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

September 2016

Open and Honest Care at Salford Royal NHS Foundation Trust : September 2016

This report is based on information from September 2016. The information is presented in three key categories: safety, experience and improvement. This report will also signpost you towards additional information about Salford Royal NHS Foundation 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.

97.10% **of patients did not experience any of the four harms whilst an in patient in our hospital**

96.76% **of patients did not experience any of the four harms whilst we were providing their care in the community setting**

96.98% **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)	21	0
Actual to date	9	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 Category 2 - Category 4 validated pressure ulcers were acquired during Acute hospital stay and in the community.

Severity	Number of Pressure Ulcers in our Acute Hospital setting	Number of pressure ulcers in our Salford Community setting
Category 2	10	6
Category 3	1	0
Category 4	0	2

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:	0.52	Hospital Setting

The pressure ulcer numbers include all pressure ulcers that occured from 48 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:	0.32	Salford

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 4 fall(s) that caused at least 'moderate' harm.

Severity	Number of falls
Moderate	3
Severe	1
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:	0.19

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 care, 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), have recieved community services or visited the outpatient department. Scores are below;*

In-patient FFT % recommended *	89%	This is based on 2199 patients asked
A&E FFT % recommended*	88%	This is based on 3621 patients asked
Community FFT % Recommended	92%	This is based on 29274 patients asked
Outpatients FFT % Recommended	93%	This is based on 19785 patients asked
Daycase FFT % Recommended	95%	This is based on 359 patients asked

We also asked 25 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?	88	
If you were concerned or anxious about anything while you were in hospital, did you find a member of staff to talk to?	96	
Were you given enough privacy when discussing your condition or treatment?	100	
During your stay were you treated with compassion by hospital staff?	68	
Did you always have access to the call bell when you needed it?	96	
Did you get the care you felt you required when you needed it most?	96	
How likely are you to recommend our ward/unit to friends and family if they needed similar care or treatment?	88	

We also asked 785 patients the following questions about their care in the community setting:

Were the staff repectful of your home and belongings?	100
Did the health professional you saw listen fully to what you had to say?	100
Did you agree your plan of care together?	100
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?	100
Do you feel staff treated you with kindness and empathy?	100
How likely are you to recommend this service to friends and family if they needed similar care or treatment?	95

A patient's story

My story starts at the end of November, beginning of December 2014 when I noticed a small scab on the bridge of my nose that was resistant to healing. I attended my brother in laws funeral in Ireland in February 2015 and at this a nephew's wife, who is a dermatology specialist nurse in the US, commented that it was something that I needed to go and get sorted out.

I returned from the funeral and made an appointment with my GP. I was seen in the second week of February 2015 and by the time of my appointment I had done some googling and reading and suspected that I had basal cell carcinoma. I mentioned this to my GP and he agreed that it looked like it could be and so would refer me to a dermatologist.

The following day I received a call from the GP surgery informing me that my choose and book referral was there ready to collect. I went to collect it and called the call centre number provided. I was offered an appointment on the 1st June 2015 but as I wanted to attend Salford Royal the first appointment was the 15th June 2015.

When I had seen the GP he informed that my referral wouldn't be under the 2 week wait as it was not considered a serious cancer but that my appointment would be in 4-6 weeks. Therefore I was surprised when the initial appointment had me waiting for 4 months.

My son works at Salford Royal and so I asked whether there was anything he could do to expedite the appointment and fortunately my appointment was moved to fill a slot that was available in mid-March 2015.

At this initial appointment the dermatologist thought it was basal cell carcinoma but said that he needed a biopsy to confirm this. I waited a further 3 weeks for my biopsy in April 2015.

One month after the biopsy I received a letter from the dermatologist informing me that the biopsy had confirmed that I had infiltrative basal cell carcinoma and I was given a subsequent appointment for the 1st June 2015. I attended on this date and was informed that I needed MOHS surgery and I was informed that I should have to wait no more than 4 weeks. I actually got my appointment confirmed the following week and so had to come in for my MOHS surgery under local anaesthetic on the 10th June 2015.

I had my appointment at 9:30am and actually ended up having three distinct treatments to remove the tumour meaning that I was in the hospital all day. The dermatologist informed that the tumour had burrowed quite deep and this was why it took 3 attempts to remove it all. I was thankful that it had been removed but was informed that I would be left with a scar; I had a huge dressing and also had a black eye.

Staff experience

We asked 20 staff in the hospital the following questions:

	% recommended
I would recommend this ward/unit as a place to work	90
I would recommend the standard of care on this ward/unit to a friend or relative if they needed treatment	90
I am satisfied with the quality of care I give to the patients, carers and their families	100

We asked 5 staff working in the community setting the following questions:

	% recommended
I would recommend this service as a place to work	60
I would recommend the standard of care in this service to a friend or relative if they needed treatment	100
I am satisfied with the quality of care I give to the patients, carers and their families	100

3. IMPROVEMENT

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

On L2 we ensure we are aware of which patients have a degree of acute kidney injury (AKI) by checking their clinical notes and significant issues
If they are AKI we ensure it is identified in the ward safety huddle , identifying what stage their AKI is at so we can help further prevention and recovery as needed so all staff are aware and ensure they are vigilant.

We ensure patients themselves are aware and that they have a magnetic AKI sign above bed board
We keep strict input and output monitoring on these patients on their intentional rounding chart ensuring they are drinking enough and if not alerting medics so other means of hydrations can be given usually Intravenously.
Medics ensure bloods are take and reviewed daily
And medications are altered as required with the medics liaising with pharmacy as needed
We ensure staff are completing the AKI electroninc learning package.

Supporting information

Sadly the acute hospital had 10 Grade 2 pressure ulcers (partial-thickness skin loss involving epidermis, dermis, or both. The ulcer is superficial and presents clinically as an abrasion or blister. Surrounding skin may be red or purple) develop on patients while receiving care and treatment. 3 of which were related to medical devices.
One patient developed a grade 3 pressure ulcer Full thickness skin loss involving damage of subcutaneous tissue but not extending to the underlying fascia.

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/