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:

Northampton General Hospital NHS Trust

June 2015

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This report is based on information from April & May 2015. The information is presented in three key categories: safety, experience and improvement.

1. SAFETY

Staffing: Hard Truths

In 2014 NHS England and the CQC launched 'Hard Truths Commitment'. This work complimented the National Quality Board guidance to optimise nursing and midwifery staffing capacity and capability. Each month the Trust will publish data that demonstrates the planned versus actual number of staff on each shift for each day of the month. The Hard Truths data will be available on the Trust website & NHS Choices for the public to see. The data will be presented in a format that is user/public 'friendly' and be supported by a narrative to enable an understanding of the information provided.

The narrative will include the rationale for some wards having more or less staff on each shift in comparison to the planning staffing numbers and what plans were put in place to maintain patient safety.

Summary
Overall fill rate for April 2015 was 91%, the same as in March and in February it was 88%. In May this was 81% due to the change in the ward establishment increasing our planned hours for registered staff. Weekly monitoring of staffing fill rates has commenced in January; this information is triangulated with sickness, vacancies and recruitment that is planned each week. Weekly monitoring also allows for prospective reviews of the ward fill rates for the forthcoming weeks to enable movement of staff in advance to reduce unfilled shifts.

As experienced in previous months, across inpatient areas there was consistent use of additional Health Care Assistants to fulfil a number of roles including specialling vulnerable patients, escalation area resourcing and supporting the registered nurses in response to the increases in patient acuity and dependency.

Staffing shortfalls were a consequence of outstanding established vacancies, maternity / other long term leave plus unpredictable short term sickness which could not be filled with temporary staff. In these instances, safe staffing levels would have been reviewed twice daily, then maintained by internal staff movements from other ward areas. There were a number of new staff across many of our wards in April & May and due to them working in a supernumerary status the hours they work will not be reflected in the fill rate data.

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.

In April 93.3% patients experienced 'harm free care' in this Trust which is just above the national average of 93%. In May the number of patients that experienced 'harm free care' increased further to 93.9%. This was due to a slight decrease in the prevalence (the total number of patients with a pressure ulcer, who are in the hospital at the time of the audit) of pressure ulcers. Catheter-related urinary tract infections., Falls & harm from blood clots, remain at or below the national average. Progress is monitored through the Trust Quality Governance Committee.

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.

In April there were 30 hospital acquired pressure ulcers reported. There were 23 Grade 2 pressure ulcers and 7 grade 3 pressure ulcers. In May there were 26 hospital acquired pressure ulcers reported. There were 21 grade 2 pressure ulcers and 5 grade 3 pressure ulcers which is a slight improvement from the previous month.

These pressure ulcers have not been validated to confirm whether they were avoidable or unavoidable. There is still extensive work focusing on staff education & training in regards to the assessment of a pressure ulcer and the correct completion of documentation that will continue.

Health Care Associated Infections (HCAIs)

HCAIs are infections acquired as a result of healthcare interventions. *Clostridium difficile* (C.difficile) and *Meticillin-Resistant Staphylococcus Aureus* (MRSA) bacteraemia 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 do not normally affect healthy people, but because some antibiotics reduce 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 preventing and reducing 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 and the previous month, plus the improvement target and results for the year to date.

	C.difficile	MRSA
Number of infections April	**1**	
Number of infections May	**3**	
Improvement target for year to-date	**21**	**0**
Actual to-date	**4**	

Falls

To monitor improvement, even if the numbers of patients we care for increases or decreases we calculate our (in-patient) falls rate as 'falls/1000 bed days'. This allows us to monitor improvement over time, but cannot be used to compare us with other hospitals whose staff may report falls differently and their patients may be more or less vulnerable to falling than our patients. For example other hospitals may have younger or older populations who are more or less mobile or who are receiving treatment for different illnesses. Our falls/1000 bed days exclude falls caused by a cardiac or respiratory arrest or seizure (fit) and includes controlled/assisted falls (where patients are lowered to the floor by a staff member).

Falls/1000 bed days in May month (last month- April - 3.8)	4.59

This measure includes all falls in the hospital that resulted in injury, categorised as moderate, severe or death.

In April we reported no in-patient falls that caused at least 'moderate' harm. In May we reported 3 in-patient falls that caused at least 'moderate' harm. One patient sustained a fractured fibula (shin bone) whilst being lowered to the floor after losing their balance, one patient's wound reopened after falling and had to return to theatre to have this repaired, one patient fell and sustained a sub-arachnoid and sub-dural haemorrhage (bleed in brain).

Severity	Number of falls
Moderate	2

Severe	0
Death	1

2. EXPERIENCE

3. Patient Experience

The Friends and Family Test

The Friends and Family Test 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?

Satisfaction is measured through looking at the % of patients that would recommend against the % of patients that wouldn't. Percentages are tracked each month to identify any progress or areas were satisfaction has decreased.

Of most significance for patient satisfaction in April & May:

- Inpatients responses: 83% said they would recommend, and 10% stated they wouldn't in April. In May this improved slightly by 85% said they would recommend, and 7% stated they wouldn't
- Maternity responses: 93% said they would recommend, and 2% stated they wouldn't in April. In May 96% said they would recommend, and 2% stated they wouldn't which is an improvement on previous month
- Emergency Department responses: 85.3% said they would recommend, and 8.8% stated they wouldn't in April. In May this improved slightly to 90% said they would recommend, and 7% stated they wouldn't
- Paediatric wards and Day case areas: 87% said they would recommend, 6% stated they wouldn't in April. In May 85% said they would recommend, 8% stated they wouldn't
- Day Case areas: 89% said they would recommend, 5% said they wouldn't in April. In May this improved to 94% said they would recommend, 3% said they wouldn't
- All Outpatient areas: 91% said they would recommend, 4% said they wouldn't for April & May.

A Patient's Story

Background:

The son raised concerns about various aspects of care that his elderly mother had received, predominantly with regard to aspects of her discharge/transfer: Communication, time of night, clothing not suitable and left in a wheelchair for some considerable time before she was transferred to another area. Nursing and medical staff were unaware of the patient's transfer which had been initiated by the night team. The patient's zimmer frame was left on her previous ward leaving the patient without any means of mobility. The patients TTO's were late being delivered and her discharge

ended up being delayed as the discharging doctor was not aware that she had moved to our dedicated discharge area.

Outcome
As part of the on-going evaluation of our discharge process we acknowledge that the patients discharge planning should have been appropriately discussed with the patient's family, and staff caring for the patient, to ensure that the necessary arrangements were in place. The concerns regarding the lateness and appropriateness of the transfer and the attire that the patient was wearing have been addressed with all of the staff involved in the process to ensure that action is taken accordingly to prevent this from happening again. Through the sharing of this complaint with staff we have raised awareness to ensure that when a patient is moved outstanding reviews/tests must be communicated to the relevant staff to ensure that the patient has these completed prior to discharge.

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

Street Talk sessions

Over the past year the Trust has been focusing on a number of Patient Improvement projects, one of these projects is our Sleep Well Campaign. A recent internal survey has highlighted some improvements have been made but also some areas to focus upon. With this in mind the Trust held a 'Street Talk' session which is a new idea for the Trust. The 'Street Talks' are held in our Cyber Café which is on the main hospital corridor and it allows patients, visitors and staff to 'drop-in' to the Café to share their views on a designated topic.

Our Street Talk Sessions were held in the Cyber Café on the 17th of June by the Patient Experience & Engagement Lead and Organisational Development. The purpose was to collect views from staff and patients on how we can improve sleeping within the hospital. A later session was held to give night staff the opportunity to give their feedback, particularly on sleep. Both events were well attended which in turn has provided the team with key areas for further improvements.

Nursing & Midwifery Quality Dashboard

The Nursing &Midwifery Quality Dashboard Summary demonstrates an overall compliance score of 86% in April & 82% in May for the wards. The two indicators that reduced this month were associated with Falls Prevention assessment and Noise at Night.

Rachael Corser
Director of Nursing Midwifery & Patient Services (interim)

Supporting information

Board Papers: http://www.northamptongeneral.nhs.uk/AboutUs/Board/Board.aspx
Safer Staffing: http://www.northamptongeneral.nhs.uk/AboutUs/Safer-staffing.aspx