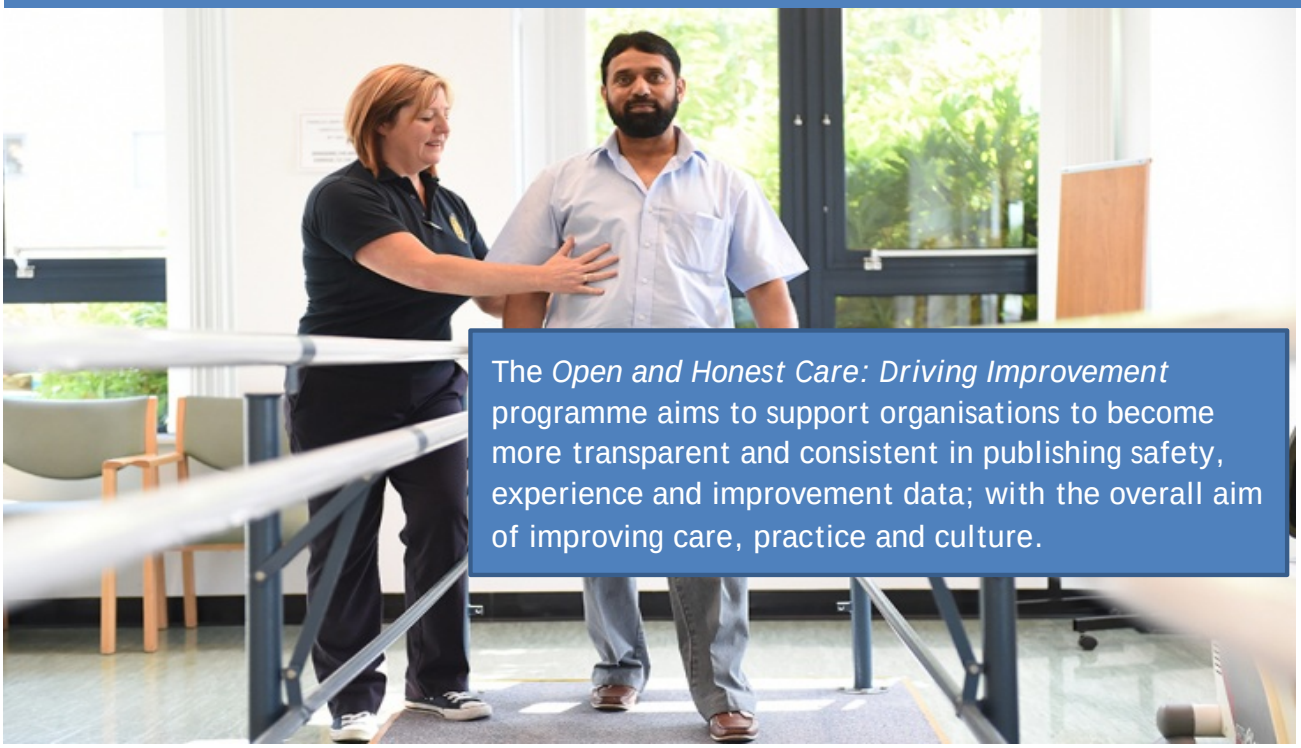
Open and Honest Care in your Local Hospital



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 Hospital NHS Trust

January 2016

Open and Honest Care at East Lancashire Hospital NHS Trust : January 2016

This report is based on information from January 2016. The information is presented in three key categories: safety, experience and improvement. This report will also signpost you towards additional information about East Lancashire Hospital 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.

99.3% **of patients did not experience any of the four harms whilst an in patient in our hospital**

99.0% **of patients did not experience any of the four harms whilst we were providing their care in the community setting**

Overall 99.2% **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	0
Trust Improvement target (year to date)	24	0
Actual to date	23	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 4 Category 2 - Category 4 validated pressure ulcers were acquired during Acute hospital stay and 0 in the community.

Severity	Number of Pressure Ulcers in our Acute Hospital setting	Number of pressure ulcers in our Community setting
Category 2	3	0
Category 3	0	0
Category 4	1	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:	0.13	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:	0.00	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	2
Severe	4
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.

Staff experience

Between July - September 2015 we asked 2007 staff in the Trust the following questions:

	% recommended
I would recommend this ward/unit as a place to work	68
I would recommend the standard of care on this ward/unit to a friend or relative if they needed treatment	78

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 *	99.08%	This is based on 2620 patients asked
A&E FFT % recommended*	78.28%	This is based on 1740 patients asked

* Currently the Friends and Family Test is in development for community services, but we use similar questions to help us understand our patients' experience.

We also asked 656 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?	96	
Were you given enough privacy when discussing your condition or treatment?	99	
During your stay were you treated with compassion by hospital staff?	97	
Did you always have access to the call bell when you needed it?	98	
Did you get the care you felt you required when you needed it most?	97	
How likely are you to recommend our ward/unit to friends and family if they needed similar care or treatment?	95	

We also asked 220 patients the following questions about their care in the community setting:

Were the staff repectful of your home and belongings?	98
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?	98
Did you feel supported during the visit?	98
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?	100

A patient's story

I attended the ED where I was assessed and then sent to the Surgical Triage Unit (STU) where I spent a couple of nights being observed; my pain required a little sorting out but once this had been achieved the nurses on the ward were great. My wife had brought me to the ED, however we had initially rung for an ambulance due to the amount of pain I was in, but were advised that as I was able to walk I would not be sent one- this presented some anxiety for my wife on the drive into RBH. I was then admitted to the STU. The STU was calm, well organised with empathetic staff, Kelly the sister and Jenna provided excellent care. I was then sent to Ward C18 which I found to be a flexible and caring environment under Richard, Emma and Michelle (ward sisters). I was then discharged home, however after 20hrs at home I was readmitted but to Ward C22- which I found more regimented so I asked if I could be moved back to C18 again- there was a bed so I was able to be moved.

I spent a total of three weeks on Ward C18 under the care of a consultant surgeon, during which time I became very unwell with pancreatitis, with involvement from the Critical Care Outreach team who were very personable, professional clinical decision makers. Some of the junior doctors appeared unsure about making decisions which presented some 'confidence' issues to me around my care. At one point I was possibly going to be admitted to the Critical Care Unit but the clinician seemed unsure on making that call. The Critical Outreach Team helped enormously at this point taking over control and decision making on the ward until I was more stable.

One very positive experience I had involved another consultant surgeon who on the Easter Saturday spotted me on the ward and came to talk to me for about half an hour not just about his own case but also about general things not just hospital related. I really appreciated this.

The ward itself was exceptionally clean, with cleaners visible and happy to help and on the one occasion I asked for the shower to be cleaned, it was done straight away and the linen was always spotless. I felt that 'my bay' had a good group of people in it which, as I was in for 3 weeks, was definitely a bonus. The food was not so good, I had to eat a low fat diet and there were few options that met this on the menu, my wife brought food in often for me. The fact that Ward C18 was so accommodating helped with this, which was different to C22. Staff were also very aware of noise at night making sure all doors were closed and lights off as far as possible.

I found that the Bank staff on wards were not particularly good and especially at weekends. This felt a little scary due to the use of bank staff and that those clinicians who were on duty did not come promptly to the ward when bleeped or called. I missed an antibiotic dose due to needing re-siting of a cannula.

I also didn't like the amount of advertising and 'pushy' Hospedia Customer Care staff when I called them about my TV access and I was buying another card for this.

I had a CT scan before my proposed keyhole procedure (16th April) and met with the consultant to discuss this; I found him to be conscientious, explaining what would take place and when. The team supporting the consultant was also good, in particular George, Jack and Rachel. The porters were chatty and always waiting to collect me straight away from any scan I went for. I felt well-informed about what was going to take place by my consultant, I walked to theatre and the anaesthetist and anaesthetic staff were also very calming when I arrived there. My operation went well, and I was advised that if I had any issues once home to go straight to STU- which I needed to do. I have subsequently had an endoscopy and stent put in for a cyst and was pleasantly surprised to be rung the day after discharge by a nurse asking me how I was feeling.

3. IMPROVEMENT

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

The Trust has launched its innovative new electronic tool – Refer-to-Pharmacy. It is an electronic referral system that allows pharmacists and pharmacy technicians to refer people from the hospital bedside to their community pharmacist for various kinds of post-hospital discharge support with their medicines.

Whilst a patient is in hospital, they may have new medicines started, or others stopped or doses changed and this can lead to potential problems for them when they are discharged.

Getting information to community pharmacists can be a tricky issue. Patients are often unaware of these services, and even with signposting by the hospital pharmacy team, they often miss out on the opportunity for their community pharmacist to help them get the best from their medicines when they are potentially at their most vulnerable following changes to their medication in hospital.

The community pharmacist can be crucial for people getting the best from their medicines, especially if they have a long term condition or for vulnerable elderly patients using multiple medicines.

Refer-to-Pharmacy provides the community pharmacist with all the information they need about medication changes allowing the community pharmacist to contact the patient in order to ensure they get the right support when they return home. This helps keep the patient safe, ensuring their patient record is up to date, and allows checks that future prescriptions from the patient's GP have the right information on them, helps reduce medicines waste, and may help prevent the patient being readmitted to hospital.

The pharmacist or pharmacy technician identify patients who are eligible and have a discussion with them on the ward and seek their consent to be referred to their local pharmacy. For example, a patient was admitted with exacerbation of COPD. His inhaler was out of date and not being used properly. The Pharmacist had a chat with the patient who agreed to be referred to a local pharmacy.

Once a patient agrees to be referred to their community pharmacist an electronic referral and a copy of their discharge letter is securely sent. The community pharmacist will then contact the patient within a few days of discharge to arrange a convenient time to meet to review their medications.

Refer to Pharmacy helps patients get the best from their medicines and to stay healthy at home.

For more information about Refer to Pharmacy please visit www.elht.nhs/refer