

## 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:

**Salford Royal NHS Foundation  
Trust**

January 2014

# Open and Honest Care at Salford Royal NHS Foundation Trust : January 2013

This report is based on information from December 2013. The information is presented in three key categories: safety, experience and improvement. This report will also signpost you towards additional information about the trust's performance.

## 1. SAFETY

### Safety thermometer

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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 new harms.

**98.0%** 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)

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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.

	C.difficile	MRSA
<b>This month</b>	1	0
<b>Improvement target (year to date)</b>	29	0
<b>Actual to date</b>	16	0

For more information please visit:

<http://www.srft.nhs.uk/for-patients/infection-prevention/>

## Pressure ulcers

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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 grades, with one being the least severe and four being the most severe.

This month 0 Grade 2 - Grade 4 pressure ulcers were acquired during hospital stays.

Severity	Number of pressure ulcers
Grade 2	9
Grade 3	0
Grade 4	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 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 1000 bed days: 0.377
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## Falls

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This measure includes all falls in the hospital that resulted in injury, categorised as moderate, severe or death, regardless of cause.

This month we reported 0 fall(s) that caused at least 'moderate' harm.

Severity	Number of falls
Moderate	0
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: 0.00
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## 2. EXPERIENCE

To measure patient and staff experience we use a Net Promoter Score.

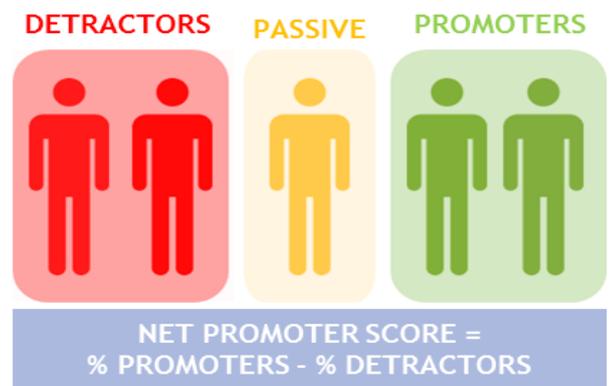
The idea is simple: if you like using a certain product or doing business with a particular company you like to share this experience with others.

From the answers given 3 groups of people can be distinguished:

Detractors - people who would probably not recommend you based on their experience, or couldn't say .

Passive - people who may recommend you but not strongly.

Promoters - people who have had an experience which they would definitely recommend to others.



This gives a score of between -100 and +100, with +100 being the best possible result.

### Patient experience

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#### The Friends and Family Test

The Friends and Family Test requires all patients, after discharge, to be asked: *How likely are you to recommend our ward to friends and family if they needed similar care or treatment?*

The hospital had a score of **70** for the Friends and Family test\*. This is based on 822 responses.

\*This result may have changed since publication, for the latest score please visit:

<http://www.england.nhs.uk/statistics/statistical-work-areas/friends-and-family-test/friends-and-family-test-data/>

We also asked 955 patients the following questions about their care:	% recommend
When you have important questions to ask a doctor, do you get answers that you understand?	70
Do you have confidence and trust in the doctors treating you?	80
When you have important questions to ask a nurse, do you get answers that you could understand?	74
Do you have confidence and trust in nurses treating you?	83
Are you involved as much as you want to be in decisions about your care and treatment?	65
Overall, how would you rate the care received on this ward?	68

## A patient's story

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This month's patient story has focused the Organisations attention on the care received by an emergency patient who required an orthopaedic assessment. The patient has previously accessed the Trusts surgical services on a number of occasions and had received excellent care. The story acknowledged positive experiences of care, for example staff going out of their way to find a wheelchair, porter's showing the patients family a short cut to the plaza area of the hospital to find shops and the café.

However there were a number of issues which fell below an acceptable standard.

In particular issues were identified as

- The waiting time for a decision to be made as to wherever the patient required an operation resulted in an absence of food and drink for a significant time period;
- Attention to individual patient experience, for example staffing promising to find out certain information and then the patient waiting for an unacceptably long period of time for further information to be shared.

## Staff experience

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We asked staff the following questions:

	Net Promoter Score
I would recommend this ward/unit as a place to work	96%
I would recommend the standard of care on this ward/unit to a friend or relative if they needed treatment	94%
I am satisfied with the quality of care I give to the patients, carers and their families	96%

# 3. IMPROVEMENT

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

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In line with Salford Royals aim to be the safest hospital in the NHS in 2013 the Trust identified the wards with highest incidences of falls and began developing improvements to bring about a reduction in the falls on those wards.

In the care of the elderly wards we have seen good results testing the "bay tagging" where the nursing staff tag someone else on to the bay if they need to leave ensuring there is someone present in the bay at all times as far as possible.

The wards have also re-tested the non-slip socks and both wards have recently changed to open visiting hours. A combination of these changes has seen both of the wards go for 20-30 days plus without any falls on the ward, with L8 not recording any falls at all in May.

The emergency department have been trialling a pressure pad on a bed and chair for particularly high risk patients in side rooms which will alarm if the patient alights the bed or chair, the trial has proved positive and they are looking at a possible purchase. There has also been testing of an "Ask me 3" version of teach back with the patients to help make the patients understand the risks and how they can help to prevent themselves from falling whilst on the ward.

A range of wards have been looking at improvements to the communication of patients transfer status with the physio's recording on a patients headboard this has meant that any staff members not receiving a handover who may be on the ward are able to identify at a glance how the patient should be transferred.

We have carried out a range of tests to reduce our falls in bathrooms with the design of posters, commode tagging and communicating with patients to highlight the importance of safety in the bathrooms.

## Supporting information

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### **Pressure ulcers**

Salford Royal is very disappointed to report that 9 patients acquired a pressure sore during their admission to Salford Royal in January. Three of these have been attributed to the use of medical device equipment. The wards and departments are as follows; ICU, Surgical High Dependency x 2, Neuro High Dependency x 2, theatres (Level 3) , Ward's B8, L2, L5.

Senior Nurses from each of these areas have been requested to attend a meeting to present the reasons as to why these patients have developed a pressure sore and to describe how learning will be applied to prevent reoccurrence.

### **Further information**

Board Papers:

<http://www.srft.nhs.uk/about-us/board-meetings/>

Council of Governors' (CoG) Papers:

<http://www.srft.nhs.uk/for-members/council-of-governors/governors-meetings/>

Membership Engagement Events:

<http://www.srft.nhs.uk/for-members/membership-news-events/upcoming-events/>

Our Values:

<http://www.srft.nhs.uk/about-us/values/>

Videos, Films:

<http://www.srft.nhs.uk/media-centre/films/>

Friends and Family Test Overview:

<http://www.srft.nhs.uk/for-patients/fft/>

Friends and Family Test Reporting:

<http://www.srft.nhs.uk/media-centre/publications/fft/>