# 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

November 2016

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

This report is based on information from November 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.

96.72% **of patients did not experience any of the four harms whilst an in patient in our hospital**

99.14% **of patients did not experience any of the four harms whilst we were providing their care in the community setting**

97.70% **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** | 4 | 0 |
| **Trust Improvement target (year to date)** | 21 | 0 |
| **Actual to date** | 14 | 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 | 7 | 6 |
| Category 3 | 0 | 1 |
| 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: | 0.36 | 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: | 0.28 | 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 | 4 |
| 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: | 0.21 |

# 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 * | 87% | This is based on 1953 patients asked |
| **A&E** FFT % recommended* | 89% | This is based on 4133 patients asked |
| **Community** FFT % Recommended | 93% | This is based on 29911 patients asked |
| **Outpatients** FFT % Recommended | 92% | This is based on 22376 patients asked |
| **Daycase** FFT % Recommended | 95% | This is based on 402 patients asked |

We also asked 21 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? | 95 | |
| If you were concerned or anxious about anything while you were in hospital, did you find a member of staff to talk to? | 95 | |
| Were you given enough privacy when discussing your condition or treatment? | 100 | |
| During your stay were you treated with compassion by hospital staff? | 81 | |
| Did you always have access to the call bell when you needed it? | 95 | |
| Did you get the care you felt you required when you needed it most? | 100 | |
| How likely are you to recommend our ward/unit to friends and family if they needed similar care or treatment? | 95 | |

We also asked 542 patients the following questions about their care in the community setting:

| | |
|---|---|
| Were the staff repectful of your home and belongings? | 99 |
| Did the health professional you saw listen fully to what you had to say? | 100 |
| Did you agree your plan of care together? | 99 |
| Were you/your carer or family member involved decisions about your care and treatment as much as you wanted them to be? | 98 |
| Did you feel supported during the visit? | 100 |
| 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? | 94 |

## A patient's story

Suffering from back pain and stomach pain, I rang 111 where they advised me to go to Accident and Emergency at my local Trust. Following the call, I started suffering from diarrhoea and once assessed in A&E, I was told I probably had gall-stones.
For the next 4 weeks, I suffered from watery diarrhoea, back pains and stomach pains. I had tests for gall stones but none were found and then I had a colonoscopy and endoscopy. The colonoscopy was unable to be completed and suffering from severe dehydration I was admitted to hospital. After a five day stay and CT scans, I was told that I had cancer of the colon and when I asked I was told I had probably around 2 years to live.
From my local hospital, I was referred to a specialist Trust in Manchester to see if I was a suitable candidate for clinical trials in 'Hot Chemo' treatment.
I was admitted to the specialist hospital for an operation five days early as I was unable to hold food down. The operation was only partially successful; the cancer had originated on my appendix, which was removed with part of my colon and the cancer had also spread to the stomach walls and was wide spread there. 'Hot chemo' treatment had not been possible and a stoma bag was fitted.
My recovery took place in hospital for 8 weeks, whereby I spent the time trying to find a stoma bag that did not leak. I was very rarely able to keep a bag on for more than 24 hours; the worst day was when I had 18 stoma bags fitted. This was partly due to my skin never fully healing so the bags would never stick.
I attended a meeting with everyone involved in my care to discuss going home and preparing for chemotherapy treatment. At this time I was being fed by peripherally inserted central line. I was told that I could expect the bag to continue leaking and that I would be going to Salford Royal the next day to get their approval for TPN at home.
At Salford Royal I was told that I would not get approval for total parental nutrion (TPN, Feeding directly into a vein) at home as the risk of infection was too high. A specialist nurse was asked to look at my stoma bag to see if they could do anything or offer any advice or guidance. After asking some questions and looking at the stoma bag the nurse provided me with some powder and cream. Within 2 days of using the cream and the powder my skin had improved remarkably and the stoma bags were staying in place more consistently.
I raised an issue of concern with PALS at the specialist trust regarding the treatment of my stoma as there are serious lessons and good practice that can be learnt from the expertise available from Salford. I do not want a 'witch hunt' or disciplinary action against any member of staff as the treatment I received was exceptional and what has happened has happened. I am confident lessons will be learnt and the same thing will not be allowed to happen again.
As a result of this, I have asked to be transferred to Salford Royal for further treatment with the aim to get off TPN and on to solid foods as well as finding a suitable stoma bag and regime that will allow a bag to work effectively and give me the confidence to go out and wear for 'reasonable' periods of time without fearing leaks.

## Staff experience

We asked 6 staff in the hospital the following questions:

| | % recommended |
|---|---|
| I would recommend this ward/unit as a place to work | 67 |
| I would recommend the standard of care on this ward/unit to a friend or relative if they needed treatment | 83 |
| I am satisfied with the quality of care I give to the patients, carers and their families | 100 |

We asked 0 staff working in the community setting the following questions:

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

# 3. IMPROVEMENT

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

The acute neurology unit have been putting processes in place to reduce the amount of time a patient has a urinary catheter in place. Every day at the staff safety huddle every patient with a catheter in place is discussed and the team access if it should still be in place using this tool
Tissue viability is the patient incontinent of urine and has skin problems that could be made worse with the incontinence.
Retention of urine, is the patient unable to pass urine without the catheter
Acutely unwell, is the patient unwell and need to have their urine output monitored.
Patient preference, has the patient requested that it stays in place, although this should be discouraged
Post urological procedure, has the patient recently had surgery related to their urinary system.
Using this tool has reduced the number of catheters that patients have in place and as a result reduced the risk of catheter associated urinary tract infections.

## Supporting information

There were 7 grade 2 pressure ulcer in the acute trust in November . A grade 2 pressure ulcer is described as 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.

**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/ |