. They said it was possibly some sort of virus, and from his urine he looked dehydrated.*

*On the Saturday morning, 26th March 2016 we were due to go to a wedding but my husband didn't feel like he should go. I left him at about 11.30 am with some Paracetamol, a bottle of Benylin and some toast. At about 6.45 pm I noticed I had some missed phone calls so told my son to ring his dad and see what he wanted.*

I don't remember ringing for an ambulance but I do remember being on the phone and being asked if I had my ventolin. I told them I didn't have one and that I was not on any medicines. I also remember seeing the blue light coming up the drive, but I don't remember the people coming out of the ambulance, or getting in the ambulance. Apparently I was conscious until late Saturday night.

*I arrived at the Hospital to see my husband at about 9.30pm on the Saturday evening. He was still talking and had obviously been given major pain relief so he was quite comfortable at this stage. At about 11.30pm the staff came and said they had a bed for him in the Critical Care Unit.*

I was sedated and on a ventilator for 3 weeks and it took me the best part of a week to waken up once they had taken me off sedation.

When I started to come round I had no idea where I was. I wasn't frightened, I wasn't panicking, I was just so uncomfortable, I was so ill and just shook all the time and was sick virtually all the time for days. I couldn't eat properly. About as bad as anything you can imagine because there was no peace at any time. There was never any relief for days and days. It was awful. But you just do your best to look for some peace and get through it.

Slowly but surely I began to realise I was in hospital and started recognising some of the staff. I didn't seem to question why I was in hospital. I think I was so poorly that all my concentration was on trying to find some peace. Quite soon after that they put me on to a ward.

I have no complaints about Critical Care. As far as I am concerned and from what people have told me, they were wonderful. The proof of the pudding is in the eating. I didn't die. I came out of it, so they obviously did the right thing.

*If my husband had died it wouldn't have been their fault. I had never seen nursing like it. It was terrific. From the cleaning staff to the canteen staff it was just wonderful. We have a really good friend who is a surgeon in America and I contacted him when my husband was ill. I sent him photographs of all the machinery and he said that my husband was getting first class care, absolutely top of tree critical care treatment. He was also in consultation with me the whole time advising me on what I should be asking the staff. The consultants had all the time in the world, and didn't take umbrage when I asked questions. They were absolutely wonderful.*

When I went into Ward C2 I was properly conscious for the first time and becoming very aware of my surroundings and it was a bit of a shock to the system because there were about 10 other people in the ward and you get a pretty cross section of society. It is not a nice place to be especially when you are so ill.

I don't know hospitals and what all the different coloured uniforms mean. If somebody had come over to me and explained that they knew I had come from Critical Care and understood what I had been through and how I felt, and also explained what drugs they were going to be giving me and when, it would have been really nice. I do understand that they are very busy people, and they have a lot to do and they work hard but I am sure they would have 2 minutes occasionally to speak to people and just explain to them that they understand their situation.

If I was to criticise any group of nurses, it would be the night nurses. Generally speaking not a lot is going on during the night and the nurses have a lot more time. It was very noisy at night and you could hear the staff talking about things such as their holidays, in the early hours of the morning. Eventually I asked them if they would be quiet because it is bad enough trying to sleep. It would have been nice if they could have come over occasionally and asked me if I was alright and if there was anything they could get me. It would have been nice to have a bit of pampering, you might say. There were a couple of patients who tried to get out of bed constantly so a nurse had to sit at the bottom of the bed all the time, doing nothing for hours and hours. It must be a terribly boring job. They were all nice people I had no personal complaints but if they are not careful they end up just focusing on doing a job and forgetting that the patients are ill and need mental support as well as tablets.

I then went on to Ward C6 the chest ward. That seemed a bit better. The nurse in charge during the day was fantastic, she worked so hard and she made everyone else work hard.

Again, the night nurses seemed to be more concerned about just running the machine of making sure nobody was falling out of bed, and if someone needed the loo they would sort that out. Nobody came over to me and asked how I was doing and if there was anything they could do. I was 64 years of age and not a child but I still needed help. When you are ill you turn back into a child because you need somebody to come and help you.

*My husband couldn't feed himself so I had been going in to hospital to assist with feeding. He felt so ill that he didn't want food and I am of the opinion that if you don't eat you die so I was at the hospital at 9.00am and didn't leave until 9.00pm. When he was transferred to Ward C6 I asked the nurse in charge if it would be alright to go into the ward in the morning to feed him. She said she did not know and said that when someone is in Critical Care they are in a bubble and then expect that sort of treatment on every other ward. He had been unconscious for 3 weeks when he was in Critical Care and didn't know what sort or if any treatment he was getting. On Ward C2 he was so poorly he didn't care. So he hadn't been in a bubble in Intensive Care where he was receiving and knew he was receiving extra special care. He was just really poorly.*

My main concern is it would have been very beneficial to me if people had come over and talked to me and explained that they understood my situation and were there to help me. They are busy people I know and there are times, such as in a morning when it is incredibly intense and very busy for the staff, but there are lulls during the day, especially at night when staff do have a few minutes to go over to each patient. But our overall feeling is that we were delighted at how it all was.

Some of those young women were doing the most demeaning jobs and doing it wonderfully, with real compassion.

I thought when I first went on to a ward that some of the nurses were quite hard but after a week or so, I realised what they have to put up with. It is a tough job. But it mustn't beat the compassion out of them. As one patient leaves another is admitted, so it must be difficult for staff to keep connecting to the new people coming in, because they might only be there for two days but they have to do it.

On Ward C6 there was a nurse who I think was from the Philippines or somewhere like that, and she always smiled and was always lovely to me and always came over to talk to me. There were one or two people who were particularly lovely – the nurse who runs Ward C6 was really good. The nurses were very compassionate and non-judgemental. Nobody seemed to judge.

On one occasion during the night the staff had to call the doctor to the patient in the bed opposite who was dying. He was given a chest x-ray and the doctor came. The patient was very upset but the doctor didn't say anything to make him feel better, it was just factual and lacked compassion. But that was the only occasion.

One of the most important things is picking the right staff. Obviously you want the most skilled people you can find but also one of the most important things, I think is having someone you get along with.

Between us we have had 4 parents who have all died and the communication now from the staff, in comparison with when my dad died, probably 8 years ago, is unbelievable. From the consultants, the doctors, the communication is terrific.

Obviously a lot of what happened I didn't know about and all my friends and family have told me. In fact, whilst I was unconscious my wife sent me emails to tell me so I can read them now. I think it affected my wife and son much more than me because whilst I was really ill and didn't know anything about it, they did.

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*When my husband was on Ward C6 there was an elderly gentleman who had some form of dementia. He was a bit disruptive in the ward, and wanted the nurses all the time. He was moved from the main ward into another ward, with two other patients who were also disruptive as the staff wanted them together. The staff had to sit with them 24 hours a day making sure they weren't getting out of bed. One Saturday afternoon these nurses came through the ward with this gentleman to let him look out of the window and see the view. And they were singing with him. What a lovely thing. They asked him what songs he knew and stood at the window looking out over Darwen and sang and it was fantastic.*

It is an experience really that you don't want to go through but from a positive point of view it gives you another view of life. All the little things that you get annoyed about, such as somebody marking your car opening a door in a car park, are put into perspective when you realise that there are all these people in a bad situation in hospital. Our overall opinion of Royal Blackburn Hospital is that it is fantastic.

I have since been back to see the consultant. He is quite a quiet man, and a good listener. If you ask him questions he will give you a full and comprehensive answer and I trust him implicitly.

We have also been back to Urgent Care a couple of times and it has been great.

Friends came up from London to visit me when I was in Critical Care, although I don't remember as I was unconscious. They were absolutely blown away with the treatment and said that you wouldn't get treatment like that in London as the hospitals are so huge and chaotic that there is absolutely no peace in there.

I am a great believer that everything is luck in life. I was unlucky to get ill but I was lucky to be near Blackburn Hospital.

Whilst on the ward I saw someone from the Critical Care Outreach Team who was quite wonderful. He came over and asked me how I was and that he knew what I had been through. He was most understanding. He saw me once or twice and he always asked me how I was feeling.

The quality of the cleaning was also fantastic. In particular, the cleaner in Critical Care who was so thorough in his job. The Unit is lucky to have him as he is so dedicated.

If we think hard I am sure we can think of a lot of people who were particularly good and probably a few that I wasn't too keen on but I am not here to praise one particular person but to give overall feedback on what you are getting right, and what can be improved on.

Assistant Director of Nursing – ICG has discussed the support of patients being transferred to medical wards from Critical Care at the Acute Matron's meeting and it has been discussed at the ward sister's meeting also.

Strategies which can be employed to improve matters were discussed including information for patients / families but also to develop further understanding by staff of the affects of "relocation anxiety" on patients (a known phenomenon post critical care). Going forward, this is a work stream that has been picked up with Critical Care.

Apologies afforded that the patient did not feel empathy from the staff at what was a very frightening time .

With regard to the issue of noise during the night, Matrons have raised this with their teams.

## Improvement story: we are listening to our patients and making changes

Royal Blackburn Hospital has teamed up with Blackburn Foodbank to trial a new referral system that will benefit patients who need extra help when they are discharged.

ELHT has now become a referral agency for the local foodbank, and the chaplaincy department at Royal Blackburn Hospital has started a pilot scheme where vouchers can be given out to 'clients' when needed.

A member of staff at the Trust who feels a patient is in urgent need of food or some other form of advice or support would contact one of our chaplains, who will visit the patient and issue the voucher. This will help the foodbank identify the cause of the crisis, as well as offer practical guidance and prepare suitable emergency food.

Blackburn Foodbank not only help with providing emergency meals, but they also offer cooking lessons, a cheap clothes bank, support in tackling debt and financial difficulties, social clubs and other holistic care for members of the community.