

Trust Board Meeting: Wednesday 12 March 2014

TB2014.27

Title	Patient's Story - Urology
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Status	For information
History	Patient stories are regularly presented to Trust Board and Quality Committee.

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

Executive Summary

1. This patient story describes the experience of an inpatient on the Urology Ward at the Churchill Hospital, described from her daughter's perspective.
2. This story highlights a number of key issues.
 - **Leadership:** Inadequate visibility of the ward sister on the ward, an poorly coordinated team and lack of clarity of leadership roles in the ward sister's absence. This contributed to a lack of continuity in nursing care.
 - **Communication, behaviour and attitude:** An unsatisfactory relationship with the patient's family, as a result of insensitive communication. Difficulty for the family in accessing nursing, medical and therapy staff to provide information on their mother's health condition; and perception of unhelpful attitudes of staff on the ward.
 - **Unclear discharge process:** Poor communication with the family and lack of coordination between staff about the patient's discharge plans. The resulting uncertainty about the requirements for a satisfactory discharge plan was compounded by a lack of clarity about whose responsibility it was to ensure that the requirements were met.
 - **Lack of knowledge and understanding:** Staff were unaware of the fact that there was a pre-existing Living Will, or implement the patient's wishes with regard to resuscitation. There was a lack of understanding of the role of a person who has Power of Attorney.
3. This story has been shared with the ward staff and clinical team and is being used to facilitate improvements in care, including working with families, strengthening ward and team leadership, through clinical supervision and team discussion in multidisciplinary meetings.
4. This story will also be shared with the Trust's Discharge Oversight Group, Dementia Steering Group and Compassionate Care Programme to ensure the lessons learned are incorporated into the Trust wide activity. This is to enable improvements in care and the patient and carer experience. It will also support safe, well led and coordinated discharge from hospital, through a patient centred approach in the care for patients with dementia.

Recommendation

The Trust Board is asked to note the patient's story, and the action plan (presented at Appendix 2), to address the issues raised.

Patient Story

1. Introduction

- 1.1. The presentation of this story to the Trust Board has been discussed with the patient's daughter, who has provided consent for her mother's story to be shared.
- 1.2. This is accompanied by a story written by the patient's daughter and son-in-law, in appendix 1.
- 1.3. The patient story is being used and shared with the Medical and Nursing Staff in the Urology Directorate, and was discussed at the directorate's governance meeting in November 2013 with a view to improvements in patient care.
- 1.4. This patient had significant cognitive impairment and was an inpatient on the Urology Ward, Churchill Hospital for five weeks.

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 key issues related to discharge planning, poor communication, poor attitude and leadership, and a lack of patient centred care.

3. Key issues highlighted and actions

The issues highlighted by the story are as follows:

Communication issues and including with family members

- 3.1. The patient's daughter had power of attorney for her mother, but found it difficult to obtain any information from staff about her mother's condition.
- 3.2. The family found it difficult to arrange to see a doctor, and other staff were not able to give the family any information. The patient's daughter observed that the system appeared to "prioritise doctors, not patients or family/primary carer needs", with respect to accessing relevant doctors for information.
- 3.3. The family were not kept informed regarding the scheduling of Occupational Therapy assessments, and the patient's family were concerned that the patient was not able to provide accurate information to contribute to her discharge planning due to her cognitive impairment.
- 3.4. A copy of the letter to the patient's GP was posted to the patient's home address, even though she had cognitive impairment. Medical staff were aware that the patient's daughter had power of attorney, and did not provide a copy of the discharge letter to the daughter's address.

Documentation in the healthcare records

- 3.5. When the patient was admitted to John Warin Ward at a later date, the patient's family were concerned that a note which stated 'resuscitation at all costs', had been placed in their mother's healthcare records. The patient had a 'Do Not Attempt to Resuscitate' (DNAR) Advance decision or 'living will' which

had been confirmed with the Urology Ward team when she was admitted, and this seemed to conflict with the recent directive.

Lack of sensitivity by medical staff

3.6. The patient's daughter had waited to see the consultant for a number of hours, to be told that he had gone home, she then waited to speak to a junior doctor who was covering out of hours. The junior doctor briefly came to see the patient's daughter and son-in-law at 23:30, and told her that her mother's tumour was inoperable and she could go home. This was inappropriate timing and the difficult news was delivered insensitively.

Lack of holistic care

3.7. The focus was on the patient's bladder condition and the patient's daughter felt that her mother's care lacked a holistic personalised approach.

Lack of continuity of care

3.8. The patient's daughter observed that the nursing staffs' working patterns should have been organised to improve the patient's continuity of care, i.e. the same named nurse for patients during their hospital stay.

The patient's cognitive assessment was based on the Abbreviated Mental Test Score (AMTS)

3.9. The patient's daughter described the lack of appreciation by clinical staff, of her mother's short term memory problems and disorientation, because the scores on the AMTS 'were generally good' and not reflective of her mother's cognitive problems. There hadn't been any detailed discussion with the family to understand the patient's wider cognitive difficulties

Poor discharge process

3.10. The individual roles and responsibilities of the multi-disciplinary team, during the discharge process were not clearly identified. At different stages the patient's family were told that discharge arrangements were the responsibility of various different professionals, which led to their confusion regarding the leadership and coordination of her discharge.

3.11. There was a lack of clear information for the family about the available relevant health and social care services and associated funding for their mother.

3.12. The perception of the patient's daughter was that the ward sister was responsible for the planning of her mother's discharge. However, she was unaware who led the team of who was in charge in the ward sister's absence.

Poor attitude of staff

- 3.13. The patient's family felt that staff attitudes changed from "friendly" to "curt formality" after they disagreed with the plan to discharge their mother, immediately following her surgery.
- 3.14. The family's perception was that following this attitude change in staff, their mother was given a reduced level of care towards her discharge.

Poor accessibility of the PALS Team at the Churchill Hospital

- 3.15. There was no PALS officer permanently based on site at the time of this patient's care. This has since been resolved.

Detail of Occupational Therapy documentation

- 3.16. The family requested to view the patient's Occupational Therapy notes, and were given no explanation as to why these could not be shared. The family were told later that these were "a few handwritten notes on [the patient's] file".

4. Key examples of good care:

- 4.1. The assessment and plans in relation to the patient's discharge were commenced within 1-2 days of her admission.
- 4.2. The Chaplain, based in the PALS office at the Churchill Hospital, was very helpful and supportive to the patient's family.
- 4.3. One doctor was described as "empathetic and informative", despite not being responsible for this particular patient's care.
- 4.4. The doctor on John Warin Ward asked to see the family, the physiotherapist gave daily mobility treatment and guidance for on-going exercises, which was a positive experience for the family and noticeably better organisation, than the experience their mother had while a patient on the Urology ward.

5. Conclusion

- 5.1. This story highlights a number of key issues. The matron provides her perspective as to the reasons for the patient and her family's poor experience on the Urology Ward, below:
- 5.2. **Leadership:** Inadequate visibility of the ward sister on the ward, an poorly coordinated team and lack of clarity of leadership roles in the ward sister's absence. This contributed to a lack of continuity in nursing care.
- 5.3. **Communication, behaviour and attitude:** An unsatisfactory relationship with the patient's family, as a result of insensitive communication. Difficulty for the family in accessing nursing, medical and therapy staff to provide information on their mother's health condition; and perception of unhelpful attitudes of staff on the ward.
- 5.4. **Unclear discharge process:** Poor communication with the family and lack of coordination between staff about the patient's discharge plans. The resulting uncertainty about the requirements for a satisfactory discharge plan was

compounded by a lack of clarity about whose responsibility it was to ensure that the requirements were met.

- 5.5. **Lack of knowledge and understanding:** Staff were unaware of the fact that there was a pre-existing Living Will, or implement the patient's wishes with regard to resuscitation. There was a lack of understanding of the role of a person who has Power of Attorney.

6. **Next steps**

- 6.1. An action plan is presented in Appendix 2
- 6.2. This story will be used to facilitate improvements in care, in working with families, strengthen team leadership, and facilitate learning through clinical supervision, and team discussion in multidisciplinary meetings.
- 6.3. This story will be shared with the Trust's Discharge Oversight Group to ensure that the lessons learnt are incorporated into the Trust wide activity to improve the patient and carer experience surrounding safe, well led and coordinated discharge from hospital.

Liz Wright
Acting Chief Nurse

Report prepared by:

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Urology Matron

March 2014

Patient Story from the daughter's perspective

My 93-year-old lady (M) spent five weeks (8 April – 14 May 2013) in the Urology Ward at the Churchill, having been transferred there from A&E, where she was brought by ambulance following a fall.

We were in the process of taking her to a pre-op Urology Outpatients appointment.

On arrival in A&E, there was no serious damage from the fall, however she was bleeding heavily due to her bladder tumour, and had severe kidney impairment. (She had been seen the previous day by an out-of-hours doctor, who prescribed antibiotics.)

She had a (planned) operation to investigate the bladder tumour on 12 April.

The tumour was inoperable; palliative care was agreed.

The discharge process was opaque and confused; it was unclear who was responsible. The family did not agree with the OT Technician's view that M should be discharged home. In the absence of any action, co-ordination, or clear advice from staff, the family decided to look for a suitable nursing home, as it was clear to them (and to M) that she could no longer live independently, even if a full 24-hour care package was put in place.

M was transferred to XXX Residential and Nursing Home on 14 May as a self-funder.

By this time a previously agile and active 93-year-old, albeit one prone to falls and with orientation problems/no short-term memory, was immobile due to very swollen legs, and had a suspected cellulitis infection.

She had to be re-admitted for emergency Intra venous antibiotics for severe cellulitis on 19 May (John Warin Ward).

The out-of-hours Emergency Practitioner who arranged this admission told us that this should be picked up as a 'failed discharge'.

She returned to the nursing home on 24 May, by now confined to a wheelchair. She declined rapidly, and died on 18 June.

A fuller chronology of her stay in hospital in relation to discharge is given as an Appendix.

We have many concerns arising from this distressing experience, which we would like brought to the attention of the Chief Executive and Board:

- **It was incredibly difficult throughout to get to see a doctor, despite visiting the ward daily.**

We were advised on various occasions that if we wanted to see a doctor we should come in for the ward round at 8am; once waited 3 hours until the doctor reached M; once told to come at 9am, to find they'd already been at 8.30am; once waited 3 hours and ward round did not happen at all. Nurses unable to tell us what had taken place during round, who had seen M, what they had said. M unable to tell us.

Prior to the operation I was told by three different nursing staff that if we came in at 7pm (mother was last on the list late pm) on 12 April, the doctor performing the

operation would come and discuss results. (In fact, never met this – or any other - consultant. M appeared to be under three different consultants during her stay.)

During that evening, we kept being told someone would come very soon; at 10.30pm (we had not eaten and no food was available), we were then informed the surgeon had gone home. The nurse had his scribbled notes on file from the operation, but was unable to tell us what they said as had to be told by a doctor; she refused to let us see the notes unless there was consent from the Legal Office at the JR, despite us having Power of Attorney. Very angry. House officer on night duty, busy on another floor, eventually agreed, exceptionally, to telephone us during the night, or we could wait another hour for him to possibly be available. We saw him very briefly around 11.30pm. He said "Huge tumour, unable to remove; she can go home tomorrow."

- **Poor communication**

Systems prioritise doctors', not patients' or family/primary carer needs; in particular, methods of communicating information (in both directions) do not take account of very elderly patients with confusion/dementia (many undiagnosed) where all significant communication about illness/treatment/discharge planning **MUST** be with the family/next of kin/primary carer, as well as or, where appropriate, instead of, with the patient. There must be recognition that family/carers also have important jobs and commitments, and unlike the patient, cannot necessarily hang around for an indefinite number of hours chasing important information.

A process did not appear to be in place to ensure that information about cognitive impairment is passed to all incoming staff at handover, including support staff - crucial with constant shift changes and agency staff. It should not be up to family to keep briefing anyone new on a daily basis.

- **Medical priorities**

The ward staff seemed only to be interested in my mother's bladder, not the whole person, and most appeared to lose interest in her once the operation was over.

- **Constantly changing ward staff add to the confusion of elderly patients,**

Why allocate a nurse to one 'end' of the ward one day and the other 'end' the next, with a totally different group of patients?

- **Caring for older people: over-reliance on a standard memory test**

My mother was articulate and plausible; had 'passed' many tests with flying colours as overall her score was invariably good, despite orientation problems and no short-term memory, so she was not diagnosed with dementia. Yet she could not manage medications, forgot she had had severe pain five minutes earlier; did not know what she had eaten or drunk or when; so, importantly, she could not be relied on to describe symptoms or pain, had no idea what doctors might have said to her on a ward round or who indeed was a doctor. 'Did I have an operation? Oh I didn't know, what was it for?'

- **The discharge process – what process?**

It was not clear who was responsible for co-ordinating the process, for making decisions, advising the family/patient on options and funding arrangements. Various told the Ward Sister was responsible (she was away on leave for first two weeks), the Staff Nurse (constantly changing), the OT Technician (who disappeared), a social worker (called in at a late stage) – no-one could give us a straight answer. A lead person should be identified and make it their business to meet, advise and keep the family informed, and to progress the discharge.

- **Poor attitudes**

After we expressed concerns to a member of the PALS staff, and a colleague from the Age UK Health and Social Care Panel intervened via senior nursing managers in an effort to help clarify the discharge process, the Ward Sister appeared reluctant to speak to us further. We found it incredible that her office was (a) outside the ward; (b) had the window blocked so that people walking past couldn't see if she was there or not. It seemed that, once we had disagreed about my mother's ability to go home immediately following the operation, the attitude of the nursing staff changed, from friendliness to curt formality. We were clearly a nuisance. Relatives/primary carers deserve to be treated with respect, to have their concerns addressed in a mature and non-defensive manner, to receive the normal courtesies of being kept informed without having to constantly chase, and might even be given the occasional apology when appropriate.

- **Funding: a minefield**

Who is entitled to what and who is responsible for telling you? We were told more than once that M was entitled to some on-going funding (NHS Continuing Care). Instead, her last five weeks of terminal illness in a nursing home cost her £4,500. Should families have to try to negotiate through the complexities of funding when they are already going through a stressful time? Despite her rights, spending our time supporting M was our priority, so we gave up.

- **Accessibility of PALS**

PALS were only available by telephone at the Churchill. The office was apparently not staffed, despite a notice on the door giving times of opening. The Chaplain who shared the office was happily very helpful. (A social worker was also difficult to access and their role unclear).

APPENDIX: Summary of M's stay in hospital, with particular reference to the discharge process

Admitted to A&E following fall; already known to have bladder tumour and had been about to leave home for pre-op assessment in Urology Outpatients; no damage from fall, but had bleeding due to tumour and severe kidney impairment; transferred to Urology Ward at Churchill to await pre-planned op.

M visited by OT (Technician) as part of discharge planning. Family were not notified or invited but happened to turn up before end of interview. Though physically active and mobile, albeit prone latterly to falls, M was confused and had no short-term memory; e.g. she informed the OT technician that she lived in a care home, so discharge home immediately after the operation was suggested as appropriate. In fact she did not live in a care home, but sheltered accommodation where any care above current two hours per week for cleaning and bathing would have to be bought in. We were informed that she would not qualify for transfer to a community hospital as she was mobile (but see below). Not informed of other options, e.g. later heard of interim care beds.

Operation to investigate and remove tumour if possible, carried out; SHO informs us (11.30pm) "Tumour huge, can't be removed; she can go home tomorrow."

M continuing to bleed and has a catheter; has to be assisted to toilet. Terrified of being sent home. Confused about what operation was for, or whether she'd had one.

Family start looking for nursing homes, in case necessary.

Spoke to Occupational Therapist (OT) on telephone re concerns about sending M home; she said too early to dismiss idea; we told her M would require overnight care as part of extensive care package if to be discharged home, given history of night falls, catheter, increasing immobility etc.

First visit from a physiotherapist (treatment patchy and petered out altogether in last couple of weeks on ward, despite worsening mobility).

Copy of letter to GP outlining technical details of operation sent to M's home address (family found letter two weeks' later).

Pre-arranged meeting we'd requested with Registrar, although he was not been present at her operation: general discussion; unable to advise on discharge, suggested we should discuss with Sister, Occupational Therapist and nurse, including NHS Continuing Care. He agreed M needed care 24/7.

Discussed discharge process with on-duty Staff Nurse; she agreed we seemed in limbo re discharge. However, said file now recorded M was medically unfit for discharge. Suggested we now leave it until the ward sister was back from leave in 4 days.

Nurse told us that M's file recorded that OT was investigating the possibility of night-care at home. Family continued to be concerned that OT(T) not taking account of age, cognitive impairment, increased immobility, terminal nature of illness.

Spoke to PALS; asked for advice on discharge planning and expressed our concerns about process and who was managing ward in absence of Sister. She would contact Sister on return from leave.

Helpful discussion with Sister: she promised to set up a meeting same week with Physiotherapy, OT and Social Services (NB. No meeting ever took place; OT reported following week as variously as 'on leave', 'working part-time', or 'off sick').

OT rang; had changed her mind – an intermediate care bed in a nominated nursing home was now the right route. Family stressed we would not wish to move M twice due to confusion/frailty. OT confirmed there would be six weeks' paid care. Unable to clarify if we could place M in a nursing home of our choice (albeit as it happened one with intermediate care beds); we said we would pay a top-up if necessary.

Meeting, pressed for by us, to discuss biopsy results. House Officer (Senior House Officer?) informed us M has cancer (!!); joined by passing Registrar who was able to explain implications of biopsy results; he instigated referral to palliative care team at Sobell House. Her Prognosis seemed uncertain but months rather than weeks. Dr B deserves special mention for his empathetic and informative approach on two occasions, despite not being in the team responsible for M.

Duty Staff Nurse decided to refer M to the Social Worker. We assumed this meant M was now ready for discharge.

Telephone call from Social Worker; said if intermediate care bed was recommended, it was up to the ward staff to progress discharge. She would check with ward.

Asked OT to contact me as had heard nothing since telecom 9 days previously. I requested a copy of the full OT assessment (not provided – later told it consisted of a few handwritten notes on M's file). Informed her that as no action or advice from staff, family had looked at nursing homes and selected one to come and assess M. Not able to come until 8 May. Asked again about intermediate care bed and funding but no answers. There was no further contact from/with OT. Felt M being given minimal care.

Spoke to the Social Worker. Told 'assessment bed' might only be paid for two weeks not six, with implication that not worth pursuing. She pointed to some other possible nursing homes we could look at as self-funders.

Assessed and accepted by XXX Residential and Nursing Home manager; M has forgotten tumour; thinks in hospital due to swollen legs (lymphoedema never confirmed).

Possible cellulitis infection mentioned. Discharged to XXX Residential and Nursing Home.

Social worker wrote to say that her involvement was now closed.

Out-of-hours 111 service called due to severely swollen suppurating legs; antibiotics prescribed with call-back requested next day if no improvement.

Re-admitted direct to John Warin Ward; Emergency Practitioner remarks that this constitutes a 'failed discharge'. Treatment of patient and family in the John Warin Ward was noticeably better: the doctors actually asked to see us; a physiotherapist gave daily

mobility treatment and guidance on a continuing regime. Registrar told us the wards differed because 'we are physicians and they are surgeons'!

M's file transferred from Urology to John Warin; the doctor queried the top document on this file which stated 'resuscitation at all costs'. My mother had a living will (handed to the Urology Ward staff on admission) requesting 'do not resuscitate', a wish confirmed at pre-op stage. Family extremely concerned about this basic error.

Intravenous antibiotics effective; infection gone and swelling reduced; M still confined to wheel chair despite physiotherapist. Discharged and returned to XXX Residential and Nursing Home.

M declined quickly; renewed bleeding and increasingly immobile over last two weeks. From today unable to swallow.

Sobell-based palliative care nurse visits and advises on pain relief; agreed not necessary to transfer to Sobell; Home and District Nurses provided excellent terminal care.

M died.

Written by the daughter and son-in-law of the patient

<ul style="list-style-type: none"> Letter sent to patient's home address. 	<p>details.</p> <ul style="list-style-type: none"> This will be addressed in the planned improvement of patients discharge home from the Urology Ward. 	To be completed by March 2014	Urology Consultant and Acting Ward Sister
Accuracy of resuscitation documentation.	<ul style="list-style-type: none"> No record of inaccuracy in notes of Do Not Attempt Resuscitation form. 	The 'Do Not Attempt Resuscitation' forms are present in patient notes and handed over. These are in agreement with the patient and next of kin.	Urology Consultant
Lack of sensitivity of medical staff.	<ul style="list-style-type: none"> Feedback to the Urological surgical team in December 2013 	Completed.	Urology Consultant
Lack of holistic care.	<ul style="list-style-type: none"> This patient story will be discussed with the Urological consultants, as this issue has previously been raised for Uro-Oncology patients. The Clinical Lead will be reviewing the patient pathway to improve patients' experience, with the Oncology Team, with involvement from the Therapies Service. 	<p>MS to arrange a meeting with Consultant Clinical Oncologist</p> <p>To be discussed again at next Urology Consultant meeting 31.01.2014</p>	<p>Urology Consultant</p> <p>Matron</p>
Continuity of care.	<ul style="list-style-type: none"> The management for the ward is now being led by a different staff member, who has reviewed and implemented a new system for allocation of staff, which has improved continuity of care for patients. Acuity and Dependency monitoring has increased staffing numbers, which will facilitate greater continuity with the allocation of permanent staff and 	<p>Complete</p> <p>December 2013 complete</p>	<p>Acting Ward Sister</p> <p>Acting Ward Sister</p>

	<p>agency staff. Urology ward has large numbers of admissions and discharges: 30%-40% turnover per day.</p> <ul style="list-style-type: none"> Therapies will maintain a single named clinician or non-qualified assistant to manage the patient. 	Complete	
Assumptions about cognitive impairment were based on the Abbreviated Mental Test Score (AMTS).	<ul style="list-style-type: none"> Urology Consultant to review with The Trusts Dementia Clinical Lead Nursing staff to consider referrals to the OTs for in-depth cognitive screening as this is an area of their specialist expertise. 	February 2014	Urology Consultant and Trusts Dementia Clinical Lead
<p>Poor discharge process.</p> <ul style="list-style-type: none"> Roles and responsibilities were not clear. 	<ul style="list-style-type: none"> Some of the ward staff were unclear of discharge process when patients required community support at home. Training and information updates were delivered for staff during October and November 2013 Discharge coordinator to provide some updates/ teaching for the ward staff. A ward coordinator on both the early and late shifts will coordinate the discharge plans for patients. Therapies service and social services to attend ward for a 15 minute board round twice per week prior to the surgical ward round. Therapies service will provide training on the discharge process and the role of OT to the medical and nursing team on Urology Posters about the OT Service will be 	<p>Complete</p> <p>December 2013</p> <p>To be Implemented once budgets set in April 2014 (with increased staffing and new staff recruited).</p> <p>April 2014</p> <p>March/April 2014</p>	<p>Discharge Liaison Nurse</p> <p>Discharge Liaison Nurse</p> <p>Acting ward sister OT Professional Lead</p>

<ul style="list-style-type: none"> Unclear information about next steps. Accessibility of senior nursing staff. 	<p>provided for both staff and patients. The posters will include contact details.</p> <ul style="list-style-type: none"> Patients will be given a contact sheet with their named therapist on and their contact details. Update ward staff on the discharge process for patients who require community support at home. Implement nurse-led discharge on the ward. The ward sister is currently on maternity leave. An acting ward sister is in post who works alongside the team on a daily basis between Monday to Friday and deputy works out of hours. The change of ward sister has addressed the leadership issues identified by the patients and has clarified the need for the ward sister to be present on the ward. 	<p>March 2014</p> <p>March 2014 Discharge coordinator on CH site, to commence weekly meetings every Thursday for those patients with delays in discharge.</p> <p>The criteria for nurse led discharge has been identified. Ratified by all consultants at the Urology Team meeting in January 2014.</p> <p>Complete</p>	<p>Discharge Liaison Nurse and Acting ward sister</p> <p>Acting ward sister, Matron and Urology Consultant</p> <p>Matron</p>
<p>Attitude of staff.</p> <ul style="list-style-type: none"> The patient's family felt that attitudes changed from 	<ul style="list-style-type: none"> This was discussed at a ward meeting, staff felt that patients whose discharge or transfer of care became delayed 	<p>Complete</p>	<p>Acting ward sister, Matron</p>

<p>“friendly” to “curt formality” after they disagreed that the patient could be discharged immediately following the operation.</p> <ul style="list-style-type: none"> • Towards the end the family’s perception was that the patient was being given minimal care. <p>Accessibility of PALS at the Churchill.</p>	<p>(DTOCs) were possibly ‘perceived’ by staff as different. Staff thought that it was possible that more junior nurses were allocated to the patient once the urological issue was resolved. This was so the more experienced nurses could care for the more complex patients still requiring specialised urological care/ management.</p> <ul style="list-style-type: none"> • All patients are overseen by an experience urological nurse to ensure that less experienced nurses are supported and patients long term management is coordinated by senior staff. • It has been reemphasised with staff that it is vital for patient safety and continuity of care that the permanent ward nurses coordinate patients’ care, despite acuity and dependency changing on patients over time. This enables the development of good working relationships with patients and their families. • A member of the PALS team is available on the Churchill site 5 days per week 	<p>Complete</p> <p>Complete</p> <p>Complete</p>	<p>and Urology Consultant</p> <p>Acting Ward sister</p> <p>Safeguarding and Patient Services Manager</p>
<p>Detail of Occupational Therapy documentation.</p>	<ul style="list-style-type: none"> • Since November 2012, therapy documentation (OT and Physiotherapy) has been recorded on the EPR system. • The Therapy staff record entries within the main clinical notes to direct their 	<p>Complete</p> <p>March 2014</p>	<p>Matron</p>

	<p>colleagues to these electronic notes.</p> <ul style="list-style-type: none">• These notes are kept in according to the HCPC and COT Standards.• Audits are conducted by the Therapy Service to ensure compliance. Matron to review this with the ward OTs	In progress	
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