EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST

REPORT TO:	**BOARD OF DIRECTORS – 25 APRIL 2014**
SUBJECT:	**PATIENT STORY**
REPORT FROM:	**CHIEF NURSE AND DIRECTOR OF QUALITY & OPERATIONS**
PURPOSE:	**FOR INFORMATION AND DISCUSSION**

CONTEXT/REVIEW HISTORY
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 concerns the care of a 91 year old lady who fell at home and fractured her hip. She underwent two admissions to the hospital where her care lacked in several areas. These included:

- Poor communication of care and treatment plans;
- Lack of involvement of the family with decision-making;
- Care without compassion and empathy;
- Poor attitude of some staff;
- Poor discharge planning.

The Divisions concerned have undertaken a number of actions to make improvements that include:

- Meeting to discuss in detail the emotions experienced by this family;
- Raising awareness among the staff of how patients and relatives feel when they do not feel involved in care or feel the care is not empathetic and compassionate;
- Setting the behaviour standards expected and monitoring them through appraisal;
- Working on improvements on discharge planning;
- Partaking in the Ward Peer Review Programme that focuses on person-centred care;
- Taking an active role in the 'We Care' Campaign.

This story has learning that is relevant to all wards and departments. This shared learning will improve the quality of care and experience that our patients and their family and friends deserve and expect.

IMPACT ON TRUST'S STRATEGIC OBJECTIVES:

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

FINANCIAL IMPLICATIONS:
None

LEGAL IMPLICATIONS / IMPACT ON THE PUBLIC SECTOR EQUALITY DUTY:
None

PROFESSIONAL ADVICE TAKEN ON ANY NOVEL OR CONTENTIOUS ISSUES:
None

BOARD ACTION REQUIRED:

(a) to note the report
(b) to discuss and determine actions as appropriate

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
April 2014

Introduction

This month's story concerns the care of a 91 year old lady (Mrs T) who fell at home and fractured her hip. She was a lady who lived with dementia that had become worse, but she was able to communicate with her family. She was finding communication more difficult in recent times due to also becoming deaf. Her mobility was limited, but she was able to maintain a level of mobility using a zimmer frame. She was cared for by her family at home.

Mrs T was admitted to the Emergency Department (ED) at the Queen Elizabeth Queen Mother Hospital at Margate (QEQM) in early October 2013. This story describes a number of issues that resulted in a poor experience for not only Mrs T, but also her family. This story is told from the perspective of her son-in-law. It reveals poor communication to the family about Mrs T's care plans and treatment plans; a lack of involvement of the family and failure to check Mrs T's and the family's understanding of interventions and the decisions made by the team; a lack of care, compassion and respect by some members of the nursing staff; poor attitude of some staff; and poor discharge planning.

A number of lessons learned have been identified and actions put in place to address the issues raised by the family.

The Patient Story

This story is written from the perspective of Mrs T's son-in-law, Mr R. It describes the care in the ward, community support and the patient's readmission. It also describes further distress for the family after Mrs T had died.

On the 4th October 2013 Mr R's mother-in-law tripped over a carpet at home using her zimmer frame and broke her hip. She had her operation on the 5th October and was discharged back home on the 9th October 2013. Mr R reports that this quick discharge was as a result of the family being asked by the nurse if Mrs T was medically fit and could she be discharged home. The family also had concerns that their mother was not receiving the help she required at mealtimes. They describe one mealtime where one of the staff took a knife from their mother and put a spoon down on the table saying that she must use the spoon, but did not assist her when she opened her mouth to be fed. The staff member is reported as having been very abrupt with Mrs T saying that she must feed herself. The family felt fearful in challenging this in case it would affect how their mother may be treated as a result. On day three of Mrs T's stay, her Grandson visited when photographs of Mrs T's heel pressure ulcer were being taken. Although he was told of the purpose of this, it took him by surprise, and he was unaware that this was routine practice. The explanation he received was only that we need to record pressure ulcers.

Mrs T was discharged home on the 9th October 2013. The family report that Mrs T's slipper was adhered to her heel wound and that she had a small wound on her left heel and a sacral pressure ulcer. The notes showed that there had been no documentation of these ulcers on arrival in the A&E, although the ward documentation did show a thorough assessment and also that a Nimbus pressure relieving mattress was made available to Mrs T. The SKINs bundle was also implemented and she was reviewed by the Tissue Viability Team. However, the family felt that it might have been more helpful to them if this had been explained especially given their carer role and their in-depth knowledge of their mother's needs. Pressure relieving equipment was ordered for her discharge home.

Mrs T remained at home under the care of the District Nurses, Physiotherapists and Speech and Language Therapists until Sunday 28th December 2013. Over this period of time Mrs T's pressure ulcers worsened and she also developed a urinary tract infection. The family called 111 and their mother was transferred to QEQM ED by ambulance with suspected sepsis. After a 4 hour wait to see a Doctor the care then offered in the ED was described by the family as brilliant, with a very caring and proactive Doctor who treated their mother. Mrs T was then transferred to the Clinical Decision Unit (CDU). Here they found that the care was less caring and effective. The family described Mrs T as being left for a long period of time on a commode. This compromised her dignity and was upsetting for the family who were willing to assist as they usually did when at home. Mrs T was also made 'nil by mouth', but this wasn't explained properly to the family. When they asked if they could give their mother a drink of water, the nurse was apparently very rude stating that she could not have a drink until properly assessed. The family lost confidence in the care on the ward to the extent they were not sure she was even receiving her intravenous antibiotics.

Mrs T was transferred to Deal Ward at QEQM where the family said the staff on this ward were 'brilliant'. Sadly, Mrs T's condition began to deteriorate as she had developed a chest infection. The family were called in to the ward to be with their mother. It was at this point, that the question of whether Mrs T should be resuscitated was raised should she deteriorate further. The family said that this was communicated in a very clumsy and blunt manner. It appeared time was not taken to explain this in detail to them. Later that day, the family were called back in to the hospital after an unsuccessful resuscitation attempt.

After Mrs T's death Mr and Mrs R contacted the Patient Experience Team to raise another concern. They had learned when they instructed the Undertakers to collect their late mother's body from the hospital, that she had been moved from the QEQM to William Harvey Hospital's mortuary. Not only were they not informed of this by us, but they also had to meet the additional Undertaker cost of the journey back to Margate from Ashford.

Mr R contacted the Trust in January raising the concerns described above. Despite the fact that the family's experience of the care that they and their mother received with us lacked in several areas, they also acknowledged those members of staff who did provide care in a compassionate way.

Themes and Learning Outcomes
The themes in this story include:

- Poor communication of care and treatment plans;
- Lack of involvement of the family with decision-making;
- Care without compassion and empathy;
- Poor attitude of some staff;
- Poor discharge planning.

Since this complaint the Divisions have undertaken a number of areas of learning and actions. The wards involved have met to discuss in detail the emotions experienced by this family. Raising awareness among the staff of how patients and relatives feel and what their experiences are has been shared among the teams. The staff members involved in this case have been managed and expectations made very clear to everyone. To monitor and receive feedback regarding involvement in decision-making, all wards invite a selection of patients to complete a survey on the iPADs while they are in hospital. This includes a question about involvement in

decisions regarding their care. Most patients state that they do feel involved either to some extent or definitely (21.5%, 74.2% respectively), the remainder (4.24%) do not feel as involved as they would want to (March 2014 data).

To monitor improvements in communication and attitude the Trust values have been incorporated into staff appraisals in order to set in place the standard of behaviour expected of all staff in the Divisions. In order to review person-centred care in our wards, the Matrons have commenced a Trust wide peer review system where every ward and department will be regularly reviewed. The review seeks to ascertain how person-centred a ward is by undertaking a period of observation for a morning of the care taking place. In addition the peer review team undertake a small number of interviews with patients. The methods include using emotional touch-points to gather feedback on patient experience and to make improvements or celebrate good practice. The team reviewing the ward includes a range of professionals of differing levels of seniority, and staff from clinical and non-clinical backgrounds. The team also includes a patient representative.

The discharge planning process continues to be an area that the Divisions are actively working on to improve. Integration of care and planning care across agencies is in progress. New ward rounds that include colleagues from the community and social services have commenced in order to facilitate a smooth as possible transition from the hospital to the patient's place of residence. The Service Improvement Team are actively involved in developing this aspect of the patient journey.

The area of concern relating to Mrs T's body being moved to another site was investigated and was due to capacity issues at the QEQM Mortuary. The family are seeking redress for these costs which will be considered at the Redress Panel. An apology for this experience has been made to the family.

Summary

This story describes the experience of an elderly patient who underwent two admissions to the Trust. The story reveals communication and attitude problems that adversely affected the quality of care the patient and family received. This included some staff practising in a way that did not demonstrate compassion and empathy. Their experience was compounded by poor discharge planning after the first admission and an upsetting event where their deceased mother was moved to another hospital site without them being informed. The lessons learned from this case have been shared in the Divisions, with actions and improvements implemented. These include raising awareness among staff around attitude and communication; setting the standards of behaviour among staff; working on improvements in discharge planning and being actively involved in implementing the 'We Care' campaign.