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

June 2015

Open and Honest Care at Calderdale and Huddersfield Foundation Trust : June 2015

This report is based on information from June 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.

94.9% **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	1	0
Annual Improvement Target	21	0
Actual to date	3	1

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

Severity	Number of Pressure Ulcers
Category 2	16
Category 3	7
Category 4	1

The pressure ulcer numbers include all pressure ulcers that occured 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:	1.19

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 3 fall(s) that caused at least 'moderate' harm.

Severity	Number of falls
Moderate	3
Severe	0
Death	0

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Rate per 1,000 bed days:	0.15

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*	97.4	% recommended	This is based on 1862 responses.
A&E FFT Score	91.1	% recommended	This is based on 835 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 patients the following questions about their care in the National Inpatient Survey 2014:

Were you involved as much as you wanted to be in the decisions about your care and treatment?	7.6/10
If you were concerned or anxious about anything while you were in hospital, did you find a member of staff to talk to?	6.3/10
Were you given enough privacy when discussing your condition or treatment?	8.6/10
Did you get the care you felt you required when you needed it most?	8.9/10

A patient's story

A patient was discharged from one of the medical wards with end-stage cancer, and as such had various palliative care needs.
The lady was very keen to go home and her daughter was very supportive of her discharge home. Lots of the discharge process went very smoothly – the district nurse referral was done electronically, the correct medications were all sent from pharmacy including the anticipatory medications for end-of-life care. The lady and her daughter were very happy with all the planning that had been done on the ward.
Unfortunately, after the lady had gone home we discovered that some parts of the discharge had not gone at all as well as they should have done.
The palliative-care handover was not filled in and sent with the patient, and to the relevant healthcare professionals in the community. This handover form has a lot of information in it about plans for patients at the end of life and therefore there was a lack of clarity about what support had been planned.
Although the district nurse referral had been sent electronically, we had asked for district nurse support the following day, and unfortunately the district nursing team were not aware of the referral for forty-eight hours.
The lady had some injectable medications sent home with her, as they were prescribed, but we had forgotten to send a Sharps bin home with her so that the district nurses could dispose of any needles safely.
The lady had a catheter in place, and we did not send her home with a spare catheter (in case that one had become blocked or displaced) and also we did not send her home with enough spare leg/night bags.

Staff experience

We asked 5 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	100

3. IMPROVEMENT

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

As soon as we became aware of the issues, we took steps to rectify them. To help to prevent a recurrence on the ward – or elsewhere – we decided to share this story to highlight what improvements have been made and what steps should have been followed.
The palliative care hand-over from should be completed for all palliative patients. It is sent with the patient and a copy should be faxed to the out-of-hours district nursing service.
All district nurse referrals that require a visit within the first 24 hours after discharge should be made electronically with a supporting telephone call to the district nursing team (Halifax) or single point of access (Huddersfield).
All injectable medications that are ordered form pharmacy for a discharge are supplied with a sharps bin and staff are aware of the importance of ensuring the patient receives one.
All staff have been made aware of the need to send patients home with a spare catheter. Discharge packs are available on certain wards within the hospital for any areas to use and staff know that they should obtain one of these and send