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

September 2015

Open and Honest Care at Blackpool Teaching Hospitals NHS Foundation Trust: September 2015

This report is based on information from August 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.

93.3% **of patients did not experience any of the four harms whilst an in patient in our hospital**

95.8% **of patients did not experience any of the four harms whilst we were providing their care in the community setting**

Overall 94.8% **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	9	3
Trust Improvement target (year to date)	17	3
Actual to date	27	3

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

There were three incidences of MRSA Bacteraemia attributed to the Acute Trust in August 2015. All three incidences have been investigated by completing a post infection review and lessons learned discussed with Clinicians and the relevant Clinical Commissioning Group. Action plans are currently underway to address the issues identified and will be will be discussed at the next Whole Health Economy Committee, then the learning points can be shared across the organisation.

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 6 Category 2 - Category 4 validated pressure ulcers were acquired during Acute hospital stay and 18 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	5	18
Category 3	0	0
Category 4	1	0

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:	0.30	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:	0.041	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:	0.10

2. EXPERIENCE

Patient experience

The results shown here are for the quarter 1, April to June 2015. These will be updated for quarter 2 in October.	Score
Were you involved as much as you wanted to be in the decisions about your care and treatment?	74%
Did you find someone on the hospital staff to talk to about your worries and fears?	64%
Were you given enough privacy when discussing your condition or treatment?	89%
Were you given enough privacy when being examined or treated?	98%
How much information about your condition or treatment was given to you?	74%
Overall, did you feel you were treated with respect and dignity?	93%
Overall, how would you rate the care you received?	84%

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?	93.4%

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

Judith Butterworth explains the care and treatment her partner Hazel received, when she was seen in Gastroenterology. Two years ago, having been admitted to A&E, Hazel was diagnosed with GAVE Syndrome. She passed away in January 2015. Judith describes her disappointment in the Consultant who saw Hazel, the attitude of staff when asked questions by Judith, and the excellent care Hazel received on Ward 12.

www.youtube.com/watch?v=dFnfAru4drc

3. IMPROVEMENT

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

Issue: The client raised issues surrounding communication of her husband's care and treatment. There were delays in a follow up appointment regarding her husband's catheter, discharge medications not being prescribed, and a DNAR (do not attempt resuscitation) notice being placed on her husband with no discussion with the patient or family.

Action: The client met with the Resuscitation Manager, who answered all her concerns. Also, a letter was posted clarifying the actions taken from the discussion. The DNAR notice was revoked.
Recommendations:

- The Resuscitation Department, on all future medical inductions (February & August), will deliver to all Doctors, a formal presentation on DNACPR to include sections from Article 8 of the European Convention of Human Rights Act. Doctors will be made aware that it is the Consultants responsibility to endorse this order, and that simply "multiple co-morbidities" is not a sufficient statement to place on an order of such. Clear guidance will be given in this area.
- Communication will be highlighted as an essential requirement when dealing with the sensitive nature of DNACPR and with patient's permission; relatives are kept continually informed under article 8 guidance.
- It will also be brought to the attention of all Doctors, the importance of regular reviews (every senior medical ward round) of the DNACPR order, especially in situations where capacity or clinical presentation changes with the patient.
- In situations where patients lack capacity under the Mental Capacity Act (MCA) 2005, the family or Independent Mental Capacity Advocate (IMCA) must be informed

Supporting information