

Trust Board Meeting: Wednesday 13 November 2013

TB2013.119

Title	Patient Story – Emergency Department
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Status	For Information
History	Patient stories are regularly presented to Trust Board and Quality Committee.

Board Lead(s)	Ms Liz Wright, Acting Chief Nurse			
Key purpose	Strategy	Assurance	Policy	Performance

Summary

1	This paper presents the story of a patient with Dementia and their experience of the Emergency Department (ED), from his wife's perspective.
2	The patient presented at the ED following a seizure at the care home where he lives.
3	Issues were identified with communication between staff and the patient with severe dementia, as well as with his wife and the care home. This contributed to the levels of this patient's and his wife's distress while undergoing assessment and treatment in the ED.
4	This story has been communicated to and discussed with staff in the ED, to raise awareness and improve understanding of the care for patients with dementia, and their carers.
Recommendation	
The Trust Board is asked to note the patient story.	

1. Introduction

- 1.1. The presentation of this story at Trust Board has been discussed with the patient's wife, who has power of attorney, and she is keen for the story to be shared (as the patient is unable to give his consent, all identifying details have been removed).
- 1.2. The story is from the patient's wife's perspective and is provided in appendix 1.
- 1.3. The patient's story has been shared with the medical and nursing staff in the Emergency Department (ED) and at the ED Clinical Governance meeting in October 2013, and will be discussed at the directorate governance meeting in December 2013 to plan service improvements.
- 1.4. This patient attended the ED with a scalp wound after a fall.
- 1.5. This patient is resident in a care home due to his advanced dementia.

2. Rationale for selection

- 2.1. This story was selected as part of the series of patient story presentations to the Trust Board and Quality Committee.
- 2.2. This story illustrates the challenges of providing emergency care for patients with dementia, who are likely to become disoriented in unfamiliar clinical environments. This presents distractions to patients as the environment is over stimulating, due to noise, bright lights and unfamiliar people.
- 2.3. This story illustrates problems and deficits surrounding communication with vulnerable patients, their carers or family.

3. Key issues highlighted and actions

- 3.1. Issues highlighted by the story:

The environment was unsettling.

- 3.2. The environment was busy, bright and noisy, which was unsettling for this patient, who tends to be disorientated in unfamiliar settings. Due to the nature of the ED, it is necessary to have a high level of monitoring, which makes it difficult to adapt the environment for patients who are distressed by noise. Solutions to improve this are being implemented in the action plan.

Communication with nurses and doctors.

- 3.3. The patient's wife felt that the nurse making the initial assessment did not listen to background information about the patient. This may have affected the way the clinical staff managed the patient's care, in particular the decision to introduce a urinary catheter, which he subsequently pulled out, when there were other options available to manage incontinence associated with seizures. Senior nurses within the department have acknowledged the importance of listening to background information provided by carers. In initial assessments, ED nurses are often required to focus on identifying physical healthcare needs that require urgent medical attention. In this instance, the junior nurse missed the opportunity to obtain important background information. Decisions about urinary catheter insertion in

patients with complex physical or psychological needs, are made by a senior member of the medical staff, preferably a consultant.

Reasons for restraint were not explained initially

3.4. Security was called to help maintain this patient's safety, as he was distressed, and he was at risk of hurting himself if left unrestrained. Security staff receive thorough training on safely restraining patients, which is updated every 6 months. In cases where physical restraint of a patient with dementia is required, security staff first discuss the situation with the clinical staff and family and ensure an assessment of mental capacity has been made. Following this, they assess the situation and work with the clinical staff to use the least restrictive option to keep the patient safe from injury: using verbal means initially, followed by physical restraint where necessary. Two security staff were present for most of the time that this patient was in the Emergency Department. Staff had not explained to the patient's wife or made clear at an early stage that this action was necessary for the patient's best interests.

Waiting

3.5. The patient's wife felt that there was a "lot of waiting around", which was acknowledged by the senior nurses listening to the story (the patient spent 11 hours in the ED). The focus of the patient's assessment was to establish whether the patient had had a seizure, which had caused him to fall and cut his forehead, or whether he had sustained a brain injury, which caused the seizure. This process of assessment was complicated by his continued seizures within the department. This necessitated care in the resuscitation room, for his safety, close monitoring, and administration of multiple medicines to control the seizures. The last seizure was eight hours after admission to the department.

3.6. There was a prolonged wait for transport to the care home, as a decision was made that two paramedics were needed to support the patient, as he was so distressed. The wait occurred due to the need for two paramedics to become available.

Communication between the Emergency Department and the care home

3.7. The doctor who had primary responsibility for the patient telephoned the GP to provide information about the ED visit and request a care home visit, or telephone call the following morning to monitor the patient's progress. The GP confirmed that a home visit would be arranged the following day. The doctor sent a detailed letter to the GP, however, did not communicate with the care home about the details of his medical treatment and reasons to seek further monitoring.

3.8. Thematic analysis of safeguarding alerts across OUH have highlighted the need to improve the clarity of handover and communication to receiving caring agencies from OUH and this includes details of the appropriate contact if there is a concern.

4. Conclusion

4.1. This story illustrates the complex psychological and physical needs of patients who are elderly, and frail suffering from dementia, who are admitted to an acute unfamiliar environment. This includes the need to address the holistic approach to their care for all the multi-disciplinary team, involving and listening to family in determining the best options for managing the situation in the patient's best interests.

5. Next steps

5.1. This story will be used as a teaching tool to improve multidisciplinary staff's understanding of the needs of patients with dementia and the need to improve communication and listen and work with to their families in the provision of appropriate care.

5.2. The patient's story told from his wife's perspective is presented in Appendix 1.

5.3. An action plan is presented in appendix 2.

6. Recommendation

6.1. The Trust Board is asked to note the patient story.

Liz Wright – Acting Chief Nurse

Report prepared by:

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Patient Experience and Involvement Manager

Rob Way

Nurse Consultant, Emergency Department

November 2013

Appendix 1: the story from the patient's wife's perspective.**Arriving at the Emergency Department**

My husband, who has dementia, came in to the ED from the care home at around 8am, with a carer, and my daughter met them there. The carer then left. My husband had had two seizures, and on the second fall he had cut his eyebrow. I arrived after my daughter as I live further away, and my husband was in a cubicle when I arrived.

He was very disturbed, and I know from past experience that when my husband is taken out of the care home doors, he is terrified. Even though he had had a carer with him, it wasn't one of his regular carers and so he probably couldn't reassure my husband. I probably wouldn't have been able to reassure him either, once he gets panicky.

The nurse and my daughter were trying to keep him on the bed, and my daughter was talking to him and trying to keep him calm. He didn't seem to know her, or me, and he didn't even look at us. The environment was very busy, bright and noisy, which contributed to his distress. He was agitated and he didn't want to lie down. He had a cut on his forehead and kept trying to take the dressing off all the time. We were trying to stop him because we didn't know where his hands had been and the wound was still bleeding.

Being listened to

We tried to explain the complexity of my husband's problems to a nurse, for example, they wouldn't be able to do an x-ray without sedating him. He had been in the ED the previous year and the only way they had been able to do an x-ray then was by sedating him. I could have given her the date he was in, so she could have easily accessed all those notes, but it didn't seem that she could vary from the standard routine and she had to go through the process. She also implied that she knew how to talk to people with dementia: that by speaking slowly and clearly, he would be able to understand. He might understand word by word, but he won't absorb and he cannot retain.

We felt that we had information to give which would have been very useful in his treatment, but we were dismissed. There was a lot of waiting around and if she had taken notice of what we had been saying, it could have been avoided. And then he wouldn't have been so stressed by being held down for so long.

My husband being restrained

We explained that my husband was potentially violent and could lash out at anybody (carers, nurses, family members and other residents in the care home), and that he was likely to lash out because he was being restrained. We tried restraining him but the nurse wanted us out of the way. The nurse asked us to leave the cubicle and we sat close by. Within minutes, security had been called.

For more or less the whole of the day, two security people were with my husband in the cubicle. It wasn't explained to us until afterwards that it was in his best interests. When it was explained, we could understand that they were trained to restrain and therefore wouldn't hurt him, whereas potentially, we might have done. Also, we could have been hurt because we are not as strong. Had it been explained at the time, it would have been better, because we weren't out to make a fuss: we just wanted him to be looked after.

Nothing had been done when my husband had a further seizure, he was taken into the resuscitation room and the opportunity was used to scan, catheterise and a drip lead put in. He subsequently pulled out the latter two.

Treatment and arranging discharge

At around lunch time, a nurse or doctor came in and put a steri-strip on the wound (because stitching or stapling would have caused too much trauma). Then he said we were just waiting for the consultant to say we could go home. My husband would need to go back in an ambulance and two teams would be needed because he was so distressed and agitated. There wasn't anyone available at the time, so they said we would just have to wait. We were still waiting at around 4pm, and then he had another seizure.

Investigations

The doctors wanted to find out why my husband was having seizures, and we put forward a theory about the increased medication dosage causing the seizures [the dosage was changed over the weekend before he came to hospital]. The theory was dismissed by the doctor. The nurse at the care home did some research that evening and found it was a possibility (1 in 10,000). Since the dosage has been reduced again, my husband has had no more seizures.

The doctors then talked about transferring my husband to neurology to find out why he was having these seizures. I reminded them there was a Do Not Attempt Resuscitation (DNAR) in place. I couldn't see the point in putting him through the stress of a visit to a ward where he wouldn't understand where he was, which would take a huge amount of resources, for something that probably wasn't a problem.

In the end, we got back to the care home at about 8pm.

Communicating between the emergency department and the care home

No information was sent with my husband from the emergency department to the care home, but we were able to explain what we had been told. It was lucky that we were able to fill the gaps, and that my husband's GP knew him really well, so she communicated with the care home the following day.

If my daughter and I hadn't been articulate, or if we had been unable to remember the information, or unable to understand the medical terms that were used, we might not have been able to pass anything on.

Appendix 2: Action plan

Issue	Action	Progress	Who responsible
<p>Environment: busy, bright and noisy, distressing for someone who can be disorientated.</p>	<p>Work is being undertaken to increase cubicle and seating capacity in the Emergency Assessment Unit (EAU). As part of this project, attention has been paid to making the environment suitable for patients with dementia. The redesign of the environment will include clocks (to help with orientation), colour of walls and flooring, and sound proofing. A dementia expert within the trust is advising on this redesign. If medically appropriate these patients could be moved to this area of EAU for monitoring and care.</p> <p>Similar principles could be applied to the ED, if there was funding available.</p> <p>This project is also considering technological solutions to ensure safety of patients who are likely to wander off the ward, whilst reducing the need to restrict these patients to one area.</p>	<p>Initial phase to be commenced before December 2013, second phase to be commenced in April 2014.</p>	<p>Senior ED Matron, EAU sister and project manager</p>
<p>Improving communication with families and training for clinical staff on caring for patients with dementia</p>	<p>The issues in this story have been discussed with the individual staff involved in this case. They have reflected on how to improve communication in future, specifically with patients with dementia as well as actively involving patients and carers.</p> <p>It can be difficult to involve families in an urgent situation, but this is acknowledged as important by the senior team and actions have been taken or are planned to support</p>	<p>Complete</p> <p>Complete</p>	<p>Nurse Consultant (ED)</p> <p>Nurse Consultant (ED)</p>

Issue	Action	Progress	Who responsible
	<p>more junior staff to actively involve families:</p> <ul style="list-style-type: none"> • The story has been shared with the wider ED staff team through the clinical governance meeting. • This story will be included in the emergency nursing degree-level education programme run through Oxford Brookes University. • Senior staff are to buddy, role model and discuss the issues involved in effectively caring for vulnerable patients with complex needs. • To be discussed at Emergency, Medicine and Therapies directorate Clinical Governance meeting in December 2013. • It is necessary to train the existing staff, both nurses and doctors in the specific communication skills needed for managing people with dementia. A consultant geriatrician will discuss with the psychogeriatrician teams, medical school and ED and the best methods to deliver the training. • Trust-wide learning: patient story to be included in Sisters leadership training, Clinical Support Worker Academy, and preceptorship training for newly qualified staff including nurses and allied health professionals. • A member of the ED nursing team is on the dementia leaders programme. This is a joint programme with Oxford Health and is being delivered by the University of Worcester. The course is training clinicians to be dementia leaders within their workplace. This individual will act as a knowledge resource to aid care planning for these patients. 	<p>November 2013</p> <p>December 2013</p> <p>December 2013</p> <p>At next available teaching sessions: February 2014</p>	<p>Nurse Consultant (ED)</p> <p>Nurse Consultant (ED)</p> <p>Nurse Consultant ED</p> <p>Consultant Geriatrician</p> <p>Non-medical education leads</p>

Issue	Action	Progress	Who responsible
		December 2013 ongoing November 2013 ongoing	Consultant Geriatrician and Dementia Lead
Communication between the Emergency Department and care homes.	<ul style="list-style-type: none"> Letters written by the ED doctors to the GPs are to be copied to care homes/carers. The emergency department now prioritise patients who come in from a care or nursing home and write the discharge summaries in real time. The letter is sent with the patient to the care or nursing home, to enable the care home to understand the medical treatment and nursing care received (as appropriate) and contact details for further concerns. An appropriate member of staff will communicate directly with the care/nursing homes by telephone at the time of discharge and document this action. 	Complete	Nurse Consultant (ED), Consultant medical staff
	<ul style="list-style-type: none"> There are now consultant geriatricians actively working in ED from 1pm-7pm, 7 days a week and on call 24 hours a day. 	November 2013	ED Clinical Director

Issue	Action	Progress	Who responsible
	<ul style="list-style-type: none"> New service for psychological medicine has recently employed three psychogeriatricians also covering 9am-5pm every day. If a consultant is not available to lead on a case with a patient with dementia, ED has the option to contact one of the on call psychogeriatricians. 		
Senior clinical assessment and triage of patients with dementia	<ul style="list-style-type: none"> The triage for patients with complex psychological needs will be undertaken by nurses or medical staff with experience, or adequately supervised by an appropriate member of the team. 	November 2013 ongoing	ED Clinical Director & ED Consultant Nurse.
Improved communication between the hospital departments, care homes and families.	<ul style="list-style-type: none"> 'Knowing me' documentation (a personalised record which provides healthcare professionals with essential information to understand the specific needs a person with dementia) to assist continuity of patient centred care. The patient can keep this document and staff in different care areas will have access to individual personal information to aid consistency of communication. 	December 2013 ongoing	Deputy Chief Nurse.

