The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Open and Honest Care in your Local Hospital

Open and Honest Care Report for:

The Robert Jones and Agnes Hunt Orthopaedic Hospital,
NHS Foundation Trust
Figure based on: April 2016

'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'

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1 Safety

1.1 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:

1. Pressure Ulcers
2. Falls
3. Blood Clots
4. 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 harm in the reported month.

96.99% 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/

1.2 Health Care Associated Infections (HCIs)

HCAIs are infections acquired as a result of healthcare interventions. Clostridium difficile (C.difficile) and methicillin-resistant staphylococcus aureus (MRSA) bacteraemia are nationally monitored as we are trying to reduce the incidence of these infections. 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. This bacterium 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 are 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 MRSA bacteraemia infections and are working towards reducing C.difficile infections; 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	0	0
Annual Target (April 15/16)	2	0
Actual to date	0	0

For more information please visit:
www.rjah.nhs.uk/Our-Services/Infection-Prevention-and-Control-at-RJAH.aspx

1.3 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. 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 **1** grade 1, **0** grade 2, **0** grade 3 and 0 grade 4 pressure ulcers were acquired during hospital stays

Severity	Number of pressure ulcers
Grade 1	**1**
Grade 2	**0**
Grade 3	**0**
Grade 4	**0**

1.4 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 1 fall(s) that caused at least 'moderate' harm

Severity	Number of falls
Moderate	**1**
Severe	**0**
Death	**0**

1.5 Safe Staffing

Guidelines recently produced by the National Institute for Health & Care Excellence (NICE) make recommendations that focus on safe nursing for adult wards in acute hospitals and maternity settings. As part of the guidance we are required to publish monthly reports showing the registered nurses/midwives and unregistered nurses we have working in each area. The information included in the report shows the monthly planned staffing hours in comparison with the monthly actual staffing hours worked on each ward and/or the percentage of shifts meeting the safe staffing guidelines.

In order to view our reports please visit:
www.rjah.nhs.uk/About-Us/Publications/Corporate-Documents/Safe-Staffing-Levels.aspx

2 Experience

To measure patient and staff experience we use a variety of methods. 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.

2.1 Patient Experience

2.1.1 The Friends and Family Test

The Friends and Family Test (FFT) requires all patients to be asked, at periodic points or following discharge, 'How likely are you to recommend our ward/ service/organisation to friends and family if they needed similar care or treatment?'

This month 99.5% of our inpatients said they would recommend our services. This is based on a total of 380 responses received; this is a response rate of 33.5%.

*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 39 patients the following questions about their care:

	% Patient Responses
1. Did you always receive the menu choice you requested	**80%**
2. Have you felt well cared for by nursing staff during your stay	**96%**
3. During your stay, have you ever been disturbed by a lot of noise at night	**16%**
4. Have you always been kept informed and involved in the decisions about your care as much as you wanted to be, by health care professionals	**68%**
5. Percentage of call bells answered within 5 minutes	**87%**
6. Did a doctor spend enough time with you to answer all your questions after your operation	**96%**

2.2 A Patient's Story –

Patient on Powys Ward, 14.06.2016
It all started whilst on holiday in our caravan at Talybont near Barmouth in September 2015. I fell and broke the femur in my left hip. I was taken to Bangor Hospital, where they replaced the broken hip. Unfortunately infection set in and after two to three attempts to clear the infection I was sent to Shrewsbury Hospital under the care of Mr Burston. That was mid-November.
After about three weeks I was sent home where I remained until I fell and broke my right hip in mid-January 2016.

My right hip repaired very well without any problem and I was sent home again two to three weeks later. I visited Mr Burston's clinic a few times, where I complained of increasing pain in my left hip. X-rays showed a problem and eventually it was decided to operate again.

I was sent to Gobowen in early May 2016, only to develop Pneumonia. I was sent back to Shrewsbury and in mid-May 2016 was returned to Gobowen, Mr Burston carried out a long and arduous operation, determined to clear the infection. It is now three weeks since the operation and I am improving daily.
I had a bag on my left thigh to catch the infected discharge from my wound and expected to have it for life.

I now have no discharge bag and hopefully won't need one. I cannot thank the nurses and staff enough for their kindness, consideration and cheerful care whilst I have been on Powys Ward. They have kept me going through all adversity. They are truly fantastic.

Thank you again and again. And to Mr Burston, thank you for your skill, determination and dedication. I will always remember.

2.3 Staff Experience

2.3.1 The Friends and Family Test

The Friends and Family Test (FFT) requires staff to be asked, at periodic points: How likely are you to recommend our organisation to friends and family if they needed care or treatment?' and 'How likely are you to recommend our organisation to friends and family as a place to work?'

For April 2016 – June 2016, 98% of staff said that they would recommend our organisation to friends and family if they needed care and treatment. This is based on 206 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 206 staff the following questions

	% Recommended
1. Would you recommend this ward/unit as a place to work?	**78%**

2.3.2 A Staff Story -

My story occurred whilst I was working on a surgical ward but not my usual place of work. I had been approached by the Ward Manager, the previous day, to nurse a male patient who was "very poorly." It had been identified that he required more intervention due to his deteriorating condition. I also work in a Hospice and have experience of palliative care.

That afternoon, I introduced myself to the patient and explained that I would be nursing him the following day. The Ward Manager provided me with his medical history. The procedure for which the patient had been admitted to the RJAH had been successful, but because of his deteriorating health he needed more nursing intervention. The question was should he be moved to a more suitable place to be cared for? Where was his preference?

I arrived on the ward the following day and was told I had a bay of patients although I had understood I would be caring for a gentleman 1:1. I questioned this but due to staffing levels and skill mix there seemed little alternative. I did what I could during the shift but have spent time reflecting since, trying to identify, what, if anything could have been done in the delivery of care. Is the Trust an appropriate place to provide end of life care and what procedures can be identified and established to improve it?

The morning began with a Doctor's round with discussion outside the patient's side room; I was told this was to prevent disturbing the patient. Following the review it was decided that 'rehabilitation' was the most appropriate way forward for the patient.

Later that afternoon, the only time the patient consented to being turned, I learnt he was so weak and uncomfortable he was unable to assist with lifting his leg. At this point I wondered whether the review in the morning was accurate. Was the patient suitable for rehab? However, I later learnt his

deterioration had been rapid. Regular observations were completed and the Early Warning Score was suggesting more regular observations were required. Clinical rational would indicate this was not necessary. Were regular observations required at all? Was this the Medical or Surgical team decision? Who was taking responsibility of this patient? Where was the clear documentation to support Staff? The patient required oxygen to maintain his saturations but would only accept this delivered through nasal specs not a mask. Unfortunately the nasal specs were causing the possible development of a pressure sore, but an oxygen mask was not an option. Without oxygen he would have developed hypoxia and deteriorate further. It actually took until 21.30pm to get the oxygen prescribed along with acceptable parameters. Could the support of the Nursing staff have improved that shift?

It was also identified that the patient had made an informed choice not to take his regular medication. This included Opiates. Could another way of administration been identified to deliver this medication? Had it even been considered? For example, a syringe drive, would not only have given a constant delivery of analgesia and better pain control, but would also have empowered the patient by allowing decisions in his care. This matter could have been decided on the ward round yet there had been no communication with the patient.

I spent considerable time during the shift speaking to the patient's relatives, his Clinical Nurse Specialist, his oncologist and the local Hospice gathering information to help decide where the most appropriate place would be for this patient during his final days. The patient had expressed he wanted to die in the Hospice but had agreed if it wasn't possible then a Nursing home. His relatives felt the Hospice would be the best place. His Clinical nurse Specialist knew this information but had not been informed that he was an inpatient at the Trust. His oncologist at the Royal Shrewsbury Hospital was expecting him for Chemotherapy that afternoon (information that we had not been given). However, it was considered the patient was not well enough for this. I contacted the Hospice to enquire about bed allocation. I was informed of protocol and that discussions were always consultant to consultant.

Apparently the previous day they had been informed by Trust that the patient was scheduled for rehabilitation. I explained the patient had deteriorated and although I appreciated the process for referral, I was enquiring about bed availability to be able to give the Doctors in the Trust up-to-date information for their consideration. Following my phone call the Clinical nurse Specialist, who knew the patient very well, had already started the process to secure a hospice bed. Only later did I learn that my conversation was with an inappropriate Hospice staff member (identified and addressed within the Hospice) with the result that a bed was available the following day for the patient. The Trust was apparently only advised of this 4 days later and the patient was allocated a Hospice bed. He was transferred and 15hrs later, he passed away peacefully. What happened to Multi - Disciplinary Team communication? Could this have been improved?

So, as an Orthopaedic Specialist Trust, what can we do, to provide a high standard of End of Life Care, when it is needed? I walked into the ward that morning believing I could make a positive difference for the patient - offering good palliative care, by sharing my knowledge of this type of care, with the help and support of other staff. When I walked off the ward I had to question my contribution and especially questioning, as a Trust, how we can improve end-of-life care. Any significant difference in the delivery of care I could have given would have required a 1:1 situation throughout the shift, as identified the previous day. It highlighted the power and importance of communication. In the circumstances I felt I did my best.

Having reflected on this with my senior Nurse colleagues, I have been asked by Deputy Director of Nursing Julie Roberts to lead on End of Life Care and incorporate this within the Deteriorating patient group. This I believe will allow for future developments within the Trust.

3 Improvement

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

Following a Duty of Candour Investigation by Theatre Sister, dressings will be cut off with plastic ended scissors rather than metal-ended scissors and bandages will be unwound not cut.