EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST

REPORT TO:	**BOARD OF DIRECTORS**
DATE:	**26 SEPTEMBER 2014**
SUBJECT:	**PATIENT STORY**
REPORT FROM:	**CHIEF NURSE & DIRECTOR OF QUALITY & OPERATIONS, DEPUTY CHIEF EXECUTIVE**
PURPOSE:	**Discussion** **Information**

CONTEXT / REVIEW HISTORY / STAKEHOLDER ENGAGEMENT

The Board of Directors have been using patient stories to understand from the perspective of a patient and/or a carer about the experiences of using our services.

Patient stories are a key feature of our ambition to revolutionise patient and customer experience. Capturing and triangulating intelligence pertaining to patient and carer experience from a variety of different sources will enable us to better understand the experiences of those who use our services.

Patient stories provide a focus on how, through listening and learning from the patient voice, we can continually improve the quality of services and transform patient and carer experience.

SUMMARY

This month's story relates to the experience of a couple during the birth of their first child. What should have been a joyful experience for them was distressing and upsetting due to their privacy and dignity not being adequately maintained, lack of information around expectations, unprofessional behaviour of some staff and poor pain control. Since this event, the family have met with Matron Harris and specific actions have been put in place that address the issues raised.

RECOMMENDATIONS:

The Board of Directors are invited to note the key themes of this story and the actions in place to prevent reoccurrence.

NEXT STEPS:

None.

IMPACT ON TRUST'S STRATEGIC OBJECTIVES:

Improving patient experience and satisfaction with the outcomes of care are essential elements of our strategic objectives.

LINKS TO BOARD ASSURANCE FRAMEWORK:

This story links to AO1 of the BAF: Implement the third year of the Trust's Quality Strategy demonstrating improvements in Patient Safety, Clinical Outcomes and Patient Experience / Person Centred Care.

IDENTIFIED RISKS AND RISK MANAGEMENT ACTIONS:

The risk identified in this story is poor patient experience. Specific actions have been put in place that are detailed in the story.

FINANCIAL AND RESOURCE IMPLICATIONS:

None

LEGAL IMPLICATIONS / IMPACT ON THE PUBLIC SECTOR EQUALITY DUTY:

None

PROFESSIONAL ADVICE TAKEN ON ANY NOVEL OR CONTENTIOUS ISSUES:

None

ACTION REQUIRED:

(a) Discuss and agree recommendations.
(b) To note

CONSEQUENCES OF NOT TAKING ACTION:

If we do not learn from events such as these there is an increased risk of further occurrences which may adversely affect both patient experience and outcomes.

Board of Directors
Patient Experience Story
September 2014

Introduction and Background
This month's story relates to the experiences of a couple's experience during the birth of their first child. What should have been a joyful experience for them was distressing and upsetting due to their privacy and dignity not being adequately maintained, lack of information around expectations, unprofessional behaviour of some staff and poor pain control. Since this event, the family have met with Matron Harris and specific actions have been put in place that address the issues raised.

The Patient Story
The story begins with a very anxious mother beginning her contractions at home. She and her husband were unsure what they should do next, so they contacted the Labour ward for advice. They were advised to monitor the contractions and when their frequency reached one minute and thirty seconds in length and were occurring two to three minutes apart, they were advised to attend the Hospital. As advised, this is indeed what they proceeded to do. On arrival Mr H's wife was in constant pain and her contractions were very close together, a minute or two apart. Mrs H was examined and she was found to be in the very early stages of labour so the couple were sent home. They were only at home for half an hour when her waters broke. This was very distressing, and the couple felt unsure what was happening and why they had been sent home. They returned to the Hospital immediately.

On Labour Ward Mrs H was examined again and it was found that the baby was becoming distressed. A further examination of Mrs H showed that she was fully dilated, ready to give birth. The midwife on this shift had advised to allow Mrs H to push and to call the doctor within an hour if the baby had not been born by this time. An hour passed and no doctor attended. Eventually a doctor arrived and asked Mrs H to stop pushing as the baby needed help to be delivered. At this stage, Mrs H had not received effective pain relief. She waited an hour for adequate pain relief whilst the keys for the controlled drug cupboard were located.

The couple were taken to the Operating Theatre for the delivery. When they arrived, the staff were arguing because nobody had been bleeped. This continued for 15 – 20 minutes and Mr and Mrs H felt very stressed; which was not noticed by anybody. Happily their daughter was born safely and taken by the Midwives and Obstetrician for checking that she was healthy as is routinely carried out. Unfortunately at this point, Mrs H was left fully exposed. The staff started cleaning the Theatre and clearing up around her, still arguing.

Their care on the Postnatal Ward was also upsetting for Mrs H. She said that the staff mislaid her notes causing delays in her discharge, she was not offered adequate pain relief, and on a number of occasions the catering and cleaning staff would enter the bed space when the curtains were drawn without checking first that it was convenient to do so. This happened on a couple of occasions where Mrs H was exposed or being examined. Both Mr and Mrs H continued to feel very stressed and all they wanted to do was go home. They said that the whole experience, which should have been a joyous event turned out for them to be a distressing experience.

It is a story that raises a number of care issues. These include couples understanding what to expect during labour; receiving clear instructions from the staff about what to do and when after contractions commence; ensuring that a thorough examination is carried out when a mother presents in the early stages of labour; ensuring adequate pain relief is administered; preserving people's dignity at all time and ensuring the highest of professional behaviour standards by staff. A meeting

was arranged with the family who met with Matron Lindis Harris to run through their concerns. A number of learning points were discussed.

Learning and Actions
The team listened carefully to the family's experience and apologies were given. A number of actions have been put in place to ensure a similar incident does not happen again. These are:

- All women telephoning to report spontaneous rupture of membranes are always invited in for a full assessment;
- Education and training has been provided for all midwives regarding advice given to women over the telephone to ensure consistency;
- Discussions have taken place with the consultant and the Theatre Matron regarding the unprofessional behaviour of the staff. In addition the Theatre Matron for QEQM is leading a piece of work around making the Trust values and behaviours a reality to staff;
- The controlled drug keys for Labour Ward are now carried by the Shift Coordinator and handed over at the start of shift changes;
- The discharge process on the Postnatal Ward is being reviewed due to the long waiting times for patients;
- Housekeepers have been informed to knock before entering rooms on the ward to ensure privacy and dignity for all patients.

Summary
A couple expecting their first child were admitted to the Labour Ward. They experienced delays in receiving pain relief; they witnessed staff arguing in front of them for 15-20 minutes; Mrs H was left exposed and feeling embarrassed both in the Theatre Department and also in the Ward. They also experienced a delayed discharge process due to their notes being mislaid. Following a meeting with the Matron, a number of actions detailed above have been implemented to prevent a similar experience happening for another family.