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:

Blackpool Teaching Hospitals NHS Foundation Trust

January 2016

Open and Honest Care at Blackpool Teaching Hospitals NHS Foundation Trust: January 2016

This report is based on information from December 2015. The information is presented in three key categories: safety, experience and improvement. This report will also signpost you towards additional information about Blackpool Teaching Hospitals 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.

94.7% **of patients did not experience any of the four harms whilst an in patient in our hospital**

93.5% **of patients did not experience any of the four harms whilst we were providing their care in the community setting**

Overall 94.0% **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)

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	5	0
Trust Improvement target (year to date)	10 per quarter	0
Actual to date	53	6

Cdiff: Post infection rewiews ongoing overall indications re antibiotic prescribing issues.

For more information please visit:
www.bfwh.nhs.uk

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 validated (i.e. reported and Root Cause Analysis undertaken and completed) avoidable/unavoidable pressure ulcers that were obtained at any time during a hospital admission or under the care of community services that were not present on initial assessment.**

This month 3 Category 2 - Category 4 validated pressure ulcers were acquired during Acute hospital stay and 9 in the community.

Severity	Number of Pressure Ulcers in our Acute Hospital setting	Number of pressure ulcers in our Adult and Long Term Conditions Community setting
Category 2	2	5
Category 3	0	1
Category 4	1	3

Stage 4: Patient admitted to hospital with existing unstageable pressure ulcer documented.

In the hospital setting, so that 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:	0.12	Hospital Setting

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:	0.020	Adult and Long Term Conditions

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

Severity	Number of falls
Moderate	2
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:	0.08

2. EXPERIENCE

Patient experience

Responses are received against questions that also feature in the annual national inpatient survey. The Patient Experience team continue to assist each Division in improving their responses to questions asked. Improvement is measured and reported back to the Division by the use of our Listeners.

The results shown here are for the quarter 3, October to December 2015. These will be updated for quarter 4 in April.

	Score
Were you involved as much as you wanted to be in the decisions about your care and treatment?	89%
Did you find someone on the hospital staff to talk to about your worries and fears?	79%
Were you given enough privacy when discussing your condition or treatment?	98%
Were you given enough privacy when being examined or treated?	99%
How much information about your condition or treatment was given to you?	81%
Overall, did you feel you were treated with respect and	99%
Overall, how would you rate the care you received?	88%

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

How likely are you to recommend this service to friends and family if they needed similar care?	98.0%

Staff experience

We asked 5 staff in the hospital the following questions:

	Score
I would recommend this ward/unit as a place to work	100%
I would recommend the standard of care on this ward/unit 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%

The scores are calculated as the number of 'Strongly Agree' + 'Agree' responses divided by the total number of responses (Strongly agree, agree, neither agree nor disagree, disagree, strongly disagree)

A patient's story

I was admitted via A&E for assessment and eventually admitted to the cardiology unit. The paramedics who attended were excellent, and gave me confidence. The A&E staff were very busy, but throughout the night, I was reassured of being cared about. Although I was allowed to go home, the Doctor from A&E phoned to see how I was managing. I admitted I was not and was advised to return; I was then admitted to medical assessment and treatment was started. I was moved to Ward C, and there I was seen by the consultant and was moved to ward 38. There I again received reassurance throughout.

I was treated over the weekend and seen by a doctor who explained what had been happening and what would happen over the next month or so. I have since been to the anti-coagulant clinic, started on treatment, and have two other appointments linked to cardiology. Throughout all, the staff and doctors have been considerate

3. IMPROVEMENT

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

Issue: A patient arrived in the Emergency Department in the early hours with chest pain and regrettably, experienced a prolonged stay until being transferred to AMU at 12:00. At the time, the patient was reviewed by the Doctor who was aware of the patient's diagnosis but did not prescribe any medication as it was their expectation that she would be transferred to AMU before the medication was required. Patient was then not reviewed by a Doctor on AMU until 13:45. The medication was not immediately available and was therefore requested from pharmacy and not administered until 18:00.

Action: In terms of actions that were identified these included:-

- Head of Department wrote to the ED medical team on advising them that patients who are on critical medications should have these prescribed whilst in the Department.
- This was discussed at AMU safety huddles week commencing 16 November for a period of a week.
- Head of Department for AMU highlighted this to his medical team on AMU.
- It was also discussed at the AMU Senior Nurse Meeting on 20 November.
- The case was also discussed at the Division's Clinical Governance Committee

Additional actions taken identified following further discussions:

- AMU Sister has placed a further notice in the handover folder on AMU together with the critical medication policy and list of medication.
- AMU has appointed a member of the nursing team as the Parkinson's link nurse.
- Contact has been made Lead nurse for Parkinson's with regards to training for staff to increase their knowledge and skills in relation to Parkinson's. ED will also going to link in on this.
- ED Matron has discussed with the team the importance of the non-delay in administering critical medications. The policy and critical medications list is also going to be placed in the handover file too.
- Critical medication check has also been added to the Electronic Patient board on AMU so this will ensure that is flagged up at handover of a patient from ED.

Supporting information