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:

East Lancashire Hospitals NHS Trust

November 2017

Open and Honest Care at East Lancashire Hospitals NHS Trust : November 2017

This report is based on information from November 2017. The information is presented in three key categories: safety, experience and improvement. This report will also signpost you towards additional information about East Lancashire Hospitals NHS 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.

99.2% **of patients did not experience any of the four harms whilst an in patient in our hospital**

99.6% **of patients did not experience any of the four harms whilst we were providing their care in the community setting**

Overall 99.4% **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	3	1
Trust Improvement target (year to date)	19	0
Actual to date	24	2

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 pressure ulcers that were obtained at any time during a hospital admission that were not present on initial assessment.**

This month 3 Category 2 - Category 4 validated pressure ulcers were acquired during Acute hospital stay and 1 in the community.

Severity	Number of Pressure Ulcers in our Acute Hospital setting	Number of pressure ulcers in our Community setting
Category 2	2	1
Category 3	1	0
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:	0.10	Hospital Setting

The pressure ulcer numbers include all pressure ulcers that occured from 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:	0.02	Community

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

Severity	Number of falls
Moderate	3
Severe	3
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.

Staff experience

Between July - September 2016 we asked 1766 staff in the Trust the following questions:

	% recommended
I would recommend this ward/unit as a place to work	74
I would recommend the standard of care on this ward/unit to a friend or relative if they needed treatment	81

Patient experience

The Friends and Family Test

The Friends and Family Test requires all patients, after discharge from hospital, 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). Both scores (if applicable) are below;*

In-patient FFT % recommended *	98.29%	This is based on 2513 patients asked
A&E FFT % recommended*	81.07%	This is based on 1463 patients asked

We also asked 590 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?	93	
If you were concerned or anxious about anything while you were in hospital, did you find a member of staff to talk to?	90	
Were you given enough privacy when discussing your condition or treatment?	96	
During your stay were you treated with compassion by hospital staff?	99	
Did you always have access to the call bell when you needed it?	97	
Did you get the care you felt you required when you needed it most?	99	
How likely are you to recommend our ward/unit to friends and family if they needed similar care or treatment?	98	

We also asked 232 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?	97
Did you feel supported during the visit?	99
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?	100

A patient's story

Mrs W’s daughter was born February 2013. She was born with feeding difficulties which was not identified until she was 3 months old, and it was found she had a cleft palate.
The consultant sent her for genetic testing which diagnosed DiGeorge syndrome, a condition present from birth that can cause a range of lifelong problems, including heart defects / learning difficulties and is caused by a problem with a person's genes called 22q11 deletion.
Mrs W’s daughter was diagnosed at 4 months old.
She suffered from severe reflux which aspirated causing Bronchiectasis, a long-term condition where the airways of the lungs become abnormally widened, leading to a build-up of excess mucus that can make the lungs more vulnerable to infection.
At 8 months old she had cleft palate surgery at Manchester Children’s Hospital.
Mrs W’s daughter was first admitted to Royal Blackburn Teaching Hospital Children’s Ward in April 2014 due to continued breathing issues; within an hour of admission she was on oxygen.

We rang the out of hours GP; they saw my daughter and arranged for her to be admitted to the Children’s Observation Unit a Royal Blackburn. She was an inpatient for a week, we then came home for 2 weeks and then she was back in for another week.
It was scary, but the consultant she had at the time was fantastic; she was on the ward round at the time of her being an inpatient. She talked us through everything and what was going on, and why she had to go into a cubicle on her own to prevent her getting more poorly from the other children.
The staff were fantastic, we remember them being so welcoming and understanding and talking us through everything.
My daughter was re-admitted after going home for 2 weeks, and this was not planned.
In 2015, a week before she turned 2 years old she got chicken pox, this was unrelated. However, because of her syndrome the pox went to her brain and she ended up in hospital for 4 weeks.
Four weeks in hospital is enough for anyone especially when you are in a room on your own and are not allowed to leave the room. They were even more cautious now that she had the chicken pox.
As a parent you just want someone there for you, and as much as they were busy they always tried their best. The nursing staff on the ward and the play staff would come and talk to us, reassure us and were there for us to cry on their shoulder.
We were in for 4 weeks and then we were transferred to another hospital to have a central line. During all this time we were able to stay with her 24/7, I would never leave her unless somebody like her Dad or my Mum was with her, but then you get to know the staff and you feel reassured.
They actually said to me, we will stay with her, you need to go and eat and shower and look after yourself, otherwise you will be ill yourself. This gave me the reassurance that she was in the best hands possible and they were thinking of me being able to care for my child which if I do not look after myself I am not going to be able to do.
Due to all my daughters hospital admissions it was very difficult to manage. Initially I was managing a full time job and also caring for my sick child, it became too much so we made the decision for me to give up work. Something had to give and it was never going to be my daughter.
We utilise a service called Direct Access. If she has a chest infection she needs to be seen by the doctor at the hospital rather than our local GP as they have more speciality and they can decide whether she needs IV antibiotics or just standard antibiotics. If she needed oxygen we do not have to go to our GP we can come straight to the hospital and this is a life saver for us.
With Direct Access we call a telephone number, all the details are pinned up at home on the kitchen cupboard with her RXR number and the step by step things that we need to do along with her care plan.
My daughter does not understand but she is such a confident and happy little girl, nothing stands in her way. The team are so brilliant with her, if she is coming in to have her line put in, she will come in and jump on her bed. They are so good with her, they really are.
She just loves coming to hospital. It is a really bad thing that she likes coming to hospital but she does because it is a positive experience for her. She should not love coming to hospital, she is 4, she should want to play out.
She does have development delays due to the DiGeorge Syndrome, but she is her own little person and I do not think I would ever let her realise her own condition because I am always there and I always spot it before anybody. She will know one day, just not yet as she is only 4.
We are not allowed to join in activities when in hospital because she is a risk to others and they are a risk to her, so we have a cubicle for every time she is in hospital, but they do bring activities to her.
On the last admission the play staff moved her bed to one side of the room, they put paper all over the floor and we painted, it was so messy but it was so much fun, she loved it.
They try to make everything as normal as possible. If there is a new doctor I ask them to stick to our home routine in hospital because it is so often that we come. If we did not stick to our routine then life could not carry on as normal and it is good that we can carry on as normal! As long as we tell the doctors what her routine is with times, they are always happy to continue with the routine.
Moving forward, we know what we are doing. We concentrate on the here and now as we do not know what is happening at the minute in terms of consultants. Our current consultant is going on maternity leave - we have received a letter about it.
At the next appointment we will find out who is taking over her care for this year, but we are still using the same plan, nothing is changing and they will keep us up to date. I am scared of it changing though as we are happy with how it has been going at the minute, and we do not want her to get poorly again.
I can pick up on the signs when she is becoming unwell. Because she has a central line we need to watch her temperatures. Recently it is due to high temperatures that we are being admitted. My daughter goes quiet, she stops eating and she will be sick, so we know she has a high temperature. We ring to say she has a high temperature and we bring her straight up to the hospital, she sees the doctor, and if it is her temperature we bring an overnight bag with us as we know she will be admitted.
It has all became so routine and fantastic, we are so happy with the care we receive and the way we are spoken to about everything.
We know them by name; my daughter knows them by name. All staff introduce themselves and my daughter has started to learn their names, she will shout for them which is lovely.
After the first day of each admission she is usually fine in herself but she has to stay to wait for all the results, and she will be running round the room shouting for them. It is good to see that she wants to see people who potentially have to put medicine into her.
I am trained to do her IV’s at home but the ones she has as an inpatient I cannot do at home. Her Dad will not train to do her IV but I have been trained so that we can have her at home and keep her at home as much as possible. We don’t like staying in hospital and if I was not trained to do the IV we would have to wait for the community nurses to come out.
The community nurses are fantastic but they see so many patients in the day that you get a 2-3 hour time slot which is difficult to manage at times.
One time we were in and her respiratory rate was so unbelievably high. You get to know the staff and the staff get to know your child when you are in for so long. Two of the nurses came in and, because they know my daughter, said she needs to see a doctor; that she is not right. They were so reassuring that she would be OK and that they just make it seem and feel so much better than it is sometimes. It is so good to have staff that reassure you as a family, because it is so very scary at times.
For the last 4 years we have been visiting the children's unit and children's observation unit with my daughter as an inpatient on a regular basis. Within all this time we have only had 1 planned admission. We have had a lot of un-planned admissions and this is all due to her chest and the Bronchiectasis.
After 21 admissions you always get the odd day when things are not always going to plan, but overall the whole time we spend here is absolutely fantastic. Everybody, they have always gone above and beyond.
At the beginning we did not have the Bronchiectasis diagnosis, and it was just breathing issues all the time. But, now we are on the right treatment plan - and we have been since August 2014 - it is great and she is getting the care that she needs.
She has never been as well as she is now and that is down to everyone and putting her on to the treatment plan that she is on.
We have had a bad experience recently with Manchester Children’s Hospital, and I came back to Royal Blackburn and cried with relief that we were back to a place we knew and to staff that we knew… and to know that they have her best interests at heart, that is the best thing.
The care we have received during these hospital admissions has been outstanding- my daughter feels safe and happy in such a scary and unknown environment.
Not only is it my daughter who feels safe, as her parents we are overjoyed with the amount of care and attention we receive as a family during difficult circumstances whilst our daughter is unwell.
The involvement of our daughter and us in her care is amazing and we are always kept informed and up to date of happenings from every person involved in her care.
I was a qualified nursery practitioner for 8 years and I am now a student, studying for 4 years on the access to nursing course. I have been inspired by the nurses here and they have pushed me to go for it.
I want to go into children’s nursing; it has to be children’s nursing, for my daughter and for me. I had always planned to do it but with everything we have been through it was not the right time, but now is the perfect time.
Overall the ward is such a happy relaxed place and we are so lucky to have Royal Blackburn as our local children's ward and I always compliment on the personal level of care that is shown towards children and their families.
From the bottom of our hearts we want to thank the Trust for everything they do and will continue to do for our daughter. We have many more years of care to come, and I have no concerns about her future care.

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

After months of planning and preparation, our new Respiratory Assessment Unit (RAU) opened at Royal Blackburn Teaching Hospital at the end of October.

As part of Trust preparations for the busy winter period, the new Unit will treat all adult patients who have a range of respiratory conditions including COPD, asthma and pneumonia.

Managed by a team of specialist respiratory nurses, the RAU will focus on assessing, stabilising and treating patients who require hospital treatment, but can be discharged home the same day.

The unit is located on Level 3 near ward C10.

Patients will be referred to the unit via the Emergency Department, Urgent Care Centres and Acute Medical Units. Patients will also transfer from inpatient wards or be referred from their GP.

Tony McDonald, Deputy Director of Operations, said: “We are extremely excited about the opening of the Respiratory Assessment Unit. The new facility will mean more timely and appropriate care for patients with respiratory conditions.”

“An additional advantage to the Unit is that it will mean patients who are suitable for the new service will have less time to wait in the Emergency Department. This, in turn, frees up capacity so that other patients can also be seen quicker by Emergency Department staff.”

Patients will be referred to relevant follow-up services in the community when they are discharged from the unit.