NHS North West Transparency Project

Reduction of Pressure Ulcers and Falls - How have we been doing?
Patient and Staff Experience- What have they been saying?

We are one of a number of NHS organisations who want to be open and transparent with our patients. This is how a modern NHS hospital should be – open and accountable, to the public and patients, driving improvements in care. As a member of the 'Transparency Project' we continue to work with patients and staff to further reduce the harm that patients sometimes experience when they are in our care, and we have made a commitment to publish a set of patient outcomes, patient experience and staff experience measures. Each month we collaborate with other care providers to share what we have learned, and to use this to identify where changes to improve care can be made.

This is the sixth month that the Trust has published data on pressure ulcers, falls and results of patient and staff experience surveys. We are continuing to work on the areas we identified as improvement work last month.

Patient experience is a vital source of information that we can use to help improve the care to our patients. To build on this we carry out a monthly patient experience audit called the '100 voices'. Through this we seek to talk to as many patients as possible about their experience of care. We encourage office based staff to support this initiative by giving an hour a month, to take part in the patient experience initiative. This provides us with very powerful feedback, allowing us to take forward any improvement actions.

In July we cared for 7216 patients	4 patients suffered a fall resulting in moderate, severe and fatal harm in our care	4 patients suffered a pressure ulcer in our care – 2 x category 2, a category 3 and a category 4

In July there were unfortunately four patients who sustained a pressure ulcer and four patients who sustained harm as a result of a fall. Work is underway to understand how the harms occurred in July, and if anything more could have been done to prevent them. The learning from these investigations will be shared in next month's report.

Sadly, one patient who sustained a fall has died as a result of this, from a head injury. From our initial review of the circumstances, everything possible had been done by the staff to prevent the fall. An inquest into the cause of death has yet to be conducted. We will share the outcome of the inquest once this has taken place.

On average, approximately thirty patients a year die in hospital from a minor head injury as a result of a fall. Frail, older people are more at risk of such injuries.

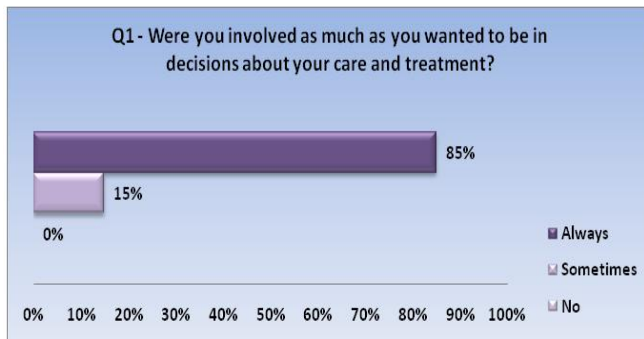
Following our review of the two patients who sustained a fall in June, it is pleasing to note that all preventative measures to avoid a fall had been put in place and nothing further could have been done to prevent the falls happening.

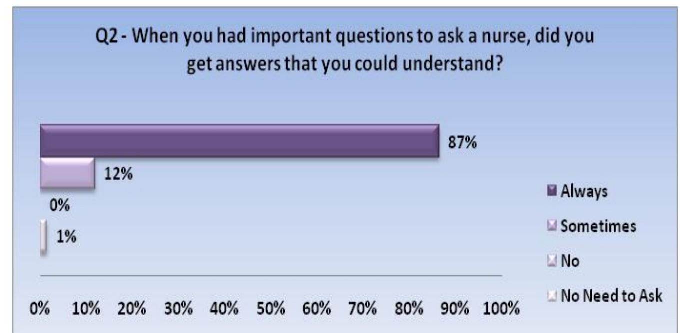
From the review of the two patients who sustained a pressure ulcer in June, all measures had been put in place. Unfortunately, due to the medical condition of both patients, the pressure ulcers were not preventable.

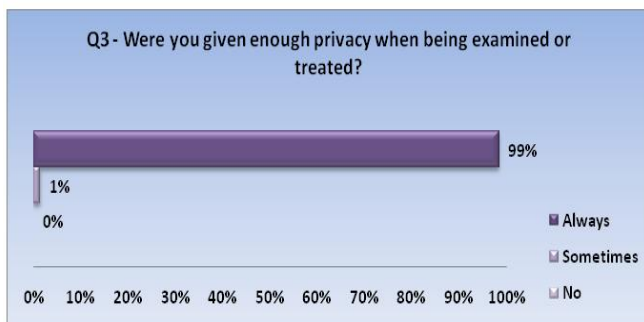
In the areas where harms occurred this is what patients said:

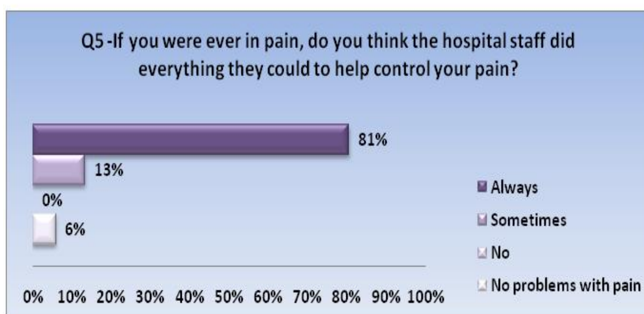
July's data overall shows an increase in patient satisfaction in six of the areas. There were two very slight decreases in patient satisfaction in question 5 and in question 7. These are important to us and we continually measure these very important aspects of patient satisfaction as part of our monthly patient '100 voices' survey.

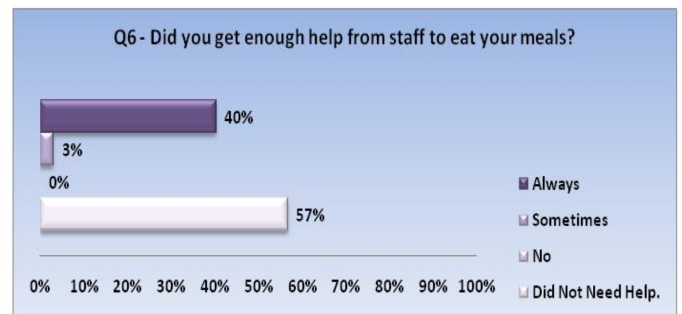
It must be emphasised that the number of patients surveyed is very small and may not necessarily be statistically representative.

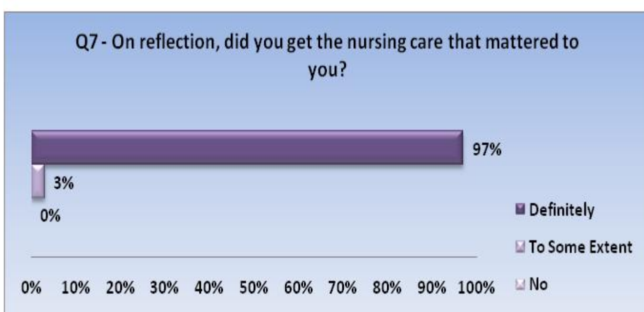


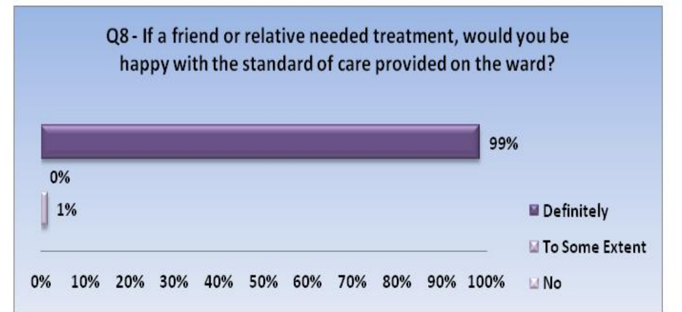






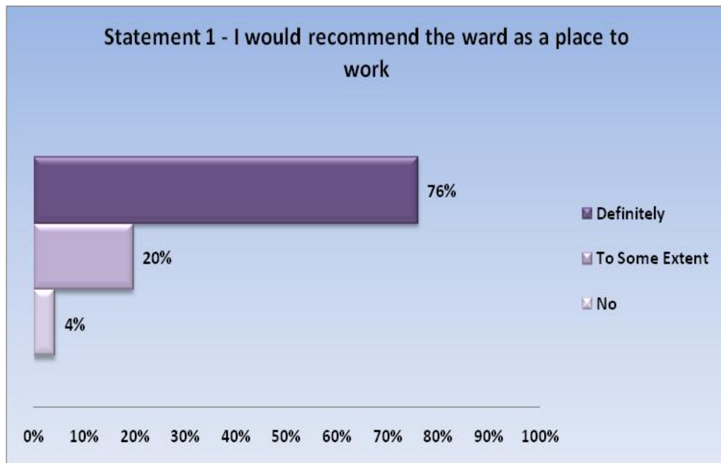


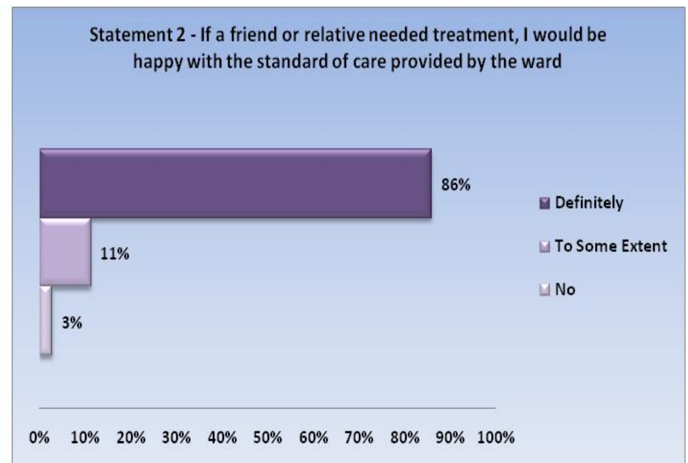


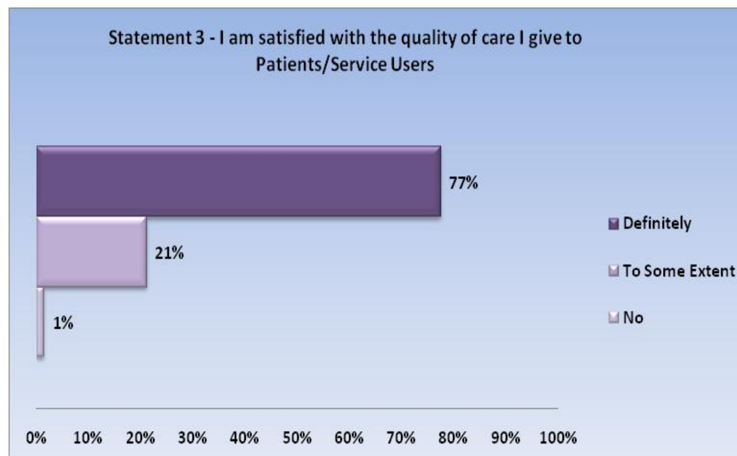


In the areas where the harms occurred this is what the Nurses said about the care they have provided:

July's data shows a slight decrease in staff satisfaction compared to June's data. This may be as a result of some of the adverse media publicity. Staff still report they are definitely, or to some extent satisfied, about the care they have provided.



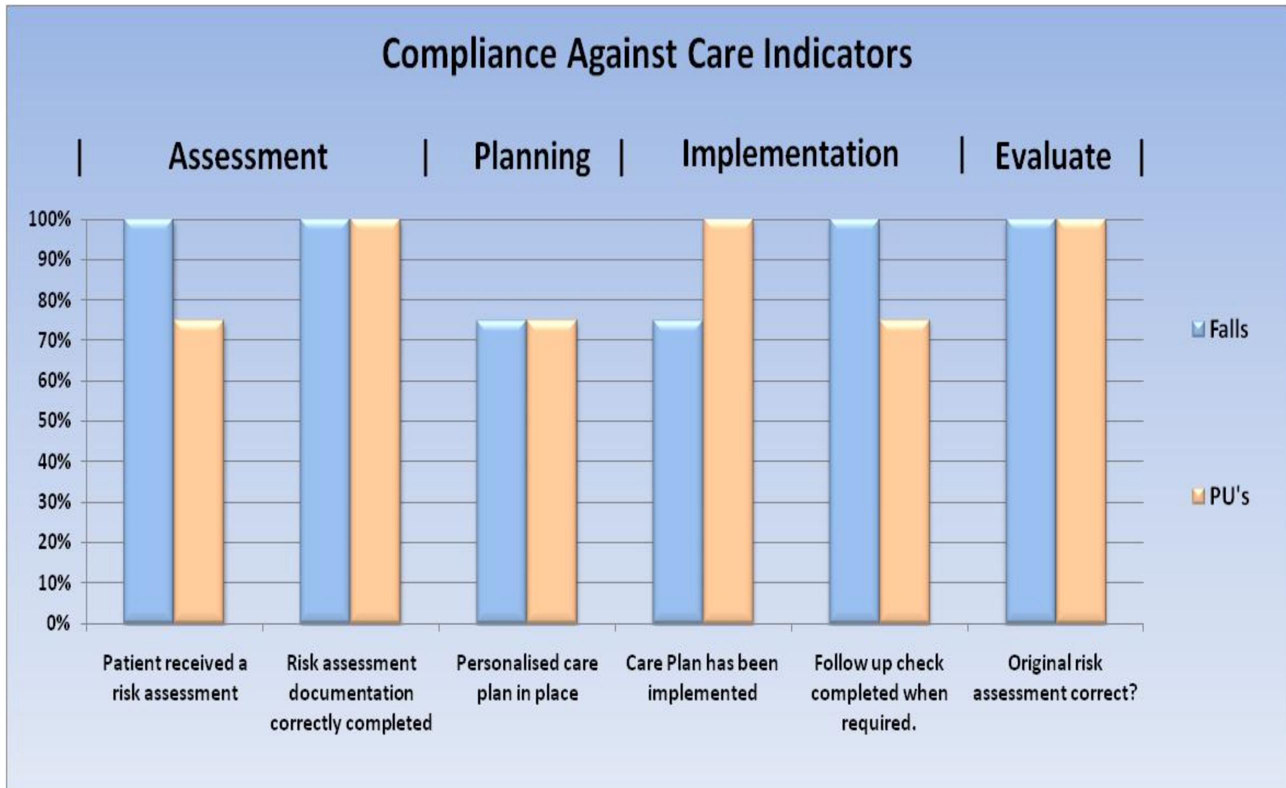




What did we learn about the care we have provided to patients?

There has been an increase in all the nursing care indicators for falls which resulted in harm. However, there has been a slight decrease in the care indicators for the patients who suffered harm as a result of a pressure ulcer.

This is a high priority area for continued improvements and a number of briefings have been taken place with our staff.



You said-We did!

We are pleased to report that as part of our monthly ‘100 Voices’ patient satisfaction surveys a number of our Trust Governors and local LINKS Team are now helping us to undertake the audit of our patients.