

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:

**South Tees Hospitals NHS
Foundation Trust**

February 2015
2014/15

Open and Honest Care at South Tees Hospitals NHS Foundation Trust : February 2015

This report is based on information from February 2015. 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 new harms.

98%	of patients did not experience any of the four harms whilst an in patient in our hospitals
97%	of patients did not experience any of the four harms whilst we were providing their care in the community setting
97%	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

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.

	C.difficile	MRSA
This month	11	0
Trust Improvement target (year to date)	45	0
Actual to date	67	4

For more information please visit:

<http://southtees.nhs.uk/patients-visitors/infection-control/>

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 60 category 2 - category 4 pressure ulcers were acquired during a hospital stay and there was also 62 in the community.

Severity	Number of pressure ulcers in the hospital setting	Number of pressure ulcers in our community setting
Category 2	54	54
Category 3	5	7
Category 4	1	1

The pressure ulcers include all pressure ulcers that occurred from after admission to this Trust

hours

In the hospital setting, so 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.

In the community setting we also calculate an average called 'rate per 10,000 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.

Community Setting

Falls

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

This month we reported 2 falls that caused at least 'moderate' harm.

Severity	Number of falls
Moderate	0
Severe	2
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:	0.07
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2. EXPERIENCE

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.



The Friends & Family Test

Patient experience

The Friends and Family Test

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

The hospitals had a score of **28** % for the Friends and Family test*.

*This result 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/>

Currently the Friends and Family Test is in development for community services, but we use similar questions to help us understand our patients' experience.

We also asked patients the following questions about their care in the hospital:

% agree or strongly

I feel I was involved as much as I wanted to be in the decisions about my care and treatment:

I feel my family were involved as much as I wanted them to be in the decisions about my care and treatment:

Whenever I was concerned or anxious about anything whilst I was in hospital, I could find a member of staff to talk to:

I feel I was given enough privacy when discussing my condition and / or treatment:

During my stay I feel I was treated with compassion by hospital staff:

I always had access to the call bell when I needed it:

I feel I received the care I required when I needed it most:

The quality of the nursing care received has met my expectations:

The quality of the medical care received has met my expectations:

A patient's story

After her surgery Mum was on an Elective Orthopaedic Ward and nursed in a side room. This was not because of infections and really she would have been better in a room with others because she felt terribly isolated and had no one to talk to. We would phone and ask how she was doing to be told she was doing well, walking with physiotherapist but when we arrived to visit she would tell us she hadn't done anything, and told nurses she didn't need pain killers when she really did but was scared of getting constipated. Mum didn't eat properly when she was on the ward. She didn't like the food and trays would go back practically untouched. I spoke with the Ward Manager and Sisters who were lovely and they put mum on a food chart to monitor what she was eating. Is there nothing else she could have, no-one seemed to consider alternatives, though I did mention to staff that she was very picky and would probably refuse something from M&S.

My mum has us to look out for her and I just wanted to highlight these issues so that staff might think "could I dig a little deeper when asking about pain" "she's not eating much, what else can we offer, what are her favourite foods". The majority of staff are very caring and some individuals stand out. Being busy is not an excuse for not getting it right first time.

3. IMPROVEMENT

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

Nursing teams and others involved in caring post-operatively for patients strive to give 100% effort every day to every patient. But there will be times when we need to reflect and say "we could have done that better" Every day we encourage, cajole, use humour and set goals for our patients to help them move forward and improve. Most times patients recover well, progress with physiotherapy and are ready for home without delay. On occasion others need a little more time and their length of stay is extended for a variety of reasons. Slow rehabilitation, poor diet, not enough fluids, constipation all contribute to extra days in hospital. If patient declines analgesia, experience tell us try to encourage the patient to reconsider, particularly if a physiotherapy assessment is expected or there are some exercises the patient needs to do. Experience tells us we should always be mindful of half eaten plates of food, and again, it's not just about monitoring but using everything at our disposal to explore other options, such as the snacks and out of hour's menu. We recognise that we will never suit every ones tastes but we try and that counts a thousand times more than just accepting things at face value. We need to reach out with that experience and stretch the thinking skills of junior colleagues. Being visible at peak times on the ward, mealtimes, visiting, board rounds will help to enrich the skills of others.

Using patient stories has been a useful way to share and spread experiences with a wider audience, and if we can improve an individuals practice by highlighting niggling discrepancies then that can only prove to be care and compassion in practice.