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

July 2014
Open and Honest Care at Wrightington, Wigan and Leigh NHS Foundation Trust : July 2014

This report is based on information from July 2014. The information is presented in three key categories: safety, experience and improvement. This report will also signpost you towards additional information about Wrightington, Wigan and Leigh NHS Foundation 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 NHS 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.

99.6% 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 (year to date)</td>
<td>11</td>
<td>0</td>
</tr>
<tr>
<td>Actual to date</td>
<td>5</td>
<td>0</td>
</tr>
</tbody>
</table>
For more information please visit:

Welcome to Wrightington, Wigan and Leigh NHS Foundation Trust
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 1 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>1</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: 0.08

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.

This month we reported 2 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>2</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: 0.17
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 (FFT) 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? We ask this question to patients who have been an in-patient and/or attended Accident & Emergency (A&E). Both scores (if applicable) are below;

| In-patient FFT score* | 77 |
| A&E FFT score*       | 67 |

This is based on 682 responses.
This is based on 774 responses.

*This result is from surveys conducted in June and may have changed since publication, for the latest score please visit: http://www.england.nhs.uk/statistics/statistical-work-areas/friends-and-family-test/friends-and-family-test-data/

We also asked 0 patients the following questions about their care:

Were you involved as much as you wanted to be in the decisions about your care and treatment? 85%
Did you find someone to talk to about your worries and fears? 86%
Were you given enough privacy when being examined, treated or discussing your care? 100%
During your stay were you treated with compassion by hospital staff? 95%
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? 95%
A patient's story

The Trust has a team of quality & safety matrons who follow up every patient who falls in our care in order to ensure that correct procedures are followed to prevent further falls and identify improvements needed. This is a brief summary of a patient story taken by one of the quality & safety matrons. The patient's name has been changed to protect confidentiality.

Grace, a 54 year old lady, attended accident & emergency with retention of urine. Following examination and treatment a decision was made to discharge her with further follow up appointments to investigate the cause of the bladder problem.

While she was getting dressed independently she fell and sustained a head injury. Following further review by a doctor, a decision was taken to admit her for further observation.

Further conversation with Grace and her relative revealed that she had been experiencing similar incidents over the previous few months associated with dizziness.

Grace was discharged 2 days later with appointments for further investigations as an outpatient. Following numerous tests she was eventually diagnosed with a complex condition which had been the cause of the falls and the urological problems she was experiencing.

This story highlights the importance of carrying out a falls risk assessment for every patient even if their presenting condition does not suggest a potential risk. In this case, the fall in hospital was useful in drawing faster attention to the other symptoms Grace had been experiencing but had not reported.

Staff experience

We asked 10 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>60</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>60</td>
</tr>
<tr>
<td>I am satisfied with the quality of care I give to the patients, carers and their families</td>
<td>80</td>
</tr>
</tbody>
</table>

3. IMPROVEMENT

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

The patients who sustained harm from falls during June & July were all patients on the Medical Assessment Unit (MAU). This is a ward where patients suffering serious acute medical conditions are admitted for emergency assessment prior to admission to a specialist ward or discharge home. The ward manager and quality & safety matron for MAU have worked together to develop a specific action plan with the aim of preventing harm from falls. This includes ensuring that there is always a nurse present in each patient bay so that patients are closely supervised at all times (as the falls have all occurred at the patients' bedsides). The falls alarms referred to in previous reports have now been purchased, staff training in their use is currently in progress and a protocol is being developed to ensure that they are used only in appropriate circumstances. It is anticipated that the alarms will be instrumental in preventing some falls in MAU.

In addition, the Trust has embarked on a patient safety programme "TalkSafe" which aims to reduce harm from patient safety incidents through cultural change which encourages staff to talk to each other about unsafe behaviours and hence raise awareness and promote safer practice. The programme is to be piloted in MAU and a baseline cultural assessment is currently being carried out prior to the commencement of staff training in "TalkSafe" techniques. Updates on progress will be provided in future reports.

With regard to pressure ulcers, it is noted that 3 of the 6 pressure ulcers acquired in hospital since April have
“TalkSafe” techniques. Updates on progress will be provided in future reports.
With regard to pressure ulcers, it is noted that 3 of the 6 pressure ulcers acquired in hospital since April have been caused by pressure from medical devices including oxygen masks, drainage tubes and vascular access devices. The tissue viability nurse is currently exploring whether any further actions could be taken to prevent such harm.

Supporting information

Sign up to Safety is a new national patient safety campaign that was announced in March 2014 by the Secretary of State for Health. It launched on 24th June 2014 with the mission to strengthen patient safety in the NHS and make it the safest healthcare system in the world. The Secretary of State for Health set out the ambition of halving avoidable harm in the NHS over the next three years, and saving 6,000 lives as a result. This is supported by a campaign that aims to listen to patients, carers and staff, learn from what they say when things go wrong and take action to improve patient’s safety helping to ensure patients get harm free care every time, everywhere.
As part of our commitment to patient safety the Trust has prepared it's sign up document and this will be published on the NHS England Sign Up to Safety website in due course.