

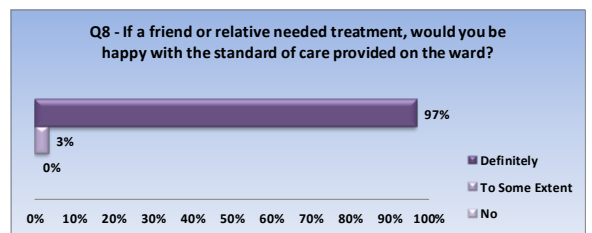
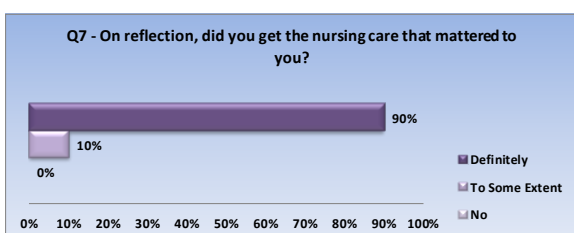
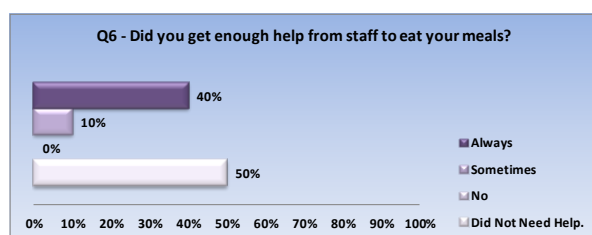
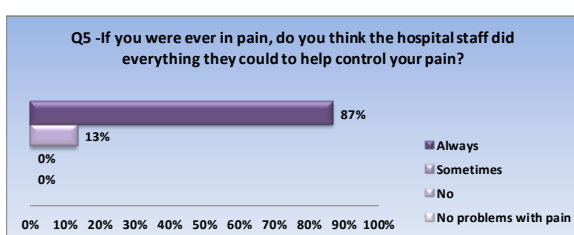
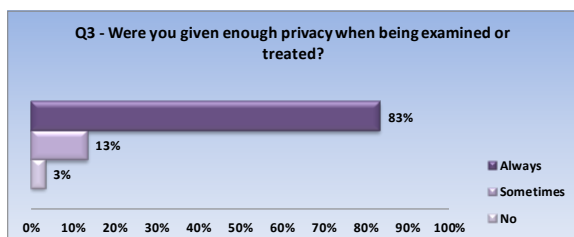
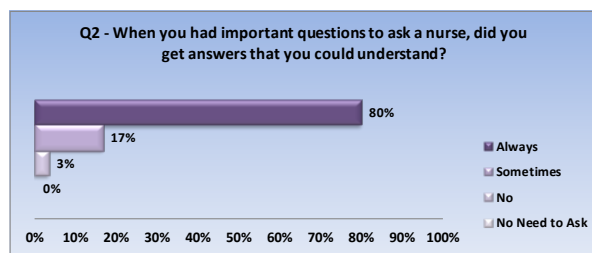
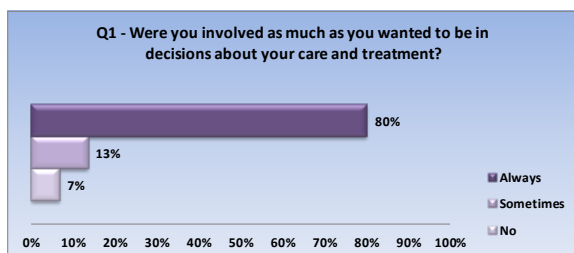
We are one of a number of NHS organisations who want to be open and transparent with our patients. This is how a modern NHS hospital should be – open and accountable to the public and patients and driving improvements in care. As a member of the ‘Transparency Project’ we continue to work with patients and staff to further reduce the harm that patients sometimes experience when they are in our care. We have made a commitment to publish a set of patient outcomes; patient experience and staff experience measures. Each month we collaborate with other care providers to share what we have learned and to use this information to identify where changes to improve care can be made.

In February we cared for 10,027 patients	1 patients suffered a fall resulting in harm in our care	Pressure Ulcers were acquired by 4 patients (2 of these are device related) whilst in our care.
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In the areas where harms occurred this is what patients said:

Salford Royal prides itself in being an open and transparent organisation. It has established processes in place to offer full and frank explanations to patients when harmful events occur. When an identified serious harm occurs a full investigation is carried out and patients and or their families are involved in the completion of this report. It can be seen from this set of results patients on the ward where the harm has occurred rank their care extremely positively with 100% of sampled patients positively rating the ward to their family or friend. Ward staff are using this data to reflect on the care they are providing and develop action plans to ensure patient experience is further enhanced.

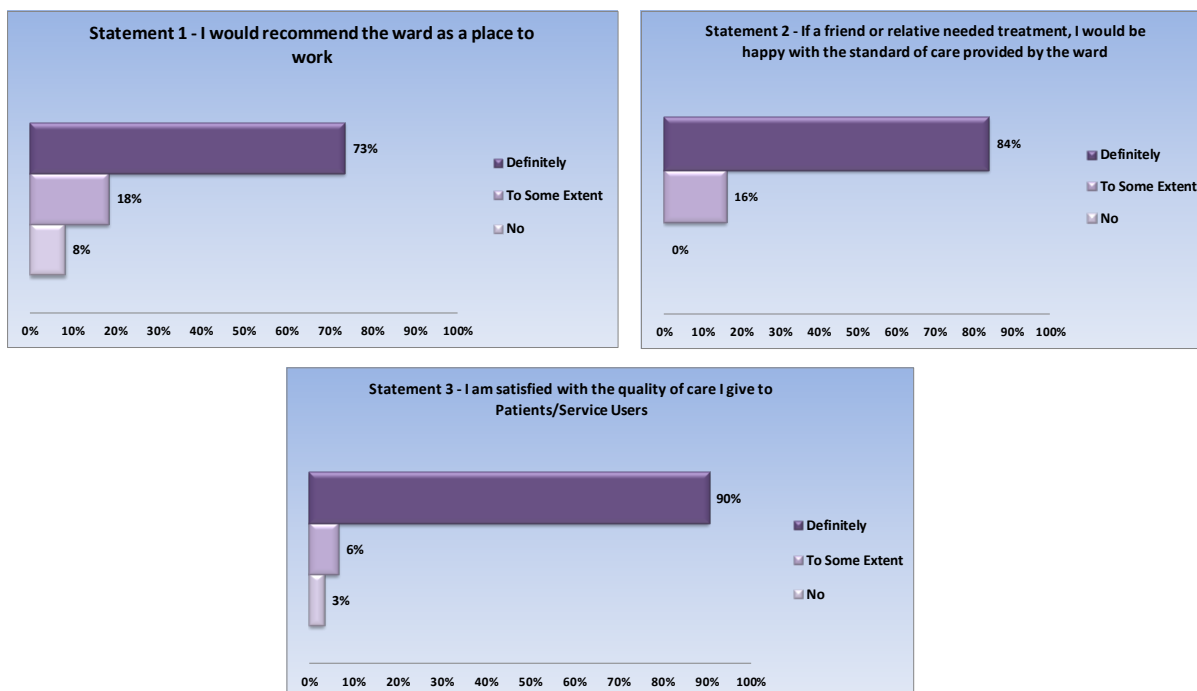
As part of the Trusts commitment to continually improve the care it delivers to patients staff on wards are testing in partnership with patient’s new ways to in which it can improve joint decision making around care and treatment.



In the areas where the harms occurred this is what the Nurses said about the care they have provided:

When patient harm occurs Nursing staff reflect and make plans to improve delivery of care so to reduce the likelihood of reoccurrence. This data in part reflects the personal accountability that nurses feel when a harmful event is observed. It should be noted that in the recent National Staff survey Salford Royal received the highest ratings of staff satisfaction on any NHS Acute Trust. The Trust continues to strive to ensure the staff we employ are cared for and included in the decision making processes within the Trust. We have established that the most frequent reason for patients developing pressure ulcers is through the use of medical device equipment (e.g. Oxygen devices, feeding tubes).

Nursing staff have established a regular meeting which shares information and tests new ways of managing these devices to ensure they don't cause pressure ulcers. This is a particularly challenging area to work in as we are but we are determined as Salford Royal Nurse to eradicate this particular type of harm.



What did we learn about the care we have provided to patients?

The Nursing teams at Salford have been undertaking tests of change in order to eliminate common pressure sores (Sacrum, Heels etc.) and we have seen significant improvement in this category. The teams are now testing and sharing learning around device related pressure sores and expect to see significant improvements within this category.

Following each identified fall and pressure ulcer an in-depth analysis is carried out; the purpose of this process is to establish why the harm has occurred and then to implement measures to ensure prevention.

You said-We did!

Salford Royal has a wide range of improvement projects which have been designed to reduce mortality and harm. Nursing staff, supported by the Board of Directors, are committed to play a prominent role in the Trust becoming the safest organisation in the NHS. Significant improvement in harm relating to Hospital acquired pressure ulcers and falls have already been realised. The Nursing team at the Trust are determined to see these harms continue to reduce and therefore patients will continue to report high levels of satisfaction relating to the care they receive.

A recent initiative which we have recently implemented is a process where nursing staff deliberately visit all patients hourly to ensure they are both safe and receiving a positive experience. We are delighted with the feedback we have received from both patients and staff in response to this

initiative. Current compliance to this metric is measured at >95% which demonstrates the system is highly reliable.

As part of the Trusts ambition to continuously improve the care and services it provides a new patient experience strategy has been developed. Patient led focus groups have been held and agreed recommendations have been included in the strategy. The first event has taken place in January 2013 and we will provide periodic updates as part of this transparency report.