Salford Royal NHS
NHS Foundation Trust

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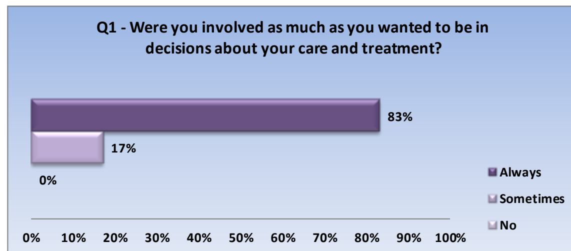
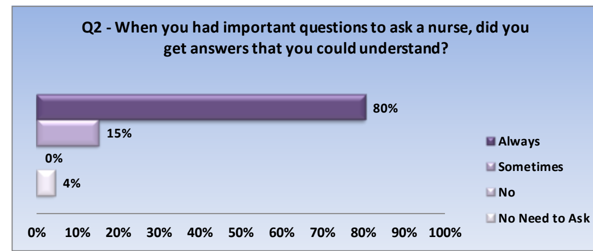
We are one of a number of NHS organisations who want to be open and transparent with our patients. This is how a modern NHS hospital should be – open and accountable to the public and patients and driving improvements in care. As a member of the 'Transparency Project' we continue to work with patients 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.

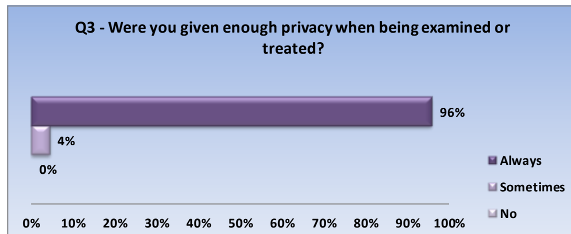
In June we cared for 10,385 Patients	3 patients suffered a fall resulting in harm in our care	Pressure Ulcers were acquired by 4 patients (2 of these are device related) whilst in our care.

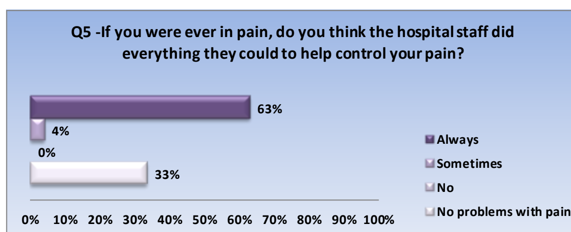
In the areas where harms occurred this is what patients said:

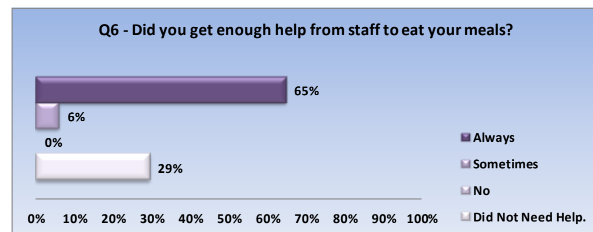
Salford Royal prides itself in being an open and transparent organisation. It has established processes in place to offer full and frank explanations to patients when harmful events occur. When an identified serious harm occurs a full investigation is carried out and patients and or their families are 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.
As a new test of change the ward teams who are responsible for pressure ulcer acquisition are required to present the reasons as to why this occurred and their solutions for prevention in the future.

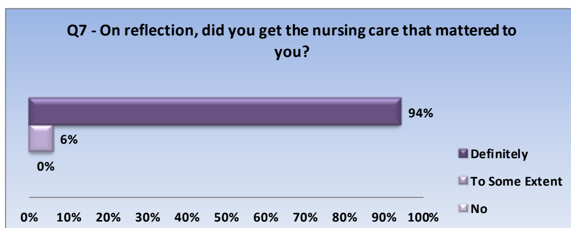


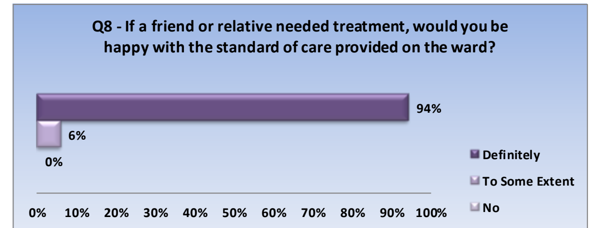








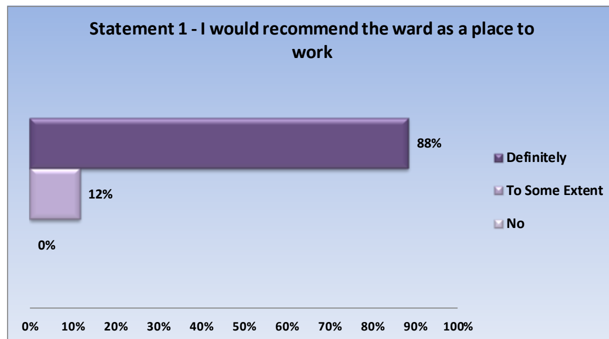


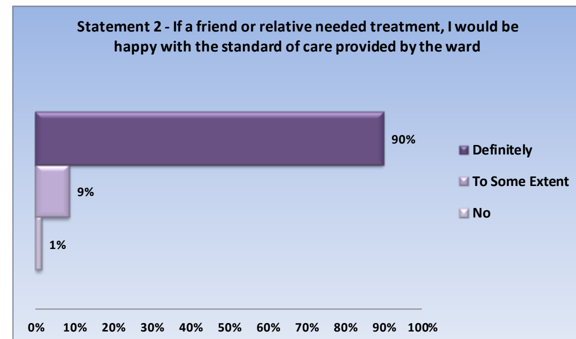


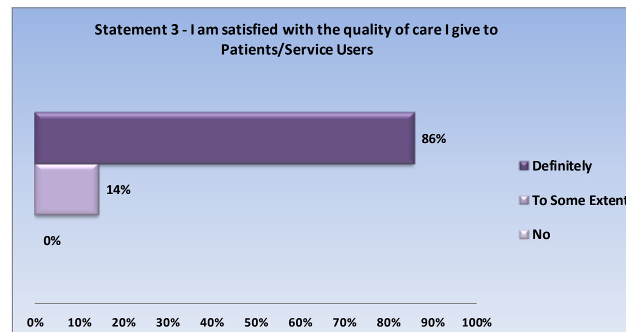
In the areas where the harms occurred this is what the Nurses said about the care they have provided:

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 second learning session has taken place in June 2013 and teams are continuing to test ways in which to work in partnership with patients and their families to improve experience.

- What matters most to me
    - Laminated A4 sheet of a paper where staff record on admission what matters most to the patient whilst being inpatient in their area. This is then displayed behind the patient's bed.
- Pen and pad at the patient bedside
    - Patients to be provided with pen and pads during their hospital stay. This provides opportunity for patients and relatives to record any questions they may have for staff they may have forgotten to ask during ward round. This can also be used as patients' diary during their stay.
- Staff uniform key
    - Most collaborative areas are now displaying staff uniform key in visible area on the ward. Each role has a colour picture of their uniform. This is to improve communication with patients and relatives as they can now see the different roles and approach the right staff for questions.
- Teach back
    - some areas have been testing teach back in relation to medication. This is to improve knowledge regarding medications in language applicable to them and help prevent medication errors. The main focus of teachback in this collaborative is around medication on discharge but teachback can be utilised for other areas.

- Patient journey video
    - To improve patient information prior to surgery, theatres teams are in process of testing the filming of a patient's journey from ward pick up to arrival to theatres. A rolling PowerPoint illustrating this journey will be displayed in pre-op
- Local Information sheet for visitors
    - To improve relatives and patients experience ICU team have developed information sheet with useful information provided (i.e. nearest hotel, supermarket, petrol station etc.) this is currently in the preparation stage and will be tested in the near future.
- Medication information
    - The development of posters and leaflets regarding drug information
- Volunteer ward rounds
    - To improve patient experience through volunteers interacting with patients and spending time with relatives on wards
- Open visiting hours
    - To improve the patient experience by having longer visiting hours. This has been taken up by a number of ward areas and they have reported that patients, relatives and carers have all preferred it. Anecdotally it is also positive for staff too as they do not have the rush of all visitors arriving and so having to deal with questions all at once, or all visitors leaving at once and so have to deal with patient requests all at once