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:

Stockport NHS Foundation Trust

December 2013

Open and Honest Care at Stockport NHS Foundation Trust : December 2013

This report is based on information from December 2013. 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.

96% **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 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
Improvement target (year to date)	28.5	0
Actual to date	29	0

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.

This month 8 Grade 2 - Grade 4 pressure ulcers were acquired during hospital stays.

Severity	Number of pressure ulcers
Grade 2	4
Grade 3	4
Grade 4	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 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:	0.47

Falls

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

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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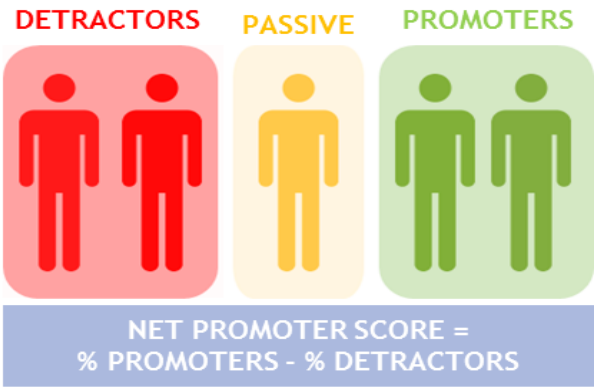
Rate per 1,000 bed days:	0.12

2. EXPERIENCE

To measure patient and staff experience we use a Net Promoter Score.

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.



From the answers given 3 groups of people can be distinguished:
Detractors - people who would probably not recommend you based on their experience, or couldn't say .
Passive - people who may recommend you but not strongly.
Promoters - people who have had an experience which they would definitely recommend to others.

This gives a score of between -100 and +100, with +100 being the best possible result.

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?*

The hospital had a score of 53 for the Friends and Family test*. This is based on 1480 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/

A patient's story

A patient experience story will be included from next month.

Staff experience

Staff experience feedback is not currently available but we are introducing this and will be reporting soon.

3. IMPROVEMENT

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

Eight patients developed pressure sores at Stepping Hill Hospital in December 2013. Four of these incidents are still under investigation.

Of the four cases that have been investigated, two of the sores were on the patients' heel and classified as device related pressure sores. One of the device related cases was caused following the application of plaster of Paris to a leg, and the other due to the application of a graduated compression stocking used to reduce the risk of a person developing deep vein thrombosis. The pressure sore third case developed in a very poorly patient who had fractured his hip, but was to unwell to undergo surgery and shortly afterwards died. The fourth pressure sore case was likely due to an epidural during labour.

The following improvements have recently been made.

1: Pressure ulcer assurance meetings started in October 2013. These are chaired by the director of nursing and all ward managers, who have had a pressure sore case occur in their ward in the last month, are invited. The purpose of these meetings is to identify what support clinical areas require in order to achieve an ongoing reduction in new pressure sores.

2: A new pressure sore screening tool has been introduced within A&E. This is to ensure that all patients who have been in the department for more than four hours have their risk of pressure damage identified and a plan of care for pressure sore prevention implemented

3: The graduated stocking pathway has been re-launched. Doctors and nurses are prompted to refer to this graduated stocking guidance at the point of prescribing the stocking. This is to ensure that stockings are required, applied appropriately and that staff check the stockings and patients skin during each shift.