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

September 2015
Open and Honest Care at Wrightington, Wigan and Leigh NHS Foundation Trust: September 2015

This report is based on information from September 2015. 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.

99.0% of patients did not experience any of the four harms

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>2</td>
<td>0</td>
</tr>
<tr>
<td>Annual Improvement target</td>
<td>19</td>
<td>0</td>
</tr>
<tr>
<td>Actual to date</td>
<td>6</td>
<td>0</td>
</tr>
</tbody>
</table>

For more information please visit: www.wwl.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 avoidable/unavoidable pressure ulcers that were obtained at any time during a hospital admission that were not present on initial assessment.

This month 1 Category 2 - Category 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>Category 2</td>
<td>1</td>
</tr>
<tr>
<td>Category 3</td>
<td>0</td>
</tr>
<tr>
<td>Category 4</td>
<td>0</td>
</tr>
</tbody>
</table>

The pressure ulcer numbers include all pressure ulcers that occurred from zero hours after admission to this Trust.

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 1,000 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 1 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>1</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: 0.08
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.

### 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 or attended A&E (if applicable) in our Trust.

<table>
<thead>
<tr>
<th>In-patient FFT score*</th>
<th>99 % recommended</th>
<th>This is based on 813 responses.</th>
</tr>
</thead>
<tbody>
<tr>
<td>A&amp;E FFT Score</td>
<td>97 % recommended</td>
<td>This is based on 1286 responses</td>
</tr>
</tbody>
</table>

*This result is for August 2015 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/](http://www.england.nhs.uk/statistics/statistical-work-areas/friends-and-family-test/friends-and-family-test-data/)

We also asked our patients the following questions about their care using our realtime patient questionnaire:

- Have you been involved as much as you wanted to be in decisions about your care and treatment? 96.1%
- Did you find someone to talk to about your worries and fears? 94.9%
- Have you been given enough privacy when being examined treated or discussing your care? 99.36%
- During your stay have you been treated with compassion by hospital staff? 99.36%
- Have you always had access to a call bell when you needed it? 96.18%
- Have you be given the care you felt you required when you needed it most? 96.82%
A patient's story

Miss M was admitted to hospital for removal of her wisdom tooth. The doctor checked Miss M's consent, that she understood what the operation involved. Miss M went to theatre and unfortunately the gum was cut on the incorrect side at this point the doctor realised the mistake and the gum was stitched back up and the correct tooth was removed. This error happened because of lots of reasons, including the failure of the systems and processes that were there to try to prevent a mistake; many of them are a result of human factors*.

Once Miss M was awake the doctor explained the error straightaway and apologised. Unfortunately Miss M did suffer some extra pain as a result of the unnecessary cut.

Miss M wanted to make sure that this didn't happen to anyone else again and she was keen to understand the changes that we made, which we shared with her.

To try to ensure that it does not happen again we have undertaken a detailed investigation to change some of our processes and systems. We understood from the investigation that we expected our senior doctor to be present in 2 places at once, the forms that we use to check to that we have made all the correct checks were not familiar to all the staff involved. We didn't mark the skin because lots of patients didn't like their face marked. See the improvement story below for how we have changed what we do to make our patient's safer.

3. IMPROVEMENT

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

Increasingly in health care we are becoming aware of the impact of human factors* on people involved in health care. As can be seen from the above patient story human factors had an influence on the problems that happened during Miss M's care. To make the changes to support patient safety we needed to look at how the incident happened and understand what made it difficult for staff to follow all the policies and checklists needed to try to minimise the risk of error.

As a result of the investigation we have changed the way dental patients are marked on the skin, before patients tended not to be marked up; this was normal practice. We have changed this and the default now is that patient's skin is marked and if it is not because the patient does not want it marked a conversation is prompted with the patient as to the importance of the skin being marked. We have changed the types of pens so the mark does not remain on the skin for too long after the operation.

As well as changing specific processes we are extending our training programme for human factors in health care and we are beginning to build a faculty of interested people. This training is available for all staff.

*Human factors are described as

> 'enhancing clinical performance through an understanding of the effects of teamwork, tasks, equipment, workspace, culture and organisation on human behaviour and abilities and application of that knowledge in the clinical setting' Catchpole 2010.

The aim of understanding human factors will be to improve the safety of patient care through a better understanding of the wide variety of factors that can impact on people’s ability to undertake their duties as safely as possible. We know that where human factors have been taken into consideration and used in the design of equipment and processes it has enhanced the safety of the environment and has been particularly well used in other safety critical industries; such as the airline and chemical industry.