NHS England

Open and Honest Care in your Local Hospital

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 Hospital NHS Trust

May 2015

Open and Honest Care at East Lancashire Hospital NHS Trust : May 2015

This report is based on information from May 2015. The information is presented in three key categories: safety, experience and improvement. This report will also signpost you towards additional information about East Lancashire Hospital 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.

98.8% **of patients did not experience any of the four harms whilst an in patient in our hospital**

99.2% **of patients did not experience any of the four harms whilst we were providing their csare in the community setting**

Overall 99.0% **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	1	0
Trust Improvement target (year to date)	4	0
Actual to date	3	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/unavoidable 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 2 in the community.

Severity	Number of Pressure Ulcers in our Acute Hospital setting	Number of pressure ulcers in our Community Community setting
Category 2	1	2
Category 3	2	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 0 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:	0.04	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 10 fall(s) that caused at least 'moderate' harm.

Severity	Number of falls
Moderate	8
Severe	2
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:	0.33

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.

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 *	98.0%	This is based on 1670 patients asked
A&E FFT % recommended*	79.0%	This is based on 1326 patients asked

* Currently the Friends and Family Test is in development for community services, but we use similar questions to help us understand our patients' experience.

We also asked 665 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?	93	
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?	97	
During your stay were you treated with compassion by hospital staff?	97	
Did you always have access to the call bell when you needed it?	98	
Did you get the care you felt you required when you needed it most?	98	
How likely are you to recommend our ward/unit to friends and family if they needed similar care or treatment?	93	

We also asked 194 patients the following questions about their care in the community setting:

	Score
Were the staff repectful of your home and belongings?	98
Did the health professional you saw listen fully to what you had to say?	99
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?	95
Did you feel supported during the visit?	96
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

I am a 71 year old retired married man. I have Situs Inversus but am in good health. On 20 October 2014 I was involved in a Road Traffic Accident. The ambulance crew really cared that I was being dealt with in the correct way that I needed. They waited until my wife came back with her own car and parked it and accompanied us to the hospital. All the way to the hospital the procedure was being carried out. The ambulance crew found it fascinating that I am the wrong way round, as I have Situs Inversus which does help when you have had an accident, as they have to work with you. You inform them where to stick the electrodes for the ECG because if they did not put them the right way round then they don't give a reading.

When we arrived at Royal Blackburn Hospital the trolley was parked on a corridor, it had to be. Every booth was being used. The Emergency Department was very busy. This was evident by the activities going on around us. However, there was nobody standing there thinking what to do, they were all action and all doing what they had to do. My wife asked the Paramedics if they were leaving us now but they said they would stay with us until they handed over to the nursing staff, and gave reassurances that we would never be left on our own.

After 20 minutes we were taken into a booth and the nursing staff came, the consultant came, and the ambulance people disappeared. That was it, they had done their job. Again, everything that could be done and was needed, was done. The consultant was extremely interested of course because I am the wrong way round, and I informed him that he could use anything he found for his own purposes, and I even volunteered to be used in an exam, if needed. I was taken to X-Ray and in the state I was in, I was in pain and not knowing what was happening, I went in and the x-ray was carried out and I forgot to mention my condition to the radiographer, so when she came out she was rather surprised.

When I came out of X-Ray that was the only time when I was left on the trolley on my own. That in a sense could have been worrying, about what was going to happen next. What was happening was that the porters brought the next person to X-Ray and were taking me back to where I was being examined. That was the only time I was left alone and that is perhaps something that could be mentioned to the patient by the Radiographer or somebody else – that you will be left outside X-Ray and collected.

I went to Booth 13, and the nurse practitioner arrived together with a trainee and I quite accepted that the trainee could look. They explained quite straightforwardly to me what was wrong, my sternum was broken and it had to be mended. All the time the conversations that were going on went beyond the professional. It was friendly. They knew I would joke with them and they would joke with my wife and me. There was no problem. The treatment was just exactly what I needed, to be calmed down. Obviously you have had an accident, your car has gone, you don't know what has happened to it, you don't know what is going to happen to you next and you are very, very upset. But every person we dealt with was there to keep us calm, and decide what to do next. With a broken sternum there is nothing to do next, apart from keep calm, go home, read this information, and be careful what you do. Don't do anything stressful.

The treatment was over, and there was no need to go back. We asked where to go and if there were taxis to get us home. The nurse made a telephone call and asked if a taxi could be organised, as we are both in our 70s, and had had an accident, and this was agreed. We went and waited in the walking wounded side. The taxi came and took us back to find my wife's car and we went home. The accident happened at about 8.30 in the morning and we were home by 11.45am. Nothing more could have been done. The delay for the ambulance coming was the fact they had had three accidents, but so what. Everything was done, we were dealt with in a friendly and professional manner and sent home and that is all you could ask.

Everything is perfect now, I have no pain, no nothing. I will tell anyone what has happened to me. People who have good experiences don't say it and if things go wrong then it is all blown out of all proportion.

Comments from this patient story have been shared with the Radiology staff at their Share to Care meeting, and staff reminded of how important it is to explain to the patient what is expected to happen next on their journey through the department, including explaining to patients on trolleys or on chairs that they will be taken back to the Emergency Department as soon as the porter is available.

Staff experience

Between January and March 2015, we asked 2032 staff the following questions:

	% recommended
I would recommend this ward/unit as a place to work	68
I would recommend the standard of care on this ward/unit to a friend or relative if they needed treatment	75

3. IMPROVEMENT

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

Our district nursing teams work with numerous residential care homes in the local East Lancashire Hospitals Trust area supporting elderly individuals with care from monthly visits to daily ones where clinically required. Pressure ulcers cause immense pain, discomfort, hugely affect quality of life and can also shorten an individual's life if left untreated/ identified.

Through a recent yearly collaborative 2014/15 the district nursing teams have worked with four selected residential homes identified as having a higher prevalence and requiring support in this area to:
Raise awareness and improve understanding
Create a standard roll-out package to replicate with other care homes
Link in with social services safeguarding team to raise awareness of the work the DN's were carrying out
Help residential homes

The teams developed:
Pressure ulcer prevention booklets for residential staff
Named nurse for each residential home around Pressure Ulcers
Temporary dressing pack procedure to cover soiled or displaced dressing until DN can attend
Red triangle system to promote position changes within the care home, innovative approaches to engaging care home staff, evaluating understanding and developing knowledge and skills with healthcare staff around pressure ulcer identification, prevention, management and treatment.

The results:
Care home staff more confident and greater understanding of prevention and management of pressure ulcers
Better communication with care home staff through regular meetings
Positive support by residential care home managers
Only one grade 2 pressure ulcer in one of the pilot care homes