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:

Wrightington, Wigan and Leigh NHS Foundation Trust

November 2013
Open and Honest Care at Wrightington, Wigan and Leigh NHS Foundation Trust : November 2013

This report is based on information from November 2013. The information is presented in three key categories: safety, experience and improvement. This report will also signpost you towards additional information about the trust’s performance.

1. SAFETY

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.

97.7% 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.

<table>
<thead>
<tr>
<th></th>
<th>C.difficile</th>
<th>MRSA</th>
</tr>
</thead>
<tbody>
<tr>
<td>This month</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Improvement target</td>
<td>25</td>
<td>0</td>
</tr>
<tr>
<td>(year to date)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Actual to date</td>
<td>25</td>
<td>1</td>
</tr>
</tbody>
</table>

For more information please visit:
http://www.wwl.nhs.uk/about us/board meetings.aspx
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 grades, with one being the least severe and four being the most severe.

This month 0 Grade 2 - Grade 4 pressure ulcers were acquired during hospital stays.

<table>
<thead>
<tr>
<th>Severity</th>
<th>Number of pressure ulcers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grade 2</td>
<td>0</td>
</tr>
<tr>
<td>Grade 3</td>
<td>0</td>
</tr>
<tr>
<td>Grade 4</td>
<td>0</td>
</tr>
</tbody>
</table>

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 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 1000 bed days: 0.00

Falls

This measure includes all falls in the hospital that resulted in injury, categorised as moderate, severe or death, regardless of cause.

This month we reported 0 fall(s) that caused at least ‘moderate’ harm.

<table>
<thead>
<tr>
<th>Severity</th>
<th>Number of falls</th>
</tr>
</thead>
<tbody>
<tr>
<td>Moderate</td>
<td>0</td>
</tr>
<tr>
<td>Severe</td>
<td>0</td>
</tr>
<tr>
<td>Death</td>
<td>0</td>
</tr>
</tbody>
</table>

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: 0.00
2. EXPERIENCE

To measure patient and staff experience we use a Net Promoter Score.

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.

From the answers given 3 groups of people can be distinguished:
- Detractors - people who would probably not recommend you based on their experience, or couldn't say.
- Passive - people who may recommend you but not strongly.
- Promoters - people who have had an experience which they would definitely recommend to others.

This gives a score of between -100 and +100, with +100 being the best possible result.

**Patient experience**

**The Friends and Family Test**

The Friends and Family Test requires all patients, after discharge, to be asked: *How likely are you to recommend our ward to friends and family if they needed similar care or treatment?*

The hospital had a score of **74** for the Friends and Family test*. This is based on 1435 responses.

Real time Patient survey Results for November 2013:

Have staff treating and examining you introduced themselves?
88.8%

Did you find someone to talk to about your worries and fears?
89.9%

Do you think the hospital staff did everything they could to help control your pain?
93.8%

If your family or someone close to you wanted to talk to a doctor, did they have enough opportunity to do so?
90.5%

Have you been involved as much as you wanted to be in decisions about your care and treatment?
85.5%

Have you been offered a choice of food during your stay?
92.7%

Has there been healthy food on the hospital menu?
91.1%

Have you been involved in decisions about your discharge from hospital?
62.0%

Do you know which consultant is treating you?
66.5%

Average
84.1%

During November the Trust scored an average of 84.1% representing an improvement on October’s results.
A patient's story

I came to Wrightington Hospital for a hip replacement. I felt the present level of nursing staff are stretched beyond their limit. While on the ward, I found the noise of the call buzzer system to be far too loud, particularly when multiplied by 6 or 7 buzzers. Add to this the tone of the alarm buzzers of electronic medication equipment, 20 patients, visitors, medical staff, and what should be a peaceful hospital ward degenerates into chaos.

I found the standards of care to be unacceptable, especially in the area of personal hygiene. The problem lies in the fact that the nurses have too much to do. This means that patients who could and should be wheeled to the toilet are instead given a bedpan.

I also had concerns regarding contact hygiene of the wheelchairs used within the ward. I only once during my stay saw a nurse cleaning the wheelchair and of all the times I was wheeled to the toilet I was never once offered the chance to wash my hands.

The events of my final evening in hospital contributed to my sudden departure. Elderly patients were lying on top of unmade beds asleep awaiting the distribution of medication which did not happen until 12 pm and the ward lights were not turned off until 1.30 am.

Concerns that the medication routine I followed at home cannot be followed in hospital due to pressure of work, resulting in me suffering discomfort through indigestion which could have been avoided.

Our Response/Action taken – taking into account what we didn’t do and what we are doing about it:

The Trust apologised that the patient was so greatly affected by the noise. The buzzer system has been reviewed by the Trust Health and Safety team.

The Trust was deeply sorry to hear that the patient found the care unacceptable in the area of personal hygiene and the Ward Manager and team are committed to ensuring that vigilance is heightened and standards improved.

At the time of the complaint the Trust did not operate patient self medication; however since this the Trust has developed and implemented this to allow the patient more flexibility.

Staff experience

We asked 5 staff the following questions:

<table>
<thead>
<tr>
<th>Question</th>
<th>Net Promoter Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>I would recommend this ward/unit as a place to work</td>
<td>80</td>
</tr>
<tr>
<td>I would recommend the standard of care on this ward/unit to a friend or relative if they needed treatment</td>
<td>80</td>
</tr>
<tr>
<td>I am satisfied with the quality of care I give to the patients, carers and their families</td>
<td>100</td>
</tr>
</tbody>
</table>
3. IMPROVEMENT

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

The falls improvement work has continued this month within the Trust. Since the October report the newly established falls improvement group has met and small scale improvement projects are in progress on some wards, which will be evaluated and if effective implemented in other areas. In addition to this a falls analysis group has commenced, which has identified key themes for further focused work to be undertaken, aimed at reducing falls in hospital.

It is noted that for the month of November the Trust did not have any harms to report, which is seen as a positive improvement from the previous month.

The work introducing the 10 always events, which were described in October’s report continues in the Trust. The launch day for the always events has been set for 6th January 2014.

Supporting information

In response to the real time patient survey scores the Trust felt it was important to provide details of the work that is in progress to inform the public of how we are responding to these results.

There are areas of concern which we need to improve based on our November results, which are:
Involvement in decisions about discharge
Knowing which consultant is treating you

A ward round checklist has been introduced; this includes a prompt to staff to give patients the opportunity to ask any questions or raise any concerns that they may have.
A new discharge checklist has been introduced with information for patients regarding their expected date of discharge and care, which aims to increase the information given and open up discussions and involvement with being involved with discharge plans.
Individual whiteboards have been implemented for each patient’s bed area, this will contain information as to the name of the nurse caring for the patient and also the patients named consultant.