

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:

**Calderdale and Huddersfield
Foundation Trust**

February 2015

Open and Honest Care at Calderdale and Huddersfield 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 Calderdale and Huddersfield 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.

93.3% 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.

	C.Difficile	MRSA
This month	4	0
Annual Improvement Target	18	0
Actual to date	26	0

For more information please visit:

www.website.com

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 9 Category 2 - Category 4 pressure ulcers were acquired during hospital stays.

Severity	Number of Pressure Ulcers
Category 2	4
Category 3	5
Category 4	0

The pressure ulcer numbers include all pressure ulcers that occurred from

72 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 1000 bed days:	0.46
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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.

Severity	Number of falls
Moderate	2
Severe	0
Death	0

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Rate per 1,000 bed days:	0.10
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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.



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.

In-patient FFT score*	95.6	% recommended	This is based on 887 responses.
A&E FFT Score	89.8	% recommended	This is based on 921 responses

*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/>

We also asked 887 patients the following questions about their care:

	% Recommended
Were you involved as much as you wanted to be in the decisions about your care and treatment?	91
If you were concerned or anxious about anything while you were in hospital, did you find a member of staff to talk to?	64
Were you given enough privacy when discussing your condition or treatment?	98
Did you get the care you felt you required when you needed it most?	99
How likely are you to recommend our ward/unit to friends and family if they needed similar care or treatment?	96

A patient's story

Mrs X was a 93 yr old lady. She lived on her own and had enjoyed a holiday in Scotland with her children the week prior to her admission. She had a fall at home getting up in the night and had sustained a head injury; she was brought by ambulance to A&E at 3 o'clock in the morning. She was therefore admitted to the Clinical Decision Unit for observations and for review regarding her mobility by the physiotherapist, she was fully alert and orientated at the time of admission on Wednesday. She was prescribed her medications, a VTE assessment was undertaken and she was prescribed Dalteparin. Mrs X was seen by the OT on Thursday morning but it was felt she required further assessment by the physiotherapist. Mrs X became increasingly drowsy as the day went on. A CT head scan was arranged to investigate the cause and this was undertaken in the early hours of Friday morning and demonstrated a subdural haematoma. Her care was discussed with the neurosurgical team at Leeds who felt that surgical intervention was not appropriate.

Her prognosis was discussed with her son and daughter and a DNA CPR was put in place and she was transferred to ward 7b where she sadly died on the Sunday.

An incident report was made with the rating of 'red' and this was also reported to the Clinical Commissioning Group. A full investigation was undertaken as well as notification of the family in line with duty of candour. There was a delay to the notification of the duty of candour. The Matron contacted Mrs X's daughter approximately 4 weeks after the incident so this was a shock for her. During this phone call she was informed of the outcome of the investigation.

The investigation concluded that Mrs X was managed appropriately and in line with the head injury pathway for CDU. Her conscious level was normal so there was no indication for her to have a CT head scan following her admission. During the course of her stay on CDU she received 2 doses of Dalteparin 5000iu on the Wednesday and Thursday as prescribed.

It is likely that Mrs X sustained the sub-dural haemorrhage as a result of the fall but that the extent was not apparent at the time of admission but that the Dalteparin exacerbated the bleeding and she then became symptomatic.

The key concern following the investigation was that Mrs X was prescribed and given Dalteparin and that this was not in line with the VTE assessment and management policy. In addition there was no consideration by the prescribing doctor or the nurses administering the Dalteparin of the potential risk factors with giving this medication to a patient with a head injury.

Staff experience

We asked 10 staff the following questions:

	% Recommended
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	90

3. IMPROVEMENT

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

The key lesson learnt was the need for better awareness amongst both the medical and nursing teams within CDU of the indications and contraindications to heparin for VTE prophylaxis. As a result a departmental package has been developed for medical and nursing staff as well as sharing the story within the Quality Improvement forum.

A meeting has taken place with the son and daughter of Mrs X led by the Consultant and Matron. The family felt they would rather not have been informed of the incident as they have found this understandably upsetting. This may have been less traumatic for them if they had been notified of the possibility of a serious omission at the time. However, it was an opportunity for them to ask questions regarding what the possible outcomes could have been for their mum and also to hear about the staff involved, their reactions and learning that has resulted from this incident. The family wrote back to the Matron to thank them for meeting and spending time discussing the investigation and answering their questions. They emphasised throughout that they felt no anger towards the staff and just felt it was important we all learnt from this experience.

They also took the opportunity to thank ward 7b for the exceptional care that their mum received from the whole team and that it was a comfort to know she was so well cared for at the end.